SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS : CIVIL TERM : PART 27
----------X
ENID TOVAR,

Plaintiff,

-against- Index No. 708719/2021

QUEENS 111-02 LLC, **JURY TRIAL**

Defendant.
----------X
Supreme Courthouse
88-11 Sutphin Boulevard
Jamaica, New York 11435
January 21, 2026

B E F O R E:

THE HONORABLE ANNA CULLEY,
J U S T I C E

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Senior Court Reporters

THE CLERK: Continuing case on trial.

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE CLERK: Good morning.

All jurors are present and properly seated.

Everyone can have a seat. Continuing case on trial.

THE COURT: Mr. Bitetti, are you ready to call your next witness?

MR. BITETTI: Yes, your Honor. At this time we would like to call life care plan expert, Dr. Stuart Khan.

THE CLERK: Witness entering.

THE COURT OFFICER: Remain standing. Please raise your right hand and face the clerk.

S T U A R T K H A N, MD, called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, was examined and testified as follows:

THE CLERK: Thank you. You can have a seat:

THE WITNESS: Thank you.

THE CLERK: Please speak into the microphone and state your name and address for the record please.

THE WITNESS: Sure. Stuart Brian Khan, M.D., office address is 25 Sutton Place South, ground floor 1C, New York, New York 10022.

THE CLERK: Thank you. The witness has been sworn

in.

MR. BITETTI: Thank you, Chris.

THE CLERK: You're welcome.

MR. BITETTI: Your Honor, if I may.

THE COURT: Yes you may.

MR. BITETTI: Thank you very much.

DIRECT EXAMINATION

BY MR. BITETTI:

Q Good morning, Dr. Khan.

A Good morning.

Q Can you please tell the jury about your educational background?

A Sure. I went to undergraduate at State University of New York in Binghamton; I graduated in 1984 with a bachelors in mathematics and went straight on to State University of New York at Stony Brook. I finished with a degree in medicine, an M.D. degree, in 1988.

I went straight on to Columbia Presbyterian's physical medicine and rehabilitation program, which is a four-year program, of which the first year is called an internship in medicine where I did that through Columbia at one of their outsourced hospitals in New Jersey called Overlook.

I got my internship and finished that in July of '89 and got my license to practice medicine a couple of months later, but finished three additional years on Columbia's main

campus in physical medicine and rehabilitation. Finished that in 1992, which made my eligible to sit for the ACGME, which stands for American College of Graduate Medical Education, Boards for rehab medicine, or physical medicine and rehabilitation part one. I took that test and passed and then part two you can take a year later after you practiced, which I did.

I then became interested and continued to study pain management, which was not a field that was even open to rehab doctors at the time. It was limited to anesthesiologists who founded the field in the '80, but in 1995 it became available to rehab doctors. So I sat for the boards, having studied and prepared to do so my whole studies and career, and I passed that board as well on the first attempt.

I've continued to remain board certified by taking recertification tests every ten years, until about 2015 when most boards in the country switched to a type of board certification or recertification called longitudinal assessment, which means every quarter you are taking board examination questions.

If you don't pass three out of the four quarters, then you're sent to take the formal test that you would have had to take every ten years. Fortunately, I've passed both boards every quarter, not just three out of four quarters, so I remain board certified.

Q All right. Thank you, Doctor.

Can you explain a little bit about your employment history. I know you got into it briefly in that answer already, but can you explain your full employment history?

A So, sure, immediately upon finishing my residency in rehabilitation medicine, my employment history is pretty easy. I've only ever had two main jobs.

I went to work at what was once called Beth Israel Medical Center, which is now no longer even a hospital. I worked for 21 years in about three different jobs there as an inpatient rehab director of the rehab unit for general rehabilitation.

They mostly specialized in orthopedic type of rehab because it was a big orthopedic hospital at the time, and I also started a practice in pain management at Beth Israel for the rehab department.

Then after about three years Beth Israel asked if I would head up the division they had, a group called DOCS. Well, it is a pun, it's an acronym, DOCS. They had about 15 different offices in Westchester County and I started the rehab in pain management division there and eventually grew it to about five doctors.

Then Beth Israel asked me to come back and head up the nonoperative part of the orthopedic spine center, so that meant that I would be running the pain division for the spine center

at Beth Israel, working alongside with spine surgeons inside the orthopedic department. That is when I was then giving an appointment to the orthopedic department in addition to rehab department, so I was teaching and running my fellowship program in the orthopedic department, no longer the rehab department.

At that point I stayed from 1998 to 2013 running the rehab division and pain management division of that orthopedic spine center, treating patients and teaching fellows, not residents, how to be pain doctors, and treating patients with all sorts of the musculoskeletal and pain disorders pertaining to the spine, but also, because I was in the orthopedic department, running treatments and plans for people with other orthopedic disorders.

Then in 2013, about six months before Beth Israel got gobbled up by Mount Sinai, my entire group of about nine doctors were recruited by Mount Sinai to become part of their spine center, and more or less I carried the same role at Mt. Sinai that I did at Beth Israel.

I was director of the nonoperative component of their spine center and also assigned to both the rehab department and the orthopedic department.

I also ran a fellowship for orthopedic sport injuries and for spine intervention and pain at Mount Sinai. Again, nonoperative care for orthopedic and spine-related conditions in pain management.

That's what I dedicated most my life to. I gave that position up in 2022 when I went to part-time work, and I see patients at Mount Sinai a few times a month through their teaching clinic, where I continue to teach, and I see patients in my private office on a consulting basis and then I do some of this medical-legal work in my semi-retirement.

Q Okay. Thank you, Doctor.

A Thank you.

Q I think you mentioned it already, but do you told any certifications?

A Yes. I am board certified in physical medicine and rehabilitation and in pain management. I am a certified life care planner, which is the purpose of my being here today to talk about a life care plan. I am not certified, but I am appointed as an associate professor, which is the second out of three levels of professorship in medical school, in both two rehab department as a rehab doctor and the orthopedic department as a rehab doctor at Mount Sinai.

