IN THE SUPREME COURT OF THE STATE OF NEVADA

DAVID G. MARTINEZ and CHILLY WILLY'S HANDYMAN SERVICES, LLC

Petitioners,

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK; THE HONORABLE RONALD J. ISRAEL, DISTRICT JUDGE,

and

TAYLOR MILES CAPE, and individual,

Respondents.

Supreme Ct. Case No.: 83911

Dist. Ct. Case No.: A-20-818569-C

REPY IN SUPPORT OF PETITIONERS' MOTION TO STAY PROCEEDINGS

I. PLAINTIFF MISTATES THE PROCEDURAL RECORD.

A. Petitioners Did Not Delay Seeking Their Rule 35 Exam.

Plaintiff's Opposition is full of numerous factual misstatements that require correction. He infers Petitioners improperly delayed setting the Rule 35 exams of Dr. Ginsburg (neurologist) and Dr. Etcoff (neuropsychologist).[1] The exam timing was due to (1) Plaintiff's delayed discovery responses as to the scope of his alleged

[1] Opposition, at 1.

injuries, (2) he lives on the east coast and he desired to limit the times he traveled to Nevada for discovery, and (3) the parties spent months attempting to iron out the scope of Dr. Etcoff's Rule 35 exam parameters.[2]

B. The Court Wholesale Adopted the Discovery Commissioner's Report and Recommendations ("DCRR").

Plaintiff wants the Court to believe the district court applied the same reasoning set forth in its Order denying the motion to stay to its Order adopting the DCRR; however, that is not true.[3] Plaintiff contends the district court adopted the DCRR, finding "'[g]ood cause under Rule 35 was independently shown … through the numerous physician affidavits offered by Plaintiff, through the APA guidelines, and through the other evidence offered in the briefing.'"[4] However, this language is from the Order denying the motion to stay, not the order adopting the DCRR.

The DCRR states "the good cause to allow a third-party observer and audio recording of the Rule 35 neuropsychological exam is the Legislature passed NRS 52.380 and the governor signed it into law."[5] The district court adopted the DCRR without any alterations, other than to add: "IT IS FURTHER ORDERED that Defendant's constitutionality argument is waived due to his failure to serve the

[2] Appendix to Motion to Stay, at APP00003-APP00006.
[3] Opposition, at 5-7.
[4] Opposition, at 5 (citing p. 25 of Supplemental Appendix, which is "Order Denying Defendants' Motion to Stay Case Pending Writ of Mandamus").
[5] Plaintiff's Supplemental Appendix to Opposition, at 329:14-16.

Secretary of State pursuant to NRS 30.130."[6] The district court attempts to rewrite the basis for its Order affirming the DCCR through the Order denying the motion to stay. Petitioners drafted the DCCR, while Plaintiff drafted the Order denying the motion to stay.

C. Dr. Ginsburg's Exam Report was Timely Produced.

Dr. Ginsburg did not perform a neuropsychological exam, else the Plaintiff would have insisted on the presence of an observer. But there was no observer present. Nor does Dr. Ginsburg note the exam was audio recorded. The exam was performed to address Plaintiff's claim of a traumatic brain injury, not to assess the validity of the neuropsychological exam performed by his neuropsychologist.[7]

Plaintiff wrongly asserts Petitioners withheld Dr. Ginsburg's Rule 35 report.[8] However, Petitioners disclosed the report two days after Plaintiff requested it, within the 30 days required by NRCP 35.[9] Petitioners' counsel asked Plaintiff's counsel to withdraw the untrue assertion in the Opposition that Petitioners did not comply with Rule 35's reporting requirements. Unfortunately, that has not happened.[10]

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[6] *Id*. at 330.
[7] Reply, APP0001to APP00014.
[8] Opposition, at 7.
[9] Reply, APP00015-APP00016-, Quist e-mail to Loosevelt, dated 3-2-22; APP00017-APP00048, Defendant's Expert Designation.
[10] Reply, APP00015-APP00016, Quist e-mail.

D. The Parties Extended Discovery Pending the Court's Ruling on the Writ Petition.

Plaintiff incorrectly states he agreed to extend discovery while the Motion to Stay is pending before this Court to allow Petitioners "to find another examiner who would comply with Rule 35[.]"[11] That is not true. The reason for the extension was "to allow for more time for the Nevada Supreme Court to rule on the [Writ]" and so "other discovery [could] proceed in the meantime."[12]

II. THE COURT SHOULD ISSUE THE WRIT PETITION.

Petitioners have a likelihood of success on their Writ Petition because the basis for denying the motion to compel was the purported constitutionality of NRS 52.380 and Petitioners having purportedly waived the constitutional argument by not serving the Secretary of State with a copy of their motion to compel.[13] This Court has held NRS 52.380 is unconstitutional. Therefore, NRS 52.380 cannot serve as a basis for denying Petitioners' motion to compel. Moreover, the district court incorrectly reasoned Petitioners waived their constitutional challenge.[14]

The object of the Writ Petition will be defeated, and the Petitioners will suffer irreparable harm if the Writ Petition is denied, because no Nevada board certified neuropsychologists will perform a Rule 35 exam with observers and recording of the

[11] Opposition, at 7.
[12] Appendix to Motion to Stay, at APP000178:10-14.
[13] Plaintiff's Supplemental Appendix to Opposition, at 329-331.
[14] Writ Petition, at 10-13.

full exam. The Nevada State Board of Psychological Examiners has affirmed Nevada licensed neuropsychologists cannot perform Rule 35 exams with observers or recordings of the exam.[15] None of the psychologists Plaintiff relies on are board-licensed in Nevada.[16] They are not qualified to testify regarding Dr Etcoff's ethical and professional obligations with respect to Nevada Rule 35 neuropsychological exams.

Finally, Plaintiff will not suffer irreparable harm if the stay issues, as a delay in conducting discovery does not constitute irreparable harm.

IV. CONCLUSION

IN ACCORDANCE WITH THE FOREGOING, Petitioners respectfully request this Court grant their Motion to Stay the district court proceedings.

DATED: 02/08/22

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[15] Motion to Stay, Appendix I, at APP000172.
[16] Opposition, at 4.

CERTIFICATE OF SERVICE

Per NRAP 21(a) and 25 (c), I certify that I am an employee of Dennett Winspear, LLP, and that on the 10th day of March, 2022, service of **Reply in Support of Petitioners' Motion to Stay Proceedings** was served via electronic means by operation of the Court's electronic filing system to:

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IN THE SUPREME COURT OF THE STATE OF NEVADA

DAVID G. MARTINEZ and CHILLY WILLY'S HANDYMAN SERVICES, LLC

Petitioners,

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Reply Appendix to Reply in Support of Motion to Stay Proceedings

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Defendants' Expert Designation 00017-00048

DATED this 10th day of March, 2022.

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Per NRAP 21(a) and 25 (c), I certify that I am an employee of Dennett Winspear, LLP, and that on the 10th day of March, 2022, service of **Reply Appendix to Reply in Support of Petititoners' Motion to Stay Proceedings** was served via electronic means by operation of the Court's electronic filing system to:

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INDEPENDENT MEDICAL EVALUATION

EXAMINEE : Taylor Cape
EXAM DATE : 11/16/21
REPORT DATE : 11/23/21
D.O.L. : 11/22/18

The independent medical evaluation process was explained to the examinee, and it is understood that there is no patient/treating physician relationship present. It was explained that the evaluation was requested by the referral source and that a report will be sent to the referral source upon completion. The examinee understands that no conclusions or recommendations will be discussed during today's evaluation. The examinee understands that full, reasonable, and consistent effort is requested during the evaluation. The examinee completed paperwork prior to being brought back to the examination room. I entered the examination room at 3:55 p.m. and completed the face-to-face evaluation at 4:50 p.m.

IDENTIFICATION

25-year-old ambidextrous, Caucasian male.

HISTORY

PREINJURY STATUS:

According to Mr. Cape's report to this examiner, prior to the subject accident he denied any history of headaches, memory or concentration difficulties. He reported a history of depression, anxiety and psychosis prior to the subject accident. He had psychiatric hospitalizations in August, September and October 2017.

PROPOSED MECHANISM OF INJURY:

According to Mr. Cape, on the date of the accident he was the restrained driver of a Mazda 2 sedan turning left, at which time his vehicle was struck by a white pickup truck that went through a stoplight. Mr. Cape's vehicle reportedly struck a third vehicle. He reportedly lost consciousness, and woke up at the scene. Mr. Cape indicated that he was amnestic for the events surrounding the accident.

CURRENT CHIEF COMPLAINT(S):

Short-term memory and concentration difficulties.

CLINICAL STATUS:

Following the subject accident, Mr. Cape was transported to UMC Trauma Center. He stated that he was confused at that time. He was subsequently driven home by another individual. Mr. Cape stated that he experienced headaches that gradually tapered off after approximately one month. The headaches were described as a constant frontal pain, 8-9/10 in severity, with nausea and photophobia. He also reported that he had problems with short-term memory, repetition of questions, word-finding, concentration, and difficulties planning a series of events. Over time, his memory has remained the same, but his concentration and ability to ability to plan have worsened. Mr. Cape was not working at the time of the accident, stopping his previous job a few days beforehand. He went back to work in July 2019 as a sales person at Kohl's. Mr. Cape also reported continued symptoms of depression and anxiety that fluctuate in severity. He is currently under the care of a psychiatrist in South Carolina, and is utilizing the medication Abilify. He had some crying spells a couple of months ago. He states his energy level drops in the afternoons. He states that his appetite is good. Mr. Cape denied difficulties with memory and concentration prior to the subject accident, indicating that his mind was previously overactive in conjunction with mania and bipolar disorder. He reports having a GPA of approximately 3.0 during high school and at UNLV. He moved with his family to South Carolina, and failed some classes at Coastal Carolina University. He is currently working as a cabinetry apprentice, and plans to return to Coastal Carolina University to complete his degree in electrical engineering.

Mr. Cape also reported that following the subject accident, he had transient double vision, and that his vision has recently become blurred. He also had some slurred speech, and stated that he was mixing up words. He also reported a variety of other symptoms that include numbness of his mid forehead, neck and low back pain, and intermittent numbness and tingling in his arms, hands and feet at night. He also has experienced sporadic episodes of dizziness, described as disequilibrium that lasts for less than one minute. He also reported experiencing intermittent bilateral tinnitus, hearing loss, as well as cramps in his calves. He has plans to see a chiropractor and a neurologist.

PAST MEDICAL HISTORY:

Allergies: He has no known drug allergies.

Medical Illnesses: Childhood chickenpox.

Past Surgical History: Esophageal surgery.

Current Medications: Abilify 5 mg p.o. q. day.

SOCIAL HISTORY:

Mr. Cape was born and raised in Las Vegas. He is single, and is employed as a cabinetry apprentice. He drinks alcohol rarely, and does not smoke cigarettes. He denies current use of recreational drugs, but reported smoking marijuana several years ago. He completed three years of college, and plans to return to his studies at Coastal Carolina University in pursuit of his electrical engineering degree.

FAMILY HISTORY:

Father is age 56 in fair health. Mother is age 53 in fair health. Mr. Cape has one sister age 16 in good health. Family history is positive for cancer, heart disease, hypertension, stroke, suicide, psychiatric treatment, bleeding tendency, arthritis, headaches.

REVIEW OF SYSTEMS:

Positive for wearing glasses for astigmatism, neck stiffness, difficulty breathing, shortness of breath with walking or laying down, heart murmur, food sticking in his throat, frequent urination, difficulty walking, history of psychiatric care.

RECORD REVIEW

Records reviewed from American Medical Response including the following:

Billing records reviewed.

08/23/17 **Clark AMR. Patient Care Report.** Patient complains of suicidal ideation and hearing voices telling him to kill himself. Patient states he is withdrawing from smoking THC. Patient behavior in presence of EMS was manic. Patient is alert and oriented times four and ambulatory on scene. Patient stated he has had demons all his life and they tell him to lie, hurt himself and hurt others. GCS 15.

08/24/17 RN stated patient was on an L2K for trying to hurt himself and others. Patient was alert and oriented with airway open and clear. Patient did state he does smoke a lot of weed but does not drink or smoke cigarettes. Medical history of schizophrenia. GCS 15.

09/24/17 Patient was being transferred to Seven Hills behavioral facility for psychiatric monitoring. Alert, oriented to person, place, time and event. GCS 15.

09/23/17 21-year-old male exhibiting bizarre behaviors. Patient states “I came to Summerlin Pavilion with Jesus Christ.” Alert, oriented times four. Having some delusional thoughts. Denies hallucinations. States he has a history of psychosis. Takes Risperdal but is not compliant with medications. GCS 15.

11/21/18 Alert, oriented times three. GCS 14. Patient was the restrained driver of a car that was struck on the passenger side. Patient’s vehicle was traveling at 45 MPH. Patient’s airbags were deployed. Patient ambulatory on the scene prior to arrival. Alert to events and

repetitive questioning. Patient is able to follow commands and is alert to self. Head-to-toe exam reveals no signs of injury. Patient denies seizures. History obtained from patient. Medical history: Psychiatric and Vater syndrome. Medications: Risperdal. Head is atraumatic, symmetrical.

EMP of Clark UMC billing statement reviewed.

Records reviewed from University Medical Center including the following:

Billing records reviewed.

