MANDELBAUM - DIRECT

THE COURT: Anything before we start?

MR. McGUINNESS: I want to go and move these Montefiore Mount Vernon medical records into evidence.

(Defendant's Exhibit G, was marked into evidence by the Reporter.)

(Jury enters courtroom.)

THE COURT: Good morning, everybody. Be seated, please.

We are ready to proceed.

Call your next witness.

MR. BOTTARI: The Plaintiffs call Dr. Chaim Mandelbaum.

C H A I M M A N D E L B A U M, called as a witness on behalf of the Plaintiff, having been duly sworn, testified as follows:

THE COURT: State your full name and spell your last name and business address.

THE WITNESS: Chaim, C-H-A-I-M, Mandelbaum, M-A-N-D-E-L-B-A-U M.

THE COURT: Your business address.

THE WITNESS: Business address is 75 Maiden Lane, suite 1206, New York, New York 10038.

THE COURT: You may inquire.

MANDELBAUM - DIRECT

DIRECT EXAMINATION BY

MR. BOTTARI:

Q Good morning, Dr. Mandelbaum.

A Good morning.

Q Could you briefly give us your professional and educational background?

A Yes. So I attended State University Health Science Center in Brooklyn, otherwise known as Downstate, graduating in 1992. That was for medical school.

After that, I did an internship at Staten Island University Hospital in internal medicine for one year followed by a residency in anesthesiology at Mount Sinai in New York City for three years and followed by a fellowship in pain medicine at Mount Sinai Hospital in New York City.

Since then, I have been -- I worked four years in New Jersey at a hospital there and then I have been working more recently for the past twenty years affiliated with hospitals at New York Methodist Hospital in Brooklyn and Mount Sinai at Beth Israel in New York City.

Q Are you what's known as Board certified?

A Yes.

Q what specialties you are Board certified in?

A Board certification is a process of me by the oversight, in this case, it's anesthesiology and pain medicine where you meet standards and qualifications, including education, taking an exam, there's a test, there is a written test, an oral test and you have met and kept up with those standards.

So I am Board certified in anesthesiology and also subspecialty Board certified in pain medicine.

Q What type of patients do you see in your practice being Board certified in pain medicine?

A So I am part of a two-physician practice. It's a private practice doing pain management. We have two offices, one in Manhattan, one in Brooklyn.

We see a host of different chronic, more complicated pain management type cases, ranging anywhere from musculoskeletal problems including neck, back issues to nerve issues to chronic headaches that have not responded to the usual treatment, that a regular internist may do. We do a lot of interventional procedures as well and that makes our practice unique in that sense.

Q When you say interventional techniques, can you describe for the jury in English what you're talking

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about?

A Okay, so there are -- depending on what the cause of pain is, for instance, back pain, we may do injections in the back, such as nerve blocks, that may help pain from the back shooting into the leg.

We may try to determine where the source of the pain is and try to get to that source by doing something interventional. It may be the joints, it may the discs, it may be the muscles and there are different techniques and procedures that can be geared towards each of those areas of origin of pain.

Q Have you ever treated in your practice people with diabetes?

A Yes.

Q Can you tell us on a percentage basis or over the years, how many people have you and/or your group treated with diabetes?

A Tough to determine -- a lot of our patients do have diabetes on top of other issues as well, so diabetes happens to be very common.

I would have to say twenty percent of patients have either diabetic related nerve issues or may have other issues together with diabetes.

earlier this year, did you have a physician working in the office -- the office is called Comprehensive Pain Management, correct?

A Correct.

Q Was there a doctor named Dr. Gary Thomas who was formerly your partner?

A Yes. Dr. Thomas, I have been working with for twenty years. I have known him for probably 25 years. Unfortunately, he was ill. He had cancer and he passed away earlier this year. He was also one of the treating physicians for Mr. Carter.

Q Now, did there come a time when Mr. Ed Carter became one of your patients?

A Yes.

Q Approximately, when was that?

A He was first seen in our office on September 1 in 2015.

Q At that point in time, did anything happen, did he have an exam, did he present to you, what happened at that point in time?

A Well, we had gotten the history and reviewed some of the medical records that was initially --

Q Let me stop you right there.

What records, if any, did you review with regard

to Mr. Carter?

A So there was --

Q Either at that point in time or over the course of next years?

A So there was a host of different records because he was seen and treated from his accident in 2012, so -- and he was seeing -- so we did have access to records from the initial accident.

We had access to records from -- he had already had prior surgery in 2015, prior to coming to our office and we had access -- so that was Dr. Gerling's records.

We had access to records by his foramen pain management physicians. He had some x-rays, the CT scans that were reviewed over time and he has had subsequent CT scans as well, so those medical records were available and reviewed.

Q So at the first visit Mr. Carter made to your office, what, if anything, happened, can you tell us about it?

A We had started to get a history from him. He actually had started to feel ill during that initial office visit. He developed some slurred speech and he was a little sweaty, very tired, lethargic.

interviewing him. He was noted to have a low blood pressure and his sugar level was actually low. He was treated with some orange juice, actually.

EMS actually came to the office and his blood pressure was low which we documented in the chart, was 76 over 55 which is pretty low, but subsequent to that, he started to come around and actually felt a little better.

He did not want to go to the hospital, but he did go home after that.

Q Did he return to your office within several days or weeks?

A Yes.

Q When was that?

A He came back two days later so on September 3, 2015.

Q At that point in time, did you or someone in your office, whether it was Dr. Thomas or someone else, take a history?

A Correct.

Q What is the clinical significance of a history?

A Well, the history is gathering information about -- before you even examine the patient, you want to know what injuries in his case happened, how they happened, what treatments he has had, what medication he is on and

then eventually, we will do a physical examination and then come up with a treatment plan.

Q What history did Mr. Carter relate to you at that point in time, that being September of 2015?

A Right, so the history was that he was involved in a motor vehicle accident. He was actually a passenger on July 3, 2012, where the vehicle he was in was hit from behind, it was rear ended by another vehicle.

He got thrown against -- his head against the dashboard, I think his right arm, I think, against the dashboard. He was taken to the hospital. They did some x-rays and noted no fractures.

Q You say you reviewed a number of records that Mr. Carter treated or presented to various medical professional, et cetera, before he got to you, correct?

A Correct.

Q Did he have any what's called pain management professionals, medical professionals treat him before you saw him?

A Yes.

Q Do you know if he had any -- you call them interventional procedures prior to him presenting at your office in September of 2015?

Q What type of procedures or interventional procedures, if any, are reflected in the notes or information you gleaned from him when you first spoke with him?

A That he actually had some epidural injections. That was prior to coming to our office and actually prior to surgery.

Q Let's stop a second. Can you explain to the jury what an epidural injection is?

A Yes.

Q What the significance of it is, what it is designed to do?

A Yes.

Q Sure, go ahead.

A So I do have a model of the spine which I can --

Q If you can --

A That I can take out.

Q That would be great.

A This is a model of the lower back which is a spine, I don't know how familiar everyone is with it.

The skin would be on the outside here. These are the bones that if you're going to feel your own spine, you would feel. These are the deep bones called vertebral bodies. This is the disc in between the

vertebral bodies. The discs act as a cushion for the spine.

Also, the spine, there are a lot of moveable joints called facet joints so you can actually move your spine up and down and back and forth.

The epidural type of injection, this is similar to epidurals that are done for like labor and delivery and OB, so the epidural refers to a space.

What's unique about the space is that that space is where the nerves which you can see in yellow that come out from the spinal column or cord, they come out through the foramen, pass through that space.

We can actually take a needle, which is an epidural needle which is a technique where you're going through the skin and you are directing the needle into that space and then injecting a small dose of medication, typically, it's a steroid medication, it would be a local anesthetic, it could be some saline.

That medication spreads through that space, getting close to where a nerve is that's inflamed. The nerve may be inflamed because of a disc that's pushing out against the nerve causing the inflammation which is common after trauma, for instance.

inflammation and, hopefully, help the healing process so that the pain will get better.

Now, typical pain from a disc problem affecting a nerve is pain shooting down into the leg, so that's called sciatica or radiculopathy. There is a lot of different terms for that, but it's typically shooting pain that goes into the -- depending on which nerve, it may go into the leg, it may go into the foot, it may go into the knee.

Q If you recall, approximately, how many epidural steroidal injections or epidural injections did Mr. Carter prior to seeing you?

A I don't remember the exact number, but it was a couple, I believe he had --

Q Do you know if it was in his neck or his back?

A Again, I believe he had in both, but I don't recall.

Q Did you do any sort of an examination of Mr. Carter, you or someone on your staff that day when he came in?

A Yes.

Q What type of examination did he do, is it a normal exam, describe it for us, did you do range of motion testing, what did you do?

A Yes. So he had -- again, when he came to our office, his major complaint was back and neck pain. He did have also some shoulder pain, but, again, his major complaints were the neck and the back.

Q Again, I don't mean to stop you, but are you familiar with what's called zero to ten pain scale?

A Yes.

Q Can you describe for the jury what the zero to ten pain scale is?

A So we do use a scale to at least get an idea of how severe someone's pain is and we do use a scale from zero to ten. Zero being no pain at all, ten being the most severe pain that you can imagine, so it's called a visual analog scale, VAS.

This is really -- it is somewhat subjective because of the patient, but it gives you an idea, if we do a procedure, start medication, where that scale is going and also it gives us something that we can look at in the future and see, okay, patient's pain was such and such at such a date and then proof and we do ask that quite frequently when patients come in.

Q By looking at your notes, doctor, can you tell us if Mr. Carter reported any pain scale numbers with regard

point in time, that being September of 2015?

MR. McGUINNESS: September 3.

Q Okay.

MR. McGUINNESS: Sorry.

MR. BOTTARI: That's fine.

A So September 3, 2015, he did state his lower back was a ten out of ten on the visual analog scale so it was severe. His neck, he described as a six out of ten on a visual analog scale.

Q Did he indicate to you if he had any problems with what's called ADLs or activities of daily living?

A Yes.

Q What were they?

