HYPOTHETICAL FACTUAL BACKGROUND FOR MOCK TRIAL

Claim CP 17-001 *James John Jones,* Petitioner *v. Waste Away Inc.* Respondent.

Petitioner was born on January 1, 1970. He is 5 foot 6 and weighs 225 pounds. He has been married for the past 17 years and has three daughters ages 15, 12 and 10 all of whom reside with his wife Jana and himself. The family was very close and while Petitioner himself was not "on Facebook," Jana was and her postings consisted almost exclusively of family events and her children's accomplishments, all of which both she and the Petitioner were extremely proud. She was proud of the Petitioner's athletic accomplishments and would occasionally post him bowling in a tournament or playing in a significant softball game. There were always candid photos as the Petitioner was not extroverted about himself and would never want to appear to be bragging.

The Petitioner graduated high school where he was an athlete as hereinafter will be described. Thereafter he was employed primarily as a truck driver most of his adult life until he became a waste removal "driver/specialist" for Waste Away Incorporated where he has been employed for the last 15 years, pridefully never having missed a day of work in his entire tenure except for a January 2, 2003 motor vehicle accident when he was out of work for three months after undergoing a C6-7 instrumented fusion surgery. He intended to return earlier for light duty, but such light duty was unavailable and he had no choice but to reluctantly accept temporary disability until he was released for full duty employment. That day could not have come quickly enough.

His primary care physician is Dr. Hope Moore who has been his primary care physician over the last 15 years. He has treated periodically with Dr. Manish Knipp, D.C. periodically over the past 15 years. He has been a reasonably healthy individual all of his life with the exception of one specific accident/injury which occurred on his first day of work at Waste Away Inc. on January 2, 2003 when he was involved in a motor vehicle accident, which was the subject matter of Claim Petition 2003-1234 for which he received a March 1, 2006 Order Approving Settlement in the amount of 27 1/2% permanent partial total for the orthopedic and neurologic residuals of a disc herniation at C6-7 for which there was an instrumented fusion to decompress and stabilize a massive left sided extruded disc which was pressing on the left side of the cervical spine cord and causing left upper extremity radiculopathy and myelopathy. There was no third party claim filed. There was also minimal treatment for a lumbosacral strain which "resolved." The permanency award was confined solely to the cervical spine as the Petitioner had only minimal short term subjective complaints with respect to the low back with no diagnostic studies performed.

That claim was never reopened mostly because Petitioner's condition slowly improved because of his intense desire to "fully recover." The permanency reports are attached which set forth the relevant medical chronology and the diagnostic and operative findings. Relevant portions of the transcript are also attached (in an abbreviated overview form) with respect to the Petitioner's Order Approving settlement and his testimony as to his loss of function at the time of the Order Approving Settlement on March 1, 2006. Following the entry of that Award Petitioner did continue with periodic chiropractic management with Dr. Knipp primarily for "maintenance"

purposes. Most of the actual manipulation occurred in the general cervical and upper thoracic region although occasionally there was manipulation to the low back.

There were no compensable nor non-compensable intervening accidents or injuries until the Petitioner's accident of July 1, 2016 which is the subject matter of this Mock Trial. The relevant dates of chiropractic management and body parts involved are also attached as representing the records summary of Dr. Manish Knipp. Following entry of his Award on March 1, 2006, the Petitioner was able to resume his full-duty employment. He was not given any restrictions in functioning by his treating neurosurgeon (Dr. Samuel Greene.)

The Petitioner was always a very hard working, loyal, responsible and reliable employee who was well liked by both his co-workers and Respondent's management. Other than missing 3 months of employment following his above-referenced cervical spine surgery, he never missed a day of scheduled employment for any medical or personal reason until his compensable accident of July 1, 2016 which is the subject matter of this claim. It would not be an unfair characterization to describe him as having a "manic" work ethic.

He typically worked at least an 8 hour day, 5 days a week with many 10 hour days during the Summer and generally a 4 hour Saturday shift. He never complained about work and never declined overtime requests. No assignment was too tough or too demanding. He was a "go to" guy whenever anything important needed to be addressed on a priority basis. His hourly wage was $20.00 at the time of the compensable accident (and has been his hourly rate for the past three years) and his total earnings for the year for each of his last 3 years of employment were $62,000.00 in 2013, $62,500.000 in 2014 and $63,000.00 in 2015. As of July 1, 2016 he had earned $30,000.00. He was basically working the same routes and days of employment as he had over the past 5 years.

His job duties involved mostly driving various sized waste removal vehicles which were outfitted with mostly hydraulic arms which lifted almost all of the waste receptacles and products which were collected and transported during his employment. There were some routes where he had to perform some manual lifting and bending with respect to making special attachments for certain trash receptacles so that waste could be discarded. There was occasionally some manual lifting of residential trash which had to be emptied by hand which lifting was a relatively minor part of his job duties. This lifting could occasionally be up to 100 pounds on a repetitive basis for an entire day perhaps as often as 5 days per month. He had no limitations on his ability to perform any of his employment duties when his accident of July 1, 2016 occurred.

At the time of his accident, the Petitioner had been very engaged with his three daughters athletic careers all of whom were excellent softball players and swimmers. He actually coached their softball league teams. He was also an avid bowler and was a member of two leagues wherein he had an average of 200 and 205 respectively. Petitioner was right hand dominant and was taking no medication for any condition at the time of his compensable accident of July 1, 2016. He was not treating for any medical condition at the time of his accident. He occasionally saw his chiropractor but as far as the Petitioner was concerned, these periodic "manipulations" were part of his good health "maintenance" program designed to keep him as healthy as possible.

The only remaining residuals from his previous cervical spine surgery were that he had lost approximately 10 degrees of flexion, extension and bilateral rotation of his cervical spine movements. He would occasionally have some achiness in the C6-7 region of his neck with some occasional radiation into his occipital region and temples. He would experience these symptoms no more than a few times per month and they were never long lasting (at most a few hours). He estimated his cervical spine pain as basically non-existent during most of the time immediately prior to the accident but on the occasional brief periods that he experienced some symptoms, the pain was generally no more than a 3 on a 0-10 scale. Such pain occurred more so in cold or damp weather, generally no more than one or two days per month. He had no radiation of pain down either arm nor into either hand. He had no tingling in either hand. He had full grip strength. He had no problems with his sleep. He was taking no medication except perhaps a Tylenol or Advil on the rare occasion that he had some cervical symptoms. He had no lifting restrictions including overhead movements.

He was a member of the Respondent's "senior" softball team, ("The Wastenots") which was for players older than 40 years of age. He had been a member of the employer sponsored softball team since starting his employment with the Respondent. The softball team was a marketing vehicle for the Respondent for which he was encouraged to remain active by the Respondent especially since he was such a talented player. He played second base, batted fifth and had a .350 average in his last three seasons of softball. He had hit 20 home runs. This was a slow pitch softball league.

Just prior to the compensable accident, the Petitioner was very content with his life. He had a loving relationship with his wife and daughters. Everyone was healthy and happy as far as he was concerned. His daughters were athletes and doing well in school. The Petitioner felt things were going well at work and there had been some discussion that he might be in line for a promotion to an Operations Assistant Manager positon largely because of his well-known commitment to the company together with his general knowledge of all aspects of its operations. He was considered a "go-to" employee especially concerning any problems that needed "on the ground" insight and solution.

On July 1, 2016 at 4:30 p.m. (a day he was working an 8 hour shift that was to end at 5:00 p.m.), the Petitioner slipped on the steps of the Respondent's rear loading dock and fell forward down five stairs falling face first (striking his forehead) onto a concrete sidewalk in a somewhat twisted fashion with his arms forward trying to brace the fall with his hands causing a hyperextension of his neck, with his torso twisting and rolling forwards, ending up onto his back. He immediately felt knifelike pain in his neck and a "pop" in his low back just below the center of his beltline. There was no loss of consciousness but he was dazed and "saw stars" for a few seconds. No one actually witnessed his fall. He laid on the ground for approximately 3 minutes before he attempted to get up. A supervisor saw him getting up. The Petitioner did not appear steady. The supervisor asked him what happened and then had the Petitioner go "clock out" and go to the local emergency care. The Petitioner left work approximately 15 minutes early and drove directly to the emergency care which was only approximately 1 mile away. He was able to drive himself but before he left he was asked by his supervisor to fill out an accident report form basically stating that he "fell down steps of loading dock" as to the question "how did the accident happen?"

As to the question "what part(s) of your body (if any) are injured?" he stated "hurt my face, neck and back". (The Petitioner was not the most verbose employee of Waste Away, Inc.)

He arrived at the local "emergency care" at approximately 4:50 p.m. at which time he had X-rays performed of his neck, jaw and low back, all of which were painful and all of which were negative for any fracture or other findings other than the instrumentation from the previous cervical spine fusion. The emergency care records indicated that the Petitioner had suffered "facial contusions/abrasions" together with "cervical spine and lumbar spine pain". He was prescribed anti-inflammatories (800 mg Ibuprofen 3 x per day) and told to make an appointment with Back to Work Medical for any further assessment he felt he might need "if symptoms persist more than 3 days."

He was also given an "out of work note" for the next 3 days and was told to call his supervisor "first thing in the morning to advise he would be out of work." However, the Petitioner did not stay out of work and instead returned to work the following day (July 2) despite his symptoms persisting.

He performed his "regular duties" including driving the trash truck and performing other physical exertion placing repetitive strain on his spine. He developed increasing neck and low back pain. He was experiencing a low-grade headache with a "foggy feeling" with muscle tightening at the base of his skull. He had bilateral trapezius spasm with pain radiating from the base of his skull to his shoulder joints. He had moderate constant "achiness" in his low back without any radiation beyond his bilateral upper buttocks. By the end of the day on July 2, he felt he should see a doctor.

Rather than scheduling an appointment with "Back to Work Medical," he decided to see his own chiropractor [Dr. M. Knipp] as he was hopeful an adjustment or two would improve his symptomatology and he would not need any further formal medical treatment (Dr. Knipp coined this treatment as proprietary "man-knipp-u-lation"). After work on the evening of July 2, he went to the chiropractor's office. Dr. Knipp "manipulated" both his neck and low back and advised him he had a "significant" amount of spasm in both regions. Dr. Knipp stated in his records that the Petitioner had a "strain/sprain" injury impacting his paravertebral musculature in both the cervical and lumbosacral regions. He did not issue any type of "out-of-work" prescription nor did the Petitioner seek one. The last thing that Petitioner wanted to do was lose any time from work. The Petitioner underwent a total of five additional adjustments over the next 10 days. His symptoms remained persistent with the pain unabated and fluctuating with activity. The Petitioner has having a hard time getting and staying asleep. By the end of the first week, due to spinal pain and discomfort, Petitioner started taking over the counter Advil 200 mg 4 tablets at a time 3 times per day to no avail. The chiropractor referred him to see an orthopedic group for further assessment. At that time the Petitioner spoke to his supervisor, Joe Johnson, about his situation (downplaying the amount of pain he was experiencing) and asked if Mr. Johnson could schedule an appointment for him at Back to Work Medical Group.
Mr. Johnson referred him to the Respondent's workers' compensation administrator who was also the human resources administrator. She made arrangements for the Petitioner to see Back to Work the following day. The administrator had a copy of the accident report and an open file

for the Petitioner. The Petitioner gave her an updated history of his seeing his chiropractor without success. He denied any new accidents or injuries. An appointment was made for 9:00 a.m. July 17 at which time the Petitioner saw Dr. James Payne [a general orthopedic surgeon with the Back to Work Group]. Dr. Payne's nurse took a history of the accident inclusive of relevant past medical history which included a reference to the Petitioner's prior cervical surgery, his history of chiropractic maintenance inclusive of the most recent chiropractic sessions. Dr. Payne performed a routine clinical evaluation of Petitioner's neck and low back noting mild cervical and lumbar spine paravertebral spasm and tenderness, with "muscle spasm in his cervical and lumbar region. His neurological exam was "negative." His "impression" was "closed head trauma, neck and low back pain" with a likely diagnosis of "mild cervical and lumbar strains without radiculopathy and moderate cephalgia." He prescribed 4 weeks of physical therapy three times per week with modified duties including no lifting greater than 50 pounds to waist level, no lifting of 25 pounds overhead with no excessive bending, twisting, reaching, pushing or pulling. He also continued the anti-inflammatory prescription from Emergency Care (800 mg Ibuprofen 3 times per day) in addition to prescribing Flexeril for what he felt was spasm in both the cervical and lumbar spine areas. He had a set of X-rays performed in his office which he felt demonstrated a "mild straightening of the cervical and lordatic curvature/early stage mild osteoarthritis C4-7 and L3-5." The Respondent accommodated the modified duties so there continued to be no compensable lost time. This was a great relief to the Petitioner because he did not want to be completely out of work. This was not only a function of his abnormally high work ethic, but he was also fearful that his employer might terminate him if he had a work-related injury. He knew two previous co-workers who were terminated after sustaining work-related injuries over the past 2 years. This "concern" became persistent and progressively more serious over time."

Following the initial 4-week period of physical therapy the Petitioner was re-examined by Dr. Payne on August 10, 2016 at which time the Petitioner essentially presented the same overall symptomatology and clinical presentation. His complaint of cervical spine pain was 3-5/10 and with similar description of pain with respect to the lumbar region. Frankly he was underestimating his subjective pain perception for fear the doctor would diagnose him with a "serious" injury (which to him meant possible job jeopardy.) He didn't want to be "terminated employee #3." He felt his headaches were "slightly" improving both with respect to severity and frequency and were now occurring approximately once a day "for an hour or so" mostly while at work and "less so while at home."

