- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 5/5 Left IO: 5/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Grossly intact in the L3-S1 dermatomes.

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis

C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0041355 Dated: 08-17-2022

Test	Result
X-Ray	
XR CSP - AP/Lat	MG: S/P ACDF C5-6 with hardware intact. C6-7 LOH

Radiology Remarks: LHR
Report:
C5-C6 SP ACDF: no lucency around the screws.
C6-C7 disc space narrowing with minimal anterior spondylosis.

Order No: EXT0043029 Dated: 10-25-2022 Rad: Duane Office

Test	Result
X-Ray	
XR LSP - AP/Lat + Flex/Ex	MG: No fractures or dislocations

Radiology Remarks: Duane on Ambra

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Herniation of cervical intervertebral disc with radiculopathy (M50.10)
Assessment: S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy
Plan: - Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- Lifting is restricted to < 20lbs.
- Physical Therapy was continued today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.

- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: .
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear
Plan: - Referral for pain management given today
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- The patient will continue to see pain management for regular follow-up appointments.
- Physical Therapy was continued today for the back along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.
- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.
.

- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Derangement of right knee (M23.91)
Assessment: .
- Right knee derangement
S/P arthroscopy
Plan: - F/U with specialist.

New Orders & Referrals:

Consultation(s):
Pain Management - LESI

DME/Bracing and/or Procedures:

CPT Codes:
Office O/p Est Mod 30-39 Min (99214)

Follow Up:
Dr. Gerling 2 months after pain management consult. to discuss discectomy if no positive results.

Please let this report represent a letter of medical necessity for our treatment plan

---

Prosper Jerome, NP-C
This has been electronically signed by Prosper Jerome, NP-C on 01-13-2023.

This has been electronically signed by on 01-13-2023.

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Manhattan

110 Duane St., New York NY 10007

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Michael Gerling, M.D.	Direct Professional	03-14-2023	SCL13601
Appointment Location:	**Appointment Location Address:**		
Manhattan	110 Duane St., New York NY 10007		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear.
- Lumbar facet joint syndrome.
- S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy.
- Myelopathic and radiculopathy findings.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
ACDF C5-6: 07-27-2022 by Dr. Gerling at Hudson
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:
Follow up consultation
Date of surgery: 07-27-2022
Juan presents today with neck disorder and with low back disorder. His symptoms remain unchanged since his last examination. He denies any bowel or bladder issues.
Juan is unable to work and requires assistance with activities of daily living including chores and lifting, and similar tasks for which he now relies on "Wife."

Neck Specific Findings:
The patient's neck pain is rated 4/10.
The patient has radiating pain to the left shoulder.
The patient's radicular pain is rated 5/10. .

Back Specific Findings:
The patient's back pain is rated 7/10.
The patient has radiating pain to the right glute and left glute.
The patient's radicular pain is rated 4/10.
The patient also reports numbness/paraesthesias in the right glute and left glute.
The patient cannot walk more than 3-5 block(s) without pain.
The patient cannot stand more than 10-15 minute(s) without pain.
Laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week.
Back-specific physical therapy sessions frequency: 2 day(s) per week.
The patient has performed a formal home exercise program

The patient denies a history of injections since the last visit.

Medications include:
other medications.

Other medications include:
Celebrex 200 mg mg.

Outside Medical Care & Conservative Management History as of 03-14-2023:
Preop CM:
HEP/PT > 1 year completed.
NSAIDs several weeks w/o success for pain control

Postop CM:
ACDF: PT 2 months completed; ongoing 2x/week
NSAIDs PRN

Past Medical History
No Known Past Medical History

Current Medication
No Known Medication

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI . **Ears/Nose/Mouth/Throat:** Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness

and/or assessments. **Respiratory:** Negative for respiratory complaints other than those listed under past medical history. **Cardiovascular:** Negative for cardiovascular complaints other than those listed under past medical history. **Gastrointestinal:** Negative for gastrointestinal complaints other than those listed under past medical history. **Genitourinary:** Negative for genitourinary complaints other than those listed under past medical history. **Musculoskeletal:** Negative except for details in HPI **Neurological:** Negative except for details in HPI **Psychiatric:** Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments. **Endocrine:** Negative for endocrinology complaints other than those listed under past medical history. **Hematologic/Lymphatic:** Negative for hematologic/lymphatic complaints other than those listed under past medical history. **Skin:** Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: The cervical spine is non-tender .
- ROM Flexion: 40 degrees (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: 45 degrees (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: 50 degrees (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: 60 degrees (Normal: 80 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.
Incision: Fully healed without complications

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline lumbar spine.***
Facet Syndrome: Focal tenderness to palpation of the facets with painful extension during range of motion testing.
Straight leg raise: Positive bilaterally
- ROM Forward Flexion: 60 degrees (Normal: 110 degrees) with firm endpoint palpable.
- ROM Extension: 20 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: ***The patient displays an antalgic gait*** The patient is able to heel and toe walk.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:

- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:
Upper Extremities:
- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 5/5 Left IO: 5/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Grossly intact in the L3-S1 dermatomes.

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis
C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0041355 Dated: 08-17-2022

Test	Result
X-Ray	
XR CSP - AP/Lat	MG: S/P ACDF C5-6 with hardware intact. C6-7 LOH

Radiology Remarks: LHR
Report:
C5-C6 SP ACDF: no lucency around the screws.
C6-C7 disc space narrowing with minimal anterior spondylosis.

Order No: EXT0043029 Dated: 10-25-2022 Rad: Duane Office

Test	Result
X-Ray	
XR LSP - AP/Lat + Flex/Ex	MG: No fractures or dislocations

Radiology Remarks: Duane on Ambra

Order No: EXT0046869 Dated: 03-14-2023 Rad: Duane Office

Test	Result
X-Ray	
XR CSP - AP/Lat + Flex/Ex	S/P ACDF C5-6 with hardware intact. C6-7 LOH/ASD

Radiology Remarks: Duane on Ambra

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear
Plan: - Surgical Indications:

Lumbar Diskectomy. Annuloplasty was discussed as possible add-on as indicated.

Levels: RT L4-5

Medical Necessity:
The patient has significant disk herniation-stenosis with correlated neurological complaints, symptoms and clinical findings

We discussed the risks and benefits of surgery at length today, the goals for treatment, peri-operative care, short-term and long-term prognosis. After lengthy discussion, the patient expressed understanding of the following issues: Though the primary goal of decompression is relief of neurologic symptoms, there are no guarantees of symptom relief, and no guarantees of improved neurologic function; Some patients have new or worsening neurologic symptoms after surgery that can be permanent at times; There is a high likelihood that axial symptoms will continue or worsen after the procedure; Reoccurrence of herniation or stenosis may require repeat decompression or fusion; Intra-operative findings or events sometimes prompt a change in plans with inclusion or exclusion of levels, a modification of the procedure, including possibly fusion with instrumentation, at the same or different operative levels; When discography is performed, it can accelerate degeneration and has no guarantee of accurately defining symptomatic levels; With or without surgery, the patient has abnormalities in the spine that may require future surgery or treatment at the index levels or adjacent levels; The concept of fusion versus non-fusion and the indications for use of instrumentation and possible future associated interventions; And wound or medical complications intrinsic to all types of surgery. The patient expressed understanding of these risks and wants to proceed with the procedure, understanding that the plan may change peri-operatively or interoperatively as needed.

Requirements for Surgery: Medical Testing satisfactory to the Pre-operative Assessment Team
Diagnostic testing:

- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Lumbar facet joint syndrome (M47.816)
Assessment: .
- Lumbar facet joint syndrome
Plan: - See plan above.

ICD: Herniation of cervical intervertebral disc with radiculopathy (M50.10)
Assessment: .
- S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy
Plan: - Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- Lifting is restricted to < 20lbs.
- Physical Therapy was continued today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to

decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.

- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Derangement of right knee (M23.91)
Assessment: .
- Right knee derangement
S/P arthroscopy
Plan: - F/U with specialist.