11/22/18 **Mitzi A. Dillon, M.D.** Patient was the restrained driver going approximately 45 miles an hour when the vehicle was T-boned by another vehicle going similar speed on the passenger side. Patient had positive seat belt, positive airbag deployment. He was ambulatory afterwards. Reportedly he had loss of consciousness and per EMS had repetitive questioning with a GCS of 14 when they arrived. He denies any headache, no nausea, no vomiting. Head is atraumatic. Neurological exam reported as normal. Alert, oriented times three with good recall of recent and remote events. No repetitive questioning. At this time he has a completely normal neuro exam. I do not feel he requires a CT scan of his brain per the Canadian head CT rules. I have explained to him that he does not need a CT scan of his brain at this time but I have spoken to him about postconcussive syndrome and what to look out for. Clinical impression: Injury of head. Concussion with loss of consciousness.

Records reviewed from Desert Radiologists.

Records reviewed from Greenawalt Chiropractic including the following:

Billing records reviewed.

11/28/18 **Initial Exam.** Problem list includes unresolved – memory issues especially short-term memory (new). Before the accident patient was awake and wearing a seat belt. During the collision the patient was struck on the head. The patient was driving a vehicle. Able to do mental work since the accident? Yes but short-term memory seems affected. Was knocked unconscious. Able to remember the impact? No. Diagnoses: Concussion with loss of consciousness of 30 minutes or less.

11/30/18 Subjective: Memory issues especially short-term memory (no change).

12/03/18 Problem list: Memory issues especially short-term memory. No headaches. Memory seemingly doing better.

12/10/18 Problem list: Memory issues especially short-term memory. The patient presents with a headache (improved). Memory issues especially short-term memory (no change).

12/14/18 Problem list: Unresolved memory issues especially short-term memory. Headache 2/10.

12/26/18 Headache resolved. Memory issue improved.

01/07/19 Headache 60 to 70% improved. Occurs five times per week. Frontal headaches are right or left as this changes. Memory issues 70% improved. Wording is sometimes challenging but getting better. Sometimes simple math is hard as I am usually gifted with math.

01/17/19 Headache improved. Short-term memory unchanged.

01/28/19 Headache resolved. Memory issue improved.

02/11/19 Headache 100% improved. Memory issue 80 to 90% improved. Seems okay but at times not as sharp reacting. Lacking connectness at times. Focus seems off at times. Oriented to time, place and person.

01/10/19 **Pueblo Medical Imaging. MRI Brain without contrast with SWI/DTI, hippocampal volume and SPECT.** Conclusion: (1) Hippocampal volume on the left is in the 88th percentile and on the right it is in the 41st percentile. Correlate clinically. (2) Abnormal spectroscopy in the white matter of both frontal lobes with depression of the NAA peaks. Correlate clinically. (3) The conventional sequences and the diffusion tensor imaging is reported separately.

11/28/18 Patient Intake Form reviewed.

Records reviewed from Enrico Fazzini, D.O., Ph.D. including the following:

12/15/18 This 22-year-old left-handed male was accompanied with his mother and presented for neurological evaluation on 12/15/18 following a motor vehicle injury which occurred on 11/21/18. The patient was reportedly the driver in a vehicle that was struck in the front and passenger side on 11/21/18. The patient struck his head on the airbag. He did not remember the sound of impact. The police and ambulance were on the scene and the patient was taken to University Medical Center because of a loss of consciousness. The patient was not sure exactly how long the loss of consciousness was. He stated that he had a probable CT scan of the head at University Medical Center and he was not told that there were any abnormalities and he was released. Since the accident the patient was complaining of headaches with balance impairment and difficulty with memory, attention and concentration. The patient stated that he had word-finding problems, difficulty getting organized and completing tasks, problems with memory and experiencing environmental overlay and concentration problems. Past medical history was not positive for the presence of a concussion. The patient was recently diagnosed on 08/2018 with a bipolar disorder and was started on Risperdal before the motor vehicle accident of 11/21/18. He was alert and oriented times three and his language skills seemed intact but formal tests of language, attention, concentration, memory and spatial orientation were not performed. Impression: (1) Postconcussive balance impairment and headaches. (2) Complaints of

cognitive deficits following possible traumatic brain injury. Recommendations: MRI scan of the brain using brain trauma protocol and SPECT.

01/12/19 The patient had less headaches and balance impairment but continued to complain of memory, attention and concentration problems. MRI scan of the brain on 01/10/19 demonstrated right hippocampal atrophy and a decrease in N-acetylaspartate in both frontal lobes. This is positive evidence for the presence of a traumatic brain injury. Mental status testing revealed that there were still signs of decreased attention and concentration. Impression: (1) Postconcussive balance impairment and headaches, gradually resolving. (2) Cognitive deficits following traumatic brain injury. Recommendations: Reevaluate in two months to see if cognitive deficits persist at which time neuropsychological testing will be ordered.

03/08/19 The patient did not have any more headaches, dizziness or balance impairment. He stated that his cognition had greatly improved since the last visit with me on 01/20/19. Impression: (1) Postconcussive balance impairment and headaches, resolved. (2) Postconcussive cognitive deficits, resolved. This patient has had a great deal of recovery and it is hoped that he will continue to return to the prior level of functioning as had existed before the motor vehicle accident of 11/21/18. Nevertheless the patient is at an increased risk for the development of dementia as a consequence of the traumatic brain injury which he sustained at the time of the accident which was on 11/21/18. The patient was told to reevaluate with me only if cognitive impairment returned or if there was any other change in neurological status.

05/31/19 The patient stated that when he started a new job he noticed that he had decreased attention and concentration and decreased memory skills. He also had increased anxiety. Mental status testing revealed that there was some decreased attention and concentration with some increase in anxiety. Impression: Complaints of cognitive deficits following traumatic brain injury, anxiety. Recommendations: Formal standardized neuropsychological testing.

07/24/19 The patient still complained of memory, attention and concentration problems although he had less anxiety on today's evaluation. Mental status testing reveals that there are still some signs of decreased attention and concentration. Impression: (1) Complaints of cognitive deficits following traumatic brain injury. Recommendations: (1) Review neuropsychological testing performed by Dr. Collins. (2) Aricept 5 mg a day after dinner to try to help memory.

10/04/19 **Addendum.** Review of neuropsychological testing. There were significant deficits in verbal and nonverbal memory as well as information processing speed. The patient had good effort and lingering was not suspected. This testing demonstrated significant cognitive deficits associated with a traumatic brain injury. MRI scan of the brain and MRI SPECT scan on 01/10/19 was significant for structural damage associated with a traumatic brain injury and demonstrated right hippocampal atrophy and a decrease in N-acetylaspartate in both frontal lobes. This patient has significant structural damage and associated cognitive deficits associated with traumatic brain injury sustained on 11/21/18.

Billing records reviewed.

Records reviewed from Oasis Counseling including the following:

Billing records reviewed.

Records reviewed from Las Vegas Radiology including the following:

06/20/19 **MRI Cervical Spine without contrast.** Report reviewed.

06/20/19 **Patient Intake Form.** Current medications: Abilify.

Records reviewed from Sunshine Collins, Psy.D., Licensed Psychologist, including the following:

Billing records reviewed.

07/09/19 Concentration change. Memory loss. Was depressed after the MVA. Abilify December 2018. Felt lethargic and depressive and cognitive slowing so we DC'd prescription for five months May 2019.

03/27/2020 Letter to Jan Roughan reviewed.

09/25/19 **Neuropsychological Evaluation Report.** Findings: Mr. Cape has a mild neurocognitive disorder due to traumatic brain injury causing clinically significant distress and impairment in multiple demands of functioning and multiple settings. His neurocognitive disorder is accompanied by behavioral disturbance primarily comprised of mood disturbance. Mr. Cape reported that he became "addicted to concentrated marijuana" in 2017. Reviewed records indicate that Mr. Cape's mother has said that he began exhibiting psychotic symptoms after one month of using "whack" which she characterized as a type of marijuana. It is unclear what substance Mr. Cape was using as this terminology is used to identify multiple different recreational substances, most common marijuana laced with PCP. Mr. Cape reported that his substance use led to "drug-induced psychosis." Reported mental health history is significant for psychiatric hospitalization twice in 2017. Mr. Cape reported that his presentation on initial hospitalization included going from a depressive state to a manic state, insomnia, delusions, religious delusions, feeling like everything had a meaning and feeling overwhelmed. He stated that he had a poor reaction to the prescribed medication Risperdal and discontinued use as soon as he was released leading to a second hospitalization soon thereafter. His symptoms began to return in July 2018. Mr. Cape resumed use of medication at father's insistence. Mr. Cape was able to transition from Risperdal to Abilify which was characterized as a better medication for him. Mr. Cape was prescribed Abilify in December 2018. He reported that he discontinued use of the medication due to feelings of lethargy, depressed mood and cognitive slowing. He did not take medication for five months. When he advised his parents in May 2019 that he had discontinued the medication and felt he was doing fine without it they insisted that he restart the medication which he reportedly did. Mr. Cape reported that he was diagnosed with "bipolar with schizoaffective disorder." Mental health treatment was positive for multiple trials of

psychotherapy. Mr. Cape stated that his mental health is “better.” Suicidal ideation last occurring in December 2018 was reported. Speech was of normal rate and volume. Pronunciation was clear. Mr. Cape spoke in spontaneous complete sentences. Speech was coherent. Affect was nervous or anxious but pleasant. Mr. Cape was alert and oriented to person, city and to the purpose of this evaluation. Mild word-finding difficulty was present as evidenced by brief pauses in spoken language followed by eventual completion of the statement. He reported a number of difficulties consistent with a significant depressive experience. The quality of his depression seems primarily marked by cognitive features such as negative expectancies and low self-esteem. He mentioned that he is experiencing some degree of anxiety and stress. Diagnosis: Mild neurocognitive disorder due to traumatic brain injury with behavioral disturbance (mood disturbance), brief psychotic disorder in full remission, schizophreniform disorder, schizophrenia, bipolar 1 disorder with psychotic features most recent episodic manic in full remission. Mr. Cape sustained a traumatic brain injury in a motor vehicle accident on 11/21/18. A traumatic brain injury is a brain trauma with specific characteristics (i.e., loss of consciousness, posttraumatic amnesia, disorientation and confusion, and/or neurological signs) that are caused by an impact to the head or other mechanism that results in rapid movement or displacement of the brain within the skull. In Mr. Cape’s case he experienced loss of consciousness. Neurologist Enrico Fazzini, D.O. diagnosed a traumatic brain injury on 01/12/19. As a result of this traumatic brain injury Mr. Cape developed neurocognitive disorder. Given the loss of consciousness was less than 30 minutes and probable Glasgow Coma Scale score (degree of disorientation and confusion at initial assessment) considering his release from the hospital without admission, Mr. Cape’s head injuries would be characterized as a mild traumatic brain injury. Neurocognitive symptoms associated with mild traumatic brain injury tend to resolve within days to weeks after the injury with complete resolution typically occurring by three months. Symptoms such as headache and photosensitivity also tend to resolve in the weeks following mild traumatic brain injury. Mr. Cape’s overall performance on measures that reflect attention and concentration fell in the average range. Taken together these factors suggest that Mr. Cape’s cognitive disturbance includes the mild behavioral disturbance of mood disturbance. Individuals who have sustained traumatic brain injuries typically report more depressive symptoms than periods without such injuries. Mental health history is significant for preexisting episodes of psychosis. Schizophrenia spectrum disorders commonly include cognitive deficits in processing speed, attention, working memory, verbal learning and memory, visual learning and memory, reasoning and problem solving. Mr. Cape’s mental health symptoms, however, were well controlled with medication at the time of and following motor vehicle accident. As such his history of brief psychotic disorders likely represent a smaller contribution due to the observed cognitive deficits identified through this evaluation than his traumatic brain injury. His neurologist would best be able to speak to if a presenting memory loss is consistent with structural damage on neuroimaging.

Records reviewed from Pueblo Medical Imaging including the following:

Billing records reviewed.

12/29/18 **MRI Brain without with SWI/DTI, hippocampal volume and SPECT.** Conclusion: (1) Normal appearance of the brain on the conventional sequences. (2) The fractional anisotropy in the corpus callosum is normal.

04/2020 **Jan Roughan, B.S.N., R.N., P.H.N., CRRN/ABSNC, CLCP, CCM.** He seems first to note that subsequent to his unfortunate 11/21/18 accident and resultant injuries, Mr. Cape is now: Slower in the performance of his ADLs and IADLs and is experiencing daily blanking out/staring episodes, forgetfulness/memory lapses, diminished focus and concentration, depression. Life care analysis: It is evident from the medical records and collateral interviews in respect to Mr. Cape's pre and post morbid functioning that he has suffered significant sequelae from the injuries incurred during the 11/21/18 incident. Recommendations: Comprehensive seizure disorder evaluation, EEG, 3 Tesla MRI scan of brain, drugs/supplies including but not limited to neuropathic pain agents/antidepressant, anti-Alzheimer antidepressant, antiseizure.

Records reviewed from Spring Mountain Treatment Center including the following:

Billing records reviewed.

09/21/17 **Robert Peprah, M.D. Discharge Summary.** Reason for admission/hospitalization: Says that he felt a demon and he was hearing voices telling him to kill himself. Also being treated for substance abuse. He reports marijuana. Discharge diagnoses: Unspecified psychosis, marijuana abuse. Discharge medications: Risperdal 2 mg p.o. nightly for psychosis.

