IN AND BEFORE THE OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
STATE OF OKLAHOMA

FILED

MAY 28 2013

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA *ex rel.* The Oklahoma Board of Medical Licensure and Supervision,

Plaintiff,

vs.

STEVEN CONSTANTINE ANAGNOST, M.D., License No. 21194,

Defendant.

Case No. 09-10-3861

PLAINTIFF STATE OF OKLAHOMA'S MOTION FOR PROTECTIVE ORDER TO PREVENT WITNESS HARASSMENT, INTIMIDATION, AND FALSE ACCUSATIONS BY COUNSEL FOR DEFENDANT STEVEN ANAGNOST, M.D. AND MEMORANDUM BRIEF IN SUPPORT

COMES NOW Plaintiff, State of Oklahoma *ex rel.* The Oklahoma Board of Medical Licensure and Supervision, by and through its attorney of record, Daniel B. Graves of the firm GRAVES MCLAIN PLLC, and pursuant to OAC 435:3-3-9 and 12 O.S. §3226, moves this Court for a protective order to prevent counsel for Steven Anagnost, M.D. ("Dr. Anagnost") from harassing, intimidating, annoying, and oppressing physician witnesses for the State of Oklahoma with irrelevant and unfounded accusations of fraud. Herein, the State accuses Dr. Anagnost of surgical incompetence resulting in grievous injuries to patients and creating fraudulent operative reports. Many of those operative reports caused Medicare and Medicaid to be defrauded by: 1) Dr. Anagnost's omission of OSU surgical residents from operative reports so that his practice's billing department would charge the agencies for physician's assistants ("PA's") in surgery; and 2) Dr. Anagnost adding PA's to operative notes that were not documented as present for surgery, causing wrongful charges to Medicare and Medicaid.

Dr. Anagnost's counsel, in an attempt to deflect attention from his client's fraud, falsely accused one of the State's witnesses, neurosurgeon Frank Tomecek, M.D., of Medicare fraud. Dr. Anagnost's counsel's "proof" was an *alleged* coding error, which did not exist, on a patient bill. The bill itself was not created by Dr. Tomecek, but by a clinical coding contractor interpreting Dr. Tomecek's *accurate* operative report. Dr. Anagnost's counsel's accusations were reckless, intended to harass, oppress, and intimidate Dr. Tomecek.

Dr. Anagnost has now asked for the continuation of Dr. Tomecek's deposition, and the depositions of all neurosurgical partners of Dr. Tomecek. *See Ex. A, 05-14-2013 Vaughn ltr.* Without intervention by this Tribunal, Dr. Anagnost's counsel will make further false and reckless accusations in order to intimidate, harass, and dissuade those witnesses from testifying for the State. This Tribunal should not allow this to occur. A protective order should be entered: 1) prohibiting Dr. Anagnost's counsel from questioning physician witnesses about their bills to patients; 2) prohibiting Dr. Anagnost's counsel from accusing physician witnesses of billing fraud; and 3) prohibiting Dr. Anagnost's counsel from asking improper hypothetical questions, without a foundation, in order to accuse them of fraud.

The undersigned counsel for the State has discussed this matter in good faith with counsel for Dr. Anagnost. Dr. Anagnost's counsel have specifically stated their intent to continue in this line of questioning with other witnesses. This dispute cannot be resolved without the intervention of this Tribunal.

WHEREFORE, the State of Oklahoma prays for a protective order as aforesaid, for attorneys fees and costs relating to this motion, and for all other proper relief.

BACKGROUND FACTS

Dr. Anagnost is accused, *inter alia,* of surgical incompetence causing the death, paralysis, and neurological injury to surgical patients. He is the subject of more than thirty (30) malpractice cases, has settled six (6) of them, and has failed to report settlements to the Board on his renewal applications. He has been able to avoid discovery of his settlements through the National Practitioner's Data Bank ("NPDB") because he private-paid Plaintiffs and then did not report the settlements to the NPDB.

Multiple neurosurgeons in the Tulsa medical community have accused Dr. Anagnost of incompetence and fraudulent surgeries. His former employer, The Orthopedic Center ("TOC"), was forced to pay back tens of thousands of dollars in Medicare and Medicaid payments wrongly collected due to Dr. Anagnost documenting the presence of a PA in operative reports – whether one was present or not – while leaving off the surgical resident assisting in the procedure. These repeated omissions caused TOC to wrongly bill both agencies for the PA, in violation of the rules. The latter incident gave rise to one of the Board's many claims against Dr. Anagnost for fraud.

There exists extensive documentation of Dr. Anagnost omitting OSU surgical residents from operative reports who were present, while documenting the presence of PA's. In some instances, he actually documents a PA as an assistant when *only a surgical resident* is present according to the nurse's intraoperative form. For example, in the case of patient DLM, the Operative Report and the Intraoperative Report read, as follows:

Hillcrest
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: 04/18/2005 13:30:57
TRANS: 04/19/2005 14:06:19

OPERATIVE REPORT

U/R: 0001079165

PATIENT: L D

BILLING NO: 0509800257

ROOM:

DATE OF PROCEDURE: 04/18/2005

SURGEON(S): STEVEN C. ANAGNOST, M.D.

ASSISTANT: IAN GUNYEA, P.A.-C.

PREOPERATIVE DIAGNOSES:
1. Lumbar herniated nucleus pulposus with severe central canal and foraminal stenosis, radiculopathy L4-5.

See Ex. B, Medicare Ex., OMLB 0878 and *0882.* As shown above, Dr. Anagnost shows Ian Gunyea, PA as "Assistant" on Patient DLM's Operative Report [left]. However, the nursing intraoperative report [right] shows "Weicherodt, D.O." present, and *no PA present at all.* Because the TOC clinical coder correctly relies upon Dr. Anagnost's Operative Report, it wrongly billed Medicare for Ian Gunyea, PA. In the case of Patient APM the records show, as follows:

Hillcrest
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: 04/20/2005 12:56:50
TRANS: 04/21/2005 12:44:51

OPERATIVE REPORT

U/R: 0001078850

PATIENT: F A

BILLING NO: 0509500296

ROOM: AMAU

DATE OF PROCEDURE: 04/20/2005

SURGEON(S): STEVEN C. ANAGNOST, M.D.

ASSISTANT: IAN GUNYEA, P.A.-C.

PREOPERATIVE DIAGNOSES:
1. Lumbar nonunion, L4-L5.

See Ex. B, Medicare Ex., OMLB 0892 and *00897.* As shown above, Dr. Anagnost again shows Ian Gunyea, PA as "Assistant" on Patient APM's Operative Report. However, the nursing intraopeartive report shows surgical resident "Weichrodt, D.O." present, as well as Ian Gunyea, PA. If Dr. Anagnost had disclosed Dr. Weicherodt's presence on his Operative Note, TOC could not, and would not, bill for Ian Gunyea – reducing Dr. Anagnost's profit on the operation.

Dr. Anagnost's pattern of surgical resident omissions continued from 2005 until discovered by TOC's office manager in 2006. The Board's investigation has revealed twenty-three (23) Medicare-funded omissions of surgical residents by Dr. Anagnost – with four (4) of

these involving *only a surgical resident* in the intraoperative report when Dr. Anagnost claimed PA was present in surgery. *See Ex. B, Medicare Ex.* Further, the Board's investigation has revealed ten (10) Medicaid-funded omissions by Dr. Anagnost – with three (3) of these involving *only a surgical resident* in the intraoperative report when Dr. Anagnost documented a PA on his operative report. In connection with this conduct, the State of Oklahoma has brought an additional fraud claim against Dr. Anagnost.

On November 9, 2012, Dr. Anagnost's counsel took Frank Tomecek, M.D.'s deposition. Dr. Tomecek is a highly respected Tulsa neurosurgeon who has been the subsequent treating physician for some of Dr. Anagnost's patients. Dr. Tomecek is a witness for the State and the State anticipates that he will testify that Dr. Anagnost claimed to do surgical procedures in operative reports when no such procedures were performed. During Dr. Tomecek's deposition, Dr. Anagnost's counsel, Barry Smith, questioned Dr. Tomecek about his knowledge of third-party contractor's coding and billing, as follows:

> Q. Are you familiar with coding and billing, how that works?
> A. Vaguely. ***I certainly don't code my own procedures. We have outsourced coding.*** I simply ***document what I do in the operative report.*** And a coder, who is outsourced, and I don't even know the name of the coding company we use off the top of my head, basically codes the charges from what is dictated on the operative report.

See Ex. C, Tomecek Dep., 113:24 – 114:6. Dr. Tomecek's method of billing is standard. A contracted certified clinical coder analyzes operative notes and then converts the described procedures into ICD-9 codes for purposes of generating bills to Medicare, Medicaid, or private insurers. Surgeons are not involved in these processes. Rather, the surgeon's job in billing is to create an *accurate operative report* upon which the clinical coder relies.

After Mr. Smith established that Dr. Tomecek did not know anything about the clinical coding, Mr. Smith then set out to accuse Dr. Tomecek of fraud based upon what *Mr. Smith* believed to be coding errors by a third-party contractor interpreting Dr. Tomecek's *accurate* operative reports. Mr. Smith aggressively inquired of Dr. Tomecek, as follows:

> Q. If the bill reflects that you billed for six levels, that would not be right, ***would it?***
> A. I don't know. What I did was bilateral laminotomies L2, L3 and L4. So if you're counting sides, I billed for six. But if you're counting levels I billed for three. I hope. I mean, that's what I documented I did. I worked at L2-3, L3-4, and L4-5. That's three levels. You asked me how many sides. Well, it's six, because I worked both sides at each level.
> Q. If you billed for eight sides, that would be over-billing, ***wouldn't it?***
> MR. GRAVES: Object to the form.
> A. I don't know. I don't know how I could have billed for eight sides based on what I dictated. I didn't do the billing, you know.
> Q. Well, you're responsible for the billing, ***aren't you?***
> A. If I reviewed every bill that was generated by me, I'd never stop reviewing bills. So I don't know how it was billed. But basically, this is what I dictated what I did. ***I had nothing to do with the formation of the bill after my dictation.***
> Q. ***"Yes" or "no": Do you agree that you are responsible ultimately for a bill?***
> A. I guess I am, yes. [Emphasis supplied]

See Ex. C, Tomecek, MD Dep., 115:4 – 116:3. This irrelevant badgering, intimidation, and hypothetical questioning about a third-party billing contractors practices persists for page after page of the transcript. *See Ex. C, Tomecek, MD Dep.*, 113:23 – 122:25. Ultimately it culminated in another hypothetical scenario wherein Mr. Smith accused Dr. Tomecek of fraud, as follows:

> Q. Well, correct. But ***assuming*** that you billed for more levels than you said you did on the record, then that would be an over-billing, wouldn't it?
> MR. GRAVES: Object to the form.
> A. If that's what, if that's what the case is, it would be. If that the way it was billed, it would be. ***I don't have any idea want any of these forms say.***
> Q. Correct. ***If it were the case,*** do you think that's ***fraudulent?***

> MR. GRAVES: Object to the form.
> A. By definition, I would say it would be.
> Q. ***If it happened*** in two of three cases we have, would you say that that demonstrates a pattern?
> A. I don't know. I guess.
> Q. ***Have you heard of*** the concept of bundling or unbundling charges?
> A. I have. But again, I don't know where in the hell we're going here. But I don't know anything about this stuff, Barry. I'm a surgeon. I do these procedures. And I expect them to be billed appropriately. I do not bill for things I don't do, that I'm aware of. If I am, it's totally out of my knowledge.

See Ex. C, Tomecek, MD, Dep. 122:3-25. This pointless badgering should not be allowed. Dr. Tomecek's counsel, Kathryn Burnett of Conner & Winters, terminated the deposition after Mr. Smith started in on another set of hypotheticals.

Notwithstanding the seriousness of counsel's accusations, there was *no good faith basis for any of Dr. Anagnost's counsel's questions.* This "double billing" did not exist. The bills were accurate because the surgeon and the first assistant bill for each level. Suzanne Quinton, a certified medical and surgical coder, reviewed the bills and found they were proper. *See Ex. D, Quinton Affidavit.* Regardless, there is no connection between a billing coder's errors on an *accurate* operative report, and Dr. Anagnost's fraud in adding PA's that were not present to his operative reports; and omitting surgical residents that were present to cause intentional overbilling of Medicare and Medicaid.

Dr. Anagnost's counsel turned his reckless and unfounded accusations into public defamation of Dr. Tomecek. He and his firm intentionally misrepresented Dr. Tomecek's testimony, cited above, to the Oklahoma Supreme Court. In direct violation of 12 O.S. §2011, Mr. Smith, *et al.,* signed off on the following language from their *Application for Original Jurisdiction:*

> 121. To date, only one deposition has been taken in preparation for the Board's hearing of the allegations against Dr. Anagnost. On November 9, 2012, Dr. Anagnost began deposing Dr. Tomecek, one of the subsequent treating physicians for some of Dr. Anagnost's patients at issue. Even then, Dr. Tomecek's counsel stopped the deposition, following speaking objections by the Board's counsel, after Dr. Tomecek admitted to fraudulent medical billing for his subsequent treatment of Dr. Anagnost's patients. The Board's counsel objected based on relevance, and yet fraudulent medical billing is the very claim Dr. Tomecek and the Board have made against Dr. Anagnost.

See Ex. E, 11-15-2012 Okl.S.Ct. App. Dr. Tomecek never admitted to fraudulent billing. *See Ex. C, Tomecek, MD Dep.,* 113:23 – 122:25. Further, there was nothing relevant in Mr. Smith's questions, as he represented to the Justices. His client's fraudulent *operative reports* are not related to *alleged* errors by clinical coders showing up in medical billing.

Mr. Smith has never corrected these outrageous misrepresentations to the Justices. Further, these defamatory statements have infected other cases. Within the last week, Dr. Tomecek was questioned about "admitting to fraud" in an unrelated civil matter in which Dr. Tomecek was a subsequent treating physician.

Dr. Anagnost has now requested another deposition of Dr. Tomecek, and is requesting depositions of all neurosurgeons in Dr. Tomecek's practice. Dr. Tomecek, and other witnesses should not be intimidated and harassed with these irrelevant, unfounded, accusations – and the public defamation and distortion of the record that will inevitably follow. The bills and billing practices of physicians other than Dr. Anagnost are not relevant to these proceedings. An appropriate protective order should be entered preventing such questions.

MEMORANDUM BRIEF

The subject matter of this case is Dr. Anagnost's incompetence and fraud – not the accuracy of clinical coders for non-party witnesses. Whether Dr. Anagnost believes that

accusing others of fraud makes him less culpable, or that his accusations will frighten witnesses expected to testify against him, this discovery exceeds the permissible scope. Litigants are only entitled to discovery of "any matter, not privileged, which is ***relevant to the subject matter*** involved in the pending action...if the information sought appear ***reasonably calculated to lead to the discovery of admissible evidence.***" *See* 12 O.S. §3226(B)(1)(a). Dr. Anagnost has no claim or defense in this matter which relates to diagnostic coding by Dr. Tomecek's, or any other physician's third-party clinical coder. Further, Dr. Anagnost's fraud arises from misrepresentations in *operative reports* – not hypothetical coding errors by third-party contractors interpreting operative reports. There is no good faith basis, and no relevant inquiry, which would allow Dr. Anagnost's counsel to accuse the State's physician witnesses of fraud. Inquiries into third-party physician billing are irrelevant, immaterial, and not within the confines of the Discovery Code.

The Discovery Code provides a remedy to prevent the type of abusive conduct practiced by Dr. Anagnost's counsel, as follows:

> Upon motion by a party...the court in which the action is pending...may enter ***any order which justice requires*** to protect a party or person from ***annoyance, harassment, embarrassment, oppression or undue delay, burden or expense,*** including one or more of the following: a. ***that the discovery not be had...***d. that certain matters ***not be inquired into,*** or that ***the scope of the disclosure or discovery be limited to certain matters...***[Emphasis supplied]

See 12 O.S. §3226. Dr. Anagnost's counsel's questions are irrelevant, false, made in bad faith, are intended to harass, intimidate, oppress, annoy, defame, and embarrass the State's witnesses. Compounding the problems created by counsel's tactics is the publicity arising from this case. The transcripts generated are public and likely to be published by the media. After only one deposition, Dr. Anagnost's counsel has distorted and misrepresented the record to the Oklahoma

Supreme Court. These misrepresentations were picked up by attorneys in unrelated civil matters.

Further abusive discovery should be prevented. A protective order should be entered: 1) prohibiting Dr. Anagnost's counsel from questioning physician witnesses about their bills to patients; 2) prohibiting Dr. Anagnost's counsel from accusing physician witnesses of billing fraud; and 3) prohibiting Dr. Anagnost from asking improper hypothetical questions, without a foundation, in order to accuse them of fraud.

Respectfully submitted,

By: ________________________

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Attorneys for Petitioner, State of Oklahoma

CERTIFICATE OF MAILING

This is to certify that on this 28th day of May, 2013, a true and correct copy of the above and foregoing writing was sent *via* U.S. Mail to the following by depositing the same with the proper U.S. Postal Service, postage prepaid:

Barry L. Smith, Esq.
Christina M. Vaughn, Esq.
MCAFEE & TAFT
1717 S. Boulder Ave., Ste. 900
Tulsa, OK 74119

____
Daniel B. Graves

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May 14, 2013

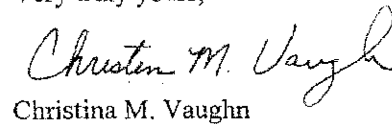
Teresa Meinders Burkett
Conner & Winters
4000 One Williams Center
Tulsa, Oklahoma 74172-0148

Re: *Oklahoma Board of Medical Licensure and Supervision v. Steven Constantine Anagnost, M.D.*, Case No. 09-10-3861

Dear Teresa:

We will be issuing subpoenas for the depositions of Drs. Baird, Covington, Tomecek, Mangels and Sherburn soon and wanted inquire with you as to whether you would like to obtain their availability before we issue subpoenas. Please advise.

Very truly yours,



Christina M. Vaughn

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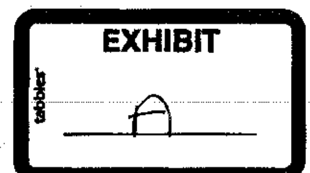
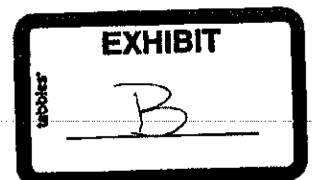


MEDICARE

	A	B	C	D	E	F	G	H
1	**PATIENT**	**DOS**	**PA**	**OP**	**INTRA-OP**	**RESIDENT**	**OP**	**INTRA-OP**
2	D L	4/18/2005	Ian Gunyea	X		Weichrodt		X
3	A P	4/20/2005	Ian Gunyea	X	X	Weichrodt		X
4	W F	4/27/2005	Ian Gunyea	X	X	Weichrodt		X
5	P R	5/23/2005	Ian Gunyea	X	X	R. Drake, DO		X
6	C M	7/20/2005	Ian Gunyea	X		R. Drake, DO		X
7	E N	7/25/2005	Ian Gunyea	X	X	R. Drake, DO		X
8	D S	8/10/2005	Ian Gunyea	X	X	J. Lowry		X
9	J A	8/10/2005	Ian Gunyea	X	X	J. Lowry		X
10	J G	8/10/2005	Ian Gunyea	X	X	J. Lowry		X
11	J I	10/5/2005	Amy Brookever	X		**Cannot Read Name**		X
12	G M	11/21/2005	Amy Brookever	X	X	Oas		X
13	E S	12/12/2005	Amy Brookever	X	X	Oas		X
14	H C	12/19/2005	Amy Brookever	X	X	Oas		X
15	M R	1/4/2006	J. Popp	X		Sands		X
16	M B	1/16/2006	J. Popp	X	X	Sands		X
17	D R	1/30/2006	J. Popp	X	X	Sands		X
18	J G	2/8/2006	J. Popp	X	X	Sands		X
19	D L	2/13/2006	J. Popp	X	X	Sands		X
20	J W	2/13/2006	J. Popp	X	X	Sands (listed as "other")		X
21	D S	2/15/2006	J. Popp	X	X	Sands		X
22	B P	2/27/2006	J. Popp	X		Sands		X
23	M F	3/1/2006	J. Popp	X	X	Basener		X
24	D C	3/15/2006	J. Popp	X	X	Basener	X	X



1120 South Utica Avenue ▫ Tulsa, Oklahoma 74101-4090

4/18 SOS

DICT: 04/18/2005 13:30:57
TRANS: 04/19/2005 14:06:19

OPERATIVE REPORT

U/R: 0001079165

PATIENT: L D

BILLING NO: ~~0509800257~~ 259

ROOM:

DATE OF PROCEDURE: 04/18/2005

SURGEON(S): STEVEN C. ANAGNOST, M.D.

ASSISTANT: IAN GUNYEA, P.A.-C.

PREOPERATIVE DIAGNOSES:
1. Lumbar herniated nucleus pulposus with severe central canal and foraminal stenosis, radiculopathy L4-5.
2. Bipolar disorder.
3. Schizophrenia.

POSTOPERATIVE DIAGNOSES:
1. Lumbar herniated nucleus pulposus with severe central canal and foraminal stenosis, radiculopathy L4-5.
2. Bipolar disorder.
3. Schizophrenia.

PROCEDURE PERFORMED:
Bilateral hemilaminectomies with medial facetectomies and diskectomy at L4-5 with removal of free disk fragments with the use of the Leica operating room microscope.

ESTIMATED BLOOD LOSS:
15 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
Large herniated nucleus pulposus at L4-5 causing central canal and foraminal stenosis and neural impingement.

INDICATION FOR OPERATION:
The patient is a 43-year-old male with a history of bipolar disorder, schizophrenia. He has been ____ with control of these disorders. When he is on his medication he does very well with these functionally. He was

initially seen and was unable to even be examined due to his poor control with his bipolar and schizophrenia but he has subsequently improved with his medication use and has reached a steady baseline.

Despite appropriate means of conservative treatment, he has continued to worsen with his back and leg pain symptoms rather than improve. The patient has refused injections. We discussed the various treatment options at length and in detail. His physical examination findings show marked radiculopathy worse on the right side with a positive straight leg raise test and extensor hallucis longus weakness as well as reflex and sensory changes. Because of this worsening of his symptoms and his physical examination findings directly coinciding with his magnetic resonance imaging scan findings, we have recommended a minimally invasive lumbar decompression diskectomy at L4-5.

The risks and benefits and necessity of the operation were fully discussed at great length and in detail including but not limited to the risk of infection, deep vein thrombosis, pulmonary embolism, myocardial infarction, risk of neural or vascular damage and/or dural damage and blood loss. Our goals and expectations of bringing his pain level down from an 8-9/10 to approximately 2-3/10 were also discussed. We do not expect his pain to be completely zero. His bipolar and schizophrenia are also risk factors for his improvement in the future. It certainly is imperative that maintain on a steady baseline with his medication. He may require adjustments of this in the future. Rather than ignore his symptoms, we have agreed to accept the risks of his bipolar disorder and his schizophrenia because again the severity of his symptoms as well as his neurologic decline. He and his family verbalize an understanding of the risks, benefits, and necessity of the operation and agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative intravenous antibiotics, placed under general endotracheal anesthesia, was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels with a lateral x-ray. Once this was confirmed, a small 16-mm incision was created just off the midline. Gentle dilation was carried out of the soft tissue up to a size 16-mm dilating retractor confirming proper anatomic levels with a lateral x-ray.

The Leica operating room microscope was then brought in for visualization. Kerrison rongeurs were used to perform hemilaminectomies with medial facetectomies and foraminotomies. The dura and the nerve roots were retracted toward the midline exposing the large disk herniation. This was incised along the annulus using the Bayonet blade. A large portion of the subligamentous components that were herniated were removed using pituitary rongeurs and straight pituitary rongeurs. A Penfield 4 elevator was placed at the disk space of L4-5 to confirm proper anatomic levels. The floor of the canal was carefully swept using the

DICT: 04/18/2005 13:30:57
TRANS: 04/19/2005 14:06:19

OPERATIVE REPORT **U/R: 0001079165**

PATIENT: L D. **BILLING NO: 0509800257**

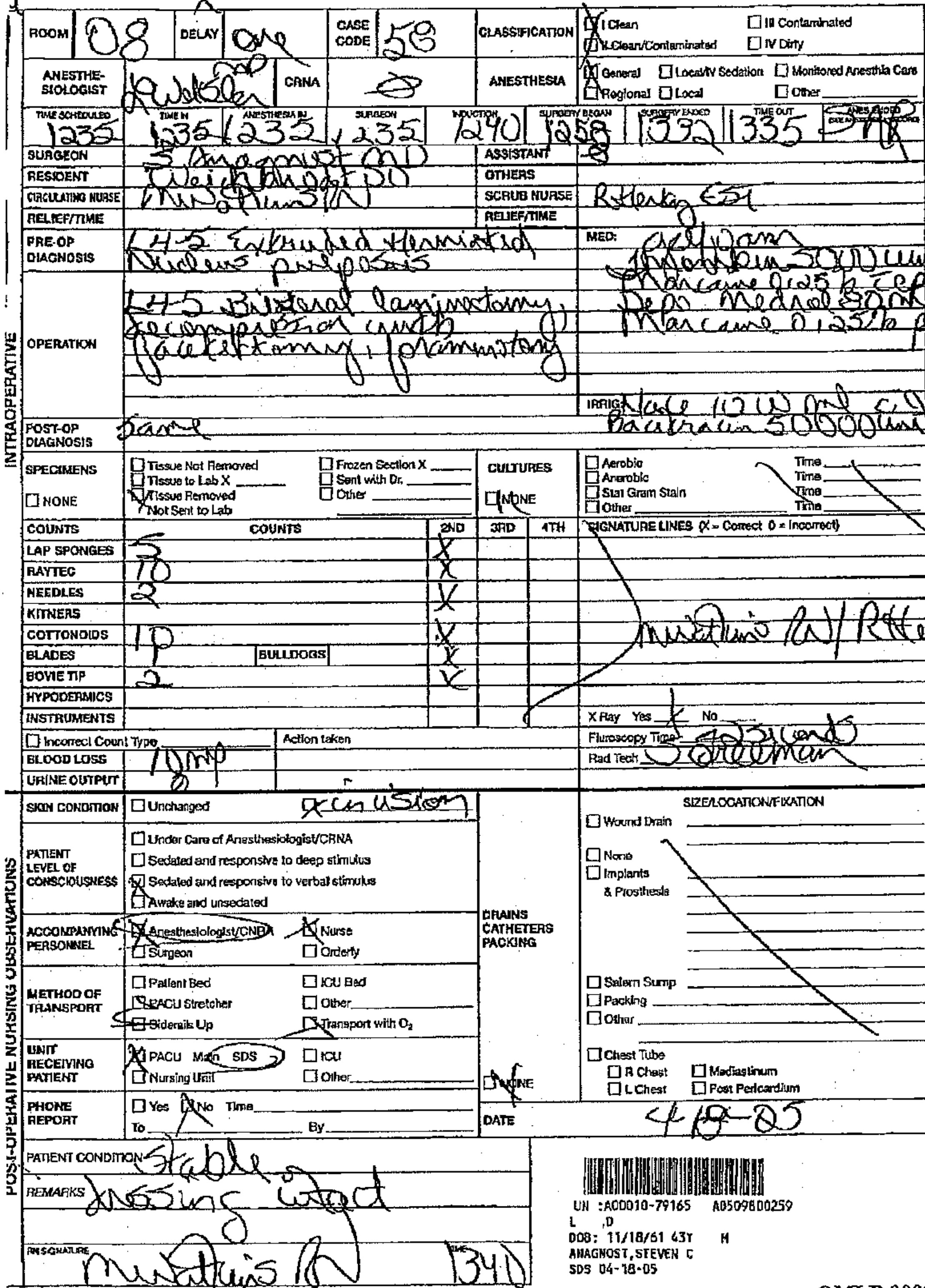
ROOM:

curved ball-tip probe to remove the extruded disk herniation fragments which were removed. The floor of the canal was then checked and rechecked to be sure there were no other loose fragments or free fragments, which there were none. The neural foramen were also thoroughly checked. Copious irrigation solution, two liters in total, were used to irrigate the wound and Gelfoam was used to obtain complete hemostasis. No further pathology was identified. A Valsalvae maneuver confirmed no violation of the dura or neural elements with no dural leak. The dilating retractor was removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion for a water tight closure followed by a 4-0 intracuticular stitch for the skin. A sterile Band-Aid was placed across the small 16-mm incision. The patient tolerated the procedure well and went to the recovery room in stable condition where he awoke neurologically intact with relief of his leg pain symptoms upon awakening in recovery.

STEVEN C. ANAGNOST, M.D.

SCA/MEDQ
#723423

cc: CENTER ORTHOPEDIC
LINDSEY B. BARNES, D.O.



☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	0	CASE CODE	58
CLASSIFICATION	☒ I Clean ☒ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	[illegible]	CRNA	0	ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES. ENDED
1235	1236	1232	1235	1240	1258	1332	1335	[illegible]

SURGEON: S. Anagnost MD
ASSISTANT: 0
RESIDENT: [illegible] DO
OTHERS:
CIRCULATING NURSE: [illegible] RN
SCRUB NURSE: R[illegible] CST
RELIEF/TIME:
RELIEF/TIME:

PRE-OP DIAGNOSIS: L4-5 Extruded Herniated Nucleus pulposus
MED: [illegible] Bacitracin 50000 units, Marcaine 0.25% [illegible], Depo Medrol 80mg, Marcaine 0.25% plain
OPERATION: L4-5 Bilateral laminectomy, decompression with facetectomy, foraminotomy
IRRIG: NaCl 1000ml c̄ Bacitracin 50000 units
POST-OP DIAGNOSIS: Same

SPECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ___ ☒ Tissue Removed Not Sent to Lab ☐ Frozen Section X ___ ☐ Sent with Dr. ___ ☐ Other ___ ☐ NONE
CULTURES: ☒ NONE ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other Time ___

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X		
RAYTEC	10	X		
NEEDLES	2	X		
KITNERS				
COTTONOIDS	10	X		
BLADES	1 BULLDOGS	X		
BOVIE TIP	2	X		
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): [illegible] RN / R[illegible] CST
X Ray Yes ✓ No ___
Fluroscopy Time: [illegible] seconds
Rad Tech: [illegible]

☐ Incorrect Count Type ___ Action taken
BLOOD LOSS: 10ml
URINE OUTPUT: 0

SKIN CONDITION: ☐ Unchanged — incision
PATIENT LEVEL OF CONSCIOUSNESS: ☐ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☒ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CRNA ☒ Nurse ☐ Surgeon ☐ Orderly
METHOD OF TRANSPORT: ☐ Patient Bed ☐ ICU Bed ☒ PACU Stretcher ☐ Other ___ ☒ Siderails Up ☒ Transport with O_2
UNIT RECEIVING PATIENT: ☒ PACU Main SDS ☐ ICU ☐ Nursing Unit ☐ Other ___
PHONE REPORT: ☐ Yes ☒ No Time ___ To ___ By ___
DRAINS CATHETERS PACKING: ☒ NONE
SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☐ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
DATE: 4-18-05

PATIENT CONDITION: Stable
REMARKS: dressing intact
RN SIGNATURE: [illegible] RN TIME: 1340

UN :A0D010-79165 A0509800259
L ,D
DOB: 11/18/61 43Y M
ANAGNOST,STEVEN C
SDS 04-18-05

OMLB 000882

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: 04/20/2005 12:56:50
TRANS: 04/21/2005 12:44:51

OPERATIVE REPORT **U/R: 0001078850**

PATIENT: P A **BILLING NO: 0509500296**

ROOM: AMAU

DATE OF PROCEDURE: 04/20/2005

SURGEON(S): STEVEN C. ANAGNOST, M.D.

ASSISTANT: IAN GUNYEA, P.A.-C.

PREOPERATIVE DIAGNOSES:
1. Lumbar nonunion, L4-L5.
2. Lumbar instability at L3-L4.
3. Severe bilateral lumbar spinal stenosis, recurrent, L3-L4 and L4-L5.
4. Myelopathy.
5. Painful deep hardware at L4-L5.

POSTOPERATIVE DIAGNOSES:
1. Lumbar nonunion, L4-L5.
2. Lumbar instability at L3-L4.
3. Severe bilateral lumbar spinal stenosis, recurrent, L3-L4 and L4-L5.
4. Myelopathy.
5. Painful deep hardware at L4-L5.

PROCEDURES PERFORMED:
1. Revision bilateral laminectomies with medial facetectomies and foraminotomies at L3-L4 and L4-L5, for complete decompression of spinal cord neural elements.
2. Inspection of fusion at L4-L5 with findings of nonunion and mild to moderate instability.
3. Noninstrumented posterior lumbar spinal fusion, L3-L4 and L4-L5.
4. Left posterior iliac crest bone graft using morselized autologous through a separate fascial incision.
5. Use of Leica operating room microscope.
6. Inspection of fusion at L4-L5.
7. Removal of deep painful hardware at L4-L5.

INTRAOPERATIVE FINDINGS:
The overall lengthen, complexity and difficulty of the case was greatly increased due to the patient's severe scar tissue formation. The revision laminectomies were very difficulty due to the patient's kyphotic position and his malunion as well as his very prominent hardware.

DICT: 04/20/2005 12:56:50
TRANS: 04/21/2005 12:44:51

OPERATIVE REPORT **U/R: 0001078850**

PATIENT: P A **BILLING NO: 0509500296**

ROOM: AMAU

INDICATION FOR OPERATION:
The patient is a 95-year-old male who has undergone L4-L5 lumbar stabilization. He has had adjacent level segment advanced degeneration with recurrent stenosis of both L3-L4 and at L4-L5. He has developed a kyphotic deformity at the L3-L4 level with collapse of multilevels. He has had multilevel degenerative disease. He has had severe back pain since shortly after the time of his previous surgery. Due to his failure to improve despite anti-inflammatory medication, pain medication, activity modification, therapy, exercises, rests and injections he has continued to worse rather than improve. His ambulatory status is markedly decreased where he can barely ambulate without assistance or with the use of a wheelchair. His quality of life he states is "miserable" because of his severe weakness and level of back pain. He was found to have a nonunion at L4-L5 as well as recurrent stenosis at L4-L5 and at L3-L4 with collapse, kyphosis and malunion.

The risks, benefits and necessity of the operation were fully discussed at great length in detail. These include but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neural or vascular damage and/or dural damage and blood loss. The revision nature of the surgery as well as his high level of complexity at his age and its inherent risk factors were also discussed. Our goals and expectations to bring his pain level down from a 9 out of 10 to approximately 3 to 4 out of 10 were also discussed. We do not expect his pain to be completely 0. He and his family verbalized an understanding of the risks, benefits, goals and expectations, necessity of the operation, and agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, and placed under general endotracheal anesthesia. He was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomical levels with a lateral x-ray.

Once this was confirmed, a longitudinal incision was created over the previous incision site. This was taken down to the level of the fascia which was incised. The hardware was immediately exposed and was found to be very prominent. It had marked bursa and irritation to the musculature bilaterally at L4-L5. The set screws and rods were removed with inspection of fusion across L4-L5. This revealed a nonunion. It was not severe in nature but there was definitely a nonunion present with motion across this level.

The decompression was then carried out by performing revision laminectomies across the L4-L5 level up to the L3-L4 level.

DICT: 04/20/2005 12:56:50
TRANS: 04/21/2005 12:44:51

OPERATIVE REPORT **U/R: 0001078850**

PATIENT: P A **BILLING NO: 0509500296**

ROOM: AMAU

There was severe scar tissue formation across both of these levels and it greatly increased the overall length, complexity and difficulty of the case. Tedious dissection was carried out to the level of the pedicles bilaterally. There was marked residual stenosis with huge osteophyte formation causing severe compression. There was a "hourglass" deformity to the dura and exiting nerve roots due to the severe long-standing compression. This was greatly relieved after removal of the offending pathology as described. A curved ball-tipped probe was placed at the pedicle of L3, L4 and L5 individually and laterally x-rays were taken to confirm a complete pedicle-to-pedicle decompression with no residual stenosis.

A Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak.

Exposure was taken along the right posterior iliac crest where osteotomes and rongeurs were used to remove the lateral wall of the ileum. Curets were used to remove the cancellous portion of the bone. Irrigation solution was used to irrigate the wound and #1 Vicryl was used to reapproximate the small osteotomy site and Gelfoam was used to obtain complete hemostasis. The main spinal wound was thoroughly irrigated using three liters of Bacitracin solution under Simpulse lavage.

Decortication was carried out of the transverse processes and facets at the L3-L4 and L4-L5 level. Bone graft was carefully packed into the areas of nonunion. An excellent amount of bone graft was available and packed into the areas of the pars interarticularis at the areas of decortication for posterior spinal fusion. It was not instrumented due to the patient's age as well as due to his mild to moderate motion which was not severe in nature. After impacting the graft into the areas of nonunion, there was already adherent instability present due to simply impacting the bone graft into the areas of motion. The canal was once again inspected and found to have an excellent decompression. Gelfoam was used to obtain complete hemostasis and all Gelfoam was removed. No further pathology was identified. Repeat AP and lateral x-rays were taken and confirmed complete removal of the hardware.

The fascia was reapproximated using a #1 Vicryl in an interrupted and running fashion for a watertight closure. A drain was brought out subcutaneous to the skin and 0 Vicryl was used to reapproximate the deep subcutaneous layers followed by 2-0 Vicryl on the subcuticular layers and a 3-0 intercuticular stitch was used to close the skin. Sterile dressings were applied. The patient tolerated the procedure well and went to

DICT: 04/20/2005 12:56:50
TRANS: 04/21/2005 12:44:51

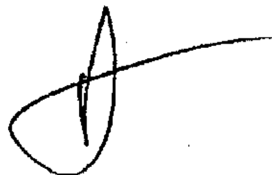
OPERATIVE REPORT **U/R: 0001078850**

PATIENT: P A **BILLING NO: 0509500296**

ROOM: AMAU

the recovery room in stable condition without any difficulty where he awoke neurologically intact with relief of his leg pain symptoms upon awakening in recovery.

STEVEN C. ANAGNOST, M.D.



SCA/MEDQ
#284455

cc: CENTER ORTHOPEDIC

☒ Scheduled Case ☒ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	8	DELAY	#1
CASE CODE	58	CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Dr Weck [illegible]	CRNA	[illegible]
ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other		

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
1100	1115	1115	[illegible]	1125	1136	1310	1315	[illegible]

SURGEON	Dr [illegible]	ASSISTANT	[illegible] PA
RESIDENT	Dr [illegible]	OTHERS	[illegible]
CIRCULATING NURSE	M. [illegible] RN	SCRUB NURSE	R. Heitz CST
RELIEF/TIME	[illegible] RN (Lunch)	RELIEF/TIME	[illegible] CST @1150

PRE-OP DIAGNOSIS: [illegible] L3-4 / [illegible] L4-5 [illegible] Syndrome

OPERATION: L3-4 / L4-5 [illegible] Decompression [illegible] exploration [illegible] removal [illegible] (MR,RN)

MED: 0.25% Marcaine [illegible] epi [illegible] .25% Marcaine + 80 Depo Medrol.

[illegible] of arterial line by [illegible] /ACL.

POST-OP DIAGNOSIS: Same

SPECIMENS: ☐ NONE ☐ Tissue Not Removed ☐ Tissue to Lab X ☒ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other

CULTURES: ☒ NONE ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other — Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X	X	
RAYTEC	20	X	X	
NEEDLES	9	X	X	
KITNERS				
COTTONOIDS	10	X	X	
BLADES	2 (BULLDOGS)	X	X	
BOVIE TIP	2	X	X	
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct, 0 = Incorrect): [illegible] RN / R Heitz CST. / M Reeves RN / F [illegible] CST

X Ray Yes ✓ No ___ Fluroscopy Time ___ Rad Tech [illegible]

☐ Incorrect Count Type ___ Action taken ___

BLOOD LOSS: 100 ml

URINE OUTPUT: 100 ml

SKIN CONDITION: ☐ Unchanged — Incision

PATIENT LEVEL OF CONSCIOUSNESS: ☐ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☒ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CRNA ☒ Nurse ☒ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☒ Patient Bed ☐ PACU Stretcher ☒ Siderails Up ☐ ICU Bed ☐ Other ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU Main/SDS ☐ Nursing Unit ☐ ICU ☐ Other

PHONE REPORT: ☐ Yes ☒ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING: ☒ Wound Drain — SIZE/LOCATION/FIXATION: Hemovac to back to closed suction [illegible] ☐ None ☐ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

[illegible] RN

DATE 4/20-05

PATIENT CONDITION Stable

REMARKS dressing intact

RN SIGNATURE M Reeves RN TIME 1320

UN :A00010-78850 A0509500296
P A
DOB: 09/27/09 95Y M
ANAGNOST, STEVEN C
INPT 04/20/05

OMLB 000897

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: 04/27/2005 10:24:54
TRANS: 04/28/2005 10:23:04

OPERATIVE REPORT

U/R: 0001079936

PATIENT: F W

BILLING NO: 0510800330

ROOM:

DATE OF PROCEDURE: 04/27/2005

SURGEON(S):

ASSISTANT: IAN GUNYEA, P.A.-C.

SURGEON:
Steven C. Anagnost, M.D.

PREOPERATIVE DIAGNOSES:
1. Severe bilateral lumbar spinal stenosis at L3-4, L4-5, and L5-S1.
2. Myelopathy and weakness of the lower extremities secondary to spinal stenosis.
3. Osteopenia/osteoporosis.

POSTOPERATIVE DIAGNOSES:
1. Severe bilateral lumbar spinal stenosis at L3-4, L4-5, and L5-S1.
2. Myelopathy and weakness of the lower extremities secondary to spinal stenosis.
3. Osteopenia/osteoporosis.

PROCEDURE PERFORMED:
Bilateral laminectomies with bilateral medial facetectomies and bilateral foraminotomies at L3-4, L4-5, and L5-S1 with use of the Leica operating room microscope.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
1. Severe bilateral lumbar spinal stenosis with markedly thickened ligamentum flavum and facets causing both central canal and foraminal stenosis.

DICT: 04/27/2005 10:24:54
TRANS: 04/28/2005 10:23:04

OPERATIVE REPORT U/R: 0001079936

PATIENT: F W BILLING NO: 0510800330

ROOM:

2. There was noted to be a "hourglass" deformity to the dura and neural elements due to the longstanding compression from the severe stenosis.

INDICATIONS FOR OPERATION:
The patient is a very pleasant, 70-year-old female with steadily increasing symptoms of bilateral leg weakness, worse on the left than on the right as well as moderate back pain. She has a history of scoliosis. Despite appropriate means of conservative treatment including physical therapy, exercises, rest, medication, and injections, she has continued to worsen rather than improve. Because of her neurologic changes and her poor quality of life and her worsening symptoms, she is present for a lumbar laminectomy and decompression bilaterally at L3-4, L4-5, and L5-S1.

The risks, benefits, and necessity of the operation were fully discussed at great length and in detail including, but not limited to the risks of infections, deep venous thrombosis, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, neural or vascular damage and/or dural damage, and blood loss. Our goals and expectations are to bring her pain level down from 8-9 out of 10 to approximately 2-3 out of 10 were also discussed. The possibility of postoperative collapse and instability were also discussed. Her osteoporosis and osteopenia were discussed as risk factors. She and her family verbalized understanding of the risks, benefits, goals, expectations, and necessity of the operation and agreed to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative intravenous antibiotics, and placed under general endotracheal anesthesia. She was placed prone on the Wilson frame and all bony prominences were carefully and tediously padded. After sterile prepping and draping, identification was obtained using a needle marker and a lateral x-ray.

A Leica operating room microscope was brought into visualization. Kerrison rongeurs were then used to perform bilateral laminectomies with bilateral medial facetectomies, bilateral foraminotomies, and bilateral excision of hypertrophied ligamentum flavum.

There was noted to be a "hourglass" deformity to the dura and neural elements due to longstanding compression. This was greatly improved after removal of the offending pathology as described. A curved, ball-tipped probe was placed at the pedicle of L3, the pedicle of L4, the pedicle of L5, and the pedicle of S1 and confirmed with individual lateral x-rays to confirm complete pedicle-to-pedicle decompression with no residual stenosis. The floor of the canal was swept with no further pathology found. The disk space was identified at L5-S1 with a small disk protrusion which was excised using a bayonet blade and micropituitary

DICT: 04/27/2005 10:24:54
TRANS: 04/28/2005 10:23:04

OPERATIVE REPORT **U/R: 0001079936**

PATIENT: F W. **BILLING NO: 0510800330**

ROOM:

rongeurs. Copious irrigation solution, two liters in total were used to irrigate the wound. Gelfoam was used to obtain complete hemostasis. A Valsalva maneuver confirmed no violation of the dura or neural elements and no dural leak.

The dilating retractors were removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion followed by a 4-0 intercuticular stitch for the skin. A sterile Band-Aid was placed across the small 16 mm incision. The patient tolerated the procedure well. She went to the recovery room in stable condition without difficulty where she awoke neurologically intact with immediate relief of her leg pain symptoms upon awakening in recovery.

STEVEN C. ANAGNOST, M.D.

SCA/MEDQ
#313840

cc: CENTER ORTHOPEDIC

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	8	DELAY	#1	CASE CODE	58	CLASSIFICATION	☐ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Dr. [illegible] Hoff	CRNA				ANESTHESIA	☐ General ☐ Local/IV Sedation ☐ Monitored Anesthesia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
900	915	915	here	920	920	1027	1035	

SURGEON	Dr. Anagnost	ASSISTANT	[illegible] PA
RESIDENT	Dr [illegible]	OTHERS	
CIRCULATING NURSE	[illegible]	SCRUB NURSE	[illegible]
RELIEF/TIME		RELIEF/TIME	

PRE-OP DIAGNOSIS: L3-4, L4-5, L5-S1 Spinal Stenosis.

OPERATION: L3-4, L4-5, L5-S1 Decompression Laminectomy, facetectomy, [illegible]

MED: .25% Marcaine [illegible] [illegible] / Bacitracin / .25% Marcaine 80 Depo Medrol

IRRIG: [illegible] NACL

POST-OP DIAGNOSIS: Same.

SPECIMEN: ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other ☒ NONE

CULTURES: ☒ NONE ☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5			
RAYTEC	10			
NEEDLES	2.			
OTHERS				
COTTONOIDS	10			
BLADES	2	BULLDOGS		
BOVIE TIP				
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect)
1 ☒ [illegible] / [illegible]
2
3
4 ☒ [illegible] / [illegible]

X Ray Yes ___ No ___
Fluroscopy Time 9 sec
Rad Tech [illegible]

Incorrect Count Type ___ Action taken ___

BLOOD LOSS: 350 ml.
URINE OUTPUT: ∅

SKIN CO.: ☐ Unchanged ☐ Per Surgery

PATIENT LEVEL OF CONSCIOUSNESS: ☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CRNA ☒ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed ☒ PACU Stretcher ☒ Siderails Up ☐ ICU Bed ☐ Other ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU Main (SDS) ☐ ICU ☐ Nursing Unit ☐ Other

PHONE REPORT: ☒ Yes ☐ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING: ☒ NONE
SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☐ Implants & Prosthesis
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 4-22-05

PATIENT CONDITION: Stable

REMARKS

SIGNATURE: [illegible] TIME: 1035

UN :A00010-79936 A05108000330
F W.
DOB: 06/04/34 70Y F
ANAGNOST, STEVEN C
042705 SDS

OMLB 000908

5|23 5 05

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon May 23 18:44:58 2005 EST
TRANS: Tue May 24 15:53:12 2005 EST

OPERATIVE REPORT **U/R:** 1078434

PATIENT: R P **BILLING NO:** 514000036

ROOM:

DATE OF PROCEDURE: 05/23/2005

SURGEON: Steven C Anagnost, MD

ASSISTANT: Mr. Gunya, PA-C

PREOPERATIVE DIAGNOSES:
1. Lower extremity weakness at L2-3, L3-4 and L4-5.
2. Degenerative disk disease with collapse at L2-3, L3-4, L4-5.

POSTOPERATIVE DIAGNOSES:
1. Lower extremity weakness at L2-3, L3-4 and L4-5.
2. Degenerative disk disease with collapse at L2-3, L3-4, L4-5.

PROCEDURE PERFORMED:
Bilateral laminectomies with bilateral medial facetectomies and foraminotomies and bilateral excision of ruptured ligamentum flavum, bleeding compression of spinal canal elements, L2-3, L3-4, and L4-5 with the use of a Leica operating microscope, with minimal invasive dilation, prep, and minimal invasive surgical techniques.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

ESTIMATED BLOOD LOSS:

INTRAOPERATIVE FINDINGS:
Marked epidural fibrosis and scarring to lamina due to chronic reactive tissue and inflammation.

Hillcrest HEALTHCARE SYSTEM 1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon May 23 18:44:58 2005 EST
TRANS: Tue May 24 15:53:12 2005 EST

OPERATIVE REPORT **U/R:** 1078434

PATIENT: R P **BILLING NO:** 514000036

ROOM:

INDICATIONS FOR OPERATION:
The patient is a very pleasant 80-year-old male who has had steadily increasing symptoms of lower extremity weakness, as well as increasing back pain. Despite appropriate and necessary treatment, it is getting worse rather than improved with his symptoms. He has undergone physical therapy, injections, rest, medication and bracing. Again, despite these measures, he is worse rather than improved and is therefore resent for a lumbar decompression using ____ techniques.

He has had a known history of collapse throughout his lumbar spine with bone-on-bone contact. He does not appear to be grossly unstable at these levels but is having symptoms of radiculopathy, as well as lower extremity weakness in the L2-L5 distribution.

The risks and benefits, and necessity of the operation were fully discussed at great length in detail including but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of neurovascular damage and/or dural damage or blood loss. Our goals are to bring his pain level down from 8-9/10 to approximately 2-3/10. We also discussed we do not expect his pain to be completely zero. Certainly at his age of 80, he has had chronic reactive changes, as well as neuropathy to his lower extremities. We hope to minimize his symptom and improve his lower extremity strength as much as possible. He and his family verbalize understanding to the risks, benefits, goals and expectations and necessity of the operation, including the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics and was placed under general endotracheal anesthesia. He was placed prone on the Wilson frame, with all the bony prominences carefully padded. After sterilely prepping and draping, a needle marker was used to obtain appropriate anatomic levels on lateral x-ray. Once this was confirmed, a small 16-mm incision was created just left of midline. Gentle dilation was carried out on the tissue up to a size 16-mm dilator retractor and this was confirmed once again to be the appropriate anatomical level by lateral x-ray.

The Leica operating room microscope was brought in for visualization. Kerrison rongeurs were then used to perform medial facetectomies and foraminotomies, as well as partial laminectomies bilaterally, as well as excision of hypertrophied ligamentum flavum. There was marked thinning of the dura itself. There were marked reactive tissue changes, some chronic, around the laminar edges where the dura was markedly fibrosed and scarred into the lamina. This required tedious dissection with Penfield 4 elevators as well as the

DICT: Mon May 23 18:44:58 2005 EST
TRANS: Tue May 24 15:53:12 2005 EST

OPERATIVE REPORT **U/R: 1078434**

PATIENT: R P **BILLING NO: 514000036**

ROOM:

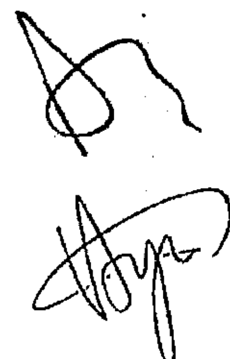
Woodson elevator. A curved ball-tip probe was placed at the pedicle of L2, the pedicle of L3, the pedicle of L4 and the pedicle of L5 to confirm a complete pedicle-to-pedicle decompression with no residual stenosis. Again, this was verified intraoperative. Copious irrigation solution, 2 L in total, was used to irrigate the wound. Gelfoam was used to obtain complete hemostasis. No further pathology was identified. Again, the dura was visualized and found to be markedly translucent and very thin. A Valsalva maneuver was performed showed a very tiny dural leak, which was present along the area of thinned dura. A 6-0 silk stitch was placed across this small area. Valsalva maneuver was repeated verifying no gross leak of fluid. A small area of seal was placed over the dura repair, as well as using Duragen patch. Valsalva was repeated again revealing no gross dural leak.

The ____was removed. The fascia was reapproximated using 2-0 Vicryl in an interrupted fashion, followed by 4 intercuticular stitches for close the skin. A sterile bandage was placed across the small incision. The patient tolerated the procedure well and went to recovery in stable condition where he awoke neurologically intact.

Steven C Anagnost, MD

MLS ID: 96979
JOB: 41495683

CC:



[X] Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	none
CASE CODE	58	CLASSIFICATION	[X] I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	S Anagnost MD	CRNA	Ø
ANESTHESIA	[X] General ☐ Regional ☐ Local/IV Sedation ☐ Local ☐ Monitored Anesthia Care ☐ Other		

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES END
1130	1305	1305	1305	1310	1322	1418	1425	SAR

SURGEON: S Anagnost MD — ASSISTANT: Ø

RESIDENT: Drake, DO — OTHERS: J Gumpey PA-C

CIRCULATING NURSE: M Reaves RN — SCRUB NURSE: R Harkins ST

RELIEF/TIME: Strickland 1400 — RELIEF/TIME:

PRE-OP DIAGNOSIS: L2-3, L3-4, L4-5 Spinal stenosis

MED: Gelfoam, Thrombin 5000 units, Marcaine 0.25% 6 cc

OPERATION: L2-3, L3-4, L4-5 Bilateral laminectomy, facetectomy, foraminotomy

IRRIG: NaCl 1000 ml, Bacitracin 50,000 units

POST-OP DIAGNOSIS: Same

SPECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ___ [X] Tissue Removed Not Sent to Lab ☐ Frozen Section X ___ ☐ Sent with Dr. ___ ☐ Other ___ — NONE

CULTURES: [X] NONE ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other — Time ___ Time ___ Time ___ Time ___

COUNTS	COUNTS	2ND	3RD	4TH
RAY SPONGES	5	X		
COTTONOID/TEC	10	X		
NEEDLES	3+1	X		
RETAINERS				
PATTONOIDS	10	X		
BLADES	1 (BULLDOGS)	X		
KNIFE TIP	2	X		
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): M Reaves RN / R Harkins ST

X Ray Yes X No ___

Fluroscopy Time ___

Rad Tech K Stout

Incorrect Count Type ___ Action taken

BLOOD LOSS: 10 ml

URINE OUTPUT: Ø

SKIN CONDITION: ☐ Unchanged — N/A incision

PATIENT LEVEL OF CONSCIOUSNESS: ☐ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus [X] Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: [X] Anesthesiologist/CRNA ☐ Surgeon [X] Nurse ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed [X] PACU Stretcher [X] Siderails Up ☐ ICU Bed ☐ Other ___ [X] Transport with O_2

RECEIVING UNIT: [X] PACU Main (SDS) ☐ Nursing Unit ☐ ICU ☐ Other ___

PHONE REPORT: ☐ Yes [X] No Time ___ To ___ By ___

DRAINS CATHETERS PACKING: [X] NONE — MRRN

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☐ Implants & Prosthesis — Durepair 5,0 cm x 5,0 cm REF 62100 LOT DR3050119 — 2-1-X2 exp 2005-10; TISSEEL VH K12604J — 5 ml Exp 2006 3/31

☐ Salem Sump ☐ Packing ☐ Other ___

☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Paricardium

DATE: 5-23-05

PATIENT CONDITION: stable

REMARKS: dressing intact

SIGNATURE: M Reaves RN — TIME: 1427

UN: A00010-78434 A0514000036
DOB: 02/17/25 80Y M
ANAGNOST, STEVEN C
SDS 5-23-05

OMLB 000921

9\70 SDS

Hillcrest HEALTHCARE SYSTEM

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Jul 20 11:52:16 2005 EST
TRANS: Wed Jul 20 12:06:42 2005 EST

OPERATIVE REPORT **U/R:** 1086733

PATIENT: M C **BILLING NO:** 519300310

ROOM:

DATE OF PROCEDURE: 07/20/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Dr. Gunyea.

PREOPERATIVE DIAGNOSES:
1. L4-5, L5-S1 bilateral lumbar spinal stenosis.
2. Lower extremity weakness, with radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. L4-5, L5-S1 bilateral lumbar spinal stenosis.
2. Lower extremity weakness, with radiculopathy.

PROCEDURES PERFORM:
Bilateral laminectomies with medial facetectomies and bilateral foraminotomies for complete decompression of the spinal cord inner elements with the use of the operating microscope and the minimally invasive dilator retractor and the ______ technique. → minimally invasive

ESTIMATED BLOOD LOSS:
15 mL.

DRAINS:
None.

COMPLICATOINS:
None.

INTRAOPERATIVE FINDINGS:
1. Severe bilateral stenosis at L4-5.
2. Moderate stenosis bilaterally at L5-S1.

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Jul 20 11:52:16 2005 **EST**
TRANS: Wed Jul 20 12:06:42 2005 **EST**

OPERATIVE REPORT **U/R:** 1086733

PATIENT: M C **BILLING NO:** 519300310

ROOM:

INDICATIONS FOR OPERATION:
This is a 60-year-old male with steadily increasing symptoms of lower extremity weakness, as well as bilateral buttock pain and moderate pain. He has decreased walking distance, as well as numbness and tingling through his lower extremities.

Despite physical therapy, epidural injections, rest, medication, and bracing, it has worsened rather than improved his symptoms. His MRI findings directed coincide with his physical exam findings. He is therefore present for a lumbar decompression at L4-5 and L5-S1, with laminectomies and facetectomies and foraminotomies.

The risks, benefits, and necessity of the operation were discussed at great length and details, including, but not limited to, the risks of infection, DVT, pulmonary embolism, myocardial infarction, risk of neural or vascular damage, and/or dural damage and blood loss. Our goals and expectations are to bring his pain level down from 8-9/10 to approximately 2-3/10 were also discussed. We do not expect his pain to be completely zero. He and his family verbalized understanding of the risks, benefits, goals, expectations, and necessity of the operation and agree to the treatment as recommended. They also agreed to postoperative compliance, including no smoking.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, administered preoperative antibiotics, and placed under general endotracheal anesthesia. He was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterilely prepping and draping, a needle marker was used to obtain proper anatomical levels with the lateral x-ray. Once this was confirmed, a small 16-mm incision was created just left of the midline. Gentle dilation was carried out on the soft tissue up to a size 16-mm dilating retractor. This confirmed once again to be at proper anatomical levels with the lateral x-ray.

The operating microscope was brought under visualization. Kerrison rongeur was used to perform lateral laminectomies, medial facetectomies, and bilateral foraminotomies. Bilateral excision of hypertrophied ligamentum flavum was also carried out at L4, L5, and S1. There was severe stenosis noted at L4-5 and moderately severe at L5-S1. Excellent decompression was obtained. The nerve roots were clearly visualized. They were exiting along the L4-5 and L5-S1. Bacitracin solution 2 L was used to irrigate the wound. Valsalva maneuver confirmed no violation of the dura or ______, no dural leak. Gelfoam was used to obtain complete hemostatic.
neural elements

OPERATIVE REPORT
Page 2

DICT: Wed Jul 20 11:52:16 2005 EST
TRANS: Wed Jul 20 12:06:42 2005 EST

OPERATIVE REPORT **U/R:** 1086733

PATIENT: M C **BILLING NO:** 519300310

ROOM:

A curved ball-tip probe was placed in the pedicle L4, the pedicle L5, and pedicle S1 and were confirmed with individual lateral x-ray to confirm a complete pedicle-to-pedicle decompression.

The retractor was removed. The fascia was reapproximated using 2-0 Vicryl in an interrupted fashion, followed by a 4 intracuticular stitch for the skin. A sterile bandage was placed across the small incision. The patient tolerated the procedure well. He went to the recovery room in stable condition without any difficulty where he awoke neurologically intact, with relief of his leg pain symptoms after awaking in recovery.

Steven C Anagnost, MD

MLS ID: 97031
JOB: 41628941

CC: Orthopedic Center

[X] Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	one	CASE CODE	58	CLASSIFICATION	[X] I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	L Webster	CRNA	Ø			ANESTHESIA	[X] General ☐ Local/IV Sedation ☐ Monitored Anesthesia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
0930	0950	0950	0950	0955	1000	1053	1158	JAR

SURGEON	S Anagnost MD	ASSISTANT	Ø
RESIDENT	Drake DO	OTHERS	Ø
CIRCULATING NURSE	M Reeves RN 1045	SCRUB NURSE	R Hartzog CST
RELIEF/TIME	Ø	RELIEF/TIME	Ø
PRE-OP DIAGNOSIS	L4-5 lumbar spinal stenosis L5-S1 Modic changes and collapse	MED:	Cefazolin 1gm; Thrombin 5000 units; Marcaine 0.25% Epi; Depo Medrol 80mg; Marcaine 0.25% plain
OPERATION	L4-5, L5-S1 Bilateral laminectomy/facetectomy, foraminotomy		
		IRRIG:	NaCl 1000 ml c Bacitracin 50000 units
POST-OP DIAGNOSIS	Same		

SPECIMENS		CULTURES	
☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ____ [X] Tissue Removed Not Sent to Lab ☐ Frozen Section X ____ ☐ Sent with Dr. ____ ☐ Other ____	[X] NONE	☐ Aerobic Time ____ ☐ Anerobic Time ____ ☐ Stat Gram Stain Time ____ ☐ Other Time ____

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X	X	
RAYTEC	10	X	X	
NEEDLES	3	X	X	
OTHERS				
COTTONOIDS	10	X	X	
BLADES	1 BULLDOGS	X	X	
BOVIE TIP	2	X	X	
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct D = Incorrect): M Reeves RN / R Hartzog CST

☐ Incorrect Count Type ____ Action taken ____

BLOOD LOSS: 100cc
URINE OUTPUT: Ø

X Ray Yes X No ____
Fluoroscopy Time: 43 seconds
Rad Tech: S Holleman

SKIN CONDITION: ☐ Unchanged [X] incision

PATIENT LEVEL OF CONSCIOUSNESS:
☐ Under Care of Anesthesiologist/CRNA
☐ Sedated and responsive to deep stimulus
[X] Sedated and responsive to verbal stimulus
☐ Awake and unsedated

ACCOMPANYING PERSONNEL: [X] Anesthesiologist/CRNA [X] Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed ☐ ICU Bed [X] PACU Stretcher ☐ Other ____ [X] Siderails Up [X] Transport with O_2

UNIT RECEIVING PATIENT: [X] PACU Main SDS ☐ ICU ☐ Nursing Unit ☐ Other ____

PHONE REPORT: ☐ Yes [X] No Time ____ To ____ By ____

DRAINS CATHETERS PACKING: [X] NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☐ Implants & Prosthesis
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 7-20-05

PATIENT CONDITION: Stable
REMARKS: dressing intact

RN SIGNATURE: M Reeves RN [signature] TIME 1158

UN :A00010-86733 A0519300310
M ,C.
DOB: 03/09/45 60Y M
ANAGNOST, STEVEN C
SDS 07-20-05

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jul 25 15:24:03 2005 EST
TRANS: Mon Jul 25 23:49:17 2005 EST

OPERATIVE REPORT

U/R: 1086953

PATIENT: N E

BILLING NO: 519600048

ROOM:

DATE OF PROCEDURE: 07/25/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Ian Gunyea, PA.

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4 and L4-5.
2. Lower extremity weakness.
3. Radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4 and L4-5.
2. Lower extremity weakness.
3. Radiculopathy.

PROCEDURE PERFORMED:
Bilateral laminectomies with bilateral medial facetectomies and foraminotomies and bilateral excision of hypertrophied ligamentum flavum at L3-4 and L4-5 for complete decompression of spinal cord and neural elements secondary to severe spinal stenosis with the use of the operating room microscope.

ESTIMATED BLOOD LOSS:
15 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
Severe facet hypertrophy and ligamentum flavum hypertrophy causing significant central canal and foraminal stenosis.

DICT: Mon Jul 25 15:24:03 2005 EST
TRANS: Mon Jul 25 23:49:17 2005 EST

OPERATIVE REPORT **U/R: 1086953**

PATIENT: N E **BILLING NO:** 519600048

ROOM:

INDICATION FOR OPERATION:
The patient is a 72-year-old female with steadily increasing symptoms of lower extremity weakness and radiculopathy. She is also having some moderate back pain in addition. Despite appropriate conservative treatment, she has continued to worsen, rather than improve. Due to her failure to improve despite injections, medications, rest, therapy and activity modification and with her lower extremity weakness and her instability with her gait, she is present for lumbar laminectomies, foraminotomies and facetectomies. The risks and benefits and the necessity of the operation were discussed at length in detail. These include but are not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of neural or vascular damage and/or dural damage and blood loss. Our goals and expectations are to bring her pain level down from a 8 to 9/10 to approximately a 3 to 4/10. We also discussed we do not expect her pain to be completely zero. She and her family verbalized understanding of the risks and benefits and goals and expectation and agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative antibiotics and was placed under general endotracheal anesthesia. She was placed prone on the Wilson frame. All the prominences were carefully and judiciously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels on lateral x-ray. Once this was confirmed, a small 16 mm incision was created just left of midline. Gentle dilation was carried out on the soft tissue up to a size 16 mm dilating retractor. This was confirmed once again with lateral x-ray.

The operating microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies and foraminotomies bilaterally. Hypertrophied ligamentum flavum was also excised bilaterally. A curved ball tipped probe was placed in the pedicle of 3 and the pedicle of 4, and pedicle of 5 with individual lateral x-rays for confirmation to confirm a complete pedicle-to-pedicle decompression with no residual stenosis. Gelfoam was used to obtain hemostasis and 2 liters of Bacitracin solution were used to irrigate the wound. The Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak. No further pathology was identified. There was excellent decompression obtained bilaterally, especially along the left side where the majority of her symptoms were present.

The retractor was removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion followed by a 4-0 intercuticular stitch for the skin. Sterile dressings were applied. The patient tolerated the

Hillcrest
HEALTHCARE SYSTEM

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jul 25 15:24:03 2005 EST
TRANS: Mon Jul 25 23:49:17 2005 EST

OPERATIVE REPORT **U/R:** 1086953

PATIENT: N E **BILLING NO:** 519600048

ROOM:

procedure well. She went to the regular rhythm in stable condition without difficulty where she awoke neurologically intact with relief of her leg pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97058
JOB: 41640955

CC: Orthopedics Center, Dr. Kenneth Miller, primary physician

7| 25 '05

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jul 25 15:24:03 2005 EST
TRANS: Mon Jul 25 23:49:17 2005 EST

OPERATIVE REPORT **U/R:** 1086953

PATIENT: N E **BILLING NO:** 519600048

ROOM:

DATE OF PROCEDURE: 07/25/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Ian Gunyea, PA.

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4 and L4-5.
2. Lower extremity weakness.
3. Radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4 and L4-5.
2. Lower extremity weakness.
3. Radiculopathy.

PROCEDURE PERFORMED:
Bilateral laminectomies with bilateral medial facetectomies and foraminotomies and bilateral excision of hypertrophied ligamentum flavum at L3-4 and L4-5 for complete decompression of spinal cord and neural elements secondary to severe spinal stenosis with the use of the operating room microscope.

ESTIMATED BLOOD LOSS:
15 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
Severe facet hypertrophy and ligamentum flavum hypertrophy causing significant central canal and foraminal stenosis.

Hillcrest
HEALTHCARE SYSTEM
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jul 25 15:24:03 2005 **EST**
TRANS: Mon Jul 25 23:49:17 2005 **EST**

OPERATIVE REPORT **U/R:** 1086953

PATIENT: N E **BILLING NO:** 519600048

ROOM:

INDICATION FOR OPERATION:
The patient is a 72-year-old female with steadily increasing symptoms of lower extremity weakness and radiculopathy. She is also having some moderate back pain in addition. Despite appropriate conservative treatment, she has continued to worsen, rather than improve. Due to her failure to improve despite injections, medications, rest, therapy and activity modification and with her lower extremity weakness and ..r instability with her gait, she is present for lumbar laminectomies, foraminotomies and facetectomies. The risks and benefits and the necessity of the operation were discussed at length in detail. These include but are not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of neural or vascular damage and/or dural damage and blood loss. Our goals and expectations are to bring her pain level down from a 8 to 9/10 to approximately a 3 to 4/10. We also discussed we do not expect her pain to be completely zero. She and her family verbalized understanding of the risks and benefits and goals and expectation and agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative antibiotics and was placed under general endotracheal anesthesia. She was placed prone on the Wilson frame. All the prominences were carefully and judiciously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels on lateral x-ray. Once this was confirmed, a small 16 mm incision was created just left of midline. Gentle dilation was carried out on the soft tissue up to a size 16 mm dilating retractor. This was confirmed once again with lateral x-ray.

The operating microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies and foraminotomies bilaterally. Hypertrophied ligamentum flavum was also excised bilaterally. A curved ball tipped probe was placed in the pedicle of 3 and the pedicle of 4, and pedicle of 5 with individual lateral x-rays for confirmation to confirm a complete pedicle-to-pedicle decompression with no residual stenosis. Gelfoam was used to obtain hemostasis and 2 liters of Bacitracin solution were used to irrigate the wound. The Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak. No further pathology was identified. There was excellent decompression obtained bilaterally, especially along the left side where the majority of her symptoms were present.

The retractor was removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion followed by a 4-0 intercuticular stitch for the skin. Sterile dressings were applied. The patient tolerated the

DICT: Mon Jul 25 15:24:03 2005 **EST**
RANS: Mon Jul 25 23:49:17 2005 **EST**

OPERATIVE REPORT **U/R:** 1086953

PATIENT: N E **BILLING NO:** 519600048

ROOM:

procedure well. She went to the regular rhythm in stable condition without difficulty where she awoke neurologically intact with relief of her leg pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97058
JOB: 41640955

CC: Orthopedics Center, Dr. Kenneth Miller, primary physician

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

OM	08	DELAY	none	CASE CODE	58
CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
NESTHE- IOLOGIST	G Chadd MD	CRNA	Ø	ANESTHESIA	☒ General ☐ Regional ☐ Local/IV Sedation ☐ Local ☐ Monitored Anesthia Care ☐ Other ______

E SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED SEE ANESTHESIA RECORD
1330	1330	1330	1330	1335	1348	1419	1425	SAR

RGEON: S Anagnost MD

SIDENT: Drake DO

ULATING NURSE: M Reeves RN

LIEF/TIME: Ø

ASSISTANT: Ø

OTHERS: [illegible] PA-C

SCRUB NURSE: M Jackson ST - 1410

RELIEF/TIME: [illegible] ST 1410

E-OP GNOSIS: L3-4, L4-5 Spinal Stenosis

ERATION: L3-5 Bilateral laminectomy, facetectomy, foraminotomy

MED: Gelfoam; Thrombin 5000 unit; Marcaine 0.125% [illegible]; Depo Medrol; Marcaine 0.125% plain

IRRIG: NaCl 1000 ml c̄ Bacitracin 50000 unit

ST-OP GNOSIS: Same

ECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ______ ☒ Tissue Removed Not Sent to Lab ☐ Frozen Section X ______ ☐ Sent with Dr. ______ ☐ Other ______

NONE

CULTURES: ☒ NONE ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other Time ______

UNTS	COUNTS	2ND	3RD	4TH
SPONGES	5	X		
YTEC	10	X		
EDLES	2	X		
HERS				
TTONOIDS	10	X		
ADES	1	X		
BULLDOGS				
VIE TIP	2	X		
PODERMICS	1	X		
ITRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): M Reeves RN / M Jackson ST

X Ray Yes X No ___

Fluroscopy time: 6 seconds

Rad Tech: S Freeman

Incorrect Count Type ______ Action taken ______

OOD LOSS: 10 ml

INE OUTPUT: Ø

N CONDITION: ☐ Unchanged — [illegible]

TENT EL OF NSCIOUSNESS: ☐ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☒ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

COMPANYING RSONNEL: ☒ Anesthesiologist/CRNA ☐ Surgeon ☒ Nurse ☐ Orderly

ITHOD OF ANSPORT: ☐ Patient Bed ☒ PACU Stretcher ☒ Siderails Up ☐ ICU Bed ☐ Other ______ ☒ Transport with O_2

IT CEIVING TIENT: ☒ PACU Main SDS ☐ Nursing Unit ☐ ICU ☐ Other ______

ONE PORT: ☐ Yes ☒ No Time ______ To ______ By ______

DRAINS CATHETERS PACKING: ☒ NONE

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☐ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ______ ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 7-25-05

TIENT CONDITION: Stable

MARKS: dressing intact

SIGNATURE: M Reeves RN TIME: 1430

UN :A00010-86953 A0519600048
N - E F
DOB: 07/23/32 72Y
ANAGNOST, STEVEN C
SDS 7-25-05

OMLB 000950

8-11

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Aug 10 17:06:56 2005 EST
TRANS: Thu Aug 11 09:59:02 2005 EST

OPERATIVE REPORT **U/R:** 1088484

PATIENT: S D **BILLING NO:** 521600197

ROOM: PACU 2

DATE OF PROCEDURE: 08/10/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Ian Gunyea, PAC

PREOPERATIVE DIAGNOSES:
1. Lumbar instability, L5-S1.
2. Herniated nucleus pulposus, L5-S1.
3. Radiculopathy, with lower extremity weakness.
4. Morbid obesity, with greater than 35% body mass index.

