IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,

v.

NEIL K. ANAND, M.D.,
Defendant.

Case No. 2:19-cr-00518-CFK

ORDER

AND NOW, this ____ day of _____, 2026, upon consideration of Defendant's Motion for Reconsideration of the Court's July 14, 2026 Order (ECF No. 803) and July 23, 2026 Order (ECF No. 811), or in the Alternative, for an Indicative Ruling Under Federal Rule of Criminal Procedure 37, IT IS HEREBY ORDERED as follows (check one):

_____ **(A)** ECF Nos. 803 and 811 are VACATED, and the Court will rule on the merits of ECF Nos. 801 and 810 by separate Order.

_____ **(B)** ECF Nos. 803 and 811 are VACATED as to Defendant's claim regarding the truthfulness of the prosecutor's representations to this Court, and the Court will rule on that claim by separate Order.

_____ **(C)** The Motion is DENIED because the Court lacks authority to grant relief while Defendant's appeal to the Third Circuit remains pending.

_____ **(D)** Pursuant to Fed. R. Crim. P. 37(a)(3), the Court states that it would grant the Motion on remand, or that the Motion raises a substantial issue, so that Defendant may seek a limited remand under Fed. R. App. P. 12.1.

IT IS SO ORDERED.

_____
HON. CHAD F. KENNEY
United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,

v.

NEIL K. ANAND, M.D.,

Defendant.

Case No. 2:19-cr-00518-CFK

DEFENDANT'S MOTION FOR RECONSIDERATION OF THE COURT'S JULY 14, 2026 AND JULY 23, 2026 ORDERS (ECF NOS. 803 AND 811) STRIKING DEFENDANT'S MOTIONS TO PERFECT THE APPELLATE RECORD (ECF NOS. 801 AND 810), OR IN THE ALTERNATIVE, FOR AN INDICATIVE RULING UNDER FEDERAL RULE OF CRIMINAL PROCEDURE 37

I. INTRODUCTION

Dr. Neil K. Anand respectfully moves this Court to reconsider its July 14, 2026 Order (ECF No. 803) and its July 23, 2026 Order (ECF No. 811), which struck Defendant's Motion to Perfect the Appellate Record Under Rule 29 and *Hazel-Atlas Glass Co. v. Hartford-Empire Co.*, 322 U.S. 238 (1944) (ECF No. 801, attached hereto as Exhibit A)[1], and Defendant's motion, filed

[1]The caption of ECF No. 801, attached as Exhibit A, mistakenly referenced Case No. 26-1359 — rather than the pending direct appeal, Nos. 25-2804 and 25-2902. That clerical error was only partially corrected in the caption of ECF No. 810, attached as Exhibit B, which retained 26-1359 in error and added 25-2804 but not 25-2902. The error had no bearing on either Order now before the Court: ECF No. 803 correctly identified the pending appeal as "United States v. Anand, Nos. 25-2804 & 25-2902 (3d Cir.)," ECF No. 803 at 1 n.1, and ECF No. 811 struck ECF No. 810 on the same Griggs/Batka grounds as ECF No. 803.

under the mistaken belief that ECF No. 801 had not reached the Clerk's Office (ECF No. 810, attached hereto as Exhibit B), respectively, as "improper." ECF No. 803 at 1 n.1; ECF No. 811 at 1 n.1.

Defendant seeks reconsideration of the Court's Orders (ECF Nos. 803 and 811), not resurrection of the underlying motions those Orders struck (ECF Nos. 801 and 810, respectively). An order that strikes a filing is itself a ruling of this Court, and remains subject to reconsideration even though the filings were stricken.

The Court's Orders rest on the same two grounds. First, the Court concluded that Defendant's characterization of his motion as one to "perfect the appellate record" mischaracterized its substance, reasoning that "'[p]erfecting' an appeal refers to the process of taking all the requisite procedural steps to file an appeal," and that Defendant therefore had "not presented a proper basis for a post-conviction motion." ECF No. 803 at 1 n.1; ECF No. 811 at 1 n.1 (striking ECF No. 810 "for the same reasons"). Second, the Court held that it lacked jurisdiction to address "arguments that relate to the sufficiency of the evidence presented at his trial and to his conviction," citing *Griggs v. Provident Consumer Disc. Co.*, 459 U.S. 56, 58 (1982), and *United States v. Batka*, 916 F.2d 118, 120 (3d Cir. 1990). *Id.* Neither Order addresses, distinguishes, or otherwise mentions *Hazel-Atlas*, the doctrine of fraud upon the court, or any concern arising from the truthfulness of the prosecutor's own representations to this Court at the April 8, 2025 proceeding. Defendant respectfully submits that reconsideration of both Orders is warranted for three independent reasons, any one of which is sufficient grounds for relief.

First, and most directly, striking Defendant's motions was not among the options available to the Court once it concluded it lacked authority to grant relief because of the pending

appeal. Striking a motion as categorically improper — the course the Court took twice — is not among the options Rule 37(a) provides. As the Supreme Court has held, a district court that lacks authority to grant relief because of a pending appeal nonetheless has jurisdiction to entertain the motion and "either deny the motion on its merits or certify its intention to grant the motion to the Court of Appeals, which could then entertain a motion to remand the case." United States v. Cronic, 466 U.S. 648, 667 n.42 (1984).

Second, and in the alternative, the Court's Orders address a different claim than the one Defendant actually raised, and the divestiture principle they invoke does not, by its own terms, reach that claim. The Court's jurisdictional holding is expressly limited to "arguments that relate to the sufficiency of the evidence," ECF No. 803 at 1 n.1, and *Griggs* divests this Court only of authority over "aspects of the case involved in the appeal." *Griggs*, 459 U.S. at 58. Defendant's motion does not ask this Court to reweigh the evidence; it alleges that the prosecutor made specific representations of fact directly to this Court that were, according to the government's own records, false — a claim most precisely understood as one arising under the Due Process Clause of the Fifth Amendment, distinct from an argument about the sufficiency of the evidence or a matter properly understood as "involved in" the pending appeal.

Third, and further in the alternative, the general divestiture principle recognized in Griggs does not deprive this Court of the authority to entertain — as distinct from grant relief on — a motion asserting fraud upon the court under Hazel-Atlas. The Supreme Court has squarely held that a district court may entertain such a motion without leave of the appellate court, in both the civil and criminal contexts. Standard Oil Co. of California v. United States, 429 U.S. 17, 18 (1976) (per curiam); United States v. Cronic, 466 U.S. 648, 667 n.42 (1984)."

Defendant therefore respectfully requests that this Court either (A) reconsider its Orders and rule upon the merits of the underlying Hazel-Atlas motion directly; (B) reconsider its Orders on the ground that they did not address Defendant's actual claim; or (C), if the Court adheres to its position that it lacks authority to reach the merits because of the pending appeal, deny the motion on that ground. In the alternative, Defendant requests (D) an indicative ruling under Rule 37(a)(3) so that Defendant may seek a limited remand from the Third Circuit pursuant to Federal Rule of Appellate Procedure 12.1.

II. PROCEDURAL BACKGROUND

On April 8, 2025, this Court conducted a bench proceeding pursuant to Federal Rule of Criminal Procedure 29 to determine whether sufficient evidence existed to sustain Defendant's conviction. Defendant's motion for judgment of acquittal was denied. Defendant's direct appeal from his conviction is currently pending before the United States Court of Appeals for the Third Circuit under Nos. 25-2804 and 25-2902. See ECF No. 803 at 1 n.1.

On July 7, 2026, Defendant filed, pro se, his Motion to Perfect the Appellate Record Under Rule 29 and *Hazel-Atlas Glass Co. v. Hartford-Empire Co.*, 322 U.S. 238 (1944) (ECF No. 801, attached hereto as Exhibit A), asserting that lead prosecutor Paul J. Koob made four materially false representations of fact directly to this Court during the April 8, 2025 Rule 29 proceeding, and that each representation was objectively refuted by the government's own records and known to be false by Paul J. Koob.

On July 14, 2026, this Court entered an Order (ECF No. 803) striking Defendant's motion as improper, on the two grounds set forth above. Neither ground mentions *Hazel-Atlas*, the doctrine of fraud upon the court, or the truthfulness of the prosecutor's own representations to this Court.

Believing, based on information conveyed to him, that the Clerk's Office had not received ECF No. 801, Defendant filed a pro se Motion to Preserve the Appellate Record Under the Prison Mailbox Rule (ECF No. 808), indicating that he was refiling the same motion out of caution. That refiled motion was docketed as ECF No. 810 (attached hereto as Exhibit B). The Court subsequently confirmed that ECF No. 801 had in fact been received and docketed, and that the Court had already ruled on it. See ECF No. 811 at 1 n.1.

On July 23, 2026, the Court entered a second Order (ECF No. 811) striking ECF No. 810 "for the same reasons" as ECF No. 803 — namely, the same *Griggs/Batka* jurisdictional rationale — and further noting that ECF No. 810 was "essentially the same" as ECF No. 801, on which the Court had already ruled. As with ECF No. 803, ECF No. 811 does not address, distinguish, or otherwise mention *Hazel-Atlas*, the doctrine of fraud upon the court, or the truthfulness of the prosecutor's representations to this Court.

III. LEGAL STANDARD FOR RECONSIDERATION

The Orders at issue here — striking Defendant's motions, rather than adjudicating them on the merits — are interlocutory. This Circuit has squarely held, in a criminal case, that a district court possesses inherent power to reconsider its own interlocutory orders "whether the case sub judice be civil or criminal," so long as it retains jurisdiction, and "can reconsider them when it is consonant with justice to do so." *United States v. Jerry*, 487 F.2d 600, 605 (3d Cir. 1973). As explained in *Jerry*, nothing in the Federal Rules of Criminal Procedure forecloses this power; to the contrary, Rule 57(b) confirms that "[i]f no procedure is specifically prescribed by rule, the court may proceed in any lawful manner not inconsistent with these rules," and "the power to

grant relief from erroneous interlocutory orders... has long been recognized as within the plenary power of courts until entry of final judgment." *Id.* at 604.

This Circuit has separately recognized that where reconsideration is instead sought of a final judgment, the movant must show: (1) an intervening change in the controlling law; (2) the availability of new evidence not previously available; or (3) the need to correct a clear error of law or fact or to prevent manifest injustice. *Max's Seafood Cafe ex rel. Lou-Ann, Inc. v. Quinteros*, 176 F.3d 669, 677 (3d Cir. 1999) (citing *North River Ins. Co. v. CIGNA Reinsurance Co.*, 52 F.3d 1194, 1218 (3d Cir. 1995)). Defendant submits that reconsideration is warranted under either standard: the Court's Orders rest on a clear error of law in applying Rule 37(a) and the *Griggs/Batka* divestiture rule without regard to its well-established exceptions, discussed below, and, independently, reconsideration of these interlocutory orders is consonant with justice given the gravity of the fraud allegations Defendant's underlying motion raises.

This motion does not seek to relitigate the merits of those allegations, but their gravity bears directly on whether reconsideration is necessary to prevent manifest injustice. Defendant's underlying motion identifies four specific instances in which representations made directly to this Court at the April 8, 2025 Rule 29 proceeding are, according to the government's own records, demonstrably false. See ECF No. 801 at 4-18. Those allegations remain unaddressed. Whatever their ultimate merit, an order foreclosing judicial consideration of a colorable claim that a federal prosecutor made knowing misrepresentations to this Court during a dispositive proceeding works precisely the kind of manifest injustice the reconsideration standard exists to prevent.

The government suffers no prejudice from reconsideration. Despite the seriousness of the allegations, the government never filed any response addressing Defendant's fraud claims in

either ECF No. 801 or ECF No. 810 before this Court struck them. Since the government never responded to these motions, it would not be prejudiced by their reconsideration now.

IV. ARGUMENT

A. Federal Rule of Criminal Procedure 37 — Not Outright Dismissal — Governs Where the Court Believes It Lacks Authority to Act, and Applies Equally to Both Orders.

Even assuming Defendant's claim falls within the scope of arguments over which the Court has disclaimed jurisdiction, the proper course was not to strike either motion as improper. Federal Rule of Criminal Procedure 37(a) provides:

"If a timely motion is made for relief that the court lacks authority to grant because of an appeal that has been docketed and is pending, the court may: (1) defer considering the motion; (2) deny the motion; or (3) state either that it would grant the motion if the court of appeals remands for that purpose or that the motion raises a substantial issue."

Rule 37 formalizes what this Circuit and the Supreme Court had already recognized as the required practice. In *United States v. Cronic*, 466 U.S. 648 (1984), the Supreme Court confronted precisely this scenario: a district court denied a Rule 33 motion for lack of jurisdiction because the case was pending on direct appeal at the time. The Supreme Court held that "that ruling was erroneous," explaining that "[t]he District Court had jurisdiction to entertain the motion and either deny the motion on its merits or certify its intention to grant the motion to the Court of Appeals, which could then entertain a motion to remand the case." *Id.* at 667 n.42 (collecting cases).

This Circuit's own precedent confirms the same principle, including in the criminal context. In *Venen v. Sweet*, 758 F.2d 117, 122 (3d Cir. 1985), the Third Circuit described the settled practice that "[m]ost Courts of Appeals hold that while an appeal is pending, a district court, without

permission of the appellate court, has the power both to entertain and to deny" a post-judgment motion, and that if the district court is inclined to grant the motion, "it should certify its inclination or its intention to the appellate court which can then entertain a motion to remand the case." *Venen* further quoted its own precedent for the proposition that "the proper procedure is for [the movant] to file his motion in the District Court. If that court indicates that it will grant the motion, the [movant] should then make a motion in this [Court of Appeals] for a remand of the case." *Id.* (quoting *Main Line Fed. Sav. & Loan Ass'n v. Tri-Kell, Inc.*, 721 F.2d 904, 906 (3d Cir. 1983), which in turn quoted *Smith v. Pollin*, 194 F.2d 349, 350 (D.C. Cir. 1952)).

Even *United States v. Batka*, 916 F.2d 118 (3d Cir. 1990) — the very case this Court relied upon in striking both of Defendant's motions — recognized this same alternative. There, the Third Circuit observed that "[c]onceivably while an appeal is pending a district court could hear a motion... and, if inclined to grant it, certify its inclination or intention to the court of appeals, which could then entertain a motion to remand the case," and further noted that "it might be desirable to have such a procedure." *Id.* at 120 n.5.

Federal Rule of Appellate Procedure 12.1 confirms that the certify-and-remand mechanism applies broadly — to "any motion that the district court cannot grant because of a pending appeal," including a fraud allegation surfacing while an appeal is pending. Fed. R. App. P. 12.1 advisory committee's note (2009). The commentary is not limited to Rule 33 or Rule 35(b) motions; it expressly states that "Rule 12.1 does not attempt to define the circumstances in which an appeal limits or defeats the district court's authority to act in the face of a pending appeal." *Id.* Defendant's motion — alleging that the prosecutor committed fraud on this Court — fits squarely within the kind of situation Rule 12.1 was written to address.

This point applies with equal force to both Orders now before the Court. ECF No. 811 struck ECF No. 810 "for the same reasons" as ECF No. 803 — the same *Griggs/Batka* jurisdictional rationale — so the error identified here was not cured between ECF No. 801 and ECF No. 810; it was simply repeated. Because striking Defendant's motions outright was not among the three options Rule 37(a) affords, both Orders should be reconsidered, and the Court should instead proceed under Rule 37(a).

B. In the Alternative, the Court's Orders Address a Different Claim Than the One Defendant Actually Raised.

The Court's Orders treat Defendant's motions as an ordinary post-conviction attack on his conviction, reasoning that "perfecting" an appeal "refers to the process of taking all the requisite procedural steps to file an appeal," and that Defendant therefore "has not presented a proper basis for a post-conviction motion." ECF No. 803 at 1 n.1. Based on that characterization, the Court held that it lacked jurisdiction to address "arguments that relate to the sufficiency of the evidence presented at his trial and to his conviction." *Id.* (citing *Griggs*, 459 U.S. at 58, and *Batka*, 916 F.2d at 120).

Defendant's motions, however, do not ask this Court to reweigh the trial evidence or reconsider whether a rational factfinder could have convicted him. They allege that the prosecutor made four specific, discrete, and materially false representations of fact directly to this Court at the April 8, 2025 Rule 29 proceeding — representations that, according to the government's own records, were false, and that this Court relied upon in denying the motion for acquittal. See ECF No. 801 at 4-18. A claim that the prosecutor's own representations to the Court were knowingly false is a claim about the integrity of the proceeding itself. It is analytically distinct from an argument that the trial evidence was legally insufficient to convict. The prosecutor — an officer

of this Court, bound by heightened duties of candor — corrupted this proceeding through knowing misrepresentations made where no cross-examination was possible.

Indeed, Defendant's claim is most precisely characterized as a violation of due process under the Fifth Amendment — a theory independent of, and requiring no resort to, the equitable fraud-upon-the-court doctrine (addressed below). A prosecutor's obligation is not "that it shall win a case, but that justice shall be done," and he is "as much" obligated "to refrain from improper methods calculated to produce a wrongful conviction as... to use every legitimate means to bring about a just one." *Berger v. United States*, 295 U.S. 78, 88 (1935). This principle is not confined to representations made before a jury: a judicial decision resting on materially false information violates due process even where no jury is involved and even absent a showing of deliberate wrongdoing. *Townsend v. Burke*, 334 U.S. 736, 741 (1948) (a sentence imposed "on the basis of assumptions... which were materially untrue" is "inconsistent with due process of law," "whether caused by carelessness or design"); *United States v. Tucker*, 404 U.S. 443, 447-49 (1972) (extending *Townsend* to federal sentencing based on constitutionally invalid information). This theory rests on the Fifth Amendment, not on any inherent equitable power to vacate a judgment.

Because the Court's jurisdictional holding was, by its own terms, limited to "arguments that relate to the sufficiency of the evidence," ECF No. 803 at 1 n.1, that holding does not resolve — and neither Order otherwise addresses — Defendant's separate and distinct claim regarding the truthfulness of the prosecutor's own representations to this Court. Reconsideration is warranted so that this claim may be addressed on its own terms, whether by this Court directly or through the certify-and-remand procedure Federal Rule of Criminal Procedure 37 provides.

This conclusion follows independently from the divestiture principle's own terms. *Griggs* divests a district court only of "control over those aspects of the case involved in the appeal." *Griggs*, 459 U.S. at 58 (emphasis added). Koob — an officer of this Court — fabricated representations directly to this Court at the April 8, 2025 Rule 29 proceeding. That fabrication goes to the integrity of a proceeding this Court itself conducted. *Griggs* and *Batka* therefore do not divest this Court of authority to consider it.

C. In the Alternative, This Court May Entertain Defendant's *Hazel-Atlas* Motion Without Leave of the Third Circuit.

The general rule that a notice of appeal "divests the district court of its control over those aspects of the case involved in the appeal," *Griggs*, 459 U.S. at 58, is not absolute. It does not bar a district court from entertaining — as opposed to granting relief on — a motion addressed to the integrity of the judicial process itself. In *Standard Oil Co. of California v. United States*, 429 U.S. 17 (1976) (per curiam), the Supreme Court held that a district court may entertain a Rule 60(b) motion alleging fraud by government counsel without leave of the appellate court, because "the appellate mandate relates to the record and issues then before the court, and does not purport to deal with possible later events." *Id.* at 18.

Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944), and Chambers v. NASCO, Inc., 501 U.S. 32 (1991), recognize a federal court's inherent power to vacate a judgment procured by fraud upon the court. In *United States v. Washington*, 549 F.3d 905, 912 (3d Cir. 2008), this Court held that both *Hazel-Atlas* and *Chambers* are civil cases, and that it was unaware of any "long unquestioned" power of federal district courts to vacate a judgment procured by fraud in the criminal context.

Washington addresses a different legal theory (inherent equitable power) than the one Defendant's due process claim invokes (a direct constitutional violation), and the identity of the alleged wrongdoer — the prosecutor, an officer of the court, rather than the defendant — underscores why this is a distinct claim. In *Washington*, the fraud at issue was committed by the defendant himself, who lied about his own identity to the court, probation officers, and federal agents to conceal his criminal history. Here, by contrast, the misrepresentations at issue were made by the prosecutor — an officer of the court bound by heightened duties of candor to the tribunal — directly to this Court at a proceeding where no cross-examination of his representations was possible.

This equitable power is preserved by Rule 60(d)(3), which provides that Rule 60 "does not limit a court's power to... set aside a judgment for fraud on the court" — a provision the Advisory Committee adopted specifically to preserve the authority recognized in *Hazel-Atlas* itself. Fed. R. Civ. P. 60(d)(3) advisory committee's note (1946). This independence from ordinary time limits reflects the same principle underlying *Standard Oil*, *supra*: fraud upon the court is treated as a matter apart from the ordinary progression of a case, unconnected to whatever procedural posture — including a pending appeal — the underlying case otherwise occupies.

For the foregoing reasons, the Rule 37 procedure discussed above provides a basis for relief that does not require resort to any theory of inherent equitable authority. This section provides an alternative ground for relief, applicable only if Rule 37 does not independently resolve the motion.

V. CONCLUSION

For the foregoing reasons, Defendant Neil K. Anand respectfully requests that this Court reconsider its July 14, 2026 Order (ECF No. 803) and its July 23, 2026 Order (ECF No. 811),

and (A) rule upon the merits of Defendant's Motion to Perfect the Appellate Record Under Rule 29 and Hazel-Atlas directly; (B) recognize that Defendant's claim regarding the truthfulness of the prosecutor's representations to this Court is different from — and was never addressed by — the Court's ruling that it lacked jurisdiction to address "arguments that relate to the sufficiency of the evidence presented at his trial and to his conviction," ECF No. 803 at 1 n.1; or (C), if the Court adheres to its position that it lacks authority to reach the merits of Defendant's claim while the appeal remains pending, deny the motion on that basis. In the alternative, Defendant requests (D) an indicative ruling pursuant to Federal Rule of Criminal Procedure 37(a)(3), stating either that it would grant the motion upon remand or that the motion raises a substantial issue, so that Defendant may seek a limited remand from the United States Court of Appeals for the Third Circuit pursuant to Federal Rule of Appellate Procedure 12.1.

Respectfully submitted,

Neil Anand

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EXHIBIT A

Defendant's Motion to Perfect the Appellate Record Under Rule 29 and

Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)

(ECF No. 801, filed July 7, 2026)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,

v.

NEIL K. ANAND, M.D.,
Defendant.

Case No. 2:19-cr-00518-CFK

MOTION TO PERFECT THE APPELLATE RECORD UNDER RULE 29 AND HAZEL-ATLAS GLASS CO. v. HARTFORD-EMPIRE CO., 322 U.S. 238 (1944)

I. INTRODUCTION

Dr. Neil K. Anand respectfully moves this Court pursuant to Federal Rule of Criminal Procedure 29 and this Court's inherent authority under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)*, to perfect the appellate record regarding this Court's April 8, 2025 denial of his Motion for Judgment of Acquittal and to preserve these issues for review by the Third Circuit in Case No. 26-1359.

This Motion is filed solely to perfect the appellate record and preserve these issues for the Third Circuit's review. Because the integrity of the judicial process itself was compromised during a dispositive proceeding before this Court, it is imperative that this evidence be formally preserved in the record for appellate review.

On April 8, 2025, during Rule 29 proceeding — the dispositive bench proceeding where Judge Kenney alone, with no jury present, was deciding whether sufficient evidence existed to sustain the conviction — lead prosecutor Paul J. Koob took the perjured testimony from trial and repeated it directly to the judge as established fact. He did not stop there. He presented a fabricated account to this Court as eyewitness proof that Dr. Anand forced patients to accept medically unnecessary "Goody Bags" of medications in exchange for opioid prescriptions written outside the usual course of professional practice and without a legitimate medical

purpose. He misrepresented the legitimacy of non-opioid medications dispensed to patients. Each statement was made directly to this Court. Each was objectively refuted by the government's records. Each was known to be false by the prosecutor who made it.

These were not arguments. They were not inferences. They were false representations of fact, stated as established truth, refuted by government records— delivered to this Court at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction, during a proceeding where no jury was present, no cross-examination of the prosecutor's representations was possible, and the integrity of the proceeding depended entirely on the prosecutor telling the truth.

That escalation — from perjury before a jury to false statements directly to this Court during a dispositive bench proceeding — is the transformation from a professional conduct violation into fraud upon the court under *Hazel-Atlas*. Fraud upon the court requires conduct directed at the judicial machinery itself — not merely at deceiving the opposing party or the jury, but at corrupting the proceeding by which the court performs its impartial function. When a prosecutor stands before a judge at Rule 29 and makes false factual representations about the content of the evidence — with no jury present, no cross-examination possible, and the judge's ruling determining whether the conviction stands or falls entirely — he is not making an argument. He is corrupting the proceeding by which this Court performs its impartial function.

These were not misrepresentations about peripheral details. They were false statements to sustain the conviction: that Dr. Anand was prescribing outside the usual course of professional practice; that patients were coerced into accepting non-opioid medications as a condition of receiving their prescriptions; that pre-signed blank prescriptions were being handed to unlicensed staff and that the patient documentation contained no basis for prescribing opioids. Koob made false representations — directly to this Court, at the precise moment it was determining whether sufficient evidence existed to sustain the conviction.