A He was having definitely difficulty with performing normal activities that we would all take for granted, such as walking, even short distances, half a block, going upstairs, other household chores.

He complained about as far as cleaning, difficulty putting on shoes and getting dressed. He does not drive. He had to take private transportation, did not take subway to our office, but he had difficulty with those normal usual activities.

Q Did you ask him if he was on any medication at that point in time?

A Yes.

Q What did he tell you about his medications?

A He was on medication when he had first come into our office.

Q Were some of those medications related to diabetes as opposed to pain?

A Yes.

Q Can you tell us what medications he was on and whether they were for diabetes or for pain or for whatever else there might be?

A Sure. So when he initially came in to our office, he was taking one for his diabetes. He was taking insulin products, that he was taking on a daily basis or a couple of times a day.

He was on a blood pressure medication called enalapril. He was also taking Oxycodone which he was taking for pain. He was also on Lasix.

Q What's that for?

A Which is a water pill, just for swelling, also helps with blood pressure and he was taking also a heart medication called Coreg and I think Diazepam was also that he was taking as necessary. It's a Valium, it's also used as a muscle relaxant at times.

A I actually don't have it on my list, but I believe he was taking it or had taken it in the past.

Q Did he tell you in his past medical history -- what did he relate to you about his past medical history and what did you deem significant as a pain clinician?

A Well, one, during that initial office visit, he is somebody who had already had one surgery for his lower back, both in his neck and his lower back.

He also had right shoulder surgery, so his right shoulder surgery was in 2012. After the accident, his neck surgery was in February 2015 and his lower back surgery was in June of 2015.

He also had a subsequent neck surgery, I guess, as a complication from the neck surgery, where he had drainage of a seroma which is a pocket of fluid in the neck area shortly after his neck surgery which was in March of 2015.

But he also had -- besides that, he had significant issues with his diabetes. He had some heart problems. He already had a defibrillator/pacemaker that was placed in his heart in 2012, so those were, obviously, significant, at least as far as his past medical history.

Q What is the significance of family history and

why do you take it?

A Family history is important, not so much necessarily in the pain management realm, but you do want to know if there is any family history of whatever medical problems or issues. It doesn't always reflect on our future as far as pain management, but family history is typically taken.

Q Did his father and mother have diabetes?

A Yes.

Q Did he indicate to you what his height and weight was?

A I believe so, yes, so he was five foot eleven inches and 257 pounds.

Q You are aware that at some point in time, in fact, at the time of this accident, do you know what his weight was?

A I do not.

Q I want you to assume that it was about 305 pounds, give or take.

A Okay.

Q Now, did you do a general examination of him and then a specific examination of him with regard to the cervical spine, the lumbar spine, et cetera?

Q Can you tell us, is this a -- tell us how you do it, is it hands on, using tools to measure, just tell us what you do?

A Physical examination is a hands on examination. We sometimes use tools to ascertain reflexes or to tell where there is numbness or tingling. We do feel the spine for different areas of spasm.

We do some range of motion testing as well, to see how, for instance, the neck, how far they can extend or flex the neck. The same thing with the lower back and the shoulder, so those are commonly done.

Q Did you examine his neck?

A Yes.

Q And can you tell us what type of exam you did with regard to his neck and what you found, is there a range of motion test that you did, tell us what you found and what is normal?

A Okay. So we did -- his neck was examined during that initial and subsequent office visits and again, he was noted to have spasm along the cervical paraspinal muscles. Those are all the muscles going down the neck going down into the upper back.

Q Let me stop you again. What is spasm and can spasm be faked?

A So spasm is referring to muscles in a particular area that are tight and that sometimes you can actually feel them and palpate them when they are tight versus areas that are not tight, so those are areas that actually can be palpated.

It can also be painful, there may be areas that are very painful and we do -- besides asking the patient, we do observe the patient and see which areas are most painful.

A lot of times, we will focus specific treatment to those painful areas. It may be treatment with an injection in a muscle. It may be something deeper because usually there is a cause of the muscle spasming and it may be a disc. It may arthritis in the area, so we may target those areas in the future.

Q Can spasm be faked?

A It's very difficult to fake spasm, so it is more of an objective type finding, versus patient just saying they are in spasm.

When you do feel muscles, and you can differentiate one side versus the area, there may be areas of -- spasms do feel different.

Q Did you do any range of motion testing on

A Yes.

Q And can you tell us, and you can show us what you mean when you say flexion on extension or rotation?

A Sure.

Q And what's normal and what you found with him?

A Well, again, he did have prior surgery, so he had a scar which was slightly tender. He did have with the range of motion, in particular, so flexion which is bending forwards, 40 degrees and normal is about 40 degrees, but he did have some pain with that movement.

He had extension at 5 degrees, he had more pain with bending his head backwards at about 5 degrees, normal is 40 degrees, you can actually extend it much more.

Right lateral bending at 10 degrees and normal is about 45 degrees. He had pain with moving his head to the right side. Left lateral bending was at 15 degrees.

He was also noted to have some weakness and they were measured in his right and left upper extremities. Again, the left upper extremity was measured at -- this is hand grasp at 60 pounds. Right upper extremity at 65 pounds, so both of those were diminished and weak.

He was also noted to have some decreased sensation in his upper extremities along C-6 and C-7

dermatomes.

What that refers to is the nerve that comes out from the neck, again, there are nerves coming from one to eight in the neck area and those go to different areas of the upper extremity, or the head in that matter.

But he had -- and if you just start feeling it where he had the numbness and tingling, along C-6, C-7 which is actually these fingers in the middle fingers, so not the little finger, but the thumb, the index finger, the middle finger, so it follows that distribution.

So that was -- he also had -- I mean most of his pain was into the right upper extremity, so there is actually a test called the Spurling test which we did which is essentially bending the head backwards, a little tilt and putting pressure on top of the head and kind of reproducing some of the pain that goes into his upper right extremity and that was positive and significant for some type of nerve compression against -- from the cervical spine into his upper extremity and that was positive, at least as far as the neck area.

Q At what level was that, approximately?

A The Spurling test, I mean, he had pain shooting down, again, it was about C-6, C-7, consistent with the

Q Now the range of motion testing up on his neck, given the fact that he had surgery, in 2015, on his neck, would those range of motion decreases be permanent at this point in time?

A Yes, so --

MR. McGUINNESS: Objection, your Honor.

THE COURT: Overruled.

Q Now, did you examine his back?

A Yes.

Q What did you find with regard to his back?

A So in his back, on physical exam, I am feeling the muscles in the back, so the lumbar spine, the paraspinal muscles which are the muscles on the outside, it's a lot of musculature on the lower back, so those were spasm, again, going from L-3 to S-1, in the lower back, noted to have pain when he was standing upright and bending backwards, there was noted to be pain.

He had what we call a positive straight leg raise. In other words, with him raising his leg up, he had pain shooting down into his lower extremity, again, at 30 degrees on the right, so you raise his leg up, approximately, 30 degrees and he had pain shooting down the leg on the right. On the left, it was about 45 degrees.

Q What is normal on a straight leg raising test, approximately?

A You shouldn't have any pain into your lower extremities with a positive straight leg raise. What happens is when someone has compression and there is, let's say, a disc or something is irritating a nerve, when you raise the leg, you are actually pulling -- stretching the nerve out from the spine and if that's irritated, it may -- it can reproduce pain shooting down into the leg and to the lower extremity, so that's significant for some type of some compression or something going on with the nerve.

Q Just in general, doctor, if you have a positive straight leg raise test as you found here, what generally are the areas in the lower back that would produce that type of pain?

A Well, you are talking about some nerve, it could be L -- which is most common, L-4, L-5 nerves which are most commonly affected and they are compressed, whether it is from a disc or probably surgery or something is irritating that nerve, so that's most commonly seen and reproduced with physical examination.

Q Did you make any notations at that point in time

A Well, he definitely had a gait disturbance and during that office visit, he was using a walker, but he does use a walker and a cane most of the time, I think as well, he was using a cane, most of the time.

Q Did you make any assessments with regard to his neck and his back at that point in time?

A Yes.

Q And can you tell us what assessments you made and what the significance of that was, specifically, with regard to the neck and the back?

A Yes, so he is and our assessment after doing an exam, getting the history is someone who is supposed -- cervical fusion with continuation of radiculopathy or radiculitis, that is referring to the pain going down into his upper extremity as well as post lumbar fusion with continuation of radiculopathy, which is the shooting pain into his lower extremities and in addition to myofascial pain which is referring to the musculature in his neck and his lower back.

Q I want you to assume that there has been testimony that Mr. Carter has indicated that he had pins and needles going down his legs for a number of years prior to July of 2012 and he was being treated with, among other things, Lyrica, for that.

First of all, is Lyrica a medication that is given for people with diabetes?

A Yes, so Lyrica is given for patients with diabetic -- it's actually indicated for diabetic neuropathy. We use it quite frequently for other nerve disorders.

I suppose it's off label, but somebody who has radiculopathy, even sometimes chronic headaches, any nerve related issues, post shingles pain, we will use Lyrica as well, so it is good in the sense that it helps subside nerves.

It's actually an antiseizure medication, that's used for that as well. What it does, it gets nerves to settle down, so it may help with some of those symptoms.

Q Is the diabetic neuropathic pain that you are aware of, just in general, the same type of pain, this radicular pain from a herniation in the back or something like that?

A So when it comes to diabetes, the pain presentation is actually very different than back presentation and radicular pain, so diabetic pain in patients are usually in the feet, it doesn't follow a particular nerve.

stocking/glove type of sensation, it is usually numbness, tingling, burning sensation and may encompass, for instance, the whole foot.

Particularly, diabetics have it in their feet versus other areas. Radicular pain or back pain is quite different in the sense that it is more sharp shooting. There may be some numbness and burning sensation as well.

I suppose there is some overlap, but the presentation is quite different for radicular pain versus diabetic pain. Also, diabetic pain in the upper extremities are not very common.

Q After your first examination, did you come to any conclusions on how to treat Mr. Carter?

