EXPERT AFFIDAVITS IN SERIOUS INJURY CASES

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October 2019

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MEDICAL AFFIDAVITS AND AFFIRMATIONS

I. OBJECTIVE MEDICAL EVIDENCE

A. Definitions

1. Subjective Medical Evidence

   (a) Evidence that is derived solely from what the patient says about the patient's own condition.

   (b) The concern is that the patient is not being truthful about the patient's own condition.

2. Objective Medical Evidence

   (a) Evidence that is derived from means that are not manipulable by the patient.

B. Examples

1. Subjective Medical Evidence

   (a) Patient's own complaints. *See, e.g., Scheer v. Koubek,* 70 N.Y.2d 678, 679 (1987); *Licari v. Elliott,* 57 N.Y.2d 230, 238-239 (1982).

   (b) Medical/chiropractic opinion based solely upon patient's subjective complaints. *See, e.g., Gaddy v. Eyler,* 167 A.D.2d 67, 71 (3d Dep't 1991), *affd.* 79 N.Y.2d 955 (1992); *Dubois v. Simpson,* 182 A.D.2d 99 (3d Dep't 1992) (pain upon palpitation).

   (c) Unelaborated results of standard range of motion tests, *i.e.*, Soto-Hall, Foramina Compression, Valsalva, Minor, Adams, Yeoman, straight-leg raising. *See, e.g., Toure v. Avis Rent A Car Systems, Inc. (Nitti v. Clerrico),* 98 N.Y.2d 345, 357-358 (2002), *revg.* 291 A.D.2d 807 (4th Dep't 2001).

2. Objective Medical Evidence

(a) Diagnostic tools, *e.g.*, MRI, CT scan, x-ray, nerve conduction. *(See also Mastroantuono v. US,* 163 F.Supp.2d 244 (SD N.Y. 2000) (discogram]).

(b) Presence of spasm (*See, Toure,* 98 N.Y.2d at 352; presence of calcium deposits, disc softening, or joint loosening, *see, Van De Bogard v. Vanderpool,* 215 A.D.2d 915 (3d Dep't 1995); trigger points, *see, Barbagallo v. Quackenbush,* 271 A.D.2d 724 (3d Dep't 2000]).

3. *Perl v. Meher,* 18 N.Y.3d 208 (2011)

(a) *In dicta*, Court commented as to P's physician's opinion under the qualitative prong of *Toure* as follows: "While his observations at his initial examinations were detailed, it is debatable whether they have an "objective basis," or are simply a recording of the patients' subjective complaints." COMMENT: *Dictum* should be viewed as a warning to physicians/chiropractors to show why their observations have an objective basis. (b) Court also stated *in dictum*: "Under the "quantitative" prong of *Toure*, numerical measurements are sufficient to create an issue of fact as to the seriousness of P's injuries." COMMENT: Court does not state or otherwise describe the ROM testing utilized and why they rest on objective findings. (c) The Court noted specifically the affidavit of D's physician was sufficient as based on objective findings, which affidavit stated: "The fact that he sits, yet presents with a show of only 10 degrees flexion of the lumbar spine is contradictory. His 'give-away' strength is contradictory with his ambulation. This individual's show of such decreased range of motion is totally contradicted by the fact that he followed me about, rotating the cervical spine 60 degrees and flexing at least 30 degrees. I do not believe that this individual presents with any true findings at this time." COMMENT: All of these findings are based upon observations. Court seemingly is saying that these findings

together create an objective basis as they reveal false inputs.
(d) It must be kept in mind that in *Toure* the Court held a physician's opinion that, where a disc pathology was noted and P alleged that she could not do certain things, such limitations are the medical sequallae of the diagnosed condition, the opined limitation of use based on a qualitative assessment was based upon objective findings.

C. Subjective Evidence Becomes Objective Evidence

1. Range of Motion Test Coupled With Objective Evidence

   (a) *Brown v. Achy,* 9 A.D.3d 30 (1st Dep't 2004) (medical explanation/ significance provided).

2. Subjective Complaints With Medical Explanation

   (a) *Toure,* 98 N.Y.2d at 353 (plaintiff's claimed inability to lift objects and difficulty in sitting, standing and walking for extended period and physician's testimony that such limitations are a "natural and expected medical consequence of his injuries [one bulging and two herniated discs]").

3. Combination Of Range of Motion Tests

   (a) When they are utilized to reveal false inputs/true inputs. *See, e.g., Cowley v. Crocker,* 186 A.D.2d 939, 940 (3d Dep't 1992).

D. Special Signs and Tests Utilized

1. Cervical

   (a) Lhermitte's Sign/Compression Test

      (i) Aggravates nerve root compression.

      (ii) Downward pressure on the skull is applied standing, seated or lying. Positive= shock-like pain radiating into the arm is experienced.

(b) Spurling's Sign

(i) Aggravates nerve root compression.
(ii) The head is tiled in extension and rotated to the side of localized pain. Positive= radiating pain down the affected arm.

2. Lumbar

(a) Laseque's Sign/Straight Leg Raising Test

(i) Seated or Supine (lying on back).

(ii) With knee straight, the leg is raised at the hip, stretches the sciatic nerve around the hip and pulls at the lumbar nerve roots exiting the spinal canal.

(iii) Positive sign = back pain w/ radiation down the opposite leg- indicates radiculopathy.

(iv) Negative sign = sciatic or hamstring pain in the same leg.

(v) Angle of elevation of the leg is noted.

(b) Kemp's Test

(i) While standing, behind patient, one hand is used to anchor the pelvis and sacrum, and the other to grasp the shoulder holding the pelvis; and shoulder is firmly forced obliquely backwards, down wards, medialwards.

(ii) A positive test is indicated when lower back pain radiates into lower extremities

(c) Hoover Test

(i) Determines malingering.

(ii) Examinee asked to raise one leg off the exam table.

(iii) Normally, the opposite leg depresses to compensate. Malingering is determined when the examiner does not feel opposite leg depression when the examinee feints inability to raise that leg - basically poor voluntary effort.

(d) Valsalva Maneuver

(i) Helpful to confirm radiculopathy.

(ii) Examinee is asked to hold their breath and bear down (*e.g.*, while in labor or at toilet).

(iii) Radiating pain down the leg is indicative of nerve impingement (disc herniation).

II. CAUSATION

A. Generally

1. Plaintiff has the burden of establishing causation as an element of plaintiff's *prima facie* case.

2. Such proof of causation, linking the alleged serious injury with the accident, must be established by competent medical proof.

B. Pre-Existing Condition/Prior Injuries and Subsequent Events

1. In instances where the plaintiff has a pre-existing injury or medical condition, or has sustained an injury or developed a medical condition after the accident, plaintiff will need to establish that the claimed injuries from the subject accident are unrelated to such prior or subsequent injury or condition.

2. A serious injury may be based upon the "aggravation" of a pre-existing condition or injury. Two situations must be distinguished.

(a) Where the plaintiff has a pre-existing but asymptomatic condition which becomes symptomatic as a result of the accident, the resulting condition can form the basis of a serious injury.

(b) Where the plaintiff's pre-existing condition was symptomatic at the time of the accident, the plaintiff must establish that the accident had a complicating and objectively determined effect on that condition, which effect can form the basis for a serious injury.

C. "*Pommells*" Rules on Summary Judgment Motions

1. Generally

Pommells v. Perez, Brown v. Dunlap, Carrasco v. Mendez
4 N.Y.3d 566 (2005)

Pommells

"P failed to address the effect of his kidney disorder on his claimed accident injuries. Dr. Rose's report - the only competent evident supporting P's response to the summary judgment motion - in fact noted the kidney surgery in P's medical history and then relied on that medical history in opining as to causation. Ps submission left wholly unanswered the question whether the claimed symptoms diagnosed by Dr. Rose were caused by the accident."

Brown

"As to an alleged pre-existing condition, there is only Dr. Berkowitz's [expert] conclusory notation, itself insufficient to establish that P's pain might be chronic and unrelated to the accident. As opposed to the undisputed proof of P's contemporaneous, causally relevant kidney condition in *Pommells*, here even two of Ds' other doctors acknowledged that Ps (relatively minor) injuries were caused by the car accident. On this record, P was not obliged to do more to overcome Ds' summary judgment motions."

Carrasco

"While P provided Dr. Lambrakis's expert's report of specific losses of range of motion in Ps spine, opining that P suffered serious and permanent injuries which were casually related to the accident, P did not refute D's evidence of a pre-existing degenerative condition. To the contrary, the Lambrakis report supplied by P explained that the pain and loss of range of

motion in the cervical spine was entirely consistent with those formations identified by the MJU and set forth by Drs. Miloradovich and Orlandi [expert] as related to a degenerative condition. In this case, with persuasive evidence that P's alleged pain and injuries were related to pre existing condition, P had the burden to come forward with evidence addressing D's claimed lack of causation. In the absence of any such evidence, we conclude—as did the trial court and Appellate Division—that D was entitled to summary dismissal of the complaint."

2. Defendant's Burden

   (a) Defendant must establish by admissible and competent proof that the plaintiff has a pre-existing injury/condition and that such injury/condition is the cause of plaintiff's claimed limitations/impairments allegedly caused by the accident.

3. Plaintiff's Burden

   (a) Plaintiff can raise a triable issue of fact through medical proof that refutes the existence of the alleged pre-existing condition or the extent of its affect upon plaintiff; or attribute the injury to a "different but equally plausible cause", *i.e.*, the accident, through competent medical proof; or through plaintiff's averment that he/she was asymptomatic before the accident.

4. Pertinent Post-*Pommells* Decisions

   (a) Court of Appeals

Perl v. Meher
18 N.Y.3d 208 (2011)

D submitted a radiologist's sworn report based on a MRI that P's injuries were "degenerative in etiology and longstanding in nature, preexisting the accident. Court held P's responding proof was sufficient to raise a triable issue of fact. Such proof consisted of: (1) a radiologist's affidavit stating that while some findings from the MRI "are consistent with degenerative disease," a single MRI cannot rule out the possibility that "the patient's soft tissue findings are . . . a result of a specific trauma." That question, this radiologist said, can best be judged "by the patient's treating physician in conjunction with exam, history

and any previous tests;" and (2) opinion of P's treating physician, who found S/I under the quantitative prong of *Toure* ROM limitations; and that since P "had not suffered any similar symptoms before the accident nor had any prior injury/medical conditions that would result in these findings," the findings were causally related to the accident. The Court then added the following: "A factfinder could of course reject this opinion: It is certainly not implausible that a man of 82 would have suffered significant degenerative changes. We cannot say as a matter of law on this record, however, that such changes were the sole cause of P's injuries." COMMENT: Is Court backing away from its position in *Carrasco* that P's opposition must directly address D's showing and explain why that conclusion of degenerative condition as source of pain etc. is not sound?

Franklin v. Gareyua
29 N.Y.3d 925 (2017)

On a SSM submission, Court held First Department correctly held that P did not raise an issue of fact as to a S/I to his shoulder. First Department held 3-2 that as P's treating orthopedist did not refute or address the findings of preexisting degeneration and lack of traumatic injury set forth in a radiological report and a MRI report contained in P's own records, nor did the orthopedist explain why degeneration was not the cause of the injury, P's proof was insufficient. Dissenters disagreed. The expert only opined that P's injuries were caused by the subject accident. NOTE: First Department decision is reported at 136 A.D.3d 464, 24 N.Y.S.3d 304 (2016).

Alvarez v. NYLC Mgt. Ltd.
24 N.Y.3d 1191 (2015)

On a SSM submission, Court held First Department correctly concluded that "P failed to raise a triable issue of fact whether she suffered a S/I." The First Department held 3-2 P's orthopedic surgeon's conclusory opinion that P's shoulder, knee and spine conditions were caused by the accident, and not degeneration, was insufficient to raise an issue of fact as to causation. Indeed, the surgeon failed to address or contest the detailed findings of preexisting degenerative conditions by Ds' experts, which were acknowledged in the reports of P's own radiologists. Dissenters were of the view that plaintiff had raised a triable issue of fact as to causation. COMMENT: First Department decision is reported at 120 A.D.3d 1043, 993 N.Y.S.2d 1 (2014).