Multiple progress notes reviewed including the following:

08/26/17 **MHT Crer.** Was very confused during the shift.

08/26/17 **Quest Diagnostics.** TSH 10.0.

Records reviewed from Aspire Mental Health.

12/14/17 **Tiffany Graston, L.C.S.W.** Taylor presents to therapy following an inpatient psychiatric hospitalization at Spring Mountain Treatment Center on 08/2017. Client reports this was his first hospitalization and has attributed this to marijuana use. Client reports a long history of extreme medical conditions causing weakness alongside of his body. Client reports being vulnerable and smoking marijuana led to a demonic possession. Client denies taking any other substance and is now clean for marijuana.

09/14/17 **Tiffany Graston, L.C.S.W.** Client using marijuana since age 16 years old off and on. Client reports a period he used daily until 2014. Client reports that he had been clean for 14 months prior to the 2017 hospitalization. Began using marijuana again in 2018 prior to psychotic break.

03/19/21 **Plaintiff's Response to Defendant Chilly Willy's Handyman Services, LLC's First Set of Interrogatories.** Response to interrogatory #3. Head/brain, concussive brain injury. Response to interrogatory #14. Plaintiff still experiences symptoms including difficulty concentrating, sensitivity to light and noise, short-term memory loss, depression and blurred vision.

11/21/18 State of Nevada Traffic Crash Report reviewed.

01/14/19 **United Financial Casualty Company.** Damage estimate for 2012 Mazda 2 Sport reviewed.

Sixty-three color photographs of white Mazda sedan reviewed.

01/16/19 **Fix Auto Las Vegas.** Damage estimate for 2013 Chevrolet Impala LT reviewed.

One hundred ninety-four color photographs of white Chevrolet Impala reviewed.

Eight pages of color photographs of Mr. Cape's injuries reviewed.

The following imaging studies were personally reviewed from Pueblo Medical Imaging:

06/20/19 **MRI Cervical Spine without contrast.**

12/29/18 **MRI Brain without contrast.**

01/10/19 **MRI Brain without contrast.**

PHYSICAL EXAMINATION

GENERAL:

Mr. Cape is a well-developed, well-nourished, Caucasian male in no acute distress.

HEENT:

Head is atraumatic, normocephalic. Ears – External auditory canals are clear. Neck is supple, nontender.

MUSCULOSKELETAL:

Tinel's sign is negative at the wrists bilaterally.

MENTAL STATUS:

Mr. Cape is alert. There is no anomia or dysarthria. He follows commands appropriately. He scored a 30 out of 30 on the Mini Mental Status examination, and demonstrates good clock drawing skills. Affect is appropriate. There is no repetition of phrases.

NEUROLOGIC EXAM:

Cranial nerves II: Pupils are equal and react from 5 to 3 mm. Optic disks are sharp. Visual fields are full to confrontation. Visual acuity is 20/30 bilaterally (unchanged with pinhole testing). III, IV and VI: Extraocular muscles are full in all directions without nystagmus. V: Facial sensation is intact to temperature and light touch bilaterally. VII: Face is symmetric. VIII: Weber test lateralized to the left. Rinne test yielded air conduction greater than bone conduction bilaterally. IX and X: Palate elevates symmetrically. XI: Trapezius muscles 5/5. XII: Tongue is midline.

MOTOR:

Strength is 5/5 throughout with normal tone and bulk. There is no evidence of muscle atrophy, fasciculations, or involuntary movements noted.

SENSORY:

Intact to pinprick, light touch, proprioception, vibration and temperature in the bilateral upper and lower extremities. Graphesthesia and stereognosis are intact in both hands.

REFLEXES:

1+ bilateral biceps, triceps, brachioradialis, knee jerks and ankle jerks. Absent Babinski's.

CEREBELLAR FUNCTION:

Finger-to-nose and rapid alternating movements are normal bilaterally. Romberg is negative.

GAIT/TANDEM GAIT:

Normal.

DISCUSSION

Based upon my review of the aforementioned documents, interview, and examination of Mr. Cape, he is alleging that he sustained a concussion as a result of the 11/22/18 subject motor vehicle accident. He also stated that he has experienced persistent problems with short term memory, concentration, and ability to plan as a result of the accident. According to the 11/21/18 paramedic report, Mr. Cape was alert, oriented times three, and exhibited a GCS of 14. He was able to provide his history to the paramedics and follow simple commands, but was noted to exhibit repetitive questioning. According to the 11/22/18 report from Dr. Dillon, Mr. Cape was alert and oriented times three, and exhibited good recall of recent and remote events. No

repetitive questioning was noted at that time. Dr. Dillon did not deem a head CT to be indicated at that time, but diagnosed Mr. Cape with a concussion with loss of consciousness. Based upon my experience as a Board-Certified neurologist, the majority of patients with concussion improve within the first-year post-injury. This is consistent with Mr. Cape's records from the office of Greenawalt Chiropractic. For example, according to the initial 11/28/18 initial examination, Mr. Cape reported impairment of short-term memory. According to the 12/03/18 report, Mr. Cape denied headaches and stated his memory was doing better. According to the 12/14/18 evaluation, Mr. Cape reported headaches at a severity of 2/10, and difficulties with short-term memory. According to the 02/11/19 report, Mr. Cape indicated that his headaches were 100% improved, and that his memory was 80 to 90% improved. In contrast to the available records, Mr. Cape reported to this examiner that his memory difficulties have remained the same, but his concentration and ability to plan a series of events have worsened over time. Despite his subjective cognitive complaints, Mr. Cape's mental status examination performed by this evaluator revealed normal findings.

Mr. Cape was also evaluated by Dr. Fazzini on several occasions. At the time of his initial evaluation on 12/15/18, Mr. Cape reported difficulties with headaches, balance, memory, attention, concentration, word-finding, and organization. Dr. Fazzini ordered a brain MRI that was subsequently performed at Pueblo Medical Imaging on 12/29/18. Based upon my personal review of his MRI images, there was no evidence of traumatic brain injury present. This is consistent with the radiology report, indicating the MRI was normal on conventional sequences. A subsequent report dated 01/16/19 noted the hippocampal volume on the left to be in the 88th percentile and on the right to be in the 41st percentile. Clinical correlation was advised. The report also indicated abnormal spectroscopy in the white matter of both frontal lobes with depression of the NAA peaks. Clinical correlation was once again advised. Dr. Fazzini reevaluated Mr. Cape on 01/12/19. According to Dr. Fazzini's report, the right hippocampal atrophy and SPECT findings of decreased N-acetylaspartate in the frontal lobes were "positive evidence for the presence of traumatic brain injury." In contrast, according to the 09/13/18 Radiological Society of North America Position Statement on traumatic brain injury and Wintermark et al.,[1] indicating "There remains insufficient evidence at the time of this writing to suggest that these methods (DTI and SPECT) are valid, sensitive and specific for routine clinical evaluation of TBI at the individual patient level." Additionally, according to Cook et al., [2] there is "preliminary evidence that hypothyroidism in adults causes significant reduction in the volume of the right hippocampus. This could explain some of the memory deficits that have been observed in those with hypothyroidism." This is significant because, according to the 08/26/17 TSH level from Quest Laboratories, Mr. Cape's TSH was elevated to a level of 10. This finding is suggestive of hypothyroidism, a condition associated with cognitive impairment. Furthermore, according to Zhou, et al., [3] caution was advised when utilizing volumetric analysis on an individual basis and "there is also a normal, non-insignificant inter-subject variability in brain MRI morphology."

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[1] Wintermark M, Sanelli PC, Anzai Y, Tsiouris AJ, Whitlow CT. Imaging Evidence and Recommendations for Traumatic Brain Injury: Advanced Neuro and Neurovascular Imaging Techniques. AJNR 2014;1-11
[2]Cooke GE et al. Hippocampal volume is decreased in adults with hypothyroidism Thyroid 2014;24:433-40.
[3] Yongxia Zhou, et. al. Mild traumatic brain injury: longitudinal regional brain volume changes. Radiology: Volume 267(3):880-890.

According to the 03/08/19 report from Dr. Fazzini, Mr. Cape's postconcussive balance impairment, headaches and cognitive deficiencies have resolved. Dr. Fazzini also indicated that Mr. Cape is at an increased risk for dementia. In contrast, according to Mehta, et al.,[4] "No increased risk of dementia or AD was found for persons with a history of head trauma with loss of consciousness." According to Julien et al.,[5] "whether TBI is a risk factor for AD remains elusive." Additionally, according to Esopenko and Levine,[6] "While the acute and subacute effects of TBI recover over time, relatively little is known about the long-term effects of TBI in relation to neurodegenerative disease."

Dr. Fazzini reevaluated Mr. Cape again on 05/31/19. According to his report, Mr. Cape was once again reporting difficulties with attention, concentration, memory and anxiety. These recurrent symptoms are considered unrelated to the subject accident. Alternatively, Mr. Cape has a pre-accident history of depression, anxiety, schizophrenia and psychosis. Based upon my experience, patients with depression and anxiety often complain of associated cognitive difficulties. According to the 09/25/19 report of Dr. Collins, his psychosis is a likely contributing factor to Mr. Cape's cognitive deficits. Finally, based upon my analysis of this case, Mr. Cape's neurological prognosis with regard to the 11/22/18 subject accident is considered excellent.

DISCLAIMER

The opinions, conclusions, and recommendations expressed above are based upon reasonable medical probability and are independent of the referral source. Multiple factors have been taken into account including the examinee's subjective complaints, provided history, medical records reviewed, direct review of diagnostic or radiographic testing, results of credibility and symptoms reporting, and the physical examination findings. Comments on appropriateness of care are professional opinions based upon the specifics of the case and are not to be generalized to the specific involved providers or disciplines. The opinions expressed above do not constitute a recommendation that specific claims or administrative decisions be made or enforced. At the conclusion of the examination today, the examinee left the office without complaints of additional injury.

Respectfully submitted,

[4]Metha, KM, et al. Head Trauma and risk of dementia and Alzheimer's disease. Neurology, December 1999, 53(9) 1959.
[5]Julien J. et al. Association of traumatic brain injury and Alzheimer disease onset: A systematic review. Annals of physical rehabilitation medicine. 2017 May 11. pii: S1877-0657(17)30053-2.
[6] Esopenko C and Levine B Journal of Neurotrauma. 2015 Feb 15; 32(4): 209-20.

_____

David L. Ginsburg, M.D.
Diplomate American Board of Psychiatry & Neurology
Diplomate American Board of Electrodiagnostic Medicine

DLG:cak

DD: 11/16/21
DT: 11/16/21

cc: Dennett Winspear
3301 North Buffalo Drive, Suite 195
Las Vegas, NV 89129
Telephone: (702) 839-1100
Fax: (702) 839-1113

Theresa Amendola

From: Brent Quist
Sent: Wednesday, March 2, 2022 4:10 PM
To: Ryan Loosvelt; J. Keating
Cc: Danielle Glave; Dillon Coil; Ashley Marchant
Subject: RE: Cape v. Chilly Willy, Martinez

Ryan:

I assume you are requesting the Rule 35 exam report prepared by Dr. Ginsburg. Per Rule 35(b)(1), the defense is required to produce a Rule 35 exam report (prior to the Rule 16.1(a)(2) expert disclosure deadline) within 30 days of when the plaintiff requests that report. The rule states: "Unless otherwise ordered by the court or discovery commissioner for good cause, the party who moved for the examination must, **upon a request by the party whom the examination order was issued**, provide a copy of the examiner's report within 30 days of the examination or by the date of the applicable expert disclosure deadline, whichever occurs first." (emphasis added). The 30 day deadline to produce a Rule 35 report, prior to the initial expert disclosure deadline, is triggered by a plaintiff requesting a copy of that report.

Your e-mail, sent earlier today, is the FIRST request you or anyone from your office has made to my office for Dr. Ginsburg's report. Therefore, we have 30 days from today to provide your office with a copy of that report as the initial expert disclosure deadline is not until after that 30-day period. However, in good faith I have instructed my paralegal to provide you with that report by the end of the week.

I have not had an opportunity to review your Opposition to the Motion to Stay filed with the Supreme Court. However, I request that if you have made unwarranted, disparaging comments about either myself, my firm, Mr. Keating of the Defendants based on an incorrect understanding of the timing requirements for Rule 35 report production, I request you file an amended Opposition or a supplemental pleading with the Supreme Court clarifying that neither myself, my office, Mr. Keating, or any of the Defendants have either failed to comply with the requirements of Rule 35 or have otherwise acted in a bad faith manner with respect to production of Dr. Ginsburg's report.

Sincerely,

Brent

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, March 2, 2022 2:54 PM
To: Brent Quist <bquist@dennettwinspear.com>; J. Keating <jkeating@keatinglg.com>
Cc: Danielle Glave <dglave@ggrmlawfirm.com>; Dillon Coil <dcoil@ggrmlawfirm.com>
Subject: Cape v. Chilly Willy, Martinez

Brent and John, as you will see in our opposition to stay, we pointed out the failure to provide your DME report since November. Please provide that by Friday end of business. We reserve all rights in that regard.

John, please provide dates for depo for your client. We will notice it if we do not hear back soon.

