Jeffrey F. Lakin, MD
Board Certified in Orthopedic Surgery
Freehold, NJ

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NEW JERSEY LOCATIONS

PARAMUS/RIDGEWOOD – BERGEN COUNTY
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ORADELL/PARAMUS – BERGEN COUNTY

Brian Smalfus
Liberty Mutual Insurance Company
Marlton Executive Park
701 Route 73 S.; Suite 201
Marlton, NJ 08053

RE: GREGORY GROMAN
DATE OF BIRTH: 8/31/1946
FILE NO.: 278585390002
DATE OF INJURY: 8/22/2013
DATE OF EVALUATION: 7/15/2015

Dear Mr. Smalfus:

The above claimant, Gregory Groman, was seen in the Freehold office for an independent medical evaluation on July 15, 2015.

Submitted for my review:

1. Medical Associates of Marlboro, PC – cardiology - 6/11/07 – 5/2/08
2. Medical Associates of Marlboro, PC – cardiology – 10/30/08
3. Medical Associates of Marlboro, PC – cardiology – 12/15/08 – 12/1/14
4. Jayendra Patel, M.D. – internal medicine – 9/21/12 – 10/11/12
5. Nasser Ani, M.D. – orthopedic surgery – 2/13/13 – 5/17/14
6. Adeel Ahmed, M.D. – physical medicine and rehabilitation – 11/18/13
7. Kashif I. Siddiqi, M.D. – pain management – 3/19/14 – 5/22/14
8. Victor J. Salvo, M.D. – occupational medicine – 4/1/14
9. Douglas E. Pitchford, M.D. – pain management – 4/15/14
10. Raritan Bay Medical Center – emergency room – 9/13/12 – 8/28/13
11. Diagnostics – ECG – unsorted
12. Diagnostics – labs – unsorted
13. Diagnostics – x-ray – chest – 9/13/12
14. Diagnostics – x-ray – pelvis – 9/13/12
15. Diagnostics – x-ray – right hip – 9/13/12
16. Diagnostics – CT scan – chest, abdomen, pelvis – 8/22/13

17. Diagnostics – x-ray – left elbow – 8/28/13
18. Diagnostics – x-ray – left humerus – 8/28/13
19. Diagnostics – MRI – lumbar spine – 9/19/13
20. VNA Health Group – physical therapy – 10/10/13
21. Manalapan Spine Care and Rehabilitation – physical therapy – 11/4/13 – 1/9/14
22. Hands On Rehabilitation – physical therapy – 1/17/14 – 4/28/14

Also submitted for my review:

1. MRI films and report – lumbar spine – 9/19/13

HISTORY:

The history is that of a 68 year old male who was involved in a motor vehicle accident on 8/22/13. At that time, he was with his caretaker in a parking lot and was holding on to a shopping cart which was struck by a vehicle causing him to fall. He developed pain in his left elbow and lower back. He also had a seizure at the time of the accident and was taken by ambulance to Raritan Bay Medical Center where he was evaluated and was noted to have a fracture of his distal humerus. He was placed in a splint and a sling and discharged from the emergency room, according to the emergency room records.

He followed up with Dr. Ani, an orthopedic surgeon, with whom he has continued closed treatment for his fracture. He was placed in a course of physical therapy for the elbow and lower back three times a week for approximately four to six months. He last saw Dr. Ani approximately six months ago for motor vehicle accident-related injuries.

PRESENT COMPLAINTS:

He has lower back pain with weather changes. He cannot stand or walk for prolonged periods of time.

He gets pain and stiffness of his left elbow. It should be noted he was involved at a fall at home several months ago and had surgery to his left arm at that time. He is right hand dominant.

PAST MEDICAL HISTORY:

Past medical history is significant for seizure disorder, hypertension, hypothyroidism, and cerebral palsy.

PAST SURGICAL HISTORY:

Past surgical history is significant for left forearm.

PREVIOUS/RECENT INJURIES:

Previous complaints of pain to the left elbow and lower back were denied. However, review of the records clearly revealed compression fractures of the L2 and L3 vertebral bodies as noted in the CT scan of the chest, abdomen and pelvis on 8/22/13 that noted prior compression fractures at L2 and L3 from the prior study dated 9/21/12.

Recent injuries are notable for the fall at home with injury to the left elbow and forearm.

SOCIAL HISTORY:

The claimant is 68 years of age. He is single. He denies tobacco use. He drinks alcohol socially.

WORK HISTORY:

He was retired at the time of the accident. He is currently still retired and not working.

REVIEW OF SYSTEMS:

He denies any bladder or bowel dysfunction. He had loss of consciousness and a seizure at the time of the accident. He is cared for by a caregiver who was with him before and after the motor vehicle accident of 8/22/13.

PHYSICAL EXAMINATION:

Physical examination is that of a 68 year old male, alert and oriented times three. He is approximately 5 feet 10 inches in height and 165 pounds in weight.

Examination of the head: atraumatic, normocephalic.

Examination of the cervical spine reveals 50 degrees of flexion and extension with lateral rotation to the left and right 70 degrees.

Sensation was intact in both upper extremities. Motor examination was symmetric in shoulder abduction 5/5, right elbow flexion and extension 5/5 with left elbow flexion and extension 4+/5, wrist flexion and extension 5/5, intrinsics of the hands and finger flexion, as well as grip and pinch strength 5/5. Reflexes of the biceps, triceps and brachial radialis are 1+ equal and reactive bilaterally. There is a negative Spurling's test, a negative Hoffmann's sign, and a negative Lhermitte's sign. There was a negative Tinel's test and a negative Phalen's test at the wrist. There was a negative elbow flexion test and a negative Tinel's test at the median nerve of the proximal forearm and elbow.

Examination of the left elbow reveals a well-healed incision in the posterior aspect of the elbow extending to the distal forearm. There is a mild deformity to the forearm proximally. There are

no signs of any infection. The elbow has limited range of motion with 20 degrees of extension and 90 degrees of flexion with crepitus on range of motion. There is no instability.

On examination of the thoracic and lumbosacral spines, there is tenderness in the lumbar spine. He was too unsteady to stand to perform forward flexion.

Motor examination is 5-/5 in bilateral hip flexion, knee extension, ankle dorsiflexion, plantar flexion, inversion and EHL. There is downgoing Babinski bilaterally and absence of clonus. There is negative straight leg raise testing in the sitting and supine positions bilaterally. There is a test negative Fabere's bilaterally. Gait is unsteady.

REVIEW OF SPECIAL TESTS AND X-RAYS:

I reviewed the films of an MRI of the lumbar spine from 9/19/13 and agree with the findings of the radiologist of benign-appearing compression fractures at L3 and to a lesser extent L2 and L1, probable stress reaction of the left pedicle at L4, multilevel disc disease with disc bulges and facet degenerative changes causing canal compromise most severe at L3-L4 with superimposed disc herniation to the left, asymmetric disc bulging and disc herniation to the left at L4-L5.

An x-ray report of the left elbow dated 8/28/13 showed a displaced fracture of the distal humerus.

A CT scan of the chest, abdomen and pelvis from 8/22/13 revealed compression fractures at the L2 and L3 vertebral bodies which were visualized on a prior study from 9/21/12.

CONCLUSIONS:

In summary, the claimant is a 68 year old male who sustained a fracture of the left distal humerus as a result of the date of injury of 8/22/13. He also sustained a sprain to the lumbosacral spine. He was noted to have a known history of compression fractures of the lumbar spine and the MRI findings are consistent with the old compression fractures of the lumbar spine that were present prior to the motor vehicle accident. These compression fractures were noted to be present on the MRI of 9/19/13 and were also noted to be present as previously seen on the CT scan in the emergency room following the accident of 8/22/13.