The doctor prescribed another 3 weeks of physical therapy three times per week and gave the Petitioner encouragement that he was going to be "fine" stating that "soft tissue injuries can take a while." Petitioner felt very reassured by Dr. Payne who advised the Petitioner that he did not have a "serious" neurologic problem and that he would likely discharge him at the time of the next office visit after physical therapy unless there was some significant change for the worse in his overall symptomatology. He advised the Petitioner that he would likely prescribe a home exercise program with a focus on range of motion exercising and core strengthening which in part were already being conducted in a formal physical therapy setting. He also advised the Petitioner that he should attempt a weight-reduction program with a target of losing 50 pounds which should help "immeasurably" with his low back symptoms. He suggested that either his primary care physician could assist him in that regard or he could see a "nutritionist" through a

prescription from his primary care physician. He further advised the Petitioner the x-rays that were performed regarding his neck and low back showed some early arthritic signs but "nothing too serious." He said it basically comes with age and the wear and tear of life "especially given the hard work you've performed over the years. It takes its toll."
This last statement did not appear in his office chart.

The Petitioner returned on August 31 after completing 3 weeks of physical therapy with no significant change in either his symptomatology or his clinical presentation. The Petitioner was becoming increasingly concerned about the persistency of his symptoms but he was assured by Dr. Payne that he had nothing more significant than a "soft-tissue injury" and that "these types of minor spine injuries" sometimes take "a while" to "fully heal." Dr. Payne said the important thing was that he did not have any severe radiation of pain down his arms or his legs and once again he observed that some people simply "take longer" to fully heal than others. The doctor did not feel that he needed any further prescription medications and that he could now take over-the-counter Ibuprofen "as needed." He advised that the Petitioner should come back in if there was any significant "change in symptoms" because he was being discharged to a less formal home exercise program. The doctor asked the Petitioner if he felt he could safely perform his regular duties and the Petitioner unhesitatingly said "ABSOLUTELY, DOC!!!" The doctor said "then I am going to release you to return to work full duty – no restrictions." This was the happiest moment the Petitioner had experienced over the last two months. He shook the doctor's hand heartily and gave him a brotherly hug. The doctor smiled and said "good luck." The doctor thought "if only most of these comp patients were like Mr. Jones."

The Petitioner decided that he was going to continue with a more aggressive course of chiropractic management than his previous regimen of maintenance one time per month. He now wanted to start with a chiropractor for one time per week which he felt would be a good supplement to his home exercise and weight loss program, the combination of which he felt would accelerate his recovery. He was careful not to complain at work and he was concealing his symptoms at home so that his family would not unduly worry about him. He continued this regimen for the next 6 months.

Since he was no longer on modified duty, he was very careful in how he performed his employment duties so that he would not further aggravate either his neck or low back pain. He re-learned proper lifting techniques in his physical therapy (which he had already been taught following his cervical spine surgery and for which he was frequently reminded by his chiropractor). Bend the knees, keep the lifted weight near your body, etc. He basically continued to work in pain during most days. It was becoming his "new normal." He did not seek any further workers' compensation treatment as he strongly believed Dr. Payne when the doctor advised him that he would "get better" but it would "take time". He figured he couldn't be too seriously injured since Dr. Payne had probably seen thousands of similar injuries and if anyone knew about spines, it would be Dr. Payne, after all, he was a general orthopedist.. He decided to have his continued medical treatment managed by his primary care physician Dr. Hope Moore who he first saw on September 15, 2016. She had been his physician for the past 10 years. He saw her mostly on the rare occasions when he had a cold, the flu or an upset stomach. He provided her with a full history of his situation and basically advised that while it was initially a workers' compensation claim he was discharged by the authorized doctor and he

just wanted to get "fully healthy." He was hoping that she would be able to help him. He had the formal discharge note (with "full duty" return to work) from Dr. Payne and he further advised Dr. Moore that his situation was "no longer a workers' compensation claim" since he was actually discharged and therefore he wasn't entitled to any further workers' compensation benefits.

Dr. Moore performed a physical evaluation of him where she noted decreased range of rotational motion in the cervical spine by 40 degrees, 15 degrees lacking of flexion/extension with palpable bilateral trapezial spasm; palpable paravertebral lumbosacral spasm with decreased forward flexion of the lumbar spine by 30 degrees. The straight leg raising test was positive bilaterally at 50 degrees but there were no muscle, reflex, sensory or strength abnormalities in either the upper or lower extremities. Actually she was surprised at the clinical findings and given the relative minimal physical therapy he had received.

The Petitioner was having some difficulty sitting in a normal upright fashion and instead was seated with his buttocks forward so that his mid and upper back was leaning on the back of the chair. She recommended that the Petitioner be seen by a pain management physician for possible injection modalities regarding his "chronic cervical and lumbosacral pain." She also provided encouragement to the Petitioner that because his pain was "axial" in nature (except arguably for his positive straight leg raising test) and that there were no "obvious" signs of any "significant" neurologic dysfunction his prognosis was "very good" and he should make a "complete recovery." Again, this was well received by the Petitioner who at this point in time was now developing increasing "anxiousness" over the chronicity of his symptoms and the impact this may have on his ability to maintain employment with his present employer. However, he kept these negative thoughts to himself.

The Petitioner spoke to his wife about undergoing "narcotic injections" as suggested by Dr. Moore. They decided that he would not schedule any such evaluation for fear that the narcotics that were injected into his system would cause more harm than good. The Petitioner had a twin brother, (John James) who became addicted to prescribed opioids in connection with a serious motor vehicle accident and ultimately died of an overdose approximately four years prior on January 10, 2014. This was a devastating loss to the Petitioner. He was closer to his brother than anyone. His brother was a role model. He was an academic and an athlete. He was captain of his high school baseball and soccer teams. His brother's crippling spine injury was difficult for the Petitioner to accept and basically the injury ruined his brother's life. When his brother died, part of the Petitioner's spirit also died, but the Petitioner never let anyone know of the grief and pain which that loss caused. He felt that "he needed to deal with it like a man" (which meant to him, no visible signs of weakness.) He never saw a psychiatrist notwithstanding that he knew the loss had caused him a deep permanent void. He vowed he would never let anything like what happened to his brother happen to him.

The Petitioner was understandably loathe to take any narcotic medications especially when he felt that if he could lose some weight and keep exercising, eventually he would make a full recovery just like the doctors stated. Over the next few months he lost 25 pounds and exercised for a half an hour every morning before work and every evening after work. Unfortunately his overall condition did not improve. By December 15, 2016 Petitioner returned to Dr. Hope

Moore who was surprised to learn the Petitioner did not avail himself of the pain management she prescribed. However, she somewhat understood the dilemma Petitioner found himself in especially since she was also the primary care physician for Petitioner's deceased brother but she was not the physician who had prescribed the opioids to address his chronic pain presentation. That physician, Dr. Felix Fraunt, was convicted of insurance fraud regarding illegal opioid prescriptions. She felt that it may be that a MRI study of the cervical region and low back might be of some assistance in better assessing a more definitive diagnosis which might give some further insight as to treatment options but that she also continued to further assure the Petitioner that he would not require any type of spinal surgery. She also recommended that he consult with a workers' compensation lawyer to determine what further rights he may have under the workers' compensation laws. She did not feel that she was "a spinal "specialist" but that now the Petitioner had a "chronic problem" that may very well be characterized as a "pain disorder" but wouldn't likely require surgery and wouldn't take the Petitioner out of work so long as he could tolerate the pain. She felt the MRI studies might reveal some specific diagnosis that could be amenable to more "targeted treatments." She felt there may be some workers' compensation "options" available to him. She wrote a formal prescription for both a cervical and lumbosacral MRI study both of which were performed on December 20, 2016. (See attached MRI reports).

She saw the Petitioner on December 24 after reviewing the MRI reports. She advised that while she was not an "expert" on reading the actual films, according to the radiologist Petitioner basically had "multi-level mild degenerative disc disease and mild osteoarthritis of his spinal vertebrae" in both his neck and low back but that none of this was the result of his workers' compensation accident but rather genetics, aging and working hard for so many years.

She then went on to explain to the Petitioner that chronic spine pain was one of the more difficult problems that modern orthopedic medicine faces not unlike the challenge of the common cold to the primary care physician. She advised that there are only so many options available and once a condition is chronic it can be difficult to obtain a definitive solution other than the passage of time, a healthy lifestyle and a "little luck". She advised that unless he wanted to reconsider a pain management physician there wasn't anything further that she could offer other than advising him to be careful at work regarding lifting and to make certain that he maintained proper posture together with continuing his present regimen on weight loss together with range of motion exercising together with his core strengthening exercising. She suggested yoga or pilates might be helpful and maybe even acupuncture. She realized and placed in her office notes, that Petitioner's presentation was challenging and he was "struggling" with a "progressively debilitating condition." The Petitioner relaxed his chiropractic schedule to once per month and did consult with workers' compensation attorney Michael Monet, Esquire who filed a formal Claim Petition on his behalf (CP 2017-0000) on January 2, 2017.

Mr. Monet was a general practitioner who was beginning to develop workers' compensation as a more significant part of his practice. He advised the Petitioner that he had a "legit case" especially because of his prior serious neck problem which was "clearly" aggravated by his fall. He advised that the Petitioner probably had a "mis-diagnosed post-concussion syndrome" especially since he was still experiencing headaches and lightheadedness but that it may be "too late" to obtain any meaningful treatment. The Petitioner was relieved to learn that "misdiagnosis" was not necessarily medical malpractice as the Petitioner was not litigious and

actually respected the medical profession, even the Respondent's authorized treatment segment. Monet advised that the Petitioner had a "really bad strain" of both his neck and back but that he "probably" did not have any major problem since the MRI reports did not indicate any clear "disc herniations" which the workers' compensation law "basically required" for anyone's spine problem to be taken "seriously" under the law. However he also advised the Petitioner that "clearly" the workers' compensation carrier had "minimized" the seriousness of his problem especially for someone as hardworking and loyal as he was. Monet indicated that the carrier was taking advantage of his decency and his not complaining by having the most conservative physicians see him and not referring him to other physicians for a more thorough investigation of a course of treatment which would be of potential benefit to him. Monet advised that he would schedule a "permanency evaluation" and make sure that the Petitioner received the compensation that "he clearly deserved." [Clearly Mr. Monet was very fond of the adverb "clearly."] Mr. Monet stated it was "too early" to predict the "full value" of the Petitioner's case but there was "clearly no doubt" that he was entitled to additional compensation and he "guaranteed" Petitioner would be compensated. Otherwise Monet would never take the case since his fee was on a contingency "set by the judge" not in excess of 20% of the recovery. No recovery – no fee. That was his motto. His would be a "guaranteed" result. Monet further stated that it was extremely important for the Petitioner to pursue his permanency rights since his monetary recovery would protect him in the future and would provide him with further re-opening rights for future medical treatment and increased permanency benefits depending upon developments.

Monet asked Petitioner if he was on Facebook. Petitioner said he was not but his wife was. Petitioner thought this was an odd question. Monet explained how the insurance company would likely be searching for evidence about his functionality and Facebook was increasingly becoming a source of damaging information to many claims. Petitioner was mildly perplexed. He said his life was an "open book." He explained that his wife loved his immediate family (as did he) more than anything and the documentation and sharing of family happiness and joy (especially that he was now more limited) was vital to her happiness. Petitioner assured Monet that there used to be photos with Petitioner being athletic but those days are "long gone" and that the photos depict nothing more than a loving family trying to enjoy their life together. Monet was satisfied.

The Petitioner was very excited about the prospect of having further medical coverage for his conditions because he felt that this would be of great help to both himself and his family if he needed further medical treatment if his condition significantly worsened especially if he wasn't able to continue working (which was a thought which he was experiencing more frequently). He was having an increasingly difficult time performing the more physical aspects of his job but he did not want to let anybody know about the problems he was having because of his increasing concerns about his continuing employment potentially being at risk.

Following the filing of the Claim Petition, an Answer was filed in a timely fashion by the Respondent and "orthopedic" permanency evaluations were obtained by both parties with a full discovery exchange inclusive of all prior records in connection with the Petitioner's previous cervical spine surgery; the complete chiropractic records of Dr. Knipp and the complete primary care physician's records from Dr. Moore. Petitioner was seen by a Dr. Jules Irving on June 1, 2017 and Petitioner was seen by Dr. Monte Jordan on behalf of the Respondent on June 2, 2017.

At the first pre-trial listing on September 1, 2017, Petitioner's attorney was surprised to learn that it was the Respondent's position that the Petitioner was not entitled to any compensation whatsoever for permanency because he had nothing more than "minor" strains of the neck and low back and as such he was not entitled to any compensation under the statute for failing to reach the statutory threshold. The Respondent's basic argument was that the Petitioner "only" had 7 total weeks of physical therapy of a fairly benign nature and "successfully" completed the same (being released to "full duty" employment) with no compensable lost time, no change in income, no diminution of his employment duties after a brief "modified duty period" with no request for further treatment. If that wasn't enough, Respondent's attorney also advised that even if there was a de minimus permanency awarded, there was no pre-existing disability as to the cervical spine since the Petitioner was completely functional at the time of the accident and therefore there would be no 12d credit or certainly not the amount that was awarded in 2006. It was Respondent's further position that the Petitioner's gross weekly wage was $800.00 giving rise to a temporary disability rate of $560.00 (40 hours at $20.00 per hour). The Respondent's counsel Donald MacDonald was a highly experienced and well-respected Respondent's attorney with a strong medical background [he had been an emergency room physician before starting a legal career in workers' compensation]. He also had a reputation of "taking advantage" of less experienced Petitioner's attorneys. He strongly viewed New Jersey workers' compensation as essentially an "adversary system" wherein his responsibility was to pay as little as possible on every case he "defended" regardless of the facts or issues presented. He was extremely fiscally conservative. His firm's website tagline was "Quality workers' compensation representation should not cost you an arm and a leg!"

