SUPREME CIVIL COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM: 41

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SAUL ROSALES,

PLAINTIFF,

-against-

ZEIDA REALTY CORP. AND DADAMAYA INC.,

DEFENDANT

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Supreme Civil Courthouse
360 Adams Street
Brooklyn, New York 11201
November 6, 2023

B E F O R E:

THE HONORABLE LARRY D. MARTIN,
J U S T I C E

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(PAGES 2-56 WERE NOT TRANSCRIBED.)

THE COURT: Are we ready to proceed.

MR. VELARDI: We are, Your Honor.

MR. BUCHMAN: Yes, Judge.

THE COURT OFFICER: Jury entering.

THE COURT: You can be seated. Does the plaintiff have a witness to call?

MR. VELARDI: Yes, Your Honor. Plaintiff calls Dr. Matthew Grimm. He's outside.

THE SUPREME COURT CLERK: Good afternoon. Just remain standing, raise your right hand. Do you swear or affirm that the testimony you're about to give the Court is the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE SUPREME COURT CLERK: Thank you. Please state your name and address for the record.

THE WITNESS: Matthew Grimm, 160 East 56th Street New York, New York 10022.

MR. VELARDI: Thank you, Your Honor.

DIRECT-EXAMINATION BY MR. VELARDI:

Q Good afternoon Dr. Grimm, it's a pleasure having you. Thank you so much for your time. Doctor, are you licensed to practice medicine in the State of New York?

A Yes.

Q Okay. And when did you become licensed in the State of

New York?

A 2011.

Q Are you licensed to practice medicine in any other state?

A No.

Q Okay. Could you tell the jury, what type of doctor are you?

A I'm in physiatrist and interventional pain specialist. What that is, is sort of non-surgical treatment of spinal pain, back pain, neck pain, and joint pain utilizing multi-disciplinary approaches. Recommendations of therapy, medication, and also interventional spinal injections to try and treat pain in an effort to try to avoid surgery if possible.

Q And can you tell the jury a little bit about your educational background?

A I did my undergraduate training at the Pennsylvania State University graduating in electrical engineering. I, then went to medical college in Philadelphia. And then I did residency with a preliminary year at Graduate Hospital of Philadelphia. And then my residency at the University of California, Irvine and the William Beaumont Hospital in Detroit for physical medicine and rehabilitation. And then I did a fellowship in interventional spine at non-surgical orthopedics in Marietta, Georgia.

Q Are you board certified in any particular discipline?

A Yes, board certified in physical medicine and rehabilitation.

Q And can you just tell the jury what is physical medicine and rehabilitation?

A That's just sort of field of medicine to try and treat musculoskeletal joint issues and non-surgical manners.

Q And what about your professional experience once you became licensed to practice medicine, can you tell the jury a little bit about that?

A I took a job with New York Ortho Sports Medicine and P.C. under Dr. Jeffrey Kaplan in 2011. That was my first job out of fellowship and that's where I worked since.

Q What types of patients do you treat at New York Ortho and Sports Medicine?

A I have primarily been treating usually patients that have neck and back pain. That's what I specialized in that year after residency. But usually it's patients that have ailments of neck, back, sometimes joint pain. But I usually will then have Dr. Kaplan takes care of those. He deals with knees, ankles, shoulders.

Q Just so the jury gets a better sense of what you do with your patients, can you be a little more specific in terms of what types of treatment you provide to treat patients for their neck and back complaints and issues?

A Well every patient is a little different. So depending

on their complaints I initially will start off treatment conservatively depending on their pain level treating with physical therapy, medications, monitoring it. If the pain persists, then we will discuss different types of injections for the spine depending on if it's a disc issue, or a joint issue, for a muscular issue. Depending on their symptoms that's how we guide treatment.

Q Okay. And you're speaking about injections, can you explain to the jury the different types of injections that you've performed for your patients in the past?

A Yeah. So the basic injections I give one is called an epidural injection. And that's in the spine. You have the bones.

MR. BUCHMAN: Before we get going, can we say what we have, what it is so that the jury knows what that is.

Q Right. Doctor you're holding something and you're referring to it from time to time, just explain to the jury what you have there?

A This is just a model of the lumbar spine, the lower part of your back. This is the coccyx, your tailbone. And this these are the vertebrae that are the lower area of your spine. I just brought in the lower back, but this would go all the way up to the neck, as well.

Q Will that model assist you in explaining the anatomy of the lumbar spine and in the treatment that you provided to my

client to allow the jury to better understand your explanations?

A Yes.

MR. BUCHMAN: And is that an anatomically correct model?

THE WITNESS: This would be smaller than a real coccyx and back.

MR. BUCHMAN: Okay. But otherwise, it's anatomically correct, right?

THE WITNESS: If it was a toddler.

MR. BUCHMAN: I have no objection I just want to make sure we're dealing with the right thing.

Q So then getting back to my prior question which was about the different types of injections that you performed for patients in the past?

A Yes, if a patient comes in with complaints of usually pain that is shooting down their legs, then I think of it most likely to being something to do with the nerves and the discs. I will confirm that with an MRI first if there is something called a herniation which is the disc that's in between the bones in the back. It's kind of like a cushion I think with the radio fibers that is holding the jelly used as cushion normally under the every day motion that jelly stays inside and allows the space for the nerves to come out of the back. If there's trauma or something to the spine, then those fibers can be become torn or weakened. I think of it as a tire that is going

to blow out, and that jelly can push out or protrude, and then the nerve can be become inflamed or irritated so when that happens if it doesn't heal on its own or with medication that would be the something called an epidural injections where using an x-ray which allows me to take live pictures. I guide a needle the down to that space where the nerve is being irritated by the disc and I'll inject a steroid to put around the nerve root to try and take the swelling down to sort of opening the nerve root to help treat the pain.

Q Okay. Any other types of injections that you performed?

A The other issues in the back, you have joints in the back like a knee joint. These are in between the vertebrae. They are called the facet joints. They can become damaged as well. If they become inflamed that is different from the disc pain you'll have pain primarily just in the back, not the electricity shooting pain in the leg. And again, if it doesn't respond to therapy, if it doesn't respond to medication, then you can do an injection, a facet block where you put medicine around those joints. Again just like you'd put on injections in the knee, this one is in the facet joint to try to take the inflammation away. Another injection is the trigger point injection. That is a muscular injection. With any pain in the body or stress to the body, the muscles can tighten and they can form something called a trigger point that is just really

tightening and very painful. If you ever push anywhere people often times will get it in the shoulders. I got it when I was carrying my kids a lot. You feel it here a lot. And a lot of times people get in their paraspinal muscles in their back. To get it out, if it doesn't respond to massages you can do something that is called a trigger point injection to try to get to release and relax. I put lidocaine in there too for comfort and I do those on a regular basis with patients.

MR. VELARDI: Okay. Your Honor, I would offer Dr. Grimm as a qualified expert in pain management.

MR. BUCHMAN: No objection, Your Honor.

THE COURT: So moved.

