|  |  |
| --- | --- |
| DISTRICT COURT, CITY AND COUNTY OF DENVER, STATE OF COLORADO  Court Address: SERVED ONLY:  1437 Bannock Street FILING ID: B15  Denver, Colorado 80202 CASE NUMBER: | December 3, 2018 9:09 PM 5CAA28C19  2018CV30947  **COURT USE ONLY** |
| **Plaintiff(s):**  **Defendant(s): insurance company name** |
| *Attorneys for Plaintiff:*  ADDRESS:  Phone Number:  Fax Number: | Case No: 2018 CV 030947 |
| **PLAINTIFF’S RULE 26(a)(2) ENDORSEMENT OF EXPERT WITNESSES** | |

F

**COMES NOW**, the Plaintiff Karen Fay, by and through her attorneys, Anderson Hemmat, LLC and pursuant to Rule 26(a)(2) and the Colorado rules of civil procedure hereby endorse the following experts to testify at trial:

# C.R.C.P. 26(a)(2)(B)(I): RETAINED EXPERTS

Experts specially retained on behalf of Plaintiff will be asked to provide testimony concerning their background, training, qualifications and experience, the materials reviewed and, where applicable, the medical literature relied upon in forming their opinions and conclusions.

Specially retained experts will be asked to testify concerning the nature of their business or practice, their education, training and experience as set forth in their *Curriculum Vitae*, their familiarity and basis for their claimed familiarity with the applicable technical standards, as well as their knowledge and experience concerning the issues. These experts will be asked to provide opinion testimony based generally on their knowledge, education, training and experience, as well as knowledge and review of applicable literature, published treatises, periodicals, pamphlets, facts or data made known to them at or before trial and any other facts or data reasonably relied upon by experts in the field of forming opinions. Retained experts will provide opinion testimony based upon their specific knowledge, education, training, and experience with the issues in the case.

Plaintiff reserves the right to offer opinion testimony deemed to be relevant and admissible by the Court in accordance with opinions rendered during depositions of experts and to pose hypothetical questions to them at trial based upon evidence introduced at trial. Plaintiff reserves the right to ask retained experts to review and possibly revise or modify their opinions based upon deposition testimony of defense experts, as well as newly provided facts, opinions, records and/ or materials and to answer, rebut or respond to the testimony and/ or opinions of defense experts deemed by the Court to be relevant and admissible.

Plaintiff anticipates using various exhibits in connection with or to illustrate testimony of all experts (retained and non-retained), including, without limitation, testimony excerpts, timelines, anatomic drawings, enlargement of records, applicable codes and standards and related records. Plaintiff also reserves the right to use diagrams, graphs, models, animations, videos and/ or other demonstrative evidence to illustrate the testimony of all experts (retained and non-retained).

# II. WITNESS[ES] NOT RETAINED OR EMPLOYEE[S] OF DISCLOSING PARTY.

**C.R.C.P. 26(a)(2)(B)(II): NON-RETAINED EXPERTS**

Plaintiff reserves the right to offer opinion testimony deemed to be relevant and admissible by the Court in accordance with opinions rendered during depositions of experts and to pose hypothetical questions to them at trial based upon evidence introduced at trial. Plaintiff reserves the right to ask retained experts to review and possibly revise or modify their opinions based upon deposition testimony of defense experts, as well as newly provided facts, opinions, records and/ or materials and to answer, rebut or respond to the testimony and/ or opinions of defense experts deemed by the Court to be relevant and admissible.

Plaintiff anticipates using various exhibits in connection with or to illustrate testimony of all experts (retained and non-retained), including, without limitation, testimony excerpts, timelines, anatomic drawings, enlargement of records, applicable codes and standards and related records. Plaintiff also reserves the right to use diagrams, graphs, models and/ or other demonstrative evidence to illustrate the testimony of all experts (retained and non-retained).

The following person[s] may be called to provide expert testimony but have neither (1) been retained to provide expert testimony, nor (2) are employees of the disclosing party whose duties regularly involve giving expert testimony:

# DENVER POLICE DEPARTMENT

* + - * 1. Officer Richard Jaramillo, No. 07055 Denver Police Department

3921 North Holly Street Denver, Colorado 80205

* + - * 1. **Qualifications:** Officer Jaramillo is a police officer with the Denver Police Department.

