

1 surgeon in our office. I believe he saw neurologists for times,
2 as well.

3 Q Is that common that a patient will treat with a number
4 of physicians?

5 A Yes, everybody specializes in their own area. So, it's
6 very common.

7 Q Is that something called the continuum of care
8 something like that?

9 A Yeah. It's sort of everybody -- I wouldn't treat
10 someone for a head injury, and someone with a head injury I
11 wouldn't treat for their neck and back.

12 Q Okay. I'd like you to assume, doctor, that Mr. Herrera
13 had no prior neck and back injuries, no prior right shoulder
14 injuries, and no complaints at the time of the happening of the
15 accident to his left ankle.

16 Do you have an opinion, to a reasonable degree of
17 medical certainty, whether the complaints and pain which Mr.
18 Herrera was exhibiting when he came to see you was the result of
19 the accident of March 5, 2013?

20 A Yes, I would say based on what I know, with a
21 reasonable degree of medical certainty, his injury was the
22 competent producing cause of his pain.

23 Q And do you have an opinion to a reasonable degree of
24 medical certainty, whether or not the treatment rendered by you
25 was the result of the accident to Mr. Herrera?

1 A Yes, I would find it with reasonable, a reasonable
2 degree of medical certainty, as a result of accident.

3 Q Tell us a little bit about Mr. Herrera's course over
4 the years as he treated with you. There seems to be a large
5 number of records there. I assume he was seen that many times,
6 I don't want you to go through every visit, but?

7 A Initially, we did do something called epidural
8 injections, which will help diagnosis and treat nerve and disc
9 issues and radiculopathy, but it can also help with diagnosis.

10 He received -- which we using a needle go into the
11 epidural space, and inject antiinflammatory medication, as well
12 as anesthetic, something to just sort of mask the pain and also
13 treat the inflammation. And then based on their response, some
14 patient's proceed with additional injection. If the response is
15 only temporary and quickly, then they sometimes go into surgery.
16 That is what happened with Mr. Herrera. He ended up proceeding
17 to a cervical lumbar fusion surgery with Doctor Brisson.

18 Q Let me backup a little bit, I know you're familiar with
19 it but. So, tell us about these epidural injection. This isn't
20 like the vaccination you get, something like that is it?

21 A No, no. So, it's something that I perform, do it every
22 week on different patients. But we use a fluoroscope which is a
23 machine that can take live x-rays. I have a peddle I will a hit
24 it, it takes an x-ray where I'm guiding a needle down into the
25 epidural space, and the epidural space is the space sort of

1 outside the spinal cord, and that's where the discs or the
2 nerves are being inflamed, and it allows me to put medication
3 around the nerves.

4 So, I'm taking live shots, and it can be swiveled so I
5 can get a 3-D sort of picture to check the depth and the top and
6 bottom view of the needle. Once the needle is in place, a die
7 is placed into the epidural space to make sure that the
8 medication is going to go around the nerve roots, and not in
9 soft tissue, and also not in the spine. And then after that,
10 the medication is injected, and then usually it takes effect
11 somewhere between 12 to 72 hours.

12 Q And is the patient awake during this procedure or
13 something else?

14 A Depends on the patient. It is a -- some patients, it
15 is a painful procedure, and somewhat traumatic for some patients
16 to have three and a half inch needle injected down into their
17 spine. So, I would say about 70 percent of patients probably
18 get some form of sedation. Some patients have a very high pain
19 tolerance would just get the area numbed and we'll drive it
20 down.

21 Q How many times did Mr. Herrera undergo these epidural
22 treatments?

23 A He had -- let's see. It was one for the lower back in
24 July of 2014, he had one to the neck in August of 2013,
25 July 2013. And then we also he had some other procedures done

1 to his lower back, because again with these injuries, with
2 traumatic injuries to the spine often time it's not just one
3 issue causing their pain. It can be pain in the joints. So, he
4 did have some injections called facet joint injection, where we
5 put some medication around the facet joints to see if that is
6 producing some or causing some of his pain. That would not be
7 pain going to the legs, that would just be pain sort of in the
8 back. And he did have I believe three injections there, as
9 well. It's the same type of procedure using the x-ray machine
10 to guide the medication down. And again it's about three and a
11 half inch needle that's guided down that to that area.

12 Q Tell us, if you would, doctor, please, what other kinds
13 of treatments did you perform on Mr. Herrera, during the course
14 of time that he was your patient?

15 A So I have performed --

16 THE COURT: Please mute all of your devices, so we
17 don't have to do this multiple times. Thank you. Just turn
18 your phone off.

19 Was there a question outstanding?

20 A So, I think you asked --

21 Q I asked tell us about the other treatments you rendered
22 to Mr. Herrera, during the course of your treatment with Mr.
23 Herrera?

24 A So, I had given him what I discussed earlier trigger
25 point injections. The trigger point injections are going into

1 the muscular type veins muscle performed on many patients when
2 they have pain. It's not always just with injuries. I mean I
3 used to get them when my children were younger and I get them in
4 my shoulder here. I actually give myself trigger point
5 injection. It's just needles in the muscle to try to get it to
6 sort of relax and release and they will reform sort of something
7 that is performed periodically on patient. I have one patient
8 who comes in weekly for them. I also gave him something called
9 occipital nerve locks which is for head aches. Again, when
10 patients have head injuries where the muscle spasm will form and
11 they have the neck muscles pulling down in the neck, you have
12 what are called occipital nerves which go up the back of your
13 neck here back of your skull and when they become irritated and
14 inflamed they get headaches that start in the back and then they
15 will sort of go around forward to your eye. Often times patient
16 will describe blurry vision and pain and so what I would do is
17 inject medication around the occipital nerve in the back of the
18 neck here. Utilizing ultrasound guidance to visualize nerves
19 and injection medication around it and that generally would help
20 treat the headache pain. He's also been given sacroiliac joint
21 injections in the office.

22 Q Telling us where that is?

23 A The sacroiliac is the joint between your coccyx and
24 your pelvis. Often times in patients who have had lumbar
25 fusions, the body generally when it's moving, any force on it is

1 distributed amongst all of the joints in the body. If you fuse
2 some joints in the body, then often times when you're moving
3 that can put an increased force in the joints either both above
4 or below.

