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Brandy DeHaven
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Aviation Business Center
252 Airport Road, Suite 3, Lower Level
Winchester, VA 22602

RE: FRANK PEREIRA
CLAIM NO.: W000434885
DOI: 01/04/12

Dear Ms. DeHaven:

I had the opportunity of seeing Mr. Frank Pereira in my Jenkintown office today for a neurologic evaluation and independent medical examination. The following is a summary of his history along with my findings, impressions and recommendations. Mr. Pereira was accompanied to the appointment by his wife.

Mr. Pereira is a 58-year-old right-handed man status post cervical fusion who presents with chief complaints of neck pain with numbness from his neck fusion down, clawing and atrophy as well as weakness of his fingers, and difficulty standing and walking. Mr. Pereira provided me with the following history. He was working as a bus attendant and on 01/04/12, the bus driver hit the gas pedal as he was on the way back to his seat. He went flying and his head hit the back of the seat and he also hit his lower back. Within a few days, Mr. Pereira was "tripping on nothing" and ended up on the ground. He was also dropping things from his hand and couldn't feel things. He worked for a week and on 01/12/12 was sent to Workhealth. They sent him to Aria and they found a problem with his neck and sent him to Jefferson.

On 01/17/12, Dr. Jallo performed a cervical fusion on Mr. Pereira. Following the surgery he was agitated and got up to go to the bathroom and fell on water. He was rescanned. He also told me his arm also got stuck in the bed during his hospital stay. He was hospitalized at Jefferson for 8 days and sent home in a cab. He told me was very upset because no one was home when he was discharged but his wife got home from work before he arrived.

Mr. Pereira did not undergo any further neck surgery. He told me his first lawyer dropped him and then he got another lawyer. He was seen by Dr. Porter and got gabapentin. He said he did not have any actual physical therapy in his office but was seen by several other doctors including Dr. Fras and Dr. Bruce Levin. They ordered tests and he told me they did not provide him with any additional treatment. He told me he saw Dr. Porter for two years. Mr. Pereira added he had anger issues and his wife had words with Dr. Porter and they were kicked out. He has been seen by his primary and still talks to Dr. Bruce Levin. Mr. Pereira told me he didn't want needles and is not getting any pain medications. He added that he smokes marijuana which just takes his mind off of it.

CURRENT COMPLAINTS:

Mr. Pereira has constant pain in his neck and has been told that there are herniated disks above and below the fusion. The pain is worse in the rain, low pressure and cold. The pain is localized and does not radiate into his upper extremities. He does have numbness from his neck fusion down but may feel the top of his hands or feet or bones. He does not feel heat. His fingers are curled up and he has atrophy in his hands. It's hard for him to get out of the chair and when he stands his body shakes. He walks with the use of a walker. He does not have any problems with his bladder but is constipated and needs a stool softener. He denied any prior neck problems or injuries.

Mr. Pereira is not bothered by headaches. He denied any history of any other head trauma. He's never had a seizure and only lost consciousness briefly one time from blood pressure. He has not noted any difficulty with his vision or speech. He chokes on certain foods and has problems with solids. He was told there was narrowing due to the neck fusion. He may have loss of hearing and told me that he played drums and did stage production. He has ringing in his ears. He is not bothered by dizziness.

PAST MEDICAL HISTORY:

His past medical history includes a hypertension, asthma and hepatitis C. He added that the hepatitis C was cured but his antibodies are still positive. He also has PTSD and gets nightmares of weird things. He does not have any flashbacks. There is no history of diabetes and he has no known heart or kidney problems.

Additional past surgical history includes a tonsillectomy and an umbilical hernia repair in 2007. He told me he needs another one on the left.

His only known allergy is to Latex but he told he had adverse reactions to morphine, Ativan, gabapentin and Wellbutrin.

His current medications include ibuprofen, diazepam 10 mg twice a day, lisinopril, albuterol inhaler, and vitamin D.

Matt Trzesniowski is his current family physician. Previously he was seeing Howard Nesbitt who retired. He is also seeing Dr. Krivinsky for PTSD, chronic depression and brain injury.

The only other injury could recall was a broken toe at work.

SOCIAL HISTORY:

He went to Frankford High School and got his GED when he was in the Army Reserve at Leonard Wood.

He has been married for almost 30 years. He is not driving.

He rarely smokes cigarettes.

He denied any history of any drug or alcohol addiction, abuse or treatment. He told me he is not on Vicodin because of his bowels

REVIEW OF SYSTEMS: On file.

NEUROLOGIC EXAMINATION:

Mental status: He was alert and oriented. He was fluent and hands comprehension and memory were fine. His affect was labile, and he and his wife repeatedly argued.

Cranial nerves: 2 through 12 were grossly intact. Visual fields were full to confrontation. Pupils were equally round and reactive to light. Extraocular movements were intact with no nystagmus. There was no facial, palatal or lingual weakness.

Motor exam revealed marked atrophy of the first dorsal interosseous muscles bilaterally and curling his fingers. He had marked weakness distally in his upper extremities with 0/5 strength in his hands. His right deltoid, biceps and triceps were 4/5 and on the left were 5/5. Strength in his lower extremities was at least 4+/5 and there was no increased tone.

There was a steppage gait as well as some possible scissoring. He had a positive Romberg.

Sensory exam revealed diminished sensation below C3.

Deep tendon reflexes were absent in his upper extremities and 2/4 in his lower extremities. His right plantar response actually appeared downgoing and his left was neutral.

REVIEW OF DIAGNOSTIC STUDIES:

The 01/12/12 and 01/18/12 CT scans of his head performed at Jefferson were negative and did not reveal any intracranial abnormality. The 04/30/13 MRI of the brain was normal.

