MEDICOLEGAL AND INDEPENDENT MEDICAL EVALUATION SERVICES

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Board Certified
Neurological Surgeon

It is a pleasure to offer my services as a Board-Certified Neurological Surgeon for medicolegal review and independent medical evaluation. I have been in practice since 1998 and have extensive experience in surgical and non-surgical management of the spine, brain and nerve disorders. I am a very conservative surgeon who generally finds non-surgical options provide the lowest risk and most benefit to patients. Advance surgical therapies are often unnecessary and I reserve such therapies only when they can provide clear benefit to the patient.

I have been performing medical record review and IME work since about 2005 and have extensive experience in report preparation, in deposition, and trial testimony. In over 20 years of practice, I have had frequent and regular experience evaluating and treating workers compensation and personal injury patients as well. I have served in numerous national, state and local positions in organized medicine and elsewhere evaluating and creating policy related to practice of medicine, medical economics, payment for physician services, liability, and quality. My background includes time as President of the Florida Neurosurgical Society, and officer positions with Florida state and county medical associations.

I offer detailed and comprehensive evaluation of medical records and my trial and deposition experience is highly respected. My turnaround time is quick and fees are reasonable. I have developed good working relationships with attorneys and insurance companies who have requested this work.

I can also offer detailed analysis based on fees and codes charged and relate them to the market and known fee schedules to determine appropriateness of billing.

The enclosures with this letter provide further details as to my background, fee schedule and work processes. I look forward to providing these services for you and your firm. Please feel free to contact me or my office at any time should you need further information or have any questions.

Sincerely,

David McKalip, M.D.

David M. McKalip, M.D.
Medicolegal Fee Schedule

Deposition	**$1,500/hour**
Record Review	**$750/hour**
IME (Includes one hour of records review & patient evaluation)	**$1,500**
Additional Records Review for IME	**$750/hour**
Off-site IME (For travel time portal-portal)	**$1,500/hour**
Surcharges (during deposition or IME)	
Video	**$400**
Court Reporter	**$250**
Interpreter (provided by attorney)	**$250**
No show Fee (to re-schedule)	**$500**
Impairment Rating (as part of IME)	**$500**
Impairment rating as separate event (IME already completed)	**$750**
Phone/Office Conference	**$250/15 minutes**
Narrative Reports	**$300**
Trial Witness Fees (portal-to-portal)	**$2,500/first hour**
$1,500/each additional hour	**($4,000 pre-pay)**

All fees are prepaid and non-refundable with any variation in fees requiring written approval of Dr. McKalip. The Memorandum of Understanding offers further details on payment obligations.

Independent Medical Evaluation Sample

By David McKalip, M.D.

May 11, 2016

RECORDS REVIEW / MEDICAL EVALUATION

Dear Mr. _____:

Today I performed a Medical Evaluation on _____ and a Records Review.

1. Records from _____ Injury Centers of 04/30/14, 05/21/14, 06/25/14, 07/16/14, 06/14/14, 11/19/14, 02/25/14.
2. Records from _____, MD on 08/27/14, 09/02/14, 09/03/14, 09/09/14, 10/06/14, 10/15/14.
3. Records from _____ of 06/01/15, 06/29/15, 08/26/15, 10/27/15.
4. _____ of Tampa Bay 07/02/15, 07/27/15, 09/17/15, 09/21/15, 09/30/15.
5. _____ Hospital 09/17/15.
6. _____ Hospital 08/04/13.
7. Community Health Center _____ 03/18/13, 06/21/13, 06/28/13, 07/12/13, 08/08/13.
8. _____ Spine Center 08/20/13, 08/30/13, 09/09/13, 09/16/13, 10/17/13, 11/18/13, 11/20/13, 12/06/13.
9. MRI images on CD and reports.

HISTORY:

Mr. _____ presented for a Medical Evaluation relating to a motor vehicle accident that occurred on 04/25/2014. However, he also had a motor vehicle accident on 11/11/2014 and a prior accident on 08/28/2013.

He presented for a Compulsory Medical Evaluation. Prior to that I performed a Records Review.

