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Preliminary Report for Settlement Purposes Only

December 4, 2017

RE: Donald ****t
Date of Birth: August 01, 1945
Date of Event: August 06, 2015
Present age: 72
Diagnosis:

- **Lumbar back pain**
- **Musculoligamentous strain of the lumbar spine**
- **Left lower extremity paresthesia**
- **Left lower leg radiculopathy**
- **Low back pain potentially associated with radiculopathy**
- **Left greater than right lumbosacral radiculitis**
- **Likely clinical exacerbation of pre-existing pseudarthrosis (back pain) and likely clinical exacerbation of foraminal stenosis vs. arachnoiditis (left greater than right leg radicular pain)**
- **L2-L3, L3-L4, L5-S1 fusion pseudarthrosis, with L2 and L3 pars fractures and with L4, L5, and possible S1 screw loosening**
- **L2-L3 osteophytic spurring and facet arthropathy causing mild midline stenosis**
- **L1-L2 retrolisthesis and osteophytes and facet arthropathy causing midline stenosis**
- **L1-L2 through L5-S1 bilateral facet arthrosis with associated foraminal stenosis**

Life Care Plan and Vocational Considerations for Donald ****t

This file was referred for preparation of a Life Care Plan on behalf of Donald ****t. The purpose of this evaluation is to assess the extent to which he had incurred disabling conditions secondary to the event of August 06, 2015.

A Life Care Plan is a detailed report that identifies the needs and services, both medical and non-medical, of an individual who is catastrophically injured or chronically ill over their lifetime. As a certified rehabilitation counselor and certified life care planner, I assess the impact these disabling conditions infringe on an individual's ability to demonstrate independent activities of daily living and the extent to which they direct the need for

medical and rehabilitation intervention. In addition, I offer opinions on the level of assistance, services, aids, and equipment required to facilitate maximum functional independence and quality of life.

The conclusions, medical cost projections, information, and recommendations presented in Mr. ****t's Life Care Plan are based upon:

- A comprehensive review of the available medical records
- A telephonic interview on August 08, 2017, with Mr. ****t. The interview lasted 2.9 hours
- Sound medical rehabilitation, case management, and psychological principles for foundation and support of the recommendations contained within this report
- Research of relevant clinical practice guidelines to further establish needs and recommendations as well as support medical and case management foundation
- Research on current information of the listed diagnoses for foundation and support of the recommendations
- Research for durable medical goods/supplies and other products and services

RECORDS REVIEWED

DATE	RECORDS REVIEWED
08/06/2015-08/07/2015	Hospitalization records from Banner Thunderbird Medical Center
08/12/2015-09/16/2016	Office visit records from A. Gianna Vishteh, M.D.
08/20/2015-09/01/2016	Office visit records from Consultants In Internal Medicine
09/09/2015	Diagnostic test report from HonorHealth
10/01/2015	Diagnostic test report from Comprehensive Pain Management
11/19/2015-04/12/2016	Independent medical examination, initial evaluation and follow-up visit records from Spine Institute of Arizona
11/23/2015-04/18/2016	Office visit, and procedure reports from Cardiovascular Consultants, Ltd.
12/21/2015	Diagnostic test report from SimonMed
01/19/2016-01/22/2016	Procedure reports from Surgcenter of Deer Valley
09/21/2016	Office visit record from Arrowhead Health Centers Glendale

SUMMARY OF RECORDS REVIEWED

On August 06, 2015, at around 09:30 a.m., Donald ****t was working inside an elevator. Suddenly, the elevator broke and began to drop two stories. During the fall, Mr. ****t was lifted off the floor and he fell flat on his feet when the elevator came to rest at the basement.

Following the incident, Mr. ****t presented to the emergency room of Banner Thunderbird Medical Center where Nattasha Huffaker, P.A., and Matthew Nerdin, M.D., examined him for the complaints of severe pain in his back, left hip, and left leg. He had numbness, and tingling in his left leg. On examination, he had tenderness in the inferior aspect of thoracic region, and in his left hip. He reported decreased sensation to touch especially on the left side. Morphine, Norflex, and Zofran were administered. Lab work-up was obtained. X-ray of hip, and CT scans of chest, abdomen, pelvis, thoracic spine, and lumbar spine were ordered.