Rivera v. Fernandez & Ulloa Auto Group
25 N.Y.3d 1222 (2015)

On a SSM submission, Court held First Department correctly concluded that "P failed to raise a triable issue of fact as to whether he suffered a S/I." The First Department held 3-2 P's surgeon's opinion failed to raise an issue of act since the surgeon not only failed to address or contest the opinion of Ds' medical experts that any condition was chronic and unrelated to the accident, but also failed to address or contest the finding of degenerative changes in the MRI report in P's own medical records, which the same surgeon had acknowledged in a prior note. Majority further stated: "Our dissenting colleague overlooks that recent precedents of this Court establish that a P cannot raise an issue of fact concerning the existence of a S/I under the No-Fault Law where, as here, the P's own experts fail to address indications from the P's own medical records, or in the P's own expert evidence, that the physical deficits in question result from a preexisting degenerative condition rather than the subject accident." Dissenters stated: "The fact that defendants' experts attribute the injury to degenerative causes is of no moment. We have held, repeatedly, that it is unnecessary for a plaintiff's expert to specifically refute defense evidence as to degeneration; attributing the injury to another, equally plausible cause, i.e., the accident, is sufficient to raise a triable issue of fact." COMMENT: First Department decision is reported at 123 A.D.3d 509, 999 N.Y.S.3d 37 (2014).

Rosa v. Delacruz
32 N.Y.3d 1060 (2018), *affg.* 158 A.D.3d 571 (1st Dep't 2018)

First Department unanimously held that Ds established that P's alleged left shoulder injuries were not causally related to the subject accident by submitting the MRI report of P's radiologist, who found multiple degenerative cysts, and no torn tendons, in the MRI of P's left shoulder performed shortly after the accident. Of note, there was no claim by Ds that the cysts caused P's injuries. It then held that P's proof was insufficient as it did not address the findings of degeneration in the radiologist's MRI report, or explained why the tears and physical deficits found by the orthopedic surgeon were not caused by the preexisting degenerative conditions. Court of Appeals affirmed, noting P's medical submissions were inadequate to raise a triable issue off fact because they failed to acknowledge, much less explain or contradict, the radiologist's finding. Instead, P relied on the purely conclusory assertion of his orthopedist that there was a causal relationship between the accident and anterior labrum/rotator cuff tears that he observed (and repaired) during surgery nearly

two years after the accident. COMMENT: Court of Appeals made no mention of the degeneration conclusion of the First Department. Three judges dissented, finding P's expert's affirmation sufficient.

(b) Appellate Division

The case law among all four departments of the Appellate Division is conflicting as to a P's *Pommells*' burden in opposing a D's S/J motion based upon medical proof that P's claimed injuries were not caused by the subject accident but the result of a pre-existing or degenerative condition.

A substantial body of case law exists in all four departments that a P must address by expert medical proof a D's expert's opinion or other evidence that a pre-existing or degenerative condition is the cause of P's injuries. (*See, e.g.*, First Department: *Alvarez, supra; Rivera, supra; Franklin, supra*; Second Department: *Cardillo v. Xenakis*, 31 A.D.3d 683 (2006); Third Department: *Shea v. Ives*, 137 A.D.3d 1404(2016); Fourth Department: *Caldwell v. Grant* (Appeal #2), 31 A.D.3d 1154 (2006).

Another substantial body of case law exists in all four departments which requires only that a P submit competent medical proof connecting the claimed injury to the subject accident; and does not require the P's expert to address the pre-existing or degenerative proof submitted by D. (*See, e.g.*, First Department: *Linton v. Nawaz*, 62 A.D.3d 434, 879 N.Y.S.2d 82 (2009), *affd.*, 14 N.Y.3d 821 (2010); Second Department: *Fraser-Baptise v. New York City Trans. Auth.*, 81 A.D.3d 878 (2011); *Colavito v. Steyer*, 65 A.D.3d 735 (2009).

A third body of case law in some of the departments appears to hold that a P can defeat a D's showing of a pre-existing or degenerative condition as the cause of P's injuries by competent medical proof alone that the subject accident caused the injuries if there is evidence that P's condition was asymptomatic prior to the accident. (*See, e.g., Yuen v. Arka Memory Cab Corp.*, 80 A.D.3d 481 (1st Dep't 2011).

The conflicting bodies of case law continue to exist through 2017-2019. (*See, generally*, Weinberg, "Sufficiency of Expert Opinion in 'Serious Injury' Cases," NYLJ, 7/3/18, p. 3, col. 3).

III. MEDICAL EVIDENCE CHECKLIST

A. Initial Inquiries

1. Defendant's Motion

   (a) Has defendant addressed all of the categories of serious injury plaintiff has pleaded in bill of particulars?

   (b) Is motion supported by admissible evidence, *e.g.* affidavits, affirmations (where permitted), deposition transcripts, affirmed medical reports, certified medical records (or with other proper foundation)?

   (c) Is the opinion of physician or chiropractor more than a conclusory assertion tailored to defeat statutory requirements of "serious injury"?

2. Plaintiff's Motion

   (a) Does the medical submission showing injury and limitation or impairment pass the initial hurdles?

      (i) Opinion must not be a "conclusory assertion tailored to meet the statutory requirements of serious injury."

      (ii) Opinion must not be based solely on plaintiff's own subjective complaints of pain.

      (iii) Opinion must purport to be based upon objective medical findings.

      (iv) Are the opposing submissions in admissible form?

      (v) If plaintiff's medical proof is insufficient, plaintiff may rely upon unsworn reports and uncertified medical records if they were submitted by defendants or were referenced in the reports of physician's when examined P on behalf of defendant and defendant submitted their reports. (*See, Kearse v. New York City Transit Auth.*, 16

A.D.3d 45 47 n. 1 (2d Dep't 2005) and *Feggins v. Fagard*, 52 A.D.3d 1221 (4th Dep't 2008]).

(b) Does the medical submission(s) show a limitation of use through quantitative assessment, *e.g.*, numeric percentage of the plaintiff's loss of range of motion compared to normal range, or qualitative assessment of plaintiff's condition, *e.g.*, proper comparisons?

(i) Mere soft tissue injury, *e.g.*, disc herniation, torn meniscus, or complaints of pain is insufficient.

(ii) Does medical submission(s) state anywhere that the established limitation is "mild"?

(c) Where the 90/180 days threshold category is relied upon, does plaintiff's proof show 90/180 days proof requirement is present/disproved?

B. Content

1. Objective Evidence

(a) Does opinion rest upon objective medical findings?

(b) What is the source of the objective medical findings?

(i) Does medical submission include names and descriptions of tests, procedures, etc. that revealed presence of objective, medical findings? ((*See, Durand v. Urick*, 131 A.D.3d 920 (2d Dept. 2015); *Bacon v. Bostary*, 104 A.D.3d 625 (2d Dept. 201]).

(ii) Where observations are relied upon, are the observations sufficiently detailed and shown to be an objective basis and show physician is not simply relying upon subjective complaints of pain of plaintiff? (*See, Perl v. Meher*, 18 N.Y.3d 208 (2011]).

(c) Have the observations, tests, procedures, etc. been shown to have an objective basis? (*See, Nitti v. Clerrico*, 98 N.Y.2d 345 (2002]).

2. Competency of Opinion

(a) Is physician qualified to render the opinion given?

(b) Is the opinion based upon a sufficient foundation?

(i) Admissible evidence?

(ii) Did physician review and rely upon another physician's report of the testing, and, if so, is the report affirmed/admitted or does physician make the *Hambsch v. NYS Trans. Auth.* (63 N.Y.2d 723 [1983]) averment, *i.e.*, the report was of the kind accepted in the profession as reliable in forming an opinion, and is in fact reliable?

3. Sufficiency of Opinion

(a) Does medical submission explain what the findings mean and correlate them to the claimed "serious injury"?

(i) Opinion must explain how the injury supported by objective medical findings affects plaintiff and curtails his/her activities. (*See, Toure v. Avis Rent-A-Car*, 98 N.Y.2d 345 [2002]).

(ii) Opinion may include an opinion as to the significance of the injury to plaintiff, *e.g.*, "Plaintiff has sustained a significant limitation of use as defined in Ins. Law § 5102(d)." (*See, Dufel v. Green*, 85 N.Y.2d 795 [1985]).

(b) Where a quantitative analysis relying upon a reduced range of motion is set forth, does the medical submission state the specific degree or percentage of the deviation from the "normal" range of motion which is set forth? (*See, Michels v. Maston*, 130 A.D.3d 476 (1st Dep't 2015); *Lewars v. Transit Facility* 84 A.D.3d 1176 (2d Dep't 2011]).

(c) Where a quantitative analysis is set forth, is it sufficient *vis-à-vis* plaintiff?

4. Contradictions

(a) Is the opinion contradicted by other medical evidence available to the physician, *e.g.*, office notes/records, x-rays?

(i) If so, is an explanation given? *See, Corcione v. John Dominick Cusomano, Inc.* 84 A.D.3d 1010 (2d Dep't 2011).

(b) Are there "gaps" in treatment? *See, Grimaldo v. Newman & Okun*, 105 A.D.3d 580 (1st Dep't 2013).

(i) If so, are they sufficiently explained, *e.g.*, reached maximum improvement, first-party benefits ceased, absence of medical insurance? *See, Ramkumar v. Grand Style Tran. Enter.* 22 N.Y.3d 905 (2013).

5. Time of Examination

(a) Where opinion is based upon a medical examination that is not "contemporaneous" with the accident and a period of time has in fact passed since the accident, does the medical submission exclude the possibility of another event causing or aggravating the claimed injury? (*See, Caines v. Diakite*, 105 A.D.3d 404 (1st Dep't 2013); *Griffith v. Munoz*, 98 A.D.3d 997 (2d Dep't 2012]).

(i) Where the issue is plaintiff's condition during 90/180 day period and the physician or chiropractor is examining the plaintiff outside that period, does the opinion provide as explanation that this examination and/or review of plaintiff's medical history can provide an assessment of plaintiff's condition during that period? (*See, Steinbergin v. Ali*, 99 A.D.3d 609 (1st Dep't 2012); *Coley v. Delarosa*, 105 A.D.3d 527 (1st Dep't 2012]).

(b) Is the opinion based upon a "recent" examination? (*See, Caliendo v. Ellington*, 104 A.D.3d 635 (2d Dep't 2013]).

(i) If not, is there a basis from which the expert can opine that no change in the condition going into the future is likely, *e.g.*, permanent condition?

CASE AFFIDAVITS AND AFFIRMATIONS

1. Case 1

Plaintiff's Opposition

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------X

AHMED

Plaintiff(s),

-against-

Defendant(s).

----------X

AFFIRMATION

Index No.: 017970/97

Joseph M. Waltz, M.D., a physician duly licensed to practice medicine in the state of New York, affirms the following to be true under penalty of perjury:

I am a board certified neurosurgeon and Director of Neurosurgery at Saint Barnabas Hospital.

The plaintiff in this action, Ahmed , has been under my care since November 1996 for injuries sustained in a motor vehicle accident which occurred on March 6, 1996.

As a normal and necessary part of my care, treatment and evaluation of Mr. , I have reviewed medical records, diagnostic test reports, and reports of prior health care providers.

Mr. began experiencing neck and back pain after the accident and sought care with a chiropractor, Dr. Millet and a neurologist, Dr. Gutstein.

Mr. was referred for an MRI examination of his cervical spine which revealed herniations at C3/4 and C4/5 and a bulge at C5/6.

When he first presented to me, Mr. had complaints of sharp intermittent neck pain and similar but more severe low back pain.

I referred Mr. for a CT Scan of his cervical spine and an MRI of his lumbar spine. The CT-Scan revealed significantly bulging possibly herniated discs at C4/5 and C5/6 compressing the thecal sac and spinal cord, and the MRI revealed significant bulging discs at L3/4, L4/5 and L5/S1 in contact with the thecal sac and extending into the foramina. This disc pathology was caused by the motor vehicle accident of March 6, 1996.

Mr. had paraspinous muscle spasms in the lumbosacral area and a decreased range of motion in his lumbar spine upon examination.

The injuries suffered by Mr. are permanent and result in restriction of use and activity of the injured areas and permanent limitation of his spine and peripheral nervous system.

Mr. has difficulty in sitting, standing or walking for any extended period of time and his inability to lift heavy

boxes at work are a natural and expected medical consequence of his injuries.