Q Okay. And do you belong to any professional societies?

A Yes. I belong to the AAP&R American Academy of Physical Medicine and Rehabilitation, and I belong to various spine treatment organizations and to the life, various life care planning organizations.

Q Have you written any articles or books on these?

A Yes, I have two -- I've published as chief editor of

two books. Well, one was just the author of a book on acupuncture. More recently in 2020, we are just approaching whether or not to do an update on it, a musculoskeletal handbook on orthopedic and sports injuries, that came out from Springer (ph), and I have multiple articles on various spine-related interventional spine procedures, interventional spine procedures, meaning those procedure that you might have heard of that a pain doctor does with needles, so like epidurals, various spine-burning procedures where you burn the nerves to lessen the pain, implantation of electrical or pump devices, micro -- not even microscopic spine surgeries, but percutaneous spine surgeries that you can do through a needle, things of that nature, discography, which a test where you inject the disk itself. I have two published articles on that.

Q It's a lot. Thank you.

A Fair amount.

Q Doctor, what is a life care planner?

A So, a life care plan is a document that a certified life care planner, or in New York State and certain other states, a rehab doctor. In my case I am a certified life care planner and a rehab doctor, puts together to support or to document what future healthcare needs a person would have related to the condition that they have. It can be anything related, for example, to none, not related at all to litigation, where a family who has a sick family member might want to know

what future resources they need to gather up when an aging parent, who is taking care of a child who has a chronic illness is going to pass and they want to know what resources they night need to leave behind, if they have those resources even, or if they don't have they have to prepare for future needs.

It could be for children who are preparing to help elderly parents who might have the early signs of dementia, what kind of resources are going to be needed to take care of that.

In litigation, it could be representing one side or another, or even helping both sides in mediation to figure out what the future health needs are of a person who was injured.

So what you look at is not just what are the doctors' costs. You look at the overwhelming total cost of what is needed to help restore the closest proximity of wellness to their preexisting state for that person, not to the most -- not, you know, not like the king or to prince be held on a chariot and walked around like that, but to basically give the person the best chance they have at as close as normal, the closest they can have to normalcy, or the closest they had to what was existing before their injury or accident, if it's a litigation case.

But also what can be done to prevent deterioration of the conditions that they got in that injury, if it's a litigation case, or if it's a diseased case, what can be done to prevent their disease from deteriorating faster.

Addressing their psychosocial needs, their emotional needs, their transportation needs, their housing needs. If they are going to need housing for disabled, if they are going to need care in their house, not just, you know, nursing care, but if they are going to need home health aides, housekeeping needs, what kinds of transportation will they need.

If they are quadriplegic or something like that, or if they are paraplegic, for example, but can drive a van with the hands, then are going to need a modified van, they are going to need parking for that van. If they are quadriplegics, they are going to need an aide who can drive them. It goes as far as that, all the way up through what kind of surgeries might they need for their condition, what kind of surgeries might they need because they already had surgeries and there are complications of those surgeries down the road. It gets pretty comprehensive.

Q Sounds like it, Doctor.

MR. BITETTI: Your Honor, at this time I ask that Dr. Stuart Khan be certified as an expert witness as a life care planner.

MR. GOLDSMITH: No objection.

THE COURT: Okay. At this time the witness will be so certified.

Q Dr. Khan, have we ever met in person?

A We have not, until this morning.

Q Prior to this morning, we spoke on the phone, correct?

A Yes, we did.
Q And last week when we spoke on the phone you discussed your testimony and some of the medical concepts and schedules?
A Yes.
Q Now if you weren't testifying here today, what would you be you be doing?
A Other work which would be patient related, or teaching, or maybe doing other medical-legal work.
Q And did there come a time that you were contacted by my office to perform a life care plan and an examination of Ms. Tovar?
A Yes.
Q And I presume you were provided with certain materials, medical records, diagnostic images, and also you performed an examination of her, right?
A That is correct.
Q And I also presume that you were compensated for that examination in drafting your report?
A Yes.
Q What is your rate of compensation?
A I bill my time out at $600 an hour.
Q Are you being compensated for your time in court?
A I hope I will be, yes.
Q I hope so, too.
A At the same rate, by the way.

Q Same rate, that was my next question. Now you already went into this a little bit, but what is a life care plan supposed to address?

A So especially when litigation is involved, as is it in this particular case, you try to limit your focus to the injuries involved from the accident and what will happen to the person's -- the person from those injuries over time.

Now, aging will clearly affect that, because that is what happens all the time, we age. The body get older, those injured parts get older. Those injured parts wear down at a disproportionally great rate than normal healthy parts.

What you don't put in to a life care plan is things that will happen to somebody due to just normal aging.

Now, what you do put in the life care plan, if there is more than one thing wrong, and that is where experience more than textbooks comes in, is how does one body part and the abnormal forces affect the other body parts, for example, in this case. How does abnormal neural nerve tissue and weakness of one body part, like the low back, affect your leg and your knee, which is already damaged.

Whether there is weakness around the quadriceps muscle, from possibly the back injury, and pain coming from the back shooting down the leg, where someone would limp from that already affect a knee that has already been injured.

Does abnormal knee forces where someone is limping

because of the knee being in pain cause aggravation to the back with each and every step. So how does that accelerate the deterioration of the back going forward? So that is where personal experience of 31 years of practice and seeing tens and hundreds, or if not hundreds, thousands of patients and teaching and being part of an academic center come into play.

The data that you see in textbooks, in medical journals and articles is usually if they say, okay, we know that two to three percent of patients who had operations on -- fusion operations on this, we know that every year two percent of those patients are going to have the level above and the level below deteriorating, but we don't do though studies on patients who multiple abnormalities, like adjacent hip and knee problems, and are limping because of other reasons. Those patients are taken out of those studies.

Q Okay. So, Doctor, does every patient who undergoes an injury and has to have surgery require a life care plan with future medical treatment?