5 And so patients often times will develop what we call
6 sacroiliitis which is inflamed sacroiliac joint because of the
7 increased force that is placed following the fusion. And then
8 they'll have pain sitting, they'll have difficulty with sitting
9 for long periods of time, and then often will have to shift and
10 stand or stand to offset at the time the pain (sic).

11 The injection is just using the x-ray machine, again,
12 and guiding the needle down into putting a die to visualize it
13 on the joint and then injection the medication.

14 Q Did you do what's known as radio frequency ablation for
15 Mr. Herrera?

16 A I did that to his the facet joints. So, as I stated
17 earlier, when we injected medication into his facet joints, he
18 did receive some temporary relief and the nerves that are there
19 pain generating nerves from those joints are called medial
20 branch nerves, and you can go in and you can burn those to try
21 and decrease your pain in those areas. He did receive some
22 relief in his axial pain but he still had significant pain going
23 to the legs, so that was sort of one of the contributing factors
24 that lead to his surgery of the lumbar spine that he did not
25 receive a tremendous response to the ablation.

1 Q Tell us, you said you burn the nerves. Tell the jury
2 what that means?

3 A Uh, again, we use -- I use a larger needle that again
4 about three and a half inches long or so, that we guide down to
5 the medial branch nerve which is generally right here beside the
6 facet joint. And it gets heated up to eighty degrees celsius
7 for 90 seconds and that denatures the nerve, so it's not
8 conducting the pain signal. It does grow back generally between
9 6 to -- 6 months to a year and a half. And some patients
10 receive periodically radial frequency ablations. Other patients
11 it does grow back, but the irritation isn't there and they do
12 fine.

13 Q Now during these epidural treatments trigger point
14 treatments, radio ablations, sacroiliac joint injections, is
15 that what we call noninvasive or conservative treatment?

16 A It's certainly less invasive than surgery, but more
17 invasive than just oral medication. So, I would still consider
18 it conservative, in terms of surgery.

19 Q Did Mr. Herrera receive oral medications, as a result
20 of his complaints?

21 A He did receive multiple oral medications. He had both
22 for awhile he was treating him with, I believe, neuropathic
23 medication called Gabapentin which just masks radiating pain in
24 generally. He was also treated with some opiate pain
25 medications. I believe Tramadol, and I think for a time he was

1 on some morphine when his pain was severe. But again we don't
2 like to keep patients on those types of medications, so it's
3 just used initially when pain is severe and we were able to
4 taper him off both --

5 THE COURT: Turn phones off all. Just pause
6 everyone turn their phone off.

7
8 (Whereupon there is a pause in the proceeding.)

9 THE COURT: Thank you. Put it into airplane mode,
10 whatever you need to do. I just don't want any
11 interruptions. Okay? Thank you.

12 DIRECT EXAMINATION

13 BY MR. KELLY:

14 Q Okay. So, did Mr. Herrera receive any topical
15 medications?

16 A Yes, he was given some topical antiinflammatory jells
17 that's an diclofenac cream which he just sort of rubbed it where
18 it hurts.

19 Q And all of these treatments are they permanent
20 solutions to pain? Do they provide temporary relief, something
21 else?

22 A They would be a temporary relief.

23 Q All right, and eventually Mr. Herrera was sent for
24 surgery, is that correct?

25 A Yes, he was. I referred him to Doctor Paul Brisson

1 who, I believe, did a cervical fusion and lumbar fusion.

2 Q And did Mr. Herrera return to you after his neck and
3 back surgery?

4 A Yes.

5 Q Tell us about his return to you and his complaints?

6 A I mean he's returned to me and been treating throughout
7 the years. He's had continued complaints of neck and lower back
8 pain. Pain radiating to his arm still pain radiating to his
9 legs. Over time he's sort of learned to deal with it.

10 Q Okay. Is that an unusual result or is that something
11 that happens or are people's pains diminished instead of going
12 away?

13 A It's not an unusual result. I'd say most patients
14 after having a fusion surgery, although they say it may help
15 some, they still have some realm of pain.

16 Q And did you continue to treat him after his surgeries?

17 A Yes.

18 Q And can you tell us, doctor, I don't want to go through
19 each individual date, but when you saw Mr. Herrera in August of
20 2024, could you tell us your observations and so on?

21 A Yes. He just, again, we discussed his pain. Like I
22 said earlier, I hadn't been seeing him quite as often over the
23 past couple years. But he said that his pain would wax and
24 wain. He reported it never completely goes away due to resource
25 available to him. He'd only been utilizing over the counter

1 medication primarily. He's just trying to live with the pain,
2 trying to stay as active as he can tolerate, still notes
3 numbness and pain to his both legs, increasing when he walks.
4 And noting an increase in pain towards the end of the day
5 feeling heavy legs. He did report that he's modified his
6 activities so that he's able to be more independent with
7 dressing and showering as previous visits. He reported that his
8 wife had to help him primarily with his activities of daily
9 living. He did reported that he can only drive short distances,
10 increase in lower back pain when he would have to sit for too
11 long in the car. He utilized a cane in the winter because of
12 instability, but in the summer warmer weather he was a bit more
13 stable, so he would not use the cane. I generally advocate
14 trying to avoid use of the cane as much at possible. Using cane
15 puts uneven pressure on the spine, and can increase the other
16 issues. He's doing home exercises mornings stretches due to
17 resources available to him.

18 Q Doctor --

19 A Sorry.

20 Q Doctor, just your treatment, if you don't mind --

21 A Okay.

22 Q Not editorials, please. Thank you.

23 A So, again, for his neck, he was reporting continued
24 cracking when he would move his neck. And, generally, I
25 generally, advice patients that's very common following these

1 injuries. It's just like every your knuckles crack the joints
2 in your neck are going to crack as your muscles stiffen up and
3 you're not using it and moving it as much. He did report pain
4 radiating to his shoulder region, muscles tension, and just
5 again he's dealing with his pain in his neck, as well.

6 Q Did you perform a physician examination that's your
7 last visit with Mr. Herrera?

8 A Yes, yes.

9 Q Tell the jury if you would your findings with your
10 physician examination August of 2024?

11 A Okay. With regards to his neck, again, he did have
12 moderate decrease ranking with extension at 45 degrees, with a
13 normal 60. Flexion at 40 degrees, normal 50 to 80. Left and
14 right lateral flexion 35 degrees, normal is around 45 degrees.
15 Rotational pain at 60 degrees, normal is around 80 degrees.