POSTOPERATIVE DIAGNOSES:
1. Lumbar instability, L5-S1.
2. Herniated nucleus pulposus, L5-S1.
3. Radiculopathy, with lower extremity weakness.
4. Morbid obesity, with greater than 35% body mass index.

PROCEDURES PERFORMED:
1. Lumbar laminectomies, L5-S1, with medial facetectomies and foraminotomies for decompression of dura and neural elements with the use of operating room microscope.
2. Posterior lumbar interbody fusion using Howmedica Stryker interbody cage device, L5-S1.
3. Posterolateral fusion with pedicle screw instrumentation with use of Danek Legacy pedicle screw instrumentation for completion of 360 degree fusion through a single posterior approach.
4. Iliac crest bone grafting, morselized autologous, with suprafascial incision.
5. EMG and SSEP monitoring.

ESTIMATED BLOOD LOSS:
30 cc.

OPERATIVE TIME:
1 hour and 15 minutes.

DICT: Wed Aug 10 17:06:56 2005 EST
TRANS: Thu Aug 11 09:59:02 2005 EST

OPERATIVE REPORT **U/R:** 1088484

PATIENT: S D **BILLING NO:** 521600197

ROOM: PACU 2

FLUOROSCOPY TIME:
34 seconds.

INDICATIONS FOR OPERATION:
'atient is a 65-year-old female with steadily increasing symptoms of back pain, as well as leg weakness and radiculopathy. She has failed conservative treatment, including injections, medication, rest, therapy, and bracing. She is getting more and more miserable with her pain. She has had an extensive open laminectomy in the past. This has caused instability at the L5-S1 level. She is therefore present for stabilization with interbody fusion, posterolateral fusion, and revision decompression. The risks, benefits, and necessity of the operation were fully discussed at great length and detail, including but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, hardware ıilure, problems with neural or vascular damage, and/or dural damage and blood loss. Our goals for this patient are to bring her pain level down from an 8 to 9/10 to approximately 3 to 4/10. We also discussed that we did not expect her pain to be completely zero. She and her family verbalized understanding, and they agree to the treatment plan as recommended.

INTRAOPERATIVE FINDINGS:
1. The revision nature of the surgery with scarring increased the length, complexity, and difficulty of the exposure.
2. This patient's morbid obesity and greater than 35% body mass index greatly increased the entire aspect of the procedure, including exposure, the procedure itself, as well as the closure.
3. Marked instability at L5-S1 noted intraoperatively.

DESCRIPTION OF THE PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, plus a general endotracheal anesthesia. She was placed prone on the Wilson frame. All body prominences were carefully and tediously padded. A special frame had to be obtained to accommodate patient's morbid obesity. Once she was appropriately positioned on the frame and was very carefully padded, proper anatomic levels were confirmed using a lateral x-ray and a needle marker.

A small 4-cm incision was created just on the midline. Gentle dilation was carried through the soft tissue with retractors and confirmed the appropriate anatomic level with the lateral x-ray.

DICT: Wed Aug 10 17:06:56 2005 EST
TRANS: Thu Aug 11 09:59:02 2005 EST

OPERATIVE REPORT **U/R: 1088484**

PATIENT: S D **BILLING NO:** 521600197

ROOM: PACU 2

An operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform revision laminectomies, as well as medial facetectomies and foraminotomies. There was copious scarring present from the previous operation, which made the exposure, as well as the decompression much more difficult. Patient's obesity also hindered the overall progress of the case.

A curved ball-tip probe was used to palpate the pedicle of L5 and the pedicle of S1 to confirm a complete pedicle-to-pedicle decompression, with no residual stenosis. A Valsalva maneuver confirmed no violation of the dura or neural elements, with no dural leak.

Iliac crest bone grafting was then attained through angling the retractor toward the iliac crest. A small curette was used to create a small cortical window within the iliac crest and cancellous bone was removed rom the iliac wing. Care was taken not to violate the sacroiliac joint. After irrigation, Gelfoam was used to obtain hemostasis, and a small Vicryl suture was used to reapproximate the fascial edge.

The main spinal wound was then once again exposed, using the retractor system, and 2 L of Bacitracin solution was used to irrigate the wound. Complete diskectomies were then carried out, with minimal to no retraction on the exiting nerve root due to the far lateral approach. Again, diskectomies were carried out across the midline to decompress both the right and left side.

The disk space was irrigated using Bacitracin solution and carefully packed with autologous bone graft. An excellent amount of bone graft was available to pack the interspace. Appropriate-sized trial implant was inserted, which restored the normal height and lordosis of the lumbar spine, and the final interbody cage device from Howmedica Stryker was then inserted across the Interspace to across the right and left sides across the midline, again to reapproximate the normal anatomic lordosis and foraminal heights. This was verified in the AP, lateral, and oblique planes, using the C-arm.

Pedicle screw instrumentation was then carried out with the posterolateral fusion. With the use of the Danek Legacy instrumentation system, an awl was then introduced to the transverse process of the facet at the level of the pedicle. The pedicle probe was inserted, followed by a straight ball-tip probe. This palpated the interior confines of the pedicle both superiorly-medially, inferiorly-laterally, and anteriorly. This confirmed no cortical breach. After pre-tapping, 6.5 mm screws were placed using this meticulous technique at L5 and S1. AP and lateral x-rays confirmed proper position of the pedicle screws.

Hillcrest HEALTHCARE SYSTEM   *1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090*

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OPERATIVE REPORT   **U/R:** 1088484

PATIENT: S D.   **BILLING NO:** 521600197

ROOM: PACU 2

EMG stimulation was carried out across the pedicle screw instrumentation, which stimulated greater than 20 mA, and the exiting nerve roots, and was established as the baseline. There was no change in the baseline with the monitoring of SSEPs or EMGs during the entire portion of the case, again verifying no cortical breach and no neural entrapment.

The entire space was irrigated once again. Completion of the posterolateral fusion was then carried out by decorticating the transverse process at the facets and pars interarticularis and carefully packing these areas with bone graft. An excellent amount of bone graft was available for completion of the 360 degree fusion though the single posterior approach. The canal was once again inspected, with no further pathology. A rod was introduced, along with the locker screws, and the entire construct was tested for stability after using the torque wrench. It was found to be extremely stable compared to initial intraoperative assessment. Repeat AP and lateral x-rays also confirmed excellent positioning of the pedicle screws, in both the interbody implant and normal restoration of the normal anatomic anatomy.

Repeat Valsalva maneuver confirmed once again no violation of the dural or neural elements. Retractor system was removed. The fascia was reapproximated using #1 Vicryl in an interrupted running fashion and the copious adipose layers, which were closed using a 0 Vicryl in interrupted. The deep subcutaneous layers were closed using a 2-0 Vicryl in interrupted fashion, followed by a 3-0 intracuticular stitch to the skin. A sterile bandage was placed across the small 4-cm incision. The patient tolerated the procedure well. She went to the recovery room in stable condition ________, where she immediately awoke with relief of her leg pain and back pain symptoms after awaking in recovery.

Steven C Anagnost, MD

MLS ID: 97104
JOB: 41680698

CC: Orthopedic Center, Khalid Gawad, MD

Rt leg pain

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	8	DELAY	—	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Wahler	CRNA	—	ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other		

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
1100	1045	1045	1046	1048	1114	1235	1241	

SURGEON: S Anagnost out 1230
ASSISTANT: [illegible] Gunyea PA
RESIDENT: D [illegible]
OTHERS: [illegible] - Dark rep, [illegible] rep
CIRCULATING NURSE: C Johnston RN
SCRUB NURSE: R Hertz CST - [illegible] ST
RELIEF/TIME: M Rowe RN (lunch) 1145-1215
RELIEF/TIME:

PRE-OP DIAGNOSIS: L5-S1 degenerative disc c̄ facet hypertrophy

MED: Thrombin c̄ gelfoam 5000 units, Marcaine 0.25% c̄ Epi - Depo 80mg -

OPERATION: L5-S1 bilateral laminectomy, facetomy foraminotomy c̄ posterior lumbar inter-body fusion, posterior spinal fusion instrumentation c̄ posterior iliac crest bone graft -

IRRIG: NS c̄ Bacitracin 50,000 units

POST-OP DIAGNOSIS: same

SPECIMENS: ☑ NONE ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other

CULTURES: ☑ NONE ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other — Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	✓		
RAYTEC	10	✓		
NEEDLES	3	✓		
KITNERS				
COTTONOIDS	10	✓		
BLADES	1 (BULLDOGS)	✓		
BOVIE TIP	2	✓		
HYPODERMICS	1	✓		
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): C Johnston RN / R. Hertz ST (1); C Johnston RN / [illegible] (2)

☐ Incorrect Count Type ___ Action taken ___

BLOOD LOSS: 30 ml
URINE OUTPUT: 600 ml

X Ray Yes ✓ No ___
Fluroscopy Time: 32
Rad Tech: Kay

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION: ☐ Unchanged ☑

PATIENT LEVEL OF CONSCIOUSNESS: ☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☑ Anesthesiologist/CNRA ☐ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☑ Siderails Up ☑ Transport with O_2

UNIT RECEIVING PATIENT: ☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other

PHONE REPORT: ☐ Yes ☑ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☑ Implants & Prosthesis — See progress note
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 08-10-05

PATIENT CONDITION: Stable

REMARKS: Cold pack to back

RN SIGNATURE: C Johnston RN TIME: 1243

UN :A00010-88484 A0521600197
S D
DOB: 02/01/40 65Y F
ANAGNOST, STEVEN C
081005 INPT

OMLB 000963

96 17B

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Aug 10 17:24:57 2005 EST
TRANS: Thu Aug 11 08:33:55 2005 EST

OPERATIVE REPORT **U/R:** 692405

PATIENT: A J **BILLING NO:** 521500431

ROOM: AMAU E

DATE OF PROCEDURE: 08/10/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Ian Gunyea, PAC

PREOPERATIVE DIAGNOSES:
1. Failed back surgery.
2. Retained internal bone stimulator and leads.
3. Painful deep hardware.
4. Nonunion lumbar 4-5.

POSTOPERATIVE DIAGNOSES:
1. Failed back surgery.
2. Retained internal bone stimulator and leads.
3. Painful deep hardware.
4. Nonunion lumbar 4-5.

PROCEDURE PERFORMED:
1. Removal of retained internal bone stimulator and leads.
2. Inspection of fusion at lumbar 4-5.
3. Removal of deep painful pedicle screw hardware at lumbar 4-5.

ESTIMATED BLOOD LOSS:.
40 cc.

DRAINS:
One Hemovac.

COMPLICATIONS:
None.

DICT: Wed Aug 10 17:24:57 2005 EST
TRANS: Thu Aug 11 08:33:55 2005 EST

OPERATIVE REPORT **U/R:** 692405

PATIENT: A J **BILLING NO:** 521500431

ROOM: AMAU E

INTRAOPERATIVE FINDINGS:

1. Solid arthrodesis at L4-5.
2. Painful deep hardware at L4-5.

INDICATIONS FOR OPERATION:
The patient is a 43-year-old male with a long-standing history of chronic pain. He has had multiple back operations including threaded cages as well as posterior pedicle screw instrumentation and bone stimulators placed. He developed severe pain around the areas of his hardware as well as his retained internal bone stimulator. Despite appropriate conservative treatment, he has continued to worsen rather than improve with his symptoms and is, therefore, present for decompression and stabilization across L4-5 as well as removal of the implants of the battery and stimulatory leads. The risks and benefits and necessity of the operation were discussed in great length and detail, including but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of neuro or vascular damage and/or dural damage and blood loss. He has had chronic pain for many years, and we are hoping to minimize his pain. We cannot undo all the aspects that happened from his previous operations. He clearly verbalizes understanding and agrees to the treatment as recommended. He agrees to both preoperative and postoperative smoking cessation and also agrees to postoperative compliance as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative IV antibiotics and was placed under general endotracheal anesthesia. He was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterilely prepping and draping, an incision as made over the previous incision site down to the level of the fascia. The fascia was incised. Blunt soft tissue dissection was carried down to the hardware, which was exposed. The cross link pedicle screws and rods were removed as was the battery, stimulator and leads. The fusion mass was inspected and found to have a solid arthrodesis with no signs of any pseudoarthrosis. Three liters of bacitracin solution were used to irrigate the wound, and Gelfoam was used to obtain hemostasis. All Gelfoam was removed. Meticulous attention to hemostasis was carried out using the Bovie cautery.

Closure was begun using #1 Vicryl in an interrupted running fashion for the fascia for a watertight closure. A drain was brought out subcutaneously through the skin, and 0 Vicryl was used to reapproximate the deep subcutaneous layers followed by 2-0 Vicryl for superficial subcutaneous layers, and a 3-0 intracuticular

DICT: Wed Aug 10 17:24:57 2005 **EST**
TRANS: Thu Aug 11 08:33:55 2005 **EST**

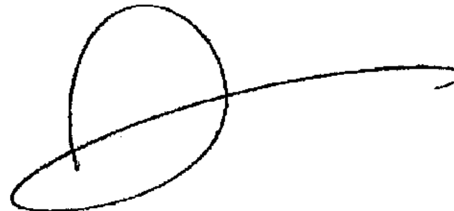
OPERATIVE REPORT **U/R:** 692405

PATIENT: A J **BILLING NO:** 521500431

ROOM: AMAU E

stitch was used to close the skin. Sterile dressings were applied. The patient tolerated the procedure well. He went to the recovery room in stable condition without difficulty where he awoke neurologically intact.

Steven C Anagnost, MD



MLS ID: 97047
JOB: 41680775

CC: Orthopedic Center

Left leg pain ☐ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	8	DELAY	—	CASE CODE	58
CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Webster	CRNA	—	ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
1300	1300	1300	1302	1305	1319	1403	1413	

SURGEON	Anagnost, S out 1345	ASSISTANT	Gunyea PAC
RESIDENT	D Lowry	OTHERS	
CIRCULATING NURSE	Johnston Rn	SCRUB NURSE	K Hertz ST
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	S/P lumbar fusion L4-L5 L5-S1 S/P bone stimulator implant	MED:	Thrombin + gelfoam - 5000 units, 1B.25% Marcaine c epi
OPERATION	Exploration of fusion Hardware removal L4-L5 - L5-S1 Bone stimulator removal	IRRIG:	NS c bacitracin 50,000 units
POST-OP DIAGNOSIS	Same		
SPECIMENS ☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☑ Other hardware	CULTURES ☑ NONE	☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	✓		
RAYTEC	10	✓		
NEEDLES	11	✓		
KITNERS				
COTTONOIDS	10	✓		
BLADES	1 — BULLDOGS	✓		
BOVIE TIP				
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect)

X Ray Yes ✓ No ___
Fluroscopy Time 7 sec
Rad Tech Susie

☐ Incorrect Count Type ___ Action taken ___

BLOOD LOSS: 20 ml
URINE OUTPUT: na

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION	☐ Unchanged ☑ incision
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CRNA ☐ Nurse ☐ Surgeon ☐ Orderly
METHOD OF TRANSPORT	☐ Patient Bed ☐ ICU Bed ☑ PACU Stretcher ☐ Other ☑ Siderails Up ☑ Transport with O_2
UNIT RECEIVING PATIENT	☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other
PHONE REPORT	☐ Yes ☑ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING ☐ NONE

SIZE/LOCATION/FIXATION
☑ Wound Drain — Hemovac x1
☐ None
☐ Implants & Prosthesis
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE 08/10/05

PATIENT CONDITION Stable

REMARKS

RN SIGNATURE C Johnston Rn TIME 1415

UN :A00006-92405 A0521500431
A J
DOB: 04/07/62 43Y M
ANAGNOST, STEVEN C
INPT 081005

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Aug 10 17:21:28 2005 EST
'RANS: Thu Aug 11 08:17:08 2005 EST

OPERATIVE REPORT **U/R:** 928165

PATIENT: O J **BILLING NO:** 520500147

ROOM: AMAU G

DATE OF PROCEDURE: 08/10/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Ian Gunyea, PAC

PREOPERATIVE DIAGNOSES:
1. Cervical instability at cervical 5-6.
2. Cervical radiculopathy cervical 5-6.

POSTOPERATIVE DIAGNOSES:
1. Cervical instability at cervical 5-6.
2. Cervical radiculopathy cervical 5-6.

PROCEDURE PERFORMED:
1. Intercervical decompression with bilateral foraminotomics and complete diskectomies and excision of posterior longitudinal ligament for decompression of dura and neural elements with use of operating room microscope.
2. Intercervical interbody fusion using Danek machine milled prosthetic implant device cervical 5-6.
3. Intercervical plating using Howmedica Stryker intercervical plating system.
4. Right iliac crest bone marrow aspiration.

ESTIMATED BLOOD LOSS:
10 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
1. Moderate osteopenia and osteoporosis.
2. Large osteophyte formation both anterior and posterior with foraminal impingement.

DICT: Wed Aug 10 17:21:28 2005 EST
RANS: Thu Aug 11 08:17:08 2005 EST

OPERATIVE REPORT **U/R:** 928165

PATIENT: G J **BILLING NO:** 520500147

ROOM: AMAU G

INDICATION FOR OPERATION:
The patient is a 55-year-old female with steadily increasing symptoms of neck pain and arm pain with numbness and tingling despite therapy, rest, medication and bracing. She has worsened rather than improved with her symptoms. Her pain level is an 8 to 9/10 on a daily basis. She is, therefore, present for decompression and stabilization with interbody fusion and plating at C5-6. The risks and benefits and necessity of the operation were fully discussed in great length and detail, including but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neuro or vascular damage and/or dural damage and blood loss. Our goals and expectations of bringing her pain level down from an 8 to 9/10 to approximately a 3 to 4/10 were also discussed. We do not expect her pain to be completely 0. She and her family verbalized understanding and eagerly agree to the treatment as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative IV antibiotics and was placed under general endotracheal anesthesia. She was placed supine on the operating table. All bony prominences were carefully and tediously padded. After sterilely prepping and draping, a needle marker was used to obtain appropriate anatomic levels once again with a lateral x-ray. Once this was confirmed, an incision was made just off of midline approximately 1.5 to 2 inches in length. Soft tissue dissection was carried down through the platysma and down to the anterior cervical vertebral bodies at C5 and C6 and verified with a needle marker and lateral x-ray.

The operating room microscope was brought in for visualization. Anterior osteophytes were excised using a Lexxel rongeur. Diskectomies were carried out back to the posterior longitudinal ligament. A 1-mm Kerrison punch was used to remove the posterior vertebral body osteophytes from the aspects of the vertebral bodies at C5 and C6 as well as to open the posterior longitudinal ligament and remove the herniated disk fragments. Excellent decompression was obtained. A 2-mm bur was used to prepare the endplates in a parallel fashion as well as to thin the foramen bilaterally. Completion of the foraminotomies was carried out using a right-angle curette and 1-mm Kerrison punches. Repalpation using a blunt right-angle nerve hook confirmed excellent decompression with no residual stenosis or impingement.

At the right iliac crest, I made a stab incision, and a trocar was inserted within the confines of the iliac wing and confirmed under direct visualization using the C-arm. Then 7 cc of aspiration were carried out across

DICT: Wed Aug 10 17:21:28 2005 EST
RANS: Thu Aug 11 08:17:08 2005 EST

OPERATIVE REPORT U/R: 928165

PATIENT: G J **BILLING NO:** 520500147

ROOM: AMAU G

the iliac wing for the bone marrow aspirate, and the trocar was removed. There was no active bleeding found, and after irrigation the area was closed using a Steri-Strip.

The main spinal wound was then thoroughly irrigated. The trial implant was inserted of a size 8, and a size 8 machine milled prosthetic implant device was then carefully soaked within the bone marrow aspiration and then placed into the interspace at C5-C6. This was confirmed to be at proper anatomic levels with excellent fit using AP and lateral x-rays to confirm.

Intercervical plating was carried out using Howmedica Stryker intercervical plating system. Bilateral drilling followed by 14-mm screw placement was carried out at C5 and C6. There was noted to be moderate osteoporosis and osteopenia. The plate had to be adjusted because of the osteopenia in order to find good purchase for the screws. This was verified to be in proper position in the AP and lateral planes using the C-arm. The screws were locked within the plate per protocol. The entire construct was tested for stability and found to be extremely stable compared to initial intraoperative assessment.

Copious irrigation solution was used to irrigate the wound, and Gelfoam was used to obtain meticulous hemostasis. All Gelfoam was removed, and the platysma was loosely reapproximated using a 3-0 Vicryl in an interrupted fashion followed by a 4-0 intracuticular stitch for the skin. Sterile dressings were applied. The patient tolerated the procedure well. She was sent to the recovery room in stable condition without difficulty where she awoke neurologically intact with relief of her arm pain symptoms. Upon extubation, the patient did have an incident where she clamped down onto the tube. She bit her tongue, and there was a laceration to her tongue. This bleeding was present for a short period of time in the recovery room. Bleeding had completely stopped on examination of the patient, and she was awake and oriented. An ENT consult was obtained in order to see if there was any further treatment needed for the patient's tongue. The patient, again, had relief of her arm pain symptoms and neck pain after awakening and was complaining only of her tongue pain.

Steven C Anagnost, MD

MLS ID: 97047
JOB: 41680763

CC: Orthopedic Center

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	3	DELAY		CASE CODE	58
CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Dr. M. Revatt	CRNA			
ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
0930	0952	0952	0952	1000	1007	1054	1105	

SURGEON	Dr. S. Anagnost	ASSISTANT	T. Gunyea, PA
RESIDENT	Dr. T. Lowry	OTHERS	G. Vincent (neurolinks)
CIRCULATING NURSE	W. Heaper, RN	SCRUB NURSE	A. Ford, ST / D. Henry, ST
RELIEF/TIME		RELIEF/TIME	

PRE-OP DIAGNOSIS: C5-6 Spondylosis

MED: 0.25% Marcaine c epi; Topical Avacel 40#; Thrombin 5,000 units

OPERATION: Anterior Cervical discectomy with fusion at C5-6 iliac crest aspiration

IRRIG: 0.9% NaCl

POST-OP DIAGNOSIS: Same

SPECIMENS: ☑ NONE — ☑ Tissue Not Removed ☒ Tissue to Lab X ______ ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ______ ☐ Sent with Dr. ______ ☐ Other ______

CULTURES: ☒ NONE — ☐ Aerobic Time ____ ☐ Anerobic Time ____ ☐ Stat Gram Stain Time ____ ☐ Other ____ Time ____

COUNTS	(1) COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X		
RAYTEC	70	X		
NEEDLES	2	X		
KITNERS	10	X		
COTTONOIDS	10	X		
BLADES	2 (BULLDOGS)	X		
BOVIE TIP	1	X		
HYPODERMICS	1	X		
INSTRUMENTS				

SIGNATURE LINES (X = Correct, 0 = Incorrect)
(1) W. Heaper, RN / A. Ford, ST
(2) W. Heaper, RN / A. Ford, ST

X Ray Yes X No ____

☐ Incorrect Count Type ______ Action taken ______

Fluroscopy Time ______

BLOOD LOSS: 10 ml

Rad Tech: K. Stout

URINE OUTPUT: Ø

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION: ☐ Unchanged ☑ Surgical Site

PATIENT LEVEL OF CONSCIOUSNESS: ☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☑ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☑ Anesthesiologist/CRNA ☑ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed ☐ ICU Bed ☑ PACU Stretcher ☐ Other ______ ☑ Siderails Up ☑ Transport with O_2

UNIT RECEIVING PATIENT: ☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other ______

PHONE REPORT: ☐ Yes ☑ No Time ______ To ______ By ______

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION

☐ Wound Drain
☐ None
☑ Implants & Prosthesis — See progress notes
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 8-10-05

PATIENT CONDITION: Stable

REMARKS:

RN SIGNATURE: W. Heaper, RN TIME: 1105

UN :A00009-28165 A0520500147
G J
DOB: 05/29/50 55Y F
ANAGNOST, STEVEN C
081005 INPT

1015 502

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Oct 05 21:48:05 2005 EST
TRANS: Thu Oct 06 13:19:14 2005 EST

OPERATIVE REPORT **U/R:** 571742

PATIENT: I J **BILLING NO:** 527300043

ROOM:

DATE OF PROCEDURE: 10/05/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Amy Brookover, PA

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis.
2. Lower extremity weakness.

POSTOPERATIVE DIAGNOSES:
The same.

PROCEDURE PERFORMED:
Bilateral laminectomies with bilateral medial fascetectomies and foraminotomies at L2-3, L3-4, and L4-5 for decompression of dura and neural elements secondary to severe stenosis and lower extremity weakness.

ESTIMATED BLOOD LOSS:
15 cc.

DRAINS:
None.

COMPLICATIONS: .
None.

INDICATION FOR OPERATION:
The patient is a very pleasant 79-year-old male who has undergone a previous fusion and decompression by Dr. Alan Holderness many years ago. He tolerated this procedure well. He has now developed progressive stenosis at the levels above at L2-3, L3-4, and L4-5. Despite epidural injections, medication, rest, and therapy, he is getting worse rather than improved with his symptoms. He is therefore present for lumbar decompression for his severe stenosis and progressive lower extremity weakness and back pain. The risks and benefits of the operation were discussed at great length in detail and include but are not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, and the risk of neural or vascular damage

DICT: Wed Oct 05 21:48:05 2005 EST
TRANS: Thu Oct 06 13:19:14 2005 EST

OPERATIVE REPORT **U/R: 571742**

PATIENT: I J **BILLING NO: 527300043**

ROOM:

and/or dural damage and blood loss. Our goals and expectations of minimizing his pain as much as possible were discussed with him and his family. All questions were answered to his satisfaction and he agrees with the treatment plan as recommended after verbalizing his understanding of these.

INTRAOPERATIVE FINDINGS:
Severe bilateral stenosis at L2-3, L3-4, and L4-5.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative antibiotics, and placed under general endotracheal anesthesia. He was placed prone on a Wilson frame, and all bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle mark was used to attain proper anatomic landmarks with a lateral x-ray. Once this was confirmed, a small 16-mm incision was created distal from midline. Gentle dilation was carried to the soft tissue to a size 16-mm dilator retractor. This was confirmed once again to be at the proper anatomic level with a lateral x-ray.

The operating microscopic was brought in for visualization. Kerrison rongeurs were used to perform laminectomies, as well as medial facetectomies, and foraminotomies bilaterally at L2-3, L3-4, and L4-5. Excellent bilateral decompression was attained and this was confirmed using a curved ball-tip probe along each of the pedicles at L2, L3, L4, and L5 confirmed with individual lateral x-rays. A Valsalva maneuver confirmed no violation of the dura or neural elements. The stenosis was most markedly severe at the L4-5 and moderately at L3-4 levels. There is a large cassette cyst also present at the L3-4 and L4-5 levels. Copious irrigation solution again was used to irrigate the wound. Final inspection revealed no further stenosis or impingement with excellent decompression. A final Valsalva maneuver once again confirmed no violation of the dura and no neural elements with no dural leak. Gelfoam was used to attain meticulous and complete hemostasis and all Gelfoam was removed.

The retractor system was removed. The fascia was reapproximated using 2-0 Vicryl in an interrupted fashion, followed by a 4-0 intracuticular stitch of the skin edges. A sterile Band-Aid was placed across a small 16-mm incision. The patient tolerated the procedure well, and he went to the recovery room in stable

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Oct 05 21:48:05 2005 EST
TRANS: Thu Oct 06 13:19:14 2005 EST

OPERATIVE REPORT **U/R:** 571742

PATIENT: I J **BILLING NO:** 527300043

ROOM:

condition without difficulty. He awoke neurologically intact with immediate relief of his leg pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97214
JOB: 41820457

CC: Orthopedic Center

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	8	DELAY	#1	CASE CODE	58	CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Dr L Waddell	CRNA				ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthesia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
1230	1455	1455	Rele	1503	1516	1602	1615	

SURGEON	Dr S Anagnost	ASSISTANT	
RESIDENT	Dr Scott	OTHERS	
CIRCULATING NURSE	H Kanington RN	SCRUB NURSE	J Janbard ST
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	Lumbar Stenosis L2-3, L3-4 and L4-5	MED:	Bacitracin, Thrombin, Gelfoam, .25% Marcaine c epi 0.25% Marcaine, 480 Dysl Nds
OPERATION	L2-3, L3-4, L4-5 Bilateral laminectomy, facetectomy, foraminotomy, Medtrle	IRRIG:	NACL
POST-OP DIAGNOSIS	Same		

SPECIMENS		CULTURES	
☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ☒ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other	☒ NONE	☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5			
RAYTEC	10			
NEEDLES	2			
KITNERS				
COTTONOIDS	10			
BLADES	1 BULLDOGS			
BOVIE TIP	1			
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect)
1) H Kanington RN / J Janbard ST
2)
3)
4) H Kanington RN / J Janbard ST

X Ray Yes ✓ No ___ C Ann
Fluroscopy Time 55 sec
Rad Tech S Freeman

☐ Incorrect Count Type ______ Action taken ______

BLOOD LOSS: min
URINE OUTPUT: Ø

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION	~~☐ Unchanged~~ ☐ Per Surgery	DRAINS CATHETERS PACKING	SIZE/LOCATION/FIXATION ☐ Wound Drain ☐ None ☐ Implants & Prosthesis
PATIENT LEVEL OF CONSCIOUSNESS	☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated		
ACCOMPANYING PERSONNEL	☒ Anesthesiologist/CNRA ☐ Surgeon ☒ Nurse ☐ Orderly		☐ Salem Sump ☐ Packing ☐ Other
METHOD OF TRANSPORT	☐ Patient Bed ☒ PACU Stretcher ☒ Siderails Up ☐ ICU Bed ☐ Other ☒ Transport with O_2		
UNIT RECEIVING PATIENT	☒ PACU Main (SDS) ☐ Nursing Unit ☐ ICU ☐ Other	☒ NONE	☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
PHONE REPORT	☒ Yes ☐ No Time ___ To ___ By ___	DATE	10-5-05

PATIENT CONDITION: Stable.

REMARKS

RN SIGNATURE: H Kanington RN TIME: 1615

UN :A00005-71742 A0527300043
DOB: 02/13/26 79Y M
ANAGNOST, STEVEN C
SDS 10-05-05

OMLB 000999

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Nov 21 22:41:08 2005 **EST**
TRANS: Tue Nov 22 14:08:16 2005 **EST**

OPERATIVE REPORT **U/R:** 1097095

PATIENT: M G **BILLING NO:** 532100054

ROOM: RR01 I

DATE OF PROCEDURE: 11/21/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Amy K Brookover, PA

PREOPERATIVE DIAGNOSES:
1. Cervical spinal stenosis at C5-6, C6-7.
2. Upper extremity radiculopathy with weakness.
3. Cervical instability, C5-6, C6-7.

POSTOPERATIVE DIAGNOSES:
1. Cervical spinal stenosis at C5-6, C6-7.
2. Upper extremity radiculopathy with weakness.
3. Cervical instability, C5-6, C6-7.

PROCEDURES PERFORMED:
1. Complete anterior cervical decompression with bilateral foraminotomies and complete discectomies and excision of posterior longitudinal ligament at C5-6, C6-7 with use of operating room microscope.
2. Anterior cervical interbody fusion using a Machine Mill prosthetic implant device from Danek, at C5-6, C6-7.
3. Endocervical plating using Howmedica Stryker anterior cervical plating system at C5-6, C6-7.
4. Right iliac crest bone marrow aspiration through separate incision.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

Hillcrest
HEALTHCARE SYSTEM
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Nov 21 22:41:08 2005 EST
TRANS: Tue Nov 22 14:08:16 2005 EST

OPERATIVE REPORT **U/R:** 1097095

PATIENT: M G **BILLING NO:** 532100054

ROOM: RR01 1

INTRAOPERATIVE FINDINGS:

1. Severe cervical instability, C5-6, C6-7.
2. Severe cervical stenosis with central canal foraminal stenosis with osteophyte formation at C5-6, C6-7.

INDICATIONS FOR OPERATION:
The patient is a 71-year-old male with steadily progressive symptoms of both neck pain and arm pain as well as upper extremity weakness. This has been of progressive and severe in nature. Despite appropriate conservative treatment, he is worsened rather than improved with his symptoms. He is present for anterior cervical decompression and stabilization, interbody fusion, and plating with autologous iliac crest bone grafting.

The risks and benefits, and the necessity of the operation were fully discussed at great length and detail. These included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, the risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neural or vascular damage and/or dural damage, and blood loss. Our goals and expectation is to bring his pain level down from 8-9/10 to approximately 2-3/10, were also discussed. We do not expect his pain to be zero. He and his family verbalized understanding of these risks, benefits, goals, and expectations, and the necessity of the operation and they agree to the treatment plan as recommended.

DESCRIPTION OF THE PROCEDURE:
The patient brought to the operating room, given preoperative IV antibiotics, was placed under general endotracheal anesthesia. He was placed supine on the operating room table, all bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain proper anatomic levels with the lateral x-ray. Once this was confirmed, an incision was made just off of midline, coursing down to the level of the platysma. The platysma was split in line with its fibers and blunt and soft tissue dissection was carried out to the anterior cervical vertebral bodies of C5, C6, and C7, and confirmed with a needle marker and a lateral x-ray.

The operating room microscope was brought in for visualization. Pituitary rongeurs were used to perform complete discectomies. The anterior osteophytes were removed using large Leksell rongeurs at both C5-6, C6-7, as the discectomies were carried out at each of these levels in addition. Dissection was carried back to the posterior longitudinal ligament. Curets were used to remove the cortical rim of bone and the

DICT: Mon Nov 21 22:41:08 2005 EST
TRANS: Tue Nov 22 14:08:16 2005 EST

OPERATIVE REPORT **U/R:** 1097095

PATIENT: M G **BILLING NO:** 532100054

ROOM: RR01 1

osteophyte formation. A 1-mm Kerrison punch was used to remove the osteophytes from the posterior aspect of the vertebral bodies of C5-6, C6-7. The posterior longitudinal ligament was then carefully excised, also using the 1-mm Kerrison punch. The 2-mm bur was used to prepare the endplates in a parallel fashion as well as extend the foramen bilaterally. Completion of the foraminotomies was carried out using a right angled curet. A blunt right angled nerve hook confirmed excellent decompression with no residual stenosis or impingement.

There was noted to be severe collapse and stenosis at C6-7, and moderately severe at C5-6.