MR. VELARDI: Okay. Thank you.

Q Okay. Doctor, did there come a time when my client Mr. Saul Rosales became a patient at your office?

A Yes.

Q Okay. And when was that?

A Well, he was referred to me by Dr. Kaplan who is also in my office. And I saw him for the first time on July 12, 2017.

Q Okay. And Doctor, you're referring to some documents. Is that your medical chart?

A Yes.

MR. VELARDI: Okay. Your Honor, would you like it if we had his medical chart marked at this time?

MR. BUCHMAN: That's fine. I have no objection, just that when he's referring to it just let us know you're referring to it as opposed to what you know.

MR. VELARDI: So we'll have it marked as Plaintiff's Exhibit One for identification.

THE COURT: Very well.

MR. BUCHMAN: And Your Honor just subject the standard redactions that we may have to look at.

MR. VELARDI: Yeah the whole thing.

Q Okay. And Doctor, on that first visit that Mr. Rosales came to see you, did you take a history from him?

A Yes.

Q And what was that history?

A He was involved in a work-related accident on 5/15/2017, suffered a fall from a height resolving injuries to his right foot, left knee, low back, as well as complaining of headaches and issues with memory. And he was initially taken by ambulance to Kings County Hospital for treatment. And then follow-up with Dr. Jeffrey Kaplan who then referred him to me.

Q And with respect to your discussions with him when he first saw you there, did he have any complaints?

A Yes.

Q And what were his complaints?

A Again, I was being referred to primarily treat him for his low back pain, but he was being treated with Dr. Kaplan who

was treating him for his left knee and ankle, right foot, and the ankle, and left knee, his left knee was buckling, persistent swelling at his left knee, and the left foot. And then with regards to his low back he stated his back pain was primarily staying in his back. He was utilizing a lumbosacral brace that was helping him support his lumbo pain. He was ambulating with a cane as his ankle had given out, and left knee was buckling, taking anti-inflammatory medications. He was to start physical therapy misdemeanor soon. Rated his pain at a scale out of eight out of ten on the VAS pain scale. And he reported that the movement of his spine would make his pain worse.

Q And just very briefly what's the VAS pain scale?

A It's just a visual analog scale. Just scale zero to ten. Usually I consider mild pain to be one to three, moderate pain four to six, and the severe pain seven to ten.

Q And did you perform a physical examination of Mr. Rosales?

A Yes.

Q And what if any findings did you have?

A He had some tenderness over of his spinous processes that is usually a form of sort of mechanical pain in the spine. He had antalgic gait. He was walking with a painful. His range of motion was decreased. He had pain with extension at five degrees. So bending the backwards where normal range of motion would be 25 degrees. He had pain with flexion at 30 degrees.

And normal was 85 to 90 degrees. Pain with left lateral flexion at ten degrees. Normal again is 25 degrees. Pain with right lateral flexion at 20 degrees. Normal is 25 degrees. Reflexes were symmetrical. And in fact he had normal sensation. He did have elicit some pain with straight leg raise testing on the left. A straight leg raise test is sort of to see if there could be some nerve issues in the spine. When the nerves exit the spine these are called foramons (phonetic.) If there is a narrowing from a disc, or from bones when you lift the leg up, if they're in the laying down position you can reproduce pain at a radiating pain at 30 degrees or more. That's considered a positive sign. It's a test to look for nerve issues. And then he was displaying some knee extension weakness on the left. Some right-sided ankle weakness with lifting his ankle up. And he had some spasm eliciting on his lumbo-musculature.

MR. BUCHMAN: And just for the record, you were referring to your records the whole time?

THE WITNESS: Yes, I don't remember.

Q Okay. Thank you Doctor. What, if any medical significance is there regarding his reduced range of motion in the spine?

A It's just when I see that, it's telling me that he's having some mechanical issues in the spine, likely issues set issues, or muscular issues, or both.

Q Okay. Doctor, at the time of your -- of Mr. Rosales's

first visit with you, did you have any diagnosis?

A Yes.

Q And what were they?

A I was diagnosing him with lumbargo (phonetic,) which is just sort of a fancy way of saying low back pain, left knee pain, right ankle pain, and consideration for a lumbar radiculopathy.

Q And can you explain to the jury what lumbar radiculopathy is?

A That's just a diagnosis if it's a nerve issue, meaning that the nerve root is inflamed somehow either from a herniation, or from something that's narrowing where the nerve comes out, and you can have distinctions of multiple diagnoses causing pain.

Q Okay. And what, if any recommendations did you make to Mr. Rosales?

A Initially, I was recommending the conservative treatment with physical therapy to his low back. I also prescribed him a muscle relaxer Xylobexa cream (phonetic.) That is a course of steroid that you take over a week. It's just a stronger anti-inflammatory to try and knock out the inflammation. He wasn't responding to just Ibuprofen which is just an oral anti-inflammatory. I'll jump to oral steroids before injections.

Q And in this instance, what was the purpose of

recommending physical therapy for Mr. Rosales?

A To try and help work out the range of motion, start to strengthen his core, to try and take some of the pressure off the back. Also physical therapy we use different modalities, heat and ice to try and treat the pain and decrease inflammation in the back. We'll also use electrical simulation. That's usually about what they do.

Q And what was the purpose for prescribing the muscle relaxer?

A He had muscular spasm. Often times people get a back injury, especially at night. When you go to sleep you start off your body will often times move in a position because you're not awake where your back will sort of tighten up. Just laying on the back, or on the side so the spasms will get worse over night. And the patient will have difficulty sleeping. So the muscle relaxers can help ease the spasms and also the side effect is it's sedating so it can be helpful.

Q What was the purpose of the steroids?

A To help inflammation.

Q Now did you make any referrals to any other doctor's at that first visit?

A As he was complaining of headaches and the memory issues and dizziness I did refer him to Dr. Nicky Bhatia whose a neurologist in the City.

Q Okay. When was the next time that you saw Mr. Rosales?

A Again, referring to my records, August 23, 2017.

Q Okay. And was there any change in Mr. Rosales's condition at that time?

A With regards to his lower back, he reported he had been attending physical therapy, stated that it was helping. On that date he rated his pain level at a five to six out of ten, down from an eight out of ten. And the metro dose pack did help as well.

Q Did you provide any additional recommendations at that time to Mr. Rosales?

A Again, since he was doing well with physical therapy I recommended we continue with conservatives efforts before considering the injection treatment. And the medrol pack helps so I gave him a prescription for Ibuprofen. You can't continuously take steroids. It's not good for the body.

Q Okay. Approximately, how often did Mr. Rosales continue to see you?

A I think just referring, I saw him again. He was doing well. He continued to do therapy. I saw him in January of 2018. And then again in March 2018. May, it looks like initially it was every couple of months.

Q Okay. I'm not going to go through in the interest of time I'm not going to go through every single visit with you Doctor, but I am going to ask you to jump around a little bit if that's okay with you. So why don't we jump to May 16, 2018.

A Okay.

Q And Mr. Rosales saw you on that date?