A No, definitely not. The majority of patients get better, I mean otherwise you wouldn't do these treatments, because if the majority of patients didn't get better, these treatments wouldn't be eligible to be gotten because they would be -- the government would probably denounce and take these treatments off the market and it wouldn't be part of the standard of care.

Q So there are times when you are consulted about a patient, maybe by a doctor or even by a lawyer, where you perform examination of the medical records and you would make the conclusion or the opinion that this individual doesn't need any more treatment?

MR. GOLDSMITH: Objection to form.

THE COURT: I'll sustain the objection and ask you to rephrase.

MR. BITETTI: Sure.

Q Doctor, in your career, have you had the experience where you were consulted by a doctor, asked to perform a life care plan for that patient, and reached the opinion that that individual did not need a life care plan?

A Well, I wouldn't say -- doctors don't usually ask me for life care plans, but I have been asked by attorneys or other people, family members --

Q Family members.

A -- and feel that there isn't enough disability or enough going on because the patient has recovered sufficiently or their diseased state isn't one that would progress sufficiently to require a life care plan.

Q And also the alternative to that, I'm sure there have been many times in your career that you've been consulted by either a family member or a lawyer and asked to perform a life care plan assessment and have found that that individual needs

future medical treatment, right?

A Yes.

Q Now, in your experience, how do you evaluate whether someone needs a life care plan and future medical treatment or not?

A I think the best was to do that is to start out looking at the medical records, and taking a comprehensive medical history, and doing an examination of the patient or the person -- in this case, it's a client because I'm not the treating physician. -- and evaluating whether or not there are not just chronic conditions, but do those chronic conditions affect them in a way that they are disabled.

If they have loss of function, does that disability and the way they move because of that loss of function, is it likely to make their condition progress; are these known conditions that are likely to progress because they haven't healed.

Just because someone has a surgery, if they get better they're one category and they might not be likely to improve. Literature shows us that when someone has continued disfunction and pain, and they have abnormal forces and abnormal movement and weakness, that actually accelerates and makes it more likely that their conditions will deteriorate.

When they have disfunction and disability, that affects their emotion. That affects their ability to get things done for themselves, which also affects their long-term health. That

affects their general physiology and their general cardiac and well-being. That affects their ability to control their weight. There are so many the on so many other systems that you have to come up with an intervention that will hopefully bring them better long-term health.

Q And what is your understanding of the injuries that Ms. Tovar sustained in this May 12, 2020 accident?

A So through what I learned through a history with her that I took on the day we met in January -- the exact date was -- I'm sorry. Yes, November of last year, not January. I'm sorry.

November 8th of '25, that she had fallen and injured her knee, her low back, little bit of her shoulder, and her neck as well, all addressing -- requiring treatment. She had been unable to work for a long period of time. She required three surgeries over approximately a year, which had left her with some improvement, which is great, but still substantial disability, substantial gait abnormality, disruptive sleep weight gain, chronic pain, and difficulty functioning in life.

She has been able to return to part-time work or full-time work, but with limitations, but substantially less work than she did. She had to relocate her home to find a place where she had far fewer stairs, but still a full flight of stairs because that's what she found within her budget.

In my opinion, there was cause to go forward with our

life care plan. What you do with chronic pain that is sometimes very helpful is you separate out -- take doctors who treat pain and you separate out the pain from the disfunction. You treat both because I think there is a misconception that, okay, let's just treat with physical therapy. If she gets stronger and better range of motion, the pain will go away, but that is not always the case.

There are so many causes underlying the pain that you have to treat both for multiple modalities and that has to come into play. You have to take care of their emotional status, their functional status, their sense of well-being, their nutritional status, and get them back to a sense of better living.

Then you have to worry about the long-term because even if you get some improvement out of your plan, because of the inability to continue to be fit and exercise, they are likely to derail.

Q Now, Doctor, I know you reviewed the medical records in this case. Were there any specific medical records that were significant to you in your analysis?

A Yes, several physicians. The first physician she saw felt that there were enough injuries to order physical therapy, put her on hundred percent disability, give her medication, and order four MRIs of her low back, her knee, her shoulder and her neck. All four of those showed substantial abnormality that

were not only consistent with trauma, but also consistent with the exact type of complaints she was having.

This doctor followed her for a while, but then sent her out to various specialists, and of which the specialists treated the different injuries. She ended up with -- and we also have to understand this was in the time of COVID so it was hard to access treatment in a location, so getting to physical therapy appointments during this time.

This was in the thick of COVID. It was not easy, so getting conservative management on a weekly basis two or three times a week made it a little difficult, but she was able to get treatment.

She had a percutaneous disk decompression, which is a procedure where a -- it is usually done by a pain management. Some surgeons, spine surgeons, will do it themselves, where under X-ray guidance a needle is placed into the center of the disk. You evaporate and you try to place the needle right in the area where the portion is herniated out against the nerve, and you try to evaporate that portion that is pressing on the nerve. Then with another, through the name needle, you introduce a guidewire that you can heat up and try to seal or meltdown the fibers of the outer disc and try to seal it so it doesn't reherniate.

She had a moderate amount of success, reported about 40 percent, which I thought was great, but she went on to have

continued pain with that.

She was referred to another surgeon, a doctor have I gone man, who is a formal spine surgeon, not a pain management doctor who works with spine, and he felt that she had, from the fall, injured her sacroiliac joint, which is the joint where this big triangular-shaped bone that sits in the pelvis and it basically connects your spine to the lower body. That junction has very -- normally should have very little motion, and I felt that joint was unstable, and he recommended she have two injections on that joint.

The reason for two is the medical literature shows, and I'm familiar with that because in pain management we are the ones who would inject it and determine whether it is a positive test or a negative test.

If you get good results short-term, it usually means that it is likely that is the cause of the pain. Because she only had short-term results, that allowed her to go forward with a fusion, a surgical implantation of a device that screws the pelvic bone to the sacral bone. That has given her some relief of her right-sided, low-back pain, but she still has left-sided, low-back pain. She still has pain radiating down the leg, and she still has weakness of her right knee and pain in her right knee.