# Substance of all opinions to be expressed and the basis and reasons therefore:

Officer Jaramillo will testify consistent with the State of Colorado Traffic Accident Report and all investigative documents for Denver Police Department Case No. 15-181989 attached hereto as ***Exhibit 1*** (bates nos. 001 - 004). Officer Jaramillo will further testify to all notes, diagrams, statements, narrative reports, etc. related to the investigation of the subject automobile accident on April 3, 2015. Officer Jaramillo will testify to the opinions and conclusions provided in the accident report based on his background, training and expertise. Officer Jaramillo will further authenticate the accident report and any and all supporting documents generated by Denver Police Department related to the subject automobile accident on April 3, 2015.

# DENVER WEST CHIROPRACTIC

* + - * 1. **Rick L. Haussler, D.C. Denver West Chiropractic**

**390 Union Boulevard, Suite 230**

**Lakewood, Colorado 80228**

* + - * 1. **Qualifications:** Dr. Haussler is a licensed chiropractor.

# Substance of all opinions to be expressed and the basis and reasons therefore:

The above witnesses will testify consistent with Plaintiff’s medical records attached hereto as ***Exhibit 2*** (bates nos. 001- 027). They will also testify consistent with their credentials. The above witnesses will further testify will also testify consistent with their deposition, if taken.

More specifically, the above witnesses will testify that on April 10, 2015, Plaintiff presented stating she was the front passenger traveling at 20mph and was hit on the passenger’s side at approximately 40-50mph. She stated the air bags did not deploy and she was fully restrained. She had pain complaints including: cervical and right shoulder pain, frequent thoraco-lumbar pain, occasional headaches and muscle spasm at problem areas. Examination revealed: visual evaluation of decreased lordosis of the cervical spine. She had hypo-mobility noted at the cervical spine C2-3, C5-6 and thoraco-lumbar spine at T4, T12-L1.

Muscle hyper-tonicity noted at levator scapulae right, rhomboids B/L, trapezius B/L, QL B/L. Palpation of above muscles revealed significant tenderness on light pressure and active myofascial trigger points. Decreased ROM in the cervical rotation and extension. Decreased ROM in the thoraco-lumbar flexion and extension. Treatment included chiropractic spinal corrections.

The above witnesses will testify that Plaintiff underwent fourteen chiropractic sessions through June 11, 2015.

The above witnesses will further testify to and authenticate Plaintiff’s entire medical chart from Denver West Chiropractic including all dates of treatment whether specifically identified herein or not. They will further testify to all areas of treatment provided to Plaintiff, including MRI, x-rays, massage therapy, acupuncture, injections, surgery and/ or physical therapy. They will also testify to opinions they have related to permanent injuries sustained by the Plaintiff and impairment ratings provided to Plaintiff. The above witnesses will authenticate and testify consistent with the entire medical record file contained at Denver West Chiropractic regarding Plaintiff which has been previously produced to Defendants and for which Plaintiff endorses herein.

Additionally, the above witnesses will testify to the medical care and treatment they provided to Plaintiff and the necessity of their own medical records and the total medical care and bills associated therewith. They will also testify to the medical care and treatment provided by other healthcare providers and to the reasonableness and necessity of their medical records and medical bills associated therewith.

Further, the above witnesses will also testify to the reasonableness and necessity of charges for the care and treatment that they and Denver West Chiropractic provided to Plaintiff and that the care was reasonable, necessary and related to the incident of April 3, 2015. They will also testify to and authenticate Plaintiff’s medical bills from Denver West Chiropractic stating that based on their background, training and years on the job they have become familiar with the reasonable charges billed in this community for similar medical services as were provided to Plaintiff and that the billing from Denver West Chiropractic was billed at the reasonable, customary rate in the community for which the services were provided. The total bills as of the date of this disclosure for Denver West Chiropractic are $970.00. ***Plaintiff reserves the right to supplement this endorsement with future additional related medical billing for medical treatment Plaintiff may receive in the future related to injuries sustained in the subject accident.***

The above witnesses will further testify that the injuries to Plaintiff were entirely caused by the at issue accident of April 3, 2015.