According to my Records Review the Claimant presented to _____ Injury Center on 04/30/2014. According to his intake sheet he was involved in a motor vehicle accident when he was in a 2001 limo-mini-van. Reportedly no airbag deployed and he was struck from behind, was not taken to the hospital and the police were involved. He reported neck pain, back pain and sciatica on his intake sheet at _____ Injury Center on 04/30/2014. He reported he was on Flexeril secondary to "the last accident". He reported carpal tunnel surgery in 1999 and mentioned that his mother had a history of Lou Gehrig's disease. On his review of

systems at the time he indicated neck pain, back pain, upper extremity pain, lower extremity pain as well as upper extremity and lower extremity weakness, numbness and tingling and decreased range of motion. He reported positive memory problems, anxiety and depression. According to the note from Dr. _____ at the clinic he had cervical and lumbar pain following a motor vehicle accident that was worse with activity with no postural symptoms. He had no loss of consciousness and no localizing neurological

signs and no mental status changes. His left lower extremity had positive extremity paresthesias with radiating extremity pain. He had left shoulder pain with range of motion and wanted pain control. On his exam he was alert and oriented with "no gross focal deficits". The neurologic exam was noted to be grossly normal. On motion he had lumbar tenderness and tightness with decreased range of motion, but there was no soft tissue swelling noted. He had cervical tenderness, tightness and decreased range of motion. The impression was cervical and lumbar pain with stiffness, decreased range of motion, and paresthesias and radiating pain. He also had left shoulder pain and increased back pain. The plan was activities tolerated, physical therapy, chiropractic therapy, cervical and lumbar MRI and nerve conduction velocity if he did not have improvement in paresthesias. He was given tramadol and was told to follow up. On 05/21/14 he came back with the same symptoms except there was no mention of the poor range of motion in his left shoulder. Physical exam had nearly identical text to the prior exam. The impression explained that there were abnormalities on the MRI, that he had extremity paresthesias and radiating pain and that he had "the sustained injuries will continue to have an effect on the remainder of the patient's life" including professional, recreational and social activities and it was defined as an emergency medical condition which is often done in personal injury cases.

On 06/25/14 Dr. _____ saw him again for ongoing cervical and lumbar pain and stiffness. He was receiving chiropractic care and he had left lower extremity paresthesias and radiating pain. Physical exam does not change in any significant way. The impression and plan were about the same. On 08/13/14 he continued to have cervical and lumbar pain and stiffness with extremity paresthesias and pain. The impression and plan were about the same and he was receiving Vicodin at this time. In 07/2014 he was complaining of cervical and lumbar pain and stiffness with extremity pain and radiation and paresthesias in the upper extremity and the left leg. He reported this was "not present before" this accident. As will be seen below this clearly contradicts the claimant's prior medical history. The physical exam indicated negative straight leg raising, 2+ DTRs. The MRI of the cervical spine reportedly showed herniated discs at multiple levels with disc protrusions and subluxation as well as straightening of the cervical lordosis. This is from 05/07/14. The lumbar spine MRI reportedly demonstrated disc bulges, protrusions and foraminal stenosis at a variety of levels. The impression was cervical and lumbar soft tissue and spinal derangement with extremity radiculopathy although it does not say which extremity. The impression included the following "posttraumatic findings are persistent and a result of the accident". "Based on history, exam, course of treatment and imaging findings patient has sustained permanent injures from accident." It is not exactly clear what the

specific injuries are in the note. The plan was pain medication, chiropractic and physical therapy, neurology evaluation for radiculopathy, possible epidural steroid injections or surgery if needed. Cost estimates were made for epidural steroids at $4,000 for three rounds in the neck and $4,000 for three rounds in the lumbar spine. Estimates for costs for cervical surgery were $40,000 to $50,000, lumbar surgery $45,000 to $50,000 and chiropractic therapy at $3,500 to $5,000 a year.

On 06/04/14 flexion/extension films were performed showing 0.14 to 1.36 mm of translation.

On 11/12/14 the patient came in following a new motor vehicle accident that had occurred on 11/11/14. Reportedly he had neck pain, back pain, upper extremity pain, joint pain and swelling. He also complained of lumbar pain, cervical pain and stiffness since the motor vehicle accident. There was cervical and lumbar tenderness with decreased range of motion. The plan was chiropractic therapy and physical therapy. On 02/25/14 Dr. _____ indicates "symptoms were not present before the accident and have been persistent since the accident". This seems to refer to the 11/11/14 accident which clearly contradicts the records from both the 04/2014 and the 08/2013 accidents. Dr. _____ reported that the symptoms were minimally improved with chiropractic care and that he had to change his job due to his symptoms from the 04/25/14 motor vehicle accident. It was noted that he had had a lumbar

microdiscectomy. MRI findings were noted from 12/24/14 in the cervical and lumbar spine for a variety of disc abnormalities. On physical exam it was noted that he had 5/5 strengths throughout with negative straight leg raising and 2+ DTRs. He had cervical and lumbar soft tissue and spinal derangement with extensive radiculopathy. He had impaired work from his symptoms and his daily activities and recreation were also impaired. It was felt these problems were all due to the accident. It is not clear which exact accident is being referred to but it appears to be the 11/11/14 accident. The recommendation was for pain medications as needed, chiropractic, physical therapy, epidural steroids and surgery with the same cost estimates as the note from 07/2014.