He told this Court that the documentation contained no basis for prescribing opioids — while holding patient files containing objective diagnostic proof: MRI reports showing spinal stenosis,

EMG reports confirming radiculopathy, and a neurosurgeon's written determination of ongoing and indefinite pain management. Each of these statements was made directly to this Court — not to a jury — during a proceeding where the judge was making a legal determination and where no cross-examination of the prosecutor's factual representations was possible.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present fabricated accounts directly to this Court — the sole decision-maker at Rule 29 — as established facts supporting denial of acquittal, in a proceeding where there was no mechanism to cross-examine his representations and where this Court was entirely dependent on his accuracy.

The elements that this motion establishes are: (1) a false representation (2) made directly to the tribunal (3) during a dispositive proceeding (4) that the prosecutor knew to be false (5) that was objectively provable as false from the government's own files, and (6) that undermined this Court's ability to perform its impartial truth-seeking function. A pattern of deliberate repetition during the April 8, 2025 Rule 29 proceeding satisfies *Hazel-Atlas's* requirement of a 'deliberately planned and carefully executed scheme.' 322 U.S. at 245.

Each of these elements is established by the government's own records. This motion is filed to preserve these issues for review by the Third Circuit in Case No. 26-1359 pursuant to this Court's inherent authority under *Hazel-Atlas* and Federal Rule of Criminal Procedure 29.

II. LEGAL STANDARDS

Federal Rule of Criminal Procedure 29 provides that the Court must enter a judgment of acquittal of any offense for which the evidence is insufficient to sustain a conviction. A post-verdict Rule 29 motion requires the Court to determine whether any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt. *Jackson v. Virginia*, 443 U.S. 307, 319 (1979). The Third Circuit reviews the denial of a Rule 29 motion de novo. *United States v. Caraballo-Rodriguez*, 726 F.3d 418, 424 (3d Cir. 2013).

Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944), establishes that a court has inherent authority to vacate a judgment procured through fraud upon the court. Fraud upon the court requires conduct directed at the judicial machinery itself — conduct that corrupts the impartial function of the proceeding. Unlike ordinary fraud, fraud upon the court has no limitations period and may be raised at any time. Id. at 244–45. The standard requires a "deliberately planned and carefully executed scheme" to defraud the court. Id. at 245.

Napue v. Illinois, 360 U.S. 264 (1959), holds that the government's knowing use of false testimony violates due process. The *Hazel-Atlas* standard is distinct from and broader than *Napue*: while *Napue* addresses false testimony presented to a jury, *Hazel-Atlas* addresses false representations made directly to the court itself during proceedings where the court is the sole decision-maker. The prosecutor's conduct here falls squarely within *Hazel-Atlas* because his false representations were made not to a jury but to this Court as the sole arbiter of the Rule 29 motion.

III. FALSE STATEMENT ONE: THE GLASGOW FABRICATION

A. What Koob Told This Court

On April 8, 2025, during Rule 29 proceedings with no jury present and this Court serving as the sole arbiter of evidentiary sufficiency, lead prosecutor Koob made the following direct representation to this Court:

"Frederick Glasgow specifically said he watched him sit there, sign and stamp a whole pad, and allowing these unlicensed folks to fill out drugs that are going out the door." (Tr. 2357:21–23.)

Koob attributed this account to Glasgow by name. The word "specifically" was deliberate — it conveyed precision, accuracy, and direct eyewitness observation of criminal conduct.

B. What Glasgow Actually Testified

Glasgow's complete testimony on this subject is a single answer to a single question on direct examination at Day 3, Tr. 454:6–13. The government asked:

Q: Did you ever see Dr. Anand sign or stamp prescriptions that weren't for you?

A: Yeah.

Q: Can you tell us about that?

A: One day I walked back to the back that — there was I guess an exam room in the back there, past his office. And he was sitting at his desk just signing and stamping a book of prescriptions.

C. The Three Fabricated Elements

Koob fabricated three elements that do not exist anywhere in Glasgow's testimony and that transform an innocent description into a federal crime:

"Whole pad." Glasgow said "a book of prescriptions." Koob changed it to "a whole pad." A physician sitting at his desk signing a book of prescriptions is doing medical paperwork — completing patient-specific prescriptions that have already been prepared. A whole pad is a blank pad of prescription forms being pre-signed for others to fill in later. The substitution transforms lawful medical documentation into a criminal pre-signing scheme. Glasgow never used that word. Koob invented it.

"Unlicensed folks to fill out drugs." Glasgow said nothing about unlicensed staff. He said nothing about anyone filling out anything. That entire element — which describes the criminal act itself — was invented by Koob and attributed to Glasgow by name before this Court. No version of Glasgow's testimony, on any day of trial, contains this description.

"Going out the door." Glasgow said nothing about drugs going anywhere. That phrase does not appear in Glasgow's testimony. It does not appear anywhere in the record as a statement attributed to Glasgow. Koob fabricated it entirely.

What Glasgow actually described — a physician at his desk doing paperwork — is consistent with ordinary medical practice. What Koob told this Court Glasgow described — a physician

pre-signing blank pads for unlicensed staff to fill out and send out the door — is a federal crime. The difference between those two accounts is not interpretation or emphasis. It is fabrication.

D. Physical Evidence Independently Confirms the Fabrication

The government produced thousands of pages of patient file records bearing PT_FILES bates numbers. Not one blank pre-signed prescription form appears anywhere in that production. The photographs in evidence — including PT_FILES_003641 (Gage), PT_FILES_004521 (Glasgow), PT_FILES_005110, PT_FILES_005252 (Lynch), PT_FILES_006781 (Rios), PT_FILES_009047 (Scicluna), and PT_FILES_010379 (Stevenson), attached as Exhibit NA-1— show fully completed patient-specific prescriptions clearly showing the scripts were not pre-signed. PT_FILES_010379 shows a prescription pad recovered from Stevenson's patient file — and not one script on that pad is pre-signed. A pre-signed script bears a signature on a blank form with no patient information. Not one such form exists anywhere in the government's production. Koob held this entire production when he told Judge Kenney that pre-signed scripts were given to scribes to write prescriptions.

E. Materiality: Koob's Own Words Establish It

On the morning of April 9, 2025, this Court acquitted co-defendant Viktoriya Makarova. Koob immediately moved for reconsideration at sidebar, stating at Trial Tr. 2471:25 – 2472:4 *"With respect to the prescriptions, it's the presigning is the issue. As the Court heard at sidebar, presigning and having somebody look at it later is not the law, that is not allowed."*

This Court denied reconsideration. The only presigning evidence Koob had attributed to Dr. Anand during Rule 29 was the Glasgow fabrication. Presenting a fabricated account as established fact to the sole decision-maker at a dispositive proceeding corrupted the integrity of that proceeding.

F. Why This Is Fraud Upon the Court

When Koob said "Frederick Glasgow specifically said" — that was a factual representation about the content of the evidentiary record, not an argument, not an inference, not advocacy. The word

"specifically" is a direct claim of accuracy — it tells this Court: I am not paraphrasing, I am not inferring, I am telling you exactly what this witness said. That statement is objectively and verifiably false. The fabricated words — whole pad, unlicensed folks, going out the door — Glasgow never said any of it.

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — the patient prescription records produced in discovery contained not one blank pre-signed form, and Koob held every one of those records when he made this representation (5) that is objectively provable as false from the trial transcript itself, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present a fabricated account directly to this Court — the sole decision-maker at Rule 29 — as an established fact supporting denial of acquittal. That is fraud upon the court under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)* — fraud "directed to the judicial machinery itself" that makes it impossible for the court to perform its "impartial task." Id. at 246.

IV. FALSE STATEMENT TWO: TAMARA GAGE "CONTINUED TO GET THE BAG EVERY MONTH"

A. What Koob Told This Court :

At trial, Koob elicited the following testimony from T.G. on direct examination (Day 6, pp. 1231: 6-12):

Q: How often or how many times did you receive the medications thereafter?

A: Every month.

Q: Why did you take them?

A: Because you had to take them or you couldn't get your prescriptions.

Having elicited that testimony himself, Koob then repeated it directly to Judge Kenney at Rule 29 as established fact — at the precise moment the Court was determining whether sufficient evidence existed to sustain the conviction:

"Ms. Gage gave the very vivid description of sitting on the floor and dumping out the bag and telling everyone that would listen she didn't want it. She continued to get the bag every month." (Tr. 2352:4–7.)

Koob continued: *"He continued to force them to take them." (Tr. 2352:17.)*

Those statements were Koob's own direct representations to this Court — not a summary of testimony — offered as established fact to sustain the coercion theory — that patients had to accept the Goody Bag medications (non-opioid anti-inflammatories and muscle relaxers) in exchange for their opioid prescriptions.

B. What Government File 303 Proves

Government File 303 — the prosecution's pharmacy dispensing records,— contains the complete in-house dispensing history for T.G. It proves:

Last in-house dispensing: December 18, 2018

Last date as active patient: September 24, 2019

Government File 303 shows no in-house dispensing to Gage from December 2018 forward — nine consecutive months of zero dispensing while Koob falsely told this Court she continued to receive the bag every month.

C. Proof of Koob's Knowledge

Government File 303 was the prosecution's foundational dispensing file — the same file the government used to build its case-in-chief, secure the indictment, and prepare Tamara Gage's direct examination. It is a mathematical impossibility for the prosecution to have vetted Tamara Gage, prepared her direct examination, and built its dispensing-coercion theory without reviewing the file that showed nine consecutive months of zero in-house dispensing. When Koob

told this Court that Tamara Gage "continued to get the bag every month," he was holding Government File 303. The statement was the direct opposite of what that file showed. Presenting a fabricated account as established fact to the sole decision-maker at a dispositive proceeding corrupted the integrity of that proceeding.

D. Why This Is Fraud Upon the Court

This meets every *Hazel-Atlas* element. The statement was made directly to this Court during a dispositive bench proceeding. Koob built the coercion theory from File 303 — a dispensing log showing zero dispensing for nine consecutive months cannot be reconciled with "every month." Koob made this representation at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the coercion theory — a representation Government File 303 directly and conclusively refutes.

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — he held Government File 303 when he told this Court dispensing continued every month, and that file contains nine consecutive months of zero entries (5) that is objectively provable as false from the government's dispensing records, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction on Count 2.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present a false factual characterization — "she continued to get the bag every month" — directly to this Court as the sole decision-maker at Rule 29, as an established fact supporting denial of acquittal. That is fraud upon the court under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)* — fraud "directed to the judicial machinery itself" that makes it impossible for the court to perform its "impartial task." Id. at 246.

V. FALSE STATEMENT THREE: "EACH OF THE PATIENTS DID NOT WANT, NEED, OR USE THIS MEDICATION"

A. What Koob Told This Court

At the April 8, 2025 Rule 29 proceeding, Koob made the following representations directly to Judge Kenney:

"Each claim that was submitted for a nonopioid medication was false and fraudulent. And each of the patients that testified did say that they gave notice to the office staff that they did not want, need, or use this medication." (Tr. 2351:19–22.)

Moments later, returning to the same point:

"[Defendant Anand] continued to do so, knowing that his patients were not using these medications, did not want them. He continued to force them to take them." (Tr. 2352:15–17.)

And again, addressing the patients on Counts 2, 3, and 4 specifically:

"The patients were clear they did not want or use them." (Tr. 2353:19–20.)

B. What the Government's Own Records Prove

These representations were not incidental. Koob's repeated assertion that patients did not want, need, or use these medications was the evidentiary foundation of the government's quid pro quo theory — that patients were required to accept bags of non-opioid medications as a condition of receiving their opioid prescriptions. The government's own records refute that premise directly. Every patient Koob named was voluntarily filling those same non-opioid medications at retail pharmacies, on their own, outside Dr. Anand's office. He made these representations at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction on Counts 2, 3, and 4.

Tamara Gage. Government File 303 shows Gage voluntarily filling tizanidine and amitriptyline — non-opioid muscle relaxer and nerve pain medications — at Yorke Pharmacy on multiple occasions between October 2015 and August 2018. Dr. Anand's DrChrono electronic medical

records, in the government's possession, show Gage continuing to fill temazepam, carisoprodol, topiramate and tizanidine - non-opioid medications at Yorke Pharmacy from January 2019 through September 2019. Government PDMP File 711 further confirms Gage voluntarily filling zolpidem — a non-opioid sleep medication — at Yorke Pharmacy on August 18, 2021, prescribed by an independent physician at Comprehensive Care. Nobody handed her these medications. She drove to Yorke and filled them herself. Gage's pattern of voluntary retail fills at Yorke Pharmacy across nearly three years is irreconcilable with Koob's representation that she did not want, need, or use these medications

Jodi Stevenson. PT_FILES_009957–009981 contain prior medication records from Morrisville Yardley Family Medicine documenting that before she ever presented as Dr. Anand's patient, Stevenson was already receiving Lyrica 225mg — a non-opioid nerve pain medication — ibuprofen 600mg — a non-opioid anti-inflammatory — Zorvolex 35mg — a non-opioid anti-inflammatory — and propranolol 80mg, all prescribed by her primary care physician. On October 26, 2022, FBI agents recovered from Stevenson's residence two completely empty bottles of cyclobenzaprine — Rx 102528 (60 tablets, 7.5mg) and Rx 105918 (120 tablets, 7.5mg) — and two partially used bottles of cyclobenzaprine — Rx 103572 and Rx 100869 — dispensed by Dr. Anand's in-house pharmacy (INT_001109–001111). She also voluntarily filled topiramate (Rx 6689673), prescribed by Dr. Anand, at Sav-On Pharmacy. Additionally, Stevenson testified at Tr. 1091–1092 that she is currently taking Lyrica — a non-opioid prescribed for nerve pain — and propranolol for migraines, and another pill that helps with the nerve pain at night, all prescribed by physicians independent of Dr. Anand. Koob made these representations at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the convictions — while holding evidence showing empty and partially used bottles recovered from her home, voluntary retail fills at an outside pharmacy, and medication records confirming her ongoing use of non-opioid medications before, during, and after her time as Dr. Anand's patient.

Jacqueline Culver. PT_FILES_002928 through PT_FILES_002939, prior medication records from Morrisville Yardley Family Medicine, document that before she ever presented as Dr. Anand's patient, Culver was already receiving Vicoprofen, Ambien CR, and zolpidem —

prescribed by her primary care physician Lawrence Peck DO from at least April 2012 through July 2015 — with documented diagnoses of migraine and osteoarthrosis of the right knee. Government File 303 further shows Culver voluntarily filling tizanidine — a non-opioid muscle relaxer — at Big Oak Pharmacy in November 2015, and cyclobenzaprine — a non-opioid muscle relaxer — at Big Oak Pharmacy in December 2015. At trial, on cross-examination at Tr. 1771–1772, Culver testified under oath that she currently takes gabapentin, duloxetine, zolpidem, diazepam, and ibuprofen — all non-opioids — prescribed by physicians independent of Dr. Anand. Her own sworn testimony, combined with the government's own records showing voluntary non-opioid use before, during, and after her time as Dr. Anand's patient, is irreconcilable with Koob's representation that she did not want, need, or use these medications.

Geraldine Lynch. Lynch testified at Tr. 1297 that she used the lidocaine patches and cream from the bags. She further testified at Tr. 1309 that Dr. Anand prescribed her gabapentin specifically for diabetic neuropathy — a non-opioid she was actively taking for a documented medical condition. Government File 303 shows she voluntarily filled Trokendi XR — branded topiramate extended release, a non-opioid migraine and nerve pain medication — at Family 1 Pharmacy on April 25, 2018, a retail pharmacy outside the in-house dispensary — the same class of non-opioid medications Koob told this Court she did not want, need, or use.

Frederick Glasgow. Dr. Nirav K. Shah, a board-certified neurosurgeon and spine specialist at Princeton Brain and Spine, examined Glasgow and concluded within a reasonable degree of medical certainty that ongoing prescriptions for muscle relaxants and anti-inflammatories would be necessary for his lifetime (PT_FILES_004201–004207, at PT_FILES_004206, attached hereto as Exhibit NA-2) — directly establishing medical need for the same class of medications Koob told this Court Glasgow did not want, need, or use. Government File 304 shows Glasgow voluntarily filling ibuprofen 800mg — a non-opioid NSAID anti-inflammatory — at Rite Aid #11110 in February and March 2016, prescribed by Dr. Christopher Belletieri, a physician independent of Dr. Anand. The same file shows Glasgow voluntarily filling gabapentin 300mg — a non-opioid nerve pain medication — at Rite Aid #11110 on February 12, 2016, prescribed by Dr. Matthew McLean, a physician independent of Dr. Anand. The same file shows Glasgow voluntarily filling meloxicam 7.5mg — a non-opioid NSAID anti-inflammatory — and

tizanidine 4mg — a non-opioid muscle relaxer — at Rite Aid #11110, prescribed by Dr. Madnani, a physician independent of Dr. Anand, in March and April 2016. The same file further shows Glasgow voluntarily filling amitriptyline — a non-opioid nerve pain medication — at Rite Aid #11110 in December 2017, Lyrica — a non-opioid prescribed for nerve pain — at Rite Aid #11110 in March 2018, and temazepam — a non-opioid sleep medication — at Rite Aid #11110 in March 2017 and April, June, and July 2019. Glasgow's pattern of voluntary retail fills across three years, corroborated by a neurosurgeon's written determination of lifetime medical need for the same class of medications, is irreconcilable with Koob's representation that he did not want, need, or use these non-opioid medications, at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction.

Andrea Scicluna. Scicluna testified at Tr. 1549 that she tried "the Celebrex and the cream, anti-inflammatory creams" from the bag. Government PDMP File 732 further shows Scicluna voluntarily filling diazepam — a non-opioid benzodiazepine — at Yorke Pharmacy in July, September, October, November, and December 2018, carisoprodol — a non-opioid muscle relaxer — at Yorke Pharmacy in July and September 2018, and zolpidem — a non-opioid sleep medication — at Yorke Pharmacy in April, May, June, and July 2018. Scicluna additionally filled temazepam at Yorke Pharmacy every month from January through July 2019 — seven consecutive months of voluntary retail fills of a non-opioid sleep medication. Scicluna's pattern of voluntary retail fills is irreconcilable with Koob's representation that she did not want, need, or use these non-opioid medications, at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction.

C. Proof of Koob's Knowledge

Koob built this case on the government's claims data, the PDMP, the DrChrono electronic medical records, FBI 321, and the patient trial testimony. He cannot have prepared this prosecution without knowing what those records showed. When he stood before this Court and told Judge Kenney three separate times that these patients did not want, need, or use these medications, he was holding the files showing every patient he named voluntarily filling those same medications at retail pharmacies on their own — outside Dr. Anand's office.

D. Why This Is Fraud Upon the Court

This satisfies every *Hazel-Atlas* element. The statements were made directly to this Court during a dispositive bench proceeding — at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the convictions. They are objectively provable as false — not a matter of characterization or inference, but of documentary record contradicting the categorical representation Koob made to this Court three separate times. The statements were known to be false at the time — Koob built his case from these same records and held FBI 321/FBI302 showing Stevenson's empty and partially used bottles when he told this Court she was not using any of it. Koob's representations at the Rule 29 proceeding required this Court to determine whether sufficient evidence existed to support the coercion theory underlying the quid pro quo scheme — while he was holding the government's own records proving every patient wanted, needed, and used these medications.

An officer of the court making knowingly false factual representations to a federal judge at a dispositive proceeding, while holding the government's own evidence proving the opposite, is the fraud upon the court that *Hazel-Atlas* was designed to reach.

VI. FALSE STATEMENT FOUR: "THE DOCUMENTATION DOESN'T SUPPORT THAT THERE IS ANY BASIS FOR PRESCRIBING THOSE OPIOIDS"

A. What Koob Told This Court

At the April 8, 2025 Rule 29 proceeding, in response to a question from Judge Kenney about whether Dr. Anand was farming out responsibility or the scrivener role, Koob made the following representation directly to this Court:

"The documentation doesn't support that there is any basis for prescribing those opioids." (Tr. 2358:7–8.)

This was a categorical representation to Judge Kenney — not a characterization of contested expert opinion, not a summary of disputed testimony, but a flat factual assertion that the patient files produced in discovery contained no documentation supporting a medical basis for the opioid prescriptions. It was made at the precise moment Judge Kenney was evaluating the

sufficiency of evidence on Count 10, the conspiracy to distribute controlled substances outside the usual course of professional practice.

B. What the Government's Records Prove

The patient files produced in discovery, admitted at trial, and in Koob's possession throughout the proceedings contained objective diagnostic findings documenting verifiable pathology for all of the six patient witnesses.

Tamara Gage. PT_FILES_003393–003394, Exhibit NA-3, contains an MRI of the cervical spine dated March 25, 2015, reporting mild multilevel cervical degenerative changes with central canal and foraminal narrowing, worst at C6-C7 where there is mild to moderate central canal stenosis. Government PDMP File 711 further confirms that after leaving Dr. Anand's practice, Gage continued receiving hydromorphone 8mg 120 tabs prescriptions from independent physicians at Yorke Pharmacy continuously from October 2019 through February 2023. Independent physicians treating Gage after she left Dr. Anand's practice reached the same prescribing conclusion — directly refuting Koob's representation to Judge Kenney that the documentation contained no basis for prescribing opioids.

Jodi Stevenson. An EMG dated June 25, 2016, Exhibit NA-4, an abnormal study confirming bilateral chronic predominantly axonal motor polyneuropathy with neuropathic changes in the lower extremities embedded in the government's records, PT_FILES_009708–009953. Stevenson's diagnoses of systemic lupus erythematosus and Guillain-Barré syndrome are independently confirmed at PT_FILES_009957–009981, which further establish that she was already receiving morphine sulfate ER 100mg from her primary care physician at Morrisville Yardley Family Medicine dating back to at least April 2014 — before she ever presented as Dr. Anand's patient. Government PDMP File 738 confirms that after leaving Dr. Anand's practice, Stevenson continued receiving oxycodone 15mg (180 tablets) and morphine sulfate ER (60 tablets) from Patrick Falls' office from March 2019 through 2023 — independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Frederick Glasgow. PT_FILES_004201–004207, Exhibit NA-2, contains a narrative report by board-certified neurosurgeon Dr. Nirav K. Shah of Princeton Brain and Spine, documenting his personal review of three MRI scans of the lumbar spine from October 2015 through June 2016, each confirming an L4-5 traumatic disc bulge, and concluding within a reasonable degree of medical certainty that Glasgow suffers from mechanical low back pain with radiculopathy, lumbar traumatic facet syndrome, and definitive permanency requiring ongoing and indefinite pain management. Government PDMP File 713 further confirms that after leaving Dr. Anand's practice, Glasgow continued receiving opioid prescriptions from independent physicians at Rite Aid through late 2019 — independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Geraldine Lynch. PT_FILES_005232–005234, Exhibit NA-5, contains an EMG dated October 26, 2017, confirming bilateral C5-C6 radiculopathy. PT_FILES_005250–005251, Exhibit NA-6, contains an MRI of the cervical spine dated October 4, 2018, documenting central canal stenosis from C4 through C7 and neural foraminal stenosis at multiple levels. Government PDMP File 718 further confirms that after leaving Dr. Anand's practice, Lynch continued receiving opioid prescriptions from multiple independent physicians — including Kenneth Fox, Lawrence Peck, Frank Colarusso, and David Hardeski — continuously from 2019 through 2023, independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Andrea Scicluna. PT_FILES_009410–009411, Exhibit NA-7, contains an MRI of the lumbar spine dated October 14, 2015, from Lower Bucks Hospital, documenting disc bulges at L2-L3 and L4-L5, a left-sided annular tear at L4-L5, and a new small broad-based central disc protrusion at L3-L4. PT_FILES_008454–008458, Exhibit NA-8, is the government's DrChrono patient records documenting an abnormal EMG dated October 13, 2015, at PT_FILES_008456, confirming active denervation in S1 innervated muscles bilaterally and bilateral S1 radiculopathies — a finding embedded in her clinical notes across all dates of service. Government PDMP File 732 confirms that after leaving Dr. Anand's practice, Scicluna continued receiving opioid prescriptions from independent physicians — including Rachel Gennaoui Abad,

Lorna Ching-Carter, and Matthew McKeever — through August 2022. FBI interview reports INT_000376–000377 and INT_001104–001105 further document Scicluna's own admissions on July 23, 2020 and November 20, 2023 that she continues receiving methadone from a methadone clinic — independent recognition of her ongoing opioid treatment need by a separate medical institution entirely outside Dr. Anand's practice. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Jacqueline Culver. PT_FILES_002940–002942, attached hereto as Exhibit NA-9, is an initial visit record from Aria 3B Orthopaedic Specialists dated February 3, 2015, documenting four prior knee surgeries and confirming that Culver was already receiving fentanyl patch 100mcg every two days — prescribed by an independent physician — before she ever presented as Dr. Anand's patient. Government PDMP File 708 further confirms that after leaving Dr. Anand's practice, Culver continued receiving opioid prescriptions from independent physician Paul Soccio continuously from 2016 through at least 2023. Koob held these records when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

C. Proof of Koob's Knowledge

The patient files containing these findings were government discovery productions bearing government exhibit numbers. They were in Koob's possession throughout the proceedings. It was physically impossible to review those records without encountering them. A lead prosecutor who reviews records containing a radiologist's finding of central canal stenosis and a neurologist's finding of bilateral radiculopathy, and then tells a federal judge that the documentation contains no basis for prescribing opioids, has made a knowingly false statement of fact to the tribunal. Koob held these records when he made that representation to this Court — at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the Count 10 conviction.