Mr. need to frequently change positions is caused by the injuries he sustained in this accident.

All opinions are stated with a reasonable degree of medical certainty.

DATED: New York, NY
March 21, 2000

Joseph M. Waltz, M.D.

BRONX DIAGNOSTIC IMAGING
2055-57 Williams Bridge Road • Bronx, New York 10461

ADMED : BX981408 REPORT DATE: November 6, 1998
DOB: 1/1/66
Joseph Waltz, MD
EXAM DATE: 11/4,98

MAGNETIC RESONANCE IMAGING SCAN OF THE LUMBAR SPINE

TECHNIQUE: Sagittal T1: TR 520 ms, TE 30 ms
Sagittal T2: TR 2200 ms, TE 85 ms
Axial T1: TR 570 ms, TE 22 ms

INTERPRETATION: The discs are normal in height and signal intensity. There is a bulging disc at the L3/4 level flattening the underlying thecal sac. There is a bulging disc at the L4/5 level flattening the underlying thecal sac and extending into the exit foramina. There is a bulging disc at the L5/S1 level which is in contact with the underlying thecal sac. There is no MRI evidence of acute compression fracture.

IMPRESSION:

1. THERE IS A BULGING DISC AT THE L3/4 LEVEL FLATTENING THE UNDERLYING THECAL SAC.
2. THERE IS A BULGING DISC AT THE L4/5 LEVEL FLATTENING THE UNDERLYING THECAL SAC AND EXTENDING INTO THE EXIT FORAMINA.
3. THERE IS A BULGING DISC AT THE L5/S1 LEVEL WHICH IS IN CONTACT WITH THE UNDERLYING THECAL SAC.

Thank you for the courtesy of this referral.

Sincerely,

Randall James, MD

Randall James, M.D.
RJ/J/ss

BRONX DIAGNOSTIC IMAGING
2055-57 Williams Bridge Road • Bronx, New York 10461

AHMED BX981408 REPORT DATE: November 9, 1998
DOB: 1/1/66
Joseph Waltz, MD
EXAM DATE: 11/4/98

CT IMAGING SCAN OF THE CERVICAL SPINE

INTERPRETATION: Axial and CT images are obtained for evaluation of the C3/4, C4/5 and C5/6 disc levels on 11/4/98.

Artifact from the patient's shoulders degrades image detail from the C5/6 level and below. There is a bulging disc at the C4/5 level compressing the underlying thecal sac. There is a bulging disc at the C5/6 level compressing the underlying thecal. If clinically indicated MRI can be obtained for further evaluation of the cervical spine.

IMPRESSION: THERE ARE BULGING DISCS AT THE C4/5 AND C5/6 LEVELS COMPRESSING THE UNDERLYING THECAL SAC.

Thank you for the courtesy of this referral.

Sincerely,

Randall James, MD

Randall James, M.D.
RJ/J/jh/jg

CASE 2.

Defendant's Proof in Support

September 17, 2007

American Transit Insurance Company
c/o Marquis Medical Administrators
2 Executive Drive
Suite 785
Fort Lee, New Jersey 07024

RE: **Joseph**
CLAIM #: **517833**
MMA #: **ATIC20071346**
D/A: **04/26/05**

To whom it may concern:

As per your request, I performed an independent orthopedic examination on the above-claimant on September 17, 2007, in my Brooklyn office. My findings are as follows:

The claimant would not allow me to photocopy his ID and would not fill out the patient questionnaire or put his name on the questionnaire. This was under the advice of his attorney.

HISTORY: The history is that of an 85-year-old male who was involved in a motor vehicle accident on 04/26/05. The claimant states being a seatbelted driver of an automobile, which was evidently struck in the front.

The claimant sustained reported injuries to the back and knees. The claimant denies neck injuries and denies an injury to the left elbow. No other injuries are reported and this individual denies any and all other injuries. There were no lacerations. He cannot state whether he lost consciousness or not as a result of this accident.

The claimant went to Maimonides emergency room where he was evaluated and released. The claimant came under the care of a physical therapist and doesn't know if he saw a chiropractor or not.

RECORDS REVIEWED:

1. Motor vehicle accident report.
2. Police accident report.
3. Verified Bill of Particulars.

No authenticated medical records were provided for review. If any authenticated medical records are available at any later time, I would be pleased to review them and advise whether they have any affect on my opinion, which is based on today's examination.

PAST MEDICAL HISTORY: Past medical history, as reported by the claimant, is denied.

SURGICAL HISTORY: Past surgical history, as reported by the claimant, is denied.

MEDICATIONS: The claimant is taking Flomax and Proscar.

INJURIES: The claimant denies any other injuries or accidents.

EMPLOYMENT HISTORY: The claimant is retired.

CHIEF COMPLAINT The claimant states feeling worse. He is complaining of back pain and pain in both knees. He denies numbness.

PHYSICAL EXAMINATION: The claimant is an 85-year-old male who does ambulate somewhat slowly. He stands 5'7" tall and weighs 205 lbs. The claimant states being right hand dominant.

The claimant was examined disrobed from the waist up.

The claimant was asked to inform me as to any pain or tenderness during the examination.

Skin: The skin was examined with no lesions, masses, or warmth noted.

Examination of the lumbar spine: Revealed no spasm or crepitus to palpation during static positioning or active range of motion. Forward flexion is to approximately 10 degrees (90 degrees or more of forward flexion normal) and lateral bending was 20 degrees to the left and right (30 degrees lateral bending normal) with a complaint of pain. Despite this, this individual sits with no indication of discomfort. The claimant states he cannot toe and heel walk, yet he ambulates without a limp and rather slowly. Deep tendon reflexes were normal at both the Achilles tendon and patellar tendon regions. Severe "give-away" strength is noted about the ankles and knees bilaterally. This contradicts this individual's ambulation without a limp. Straight leg raising was negative.

Examination of the cervical spine: Examination revealed this individual to present with 5 degrees of rotation to the right and 0 degrees to the left (70 to 80 degrees rotation left and right is normal) and 0 degrees of flexion and extension (30 to 50 degrees of flexion and extension is normal). This individual then promptly looked about, rotating the cervical spine at least 60 degrees or more to the left and right and flexing at least 30 degrees to follow me about during the examination with no indicating of discomfort. The claimant complains of pain as I palpate the cervical spine. There was no spasm or crepitus to palpation during static positioning or active range of motion. Deep tendon reflexes are 2+. The claimant presents with severe "give-away" strength of the biceps, triceps, and deltoid and wrist extensors. Weakness of the finger flexors and extensors is noted as well. Tinel's sign was negative at the elbow and wrists bilaterally.

Examination of the left elbow: There was no effusion or bogginess No complaint of pain is reported as I palpate the elbow. 130 degrees of flexion with full extension is noted (normal range of motion 130/0). There is no crepitus through range of motion. Pronation and supination are full and equal bilaterally.

Knee examination: This individual was originally sitting on the examining room table and chair with his knees bent 90 degrees and was able to Straight Leg Raise. However, during the knee portion of the examination, this individual indicated only 80 degrees of flexion and lacked 10 degrees of full extension (normal range of motion is 0 to 130-135 degrees of flexion). This individual presents with significant varicosities about the lower extremities. He complains of pain as I palpate the knees anteriorly, medially and laterally. There is retropatellar crepitus bilaterally. The left knee appears to be somewhat arthritic looking. The quads measure 17½ inches circumferentially about the left and 17¼ inches about the right. There was no effusion nor bogginess noted. The knee is stable. A negative Apley's, McMurray's, and Drawer Signs were noted. Quad and patella tendons are intact.

Sensory Examination: Equal sensation was noted in both upper and lower extremities.

IMPRESSION: This individual denies any injury to the neck and elbow despite the fact that these are listed in the Verified Bill of Particulars as reported injuries. This individual presents with no objective orthopedic findings despite what appears to be significant contradictions and exaggeration of symptoms. This individual appears to be exaggerating his symptoms and presents with no true objective findings at this time. The fact that he sits, yet presents with a show of only 10 degrees of flexion of the lumbar spine is contradictory. His "give-away" strength is contradictory with his ambulation. This individual's show of such decreased range of motion is totally contradicted by the fact that he followed me about, rotating the cervical spine 60 degrees and flexing at least 30 degrees. I do not believe that this individual presents with any true findings at this time.

The claimant is examined in accordance with the restrictive rules concerning an Independent Medical Examination. It is therefore understood that no physician-patient relationship exists or is implied by this examination.

The above opinion is based on the examination as performed on the above claimant. This opinion takes into account the claimant's subjective complaints as compared to objective findings both on clinical examination and on the available medical records.

I Declare, under the penalties of perjury, pursuant to CPLR 2106, due hereby affirm that the information contained within this document was prepared and is the work product of the undersigned, and is true to the best of my knowledge and information.

Sincerely,

S. Farkas, M.D.
New York State License No. 141639

David L. Milbauer, M.D.

June 16, 2007

American Transit Insurance Company
Care of Marquis Medical Administrators
2 Executive Drive - Suite 785
Fort Lee, N.J. 07024

Attention : Shem Lutchman

CLAIMANT: Joseph
File #: 517833-02
Date of Accident: April 26, 2005

DESCRIPTION:

An MRI of the Left Knee dated May 16, 2005 is submitted for review. The examination is comprised of sagittal and coronal T1, sagittal T2, coronal STIR and axial gradient echo images.

Marked degenerative changes of the medial femorotibial compartment are noted including extensive articular cartilage loss and subchondral bony degenerative change along the medial femoral condyle associated with hypertrophic bony spurring about the medial femorotibial joint margins. There is a complex degenerative tear throughout the body and anterior horn of the medial meniscus. Milder degenerative changes of the lateral femorotibial compartment are noted where erosions of the articular cartilage and degenerative intrasubstance signal within the lateral meniscus are noted. Degenerative changes of the patellofemoral compartment are noted where erosions of the articular cartilage and related foci of subchondral bony degenerative signal change are seen, primarily along the lateral portion of the femoral trochlea and along the lateral patellar facet. The anterior cruciate ligament (ACL) is poorly depicted compatible with a chronic ACL rupture, without signs of acute ACL tear. The posterior cruciate ligaments and the collateral ligaments appear intact. A moderate sized joint effusion is present and fluid is seen within the gastrocnemius-semimembranosus bursa.

David L. Milbauer, M.D.

IMPRESSION:

Multi-compartment degenerative changes are noted associated with an extensive degenerative tear of the medial meniscus and chronic anterior cruciate ligament rupture. A moderate sized joint effusion and popliteal cyst are noted.

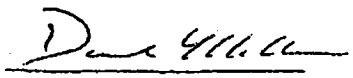
CONCLUSION:

The examination demonstrates no specific findings to indicate that a traumatic injury of the left knee was sustained in the accident of April 26, 2005. The anterior cruciate ligament tear appears chronic, preexisting the accident of April 26, 2005, without signs of edema along the ligament or acute osseous impaction injuries to suggest recent ligament injury. The medial meniscal tear and articular cartilage erosions described are degenerative in etiology and longstanding in nature, preexisting the accident of April 26, 2005. The joint effusion present, while nonspecific, frequently accompanies degenerative joint disease.

I, David L. Milbauer, M.D. being a physician duly licensed to practice medicine in the State of New York pursuant to CPLR-Section 2106, under the penalties of perjury, do hereby affirm that the contents of this expert report are true and accurate to the best of my knowledge.

My New York Medical License number is 168702.

Sincerely,



David L. Milbauer, M.D.

DLM:jmd

David L. Milbauer. M.D.

June 16, 2007

American Transit Insurance Company
Care of Marquis Medical Administrators
2 Executive Drive - Suite 785
Fort Lee, N.J. 07024

Attention : Shem Lutchman

CLAIMANT: , Joseph
File #: 517833-02
Date of Accident: April 26, 2005

DESCRIPTION:

An MRI of the Right Knee dated May 16, 2005 is submitted for review. The examination is comprised of sagittal and coronal T1, sagittal T2, coronal STIR and axial gradient echo images.