Petitioner's attorney was surprised at Respondent's ultra-conservative position on this case. MacDonald was a no-nonsense attorney who clearly knew comp and had been practicing workers' compensation exclusively for the last 25 years. He received the first New Jersey Supreme Court Workers' Compensation Law Attorney certification whereas Monet had handled only 25 workers' compensation claims in his entire career. He actually thought that this was one of his "better" non-surgical cases especially with respect to an individual as credible and hardworking as this Petitioner was. He had thought of the case as a "slam dunk" permanency case which he valued in the area 10% compensable cervical permanency "stacked" on the 27 ½% cervical award and at least another 10% with regard to the low back making the overall award 47 ½% apportioned 37 ½% cervical, 27 ½% pre-existing and 10% permanent partial disability for the low back. MacDonald advised Monet that the absolute "most" that he would be willing to consider was a Section 20 payment equivalent to a 10% rating (60 weeks of compensation totaling $13,920.00.) He advised that he would recommend a $15,000.00 Section 20 figure to also take care of some part of fees and costs which he considered to be a "very generous" offer. That was also his "final offer." He further suggested that if the Petitioner's attorney had any questions he would certainly be amenable to discussing the same with the Judge of Compensation who he was "certain" would feel that this was a "fair offer" in view of the paucity of findings with respect to any compensable "demonstrable objective medical evidence" of permanent loss of function. He said Petitioner's subjective complaints were irrelevant since there wasn't sufficient objectivity to meet the first prong of Perez without which there could be no permanency. He stated that normally he doesn't consider Section 20 permanency when the Petitioner is still working for one of his clients, but he would make an exception here since the Petitioner seemed to be a "nice guy" according to his insured and Monet, while inexperienced,

was conducting himself civilly and respectfully which he appreciated. Monet said he would have to speak to this client although, "respectfully" he felt the offer to be "a little light."

Following the September 1, 2017 pre-trial "conference" [without judicial involvement] the Petitioner's attorney contacted one of his colleagues concerning the Section 20 settlement offer and the circumstances of the claim. Monet did not glean any real insight into the "value" of his claim and therefore decided to have a meeting with the Petitioner personally to discuss the options including communicating the offer. At an office meeting on November 1, 2017 Monet explained the situation to the Petitioner and advised the "only way" the claim was going to be resolved would be by way of a one-time lump sum Section 20 settlement in the gross amount of $15,000.00 which he suggested normally would be a "substantial" payment for a "soft-tissue" injury. The Petitioner was stunned at this suggestion especially since it seemed to be completely contradictory to everything Monet had previously indicated to him about the strength of his claim and the importance of the future protection which was one of the main reasons why the Petitioner decided to get representation in the first place. The Petitioner then advised his attorney that he had been "suffering" with his situation for 16 months with modern medicine offering him absolutely nothing in terms of any type of meaningful relief. He did not want to end up like his brother. Surgery was not even a suggestion (and even if it was, it is doubtful the Petitioner would undergo the same). He explained, partially tearfully, that he had completely failed at any type of meaningful physical rehabilitation despite doing everything that his chiropractor and primary care physician was suggesting. He even underwent additional "core physical therapy" suggested by Dr. Moore from June 1, 2017 through September 1, 2017 at a cost of $5,000.00 paid entirely by his wife's ERISA based insurance coverage. The therapy was provided by "Ultimate Recovery Fitness" which Dr. Moore felt was by far the finest rehabilitation/fitness facility in the area. Petitioner had provided a complete and accurate medical history at the time of his application. Monet never requested these records as the "unauthorized" program did not help and the bill was paid by a collateral source. No formal lien was filed by the carrier. Monet had not previously appreciated the depth of Petitioner's suffering and was moved by the sincerity and severity of Petitioner's description. Monet felt compelled to try to help but didn't really know what to do.

Petitioner then advised that he had also been referred to an "alternative" medicine physician who felt he was a candidate for enrollment in New Jersey's Medicinal Marijuana Program. He saw Dr. Mello one time only (September 10, 2017). He said it was by far the longest he spent with any physician. She reviewed all his diagnostic studies and put him through an extremely complex clinical evaluation. He felt this was an extremely exciting potential development. She even inquired about his emotional status and psychiatric history. He explained his opioid aversion and the reason he felt as he did.

He had never previously used marijuana recreationally or otherwise, but two of his closest friends knew of two different people who had benefitted from medicinal marijuana and Petitioner felt that this was at least an option that held out at least some potential for improvement in the quality of his life. Nothing else had even remotely helped. He realized that there was no insurance coverage yet for this type of treatment and therefore he would have to pay out of pocket to avail himself of this "state of the art" treatment. However Petitioner was rejected by the program. He was advised he didn't have a serious enough problem to meet the

program's original pre-requisites. Also, he did not have the funds for long term treatment. He was devastated about these developments. This ineligibility of availing himself of a possible non-opioid pain management solution to his problem was a difficult pill to swallow.

The Petitioner asked Monet whether this medicinal marijuana treatment could be obtained under the workers' compensation law since clearly the workers' compensation injuries were the reason he needed this potentially helpful treatment. Monet advised that it was not likely, but the issue could be raised at Trial if his treating doctor would state the need for the same. Frankly, Monet had no experience regarding medicinal marijuana, nor had he ever filed any motion for medical and temporary disability for that matter. He thought medicinal marijuana was limited to a few extremely "debilitating" conditions and even then it was strictly limited.

Monet advised that since this was "unauthorized" treatment and that there had not been any "request for treatment" the carrier would not be paying for any "medicinal marijuana". Petitioner then asked whether or not Monet could make a request for treatment and he could probably get a prescription and report from Dr. Mello who had told him she would be happy to help him in any way she could. It was Petitioner's understanding from Dr. Mello that he had both a qualifying "anxiety" and an "intractable chronic musculoskeletal pain disorder." Monet advised the Petitioner that while this would likely be a futile undertaking as there would be "no way" that the workers' compensation carrier would voluntarily provide medicinal marijuana probably even if it was recommended by its own authorized physician. Monet advised he believed while at the present time the issue was very controversial, perhaps within a few months there could be better legal precedent or even a change in the law for specific legalization. He said there are thousands of injured workers in the "same boat" and sooner or later something "had to give." Petitioner asked if the need for ongoing future medical treatment could be part of his permanency case and Monet advised he did not see why that could not occur especially if it was going to be some type of future chronic pain management that was only going to be "palliative." He advised that that issue would probably be placed in part as part of the trial if he could not otherwise resolve the claim. Petitioner advised that he did not feel that a $15,000.00 payment could possibly be adequate especially if he "needed" medicinal marijuana for a condition which he felt was "entirely" a workers' compensation disability. Monet then inquired further about Petitioner's "anxiety" diagnosis and whether he had seen a psychiatrist. Petitioner explained that all he knew was that he told Dr. Mello he wasn't sleeping due to his pain and that he was worried about his future. Monet amended the Claim Petition to add "anxiety" or "chronic musculoskeletal pain disorder." He notified Respondent's attorney to expedite scheduling a psychiatric evaluation even though there was no formal psychiatric treatment. Both neuropsychiatric evaluations were performed on February 14, 2018.

Monet further advised MacDonald that the matter would have to be tried as the $15,000.00 Section 20 offer was rejected.

A formal e-mail was sent to MacDonald requesting medicinal marijuana and psychiatric treatment and MacDonald responded that his client would not consider, under any circumstance, the authorization of medicinal marijuana which it felt was a violation of federal law. The carrier was not going to knowingly commit a federal criminal offense. MacDonald further advised that it was his position that if the Petitioner was seeking treatment then the claim was not "ripe" for a

permanency consideration and an appropriate motion would have to be filed which would be appealed in the highly unlikely event that a judge found in the Petitioner's favor. Monet then further consulted with the Petitioner and concluded that rather than making an application for medicinal marijuana medical treatment at this time, his preference would be to have the Petitioner's medical marijuana claim addressed at the time of the permanency trial as part of the need for ongoing "palliative" care and to bolster the claim by way of a psychiatric assessment. Monet also saw the potential for compensable psychiatric disability "stacked" on prior depression with the compensable disability resultant from both Petitioner's chronic pain and anxiety, but also ironically (in part) resulting in a significant depression resultant from not being eligible for the "illegal" medical marijuana program and thereby losing an ever-shrinking chance of his getting better. He thought this might even be a "novel" theory of liability that could gain him enhanced stature with MacDonald.

It was ultimately agreed at the time of the next pre-trial conference (at which time both sides were ready to proceed), that permanency remained contested. Respondent had no interest in violating federal law and would not even need to obtain an evaluation in opposition to the opinion of Dr. Mello and that as an accommodation to the court it would allow Dr. Mello's report in order to expedite a disposition of the claim which Respondent felt had de minimis overall value.

At the next pre-trial listing the judge conducted a brief pre-trial conference at which time MacDonald advised the judge that the matter will have to be tried as the Petitioner has rejected a $15,000 Section 20 settlement offer and the parties were otherwise ready to proceed. MacDonald further stated he did not believe any further discussions would be fruitful. He advised the court that both sides are ready to execute the pre-trial memorandum with the main issue being the nature and extent of any compensable permanency with each side having two permanency evaluating physicians who would testify. The Honorable Benjamin Warren Wrightman had been a member of the New Jersey Workers' Compensation Judiciary since January 2, 2014. He was not yet tenured. He also had three lists per cycle with MacDonald who he felt was a very competent workers' compensation attorney. If MacDonald indicated a case must be tried there was usually a bona fide basis for doing so. Judge Wrightman would not normally "pre-judge" a case. He would let the proofs unfold organically. He was not particularly enamored with the 3-week cycle system for trial dates as he felt that it was not the ideal method of having a case decided, but he was not one to "rock the boat." He was an avid supporter of the Justice James H. Coleman, Jr. New Jersey Workers' Compensation American Inn of Court which he felt was an excellent organization and a valuable learning tool for attorneys and judges alike. (He also correctly believed it was the longest named Inn in the nation.)

He was appreciative of preparedness, confidence, professionalism, civility, collegiality and candor to the tribunal. MacDonald had tried five cases to a conclusion before Judge Wrightman and won all five of them. All five were on entitlement to permanency benefits. He always felt that MacDonald had a strong understanding of the issues presented in any case and normally was very efficient with respect to both his direct and cross-examination. He got to the point and focused on the relevant issues presented.

On the other hand, Judge Wrightman had virtually no experience with Monet, other than his conduct of pre-trial conferences. Monet had never tried a workers' compensation claim nor even started one. Monet was the first one to admit that he was relatively inexperienced in workers' compensation but he was a certified civil trial attorney and was considered a competent personal injury attorney. Judge Wrightman had a reputation for being fair and intellectually honest. These were judicial virtues which Monet held in the highest of esteem and therefore liked appearing before Judge Wrightman.

On April 5, 2018, the pre-trial memoranda were executed with the trial to start June 4, 2018. There was a scheduling order signed by the parties. Opening statements and Petitioner's direct and cross-examination would be on Trial Day 1; Petitioner's evaluating orthopedist Trial Day 2; Petitioner's evaluating neuropsychiatrist Trial Day 3; Respondent's evaluating orthopedist Day 4; Respondent's neuropsychiatrist Day 5; closing arguments Day 6. He expected a complete exhibit list prior to the doctors' testimony and confirmed with the parties that there was no surveillance or other fact witnesses being presented. Monet had not agreed to wage and rate. There was an agreed stipulation that the issue of Petitioner's potential need for medicinal marijuana could be addressed by the court primarily during the permanency trial on the basis that Respondent's position was as a matter of law that this could not be ordered by the court under any circumstance and it might as well be addressed now rather than later in the case or on a re-opener. The Respondent required a finding that the same would be stipulated as "palliative" and not "curative" and Monet agreed. Additionally Judge Wrightman required an exchange of the permanency reports at the time of the execution of the pre-trial memo which did occur. However attached to each of Respondent's paper copy permanency reports was a covering letter inadvertently attached by MacDonald's secretary which covering letter basically set forth Respondent's "position" to his experts with respect to the claim with a clear recommendation for findings expected or lack thereof by the Respondent. The covering letter to each physician was not discovered by Monet until the night before he was first preparing for cross-examination of Petitioner's orthopedic expert which was the very first time he actually even looked at the expert's report recognizing the covering letter which presumably was not meant for his file but also was correspondence that he felt was fertile ground for cross-examination as to the experts' absence of objectivity relative to his opinions concerning compensable disabilities. The handling of this issue will be part of the Mock Trial. Have fun.

EPILOGUE (POST TRIAL AND DECISION) CONSIDERATIONS

1. Assume there was a permanency recovery in this claim and the Petitioner then filed a timely post-judgment application for medicinal marijuana since by that time the program was more commonplace and accepted. (You may assume "palliative" medicinal marijuana was not awarded.) The Petitioner prevailed and an order for medicinal marijuana was entered by the court. The treatment in turn had the hoped for beneficial impact on Petitioner's functioning so long as he maintained a relatively low-level dosage. It was determined by the court that the marijuana usage had to be maintained on a "palliative" basis to sustain the Petitioner's improved function and therefore an order was entered for indefinite treatment "until further order of the court." Because of this provision, Petitioner waived any claim for increased permanency benefits since he was so grateful to have improved overall functioning. However, Respondent then filed its own Application for Review or Modification to have the permanency award reduced. Would such an application be viable under these circumstances and if so, would it matter whether or not the award was already fully paid. Can a permanency be reduced, and if so, what must be proven?

Is there a time limitation for a Respondent's Application for Review or Modification? Can a timely Application for Review or Modification be predicated upon the permanent prescription of a medication to allow increased functionality, so long as the medication was provided.

