1 IN THE STATE COURT OF RICHMOND COUNTY
STATE OF GEORGIA
2
3 CHRISTOPHER and JENNIFER MALPASS,)
)
4 Plaintiffs,) CIVIL ACTION FILE
) NO.: 2014RCSC00358
5 vs.)
)
6 ANGELA FRANKLIN,)
)
7 Defendant.)
)
8
9
10 Deposition of KEVIN L. STEVENSON, M.D., taken
11 on behalf of the Defendant, pursuant to the
12 stipulations agreed to herein, before Camille
13 Cunningham, Certified Court Reporter, CVR, at 4660
14 Riverside Park Boulevard, Macon, Georgia, on the
15 9th day of December, 2014, commencing at 9:00 a.m.
16
17
18
19
20
21
22
23
24
25

Page 2

1 APPEARANCES OF COUNSEL:
2 On behalf of the Plaintiffs:
3 JOSEPH R. NEAL, JR.
Attorney at Law
4 Neal Law Office
2056 Lenox Road
5 Atlanta, Georgia 30324
706-829-6229
6 joenealjr@neal-law.com
7
8 On behalf of the Defendant:
9 CHARLES C. MAYERS
Attorney at Law
10 Charles C. Mayers Law
515 Fifth Street
11 Augusta, Georgia 30901
706-724-1698
12 cmayers15@comcast.net
13
14 Also Present: Christopher Malpass
15
16
17
18
19
20
21
22
23
24
25

Page 3

1 INDEX TO EXAMINATION
2 Page

3	Direct Examination	4
4	By Mr. Mayers	
5	Cross-Examination	35
6	By Mr. Neal, Jr.	
7	Re-Direct Examination	40
8	By Mr. Mayers	

9 INDEX TO EXHIBITS

10	Plaintiffs' Exhibit No. 1	37
11	ML Healthcare Surgical Cost Estimation	

12
13
14
15
16
17
18
19
20
21
22
23
24
25

Page 4

1 P R O C E E D I N G S
2 (BEGAN AT 8:52 AM)
3 MR. MAYERS: This is the deposition of
4 Dr. Kevin Stevenson taken for all purposes allowed
5 under the Civil Practice Act. It's a discovery
6 deposition. All objections will be reserved until
7 use of the deposition, except to the form of the
8 question and responsiveness of the answer, and the
9 usual stipulations as to the taking, transcribing
10 and qualifications of the court reporter.
11 Is that agreed?
12 MR. NEAL, JR.: Yes.
13 MR. MAYERS: All right. Would you swear the
14 Doctor for me, please.
15 KEVIN L. STEVENSON, M.D.
16 was sworn by the court reporter and was examined and
17 deposed as follows:
18 DIRECT EXAMINATION
19 BY MR. MAYERS:
20 Q Dr. Stevenson, I'm Chuck Mayers. I represent
21 the Defendant in this lawsuit. And we're getting
22 ready to take a discovery deposition to find out what
23 your testimony is going to be.
24 And, in this situation, I don't know if you've
25 ever had this happen before, but we're going to take a

Page 5

1 deposition for use at trial, the Plaintiff is
2 immediately afterwards. So we'll basically be talking
3 about it twice, the second time for use at trial. But
4 it's a little bit unusual.
5 I normally take a discovery deposition to find
6 out what your testimony is going to be, get a copy of
7 the transcript, and then we can use the transcript in
8 the trial deposition. But we're not going to have an
9 opportunity to do that.
10 So we may have to actually to read stuff off,
11 in the event there's a discrepancy about what somebody
12 said or didn't say, or along those lines. So, anyway,
13 try to keep that in mind as you testify here.
14 You've had your deposition taken many times, I
15 take it?
16 A I have.
17 Q And, if you want to read the deposition, we
18 can't read this one because we don't have it printed,
19 so I guess I don't really need to ask that question.
20 A Okay. And I don't know how to answer it.
21 Q Okay. All right. Give me your educational
22 qualifications, beginning with your undergraduate
23 degree, and then your medical training thereafter.
24 A Bachelor's degree from Augustana College in
25 Rock Island, Illinois. Went on to medical school at

Page 6

1 Loyola University Stritch School of Medicine in
2 Chicago. From there, a seven-year residency in
3 neurological surgery at the University of Pittsburgh,
4 followed by a one-year fellowship at the University of
5 Washington in Seattle.
6 Q Are you Board certified in neurosurgery?
7 A I am.
8 Q Do you have any sub-specialty in neurosurgery?
9 A Spinal neurosurgery. My practice is a hundred
10 percent spinal neurosurgery.
11 Q And licensed in Georgia. Any other states?
12 A No active license in another state.
13 Q And hospital privileges where?
14 A I'm on staff at Coliseum Medical Center,
15 Macon, Georgia; Northside Hospital in Macon, Georgia;
16 and the Piedmont Surgery Center in Macon, Georgia.
17 Q Is Piedmont Surgery Center owned by your
18 practice, Piedmont Orthopaedics?
19 A I'm not a business partner within that. But
20 my understanding is that it is a separate business
21 entity under one umbrella. But, again, I'm not a
22 financial stakeholder in the Surgery Center.
23 Q In other words, Piedmont Orthopaedics -- in
24 other words, a holding company owns Piedmont
25 Orthopaedics and the Piedmont Surgery Center; would