Degenerative erosions of the articular cartilage within the lateral femorotibial compartment are noted associated with degenerative signal within the posterior two-thirds of the lateral meniscus which appears to extend to the meniscal surface compatible with a degenerative tear. The body of the medial meniscus exhibits a small configuration and degenerative grade III signal compatible with a degenerative medial meniscal tear. Marked degenerative changes of the patellofemoral compartment are noted including extensive full thickness articular cartilage erosion and related subchondral bony degenerative changes are seen particularly along the lateral half of the femoral trochlea. The cruciate ligaments, collateral ligaments and extensor tendons appear intact. A small joint effusion is present. Bony cystic degenerative changes of the tibia are seen posteriorly without any fractures or occult osseous injuries noted. There are no signs of hematoma or contusion within the visualized soft tissues.

IMPRESSION:

Degenerative articular cartilage loss within the patellofemoral and lateral femorotibial compartments noted associated with degenerative tears of the medial and lateral menisci. A small joint effusion is present.

CONCLUSION:

The examination demonstrates no specific findings to indicate that a traumatic injury of the right knee was sustained in the accident of April 26, 2005. The medial and lateral meniscal tears and the articular cartilage erosions within the patellofemoral and lateral femorotibial compartments are degenerative in etiology and longstanding in nature, preexisting the accident of April 26, 2005. The small joint effusion is nonspecific and frequently accompanies degenerative joint disease.

I, David L. Milbauer, M.D. being a physician duly licensed to practice medicine in the State of New York pursuant to CPLR-Section 2106, under the penalties of perjury, do hereby affirm that the contents of this expert report are true and accurate to the best of my knowledge.

My New York Medical License number is 168702.

Sincerely,

David L. Milbauer, M.D.

DLM:jmd

Plaintiff's Opposition

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

----------X

JOSEPH ;

AFFIRMATION

Plaintiffs,

Index No.: 6232/07

-against-

Defendants.

----------X

I, **LEONARD BLEICHER**, a physician duly licensed to practice medicine in the State of New York hereby states and affirms under penalties of perjury the following:

1. I perform medical services at Ledo Medical Rehabilitation P.L.L.C. located at 2118 Coney Island Ave Brooklyn New York, 11223.

2. On May 2, 2005, Joseph came to my office with complaints of dizziness, headaches, back pain, arm pain and pain to both knees. The patient informed me that he was involved in a motor vehicle accident on April 26, 2005.

3. I performed complete and thorough physical examinations of the patient which revealed: antalgic gait favoring the left side due to left knee pain; extens ve bruising over both knees; digitial palpitation showing paravertebral pain and tenderness of the lumbosacral spine with terminal range pain. The patient's range of motion was less than 60% of normal in the cervical and lumbar spine; left and right knee extension decrease; muscular strength decrease in the left wrist/hand;

decreased pinwheel sensation over the left arm and left 1st – 3rd digits; positive SotoHall test; positive Lhermitte's test; Positive Tinel sign at the wrist bilaterally more intense on the left and at the right elbow; fluid effusion and medial joint pain of the knee joints; positive McMurray's test for the medial meniscus with positive patella apprehension bilaterally more pronounced on the left. Additionally, the straight leg raising test was reproducing lower back pain at 40 degrees bilaterally.

4. As a result of my examination on May 2, 2005, the patient was provided therapy and treatment for approximately 3 times a week for 5 months, gradually decreasing to the present rate of approximately once a month. Therapy included diathermy, massage, hot packs, paraffin and modalities. On August 31,2005, maximum benefits from conservative medical treatment had been reached but continued treatment on multiple occasions in 2006 and 2007 when patient experienced worsening of musculo skeletal pain. The patient also was referred to Dr. Diamond for MRIs,and underwent other diagnostic and neurological testing.

5. On or about June 16, 2005, I performed EMG/Nerve conduction studies on the patient, which revealed evidence of bilateral median nerve entrapment at the wrist affecting sensory and motor components as well as an Ulnar nerve injury to the left elbow. These nerve conduction studies of the left extremities revealed nultiple abnormalities including revealed median nerve entrapment at the wrists affecting sensory and motor components and an Ulnar nerve injury at the left elbow.

6. Based on the fact that Plaintiff had not suffered any similar symptoms before the accident or had any prior injuries/medical conditions that would result in

these findings. In conjunction with my own examinations and based on objective tests, I can conclude with a reasonable degree of medical certainty that the above findings were causally related to the motor vehicle accident of April 26, 2005.

7. On June 25, 2007, I re-evaluated the patient's condition. At that time the patient complained of worsening pain in his knees more intense of the left affecting most activities of daily living, walking, stair climbing, with frequent "giving way" conditions and "locking" on rising from a sitting position along with neck/upper and lower back pain which intensified on extreme motions accompanied by morning stiffness and weakness of the left hand.

8. Cervical/Thoracic range of motion studies I conducted revealed the following significant limitations:

	EXAMINATION	***NORMAL*** *(Grieve G.P. 198)*
Coupled flexion	50 degrees	80 to 90 degrees
Coupled extension	30 degrees	60-70 degrees
Right Rotation	50 degrees	70-90 degrees
Left Rotation	50 degrees	70-90 degrees
Right side flexion	20 degrees	20-45 degrees
Left side flexion	15 degrees	20-45 degrees

9. Regarding the cervical spine, the Spurling's test was positive on the left and the Soto/Hall test was also positive. Digital palpation confirmed paravertebral pain/tenderness in the cervical, upper thoracic and lumbrosacral spine more intense in the cervical/ thoracic spine along with pain/tenderness over the trapezius, rhomboid and iliopsoas muscles with radiating pain indicative of trigger points.

10. Lumbosacral spine range of motion studies I conducted revealed

deficiencies as follows:

	EXAMINATION	NORMAL
Coupled flexion	30 degrees	40-60 degrees
Coupled extension	15 degrees	20-35 degrees
Right side flexion	15 degrees	15-20 degrees
Left side flexion	10 degrees	15-20 degrees
Right rotation	10 degrees	3-18 degrees
Left rotation	5 degrees	3-18 degrees

11. The Tinels's sign at sciatic notch was positive on the left, the Trendelenburg and S-1 root test was positive on the left and Straight leg raising test was positive at 60° on the left.

12. Right knee examination included: digital palpation which revealed pain and tenderness at medial joint line, pes anserinus, supra- and subpatellar bursas and varus deformation.

13. Right knee joint range of motion studies that I conducted revealed the following deficiencies:

RIGHT KNEE JOINT	EXAMINATION	NORMAL
Flexion	5 to 120 degrees	0 to 135 degrees
Extension	deficient 5-20 degrees	0 to -15 degrees

14. Left Knee Joint range of motion study revealed:

	Normal	Plaintiff
Left Knee flexion	0 - 135 degrees	10-120 degrees
Left Knee extension	0-15 degrees deficient	10-25 degrees

15. Clinical tests also included the following: McMurray's test which was positive for medial meniscus, valgus and varus stress test showed no excessive

laxity, Lachman's test was positive for posterior laxity, the Passive Patellar Tilt revealed pain and the Patellar Grind test was positive.

16. A neuromuscular examination revealed notable decrease pinwheel sensation below the left elbow. The muscular strength of patient's upper and lower extremities revealed weakness 5-/5 in the left hand grips/digits abduction, right flexion, both knees extension and both ankles dorsiflexion. The upper and lower extremities circumference measurement at designated points revealed decreased 2cm left proximal forearm and decreased 1cm left calf in comparison with the right side.

17. On the basis of patient's medical history, his treatment history, subjective complaints, June 25, 2007 physical examination findings, objective testing, range of motion studies and the MRI results, I can conclude with a reasonable degree of medical certainty that Plaintiff continues to suffer from: ulnar nerve injury and contusions/sprains to the left elbow; contusions/sprains to both knees; chondromalacia patella, bilaterally, post traumatic; meniscopathy/tear to both knees; ligament tears to both knees; cervical spine soft tissue sprain; lumbosacral spine soft tissue sprain; clinical discogenic neck and lower back pain; difficulties walking due to leg pain; muscular spasm/trigger points and muscular wasting/disuse atrophy. Given the duration and extent of these symptoms and injuries, they are permanent and consequential in nature.

18. I further opine patient's prognosis is guarded with a progressive downhill course and that patient will experience chronic pain and needs assistance in most activities of daily living. Additionally, the patient sustained permanent

injuries to the left elbow, both knees, cervical and lumbosacral spine creating motor units malfunctioning and nerve injuries leading to the accelerated post-traumatic osteoarthritis, muscular weakness and atrophy.

19. I can conclude with a reasonable degree of medical certainty that the patient suffers from numerically and objectively determined restrictions of range motion of both knees, cervical and lumbar spine. Further that the significant and permanent injuries of both knees, cervical and lumbar spine represent impairments with limitation of body functions are causally related to the motor vehicle accident of April 26, 2005.

20. As the patient was asymptomatic before the motor vehicle accident, and never had any physical therapy necessity previously, I can conclude the patient's injuries and symptomology are based upon a traumatic event and not degeneration.

Dated: New York, New York
April 2008

LEONARD BLEICHER, M.D.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF Kings

AFFIRMATION

----------X

JOSEPH

Index No.: 6232/07

Plaintiffs,

-against-

Defendants.

----------X

ROBERT DIAMOND, M.D., a physician duly licensed to practice medicine in the State of New York hereby states and affirms under penalties of perjury the following:

1. I am not a party to the above-captioned action.

2. I am a Board Certified Radiologist duly licensed by the State of New York and perform services for STAND UP MRI OF BENSONHURST, P.C., with offices located at 2671 86th Street, Brooklyn, New York 11223.

3. On May 16, 2005, I supervised the taking of MRI film of the left knee and right knee of the plaintiff in this action. This study was performed by Dr. Leonard Bleicher.

4. These MRI films were taken under my supervision by technicians employed by STAND UP MRI OF BENSONHURST, P.C.

5. Photographically inscribed on said MRI films are: the patient's name, identification number, the facility name, date taken and the part of the body taken.

6. I have read the aforementioned MRI films and memorialized

the findings of my readings annexed hereto and made part of the Affirmation. These reports contain the following findings:

Right Knee

Synovial fluid with postermodial popliteral cyst. Patellofemoral chondromalacia with patellofemoral spurs and inferior patellar bruise. Narrowing of the medial femrotibial joint compartment with chondromalacia. Tear of the anterior horn and body and to the lesser extent posterior horn of the medial meniscus with a partial tear of the medial collateral ligament. Posterior intercondylar tibial surface erosion. Anterolateral distal femoral chondromalacia with underlying bruising. Grade III signal compatible with tear seen in the posterior horn of the lateral meniscus.

Left Knee

Synovial fluid with postermodial popliteral cyst. Medial and lateral reticulated soft tissue edema. Narrowing of the medial femorotibial joint compartment, along with medial femorotibial spurs, and distal medial femoral and proximal medial tibial bruising. Tear of the medial meniscus with a partial tear of the medial collateral ligament. Anterior cruciate tear. Anterolateral distal femoral bruising and marginal irregularity. Lateral femortibial spurs. Patellofemoral chondromalacia. Tear of the posterior horn of meniscus. Intercondylar tibial surface erosion.

7. Although some of these findings are consistent with degenerative disease, without considering the patient's history and exam, it is not possible radiologically to determine on this single exam, whether the patient's soft tissue findings are acute or long term as a result of a specific trauma. Determination as to whether these findings are a result of trauma are best opinioned by the patient's treating physician in conjunction with exam, history and any previous tests.

B. The information inscribed thereon is true to the best of my knowledge and belief, and if called as a witness in the above entitled action, I would so testify.

Dated: New York, New York
May 19, 2008

ROBERT DIAMOND, M.D.

CASE 3

Defendants Proof In Support

Alan M. Crystal, M.D., F.A.C.S.

ORTHOPEDIC SURGERY SPORTS MEDICINE

545 West 236th Suite C

Riverdale, New York 10463

(718) 435-2000

FAX (718) 854-4623

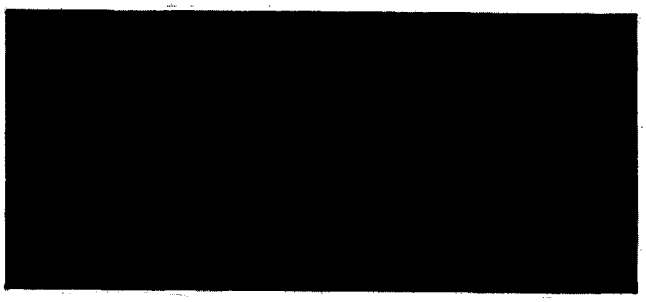
INDEPENDENT ORTHOPEDIC EVALUATION

Claimant: KYREESE	**PLAINTIFF'S ATTORNEY**
FILE No. 764495	**Date of Accident: 11/03/2011**
	Date of Examination: 05/09/2013

06/12/2013

I, Alan M. Crystal M.D., am duly licensed to practice medicine in the State of New York and I hereby affirm under penalties of perjury, that the statements herein are, to the best of my knowledge, true and accurate.