A Yes. So the treatment, again, when we treat patients, we are treating them in many different ways, so one, we revisit one medication and see what he is on, what works, what doesn't work and make recommendations and make changes as far as that goes.

Then there are also some interventional procedures that we had discussed during that initial office visit.

In particular, the interventions that we discussed were one, something called a transforaminal injection.

That is similar to an epidural injection that I described before except that because he has surgery, he has a very complicated back because there tends to be a lot of scar tissue post-surgery.

It's also not easy to get an epidural needle into that space and to spread the medication because of the prior surgery, so there is a different approach.

There are a couple of different approaches, but one is called transforaminal which is coming more on the outside and getting close to a nerve on the outside, so that's in his case, L-4, L-5 nerve and injecting a small dose of steroid that goes down close to that nerve root and may help with the shooting pain going into his lower extremities.

We had discussed other interventions because he had pain both in the neck and the lower back, where standing upright or bending backwards or bending his neck backyards, that was felt to actually be coming from the joints in the neck and the lower back.

These are called facet joints, so there are particular injections that could be done to help with that particular pain and those injections are facet joint injections.

procedure called radiofrequency which is a procedure where a needle is placed close to the little nerve that goes to those joints and you are destroying that little nerve using radiofrequency.

It's essentially heating the tip of the needle and destroying that little nerve that goes to those joints and helping with pain, so that's called radiofrequency of the facet joints which, again, these joints are throughout the spine, cervical, thoracic and lumbar. We had discussed other options including Botox injections.

Q For what areas, doctor?

A Botox was mostly for his neck area because he had significant spasm and diminished range of motion in his neck.

Botox is an injection that could be done in the muscles and what they do is they cause muscles to relax, so Botox, most people are familiar with it because it's used for wrinkles, but essentially, it's causing musculature which wrinkles are contraction of the muscles, it causes it to relax. It smooths out muscles. It could be injected in the neck area. It's very commonly done now for headaches, for migraine headaches, so that was also discussed.

We had discussed more interventional type of procedures, something called a spinal cord stimulator which were discussed actually for a long period of time, over the past few years, as far as putting in a wire device in the back or neck.

Most of this pain, when we had seen him initially, was the lower back. That wire which goes in the epidural space in the spine, a little higher than the lower back, causes -- gets hooked up to a battery and the battery generates an impulse that goes through the wire that essentially covers up some of his pain that he feels in the back and the lower extremities, so we had discussed that on multiple occasions.

That is something that is actually highly recommended. Of course, he has multiple medical problems and we are dealing with that and he had some subsequent injury, so there have been barriers in some of these treatments.

Q Did you see him again on September 29, 2015?

A Yes.

Q Just briefly, were his complaints about the same, worse, better, you tell us?

A So his complaints were essentially the same. I

to the lower back, pain shooting down into the right hip and down into the right lower extremity. He was describing that sharp shooting, numbness, tingling sensation going down into his legs and he was still having pain in the neck area as well going into his upper extremities.

Q What were his pain scale levels if they were recorded?

A The lower back, he complained of eight to nine out of ten versus the neck which was six out of ten.

Q So there was a slight improvement as opposed to ten out of ten in the back?

A Correct, and he was, again, started on some different medication which we frequently follow-up with him and make adjustments.

Q Did you do range of motion testing and do all the same types of things that you did during the earlier September 3, 2015, office visit?

A Yes.

Q Without listing everything, were the results similar, give or take?

A Yes.

Q Did you make any recommendations or do any sort of treatments, interventional or otherwise, at that point

in time?

A So yes, we had actually further discussed the idea of that spinal cord stimulator. We were actually -- our approach was to push that a little bit more and try to get authorization for that stimulator.

Then we had discussed the radiofrequency procedure which is to the facet joints as well during that office visit. I do not believe he had any particular injection done during that follow-up visit.

Q When was the next time you saw him, doctor?

A The next visit was on October 6, 2015.

Q Briefly, what were his complaints, were they approximately the same?

A Yes.

Q Were any medications added to his medication list and what was the significance, if any, of that?

A Yes, so one, he was given -- I mean, it was noted during that office visit that he was on Lyrica, so that was added to his list of medication because I don't think it was on the initial office visit, but on the subsequent, we did.

He was still taking all his blood pressure medication, his heart medication. He was started on an

that was changed to Percocet during this latter visit.

Q Is that also a narcotic medication?

A Yes.

Q Is that a fairly strong narcotic medication, how would you describe it?

A Yes. So both Percocet and Hydromorphone which is Dilaudid are both opioid medication. They are a highly addictive type medication, so they are strong. There are definitely dependency issues with any of these medications.

Unfortunately, there is not great alternatives when it comes to pain, so sometimes, we are forced to actually give some of these narcotic medications.

The other type of medications that are used for pain, they all have limitations and risks, so everything poses a little bit of a risk.

Q Did you see him several more times during the year 2015?

A Yes.

Q Just to speed it up, tell me about his complaints, were they the same, worse, getting a little better, how many more times did you see him in 2015?

A We saw him three more times in 2015, so October, November, December, we saw him.

Q Was he still having complaints of pain in his back and neck?

A Yes.

Q What were the pain levels, approximately?

A Again, they were -- they all ranged anywhere between usually eight out of ten. The medication would help a little bit.

He stated in November that the pain medication dropped it down to a five out of ten with the medication, but he is still having the pain shooting into the leg, neck pain was seven out of ten.

Q So the medication was helping a little bit, correct?

A Correct.

Q But not wiping out his pain?

A No.

Q Did you then see him in February of 2016?

A Yes.

Q At that point in time, was he still complaining about what you described as radiculopathy?

A Yes.

Q To which areas of his body?

A Both his lower back to his leg and especially the

neck pain going into his upper extremities during that office visit, it was more on the right side than the left.

Q Were any interventional procedures done at that point in time, that being February of 2016?

A Yes.

Q Can you tell us what was done, if you can describe it briefly and what the effect, if any, was?

A Yes, so he had during that office visit a what we call diagnostic facet joint injection which is what I described before.

There are joints in the back called facet joints where one bone kind of sits on the other one.

It's a moveable joint, so he had a diagnostic block which is done with local anesthetic to see if it helps with the pain, so it's a needle approaching close to that joint or getting close to that nerve that goes to the joint and injecting some numbing medication and seeing if this helps.

This is in anticipation of doing a more permanent procedure of radiofrequency procedure which he subsequently had.

Q When did he have the radiofrequency procedure?

A He had the radiofrequency on February 17, 2016.

Q Can you tell us what that procedure consisted of and at what levels you put it in at and what was the net result to Mr. Carter?

A Okay, the procedure is as I described before, is taking a radiofrequency needle, at this point, placing it into the spine near where the nerve is that goes to these facet joints and that tip of that needle is heated to 80 degrees Celsius.

Q How hot is that?

A It's hot, it's up there, 200 degrees Farenheit, and essentially, it's destroying that little nerve that goes to those joints and that's done -- you're doing 60 seconds at each level.

In this case, it was the levels of the joint spaces at L-3-4, L-4-5 and L5-S1, so three spots in the lower back, the lower three and hopefully, that helps. Most of his pain was on the right side.

What's nice about it is that you are destroying the nerve, you are not using any steroid medication which has always been an issue with him because of his diabetes.

It can sometimes increase the sugar level, so that always has to be taken into consideration with any

It did help significantly with that right sided localized pain. It doesn't always help with the pain shooting down into the right lower extremity because the source of the pain is different, so as I tried to explain before, there are different sources of pain.

There may be the joint, there may be the disc, there may be the nerve and each pain could be treated differently.

Q Did you note at any point in your chart, either on that visit or the next set of notes in March of 2016 whether that procedure helped Mr. Carter?

A It did. It helped. I'm looking for the percentage, but he did note that it did help with that localized pain in the lower back.

Q Was there a percentage or did you just say it helped?

A I'm looking for the percentage. The diagnostic block, I see that it helped about 80 percent with the localized pain and the radiofrequency. I don't see exact percentage, but he was evaluated for radiofrequency of the neck as well after that.

Q But did he next see you in March of 2016?

A Yes.

Q Can you tell us how he was doing in terms of his

neck and back pain and what procedures, if any, you performed?

A So on March 15, 2016, when he came back, he was complaining actually more of neck pain during that particular office visit and he had subsequently done the radiofrequency for the lower back, so that wasn't bothering him as much.

Again, I don't see a percentage, but that wasn't the main issue. The main issue was the neck and more on the right side, so for the neck, he actually during that office visit had a diagnostic facet joint injection done on the right side, again, at C-3-4, C-4-5 and C-5-6 which are the three cervical areas.

That diagnostic block was done and he did have some good relief after the local anesthetic and, again, that's in anticipation of doing a radiofrequency for the cervical spine which he subsequently had done a few weeks later on May 11.

Q April 11?

A April, sorry, April 11, 2016.

Q So what were his pain levels if you have them noted with regard to his neck and back in April before he underwent the radiofrequency cervical facet ablation

A So the pain level which again was mostly in his neck during that particular office visit was eight to nine out of ten.

Q How was his back?

A Actually, it says eight to nine out of ten and I'm looking at the office note on March 15, 2016.

Q So in April, he underwent what, doctor?

A He had the radiofrequency cervical facet on the right side, again at C-4-5, C-5-6 and C-6-7 levels.

Q What is a trigger point injection?

A Trigger point injections are muscular injections where a needle is placed deep within a muscle. It could be in the neck or the lower back and a numbing medication such as Bupivacaine, it's typically injected, and in his case, it was injected in the deep muscles in the neck and lower back and they do help one with pain, help diminish spasm, help with range of motion and facilitate him doing exercise and massage and improving range of motion and trying to maintain that muscle relaxation, so he had trigger point injections on multiple visits including when we did the diagnostic block and the radiofrequency.

He also had some Botox injections as well in the neck area.

Q Did he indicate how the trigger point injections

and radiofrequency ablation techniques helped him or hurt him or what?

A They did help with his pain, so he did indicate that they were helpful with the pain and range of motion.