Interbody fusion was begun by broaching each of the endplates in a parallel fashion until subsequent size 8 trial prosthesis was inserted at C5-6 and a size 9 at C6-7.

A right iliac crest bone grafting aspiration was then carried out through a separate incision on the iliac wing. A small stab incision was created followed by a Jamshidi needle. Then 8 cc of aspiration was carried out along with bone marrow aspirate, and the needle was removed. Complete hemostasis was obtained and irrigation solution was used to irrigate the wound, and sterile dressings were applied.

The main spinal wound was then thoroughly irrigated once again. Appropriate sized Mill prosthetic implant device from Danek were opened and injected then with the bone marrow aspiration. These Mill prosthetic implant devices were then inserted across the interspace at C5-6, C6-7 which restored the normal foraminal height and lordosis. This was verified in the AP and lateral planes using the C-arm.

Anterior cervical plating was carried out using Howmedica Stryker anterior cervical plating system. Bilateral drilling followed by 14-mm screw placement was carried out at each of these levels, and the screws were locked within the plate per protocol. The entire conduit was tested for stability and found to be extremely stable. Gelfoam as used to attain meticulous and complete hemostasis, and all Gelfoam was removed. The wound was completely dry upon closure.

There were no changes in the EMG monitoring. Motor-evoked potentials showed actual improvement up along the left side where the patient had a preoperative deficit. Again, this baseline improved after decompression of the neural elements as described and stabilization as described.

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DICT: Mon Nov 21 22:41:08 2005 EST
TRANS: Tue Nov 22 14:08:16 2005 EST

OPERATIVE REPORT

U/R: 1097095

PATIENT: M G

BILLING NO: 532100054

ROOM: RR01 1

The platysma was then loosely reapproximated using a 3-0 Vicryl in interrupted fashion followed by a 4-0 intracuticular stitch for the skin edge. Sterile dressings were applied.

The patient was placed in a soft collar, and he went to the recovery room in stable condition without difficulty. He awoke with immediate relief of his arm pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97150
JOB: 62000815

CC: Orthopedic Center

☐ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	04	DELAY	→	CASE CODE	58
CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Imhoff	CRNA			
ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
1114	1115		[illegible]	1115	1135	1251	1300	

SURGEON	S Anagnost	ASSISTANT	A Buckner
RESIDENT	D Orr	OTHERS	J Rice, D Wilson
CIRCULATING NURSE	F Rolsman RN	SCRUB NURSE	F Jamhand, K Crowder
RELIEF/TIME		RELIEF/TIME	

PRE-OP DIAGNOSIS: Cervical canal stenosis with radiculopathy Cervical 5-6, 6-7

OPERATION: Cervical 5-6, 6-7 Anterior Cervical Decompression with Anterior Cervical Interbody Fusion w/ iliac crest bone Aspiration

MED: 1) 0.25 marcaine w/epi [illegible] 2) 5K Thrombin + 100 gelfoam 3) 50K Bacitracin

IRRIG: 1000 NS

POST-OP DIAGNOSIS:

SPECIMENS: ☒ NONE ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other

CULTURES: ☒ NONE ☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	✓	✓	
RAYTEC	10	✓	✓	
NEEDLES				
KITNERS	10	✓	✓	
COTTONOIDS				
BLADES	2 (BULLDOGS)	✓	✓	
BOVIE TIP	1	✓	✓	
HYPODERMICS	2	✓	✓	
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): Rolsman RN; K Crowder st; F Jamhand st

X Ray Yes ✓ No ___
Fluroscopy Time 8 sec
Rad Tech K Stout

☐ Incorrect Count Type ___ Action taken ___

BLOOD LOSS: 40 ml
URINE OUTPUT: N/A

SKIN CONDITION: ☐ Unchanged ☐ surgical site

PATIENT LEVEL OF CONSCIOUSNESS: ☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CNRA ☒ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☒ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☒ Siderails Up ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other

PHONE REPORT: ☐ Yes ☐ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☒ Implants & Prosthesis: see preop note ☐ Salem Sump ☐ Packing ☐ Other ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 11-21-05

POST-OPERATIVE NURSING OBSERVATIONS

PATIENT CONDITION: stable

REMARKS: Pt transported to PACU w/ no complications

RN SIGNATURE: F Rolsman RN TIME: 1300

UN :A00010-97095 A0532100054
H C
DOB: 09/19/34 71Y M
ANAGNOST, STEVEN C
INPT 112105

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

12/13

DICT: Tue Dec 13 07:52:27 2005 **EST**
TRANS: Tue Dec 13 09:41:49 2005 **EST**

OPERATIVE REPORT **U/R:** 704611

PATIENT: S E **BILLING NO:** 533900232

ROOM: SURG E

DATE OF PROCEDURE: 12/12/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Brookover

PREOPERATIVE DIAGNOSES:
1. Multilevel cervical instability C4-5, C5-6, and C6-7.
2. Cervical radiculopathy with foraminal stenosis C4-5, C5-6, and C6-7.
3. Upper extremity weakness.

POSTOPERATIVE DIAGNOSES:
1. Multilevel cervical instability C4-5, C5-6, and C6-7.
2. Cervical radiculopathy with foraminal stenosis C4-5, C5-6, and C6-7.
3. Upper extremity weakness.

PROCEDURE PERFORMED:
1. Complete anterior cervical decompression with diskectomies and bilateral foraminotomies and excision of posterior longitudinal ligament and posterior vertebral body osteophytes at C4-5, C5-6, and C6-7 with the use of operating room microscope.
2. Anterior cervical interbody fusion with use of Danek milled prosthetic implant device C4-5, C5-6, and C6-7.
3. Anterior cervical plating using Howmedica Stryker anterior cervical plating system, C4-5, C5-6, and C6-7.
4. Right iliac crest bone grafting with morselized autologous through a separate incision.

ESTIMATED BLOOD LOSS:
15 cc.

DRAINS:
None.

COMPLICATIONS:
None.

DICT: Tue Dec 13 07:52:27 2005 **EST**
TRANS: Tue Dec 13 09:41:49 2005 **EST**

OPERATIVE REPORT **U/R:** 704611

PATIENT: S E **BILLING NO:** 533900232

ROOM: SURG E

DESCRIPTION OF THE PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, placed under general endotracheal anesthesia. She was placed supine on the operating table. All bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain appropriate anatomic levels with a lateral x-ray. Once this was confirmed, a longitudinal incision was created just left of the midline, coursing down to the level of the platysma. The platysma was split in line with its fibers, and blunt and soft tissue dissection was carried out to expose the vertebral bodies of C4, C5, C6, and C7 and confirmed with a needle marker and a lateral x-ray.

The operating room microscope was brought in for visualization. Complete discectomies were carried out at C4-5, C5-6, and C6-7. Dissection was carried out back to the posterior longitudinal ligament with good pituitary rongeurs. Then 1-mm Kerrison punches were used to remove the posterior vertebral body osteophytes along the superior and inferior respective aspects of each of the vertebral body levels from C4 to C7. The posterior longitudinal ligament was also excised using a 1-mm Kerrison punch. There was marked stenosis present along the neural foramen in addition. Completion of foraminotomies was carried out bilaterally using a right-angle curet at C4-5, C5-6, and C6-7. Confirmation of excellent decompression was carried out using a blunt right-angle nerve hook at each level bilaterally. Copious irrigation solution was used to irrigate the wound.

Iliac crest bone aspiration was carried out through a separate incision along the iliac wing. A stab incision was created, followed by insertion of a Jamshidi needle, and 10 cc of bone marrow aspirate were removed, and the area was irrigated and covered using sterile dressings.

The main spinal wound was then once again irrigated thoroughly using 2 L of bacitracin solution.

Interbody fusion was then carried out by machining the endplates in a parallel fashion using the broach instrumentation and with trial instrumentation for sizing to restore the normal foraminal height and lordosis. The final prostheses were then opened and injected with bone marrow aspirate individually, and then inserted into the respective interspaces at C4-5, C5-6, and C6-7, and this restored the normal foraminal height and lordosis and was verified in the AP and lateral planes using the C arm.

DICT: Tue Dec 13 07:52:27 2005 EST
TRANS: Tue Dec 13 09:41:49 2005 EST

OPERATIVE REPORT **U/R:** 704611

PATIENT: S E **BILLING NO:** 533900232

ROOM: SURG E

Intercervical plating was then carried out using Howmedica Stryker intercervical plating system. Bilateral drilling followed by 14-mm screw placement was carried out to secure the plate into place and to secure the entire construct. The screws were recessed within the locking mechanism per protocol and tested intraoperatively. There was noted to be marked osteoporosis and osteopenia to the vertebral bodies but overall, the screws had good purchase. The screw and plate construct had to be adjusted slightly in order to accommodate proper bone density. Repeat irrigation solution was once again used to irrigate the wound. There was no further pathology found. The wound was completely dry upon closure. The platysma was loosely reapproximated using 3-0 Vicryl in an interrupted fashion, followed by 4-0 intracuticular stitch for the skin edges. Sterile dressings were applied. The patient was placed in a soft collar, and she went to the recovery room in stable condition without difficulty where she awoke neurologically intact.

Steven C Anagnost, MD

MLS ID: 96566
JOB: 62060204

CC: Orthopedics Center

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	8	DELAY	[illegible]	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	L. Weksler	CRNA	—			ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
0930	0915	0915	here	0918	0933	1045	1100	

SURGEON	S. Anagnost	ASSISTANT	A. Brookover, PA / J. Pop PA
RESIDENT	Dr. Das	OTHERS	A. Scoggin, RN / P. Lybarger RN > EMG
CIRCULATING NURSE	K. Ward RN / K. Best S. RN	SCRUB NURSE	R. Hertz, CST
RELIEF/TIME	Hooper RN (1040 - out time)	RELIEF/TIME	K. Summers ST (1045 out)
PRE-OP DIAGNOSIS	C4-5, C5-6, C6-7 myelopathy, very severe C4-5 stenosis, C5 radiculopathy	MED.	Bacitracin 50,000 u; Sensorcaine 0.25% c̄ epi; Thrombin 5,000 u; Gelfoam dry
OPERATION	C4-5, C5-6, C6-7 anterior cervical decompression with anterior cervical interbody fusion with plating with iliac crest bone aspiration	IRRIG:	NaCl
POST-OP DIAGNOSIS	Same		

SPECIMENS	CULTURES
☐ NONE; ☐ Tissue Not Removed; ☐ Tissue to Lab X ____; ☐ Tissue Removed Not Sent to Lab; ☐ Frozen Section X ____; ☐ Sent with Dr. ____; ☐ Other ____	☐ NONE; ☐ Aerobic Time ____; ☐ Anerobic Time ____; ☐ Stat Gram Stain Time ____; ☐ Other Time ____

COUNTS	COUNTS	2ND	3RD	4TH
	✓			
LAP SPONGES	5	✓		
RAYTEC	10	✓		
NEEDLES	2	✓		
[illegible]TNERS	10	✓		
COTTONOIDS	10	✓		
BLADES	2 (BULLDOGS)	✓		
BOVIE TIP	1	✓		
HYPODERMICS	1	✓		
INSTRUMENTS		✓		

SIGNATURE LINES (X = Correct 0 = Incorrect)
X K. Best RN / R. Hertz CST
② K. Ward RN / R. Hertz CST

X Ray Yes ✓ No ____
Fluroscopy Time 12
Rad Tech Susie / Kay Stuart

☐ Incorrect Count Type ____ Action taken ____

BLOOD LOSS	50 ml
URINE OUTPUT	Ø
SKIN CONDITION	☐ Unchanged ☑ Surgical incision
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☑ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CNRA ☑ Nurse ☐ Surgeon ☐ Orderly
METHOD OF TRANSPORT	☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ____ ☑ Siderails Up ☑ Transport with O_2
UNIT RECEIVING PATIENT	☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other ____
PHONE REPORT	☐ Yes ☑ No Time ____ To ____ By ____

DRAINS CATHETERS PACKING — SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☐ Implants & Prosthesis — In progress notes
☐ Salem Sump
☐ Packing
☐ Other ____
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
☐ NONE

DATE 12-12-05

PATIENT CONDITION Stable

REMARKS To PACU per bed c̄ SR; NC 2 O_2

RN SIGNATURE Hooper TIME 1100

UN :A00007-04611 A0533900232
S E
DOB: 03/27/28 77Y F
ANAGNOST, STEVEN C
121205 INPT

OMLB 001024

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Tue Dec 20 08:29:55 2005 EST
TRANS: Tue Dec 20 10:00:53 2005 EST

OPERATIVE REPORT U/R: 714313

PATIENT: C H **BILLING NO:** 534300311

ROOM: AMAU H

DATE OF PROCEDURE: 12/19/2005

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Brookover

PREOPERATIVE DIAGNOSES:
1. Cervical malunion, C4-C7.
2. Cervical nonunion, C4-5 and C5-6.
3. Prominent displaced hardware impinging on C3-4 level, causing instability.
4. Upper extremity radiculopathy.
5. Foraminal stenosis.
6. Upper extremity weakness.

POSTOPERATIVE DIAGNOSES:
1. Cervical malunion, C4-C7.
2. Cervical nonunion, C4-5 and C5-6.
3. Prominent displaced hardware impinging on C3-4 level, causing instability.
4. Upper extremity radiculopathy.
5. Foraminal stenosis.
6. Upper extremity weakness.

PROCEDURE PERFORMED:
1. C3-4, C5-6 revision, anterior cervical decompression with complete discectomies and bilateral foraminotomies, and excision of posterior longitudinal ligament for complete decompression of spinal cord and neural elements with the use of the operating room microscope.
2. Anterior cervical interbody fusion and revision, C3-4, C4-5, and C5-6.
3. Revision anterior cervical plating, C3-4, C4-5, C5-6.
4. Right iliac crest bone marrow aspiration through a separate incision.
5. Inspection of fusion C3-C7.
6. Removal of loose displaced anterior cervical plate hardware and screws, C4-C7.

ESTIMATED BLOOD LOSS:
15 cc.

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Tue Dec 20 08:29:55 2005 EST
TRANS: Tue Dec 20 10:00:53 2005 EST

OPERATIVE REPORT **U/R: 714313**

PATIENT: C H **BILLING NO:** 534300311

ROOM: AMAU H

DRAINS:
None.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
1. Obvious nonunion at C4-5 and C5-6.
2. Marked instability at C3-4 with prominent hardware.
3. Marked foraminal stenosis and central canal stenosis at C3-4 and at C5-6.
4. The revision nature of the surgery increased the overall length, complexity, and difficulty of the entire portion of the case including both the exposure, the hardware removal, and the subsequent revision decompression and fusion.

INDICATION FOR OPERATION:
The patient is a 78-year-old female who underwent a previous attempted anterior cervical decompression and fusion. She had displacement of her hardware and an obvious nonunion and now malunion. She is present for revision decompression and stabilization. The risks and benefits and the necessity of the operation were fully discussed at great length and detail. These included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neural or vascular damage, and/or dural damage, and blood loss. The revision nature of the surgery was discussed. The increased risk of difficulty with hoarseness and swallowing, as well as the scarring, and the possible need for posterior surgery in the future were discussed. The fact that she has now collapsed and had partial fusion with a malunion at certain areas of her spine were also discussed which limit her overall outcome. All questions were answered to her satisfaction. She understands we do not expect her pain to be 0, but hope to improve her symptoms as much as possible. She agrees to the treatment plan as recommended.

DESCRIPTION OF THE PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, placed under general endotracheal anesthesia. She was placed supine on the operating table. All bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain

DICT: Tue Dec 20 08:29:55 2005 EST
TRANS: Tue Dec 20 10:00:53 2005 EST

OPERATIVE REPORT U/R: 714313

PATIENT: C H **BILLING NO: 534300311**

ROOM: AMAU H

appropriate anatomic levels with a lateral x-ray. Once this was confirmed, a longitudinal incision was made off of the midline, coursing down to the level of the platysma. The platysma was split in line with its fibers, and blunt and soft tissue dissection was carried down to the anterior cervical vertebral bodies, exposing C3, C4, C5, C6, and C7. The previous hardware was exposed and found to be very loose. The scar tissue was carefully removed through tedious dissection, and the set screws and locking mechanisms and cervical screws were removed. The cervical screws were found to be extremely loose, and the plate was impinging directly upon the C3-4 level, which had violated the C3-4 interspace, compromising the disk itself

The inspection of fusion revealed overall solid arthrodesis at C6-7. There was a malunion and nonunion at C4-5 and C5-6, and again increased mobility due to the disk instability as described at C3-4. The disk space was clearly identified at C3-4, as it was at C5-6, and at C4-5. There was obvious disk material found across each of these levels. Curets and pituitary rongeurs were used to perform complete discectomies back to the posterior longitudinal ligament across each of these levels. The posterior longitudinal ligament was carefully opened using 1-mm Kerrison punch, as were the posterior vertebral body osteophytes. Excellent decompression was attained at each level and verified using a blunt right-angle nerve hook bilaterally. Foraminotomies were then completed using a 2-mm burr and the right-angled curet, and the 1-mm Kerrison punch bilaterally from C3-C6.

Please note this was performed completely with the use of the operating room microscope for visualization.

Interbody fusion was then begun by taking the iliac crest bone marrow aspiration. A separate incision along the iliac wing was created, and a Jamshidi needle was inserted. Then 10 cc of bone marrow aspirate were removed. After irrigation, Steri-Strip and Band-Aid were placed across the small stab incision site.

The main spinal wound was thoroughly irrigated using 2 L of bacitracin solution. The endplates were repaired in a parallel fashion to begin the distraction instrumentation for the interbody fusion. Proper sized implants were then trialed, and then opened on the back table. These were then infused and injected with the bone marrow aspirate, and the final milled prosthetic interbody devices were then inserted across the C3-4, C4-5, and C5-6 levels for the revision interbody fusion. This restored the normal foraminal height and lordosis and was extremely stable. This opened the neural foramen properly as well, as well as created good stability as was tested intraoperatively, compared to initial intraoperative inspection.

DICT: Tue Dec 20 08:29:55 2005 **EST**
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OPERATIVE REPORT **U/R:** 714313

PATIENT: C H. **BILLING NO:** 534300311

ROOM: AMAU H

Anterior cervical plating was then begun by properly measuring the plate size, the previous screw holes, and nonunion sites, and limited somewhat the ability and size of the plate. The plate was spanned from C3 to C6 and screw fixation was obtained through bilateral drilling and 14-mm screw placement. These were locked within the plate per protocol and tested intraoperatively. The plate was extremely stable compared to initial intraoperative assessment. Final AP and lateral x-rays confirmed proper positioning of the interbody devices, proper anatomic levels, as well as proper positioning of the plate. There was some moderate osteopenia noted, requiring that the plate be adjusted in a medial to lateral fashion in order to accommodate good bone quality. Repeat irrigation solution was used to irrigate the wound. No further pathology was identified. The wound was completely dry upon closure. The platysma was loosely reapproximated using 3-0 Vicryl followed by 4-0 intracuticular stitch for the skin edges. Sterile dressings were applied. The patient was placed in a soft collar, and she went to the recovery room in stable condition without difficulty where she awoke neurologically intact.

Please note there were no changes in the EMG and SSEP monitoring throughout the entire portion of the case as these were monitored electrically as well.

Steven C Anagnost, MD

MLS ID: 96566
JOB: 42022128

CC: Orthopedic Center, Debra K Madaj, MD

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	04	DELAY	—	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Unkofe	CRNA	—			ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthesia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
1200	1148	1150	1153	1153	1217	1355	1401	

SURGEON	Anagnost	ASSISTANT	Brookover PA out 1320
RESIDENT	[illegible]	OTHERS	
CIRCULATING NURSE	[illegible]	SCRUB NURSE	R. Rodriguez
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	Status post attempted fusion C3-7 C3-C7 nonunion, malunion, radiculopathy and weakness	MED:	0.25% Marcaine ē Epi; Thrombin 5,000U; Gelfoam 100
OPERATION	C3-C4, C4-C5, C5-C6, C6-C7 Anterior cervical decompression with anterior cervical interbody fusion and plating with left-sided approach. Iliac crest bone marrow aspiration.	IRRIG:	0.9% NaCl c Bacitracin 50,000 Units
POST-OP DIAGNOSIS	Same		

SPECIMENS ☑ NONE — ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other

CULTURES ☑ NONE — ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X	X	
RAYTEC	10	X	X	
NEEDLES	2	X	X	
KITNERS	10	X	X	
COTTONOIDS				
BLADES	2 (BULLDOGS)	X	X	
BOVIE TIP	1	X	X	
HYPODERMICS	1	X	X	
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): C. [signature] RR

X Ray Yes X No
Fluoroscopy Time 12
Rad Tech Suze

☐ Incorrect Count Type — Action taken

BLOOD LOSS: 50
URINE OUTPUT: None

SKIN CONDITION: ☐ Unchanged ☑ Surgical incision

PATIENT LEVEL OF CONSCIOUSNESS: ☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☑ Anesthesiologist/CRNA ☐ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☑ Siderails Up ☑ Transport with O_2

UNIT RECEIVING PATIENT: ☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other

PHONE REPORT: ☑ Yes ☐ No Time 1348 To Willie By [initials]

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION

☐ Wound Drain
☐ None
☑ Implants & Prosthesis: Lordotic ASR cortical Cancellous BLK 8x14x11 ID: 3107377 Exp: 10/13/08 Lot: 101045664; 7x14 x11, ID: 3045310 Exp: 9/7/08, Lot# 101044371
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 12-19-05

PATIENT CONDITION: Stable

REMARKS

RN SIGNATURE: C. [signature] TIME 1403

UN :A00007-14313 A0534300311
C... .K.
DOB: 11/08/27 78Y F
ANAGNOST, STEVEN C
INPT 121905

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Fri Jan 13 07:02:43 2006 **EST**
TRANS: Fri Jan 13 07:22:47 2006 **EST**

OPERATIVE REPORT **U/R:** 1100141

PATIENT: R M **BILLING NO:** 536200378

ROOM: 9617 B

DATE OF PROCEDURE: 01/04/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Popp

PREOPERATIVE DIAGNOSES:
1. Lumbar instability L4-5.
2. Lumbar spinal stenosis L4-5.
3. Lower extremity radiculopathy and weakness.
4. Painful deep hardware L5-S1.
5. Nonunion L5-S1.

POSTOPERATIVE DIAGNOSES:
1. Lumbar instability L4-5.
2. Lumbar spinal stenosis L4-5.
3. Lower extremity radiculopathy and weakness.
4. Painful deep hardware L5-S1.
5. Nonunion L5-S1.
6. Solid arthrodesis L5-S1.

PROCEDURE PERFORMED:
1. Complete bilateral L4-5 laminectomies with bilateral medial fasciectomies and foraminotomies for decompression of dura and neural elements with the use of the operating room microscope.
2. Transforaminal interbody fusion L4-5 with the use of Howmedica Stryker interbody cage device.
3. Posterior spinal fusion and instrumentation with posterolateral fusion using Howmedica Stryker Xia pedicle screw instrumentation at L4-5.
4. Iliac crest bone grafting with morselized autologous through a separate fascial incision.
5. Inspection of fusion at L5-S1.
6. Removal of deep painful hardware at L5-S1.

ESTIMATED BLOOD LOSS:
150 cc.

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

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OPERATIVE REPORT **U/R:** 1100141

PATIENT: R M **BILLING NO:** 536200378

ROOM: 9617 B

DRAINS:
One Hemovac drain.

COMPLICATIONS:
None.

INTRAOPERATIVE FINDINGS:
1. Marked instability and spinal stenosis at L4-5.
2. Solid arthrodesis at L5-S1.

INDICATION FOR OPERATION:
The patient is a 50-year-old female who had a previous lumbar fusion at L5-S1. She has developed instability at the level above and is present for stabilization and fusion and decompression at L4-5 and inspection of her previous fusion at L5-S1 with removal of her deep painful hardware. The risks and benefits and necessity of the operation were fully discussed at great length and detail, which included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, as well as neural or vascular damage, and blood loss. Our goals and expectations are to minimize her pain as much as possible were discussed. We do not expect her pain to be 0. All questions were answered to her satisfaction. She eagerly agreed to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative antibiotics and was placed under general endotracheal anesthesia. She was placed prone on the Wilson frame, with all bony prominences very carefully and tediously padded. After sterilely prepping and draping, a needle marker was used to obtain appropriate anatomic levels with a lateral x-ray. Once this was confirmed, an incision was made over the previous incision site, extended proximally slightly, exposing the hardware at L5-S1 as well as a previous operative site in the level at L4-5. This was confirmed with a lateral x-ray. The previous hardware was removed with the pedicle screws and rods, and curets and Cobb elevators were used to free the soft tissue around the fusion mass, and the fusion appeared to be solid at L5-S1.

Decompression was then begun at the L4-5 level. There was copious scar formation present. Lexxel rongeurs and Kerrison rongeurs were used to perform bilateral laminectomies as well as medial

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fasciectomies and foraminotomies. Hypertrophied ligamentum flavum was also excised giving excellent decompression. Again the scar tissue was tediously dissected through to dissect to the dura for excellent decompression which was confirmed using a curved ball-tip probe from the pedicle of L4 to the pedicle of L5.

Transforaminal interbody fusion was then carried out through a far-lateral extracavitary type approach. The dissection was carried out through the paraspinous musculature around the scar tissue to access the disk space at L4-5. This was confirmed using a needle marker and a lateral x-ray. Complete diskectomies were carried out, and ring curets were used to prepare the endplates in a parallel fashion. Care was taken to protect the cortical portion of the endplate. Trial instrumentation was then inserted with paddle distraction instrumentation to gently and sequentially dilate the area to restore the normal foraminal height and lordosis. There was marked instability noted upon initial dissection at the L4-5 level, confirming the diagnosis again of marked instability and stenosis.

Through a separate fascial incision, the iliac crest was exposed and osteotomes and rongeurs were used to open the lateral wall of the ilium, and curets were used to remove the cancellous portion of the bone. Care was taken not to violate the sacroiliac joint. Gelfoam was used to obtain hemostasis after irrigation, and the fascial layer was closed using #1 Vicryl in an interrupted fashion for watertight closure.

The main spinal wound was irrigated once again. Bone graft was carefully packed along the entire aspect of the anterior longitudinal ligament, and an interbody cage device and Howmedica Stryker was inserted across the L4-5 level which restored the normal foraminal height and lordosis.

Pedicle screw instrumentation was then carried out by placing an awl at the junction of the transverse process of the facet at the level of the pedicle. The pedicle probe was inserted, followed by a straight ball-tip probe. This confirmed no cortical breech. The 6.5-mm pedicle screws were then inserted at the L4-5 level and confirmed to be of appropriate anatomic level with a lateral x-ray. Palpation of the nerve roots as well as the pedicles revealed no cortical breech and no neurologic impingement.

EMG stimulation was carried out across each of the pedicle screws as well as the exiting nerve root, which all stimulated appropriately, confirming proper positioning with no neurologic impingement.

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OPERATIVE REPORT **U/R:** 1100141

PATIENT: R M **BILLING NO:** 536200378

ROOM: 9617 B

Rods were contoured within the pedicle screws and locked into place using the torque wrench. The entire construct was tightened into place with a torque wrench under slight compression and was tested for stability and found to be extremely stable compared to initial intraoperative assessment.

Decortication across the transverse processes, facets, and pars interarticularis was carried out, also extending into the previous fusion mass, with decortication and bone graft carefully packed posterolaterally along the gutters for completion of the 360-degree fusion through the single posterior incision. A final Valsalva maneuver confirmed no violation of the dura or neural elements. The wound was completely dry upon closure. After Gelfoam was used to obtain hemostasis and all Gelfoam was removed, the fascia was reapproximated using #1 Vicryl in an interrupted and running fashion for watertight closure. The drain was brought out subcutaneously through the skin. Then 0 Vicryl was used to reapproximate the deep subcutaneous layers, followed by 2-0 Vicryl for the subcutaneous layers, and a 4-0 intracuticular stitch was used to close the skin edges. Sterile dressings were applied. The patient tolerated the procedure well, and she went to the recovery room in stable condition without difficulty where she awoke neurologically intact.

Steven C Anagnost, MD

MLS ID: 96566
JOB: 42078899

CC: Orthopedic Center

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	7	DELAY	⊗	CASE CODE	58
CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Dr S Chadd CRNA S Martin CRNA				
ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
1045	1050	1050	here	1055	1108	1330	1340	

SURGEON	Dr Anagnost	ASSISTANT	
RESIDENT	DO Sands	OTHERS	D Wybacher, CST - Synaptic EMG
CIRCULATING NURSE	A Remington RN / K Ward RN	SCRUB NURSE	R Nertz CST
RELIEF/TIME		RELIEF/TIME	F. Jambard, ST - 1300 complete
PRE-OP DIAGNOSIS	S/P lumbar fusion w/ continued L. radiculopathy. Osteopenia w/o osteoporosis, L4 retrolisthesis T11-12, T12-L1, L2-3, L4-5 herniated nucleus with radiculopathy.	MED: 0.25% Marcaine w/ Epi + Heparin, Thrombin, Gelfoam, Bacitracin; Depo-Medrol 80mg; 0.25% Marcaine plain	
OPERATION	L4-5 revision laminectomy, decompression, facetectomy, foraminotomy, transforaminal lumbar interbody fusion, posterior spinal fusion with instrumentation, L5-S, Exploration and hardware removal.	IRRIG NaCl 3000ml with Bacitracin 150,000 units	
POST-OP DIAGNOSIS	Same as above		
SPECIMENS ☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ____ ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ____ ☐ Sent with Dr. ____ ☐ Other ____	CULTURES ☐ NONE	☐ Aerobic Time ____ ☐ Anerobic Time ____ ☐ Stat Gram Stain Time ____ ☐ Other Time ____

COUNTS	① COUNTS	2ND	3RD	4TH
LAP SPONGES	5	✓		
RAYTEC	10	✓		
NEEDLES	5	✓		
KITNERS				
COTTONOIDS	10	✓		
BLADES	2 BULLDOGS	✓		
BOVIE TIP	1	✓		
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect)
1) A. Remington RN / R. Nertz, ST
2) K Ward RN / F. Jambard ST

X Ray Yes ✓ No ____
Fluoroscopy Time 8 sec.
Rad Tech S. Freeman, RT

☐ Incorrect Count Type ____ Action taken ____

BLOOD LOSS	300ml
URINE OUTPUT	not measured
SKIN CONDITION	☐ Unchanged ☒ per surgery
PATIENT LEVEL OF CONSCIOUSNESS	☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☒ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL	☒ Anesthesiologist/CNRA ☒ Nurse ☐ Surgeon ☐ Orderly
METHOD OF TRANSPORT	☒ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ____ ☒ Siderails Up ☒ Transport with O_2
UNIT RECEIVING PATIENT	☒ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other ____
PHONE REPORT	☐ Yes ☒ No Time ____ To ____ By ____

DRAINS CATHETERS PACKING ☐ NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain ____
☐ None
☒ Implants & Prosthesis — See progress notes
☐ Salem Sump ____
☐ Packing ____
☐ Other ____
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE 1/4/06

PATIENT CONDITION Stable

REMARKS

RN SIGNATURE Kay Ward RN TIME 1342

UN :A00011-00141 A0535200378
R M
DOB: 06/21/55 50Y F
ANAGNOST, STEVEN C
INPT 01/04/06

(margin note: Greg Vining - EMG Tech - Synaptic)

POST-OPERATIVE NURSING OBSERVATIONS

Hillcrest
HEALTHCARE SYSTEM
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jan 16 22:51:57 2006 **EST**
TRANS: Mon Jan 16 23:34:40 2006 **EST**

OPERATIVE REPORT **U/R:** 896081

PATIENT: B M **BILLING NO:** 600800234

ROOM: RR05 1

DATE OF PROCEDURE: 01/16/2006

SURGEON(S): Steven C. Anagnost, MD

ASSISTANT: Jodie Popp, CFA

PREOPERATIVE DIAGNOSES:
1. Lumbar instability, L4-5.
2. Lumbar spondylolisthesis, L4-5.
3. Foraminal stenosis and central canal stenosis, with herniated nucleus pulposus, L4-5.
4. Lower extremity weakness and radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Lumbar instability, L4-5.
2. Lumbar spondylolisthesis, L4-5.
3. Foraminal stenosis and central canal stenosis, with herniated nucleus pulposus, L4-5.
4. Lower extremity weakness and radiculopathy.

PROCEDURES PERFORMED:
1. Bilateral lumbar decompression with laminectomies and medial facetectomies and foraminotomies with use of operating room microscope.
2. Transforaminal interbody fusion with bilateral extracavitary-type approach with use of Howmedica-Stryker interbody cage device, L4-5.
3. Posterolateral fusion at L4-5 for completion of 360-degree fusions through a single posterior incision.
4. Posterior spinal pedicle screw instrumentation with use of Danek Legacy pedicle screw instrumentation, L4-5.
5. Reduction of spondylolisthesis at L4-5, mechanical reduction through pedicle screw instrumentation.
6. Autologous bone grafting.
7. Intraoperative EMG and SSEP monitoring.

ESTIMATED BLOOD LOSS:
30 cc.

DICT: Mon Jan 16 22:51:57 2006 **EST**
TRANS: Mon Jan 16 23:34:40 2006 **EST**

OPERATIVE REPORT **U/R:** 896081

PATIENT: B M **BILLING NO:** 600800234

ROOM: RR05 1

OPERATIVE TIME:
1 hour, 22 minutes.

C-ARM FLUOROSCOPY TIME:
18 seconds.

INTRAOPERATIVE FINDINGS:
1. Marked instability at L4-5.
2. Foraminal stenosis and central canal stenosis at L4-5.

INDICATIONS FOR OPERATION:
Patient is a 55-year-old female with steadily increasing symptoms of both back pain and leg pain. In spite of appropriate conservative treatment, she has worsened rather than improved with her symptoms and is present for a lumbar laminectomy and decompression with interbody fusion and stabilization with posterolateral fusion and pedicle screw instrumentation. The risks, benefits, and the necessity of the operation were fully discussed with her at length and detail, including but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, the risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neural or vascular damage and/or dural damage and blood loss. The goals and expectations are to bring her pain level down from an 8 to 9/10 to approximately 3 to 4/10. We also discussed that we do not expect her pain to be zero. All questions were answered to her satisfaction. She verbalized understanding. She agrees with the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
Patient was brought to the operating room and given preoperative IV antibiotics and placed under general endotracheal anesthesia. She was placed prone on the Wilson frame and all body prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain appropriate anatomic levels on lateral x-ray, and once this was confirmed, a 3-cm incision was created just below the midline, with a retractor inserted and confirming appropriate anatomic levels on lateral x-ray. The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform bilateral lumbar decompression with laminectomies, and medial facetectomies with foraminotomies. Excellent decompression was obtained and the hypertrophied ligamentum flavum was also excised. Irrigation solution was used to irrigate the wound, and a curved ball-tip probe was used to palpate the

pedicle at L4 and the pediclo at L5 to confirm a complete pedicle-to-pedicle decompression with no residual stenosis.

Interbody fusion was carried out through a transforaminal technique through a far lateral extracavitary-type approach. Dissection was carried out through the paraspinous musculature to identify the disk space at L4-5. This was confirmed using the needle marker and lateral x-ray. The diskectomies were then carried out across the midline using pituitary rongeurs. Ring curettes were used to remove the cartilaginous portion of the endplate but to protect the cortical portion of the endplate. Copious irrigation solution was used to irrigate the wound. Gelfoam was used to obtain complete meticulous complete hemostasis, and all Gelfoam was removed.

Autologous bone grafting was then taken and then carefully packed along the interspace along the entire aspect of the anterior longitudinal ligament. A trial prosthesis was inserted using sequential dilation across the interspace, using the dilating paddle distraction instrumentation up to a size final implant size. A trial prosthesis confirmed excellent restoration of the normal foraminal height and lordosis. The final implant was then inserted using this meticulous technique through the far lateral extracavitary-type approach as described. This was verified in the AP and lateral planes using the C-arm.