The captioned patient has been examined in accordance with the restrictive rules concerning an independent medical examination. This examination was performed at the request of Baker, McEvoy, Morrissey & Moskovits, P.C. It is therefore understood that no doctor-patient relationship exists or is implied by this examination. The claimant prior to the examination presented photo identification.



KYREESE L. FRANKLIN

MOTOR EXAM UPPER

MUSCLE	LEFT	RIGHT
DELTOID	5	5
WRIST EXTENSORS	5	5
FINGER EXTENSORS	5	5
FINGER FLEXION	5	5
ATROPHY OR WEAKNESS OF INTEROSSEOUS	NO	NO
FINGER FANNING ABDUCTION	5	5
FINGER ADDUCTION	5	5
ELBOW FLEXION	5	5
ELBOW FLEXION - BICEPS	5	5
ELBOW EXTENSION - TRICEPS	5	5

DEEP TENDON REFLEXES UPPER

	LEFT	RIGHT
BICEPS	+3	+3
BRACHIORADIALIS	+3	+3
TRICEPS	+3	+3

IMPRESSIONS:

The claimant is fully functional to perform all normal and usual daily activities, including work, without any restrictions.

CERVICAL, THORACIC & LUMBAR

Although imaging studies such as MRIs and other studies may assist physicians in making a diagnosis, it is important to note that a positive imaging study in and of itself does not make a diagnosis. For imaging studies to be of diagnostic value, clinical symptoms and signs resulting from an injury must correlate with the imaging findings. In other words, an imaging study such as an MRI is useful to confirm a diagnosis, but the result of an imaging study alone is insufficient to qualify for an impairment. EMGs should be used to confirm objective findings and not used as the sole determinant of a diagnosis. The claimant has absolutely no objective findings of a symptomatic herniated disc at a lumbar or cervical level causing nerve root impingement. The claimant does not have any objective findings of a symptomatic C-5 or L-5 radiculopathy. Because of the lack of any objective neurological findings, it is my firm opinion and conclusion that there is no basis to causally relate the alleged injuries of record of the spine to the accident of 11/03/2011.

LEFT SHOULDER

The claimant claims that on 11/03/2011 he was stopped at a red light and that his left hand was on the steering wheel when his vehicle was rear-ended. Contrary to what appears intuitive to one involved in a rear end accident that one is propelled forward on impact, the reality of the Laws of Motion dictate that upon impact that one is propelled in the direction of the force which is into the seat. In a rear-end scenario, the lumbar spine, cervical spine, and shoulders are protected by the energy absorbing pads of the seat-back and head-rest. The torso can subsequently rebound from the seat-back which typically absorbs 40%-60% of the energy giving a significantly diminished forward force. When the torso moves forward, the torso impacts on the shoulder belt which loads the anterior chest and does not significantly load the lumbar or thoracic spine in compression or bending. The shoulder does not have any forces on it that could produce an acute rotator cuff tear or labral tear.

The claimant had an x-ray of the left shoulder on 11/04/2011 which was interpreted by Dr. Lang as not showing any osseous pathology. Dr. Lang does not report any soft tissue swelling that would accompany a shoulder injury. The claimant had a left shoulder MRI performed on 12/01/2011. The MRI report by Dr. Jack Lyons notes that the AC joint is impinging on the rotator cuff. Dr. Lyons notes that there were no bone marrow abnormalities. Dr. Lyons does not note any finding that is associated with acute trauma. The claimant had surgery on 01/19/2012. The surgeon notes: "It was apparent that there was extreme narrowing of the subacromial space region with inspection of the rotator cuff, which did have some tearing on its dorsal surface," and "Inspection at the acromioclavicular joint did reveal there to be some underlying aspect of the clavicle, which was also pressing on the rotator cuff..." The operative findings are compatible with chronic impingement, not acute trauma. The impingement has zero causation to the MVA of 11/03/2011. It is my firm opinion and conclusion that there is no basis to causally relate the alleged injuries of record of the left shoulder to the accident of 11/03/2011.

I am a physician authorized by law to practice in the state of New York and I am not a party to this proceeding and am hereby affirming the forgoing is true to the best of my knowledge under penalty of law. The claimant's ID was checked prior to the examination.

Pursuant to CPLR Sec. 2106, and as a physician duly licensed to practice in the state of New York, I hereby affirm the truth of the foregoing, I declare, under the penalties of perjury that the information contained in this document was prepared and is the work product of the undersigned, and is true to the best of my knowledge and information.

Sincerely,

A. Crystal M.D.

Alan M. Crystal M.D., F.A.A.O.S., F.A.C.S.

THROGGS NECK MULTICARE

3058 East Tremont Avenue
Bronx, New York 10461

Louis Rose, M.D.

Patient: KYREESE
D.O.S.: 11/04/2011

X-RAY OF THE CERVICAL SPINE:
AP, lateral and open mouth odontoid view of the cervical spine shows no fracture or subluxation. The prevertebral soft tissues and overlying airway is unremarkable. The disc spaces are preserved. There are no lytic or blastic lesions.

IMPRESSION:
Normal x-ray of the cervical spine.

X-RAY OF THE LEFT SHOULDER:
There is no evidence of a fracture or other focal osseous abnormality. There is no dislocation. The glenohumeral and acromioclavicular joints are preserved. No periarticular soft tissue calcification is seen.

IMPRESSION:
No osseous abnormality in the left shoulder.

X-RAY OF THE THORACIC SPINE:
AP and lateral views of the thoracic spine show no vertebral body or rib anomalies. No fracture is seen. The pedicles are intact and the disc spaces are preserved. There are no lytic or blastic lesions. The surrounding soft tissues are grossly unremarkable.

OPINION:
Normal x-ray of the thoracic spine.

X-RAY OF THE RIGHT HIP:
Films show no avascular necrosis. There is hypertrophic change of the femoral neck suggesting the possibility of femoral acetabular impingement. The joint space is preserved. There are no lytic or blastic lesions. No cortical fracture is seen.

IMPRESSION:
Hypertrophic change of the femoral neck suggesting femoral acetabular impingement.

X-RAY OF THE LUMBOSACRAL SPINE:
AP and lateral views of the lumbosacral spine show no spondylolysis or spondylolisthesis. The pedicles are intact and the disc spaces are preserved. No fracture is seen. There are no lytic or blastic lesions. The surrounding soft tissues are grossly unremarkable.

43806

IMPRESSION:
Normal x-ray of the lumbosacral spine.

Yours Truly,

Jeffrey N. Lang, M.D.
Board Certified Neuroradiologist

JNL/cm
dd: 11/04/2011 dt: 11/12/2011

43800

40

DDI DISTINGUISHED DIAGNOSTIC IMAGING P.C.

Distinguished Diagnostic Imaging, P.C.
1484 Williamsbridge Road
BRONX, NY, 10461
Tel: 718.828.6300 Fax: 718.828.6585

Examination Report

To: Dr. LOUIS ROSE MD
3058 EAST TREMONT AVE
BRONX, NY - 10461

Fax#: 718-409-0306
Exam#: 112250

Patient Name : KYREESE
DOB: [redacted]
Gender: Male
Exam Date: 12/01/2011

Exam Description : 73221 73221 MRI OF THE LEFT SHOULDER W/O

CLINICAL HISTORY: Post-traumatic pain. Clinical concern for rotator cuff tear.

Routine non-contrast MRI images of the left shoulder were obtained on 12/1/2011. Prior imaging correlation is not available.

There is mild AC joint arthrosis and malalignment of the AC joint with impingement upon the underlying supraspinatus muscle. There is no evidence of fracture, dislocation, or bone marrow abnormalities to be suspicious for bone contusion, stress fractures, or acute trabecular microfractures.

There is minimal fluid in the subdeltoid bursa and mild fluid in the joint capsule. There is no communication between these fluid compartments across the conjoined tendon. There is no evidence of tendon laxity or retraction. There is swelling of the conjoined tendon. There are no appreciable surface defects to be suspicious for focal partial tears.

There is mild fluid in the subscapularis bursa. There is increased signal and swelling of the subscapularis tendons. There is no evidence of tendon laxity or retraction. The findings are compatible with mild subscapularis tendonopathy/bursitis. The biceps tendon is intact. The visualized portions of the labrum are unremarkable.

IMPRESSION:

MILD AC JOINT ARTHROSIS AND MALALIGNMENT WITH IMPINGEMENT.

MILD CONJOINED TENDON TENOSYNOVITIS/BURSITIS.

MILD SUBSCAPULARIS TENDONOPATHY AND BURSITIS.

EB

Jack Lyons, M.D.
Electronically Signed On: 12/02/2011 10:46 AM

Plaintiff's opposition

metSUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------X

KYREESE

Plaintiff(s),

~ against ~

Defendant(s).

----------X

Index#: 20308/2012E
PHYSICIAN'S AFFIRMATION

Louis C. Rose M.D., a physician duly licensed and authorized to practice medicine in the state of New York, affirms under the penalties of perjury as follows:

1. I maintain offices in the practice of Orthopedic Surgery at 3058 East Tremont Avenue, Bronx, New York 10461. I received my undergraduate degree from C.W. Post College, Greenvalle, New York in 1974; my medical degree from Rutgers Medical School, University Heights, New Jersey in 1981; completed my one year internship at Northshore University Hospital, Manhasset, New York in 1982; completed my Orthopedic Residency at New York Medical College in 1986; completed my fellowship at New York Medical College in 1987; was licensed to practice medicine in the State of New York in 1984; was licensed to practice medicine in the state of New Jersey in 1986; I am Board Certified in Orthopedic Surgery and have practiced exclusively in the field of Orthopedic surgery since 1984. I have hospital privileges at Our Lady of Mercy Hospital, Bronx, New York, Lincoln Hospital, Bronx, New York and Westchester County Medical Center, Valhalla, New York.

2. I first saw the patient on November 4, 2011 following a motor vehicle accident he was involved in on November 3, 2011. He advised me that he was the driver, stopped at a red light when his vehicle was forcefully rear ended. The patient reported that he went to the St. Barnabas Hospital's emergency room. I reviewed his hospital records and they confirmed immediate complaints of injury to his back, left shoulder and right hip on the date of accident. He complained of aching, decreased range of motion, pain, and stiffness of the neck radiating down his left arm; aching, pain, decreased range of motion and burning of the left shoulder; aching, pain, spams, stiffness and decreased range of motion of the low back radiating down the right foot and aching pain and stiffness of the right hip. The left shoulder symptoms were constant and worsened with activity, exertion, lifting and motion. The patient reported that he had no past orthopedic surgeries, was a developmental therapist and was active before his accident.

3. On physical examination the day after his accident, the patient exhibited left shoulder active forward flexion to 110° (≥ 180° normal), active abduction to 100° (≥ 170° normal), external rotation to 75° (≥ 60° normal) and internal rotation to 75° (≥ 80° normal). He exhibited tenderness to direct palpation at the acromioclavicular joint and rotator cuff insertion with a positive impingement test. Examination of his cervical spine revealed 40° cervical spine flexion (60° normal), 30° cervical extension (60° normal) with paravertebral spasms. Examination of his lumbar spine revealed a shuffling type gait, forward flexion to 50° (60° normal), squats to 60% of normal and bilateral straight leg raises with pain to 70° (80-90° normal). X-ray evaluation was negative for fracture. He was diagnosed with cervical, thoracic and lumbar strain, lumbar radiculopathy, impingement syndrome of the left shoulder, possible tear of the left rotator cuff and strain of the hip. He was advised to modify activities to avoid injury, to apply a heating pad to

the area, to avoid overhead lifting, avoid sudden movements and to return in one week. He was prescribed physical therapy three times per week for six weeks, and prescribed Mobic, Soma and Ultram.