New Orders & Referrals:

Lab(s) & EMG(s): HL7ADHOC: Basic Metabolic Panel, CBC with Differential/Platelet, EKG (electrocardiogram) with at least 12 leads, GFR:African American, GFR:Non African American, Hemoglobin A1c, Prothrombin Time (PT) / INR, PTT Activated, Urinalysis, Complete

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Education Material Given: URLs: *Home Exercises (HEPs) - Neck and Back, *Ambra Upload Instructions, *AAOS - Basic Back Info, *AAOS - Basic Herniated Disk Info, *AAOS - Low Back Pain, *Injection Treatment Log, **CSRS - What is Cervical Radiculopathy?, **CSRS - What is Cervical Myelopathy?, **CSRS - Neck Pain

CPT Codes:
Office O/p Est Hi 40-54 Min (99215)
X-ray Exam Of Neck Spine (72040)
Language Translation Services (T1013)

Follow Up: 2 weeks postop.
RZ

Please let this report represent a letter of medical necessity for our treatment plan

---

Michael Gerling, M.D.
This has been electronically signed by Michael Gerling, M.D. on 03-14-2023.

This has been electronically signed by on 03-14-2023.

Case
Amat v Hand to Hand
03-24-25

Exhibit Gerling-5

OPERATIVE REPORT

Hudson Regional Hospital, NJ

Patient Name: GANDO AMAT, JUAN
MRN: N2327302 1100218254
Date of Birth: 01/26/1954
Surgeon: Michael Gerling M.D.
Co-Surgeon/Assistant 1: Matthew Miller, PA

Date of Procedure: 07/27/2022

INDICATIONS:

The patient presents with cervical disk herniation after a traumatic injury to the cervical spine with severe neck pain radiating to the upper extremity, with numbness and weakness in the signature pattern. There is weakness and numbness on examination and MRI demonstrates posterior disc herniation correlating with symptoms.

Conservative management failed to improve the symptoms including physical therapy, medications, and pain management trials.

The risks and benefits of surgery were discussed at length. The patient understood there could be worsening neurologic function and there may not be an improvement. They could have ongoing or worse neck pain and may require more surgery because of accelerated degenerative disease, adjacent level disease, nonunion, or hardware complications. We discussed wound complications, dysphagia, and dysphonia post-operatively, along with blindness. Stroke, death, and medical complications were also discussed at length.

PRE-OPERATIVE DIAGNOSES:

Herniated cervical disc
Mid-cervical region(M50.22)
Cervical Level(s): **C5-6**

POST-OPERATIVE DIAGNOSES:

Same

PROCEDURE PERFORMED:

1. Anterior cervical diskectomy and fusion (including discectomy, arthrodesis, and anterior instrumentation)

i. Cervical Level(s): **C5-6**
ii. Vertebral Sub-total Corpectomy **C5**
iii. Anterior Instrumentation: Nexus Titanium plate and screws
iv. Biomechanical Device(s): Titanium Spacer
v. Spinal Graft(s): Allograft, morselized Autograft, local (through same incision)
vi. Imaging: Fluoroscopic Guidance
vii. Neurologic Monitoring Type(s): SSEP MEP

ANESTHESIA: General endotracheal
ESTIMATED BLOOD LOSS: 20 mL
SPECIMENS REMOVED: Disk Herniation

FINDINGS:

1. Headlights and Loupes were used
2. Disc herniation was noted intra-operatively and sent for pathologic examination.
3. Neuro-monitoring stable throughout the procedure and the patient was neurologically at baseline at the end.
4. Local Depomedrol used at the end of the case.
5. Antibiotics were given before incision.
6. Dex 10

TECHNIQUE

After the site was marked and timeout was called, the patient received antibiotics and was intubated supine. The arms were tucked at the side. Bony prominences were protected. The neck was prepped and draped in the usual sterile fashion. A left-sided transverse incision was carried down sharply through platysma with a Smith-Robinson approach utilized on the left side. The midline structures were swept to the left side and the longus colli were undermined. The disk was identified using fluoroscopy. Caspar pins were then placed in the adjacent bone with gentle distraction while hand-held retractors were used to retract the longus colli.

Anterior Cervical Diskectomy C5-6: The discectomy procedure was carried out using #11 blade scalpel, pituitaries, and curettes. Posterior longitudinal ligament was left intact. The posterior disc herniation was visualized and excised. The decompression and carpentry was carried out laterally at the uncovertebral joints. Posterior longitudinal ligament was left intact.

Partial corpectomy C5: The decompression was extended cephalad from the disk level in order to complete the decompression as the disk was found to extend behind the body. A partial corpectomy was carried out, removing approximately 50% of the body.

Fusion: After adequate decompression, fusion was then carried out by squaring off the vertebral end plates and decorticating the uncovertebral joints. The bone was saved as a local autograft. Minimal bleeding was encountered and well controlled. The space was then sized for an interbody spacer cage that was then filled with local autograft and allograft, and tapped into position with excellent stability. The Caspar pins were then released and uncovertebral joint grafting with local graft was carried out. Using fluoroscopy, I was able to visualize the implant clearly. The bone position was excellent. Caspar pins were removed with wax placed in the holes.

Anterior instrumentation using a titanium plate with fixed angle screws above and variable screws below was performed at the level. The plate sat flush with the bone and all screws locked into the plate with excellent end torque resistance. Using fluoroscopy, I was able to visualize the implants clearly. The position was excellent.

The wound was then explored and minimal bleeding was present. Though hemostasis was excellent without concern, a Hemovac drain was prophylactically placed through the platysma and sewn into position with a 2-0 nylon. Depomedrol medicated Gelfoam sponge, 1cm x 1cm was placed on top of the implant at the end of the case. The platysma was closed in a standard fashion with a 2-0 Vicryl followed by 3-O Vicryl subdermal buried sutures, followed by Dermabond glue. Steri-strips and dressings were then utilized, and a hard collar was placed before awakening uneventfully having tolerated the procedure well. Neurologic monitoring remained stable through the procedure.

Michael Gerling, MD

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Coney Island Ave.

2279 Coney Island Avenue, 2nd Floor, Brooklyn NY 11223

Tel: 212 882-1110, Fax: 212 882-1120

RADIOLOGY RESULT

PATIENT DEMOGRAPHICS

Patient: GANDO AMAT, Juan
DOB: 01-26-1954 **Age**: 68 year **Sex**: Male
Address: 109-68 PARK LANE SOUTH Richmond Hill NY 11418
Phone:

GUARANTOR & INSURANCE INFORMATION

Insurance:Bristol West Claims
Guarantor: GANDO AMAT Juan
Policy# 70021344611
Group#

LAB VENDOR DETAILS

Lab Name:
Address:
Phone: **Fax:**

ORDERING PHYSICIAN DETAILS

Ordering Physician Name: Michael Gerling, M.D.
Order#: EXT0038543 **Order Date**: 03-14-2022
Result Date: 2022-03-14 00:00:00.0

Sr.No.	Test Name	Result	Abn-Type
1	MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis	

Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis
C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Michael Gerling, M.D.
This has been electronically signed on 03-14-2022.

Result by Matthew Miller, PA-C last date time 2022-05-12 12:30:42 EST

Enc Edit by date time

Enc Reopen by date time

Community Medical Imaging
ACR Accredited Facility
159-16 Union Tpke • Fresh Meadows, NY 11366
Tel: 718-275-1010 • Fax: 718-591-3300

VAGMIN VORA, M.D.
158-16 79TH AVENUE
FRESH MEADOWS, NY 11366

PATIENT: JUAN ALFREDO GANDO AMAT
DOB: 01/26/1954
DOS: 03/14/2022
CHART #: 24536
EXAM: MRI OF THE CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Low back pain, left leg pain.

COMPARISON: None.

Additional sanitizing / safety protocols recommended by the CDC were performed.

TECHNIQUE: Multiplanar MR imaging of the cervical spine was performed without contrast on Hitachi open MRI unit.

Sagittal T1 weighted images, sagittal STIR weighted images, sagittal T2 weighted images and axial T2 weighted gradient echo images of the cervical spine were obtained.

FINDINGS: The vertebral bodies are unremarkable.

The facet joints are normal in alignment. The cord is unremarkable.

The posterior elements are unremarkable. There is no asymmetry of the paraspinal musculature. C1 ring and skull base are unremarkable. Limited visualization of the brainstem and cerebellum appears unremarkable. There is no paravertebral abnormality.

There is prominent straightening of the cervical lordosis. There is disc desiccation throughout. Prominent loss of disc height is seen at the C5-C6 and C6-C7 levels.

C2-C3: There is no central or foraminal stenosis.

C3-C4: There is a diffuse disc bulge. A midline and left paramedian herniation is seen projecting locally. There is partial effacement of the anterior subarachnoid space. There is moderate right foraminal narrowing.