The case is complicated by trauma following the accident with two falls at home resulting in injuries to the left elbow and forearm which required surgical intervention. It should be noted that the review of records including that of the emergency room at Raritan Bay Medical Center from 9/13/12 revealed complaints of back pain, neck pain and hip pain when he went to a dentist's office and tripped.

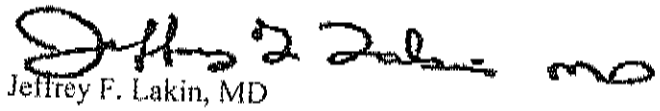
The claimant had preexisting compression fractures to the lumbar spine and sustained a lumbosacral sprain but no new injuries to the lumbar spine as a result of the accident. He sustained a distal humerus fracture of the left elbow. Both the lumbosacral sprain and the distal humerus fracture are directly related to the motor vehicle accident of 8/22/13. There are

significant preexisting conditions as well as a recent trauma to the left elbow. The claimant has reached maximum medical improvement in my field of specialty. No further treatment is needed. He sustained no permanent injuries to the lumbar spine but he did sustain a fracture to the left distal humerus which is described as displaced in the x-ray reports and the case was complicated by recent trauma to the left elbow.

All the above opinions are expressed within reasonable medical probability.

If you have any further questions, please feel free to contact me.

Respectfully yours,



Jeffrey F. Lakin, MD

JFL/cd

(DS349319)

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May 28, 2015

James Ricciardi, Esq.
White, Fleischner, & Fino, Holmdel, LLP
Holmdel Corporate Plaza
2137, Route 35
Holmdel, New Jersey 07733

Re: Nicole Calautti
Claim No.: 241-1794
Date of Accident: 7/3/11
Date of Examination: 5/28/15

Dear Mr. Ricciardi:

Below is an independent medical evaluation on the examinee, Nicole Calautti, who was seen in my office for an independent medical evaluation on date of 5/28/15.

History of Accident

The examinee is a 19-year-old female who was involved in a motor vehicle accident on 7/3/11. At that time, she was in the back seat of limousine that was involved in a front impact. She outstretched her right wrist, which struck the seat in front of her and developed right wrist pain.

She was seen the next day in urgent care center, where x-rays were taken, told there was a possible fracture and was placed in a splint. She returned back to her home state in New Hampshire where she came under the care of physicians at the Dartmouth-Hitchcock Medical Center; she was seen by Dr. Zimmermann and had x-rays done and was placed in a cast for six weeks. She did have an MRI done of the wrist and was placed in a course of physical therapy one time a week for a couple of months.

She had persistence of pain in the wrist and was seen by Dr. Weintraub and diagnosed with de Quervain's tendonitis, had injections to wrist, first one according to the review of

records was in April of 2013 and then was most recently seen by Dr. Weintraub and given an injection in April of 2015.

Current Complaints

Present complaint is right wrist; it is made worse with turning. She occasionally gets pain at nighttime. She gets pain with lifting.

She denies any numbness, tingling, or paresthesias. She does play multiple instruments, including piano and cello and gets pain with any prolonged instrument playing.

She had difficulty at times doing pushups, which she cannot do. She is right-hand dominant.

Past History

Past medical history: She denies hypertension, diabetes, peptic ulcer disease, respiratory problems, or endocrine disturbances.

Past surgical history: No recent surgeries in the past five years.

Previous injuries to the right wrist denied and recent injuries to the right wrist denied, but according to the review of records including that of Dr. Weintraub on 4/1/13, "I was picking up a bass clarinet and felt pain in wrist last Sunday" and this was from note of 4/1/13.

Again, previous injuries denied. Recent injuries, just that of 4/1/13 as documented in the medical records, not given by the examinee.

Social History

She is 19 years of age, right-hand-dominant. She is presently a Junior in college. She was in school at the time of the accident. She did not miss any time from school.

Review of Systems

She denies any neck pain. She is right-hand-dominant.

Physical Examination

The examinee is a 19-year-old female, who is alert and oriented x3, in no apparent distress. She is able to get on and off the examination table without difficulty. She is approximately 5'4" in height and 145 lbs in weight.

Examination of the right wrist has an extension to 50° compared to contralateral to 60°. She has 75° of flexion of the right wrist compared to contralateral wrist, which is 80°. She has ulnar deviation to 30° of right wrist compared to contralateral wrist, which is 40°. She has 25° of radial deviation to the right wrist and 25° deviation to the contralateral wrist. Supination and pronation: 85° of supination and 90° of pronation which is the same as the contralateral wrist. Grip and pinch strength is 5/5. A 6-mm two-point discrimination in all digits tested. Negative Tinel's and Phalen's test for the right wrist. There is some tenderness in the first dorsal compartment. Positive Finkelstein test. No tenderness on crank test of CMC joint of the right thumb. No pain with ulnar deviation. Negative Watson shift test. No tenderness on the ulnar side of the wrist and negative pain and tenderness with provocative testing of the distal radioulnar joint.

Review of Records

Submitted for my review were:

1. Notes from Bay Health Medical Center and Eden Hill Express Care dated 7/31/11.
2. Notes from Southern New Hampshire Medical Center dated 9/25/11.
3. Notes from Southern New Hampshire Medical Center dated 3/24/13.
4. Note of Dartmouth-Hitchcock Medical Center, Dr. Susanne Zimmerman, from the date of 8/8/11.
5. Note of the Dartmouth-Hitchcock Medical Center, Dr. Zimmerman, from the date of 9/13/11.
6. An x-ray report, dated 8/8/11 of the right wrist, done at Dartmouth-Hitchcock Medical Center.
7. An x-ray report of the right wrist from 9/13/11, done at Dartmouth-Hitchcock Medical Center.
8. Notes of the Dartmouth-Hitchcock Medical Center from

9/13/11.

9. Physical therapy notes from Merrima CHK Rehab dated 10/24/11-10/24/12.
10. Notes of the Dartmouth-Hitchcock Medical Center from the date of 10/6/11, 10/19/11, and 11/3/11.
11. An MRI report of the right wrist from, dated 11/3/11 done at Dartmouth-Hitchcock Medical Center.
12. Notes of the Dartmouth-Hitchcock Medical Center from 12/4/12.
13. Notes of the Dartmouth-Hitchcock Medical Center from 4/1/13.
14. Notes of the Dartmouth-Hitchcock Medical Center from 4/4/13 and 7/24/14.
15. An x-ray film on a CD of the right wrist from 3/24/13. Again, this was x-ray of right wrist, CD imaging from 3/24/13.
16. An x-ray report of right elbow, dated 9/29/06.
17. An x-ray report of left knee, dated 5/12/08.
18. An EEG report, dated 6/18/08.

Review of Special Tests and X-rays

1. It should be noted that the review of imaging includes those following the accident, of reports including that of the records of 8/8/11, five-view projection reviewed of the right without any priors, and the impression of the radiologist is no radiologic evidence of acute osseous injury.
2. She also had an MRI report of the right wrist from 11/4/11 that showed normal appearance of the scaphoid. No MRI evidence of ligamentous or tendon injury or abnormal bone marrow signal. The tendons of extensor compartment noted to be normal in signal. No evidence of any tenosynovitis and the scaphoid was noted to be normal in signal and configuration. No evidence of acute fracture. There is no increased bone signal to the scaphoid or cystic changes.

Impression and Discussion

The examinee is a 19-year-old female. Based upon the records submitted to my review, including that of 4/1/13 of Dr. Weintraub, there was questionable scaphoid fracture that has fully resolved, but, again, reviewing the x-rays reports following the accident there was no fracture noted of the scaphoid and reviewing the MRI report of 11/4/11, there was normal MRI appearance of the scaphoid and there was no evidence

of any acute fracture and no evidence of increased bone signal in the scaphoid or cystic changes. I also had an opportunity to review an x-ray of the right wrist from 3/24/13, which did not reveal any fractures and was unremarkable.

