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TOPIC SUMMARY OF JOHN DOE, M.D.

DEPOSITION DATE: MM DD, 2025

Jane Doe

Vs

XX Services

INITIAL PROCEEDINGS AND DIRECT EXAMINATION OF JOHN DOE, M.D.

The examination began after Dr. XXX was sworn in, with Mr. XXX stating that the deposition was acknowledged as evidence under the XXX Workers' Compensation Act and related rules. When prompted by Mr. XXX to state and spell his name, Dr. XXX responded that his first name was spelled 'X-X-X-X' and his last name was 'X-X-X-X'. He identified his profession as a board-certified physician in anesthesiology and interventional pain.

PAIN MANAGEMENT SPECIALTY: OVERVIEW AND CREDENTIALS OF DR. XXX

Dr. XXX explained that interventional pain management was a subspecialty of anesthesiology focused on evaluating, examining, diagnosing, and treating a wide spectrum of pain syndromes using conservative and minimally invasive surgical procedures. He noted that over 90 percent of patients typically presented with some form of spine pathology. He provided an overview of his educational background, which included a bachelor's degree in chemical engineering and a medical degree from Medical School, along with a residency and various training in anesthesiology and interventional pain management from 2000 to 2005. Dr. XXX confirmed his board certifications in anesthesiology and interventional pain management, which were valid for ten years, and stated that he had been with the XXXXX since 2006. He mentioned that their practice served approximately 600 patients per week across multiple providers. He highlighted that while they treated a variety of orthopedic conditions, the majority of cases, over 90 percent, involve spinal pathologies. Dr. XXX performed spinal cord stimulator procedures, averaging about 50 such procedures annually, which decreased over time. Finally, he noted that his curriculum vitae was slightly outdated but remained accurate in terms of his positions as a a director position for the XXXXX , XXX chapter.

MEDICAL HISTORY AND EXAMINATION FINDINGS FOR JANE DOE

Dr. XXX confirmed he had been treating a patient named Jane Doe and stated that for detailed questions about her, he would refer to his medical records. He clarified that Ms. XX first consulted him on MM DD, 2022, presented a pain complaint linked to a 2016 work-related injury and reported a pain score of 8 out of 10. He elaborated that she had previously received care from another pain physician was in Morris, XXX ; whose treatment had not continued. He noted Ms. XX's pain involved both low back and lower extremities as a result of complications from a

surgical intervention associated with her work-related injury. During the examination, Dr. XXX found no nonorganic exam findings, explained that this indicated no significant underlying spine pathology but rather possible soft tissue contributors. He identified the prevalent pain location as primarily in the lower back and bilaterally in the lower extremities, more on the left side. Dr. XXX described a positive straight leg raise test, indicating potential nerve irritation, and explained the significance of this and the positive FABER test, which evaluates hip and sacroiliac joint issues.

DIAGNOSIS AND TREATMENT PROCEDURES DISCUSSED BY DR. XXX

Dr. XXX described a test for assessing hip and sacroiliac joint pathology, where a patient either sat or laid down and crossed their leg. This test identified pain in the lower back and gluteal region, particularly on the left side, indicating sacroiliac joint issues. He confirmed a diagnosis of radiculopathy and post-laminectomy syndrome on the date in question, which was indicated as a general diagnosis for continuing symptoms after surgical intervention. He explained that radiculopathy implied neurological deficits, which could present as pain, numbness, or weakness in the lower extremity due to nerve injury. He mentioned that medications were ordered for Ms. XX, which included continuing her previous medications and obtaining earlier medical records for further assessment. They discussed conducting diagnostic tests on her sacroiliac joint. On a follow-up date, Dr. XXX noted the diagnosis of lumbar disk disease and sacroiliac dysfunction, explaining that the difference in diagnosis stemmed from the ICD-10 coding method related to her treatment plan. He elaborated on the procedure for testing the sacroiliac joints, aiming to understand the source of pain in the lumbar region. Dr. XXX discussed performing a bilateral sacral ala lateral branch block procedure as a diagnostic test without the use of steroids, explaining its intent to assess pain relief response.