The patient went to see _____, MD on 08/04/14. He was complaining of neck pain and low back pain, with low back pain into the left leg, neck pain and left upper extremity pain, hand numbness and tingling. He was on Vicodin. The pain chart indicated neck pain, low back pain, pain in the dorsum of his hands, left lateral leg pain down to the ankle. Dr. _____ indicated that he had had the rear-end motor vehicle accident and was receiving chiropractic and physical therapy. It was noted that he had neck pain with numbness and tingling in his hands bilaterally with no upper extremity radiating pain. It was noted that his symptoms were worse when he moved his neck and better with medications. It was noted that he had had a prior injury to his cervical spine about six months prior to this accident, that chiropractic therapy reportedly had improved those symptoms and that he had a recurrence of these symptoms with this current motor vehicle accident on 04/2014. Reportedly he had low back pain radiating into his left leg. It was also noted that he had had a prior injury in his low back prior to the motor vehicle accident in 08/2013, but now had a recurrence. The physical exam indicated 5/5 strengths with downgoing toes and negative straight leg raising. He had tenderness in his neck and back. The imaging findings were noted as described above. The impression was multiple cervical disc herniations at C3-4 and C6-7 and C7-T1 with new herniations or of symptoms exacerbated from this accident. Reportedly he had lumbar disc herniations at L4-5 and L5-S1 that were new and associated with annular tears. The recommendation was epidural steroid injections or decompressive surgery focusing first on the cervical spine. It was indicated that there was "new permanent injury of the L-spine and body as a whole". It was not specified exactly what injuries were caused by the accident. There is a form on 08/27/14 scheduling surgery. The plan was plasma disc decompression at L4-5 and L5-S1 with laser facet ablation, facet injections and cervical epidural steroids. On 09/02/14 he presented complaining of severe low back pain but his neck pain was doing better. Physical exam showed L-spine guarding and some residual guarding of the cervical spine. The impression was similar to that described above and apparently the patient wanted a lumbar disc decompression at this point. On 09/03/14 there is an operative report from surgery done at _____ Surgery Center. This indicated that he had lumbar decompression at L4-5, L5-S1 with what was probably a plasma disc decompression procedure. It was indicated he had lumbar facet capsule thermoplasty with facet nerve ablation at L3-4 and L5-S1 and lumbar facet injections at L3-4 through L5-S1. According to the note plasma-rich protein was placed into these areas. He had selected nerve root blocs at L4 and L5 and trigger point injections as well as fluoroscopy. This was done under general anesthesia.

On 09/09/14 and 10/06/14 he came in for postoperative visits saying that his sciatica resolved. On 10/15/14 a final narrative is done saying he is doing well with quick relief of sciatica over the last few weeks and significant improvement in his low back pain. The impression further went on to say that the 04/25/14 motor vehicle accident was causally related to the cervical and lumbar disc herniations and the cervical disc herniation may have been old, but he may have had an exacerbation of his symptoms due to his pre-existing findings on the MRI. However, the doctor also concluded somehow that the lumbar herniations were new. The doctor then indicated that based on the surgical repair he had a permanent injury to the lumbar spine.

There are records from_____ Diagnostic Clinic in _____ predominately from _____, MD. On 06/01/15 he saw this doctor to establish a relationship with the complaint of "cervical" and a complaint of history of "pain right foot and ankle". The review of systems was positive for numbness, hand swelling and weight gain. It was noted that he was on Mobic and Flomax at the time and that he had no acute distress on his physical exam. He had pain in his ankle and foot. On 06/29/15 he saw a physician's assistant for right elbow pain and was diagnosed with lateral epicondylitis. On 06/29/15 he saw a podiatrist with complaints of foot and ankle pain, but it was not clear what was planned at that time as the note was incomplete. On 08/26/15 he went in for preoperative clearance to have surgery done. It should be noted on 08/26/15 a chest x-ray was done indicating moderate thoracic spine degenerative disease. On 10/27/15 there was pain in both feet with walking and standing at work with increased paresthesias in the right hand and chronic right elbow pain. He was still on Vicodin. Physical exam indicated no neural deficits. The impression was carpal tunnel syndrome and lateral epicondylitis.

There are records from _____ Center of Tampa Bay. On 07/02/15 there is a complaint of pain in the top of the left foot with swelling when he stands for eight hours. It was noted that he had chronic pain on the dorsal lateral aspect of his left foot for a year that resulted when he stepped out of a truck "about a year ago". Ultimately an old fracture fragment was diagnosed on the lateral aspect of the cuboid bone. It was felt to be an old fracture and the plan was trigger point injection. On 07/27/15 it was noted that the trigger point injection did not work and surgery was planned. On 09/17/15 an operative report shows that a fragment of bone was removed. On 09/21/15 and 09/30/15 it was noted that he was improving from this and was healing.