Brent, we will be noticing a Rule 30(b)(6) so you know the subjects for designees. If you have preferred dates in the meantime for your company rep, please provide them.

Finally, please let me know a date you are each available next week to confer over your respective clients' discovery responses; we can do these separately since you each have separate clients and separate responses.

Thanks,

-Ryan

GGRM
NEVADA'S PREMIER INJURY LAW FIRM

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Attorneys for Defendant, CHILLY WILLY'S HANDYMAN SERVICES, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TAYLOR MILES CAPE, Plaintiff, vs. DAVID G. MARTINEZ, individually; CHILLY WILLY'S HANDYMAN SERVICES, LLC, a domestic limited-liability company; DOES I through X; and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	Case No: A-20-818569-C Dept. No: 28

DEFENDANT'S EXPERT DESIGNATION

Defendants, CHILLY WILLY'S HANDYMAN SERVICES, LLC., by and through their attorneys, DENNETT WINSPEAR, LLP, submit the following information with respect to the expert witnesses that may be presented at trial in the above-captioned matter in accordance with the requirements of rule 16.1(a)(2) of the Nevada Rules of Civil Procedure.

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	EXPERT WITNESS	ANTICIPATED TESTIMONY	EXHIBITS	
1	David L. Ginsburg, M.D. 851 S. Rampart Blvd., Suite 115 Las Vegas, NV 89145 (702) 778-9300	Dr. Ginsburg is an expert in neurology and is expected to testify regarding his review of Plaintiff's records and his opinion regarding the nature and extent of Plaintiff's alleged injuries, reasonableness and necessity of treatment and costs of treatment and other matters related to his review and examination. Dr. Ginsburg's written reports are attached hereto.	**A**	Curriculum Vitae of David L. Ginsburg, M.D.
			B	Fee Schedule of David L. Ginsburg, M.D.
			C	Testimony history of David L. Ginsburg, M.D.
			D	Written report regarding Plaintiff by David L. Ginsburg, M.D.
			E	Supplemental report by David L. Ginsburg, M.D.

Defendant specifically reserves the right to supplement its expert disclosures pursuant to NRCP 16.1(a)(2) and NRCP 26(e)(1). Additionally, Defendant reserves the right to retain additional expert witnesses, to supplement this witness list if additional information or witnesses are revealed as discovery proceeds, or if additional experts are retained, and to identify rebuttal and impeachment witnesses as may become necessary or may be revealed during the trial of this case.

DATED this 4th day of March, 2022.

DENNETT WINSPEAR, LLP

By /s/ Brent D. Quist
RYAN L. DENNETT, ESQ.
Nevada Bar No. 005617
BRENT D. QUIST, ESQ.
Nevada Bar No. 009157
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Attorneys for Defendant, Chilly Willy's Handyman Services, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), EDCR 7.26 and N.E.F.C.R. 9, I certify that on this date, I served the foregoing **DEFENDANT'S EXPERT DESIGNATION** on all parties to this action by the following method:

_____ Facsimile

_____ Mail

__X__ Electronic Service

Ryan A. Loosvelt, Esq.
Nevada Bar No. 8550
GREENMAN GOLDBERG RABY & MARTINEZ
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Taylor Miles Cape

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KEATING LAW GROUP
9130 W. Russell Road, Suite 200
Las Vegas, Nevada 89148
Telephone: 702.228.6800
Facsimile: 702.228.0443
Attorneys for Defendant
David G. Martinez

DATED this 4th day of March, 2022.

/s/ Ashley Marchant
an Employee of DENNETT WINSPEAR, LLP

CURRICULUM VITAE

DAVID L. GINSBURG, M.D.
Adult Neurology
851 S. Rampart Blvd., Suite 115
Las Vegas, NV 89145
Phone (702) 778-9300
Fax (702) 778-9301

Education:

1980-1984	University of Southern California Los Angeles, California Bachelor of Science Magna Cum Laude Psychobiology Honors Program
1984-1988	University of Pittsburgh School of Medicine Pittsburgh, Pennsylvania Doctor of Medicine
1988-1993	University of Southern California Medical Center Los Angeles, California Internal Medicine Internship Neurology Residency Clinical Neurophysiology Fellowship

Professional Experience:

2017- Present	Professor of Neurology Roseman University of Health Sciences 5380 S. Rainbow Blvd., Suite 120 Las Vegas, Nevada 89118
2007- 2017	Professor of Neurology (promoted from Associate Professor 07/01/15) University of Nevada School of Medicine Division of Neurology 1707 W. Charleston Blvd, Suite 220 Las Vegas, Nevada 89102
2006 - Present	Medical Director ALS Association – sponsored clinic 1707 W. Charleston Blvd, Suite 220 Las Vegas, Nevada 89102
2002- 2007	Medical Advisor Nevada Neuroscience Foundation 1707 W. Charleston Blvd, Suite 220 Las Vegas, Nevada 89102
2002- 2017	Co-Director MDA-sponsored clinic 1707 W. Charleston Blvd, Suite 220 Las Vegas, Nevada 89102

Professional Experience (continued):

1994-2007	Private Practice Nevada Neurological Consultants, Ltd. 880 Seven Hills Drive, Suite 200 Henderson, Nevada 89052
1993-1994	Private Practice Jack Florin, M.D., Inc. 400 W. Central Ave. Brea, California 92621

Professional Memberships/Committees:

2019	Member, Better Business Bureau of Southern Nevada
2014-Current	National Myasthenia Gravis Foundation, Board Member
2013-2016	University of Nevada School of Medicine, Member, Promotions and Tenure Committee
2013-2015	University of Nevada School of Medicine, Chairman, Epileptologist Search Committee (Las Vegas Campus)
2012-Current	University of Nevada School of Medicine Southern Regional Executive Committee
2012-2013	University of Nevada School of Medicine Integrated Clinical Services Committee
2011-2012	University Medical Center, Health Advisory Board Patient Care Committee
2011	University Medical Center, Interim Director of Stroke
2011	University of Nevada School of Medicine, Chairman, Neurology Faculty Search Committee (Reno Campus)
2010-2012	University of Nevada, Reno/Member, Institutional Review Board
2009-2011	American Academy of Electrodiagnostic Medicine/Marketing Committee
2009-2011	University of Nevada School of Medicine, Member, Internal Medicine Chairman (Las Vegas Campus) Search Committee
2009-Current	Section Chief, Neurology, University of Nevada School of Medicine
2007-Current	Member, Northeast ALS Association (NEALS)
1996-Current	Member, American Association of Neuromuscular and Electrodiagnostic Medicine
1990-Current	Member, American Academy of Neurology

Licenses/Certifications:

Current	Nevada State Board of Medical Examiners, License #7255
Current	Medical Board of California, Certificate #G66258
Current	Diplomate of the American Board of Psychiatry and Neurology
Current	Diplomate of the American Board of Electrodiagnostic Medicine
2020-Current	Earned Accredited Electrodiagnostic Laboratory with Exemplary Status for Roseman University of Health Sciences from American Association of Neuromuscular and Electrodiagnostic Medicine
2012-2017	Earned First Accredited Electrodiagnostic Laboratory in state of Nevada for University of Nevada School of Medicine from American Association of Neuromuscular and Electrodiagnostic Medicine (issued June 1, 2012)

Awards:

2014, 2017, 2019	Listed among Top Doctors List in Vegas Inc. Magazine
2014-2017	Listed among Top Doctors List in Seven Magazine
2014	Service Recognition Award, Las Vegas Muscular Dystrophy Association
2010-2014	Listed among Top Doctors List in Las Vegas Life Magazine
2013	ALS of Nevada Service Recognition Award

Publications/Presentations:

DeGiorgio, C.M., Correale, J.D., **Ginsburg, D.L.**, Bracht, K.A., Gott, P.S., Smith, T. and Rabinowicz, A.L., "Neuron Specific Enolase and Status Epilepticus". Neurology, 1994: 44, Suppl.2:A205

Rabinowicz, A.L., **Ginsburg, D.L.**, DeGiorgio, C.M., Gott, P.S. and Giannotta, S.L, "Unruptured Intracranial Aneurysms: Seizures and Antiepileptic Drug Treatment Following Surgery". Journal of Neurosurgery, 1991; 75:371-373
DeGiorgio, C.M., Correale, J.D., Gott, P.S., **Ginsburg, D.L.**, Bracht, K.A., Smith, T., Boutros, R., Loskota, W.J., and Rabinowicz, A.L., "Serum Neuron-Specific Enolase in Human Status Epilepticus". Neurology, 1995; 45:1134-1137

Rabinowicz, A.L., Correale, J.D., **Ginsburg, D.L.**, and DeGiorgio, C.M., "Neuron Specific Enolase: A New in Vivo Marker of Seizure Induced Brain Injury".

Research Experience:

Edmonds Research Fellowship, UCS School of Medicine, Summer 1981

Weitzmann Institute of Science Research Fellowship, Rehovot, Israel, Summer 1982

Blockade of the GP IIB/IIIA Receptor to Avoid Vascular Occlusion
A Single-Dose, Double-Blind, Placebo-Controlled, Randomized, Parallel-Design, Oral Dose (1.2 mg, 0.8 mg, 0.4 mg, and 0.2 mg) Response Study of XXXX in the Treatment of Acute Migraine Headache With or Without Aura

Open-Label Extension Study to Evaluate the Safety of XXXX in Subjects with Painful Diabetic NeuropathyA 12-Week, Double-Blind, Placebo-Controlled, Parallel Group Study to Assess the Efficacy and Safety of XXXX in Patients Suffering from Restless Leg Syndrome

Sponsor: Allergan
Protocol: 191622-036 Date: 2000 PI: Steven A. Glyman, M.D.
A Multicenter, Double-Blind, Randomized, Placebo-Controlled, Parallel Group Study of the Safety and Efficacy of Three Doses of Botox (Botulinum Toxin, Type A) Purified Neurotoxin Complex for the Prophylactic Treatment of Migraine Headaches

Sponsor: Amgen
Protocol: 20000105 Date: 2000 PI: Steven A. Glyman, M.D.
Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, 6-month Safety, Efficacy and Neuroimaging Trial of AMG-474-00 in the Treatment of Patients with Parkinson's Disease

Research Experience (continued):

Sponsor: Kyowa Pharmaceutical, Inc.
Protocol: 6002-US-001 Date: 2000 PI: Steven A. Glyman, MD
A 12-Week, Double-Blind, Placebo-Controlled, Randomized, Parallel-Group, Multi-center, Exploratory Study of the Safety and Efficacy of KW-6002 as Adjunctive Therapy in Patients with Parkinson's Disease Who Have Motor Response Complications on Levodopa/Carbidopa

Sponsor: Berlex Labortories
Protocol: Date: 2000 PI: Steven A. Glyman, MD
The Betaseron® Experience Satisfaction Trial in Educated Multiple Sclerosis Patients

Sponsor: Ortho-McNeil Pharmaceuticals, Inc.
Protocol: CAPSS-155 Date: 2000 PI: John Schaeffer, DO
A Comparison of the Efficacy and Safety of Topamax® (Topiramate) Tablets vs. Placebo for the Prophylaxis of Migraine

Sponsor: Endo Pharmaceuticals Inc.
Protocol: EN3231-M031 Date: 2001 PI: Steven A. Glyman, MD
Dose Escalation of MorphiDex® versus Morphine in Opioid-Responsive Chronic Pain Patients

Sponsor: Schwarz BioSciences
Protocol: SP650 Date: 2001 PI: Steven A. Glyman, MD
A Multicenter, Multinational, Phase III, Randomized, Double-Blind, Parallel Group, Placebo Controlled Trial of the Efficacy and Safety of Rotigotine CDS Patch (2 Target Doses) in Subjects with Advanced Stage, Idiopathic Parkinson's Disease Who Are Not Well Controlled on Levodopa

Sponsor: Schwarz BioSciences
Protocol: SP512 Date: 2001 PI: Steven A. Glyman, MD
A Multicenter, Multinational, Phase III, Randomized, Double Blind, Placebo Controlled Trial, of the Efficacy and Safety of the Rotigotine CDS Patch in Subjects with Early Stage, Idiopathic Parkinson's Disease

Sponsor: EMD Serono
Protocol: 22982 Date: 2001 PI: Steven A. Glyman, MD
A Randomized, Multicenter, Parallel-Group Open-Label Study Comparing the Tolerability of Rebif® Injection With and Without the Use of Rebiject™Mini, In Relapsing-Remitting MS PatientSponsor: GSK
Protocol: SUM40287 Date: 2001 PI: John Schaeffer, DO
A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Single-Attack Study of Sumatriptan 6 mg Injection in the Treatment of Moderate-to-Severe Migraine Present Upon Awakening

Sponsor: Ortho-Mcneil Pharmaceutical, Inc.
Protocol: CAPSS 149 Date: 2001 PI: John D. Schaeffer, DO
A Comparison of the Efficacy and Safety of Topiramate versus Placebo in the Treatment of Essential Tremor

Sponsor: Biogen, Inc.
Protocol: C-858 Date: 2001 PI: Steven A. Glyman, MD
A Multicenter, Phase IV, Randomized, Open-Label Study to Compare the Efficacy of Two Therapies (Acetaminophen and Prednisone) in the Management of Flu-Like Symptoms Associated with AVONEX® (Interferon beta-1a) Treatment in Patients with Relapsing Multiple Sclerosis