C4-C5: There is a diffuse disc bulge. Protrusions are seen of the right and left margins of the canal.

Community Medical Imaging
ACR Accredited Facility
159-16 Union Tpke • Fresh Meadows, NY 11366
Tel: 718-275-1010 • Fax: 718-591-3300

PATIENT: JUAN ALFREDO GANDO AMAT
DOB: 01/26/1954
DOS: 03/14/2022
CHART #: 24536
EXAM: MRI OF THE CERVICAL SPINE WITHOUT CONTRAST
PAGE 2

C5-C6: There is a diffuse disc bulge. Prominent foraminal narrowing is noted bilaterally.

C6-C7: There is a diffuse disc bulge. There is prominent foraminal narrowing bilaterally. There is no central stenosis.

C7-T1: There is a diffuse disc bulge. There is moderate right foraminal narrowing. A midline herniation is seen projecting locally.

There is a disc bulge at the T1-T2 level.

IMPRESSION:

1. STRAIGHTENING OF THE CERVICAL LORDOSIS IS SEEN CONSISTENT WITH SEVERE SPASM.
2. A MIDLINE HERNIATION IS SEEN AT THE C7-T1 LEVEL AS NOTED.
3. A MIDLINE AND LEFT PARAMEDIAN HERNIATION IS SEEN AT THE C3-C4 LEVEL AS NOTED.
4. PROTRUSIONS ARE SEEN AT THE C4-C5 LEVEL, AS NOTED.
5. MULTILEVEL FORAMINAL NARROWING IS SEEN, WHICH IS MORE FOCAL AT THE C5-C6 AND C6-C7 LEVELS.

Thank you for referring this patient to us.

Andrew McDonnell, MD
Neuroradiologist
Diplomate, American Board of Radiology
AM/man/pr D: 03/15/2022

E-Sig By A. McDonnell, MD on 03/15/2022 16:15:53

Case
Amat v Hand to Hand
03-24-25

Exhibit Gerling-7

OPERATIVE REPORT

Hudson Ambulatory Surgery Center (ASC)

Patient Name: GANDO AMAT, JUAN
MRN: 16539
Date of Birth: 01/26/1954
Proceduralist/Surgeon: Michael Gerling M.D.
Assistant: Darielle Connor, PA

Date of Procedure: 6/2/2023

PRE-OPERATIVE DIAGNOSES:
1) Herniated lumbar disc, Lumbar region
- Lumbar Level(s): L4-5

POST-OPERATIVE DIAGNOSES:
1) Herniated lumbar disc, Lumbar region
- Lumbar Level(s): L4-5

PROCEDURE PERFORMED:
1) Discography, lumbar, radiological supervision and interpretation: L4-5
2) Lumbar Discectomy (Tubular/ Wolf Assist):
    - Extraforaminal: Right L4-5
3) Annuloplasty: L4-5
4) Fluoroscopic Guidance

SURGEON: Michael Gerling, MD
CO-SURGEON / ASSISTANT: Darielle Connor, PA

ANESTHESIA: Monitored Anesthesia Care
ESTIMATED BLOOD LOSS: 10cc
SPECIMENS REMOVED: Herniated Disk

Summary:
Antibiotics were given before incision.
Diskography demonstrated HNP with concordant pain response
Disc herniation was noted intra-operatively and sent for pathologic examination
Neurologic Exam was stable throughout and similar to baseline at the end of the procedure
Preoperative Medication: N/A

Intraop Medication: Dexamethasone 10 Mg IV was given by anesthesia

INDICATIONS:
The patient presents with severe low back pain radiating to the lower extremity with numbness and weakness. They failed conservative management including physical therapy, medications, and pain management trials. On examination we found a positive straight leg test, numbness and weakness that corresponds to the symptoms.

Posterior disc herniation diagnosed using advanced imaging, and correlates with our clinical findings.

The alternatives to surgery, along with risks and benefits of surgery were discussed at length. The patient understood there could be worsening neurologic function, including numbness, weakness, bowel or bladder incontinence, or no improvement. There may be ongoing or worse back pain and possible future surgery because of accelerated degenerative disease. We discussed wound complications, dysphagia, and dysphonia post op along with blindness. Stroke, death, and medical complications were also discussed at length.

TECHNIQUE
After the patient positioned themselves on the Wilson frame, timeout was called, antibiotics were given, they were prepped and draped with bony prominences padded and the patient stated that they were satisfied with the positioning.

The fluoroscope was brought in to identify each indicated level. At each level, the interspace was identified in both the AP and lateral views, and the approach was initiated with overlying skin localized using Marcaine with epinephrine. The patient tolerated it well.

Discography
I passed a spinal needle down to the safe triangle and entered the disc confirming that the tip of my needle was in the center of the disc space on fluoroscopic imaging, in orthogonal planes, AP and lateral views. I then injected a small amount of Isovue contrast mixed with dye to confirm position. The annulus was filled to evaluate the disc morphology. The patient's symptoms were carefully monitored to confirm adequate anesthesia and comfort.

<u>Diskogram Findings</u>

Pressurization: firm endpoint at L4-5
Herniation: Noted L4-5
Annular tear: Noted L4-5
Dye Leakage: None
Concordance with typical back pain: Yes L4-5
Leg Pain Elicited: None

We then elected to proceed with diskectomy procedures at L4-5

Diskectomy from the extra-foraminal approach at the L4-5 level
We localized the level using fluoroscopic guidance, incised the skin and used a dilator to bluntly dissect down to the safe triangle. A tubular retractor was placed exposing the posterior disk from the lateral vantage point. The exiting nerve root was carefully protected with a dissecting tool and legs monitored for neurologic irritation or hyperactivity. The patient tolerated it well without new leg symptoms. Foraminotomy with Trephine and Kerrison was used to improve access. This was tolerated well by the patient and no instability was encountered.

Diskectomy Findings
Disc herniation was apparent and excised under direct visualization using pituitary graspers. The annulus was penetrated and loose nucleus pulposus fragments deep to the annulus were removed.
Annular defect: Not noted from external perspective
Contralateral Disk fragments: Herniation extended beyond the midline and therefore, bilateral diskectomy was necessary.

All fragments were sent to pathology for analysis. The disc space was then irrigated out copiously and hemostasis attained.

Annuloplasty at L4-5
As significant defects were noted in the annulus after diskectomy, annuloplasty was performed to reduce the defect and improve the morphology of the residual disk.
The disk was localized using fluoroscopic guidance followed by placement of the spinal needle tip in the center of the posterior annulus, confirmed on orthogonal views. Guide wire, then dilator, then tubular retractor and endoscope were then placed into the disk space with careful attention to hug the caudal pedicle cortex and protect the exiting nerve root which was unharmed. The radiofrequency probe was then introduced with fluoroscopic confirmation and used to ablate the posterior annulus using high and low frequency radio waves. It was tolerated well by the patient. Copious irrigation of the wound was performed with antibiotic-containing solution. Careful and meticulous hemostasis was achieved.

Therapeutic intradiscal injection at L4-5
After adequate decompression and ablation, I repositioned the tubular retractor at the residual annular defect and directly visualized my placement of the guidewire within the disk.
Fluoroscopy was used to confirm central positioning. A spinal needle was passed over the wire and I then injected 1cc Depomedrol 40mg with antibiotic and 2 cc Marcaine into the disk space.

Closure
Once decompression proved satisfactory, copious irrigation of the wound was performed with antibiotic-containing solution. Careful and meticulous hemostasis was achieved. The skin was then reapproximated using monocryl sutures and Dermabond skin glue. The wound was cleaned and sterile dressing applied. The drapes were then removed and the patient flipped supine in stable condition without complaints or neurological changes. They tolerated the procedure well.

We were then authorized for transport to the recovery room in stable condition.

Michael Gerling, MD

OPERATIVE REPORT

Hudson Regional Hospital, NJ

Patient Name: GANDO AMAT, JUAN
MRN: N2327302 1100218254
Date of Birth: 01/26/1954
Surgeon: Michael Gerling M.D.
Co-Surgeon/Assistant 1: Matthew Miller, PA

Date of Procedure: 07/27/2022

INDICATIONS:

The patient presents with cervical disk herniation after a traumatic injury to the cervical spine with severe neck pain radiating to the upper extremity, with numbness and weakness in the signature pattern. There is weakness and numbness on examination and MRI demonstrates posterior disc herniation correlating with symptoms.