Q Just going back for a second, February 17, 2016, is there a note that you switched out his medication from Percocet to Dilaudid?

A What office visit was that?

Q February 17, 2016.

A So, yes, I believe that his medication was changed during that office visit.

Q Is Dilaudid the same strength, less a strength, tell us what the difference is and why?

A Dilaudid is another narcotic medication. He was taking four milligrams which is, again, is it similar to Percocet, they are both narcotic medications.

Sometimes, when one doesn't not work well, though they might have similar receptors, a different narcotic which is similar in strength, it may be slightly stronger, but similar enough, they bind slightly different to those receptors and actually may be more effective.

Q Moving to April 14, 2016, any procedures at that

A So on April 14, which I described before, he was having significant spasm in the neck area, so we actually did Botox injections in the neck area.

Botox is similar to what I described before with trigger points, but instead of injecting a local anesthetic or muscle relaxant, you are injecting Botox into those muscles.

Botox is unique in the fact that it causes relaxation that lasts for an extended period of time, so it may last three to six months versus a trigger point which only may last two to four weeks, so he did have Botox done during that office visit.

Q You continued him with the regimen of the medications that you described to us earlier?

A Yes, so the medication, again, we constantly reevaluated him and we did make changes throughout on multiple office visits, but essentially, the regimen was the same.

Q Now, did he again present to you in July of 2016?

A Yes.

Q What type of complaints did he have?

A He was still complaining of lower back pain shooting into his right lower extremity. He was describing numbness. He was describing neck pain and

spasm shooting into his left upper extremity.

He was having some issues with medication, some constipation and then he was actually given a medication to help with the constipation that caused diarrhea. There was changes in that.

Q When you assumed -- he had a second back surgery in September of 2016, are you aware of that?

A Yes.

Q So the next time you saw him was when?

A We saw him in November of 2016.

Q Did he complain to you at that point in time with regard to his neck and back?

A Yes.

Q What type of pain was he experiencing in his neck and back at that point in time?

A So he was describing pain, again, he just had undergone the revision surgery in his lower back and what he was describing mostly during that particular visit was the lower back with pain shooting into the back of the right leg.

He described it as an eight to nine out of ten during that office visit, despite the use of pain medication.

on at that point in time?
A Well, he was still taking -- I believe he was on Percocet and he was continued on the Percocet. It was actually changed to Oxycodone which is a formulation of Percocet without the Tylenol during that particular office visit.
Q When was the next time you saw him, was it in 2017?
A Yes, January 24, 2017.
Q What were his complaints at that point in time, just briefly?
A He was still having issues with lower back pain. In the interim, since we had seen him the last time --
MR. McGUINNESS: I would object about the visit on the basis of non-disclosure as to visits in 2017.
MR. BOTTARI: He is a treating doctor, Judge.
THE COURT: I'm going to permit it.
MR. McGUINNESS: Can I have a ruling?
THE COURT: Yes, I said I was going to permit it.
MR. McGUINNESS: Am I overruled?
THE COURT: Overruled.
Q So tell us, did you see him in 2017?

A Yes, so we had seen him in 2017, so he gave us a history, one, he had the back surgery, but in the interim, he also was admitted to Montefiore Hospital.
He had issues with diabetes, high glucose level. He had an amputation of his left big toe, I think the big toe and the second toe and he was in a rehab facility.
He was still on antibiotics, but he was regardless complaining of lower back pain and pain shooting into his lower extremity during that follow-up visit.
Q How many times overall did you see him in 2017?
A 2017, he came to our office, approximately, ten times.
Q During those time periods, was his neck and back pain ever zero?
A No.
MR. McGUINNESS: Objection, on the basis --
THE COURT: Same ruling.
Q At any time during 2017, did your office perform anymore what you called interventional procedures?
A No. He didn't have any injections during that time period.
Q Approximately, just briefly, what were his pain

MR. McGUINNESS: Continuing objection, your Honor.
THE COURT: Of course.
MR. McGUINNESS: Thank you, your Honor.
A The levels remained high. Anywhere from seven to eight out of ten, to ten out of ten depending on the day.
When it comes to pain, it's actually very dynamic, so it may change. There are a lot of factors that affect pain including when he took medication and what the pain is or what are his activity levels, so that changes, but it was pretty constant and ranged anywhere from seven to eight to ten out of ten.
Q Did you see Mr. Carter -- by the way, you were still prescribing medication to him, correct?
A Yes.
Q Did you make some changes to the medication regimen over that period of time in 2017?
A Yes.
Q What was the basis of changing the meds?
A The basis was, we are dealing with pain issues, especially someone who has had back and neck pain. He has been on opioid medication which we had actually stopped at one point and put him on something called Buprenorphine and then we had restart and that wasn't

really helping with the pain.
We had restarted the opioid medication and he was still on the -- what we call adjunctive medication, he was on a muscle relaxant, he was on Lyrica and they weren't quite helping enough with the pain so he's not somebody that can take an anti-inflammatory medication because there are issues with that, especially with diabetes and heart problems and it can affect the kidneys and the liver and Tylenol can affect the kidneys and the liver, so you are a little bit stuck as far as medication goes.
So that's why there were various changes throughout and we tried different modalities, different narcotics anywhere between long acting, morphine products to Fentanyl patch that was on his skin, to Percocet, so, again, that was constantly reevaluated and changes were made just a little bit trial and error to see what works, what doesn't work.
Q Did you see him in the year 2018?
A Yes.
Q And can you tell us briefly how many times you saw him in 2018?
A We saw him --

THE COURT: Overruled.

A We saw him about six or seven times in 2018.

Q Can you tell us, were his pain scales ever zero for the back and neck?

A No.

Q What were they on average, approximately?

A Eight out of ten.

Q Was he under the same medication regimen give or take a few changes by yourself or your other office professionals?

A Yes.

Q Did you do the same type of range of motion testing, same type of checking for spasm and things like that?

A Yes.

Q Did he have spasm when you examined him?

A Yes.

Q Did he have range of motion deficits for both his back and his neck?

A Yes.

Q Have you seen him in the year 2019?

A Yes.

Q Approximately, when?

A We saw him three times in 2019 on January 21,

2019, March 6, 2019 and April 1, 2019.

MR. McGUINNESS: Same objection, your Honor.

MR. NASTRO: As well.

THE COURT: Same ruling.

MR. McGUINNESS: Overruled?

THE COURT: Same ruling, yes.

Q The last time you saw him, what were -- that being April 19, 2019, correct or April of -- when was it?

A April -- yes, April 1.

Q Can you tell us what his pain scales were, neck and back?

A Yes, so he was complaining of pain both neck and the lower back. It would range from eight out of ten, going down to seven out of ten, depending on the medication, his usage of medication.

Q Have you seen any recent CT scans from Mr. -- that were done on Mr. Carter either in 2008 or 2019?

A Yes.

MR. McGUINNESS: Objection, your Honor. Non-disclosure.

MR. NASTRO: As well.

THE COURT: Let's have a side bar.

Q I will withdraw the last question, doctor.

Doctor, do you have an opinion within a reasonable degree of medical certainty what diagnostic or interventional procedures or pain medications that Mr. Carter will require at this point in time and in the future?

A Yes.

Q What is your opinion with regard to the future, how long will he need these interventionals, if you will, or pain medications, et cetera?

A He will, unfortunately, need pain medication for the rest of his life.

That would include some type of opioid type of medication, versus the nerve type of medication and the muscle relaxant and possibly some other newer medications which we had discussed with him, again, for the rest of his life.

Q Can you quantify in terms of dollars, approximately, how much pain medication Mr. -- on a monthly basis Mr. Carter will require?

MR. McGUINNESS: Your Honor, can I object? I would like to object and take the witness on voir dire.

THE COURT: Okay, you may. Brief voir dire.

VOIR DIRE EXAMINATION BY

MR. McGUINNESS:

Q Dr. Mandelbaum, you supplied a narrative report back in November of 2016, right?

A Correct.

Q Or your office did?

A Yes.

Q And you have not supplied any narrative report since that time, correct?

A Correct.

Q Now, you listed future expenses for certain procedures, correct?

A Correct.

Q Those procedures have diagnostic codes, correct?

A Correct.

Q And each of those diagnostic codes will have a price or a value that is established by either the no-fault regulations or Medicare regulations, correct?

MR. BOTTARI: Objection.

THE COURT: Sustained.

Q Are there regulatory prices for those -- for those procedure codes?

MR. BOTTARI: Objection.

A There are standard fees.
Q I didn't ask that. Are there regulated prices for those procedures and those treatments?
MR. BOTTARI: Objection.
Q Procedure codes?
A Within the work injury system, there are certain prices that are established, yes.
Q And does your report reflect those precise prices that are established by the regulations, yes or no?
MR. BOTTARI: Objection.
THE COURT: Sustained.
Q Do they reflect the exact prices established by the regulations?
MR. BOTTARI: Objection.
THE COURT: Sustained. Let's have a side bar again.
(Discussion held at side bar.)
Q Under the Medicare regulations, are there scheduled prices for these -- for those procedure codes and for those medications?
MR. BOTTARI: Objection.
Q Yes or no?
THE COURT: Overruled.
A There are prices, yes.

Q And do the numbers here, they reflect the actual prices and fees permitted under the Medicare regulations, yes or no?
MR. BOTTARI: Objection.
THE COURT: Overruled.
A The prices reflect --
Q The actual prices, doctor, yes or no, these are not, are they?
MR. BOTTARI: Objection.
Q They are not, are they?
A They reflect our prices.
Q I didn't ask your prices, doctor.
MR. BOTTARI: Objection.
THE COURT: Don't argue.
MR. McGUINNESS: I won't.
Q I'm asking, are they the prices that are listed in the regulations under Medicare for those procedure codes, simple yes or no question, doctor?
A No.
MR. BOTTARI: Objection.
MR. McGUINNESS: Thank you.
THE COURT: Do you accept Medicare, doctor?
THE WITNESS: We do accept Medicare, yes.

