

Mr. John Smith Esq.
Miami, Florida 33111

Cost Projection for Sally Chester

This file was referred for preparation of a cost projection for future medical care and treatment for Ms. Sally Chester secondary to a motor vehicle accident on 01/19/2017. The purpose of this cost projection is to inform all parties of the estimated or expected treatments and associated costs over a lifetime or throughout a medical event.

This cost projection was prepared using:

1. Standards of care treatment patterns for the condition or diagnoses with focus on the medical needs related to the primary injury.
2. A comprehensive review of the available medical records and other pertinent documents provided by the referring party.
3. Researched data and clinical practice guidelines of the listed diagnoses for foundation and support of the recommendations.
4. Calculations of medical treatment needs, and associated costs based on standard methodology which includes median range and geographic specific private pay costs.
5. Sound medical, rehabilitation, nursing, case management and psychological principles for foundation and support of the recommendations

General Information

Name: Sally Chester

Gender: Female

Date of Birth: December 9, 1961

Date of Event: January 19, 2017

Present Age: 56.10 years old

Records Reviewed:

- Records of Mount Sinai Medical Center ER
- Records and narrative report of Dr. Martin Zeller, DC
- Reports of Imaging of Miami
- Records of Dr. Harold Williams, Pain Management Center
- Records of Dr. Joseph Donahue – Orthopedic Consultants of Miami

Brief description of events and medical care:

- Ms. Jones was involved in a motor vehicle accident on 1/19/2017.
- She sustained injury to her neck and upper back and right knee.
- She was evaluated by EMTs at the scene of the accident and transported to the ER at Mt. Sinai Hospital where she was evaluated and released.
- After two days, she experienced an increase in pain in her neck and right knee.
- She began treatment with chiropractic care who implemented physical therapy modalities.
- She was referred for an MRI of her cervical spine and right knee by Dr. Zeller.
- MRI studies noted a small herniation at C5-6 and bulging discs at C3-C4, and C4-5. Her right knee noted a tear of the ACL.
- She continued to experience pain and difficulty walking. Her neck pain radiated to her right arm.
- She was referred to Dr. Williams, pain management who performed 1 ESI injection to her neck. Follow up records noted she achieved good results and will return as needed.
- She was referred to orthopedics who reviewed the knee MRI and recommended arthroscopic surgery to repair the ACL.
- The records note her neck pain returned, additional PT modalities were implemented with good results.
- Dr. Zeller stated that Ms. Chester “sustained permanent partial impairment.” “Within a reasonable degree of medical certainty, it is most certain that Ms. Chester will suffer exacerbation from her activities of daily living.” “She may well require one to two treatments per month to maintain current progress.”
- The records note Ms. Chester is employed as a child care worker. She is responsible for caring for 5 young children ages ranging from 1 year to 2 years. Per records, her job requires lifting, reaching and carrying the children as needed

Factors considered for cost projection:

This medical cost projection estimate is based on the condition of cervical disc herniations and bulges and arthroscopic ACL repair. Factors considered for these conditions include:

- Future care recommendations noted in the report of Dr. Zeller DC.
- Ongoing care considered in notes of Dr. Williams.
- Surgical recommendation for the ACL repair and post-operative physical therapy.

Sources of cost factoring:

- Costs are based on midrange pricing quoted by The Physicians Fee Reference 2018 with geographic multiplier 1.153, Official Disability Guidelines, Fair Health Benchmark and internet research.

Life Expectancy based on the National Vital Statistics Reports, Vol. 66, No. 4, August 14, 2017; United States, 2014; 28.1 additional years to age 84.2

Summary and Conclusions

The attached cost projection is based on current dollars and does not reflect inflationary trends of the health care industry. This cost projection is not to be used in lieu of a life care plan as there was no client assessment or collaboration with treating providers or experts on this case. This report does not address loss of wages or vocational concerns.

Base costs are broken out for itemization in the attached cost projection tables as well as an estimation of lifetime expenditures based upon Sally Chester's current age of 56.10 years old and an estimated 28.1 additional life expectancy.