Conservative management failed to improve the symptoms including physical therapy, medications, and pain management trials.

The risks and benefits of surgery were discussed at length. The patient understood there could be worsening neurologic function and there may not be an improvement. They could have ongoing or worse neck pain and may require more surgery because of accelerated degenerative disease, adjacent level disease, nonunion, or hardware complications. We discussed wound complications, dysphagia, and dysphonia post-operatively, along with blindness. Stroke, death, and medical complications were also discussed at length.

PRE-OPERATIVE DIAGNOSES:

Herniated cervical disc
Mid-cervical region(M50.22)
Cervical Level(s): **C5-6**

POST-OPERATIVE DIAGNOSES:

Same

PROCEDURE PERFORMED:

1. Anterior cervical diskectomy and fusion (including discectomy, arthrodesis, and anterior instrumentation)

i. Cervical Level(s): **C5-6**
ii. Vertebral Sub-total Corpectomy **C5**
iii. Anterior Instrumentation: Nexus Titanium plate and screws
iv. Biomechanical Device(s): Titanium Spacer
v. Spinal Graft(s): Allograft, morselized Autograft, local (through same incision)
vi. Imaging: Fluoroscopic Guidance
vii. Neurologic Monitoring Type(s): SSEP MEP

ANESTHESIA: General endotracheal
ESTIMATED BLOOD LOSS: 20 mL
SPECIMENS REMOVED: Disk Herniation

FINDINGS:

1. Headlights and Loupes were used
2. Disc herniation was noted intra-operatively and sent for pathologic examination.
3. Neuro-monitoring stable throughout the procedure and the patient was neurologically at baseline at the end.
4. Local Depomedrol used at the end of the case.
5. Antibiotics were given before incision.
6. Dex 10

TECHNIQUE

After the site was marked and timeout was called, the patient received antibiotics and was intubated supine. The arms were tucked at the side. Bony prominences were protected. The neck was prepped and draped in the usual sterile fashion. A left-sided transverse incision was carried down sharply through platysma with a Smith-Robinson approach utilized on the left side. The midline structures were swept to the left side and the longus colli were undermined. The disk was identified using fluoroscopy. Caspar pins were then placed in the adjacent bone with gentle distraction while hand-held retractors were used to retract the longus colli.

Anterior Cervical Diskectomy C5-6: The discectomy procedure was carried out using #11 blade scalpel, pituitaries, and curettes. Posterior longitudinal ligament was left intact. The posterior disc herniation was visualized and excised. The decompression and carpentry was carried out laterally at the uncovertebral joints. Posterior longitudinal ligament was left intact.

Partial corpectomy C5: The decompression was extended cephalad from the disk level in order to complete the decompression as the disk was found to extend behind the body. A partial corpectomy was carried out, removing approximately 50% of the body.

Fusion: After adequate decompression, fusion was then carried out by squaring off the vertebral end plates and decorticating the uncovertebral joints. The bone was saved as a local autograft. Minimal bleeding was encountered and well controlled. The space was then sized for an interbody spacer cage that was then filled with local autograft and allograft, and tapped into position with excellent stability. The Caspar pins were then released and uncovertebral joint grafting with local graft was carried out. Using fluoroscopy, I was able to visualize the implant clearly. The bone position was excellent. Caspar pins were removed with wax placed in the holes.

Anterior instrumentation using a titanium plate with fixed angle screws above and variable screws below was performed at the level. The plate sat flush with the bone and all screws locked into the plate with excellent end torque resistance. Using fluoroscopy, I was able to visualize the implants clearly. The position was excellent.

The wound was then explored and minimal bleeding was present. Though hemostasis was excellent without concern, a Hemovac drain was prophylactically placed through the platysma and sewn into position with a 2-0 nylon. Depomedrol medicated Gelfoam sponge, 1cm x 1cm was placed on top of the implant at the end of the case. The platysma was closed in a standard fashion with a 2-0 Vicryl followed by 3-O Vicryl subdermal buried sutures, followed by Dermabond glue. Steri-strips and dressings were then utilized, and a hard collar was placed before awakening uneventfully having tolerated the procedure well. Neurologic monitoring remained stable through the procedure.

Michael Gerling, MD

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Manhattan

110 Duane St., New York NY 10007

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Prosper Jerome, NP-C	Direct Professional	01-13-2023	SCL13601
Appointment Location:	**Appointment Location Address:**		
Manhattan	110 Duane St., New York NY 10007		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy.
- Myelopathic and radiculopathy findings.
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
ACDF C5-6: 07-27-2022 by Dr. Gerling at Hudson
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:
Follow up consultation
Date of surgery: 07-27-2022
Juan presents today with neck disorder and with low back disorder. His symptoms remain unchanged since his last examination. He denies any bowel or bladder issues.
Juan is unable to work and requires assistance with activities of daily living including chores and lifting, and similar tasks for which he now relies on "Wife."

Neck Specific Findings:

The patient's neck pain is rated 5/10
The patient has radiating pain to the left shoulder.
The patient's radicular pain is rated 5/10. .

Back Specific Findings:
The patient's back pain is rated 5/10.
laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week.
Back-specific physical therapy sessions frequency: 2 day(s) per week.
The patient has performed a formal home exercise program

The patient denies a history of injections since the last visit.

Medications include:
other medications.

Other medications include:
Celebrex 200 mg PRN mg.

Outside Medical Care & Conservative Management History as of 01-13-2023:
Preop CM:
HEP/PT > 1 year completed.
NSAIDs several weeks w/o success for pain control

Postop CM:
ACDF: PT 2 months completed; ongoing 2x/week
NSAIDs PRN

Past Medical History
No Known Past Medical History

Current Medication
No Known Medication

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI . **Ears/Nose/Mouth/Throat:** Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness and/or assessments. **Respiratory:** Negative for respiratory complaints other than those listed under past medical history. **Cardiovascular:** Negative for cardiovascular complaints other than those listed under past medical history. **Gastrointestinal:** Negative for gastrointestinal complaints other than those listed under past medical history. **Genitourinary:** Negative for genitourinary complaints other than those listed under past medical history. **Musculoskeletal:** Negative except for details in HPI **Neurological:** Negative except for details in HPI **Psychiatric:**

Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments. **Endocrine:** Negative for endocrinology complaints other than those listed under past medical history. **Hematologic/Lymphatic:** Negative for hematologic/lymphatic complaints other than those listed under past medical history. **Skin:** Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: The cervical spine is non-tender .
- ROM Flexion: 40 degrees (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: 45 degrees (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: 50 degrees (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: 60 degrees (Normal: 80 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.
Incision: Fully healed without complications

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline lumbar spine.***
- ROM Forward Flexion: 60 degrees (Normal: 110 degrees) with firm endpoint palpable.
- ROM Extension: 20 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: The patient displays a grossly stable gait. The patient is able to heel and toe walk.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:
- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:
Upper Extremities:

- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 5/5 Left IO: 5/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Grossly intact in the L3-S1 dermatomes.

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis

C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0041355 Dated: 08-17-2022

Test	Result
X-Ray	
XR CSP - AP/Lat	MG: S/P ACDF C5-6 with hardware intact. C6-7 LOH

Radiology Remarks: LHR
Report:
C5-C6 SP ACDF: no lucency around the screws.
C6-C7 disc space narrowing with minimal anterior spondylosis.

Order No: EXT0043029 Dated: 10-25-2022 Rad: Duane Office

Test	Result
X-Ray	
XR LSP - AP/Lat + Flex/Ex	MG: No fractures or dislocations

Radiology Remarks: Duane on Ambra

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Herniation of cervical intervertebral disc with radiculopathy (M50.10)
Assessment: S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy
Plan: - Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- Lifting is restricted to < 20lbs.
- Physical Therapy was continued today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.

- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: .
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear
Plan: - Referral for pain management given today
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- The patient will continue to see pain management for regular follow-up appointments.
- Physical Therapy was continued today for the back along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.
- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.
.

- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Derangement of right knee (M23.91)
Assessment: .
- Right knee derangement
S/P arthroscopy
Plan: - F/U with specialist.

New Orders & Referrals:

Consultation(s):
Pain Management - LESI

DME/Bracing and/or Procedures:

CPT Codes:
Office O/p Est Mod 30-39 Min (99214)

Follow Up:
Dr. Gerling 2 months after pain management consult. to discuss discectomy if no positive results.