Research Experience (continued):

Sponsor: Vernalis, Ltd.
Protocol: VML 251-00-02 Date: 2001 PI: John D. Schaeffer, DO
A Double-Blind, Placebo-Controlled, Three-Way Crossover Clinical Study to Assess the Safety and Efficacy of Two Dose Regimens of Frovatriptan, Compared with Placebo, in Preventing Menstrually-Associated Migraine (MAM) Headaches

Sponsor: Pharmacia Corporation
Protocol: 666E-CNS-0075-021 Date: 2001 PI: Steven A. Gklyman, MD
A Phase III, Double-Blind, Placebo-Controlled, Randomized Study Comparing the Efficacy, Safety, and Tolerability of Sumanirole versus Placebo or Ropinirole in Patients with Early Parkinson's Disease

Sponsor: Endo Pharmaceuticals
Protocol: EN3231-M032 Date: 2002 PI: Steven A. Glyman, MD
Open-Label Extension of MorphiDex® Use in Chronic Pain Patients

Sponsor: Pfizer Inc
Protocol: A945-1008 Date: 2002 PI: Steven A. Glyman, MD
A 15-week, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study of Neurontin® (gabapentin) for Efficacy and Quality of Life in Subjects with Painful Diabetic Peripheral Neuropathy

Sponsor: Neurocrine Biosciences, Inc.
Protocol: NBI-34060-MR-0217 Date: 2002 PI: Steven A. Glyman, MD
A Phase III, Randomized, Double-Blind, Placebo-Controlled, Outpatient Study to Assess the Efficacy and Safety of a Modified Release Formulation of Indiplon in Elderly Primary Insomnia Patients with Sleep Maintenance Difficulties

Sponsor: GSK
Protocol: NPP30010 Date: 2003 PI: John Schaeffer, DO
A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel Group Study to Evaluate the Safety and Efficacy of Lamotrigine in Subjects with Neuropathic Pain and Inadequate Pain Relief with Gabapentin, Tricyclic Antidepressants or Non-Narcotic Analgesic

Sponsor: Pharmacia Corporation
Protocol: DA2APD-0075-031 Date: 2003 PI: Steven A. Glyman, MD
A Phase III, Multicenter, Randomized, Double-Blind, Placebo-Controlled, Fixed Dose Response Study Comparing the Efficacy and Safety of Sumanirole versus Placebo in Patients with Early Parkinson's Disease

Sponsor: Allergan
Protocol: 191622-056 Date: 2003 PI: M. Gabriela Gregory, MD
A Multicenter, Open-Label Study of the Safety of Repeated Doses of BOTOX® (Botulinum Toxin Type A) Purified Neurotoxin Complex for the Treatment of Focal Upper Limb Poststroke Spasticity

Sponsor: Bristol Myers Squibb Date: 2003 PI: Steven A. Glyman, MD
A Phase II, Randomized, Double-Blind, Placebo Controlled Study to Evaluate the Preliminary Efficacy, Pharmacokinetics and Immunogenicity of CTLA4Ig Administered to Subjects with Relapsing-Remitting Multiple Sclerosis

Research Experience (continued):

Sponsor: ILEX Pharmaceuticals, L.P.
Protocol: CAMMS223-A1 Date: 2003 PI: Steven A. Glyman, MD
A Phase II, Randomized, Open-Label, Three-Arm Study Comparing Low- and High-Dose CAMPATH® (MABCAMPATH®) and High-Dose Rebif® in Patients With Early, Active Relapsing-Remitting Multiple Sclerosis

Sponsor: GSK Date: 2003
A Randomized, Double-Blind, Placebo-Controlled, Parallel-Groups Study to Examine the Safety, Tolerability, and Efficacy of IMITREX 50 and 25 mg for the Acute Treatment of Migraine

Sponsor: Janssen Pharmaceutica Date: 2003 PI: David L. Ginsburg, M.D.
An Open-Label Study to Demonstrate Equivalence of Twice Daily Dosing of Reminyl Compared to Once Daily Dosing of Vitamin E in Regard to Compliance and to Determine Caregiver and Physician Satisfaction with Reminyl in the Treatment of Patients with Alzheimer's Disease Using the Reminyl Satisfaction Questionnaire

Sponsor: AstraZeneca Date: 2003 PI: David L. Ginsburg, M.D.
A Multicenter, Randomized, Open-Label Comparison of the Effects of Zomig-ZMT® (Zolmitriptan) and Non-Triptan Usual Migraine Care on Work Loss, Productivity, and Patient Preference

Sponsor: MGI/SNDC Date: 2004 PI: Steven A. Glyman, MD
A Phase II, Multi-center, Randomized, Double-Blind, Placebo-controlled, Parallel-Group, 2-year Study to Evaluate the Effects of GPI 1485 (1000mg QID) on B-CIT/SPECT Scanning and Clinical Efficacy in Symptomatic Parkinson's Disease Patients Receiving Dopamine Agonist Therapy

Sponsor: Eli Lilly and Company
Protocol: B7A-MC-MBBP Date: 2004 PI: Steven A. Glyman, MD
A Double Blind, Multicenter, Placebo-Controlled Study to Evaluate the Efficacy and Safety for the Treatment for Symptomatic Peripheral Neuropathy in Patients with Diabetes

Sponsor: Eli Lilly and Company
Protocol: B7A-MC-MBBR Date: 2004 PI: Steven A. Glyman, MD
A Double-Blind, Placebo-Controlled, Parallel-Group Study to Evaluate the Efficacy and Safety for the Treatment of Peripheral Neuropathy in Patients with Diabetes

Sponsor: UCB Pharma, Inc.
Protocol: RPCE03K0605/N01087 Date: 2004 PI: David L. Ginsburg, MD
A Double-Blind, Randomized, Placebo-Controlled, Parallel-Group, 16 week, Multicenter Trial Evaluating the Efficacy and Safety of Levetiracetam 500mg Tablets in bid Administration (Daily Dose Ranging from 1000mg to

3000mg), in Adults (18 years of age) Suffering from Postherpetic Neuralgia

Sponsor: GSK
Protocol: RRL100013 Date: 2004 PI: David L. Ginsburg, MD
A 12-Week, Double-Blind, Placebo-Controlled, Twice-Daily Dosing Study to Assess the Efficacy and Safety of Ropinirole in Patients Suffering from Restless Legs Syndrome (RLS) Requiring Extended Treatment Coverage

Research Experience (continued):

Sponsor: GSK
Protocol: TRX101998 Date: 2004 PI: David L. Ginsburg, MD
A Randomized, Double-Blind, Parallel Group, Placebo-Controlled, Single-Attack Evaluation of the Efficacy and Tolerability of TREXIMA™ (Sumatriptan 85mg/Naproxen Sodium 500mg) Tablets vs. Placebo When Administered During the Mild Pain Phase of A Migraine

Sponsor: Allergan
Protocol: 191622-057 Date: 2005 PI: David L. Ginsburg, MD
A Multicenter, Double-Blind, Placebo-Controlled, Parallel Group Safety Study of Pulmonary Function in Patients with Reduced Lung Function Treated with BOTOX® (Botulinum Toxin Type A) for Focal Upper Limb Poststroke Spasticity

Sponsor: Teva Pharmaceuticals Date: 2005 PI: Steven A. Glyman, MD
Phase IV, Multicenter, Open-Label, Randomized Study of Interferon b1-a xxmcg Administered Three Times per Week Subcutaneous Compared with Glatiramer acetate 20 mg Administered Daily Subcutaneous in the Treatment of Relapsing Remitting Multiple Sclerosis

Sponsor: Berlex
Protocol: 306440 Date: 2005 PI: Steven A. Glyman, MD
International, Randomized, Multicenter, Phase III Study in Patients with Relapsing-Remitting Multiple Sclerosis Comparing Over a Treatment Period of 104 Weeks: 1. Double-Blinded Safety, Tolerability, and Efficacy of Betaseron/Betaferon 250 ug (8 MIU) and Betaseron/Betaferon 500 ug (16 MIU), Both Given Subcutaneously Every Other Day, and 2. Rater-Blinded Safety, Tolerability, and Efficacy of Betaseron/Betaferon s.c. Every Other Day with Copaxone 20 mg s.c. Once Daily

Sponsor: Novartis Date: 2005 PI: Steven A. Glyman, MD
A Multicenter, Open-Label Randomized Crossover Trial to Assess Subject Preference for Lioresal Compared to Conventional Baclofen Tablets in Subjects with Stable Multiple Sclerosis

Sponsor: Schwarz Pharma Date: 2005 PI: Steven A. Glyman, MD
A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Five-Arm Parallel-Group Trial to Investigate the Efficacy and Safety of Four Different Transdermal Doses of Rotigotine in Subjects with Idiopathic Restless Leg Syndrome

Sponsor: James P. Bennett, Jr., MD, Ph.D.
University of Virginia Date: 2005 PI: Steven A. Glyman, MD
Clinical Trial Protocol Use of R (+) Pramipexole (PPX) 10 mg TID (30 mg/day) in Patients with ALS

Sponsor: Schwarz BioScienses
Protocol: SP793 Date: 2005 PI: Steven A. Glyman, MD
An Open-Label Extension Trial to Investigate the Safety and Tolerability of Long-Term Treatment With Transdermal Rotigotine In Subjects With Idiopathic Restless Legs Syndrome

Sponsor: Serono International S.A.
Protocol: 25643 Date: 2006 PI: Steven A. Glyman, MD
A Phase III, Randomized, Double-Blind, Three-Arm, Placebo-Controlled, Multicenter Study to Evaluate the Safety and Efficacy of Oral Cladribine in Subjects with Relapsing Remitting Multiple Sclerosis (RRMS)

Research Experience (continued):

Sponsor: Endo Pharmaceuticals
Protocol: EN3272-301 Date: 2006 PI: David L. Ginsburg, MD
A Randomized, Double-Blind Study Comparing the Safety and Efficacy Of The Lidocaine Patch 5% with Placebo In Patients With Pain From Carpal Tunnel Syndrome

Sponsor: Excel-Tech Ltd. (XLTEK) or Alquest, Inc.
Protocol: VALP-000986 Date: 2006 PI: David L. Ginsburg
NeuroPath Comparative Validation Study

Sponsor: Impax Laboratories
Protocol: IPX054B04-06 Date: 2007 PI: Steven A. Glyman, MD
An Open-Label Study to Assess the Pharmacokinetics and Pharmacodynamics of IPX054 in Subjects with Parkinson's Disease

Sponsor: Serono, Inc.
Protocol: 27955 Date: 2007 PI: Steven A. Glyman, MD
A Phase IIIb, Randomized, Multicenter, Two-Arm, 12 Week Study to Evaluate Quality of Life (QOL) Measures in Subjects with Relapsing Forms of Multiple Sclerosis Who Are Transitioning From Rebif (Interferon beta 1a) to Rebif New Formulation (RNF).

Sponsor: Berlex
Protocol: 309363 Date: 2007 PI: Steven A. Glyman, MD
A Phase IIIb, International, Multicenter Study of Subcutaneous Every-Other-Day Treatment of Patients with Relapsing Remitting Multiple Sclerosis with (Phase A) Double-Blind Betaseron/Betaferon 250 ug or 500 ug or Open-Label Betaseron/Betaferon 250 ug and (Phase B) Open-Label Betaseron/Betaferon 500ug Beyond Follow-Up Study

Sponsor: BioMS Technology Corp.
Protocol: MBP8298-SP-03 Date: 2007 PI: Steven A. Glyman, MD
A Double-Blind, Placebo Controlled Multicenter Study to Evaluate the Efficacy and Safety of MBP8298 in Subjects With Secondary Progressive Multiple Sclerosis

Sponsor: Biogen Idec Inc.
Protocol: 109MS301 Date: 2007 PI: Steven A. Glyman, MD
A Randomized, Multicenter, Double-Blind, Placebo-Controlled, Dose Comparison Study to Determine the Efficacy and Safety of BG00012 in Subjects with Relapsing-Remitting Multiple Sclerosis

Sponsor: Biogen Idec
Protocol: 101JC402 Date: 2010 PI: David L. Ginsburg, MD

JCV Antibody Program in Patients with Relapsing Multiple Sclerosis Receiving or Considering Treatment with Tysabri: Stratify 2

Sponsor: Chelsea Therapeutics, Inc.
Protocol: NOH306 Date: 2010 PI: Eric S. Farbman, MD
A Multi-Center, Double-Blind, Randomized, Parallel-Group, Placebo-Controlled Study to Assess the Clinical Effect of Droxidopa in the Treatment of Symptomatic Neurogenic Orthostatic Hypotension in Patients with Parkinson's Disease

Research Experience (continued):

Sponsor: Impax Laboratories, Inc.
Protocol: IPX066-B09-06 Date 2010 PI: Eric S. Farbman, MD
A Study to Compare IPX066 and Carbidopa/Levodopa/Entacapone (CLE) in Advanced Parkinson's Disease

Sponsor: Chelsea Therapeutics, Inc.,
Protocol: Droxidopa-304 Date: 2010 PI: Eric S. Farbman, MD
A Multi-Center, Open-Label Study to Assess the Long-Term Safety of Droxidopa in Subjects with Primary Autonomic Failure, Dopamine Beta Hydroxylase Deficiency or non-Diabetic Neuropathy and Symptomatic Neurogenic Orthostatic Hypotension

Sponsor: Biogen Idec
Protocol: 223AS302 Date: 2011 PI: David L. Ginsburg, MD
A Randomized, Double-Blind, Placebo-Controlled, Multi-Center Study of the Safety and Efficacy of Dexpramipexole in Subjects With Amyotrophic Lateral Sclerosis

Sponsor: EMD Serono
Protocol: EMR700568-012 Date: 2011 PI: David L. Ginsburg, MD
Prospective observational long-term safety registry of Multiple Sclerosis patients who have participated in cladribine clinical trials.