(Discussion held at side bar.)
THE COURT: We're going to take a five-minute recess. Everybody can get up and stretch.
(Recess taken.)
MR. BOTTARI: Let the record that during my direct examination of Dr. Mandelbaum, I asked Dr. Mandelbaum for projected treatments and costs in the future.
Counsel for the City of New Rochelle objected and did a voir dire on the usual and customary, quote, unquote, Medicare rates and that those were similar to the projections in Dr. Mandelbaum's disclosure. Obviously, they are not Medicare acceptable or Medicare accepted rates.
The Court instructed me to ask Dr. Mandelbaum approximately how much his office has billed and how much it has been paid over the last several years.
He informed me that the sum was approximately about $15,000 in bills. He has been paid approximately $6,000 from he says, he thinks no-fault. He has not been paid any bills that his office has submitted to Medicare.
Apparently, Medicare is taking the position that since this is a litigation case, they will pay

nothing until the case is over and will assert a lien on whatever or any of the proceeds.
I'm not sure on that part, but he has been told that his -- that whatever bills he has submitted to Medicare have not been paid, so there is an outstanding balance of approximately, $9,000 of the $15,000 and I understand that counsel has an objection.
THE COURT: Mr. McGuinness?
MR. McGUINNESS: Yes, your Honor. The problem that I have with it is he is only entitled to the regulated rates, whether it be Mr. Carter, no-fault.
My understanding, they are pretty similar. We don't know why Medicare is not paid. They may have determined that it was not medically necessary. They may decide that there is not -- they may have peer reviewed and said this is not something that's warranted under the circumstances.
We don't actually know why Medicare is not paying, but whether he gets it or doesn't get it, these are specific numbers.
To go in there with a street rate or his

he's not entitled to that.

Mr. Carter wouldn't be entitled to it, so what you're doing, by allowing him to go into those numbers, he's going to create an inflated number for the jury to use as a yardstick.

He's going to create the impression in the jury's mind that there is a bigger number as a reason to award something, and when, in fact, the number the jury is going to hear has got nothing to do with the reality of what the costs of these services actually are.

It will be confusing to the jury. It's going to be misleading to the jury and we're going to object to anything unless it is specifically code by code, diagnostic code by diagnostic code, line by line of what he is actually given in terms of medications and the treatment, submitting that issue to the jury, that they could only speculate as to a number somewhere between one place and another.

MR. BOTTARI: Judge, I would only add that not all doctors take Medicare and Mr. Carter should be entitled to see the doctors he is continuing to see, whether or not they take Medicare.

THE COURT: Anything else?

MR. NASTRO: I'm going to join in co-Defendant's objection.

THE COURT: All right. We have discussed this at the side bar.

My conclusion is that the doctor can testify as to what he has billed and what's outstanding and what he has been paid, that he can testify as to what his customary charges would be for future care, that, obviously, there is no guarantee as to Medicare in the future or as to what positions were taken, but that certainly, the defense will be entitled to a collateral source hearing post-trial on the issue of future medical expenses, if there is an award for future medical expenses to be contemplated, but since it's a lienable amount, the jury is entitled to consider it, make an award and then the lien could be paid from the award. That's where we are.

MR. McGUINNESS: Your Honor, just one point, as far as the lien, Mr. Bottari provided or showed me two letters from CMA, the Medicare or Medicaid lien people, both in 2016 and up to 2018, there are no Medicare liens.

MR. BOTTARI: Right. That's because --

MR. BOTTARI: Apparently, they refused to pay.

MR. McGUINNESS: Well, no, refused to pay because it wasn't medically necessary.

THE COURT: The jury is not bound by that. You can argue that these treatments are not medically necessary and he can argue that they are.

MR. McGUINNESS: But that shifts the burden of proof.

THE COURT: No, no. He doesn't have to be bound by whatever no-fault or Medicare may have ruled or may be considering.

He can produce as medical evidence and you can produce through cross examination or otherwise contest it.

MR. McGUINNESS: That's fine.

THE COURT: Thank you, gentlemen.

MR. McGUINNESS: So our objection is overruled.

THE COURT: I guess overruled, modified or explained.

MR. McGUINNESS: Exception, your Honor. Thank you.

THE COURT: Doctor, you may take the stand

again. We will bring the jury in and we will continue.

By the way, one of the alternate jurors is not feeling well, Alternate Number 1 wants to speak to us.

MR. BOTTARI: That's fine, your Honor. I saw her in some discomfort when we started the matter this morning. She seemed to be in some sort of discomfort.

THE COURT: Do you want to bring her in and question or let her go?

MR. McGUINNESS: I'm fine, your Honor.

MR. BOTTARI: I will consent.

MR. McGUINNESS: Me too.

THE COURT: We will just let her go.

MR. BOTTARI: You may want to bring her in so the other jurors don't get the impression that you just walk out.

COURT OFFICER: The other jurors are defending her also, asking for a break for her.

THE COURT: We will bring her in.

(Juror enters courtroom.)

THE COURT: We were advised that you're not

don't know if she has to go down to -- check with the Commissioner of Jurors, but this service will have satisfied your obligations. We will let you go.

MR. McGUINNESS: Thank you.

COURT CLERK: She can go straight home.

COURT OFFICER: Alternate Number 1, Cabrera.

(Juror exits courtroom.)

THE COURT: The jury is anxious to know the scheduling too, I'm going to bring that up.

MR. BOTTARI: I think the doctor should be finished by quarter to 1:00, I hope.

MR. McGUINNESS: I have Dr. Dickson at two.

THE COURT: It may not be as long.

MR. BOTTARI: Then Dr. Weintraub tomorrow morning.

THE COURT: We're not going to be in session tomorrow afternoon.

(Jury enters courtroom.)

THE COURT: Be seated, everybody.

Sometimes, our evidentiary discussion takes a little longer than others, but we are ready to proceed now.

We will continue. Mr. Bottari.

DIRECT EXAMINATION

BY MR. BOTTARI:

Q Good morning again, Dr. Mandelbaum.

A Good morning.

Q At the break, did I ask you to make a phone call to your office to determine how much your office has approximately billed for all the treatments that you rendered to Mr. Carter over the last several years?

A Yes.

Q Approximately, how much of that -- approximately, what is the amount of the billings that you are aware?

A It is approximately, $15,000.

Q Of that amount, how much has been paid?

A About $6,000.

Q Now, can we talk about what you recommend for the future. You can refer to your report, that narrative report, okay?

A Yes.

MR. McGUINNESS: Continuing objection, your Honor.

THE COURT: So noted.

MR. McGUINNESS: Thank you, your Honor.

opinion within a reasonable degree of medical certainty as to what Mr. Carter is going to need on an ongoing basis, I believe you testified for the rest of his life; is that correct?

A Correct.

Q So we can save some time, are all of the opinions that you are about to give us within a reasonable degree of medical certainty?

A Yes, they are.

Q Are all of your costs in the future over his life span, whatever that is?

A Yes.

Q What in your professional opinion at this juncture, do you have an opinion as to what medications he will need in the future?

A Yes.

Q And, approximately, on a monthly basis, how much of those -- what's the reasonable and customary cost of those medications?

A Looking at what he is currently on which has changed over the years, it's about $1,200 per month in medication costs.

Q Do you have an opinion if he needs any what's called pain management office visits?

A Yes. He will need to continue to come to pain management for reevaluation on a monthly basis at a cost of $200 per office visit.

Q That's one a month for life?

A Once a month for life.

Q Do you have an opinion as to whether he needs he follow-up procedures with spine surgeons or anything like that?

A Yes, so he will need to continue to follow-up with an orthopedic spine surgeon once every three months for the rest of his life at a cost of $300 per office visit.

Q Do you have an opinion as to whether he needs any treatment plans from a spine surgeon or anything like that?

A Yes, within a reasonable degree of medical certainty, he's going to need future surgery for his lumbar spine in the upcoming future.

Q Do you have an opinion as to whether he needs any lumbar epidural steroidal injections with lysis of adhesion?

A Yes, within a reasonable degree of medical certainty, he will need an epidural injection. This is a

little bit more complicated, at the cost of $2,000 per injection, $1,000 for anesthesia, a facility fee of $2500, we are talking three injections, over two-year span for the rest of his life.

Q Do you have an opinion as to whether or not Mr. Carter needs any transforaminal steroidal injections?

A Yes.

Q What is your opinion?

A Within a reasonable degree of medical certainty, a transforaminal injection would be helpful for his radicular pain at a cost of $2,000, plus $2,500 facility fee once every two years for the rest of his life.

Q And how about radiofrequency facet ablation?

A So radiofrequency facet ablation is also medically necessary too, at a cost of $2,000 for the injection, plus an anesthesia of $1,000 plus $2,500 facility fee once every two years for the rest of his life.

Q Do you have an opinion with regard to the same type of procedure with regard to the cervical spine?

A Yes, so a radiofrequency for the cervical facet injection which he has had and would continue to need, the cost would be $2,000 for the injection plus $1,000 for anesthesia plus $2,500 facility fee once every two

years for the rest of his life.

Q How about any cervical transforaminal steroidal injections?

A Yes, the cervical transforaminal injection is medically necessary at a cost of $2,000 per injection, $1,000 for anesthesia and $2,500 for facility fee.

Q Did you already do the radiofrequency cervical facet?

A Yes.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Carter needs a spinal cord stimulator?

A Yes. Which we have discussed quite frequently with Mr. Carter, a spinal cord stimulator would be ultimately the best modality for his ongoing pain.

This is a device that could be placed for the lower back pain shooting into his legs and the neck, so it's actually two separate devices.

The spinal cord stimulator is done in two parts. There is a trial and if the trial is effective, a permanent one could be inserted, so the cost of a trial which includes two leads is $12,000 -- $12,197.04, again, once within the next five years. That would be a so two, actually double. If he ends up --

MR. McGUINNESS: Objection, on the basis of non-disclosure.

THE COURT: Overruled.