Please let this report represent a letter of medical necessity for our treatment plan

---

Prosper Jerome, NP-C
This has been electronically signed by Prosper Jerome, NP-C on 01-13-2023.

This has been electronically signed by on 01-13-2023.

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Manhattan

110 Duane St., New York NY 10007

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Michael Gerling, M.D.	Direct Professional	03-14-2023	SCL13601
Appointment Location:	**Appointment Location Address:**		
Manhattan	110 Duane St., New York NY 10007		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear.
- Lumbar facet joint syndrome.
- S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy.
- Myelopathic and radiculopathy findings.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
ACDF C5-6: 07-27-2022 by Dr. Gerling at Hudson
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:
Follow up consultation
Date of surgery: 07-27-2022
Juan presents today with neck disorder and with low back disorder. His symptoms remain unchanged since his last examination. He denies any bowel or bladder issues.
Juan is unable to work and requires assistance with activities of daily living including chores and lifting, and similar tasks for which he now relies on "Wife."

Neck Specific Findings:
The patient's neck pain is rated 4/10.
The patient has radiating pain to the left shoulder.
The patient's radicular pain is rated 5/10. .

Back Specific Findings:
The patient's back pain is rated 7/10.
The patient has radiating pain to the right glute and left glute.
The patient's radicular pain is rated 4/10.
The patient also reports numbness/paraesthesias in the right glute and left glute.
The patient cannot walk more than 3-5 block(s) without pain.
The patient cannot stand more than 10-15 minute(s) without pain.
Laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week.
Back-specific physical therapy sessions frequency: 2 day(s) per week.
The patient has performed a formal home exercise program

The patient denies a history of injections since the last visit.

Medications include:
other medications.

Other medications include:
Celebrex 200 mg mg.

Outside Medical Care & Conservative Management History as of 03-14-2023:
Preop CM:
HEP/PT > 1 year completed.
NSAIDs several weeks w/o success for pain control

Postop CM:
ACDF: PT 2 months completed; ongoing 2x/week
NSAIDs PRN

Past Medical History
No Known Past Medical History

Current Medication
No Known Medication

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI . **Ears/Nose/Mouth/Throat:** Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness

and/or assessments. **Respiratory:** Negative for respiratory complaints other than those listed under past medical history. **Cardiovascular:** Negative for cardiovascular complaints other than those listed under past medical history. **Gastrointestinal:** Negative for gastrointestinal complaints other than those listed under past medical history. **Genitourinary:** Negative for genitourinary complaints other than those listed under past medical history. **Musculoskeletal:** Negative except for details in HPI **Neurological:** Negative except for details in HPI **Psychiatric:** Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments. **Endocrine:** Negative for endocrinology complaints other than those listed under past medical history. **Hematologic/Lymphatic:** Negative for hematologic/lymphatic complaints other than those listed under past medical history. **Skin:** Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: The cervical spine is non-tender .
- ROM Flexion: 40 degrees (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: 45 degrees (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: 50 degrees (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: 60 degrees (Normal: 80 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.
Incision: Fully healed without complications

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline lumbar spine.***
Facet Syndrome: Focal tenderness to palpation of the facets with painful extension during range of motion testing.
Straight leg raise: Positive bilaterally
- ROM Forward Flexion: 60 degrees (Normal: 110 degrees) with firm endpoint palpable.
- ROM Extension: 20 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: ***The patient displays an antalgic gait*** The patient is able to heel and toe walk.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:

- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:
Upper Extremities:
- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 5/5 Left IO: 5/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Grossly intact in the L3-S1 dermatomes.

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis
C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0041355 Dated: 08-17-2022

Test	Result
X-Ray	
XR CSP - AP/Lat	MG: S/P ACDF C5-6 with hardware intact. C6-7 LOH

Radiology Remarks: LHR
Report:
C5-C6 SP ACDF: no lucency around the screws.
C6-C7 disc space narrowing with minimal anterior spondylosis.

Order No: EXT0043029 Dated: 10-25-2022 Rad: Duane Office

Test	Result
X-Ray	
XR LSP - AP/Lat + Flex/Ex	MG: No fractures or dislocations

Radiology Remarks: Duane on Ambra

Order No: EXT0046869 Dated: 03-14-2023 Rad: Duane Office

Test	Result
X-Ray	
XR CSP - AP/Lat + Flex/Ex	S/P ACDF C5-6 with hardware intact. C6-7 LOH/ASD

Radiology Remarks: Duane on Ambra

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear
Plan: - Surgical Indications:

Lumbar Diskectomy. Annuloplasty was discussed as possible add-on as indicated.

Levels: RT L4-5

Medical Necessity:
The patient has significant disk herniation-stenosis with correlated neurological complaints, symptoms and clinical findings

We discussed the risks and benefits of surgery at length today, the goals for treatment, peri-operative care, short-term and long-term prognosis. After lengthy discussion, the patient expressed understanding of the following issues: Though the primary goal of decompression is relief of neurologic symptoms, there are no guarantees of symptom relief, and no guarantees of improved neurologic function; Some patients have new or worsening neurologic symptoms after surgery that can be permanent at times; There is a high likelihood that axial symptoms will continue or worsen after the procedure; Reoccurrence of herniation or stenosis may require repeat decompression or fusion; Intra-operative findings or events sometimes prompt a change in plans with inclusion or exclusion of levels, a modification of the procedure, including possibly fusion with instrumentation, at the same or different operative levels; When discography is performed, it can accelerate degeneration and has no guarantee of accurately defining symptomatic levels; With or without surgery, the patient has abnormalities in the spine that may require future surgery or treatment at the index levels or adjacent levels; The concept of fusion versus non-fusion and the indications for use of instrumentation and possible future associated interventions; And wound or medical complications intrinsic to all types of surgery. The patient expressed understanding of these risks and wants to proceed with the procedure, understanding that the plan may change peri-operatively or interoperatively as needed.

Requirements for Surgery: Medical Testing satisfactory to the Pre-operative Assessment Team
Diagnostic testing:

- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Lumbar facet joint syndrome (M47.816)
Assessment: .
- Lumbar facet joint syndrome
Plan: - See plan above.

ICD: Herniation of cervical intervertebral disc with radiculopathy (M50.10)
Assessment: .
- S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy
Plan: - Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- Lifting is restricted to < 20lbs.
- Physical Therapy was continued today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to

decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.

- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Derangement of right knee (M23.91)
Assessment: .
- Right knee derangement
S/P arthroscopy
Plan: - F/U with specialist.

New Orders & Referrals:

Lab(s) & EMG(s): HL7ADHOC: Basic Metabolic Panel, CBC with Differential/Platelet, EKG (electrocardiogram) with at least 12 leads, GFR:African American, GFR:Non African American, Hemoglobin A1c, Prothrombin Time (PT) / INR, PTT Activated, Urinalysis, Complete

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Education Material Given: URLs: *Home Exercises (HEPs) - Neck and Back, *Ambra Upload Instructions, *AAOS - Basic Back Info, *AAOS - Basic Herniated Disk Info, *AAOS - Low Back Pain, *Injection Treatment Log, **CSRS - What is Cervical Radiculopathy?, **CSRS - What is Cervical Myelopathy?, **CSRS - Neck Pain

CPT Codes:
Office O/p Est Hi 40-54 Min (99215)
X-ray Exam Of Neck Spine (72040)
Language Translation Services (T1013)

Follow Up: 2 weeks postop.
RZ

Please let this report represent a letter of medical necessity for our treatment plan

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Michael Gerling, M.D.
This has been electronically signed by Michael Gerling, M.D. on 03-14-2023.

This has been electronically signed by on 03-14-2023.

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Coney Island Ave.

2279 Coney Island Avenue, 2nd Floor, Brooklyn NY 11223

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Michael Gerling, M.D.	Direct Professional	05-12-2022	SCL13601
Appointment Location:	**Appointment Location Address:**		
Coney Island Ave.	2279 Coney Island Avenue, 2nd Floor, Brooklyn NY 11223		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
Cervical disc herniation with myelopathy and radiculopathy
MRI 3/14/2022: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis.
- Myelopathic and radiculopathy findings.
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with rigth-sided annular tear.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:
Initial Patient Visit - New

Mr. Juan GANDO AMAT is a 68 year year old male who presents today with neck, low back, left shoulder, left elbow, left wrist, left hand, right knee, right ankle, left hip, left knee, left ankle and left foot complaints, with the pain in the neck being the most severe. The symptoms began after the patient sustained an accident. The symptoms have been present for 6 months The symptoms have been present for 1 years and are becoming progressively worse.
Since the onset, he has not been able to work. At the time of the accident, he was working as a manual laborer Mr.

