New York State
ACADEMY
OF TRIAL LAWYERS

WORKING WITH EXPERTS TO BUILD YOUR CASE

LIVE STREAMING – October 8, 2020

Materials By:
Andrew Smiley, Esq.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------x

OSCAR E. AMADOR,

Index No.: 717192/17

Plaintiff,

3101(d) EXPERT WITNESS EXCHANGE

-against-

CAROL R. LYNCH and PHILIP J. LYNCH,

Defendants.

----------x

PLEASE TAKE NOTICE, that pursuant to CPLR 3101(d)(1), the plaintiff, OSCAR AMADOR, by his attorneys, SMILEY & SMILEY, LLP, hereby submits the following as and for his Expert Witness Exchange.

The plaintiff, OSCAR AMADOR, intends to call Michael A. Dicicco to testify at the trial on his behalf as an expert witness in the field of Traffic Accident Reconstruction.

1. The *Curriculum Vitae* of Michael A. Dicicco is annexed as Exhibit "*A*".

2. The opinions of the expert will be based upon his knowledge, training and expertise in the field of Traffic Accident Reconstruction. The expert will also base his opinions upon appropriate literature, texts, articles, indexes and treatises in the field of Traffic Accident Reconstruction as well as the litigation materials herein including deposition transcripts, discovery exchanged between the parties, the NYPD accident report and upon an inspection of the plaintiff's motorcycle and an inspection of the scene of the accident and upon photographs exchanged between the parties and photographs and diagrams that are annexed hereto as Exhibit "B".

3. Mr. Dicicco will testify to the following opinions to within a reasonable degree of accident reconstruction certainty regarding the subject accident that occurred on September 23, 2017:

1. The damage on the Amador motorcycle is consistent with the front bumper of Mrs. Lynch's Audi striking the right rear saddlebag on Mr. Amador's motorcycle in a nearly in-line orientation.

2. When Mr. Amador began his left turn, Mrs. Lynch's Audi was at least 220 feet away.

3. As Mr. Amador was turning left, all approaching traffic (including Mrs. Lynch) must yield right-of-way to Mr. Amador since he is already using the intersection.

4. Traveling at her stated 25 mph and utilizing a 0.8g deceleration rate for hard braking, Mrs. Lynch required approximately 81 feet (55 feet perception/reaction, 26 feet braking) to stop after observing Mr. Amador's motorcycle as a hazard.

5. Mrs. Lynch's Audi was approximately at the start of the service road when she perceived Amador's motorcycle as a hazard and began to react. At this location, Mrs. Lynch's Audi was approximately 45 feet or 1.2 seconds from the impact location and Mrs. Lynch would have been unable to begin braking until after the collision occurred.

6. Mrs. Lynch failed to yield the right-of-way to Mr. Amador's motorcycle as he was properly executing a left turn.

7. Mr. Amador should have been clearly visible to Mrs. Lynch as she approached the intersection.

8. Mrs. Lynch was not driving attentively and her inattentive driving caused the collision.

PLEASE TAKE FURTHER NOTICE, that plaintiff reserves the right to amend and/or supplement this response up to an including the time of trial.

EXHIBIT "A"

SKE Forensic Consultants, LLC

169 Ramapo Valley Road
Oakland, NJ 07436
Office 201.644.0700
Fax 201.644.0701
www.skefc.com

MICHAEL A. DICICCO

CURRICULUM VITAE

CURRENT POSITION:

Senior Associate of SKE Forensic Consultants, LLC, a private consulting firm specializing in the analysis and reconstruction of vehicle collisions and defects.

- Crash Reconstruction: Inspection of vehicles and crash sites. Review of police reports, witness testimony, medical records, scene photos, weather records, repair bills, black box crash data, and other documents. Computational recreation of the crash using facts and scientifically accepted methodology to determine how the crash occurred. Determine the causes(s) of the crash, which may typically include driver actions, roadway issues, weather conditions, and vehicle defects.

- Motor Vehicle System Failure Analysis: Conventional and anti-lock braking, restraints, power-train, throttle-by-wire (drive-by-wire), seat, suspension, steering, wheels and tires, fuel delivery, emission controls, electrical, climate control, cooling, frame and unibody.

- Motor Vehicle Failures: Airbag, seat belt, seat performance, structural, suspension, axle, spindle failure and separation, wheel bearing failure, transmission failure, sudden acceleration, cruise control, steering, wheel separation, brakes, fuel injection, fuel delivery, electronic engine controls, electronic throttle control.

- Motor Vehicle Repair: Diagnosis and repair of engine, transmission, transfer case, differential and final drive, suspension and steering systems, conventional and anti-lock brake systems, stability/traction control, fuel system, emission systems, climate control, entertainment, restraint systems, lighting/electrical, interior/exterior components and systems, and Safety Recall repairs. Proper repair procedures and shop practices including proper use of tools and equipment.

- Manufacturing Processes: Experienced in metal fabrication, machining, welding, die-casting, injection molding, stampings, painting and coatings. Common issues and failure modes for these include premature corrosion, porosity, excessive burrs and flash, which lead to fires, injuries, and reduced crash performance.

PROFESSIONAL EXPERIENCE:

Robson Forensic (2008-2016)

Vehicle and Crash Reconstruction Expert

- Provide technical investigations, crash reconstruction, testing, analysis, reports, and testimony toward the resolution of litigation arising from motor vehicle collisions, vehicle design/manufacturing defects, improper repairs, and vehicle fires.
- Over 400 investigations of real-world collisions: vehicle-to-vehicle, single-vehicle, hit pedestrian.

Ford Motor Company (2007-2008)

Product Engineer - Restraints

- Developed and released design changes for the Ford Escape, Edge, and F-150 curtain and side airbag programs. This process included feasibility analysis and meeting federal crash standards for sled, barrier, and rollover testing.
- Launched several design changes for the MY09 Ford Escape Curtain Airbag. Developed and approved Ford's first non-sealed side airbag connectors.

Takata – Automotive Inflation Systems (2006-2007)

Sr. Product Engineer - Inflators

- Developed and qualified new airbag inflator designs. Tuned inflators for OEM airbag module testing, coordinated USCAR DV/PV testing, completed FMEA studies, conducted design reviews, released drawings and BOMs, provided mass flow data for system-level testing (Madymo), and evaluated design changes (margin testing, tolerance stack-ups, feasibility/cost analysis).

Autoliv – Automotive Safety Products (2003-2006)

Project Engineer – Ford Business Unit

- Coordinated design changes for Ford airbags, seat belts and steering wheels. Conducted design change workshops and benchmarked restraint systems manufactured by Takata, TRW, Delphi, and Key Safety.

Autoliv – Automotive Inflators (2000-2003)

Mechanical Design Engineer

- Completed design/product validation testing and provided engineering for automotive airbag inflators. Designed test fixtures, evaluated design changes, completed failure mode analysis, control plans, investigated lot testing anomalies, reviewed customer complaints, implemented permanent corrective actions, and created/edited drawings and test procedures. Utilized the Ford 8D process to address customer/internal corrective action issues, created statistical control charts, and performed Gage R/R's on critical processes.

IMI Norgren, Inc. (1998-2000)

Mechanical Engineer, RMA Supervisor

- Supervised the Returned Merchandise Department and provided general manufacturing support for pneumatic airline products. Maintained customer complaint and supplier confidence-level reports for Executive review. Conducted laboratory product testing, performed customer product evaluations, maintained ISO 9001 procedures, and improved products/processes on a Value Analysis Team.

Jetstream Systems, Inc. (1997-1998)

Mechanical Design Engineer

- Designed air conveying systems for the aluminum can industry. Rigorous AutoCAD design/detail experience.

EDUCATION/TRAINING:

Fully Accredited Traffic Accident Reconstructionist from the Accreditation Commission for Traffic Accident Reconstructionists – ACTAR #3201 (2016)

California Polytechnic State University, San Luis Obispo, CA

- Bachelor of Science, Mechanical Engineering, 1997

Northwestern University, Traffic Institute, Evanston, IL

- Traffic Crash Reconstruction I, 2008
- Traffic Crash Reconstruction II, 2015
- Traffic Crash Reconstruction III, 2016

Court-qualified as a Crash Reconstruction Expert Witness

Investigating Motor Vehicle Fires, 2012

Fundamentals of Motor Vehicle Fire Investigation, SAE, 2013

Certified Motor Vehicle Air Conditioning Technician, 2007

NAPARS – NATARI – MATAI – NJAAR – NYSTARS – MATAI Conference, 2018

- Investigating Pedestrian Collisions, History of Pedestrian Crash Testing and Reconstruction, Pedestrian Crash Testing, Medical Perspective/Pedestrian Injury Patterns, Perception Response Times, Nighttime Perception, Pedestrian Distraction, Pedestrian Formulas Preferred and Problematic, Eye Tracking Testing Review, Crash Testing Results Review.
  Lake George, New York – October 17-19, 2018

NJAAR - Video Analysis Seminar

- Velocity Analysis from Traffic, Dash, and Witness Cameras which included Geolocation fundamentals, photography for photogrammetry, velocity comparison & testing, matchmoving, temporal analysis, and traffic/dash/witness camera analysis.
  Sayreville, New Jersey – March 20, 2019

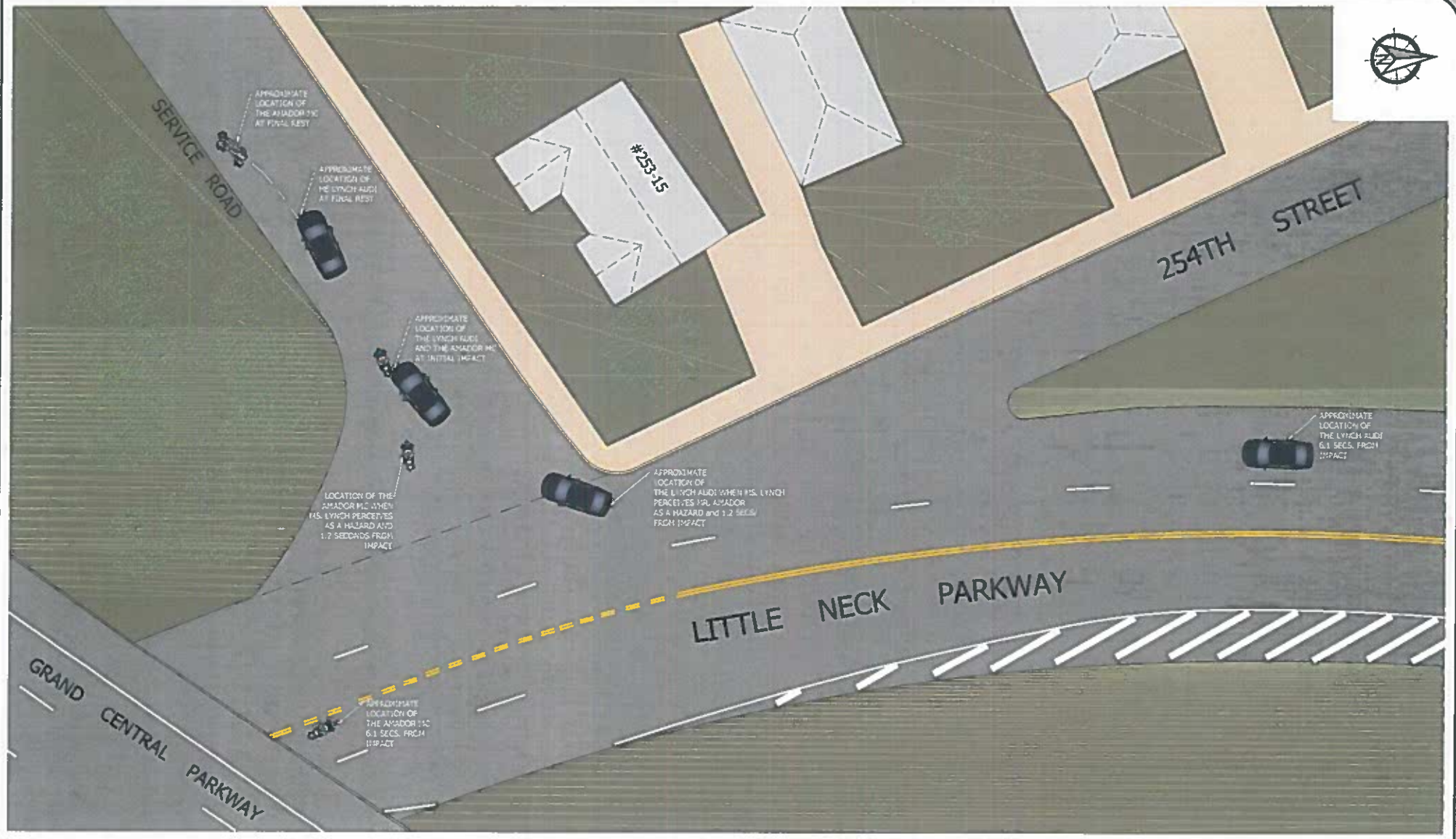
PROFESSIONAL AFFILIATIONS:

PI Tau Sigma	Engineering Honor Society, 1995
SAE	Society of Automotive Engineers, 2003
NJAAR	New Jersey Association of Accident Reconstructionists
NATARI	National Association of Traffic Accident Reconstruction

GUEST SPEAKER

OACTA Personal Injury Defense Seminar, Columbus, Ohio, 2014
Topic – Event Data Recorders.

EXHIBIT "B"



Accident Site Diagram

SKE No. 17.0923.C
Drawing Date: 12-13-2019
Drawn by: MAD & ZH

Inspection date: 10-23-2019
Inspection by: MAD & MJM
Accident date: 09-23-2017

Location: 253-15 Grand Central Parkway & Little Neck Parkway Queens, New York

scale in feet
0 10 20 30 40 50 60 70 80 90

SKE Forensic Consultants, LLC
169 Ramapo Valley Road, Oakland, NJ 07436

Accident Reconstruction Experts
www.skefc.com


Little Neck
Parkway
Grand Central Par
253-15
Service Road
Goog

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

Madlyn I. Solivan, being duly sworn, deposes and says:

I am not a party to this action, am over 18 years of age and reside in New York, New York.

On **December 18, 2019,** I served the annexed **3101(d) EXPERT WITNESS EXCHANGE** upon whose name and address are set forth below, by enclosing a true copy thereof in a securely sealed envelope, and/or container, with proper postage, at the address designated by them for that purpose, by depositing the same in an official box of the U.S. Post Office regularly maintained by the United States Government, 122 East 42nd Street, New York, New York 10168, as follows:

PICCIANO & SCAHILL, P.C.
Attorneys for Defendants,
CAROL R. LYNCH and PHILIP J. LYNCH
1065 Stewart Avenue, Suite 210
Bethpage, New York 11714

Madlyn I. Solivan
MADLYN I. SOLIVAN

Sworn to before me this
18th day of December, 2019

NOTARY PUBLIC

JASON D. FRIEDMAN
Notary Public, State of New York
No. 02FR5075277
Qualified in Kings County
Commission Expires March 31, 2023

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

Index No.: [redacted]

----------x

[redacted] individually and as Executor of the [redacted] Deceased,

Plaintiff,

-against-

[redacted]

Defendants.

----------x

PLAINTIFF'S EXPERT WITNESS EXCHANGE PURSUANT TO CPLR 3101(d)(1)

PLEASE TAKE NOTICE, that the plaintiff, [redacted] individually and as Executor of the [redacted] Deceased, by his attorneys, SMILEY & SMILEY, LLP, hereby submits the following as and for his Expert Witness Exchange pursuant to CPLR 3101(d)(1):

1. The expert witness received a M.D. degree from Cornell University Medical College. The expert completed an internship at Cornell Cooperating Hospitals, North Shore University Hospital, Manhasset, New York and Memorial Hospital in New York, New York. The expert completed a Residency with Cornell Cooperating Hospitals and a Cardiology Fellowship at North Shore University Hospital. The expert is licensed to practice medicine in the State of New York and is Board Certified by the American Board of Internal Medicine. The expert has privileges at a hospital in Westchester County, New York. The expert is a cardiologist, currently in private practice in New York. This expert will testify based upon a review of the decedent's medical records, upon the depositions and pleadings in the case, upon the appropriate medical literature/research and upon this expert's experience in the field of cardiology.

2. This expert will testify, to within a reasonable degree of medical certainty, that the medical care and treatment provided by [redacted] was substandard and not in accordance

with the standard of care in the field of cardiology. More specifically, the expert will testify that [redacted] failed to timely diagnose that patient [redacted] was suffering from an intracerebral hemorrhage ("ICH"); failed to timely recognize the signs and symptoms of an ICH; failed to advise [redacted] and/or her family members present at the relevant times herein, that she could be suffering from an ICH; and failed to properly act upon [redacted] physical complaints including her complaint of a severe headache.

3. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to order a diagnostic assessment, including but not limited to an MRI or CT–Scan of the brain to rule out an ICH.

4. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to follow up with, or in any way monitor, [redacted] following his evaluation of her at approximately (1:00 P.M.) in response to complaints of a severe headache.

5. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to advise any hospital staff members, nurses or physicians at Sound Shore Medical Center that [redacted] could be suffering from an ICH and/or to monitor her for additional signs of ICH such as nausea and vomiting.

6. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to advise [redacted], or any other physicians or medical personnel at Westchester County Medical Center that [redacted] could be suffering from an ICH and that she may be in need of immediate evaluation for ICH.

7. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to advise [redacted], or any other

physicians or medical personnel at Westchester County Medical Center, that it was his belief that [redacted] could be suffering from an ICH and that she should be assessed for an ICH upon her arrival.

8. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departed from good and accepted practice in failing to order a STAT Ct-Scan or MRI of [redacted] brain; in failing to request a neurological/neurosurgical consult; in failing to discontinue the administration of anticoagulants; and in failing to commence appropriate reversal procedures which could have ultimately saved [redacted] from suffering a massive ICH and which could have prevented her death.

9. This expert will testify, to within a reasonable degree of medical certainty, that [redacted] departures from the standard of care as set forth herein, directly resulted in her suffering a massive ICH and a loss of chance of her survival. This expert will further testify, to within a reasonable degree of medical certainty, that [redacted] departures from the standard of care as set forth herein were the proximate cause of [redacted] suffering from a massive ICH and were the proximate cause of her death.

10. Finally, this expert will testify, to within a reasonable degree of medical certainty, that had the ICH been timely diagnosed, it could have been successfully treated and [redacted] would not have died as a result of a massive ICH.

PLEASE TAKE FURTHER NOTICE that the plaintiff reserves his right to amend and/or supplement this response up to and including the time of trial.

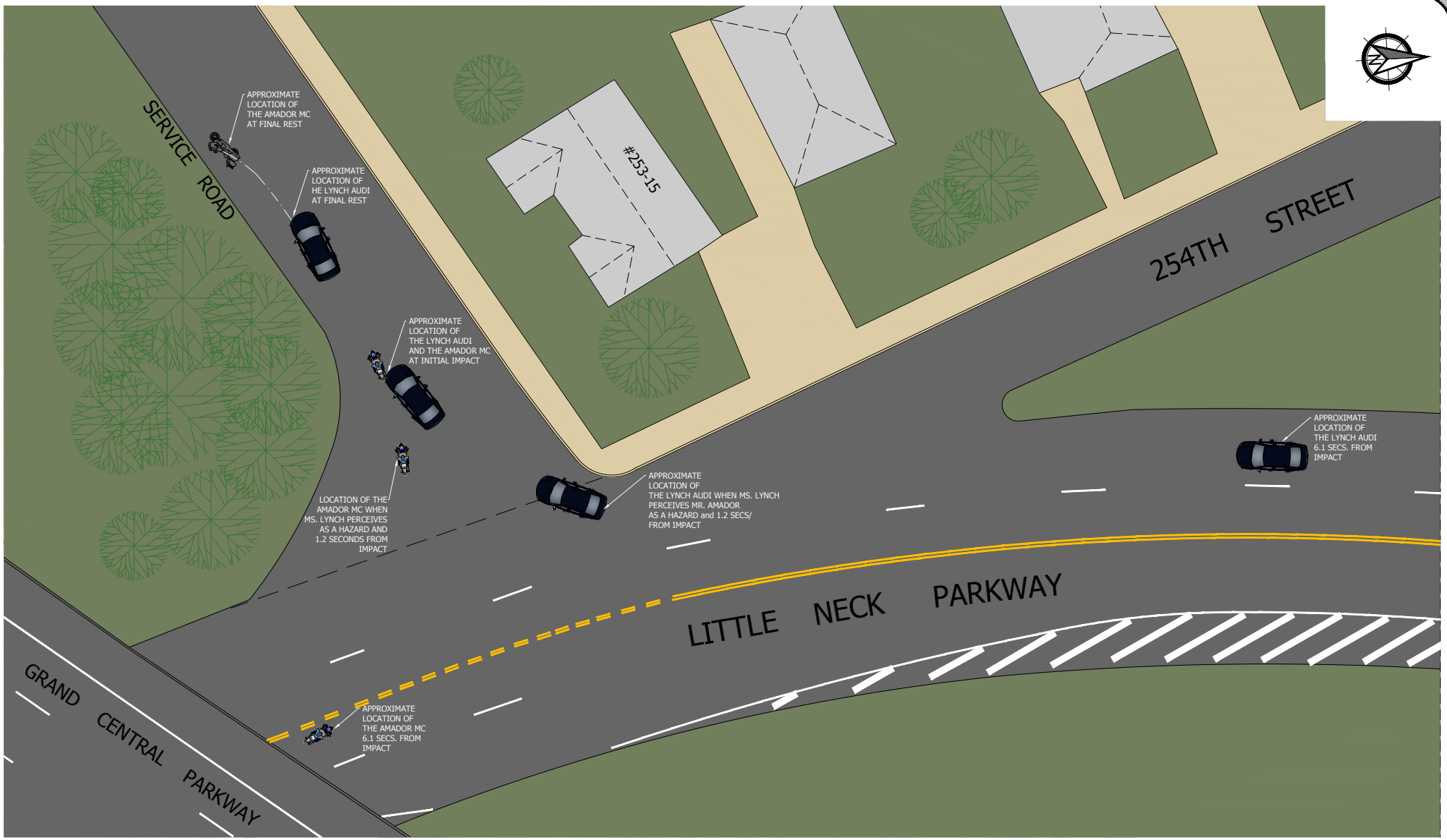
Dated: New York, New York
October 25, 2016

Yours, etc.