On 08/04/13 he went to _____ Hospital complaining of left eye irritation, but left without being seen. There are records also from Community Health Center. On 08/0813 he presented with a history of chronic back pain and carpal tunnel syndrome, but again the patient left before being seen.

On 06/21/13 there are notes from _____, D.O. at Community Health Center. On 06/21/13 prior to the automobile of 08/2013 he was complaining of left leg pain with his hands hurting and trouble closing his hands. The active problem list included morbid obesity and sciatica. It was noted that he had low back pain into his legs with thigh pain radiating down the leg and leg pain. It was noted there was no intermittent leg claudication. It was indicated he had left lateral leg severe pain, much worse after he delivers packages for work and that it occurs about twice a week. It was noted to be 8/10 in the pain scale rating when at work. It was noted that it interferes with what used to be an intense one-hour daily aerobic exercise workout. On physical exam it was noted he was morbidly obese although his weight was only 234 pounds while having a height of 66". His exam essentially was normal for the musculoskeletal and neurologic exam. The diagnosis was sciatica and he was given a 30-day prescription for a Medrol Pack and gabapentin. On 06/28/13 he presented again with an active problem of sciatica. On 07/12/13 it was noted that he was "very frustrated with left leg pain". He had lost 21 pounds in the last 21 days. He had left buttock pain into the left leg in a band-like sensation worse with exercise. The neurologic exam was essentially normal with abnormal DTRs and his left ankle jerk decreased. He was diagnosed with sciatica, given Norco, meloxicam and physical therapy. On 08/08/13 he came in complaining of eye irritation and it was reported that he had a corneal abrasion. This appears to be a second visit on the same day.

On 08/30/2013 he saw _____, D.C. at _____Center. It was noted he had a motor vehicle accident on 08/28/13. It was noted he was on Alternate 19 in a Toyota Four-Runner for this accident. It was also noted that he had had a prior motor vehicle accident when another person had run a stop sign. The pain chart showed a dot in the left lateral upper posterior thigh but it does not appear to have been filled out properly. On 09/09/13 he saw chiropractor Dr. _____, D.C. It was noted that he was being evaluated for posttraumatic injury sustained in a motor vehicle accident on 08/28/13. Apparently this was a three-

car chain reaction rear-end collision where he was in the front of the line. He denied loss of consciousness or head injury. He says in a few days after the accident his symptoms worsened. He was complaining of neck pain at 3-4/10, low back pain at 3-4/10, left leg sciatica which was a pre-existing condition that was now with a notable aggravation. He had left arm strain. It was noted he had a prior motor vehicle accident 20 years ago and a Workers' Compensation injury leading to left carpal tunnel release. The physical exam showed tenderness in the cervical and lumbar spine with decreased range of motion. Straight leg raising was mild for positive low back pain. The assessment was cervicalgia, lumbalgia, left sciatic neuropathy, left lower extremity strain. All of these were secondary to the 08/28/13 accident according to this doctor. He was placed on meloxicam,

Tylenol #3 and Flexeril and given physical therapy and chiropractic therapy. It should be noted that an out of order record from 08/30/13 is also present in this stack of records. This was from chiropractor _____, D.C. He reported that after the accident he did not go to the hospital, the pain got worse since the accident. He had neck pain with moderate intensity, left shoulder pain, right low back pain and bilateral leg pain and stiffness. It was noted he had a prior motor vehicle accident and that he had treatment for neck pain and back pain. He said he had no work-related accidents, slip or fall. Reportedly he was symptom free at the time of the motor vehicle accident of 08/23/13 but this is highly unlikely given the frustration he reported with severe pain in 07/2013 at the Community Health Center. Reportedly he had not lost time from work. The physical exam showed positive trigger points in the cervical and lumbar areas with decreased range of motion in those areas. Reportedly he had hypoesthesia in C5-T1 and L3-S1. He had 1+ DTRs and positive bilateral Achilles reflex. He had right upper extremity paresthesias related to his cervical radiculitis. Reportedly he had compromise of intravertebral foramen opening due to vertebral displacement of C5 and C7 and ankylosis of C4, C5, C6, C7 on the chiropractic x-rays. Reportedly the L-spine x-rays showed pre-existing degenerative spondylosis and osteophytosis with decreased disc spaces at L4-5 and L5-S1. The diagnosis was that he had posttraumatic neck pain, back pain, sciatica, cervical radiculitis and a whole host of other nonspecific diagnoses related to the motor vehicle accident of 08/28/13 relating to his neck and back.