Finally, the above witnesses will also testify to demonstrative summaries of medical care as well as demonstrative summaries of any medical procedures or surgeries performed on Plaintiff.

# PANORAMA ORTHOPEDICS

* + - * 1. **Michael Horner, D.O. Panorama Orthopedics**

**660 Golden Ridge Road, Suite 250**

**Golden, Colorado 80401**

* + - * 1. **Qualifications:** Dr. Horner is board-certified in physiatry.

# Substance of all opinions to be expressed and the basis and reasons therefore:

The above witnesses will testify consistent with Plaintiff’s medical records attached hereto as ***Exhibit 3*** (bates nos. 001- 053) and ***Exhibit 4*** (bates nos. 001- 034). They will also testify consistent with their credentials. The above witnesses will further testify will also testify consistent with their deposition, if taken.

More specifically, the above witnesses will testify that on June 4, 2015, Plaintiff presented with pain, weakness and numbness. She stated that the symptoms began acute non-traumatic and began on 04/04/2015. She indicated the injury occurred during a motor vehicle accident. The symptoms occurred constantly. The problem was stable. She indicated that the pain was located in the neck. The pain radiated then into her shoulder on the right side. She reported numbness in the down arm into hand involving all fingers on the right side.

Examination: Cervical MRI was reviewed and revealed C4-5) central disc bulge with annular fissure effacing the ventral thecal sac. This was causing mild right foraminal stenosis. C6-7) central disc bulge with annular fissure effacing the ventral thecal sac. No foraminal stenosis was noted. Various treatment options were discussed with the Plaintiff including physical therapy, medications, interventional injection therapy, alternative therapies, and rarely surgical intervention. The following plan was discussed in detail and agreed upon:

Physical Therapy - commence formal physical therapy.

Medications - D/C Ibuprofen. Start Gabapentin 100mg 1cap @ HS, Mobic 7.5mg 1tab daily. Both scripts given to pt today.

MRI of the cervical spine reviewed today.

Interventional Injection Therapy - pending the outcome of PT and medication trial

Continue activity as tolerated and home exercise program daily

Return to Clinic -- 4 weeks

The above witnesses will testify that on June 17, 2015, Plaintiff presented for initial evaluation after being referred to PT for neck and R arm pain s/p MVC 4/3/15. Plaintiff was the passenger in a car when she was hit on the passenger side. She did not think her head or shoulder hit anything but was not able to get out of the passenger door. She had an MRI that shows multi disc tears and bulging discs. She initially went to a chiropractor for manipulations which did help her start to move again but at this point it did seem to help. She had constant pain throughout the day and HAs. The R arm also varies between throbbing, numbness, tingling and pain. Driving was difficult, anything overhead has no strength. All fingers were affected. Treatment included: Exercises include range of motion, strengthening, posture training, neuro reeducation. Modalities were ultrasound, electrical stimulation, biofeedback, iontophoresis, heat, cold, TENS, traction, manual therapy. Plaintiff was prescribed twice per week for a duration of 6 weeks.

The above witnesses will testify that on July 29, 2015 Plaintiff presented and reported after last session she had a few days of relief but continued to have recurring arm and neck pain. Notes read: she fatigued quickly w/therapy, but able to perform full sets. Neck mobility was WNL, her main deficit was her strength/stability. She was given written exercises for HEP which she requested. She had completed the 12 insurance approved appointments through July 29, 2015.

The above witnesses will testify that on July 17, 2015, Plaintiff presented and stated the problem was constant and slightly better. Currently she stated that the symptoms were moderate. She indicated that the pain was located in the neck. The pain radiated into the shoulder on the right side. She reported numbness down arm into hand involving all fingers on the right side. Plaintiff had been complaint with formal physical therapy, she felt the right arm strength was improving and her pain was slightly better. She did try the Gabapentin, however had to d/c due to grogginess. She did have frequent headaches that Tylenol did not help, she d/c'd the Mobic so that she could go back to using Ibuprofen for the headaches. Plan:

1. Physical Therapy - continue current PT program
2. Medications - continue medication (Ibuprofen).
3. Interventional Injection Therapy - we discussed a CESI, ordered today
4. Continue activity as tolerated and home exercise program daily
5. Return to Clinic -- 2 weeks post injection