Again, based upon the records submitted to my review and especially since the MRI revealed normal scaphoid appearance in the timeframe of approximately four months after the date of injury and that the x-ray reports did not reveal any scaphoid fractures or scaphoid healing, and there are no signs of any scaphoid fracture. In my review of films of 3/24/13, the examinee did not sustain any fracture to the wrist as a result of the date of loss of 7/3/11.

Again, as far as the de Quervain's tendonitis, the examinee is music major, does play multiple instruments, and again there was a report in the notes of 4/1/13 of injuring her wrist while picking up her bass clarinet and at that time was given diagnosis of de Quervain's disease. Clearly, based upon the records submitted to my review, the claimant just sustained a wrist sprain/contusion. The MRI done after the motor vehicle accident did not reveal any acute fractures of the scaphoid and showed normal configuration of the scaphoid and showed no evidence of any tendonitis of the wrist. It should be noted that the x-rays following the report on the date of loss did not reveal any fractures to the scaphoid.

Again, based upon this exam and the review of the records, the examinee just sustained a wrist sprain/contusion as a result of date of loss of 7/3/11, sustained no permanent injuries to the right wrist. The examinee does have signs and symptoms of de Quervain's tenosynovitis, but this is unrelated to the motor vehicle accident of 7/3/11 and this is related to her subsequent injury while picking up her clarinet and also most likely related to playing multiple instruments.

Again, the sprain/contusion of the wrist is related to motor vehicle accident. The examinee had no pre-existing conditions. The current subjective complaint is consistent with objective finding on today's examination and the diagnosis of de Quervain's tendonitis is not related to motor vehicle accident.

Again, as it is notable of the MRI reveals no tenosynovitis following the motor vehicle accident and also history of subsequent injury on 4/1/13 as most likely related to subsequent injury and playing of multiple instruments. Therefore, in

review for the injury sustained from the motor vehicle accident of right wrist sprain/contusion within reasonable probability. The examinee sustained no permanent injury as a result of the motor vehicle accident of 7/3/11, and this is within reasonable medical probability.

All the opinions above expressed are within a reasonable degree of medical probability.

All history was obtained from the examinee and from any medical records made available for my review. All complaints expressed by the examinee as they relate to the above-noted history were documented. The examination was complete and accurate relating to the above incident. At the conclusion of the examination, the examinee left in the same condition as that noted upon arrival. No dissatisfaction was voiced.

I declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

As is customary, I am being paid for my time examining this individual and reviewing the medical records provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

The above are my opinions expressed within a reasonable degree of medical probability.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/S/ JEFFREY F. LAKIN, M.D.

JFL:et/gt/kf

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June 15, 2015

James Ricciardi, Esq.
White, Fleischner & Fino
Holmdel Corporate Plaza
2137 Route 35
Holmdel, New Jersey 07733

Re: Nicole Calautti
Claim No.: 241-17974
Date of Incident: 7/30/11

Dear Mr. Ricciardi:

Below is an addendum to my independent medical evaluation, dated 5/28/15, to clarify the date of accident was 7/30/11, not 7/3/11. Actually it should be corrected throughout the body of the report. Also should be noted in review of records number 9 should be read as Merrima CK Rehab, not CHK Rehab and under number 16 in the records, it should be x-ray report of the left elbow, dated 9/29/06, not of the right elbow.

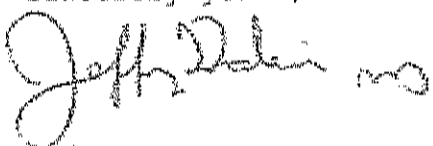
Again, this is a clarification to my independent medical evaluation, dated 5/28/15.

The above opinions are expressed within a reasonable degree of medical probability and certainty.

I, Jeffrey F. Lakin, declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information. As is customary, I am being paid for my time examining the examinee and reviewing the medical records when provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,



/S/ JEFFREY F. LAKIN, M.D.
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July 8, 2015

James Ricciardi, Esq.
White, Fleischner, & Fino, LLP
Holmdel Corporate Plaza
2137 Route 35
Holmdel, New Jersey 07733

Re: Nicole Calauttie
Claim No.: 241-17974
Date of Incident: 7/30/11

Dear Mr. Ricciardi:

Below is an addendum to my independent medical evaluation conducted on 5/28/15 in response to your correspondence dated 6/25/15.

Review of Records

I reviewed the following records:

1. Submitted to my review was an x-ray report of the right wrist from 8/8/11 which I agree with of no radiographic evidence of acute osseous injury of the wrist.
2. There is an x-ray report of the right wrist from 9/13/11 which I agree with, which showed no radiographic evidence of osseous injury.
3. I also agree with findings of the MRI report of 11/3/11 which shows normal appearance of scaphoid. No evidence of ligamentous or tendon injury or abnormal bone marrow signal.

Review of Radiology Studies

Submitted to my additional review was a CD containing x-rays of the right wrist from 8/8/11, x-rays of the right wrist from 9/13/11, and an MRI of the right wrist dated 11/3/11.

1. After reviewing the imaging, the x-ray of the right wrist from 8/8/11, there were no fractures, no dislocations, and was unremarkable including that of no evidence of any fractures of the carpal bones including scaphoid and no fractures to the distal radius and ulna. Again, no fractures were seen in the wrist. There were no dislocations and unremarkable x-ray of the wrist from 8/8/11.
2. Also submitted to my review are x-rays of the right wrist from 9/13/11. Again, my review of the films reveal no fractures and no dislocations including that of the carpal bones as well as to the scaphoid, and distal radius, and ulna. Again unremarkable x-rays of the right wrist from 9/13/11.
3. Also submitted to my review were MRI films of the right wrist from 11/3/11. I found no fractures and no dislocations of the osseous structures of the wrist. No tear of the TFCC complex and no ligamentous tears. An unremarkable MRI of the right wrist.

Conclusion and Summary

Again based upon additional information submitted to my review, the opinions in my independent medical evaluation of 5/28/15 remain unchanged. Again, the claimant sustained no fracture of the wrist and to the scaphoid as a result of the accident of 7/30/11 and sustained no permanent injuries as a result of the motor vehicle accident of 7/30/11 and the examinee just sustained a sprain and contusion to the wrist as related to motor vehicle accident and sustained no permanent injuries as a result of the motor vehicle accident of 7/30/11.

Again based upon additional records submitted to my review, my opinion remains unchanged and again all opinions above are expressed within a reasonable degree of medical certainty.

Again, I agree with these findings. Again based upon the additional records submitted to my review, the claimant sustained no permanent injuries as a result of motor vehicle accident of 7/30/11 and just sustained sprain and contusions to the wrist. No fracture was sustained to the wrist including the scaphoid and the examinee sustained no permanent injuries as a result of the accident of 7/30/11.

All opinions expressed are within a reasonable degree of medical probability.

I, Jeffrey F. Lakin, declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information. As is customary, I am being paid for my time examining the examinee and reviewing the medical records when provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/S/ JEFFREY F. LAKIN, M.D.

JL:et/gt/kf

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January 23, 2015

Ms. Nitasha Bansal
Liberty Mutual Insurance Company
399 Campus Drive
Somerset, New Jersey 08873

Re: Mark Cava
Claim No.: 2116264303
Date of Incident: 11/18/11

Dear Ms. Bansal:

Below is an addendum as requested on the examinee, Mark Cava, for my independent medical evaluation done on 9/9/14.

Review of Records

I reviewed the following records:

1. Submitted to my additional review were records from Bergen Pain Management, Dr. Thomas Ragukonis, from 10/16/14.
2. Also submitted to my review were notes of Dr. Sammy Masri from date of 12/5/14 and from the date of 12/29/14 as well as electrodiagnostic testing from the date of 12/15/14.