D. Why This Is Fraud Upon the Court

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — he held patient files containing MRI reports showing spinal stenosis, EMG reports confirming radiculopathy,

and a neurosurgeon's written determination of ongoing and indefinite pain management when he told this Court the documentation contained no basis for prescribing (5) that is objectively provable as false from records bearing government exhibit numbers, without resort to competing expert opinion — no expert is needed to read a radiologist's finding of stenosis or a neurologist's finding of radiculopathy, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the Count 10 conviction. A prosecutor making a categorical false representation to a federal judge at a dispositive proceeding, while holding diagnostic records proving the opposite, is the fraud upon the court that *Hazel-Atlas* was designed to reach.

CONCLUSION

AUSA Koob knowingly made false representations of fact directly to this Court during the April 8, 2025 Rule 29 proceeding, corrupting the court's truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction: he fabricated words never spoken by Frederick Glasgow; he told this Court Tamara Gage continued to receive the bag every month when Government File 303 showed nine consecutive months of zero in-house dispensing; he told this Court patients did not want, need, or use these medications — when the government's own records show patients voluntarily filling non-opioid medications at retail pharmacies outside Dr. Anand's office; and he told this Court the documentation contained no basis for opioid prescribing when the government's patient medical records contained MRI reports, EMG reports, and independent physician determinations of medical necessity.

Each representation was made directly to this Court during a dispositive bench proceeding, with no jury present, no cross-examination possible, and this Court's ruling depending entirely on the prosecutor's accuracy. Each representation was known to be false at the time, and objectively provable as false from the government's patient records — without expert testimony or inference. These four false representations of fact satisfy *Hazel-Atlas's* requirement of a "deliberately planned and carefully executed scheme." 322 U.S. at 245. The scheme was not to deceive the jury. The scheme was to deceive this Court — the sole decision-maker at the one proceeding

where no cross-examination of the prosecutor's representations was possible and where this Court's ruling depended entirely on his accuracy.

Dr. Neil K. Anand respectfully requests that this Court perfect the appellate record and preserve these issues for review by the Third Circuit in Case No. 26-1359 pursuant to this Court's inherent authority under *Hazel-Atlas Glass Co. v. Hartford-Empire Co.*, 322 U.S. 238 (1944), and Federal Rule of Criminal Procedure 29.

Respectfully submitted,

Neil K. Anand, Pro Se

FCI Danbury
33 Pembroke Station
Danbury, CT06811

Date: June 19, 2026

CERTIFICATE OF SERVICE

I hereby certify that on June 19, 2026, I caused a true and correct copy of the foregoing Motion to be served upon the following by United States Mail, postage prepaid or ECF/EDS to Paul J. Koob, Arun Bodapati, and Patrick J. Campbell Assistant United States Attorneys United States Attorney's Office Eastern District of Pennsylvania 615 Chestnut Street, Suite 1250 Philadelphia, Pennsylvania 19106

Neil K. Anand

Neil K. Anand, Pro Se
33 Pembroke Rd
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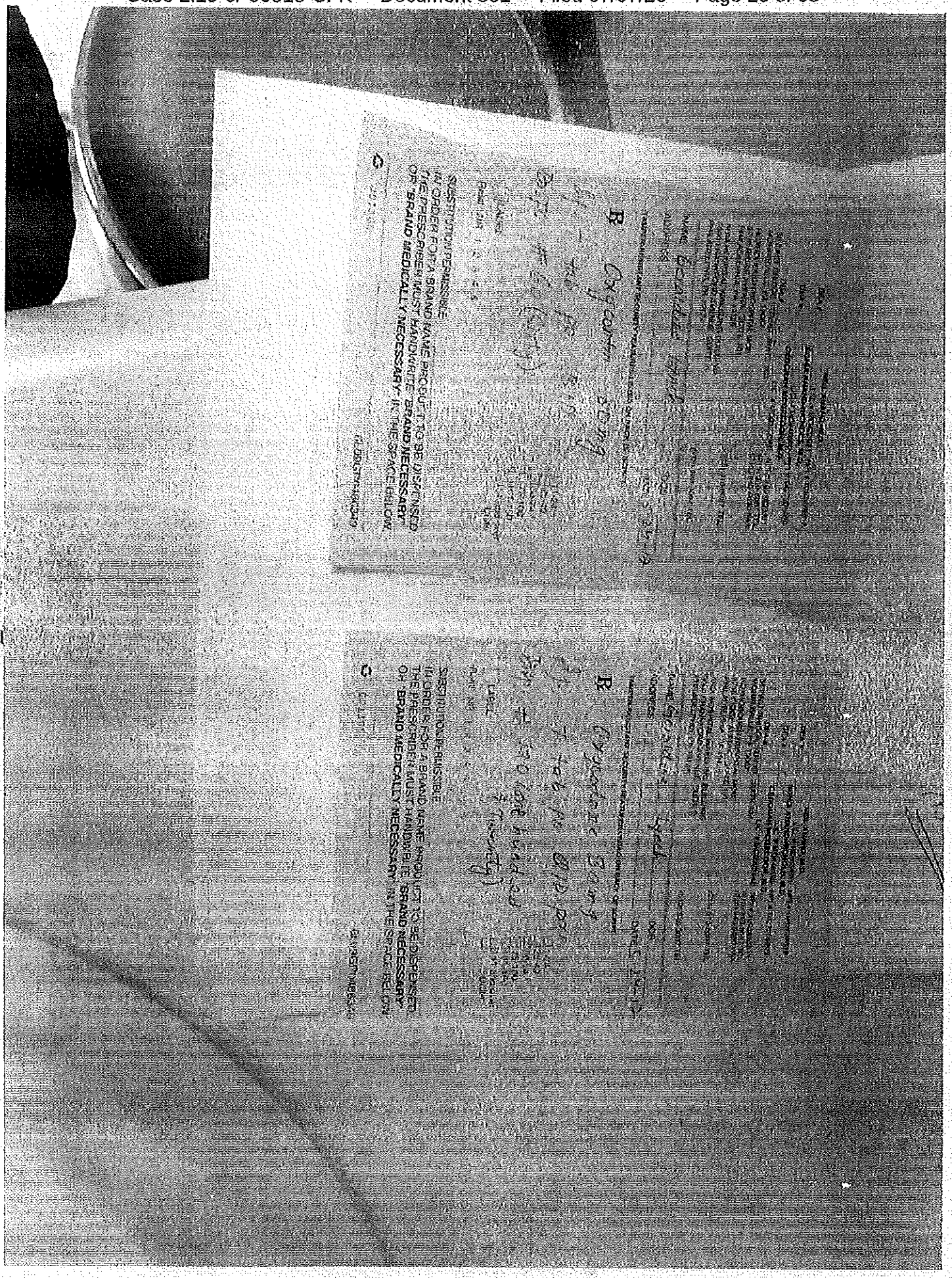
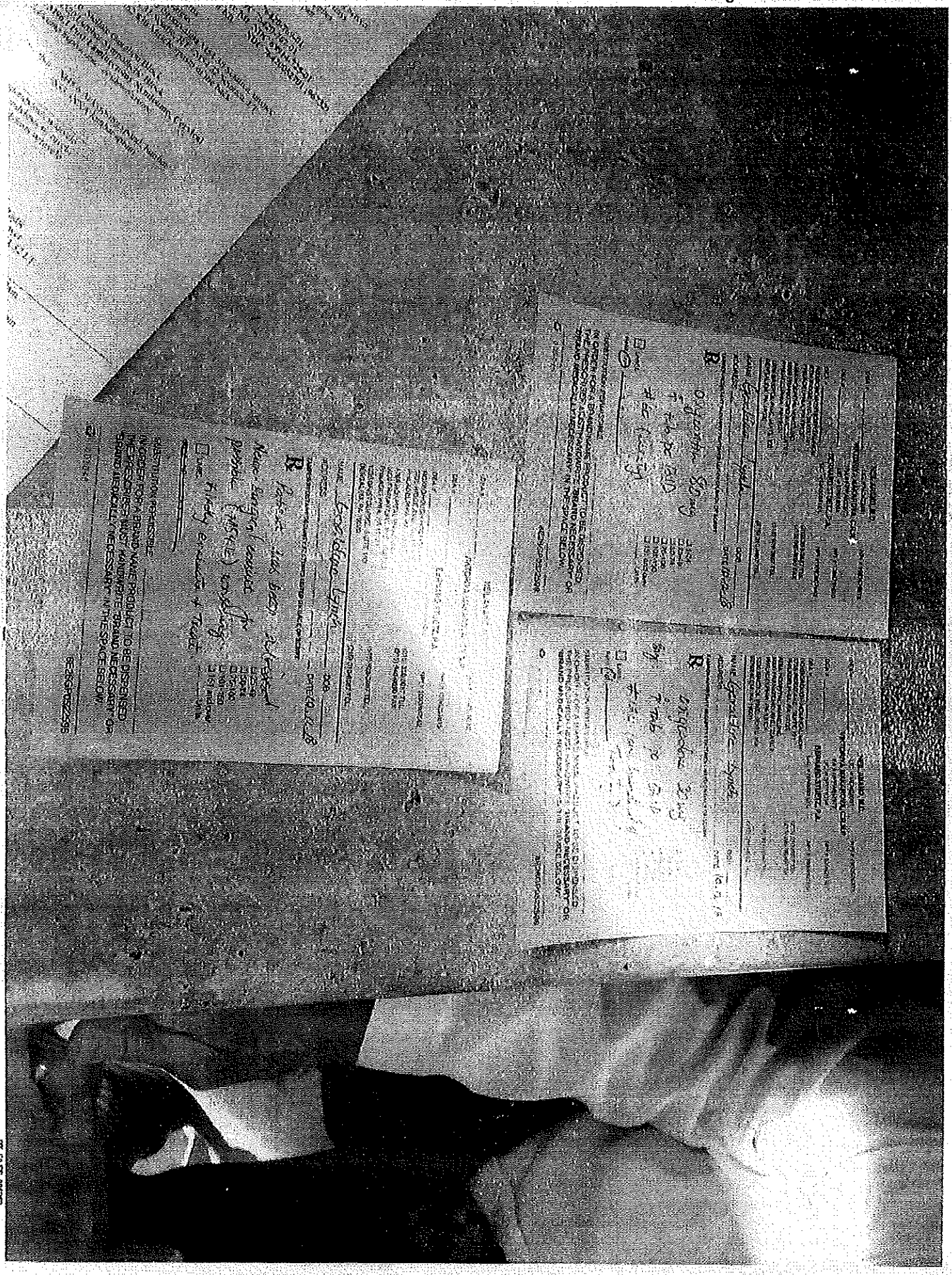
Date: June 19, 2026

EXHIBIT NA-1

PT_FILES_004521





PT_FILES_006781

NEIL ANAND, M.D.
DEA # ______ LIC. # MD422681 NPI # 1952626818
VIKTORIYA MAKAROVA, C.R.N.P.
PA # NPPA032972
DEA # ______ LIC. # SP018354 NPI # 1396251815
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(215) 310-8087 TEL

NAME Tamara Gage DOB ______
ADDRESS ______ DATE 1/16/19

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

℞
Clonidine patch 0.1mg/hr
i patch q 7 days
#4 (Four)

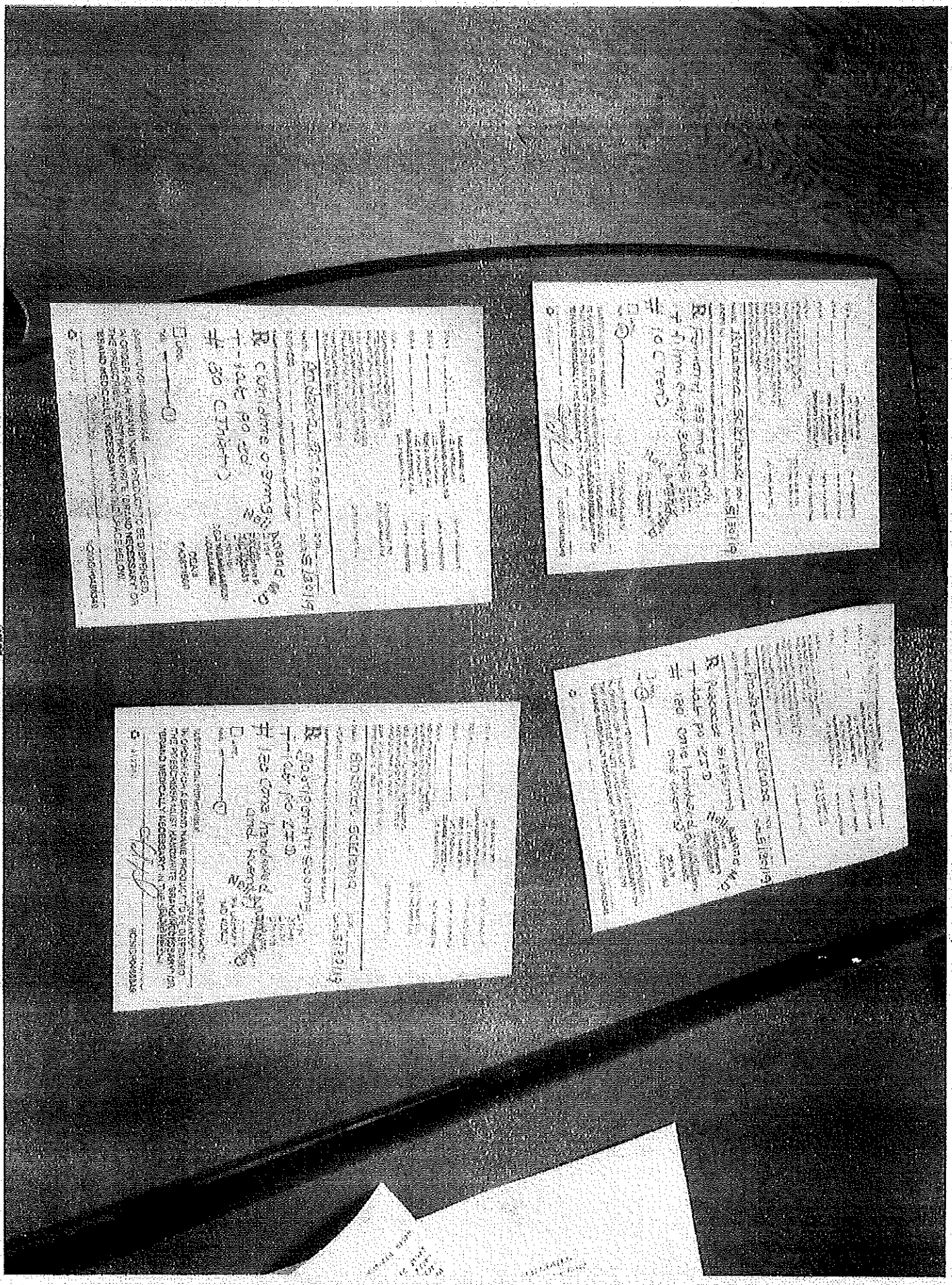
☐ 1-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 and over
______ Units

☐ LABEL
Refill (NR) ~~1 2 3 4 5~~

SUBSTITUTION PERMISSIBLE ______
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE **"BRAND NECESSARY"** OR **"BRAND MEDICALLY NECESSARY"** IN THE SPACE BELOW.

8J25GP0522598

PT_FILES_003641



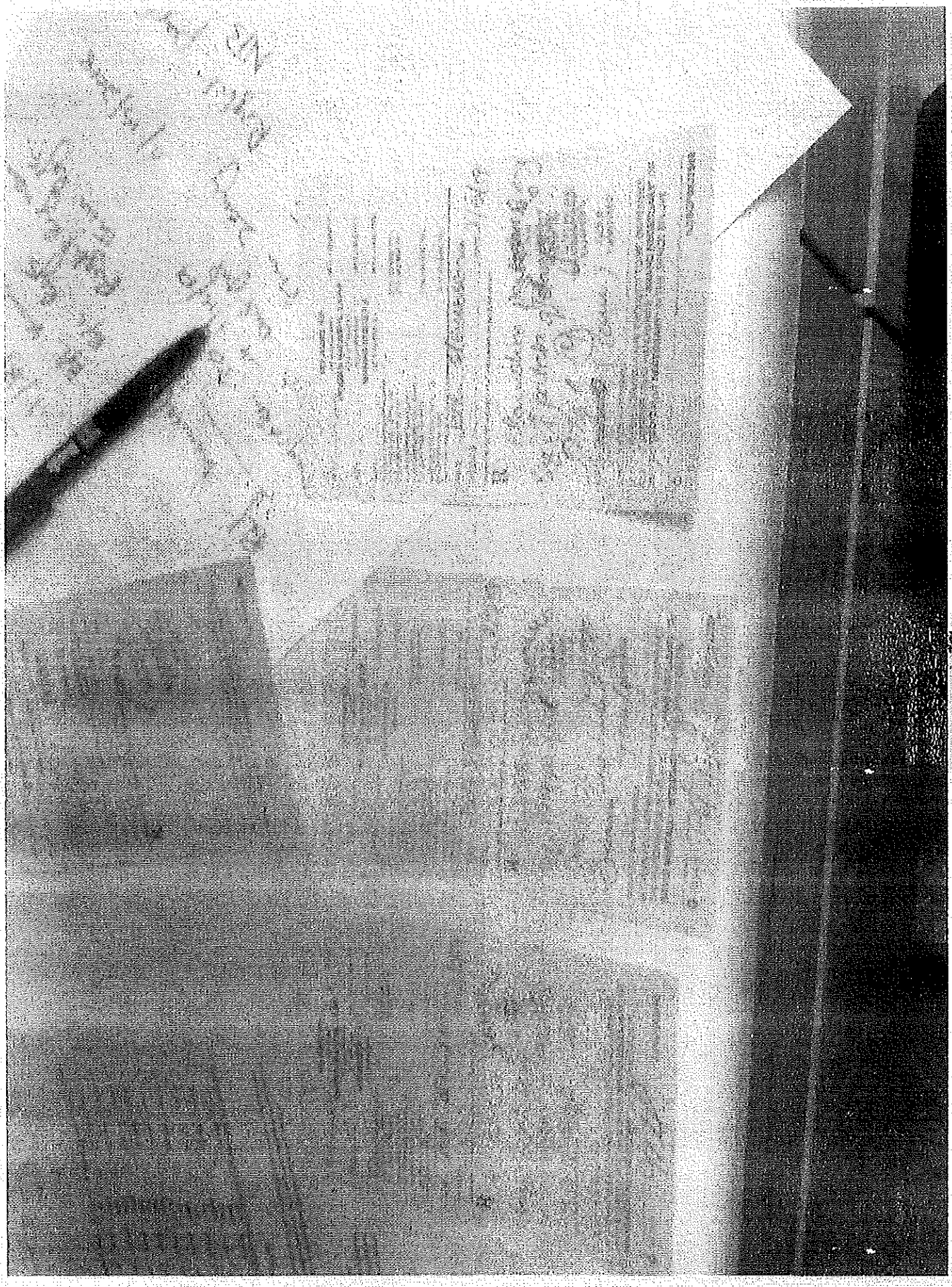

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EXHIBIT NA-2

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Herniated Disc Management
Stereotactic Radiosurgery
Complex Spine Reconstruction
Surgical Pain Management
Pituitary Tumor Surgery
Trigeminal Neuralgia
Traumatic Brain and Spine Injury

August 17, 2016

Stark & Stark
777 Township Line Road
Suite 120
Yardley, Pennsylvania 19067

Patient Name: Fredrick Glasgow
Date of Birth: November 2, 1990
Date of Injury: August 23, 2015
Date of Examination: July 1, 2016

NARRATIVE REPORT

Dear Mr. Tomlinson:

I had the opportunity to treat and evaluate medical records regarding your client Mr. Fredrick Glasgow and prepare a narrative report.

RECORDS REVIEWED:
The following records were reviewed:

1. Medical Records – Aria Orthopedic – January 22, 2016
2. Medical Records – Princeton Brain and Spine – March 3, 2016 to July 1, 2016
3. Medical/Chiropractic/Physical Therapy Records – Dedicated Doctors – August 2015 to May 2016
4. Medical Records – Dr. Louis Pearlstein – January 14, 2016
5. Medical Records – Oxford Valley Pain and Spine Center – March 7, 2016
6. Physical Therapy Records – Riverside Physical Therapy

HISTORY:

Mr. Fredrick Glasgow is a 25 year old male who was involved in a motor vehicle accident on August 23, 2015. The patient was a restrained driver in a vehicle that was moving around 35 miles per hour. A car came into his lane from the left side and hit him head on and caused him to careen into a telephone pole that was upright as well as one that was on the ground. The patient denies loss of consciousness. The airbags did deploy. The driver's side door was bent into a 'U' shape. Upon impact, he was jostled significantly as he was not braced for this injury. When he was driving, he was downshifting with his right hand and steering with his left with his foot

on the brake/clutch. His passenger and the other driver went to the ER via ambulance. He went to the ER one hour later. He was diagnosed with left rib fractures.

On August 24, 2015Mr. Glasgow presented to Dr. Michael Fischer, a primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy

On August 31, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy.

On September 14, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and PENS therapy.

On September 15, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended continued physical therapy and medical management.

On October 1, 2015 Mr. Glasgow presented to Dr. Michael Fischer, an associate of Dr. Belletier, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy.

On October 13, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended continued physical therapy.

On October 27, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and medical management.

On November 6, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and medical management.

On November 13, 2015 Mr. Glasgow presented to Dr. Michael Fischer, an associate of Dr. Belletier, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy.

On January 14, 2016 Mr. Glasgow obtained an EMG of the lower extremities. This was performed by Dr. Louis Pearlstein. There was no evidence of neuropathy, radiculopathy or myopathy.

On January 22, 2016 Mr. Glasgow presented to Dr. Matthew McLean, an orthopedist, with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended oral steroid medication.

On February 12, 2016 Mr. Glasgow returned for follow up with Dr. McLean with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended aqua therapy and a trial of gabapentin.

On March 3, 2016 Mr. Glasgow presented to me for evaluation with reports of low back pain with radiation into the lower extremities. I recommended he obtain a pain management evaluation and treatment.

On March 7, 2016 Mr. Glasgow presented to Dr. Anju Madnani, a pain management physician, with reports of low back pain with radiation into the left lower extremity. Dr. Madnani recommended facet nerve block injections.

On March 10, 2016 Mr. Glasgow returned for follow up with Dr. McLean with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended pain management.

On March 25, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended continued medical management.

On May 12, 2016 Mr. Glasgow presented to St. Mary Medical Center Emergency Room due to low back pain with radiation into the left lower extremity. He also reported headaches and fever. On observation he was found to be febrile with leukocytosis so he was admitted into the hospital. He was admitted until May 15, 2016.

On June 10, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended indefinite medical management and pain management.

On July 1, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended indefinite pain management.

PRE-EXISTING CONDITION:

The patient had nonspecific back pain prior to this injury but was pain-free up to a month ongoing prior to the injury date.

PHYSICAL EXAMINATION:

Lower back:

- Spine tenderness present.
- Paraspinal muscle spasm: present on left side.
- SI joint tenderness: present on left side.
- Motor system: 5/5 strength in all major muscle groups.
- Sensory: normal bilateral lower extremity.
- Reflexes: absent.
- Gait: antalgic.
- Range of motion flexion to 10 degrees, extension to 10 degrees, and 25 degrees lateral rotation to the right and left
- Straight leg raising test: positive straight leg raise on left.

DIAGNOSTIC IMAGING:
(I personally reviewed the following relevant medical imaging)

1. MRI of the lumbar spine performed on October 3, 2015 at Saint Mary Medical Center. This had shown evidence for L4-5 disk bulge.
2. MRI of the lumbar spine performed May 12, 2016 revealing similar findings of L4-5 disk bulge.
3. MRI of the lumbar spine performed June 3, 2016 revealed again L4-5 disk bulge.

DISCUSSION:

Based on my evaluation of the patient and review of the above records, the following conclusions may be made within a reasonable degree of medical certainty.

CAUSALITY:
The patient has the following diagnoses causally related to the above injury:

1) L4-5 traumatic disk bulge.
2) Mechanical low back pain with radiculopathy, left-sided.
3) Lumbar traumatic facet syndrome.
4) Lumbar aggravation injury.
5) Left rib fractures.