SMILEY & SMILEY, LLP
Attorneys for Plaintiff

By:_____
ANDREW J. SMILEY
122 East 42nd Street – Suite 3900
New York, New York 10168
Tel: (212) 986-2022

TO: [redacted]



Accident Site Diagram

SKE No. 17.0923.C
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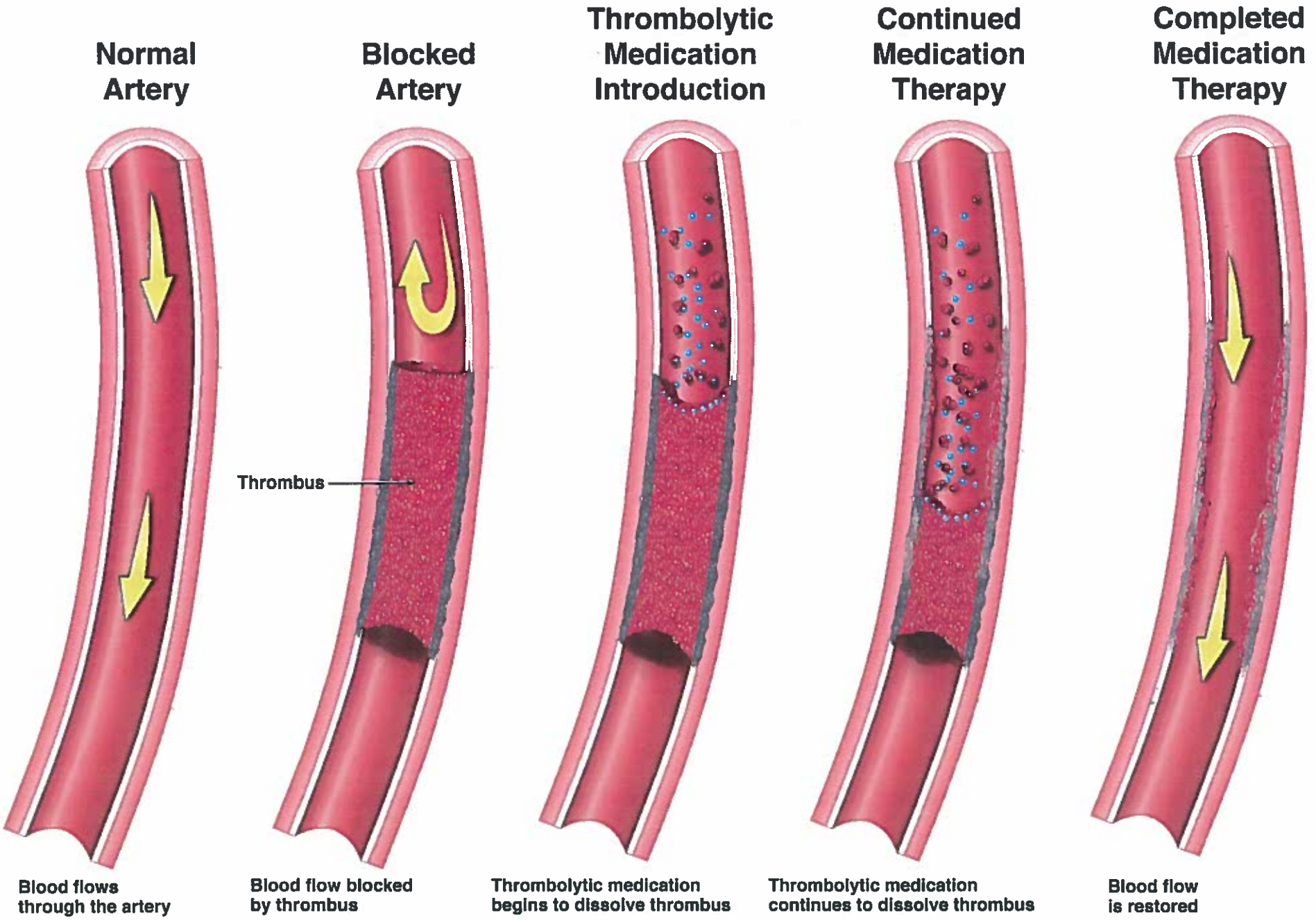
Accident Reconstruction Experts
www.skefc.com

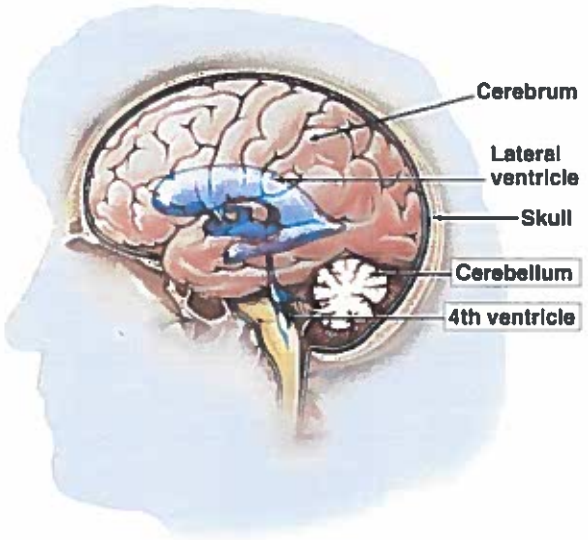
scale in feet

0 10 20 30 40 50 60 70 80 90

Thrombolytic Therapy

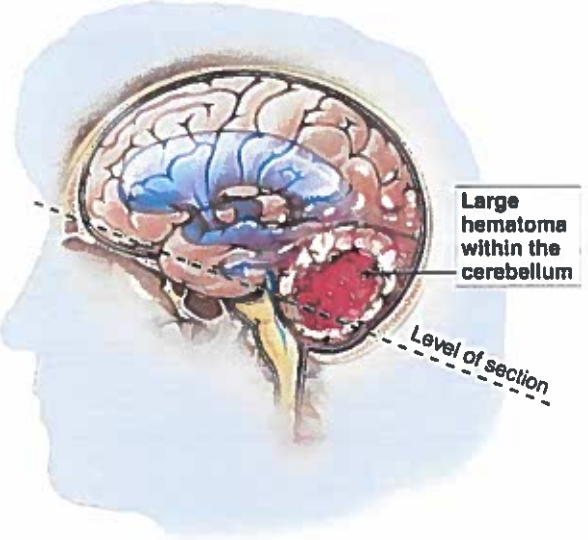


Normal Anatomy

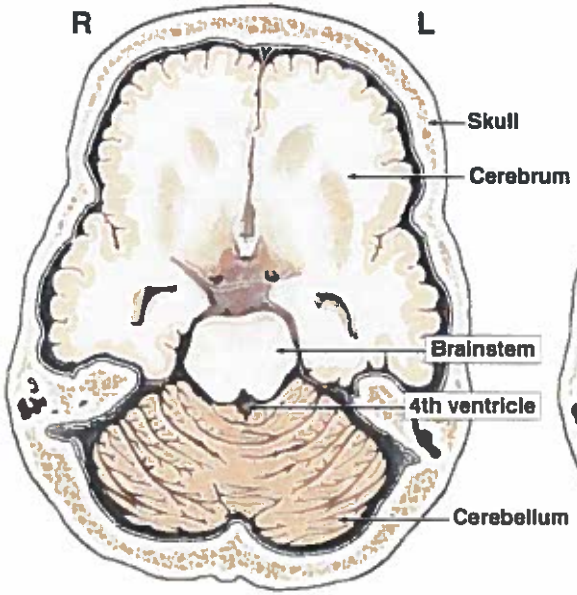


Lateral view

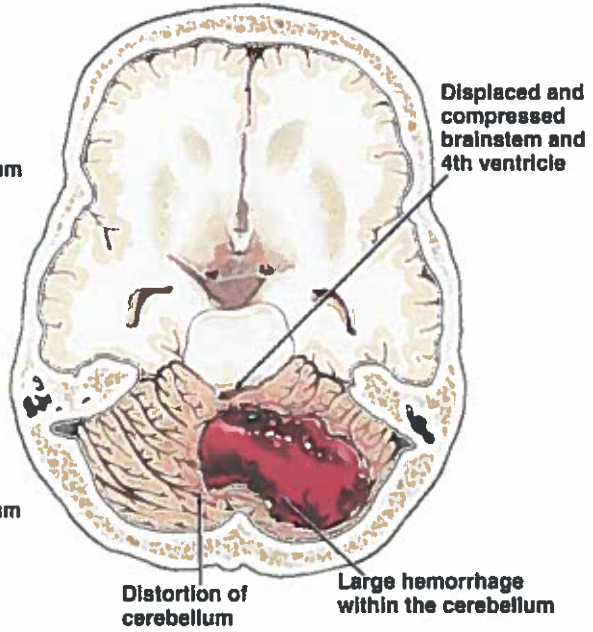
Cerebellar Hemorrhage



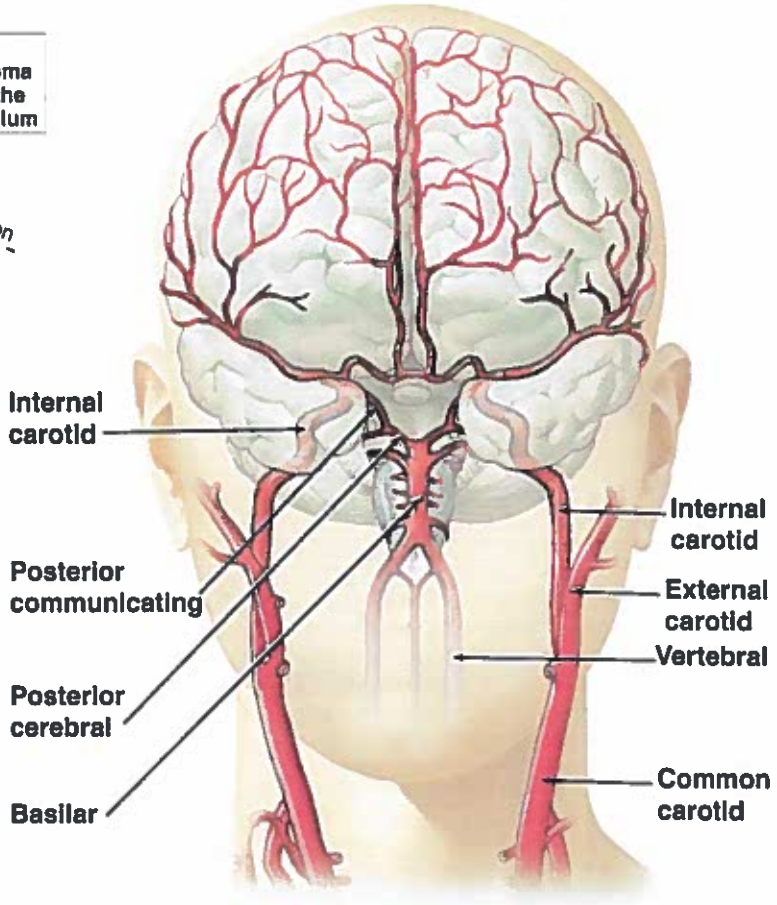
Normal Anatomy



Section through brain



Cerebral Arteries



Anterior view of Head

Medical Legal Art

SMILEY & SMILEY, LLP

ATTORNEYS AT LAW

(212) 986-2022

122 EAST 42ND STREET
39TH FLOOR
NEW YORK, NEW YORK 10168

WWW.SMILEYLAW.COM
FAX: (212) 697-4689

March 15, 2016

VIA EMAIL and FIRST CLASS MAIL

[redacted]
Rutland, VT 05702

Re: [redacted]

Dear Mr. [redacted]:

Enclosed, please find the report of Peter Barry. The plaintiff, [redacted] intends to call Mr. Barry as an expert witness to testify on his behalf at the time of trial in this action.

Very truly yours,

ANDREW J. SMILEY

AJS:mis
Enclosure

Review and Analysis of [redacted] Accident of February 25, 2015

[redacted]

CONFIDENTIAL

Document # 031516
Date: March 15, 2016
This document contains 76 pages

Peter Barry
6110 Boul. des Grandes-Prairies, Montréal QC H1P 1A2 CANADA
Telephone: 514-730-0253
pbarry@barry.ca

Table of contents

Testimony

I, Peter Barry, certify and declare that the observations and comments presented herein are true and to the best of my knowledge.

J. Peter Barry
Montreal, March 15, 2016

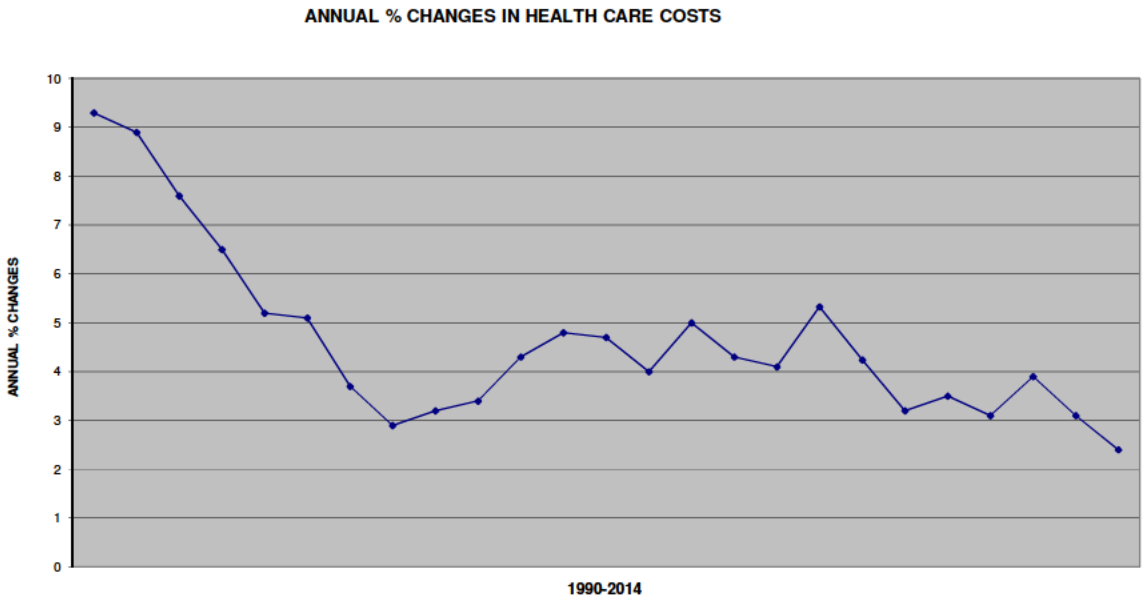
* The original copy is signed and kept on file at Barry Cordage Ltd headquarters, Montreal, Canada.

ECONOMIC LOSS ANALYSIS
THE FUTURE COST OF HEALTH CARE

[redacted]

Prepared November 18, 2015

As a result of his condition [redacted] requires health care. The Life Care Plan prepared by [redacted] Ph.D. identifies the required care, the frequency, the time frame and the current costs. The cost of medications is increased by 4.5% per year. The cost of physician services and the cost of diagnostics are increased by 4% per year. The cost of prosthetics, aids and supplies are increased by 2% per year. The other costs are increased by 3% per year. As per data provided by the U.S. Bureau of Labor Statistics, over the past 25 years, the costs for health care have been increasing at an average annual rate of approximately 5%. The following graph shows changes in health care costs for each year since 1990.



The future costs are determined commencing January 2016 and continuing over the remainder of his life expectancy to age 78.9. The future cost of health care is **$1,682,471**. The costs for each year in each category appear in the following table.

Respectfully submitted,

[redacted] Ph.D.

Respectfully submitted,

[redacted] Ph.D.

YEARLY BREAKDOWN OF THE FUTURE COST OF HEALTH CARE

Mr. [redacted]

Year	Physicians	Diagnostics	Therapies & evaluations	Medication	Aids, orthotics & supplies	Home care	Case management	One time costs
2016	$ 2,198	$ 4,854	$ 24,012	$ 14,146	$ 1,924	$ 13,728	$ 1,800	$ 269,837
2017	$ 2,286	$ 5,048	$ 13,349	$ 14,783	$ 1,962	$ 14,140	$ 1,854	
2018	$ 2,377	$ 5,250	$ 2,928	$ 15,448	$ 2,002	$ 14,564	$ 1,910	
2019	$ 2,472	$ 5,460	$ 3,016	$ 16,143	$ 2,098	$ 15,001	$ 1,967	
2020	$ 2,571	$ 5,678	$ 3,106	$ 16,869	$ 2,140	$ 15,451	$ 2,026	
2021	$ 2,674	$ 5,906	$ 3,200	$ 17,628	$ 2,183	$ 15,915	$ 2,087	
2022	$ 2,781	$ 6,142	$ 3,295	$ 18,422	$ 2,226	$ 16,392	$ 2,149	
2023	$ 2,892	$ 6,388	$ 3,394	$ 19,251	$ 2,271	$ 29,419	$ 2,214	
2024	$ 3,008	$ 6,643	$ 3,496	$ 20,117	$ 2,316	$ 30,302	$ 2,280	
2025	$ 3,128	$ 6,909	$ 3,601	$ 21,022	$ 2,362	$ 31,211	$ 2,349	
2026	$ 3,254	$ 7,185	$ 3,709	$ 21,968	$ 2,410	$ 32,147	$ 2,419	
2027	$ 3,384	$ 7,473	$ 3,820	$ 22,957	$ 2,458	$ 33,111	$ 2,492	
2028	$ 3,519	$ 7,771	$ 3,935	$ 18,818	$ 2,507	$ 34,105	$ 2,566	
2029	$ 3,660	$ 8,082	$ 4,053	$ 19,665	$ 2,557	$ 35,128	$ 2,643	
2030	$ 3,806	$ 8,406	$ 4,175	$ 20,550	$ 2,608	$ 36,182	$ 2,723	
2031	$ 3,958	$ 8,742	$ 4,300	$ 21,474	$ 2,660	$ 37,267	$ 2,804	
2032	$ 4,117	$ 9,091	$ 4,429	$ 22,441	$ 2,714	$ 38,385	$ 2,888	
2033	$ 4,281	$ 9,455	$ 4,562	$ 23,451	$ 2,768	$ 39,537	$ 2,975	
2034	$ 4,453	$ 9,833	$ 4,699	$ 24,506	$ 2,823	$ 40,723	$ 3,064	
2035	$ 4,631	$ 10,227	$ 4,840	$ 25,609	$ 2,880	$ 41,944	$ 3,156	
2036	$ 2,023	$ 4,467	$ 2,094	$ 11,240	$ 1,234	$ 18,145	$ 1,365	
Total	$ 67,475	$ 149,010	$ 108,012	$ 406,507	$ 49,103	$ 582,795	$ 49,732	$ 269,837

THE TOTAL FUTURE COST OF HEALTH CARE IS **$1,682,471**

[redacted]

March 17, 2017

Mr. Guy Smiley, Esquire
Smiley & Smiley, LLP
122 East 42nd Street, 39th Floor
New York, New York 10168
Tel: 212-986-2022
Fax: 212-697-4689

Re: [redacted]

Dear Mr. Smiley:

Enclosed you will find the Life Care Plan and Cost Projections for [redacted] as it pertains to the injury sustained on January 13, 2014.

It has been a pleasure assisting you with this matter and if you require anything further, please do not hesitate to contact me at (201) 343-0700.

[redacted]

[redacted]

[redacted]

Life Care Plan
for

[redacted]

March 17, 2017

Prepared by:

[redacted], CLCP

[redacted]

TABLE OF CONTENTS

LIFE CARE PLAN FOR [redacted]

PREPARED ON: March 17, 2017

PREPARED FOR: Mr. Guy Smiley, Esquire
Smiley & Smiley, LLP
122 East 42nd Street, 39th Floor
New York, New York 10168
Tel: 212-986-2022
Fax: 212-697-4689

CLIENT: [redacted]

DATE OF BIRTH: 06/24/57

AGE: 59.7

LIFE EXPECTANCY: 82.2 (+22.5 years)

DATE OF INJURY: 01/13/14

INTRODUCTION

[redacted] is a 59-year-old Caucasian male referred for development of a Life Care Plan. The purpose of this evaluation is to assess the extent to which disabling conditions, as a result of a work-related fall on January 13, 2014, will impact his future medical, educational, vocational, activities of daily living and independent living needs.

The specific manner in which the resulting deficits impede [redacted] ability to demonstrate independent living skills was assessed in this report. The assessments and resulting recommendations focus on the costs, arising from his deficits, through his life expectancy. These recommendations are contained in the following Life Care Plan.

A Life Care Plan is a dynamic document, based upon published standards of practice, comprehensive assessment, data analysis, and research, that provides an organized concise plan for current and future needs with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs.[1] This report is based on the documents available for review at the time of issue, and should additional documents become available, I reserve the right to amend this plan.

The Life Care Plan will assist in determining long-term needs, including a plan of care with associated projected costs over [redacted] lifetime. The goal of the life care

[1]Life Care Planning Standards of Practice, 3rd Ed. International Association of Rehabilitation Professionals; International Academy of Life Care Planners (2015).

plan is to assist in maintaining his medical stability and maintaining or increasing his functional status and quality of life, in addition to assisting with the prevention of further potential complications.

This report will consist of three sections: a narrative, tables, and a list of resources. The narrative section will include a client interview, summarization of the available medical records, life expectancy and conclusions. The second section (Appendix A) is in table format and provides in detail the present and future projected care needs, costs, rationale, and recommendations for care. The costs will be broken down into annual (recurring) and one-time (non-recurring) costs. The final section (Appendix B) is a list of all resources used throughout both the narrative and table sections.

METHODOLOGY

The cost figures contained in this plan are primarily based on national charge data from three sources: the Optum National Fee Analyzer[2], the Context4 Healthcare Medical Fees[3], and the Yale Wasserman Physicians' Fee Reference[4]. Where applicable, HCPCS© and CPT© coding was applied to the item, and national 50th and 75th percentile charge data was assembled. This data was then modified by a geographic adjustment factor (GAF) relevant to the location of the client.

Costs gleaned from the Optum National Fee Analyzer (NFA) reflect actual provider charge data collected from health insurance payers by FAIR Health, Inc. No "allowed amounts" or "reimbursed amounts" are compiled into the data – it simply reflects what providers charge for a given service. As FAIR Health, Inc. has collected this charge data from many payers, and each payer has collected the data from its thousands of providers, this resource is comprehensive.

Costs gleaned from the Context4 Healthcare Medical Fees in the United States (MFUS) reflect "usual, customary, and reasonable fees" derived from over 400 million actual physician charges. As with the data compiled by FAIR Health, Inc. no "allowed amounts" or "reimbursed amounts" are compiled into the data. Again, it simply reflects what providers charge for a given service. As this data is derived from millions of physician charges, this resource is comprehensive.

Costs gleaned from the Physicians' Fee Reference (PFR) reflect claims made to Medicare in exchange for services rendered. While the previous two resources reflect data from calendar year 2016, note that the 2017 PFR is based on upon data from

[2] Data used in the National Fee Analyzer (NFA) is collected by FAIR Health, Inc. FAIR Health licenses the data to many of its insurance payer customers under the name FAIR Health RV Medical Module. The NFA uses data that falls within a 12-month period. The NFA 2017, used in this Life Care Plan, is based on data from 2016. Costs arising from the NFA are provided in 2016 dollars.
[3] Data used in the Context4 Healthcare 2017 Medical Fees in the United States (MFUS) is derived from the Federal Register Medicare Physician Fee Schedule for the calendar year 2016. The 2017 MFUS, used in this Life Care Plan, is based on data from 2016. Costs arising from the MFUS are provided in 2016 dollars.
[4] Data used in the 2017 Physicians' Fee Reference (PFR) is derived from the CMS Limited Data Set Standard Analytical Files for the calendar year 2015. Costs arising from the PFR are provided in 2015 dollars.

calendar year 2015. Having thoroughly evaluated the relative values of the three fee references, it is my observation that the costs designated by the PFR consistently fall between or within narrow range of the costs quoted by the NFA and the MFUS, and those costs that do not fall between the NFA and MFUS often fall within a narrow margin. As such, this source is utilized as though costs were synchronous with the other resources.

To further ensure the integrity of the data derived from the above-mentioned resources, the data is averaged and supplied as a range as follows: the low end of the range reflects an average of the GAF-adjusted 50th percentile charges across all three resources; the high end of the range reflects an average of the GAF-adjusted 75th percentile charges across all three resources. Note that by this methodology, data based on the 2016 calendar year is averaged together with data from the 2015 calendar year.

Other frequent resources used include the American Hospital Directory and Truven Health Analytics' Red Book™ (for pharmaceutical costing). See *Resources*, Appendix B, for a complete list of sources used.

American Hospital Directory is a standalone resource; it reproduces (rather than projects) actual charges. The information is gleaned from various public and proprietary data sources and therefore represents a compilation of many resources.

Truven Health Analytics' Red Book™ is a resource dedicated to information on prescription and over-the-counter medications, gleaned directly from pharmaceutical manufacturers. It provides data that, when applied appropriately, consistently corresponds with retail prices of major pharmaceutical retailers (pharmacies) across the United States.

NOTES

Please note that this report reflects an update to my original life care plan rendered on November 17, 2015. Additional medical records were provided and reviewed. This plan should be modified if/when updated recommendations by [redacted] physicians become available.

BACKGROUND INFORMATION

[redacted] a 59-year-old male born in New York. He is married to his wife, [redacted], and they reside together in Lindenhurst, New York. Together, Mr. and Mrs. [redacted] have two children, [redacted]), both of whom reside in the home with them. [redacted] also has a stepson, T[redacted] who is 32 years of age, and lives independently. [redacted] reported that prior to injury, he enjoyed training at the gym,

camping in his RV, and driving his ATV on the beach, which he states he is no longer able to perform at pre-injury levels.

[redacted] reported that he earned a high school diploma in 1976 from North Babylon Senior High School. He completed a 2-year vocational program in HVAC at Wilson Technological Center, as well as a 3-year program in Ornamental Ironworking with the Local 580.

[redacted] is a licensed burning operator and gas handler, has training in scaffolding and arc welding, and has completed the 30-hour OSHA course. He also received on-the-job training as a shop steward. He served in the United States Navy as a corporal (E4) from 1984 to 1988, receiving honorable discharge. No other training or education was reported.

At the time of injury, [redacted] was employed by Coordinator Metals as a Foreman/Ornamental Ironworker. He had been employed in this capacity since 2010. He has not returned to work following his injury. He has prior experience in Foreman Worker, Housekeeper, and Router Operator positions. No other vocational history was reported.

INTERVIEW

Records and data regarding [redacted] were provided by the law offices of Smiley and Smiley for review and use in evaluating his medical status and prognosis. He was interviewed on September 14, 2015 at their offices, located in New York, New York. He was re-interviewed via telephone on March 16, 2017, for updated information regarding his medical conditions.

LEGAL EXHIBITS REVIEWED

Summons: [redacted]

Verified Complaint: [redacted]

Verified Bill of Particulars: [redacted]

Verified Bill of Particulars (in response to demand of Genie Industries): [redacted]

Verified Bill of Particulars [redacted]

DOCUMENTS REVIEWED

2009-2013 Income Tax Returns for [redacted].

2009-2013 W-2 Forms for [redacted].

Local 580 Fund Office Records for [redacted].