Conclusion and Summary

Based upon the additional information submitted to review, the opinion in my independent medical evaluation from 9/9/14 remains unchanged. It has been noted that in my review of the MRI of the lumbar spine from 1/14/12, there was no disc herniation noted.

It should also be noted that in my review of the recently submitted electrodiagnostic testing of 12/15/14 that the examinee had normal electrophysiological study and no evidence to suggest radiculopathy, peripheral neuropathy, myopathy, or plexopathy.

Again, based upon the additional records submitted to my review, the opinion in my independent medical evaluation remains unchanged that the examinee just sustained sprains to cervical and lumbosacral spines and has no permanency as a result of the injury sustained from the motor vehicle accident of 11/18/11. Again, the electrophysiological testing was normal.

The above opinions are expressed within a reasonable degree of medical probability and certainty.

I, Jeffrey F. Lakin, declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information. As is customary, I am being paid for my time examining the examinee and reviewing the medical records when provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/S/ JEFFREY F. LAKIN, M.D.

JL:et/gt/kf

Jeffrey F. Lakin, M.D., P.A.
Orthopedic and Hand Surgery
Diplomate of the American Board of Orthopedic Surgery
F.A.A.O.S.

642 Broad Street
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(973) 365-1139

March 5, 2013

Premier Prizm Solutions
10 East Stow Road
Suite 100
Marlton, New Jersey 08053

RE:	Barbara Pieroni
DOI:	August 6, 2011
Claim #:	0372861290101018
Start Time:	12:37 p.m.
End Time:	1:04 p.m.

INDEPENDENT MEDICAL RE-EVALUATION

To Whom It May Concern:

The above captioned claimant, Barbara Pieroni, was seen in my office for an Independent Medical Re-Evaluation on March 5, 2013. The claimant was previously in my office for an Independent Medical Evaluation on the date of November 20, 2012.

Submitted for my review were the following: My independent medical evaluation dated November 20, 2012, note of Dr. Roger Pollack dated July 26, 2012, a discogram of the lumbar spine dated January 10, 2013, notes of Dr. Quartararo dated January 23, 2013, MRI report of the right shoulder arthrogram dated September 11, 2012, MRI report of the lumbar spine dated February 11, 2013, as well as images.

HISTORY: The claimant is a 55-year-old female who was involved in a motor vehicle accident on August 6, 2011. At that time, she was the driver of a vehicle which was struck head on by another vehicle. The claimant had complaints of pain in the neck, lower back and right shoulder.

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

She was taken to St. Joseph's Hospital in Paterson, New Jersey, where she was evaluated, given medication and injections. She was discharged with no durable medical equipment, including slings or spinal immobilization.

The claimant followed up with Dr. Perez and was then referred to an orthopedic surgeon where she was placed in a course of physical therapy three times a week for three months.

She eventually came under the care of pain management specialist, Dr. Visco, and underwent trigger point injections. She had two to three sets of trigger point injections with the last being approximately one year ago. The claimant has had no significant relief and was also treated with lumbar epidural steroid injections, the last of which was in July of 2012 which also gave no relief.

She was also under the care of Dr. Quartararo who was treating her for her lower back and obtained additional imaging including a discogram of the lumbar spine as well as a repeat MRI of the lumbar spine.

The claimant is indicated for surgery as she has failed the conservative treatment. She was also under the care of Dr. Pollack, an orthopedic surgeon, for the right shoulder. She had an MRI arthrogram done of the right shoulder. The pain has persisted and she was told she would need surgery to the right shoulder.

PRESENT COMPLAINTS: The claimant complains neck pain that is present constantly and radiates into her right arm and goes into the ulnar one-and-a-half digits.

She also has pain in the right shoulder, worse with sleeping. She cannot do any overhead activities or lifting and has to be cautious with her movements.

The lower back pain is present constantly and is worse with prolonged positions such as sitting, standing or walking. She has to change positions frequently and has pain that radiates to both lower extremities to the back of her thighs.

The pain has persisted, especially in her shoulder and her lower back, despite the conservative treatment. She states that surgery was recommended by Dr. Quartararo for the lower back and Dr. Pollock for the right shoulder.

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 037286129010101 8

PAST MEDICAL HISTORY: The claimant denies any history of hypertension, diabetes, peptic ulcer disease, respiratory problems or endocrine disturbances.

PAST SURGICAL HISTORY: Denied.

PREVIOUS INJURIES (to spine and extremities): Denied.

RECENT INJURIES (to spine and extremities): Denied.

SOCIAL HISTORY: The claimant smokes approximately a half-pack of cigarettes per day and uses alcohol socially. She is single and has five children, four adults and one 17 years of age.

WORK HISTORY: The claimant is self-employed as an editor. She states that she has not returned to work since the accident, as she is on pain medication and has had significant pain and has a hard time concentrating.

REVIEW OF SYSTEMS: The claimant denies loss of consciousness. She denies bladder or bowel dysfunction. Review of systems is otherwise non-contributory.

PHYSICAL EXAMINATION: The claimant is a 55-year-old female. She is alert and oriented x 3. The claimant needed some assistance getting on and off of the examination table.

Height: 5 feet 4 inches
Weight: 115 pounds

Head: Atraumatic, normocephalic.

Cervical Spine: There is minimal tenderness in the midline of the lower cervical spine. There are no spasms or step-offs. Flexion is to 50 degrees actively. Extension is to 60 degrees actively. Lateral rotation to the left and right is 80 degrees actively. Hoffmann's sign is negative. Spurling's test is negative. Lhermitte's sign is negative.

Upper Extremities: Sensation is intact to light touch; 6 mm two-point discrimination is noted in all digits. Motor examination reveals 5/5 strength bilaterally except for a minimal decrease in shoulder abduction on the right as compared to the left at 5-/5. Strength was 5/5 in shoulder forward flexion, elbow

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

flexion and extension, wrist flexion and extension, intrinsics of the hand including finger flexors and extensors. Biceps, triceps and brachioradialis reflexes are 2+, equal and reactive bilaterally. No pathologic reflexes are noted. Tinel's sign and Phalen's test are negative over the median nerve at the level of the wrist bilaterally. Tinel's sign is negative over the median and ulnar nerve at the level of the proximal forearm and elbow.

Right Shoulder: There is tenderness in the anterior aspect of the glenohumeral joint. There is marked guarding with testing of range of motion actively with 95 degrees of abduction and 110 degrees of forward flexion with pain at the extremes. Internal and external rotation is to 60 degrees. There is no acromioclavicular joint or sternoclavicular joint tenderness. Motor examination of the shoulder reveals 5-/5 strength in right shoulder abduction, but otherwise was 5/5 strength in forward flexion, adduction, internal and external rotation. There is some pain with resistive abduction. Impingement maneuver is negative. Drop arm test is negative. Anterior apprehension test is negative. Cross arm adduction test is negative.

Thoracic-Lumbosacral Spine: There is tenderness over the lower lumbar spine in the midline and paravertebral musculature in the lower lumbar spine. No spasms no step offs were noted. There is no tenderness over bilateral sciatic notches or sacroiliac joints. Forward flexion is fingertips to knees. Straight leg raise testing is negative bilaterally in the sitting and supine positions. Patrick's test is negative bilaterally.

Lower Extremities: Deep tendon reflexes, ankle jerk and knee jerk, are 2+, equal and reactive bilaterally. Sensation is intact to light touch bilaterally. Babinski responses are downgoing bilaterally. There is no evidence of clonus. Motor examination reveals 5/5 strength bilaterally in hip flexion, knee flexion and extension, dorsiflexion, plantarflexion, inversion, eversion and great toe extension. No pathologic reflexes are noted. Gait is unremarkable.

DIAGNOSTIC STUDIES: An MRI of the right shoulder arthrogram dated September 11, 2012 showed findings that suggest a chronic Hill-Sach's deformity of the humeral head with Patullus joint capsule. Correlation for laxity is suggested. There is a partial articular-side of the tear of the supraspinatus allowing for motion. The labrum is intact.