The 01/12/12 CT of his cervical spine revealed degenerative changes at C5-6 with associated osteophyte formation and uncovertebral hypertrophy. There was a moderate disc bulge at C5-C6 most pronounced in the right paracentral region resulting in moderate canal stenosis and significant crowding of the right lateral recess. In the impression they also stated there was probable mass effect upon the cord of unclear chronicity. A repeat CT scan performed at Jefferson on 01/12/12 revealed multilevel degenerative changes with uncovertebral hypertrophy from C2-3 through C6-7. At C4-5, there was right-sided neuroforaminal stenosis and at C5-6, there was bilateral neuroforaminal stenosis

The 01/12/12 MRI of his cervical spine was nondiagnostic and incomplete. A repeat MRI performed on 01/15/12 revealed degenerative changes most severe at C5-6 and C6-7 where there was significant central canal stenosis. It was most severe at C6-7 where there was cord compression and cord signal abnormality.

The 03/01/13 MRI of his cervical spine performed at Chester County Open MRI revealed anterior fusion at C5-6 and C6-7 with no recurrent disc herniation. At C4-5, there was disc degeneration with broad base protrusion reducing the canal diameter narrowing of both neuroforamina right greater than left. At C3-4 and C2-3, there was moderate broad-based disc protrusion eccentric to the left. They stated there was no distinct evidence of intrinsic cord abnormality.

The 02/27/18 CT of his cervical spine revealed postoperative changes at C5-6 and C6-7. At C2-3, there was left uncinate hypertrophy causing mild left foraminal stenosis. At C3-4, there was a disc bulge, focal ossification of the posterior longitudinal ligament and uncinate and facet hypertrophy causing minimal to mild spinal canal stenosis and moderate left and mild right foraminal stenosis. At C4-5, there was OPLL and right greater than left uncinate hypertrophy causing mild right sided spinal canal stenosis

and moderate severe right and mild to moderate left foraminal stenosis. At C5-6, there was asymmetric right OPLL and uncinate hypertrophy causing mild to moderate right-sided spinal canal stenosis and mild bilateral foraminal stenosis. At C6-7, there was endplate spurring and bilateral uncinate arthropathy with mild bilateral foraminal stenosis and no spinal canal stenosis. At C7-T1, there was severe left facet hypertrophy and mild bilateral uncovertebral arthropathy without significant spinal canal stenosis and moderate left and mild right foraminal stenosis.

The 01/12/12 CT of his thoracic spine performed at Jefferson revealed right sided paracentral osteophytes causing right lateral recess stenosis at T2-3 and T3-4. At T9-10, there was ligamentous involvement with bilateral facet hypertrophy and at T10-11 through T12-L1, there was bilateral facet hypertrophy with no significant stenosis.

The 01/12/12 CT of his lumbar spine revealed disc bulging with ligamentous enfolding and bilateral neural foraminal stenosis at L2-3. At L3-4, there was minimal disc bulging and bilateral neural foraminal stenosis. At L4-5, there was mild disc bulge and lateral facet hypertrophy. At L5-S1, there is only minimal disc bulge.

The 01/15/12 MRI scans of his thoracic and lumbar spines were limited. The 11/21/12 MRI of his lumbar spine performed at Chester County Open MRI revealed degenerative disc changes from T11-12 to L5-S1. At L2-3, there was a mild to moderate disc protrusion with left greater than right neural foraminal narrowing. At L3-4, there was a mild to moderate disc protrusion somewhat eccentric to the left. There was no report of any accompanying stenosis. At L4-5, there was moderate disc protrusion and left greater than right neural foraminal narrowing. At L5-S1, there was mild central disc protrusion.

The 01/19/12, x-ray of his right shoulder revealed mild degenerative changes of the glenohumeral joint. The x-rays of his right hand and forearm were negative and there was no fracture.

The 02/25/13 EMG and nerve conduction testing of his upper extremities performed by Ronald L. Brody, M.D. revealed **bilateral C7-8 radiculopathies**. Dr. Brody stated there was denervation but the accompanying data did not reveal any abnormal spontaneous activity (fibrillations or positive sharp waves). There was also no report of any polyphasic potentials. He said there were also mild **ulnar and median nerve compression neuropathies.**

The 08/26/13 EMG and nerve conduction testing of his lower extremities performed by Dr. Brody revealed <u>chronic</u> left L5 and the right L5-S1 radiculopathies and the accompanying data again did no report of any abnormal spontaneous activity.

The 06/05/17 EMG and nerve conduction study of his upper extremities performed by Joseph Lubeck, D.O. revealed **chronic right C7 and bilateral C8 radiculopathies** without evidence of active denervation.

The 01/15/19 EMG and nerve conduction testing of his lower extremities performed at Temple revealed a **sensorimotor polyneuropathy** with no electrodiagnostic evidence of lumbar radiculopathy.

REVIEW OF RECORDS:

The following records were reviewed:

1. Work Health	01/12/12
2. Aria Health	01/12/12 & 06/01/16
3. Jefferson University Hospital / Jack Jallo, M.D.	01/12/12 - 01/20/12; 10/04/16
4. Theodore Porter, M.D. /Premier Physical Therapy	10/24/12 - 06/08/16
5. Bruce H. Levin, M.D.	02/14/13 - 06/05/20
6. Ronald L. Brody, M.D. (EMGs)	02/25/13 - 10/21/13
7. Jonas J. Gopez, M.D.	05/10/13
8. Steven Mazlin, M.D.	06/20/13
9. Jed Shapiro, M.D.	04/08/16 - 09/15/16
10. Evan S. Kovalsky, M.D.	06/01/16
11. Matthew Tormenti, M.D.	06/14/16 & 01/24/17
12. Lee D. Rowe, M.D.	01/19/17
13. Temple Health	02/07/17 - 11/22/19
14. Joseph S. Lubeck, D.O. (EMG)	06/05/17
15. Mario J. Arena, M.D.	03/29/18
16. Forteleza Physical Therapy	01/16/19 - 03/08/19
17. Moss Rehabilitation	05/15/19
18. Diagnostic studies	
19. Stephen B. Lewis, M.D.	08/30/19
20. Deposition transcripts	

On 01/12/12, when Mr. Pereira was seen at WorkHealth, they discussed the history of the incident that occurred at work one week earlier and said he was complaining of neck pain, numbness, and an unstable gait. They reviewed the findings on his exam and in addition to an unstable gait said he had tremor of both hands and diffusely decreased sensation in a ***glove-like pattern***. They suggested ruling out an **acute neurologic event, possible withdrawal and intermittent use of marijuana.** They

referred him to the ER. They also subsequently commented that he ambulated with a normal gait when he did not realize he was being observed and noted that he had a history of poorly controlled blood pressure which was **162/110**.