Page 7

1 that be a fair statement?
2 A To the best of my knowledge. But I'm an
3 employee, so I don't have the books available to me.
4 Q But that's your understanding?
5 A That's my understanding, yes, sir.
6 Q And, if Mr. Malpass were to have surgery, it
7 would be done at Piedmont Surgery Center?
8 A It might. It might not. It depends.
9 Q You've been practicing neurosurgery for how
10 long?
11 A I finished my residency in 2002. Finished my
12 fellowship in 2003. So, active practice, now going on
13 12 years.
14 Q Now, when we talk about ML Healthcare as a
15 sort of medical provider in this case, as opposed to
16 another entity, MedFin, do you know anything about
17 those two entities at all?
18 A MedFin, no. ML Healthcare, my understanding,
19 is a medical funding company for un- or under-insured
20 patients.
21 Q And this funding company is limited to those
22 patients who have a third-party claim for damages; is
23 that true?
24 A I don't know.
25 Q Do you know how many surgeries you've done in

Page 8

1 the past year for ML Healthcare?
2 A I don't know.
3 Q Do you know if ML Healthcare is in any way
4 involved in Mr. Malpass's case?
5 A I think they were at one point, but they
6 aren't anymore.
7 Q Did they refuse to fund the surgery?
8 A I don't know.
9 Q Okay. Do you know why they're not involved
10 anymore?
11 A I don't.
12 Q Would there be some documents in your file
13 that might indicate why?
14 A There might be.
15 Q Is that your file right there (indicating)?
16 A Yeah. This was printed off the paper version
17 of the file.
18 Q Do you mind if I take a look at that?
19 A Sure.
20 Q This on the top here (indicating), these are
21 just notes that --
22 A Oh. That looks like nursing correspondence.
23 In situations like this, the staff prints off
24 everything that's in the records. So that looks like
25 nursing correspondence.

Page 9

1 Q Okay. It says here that MLH, which is ML
2 Healthcare, will no longer be funding this patient's
3 medical care as of 1/20/14. And that's your
4 understanding, or do you know one way or the other?
5 A It's the first I've seen that. But I know
6 there was an insurance change at some point.
7 Q Okay. But there's been no approval for the
8 surgery as of yet?
9 A No.
10 Q And this insurance, that's not something he
11 pays a premium for, ML Healthcare, he doesn't pay a
12 premium for that, or with MedFin?
13 A I don't know.
14 Q In order for ML Healthcare or MedFin to
15 approve these surgeries, do you have to find that they
16 are related to the accident that's the basis of the
17 lawsuit?
18 A Not that I'm aware of.
19 Q You've never had that circumstance where you
20 have to send any document in that regard indicating
21 that?
22 A With any surgery at any insurance, the medical
23 records get sent to Blue Cross or whatever.
24 Q Okay. So just the records get sent?
25 A To the best of my knowledge. Now, I don't

Page 10

1 deal with the insurance side of things. But I've
2 never seen any special forms or anything like that.
3 Q You don't have any forms where they ask you
4 fill out and sign saying this is or is not related or
5 anything like that?
6 A No. Not that I've seen.
7 Q All right. Let's talk about Mr. Malpass. I
8 think he came to see you for the first time on
9 11/19/2013; does that sound right to you?
10 A Okay. May I take a look at my records?
11 Q Sure.
12 A Could you repeat the question, please?
13 Q I asked when was the first date that Mr.
14 Malpass came to see you.
15 A The first date I have in my record is October
16 15th, 2013.
17 Q Tell me how he presented that day.
18 A He presented with axial low-back pain, and, by
19 axial, I mean, pain that's in the lower back and
20 doesn't typically radiate down a leg, such as
21 sciatica, that he had developed after he was in a
22 motor vehicle collision.
23 Q Let me stop you there. I'm looking at the
24 record, and it says sudden onset, axial low-back pain;
25 is that what he told you?

Page 11

1 MR. NEAL, JR.: Where are you looking at?
2 What record?
3 MR. MAYERS: History and Present Illness on
4 10/15/2013.
5 BY MR. MAYERS: (Resuming)
6 Q Do you see it, Doctor?
7 A I do.
8 MR. NEAL, JR.: Let me see what you've got,
9 because I don't see that on mine. Okay. I see
10 it. Go ahead. I'm sorry.
11 BY MR. MAYERS: (Resuming)
12 Q Doctor, it says sudden onset axial low-back
13 pain; is that what he told you?
14 A In my mind's eye, I don't remember. But I'm
15 assuming so, based on this documentation.
16 Q And, when you say sudden onset, you mean
17 immediately at the time of collision; is that what you
18 mean?
19 MR. NEAL, JR.: I object to leading questions.
20 You've called him for direct examination, and
21 you're leading him and you're putting words in his
22 mouth. Why don't you just ask him the question
23 instead of leading him?
24 BY MR. MAYERS: (Resuming)
25 Q You can go ahead and answer the question.