4. The patient returned to my office on November 11, 2011 with essentially unchanged symptoms. On November 28, 2011 he returned with increased complaints of pain to his left shoulder, neck, mid back and low back. He rated the pain to his left shoulder as an 8-9 out of 10. The symptoms worsened with activity. Examination of his left shoulder revealed active forward flexion to 110° ($\geq$ 180° normal), active abduction to 90° ($\geq$ 170° normal), external rotation to 75° (60° normal), internal rotation to 60° (80° normal) and his right hip flexion was to 95°. On physical examination the patient exhibited 30° cervical spine flexion (60° normal), 20° cervical extension (60° normal) with paravertebral spasms. Examination of his lumbar spine revealed forward flexion to 40° (60° normal), extension to 0° with pain (25° normal) and bilateral straight leg raises with pain to 50° (80-90° normal). He was advised to undergo MRI evaluation of his left shoulder, cervical spine and lumbar spine to modify activities to avoid injury, continue using the heating pad and to refrain from work for three weeks.

5. On December 1, 2011 the patient underwent MRI evaluation of his left shoulder, reviewed by me, which revealed malalignment of the AC joint with impingement upon the underlying supraspinatus muscle, conjoined tendon tenosynovitis/bursitis and subscapularis tendonopathy and bursitis. On December 13, 2011 the patient underwent EMG testing at my office which revealed right L5 radiculopathy. On 1/10/2012 the patient returned for a followup visit to my office to discuss the diagnostic findings. His complaints were essentially unchanged. Following review of his MRI, the patient was recommended surgery for his left shoulder.

6. On January 19, 2012 the patient underwent surgery to his left shoulder, performed by me. The post operative diagnosis was internal derangement of the left shoulder with partial tear of the glenoid labrum requiring arthroscopy of the left shoulder with debridement of the glenoid labrum, hypertrophic synovium with acromioplasty. During his procedure, I took intraoperative photos. These photographs are attached to my affirmation and they fairly and accurately reflect those photographs that I took on the date of surgery. I have additionally made the marks on these photographs. They demonstrate that the labrum was present (IMG_001, IMG_002), there was a labrum abnormality (IMG_001) and that there was rotator cuff pathology with tearing of the rotator cuff (IMG_005 and IMG_007). It is my opinion to a reasonable degree of medical certainty that these operative findings are causally related to the accident and that the clinical symptoms, signs and complaints correlate with both the imaging and operative findings.

7. The patient returned to my office on 1/25/2012 following shoulder surgery. He complained about aching, burning and soreness of his left shoulder. Examination of his left shoulder revealed active forward flexion to 120° (≥ 180° normal), active abduction to 100° (≥ 170° normal), external rotation to 75° (≥ 60° normal) and internal rotation to 75° (≥ 80° normal). Impingement sign was negative. There was tenderness to palpation at the anterior aspect of the shoulder. He was advised to continue using the heating pad, continue home exercise program, avoid overhead lifting, pushing and pulling, avoid sudden rotations and to modify activities to avoid injury. He was prescribed physical therapy and advised to return in one week.

8. The patient returned to my office on 2/2/2012 and had his sutures removed and then returned on 3/16/2012, 4/27/2012, 6/8/2012, 9/6/2012 and 11/12/2012 for followup care. On November 12, 2012 he complained of pain, stiffness and weakness of the left

shoulder which was aching, sharp, sore, stiff and throbbing, rating the pain at 6 out of 10. He complained of aching, decreased range of motion, pain, spasms and stiffness of the low back with constant symptoms as pain at its highest being a 6 out of 10. He reported shoulder pain post-operatively. On physical examination his cervical spine exhibited limited range of motion at the extremes, lumbar forward flexion to 60° (60° normal), extension to 0° with pain (25° normal) and bilateral straight leg raises with pain to 60° (80-90° normal). Examination of his left shoulder revealed active forward flexion to 150° (≥ 180° normal), active abduction to 150° (≥ 170° normal), external rotation to 75° (≥ 60° normal) and internal rotation to 75° (≥ 80° normal). Impingement sign was positive. He was advised to modify activity to avoid injury, continue using the heating pad, to continue his home exercise program, avoid sudden movements and continue taking medications as prescribed. He was advised to return to my office in two months. As his condition had essentially unchanged, he had reached a point of monitoring and maintenance. It is my opinion to a reasonable degree of medical certainty that he had reached a point of maximum recovery for his injuries and the pain he experienced would continue to worsen as he ages.

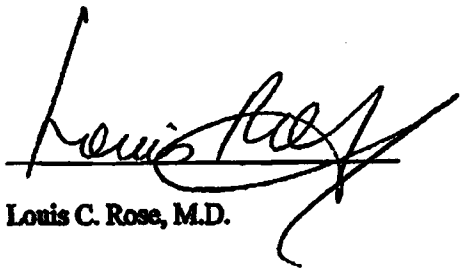
9. On November 4, 2013 the patient most returned to my office. He complained of aching, clicking decreased range of motion, pain, stiffness and weakness to the left shoulder. He rated his pain as a 6-7 out of 10 and described the pain as aching, sharp, sore, stiff and throbbing. He explained that symptoms worsened with activity or exertion, that the joint pain was severe occasionally on the left and that he had decreased range of motion, stiffness, weakness and pain when raising his arm. He also complained of aching, decreased range of motion, numbness, tingling, pain, spasms and stiffness of the low back radiating down the right foot and toes. Pain was rated at a 5 out of 10.

10. Examination of his left shoulder revealed active forward flexion to 150° with pain and stiffness (≥ 180° normal), active abduction to 150° with pain and stiffness (≥ 170° normal), external rotation to 60° (≥ 60° normal) and internal rotation to 90° (≥ 80° normal). Impingement sign test was positive, lift-off test was positive and the patient exhibited moderate tenderness to direct palpation at the rotator cuff insertion. Examination of his lumbar spine revealed forward flexion to 60° with pain and stiffness (60° normal), extension to 10° with pain and stiffness (25° normal) and bilateral straight leg raises with pain to 60° (80-90° normal). On physical examination of the patient's cervical spine range of motion was limited at its extremes and he exhibited paravertebral spasms with associated tenderness. He was advised that his shoulder condition was worsening and that he should modify activities to avoid injury. He was cautioned against impact and forceful extending. He was advised to continue taking his medications as prescribed and to return in six weeks.

11. Based on the Patient's left shoulder MRI which I reviewed, his operative findings, which I performed and my physical examination and treatment of Kyreese Franklin for a period of two years, it is my opinion to a reasonable degree of medical certainty that Kyreese [illegible] sustained left shoulder, neck and back injuries requiring surgery including malalignment of the AC joint with impingement, bursitis, internal derangement, tear of the glenoid labrum and tear of the rotator cuff requiring arthroscopy of the left shoulder, debridement of the glenoid labrum and hypertrophic synovium and L5 radiculopathy as a result of the forceful rear end automobile accident on November 3, 2011. It is my opinion to a reasonable degree of medical certainty that these injuries were caused by the rear end automobile accident and are causally attributable to the rear end impact. Given the persistence and worsening of his symptoms with loss of range of

motion for over two years after his accident, it is my opinion to a reasonable degree of medical certainty that his pain and limitation of range of motion in his left shoulder, cervical spine and lumbar spine are permanent and will continue to worsen as he ages.

Dated: January 6, 2014
Bronx, New York



Louis C. Rose, M.D.

CASE 4

Defendant Medical Proof

PREFERRED MEDICAL NUCLEAR IMAGING, P.C.
1111 EAST TREMONT AVENUE
BRONX, NEW YORK 10460
TEL (718) 931-3232
FAX (718) 931-2023

PATIENT NAME: , **Agripino**

DATE OF SERVICE: **05/22/12**

DATE OF BIRTH: [redacted]

REFERRING PHYSICIAN: **Dr. McCulloch**

MRI OF THE LEFT SHOULDER

INDICATION: Pain.

TECHNIQUE: Multiple T1 and T2 weighted MRI images of the left shoulder were obtained in the axial, sagittal and coronal planes without intravenous or intraarticular contrast.

FINDINGS: There are no acute displaced fractures, dislocations, destructive bony lesions or marrow infiltration in the proximal humerus and glenoid. The acromioclavicular joint is intact. There is bone marrow edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint, likely as a result of recent trauma, in an appropriate clinical setting.

The rotator cuff tendons including the supraspinatus, subscapularis, infraspinatus and teres minor are intact without MRI evidence of a tear or tendinosis/tendinopathy. There is mild thickening with heterogeneous signal of the distal subscapularis tendon consistent with tendinosis/tendinopathy without MRI evidence of a partial or complete tear or retraction, in an appropriate clinical setting. The supraspinatus, infraspinatus and teres minor tendons are intact without MRI evidence of a tear or tendinosis/tendinopathy. There are multiple subcortical degenerative cysts in the humeral head under the insertion of rotator cuff. The biceps tendon is situated within the bicipital groove and its attachment to the superior labrum is intact. The glenoid labrum is grossly intact. There is no joint effusion. There are no masses or fluid collections associated with the glenohumeral joint.

IMPRESSION:

1. **Bone marrow edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint, likely as a result of recent trauma, in an appropriate clinical setting.**
2. **Mild thickening with heterogeneous signal of the distal subscapularis tendon consistent with tendinosis/tendinopathy without MRI evidence of a partial or complete tear or retraction, in an appropriate clinical setting.**
3. **The supraspinatus, infraspinatus and teres minor tendons are intact without MRI evidence of a tear or tendinosis/tendinopathy.**
4. **Multiple subcortical degenerative cysts in the humeral head under the insertion of rotator cuff.**

Steve B. Losik M.D.

Steve B. Losik, M.D.
Board Certified Radiologist
Electronically Signed

Jacquelin Emmanuel, M.D.

Diplomate of American Board of Orthopedic Surgeons
337 Court Street
Brooklyn, NY 11231

Exam Works, Inc
P.O. Box 487
Syosset, NY 11791

DOE: August 6, 2012
RE: Agripino
CLAIM#: 000274706-001
DOA: April 5, 2012
FILE #: 550809

To Whom It May Concern:

The above claimant presented for evaluation for injuries sustained in a motor vehicle accident said to have occurred on April 5, 2012. The claimant did present with photo identification. I performed an independent orthopedic examination on August 6, 2012 at my Bronx office. My office assistant was present during examination and provided Spanish interpretation.

History as Stated by Claimant:
The claimant states that on April 5, 2012, he injured his neck, left shoulder, mid and lower back, as he was the driver who was struck by a motor vehicle. There was no loss of consciousness reported. He states that he presented by ambulance to New York Presbyterian Hospital emergency room treatment for his injuries. The claimant states that he did not sustain any fractures or lacerations at the time of the reported accident.

Following the reported accident, the claimant states that he presented to a local facility for treatment. Treatment consisted of physical therapy three times a week. He is currently continuing with her therapy.

No surgery has been performed as a result of the alleged accident. He did not require any ambulatory assistive devices.

Past Medical History:
The claimant denies any previous history of trauma or functional disability. He denies any illnesses. The claimant denies history of surgery. He states he does not take medication.

The claimant reports that since the accident, no new injuries have been sustained and no new accidents have occurred.

Current Complaints:
At today's examination, the claimant has complaints of pain in the neck, left shoulder, mid and lower back.

Occupational Status:
The claimant states that he was employed as a technician at the time of the accident. He states he is currently working.

Review of Medical Records:
No medical records were available for review.

Findings on Physical Examination:
For identification purposes only, the claimant is a 39-year-old, right-handed male. He stands 5' feet 9" inches tall and weighs 165 pounds. He has black hair and brown eyes.

Cervical Spine: Examination of the neck reveals no tenderness to palpation of the cervical paraspinal musculature. No muscle spasm was noted. Cervical compression was negative. There was full range of motion of the cervical spine on flexion to 45 degrees (45 degrees normal), extension to 45 degrees(45 degrees normal), lateral bend to 45 degrees (45 degrees normal), right and left rotation to 70 degrees (70 degrees normal).

Neurological examination, there were no motor or sensory deficits in the upper extremities. Deep tendon reflexes in the biceps and triceps were present and equal bilaterally. Muscle strength in each range was 5/5. There is firm grasping power in both hands. There is no radiation of pain or paresthesia.