On 01/12/12, when Mr. Pereira was seen in the ER at Aria, he complained of numbness of both arms, neck pain, and bilateral hip pain. He again admitted to the use of marijuana. They reviewed the findings on his exam and reported weakness in hand grips bilaterally and decreased temperature and pain to C8. They also said he had non-specific weakness in both lower extremities and was barely able to ambulate. They obtained a CT of his cervical spine and diagnosed him with a **spinal cord injury** and transferred him to Jefferson.

The 01/12/12 admission note from Jefferson Neurosurgery stated Mr. Pereira complained of upper greater than lower extremity weakness, numbness, and dysesthesias. They reviewed the findings on his exam and Dr. Jallo diagnosed him as suffering **cervical stenosis**. He discussed the possibility of surgery but surgery was not performed until five days later. He was seen for consultations by medicine/cardiology and physical medicine and rehabilitation prior to the surgery. He was noted to have chest pain and uncontrolled blood pressure and also discussed the possibility of diabetes. On 01/17/12 Dr. Jallo performed anterior cervical discectomy and fusion at C5-6 and C6-7 and his pre- and post-operative diagnoses were **cervical disc herniation with myelopathy.** Progress notes indicated he was very combative and cursing and threatening all staff on emergence from anesthesia and had to be placed in restraints. The morning after the surgery he fell in the bathroom and hit his head and was sent for a CT. The note commented that he was extremely impulsive and attempting ambulation without assistance. A subsequently noted that he was constantly arguing with his wife, cursing, and making derogatory comments to her. A 01/18/12 progress said he felt stronger in both arms and the paresthesias had resolved and he only had pain at the incision site. Another note said he had decreased proprioception of his lower extremities and was weaker in the left than right mostly at the C8-T1. On 01/19/12, he complained of right shoulder pain and very noted that his arm went through the bed handle. Later that morning they said he was found on his knees at bedside. Later on the evening of the 19th, they were called to the bedside for agitation and reported he was treating the nursing staff inappropriately and yelling at staff. He demanded Valium for sleep. On the morning of the 20th, they noted he was irritable, impulsive, and demanding Valium. They offered him Percocet for pain and he told them he reacted violently to it. He was given Benadryl and eventually calmed down and slept. A progress note from 01/20/12 stated he was feeling stronger but still demonstrating impulsivity and agitation. A nursing progress note that afternoon said that he was found walking around packing belongings for discharge without complaints of pain. He was discharged on 01/20/12. Discharge instructions were

provided, but no physician's discharge summary was included with the records from Jefferson.

No records were provided of any follow-up or treatment Mr. Pereira received in the 10 months following his discharge from Jefferson.

On 10/24/12, Mr. Pereira was seen by Dr. Porter. As usual, his note made no mention who referred the patient to him nor was there any indication who his report was being sent to. He reviewed the history of the incident that occurred at work and discussed his subsequent course of treatment. He said he had received an EMG of his upper extremities and was treating with Physician's Rehab Associates, but no notes were provided from them. Dr. Porter discussed his subjective complaints which included pain in his neck, mid back, low back, both knees, right shoulder, right wrist, and hand and numbness and weakness in his upper and lower extremities. Mr. Pereira told him that his condition had actually been getting worse not better. He listed the records which he reportedly reviewed but did not discuss them in any further detail. Those records included notes from Episcopal from 10/10/12, an EMG and nerve conduction study of his upper extremities from 05/07/12, and records from Physician's Rehab Associates from 04/30/12 to 05/07/12. Dr. Porter reviewed the findings on his exam. He reported diffuse weakness in his upper and lower extremities with 4/5 strength throughout. He had diminished sensation on the right over the C5, 6, and 7 dermatomes and left C7 dermatome. He noted he had diminished reflexes in his upper extremities with normal reflexes in his lower extremities. He did not report the presence of any atrophy. He described his gait as antalgic. He also said he was ambulating without an assistive device. Dr. Porter discussed his assessment and listed numerous diagnoses that were clearly not mentioned in the records from WorkNet, Aria, or Jefferson and would be unrelated to the injury he sustained at work. In addition to right cervical radiculopathy, he listed the findings on EMG testing and did not appropriately address the fact that it did not even correlate with the findings he described on Mr. Pereira's exam. In addition to cervical strain and sprain, he said he had thoracic and lumbar spine sprain and strain and myofascitis/myospasms with lumbar radiculitis. He listed findings on his thoracic and lumbar MRI scans and did discuss the clinical significance of those findings. He said he had a closed head injury with a post-traumatic concussion syndrome there was no indication he actually suffered any head injury or alteration of consciousness at the time of the accident nor did Dr. Porter even make any mention that Mr. Pereira was currently complaining of any headaches or post-concussive symptoms. He did not address the issue of his hypertension and the need for follow-up and treatment even though his blood pressure was elevated (140/100). He concluded his report by stating his initial diagnoses were directly related to the accident that occurred at work which only raises serious

questions regarding the thoroughness and accuracy of his evaluation and the opinions he expressed was well as his actual role in Mr. Pereira's case.