The estimated future care of Ms. Sally Chester is: **\$194,722.65**

Sincerely,

William Evers, Certified Life Care Planner
Attachments: Cost projection for Sally Chester

Medical Cost Projection for Sally Chester

Date of Birth 12/9/1961 Date of Injury 1/19/2017
 Life Expectancy: 28.1 years to age 84.2

Item	Frequency	Base Cost	Annual Cost	Total Cost	Comments
Chiropractic Care 1-2 x per month at \$150 per trx - Annual \$1800 to \$3600	18 per year	\$150.00	\$2,700.00	\$75,870.00	Per Dr. Zeller's records required to maintain current status
Physical Therapy for exacerbations - allow for 1 occurrence per year neck	10 visits over 8 weeks per occurrence	\$313.61	\$3,136.10	\$88,124.41	Per Dr. Zeller's records, Ms. Chester will suffer exacerbations from ADL's
Orthopedic eval for ACL -	4	\$147.90	\$591.60	\$591.60	Pre op to schedule and receive instructions and post op after 90 day global period
PCP for pre op clearance	1	\$800.00		\$800.00	Will include exam, chest x-ray, EKG, and blood work
Arthroscopic ACL Repair	1 time only	\$21,810.00	\$0.00	\$21,810.00	Per records for CPT code 29888, Fair Health
Post op PT for knee surgery 24 sessions over 16 weeks	24	\$313.61	\$7,526.64	\$7,526.64	Per ODG guidelines -

\$194,722.65

Sources

The Physicians Fee Reference 2018

Geographic Multiplier 1.153 for zip code 33131

Therapeutic exercises

mid- range cost (\$68 per 15 minutes) for 1 hour of physical therapy using CPT code 97110 is \$313.61

Established patient CPT Code: 99213 \$147.90

Pre op testing typically includes EKG, Chest X-ray, Blood tests

CPT codes 73600,73700, 71046

CPT code 29888 in Florida per Fair Health for zip code 33131 is \$21810.00 .

Per ODG, physical therapy post - surgical ACL repair is typically 24 sessions over 16 weeks.


[Knee and Leg Physical therapy x](#)
[Knee and Leg Physical medicine treatment x](#)

Physical medicine treatment

Body system:

Knee and Leg

Treatment type:

Physical Medicine

Related Topics:

See specific physical therapy modalities by name, as well as Exercise. See also Aerobic exercises; Activity restrictions; ACL injury rehabilitation; Aquatic therapy; Barefoot walking; Cold/heat packs; Compression garments; Computerized muscle testing; Continuous-flow cryotherapy; Continuous passive motion (CPM); Deep transverse friction massage (DTFM); Diathermy; Durable medical equipment (DME); Education; Electrical stimulators (E-stim); Electromyographic biofeedback treatment; Electrothermal shrinkage (for lax ACL); Flexionators (extensionators); Footwear, knee arthritis; Functional improvement measures; Functional restoration programs (FRPs); Gait training; Game Ready™ accelerated recovery system; Group physical therapy; Gym memberships; Heat; Home exercise kits; Immobilization; Interferential current stimulation (ICS); Iontophoresis; Joint active systems (JAS) splints; Joint mobilization; Kinesio tape (KT); Knee brace; Low level laser therapy (LLLT); Magnet therapy; Manipulation; Manual therapy; Massage therapy; Mechanical stretching devices (for contracture and joint stiffness); Mud pack therapy; Non-surgical intervention for PFPS (patellofemoral pain syndrome); Orthoses; Phonophoresis; Power mobility devices (PMDs); Proprioception exercises; Pulsed magnetic field therapy (PMFT/PEMF); Static progressive stretch (SPS) therapy; Strapping; Strengthening exercises; Stretching and flexibility; Tai Chi; Taping; Therapeutic knee splint (patellofemoral pain); Traction, knee (skeletal traction treatment); Ultrasound, therapeutic; U-Step walker; Walking aids (canes, crutches, braces, orthoses, and walkers); Work conditioning, work hardening.

CR Conditionally Recommended

Recommended as indicated below. As with any treatment, if there is no improvement after 2-3 weeks, the protocol may be modified or re-evaluated. See also specific modalities linked below. (Philadelphia, 2001)

ODG Criteria

ODG Physical Medicine Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT.

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella:

Medical treatment: 9 visits over 8 weeks

Post-surgical (Meniscectomy): 12 visits over 12 weeks

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear):

Medical treatment: 12 visits over 8 weeks

Post-surgical (ACL repair): 24 visits over 16 weeks

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis:

Medical treatment: 9 visits over 8 weeks

Post-surgical: 12 visits over 12 weeks

Articular cartilage disorder - chondral defects:

Medical treatment: 9 visits over 8 weeks

Post-surgical (Chondroplasty, Microfracture, OATS): 12 visits over 12 weeks

Pain in joint; Effusion of joint:

9 visits over 8 weeks

Arthritis (Arthropathy, unspecified):

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks

Abnormality of gait:

9-48 visits over 8-16 weeks (based on specific condition)

Fracture of neck of femur:

Medical treatment: 18 visits over 8 weeks

Post-surgical treatment: 24 visits over 10 weeks

Fracture of other and unspecified parts of femur:

Post-surgical: 30 visits over 12 weeks

Fracture of patella:

Medical treatment: 10 visits over 8 weeks

Post-surgical (closed): 10 visits over 8 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Fracture of tibia and fibula:

Medical treatment: 12-18 visits over 8 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Amputation of leg:

Post-replantation surgery: 48 visits over 26 weeks

Quadriceps tendon rupture:

Post-surgical treatment: 34 visits over 16 weeks

Patellar tendon rupture:

Post-surgical treatment: 34 visits over 16 weeks

Hamstring strain:

Medical treatment: 12 visits over 8 weeks

Post-surgical: 24 visits over 16 weeks

Work conditioning

See Work conditioning, work hardening

Evidence Summary

Acute muscle strains often benefit from daily treatment over a short period, whereas chronic injuries are usually addressed less frequently over an extended period. It is important for the physical therapy provider to document the patient's progress so that the physician can modify the care plan, if needed. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (e.g., joint range-of-motion and weight-bearing limitations, and concurrent illnesses). (Rand, 2007) Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) A randomized controlled trial of the effectiveness of water-based exercise concluded that group-based exercise in water over 1 year can produce significant reduction in pain and improvement in physical function in adults with lower limb arthritis, and may be a useful adjunct in the management of hip and/or knee arthritis. (Cochrane, 2005) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term, physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Supervised therapeutic exercise improves outcomes in patients who have osteoarthritis or claudication of the knee. Compared with home exercise, supervised therapeutic exercise has been shown to improve walking speed and distance. (Rand, 2007)

A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. (Zhang, 2008) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In patients with ACL injury willing to moderate activity level to avoid re-injury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Limited gains for most patients with knee OA. (Bennell, 2005) More likely benefit for combined manual physical therapy and supervised exercise for OA. (Deyle, 2000) Many patients do not require PT after partial meniscectomy. (Morrissey, 2006) There are short-term gains for PT after TKR. (Minns Lowe, 2007) Physical therapy and patient education may be underused as treatments for

knee pain, compared to the routine prescription of palliative medication. (Mitchell, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) This study sought to clarify which type of postoperative rehabilitation program patients should undergo after ACL reconstruction surgery, comparing a neuromuscular exercise rehabilitation program with a more traditional strength-training regimen, and it showed comparable long-term primary and secondary outcomes between the 2 groups at 12 and 24 months. Based on this study, the authors recommend a combined approach of strength exercises with neuromuscular training in postoperative ACL rehabilitation programs. (Risberg, 2009) This RCT concluded that, after primary total knee arthroplasty, an outpatient physical therapy group achieved a greater range of knee motion than those without, but this was not statistically significant. (Mockford, 2008)

Knee bracing after ACL reconstruction appears to be largely useless, according to a systematic review. The most important rehab for ACL surgery patients is to start physical therapy early and rigorously. Accelerated rehabilitation (starting at 3 weeks postoperatively rather than the traditional 3 months and intended to reduce the usual 6-month time for return to activity) was considered to be safe according to this review. The authors conclude that immediate postoperative weight-bearing, range of knee motion from 0° to 90° of flexion, and strengthening with closed-chain exercises are likely to be safe. They also suggest that starting eccentric quadriceps strengthening and isokinetic hamstring strengthening at week 3 after surgery may accelerate recovery. The reviewers found promising data for home-based rehabilitation for the motivated patient, but found doubtful support for neuromuscular training such as proprioceptive and balance training, perturbation training, and vibratory stimulation. (Kruse, 2012) In this systematic review, strength training, Tai Chi and aerobics exercises improved balance and falls risk in older individuals with knee OA, while water-based exercises and light treatment did not. (Mat, 2015) For acute hamstring injury, rehabilitation (lengthening) exercises showed a significantly reduced time to return to play. (Pas, 2015)

Active Treatment versus Passive Modalities: See the "Active treatment versus passive modalities" section of Physical therapy (PT) in the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). This systematic review concluded that PT interventions that empower patients to actively self-manage knee OA (such as aerobic, strength, and proprioception exercise) improved outcomes the best. (Wang, 2012) The latest AAOS Guidelines for Treatment of Osteoarthritis of The Knee, include a strong recommendation that patients with symptomatic osteoarthritis of the knee participate in self-management programs, strengthening, low-impact aerobic exercises, and neuromuscular education; and engage in physical activity consistent with national guidelines. (AAOS, 2013)

Physical therapy

Body system:

Knee and Leg

Treatment type:

Physical Medicine

Related Topics:

See Physical medicine treatment.

x See Reference

This topic is indexed as a common search term for guidelines hosted elsewhere. Click-through and see related topics field.

Copyright © 2018 ODG by MCG Health. All rights reserved. No part of this publication may be reproduced, scanned or distributed in any printed or electronic form without written permission. Distribution of PDFs should be limited to 1:1 exchange with parties involved in the management of individual claims