The above witnesses will testify that on September 11, 2015Plaintiff presented with continued with pain, weakness and numbness. The problem was constant and fluctuating. She stated that the symptoms were mild-moderate and indicated that the pain was located in the neck. She reported numbness down the arm into hand involving all fingers on the right side, which was improving. She had arm weakness on the right side. Since last seen she had not been able to have the previously ordered CESI, due to her health insurance trying to make her auto insurance cover the cost of everything. Both insurances were denying coverage. She also had complaints of severe right shoulder pain with rotation, overhead work, and ROM. No known new trauma or injury. She believed that with her neck pain slightly improving and tingling improving, she was able to notice the right shoulder issues more. Assessment: Cervical radiculopathy, Symptomatic HNP (herniated nucleus pulposus), cervical, Symptomatic Cervicalgia, Symptomatic, Shoulder pain, right, Symptomatic

Procedure: Injection/Aspiration: Arthrocentesis major joint. Site was prepped using sterile prep w/ povidone-iodine, ethyl chloride was Right shoulder subacromial space injection was performed with 4 mL(s) of .5% bupivacaine & 1% lidocaine for anesthetic. Depo-Medrol (methylprednisolone acetate) 40 mg (1 mL) was injected using a 22-gauge needle. A sterile adhesive dressing was applied.

Plan:

1. Physical Therapy – she had completed formal physical therapy, continue HEP
2. Medications - continue medication (Ibuprofen).
3. Interventional Injection Therapy - proceed with already ordered CESI, once insurance approves. Dr. and Plaintiff discussed a right sub-acromial injection, done by Ortho today.
4. Continue activity as tolerated and home exercise program daily
5. Return to Clinic -- 2 weeks post injection.

The above witnesses will testify that on December 18, 2015, Plaintiff presented for an C7-T1 interlaminar Epidural Steroid Injection Under Fluoroscopic Guidance. The cervical area was prepped and draped in the appropriate sterile fashion. The C7-T1 level was identified for an interlaminar epidural injection and a skin wheal was made at the spinal needle entry site. The overlying skin and subcutaneous tissue were anesthetized. A 3.5-inch 20-gauge Tuohy spinal needle was passed through the skin wheal and advanced in a posterior to anterior direction and using the loss of resistance technique until the tip of the needle was through the ligamentum flavum and properly placed in the posterior epidural space as confirmed by AP and Contralateral Oblique fluoroscopic views. Proper loss of resistance was noted. No blood was aspirated. There was no CSF flow.

Following negative aspiration, 1 ml lsovue-M300 was injected to produce the epidurogram. There was appropriate needle placement, no intravascular or intrathecal flow and good epidural flow. 2 ml of a 6 mg/ml solution of Celestone and 2 ml of 1% lidocaine (all injectables preservative free) was injected.

Following the injection, the needle was withdrawn. Plaintiff was sent to the Recovery Room, then discharged in stable condition. She was advised use pain log, resume normal activity the following day and to follow up in 2-4 weeks.

The above witnesses will testify that on January 15, 2016, Plaintiff presented after C7-T1 interlaminar ESI on 12/18/2015. She did report relief. She was taking less ibuprofen. She felt that this week she began to feel the benefit of injection. She did have an injection into the subacromial injection which provided about 3 weeks of relief. Additional treatment options were discussed, and the following plan was discussed in detail and agreed upon:

Plan:

1. Physical Therapy - Plaintiff had completed formal physical therapy, continue HEP
2. Medications - continue medication (Ibuprofen).
3. Interventional Injection Therapy -No injection indicated at this time. She can call to set up another injection. She could also call to have a glenohumeral joint under ultrasound guidance if she wished.
4. Continue activity as tolerated and home exercise program daily
5. Return to Clinic -- as needed.

The above witnesses will further testify to and authenticate Plaintiff’s entire medical chart from Panorama Orthopedics and/ or Golden Ridge Surgery Center including all dates of treatment whether specifically identified herein or not. They will further testify to all areas of treatment provided to Plaintiff, including MRI, x-rays, massage therapy, acupuncture, injections, surgery and/ or physical therapy. They will also testify to opinions they have related to permanent injuries sustained by the Plaintiff and impairment ratings provided to Plaintiff. The above witnesses will authenticate and testify consistent with the entire medical record

file contained at Panorama Orthopedics and/ or Golden Ridge Surgery Center regarding Plaintiff which has been previously produced to Defendants and for which Plaintiff endorses herein.