Notes provided from Dr. Porter indicate he saw Mr. Pereira until 06/08/16. His notes discussed his symptoms and the findings on his exam and indicate his problems actually increased. In addition to diagnoses which he listed in his initial report, he subsequently stated he was suffering from PTSD, anxiety, insomnia, and depression. His notes repeatedly indicated his blood pressure was elevated, but he did not discuss what medications he was taking for his blood pressure in the next 2 years or suggest that he be seen for follow-up and treatment. His 06/24/13 note said that Mr. Pereira had swelling and bruising in the left lower extremity secondary to elevator door at Penn Hospital shutting on it which Mr. Pereira made no mention of to me, and there was no documentation in Dr. Porter's note that he even examined his left lower extremity or referred him for any testing or treatment. His 09/04/13 note said his pain was **10/10** and that he had no relief with medications. He gave him a prescription for Vicodin but he failed to document the quantity that was being dispensed nor was there any indication he obtained a signed narcotic contract or conducted any drug screening. When he was next seen on 09/25/13, he said he had good relief with medications even though he reported that the pain in his neck was **9-10.** He said he was to continue with his current medications and did not actually discuss what specific medications he was taking. His notes from October and November 2013 continued to state he had some good pain relief with medications even though he continued to report **9-10/10** pain in his neck. On 10/22/13, he increased his hydrocodone to 7.5 mg two to three times a day even though he reported the medication was providing good pain relief. Subsequent notes from November 2013 to 11/12/14 stated he was to continue with his current medications and did not discuss his use of Vicodin or mention how much was being prescribed to Mr. Pereira. There continued to be no documentation that Dr. Porter obtained a signed narcotic screen or conducted any drug screening. There was also no indication in these notes or any of his notes that any of the medications he provided to Mr. Pereira actually resulted in any improvement in his functional status. No progress notes were provided from Dr. Porter in the 2+ years following his 01/23/14 visit. When he returned on 03/07/16, Dr. Porter reported his pain was a **9-10/10** and he indicated his current medications included hydrocodone/APAP 5/325 along with lisinopril, diazepam, and ibuprofen. There was no documentation in his note that he checked Mr. Pereira's blood pressure even though he was complaining of intermittent headaches and was taking lisinopril. His 03/31/16 note made no mention of the medications he was taking and once again said he was to continue with his current medications. His last two notes from 05/02/16 and 06/08/16 indicated he was taking hydrocodone 7.5 mg, diazepam 5 mg, and ibuprofen 800 mg. He made no mention he was taking anything for his blood pressure nor was there any documentation he re-checked his blood pressure even though his last note said he was reporting regular

headaches. In his next to last note from 05/02/16 he reported that he was having troubling with grasping objects.
His last note said he was to be seen by Dr. Wolfe as well as Dr. Shapiro from pain management but no notes were provided from Dr. Wolfe. Dr. Porter stated he was to follow-up in six weeks, but no further notes were provided from Dr. Porter. It should be noted that while Dr. Porter's progress notes discussed the findings on the cervical and lumbar spine exams, there was no documentation he ever conducted repeat neurologic exam or checked for any signs of radiculopathy or myelopathy in the 3-1/2 years after he first saw Mr. Pereira even though he continued to report that he had paresthesias and radicular symptoms.

On 10/24/12, when Mr. Pereira was seen for initial physical therapy evaluation at Premier, they discussed the history of his current condition and his pain and associated symptoms. They reviewed the findings on his exam but there was no documentation that they conducted any exam of his upper extremities or checked for any signs of myelopathy or radiculopathy in spite of the referring diagnoses listed in their report. They discussed their "physical therapy diagnoses" and actually stated that ***physical therapy services would not be helpful at that time*** which incredibly was not mentioned by Dr. Porter. It should also be noted that every one of Dr. Porter's notes from November 2012 to March 2013 stated Mr. Pereira was to continue physical therapy even though he was not being seen for any physical therapy. On 11/27/12, Dr. Porter even stated that the physical therapy treatments provided temporary relief of his pain. It was not until his 04/18/13 note that Dr. Porter actually stated physical therapy treatments had been placed on hold. Following his initial physical therapy evaluation on 10/24/12, there was no indication Mr. Pereira was seen at Premier until 06/24/13. The 06/24/13 handwritten note said he was being seen for reevaluation and a program update. A copy of that report was not provided. They did note that his blood pressure was 158/100, and there was no documentation they conducted any additional exam. The only treatment they provided to him was moist heat/cold packs and massage. Records from Premier indicated that Mr. Pereira did not return there until four months later. Handwritten physical therapy examination notes from 10/21/13 discussed areas symptoms and the findings on imaging studies of his cervical spine and exam. They noted that he had cold hands, left greater than right which was actually never reported by Dr. Porter. They said his static balance was fair and his dynamic balance was poor. They checked off their diagnoses and outlined a plan of treatment. They said he was to reinitiate the therapy two to three times a week but no further treatment notes were provided from Premier.

On 02/04/13, Mr. Pereira was seen by Dr. Bruce Levin according to somewhat illegible notes. Notes provided from Dr. Levin indicated that Mr. Pereira apparently returned to see him for monthly follow-up visits from March through May 2013 and then did not

return again until 10/24/13. He was seen for follow-up visits on 03/31/14 and 06/02/14 and then did not return until two years later (07/11/16). When he returned on 08/05/16, he reported that his symptoms were worse and on 11/20/16 he said there was no change in his symptoms. He was seen for four follow-up visits in 2017 and four visits in 2018. Following his 10/21/18 visit, no records were provided indicating Mr. Pereira had any contact with Dr. Levin until he had a telemedicine visit 1-1/2 years later (05/26/20).

On 02/25/13 and 08/26/13 Mr. Pereira was seen by Dr. Brody at Phoenix Physical Medicine and underwent EMG and nerve conduction testing. He subsequently returned for another follow-up visit on 10/21/13 and said that Temple Neurosurgery was asking for motor conduction studies of the upper extremities and Dr. Brody questioned why. No further notes were provided from Dr. Brody or Phoenix.