The patient has mechanical low back pain with radiculopathy causally related to the injury above. Based on the mechanism of injury, the above diagnoses would be causally related. The patient had prior history for mechanical low back pain but was working unrestricted and pain free at the time of the accident. Thus, a general aggravation injury to the lumbar spine with facet irritation/injury was noted.

I personally reviewed the patient's 2015-2016 MRIs of the lumbar spine that showed traumatic bulging at L4-5. In addition, there is a lack of overwhelming degenerative findings throughout the spine to suggest it was present prior to the accident. Specifically, there is no evidence for disk collapse, Modic changes, osteophyte formation, or other degenerative features at any other level. If the L4-5 bulge was pre-existing, then the other levels in the spine would carry

degenerative features. Thus, the bulge would be causally related to the injury. Isolated bulging in this clinical scenario, is considered to be the result of posterolateral annular stress. In the absence of significant pre-existing degenerative conditions throughout the rest of the lumbar spine, this stress would be directly a result from the acute TRAUMA. Furthermore, there are no prior MRIs to compare the post-injury ones to. In the absence of chronic findings, the disk bulge then would be related to the above accident.

From the internal disk disruption, he has DISCOGENIC pain mediated by axial symptoms. Various theories have been proposed as the sources of pain generation in disc injury, involving an intervertebral disc that is bulging, or herniated acutely. Mechanical compression and an immunologic or inflammatory response are related to pain from a disc injury. The basis for an immunologic source for disc-related pain has been based upon the lack of blood supply to the nucleus pulposus, thus hiding it and its contents from the immune system. Injury to the disc would expose these foreign substances, initiating an autoimmune reaction. The nucleus pulposus has been shown to elicit an immune response. Various authors have reported that disc material can incite a leukocyte cell reaction, cytokine, and immunoglobulin response. Thus, there is a real biochemical and physiological response to traumatic disk injury resulting in the progressive mechanical back. The radiculopathy in the left lower extremity objectified by the positive straight leg raise and supported by his subjective dermatomal complaints, would be due to the neural effacement from the disk bulge.

In addition the patient's discogenic pathology, he also suffers from lumbar facet syndrome. The existence of this condition and the severity of same is well documented in the notes and operative reports of both Dr. Madnani. The patient has been recommended this intervention only after the accident and thus, it is clear that the patient's current pain and symptomology is due, in part, to his lumbar facet syndrome. Future treatment would continue to provide him with transient relief but this this condition is clearly permanent in nature.

At this point, the patient has undergone some reasonable and necessary conservative and surgical care for the lumbar spine in particular. My concern is that the patient has persistent functional disability from pain attributed to this particular accident. There is limitation to range of motion leading to the axial pain. Furthermore, there are signs for neural irritation for the lumbar spine including paraspinal tenderness and limitations to range of motion. While these findings are primarily subjective, they are present and represent an expected complaint from this injury. The weakness is not profound and I would not expect it to be so given the lack of severe thecal sac compression. Thus, there is no evidence for symptom magnification. Nevertheless, there is positive straight leg raising on the left lower extremity. Clearly, his quality of life and day to day activities are compromised from these causally related lumbar issues. He is unable to sit, stand, walk, or drive for meaningful periods of time without discomfort. He is unable to return to work as a FEDEX dock worker unrestricted due to the repetitive activities involving the lumbar spine inherent to his job duties. These activities would exacerbate his symptomology.

RECOMMENDATIONS:

capable of exceeding light duty capacity with the restrictions of no repetitive bending, stooping, climbing, crouching. He would not be able to lift greater than 20 pounds. He would not be able to sit or stand for greater than 30 minutes at a time without a 10 minute break, and no greater than a total of 4 hours in a work day. No driving a company vehicle at all. I have signed off on a handicap parking tag for him.

The statements and diagnoses contained in my report are made within a reasonable degree of medical certainty and probability based on a standard of care and expectation of neurosurgery and spine surgery for this particular injury. I reserve the right to amend this report should additional information become available.

I am a board certified neurosurgeon licensed in the states of NJ and PA. I have an active specialty practice and have treated patients for conditions similar to or identical to those of the above patient.

Sincerely,

Nirav K. Shah, M.D. F.A.C.S.
Neurosurgeon and Spine Specialist
Princeton Brain and Spine Care

EXHIBIT NA-3

St. Mary Medical Center
1201 Langhorne-Newtown Road, Langhorne, PA19047
215-710-2185
Diagnostic Imaging

PATIENT NAME: GAGE,TAMARA J
MED REC NO: M005519445
ACCT NO.: LP0323655282
ORDER NO: 0325-0040

DOB: 11/09/1970 AGE: 44 SEX: F
PT CLASS: REG CLI
PT ROOM/BED:
DEPT: Magnetic Resonance Imaging

ORDERING DR. : ANAND, NEIL MD
ATTENDING DR.: ANAND,NEIL MD
CC:ANAND,NEIL MD; KHAN,ZAFAR MD

REASON FOR EXAM: 724.1 PAIN IN T SPINE, 723.1 CERVICALGIA
COMMENTS:
ADMITTING REASON: 724.1 PAIN IN THORACIC SPINE 723.1 CERVICALGIA
PREGNANT: N

SERVICE DATE/TIME: 03/25/15 1253
REPORT DATE/TIME: 03/25/15 1622

PROCEDURE: MR Cervical Spine WO
REPORT NO.: 0325-0549

Status: Signed

CLINICAL HISTORY: Neck pain for several years

COMPARISON : None

STUDY/TECHNIQUE: Multiplanar MRI examination of the cervical spine was performed using a combination of T1 and T2 weighted pulse sequences.

FINDINGS:

ALIGNMENT: Straightening of the normal lordosis which may be due to patient position or muscle spasm.

VERTEBRAL BODIES: Vertebral body heights are maintained. Loss of disc height, disc desiccation, marginal spurring at multiple levels in keeping with degenerative disc disease.

SPINAL CORD: No definite cervical spinal cord signal abnormality identified.

AXIAL IMAGES

C2-C3: No significant disc bulge, herniation, or stenosis.

C3-C4: Mild disc bulge. Borderline mild narrowing of central canal. No significant foraminal encroachment.

C4-C5: Mild disc bulge. There is some uncovertebral arthropathy. Borderline mild narrowing of central canal and right neural foramen. Left neural foramen is patent.

C5-C6: Disc bulge which is slightly asymmetric to the right. There is some uncovertebral arthropathy. Mild narrowing of central canal. No significant foraminal encroachment.

C6-C7: Disc bulge. There is some uncovertebral arthropathy. There is mild to moderate narrowing of central canal. No significant foraminal encroachment.

ST. MARY'S MEDICAL CENTER
DIAGNOSTIC IMAGING
PT. NAME:GAGE,TAMARA J
MED REC NO:M005519445
ACCOUNT#:LP0323655282
REPORT#:0325-0549

C7-T1: No significant disc bulge, herniation, or stenosis.

There are partially imaged thyroid nodules for which ultrasound is recommended.

IMPRESSION:

1. Mild multilevel cervical degenerative changes with central canal and foraminal narrowing as described above. Findings are worst at C6-C7 where there is mild to moderate central canal stenosis.

2. Straightening of the normal cervical lordosis which may be due to patient position or muscle spasm.

3. Partially imaged thyroid nodules for which ultrasound is recommended.

TECHNOLOGIST: HPM
READING DOCTOR: KIRKPATRICK,CHRISTOPHER T MD

ELECTRONICALLY SIGNED BY: KIRKPATRICK,CHRISTOPHER T MD
PRINTED: 1631

EXHIBIT NA-4

Stevenson, Jodie ID #: 101574JS

Name: Stevenson, Jodie

Patient ID: 101574JS
Date of Birth: 10/15/1974
Gender: Female
Date of Exam: 6/25/2016 1:05 PM

Referring Physician:
Examining Physician:

Patient History: 42 y/o right handed female who presents with weakness in her lower extremities from her knees down to her feet as well as associated numbness bilaterally. The patient was diagnosed with GBS in 2006 after noticing frequent tripping over her feet, difficulty going up the stairs, and numbness from her feet to her chest after suffering from an upper respiratory tract infection. The patient states that she underwent IVIG treatment and currently notes weakness from her knees down to her feet described as a burning, tingling, pins and needles type of sensation with associated numbness. Neurological examination reveals diminished strength 3+/5 in bilateral lower extremities when the patient is sitting up and decreased sensation in her lower extremities particularly the calves and feet. Reflexes were trace throughout.

Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Peroneal.R						
Ankle	7.9 ms	0.5 mV	Extensor digitorum brevis-Ankle	7.9 ms	90 mm	m/s
Fibula (head)	15.8 ms	0.7 mV	Ankle-Fibula (head)	7.9 ms	290 mm	37 m/s
Popliteal fossa	18.0 ms	0.7 mV	Fibula (head)-Popliteal fossa	2.2 ms	70 mm	32 m/s
Tibial.R						
Ankle	4.3 ms	2.1 mV	Abductor hallucis-Ankle	4.3 ms	90 mm	m/s
Popliteal fossa	11.1 ms	1.9 mV	Ankle-Popliteal fossa	6.8 ms	350 mm	51 m/s
Peroneal.R						
Fib Head	2.2 ms	4.2 mV	Tibialis anterior-Fib Head	2.2 ms	80 mm	m/s
Pop fossa	4.0 ms	4.8 mV	Fib Head-Pop fossa	1.8 ms	80 mm	44 m/s
Peroneal.L						
Ankle	5.2 ms	1.9 mV	Extensor digitorum brevis-Ankle	5.2 ms	90 mm	m/s
Fibula (head)	11.6 ms	1.5 mV	Ankle-Fibula (head)	6.4 ms	280 mm	44 m/s
Popliteal fossa	13.4 ms	1.4 mV	Fibula (head)-Popliteal fossa	1.8 ms	80 mm	44 m/s
Peroneal.L						
Fib head	4.3 ms	5.3 mV	Tibialis anterior-Fib head	4.3 ms	120 mm	m/s
Pop fossa	6.0 ms	5.6 mV	Fib head-Pop fossa	1.7 ms	90 mm	53 m/s
Tibial.L						
Ankle	5.1 ms	0.9 mV	Abductor hallucis-Ankle	5.1 ms	90 mm	m/s
Popliteal fossa	15.2 ms	0.3 mV	Ankle-Popliteal fossa	10.1 ms	350 mm	35 m/s

Stevenson, Jodie ID #: 101574JS

F-Wave Studies

Nerve	M-Latency	F-Latency
Peroneal.R	18.0	77.8
Tibial.R	11.1	62.9
Peroneal.L	13.4	61.7
Tibial.L	15.2	62.1

Sensory Nerve Conduction:

Nerve and Site	Onset Latency	Peak Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Superficial peroneal.R							
Ankle	2.6 ms	3.1 ms	6 µV	Dorsum of foot-Ankle	2.6 ms	130 mm	41 m/s
Sural.R							
Lower leg	2.1 ms	3.0 ms	7 µV	Ankle-Lower leg	2.1 ms	110 mm	48 m/s
Superficial peroneal.L							
Ankle	3.1 ms	4.0 ms	7 µV	Dorsum of foot-Ankle	3.1 ms	130 mm	42 m/s
Sural.L							
Lower leg	2.4 ms	3.2 ms	6 µV	Ankle-Lower leg	2.4 ms	110 mm	49 m/s

Needle EMG Examination:

	Insertional	Spontaneous Activity			Volitional MUAPs					Max Volitional Activity		
Muscle	Insertional	Fibs	+Waves	Fasc	Duration	Amplitude	Poly	Config	Recruitment	Amplitude	Pattern	Effort
Tibialis anterior.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Gastrocnemius.R	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Tibialis posterior.R	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Extensor hallucis longus.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Vastus medialis.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
L5 paraspinal.R	Normal	None	None	None	Normal	Normal	None	Normal	Normal			
L5 paraspinal.L	Normal	None	None	None	Normal	Normal	None	Normal	Normal			
Tibialis anterior.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Gastrocnemius.L	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Tibialis posterior.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Extensor hallucis longus.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Vastus medialis.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			

Impression: Abnormal study demonstrating a bilateral chronic predominately axonal motor polyneuropathy. The conduction velocities were at times slow though they did not meet the criteria for demyelinating range. The patient did have prolonged F-waves bilaterally. There were neuropathic changes seen in her lower extremities when performing the electromyography testing. There have been case reports in the literature of axonal damage on clinical neurophysiological testing in patients who were diagnosed with CIDP. When comparing to her previous study, although the records were incomplete, there was slight improvement seen when testing the motor nerves on nerve conduction testing and there was no active denervation seen on electromyography with this study. Clinical correlation advised.

Sonia Anand-Nichols, M.D.

EXHIBIT NA-5

Neurography & Electromyography Report

Full Name: Geraldine Lynch **Gender:** Female
Patient ID: 032961GL **Date of Birth:** 3/29/1961

Visit Date: 10/26/2017 14:05
Age: 56 Years 6 Months Old

History: 56 y/o right handed female with history of diabetes and neck pain that radiates down her arms and into her hands, worse on the right side, for over a year. She does endorse associated tingling and numbness. Neurological examination demonstrates trace reflexes throughout and hyperesthesia in the right upper extremity to pinprick.

MNC

Nerve / Sites	Muscle	Latency ms	Amplitude mV	Segments	Distance mm	Lat Diff ms	Velocity m/s
R Median - APB							
Wrist	APB	5.5	8.7	Wrist - APB	60		
Elbow	APB	10.3	8.1	Elbow - Wrist	240	4.8	50
L Median - APB							
Wrist	APB	4.0	8.0	Wrist - APB	60		
Elbow	APB	8.6	7.7	Elbow - Wrist	260	4.6	56
R Ulnar - ADM							
Wrist	ADM	2.8	10.2	Wrist - ADM	60		
B.Elbow	ADM	5.2	10.1	B.Elbow - Wrist	140	2.4	58
A.Elbow	ADM	8.6	9.3	A.Elbow - B.Elbow	170	3.4	50
L Ulnar - ADM							
Wrist	ADM	2.6	9.3	Wrist - ADM	60		
B.Elbow	ADM	4.7	9.0	B.Elbow - Wrist	130	2.2	59
A.Elbow	ADM	8.1	8.5	A.Elbow - B.Elbow	170	3.3	51

F Wave

Nerve	F Lat ms	M Lat ms	F-M Lat ms
R Median - APB	26.0	6.1	18.9
R Ulnar - ADM	32.0	3.0	29.1
L Median - APB	29.6	3.8	25.8
L Ulnar - ADM	30.7	2.7	28.0

Geraldine Lynch 032961GL 10/26/2017 14:05

SNC

Nerve / Sites	Rec. Site	Onset Lat ms	Peak Lat ms	Amp µV	Segments	Distance mm	Velocity m/s
R Median - Digit II (Antidromic)							
Wrist	Dig II	4.11	5.52	26.5	Wrist - Dig II	165	40
L Median - Digit II (Antidromic)							
Wrist	Dig II	3.33	4.43	22.8	Wrist - Dig II	155	47
R Ulnar - Digit V (Antidromic)							
Wrist	Dig V	2.40	3.28	15.2	Wrist - Dig V	120	50
L Ulnar - Digit V (Antidromic)							
Wrist	Dig V	2.45	3.13	15.2	Wrist - Dig V	125	51
R Radial - Anatomical snuff box (Forearm)							
Forearm	Wrist	1.56	2.40	16.5	Forearm - Wrist	100	64
L Radial - Anatomical snuff box (Forearm)							
Forearm	Wrist	1.77	2.34	35.6	Forearm - Wrist	100	56

EMG

EMG Summary Table										
	Spontaneous					MUAP			Recruitment	Max Vol Act
Muscle	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern	Effort
R. Abductor pollicis brevis	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Abductor digiti minimi (manus)	N	None	None	None	None	N	N	N	N	Max
R. Biceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Triceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Deltoid	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Abductor pollicis brevis	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Abductor digiti minimi (manus)	N	None	None	None	None	N	N	N	N	Max
L. Biceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Triceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Deltoid	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Cervical paraspinals	N	None	None	None	None	N	N	N	N	Poor
L. Cervical paraspinals	N	None	None	None	None	N	N	N	N	Poor

Summary

The motor conduction test was performed on 4 nerve(s). The results showed prolonged distal latency in bilateral median motor nerves

The sensory conduction test demonstrated slowing across the wrist when testing the median sensory nerve bilaterally.

The F wave study was normal in all 4 of the tested nerves: R Median - APB, R Ulnar - ADM, L Median - APB, L Ulnar - ADM.

The needle EMG examination was performed in 12 muscles. It was normal in 2 muscle(s): R. Abductor digiti minimi (manus), L. Abductor digiti minimi (manus). The study was abnormal in 8 muscle(s), with the following distribution:

Geraldine Lynch 032961GL 10/26/2017 14:05

- The MUP waveform abnormality was found in R. Abductor pollicis brevis, R. Biceps brachii, R. Triceps brachii, R. Deltoid, L. Abductor pollicis brevis, L. Biceps brachii, L. Triceps brachii, L. Deltoid.
- Abnormal Interference pattern was found in R. Abductor pollicis brevis, R. Biceps brachii, R. Triceps brachii, R. Deltoid, L. Abductor pollicis brevis, L. Biceps brachii, L. Triceps brachii, L. Deltoid.
- Poor Vol Act was found in R. Cervical paraspinals, L. Cervical paraspinals due to pain, making their recruitment pattern difficult to fully assess.

Conclusion: Abnormal study demonstrating

1) A moderate to severe median neuropathy with slowing across the wrist, worse on the right side (b/l carpal tunnel syndrome); patient may benefit from a referral to hand specialist to see if she warrants carpal tunnel release surgery
2) A bilateral C5, C6 radiculopathy without active denervation seen.

Clinical correlation advised.

Sonia Anand-Nichols, M.D.

EXHIBIT NA-6

Jefferson Health.

Bucks Campus
380 North Oxford Valley Road
Langhorne, PA 19047-0000

Patient: LYNCH, GERALDINE
Address: 63 PLEASANT LANE
LEVITTOWN, PA 19054-

DOB: 3/29/1961
MR#: 00995820
AR#: 1827142430
LOC: BOP1

Phone#: (215)943-5329

ORD DR: Anand MD,Neil
CONSULT DR:

Magnetic Resonance Imaging

ACCESSION	EXAM DATE/TIME	PROCEDURE
MR-18-0014891	10/4/2018 11:06 EDT	MRI Spine Cervical w/o Contrast

Reason For Exam
(MRI Spine Cervical w/o Contrast) M54.2 M54.12 R20.9 Z12.31

Report

IMPRESSION: Central canal stenosis from C4 through C7. There is no evidence of myelopathy. Neural foraminal stenosis at multiple levels.

TECHNIQUE: Magnetic Resonance Imaging of the cervical spine was performed utilizing axial T1, fat suppressed T1, and fat suppressed T2, as well as coronal fat suppressed T2 weighted sequences.

COMPARISON: There are no known prior examinations for comparison.

TECHNIQUE: Magnetic Resonance Imaging of the cervical spine was performed utilizing axial T1, fat suppressed T1, and fat suppressed T2, as well as coronal fat suppressed T2 weighted sequences.
There are no known prior examinations for comparison.

COMMENT: The cervical vertebral bodies maintain norma stature. There is scant anterolisthesis of C4 on C5. L endplate changes without edema are seen at C6-C7.

The cerebellar tonsils are above the foramen magnum. The cervical spinal cord is normal.
Visualized lungs: No suspicious abnormality.
At C2-C3, There is no evidence of disc pathology. There is no evidence of central or neural foraminal stenosis. The facet joints are unremarkable.

Thank you for referring your patient to our facility.

Report ID: 6304198
Printed Date/Time: 10/11/2018 09:25 EDT
Page 1 of 2

Bucks Campus
380 North Oxford Valley Road
Langhorne, PA 19047-0000

Patient: **LYNCH, GERALDINE**
ORD DR: Anand MD,Neil

DOB: 3/29/1961
MR#: 00995820
AR#: 1827142430
LOC: BOP1
ADM: 10/4/2018

Magnetic Resonance Imaging

ACCESSION	EXAM DATE/TIME	PROCEDURE
MR-18-0014891	10/4/2018 11:06 EDT	MRI Spine Cervical w/o Contrast

Report
At C3-C4, there is no evidence of disc protrusion. There is severe right neural foraminal stenosis secondary to facet hypertrophy.
At C4-C5, there is disc space narrowing. There is minimal bulging. There is mild ligamentum flavum hypertrophy. There is a small central protrusion. There is left greater than right neural foraminal stenosis secondary to facet hypertrophy.
At C5-C6, the disc space is narrowed. There is spondylitic bulging. There is severe bilateral neural foraminal stenosis. There is central canal stenosis. Ligaments are hypertrophied.
At C6-C7, there is disc space narrowing. There is spondylitic bulging. There is hypertrophy of ligaments. There is bilateral neural foraminal stenosis.
At C7-T1, There is no evidence of disc pathology. There is no evidence of central or neural foraminal stenosis. The facet joints are unremarkable.

INDICATION: M54.2 M54.12 R20.9 Z12.31
***** *Final* *****

Dictated by: Barry Siskind MD
Dictated DT/TM: 10/04/2018 3:20 pm
Signed by: Barry Siskind MD
Signed (Electronic Signature): 10/04/2018 3:21 pm

Report ID: 8304188
Printed Date/Time: 10/11/2018 09:25 EDT
Page 2 of 2

EXHIBIT NA-7

Lower Bucks Hospital

LBH HEALTH INFORMATION MANAGEMENT
501 Bath Road
Bristol PA 19007-3101

Scicluna, Andrea P
MRN: 105089820, DOB: 11/19/1969, Sex: F
Adm: 10/14/2015, D/C: 10/14/2015

MRI LUMBAR SPINE W/O IV C [100135007]

Resulted: 10/15/15 0926, Result status: Final result

Ordering provider: Maria F Chen, MD 10/14/15 1739
Accession number: 15MR2314

Resulted by: Conversion Provider
Resulting lab: LOWER BUCKS HOSPITAL CLINICAL LABORATORY

Narrative
LOWER BUCKS HOSPITAL
RADIOLOGY DEPARTMENT
501 BATH ROAD * BRISTOL PA * 19007
215-785-9333
M.W.ANSLEY,M.D. CHAIRMAN P.S.BRACKIN,M.D. M.C.GIUDICI,M.D.
S.H.KALCHMAN,M.D. VICE CHAIR L.LIBFRAIND,M.D.
****

15MR2314 REPORT STATUS:Final/Adde

PATIENT: SCICLUNA,ANDREA P PH#: 2676229476 REG#: 4003371962
ADDRESS: 134 BLUE RIDGE DR ROOM#: RADIOL MR#: 470638
LEVITTOWN, PA 19057 PRIORITY: TODAY SERV: MED
ORDER PLACED: 10/14/2015 1713
DATE OF BIRTH: 11/19/1969 SEX: F ORDERED FOR:

REASON: 729.5 COMMENT:
PROCEDURE(S): COMPLETED DATE/TIME: ORDER #:
MRI LUMBAR SPINE W/O IV CONTRAST 10/14/2015 1739 15MR2314

ATTENDING DR: REFERRING DR:
CHEN, MARIA FANG-CHUN, M.D.

ORDERING DR: FAMILY DR:
CHEN, MARIA FANG-CHUN, M.D. LINDENBAUM, JEFFRY A., D.O.,PC

PROCEDURE: MRI LUMBAR SPINE W/O IV CONTRAST

INDICATION: Pain

COMPARISON: Comparison made with the prior exam from 5/16/2013.

MRI of the lumbar spine was performed without intravenous contrast. Sagittal T1, proton density and T2 imaging was performed. Axial proton density and T2 imaging was performed angled to the disc spaces.

FINDINGS: No fractures or bony destructive lesions are seen. The spinal cord terminates at the L1 level. No mass lesion is seen associated with the terminal portion of the spinal cord.

L1-L2: There is no evidence for disc herniations or bulges. The nerve roots exit normally. There is no evidence for spinal stenosis.

L2-L3: There is a small posterior osteophyte with a disc bulge. The nerve roots exit normally. There is no evidence for spinal stenosis.

L3-L4: There is a new small broad-based central disc protrusion. The nerve

Lower Bucks Hospital
LBH HEALTH INFORMATION MANAGEMENT
501 Bath Road
Bristol PA 19007-3101

Solciuna, Andrea P;
MRN: 105089820, DOB: 11/19/1969, Sex: F
Adm: 10/14/2015, D/C: 10/14/2015

roots exit normally. There is no evidence for spinal stenosis.

L4-L5: [There is a mild disc bulge. There is a left-sided annular tear. This is unchanged. The nerve roots exit normally. There is no evidence for spinal stenosis.

L5-S1: There is no evidence for disc herniations or bulges. The nerve roots exit normally. There is no evidence for spinal stenosis.

Impression: Again there are disc bulges at L2-L3 and L4-L5. Again there is a left-sided annular tear at L4-L5. There is a new small broad-based central disc protrusion at L3-L4.