1a. Assume during the mock trial there was a successful motion for medicinal marijuana which resulted in the same positive therapeutic result as with ongoing continued usage. Permanency evaluations were re-conducted with a finding that none of the experts percentages of disability changed other than the findings of petitioner's psychiatric expert regarding compensable depression/anxiety (each estimate reduced by 10%) on the basis that "the therapeutic maintenance of medicinal marijuana has made the petitioner's chronic compensable pain disorder more manageable which in turn has decreased his levels of depression/anxiety to a moderate degree." How, if at all, would this development impact any compensable permanency award?

2. Assume that one year after the original award was entered Petitioner received a lien letter from his wife's insurance carrier that in light of the award that has been entered for the medical condition for which the insurance has paid in the amount of $5,000.00, the carrier was demanding immediate payment of reimbursement of $5,000.00 since the benefits were paid in connection with medical conditions claimed to be as a result of a work-related injury. What are the basic rights and obligations of an insured who uses an ERISA plan to seek collateral source benefits in a workers' compensation claim? What are the potential defenses which the Petitioner has? What is the potential liability of the Petitioner and/or his/her attorney for failing to satisfy the lien of an ERISA based plan even if the medical provided was unauthorized and not known to be an ERISA plan by any of the parties. What would his options be to address this lien and what would the most advisable course of action be?

SUMMARY OF TRANSCRIPT OF MARCH 1, 2006 ORDER APPROVING SETTLEMENT

Petitioner described his pain as basically a "general achiness in the back of my neck that is there most of the time and varies in intensity between a 3 to a 5 on a scale of 0 to 10." There was "sometimes" a "sharp jabbing pain" that was "more intense" but that was only occurring about "two or three times per month" and seemed to mostly occur with any type of "sudden movement" of his head. He would also experience "frequent" headaches that "seemed to start from the base of my skull and go up to my temples" which would occur approximately once per week and would last about a half an hour to an hour. He described some "radiation" of pain from the neck into his shoulders which seemed to occur more towards the end of the workday. He did not have to wear a brace/collar on his neck. He described his biggest problem as a general "stiffness" of the neck which basically had prevented him from "going back to any of his sports" which had included being both an avid softball player and an avid bowler." He hoped to try to return to them within "a few months." He had basically discontinued both of those sports following the compensable accident and did not return to them until almost a year after he had testified in connection with his claim and gradually progressed in frequency of performing athletics as his functionality improved.

He was also taking at least 800 milligrams of ibuprofen every day; 400 milligrams in the morning and 400 milligrams in the evening. Sometimes he would take two additional pills. He had a prescription for Percocet but he "never used it" after approximately 3 days following his surgery. He testified that he initially had injured his low back but the back pain had only lasted approximately 2 months and he felt that he did not have any ongoing back pain but that it was his intention to continue with chiropractic maintenance so that he could "have the best health possible" both with respect to his neck and his low back. He conceded that he understood that the chiropractic management was not authorized and that he would have to pay the same for himself. He told the court that "the most important thing to me is being able to work and support my family and I want to do everything I can to keep my spine as healthy as possible. I do not intend to do anything that would jeopardize my health but I now believe in chiropractic manipulation. It makes my spine feel more flexible and stronger and I intend to continue to have chiropractic management even once I am able to get back into more rigorous exercising." In response to the question as to whether or not his condition has remained the same, improved or worsened since the time he had been evaluated by the physicians, he stated that he felt that his condition was "slowly improving" and he was hoping that it would continue to do so until "I fully get rid of this problem."

Jules Irving, M.D.
Board Certified
Physical Medicine Rehabilitation, Internal Medicine
Pain Management

431 Complex Street
Northfield, NJ 08215

PERMANENCY EVALUATION

November 1, 2005

Jonas Cochran, Esquire
1750 Main Street
Linwood, NJ 08221

Petitioner:	James John Jones
Respondent:	Waste Away, Inc.
Date of Injury:	January 2, 2003
Date of Examination:	November 1, 2005

Dear Mr. Cochran:

Mr. James John Jones presented for a permanency evaluation in connection with the above referenced work-related injury. The narrative that follows is a summary of the review of the relevant medical records that were provided to me for the purpose of this evaluation. The history and complaints have been obtained from the Petitioner and the clinical findings of the physical evaluation are the results of my personal assessment of the Petitioner.

Mr. James John Jones is a 35 year old male who sustained a serious cervical spine injury during the course and scope on his first day of employment as a driver for Waste Away, Inc. on January 2, 2003. He states that his vehicle was struck in the driver's side door by a pick-up truck which was being operated by an intoxicated individual who ran a red light. The collision caused a significant torsion and flexion/extension trauma to the patient's cervical spine.

The trauma caused Mr. Jones to lose control of his vehicle which then struck a telephone pole causing a brief loss of consciousness.

Mr. Jones was taken by ambulance to the Smithtown General Hospital where x-rays were taken which were negative for fracture.

The Petitioner was admitted for a one-day observation in view of his having lost consciousness and complaining of a severe headache. A brain MRI study was negative as was a skull CT scan, however, a cervical spine MRI study revealed a significant herniation at the left side at C6-7 with

cord contract but no significant indentation of compression. The Petitioner had left-sided radiculopathy. He was seen in neurosurgical consultation by Dr. Samuel Greene who felt that he could safely be discharged for conservative management.

He did not undergo any meaningful physical therapy because it was only making his symptoms worse. He was developing an increase in cervical spine pain with increase in left-sided radiculopathy.

The patient had declined any recommended epidural injections and it was determined that the Petitioner required a C6-7 instrumented fusion to decompress and stabilize his massive disc extrusion which was causing both radiculopathy and myelopathy.

The above-referenced surgical procedure was performed on August 1, 2004 notwithstanding that the original surgery was recommended in May of 2003 but the patient wanted to try everything he could to avoid undergoing surgery. Ultimately the patient had a relatively uneventful surgical rehabilitation. The patient had been preliminarily terminated from his position when he failed a functional capacity evaluation, but upon union intervention, another functional capacity evaluation was performed which demonstrated the patient's ability to perform the essential functions of his job duties.

He had some low back pain initially following the accident, but his symptoms fully resolved after a few weeks.

Mr. Jones now presently complains of pain averaging a 3-5/10 at baseline and worsens to 7-9/10 with any type of overhead exertional activities. He has residual numbness in his left upper extremity in the C6-7 distribution. He has been permitted to resume full duty employment with no lifting restrictions. He currently is taking 2 200 mg of Advil/Tylenol in the morning and evenings and on more physically demanding days, he is taking double the dosage. He is continuing stretching exercises on a daily basis.

He had been an avid bowler and softball player, neither of which he has performed since the compensable accident. He no longer goes into the ocean which he previously enjoyed. He tends to twist his torso to look in the side view mirrors while driving rather than rotating his head. He has some difficulty swallowing. The swallowing difficulty occurred during intubation in connection with his ACDF, however he has not had any formal diagnosis of any esophageal issue on either a traumatic or a neurologic basis.

PHYSICAL EXAMINATION: Physical examination reveals a well-developed male in moderate distress with pain especially with overhead reaching or pulling. There was hyper-esthetic sensation to pinprick in the C6 and C7 dermatomal distribution on the left with decreased sensation to pinprick in the C6 distribution in the left upper extremity. Muscle testing revealed 5/5 motor power throughout both upper extremities. Cervical spine range of motion revealed 20 degree deficits in all spheres with palpable spasm and tenderness at C4-T1 with bilateral posterior trapezius tightness.

IMPRESSION: Orthopedic residuals of chronic cervical spine pain with cervical spine loss of motion and left cervical radiculopathy with residual left upper extremity sensory loss and left upper extremity weakness status-post work related disc herniation at C5-6 status-post decompression of large extruded C6-7 disc with anterior cervical discectomy with interbody fusion.

Within a reasonable degree of medical probability, the above noted injuries are directly and causally related to the patient's work related accident of January 2, 2003. These injuries have produced demonstrable objective medical evidence of restriction of function and lessening to a material degree of working ability as well as interferences with the ability to perform activities of daily living as noted in my narrative report above. The objective findings noted in the body of this report have resulted in permanency in the amount of 65% permanent partial disability with reference to the cervical spine. The estimated disability is based upon demonstrable objective medical evidence and restriction of function to a material degree and is based upon a reasonable degree of medical probability. He has no lumbosacral disability.

Mr. Jones was examined for the sole purpose of evaluating permanent disability and has consented to the release of this report.

Sincerely,

Jules Irving, M.D.

JI/vlh

MONTE JORDAN, M.D.
714 Jersey Road
Westmont, NJ 08108

Phone: 609-108-2018

October 31, 2005

Donald MacDonald, Esquire
16 Rockwell Avenue
Northfield, NJ 08215

Re: James John Jones vs. Waste Away, Inc.
Date of Accident: July 1, 2016

Dear Mr. MacDonald:

You requested an Independent Medical Evaluation for the purpose of addressing the issues of permanency made by Mr. James John Jones which examination was performed on October 31, 2005 at 9:30 a.m. The following is the report on that examination. Mr. James John Jones offers the following past medical history, past work history, a history of injury and present physical complaints, statements and past medical history and subsequent unrelated medical history.

PAST MEDICAL HISTORY AND SUBSEQUENT UNRELATED HISTORY: The examinee relates no prior medical history other than the compensable accident of January 2, 2003. The examinee denies any prior to or problems referable to his cervical or low back. He also denies history of any prior surgeries, fractures, motor vehicle accidents or work-related injuries.

ALLERGIES: None.

FAMILY PHYSICIAN: Dr. Hope Moore

PAST WORK HISTORY: At time of the incident in question, the examinee was employed by Waste Away Inc. as a waste removal driver/specialist.

HISTORY OF INJURY OR CONDITIONS: The examinee alleges primary injury to the cervical spine and secondary low back as a result of a motor vehicle accident occurring on January 2, 2003. Following that accident there was a loss of consciousness with an admission to Smithtown General Hospital where X-rays were negative for fracture. MRI study was negative. CT scan was also negative. An MRI study revealed right-sided C6-7 herniation. He came under the neurosurgical care of Dr. Samuel Greene. His physical therapy only made his overall

symptomology worse. He declined epidural injections and ultimately underwent August 1, 2004 C6-7 instrumented fusion and was released to full duty employment after 3 months of post-surgical rehabilitation.

PRESENT COMPLAINTS: The examinee offers complaints regarding low back: occasional soreness and achiness but essentially he feels he has made a "full recovery". Cervical spine: he complains of occasional mild to moderate pain in the neck with increased severity on overhead activities. He has mild numbness in his left upper extremity extending to his wrist. He has no restrictions on his duties of employment. He takes Advil and Tylenol as needed.

The physical examination of the cervical spine reveals an approximate 4-inch horizontal scar in the anterior cervical spine. Range of motion of all spheres lacked 10 degrees. He has 5/5 motor strength throughout both his upper extremities. He has no spasm or tenderness in his paravertebral cervical musculature or lumbosacral musculature. He has a completely normal examination with respect to his lumbosacral spine with full range of motion; negative sitting and supine straight leg raising; no reflex abnormalities.

I find that the patient has a compensable disability with respect to his cervical spine in the amount of 7 ½% which disability is primarily in connection with the impairment associated with his successful cervical spine instrumented fusion. He has no objective evidence of any permanent partial disability in his low back.

Should you have any further information available on this examinee, I would be happy to review it and offer a supplemental report. Thank you for the privilege of examining this patient regarding the incident in question.

Very truly yours,

Monte Jordan, M.D.

MJ/vlh

AMI
APEX MEDICAL IMAGING

474 Apex Avenue
Somers Point, NJ 08244

PATIENT:	James John Jones
MRN #:	920593812
D.O.B.:	01-01-1970
GENDER:	Male
Exam Date:	05/05/2003

MRI OF THE CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Neck pain with paresthesias of bilateral upper extremities after a work related motor vehicle accident of 01/02/2003.

COMPARISON: None

TECHNIQUE: Multiplanar, multisequence imaging was performed on a 1.5 Tesla MRI scanner without intravenous contrast. There is motion artifact on some of the sequences, mildly limiting evaluation.

FINDINGS:

- CRANIOCERVICAL JUNCTION: Unremarkable.
- ALIGNMENT: Normal.
- MARROW: Within normal limits.
- FRACTURES: None.
- SPINAL CORD: No abnormal signal is seen within the cervical spinal cord.
- DISC SPACES: A few mild degenerative changes are seen in the mid cervical region.
- SOFT TISSUES: Within normal limits.

- C2-3: No disc bulge or herniation is seen. The neural foramina are patent.
- C3-4: No disc bulge or herniation is seen. The neural foramina are patent.
- C4-5: No disc bulge or herniation is seen. The neural foramina are patent.
- C5-6: No disc bulge or herniation is seen. The neural foramina are patent.
- C6-7 There is a large central to left-sided disc herniation impinging the bilateral sides of the thecal sac and to a lesser extent, the cord with bilateral inferior extrusion to the disc margin
- C7-T1 No disc bulge or herniation is seen. The neural foramina are patent.

IMPRESSION:

1. There is a large herniation asymmetric to the left at C6-7

Date of Dictation – 05/05/2003 at 8:37 a.m.

John Jacobs

AMI
APEX MEDICAL IMAGING

474 Apex Avenue
Somers Point, NJ 08244

PATIENT:	James John Jones
MRN #:	920593812
D.O.B.:	01-01-1970
GENDER:	Male
Exam Date:	12/20/2016

MRI OF THE CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Prior cervical fusion of 06/20/2003 with good recovery with re-injury after a work-related fall down steps with hyper-extension of cervical spine and low back trauma.