She also is noted to have a discogram of the lumbar spine which showed concordant pain at L3-L4, L4-L5 and L5-S1.

RE: Barbara Pieroni
DOI: August 6, 2011
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She also was noted to have an MRI of the lumbar spine from the date February 11, 2013 that showed L5-S1 loss of disc height. There is a focal mid line disc herniation superimposed on underlying disc bulge. There is mild effacement of the ventral thecal sac without significant spinal stenosis. At L4-L5, there is a right paracentral annular tear and focal disc herniation detected. There is mild right lateral recess narrowing with no evidence of spinal stenosis. At L3-L4 there is a mid-line annular tear and focal mid-line disc herniation abutting the ventral thecal sac with no evidence of spinal stenosis or neural foraminal narrowing.

ASSESSMENT: The claimant is a 55-year-old female who sustained sprains to the cervical spine as well as injuries to the lumbar disc with disc herniations at multiple levels and positive discogram as well as a right shoulder sprain and a partial tear of the rotator cuff.

For the cervical spine, she has reached maximal medical improvement. For her right shoulder and lumbar spine, she has not reached maximal medical improvement.

DISCUSSION: As for the right shoulder, the claimant has reached maximal medical improvement from conservative care. She has had significant therapy and with the persistence of pain. Due to signs and symptoms consistent with a partial rotator cuff tear, surgery is indicated and is related to the motor vehicle accident of August 6, 2011.

The claimant also has pain in her lower back that has not responded to conservative treatment. With a positive discogram as well as positive disc herniations of the lumbar spine, surgery is indicated and is related to the motor vehicle accident of August 6, 2011.

There is no need for any further conservative treatment to the right shoulder or lower back. During this examination, the claimant asked multiple questions of me regarding findings she had at the time of my prior report. Again, I explained to the claimant several times during this examination that I cannot answer any questions, as this examination was for independent medical examination and that there is no doctor-patient relationship established and I cannot answer any of her questions.

Based upon this examination, there is no reason why she cannot perform her activities of daily living and there is no reason why she cannot work. From an

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

orthopedic standpoint, there is nothing that prevents her from returning to work as a self-employed editor.

The claimant has reached maximal medical improvement in my field of specialty with respect to cervical spine injuries sustained in the motor vehicle accident. No further conservative treatment is indicated to the right shoulder or lumbar spine. Further treatment is required with respect to her right shoulder and lumbar spine including surgical intervention.

There is no reason why the claimant cannot continue to work and perform her activities of daily living.

The report submitted here is based on information supplied to me by the claimant, the findings of my examination as reported above and all medical records sent to my office. If any additional information is provided, an addendum may be required.

The claimant left the examination in the same condition as she arrived with no complaints or evidence of dissatisfaction.

I, Dr. Jeffrey F. Lakin, being a physician duly licensed to practice medicine in the State of New Jersey, pursuant to CPLR Section 2106, hereby affirm under the penalty of perjury that the statements contained herein are true and accurate.

The examination has been performed as an Independent Medical Evaluation only. No doctor/patient relationship exists or is implied.

If you have any further questions, please feel free to contact me.

Very truly yours,

Jeffrey F. Lakin MD

Jeffrey F. Lakin, M.D.
License MA048918

JFL/tad
DD: 03/07/13
DT: 03/08/13 Job # 343694

Jeffrey F. Lakin, M.D.
4 Becker Farm Road, First Floor
Roseland, New Jersey 07068
973-669-9767
Fax 973-669-2968

September 9, 2014

Nitasha Bansal
Liberty Mutual Insurance Company
399 Campus Drive
Somerset, New Jersey 08873

Re: Mark Cava
Claim No.: 2116264303
Date of Accident: 11/18/11
Date of Examination: 9/9/14

Dear Ms. Bansal:

Below was an independent medical evaluation on examinee, Mark Cava, who was seen in my office in independent medical evaluation on the date of 9/9/14.

History of Accident

This is a male, date of birth 10/31/90, 23 years of age at the time of the examination, who was involved in a motor vehicle accident on 11/18/11. At that time, he was the driver of a car that was struck on the rear by another vehicle. He was stopped at the time of the accident.

At the time of accident, the examinee complained of pain in the neck and lower back and was taken to Hackensack Hospital by ambulance where x-rays were done. He was released that same day. He was told that there were no fractures and was given no braces, crutches, immobilizations, or splints.

He came under the care of his primary care physician, Dr. Raza and had an MRI done of his lumbar spine by Dr. Raza. He had been treated with medication and then was referred to Dr. Matarese where he was placed in a course of physical therapy for approximately three times a week for a couple of months.

The examinee states he was doing well at that time and was released from Dr. Matarese's care and released from physical therapy and then recently this past winter in February 2013 had increased pain in his lower back. He came under the care of a chiropractor, Dr. Weber, and was treated from February 2013 to March 2014. Presently, he is not under the care of any physicians.

Current Complaints

Present complaints include neck and lower back pain. The neck pain has significantly gotten better and is no longer present.

The lower back pain is made worse with prolonged positions such as sitting, standing, and also gets some pain with sleeping. It varies. Some days are worse than others. He has some difficulty lifting 120 lbs.

He occasionally gets pain that radiates to his right leg to his midthigh and has not had any recent episodes radiating pain in the past several months. He denies any increasing symptoms with sneezing or coughing and again, there is no radicular pain, numbness, or paresthesias in the upper extremities.

Past History

The examinee denies hypertension, diabetes, peptic ulcer disease, respiratory problems, or endocrine disturbances.

Past surgical history is unremarkable.

Previous injury to the neck and lower back denied. Recent injuries to the neck and lower back denied.

Social History

He is 23 years of age, single. He denies tobacco. He denies alcohol use.

Review of Systems

He denies any bladder or bowel dysfunction. He denies any loss of consciousness. He is left-hand dominant.

Physical Examination

He is a 23-year-old male, alert and oriented x3. He is in no apparent distress. He is able to get on and off the examination table without difficulty. He is approximately 5'6" in height and 175 lbs in weight.

Head is atraumatic and normocephalic.

Cervical spine, nontender. He has full active range of motion in all planes tested. He has forward flexion 50°, extension 60°, and lateral rotation 80°. Nontender in the cervical spine posteriorly. No step-offs. No spasms.

The examinee's upper extremity sensation is intact to light touch with 6-mm two-point discrimination in all digits tested. Reflexes of the biceps, triceps, and brachioradialis 2+ equal and active bilaterally.

Negative Tinel's and negative Phalen's test medial nerve of the wrist. Negative Tinel's test medial nerve proximal forearm and elbow.

Motor examination is 5/5 in bilateral shoulder abduction, elbow flexion and extension, wrist flexion and extension, intrinsics of the hand, and finger flexion. No evidence of any thenar or hypothenar atrophy.

Negative Spurling's test. Negative Lhermitte's sign. Negative Hoffmann's sign.

Examination of the thoracolumbosacral spine reveals minimal tenderness in the lower lumbar spine, midline. No spasms. No step-offs. Nontender bilateral SI joints. He is able to forward flex to 2 inches from fingertips to toes. Negative straight leg raise testing in the sitting and supine positions.

Sensation is intact to light touch in both lower extremities. Ankle jerk and knee jerk 2+ equal and active bilaterally. Downgoing Babinski. Absent clonus. He was able to stand on heels and toes without difficulty. Gait is unremarkable.

Motor examination in hip flexion, knee extension, ankle dorsiflexion and plantar flexion, inversion, and EHL 5/5 bilaterally. Sensation is intact to light touch in both lower extremities.