Interpreted by Lester Libfraind, M.D.
Date 10/15/2015 07:34
Date Signed 10/15/2015 07:36

ADDENDUM
This addendum is to document the correct Ordering clinician on the initially released result. The findings of the examination(s) remain the same.
dor

Interpreted by Administrative Support
Date 10/15/2015 09:18
Date Signed 10/15/2015 09:20
****
*** PERMANENT CHART COPY - RADIOLOGY ***
****

Order

MRI LUMBAR SPINE W/O IV C [100135006]

Electronically signed by: **Interface, Radiology Results Conversion on 10/14/15 1739** Status: **Completed**
Ordering user: Interface, Radiology Results Conversion 10/14/15 1739 Ordering provider: Maria F Chen, MD
Authorized by: Maria F Chen, MD
Frequency: Once 10/14/15 1739 - 1 occurrence

FOOT (3+ VWS)-RT [100135013]

Resulted: 07/10/17 1137, Result status: Final result

Ordering provider: Shireen Khan, MD 07/10/17 1130
Accession number: 17DX15871
Resulted by: Phillip S Brackin, MD
Resulting lab: LOWER BUCKS HOSPITAL CLINICAL LABORATORY

Narrative:
LOWER BUCKS HOSPITAL
RADIOLOGY DEPARTMENT
501 BATH ROAD * BRISTOL PA * 19007

EXHIBIT NA-8

Patient: Andrea Scicluna **DOB:** 11/19/1969 **Sex:** M
Provider: Dr. Neil Anand, M.D. **Visit:** 01/28/2016 10:30AM **Chart:** SCAN000001

History of Present Illness:

I had the pleasure of seeing Andrea Scicluna today in kind referral from Dr. Fox
Andrea Scicluna is a pleasant, articulate 46 year old male who describes the insidious onset of Low back and both legs & ankle pain. Patient states that the onset of this complaint was a few years ago. The cause of injury was due to a non-work injury. Patient advised that the pain happened gradually over time The primary location of pain is to the bilateral of the lower back. Pt also complains of pain to the bilateral ankle. The patient reports that the pain radiates to the right leg, to the left leg. The pt describes the pain as sharp, radiating, tingling, burning. Furthermore, the patient states that when present, the pain lasts continuously without abating. The patient states that they avoid work, household chores, socializing, exercise due to the pain. The pain is worse throughout the day. However medications, sitting, lying down makes the pain better. Pt rates the worst pain as a 6 on a scale of 0-10 with "0" being no pain and "10" being the worst pain imaginable. Pt has seen a pain management specialist. Pt had interventional pain injections, such as Patient advised that she had a sterold injections four years ago with Dr. Buck PM. The patient is undergoing physical therapy, is currently taking medications. With the use of the prescribed multi-modal pain therapy, the pain has substantially improved. The patient has tried Methadone, baclofen, Celebrex, Bupropoin, Clonezepam, gabapentin, Nortriptyline, Polyethlene glycoll. Pt denies muscle weakness. Pt denies any other issues. A urine or oral saliva drug screen was obtained this visit to evaluate if the patient is complying with the medication treatment plan. The screen will evaluate for any unauthorized use of illegal substances and violation of the opioid agreement. The cups are mailed out to a lab for confirmation testing to determine the exact amounts of medications that are present as well as any other illicit substances. Andrea Scicluna's stated treatment goals this visit include: eventually being pain free, interact more with family and friends, to return to leisure activities, to increase walking tolerance.

Med / Fam / Social History:

Current Medication:Methadone, baclofen, Celebrex, Bupropoin, Clonezepam, gabapentin, Nortriptyline, Polyethlene glycoll
Pt is not taking insulin.
The pt is currently not pregnant.
Pt is not on blood thinning medications.
Pt is not allergic to contrast dye. The patient denies suicidal/homicidal ideation.

Past Medical History: Nose reconstruction, right knee surgery, right carpel tunnel sx, tubal ligation.
Father's Medical History: non contributory.
Mother's Medical History: non contributory. Pt is divorced. Pt is a smoker. Pt rarely drinks alcohol. Pt does not use illegal substances.

Review of Systems:

GENERAL: Positive --, trouble sleeping.
HEENT: no lightheadedness, no vision changes, no hearing problems, no tinnitus, no vertigo, no earaches, no

Patient: Andrea Scicluna **DOB:** 11/19/1969 **Sex:** M
Provider: Dr. Neil Anand, M.D. **Visit:** 01/28/2016 10:30AM **Chart:** SCAN000001

nasal stuffiness, no nasal discharge, no nosebleeds, no sinus trouble, no dry mouth, no hoarseness.
NECK: no lumps, no lymphadenopathy, no goiter, no pain, no stiffness.
CARDIOVASCULAR: no chest pain or discomfort, no palpitations, no dyspnea, no orthopnea, no paroxysmal nocturnal dyspnea, no edema.
RESPIRATORY: no cough, no sputum, no hemoptysis, no dyspnea, no wheezing.
GI: no abdominal pain, no nausea, no vomiting, no constipation, no diarrhea, no heartburn, no bloody stool.
GU: no painful urination, no painful defecation, no painful periods, no incontinence, no difficulty urinating, no difficulty defecating, no pelvic pain, no sexual dysfunction.
PERIPHERAL VASCULAR: no intermittent claudication, no leg cramps, no varicose veins.
MSK: Positive--, joint pain, backache, tenderness. Pain in both legs, ankle and lower back
NEUROLOGICAL: Positive--, tingling.
ENDOCRINE: no heat intolerance, no cold intolerance, no weight gain, no weight loss, no excessive sweating, no excessive thirst, no excessive hunger, no change in glove/hat/shoe size.
PSYCHIATRIC: no nervousness, no depression, no memory change.

Medications & Allergies:

Current Medication & Dosage	Route	Frequency	SIG	PRN?	Indication
Trezix oral capsule			3 tabs daily	No	
methadone 10 mg oral tablet			4 tabs po tid	No	pres 03/24/16
fentaNYL 100 mcg/10 mL-D5% injectable solution			1 patch q 3 days	No	pres 03/24/16

Physical Exam:

Pain
6/10

GENERAL: Patient in distress
HEENT: AT/NC; EOMI b/l; no scleral injection; mucus membranes moist
NECK: supple; no lumps; no lymphadenopathy; no goiter; no pain; no stiffness
CARDIOVASCULAR: RRR, no JVP, no carotid bruits, no murmurs, rubs or gallops, S1 S2 present, no S3/S4.
LUNGS: CTAB, no adventitious sounds
ABDOMEN: soft, non-tender, non-distended, no trauma on inspection, normal bowel sounds all 4 quadrants, no masses noted on light or deep palpation, no CVA tenderness, no hepatosplenomegaly, no rebound tenderness
MSK: Positive-- abnormal static stance assessment, facet arthropathy elicited with extension, discogenic like pain elicited with flexion, myofascial tenderness with palpation, jump sign muscle twitch, stiffness & pain with flexion/extension, joint pain with flexion and extension, swelling of the joint, redness of the joint
Physical examination of the lumbar back was abnormal with: Positive--, B/L lumbar muscle atrophy, stiffness & pain with flexion/extension, facet arthropathy elicited with extension, compression testing, sacroilliac joint border tenderness, patrick's test, gaenslen's test, POSH thigh thrust, PSIS distraction test, myofascial tenderness with palpation, jump sign muscle twitch, palpable taut muscle band, decreased range of motion.

Patient: Andrea Scicluna **DOB:** 11/19/1969 **Sex:** M
Provider: Dr. Neil Anand, M.D. **Visit:** 01/28/2016 10:30AM **Chart:** SCAN000001

Physical exam of the knee was abnormal with: Positive--, left, right, knee swelling, knee redness, knee warmness.
Physical exam of the ankle/foot was abnormal with: Positive--, right, left, ankle warmness, ankle redness, ankle swelling.
NEUROLOGICAL: muscle strength 5/5 in all major muscle groups, cranial nerves II-XII intact, rapid alternating movements intact, finger to nose movements intact, heel to shin movements intact, pain/temperature/light touch/ vibration/discrimination intact, DTR's intact, no pronator drift
Extrem: edema present-, gait abnormal-, gait antalgic-

The patient's studies were reviewed : abnormal EMG 10/13/15 evidence of active denervation in S1 innervated muscle bilaterally. Bilateral S1 radiculopathies

MRI Ankle w/o contrast right 2/19/15 Marked arthritis changes in midfoot, tibiotalar and subtalar articulation, acute and chronic plantar fasciitis. Marked dissension with fluid of the anterior tibial bursa.
Perineal tendon, there's an Interstitial of the peroneus bare is and there's thinking of the anterior talofibular ligament

MRI lumbar spine w/o contrast 2010 prominent facet degeneration noted at T11-12. Disc bulge L2,3 and L3,4

MRI lumbar spine w/o contrast 05/16/15 No significant changes from 2011. Disc bulge L1,2 , L2,3, L3,4 L4,5, L5S1

Assessment:

Type	Code	Description
ICD-10-CM Condition	M54.5	Low back pain
ICD-10-CM Condition	M54.16	Radiculopathy, lumbar region
ICD-10-CM Condition	M46.1	Sacroiliitis, not elsewhere classified
ICD-10-CM Condition	M25.571	Pain in right ankle and joints of right foot
ICD-10-CM Condition	M25.561	Pain in right knee
ICD-10-CM Condition	M25.562	Pain in left knee
ICD-10-CM Condition	M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region

Plan:

Patient referred to dedicated doctors in Bensalem, PA to follow up and prescribed clonazepam.
I have advised the pt to perform activity as tolerated, avoid prolonged sitting, avoid prolonged standing, avoid frequent bending / pulling / pushing, increase rest and relaxation, to refrain from heavy lifting of more than 10 lbs, routinely follow up with PCP.

PHYSICAL THERAPY: Evaluate and Treat.
The patient would benefit from the following therapies:Interventional pain procedures, physical therapy.

Patient: Andrea Scicluna **DOB:** 11/19/1969 **Sex:** M
Provider: Dr. Neil Anand, M.D. **Visit:** 01/28/2016 10:30AM **Chart:** SCAN000001

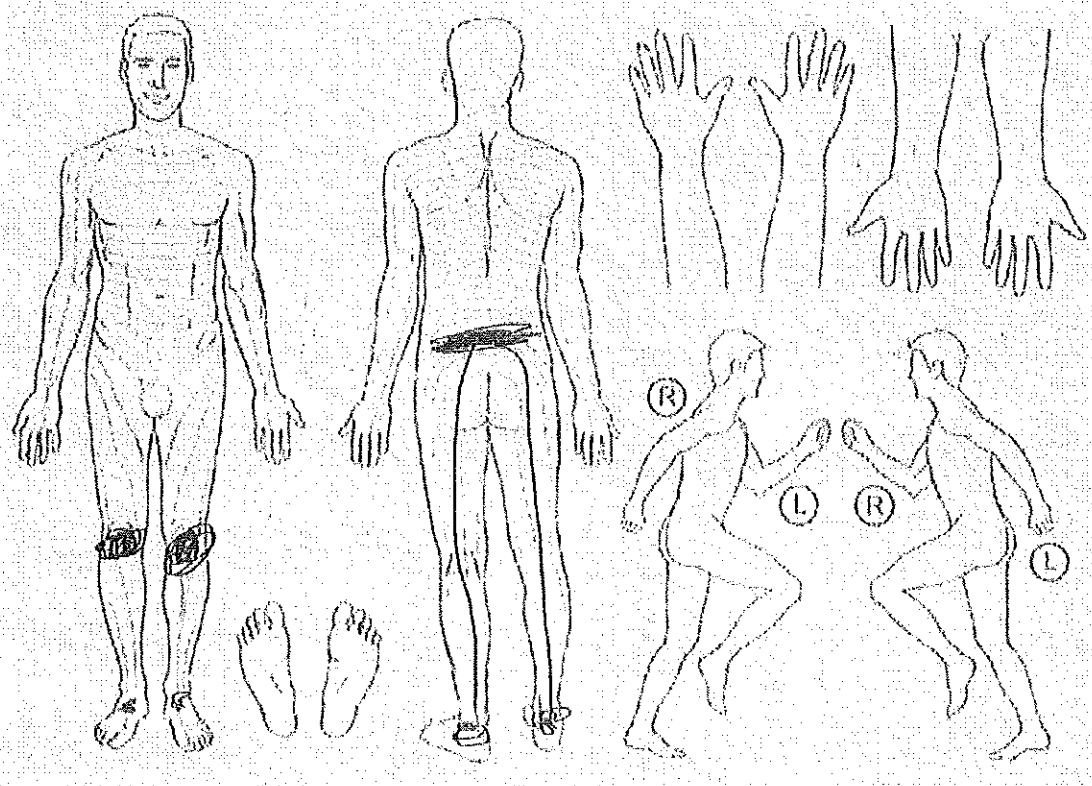
Patient has been advised to return in 1 month.

Patient will bring her recent EKG next visit as she's taking Methadone.

Conservative, interventional and surgical options were discussed in detail with the patient.
I will continue managing Andrea Scicluna pain syndrome utilizing all available interventional techniques. I have instructed the patient to contact either myself or my office if they have any further questions.

The total amount of face to face time examining, counseling, and reviewing medical records was 60 minutes.

Medications Prescribed	SIG	PRN?	Indication
CeleBREX 200 mg oral capsule	1 tab po qd	No	
gabapentin 800 mg oral tablet	1 tab po q8 hrs	No	
nortriptyline 25 mg oral capsule	2 tab po qhs	No	
baclofen 20 mg oral tablet	1 tab po tid	No	
Wellbutrin SR 150 mg/12 hours oral tablet, extended release	1 tab tid	No	



Patient: Andrea Scicluna
Provider: Dr. Neil Anand, M.D.

DOB: 11/19/1969 **Sex:** F
Visit: 01/28/2016 10:30AM **Chart:** SCAN000001

System Amendment

Patient: Andrea Scicluna **Doctor:** Dr. Neil Anand, M.D. **Appointment:** 01/28/2016 10:30AM EST	**Date:** 08/07/2018 1:45AM EDT **Source:** drchrono system

The drchrono system has added a timestamp to this locked clinical note. The previous four pages were saved on 3/24/2016 12:11PM EDT.

EXHIBIT NA-9

ARIA 3B
ORTHOPAEDIC SPECIALISTS

BUCKS COUNTY OFFICE
INITIAL VISIT

JACQUELINE CULVER
DOB: 04/05/1970

FEBRUARY 3, 2015

HISTORY: This 36-year-old right-handed female, in with right elbow pain. She has had pain intermittently in the right elbow over the last several years recently worsened in the last six months. She does not recall any injury, but has had progressive problems on the lateral aspect with activity, but it does not wake her up nor radiate down the arm. She is pointing anterolateral. She has had x-rays and MRIs and referred in for evaluation by Dr. Peck.

PAST MEDICAL HISTORY: Medical history sheet is reviewed. PCP is Dr. Larry Peck.

PAST SURGICAL HISTORY: Four knee surgeries.

CURRENT MEDICATIONS: Fentanyl patch 100 mcg every two days, Wellbutrin, Celexa, and Ambien.

ALLERGIES: Denied.

FAMILY HISTORY: Diabetes. Patient is a homemaker, unemployed. No small children. Nonsmoker and no alcohol.

ROS: Serious illnesses, ROS is negative.

PHYSICAL EXAMINATION: The patient is alert and oriented in no distress. She is 5 feet 8 inches and 133 pounds, BMI is 21.

On gross inspection, the patient has full motion of both shoulders pointing slightly to anterolateral as an area of mild discomfort, but she has full overhead elevation and abduction. These maneuvers do not cause any elbow pain. The patient's left elbow demonstrates a -7 degrees hyperextension, flexion 150

APR 06 2015

degrees. Right elbow demonstrates + 7 degrees of extension and 135 degrees of flexion thus an overall flexion-extension lag of 22 degrees. Supination, right is 75 degrees, 90 degrees left, pronation is full. The patient can readily oppose her thumb to all digits and has excellent motion of her right wrist. Resisted right wrist extension, lifting her heavy pocketbook causes mild discomfort laterally while she lifted in the pronated posture, but not supinated. Tactile exam reveals biceps and triceps to be normal, right elbow demonstrates no effusion, popping, snapping, or crepitus and no instability. She is moderately tender on the lateral epicondyle right elbow, but not the extensor wad. The radial humeral joint is normal as is the humeral ulnar joint. Biceps and triceps tendon respectively are normal, medial epicondyle and ulnar nerves are unremarkable. While she has a full grip on the right, Jamer grip shows deficit. Position one, right is 5 pounds left 30 pounds, position 2 right is 24 pounds left 50 pounds, position 3 right is 34 pounds left 52 pounds, all diminished by a local discomfort laterally. She shows intact MVS to her right hand.

For complete details of history, please refer to the patient's office chart.

IMAGING: I did not open the x-ray disc, but went right to the MRI of her right elbow. This shows a mild degree of extensor tendinopathy with a tiny ends and substance tear seen on only the coronal cut sequences, perhaps 1-2 mm. The remainder of the MRI study is completely normal.

IMPRESSION: Chronic lateral extensor tendinopathy (lateral epicondylitis, tennis elbow), right elbow.

TREATMENT:

1. Review of anatomy of the region with patient using anatomic model in correlation to the bony anatomy and then I demonstrated the MRI sequences to her.
2. She has to avoid using her hand in the pronated posture as much as possible to try and diminish symptoms, especially with her everyday activities.
3. Further options including physical therapy, tennis elbow strap (she has several of those), and/or injection, and lastly surgery were all discussed. She is clearly not surgical, she is an excellent candidate for physical therapy and could consider an

injection for severe pain should she want and she declined.
4. Ultimately the patient is referred to physical therapy after lengthy discussion of various activities and how to deal with the problem. It is pointed out that this problem can be a chronic with periodic flare-up and she basically needs to learn to live with it and therefore I am pushing for physical therapy as a means of helping her deal with that.
5. No medication requested or prescribed, she declined the injection and was not interested in pills.
6. Activities as tolerated and followup on a p.r.n. basis.
7. I also briefly discussed so-called off-label injection such as PRP to be complete knowing that she probably will go on the Internet.
8. Follow up p.r.n.

Stephen Lowe, M.D.

SL:cbs/rt

cc: Dr. Larry Peck

c/o 77458-066
Neil Anand
33 1/2 Pembroke RD
Danbury-Fci
Danbury, CT 06811
United States

Clerk, United States District Court
Eastern District of Pennsylvania
Attn: Filing Clerk
Case # 2:19-cr-00518-CFK
Motion for Reconsideration of Sentence

U.S.M.S.
X-RAY

RECEIVED
JUL 17 2025
CLERK, U.S. DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

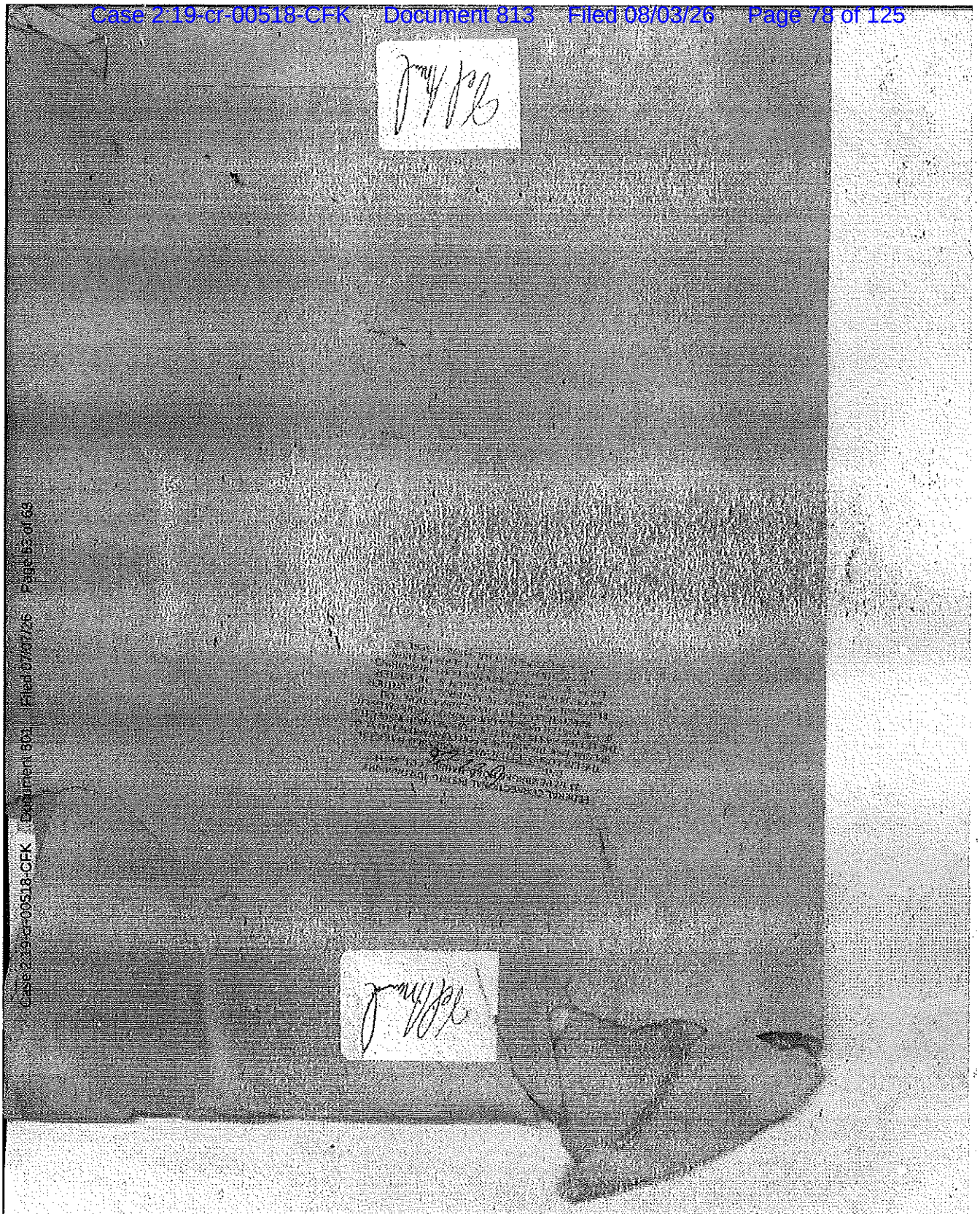


EXHIBIT B

Defendant's Motion to Perfect the Appellate Record Under Rule 29 and

Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)

(ECF No. 810)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,

v.

NEIL K. ANAND, M.D.,
Defendant.

Case No. 2:19-cr-00518-CFK

MOTION TO PERFECT THE APPELLATE RECORD UNDER RULE 29 AND HAZEL-ATLAS GLASS CO. v. HARTFORD-EMPIRE CO., 322 U.S. 238 (1944)

I. INTRODUCTION

Dr. Neil K. Anand respectfully moves this Court pursuant to Federal Rule of Criminal Procedure 29 and this Court's inherent authority under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)*, to perfect the appellate record regarding this Court's April 8, 2025 denial of his Motion for Judgment of Acquittal and to preserve these issues for review by the Third Circuit in Case No. 26-1359/ Case No. 25-2804 (3rd Circuit).

This Motion is filed solely to perfect the appellate record and preserve these issues for the Third Circuit's review. Because the integrity of the judicial process itself was compromised during a dispositive proceeding before this Court, it is imperative that this evidence be formally preserved in the record for appellate review.

On April 8, 2025, during Rule 29 proceeding — the dispositive bench proceeding where Judge Kenney alone, with no jury present, was deciding whether sufficient evidence existed to sustain the conviction — lead prosecutor Paul J. Koob took the perjured testimony from trial and repeated it directly to the judge as established fact. He did not stop there. He presented a fabricated account to this Court as eyewitness proof that Dr. Anand forced patients to accept medically unnecessary "Goody Bags" of medications in exchange for opioid prescriptions written outside the usual course of professional practice and without a legitimate medical

purpose. He misrepresented the legitimacy of non-opioid medications dispensed to patients. Each statement was made directly to this Court. Each was objectively refuted by the government's records. Each was known to be false by the prosecutor who made it.

These were not arguments. They were not inferences. They were false representations of fact, stated as established truth, refuted by government records— delivered to this Court at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction, during a proceeding where no jury was present, no cross-examination of the prosecutor's representations was possible, and the integrity of the proceeding depended entirely on the prosecutor telling the truth.

That escalation — from perjury before a jury to false statements directly to this Court during a dispositive bench proceeding — is the transformation from a professional conduct violation into fraud upon the court under *Hazel-Atlas*. Fraud upon the court requires conduct directed at the judicial machinery itself — not merely at deceiving the opposing party or the jury, but at corrupting the proceeding by which the court performs its impartial function. When a prosecutor stands before a judge at Rule 29 and makes false factual representations about the content of the evidence — with no jury present, no cross-examination possible, and the judge's ruling determining whether the conviction stands or falls entirely — he is not making an argument. He is corrupting the proceeding by which this Court performs its impartial function.

