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1                   I N D E X  
23                   DIRECT    CROSS  
45                   DR. MICHAEL GERLING  
6

7                   BY:    MR. DALY

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1 DR. MICHAEL GERLING

2 740 Park Avenue, New York, New York 10021, Sworn

3 DIRECT EXAMINATION BY MR. DALY:

4 Q. Good afternoon, Doctor. My name is  
5 Paul Daly. I'm an attorney with the law firm of  
6 Hardin, Kundla, McKeon & Poletto. We represent some  
7 of the defendants in a lawsuit brought by a Mr. Amat  
8 regarding injuries that he sustained in a car crash  
9 that happened in November 2020, and we're here today  
10 for the purpose of taking your deposition because  
11 you've been identified as an expert witness who may  
12 testify at the time of trial in this matter.

13 Have you ever had your deposition taken  
14 before, Doctor?

15 A. Yes.

16 Q. Okay. Approximately how many times?

17 A. I don't know. I mean I take Workman's  
18 Compensation insurance. I do depositions a couple  
19 times a month for them.

20 Q. Okay.

21 A. I've been doing it -- I've been in  
22 practice for almost 20 years, so I've done a lot.

23 Q. Sure. That's all I need to know.  
24 That's fine.

25 Do you maintain a list of cases where you have

1 testified as an expert witness?

2 A. I have somebody in my practice who does  
3 that, yes.

4 Q. Okay. And have you testified in court,  
5 in Federal Court as an expert witness ever?

6 A. Yes.

7 MR. DALY: Okay. So, Roman, I don't  
8 think I have his testimony list. I'll follow up  
9 with you for that, if you could provide that.

10 MR. AVSHALUMOV: Sure. I'll supplement  
11 it if you don't have it.

12 MR. DALY: I appreciate it. Okay.

13 Q. Doctor, when you've testified in court,  
14 has it always been for treatments that you've --  
15 sorry -- for patients that you've treated?

16 A. Yes. Yes.

17 Q. Okay. So in other words, there haven't  
18 been any occasions where you've been asked to do  
19 what might be called an independent medical  
20 examination of someone that you have not been  
21 involved in the treatment?

22 A. Correct.

23 Q. Okay. Now, your attorneys in this case  
24 have made a representation with respect to your  
25 association with NYU Langone, and I'd just like to

1 ask you to validate that representation for me. The  
2 representation is that you resigned your privileges  
3 at NYU Langone while there was an investigation that  
4 was in process.

5 Is that an accurate representation?

6 MR. AVSHALUMOV: I just want a notation  
7 of my objection for the record, but he can answer  
8 over my objection.

9 A. Yes. That's true.

10 MR. DALY: Okay. And, Roman, just so  
11 you know, I'm well aware of the court's order on the  
12 motion to quash. I fully intend to. But I  
13 understood that part of the ruling was based upon  
14 that stipulation from counsel, so...

15 MR. AVSHALUMOV: Yes. Yes.

16 Q. Okay. Doctor, have you ever resigned  
17 your privileges at any other hospital?

18 A. Yes.

19 Q. Which others or other?

20 A. At Lenox Hill.

21 Q. Okay. And what were the circumstances  
22 there?

23 A. I was -- I was -- I was at the point  
24 where I was renewing my privileges, and due to the  
25 fact that there was a -- like I wasn't practicing

1 there, I had to renew them, and because of the fact  
2 that there was a -- an ongoing civil lawsuit which  
3 was causing significant disruptions in  
4 investigations, I chose not to renew and then  
5 resigned.

6 Q. Okay. Any others other than just NYU  
7 and Lenox Hill?

8 A. No.

9 Q. Okay. Have you ever had your  
10 privileges revoked or suspended?

11 MR. AVSHALUMOV: Just note my objection  
12 to the question. I'll allow him to answer.

13 A. The only time was when I was in the  
14 middle of the administrative investigation due to  
15 the civil lawsuit.

16 Q. Was that at Lenox Hill or NYU?

17 A. At both.

18 Q. Okay.

19 A. But I mean at Lenox Hill it was  
20 irrelevant, because I wasn't practicing there.

21 Q. Okay.

22 A. It was more symbolic, really.

23 Q. How many surgical procedures do you  
24 perform on an average week or month or whatever time  
25 frame you want to use?

1                   A.           It depends on the week.  Sometimes two.

2                   Sometimes six.

3                   Q.           Okay.  And what percentage of the  
4                   surgeries that you perform are spinal surgeries?

5                   A.           100 percent.

6                   Q.           Okay.  Can you break that down further  
7                   into fusion surgeries?

8                   A.           Probably between 50 percent and 75  
9                   percent.

10                  Q.           Okay.  Doctor, when you testify in a  
11                  case involving a patient, do you consider yourself  
12                  to be acting at all as an advocate for your patient?

13                  A.           When I do a surgery on them?

14                  Q.           No.  When you testify.

15                  A.           Yes.  Of course.  I mean I'm being  
16                  asked -- I'm being asked to testify as their  
17                  treating doctor, and I have intrinsically their  
18                  interests at, you know, you know, I'm their -- I'm  
19                  their -- I'm their treating doctor.  I mean I'm  
20                  there as a fact witness to some extent I guess, and  
21                  of course I have opinions.  But most of my opinions  
22                  relate to the care that I performed, and the care I  
23                  performed is in keeping with the standard of care  
24                  and -- and in, you know, and those are the things I  
25                  agree to testify to when I go to court.

1 Q. Okay. Now, you treated Mr. Amat for  
2 injuries to his neck and back, correct?

3 A. Yes.

4 Q. Okay. And one of the opinions that you  
5 have offered is that the injuries you've treated Mr.  
6 Amat for were caused by the car crash of November  
7 23, 2020.

8 Is that correct?

9 A. I believe so. I'm just going to open  
10 up my initial note. Let's see. The initial note I  
11 believe was May 12, 2022, correct?

12 Q. I believe that's when you first saw  
13 him, correct, yeah.

14 A. Right. Right.

15 Q. Yeah.

16 A. And that was -- that was based -- when  
17 he presented, he did complain of injuries related to  
18 an accident on 11 -- on November 23, '20, 2020.

19 Q. Got it. You might be answering a  
20 slightly different question than the one I asked, so  
21 I'll ask it again to clarify, if that's all right.

22 A. Sure.

23 Q. One of the opinions that you offered is  
24 that the injuries you treated Mr. Amat for were  
25 caused by the car crash of November 23, 2020.

1           Is that correct?

2           A.       Yes.

3           Q.       Okay. And in forming an opinion as to  
4 causation, one thing that you would consider as a  
5 physician is the onset of symptoms.