Additionally, the above witnesses will testify to the medical care and treatment they provided to Plaintiff and the necessity of their own medical records and the total medical care and bills associated therewith. They will also testify to the medical care and treatment provided by other healthcare providers and to the reasonableness and necessity of their medical records and medical bills associated therewith.

Further, the above witnesses will also testify to the reasonableness and necessity of charges for the care and treatment that they and Panorama Orthopedics and/ or Golden Ridge Surgery Center provided to Plaintiff and that the care was reasonable, necessary and related to the incident of April 3, 2015. They will also testify to and authenticate Plaintiff’s medical bills from Panorama Orthopedics and/ or Golden Ridge Surgery Center stating that based on their background, training and years on the job they have become familiar with the reasonable charges billed in this community for similar medical services as were provided to Plaintiff and that the billing from Panorama Orthopedics and/ or Golden Ridge Surgery Center was billed at the reasonable, customary rate in the community for which the services were provided. The total bills as of the date of this disclosure for Panorama Orthopedics are $3,419.75 and Golden Ridge Surgery Center are

## $1,764.00. Plaintiff reserves the right to supplement this endorsement with future additional related medical billing for medical treatment Plaintiff may receive in the future related to injuries sustained in the subject accident.

The above witnesses will further testify that the injuries to Plaintiff were entirely caused by the at issue accident of April 3, 2015.

Finally, the above witnesses will also testify to demonstrative summaries of medical care as well as demonstrative summaries of any medical procedures or surgeries performed on Plaintiff.

# LUTHERAN MEDICAL GROUP

* + - * 1. **Susan Nack, M.D. Deborah Hubbard, P.T. Annie Neisen, P.T. Lutheran Medical Group**

**1687 Cole Boulevard, Suite 103**

**Lakewood, Colorado 80401**

* + - * 1. **Qualifications:** Dr. Nack is board-certified in physical and rehabilitation medicine. Ms. Hubbard and Ms. Neisen are licensed physical therapists.

# Substance of all opinions to be expressed and the basis and reasons therefore:

The above witnesses will testify consistent with Plaintiff’s medical records attached hereto as ***Exhibit 5*** (bates nos. 001-145). The above witnesses will further testify will also testify consistent with their deposition, if taken.

More specifically, the above witnesses will testify that on May 24, 2017, Plaintiff presented with chronic neck and right arm pain. She stated that she had minor aches and pain in her cervical and lumbar back her whole life. She had always been very active and thought she had been hard on her back but was manageable with chiropractic care and massage therapy until April 2015, when she was involved in a MVA where as a passenger the car was side swiped by a hit and run accident. She developed neck and right shoulder pain later that day. She saw a physician who told her nothing was broken. Examination revealed: Cervical tenderness throughout the cervical spine and paraspinal, tenderness along the right occipital nerve, tenderness in the anterior chest wall and clavicular area, over the bicep tendon on the right and medical elbow. She was positive for the empty can test. Diminished PP in the last 3 digits on the right, no dermatomal pattern identified.

Diagnoses:

Chronic neck pain;

Myofascial pain dysfunction syndrome;

Dysfunction of the right rotator cuff;

Paresthesia of right arm;

Chronic right shoulder pain. Plan:

X-ray of the cervical spine and right shoulder;

Referral for supervised PT, 1-2 x’s weekly for 4-8 weeks; Psychological therapy – consider referral;

Cymbalta

Follow-up care 8 weeks.

The above witnesses will testify that on June 2, 2017, Plaintiff presented for X- ray of her right shoulder and cervical spine.

Right Shoulder:

Findings:

The osseous structures of the right shoulder were normal.

The acromioclavicular and glenohumeral joints were normal. Soft tissue was normal.

Cervical Spine:

Findings:

The cervical vertebral were intact with no evidence of fracture or other focal bone lesion.

Alignment was normal I neutral position, flexion and extension. No abnormality seen craniovertebral junction.