A Yes.

Q And what, if any complaints did he have on that date?

A On that date he was still complaining of the back pain, but the pain level was at a five out of ten. That's sort of moderate. Physical therapy had helped. He had stopped using his cane, but he was complaining of some sharp, stabbing pain to his right foot and the heel. And on that date he was complaining of increased neck pain in his neck. As I stated that over time neck pain had progressed and he was having increasing headaches post-head pain due to falling and striking his head during the accident.

Q Now did you have any recommendations relating to his complaint regarding neck pain?

A With regards to his neck, I'm referring to my records. And he said that over time the neck pain had progressed and I just opined in my report that the mechanism of injury from falling, striking several spine injury which can progress over time. At that time I just wanted to monitor it. We hadn't talked about it too much. If it persisted then I would consider recommendations for an MRI.

Q And did you perform a physical exam relative to his neck on that date?

A Yes.

Q What, if any findings did have?

A With ranging of the cervical spine he had pain in extension bending back 45 degrees, normal degrees would be 60 degrees. He had full flexion down. He was within the normal range of flexion. Left lateral flexion, he had 40 degrees. Norm would be 45 degrees. Left rotational movement 70 degrees, normal is 80 degrees. Right rotation 65 degrees, where normal was 85 degrees. His strength was in tact. His reflex was normal. Sensation was normal. I was able to elicit a positive Spurling's Sign. Spurling's Sign, like I talked about the Straight Leg Sign is when you take the neck, rotate to the right and elicit downwards pressure on to the neck. Narrow this to the foramen. And you're narrowing, and the nerve root is irritated then that will sort of provoke continued and you could have some reproduced radiating pain. So he did have some reproduced radiating pain, as well.

Q During this time period in May of 2018, was he still receiving physical therapy?

A Yes, I believe he was attending the therapy one to two times a week according to my records.

Q All right. Now jumping to August 14, 2018.

A Okay.

Q Did you see Mr. Rosales on this date?

A Yes.

Q And what, if any recommendations did you have for

Mr. Rosales upon seeing him on this particular date?

A On that date I performed muscular trigger point injections. He had muscular pain in the back. You can palpate the muscle spasm if you need the muscle it can help relax with muscular pain in the back and I also was making a recommendations for lumbar facet injections. Again, that's injections in to the facet joints and if they're having joint related pain in the low back.

Q And how did Mr. Rosales respond with the trigger point injections?

A They had helped. With his muscle pain I think I had given him periodic trigger point injections throughout my treatment both in his neck and his back.

Q And did Mr. Rosales eventually have the lumbar facet injection?

A Yes, I did a facet injection on October 29, 2018.

Q Do you have anything in there for September 10, 2018?

A Scratch that, yeah he did. I gave him two of the facet injections. The first was September 10th of 2018. And the second was October 29th of 2018.

Q Okay. And what was the purpose of providing those two injections?

A Again, he was having axel, meaning non-radiating pain in his upper lumbar, lower thoracic region of his back. And there's decreased inflammation to help with that pain.

Q And where were these injections performed?

A They were performed at Manhattan Surgery Center which is on West 54th Street.

Q And why weren't they performed at your office?

A If the patient wants to be sedated they'll be done at a surgical center not to intubate them, but to relax them so they'll fall asleep. The facet injections you have to go to each individual points. So it's about six to eight individual needle pricks. It can be quite painful.

Q And was Mr. Rosales sedated for this procedure?

A Yes, I believe so.

Q What level of sedation?

A It's max monitored anesthetic care. But an IV give you some sedation and hopefully.

Q Was that the same for the second injection as well in October?

A Yes.

Q When is the first time that you saw Mr. Rosales following the -- well, withdrawn. Did you see Mr. Rosales at your office in between the two injections?

A I believe I did.

Q And what date was that?

A I saw him on 9/25/2018.

Q Okay. And did you and Mr. Rosales have a discussion about how he was feeling following the injection?

A Yes.

Q And how was Mr. Rosales feeling?

A He reported approximately 60, 70 percent improvement in his complaints of those issues following the injections. He said the pain was starting to return some. And we discussed the proceeding with an additional injection if you don't receive long term response from the injections sometimes patients do something called radio frequency ablation. What that is there's nerves that are the pain generating nerves from the said joint that sort of take the pain signal to your brain continues each to heat up those nerves so they stop conducting just pain nerve, it's not for muscle strain, they're sensations. And we learn that if you heat them up and they don't conduct, you can get relief for six to twelve months sometimes longer. You only go to do that the pain returns following the facet injections.

Q Okay. And what was the purpose for having the second injection within, I guess approximately a month after the first?

A The pain was starting to return. So sort of a build of it. And for insurance purposes or sometimes, not sometimes they require two positive responses to the facet joint injections before they authorize you do ablation if you wish to do this.

MR. BUCHMAN: Your Honor, just note my objection to striking of the word insurance which has nothing to do with this.

THE COURT: Sustained. The jury is to disregard

that time.

Q Doctor, you had mentioned before that Mr. Rosales was having some positive improvements in the regions that were addressed in the injections. Can you tell the jury what those regions were?

A Yeah. He was having the upper lumbar and lower thoracic pain. So it's just sort of before your bill button. So following the injections he reported some improvements and he did trigger point injections.

Q Okay. Now if you could jump to December 4, 2018?

A Okay.

Q This was the first appointment following the second injection; is that correct?

A Yes.

Q Now what complaints did my client have, if any, on that date?

A He, again was complaining of the back pain, but we were post second facet joint injections. And he reported that at the time although there was pain present, it was at a level that you could tolerate.

Q Did he have any other complaints about any other parts of his body?

A He was still complaining of the pain in the neck and it was radiating to the left shoulder region. There was no upper thoracic paraspinal pain. And then as muscular pain in his low

back which we then proceeded with trigger point injections at that point.

Q Did you recommend anything to my client relative to his complaints of neck pain at that time?

A Yes, as it was many months after we started discussing the neck issue. I did refer him for an MRI to the neck.

Q Do you know whether or not my client obtained that MRI?

A There was an MRI done of the neck on 1/10/2010. Well I think that was the second one. That was referred by Dr. Merola. There is an MRI done on 12/14/2018 that I referred him for the cervical spine.

Q And what were the results of that MRI?

A If showed a disc bulge at C5/C6 that was impinging upon the fecal sack. The fecal sack is the covering of the spinal cord.

Q And what significance if any is there that the bulge is impinging upon the fecal sack?

A If it's producing the pain in the C5/C6 that's usually the shoulder area. You can usually feel it depending on which nerves are involved. C5/C6 if the nerve is irritating it can produce a pattern of pain to the shoulder. So it goes along with his pain complaints in the neck.

Q By the way, going back to earlier on when you first began treating my client, do you know whether he had an MRI of his lumbar spine?

A Yes. He's had an MRI to the lumbar spine which was done on 6/21/2017 referred to it by Dr. Jeffrey Kaplan.

Q And what were the results of that MRI?