6           Is that correct?

7           A.       Yes.

8           Q.       Okay. In other words, if a patient  
9 complained of pain in his neck and back immediately  
10 after a crash, that would tend to support the  
11 conclusion that the crash caused or contributed to  
12 the injury, correct?

13          A.       That it contributed to, yes, to neck  
14 and back issues, yes.

15          Q.       And likewise, if there was a  
16 significant lapse of time in the onset of symptoms,  
17 that would tend to support the conclusion that the  
18 injury did not support -- did not cause or  
19 contribute to the injury.

20          Is that correct?

21          A.       It's all relative. I mean it depends  
22 on the circumstance. If they have significant  
23 distracting injuries, like other broken bones and  
24 whatnot, it's well-known that they won't complain or  
25 focus upon disc herniations and things like that in

1 the short term. That's why we do skeletal surveys  
2 and do examinations of other body parts, because of  
3 that issue. So when patients have high energy  
4 trauma, in those scenarios they're more likely to  
5 have a delay in their complaints of axial pain than  
6 in patients that have isolated, more minor injuries.

7 Q. Sure. And I understand that Mr. Amat  
8 did have other injuries in this crash. That's not I  
9 don't think at all disputed. But and while there  
10 may be other explanations for a delay in onset of  
11 symptoms, generally speaking a delay in onset is  
12 something which would support the conclusion of a  
13 lack of causation as to -- as opposed to causation.

14 Is that correct?

15 A. It depends on what the delay is.  
16 That's a very open statement. It's very broad.  
17 Certainly there are circumstances where a  
18 substantial delay would -- would imply that the --  
19 that the symptoms were not related.

20 Q. Okay. And I know it's an open ended  
21 question, but at what point, what would you consider  
22 a substantial delay that would begin to imply that  
23 the symptoms are not related?

24 A. Like two to three months.

25 Q. Okay. Now, Doctor, we've been provided

1 with some records from you, and I'll show them.  
2 I'll show you -- hold on. I've got to share my  
3 screen, don't I?

4                   Are you able to see my screen, Doctor?

5                   A.           Yes, sir.

6                   Q.           And you see --

7                   A.           Yes.

8                   Q.           -- plaintiff's expert witness  
9 disclosure?

10                  Okay. I'm going to go to your report, which  
11 is part of -- part of this, and specifically page  
12 seven of your report. I'll shrink it a little bit  
13 so the whole thing fits on the screen. Hopefully  
14 it's still legible.

15                  According to your -- page seven of your  
16 report, you reviewed a number of records from  
17 various medical providers for treatment that Mr.  
18 Amat received during the days right after the crash,  
19 correct?

20                  A.           Yes.

21                  Q.           Okay. For example, you reviewed  
22 records from Raritan Bay Medical Center and Jersey  
23 Shore Hospital, correct?

24                  A.           I believe so. I'm just looking for it  
25 on the list. It's very small.

1 Q. Hold on. I can increase that size.

2 A. Oh. I see it. I see it. Yes.

3 Q. Okay.

4 MR. AVSHALUMOV: Yeah. Paul, I think  
5 you can maximize it, but it's completely small.  
6 It's better now.

7 A. That is so much better.

8 Q. Yes. I just wanted to try to get the  
9 whole page on, but that doesn't work. All right.

10 And you reviewed records from when he was in  
11 rehab in December 2020, correct?

12 A. Yes.

13 Q. Okay. To the best of your knowledge,  
14 do any of those records contain any reference to Mr.  
15 Amat complaining of pain in his neck and back?

16 A. Oh, I don't recall off the top of my  
17 head.

18 Q. Do you have an understanding of when  
19 Mr. Amat first began to complain of symptoms to his  
20 neck and back?

21 A. I -- I don't recall right now. I  
22 haven't -- I did not review those records in  
23 preparation for this deposition.

24 Q. Okay. Did you review anything in  
25 preparation for today's deposition?

1           A.        I briefly reviewed my narrative report.

2           Q.        Okay.  How did Mr. Amat become a

3 patient of yours?

4           A.        He made an appointment in my -- it

5 looks like my Coney Island office, and I did not  
6 make note -- I don't think that there is a referring  
7 provider.  I think he just made the appointment.

8           Q.        Okay.  So do you know if he had a

9 referral from somebody?

10          A.        No.

11          Q.        Okay.  Do you typically note in your

12 chart or other records if a patient was referred to  
13 you?

14          A.        Yeah.  We try to.  Yeah.  When we --

15 like regardless of whatever way they found us, we  
16 try to keep track of it.  So he may have told the  
17 front desk that he was in treatment, that he had  
18 multiple people telling him to go see a specialist,  
19 and he didn't recall specifically who told him that  
20 he should come see me.  So if it says in the  
21 referral, referring provider section direct  
22 professional, so it could have been like some -- it  
23 could have been a physical therapist, a doctor, it  
24 could have been a -- it could have been anybody.  It  
25 was like a professional helping him with his care.

1 Q. Where --

2 A. Or it could be that he doesn't even  
3 recall at all. But if they find me specifically on  
4 the Internet, we do specifically try to put in that,  
5 you know, we try to keep track of it.

6 Q. In your last answer, were you referring  
7 to a document?

8 A. No.

9 Q. No. Okay. Is there -- where would you  
10 -- if you did record that somebody was referred,  
11 where would that be recorded?

12 A. In here, in the front of the progress  
13 note, at the top of it, it says, "Referring  
14 provider."

15 Q. That's what I was asking about. Which  
16 progress note are you referring to?

17 A. May 12, '22.

18 Q. Okay. Thank you.

19 Have you treated any patients represented by  
20 the law office of Helen Dalton before?

21 A. I'm -- I'm not sure. I mean I've heard  
22 of them before possibly.

23 Q. Okay. Have you worked on any cases  
24 where the patient was represented by Mr. Avshalumov?

25 MR. DALY: Did I say your name close to

1 correctly, Roman?

2 MR. AVSHALUMOV: That's pretty good,  
3 yeah.

4 A. I don't think so.

5 Q. Have you worked with Roman before  
6 today, before this case?

7 A. If you can consider working with him  
8 being on this deposition with him as the plaintiff's  
9 attorney, I guess so. This is the only time, yeah.

10 Q. Do you ever receive referrals of  
11 patients from attorneys?

12 A. I'm sure that I do. I mean I  
13 specialize in -- in orthopedic spine surgery  
14 patients, I see patients that have a real wide  
15 variety of degenerative and traumatic injuries, and  
16 some of them I'm sure, you know, are given lists of  
17 good providing doctors. I'm sure that I'm getting  
18 referrals from them, sure.

19 Q. Okay. And if you are referred by an  
20 attorney, would that be in the referring  
21 professional section of the initial intake?