The X-ray of his hip revealed the following:

- No acute osseous abnormalities

The CT of his chest, abdomen, and pelvis revealed the following:

- Negative acute CT chest, abdomen, and pelvis

The CT of his thoracic spine revealed the following:

- Negative acute thoracic spine CT

The CT of his lumbar spine revealed the following:

- Postsurgical and degenerative changes with no acute osseous abnormalities

Assessment:

- Two story elevator fall
- Lumbar back pain
- Left lower extremity paresthesia

A telephone consultation was done with Christopher Iannotti, M.D., a neurosurgeon, regarding the symptoms of paresthesia in his left leg and decreased rectal tone. Dr. Iannotti recommended admission for further evaluation and management.

On the same day, Dan Byun, M.D., examined Mr. ****t for admission. He complained of pain in the left side of his low back associated with radiating pain, numbness, and tingling in his left leg. He reported the pain level as 5/10. Pain increased with movements.

Assessment:

- Left lower leg radiculopathy

He was recommended to obtain an MRI of his lumbar spine, but Mr. ****t stated that it was not safe for him to obtain an MRI because of his stent. Dr. Byun recommended him to consult a cardiologist for clearance.

On the same day, Steve Dorsey, M.D., examined Mr. ****t. He complained of pain in his back, left hip, and left leg. He reported the pain level as 9/10. The pain in his low back was radiating to his left leg associated with numbness. On examination, he appeared to be in a lot of pain. He had tenderness in the muscles of his low back on the left side.

Assessment

- Lumbar spine pain

Dr. Dorsey stated that he had a history of lumbar degenerative disc diseases with surgical fusion of L2-S1 with acute pain after a fall injury. He was recommended to stay off work.

On August 07, 2015, David Wilson, M.D., examined Mr. ****t for the complaint of pain in his low back, and numbness in his left leg. He reported increased sensory disturbance in his low back, and in the proximal aspect of his left leg while walking. He also reported symptoms of numbness in his left leg. On examination, he had tenderness in the muscles of his left lower lumbar region. Dr. Wilson suspected musculoskeletal etiology such as lumbar strain or hip strain, and recommended physical therapy.

On the same day, an X-ray of his lumbar spine was obtained and the study revealed the following:

- Post-laminectomy and posterior fusion changes from L2 through S1
- Minimal retrolisthesis of L1 and L2 and anterolisthesis of L3 on L4. Findings are stable on flexion-extension views with no evidence for dynamic instability
- Mild to moderate multilevel degenerative lumbar disc disease
- Levoconvex lumbar curvature

On the same day, Scott Bear, D.O., performed a cardiovascular evaluation and assessed him to have the following:

Assessment:

- Status post 2-story elevator fall
- History of multiple coronary artery stents and prior myocardial infarction back in 2006
- Persistent tobacco abuse
- History of paroxysmal atrial fibrillation

He was recommended to obtain an EKG. Dr. Bear stated that he was stable from a cardiovascular standpoint, and instructed him to continue medications. He was advised to follow-up with the cardiology department after discharge.

On the same day, Charles Otuonye, M.D., examined Mr. ****t for discharge.

Assessment:

- Fall from a height
- Back pain
- Hypertension
- Dyslipidemia
- Coronary artery diseases
- Atrial fibrillation

Dr. Otuonye advised him to follow-up with his primary care physician and neurosurgeon in one or two weeks, and discharged him from care.

On August 12, 2015, Mr. ****t presented to A. Gianni Vishteh, M.D., for the complaint of pain in his back and left leg associated with numbness. On examination, he had weakness in the muscles of his thigh. He had trace jerk in his knees. Dr. Vishteh recommended him to obtain a CT myelogram of lumbar spine for evaluation of persistent radicular symptoms. He was advised to follow-up after the CT scan.