A That MRI showed disc herniations at L4/5 and L5/S1 impinging upon the fecal sack and as well as based upon the compare methods of the foraminal spasm of the fecal sac is the offering of the cord and the noralprame (phonetic.) So the holes on the side.

Q Okay. Jumping to March 5th of 2019.

A Okay.

Q What, if any recommendations did you provide to my client on that date?

A You said March 5th?

Q March 5, 2019.

A So on that date, so we discussed the radio frequencies ablation. Like I talked earlier, but he was still -- the pain was at a tolerable level. I did note that complaints were returning. I was requesting an EKG of his radiculopathy. And I was requesting that the cervical spine be established as a sight of injury. And the lumbar trigger point injections were given.

Q What was the reason for recommending an MRI to the thoracic spine now?

A He had only met which is the middle part of the back. We had discussed during the radio frequency ablation, but prior to do something like that I just wanted to make sure there

wasn't something I was missing so I got an MRI of the thoracic spine.

Q And he had that done?

A He did have that done.

Q When did he have that done?

A That was done on 3/12/2019.

Q And what were the results of that MRI?

A That did show disc herniations at C7/C8 and C9/C10.

Q And if you could jump to the next appointment following that MRI 3/27/19.

A Okay.

Q And what complaints, if any did my client have on that date?

A He was complaining of thoracic pain in the high region of his spine. He was post left knee surgery with Dr. Kaplan from November 2018. He was complaining of neck pain, complaints of pain radiating and through his arms. And he denied any interval injuries.

Q And did you provide any recommendations to my client at that time?

A Again, I was just recommending EMG. I gave him trigger point injections. And we discussed the radio frequency ablation.

Q And what is a radio frequency ablation?

A We talked about that earlier, if there's pain generated

in the facet joint there's a nerve called the medial branch nerve that sends a signal from your joint to your brain. And if you don't get a long term facet injection it should give you six to eight months of relief. But the goal is if you take down with the injections, follow-up with the physical therapy, hopefully you can get the longer term releases with just the injections and not needing to do.

Q And just briefly what is an EMG?

A An EMG is an electromyography. It's a test that's done to test to see a nerve issue across the wrist. Sometimes it's the elbows. I use it a lot for radio radiculopathy. You take a small pins put it in another way. I'd describe it as think of a nerves as a water hose, if it's being kinked. If it's kinked for too long things downstream start to die. In this case, it's the muscles and this test will pickup on any damage to the muscle, because the nerve is inflamed and irritated.

Q Now did there come a time where he had EMG tests performed?

A He did have EMG's done on both the upper and lower extremities.

Q And who performed those EMG's?

A I did.

Q And when you say upper extremities, do you mean neck?

A Neck and the arms.

Q And when did he have that EMG done?

A That's was done on May 21, 2020.
Q And what was the result of that test?
A That test was essentially normal. That doesn't rule out -- it doesn't mean there's not radiculopathy present. It's just the amount where the muscles aren't being damaged or anything yet. But you can still have pain. I usually recommended that we do repeat sites.
Q Were you surprised by those results given that there was a bulge in the neck?
A No.
Q And when did he have the lower extremity EMG test?
A May 28, 2020.
Q And what were the results of that test?
A Bilateral S1 radiculopathy, meaning that it found that the L5 nerve and the S1 nerve were being inflamed by some sort of process in the back.
Q Is that consistent with the findings that were on the MRI of the lumbar spine?
A Yes.
Q Did there come a time when recommended that my client see a spine specialist?
A Yes.
Q And who was that?
A He saw Dr. Andrew Merola.
Q And when did you make that recommendation?

A I don't have the exact date. Here we go. It looks like approximately December of 2019.

Q Okay. And what was your reason for referring him to Dr. Merola?

A Just we've been treating him for some time. He did have the disc issues in addition to the facet issues. And I agreed to talk to him as I said earlier you have to be sedated for the other previous injections. So we discussed epidural verses the surgical evaluation and he preferred to seek a surgical evaluation prior to trying the epidural.

Q When you say "he," do you mean my client or someone else?

A Yes, my discussions with him. I usually give my patients options. I will explain we can either go one road or we can just deal with it, or we can do another route. We can do some injections. It's not a one side fits all.

Q And do you know whether or not my client eventually saw Dr. Merola?

A Yes, he did.

Q And did you see my client after he had seen Dr. Merola?

A Yes.

Q And if you'll jump to November 18, 2020.

A Okay.

Q And what, if any complaints did my client have on that date?

A He was, again, complaining of the upper thoracic pain. He reported that trigger point injections and the facet blocks have helped. He was complaining of some lower back pain that was radiating post anterior under his legs. He had discussed that he did see Dr. Merola who had recommended surgery to his lumbar spine. With regards to his neck, he had continued complaints of some pain radiating to the right shoulder, as well as he was reporting some increased left-sided axel pain non-radiating pain to the left. And on that day, his neck was effecting him more than his low back on that date.

Q And when was the last time that you saw my client?

A I saw him in August of this year, August 7th.

Q I'm sorry.

A August 7, 2023.

Q And what was the condition of my client on that date?

A We discussed his lower back pain. He did state that the radiating pain complaints persist. But he reports at the present it's tolerable. It gets worse when he walks. He states that he learned to deal with it. It waxes and wanes depending on activities and weather. And if it flares up he takes medications, rest, ices his back, pain levels around five out of ten. I guess surgery had been recommended; laminectomy and discectomy. I guess due to resources available he never proceeded with the surgery. He did report his wife will help him with some shopping, and home care. He can dress

independently. Independent with his personal hygiene. His neck pain again is present daily but he's learned to live with it. However tolerable rest it increases when he rotates his head and he does try to stretch and do home exercises daily. And again his pain is rated a five out of ten.

Q In what area?

A That was the neck and the back actually.

Q Are you able to tell the jury what the total cost for his treatment was with you from start to finish do you have any records?

A I don't have those records.

Q Would Dr. Kaplan have those records?

A I mean the office would.

Q All right. Moving along Doctor, I would now like you to assume that we'll be hearing some testimony from Mr. Rosales in this trial and he will state that he fell approximately five to six feet from a ladder falling on to hiss right side forcefully to the floor. Assume further that he will testify that he felt pain to his lower back and complained about such pain to Dr. Kaplan at your office when he first saw him on June 12th of 2017. Assume further that Mr. Rosales will testify that he never had any low back pain, accident, or injury to his lower back before the accident. Do you have an opinion within a reasonable degree of medical certainty as to whether the injuries and the complaints of pain that Mr. Rosales had

communicated to you about his lower back was causally related to that accident?

A Yes, I would say with a reasonable degree of medical certainty I would find it causally related.

Q And why do you hold that opinion?

A He reported to me no prior history of low back pain. He's responded appropriately for treatment. And a fall did occur especially of someone his age can cause an uneven pressure to the lumbar spine which can then cause injury, as well as irritation to the joints. So the mechanism of action of the injury is consistent with his complaints.

Q Now when you say especially a man of his age, what do you mean by that?