16 Mild shoulder area weakness on the right compared to
17 the left with resistance testing. And he did show positive
18 Spurling sign. Spurling sign is a tension compression test for
19 the neck to see if there's any irritation of the nerves. The
20 way we do that is you put down pressure with rotational movement
21 to the affected side, and extension. And what we're trying to
22 do is narrow where the nerves are coming out. If there's
23 infected irritated nerve, then it should reproduced some pain in
24 the manner of like I talked about earlier. If it's nerve that's
25 irritated, we should see a pattern of pain in that area. And he

1 did show a more severe pain than testing to the right and the
2 left.

3 He did show muscle spasm in his paraspinous muscles, as
4 well as his shoulder girdle muscles, trapezius and rhomboid
5 muscles which are just muscles in the shoulder areas.

6 The lumbar of the low back, he was walking with an
7 antalgic gait, altered painful walking partner, and he does have
8 an ankle foot orthosis in his left ankle, that's to give him
9 strength because he does have severe weakness with bringing his
10 ankle up. Without it, it would catch on and cause him to trip.

11 Q Is that due to the surgery?

12 A I think I believe he did have in record review of other
13 doctors he had some type of preexisting issue, but it's
14 something that got much mores on his accident, the foot drop,
15 from what I understand.

16 He has the weakness in the left, and again with regard
17 to his ranging of his lower back probably put it moderate
18 deficit with pain at extension to 15 degrees flexion at
19 approximately 55 degrees left and right lateral flexion at
20 15 degrees, and I think his initial visits he had pretty much he
21 shown some improvement over time, which is good following his
22 surgery and treatments. And he has a positive straight leg
23 raise which that's another tension provocative test that you
24 would do to see if there's nerves still irritated in his lower
25 back, low back, which is fairly common after surgeries.

1 Patients have these injuries their nerves get sort of fried over
2 time. The structural elements maybe healed, but the nerves can
3 still be irritated and inflamed. And if you do provocative
4 test, you can reproduce some pain. And then he showed some
5 depression of sensation on his left side in the L-5/S-1 nerve
6 roots and he was showing some trigger points present on
7 examination.

8 Q Did you test his reflections?

9 A He showed a depressed patella and ankle jerk reflex and
10 that's just that test to see if there's any still nerve issues
11 related to the L2/L4 nerves for the knee reflex. And the S1
12 nerve for the ankle reflex.

13 Q All right, were they depressed or normal?

14 A Depressed on the left side.

15 Q Okay, and what does that mean if they are depressed?

16 A That there's still some sort of issue going on with the
17 nerves in that area.

18 Q Did you make any further findings at your August 2024,
19 examination?

20 A He did have a great deal of atrophy. So the muscle
21 loss involving his left lower extremity.

22 Q Did you make any diagnoses at your August 2024
23 examination?

24 A Again, he had diagnosis of cervicalgia and lumbago
25 which is a fancy terms for mechanical neck and back pain. Felt

1 back syndrome which is terminology for patients who had surgery
2 and have continued radiating pain related to the nerves, back
3 and or the neck. Sacroiliitis which is what I described
4 earlier. He does display the irritation of the SI nerves and he
5 did show positive response to pain office SI injections on prior
6 office visits which helps diagnosis and treat.

7 He was diagnosed with cervical radiculopathy, and then
8 trigger points which he had received injection for in the past,
9 and then foot drop and depression. I'm not treating him for
10 those.

11 Q Okay. Doctor, based upon Mr. Herrera's complaints to
12 you in August of 2024, years after the surgeries, do you have an
13 opinion to a reasonable degree of medical certainty, whether or
14 not Mr. Herrera's condition on his presentation to you
15 August 2024 is permanent?

16 A Yes, he has permanent deficits on examination.

17 Q Do you have an opinion, to a reasonable degree of
18 medical certainty, whether the condition he presented to you in
19 August of 2024, was the result of the accident on March 5, 2013?

20 A Yes, with a reasonable degree medical certainty related
21 to the accident.

22 Q All right, and all of Mr. Herrera's treatments up to
23 that time, do you have an opinion, as to whether or not they're
24 caused by the accident of March 5, 2013?

25 A Yes, I think the treatments are related to the

1 accident.

2 Q And, doctor, did you make a plan for Mr. Herrera's
3 lifetime medical care?

4 A Yes, I was asked to come up with treatment plan for
5 future care for some of his injuries.

6 Q We'll get into that in just a second, but do you have a
7 prognosis, and tell the jury or remind the jury, again, what
8 prognosis means, and do you have a prognosis for Mr. Herrera?

9 A Prognosis is just how his future outcome is likely.
10 For him, with all his injuries and generally it's a progressive
11 issue over time with chronic pain I would classify it as poor.

12 Q Poor? Okay. Well, does the condition worsen over
13 time?

14 A Again, as I stated earlier, with these fusion
15 surgeries, you're disrupting the body's natural mechanics, so
16 you are changing what the stressors would normally be placed on
17 the spine. So, it's something that generally does progress over
18 time and then everything stems from that with the pain from
19 those issues the muscles become involved, and so yes it's
20 something that I feel will progress.

21 Q And do you anticipate that Mr. Herrera will continue
22 with some level of pain for the balance of his lifetime?

23 A Yes. Some level. Like I said he's shown that he does
24 have a pretty good tolerance to pain. He's trying to deal with
25 it, but as it progresses, he may require or he may be hoping to

1 doing more things.

2 Q Is Mr. Herrera disabled from his chosen profession, as
3 a construction worker and heavy laborer?

4 A Absolutely.

5 Q And is that permanent?

6 A Yes.

7 Q Doctor, I want to talk briefly about the medical costs
8 and plan you projected over Mr. Herrera's life time. Did you
9 project medications, including anti-inflammatories, muscles
10 relaxants, neuropathic pain medications, topical medications and
11 Tens Unit supplies for Mr. Herrera?

12 A Yes, I've -- and in an ideal world, I came up with what
13 I think would help and benefit a patient with his complaints and
14 injuries.