Page 12

1 A That would mean that the onset of the
2 symptoms, in this case, axial back pain, occurred
3 suddenly, as opposed to developing over a prolonged
4 period of time.
5 MR. NEAL, JR.: I'll object. Chuck, you read
6 that out of context. It says after rear MVC
7 sudden onset, after rear MVC, that's how this is
8 worded. You left out the beginning of the
9 sentence.
10 BY MR. MAYERS: (Resuming)
11 Q All right, Doctor. I guess you did a physical
12 examination of him at that time, and a Straight Leg
13 Raise Test?
14 A Marked here as equivocal.
15 Q What does that mean?
16 A It means not a wildly positive, but not
17 completely normal.
18 Q And the Straight Leg Raise Test, normally when
19 that happens, is basically you raise a leg and, if
20 there's some radiculopathy in the leg, it'll elicit
21 that radiculopathy?
22 A That's what it's used for, yes.
23 Q All right. And, in this particular
24 circumstance, you didn't really get a positive finding
25 and you didn't really get a negative finding?

Page 13

1 A Correct.
2 Q Okay. So what was your impression at that
3 time as to what was wrong? Was it mechanical back
4 pain, or what did you think?
5 A Based on this, he appeared to have a
6 degenerated disc at L5/S1, at least on the MRI. And
7 his symptoms were consistent with what we call
8 discogenic back pain.
9 Q So you'd already had an MRI by that time?
10 A Looks like he presented with it that day.
11 Q Did you take a look at that film?
12 A Yes, I did.
13 Q Do you happen to have the MRI report from that
14 film in your file?
15 A I don't know that I ever had that one. And
16 it's often the case, when someone presents after being
17 treated elsewhere, what I require is --
18 MR. NEAL, JR.: Is it the 4/29/13?
19 THE WITNESS: At some point, I ordered a new
20 MRI, and I have that report.
21 BY MR. MAYERS: (Resuming)
22 Q Okay. Go ahead.
23 A But it's not uncommon for a patient coming
24 from elsewhere, if their primary care physician
25 ordered the MRI, I always ask that they bring the

Page 14

1 actual disk so I can see the images. Oftentimes, a
2 patient has a hard time getting the reports or
3 tracking that down, so it's non uncommon for me not to
4 have a report. And I don't believe I do have the
5 report of the MRI that he presented to me initially
6 with.
7 Q All right. In any event, you had indicated
8 that he had a ruptured disc in his back?
9 A A disrupted disc.
10 Q And, when you say disrupted, is that like a
11 bulge?
12 A Disrupted, meaning the disc appeared darker
13 than normal. You can have bulges with that. You can
14 have loss of the disc height. You can have edema in
15 the bone vertebral bodies. So, no. The disc was
16 bulging, degenerated, but there wasn't like a freed
17 piece of disc that had broken off.
18 Q When we talk about disc bulges versus
19 herniations versus protrusions, it's basically
20 semantics, just different words that can mean
21 different things?
22 A You're right, yes.
23 Q Okay. This disc degeneration that you saw, is
24 that something that could have been developing over
25 years or how long; could you tell?

Page 15

1 A I can't.
2 Q No way to tell?
3 A No.
4 MR. NEAL, JR.: I object.
5 BY MR. MAYERS: (Resuming)
6 Q There's no way for you to look at an MRI or
7 have any objective finding to really determine how
8 long a patient might have had a condition for his
9 back, is there?
10 A That's not necessarily true.
11 Q How about in Mr. Malpass's situation?
12 A Typically speaking, signs of, say, darkened
13 disc, would speak to it not being a hyperacute event.
14 MR. NEAL, JR.: Object.
15 THE WITNESS: But, certainly, you can see that
16 anywhere from months to years.
17 (Christopher Malpass enters deposition room.)
18 BY MR. MAYERS: (Resuming)
19 Q All right. So, when he comes back to see you,
20 I think you all do a discogram. And tell me what that
21 discogram showed.
22 A The discogram showed a couple of things. It
23 showed, imaging-wise, that the L5/S1 disc had what we
24 call annular tears in it, that contrast or dye that
25 was injected into the disc leaked out of the disk.

Page 16

1 And that was not present at the other two levels that
2 were tested.
3 It showed that the patient reported pain that
4 was similar to his normal pain at both the L3-4 and
5 the L5/S1 level. But that the L3-4 disc
6 morphologically or picture-wise was normal.
7 Q And an annular tear, is that like a tear on
8 the outside of the disc?
9 A I think of a disc, and I think the best way to
10 describe it is being like a jelly doughnut. So, if
11 you can imagine a fresh doughnut, all the jelly is
12 contained in the inside of the doughnut. Think of
13 taking a knife and slicing into a jelly doughnut, but
14 not cutting a piece apart, that's an annular tear.
15 Q And these annular tears are also due to disc
16 degeneration?
17 MR. NEAL, JR.: I object to your repeated
18 putting words in the surgeon's mouth when he's on
19 direct exam. Object to leading questions.
20 BY MR. MAYERS: (Resuming)
21 Q You can go ahead and answer, Doctor.
22 A That's one way you can develop an annular
23 tear.
24 Q Okay. And there's no way to look at an
25 annular tear and determine how it occurs?

Page 17

1 MR. NEAL, JR.: Objection again. I'm going to
2 make this a continuing objection. This is now not
3 a discovery deposition. You're actually leading
4 him through every question. You're not trying to
5 find out what he knows. You're telling him what
6 you think he knows.
7 BY MR. MAYERS: (Resuming)
8 Q Answer as you see fit.
9 A Could you repeat the question, please?
10 Q These annular tears, they can occur through
11 degeneration?
12 A They can.
13 Q And there's no way for you to determine one
14 way or the other how they occur, I mean, other than
15 history from a patient?
16 A That is probably the most important way in
17 trying to figure that question out, yes.
18 Q All right. So I understand that at some point
19 you planned to have a surgery?
20 A At what point?
21 Q Rather go through all these records, I was
22 just kind of skipping around. So you offered him a
23 fusion of L5/S1?
24 A I think we talked about several different
25 options, that being one of several.