MEDICAL RECORDS REVIEWED

Ambulance Call Report: 01/13/14

New York-Presbyterian Hospital
- Brian Ward, M.D.
  - Orthopedic Consultation: 01/13/14
- Gregory Salzler, M.D.
  - General Surgery Note: 01/13/14
- Andrew Meltzer, M.D.
  - Operative Report: 01/13/14
- Jian Shou, M.D.
  - Operative Report: 01/13/14
- David Helfet, M.D.
  - Operative Report: 01/13/14
- Kevin Mennitt, M.D.
  - Imaging Reports: 01/13/14 (x2), 01/14/14, 01/15/14, 01/18/14, 01/29/14, 02/13/14, 02/18/14
- Roger Bartolotta, M.D.
  - Imaging Reports: 01/13/14 (x3), 01/17/14, 01/27/14 (x2), 01/30/14, 02/04/14
- Soumitra Eachempati, M.D.
  - Operative Reports: 01/13/14, 01/31/14
  - Discharge Summary: 02/27/14
- Mohamad Alkadi, M.D.
  - Nephrology Consultation: 01/14/14

Mildred Chen, M.D.
Imaging Report: 01/14/14
Christopher Wladyka, M.D.
Imaging Reports: 01/14/14 (x2), 01/25/14, 01/31/14. 02/02/14
Yong Auh, M.D.
Imaging Reports: 01/14/14, 02/25/14
Robert Zimmerman, M.D.
Imaging Report: 01/15/14 (x2)
George Shih, M.D.
Imaging Reports: 01/15/14, 01/22/14
Lily Belfi, M.D.
Imaging Reports: 01/15/14 (x2), 01/21/14, 01/28/14 (x2), 01/30/14, 01/31/14, 02/04/14, 02/23/14
Michael Loftus, M.D.
Imaging Reports: 01/15/14, 02/10/14, 02/22/14
Keith Hentel, M.D.
Imaging Reports: 01/16/14, 01/19/14, 01/22/14 (x2), 01/27/14 (x3), 01/28/14, 02/01/14, 02/02/14 (x2), 02/03/14, 02/04/14, 02/06/14, 02/07/14, 02/08/14, 02/09/14 (x2), 02/14/14
Jocelyn Scheinert, M.D.
Imaging Report: 01/17/14
Tiffany Newman, M.D.
Imaging Report: 01/19/14
*David Wellman, M.D.
Operative Reports: 01/20/14, 02/09/14
Mildred Chen, M.D.
Imaging Reports: 01/22/14 (x2), 01/24/14, 01/27/14, 01/29/14, 02/04/14
Neil Shah, M.D.
Imaging Reports: 01/26/14, 02/08/14, 02/14/14
Krishna Juluri, M.D.
Imaging Report: 02/05/14
Ashwin Asrani, M.D.
Imaging Reports: 02/05/14, 02/06/14, 02/12/14, 02/18/14
Jessica Fisher, M.D.
Imaging Reports: 02/06/14, 02/07/14
*David Wellman, M.D.
Attending Note: 02/08/14
Robert Schloss, M.D.
Imaging Report: 02/09/14
Johnson Chen, M.D.
Imaging Report: 02/19/14
Duretti Fufa, M.D.
Orthopedic Consultation: 01/29/14
Operative Report: 02/26/14

Smithtown Center for Rehab

Multiple Practitioners
Physical Therapy Evaluation: 03/01/14
Occupational Therapy Evaluation: 03/01/14
Speech Language Evaluation: 03/02/14

NOA Diagnostics
Carl Kubek, D.O.
Imaging Reports: 03/05/14, 03/12/14
Frank Fayz, M.D.
Imaging Reports: 03/06/14, 04/11/14
Naiyer Imam, M.D.
Imaging Reports: 03/07/14 (x3), 04/12/14
Anne Glaser, M.D.
Imaging Reports: 03/26/14, 04/29/14

St. Catherine of Siena Medical Center
Harvey Gutman, M.D.
Consultation: 03/12/14

Hospital for Special Surgery
*David Wellman, M.D.
Orthopedic Progress Notes: 03/13/14, 04/24/14, 07/10/14, 07/21/14, 08/07/14, 08/14/14, 08/19/14, 09/03/14, 09/23/14, 10/02/14, 10/29/14, 12/10/14, 03/04/15, 09/02/15
Operative Report: 07/20/14
Robert Schneider, M.D.
Imaging Reports: 08/14/14, 08/19/14, 10/02/14, 12/10/14, 03/04/15, 09/02/15
Carolyn Sofka, M.D.
Imaging Reports: 08/14/14, 09/03/14
Eric Bogner, M.D.
Imaging Report: 08/22/14
John Carrino, M.D.
Imaging Report: 09/23/14
Shari Jawetz, M.D.
Imaging Report: 10/29/14
Christine Yu, M.D.
History and Physical: 01/14/15
Dacia Neuffer, P.A.
Admission Note: 01/30/15
Aaron Daluiski, M.D.
Follow-up Evaluations: 01/14/15, 06/03/15
Operative Report: 01/30/15
Orthopedic Consultation: 01/31/15
Post-operative Reports: 02/04/15, 02/11/15 (x2), 03/04/15
Romona Satchi, M.D.
Progress Note: 01/31/15

Philip Wagner, M.D.
Pain Consultations: 01/31/15, 02/01/15
Stephanie Malliaris, M.D.
Progress Note: 02/01/15
Discharge Summary: 02/01/15

Stony Brook Urology
Jason Kim, M.D.
Urology Progress Notes: 04/15/14, 05/22/14, 06/12/14, 06/17/14
Urodynamic Evaluation: 10/03/14
Alek Mishail, M.D.
Urology Progress Notes: 07/01/14, 09/17/14, 10/08/14

Advanced Rehabilitation Medicine
Jennifer Gray, D.O.
Diagnostic Study: 05/05/14

Long Island Premier Physical and Aquatic Therapy
Brandon Spahn, D.P.T.
Physical Therapy Initial Evaluation: 05/28/14
Physical Therapy: 05/30/14-06/11/14 (7 notes)

SouthBay Sports & Physical Therapy, P.C.
Multiple Practitioners
Physical Therapy Initial Evaluation; 06/30/14
Physical Therapy Plans of Care: 06/30/14, 07/03/14
Physical Therapy Re-evaluation: 07/03/14
Physical Therapy: 07/07/14-07/15/14 (4 notes)

Suffolk Orthopaedic Associates, P.C.
Matthew Kalter, M.D.
Office Visits: 07/18/14, 11/11/14, 11/25/14, 12/15/14, 01/07/15, 01/16/15, 06/08/15, 08/17/15, 06/27/16, 07/27/16, 08/24/16, 09/22/16
Richard Tabershaw, M.D.
Medical Records: 11/03/16, 11/30/16, 12/29/16, 01/26/17, 02/23/17
Procedure Note: 01/19/17

Broadlawn Manor Nursing and Rehab Center
Multiple Practitioners
Occupational Therapy Initial Evaluation: 08/02/14
Physical Therapy Initial Evaluations: 08/02/14, 08/27/14
Physical Therapy Discharge Summary: 08/22/14
Occupational Therapy Discharge Summaries: 08/22/14, 11/05/14

Mobilex USA
Robert Greco, M.D.

Imaging Reports: 09/04/14 (x2)
William Betz, M.D.
Imaging Report: 09/17/14
Jason Liu, M.D.
Addendum Report: 09/17/14
Teresa Huchun, M.D.
Imaging Reports: 09/29/14 (x2)
Unspecified Practitioner
Imaging Report: 11/04/14

Zwanger-Pesiri Radiology
Brett Helfner, M.D.
Imaging Report: 09/11/14
Matthew Young D.O.
Imaging Reports: 03/17/16 (x2)
Alex Rosioreanu, M.D.
Imaging Report: 03/23/16

Advanced Urology Centers of New York
Eric Thall, M.D.
Urology Progress Note: 02/19/15

South Nassau Communities Hospital
*Gary Lefkowitz, M.D.
Operative Report: 02/25/15

RC Island Urological Associates
*Gary Lefkowitz, M.D.
History and Physicals: 02/28/15, 03/09/15, 03/12/15
Steven Harris, M.D.
History and Physical: 03/11/15

Lenox Hill Hospital
Justin Mazur, M.D.
ED Evaluation: 03/15/15
*Christopher Dixon, M.D.
History and Physical: 03/15/15
Operative Reports: 03/16/15, 04/23/15
Discharge Note: 03/16/15
Eva Guy-Rodriguez, M.D.
Imaging Report: 03/16/15
Devon Klein, M.D.
Imaging Report: 03/16/15
Neal Epstein, M.D.
Imaging Report: 03/16/15
Pamela Unger, M.D.

Surgical Pathology Report: 04/28/15

*Christopher Dixon, M.D.
Follow-up Notes: 04/01/15, 04/29/15, 05/13/15, 06/03/15, 07/08/15
Procedure Note: 06/03/15

Matthew Skolnick, M.D.
Independent Orthopedic Examination: 04/03/15

Southside Hospital
Siram Satyanath, M.D.
Imaging Report: 04/06/15

Jonathan Vapnek, M.D.
Independent Urological Examination: 08/24/15

Stony Brook University / Department of Clinical Neurophysiology
Nurcan Gursoy, M.D.
Medical Record: 03/07/16
Michael Guido, M.D.
Electrodiagnostic Study: 05/10/16

Phelps Memorial Hospital
*Christopher Dixon, M.D.
Operative Report: 12/13/16
Medical Records: 01/04/17, 02/15/17

* Please note that an asterisk next to the name of a practitioner indicates that he or he may be found in more than one location in the above medical summary.

MEDICAL HISTORY SUMMARY

The medical records reviewed for this evaluation indicate that [redacted] was involved in a work-related fall on January 13, 2014. He sustained extensive injuries to the pelvis, as well as suffering subsequent respiratory failure with hypoxia. He was brought to New York-Presbyterian Hospital for evaluation and treatment. A synopsis of the medical records is as follows:

On 01/13/14 there was an ambulance call report that read as follows:

> Pt is a 56 y/o male found lying supine at construction site c/o back pain after falling approx. 30 ft when a scissor lift tipped over. Pt stated he landed on his (L) elbow.

On 01/13/14 [redacted] was admitted to New York-Presbyterian Hospital. Dr. Brian Ward held an orthopedic consultation. He noted:

> A/P: 56M APC pelvic injury, L elbow deformity, and low back pain s/p pelvic binder placement.

On 01/13/14 Dr. Andrew Meltzer performed surgery. He specified:

> Pre-op Diagnosis: Trauma.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Aortogram with runoff, selective angiography of the right iliac and right hypogastric artery, selective angiography of the left hypogastric artery, and inferior vena cava filter placement with ascending venogram.

On 01/13/14 Dr. Jian Shou performed a surgical procedure. He outlined:

> Pre-op Diagnosis: Respiratory failure and hypoxia and urethral injury.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Bilateral chest tubes and retrograde urethrogram.

On 01/13/14 Dr. David Helfet performed a surgical procedure. He delineated:

> Pre-op Diagnosis: Unstable pelvic ring injury in a closed dislocated left elbow.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Closed reduction and application of a pelvic external fixator and right femoral traction pin, as well as closed reduction and splinting of left elbow.

On 01/13/14 Dr. Roger Bartolotta conducted imaging procedures. He determined:

> Study #1: Pelvis
>
> Impression: 1. Pubic symphyseal diastasis measuring up to 6.3 cm.
> 2. Probable right sacral fracture …
>
> Study #2: Pelvis
>
> Impression: Interval decrease in pubic symphyseal diastasis, now measuring up to 3.3 cm.

On 01/13/14 Dr. Soumitra Eachempati operated on Mr. [redacted] He indicated:

Pre-op Diagnosis: Multiple trauma, shock.

Post-op Diagnosis: [Same.]

Operation: Exploratory laparotomy.

On 01/14/14 Dr. Mohamad Alkadi administered a nephrology consultation. He recorded:

A/P
oliguric Acute kidney injury in setting of urethral injury, rhabdomyolysis, hypotension …

On 01/14/14 Dr. Christopher Wladyka performed imaging procedures. He asserted:

Study: Right Hip

Impression: Partially imaged is persistent widening of the symphysis pubis. No definite acute displaced fracture in the right femur and right hip is identified. An external screw seen in the distal femoral diaphysis.

On 01/15/14 Dr. Robert Zimmerman reviewed images. He concluded:

Study: CT Cervical Spine w/o Contrast

Impression: 1. No acute fracture or soft tissue injury.
2. Congenital-developmental canal stenosis with multilevel stenosis … Canal stenosis is most marked at C5-C6 and C6-C7

On 01/15/14 Dr. George Shih analyzed images. He assessed:

Study: CT Abdomen w Contrast

Impression: 1. No evidence of contrast extravasation on CT urogram to suggest injury to the bilateral ureters. However artifact related to positioning of patient upper extremities somewhat limits the evaluation.
2. Retroperitoneal hematoma centered along the right psoas muscle …
3. Comminuted fracture of the right sacral ala. No other fractures identified.

On 01/15/14 Dr. Lily Belfi interpreted images. He averred:

Study: Pelvis

Impression: 1. External fixation of bilateral iliac wings with decreased widening of the pubic symphysis …
2. Distal femoral fixation screw with tricompartment osteoporosis at the knee.

On 01/20/14 Dr. David Wellman conducted an operative procedure. He recorded:

Pre-op Diagnosis: Unstable tile-C pelvic ring injury.

Post-op Diagnosis: [Same.]

Operation: 1. Anterior pelvic ring external fixation application and revision.
2. Posterior L sacroiliac screw placement.
3. Posterior R sacroiliac screw placement.
4. Diagnostic fluoroscopy.

On 01/27/14 Dr. Roger Bartolotta administered imaging procedures. He opined:

Study #1: Left Elbow

Impression: 1. Apparent dorsal dislocation of the radiocapitellar joint.
2. Evaluation of ulnohumeral alignment is limited by obliquity of the lateral view; ulnohumeral subluxation/dislocation cannot be excluded.

Study #2: Left Elbow

Impression: Limited examination due to overlying splint material and nonstandard radiographic positioning. Apparent interval reduction of radiocapitellar dislocation.

On 01/28/14 Dr. Lily Belfi conducted imaging procedures. She found:

Study #1: CT Pelvis w/o Contrast

Impression: 1. Interval improvement in alignment of bilateral sacral fractures status post placement of additional bilateral external fixation screws.
2. Additional external fixation screws and internal fixation screws transfixing bilateral sacroiliac joints are identified in unchanged position.
3. New intramuscular hematoma extending into the bilateral adductor musculature.

Study #2: CT Elbow w/o Contrast (Lt)

Impression: 1. Subluxation of the humeroulnar articulation and widening of the radiocapitellar joint.
2. Fracture of the ulnar coronoid process, tiny intra-articular fracture fragment within the radiocapitellar joint and avulsion fracture at the lateral humeral epicondyle …

On 01/31/14 Dr. Soumitra Eachempati operated on Mr. [redacted]. She documented:

Pre-op Diagnosis: Respiratory failure, multiple trauma.

Post-op Diagnosis: [Same.]

Operation: Tracheostomy.

On 02/02/14 Dr. Christopher Wladyka performed imaging procedures. He related:

Study #1: Elbow Left

Impression: Radiocapitellar and ulnohumeral dislocation with anterior and superior displacement of the distal left humerus.

Study #2: Left Elbow

Impression: The overlying cast has been removed in the interval. There has been interval relocation of the elbow. No dislocation is identified on the current single lateral view. Evaluation is slightly limited due to increased flexion, limiting evaluation for joint effusion. Tiny ossific fragment is seen adjacent to the coronoid process.

On 02/04/14 Dr. Roger Bartolotta analyzed images. He determined:

Study: Left Elbow

Impression: 1. Small minimally displaced fracture of the ulnar coronoid process and impaction fracture at the dorsal aspect of the capitellum are unchanged.
2. No new fracture or dislocation is identified. Overlying splint material obscures fine osseous detail.

On 02/09/14 Dr. David Wellman performed surgery. He indicated:

Pre-op Diagnosis: Unstable pelvic ring injury.

Post-op Diagnosis: [Same.]

Operation: 1. Removal anterior external fixation.
2. Revision anterior external fixation.

On 02/09/14 Dr. Robert Schloss reviewed images. He asserted:

Study: Pelvis

Impression: Diastasis of the pubic symphysis.

On 02/18/14 Dr. Kevin Mennitt interpreted images. He assessed:

Study: [Right foot, right ankle, pelvis, and left elbow]

Impression: 1. Right foot: Osteoarthrosis … No significant [abnormality?] at the first metatarsophalangeal joint where there is also hallux valgus.
2. Right ankle: No acute fracture or dislocation. There is minimal mature periosteal reaction along the distal lateral shaft. This may be unrelated to the trauma.
3. Pelvis: Bilateral screws fixing the sacroiliac joints are again noted with bilateral sacral fractures and widening of the left sacroiliac joint unchanged. The pubic symphysis is widened. Increased since the previous [exam?] measuring up to 15 mm but with intact alignment. Probable maturing heterotopic ossification in the adjacent soft tissues of the pelvis particularly along the right iliac wing and near the pubic symphysis.
4. Left elbow: There is circumferential maturing heterotopic ossification in the soft tissues.

On 02/22/14 Dr. Michael Loftus administered imaging procedures. He concluded:

Study: Elbow Left

Impression: No new fracture. The radial head is minimally dorsally subluxed relative to the capitellum.

On 02/26/14 Dr. Duretti Fufa conducted an operative procedure. She specified:

Pre-op Diagnosis: Left elbow dislocation.

Post-op Diagnosis: [Same.]

Operation: Left elbow closed reduction and placement of a hinged external fixator.

On 02/27/14 Dr. Soumitra Eachempati authored a discharge summary. She documented:

Discharge Diagnosis:
1. Fall from 30 ft
2. Open book pelvic fracture
3. L elbow dislocation
4. Urethral injury.

On 03/07/14 Dr. Naiyer Imam conducted imaging procedures. He averred:

Study #1: Lt hand

Impression: 1. No definite radiographic evidence of acute fracture or dislocation.
2. Moderate soft tissue swelling of the wrist and palm of hand.
3. Mild osteoporosis demonstrated.
4. Mild degenerative arthritis.

Study #2: Abdomen

Impression: 1. Mild degree of osteoporosis.
2. Mild spondylosis.

On 03/12/14 Dr. Harvey Gutman held a consultation. He wrote:

Impression: Malfunction of suprapubic tube with current obstruction of suprapubic site and cystostomy is now obstructed.

On 04/11/14 Dr. Frank Fayz performed imaging procedures. He opined:

Study: Right hip

Impression: 1. No definite radiographic evidence of an acute fracture or dislocation.
2. Moderate osteoporosis demonstrated.

On 04/15/14 Dr. Jason Kim drafted a urology progress note. He stated:

Diagnosis: transected urethra.

A/P
1. Urethral distraction injury
2. bladder spasms

On 04/29/14 Dr. Anne Glaser analyzed images. She found:

Study: Chest

Impression: 1. No focal infiltrates or pleural effusion.
2. Mild osteoporosis demonstrated.
3. Mild osteoarthritis.

On 04/24/14 Dr. David Wellman re-examined [redacted]. He reported:

The patient is status post a fall of 30 feet with poly trauma, including respiratory failure requiring a trache PEG, as well as left elbow dislocation and pelvic ring injury requiring anterior and posterior fixation which includes urethral damage.

On 05/05/14 Dr. Jennifer Gray performed a diagnostic study. She related:

Study: Electrodiagnostic examination of the bilateral lower extremities

Impression: 1. A right lumbosacral plexopathy affecting at least the sciatic (peroneal component predominantly), inferior gluteal, and superior gluteal nerves, severe in degree electrically. The inferior and superior gluteal nerves appear to be involved more than the sciatic, with severe neuropathic changes and evidence of reinnervation to the gluteus maximus and minimus muscles.
2. Active and chronic motor axon loss changes in L5/sciatic innervated muscles, along with abnormal sensory and motor nerve conduction responses in the left lower extremity are supportive of a left sciatic nerve lesion, moderate in degree electrically, best located proximal to the innervations to the hamstrings.

On 06/12/14 Dr. Jason Kim composed a urology progress note. He stated:

A/P
1. urethral trauma

On 07/01/14 Dr. Alek Mishail made a urology progress note. He wrote:

… pt developed progressive slower stream and urinary incontinence, has been leaking at night and daytime requiring diaper.

On 07/18/14 Dr. Matthew Kalter evaluated [redacted]. He noted:

he fx his pelvis which tore his urethra and caused kidney failure. He was then in a drug induced coma for 6 weeks followed by 3 months of rehab.

Pain is worse with sitting and lying down and he cannot get comfortable to sleep at night.

On 07/20/14 Dr. David Wellman operated on [redacted]. He wrote:

Pre-op Diagnosis: Pelvic instability with nonunion of the sacrum and vertical migration of the right hemipelvis.

Post-op Diagnosis: [Same.]

Operation:
1. Open reduction and internal fixation anterior pelvic ring.
2. Removal of hardware from both right and left pelvis (deep buried implants).
3. Placement right side iliosacral screw.
4. Open reduction and internal fixation of sacrum nonunion with local autograft and DMP.

On 08/14/14 Dr. Robert Schneider conducted imaging procedures. He assessed:

Study: CT pelvis w/o contrast

Impression:
1. Ununited fracture of the right sacral ala with internal fixation. United fracture of the left sacral ala.
2. United displaced fracture of the coccyx.
3. Side plate across the symphysis pubis.
4. Heterotopic ossification around the symphysis pubis and inferior pubic rami bilaterally.

On 08/19/14 Dr. Robert Schneider performed imaging procedures. He concluded:

Study: Pelvis

Impression: Fractures of the right and left sacral ala with fixation. Widening of the symphysis pubis with reconstruction plate across the superior aspect of the symphysis pubis.

On 09/04/14 Dr. Robert Greco reviewed images. He related:

Study: Bilateral hips

Impression: Postoperative changes of the sacroiliac joints and symphysis pubis. Prominent enthesophytes of the anterior/superior iliac spines bilaterally.

On 09/17/14 Dr. William Betz interpreted images. He determined:

Study: Pelvis

Impression: Bone demineralization is present. There is degenerative joint disease in the hips bilaterally.

On 09/29/14 Dr. Teresa Huchun administered imaging procedures. She asserted:

Study #1: Hip … left

Impression: Mild osteoarthritis of the left hip. Fixation of the pubic symphysis …

Study #2: Hip … right

Impression: Modest osteoarthritis of the right hip.

On 10/02/14 Dr. Robert Schneider analyzed images. He averred:

Study: Pelvis

Impression: Right sacral ala fracture.

On 10/03/14 Dr. Jason Kim conducted a urodynamic evaluation. He commented:

A/P
1. Decreased bladder compliance.
2. High pressure voiding with a poor flow.

On 01/07/15 Dr. Matthew Kalter followed up with [redacted]. He reported:

… a solution containing 1 ½ cc of 1% lidocaine and 6mg of Celestone was injected into each transforaminal space …

On 01/14/15 Dr. Christine Yu administered a history and physical. She commented:

Impression: The patient is a 57 year old male with past medical history of HTN, OSA, respiratory failure s/p trach, ARF requiring suprapubic catheter and dialysis (now recovered), neuropathy, obesity, DVT presenting for preoperative medical evaluation for L elbow contracture release.

On 01/14/15 Dr. Aaron Daluiski followed up with [redacted]. He remarked:

Diagnosis: Contracture left elbow, status post dislocation.

On 01/16/15 Dr. Matthew Kalter held an orthopedic office visit. He stated:

Occupation: The patient has been disabled.

Diagnosis:

1. Lumbar Neuritis or Radiculitis Not Otherwise Specified
2. Lumbago

Temporary impairment: Temporary impairment is 100%.

On 01/30/15 Dr. Aaron Daluiski conducted an operative procedure. He documented:

Pre-op Diagnosis: Left stiff elbow.

Post-op Diagnosis: Same.

Operation: Contracture release left elbow, ulnar nerve neurolysis, anterior transposition and excision of extensive heterotopic bone left elbow. Triceps tenolysis.

On 02/01/15 Dr. Stephanie Malliaris authored a discharge summary. She remarked:

Admitting Diagnosis:
Joint contracture of the upper arm

On 02/25/15 Dr. Gary Lefkowitz operated on Mr. [redacted]. He outlined:

Pre-op Diagnosis: Urethral stricture.

Post-op Diagnosis: [Same.]

Operation: Cystoscopy and holmium laser incision of urethral stricture.

On 03/04/15 Dr. Robert Schneider reviewed images. He opined:

Study: Pelvis

Impression: Posttraumatic changes in the pelvis with internal fixation of the sacroiliac joints and symphysis pubis.

On 03/09/15 Dr. Gary Lefkowitz treated Mr. [redacted]. He wrote:

Assessment …
1. Urethral stricture
2. Urgency of urination
3. Erectile dysfunction

On 03/15/15 Dr. Justin Mazur conducted an ED evaluation. He stated:

Diagnosis:
1. Acute urinary retention

2. Urethral injury

On 03/16/15 Dr. Christopher Dixon performed a surgical procedure. He recorded:

Pre-op Diagnosis: 1. Urinary retention.
2. Traumatic membranous urethral stricture.

Post-op Diagnosis: [Same.]

Operation: 1. Cystoscopy.
2. Dilation and placement of suprapubic tube.
3. Retrograde urethrogram.
4. Cystogram.

On 04/03/15 Dr. Matthew Skolnick performed an independent orthopedic examination. He reported:

> The claimant stated that he was working on a scissor lift when the lift tipped over. The claimant sustained reported injuries to the head, left shoulder, left elbow, right ankle, "broken" pelvis and "torn" urethra. There were no lacerations. There was a loss of consciousness (unspecified amount of time) as a result of this accident.
>
> Employment History: The claimant was employed full-time as an ironworker. He has not returned to work since the accident occurred on 1/13/14 …
>
> Diagnoses:
> 1. Lumbar spine strain with possible radiculopathy.
> 2. Status post left shoulder dislocation.
> 3. Status post left elbow ulnar nerve transposition and fracture/dislocation.
> 4. Status post pelvic fracture and diastasis of pubic symphysis and sacroiliac joint.
>
> Causal Relationship: … it appears that the above-diagnosed injuries are causally related to the accident on 1/13/14.
>
> Treatment: Physical therapy treatment to all affected areas is reasonable, related, and necessary for 8 weeks at a frequency of 3 times per week, after which the claimant should have an orthopedic re-examination to determine the necessity for further treatment. … An EMG of the lower extremities for possible radiculopathy is requested.
>
> Disability/Ability to Work: … there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time.