15 Q Okay, and do those medication costs -- the medications
16 have a cost?

17 A Yeah. I put it an approximate roughly \$400 a month.

18 Q And is that to occur over the balance of Mr. Herrera's
19 life time?

20 A Yes.

21 Q And this approximation of \$400 a month, is that based
22 upon your experience and your profession prescribing such
23 medications?

24 A Yes, based on the medications I would prescribe.
25 Again, if resource were available to patients with his

1 complaints that I feel would help.

2 Q Did you include in your treatment plan pain management
3 office visits?

4 A Yes.

5 Q And is there a cost affiliated with those visits?

6 A The out of pocket costs would be approximately \$250,
7 for the visit.

8 Q And what is the frequency of those visits over Mr.
9 Herrera's life time?

10 A For chronic pain patients, I generally will have them
11 schedule visits every 3 to 4 months, but I was -- I always tell
12 them -- I mean, that's variable. If they are doing well they
13 may stretch those out. If something immediate happens, they
14 come in sooner but that's what I usually recommend.

15 Q Did you design a treatment plan for which included
16 orthopedic surgeon office visits for Mr. Herrera?

17 A Yes. My boss Doctor Kaplan is and orthopedic surgeon
18 and I've asked him generally in patients who he performed
19 surgery on how often he likes follow-up.

20 Q And what is the frequency per year of those visits?

21 MR. RAINIS: I'm going to object, Your Honor. It's
22 hearsay.

23 MR. KELLY: It's not.

24 THE COURT: I'm sorry, I just got the Order to Show
25 Cause.

1 Last one that you -- very last one answer to the
2 one before, can you just read me the answer.

3 (Whereupon, the requested testimony was read back
4 by the Court Reporter.)

5 THE COURT: Overruled.

6 Q You may answer, doctor.

7 A Yes. So he's generally, like approximately, 2 to 4
8 time a year is what he advises to me.

9 Q Is there a cost affiliated with them?

10 A Out of pocket costs for his visit is approximately
11 \$300.

12 Q And that for the right shoulder?

13 A Yes.

14 THE COURT: Your testimony that you just gave was
15 that based on your own opinion or was that from a
16 conversation you had with Doctor Kaplan?

17 THE WITNESS: So, in making these plans, I have I
18 generally do research to try and discuss with surgeons what
19 their -- because I'm not an orthopedic surgeon, to ask them
20 what their frequency follow-up is, recommendations are, and
21 then I use that base to put in my plan.

22 THE COURT: And you're adopting that.

23 THE WITNESS: Pardon?

24 THE COURT: And you're adopting that?

25 THE WITNESS: Right.

1 THE COURT: Okay, let's -- we'll leave it in.

2 MR. ROBERTA: Your Honor, can we just be --

3 THE COURT: Come in the back.

4 (Whereupon, the following discussion takes place in
5 the robing room among the Court and Counsel, outside the
6 hearing of the sworn jury.)

7 THE COURT: So, he's saying he talked to Kaplan,
8 basically Kaplan told me and I just adopted it, but he
9 didn't say --

10 MR. KELLY: No, so I thought throughout the course
11 of this are I developed -- I can do the foundation in very
12 brief like three questions. You know, who do you work with,
13 who do you consult with to design these plans. Is it the
14 nature of your discipline to design such plans. How do you
15 go about doing it. Who do you talk to, why do you talk to
16 them. Pretty simple stuff. He's a physician and he's in
17 consultation with the continuum care with other physicians
18 and he developed these future life.

19 THE COURT: It didn't really feel like hearsay to
20 me. He said I talked to him based on that conversation this
21 was my --

22 MR. RAINIS: My objection was really that I think
23 it was hearsay. It's like, I don't know so I asked Doctor
24 Kaplan and Doctor Kaplan says this.

25 THE COURT: But he didn't say that did he?

1 MR. RAINIS: And he didn't say and Doctor Kaplan
2 says. He didn't quite say that, but that's essentially what
3 he said.

4 MR. ROBERTA: I think some of also what the problem
5 is he's relying upon undisclosed sources, as well. He said
6 I do it my research in this and none of that was attached to
7 his disclosure.

8 MR. KELLY: He's a physician entitled to rely on
9 the customary material relied upon by physicians. He
10 doesn't have to disclose it all. That's black letter law in
11 New York. He is allowed to rely on.

12 MR. ROBERTA: Is that case law on that?

13 MR. BAXTER: Does he have to say what it is?

14 MR. ROBERTA: He does have to say what it is, yes
15 he does.

16 MR. KELLY: Okay, so every time he's answers a
17 question he says I went to school and at school they taught
18 me this and we went through. No he's not every time he's
19 ask question I went to -- off, off the.

20 THE COURT: I think it's like right up to the line
21 but I think it's okay. If you keep him away from the, you
22 know, and Kaplan told me and I like copied and pasted it
23 into my thing. I think like somewhere there's a little
24 distance where -- like he's free to adopt or reject
25 whatever, you know -- I know you're kinds of making a face,

1 Mr. Rainis, I get it. I'd like I said it's close to the
2 line. It's not quite there.

3 MR. ROBERTA: It's an out of court statement not
4 for the truth of the matter asserted.

5 THE COURT: No it isn't, it isn't. He's saying I
6 consulted with my colleague who gave me some information or
7 shared his opinion, and based on that opinion he shared, my
8 recommended treatment plan is X Y Z, no?

9 MR. KELLY: That's correct.

10 THE COURT: Okay, so I think it stays in. You guys
11 go out. I want to talk to my court attorney for a second.

12 (Whereupon, the following takes place in open
13 court, in the presence of the defendant and the sworn jury.)

14 THE COURT: Okay, let's continue.

15 DIRECT EXAMINATION

16 BY MR. KELLY:

17 Q Doctor Grimm, is it a normal part of your work to
18 create care plans for patients?

19 A Yes.

20 Q And in the course of creating such care plans, do you
21 consult with other treating physicians and colleagues?

22 A Yes.

23 Q Have you adopt their recommendations occasionally
24 creating such plans?

25 A Yes.

1 Q Do you apply your independent skill, and knowledge to
2 creating such plans?

3 A Yes.

4 Q Based on input from colleagues?

5 A Yes.

6 Q And it's normal and customary for you in care and
7 treatment of patients to rely on conversations and discussions
8 with colleagues?