A The cost of a permanent implant which is a permanent placement of the leads in the spine, separate leads for the lumbar, separate leads to the cervical, it gets attached to an implanted generator that's actually implanted under his skin, the cost of that is $46,493, once within the next five years, in addition to the anesthesia cost and the facility costs since it's an operation and that will range between $30,000 and $50,000 for the facility fee.

MR. McGUINNESS: Objection, non-disclosure.

THE COURT: So noted. Overruled.

A In addition, the longevity of the permanent placement is approximately ten years and would need to be -- the generator would need to be replaced at a cost of $24,000, again, added to the cost of the physician fee of $3,000, anesthesia fee, approximately, $2,000 and the facility fee will range because it's an operative procedure, probably closer to $20,000 to $30,000 for the facility.

Q Do you have an opinion as to whether or not

Mr. Carter needs any trigger point injections?

A Yes, so trigger point injections which he has had in the past are those muscular injections and they are very helpful on a more continuous basis.

The cost of those injections, could be done both cervical and lumbar, are $300 per set of injection, one injection every three months for the rest of his life.

Q How about with regard to Botox injections?

A The Botox injection which similar to trigger point injections adds a lot of longevity when the spasm gets really bad, it does help subside a significant amount of spasm, it could last for up to three months. The cost is $1,500 per set of injection and we are talking one set once a year for the rest of his life.

Q How about MRIs, do you have an opinion as to whether Mr. Carter needs MRIs of his cervical spine?

A Yes, so he will need to follow up, again, with us and the orthopedists and will need future MRIs in the cervical spine as well as future MRIs of his lumbar spine. The cost of MRIs are $1,300 once every five years for the rest of his life.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether or not all of the

us are related to the motor vehicle accident that happened in July -- on July 3, 2012?

A Yes.

MR. McGUINNESS: Objection.

THE COURT: Overruled.

Q What is your opinion?

A So my opinion within a reasonable degree of medical certainty, again, given the history and the subsequent surgeries and that his current condition and the future costs and treatment and surgery are within a reasonable degree of medical certainty resulting from the motor vehicle accident on July 3, 2012.

Q What's the basis for your opinion, doctor?

A The basis of my opinion is, again, given the history, examination, the surgeries, subsequent treatment as well as my experience with dealing with these chronic patients who have suffered an injury, it is within a reasonable degree of medical certainty resulting from the accident.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether Mr. Carter sustained a permanent consequential limitation of use of a body organ or member as a result of the accident in July of 2012?

MR. McGUINNESS: Objection.

THE COURT: Overruled.

A Yes, within a reasonable degree of medical certainty, he has suffered and will continue to suffer permanently from ongoing injury to his neck and lower back for the rest of his life.

Q Do you have an opinion -- what's the basis, obviously, I have to ask you that?

A The basis is, again, given his history, no prior history of issues with ongoing subsequent treatment, surgeries, and my experience dealing with chronic patients.

Q Do you have an opinion within a reasonable degree of medical certainty if Mr. Carter sustained a significant limitation of use of a body function or system as a result of the accident on July 3, 2012?

MR. McGUINNESS: Objection.

THE COURT: Overruled.

A Yes. Within a reasonable degree of medical certainty, he will continue to have limitations with regard to his functioning in his body as a result of the accident on July 3, 2012. Again, this is based on his ongoing history with the injury, subsequent surgeries, treatment and my experience.

of medical certainty as to whether or not the injuries that Mr. Carter sustained prevented him from his customary daily activities for 90 out of 180 days subsequent to July 3, 2012?

A Yes, within a reasonable degree of medical certainty --

MR. McGUINNESS: Objection.

THE COURT: Overruled.

Q You can answer.

A He has suffered with limitations as far as his daily activities, again, as a result of the accident of July 3, 2012, that is again based on my experience as far as -- as well as the history and subsequent treatment and surgeries that he has had.

MR. BOTTARI: Thank you, doctor. I have nothing further.

CROSS EXAMINATION BY

MR. MCGUINNESS:

Q Dr. Mandelbaum, again, Dennis McGuinness, we have never met before today, have we; is that correct?

A No.

Q Is that correct?

A That's correct.

Q In addition to people being involved in

accidents, you also see people who have degenerative spine conditions?

A Yes.

Q So you are familiar with the degenerative disc disease process of the spine?

A Yes.

Q And the jury has heard some description, it's also called spondylosis?

A Correct.

Q And some of that presentation includes something called facet joint arthrosis?

A It can, yes.

Q It can be painful, right?

A Yes.

Q Now, you first -- your office, first off, back on -- you saw him on 9/1/15, but he was sick, he had to come back?

A Correct.

Q He was sick and he had to go home because he basically was having a hypoglycemic episode from his diabetes, correct?

A Correct.

Q You offered to get him an ambulance, he refused?

Q You wanted him to go to the emergency room, he refused?
A Correct.
Q Now, you saw him next two days later on the 3rd, correct?
A Yes.
Q Did Dr. Thomas or did you see him?
A Dr. Thomas.
Q When Dr. Thomas saw him, he put -- as part of his examination, he put his hands on him and he found that he was found in pain and spasm at C-3 through C-7, correct?
A Correct.
Q He found myofascial trigger points were present and paraspinal tenderness, right greater than left, and he found right sided C-3-4, C-4-5, C-5-6, facet joint tenderness upon palpation, correct?
A Correct.
Q And that's a response to arthritis in the facet joints, is it not?
MR. BOTTARI: Objection.
Q Yes or no, doctor?
THE COURT: Overruled.
A No.
Q Never?

A I wouldn't say never, it is more complicated than just saying it stems from arthritis.
Q All right. He is having pain at the facet joints, correct?
A Correct.
Q That's fine. In fact at every visit, where Dr. Thomas examined him and you examined him, he had right sided C-3-4, C-4-5 and C-5-6 facet joint tenderness, every visit, correct?
A Correct.
Q Now, let's say Dr. Gerling, he was initially going to do a surgery that involved C-3, C-4, C-5. Let's assume further, doctor, if he has arthritis on CT scan at C-3, C-4, C-5 and he only does the surgery at C-4-5 or -- I'm sorry, C-5-6, that surgery is not going to address the issues of C-3-4 or C-4-5, correct?
A It can make it worse.
Q It could make it worse. So the decision there is whether or not you should do the surgery at all if it's not going to solve the patient's problem, correct?
MR. BOTTARI: Objection.
Q Yes or no.
THE COURT: Overruled.
Q Yes or no.
A We are post-surgery at this point when we --
Q I understand, but I'm talking about the surgical choice?
MR. BOTTARI: Objection.
A That is the opinion of the surgeon who made that decision, what levels to do his surgery.
Q But you recognize that just doing that one level could make it worse, correct?
A Doing --
Q Yes or no?
THE COURT: Overruled.
Q Did you not say that?
A Doing at one level puts -- a fusion in one level puts a strain on other levels which, again, is resulting from the accident.
Q It's not --
THE COURT: Let him finish his sentence before you go, okay.
Q But it's not going to repair the facet joints above, if you only do it at one level, correct?
A That's why he came to a pain management office.
Q Now, you talked about the epidural steroid injections in the -- I believe you did them initially in

the lumbar spine, correct, the lumbar facet injections?
A He had facet injections. He had epidurals prior to coming to our office.
Q Right, I understand, but in your office, you did the facet injections, the Cortisone injections into the facet area, correct?
A He had a nerve -- facet block, yes.
Q Now, one thing of the facet block where you are giving them steroid or medication, the idea is the steroid is going to reduce the inflammation of the nerves in the area?
A He was given local anesthetic and I don't believe there were steroids but the diagnostic block.
Q So you give -- and he responded favorably to the diagnostic block, correct?
A Correct.
Q And when you gave him the diagnostic block in the neck, he -- in the facet joints in the neck, he responded favorably to that too, correct?
A Correct.
Q Now, what that told you was a possibly more permanent treatment at those two areas in the facet joints might be beneficial to the patient, correct?

MR. BOTTARI: Objection.

Q So you did initially the radiofrequency ablation, with the little wand that goes to 80 degrees Centigrade, in the lumbar, in the lumbar spine next, correct?

A Correct.

Q And that reduces pain by 30 percent, correct?

A Correct.

Q So it was successful in part?

A Correct.

Q Now, if he has neurogenic pain from his diabetes that's down in his leg, that facet block is not going to stop the diabetic pain, is it?

A Correct.

Q It would just stop the facet joint pain or the pain emanating from the facet joint, correct?

A Correct.

Q When you did the radiofrequency ablation in the cervical spine, in the facet joints, he responded favorably, correct?

A Correct.

Q Now, these small nerves that go in there in the facet joints, that you are ablating, they can regenerate?

A Yes.

Q So when you do the RFAs, radiofrequency

ablations, sometimes they last two months, six months, sometimes, it's permanent, but these small nerves, rhizomes, very small nerves, correct?

A Yes.

Q They can regenerate and the pain can come back, right?

A Correct.

Q And that pain is down there, it is still emanating from the facet joints, correct?

A Yes.

Q Now, you talked about reviewing records from Dr. Gerling, for Dr. Reyfman, you said that you had access to them. Were you able to look at their records on-line?

A I believe we had a paper copy.

Q How about for Dr. Gerling's records, paper copy or on-line?

A I believe it was a paper copy, but I don't remember.

Q Now, at this point, the only thing that you have done and seem to have some success or result is when you treat the facet joints, whether by block or by RFA, correct?

Q Yes or no.

THE COURT: Overruled.

A The facet joints are very helpful, by the way. The other injections which we want to do, he has had a lot of other subsequent issues and has had surgery and had his toe amputation and had the subsequent spinal surgery and then the issues with diabetes, but there are those other modalities which I described including the epidural, transforaminal, spinal cord stimulator that are all clinically indicated.

Q But my question was, doctor, if you would be just kind enough to answer it, of the things that you have done so far, this block of the facet joints and the RFA of the facet joints are the only two things that have given him some relief?

A Well, he --

Q Correct?

A No, he has had medication, medication changes which has been helpful. He has trigger point injections and Botox injections all which have been helpful and again there is future modalities which are indicated.