On 04/23/15 Dr. Christopher Dixon performed surgery. He delineated:

Pre-op Diagnosis: Traumatic membranous urethral stricture.

Post-op Diagnosis: [Same.]

Operation:
1. One-stage excision and end-to-end repair of membranous urethral stricture.
2. Flexible cystoscopy.
3. Change of suprapubic tube.

On 06/03/15 Dr. Christopher Dixon performed a procedure. He noted:

Procedure: Flexible cystoscopy.

On 06/03/15 Dr. Aaron Daluiski treated Mr. [redacted]. He indicated:

Diagnosis: Status post left elbow contracture release.

On 06/08/15 Dr. Matthew Kalter examined the patient in follow-up. He reported:

History:
[redacted] a 57 year 11 month old patient, presents today for a follow-up evaluation of a Worker's Compensation injury. This involves primarily the lumbar spine. The patient states the pain has neither worsened nor improved since the last visit. Patient still complains of pain and numbness in the right leg and the lateral side of the right foot. Did get relief from selective nerve root block but pain had returned already. We will be starting acupuncture today and hoping that gives him some relief…

Diagnosis: Lumbar neuritis or radiculitis not otherwise specified.

On 08/24/15 Dr. Jonathan Vapnek performed an independent urological examination. He commented:

In summary, [redacted] was injured on January 13, 2011[5], when he fell nearly 30 feet from a scissor lift, sustaining severe pelvic fractures, membranous urethral disruption and injuries to the left elbow and shoulder. His urethral disruption was initially managed with a suprapubic tube and then with a minimally invasive endoscopic alignment. When that failed, he underwent definitive treatment with an open, end-to-end membranous urethroplasty by Dr. Dixon. While that surgery was technically successful, Mr. [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture. In the future, he may very well require placement of an artificial urinary sphincter if these symptoms do not improve over time.

[5] This should likely read "2014".

His erectile dysfunction is an expected consequence of the pelvic fracture, in which there is often damage to the arteries and the nerves involved in normal erectile function. The use of daily Cialis 10 mg is clearly indicated and may not only improve his erectile function currently but may do so long-term as well. If his response proves to be inadequate, he would be an excellent candidate for intracavernosal injection of vasoactive medication or even surgical placement of an inflatable penile prosthesis.

On 09/02/15 Dr. Robert Schneider interpreted images. He found:

Study: Pelvis

Impression: 1. Internal fixation of a sacral fracture.
2. Internal fixation of the symphysis pubis.

On 09/02/15 Dr. David Wellman re-evaluated [redacted]. He noted:

Assessment/Plan: We have continued his physical therapy prescription for overall strengthening an[d] gait training. I have also re-referred him back to the orthotics to have him evaluated for a spring-loaded AFO.

Problem List:
1. Nonunion Of Fracture
2. Unspecified Closed Fracture Of Pelvis

On 03/07/16 Dr. Nurcan Gursoy completed a neurology consultation. He reported:

Impression and Plan:
The patient is a 58 year old right handed male with past medical history significant for hypertension, status post fall from 30 feet at work on 01/13/14 which resulted in multiple injuries including unstable pelvic fracture and transection of urethra, left elbow dislocation, status post surgery. He had prolonged hospitalization [he says he was in coma for 2 months with status post trach and PEG (both were removed)] and prolonged rehabilitation at Smith Town for 3 months who presents today with complaints of severe pain and right buttocks while sitting radiating to right leg and foot. Since his symptoms only occur while he was sitting we discussed sciatic nerve compression like that seen pyriformis syndrome. It is possible that this pain can be due to lumbar radiculopathy. I will obtain MRI of lumbar spine for evaluation of lumbar radiculopathy. I will also obtain MRI of right leg for rule out any sciatic nerve compression and gluteal area.

He also has urinary incontinence, ED, and numbness in penis and scrotum. He also reports having severe sharp pain in penis. We discussed that this can be due to pudendal nerve injury. We also discussed that he may have

genitofemoral, sacral plexus injury… He does report having "fecal incontinence feeling the need to go all the time"… We discussed that it is impossible to predict whether he will get complete recovery, but given he has symptoms since January 2014, even if he gets some improvement, he may always have symptoms at some degree…

On 03/17/16 Dr. Matthew Young performed imaging procedures as follows:

Study: MRI Lumbar

Impression: Unchanged moderate-severe central spinal canal stenosis at L4-L5 secondary to a shallow disc bulge and facet arthropathy. Unchanged moderate left subarticular recess stenosis and moderate left foraminal stenosis at L5-S1. Unchanged mild disc degenerative changes from L1-L4. Susceptibility artifact related to prior posterior pelvic stabilization.

Study: MRI Sacral Plexus w/w/o Contrast

Impression: Chronic vertically oriented fracture of the right hemisacrum transversing the visualized lower sacral foramina. There is scar tissue within the right presacral fat, in the expected location of the lower band of the right sacral plexus. The plexus itself is not definitively seen within the region of the scar tissue.

On 03/23/16 Dr. Alex Rosioreanu completed imaging procedures. He opined:

Study: MRI Right Thigh w/w/o Contrast

Impression: No evidence of abnormal contrast enhancement or lesions. Small right knee joint effusion. Small popliteal cyst.

On 05/10/16 Dr. Michael Guido performed an electrodiagnostic study. He noted:

Study: SSEP

Impression: Abnormal pudendal nerve evoked potentials due to absent responses; this is indicative of pudendal nerve neuropathy.

On 09/22/16 Dr. Gary Halter examined [redacted] in follow-up. He documented:

[redacted] presents today for a follow-up for a Worker's Compensation injury related to the right leg and pelvis bone…

Diagnoses:
1. Radiculitis lower lumbar.

2. Spondylosis with radiculopathy, lower lumbar.
3. Spinal stenosis, lower lumbar.

Work Status: Continue current status and disability.

On 09/24/15 Dr. Matthew Kalter performed a pain management intervention as follows:

Procedure: Right L4 and L5-S1 selective nerve root block.

On 12/13/16 Dr. Christopher Dixon performed a surgical procedures as follows:

Pre-op Dx: Urinary incontinence secondary to severe pelvic trauma.

Post-op Dx: [Same.]

Procedure:
1. Insertion of artificial urinary sphincter.
2. Flexible cystoscopy.

On 01/19/17 Dr. Richard Tabershaw performed a pain management intervention as follows:

Procedure: Right L5 and S1 transforaminal epidural steroid injection.

Diagnoses:
1. Spondylosis with radiculopathy, lower lumbar.
2. Radiculitis lower lumbar.

On 02/15/17 Dr. Christopher Dixon examined the patient in follow-up. He noted:

> We activated the artificial sphincter. I think he will do quite well. It was very easy for him to figure out how to work the device.
>
> It activated without any difficulty.
>
> He is also pretty dry even without it, although he does wear a pad. I think now that it is activated, his incontinence should get quite a bit better.
>
> He will have some time for his bladder to hopefully improve its functions.
>
> He is interested in starting the process for penile prosthesis for impotence. We will give a little bit of time, but we will see him back in 1 month to see how he is doing. Once we're confident that the sphincter is working without any issues, we will proceed with the penile implant.

On 02/23/17 Dr. Richard Tabershaw re-examined [redacted]. He reported:

[redacted] presents today for a follow-up for a Worker's Compensation injury related to the lumbar spine… Patient states the pain has neither worsened nor improved since last visit. Patient rates his pain as 6 on scale of 0-10…

Diagnoses:
4. Radiculitis lower lumbar.
5. Spondylosis with radiculopathy, lower lumbar.
6. Spinal stenosis, lower lumbar.

Temporary disability: 100% status post right L5 and S1 selective nerve root block with no relief…

SURGERY / PROCEDURE TIMELINE

Date(s); Physician	Procedure(s)	Diagnoses
01/13/14; Dr. Soumitra Eachempati	Exploratory laparotomy.	Multiple trauma, shock.
01/13/14; Dr. Andrew Meltzer	Aortogram with runoff, selective angiography of the right iliac and right hypogastric artery, selective angiography of the left hypogastric artery, and inferior vena cava filter placement with ascending venogram.	Trauma.
01/13/14; Dr. Jian Shou	Bilateral chest tubes and retrograde urethrogram.	Respiratory failure and hypoxia and urethral injury.
01/13/14; Dr. David Helfet	Closed reduction and application of a pelvic external fixator and right femoral traction pin, as well as closed reduction and splinting of left elbow.	Unstable pelvic ring injury in a closed dislocated left elbow.
01/20/14; Dr. David Wellman	1. Anterior pelvic ring external fixation application and revision. 2. Posterior L sacroiliac screw placement. 3. Posterior R sacroiliac screw placement. 4. Diagnostic fluoroscopy.	Unstable tile-C pelvic ring injury.
01/31/14; Dr. Soumitra Eachempati	Tracheostomy.	Respiratory failure, multiple trauma.
02/09/14; Dr. David Wellman	1. Removal anterior external fixation. 2. Revision anterior external fixation.	Unstable pelvic ring injury.
02/26/14; Dr. Duretti Fufa	Left elbow closed reduction and placement of a hinged external fixator.	Left elbow dislocation.

Date(s); Physician	Procedure(s)	Diagnoses
07/20/14; Dr. David Wellman	1. Open reduction and internal fixation anterior pelvic ring. 2. Removal of hardware from both right and left pelvis (deep buried implants). 3. Placement right side iliosacral screw. 4. Open reduction and internal fixation of sacrum nonunion with local autograft and DMP.	Pelvic instability with nonunion of the sacrum and vertical migration of the right hemipelvis.
01/30/15; Dr. Aaron Daluiski	Contracture release left elbow, ulnar nerve neurolysis, anterior transposition and excision of extensive heterotopic bone left elbow. Triceps tenolysis.	Left stiff elbow.
02/25/15; Dr. Gary Lefkowitz	Cystoscopy and holmium laser incision of urethral stricture.	Urethral stricture.
03/16/15; Dr. Christopher Dixon	1. Cystoscopy. 2. Dilation and placement of suprapubic tube. 3. Retrograde urethrogram. 4. Cystogram.	1. Urinary retention. 2. Traumatic membranous urethral stricture.
12/13/16; Dr. Christopher Dixon	1. Insertion of artificial urinary sphincter. 2. Flexible cystoscopy.	Urinary incontinence secondary to severe pelvic trauma.

PERTINENT MEDICAL HISTORY

[redacted] reported having been in good physical and mental health prior to the incident in question. He did note having a previous diagnosis of hypertension, which was being managed by Bystolic, nisoldipine, and losartan. The medical records support him as a historian.

CURRENT PHYSICAL LIMITATIONS

In interview, [redacted] noted that many of his physical capacities have been diminished. Specifically, he indicated:

- Lifting: avoids
- Sitting: less than 15 minutes; weight-shifting no longer alleviates pain
- Navigating Stairs: very difficult due to right-sided weakness; ascending is harder; ascends using all four limbs on stairs or relying heavily on banister; descending is frightening
- Balancing: difficult; has had 5 major falls and several additional minor falls since 2014
- Stooping: difficult; avoids
- Driving: up to 60 minutes with pain

- Reaching: moderately difficult due to loss of range of motion in left elbow
- Standing: less than 5 minutes
- Walking: less than ¼ block; breaks frequently
- Sleeping: disrupted by pain and urinary urgency; 60-90 minutes before waking; total 5-6 hours of sleep nightly

He rated his pain on the following pain scale:

Pain Level	Description
0	No pain
1	Mild pain; you're aware of it, but it doesn't bother you
2	Moderate pain; tolerable without medications
3	Moderate pain; requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; unbearable

Area	Frequency	Pain Intensity
Left Shoulder	1x/month	6
Left Elbow	3-4x/week	6; locking, popping
Low Back	1x/month	6 to 7
Right Leg/Heel	Constant	8; numbness, tingling

In addition, [redacted] reported experiencing discomfort in his penis/urethra as a result of urinary urgency. He urinates hourly, and has incontinent episodes once to twice per week. He reported that this is significantly better than prior to his recent artificial sphincter insertion, but that it still occurs.

[redacted] also reported being constipated, and attempting to move his bowels 5 to 6 times per day. He noted that sometimes he cannot distinguish between the urge to urinate and the urge to defecate.

HOME / DAILY ACTIVITIES

As noted above, [redacted] lives with his wife and two sons in the family home in Lindenhurst, New York. There are three steps between street level and the front door. Theirs is a two-story home with a finished basement.

[redacted] goes to the gym 4 to 5 times per week in an attempt to lose weight. His daily routine is generally comprised of running errands with his wife and watching television, as well as attending any scheduled medical appointments.

He is independent in his personal care tasks, including toileting, bathing, grooming, and dressing. He is also able to perform light home cleaning tasks, such as dusting or loading the dishwasher.

[redacted] reported using an electric scooter for community mobility; he uses the scooters with attached carts provided by stores for grocery shopping. He is able to complete routine errands, such as going to the bank or post office, but noted that he must park his car very near to the entrance so as to minimize walking distance. He possesses a disabled parking placard.

[redacted] has the most difficulty with heavier home cleaning tasks, with which he previously assisted his wife. He is also no longer able to launder clothing independently, as he cannot navigate stairs while carrying a laundry basket. His family members carry the basket for him, and he is able to load the washer and dryer independently. He also relies on his family members for lawn care and home maintenance.

[redacted] related that he feels sad at times due to his condition. He experiences fear of heights, and anxiety about his pain and his future. When his pain flares, he becomes irritable and snaps at his wife. He was willing to entertain the idea of counseling services.

CURRENT MEDICATIONS

[redacted] takes the following medications related to his injury:

Medication	Dosage	Purpose
Oxycodone 10mg	2x/day	Opioid analgesic

TREATING PROVIDERS

[redacted] is currently followed by:

- Dr. David Wellman, orthopedic surgeon (pelvis)
- Dr. Aaron Daluski, orthopedic surgeon (elbow)
- Dr. Christopher Dixon, urologist
- Dr. Richard Tabershaw, pain management specialist (replaced Dr. Kalter)

[redacted] reported that he is being scheduled for a penile implant in the near future. He is also planning to establish care with a bariatric surgeon for a gastric bypass procedure.

MEDICAL TEAM / PROVIDER COMMENTS

In teleconference on November 13, 2015, Dr. Dixon recommended:

- Lifelong follow-up with a urologist 2 to 4 times per year
- Lifelong uroflowmetry, post-void residual, and urinalysis 2 times per year
- Penile Doppler and/or arteriogram 1 to 2 times
- Probable artificial urinary sphincter placement (completed)
- Possible treatment for recurrent stricture
- Possible penile prosthesis implant (forthcoming)
- Possible other urethral repairs
- Continued use of medications and intracavernosal injections to treat erectile dysfunction (has ceased; will be redundant with penile prosthesis)

In teleconference on November 16, 2015, Dr. Wellman recommended:

- Lifelong annual follow-up with an orthopedic surgeon (pelvis)
- Routine annual x-rays
- Physical therapy twice per week for 2 years; beyond that timeframe, on an as-needed basis
- Lifelong use of an ankle foot orthosis
- Possible conservative or surgical interventions to the lumbar spine as a result of altered gait biomechanics

In teleconference on November 17, 2015, Dr. Kalter recommended:

- Lifelong follow-up with a pain management specialist every 1 to 2 months
- Lifelong annual MRI of the lumbar spine
- Lifelong nerve block injections to the lumbar spine 3 times per year
- One-time lumbar laminectomy with possible fusion

LIFE CARE PLAN RECOMMENDATIONS

1. Medical care including, but not limited to:
   - Lifelong follow-up with two orthopedists (pelvis, upper extremity), a urologist, and a pain management specialist at variable frequencies.

2. Diagnostic testing including, but not limited to:
   - Lifelong uroflowmetry, post-void residual, and urinalysis 2 times per year.
   - One to two penile duplex scans and penile angiographies over life expectancy.
   - Lifelong annual x-ray of the pelvis, x-ray of the elbow, and MRI of the lumbar spine.

- Lifelong periodic MRI of the elbow, MRI of the pelvis, and CT of the abdomen.
- One to two EMG/NCV studies over life expectancy.

3. Therapy interventions including, but not limited to:
   - Lifelong annual physical therapy evaluation, plus resumption of biweekly physical therapy for remainder of 2-year expected duration. Beyond this timeframe, an allowance of 12 to 24 sessions per year through life expectancy.
   - Lifelong periodic occupational therapy evaluation, plus 8 to 16 immediate occupational therapy sessions.
   - Immediate psychological evaluation, plus weekly counseling sessions for one year.
   - Immediate nutritional evaluation, plus biweekly counseling sessions for 1 to 2 years.
   - Post-operative course of physical therapy 3 times per week for 8 to 12 weeks.

4. Medications as reported by [redacted].

5. Surgical procedures including, but not limited to:
   - An allowance of 1 to 3 urinary sphincter replacements over life expectancy.
   - Lifelong lumbar nerve blocks 3 times per year.
   - One-time lumbar laminectomy with or without fusion.
   - One-time penile prosthesis implantation, and an allowance of 0 to 1 replacement over life expectancy.

6. Aids for independence and supplies as recommended to reduce pain, minimize exacerbations, and maximize independence in routine activities of daily living.

7. Lifelong replacement of a unilateral ankle foot orthosis.

8. The services of a companion/homemaker beginning immediately for 9 hours per week, extending to age 65; beyond this timeframe, home health services 26 hours per week through life expectancy.

9. Case management services for medical management and cost containment.

The plan provides for continuation of care through life expectancy.

LIFE EXPECTANCY

To estimate the life expectancy of an individual is beyond the scope of practice of a Life Care Planner. For cost projection purposes, the tables compiled by the National Center

of Health Statistics are utilized in order to provide an approximation of [redacted] remaining lifespan. The use of these tables does not signify any endorsement of their validity, and I reserve the right to modify the life expectancy and cost projections contained in this plan if [redacted] treating physicians provide alternative estimations.

[redacted] is currently 59.7 years of age. An individual of this age, gender, and ethnicity is projected to live an additional 22.5 years, to the age of 82.2, according to the National Center of Health Statistics.[6]

CONCLUSIONS

Pertinent medical, rehabilitation reports and data were carefully considered in this report. This life care plan is based on record review and interview with [redacted] and his treating practitioners.

His disability has affected all aspects of his life. It is essential that he receive sufficient medical care to assist him in activities of daily living and to maximize his potential.

[redacted] residual injuries will impact his future medical, educational, vocational, activities of daily living and independent living needs. He will require medical and rehabilitation intervention and support throughout the remainder of his life. Specific recommendations and needs have been provided in this life care plan.

The goal of this Life Care Plan is to provide the care that will maintain/increase [redacted] medical stability and quality of life, and prevent potential complications. The plan provides for medical care, evaluations, therapies, and other services to promote and maintain independence and to prevent complications. This plan should be re-evaluated/modified if complications develop and/or as progressive aging alters his medical condition and functional status.

I reserve the right to amend my findings contingent on additional medical or educational documentation furnished to me in the future.

[6] National Vital Statistics Reports, Vol. 65, No. 8. *Table 5: Life table for white males:* United States, 2012. Centers for Disease Control and Prevention. November 28, 2016.

[redacted]

[redacted]

[redacted]

APPENDIX A: LIFE CARE COST PROJECTIONS

TABLE OF CONTENTS

Lifetime Projected Costs: [redacted]				
Projected Care:	**Duration Required (Years):**	**Annual Cost:**	**Annual Cost x Duration Required:**	**Total One-Time Cost:**
Physician Follow-Up	1.0	$1,740.00 - $2,184.00	$1,740.00 - $2,184.00	$0.00
Physician Follow-Up	21.5	$290.00 - $728.00	$6,235.00 - $15,652.00	$0.00
Physician Follow-Up	22.5	$1,160.00 - $2,730.00	$26,100.00 - $61,425.00	$0.00
Diagnostics	22.5	$3,750.20 - $5,733.00	$84,379.50 - $128,992.50	$3,169.00 - $8,778.00
Therapy Evaluations	0.1	$0.00	$0.00	$432.00 - $556.00
Therapy Evaluations	22.5	$211.67 - $261.67	$4,762.58 - $5,887.58	$160.00 - $198.00
Therapies	0.7	$12,384.00 - $15,648.00	$8,668.80 - $10,953.60	$0.00
Therapies	1.0	$7,536.00 - $9,504.00	$7,536.00 - $9,504.00	$968.00 - $2,432.00
Therapies	2.0	$0.00	$0.00	$3,000.00 - $7,900.00
Therapies	21.8	$1,548.00 - $3,912.00	$33,746.40 - $85,281.60	$0.00
Therapies	22.5	$0.00	$0.00	$3,096.00 - $5,868.00
Medications	22.5	$540.20 - $569.40	$12,154.50 - $12,811.50	$0.00
Surgical Interventions	0.5	$0.00	$0.00	$10,912.00 - $37,135.00
Surgical Interventions	22.5	$8,658.00 - $15,546.00	$194,805.00 - $349,785.00	$28,012.00 - $363,293.00
Prosthetics / Orthotics	22.5	$14.67 - $25.67	$330.08 - $577.58	$0.00

Lifetime Projected Costs: [redacted]				
Projected Care:	**Duration Required (Years):**	**Annual Cost:**	**Annual Cost x Duration Required:**	**Total One-Time Cost:**
Aids for Independence	17.2	$19.43 - $132.13	$334.20 - $2,272.64	$0.00
Aids for Independence	19.2	$235.57 - $656.80	$4,522.94 - $12,610.56	$0.00
Aids for Independence	22.5	$167.52 - $428.85	$3,769.20 - $9,649.13	$0.00
Supplies	22.5	$356.40 - $964.20	$8,019.00 - $21,694.50	$0.00
Home Services	5.3	$9,828.00 - $10,764.00	$52,088.40 - $57,049.20	$0.00
Home Services	17.2	$29,744.00 - $32,448.00	$511,596.80 - $558,105.60	$0.00
Case Management	22.5	$1,032.00 - $2,712.00	$23,220.00 - $61,020.00	$0.00
			Total of Annual Costs Over Lifetime:	**$984,008.39 - $1,405,455.97**
			Total of One-Time Costs Over Lifetime:	**$49,749.00 - $426,160.00**
			Grand Total:	**$1,033,757.39 - $1,831,615.97**

Physician Follow-Up						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Orthopedic (Pelvis) Follow-Up	59.7	82.2	$145.00 - $182.00	1x/year	$145.00 - $182.00	$0.00
Orthopedic (Upper Extremity) Follow-Up	59.7	82.2	$145.00 - $182.00	1-2x/year	$145.00 - $364.00	$0.00
Urologic Follow-Up	59.7	60.7	$145.00 - $182.00	12x/year, for 1 year	$1,740.00 - $2,184.00	$0.00
Urologic Follow-Up	60.7	82.2	$145.00 - $182.00	2-4x/year, for 21.5 years	$290.00 - $728.00	$0.00
Pain Management Follow-Up	59.7	82.2	$145.00 - $182.00	6-12x/year	$870.00 - $2,184.00	$0.00
				Total:	**Variable by year**	**$0.00**

Rationale:

Dr. Wellman recommended lifelong annual orthopedic follow-up.

[redacted] would benefit from continued follow-up to monitor his upper extremity.

Dr. Dixon recommended lifelong urologic follow-up 2 to 4 times per year. [redacted] is currently following with Dr. Dixon on a monthly basis; this is extended for one year, beyond which timeframe Dr. Dixon's regimen of 2 to 4 visits per year is initiated.

Dr. Kalter recommended lifelong follow-up with a pain management specialist every 1 to 2 months.

Notes:

Follow-up levels of care determined using national utilization statistics.

I reserve the right to modify these projections should additional information become available.

Diagnostics						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Uroflowmetry	59.7	82.2	$230.00 - $326.00	2x/year	$460.00 - $652.00	$0.00
Post-Void Residual	59.7	82.2	$69.00 - $103.00	2x/year	$138.00 - $206.00	$0.00
Urinalysis	59.7	82.2	$28.00 - $41.00	2x/year	$56.00 - $82.00	$0.00
Penile Duplex Scan	59.7	82.2	$628.00 - $861.00	1-2x	$0.00	$628.00 - $1,722.00
Penile Angiography	59.7	82.2	$1,664.00 - $2,149.00	1-2x	$0.00	$1,664.00 - $4,298.00
X-ray Pelvis	59.7	82.2	$132.00 - $169.00	1x/year	$132.00 - $169.00	$0.00
MRI Lumbar	59.7	82.2	$1,913.00 - $2,447.00	1x/year	$1,913.00 - $2,447.00	$0.00
X-ray Elbow	59.7	82.2	$121.00 - $152.00	1x/year	$121.00 - $152.00	$0.00
MRI Elbow	59.7	82.2	$1,758.00 - $2,230.00	1x/3-5 years	$351.60 - $743.33	$0.00
MRI Pelvis	59.7	82.2	$1,867.00 - $2,375.00	1x/3-5 years	$373.40 - $791.67	$0.00
CT Abdomen	59.7	82.2	$1,026.00 - $1,470.00	1x/3-5 years	$205.20 - $490.00	$0.00
EMG/NCV Study	59.7	82.2	$877.00 - $1,379.00	1-2x	$0.00	$877.00 - $2,758.00
				Total:	**$3,750.20 - $5,733.00**	**$3,169.00 - $8,778.00**

Rationale:

Dr. Dixon recommended lifelong biannual uroflowmetry, post-void residual, and urinalysis. He also recommended penile duplex and/or arteriogram 1 to 2 times.