22 A. Right. We try to keep track of it.  
23 Yeah. It would be in there.

24 Q. Okay. Were you able to communicate  
25 with Mr. Amat in English?

1           A.        I don't recall another language  
2        specifically. Let me see. I mean I think so.

3           Q.        Okay. You performed two surgeries on  
4 Mr. Amat, correct?

5           A.        I believe so.

6           Q.        Okay. Do you classify either or both  
7 of them as elective surgeries?

8           A.        Yes.

9           Q.        Okay. And how do you define elective?

10          A.        Well, the patient had a scheduled  
11 surgery, they had a choice of whether to have the  
12 surgery or not. The surgeries were not life  
13 threatening. There are patients that refuse cancer  
14 care. There are patients that refer -- refuse  
15 surgical care, despite the fact that they're in pain  
16 or have some disability caused by the -- the  
17 symptoms and the ailment. So I mean I think that  
18 that makes it elective, yes.

19          Q.        Okay. What is The Gerling Institute?

20          A.        It's an academic private practice.  
21 Basically it's an institute where we do research and  
22 conduct practice of orthopedics.

23          Q.        And who is or who are the owners of The  
24 Gerling Institute?

25          A.        I am. I started it.

1                   Q.            Okay. So I'm going to show you an --  
2 well I've got to share the screen again. I'm going  
3 to show you what I've premarked as Exhibit G-2 --  
4 Gerling-2. Sorry.

5                   So do you see this document, Gerling-2?

6                   A.            Yes.

7                   Q.            Okay. And this is a statement from The  
8 Gerling Institute. And on the second page of this,  
9 it shows -- I'm sorry -- the bottom of the first  
10 page, not the bottom of the second page, has a  
11 balance due of \$456,325.73, if I read that  
12 correctly.

13                  Do you see that?

14                  A.            Yes.

15                  Q.            Okay. And it indicates in the header,  
16 the first part that Mr. Amat is insured by -- under  
17 a policy of insurance issued by an insurance  
18 company, it's identified as Bristol West Claims.

19                  Do you see that?

20                  A.            Yes.

21                  Q.            Did Bristol West pay for any of the  
22 services that you rendered to Mr. Amat?

23                  A.            It looks like they -- I don't know. It  
24 looks like there was a payment of \$535.30.

25                  Q.            Okay.

1                   A.         Could you just scroll up -- scroll up  
2 and let me see the top of the page, the very top?

3                   Q.         Sure. I'm sorry. The top, the very  
4 top.

5                   A.         Okay. Thank you.

6                   Q.         Do you know why the insurance company  
7 didn't pay for more of the services?

8                   A.         No.

9                   Q.         Okay. And the statement also has a  
10 reference to Mr. Amat's attorney. Do you know why  
11 there is -- the billing statement includes a section  
12 for Mr. Amat's attorney?

13                  A.         This -- this is an outside insurance  
14 company -- I mean an outside billing company, so  
15 they manage my billing, and they probably put that  
16 in there because the patient has a type of  
17 insurance, a class of insurance that requires  
18 statements and support from an attorney where they  
19 would give, you know, supporting documents that  
20 would help the billing process.

21                  Q.         Okay. Who is the billing company that  
22 you were using for this -- this particular invoice?

23                  A.         MBA.

24                  Q.         Is that like Mary Brown Arthur, like  
25 that?

1           A.        Yes.

2           Q.        Okay.  Is the law firm in any way  
3 responsible for satisfying the outstanding balance  
4 shown on Gerling-2?

5           A.        Yeah.  Usually they are.  I mean  
6 they're not personally responsible, but I mean we  
7 normally, if we take on performing a procedure, we  
8 -- we will -- will indicate the patient clinically,  
9 we'll make recommendations for care.  If they -- if  
10 they would like to proceed with that, if they agree  
11 to it, then we would investigate the status of what  
12 types of insurance they have, figure out what the  
13 appropriate billing would be.  If in fact it's a  
14 type of billing where we're uncertain of payment,  
15 such as like a car accident insurance, then we  
16 usually will ask the attorneys to sign a letter of  
17 -- letter of protection, which basically means that  
18 the patient agrees that they will -- that any money  
19 that's not paid by the insurance company would be  
20 covered by their lawsuit.

21           Q.        Okay.  And do you know if you have a  
22 letter of protection in this case?

23           A.        I don't recall right now.

24           MR. DALY:  Okay.  And, Roman, I'd ask  
25 that to follow up on that, and if there is an LOP,

1 to be provided a copy of that.

2 Q. And the way that works with a letter of  
3 protection is that assuming there is a recovery in  
4 the case, your firm will be paid out of the  
5 recovery, correct?

6 A. Yes.

7 Q. Your I said firm. I meant practice.  
8 You knew what I meant, right?

9 A. Yes.

10 Q. Okay. Are you familiar at all with the  
11 term litigation funding agreement?

12 A. Not specifically that term, but I  
13 understand the concept of it.

14 Q. Okay. Are you familiar with the idea  
15 that there are companies that will advance funds to  
16 litigants against the proceeds of a lawsuit?

17 A. Yes.

18 Q. Okay. Do you personally have any  
19 ownership interest in any company that deals in  
20 litigation funding agreements in any way?

21 A. No.

22 Q. Okay. And just slightly different  
23 question. Does any company that you have an  
24 ownership interest in have an ownership interest in  
25 any company that does litigation funding agreements?

1           A.           No.

2           Q.           Okay. And a just slightly different  
3 question. Do any of your immediate family members  
4 have an ownership interest in any litigation funding  
5 companies?

6           A.           No.

7           Q.           Okay. You've performed -- and I can  
8 pull up the operative report if that helps you.  
9 I'll just do that. Whether it helps you or not,  
10 I'll do it. I've marked this as Gerling-7, or I  
11 will mark this as Gerling-7, and then this is your  
12 operative report for -- I'm sorry. I pulled the  
13 wrong one. One moment. Your operative report for  
14 July 27, 2022. You operated on C5-6.

15           Is that correct?

16           A.           Yes.

17           Q.           And you performed a fusion surgery  
18 generically speaking?

19           A.           Yes. Yes.

20           Q.           Okay. And can you explain why you  
21 operated on that level as opposed to any other level  
22 in his cervical spine?

23           A.           Because I believed that was the  
24 symptomatic level.

25           Q.           Okay. And how is it that you came to

1 that determination?

2 A. Based off of my findings in the  
3 history, physical examination, and review of  
4 imaging.

5 Q. Okay. When you take a history from a  
6 patient, is it correct that you are relying on the  
7 patient being accurate and candid in providing that  
8 history?