He told this Court that the documentation contained no basis for prescribing opioids — while holding patient files containing objective diagnostic proof: MRI reports showing spinal stenosis, EMG reports confirming radiculopathy, and a neurosurgeon's written determination of ongoing and indefinite pain management. Each of these statements was made directly to this Court — not to a jury — during a proceeding where the judge was making a legal determination and where no cross-examination of the prosecutor's factual representations was possible.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present fabricated accounts directly to this Court — the sole decision-maker at Rule 29 — as established facts supporting denial of acquittal, in a proceeding where there was no

mechanism to cross-examine his representations and where this Court was entirely dependent on his accuracy.

The elements that this motion establishes are: (1) a false representation (2) made directly to the tribunal (3) during a dispositive proceeding (4) that the prosecutor knew to be false (5) that was objectively provable as false from the government's own files, and (6) that undermined this Court's ability to perform its impartial truth-seeking function. A pattern of deliberate repetition during the April 8, 2025 Rule 29 proceeding satisfies *Hazel-Atlas's* requirement of a 'deliberately planned and carefully executed scheme.' 322 U.S. at 245.

Each of these elements is established by the government's own records. This motion is filed to preserve these issues for review by the Third Circuit in Case No. 26-1359 (Case No. 25-2804) pursuant to this Court's inherent authority under *Hazel-Atlas* and Federal Rule of Criminal Procedure 29.

II. LEGAL STANDARDS

Federal Rule of Criminal Procedure 29 provides that the Court must enter a judgment of acquittal of any offense for which the evidence is insufficient to sustain a conviction. A post-verdict Rule 29 motion requires the Court to determine whether any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt. *Jackson v. Virginia*, 443 U.S. 307, 319 (1979). The Third Circuit reviews the denial of a Rule 29 motion de novo. *United States v. Caraballo-Rodriguez*, 726 F.3d 418, 424 (3d Cir. 2013).

Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944), establishes that a court has inherent authority to vacate a judgment procured through fraud upon the court. Fraud upon the court requires conduct directed at the judicial machinery itself — conduct that corrupts the impartial function of the proceeding. Unlike ordinary fraud, fraud upon the court has no limitations period and may be raised at any time. Id. at 244–45. The standard requires a "deliberately planned and carefully executed scheme" to defraud the court. Id. at 245.

Napue v. Illinois, 360 U.S. 264 (1959), holds that the government's knowing use of false testimony violates due process. The *Hazel-Atlas* standard is distinct from and broader than

Napue: while *Napue* addresses false testimony presented to a jury, *Hazel-Atlas* addresses false representations made directly to the court itself during proceedings where the court is the sole decision-maker. The prosecutor's conduct here falls squarely within *Hazel-Atlas* because his false representations were made not to a jury but to this Court as the sole arbiter of the Rule 29 motion.

III. FALSE STATEMENT ONE: THE GLASGOW FABRICATION

A. What Koob Told This Court

On April 8, 2025, during Rule 29 proceedings with no jury present and this Court serving as the sole arbiter of evidentiary sufficiency, lead prosecutor Koob made the following direct representation to this Court:

"Frederick Glasgow specifically said he watched him sit there, sign and stamp a whole pad, and allowing these unlicensed folks to fill out drugs that are going out the door." (Tr. 2357:21–23.)

Koob attributed this account to Glasgow by name. The word "specifically" was deliberate — it conveyed precision, accuracy, and direct eyewitness observation of criminal conduct.

B. What Glasgow Actually Testified

Glasgow's complete testimony on this subject is a single answer to a single question on direct examination at Day 3, Tr. 454:6–13. The government asked:

Q: Did you ever see Dr. Anand sign or stamp prescriptions that weren't for you?

A: Yeah.

Q: Can you tell us about that?

A: One day I walked back to the back that — there was I guess an exam room in the back there, past his office. And he was sitting at his desk just signing and stamping a book of prescriptions.

C. The Three Fabricated Elements

Koob fabricated three elements that do not exist anywhere in Glasgow's testimony and that transform an innocent description into a federal crime:

"Whole pad." Glasgow said "a book of prescriptions." Koob changed it to "a whole pad." A physician sitting at his desk signing a book of prescriptions is doing medical paperwork — completing patient-specific prescriptions that have already been prepared. A whole pad is a blank pad of prescription forms being pre-signed for others to fill in later. The substitution transforms lawful medical documentation into a criminal pre-signing scheme. Glasgow never used that word. Koob invented it.

"Unlicensed folks to fill out drugs." Glasgow said nothing about unlicensed staff. He said nothing about anyone filling out anything. That entire element — which describes the criminal act itself — was invented by Koob and attributed to Glasgow by name before this Court. No version of Glasgow's testimony, on any day of trial, contains this description.

"Going out the door." Glasgow said nothing about drugs going anywhere. That phrase does not appear in Glasgow's testimony. It does not appear anywhere in the record as a statement attributed to Glasgow. Koob fabricated it entirely.

What Glasgow actually described — a physician at his desk doing paperwork — is consistent with ordinary medical practice. What Koob told this Court Glasgow described — a physician pre-signing blank pads for unlicensed staff to fill out and send out the door — is a federal crime. The difference between those two accounts is not interpretation or emphasis. It is fabrication.

D. Physical Evidence Independently Confirms the Fabrication

The government produced thousands of pages of patient file records bearing PT_FILES bates numbers. Not one blank pre-signed prescription form appears anywhere in that production. The photographs in evidence — including PT_FILES_003641 (Gage), PT_FILES_004521 (Glasgow), PT_FILES_005110, PT_FILES_005252 (Lynch), PT_FILES_006781 (Rios), PT_FILES_009047 (Scicluna), and PT_FILES_010379 (Stevenson), attached as Exhibit NA-1—

show fully completed patient-specific prescriptions clearly showing the scripts were not pre-signed. PT_FILES_010379 shows a prescription pad recovered from Stevenson's patient file — and not one script on that pad is pre-signed. A pre-signed script bears a signature on a blank form with no patient information. Not one such form exists anywhere in the government's production. Koob held this entire production when he told Judge Kenney that pre-signed scripts were given to scribes to write prescriptions.

E. Materiality: Koob's Own Words Establish It

On the morning of April 9, 2025, this Court acquitted co-defendant Viktoriya Makarova. Koob immediately moved for reconsideration at sidebar, stating at Trial Tr. 2471:25 – 2472:4 *"With respect to the prescriptions, it's the presigning is the issue. As the Court heard at sidebar, presigning and having somebody look at it later is not the law, that is not allowed."*

This Court denied reconsideration. The only presigning evidence Koob had attributed to Dr. Anand during Rule 29 was the Glasgow fabrication. Presenting a fabricated account as established fact to the sole decision-maker at a dispositive proceeding corrupted the integrity of that proceeding.

F. Why This Is Fraud Upon the Court

When Koob said "Frederick Glasgow specifically said" — that was a factual representation about the content of the evidentiary record, not an argument, not an inference, not advocacy. The word "specifically" is a direct claim of accuracy — it tells this Court: I am not paraphrasing, I am not inferring, I am telling you exactly what this witness said. That statement is objectively and verifiably false. The fabricated words — whole pad, unlicensed folks, going out the door — Glasgow never said any of it.

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — the patient prescription records produced in discovery contained not one blank pre-signed form, and Koob held every one of those records when he made this representation (5) that is objectively provable

as false from the trial transcript itself, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present a fabricated account directly to this Court — the sole decision-maker at Rule 29 — as an established fact supporting denial of acquittal. That is fraud upon the court under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)* — fraud "directed to the judicial machinery itself" that makes it impossible for the court to perform its "impartial task." Id. at 246.

IV. FALSE STATEMENT TWO: TAMARA GAGE "CONTINUED TO GET THE BAG EVERY MONTH"

A. What Koob Told This Court :

At trial, Koob elicited the following testimony from T.G. on direct examination (Day 6, pp. 1231: 6-12):

Q: How often or how many times did you receive the medications thereafter?

A: Every month.

Q: Why did you take them?

A: Because you had to take them or you couldn't get your prescriptions.

Having elicited that testimony himself, Koob then repeated it directly to Judge Kenney at Rule 29 as established fact — at the precise moment the Court was determining whether sufficient evidence existed to sustain the conviction:

"Ms. Gage gave the very vivid description of sitting on the floor and dumping out the bag and telling everyone that would listen she didn't want it. She continued to get the bag every month." (Tr. 2352:4–7.)

Koob continued: *"He continued to force them to take them." (Tr. 2352:17.)*

Those statements were Koob's own direct representations to this Court — not a summary of testimony — offered as established fact to sustain the coercion theory — that patients had to

accept the Goody Bag medications (non-opioid anti-inflammatories and muscle relaxers) in exchange for their opioid prescriptions.

B. What Government File 303 Proves

Government File 303 — the prosecution's pharmacy dispensing records,— contains the complete in-house dispensing history for T.G. It proves:

Last in-house dispensing: December 18, 2018

Last date as active patient: September 24, 2019

Government File 303 shows no in-house dispensing to Gage from December 2018 forward — nine consecutive months of zero dispensing while Koob falsely told this Court she continued to receive the bag every month.

C. Proof of Koob's Knowledge

Government File 303 was the prosecution's foundational dispensing file — the same file the government used to build its case-in-chief, secure the indictment, and prepare Tamara Gage's direct examination. It is a mathematical impossibility for the prosecution to have vetted Tamara Gage, prepared her direct examination, and built its dispensing-coercion theory without reviewing the file that showed nine consecutive months of zero in-house dispensing. When Koob told this Court that Tamara Gage "continued to get the bag every month," he was holding Government File 303. The statement was the direct opposite of what that file showed. Presenting a fabricated account as established fact to the sole decision-maker at a dispositive proceeding corrupted the integrity of that proceeding.

D. Why This Is Fraud Upon the Court

This meets every *Hazel-Atlas* element. The statement was made directly to this Court during a dispositive bench proceeding. Koob built the coercion theory from File 303 — a dispensing log showing zero dispensing for nine consecutive months cannot be reconciled with "every month." Koob made this representation at the precise moment Judge Kenney was determining whether

sufficient evidence existed to sustain the coercion theory — a representation Government File 303 directly and conclusively refutes.

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — he held Government File 303 when he told this Court dispensing continued every month, and that file contains nine consecutive months of zero entries (5) that is objectively provable as false from the government's dispensing records, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction on Count 2.

This exceeds a *Napue* violation. *Napue* addresses false testimony presented to a jury. What Koob did was present a false factual characterization — "she continued to get the bag every month" — directly to this Court as the sole decision-maker at Rule 29, as an established fact supporting denial of acquittal. That is fraud upon the court under *Hazel-Atlas Glass Co. v. Hartford-Empire Co., 322 U.S. 238 (1944)* — fraud "directed to the judicial machinery itself" that makes it impossible for the court to perform its "impartial task." Id. at 246.

V. FALSE STATEMENT THREE: "EACH OF THE PATIENTS DID NOT WANT, NEED, OR USE THIS MEDICATION"

A. What Koob Told This Court

At the April 8, 2025 Rule 29 proceeding, Koob made the following representations directly to Judge Kenney:

"Each claim that was submitted for a nonopioid medication was false and fraudulent. And each of the patients that testified did say that they gave notice to the office staff that they did not want, need, or use this medication." (Tr. 2351:19–22.)

Moments later, returning to the same point:

"[Defendant Anand] continued to do so, knowing that his patients were not using these medications, did not want them. He continued to force them to take them." (Tr. 2352:15–17.)

And again, addressing the patients on Counts 2, 3, and 4 specifically:

"The patients were clear they did not want or use them." (Tr. 2353:19–20.)

B. What the Government's Own Records Prove

These representations were not incidental. Koob's repeated assertion that patients did not want, need, or use these medications was the evidentiary foundation of the government's quid pro quo theory — that patients were required to accept bags of non-opioid medications as a condition of receiving their opioid prescriptions. The government's own records refute that premise directly. Every patient Koob named was voluntarily filling those same non-opioid medications at retail pharmacies, on their own, outside Dr. Anand's office. He made these representations at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction on Counts 2, 3, and 4.

Tamara Gage. Government File 303 shows Gage voluntarily filling tizanidine and amitriptyline — non-opioid muscle relaxer and nerve pain medications — at Yorke Pharmacy on multiple occasions between October 2015 and August 2018. Dr. Anand's DrChrono electronic medical records, in the government's possession, show Gage continuing to fill temazepam, carisoprodol, topiramate and tizanidine - non-opioid medications at Yorke Pharmacy from January 2019 through September 2019. Government PDMP File 711 further confirms Gage voluntarily filling zolpidem — a non-opioid sleep medication — at Yorke Pharmacy on August 18, 2021, prescribed by an independent physician at Comprehensive Care. Nobody handed her these medications. She drove to Yorke and filled them herself. Gage's pattern of voluntary retail fills at Yorke Pharmacy across nearly three years is irreconcilable with Koob's representation that she did not want, need, or use these medications

Jodi Stevenson. PT_FILES_009957–009981 contain prior medication records from Morrisville Yardley Family Medicine documenting that before she ever presented as Dr. Anand's patient, Stevenson was already receiving Lyrica 225mg — a non-opioid nerve pain medication — ibuprofen 600mg — a non-opioid anti-inflammatory — Zorvolex 35mg — a non-opioid anti-

inflammatory — and propranolol 80mg, all prescribed by her primary care physician. On October 26, 2022, FBI agents recovered from Stevenson's residence two completely empty bottles of cyclobenzaprine — Rx 102528 (60 tablets, 7.5mg) and Rx 105918 (120 tablets, 7.5mg) — and two partially used bottles of cyclobenzaprine — Rx 103572 and Rx 100869 — dispensed by Dr. Anand's in-house pharmacy (INT_001109–001111). She also voluntarily filled topiramate (Rx 6689673), prescribed by Dr. Anand, at Sav-On Pharmacy. Additionally, Stevenson testified at Tr. 1091–1092 that she is currently taking Lyrica — a non-opioid prescribed for nerve pain — and propranolol for migraines, and another pill that helps with the nerve pain at night, all prescribed by physicians independent of Dr. Anand. Koob made these representations at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the convictions — while holding evidence showing empty and partially used bottles recovered from her home, voluntary retail fills at an outside pharmacy, and medication records confirming her ongoing use of non-opioid medications before, during, and after her time as Dr. Anand's patient.

Jacqueline Culver. PT_FILES_002928 through PT_FILES_002939, prior medication records from Morrisville Yardley Family Medicine, document that before she ever presented as Dr. Anand's patient, Culver was already receiving Vicoprofen, Ambien CR, and zolpidem — prescribed by her primary care physician Lawrence Peck DO from at least April 2012 through July 2015 — with documented diagnoses of migraine and osteoarthrosis of the right knee. Government File 303 further shows Culver voluntarily filling tizanidine — a non-opioid muscle relaxer — at Big Oak Pharmacy in November 2015, and cyclobenzaprine — a non-opioid muscle relaxer — at Big Oak Pharmacy in December 2015. At trial, on cross-examination at Tr. 1771–1772, Culver testified under oath that she currently takes gabapentin, duloxetine, zolpidem, diazepam, and ibuprofen — all non-opioids — prescribed by physicians independent of Dr. Anand. Her own sworn testimony, combined with the government's own records showing voluntary non-opioid use before, during, and after her time as Dr. Anand's patient, is irreconcilable with Koob's representation that she did not want, need, or use these medications.

Geraldine Lynch. Lynch testified at Tr. 1297 that she used the lidocaine patches and cream from the bags. She further testified at Tr. 1309 that Dr. Anand prescribed her gabapentin

specifically for diabetic neuropathy — a non-opioid she was actively taking for a documented medical condition. Government File 303 shows she voluntarily filled Trokendi XR — branded topiramate extended release, a non-opioid migraine and nerve pain medication — at Family 1 Pharmacy on April 25, 2018, a retail pharmacy outside the in-house dispensary — the same class of non-opioid medications Koob told this Court she did not want, need, or use.

Frederick Glasgow. Dr. Nirav K. Shah, a board-certified neurosurgeon and spine specialist at Princeton Brain and Spine, examined Glasgow and concluded within a reasonable degree of medical certainty that ongoing prescriptions for muscle relaxants and anti-inflammatories would be necessary for his lifetime (PT_FILES_004201–004207, at PT_FILES_004206, attached hereto as Exhibit NA-2) — directly establishing medical need for the same class of medications Koob told this Court Glasgow did not want, need, or use. Government File 304 shows Glasgow voluntarily filling ibuprofen 800mg — a non-opioid NSAID anti-inflammatory — at Rite Aid #11110 in February and March 2016, prescribed by Dr. Christopher Belletieri, a physician independent of Dr. Anand. The same file shows Glasgow voluntarily filling gabapentin 300mg — a non-opioid nerve pain medication — at Rite Aid #11110 on February 12, 2016, prescribed by Dr. Matthew McLean, a physician independent of Dr. Anand. The same file shows Glasgow voluntarily filling meloxicam 7.5mg — a non-opioid NSAID anti-inflammatory — and tizanidine 4mg — a non-opioid muscle relaxer — at Rite Aid #11110, prescribed by Dr. Madnani, a physician independent of Dr. Anand, in March and April 2016. The same file further shows Glasgow voluntarily filling amitriptyline — a non-opioid nerve pain medication — at Rite Aid #11110 in December 2017, Lyrica — a non-opioid prescribed for nerve pain — at Rite Aid #11110 in March 2018, and temazepam — a non-opioid sleep medication — at Rite Aid #11110 in March 2017 and April, June, and July 2019. Glasgow's pattern of voluntary retail fills across three years, corroborated by a neurosurgeon's written determination of lifetime medical need for the same class of medications, is irreconcilable with Koob's representation that he did not want, need, or use these non-opioid medications, at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction.

Andrea Scicluna. Scicluna testified at Tr. 1549 that she tried "the Celebrex and the cream, anti-inflammatory creams" from the bag. Government PDMP File 732 further shows Scicluna

voluntarily filling diazepam — a non-opioid benzodiazepine — at Yorke Pharmacy in July, September, October, November, and December 2018, carisoprodol — a non-opioid muscle relaxer — at Yorke Pharmacy in July and September 2018, and zolpidem — a non-opioid sleep medication — at Yorke Pharmacy in April, May, June, and July 2018. Scicluna additionally filled temazepam at Yorke Pharmacy every month from January through July 2019 — seven consecutive months of voluntary retail fills of a non-opioid sleep medication. Scicluna's pattern of voluntary retail fills is irreconcilable with Koob's representation that she did not want, need, or use these non-opioid medications, at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the conviction.

C. Proof of Koob's Knowledge

Koob built this case on the government's claims data, the PDMP, the DrChrono electronic medical records, FBI 321, and the patient trial testimony. He cannot have prepared this prosecution without knowing what those records showed. When he stood before this Court and told Judge Kenney three separate times that these patients did not want, need, or use these medications, he was holding the files showing every patient he named voluntarily filling those same medications at retail pharmacies on their own — outside Dr. Anand's office.

D. Why This Is Fraud Upon the Court

This satisfies every *Hazel-Atlas* element. The statements were made directly to this Court during a dispositive bench proceeding — at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the convictions. They are objectively provable as false — not a matter of characterization or inference, but of documentary record contradicting the categorical representation Koob made to this Court three separate times. The statements were known to be false at the time — Koob built his case from these same records and held FBI 321/FBI 302 showing Stevenson's empty and partially used bottles when he told this Court she was not using any of it. Koob's representations at the Rule 29 proceeding required this Court to determine whether sufficient evidence existed to support the coercion theory underlying the quid pro quo scheme — while he was holding the government's own records proving every patient wanted, needed, and used these medications.

An officer of the court making knowingly false factual representations to a federal judge at a dispositive proceeding, while holding the government's own evidence proving the opposite, is the fraud upon the court that *Hazel-Atlas* was designed to reach.

VI. FALSE STATEMENT FOUR: "THE DOCUMENTATION DOESN'T SUPPORT THAT THERE IS ANY BASIS FOR PRESCRIBING THOSE OPIOIDS"

A. What Koob Told This Court

At the April 8, 2025 Rule 29 proceeding, in response to a question from Judge Kenney about whether Dr. Anand was farming out responsibility or the scrivener role, Koob made the following representation directly to this Court:

"The documentation doesn't support that there is any basis for prescribing those opioids." (Tr. 2358:7–8.)

This was a categorical representation to Judge Kenney — not a characterization of contested expert opinion, not a summary of disputed testimony, but a flat factual assertion that the patient files produced in discovery contained no documentation supporting a medical basis for the opioid prescriptions. It was made at the precise moment Judge Kenney was evaluating the sufficiency of evidence on Count 10, the conspiracy to distribute controlled substances outside the usual course of professional practice.

B. What the Government's Records Prove

The patient files produced in discovery, admitted at trial, and in Koob's possession throughout the proceedings contained objective diagnostic findings documenting verifiable pathology for all of the six patient witnesses.

Tamara Gage. PT_FILES_003393–003394, Exhibit NA-3, contains an MRI of the cervical spine dated March 25, 2015, reporting mild multilevel cervical degenerative changes with central canal and foraminal narrowing, worst at C6-C7 where there is mild to moderate central canal stenosis. Government PDMP File 711 further confirms that after leaving Dr. Anand's practice, Gage continued receiving hydromorphone 8mg 120 tabs prescriptions from independent physicians at Yorke Pharmacy continuously from October 2019 through February 2023.

Independent physicians treating Gage after she left Dr. Anand's practice reached the same prescribing conclusion — directly refuting Koob's representation to Judge Kenney that the documentation contained no basis for prescribing opioids.

Jodi Stevenson. An EMG dated June 25, 2016, Exhibit NA-4, an abnormal study confirming bilateral chronic predominantly axonal motor polyneuropathy with neuropathic changes in the lower extremities embedded in the government's records, PT_FILES_009708–009953. Stevenson's diagnoses of systemic lupus erythematosus and Guillain-Barré syndrome are independently confirmed at PT_FILES_009957–009981, which further establish that she was already receiving morphine sulfate ER 100mg from her primary care physician at Morrisville Yardley Family Medicine dating back to at least April 2014 — before she ever presented as Dr. Anand's patient. Government PDMP File 738 confirms that after leaving Dr. Anand's practice, Stevenson continued receiving oxycodone 15mg (180 tablets) and morphine sulfate ER (60 tablets) from Patrick Falls' office from March 2019 through 2023 — independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Frederick Glasgow. PT_FILES_004201–004207, Exhibit NA-2, contains a narrative report by board-certified neurosurgeon Dr. Nirav K. Shah of Princeton Brain and Spine, documenting his personal review of three MRI scans of the lumbar spine from October 2015 through June 2016, each confirming an L4-5 traumatic disc bulge, and concluding within a reasonable degree of medical certainty that Glasgow suffers from mechanical low back pain with radiculopathy, lumbar traumatic facet syndrome, and definitive permanency requiring ongoing and indefinite pain management. Government PDMP File 713 further confirms that after leaving Dr. Anand's practice, Glasgow continued receiving opioid prescriptions from independent physicians at Rite Aid through late 2019 — independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Geraldine Lynch. PT_FILES_005232–005234, Exhibit NA-5, contains an EMG dated October 26, 2017, confirming bilateral C5-C6 radiculopathy. PT_FILES_005250–005251, Exhibit NA-6,

contains an MRI of the cervical spine dated October 4, 2018, documenting central canal stenosis from C4 through C7 and neural foraminal stenosis at multiple levels. Government PDMP File 718 further confirms that after leaving Dr. Anand's practice, Lynch continued receiving opioid prescriptions from multiple independent physicians — including Kenneth Fox, Lawrence Peck, Frank Colarusso, and David Hardeski — continuously from 2019 through 2023, independent physicians reaching the same prescribing conclusion. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Andrea Scicluna. PT_FILES_009410–009411, Exhibit NA-7, contains an MRI of the lumbar spine dated October 14, 2015, from Lower Bucks Hospital, documenting disc bulges at L2-L3 and L4-L5, a left-sided annular tear at L4-L5, and a new small broad-based central disc protrusion at L3-L4. PT_FILES_008454–008458, Exhibit NA-8, is the government's DrChrono patient records documenting an abnormal EMG dated October 13, 2015, at PT_FILES_008456, confirming active denervation in S1 innervated muscles bilaterally and bilateral S1 radiculopathies — a finding embedded in her clinical notes across all dates of service. Government PDMP File 732 confirms that after leaving Dr. Anand's practice, Scicluna continued receiving opioid prescriptions from independent physicians — including Rachel Gennaoui Abad, Lorna Ching-Carter, and Matthew McKeever — through August 2022. FBI interview reports INT_000376–000377 and INT_001104–001105 further document Scicluna's own admissions on July 23, 2020 and November 20, 2023 that she continues receiving methadone from a methadone clinic — independent recognition of her ongoing opioid treatment need by a separate medical institution entirely outside Dr. Anand's practice. Koob held these findings when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

Jacqueline Culver. PT_FILES_002940–002942, attached hereto as Exhibit NA-9, is an initial visit record from Aria 3B Orthopaedic Specialists dated February 3, 2015, documenting four prior knee surgeries and confirming that Culver was already receiving fentanyl patch 100mcg every two days — prescribed by an independent physician — before she ever presented as Dr. Anand's patient. Government PDMP File 708 further confirms that after leaving Dr. Anand's practice, Culver continued receiving opioid prescriptions from independent physician Paul

Soccio continuously from 2016 through at least 2023. Koob held these records when he told Judge Kenney that the documentation contained no basis for prescribing opioids.