Q We're not asking about future modalities. When you treat the facet joints, he gets relief there?

A It is helpful for the facet mediated pain.

Again, when it comes to back and neck pain, it is somewhat complicated, there are different sources of pain.

One happens to be the facet joint and then you have the disc changes and you have the radicular component, the sciatica type component and each one is treated differently and that's where all those other modalities come into play.

Q But the facet joints, you can have arthritis of the facet joints that comes into the neural foramen, correct, correct, you can have spurring from the facet joints, that enters into the foramen, correct?

A Correct.

Q And the arthritis disperse from the facet joints when they go into the foramen, they can choke down the foramen, correct?

A It can, yes.

Q That's called foraminal stenosis, correct?

A Correct.

Q So when a person moves, the little nerve root that comes out, becomes irritated by the bone spurs, correct?

A Correct.

spine from July 12, 2012, nine days after the accident, did you not?

A Yes.

Q And you would agree, the CT scan report shows at C-3-4, there was no evidence of a disc herniation or central canal stenosis, there was bilateral uncinate spurring with foraminal narrowing, a mild disc bulge is seen.

You know that's what the first radiologist found, correct?

A Correct.

Q At C-4-5, there is no evidence of disc herniation, foraminal narrowing or central canal stenosis, there is posterior bony spurring with an underlying disc bulging is noted, correct?

A Correct.

Q And they are -- you are talking about bony spurring and disc bulging that's going back into the central canal, not into the foramen at that level, correct?

A Correct.

Q And that can cause pain, correct?

A It can.

Q Then at C-5-6, there is no evidence of disc

herniation or central canal stenosis, there is bilateral uncinate spurring, those are those bone spurs again, right, with foraminal narrowing, correct?

A Again, you are reading the radiology report.

Q Yes, I mean, this is the same report you read and you are making your diagnosis on, correct?

A Correct.

Q And you would agree having bone spurs on a CT scan, nine days after the accident, those bone spurs would have been there before the accident, yes or no?

A Again --

Q To a moral certainty, doctor, yes or no?

A He had bone spurs, but he also --

Q He had bone spurs and they were there before the accident, right?

A And he had an accident.

Q Okay, I understand he had an accident --

A And that --

Q -- but these conditions that are on this CT scan were there well before the accident?

A Again --

Q Agreed or not?

A Well, you have an accident and now everything is

Q I'm asking you a simple question. Were these bone spurs there before the accident?

A Sure. Everybody has arthritis in their neck.

Q All right, all right. You looked at the lumbar spine as well, correct?

A Correct.

Q And there was no evidence of disc herniation, no evidence of foraminal narrowing or central canal stenosis at any of the levels of the lumbar spine from L-1-2, 2-3, 3-4, 4-5 or 5S-1, correct?

A You are reading the report, yes.

Q And that's nine days after the accident, correct?

A Correct.

Q Now, it's your understanding, doctor, that the accident, it was a rear end contact?

A Yes.

Q Do you have any information as to the speed of the contact or the forces involved in the accident?

A No.

Q Let's assume there has been testimony that Mr. Carter was seeing his family doctor once every three months for his diabetic care.

Your office beginning in September of 2016, you are seeing him every month thereabouts?

A Roughly, yes.

Q Now, Mr. Carter comes in to see you.

When you do your examination of him, you have him disrobe?

A Partially, yes.

Q You make him take his shoes and socks off?

A Yes.

Q Every time?

A Majority of the time, yes.

Q Every time, I'm asking.

A Again, I don't recall every office visit, but yes.

Q Mr. Carter has already testified that it never happened?

A Again, we are testing --

Q Supposed to --

A We are testing --

MR. BOTTARI: Objection.

THE COURT: Let him finish the answer, okay.

A We are testing, as far as his sensory distribution, as far as numbness and tingling, so again, the initial office visit, we will do a physical examination. We will examine his feet and shoes,

look at the wound, but on every office visit, again, I do not recall.

Q Now, you personally only saw him, at least the records we have up to 2016, you saw him on one visit?

A Correct.

Q On November 15 of 2016?

A Correct, so I can't testify as far as Dr. Thomas.

Q What Dr. Thomas did?

A Yes.

Q Is osteomyelitis painful?

A It can be, yes.

Q So the jury understands, around all of our bones, there is a membrane called the periosteum, correct?

A Correct.

Q And one things about the periosteum is that it is full of nerves, correct?

A Correct.

Q So when you break a bone and you tear or rupture the periosteum, it's going to hurt, correct?

A It can, yes.

Q Immediately, manditorily, it's going to hurt, correct?

A Depends on the patient, actually.

Q Unless they have got dead tissue there instead of

live tissue?

A For instance, in diabetic patients, the pain would be quite different than in other patients because of ongoing neuropathy associated with diabetes. It includes --

Q All right.

A -- things like heart attacks.

Q For example, what's going on, even neuropathic pain in a diabetic has a vascular underlying cost, correct?

A There are vascular changes with diabetes, yes.

Q And once these very, very small blood vessels shut down, that tissue begins to die, correct?

A Correct.

Q And it's like putting on -- if someone puts a tourniquet on it and eventually their arm begins to ache and it brings pain, it begins to have -- as the tissues are deprived of oxygen and glucose, correct?

A It can be, yes.

Q It becomes necrotic, it begins to die?

A It can, yes.

Q While you are treating his neck and the back, did you offer him any treatment whatsoever for his feet?

specifically in the office note, though bear in mind that pain medication will help. Besides his back and neck pain, it will help with other pain issues.

Q Pain medications, they are systemic, they go throughout the body, they help all kinds of pain?

A Correct.

Q But they are not going to take care of his diabetic problems in his foot, are they?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A Interestingly enough, when it comes to diabetic pain and ulcers, one of the big issues with diabetic patients is at times, they don't even feel that they have an ulcer that's tearing in and ripping apart their tissue.

They go to their doctor and look at the bottom of their feet and they notice an ulcer, so that's why shoe care, foot care is so important in diabetic patients. Again, I'm not treating his diabetes, it is unrelated to what we were treating.

Q But if the diabetes is a source of the pain, then it is relevant to what you're treating, is it not, doctor?

A Again, he wasn't --

Q Yes or no?

A He wasn't assessed for his diabetic pain.

Q You are treating him for pain?

MR. BOTTARI: Objection.

A Correct, we were treating him for neck and back pain, majority --

THE COURT: Overruled.

A He also had some shoulder, but that's --

Q The pain was his neck and back and transferring down to his leg and feet?

A That's the radicular component of his back pain.

Q And there was pain that was involving his entire foot, his calf, his mid-thigh that he was complaining about, so you only treat pain that goes down and not pain that works its way up, is that what you're telling these good people over here?

MR. BOTTARI: Objection.

THE COURT: You can answer.

A Again, pain, there are different sources of pain and for his diabetes in particular, the pain is quite different than his radicular and back pain.

Again, diabetics are -- it's an interesting phenomena where diabetic patients may feel pain initially

and they have more numbness and tingling and sometimes, the pain actually goes away and that's why they can develop ulcers, and if they have a pebble in their shoe and they don't even notice it because it's not painful and they develop an ulcer even in a short amount of time. Their vasculature is not the same and I have seen patients who have had ulcers and surprisingly, it's not painful. It looks painful, but it's not as painful as it looks.

Q The pain that a patient tells you, that's purely subjective, correct?

A There is a subjective component to pain, yes.

Q I mean, the statement that someone has pain, that's purely subjective, you are entirely relying on their truth and their accuracy, correct?

A We definitely have a doctor/patient relationship and --

Q That statement is by definition, subjective, correct, doctor, you don't have to equivocate on that?

A There is a subjective component to pain, yes.

Q And when the patient says it's going down the leg or up the leg, that's subjective as well, correct?

A Correct.

Q And if he says it bothers this part of the leg

and that part of the leg, that description of where he feels the pain, that's subjective as well, correct?

A There is a subjective, but interestingly enough, when it comes to pain and distribution of pain, diabetic pain tends to be that stocking/glove distribution versus a radicular type pain which follows a nerve foot distribution and that's also ascertained on history and the physical examination done to confirm or corroborate.

Q And you know that, but the patient doesn't necessarily know that, correct?

A Correct.

Q So you're asking him to be very, very specific in the source of all of his pain, correct?

A Correct.

Q You asked Mr. Carter how he is doing, he reports after his lumbar radiofrequency ablation, he reports back, I feel 30 percent better, but he still has pain, you didn't specify in your report, was it 30 percent of his -- was it 30 percent of his radicular pain that went away, he just reports back that it is 30 percent of his pain went away, that would be expected with a successful radiofrequency block, if the other 70 percent of his pain was caused by his diabetes, correct?

A No.

Q Not at all?

A No.

THE COURT: Overruled.

A Because the notes actually state that it helped 30 percent of his back pain and he still had some radicular pain from his back into his legs.

Q But again that's all subjective and based upon his ability to report that to you?

A But that's what would be expected.

Q Okay. Doctor, anything in your notes where you have written in your office notes where -- any record whatsoever that you ever inspected his feet or made findings about an ulcer on his feet that had been there for two years?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A Again, we were treating his neck and his lower back, not specifically his feet, so there is --

Q Doctor, it will go a whole lot faster if you answer my question.

A Let me put it this way, when patients come in on an injury, some type of disability, we specifically treat those injured parts and we specifically leave out some of

the other parts even though we may inspect them or we talk about it and that's done intentionally for reimbursement purposes, I should say, because things get excluded as soon as we start treating other parts. We very much focus on certain areas and that's part of the motor vehicle --

Q And those things happen to be helpful to Plaintiffs in litigation --

MR. BOTTARI: Objection.

THE COURT: Sustained. Disregard that.

Q You are a pain doctor, Mr. Carter is a whole person --

A Is that a question?

Q I am finishing, doctor. Mr. Carter is a whole person, correct, it shouldn't matter where his pain is coming from for you to treat it, should it?

A Again, he was --

Q Yes or no, doctor. It's a simple question.

A It does matter.

Q And you decided to treat his back pain, but not his foot pain?