COMPARISON: 05/05/2003

TECHNIQUE: Multiplanar, multisequence imaging was performed on a 1.5 Tesla MRI scanner without intravenous contrast. There is motion artifact on some of the sequences, mildly limiting evaluation.

FINDINGS:

- CRANIOCERVICAL JUNCTION: Unremarkable.
- ALIGNMENT: Normal.
- MARROW: Within normal limits.
- FRACTURES: None.
- SPINAL CORD: No abnormal signal is seen within the cervical spinal cord.
- DISC SPACES: A few mild degenerative changes are seen in the mid cervical region.
- SOFT TISSUES: Within normal limits.
- There is straightening of the cervical spine
- C2-3 No disc bulge or herniation is seen. The neural foramin are patent.
- C3-4 Mild spurring is noted centrally with mild narrowing of the canal with mild disc desiccation with bilateral facet arthropathy.
- C4-5 Mild spurring is noted centrally with mild narrowing of the canal with mild disc desiccation with bilateral facet arthropathy.

- C5-6 Mild spurring is noted centrally with mild narrowing of the canal with mild disc desiccation with bilateral facet arthropathy. Mild concentric disc bulging is noted
- C6-7 There is evidence of a solid symmetric instrumented fusion.
- C7-T1 No disc bulge or herniation is seen. The neural foramina are patent.

IMPRESSION:

1. There is a mild degenerative osteoarthritis an degenerative disc disease at C3-6 with mild bulge at C5-6 representing early adjacent disc disease.
2. There is a solid symmetric instrumented fusion with no signs of instability or pseudoarthoris. As compared to prior 05/05/03 MRI study, there is multi-level evidence of early osteoarthritic and degenerative disc disease.

Date of Dictation – 12/20/2016 at 10:17 a.m.

John Jacobs

John Jacobs

AMI
APEX MEDICAL IMAGING

474 Apex Avenue
Somers Point, NJ 08244

PATIENT:	James John Jones
MRN #:	920593812
D.O.B.:	01-01-1970
GENDER:	Male
Exam Date:	12/20/2016

MRI lumbar spine without contrast.

HISTORY: Low back pain without radiculopathy after a work-related fall down steps on July 1, 2016.

COMPARISON:

TECHNIQUE: Multiplanar, multisequence imaging was performed on a 1.5 Tesla MRI scanner without intravenous contrast. There is motion artifact on some of the sequences, mildly limiting evaluation.

FINDINGS:

- There is straightening of lumbar spine.
- Conus medullaris is normal in location and signal.
- At L1-L2 there is no spinal canal or neural foramina stenosis nor any disc abnormality.
- At L2-L3 there is no spinal canal or neural foramina stenosis nor any disc abnormality.
- At L3-L4 there is no spinal canal or neural foramina stenosis nor any disc abnormality.
- At L4-L5 there is no spinal canal or neural foramina stenosis nor any disc abnormality.
- At L5-S1 there is mild disc desiccation with left sided focal bulge abutting the thecal sac.

IMPRESSION:

Normal age specific presentation with minimal early signs of degenerative disc disease at L5-S1

Date of Dictation – 12/20/2016 at 10:37 a.m.

John Jacobs

Jules Irving, M.D.
Board Certified
Physical Medicine Rehabilitation, Internal Medicine
Pain Management

431 Complex Street
Northfield, NJ 08215

PERMANENCY EVALUATION

June 1, 2017

Michael Monet, Esquire
1217 Lock Road
Cherryfield, NJ 08035

Petitioner:	James John Jones
Respondent:	Waste Away, Inc.
Date of Injury:	July 1, 2016
Date of Examination:	June 1, 2017

Dear Mr. Monet:

Mr. James John Jones presented for a permanency evaluation in connection with the above-referenced work-related injury. The narrative that follows is a summary of the review of the relevant medical records that were provided to me for the purpose of this evaluation. A history and complaints have been obtained from the Petitioner and the clinical findings of the physical examinations are the results of my personal assessment of the Petitioner.

Mr. James John Jones is a 48-year-old male who sustained head, cervical spine and lumbosacral spine injuries during the course and scope of his employment as a waste removal "driver/ specialist" for Waste Away, Inc. on July 1, 2016. He states that he had a slip and fall while descending the steps of his employer's rear loading dock and fell forward down five stairs falling face first [striking his forehead] onto a concrete sidewalk with his body twisted and his arms extended forward in a preventative bracing posture to avoid major head trauma. His head nevertheless struck the concrete with force and with a hyperextension of his neck with his torso twisting with his momentum causing him to tumble forward and ending in a supine position on the concrete based area around the loading dock.

He describes immediate knifelike pain in his neck and a "popping" sensation in his low back. He does not recall whether or not he lost consciousness but describes having felt "dazed" for a few seconds.

He was able to drive himself directly to emergency care at which time he had X-rays performed of his neck, jaw and low back all of which were negative for fracture but were positive for mild

osteoarthritic findings throughout the last three cervical and lumbosacral vertebra. He was diagnosed by that facility as having suffered "facial contusions and abrasions" together with "cervical spine and lumbar spine pain". He was prescribed 800 mg of Ibuprofen three times per day and was referred to "Back to Work Medical" for any further assessment which he would need "if symptoms persisted more than 3 days".

He was given, but did not utilize a "two-day out of work certificate." He actually returned to work the next day performing his regular duties and sought chiropractic treatment with Dr. Manish Knipp by whom he had been treated on a "maintenance basis" for an approximate 15 year period. Dr. Knipp performed manipulations therapy on his cervical spine and lumbosacral spine. The chiropractic modality did not help him and he ultimately was seen at Back to Work Medical on July 16 and on July 17, 2016 by Dr. James Payne (orthopedic surgeon) Dr. Payne performed a routine orthopedic clinical assessment and his impression was "closed head trauma", "neck and low back pain" with a diagnosis of "mild cervical and lumbar strains without radiculopathy".

Petitioner underwent a total of 7 weeks of physical therapy which did not improve his clinical presentation or symptomology. He had been placed on modified duties and had no compensable lost time. He continued with Ibuprofen 800 mg three times per day and was also undergoing a regimen of Flexeril for cervical and lumbosacral paravertebral spasm. The X-rays performed at Emergency Care demonstrated "mild straightening of the cervical and lordotic curvature" together with an early stage of mild osteoarthritis C4-7 and L3-5.

Dr. Payne discharged him for full duty on August 31, 2016 with "no restrictions". The Petitioner thereafter saw his primary care physician [Dr. Hope Moore] beginning September 15, 2016. She found that his bilateral cervical rotation was decreased by 40 degrees; cervical flexion and extension both decreased by 15 degrees with palpable bilateral trapezial spasm; she further found that the lumbosacral spine region demonstrated palpable paravertebral muscle spasm with forward flexion of the lumbar spine decreased by 30 degrees. His straight leg-raising test was negative bilaterally and there was no apparent muscle reflex sensory or strength abnormalities in either the upper or lower extremities.

Her records indicate that the Petitioner was having difficulty sitting in a normal upright fashion. She prescribed a pain management assessment with possible injection modalities regarding her impression of "chronic cervical and lumbosacral pain". It should be noted the Petitioner had also been complaining of headache and continued lightheadedness but there was no referral to a neurologist notwithstanding the signs of a post-concussion disorder at that time. She also took a history of Petitioner developing increased "anxiousness" over the failure of his symptomatology to improve and that he was similarly concerned about maintaining employment if his symptoms persisted much longer.

Ultimately Petitioner declined injection modalities. Parenthetically this report should reference that I previously evaluated this Petitioner on November 1, 2005 in connection with a prior January 2, 2003 injury which resulted in massive disc herniation left sided at C6-7 for which he

underwent August 1, 2004 instrumented fusion surgery notwithstanding that this surgery had been recommended in May 2003. This Petitioner was unusually adamant about rejecting any type of injection modalities and he further attempted to defer recommended and obviously needed significant spinal intervention since his spinal cord was compressed and he had significant cervical myelopathy.

He provided a previous history of being "anti-narcotics" and similarly, it appeared that he was taking a very "holistic" view of rehabilitation following his most recent compensable injury.

Petitioner did not improve with conservative management although he was able to maintain full duty employment but described working in "great pain".

He underwent a weight reduction program and lost 25 pounds. He was home exercising both before and after work for ½ hour with a particular focus on core strengthening and improvement of both cervical and lumbosacral range of motion performing prescribed exercises from the authorized physical therapy.

The Petitioner underwent December 20, 2016 MRI studies of both his cervical spine and lumbosacral spine which revealed C2-5 mild spurring centrally, bilateral facet arthropathy and mild disc desiccation at C3-5. At C5-7 there was mild concentric disc bulging. His C6-7 instrumented fusion was intact. The lumbosacral MRI was normal at all levels except L5-S1 which revealed left sided focal disc bulge with disc desiccation.

The patient had undergone a further course of physical therapy at Core Physical Therapy from June 2, 2017 through September 1, 2017 for the purpose of formal core strengthening and range of motion improvement. These records were not provided but this facility is well known to me because it is the facility which has the reputation as being the best outpatient rehabilitation program for most serious orthopedic injuries.

The Petitioner also was seen by Dr. I.M. Mello on September 10, 2017 who felt he was a candidate for epidural and transforaminal injections. It appears that Dr. Mello had also recommended that Petitioner avail himself of medicinal marijuana especially in view of his aversion to narcotic/opioid pain management modalities. He was not accepted by New Jersey's medical marijuana program. He was "extremely frustrated" and extremely disappointed" over his inability to obtain a course of treatment that was efficacious. I would suggest that he should consider re-application as eligibility pre-requisites have been broadened since his rejection and may have better luck. He would appear to be an ideal candidate given his anxiety and chronic pain with his aversion to narcotics/opioids.

The Petitioner advises that following his previous compensable award for his C6-7 instrumented fusion which award was entered on March 1, 2006 [and I have been provided with a copy of that award] his condition slowly but surely improved. He credited continued aggressive chiropractic maintenance program with Dr. M. Knipp as being a material contributing factor to his functional improvement. By the time of the compensable accident of July 1, 2016 the Petitioner had no

restrictions in connection with his employment duties. He was able to work full time employment with routine overtime without restriction. He had been playing competitive softball and was in two bowling leagues with a reported bowling average in the area of 200. He could routinely lift up to 100 pounds on a repetitive basis in connection with his employment with no difficulty or restrictions. He stated that he had no problem with swallowing. He described occasional symptoms in his C6-7 region which he described as achiness with some radiation into his occipital region and upwards into his temples. He did not describe specific headaches but rather a generalized achiness as above described.

His symptoms lasted no more than an hour and the pain was usually not more than 3/10.

Petitioner has no other history of any pre-existing medical conditions or treatment to his head, cervical spine and/or low back. Petitioner continues to work as a waste removal driver specialist and has had no new accidents or injuries.

PRESENT COMPLAINTS:

He has persistent and moderately severe neck pain that is present on a daily basis. There is no radiculopathy. Petitioner describes his average pain as moderate to severe in the cervical spine region. He has moderately severe axial cervical spine pain that is present on a daily basis. He has similar moderately severe low back pain which is axial in nature and only occasionally radiates into his buttocks on a bilateral basis. All activities such as sitting, standing, lifting or bending increases his neck and low back symptomatology and as such the Petitioner attempts to limit as much of his activities as possible impacting his neck and low back. Petitioner is not sleeping well at night. He is up frequently and has to reposition himself. Petitioner is taking ibuprofen 800 milligrams 3 times per day. Petitioner has discontinued bowling and playing softball. Petitioner has had no new accidents or injuries.

PHYSICAL EXAMINATION:

Examination of the lumbar spine revealed lumbar paraspinal muscle spasm with trigger points noted in both lower paraspinal areas with positive jump and apprehension signs. Sensation to light touch was appreciated fairly symmetrically and in all major dermatomal distributions tested in both lower extremities. Reflexes were +1 and symmetric at the knees and ankles bilaterally. Straight-leg raising to 90 degrees was negative for any radiation of pain in the lower extremity. Manual muscle testing of both legs revealed 5/5 motor power throughout. Range of motion of the lumbar spine revealed lumbar extension of 15 degrees [normal 25 degrees], lumbar flexion of 30 degrees [normal 60 degrees], left and right lumbar flexion of 10 degrees ; 15 degrees lumbar normal (25 degrees]. All normal range of motion values were taken from the AMA Guide to the Evaluation of Permanent Impairment, Fifth Edition.

Examination of the cervical spine revealed bilateral paraspinal muscle spasm with trigger points noted at C4-T1. Sensation to light touch was appreciated fairly symmetrically and in all major

dermatomal distributions tested in both upper extremities. Range of motion revealed deficits in all spheres of 20 degrees.

DIAGNOSES:

1. Orthopedic residuals of cervical strain: chronic cervical spine pain disorder, loss of cervical range of motion, cervical myofascial pain syndrome with likely facet arthropathies at C4-7 with degenerative early disc desiccation and of C3 through C7 with early osteoarthritis at C3 through 7 superimposed upon prior C6-7 instrumented fusion with chronic pain disorder, symptomatic facet arthropathies , cervical myofascial pain syndrome, secondary to aggravation of previous asymptomatic osteoarthritis and relatively asymptomatic degenerative disc disease together with compensable facet arthropathies at C4 through C7.

2. Orthopedic residuals with lumbar strain; chronic low back pain with loss of range of motion, lumbar myofascial pain syndrome and disc desiccation with focal bulge with likely facet arthropathy at L5 - S1.

In my medical opinion, within a reasonable degree of medical probability, the injuries above-noted are directly and causally related to the work-related injuries of July 1, 2016. These injuries have produced demonstrative objective medical evidence of restriction of functioning and lessening of a material degree of the working ability as well as interferences with the ability to perform activities of daily living as noted in my narrative report above.