There was a neurosurgical consult done by _____ , MD on 09/16/13. The complaint was cervical strain, trapezius strain and lumbar strain. It was noted that his past medical history included occasional problems with low back pain since an old motor vehicle accident. Reportedly he had a prior MRI with L4-5 abnormalities and a history of a Workers' Compensation injury requiring carpal tunnel surgery. The review of systems reportedly showed no history of prior neuropathy or radiculopathy, but this clearly contradicts his multiple visits for sciatica to the Community Health Centers earlier that year. His physical exam had

positive straight leg raising bilaterally at 40 degrees and his motor exam strength apparently was all "good". He had decreased light touch in the left L5 distribution. The diagnosis was traumatic cervical strain and sprain, hypoalgesia at L5 on the left, left foot discomfort. The plan was an x-ray of the left foot and an MRI. Also planned was chiropractic therapy, physical therapy, medications, and no lifting greater than 15 pounds. On 10/07/13 he was seen again complaining of neck pain of 3-7/10, low back pain at 3-4/10 with a "aggravation of some pre-existing sciatica". He also had a left elbow strain and sprain. The medications were meloxicam and Flexeril. On physical exam he had tenderness in his neck and L-spine and in his upper extremity he had left elbow tenderness. Impression was similar diagnoses as above with strains and sprains, myofascial pain in a variety of areas in his cervical, thoracic and lumbar areas. It was felt these findings were all related to the 08/28/13 motor vehicle accident.

On 11/18/13 there is another neurosurgical evaluation by Dr. _____ for prior L4-5 abnormality. Surgery apparently was discussed in the past before this accident but not performed. No records on this are available for me. The MRI of 11/11/13 reportedly showed a grade I anterolisthesis of L5 on S1 with a

pars defect bilaterally at L5 and an L3-4 disc protrusion. The MRI of the C-spine reportedly showed problems at C3-4 and C7-T1. The impression was for posttraumatic lumbar sprain and strain, cervical sprain and strain, L5-S1 disc bulges and disc bulges at C3-4. He is referred for surgical evaluation but it is unclear what happened to that referral or where it was to. Reportedly he had sustained injury secondary to this automobile accident of 08/28/13. His prognosis was guarded and he was given a 13-percent whole body impairment rating with instructions not to lift greater than 15 pounds. On 11/20/13 there was a final medical evaluation which turned out not to be the final evaluation. He was complaining of persistent neck pain and low back pain at 3-5/10, left lower extremity sciatic pain increased with activity and the MRI findings were discussed. On 12/06/13 another final exam was done summarizing all the prior exams.

The claimant presented for a history and physical. He was very evasive and clearly not interested in participating in the evaluation completely. At first he refused stating he was not going to answer any questions and attempted to remain silent or to give non-answers to my questions initially. I advised him he could answer in any way he wanted. I advised him and he acknowledged that I was not there as his doctor today and would not give him any treatment recommendations. I advised him and he acknowledged that if I was causing any discomfort during the evaluation that he could simply tell me to stop and I would. He reported to my staff that he was feeling very sick. I confirmed that he felt able to proceed. He was not diaphoretic during the evaluation. He did have some episodes of belching during the evaluation. There was no flushing. He was not tachypneic during the evaluation. He was not off balance during the evaluation when walking from one place to the next.

He was not very specific with his answers and a number of questions had to be asked to try to clarify his symptoms. Ultimately he said that he had neck pain, back pain, and numbness and tingling in his hands. He says that his neck pain was worse with movement and that it led to difficulty sleeping. He says it occurs at night and during the day. He says it is often and usually present every day. He says it is on the back and the sides of his neck and is sharp in nature and with tingling in the neck. He said there are times when he will have pain that is "really bad" for one to two hours. It should be noted that obtaining this level of detail was very difficult as he would not answer questions directly and objected to the questions being asked at all. This is all recorded on video. He says the pain is worse when he rotates his neck from side to side while driving and that sometimes he has to stop and pull over and take a break from driving. He works as an Uber driver. He says the pain will occasionally go to his shoulders, but when asked if the pain travels from his neck he often ays "I don't know". In fact, when asked about his symptoms he often says "I don't know". He often says "I don't know" when asked about where he hurts, when he hurts, how he hurts, what causes things to get worse and better and what parts of his body hurt. He says he cannot provide specific dates even though he is told that he is not being asked for specific dates. Ultimately he says he has no pain on any other part of his body besides his neck and low back and hands. He reports that he has tingling in his hands bilaterally in all the fingers that typically wake him a half a dozen times at night. He seems to remember this quite well. He says this will also occur during the day when he is driving. He denies radiating pains into his arm although he does admit that occasionally he gets moments of weakness generally in his arms. He says he occasionally gets pain in his forearm when asked further about his symptoms. He says that he has low back pain just above the belt line as well as upper back pain which is lesser than the neck pain and low back pain. He says the neck pain and low back pain can be equally bad. The low back pain can occur lasting less than half a day several times a week. Again, getting this level of detail is very difficult and he is not very cooperative in answering these questions. He says pain is worse if he sits down and drives for too long. He says the low back pain used to go to his legs all the way down to the ankle area. He says he still gets occasional pain into his leg about twice a month. He says his leg pain is much better since surgery he had done. He says he cannot recall if he had any of these pain before the motor vehicle accident of 04/25/14. Again, he is