DISCUSSION OF TREATMENT PROCEDURES AND PATIENT EVALUATION

Dr. XXX explained that the initial test was followed by a confirmation diagnostic test if the patient showed a positive response. He noted that a positive response of over 50 percent across both tests indicated the patient would likely respond to radiofrequency ablation for sacroiliac joint pain. He described the procedure as being conducted in an operating room under sterile conditions, using a needle without any incision, guided by live X-ray. It was emphasized that the patient would not sedated and needed to monitor their pain after the procedure. Dr. XXX confirmed that a follow-up note indicated significant improvement in pain shortly after the procedure, with the patient showing a rating of 2 out of 10 pain level during post-procedure evaluations. Dr. XXX further explained that patients reported 100 percent relief initially but experienced pain return thereafter. He clarified the patient's responses regarding pain relief were subjective and specific to the targeted sacroiliac area, described the anesthetic used and the intent of follow-up procedures to confirm treatment efficacy.

DISCUSSION ON PAIN MANAGEMENT PROCEDURES FOR MS. XX

Dr. XXX indicated that the patient experienced about 75 percent improvement in pain response but reported the return of pain sooner than after the first injection. He clarified that no pain medications were administered and that anesthetics were given, with the patient monitoring her pain about one or two hours after leaving. He confirmed that radiofrequency ablation was recommended to provide long-term relief based on the assessment of her pain sources. Dr. XXX explained the details of performing left-sided radiofrequency ablation on MM DD, 2023, noting it involved ablating the nerves rather than just numbing them. The procedure was completed with a similar-sized needle used for injections, but with significant heating applied to target the nerves for longer-term relief. He referenced a follow-up procedure performed on the right side on MM DD, 2023, and noted that the patient showed an 80 percent improvement overall in a subsequent evaluation after the procedures.

DIAGNOSIS AND RECOMMENDED TREATMENT PLAN BY DR. XXX

Dr. XXX diagnosed Ms. XX with radiculopathy and post-laminectomy syndrome. He prescribed medications, ordered additional diagnostic tests, and recommended a bilateral sacral ala lateral branch block as a diagnostic procedure. Over time, her diagnosis expanded to include lumbar disk disease and sacroiliac dysfunction. Dr. XXX explained sacroiliac joint pathology assessment through diagnostic injections. He noted that if a patient experienced more than 50% pain relief across two tests, they would likely benefit from radiofrequency ablation (RFA). The procedure was conducted in an operating room under sterile conditions, using a needle without any incision, guided by live X-ray. He stated that patients were monitored post-procedure to assess pain relief and response to treatment. Ms. XX’s pain management included a combination of medications, injections, and interventional procedures. Dr. XXX emphasized that sacroiliac joint pain relief from RFA typically lasted 6–12 months before requiring repeat intervention. Imaging confirmed her lumbar spine was decompressed without direct nerve compression. Dr. XXX confirmed that radiofrequency ablation targeted specific nerves to provide extended relief. He also noted that spinal cord stimulation was being considered as a possible treatment option. Diagnostic testing revealed that Ms. XX's sacroiliac joint dysfunction was a primary contributor to her pain.

ASSESSMENT AND IMPLEMENTATION OF SPINAL CORD STIMULATION FOR PAIN RELIEF FOR MS. XX

Dr. XXX explained the two-phase process for spinal cord stimulation: a trial phase and permanent implantation if successful. He emphasized the importance of objective improvements, including reduced medication use and enhanced mobility, in determining candidacy. He detailed the process, ensuring that both pain reduction and functional improvements were considered before final implantation.

NEED FOR SPINAL CORD STIMULATOR (SCS):

Dr. XXX explained that a spinal cord stimulator (SCS) was considered due to Ms. XX's refractory post-laminectomy pain syndrome and lumbar radiculopathy, which did not fully respond to previous interventional treatments. He noted that while the SCS was aimed at addressing neuropathic pain, it was not expected to alleviate sacroiliac joint-related pain. Concerns regarding implantation included her history of infection and an open wound from a failed hernia repair, which could pose a risk for post-operative complications. However, Dr. XXX asserted that appropriate preoperative precautions, such as antibiotic prophylaxis and MRSA screening, could mitigate infection risks. He also indicated that the effectiveness of the SCS could only be determined through a therapeutic trial.

Dr. XXX confirmed that he performed the second round of blocks and radiofrequency ablation at S1 to S3 between MM and MM 2024. On MM DD, 2024, he noted improvements in Ms. XX's lower back and gluteal pain, reporting a 75 to 80 percent reduction but no benefit in the lower extremities. He attributed this to the complexities of her post-laminectomy syndrome, lumbar radiculopathy, sacroiliac dysfunction, and degenerative disk disease. He stated the procedures aimed to alleviate SI joint pain but not lumbar radiculopathy. Dr. XXX elaborated that spinal cord stimulation had not been approved as a diagnosis related to these concerns and that the SI joint pain could see relief for 9 to 12 months following the ablation before needing a repeat procedure. While Ms. XX felt better in her lower back and buttock region, there was no noted improvement in her left leg symptoms, consistent with lumbar radiculopathy. He described that both left and right SI radiofrequency ablations were repeated by the end of 2024, with the right-side procedure performed on MM DD, 2024, and the left side on MM DD, 2024. There was a noted timeframe between the right and left-side treatments, and upon noticing pain resurgence in her right side, he conducted a retreat on MM DD, 2024.