GANDO AMAT requires assistance with activities of daily living including chores and lifting and similar tasks for which he now relies on his family for help. The symptoms have impaired his ability to sleep normally.

Neck Specific Findings:
The patient's neck pain is rated 8/10.
The patient has radiating pain to the right shoulder, right arm, left shoulder and left arm.
The patient's radicular pain is rated 8/10.
The patient reports numbness/paraesthesias in the right arm, right elbow, right forearm, right wrist, right hand, right fingers, left arm, left elbow, left forearm, left wrist, left hand and left fingers.
The patient is experiencing occipital headaches. Including instances of tripping/stumbling.

Back Specific Findings:
The patient's back pain is rated 8/10.
The patient has radiating pain to the left glute, left lateral thigh, left posterior thigh, anterior left thigh, left shin, left calf, dorsal aspect of the left foot and ventral aspect of the left foot.
The patient's radicular pain is rated 8/10.
The patient also reports numbness/paraesthesias in the left glute, left lateral thigh, left posterior thigh, anterior left thigh, left shin, left calf, dorsal aspect of the left foot and ventral aspect of the left foot.
The patient cannot walk more than 1-2 block(s) without pain.
The patient cannot stand more than 5 minute(s) without pain.
Laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Conservative management:
The patient requires the use of a cane.
Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week. For 1 year(s).
Back-specific physical therapy sessions frequency: 2 day(s) per week. For 1 years(s).

Medications include:
Ibuprofen.

Accident details:
The patient was involved in a motor vehicle accident while in a car/driving. After the accident, they went to the emergency room by ambulance for care

Prior Neck and Back History:
The patient was asymptomatic in the neck prior to the accident
The patient was asymptomatic in the back prior to the accident

Motor Vehicle Accident Details:
The patient was in a car at the time of the accident and was a passenger in the back left of the vehicle, when they were struck by a tractor trailer.

Outside Medical Care & Conservative Management History as of 05-12-2022:
PT > 1 year completed. Ongoing 2x/week
NSAIDs
Recommended injections but not attempted.

Past Medical History
No Known Past Medical History

Current Medication
ibuprofen

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI .
Ears/Nose/Mouth/Throat: Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness and/or assessments.
Respiratory: Negative for respiratory complaints other than those listed under past medical history.
Cardiovascular: Negative for cardiovascular complaints other than those listed under past medical history.
Gastrointestinal: Negative for gastrointestinal complaints other than those listed under past medical history.
Genitourinary: Negative for genitourinary complaints other than those listed under past medical history.
Musculoskeletal: Negative except for details in HPI
Neurological: Negative except for details in HPI
Psychiatric: Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments.
Endocrine: Negative for endocrinology complaints other than those listed under past medical history.
Hematologic/Lymphatic: Negative for hematologic/lymphatic complaints other than those listed under past medical history.
Skin: Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: ***The cervical spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline.***
Spurling's sign: Positive on the left.
Lhermitte's: Positive
- ROM Flexion: 30 degrees (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: 35 degrees (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: 50 degrees (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: 65 degrees (Normal: 80 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain***

with tenderness to palpation and spasm noted midline lumbar spine.
- ROM Forward Flexion: 40 degrees (Normal: 110 degrees) with firm endpoint palpable.
- ROM Extension: 10 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: The patient displays a grossly stable gait. The patient is able to heel and toe walk.
Romberg: Positive.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:
- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:
Upper Extremities:
- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 4/5 Left IO: 4/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Numbness diffuse left LE

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis
C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Cervical disc herniation (M50.20)
Assessment: Cervical disc herniation with myelopathy and radiculopathy
MRI 3/14/2022: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis
Plan: - Medical Advice:
Activity modification; Avoid prolonged bending, standing, or lifting.
Eat a low fat, high fiber diet, including fruits and vegetables.
Observation. Should patient develop any new bowel or bladder incontinence, progressive numbness or weakness, unrelenting pain into a extremity, they should call the office or on call provider, or present to the nearest emergency room for reevaluation
- The patient was counseled on the potential for worsening of their myelopathy.
Https://www.Orthoinfo.Org/en/diseases--conditions/cervical-spondylotic-myelopathy-spinal-cord-compression/
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- The patient will continue to see pain management for regular follow-up appointments.
- Physical Therapy was continued today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas.

We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.
- Surgical Indications:

Anterior Cervical Diskectomy and Fusion, with instrumentation and Allograft from cadaver bone.
Levels: C5-6

Medical Necessity:
Surgical treatment is indicated for patients diagnosed with cervical myelopathy. Physical Therapy, medications and pain management injections have not shown significant impact on outcomes and surgery demonstrates clear improvements over conservative treatment in randomized controlled trials.
Possible corpectomy required due to stenosis behind the vertebral body.

4. Rhee JM, Shamji MF, Erwin WM, et al. Nonoperative management of cervical myelopathy: a systematic review. Spine (Phila Pa 1976). 2013;38:S55-67. Systematic review of evidence regarding nonoperative treatment of cervical myelopathy. They concluded nonoperative treatment is not routinely recommended given the paucity of evidence.

5. Ghobrial GM, Harrop JS. Surgery vs conservative care for cervical spondylotic myelopathy: nonoperative operative management. Neurosurgery. 2015;62(Suppl 1):62-5. Doi: 10.1227/NEU.0000000000000816.

We discussed the risks and benefits of surgery at length today, the goals for treatment, peri-operative care, short-term and long-term prognosis. After lengthy discussion, the patient expressed understanding of the following issues: Though the primary goal of decompression is relief of neurologic symptoms, there are no guarantees of symptom relief, and no guarantees of improved neurologic function; Some patients have new or worsening neurologic symptoms after surgery that can be permanent at times; There is a high likelihood that axial symptoms will continue or worsen after the procedure; Reoccurrence of herniation or stenosis may require repeat decompression or fusion; Intra-operative findings or events sometimes prompt a change in plans with inclusion or exclusion of levels, a modification of the procedure, including possibly fusion with instrumentation, at the same or different operative levels; When discography is performed, it can accelerate degeneration and has no guarantee of accurately defining symptomatic levels; With or without surgery, the patient has abnormalities in the spine that may require future surgery or treatment at the index levels or adjacent levels; The concept of fusion versus non-fusion and the indications for use of instrumentation and possible future associated interventions; And wound or medical complications intrinsic to all types of surgery. The patient expressed understanding of these risks and wants to proceed with the procedure, understanding that the plan may change peri-operatively or interoperatively as needed.

Requirements for Surgery: Medical Testing satisfactory to the Pre-operative Assessment Team
Diagnostic testing: Cervical spine X-rays.
- The patient will return to our office following the procedure for an initial post-operative consultation.

Should any complications arise, they have been instructed to call our office to reschedule for an appointment as soon as possible.
.

- CAUSATION:
As the patient was asymptomatic in the cervical spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant

disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: .
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with rigth-sided annular tear
Plan: - Medical Advice:
Activity modification; Avoid prolonged bending, standing, or lifting.
Eat a low fat, high fiber diet, including fruits and vegetables.
Observation. Should patient develop any new bowel or bladder incontinence, progressive numbness or weakness, unrelenting pain into a extremity, they should call the office or on call provider, or present to the nearest emergency room for reevaluation
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- The patient will continue to see pain management for regular follow-up appointments.
- Physical Therapy was continued today for the back along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.
- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.
.

- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
.

- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Derangement of right knee (M23.91)

Assessment: .
- Right knee derangement
S/P arthroscopy
Plan: - F/U with specialist.