Review of Records

I reviewed the following records:

1. MRI report and MRI films on a CD of the lumbar spine from 1/14/12.
2. Answers to interrogatories and deposition.
3. An accident report from 11/18/11.
4. Notes of emergency room from Hackensack University Medical Center from date of 11/19/11.
5. Notes of Dr. Matarese from the date of 1/27/12, 2/15/12, and 3/5/12.
6. Notes of Dr. Raza, dated 11/23/11 and 12/7/11.
7. Notes of Dr. Raza, dated 12/15/11.
8. Physical therapy notes from High Mountain Physical Therapy & Sports Medicine from the dates of 2/7/12 and 2/17/12 and including also notes of 3/5/12 physical therapy.
9. Photographs of the vehicle.
10. Miscellaneous medical records.

Review of Special Tests and X-Rays

1. A CD of an MRI of the lumbar spine from 1/14/12 was reviewed. In my review of the films, there were no disc herniations, just a small disc bulge at L5-S1, otherwise, unremarkable. The radiologist's report revealed a small central disc herniation at L5-S1 with slight indentation of thecal sac.

Impression and Discussion

The examinee is a 23-year-old male, who was involved in a motor vehicle accident on the date of 11/18/11. He sustained sprains to the cervical and lumbosacral spines and has no permanency as a result of the injury sustained from the motor vehicle accident of 11/18/11. He is neurologically intact and has essentially unremarkable examination and there is no correlation of any subjective findings.

It should be noted for work history at the time of the accident, he was employed installing doors. He missed three weeks of work and now has been released and is presently working as an apprentice doing general contracting.

Based upon this examination, the examinee has no permanency as a

result of the cervical and lumbosacral sprains. There is no need for any further treatment. The diagnosis of cervical sprain and lumbosacral sprain is related to the motor vehicle accident. There is no history of any comorbidities of prior injuries of pre-existing conditions and he has excellent function of his spine.

Extremities neurologically intact and has no permanency based upon this exam and review of records.

All history was obtained from the examinee and from any medical records made available for my review. All complaints expressed by the examinee as they relate to the above-noted history were documented. The examination was complete and accurate relating to the above incident. At the conclusion of the examination, the examinee left in the same condition as that noted upon arrival. No dissatisfaction was voiced.

I declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

As is customary, I am being paid for my time examining this individual and reviewing the medical records provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

The above are my opinions expressed within a reasonable degree of medical probability.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/S/ JEFFREY F. LAKIN, M.D.

JFL: et/gt/ck/ kf

Jeffrey F. Lakin, M.D.
4 Becker Farm Road, First Floor
Roseland, New Jersey 07068
973-669-9767
Fax 973-669-2968

January 23, 2015

Ms. Nitasha Bansal
Liberty Mutual Insurance Company
399 Campus Drive
Somerset, New Jersey 08873

Re: Mark Cava
Claim No.: 2116264303
Date of Incident: 11/18/11

Dear Ms. Bansal:

Below is an addendum as requested on the examinee, Mark Cava, for my independent medical evaluation done on 9/9/14.

Review of Records

I reviewed the following records:

1. Submitted to my additional review were records from Bergen Pain Management, Dr. Thomas Ragukonis, from 10/16/14.
2. Also submitted to my review were notes of Dr. Sammy Masri from date of 12/5/14 and from the date of 12/29/14 as well as electrodiagnostic testing from the date of 12/15/14.

Conclusion and Summary

Based upon the additional information submitted to review, the opinion in my independent medical evaluation from 9/9/14 remains unchanged. It has been noted that in my review of the MRI of the lumbar spine from 1/14/12, there was no disc herniation noted.

It should also be noted that in my review of the recently submitted electrodiagnostic testing of 12/15/14 that the examinee had normal electrophysiological study and no evidence to suggest radiculopathy, peripheral neuropathy, myopathy, or plexopathy.

Again, based upon the additional records submitted to my review, the opinion in my independent medical evaluation remains unchanged that the examinee just sustained sprains to cervical and lumbosacral spines and has no permanency as a result of the injury sustained from the motor vehicle accident of 11/18/11. Again, the electrophysiological testing was normal.

The above opinions are expressed within a reasonable degree of medical probability and certainty.

I, Jeffrey F. Lakin, declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information. As is customary, I am being paid for my time examining the examinee and reviewing the medical records when provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/s/ JEFFREY F. LAKIN, M.D.

JL:et/gt/kf

03/12/2013 10:31AM (GMT-04:00)

Jeffrey F. Lakin, M.D., P.A.
Orthopedic and Hand Surgery
Diplomate of the American Board of Orthopedic Surgery
F.A.A.O.S.

642 Broad Street
Clifton, New Jersey 07013
(973) 365-1139

March 5, 2013

Premier Prizm Solutions
10 East Stow Road
Suite 100
Marlton, New Jersey 08053

RE:	Barbara Pieroni
DOI:	August 6, 2011
Claim #:	0372861290101018
Start Time:	12:37 p.m.
End Time:	1:04 p.m.

INDEPENDENT MEDICAL RE-EVALUATION

To Whom It May Concern:

The above captioned claimant, Barbara Pieroni, was seen in my office for an Independent Medical Re-Evaluation on March 5, 2013. The claimant was previously in my office for an Independent Medical Evaluation on the date of November 20, 2012.

Submitted for my review were the following: My independent medical evaluation dated November 20, 2012, note of Dr. Roger Pollack dated July 26, 2012, a discogram of the lumbar spine dated January 10, 2013, notes of Dr. Quartararo dated January 23, 2013, MRI report of the right shoulder arthrogram dated September 11, 2012, MRI report of the lumbar spine dated February 11, 2013, as well as images.

HISTORY: The claimant is a 55-year-old female who was involved in a motor vehicle accident on August 6, 2011. At that time, she was the driver of a vehicle which was struck head on by another vehicle. The claimant had complaints of pain in the neck, lower back and right shoulder.

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RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

She was taken to St. Joseph's Hospital in Paterson, New Jersey, where she was evaluated, given medication and injections. She was discharged with no durable medical equipment, including slings or spinal immobilization.

The claimant followed up with Dr. Perez and was then referred to an orthopedic surgeon where she was placed in a course of physical therapy three times a week for three months.

She eventually came under the care of pain management specialist, Dr. Visco, and underwent trigger point injections. She had two to three sets of trigger point injections with the last being approximately one year ago. The claimant has had no significant relief and was also treated with lumbar epidural steroid injections, the last of which was in July of 2012 which also gave no relief.

She was also under the care of Dr. Quartararo who was treating her for her lower back and obtained additional imaging including a discogram of the lumbar spine as well as a repeat MRI of the lumbar spine.

The claimant is indicated for surgery as she has failed the conservative treatment. She was also under the care of Dr. Pollack, an orthopedic surgeon, for the right shoulder. She had an MRI arthrogram done of the right shoulder. The pain has persisted and she was told she would need surgery to the right shoulder.

PRESENT COMPLAINTS: The claimant complains neck pain that is present constantly and radiates into her right arm and goes into the ulnar one-and-a-half digits.

She also has pain in the right shoulder, worse with sleeping. She cannot do any overhead activities or lifting and has to be cautious with her movements.

The lower back pain is present constantly and is worse with prolonged positions such as sitting, standing or walking. She has to change positions frequently and has pain that radiates to both lower extremities to the back of her thighs.

The pain has persisted, especially in her shoulder and her lower back, despite the conservative treatment. She states that surgery was recommended by Dr. Quartararo for the lower back and Dr. Pollock for the right shoulder.

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

PAST MEDICAL HISTORY: The claimant denies any history of hypertension, diabetes, peptic ulcer disease, respiratory problems or endocrine disturbances.

PAST SURGICAL HISTORY: Denied.

PREVIOUS INJURIES (to spine and extremities): Denied.

RECENT INJURIES (to spine and extremities): Denied.

SOCIAL HISTORY: The claimant smokes approximately a half-pack of cigarettes per day and uses alcohol socially. She is single and has five children, four adults and one 17 years of age.