9 A. Yes.

10 Q. Okay. And you're familiar with the  
11 term secondary benefit.

12 Is that correct?

13 A. Yes.

14 Q. Okay. And basically it means when a  
15 patient is pursuing medical treatment for some  
16 reason other than or in addition to improving their  
17 health.

18 Is that a fair statement?

19 A. I guess so, yeah.

20 Q. Okay. Have you ever had a patient  
21 where you thought to yourself, "This patient is here  
22 pursuing a secondary benefit"?

23 A. Yeah. I've been in practice for 20  
24 years. Of course.

25 Q. Yeah. Okay. And what have you done in

1 those situations or what types of things do you do  
2 in those situations?

3           A.        I mean I try to help them, and, you  
4 know, I really try to be objective about -- about  
5 what symptoms they're having and whether or not --  
6 whether they can be helped in a reasonable fashion.  
7 I mean I do what I think is appropriate to help them  
8 feel better. I mean I refer them for extensive  
9 conservative management, and I try to avoid doing  
10 surgeries or anything aggressive or invasive with  
11 them, but you know, if somebody says that they're in  
12 pain, just because you suspect that they have some  
13 secondary gain by -- by complaining of it doesn't  
14 mean that you have the, you know, the ability to  
15 ignore it. As a doctor we're obligated to try and  
16 help them, if they complain of pain, we're obligated  
17 to try and help them with their pain, so I will, you  
18 know, I will offer them -- I will offer them  
19 options. I certainly would be very cautious about  
20 doing any type of aggressive intervention though, of  
21 course, unless I believe that it's something that's  
22 reasonably going to help them.

23           Q.        What are the sort of things that you  
24 look for that might indicate to you that a patient  
25 is pursuing a secondary gain?

1                   A.           There are -- there are things called  
2                   Waddell signs, W-A-D-D-E-L-L, that are -- that  
3                   they're kind of -- kind of classically used for  
4                   that. So, you know, patients that -- patients that  
5                   where their history doesn't match up with their, you  
6                   know, their mobility and their function in the  
7                   office, so in other words, the physical exam doesn't  
8                   match the history, where their history doesn't  
9                   somehow make sense. Most of the Waddell signs are  
10                  related to physical examination findings. You know,  
11                  at the end of the day, it's very challenging. I  
12                  think that's one of the major issues that doctors  
13                  face with patients of all -- all types, even  
14                  patients that are, you know, even pediatric  
15                  patients, sometimes they're accompanied by their  
16                  parents, and their parents are -- are -- are, you  
17                  know, are telling a history that doesn't make sense,  
18                  and there have been disorders whereby they -- they  
19                  have, you know, they have noted psychological  
20                  disorders the parents have, secondary gain issues  
21                  the parents have, so there are a lot in every field,  
22                  we have to be conscious of it. Sometimes patients  
23                  have psychological factors that are impacting the  
24                  symptoms that they have. So we have to be very  
25                  careful and conscious, and we do our best to

1 mitigate those issues.

2 Q. Going back to Mr. Amat and going back  
3 -- I'm sorry to jump around a bit here with regard  
4 to the billing. Did you at all request that any  
5 payment be made up front for the services that you  
6 rendered?

7 A. I don't recall at all right now. I  
8 mean it looks like we used insurance.

9 Q. Okay. And do -- did you receive any  
10 payment up front for the services you rendered?

11 A. I don't know.

12 Q. Okay. Now, different payers of medical  
13 services, they pay different rates for the same  
14 service.

15 Is that correct?

16 A. Yes.

17 Q. Okay. In other words, like Medicare  
18 may pay one rate, an auto insurance company may pay  
19 another rate, and a health insurance company may pay  
20 an even different rate, all for the same procedure,  
21 correct?

22 A. That's true.

23 Q. Okay. Going back to Gerling-2, which  
24 is your -- your invoice here. The rates that are  
25 reflected here, what rates are these? In other

1 words, these aren't Medicare rates I assume, right?

2 A. These are the same rates that we would  
3 send to Medicare. They're -- they're called usual  
4 and customary rate fee schedule or Fair Health based  
5 rates. In other words, we -- we don't bill  
6 insurance companies or patients differently based  
7 off of insurance company. In other words, we don't  
8 use a fee schedule that's special for Medicare  
9 versus, you know, a car accident insurance or a  
10 commercial insurance company. We send the same bill  
11 to everybody, unless we participate as an inpatient  
12 -- as an in network provider and there's a specific  
13 fee schedule that we're required to follow.

14 Q. Okay.

15 A. But otherwise everybody else we send  
16 the same bill for, and those rates for each  
17 individual procedure or service are based off of  
18 usually Fair Health. Fair Health is a database that  
19 compiles the reimbursements for services by  
20 specialty and by sort of region or sub area, and so  
21 within like zip codes, for example, they'll collect  
22 all of the bills from all the providers, and they'll  
23 -- they'll give you a range of what the values are  
24 for what providers performing the service that you  
25 performed are getting paid. So it's based off of

1 actual payments to doctors by -- by insurance  
2 companies.

3 Q. Okay. I just want to clarify. So you  
4 will, regardless of who the payer is, you're going  
5 to bill the UCR rate, correct?

6 A. We usually do, yes.

7 Q. And usually. Okay. But the payer will  
8 pay a different rate irrespective of what you  
9 billed.

10 Is that correct?

11 A. Well...

12 Q. Let me clarify that. That was poorly  
13 phrased.

14 A. Yeah. You know, there are people that  
15 work in insurance companies that look at the bill,  
16 and they have ways of analyzing it and interpreting  
17 it, and it seems like it's kind of it does vary  
18 quite a bit from insurance company to insurance  
19 company, and that's true not just with my billing  
20 and with even with surgeon or medical doctor  
21 services, but that's true with all services. That's  
22 true with radiology services. That's true with  
23 hospital services. Regardless of the medical  
24 organization that's sending the bill, insurance  
25 companies seem to treat the bills uniquely, and even

1 the same insurance company can get the exact same  
2 bill and still pay differently from patient to  
3 patient, just for whatever reason. And, you know,  
4 and so it's not the most simple thing in the world,  
5 but that's the reason why we base our rates off of  
6 what's called the usual customary rate fee schedule,  
7 which is very similar to like Fair Health, basically  
8 it's Fair Health, which is the Fair Health database,  
9 it has sort of the averages and the range of which  
10 doctors are being paid for their services.

11 Q. Okay. So and are those done by codes?  
12 Are there codes for each service?

13 A. Yes.

14 Q. And so, for example, on your invoice,  
15 the first one here is for May 12, 2022. There's a  
16 five digit code of 99245, office consultation, and  
17 that's charged at \$760.