Dr. Wellman recommended routine annual x-rays of the pelvis.

Diagnostics
Dr. Kalter recommended lifelong annual MRIs of the lumbar spine. Additional periodic x-ray of the elbow, MRI of the pelvis, and CT of the abdomen are provided to monitor [redacted] various injuries for stability versus degeneration. One to two EMG/NCV studies are provided for re-evaluation of Mr. [redacted] neuropathy.
Notes:
I reserve the right to modify these projections should additional information become available.

Therapy Evaluations						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Physical Therapy Evaluation (Routine)	59.7	82.2	$160.00 - $198.00	1x/year	$160.00 - $198.00	$0.00
Occupational Therapy Evaluation (Routine)	59.7	82.2	$155.00 - $191.00	1x/3 years	$51.67 - $63.67	$0.00
Psychological Evaluation	59.7	59.8	$242.00 - $308.00	1x, immediate	$0.00	$242.00 - $308.00
Nutritional Evaluation	59.7	59.8	$190.00 - $248.00	1x, immediate	$0.00	$190.00 - $248.00
Physical Therapy Evaluation (Post-Op)	59.7	82.2	$160.00 - $198.00	1x	$0.00	$160.00 - $198.00
				Total:	**$210.67 - $261.67**	**$592.00 - $754.00**

Rationale:

Dr. Wellman recommended physical therapy interventions for 2 years. Beyond this timeframe, [redacted] would benefit from an annual allowance of physical therapy sessions to maintain strength and range of motion, address acute exacerbations, and manage his home exercise routine. Annual evaluation will be necessary to determine therapy protocol.

[redacted] would likely benefit from require periodic occupational therapy evaluation to instruct him in activity modifications, safety procedures, and the use of assistive devices. Evaluation every 3 years is provided.

[redacted] would benefit from a course of psychotherapy to assist him with acceptance of his disability and to promote adaptive coping mechanisms. One-time evaluation will be necessary to initiate treatment.

[redacted] has gained approximately 100 lbs. over the three years since the incident in question. He would likely benefit nutritional intervention to restore him to his pre-injury weight. One-time evaluation will be necessary to initiate treatment.

Dr. Kalter recommended a surgical intervention to the lumbar spine. One-time physical therapy evaluation will be necessary to initiate a post-operative course of physical therapy.

Notes:

I reserve the right to modify these projections should additional information become available.

Therapies						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Physical Therapy Session	59.7	60.4	$129.00 - $163.00	2x/week, for 0.7 years	$12,384.00 - $15,648.00	$0.00
Physical Therapy Session (Routine)	60.4	82.2	$129.00 - $163.00	12-24x/year, for 21.8 years	$1,548.00 - $3,912.00	$0.00
Occupational Therapy Session	59.7	60.7	$121.00 - $152.00	8-16x, immediate	$0.00	$968.00 - $2,432.00
Psychotherapy Session	59.7	60.7	$157.00 - $198.00	1x/week, for 1 year	$7,536.00 - $9,504.00	$0.00
Nutritional Counseling Session	59.7	61.7	$120.00 - $158.00	25-50x, over 2 years	$0.00	$3,000.00 - $7,900.00
Physical Therapy Session (Post-Op)	59.7	82.2	$129.00 - $163.00	24-36x	$0.00	$3,096.00 - $5,868.00
				Total:	**Variable by year**	**$7,064.00 - $16,200.00**

Rationale:

Dr. Wellman recommended biweekly physical therapy interventions for 2 years. This is provided for the remainder of this period (0.7 years). Beyond this timeframe, [redacted] would likely benefit from an annual allowance of physical therapy sessions to maintain range of motion, address acute exacerbations, and manage his home exercise routine; 12 to 24 sessions per year are provided to address the elbow, low back, pelvis, and leg/foot.

[redacted] would likely benefit from an immediate short course of occupational therapy to instruct him in activity modifications, safety procedures, and use of assistive technology.

[redacted] would likely benefit from a course of psychotherapy to assist him with acceptance of his disability and to promote adaptive coping mechanisms.

[redacted] would likely benefit nutritional intervention to restore weight to pre-injury levels. He has gained approximately 100 lbs. since the incident in question. At a weight loss rate of 1 to 2 lbs. per week, this will require 50 to 100 weeks. Biweekly sessions are provided for this duration.

Dr. Kalter recommended surgical intervention to the lumbar spine. [redacted] will require a post-operative course of physical therapy. Three sessions per week for 8 to 12 weeks are provided.

Notes:

I reserve the right to modify these projections should additional information become available.

Medications						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Oxycodone 10mg	59.7	82.2	$0.74 - $0.78	2x/day	$540.20 - $569.40	$0.00
				Total:	**$540.20 - $569.40**	**$0.00**
Rationale:						
Medications as reported by [redacted].						
Notes:						
I reserve the right to modify these projections should additional information become available.						

Surgical Interventions						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Replacement of Artificial Urinary Sphincter	59.7	82.2	$14,715.00 - $41,222.00	1-3x	$0.00	$14,715.00 - $123,666.00
Lumbar Nerve Block	59.7	82.2	$2,886.00 - $5,182.00	3x/year	$8,658.00 - $15,546.00	$0.00
Laminectomy with or without Fusion	59.7	82.2	$13,297.00 - $239,627.00	1x	$0.00	$13,297.00 - $239,627.00
Penile Prosthesis Implantation (Initial)	59.7	60.2	$10,912.00 - $37,135.00	1x, within 6 months	$0.00	$10,912.00 - $37,135.00
Penile Prosthesis Replacement	60.2	82.2	$11,056.00 - $41,650.00	0-1x, over 22 years	$0.00	$0.00 - $41,650.00
				Total:	**Variable by year**	**$38,924.00 - $442,078.00**

Rationale:

Dr. Dixon indicated that [redacted] would benefit from artificial urinary sphincter implant. This occurred in December 2016. A range of 1 to 3 replacements is provided. A range of 1 to 3 replacements is provided, as individuals undergoing this procedure have a significant change of future replacement.[7]

Dr. Kalter recommended three lumbar nerve block injections per year indefinitely.

Dr. Kalter indicated that [redacted] will require lumbar laminectomy with possible fusion. The range provided above reflects a laminectomy without fusion (low) to laminectomy with fusion (high).

[redacted] has been recommended and is scheduled for implantation of a penile prosthesis; initial implant and up to 1 replacement are provided.

Notes:

I reserve the right to modify these projections should additional information become available.

[7] Montague, D. K. Artificial urinary sphincter: long-term results and patient satisfaction. *Advances in Urology 2012*. Article ID 835290. Accessed 03/17/17 from https://www.hindawi.com/journals/au/2012/835290/.

Prosthetics / Orthotics						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Spring-Loaded Ankle Foot Orthosis	59.7	82.2	$44.00 - $77.00	1x/3 years	$14.67 - $25.67	$0.00
				Total:	**$14.67 - $25.67**	**$0.00**
Rationale:						
Dr. Wellman indicated that [redacted] will require ankle-foot orthoses through his life expectancy. Periodic replacement is provided.						
Notes:						
I reserve the right to modify these projections should additional information become available.						

Aids for Independence						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Bariatric Quad Cane	65.0	82.2	$20.00 - $89.00	1x/5-7 years, for 17.2 years	$2.86 - $17.80	$0.00
Bath Transfer Bench	65.0	82.2	$58.00 - $174.00	1x/3-7 years, for 17.2 years	$8.29 - $58.00	$0.00
Bathroom Grab Bar	59.7	82.2	$25.00 - $69.00	2x/7-10 years	$5.00 - $19.71	$0.00
Handheld Shower	65.0	82.2	$19.00 - $54.00	1x/3-7 years, for 17.2 years	$2.71 - $18.00	$0.00
Lumbar Support Back Cushion	59.7	82.2	$35.00 - $89.00	1x/3-5 years	$7.00 - $29.67	$0.00
Ergonomic Postural Support Cushion (Under Hips)	59.7	82.2	$35.00 - $52.00	1x/1-3 years	$11.67 - $52.00	$0.00
Raised Toilet Seat with Handles	65.0	82.2	$39.00 - $115.00	1x/3-7 years, for 17.2 years	$5.57 - $38.33	$0.00
Reacher/Grabber	59.7	82.2	$8.00 - $23.00	1x/3-7 years	$1.14 - $7.67	$0.00
Mobility Scooter (4 Wheel)	63.0	82.2	$1,649.00 - $3,284.00	1x/5-7 years, for 19.2 years	$235.57 - $656.80	$0.00
Vehicle Scooter / Light Wheelchair Lift (Outdoor, Powered)	59.7	82.2	$999.00 - $1,599.00	1x/5-7 years	$142.71 - $319.80	$0.00
				Total:	**Variable by year**	**$0.00**
Rationale:						
Items to reduce pain, minimize the likelihood of exacerbations, increase mobility, and maximize independence in routine activities of daily living.						
Notes:						
I reserve the right to modify these projections should additional information become available.						

Supplies						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Rubber Cane Tip	59.7	82.2	$1.00 - $3.00	2-4x/year	$2.00 - $12.00	$0.00
Incontinence Underwear Liner	59.7	82.2	$0.18 - $0.37	2-4x/day	$131.40 - $540.20	$0.00
Mobility Scooter Maintenance	59.7	82.2	$139.00 - $277.00	1x/year	$139.00 - $277.00	$0.00
Vehicle Lift Maintenance	59.7	82.2	$84.00 - $135.00	1x/year	$84.00 - $135.00	$0.00
				Total:	**$356.40 - $964.20**	**$0.00**
Rationale:						
Supplies as necessary for the use and maintenance of *Aids for Independence*.						
Notes:						
Maintenance costs have been reduced to account for purchase years, wherein these expenses will not be incurred. I reserve the right to modify these projections should additional information become available.						

Home Services						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Companion / Homemaker	59.7	65.0	$21.00 - $23.00	9x/week, for 5.3 years	$9,828.00 - $10,764.00	$0.00
Home Health Aide	65.0	82.2	$22.00 - $24.00	26x/week, for 17.2 years	$29,744.00 - $32,448.00	$0.00
				Total:	**Variable by year**	**$0.00**

Rationale:

[redacted] relies on his family members for food preparation, cleaning, and home/yard maintenance tasks. As their ongoing willingness and ability to participate in his care cannot be relied upon, replacement services are provided to ensure his ongoing independence.

As the naturally degenerative processes of aging are superimposed on an individual's injuries, functional capacities are expected to become diminished. Increased services are initiated at age 65 to accommodate for reduced ability to perform activities of daily living.

Notes:

Weekly hours based on Expectancy Data's *Dollar Value of a Day* methodology.

I reserve the right to modify these projections should additional information become available.

Case Management						
Description:	**Age Initiated:**	**Through Age:**	**Cost:**	**Frequency:**	**Annual Cost:**	**One-Time Cost:**
Case Manager	59.7	82.2	$86.00 - $113.00	1-2x/month	$1,032.00 - $2,712.00	$0.00
				Total:	**$1,032.00 - $2,712.00**	**$0.00**
Rationale:						
Case management services for medical coordination, cost containment, and monitoring the overall plan for adherence. If [redacted] condition deteriorates, increased case management may become necessary.						
Notes:						
I reserve the right to modify these projections should additional information become available.						

APPENDIX B: RESOURCES

1. Standards of Practice: International Academy of Life Care Planners, 2015. IARP, Glenview, IL. Accessible at www.rehabpro.org/sections/ialcp/focus/standards/ialcp-standards-of-practice.

2. Optum National Fee Analyzer, 2017: Charge Data for Evaluating Fees Nationally. Optum360, LLC. ISBN 978-1-62254-202-4.

3. Context4 Healthcare Medical Fees, 2017: A Comprehensive Listing of Current UCR and Medicare Fees with Relative Value Units. Context4 Healthcare, Inc. Practice Management Information Corporation, Inc. ISBN 978-1-943009-49-7.

4. Yale Wasserman 2017 Physicians' Fee Analyzer: 32nd Edition. Yale Wasserman, DMD Medical Publishers, Ltd. ISBN: 978-1-59891-121-3.

5. United States Life Tables, 2012: Centers for Disease Control and Prevention; National Center for Health Statistics. National Vital Statistics Reports, Volume 65, Number 8: November 28, 2016.

6. Dollar Value of a Day: 2015 Valuation. Expectancy Data. Shawnee Mission, KS.

7. Weed, R. O. (2007). The Life Care Planning and Case Management Handbook, 3rd Edition. Boca Raton, FL: CRC Press; Taylor and Francis Group, 2010.

8. Usual, Customary, and Reasonable Charge Data, 2017. United States Department of Veterans Affairs.

9. DMEPOS Fee Schedule, 2017. Centers for Medicare and Medicaid Services.

10. Target Pharmacy via GoodRx.com.

11. CVS Pharmacy via GoodRx.com.

12. Rite-Aid Pharmacy via GoodRx.com.

13. www.pattersonmedical.com.

14. www.southwestmedical.com.

15. www.allegromedical.com.

16. www.alimed.com.

17. www.atcmedical.com.

18. www.expressmed.com.

19. Cost of Care Survey, New York, 2016: Genworth Financial, Inc.

20. Senior Care Companions, Inc.

21. Attentive Care Services.

22. Progressive Companion Home Care Agency, LLC.

23. Right at Home.

24. Gurwin Home Health Agency.

25. American Hospital Directory: www.ahd.com.

    Montefiore Hospital – Moses Campus
    Mount Sinai Saint Luke's Hospital
    NY Presbyterian Hospital
    North Shore University Hospital
    Saint Francis Hospital
    Winthrop University Hospital
    Good Samaritan Hospital Medical Center
    Hospital for Special Surgery
    Hackensack University Medical Center
    The Mount Sinai Medical Center
    Lenox Hill Hospital
    NYU Langone Medical Center
    The Mount Sinai Medical Center

26. HCPCS/APC/MS-DRGs Used:

    0206, 0208, 0386, 460, 00630, 00670, 672, 675, 697, 860, 920, 938, 20926, 20930, 20936, 22612, 22840, 22853, 51741, 51798, 52000, 53415, 53447, 54405, 54410, 63005, 64483, 72148, 72170, 72191, 72195, 73080, 73221, 74176, 81001, 90791, 90834, 93980, 95885, 95905, 97110, 97140, 97161, 97165, 97535, 97537, 97802, 97803, 99203, 99213, 99368, A4637, E0105, E0190, E0241, E0244, E0248, E0256, E1399, K0806, L1930, T4535

[redacted]

ECONOMIC LOSS ANALYSIS

Mr. [redacted]

Prepared August 3, 2015

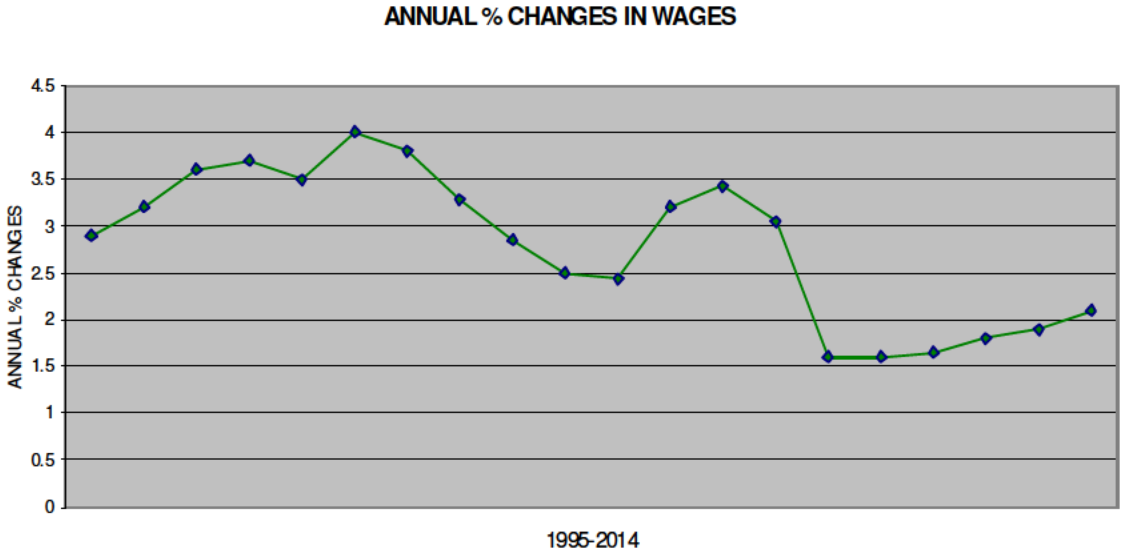
As a result of his condition, Mr. [redacted] has been unable to maintain employment. He has sustained an economic loss. The sources of the loss included in this analysis are:

- Income loss.
- Loss in health insurance.
- Loss in the employer funding of the pension and the annuity.
- Loss in social security retirement income.

Each of these losses is explained and quantified below.

INCOME LOSS

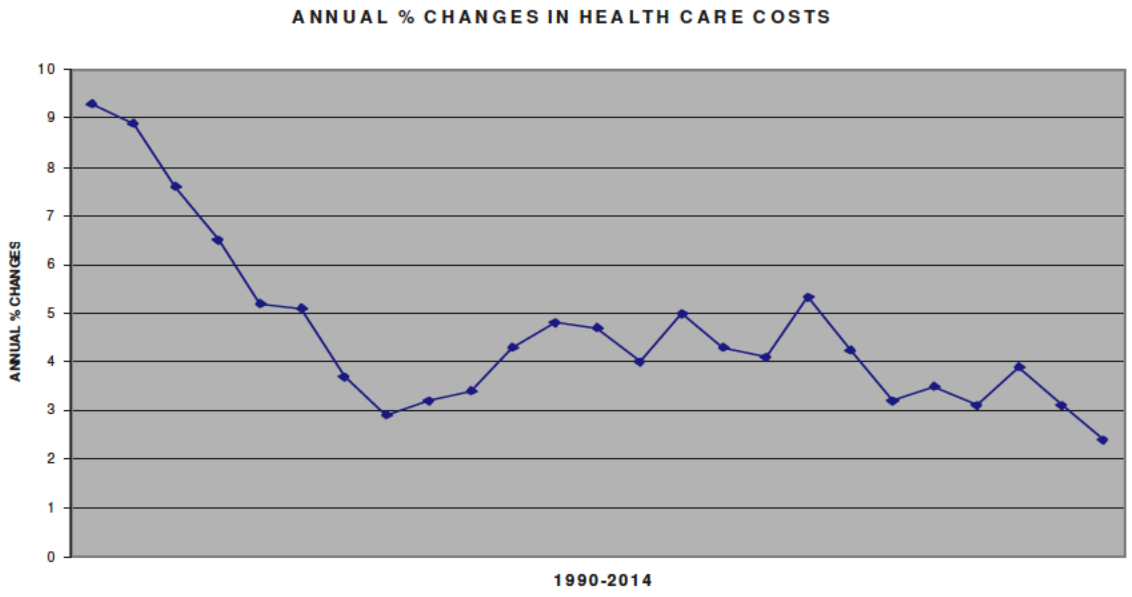
[redacted] was an iron worker and a member of Local Union 580. During the year 2013, he earned $99,646. This figure is increased by 3.0% per year. Data provided by the U.S. Bureau of Labor Statistics reveals that wage increases have averaged approximately 3.0% per year over the past 20 years. Annual wage increases for each year since 1995 appear in the following graph.



The income loss is determined until retirement at age 65. The income loss is **$969,941**. The loss for each year appears in the table entitled YEARLY BREAKDOWN OF THE SOURCES OF ECONOMIC LOSS.

LOSS IN HEALTH INSURANCE

The replacement cost for health insurance is $12,000 in the year 2013. The cost is increased by 4.6% per year. As per data provided by the U.S. Bureau of Labor Statistics, over the past 25 years, the costs for health care have been increasing at an average annual rate of approximately 5%. The following graph shows changes in health care costs for each year since 1990.



The loss in health insurance is **$101,109**. The loss for each year appears in the table entitled YEARLY BREAKDOWN OF THE SOURCES OF ECONOMIC LOSS.

LOSS IN THE EMPLOYER FUNDING OF THE PENSION & THE ANNUITY

As per the Agreement, the employer funds the pension and the annuity. For example, in the year 2014, $17,676 would be contributed by the employer in the pension and $19,350 in the annuity. These figures are increased by 3% per year. The loss in the employer funding of the pension is **$158,428** and the loss in the employer funding of the annuity is **$183,832**. The loss for each year appears in the table entitled YEARLY BREAKDOWN OF THE SOURCES OF ECONOMIC LOSS.

LOSS IN SOCIAL SECURITY RETIREMENT INCOME

Based upon the income of [redacted] and the number of years of credited service lost, he will sustain a loss in social security retirement income in the amount of $5,975 per year in the year 2015 dollars. This figure is increased by 2.5% per year. This rate of increase is utilized because data provided by the Social Security Administration reveals that the average annual cost of living increase has been 2.5% over the last 20 years.

The loss commences upon retirement and it continues over the remainder of his life expectancy. According to data provided by the U.S. National Center for Health Statistics, he has a life expectancy of 78.9 years. The loss in social security retirement income is **$118,130**. The loss for each year appears in the table entitled YEARLY BREAKDOWN OF THE SOURCES OF ECONOMIC LOSS.

TOTAL ECONOMIC LOSS

The total economic loss from these sources is **$1,531,440**.

[redacted]

YEARLY BREAKDOWN OF THE SOURCES OF ECONOMIC LOSS

Mr. [redacted]

Year	Income loss	Loss in health insurance	Loss in the employer funding of the pension	Loss in the employer funding of the annuity	Loss in social security retirement income
2014	$ 97,504	$ -	$ 16,676	$ 19,350	$ -
2015	$105,714	$ -	$ 17,176	$ 19,931	$ -
2016	$108,885	$ 13,733	$ 17,692	$ 20,528	$ -
2017	$112,152	$ 14,365	$ 18,222	$ 21,144	$ -
2018	$115,517	$ 15,025	$ 18,769	$ 21,779	$ -
2019	$118,982	$ 15,717	$ 19,332	$ 22,432	$ -
2020	$122,551	$ 16,440	$ 19,912	$ 23,105	$ -
2021	$126,228	$ 17,196	$ 20,509	$ 23,798	$ -
2022	$ 62,407	$ 8,634	$ 10,140	$ 11,766	$ 3,693
2023					$ 7,280
2024					$ 7,462
2025					$ 7,649
2026					$ 7,840
2027					$ 8,036
2028					$ 8,237
2029					$ 8,443
2030					$ 8,654
2031					$ 8,870
2032					$ 9,092
2033					$ 9,319
2034					$ 9,552
2035					$ 9,791
2036					$ 4,215
Total	$969,941	$101,109	$158,428	$183,832	$118,130

[redacted]

VOCATIONAL EVALUATION AND EARNING CAPACITY ANALYSIS

PREPARED BY: [redacted]

PREPARED FOR: Guy Smiley, Esquire
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REGARDING: [redacted]

DATE OF BIRTH: June 24, 1957

REPORT DATE: October 12, 2015

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CERTIFICATION

This is to certify that I am not related to any of the parties to subject action, nor do I have any present or intended financial interest in the outcome of this case beyond the fees due for professional services rendered in connection with this report and possible subsequent services. Further, I certify that my professional fees are not contingent upon the resultant financial awarding of this matter, but are based on the time expended on the services provided to counsel in connection with the subject action.

This is to further certify that all assumptions, methodologies and calculations utilized in this evaluation and assessment report are based on current knowledge and methods applied in the determination of employability, labor market access, job placement and earnings capacity.

Duly noted are the professional committees to whose code of ethics I subscribe: The Commission on Rehabilitation Counselor Certification, International Association of Rehabilitation Professionals, Commission on Health Care Certification and the State of New Jersey, Professional Counselor Licensure Board.

DISCLOSURE

Mr. [redacted] was advised about the purpose of the evaluation, in accordance with the professional Code of Ethics of the Commission on Rehabilitation Counselor Certification. He was advised that the evaluation was being conducted within the parameters of litigation and that any information obtained during the evaluation was not confidential.

In addition, [redacted] was advised that this was a one-time evaluation, forensic in nature, and that no client-counselor relationship exists or was implied; that no direct rehabilitation services would be provided to him by this office; and that an unbiased, objective evaluation of his employability, labor market access, and earning capacity, post injury, was the only purpose of this interview.

He was also advised that [redacted] fully complies with all federal laws concerning medical records and that these would be kept confidential. Once the case is resolved, the corporate policy is to destroy the case records. [redacted] indicated understanding of these rules of procedure and conduct and agreed to proceed.