A I mean just usually, and again I'm not -- I don't have a prior MRI to compare it to, but you wouldn't see any issues at an age yes you can get herniations when your older. And usually you will see other degenerative issues on this man as well. If he had two herniations, three bulges, a degenerative process usually you'll see multi-level issues not just the one or two issues in someone of his age. But again, I didn't have a prior study. So all I can say is his symptoms were not present prior to the accident. The symptoms were present after the accident. So that's my answer.

Q Okay. Thank you. So was the pain management treatment that you provided to my client, as well as the MRI that was

recommended and done for him, of the lumbar spine, I'm just focusing right now, as well as the physical therapy, the medications, and the two injections that you performed, were they necessary due to his lower back injury?

A Yes.

Q Do you have an opinion within a reasonable degree of member certainty as to whether Mr. Rosales lower back injury is permanent?

A Yes, unfortunately the back is supporting your body for the rest of your life. It's a degenerative condition. Sometimes people have traumatic arthropathy meaning he had trauma. It's causing to age at a little bit faster rate. So it is something that will progress and again wax and wane over time. But for the rest of his life.

Q Okay. Now Doctor I would like you to now assume that the Defense will call an expert neurologist who will testify that if the lumbar herniations had been due to the accident there would have been an inflammatory reaction manifested by an ambula fisher (phonetic,) but there were not. And therefore, the herniations preexisted the accident. With that assumption, do you have an opinion within a reasonable degree of medical certainty whether the forset (phonetic) of that opinion of the Defense expert is correct?

MR. BUCHMAN: Objection.

THE COURT: On what basis?

MR. BUCHMAN: On the basis he's assuming a fact. I have no idea whether it's true or not. That his assumption may or may not be true.

THE COURT: In terms of the report?

MR. BUCHMAN: In terms of what he just said the assumption of what a Defense expert going to come in and say.

MR. VELARDI: But it's an assumption.

MR. BUCHMAN: As long as we know it's an assumption.

THE COURT: Hypothetical. Let's continue.

A Like I was saying earlier I would, without an MRI predating the accident, the only thing I know is his symptoms were present after the accident not present before. I wouldn't be able to. No I would disagree with his statement.

Q Okay. Moving on to the cervical spine. Same assumption -- well let me just repeat the assumption since I had a different assumption in the last question. So again, assume that you'll be hearing the testimony of Mr. Rosales and he's going to state that he fell approximately five to six feet from a ladder, falling onto his right side on the floor hitting his head in the process. Assume further that he'll testify he begin to develop pain in his neck over time which you also noted in your examinations of the plaintiff in May of 2018. Assume further that he'll testify he has never had any neck pain,

accident, or injury to his neck prior to this accident. Do you have an opinion within a reasonable degree of medical certainty as to whether the injury and the complaints of pain to his neck are causally related to the accident?

A Yes.

Q And what is that opinion?

A With a reasonable degree of medical certainty it's my opinion that his neck pain is causally related to the accident.

Q And why do you hold that opinion?

A He reports to me no prior history of neck pain or neck injury. The symptoms he developed over time that can progress in time.

Q Now the treatment that he received for his neck was that medically necessary based on his injury and complaints?

A Yes.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether my client's neck injury is permanent in nature?

A Yes, I think it's a permanent injury in nature that will wax and wane just like the low back. I think his low back injury is more severe than the neck. But I think he's responded to treatment and conservative treatment. So hopefully he will continue and be able to treat it.

Q And Doctor I would like you to now assume that an expert will testify on behalf of Defense in this trial and will

testify that the condition of Mr. Rosales cervical spine represents only a minimal degenerative change that was not accident related. Do you have an opinion within a reasonable degree of medical certainty whether the forset (phonetic) opinion is correct?

A I would disagree with that opinion. Again, just him describing no prior accidents or histories pre-accidents and after I started treating him after the accident so I would disagree.

Q Now Dr. Grimm, do you have an opinion within a reasonable degree of medical certainty as to whether Mr. Rosales will need any other medical care in the future other than what you've already testified to?

A Yes.

Q What are those items of treatment so to speak?

A Like I said, as it is a progressive condition that can degenerate over time I think as he ages in the future his issue will start to flare up more often. So he will need future treatment. I think he will start to need medications more often. One including an anti-inflammatory nerve relaxants, a topical anti-inflammatory medications. I would say approximate cost of $100 per month as it persist as his condition progresses. Pain management office visits at a cost of $250 per visit every three months. Orthopedic surgery office visits a cost of $400 four times a year. Orthopedic $500 per visit once

a year. He's a candidate for the lumbar steroid injections, a cost of $1,200 per injections, $2,000 facility cost for the guidance and the anesthesia. Approximately three injections every two years if his pain warrants it. Cervical epidural steroid injections again $1,200 an injection, $2,000 facility cost. Trigger point injections a cost of $300 per set of injections. Up to one set of injections every three months to the cervical, and thoracic, and lumbar spine as needed. He's a candidate for the lumbar laminectomy and partial discectomy which is a cost of approximately $60,000; including, the facility cost of anesthesia and equipment.

Q Now let me just stop you there. That was the surgery that Dr. Merola had recommended?

A Yes. And then as his issue progresses if he comes in and he's having increases in pain I'll want to get updated studies to see if there's any worsening of his condition that would warrant further treatment. So MRI of lumbar spine cost of $1,300 every five years. MRI of the cervical spine at the cost of $1,300 every five years. The MRI of the thoracic spine cost of $1,300 every five year. It could be if he flares up sooner it could be more. I'm just saying an average of maybe one every five years and then he's being treated by orthopedics. The MRI of the right foot a cost of $1,300 every five years. MRI to the right knee a cost of $1,300 once every five years. MRI to the right shoulder a cost of $1,300 every five years. And then

x-ray films yearly of the lumbar spine $400 yearly. X-ray film of the cervical spine, $400 yearly. X-ray of the right foot, $400 yearly. X-ray films of the left knee, cost of $400 yearly. X-ray films of the right shoulder a cost of $400 yearly.

Q If I can just stop you for a moment so you explained what the MRI's showed and essentially what was the reasoning that the MRI were performed on him previously. What would be the purpose of having these x-rays done in the future that you're talking about now?

A Because x-rays look at the bones more so than the nerves and the disc. So if the joints in discussions with Dr. Kaplan the orthopedic surgeon he's looking for, it's traumatic arthropathy to check the joint to see if it's degenerating past to just monitoring it were.

Q Are you finished with respect to my question regarding any future treatment?

A EMG of the upper extremities up to every five years to check for progression. EMG it can find whether something is sort of QTU damage or chronic old damage. Especially if he has continuous symptoms like I said if it's a mild radiculopathy you want to see it on the EMG as it progresses. It can start to be shown so you know it's an ongoing issue. So upper and lower extremities $2,000. And again if we do the thoracic and facet injections which he did respond quite well to, we can do those up to four times a year as needed if he flares up to the cost of

$1,500 per injection and $2,000 hospital cost per anesthesia and the guidance.