Thoracic Spine: The shoulder blades are symmetrical and no discomfort is noted. There is no tenderness over the trapezius proximal to the superior angle of the scapula, along the medial border down to the interior angle or over the spinous process from T1 through T12. The thoracic curvature is normal. There is no sensory loss.

Left Shoulder: There is no deltoid atrophy. There is no tenderness on palpation of the acromioclavicular joint or over the greater tuberosity. Range of motion of the shoulder reveals anterior flexion to 170 degrees (170 degrees normal), abduction to 180 degrees (180 degrees normal), adduction to 45 degrees (45 degrees normal), internal rotation to 45 degrees (45 degrees normal) and posterior extension to 45 degrees (45 degrees normal). Apley, drop arm, and apprehension tests are all

negative. Impingement sign is negative. There is no winging of the scapula. There is no sensory loss to light touch or pinprick.

Lumbosacral Spine: Claimant has a normal gait. The claimant has a normal toe/heel walk. The lordotic curve is normal. There is no spasm or tenderness noted over the paraspinal musculature on palpation. Sitting lasegue testing is negative to 80 degrees. Straight leg raising is negative to 75 degrees in both the seated and supine positions. Range of motion of the lumbar spine reveals; flexion: 90 degrees (90 degrees normal), extension: 30 degrees (30 degrees normal), right and left lateral flexion: 45 degrees (45 degrees normal), rotation: 45 degrees (45 degrees normal).

Neurological examination reveals patellar and Achilles deep tendon reflexes to be 2+ (2+ normal). There is no sensory deficit. Muscle strength of the lower extremities is graded at 5/5 (5/5 normal). There is no atrophy noted in the muscles of the lower extremities. There is no radiation of pain, numbness or tingling.

Diagnosis:

1. Status post cervical, thoracic and lumbar sprain/strain, resolved
2. Status post left shoulder sprain, resolved

Impression:

Based on my examination, there is no medical necessity for further treatment including physical therapy. There is no need for diagnostic testing, durable medical equipment, household help or medical transportation.

I find the claimant has no objective evidence of disability. He may continue to work without limitations.

Causality:

If the claimant's history is truthful, his neck, left shoulder, mid and lower back injuries are causally related to the accident on April 5, 2012.

I, Jacquelin Emmanuel, M.D., being a Diplomate of the American Board of Orthopedic Surgeons, am duly licensed to practice medicine in the State of New York pursuant to CPLR section 2106 and hereby affirm under the penalty of perjury, that the foregoing is true and accurate to the best of my knowledge.

Sincerely;

J Emmanuel

Jacquelin Emmanuel, M.D.
Diplomate of American Board of Orthopedic Surgeons

ALVIN M. BREGMAN, M.D., F.A.A.O.S., P.C.
ORTHOPAEDIC AND ARTHROSCOPIC SURGERY
FELLOW OF THE AMERICAN COLLEGE OF SURGEONS
DIPLOMATE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

79-07 Metropolitan Avenue
Middle Village, NY 11379
Tel.: (718) 326-8484
Fax: (718)-326-4480

October 16, 2014

Richard T. Lau & Associates
P.O. Box 9040
300 Jericho Quadrangle, Suite 260
Jericho, NY 11753

Claimant: Agripino
Claim #: 32 0W25 675
Date of Accident: April 5, 2012

To Whom It May Concern:

At your request, the above claimant was seen today in my Bronx office for an independent orthopedic examination. The claimant presented with valid photo identification. My findings are as follows:

HISTORY OF ACCIDENT:

Mr. is a 41-year old male who states that on April 5, 2012, he was the restrained driver of the automobile involved in a motor vehicle accident. Impact was to the driver's side of the vehicle (sideswiped). There was no loss of consciousness reported. Mr. Rosa states he was taken by ambulance to New York Presbyterian Hospital Emergency Department where he was evaluate and x-rays were taken. There were no fractures reported. He states he was treated and released the same day.

Mr. states his initial complaints were of pain to his neck, mid-back, lower back and left shoulder.

Subsequently, Mr. presented to a local medical facility for treatment which consisted of chiropractic care, physical therapy and acupuncture

treatments at an initial rate of three times per week. Mr. reports he is currently continuing the recommended treatments three times per week. Mr. Rosa states left shoulder surgery was performed in February 2014, as a result of the accident in question.

PAST MEDICAL HISTORY:

Mr. a denies a history of any prior motor vehicle accidents or injuries. He states there is no history of diabetes or high blood pressure. His past surgical history is negative. The claimant states he is not taking any medications at the present time.

The claimant reports that since the accident, no new injuries have been sustained and no new accidents have occurred.

PRESENT COMPLAINTS:

At today's examination, Mr. a complained of pain in his neck, back and left shoulder. Mr. states his condition is the same.

OCCUPATIONAL HISTORY AND CURRENT STATUS:

Mr. a reports that at the time of this accident he was employed full-time. He states he missed seven to eight months from work due to the reported accident and is currently working as a taxi cab driver on a part-time basis.

ORTHOPEDIC EXAMINATION

Physical Examination:

For identification purposes only, Mr. a is a 41-year-old right-handed male who presents today for examination. He is 5 feet 9 inches tall and weighs 185 pounds. He has black hair and black eyes.

Range of motion determination was performed by visual clinical expertise in conjunction with the use of an orthopaedic goniometer in accordance with the AMA Guidelines.

Cervical Spine:

Examination of the cervical spine reveals a normal lordosis. The cervical paraspinal region was palpated using light touch and no paraspinal muscle spasm is noted. Voluntary range of motion of the cervical spine:

flexion is 0 to 45 degrees (0 to 45 degrees normal), extension 0 to 45 degrees (0 to 45 degrees normal), right rotation 0 to 70 degrees (0 to 70 degrees normal), left rotation 0 to 70 degrees (0 to 70 degrees normal), right lateral flexion 0 to 45 degrees (0 to 45 degrees normal) and left lateral flexion 0 to 45 degrees (0 to 45 degrees normal).

Neurological examination reveals muscle strength graded at 5/5 in the biceps, triceps, wrist flexor and extensor bilaterally. Deep tendon brachioradialis, biceps and triceps reflexes are present and active bilaterally at 2+. Grasping power is firm in both hands. There is no radiation of pain or paresthesia.

Thoracic Spine:

The shoulder blades are symmetrical and no discomfort is noted. There is no tenderness over the trapezius proximal to the superior angle of the scapula, along the medial border down to the inferior angle or over the spinous process from T1 through T12. The thoracic curvature is normal with no paraspinal spasm. There is no sensory loss.

Lumbar Spine:

The claimant has a normal gait and walks on toes and heels without difficulty. There are no spasms or tenderness noted over the paraspinal musculature on palpation. Straight leg raising is negative in both the seated and supine positions. Voluntary range of motion of the lumbar spine reveals forward flexion 0 to 90 degrees (0 to 90 degrees normal), extension 0 to 30 degrees (0 to 30 degrees normal), right lateral flexion 0 to 45 degrees (0 to 45 degrees normal) and left lateral flexion 0 to 45 degrees (0 to 45 degrees normal).

Neurological examination reveals patellar and Achilles deep tendon reflexes to be 2+ bilaterally. There is no sensory deficit. Muscle strength of the lower extremities is graded at 5/5. There is no atrophy noted in the muscles of the lower extremities. There is no radiation of pain, numbness or tingling.

Left Shoulder:

There is no deltoid atrophy. There is no tenderness on palpation of the acromioclavicular joint or over the greater tuberosity. Voluntary range of motion of the shoulder reveals anterior flexion 0 to 170 degrees (0 to 170 degrees normal), abduction 0 to 180 degrees (0 to 180 degrees normal), adduction 0 to 45 degrees (0 to 45 degrees normal), external rotation 0 to

45 degrees (0 to 45 degrees normal), internal rotation 0 to 45 degrees (0 to 45 degrees normal) and posterior extension 0 to 45 degrees (0 to 45 degrees normal). Drop arm and apprehension tests are negative. Impingement sign is negative. There is no winging of the scapula. There is no sensory loss to light touch or pinprick.

REVIEW OF MEDICAL RECORDS:

I reviewed the following medical records:

- Supplemental Bill of Particulars
- Bill of Particulars cervical spine thoracic spine left shoulder lumbar spine
- Police accident report dated 4/5/12
- Report from Jean-Robert Desrouleaux, M.D., dated 8/6/12
- Records from New York Presbyterian Hospital
- MRI report of the left shoulder dated 5/22/12
- MRI report of the lumbar spine dated 6/5/12
- MRI report of the cervical spine dated 5/31/12
- X-ray report of the cervical spine dated 5/8/12
- X-ray report of the lumbar spine dated 5/8/12
- Operative report from Kenneth McCulloch, M.D., dated 2/20/14
- Office notes from Kenneth McCulloch, M.D.
- Narrative report from Kenneth McCulloch, M.D., 5/16/12
- EMG/NCV of the lower extremities dated 5/21/12
- Office notes from Joseph Mentah, M.D.
- Range of motion/muscle test reports dated 4/23/12 and 6/18/12
- Report from Carl Hardy, DC, dated 8/6/12
- Outcome assessment test report dated 4/16/12
- Physical therapy notes
- Chiropractic notes
- Acupuncture notes
- Report from Jacqulin Emmanuel, M.D., dated 8/6/12

IMPRESSION:

Based on today's clinical examination, the records reviewed and the history given by the claimant with reasonable degree of medical certainty, my impression is:

- Resolved sprain of the cervical spine.
- Resolved sprain of the thoracic spine.
- Resolved sprain of the lumbar spine.

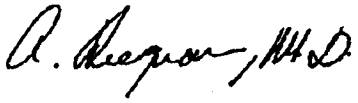
- Status post arthroscopy of the left shoulder, 2/20/14

In my opinion, with a reasonable degree of medical certainty, I find Mr. ı has no disability.

Based upon the findings of this examination, available medical records and the history provided by the claimant, there is a causal relationship between the current diagnosis and the reported accident.

I, Alvin M. Bregman, M.D., being a Diplomate of the American Board of Orthopaedic Surgery, am duly licensed to practice medicine in the State of New York pursuant to CPLR section 210.6 and hereby affirm under a penalty of perjury, that the foregoing is true and accurate to the best of my knowledge.

Yours truly,



Alvin M. Bregman, M.D.
New York State License #: [redacted]
AMB:rl

Plaintiff's opposition

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX
----------X
AGRIPINO F O,

Plaintiffs, Index No.: 308543/12

-against-

AFFIRMATION

Defendants.
----------X

Steve B. Losik, M.D., hereby certifies and affirms the following to be true under the penalties of perjury:

1. That I am a physician duly licensed to practice medicine in the State of New York.

That I am a Board Certified Radiologist.

2. That I maintained an office at Preferred Medical Nuclear Imaging, P.C. located at 1111 East Tremont Avenue, Bronx, NY 10460.

3. That I reviewed the MRI films of the Left Shoulder, Cervical Spine and Lumbar Spine of AGRIPINO , performed May 22, 2012, May 31, 2012, and June 5, 2012 and I prepared the attached reports.

4. I hereby state that the following information is photographically inscribed on the MRI films; the name of the patient is AGRIPINO A, and the dates of the MRI tests were May 22, 2012, May 31, 2012, and June 5, 2012.

5. Based upon my evaluation and review, AGRIPINO ROSA, has sustained bone marrow edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint, likely as a result of recent trauma (left shoulder), mild thickening with heterogeneous signal of the distal subscapularis tendon consistent with tendinosis/tendinopathy (left shoulder); C3-4 disc bulge which compresses anterior thecal sac, C5-6 disc bulge which compresses anterior thecal sac, straightening of cervical lordosis; mild loss of L4-5 disc space height with a disc herniation with compression of anterior thecal sac and impingement on neural foramina.

6. I attest that the information contained within the attached reports is true and accurate.

7. If called as a witness in the trial of this lawsuit, I would testify as to matters related to said MRI and according to the attached report.

Dated: Brooklyn, New York
06/17/, 2016

Steve B. Losik, M.D.

June 05, 2016

TO: Gratt & Associates, P.C.
2021 Nostrand Avenue, #2
Brooklyn, NY 11210

RE: [redacted], Agripino

DATE OF ACCIDENT: April 5, 2012

Dear Sir/Madam,

The following is a narrative report summarizing the orthopedic evaluation and treatment of the above-named patient. He was seen initially seen in my office at 333 East 56th Street, New York, New York 10022 on May 16, 2012.