A He was referred, specifically, because of ongoing back and neck pain, not specifically for the foot pain.

actually be very different.

There are actually different type of radiofrequency procedures that would help with his foot pain and even the spinal cord stimulator is something that could help with his foot pain and may actually even help vascular blood flow to lower extremity.

Again, that's not discussed because that's not the type of treatment, but that is something that I don't recall, but I'm sure I mentioned to Mr. Carter that it may help with actually his blood flow to his lower extremity and that's just -- let's call it a fringe benefit from some of these other treatments that could be done for his back that may actually help his legs, so --

Q But none of that care would have had anything to do with the accident, correct?

A Again --

Q Yes or no, doctor.

A We are treating his accident pain.

Q And --

A And, again, I'm trying to keep it separate.

Q If it turns out, doctor, that his pain is -- I don't think it's funny.

A If it turns out that he gets relief from his diabetic pain, as a result of, for instance, getting a

stimulator, yes, it can -- can it help, stimulators are used for diabetic pain in addition to post fusion type pain, yes.

Q And it may do him some good for his diabetic pain, would you agree, pain emanating from his diabetes has nothing to do with this accident, correct?

A I'm trying to keep those two separate, but yes, he has different pain.

Q The treatment that he needs for his diabetic pain did not arise out of the accident, it arose out of his diabetes, correct?

A Again, I'm not --

Q Yes or no, doctor.

A I'm not treating his diabetes, but he has diabetic pain.

MR. McGUINNESS: Doctor, thank you.

THE COURT: Counsel?

MR. NASTRO: Just some follow-ups.

CROSS EXAMINATION BY

MR. NASTRO:

Q Good afternoon, doctor.

A Good afternoon.

Q Just a couple of follow-up questions for you.

A Yes.

Q How many times, about?

A Eleven or twelve times, maybe, over the past twenty years.

Q And have you ever testified for the law office of William Schwitzer before?

A Yes.

Q About how many times?

A I do not know. I mean, I testify on behalf of patients and I don't know which law firms and it could be three or four times, I do not know.

Q Are you being compensated for your time here today?

A Yes.

Q How much are you being compensated?

A Our hourly rate -- my hourly rate is $400 per hour.

Q And off of what Mr. McGuinness was asking you, you discussed that you measured a pain scale of Mr. Carter, correct, during his visits with you?

A Yes.

Q And that's a pain scale of one to ten?

A Correct.

Q And is the only measurement of that pain scale

you asking Mr. Carter on a scale of one to ten how much pain are you in?

A Yes.

Q So his answers to you -- you are limited in your report of his answers to you, correct?

A Correct.

Q So it's a subjective measurement of pain; is that correct?

A Correct.

Q Also, building off of what Mr. McGuinness was saying, regarding his neuropathy, I think you described it as a stocking/glove type sensation?

A That's typical for diabetic pain. Again, I described a diabetic patient. I didn't describe his particular neuropathy or diabetic neuropathy if you're going to call it. We are specifically treating his radicular pain from his back.

Q I'm just asking how you described it before and it was stocking/glove sensation, correct?

A Typically in diabetic patients, yes.

Q Conversely, radiculopathy described it as a more narrow traveling pain down the nerve root, correct?

A Correct.

as an examining physician of what sensation that individual is feeling is by asking them, correct?

A Correct, that's part of it and then physical examination to corroborate with the patient's subjective descriptions, yes.

Q One of the things that you distinguished before is that neuropathy is more of a tingling and numbness feeling whereas radiculopathy is more of a shooting pain; is that correct?

A Typically, textbook, yes.

Q You said you are familiar with Mr. Carter's medical history, correct?

A Correct.

Q And would it surprise you if he had told other physicians who examined him in the past that he had leg pain -- traveling leg pain prior to this accident?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A Again, from my history of Mr. Carter, as far as him having radicular pain, that he did not have that prior to the accident.

Q Looking at some of the items you suggested, he would need in the future, one of those items is MRIs; is that correct?

A Correct.

Q Have you ever examined an MRI of Mr. Carter before?

A Well, one of the -- which you should correct, it should actually be a CT scan, when I stated all of those, the cost would be the same, he does have a pacemaker, so I will correct that statement. It was put on this narrative report from 2016, but CT scans would be better indicated because MRIs are contraindicated in somebody who has a pacemaker at this point.

Q But would you consider Mr. Carter's medical history when generating your reports and considering the other items in your suggested need for future care?

A Am I considering what?

Q His medical history?

A Considering his medical history?

Q Right.

A What's the rest of the question?

Q Considering his medical history when determining his need for future care?

A Yes.

Q And you are familiar with his medical history; is that correct?

Q Based on what I'm seeing in your narrative report, it looks like Mr. Carter was prescribed some form of pain medication after every visit; is that correct?

A Correct.

Q Are you familiar with Mr. Carter's history of substance abuse and addiction?

A Correct.

Q You are familiar?

A Yes.

Q And does that impact your decision to prescribe pain medication?

A Yes.

Q Are you aware that Mr. Carter is currently treating with Suboxone as well?

A Given by our office, yes.

Q So you prescribed that in concordance with the pain medication; is that correct?

A He is now off of the opioid medication and on the Suboxone, yes.

Q And I believe you testified earlier that with respect to the way Mr. Carter walks; is that correct?

A Correct.

Q And you said you observed him walking with difficulty?

A Correct.

Q Using a cane?

A He typically has a cane. I think the initial office visit, he had a walker.

Q And you being familiar with medical history understand that he had difficulty walking long before this accident; is that correct?

A He has had issues with his diabetic issues, but yes.

MR. NASTRO: I have no further questions.

THE COURT: Mr. Bottari?

REDIRECT EXAMINATION BY
MR. BOTTARI:

Q Any record that you have seen, doctor, that indicated that Mr. Carter had facet joint pain prior to the accident of July 3, 2012?

MR. McGUINNESS: Objection. No predicate, your Honor.

THE COURT: Overruled.

A No.

Q Do you know what asymptomatic is versus symptomatic?

A Yes.

asymptomatic versus symptomatic is?
A Well, asymptomatic is when the patient is not exhibiting any pain or symptoms related to that specific area versus symptomatic where they actually have, for instance, pain, from a specific area.
Q I want you to assume that prior to July 3, 2012, Mr. Carter had never made complaints of back or neck pain, can you assume that?
A Yes.
Q I want you to assume that after the accident of 2012, July 3, 2012, that same day, he made complaints of neck and back pain and thereafter treated and you are familiar with that treatment, correct?
A Yes.
Q So if he did have some sort of facet joint whatever, would it be your opinion that he was asymptomatic prior to July of 2012?
A Yes.
Q And if he did have some sort of pain emanating from the facet joints, what would that accident signify to you as a clinician?
MR. McGUINNESS: Objection.
THE COURT: Overruled.
A That the accident is the precipitating cause of

his ongoing now symptomatic pain.
Q And you have seen the MRIs prior to Dr. Gerling's surgery -- I'm sorry, the CT scans prior to Dr. Gerling's surgery?
A Yes.
Q And you have read his operative reports?
A Yes.
Q And you found evidence of herniated discs in the back and the neck when he did the operations?
A Correct.
MR. BOTTARI: I have nothing further.
RECROSS EXAMINATION BY
MR. MCGUINNESS:
Q Those CT scans of the neck and the back that Dr. Gerling did, they were taken about three years after the accident or four years after the accident, taken in 2016, correct?
A Correct.
Q Now, you did a narrative report in this case?
A Yes.
Q Or your office did, did you actually do it or did Dr. Thomas do it?
A I believe Dr. Thomas did it, but I did review it

Q You put both signature blocks on it, but it's not signed by you?
A Correct.
Q And was your firm compensated for doing that report by Mr. Schweitzer's office?
MR. BOTTARI: Objection.
THE COURT: Overruled. He can ask that.
A I do not know what compensation, if any, that we got.
Q How many of those narratives has your office done for Mr. Schweitzer's office in addition to the times that you have testified?
MR. BOTTARI: Objection.
THE COURT: Overruled.
A Again, I do not know. There are requests from the --
Q I'm asking about Mr. Schweitzer's office specifically.
A I do not know.
Q You testified at least four times. The times that you had testified would be a fraction of the narrative reports that you have written up, correct?
MR. BOTTARI: Objection.
THE COURT: If you know.

A Again, we do narrative reports quite often on patients that we see.
Q But the number of narrative reports is many more than the ones you actually come to court to testify in, correct?
A Yes.
Q And when Mr. Schweitzer's office asked you to do that narrative report back in 2016, did they supply you with all of Mr. Carter's disability records from Social Security?
MR. BOTTARI: Objection.
THE COURT: Sustained.
Q Did they supply you with any of his records from prior to this accident, doctor?
MR. BOTTARI: Objection.
THE COURT: He can answer that, it's a yes or no.
A I do not know.
Q You didn't see them laying around the office or --
A No, but when new patients come in, we do try to obtain from whatever sources the prior records.
Q I understand, but I'm asking you specifically

stored in a paper file, other than the records from Dr. Reyfman's office and Dr. Gerling's office which are subsequent to the accident, do you have any personal knowledge of ever having seen any of Mr. Carter's records from before the accident, yes or no?

A No.

MR. McGUINNESS: Thank you.

MR. BOTTARI: No further questions.

THE COURT: Thank you, doctor. You could step down.

Whatever you brought with you, you can take it back.

Okay, ladies and gentlemen, you have some inquiries, I know, of our schedule, so we have discussed it. The most that I can tell you at this point, we have a medical witness this afternoon. We have another one scheduled for tomorrow morning. We will not be in session tomorrow afternoon and on Monday, we expect to have the case basically completed.

You will hear summations, you will hear my charge to you on the law of damages and you will deliberate.

We will take care of the charging conference

and whatever else we need to do on Friday afternoon and that's our schedule as of now. I expect that we will pretty much adhere to that, so enjoy your lunch. Don't discuss the case. We will see you at two o'clock.

(Jury exits courtroom.)

(Luncheon recess.)

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