18 Do you see that?

19 A. Yes.

20 Q. Okay. So if I'm understanding you  
21 correctly, there's some database that -- and I'm  
22 sure it varies by geography and specialty and some  
23 other information, but there's some database where  
24 you would type in the numbers 99245, and the result  
25 would be \$760.

1                   Is that more or less correct?

2                   A.        Yeah.  Well, yup.  It would give you a  
3 range.  It doesn't give you an exact number.  It  
4 would say, because there is a range, as I said, like  
5 insurance, even the same insurance company will pay  
6 different depending on what the weather is outside  
7 that day, I don't know what they decide, but there  
8 will be a range of what's being paid.  In this case  
9 for that 99245, the range might be between \$500 and  
10 \$850 let's say, you know, and that's -- that's the  
11 range by which they're reimbursing.

12                  Q.        Okay.  And is it your billing company  
13 that actually does those codes and inputs the  
14 billing amounts?

15                  A.        Yes.  So the -- the -- they would  
16 create this document.  They -- they confirm that all  
17 of those codes are relevant to the surgery that I  
18 performed, and then they would send, or the office  
19 visit, whatever the services are that are performed,  
20 and then they would send that bill to an insurance  
21 company.

22                  Q.        And getting into some nitty gritty  
23 details I suppose, do you actually just send them  
24 the medical records and then they look at the  
25 medical records and determine the appropriate codes

1 to put in or do you give them more information than  
2 that?

3 A. It's based off of what's documented.

4 Q. In terms of treatment records?

5 A. Yes.

6 Q. Okay. And your rates, are they  
7 generally higher than what an insurance -- auto  
8 insurance company would pay?

9 A. No. Not necessarily.

10 Q. Okay. Are they generally higher than  
11 what Medicare would pay?

12 A. Yes.

13 Q. Okay. And I'm going to ask you to  
14 estimate here obviously, although you might have an  
15 exact number, I don't know.

16 What percentage of your patients are seeing  
17 you because of a traumatic condition, they were in  
18 some kind of a crash or a collision or something  
19 like that, a fall down?

20 A. Like 30 percent historically probably  
21 around there.

22 Q. And this may be -- this may overlap  
23 with the last question, but what percentage are  
24 seeing you because of an injury which is acute, but  
25 not necessarily traumatic, if that's a fair

1 distinction to make?

2 A. That's not really -- that's confusing,  
3 because --

4 Q. Yeah.

5 A. -- traumatic injuries are acute.

6 Q. Okay.

7 A. Yeah.

8 Q. So it may be something that happened  
9 traumatically, in other words, they were just  
10 walking down the stairs, and all of a sudden, they  
11 had tremendous back pain, but they didn't fall.  
12 You're classifying that as that's within traumatic  
13 as well?

14 A. No. It would be -- that would be, if  
15 they didn't fall and get injured, if they just had  
16 back pain that occurred, but it happened recently,  
17 then it would be acute. It would not be considered  
18 traumatic. Traumatic is when somebody has an  
19 injury.

20 Q. Okay. And what percentage, again, if  
21 you know, what percentage of your patients are  
22 involved in litigation of any type?

23 A. I have no idea.

24 Q. Okay.

25 A. I'm going to guess that it's less than

1 20 percent.

2 Q. Okay. Going to the bills in this case,  
3 Mr. Amat, he was a manual laborer. How would you  
4 expect him to pay \$450,000 in medical expenses if he  
5 doesn't have insurance or if he doesn't have a  
6 recovery in this lawsuit? Would you?

7 A. Oh, if he doesn't have a recovery in  
8 the lawsuit?

9 Q. Yeah.

10 A. Oh. I don't know. We'd have to -- I  
11 don't judge people based off their profession, you  
12 know, we -- just like a hospital, a hospital would  
13 send you a bill if you go to the emergency room, and  
14 then if you have, you know, a certain income level,  
15 they -- they work with you and try to help you with  
16 the -- with it. It's no different with my practice  
17 than if you went into the hospital and went to the  
18 emergency room and had care. He probably has bills  
19 from the hospital from his treatment, and I'm sure  
20 that's the same thing.

21 Q. Yeah. Have you referred his account to  
22 a debt collection agency?

23 A. I don't think so. I don't think so.

24 Q. Okay. Is that because of the letter of  
25 protection?

1           A.       Probably.

2           Q.        My office retained Dr. Edward Decter to

3 examine plaintiff.

4           Have you reviewed his reports at all?

5           A.        I don't think so. I mean I -- I don't

6 think so, no.

7           Q.        Okay. I did not see them referenced in

8 your report, so --

9           A.        Right.

10          Q.        -- that's why I ask.

11          Okay. Do you know Dr. Decter at all?

12          A.        No.

13          Q.        So you have no opinion as to either his

14 skill as a physician or his integrity as a witness?

15          A.        No.

16          Q.        Okay. Have you ever in any way sought

17 out or solicited referrals of patients from law

18 firms?

19          A.        No. I mean I wouldn't say so.

20          Q.        Okay. Have you ever done any like

21 speaking events for groups of lawyers or anything

22 like that?

23          A.        I don't think so.

24          Q.        Okay. I marked as Gerling-4 progress

25 notes and treatment records from your office. I put

1       them all together into one exhibit. Just I thought  
2       -- I thought it might make it easier. I might be  
3       wrong. But that's what I was trying to do. And we  
4       have -- what I have here is Exhibit 4 is treatment  
5       records from May 12, 2022, October 11, 2022, and  
6       January 13, 2022 -- I'm sorry -- 2023, and then  
7       March 14, 2023. Just I didn't press that. Hold on.  
8       I'll represent to you and I'll show you if you want  
9       each of these has your signature at the end of the  
10      record, or electronic signature probably, it looks  
11      like an electronic signature to me, but you can tell  
12      me.

13           Do you see that?

14           A.        Yes.

15           Q.        Okay. Does that mean that you  
16      personally examined Mr. Amat on each of these  
17      occasions?

18           A.        If I -- if the patient had a visit with  
19      me, yes.

20           Q.        Okay. So I can take that, the fact  
21      that each of these is signed to mean that you saw  
22      him on each of those dates.

23           Is that correct?

24           A.        Yes.

25           Q.        Now, there are sections of each of

1 these reports that are verbatim in many if not all  
2 of the records, for example, the first paragraph of  
3 each of the reports. And I'll show you. I'm happy  
4 to do that. The first paragraph is identical in  
5 each of these reports. I don't know if you need me  
6 to, but I'm happy to do it.

7 A. No. No. You do not need to.

8 Q. Okay. Thank you.

9 How does it happen that we wind up with the  
10 identical sections in each of these reports? Can  
11 you explain that to me?