The posterolateral fusion was then carried out for the completion of the 360-degree fusion through a single posterior incision. Decortication was carried out across the transverse processes of the facets and the pars interarticularis and bone graft was carefully packed along the posterolateral gutters for completion of a 360-degree fusion and the posterolateral fusion.

Pedicle screw instrumentation was then carried out using the Danek Legacy pedicle screw instrumentation. An awl was inserted at the junction of the transverse process of the facet, at the level of the pedicle. The pedicle probe was inserted followed by a straight ball-tip probe. Pretapping was carried out and the interior confines of the pedicle were carefully palpated both superomedially, inferolaterally, and anteriorly. No cortical breech. The 6.5-mm screws were placed using this meticulous technique at L4 and L5.

EMG stimulation was then carried out and confirmed after stimulation of each of the pedicle screws to greater than 20 mA, and the exiting nerve roots were established at the baseline, which was stimulated appropriately. AP and lateral x-rays also confirmed proper position of the pedicle screws.

DICT: Mon Jan 16 22:51:57 2006 **EST**
TRANS: Mon Jan 16 23:34:40 2006 **EST**

OPERATIVE REPORT **U/R:** 896081

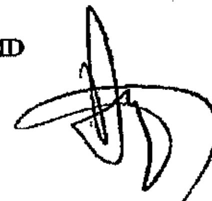
PATIENT: B M **BILLING NO:** 600800234

ROOM: RR05 1

Mechanical reduction of the spondylolisthesis was then carried out by inserting a rod at the pedicle screw junction. A mechanical reduction tool was then attached to the pedicle screws and slow, steady reduction of the pedicle screw spondylolisthesis was carried out and the final construct was locked into place using the torque wrench. The entire construct was tested for stability and found to be extremely stable, and Gelfoam was used to obtain complete hemostasis. The confirmation reduction of the spondylolisthesis and proper anatomic levels was confirmed with unilateral x-rays. Copious irrigation solution was used to irrigate the wound once again, with no further pathology found. A Valsalva maneuver confirmed no violation of the dura or neural elements, with no dural leak.

The fascia was reapproximated using #1 Vicryl in interrupted running fashion for watertight closure. 2-0 Vicryl was used to reapproximate the subcutaneous layers, followed by a 4-0-intracuticular stitch for the skin edges. Sterile dressings were applied. The patient tolerated the procedure well and she went to the recovery room in stable condition without difficulty, where she awoke neurologically intact.

Steven C Anagnost, MD



MLS ID: 97104
JOB: 42086913

CC: Orthopedic Center, Thomas D Mihelich, MD

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	8	DELAY	6	CASE CODE	58
CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Wheeler	CRNA	Cunningham		
ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
0900	0841	0847	0905	0852	0923	1051	1112	

SURGEON	Anagnost	ASSISTANT	[illegible]
RESIDENT	[illegible]	OTHERS	[illegible]
CIRCULATING NURSE	J Brockman	SCRUB NURSE	R Rodriguez ST
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	Lumbar instability HNP L4-5 L5-S1	MED:	Marcaine .25% c epi, Bone Marrow

OPERATION: L4-5 Bilateral laminectomy, decompression, facetectomy, foraminotomy, [illegible] lumbar interbody fusion, posterior spinal fusion instrumentation, posterior iliac crest bone graft [illegible] interbody cage

IRRIG: NaCl .9%

POST-OP DIAGNOSIS: Same as above

SPECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other ☒ NONE

CULTURES: ☒ NONE ☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X		
RAYTEC	10	X		
NEEDLES	3	X		
KITNERS				
COTTONOIDS	0	X		
BLADES	2 (BULLDOGS)	X		
BOVIE TIP	2	X		
HYPODERMICS				
INSTRUMENTS				

SIGNATURE LINES (X = Correct/0 = Incorrect): J Brockman / R Rodriguez ST

X Ray Yes ✓ No
Fluroscopy Time 1:32 min
Rad Tech [illegible]

☐ Incorrect Count Type Action taken

BLOOD LOSS 30 ml
URINE OUTPUT [illegible]

SKIN CONDITION ☐ Unchanged ☐ Surgical site

PATIENT LEVEL OF CONSCIOUSNESS: ☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CNRA ☐ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☒ Patient Bed ☐ PACU Stretcher ☒ Siderails Up x 4 ☐ ICU Bed ☐ Other ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU Main SDS ☐ Nursing Unit ☐ ICU ☐ Other

PHONE REPORT: ☐ Yes ☒ No Time To By

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☒ Implants & Prosthesis — See progress record
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE 01/16/06

PATIENT CONDITION Stable

REMARKS

RN SIGNATURE J Brockman TIME 1115

UN :A00008-96081 A0600800234
B .M.
DOB: 11/06/40 65Y F
ANAGNOST, STEVEN C
INPT 1/16/2006

OMLB 001065

DICT: Mon Jan 30 22:44:28 2006 EST
TRANS: Tue Jan 31 02:59:19 2006 EST

OPERATIVE REPORT **U/R:** 929764

PATIENT: R D **BILLING NO:** 601700215

ROOM:

DATE OF PROCEDURE: 01/30/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, MD

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4, L4-5, and L5-S1.
2. Lower extremity weakness.
3. Lower extremity radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis, L3-4, L4-5, and L5-S1.
2. Lower extremity weakness.
3. Lower extremity radiculopathy.

PROCEDURES PERFORMED:
Bilateral lumbar decompression with laminectomies, medial facetectomies, and foraminotomies at L3-4 and L4-5, and L5-S1, for complete decompression of dura and neural elements with the use of the operating room microscope.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
No drains.

COMPLICATIONS:
No complications.

INTRAOPERATIVE FINDINGS:
Markedly severe at L4-5, moderately severe stenosis at L3-4 and L5-S1.

Hillcrest
HEALTHCARE SYSTEM
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Jan 30 22:44:28 2006 EST
TRANS: Tue Jan 31 02:59:19 2006 EST

OPERATIVE REPORT **U/R:** 929764

PATIENT: R D **BILLING NO:** 601700215

ROOM:

DESCRIPTION OF PROCEDURE:
The patient brought to the operating room, given preoperative IV antibiotics and placed under general endotracheal anesthesia. He was placed prone on the Wilson frame, all bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain proper anatomic levels with a lateral x-ray. Once this was confirmed, a small incision 16 mm in length was inserted, and the retractor system was inserted through the small incision, and verified in the AP and lateral planes using the C-arm.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies, and foraminotomies bilaterally. There was severe stenosis noted at bilateral L4-5, and moderately severe at L3-4, L5-S1. Excellent decompression was attained. A curved ball-tipped probe was placed in the pedicle of L3, the pedicle of L4, the pedicle of L5, and the pedicle of S1, and confirmed a complete pedicle-to-pedicle decompression with no residual stenosis. Gelfoam was used to attain hemostasis, and 2 L of Bacitracin solution was used to irrigate the wound. All Gelfoam was completely removed. A Valsalva maneuver was performed to confirm no violation of the dura or neural elements with no dural leak. The wound was completely dry upon closure. The retractor was removed. The fascia was reapproximated using a 2-0 Vicryl in an interrupted fashion, followed by a 4-0 intracuticular stitch for the skin edges. A sterile Band-Aid was placed across the small 16-mm incision.

The patient tolerated the procedure well, and went to the recovery room in stable condition without any difficulty where he awoke neurologically intact with relief of his back and leg pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97150
JOB: 62204059

CC:

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	00	CASE CODE	58
CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Wehsler, L	CRNA	—		
ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED
0945	0945	0945	0945	0950	1008	1052	1100	

SURGEON	Anagnost, MD
RESIDENT	S Gadda, DO
CIRCULATING NURSE	C Johnston RN
RELIEF/TIME	
ASSISTANT	[illegible] - PA out @ 1020
OTHERS	
SCRUB NURSE	Fletcher ST
RELIEF/TIME	
PRE-OP DIAGNOSIS	Lumbar L3-4, 4-5, 5-S1 Spinal Stenosis
OPERATION	Lumbar L3-4, 4-5, 5-S1 laminectomy facetomy, foraminotomy, Bilateral (decompression)
MED:	0.25% Marcaine c Epi, 0.25% Marcaine plain to Demerol 8mg, Thrombin 5,000 units to gelfoam
IRRIG:	NS & Bacitracin 50,000 units
POST-OP DIAGNOSIS	Same
SPECIMENS	☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other ☑ NONE
CULTURES	☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other ☑ NONE Time Time Time Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X		
RAYTEC	10	X		
NEEDLES	2	X		
KITNERS				
COTTONOIDS	10	X		
BLADES	1 (BULLDOGS)	X		
BOVIE TIP	2	X		
HYPODERMICS	2	X		
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect): C Johnston RN / L Fletcher

☐ Incorrect Count Type ____ Action taken

X Ray Yes ✓ No ____
Fluroscopy Time 5 secs
Rad Tech H Stout

BLOOD LOSS: 20 ml
URINE OUTPUT: NA

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION	☐ Unchanged ☑ incisional
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CNRA ☐ Surgeon ☑ Nurse ☐ Orderly
METHOD OF TRANSPORT	☐ Patient Bed ☑ PACU Stretcher ☑ Siderails Up ☐ ICU Bed ☐ Other ☑ Transport with O_2
UNIT RECEIVING PATIENT	☑ PACU Main / SDS ☐ Nursing Unit ☐ ICU ☑ Other SDS
PHONE REPORT	☑ Yes ☐ No Time 1045 To June / Debbie By CJ
DRAINS CATHETERS PACKING	☑ NONE

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☐ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE 01/30/06

PATIENT CONDITION: Stable

REMARKS

RN SIGNATURE: C Johnston RN TIME 1101

UN :A00009-29764 A0601700215
R ,D
DOB: 06/22/37 68Y H
ANAGNOST,STEVEN C
SDS 01-30-06

2-9

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Thu Mar 02 08:50:50 2006 EST
TRANS: Thu Mar 02 10:00:35 2006 EST

OPERATIVE REPORT **U/R:** 000983943

PATIENT: G J **BILLING NO:** 603201216

ROOM: 9613 B

DATE OF PROCEDURE:

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, PA-C

PREOPERATIVE DIAGNOSES:
1. Cervical 5-6 instability.
2. Cervical 5-6 herniated nucleus pulposus.
3. Radiculopathy, bilateral upper extremity weakness, left arm worse than the right.

POSTOPERATIVE DIAGNOSES:
1. Cervical 5-6 instability.
2. Cervical 5-6 herniated nucleus pulposus.
3. Radiculopathy, bilateral upper extremity weakness, left arm worse than the right.

PROCEDURE PERFORMED:
1. Complete anterior cervical decompression with diskectomies and bilateral foraminotomies with excision of posterior longitudinal ligament at cervical 5-6 for decompression of dura and neural elements with use of operating room microscope.
2. Anterior cervical interbody fusion using machine-milled prosthetic implant device at cervical 5-6.
3. Anterior cervical plating using Howmedica Stryker anterior cervical plating system cervical 5-6.
4. Iliac crest bone marrow aspiration through a separate incision.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

Hillcrest HEALTHCARE SYSTEM 1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Thu Mar 02 08:50:50 2006 EST
TRANS: Thu Mar 02 10:00:35 2006 EST

OPERATIVE REPORT U/R: 000983943

PATIENT: G J BILLING NO: 603201216

ROOM: 9613 B

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative IV antibiotics and was placed under general endotracheal anesthesia. He was placed supine on the operating table. All bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain appropriate anatomic levels with a lateral x-ray. Once this was confirmed, an incision was made just over midline coursing down to the level of the platysma. The platysma was split in line with its fibers, and blunt soft tissue dissection was carried down to the anterior cervical bodies of C5 and C6, again confirmed with a needle marker and lateral x-ray.

The operating room microscope was brought in for visualization. Pituitary rongeurs were used to performed complete diskectomies with marked instability across the C5-6 level. Foraminotomies were then begun by using a 1-mm Kerrison punch and right-angle curettes to perform the foraminotomies bilaterally. A 2-mm bur was used to prepare the endplates in a parallel fashion. Copious irrigation solution was used to irrigate the wound, and a straight probe was used to palpate the posterior aspect of the vertebral bodies and along the neural foramen to confirm complete decompression with no residual stenosis.

Interbody fusion and stabilization was then carried out machining the endplates in a parallel fashion. Broaching was carried out across the endplates to a proper size trial. This was then opened on the back table in preparation for the fusion.

Right iliac crest bone marrow aspiration was then taken through as separate incision. A small stab incision was created, and a Jamshidi needle was inserted within the confines of the iliac wing. 8 cc of aspirate were removed and then injected within the milled prosthetic implant device. The device was then inserted carefully across the interspace at C5-6 to help restore the normal foraminal height and lordosis and was verified in the AP and lateral planes using the C-arm.

Anterior-cervical plating was then carried out. Bilateral drilling followed by 14-mm screw placement was carried out bilaterally, and the screws were recessed within the plate per protocol. There was some slight osteopenia noted, and the plate was slightly adjusted in order to find good bone purchase with the screws. This was verified in the AP and lateral planes using the C-arm. Copious irrigation was used to irrigate the wound. No further pathology was identified. The wound was completely dry upon closure. The platysma was loosely reapproximated using a 3-0 Vicryl in an interrupted fashion followed by a 4-0 intracuticular

DICT: Thu Mar 02 08:50:50 2006 EST
TRANS: Thu Mar 02 10:00:35 2006 EST

OPERATIVE REPORT **U/R:** 000983943

PATIENT: G J. **BILLING NO:** 603201216

ROOM: 9613 B

stitch for the skin edges. Sterile dressings were applied. The patient went to the recovery room in stable condition in a soft collar, and he awoke neurologically intact with relief of his neck and arm pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97047
JOB: 62293320

CC: Orthopedic Center

INTRAOPERATIVE

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	9	DELAY	1	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Pierre	CRNA				ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANES RECORD)
1130	1152	1152	1200	1159	1213	1315	1325	

SURGEON	Anagnost	ASSISTANT	J. Popp PA-C
RESIDENT	Sands	OTHERS	
CIRCULATING NURSE	R Prince RN	SCRUB NURSE	F. [illegible] ST / M. Bodner ST
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	Cervical five-six degenerative disc disease, Cervical Stenosis	MED:	0.25% Sensorcain c [illegible] Gelfoam 100 c 5,000 units thrombin
OPERATION	Cervical five-six anterior cervical decompression with anterior cervical interbody fusion with plating with posterior iliac crest [illegible] with [illegible] bone aspiration, Right		
		IRRIG:	NS c 50,000 units bacitracin
POST-OP DIAGNOSIS	Same		
SPECIMENS ☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ☑ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other	CULTURES ☑ NONE	☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH	SIGNATURE LINES (X = Correct, 0 = Incorrect)
LAP SPONGES	5				R Prince RN / M. Bodner ST
RAYTEC	10				
NEEDLES	2				
KITNERS	10				
COTTONOIDS					
BLADES	2 BULLDOGS				
BOVIE TIP	1				
HYPODERMICS	2				
INSTRUMENTS					X Ray Yes ✓ No
☐ Incorrect Count Type	Action taken				Fluroscopy Time 11 sec
BLOOD LOSS	[illegible] ml				Rad Tech M. [illegible]
URINE OUTPUT					

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION	☑ Unchanged ☐	DRAINS CATHETERS PACKING	SIZE/LOCATION/FIXATION ☐ Wound Drain
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated		☐ None ☑ Implants & Prosthesis: See Progress notes
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CRNA ☑ Nurse ☐ Surgeon ☐ Orderly		
METHOD OF TRANSPORT	☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☐ Siderails Up ☐ Transport with O_2		☐ Salem Sump ☐ Packing ☐ Other
UNIT RECEIVING PATIENT	☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other	☐ NONE	☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
PHONE REPORT	☐ Yes ☑ No Time To By	DATE	2/8/06

PATIENT CONDITION

REMARKS

RN SIGNATURE R Prince RN TIME 1325

UN :A00009-83943 A0603201216
G J
DOB: 02/25/52 53Y M
ANAGNOST, STEVEN C
INPT 020806

OMLB 001088

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Feb 20 22:51:49 2006 EST
TRANS: Mon Feb 20 23:24:19 2006 EST

OPERATIVE REPORT **U/R:** 1102769

PATIENT: L D **BILLING NO:** 603201061

ROOM:

DATE OF PROCEDURE: 02/13/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, MD

PREOPERATIVE DIAGNOSES:
1. Previous lumbar laminectomy, medial facetectomies, and foraminotomies at L4-5 and L5-S1.
2. There was recurrent stenosis and collapse at L4-5 and L5-S1.
3. Lower extremity weakness and radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Previous lumbar laminectomy, medial facetectomies, and foraminotomies at L4-5 and L5-S1.
2. There was recurrent stenosis and collapse at L4-5 and L5-S1.
3. Lower extremity weakness and radiculopathy.

PROCEDURE PERFORMED:
Lumbar laminectomies, medial facetectomies and foraminotomies revision with use of operating room microscope at L4-5 and L5-S1 bilaterally.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

INDICATIONS FOR OPERATION:
The patient is a 76-year-old male with previous lumbar laminectomies. He has had recurrent collapse and instability at L4-5 and L5-S1 with stenosis and is present for decompression. The risks, benefits and necessity of the operation were discussed at length in detail, including but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, the risk of neural or vascular damage and/or dural

DICT: Mon Feb 20 22:51:49 2006 EST
TRANS: Mon Feb 20 23:24:19 2006 EST

OPERATIVE REPORT **U/R:** 1102769

PATIENT: L D **BILLING NO:** 603201061

ROOM:

damage and blood loss. Our goals and expectations are to bring his pain level down from an 8 to 9/10 to approximately a 3 to 4/10. We also discussed that we did not expect the pain to be zero. All questions were answered to his satisfaction and he verbalized understanding of these and he agrees to the treatment plan as recommended

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative antibiotics, and placed under general endotracheal anesthesia. He was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels once again with lateral x-ray. Once this was confirmed, the retractor system was inserted over a small incision, approximately 16 mm in length and confirmed with lateral x-ray at proper levels.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform revision laminectomies, as well as medial facetectomies and foraminotomies. There was noted to be marked scar tissue formation present throughout the L4-5 and L5-S1 levels. This increased the overall length and complexity and difficulty of the approach as well as the decompression portion of the procedure. A Penfield 4 elevator was used to steadily retract the scar tissue and this was eventually removed using Kerrison rongeurs. Excellent decompression was obtained bilaterally at L4-5 and L5-S1 with the foraminotomies and facetectomies, and revision laminectomies. A curved ball-tipped probe was used to palpate the pedicle of L4, the pedicle of L5, and the pedicle of S1. Again this was confirmed using individual lateral x-rays.

A final Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak. Gelfoam was used to obtain meticulous, excellent hemostasis. All Gelfoam was removed. Two liters of Bacitracin solution were used to irrigate the wound.

The retractor system was removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion followed by a 4-0 intercuticular stitch for the skin edges. A sterile Band-Aid was placed across the small 16 mm incision.

DICT: Mon Feb 20 22:51:49 2006 **EST**
TRANS: Mon Feb 20 23:24:19 2006 **EST**

OPERATIVE REPORT **U/R:** 1102769

PATIENT: L D **BILLING NO:** 603201061

ROOM:

The patient tolerated the procedure well and went to the recovery room in stable condition without difficulty, where he awoke neurologically intact.

Steven C Anagnost, MD

MLS ID: 97058
JOB: 62265631

CC: Orthopedics Center, Casey Hanna, MD

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	7	DELAY	1	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Imhoff	CRNA				ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthesia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
12:00	13:07	13:07	1315	13:11	13:20	1355	14:05	

SURGEON	Anagnost	ASSISTANT	J. Popp PA-C
RESIDENT	Spick	OTHERS	
CIRCULATING NURSE	R. Rivas RN	SCRUB NURSE	R. Rodriguez
RELIEF/TIME		RELIEF/TIME	

PRE-OP DIAGNOSIS: Lumbar four-five, Lumbar five-sacral one, spinal stenosis

OPERATION: Lumbar four-five Lumbar five sacral one Bilateral laminotomy with facetectomy, foraminotomy

MED: 0.25% Sensorcaine Epi; Gelfoam 100; Thrombin 5,000 units; 0.25% Sensorcaine; Depo medrol 80mg

IRRIG: NS 1000ml with 50,000 units Bacitracin

POST-OP DIAGNOSIS: Same

SPECIMENS		CULTURES	
☑ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ___ ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ___ ☐ Sent with Dr. ___ ☐ Other ___	☑ NONE	☐ Aerobic Time ___ ☐ Anerobic Time ___ ☐ Stat Gram Stain Time ___ ☐ Other ___ Time ___

COUNTS	COUNTS	2ND	3RD	4TH	SIGNATURE LINES (X = Correct 0 = Incorrect)
LAP SPONGES	5				R. Rivas RN / R. Rodriguez
RAYTEC	10				
NEEDLES	2				
KITNERS					
COTTONOIDS	10				
BLADES	2 BULLDOGS				
BOVIE TIP	2				
HYPODERMICS	2				X Ray Yes ✓ No ___
INSTRUMENTS					Fluoroscopy Time 3sec
☐ Incorrect Count Type	Action taken				Rad Tech S. Dawson RN
BLOOD LOSS	20 ml				
URINE OUTPUT	Ø				

POST-OPERATIVE NURSING OBSERVATIONS

		DRAINS CATHETERS PACKING	SIZE/LOCATION/FIXATION
SKIN CONDITION	☑ Unchanged ☐		☐ Wound Drain
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated		☐ None ☐ Implants & Prosthesis
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CNRA ☑ Nurse ☐ Surgeon ☐ Orderly		
METHOD OF TRANSPORT	☐ Patient Bed ☐ ICU Bed ☑ PACU Stretcher ☐ Other ___ ☑ Siderails Up ☑ Transport with O_2		☐ Salem Sump ☐ Packing ☐ Other
UNIT RECEIVING PATIENT	☑ PACU Main (SDS) ☐ ICU ☐ Nursing Unit ☐ Other ___	☑ NONE	☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
PHONE REPORT	☐ Yes ☑ No Time ___ To ___ By ___	DATE	2/13/06

PATIENT CONDITION

REMARKS

RN SIGNATURE R. Rivas RN TIME

UN :A00011-02769 A0603201061
L... 0
DOB: 06/22/29 76Y M
ANAGNOST, STEVEN C
SDS 02-13-06

OMLB 001099

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Feb 20 23:08:21 2006 **EST**
TRANS: Mon Feb 20 23:42:07 2006 **EST**

OPERATIVE REPORT **U/R:** 1102774

PATIENT: W J **BILLING NO:** 603201073

ROOM:

DATE OF PROCEDURE: 02/13/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, MD

PREOPERATIVE DIAGNOSES:
1. L3-4 and L4-5 lumbar spinal stenosis.
2. Previous lumbar spinal surgery, L3-4 and L4-5.
3. Lumbar spondylolisthesis.
4. Lower extremity radiculopathy and weakness.

POSTOPERATIVE DIAGNOSES:
1. L3-4 and L4-5 lumbar spinal stenosis.
2. Previous lumbar spinal surgery, L3-4 and L4-5.
3. Lumbar spinal spondylolisthesis.
4. Lower extremity radiculopathy and weakness.

PROCEDURE PERFORMED:
Revision laminectomies, medial facetectomies and foraminotomies at L4-5 with the use of the operating room microscope for complete decompression of dura and neural elements.

ESTIMATED BLOOD LOSS:
20 cc.

DRAINS:
None.

COMPLICATIONS:
None.

DICT: Mon Feb 20 23:08:21 2006 **EST**
TRANS: Mon Feb 20 23:42:07 2006 **EST**

OPERATIVE REPORT **U/R:** 1102774

PATIENT: W J **BILLING NO:** 603201073

ROOM:

INTRAOPERATIVE FINDINGS:
1. A severe stenosis at L3-4 and L4-5.
2. Marked scar tissue formation from previous laminectomies which greatly increased the overall length, complexity and difficulty of the case.
3. Moderate instability of L3-4 and L4-5.

INDICATIONS FOR OPERATION:
The patient is a 71-year-old female who had previous laminectomies and decompressions. She has now developed recurrent stenosis and collapse as well as slight worsening of her spondylolisthesis. Most of her pain is with her legs and radiculopathy. She is therefore present for a decompression and revision at L3-4 and L4-5.

The risks, benefits and the necessity of the operation were discussed at length in detail. These included but are not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction; the risk of neural or vascular damage and/or dural damage and blood loss. Our goals and expectations are to bring her pain level from an 8 to 9/10 to approximately 2 to 3/10. We also discussed we did not expect her pain to be zero. All questions were answered to her satisfaction. She verbalizes understanding of these and she agrees to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative antibiotics. After establishment of general endotracheal anesthesia, she was placed prone on the Wilson frame. All bony prominences were carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels with a lateral x-ray. Once this was confirmed, a small 16 mm incision was created just off midline. The retractor system was inserted and confirmed with lateral x-ray to be at proper levels. The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform revision laminectomies as well as medial facetectomies and foraminotomies. There was marked scar tissue formation present which was carefully dissected out using Penfield 4 elevators and the Kerrison rongeurs. There was some moderate instability also noted at L3-4 which was not severe in nature, but was definitely present. Excellent decompression was obtained and a curved ball-tipped probe was placed at the pedicle of L3, the pedicle ofd L4 and the pedicle ofd L5. This confirmed a complete pedicle-to-pedicle decompression with no residual stenosis. A Valsalva maneuver confirmed no violation of the dura or neural elements.

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Feb 20 23:08:21 2006 **EST**
TRANS: Mon Feb 20 23:42:07 2006 **EST**

OPERATIVE REPORT **U/R:** 1102774

PATIENT: W J **BILLING NO:** 603201073

ROOM:

There was no dural leak. Gelfoam was used to obtain meticulous and good hemostasis. All Gelfoam was removed. Copious irrigation solution was used irrigate the wound.

Again there was noted to be some moderate instability noted at L3-4 and L4-5 but it was not deemed to be severe in nature. The patient had a known preoperative spondylolisthesis which was noted intraoperatively 'n addition, but was not deemed to be extremely unstable.

The retractor system was removed. The fascia was reapproximated using 2-0 Vicryl in interrupted fashion followed by 4-0 intercuticular stitch for the skin edges. A sterile Band-Aid was placed across the small 16 mm incision. The patient tolerated the procedure well and she went to the recovery room in stable condition without difficulty where she awoke, neurologically intact.

Steven C Anagnost, MD

MLS ID: 97058
JOB: 62265647

CC: Orthopedics Center, Dr. Clayton Flannery, primary care physician.

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	17	DELAY	/	CASE CODE	58	CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Imhoff	CRNA				ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
0900	10 12	1012	10 18	1017	10 33	11 15	1127	

SURGEON	Anagnost	ASSISTANT	J. Popp PA-C
RESIDENT		OTHERS	S. [illegible] MD
CIRCULATING NURSE	R. Prince RN	SCRUB NURSE	R. Rodriguez ST
RELIEF/TIME		RELIEF/TIME	
PRE-OP DIAGNOSIS	Lumbar three - four, Lumbar four-five stenosis	MED:	0.25% Marcaine [illegible]; Gelfoam 100; Thrombin 5,000 units; 0.25% Marcaine; 80 mg Depomedrol
OPERATION	Lumbar three - four, Lumbar four-five, Bilateral revision Laminectomy, Foraminotomy, Foraminotomy		
		IRRIG:	NS 1,000 ml c 50,000 units Bacitracin
POST-OP DIAGNOSIS	Same		

SPECIMENS ☒ NONE — ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other

CULTURES ☒ NONE — ☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5			
RAYTEC	10			
NEEDLES	2			
KITNERS				
COTTONOIDS	10			
BLADES	2 BULLDOGS			
BOVIE TIP	2			
HYPODERMICS	2			
INSTRUMENTS				

SIGNATURE LINES (X = Correct 0 = Incorrect) R. Prince RN / R. Rodriguez ST

X Ray Yes ✓ No ___

☐ Incorrect Count Type ___ Action taken ___

Fluroscopy Time 6 sec

BLOOD LOSS 20 ml

Rad Tech R. Stout [illegible]

URINE OUTPUT

SKIN CONDITION	☒ Unchanged ☐
PATIENT LEVEL OF CONSCIOUSNESS	☒ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated
ACCOMPANYING PERSONNEL	☒ Anesthesiologist/CNRA ☒ Nurse ☐ Surgeon ☐ Orderly
METHOD OF TRANSPORT	☐ Patient Bed ☐ ICU Bed ☒ PACU Stretcher ☐ Other ☒ Siderails Up ☒ Transport with O_2
UNIT RECEIVING PATIENT	☒ PACU Main (SDS) ☐ ICU ☐ Nursing Unit ☐ Other
PHONE REPORT	☐ Yes ☒ No Time ___ To ___ By ___

DRAINS CATHETERS PACKING ☒ NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☐ Implants & Prosthesis
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE 2/13/06

PATIENT CONDITION

REMARKS

RN SIGNATURE R. Prince RN TIME 1127

UN :A00011-02774 A0603201073
DOB: 09/24/34 71Y F
ANAGNOST, STEVEN C
SDS 02-13-06

OMLB 001111

2-16

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Tue Feb 21 09:57:41 2006 EST
TRANS: Tue Feb 21 10:12:38 2006 EST

OPERATIVE REPORT **U/R:** 1103384

PATIENT: S D **BILLING NO:** 603900394

ROOM:

DATE OF PROCEDURE: 02/15/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, PA-C

PREOPERATIVE DIAGNOSES:
1. Lumbar 4-5 instability.
2. Lumbar radiculopathy with lower extremity weakness.

POSTOPERATIVE DIAGNOSES:
1. Lumbar 4-5 instability.
2. Lumbar radiculopathy with lower extremity weakness.

PROCEDURE PERFORMED:
1. Lumbar 4-5 laminectomies with medial facetectomies and foraminotomies for decompression of dura and neural elements with use of operating room microscope.
2. Transforaminal interbody fusion with use of Howmedica Stryker interbody cage device lumbar 4-5.
3. Posterolateral fusion lumbar 4-5.
4. Posterior spinal pedicle screw instrumentation using Danek legacy pedicle screw instrumentation.
5. Intraoperative EMG monitoring.

ESTIMATED BLOOD LOSS:
50 ml.

OPERATIVE TIME:
One hour and 45 minutes.

C-ARM FLUOROSCOPY TIME:
5 seconds.

INTRAOPERATIVE FINDINGS:
Marked instability at L4-5 with collapse and central canal foraminal impingement.

Hillcrest
HEALTHCARE SYSTEM
1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Tue Feb 21 09:57:41 2006 EST
TRANS: Tue Feb 21 10:12:38 2006 EST

OPERATIVE REPORT **U/R:** 1103384

PATIENT: S D **BILLING NO:** 603900394

ROOM:

INDICATION FOR OPERATION:
The patient is a 67-year-old male who has had steadily increasing symptoms of back pain and leg pain. Despite appropriate conservative treatment he has worsened rather than improved with his symptoms. He is present for decompression and interbody fusion and stabilization and posterolateral fusion and pedicle screw fixation.

The risks, benefits, and the necessity of the operation were discussed at length in detail. These included but not limited to the risk of infection, DVT, pulmonary embolism, myocardial infarction, risk of malunion, nonunion, pseudoarthrosis, hardware failure, possible neural or vascular damage and/or dural damage and blood loss. Our goals and expectations to bring his pain level down from 8-9/10 to approximately a 3-4/10 were also discussed. We do not expect his pain to be 0. All questions were answered to his satisfaction, and he and his family verbalize understanding of these and agree to treatment plan as recommended. The also agree to postoperative compliance as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and given preoperative IV antibiotics and was placed under general endotracheal anesthesia. She was placed prone on the Wilson frame. All bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to obtain proper anatomic levels with a lateral x-ray. Once this was confirmed, a small 2.5-cm incision was created just off midline. The retractor system was inserted and confirmed with lateral x-ray to be at proper levels.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies and foraminotomies. Bilateral laminectomies were carried out along the left side and sublaminar decompression was carried out along the right side for decompression. A hypertrophied ligamentum flavum was also excised. Excellent decompression was obtained. There was noted to be marked collapse and instability upon initial inspection prior to laminectomies. There was also noted to be marked foraminal stenosis. Excellent decompression was obtained after removing the offending pathology. The exiting nerve roots were clearly visualized, and a curved ball-tipped probe was placed on the pedicle of L5 to confirm a complete pedicle-to-pedicle decompression with no residual stenosis.

Interbody fusion was carried out by dissecting out laterally through the paraspinous musculature to access the disk space at L4-5. Diskectomies were carried out across the midline for complete decompression, and

DICT: Tue Feb 21 09:57:41 2006 **EST**
TRANS: Tue Feb 21 10:12:38 2006 **EST**

OPERATIVE REPORT **U/R:** 1103384

PATIENT: S D **BILLING NO:** 603900394

ROOM:

ring curettes were used to prepare the endplates in the parallel fashion. Slow, steady paddle distraction instrumentation was carried out across the L4-5 interspace to help restore the normal foraminal height and lordosis, and a trial prosthesis was inserted from Howmedica Stryker. This, again, gave excellent fit and excellent restoration of the normal foraminal height and lordosis verified in the AP and lateral planes using the C-arm.

Copious irrigation solution was used to irrigate the wound. Bone graft was carefully packed along the interspace at L4-5 with excellent amount of bone graft packed into the interspace, and a final Howmedica Stryker interbody cage was then inserted across the L4-5 level through a transforaminal approach. Little to no retraction was applied along the exiting nerve roots through the entire portion of the interbody stabilization due to the far lateral type approach through the transforaminal fusion. AP and lateral x-rays confirmed proper positioning of the implant and proper restoration of the normal foraminal-height and lordosis.

Posterolateral fusion and pedicle screw instrumentation was then carried out. Decortication was carried out across the transverse processes and facets and pars inarticularis in preparation for the fusion. Pedicle screws were then inserted by using the Danek Legacy pedicle screw instrumentation system. An awl was inserted at the junction of the transverse process and facet at the level of the pedicle. The pedicle probe was inserted with no cortical breach palpated both interior and exterior confines of the pedicle. 6.5-mm screws were placed using this meticulous technique and verified in the AP and lateral planes using the C-arm. The nerves were clearly palpated once again with no neural impingement. A rod was set within the pedicle screws and locked into place using the torque wrench under slight compression. The entire construct was very stable. Bone graft was then finally packed along the posterolateral gutters for completion of the 360-degree fusion through the single posterior incision. A final Valsalva maneuver confirmed no violation of the dura or neural elements with no dura leak. Gelfoam was used to obtain meticulous complete hemostasis. All Gelfoam was removed. The retractor was then removed. Final AP and lateral x-rays were taken. The fascia was reapproximated using #1 Vicryl in interrupted and running fashion for watertight closure. A 2-0 Vicryl was used to reapproximate the subcutaneous layers, and a 4-0 intracuticular stitch was used to close the small 3-cm incision. The patient tolerated the procedure well and went to the recovery room in stable

DICT: Tue Feb 21 09:57:41 2006 **EST**
TRANS: Tue Feb 21 10:12:38 2006 **EST**

OPERATIVE REPORT **U/R:** 1103384

PATIENT: S D **BILLING NO:** 603900394

ROOM:

condition without difficulty where he awoke neurologically intact with immediate relief of his symptoms. He was able to ambulate on his own accord upon his arrival to the floor.