Then she went to a Dr. Capiola, an orthopedic knee and shoulder surgeon, who recommended surgery of her right knee, and

that was done a few months with some mild results.

Overall, it's now four and a half, five years from her accident, a little more than five years from her accident, closing in on six, and she is suffering less than she was at the beginning, but still, in my opinion, having pain in multiple areas.

She still has substantial back pain that radiates into her legs. She still has weakness, muscle wasting, and loss of range of motion of her right knee. She still has kinds of pinched nerves of her low back, as well as sacroiliac pain on the opposite side. She still has some shoulder and neck pain as well.

Q Now, you performed your physical examination, as you said, on November 18, 2025?

A Yes, I did.

Q And as part of that you performed range of motion testing and are physical manipulation of Ms. Tovar, correct?

A Yes.

Q And what were the results of your physical examination?

A O one of the things I like to do, because patients don't necessarily know they are being examined while you are doing this is look at their -- just their resting posture when they first stand up. You know, do they stand erect, do they stand straight, are they bent over, can they hold themselves upward.

There is a range of what we would call normal. Not every person stands as though they are a world class athlete, but there's a range of what you would accept as normal.

She had a posture that was clearly bent and flexed forward, meaning at all times she is holding her body weight forward, which means her muscles in her back, that adds to someone's pain.

When their resting posture is forward, that also implies that someone is having back spasm and her neck was forward and neck spasm, which is something that I could objectively feel for.

When you palpate or press on those areas, you don't just wait for someone to say, ouch, and then you say they are in spasm. You can usually feel how tight, and tender, and ropey those muscles are, so I do that before I start ranging or working on any areas.

She had about a 40- to 50-percent reduction of range of motion of her low back and about a 25-percent reduction of range of motion of her cervical spine, her neck. If you want me to go specifically through numbers, I could.

Q No, that's fine, Doctor.

A Also her right shoulder had also about a 20-percent reduction, also of range of motion with pain. Her left knee was substantial, not some much for the same percentages, but she couldn't come to straight. She couldn't straighten her knees.

So that means with each step, when her heel lands on the ground, where every human being you land with three times of body weight. When you are landing on your heel, everything single step, it's just fact, you land with three times force of your body weight. So if she can't straighten her leg on landing, that means her knee is absorbing so much of that force, because it is not going through the bones, it's going through the muscles and the soft tissues of the knee. So she was minus ten degrees, which is about if this is straight, that is about minus ten, and she could only bend to about 100, which that is not as bad as not being able to straighten.

She had substantial pain with range of motion. She did not show any signs of knee instability. She had wasting or loss of girth of her muscles on that right side compared to the left side.

She had signs in her low back of some nerve tension signs, we call it, when you, you know, it's a classic, everyone knows this sign. When you lift the leg up and someone has pain shooting down the leg, it hurts in the back and the leg, that is considered positive.

But also in the sitting position, most people don't know about that sign. If you lift the leg and have them bend their head forward and it shoots down the leg, that is the equivalent sign, that was positive as well on the right side.

She had muscle spasm in the low-back muscles as well

and tenderness over the sacrum, both pressing on specific areas that are known to be related to the sacroiliac joint, but she also had tenderness when you give a little thump over the sacrum; that made her scream. Those are the highlights.

Q Very thorough. Thank you, Doctor.

Now, I can assume, since you are here today with us, that based on your examination, you reviewed all the medical records, you reached the opinion that a life care plan was needed for Ms. Tovar, correct?

A Yes.

Q Now, sir, would I be correct in stating that part of your analysis is to determine the life expectancy of the individual?

A Yes.

Q And how do you go about doing that?

A I use, pretty much exclusively, the U.S. Census Bureau.

Q And why is it important to understand the life expectancy of a patient of yours?

A Well, you have to plan for how many years someone is going to be alive, because each item of care that might be recommended, is recommended for a certain number of years. It might not be recommended for their whole life. But if it is recommended for their whole life, you need to know how many years that is.

When you do an Excel spreadsheet on each item, you have

to multiply by the number of years it is to come up with a total cost. Now, when I say a total cost, it is total cost in today's dollars. If someone is going to live approximately 30 or 40 years, it does not include any inflation over the years in my charts. Usually a different person, if a lawyer chooses to, they bring in an economist who can figure that out.

Q Now, Doctor, what is Ms. Tovar's life expectancy?

A It's somewhere in the 40 range. She's about -- she is presently --

Q Forty-three.

A Yes. Her birthday was last week, so, yes. So let me just look at my chart, if I may zoo.

Q Yes, take your time, Doctor.

A It's 40.8 years when we did this two months ago.

Q Is it fair to say about 40 more years?

A 40 and a half years, yes.

Q And that puts her life expectancy around 83.6 years, correct?

A Yes.

Q Okay, thank you. Ms. Tovar's birthday was yesterday, Doctor. She got to spend it here with us.

So, Dr. Khan, all the opinions that you reached in your life care plan and the tables were within a reasonable degree of medical certainty, right?

A Yes, there is nothing that I recommended that wasn't

within a reasonable degree of medical certainty, and all the diagnoses on -- there's a couple of pages of diagnoses, but they are all also within a reasonable degree of medical certainty related to the accident.

Q Thank you, Doctor. You developed a life care plan and you categorized the life care plan to four specific tables for Ms. Tovar, correct?

A Yes.

Q What were those tables?

A So the tables are basically, and I'll tell you what they are called, and then we'll -- I'll tell you what they are. Special medical care and evaluations, which are the care that are given by licensed MDs or licensed DOs primarily.

What we call specialized therapeutic care, which are the care given by paraprofessional and other licensed healthcare providers, such as physical therapists, occupational therapists, what I call complementary integrated therapists and therapist of that nature.

Then future complications, such as potential surgeries in the future, potential rehabilitation stays. In her case, there are no foreseeable other hospitalizations other than the future surgeries, but if there were, that would be under that list. Then durable medical equipment and pharmaceuticals.