12 A. Yeah. So that section right there is  
13 sort of what we consider like a summary section of  
14 the way that person had their -- like their problems  
15 start. So let's just say that it was an 80 year old  
16 that, you know, had a chronic non traumatic  
17 condition that started at home and it was mechanical  
18 pain. You know, we would make an effort to put that  
19 summary in -- in this section of the chart, and so  
20 that every time that you open the chart you kind of  
21 know the general injury of the patient, and we add  
22 to it, like if there was a subsequent injury or  
23 something like that, or if we find out about  
24 something else, we'll add to that section, we think  
25 that's like the most pertinent information related

1 to the overall condition that the patient is  
2 presenting with.

3 Q. Okay.

4 A. But it didn't change, if we didn't find  
5 out more information about the accident, for  
6 example, we would not change that section.

7 Q. Yeah. I meant it in a more mechanical  
8 sense, and so I'll clarify. Do you use a particular  
9 type of software for your medical records?

10 A. Yes.

11 Q. Okay. What -- what type is that or  
12 what type was that during this relevant time period?

13 A. Prognosis.

14 Q. Prognosis. Okay. And when a patient  
15 comes to see you on a particular date, how do you go  
16 about generating a record in Prognosis?

17 A. It's electronic medical record. We go  
18 in and we -- there are different sections of the  
19 patient's chart that we have to go in and we have to  
20 adjust or -- or verify with the patient, for  
21 example, there will be windows for like past medical  
22 history, and we'll -- we'll have to review them with  
23 the patient and make sure that they haven't changed  
24 their medications and review it, make sure they  
25 haven't changed, so you have to -- it's sort of like

1 -- it's like most electronic medical records, you  
2 point and click, and then in areas you fill in, you  
3 type in whatever you feel like is relevant to the  
4 issue.

5 Q. If a patient is seeing you for a second  
6 or a subsequent time, does the software auto  
7 populate certain fields?

8 A. If you tell it to.

9 Q. I mean from prior visits.

10 A. But you check boxes, you check boxes,  
11 and it will have, when you check the box, it will  
12 have what was there the last time, and then you go  
13 in and you verify, and you change whatever you think  
14 needs to be changed.

15 Q. Okay. So, yeah. So like when he came  
16 to see you, Mr. Amat came to see you on August 11,  
17 2022, which I think was his second visit to you,  
18 when you opened this record, would there be this  
19 information?

20 A. Yes.

21 Q. Mechanism of injury, would that already  
22 be there?

23 A. Yes.

24 Q. And then you would need to verify that  
25 and check that, correct?

1                   A.        Well, it would be the first thing that  
2 we see, yes, we would look at it and we would just,  
3 in this case it's usually something that hasn't  
4 changed, but we would ask them, have you had any new  
5 injuries or issues. If they say no, then we just --  
6 we would -- we would continue that. I mean usually  
7 I'll read it just for accuracy to make sure that  
8 there were no mistakes in it, but...

9                   Q.        Okay. So and maybe a dumb question,  
10 but you don't actually retype this each time?

11                  A.        No.

12                  Q.        Okay. Now, and again, help me out with  
13 understanding Prognosis and how that works. There  
14 are some sections, and I'm on page 11 of the PDF for  
15 this exhibit that are in red. What does the red  
16 indicate, if anything?

17                  A.        If it's -- if it's something with  
18 specifically changed that day, like if the patient  
19 changed, if their weight was changed.

20                  Q.        Okay.

21                  A.        If their, you know, we looked below  
22 where it's red, after cervical spine exam. Those  
23 are things that we specifically change that day or  
24 added to, yeah, manipulated.

25                  Q.        So red indicates that this was not in

1 the prior record essentially?

2 A. Or was modified.

3 Q. Or was modified. Fair.

4 A. That's not always true. Like up above  
5 there are sections that have new things in them that  
6 were not necessarily there during the prior visit.

7 They just won't be red.

8 Q. Okay. Is there any way to know aside  
9 from doing a line by line comparison about those  
10 other ones?

11 A. No.

12 Q. Okay. And do you know why some changes  
13 are highlighted in red and others -- others aren't?

14 A. No.

15 Q. Okay. Prior to operating on Mr. Amat,  
16 did you personally review his imaging studies?

17 A. Yes.

18 Q. And did you review all of the available  
19 imaging studies?

20 A. Yes.

21 Q. Okay. Do you have x-ray equipment at  
22 your offices where you practice?

23 A. Yes.

24 Q. Did someone at your office take any  
25 x-rays of Mr. Amat in your office?

1                   A.        If we did, it's in the note.  
2                   Q.        Okay. And if you didn't, it's not?  
3                   A.        Most likely, unless there's a mistake.  
4                   Q.        Okay. I'm going to show you again what  
5                   I marked as Gerling-5, which is your operative  
6                   report from July 27, 2022. And I have also, if you  
7                   -- if you want to review it, it's fine, I have the  
8                   -- an MRI report from May 14, 2022, which is the  
9                   cervical spine. The reason I mention that is my  
10                  question is during the course of this procedure on  
11                  July 27th, were there any findings which you made  
12                  which were in any way different or inconsistent with  
13                  the MRI films that you reviewed?

14                  A.        I don't believe so. I don't recall  
15                  right now.

16                  Q.        Okay. Did you take any photographs or  
17                  I suppose more accurately digital images during the  
18                  July 27th procedure?

19                  A.        No.

20                  Q.        Okay. The procedure took place at  
21                  Hudson Regional Hospital?

22                  A.        Yes.

23                  Q.        Why did you choose this location?

24                  A.        I -- I didn't choose it. My  
25                  coordinator and the patient did.

1 Q. Okay. You perform surgeries at more  
2 than one facility?

3 A. Yes.

4 Q. And essentially, your coordinator and  
5 the patient, they -- they pick the dates and the  
6 facilities, and you go where they tell you?

7 A. Yes.

8 Q. Essentially. Okay. I don't mean to be  
9 flippant there, but that's the basic process?

10 A. Yes.

11 Q. Okay. Do you have any ownership  
12 interest in Hudson Regional Hospital?

13 A. No.

14 Q. How about Care Point Health?

15 A. No.

16 Q. Okay. Do you know Yan Moshe at all?

17 A. Oh, yeah.

18 Q. You've met him?

19 A. Yes.

20 Q. How do you know him?

21 A. He was the former owner of Hudson  
22 Regional Hospital.

23 Q. Okay. And when did he cease to be the  
24 owner, do you know?

25 A. No.

1 Q. I actually wasn't aware of that. Okay.  
2 Have you ever had any business dealings with him of  
3 any kind?

4 A. Not -- not directly. I mean he -- he  
5 is very involved. I don't know what his title is or  
6 his direct involvement is with -- with Hudson  
7 Regional Hospital, but he's been involved in the  
8 acquisition and management of a hospital called  
9 Bayonne Medical Center, which is a part of the Care  
10 Point system which you brought up earlier, so I  
11 assume you're familiar with it.