On August 20, 2015, Mr. ****t presented to James Amen, M.D., at Consultants in Internal Medicine for the complaint of pain in his low back and left leg associated with symptoms of paresthesia. Walking caused increase in pain. On examination, he had a slow and deliberate gait.

Assessment:

- Low back pain potentially associated with radiculopathy

Hydrocodone/Acetaminophen was prescribed. He was recommended to follow-up with an orthopedist for further evaluation. He was instructed to limit activities and follow-up in four weeks.

On September 09, 2015, Peter Steinberg, M.D., obtained a CT myelogram of Mr. ****t's lumbar spine from HonorHealth. The study revealed the following:

- Status post decompressive laminectomy and pedicle screw fixation between L2 and S1, unchanged
- Mild disc bulging at L1-L2. There was some thickening of ligamentum flavum, but no significant central canal or neural foraminal narrowing detected at this level
- No significant central canal or neural foraminal narrowing throughout the operative region between L2-L3, and L5-S1
- Diffuse bilateral facet arthrosis between L1-L2 and L5-S1

On September 16, 2015, Mr. ****t had a follow-up visit with Dr. Vishteh for the complaint of persistent pain in his low back and left leg. He reported symptoms of numbness and tingling in his entire left leg. He was walking using a cane and he stated that his foot felt cold. Dr. Vishteh recommended him to obtain an Electromyogram /Nerve Conduction Velocity of legs for further evaluation. Epidural steroid injections were recommended for pain management. He was instructed to follow-up with his primary care physician for evaluation of coldness in his feet. Elavil was prescribed for neuropathic pain, and he was advised to follow-up after the Electromyogram /Nerve Conduction Velocity study.

On October 01, 2015, Joel Braun, M.D., obtained an Electromyogram /Nerve Conduction Velocity of Mr. ****t's lower extremities from Comprehensive Pain Management. The study revealed the following:

- Evaluation of the left sural sensory nerve showed prolonged distal peak latency (4.5 ms) and decreased conduction velocity (Calf-Lat Mail, 31 m/s)
- All remaining nerves (as indicated in the following tables) were within normal limits
- All F Wave latencies were within normal limits
- Needle evaluation of the Left gastroc muscle showed increased insertional activity and slightly increased spontaneous activity
- All remaining muscles (as indicated in the following table) showed no evidence of electrical instability

On October 15, 2015, Mr. ****t presented to A. Villamor, M.D., at Consultants in Internal Medicine for the complaint of persistent and increased pain in his low back, and left leg. He reported sleep disturbance because of pain.

Assessment:

- Low back pain

A refill of Hydrocodone/Acetaminophen was provided. He was referred to a pain specialist and a neurologist for further evaluation. He was advised to follow-up as needed.

On November 19, 2015, Mr. ****t presented to Edward Dohring, M.D., at Spine Institute of Arizona for an independent medical examination. He presented with the complaint of tightness and pain in his back, left leg, and right gluteal muscle. He reported the pain level in his back as 7/10, in his left leg as 6/10, and right gluteal as 4/10. He stated that he had undergone decompressive lumbar laminectomy at L2-S1 level with partial hemi-

laminectomy at Ll. Internal fixation of L2, L3 L4, L5 and S1 with bilateral pedicle screws, and arthrodesis were also performed. He stated that the surgery was successful and he returned to full time work as a maintenance worker at Maricopa Hospital without any restrictions. His work requires a lot of heavy duties, including climbing ladders. He reported increased pain with movements. He had weakness in his left leg. He had been off work since the fall injury. He was taking Hydrocodone for pain.

On examination, he had difficulty performed heel and toe walk, especially on the left side because of weakness. He had tenderness in the left side of his low back. The movements of his low back had become restricted because of severe pain. Patella reflexes had decreased and his left Achilles reflex was absent. He had decreased sensation in the medial aspect of his left leg.