On 05/10/13, Mr. Pereira was seen for an independent medical evaluation by Dr. Gopez. He said that Mr. Pereira's chief complaints included neck pain, pins and needles throughout his body below his neck, loss of dexterity in his hands, and an unsteady gait. Dr. Gopez reviewed the history of the incident that occurred at work and discussed Mr. Pereira's subsequent course of treatment. He went on to discuss his neurological complaints in further detail and his activities of daily living. His current medications include diazepam, Wellbutrin, and gabapentin and he also noted that he was smoking marijuana one to two times per day. Dr. Gopez reviewed the findings on his physical exam. He noted that he had limited range of motion of his cervical spine but did not report any spasm. He said there was visible atrophy in both the hand intrinsic bilaterally with clawing of both hands which Dr. Porter had never mentioned and diminished sensation to pinprick beginning at the C5 dermatome and down. He noted absent reflexes in the upper extremities and 1-2+ reflexes in his lower extremities. He discussed the findings on his imaging studies and his impressions and recommendations. He said he had suffered an **incomplete spinal cord injury** with residuals of abnormal sensory changes from the neck down, weakness and loss of dexterity in his hands, and gait dysfunction. He said his deficits were permanent and said that physical therapy and surgery were unlikely to be of any benefit. He said he found him to be at **maximal medical improvement** with regards to the cervical spine and did not have any treatment recommendations. He did state that a motorized scooter was indicated because of his instability of gait and high risk for falls. He said the only type of work he would be eligible for would be sedentary and did not require fine dexterities of his hand.

On 06/20/13, Mr. Pereira was seen for neurologic consultation by Dr. Mazlin. He reviewed the history of the incident that occurred at work and the evaluation and treatment he received at Jefferson. He made no mention that any of the treatment he

had received since his discharge from Jefferson. He discussed the symptoms he was experiencing and said he was seen for work-up at The University of Pennsylvania for episodes of trauma and shaking with reduced responsiveness which certainly had not been mentioned by Dr. Porter. Dr. Mazlin reviewed the findings on Mr. Pereira's exam and said he had "hand spasticity" with a tendency towards flexing and posturing and interosseous atrophy in both hands with mild weakness. He also noted moderate weakness of his right triceps and said his upper extremity power was otherwise intact. He stated his reflexes were trace/1+ in the upper extremities, 1+ at the knees, 1+ at the right ankle, and trace/absent at the left ankle. He noted that he had flexor plantar responses and no Hoffman's sign. He described his gait as spastic with increased base. He said sensory testing showed more of a "pressure" sensation with pinprick below the neck bilaterally and reduced vibration in all extremities and impaired position sense in the fingers normal at the wrist, absent in the toes, and normal at the ankles. He went on to discuss his impressions and said he was not sure he had anything further to offer him with respect to his myelopathy apart from a possible trial with baclofen. He said he would not recommend taking Wellbutrin if there was a concern for seizures.

On 04/08/16, Mr. Pereira was seen by Dr. Shapiro. The first page of his report was not provided. The second page discussed the symptoms he was experiencing in his back and reviewed his past history. He went on to discuss his review of systems and findings on his physical exam. He reported 3/5 strength in his biceps, triceps, and grip and did not note any weakness elsewhere. He also made no mention that there was any atrophy, and there was no documentation that he performed sensory testing or checked Mr. Pereira's deep tendon reflexes. There was also no indication he checked for any signs of radiculopathy or myelopathy even though he diagnosed him as suffering from cervical and lumbar radiculopathies and cervical myelomalacia per MRI. He went on to outline a plan of treatment. Subsequent notes provided from Dr. Shapiro indicate Mr. Pereira returned to see him on a monthly basis through September 2016. The findings he described on his exam were remarkably similar if not identical and he continued to list the same impressions. The notes indicate he was prescribing diazepam and Norco to Mr. Pereira, but there was no documentation he conducted any drug screening. It should also be noted that neither Dr. Shapiro nor Dr. Porter discussed the need for psychiatric evaluation and clearance even though Dr. Porter had repeatedly indicated he was suffering from anxiety and depression. Dr. Shapiro's last note from 09/15/16 said he was given a follow-up appointment for one month, but no further notes were provided from him.

On 06/01/16, Mr. Pereira was seen by Dr. Kovalsky at Valley Forge Orthopaedics. Dr. Kovalsky reviewed the history of the incident that occurred at work on 01/04/12 and discussed his subsequent course of treatment, medications, and other treatment he was currently receiving. He discussed his current complaints and the findings on his exam.

He said there were some bizarre behaviors in the examination and some unusual findings and also commented that despite his complaints of pain rated as 10/10, he was seated relatively calm and comfortable and did not appear to be in any severe distress. Dr. Kovalsky reported that he walked with a spastic type of gait and had difficulty with balance. He noted that he had clawed fingers and said there was some spasticity in his hands. He said his motor strength appeared to be intact at 5/5 in his upper extremity and subsequent noted that grip testing revealed nonphysiologic and non-bell shaped curves bilaterally. He said there was decreased sensation throughout the upper extremities and absent DTRs. He added there was hypersensitivity and with just light touch in the right cervicothoracic region he would jump and have significant pain. He said motor testing in his lower extremities was 4+/5. He noted he had decreased sensation throughout the lumbar and gluteal but not perineal region. He also said that sensory testing was decreased to sharp throughout his entire body which was bilaterally in the lower extremities, chest, abdomen, and back to just above his mouth as well as both upper extremities. His knee jerks were slightly decreased at 1+ and his ankle jerks were absent. Dr. Kovalsky went on to discuss his review of Mr. Pereira's medical records and diagnostic studies and diagnostic impressions. He said he appeared to have a **cervical myelopathy** and said the subsequent treatment head with Dr. Porter was not entirely reasonable or necessary. He agreed with Dr. Gopez that he did have permanent nerve injury but said his most recent MRI did not reveal any changes that would account for his global loss of sensation. Dr. Kovalsky discussed his recommendations and said it would be very difficult for him to perform any type of gainful employment. He discussed additional EMG testing due to the fact that there was mixed picture with some myelopathic findings but other findings were not consistent with a myelopathy which he commented on. He also said there appeared to be some subtle signs of symptom magnification. He said that baclofen might be of benefit along with some home exercises and therapy to try and work on the spasms in his hands. He did not see any indication for additional surgery. He added that he might be at maximal medical improvement but might benefit from additional medical treatment to try to control the spasms.