C. Proof of Koob's Knowledge

The patient files containing these findings were government discovery productions bearing government exhibit numbers. They were in Koob's possession throughout the proceedings. It was physically impossible to review those records without encountering them. A lead prosecutor who reviews records containing a radiologist's finding of central canal stenosis and a neurologist's finding of bilateral radiculopathy, and then tells a federal judge that the documentation contains no basis for prescribing opioids, has made a knowingly false statement of fact to the tribunal. Koob held these records when he made that representation to this Court — at the precise moment Judge Kenney was determining whether sufficient evidence existed to sustain the Count 10 conviction.

D. Why This Is Fraud Upon the Court

Each *Hazel-Atlas* element is satisfied: (1) Koob made a false representation (2) directly to this tribunal (3) during a dispositive bench proceeding (4) that he knew to be false — he held patient files containing MRI reports showing spinal stenosis, EMG reports confirming radiculopathy, and a neurosurgeon's written determination of ongoing and indefinite pain management when he told this Court the documentation contained no basis for prescribing (5) that is objectively provable as false from records bearing government exhibit numbers, without resort to competing expert opinion — no expert is needed to read a radiologist's finding of stenosis or a neurologist's finding of radiculopathy, and (6) that undermined this Court's ability to perform its impartial truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the Count 10 conviction. A prosecutor making a categorical false representation to a federal judge at a dispositive proceeding, while holding diagnostic records proving the opposite, is the fraud upon the court that *Hazel-Atlas* was designed to reach.

CONCLUSION

AUSA Koob knowingly made four false representations of fact directly to this Court during the April 8, 2025 Rule 29 proceeding, corrupting the court's truth-seeking function at the precise moment it was deciding whether sufficient evidence existed to sustain the conviction: he fabricated words never spoken by Frederick Glasgow; he told this Court Tamara Gage continued to receive the bag every month when Government File 303 showed nine consecutive months of zero in-house dispensing; he told this Court patients did not want, need, or use these medications — when the government's own records show patients voluntarily filling non-opioid medications at retail pharmacies outside Dr. Anand's office; and he told this Court the documentation contained no basis for opioid prescribing when the government's patient medical records contained MRI reports, EMG reports, and independent physician determinations of medical necessity.

Each representation was made directly to this Court during a dispositive bench proceeding, with no jury present, no cross-examination possible, and this Court's ruling depending entirely on the prosecutor's accuracy. Each representation was known to be false at the time, and objectively provable as false from the government's patient records — without expert testimony or inference. These four false representations of fact satisfy *Hazel-Atlas's* requirement of a "deliberately planned and carefully executed scheme." 322 U.S. at 245. The scheme was not to deceive the jury. The scheme was to deceive this Court — the sole decision-maker at the one proceeding where no cross-examination of the prosecutor's representations was possible and where this Court's ruling depended entirely on his accuracy.

Dr. Neil K. Anand respectfully requests that this Court perfect the appellate record and preserve these issues for review by the Third Circuit in Case No. 25-2804 Case No. 26-1359 pursuant to this Court's inherent authority under *Hazel-Atlas Glass Co. v. Hartford-Empire Co.*, 322 U.S. 238 (1944), and Federal Rule of Criminal Procedure 29.

Respectfully submitted,
Neil Anand July 13, 2026
Neil K. Anand, Pro Se

CERTIFICATE OF SERVICE

I hereby certify that on July 13, 2026, I caused a true and correct copy of the foregoing Motion to be served upon the following by United States Mail, postage prepaid:

Paul J. Koob, Arun Bodapati, and Patrick J. Campbell Assistant United States Attorneys United States Attorney's Office Eastern District of Pennsylvania 615 Chestnut Street, Suite 1250 Philadelphia, Pennsylvania 19106

Neil K. Anand, Pro Se
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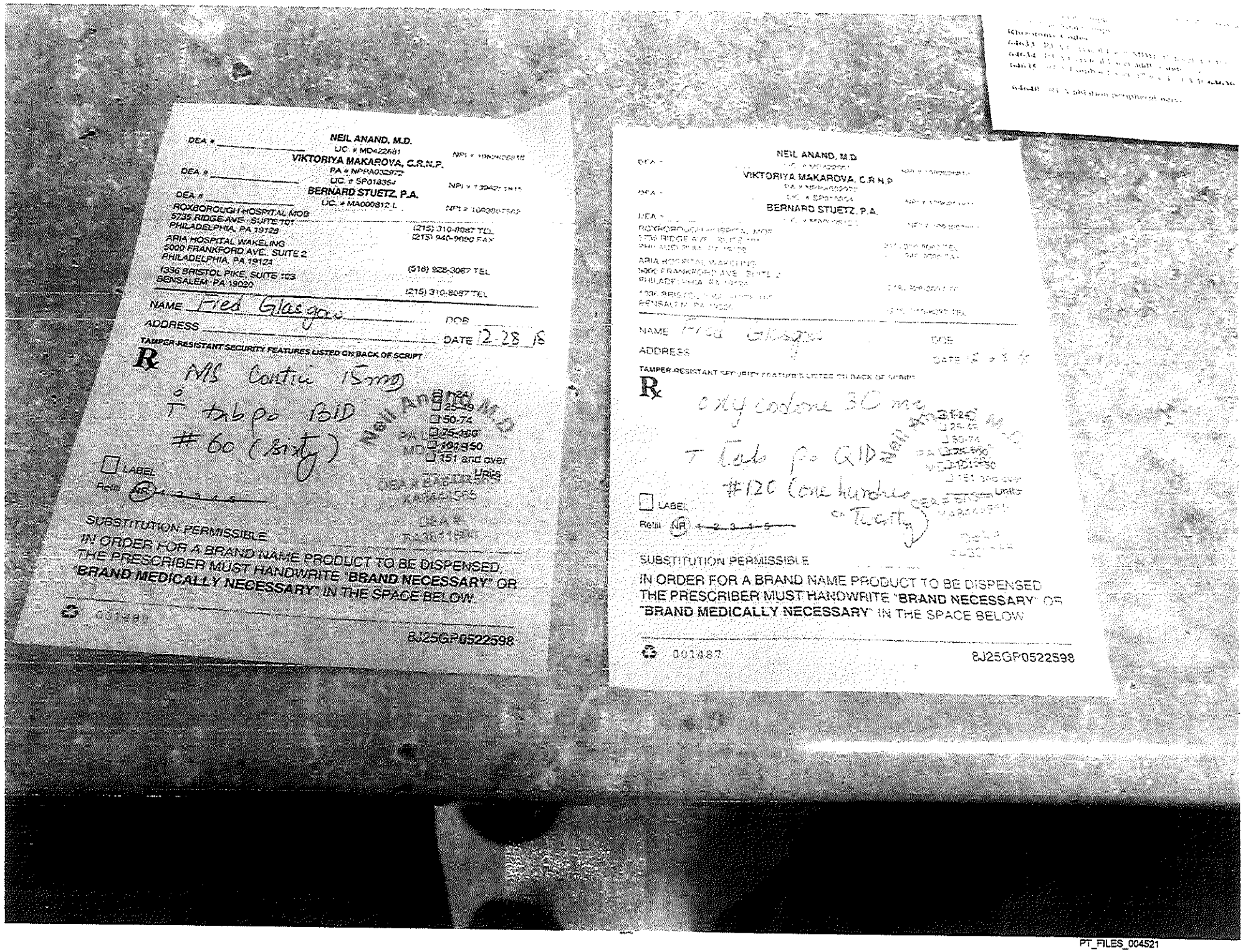
Date: July 13, 2026

Original filing filed through prison mailbox on 6/22/2026. Pursuant to prison mailbox rule, "a document is docketed filed on the date it is given to prison officials for mailing." Pabon v. Mahanoy 654 F.3d 385 (3rd Circuit). See attached outgoing legal mail log.

OUT GOING LEGAL MAIL LOG

INMATE NAME	REG #	UNIT	OUT GOING DATE & TIME	DESTINATION	STAFF SIGNATURE	INMATE SIGNATURE
Neil Anand	77458-066	M	6/22	Clerk, United States District Court Eastern District of Pennsylvania 2609 U.S. Courthouse 601 Market Street Philadelphia, PA 19106 Case: 2:19-cr-00518-CFK		

EXHIBIT NA-1


NEIL ANAND, M.D.
UC # MD422681
VIKTORIYA MAKAROVA, C.R.N.P.
PA # NP#A032972
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5735 RIDGE AVE., SUITE 701
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(215) 940-9690 FAX
ARIA HOSPITAL WAKELING
5000 FRANKFORD AVE., SUITE 2
PHILADELPHIA, PA 19124
1936 BRISTOL PIKE, SUITE 103
BENSALEM, PA 19020
(516) 928-3087 TEL
(215) 310-8087 TEL
NAME Fred Glasgow
ADDRESS
DOB
DATE 12 28 16
TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT
Rx
MS Contin 15mg
1 Tab po BID
#60 (sixty)
Neil Anand M.D.
LABEL
Refill NR 1 2 3 4 5
SUBSTITUTION PERMISSIBLE
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED,
THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR
"BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.
001488
8J25GP0522598
NEIL ANAND, M.D.
VIKTORIYA MAKAROVA, C.R.N.P.
BERNARD STUETZ, P.A.
NAME Fred Glasgow
ADDRESS
DOB
DATE 12 28 16
TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT
Rx
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1 Tab po QID
#120 (one hundred twenty)
Neil Anand M.D.
LABEL
Refill NR 1 2 3 4 5
SUBSTITUTION PERMISSIBLE
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED
THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR
"BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW
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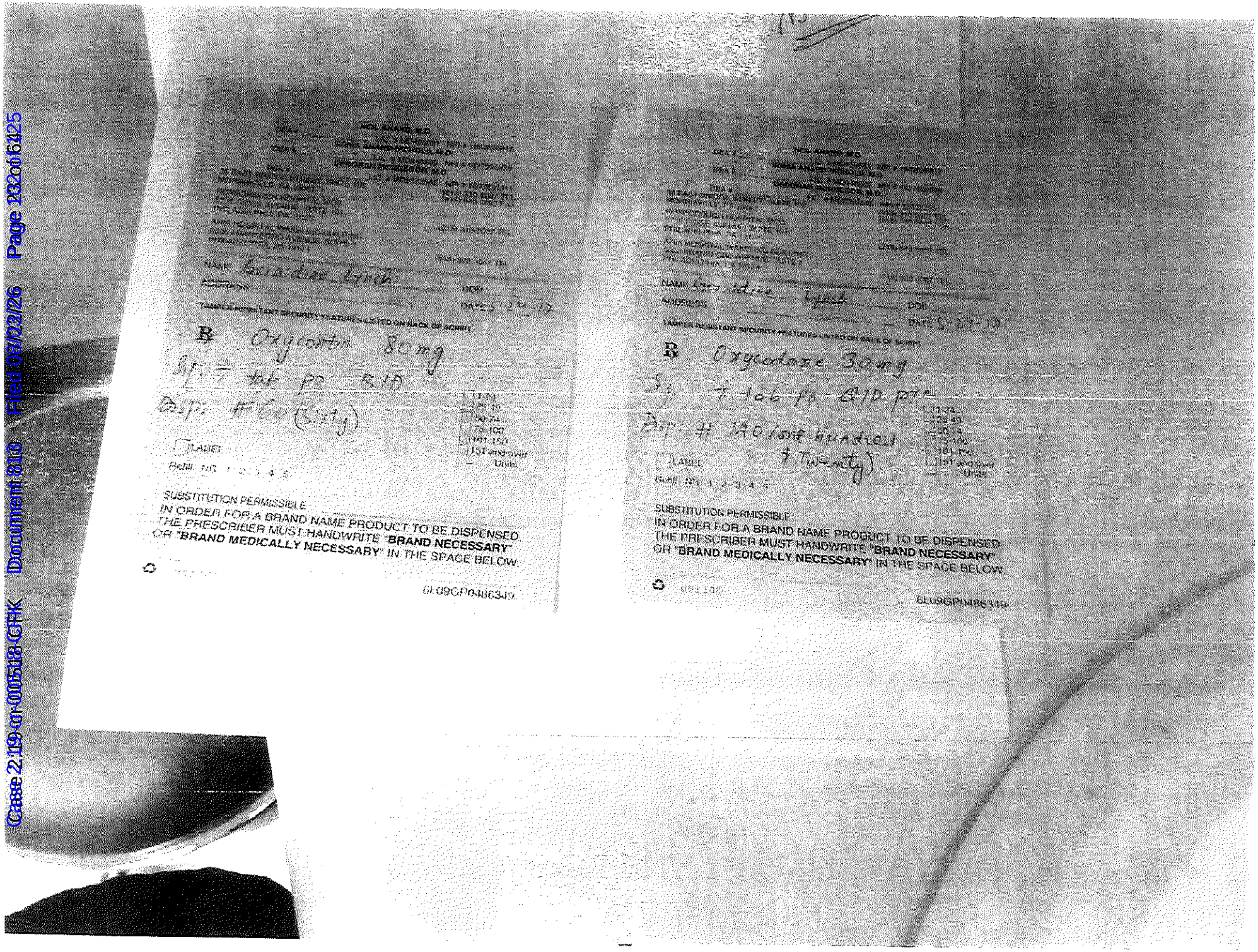
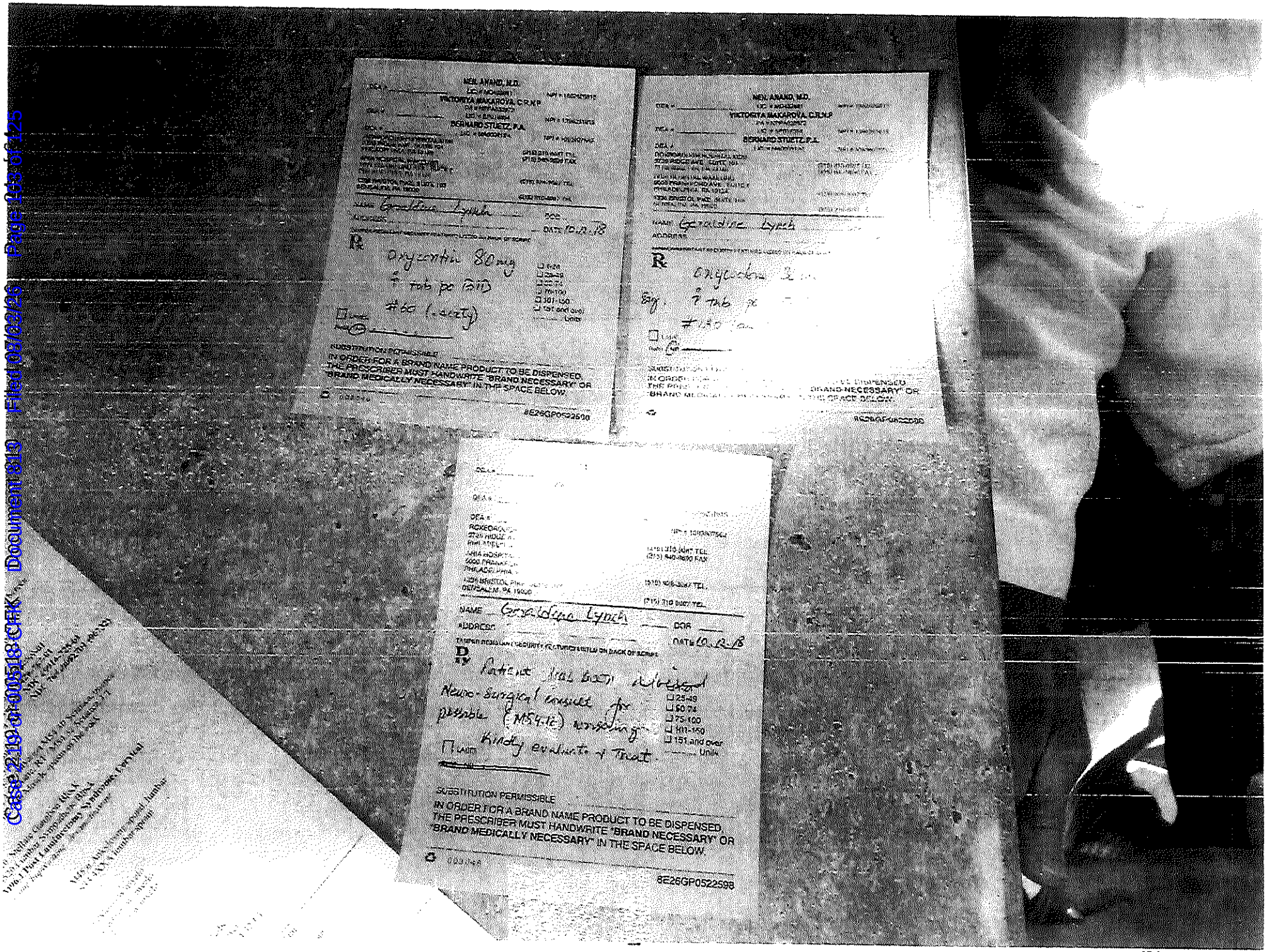


SUBSTITUTION PERMISSIBLE
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED
THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY"
OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW

SUBSTITUTION PERMISSIBLE
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED
THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY"
OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW



PT_FILES_005252

3/12

steroid

DEA #
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DEA #
DEA #

NEIL ANAND, M.D.
LIC. # MD422681
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NPI # 1457980301

BERNARD STUETZ, P.A.
LIC. # MA005812-L
NPI # 1093807162

ROXBOROUGH HOSPITAL MOB
5700 RIDGE AVENUE, SUITE 101
PHILADELPHIA, PA 19128

(215) 310-6067 TEL
(215) 940-8650 FAX

ARIA HOSPITAL WAKELING BUILDING
3300 FRANKFORD AVENUE, SUITE A
PHILADELPHIA, PA 19134

(267) 664-1361 TEL

3501 HULMEVILLE ROAD, SUITE 101
BENSALEM, PA 19020

NAME Ruth Ries DOB

ADDRESS DATE 5/20/19

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF REVERSE

℞ Percocet 5/325 mg
1 tab po QID
120 one hundred twenty

☐ 1 brand M.D.
☐ 2-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 and over

DEA/N: BA6844765
2A2444565

DEA #
FA1311681

☐ LABEL
Refill (0)

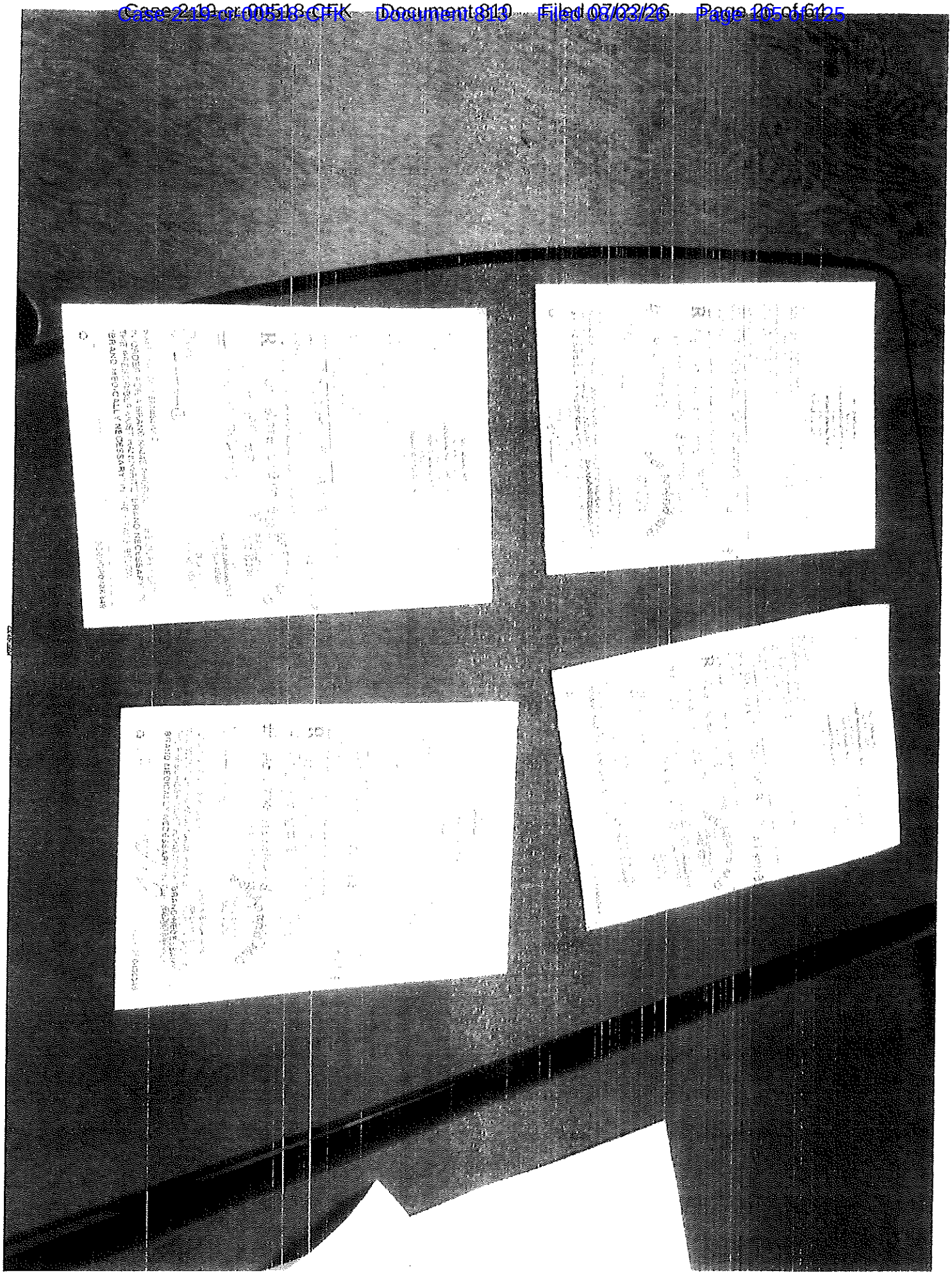
SUBSTITUTION PERMISSIBLE

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

000302

9C09GP0486349

PT_FILES_006781



PT_FILES_010379

NEIL ANAND, M.D.

DEA # ______________ LIC. # MD422681 NPI # 1982626818

VIKTORIYA MAKAROVA, C.R.N.P.

PA # NPPA032972

DEA # ______________ LIC. # SP018354 NPI # 1396251815

BERNARD STUETZ, P.A.

DEA # ______________ LIC. # MA000812-L NPI # 1093807562

ROXBOROUGH HOSPITAL MOB
5735 RIDGE AVE., SUITE 101
PHILADELPHIA, PA 19128
(215) 310-8087 TEL
(215) 942-8690 FAX

ARIA HOSPITAL WAKELING
5000 FRANKFORD AVE. SUITE 2
PHILADELPHIA, PA 19124
(215) 428-3087 TEL

1336 BRISTOL PIKE SUITE 103
BENSALEM, PA 19020
(215) 310-8087 TEL

NAME [illegible] DOB ______

ADDRESS ______________ DATE 1/16/19

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

℞ Clonidine patch 0.1mg/hr
1 patch q 7 days
#4 (four)

☐ 1-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 and over
Units

☐ LABEL

Refill (NR) ————

SUBSTITUTION PERMISSIBLE

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "**BRAND NECESSARY**" OR "**BRAND MEDICALLY NECESSARY**" IN THE SPACE BELOW.

8J25GP0522598

PT FILES 002641

EXHIBIT NA-2

PRINCETON BRAIN & SPINE
"The art and science of care."

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Mark R. McLaughlin, MD, FACS
Neurosurgery & Spine Surgery

Nirav K. Shah, MD, FACS
Neurosurgery & Spine Surgery

Seth S. Jaeffer, MD, FACS
Neurosurgery & Spine Surgery

Matthew J. Tormenti, MD,
Neurosurgery & Spine Surgery

Nazer H. Qureshi, MD,
D.Stat, M.Sc, FAANS
Neurosurgery & Spine Surgery

Kevin Trolene, PA-C
Physician Assistant

Warren Strauss, PA-C
Physician Assistant

Susan Beckman, PA-C
Physician Assistant

Meghan Gentile, PA-C
Physician Assistant

Renee Rizzo, PA-C
Physician Assistant

Toni Luongo, CRNP
Certified Nurse Practitioner

Hope Mazurek, CRNP
Certified Nurse Practitioner

Kathryn Carlson, CRNP
Certified Nurse Practitioner

Specializing in:
Nonoperative Neck and Back Care
Minimal Access Spine Surgery
Brain Tumor Microsurgery
Herniated Disc Management
Stereotactic Radiosurgery
Complex Spine Reconstruction
Surgical Pain Management
Pituitary Tumor Surgery
Trigeminal Neuralgia
Traumatic Brain and Spine Injury

August 17, 2016

Stark & Stark
777 Township Line Road
Suite 120
Yardley, Pennsylvania 19067

Patient Name: Fredrick Glasgow
Date of Birth: November 2, 1990
Date of Injury: August 23, 2015
Date of Examination: July 1, 2016

NARRATIVE REPORT

Dear Mr. Tomlinson:

I had the opportunity to treat and evaluate medical records regarding your client Mr. Fredrick Glasgow and prepare a narrative report.