Page 18

1 Q All right. And eventually you asked for your
2 own MRI, since you hadn't seen him in a while?
3 A Yes. At some point, there was a long enough
4 gap between the date of the first MRI and where we
5 were at in his care that I felt it important to get an
6 updated roadmap, if you will.
7 Q And you did that one from Open MRI of Macon
8 that is dated on 8/5/2014?
9 A I believe that sounds about correct.
10 Q Okay. It's a radiologist by the name of Lee
11 Hall did that for you?
12 A Yeah. That's what it looks like.
13 Q Do you work with Mr. Hall a good bit?
14 A There's a huge group in town. And I've seen
15 the name before, but I couldn't pick him out of a
16 crowd.
17 Q And a radiologist is trained to read these
18 MRIs? That's their specialty, correct?
19 A That is -- I don't believe that Dr. Hall is a
20 neuroradiologist.
21 Q Well, do you agree with his findings on his
22 MRI report?
23 A Yes.
24 Q Now, disc bulges, are we using the right
25 terminology here? Would that be what you would

Page 19

1 describe Mr. Malpass's condition as, disc bulges?
2 A No.
3 Q How would you describe them?
4 A Annular tears and disc disruption.
5 Q Is an annular tear shown on an MRI?
6 A A very acute one can. It's referred to as a
7 high-intensity zone.
8 Q How about an older one?
9 A No.
10 Q If it's, say, a year old, can you see it?
11 A No. You cannot see the tear directly. You
12 can see the sequela of that. But this high-intensity
13 zone I'm referring to lasts a very short period of
14 time.
15 Q How long is a short period of time?
16 A I don't know of there being any hard
17 literature that can put a strict definition on that,
18 but maybe a month or two.
19 Q Well, do you know how many annular tears
20 Mr. Malpass had? I mean, could you count them?
21 A No.
22 Q Are we talking about less than five? Less
23 than three? Less than two?
24 A There's no way of knowing.
25 Q So annular tear and disruption is how you

Page 20

1 describe it. Let's go back to disc bulges, which is a
2 common term used in back complaints, correct?
3 A I think in layman's terms, yes.
4 Q All right. What would be the proper medical
5 term for a disc bulge? Protrusion?
6 A Again, those aren't scientific words that
7 have, I think, a definition, certainly that I use.
8 Q I notice that the radiologist used the word
9 bulge here. The point I'm getting to is: Disc bulges
10 can wax and wane; they can go in and get better; they
11 can get worse; is that a fair statement?
12 A I don't know.
13 Q Have you ever taken an MRI that shows a disc
14 disruption or herniation that you went back six months
15 later and it had improved on its own?
16 A A herniation?
17 Q Well, let's use a disc disruption instead.
18 A No.
19 Q You've never seen that?
20 A No.
21 Q Once a disc has a disruption, is it going to
22 stay like ad infinitum, in your opinion?
23 A Typically, yes.
24 Q This MRI report at L5/S1 says reveals a
25 minimal disc bulge which reveals no significant

Page 21

1 asymmetry of focality and there is mild degenerative
2 change involving the facets. So the radiologist here
3 showed a minimal, meaning small?
4 A Yes. That's what it says.
5 Q And is that what you saw when you looked at
6 the MRI?
7 A You know, as a descriptor, yes. But, in
8 context, no.
9 Q Tell me what you mean by in context.
10 A Every 80-year-old will have these findings.
11 Very few to no 5-year-olds would have these findings.
12 Q When you say findings, you're talking about
13 here?
14 A Yes. Facet changes, disc changes, and so on.
15 So what is common in an 80-year-old would be uncommon
16 in a 30-year-old. That's what I mean by context. As
17 a picture description, that's very accurate. But how
18 it translates clinically is much different.
19 Q You're saying that this MRI you would not
20 expect to find in Mr. Malpass's case?
21 A Typically speaking, at that age, no.
22 Q Do you know what he does for a living?
23 A I can't remember exactly. I know it is not a
24 desk job.
25 Q It's construction work, right?

Page 22

1 A Yes, that's right.
2 Q Now, I noticed that in some of your records
3 you indicated that he had some subluxation?
4 A Yes. On flex extension.
5 Q And flexion is bending forward?
6 A Correct.
7 Q And extension is bending backward?
8 A Correct.
9 Q And subluxation is where maybe L5 slips
10 forward on to S1?
11 A Yes. Abnormal movement.
12 Q Now, I also noticed that you made mention of a
13 Pars Defect?
14 A I believe in the record I used the word
15 suggestive or possible. But I don't know -- I know
16 the record you're referring to says likely, likely.
17 Q All right. A Pars Defect is generally a
18 repetitive motion type injury that occurs to people
19 who, you know, athletes get it, like javelin throwers,
20 people who do stuff like that, they would get a Pars
21 Defect?
22 A No one really knows how they develop. Because
23 they're often seen also in -- or not often, they're
24 occasionally seen one-year-olds. So it's actually a
25 point of debate in neurosurgery. Is this a congenital