On 06/01/16, Mr. Pereira presented to Aria following a fall. He said he fell backwards hitting his head on the door while at his independent medical exam office and was now numb from the neck down. He denied any pain at that time. They reviewed the findings on his exam and obtained a CT scan of his brain which showed mild periventricular lucencies suggesting deep white matter ischemic changes and atrophy. No acute abnormalities were reported. He was discharged with a diagnosis of **accidental fall, blunt head trauma, and cervical strain.**

On 06/14/16, Mr. Pereira presented to Dr. Tormenti with neck pain. He discussed the incident that occurred at work on 01/04/12 and the treatment he received at Jefferson.

He said he had "no treatment since his surgery" which is clearly inaccurate and misleading. Dr. Tormenti then noted that he fell at the independent medical exam and was experiencing neck and joint pain and had diminished sensation from his neck down and no sensation when he had bowel movements or urinates. Dr. Tormenti then discussed the conservative modalities that were attempted which is certainly inconsistent with his previous statement that he had no treatment since surgery. He reviewed the findings on Mr. Pereira's exam and said there tongue fasciculations, diminished grip bilaterally with severe atrophy and clawing of both hands and absent reflexes. He went on to discuss his assessment and said he had an unspecified injury at the C5 level of his cervical spinal cord but did note that tongue fasciculations could be somewhat warning for progressive neuromuscular disease and said he wanted to get an EMG. He said he would return in six weeks time, but notes provided from Dr. Tormenti indicate Mr. Pereira did not return to see him until over seven months later. He also said that in addition to MRIs of his lumbar and thoracic spine, he was being referred to neurology.

On 10/04/16, Mr. Pereira was seen by Dr. Jallo. He discussed the surgery he performed on Mr. Pereira and said he presented for the first time since April 2012 with increasing gait dysfunction as well as hand weakness and contractures and diminished sensation of pain from his neck throughout the rest of his body. He discussed the findings on his imaging studies and his recommendations, but his note did not actually include any discussion regarding the findings on Mr. Pereira's exam or Dr. Jallo's current diagnostic impressions.

On 01/19/17, Mr. Pereira was seen for follow-up by Dr. Rowe because of dysphasia to solids and liquids. Dr. Rowe's prior notes were not provided. He discussed the report of a video fluoroscopic study he performed on 01/16/17 and the findings on his exam. He said the findings supported probable diagnosis of post-anterior cervical disc fusion dysphasia. He made a series of recommendations.

On 01/24/17, when Mr. Pereira returned to see Dr. Tormenti, he reviewed history and said his symptoms were worse. He continued to report tongue fasciculations, absent reflexes, and diminished grip strength bilaterally with severe atrophy and clawing of both hands. He then went on to discuss his impressions and recommendations and contended that the surgeon wanted to proceed with a spinal specialist to remove the C3 osteophyte which was certainly not suggested by Dr. Rowe. He went on to discuss his recommendations and said he should follow-up prn. No further notes were provided from Dr. Tormenti or his office.

On 02/07/17, Mr. Pereira was seen by the speech language pathologist at Temple for dysphasia. She stated that the onset of his problems was gradual and initiated five

years ago and was worsening. She discussed the findings on his evaluation. She stated the direct laryngoscopy did not reveal any laryngeal pathology and that the fiber optic endoscopic evaluation while swallowing revealed normal oral stage and an impaired pharyngeal stage. She went on to discuss her impressions and recommendations and said that behavioral adaptations noted during exam may be exacerbating the symptoms/anticipatory fear. On 07/06/17 Mr. Pereira was seen by another speech language pathologist at Temple and underwent modified barium swallow test. She discussed the results of the testing and made a series of recommendations. On 09/19/17, Mr. Pereira was seen for follow-up evaluation of dysphasia by Nausheen Jamal, M.D. at Temple. He briefly reviewed his history and said he did not have swallow therapy because he had too many other medical issues ongoing. He discussed the results of the modified barium swallow that had been performed two months earlier and the findings on his exam. He performed fiberoptic laryngoscopy which was totally normal except for enlargement of the base of his tongue. He recommended swallow therapy. On 04/17/18, when he was seen by the speech language pathologist for follow-up, Mr. Pereira reported that his swallowing had gotten worse despite the therapy. She discussed the results of direct laryngoscopy and fiber optic endoscopic evaluation of swallowing and did not address why his symptoms were worsening. She stated that no further work-up was warranted and made a series of recommendations. She recommended follow-up with Dr. Jamal, but no further notes were provided from him or any other ENT specialists.

A 09/12/17 note from Temple Hepatology stated his liver biopsy showed state 3 /4 fibrosis and that the ultrasound showed a nodule liver and portal hypertension. He diagnosed him as suffering from **hepatic cirrhosis** and noted that his past medical history included **alcohol and drug abuse in remission** with elevated LFTs, hepatitis C antibody positive. It should be noted that none of these problems were mentioned in any of the records provided from any of the doctors who treated Mr. Pereira for his work injury and provided him with prescriptions for opioids. On 11/24/19, when he was seen for cirrhosis follow-up, they reviewed his history and said he remained asymptomatic and denied any signs or symptoms concerning acute or chronic liver disease. They stated he had HCV-related compensated cirrhosis which was complicated by thrombocytopenia as well as mild portal hypertension. They went on to discuss their recommendations and the discussion they had with Mr. Pereira.