PERMANENCY RATINGS:

- The objective medical findings noted in the body of this report resulted in a 40% permanent partial disability in reference to the cervical spine secondary to compensable residuals only with overall disability greater due to the pre-existing cervical spine instrumented fusion for which the Petitioner has received an award of 27½% of permanent partial total.
- Objective medical findings in the body of this report have resulted in a 30% permanent partial disability in reference to the Petitioner's for lumbar spine solely to the compensable accident of July 1, 2016.

These estimated disabilities are based on demonstrable objective medical evidence and restriction of function of the above body parts to a material degree and are based upon a reasonable degree of medical probability. Mr. Jones was examined for the sole purpose of evaluating permanent disability and has consented to the release of this report.

Sincerely,

Jules Irving, M.D.
JI/vlh

Law Offices of Donald MacDonald, P.C.

16 Rockwell Avenue Northfield,
New Jersey 08215

Certified by the NJ Supreme Court as a
NJ Worker's Compensation Law Attorney

Telephone: 609-873-8713

May 16, 2017

Dr. Monty Jordan
226 76th Street
Smithtown,NJ 08443

Re: James John Jones vs. Waste Away, Inc.
Date of Accident: 01/02/2003
Claim Petition: 2017-001

Dear Dr. Jordan:

The permanency evaluation in the above-referenced matter has been scheduled for June 2, 2017. You will note that you performed a previous evaluation on this Petitioner on June 2, 2005, a copy of which is enclosed for your quick and easy reference. That was in connection with a compensable accident of January 2, 2003, at which time the Petitioner was involved in a compensable accident and ultimately underwent an August 1, 2004 C6-7 instrumented fusion for which you found compensable disability in the amount of 5% permanent partial total. I am also enclosing a copy of the transcript in connection with the Order Approving Settlement entered on March 1, 2006, for which Petitioner received an Award of 27 1/2% of permanent partial total.

Normally this award would be the baseline for all pre-existing cervical spine disability as of the time of the accident of which we are concerned [July 1, 2016] except all the medical records suggest that the Petitioner was functioning with little or no "disability" at the time of the most recent compensable accident. You are not necessarily bound to your previous rating. The issue in this case is the extent to which the Petitioner has any compensable cervical and/or lumbosacral disability. You will note that he has only had 7 weeks of aggregate physical therapy and that he never lost a day from work. He is now doing his full duty employment without any known requests for accommodation. By all reports he was one of the hardest working employees of the 150 waste removal specialists/drivers that the Respondent employs.

You will further note that there is no evidence of radiculopathy from the cervical spine and or lumbosacral spine and the Petitioner has no disc herniations. Please take a careful history to determine what, if any new accidents or injuries he may have had either at work or otherwise. We are not aware of any. If you have any questions please do not hesitate to contact me directly on my cell phone 201-412-3456.

It is Respondent's position that there is no compensable permanent disability because this claim does not reach the threshold of representing "demonstrable objective medical evidence" of permanent loss of function. At best this would appear to he a minor cervical and/or lumbosacral strain and/or contusion based upon the diagnoses of the authorized treating physicians. It would seem that the MRI findings are strictly degenerative in nature both in respect to disc and vertebral appearance. Please do not hesitate to contact me should you have any questions or wish to discuss any of these issues further.

Very truly yours,

Donald MacDonald, Esquire

DMD/fap

MONTE JORDAN, M.D.
714 Jersey Road
Westmont, NJ 08108

Phone: 609-108-2018

June 2, 2017

Donald MacDonald, Esquire
16 Rockwell Avenue
Northfield, NJ 08215

Re: James John Jones vs. Waste Away, Inc.
Date of Accident: July 1, 2016

Dear Mr. MacDonald:

You requested an Independent Medical Evaluation for the purpose of addressing the issues of permanency made by Mr. James John Jones which examination was performed on June 2, 2017 at 9:30 a.m. The following is the report on that examination. Mr. James John Jones offers the following past medical history, past work history, a history of injury and present physical complaints, statements and past medical history and subsequent unrelated medical history.

PAST MEDICAL HISTORY AND SUBSEQUENT UNRELATED HISTORY: The examinee relates no prior medical history other than a previous compensable accident of January 2, 2003 for which I examined for residual alleged permanency on June 2, 2005. The examinee denies any prior problems referable to his cervical or low back. He also denies history of any prior surgeries, fractures, motor vehicle accidents or work-related injuries.

ALLERGIES: None.

FAMILY PHYSICIAN: Dr. Hope Moore

PAST WORK HISTORY: At time of the incident in question, the examinee was employed by Waste Away Inc. as a waste removal driver/specialist.

HISTORY OF INJURY OR CONDITIONS: The history is a compilation of the examinee's statements and a review of the medical records provided as set forth in the report.

Following my previous evaluation of the examinee, an award of compensation was entered on March 1, 2006 in the amount of 27 ½% permanent partial total for the orthopedic and neurologic residuals of the Petitioner's instrumented fusion at the C6-7 level. The Petitioner states that he continued to perform the essential functions of his job duties which were physically demanding without limitation and that he routinely worked overtime.

He states that he actually never missed a day of work since the time of his last examination by me. He further states that his cervical spine condition progressively improved to the point where he was functioning very well (his words) by the time of the most recent alleged compensable accident of July 1, 2016. He stated that he was able to resume a very ambitious non-working exercise regimen including competitive league bowling two times per week and high performing softball play every season prior to the last compensable accident. He also states that he was not on any medication and had no ongoing medical treatment other than chiropractic maintenance management which he basically was undertaking for what he described as health purposes rather than addressing any type of injury or particular symptom complex.

He states that on July 1, 2016 he fell during the course of his employment sustaining an alleged injury to his neck and low back. He was seen at a local Emergency Care facility on the date of the accident and was diagnosed as having soft tissue injuries and was conservatively managed by way of approximately seven weeks of physical therapy through August 31, 2016. He had undergone a December 20, 2016 MRI studies of his neck and low back which did not reveal any trauma related abnormalities. He had no compensable time lost in connection with this claim. He is performing his full duties and is not treating with any physician at this time nor is he taking any prescription medication.

PRESENT COMPLAINTS: He describes ongoing pain in his neck and low back without a radicular component. He continues to be employed in the same capacity as he was before the accident occurred. He describes enjoying activities involving his family, but that he no longer plays softball or bowls because this type of exertional activity aggravates his spine pain. He has specifically declined any use of narcotic medication. He has declined any potentially helpful pain management injection modalities. He states that his pain presentation has not improved with time nor any physical therapy modalities which he has undertaken. He continues on chiropractic management on a maintenance basis which was part of his "health maintenance" program before July 1, 2016. He denies any new accidents or injuries.

He does not utilize any type of brace or supports.

PHYSICAL EXAMINATION:

Height:	5' 6"
Weight	225
Occupation:	Waste Removal Driver/Specialist
Blood Pressure:	126/82
Age:	48
Dominant Hand:	Right
Pulse:	70

Mr. James John Jones presented to the scheduled appointment in a timely manner. The purpose of this IME is to determine permanency and work status and the need for treatment. My opinions expressed in this report are within a reasonable degree of medical probability. I did not engage in any doctor/patient relationship with the examinee. The examinee was aware of this fact. No radiologist images were provided to me for review at the time of this examination.

GENERAL APPEARANCE: The examinee is generally well-developed, well-nourished male who appears his stated age of 48.

He is a right-handed person who does not wear glasses and appears moderately obese, but appears otherwise fit and in no acute distress.

MUSCULOSKELETAL SYSTEM:

Lumbosacral Spine: On gross examination of the lumbar spine there was no measurable or palpable paraveretbral muscle spasms, swelling or tenderness. He appears to have some flattening of the normal lordotic curvature at the lumbosacral spine. There are no trigger points or tender points noted and there was no asymmetry at the erector spinae. There was no sciatic tilt or list noted at this time. Sitting root test is negative bilaterally. Straight leg raising is accomplished to 80 degrees on the right, as well as 80 degrees on the left.

He extends to 30 degrees and flexes to 70 degrees and could reach the lower part of his lower leg, and the movement of the spine appears to be smooth without any muscle spasm or discomfort. He right laterally rotates to 30 degrees and left laterally rotates to 30 degrees and laterally flexes to 70 degrees bilaterally.

He could stand on toes and heels, and accomplish walking in the examination room without muscle spasm or radicular pain. He appears to have a normal gait with a normal walking pattern and secure balance with good coordination.

LOWER EXTREMITIES: There is no joint effusion swelling, tenderness or muscle atrophy noted about the lower extremities.

NEUROLOGIC: There is no focal neurological deficit or radiculopathy noted at this time.

CERVICAL SPINE: On gross inspection, there is an approximate 4" (four inch) size scar of the anterior cervical spine. All range of motion lacked approximately 10 degrees. He had 5/5 motor strength throughout his upper extremities. He has no significant spasm nor any significant tenderness in his paravertebral cervical musculature.

He had a completely normal examination with respect to his lumbar spine. I find that there has been no change in his clinical presentation since he was last evaluated by me except for his complaints of increased "pain" His overall cervical examination is improved over my last evaluation.

I find that he continues to have a compensable disability with respect to his cervical spine in the amount of 5% solely due to his prior cervical repair. This disability is entirely associated with his successful cervical spine instrumented fusion. He has no objective evidence of any permanent partial disability with respect to his low back.

Should you have any further information available on this examinee I would be happy to review it and offer a supplemental report. Thank you for the privilege of examining this patient regarding the incident in question.

Very truly yours,

Monte Jordan, M.D.

MJ/vlh

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February 1, 2018

Dr. Sigmund Voyyd
284 Center Street
Jonesville, NJ 08332

Re: James John Jones vs. Waste Away, Inc.
Date of Accident: 01/02/2003
Claim Petition: 2017-001

Dear Dr. Voyyd:

You are scheduled to evaluate the Petitioner on February 1, 2018, in connection with the existence of any compensable neuropsychiatric disability resulting from a compensable fall which occurred on July 1, 2016. It appears that the Petitioner fell forward down a flight of steps and in fact had actually fallen perhaps three or four steps forward striking his face and sustaining alleged trauma to his neck and low back. He was treated conservatively [7 weeks of physical therapy] which he successfully completed. He did not have any loss of consciousness or alteration of consciousness. He did not lose any time from work. He has had no known limitations in his ability to perform his duties. By all reports he is one of the hardest working individuals who continue to drive a waste removal vehicle.

He has had no authorized compensable psychiatric treatment nor any real psychiatric treatment at all for that matter. He does have what appears to be a prior personal tragedy when his twin brother died approximately 4 years ago. There was no known form of psychiatric treatment in connection with that death but it is well-known to his co-workers that he was very close to his brother and the loss was of significance to the Petitioner.

Apparently he has some level of an aversion to narcotic medications. He has not taken any in his life as far as we can tell. He recently alleged that there may be "neuropsychiatric" residuals in connection with his claim. Please conduct your customarily thorough evaluation and advise what if any compensable neuropsychiatric disability you feel the Petitioner has either with respect to his alleged "concussion" and/or any compensable neck/low back disability. Please note that he did have a prior C6-7 instrumented fusion for which he received the previous award of 27 1/2% permanent and partial total which appears has significantly improved to the point where that disability was probably non-existent at the time the most recent accident occurred.

We are in the process of obtaining whatever additional records exist regarding any previous psychiatric treatment but to the best of our knowledge and based upon answers to interrogatories there have been none presented. As you are no doubt aware the statute normally requires both "demonstrable objective medical evidence" of permanent loss of function and/or material interference in his working or non-working activities. That statute applies to all injuries inclusive of head injury and/or neuropsychiatric claims. Here there has been no objective study indicating that there has been any brain injury nor has the Petitioner actually treated for any alleged "concussion syndrome." The medical records suggest some headache and lightheadedness in the physical therapy records but nothing of any significance and certainly no significant course of treatment. It would appear that by the time this accident occurred most if not all of his previous cervical residuals no longer existed.

A psychiatric claim's case law requires a "careful professional analysis" to support a finding of actual psychiatric disability. It would appear that at most this patient may have had some pre-existing depression referable to his brother's death. He had a twin brother with whom he was extremely close. The brother died of an opioid overdose 4 years ago. Please take a careful history in that regard as it may very well explain most if not all of any psychiatric "presentation" that this patient may have.

Should you have any questions please don't hesitate to contact us.

Very truly yours,

Donald MacDonald, Esquire

DMD/fap

SIGMUND VOYYD, MD.
284 Center Street
Jonesville, NJ 08332

Telephone: 609-123-0796

February 15, 2018

Donald MacDonald, Esquire
c/o MMI INSURANCE COMPANY
P.O. Box 123
Bargainville, NJ 07960

Re:	James J. Jones
DOB:	01/01/1970
Claim #:	ZZZ9876
DOA:	07/01/2016

Dear Mr. McDonald:

Thank you very much for referring to me for an Independent Medical Evaluation, Mr. James John Jones who I examined in my office on February 15, 2018. Mr. Jones was identified by photo ID, was unaccompanied and was advised that there was no doctor-patient relationship.

The following records were reviewed:

1. Employee Claim Petition
2. Respondent's Answering Statement
3. Treating records of Back to Work Medical of 07/16/16 – 08/31/16
4. Chiropractic Records of Dr. Manish Knipp of 01/10/03 – 01/10/18
5. March 1, 2006 Order Approving Settlement for 01/02/03 Motor vehicle accident
6. Treating records of Dr. Samuel Greene – 01/10/03 – 05/01/23
7. Transcript of Petitioner's testimony of March 1, 2006
8. Records of Ultimate Recovery Fitness of 06/01/17 – 09/01/17
9. Treating records of Dr. Hope Moore
10. Report of Dr. I.M. Mello; Treating records/report of Dr. I.M. Mello – 02/10/18
11. Cervical and lumbar MRI studies of 12/20/16

Mr. Jones is a 48-year old married man who states that he was injured on July 1, 2016 while working for Waste Away, Inc. He was employed as a Waste Removal Truck "Driver/Specialist." On July 1, 2016 he fell down "three or four steps" during the course of his employment. Following the accident he was evaluated and treated at a local emergency care on July 1, 2016. He underwent a course of medical treatment which essentially consisted of seven weeks of physical therapy for what appeared to be minor soft tissue injuries through August 31,

2016. He underwent December 20, 2016 MRI studies which were reported to be negative for any trauma related pathology.

The patient did not lose any time from work. The patient has stated he has a chronic "pain" condition for which he is self-medicating.