9 A Yes.

10 Q Did you design a lifetime care plan for Mr. Herrera for
11 his left foot?

12 Orthopedic surgery visits for his left foot?

13 A Yes.

14 Q And is there a cost associated with those visits?

15 A \$300 per visit.

16 Q How many times a year do you anticipate those visits to
17 be?

18 A Up to four times a year.

19 Q And do you also plan for Mr. Herrera's medical care to
20 include visits with an orthopedic spinal surgeon?

21 A Yes.

22 Q And what is the cost of those visits?

23 A \$500.

24 Q And is there a frequency with which you project those
25 visits?

1 A I'd say roughly once a year.

2 Q Over his lifetime; is that correct?

3 A Yes.

4 Q Do you project lumbar steroid injection series for Mr.
5 Herrera over the course of his lifetime?

6 A Yes, as his condition progresses and he has radiating
7 pain.

8 Q Is there a cost affiliated with those lumbar steroid
9 injections?

10 A Cost of \$1,200 for the injection, and \$2,000 for the
11 facility costs.

12 Q And what is the frequency with which those are
13 projected over Mr. Herrera's lifetime?

14 A I find that patient in his condition the average can be
15 roughly, approximately, three every two years for a lifetime.

16 Q And do you project cervical steroid injections for Mr.
17 Herrera over his lifetime?

18 A Yes.

19 Q Is there a cost affiliated with that?

20 A The same \$1,200 per injection, plus a \$2,000 facility
21 cost.

22 Q What is the frequency with which Mr. Herrera's
23 projected to have these treatments?

24 A Again, for systematic relief up to three injections
25 every two years on average for lifetime.

1 Q You project trigger point injections for Mr. Herrera
2 over his lifetime?

3 A Yes.

4 Q Is there a cost affiliated with such projections?

5 A \$300 per set.

6 Q And what is the frequency with which you anticipate Mr.
7 Herrera will get these injections?

8 A Again, on average, one set every three months for
9 lifetime duration for the cervical lumbar spine, as needed.

10 Q Did you plan future treatment for physician therapy for
11 Mr. Herrera?

12 A I feel he'd benefit from, yes, structured therapy to
13 assist with home and monitoring home exercises and stretching.

14 Q Is there a cost affiliated with physician therapy?

15 A \$100 to \$150 per visit.

16 Q Is there a frequency with which Mr. Herrera should
17 attend such therapy?

18 A I recommend once or twice a month.

19 Q Do you project occipital nerve block injections for Mr.
20 Herrera over his lifetime?

21 A Yeah, as needed for occipital headaches.

22 Q Cost associated with that?

23 A \$800.

24 Q What is the frequency with which you anticipate Mr.
25 Herrera will receive these occipital nerve block injections?

1 A Up to three times a year for lifetime.

2 Q Did you project a spinal cord stimulator for Mr.
3 Herrera?

4 A We have discussed the spinal cord stimulator in the
5 office. It is an excellent treatment option for patients who
6 chronic pain and who have diagnoses failed neck and back
7 syndrome. The spinal cord stimulator is a device where like I
8 said earlier if everything structurally is okay, but they're
9 having nerve related pain after surgery, and initial trial is
10 done where a lead or cable is put into the epidural space where
11 the medication's going before, but this cable is inserted up to
12 an area and it has leads on it they get fired at a very fast
13 rate, and what it does is just sort of stimulates your brain an
14 just sort of override the pain signal. And the way patients
15 have describe it to me as this sort of nerve pain just sort of
16 washes away while the stimulators on. There's a trial first
17 where you wear this device for one week, and the battery is sort
18 of taped on the side of your body. If that works, then the
19 trial gets removed and a permanent device will get placed.
20 That's why I sort of really like that procedure because patients
21 get to test drive it before doing anything permanent. The
22 permanent one will then be placed in the battery instead of
23 being taped on your body is actually just inserted under the
24 skin, that's similar to pacemaker battery. And I have discussed
25 it with Mr. Herrera. I feel he would be an excellent candidate.

1 Resources haven't been available to really proceed --

2 Q Doctor, have you performed such surgery yourself?

3 A I probably 30 a year.

4 Q Okay, and is there a cost affiliated with the trial?

5 A Yes.

6 Q Tell the jury what the cost is for the trial?

7 A The cost of the trial again for the week is
8 approximately \$25,000 that's including facility costs, equipment
9 costs, and physician costs.

10 Q And is there a cost affiliated with the permanent
11 implantation of spinal cord stimulator?

12 A The permanent implantation is the cost of approximately
13 \$50,000. Most of that cost is involved in the battery, the
14 device itself is the battery costs I believe it's about \$30,000.
15 And so that is -- and then the rest of the cost is, again, the
16 physician cost, the facility cost.

17 Q Does that battery have to be replaced?

18 A It does need to be replaced depending on the use it
19 gets fired at a frequency. Some patients again this is
20 something that gets tweaked and adjusted over time. Some
21 patients like it to be firing at very high frequency, so they
22 burn through their batteries quite quickly. And some people
23 like it at a much lower frequency, so those ones last a little
24 longer. So, I'd say the average replacement can be somewhere
25 between 3 to 7 years; and some people have gone on to like ten

1 years or so. But the earliest is about three years.

2 Q Is there a fee affiliated with the battery replacement?

3 A Yes. Again, it's about \$30,000 for the battery, and
4 then \$5,000 physician fee, and \$2,000 for the facility fee.

5 Q How frequently does the battery need to be replaced?

6 A Like I said, it's uses possibly at high frequency it
7 can be as early as like 3 to 5 years or upward of 7 to 10 years.

8 Q Okay, and that's for Mr. Herrera to use over the
9 lifetime; is that correct?

10 A Yes, if, again, provided the --

11 Q Doctor?

12 A Yes.

13 Q Is a separate spinal cord stimulator required for Mr.
14 Herrera's cervical spine?

15 A Yes, if he liked it for the lower back or the neck
16 whichever he tried first, then he would proceed with the trial
17 for the other and generally if he likes high frequency two
18 battery would be needed.