On 03/29/18, Mr. Pereira was seen for an independent medical examination by Dr. Arena. He stated that Mr. Pereira's chief complaints were neck pain, upper and lower extremity numbness with tremors, and gait disturbance. He reviewed the history of the incident that occurred at work and discussed his subsequent course of treatment and described the problems he was experiencing in further detail. Dr. Arena briefly noted the records which he reviewed and discussed the findings on Mr. Pereira's exam. He

reported weakness in grip and interosseous strength bilaterally with claw deformity in the hands and severe first dorsal interosseous atrophy bilaterally. He reported 5/5 strength proximally in his lower extremities and 4/5 strength distally with involuntary tremor. He said there was complete absence of sensation in the upper and lower extremities with trace and equal reflexes in his upper extremities, 2+ patellar reflexes, and trace Achilles reflexes. He said his Babinski's were downgoing and that Hoffman's reflexes were present bilaterally. Dr. Arena went on to discuss diagnostic studies which he reviewed. He discussed his assessment. He had incomplete spinal cord injury at C7 with quadraparesis. He recommended follow-up with Dr. Jallo and an updated cervical MRI and follow-up at Magee Hospital spinal cord injury clinic once per year. He said that neurologic changes were all consistent with and resulting from his original work injury and commented that it resulted in a cervical myelopathy with spinal cord compression necessitating the surgery he underwent. Dr. Arena said he was capable of gainful employment at a sedentary level.

On 11/27/18, Mr. Pereira was seen in the physical medicine and rehab clinic at Temple for initial consultation for numbness from the neck down as well as gait abnormality. They discussed the incident that occurred at work and briefly discussed the treatment he had received along with his current complaints. They reviewed the findings on his diagnostic testing and physical exam. They noted that he had significant gait disturbance and muscle atrophy in both hands as well as tremors and fasciculations in both upper limbs. They reported 5/5 strength proximally in his upper extremities, weakness in his finger flexors and abductors, and 5/5 strength in both lower limbs. They said there was decreased sensation in all four limbs. They actually described rather brisk reflexes in his upper extremities inconsistent with what been repeatedly described and the findings on his examination today. They said his Hoffman's reflex was absent bilaterally and tone was normal throughout his upper limbs. They listed their impressions and recommended an ENG of both lower extremities and follow-up with wheelchair clinic at Moss and referral to aqua therapy. When he returned on 01/28/19, they noted he had an EMG which revealed a **sensorimotor peripheral polyneuropathy** with no evidence of radiculopathy, motor neuropathy, plexopathy, or upper motor neuron disease. They said he had been seen for one session of aqua therapy and had not been at the wheelchair clinic at Moss. He briefly discussed his symptoms and noted that he had multiple falls in the past few months. The findings described on his exam were remarkably similar to their previous noted. The impression said he had bilateral leg weakness even though they reported that his strength was 5/5 in both lower extremities. They diagnosed him with ambulatory dysfunction and subsequently commented it was "very unlikely that upper motor neuron issues/changes secondary to cervical issues were causal for his legs/ambulatory issues and that it was far more likely that the primary factor for these issues or his chronic sensory motor polyneuropathy". They also said it was very likely that his arms were

duly affected by upper motor neuron/post-myelopathic changes as well as peripheral neuropathic changes. They discussed their recommendations which included additional blood tests. Results from Quest Diagnostics from blood specimens collected on 03/08/19 indicated Mr. Pereira had an elevated blood glucose level (111) and also elevated hemoglobin and hematocrit. The serum TSH, B6, B12, and folate levels were within normal limits. He did have an elevated homocysteine level but his methylmalonic acid level was within normal limits. On 03/28/19 when Mr. Pereira returned, they reviewed his interim history and said he had been falling a lot and fell face forward on the floor three weeks earlier. He complained of pins and needles throughout his whole body and dysesthesias along the left leg. They said he underwent blood work ordered at the last visit which showed low vitamin D levels. They reviewed the findings on his exam and continued to report that he had 5/5 strength in both lower extremities with decreased sensation to light touch and pinprick in all four limbs. He now said he had atrophic changes in both lower extremities along with muscle atrophy in both hands. He did not describe any myelopathic findings on his exam. They discussed their assessment and plan and actually recommended playing musical instruments in spite of the difficulties he was clearly having with his hands. They stated the **numbness from his neck down and ambulatory dysfunction was due to peripheral sensory neuropathy of the lower limbs.** They went on to discuss their recommendations and said he would follow-up in three months, but no further notes were provided from them. On 07/01/19 when he returned, they said he was continuing to note multiple non-traumatic falls and was awaiting a motorized scooter and had been unable to start aqua therapy and actually had an aboveground pool installed at his home. They discussed his symptoms and reviewed findings on his diagnostic testing and exam. His blood pressure was **185/114** ***and*** they now said he had 4 - 4+/5 strength in both lower limbs along with atrophy in both hands and atrophic changes in both lower extremities and decreased sensation to light touch and pinprick in all four limbs. They again did not describe any myelopathic findings on his exam. They discussed their impressions and said his **polyneuropathy** ***was affecting all four limbs and possibly GI tract/penile function.*** They went on to outline a plan of treatment. They said he was to follow-up in four months, but no further notes were provided from them.

From 01/16/19 to 03/08/19 Mr. Pereira was seen for seven visits at La Fortaleza. Records indicated there was a two week gap between his 02/08/19 and 02/22/19 visits, and their 02/22/19 report said he had fallen down the steps the week before but did not sustain any major injuries. They did not provide any explanation for why he had not been seen in the past two weeks. The 03/06/19 progress report stated he was to be seen two to three times a week for eight weeks, but records that were provided indicate he was seen for only one more session of therapy and no discharge summary was provided nor was there an initial evaluation report included with the records.

On 05/15/19, Mr. Pereira was seen for a wheelchair & seating eval at Moss. They noted his history and the results of their evaluation along with their assessment and recommendations. No further notes from Moss were provided.