Page 23

1 problem you're born with that becomes symptomatic when
2 you play high school football, or is it something that
3 wasn't there and develops because you played high
4 school football.
5 And, short of having x-rays from Day-One, you
6 know, a CAT scan every six months for your whole life,
7 that's why it's a point of debate. No one really
8 knows.
9 Q However, having a Pars Defect will make it
10 more likely that you might have some subluxation?
11 A True.
12 Q And bending forward, picking up stuff, is
13 going to aggravate a subluxation and also aggravate
14 disc disruption?
15 A It can.
16 MR. NEAL, JR.: I object to the form of the
17 question. You have no basis for that question at
18 all. You have no proof he ever got hurt on the
19 job and hurt his back, ever.
20 BY MR. MAYERS: (Resuming)
21 Q What did he tell you about prior back
22 complaints?
23 A To my knowledge, nothing. Prior to seeing me,
24 he had sought care for his back pain, but I don't
25 remember him saying anything about back pain prior to

Page 24

1 what I've documented in the record.
2 MR. NEAL, JR.: You mean other than the wreck?
3 THE WITNESS: Yes. June of 2012.
4 BY MR. MAYERS: (Resuming)
5 Q I asked that badly. So, in other words, it's
6 your understanding no back complaints prior to June of
7 2012?
8 A That's my understanding, yes.
9 Q If he had back complaints prior to June of
10 2012, would that affect your opinion any as to
11 causation?
12 A It might.
13 Q Okay. I don't think the MRI shows there's any
14 nerve root involvement here; am I correct?
15 A Correct.
16 Q And nerve root would be impingement on any
17 nerves exiting from the spinal cord, or any
18 impingement on the spinal cord?
19 A Correct.
20 MR. NEAL, JR.: Object.
21 BY MR. MAYERS: (Resuming)
22 Q Now, I understand that you offered him fusion
23 of the low back. Because we don't have any nerve
24 involvement, tell me why that might be necessary.
25 A It is an option for treating discogenic or

Page 25

1 facetogenic back pain.
2 Q And facetogenic is, I guess, like an arthritic
3 condition of the facet joint?
4 A Typically, the two go hand-in-hand. If you
5 think of a healthy disc as a healthy shock absorber or
6 a good shock absorber on a car, if a disc gets
7 disrupted, a lot of the stress, if you will, that the
8 disc normally absorbs is then transmitted to the facet
9 joints, which are the bony joints on the back of the
10 spine. So typically one will follow the other.
11 Q And discogenic pain, tell me what's the pain
12 generator in discogenic pain.
13 A There are millions of microscopic nerve
14 endings at the junction of the disc and the vertebral
15 body, the bone. And those nerve findings normally
16 with a healthy disc are cushiony, and forgive the
17 non-scientific words, but, when it becomes less
18 cushiony, disc desiccation, disruption, any
19 derangement of that disc, will cause what we call
20 axial back pain. I tell patients it's like there's an
21 alarm clock in your back telling you, hey, there's
22 something wrong back here, get it checked out.
23 Q Now, a fusion will basically take that shock
24 absorber away?
25 A Correct.

1 Q But isn't it true that, when you do the
2 fusion, you greatly increase the probability that the
3 disc above or below will eventually cause problems?
4 A There is, in the traditional literature,
5 probably a 20 percent chance of that, made less so if
6 you use minimally invasive techniques.
7 Q But it's still going to be fused?
8 A Correct.
9 Q Well, if it's fused using minimally invasive
10 techniques versus an invasive technique, what's
11 different about the fusion?
12 A You mean between a minimally invasive and a
13 normal, traditional technique?
14 Q Yes.
15 A You're disrupting the supportive structures of
16 the spine, the muscles, ligaments, much less so using
17 minimally invasive technique. And the science shows
18 that that's beneficial in preventing what we call
19 adjacent-level disease, or not preventing, it is
20 beneficial in lessening the chances of developing
21 adjacent-level disease.
22 Q How much do you charge for a -- Or how much do
23 you get paid for by Aetna, you know, all of the
24 insurers, for a minimally invasive fusion of L5/S1?
25 A I don't know.

1 Q You don't have any idea?
2 A No.
3 Q Is it $22,000?
4 A I'm strictly salaried, so what I get paid, I
5 know what I get paid, but it's not based on this
6 surgery or any surgery.
7 Q So you don't have any idea of, say, what Aetna
8 might pay you for a fusion?
9 A No.
10 Q Do you know what Aetna might pay Piedmont
11 Surgery Center for a fusion?
12 MR. NEAL, JR.: Object to the form of all of
13 these collateral source questions. They're not
14 admissible at all. They're really not
15 discoverable. I've never had a lawyer ever get
16 into this in a deposition.
17 BY MR. MAYERS: (Resuming)
18 Q You can go ahead and answer the question.
19 A I don't know.
20 Q Who would be the person here that would know
21 what, say, Aetna or United Health Care, might pay for
22 a minimally invasive fusion of L5/S1?
23 A That would depend on where the surgery was
24 done. If it were done at the hospital, the person who
25 would know that would be, or the best person, would be

1 Brandy Brock, she's our clinic billing manager. If
2 the surgery were done at the Piedmont Surgery Center,
3 it would be Brandy Brock for the professional's or
4 doctor's fee component of that. And then it would be
5 someone named Jessie Hammond, who is the director of
6 the Piedmont Surgery Center. And Brandy has no
7 involvement in that.
8 Q So you don't personally know basically what
9 they charge?
10 A No, I don't.
11 Q Is there any objective finding that you have
12 that could tell you whether or not Mr. Malpass's
13 condition was a chronic condition or an acute
14 condition?
15 A At the first time that I saw him, and defining
16 acute as within six weeks, it was not an acute
17 condition, by that definition. Beyond that, I can't
18 say.
19 Q If we define acute by six months prior versus
20 two or three years prior, does that change your answer
21 any?
22 A I don't know that that would be an accurate
23 description of the word acute. I think --
24 MR. NEAL, JR.: I agree. I object. That's
25 not how acute is defined in medicine.