very evasive and objects to these questions. He says that his low back pain got worse after the motor vehicle accident. He finally admits that he had a motor vehicle accident in 08/2013, but claims that he had no pain before that accident and he says he does not believe he saw any doctors for pain prior to the 08/2013 accident. Again, he is very evasive. He says that his hand numbness and tingling began after the motor vehicle accident. He says he does not know if he had it before the accident. He says he never got any better following the motor vehicle accident of 04/2014 except with the surgery. He says after the motor vehicle accident in 11/2014 that he cannot recall if his pain has changed.

PAST MEDICAL HISTORY: Is otherwise negative.

MEDICATIONS: Are currently hydrocodone.

SOCIAL HISTORY: He is an Uber driver. He does not do any lifting or labor on the job. He says he has two small children he cares for and his primary concern everyday is putting food on the table for the children. He says he can no longer exercise. He said in 2012 he used to jog every day. He said he used to do lifeguard work in the 1990s, but has not done it since then.

REVIEW OF SYSTEMS: Is negative for any other complaints although he does report poor balance when he gets up at night with some leg weakness.

PHYSICAL EXAMINATION: He was reminded that if I was causing any discomfort during the evaluation that I would stop if he asked me to. He has tenderness to moderate palpation in the left and right SI joints and somewhat in the left lumbar paraspinous area and left periscapular area. He has some tenderness to moderate palpation in the left neck. He has decreased range of motion in his shoulders, but do not report pain with those motions above his head or behind his back with his hand. He produces 5/5 strengths in both upper and

lower extremities with 1+ DTRs throughout. He has decreased light touch in the right S1 distribution. He has multiple small white papular lesions on his feet that he says had been present for some time, but he does not know how long. His gait is steady.

MRI REVIEW:

I reviewed the MRIs on Mr. _____. The MRIs of the C-spine and L-spine were reviewed from 11/11/2013, 05/07/2014 and 12/24/2014. There was no significant difference among any of the scans. There are significant degenerative problems on all studies. It is clear that all of the problems pre-existed the automobile accident of 04/25/14. The cervical spine reveals loss of lordosis with cervical disc herniations or bulges at every single level from C3-4 to C7-T1. There is significant neuroforaminal stenosis bilaterally at C3-4 and some posterior ligamentum hypertrophy contributing to the stenosis. There is mild stenosis bilaterally at C5-6, moderate stenosis at C6-7 and C7-T1 bilaterally. In my opinion these are all pre-existing the accident.

The lumbar MRI demonstrates disc herniations at L1-2 down to L5-S1. The most severe are at L4-5 and L5-S1 with significant osteophyte formation. There is a grade I spondylolisthesis of L5 on S1. There is significant neuroforaminal stenosis bilaterally at L4-5 and L5-S1 and lateral recess stenosis. In my opinion, these findings are all pre-existing the automobile accident. There is no significant change between studies.

Based on these I believe the claimant would likely benefit from cervical and lumbar epidural steroid injections and physical therapy. If these failed then he may be a candidate for cervical discectomy at C3-4 with fusion. Another alternative would be a C3-C7 laminectomy with foraminotomies, instrumentation and fusion. The lumbar spine may respond to lumbar decompressive surgery from L3-S1 with laminectomies with mobilization of the spine to help with any ongoing leg symptoms. This may provide

indirect relief of back pain and ultimately he may require a fusion for back pain. However, none of these procedures would be necessary due to the automobile accident of 04/2014. All of these problems were pre-existing all of the automobile accidents mentioned here. His symptoms exacerbated temporarily in my opinion, and are consistent with the pain patterns he had before his automobile accident of 04/2014.

IMPRESSION: This claimant clearly had pre-existing sciatica before the automobile accident of 04/25/2014 as well as before the auto accident of 08/2013. In my opinion he had temporary exacerbation of symptoms following the automobile accident and there was no causal relationship between the 04/2014 accident and the surgeries he had performed on one date. In my opinion his neck and back pain were all pre-existing and there is no causal relationship between his chronic neck pain and back he has now. He was clearly having neck pain and back pain following the 08/2013 accident. He was clearly having sciatica before the 08/28/2013 accident.

He is very evasive about his current level of symptomatology and may have had a significant improvement. It does not appear that he is receiving medical care for this except for Vicodin. It does not appear that he has undergone any basic pain management such as facet injections in his neck or epidural steroid injections in his neck or physical therapy for his neck recently. I believe any medical care he needs for his neck and back are not related to the motor vehicle accident of 04/25/2014 and are simply related to his chronic degenerative spinal problems. I believe any further disability he has is not related to this motor vehicle accident. I believe the surgery he had done was mainly due to his pre-existing sciatica and disc problems.