Steven C Anagnost, MD

MLS ID: 97047
JOB: 42173794

CC: Orthopedic Center

☒ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	8	DELAY	04	CASE CODE	56	CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	Dr Kesler	CRNA				ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
1030	1100	1111	1111	1115	1131	1315	1335	

SURGEON: Dr Anagnost
ASSISTANT: [illegible] PA
RESIDENT: [illegible] D.O.
OTHERS:
CIRCULATING NURSE: K Beatt RN
SCRUB NURSE: K Hertz ST / L [illegible] ST
RELIEF/TIME:
RELIEF/TIME:

PRE-OP DIAGNOSIS: Lumbar 4-5 instability Radiculopathy, weakness lower extremities

OPERATION: L4-5 Bilateral Laminectomy - facetectomy foraminotomies with transforaminal lumbar interbody fusion with posterior spinal fusion instrumentation with autograft iliac crest bone graft

MED: [illegible] large
[illegible] 5,000u
Bacitracin 50,000u
Sensorcaine 0.25% c epi
Sensorcaine 0.25%
Depomedrol [illegible]
Used VH5 ml

TISSEEL VH Aug 31-07 VNT3A048

IRRIG: NS

POST-OP DIAGNOSIS: Same

SPECIMENS: ☒ NONE
☐ Tissue Not Removed ☐ Tissue to Lab X ____ ☐ Tissue Removed Not Sent to Lab
☐ Frozen Section X ____ ☐ Sent with Dr. ____ ☐ Other ____

CULTURES: ☒ NONE
☐ Aerobic Time ____ ☐ Anerobic Time ____ ☐ Stat Gram Stain Time ____ ☐ Other Time ____

COUNTS	1 COUNTS	2ND	3RD	4TH
LAP SPONGES	5	X		
RAYTEC	10	X		
NEEDLES	3+2+2	X		
KITNERS	X	X		
COTTONOIDS	10	X		
BLADES	1 BULLDOGS X	X		
BOVIE TIP	2	X		
HYPODERMICS	2+4	X		
INSTRUMENTS	X	X		

SIGNATURE LINES (X = Correct 0 = Incorrect): K Beatt RN / K Hertz ST

X Ray Yes X No ____
Fluroscopy Time 10 sec
Rad Tech [illegible] ST

☐ Incorrect Count Type ____ Action taken ____
BLOOD LOSS: 500cc
URINE OUTPUT: 50

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION: ☐ Unchanged ☐ Surgical Incision

PATIENT LEVEL OF CONSCIOUSNESS:
☐ Under Care of Anesthesiologist/CRNA
☐ Sedated and responsive to deep stimulus
☒ Sedated and responsive to verbal stimulus
☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CRNA ☒ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed ☐ ICU Bed ☒ PACU Stretcher ☐ Other ____ ☒ Siderails Up ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other ____

PHONE REPORT: ☐ Yes ☒ No Time ____ To ____ By ____

DRAINS CATHETERS PACKING: ☐ NONE

SIZE/LOCATION/FIXATION
☐ Wound Drain
☐ None
☐ Implants & Prosthesis — See Progress Note
☐ Salem Sump
☐ Packing
☐ Other
☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Paricardium

DATE: 2-15-06

PATIENT CONDITION: Stable

REMARKS:

RN SIGNATURE: K Beatt RN TIME: 1335

UN :A00011-03384 A0603900394
S D
DOB: 07/03/38 67Y M
ANAGNOST, STEVEN C
INPT 02/15/06

OMLB 001124

2-27 3D>

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Mon Feb 27 17:41:39 2006 EST
TRANS: Tue Feb 28 09:37:24 2006 EST

OPERATIVE REPORT **U/R:** 1103917

PATIENT: P , B **BILLING NO:** 604600300

ROOM:

DATE OF PROCEDURE: 02/27/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, PA-C

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis.
2. Lower extremity weakness with radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Lumbar spinal stenosis.
2. Lumbar lower extremity weakness with radiculopathy.

PROCEDURES PERFORMED:
Bilateral decompression with laminectomies, facetectomies, and foraminotomies at L3-4 and L4-5 for decompression of dura and neural elements with the use of the operating room microscope.

ESTIMATED BLOOD LOSS:
0 cc.

DRAINS:
No drains.

COMPLICATIONS:
No complications.

INTRAOPERATIVE FINDINGS:
1. Severe lumbar spinal stenosis.
2. Moderate intraoperative instability noted intraoperatively.

DICT: Mon Feb 27 17:41:39 2006 EST
TRANS: Tue Feb 28 09:37:24 2006 EST

OPERATIVE REPORT **U/R:** 1103917

PATIENT: P B **BILLING NO:** 604600300

ROOM:

INDICATIONS FOR OPERATION:
The patient is a 74-year-old male with steadily increasing severe symptoms of lower extremity weakness and back pain. He was found to have very significant spinal stenosis at L3-L4 and L4-5, and is present for lumbar decompression.

The risks, benefits, and the necessity of the operation were discussed at length and detail. These included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction, the risk of neural or vascular damage, and/or dural damage or blood loss. The possible need for stabilization in the future were also discussed. All questions were answered to his satisfaction along with his family. They verbalized understanding and they agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics and placed under general endotracheal anesthesia. He was placed prone on the Wilson frame, all bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain proper anatomic levels once again with lateral x-ray. Once this was confirmed, a small 16 mm incision was created just off of midline. The retractor system was inserted and confirmed with lateral x-ray to be at proper anatomic levels.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies, and foraminotomies bilaterally. There was marked instability noted. It was not severe but it was hypermobility. There was severe ligament of flavum ______________________ facet hypertrophy. The dura and neural elements were well decompressed. After the decompression it was confirmed using a curved ball-tipped probe at L3, L4, and L5. ______________________ was most severe at L3-4 and moderately severe at L4-5. Copious irrigation solution was used to irrigate the wound and Gelfoam was use to attain meticulous and complete hemostasis. A final Valsalva maneuver confirmed no violation of the dura or neural elements, with no dural leak.

The retractor system was removed. The fascia was reapproximated using 2-0 Vicryl in an interrupted fashion, followed by a 4-0 intracuticular stitch for the skin edges. Sterile dressings were applied.

DICT: Mon Feb 27 17:41:39 2006 **EST**
TRANS: Tue Feb 28 09:37:24 2006 **EST**

OPERATIVE REPORT **U/R:** 1103917

PATIENT: P B **BILLING NO:** 604600300

ROOM:

The patient tolerated the procedure well, and he went to the recovery room in stable condition without difficulty where he awoke neurologically intact.

Steven C Anagnost, MD

MLS ID: 97150
JOB: 62284719

CC: Orthopedic Center

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

INTRAOPERATIVE

ROOM	08	DELAY	No	CASE CODE	58
CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Weksler	CRNA	—		
ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
0900	0841	0841	0841	0843	0853	1020	10:25	

SURGEON	Anagnost	ASSISTANT	
RESIDENT	S Smith DO	OTHERS	—
CIRCULATING NURSE	K Bristen RN	SCRUB NURSE	K Rodriguez ST
RELIEF/TIME	C Brazile RN out	RELIEF/TIME	

PRE-OP DIAGNOSIS: L3-5 - Stenosis c radiculopathy.

OPERATION: Laminectomy Decompression Facetectomy Foraminotomy L3-4 L4-5

MED: 0.25% Marcaine c Epi; Gelfoam 100 x2; Thrombin 5000 units x2; Bacitracin 50,000u; Sensorcaine 0.25%; Depomedrol 40mg; Floseal x1

IRRIG: 0.9% NACL c Bacitracin 50,000 units

POST-OP DIAGNOSIS: Same

SPECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other ☑ NONE

CULTURES: ☐ Aerobic ☐ Anerobic ☐ Stat Gram Stain ☐ Other ☑ NONE — Time ____

COUNTS	COUNTS	2ND	3RD	4TH
LAP SPONGES	5	✓		
RAYTEC	10	✓		
NEEDLES	2	✓		
KITNERS	10	✓		
COTTONOIDS	X	✓		
BLADES	#20 #15 x1; BULLDOGS 1	✓		
BOVIE TIP	2	✓		
HYPODERMICS	2	✓		
INSTRUMENTS	X	✓		

SIGNATURE LINES (X = Correct, ∅ = Incorrect):
1) K Bristen / K Rodriguez ST
2) K Bristen / K Rodriguez ST

☐ Incorrect Count Type ____ Action taken ____

X Ray Yes ✓ No ____

Fluoroscopy Time 15 sec

Rad Tech K Stuart RT

BLOOD LOSS: 30 ml

URINE OUTPUT: —

POST-OPERATIVE NURSING OBSERVATIONS

SKIN CONDITION: ☐ Unchanged ☐ Surgical Incision

PATIENT LEVEL OF CONSCIOUSNESS: ☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☑ Anesthesiologist/CNRA ☑ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☑ Siderails Up ☑ Transport with O_2

UNIT RECEIVING PATIENT: ☑ PACU Main (SDS) ☐ ICU ☐ Nursing Unit ☐ Other

PHONE REPORT: ☐ Yes ☑ No Time ____ To ____ By ____

DRAINS CATHETERS PACKING: ☑ NONE

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☑ None ☑ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 2-27-06

PATIENT CONDITION: Stable

REMARKS:

RN SIGNATURE: K Bristen RN TIME 10:25

UN :A00011-03917 A0604800106
P B
DOB: 07/06/31 74Y M
ANAGNOST, STEVEN C
SDS 02-27-06

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Mar 01 11:21:14 2006 **EST**
'RANS: Thu Mar 02 01:25:25 2006 **EST**

OPERATIVE REPORT **U/R:** 547226

PATIENT: F M **BILLING NO:** 605400040

ROOM:

DATE OF PROCEDURE: 03/01/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, PA-C

PREOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis at L2-3, L3-4, L4-5.
2. Lower extremity weakness.

POSTOPERATIVE DIAGNOSES:
1. Severe lumbar spinal stenosis at L2-3, L3-4, L4-5.
2. Intraoperative findings of additional severe stenosis at L5-S1.
3. Lower extremity weakness.

PROCEDURES PERFORMED:
L2-3, L3-4, L4-5, and L5-S1 lumbar laminectomies with medial facetectomies and foraminotomies bilaterally for complete decompression of dura and neural elements secondary to severe spinal stenosis with the use of operating room microscope.

ESTIMATED BLOOD LOSS:
20 cc

DRAINS:
None.

COMPLICATIONS:
None.

OPERATIVE TIME:
50 minutes.

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Mar 01 11:21:14 2006 EST
TRANS: Thu Mar 02 01:25:25 2006 EST

OPERATIVE REPORT **U/R:** 547226

PATIENT: F M. **BILLING NO:** 605400040

ROOM:

INTRAOPERATIVE FINDINGS:

1. Severe spinal stenosis L2-3, L3-4, L4-5.
2. Additional findings of severe intraoperative spinal stenosis at L5-S1 requiring additional decompression.

INDICATION FOR OPERATION:
The patient is a 84-year-old female with steadily increasing symptoms of leg weakness and neurogenic claudication in addition to her severe back pain. Despite appropriate conservative treatment, she is worsened rather than improved with her symptoms and her neurologic status is markedly declining. She rates her pain level an 8-9/10 on a daily basis. She is present for bilateral lumbar decompression with laminectomies, facetectomies, and foraminotomies at L2-3, L3-4, and L4-5.

The risks, benefits, and the necessity of the operation were fully discussed at great length and detail, included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction. The risk of malunion, neural or vascular damage, and/or dural damage, and blood loss. Our goals and expectations is to bring her pain level down from a 8-9/10 to approximately 2-3/10 were also discussed. We do not expect her pain to be zero. She and her family verbalized the understanding of the risks, benefits, goals, expectations, and the necessity of the operation, and they agree to the treatment plan as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, and placed under general endotracheal anesthesia. She was placed prone on the Wilson frame, all bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain proper anatomic levels once again with a lateral x-ray. Once this was confirmed, a small 16 mm incision was created just off of midline. The retractor system was inserted and confirmed with lateral x-ray to be at proper levels.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies, as well as medial facetectomies, and foraminotomies. The dissection was carried out across the midline to give bilateral decompression. There was severe stenosis noted at L3-L4 and L4-5. Inspection towards the L5-S1 level revealed additional marked stenosis where the dissection was carried down inferiorly to also include the L5-S1 level. It was then carried approximately towards the L3-4 and L2-3 levels. A curved ball-tipped probe was placed at the pedicle of L2, the pedicle of L3, the pedicle of L4, the

DICT: Wed Mar 01 11:21:14 2006 EST
'RANS: Thu Mar 02 01:25:25 2006 EST

OPERATIVE REPORT **U/R:** 547226

PATIENT: F M **BILLING NO:** 605400040

ROOM:

pedicle of L5, the pedicle of S1. This was confirmed with individual lateral x-rays to confirm a complete pedicle-to-pedicle decompression bilaterally with n residual stenosis. A Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak. Copious irrigation solution, 2 L in total were used to irrigate the wound, and Gelfoam was used to attain meticulous and complete hemostasis. All Gelfoam was removed. The canal was once again thoroughly inspected with no further pathology found with excellent decompression and excellent increase of the overall diameter of the canal. (SA)

There was noted to be an "hourglass" deformity to the dura and neural elements due to the longstanding compression. This was markedly improved after removal of the offending pathology described by widening the canal diameter. The retractor was removed.

The fascia was reapproximated using a 2-0 Vicryl in interrupted fashion. A small 4-0 intracuticular stitch was used to close the small 16 mm incision. A sterile Band-Aid was placed across the small incision site.

The patient tolerated the procedure well. She went to the recovery room in stable condition without difficulty where she awoke neurologically intact with immediate relief of her back and leg pain symptoms after awakening in recovery.

Steven C Anagnost, MD

MLS ID: 97150
JOB: 42192754

CC: Orthopedic Center, Michael L Hubner, MD

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	—	CASE CODE	58
CLASSIFICATION	☒ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty				
ANESTHESIOLOGIST	Dr. Kekler	CRNA	—		
ANESTHESIA	☒ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other ____				

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (S.E. ANESTHESIA RECORD)
0900	0908	0909	0910	0911	0922	1020	1029	

SURGEON	Dr. S. Anagnost	ASSISTANT	S Popp PA
RESIDENT	Dr Basenyc	OTHERS	
CIRCULATING NURSE	K Best RN	SCRUB NURSE	K Hertz ST
RELIEF/TIME	K Hopelan 1000-1010	RELIEF/TIME	

PRE-OP DIAGNOSIS: Severe Spinal Stenosis L2-3 L3-4 L4-5

OPERATION: L2-3, L3-4 L4-5 Bilateral Laminectomy Foraminotomy & Foraminotomy

MED: Gelfoam lig. Thrombin 5,000 u; Bacitracin 50,000 u irrigation; Sensorcaine 0.25% epi; Sensorcaine 0.75%; Depo Medrol 40mg

IRRIG: NaCl

POST-OP DIAGNOSIS: Same

SPECIMENS: ☐ Tissue Not Removed ☐ Tissue to Lab X ____ ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ____ ☐ Sent with Dr. ____ ☐ Other ____ ☒ NONE

CULTURES: ☒ NONE ☐ Aerobic Time ____ ☐ Anerobic Time ____ ☐ Stat Gram Stain Time ____ ☐ Other Time ____

COUNTS	COUNTS		2ND	3RD	4TH
LAP SPONGES	5		X		
RAYTEC	10		X		
NEEDLES	2		X		
KITNERS	10		X		
COTTONOIDS	X		X		
BLADES	1	BULLDOGS X	X		
BOVIE TIP	2		X		
HYPODERMICS	2		X		
INSTRUMENTS	X		X		

SIGNATURE LINES (X = Correct 0 = Incorrect): K Best RN / K Hertz ST

X Ray Yes X No ____

☐ Incorrect Count Type ____ Action taken ____

Fluroscopy Time ____

BLOOD LOSS: 20ml

Rad Tech: K Stratt ST

URINE OUTPUT: none

SKIN CONDITION: ☐ Unchanged ☐ Surgical Incision

PATIENT LEVEL OF CONSCIOUSNESS: ☐ Under Care of Anesthesiologist/CRNA ☒ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated

ACCOMPANYING PERSONNEL: ☒ Anesthesiologist/CRNA ☒ Nurse ☐ Surgeon ☐ Orderly

METHOD OF TRANSPORT: ☐ Patient Bed ☒ PACU Stretcher ☒ Siderails Up ☐ ICU Bed ☐ Other ____ ☒ Transport with O_2

UNIT RECEIVING PATIENT: ☒ PACU Main (SDS) ☐ ICU ☐ Nursing Unit ☐ Other ____

PHONE REPORT: ☒ Yes ☐ No Time: Oral To ____ By ____

DRAINS CATHETERS PACKING: ☒ NONE

SIZE/LOCATION/FIXATION: ☐ Wound Drain ☐ None ☐ Implants & Prosthesis ☐ Salem Sump ☐ Packing ☐ Other ____ ☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium

DATE: 3-1-06

PATIENT CONDITION: Stable

REMARKS:

RN SIGNATURE: K Best RN TIME: 1029

UN :A00005-47226 A0605400040
F M
DOB: 06/13/21 84Y F
ANAGNOST, STEVEN C
SDS 3-01-06

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Mar 15 19:36:47 2006 EST
TRANS: Fri Mar 17 21:54:57 2006 EST

OPERATIVE REPORT **U/R:** 1037751

PATIENT: C D **BILLING NO:** 606800252

ROOM: AMAU A

DATE OF PROCEDURE: 03/15/2006

SURGEON(S): Steven C Anagnost, MD

ASSISTANT: Jodie Popp, PA-C / Bascue D.O.

PREOPERATIVE DIAGNOSES:

1. Lumbar instability at L2-3
2. Lumbar spinal stenosis at L2-L3.
3. Lower extremity radiculopathy and weakness.

POSTOPERATIVE DIAGNOSES:

1. Lumbar instability at L2-3
2. Lumbar spinal stenosis at L2-L3.
3. Lower extremity radiculopathy and weakness.

PROCEDURE PERFORMED:

1. Lumbar laminectomies with medial facetectomies and foraminotomies for complete decompression of dura and neural elements at L2-3 with use of operating room microscope.
2. Transforaminal interbody fusion at L2-3 with use of Howmedica Stryker interbody cage device.
3. Posterolateral fusion L2-3.
4. Posterior spinal pedicle screw instrumentation, L2-3.
5. Intraoperative EMG and SSEP monitoring.

ESTIMATED BLOOD LOSS:
40 cc.

OPERATIVE TIME:
1 hour and 20 minutes.

FLUOROSCOPY TIME:
21 seconds.

DICT: Wed Mar 15 19:36:47 2006 EST
TRANS: Fri Mar 17 21:54:57 2006 EST

OPERATIVE REPORT **U/R:** 1037751

PATIENT: C D **BILLING NO:** 606800252

ROOM: AMAU A

INTRAOPERATIVE FINDINGS:

1. Marked instability a L2-3.
2. Marked foraminal stenosis and impingement at L2-3.

INDICATION FOR OPERATION:
The patient is a very pleasant 64-year-old female with steadily increasing symptoms of both back pain and leg pain. Despite appropriate conservative treatment she is markedly worse rather than improved with her symptoms. She rates her pain as 9/10 on an average daily basis. Her diskogram reveals highly concordant pain at the L2-3 level, and she is present for decompression and stabilization at L2-3.

The risks, benefits, and the necessity of the operation were fully discussed at great length and detail. These included but not limited to risk of infection, DVT, pulmonary embolism, myocardial infarction. The risk of neural or vascular damage, and/or dural damage, and blood loss. The risk of malunion, nonunion, and pseudoarthrosis were also discussed. Our goals and expectations is to bring her pain level down from an 8-9/10 to approximately 3-4/10 were also discussed. We do not expect her pain to be zero. All questions were answered to her satisfaction. She verbalizes understanding of these risks, benefits, goals, and expectations, and the necessity of the operation. She agrees to the treatment plan as recommended. She also agrees to postoperative compliance as recommended.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, given preoperative IV antibiotics, and placed under general endotracheal anesthesia. She was placed prone on the Wilson frame, all bony prominences were very carefully and tediously padded. After sterile prepping and draping, a needle marker was used to attain proper anatomic levels with lateral x-ray. Once this was confirmed, a 3 cm incision was created and the retractor system was inserted and confirmed with lateral x-ray to be at proper levels.

The operating room microscope was brought in for visualization. Kerrison rongeurs were used to perform laminectomies as well as medial facetectomies, and foraminotomies. The dissection was carried out across the midline to give sublaminar decompression on the contralateral side. Excellent decompression was attained. The majority of the stenosis was on the left side consistent with the majority of left-sided symptoms. There was noted to be marked instability again noted at the L2-3 level prior to the laminectomies upon initial inspection of the stability of the spine. A curved ball-tipped probe was placed to the pedicle of L2, the pedicle of L3 to confirm a complete pedicle-to-pedicle decompression. The exiting

and traversing nerve roots were clearly visualized with no neurologic impingement and excellent decompression.

Transforaminal interbody fusion was carried out by dissecting out to the paraspinous musculature down to the level of the disk space. It was identified with a needle marker and a lateral x-ray. Complete discectomies were carried out across the midline. There was very little normal disk material found at the L2-3 level. The majority of the disk was herniated or dehydrated. Ring curets were used to prepare the endplates in a parallel fashion. Slow, steady paddle distraction instrumentation was carried out across the L2-3 level to help restore the normal foraminal height and lordosis. Trial instrumentation was inserted and confirmed excellent restoration of the normal foraminal height and lordosis. Then 2 L of Bacitracin solution were used to irrigate the wound, and copious amounts of bone graft were packed along the anterior longitudinal ligament and along the interspace for the interbody fusion. The interbody fusion stabilization cage from Howmedica Stryker was placed which restored the normal foraminal height and lordosis, and verified in the AP and lateral planes using the C-arm.

Pedicle screw instrumentation was then carried out using a Danek-Legacy pedicle screw instrumentation system. An awl was inserted at the junction of the transverse process of the facet, at the level of the pedicle. The pedicle probe was inserted confirming no cortical breach by palpating both the interior and external landmarks of the pedicle. Then 6.5-mm screws were placed using this meticulous technique. The external landmarks of the pedicle were carefully palpated with no neurologic impingement and no cortical breach.

EMG stimulation was carried out across each of the pedicle screws and stimulated greater than 20 mA, and the exiting nerve root was established as a baseline at less than 1 mA, confirming proper positioning of the pedicle screws with no neurologic impingement.

Posterolateral fusion was carried out by decorticating the transverse processes, facets, and pars interarticularis. Bone graft was carefully packed on the posterolateral gutters for the posterolateral fusion. A rod was contoured within the pedicle screws and locked into place under slight compression using the torque wrench. The entire construct was tested for stability and found to be extremely stable compared to initial intraoperative assessment. No further pathology was identified. The canal was once again inspected with no neurologic impingement, and a final Valsalva maneuver confirmed no violation of the dura or neural elements with no dural leak. Gelfoam was used to attain meticulous and complete hemostasis.

Hillcrest
HEALTHCARE SYSTEM

1120 South Utica Avenue • Tulsa, Oklahoma 74101-4090

DICT: Wed Mar 15 19:36:47 2006 **EST**
TRANS: Fri Mar 17 21:54:57 2006 **EST**

OPERATIVE REPORT **U/R:** 1037751

PATIENT: C D **BILLING NO:** 606800252

ROOM: AMAU A

Final AP and lateral x-rays were taken intraoperatively.

The retractor was removed. The fascia was reapproximated using #1 Vicryl in an interrupted, then running fashion for watertight closure. A 2-0 Vicryl was used to reapproximate the subcutaneous layers, and a 4-0 intracuticular stitch was used to close the skin edges. Sterile dressings were applied with a Band-Aid across the 3 cm incision.

The patient tolerated the procedure well. She went to the recovery room in stable condition without any difficulty where she awoke neurologically intact. She had immediate relief of her back and leg pain symptoms after awakening in recovery. She was able to ambulate upon her arrival to the floor on her own accord.

Steven C Anagnost, MD

MLS ID: 97150
JOB: 62329824

CC: Orthopedic Center, William Gupton, MD

☑ Scheduled Case ☐ Add-on Elective ☐ Add-on Urgent/Emergency

ROOM	08	DELAY	—	CASE CODE	58	CLASSIFICATION	☑ I Clean ☐ II Clean/Contaminated ☐ III Contaminated ☐ IV Dirty
ANESTHESIOLOGIST	[illegible]	CRNA	—			ANESTHESIA	☑ General ☐ Local/IV Sedation ☐ Monitored Anesthia Care ☐ Regional ☐ Local ☐ Other

TIME SCHEDULED	TIME IN	ANESTHESIA IN	SURGEON	INDUCTION	SURGERY BEGAN	SURGERY ENDED	TIME OUT	ANES ENDED (SEE ANESTHESIA RECORD)
1045	1057	1057	1100	1104	1121	1240	1247	

SURGEON	Anagnost	ASSISTANT	J. Papa PA-C
RESIDENT	Kosmels DO	OTHERS	[illegible] – Medtronic Rep
CIRCULATING NURSE	R. Brayden	SCRUB NURSE	[illegible] CST / L. Fletcher ST
RELIEF/TIME	[illegible] RN (Lunch)	RELIEF/TIME	
PRE-OP DIAGNOSIS	Degenerative Disk disease Lumbar two – Lumbar three	MED:	0.25% Sensorcaine c epi. Gelfoam 100 c Thrombin 5,000 units / 0.25% Sensorcaine 4ml c 80 mg Depo-medrol Bilateral
OPERATION	Lumbar two – Lumbar three Bilateral Laminectomy, facetectomy, foraminotomy, transforaminal Lumbar Interbody fusion, posterior spinal fusion, Instrumentation, posterior Iliac Crest bone graft	IRRIG:	NS 1,000ml c 50,000 units Bacitracin
POST-OP DIAGNOSIS	Same		
SPECIMENS ☐ NONE	☐ Tissue Not Removed ☐ Tissue to Lab X ☐ Tissue Removed Not Sent to Lab ☐ Frozen Section X ☐ Sent with Dr. ☐ Other	CULTURES ☑ NONE	☐ Aerobic Time ☐ Anerobic Time ☐ Stat Gram Stain Time ☐ Other Time

COUNTS	COUNTS	2ND	3RD	4TH	SIGNATURE LINES (X = Correct 0 = Incorrect)
LAP SPONGES	5	X	X		R. Brayden c L. Fletcher ST
RAYTEC	10	X	X		
NEEDLES	3	X	X		[signature] c LF
KITNERS					
COTTONOIDS	10	X	X		
BLADES	1 BULLDOGS	X	X		
BOVIE TIP	2	X	X		
HYPODERMICS	3	X	X		
INSTRUMENTS					X Ray Yes X No

☐ Incorrect Count Type	Action taken	Flurescopy Time
BLOOD LOSS	— mL	Rad Tech [illegible] Freeman RT
URINE OUTPUT	—	

SKIN CONDITION	☐ Unchanged ☑ Incision		SIZE/LOCATION/FIXATION
PATIENT LEVEL OF CONSCIOUSNESS	☑ Under Care of Anesthesiologist/CRNA ☐ Sedated and responsive to deep stimulus ☐ Sedated and responsive to verbal stimulus ☐ Awake and unsedated		☐ Wound Drain ☐ None ☑ Implants & Prosthesis: See progress notes
ACCOMPANYING PERSONNEL	☑ Anesthesiologist/CNRA ☑ Nurse ☐ Surgeon ☐ Orderly	DRAINS CATHETERS PACKING	
METHOD OF TRANSPORT	☑ Patient Bed ☐ ICU Bed ☐ PACU Stretcher ☐ Other ☑ Siderails Up ☑ Transport with O_2		☐ Salem Sump ☐ Packing ☐ Other
UNIT RECEIVING PATIENT	☑ PACU (Main) SDS ☐ ICU ☐ Nursing Unit ☐ Other	☐ NONE	☐ Chest Tube ☐ R Chest ☐ L Chest ☐ Mediastinum ☐ Post Pericardium
PHONE REPORT	☑ Yes ☐ No Time 1230 To Amy By amz	DATE	3/15/06

PATIENT CONDITION: Stable

REMARKS

RN SIGNATURE: [signature] TIME 1249

UN :A00010-37751 A0606000252
DOB: 01/01/42 64Y F
ANAGNOST,STEVEN C
INPT 031506

OMLB 001163

1 IN AND BEFORE THE OKLAHOMA STATE BOARD
2 OF MEDICAL LICENSURE AND SUPERVISION
3 STATE OF OKLAHOMA

4 STATE OF OKLAHOMA, ex rel,)
OKLAHOMA STATE BOARD OF)
5 MEDICAL LICENSURE AND)
SUPERVISION,)
6)
Plaintiff,)
7)
-vs-) Case No. 09/10/3861
8)
STEVEN C. ANAGNOST)
9 MEDICAL LICENSE #21194,)
)
10 Defendant.)

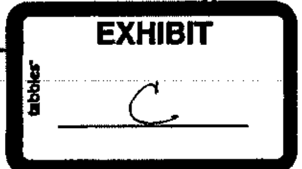
COPY

11 *****************
VOLUME I OF THE DEPOSITION OF **DR. FRANK TOMECEK**, taken
12 on behalf of the Defendant in the above styled and numbered
cause, taken on the 9th day of November, 2012, in Tulsa,
13 Oklahoma before me, Dalene Lawrence, a Certified Shorthand
Reporter duly certified under and by virtue of the laws of
14 the State of Oklahoma, pursuant to the stipulations
hereinafter set forth.
15 *****************
A-P-P-E-A-R-A-N-C-E-S
16
FOR THE PLAINTIFF: MR. DANIEL B. GRAVES
17 Graves McLain
1437 S. Boulder, Ste. 1010
18 Tulsa, OK 74119

19 FOR THE DEFENDANT: MR. BARRY SMITH
MS. CHRISTINA VAUGHN
20 McAfee & Taft
1717 South Boulder
21 Tulsa, OK 74119

22 FOR THE WITNESS: MS. TERESA MEINDERS BURKETT
MS. KATHRYN S. BURNETT
23 Conner & Winters
4000 One Williams Center
24 Tulsa, OK 74103

25 ALSO PRESENT: DR. STEVEN ANAGNOST
MR. SEAN McKEE



1 **FRANK J. TOMECEK, JR., M.D.,**
2 of lawful age, who having been first duly sworn to testify
3 the truth, the whole truth and nothing but the truth,
4 answered in reply to the questions propounded as follows:
5
6 **DIRECT EXAMINATION**
7 **BY MR. SMITH:**
8 Q Will you state your full name for the record.
9 A Frank Joseph Tomecek, Jr., M.D.
10 Q And what's your specialty, Doctor?
11 A I'm a board certified neurosurgeon
12 fellowship-trained spine surgeon. I actually
13 fellowship-trained with orthopedists at the University of
14 Louisville after my neurosurgery residency for a year. So
15 I'm kind of a mutant of sorts. I do both. But nowadays,
16 most neurosurgeons get a lot of training in several aspects
17 of spine. So not as many tend to go to orthopedic type
18 fellowships. Back in my day, you know, 20 years ago, it was
19 becoming more common.
20 Q When did you do that fellowship?
21 A 1992 to 1993. I came here to Tulsa in 1993,
22 in December of 1993.
23 Q Where was that at?
24 A University of Louisville.
25 Q Would you just briefly go through your

1 A Four.
2 Q Have you seen his billing?
3 A No, I don't think so.
4 Q You said earlier that you believed that he was
5 committing some fraudulent acts for financial gain. Correct?
6 A That's correct.
7 Q So that would be revealed in his billing.
8 Correct?
9 A Yes.
10 Q Based on what you observed about his surgery,
11 how many levels do you think he could have appropriately --
12 or levels, sides -- do you think he could have appropriately
13 billed for?
14 A I would have stated he should have billed for,
15 if I'm not mistaken, a left-sided L3-4 hemilaminotomy,
16 foraminotomy and diskectomy, one level, one side.
17 MR. SMITH: I need the Dr. Tomecek bill.
18 Let's mark this as Number 12, please.
19 (Whereupon, Exhibit No. 12 was
20 marked for identification).
21 Q Sir, this is a bill from Oklahoma Spine and
22 Brain Institute for patient G M . Correct?
23 A That's what it states here.
24 Q Are you familiar with coding and billing, how
25 that works?

1 A Vaguely. I certainly don't code my own
2 procedures. We have outsourced coding. I simply document
3 what I do in the operative report. And a coder, who is
4 outsourced, and I don't even know the name of the coding
5 company we use off the top of my head, basically codes the
6 charges from what is dictated in the operative report.
7 Q In this case, you had an assistant surgeon.
8 Is that right?
9 A The assistant was Rene Frenette, my P.A. -- or
10 was at the time. We no longer work together.
11 Q At the bottom of the bill is a 63042. That
12 represents, I will tell you, a lumbar laminotomy
13 re-exploration. Does that sound right?
14 A Yes. And we re-explored the L3-4 level, as
15 I've documented in this report, a re-do diskectomy on the
16 left at L3-4.
17 Q On the next page, there is a 63030, which
18 again is a primary lumbar laminotomy. Is that correct?
19 A I think so, sir. I really don't know anything
20 about billing. But you would know better than I would.
21 Q Do you know what the modifier "50" means?
22 A No.
23 Q I'll represent to you that it means that the
24 procedure was done bilaterally. Does that sound right?
25 MR. GRAVES: Object to the form.

1 A Yeah. That's what my dictation states that I
2 did, yes. So I think I understand why it was billed
3 bilaterally.
4 Q If the bill reflects that you billed for six
5 levels, that would not be right, would it?
6 A I don't know. What I did was bilateral
7 laminotomies L2, L3 and L4. So if you're counting sides, I
8 billed for six. But if you're counting levels, as I said, I
9 billed for three. I hope. I mean, that's what I documented
10 I did. I worked at L2-3, L3-4, and L4-5. That's three
11 levels. You asked me how many sides. Well, it's six,
12 because I worked both sides at each level.
13 Q If you billed for eight sides, that would be
14 over-billing, wouldn't it?
15 MR. GRAVES: Object to the form.
16 A I don't know. I don't know how I could have
17 billed for eight sides based on what I dictated. I didn't do
18 the billing, you know.
19 Q Well, you're responsible for the billing,
20 aren't you?
21 A If I reviewed every bill that was generated by
22 me, I'd never stop reviewing bills. So I don't know how it
23 was billed. But basically, this is what I dictated what I
24 did. I had nothing to do with the formation of the bill
25 after my dictation.

1 Q "Yes" or "no": Do you agree that you are
2 responsible ultimately for a bill?
3 A I guess I am, yes.
4 Q Do you have auditors at your hospital?
5 A Yes. We have auditors in our practice and in
6 our hospital.
7 Q If it's determined that you did indeed bill
8 for more than three levels or more than six sides, do you
9 think that puts any obligation on you to do something about
10 it?
11 MR. GRAVES: Object to the form.
12 A I don't know what I did. I've never seen any
13 of this billing before and I have no idea what I billed for
14 under this thing. I only know what I dictated. I certainly
15 didn't dictate eight levels or eight sides. I mean, what I
16 dictated is what I stated I did, you know? I don't know what
17 you're proposing.
18 Q I'm proposing, sir, just to be very clear,
19 that you billed for more levels and more sides than you
20 dictated.
21 A I don't know that that's true.
22 MR. GRAVES: Object to the form. Barry, if
23 we're going to continue this type of questioning where you're
24 going to be accusing Dr. Tomecek of some sort of billing
25 error when that has nothing to do with this case, Dr. Tomecek

1 is not the subject of this matter. I'm going to stop the
2 deposition and get a protective order and we can start back
3 up with new parameters.
4 MR. SMITH: You have no authority to do that.
5 MR. GRAVES: Actually, I do.
6 MR. SMITH: And yes, actually, the Doctor has
7 testified that he saw a pattern of fraud from three cases.
8 If indeed we look at those same three cases and we see
9 over-billing in all of them, that is relevant to the matter
10 before us.
11 MR. GRAVES: It's just not. You're not going
12 to waste my time with this stuff.
13 MR. SMITH: Then you can stop the deposition
14 if that's what you want to do. But I'm going to keep going.
15 MS. BURNETT: Not with him. If the deposition
16 is stopped, then we'll leave and we'll let the State decide
17 what type of order they would like to get in place and then
18 we'll resume.
19 MR. SMITH: Well, I intend to continue with
20 this line of questioning. So if you all want to stop the
21 deposition, then do so. Otherwise, I'm going to continue.
22 MR. GRAVES: I tell you what: You've got your
23 30 minutes to continue on with this stuff. When you get done
24 with it, I'll go ahead and move for a protective order, and
25 we can re-up with new parameters. But go ahead. Let's quit

1 wasting time.