19 Q All right and is the cost the same --

20 A Yes.

21 Q \$5,000 for the trial?

22 A Yes.

23 Q And is the cost the same for the permanent implantation
24 in the neck as it is for the low back?

25 A Yes.

1 Q And is the battery replacement costs, physician's fees
2 and facility fees the same?

3 A Yes.

4 Q All right, and is there any difference between the pace
5 at which the cervical battery has to be replaced? Or is that
6 the same?

7 A Again, it all depends on the patient's use of it. So,
8 it's about the same.

9 Q Okay, 3 to 5 or 7 to 10?

10 A Yeah depending on how fast they go through it.

11 Q Did you make a plan which includes MRIs for Mr.
12 Herrera's lumbar spine?

13 A Yes.

14 Q And what is the cost of those MRI?

15 A Approximately \$1,300 every five years to monitor his
16 back.

17 Q Did you plan for MRI of the cervical spine?

18 A Yes.

19 Q And what's the cost of that?

20 A \$1,300 every five years over a lifetime.

21 Q And did you plan for MRI of the right shoulder?

22 A Yes.

23 Q And what is the cost of that?

24 A \$1,300 same every five years.

25 Q And did you prescribe an MRI of the left foot?

1 A Yes.

2 Q And tell us the cost there?

3 A At \$1,300 every five years. And it can be -- these are
4 just estimates -- if they are having pain. It's not like I tell
5 a patient, oh, you have to wait five years. And if they are
6 doing very well, it can be a bit more. I'm just giving an
7 average.

8 Q There is your plan consultation with other treating
9 physicians reflect upon the usual customary material you apply
10 and your examination of Mr. Herrera?

11 A Yes.

12 THE COURT: Slow down Mr. Kelly.

13 Q Your examination of Mr. Herrera, correct?

14 A Yes.

15 Q And did you prescribe x-rays for Mr. Herrera's lumbar
16 spine over the course of his lifetime?

17 A Yes, approximately every six-month cost of \$400.

18 Q Did you prescribe x-rays for Mr. Herrera's cervical
19 spine?

20 A Yes.

21 Q And is that over his lifetime?

22 A Yes.

23 Q What is the cost of that?

24 A Same every six months at a cost of \$400.

25 Q And did you prescribe x-rays for Mr. Herrera's right

1 shoulder?

2 A Yes.

3 Q What is the frequency?

4 A The same.

5 Q And the cost?

6 A The same.

7 Q And did you prescribe x-rays of Mr. Herrera's left
8 foot?

9 A Yes.

10 Q And the frequency for that?

11 A The same.

12 Q And the cost?

13 A The same.

14 Q Tell the jury, if you would, what EMG or NCV?

15 A EMG is a test that is done, so when I was discussing
16 earlier, about radiculopathy and the nerves being inflamed to
17 not having signal. The way I describe it to patients is sort of
18 thinking as a water hose it's now kinked and everything down
19 stream starts to die, whatever, it's watering grass. Whereas
20 the nerve is supplying water to the muscles and now if it's
21 being kinked the muscles will start to die. And EMG will just
22 pickup on that at a level, even if they are not showing weakness
23 it will show that starting to become some damage to the muscle.
24 And it will sort of tell us which nerves are involved depending
25 on which muscle is affected. And the EMG also give us an

1 ongoing issues if there's new damage, then we'll see high sort
2 of action potentials on the test. If it's old chronic damage,
3 then they are very small and low and we'll see different types
4 of findings on the EMG.

5 So, it can be helpful to determine if it's still just a
6 chronic issue or if because of some adjacent issue's going on
7 there's now a new acute issue happening, so that's why it's safe
8 to order get period EMG just to make sure it's either still just
9 a chronic issue or if it's not turned into acute or chronic.

10 Q Do you plan for EMG/NCV study for Mr. Herrera's upper
11 extremity over his lifetime?

12 A Yes.

13 Q And is there a cost affiliated with that?

14 A \$2,000 per study.

15 Q And what's the frequency of that study?

16 A Five years.

17 Q And did you prescribe EMG/NCV studies for Mr. Herrera's
18 lower extremity?

19 A Yes.

20 Q Over the course of his lifetime?

21 A Yes.

22 Q And what's the cost of that?

23 A \$2,000.

24 Q And frequency?

25 A Five years.

1 Q Now, this plan that you've made admittedly it's an
2 optimal plan, the best care for Mr. Herrera?

3 A Yes, I don't want to give and I don't think it would be
4 good to give a second best plan or crappy plan. Yes.

5 Q That's fine?

6 A I prefer to -- this is in an ideal world.

7 Q Okay, and the recommendations in your plan, Doctor, do
8 you have an opinion, to a reasonable degree of medical
9 certainty, whether the recommendations you make in your plan are
10 caused by the accidents to Mr. Herrera of March 5, 2013?

11 A Yes.

12 Q And what is that opinion?

13 A It's with a reasonable degree of medical certainty,
14 these recommendations are related to that accident.

15 Q Okay, doctor, if you weren't here with us today, what
16 would you be doing?

17 A I had to cancel my entire afternoon of patients and its
18 jacked up my scheduled for next week or so.

19 Q Is your office charging a fee for your appearance here
20 today?

21 A My office is charging yes a fee of, I believe, \$8,500
22 for my time.

23 Q Did you prepare certain reports in this case?

24 A Yes.

25 Q Is your office charging a fee from to those reports?

1 A Yes.

2 Q Do you know what it is?

3 A I think it's \$700. I think the first one is \$750 and
4 then each subsequent is \$450, but I'm not -- I believe that's
5 what it is.

6 Q All right. And, doctor, have I done an examination of
7 you in court before?

8 A Yes.

9 Q Probably over the last ten years, three times?

10 A With you, yeah. Three times or so.

11 Q Okay.

12 MR. KELLY: Doctor, I appreciate your time. I have
13 no further questions for you. Thank you.

14 MR. ROBERTA: Judge, can we just speak for one.

15 (Whereupon, the following discussion takes place in
16 the robing room among the Court and Counsel, outside the
17 hearing of the sworn jury.)