Q Anything else?

A That's it.

Q Now Doctor, have you testified regarding persons you've treated who were also represented by my law office, Gorayeb & Associates P.C.?

A Yes, it's a service I provide only patients really that I treat if they ask me I will.

Q Approximately, how many times, just an approximation, have you testified for a patient that was referred by Gorayeb & Associates?

A I can't given you an exact figure. Within the 12 years I've probably done it 20 times or so.

Q And are you being compensated today for your time?

A My office is being compensated. I'm an employee of New York Ortho.

Q Do you know how much your office is being compensated?

A For my time we had to cancel my afternoon of patients. I had a full schedule. So I think office is being compensated $8,500.

MR. VELARDI: Thank you I have no further questions.

MR. BUCHMAN: Could we take five minutes so I can look at his record?

THE COURT: Members of the Jury we're going to take a brief recess. We'll be rejoining shortly. And once again please do not discuss anything concerning the case or with anyone else.

THE COURT OFFICER: Jury exiting.

(Jury exiting.)

THE COURT: Approach. Doctor you can step down.

(Off-the-record discussion.)

THE COURT: Are we ready for the jury?

MR. BUCHMAN: Yes, Your Honor.

MR. VELARDI: Yes, we are.

THE COURT OFFICER: All rise. Jury is entering.

THE COURT: You can be seated.

MR. BUCHMAN: May I inquire, Your Honor?

THE COURT: Yes.

CROSS-EXAMINATION BY MR. BUCHMAN:

Q Doctor, we're going to try to move through this in 22 minutes. Can I just get Exhibit One for the witness so he will be able to refer to his records.

THE COURT: Sure.

Q Good afternoon, Doctor. I'm just going to refer to a couple of hypotheticals and questions that Counsel put to you first before I get to my stuff. Counsel posed a question to you about degenerative conditions and assume that my doctor is going to come in and say something. And you made the point about

something about fishers and I haven't seen prior films, therefore I really wouldn't know. Is that part correct?

A Yes.

Q So different question, I looked through your records there are no actual films in there, are there?

A I don't have the films here.

Q Did you see the films in your office?

A The one's that I've sent the patient for, yeah the films are online.

Q And you read the films?

A I read the films when I sent him for it. I also rely on the radiology appointment. I don't remember again that was a long time ago.

Q No, I understand. So then your idea that whether they're degenerative or not is not from your memory of looking at the films?

A Right.

Q And did you have your opinion on the films?

A I had the report and I just sort of corroborated it. But my wife's a radiologist so I do rely on the radiologist because people do miss things.

Q Now part of an exam that you would give as a treating doctor you take a history and the information, etc., right?

A Yes.

Q Do you have in your records Mr. Rosales's weight? I

didn't see it there.

A His weight?

Q Yeah.

A In my notes I do not have his weight.

Q Do you have his height?

A No.

Q Do you have his work history?

A No.

Q Okay. Do you have his smoking history?

A No.

Q Okay. And if someone was a smoker that's generally not good for their spine as a general rule, right?

A I guess. I wouldn't characterize it. It's just generally not good overall for your health.

Q But excessive smoking could hinder someone's healing process if they were injured?

A Yes.

Q And say if there spine was injured whether in the past or current, or even through wear and tear, smoking would hinder that too, right?

A I don't know to what extent. I'd have to do a deep dive into journal articles to see what extent smoking could have on that type of situation.

Q Okay, well we know smoking increases osteoporosis and with coughing that could also lead to problems with your spine

because of smoking, right?

A What's that?

Q I'll say it again. That smoking decreases blood flow which increases your risk of osteoporosis and also excessive smoking could lead to coughing, and that's not good for your neck and back?

A Again, I'm not an expert on smoking and its effect on the body. I couldn't comment on an expert opinion on that, but I could say smoking is not good in general in my opinion.

Q Well, there's a website called best pain doctor NYC dot com. That's you right?

A Yes.

Q And this looks like your website Matthew Grimm with a plus sign and Matthew Grimm M.D.?

A Yes.

Q Now I don't know if I have a picture of you on here. And one of them, one of the pages has to do with spinal pain causes and pain management options. And as you go down I don't know the second or third page, risk factors for spinal pain and one of them talks about smoking. And I want to know if this refreshes your recollection. Well how about this, you have a website and you put information on there that you believe is true, correct, for your patients?

A Yes.

Q And if says here on your website you would agree with

me to the best of your knowledge it's true?

A Yes.

Q So when it says here smokers have a high risk of developing back pain, excessive smoking leads to coughing which puts pressure on cervical discs, this can cause herniated disc furthermore. Smoking decreases blood flow in the spinal region increasing the risk of osteoporosis. Does that sound like something that's on your website?

A It must be. I don't remember putting it up there, but I have sort of a blog for marketing purposes.

Q For marketing, okay. And also weight lifting could put pressure on the back?

A Yes.

Q And how about you know you mentioned someone who's 31 and you said that's young before the degenerative spine process. How about somebody who would be 31 turning 32 who had been working in the construction and hard physical labor for like ten or fifteen years. Would that change your opinion that maybe due to repetitive movements in hard labor that maybe he or she might start developing some degenerative conditions?

A It could.

Q Okay. So that would be ten or fifteen years. Well Mr. Rosales had been working in construction as a brick layer and as a painter for almost 18 or 19 years prior to this accident. So as you just said 10 to 15, I'm thinking 18 or 19

years that certainly could lead to some degenerative changes, correct?

A It could, sure.

Q And especially a painter doing this a lot, moving his arm forward and back reaching for a ceiling that could lead to some conditions, correct?

A Yeah.

Q And bending up and down a lot, and the reaching for the paint, and removing the drop cloth, that would also lead to that, correct?

A Depending on the patient it may or may not, yes.

Q And being a brick layer and moving bricks and heavy masonry that of course same thing, correct?

A Yes.

Q Makes sense?

A Yes.

Q Now, how many Gorayeb patients do you treat a year, the law firm Gorayeb?

A They refer the office patients. I couldn't give you an exact number. I don't see their name on my referrals all the times. My patients come from other surgeons or Dr. Kaplan. So I don't see where they're coming from always.

Q Look at the last page of your records. I don't mean the page, but I mean on the folder. It tells you where Mr. Rosales was referred from, right?

A Yes.
Q From Gorayeb's Office, right?
A Yes, the name is here.
Q But it says Gorayeb on it as referral?
A Yes.
Q So if you were to look at the last page of every record in your office I guess you could tell yes or not?
A I could go looking for it. This would be put on the electronic records. We're not paper charts.
Q And again I'm making the assumption that you look at paper and you don't look at the page on the back of the chart, correct?
A Umm hmm.
Q Well for this one we had to open the folder all the way and look on the back pages right?
A Right.
Q So would you say maybe you see one or two patients a week that are referred by Gorayeb's Office or would you be guessing?
A I see more than one or two.
Q More than one or two per week?
A I see patiens from various avenues. So I get generated referrals from the website. Some from various. I go to networking events meet physical therapist, attorney's, contractors. So I get referrals from all over.