12 Q. Somewhat.

13 A. And they asked me, the institution at  
14 Bayonne asked me to be their director of  
15 musculoskeletal care, and which I am now, and so he  
16 as a part of the organization of course would have  
17 been involved as a part of the organization, not  
18 personally, just direct -- just through the  
19 organization.

20 Q. Now, after the surgical procedure that  
21 you performed for -- sorry -- the cervical procedure  
22 that you performed for Mr. Amat, he remained  
23 symptomatic, correct?

24 A. Yes.

25 Q. Okay. Did he have any improvement with

1 respect to the symptoms of his neck after the  
2 surgery?

3 A. We'd have to review the chart.

4 Q. Okay. Progress note for March 14,  
5 2023. Is there a particular section of the chart  
6 that you would look at to determine that? I'm  
7 showing you now your progress note from March 14,  
8 2023, which I believe is your last progress note.

9 And my question is: Is there a particular  
10 section of this report that you would look at to  
11 determine what kind of improvement Mr. Amat had  
12 after the surgery?

13 A. Yeah. I mean it's not -- it's not one  
14 particular thing, it's everything. I mean in -- in  
15 everything below history of present illness,  
16 follow-up consultation, which is at the bottom of  
17 the page, everything is what we found that day, and  
18 so I mean it very specifically says the symptoms  
19 remain unchanged since the last examination. He is  
20 unable to work due to the symptoms. It specifies  
21 how much neck and shoulder and arm pain he had,  
22 which I believe is actually less than how he  
23 presented initially. He had pain going to his  
24 shoulder as opposed to during his initial visit, in  
25 his initial visit he had pain that was radiating

1 down his right arm and left arm, so on both sides,  
2 so not just the shoulder, but the arms bilaterally,  
3 and he had numbness and paresthesias extending into  
4 both hands with occipital cervical headaches versus,  
5 you know, during the -- during the visit that we  
6 were just referring to, his -- his neck pain was  
7 associated with pain radiating to the left shoulder  
8 only without numbness and paresthesias ranging down  
9 to the hand. His pain levels, the visual analog  
10 scale pain numbers were at four for neck and five  
11 for arm. So they were -- I think he did have  
12 substantial improvement at that point.

13 Q. Okay. You've answered the next  
14 question I was going to ask. How would you qualify  
15 or describe the improvement he had? You would say  
16 substantial?

17 A. Yes.

18 Q. Okay. Do you consider cervical fusion  
19 to be a high risk procedure?

20 A. In some doctor's hands, yes.

21 Q. You don't consider it to be in your  
22 hands? Is that what you're saying?

23 A. Well, I mean it's -- I would -- it  
24 depends on the patient, too. I operate on patients  
25 that are high risk all the time. You know, if it

1        were a healthy younger person, doing this procedure,  
2        it's less dangerous and less risky than in a patient  
3        of this age. I mean this gentleman, look, at the  
4        time of the accident, was 79 years old. Is that  
5        right?

6            Q.        No. I don't think so. Wait. Hold on.

7            A.        He was from '54 to 70 -- to 2022.

8            Q.        I believe he was mid 60's, I believe it  
9        was.

10          A.        He was born January 26, '54?

11          Q.        Oh. Yeah. You're right. There it is.

12        Sorry. Around 60.

13          A.        60 would be if he was born in '64. He  
14        was born in '54, right?

15          Q.        You're right. You're right.

16            MR. AVSHALUMOV: He turned 71 just  
17        recently.

18            MR. DALY: Okay.

19          A.        No. Right. Right. That makes sense.

20          Q.        Last January. Yes.

21          A.        Right.

22          Q.        You're right.

23            MR. AVSHALUMOV: So he was 69 at the  
24        time, 68, 69.

25          Q.        No. You're correct. Okay. So you

1        were saying? Sorry. I interrupted.

2            A.        Yes. He was about 70 years old, so I  
3        mean he's not -- he's not a young person, and so,  
4        you know, obviously older people have more risk.

5            Q.        So for Mr. Amat would you classify as  
6        high risk, given his condition and his situation?

7            A.        I'd say moderate risk.

8            Q.        Okay. And what risks did you tell Mr.  
9        Amat about prior to the surgery?

10          A.        I mean older patients have the same  
11        risks that younger patients have, they just have  
12        higher percentages of occurrence.

13          Q.        Yeah. No. I just meant what are the  
14        risks associated with this procedure that you  
15        informed him of?

16          A.        There are a lot. There are anesthesia  
17        related risks and then there are surgical risks.  
18        Anesthesia can be anything from blindness, deaf,  
19        heart attack, stroke, ventilation issues with the  
20        lungs, organ failure, and then with the wound, you  
21        can have complications related to the surgery  
22        itself, cutting the skin, and no matter what the  
23        procedure is, there's always some intrinsic risk of  
24        infection, of bleeding, vascular injuries. I mean  
25        there are some pretty sensitive structures where

1 we're operating in the neck, and all of those  
2 structures could be damaged, problems with the  
3 esophagus, the trachea, the innervation to those  
4 areas, so patients can have hoarseness of their  
5 voice, they can have problems swallowing afterwards,  
6 they can have problems with -- with aspiration and  
7 other issues related to their -- the functioning of  
8 their throat. They can have wound complications  
9 like infection as I said and bleeding. They can  
10 have neurologic injuries related to the spinal cord  
11 and the nervous system that's actually coming out of  
12 the spinal cord, we call those nerve roots. They  
13 can have a recurrence of their injuries or of their  
14 symptoms. They can have what we call adjacent  
15 segment disease, where like other levels have  
16 accelerated arthritis. They can have major vascular  
17 injuries, which if you do enough of these, you will  
18 see those, you know. You could have hardware  
19 problems, hardware failure, which is something that  
20 we see occasionally. Yeah. So -- so I mean quite a  
21 few risks.

22 Q. Yeah. Okay. And what did you tell Mr.  
23 Amat about the potential benefits of the surgery?

24 A. That we hoped we would improve his --  
25 his arm pain, his -- his numbness. Let me just go

1 back to his original symptoms here. He had  
2 headaches which did improve post op. He had  
3 difficulty with sleep, that his, you know, his neck  
4 pain was eight, his arm pain was eight. As I said,  
5 even in March, which was quite soon after the  
6 surgery, he was down to five and four, so, you know,  
7 the hope is that he has some improvement of the neck  
8 pain and that he had some improvement of the arm  
9 pain, you know, and that the neurologic symptoms,  
10 including like he said that he had instances of  
11 tripping and stumbling, so his balance was not  
12 ideal, that those things would ultimately be  
13 effected by things and the neck will improve.