Dr. XXX was discussed on Dr. XXX's initial IME, indicating that there was a likely minimally symptomatic pseudoarthrosis prior to the work accident, which was aggravated by the accident itself. He was asked about Ms. XX's need for clearance from her primary care doctor before undergoing a spinal cord stimulator trial; Dr. XXX confirmed Ms. XX would need such clearance. For Ms. XX's ongoing treatment with Dr. XXX concerning her abdominal wound, to which Dr. XXX confirmed there would be no change in his recommendations regarding the stimulator.

MEDICAL EVALUATION AND IMAGING FINDINGS IN MS. XX'S SPINE CONDITION

MRI findings indicated no direct compression on the spinal cord or nerves. However, diagnostic injections confirmed sacroiliac joint pain. A CT scan was recommended to evaluate spinal cord stimulator candidacy. Dr. XXX discussed discrepancies in imaging interpretations among different physicians.

PHARMACOLOGICAL MANAGEMENT: MEDICATIONS AND TREATMENT STRATEGIES

Ms. XX's medication regimen included various pain management and supportive treatments. Duloxetine and Gabapentin were prescribed for nerve irritation and neuropathic pain. Hydrocodone , an opioid analgesic, and Tramadol , a narcotic pain reliever used since the 2016 injury , were part of the overall pain management strategy. Lidocaine patches were applied topically for direct pain relief, while Ibuprofen , a nonsteroidal anti-inflammatory drug (NSAID), was used to reduce inflammation and structural pain. To mitigate NSAID-related complications, famotidine was included to protect the stomach lining. Cyclobenzaprine (Flexeril) was prescribed as a muscle relaxant for pain relief. Buprenorphine was considered as an alternative due to adverse reactions, and oxycodone was used for severe pain management. Additionally, antidepressants were noted as part of the treatment plan, though the specific type was not listed. Dr. XXX confirmed that Ms. XX was carefully monitored for medication tolerance and compliance through monthly evaluations and urine toxicology screenings. He indicated that while opioid therapy was part of her pain management, the goal was to reduce reliance on such medications through interventional procedures like the SCS.

REASONABLENESS AND NECESSITY OF TREATMENT

Dr. XXX's testimony established that the treatments provided to Ms. XX were appropriate and medically necessary due to her persistent post-laminectomy pain syndrome, radiculopathy, and sacroiliac dysfunction. The diagnostic tests, including lumbar imaging and sacroiliac joint injections, confirmed her condition, leading to the administration of radiofrequency ablations for pain relief. He emphasized that the pain relief was temporary, necessitating follow-up interventions, including trigger point injections and ablation procedures, which provided significant yet transient improvements. Additionally, he confirmed that her treatment aligned with standard interventional pain management practices.

DIABETES AND PAIN MANAGEMENT FOR MS. XX:

Dr. XXX noted that while diabetes could impact healing, he could not directly attribute Ms. XX's pain persistence to high blood sugar levels. Blood sugar management was monitored before procedures but was not his area of expertise. He emphasized the importance of managing glucose levels, particularly in surgical candidates.

DR. XXX'S OVERVIEW FROM HIS TESTIMONY

Work-Related Injury (MM DD, 2016 & MM DD, 2016): Ms. XX was injured at work when operating a heavy floor scrubber machine that unexpectedly accelerated backward, causing strain on her back. Shortly after, she suffered another work-related injury while lifting heavy mats, further contributing to her spinal issues. Dr. XXX affirmed that these workplace incidents aggravated preexisting spinal conditions. Prior to these injuries, Ms. XX was noted to be minimally symptomatic and able to work. Following the work accident, she developed post-laminectomy pain syndrome, lumbar radiculopathy, and sacroiliac joint dysfunction. Imaging

results and pain management evaluations confirmed the progression of her spinal conditions post-injury. He diagnosed her with SI joint disease, lumbar facet syndrome, and degenerative disc disease, conditions worsened by her prior work injuries.