Q All right. Doctor so let's go through these tables now.

MR. BITETTI: Your Honor these tables are shown purely for demonstrative purposes. They were provided to counsel in advance.

MR. GOLDSMITH: No objection.

THE COURT: Okay.

Q Doctor, would these tables help you to explain the future medical care?

A Yes.

Q The first category here, I don't know if you can see it from where you are sitting, says special medical care and evaluation. Can you kind of go through this table and the treatment that you recommended under this category?

A Can I come down so I can --

MR. BITETTI: Your Honor, may he?

THE COURT: Yes, you may.

A So a physiatrist is a doctor like -- well, not quite like me. A physiatrist is just a rehab doctor. Doesn't mean they are a pain management doctor. Most of them are not double boarded in pain management, but you see there is another listing. So there's three listings for physiatrist. That doesn't mean -- I'm not double dipping or triple dipping. I'm not asking her to see three different doctors at different times, or different frequencies. It is for the ease of Excel spreadsheet.

So, one, there is an initial evaluation because it is

at a higher cost. That is another thing we should maybe go over where the costs come from. I don't make numbers up in my head. If anything, as a life care planner compared to -- you have to trust me. You don't have to trust me. This is going to tell you my opinion. I am probably in the middle to the lower side of listing the costs.

Usually life care planners, I would say almost all life care planners are also not in the certification process. We use private pay doctors rather than insurable dollars because the assumption is that a life care planner makes the assumption that a patient will be paying for out of settlement money or out of private pay.

If it is out of settlement money, it would be usually private pay because of various insurance rules that apply to a patient after they have a settlement, so that is the reason I use lower than other people's numbers, is probably because many of my colleagues who take private pay patients don't use their full published fee as their acceptable fee for private pay, because many patients can't afford that, number one.

The reason you have an exceedingly high published fee rate also has to do with the way insurance laws work, the way that out-of-network payments work, but it doesn't necessarily mean that it is a legitimate, or fair, or acceptable fee.

So I come up with these based on the doctor. I come up with fees based on a couple of things, one is a group called

Fair Health which, for the United States, is the number one database for fees by ZIP code based on what private, out-of-network insurers will pay doctors.

Now, that doesn't mean a doctor won't ask for more from someone who is literally paying for private pay with no insurance, but more or less doctors kind of know if they are getting a really good fee from private out-of-network insurance, at least most of my colleagues and I practice with a large institution, they would usually accept somewhere around that fee. So these numbers are mostly based on 80 percent of the highest level of Fair Health. That is probably for the New York region about the right level, and this is done by New York region, so that is where I go.

A lot of people, a lot of life care planners will use literally the highest published rate because you can get to that from Fair Health as well and that would be three or four times the amount.

Q So you are conservative in your estimations?

A I believe that I am, yes, all right, so let's get to the meat of it.

So the reason the physiatrist is listed a few times is because the first is just for one initial evaluation because she doesn't have a present rehabilitation doctor. Then during the first year of her care, since it's the first year, she would need to go multiple times just to get her on target.

So why a rehab doctor? So a rehab doctor can help her with understanding her disabilities and then getting her into a program for different types of therapy. She has done PT, she's done OT, but not for a while and not in a specific manner that addresses both of her disabilities and her pain.

As I said earlier, it is not uncommon for patients to think, oh, I am going to go to PT and get better. You don't always get better, number one, and the therapist usually addresses specific tissue damage. They don't necessarily address a functional deficit.

In this case you'll see lower down we have a whole different type of therapy called complementary integrated therapy that is specifically for pain. Then in the rest of her life I have her just going for maintenance and to address different changes in her condition over her lifetime twice a year.

So pain management specialist, again she has seen a pain management specialist in the past but isn't presently going to one. One consultation initially for four straight months to try different medication. She presently takes mostly over-the-counter medications; it is clearly not cutting it. The pain level is very high on an average day of five out of ten. It causes her dysfunction and disability and abnormal gait.

There are medications that are nonaddictive and always new medications out there. There are medications that can also

help at the same time addressing her pain and her mood disorder. So having a few months in a row, giving a doctor four months to try different medications would be helpful.

You'll see later on the charge, the medications actually are all genetic, four months of medication only costs about 300 to 600. Then for the rest of her life, only-twice-a-year visit to a pain doctor.

Okay, because of her back condition, and I listed it spinal epidurals versus sacroiliac joint injections, one to two a year for the rest of her life. Again, a conservative cost of $3,100. If she has it done in a facility versus a doctor's office, that would go up to 6,000 or 8,000. Since these shots can be done in a doctor's office, I applied 7,000. This is the rate in the New York City region, and that would be between $65,000 and $128,000 over 40 years, so somewhere between $1,500 and $3,000 a year.

Again, a spine surgeon, just not including surgeries, just to be evaluated annually. Presently she is going more than that, but I think once she settles and she is in a steady state, probably once a year. Maybe at the time, if and when, she does have further surgeries, she would go more frequently for a few months and then there might be years where she doesn't go, on an average once a year. A general orthopedist to take care of her knee, and also a little bit of her shoulder once a year as well.

For her knee, until she gets to a point where she does

have a knee replacement, that is once a joint is replaced you can't put anything in it, it's a sterile environment, and there is metal in there. But until she would have that knee replacement, she would need injections in the knee, which she's had in the past.

Q Doctor, would you like a water?

A Yes. You're very kind.

Q I try.

A And this is the last portion of that first category as well as the total.

Okay, so because of her lack of mobility, her weight gain as she ages as a woman, her lack of mobility causing risks of osteoporosis, hypertension, diabetes.

All Americans tend to or are recommended for a certain number of visits at their varies ages to see primary care doctors. This would be an additional visit a year to address those other risk issues, so one additional visit a year to a primary care doctor to address those other risks.

Then various diagnostic studies to the various joints that are affected over 40 years, which include MRIs, CAT scans, the knee, the sacroiliac joint, the lumbar spine, and other areas that are involved.