CASE CONCEPTUALIZATION MODEL:

Case conceptualization for forensic vocational consulting should rely upon a methodology that is reliable and valid, since these aspects are crucial to an objective vocational evaluation. It is important to select a case conceptualization model that is referenced in the literature, or regarded as a sound methodology[1]. The RAPEL model defines five domains: rehabilitation plan, access to the labor market, placeability, earning capacity, and labor force participation. Field (2008) states that RAPEL is a widely inclusive model, encompassing many resources ranging from labor market access, placeability considerations, attention to earning capacity issues, and other facets that assist in case conceptualization[2]. Robinson (2014) states that RAPEL is the most frequently referenced methodology for earning capacity analysis, with high levels of content validity and face validity.

Rehabilitation plan: The rehabilitation plan is an individualized plan tailored to the specific needs of the evaluee, and all factors affecting return to work should be considered. In this vocational evaluation, rehabilitation considerations and job accommodations are often found in the Vocational Rehabilitation and Assistive Technologies sections, though they may be absent depending on the viability of rehabilitative efforts for the evaluee.

Access to the labor market: Access to the labor market is based on the evaluee's ability to obtain work, or, in other words, personal access to the competitive labor market. This issue is addressed in the analysis of employability section via the transferable skills analysis.

Placeability: Placeability is also an aspect of vocational evaluation that uses the RAPEL model. Placeability can be regarded as the ability to secure employment based on the interaction of an individual's employability and factors in the community, such as job availability and employer attitudes[2]. The transferable skills analysis considers the availability of jobs down to the local labor market level. The specificity of the McCroskey Transferable Skills Programs allows analysis at the county level.

Earning Capacity: Earning capacity is a function of the capacity to perform work. Pre-injury earning capacity must be considered versus post-injury earning capacity[2]. Any difference in earning capacities attributable to loss of access to the labor market can result in lost earnings, which are addressed in the Analysis of Earnings/Earning Capacity section.

Labor force participation: Labor force participation represents issues of working life. Loss of access to the competitive labor market can result in a reduced worklife expectancy, including being unable to hold employment (total absence from the labor market and substantial gainful activities), being limited to part-time work, or being able to carry on a full-time work schedule[2]. Labor force participation is also addressed in the Analysis of Employability section, and, depending upon the needs of the evaluation, in a Worklife Expectancy section as well.

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[1] International Associate of Rehabilitation Professionals. http://www rehabpro.org/publications/standards-ethics/12.2007.pdf/view

[2] Field, T. (2008). Estimating earning capacity: Venues, factors, and methods. *Estimating Earning Capacity,* 1(1), 5-40.

REFERRAL INFORMATION

[redacted] case was referred for Vocational Assessment and determination as to whether or not, as a result of injuries incurred in a work-related fall on January 13, 2014, he sustained a Vocational Impairment or Work Disability, and if so, how that impairment or disability might affect his earning capacity. In addition, determination was made as to whether he would benefit from Vocational Rehabilitation services. A Vocational Evaluation was conducted based upon assessment of pertinent information provided regarding [redacted] age, education, past relevant employment and earnings history, and current employment and earnings. The information gathered pertains to the relevant vocational factors for [redacted] in relation to the competitive employment market.

EVALUATION METHODOLOGY

Records and data regarding [redacted] were provided by the law offices of Smiley & Smiley, L.L.P. for review and use in evaluating his employability and earning capacity. Mr. [redacted] was interviewed on September 14, 2015, at the offices of Smiley & Smiley, L.L.P., located in New York, New York. The following procedures were followed:

1. An in-depth interview was conducted to obtain relevant background information with regard to [redacted] age, education, present employment and earnings status, past employment and earnings experience, and current work/life status.

2. Vocational testing was conducted to ascertain vocational traits. [redacted] test results were utilized to compare his aptitudes to job requirements. The following tests were administered:

    - Wonderlic Personnel Test (WPT)
    - Wide Range Achievement Test (WRAT-IV)
    - Minnesota Clerical Test (MCT)

3. The employment history was researched using standard vocational reference materials that are detailed in the Resources and References section at the end of this narrative. This employed the **McCroskey Transferable Skills Program**, a job-person matching system that enables the comparison of individual abilities and job requirements to see where the two intersect. This system, which has been shown to have a high degree of reliability and validity, employs the U.S. Department of Labor (DOL) worker trait factor system as a means of comparing individual capacities against the mental and physical demands of jobs as they exist in the local labor market. In addition, the **McCroskey Vocational Quotient System** was used to analyze further the employability of [redacted]. Labor market and wage information was gathered for the New York State area.

4. From the information generated and reviewed, a pre-injury profile of worker trait capacity levels was established and used to compare the pre-injury capacities of [redacted] against the demands of jobs as they exist in the local labor market.

Educational attainment level and vocational preparation were also considered.

5. Medical information was received and reviewed to determine the nature, extent, and duration of injuries sustained and any permanent functional limitations resulting from injury. This information was then used to adjust the pre-injury profile, leading to the development of a post-injury vocational profile in the context of [redacted] injuries and the functional impairments and limitations resulting from injury.

6. Both profiles were then compared to profiles for all 12,775 jobs in the **Dictionary of Occupational Titles**, combined with a labor market survey of the most frequently hired for jobs in the State of New York, 2015. This was done using the **McCroskey Transferable Skills Program**, which evaluates vocational information in accordance with U.S. Department of Labor criteria (worker trait-factor capacity levels).

7. From this analysis, further assessment was then done to ascertain pre- and post-injury employability, labor market access, job placement potential, vocational rehabilitation needs, and wage earning capacity at this time.

EVALUATION ASSUMPTIONS

This vocational evaluation and earning capacity analysis is based upon the skills, training, knowledge, clinical discretion, and professional experience of the authors. This evaluation assumes the following:

1. The medical records were provided in their entirety and accurately reflect the medical condition and functional abilities of the evaluee;

2. The evaluee provided true and accurate information in the vocational interview;

3. All testing administered was completed to the best of the evaluee's abilities; and

4. The evaluee's employment history, education, and training are demonstrative of his or her vocational capacities and ability to benefit from job training.

LEGAL EXHIBITS

1. Summons: [redacted]

2. Verified Complaint: [redacted]

[redacted]

DOCUMENTS REVIEWED

1. 2009-2013 Income Tax Returns for [redacted].
2. 2009-2013 W-2 Forms for [redacted]
3. Local 580 Fund Office Records for [redacted]

EDUCATIONAL/MILITARY BACKGROUND

[redacted] indicated that he earned a high school diploma in 1976 at North Babylon Senior High School located in North Babylon, New York. He received HVAC training at Wilson Tech for 2 years on a half-day program. Mr. Harrigan also received vocational training as an Ornamental Iron Worker with Local 580 from 1993 to 1996. He completed a 30-hour OSHA module and has certification in arc welding, is a licensed burning operator and gas handler, and has received training in scaffolding. Mr. [redacted] also received on-the-job training in being a shop steward. He served in the United States Navy as an E-4 from 1984 to 1988 and was relieved on honorable discharge. No other training or education is noted.

FAMILY/SOCIAL

[redacted] was born in New York. He is married to [redacted]. Mr. Harrigan has a Class D New York State Automobile driver's license, as well as a handicapped placard. Prior to injury, he noted enjoying Training at

the gym, camping with an RV, and driving four-wheelers on the beach, which he states he is no longer able to perform at pre-injury levels.

EMPLOYMENT EXPERIENCE

[redacted] reported that from 2010-January 13, 2014, he had worked as a Foreman/Ornamental Ironworker in the New Jersey State area. Following his injury on January 13, 2014, he was not able to return to work. He stated that he was earning Foreman/Ornamental Ironworker union wage rates and union fringe benefits at the time of injury. His past work experience includes Foreman/Ornamental Ironworker, Foreman Ironworker, Housekeeper (part time) and Router Operator job positions.

Of note, [redacted] has been a Volunteer Fireman for 25 years, and has been a Captain for 6-7 years. He has been with the Lindenhurst Hook and Ladder Company since 1990, when he graduated from fire school, and rose through the ranks from First Lieutenant to Second Lieutenant to Captain. [redacted] is an active life member, but is no longer required to go to fires; instead, he helps with fund raisers, attends meetings, and is on committees. Previously, he had had training one day a week in fire [redacted], masks, ladders, and driving and had fought approximately 14 to 15 fires a year. [redacted] employment experience, as related by him, is as follows:

Position:	**Foreman/Ornamental Ironworker**
Union:	Local 580
Employer:	Coordinated Metals
Location:	Carlstadt, New Jersey
Dates:	2010-January 13, 2014
Earnings:	$41 an hour (an extra $150 a week as a foreman; $100+ a year)
Duties:	"Working formane in charge of three-man crew; putting up storefront canopy, entrance ways, storefront first floor, lobby/ground floor; lay out work; read blueprints; tools: arc welders, hammer, drills, grinders, sawzall, come-along, and ratchet straps."

Position:	**Foreman Ironworker**
Union:	Local 580
Employer:	Post Road
Dates:	2000s (2 years)
Earnings:	Union rates
Duties:	"Railings at Yankee Stadium."

Position:	**Foreman Ironworker**
Union:	Local 580
Employer:	Pyramid/Regal/Eagan
Dates:	1990s-2000s
Earnings:	Union rates
Duties:	"Lobby work/railings/storefronts"

Position: **Housekeeper (part time)**
Employer: Good Samaritan
Location: West Islip, New York
Dates: 1991-1999
Earnings: $13 an hour
Duties: ″Saturday and Sunday: clean ER area mostly.″

Position: **Router Operator**
Employer: Gruman Aerospace
Location: Bethpage, New York
Dates: 1980-1993
Earnings: $13 an hour
Duties: ″Aluminum/titanium F-14

PRE-INJURY PROFILE AND EMPLOYMENT EXPERIENCE ANALYSIS

The jobs that [redacted] has successfully performed in the past 15 years were researched in the U.S. Department of Labor's **Dictionary of Occupational Titles**, along with addendum publications that include the **Revised Handbook for Analyzing Jobs**, the **O*Net Dictionary of Occupational Titles**, the **Encyclopedia of Job Requirements**, and **Occupational Outlook Handbook**. The job definitions provided from the Dictionary of Occupational Titles are not intended to be exact representations of the jobs performed in [redacted] employment history. Instead, the job definitions are intended to provide a synthesis of general information that most closely encapsulates the skills, abilities, educational requirements, and physical capacities that are required to perform a specific job position or array of work tasks. It is duly noted that each occurrence of a job position in the workforce varies, to some degree, with unique worksite and employer needs.

Reference to these job titles is important, since they have known capacity statements attached to them, which represent modal ability levels associated with the types of jobs [redacted] has performed in the past.

DOT Number	DOT Title	VQ	Skill Level – Specific Vocational Preparation[3]	Physical Demands
809.381-022	Ornamental-Iron Worker	119.6	SVP = 7 (Skilled)	Heavy
860.137-010	Craft Foreman	111.1	SVP = 7 (Skilled)	Light

These jobs require a range of Light to Heavy physical duty on a five-point scale (sedentary, light, medium, heavy and very heavy).

According to the **Dictionary of Occupational Titles**, light work is defined as:

> Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force

[3] SVP 1 = <5 Days, SVP 2 = 5-30 Days, SVP 3 = 1-3 Months, SVP 4 = 3-6 Months, SVP 5 = 6-12 Months SVP 6 = 1-2 Years, SVP 7 = 2-4 Years, SVP 8 = 4-10 Years, SVP 9 = >10 Years

frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may only be negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree: or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when a job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

According to the **Dictionary of Occupational Titles**, heavy work is defined as:

Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.

These jobs require combined aptitudes in the following areas:

Code	Aptitude	Level
R	Reasoning	Middle Average
M	Mathematics	Low Average
L	Language	Low Average
S	Spatial Perception	Low Middle Average
P	Form Perception	Low Middle Average
Q	Clerical Perception	Below Average
K	Motor Coordination	Low Middle Average
F	Finger Dexterity	Low Middle Average
M	Manual Dexterity	High Middle Average
E	Eye Hand Foot Coordination	Low Middle Average
C	Color Discrimination	Very Low[4]

These jobs are rated in the Average to Above Average range on the **McCroskey Vocational Quotient Scale**, a standardized empirically-derived index of vocational difficulty that considers all of the worker traits that are measures of mental and physical **capacity** in order to derive an overall statistical index of job difficulty. This index ranges from a low of approximately 72.00 to a high of about 154.00. The VQ distribution for all jobs in the DOT has been transformed (McCroskey, 1992) to a Mean of 100.00 and a Standard Deviation of 15.00. In general, the higher the VQ, the more difficult and rewarding is the job. Jobs with VQs ranging between 85.00 and 115.00 fall within the "average range" of overall job difficulty.

[4] Very Low – Under 10%ile; Below Average – 10 to 33%ile; Average – 34 to 65%ile; Above Average – 66-89%ile; Superior – Over 89%ile.

Conclusion(s) from Pre-Injury Profile:

1) [redacted] demonstrated the ability to perform work successfully as a Foreman/Ornamental Ironworker, Foreman Ironworker, Housekeeper and Router Operator. He showed the ability to perform duties, develop skills, and acquire the knowledge and training necessary to obtain and maintain employment in these job positions.

MEDICAL RECORDS REVIEWED

1. Ambulance Call Report: 01/13/14

2. New York-Presbyterian Hospital
   Brian Ward, M.D.
   Orthopedic Consultation: 01/13/14
   Gregory Salzler, M.D.
   General Surgery Note: 01/13/14
   Andrew Meltzer, M.D.
   Operative Report: 01/13/14
   Jian Shou, M.D.
   Operative Report: 01/13/14
   David Helfet, M.D.
   Operative Report: 01/13/14
   Kevin Mennitt, M.D.
   Imaging Reports: 01/13/14 (x2), 01/14/14, 01/15/14, 01/18/14, 01/29/14, 02/13/14, 02/18/14
   Roger Bartolotta, M.D.
   Imaging Reports: 01/13/14 (x3), 01/17/14, 01/27/14 (x2), 01/30/14, 02/04/14
   Soumitra Eachempati, M.D.
   Operative Reports: 01/13/14, 01/31/14
   Discharge Summary: 02/27/14
   Mohamad Alkadi, M.D.
   Nephrology Consultation: 01/14/14
   Mildred Chen, M.D.
   Imaging Report: 01/14/14
   Christopher Wladyka, M.D.
   Imaging Reports: 01/14/14 (x2), 01/25/14, 01/31/14. 02/02/14
   Yong Auh, M.D.
   Imaging Reports: 01/14/14, 02/25/14
   Robert Zimmerman, M.D.
   Imaging Report: 01/15/14 (x2)
   George Shih, M.D.
   Imaging Reports: 01/15/14, 01/22/14
   Lily Belfi, M.D.
   Imaging Reports: 01/15/14 (x2), 01/21/14, 01/28/14 (x2), 01/30/14, 01/31/14, 02/04/14, 02/23/14

Michael Loftus, M.D.
Imaging Reports: 01/15/14, 02/10/14, 02/22/14
Keith Hentel, M.D.
Imaging Reports: 01/16/14, 01/19/14, 01/22/14 (x2), 01/27/14 (x3), 01/28/14, 02/01/14, 02/02/14 (x2), 02/03/14, 02/04/14, 02/06/14, 02/07/14, 02/08/14, 02/09/14 (x2), 02/14/14
Jocelyn Scheinert, M.D.
Imaging Report: 01/17/14
Tiffany Newman, M.D.
Imaging Report: 01/19/14
*David Wellman, M.D.
Operative Reports: 01/20/14, 02/09/14
Mildred Chen, M.D.
Imaging Reports: 01/22/14 (x2), 01/24/14, 01/27/14, 01/29/14, 02/04/14
Neil Shah, M.D.
Imaging Reports: 01/26/14, 02/08/14, 02/14/14
Krishna Juluri, M.D.
Imaging Report: 02/05/14
Ashwin Asrani, M.D.
Imaging Reports: 02/05/14, 02/06/14, 02/12/14, 02/18/14
Jessica Fisher, M.D.
Imaging Reports: 02/06/14, 02/07/14
*David Wellman, M.D.
Attending Note: 02/08/14
Robert Schloss, M.D.
Imaging Report: 02/09/14
Johnson Chen, M.D.
Imaging Report: 02/19/14
Duretti Fufa, M.D.
Orthopedic Consultation: 01/29/14
Operative Report: 02/26/14

3. Smithtown Center for Rehab
Multiple Practitioners
Physical Therapy Evaluation: 03/01/14
Occupational Therapy Evaluation: 03/01/14
Speech Language Evaluation: 03/02/14

4. NOA Diagnostics
Carl Kubek, D.O.
Imaging Reports: 03/05/14, 03/12/14
Frank Fayz, M.D.
Imaging Reports: 03/06/14, 04/11/14
Naiyer Imam, M.D.
Imaging Reports: 03/07/14 (x3), 04/12/14
Anne Glaser, M.D.

Imaging Reports: 03/26/14, 04/29/14

5. St. Catherine of Siena Medical Center
   Harvey Gutman, M.D.
   Consultation: 03/12/14

6. Hospital for Special Surgery
   *David Wellman, M.D.
   Orthopedic Progress Notes: 03/13/14, 04/24/14, 07/10/14, 07/21/14, 08/07/14, 08/14/14, 08/19/14, 09/03/14, 09/23/14, 10/02/14, 10/29/14, 12/10/14, 03/04/15, 09/02/15
   Operative Report: 07/20/14
   Robert Schneider, M.D.
   Imaging Reports: 08/14/14, 08/19/14, 10/02/14, 12/10/14, 03/04/15, 09/02/15
   Carolyn Sofka, M.D.
   Imaging Reports: 08/14/14, 09/03/14
   Eric Bogner, M.D.
   Imaging Report: 08/22/14
   John Carrino, M.D.
   Imaging Report: 09/23/14
   Shari Jawetz, M.D.
   Imaging Report: 10/29/14
   Christine Yu, M.D.
   History and Physical: 01/14/15
   Dacia Neuffer, P.A.
   Admission Note: 01/30/15
   Aaron Daluiski, M.D.
   Follow-up Evaluations: 01/14/15, 06/03/15
   Operative Report: 01/30/15
   Orthopedic Consultation: 01/31/15
   Post-operative Reports: 02/04/15, 02/11/15 (x2), 03/04/15
   Romona Satchi, M.D.
   Progress Note: 01/31/15
   Philip Wagner, M.D.
   Pain Consultations: 01/31/15, 02/01/15
   Stephanie Malliaris, M.D.
   Progress Note: 02/01/15
   Discharge Summary: 02/01/15

7. Stony Brook Urology
   Jason Kim, M.D.
   Urology Progress Notes: 04/15/14, 05/22/14, 06/12/14, 06/17/14
   Urodynamic Evaluation: 10/03/14
   Alek Mishail, M.D.
   Urology Progress Notes: 07/01/14, 09/17/14, 10/08/14

8. Advanced Rehabilitation Medicine
   Jennifer Gray, D.O.
      Diagnostic Study: 05/05/14

9. Long Island Premier Physical and Aquatic Therapy
   Brandon Spahn, D.P.T.
      Physical Therapy Initial Evaluation: 05/28/14
      Physical Therapy: 05/30/14-06/11/14 (7 notes)

10. SouthBay Sports & Physical Therapy, P.C.
    Multiple Practitioners
      Physical Therapy Initial Evaluation; 06/30/14
      Physical Therapy Plans of Care: 06/30/14, 07/03/14
      Physical Therapy Re-evaluation: 07/03/14
      Physical Therapy: 07/07/14-07/15/14 (4 notes)

11. Suffolk Orthopaedic Associates, P.C.
    Matthew Kalter, M.D.
      Office Visits: 07/18/14, 11/11/14, 11/25/14, 12/15/14, 01/07/15, 01/16/15

12. Broadlawn Manor Nursing and Rehab Center
    Multiple Practitioners
      Occupational Therapy Initial Evaluation: 08/02/14
      Physical Therapy Initial Evaluations: 08/02/14, 08/27/14
      Physical Therapy Discharge Summary: 08/22/14
      Occupational Therapy Discharge Summaries: 08/22/14, 11/05/14

13. Mobilex USA
    Robert Greco, M.D.
      Imaging Reports: 09/04/14 (x2)
    William Betz, M.D.
      Imaging Report: 09/17/14
    Jason Liu, M.D.
      Addendum Report: 09/17/14
    Teresa Huchun, M.D.
      Imaging Reports: 09/29/14 (x2)
    Unspecified Practitioner
      Imaging Report: 11/04/14

14. Zwanger-Pesiri Radiology
    Brett Helfner, M.D.
      Imaging Report: 09/11/14

15. Advanced Urology Centers of New York
    Eric Thall, M.D.
      Urology Progress Note: 02/19/15

16. South Nassau Communities Hospital
    *Gary Lefkowitz, M.D.
        Operative Report: 02/25/15

17. RC Island Urological Associates
    *Gary Lefkowitz, M.D.
        History and Physicals: 02/28/15, 03/09/15, 03/12/15
    Steven Harris, M.D.
        History and Physical: 03/11/15

18. Lenox Hill Hospital
    Justin Mazur, M.D.
        ED Evaluation: 03/15/15
    *Christopher Dixon, M.D.
        History and Physical: 03/15/15
        Operative Reports: 03/16/15, 04/23/15
        Discharge Note: 03/16/15
    Eva Guy-Rodriguez, M.D.
        Imaging Report: 03/16/15
    Devon Klein, M.D.
        Imaging Report: 03/16/15
    Neal Epstein, M.D.
        Imaging Report: 03/16/15
    Pamela Unger, M.D.
        Surgical Pathology Report: 04/28/15

19. *Christopher Dixon, M.D.
        Follow-up Notes: 04/01/15, 04/29/15, 05/13/15, 06/03/15, 07/08/15
        Procedure Note: 06/03/15

20. Matthew Skolnick, M.D.
        Independent Orthopedic Examination: 04/03/15

21. Southside Hospital
    Siram Satyanath, M.D.
        Imaging Report: 04/06/15

22. Jonathan Vapnek, M.D.
        Independent Urological Examination: 08/24/15

* Please note that an asterisk next to the name of a practitioner indicates that he or she may be found in more than one location in the above medical summary.

MEDICAL HISTORY SUMMARY

The medical records reviewed for this evaluation indicate that [redacted] was involved in a work-related fall on January 13, 2014. He was brought to New York-Presbyterian Hospital for evaluation and treatment. A synopsis of the medical records is as follows:

On 01/13/14 there was an ambulance call report that read as follows:

> Pt is a 56 y/o male found laying supine at construction site c/o back pain after falling approx. 30 ft when a scissor lift tipped over. Pt stated he landed on his (L) elbow.

On 01/13/14 [redacted] was admitted to New York-Presbyterian Hospital. Dr. Brian Ward held an orthopedic consultation. He noted:

> A/P: 56M APC pelvic injury, L elbow deformity, and low back pain s/p pelvic binder placement.

On 01/13/14 Dr. Andrew Meltzer performed surgery. He specified:

> Pre-op Diagnosis: Trauma.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Aortogram with runoff, selective angiography of the right iliac and right hypogastric artery, selective angiography of the left hypogastric artery, and inferior vena cava filter placement with ascending venogram.

On 01/13/14 Dr. Jian Shou performed a surgical procedure. He outlined:

> Pre-op Diagnosis: Respiratory failure and hypoxia and urethral injury.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Bilateral chest tubes and retrograde urethrogram.

On 01/13/14 Dr. David Helfet performed a surgical procedure. He delineated:

> Pre-op Diagnosis: Unstable pelvic ring injury in a closed dislocated left elbow.
>
> Post-op Diagnosis: [Same.]
>
> Operation: Closed reduction and application of a pelvic external fixator and right femoral traction pin, as well as closed reduction and splinting of left elbow.

On 01/13/14 Dr. Roger Bartolotta conducted imaging procedures. He determined:

Study #1: Pelvis

Impression: 1. Pubic symphyseal diastasis measuring up to 6.3 cm.
2. Probable right sacral fracture …

Study #2: Pelvis

Impression: Interval decrease in pubic symphyseal diastasis, now measuring up to 3.3 cm.

On 01/13/14 Dr. Soumitra Eachempati operated on [redacted]. He indicated:

Pre-op Diagnosis: Multiple trauma, shock.

Post-op Diagnosis: [Same.]

Operation: Exploratory laparotomy.

On 01/14/14 Dr. Mohamad Alkadi administered a nephrology consultation. He recorded:

A/P
oliguric Acute kidney injury in setting of urethral injury, rhabdomyolysis, hypotension …

On 01/14/14 Dr. Christopher Wladyka performed imaging procedures. He asserted:

Study: Right Hip

Impression: Partially imaged is persistent widening of the symphysis pubis. No definite acute displaced fracture in the right femur and right hip is identified. An external screw seen in the distal femoral diaphysis.

On 01/15/14 Dr. Robert Zimmerman reviewed images. He concluded:

Study: CT Cervical Spine w/o Contrast

Impression: 1. No acute fracture or soft tissue injury.
2. Congenital-developmental canal stenosis with multilevel stenosis … Canal stenosis is most marked at C5-C6 and C6-C7

On 01/15/14 Dr. George Shih analyzed images. He assessed:

Study: CT Abdomen w Contrast

Impression: 1. No evidence of contrast extravasation on CT urogram to suggest injury to the bilateral ureters. However artifact related to positioning of patient upper extremities somewhat limits the evaluation.
2. Retroperitoneal hematoma centered along the right psoas muscle …
3. Comminuted fracture of the right sacral ala. No other fractures identified.