New Orders & Referrals:

Diagnostic Imaging: X-Ray: Chest (PA and LAT), XR CSP - AP/Lat + Flex/Ex

Lab(s) & EMG(s): HL7ADHOC: Basic Metabolic Panel, CBC with Differential/Platelet, EKG (electrocardiogram) with at least 12 leads, GFR:African American, GFR:Non African American, Hemoglobin A1c, Prothrombin Time (PT) / INR, PTT Activated, Urinalysis, Complete

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Education Material Given: URLs: *Home Exercises (HEPs) - Neck and Back, *Ambra Upload Instructions, *AAOS - Basic Back Info, *AAOS - Basic Herniated Disk Info, *AAOS - Low Back Pain

CPT Codes: Office Consultation (99245)

Follow Up: 2 weeks post ACDF or 3 months with advanced provider if any delay with the proposed surgery.
RZ

Please let this report represent a letter of medical necessity for our treatment plan

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Michael Gerling, M.D.
This has been electronically signed by Michael Gerling, M.D. on 05-12-2022.

This has been electronically signed by on 05-12-2022.

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Coney Island Ave.

2279 Coney Island Avenue, 2nd Floor, Brooklyn NY 11223

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Prosper Jerome, NP-C	Direct Professional	08-11-2022	SCL13601
Appointment Location:	**Appointment Location Address:**		
Coney Island Ave.	2279 Coney Island Avenue, 2nd Floor, Brooklyn NY 11223		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
S/P ACDF C5-6 07-27-2022.
- Myelopathic and radiculopathy findings.
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with rigth-sided annular tear.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
ACDF C5-6: 07-27-2022 by Dr. Gerling at Hudson
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:
Initial Patient Visit - New

Mr. Juan GANDO AMAT is a 68 year year old male who presents today with neck, low back, left shoulder, left elbow, left wrist, left hand, right knee, right ankle, left hip, left knee, left ankle and left foot complaints, with the pain in the neck being the most severe. The symptoms began after the patient sustained an accident. The symptoms have been present for 6 months The symptoms have been present for 1 years and are becoming progressively worse.
Since the onset, he has not been able to work. At the time of the accident, he was working as a manual laborer Mr.

GANDO AMAT requires assistance with activities of daily living including chores and lifting and similar tasks for which he now relies on his family for help. The symptoms have impaired his ability to sleep normally.

Neck Specific Findings:
The patient's neck pain is rated 8/10.
The patient has radiating pain to the right shoulder, right arm, left shoulder and left arm.
The patient's radicular pain is rated 8/10.
The patient reports numbness/paraesthesias in the right arm, right elbow, right forearm, right wrist, right hand, right fingers, left arm, left elbow, left forearm, left wrist, left hand and left fingers.
The patient is experiencing occipital headaches. Including instances of tripping/stumbling.

Back Specific Findings:
The patient's back pain is rated 8/10.
The patient has radiating pain to the left glute, left lateral thigh, left posterior thigh, anterior left thigh, left shin, left calf, dorsal aspect of the left foot and ventral aspect of the left foot.
The patient's radicular pain is rated 8/10.
The patient also reports numbness/paraesthesias in the left glute, left lateral thigh, left posterior thigh, anterior left thigh, left shin, left calf, dorsal aspect of the left foot and ventral aspect of the left foot.
The patient cannot walk more than 1-2 block(s) without pain.
The patient cannot stand more than 5 minute(s) without pain.
Laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Conservative management:
The patient requires the use of a cane.
Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week. For 1 year(s).
Back-specific physical therapy sessions frequency: 2 day(s) per week. For 1 years(s).

Medications include:
Ibuprofen.

Accident details:
The patient was involved in a motor vehicle accident while in a car/driving. After the accident, they went to the emergency room by ambulance for care

Prior Neck and Back History:
The patient was asymptomatic in the neck prior to the accident
The patient was asymptomatic in the back prior to the accident

Motor Vehicle Accident Details:
The patient was in a car at the time of the accident and was a passenger in the back left of the vehicle, when they were struck by a tractor trailer.

Outside Medical Care & Conservative Management History as of 08-11-2022:
PT > 1 year completed.

Past Medical History
No Known Past Medical History

Current Medication
No Known Medication

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI . **Ears/Nose/Mouth/Throat:** Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness and/or assessments. **Respiratory:** Negative for respiratory complaints other than those listed under past medical history. **Cardiovascular:** Negative for cardiovascular complaints other than those listed under past medical history. **Gastrointestinal:** Negative for gastrointestinal complaints other than those listed under past medical history. **Genitourinary:** Negative for genitourinary complaints other than those listed under past medical history. **Musculoskeletal:** Negative except for details in HPI **Neurological:** Negative except for details in HPI **Psychiatric:** Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments. **Endocrine:** Negative for endocrinology complaints other than those listed under past medical history. **Hematologic/Lymphatic:** Negative for hematologic/lymphatic complaints other than those listed under past medical history. **Skin:** Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: ***The cervical spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline.***
- ROM Flexion: Restricted (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: Restricted (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: Restricted (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: Restricted (Normal: 80 degrees) with firm endpoint palpable.
The patient is wearing a neck brace in the office today
Incision: Fully healed without complications

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline lumbar spine.***
- ROM Forward Flexion: 40 degrees (Normal: 110 degrees) with firm endpoint palpable.

- ROM Extension: 10 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: The patient displays a grossly stable gait. The patient is able to heel and toe walk.
Romberg: Positive.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:
- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:
Upper Extremities:
- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 4/5 Left IO: 4/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Numbness diffuse left LE

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result

Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis
C4-5 bulge with right and left-sided protrusions narrowing cervical canal
C5-6 bulge with B/L foraminal stenosis
C6-7 herniation with right foraminal stenosis

Order No: EXT0004635 Dated: 12-29-2021

Test	Result	Unit	Range
HL7ADHOC			
EMG - UE	***right median nerve entrapment at the wrist and right ulnar entrapment at the elbow***		

Assessment and Plan:

ICD: Cervical disc herniation (M50.20)
Assessment: S/P ACDF C5-6 07-27-2022
Plan: - A cervical spine soft collar was fitted, trialed, and provided to the patient.
- The use of a cane was continued.
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- Lifting is restricted to < 20lbs.
- Physical Therapy was prescribed today for the neck along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.

- The patient will return to our office with CDs containing the following diagnostic imaging for review along with the corresponding radiology report (see order for additional details):
Cervical X-rays

ICD: Myelopathy of cervical spinal cord with cervical radiculopathy (G95.9)
Assessment: .
- Myelopathic and radiculopathy findings
Plan: - See plan above.

ICD: Lumbar disc herniation with radiculopathy (M51.16)
Assessment: .
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with rigth-sided annular tear
Plan: - Medical Advice:
Activity modification; Avoid prolonged bending, standing, or lifting.
Eat a low fat, high fiber diet, including fruits and vegetables.
Observation. Should patient develop any new bowel or bladder incontinence, progressive numbness or weakness, unrelenting pain into a extremity, they should call the office or on call provider, or present to the nearest emergency room for reevaluation
- Analgesic medications have been discussed at length including risks and benefits of over-the-counter anti-inflammatory and Tylenol use.
- The patient will continue to see pain management for regular follow-up appointments.
- Physical Therapy was continued today for the back along with a thorough discussion regarding our home physical therapy program.

The patient was extensively counseled on home therapy that should commence immediately to the affected areas. We discussed the use of temperature modalities including Heat before stretching, mobilization, massage and home exercises. Ice will be used to cool down after the exercise program along with other times throughout the day to decrease local inflammation and sooth pain. Ice should always be wrapped in a towel to protect the skin and never exceed 20 minutes in length. A structured Home Exercise Program (HEP) was sent to the patient today. We described the stretching and graduated local muscular activation and strengthening program in detail, and recommended it for twice daily use every day of the week including days when the patient may attend an outside therapy program.
- The patient will return to our office for a regular follow-up consultation.

They have been directed to call our office should any complications arise before their next appointment.
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- CAUSATION:
As the patient was asymptomatic in the lumbar spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above stated accident.
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- The patient has 100% total temporary disability at this time. Disability status will be re-assessed at future visits.

ICD: Derangement of right knee (M23.91)
Assessment: .
- Right knee derangement
S/P arthroscopy

Plan: - F/U with specialist.

New Orders & Referrals:

Diagnostic Imaging:

X-Ray: XR CSP - AP/Lat

Consultation(s):
Physical Therapy - Neck The patient is being referred for physical therapy following surgical procedure.

Restrictions:
No lifting over 20lbs. following spine surgery
No manual manipulation of the neck following neck/cervical spine surgery

DME/Bracing and/or Procedures:
Order No: INT03095 Dated: 08-11-2022 Procedure: DME New York (In-Office) Soft Collar Performed By: Prosper Jerome, NP-C

CPT Codes:
Postop Follow-up Visit (99024)

Follow Up: 2 months for subsequent postop with MD

Please let this report represent a letter of medical necessity for our treatment plan

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Prosper Jerome, NP-C
This has been electronically signed by Prosper Jerome, NP-C on 08-11-2022.