Q But my question is more focused on how many patients per week are you seeing that are referred by lawyer's?

A Somewhere in the range of 40 to 60, 70.

Q Per week?

A Maybe. Again, I couldn't give you an exact number. So I don't know. It's more than one or two.

Q Let's go to the low number 40.

A Not new patients.

Q Just patients, existing patients. So then if we go 40 per week. Now let's say you take some time off. You don't work 52 weeks, nobody does. Even if you do 50 weeks it would be like 2,000. But if you take more weeks off, maybe 16, 1,900 patients that are referred to you by lawyer's does that sound about right?

A No these patient's I'm not -- I see them every six weeks so the math wouldn't be 40 times.

Q No, no I'm not trying to infer that they're all new patients. I'm just talking about in general, some of them are repeats, some come every six weeks, some come every four weeks, some come every three months. But in general would it take 15, 1,800 visits a year from lawyer referred patients?

A If you include repeat visits, yeah sounds about right.

Q So 1,800. How much you get per visit?

A That would be --

Q The billing office?

A I work for Dr. Kaplan.

Q Okay. Never mind, let's mover on. I just want to get that idea? And you said you testified for Gorayeb's Office about 20 times. How about other law firms, how often have you testified for them? For Subin's Office, Levin's Office, Block and O'Toole?

A I can go years where I don't testify at all. This year I think I've testified maybe four times.

Q And is there another ongoing trial in this building I believe that maybe you're an expert that may require your testimony probably this week or next week?

A That I couldn't answer. I just found out I was coming here on Friday afternoon and I was not happy because I had to cancel all my patients.

Q What percentage of the patients you see are referred by lawyer's?

A I couldn't give you a number, but there's a lot of construction. My field in general is people get injured so there's a decent, I mean it makes up a decent portion of my practice.

Q A decent portion. Five percent, 20 percent, 30 percent, can you give us a range?

A That's just the nature of pain management. I don't know the numbers. It's more than five percent.

Q More than 20 percent?

A I couldn't tell you an exact number.

Q Would you agree with me that a patient might skew their answers or complaints to help their case?

A I would hope that they're honest. Just human nature I could see them, you know, if they say pain is a six they might say a seven. I can usually weed out the one's and I've on more than one occasion told patient that I won't see them anymore because I don't believe them. If I had a patient that I think is skewing or not being truthful I won't accept them as a patient.

Q You're aware that Mr. Rosales did not complain to the EMS about his right foot, correct?

A Umm, I --

Q Well are you aware?

A I'm not sure. It's in my records. You're refreshing my memory. Yes, I believe you.

Q Are you aware he didn't complain in the hospital about his right foot?

A I believe you.

Q So you're not aware one way or the other?

A I don't remember.

Q Are you aware that he did not lose -- that he told EMS -- are you aware that Mr. Rosales had told the hospital personnel that he did not lose consciousness at the scene?

A I believe you.

Q Are you aware he did not -- that he told EMS that he did not lose consciousness at the scene?

A Okay.

Q Are you aware that he told the hospital personnel that he remembered the scene back at the incident, and that he was ambulating at the scene, are you aware of that?

A I'm believing you.

Q Okay. And are you aware that Mr. Rosales was ambulatory in the hospital and that he ambulated on discharge out of the hospital are you aware of that?

A I would believe you, yes.

Q Is that consistent? All that ambulatory stuff, is all that consistent with somebody who traumatically fractured his calcaneal bone that day?

MR. VELARDI: Objection, Your Honor. There's been no testimony regarding the calcaneus fracture with this witness. This goes beyond the scope of the direct.

MR. BUCHMAN: I disagree, because it's all over his records that are in evidence. And he's discussed injury to the foot.

THE COURT: Overruled.

A I generally defers treatment to the ankle to Dr. Kaplan with our practice. He's the ankle, knee, shoulder specialist. I do the neck and the back. I meet if someone is complaining of pain, but I'm not diagnosing and treating the fractures, or the

ankle, or that. But I will prescribe pain medication. But then if the patients ask me questions about their knee or the ankle I say you have to check to see when they save that question for Dr. Kaplan.

Q So you don't have an opinion on that?

A No.

Q So now, how many lumbar injections has Mr. Rosales had to date?

A He's had two of the thoracic lumbar facet injections and he's had the trigger points injections on various occasions.

Q How about the lumbar steroid -- I'm talking about the epidural injections. Has he had any epidural injections to this date?

A No.

Q Now, when you talk about lumbar steroid injections fluoroscopically guided, those are epidurals, correct?

A Or facet. You need the fluoroscope. You don't need the fluoroscope for the trigger points.

Q But you need -- when you talk about these lumbar steroid injections and cervical steroid injections, are you also talking about epidurals?

A If it's for disc-related pain, then it would be the epidurals. If it's for the facet medicated then it would be the branch blocking facet injections. Both of which are steroid injections.

Q And he's had no epidurals to date.

A Correct. We discussed it he preferred to go speak with Dr. Merola.

Q With a surgeon. Instead of having an injection let's go have a surgery, is that correct?

A Yes.

Q And how many facet injections has he had to date?

A Two.

Q So he's had two injections in six years, right?

A Yes.

Q And yet you estimate he's going to need three injections every two years in his lumbar, and three injections every two years in his cervical which would be six every two years, correct?

A Like I said, as it progresses I'm asking to give a future possibility.

Q I understand. But you know, we can base -- we also have to base our projections on what we know to date, correct, I mean that doesn't sound crazy, does it?

A No.

Q So the more information we have, the better. So let's talk about if, I'm just doing some math. So it's $1,200 per injection, plus $2,000 facility cost, that's $3,200 a pop. And that's three of them so that's $3,200 times three is $9,600. And then we add the cervical and the lumbar that is $19,200

every two years which according to my math, because I use my special calculator here that in 40 years that would be 20 times which would get us somewhere around $385,000 to $400,000, correct?

A Okay.

Q And if it's 50 years if he's lucky enough to live into his 80's. That would be somewhere around a half a million dollars worth of injections. That would be somewhere around I don't know 150 to 160 epidural injections or lumbar facet injections. Have you ever given that many injections to a patient in their lifetime?

A I've only been practicing ten years.

Q Right, so you've never done that, correct?

A Correct.

Q So it's beyond what you would know in your practice?

A I would state that. And I think I might have phrased it before I would say up to those injections if he's had the pain. So initially obviously he's not getting them now because he's tolerating the pain. As he gets older I think it will progress and it would be my recommendation and he can take the recommendation which I feel would benefit him or not.

Q But it may not progress and get worse, isn't that true?

A In my history in treating patients, back issues usually get worse over time.

Q Okay. What about if he took medications instead of

your injections?

A It will probably eat a hole in his stomach.

Q What about going on and going off?