18 THE COURT: All right, Mr. Roberta.

19 MR. ROBERTA: So, obviously elicited twice
20 testimony regarding cost. We had a ruling that that was not
21 suppose to happen, it happened. And I didn't want to inject
22 on the spot because then that just draws more attention to
23 the testimony that wasn't supposed to come in. I'd like to
24 renew our application and just ask the doctor if he's a
25 named defendant in a Ricco suit, Federal Ricco suit, two of

1 them. I think it's the only fair way to proceed.

2 There was a motion in limine they weren't allowed
3 to negligence that, it got mentioned. I think it would be
4 allowed to ask --

5 THE COURT: It got mentioned? How did it get
6 mentioned.

7 MR. ROBERTA: It got mentioned the cost. The
8 doctor elicited the testimony he couldn't afford the
9 treatment.

10 MR. KELLY: He said if they are available.

11 MR. ROBERTA: Resources, resource is available.

12 THE COURT: Hold on don't talk over each other.
13 What did you think he said Mr. Roberta.

14 MR. ROBERTA: He said resources available. The
15 exact thing he wasn't supposed to say from this morning. He
16 said it twice.

17 THE COURT: So, I can barely hear the guy. It's so
18 hard to hear. What do you think he said, I will have
19 Lorraine read it back.

20 MR. KELLY: He said generally patients if resources
21 are available will avail themselves of these, whatever it
22 was. But he didn't say this patient doesn't have the
23 resources. That's completely mischaracterization.

24 THE COURT: First of all, I'm not, we're not -- the
25 Ricco stuff is not coming in. Nice try Mr. Roberta.

1 MR. ROBERTA: We have a ruling that we weren't
2 suppose to say it.

3 THE COURT: I respect your zealous advocacy. It's
4 not coming in. I do agree, I don't think -- that's not what
5 I was contemplating with my ruling.

6 MR. ROBERTA: He said resources available.

7 THE COURT: I know, but we were talking about
8 specifically with testimony that how would this guy know
9 that this plaintiff doesn't have the money and that's the
10 reason why he didn't follow-up with certain recommended
11 treatment, that's what we were talking about. And I already
12 gave you a ruling that we're going to deal with that. If
13 you guys want to bring it in, you can talk to plaintiff
14 about that. So I don't think, I don't think we're at
15 that --

16 MR. ROBERTA: I just thought the testimony was
17 elicited contrary to the ruling this morning that was my
18 opinion, Judge.

19 THE COURT: I disagree, but I respect your --

20 MR. ROBERTA: Thank you.

21 THE COURT: Desire to raise that. Okay, let's step
22 out.

23 (Whereupon, the following takes place in open
24 court, in the presence of the defendant and the sworn jury.)

25 CROSS EXAMINATION

1 BY MR. RAINIS:

2 Q Doctor Grimm, you have your records in front of you?

3 A Yes.

4 Q Could you just tell us when the last time it is that
5 you saw Mr. Herrera, the date?

6 A The last time was August 14, 2024.

7 Q Okay, so a month and a half or two months ago,
8 something like that?

9 A Yes.

10 Q And when was the time before that?

11 A Time before that was May 15, 2024.

12 Q Okay. Now, can you tell us, please, when was the last
13 time that he saw Doctor Sheskier his foot orthopedic surgeon?

14 A I don't have an exact date, but I believe it's been
15 sometime.

16 Q Okay, how about when is the last time he saw the
17 orthopedic surgeon in your practice group Doctor Kaplan?

18 A Doctor Kaplan I believe he'd seen --

19 Q Withdrawn. The question -- let me ask you this. Are
20 you aware that Doctor Kaplan was here testifying yesterday?

21 A Yes.

22 Q Did you speak with him about your testimony before
23 coming in today?

24 A Yes.

25 Q What did you say to him and what did he say to you

1 about testifying?

2 A I said -- he asked about you.

3 Q He had nice stuff to say, right?

4 A What?

5 Q He said nice sufficient to say, right?

6 A He said you were very respectful.

7 Q Are you aware that when he was here yesterday, Doctor
8 Kaplan said that the last time he treated the patient was in
9 2021, and that he had never told the patient to come back for
10 any schedule four time a year visits, but rather come back as
11 the need arises, are you aware of that?

12 A No.

13 Q And that would be in contravention of the plan you just
14 gave us about what the orthopedic visits are required and how
15 frequently they are going to be required in the future, correct?

16 A It's just average.

17 Q Now, when is the last time Mr. Herrera saw his spine
18 surgeon Doctor Brisson?

19 A I believe it's been sometime.

20 Q Doctor Brisson was here I think on Monday? I forget.
21 And he testified, as I recall it, that he last saw the patient
22 six years ago. And he had not seen him since, and he was not
23 seeking to see him with any frequency. And that would be in
24 contravention in what you just told the jury would be required
25 for future plan for Mr. Herrera, correct?

1 A I'm just giving you what I think an ideal plan would
2 be. I'd prefer to see a surgeon, if I had surgery. But, yes, I
3 know Brisson does not always follow.

4 Q And you would defer to the spine surgeon with respect
5 to how frequently the patient should see his spine surgeon,
6 correct?

7 A I think it's up to the spine surgeon and the patient.

8 Q And you would defer to Doctor Kaplan in terms of how
9 often, in fact, you asked Doctor Kaplan, you had said you asked
10 Doctor Kaplan this question, but you would certainly defer to
11 him in terms of how frequently Mr. Herrera needs orthopedic
12 evaluation, correct?

13 A Yeah, a lot of this is symptom dependent. If they are
14 having symptoms, you come in sooner. If you're not --

15 Q When is the last time you administered any injection of
16 any kind to Mr. Herrera?

17 A It's been quite sometime. We've discussed them, but I
18 believe for one reason or another we have not proceeded.

19 Q I'm sorry what?

20 A We discussed them in the office I offered them.

21 Q When is the last time you administered any injection of
22 any type to Mr. Herrera?

23 A I don't have an exact date. I can go through -- it's
24 been sometime.

25 Q In years we'd agree?

1 A Yeah.

2 Q Over five years?

3 A That I don't know.

4 THE COURT: What was the answer to that?

5 THE WITNESS: That I'm not sure. I'd have to go
6 through and look.

7 Q When is the last time you prescribed physician therapy
8 for Mr. Herrera?

9 A I recommend therapy every visit. Resources aren't
10 available, so I can't prescribe it, if he can't get it.

11 MR. ROBERTA: Objection.

12 THE COURT: Sustained. The jury is directed to
13 disregard that last question and answer.

14 Q When you recommend physician therapy, in order to get
15 physician therapy, doesn't a patient need a prescription?

16 A Yes.

17 Q Did you give him a prescription?

18 A Not if he can't get it.

19 Q When is the last time he had physician therapy?

20 A It's been years.

21 Q What medications is he taking currently for his
22 condition that you're treating him for?

23 A Currently he's -- as we talked about in his last visit,
24 he's getting -- buying over the counter medications.

25 Q And the plan that you came up with for his future care,

1 that was memorialized in your report dated September 25th of
2 this year?