My conclusions are reached based on reasonable degree of medical probability.

Sincerely,

David M. McKalip, MD

(Sample Note, some editing to the format of this original document was performed for confidentiality and clarity)

Billing Analysis Sample

By David McKalip, M.D.

April 27, 2016

CLAIMANT: _____

BILLING ANALYSIS

Dear Mr. _____:

As requested I performed a Billing Analysis on the surgery for _____.

On 09/09/14 he underwent a C3-4 anterior cervical discectomy with artificial disc replacement by Dr. _____ at the _____Surgery Center. Dr. _____ charged $28,842.00 using Code 22856 for the procedure. His assistant charged $5,768.40. These charges are vastly above what a common fee schedule would pay in the Tampa Bay Market. Using the common fee schedule he would likely receive for both he and his assistant $2,031.37. If he had contracts that were higher he may receive $2,539.22 if he was able to receive 125-pecent of the common fee schedule.

I have included an analysis in the form of an Excel Spreadsheet with this letter.

I also evaluated the Ambulatory Surgery Center charges. I used the Mobi-C Cervical Disc Reimbursement Guide. According to the company that makes the disc, single level cervical disc arthroplasties are approved for ambulatory surgery centers. In other words they will be paid using the common fee schedule. The common fee schedule would pay $3,759.00 for the surgery only at the ambulatory surgery center and not the implant. Of note, the implant bill was $16,200.00 but it is not clear what the cost of the surgery center was for that. Certainly there is a mark-up to consider.

The surgery center charged $36,000.00 for that procedure. Thus they charged 9.58 times the common fee schedule. Dr. _____ charged 17 times the common fee schedule. The analysis of the Ambulatory Surgery Center billing is also attached. I would be happy to review any further records. It should be noted that I do not routinely perform billing or procedures in ambulatory surgery centers. However, the guidance on this is pretty clearcut from the company that makes the product.

Sincerely,

David M. McKalip, MD

(Sample Note: some editing to the format of this original document was performed for confidentiality and clarity)

DAVID MCKALIP, M.D.
BRAIN AND SPINE SURGEON
Board Certified Neurological Surgeon

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INFORMATION, INSTRUCTIONS, CONSENT FOR YOUR IME, RELEASE OF RECORDS

I understand that I am agreeing to an Independent Medical Evaluation (IME), which means the doctor performing the evaluation is neither treating me nor an employee of whomever requested the IME (insurance company, third party administrator, attorney, governmental agency, employee, or physician.) I understand the purpose of the Independent Medical Evaluation is to provide a thorough, objective evaluation of the specific conditions related to my injury or illness which is in question, as well as prior or subsequent conditions that may affect it, and to answer whatever questions the requesting party has. This sheet outlines the process, my rights, and my responsibilities.

This IME is not a comprehensive medical examination. I understand that it will not provide advice or treatment to me or substitute for an evaluation or treatment by my regular treating doctor. I understand a patient/physician relationship is not established between the evaluating physician and me. Accordingly, there is no patient/physician privilege associated with this evaluation. Typically, a written report will be prepared summarizing today's evaluation and sent to the requesting party. If I would like a copy of that report, I will contact them.

I understand that generally the evaluations will begin with obtaining a history of how my problem began and what evaluation or treatment has been rendered since, utilizing information I provide verbally and on the history forms, as well as that contained within whatever records may be available for review. I will then be asked about my current symptoms and recount a relatively brief past medical history and other information such as my work status, etc. All information which I provide may be included in the report.

After the interview, a physical exam of the body will be conducted. **I understand that I need not perform any maneuver I feel might cause injury or worsening of my symptoms and I will immediately inform the examiner if anything he is doing is causing excessive discomfort so it can be stopped right away.** I understand some pain, stiffness and other symptoms are produced in most physicians' examinations of this sort and are helpful in understanding the condition. The IME, however, is not intended to cause injury or excessive pain. I understand

that in order to avoid that, I must fulfill my responsibility to inform the doctor if there is something I cannot do, a certain test is causing too much discomfort, or other concerns.

I also understanding that I will be permitted to have a chaperone present during the physical examination if I request it. Further, the doctor may bring a chaperone or other party into the room to assist him. It may be necessary to obtain additional x-rays or other diagnostic tests in order to answer certain questions. These may be performed here or at another facility but will not be ordered by the Doctor conducting this IME. These may be performed here or at another facility.