2 Q Do you think it's a waste of time?

3 A I don't have any idea what's going on here.

4 Obviously, I'm being blindsided. I don't, I don't, I don't

5 make my bills. I just dictate what I do, and I do what I do.

6 When I do a surgery, I dictate exactly what I do. And from

7 there, I'm sorry, I've not been trained to code. I have

8 never attended a coding seminar. I have no idea how to bill

9 any of this. That's not what I do. I'm a surgeon. So

10 basically, if a bill is done inaccurately, I have no

11 knowledge of it. If it was done inaccurately, it's very

12 concerning to me -- because I certainly don't intend it to be

13 inaccurate.

14 MR. SMITH: Let's take a look at, moving very

15 quickly.

16 Q Do you recall Mr. S ?

17 A Vaguely. Very similar case.

18 Q I'm going to hand you a letter I believe you

19 wrote to the Board dated March 25, 2010.

20 (Whereupon, Exhibit No. 13 was

21 marked for identification).

22 Q I hand you what's marked as Defendant's

23 Exhibit 13. Do you recognize that?

24 A Yes.

25 Q Tell us what it is, please.

1 A It's a letter I dictated to Gayla McClenney on
2 March 25, 2010 in regards to patient L S . It's a
3 summary note that I probably followed on a form they gave me
4 to dictate, as you were commenting on; I believe that's
5 probably true.
6 Q And does this report tell you what surgery you
7 performed on Mr. S ?
8 A I believe that what I ended up doing, but I'd
9 need my operative report to know for sure, to make sure there
10 were no inconsistencies, I know -- I take that back. It
11 states it right here. On May 8 of 2007, I did a bilateral L4
12 laminotomy, re-do bilateral L4 laminectomy, bilateral L3-4 --
13 and I'm sorry, but anyway, basically I did an L3 to L5
14 fusion, bilateral decompression, bilateral laminectomies,
15 foraminotomies, diskectomies, and fusion with instrumentation
16 -- pedical screw instrumentation.
17 Q So on how many levels did you do a laminotomy
18 or laminectomy?
19 A I'd prefer if I could look at my op note.
20 Because there may be some slight inaccuracies somehow in the
21 translation of this letter to my true op note.
22 (Whereupon,Deposition Exhibit No. 14
23 was marked for identification).
24 Q I'm handing you what's been marked as
25 Defendant's Exhibit 14.

1 A Yes. This is definitely more clear and
2 accurate. Bilateral L3 laminotomy; re-do bilateral L4
3 laminectomy; bilateral L3-4 foraminotomies and diskectomies.
4 And bilateral re-do L4-5 foraminotomies, bilateral L4-5
5 diskectomy for decompression. Then I did a posterior lumbar
6 interbody fusion at L3-4 and L4-5. And posterial spinal
7 fusion from L3 to L5 with instrumentation and bone graft.
8 Q From reading your operative report, how many
9 levels did you operate on?
10 A Levels? Two.
11 Q How many sides?
12 A Four.
13 MR. SMITH: Let's see the billing records.
14 (Whereupon, Exhibit No. 15 was
15 marked for identification).
16 Q I hand you what's marked as Defendant's 15.
17 Do you recognize that?
18 A Sir, I've never seen this before.
19 Q Would you read into the record what it says it
20 is?
21 A This is an Open Item Payment History By
22 Account at the Oklahoma Spine and Brain Institute on I
23 S And a balance of account.
24 Q If this bill indicates that you operated on
25 M S at six levels, would that be accurate?

1 MR. GRAVES: Object to the form. Lack of
2 foundation.
3 A I don't know. I mean, if it's extra to do
4 re-do and they bill it differently, I have no idea how that's
5 billed. I mean, you're asking me questions that I have no
6 idea how to answer. I don't know what's accurate, I don't
7 know what the form states, and I don't know how to answer
8 that question.
9 Q Would you agree with me that it would not have
10 been appropriate, given the surgery that you did on
11 M S , to have billed him for six levels?
12 MR. GRAVES: Object to the form.
13 A If I billed this for six levels, it was done
14 improperly. And I certainly wasn't responsible for the
15 generation of the bill in this form if it's anything other
16 than what I dictated on this operative sheet which is exactly
17 what I did. I have no idea what this form says or how to
18 translate it. It's like Chinese.
19 Q But again, sir, would you ultimately be
20 responsible for bills that were submitted to Medicaid?
21 MR. GRAVES: Object to the form.
22 A Yes, I am responsible for all billing. I
23 don't produce this coded bill. I've never done it before in
24 my life. I've been practicing for 19 years. So I have to
25 pray and assume that people that are working for me code this

1 properly. That certainly doesn't mean I didn't perform the
2 surgery I stated I did on this record.
3 Q Well, correct. But assuming that you billed
4 for more levels than you said you did on the record, then
5 that would be an over-billing, wouldn't it?
6 MR. GRAVES: Object to the form.
7 A If that's what, if that's what the case is, it
8 would be. If that's the way it was billed, it would be. I
9 don't have any idea what any of these forms say.
10 Q Correct. If it were that case, do you think
11 that's fraudulent?
12 MR. GRAVES: Object to the form.
13 A By definition, I would say it would be.
14 Q If it happened in two of the three cases we
15 have, would you say that that demonstrates a pattern?
16 MR. GRAVES: Object to the form.
17 A I don't know. I guess.
18 Q Have you heard of the concept of bundling or
19 unbundling charges?
20 A I have. But again, I don't know where in the
21 hell we're going here. But I don't know anything about this
22 kind of stuff, Barry. I'm a surgeon. I do these procedures.
23 And I expect them to be billed appropriately. I do not bill
24 for things I don't do, that I'm aware of. If I am, it's
25 totally out of my knowledge.

IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

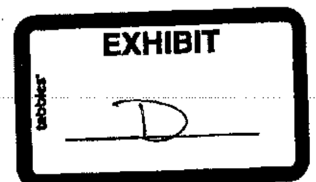
STATE OF OKLAHOMA, ex rel, OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
-v.-	)	**Case No. 09/10/3861**
STEVEN C. ANAGNOST MEDICAL LICENSE #21194,	)	
Defendant.	)	

AFFIDAVIT OF SUZANNE QUINTON

STATE OF OKLAHOMA	)	
	)	**ss.**
COUNTY OF TULSA	)	

I, Suzanne Quinton, being of lawful age and sound mind, and having been first duly sworn, upon my oath swear and state as follows:

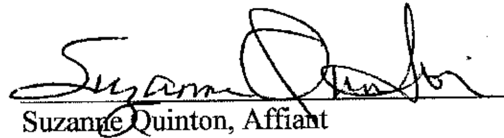
1. I am a certified medical and surgical coder, and am the owner of Quinton Coding Consultants, Inc., a medical and surgical coding corporation located in Broken Arrow, Oklahoma.
2. I make this Affidavit having been asked to evaluate a series of three (3) coded billing statements (attached as Exhibits A, B, and C) and their corresponding operative reports (attached as Exhibits A(i), B(i), and C(i)) for evidence that Dr. Frank Tomecek had engaged in double billing and/or had billed for performing surgery on more levels of the spine than were represented in his operative reports.
3. I have evaluated the medical and surgical codes contained in Exhibits A, B, and C, as well as their corresponding operative reports (Ex. A(i), B(i), and C(i), respectively), and



have not found any evidence in Exhibits A, B, and/or C, that Dr. Frank Tomecek engaged in double billing and/or billed for performing surgery on more levels of the spine than were represented in his operative reports.

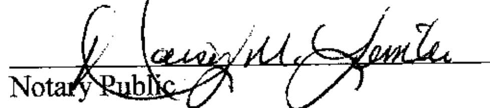
4. Many of the codes in these statements are attached to modifiers (letter and number combinations attached to 5-digit billing codes), including for example modifiers representing the presence of an assistant during surgery.
5. It is possible that a layperson, not trained in medical and surgical coding, could view a coded statement and mistake the use of a 5-digit code with a modifier and the use of the same code without a modifier as evidence of double billing rather than, for example, evidence of a procedure performed by a surgeon and surgeon's assistant.

Further Affiant sayeth not.



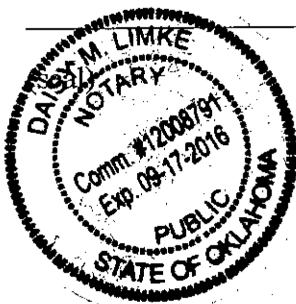
Suzanne Quinton, Affiant

Subscribed and sworn before me this ~~16th day of November, 2012.~~ 23RD DAY OF MAY 2013



Notary Public

My commission expires: 9-17-16



OPEN ITEM PAYMENT HISTORY BY ACCOUNT

OKLAHOMA SPINE & BRAIN INSTITUTE

Accounts : 73876 - 73876, Location :

Account	Dt Serv	Patient	Units	Proc Code	Diag Code	Dr#/Vchr/Stat/Loc	Ins 1-Billed	Ins 2-Billed	Amount	Balance
73876	M	G			(918) 367-6978	Unapplied Credits :				0.00
	11/26/07	G	1.00	99245	722.10	5/100728 /4/18	365-11/30/07e	0-	426.00	
		Check Payment (4306 12/17/07 for $ 256.72) from Ins #365						on 12/17/07	-258 72	
		A63 (4306 12/17/07) UHC Adjustment						on 12/17/07	-102.60	
		Transfer (4306) from Ins #365 to Patient						on 12/17/07		
		Check Payment (3348 02/22/08 for $ 100.00) from Patient						on 02/22/08	-64.68	
										0.00
	11/28/07	G	1.00	99215	722.10	5/100850 /4/18	365-12/05/07e	0-	300.00	
		Check Payment (4306 12/21/07 for $ 185.68) from Ins #365						on 12/21/07	-141 68	
		A63 (4306 12/21/07) UHC Adjustment						on 12/21/07	-122.90	
		Transfer (4306) from Ins #365 to Patient						on 12/21/07		
		Check Payment (3348 02/22/08 for $ 100.00) from Patient						on 02/22/08	-35.32	
		Check Payment (3358 03/07/08 for $ 100.00) from Patient						on 03/07/08	-0.10	
										0.00
	11/28/07	G	1.00	72100	722.10	5/100850 /4/18	365-12/05/07e	0-	127.00	
		Check Payment (4306 12/21/07 for $ 185.68) from Ins #365						on 12/21/07	-44.00	
		A63 (4306 12/21/07) UHC Adjustment						on 12/21/07	-72.00	
		Transfer (4306) from Ins #365 to Patient						on 12/21/07		
		Check Payment (3358 03/07/08 for $ 100.00) from Patient						on 03/07/08	-11.00	
										0.00
	12/13/07	G	1.00	63042,AS	722.10	25/ /4/	365-01/08/08e	0	994.00	
		Check Payment (6560 01/28/08 for $ 436.07) from Ins #365						on 01/28/08	-198.35	
		A63 (6560 01/28/08) UHC Adjustment						on 01/28/08	-746.06	
		Transfer (6560) from Ins #365 to Patient						on 01/28/08		
		Check Payment (3461 09/25/08 for $ 100.00) from Patient						on 09/25/08	-49.59	
										0.00
	12/13/07	G	1.00	63030,AS	721.3	25/ /4/	365-01/08/08e	0-	790.00	
		Check Payment (6560 01/28/08 for $ 436.07) from Ins #365						on 01/28/08	-71.55	
		A63 (6560 01/28/08) UHC Adjustment						on 01/28/08	-700.57	
		Transfer (6560) from Ins #365 to Patient						on 01/28/08		
		Check Payment (3461 09/25/08 for $ 100.00) from Patient						on 09/25/08	-17.88	
										0.00
	12/13/07	G	1.00	63030,AS	721.3	25/ /4/	365-01/08/08e	0-	790 00	
		Check Payment (6560 01/28/08 for $ 436.07) from Ins #365						on 01/28/08	-71.54	
		A63 (6560 01/28/08) UHC Adjustment						on 01/28/08	700.57	
		Transfer (6560) from Ins #365 to Patient						on 01/28/08		
		Check Payment (3461 09/25/08 for $ 100.00) from Patient						on 09/25/08	-17.89	
										0.00
	12/13/07	G	2.00	63035,AS	721.3	25/ /4/	365-01/08/08e	0-	462.00	
		Check Payment (6560 01/28/08 for $ 436.07) from Ins #365						on 01/28/08	-63.09	
		A63 (6560 01/28/08) UHC Adjustment						on 01/28/08	-383.14	
		Transfer (6560) from Ins #365 to Patient						on 01/28/08		
		Check Payment (3461 09/25/08 for $ 100.00) from Patient						on 09/25/08	-14.64	
		Check Payment (3514 10/27/08 for $ 150.00) from Patient						on 10/27/08	-1.13	
										0.00
	12/13/07	G	1.00	63035,AS	721.3	25/ /4/	365-01/08/08e	0-	231.00	
		Check Payment (6560 01/28/08 for $ 436.07) from Ins #365						on 01/28/08	-31.54	
		A63 (6560 01/28/08) UHC Adjustment						on 01/28/08	-151.57	
		Transfer (6560) from Ins #365 to Patient						on 01/28/08		
		Check Payment (3514 10/27/08 for $ 150.00) from Patient						on 10/27/08	-7.89	
										0.00
	12/13/07	G	1.00	63042	722.10	5/ /4/	365-01/08/08e	0-	4969.00	

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Account Dt Serv	Patient	Units Proc Code Diag Code	Dr#/Vchr/Stat/Loc	Ins 1-Billed Ins 2-Billed	Amount	Balance
	Check Payment (6060	01/16/08 for $ 3114.78) from Ins #365		on 01/16/08	-1416.80	
	A63 (6060	01/16/08) UHC Adjustment		on 01/16/08	-3198.00	
	Transfer (6060	) from Ins #365 to Patient		on 01/16/08		
	Check Payment (3358	03/07/08 for $ 100.00) from Patient		on 03/07/08	-88.90	
	Check Payment (3363	03/19/08 for $ 100.00) from Patient		on 03/19/08	-100.00	
	Check Payment (3379	04/22/08 for $ 100.00) from Patient		on 04/22/08	-100.00	
	Check Payment (3384	for $ 100.00) from Patient		on 05/23/08	-65.30	
						0.00
12/13/07	G	1.00 63030,59 721.3	5/ /4/	365-01/08/08e 0-	3948.00	
	Check Payment (6060	01/16/08 for $ 3114.78) from Ins #365		on 01/16/08	-511.05	
	A63 (6060	01/16/08) UHC Adjustment		on 01/16/08	-3309.18	
	Transfer (6060	) from Ins #365 to Patient		on 01/16/08		
	Check Payment (3384	for $ 100.00) from Patient		on 05/23/08	34.70	
	Check Payment (3405	06/25/08 for $ 100.00) from Patient		on 06/25/08	-93.07	
						0.00
12/13/07	G	1.00 63030,50 721.3	5/ /4/	365-01/08/08e 0-	5247.00	
	Check Payment (6060	01/16/08 for $ 3114.78) from Ins #365		on 01/16/08	-511.05	
	A63 (6060	01/16/08) UHC Adjustment		on 01/16/08	-638.82	
	Transfer (6060	) from Ins #365 to Patient		on 01/16/08		
	Check Payment (3406	06/25/08 for $ 100.00) from Patient		on 06/25/08	-6.93	
	Check Payment (3441	08/04/08 for $ 100.00) from Patient		on 08/04/08	-100.00	
	Check Paymdnt (3446	08/21/08 for $ 150.00) from Patient		on 08/21/08	-150.00	
	Check Payment (3514	10/27/08 for $ 150.00) from Patient		on 10/27/08	-140.98	
	Check Payment (3466	11/25/08 for $ 100.00) from Patient		on 11/25/08	-100.00	
	Check Payment (3538	01/06/09 for $ 100.00) from Patient		on 01/06/09	-100.00	
	Check Payment (	01/23/09 for $ 100.00) from Patient		on 01/23/09	-100.00	
	Check Payment (3554	02/25/09 for $ 100.00) from Patient		on 02/25/09	-100.00	
	Check Payment (3569	03/25/09 for $ 100.00) from Patient		on 03/25/09	-100.00	
	Check Payment (3492	04/28/09 for $ 100.00) from Patient		on 04/28/09	-100.00	
	Check Payment (3499	05/27/09 for $ 100.00) from Patient		on 05/27/09	-100.00	
	Check Payment (3609	06/23/09 for $ 100.00) from Patient		on 06/23/09	-100.00	
	Check Payment (3615	08/06/09 for $ 100.00) from Patient		on 08/06/09	-100.00	
	Check Payment (3641	09/23/09 for $ 100.00) from Patient		on 09/23/09	-100.00	
	Check Payment (3643	10/14/09 for $ 100.00) from Patient		on 10/14/09	-100.00	
	Check Payment (3659	11/11/09 for $ 100.00) from Patient		on 11/11/09	-100.00	
	Check Payment (3663	11/24/09 for $ 100.00) from Patient		on 11/24/09	-100.00	
	Check Payment (3724	01/11/10 for $ 100.00) from Patient		on 01/11/10	-100.00	
	Check Payment (3743	02/08/10 for $ 100.00) from Patient		on 02/08/10	-100.00	
	Check Payment (3686	03/10/10 for $ 100.00) from Patient		on 03/10/10	-100.00	
	Check Payment (3707	04/14/10 for $ 100.00) from Patient		on 04/14/10	-100.00	
	Check Payment (3760	05/13/10 for $ 100.00) from Patient		on 05/13/10	-100.00	
	Check Payment (3791	06/25/10 for $ 200.00) from Patient		on 06/25/10	200.00	
	Check Payment (3817	08/10/10 for $ 100.00) from Patient		on 08/10/10	-100.00	
	Check Payment (3823	08/30/10 for $ 100.00) from Patient		on 08/30/10	-100.00	
	Check Payment (3840	09/30/10 for $ 100.00) from Patient		on 09/30/10	-100.00	
	Check Payment (3865	11/09/10 for $ 100.00) from Patient		on 11/09/10	-100.00	
	Check Payment (	12/01/10 for $ 100.00) from Patient		on 12/01/10	-100.00	
	Check Payment (3905	01/11/11 for $ 100.00) from Patient		on 01/11/11	-100.00	
	Check Payment (3910	02/14/11 for $ 100.00) from Patient		on 02/14/11	-100.00	
	Check Payment (4038	03/30/11 for $ 100.00) from Patient		on 03/30/11	-100.00	
	Check Payment (4067	04/29/11 for $ 100.00) from Patient		on 04/29/11	-100.00	
	Check Payment (4082	05/24/11 for $ 100.00) from Patient		on 05/24/11	-100.00	
	Check Payment (3991	06/28/11 for $ 100.00) from Patient		on 06/28/11	-100.00	
	Check Payment (4011	08/12/11 for $ 100.00) from Patient		on 08/12/11	-100.00	

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Account Dt Serv	Patient	Units Proc Code	Diag Code	Dr#/Vchr/Stat/Loc	Ins 1-Billed	Ins 2-Billed	Amount	Balance
	Check Payment (3955		08/30/11 for $	100.00) from Patient	on 08/30/11		-100.00	
	Check Payment (3978		09/29/11 for $	100.00) from Patient	on 09/29/11		-100.00	
	Check Payment (4117		10/26/11 for $	100.00) from Patient	on 10/26/11		-100.00	
	Check Payment (4143		11/29/11 for $	383.17) from Patient	on 11/29/11		-199.21	
								0.00
12/13/07	G	2.00 63035,59	721.3	5/ /4/	365-01/08/08e	0-	2310.00	
	Check Payment (6060		01/16/08 for $	3114.78) from Ins #365	on 01/16/08		-450.58	
	A63 (6060		01/16/08)	UHC Adjustment	on 01/16/08		-1746.78	
	Transfer (6060		) from Ins #365 to Patient		on 01/16/08			
	Check Payment (4143		11/29/11 for $	383.17) from Patient	on 11/29/11		-112.64	
								0.00
12/13/07	G	1.00 63035,50	721.3	5/ /4/	365-01/08/08e	0-	1732.00	
	Check Payment (6060		01/16/08 for $	3114.78) from Ins #365	on 01/16/08		-225.29	
	A63 (6060		01/16/08)	UHC Adjustment	on 01/16/08		-1450.39	
	Transfer (6060		) from Ins #365 to Patient		on 01/16/08			
	Check Payment (4143		11/29/11 for $	383.17) from Patient	on 11/29/11		-56.32	
								0.00
01/07/08	G	1.00 99024	722.10	5/102195 /2/18	0-	0-		0.00
02/04/08	G	1.00 99024	V45.89	5/103110 /2/18	0-	0-		0.00
04/18/08	G	1.00 99213	724.5	5/105834 /4/18	1708-06/05/08e	0-	135.00	
	Check Payment (2186		06/25/08 for $	51.45) from Ins #1708	on 06/25/08		-51.45	
	A64 (2186		06/25/08)	AETNA Adjustment	on 06/25/08		-68.55	
	Transfer (2186		) from Ins #1708 to Patient		on 06/25/08			
	Check Payment (4143		11/29/11 for $	383.17) from Patient	on 11/29/11		-15.00	
								0.00

BALANCE FOR ACCOUNT 73876 0.00

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Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: G M	**Date of Procedure:** 12/13/2007
Date of Birth: 08/10/1970	**Case No:** 58869
Account No: 025438	**Dictating Physician:** Frank J. Tomecek, Jr., MD
Date of Admission: 12/13/2007	

PREOPERATIVE DIAGNOSES:

1. Lumbar spondylosis and stenosis at L2-3, L3-4, and L4-5.
2. Right L3 and L5 radiculopathies.
3. Left L4 radiculopathy.
4. Recurrent herniated disk at L3-4 on the left status post a left-sided microdiskectomy at L3-4.

POSTOPERATIVE DIAGNOSES:

1. Lumbar spondylosis and stenosis at L2-3, L3-4, and L4-5.
2. Right L3 and L5 radiculopathies.
3. Left L4 radiculopathy.
4. Recurrent herniated disk at L3-4 on the left status post a left-sided microdiskectomy at L3-4.

PROCEDURE PERFORMED:

1. Bilateral L2 laminotomy.
2. Bilateral L3 and L4 laminectomies.
3. Bilateral L2-3, L3-4, and L4-5 foraminotomies.
4. Right-sided L2-3 and L4-5 diskectomies.
5. Left-sided L3-4 redo diskectomy.
6. Fluoroscopic guidance was used.

SURGEON: Frank J. Tomecek, Jr., MD

ASSISTANT: Renee Frenette, PA-C

ANESTHESIA: General per Jason P. Biggs, MD.

PREPARATION: Routine ChloraPrep and Ioban.

Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: G M	**Date of Procedure:** 12/13/2007
Date of Birth: 08/10/1970	**Case No:** 58869
Account No: 025438	**Dictating Physician:** Frank J. Tomecek, Jr., MD
Date of Admission: 12/13/2007	

OPERATION: This is a 37-year-old white male who was complaining of recurrent back pain and bilateral leg pain, worse on the left than the right. The patient has had a past left-sided L3-4 and L4-5 micro decompression. He had done well for some time after this operation. This procedure was done at an outside institution. The patient developed recurrent pain over the last several months and has failed nonoperative treatments. The patient had a MRI with and without contrast that showed recurrent herniated disks with osteophyte on the left side at L3-4 and a herniated disk eccentric to the right side at L2-3 and L4-5 with congenitally narrowed spinal canal and lumbar spondylosis and stenosis at L2-3, L3-4, and L4-5. The procedure of a bilateral L2-3, L3-4, and L4-5 decompression, right L2-3 and L4-5 diskectomy, and left L3-4 redo diskectomy was explained to the patient as well as the potential risks and complications. The risks explained included infection, bleeding, nerve injury that could lead to partial or complete paralysis, rerupture of disk that could require another operation, dural tear that could cause a delayed spinal fluid leak, chronic pain despite surgery, and medical risks of pneumonia, deep venous thrombosis, pulmonary embolism, myocardial infarction, stroke, and even death. The patient understood and elected to proceed.

After signing an informed consent the patient was taken into the operating room in the supine position. Intravenous lines were placed. The patient was induced with general anesthesia and intubated. The patient was positioned prone on the OSI spine table. The back was prepped and draped in a sterile fashion. He was given 2 grams of Ancef for antibiotic prophylaxis. He was given 250 mg of intravenous Solu-Medrol for nerve protection and then later in the procedure he received a second dose of 250 mg of intravenous Solu-Medrol.

An incision was made in the midline from L2 to the bottom of L5. Hemostasis was obtained with Bovie electrocautery. Gelpi retractors were placed for exposure. Fluoroscopic guidance was used intermittently to localize our levels. The incision was carried down through the lumbodorsal fascia and subperiosteal stripping was performed with Cobb periosteal and Bovie electrocautery exposing the L2, L3, L4, and L5 spinous process, lamina, and facet complexes. Deep Gelpi retractors were placed for exposure. Extensive scar tissue was encountered on the left side at L3-4. Dissection was carried out through the scar with straight and angled curettes. The supraspinous and intraspinous ligaments were removed at L2-3, L3-4, and L4-5 with Leksell

Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: G M	**Date of Procedure:** 12/13/2007
Date of Birth: 08/10/1970	**Case No:** 58869
Account No: 025438	**Dictating Physician:** Frank J. Tomecek, Jr., MD
Date of Admission: 12/13/2007	

rongeur. The spinous processes of L3 and L4 were removed with Leksell rongeur. Extensive scar was further worked on the underside of the lamina of L3 on the left. A 4-mm Kerrison punch was used in the midline to start to widen the laminotomy and a dural tear was encountered. Because there was so much stenosis and scar, it was decided that laminectomy should be done at L3 and L4.

The lamina was drilled through with the Anspach drill with AM8 bit. The lamina was removed with Leksell rongeur. The laminectomy was widened after the dura was carefully separated from the underside of the lamina of L3 and L4 with a Woodson and angled curettes. The laminectomy was widened with Kerrison punches, 4- and 5-mm, at L3 and L4 bilaterally. Bilateral foraminotomies were done at L3-4 and L4-5 with Kerrison punch. The ligamentum flavum was removed at L3-4 and L4-5. The dural tear in the midline was closed with 6-0 Prolene in a running fashion. A second small dural tear to the right of midline at the L3 level was closed with 6-0 Prolene in a figure-of-eight fashion. There was some thinning in the dura down at the L4-5 level slightly to the right of midline but it was not leaking. The anesthesiologist performed Valsalva several times through the procedure and there was no spinal fluid leak.

Then, extensive scar was further dissected in the epidural space with bipolar electrocautery. The nerve root was identified and retracted on the left side at L4. A recurrent herniated disk was encountered at L3-4. It was opened with an 11-bladed knife. The disk was removed with pituitary rongeur. Straight and angled curettes and Epstein curettes were used to strip the disk into the interspace both medially and laterally. Large bone spurs were encountered off the endplate at L3-4 and this was tapped into the interspace with an impactor and Epstein curette and bone fragments and further disk was removed with pituitary rongeurs. Decompression was checked with a nerve hook and a Woodson. Scar tissue was further removed from the thecal sac with a Woodson and an 11-bladed knife. Then, the right L5 nerve root was retracted and a herniated disk was encountered. Epidural bleeding was controlled with bipolar electrocautery. The annulus was opened on the right side at L4-5 with an 11-bladed knife. Disk was removed with pituitary rongeurs, straight and curettes, and Epstein curettes were used to strip loose pieces of disk into the interspace at L4-5 and these were removed with pituitary rongeurs. The Kerrison punch was also used to remove some posterior bone spurs at L4-5. Decompression was checked

Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: G M	**Date of Procedure:** 12/13/2007
Date of Birth: 08/10/1970	**Case No:** 58869
Account No: 025438	**Dictating Physician:** Frank J. Tomecek, Jr., MD
Date of Admission: 12/13/2007	

with the Woodson. Epidural bleeding was controlled at L3-4 and L4-5 with FloSeal and cottonoids. Hemostasis in the epidural space was obtained with bipolar electrocautery.

Then, the nerve root on the right at L3 was retracted. The L2-3 disk was exposed and the annulus was coagulated with bipolar electrocautery. There was a hole in the annulus which was widened with an 11-bladed knife. Disk fragments were removed with pituitary rongeurs. There were herniated disks at L2-3 on the right side. Again, posterior osteophytes were removed with Kerrison punch 2-mm and 3-mm. Posterior osteophytes and loose pieces of disk were tapped into the interspace with Epstein curette, loosening both medial pieces of disk and lateral pieces of disk which were removed with pituitary rongeurs. After a thorough diskectomy was performed on the right side at L2-3, the decompression was again checked with a Woodson instrument in the foramen of L3. FloSeal again was used in the epidural space at L2-3 for hemostasis.

Copious quantities of Kantrex irrigation were performed to washout the wound. It should be mentioned that the Anspach drill with AM8 bit was used to thin the facets bilaterally at L2-3, L3-4, and L4-5 and to widen the laminotomies of L2 which were done bilaterally and further widened with Kerrison punch as were the foraminotomies with Kerrison punch. The anesthesiologist performed Valsalva two more times to the level of 40 and there was no spinal fluid leak after the repair.. DuraSeal was then injected over the posterior tears of the dura. The retractors were removed. Muscular bleeding was controlled with Bovie electrocautery.

The fascia was closed with #1 Vicryl in a simple interrupted fashion. A subcutaneous drain was tunneled through a separate stab wound and sewn to the skin with 2-0 silk. The subcutaneous tissue was closed with 2-0 Vicryl in an inverted interrupted fashion and the subcuticular closed with 3-0 Vicryl in an inverted interrupted fashion. Staples were applied to the skin. A sterile dressing was applied to the wound.

GMM 000149

Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: G M	**Date of Procedure:** 12/13/2007
Date of Birth: 08/10/1970	**Case No:** 58869
Account No: 025438	**Dictating Physician:** Frank J. Tomecek, Jr., MD
Date of Admission: 12/13/2007	

Sponge and needle counts were correct at the end of the procedure. Estimated blood loss was 200 mL. The patient was placed on a stretcher and wheeled to the recovery room in stable condition moving all extremities.

Frank J. Tomecek, Jr., MD
Dictated: 12/13/2007 5:34 PM
Transcribed: 12/13/2007 10:11 PM
FJT/krh: 73831

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | 1 PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code) (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 05/24/13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE RACHEL WHITEHOUSE DO

17a. 17b. NPI 1306955141

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 23 09 TO 06 27 09

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 7213
2. 72402
3. 72252
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 91027211 THERES

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06232009	06232009	21		22612		123	4830 00	1		NPI	1366403990
2	06232009	06232009	21		22614		123	2730 00	2		NPI	1366403990
3	06232009	06232009	21		22630	51	123	4830 00	1		NPI	1366403990
4	06232009	06232009	21		22632		123	2216 00	2		NPI	1366403990
5	06232009	06232009	21		22842		123	5650 00	1		NPI	1366403990
6	06232009	06232009	21		22851		123	1408 00	1		NPI	1366403990

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [X] 730791858

26. PATIENT'S ACCOUNT NO. 77787-090600PR

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 21664.00

29. AMOUNT PAID $ 5440.58

30. BALANCE DUE $ 16223.4

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
FRANK J TOMECEK, MD
Signature on File
SIGNED 05 24 2013 DATE

32. SERVICE FACILITY LOCATION INFORMATION
TULSA SPINE HOSPITAL
6901 S OLYMPIA AVE
TULSA OK 74132-1843
a. 1033185293 b.

33. BILLING PROVIDER INFO & PH # (918)7490762
OKLAHOMA SPINE & BRAIN INSTI
PO BOX 25885
OKLAHOMA CITY OK 7
a. 1588625339 b.

EXHIBIT B

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 F

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): P

3. PATIENT'S BIRTH DATE MM DD YY — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 05/24/13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RACHEL WHITEHOUSE DO

17a. | 17b. NPI 1306955141

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 23 09 TO 06 27 09

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 7213
2. 72402
3. 72252
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 91027211 THERES

	24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06232009	06232009	21		22851	59	123	2816 00	2		NPI	1366403990
2	06232009	06232009	21		20930		123	275 00	1		NPI	1366403990
3	06232009	06232009	21		20936		123	464 00	1		NPI	1366403990
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 730791858 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 77787-090600PR

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 3555.00

29. AMOUNT PAID $ 1136.66

30. BALANCE DUE $ 2418.34

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

FRANK J TOMECEK, MD
Signature on File

SIGNED 05 24 2013 DATE

32. SERVICE FACILITY LOCATION INFORMATION

TULSA SPINE HOSPITAL
6901 S OLYMPIA AVE
TULSA OK 74132-1843

a. 1033185293 b.

33. BILLING PROVIDER INFO & PH # (918)7490762

OKLAHOMA SPINE & BRAIN INSTI
PO BOX 25885
OKLAHOMA CITY OK 73125-0885

a. 1588625339 b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500 1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | 1 PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): P

3. PATIENT'S BIRTH DATE MM DD YY — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 05/24/13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RACHEL WHITEHOUSE DO

17a. | 17b. NPI 1306955141

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 23 09 TO 06 27 09

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 7213
2. 72402
3. 72252
4. M4589

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 91Q27211 THERES

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06232009	06232009	21		22612	AS	123	966 00	1		NPI	1346288156
2	06232009	06232009	21		22614	AS	123	546 00	2		NPI	1346288156
3	06232009	06232009	21		22630	AS 51	123	966 00	1		NPI	1346288156
4	06232009	06232009	21		22632	AS	123	444 00	2		NPI	1346288156
5	06232009	06232009	21		63042	AS	24	994 00	1		NPI	1346288156
6	06232009	06232009	21		63042	AS 50	24	994 00	1		NPI	1346288156

25. FEDERAL TAX I.D. NUMBER: 730791858 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 77787-090600PS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 4910.00

29. AMOUNT PAID $ 511.09

30. BALANCE DUE $ 4398.91

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

BARBARA STEWART, CFA
Signature on File
SIGNED 05 24 2013 DATE

32. SERVICE FACILITY LOCATION INFORMATION

TULSA SPINE HOSPITAL
6901 S OLYMPIA AVE
TULSA OK 74132-1843
a. 1033185293 b.

33. BILLING PROVIDER INFO & PH # (918)7490762

OKLAHOMA SPINE & BRAIN INSTI
PO BOX 25885
OKLAHOMA CITY OK 73125-0885
a. 1588625339 b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): L, P

3. PATIENT'S BIRTH DATE MM DD YY — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 05/24/13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RACHEL WHITEHOUSE DO

17a. | 17b. NPI 1306955141

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 23 09 TO 06 27 09

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 72402
2. V4589
3. 7213
4. 72252

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 91027211 THERES

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06232009	06232009	21		63044	AS	12	231 00	1		NPI	1346288156
06232009	06232009	21		63044	AS 50	12	231 00	1		NPI	1346288156
06232009	06232009	21		22842	AS	314	1130 00	1		NPI	1346288156
06232009	06232009	21		22851	AS	314	282 00	1		NPI	1346288156
06232009	06232009	21		22851	AS 59	314	564 00	2		NPI	1346288156
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]: 730791858

26. PATIENT'S ACCOUNT NO.: 77787-090600PS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 2438.00

29. AMOUNT PAID $ 304.87

30. BALANCE DUE $ 2133.13

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
BARBARA STEWART, CFA
Signature on File
SIGNED 05 24 2013 DATE

32. SERVICE FACILITY LOCATION INFORMATION
TULSA SPINE HOSPITAL
6901 S OLYMPIA AVE
TULSA OK 74132-1843
a. 1033185293 b.

33. BILLING PROVIDER INFO & PH # (918)7490762
OKLAHOMA SPINE & BRAIN INSTI
PO BOX 25885
OKLAHOMA CITY OK 73125-0885
a. 1588625339 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Tulsa Spine & Specialty Hospital

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6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: P L	**Date of Admission:** 06/23/2009
Date of Birth: 10/21/1949	**Case No:** 84891
Account No: 035983	**Dictating Physician:** Frank J. Tomecek, MD
Date of Operation: 06/23/2009	

PREOPERATIVE DIAGNOSES:

1. Recurrent right L4 radiculopathy.
2. Recurrent lumbar spondylosis and stenosis at L3-4 and L4-5.
3. Lumbar spondylosis and stenosis also noted at L5-S1.
4. Degenerative disc disease at L3-4, L4-5 and L5-S1.
5. Post laminectomy syndrome status post a right L4 and L5 laminotomy and L4-5 foraminotomy with a grade 1 to grade 2 L3-4 spondylolisthesis and lumbar instability.