1 THE WITNESS: I think I would define acute as
2 within six weeks. Subacute within six months.
3 Chronic, beyond that. But, again, that's how I
4 think of it and I think how most neurosurgeons in
5 general think of it. But I know don't if that's a
6 strict definition.
7 BY MR. MAYERS: (Resuming)
8 Q Have you reviewed any other medical records
9 other than yours?
10 A With regard to Mr. Malpass?
11 Q Yes. And I already know you have. Other than
12 the MRI, have you looked at any other medical records?
13 A I don't believe -- I have the records from the
14 Interventional Pain physician who did the discogram.
15 But I don't know that I have any other records, apart
16 from the couple of radiology reports.
17 Q And you have no way of knowing what caused Mr.
18 Malpass's condition, other than what he's told you?
19 A Correct.
20 Q I notice that there was a mention of a
21 transitional segment. Does he have a transitional
22 segment?
23 A I believe so. And I've not reviewed all of
24 his films here recently. But I make mention of it
25 here in the first office note that he did have a

1 transitional segment.
2 Q Is that at L5/S1?
3 A That's what I'm calling it. But you get into
4 some semantics there.
5 Q That's what I'm trying to understand. I guess
6 there's some confusion about whether it's L5/S1, the
7 L5, L4. Tell me why a transitional segment causes
8 that confusion, or if it does.
9 A A transitional segment is a generic term for
10 an extra disc and/or vertebra, either partial or
11 complete. And the confusion can arise -- it's a
12 little bit tomato-tomatoe, if you will. And the
13 confusion can arise, say, if a radiologist interprets
14 an MRI and calls a level.
15 Let's say there is a disc herniation and a
16 transitional segment. If the radiologist calls that
17 level L5/S1, and then a surgeon or another radiologist
18 looks at it and says, no, that's L6/S1 because there's
19 an extra vertebra, that's where the confusion can
20 arise, which is why, in Mr. Malpass's case and in
21 every case, I put that in all caps and describe what
22 I'm describing.
23 So here I said transitional segment, L5/S1,
24 and then parentheses, first full disc above
25 rudimentary disc. That's just so I know this is what

1 I'm talking about.
2 Q All right. And what's the rudimentary disc?
3 Would that be S1?
4 A The rudimentary disc might be an S/1 S2 disc.
5 It might be --
6 Q S2 being the extra?
7 A Yes. When you're born, the sacrum, which, in
8 adults, the sacrum is a single bone. In a newborn or
9 in the womb, the sacrum has discs in it. And, if a
10 person, for one reason or another doesn't dissolve one
11 of those discs, which can happen, it's not uncommon,
12 that's where you get the transitional segment. You
13 can also have congenital anomalies where the L5
14 vertebra is partially fused to the sacrum or an S1
15 bony segment is partially free from S2.
16 Q I have here a print-out of a transitional
17 segment. Is that what one looks like?
18 A That's a -- That is one of many variations.
19 Q Tell me: What is the clinical significance of
20 a transitional segment? I mean, what will it do, if
21 anything?
22 A Well, it can predispose a person to having
23 more problems at that level. Because forces can be
24 normal, they can be abnormal. But, again, there's no
25 hard science, because we don't know how many people

1 actually have these. We know the ones who have them
2 that have a problem. I don't know if I have a
3 transitional segment or not. I might.
4 Q But you don't have symptoms associated with
5 it?
6 A Correct.
7 Q But there is a correlation between a
8 transitional segment and having low-back problems, if
9 the segment is in the low back?
10 A There is a biomechanical difference between a
11 transitional segment and a normal segment.
12 Q Would that be because there's no free movement
13 because of the fusion, a congenital fusion?
14 A Well, in the example you're showing me here,
15 yes. If you have an extra disc without autofusion
16 there, that's a different scenario completely. So we
17 know, if you take this and try to reproduce it on a
18 computer in the lab, the forces are different. And
19 the forces are different depending on what type of
20 transitional segment you're talking about.
21 Does that necessarily translate into more
22 problems? Well, it might, because the forces are
23 different. But there's no science to say -- there's
24 no science to prove that. No science in the human
25 being. There's lab evidence.