RECORDS REVIEWED:

The following records were reviewed:

1. Medical Records – Aria Orthopedic – January 22, 2016
2. Medical Records – Princeton Brain and Spine – March 3, 2016 to July 1, 2016
3. Medical/Chiropractic/Physical Therapy Records – Dedicated Doctors – August 2015 to May 2016
4. Medical Records – Dr. Louis Pearlstein – January 14, 2016
5. Medical Records – Oxford Valley Pain and Spine Center – March 7, 2016
6. Physical Therapy Records – Riverside Physical Therapy

HISTORY:

Mr. Fredrick Glasgow is a 25 year old male who was involved in a motor vehicle accident on August 23, 2015. The patient was a restrained driver in a vehicle that was moving around 35 miles per hour. A car came into his lane from the left side and hit him head on and caused him to careen into a telephone pole that was upright as well as one that was on the ground. The patient denies loss of consciousness. The airbags did deploy. The driver's side door was bent into a 'U' shape. Upon impact, he was jostled significantly as he was not braced for this injury. When he was driving, he was downshifting with his right hand and steering with his left with his foot

on the brake/clutch. His passenger and the other driver went to the ER via ambulance. He went to the ER one hour later. He was diagnosed with left rib fractures.

On August 24, 2015Mr. Glasgow presented to Dr. Michael Fischer, a primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy

On August 31, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy.

On September 14, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and PENS therapy.

On September 15, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended continued physical therapy and medical management.

On October 1, 2015 Mr. Glasgow presented to Dr. Michael Fischer, an associate of Dr. Belletier, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy.

On October 13, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended continued physical therapy.

On October 27, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and medical management.

On November 6, 2015 Mr. Glasgow presented to Dr. Christopher Belletieri, his primary care physician, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Belletieri recommended physical therapy and medical management.

On November 13, 2015 Mr. Glasgow presented to Dr. Michael Fischer, an associate of Dr. Belletier, with reports of neck pain and low back pain with radiation into the left lower extremity. Dr. Fischer recommended physical therapy.

On January 14, 2016 Mr. Glasgow obtained an EMG of the lower extremities. This was performed by Dr. Louis Pearlstein. There was no evidence of neuropathy, radiculopathy or myopathy.

On January 22, 2016 Mr. Glasgow presented to Dr. Matthew McLean, an orthopedist, with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended oral steroid medication.

On February 12, 2016 Mr. Glasgow returned for follow up with Dr. McLean with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended aqua therapy and a trial of gabapentin.

On March 3, 2016 Mr. Glasgow presented to me for evaluation with reports of low back pain with radiation into the lower extremities. I recommended he obtain a pain management evaluation and treatment.

On March 7, 2016 Mr. Glasgow presented to Dr. Anju Madnani, a pain management physician, with reports of low back pain with radiation into the left lower extremity. Dr. Madnani recommended facet nerve block injections.

On March 10, 2016 Mr. Glasgow returned for follow up with Dr. McLean with reports of low back pain with radiation into the left lower extremity. Dr. McLean recommended pain management.

On March 25, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended continued medical management.

On May 12, 2016 Mr. Glasgow presented to St. Mary Medical Center Emergency Room due to low back pain with radiation into the left lower extremity. He also reported headaches and fever. On observation he was found to be febrile with leukocytosis so he was admitted into the hospital. He was admitted until May 15, 2016.

On June 10, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended indefinite medical management and pain management.

On July 1, 2016 Mr. Glasgow returned for follow up with me with reports of low back pain with radiation into the left lower extremity with associated weakness. I recommended indefinite pain management.

PRE-EXISTING CONDITION:

The patient had nonspecific back pain prior to this injury but was pain-free up to a month ongoing prior to the injury date.

PHYSICAL EXAMINATION:

Lower back:

- Spine tenderness present.
- Paraspinal muscle spasm: present on left side.
- SI joint tenderness: present on left side.
- Motor system: 5/5 strength in all major muscle groups.
- Sensory: normal bilateral lower extremity.
- Reflexes: absent.
- Gait: antalgic.
- Range of motion flexion to 10 degrees, extension to 10 degrees, and 25 degrees lateral rotation to the right and left
- Straight leg raising test: positive straight leg raise on left.

DIAGNOSTIC IMAGING:
(I personally reviewed the following relevant medical imaging)

1. MRI of the lumbar spine performed on October 3, 2015 at Saint Mary Medical Center. This had shown evidence for L4-5 disk bulge.
2. MRI of the lumbar spine performed May 12, 2016 revealing similar findings of L4-5 disk bulge.
3. MRI of the lumbar spine performed June 3, 2016 revealed again L4-5 disk bulge.

DISCUSSION:

Based on my evaluation of the patient and review of the above records, the following conclusions may be made within a reasonable degree of medical certainty.

CAUSALITY:
The patient has the following diagnoses causally related to the above injury:

1) L4-5 traumatic disk bulge.
2) Mechanical low back pain with radiculopathy, left-sided.
3) Lumbar traumatic facet syndrome.
4) Lumbar aggravation injury.
5) Left rib fractures.

The patient has mechanical low back pain with radiculopathy causally related to the injury above. Based on the mechanism of injury, the above diagnoses would be causally related. The patient had prior history for mechanical low back pain but was working unrestricted and pain free at the time of the accident. Thus, a general aggravation injury to the lumbar spine with facet irritation/injury was noted.

I personally reviewed the patient's 2015-2016 MRIs of the lumbar spine that showed traumatic bulging at L4-5. In addition, there is a lack of overwhelming degenerative findings throughout the spine to suggest it was present prior to the accident. Specifically, there is no evidence for disk collapse, Modic changes, osteophyte formation, or other degenerative features at any other level. If the L4-5 bulge was pre-existing, then the other levels in the spine would carry

degenerative features. Thus, the bulge would be causally related to the injury. Isolated bulging in this clinical scenario, is considered to be the result of posterolateral annular stress. In the absence of significant pre-existing degenerative conditions throughout the rest of the lumbar spine, this stress would be directly a result from the acute TRAUMA. Furthermore, there are no prior MRIs to compare the post-injury ones to. In the absence of chronic findings, the disk bulge then would be related to the above accident.

From the internal disk disruption, he has DISCOGENIC pain mediated by axial symptoms. Various theories have been proposed as the sources of pain generation in disc injury, involving an intervertebral disc that is bulging, or herniated acutely. Mechanical compression and an immunologic or inflammatory response are related to pain from a disc injury. The basis for an immunologic source for disc-related pain has been based upon the lack of blood supply to the nucleus pulposus, thus hiding it and its contents from the immune system. Injury to the disc would expose these foreign substances, initiating an autoimmune reaction. The nucleus pulposus has been shown to elicit an immune response. Various authors have reported that disc material can incite a leukocyte cell reaction, cytokine, and immunoglobulin response. Thus, there is a real biochemical and physiological response to traumatic disk injury resulting in the progressive mechanical back. The radiculopathy in the left lower extremity objectified by the positive straight leg raise and supported by his subjective dermatomal complaints, would be due to the neural effacement from the disk bulge.

In addition the patient's discogenic pathology, he also suffers from lumbar facet syndrome. The existence of this condition and the severity of same is well documented in the notes and operative reports of both Dr. Madnani. The patient has been recommended this intervention only after the accident and thus, it is clear that the patient's current pain and symptomology is due, in part, to his lumbar facet syndrome. Future treatment would continue to provide him with transient relief but this this condition is clearly permanent in nature.

At this point, the patient has undergone some reasonable and necessary conservative and surgical care for the lumbar spine in particular. My concern is that the patient has persistent functional disability from pain attributed to this particular accident. There is limitation to range of motion leading to the axial pain. Furthermore, there are signs for neural irritation for the lumbar spine including paraspinal tenderness and limitations to range of motion. While these findings are primarily subjective, they are present and represent an expected complaint from this injury. The weakness is not profound and I would not expect it to be so given the lack of severe thecal sac compression. Thus, there is no evidence for symptom magnification. Nevertheless, there is positive straight leg raising on the left lower extremity. Clearly, his quality of life and day to day activities are compromised from these causally related lumbar issues. He is unable to sit, stand, walk, or drive for meaningful periods of time without discomfort. He is unable to return to work as a FEDEX dock worker unrestricted due to the repetitive activities involving the lumbar spine inherent to his job duties. These activities would exacerbate his symptomology.

RECOMMENDATIONS:

At this point, the following causally related recommendation would be made regarding the lumbar trauma:

- RADIOLOGICAL ASSESSMENT: a lumbar flexion extension x-ray would be necessary to determine stability. Periodic x-rays of the lumbar spine will be required to assess the integrity of the spine. The total cost of this would be in the range of $10,000.

- NEUROLOGY ASSESSMENT: Periodic neurological exams would be required given the positive bulge noted objectively on the lumbar spine MRI. This would be helpful to guide future therapies such as intervention pain management and/or surgery. Indeed, given that the L4-5 disk is traumatized due to the injury, there is real concern that worsening neural compression will occur as noted above. The cost would be in excess of $3,000.

- PAIN MANAGEMENT: The patient will require ongoing interventional pain management for the lumbar spine in the form of injections to treat the traumatic mechanical pain symptoms. In addition, trigger point injections and facet blocks would be considered for the post-traumatic lumbar symptoms. Also, ongoing medical management through periodic but regular visits to the primary care for prescriptions (muscle relaxants, steroids, anti-inflammatories) would be necessary for his lifetime. Finally, continued physical therapy and indefinite medical management through periodic but regular visits to the primary care for prescriptions (muscle relaxants, steroids, and anti-inflammatories) would be necessary for his lifetime. The costs of these interventions would be in excess of $20,000.

- SURGICAL MANAGEMENT: Within a reasonable degree of medical certainty, the patient will require lumbar surgical intervention as he continues to fail conservative measures. A lumbar discogram would be considered and ordered with ongoing lumbar complaints. There is a reasonable degree of medical certainty that the discogram would be positive and would lead to surgical decision making in the form of L4-5 decompression and fusion. The cost of this operation is no less than $75,000 inclusive of hospital stay and postoperative care.

PROGNOSIS and PERMANENCY:

There is definitive permanency to his post-traumatic low back condition. Indeed, based on the amount of time he has carried the post-traumatic symptoms of his back, and based on the objective finding on MRI, the above diagnoses would be permanent in nature leading to persistent restrictions and limitations to activity of daily living. There are permanent anatomic changes to the spine in the form of the bulge as well. He will require ongoing and indefinite pain management, activity modifications, and core-strengthening exercises in order to prevent these injuries from worsening. This back injury with aggravation, secondary to the accident, has served to functionally affect this patient with chronic pain. Surgery to the lumbar spine will create another permanent alteration to the spine resulting in limitations to range of motion and some chronic pain that will require periodic surveillance, imaging, and medical management. He is not

capable of exceeding light duty capacity with the restrictions of no repetitive bending, stooping, climbing, crouching. He would not be able to lift greater than 20 pounds. He would not be able to sit or stand for greater than 30 minutes at a time without a 10 minute break, and no greater than a total of 4 hours in a work day. No driving a company vehicle at all. I have signed off on a handicap parking tag for him.

The statements and diagnoses contained in my report are made within a reasonable degree of medical certainty and probability based on a standard of care and expectation of neurosurgery and spine surgery for this particular injury. I reserve the right to amend this report should additional information become available.

I am a board certified neurosurgeon licensed in the states of NJ and PA. I have an active specialty practice and have treated patients for conditions similar to or identical to those of the above patient.

Sincerely,

Nirav K. Shah, M.D. F.A.C.S.
Neurosurgeon and Spine Specialist
Princeton Brain and Spine Care

EXHIBIT NA-3

St. Mary Medical Center
1201 Langhorne-Newtown Road, Langhorne, PA19047
215-710-2185
Diagnostic Imaging

PATIENT NAME: GAGE,TAMARA J
MED REC NO: M005519445
ACCT NO.: LP0323655282
ORDER NO: 0325-0040

DOB: 11/09/1970 AGE: 44 SEX: F
PT CLASS: REG CLI
PT ROOM/BED:
DEPT: Magnetic Resonance Imaging

ORDERING DR. : ANAND, NEIL MD
ATTENDING DR.: ANAND,NEIL MD
CC:ANAND,NEIL MD; KHAN,ZAFAR MD

REASON FOR EXAM: 724.1 PAIN IN T SPINE, 723.1 CERVICALGIA
COMMENTS:
ADMITTING REASON: 724.1 PAIN IN THORACIC SPINE 723.1 CERVICALGIA
PREGNANT: N

SERVICE DATE/TIME: 03/25/15 1253
REPORT DATE/TIME: 03/25/15 1622

PROCEDURE: MR Cervical Spine WO
REPORT NO.: 0325-0549

Status: Signed

CLINICAL HISTORY: Neck pain for several years

COMPARISON : None

STUDY/TECHNIQUE: Multiplanar MRI examination of the cervical spine was performed using a combination of T1 and T2 weighted pulse sequences.

FINDINGS:

ALIGNMENT: Straightening of the normal lordosis which may be due to patient position or muscle spasm.

VERTEBRAL BODIES: Vertebral body heights are maintained. Loss of disc height, disc desiccation, marginal spurring at multiple levels in keeping with degenerative disc disease.

SPINAL CORD: No definite cervical spinal cord signal abnormality identified.

AXIAL IMAGES

C2-C3: No significant disc bulge, herniation, or stenosis.

C3-C4: Mild disc bulge. Borderline mild narrowing of central canal. No significant foraminal encroachment.

C4-C5: Mild disc bulge. There is some uncovertebral arthropathy. Borderline mild narrowing of central canal and right neural foramen. Left neural foramen is patent.

C5-C6: Disc bulge which is slightly asymmetric to the right. There is some uncovertebral arthropathy. Mild narrowing of central canal. No significant foraminal encroachment.

C6-C7: Disc bulge. There is some uncovertebral arthropathy. There is mild to moderate narrowing of central canal. No significant foraminal encroachment.

ST. MARY'S MEDICAL CENTER
DIAGNOSTIC IMAGING
PT. NAME:GAGE,TAMARA J
MED REC NO:M005519445
ACCOUNT#:LP0323655282
REPORT#:0325-0549

C7-T1: No significant disc bulge, herniation, or stenosis.

There are partially imaged thyroid nodules for which ultrasound is recommended.

IMPRESSION:

1. Mild multilevel cervical degenerative changes with central canal and foraminal narrowing as described above. Findings are worst at C6-C7 where there is mild to moderate central canal stenosis.

2. Straightening of the normal cervical lordosis which may be due to patient position or muscle spasm.

3. Partially imaged thyroid nodules for which ultrasound is recommended.

TECHNOLOGIST: HPM
READING DOCTOR: KIRKPATRICK,CHRISTOPHER T MD

ELECTRONICALLY SIGNED BY: KIRKPATRICK,CHRISTOPHER T MD
PRINTED: 1631

EXHIBIT NA-4

Stevenson, Jodie ID #: 101574JS

Name: Stevenson, Jodie

Patient ID: 101574JS
Date of Birth: 10/15/1974
Gender: Female
Date of Exam: 6/25/2016 1:05 PM

Referring Physician:
Examining Physician:

Patient History: 42 y/o right handed female who presents with weakness in her lower extremities from her knees down to her feet as well as associated numbness bilaterally. The patient was diagnosed with GBS in 2006 after noticing frequent tripping over her feet, difficulty going up the stairs, and numbness from her feet to her chest after suffering from an upper respiratory tract infection. The patient states that she underwent IVIG treatment and currently notes weakness from her knees down to her feet described as a burning, tingling, pins and needles type of sensation with associated numbness. Neurological examination reveals diminished strength 3+/5 in bilateral lower extremities when the patient is sitting up and decreased sensation in her lower extremities particularly the calves and feet. Reflexes were trace throughout.

Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Peroneal.R						
Ankle	7.9 ms	0.5 mV	Extensor digitorum brevis-Ankle	7.9 ms	90 mm	m/s
Fibula (head)	15.8 ms	0.7 mV	Ankle-Fibula (head)	7.9 ms	290 mm	37 m/s
Popliteal fossa	18.0 ms	0.7 mV	Fibula (head)-Popliteal fossa	2.2 ms	70 mm	32 m/s
Tibial.R						
Ankle	4.3 ms	2.1 mV	Abductor hallucis-Ankle	4.3 ms	90 mm	m/s
Popliteal fossa	11.1 ms	1.9 mV	Ankle-Popliteal fossa	6.8 ms	350 mm	51 m/s
Peroneal.R						
Fib Head	2.2 ms	4.2 mV	Tibialis anterior-Fib Head	2.2 ms	80 mm	m/s
Pop fossa	4.0 ms	4.8 mV	Fib Head-Pop fossa	1.8 ms	80 mm	44 m/s
Peroneal.L						
Ankle	5.2 ms	1.9 mV	Extensor digitorum brevis-Ankle	5.2 ms	90 mm	m/s
Fibula (head)	11.6 ms	1.5 mV	Ankle-Fibula (head)	6.4 ms	280 mm	44 m/s
Popliteal fossa	13.4 ms	1.4 mV	Fibula (head)-Popliteal fossa	1.8 ms	80 mm	44 m/s
Peroneal.L						
Fib head	4.3 ms	5.3 mV	Tibialis anterior-Fib head	4.3 ms	120 mm	m/s
Pop fossa	6.0 ms	5.6 mV	Fib head-Pop fossa	1.7 ms	90 mm	53 m/s
Tibial.L						
Ankle	5.1 ms	0.9 mV	Abductor hallucis-Ankle	5.1 ms	90 mm	m/s
Popliteal fossa	15.2 ms	0.3 mV	Ankle-Popliteal fossa	10.1 ms	350 mm	35 m/s

Stevenson, Jodie ID #: 101574JS

F-Wave Studies

Nerve	M-Latency	F-Latency
Peroneal.R	18.0	77.8
Tibial.R	11.1	62.9
Peroneal.L	13.4	61.7
Tibial.L	15.2	62.1

Sensory Nerve Conduction:

Nerve and Site	Onset Latency	Peak Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Superficial peroneal.R							
Ankle	2.6 ms	3.1 ms	6 µV	Dorsum of foot-Ankle	2.6 ms	130 mm	41 m/s
Sural.R							
Lower leg	2.1 ms	3.0 ms	7 µV	Ankle-Lower leg	2.1 ms	110 mm	48 m/s
Superficial peroneal.L							
Ankle	3.1 ms	4.0 ms	7 µV	Dorsum of foot-Ankle	3.1 ms	130 mm	42 m/s
Sural.L							
Lower leg	2.4 ms	3.2 ms	6 µV	Ankle-Lower leg	2.4 ms	110 mm	49 m/s

Needle EMG Examination:

	Insertional	Spontaneous Activity			Volitional MUAPs					Max Volitional Activity		
Muscle	Insertional	Fibs	+Wave	Fasc	Duration	Amplitude	Poly	Config	Recruitment	Amplitude	Pattern	Effort
Tibialis anterior.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Gastrocnemius.R	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Tibialis posterior.R	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Extensor hallucis longus.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Vastus medialis.R	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
L5 paraspinal.R	Normal	None	None	None	Normal	Normal	None	Normal	Normal			
L5 paraspinal.L	Normal	None	None	None	Normal	Normal	None	Normal	Normal			
Tibialis anterior.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Gastrocnemius.L	Normal	None	None	None	Normal	Normal	Few	Normal	Reduced			
Tibialis posterior.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Extensor hallucis longus.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			
Vastus medialis.L	Normal	None	None	None	Gr. Incr.	Gr. Incr.	Few	Normal	Reduced			

Impression: Abnormal study demonstrating a bilateral chronic predominately axonal motor polyneuropathy. The conduction velocities were at times slow though they did not meet the criteria for demyelinating range. The patient did have prolonged F-waves bilaterally. There were neuropathic changes seen in her lower extremities when performing the electromyography testing. There have been case reports in the literature of axonal damage on clinical neurophysiological testing in patients who were diagnosed with CIDP. When comparing to her previous study, although the records were incomplete, there was slight improvement seen when testing the motor nerves on nerve conduction testing and there was no active denervation seen on electromyography with this study. Clinical correlation advised.

Sonia Anand-Nichols, M.D.

EXHIBIT NA-5

Neurography & Electromyography Report

Full Name: Geraldine Lynch
Patient ID: 032961GL
Gender: Female
Date of Birth: 3/29/1961

Visit Date: 10/26/2017 14:05
Age: 56 Years 6 Months Old

History: 56 y/o right handed female with history of diabetes and neck pain that radiates down her arms and into her hands, worse on the right side, for over a year. She does endorse associated tingling and numbness. Neurological examination demonstrates trace reflexes throughout and hyperesthesia in the right upper extremity to pinprick.

MNC

Nerve / Sites	Muscle	Latency ms	Amplitude mV	Segments	Distance mm	Lat Diff ms	Velocity m/s
R Median - APB							
Wrist	APB	5.5	8.7	Wrist - APB	60		
Elbow	APB	10.3	8.1	Elbow - Wrist	240	4.8	50
L Median - APB							
Wrist	APB	4.0	8.0	Wrist - APB	60		
Elbow	APB	8.6	7.7	Elbow - Wrist	260	4.6	56
R Ulnar - ADM							
Wrist	ADM	2.8	10.2	Wrist - ADM	60		
B.Elbow	ADM	5.2	10.1	B.Elbow - Wrist	140	2.4	58
A.Elbow	ADM	8.6	9.3	A.Elbow - B.Elbow	170	3.4	50
L Ulnar - ADM							
Wrist	ADM	2.6	9.3	Wrist - ADM	60		
B.Elbow	ADM	4.7	9.0	B.Elbow - Wrist	130	2.2	59
A.Elbow	ADM	8.1	8.5	A.Elbow - B.Elbow	170	3.3	51

F Wave

Nerve	F Lat ms	M Lat ms	F-M Lat ms
R Median - APB	25.0	6.1	18.9
R Ulnar - ADM	32.0	3.0	29.1
L Median - APB	29.6	3.8	25.8
L Ulnar - ADM	30.7	2.7	28.0

SNC

Nerve / Sites	Rec. Site	Onset Lat ms	Peak Lat ms	Amp µV	Segments	Distance mm	Velocity m/s
R Median - Digit II (Antidromic)							
Wrist	Dig II	4.11	5.52	28.5	Wrist - Dig II	165	40
L Median - Digit II (Antidromic)							
Wrist	Dig II	3.33	4.43	22.8	Wrist - Dig II	155	47
R Ulnar - Digit V (Antidromic)							
Wrist	Dig V	2.40	3.28	15.2	Wrist - Dig V	120	50
L Ulnar - Digit V (Antidromic)							
Wrist	Dig V	2.45	3.13	15.2	Wrist - Dig V	125	51
R Radial - Anatomical snuff box (Forearm)							
Forearm	Wrist	1.56	2.40	16.5	Forearm - Wrist	100	64
L Radial - Anatomical snuff box (Forearm)							
Forearm	Wrist	1.77	2.34	35.6	Forearm - Wrist	100	56

EMG

EMG Summary Table										
	Spontaneous					MUAP			Recruitment	Max Vol Act
Muscle	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern	Effort
R. Abductor pollicis brevis	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Abductor digiti minimi (manus)	N	None	None	None	None	N	N	N	N	Max
R. Biceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Triceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Deltoid	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Abductor pollicis brevis	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Abductor digiti minimi (manus)	N	None	None	None	None	N	N	N	N	Max
L. Biceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Triceps brachii	N	None	None	None	None	1+	1+	1+	Reduced	Max
L. Deltoid	N	None	None	None	None	1+	1+	1+	Reduced	Max
R. Cervical paraspinals	N	None	None	None	None	N	N	N	N	Poor
L. Cervical paraspinals	N	None	None	None	None	N	N	N	N	Poor

Summary

The motor conduction test was performed on 4 nerve(s). The results showed prolonged distal latency in bilateral median motor nerves

The sensory conduction test demonstrated slowing across the wrist when testing the median sensory nerve bilaterally.

The F wave study was normal in all 4 of the tested nerves: R Median - APB, R Ulnar - ADM, L Median - APB, L Ulnar - ADM.

The needle EMG examination was performed in 12 muscles. It was normal in 2 muscle(s): R. Abductor digiti minimi (manus), L. Abductor digiti minimi (manus). The study was abnormal in 8 muscle(s), with the following distribution:

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Motion to be served upon the following by United States Mail, postage prepaid, or ECF/EDS to: Paul J. Koob, Arun Bodapati, and Patrick J. Campbell, Assistant United States Attorneys, United States Attorney's Office, Eastern District of Pennsylvania, 615 Chestnut Street, Suite 1250, Philadelphia, Pennsylvania 19106.

Neil Anand

Neil K. Anand, Pro Se

8/3/2026