WORK HISTORY: The claimant is self-employed as an editor. She states that she has not returned to work since the accident, as she is on pain medication and has had significant pain and has a hard time concentrating.

REVIEW OF SYSTEMS: The claimant denies loss of consciousness. She denies bladder or bowel dysfunction. Review of systems is otherwise non-contributory.

PHYSICAL EXAMINATION: The claimant is a 55-year-old female. She is alert and oriented x 3. The claimant needed some assistance getting on and off of the examination table.

Height: 5 feet 4 inches
Weight: 115 pounds

Head: Atraumatic, normocephalic.

Cervical Spine: There is minimal tenderness in the midline of the lower cervical spine. There are no spasms or step-offs. Flexion is to 50 degrees actively. Extension is to 60 degrees actively. Lateral rotation to the left and right is 80 degrees actively. Hoffmann's sign is negative. Spurling's test is negative. Lhermitte's sign is negative.

Upper Extremities: Sensation is intact to light touch; 6 mm two-point discrimination is noted in all digits. Motor examination reveals 5/5 strength bilaterally except for a minimal decrease in shoulder abduction on the right as compared to the left at 5-/5. Strength was 5/5 in shoulder forward flexion, elbow

RE: Barbara Pieroni
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flexion and extension, wrist flexion and extension, intrinsics of the hand including finger flexors and extensors. Biceps, triceps and brachioradialis reflexes are 2+, equal and reactive bilaterally. No pathologic reflexes are noted. Tinel's sign and Phalen's test are negative over the median nerve at the level of the wrist bilaterally. Tinel's sign is negative over the median and ulner nerve at the level of the proximal forearm and elbow.

Right Shoulder: There is tenderness in the anterior aspect of the glenohumeral joint. There is marked guarding with testing of range of motion actively with 95 degrees of abduction and 110 degrees of forward flexion with pain at the extremes. Internal and external rotation is to 60 degrees. There is no acromioclavicular joint or sternoclavicular joint tenderness. Motor examination of the shoulder reveals 5-/5 strength in right shoulder abduction, but otherwise was 5/5 strength in forward flexion, adduction, internal and external rotation. There is some pain with resistive abduction. Impingement maneuver is negative. Drop arm test is negative. Anterior apprehension test is negative. Cross arm adduction test is negative.

Thoracic-Lumbosacral Spine: There is tenderness over the lower lumbar spine in the midline and paravertebral musculature in the lower lumbar spine. No spasms no step offs were noted. There is no tenderness over bilateral sciatic notches or sacroiliac joints. Forward flexion is fingertips to knees. Straight leg raise testing is negative bilaterally in the sitting and supine positions. Patrick's test is negative bilaterally.

Lower Extremities: Deep tendon reflexes, ankle jerk and knee jerk, are 2+, equal and reactive bilaterally. Sensation is intact to light touch bilaterally. Babinski responses are downgoing bilaterally. There is no evidence of clonus. Motor examination reveals 5/5 strength bilaterally in hip flexion, knee flexion and extension, dorsiflexion, plantarflexion, inversion, eversion and great toe extension. No pathologic reflexes are noted. Gait is unremarkable.

DIAGNOSTIC STUDIES: An MRI of the right shoulder arthrogram dated September 11, 2012 showed findings that suggest a chronic Hill-Sach's deformity of the humeral head with Patullus joint capsule. Correlation for laxity is suggested. There is a partial articular-side of the tear of the supraspinatus allowing for motion. The labrum is intact.

She also is noted to have a discogram of the lumbar spine which showed concordant pain at L3-L4, L4-L5 and L5-S1.

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861280101018

She also was noted to have an MRI of the lumbar spine from the date February 11, 2013 that showed L5-S1 loss of disc height. There is a focal mid line disc herniation superimposed on underlying disc bulge. There is mild effacement of the ventral thecal sac without significant spinal stenosis. At L4-L5, there is a right paracentral annular tear and focal disc herniation detected. There is mild right lateral recess narrowing with no evidence of spinal stenosis. At L3-L4 there is a mid-line annular tear and focal mid-line disc herniation abutting the ventral thecal sac with no evidence of spinal stenosis or neural foraminal narrowing.

ASSESSMENT: The claimant is a 55-year-old female who sustained sprains to the cervical spine as well as injuries to the lumbar disc with disc herniations at multiple levels and positive discogram as well as a right shoulder sprain and a partial tear of the rotator cuff.

For the cervical spine, she has reached maximal medical improvement. For her right shoulder and lumbar spine, she has not reached maximal medical improvement.

DISCUSSION: As for the right shoulder, the claimant has reached maximal medical improvement from conservative care. She has had significant therapy and with the persistence of pain. Due to signs and symptoms consistent with a partial rotator cuff tear, surgery is indicated and is related to the motor vehicle accident of August 6, 2011.

The claimant also has pain in her lower back that has not responded to conservative treatment. With a positive discogram as well as positive disc herniations of the lumbar spine, surgery is indicated and is related to the motor vehicle accident of August 6, 2011.

There is no need for any further conservative treatment to the right shoulder or lower back. During this examination, the claimant asked multiple questions of me regarding findings she had at the time of my prior report. Again, I explained to the claimant several times during this examination that I cannot answer any questions, as this examination was for independent medical examination and that there is no doctor-patient relationship established and I cannot answer any of her questions.

Based upon this examination, there is no reason why she cannot perform her activities of daily living and there is no reason why she cannot work. From an

RE: Barbara Pieroni
DOI: August 6, 2011
Claim #: 0372861290101018

orthopedic standpoint, there is nothing that prevents her from returning to work as a self-employed editor.

The claimant has reached maximal medical improvement in my field of specialty with respect to cervical spine injuries sustained in the motor vehicle accident. No further conservative treatment is indicated to the right shoulder or lumbar spine. Further treatment is required with respect to her right shoulder and lumbar spine including surgical intervention.

There is no reason why the claimant cannot continue to work and perform her activities of daily living.

The report submitted here is based on information supplied to me by the claimant, the findings of my examination as reported above and all medical records sent to my office. If any additional information is provided, an addendum may be required.

The claimant left the examination in the same condition as she arrived with no complaints or evidence of dissatisfaction.

I, Dr. Jeffrey F. Lakin, being a physician duly licensed to practice medicine in the State of New Jersey, pursuant to CPLR Section 2106, hereby affirm under the penalty of perjury that the statements contained herein are true and accurate.

The examination has been performed as an Independent Medical Evaluation only. No doctor/patient relationship exists or is implied.

If you have any further questions, please feel free to contact me.

Very truly yours,

Jeffrey F. Lakin, MD

Jeffrey F. Lakin, M.D.
License MA048918

JFL/tad
DD: 03/07/13
DT: 03/08/13 Job # 343694

Jeffrey F. Lakin, M.D.
4 Becker Farm Road, First Floor
Roseland, New Jersey 07068
973-669-9767
Fax 973-669-2968

January 23, 2015

Ms. Nitasha Bansal
Liberty Mutual Insurance Company
399 Campus Drive
Somerset, New Jersey 08873

Re: Mark Cava
Claim No.: 2116264303
Date of Incident: 11/18/11

Dear Ms. Bansal:

Below is an addendum as requested on the examinee, Mark Cava, for my independent medical evaluation done on 9/9/14.

Review of Records

I reviewed the following records:

1. Submitted to my additional review were records from Bergen Pain Management, Dr. Thomas Ragukonis, from 10/16/14.
2. Also submitted to my review were notes of Dr. Sammy Maari from date of 12/5/14 and from the date of 12/29/14 as well as electrodiagnostic testing from the date of 12/15/14.

Conclusion and Summary

Based upon the additional information submitted to review, the opinion in my independent medical evaluation from 9/9/14 remains unchanged. It has been noted that in my review of the MRI of the lumbar spine from 1/14/12, there was no disc herniation noted.