When asked about his present medical condition, he stated that he experiences constant pain in his low back and constant pain in his neck. Upon further questioning he indicates that it does not prevent him from performing his "full duties" and he further states with some prideful tone in his voice that he has never missed a day of work since this accident occurred.

Mr. Jones' present situation is that he lives in a house two miles from where he works. He has been married one time to his present wife for the past 17 years. They have three daughters ages 15, 12 and 10 all of whom reside in his household. He describes the intra-family relationship as "very close."

His wife and three children are reportedly "doing well."

The Petitioner continues to be employed as a Waste Removal "Driver/Specialist" for the same employer where he has been employed for the last 15 years.

He states that he enjoys watching his children participate in various school activities including sports. They are all softball players and he "never misses a game." He enjoys listening to music, attends church and church social activities. He is capable of driving an automobile without limitation. He will walk for exercise. He does little in terms of cooking, housework or home maintenance, all of which is mostly done by his wife and daughters. Mr. Jones has lived in New Jersey all of his life. He came from a "close family." He denies any prior criminal record by way of any arrest or conviction. He denies the past or present use of alcohol or narcotics. Both of his parents are alive and "healthy." He describes having a twin brother who passed away approximately five years ago after being involved in a very serious motor vehicle accident. He denies any family history of any emotional disorder or substance abuse except for his twin brother who he stated had an "opioid addiction." He denies any history of psychiatric illness. He denies any psychiatric diagnosis in the past. He has never sought psychiatric treatment for any condition. He has no relevant past medical history except for a work related injury of January 2, 2003 when he injured his cervical spine and underwent a C6-7 instrumented fusion. He pridefully states that he was determined to succeed in accomplishing an "almost" complete recovery despite records revealing a 27 ½% permanency award.

He graduated high school and basically has worked throughout his adult life. When asked about his current emotional state, he stated that his chronic physical symptoms are a "challenge" for him, but thus far he has been able to function in an adequate capacity at work. He describes a strong aversion to any type of prescription narcotic medications. He has taken 800 mg Ibuprofen three times per day for his chronic pain presentation. He has sought various modalities of treatment including chiropractic and physical therapy. He investigated the use of medicinal marijuana but it appears that he was not eligible for same in view of what

appears to be an inadequate or insufficient debilitating medical condition to give rise to eligibility. He reports "diminished sleep" because of chronic pain in his cervical and lumbosacral regions. He reports diminished frequency of sexual relations with his wife because of his spine pain. He states that she has been understanding which he "appreciates." He describes having a "strong" relationship with his wife who he states has been "better than any medicine" for him since his accident occurred.

On examination, Mr. Jones appeared as a physically healthy individual who appeared to his stated age. He appeared to have a somewhat muscular build but also appeared to be mildly overweight. He stated that he had gained approximately 20 pounds since the date of the accident.

He related to me in an open, friendly and cooperative manner. His dress and grooming were causal and appropriate. I could detect no bizarre gesturing or posturing. He displayed a normal range of emotions, sometimes smiling appropriately during the evaluation. His thought processes revealed reasonable focus and were goal directed. He seemed prideful of his work ethic and his ability to raise and maintain his family. He stated with conviction that he was not going to let these injuries "get the best of me."

He did not appear to have any difficulty presenting his chronological history. He was clearly oriented as to time and space. There was no evidence of trembling, strained facies, restlessness or other signs of anxiety. There was pause in his response concerning the loss of his brother and he presented with a "healthy concern" about his future as any normal person in his position would. He displayed sadness primarily related to the loss of his brother, but he did not appear to be clinically depressed nor obsessively focused with his loss. I could not detect any evidence of anxiety or depression concerning any of his remarks, tone, gestures or general body language. His memory and orientation were grossly intact. He had no sign of any psychotic thinking, of delusion or formation or hallucinations. There was no sign of obsessional thinking, compulsive activity or phobic avoidance. Judgment was adequate. Intellect was consistent with his level of education.

On the basis of my evaluation, I find at present that Mr. James John Jones is suffering from no clinical evidence of psychiatric disability resultant from his compensable accident of July 1, 2016. Any clinical manifestation of depression or anxiety is most likely related to his brother's death.

Thank you again for referring to Mr. James John Jones. If you have any further questions regarding this case, please do not hesitate to contact me.

Sincerely yours,

Sigmund Voyyd, M.D.

SV/wmh

DR. I.M. MELLO
12 Weed Street
Northfield, NJ 08225

February 10, 2018

Michael Monet, Esquire
1217 Locke Road
Cherry Field, New Jersey

Re: James J. Jones vs. Waste Away, Inc.
DOB: 1/1/1970

Dear Mr. Monet:

You had requested that I provide you a narrative report regarding my treatment of the above-named patient and my opinion concerning the patient's diagnosis [diagnoses], course of treatment, prognosis and whether or not he has any medical condition within my area of expertise which is related based upon reasonable medical probability by way of causation, aggravation, acceleration and/ or exacerbation to a specific work accident of July 1, 2016.

You have advised that under workers' compensation law if a particular trauma is more likely than not a material contributing factor to either the causation, aggravation, acceleration and/ or exacerbation of a medical condition, the same is compensable under the New Jersey workers' compensation law.

It may be of interest to you concerning my credentials. I am the Medical Director of Holistic Pain Management. I am board certified in both pain management and physical medicine and rehabilitation. I received my fellowship training in pain management at Thomas Jefferson University Hospital. I received my pain fellowship from the Memorial Sloan-Kettering Cancer Center. I also have a PhD in psychology. I specialize in interventional procedures including epidural steroid injections, sympathetic blocks and facet injections.

I saw Mr. Jones as a referral from his primary care physician Dr. Hope Moore on September 10, 2017. Mr. Jones provided a medical history of being in an otherwise normal state of health when on July 1, 2016 he fell during the course of his employment. He apparently fell down five to seven stairs landing face first onto a concrete sidewalk striking his forehead causing significant skull trauma but also a hyperextension of his neck with his torso twisting and rolling forward and landing on his back on a concrete surface with immediate sensation of knifelike pain in his cervical spine and a "pop" in his lower back. He also stated that he did not lose consciousness but had a mild alteration of consciousness being "dazed" and "seeing stars" for a "few seconds." This was treated as a workers' compensation injury. He received approximately 7 weeks of

physical therapy for what was diagnosed as cervical and lumbosacral strains which treatment was unsuccessful. He had persistent pain in both his neck and low back. He received chiropractic manipulations performed by Dr. Mannish Knipp [with whom he had treated on a maintenance basis since January 2003]. Because of persistent symptoms he ultimately underwent cervical and lumbar MRI studies on December 20, 2016. I had opportunity to review the reports in connection with those studies together with X-rays taken by both Emergency Care and Back to Work Medical [Dr. Payne]. The patient provided me with a relevant past medical history of having undergone a successful C6-7 instrumented fusion two years following a motor vehicle accident on January 2, 2003 which surgery was performed by Dr. Samuel Greene. He recovered in relatively uneventful fashion and was able to resume full-duty employment with no restrictions and only occasional soreness. He had no restrictions in connection with the performance of his employment duties which were physically demanding. He was athletic playing both competitive softball and bowling. He advised that the only other minor issues he had with the surgery was that he had lost "a little" range of motion mostly in bilateral rotation but basically he felt that he had made a "95%" recovery. He had not been seen by any physician for any cervical spine condition following his discharge by Dr. Greene in 2004.

He would have "routine" chiropractic maintenance which involved his entire spine but these periodic adjustments were more prophylactic in nature rather than addressing any ongoing medical condition. He has only had the above mentioned one set of MRI studies performed regarding his spine. My personal review of the December 20, 2016 cervical and lumbosacral MRI studies vary to some extent from the radiologist's assessment. I am also a certified "B-reader" although I am no longer practicing radiology. The radiographic studies clearly indicate degenerative disc disease as accurately stated by the radiologist. However more specifically there is multilevel facet arthropathies at the affected vertebral levels referenced in both the cervical and lumbosacral spines. There is also moderate diffuse disc bulging at these same levels with mild to moderate foraminal stenosis.

The patient has described a chronic unabated pain presentation that has been moderately severe since the date of his accident with no meaningful improvement despite modalities of conservative management of traditional physical therapy of 7 weeks at Back to Work. He had subsequent failed core physical therapy at "Ultimate Recovery Fitness" from June 1, 2017 to September 1, 2017. This facility is the leading facility in our area and it is our medical group's preferred facility for core strengthening.

The patient explained to me the tragic loss of his twin brother from an apparent opioid overdose relative to an addiction associated with a serious spinal injury. The patient has an abnormal but understandable aversion to any type of injection modalities and as such he declined any preferred facet injection modalities which I feel are otherwise clearly indicated in this patient as a starting point for a regimen of efficacious pain management as also suggested by his primary care physician.. I explained to him that while there is no "guarantee," at this point the risk would be worth the potential benefit but the patient stated that he simply "could not" undergo any type of injection modalities unless and until he had such severe intractable pain that he was absolutely dysfunctional from working. He preferred to live in chronic significant pain than undergo injection modalities.

He is clearly not a surgical candidate at this point in time. There is no need for any neurosurgical referral. He does not have any type of a serious, significant nerve compression but he clearly has a chronic pain disorder and at the time of my evaluation I felt that he potentially could qualify for medicinal marijuana. I feel this would also be helpful in connection with what appears to be an obvious anxiety which he has over the potential of his losing his employment. He confided that he was not forthright with authorized doctors concerning the severity of his pain. To be sure, while a chronic pain condition can be exacerbated by a concurrent psychiatric diagnosis, the severity of chronic pain created by an aggravation of an otherwise asymptomatic pre-existing facet arthropathy can be severe notwithstanding that the radiographic findings now stating that the diagnostic testing may not necessarily reveal "severe" pathology. In other words the level of chronic pain is not necessarily directly proportionate to the amount of degeneration or osteoarthritic pathology demonstrated by the diagnostic testing. This is a well-established pain management phenomenon.

Utilizing your medical causal relationship test I would conclude that the compensable accident was indeed the material contributing factor for the patient's present onset of chronic pain disorder. Specifically there has been aggravation of asymptomatic pre-existing facet arthropathy for which the most efficacious modalities of treatment would start with injections for facet arthropathies and secondarily medicinal marijuana. The prerequisites for admission to the program have been relaxed by recent legislation and I have recommended the Petitioner to the New Jersey program as a reasonable treatment option for him given his aversion to narcotics and his failure to improve notwithstanding reasonable sustained efforts at physical rehabilitation.

Mr. Jones also could be a candidate for epidural steroid transforaminal injections and possible acupuncture but these would be secondary considerations after a failed attempt at addressing his presumed symptomatic facet arthropathies,

I trust this report addresses your concerns. The prognosis is somewhat guarded. The patient appears to be highly motivated but at the same time his failure to improve is of concern from not only a physical perspective, but it is also an increasing stressor driving his anxiety for which he should take anti-anxiety medications. He clearly has been affected by the loss of his brother but but I have not been able to determine the severity of his depression in my one-time session with him. He may or may not need treatment in that regard.

Should you have any questions, please do not hesitate to contact me.

Sincerely yours,

Ingrid M. Mello, M.D.

IMM/vlh

ALAN D. DRAKE, D.O., P.A.
242 Mallard Road
Ducktown, NJ 08442

609-242-0844
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February 15, 2018

Michael Monet, Esquire
1217 Locke Road
Cherry Field, NJ 08035

Re: James John Jones

Dear Mr. Monet:

I psychiatrically evaluated Mr. James John Jones on February 15, 2018. This evaluation considered the numerous reports which have been downloaded and reviewed and as set forth below:

1. Employee Claim Petition
2. Respondent's Answering Statement
3. Treating records of Back to Work Medical of 07/16/16 – 08/31/16 (Dr. Payne)
4. Chiropractic Records of Dr. Manish Knipp of 01/10/03 – 01/10/18
5. March 1, 2006 Order Approving Settlement for 01/02/03 Motor vehicle accident
6. Treating records of Dr. Samuel Greene – 01/10/03 – 05/01/23
7. Transcript of Petitioner's testimony of March 1, 2006
8. Records of Ultimate Recovery Fitness of 06/01/17 – 09/01/17
9. Treating records of Dr. Hope Moore
10. Treating records of Dr. I.M. Mello – 09/10/17 and 02/10/18
11. Cervical and lumbar MRI studies of 12/20/16
12. Report of Dr. Jules Irving dated 11/01/05
13. Report of Dr. Monte Jordan – 10/31/05

Mr. Jones indicates that Waste Away, Inc. employed him. He describes a rather significant trauma which occurred on July 1, 2016 near the end of his shift when he was walking down concrete steps of his employer's rear loading dock and accidently slipped falling forward down five-seven stairs falling face-first on to a concrete sidewalk striking his forehead with his arms unsuccessful in bracing the fall causing not only a severe frontal blow to his head, but also a significant hyper-extension of his neck with his torso twisting and rolling forward wherein he landed on his back feeling a knife-like pain in his neck and a "pop" in his back. He describes an alteration of consciousness inasmuch as he was "dazed for a few seconds" and "saw stars" for a few seconds.