On 01/15/14 Dr. Lily Belfi interpreted images. He averred:

Study: Pelvis

Impression: 1. External fixation of bilateral iliac wings with decreased widening of the pubic symphysis …
2. Distal femoral fixation screw with tricompartment osteoporosis at the knee.

On 01/20/14 Dr. David Wellman conducted an operative procedure. He recorded:

Pre-op Diagnosis: Unstable tile-C pelvic ring injury.

Post-op Diagnosis: [Same.]

Operation: 1. Anterior pelvic ring external fixation application and revision.
2. Posterior L sacroiliac screw placement.
3. Posterior R sacroiliac screw placement.
4. Diagnostic fluoroscopy.

On 01/27/14 Dr. Roger Bartolotta administered imaging procedures. He opined:

Study #1: Left Elbow

Impression: 1. Apparent dorsal dislocation of the radiocapitellar joint.
2. Evaluation of ulnohumeral alignment is limited by obliquity of the lateral view; ulnohumeral subluxation/dislocation cannot be excluded.

Study #2: Left Elbow

Impression: Limited examination due to overlying splint material and nonstandard radiographic positioning. Apparent interval reduction of radiocapitellar dislocation.

On 01/28/14 Dr. Lily Belfi conducted imaging procedures. She found:

Study #1: CT Pelvis w/o Contrast

Impression: 1. Interval improvement in alignment of bilateral sacral fractures status post placement of additional bilateral external fixation screws.
2. Additional external fixation screws and internal fixation screws transfixing bilateral sacroiliac joints are identified in unchanged position.
3. New intramuscular hematoma extending into the bilateral adductor musculature.

Study #2: CT Elbow w/o Contrast (Lt)

Impression: 1. Subluxation of the humeroulnar articulation and widening of the radiocapitellar joint.
2. Fracture of the ulnar coronoid process, tiny intra-articular fracture fragment within the radiocapitellar joint and avulsion fracture at the lateral humeral epicondyle …

On 01/31/14 Dr. Soumitra Eachempati operated on [redacted]. She documented:

Pre-op Diagnosis: Respiratory failure, multiple trauma.

Post-op Diagnosis: [Same.]

Operation: Tracheostomy.

On 02/02/14 Dr. Christopher Wladyka performed imaging procedures. He related:

Study #1: Elbow Left
Impression: Radiocapitellar and ulnohumeral dislocation with anterior and superior displacement of the distal left humerus.

Study #2: Left Elbow
Impression: The overlying cast has been removed in the interval. There has been interval relocation of the elbow. No dislocation is identified on the current single lateral view. Evaluation is slightly limited due to increased flexion, limiting evaluation for joint effusion. Tiny ossific fragment is seen adjacent to the coronoid process.

On 02/04/14 Dr. Roger Bartolotta analyzed images. He determined:

Study: Left Elbow

Impression: 1. Small minimally displaced fracture of the ulnar coronoid process and impaction fracture at the dorsal aspect of the capitellum are unchanged.
2. No new fracture or dislocation is identified. Overlying splint material obscures fine osseous detail.

On 02/09/14 Dr. David Wellman performed surgery. He indicated:

Pre-op Diagnosis: Unstable pelvic ring injury.

Post-op Diagnosis: [Same.]

Operation: 1. Removal anterior external fixation.
2. Revision anterior external fixation.

On 02/09/14 Dr. Robert Schloss reviewed images. He asserted:

Study: Pelvis

Impression: Diastasis of the pubic symphysis.

On 02/18/14 Dr. Kevin Mennitt interpreted images. He assessed:

Study: [Right foot, right ankle, pelvis, and left elbow]

Impression: 1. Right foot: Osteoarthrosis … No significant [abnormality?] at the first metatarsophalangeal joint where there is also hallux valgus.
2. Right ankle: No acute fracture or dislocation. There is minimal mature periosteal reaction along the distal lateral shaft. This may be unrelated to the trauma.
3. Pelvis: Bilateral screws fixing the sacroiliac joints are again noted with bilateral sacral fractures and widening of the left sacroiliac joint unchanged. The pubic symphysis is widened. Increased since the previous [exam?] measuring up to 15 mm but with intact alignment. Probable maturing heterotopic ossification in the adjacent soft tissues of the pelvis particularly along the right iliac wing and near the pubic symphysis.
4. Left elbow: There is circumferential maturing heterotopic ossification in the soft tissues.

On 02/22/14 Dr. Michael Loftus administered imaging procedures. He concluded:

Study: Elbow Left

Impression: No new fracture. The radial head is minimally dorsally subluxed relative to the capitellum.

On 02/26/14 Dr. Duretti Fufa conducted an operative procedure. She specified:

Pre-op Diagnosis: Left elbow dislocation.

Post-op Diagnosis: [Same.]

Operation: Left elbow closed reduction and placement of a hinged external fixator.

On 02/27/14 Dr. Soumitra Eachempati authored a discharge summary. She documented:

Discharge Diagnosis:
1. Fall from 30 ft
2. Open book pelvic fracture
3. L elbow dislocation
4. Urethral injury.

On 03/07/14 Dr. Naiyer Imam conducted imaging procedures. He averred:

Study #1: Lt hand
Impression: 1. No definite radiographic evidence of acute fracture or dislocation.
2. Moderate soft tissue swelling of the wrist and palm of hand.
3. Mild osteoporosis demonstrated.
4. Mild degenerative arthritis.

Study #2: Abdomen
Impression: 1. Mild degree of osteoporosis.
2. Mild spondylosis.

On 03/12/14 Dr. Harvey Gutman held a consultation. He wrote:

Impression: Malfunction of suprapubic tube with current obstruction of suprapubic site and cystostomy is now obstructed.

On 04/11/14 Dr. Frank Fayz performed imaging procedures. He opined:

Study: Right hip

Impression: 1. No definite radiographic evidence of an acute fracture or dislocation.
2. Moderate osteoporosis demonstrated.

On 04/15/14 Dr. Jason Kim drafted a urology progress note. He stated:

Diagnosis: transected urethra.

A/P
1. Urethral distraction injury
2. bladder spasms

On 04/29/14 Dr. Anne Glaser analyzed images. She found:

Study: Chest

Impression: 1. No focal infiltrates or pleural effusion.
2. Mild osteoporosis demonstrated.
3. Mild osteoarthritis.

On 04/24/14 Dr. David Wellman re-examined [redacted]. He reported:

The patient is status post a fall of 30 feet with poly trauma, including respiratory failure requiring a trache PEG, as well as left elbow dislocation and pelvic ring injury requiring anterior and posterior fixation which includes urethral damage.

On 05/05/14 Dr. Jennifer Gray performed a diagnostic study. She related:

Study: Electrodiagnostic examination of the bilateral lower extremities

Impression: 1. A right lumbosacral plexopathy affecting at least the sciatic (peroneal component predominantly), inferior gluteal, and superior gluteal nerves, severe in degree electrically. The inferior and superior gluteal nerves appear to be involved more than the sciatic, with severe neuropathic changes and evidence of reinnervation to the gluteus maximus and minimus muscles.
2. Active and chronic motor axon loss changes in L5/sciatic innervated muscles, along with abnormal sensory and motor nerve conduction responses in the left lower extremity are supportive of a left sciatic nerve lesion, moderate in degree electrically, best located proximal to the innervations to the hamstrings.

On 06/12/14 Dr. Jason Kim composed a urology progress note. He stated:

A/P
1. urethral trauma

On 07/01/14 Dr. Alek Mishail made a urology progress note. He wrote:

… pt developed progressive slower stream and urinary incontinence, has been leaking at night and daytime requiring diaper.

On 07/18/14 Dr. Matthew Kalter evaluated [redacted]. He noted:

> he fx his pelvis which tore his urethra and caused kidney failure. He was then in a drug induced coma for 6 weeks followed by 3 months of rehab.
>
> Pain is worse with sitting and lying down and he cannot get comfortable to sleep at night.

On 07/20/14 Dr. David Wellman operated on [redacted]. He wrote:

> Pre-op Diagnosis: Pelvic instability with nonunion of the sacrum and vertical migration of the right hemipelvis.
>
> Post-op Diagnosis: [Same.]
>
> Operation:
> 1. Open reduction and internal fixation anterior pelvic ring.
> 2. Removal of hardware from both right and left pelvis (deep buried implants).
> 3. Placement right side iliosacral screw.
> 4. Open reduction and internal fixation of sacrum nonunion with local autograft and DMP.

On 08/14/14 Dr. Robert Schneider conducted imaging procedures. He assessed:

> Study: CT pelvis w/o contrast
>
> Impression:
> 1. Ununited fracture of the right sacral ala with internal fixation. United fracture of the left sacral ala.
> 2. United displaced fracture of the coccyx.
> 3. Side plate across the symphysis pubis.
> 4. Heterotopic ossification around the symphysis pubis and inferior pubic rami bilaterally.

On 08/19/14 Dr. Robert Schneider performed imaging procedures. He concluded:

> Study: Pelvis
>
> Impression: Fractures of the right and left sacral ala with fixation. Widening of the symphysis pubis with reconstruction plate across the superior aspect of the symphysis pubis.

On 09/04/14 Dr. Robert Greco reviewed images. He related:

> Study: Bilateral hips

Impression: Postoperative changes of the sacroiliac joints and symphysis pubis. Prominent enthesophytes of the anterior/superior iliac spines bilaterally.

On 09/17/14 Dr. William Betz interpreted images. He determined:

Study: Pelvis

Impression: Bone demineralization is present. There is degenerative joint disease in the hips bilaterally.

On 09/29/14 Dr. Teresa Huchun administered imaging procedures. She asserted:

Study #1: Hip … left
Impression: Mild osteoarthritis of the left hip. Fixation of the pubic symphysis …

Study #2: Hip … right
Impression: Modest osteoarthritis of the right hip.

On 10/02/14 Dr. Robert Schneider analyzed images. He averred:

Study: Pelvis

Impression: Right sacral ala fracture.

On 10/03/14 Dr. Jason Kim conducted a urodynamic evaluation. He commented:

A/P
1. Decreased bladder compliance.
2. High pressure voiding with a poor flow.

On 01/07/15 Dr. Matthew Kalter followed up with [redacted]. He reported:

… a solution containing 1 ½ cc of 1% lidocaine and 6mg of Celestone was injected into each transforaminal space …

On 01/14/15 Dr. Christine Yu administered a history and physical. She commented:

Impression: The patient is a 57 year old male with past medical history of HTN, OSA, respiratory failure s/p trach, ARF requiring suprapubic catheter and dialysis (now recovered), neuropathy, obesity, DVT presenting for preoperative medical evaluation for L elbow contracture release.

On 01/14/15 Dr. Aaron Daluiski followed up with [redacted]. He remarked:

Diagnosis: Contracture left elbow, status post dislocation.

On 01/16/15 Dr. Matthew Kalter held an orthopedic office visit. He stated:

Occupation: The patient has been disabled.

Diagnosis:
1. Lumbar Neuritis or Radiculitis Not Otherwise Specified
2. Lumbago

Temporary impairment: Temporary impairment is 100%.

On 01/30/15 Dr. Aaron Daluiski conducted an operative procedure. He documented:

Pre-op Diagnosis: Left stiff elbow.

Post-op Diagnosis: Same.

Operation: Contracture release left elbow, ulnar nerve neurolysis, anterior transposition and excision of extensive heterotopic bone left elbow. Triceps tenolysis.

On 02/01/15 Dr. Stephanie Malliaris authored a discharge summary. She remarked:

Admitting Diagnosis:
Joint contracture of the upper arm

On 02/25/15 Dr. Gary Lefkowitz operated on [redacted]. He outlined:

Pre-op Diagnosis: Urethral stricture.

Post-op Diagnosis: [Same.]

Operation: Cystoscopy and holmium laser incision of urethral stricture.

On 03/04/15 Dr. Robert Schneider reviewed images. He opined:

Study: Pelvis

Impression: Posttraumatic changes in the pelvis with internal fixation of the sacroiliac joints and symphysis pubis.

On 03/09/15 Dr. Gary Lefkowitz treated [redacted]. He wrote:

Assessment …
1. Urethral stricture
2. Urgency of urination

3. Erectile dysfunction

On 03/15/15 Dr. Justin Mazur conducted an ED evaluation. He stated:

Diagnosis:
1. Acute urinary retention
2. Urethral injury

On 03/16/15 Dr. Christopher Dixon performed a surgical procedure. He recorded:

Pre-op Diagnosis: 1. Urinary retention.
2. Traumatic membranous urethral stricture.

Post-op Diagnosis: [Same.]

Operation: 1. Cystoscopy.
2. Dilation and placement of suprapubic tube.
3. Retrograde urethrogram.
4. Cystogram.

On 04/03/15 Dr. Matthew Skolnick performed an independent orthopedic examination. He reported:

The claimant stated that he was working on a scissor lift when the lift tipped over. The claimant sustained reported injuries to the head, left shoulder, left elbow, right ankle, “broken” pelvis and “torn” urethra. There were no lacerations. There was a loss of consciousness (unspecified amount of time) as a result of this accident.

Employment History: The claimant was employed full-time as an ironworker. He has not returned to work since the accident occurred on 1/13/14 …

Diagnoses:
1. Lumbar spine strain with possible radiculopathy.
2. Status post left shoulder dislocation.
3. Status post left elbow ulnar nerve transposition and fracture/dislocation.
4. Status post pelvic fracture and diastasis of pubic symphysis and sacroiliac joint.

Causal Relationship: … it appears that the above-diagnosed injuries are causally related to the accident on 1/13/14.

Treatment: Physical therapy treatment to all affected areas is reasonable, related, and necessary for 8 weeks at a frequency of 3 times per week, after which the claimant should have an orthopedic re-examination to determine the

necessity for further treatment. … An EMG of the lower extremities for possible radiculopathy is requested.

Disability/Ability to Work: … there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time.

On 04/23/15 Dr. Christopher Dixon performed surgery. He delineated:

Pre-op Diagnosis: Traumatic membranous urethral stricture.

Post-op Diagnosis: [Same.]

Operation: 1. One-stage excision and end-to-end repair of membranous urethral stricture.
2. Flexible cystoscopy.
3. Change of suprapubic tube.

On 06/03/15 Dr. Christopher Dixon performed a procedure. He noted:

Procedure: Flexible cystoscopy.

On 06/03/15 Dr. Aaron Daluiski treated [redacted]. He indicated:

Diagnosis: Status post left elbow contracture release.

On 08/24/15 Dr. Jonathan Vapnek performed an independent urological examination. He commented:

In summary, [redacted] was injured on January 13, 2011[5], when he fell nearly 30 feet from a scissor lift, sustaining severe pelvic fractures, membranous urethral disruption and injuries to the left elbow and shoulder. His urethral disruption was initially managed with a suprapubic tube and then with a minimally invasive endoscopic alignment. When that failed, he underwent definitive treatment with an open, end-to-end membranous urethroplasty by Dr. Dixon. While that surgery was technically successful, [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture. In the future, he may very well require placement of an artificial urinary sphincter if these symptoms do not improve over time.

His erectile dysfunction is an expected consequence of the pelvic fracture, in which there is often damage to the arteries and the nerves involved in normal erectile function. The use of daily Cialis 10 mg is clearly indicated and may not only improve his erectile function currently but may do so long-term as well. If his response proves to be inadequate, he would be an excellent candidate for

[5] This should read "2014".

intracavernosal injection of vasoactive medication or even surgical placement of an inflatable penile prosthesis.

On 09/02/15 Dr. Robert Schneider interpreted images. He found:

Study: Pelvis

Impression: 1. Internal fixation of a sacral fracture.
2. Internal fixation of the symphysis pubis.

On 09/02/15 Dr. David Wellman re-evaluated [redacted]. He noted:

Assessment/Plan: We have continued his physical therapy prescription for overall strengthening an[d] gait training. I have also re-referred him back to the orthotics to have him evaluated for a spring-loaded AFO.

Problem List:
1. Nonunion Of Fracture
2. Unspecified Closed Fracture Of Pelvis

Surgical Treatment:

Dates; Physicians	Procedures	Diagnoses
01/13/14 Dr. Soumitra Eachempati	Exploratory laparotomy.	Multiple trauma, shock.
01/13/14 Dr. Andrew Meltzer	Aortogram with runoff, selective angiography of the right iliac and right hypogastric artery, selective angiography of the left hypogastric artery, and inferior vena cava filter placement with ascending venogram.	Trauma.
01/13/14 Dr. Jian Shou	Bilateral chest tubes and retrograde urethrogram.	Respiratory failure and hypoxia and urethral injury.
01/13/14 Dr. David Helfet	Closed reduction and application of a pelvic external fixator and right femoral traction pin, as well as closed reduction and splinting of left elbow.	Unstable pelvic ring injury in a closed dislocated left elbow.
01/20/14 Dr. David Wellman	1. Anterior pelvic ring external fixation application and revision. 2. Posterior L sacroiliac	Unstable tile-C pelvic ring injury.

	screw placement. 3. Posterior R sacroiliac screw placement. 4. Diagnostic fluoroscopy.	
01/31/14 Dr. Soumitra Eachempati	Tracheostomy.	Respiratory failure, multiple trauma.
02/09/14 Dr. David Wellman	1. Removal anterior external fixation. 2. Revision anterior external fixation.	Unstable pelvic ring injury.
02/26/14 Dr. Duretti Fufa	Left elbow closed reduction and placement of a hinged external fixator.	Left elbow dislocation.
07/20/14 Dr. David Wellman	1. Open reduction and internal fixation anterior pelvic ring. 2. Removal of hardware from both right and left pelvis (deep buried implants). 3. Placement right side iliosacral screw. 4. Open reduction and internal fixation of sacrum nonunion with local autograft and DMP.	Pelvic instability with nonunion of the sacrum and vertical migration of the right hemipelvis.
01/30/15 Dr. Aaron Daluiski	Contracture release left elbow, ulnar nerve neurolysis, anterior transposition and excision of extensive heterotopic bone left elbow. Triceps tenolysis.	Left stiff elbow.
02/25/15 Dr. Gary Lefkowitz	Cystoscopy and holmium laser incision of urethral stricture.	Urethral stricture.
03/16/15 Dr. Christopher Dixon	1. Cystoscopy. 2. Dilation and placement of suprapubic tube. 3. Retrograde urethrogram. 4. Cystogram.	1. Urinary retention. 2. Traumatic membranous urethral stricture.
04/23/15 Dr. Christopher Dixon	1. One-stage excision and end-to-end repair of membranous urethral	Traumatic membranous urethral stricture.

	stricture. 2. Flexible cystoscopy. 3. Change of suprapubic tube.	

Conclusion(s) from Medical Records:

1) Based on the medical records, [redacted] has significant physical functional impairments that impact his employability and functional abilities to perform work. On January 16, 2015, Dr. Matthew Kalter stated: "The patient has been disabled." On April 3, 2015, Dr. Matthew Skolnick stated: "there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time." On August 24, 2015, Dr. Jonathan Vapnek stated: "… Mr. [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture."

[redacted] SELF-REPORT

[redacted] currently reports that he suffers from daily chronic pain in his pelvis, low back, left elbow/left shoulder, and urethra, along with variable pain in his right heel. Mr. [redacted] rated his pain on the following pain scale:

Pain Level	Description
0	No pain
1	Mild pain; you're aware of it, but it doesn't bother you
2	Moderate pain; tolerable without medications
3	Moderate pain; requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; unbearable

Area	Frequency	Pain Intensity
Pelvis	Daily	3
Low Back	Daily	4-5
Left Elbow/Left Shoulder	Daily	2
Urethra	Daily	4-5
Right Heel	Varies	6-7

Furthermore, he indicated that his abilities for lifting, sitting, climbing, balancing, stooping, driving, reaching, standing, walking, bending, kneeling and sleeping are impaired as a result of his injury. [redacted] noted the following specific limitations:

Activity	Functional Ability
Lifting	Light items, difficult carrying
Sitting	30 minutes, uncomfortable
Climbing	Stairs, up harder
Balancing	Uses cane for walks
Stooping	Difficult
Driving	60-90 minutes
Reaching	Difficult with left arm
Standing	10 minutes
Walking	1 block
Bending	Painful
Kneeling	Painful
Sleeping	Disrupted, pain, need to urinate

[redacted] reported that his daily activities include bathing and dressing himself, driving to physical therapy sessions, watching TV and resting, some light cleaning, dusting and putting dished in/out of dishwasher, and home exercises on a stationary bike. His son does lawn care and his wife does heavy cleaning and laundry. During the course of his 2-hour interview he had to use the bathroom three times.

[redacted] takes the following prescribed medications. This is consistent with the medical information received and noted above.

Medication	Purpose	Frequency
Bystolic	Control HBP	10 mg 2x/Day
Nisoldipine	Control HBP	34 mg 1x/Day
Losartan	Control HBP	50 mg 2x/Day
Cialis	Control Urine/E.D.	5 mg 1x/Day
Vesicare	Control Urine Output	10 mg 1x/Day
Contrave	Hunger Suppressant	90 mg 2x/Day
Caverject Impulse	Erectile Dysfunction	20 mcg

[redacted] reported that he is being treated by the following physicians on a regular basis:

Physician	Specialty	Frequency
Dr. David Wellman	Orthopedic Surgeon	1x/6 Months
Dr. Aaron Daluiski	Hand Surgeon	1x/6 Months
Dr. Christopher Dixon	Urologist	1x/Month
Dr. Matthew Kalter	Pain Management	1x/Month

Conclusion(s) from Self-report:

1) [redacted] reports physical functional limitations that are consistent with the information and treatment regimen derived from the medical records.

VOCATIONAL TESTING

During the course of our interview, [redacted] was administered three tests to help ascertain vocational traits. The tests measure factors that correspond to the U.S. Department of Labor (DOL) worker trait factor system used to categorize jobs and to compare worker aptitudes to job requirements. These tests were as follows:

Test	Department of Labor – Related Trait Factors
Wonderlic Personnel Test	Reasoning (R), Mathematics, (M), Language (L)
Wide Range Achievement Test IV	Reasoning (R), Mathematics, (M), Language (L), Clerical Perception (Q)
Minnesota Clerical Test	Clerical Perception (Q)

Test results for [redacted] are as follows:

Wonderlic Personnel Test (Form B):

The Wonderlic Personnel Test is a test of general intelligence. [redacted] score was as follows:

Raw Score:	16
Adjusted Raw Score	20
Grade Equivalent:	11-12 Years Education
Cumulative Percentile Rank:	40.90% (Adult Working Population Norms)
WAIS Equivalent:	100 Full Scale IQ = 100 (Norm = 100)

[redacted] timed score was in the Low Middle Average range for his age group. A score of 20 on the Wonderlic Personnel Test is common for individuals with 11-12 years of education. The job potential for individuals who score in this range includes routine office work and jobs with routinized steps. Twenty seven percent of the working population score within this range (16-22). As a group they are successful in elementary settings and would benefit from programmed or mastery learning approaches combined with on-the-job experience prior to work.[6]

Wide Range Achievement Test, Revision 4 (WRAT-IV):

The WRAT-IV has sub-tests for Word Reading, Sentence Comprehension, Spelling, and Math Computation. (For the purposes of this evaluation, the spelling sub-test was not administered.) This is a test of achievement and learning ability and can be compared to achievement levels of other individuals in the same age group. His scores were as follows:

[6] **Wonderlic Personnel Test & Scholastic Level Exam,** 1992, Wonderlic Personnel Test, Inc., p.26, Libertyville, IL.

Subtest	Standard Score	Percentile	Grade Score
Word Reading	94	34	11.9
Sentence Comprehension	91	27	11.3
Math Computation	90	25	6.3
Reading Composite	91	27	--

[redacted] scores were in the Average Range for Word Reading, Sentence Comprehension, Math Computation, and Reading Composite, indicating adequate abilities in Word Reading, Sentence Comprehension, Math Computation, and Reading Composite for most jobs.

Minnesota Clerical Test: Clerical Perception (Q)

The Minnesota Clerical Test has sub-tests for number and name comparison. This test is designed to measure factors of perceptual speed and accuracy of the type required to perform various clerical tasks. His scores were as follows:

Subtest	Score	Percentile	Retail Store Employee Percentile
Number Comparison	87	25th	20th Percentile
Name Comparison	63	9th	10th Percentile

[redacted] score for Number Comparison was 87, placing him in the 25th percentile and in the Low Average range compared to the adult working population in the U.S. His score for Name Comparison was 63, placing him in the 9th percentile and in the Below Average range compared to the adult working population in the U.S. These scores indicate limited clerical abilities.

Conclusion(s) from Vocational Testing:

1) [redacted] scores on the vocational test battery indicate limited abilities for clerical job positions and Low Middle Average to Average academic abilities for job retraining. However, his potential for retraining is significantly attenuated by other vocational factors he presents with, including his advanced vocational age status and significant functional limitations. His advanced vocational age status limits the remaining time he has for labor force participation, which also limits the amount of time he can benefit from retraining.

POST-INJURY VOCATIONAL PROFILE

The profile developed from the education and employment experience was adjusted to reflect the functional limitations that [redacted] currently demonstrates, as derived from the records reviewed and generated for this evaluation.