On 02/22/19, Mr. Pereira was seen by Thomas Santora, a general surgeon at Temple for umbilical hernia. He reviewed his history and noted that he had a prior umbilical hernia repair performed by him in 2007. He reviewed his past history and noted that he maintained his alcohol sobriety since 2007. Dr. Santora reviewed the findings on his exam and said he had a well-healed smiley incision in the infraumbilical region with fullness on the left side of the incision which was non-reproducible and non-tender. He went on to discuss his assessment and said operative intervention was not warranted for the incarcerated hernia which was not causing pain or obstructive symptoms. He also added that due to portal hypertension, operative repair was not recommended and that an abdominal binder had been ordered for comfort.

On 08/30/19, a report was issued by Dr. Lewis providing an estimate of Mr. Pereira's survival time (life expectancy). He listed factors that could impact his life expectancy figure and said that within a reasonable degree of medical probability, based on those factors, his life expectancy figure would be reduced by 12 years with a life expectancy estimate of 68.

On 05/26/20, Mr. Pereira was seen for a telemedicine visit by Dr. Bruce Levin. He said he had baseline severe neck and upper extremity pain and related issues and was finding it harder and harder to swallow. He noted that his electrodiagnostic studies were abnormal in his lower as well as his upper extremities, but he did not discuss the findings on those studies nor was there any indication he reviewed any of his medical records. He discussed the findings he observed on his exam and his recommendations and on 06/05/10 wrote a letter for Mr. Pereira requesting approval of a home treatment program.

IMPRESSION:

Based on my evaluation of Mr. Pereira and review of his records and diagnostic studies, he appears to be suffering from multiple problems contributing to the symptoms he is experiencing and has not fully recovered. I would certainly concur that the clawing and atrophy as well as weakness of his fingers is related to the incomplete injury he sustained to his spinal cord at work and cervical radiculopathy with disc herniations at C3-4, C5-6, C6-7 and a disc bulge at C4-5, stenosis and postlaminectomy syndrome. There is little if any evidence to suggest he is suffering from an ongoing cervical myelopathy and the problems he has subsequently developed with standing and

walking and the other findings on his exam are clearly suggestive of unrelated peripheral sensorimotor neuropathy as was noted in the records provided from the physiatrist at Temple. He actually has fairly good strength in his lower extremities, and if anything, the problems he is having with balance and falling appear to be a result of proprioceptive impairment that may be a result of peripheral neuropathy and was certainly not noted following surgery performed on his neck. It also appears in reviewing his records that Mr. Pereira may be suffering from a number of other problems which he failed to mention to me and could be contributing to his development of peripheral neuropathy including diabetes, alcohol, and substance abuse.

RECOMMENDATIONS AND ADDITIONAL COMMENTS:

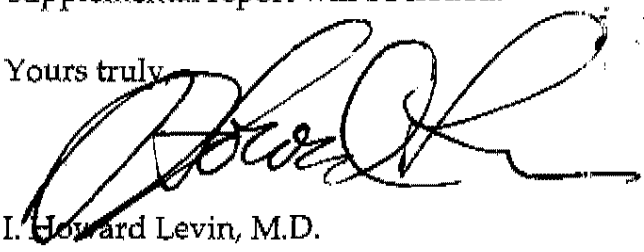
I feel that Mr. Frank Pereira has reached maximal medical improvement with regards to the injury he sustained at work on 01/04/12 and would concur with the opinions expressed by Dr. Kovalsky that it is unlikely that he would be able to perform any type of gainful employment. Given the problems he is experiencing with his hands from the incident that occurred at work he may benefit from special utensils and other hand implements. While he is experiencing difficulty with his balance and falling from the peripheral neuropathy that would necessitate modifications of his home including remodeling of his bathroom or a lift it is clearly unrelated to the incident that occurred at work and as was noted there is no evidence on his exam or the records are reviewed from his treating physicians would suggest he is suffering from ongoing cervical myelopathy as a result of the incident that occurred at work,. I do not feel that the recommendations made by Dr. Bruce Levin for an OrthoCor device or cognitive behavioral therapy with virtual reality are either reasonable or appropriate for the injuries Ms. Pereira sustained nor is there sufficient medical evidence to support the use of those modalities in this setting. I would suggest that instead of focusing on this incident he be referred for appropriate care and treatment for other medical problems and psychiatric issues he is experiencing.

The care and treatment that has been provided to Mr. Pereira by Dr. Porter and the doctors who saw Mr. Pereira in his office was inappropriate and the notes from Dr. Porter and his associates raise extremely serious questions regarding the thoroughness and accuracy of their evaluations, the opinions they expressed, and the care and treatment they provided to him. I certainly concur with Dr. Kovalsky that it was highly inappropriate for Dr. Porter to have not conducted any follow-up neurologic exams particularly given the symptoms Ms. Pereira was reporting. Dr. Porter's statements in his notes from 2012 and early 2013 that he continue physical therapy are certainly inconsistent with the records provided from Premier. Prescriptions from Dr. Porter and Dr. Shapiro provided for opioids were totally inappropriate and there is certainly no

documentation they resulted in any improvement in his functional status. There is also no indication they conducted any drug screening or referred him for appropriate psychiatric evaluation and clearance even though Dr. Porter indicated he was suffering from anxiety and depression. The numerous diagnoses Dr. Porter continued to list in his notes were also not supported by the history he obtained from Mr. Pereira, the symptoms he described or the previous records from his previous physicians. There was certainly no indication in the records that would suggest he sustained any injuries to his thoracic and lumbar spines as result of the incident that occurred at work and Dr. Porter did not describe any injuries or symptoms that would suggest he was suffering from post-concussion syndrome. None of Dr. Porter's notes made any mention as to his past history of alcohol and substance abuse but I would add that Mr. Pereira also denied any history of any drug or alcohol problems to me which is totally inconsistent with the records which I subsequently reviewed.

All of my opinions have been expressed within a reasonable degree of medical certainty. I would certainly be willing to review any additional medical records on Mr. Pereira including notes from his family physicians and his complete prescription records. If any records are provided that contain any pertinent information that changes any of my impressions, a supplemental report will be issued.

Yours truly,



I. Howard Levin, M.D.

IHL/mh