Q What is the total lifetime cost for that first category, special medical care and evaluations?

A Sure. 107,500 and change to 282,291, so somewhere

between 4,500 to 5,500 each year.

Q And that is your total for the lifetime average, right?

A Yes.

So this table we talked what the paraprofessionals, who are people who are going to actually lay their hands on her for the actual treatment, not that doctors don't, but they are the ones to diagnose and prescribe.

So just to start since she hasn't had a physical therapy course for a long time and to get her back with some range of motion exercises and strengthening, trying to improve that range on her knee.

Again, very clear that for me if she gains improvement in her pain with the therapy, that is a bonus, but if for me the therapy in this case this far down the road, six years later, it is more about range of motion, strengthening and functioning. I don't anticipate that therapy six years later is going to help her pain. It doesn't mean she shouldn't have it because it might help her function, and her range, and posture, and just get stronger.

So six months of therapy now at twice a week, that's just the cost. Using, again, cost in New York private pay, the bills that are going to be sent out, they are published rates and this is standard in New York, it's about $610. But the average receipt that they get for private pay is between 150 and 210, so I put 150 to 175.

Q Again, conservative values?

A Conservative values.

Courses of short-term therapy for exacerbations and flareups of the condition over her lifetime, every couple of years, eight to ten sessions, cost of $24,000 to $35,000 over her lifetime, so not a lot.

Occupational therapy, so she doesn't have -- OT isn't about work, it's about hand function, and upper body function, and activities of daily living function. So even though she doesn't have a specific injury to her hands, which usually is what OT does, she has from her body movements an inability to stand straight and stand erect and to have pain with activities. She has decreased functional abilities.

So this would be a few sessions of OT actually at home to try to direct her on better body mechanics and how she could manipulate and maneuver a little bit better to decrease her pain and inability to do certain things, so that's it. I think I wrote for one or two more rounds only over her lifetime, and that would be the therapy.

Q And and that helps with her activities of daily living, right?

A Yes.

So this next set of treatments, and again it's listed three times, but similar to the rehab doctor and the pain doctor, it is all the same thing at different intervals and

different times in her life.

The first is trial and see what helps her, the second is once you find out which one helps her, and the third is maintenance for life. So, as I said many times as a pain management doctor for now over 30 years, you have to separate disfunction from the pain. Not every patient is going to just get better because they have physical therapy or they took pain meds, or their body heals so you have to find our ways to address the pain, whether it's psychological counseling, or acupuncture, or massage therapy, or stretching therapy, or what we call craniosacral therapy. It is light touch to the back of the head and maneuvering or meditation classes or other feedback classes, and working with someone on other ways to address pain.

If you don't have chronic pain, it might sound a little touchy-feely and off base to you, but, trust me, this is what we do, this is how it helps. So this is a whole program for instituting a whole other way to address her pain that has never been done, and that's in there?

(Whereupon, the following was recorded and transcribed by Official Court Reporter Noah Collin.)

(Continued on next page.)

* * * * *

Q The total lifetime cost over a course of four years, it equates to about $1,000 a year; correct?
A Give or take. A little less to a little more.
Q Again, very conservative values; right?
A Yes.
Q Now the third category, I believe this is likely surgical interventions; right?
A Yes. Because she's already had surgery on her low back and the lowest is the L5-S1, subcutaneous surgery, but still had residual symptoms, if you remember, the surgeon even documented that it helped 40 percent, because she has now a fusion of the sacroiliac joint which is now the joint -- if the L5-S1 is the lowest disk in the back and the sacroiliac joint is the next portion where the sacrum attaches to the pelvis, you're now locking in that area for motion. That puts the L5-S1 disk at risk of two additional reasons why it might need surgery. So it as at higher risk in the future it is at highest risk for needing future surgery in the future. That category is -- actually, that would be the range for a simple lumbar surgery, surgery on the low back is extremely expensive. If it was a fusion surgery, it would be more in line with $150,000 to $250,000 range. But because she's probably not at risk as a fusion at that level as a first next surgery, it's in that range.
Q So a fusion is a possibility down the line, but the

next surgery is not --

A Correct, correct. A life care planner could put in what they think is probable, greater than fifty percent likelihood, but not an unknown instance. We don't know what the outcome of a probable surgery would be. I can't put it in with any reasonable fairness, I couldn't put in a potential.

Q Makes perfect sense, Doctor.

A OK. So after a surgery like that, she would probably need another course of a few months of physical therapy. That's above and beyond the every few year flare up therapy. Then we already know from Dr. Vagmin's recommendations --

Q That is Dr. Vagmin Vora?

A Yes, I'm sorry. Dr. Vora's recommendations that he is proposing a fusion to the left sacroiliac joint. And these are the costs for left sacroiliac joint the range being whether you do it in a hospital or surgery center. And those costs are 84,000 to $177,000.

Q Now Doctor, I want you to assume Dr. Capiola testified here yesterday before this jury and he provided some insight into the future medical treatment that he recommended. I want you to assume that he said in his opinion, within a reasonable degree of medical certainty, Ms. Tovar will need a right knee replacement down the line. What is the cost of that?

A So, in the New York City region, almost any hospital you go to, the cost of a knee replacement are $59,000 to

$69,000. I know that because Mount Sinai when I was there in the orthopedic department, we were part of a study on costs of knee replacement. That includes the surgical fees, the OR fees, the anesthesia fees, and the hospital fees.

Q That would be in addition on top of that?

A That would be additional.

Q Thank you. So this is the last category we have, it's durable medical equipment, adaptive/assistive aides, ambulatory devices, and pharmaceuticals. Can you explain a little bit about what this category means?

A Sure. These are literally objects, some you hold in your hand, some you hold on the ground to help support her, some are installed in her shower around her sink and toilet to help make it easier for help her to get up and down, less likely that she would fall, some are to help her have a restorative sleep cycle, some are to make her more comfortable and have less pain like a home TENS unit. These are not just the initial purchase, but with purchases in the what the manufacturers recommend are their life expectancy of use.