Sponsor: Merz Pharmaceuticals LLC Date: 2011 PI: David L. Ginsburg, MD
Protocol: MRZ 60201-4066-5
Prospective, observational trial evaluating Xeomin® (incobotulinumtoxinA) for cervical dystonia or blepharospasm in the United States

Sponsor: Impax Laboratories
Protocol: IPX-066-B11-01 Date: 2011 PI: Eric S. Farbman, MD
An Open-Label Conversion Study of Carbidopa-Levodopa Extended-Release (CD-LD ER) Taken Alone or in Combination with Carbidopa-Levodopa Immediate Release (IR) to IPX066 Followed by an Open-Label Extension Safety Study of IPX066 in Subjects with Advanced Parkinson's Disease

Sponsor: Teva Neurosciences
Protocol: TVP-102/PM103 Date: 2011 PI: Eric S. Farbman, MD
A Double-blind, Placebo Controlled, Randomized, Multicenter Study to Assess the Safety and Clinical Benefit of Rasagiline as an Add on Therapy to Stable Dose of Dopamine Agonists in the Treatment of Early Parkinson's Disease

Sponsor: NIH 2Care 01.00
Protocol: 109MS301 Date: 2011 PI: Eric S. Farbman, MD
COENYZME Q10 IN HUNTINGTON'S DISEASE (HD)

Sponsor: Biogen Idec Inc.
Protocol: 223AS304 Date: 2012 PI: David L. Ginsburg, MD
An Open-Label, Multicenter, Extension Study to Evaluate the Long-Term Safety and Efficacy of Dexpramipexole (BIIB050) in Subjects With Amyotrophic Lateral Sclerosis

Sponsor: McKing Consulting Corporation
Protocol: 5923.0 Date: 2013 PI: David L. Ginsburg, MD
State and Metropolitan Area-Based Amyotrophic Lateral Sclerosis (ALS) Surveillance Retrospective Chart Review

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FEE SCHEDULE

Records Review; paid. Deposition and Trial Preparation; Meetings and Phone Conferences	$800.00/ Hr. The report will be sent after all charges have been
IME	$3,500.00 An IME appointment will include the interview and examination by the physician, and an Independent Medical Evaluation Report. Additional time spent reviewing records will be billed at $800.00 per hour or part thereof. The IME fee must be received one week in advance of the appointment. If not received, the appointment will be canceled. If the examinee does not show for the appointment, a fee of $1,500.00 will be required to reschedule the IME.
Deposition	$3,000.00 for two hour deposition, payable one week in advance. $1,500.00 for each additional hour. If the deposition is canceled less than 7 days prior, a fee of $1,500.00 will be required to reschedule the deposition.
Video Deposition	$4,000.00 for two hour video deposition, payable one week in advance. $2,000.00 for each additional hour. If the deposition is canceled less than 7 days prior, a fee of $2,000 will be required to reschedule the deposition
Expert Witness or Arbitration Testimony	$6,000.00 per 4 hour time block (local). Pre-payment of the retainer is required one week in advance.
Out of Town Services	$14,000.00 per day plus travel related expenses, payable one week in advance. Travel/lodging/transfers to be arranged and paid by requesting party.
Cancellation Policy	7 days or less - no refund. Over 7 days - 50% refund.

PLEASE NOTE: PRE-PAYMENT MINIMUM ONE WEEK IN ADVANCE IS REQUIRED. WORK WILL COMMENCE ONCE SIGNED AUTHORIZATION HAS BEEN RECEIVED.

ALL CHECKS PAYABLE TO GINSBURG NEUROLOGY PLLC
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TAX ID: 82-2274803

Fees subject to change.

Reviewed 10/18

David L. Ginsburg, M.D.
Testimony History

DATE	CASE NAME	TESTIMONY	CASE #
08/30/17	WILLIAM CALHOON VS. UNITED STATES BOWLING CONGRESS	Court	A-11-635644-C
10/11/17	NICHOLAS BLOMGREN VS. TOWN SQUARE LAS VEGAS, LLC; GALAXY BOARD	Deposition	A-16-736230-C
10/18/17	JUDITH T. LOKKEN VS. DUANE E. CURTIS; BRASWELL MOTOR CARRIERS, INC.	Deposition	A- 16-734565-C
10/26/17	WILLIAM MCKNIGHT, ELLA MCKNIGHT VS. NOBU HOSPITALITY GROUP	Deposition	A-16-737786-C
02/13/18	CARL THOMPSON VS. PLAYLAND INTERNATIONAL, INC.	Court	A-14-697688-C
05/24/18	TAN PATEL VS. TAB WICK	Court	A-16-730483-C
06/20/18	GLENN & GAYLE RICHARDSON V. MANDALAY CORP.	Deposition	A-17-750846-C
09/17/18	KC KNIGHT VS. GERARDO ALONSO ROSALES	Deposition	A-17-750945-C
10/29/18	NORA NARDI VS. FRANCIS EUGENE AURRERT; NEVADA CHECKER CAB CORP.	Deposition	A-16-745646-C
11/13/18	GLENN & GAYLE RICHARDSON V. MANDALAY CORP.	Court	A-17-750846-C
01/14/19	CHRISTOPHER SCOTT SYKES V. LAS VEGAS SANDDS, LLC	Deposition	A-16-737181-C
01/29/19	THOMAS BASS VS. UNITED SERVICES AUTOMOBILE ASSOCIATION	Court	A-16-731381-C
03/12/19	SHELBY LAURSEN VS. WESTERN CAB COMPANY	Deposition	A-17-762640-C

David L. Ginsburg, M.D.
Testimony History

04/30/19	ESTATE OF RUTH BLAKELY V. TROPICANA LAS VEGAS INC.	Deposition	A-17-751784-C	
05/21/19	SALES, ET AL. V. SUMMERLIN HOSPITAL AND MEDICAL CENTER, LLC ET AL.	Deposition	A-17-758060-C	
08/20/20	CYNTHIA GOODWYN V. ALBERTSON'S	Deposition	A-18-775832-C	
08/27/20	JOSE RAMON LOZA-GARCIA V. LAWYER MECHANICAL SERVICES, INC.	Deposition	A-18-781312-C	
12/22/20	JANE ELIZABETH ROTHMAN V. HARRY GRAY BRETSCHNEIDER	Deposition	CV18-02481	WASHOE COUNTY
11/10/20	KEVIN SCHARRINGHAUSEN VS. VENTURE POINT, LLC	Deposition	A-18-777160-C	
02/02/21	KEVIN SCHARRINGHAUSEN VS. VENTURE POINT, LLC	Deposition	A-18-777160-C	
03/09/21	NADIA MARIN V. ANDREW CLARK	Deposition	A-18-776332-C	
04/22/21	RUSSELL HIGGINS, ET. AL. V. HAZEL TRUCKING, LLC ET. AL.	Deposition	2:19-cv-01145-APG-BNW	
04/26/21	JAMES HENEGHAN VS. HAMPTON INNS MANAGEMENT, LLC AND FIRST HOSPITALITY GROUP, INC.	Deposition	18 L 11534	COOK COUNTY, ILL.
05/03/21	TRISHA CODD VS. FLAMINGO LAS VEGAS OPERATING COMPANY, LLC	Deposition	A-18-780236-C	
05/10/21	DALE COOPER VS. XPERRTES, LLC.	Deposition	A-19-796405-C	
06/15/21	JANE ELIZABETH ROTHMAN V. HARRY GRAY BRETSCHNEIDER	Testimony	CV18-02481	WASHOE COUNTY
08/03/21	KEVIN SCHARRINGHAUSEN VS. VENTURE POINT, LLC	Arbitration	A-18-777160-C	
08/12/21	KEITH STIPP AND JANICE STIPP V. CONSUMER TECHNOLOGY ASSOCIATION	Deposition	A-19-7954265-C	

DAVID L. GINSBURG, M.D.
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
DIPLOMATE, AMERICAN BOARD OF ELECTRODIAGNOSTIC MEDICINE

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INDEPENDENT MEDICAL EVALUATION

EXAMINEE : Taylor Cape
EXAM DATE : 11/16/21
REPORT DATE : 11/23/21
D.O.L. : 11/22/18

The independent medical evaluation process was explained to the examinee, and it is understood that there is no patient/treating physician relationship present. It was explained that the evaluation was requested by the referral source and that a report will be sent to the referral source upon completion. The examinee understands that no conclusions or recommendations will be discussed during today's evaluation. The examinee understands that full, reasonable, and consistent effort is requested during the evaluation. The examinee completed paperwork prior to being brought back to the examination room. I entered the examination room at 3:55 p.m. and completed the face-to-face evaluation at 4:50 p.m.

IDENTIFICATION

25-year-old ambidextrous, Caucasian male.

HISTORY

PREINJURY STATUS:

According to Mr. Cape's report to this examiner, prior to the subject accident he denied any history of headaches, memory or concentration difficulties. He reported a history of depression, anxiety and psychosis prior to the subject accident. He had psychiatric hospitalizations in August, September and October 2017.

PROPOSED MECHANISM OF INJURY:

According to Mr. Cape, on the date of the accident he was the restrained driver of a Mazda 2 sedan turning left, at which time his vehicle was struck by a white pickup truck that went through a stoplight. Mr. Cape's vehicle reportedly struck a third vehicle. He reportedly lost consciousness, and woke up at the scene. Mr. Cape indicated that he was amnestic for the events surrounding the accident.

CURRENT CHIEF COMPLAINT(S):

Short-term memory and concentration difficulties.

CLINICAL STATUS:

Following the subject accident, Mr. Cape was transported to UMC Trauma Center. He stated that he was confused at that time. He was subsequently driven home by another individual. Mr. Cape stated that he experienced headaches that gradually tapered off after approximately one month. The headaches were described as a constant frontal pain, 8-9/10 in severity, with nausea and photophobia. He also reported that he had problems with short-term memory, repetition of questions, word-finding, concentration, and difficulties planning a series of events. Over time, his memory has remained the same, but his concentration and ability to ability to plan have worsened. Mr. Cape was not working at the time of the accident, stopping his previous job a few days beforehand. He went back to work in July 2019 as a sales person at Kohl's. Mr. Cape also reported continued symptoms of depression and anxiety that fluctuate in severity. He is currently under the care of a psychiatrist in South Carolina, and is utilizing the medication Abilify. He had some crying spells a couple of months ago. He states his energy level drops in the afternoons. He states that his appetite is good. Mr. Cape denied difficulties with memory and concentration prior to the subject accident, indicating that his mind was previously overactive in conjunction with mania and bipolar disorder. He reports having a GPA of approximately 3.0 during high school and at UNLV. He moved with his family to South Carolina, and failed some classes at Coastal Carolina University. He is currently working as a cabinetry apprentice, and plans to return to Coastal Carolina University to complete his degree in electrical engineering.

Mr. Cape also reported that following the subject accident, he had transient double vision, and that his vision has recently become blurred. He also had some slurred speech, and stated that he was mixing up words. He also reported a variety of other symptoms that include numbness of his mid forehead, neck and low back pain, and intermittent numbness and tingling in his arms, hands and feet at night. He also has experienced sporadic episodes of dizziness, described as disequilibrium that lasts for less than one minute. He also reported experiencing intermittent bilateral tinnitus, hearing loss, as well as cramps in his calves. He has plans to see a chiropractor and a neurologist.

PAST MEDICAL HISTORY:

Allergies: He has no known drug allergies.

Medical Illnesses: Childhood chickenpox.

Past Surgical History: Esophageal surgery.

Current Medications: Abilify 5 mg p.o. q. day.

SOCIAL HISTORY:

Mr. Cape was born and raised in Las Vegas. He is single, and is employed as a cabinetry apprentice. He drinks alcohol rarely, and does not smoke cigarettes. He denies current use of recreational drugs, but reported smoking marijuana several years ago. He completed three years of college, and plans to return to his studies at Coastal Carolina University in pursuit of his electrical engineering degree.

FAMILY HISTORY:

Father is age 56 in fair health. Mother is age 53 in fair health. Mr. Cape has one sister age 16 in good health. Family history is positive for cancer, heart disease, hypertension, stroke, suicide, psychiatric treatment, bleeding tendency, arthritis, headaches.

REVIEW OF SYSTEMS:

Positive for wearing glasses for astigmatism, neck stiffness, difficulty breathing, shortness of breath with walking or laying down, heart murmur, food sticking in his throat, frequent urination, difficulty walking, history of psychiatric care.

RECORD REVIEW

Records reviewed from American Medical Response including the following:

Billing records reviewed.

08/23/17 **Clark AMR. Patient Care Report.** Patient complains of suicidal ideation and hearing voices telling him to kill himself. Patient states he is withdrawing from smoking THC. Patient behavior in presence of EMS was manic. Patient is alert and oriented times four and ambulatory on scene. Patient stated he has had demons all his life and they tell him to lie, hurt himself and hurt others. GCS 15.