3 A Yes.

4 Q Just what 5 or 6 days ago?

5 A Yes.

6 Q And you were asked to come up with that plan by the
7 plaintiff's lawyers for use at trial, correct?

8 A Yes.

9 Q Now, in your report it says that -- it doesn't say that
10 he's gonna need a spinal cord stimulator, but rather that he is
11 a candidate for someone who might need a stimulator, correct?

12 A Yes, I've discussed it with him. And feel he's good
13 candidate.

14 Q And it's true that in more than 50 percent of the
15 people who have a trial of spinal cord stimulators, don't get
16 benefit from it, correct?

17 A No. I'd say if selected properly, I have success rate
18 in the 70 to 80 range of patients proceeding on a permanent.

19 Q When was the last time you got an MRI of Mr. Herrera?

20 A Again, I've tried to send him for MRIs for one reason
21 or another we haven't been able to. His last MRI was dated --

22 Q Other than the -- can you other than the visit, you
23 talked about in your report in preparation for trial. Can you
24 tell me the last time in your office record there's a
25 prescription for that you wanted him to get an MRI of anything?

1 A I know we've discussed it, and he's been reluctant
2 to --

3 Q Can you point other than the last --

4 MR. KELLY: Can the witness complete his answer
5 before he shout over him.

6 THE COURT: Hold on, hold on, hold on. She can't
7 takedown multiple people talking over each other. There was
8 an objection, correct?

9 MR. KELLY: I apologize. I objected. :

10 THE COURT: Approach. Lorraine can you read that
11 back.

12 (Whereupon, there is a discussion held in the
13 robing room, outside the presence of the jury.

14 Whereupon, the Court Reporter reads back the
15 requested testimony.)

16 THE COURT: Look if it's nonresponsive it's
17 nonresponsive. Make your objection. Because he's not
18 responding to your question and that's not really what's
19 supposed to be coming in, unless you have another
20 suggestion. But your wincing Mr. Kelly. :

21 MR. KELLY: So, the they're creating a false
22 impression. Workers comp has to approve the MRI before he
23 issues a prescription for MRI.

24 MR. ROBERTA: That's not the case --

25 MR. KELLY: Workers Comp has to approve MRIs and

1 all this other treatment. They can't just raise the
2 impression that he's willy-nilly not doing the treatment.
3 And so the doctor's not going to have a prescription in his
4 records because workers compensation didn't approve it.

5 THE COURT: You can ask him that on redirect,
6 can't you? I mean.

7 MR. KELLY: I can.

8 THE COURT: And so the questions pretty simple it
9 was when is the last time there was a prescription for MRI?
10 I don't know, or last Tuesday or five years ago. But then
11 if he starts going off, that's on you.

12 MR. RAINIS: Understood.

13 THE COURT: Okay, anything else anyone wants to put
14 on.

15 MR. RAINIS: Excuse me?

16 MR. BAXTER: He's not on comp.

17 MR. KELLY: Not now.

18 THE COURT: Keep it on.

19 MR. RAINIS: The thing is, and my understanding of
20 the process for workers compensation, I have to put in a
21 request for authorization which is essentially a
22 prescription saying I want him to get an MRI, workers comp
23 will say yes or no, and then he will or won't.

24 MR. KELLY: Yes.

25 THE COURT: Ask him what you want to ask him.

1 MR. RAINIS: Okay.

2 THE COURT: If he starts going off track, that's on
3 you.

4 MR. RAINIS: Got it.

5 THE COURT: And you've already heard my ruling, so.

6 MR. RAINIS: Understood. Thank you.

7 THE COURT: Everybody out. I need to talk to my
8 court attorney.

9 (Whereupon, the following takes place in open
10 court, in the presence of the defendant and the sworn jury.)

11 THE COURT: Back on the record. Why don't we start
12 fresh.

13 CROSS EXAMINATION

14 BY MR. RAINIS:

15 Q When's the last time, and you had time to look now?

16 A Yes, I got it.

17 Q When is the last time you prescribed an MRI for Mr.
18 Herrera?

19 A So, I mean just looking back through, I've been
20 recommending an updated MRI and EMG, like in the 2023 visit,
21 2022. Back into -- so here I found it. This one is before the
22 2024 ones. February 2023, recommended update MRI/EMG, May of
23 May of 2022. Again, recommending update MRI and EMG. February
24 of 2022, again, was recommending update. So I have been
25 recommending it at our subsequent visits we --

1 Q Did you give him a prescription to get it done?

2 A I believe I did at one visit give him prescriptions to
3 get it done and he wasn't able to.

4 Q In the 11 or so years that you've been treating Mr.
5 Herrera, has any of the treatment that you've given him
6 significantly reduce his pain for any significant period of
7 time?

8 A Uhm, again, giving him some of the trigger points, the
9 SI injections has reduced his pain.

10 Q For how long?

11 A It was temporarily relief. The pain would return and
12 he's presently dealing with it.

13 MR. RAINIS: Thank you. I think that's all I have.

14 MR. ROBERTA: No questions, Your Honor.

15 MR. BAXTER: No.

16 REDIRECT EXAMINATION

17 BY MR. KELLY:

18 Q Doctor, the plan that you created for Mr. Herrera, what
19 is the standard that you use?

20 Is it the minimal care possible? Is it the ideal plan
21 for a person in pain? Is it the best medical practice, or
22 something else?

23 A It would be what I would consider the best plan for a
24 patient with his symptoms after surgery, and the best thing to
25 offer them for monitoring, as well as treatment.

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