Q Some of these will be needed sooner rather than later, and then there are other ones as she ages and her body continues to deteriorate?

A Correct.

MR. GOLDSMITH: Objection to form.

MR. BITETTI: That's fine. We can move on.

THE COURT: You want to rephrase? Objection sustained.

MR. BITETTI: I think the jury heard it. We can keep going.

A The way I price these, for each item, I use three different online catalogs. I take the lowest price, the highest price, the middle price, and I take the average of the three.

Q What are some of these assistive devices or medical --

A So, a simple cane which we recommend to replace every three to five years. They get worn down. Sometimes, it's just the rubber tip that wears down, sometimes the whole cane breaks, especially if -- if it's a wood cane, the cheapest one, it tends to last longer. The little one with the elastic down the middle, they tend to break faster. It could be grab bars you install in your shower next to the toilet, in the sink, those can last a couple of decades. But if you move, if she was in a rental with a roommate, she might not stay there forever. You can't take them with you. Those are things you need to reinstalled in your next home if they aren't there when you get there. Things like a neck place, the surgical soft collar, the manufacturer says they can last two to three years. It's my experience that they last six months. They get disgusting and smelly and gross. The back brace, usually those can last a few years. But they range from inexpensive to a couple of hundred bucks. Knee brace, also inexpensive to a couple hundred bucks.

Things like that.

Q OK. And there's also I think medication?

A Yeah. This is just the cost of, you know, frequent use of ibuprofen. Even though it doesn't sound like much, it adds up over forty years to a couple of thousand dollars.

Q The total cost for durable medical equipment and medication is what?

A $8,000 to $24,000. So $250 a year to $800 a year or so, $600 a year.

Q So Doctor, do you have an opinion within a reasonable degree of medical certainty about the total costs of Ms. Tovar's future medical treatment and needs?

A Yeah. So I think if you were to add a knee replacement to this, the total expenses would be let's add 60 grand to that. It'd be $375,000 and change to $594,000 and change. There were other items on the life care plan that are not included in this total.

Q And this is over the course of the next 40 years of her life?

A Correct.

MR. BITETTI: Thank you, Doctor. No further questions.

(Continued on the next page.)

CROSS-EXAMINATION

BY MR. GOLDSMITH: :

Q Doctor, you spent some period of your testimony going through the line items on your report which just take, for example, the durable medical equipment we just heard most recently about. When you were adding that up, you were adding up multiple different durable medical equipment pieces.

A Correct.

Q It's not to say that Ms. Tovar would use all of those pieces; correct?

A No, but all of them are recommended.

Q Not even to say that she, in fact, is going to use all of these; right?

A I can't predict the future, but I can predict what is recommended.

Q OK. Just to be clear, all of your testimony here is, as you said, not to predict the future, just what could be recommended?

A Not could be recommended, is recommended to bring about the best outcome as we described in the life care plan.

Q For the surgical components which you recommended, again, you can't predict the future; right?

A No, but I can predict what is necessary and what is likely to occur based upon history, based upon the medical literature and outcome of what occurs in people that have her conditions.

Q But based upon your one evaluation of her November 18, 2025?

A Well, no, not just based upon that. I only evaluated her the one time which is not uncommon for doctors to do. That's how medicine works. We evaluate patients and we make treatment plans.

Could I ask you to move the screen?

THE COURT: The Court officer will take care of if it. We don't want anybody else touching the equipment. Just push it back, Officer.

BY MR. GOLDSMITH: :

Q I don't want you to incur any durable medical equipment with your neck looking over there.

A Thank you so much.

Q So we are also going down through, when you went through, the surgical calculations, you also included the possibility of multiple surgical interventions in the future; right?

A True, one that's already been recommended and one that is more likely to occur than not based upon medical literature, statistics of recurrence of disk abnormalities in the conditions that she has.

Q Same for the different physicians. In fact, you even highlighted the distinctions between putting a line item for initial consult and then putting in additional consults for each

additional line item; right?

A Well, those would be followup visits, but yes.

Q And you also included as you testified to before, including a pain rehab physician which Ms. Tovar has not seen one to date right.

A I put in a rehab physician which is different than pain physician.

Q OK. And that's not what she's had so far; right?

A That is correct.

Q So we take all of those, we have added those up. Those are the totals you described before, which the grand total being somewhere around $315,000 to $435,000?

A Plus the knee replacement, yes.

Q The knee replacement, counsel posed the question of Dr. Capiola that said there was a recommendation for a knee replacement. Now I'm going to ask you what if Dr. Capiola had testified yesterday that the knee replacement would be the last resort?

MR. BITETTI: I object to form, Your Honor.

THE COURT: I will allow it. Objection overruled.

A Well, if you would say that, then two things. One is then she would likely need continuation and a greater amount long term of other treatments for her knee, which would be the viscosupplementation and the injection of the PRP over time.

Q What about physical therapy?

A That's already included in the plan.
Q Right. Physical therapy, you'd agree, is far less expensive than surgical intervention?
A Well, it depends how much therapy you need.
Q Well, let's go off the rough numbers that you were calculating in your experience, in your specialty. Knee replacement versus physical therapy for a knee, the PT is much less expensive?
A Usually it is, yes.
Q And specifically if Dr. Capiola were to testify yesterday that he would undergo physical therapy as a first round of intervention; right? That's something that most physicians would do?
A He would -- I would hope he would want to prescribe that first and try conservative management first, yes.
Q Now, you also testified that all these numbers, they're very specific to say you were not using the out-of-pocket expenses for an individual if they had health insurance; correct?
A I don't think that's correct, but I don't think I quite understand the question.
Q So for the numbers you were discussing; right?
A Yes.
Q Let's -- that $315,000 to $535,000. That's the total costs on a conservative level within the industry; right?