08/24/17 RN stated patient was on an L2K for trying to hurt himself and others. Patient was alert and oriented with airway open and clear. Patient did state he does smoke a lot of weed but does not drink or smoke cigarettes. Medical history of schizophrenia. GCS 15.

09/24/17 Patient was being transferred to Seven Hills behavioral facility for psychiatric monitoring. Alert, oriented to person, place, time and event. GCS 15.

09/23/17 21-year-old male exhibiting bizarre behaviors. Patient states “I came to Summerlin Pavilion with Jesus Christ.” Alert, oriented times four. Having some delusional thoughts. Denies hallucinations. States he has a history of psychosis. Takes Risperdal but is not compliant with medications. GCS 15.

11/21/18 Alert, oriented times three. GCS 14. Patient was the restrained driver of a car that was struck on the passenger side. Patient’s vehicle was traveling at 45 MPH. Patient’s airbags were deployed. Patient ambulatory on the scene prior to arrival. Alert to events and

repetitive questioning. Patient is able to follow commands and is alert to self. Head-to-toe exam reveals no signs of injury. Patient denies seizures. History obtained from patient. Medical history: Psychiatric and Vater syndrome. Medications: Risperdal. Head is atraumatic, symmetrical.

EMP of Clark UMC billing statement reviewed.

Records reviewed from University Medical Center including the following:

Billing records reviewed.

11/22/18 **Mitzi A. Dillon, M.D.** Patient was the restrained driver going approximately 45 miles an hour when the vehicle was T-boned by another vehicle going similar speed on the passenger side. Patient had positive seat belt, positive airbag deployment. He was ambulatory afterwards. Reportedly he had loss of consciousness and per EMS had repetitive questioning with a GCS of 14 when they arrived. He denies any headache, no nausea, no vomiting. Head is atraumatic. Neurological exam reported as normal. Alert, oriented times three with good recall of recent and remote events. No repetitive questioning. At this time he has a completely normal neuro exam. I do not feel he requires a CT scan of his brain per the Canadian head CT rules. I have explained to him that he does not need a CT scan of his brain at this time but I have spoken to him about postconcussive syndrome and what to look out for. Clinical impression: Injury of head. Concussion with loss of consciousness.

Records reviewed from Desert Radiologists.

Records reviewed from Greenawalt Chiropractic including the following:

Billing records reviewed.

11/28/18 **Initial Exam.** Problem list includes unresolved – memory issues especially short-term memory (new). Before the accident patient was awake and wearing a seat belt. During the collision the patient was struck on the head. The patient was driving a vehicle. Able to do mental work since the accident? Yes but short-term memory seems affected. Was knocked unconscious. Able to remember the impact? No. Diagnoses: Concussion with loss of consciousness of 30 minutes or less.

11/30/18 Subjective: Memory issues especially short-term memory (no change).

12/03/18 Problem list: Memory issues especially short-term memory. No headaches. Memory seemingly doing better.

12/10/18 Problem list: Memory issues especially short-term memory. The patient presents with a headache (improved). Memory issues especially short-term memory (no change).

12/14/18 Problem list: Unresolved memory issues especially short-term memory. Headache 2/10.

12/26/18 Headache resolved. Memory issue improved.

01/07/19 Headache 60 to 70% improved. Occurs five times per week. Frontal headaches are right or left as this changes. Memory issues 70% improved. Wording is sometimes challenging but getting better. Sometimes simple math is hard as I am usually gifted with math.

01/17/19 Headache improved. Short-term memory unchanged.

01/28/19 Headache resolved. Memory issue improved.

02/11/19 Headache 100% improved. Memory issue 80 to 90% improved. Seems okay but at times not as sharp reacting. Lacking connectness at times. Focus seems off at times. Oriented to time, place and person.

01/10/19 **Pueblo Medical Imaging. MRI Brain without contrast with SWI/DTI, hippocampal volume and SPECT.** Conclusion: (1) Hippocampal volume on the left is in the 88th percentile and on the right it is in the 41st percentile. Correlate clinically. (2) Abnormal spectroscopy in the white matter of both frontal lobes with depression of the NAA peaks. Correlate clinically. (3) The conventional sequences and the diffusion tensor imaging is reported separately.

11/28/18 Patient Intake Form reviewed.

Records reviewed from Enrico Fazzini, D.O., Ph.D. including the following:

12/15/18 This 22-year-old left-handed male was accompanied with his mother and presented for neurological evaluation on 12/15/18 following a motor vehicle injury which occurred on 11/21/18. The patient was reportedly the driver in a vehicle that was struck in the front and passenger side on 11/21/18. The patient struck his head on the airbag. He did not remember the sound of impact. The police and ambulance were on the scene and the patient was taken to University Medical Center because of a loss of consciousness. The patient was not sure exactly how long the loss of consciousness was. He stated that he had a probable CT scan of the head at University Medical Center and he was not told that there were any abnormalities and he was released. Since the accident the patient was complaining of headaches with balance impairment and difficulty with memory, attention and concentration. The patient stated that he had word-finding problems, difficulty getting organized and completing tasks, problems with memory and experiencing environmental overlay and concentration problems. Past medical history was not positive for the presence of a concussion. The patient was recently diagnosed on 08/2018 with a bipolar disorder and was started on Risperdal before the motor vehicle accident of 11/21/18. He was alert and oriented times three and his language skills seemed intact but formal tests of language, attention, concentration, memory and spatial orientation were not performed. Impression: (1) Postconcussive balance impairment and headaches. (2) Complaints of

cognitive deficits following possible traumatic brain injury. Recommendations: MRI scan of the brain using brain trauma protocol and SPECT.

01/12/19 The patient had less headaches and balance impairment but continued to complain of memory, attention and concentration problems. MRI scan of the brain on 01/10/19 demonstrated right hippocampal atrophy and a decrease in N-acetylaspartate in both frontal lobes. This is positive evidence for the presence of a traumatic brain injury. Mental status testing revealed that there were still signs of decreased attention and concentration. Impression: (1) Postconcussive balance impairment and headaches, gradually resolving. (2) Cognitive deficits following traumatic brain injury. Recommendations: Reevaluate in two months to see if cognitive deficits persist at which time neuropsychological testing will be ordered.

03/08/19 The patient did not have any more headaches, dizziness or balance impairment. He stated that his cognition had greatly improved since the last visit with me on 01/20/19. Impression: (1) Postconcussive balance impairment and headaches, resolved. (2) Postconcussive cognitive deficits, resolved. This patient has had a great deal of recovery and it is hoped that he will continue to return to the prior level of functioning as had existed before the motor vehicle accident of 11/21/18. Nevertheless the patient is at an increased risk for the development of dementia as a consequence of the traumatic brain injury which he sustained at the time of the accident which was on 11/21/18. The patient was told to reevaluate with me only if cognitive impairment returned or if there was any other change in neurological status.

05/31/19 The patient stated that when he started a new job he noticed that he had decreased attention and concentration and decreased memory skills. He also had increased anxiety. Mental status testing revealed that there was some decreased attention and concentration with some increase in anxiety. Impression: Complaints of cognitive deficits following traumatic brain injury, anxiety. Recommendations: Formal standardized neuropsychological testing.

07/24/19 The patient still complained of memory, attention and concentration problems although he had less anxiety on today's evaluation. Mental status testing reveals that there are still some signs of decreased attention and concentration. Impression: (1) Complaints of cognitive deficits following traumatic brain injury. Recommendations: (1) Review neuropsychological testing performed by Dr. Collins. (2) Aricept 5 mg a day after dinner to try to help memory.

10/04/19 **Addendum.** Review of neuropsychological testing. There were significant deficits in verbal and nonverbal memory as well as information processing speed. The patient had good effort and lingering was not suspected. This testing demonstrated significant cognitive deficits associated with a traumatic brain injury. MRI scan of the brain and MRI SPECT scan on 01/10/19 was significant for structural damage associated with a traumatic brain injury and demonstrated right hippocampal atrophy and a decrease in N-acetylaspartate in both frontal lobes. This patient has significant structural damage and associated cognitive deficits associated with traumatic brain injury sustained on 11/21/18.

Billing records reviewed.

Records reviewed from Oasis Counseling including the following:

Billing records reviewed.

Records reviewed from Las Vegas Radiology including the following:

06/20/19 **MRI Cervical Spine without contrast.** Report reviewed.

06/20/19 **Patient Intake Form.** Current medications: Abilify.

Records reviewed from Sunshine Collins, Psy.D., Licensed Psychologist, including the following:

Billing records reviewed.

07/09/19 Concentration change. Memory loss. Was depressed after the MVA. Abilify December 2018. Felt lethargic and depressive and cognitive slowing so we DC'd prescription for five months May 2019.

03/27/2020 Letter to Jan Roughan reviewed.

09/25/19 **Neuropsychological Evaluation Report.** Findings: Mr. Cape has a mild neurocognitive disorder due to traumatic brain injury causing clinically significant distress and impairment in multiple demands of functioning and multiple settings. His neurocognitive disorder is accompanied by behavioral disturbance primarily comprised of mood disturbance. Mr. Cape reported that he became "addicted to concentrated marijuana" in 2017. Reviewed records indicate that Mr. Cape's mother has said that he began exhibiting psychotic symptoms after one month of using "whack" which she characterized as a type of marijuana. It is unclear what substance Mr. Cape was using as this terminology is used to identify multiple different recreational substances, most common marijuana laced with PCP. Mr. Cape reported that his substance use led to "drug-induced psychosis." Reported mental health history is significant for psychiatric hospitalization twice in 2017. Mr. Cape reported that his presentation on initial hospitalization included going from a depressive state to a manic state, insomnia, delusions, religious delusions, feeling like everything had a meaning and feeling overwhelmed. He stated that he had a poor reaction to the prescribed medication Risperdal and discontinued use as soon as he was released leading to a second hospitalization soon thereafter. His symptoms began to return in July 2018. Mr. Cape resumed use of medication at father's insistence. Mr. Cape was able to transition from Risperdal to Abilify which was characterized as a better medication for him. Mr. Cape was prescribed Abilify in December 2018. He reported that he discontinued use of the medication due to feelings of lethargy, depressed mood and cognitive slowing. He did not take medication for five months. When he advised his parents in May 2019 that he had discontinued the medication and felt he was doing fine without it they insisted that he restart the medication which he reportedly did. Mr. Cape reported that he was diagnosed with "bipolar with schizoaffective disorder." Mental health treatment was positive for multiple trials of

psychotherapy. Mr. Cape stated that his mental health is “better.” Suicidal ideation last occurring in December 2018 was reported. Speech was of normal rate and volume. Pronunciation was clear. Mr. Cape spoke in spontaneous complete sentences. Speech was coherent. Affect was nervous or anxious but pleasant. Mr. Cape was alert and oriented to person, city and to the purpose of this evaluation. Mild word-finding difficulty was present as evidenced by brief pauses in spoken language followed by eventual completion of the statement. He reported a number of difficulties consistent with a significant depressive experience. The quality of his depression seems primarily marked by cognitive features such as negative expectancies and low self-esteem. He mentioned that he is experiencing some degree of anxiety and stress. Diagnosis: Mild neurocognitive disorder due to traumatic brain injury with behavioral disturbance (mood disturbance), brief psychotic disorder in full remission, schizophreniform disorder, schizophrenia, bipolar 1 disorder with psychotic features most recent episodic manic in full remission. Mr. Cape sustained a traumatic brain injury in a motor vehicle accident on 11/21/18. A traumatic brain injury is a brain trauma with specific characteristics (i.e., loss of consciousness, posttraumatic amnesia, disorientation and confusion, and/or neurological signs) that are caused by an impact to the head or other mechanism that results in rapid movement or displacement of the brain within the skull. In Mr. Cape’s case he experienced loss of consciousness. Neurologist Enrico Fazzini, D.O. diagnosed a traumatic brain injury on 01/12/19. As a result of this traumatic brain injury Mr. Cape developed neurocognitive disorder. Given the loss of consciousness was less than 30 minutes and probable Glasgow Coma Scale score (degree of disorientation and confusion at initial assessment) considering his release from the hospital without admission, Mr. Cape’s head injuries would be characterized as a mild traumatic brain injury. Neurocognitive symptoms associated with mild traumatic brain injury tend to resolve within days to weeks after the injury with complete resolution typically occurring by three months. Symptoms such as headache and photosensitivity also tend to resolve in the weeks following mild traumatic brain injury. Mr. Cape’s overall performance on measures that reflect attention and concentration fell in the average range. Taken together these factors suggest that Mr. Cape’s cognitive disturbance includes the mild behavioral disturbance of mood disturbance. Individuals who have sustained traumatic brain injuries typically report more depressive symptoms than periods without such injuries. Mental health history is significant for preexisting episodes of psychosis. Schizophrenia spectrum disorders commonly include cognitive deficits in processing speed, attention, working memory, verbal learning and memory, visual learning and memory, reasoning and problem solving. Mr. Cape’s mental health symptoms, however, were well controlled with medication at the time of and following motor vehicle accident. As such his history of brief psychotic disorders likely represent a smaller contribution due to the observed cognitive deficits identified through this evaluation than his traumatic brain injury. His neurologist would best be able to speak to if a presenting memory loss is consistent with structural damage on neuroimaging.