The prevertebral soft tissue was unremarkable.

Moderate changes of chronic spondylosis were present at C6-7 with mild narrowing of the disc space and early endplate sclerosis and spurring.

The articular pillars were intact and align properly and the facet joint and neural arches were normal. The neural foramina were widely patent bilaterally.

Impression:

1. Chronic cervical spondylosis at C6-7, otherwise normal.

The above witnesses will testify that on June 1, 2017, Plaintiff presented for initial evaluation with pain complaints including: cervical pain, right shoulder pain and headaches which were worse with activity and stress. She stated her pain was dull, aching, burning and tender. Examination revealed: tender right suboccipital with myofascial tightness and tight right cervicothoracic pvm.

Treatment included: aquatic therapy, body mechanics training, cryotherapy/heat, dry needling, electrotherapy, home/pool/gym exercise program, joint mobilization, neuromuscular reeducation, posture training, soft tissue mobilization, manual therapy, therapeutic exercise and therapeutic/functional activities training.

The above witnesses will testify that on November 16, 2017 Plaintiff had reached maximum benefits from PT and had learned many pain management techniques and was released to home management. Plaintiff had undergone twenty-one therapy sessions.

The above witnesses will testify that on July 19, 2017, Plaintiff presented after being previously evaluated with a diagnosis of cervical spondylosis, myofascial pain syndrome and rotator cuff pathology. Since then she had been taking Cymbalta and reported that the scapular pain had resolved on the left and her overall pain was better. She was participating in physical therapy and stopped yoga. She was encouraged about her progress. Examination revealed:

Diffused tenderness throughout cervical spine and paraspinal, tenderness along the right occipital nerve diminished, over the bicep tendon on the right.

Restriction of the cervical ROM and myofascial tenderness in multiple areas. Plan: Continue with PT, increase Cymbalta to 30 mg. follow up in 3 months.

The above witnesses will further testify to and authenticate Plaintiff’s entire medical chart from Lutheran Medical Group including all dates of treatment whether specifically identified herein or not. They will further testify to all areas of treatment provided to Plaintiff, including MRI, x-rays, massage therapy, acupuncture, injections, surgery and/ or physical therapy. They will also testify to opinions they have related to permanent injuries sustained by the Plaintiff and impairment ratings provided to Plaintiff. The above witnesses will authenticate and testify consistent with the entire medical record file contained at Lutheran Medical Group regarding Plaintiff which has been previously produced to Defendants and for which Plaintiff endorses herein.

Additionally, the above witnesses will testify to the medical care and treatment they provided to Plaintiff and the necessity of their own medical records and the total medical care and bills associated therewith. They will also testify to the medical care and treatment provided by other healthcare providers and to the reasonableness and necessity of their medical records and medical bills associated therewith.

Further, the above witnesses will also testify to the reasonableness and necessity of charges for the care and treatment that they and Lutheran Medical Group

provided to Plaintiff and that the care was reasonable, necessary and related to the incident of April 3, 2015. They will also testify to and authenticate Plaintiff’s medical bills from Lutheran Medical Group stating that based on their background, training and years on the job they have become familiar with the reasonable charges billed in this community for similar medical services as were provided to Plaintiff and that the billing from Lutheran Medical Group was billed at the reasonable, customary rate in the community for which the services were provided. The total bills as of the date of this disclosure for Lutheran Medical Group are $5,025.75. ***Plaintiff reserves the right to supplement this endorsement with future additional related medical billing for medical treatment Plaintiff may receive in the future related to injuries sustained in the subject accident.***

The above witnesses will further testify that the injuries to Plaintiff were entirely caused by the at issue accident of April 3, 2015.

Finally, the above witnesses will also testify to demonstrative summaries of medical care as well as demonstrative summaries of any medical procedures or surgeries performed on Plaintiff.

All documents are available for review at the office of the Plaintiff’s counsel upon prior arrangement.

## \* Plaintiff reserves the right to supplement her endorsement and areas of testimony prior to trial should Plaintiff undergo additional treatment/ care/ testing with the above endorsed expert physicians.

DATED this 3rd day of December, 2018.

FIRM NAME

*s/ LAWYER NAME*

*Attorneys for Plaintiff*