HISTORY OF PRESENT ILLNESS: Mr. [redacted] is a 42-year-old male who was in his usual state of health until he was involved in a motor vehicle accident on April 5, 2012. He sustained multiple injuries including to his neck, back, left shoulder and left hand. He denied any prior pain to the accident and was asymptomatic prior to the accident.

On May 16, 2012, Mr. [redacted] presented to my office as a 38-year-old male who was in his usual state of health until he was involved in a motor vehicle accident on April 5, 2012 in which he injured his neck, back, left shoulder and left hand. He had no pain prior to the accident in question but had persistent pain in the aforementioned locations afterwards. The neck pain radiated into the left upper extremity, the back pain stayed localized to the lumbar spine. The left shoulder did cause pain with overhead activities, reaching and lifting and he had difficulty moving and utilizing his left hand secondary to pain on the dorsum with any activity. On physical examination, he had decreased sensation in the radial nerve, median nerve and ulnar nerve distribution of the left hand compared to the contralateral side. He had forward elevation of the left shoulder to 140 degrees, external rotation to 50 degrees and internal rotation to T12. Normal is 180 degrees, 80 degrees and T8. He did have tenderness to palpation over the anterior humeral head of the left shoulder with a positive Neer test, positive Hawkins test, weakness with resisted external rotation and positive supraspinatus stress test. He had both cervical and lumbar tenderness to palpation and tenderness to the paraspinal musculature. On the left hand, he had decreased range of motion with flexion of the DIP joint to 90 degrees but not past this point. He had tenderness to palpation over the dorsum of the index and long finger metacarpals. My assessment was that Mr. [redacted] was a 38-year-old male with cervical and lumbar radiculopathy and left shoulder traumatic rotator cuff injury. I recommended obtaining an MRI to each of the aforementioned structures. He reported having radiographs of the left hand which were

negative. I recommended physical therapy to maximize recovery of strength and range of motion. He was to follow up with me after the MRI, at which point, further treatment decisions would be decided upon.

On May 22, 2012, MRI of the left shoulder was obtained at Preferred Medical Nuclear Imaging in Bronx New York. MRI results were bone marrow edema in the distal clavicle and adjacent acromion, likely as a result of recent trauma, tendinosis and tendinopathy of the rotator cuff, and a subcortical cyst in the humeral head at the insertion of the rotator cuff.

On May 30, 2012, Mr. presented to my office for follow-up evaluation of his persistent left shoulder pain since his accident of April 5, 2012. He had been treated with conservative measures but persisted in having pain without improvement. Range of motion, forward elevation was to 140 degrees, external rotation to 60 degrees and internal rotation to T12. Normal is 180 degrees, 80 degrees and T8. He did have tenderness to palpation over the anterior humeral head with a positive Neer test, positive Hawkins test and positive supraspinatus test. My assessment was that Mr. was a 38-year-old male with left shoulder traumatic rotator cuff injury and impingement. We discussed with him conservative measures based on his examination. If his symptoms were persistent, then arthroscopy may be necessary.

On June 13, 2012, Mr. presented to our office once again for follow-up evaluation as a 38-year-old male continuing to complain of left shoulder pain present for approximately two and a half months since being involved in a motor vehicle accident on April 5, 2012. He continued to complain of pain with overhead activities, reaching and lifting. There was no change in his physical examination. My assessment was that Mr. was a 38-year-old male with left shoulder traumatic rotator cuff tearing and impingement. In light of his lack of improvement with conservative measures, arthroscopic subacromial decompression, evaluation and possible repair of the rotator cuff was reviewed as well as the risks, benefits and recovery time. This was a medically necessary procedure given the positive findings on history, exam, and MRI and he was going to contact us as needed for this procedure and continue conservative measures in the interim.

On July 27, 2012, Mr. presented to our office as a 39-year-old male continuing to complain of left shoulder pain since the aforementioned motor vehicle accident in which he was involved on April 5, 2012. There was no significant change in his examination. We once again discussed conservative measures versus arthroscopic intervention. He wished to continue with conservative measures and he was to follow up with us as needed.

On November 28, 2012, Mr. presented to our office as a 39-year-old male continuing to complain of left shoulder pain which began with the motor vehicle accident in question of April 5, 2012. At this time, it had been over seven months since the accident which caused his injury and he had not had improvement with conservative measures such as physical therapy and had ongoing pain with overhead activities such as reaching and lifting. There was no change in his physical examination. We once again discussed arthroscopic intervention for his left shoulder given the positive findings on

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history, exam, MRI, lack of response to conservative measures over an extended period of time and acute change in function associated with the motor vehicle accident of April 5, 2012. He stated that he wished to proceed and we scheduled him at a time that was convenient for him.

On June 17, 2013, Mr. ' a presented to our office once again as a 40-year-old male with ongoing left shoulder pain since involvement in a motor vehicle accident on April 5, 2012. At this time, it had now been more than one year since the accident. We had previously discussed with him arthroscopic intervention on multiple occasions. He wished to continue with conservative measures but his pain was not improving. He continued to have pain with reaching, lifting, and overhead activities and he presented today on this date to discuss arthroscopic intervention once again secondary to his lack of improvement with conservative measures in over one year. On physical examination, forward elevation was to 130 degrees, external rotation 50 degrees and internal rotation to L2. Normal is 180 degrees, 80 degrees and T8. He had tenderness to palpation over the anterior humeral head with a positive Neer test, positive Hawkins test, weakness with resisted external rotation and a positive supraspinatus stress test. My assessment was that Mr.] a continued to have left shoulder traumatic rotator cuff tendinopathy and impingement which had been present for an extended period of time, refractory to conservative measures. Once again, we did discuss with him left shoulder arthroscopic subacromial decompression and evaluation and possible repair of the rotator cuff. Risks, benefits, recovery time and postoperative course were all reviewed and once again, he stated that he wished to proceed.

On January 15, 2014, Mr. a presented to my office once again as a 40-year-old male with ongoing left shoulder pain which began with the motor vehicle accident in which he was involved on April 5, 2012. At this time, it had now been more than a year and a half since the accident in question which caused the shoulder injury and his symptoms had not improved or remitted with conservative measures. We had discussed on multiple occasions arthroscopic intervention but he wished to continue with conservative measures; however, his symptoms did not improve. He continued to have pain with reaching, lifting, overhead activities and at night. On physical examination, there was no significant change on exam. My assessment once again was that Mr. was a 40-year-old male with left shoulder traumatic rotator cuff tendinopathy and impingement present for an extended period of time and refractory to conservative measures. We discussed once again left shoulder arthroscopic subacromial decompression evaluation and possible repair of the rotator cuff. He stated he wished to proceed and was scheduled accordingly.

On February 20, 2014, Mr.] underwent left shoulder arthroscopic subacromial decompression, arthroscopic SLAP debridement, arthroscopic labral debridement, rotator cuff debridement and arthroscopic synovectomy. Intraoperatively, he was noted to have tearing of the anterior labrum as well as a type I SLAP tear. Each of these were debrided. Subacromial decompression was performed and partial thickness tearing of the rotator cuff on the bursal side was debrided in the subacromial space.

On March 3, 2014, Mr. I presented for his first postoperative visit approximately 11 days postoperatively. Incisions were clean. Physical therapy was

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prescribed. He was instructed to return in six weeks.

On August 11, 2014, Mr. I a presented now as a 41-year-old male status post left shoulder arthroscopic subacromial decompression, SLAP, labrum and rotator cuff debridement performed on February 20, 2014 for traumatic injury to his shoulder occurring as a result of the motor vehicle accident in which he was involved on April 5, 2012. It had now been almost six months since the time of the surgery and he continued to have pain with reaching, lifting, and overhead activities. He had forward elevation 130 degrees, external rotation to 60 degrees and internal rotation to T12. Normal is 180 degrees, 80 degrees and T8. He had minimal tenderness to palpation. a negative Neer, negative Hawkins and good strength. My assessment was that Mr. I was a 41-year-old male with residual inflammation of the left shoulder status post arthroscopic intervention. We recommended physical therapy, antiinflammatories, and if symptoms were persistent, a corticosteroid injection could be provided.

On December 8, 2014, Mr. a presented to my office as a 41-year-old male who had suffered left shoulder injury as a result of the motor vehicle accident in which he was involved on April 5, 2012 which also required left shoulder arthroscopic subacromial decompression, evaluation and debridement of the rotator cuff, labrum and SLAP tears that were encountered. The date of surgery was February 20, 2014. He was now approximately 10 months out from the procedure. He continued to have ongoing symptoms with overhead activities, reaching, lifting, pushing and pulling. He reported 25% improvement overall compared to preoperatively. He wished to return for more aggressive physical therapy to improve his range of motion and strength. On physical examination, forward elevation was to 130 degrees, external rotation 60 degrees and internal rotation to T12. Normal is 180 degrees, 80 degrees and T8. He had a negative Neer test and negative Hawkins test. The arthroscopic portal sites were clean. We recommended physical therapy once again at a frequency of two times per week and antiinflammatories to supplement. If he continued to show lack of improvement, then corticosteroid injections would be provided for what was perceived to be residual inflammation.

On May 25, 2016, Mr. I a presented to my office once again as a 42-year-old male who was involved in the aforementioned motor vehicle accident on April 5, 2012. He required arthroscopic intervention for his left shoulder which was performed on February 20, 2014. He had very slow improvement after the procedure; however, at this visit, he had reached approximately 40% improvement compared to preoperatively by his own estimation. He still had pain with reaching, lifting, overhead activities and pain at night and restrictions in motion. On physical examination, forward elevation was to 130 degrees, external rotation 60 degrees and internal rotation to L2. Normal is 180 degrees, 80 degrees and T8. He did have tenderness to palpation over the anterior humeral head with a mildly positive Hawkins, good strength with resisted external rotation, negative supraspinatus stress test. My assessment was that Mr. was a 42-year-old male with residual pain in the left shoulder after traumatic injury requiring arthroscopic intervention. I recommended an ongoing stretching exercise program as well as physical therapy to maximize recovery of range of motion, antiinflammatories and Tylenol and he was to follow up with us on an as-needed basis.

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IMPRESSION: Mr. a continues to reveal evidence of unresolved injury to his left shoulder. He is status post left shoulder arthroscopic subacromial decompression, arthroscopic SLAP debridement, labral debridement, and rotator cuff debridement performed on February 20, 2014.

He has a moderate impairment due to the injuries sustained to his left shoulder. He is restricted to working in a sedentary capacity and should not engage in work-related activities that require reaching, lifting, overhead activities, climbing, or operating heavy machinery.

It is my opinion, within a reasonable degree of medical certainty that, based on the history as has been provided to me by the patient, a review of the medical records, physical examination findings, intraoperative findings, and radiographic findings, the injuries in question for Mr. left shoulder are causally related to the accident in which he was involved on April 5, 2012.

It is also my opinion, within a reasonable degree of medical certainty, that Mr. Polanco-Rosa has sustained a permanent partial disability.

Mr. a continues to manifest ongoing pain in the left shoulder as well as loss of range of motion. He was treated conservatively after his accident, in which he injured the left shoulder on April 5, 2012 for almost two years. He then underwent surgical intervention and it has now been more than two years since that intervention and by his own estimation, he had achieved only 40% relief of his preoperative symptoms at this point. He will benefit from ongoing physical therapy at a frequency of two to three times per week for six-week periods at a cost of approximately $150 per session. He would benefit from ongoing medical management, Tylenol and antiinflammatories. For flare-ups, corticosteroid injections can be provided into the subacromial space at a cost of approximately $400 per injection for the office visit as well as the medication. Given Mr. substantial residual symptoms in the left shoulder, he will also benefit from a repeat 3-Tesla MRI of the left shoulder to evaluate for ongoing pathology at a cost of approximately $1500 for the 3-Tesla MRI.

My prognosis for Mr. is guarded as he remains substantially symptomatic.

I, Kenneth McCulloch, M.D., being a physician duly licensed to practice in the State of New York, pursuant to CPLR Section 2106, hereby affirm under the penalties of perjury that the statements contained herein are true and accurate. I declare under the penalties of perjury that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

Sincerely,

Kenneth McCulloch, M.D., F.A.A.O.S.
Diplomate of the American Board of Orthopaedic Surgery

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