14 Q. And did you discuss with him at all --  
15 and this is a similar question, but just slightly  
16 different.

17 Did you discuss with him the likelihood that  
18 he would receive those benefits of the procedure?

19 A. Probably. You know, I don't recall  
20 specifically, but usually we talk about it.

21 Q. With respect to the lumbar spine, I can  
22 put that up if it helps you. I'll put it up whether  
23 it helps you or not. This was a procedure you did  
24 on June 2, 2023. And my first question is why did  
25 you perform a discectomy instead of a fusion like

1 you did on the cervical spine?

2 A. I'm looking at the notes.

3 Q. Sure.

4 A. Well, I do a discectomy when I believe  
5 that the patient has neurologic symptoms being  
6 caused by a nerve that's being pinched, but I don't  
7 think that there's like a structural problem that  
8 needs to be corrected.

9 Q. Okay. Did your decision to go with the  
10 discectomy at all have anything to do with the level  
11 of degeneration that he had in his spine at any  
12 point?

13 A. No.

14 Q. Okay. And I'll ask a similar question  
15 to what I asked with regard to the cervical spine.

16 During the course of your procedure, did you  
17 find anything which differed in any clinically  
18 significant way from the MRI studies that you viewed  
19 beforehand?

20 A. I don't believe so.

21 Q. All right. Similar questions to what I  
22 asked with the cervical spine. After he remained --  
23 he had some symptoms after the lumbar surgery,  
24 correct?

25 A. Yes.

1                   Q.         Did he have some level of improvement  
2                    after the lumbar surgery?

3                   A.         Well, preoperatively he had eight out  
4                    of ten back pain, eight out of ten leg pain,  
5                    primarily going down the left leg, it looks like  
6                    numbness in the leg, balance -- or no, difficulty  
7                    walking one to two blocks because of the symptoms,  
8                    couldn't stand more than five minutes without  
9                    symptoms, and then if we look at his post op, see,  
10                  when was that surgery done?

11                  Q.         I just had it. Give me a second. June  
12                  2, 2023.

13                  A.         If we look at his post op visit on  
14                  August 1, 2023, so the two month point, he had four  
15                  out of ten back pain, he could walk 20 blocks, stand  
16                  for 30 minutes, didn't have any leg numbness, so I  
17                  would say that he had substantial improvements, even  
18                  though -- even though there was, you know, there was  
19                  still some residual symptoms.

20                  Q.         Okay.

21                  (There is a discussion off the record.)

22                  (There is a recess.)

23                  Q.         So, Doctor, I only have a few more  
24                  questions for you. I won't be much longer.

25                  So referring to the MRI's of the cervical

1       spine, do you acknowledge that there is some level  
2       of degeneration in Mr. Amat's spine?

3           A.        Yes.

4           Q.        Okay. I mean he's 60, whatever we  
5        figured out he is, 70 years old, you would be  
6       surprised if there wasn't degeneration in his spine,  
7       correct?

8           A.        Not surprised. I mean just it's more  
9        common. He has degenerative changes that we see.

10          Q.        So pretty typical and common.

11          Is that correct?

12          A.        Yes.

13          Q.        Okay. Now, counsel advised in his  
14        disclosure statement that you charge \$11,000 per day  
15       for testifying.

16          Is that correct?

17          A.        Yes.

18          Q.        Okay.

19          A.        I mean I haven't sent the invoices in a  
20       long time. I have somebody who does that.

21          Q.        Okay. And is that whether you testify  
22       for an hour or full day, it's the same, same rate?

23          A.        Yeah. I mean if they book, if they  
24       tell me they need me for the full day, yeah.

25          Q.        Okay. Okay. If they don't tell you

1       they need you for the full day, you'll adjust for  
2       the charge accordingly?

3           A.        Yeah.  Oftentimes.  I mean it depends.

4        Yeah.  If they tell me they only need me for two  
5        hours, it's different, of course.

6           Q.        Okay.  Okay.  And how did you -- and  
7        maybe it wasn't you, but I'll ask it this way.  How  
8        did you determine your rate to charge for  
9        testimonial work that you do?

10          A.        You know, it's not like -- it's not --  
11        not based off of some index or something like that.  
12        I mean I think that's the reasonable going rate in  
13        my area that I work in.  I know surgeons that charge  
14        a lot more.  I know defense doctors who charge a lot  
15        more.  I know -- I know surgeons that charge less.  
16        You know, like I -- I have to cancel surgeries, I  
17        have to cancel sometimes 30 or 40 patients in the  
18        office in order to reserve the day for testimony,  
19        and it's very damaging to my practice, and  
20        oftentimes it gets moved around last minute, so it's  
21        very, very hard on my practice, very damaging, so I  
22        think that what I'm paid is -- is what I would  
23        consider acceptable for making those cancellations.

24          Q.        But it sounds like, and I don't want to  
25        put words in your mouth, but it sounds like you've

1       asked other practitioners what kind of rates they  
2       charge and used that as something of a guide?

3           A.        Yeah.  I mean early on.  I mean I don't  
4       think I've raised my rates for years, like for a  
5       long time, you know.  I -- yeah.  I mean I did back  
6       in the day, I guess.

7           MR. DALY:  Sir, I don't have any other  
8       questions for you.  I don't know if any other  
9       attorney does.  I'd be surprised, but they have the  
10      right.

11           MS. ADAMS:  I don't have any other  
12      questions.  Thank you.

13           MR. AVSHALUMOV:  Thank you, Doctor.  
14      Much appreciated, you being here today.  We're done.

15           MR. DALY:  Okay.  All right.

16           (Plaintiff's expert witness disclosure is  
17      marked Gerling-1.)

18           (Itemized statement is marked Gerling-2.)

19           (Report of Edward M. Decter, M.D., FACS  
20      (2/27/2023) is marked Gerling-3.)

21           (Packet of progress reports is marked  
22      Gerling-4.)

23           (Operative report (7/27/2022) is marked  
24      Gerling-5.)

25           (Packet of radiology results (3/14/2022) is

1 marked Gerling-6.)  
2 (Operative report (6/2/2023) is marked  
3 Gerling-7.)  
4 (Packet of radiology results (3/14/2022) is  
5 marked Gerling-8.)  
6 (Proceeding adjourned at 4:49 P.M.)  
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## C E R T I F I C A T E

I, FRANK BIELY, a Certified Court Reporter of the State of New Jersey, certify that the foregoing is a verbatim transcript of the testimony of the aforementioned first duly sworn by me. I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which the deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in the action.

FRANK J. BIELY

CERTIFIED COURT REPORTER

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