He felt an immediate onset of significant pain of his neck and low back both of which have been chronic to this date and have failed all modalities of conservative management which he has received. Of significance is a past medical history of a compensable accident which occurred on his first day of employment on January 2, 2003 for this very same Respondent when he was involved in a motor vehicle accident. This was the subject matter of a formal Claim Petition and he received an Order Approving Settlement on March 1, 2006 for the orthopedic and neurologic residuals of a disc herniation at C6-7 for which there was an instrumented fusion to decompress and stabilize a massive left-sided extruded disc which was pressing on the left side of the cervical cord and causing left-sided extremity radiculopathy and myelopathy. There was no third party claim filed. He also sustained a lumbosacral strain but this was minimal in nature and resolved. His permanency award was confined solely to his cervical spine and I reviewed a copy of the transcript of March 1, 2006 concerning his complaints at that point in time. I inquired of this patient how he was doing from the date he was in Court until the date of this compensable accident at which time he advised that he continued to make slow and steady progress as a result of his very high determination to "fully" recover. He stated that he was "absolutely determined" to be as strong as he possibly could for his wife and three daughters to which he consistently made reference in a way that made it clear that they are the most important considerations in his life. He stated he had minimal cervical spine residuals by the time his compensable accident of July 1, 2016 occurred.

He stated that his compensable accident of January 2, 2003 was the only time in his 15 years of employment at Waste Away, Inc. that he even lost one day from work for any reason. In fact, he stated that he would have been back to work within two weeks after the surgery, but the employer would not allow him to go back to light duty employment. He stated that I could "look it up" regarding the accuracy of his statement. I suggested that his memory might not be perfect, but he quickly and politely stated that he was "certain of it" as this attendance record is a "very big deal to me." He stated that immediately prior to the accident of July 1, 2016 he was very active in sporting activities including competitive bowling and softball and he was the coach of his three daughters' softball teams. He conceded that immediately before the accident of July 1, 2016, he still had some occasional neck pain and "soreness" notwithstanding that he was in a health maintenance chiropractic program. However, he had no limitations in doing his job. He was not taking any type of medication and he felt very "optimistic" about his future. He stated that he was actually "up for a promotion" as he felt that he was an integral part of his employer's business as it pertained to dealing with customer relations and general employee productivity/responsibility. He felt that he got along with everyone and that he was "respected" by his colleagues at work especially for his take charge attitude.

He states that "everything has changed" since the July 1, 2016 accident occurred. He has basically been in chronic and occasionally severe pain. He admitted that he has been very guarded about admitting as much. He has not been able to undergo a modality of treatment that has allowed him any meaningful recovery. I inquired of him at greater length because I have reviewed the medical records and recognize that he did not have an obvious surgical lesion in either his neck or his low back according to the December 20, 2016 MRI studies nor did he have any significant neurologic deficit in either of his upper or lower extremities. It seemed at first blush somewhat odd to me that a man who has professed such a strong work ethic and desire to provide for his family, was not availing himself of at least preliminary mundane pain

management modalities to determine treatment efficacy. He then provided me with better insight as to this seeming irreconcilable issue. He stated that he is against opioids/narcotics as his main goal in life is providing for his family. He explained the extremely close relationship he had with his twin brother who had been seriously injured in a motor vehicle accident and tragically became addicted to opioids and ultimately died of what appears to be an accidental overdose although this is not entirely clear. The Petitioner did not clearly exclude the possibility of suicide. He was tearful while discussing the issue and therefore I did not press a complete history on the cause of death as being other than an overdose. What is clear is that the brother suffered for a long time with intractable pain and drug addiction and the Petitioner suffered watching his beloved brother experience such a personal nightmare. Mr. Jones was closer to his brother than even the usual enhanced closeness which twin siblings frequently experience. His brother represented a role model to him. His brother was accomplished in academics and athletics and essentially he was successful in almost everything that he tried to do. He lived his life in a way that the Petitioner admired and all of this "came crashing down" when the brother's motor vehicle accident occurred. He never recovered. The Petitioner saw his brother every day of his life (they were next door neighbors as adults) and described that he actually "felt his brother's pain" as he watched his brother spiral downward with his opioid addiction. The Petitioner admitted to feeling "guilt and responsibility" for his brother's death for failing to be more aggressive with his brother in trying to get him to different doctors and/or possibly detoxification. It is clear to this examiner that this tragedy has had a marked effect on the Petitioner at a very deep level representing a major depression. He could benefit from psychiatric intervention inclusive of anti-depressants and psychotherapy even at this late date. I actually discussed this with the Petitioner, but his notions of "masculinity" are such that he would never undergo psychiatric treatment for any level of "mere anxiety and/or depression" as he views such treatment as representing being "weak" and therefore "unmanly."

Other than these deep-seeded convictions, the Petitioner has an otherwise relatively benign psychosocial history. He has spent his entire life in a stable environment in Southern New Jersey. He graduated high school. His parents are living and they are healthy. He has no military or police record. By his account he has had a successful marriage and a faithful marriage over the past 15 years. He is very devoted to his wife who he states has been very understanding of him although he feels a feeling of guilt for "not being the husband she deserves" due to his spinal symptomatology. He derives a great deal of self-esteem from his unusual work ethic and commitment to his employment. He is clearly obsessed with his inability to rehabilitate himself to the point where he could functionally perform physically exertional activities without the significant pain he experienced.

He has insomnia because of his obsessive thoughts regarding his future which he perceives as an uncertainty. He feels that as integral a person which he has been with the company, he will only stay in that position so long as he can provide value to his employer. While he has been doing everything he can to conceal his chronic pain presentation, he is concerned that management "senses" that he is not the same person at this point in time. He feels he is moving slower and cannot perform the repetitive tasks of exertional activities the way he could previously. Sometimes he is not as enthusiastic nor energized as he once was. He does not describe despair, but he does describe being "really scared" about his future.

He further relates that he felt a "potential solution" for his situation was the recommendation of medicinal marijuana by his primary care physician and a pain management physician, Dr. I. M. Mello with whom he consulted. He describes a number of acquaintances who had successfullyutilized medical marijuana and they had previously been hard-working people who were similarly afflicted as he was, but they had both failed surgeries. No physician has suggested that he needs spinal surgery. He feels a further depression due to his ineligibility to at least attempt to benefit from medicinal marijuana.

Mr. Jones presents himself as a 5'6" tall 225 pound 48 year old man. He is very polite. He appears to be a forthcoming individual who is not accustomed to expressing his true inner feelings. He is afraid of his inner feelings insofar as they pertain to a "worse outcome" (i.e. in ability to continue with his employment.) He candidly advised that he has not expressed the depth of what we spoke about to anyone else including his wife. He feels vulnerable. He was alert, cogent and of at least normal intellect. His affects evidenced a certain level of fear in his face and voice when discussing his deep concerns over chronic pain disorder. Analysis of his mood noted dysphoria. Thought content is coherent and goal directed. Analysis of his thought content notes an underlying sense of despair, a loss of sense of wellbeing in which his ambitions and hopes in his life are at risk. He feels that he has done the right thing in devoting himself to his employment as a means for supporting, protecting and providing for his family. He is not a bitter person. His determination is not destructive. There is no evidence of psychosis noted. He was oriented x3. Judgment and reality testing were in keeping with his education.

Mr. Jones has been through two traumatic incidents in his life. The first is the death of his brother which clearly pre-existed his compensable accident of July 1, 2016. The second is his chronic pain disorder secondary to his compensable accident. He is having difficulty coping with his "new normal" of chronic pain which he is having a great deal of difficulty accepting as being potentially permanent in which case he feels his present employment career will be lost. Accordingly he has a Mood Disorder (NOS) with overtones of depression and anxiety causing a 35 percent permanent partial psychiatric disability on a compensable basis. There is an inadequately treated Mood Disorder (NOS) secondary to the trauma of the loss of his brother under very unfortunate circumstances for which the Petitioner feels a certain level of blame. His pre-existing disability on an un-treated basis is 25% permanent partial disability.

He has post concussive syndrome with chronic cephalgia representing 17 ½% permanent partial total.

This examiner recognizes that to the untrained eye it may very well be that the patient is performing the essential functions of his employment duties at work, but they are being performed in spite of a significant pain disorder challenge which has both physical and emotional components.

These estimates of psychiatric disability are based upon objective medical findings and do materially impair the ordinary pursuits of life. My professional opinion is based upon a careful professional analysis of the Petitioner's subjective, observations of the physical manifestations of the symptoms related to his subjective statement and analysis of states of mind beyond his mere subjective statement. All of my opinions are stated within a reasonable degree of medical probability.

Sincerely yours,

Alan D. Drake, D.O.,

ADD/fap

ABBREVIATED CREDENTIALS OF MEDICAL WITNESSES IN LIEU OF FORMAL CV

JULES IRVING: Dr. Irving is a graduate of Johns Hopkins University School of Medicine and has been licensed to practice medicine in the State of New York for the past 30 years and the State of New Jersey over the past 25 years. He holds Board Certifications in physical medicine and rehabilitation; internal medicine and pain management. He is a Fellow of the American Family of Physical Medicine and Rehabilitation and a member of the American Congress of Rehabilitation Medication and he is certified with the National Board of Medical Examiners.

For the past 10 years his medical practice has been split between performing workers' compensation need for treatment and permanency evaluations on behalf of petitioners together with an active pain management practice (Recover Now Institute) of which he is a 25% Principal. He has performed approximately 10,000 permanency evaluations and has appeared for testimony in the Workers' Compensation Court at least 50 times.

ALAN D. DRAKE: Dr. Drake is a Stanford University School of Medicine graduate and is licensed to practice medicine in New Jersey for the past 25 years primarily in the clinical practice of psychiatry with a solo medical practice with the last 20 years spent performing permanency evaluations as to the existence of need for treatment or permanency in the area of workers' compensation on behalf of injured workers. For the past 5 years, 90% of his practice is devoted to workers' compensation evaluations. He has testified in Workers' Compensation Court 75 times. He is Board Certified in the area of both psychiatry and psychology.

MONTE JORDAN: Dr. Jordan is a graduate of the Geisel School of Medicine (Dartmouth) and licensed to practice medicine in New Jersey for the past 35 years. His first 10 years of practice was in the area of emergency room medicine. He was certified by the American Board of Emergency Medicine, but thereafter left that practice to become a principal in the "Back to Work Medical Group" where he was employed for 10 years. He retired from that group to become a need for treatment/permanency evaluator exclusively for respondents in the area of New Jersey workers' compensation for the last 15 years. He has appeared in Workers' Compensation Court at least 40 times.

SIGMUND VOYYD: Dr. Voyyd is a graduate of the Medical University of Vienna. He practiced medicine in Vienna for 10 years and has been licensed to practice psychiatry in New Jersey for the past 20 years. His first 10 years was spent in a private adult clinical practice with his last 10 years confined solely to performing psychiatric evaluations as to the extent of permanency for respondents in workers' compensation. He has testified in Workers' Compensation at least 20 times. He became a US Citizen in 2000 and is fluent in Austrian.

SUMMARY OF OFFICE RECORDS OF MANISH KNIPP, D.C.

Petitioner started treating with Dr. Knipp in May 1, 2003 following his motor vehicle accident of January 2, 2003. His first office visit provided a history of a motor vehicle accident of January 2, 2003 as being a precipitating factor of significant cervical spine and secondary low back pain. He basically went through a period of two months of aggressive adjustment modalities which appear to have resolved the low back condition but the cervical spine condition persisted. There is a hiatus in treatment following the patient's undergoing the C6-7 fusion surgery and six months thereafter, the Petitioner had a "regular" maintenance routine of approximately one month visitation with no documented intervening accidents or injuries other than a few references to some enhanced cervical and/or low back soreness (mostly cervical) following a particularly hard day or week at work. There are a couple of references to minor exacerbations of cervical spine pain following a bowling tournament or two, but no specific diagnostic study performed or recommended and no injury diagnosed. There are periodic references beginning in January of 2008 where Dr. Knipp had been cautionary about and reminding his patient to be careful to lift properly at work because repetitive stress of his physically demanding job could otherwise take a toll on his spine over time.

All office visits were coded as maintenance until following the compensable injury of July 1, 2016 wherein the records consistently document chronic neck and low back pain of un-abating nature with the neck more significantly severe than the low back with neither of the injuries having any confirmed radicular components. The records document recommendations for formal pain management, acupuncture and MRI studies together with orthopedic consult. The records do not document any new accidents or injuries. Each entry was fairly illegible and minimal with the Petitioner back on a general maintenance program on a one-time per month basis but now on a two-time per month basis which has been the frequency over the past 9 months with consistent moderate to severe pain documented in the cervical and lumbosacral spine.

SUMMARY OF DR. HOPE MOORE RECORDS

The records demonstrate a corroboration of the Petitioner's history with no non-compensable accidents or injuries documented. The records also document progressive improvement of the Petitioner's cervical spine following his award of permanency benefits. There is a September 6, 2011 entry indicating an experience of back pain a few days after "sliding into third base in the employer softball championship tournament" for which bedrest was prescribed and a one-week disability certificate issued. The records indicate that 5 days after that incident, the Petitioner was back advising that his back had improved and that he had not taken any time off from work. There is also a note of development of neck pain with spasm on December 5, 2014 with no known accident or injury other than bowling an excessive number of games over the weekend in a bowling tournament. The Petitioner had palpable spasm and anti-inflammatories were prescribed. There was no referral to an orthopedist. The Petitioner was not taken out of work. He returned two weeks later with a resolution of those symptoms but the development of a severe upper respiratory infection which was treated. The medical records otherwise demonstrate a health individual who was not on any type of medication for any medical condition at the time of his last compensable accident.