This has been electronically signed by on 08-11-2022.

CENTER for MUSCULOSKELETAL and NEUROLOGICAL CARE
GERLING INSTITUTE

Manhattan

110 Duane St., New York NY 10007

Tel: 212 882-1110, Fax: 212 882-1120

Progress Report

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Juan	GANDO AMAT	01-26-1954	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Michael Gerling, M.D.	Direct Professional	10-25-2022	SCL13601
Appointment Location:	**Appointment Location Address:**		
Manhattan	110 Duane St., New York NY 10007		

Mechanism of Injury/Nature of Illness:
MVA NJ DOA 11-23-2020
Patient was the passenger in the back. Rear ended impact by tractor trailer. Denies LOC.
Sustained injuries to neck, back, right leg, left sided of the body, left clavicle fracture, left-sided rib cage fracture with left sided pneumothorax, hepatic and splenic trauma.
Neck pain radiating to B/L UE
Back pain radiating to B/L LE

Main findings:
S/P ACDF C5-6 07-27-2022 related to traumatic cervical disc herniation with myelopathy and radiculopathy.
- Myelopathic and radiculopathy findings.
- Lumbar disc herniation with radiculopathy
MRI 3/14/2022: L4-5 herniation with right-sided annular tear.
- Right knee derangement
S/P arthroscopy.

Surgical History (If applicable):
ACDF C5-6: 07-27-2022 by Dr. Gerling at Hudson
Arthroscopy of Right Knee : 02-16-2022
Cholecystectomy : 1990

History of Present Illness:

Follow up consultation
Date of surgery: 07-27-2022
Juan presents today with neck disorder and with low back disorder. His symptoms remain ongoing with slight improvement since his last examination. He denies any bowel or bladder issues.
Juan is unable to work and requires assistance with activities of daily living including chores and lifting, and similar tasks for which he now relies on "Wife."

Neck Specific Findings:
The patient reports axial neck pain. .

Back Specific Findings:
The patient's back pain is rated 5/10.
The patient cannot walk more than Unlimited block(s) without pain.
The patient cannot stand more than >60 minute(s) without pain.
Laying down helps to relieve the patient's pain.
Lifting and bending exacerbates the patient's pain.

Conservative management:
The patient requires the use of a cane and a neck brace.
Physical therapy:
Physical therapy has been attempted for the neck and
Physical therapy has been attempted for the back.
Neck-specific physical therapy sessions frequency: 2 day(s) per week.
Back-specific physical therapy sessions frequency: 2 day(s) per week.
The patient has performed a formal home exercise program

The patient denies a history of injections since the last visit.

Medications include:
other medications.

Other medications include:
Celebrex 200 mg PRN mg.

Outside Medical Care & Conservative Management History as of 10-25-2022:
Preop CM:
HEP/PT > 1 year completed.
NSAIDs several weeks w/o success for pain control

Postop CM:
ACDF: PT 2 months completed; ongoing 2x/week
NSAIDs PRN

Past Medical History
No Known Past Medical History

Current Medication
No Known Medication

Allergy
No Known Drug Allergies.

Review of Systems:
Constitutional Symptoms: Negative except for details in HPI . **Ears/Nose/Mouth/Throat:** Negative for ears/nose/mouth/throat complaints other than those listed under past medical history, history of present illness and/or assessments. **Respiratory:** Negative for respiratory complaints other than those listed under past medical history. **Cardiovascular:** Negative for cardiovascular complaints other than those listed under past medical history.

Gastrointestinal: Negative for gastrointestinal complaints other than those listed under past medical history. **Genitourinary:** Negative for genitourinary complaints other than those listed under past medical history. **Musculoskeletal:** Negative except for details in HPI **Neurological:** Negative except for details in HPI **Psychiatric:** Negative for psychiatric complaints other than those listed under past medical history, history of present illness and/or assessments. **Endocrine:** Negative for endocrinology complaints other than those listed under past medical history. **Hematologic/Lymphatic:** Negative for hematologic/lymphatic complaints other than those listed under past medical history. **Skin:** Negative for dermatological complaints other than those listed under past medical history, history of present illness and/or assessments.

Social History:
Family:
Use of Drugs / Alcohol / Tobacco: Patient states that he drinks alcohol rarely. Smoking Status (MU) former smoker Quit 2017. He has never used any illicit drugs.
Work History: He is on disability. The patient states that they are right hand dominant.

Vitals:
Weight: 180 lbs. **Height:** 63 inches. ***BMI: 31.89.***

Physical Examination:

General: Patient is alert and oriented. They present sagittally balanced.
He is in no acute distress.

Cervical Spine Exam: The cervical spine is non-tender .
- ROM Flexion: 40 degrees (Normal: 60 degrees) with firm endpoint palpable.
- ROM Extension: 45 degrees (Normal: 75 degrees) with firm endpoint palpable.
- ROM Left lateral rotation: 50 degrees (Normal: 80 degrees) with firm endpoint palpable.
- ROM Right lateral rotation: 60 degrees (Normal: 80 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.
Incision: Fully healed without complications

Examination of the Thoracolumbar Spine: ***The thoracolumbar spine has limited range of motion due to pain with tenderness to palpation and spasm noted midline lumbar spine.***
- ROM Forward Flexion: 60 degrees (Normal: 110 degrees) with firm endpoint palpable.
- ROM Extension: 20 degrees (Normal: 25 degrees) with firm endpoint palpable.
All range of motion is tested with a Goniometer and the normal limits for range of motion use established AMA guidelines.

Gait/Balance: The patient displays a grossly stable gait. The patient is able to heel and toe walk.

Musculoskeletal exam: Both upper extremities were examined. There was no gross mal-alignment or deformity.
There is pain with left shoulder abduction There is impingement of the left shoulder. There is atrophy of the hands bilaterally Tinel's positive at the right elbow and Tinel's positive at the right wrist Phalen's positive at theright wrist
Both lower extremities were examined. Right knee reduced ROM

SI Joint Provocative Tests:
- FABER: Positive on the left
- Compression: Positive on the left

Neurology - Deep Tendon Reflexes:

Upper Extremities:
- Right biceps: 1+. Left biceps: 0.
- Right triceps: 1+. Left triceps: 0.
- Right brachioradialis 3+. Left brachioradialis: 3+.

Lower Extremities:
- Right patella: 1+. Left patella: 1+.
- Right Achilles: 1+. Left Achilles: absent.

Motor:
Upper Extremities:
- Right deltoids: 5/5 Left deltoids: 5/5
- Right biceps: 5/5 Left biceps: 5/5
- Right wrist extension: 5/5 Left wrist extension: 5/5
- Right triceps: 5/5 Left triceps: 5/5
- Right grip: 5/5 Left grip: 5/5
- Right IO: 5/5 Left IO: 5/5

Lower Extremities:
- Right EHL: 5/5 Left EHL: 5/5
- Right Tibialis Anterior: 5/5 Left Tibialis Anterior: 5/5
- Right Plantar Flexion: 5/5 Left Plantar Flexion: 5/5
- Right Quadriceps: 5/5 Left Quadriceps: 5/5
- Right Hamstrings: 5/5 Left Hamstrings: 5/5
- Right Iliopsoas: 5/5 Left Iliopsoas: 5/5

Sensation:
Upper Extremities: Grossly intact to light touch in the C5-T1 dermatomes.
Lower Extremities: Grossly intact in the L3-S1 dermatomes.

Diagnostic Studies Reviewed:

Order No: EXT0038542 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI LSP w/o Contrast	MG: L4-5 herniation with right-sided annular tear

Radiology Remarks: Community Medical Imaging
Report:
L2-3 bulge with left paramedian annular tear
L3-4 bulge protruding to B/L foramina
L4-5 bulge with right posterolateral annular tear
L5-S1 diffuse bulge

Order No: EXT0038543 Dated: 03-14-2022

Test	Result
Magnetic Resonance Imaging	
MRI CSP w/o Contrast	MG: C5-6 herniation and loss of height causing cord impingement and B/L foraminal stenosis

Radiology Remarks: Community Medical Imaging
Report:
C3-4 paramedian injection with right foraminal stenosis