[redacted] Post-Injury Vocational Profile is comprised of multiple factors: education, employment experience, vocational testing, medical records, and [redacted] self-report. The information relevant to his vocational situation is as follows:

- Education:
  - [redacted] earned a High school Diploma in 1976. He completed vocational training related to ironworking and firefighting.
- Employment:
  - Pre-Injury: Light to Heavy Physical Demands.
  - Post-Injury: Sedentary Physical Demands at best.
- Vocational Testing:
  - [redacted] scores on the vocational test battery indicate limited abilities for clerical job positions and Low Middle Average to Average academic abilities for job retraining. However, his potential for retraining is significantly attenuated by other vocational factors he presents with, including his advanced vocational age status. His advanced vocational age status limits the remaining time he has for labor force participation, which also limits the amount of time he can benefit from retraining.
- Medical Records:
  - Based on the medical records, [redacted] has significant physical functional impairments that impact his employability and functional abilities to perform work. On January 16, 2015, Dr. Matthew Kalter stated: "The patient has been disabled." On April 3, 2015, Dr. Matthew Skolnick stated: "there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time." On August 24, 2015, Dr. Jonathan Vapnek stated: "… [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture."
- Mr. [redacted] Self-Report:
  - Lifting: Light items, difficult carrying;
  - Sitting: 30 minutes, uncomfortable;
  - Climbing: Stairs, up harder;
  - Balancing: Uses cane for walks ;
  - Stooping: Difficult;
  - Reaching: Left arm;
  - Standing: 10 minutes;
  - Walking: 1 Block;
  - Bending: Painful; and
  - Kneeling: Painful.

Based on the medical records, [redacted] was limited to sedentary work, precluding him from activities involving light, medium, and heavier physical exertion, and reducing his capacity for lifting, climbing, balancing, stooping, standing, walking, bending, and kneeling. Jobs performed in environments containing hazards or vibrations were omitted from the list of viable post-injury occupations. The remainder of the pre-injury profile was held constant.

According to the **Dictionary of Occupational Titles**, sedentary work is defined as:

> Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are Sedentary if walking and standing are required only occasionally and all other sedentary criteria.

In accordance with the opinions expressed in the medical records reviewed for this evaluation, sedentary duty represents [redacted] reduced functional capacities. The following transferable skills analysis assumes that he is capable of performing sedentary work at a competitive rate.

TRANSFERABLE SKILLS ANALYSIS

Labor market area and availability of jobs in a specific labor market must also be considered, since certain occupations and professions are concentrated in various geographic regions. According to Field, placeability exists when "economic conditions and employer attitudes are such that a person can actually be placed in a job."[7]

Both the pre-injury profile of worker traits and the post-injury profile for [redacted] were compared to all 12,775 jobs in the D.O.T., interfaced with a labor market survey of the most frequently hired for jobs in the State of New York, 2015. This was done, as noted, using the **McCroskey Transferable Skills Program**, which matches and compares worker capacities against the demands of jobs to determine where the two intersect. The program has proven over time, through continually published, peer-reviewed research, to have a high degree of validity and reliability for measuring probable outcomes and entry point wages.

Pre-injury, [redacted] profile matched 199 of the 1,258 most frequently hired for jobs statewide, or about 16% of this job database using the MTSP program. This is reflective of his prior employment experience in Foreman/Ornamental Ironworker, and Foreman Ironworker job positions. It also indicates that he had the **capacity** to perform, or to learn to perform, these jobs. The numbers of matching pre-impairment and post-impairment vocational profiles for each of the 10 categories of work in the D.O.T. are indicated in **Table 1** below.

[7] Field, op. Cit., pI-12

TABLE 1
Pre-impairment & Post-impairment Job Matches
(By Job Category)

No. of Job Categories	Pre-impairment No. of Jobs	Post-impairment No. of Jobs
0 Professional	0	0
1 Technical	1	0
2 Clerical/Sales	8	1
3 Service	42	1
4 Agriculture	3	0
5 Processing	20	0
6 Machine Trades	43	0
7 Bench Work	28	1
8 Structural	29	0
9 Miscellaneous	25	0
Total	**199**	**3**

Jobs with transferable skills are indicated in **Table 2**.

TABLE 2
Pre-impairment & Post-impairment Job Transferability
(Number of Jobs by Level of Transferable Job Skills)

Category	Pre-impairment	Post-impairment
Moderate to high skill transferability	10	0
Job transferability requiring little or no transferable skills	189	3

Post-injury, with his functional limitations as well as his residual functional capacities, [redacted] profile matched 3 of the most frequently hired for jobs in the State of New York. Realistically, this is indicative of a complete elimination of personal access to the local labor market, pre- vs. post-injury, based solely upon the trait-factor job matching analysis. None of the jobs were in a transferable skills category for which moderate to high levels of transferable skills were available. The job titles are:

D.O.T. Code	Job Title
235.662-022	Telephone Operator
704.682-010	Engraver, Machine I
379.367-010	Surveillance-System Monitor

The results of the transferable skills analysis are consistent with diminished physical capacities at the sedentary level, combined with his educational level and work history. A copy of the report is attached as an addendum to this narrative (See Appendix A).

Conclusion(s) from Transferable Skills Analysis:

1) The results of the transferable skills analysis indicate that, based solely on the trait-factor system, [redacted] post-injury profile matched 3 occupations, a diminution of 87% compared to the 199 occupational titles contained in his pre-injury profile, realistically indicating that his personal access to the competitive labor market has been eliminated.

ANALYSIS OF EMPLOYABILITY

Employability, technically defined, is a status that "exists if a person possesses skills, abilities, and traits necessary to perform a job or jobs."[8] According to McCroskey, employability theoretically exists when "worker capacity equals or exceeds the demands of a job."[9] When an individual's capacities, experiences, and skills are equal to or greater than the demands of a job, the person has the **capacity** to perform the job or learn to perform the job. Employability is solely a measure of individual capacity measured against job demands. While interests associated with jobs are indicators of preference, not capacity, they nevertheless provide signals as to what types of work and environment an individual prefers.

[redacted] employability is influenced by and dependent upon a synthesis of factors. In Mr. [redacted] case, the following factors are pertinent:

- Physical functional limitations;
- Transferability of previously developed vocational skills;
- Ability to return to past work;
- Vocational age;
- Ability to pursue alternative employment; and
- Candidacy for vocational rehabilitation services.

Physical functional limitations:
The medical records reviewed for this evaluation indicate that [redacted] has physical functional impairments and ongoing treatment needs including the possibility of future surgical intervention. On January 16, 2015, Dr. Matthew Kalter stated: "The patient has been disabled." On April 3, 2015, Dr. Matthew Skolnick stated: "there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time." On August 24, 2015, Dr. Jonathan Vapnek stated: "… Mr. [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture."

Transferability of previously developed vocational skills:
[redacted] physical functional limitations have a direct impact on the transferability

[8] Field, T., 1993. **Strategies for the Rehabilitation Consultant**, p. I-7, Elliott & Fitzpatrick, Inc., Athens, GA.
[9] McCroskey, B.J., 1994. **Manual for the McCroskey Transferable Skills Program**, Expert Vocationologist Edition, Ver. 7., Vocationology, Inc., Minneapolis, MN.

of his previously developed vocational skills. Accordingly, at the sedentary level, he has significantly reduced transferable skills that negatively affect his employability. The results of the transferable skills analysis indicate that, based solely on the trait-factor system, Mr. [redacted] post-injury profile matched 3 occupations, a diminution of 98% compared to the 199 occupational titles contained in his pre-injury profile, realistically indicating that his personal access to the competitive labor market has been eliminated.

Ability to return to past work:

[redacted] more recent vocational history is comprised of heavy level job duties, which involve frequent lifting from 25 lbs. to 50 lbs. and occasional lifting of 50 lbs. to 100 lbs. Based on the medical records reviewed for this evaluation, it is very unlikely that Mr. [redacted] will ever have the physical capacity to return to work in his customary capacity as a Foreman/Ornamental Ironworker.

Vocational age:

[redacted] presents with additional vocational barriers, aside from the physical functional limitations he presents with. Specifically, he is 58 years of age, which is considered to be at an advanced vocational age and approaching a very advanced vocational age. Having an advanced vocational age status can negatively impact the hiring decisions of potential employers, and limits the amount of time to benefit from job retraining too.

Ability to pursue alternative employment:

[redacted] ability to pursue new employment is salient as well, including his academic abilities and his medical issues. [redacted] academic abilities for job retraining are best represented by the level of education he has completed, in conjunction with his results on the vocational test battery. He has obtained a High School Diploma and completed on-the-job training. [redacted] results on the vocational test battery indicate that, ordinarily, he would be capable of benefiting retraining. However, his capacity for retraining is attenuated by his advanced vocational age.

[redacted] medical issues also negatively impact his ability to pursue new employment. The medical records above document that he is experiencing urgency, frequency, incontinence, sphincter weakness, and nerve damage. These symptoms could lead to work-related anxiety due to the possibility of extreme embarrassment. The frequency of bathroom breaks that [redacted] would require, would be disruptive to task completion and performing job duties at a competitive rate of production. It is highly likely that [redacted] medical condition (including the urinary and incontinence issues) would need to improve in order to obtain and maintain employment in the competitive labor market.

Candidacy for vocational rehabilitation services:

[redacted] ability to benefit from vocational rehabilitation services is a function of all of the factors discussed above; the viability of these resources will be discussed in the Vocational Rehabilitation section below.

Conclusion(s) from Analysis of Employability:

1) Considering the physical functional limitations derived from the medical records reviewed for this evaluation, significant reduction of transferable skills yielded by the transferable skills analysis, urinary and incontinence issues, and advanced vocational age status, it is within a reasonable degree of vocational certainty that [redacted] is unemployable. His medical symptoms (including frequency, urgency and incontinence issues) would need to improve in order to return to work in a reduced capacity.

VOCATIONAL REHABILITATION

[redacted] is 58 years old and, as a consequence of a work related injury, has physical functional limitations which hinder him from his former occupation as a Foreman/Ornamental Ironworker. The purpose of vocational rehabilitation is to provide training and other services when there is reasonable probability of the individual returning to gainful employment. Usually this includes provision of educational training, on-the-job training, medical evaluation if indicated, job placement assistance, assistive technologies, and related services.

[redacted] diminished physical functional capacities and work history of heavy physical labor indicate a need for job placement and training to maximize employability and earning capacity. The medical records reviewed for this evaluation indicate that he has ongoing treatment needs including possibility of future surgical intervention. If released by his treating physicians to return to work in a reduced capacity, he would be eligible for vocational rehabilitation services.

The vocational rehabilitation process has five phases in order of preference. A vocational rehabilitation client receives services for the phase best suited to him or her:

- *Phase One*: The vocational rehabilitation counselor assists the worker to return to the same job with the pre-impairment employer. Interventions at this phase may include programs of physical conditioning or work-hardening, graduated return to work, work evaluation, and refresher training or skill upgrading.

- *Phase Two*: If it is determined the worker cannot return to the same job, the vocational rehabilitation counselor encourages and works with the pre-impairment employer to make worksite accommodations and job modification, or to provide alternative in-service placement.

- *Phase Three*: If the employer is unable or unwilling to accommodate the worker, the vocational rehabilitation counselor identifies suitable occupational options in the same or related industry.

- *Phase Four*: If the worker is unable to return to alternative employment in the

same or related industry, the vocational rehabilitation counselor explores opportunities in all industries, with emphasis placed on the worker's transferable skills, aptitudes, and interests.

- *Phase Five*: If existing skills are insufficient to return the worker to suitable employment, the vocational rehabilitation counselor uses training programs to enable the worker to acquire new occupational skills. In addition, the vocational rehabilitation counselor assists the worker to secure employment once the training is complete.

In [redacted] case, it is my opinion that he would not be suitable for any rehabilitative efforts unless his medical condition improved. Vocational rehabilitation services are available through the Suffolk County office of the New York State Office of Adult Career and Continuing Education Services- Vocational Rehabilitation (ACCES-VR). There is no cost for meeting with an ACCES-VR counselor or for anything that is needed to determine if ACCES-VR can help an individual (this would include medical examination, vocational testing, and other assessments). There is also no cost for job placement services. Other services may be based upon a person's income and/or family resources.

Ticket to Work and Self-sufficiency Program:

[redacted] is currently a Social Security Disability Income beneficiary. He is also eligible for the Ticket to Work and Self-Sufficiency Program. The benefits of the program are described as:

> The Ticket to Work and Self-sufficiency Program is an employment program for people with disabilities who are interested in going to work. The Ticket Program is part of the Ticket to Work and Work Incentives Improvement Act of 1999 – legislation designed to remove many of the barriers that previously influenced people's decisions about going to work because of the concerns over losing health care coverage. The goal of the Ticket Program is to increase opportunities and choices for Social Security disability beneficiaries to obtain employment, vocational rehabilitation (VR), and other support services from public and private providers, employers, and other organizations.[10]
>
> While you are actively participating in the Ticket to Work program, you can get the help you need to find the job that is right for you and you can safely explore your work options without losing your benefits.
>
> - You can easily return to benefits if you have to stop working (known as "expedited reinstatement of benefits");
> - You can continue to receive healthcare benefits; and
> - You will not receive a medical continuing disability review (CDR) while using

[10] http://www.yourtickettowork.com/program_info Ticket to Work Program.

your Ticket.[11]

Although [redacted] would be a candidate for both of the vocational rehabilitation options described above, he does not have sufficient transferable job skills to expect that he would be capable of returning to work on his own initiative.

[redacted] would only benefit from the Ticket to Work and Self Sufficiency Program if his medical condition improves. In which case, he can attempt to return to work for a trial period. If he is unable to sustain working activities, he can get reinstated for Social Security Disability Income benefits in an expedited manner.

Assistive Technology

Individuals with disabilities can benefit from the application of technology to overcome the barriers that interfere with their functioning in a work environment. According to PL 100-407[12], assistive technology has been defined as:

> Any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized that is used to increase or improve functional capacities of individuals with disabilities.

[redacted] reported that he was experiencing functional limitations in the areas of lifting, sitting, climbing, balancing, stooping, driving, reaching, standing, walking, bending, kneeling and sleeping. The following items of assistive technology (AT) would likely be of benefit to his daily functioning:

Functional Limitation	AT Currently Used	AT Options
Bending/Kneeling/Stooping	None	Reacher/Grabber Ergonomic Desk/Work Area
Reaching	None	Reacher/Grabber Ergonomic Desk/Work Area
Sitting	None	Back Support Pillow Ergonomic Chair
Ambulation	Cane	Walkers Electric Scooters Wheelchairs
Climbing/Physical Access	Cane	Chair Lifts Elevator /Ramp
Standing	Cane	Sit/Stand Stool Adjustable Table
Sleeping	None	Motorized Bed Frame Adjustable Mattress

[11] Social Security Administration, http://www.ssa.gov/work/receivingbenefits html

[12] United States Congress: PL 100-407, **The Technology Related Assistance for Individuals with Disabilities Act of 1988**.

Bending/Kneeling/Stooping: [redacted] reported that he has difficulty or experiences pain while bending, kneeling and stooping. There are hand-operated reachers that extend a person's range for reaching and retrieving objects, which reduce the need to bend, kneel or stoop. In addition, specially-designed desks and work areas place materials and tools within easy reach for use by a person with limited range of motion.

Reaching: [redacted] stated that he has difficulty reaching with his left arm. There are hand-operated reachers that extend a person's range for reaching and retrieving objects. In addition, specially-designed desks and work areas place materials and tools within easy reach for a person with limited range of motion.

Sitting: [redacted] indicated that sitting for extended periods is difficult, usually longer than 30 minutes. Back support pillows and specially-designed ergonomic chairs with multiple adjustments for height, firmness, and tilt angle can alleviate discomfort and extend sitting time.

Ambulation: [redacted] currently uses a cane to assist him in walking. If his ability to ambulate is further impaired, there are a variety of walkers, electric scooters, and wheelchairs that individuals with mobility impairments use to ambulate. In a home or public setting, these could be used to get to a location and move about during the course of activities.

Climbing/Physical Access: [redacted] can use his cane and/or handrails to assist him in climbing steps. Other options are a ramp, chair lift, or elevator that could carry him from one level to another.

Standing: [redacted] uses a cane to help him when standing. He may benefit from sit/stand tools and adjustable tables that would allow him to change positions from sitting to standing as needed.

Sleeping: [redacted] stated that his sleep cycle has been disrupted due to pain (as well as the need to urinate at night). Motorized bed frames are available to enable postural changes when going to sleep. Adjustable mattresses are also available to help in obtaining a comfortable sleep position. These devices would not be applicable to job sites, but could decrease fatigue or sleep deprivation improve an individual's vocational functioning.

Conclusion(s) from Vocational Rehabilitation:

1) [redacted] has diminished physical functional capacities along with ongoing medical treatment needs. Considering his specialized work history requiring the performance of heavy physical labor, significantly reduced transferable job skills, advanced vocational age, and incontinence and bowel issues that can create issues with being in public (including work environments) for extended periods of time, it is highly unlikely that he would benefit from vocational rehabilitation services unless his medical condition improved.

ANALYSIS OF EARNINGS/EARNINGS CAPACITY

The power to earn money is a function of the capacity to perform work. The capacity to perform work is predicated upon individual mental and physical abilities that are measurable and quantifiable. This analysis was done in accordance with the worker trait-factor system developed by the U.S. Department of Labor, which provides the means for such measurement.

[redacted] was earning Foreman/Ornamental Ironworker union wage rates plus fringe benefits at the time of his injury. His U.S. Individual Income Tax Returns and W-2 Wage and Tax Statements for 2009 to 2013 show the following demonstrated wage earnings:

Year	Wages
2009	$139,092
2010	$112,043
2011	$129,737
2012	$143,028
2013	$144,283

These wages are representative of his pre-injury earning capacity. [redacted] has not returned to work since January 13, 2014. His loss of earnings during this period was total and is still continuing.

For the three job titles identified with the MTSP, average entry level wages in Suffolk County, New York were $9.71 per hour or approximately $17.50 per year. Mean wages were $17.50 per hour or approximately $41,745 per year. Mean wages can reasonably be expected after 6-9 years of successful job performance in an occupation.

[redacted] loss of earning capacity is directly related to the severity of his disability. According to the Bureau of Labor Statistics, U.S. Department of Labor, the following labor force characteristics for Persons with a Disability are noted:

> In 2014, 17.1 percent of persons with a disability were employed, the U.S. Bureau of Labor Statistics reported today. In contrast the employment-population ratio for those without a disability was 64.6 percent. The ratio for persons with a disability declined by 0.5 percentage point from 2013 to 2014, while the ratio for those with no disability increased by 0.6 percentage point. The unemployment rate of persons with a disability edged down to 12.5 percent from 2013 to 2013, while the rate for those without a disability declined to 5.9.
>
> The data on persons with a disability are collected as part of the Current Population Survey (CPS), a monthly sample survey of about 60,000 households that provides statistics on employment and unemployment in the United States. The collection of data on persons with a disability is sponsored by the

Department of Labor's Office of Disability Employment Policy.

- For all age groups, the employment-population ratio was much lower for persons with a disability than for those with no disability.
- Unemployment rates were higher for persons with a disability than for those with no disability among all educational attainment groups.
- In 2014, 33 percent of workers with a disability were employed part time, compared with 18 percent for those with no disability.
- Employed persons with a disability were more likely to be self-employed than those with no disability.[13]

Accordingly, [redacted] lifetime earnings would likely be reduced further by periods of unemployment, depending on the severity of his disability as he ages.

If [redacted] medical condition improved (including the urinary and incontinence issues), he would be a candidate for vocational rehabilitation services. Competitiveness increases with the attainment of vocational training, but due to his advanced vocational age, Mr. [redacted] would be most suitable for short duration job retraining. Even with completion of vocational training, [redacted] expected entry point annual earnings would likely be lower than his demonstrated wages as a Foreman/Ornamental Ironworker.

The above wage earnings do not include computation for such variables as wage growth over time, lost promotional opportunities and advancement, the value of fringe benefits, income taxes, present value computation, and other economic factors. The figures do represent an estimate of the diminution of annual gross wage earning power as a consequence of diminished functional work capacity for [redacted]. His future occupational base has also been significantly reduced as a consequence of his disability and resultant functional impairments.

Conclusion(s) from Analysis of Earnings/Earning Capacity:

1) Prior to injury, [redacted] demonstrated the ability to earn prevailing level wage rates for Foreman/Ornamental Ironworker in his local labor market plus fringe benefits.

2) [redacted] wage earning power is currently eliminated. Based on the vocational factors he presents with (from the analysis of employability section), his medical condition would need to improve in order to pursue vocational rehabilitation services to return to work in an alternative capacity.

3) [redacted] ongoing permanent medical condition and need for further treatment eliminates the option of returning to work in his customary capacity or

[13] U.S. Department of Labor, Bureau of Labor Statistics, **Current Population Survey** USDL-15-1162, Persons with a Disability: Labor Force Characteristics. Released Tuesday, June 16, 2015.

in similar jobs.

4) As a result of the injuries incurred January 13, 2014, [redacted] has experienced lost earnings to the present. He will continue to experience lost earnings that comprise the rate of earnings and former wage rates plus benefits, from the date of his injury through his estimated work life unless his medical condition improves.

5) If he is successfully rehabilitated and placed in an alternative job setting, [redacted] will experience loss of earnings based on the differential between his former rate of earnings as a union Foreman/Ornamental Ironworker and a significantly lower future earnings rate. He would be limited to entry-level occupations with wage rates that are influenced by the occupation, industry, and local labor market in which he seeks workforce reentry.

SUMMARY

In summary, based on the results of the vocational evaluation of [redacted], and considering his age, education, past work experience, and the opinions expressed in the medical records, the following are my opinions within a reasonable degree of vocational certainty regarding Mr. [redacted] employability and earning capacity.

1. [redacted] demonstrated the ability to perform work successfully as a Foreman/Ornamental Ironworker, Foreman Ironworker, Housekeeper and Router Operator. He showed the ability to perform duties, develop skills, and acquire the knowledge and training necessary to obtain and maintain employment in these job positions.

2. Based on the medical records, [redacted] has significant physical functional impairments that impact his employability and functional abilities to perform work. On January 16, 2015, Dr. Matthew Kalter stated: “The patient has been disabled.” On April 3, 2015, Dr. Matthew Skolnick stated: “there is evidence of a total (100%) causally related disability. … This individual is incapable of returning to work at this time.” On August 24, 2015, Dr. Jonathan Vapnek stated: “… Mr. [redacted] now suffers from the expected symptoms of urgency, frequency and incontinence because of sphincter weakness and nerve damage from the severe pelvic fracture.”

3. [redacted] reports physical functional limitations that are consistent with the information and treatment regimen derived from the medical records.

4. [redacted] scores on the vocational test battery indicate limited abilities for clerical job positions and Low Middle Average to Average academic abilities for job retraining. However, his potential for retraining is significantly attenuated by other vocational factors he presents with, including his advanced vocational age status and significant physical functional limitations. His advanced vocational age status limits the remaining time he has for labor force participation, which also limits the amount of time he can benefit from retraining.

5. [redacted] ongoing permanent medical condition and need for further treatment eliminates the option of returning to work in his customary capacity or in similar jobs.

6. The results of the transferable skills analysis indicate that, based solely on the trait-factor system, [redacted] post-injury profile matched 3 occupations, a diminution of 98% compared to the 199 occupational titles contained in his pre-injury profile, realistically indicating that his personal access to the competitive labor market has been eliminated.

7. Considering the physical functional limitations derived from the medical records reviewed for this evaluation, significant reduction of transferable skills yielded by the transferable skills analysis, urinary and incontinence issues, and advanced vocational age status, it is within a reasonable degree of vocational certainty that [redacted] is unemployable. His medical symptoms (including frequency, urgency and incontinence issues) would need to improve in order to return to work in a reduced capacity.

8. [redacted] has diminished physical functional capacities along with ongoing medical treatment needs. Considering his specialized work history requiring the performance of heavy physical labor, significantly reduced transferable job skills, advanced vocational age, and incontinence and bowel issues that can create issues with being in public (including work environments) for extended periods of time, it is highly unlikely that he would benefit from vocational rehabilitation services unless his medical condition improved.

9. Prior to injury, [redacted] demonstrated the ability to earn prevailing level union wage rates for Foreman/Ornamental Ironworker in his local labor market plus union fringe benefits.

10. [redacted] wage earning power is currently eliminated. As a result of the injuries incurred January 13, 2014, [redacted] has experienced lost earnings to the present. He will continue to experience lost earnings that comprise the rate of earnings and former wage rates plus benefits, from the date of his injury through his estimated work life unless his medical condition improves.

11. If his medical condition improves and he is successfully rehabilitated and placed in an alternative job setting, [redacted] will experience loss of earnings based on the differential between his former rate of earnings as a union Foreman/Ornamental Ironworker and a significantly lower future earnings rate. He will be limited to entry-level occupations with wage rates that are influenced by the occupation, industry, and local labor market in which he seeks workforce reentry. He would be limited to entry-level positions and his wage rates would depend upon the occupation, industry, and the locality of the labor market in which he would pursue workforce reentry.

If additional information is made available, I reserve the right to amend my conclusions as needed.

[redacted]

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ADDENDUM A

MCCROSKEY TRANSFERABLE SKILLS ANALYSIS

RESULTS

[redacted]