1. I hereby authorize Dr. McKalip to perform an impairment and/or Independent Medical Evaluation upon me and to release that information and the results of this IME (verbally or in writing) to any entity who has requested the IME.
2. I understand that this physician will not provide treatment to me and that a patient/physician relationship will not be created.
3. I hereby authorize any physician, hospital, medical attending, psychiatrist, psychologist, mental health counselor or the custodian of any file or records pertaining to me to furnish David M. McKalip, MD any and all documents or records in their possession with respect to any illness, injury, medical history, examination, consultation, prescription or treatment and to allow David M. McKalip, MD, to see and/or copy any x-rays or records or reports relating to me. This authorization includes the releases of all tests, test results, opinions, records, documents, and other information relating to any psychiatric, psychological, or other mental health examinations, treatment, including treatment for alcohol or drug use, counseling or evaluation relating to me. I hereby waive any privilege or right to have this information kept confidential, and I hereby consent to the release of this information to the above upon presentation of this authorization or photocopy thereof.

_____ _____ _____

Signature Date Printed Name

_____ _____ _____

Witness Signature Date Printed Name

MEMORANDUM OF UNDERSTANDING

RE: _____

This Memorandum describes the terms of the relationship between David McKalip, M.D. and the attorney, company or representative (AKA "the Party") seeking his services. It is understood and agreed by and between David McKalip, M.D. (Dr. McKalip) and _____ (Party) that the Party has asked for certain expert medical services in the form of medical records review, possible testing of claimant/plaintiff, evaluation and expert opinions from Dr. McKalip in conjunction with the Party's client,_____ _____, and Dr. McKalip has agreed to render those services within the confines of the statutory, regulatory and common law schemes of the State of Georgia governing the practice of medicine and within the standards of good medical practice. The parties hereto agree that Dr. McKalip has not been asked to provide any medical treatment to the plaintiff/claimant nor will he provide any such treatment, in other words, no doctor/ patient relationship exists or shall exist between Dr. McKalip and these claimants/plaintiffs referred by the Party on behalf of the client. Dr. McKalip's sole function is to test, evaluate and, where appropriate, give testimony on behalf of the Party's client.

It is agreed between Dr. McKalip and the Party that the Party and client shall be responsible for the payment of Dr. McKalip's fees and expenses as the same shall be incurred and billed to the Party from time to time. Dr. McKalip will bill for his time as indicated in the attached fee schedule. All out of pocket expenses will be additional. It shall be required that payment be received in advance for the time required for any service provided. In addition, it is understood and agreed that scheduled services will not be provided without prepayment without the express written consent of Dr. McKalip. It is understood and agreed that unless otherwise stated in writing, all fees paid are nonrefundable. It is understood and agreed that scheduling of time represents an opportunity loss for the medical practice of Dr. McKalip. It is understood and agreed that services will not be scheduled without prepayment of fees in a nonrefundable fashion.

Further, the Party and client agree to pay each of Dr. McKalip's bills or invoices within 30 days of the date shown on such bill or invoice. In the event that Dr. McKalip's bills or invoices remain unpaid for 30 days after the date shown on such bill or invoice, then Dr. McKalip may withdraw his services in any and all matters involving client by giving notice either orally or in writing to the Party at the Party's last known address or telephone number. Withdrawal by Dr. McKalip shall be considered complete upon giving of such notice.

It is also understood and agreed that the Party's office will be responsible for ensuring all medical records and films are available in Dr. McKalip's office prior to the services to be performed. In addition, in cases of Independent Medical Evaluation (IME) and legal records reviews, the Party will provide a list of questions to be answered by Dr. McKalip.

On occasion, other parties involved in proceedings relating to the case under review may dispute the fees charged and collected by Dr. McKalip. They may seek relief from the court and an order from the court to alter the fee schedule used by Dr. McKalip. Party agrees that when charges for services are in dispute by another party ("Disputing Party"), they will:

1. Seek to work with the Disputing Party to prevent a motion from reaching the court on the matter.

2. Alert the Disputing Party that they will pay the difference relating to disputed fees.

3. Notify Dr. McKalip within one week of their awareness of the dispute.

4. Forward any motions or court orders on the dispute to Dr. McKalip within one week.

5. Agree to pay the difference of the fees in dispute to Dr. McKalip for disputed work performed. For example, if the work is for 2 hours of record review at
$1,500, and the Disputing Party agrees to only $500, the Party engaging Dr. McKalip for his services (the "Party") will pay the additional $1,000.

6. Agree to pay all fees described under this paragraph in advance and in a non- refundable fashion.

7. Acknowledge that disputed work will be postponed or cancelled until full payment is received.

Party agrees that should Dr. McKalip withdraw from any case for nonpayment of a bill then the Party will not and may not require Dr. McKalip's presence for the purposes of giving a deposition or testimony concerning the Party's client referenced herein.

Agreed this _____day of_____, 20_____.

_____

Party

_____

David McKalip, M.D.