POSTOPERATIVE DIAGNOSES:

1. Recurrent right L4 radiculopathy.
2. Recurrent lumbar spondylosis and stenosis at L3-4 and L4-5.
3. Lumbar spondylosis and stenosis also noted at L5-S1.
4. Degenerative disc disease at L3-4, L4-5 and L5-S1.
5. Post laminectomy syndrome status post a right L4 and L5 laminotomy and L4-5 foraminotomy with a grade 1 to grade 2 L3-4 spondylolisthesis and lumbar instability.

PROCEDURES PERFORMED:

1. Redo posterior approach bilateral L3 and L4 laminotomies.
2. Left-sided L5 laminotomy. FT
3. Bilateral L3-4 and L4-5 foraminotomies.
4. Left-sided L5-S1 foraminotomy.
5. Bilateral L3-4 discectomy.
6. Left-sided L4-5 and L5-S1 discectomy.
7. Posterior lumbar interbody fusion which is a 360-degree fusion through a single posterior incision at L3-4, L4-5 and L5-S1 with Novel PEEK cages and Osteocele stem cells.
8. Posterior spinal fusion from L3 to the sacrum with Polaris instrumentation, morselized autograft and InFUSE bone morphogenic protein.
9. Fluoroscopic guidance, EMG and SSEP monitoring were used.

SURGEON: Frank J. Tomecek, MD.

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Date of Birth: 10/21/1949	**Case No:** 84891
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Date of Operation: 06/23/2009	

ASSISTANT: Barbara Stewart, CFA.

ANESTHESIA: General per Mark Welcher, CRNA.

PREPARATION: Routine ChloraPrep and Ioban.

HISTORY: This is a 59-year-old white female who was complaining of back pain, bilateral leg pain right greater than left despite the fact that she had had a past minimally invasive right-sided L3 and L4 laminotomy and foraminotomy per Dr. Steve Anagnost. She had a magnetic resonance imaging (MRI) that showed a grade 1 to grade 2 spondylolisthesis at L3-4, severe degenerative changes of the disc at L4-5 and L5-S1, persistent or recurrent lumbar spondylosis and stenosis at L3-4 and L4-5, but also spondylosis and stenosis at L5-S1. She was suffering from post laminectomy syndrome as well. She had had chronic severe right leg pain. She had failed nonoperative treatments. She had plain films that confirmed a severe spondylolisthesis at L3-4 and degenerative change of the disc with nearly loss of all cartilage between L4-5 and L5-S1. The procedure of a bilateral decompression and posterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 with Novel PEEK cages and Osteocele stem cells, posterior spinal fusion from L3 to the sacrum with Polaris instrumentation, morselized autograft and InFUSE bone morphogenic protein was explained to her. Also the potential risks and complications were explained that include infection, bleeding, failure of fusion, failure of instrumentation, nerve injury that could lead to partial or complete paralysis, chronic pain despite surgery and medical risks of pneumonia, deep venous thrombosis, pulmonary embolism, myocardial infarction, stroke and even death. She understood all these things and elected to proceed.

DESCRIPTION OF PROCEDURE: The patient was wheeled into the operating room in the supine position. She had IVs placed. She was induced with general anesthesia and intubated. She had a Foley catheter inserted. She had EMG and SSEP monitoring placed on the lower extremities. She had pneumatic compression boots placed on the lower extremities. She was positioned prone on the OSI spine table and her joints were padded. Her back was prepped and draped in a sterile fashion using ChloraPrep and Ioban. An incision was marked in the midline from L3 to the sacrum. She had had an old incision that was about an inch long that was to the

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Date of Operation: 06/23/2009	

right of midline over the L3-4 region. A new incision was marked in the midline not directly over her old incision. The patient received 2 grams of Ancef for antibiotic prophylaxis. She received 250 milligrams of intravenous Solu-Medrol for nerve protection.

An incision was made in the midline through skin and subcutaneous tissue. Hemostasis was obtained with Bovie electrocautery. Gelpi retractors were placed for exposure. The incision was carried down through dense scar tissue especially on the right side. Subperiosteal stripping was performed to expose the spinous process, lamina and facet complexes at L3, L4, L5 and the sacrum. Dissection was carried out laterally lateral to the facet complexes. A bear claw was used for exposure. Muscle was tripped off the transverse processes exposing them at L3, L4, L5 and the sacral ala was exposed bilaterally with Bovie electrocautery and Cobb periosteal. Muscular tissue and other soft tissue were removed from around the pars at L3-4, L4-5 and L5-S1 with Leksell rongeur. A large pars defect was noted at L3-4 explaining the spondylolisthesis. The lamina of L3 was extremely mobile due to the pars defect. Fluoroscopic guidance was used intermittently to confirm all levels. The supraspinous and intraspinous ligaments were removed at L3-4, L4-5 and L5-S1 with Leksell rongeur. The spinous processes of L3, L4 and L5 were removed with Leksell rongeur. The L3 lamina was drilled through with the Anspach drill with AM8 bit. The L4 lamina was also drilled through with the Anspach drill. The L4 lamina was removed with Leksell rongeur. The L3 lamina was extremely adherent to the dura. It was carefully separated from the dura with a Woodson. It was removed with Kerrison punch 3 and 4 millimeters. The lamina was still scarred to the dura and it was actually separated from the dura with a Woodson and with an 11-bladed knife. The lamina was removed with Leksell rongeur. A complete laminectomy was done at L3. Foraminotomies were done at L3-4 with Kerrison punch 4 and 5 millimeters. At L4-5 on the right there was extensive epidural fibrosis from previous surgery. There was concern that further manipulation around the right L5 nerve root could lead to spinal fluid leak so this was not done. A wide foraminotomy was done on the left side with Kerrison punch 4 and 5 millimeters at L4-5. The ligamentum flavum was removed at L3-4 and L4-5 with a Kerrison punch. The lamina of L5 was drilled down with the Midas Rex. The ligamentum flavum was remove with Kerrison punch 4 and 5 millimeters. Medial facetectomy and foraminotomy was done at L5-S1 on the left with a Kerrison punch. Then the nerve root was retracted between L3 and L4 on the left. The disc space was exposed. Epidural bleeding

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OPERATIVE REPORT

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was controlled with bipolar electrocautery. The disc was opened with an 11-bladed knife. A 6-millimeter double edged chisel was used to strip the endplates. Then an 8-millimeter double edged chisel was used to prepare the endplates on the left side at L3-4. Further disc was removed with pituitary rongeur. To distract the disc space it was decided that we should put pedicle screws in first before completing the decompression. The transverse processes of L3, L4 and L5 were decorticated with the Anspach drill. The sacral ala was decorticated. The facets on the right side were decorticated with the osteotome and mallet at L4-5 and L5-S1 and partially at L3-4. The transverse processes were further decorticated with the Anspach drill The pedicles were tapped on the right at L3, L4 and L5 under fluoroscopic guidance using the Anspach drill followed by Steffee probe. A small ball tip probe was used to palpate the pedicles. A 5.5-millimeter tap was used to prepare the pedicles on the right side. On the right side at 6.5 by 40-millimeter Polaris polyaxial screw was inserted in L3, a 6.5 by 40-millimeter Polaris polyaxial screw was inserted in L4, a 6.5 by 35-millimeter screw was inserted in the L5 pedicle on the right. This was all done under fluoroscopic guidance. Then the sacral ala was decorticated with the Anspach drill. The S1 pedicle was tapped on the right with the Anspach drill followed by a Steffee probe followed by a small ball tip probe. A 6.5-millimeter tap was used and a 7.5 by 35-millimeter Polaris polyaxial screw was inserted on the right side in the sacrum. A special end screw distractor system was placed in the Polaris screws. They were opened to widen and distract the disc space at L3-4. An 8-millimeter rasp was used on the left side to prepare the endplate. Further disc was removed with pituitary rongeur. An Epstein curette was used to remove loose, medial and lateral pieces of disc that were removed with pituitary rongeur. Then an 8-millimeter football-shaped Novel PEEK cage was filled with Osteocele stem cells and inserted into the L3-4 interspace on the left side and countersunk with impactor and mallet several millimeters. This was an 8-millimeter height and 25-millimeter depth cage. Fluoroscopic guidance confirmed good position of the pedicle screws on the right and good position of the interbody cage on the left. Then the nerve root of L5 was retracted on the left. The epidural bleeding was controlled with bipolar electrocautery. The 11-bladed knife was used to open the disc space at L4-5 on the left. Disc was removed with pituitary rongeur. An end screw distractor system was placed in the L4-5 pedicle screws and opened for distraction of the disc space of L3-4. A #6 followed by a #8 double edges chisel was used to prepare the endplates. An 8-millimeter rasp was used to prepare the endplates. Disc was removed with

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pituitary rongeur, straight and angled curettes and Epstein curettes were used to strip disc off the endplates. An 8-millimeter lordotic Novel PEEK cage was filled with osteocele stem cells. A small strip of InFUSE bone morphogenic protein that had been allowed to bind to a collagen sponge for several minutes was placed in the anterior disc space. The Novel PEEK cage was inserted on the left side at L4-5 and countersunk with impactor and mallet. It should be mentioned that at L3-4 before placing the cage a small strip of InFUSE bone morphogenic protein was placed anteriorly at L3-4 as well. This was anterior to the Novel PEEK cage device. A wide foraminotomy was done bilaterally at L4-5 with Kerrison punch 4 and 5 millimeters. The nerve root was retracted on the left side at L5-S1. The disc was opened on the left at L5-S1. Under the screw distractors were placed at L5-S1 distracting the disc space. The disc was partially removed with pituitary rongeur. A #6 followed by a #8 double edged chisel was used to prepare the endplates. Disc was removed with pituitary rongeur. An 8-millimeter rasp was used to prepare the endplates. A 9-millimeter football-shaped cage, this was a Novel PEEK cage, was filled with Osteocele stem cells. A small strip of InFUSE bone morphogenic protein was placed in the anterior disc space at L5-S1. The Novel PEEK cage 9-millimeter football-shaped by 25-millimeter in length was placed in the interbody space at L5-S1 and countersunk with impactor and mallet. Fluoroscopic guidance confirmed good position of the cages on the left side. Again interbody cages had been placed at L3-4, L4-5 and L5-S1 as described. Then the pedicles were tapped on the left side. First the transverse process infusion bed was decorticated with the Anspach drill with AM8 bit. The pars was decorticated at the pars defect at L3-4. The pars was decorticated at L4 and L5 on the left. The facets were decorticated with the osteotome and mallet and with the Anspach drill. The pedicles were tapped at the pedicle entry zone at L3, L4 and L5 on the left with the Midax Rex followed by a Steffee probe followed by a small ball tip probe to check the integrity of the pedicle and then a 5.5-millimeter tap was used. Then a 6.5 by 40-millimeter Polaris polyaxial screw was inserted in L3 and L4 on the left. A 6.5 by 35-millimeter Polaris polyaxial screw was inserted in L5 on the left. The sacrum was then tapped the pedicle was with the Anspach drill followed by a Steffee probe. A small ball tip probe again was used. A 6.5-millimeter tap was used and then a 7.5 by 35-millimeter Polaris polyaxial screw was inserted in the sacrum on the left. All screws were felt to be in good position on lateral x-ray of the fluoroscope. Then a wide laminotomy was done at L3 on the right. The pars was drilled down on the right with the Anspach drill. Medial facetectomy and

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OPERATIVE REPORT

Patient Name: P I	**Date of Admission:** 06/23/2009
Date of Birth: 10/21/1949	**Case No:** 84891
Account No: 035983	**Dictating Physician:** Frank J. Tomecek, MD
Date of Operation: 06/23/2009	

foraminotomy was done widely on the right at L3-4. The nerve root was retracted on the right at L4. The annulus was opened with an 11-bladed knife. Disc was removed with pituitary rongeur. Under the screw distractor was placed on the left side between the L3 and L4 screws and opened for exposure of the disc space and distraction of the disc space. While the nerve root was still being retracted a #6 followed by a #8 double edged chisel was used to prepare the endplates. Disc was removed with pituitary rongeur. An 8-millimeter rasp was used to prepare the endplates on the right side at L3-4. A complete discectomy was done on the right at L3-4 with pituitary rongeur. Again a small strip of collagen infused with bone morphogenic protein was placed in the anterior disc space at L3-4 on the right. A 9-millimeter football-shaped Novel PEEK cage was filled with Osteocele stem cells and inserted at L3-4 on the right and countersunk with impactor and mallet. AP and lateral fluoroscopy confirmed excellent position of the cages, excellent position of the screws, excellent reduction of the spondylolisthesis with distraction with the cages, and thus good alignment of the spine was achieved. FloSeal was placed in the epidural space for hemostasis. A precut prebent rod, this was titanium type, was placed in the top loading Polaris screws. Before this was done however the nerve roots were stimulated at L3 and L4. They stimulated at about 0.4 milliamperes. Then the screws were stimulated. At L3 on the left the screw stimulated at 19 milliamperes. On the right the screw did not stimulate even at greater than 20 milliamperes. At L4 on the left the screw stimulated at 10.6 milliamperes. On the right it stimulated at 18 milliamperes. At L5 the left screw stimulated at 9.8 milliamperes after initially stimulated at 6.9 milliamperes. This screw was moved more medially because there was felt to be a lateral breach in the pedicle and it stimulated at 9.8 milliamperes after it was moved. On the right side at L5 the screw stimulated at 11.4 milliamperes. In the sacrum the left screw did not stimulate even at greater than 20 milliamperes. The right screw stimulated at 19 milliamperes. Ap and lateral fluoroscopy confirmed excellent position of the screws and cages. Two precut prebent rods were placed in the top loading screws. Caps were tightened to provisional tightness. Compression was placed between the screws to lock the bone grafts into place on the left side. Caps were tightened to full tightness with torque and counter torque wrench at L3, L4, L5 and the sacrum. On the right side the precut prebent rod was placed in the top loading Polaris screws. Caps were tightened to provision tightness. Compression was performed between L3 and L4 to lock the interbody graft into place on the right and then the caps were tightened to full tightness with torque and counter

PLM 000193

OPERATIVE REPORT

Patient Name: P I	**Date of Admission:** 06/23/2009
Date of Birth: 10/21/1949	**Case No:** 84891
Account No: 035983	**Dictating Physician:** Frank J. Tomecek, MD
Date of Operation: 06/23/2009	

torque wrench at L3, L4, L5 and in the sacrum on the right. Excellent fixation was achieved. This was checked with a Kocher. Copious quantities of bacitracin irrigation was used to wash out the wound.

Then the bone graft from the laminectomy and decompression was morselized. It was mixed with 40 milliliters of cancellous bone bank bone. InFUSE bone morphogenic protein that had been allowed to bind to a collagen sponge for several minutes was placed over the autograft from the laminectomy and then it was placed over the decorticated fusion bed from L3 to the sacrum bilaterally. The fusion bed was decorticated with the Midas Rex with AM8 bit. This was used to decorticate the facets and the transverse processes and the sacral ala. This was done bilaterally. A bear claw was used to retract the paraspinous muscles. InFUSE bone morphogenic protein wrapped around the morselized autograft was placed over the decorticated fusion bed on the right side. Again cancellous bone bank bone was placed over the mixture of bone morphogenic protein and morselized autograft. Then cancellous bone bank bone was placed over the decorticated fusion bed on the right side.

A subfascial #10-French Blake drain was tunneled through a separate stab wound and sewn to the skin with 2-0 silk. This was tunneled out the left side. EMG monitoring done throughout the procedure showed minimal transient activity of the left vastus lateralis muscle. Otherwise there was no sign of nerve irritation. There was no sign of nerve injury. Somatosensory evoked potential monitoring was stable throughout the procedure. The fascia was then closed with #1 Vicryl in a simple interrupted fashion. The subcutaneous was closed with 2-0 Vicryl in an inverted interrupted fashion. The subcuticular was closed with 3-0 Vicryl in an inverted interrupted fashion. Staples were applied to the skin. A sterile dressing was applied to the wound. Sponge and needle counts were correct at the end of the procedure. Estimated blood

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loss was 250 milliliters. Dr. John Hastings was the real time reading neurologist throughout the procedure on the monitoring. Again there was no sign of nerve injury or irritation.

Frank J. Tomecek, MD
Dictated: 06/23/2009 3:38 PM
Transcribed: 06/23/2009 5:35 PM
FJT/dmp: 112604

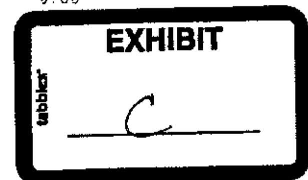
Dictated: 06/23/2009 4:01 PM
Transcribed: 06/23/2009 6:25 PM
FJT/dmp: 112605

10/10/12 OPEN ITEM PAYMENT HISTORY BY ACCOUNT Page 1

OKLAHOMA SPINE & BRAIN INSTITUTE

Accounts : 72227 - 72227, Location :

Account	Dt Serv	Patient	Units	Proc Code	Diag Code	Dr#/Vchr/Stat/Loc	Ins 1 Billed	Ins 2 Billed	Amount	Balance
72227	S	L		(918) 245-6521	Unapplied Credits :					0.00
	05/21/07	L	1.00	87	88	5/ /2/1	0-	0	25.00	
		Cash Payment (		05/21/07 for $ 25.00) from Patient				on 05/21/07	-25.00	
										0.00
	05/08/07	L	1.00	22612	721.3	5/ /2/	571-07/12/07	0-	4830.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		Check Payment (6368		10/22/07 for $ 2638.79) from Ins #571				on 10/22/07	-1320.15	
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-3509.85	
										0.00
	05/08/07	L	1.00	22614	721.3	5/ /2/	571-07/12/07	0-	1365.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		Check Payment (6368		10/22/07 for $ 2638.79) from Ins #571				on 10/22/07	-372.40	
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-992.60	
										0.00
	05/08/07	L	1.00	22630,51	721.3	5/ /2/	571-07/12/07	0-	4930.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		Check Payment (6368		10/22/07 for $ 2638.79) from Ins #571				on 10/22/07	-649.21	
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-4180.79	
										0.00
	05/08/07	L	1.00	22632	721.3	5/ /4/	571-07/12/07	0	1108.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		Check Payment (6368		10/22/07 for $ 2638.79) from Ins #571				on 10/22/07	-297.03	
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-810.97	
		Transfer (6368		) from Ins #571 to Patient				on 10/22/07		
										0.00
	05/08/07	L	2.00	63042,53	721.3	5/ /2/	571-07/12/07	0-	9938.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-9938.00	
										0.00
	05/08/07	L	4.00	63044,50	721.3	5/ /2/	571-07/12/07	0-	4620.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		A16 (6368		10/22/07) Medicaid Adjustment				on 10/22/07	-4620.00	
										0.00
	05/08/07	L	1.00	22842	721.3	5/ /4/	571-07/12/07	0-	5650.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		Check Payment (2942		10/05/07 for $ 829.60) from Ins #739				on 10/05/07	-726.68	
		A16 (2942		10/05/07) Medicaid Adjustment				on 10/05/07	-4923.32	
		Transfer (2942		) from Ins #571 to Patient				on 10/05/07		
										0.00
	05/08/07	L	1.00	20930	721.3	5/ /2/	571-07/12/07	0-	275.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		
		Transfer (		) from Ins #571 to Ins #571				on 07/12/07		
		A16 (2942		10/05/07) Medicaid Adjustment				on 10/05/07	-275.00	
										0.00
	05/08/07	L	1.00	20931	721.3	5/ /2/	571-07/12/07	0-	418.00	
		Transfer (		) from Ins #571 to Ins #571				on 07/11/07		



Account	Dt Serv	Patient	Units	Proc Code	Diag Code	Ord#/Vchr/Stat/Loc	Ins 1-Billed	Ins 2-Billed	Amount	Balance
		Check Payment	(60024	12/20/07 for $	31.62) from Ins #734		on 12/20/07		-31.62	
		A16	(60024	12/20/07)	Medicaid Adjustment		on 12/20/07		-95.38	
										0.00
	01/09/08	L	1.00	99212	722.83	5/102198 /4/18	571-01/21/08e	0-	95.00	
		Transfer	(	) from Ins #571 to Ins #571			on 02/05/08			
		Transfer	(	) from Ins #571 to Ins #571			on 06/19/08			
		Transfer	(	) from Ins #571 to Ins #571			on 07/21/08			
		Check Payment	(8962	08/15/08 for $	32.10) from Ins #571		on 08/15/08		-32.10	
		A16	(8962	08/15/08)	Medicaid Adjustment		on 08/15/08		62.90	
		Transfer	(8962	) from Ins #571 to Patient			on 08/15/08			
										0.00
	01/09/08	L	1.00	72100	722.83	5/102198 /2/18	571-01/21/08e	0-	127.00	
		Check Payment	(4759	02/04/08 for $	31.62) from Ins #571		on 02/04/08		-31.62	
		A16	(4759	02/04/08)	Medicaid Adjustment		on 02/04/08		-95.38	
										0.00
	09/29/08	L	1.00	99214	726.5	5/111450 /2/18	571-10/01/08e	0-	205.00	
		Check Payment	(89204	12/02/08 for $	114.21) from Ins #571		on 12/02/08		-83.00	
		A16	(89204	12/02/08)	Medicaid Adjustment		on 12/02/08		-122.00	
										0.00
	09/29/08	L	1.00	72100	726.5	5/111450 /2/18	571-10/01/08e	0-	127.00	
		Check Payment	(89204	12/02/08 for $	114.21) from Ins #571		on 12/02/08		-31.21	
		A16	(89204	12/02/08)	Medicaid Adjustment		on 12/02/08		-95.79	
										0.00
	03/25/09	L	1.00	99213	726.5	5/117743 /4/18	571-03/30/09e	0-	135.00	
		Transfer	(	) from Ins #571 to Ins #571			on 07/10/09			
		Check Payment	(2569	08/04/09 for $	54.14) from Ins #734		on 08/04/09		-54.14	
		A16	(2569	08/04/09)	Medicaid Adjustment		on 08/04/09		-80.86	
		Transfer	(2569	) from Ins #571 to Patient			on 08/04/09			
										0.00
	03/25/09	L	1.00	72100	726.5	5/117743 /4/18	571-03/30/09e	0-	127.00	
		Check Payment	(7571	04/14/09 for $	32.21) from Ins #571		on 04/14/09		-32.21	
		A16	(7571	04/14/09)	Medicaid Adjustment		on 04/14/09		-94.79	
		Transfer	(7571	) from Ins #571 to Patient			on 04/14/09			
										0.00

BALANCE FOR ACCOUNT 72227 0.00

Tulsa Spine & Specialty Hospital

6901 South Olympia Ave. – Tulsa, OK 74132 Telephone: 918-388-5724 Facsimile: 918-388-2733

OPERATIVE REPORT

Patient Name: L S	**Date of Procedure:** 05/08/07
Date of Birth: 09/24/44	**Case No:** 48826
Account No: 021310	**Dictating Physician:** Frank J. Tomecek, M.D.
Date of Admission: 05/08/07	

PREOPERATIVE DIAGNOSES

1. Lumbar spondylosis and stenosis with degenerative disks at L3-4 and L4-5.
2. L4-5 radiculopathy with neurogenic claudication.
3. The patient is status post right-sided L4 laminotomy and L4-5 foraminotomy.

POSTOPERATIVE DIAGNOSES

1. Lumbar spondylosis and stenosis with degenerative disks at L3-4 and L4-5.
2. L4-5 radiculopathy with neurogenic claudication.
3. Right L4-5 fractured facet.
4. The patient is status post right-sided L4 laminotomy and L4-5 foraminotomy.

PROCEDURE PERFORMED

1. Bilateral L3 laminotomies.
2. Redo bilateral L4 laminectomy.
3. Bilateral L3-4 foraminotomies and diskectomies.
4. Bilateral redo L4-5 foraminotomies.
5. Bilateral L4-5 diskectomy for decompression.
6. Posterior lumbar interbody fusion at L3-4 and L4-5, which is a 360 degree fusion through a single posterior incision using Alphatech precut bone-bank bone graft.
7. Posterior spinal fusion from L3 to L5 with Array instrumentation, morselized autograft, cancellous bone-bank bone chips, and InFuse bone morphogenic protein.
8. Fluoroscopic guidance was used.
9. EMG and SSEP monitoring were used.

SURGEON

Frank J. Tomecek, M.D.

LSM 000206

OPERATIVE REPORT

Patient Name: L. S	Date of Procedure: 05/08/07
Date of Birth: 09/24/44	Case No: 48826
Account No: 021310	Dictating Physician: Frank J. Tomecek, M.D.
Date of Admission: 05/08/07	

ASSISTANT
Doug Isgrigg, CFA

ANESTHESIA
General, per Mary Jo Gallo, CRNA

PREPARATION
Routine Chloraprep.

INDICATIONS
This is a 62-year-old male who is complaining of recurrent back pain and leg pain with difficulty standing and walking. He had previously been operated on at an outside institution where a minimally invasive decompression was performed. Despite this operation he got no relief and had difficulty walking. MRI of the lumbosacral spine showed persistent significant spondylosis and stenosis at L3-4 and L4-5 with degenerative disks and osteophytes. There was significant facet hypertrophy and foraminal encroachment. The procedure of a bilateral redo operation with decompression and fusion was explained to him as well as the potential risks and complications. He understood and elected to proceed.

DESCRIPTION OF PROCEDURE
The patient was wheeled into the operating room in the supine position. He had IVs placed. He was induced with general anesthesia and intubated. He received 2 grams of Ancef for antibiotic prophylaxis. He had a Foley catheter inserted. He had EMG and SSEP monitoring placed on the lower extremities with sphincter electrodes. He had pneumatic compression boots placed on his lower extremities. He was positioned prone on the OSI spine table and his joints were padded. His back was prepped and draped in sterile fashion using Chloraprep and Ioban. An incision was marked in the midline from L3 to L5. He had a previous incision that was off the midline for a minimally invasive approach.

An incision was made through skin and subcutaneous tissue. Hemostasis was obtained with Bovie electrocautery. Gelpi retractors were placed for exposure. The incision was carried down through the lumbodorsal fascia and subperiosteal stripping was performed to expose the spinous process, lamina and facet complexes of L3, L4 and L5. Hemostasis was obtained with the Aquamantis cautery system. Deep Gelpi retractors were placed for exposure.

OPERATIVE REPORT

Patient Name: L S	Date of Procedure: 05/08/07
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DESCRIPTION OF PROCEDURE (continued)

A bear claw was used for retraction as well, and dissection was carried out lateral to the facet complexes exposing the transverse processes and pars bilaterally at L3, L4 and L5. Again, bleeding was controlled with the Aquamantis. Intermittent fluoroscopy confirmed our levels. Scar tissue was dissected through on the right side at L4-5 where a previous surgery was performed. The supraspinous and intraspinous ligaments were removed at L3-4 and L4-5. The spinous process of L4 was removed. All this was done with a Leksell rongeur. There was severe stenosis around the L4 lamina. It was decided that it had to be completely removed. The right side of the L4 lamina had been removed, 80%. The facet at L4-5 on the right had been broken and had fragments of the inferior facet of L4 that were loose and impinging on the right L4-5 nerve roots. These fragments of bone were removed with a curet and Leksell rongeur. The L4 lamina was drilled through. The L4 lamina was removed with the Leksell rongeur. An L3 laminotomy was done with the Kerrison punch 4 and 5-mm bilaterally. Ligamentum flavum was removed. Scar was dissected from around the nerve roots at L4 and L5 using a nerve hook and a Woodson. Epidural scar was dissected through with bipolar electrocautery. Wide decompression was done out to the pedicles with the Kerrison punches. The nerve roots were protected with nerve root retractors. The disk spaces were opened with a #11 blade knife and bilateral diskectomies were performed with pituitary rongeurs, straight and angled curets and Epstein curets at L3-4 and L4-5. A #8, #9 and #10 double-edge chisels were used to strip cartilage off the endplates. A 10-mm box chisel was used on the left side at L3-4 and L4-5 to prepare the endplates and remove posterior lips and osteophytes off the endplates. A #10 trial was used to at L3-4 and L4-5. A #10 Alphatech precut bone-bank bone graft was inserted at L3-4 and L4-5 on the left side and countersunk with impactor and mallet. After this was done, the endplates were prepared on the right side while protecting the nerve roots with nerve root retractors. This was again done with #8, #9 and #10 double-edge chisels. On the right side a 10-mm rasp was used to prepare the endplates at L3-4 and L4-5, and then a 10-mm Alphatech precut bone-bank bone graft was inserted on the right at L3-4 and L4-5 and countersunk with impactor and mallet. Fluoroscopic guidance confirmed good position of the bone grafts.

After this was done, the pedicles were tapped bilaterally at L3, L4 and L5 using initially the Anspach drill with AM8 bit followed by a Steffee probe followed by a 5.5-mm tap. A small ball-tip probe was used to palpate the pedicle and make sure it was intact. Under fluoroscopic guidance, 6.5 x 50-mm screws were placed bilaterally at L3 and L4 and tightened to full tightness into the pedicle. At L5, 6.5 x 45-mm screws were replaced bilaterally.

OPERATIVE REPORT

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DESCRIPTION OF PROCEDURE (continued)
After placing the screws, the nerve roots were stimulated. They stimulated at about 1 milliamp. The screws were then stimulated, and none of the screws stimulated even at greater than 20 milliamps. After this was completed, copious quantities of Kantrex irrigation was performed in the wound to wash it out. The bone graft that had been morselized was mixed with 60 ml of cancellous bone-bank bone chips. InFuse bone morphogenic protein had been injected on a collagen sponge and part of it was placed inside the InFuse impregnated sponge and wrapped around the graft. Then the transverse processes of L3, L4 and L5 were decorticated with the Anspach drill with AM8 bit, and the pars and facets were decorticated. The facets were so hypertrophied they had to be either drilled down or osteotomed down with the osteotome and mallet. After preparing the fusion bed in this fashion, the bone graft was placed over the decorticated fusion bed from L3 to L5. Then, rods were placed in the top-loading Array polyaxial screws. Caps were tightened to provisional tightness. Compression was performed between the screws to lock the bone grafts into place and then the caps were tightened to full tightness with torque and counter-torque wrench. AP and lateral fluoroscopic imaging confirmed good position of the hardware, good alignment of the spine, and good position of the bone grafts.

A #10 french Blake drain was tunneled through a separate stab wound and sewn to the skin with #2-0 silk. The fascia was closed with #1 Vicryl in simple interrupted fashion, subcutaneous tissue closed with #2-0 Vicryl in an inverted interrupted fashion, subcuticular closed with #3-0 Vicryl in an inverted interrupted fashion, and staples were applied to the skin. A sterile dressing was applied to the wound.

EMG and SSEP monitoring was stable throughout the procedure. There was no sign of nerve injury or irritation. The patient was placed on a stretcher and wheeled to the recovery room in stable condition.

COUNTS
Sponge and needle counts were correct at the end of the procedure.

OPERATIVE REPORT

Patient Name: L S	Date of Procedure: 05/08/07
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Date of Admission: 05/08/07	

ESTIMATED BLOOD LOSS
500 ml; the patient was given back 130 ml via Cell Saver washed cells.

Frank J. Tomecek, M.D.
Dictated: 05/09/07 7:34a
Transcribed: 05/09/07 11:17a
FJT/llc: 59700

LSM 000210

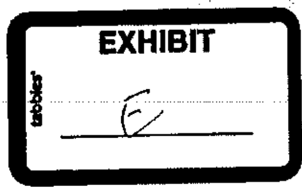
SUPREME COURT
STATE OF OKLAHOMA
FILED
NOV 15 2012
MICHAEL S. RICHIE
CLERK

IN THE SUPREME COURT OF THE STATE OF OKLAHOMA

Steven Constantine Anagnost, M.D., License No. 21194 Petitioner, v. State of Oklahoma ex rel. the Oklahoma Board of Medical Licensure and Supervision, Respondent.	)	Case No. #111246 Case No. 09-10-3681 Oklahoma Board of Medical Licensure and Supervision

APPLICATION FOR ORIGINAL JURISDICTION,
<u>AND PETITION FOR WRIT OF PROHIBITION</u>

Petitioner Steven Constantine Anagnost, M.D. (Dr. Anagnost) petitions this Court pursuant to Okla.Sup.Ct.R. 1.191 to assume original jurisdiction over this matter and issue a writ of prohibition prohibiting respondent, the Oklahoma Board of Medical Licensure and Supervision (Board), from proceeding any further against Dr. Anagnost. At a minimum, Dr. Anagnost requests this Court to disqualify the entire Board, the Trial Examiner, the Board prosecutor, the Board investigator, and any other Board functionary who has been involved in the investigation or prosecution of Dr. Anagnost. Dr. Anagnost further requests that this Court prohibit the Board from utilizing a Trial Examiner as such constitutes an improper delegation of the Board's discretion and quasi-judicial authority. Dr. Anagnost also requests that this Court prohibit John Wiggins, the Board's Advisor, from acting as the Trial Examiner for Dr. Anagnost's case if the use of a trial examiner is found permissible. Finally, Dr. Anagnost requests that this Court prohibit any trial examiner from hearing testimony from physician witnesses, including expert witnesses, in violation of O.A.C. § 453:3-3-13. In support of this Application and Petition, Dr. Anagnost shows this Court as follows:



121. To date, only one deposition has been taken in preparation for the Board's hearing of the allegations against Dr. Anagnost. On November 9, 2012, Dr. Anagnost began deposing Dr. Tomecek, one of the subsequent treating physicians for some of Dr. Anagnost's patients at issue. Even then, Dr. Tomecek's counsel stopped the deposition, following speaking objections by the Board's counsel, after Dr. Tomecek admitted to fraudulent medical billing for his subsequent treatment of Dr. Anagnost's patients. The Board's counsel objected based on relevance, and yet fraudulent medical billing is the very claim Dr. Tomecek and the Board have made against Dr. Anagnost.

122. A court of competent jurisdiction will have to rule upon either a motion to compel by Dr. Anagnost or a motion for protective order by Dr. Tomecek before that deposition can be continued.

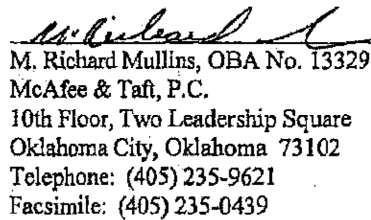
123. Not only has Dr. Tomecek's deposition not been concluded, but no other subsequent treating physicians, patients, nurses, other medical professionals, or any other witness with testimony relevant to the prosecution and defense of the Board's allegations against Dr. Anagnost have been deposed.

124. None of the parties' expert witnesses have been deposed.

125. In fact, although the Board has identified an expert, the Board has refused to provide any discovery regarding its expert. *See* Board's Responses to Dr. Anagnost's First Interrogatories, Request for Admission and Requests for Production of Documents (Appx. Ex. 60).

126. Dr. Anagnost filed a motion to compel asking the Board to compel the Board prosecutor to provide discovery regarding the Board's expert. *See* Defendant's Motion to Compel Discovery Responses and Production of Documents (Appx. Ex. 61). Trial Examiner

Respectfully submitted,



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Attorneys for Petitioner, Steven C. Anagnost, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on November 15, 2012, a true and correct copy of the foregoing was furnished via U.S. Mail to:

Daniel B. Graves
Graves McLain, PLLC
Boulder Towers
1437 S. Boulder Ave., Suite 1010
Tulsa, Oklahoma 74119

M. Richard Mullins