A I think it would be beneficial for again if a patient comes in and says I have two weeks of pain I wouldn't say let's jump to epidural let's try some medications, try the oral pills first. And then in four to six weeks the pain was still there, then we would possibly go to the injections if they came in saying I'm having ten out ten pain then I might jump to the injections if they wanted to.

Q Now you took these fluoroscopically guided one's. Those are also the facet block injections or is that something different?

A Yeah, he's got two issues it's his higher pain.

Q I'm not asking you to explain, what I'm is are the lumbar steroid injections different than the lumbar facet injections or they're the same?

A Different area of the spine.

Q So then you're also just so I'm looking at number -- you wrote a report and you gave us all this information about future plans. And you also talked about candidate for thoracic and lumbar facet block injections at a cost of $1,500 per injection plus $2,000 for the hospital cost. That's $3,500 a pop. And if we do that four times a year, that's $14,000 per year just for the thoracic and $14,000 a year for lumbar.

That's $28,000 a year. And it's your estimation that if he lives another 40 years that your going to put like 400 facet injections in him?

A No.

Q I just want to make sure.

A I'm saying up to those amounts is what he could get if he had exacerbations.

Q But your projections you know you got really high numbers. And you know an economist is going to come in here on Monday and he's going to take your numbers and he's going to add inflation. I mean if it is says here 40 years $1.1 and 50 years $1.4 what do you think an economist is going to do with that, but that's really the high end that's really high isn't it?

A I don't anticipate full every year, but as he progresses I think he will start having --

Q You're saying -- you're suggesting that you know what this says up to four years per year for the life time for his lumbar facet. And four injections per year for his life time on the thoracic facet. And it says three injections every two years for lumbar steroid injections. And three injections every two years for his life for cervical steroid injections. To me your opining 600 or 700 injections. Have you ever to this point, I know you've only been doing this 11 or 12 years. Have you ever injected anybody 100 times in your 11 years?

A I have not given one patient 100 epidural injections.

Q Have you given any patient more than 50?

A Fifty over ten years, one patient no, not in one year because you're limited to a certain number because of the dosage.

Q Correct. So I'm just trying to get a handle on this. In your own practice you really don't give more than 50. You've never given 100, yet in these you've got 4, 500 injections going into Mr. Rosales which runs these numbers up in to the $1.1 to $1.4 just in facets. And then in the lumbars it's up to the 5/$600,000. Can we agree that's really high?

A That's why I put up to.

Q I know. I just want us to agree that you've never done that before with a patient, correct?

MR. VELARDI: Objection. Asked and answered.

THE COURT: You can answer.

A I have not given that many injections.

Q Not even half. You've probably given a quarter?

A I have some patients who will come in for three injections every six months that have chronic issues plus that's the generally the safe zone.

Q But never over 30, 40 years? I know you've only been there for 11 years. So let's move on from this.

THE COURT: What happened to that 22 minute projection, but continue.

MR. BUCHMAN: I am apologizing. Let me move on.

We're done with that. We hit the website.

Q And then let's talk about. I guess all the other things. So all these other projections that you've given. I mean, how about this, how many times have you seen Mr. Rosales in six years?

A I saw him every few months.

Q But how many times in total have you seen him?

A I don't have the number.

Q More or less than ten?

A I think more.

Q More or less than fifteen?

A I'd have to count them. Maybe more, I don't know.

Q Because you have him seeing you more or less than 25? I'm just trying to get a handle on it?

A I can go through.

Q If you have billing records maybe you can just look in the front and see how many times.

A I don't have the billing records. I just have each individual date.

Q So you'd have to look and count them?

A Yes. Some years I was seeing him every two months. That sort of going along with pain waxing and wane.

Q Let's go more recent. How many times have seen him in 2023?

A I think I saw him in August and then I saw him in

December of 2022. So once.

Q And how about '22?

A Twenty-two, I saw him in December. Then I saw him in May. Then I saw him in February. And the time before that, I saw him December 6th.

Q Three in '22 and four in '23. So that's four times in two years, right?

A Yes.

Q You have him seeing a pain management which would be you, once every three months for his lifetime which would make it four times a year. So you've got him for like, oh that's a lot for 40 years that's like 160 times in 40 years, or in 50 years 200 times. But yet, in the last two years you've seen him twice. So that's sounds like double of what you're projecting. Now I know you said he might get worst in the future --

MR. VELARDI: Is he asking a question?

THE COURT: Counsel, can we move on.

A I stand behind that recommendation. If I'm giving medication, if I'm treating the back, I would want to monitor it. Sometimes they would get worse. If they're doing very well, your doing great, let's do six months. If I treat them once then I need to see them in follow-up. I would say an average four times a year. Treating neck and back is not an over estimate.

MR. BUCHMAN: You know what, I'm done. Thank you.

MR. VELARDI: Doctor, just one question on redirect.

THE COURT: We'll see about that.

MR. VELARDI: Just one, I promise. Doctor, Mr. Buchman asked you whether or not it's possible for patient's to skew their complaints or to be untruthful. Do you have any reason to believe that Mr. Rosales was ever untruthful to you or skewed his complaints?

THE WITNESS: No, actually looking at his record he's responded appropriately to conservative treatments. He would say he was an eight out of ten and then come in and say five out of ten. I'm still eight. He's responded appropriately to treatment which is what I like seeing that.

MR. VELARDI: Okay. Great. That was my only question thank you.

MR. BUCHMAN: Well no, I've got to recross just on that issue. Are you aware that Mr. Rosales was examined by his own neuropsychiatrist, psychologist and he failed a reliability test when he it came to responses regarding symptoms, are you aware of that?

THE WITNESS: No.

THE COURT: Thank you Doctor, you may step down.

MR. VELARDI: It's been marked so we have to leave it here.

THE COURT: Approach.

(Off-the-record discussion.)

THE COURT: All right. Members of the Jury, we don't have any other witness's today. Tomorrow is Election Day so you'll be voting. We will not be meeting tomorrow. And Friday we will be celebrating Veterans Day so we will not be meeting on Friday. So we will see you on Wednesday. We'd like you to be here Wednesday morning at 9:30. How was the Promenade?

THE JURORS: Lovely.

THE COURT: Okay. And once again, please do not discuss anything concerning the case among yourselves or with anyone else. We'll see you Wednesday at 9:30.

THE COURT OFFICER: Jury exiting.

(Jury exits.)

THE COURT: Approach.

(Off-the-record discussion.)

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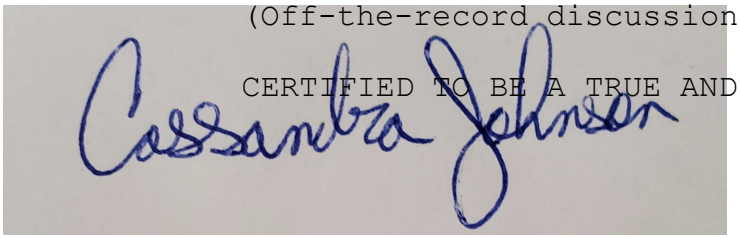

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CASSANDRA JOHNSON

SENIOR COURT REPORTER