Records reviewed from Pueblo Medical Imaging including the following:

Billing records reviewed.

12/29/18 **MRI Brain without with SWI/DTI, hippocampal volume and SPECT.** Conclusion: (1) Normal appearance of the brain on the conventional sequences. (2) The fractional anisotropy in the corpus callosum is normal.

04/2020 **Jan Roughan, B.S.N., R.N., P.H.N., CRRN/ABSNC, CLCP, CCM.** He seems first to note that subsequent to his unfortunate 11/21/18 accident and resultant injuries, Mr. Cape is now: Slower in the performance of his ADLs and IADLs and is experiencing daily blanking out/staring episodes, forgetfulness/memory lapses, diminished focus and concentration, depression. Life care analysis: It is evident from the medical records and collateral interviews in respect to Mr. Cape's pre and post morbid functioning that he has suffered significant sequelae from the injuries incurred during the 11/21/18 incident. Recommendations: Comprehensive seizure disorder evaluation, EEG, 3 Tesla MRI scan of brain, drugs/supplies including but not limited to neuropathic pain agents/antidepressant, anti-Alzheimer antidepressant, antiseizure.

Records reviewed from Spring Mountain Treatment Center including the following:

Billing records reviewed.

09/21/17 **Robert Peprah, M.D. Discharge Summary.** Reason for admission/hospitalization: Says that he felt a demon and he was hearing voices telling him to kill himself. Also being treated for substance abuse. He reports marijuana. Discharge diagnoses: Unspecified psychosis, marijuana abuse. Discharge medications: Risperdal 2 mg p.o. nightly for psychosis.

Multiple progress notes reviewed including the following:

08/26/17 **MHT Crer.** Was very confused during the shift.

08/26/17 **Quest Diagnostics.** TSH 10.0.

Records reviewed from Aspire Mental Health.

12/14/17 **Tiffany Graston, L.C.S.W.** Taylor presents to therapy following an inpatient psychiatric hospitalization at Spring Mountain Treatment Center on 08/2017. Client reports this was his first hospitalization and has attributed this to marijuana use. Client reports a long history of extreme medical conditions causing weakness alongside of his body. Client reports being vulnerable and smoking marijuana led to a demonic possession. Client denies taking any other substance and is now clean for marijuana.

09/14/17 **Tiffany Graston, L.C.S.W.** Client using marijuana since age 16 years old off and on. Client reports a period he used daily until 2014. Client reports that he had been clean for 14 months prior to the 2017 hospitalization. Began using marijuana again in 2018 prior to psychotic break.

03/19/21 **Plaintiff's Response to Defendant Chilly Willy's Handyman Services, LLC's First Set of Interrogatories.** Response to interrogatory #3. Head/brain, concussive brain injury. Response to interrogatory #14. Plaintiff still experiences symptoms including difficulty concentrating, sensitivity to light and noise, short-term memory loss, depression and blurred vision.

11/21/18 State of Nevada Traffic Crash Report reviewed.

01/14/19 **United Financial Casualty Company.** Damage estimate for 2012 Mazda 2 Sport reviewed.

Sixty-three color photographs of white Mazda sedan reviewed.

01/16/19 **Fix Auto Las Vegas.** Damage estimate for 2013 Chevrolet Impala LT reviewed.

One hundred ninety-four color photographs of white Chevrolet Impala reviewed.

Eight pages of color photographs of Mr. Cape's injuries reviewed.

The following imaging studies were personally reviewed from Pueblo Medical Imaging:

06/20/19 **MRI Cervical Spine without contrast.**

12/29/18 **MRI Brain without contrast.**

01/10/19 **MRI Brain without contrast.**

PHYSICAL EXAMINATION

GENERAL:

Mr. Cape is a well-developed, well-nourished, Caucasian male in no acute distress.

HEENT:

Head is atraumatic, normocephalic. Ears – External auditory canals are clear. Neck is supple, nontender.

MUSCULOSKELETAL:

Tinel's sign is negative at the wrists bilaterally.

MENTAL STATUS:

Mr. Cape is alert. There is no anomia or dysarthria. He follows commands appropriately. He scored a 30 out of 30 on the Mini Mental Status examination, and demonstrates good clock drawing skills. Affect is appropriate. There is no repetition of phrases.

NEUROLOGIC EXAM:

Cranial nerves II: Pupils are equal and react from 5 to 3 mm. Optic disks are sharp. Visual fields are full to confrontation. Visual acuity is 20/30 bilaterally (unchanged with pinhole testing). III, IV and VI: Extraocular muscles are full in all directions without nystagmus. V: Facial sensation is intact to temperature and light touch bilaterally. VII: Face is symmetric. VIII: Weber test lateralized to the left. Rinne test yielded air conduction greater than bone conduction bilaterally. IX and X: Palate elevates symmetrically. XI: Trapezius muscles 5/5. XII: Tongue is midline.

MOTOR:

Strength is 5/5 throughout with normal tone and bulk. There is no evidence of muscle atrophy, fasciculations, or involuntary movements noted.

SENSORY:

Intact to pinprick, light touch, proprioception, vibration and temperature in the bilateral upper and lower extremities. Graphesthesia and stereognosis are intact in both hands.

REFLEXES:

1+ bilateral biceps, triceps, brachioradialis, knee jerks and ankle jerks. Absent Babinski's.

CEREBELLAR FUNCTION:

Finger-to-nose and rapid alternating movements are normal bilaterally. Romberg is negative.

GAIT/TANDEM GAIT:

Normal.

DISCUSSION

Based upon my review of the aforementioned documents, interview, and examination of Mr. Cape, he is alleging that he sustained a concussion as a result of the 11/22/18 subject motor vehicle accident. He also stated that he has experienced persistent problems with short term memory, concentration, and ability to plan as a result of the accident. According to the 11/21/18 paramedic report, Mr. Cape was alert, oriented times three, and exhibited a GCS of 14. He was able to provide his history to the paramedics and follow simple commands, but was noted to exhibit repetitive questioning. According to the 11/22/18 report from Dr. Dillon, Mr. Cape was alert and oriented times three, and exhibited good recall of recent and remote events. No

repetitive questioning was noted at that time. Dr. Dillon did not deem a head CT to be indicated at that time, but diagnosed Mr. Cape with a concussion with loss of consciousness. Based upon my experience as a Board-Certified neurologist, the majority of patients with concussion improve within the first-year post-injury. This is consistent with Mr. Cape's records from the office of Greenawalt Chiropractic. For example, according to the initial 11/28/18 initial examination, Mr. Cape reported impairment of short-term memory. According to the 12/03/18 report, Mr. Cape denied headaches and stated his memory was doing better. According to the 12/14/18 evaluation, Mr. Cape reported headaches at a severity of 2/10, and difficulties with short-term memory. According to the 02/11/19 report, Mr. Cape indicated that his headaches were 100% improved, and that his memory was 80 to 90% improved. In contrast to the available records, Mr. Cape reported to this examiner that his memory difficulties have remained the same, but his concentration and ability to plan a series of events have worsened over time. Despite his subjective cognitive complaints, Mr. Cape's mental status examination performed by this evaluator revealed normal findings.

Mr. Cape was also evaluated by Dr. Fazzini on several occasions. At the time of his initial evaluation on 12/15/18, Mr. Cape reported difficulties with headaches, balance, memory, attention, concentration, word-finding, and organization. Dr. Fazzini ordered a brain MRI that was subsequently performed at Pueblo Medical Imaging on 12/29/18. Based upon my personal review of his MRI images, there was no evidence of traumatic brain injury present. This is consistent with the radiology report, indicating the MRI was normal on conventional sequences. A subsequent report dated 01/16/19 noted the hippocampal volume on the left to be in the 88th percentile and on the right to be in the 41st percentile. Clinical correlation was advised. The report also indicated abnormal spectroscopy in the white matter of both frontal lobes with depression of the NAA peaks. Clinical correlation was once again advised. Dr. Fazzini reevaluated Mr. Cape on 01/12/19. According to Dr. Fazzini's report, the right hippocampal atrophy and SPECT findings of decreased N-acetylaspartate in the frontal lobes were "positive evidence for the presence of traumatic brain injury." In contrast, according to the 09/13/18 Radiological Society of North America Position Statement on traumatic brain injury and Wintermark et al.,[1] indicating "There remains insufficient evidence at the time of this writing to suggest that these methods (DTI and SPECT) are valid, sensitive and specific for routine clinical evaluation of TBI at the individual patient level." Additionally, according to Cook et al., [2] there is "preliminary evidence that hypothyroidism in adults causes significant reduction in the volume of the right hippocampus. This could explain some of the memory deficits that have been observed in those with hypothyroidism." This is significant because, according to the 08/26/17 TSH level from Quest Laboratories, Mr. Cape's TSH was elevated to a level of 10. This finding is suggestive of hypothyroidism, a condition associated with cognitive impairment. Furthermore, according to Zhou, et al., [3] caution was advised when utilizing volumetric analysis on an individual basis and "there is also a normal, non-insignificant inter-subject variability in brain MRI morphology."

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[1] Wintermark M, Sanelli PC, Anzai Y, Tsiouris AJ, Whitlow CT. Imaging Evidence and Recommendations for Traumatic Brain Injury: Advanced Neuro and Neurovascular Imaging Techniques. AJNR 2014;1-11
[2]Cooke GE et al. Hippocampal volume is decreased in adults with hypothyroidism Thyroid 2014;24:433-40.
[3] Yongxia Zhou, et. al. Mild traumatic brain injury: longitudinal regional brain volume changes. Radiology: Volume 267(3):880-890.

According to the 03/08/19 report from Dr. Fazzini, Mr. Cape's postconcussive balance impairment, headaches and cognitive deficiencies have resolved. Dr. Fazzini also indicated that Mr. Cape is at an increased risk for dementia. In contrast, according to Mehta, et al.,[4] "No increased risk of dementia or AD was found for persons with a history of head trauma with loss of consciousness." According to Julien et al.,[5] "whether TBI is a risk factor for AD remains elusive." Additionally, according to Esopenko and Levine,[6] "While the acute and subacute effects of TBI recover over time, relatively little is known about the long-term effects of TBI in relation to neurodegenerative disease."

Dr. Fazzini reevaluated Mr. Cape again on 05/31/19. According to his report, Mr. Cape was once again reporting difficulties with attention, concentration, memory and anxiety. These recurrent symptoms are considered unrelated to the subject accident. Alternatively, Mr. Cape has a pre-accident history of depression, anxiety, schizophrenia and psychosis. Based upon my experience, patients with depression and anxiety often complain of associated cognitive difficulties. According to the 09/25/19 report of Dr. Collins, his psychosis is a likely contributing factor to Mr. Cape's cognitive deficits. Finally, based upon my analysis of this case, Mr. Cape's neurological prognosis with regard to the 11/22/18 subject accident is considered excellent.

DISCLAIMER

The opinions, conclusions, and recommendations expressed above are based upon reasonable medical probability and are independent of the referral source. Multiple factors have been taken into account including the examinee's subjective complaints, provided history, medical records reviewed, direct review of diagnostic or radiographic testing, results of credibility and symptoms reporting, and the physical examination findings. Comments on appropriateness of care are professional opinions based upon the specifics of the case and are not to be generalized to the specific involved providers or disciplines. The opinions expressed above do not constitute a recommendation that specific claims or administrative decisions be made or enforced. At the conclusion of the examination today, the examinee left the office without complaints of additional injury.

Respectfully submitted,

[4]Metha, KM, et al. Head Trauma and risk of dementia and Alzheimer's disease. Neurology, December 1999, 53(9) 1959.
[5]Julien J. et al. Association of traumatic brain injury and Alzheimer disease onset: A systematic review. Annals of physical rehabilitation medicine. 2017 May 11. pii: S1877-0657(17)30053-2.
[6] Esopenko C and Levine B Journal of Neurotrauma. 2015 Feb 15; 32(4): 209-20.

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Diplomate American Board of Electrodiagnostic Medicine

DLG:cak

DD: 11/16/21
DT: 11/16/21

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SUPPLEMENTAL REPORT #1

EXAMINEE : Taylor Cape
REPORT DATE : 12/13/21
D.O.L. : 11/22/18

To Whom It May Concern:

As discussed previously in my initial 11/16/21 Independent Medical Evaluation, Mr. Cape was diagnosed with a concussion as a result of his 11/22/18 motor vehicle accident. Based upon his clinical presentation, his evaluation by Dr. Dillon at University Medical Center can be reasonably attributed to the subject accident. Furthermore, his initial 12/15 evaluation with Dr. Fazzini and brain MRI performed at Pueblo Medical Imaging are also considered to be attributed to this accident. Mr. Cape followed up with Dr. Fazzini on 01/12/19 and 03/08/19. As discussed in my previous report, according to Dr. Fazzini's 03/08/19 report, Mr. Cape's postconcussive balance impairment, headaches and cognitive deficiencies resolved. Therefore, any further neurological care beyond 03/08/19 is considered unrelated to the subject accident. My opinions in this case are otherwise unchanged relative to my 11/23/21 report.

The above statements are made within a reasonable degree of medical probability.

Respectfully submitted,

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David L. Ginsburg, M.D.
Diplomate American Board of Psychiatry & Neurology
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DD: 12/13/21
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