It should also be noted that in my review of the recently submitted electrodiagnostic testing of 12/15/14 that the examinee had normal electrophysiological study and no evidence to suggest radiculopathy, peripheral neuropathy, myopathy, or plexopathy.

Again, based upon the additional records submitted to my review, the opinion in my independent medical evaluation remains unchanged that the examinee just sustained sprains to cervical and lumbosacral spines and has no permanency as a result of the injury sustained from the motor vehicle accident of 11/18/11. Again, the electrophysiological testing was normal.

The above opinions are expressed within a reasonable degree of medical probability and certainty.

I, Jeffrey F. Lakin, declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information. As is customary, I am being paid for my time examining the examinee and reviewing the medical records when provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/s/ JEFFREY F. LAKIN, M.D.

JL:et/gt/kf

Jeffrey F. Lakin, M.D.
4 Becker Farm Road, First Floor
Roseland, New Jersey 07068
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September 9, 2014

Nitasha Bansal
Liberty Mutual Insurance Company
399 Campus Drive
Somerset, New Jersey 08873

Re: Mark Cava
Claim No.: 2116264303
Date of Accident: 11/18/11
Date of Examination: 9/9/14

Dear Ms. Bansal:

Below was an independent medical evaluation on examinee, Mark Cava, who was seen in my office in independent medical evaluation on the date of 9/9/14.

History of Accident

This is a male, date of birth 10/31/90, 23 years of age at the time of the examination, who was involved in a motor vehicle accident on 11/18/11. At that time, he was the driver of a car that was struck on the rear by another vehicle. He was stopped at the time of the accident.

At the time of accident, the examinee complained of pain in the neck and lower back and was taken to Hackensack Hospital by ambulance where x-rays were done. He was released that same day. He was told that there were no fractures and was given no braces, crutches, immobilizations, or splints.

He came under the care of his primary care physician, Dr. Raza and had an MRI done of his lumbar spine by Dr. Raza. He had been treated with medication and then was referred to Dr. Matarese where he was placed in a course of physical therapy for approximately three times a week for a couple of months.

The examinee states he was doing well at that time and was released from Dr. Matarese's care and released from physical therapy and then recently this past winter in February 2013 had increased pain in his lower back. He came under the care of a chiropractor, Dr. Weber, and was treated from February 2013 to March 2014. Presently, he is not under the care of any physicians.

Current Complaints

Present complaints include neck and lower back pain. The neck pain has significantly gotten better and is no longer present.

The lower back pain is made worse with prolonged positions such as sitting, standing, and also gets some pain with sleeping. It varies. Some days are worse than others. He has some difficulty lifting 120 lbs.

He occasionally gets pain that radiates to his right leg to his midthigh and has not had any recent episodes radiating pain in the past several months. He denies any increasing symptoms with sneezing or coughing and again, there is no radicular pain, numbness, or paresthesias in the upper extremities.

Past History

The examinee denies hypertension, diabetes, peptic ulcer disease, respiratory problems, or endocrine disturbances.

Past surgical history is unremarkable.

Previous injury to the neck and lower back denied. Recent injuries to the neck and lower back denied.

Social History

He is 23 years of age, single. He denies tobacco. He denies alcohol use.

Review of Systems

He denies any bladder or bowel dysfunction. He denies any loss of consciousness. He is left-hand dominant.

Physical Examination

He is a 23-year-old male, alert and oriented x3. He is in no apparent distress. He is able to get on and off the examination table without difficulty. He is approximately 5'6" in height and 175 lbs in weight.

Head is atraumatic and normocephalic.

Cervical spine, nontender. He has full active range of motion in all planes tested. He has forward flexion 50°, extension 60°, and lateral rotation 80°. Nontender in the cervical spine posteriorly. No step-offs. No spasms.

The examinee's upper extremity sensation is intact to light touch with 6-mm two-point discrimination in all digits tested. Reflexes of the biceps, triceps, and brachioradialis 2+ equal and active bilaterally.

Negative Tinel's and negative Phalen's test medial nerve of the wrist. Negative Tinel's test medial nerve proximal forearm and elbow.

Motor examination is 5/5 in bilateral shoulder abduction, elbow flexion and extension, wrist flexion and extension, intrinsics of the hand, and finger flexion. No evidence of any thenar or hypothenar atrophy.

Negative Spurling's test. Negative Lhermitte's sign. Negative Hoffmann's sign.

Examination of the thoracolumbosacral spine reveals minimal tenderness in the lower lumbar spine, midline. No spasms. No step-offs. Nontender bilateral SI joints. He is able to forward flex to 2 inches from fingertips to toes. Negative straight leg raise testing in the sitting and supine positions.

Sensation is intact to light touch in both lower extremities. Ankle jerk and knee jerk 2+ equal and active bilaterally. Downgoing Babinski. Absent clonus. He was able to stand on heels and toes without difficulty. Gait is unremarkable.

Motor examination in hip flexion, knee extension, ankle dorsiflexion and plantar flexion, inversion, and EHL 5/5 bilaterally. Sensation is intact to light touch in both lower extremities.

Review of Records

I reviewed the following records:

1. MRI report and MRI films on a CD of the lumbar spine from 1/14/12.
2. Answers to interrogatories and deposition.
3. An accident report from 11/18/11.
4. Notes of emergency room from Hackensack University Medical Center from date of 11/19/11.
5. Notes of Dr. Matarese from the date of 1/27/12, 2/15/12, and 3/5/12.
6. Notes of Dr. Raza, dated 11/23/11 and 12/7/11.
7. Notes of Dr. Raza, dated 12/15/11.
8. Physical therapy notes from High Mountain Physical Therapy & Sports Medicine from the dates of 2/7/12 and 2/17/12 and including also notes of 3/5/12 physical therapy.
9. Photographs of the vehicle.
10. Miscellaneous medical records.

Review of Special Tests and X-Rays

1. A CD of an MRI of the lumbar spine from 1/14/12 was reviewed. In my review of the films, there were no disc herniations, just a small disc bulge at L5-S1, otherwise, unremarkable. The radiologist's report revealed a small central disc herniation at L5-S1 with slight indentation of thecal sac.

Impression and Discussion

The examinee is a 23-year-old male, who was involved in a motor vehicle accident on the date of 11/18/11. He sustained sprains to the cervical and lumbosacral spines and has no permanency as a result of the injury sustained from the motor vehicle accident of 11/18/11. He is neurologically intact and has essentially unremarkable examination and there is no correlation of any subjective findings.

It should be noted for work history at the time of the accident, he was employed installing doors. He missed three weeks of work and now has been released and is presently working as an apprentice doing general contracting.

Based upon this examination, the examinee has no permanency as a

result of the cervical and lumbosacral sprains. There is no need for any further treatment. The diagnosis of cervical sprain and lumbosacral sprain is related to the motor vehicle accident. There is no history of any comorbidities of prior injuries of pre-existing conditions and he has excellent function of his spine.

Extremities neurologically intact and has no permanency based upon this exam and review of records.

All history was obtained from the examinee and from any medical records made available for my review. All complaints expressed by the examinee as they relate to the above-noted history were documented. The examination was complete and accurate relating to the above incident. At the conclusion of the examination, the examinee left in the same condition as that noted upon arrival. No dissatisfaction was voiced.

I declare that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

As is customary, I am being paid for my time examining this individual and reviewing the medical records provided to me in preparation of this report, as well as for any future services, which may be required such as review of additional records, and/or future legal services referable to the above case.

The above are my opinions expressed within a reasonable degree of medical probability.

If I can be of further assistance to you regarding this matter, please feel free to contact me.

Sincerely yours,

/S/ JEFFREY F. LAKIN, M.D.

JFL: et/gt/ck/ kf