A I would say it's very conservative.
Q OK. So does that reflect the total out-of-pocket costs for Ms. Tovar?
A For her overall health care or just for the --
Q For what you've laid out as a possibility for her future care.
A For all of her care or just for the items here?
Q For the items you testified about.
A It could be more. Because as I said, it's a very conservative number.
Q OK. So a factor in calculating those numbers that you testified about here, did you calculate the out-of-pocket expenses if all of those procedures were covered by a health care plan?
A We don't do that in life care planning. You know as an attorney, that's not how it works, especially in New York State. Where there's not only federal set aside, there is New York State set aside, there's insurance subrogation laws that are very clear.
Q So what you did was you took into account, as you testified, as if she had received either a settlement or award for a court proceeding, correct?
A I did, yes. Isn't that why we are here today?
Q It is.
A OK.

Q Now, you saw her in November of 2025 and you noted obviously that you had reviewed all of her treating physicians' reports in the records; correct?

A I reviewed the one I had listed, yes.

Q Did that include any reports or recommendation -- well, withdrawn.

Were you given the chance to see any of the records or reports from Dr. Capiola or Dr. Vora from their visits with her in December of 2025?

A At the time, no. I think I saw Dr. Vagmin's note from '25 more recently.

Q OK.

A Dr. Vora's note rather.

Q Now, you testified earlier about there being a number of different medications available to alleviate pain and inflammation; right?

A Correct.

Q In fact, you also testified about sort of the relationships that a patient might have in the pain and rehab field, sort of this trial and error experimental period?

A Yes, for a total of $600.

Q Right. For about four months I think you said.

A Correct.

Q Tried different medications and see what works?

A Correct.

Q Not habit forming, not the dangerous stuff, just regular day in and day out meds; right? So does it change anything about the calculations in here if Dr. Capiola and his last time seeing Ms. Tovar only recommended that she take Aleve?

A No, he's not a pain management doctor. I wouldn't have expected him to have come up those ideas.

Q OK. Does it change your perspective or any of the calculations here if, in the last time that Ms. Tovar saw Dr. Vora, he qualified her as being 60 to 70 percent better?

MR. BITETTI: Your Honor, I'm going to object. Show the medical record that he's talking about. It's one thing with Dr. Capiola who testified yesterday.

THE COURT: You want to approach?

(Whereupon a sidebar conference was held outside the presence of the jury.)

THE COURT: Counsel, the jurors are requesting a five-minute break.

MR. BITETTI: That's fine with me.

MR. GOLDSMITH: I will say this Your Honor. If it impacts anybody's comfort, I probably have got two more questions. Then I don't think we have another witness until the afternoon.

THE COURT: So do you guys want to you wait? OK. We will let them continue.

MR. BITETTI: OK.

BY MR. GOLDSMITH: :

Q Doctor, I will move on and withdraw that question. You mentioned briefly about Ms. Tovar's posture, about leaning forward and you noticed because of her posture she had muscle spasms in her back. You also mentioned that the part of the goal for physical therapy and occupational therapy is to improve her functionality and including that posture; right?

A Correct.

Q In your experience, improving her posture is something that would help alleviate her pain and her functionality; correct?

A It could help decrease. I don't know that it would alleviate it.

Q All right. Doctor, I also wanted to ask you, you mentioned about the percutaneous discectomy that Ms. Tovar had. You described that as being used with a needle; correct?

A Being done through a needle.

Q Being done by needle. So it's not like there's a scalpel and there are multiple incisions going on.

A There are multiple incisions. There are incisions being done as well. It's a full surgery.

Q OK. Doctor, you also testified you charge about $600 an hour?

A That is correct.

Q How much have you charged prior to today's testimony?

A The report, in total, came to $9,250.

Q Now Doctor, with all of your calculations that you used so far, because again, it's all based upon if Ms. Tovar actually has some of those procedures or treatments; correct?

A Well, it is not -- it is if, but it is based upon medical statistics and likelihood.

Q Right. That's also assuming that Ms. Tovar would take advantage or actually undergo those treatments in accordance with what the recommendations would be within the field?

A That is correct.

Q Does it change your opinion at all if you were to note that Ms. Tovar spent about three years in between seeing Dr. Capiola post her knee surgery up until a few months ago?

A Not really, no.

Q It doesn't similarly change your opinion or your calculations knowing that Ms. Tovar did not see Dr. Vora since her last procedure in 2022 up until a few months ago?

MR. BITETTI: I will object to that. If he wants to show the records, he can. But Vora has not testified.

THE COURT: I will allow it. Objection overruled subject to connection.

A No, that would not change my mind.

MR. GOLDSMITH: No further questions.

THE COURT: Any redirect?

MR. BITETTI: Just one question.

REDIRECT EXAMINATION

BY MR. BITETTI::

Q Doctor, you brought up the treatment following a surgery sometimes, people reach a plateau, they really can't improve much --

THE COURT: Counsel, I am going to object. Are you testifying? Ask the question.

MR. BITETTI: Your Honor, let him do his work; all right?

BY MR. BITETTI::

Q You mentioned that there was a gap in treatment with Dr. Capiola. I want you to assume for purposes of this question, and this question only, that Dr. Capiola testified before this jury yesterday and said that that occurs quite often following surgeries, that people plateau, not get any better, not get any worse, but as they age they start to get worse again and need future treatment. Is that your understanding of why gaps in treatment occur?

A That's definitely one of the reasons for sure.

MR. BITETTI: I have no further questions. Let the jury get a nice, long lunch.

THE COURT: Do you have any follow up?

MR. GOLDSMITH: No, Your Honor.

MR. BITETTI: Thank you, Your Honor.

THE COURT: The doctor is excused. Thank you for

coming.

THE WITNESS: Thank you.

(Whereupon the witness left the stand.)

THE COURT: All right. At this time we will recess until 2 o'clock. You have an extra fifteen, twenty minutes for lunch. Stay warm. It's very cold out there. See you back at 2 o'clock.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon the jury exited the courtroom.)

THE COURT: See you at 2.

MR. BITETTI: Thank you, Your Honor.

MR. GOLDSMITH: Thank you, Your Honor.

(Whereupon the luncheon recess was held.)