1 Q Would it be fair to say that most low-back
2 problems are caused by flexion lifting type problems?
3 A Most, no.
4 Q What's the most common cause of a low-back
5 problem?
6 A Taking all comers?
7 Q Yes.
8 A Age.
9 Q How about when -- Flexion lifting, is that a
10 common cause?
11 A In my practice, no.
12 MR. NEAL, JR.: I think he just answered that
13 a minute ago. Objection to the repeated asking
14 him the same question.
15 BY MR. MAYERS: (Resuming)
16 Q Other than age, what would you find is the
17 most common cause?
18 A Again, in my practice, it's minor trauma.
19 Q What is the percentage of people who come to
20 you and say, look, my back is killing me, I don't know
21 what caused it, it just started hurting?
22 A That's probably most. Or a majority.
23 Q If you were going to give it a percentage, how
24 much would you say it would be?
25 A Completely rough guess, I would say

1 51 percent, there's more people who just say it's just
2 developed over time and there's no specific inciting
3 event.
4 Q Bear with me just a minute, Doctor. Does Mr.
5 Malpass have a fusion of some degree, as we see in
6 that transitional settlement there, or is that not
7 something that he has, or does he have like an extra
8 disc?
9 A According -- And, again, this is -- I don't
10 want to rely on my mental/visual memory. I don't make
11 mention in my notes of there being an autofusion. But
12 the radiology report says L5 is partially sacralized
13 and transitional. But I don't see the word
14 autofusion, so I can't say for sure that there is
15 autofusion.
16 Q What does he mean, if you can tell, by those
17 words?
18 A This would suggest to me that in the radiology
19 report that there is some degree potentially of
20 autofusion of the L5 vertebra.
21 Q Now, when you do a fusion of L5/S1, what will
22 you do to that autofusion, if anything? Will you
23 correct it in any way or leave it alone?
24 A Oh, you leave that alone.
25 MR. MAYERS: I don't have any other questions.

1 MR. NEAL, JR.: Dr. Stevenson, I'm going to
2 ask you a few before we do the video depo.
3 CROSS-EXAMINATION
4 BY MR. NEAL, JR.:
5 Q Is it your understanding in this case that
6 Chris's back pain in his lower back that he came to
7 see you for that had been persisting for a year and a
8 half came from the auto wreck that he told you about?
9 A That's my understanding.
10 Q Have you been given any other information by
11 the defense lawyer for Farm Bureau Insurance to
12 suggest that he got hurt in some other accident that
13 caused the low-back pain?
14 A Not that I'm aware of.
15 Q And he just questioned you for 45 minutes and
16 he didn't give you any other medical records or any
17 other potential cause of his back pain, did he?
18 A Not that I remember.
19 Q Is it your understanding that Chris, based on
20 your records I've reviewed, he has, you indicated
21 through an MRI and a discogram, he has a herniated
22 disc in his L5/S1 and you called it an annular tear?
23 A I wouldn't call it a herniated disc. I would
24 call it disc disruption with annular tears.
25 Q Some of your records say herniated disc or

1 HPN?
2 A Yes. It's disruptive. And, again, these are
3 all terms, and some of the terms, herniated, bulge,
4 protrude, but the main thing he was symptomatic from
5 was from the degeneration and the annular tears.
6 Q And could that be caused by a trauma, such as
7 a car wreck, getting hit from behind?
8 A It can.
9 Q In this case, is that the most likely
10 conclusion you can draw based on the history?
11 A That is the only inciting event that I'm aware
12 of in this case.
13 Q At some point, you recommended surgery?
14 A That was one of the options that I discussed
15 with Mr. Malpass.
16 Q Was that something that you felt would help
17 his condition?
18 A Based on his lack of response to more
19 conservative treatments that had already been rendered
20 elsewhere, I felt it gave him an opportunity to
21 improve upon his condition, but certainly you can't
22 ever guarantee.
23 Q I understand that. But you recommended it and
24 said it would be reasonably necessary to control his
25 pain?

1 A It would be a reasonable option.
2 (Plaintiffs' Exhibit No. 1 was marked.)
3 BY MR. NEAL, JR.: (Resuming)
4 Q And we have a surgery estimate that we got
5 when you were preparing for the surgery. I'm going to
6 show you that as Exhibit 1 from ML Healthcare. And it
7 has the costs not only for your services and your
8 practice, but for the Piedmont Hospital and the
9 anesthesia and all the other charges that go with the
10 pre-operative care.
11 Does that look like the estimate that was
12 prepared for Mr. Malpass's surgery that you
13 recommended?
14 A This is the first I've seen this.
15 Q Well, take a look at it.
16 MR. MAYERS: If he's never seen it --
17 BY MR. NEAL, JR.: (Resuming)
18 Q He's looking at it now. And I'm asking you to
19 review it and tell us if that is a typical estimate
20 for this type of surgery that you recommended on Mr.
21 Malpass.
22 MR. MAYERS: Object to the form of the
23 question.
24 BY MR. NEAL, JR.: (Resuming)
25 Q Okay.

Page 38

1 A I can speak authoritatively on the
2 professional fee side. And I would say, yes, that
3 that looks correct.
4 Q Specify which ones you're talking about.
5 A Talking about the charges for Dr. Kevin
6 Stevenson, M.D. That's called a professional fee, and
7 I don't want to belabor all the billing.
8 Q Is that the customary fee for this type of
9 surgery?
10 A Yes. Yes. That looks correct. And the
11 Piedmont Surgery, the anesthesia charges, that looks
12 customary. I know what they charge. The Piedmont
13 Surgery Center charges, as I mentioned, I'm not a
14 financial stakeholder in that, so I don't have
15 intimate knowledge of every in-and-out, but I can say,
16 generally speaking, that looks about ballpark for what
17 the industry norm would be.
18 Q And I've seen many of these as a lawyer, and
19 that's basically what they cost. So it's your
20 understanding, based on the estimate in front of you,
21 Exhibit 1, based on the diagnostic codes, that those
22 charges are typical and customary for this type of
23 surgery on someone's lower back?
24 MR. MAYERS: Objection to the form.
25 THE WITNESS: This seems within reasonable --

Page 39

1 from my understanding, this seems reasonable and
2 customary.
3 BY MR. NEAL, JR.: (Resuming)
4 Q And how many of these have you done in 12
5 years, not including your residency? Hundreds?
6 A Easily.
7 Q Do these charges look reasonable, necessary
8 and customary for a lower-back fusion?
9 MR. MAYERS: Objection. It's a spinal fusion.
10 BY MR. NEAL, JR.: (Resuming)
11 Q Based on your experience with hundreds of
12 surgeries?
13 MR. MAYERS: Objection to the form.
14 THE WITNESS: Yes.
15 BY MR. NEAL, JR.: (Resuming)
16 Q I mean, if they're not, tell us.
17 A The only caveat is, these charges, I'm
18 assuming, came from our Surgery Center billing people.
19 So I'm assuming those are correct.
20 Q Does anything look --
21 A Nothing looks out of the ordinary.
22 Q That's what I'm getting at. Okay.
23 MR. NEAL, JR.: All right. Thank you. And
24 then we'll go ahead and set up for the other one,
25 if you're done, Chuck.

Page 40

1 MR. MAYERS: All right. Well, not quite.
2 RE-DIRECT EXAMINATION
3 BY MR. MAYERS:
4 Q Doctor, we talked earlier and we actually
5 talked about that surgery list, and you indicated that
6 you don't know really what gets charged?
7 A And that's what I just said here. I can't say
8 -- I can't say that the Surgery Center charges are
9 indeed what gets charged.
10 MR. NEAL, JR.: Chuck, we can go to Piedmont
11 Hospital Surgery Center and take their depo if you
12 want to. Because, I mean, I know you know, from
13 all the work you've done, this is what a neck
14 surgery costs. I know that from what I do. We
15 can go to Piedmont Surgery Center, if you're not
16 going to stipulate to it.
17 MR. MAYERS: Well, I'm not.
18 MR. NEAL, JR.: Okay. Well, then we'll go to
19 Piedmont Surgery Center, if we have to. It's
20 admissible based on what he's said already anyway.
21 BY MR. MAYERS: (Resuming)
22 Q And you didn't prepare that document?
23 A I did not.
24 Q And I think you've testified you're making
25 assumptions based on the document --

Page 41

1 MR. NEAL, JR.: I object to you trying to
2 recharacterize his previous testimony.
3 BY MR. MAYERS: (Resuming)
4 Q Let me ask it this way: Do you have any
5 personal knowledge about what the actual billing is
6 for either your services or Piedmont Surgery Center or
7 Middle Georgia Anesthesia is?
8 A Having just looked at that, based on the
9 assumption that that is what is billed that I now
10 know, but, when you asked me earlier, no. And, if you
11 were to ask me what do I charge for CPT Code 63047, I
12 couldn't give you a dollar amount.
13 But, looking at that, I can say that seems --
14 I know what the industry norms are within, you know,
15 bracketing it. But I can't say what Piedmont bills to
16 the penny for a particular code or procedure.
17 Q So basically what you're doing is you're
18 depending on what's on Exhibit 1 in giving your
19 answer?
20 A Yes, sir.
21 MR. MAYERS: That's all the questions I have.
22 MR. NEAL, JR.: I object to that. That's not
23 what he just said. You just said that you know
24 what the industry norms are, and now he's getting
25 you to say you're just relying on this piece of

Page 42

1 paper. You're relying on your 12 years' of
2 experience and doing hundreds of these surgeries;
3 is that not correct?
4 THE WITNESS: To say that those charges are
5 reasonable.
6 MR. NEAL, JR.: Thank you. That's all.
7 (CONCLUDED AT 9:51 AM)
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Page 43

1 C E R T I F I C A T E
2 G E O R G I A:
3 FULTON COUNTY:
4
5 I hereby certify that the foregoing deposition
6 was reported, as stated in the caption, and the
7 questions and answers thereto were reduced to the
8 written page under my direction; that the
9 foregoing pages 1 through 42 represent a true and
10 correct transcript of the evidence given.
11 I further certify that I am not in any way
12 financially interested in the result of said case.
13 Pursuant to Rules and Regulations of the Board of
14 Court Reporting of the Judicial Council of
15 Georgia, I make the following disclosure:
16 I am a Georgia Certified Court Reporter. I am
17 here as an independent contractor for Huseby, Inc.
18 I was contacted by the offices of Huseby, Inc. to
19 provide court reporting services for this
20 deposition. I will not be taking this deposition
21 under any contract that is prohibited by O. C. G.
22 A. 15-14-7 (a) or (b).
23
24
25

Page 44

1 I have no written contract to provide
2 reporting services with any party to the case, any
3 counsel in the case, or any reporter or reporting
4 agency from whom a referral might have been made
5 to cover this deposition. I will charge my usual
6 and customary rates to all parties in the case.
7 This, the 22nd day of January, 2015.
8 Camille Cunningham
9 ____________________________
10 CAMILLE CUNNINGHAM, CCR - 2767
My Commission Expires
11 March 31st, 2015
12
13
14
15
16
17
18
19
20
21
22
23
24
25