Assessment related to the industrial injury:

- Musculoligamentous strain of the lumbar spine
- Left greater than right lumbosacral radiculitis
- Likely clinical exacerbation of pre-existing pseudarthrosis (back pain) and likely clinical exacerbation of foraminal stenosis vs. arachnoiditis (left greater than right leg radicular pain)

Additional assessment:

- L2-L3, L3-L4, L5-S1 fusion pseudarthrosis, with L2 and L3 pars fractures and with L4, L5, and possible S1 screw loosening
- L2-L3 osteophytic spurring and facet arthropathy causing mild midline stenosis
- L1-L2 retrolisthesis and osteophytes and facet arthropathy causing midline stenosis
- L1-L2 through L5-S1 bilateral facet arthrosis with associated foraminal stenosis
- 08/14/2012 L1 partial, L2-S1 complete laminectomies, L2 through S1 posterolateral screw-rod fusion
- History of Ml, on Plavix.
- Hypertension
- History of kidney stones
- History of cancer

Dr. Dohring stated that it was more likely that the mechanism of his injury resulted in a musculoligamentous strain of the lumbar spine and a potential clinical exacerbation of factors related to his prior lumbar fusion surgery, including pseudarthrosis, residual stenosis, and arachnoiditis.

The doctor stated that Mr. ****t could perform his duties without any difficulty until the date of the event, and his current symptoms were related to radiculopathy.

Epidural steroid injections were recommended for pain management. However, in the light of his prior history of myocardial infarction, he was recommended to obtain cardiological clearance prior to the procedure. Dr. Dohring stated that he would need medial branch blocks, if he had persistent pain despite the epidural steroid injection. If the medial branch block provided adequate pain relief, the doctor stated that he would need radiofrequency ablation.

The doctor stated that the medial branch blocks should be administered as per proper guidelines without sedation and Steroids.

The doctor stated that a possible bridging with Lovenox could also be considered, if his cardiologist did not feel comfortable, taking him off Plavix for the epidural steroid injection. The doctor also stated that he would benefit from activity-based physical therapy program for core strengthening and lumbar stabilization. Gabapentin or Lyrica was recommended for nerve stabilization. An MR of lumbar spine and a bone scan were also recommended for evaluation of lumbar radiculopathy and pseudo arthrosis. He was encouraged to contact his physician to find out the type of stent he was using, so that an MR of lumbar spine could be obtained.

In addition, he was recommended to obtain flexion and extension X-rays of lumbar spine to evaluate the stability of his spine given the suspected pseudarthrosis and screw loosening seen in his CT scan.

Mr. ****t was recommended to stay off-work as further diagnostic workups were pending. The doctor stated that he was not medically fixed and stationary with regards to the reported industrial injury.

On November 23, 2015, Mr. ****t presented to Francis Surdakowski, M.D., at Cardiovascular Consultants, Ltd., for a cardiac evaluation. He had no new complaints. Dr. Surdakowski recommended obtaining an echocardiogram, carotid ultrasound, and a chemical stress test for further evaluation.

On December 11, 2015, Anthony Pozun, D.O., obtained a stress ECG from Cardiovascular Consultants, Ltd. The study revealed the following:

- The ECG portion of the stress test did not demonstrate ST-segment changes consistent with myocardial ischemia
- Overall left ventricular systolic function was (33%) moderately abnormal
- Regional wall abnormalities were noted
- Evidence of reversible ischemia was noted
- Myocardial perfusion imaging was abnormal. There was a large-sized, mild-moderate intensity infarct involving the mid inferior, mid inferior-lateral, basal inferior-lateral and basal inferior-septal segments with moderate peri-infarct ischemia of the apical lateral, mid inferior-lateral and mid inferior segments

On December 14, 2015, Mr. ****t followed-up with Dr. Surdakowski for review of diagnostic test. The doctor stated that his stress test was abnormal. Nuclear images revealed a fixed defect in the inferior region with peri-infarct ischemia. The echo test revealed evidence of left atrial enlargement. The carotid ultrasound revealed bilateral moderate carotid disease of 40-70%. The doctor stated that he was stable from a cardiovascular standpoint and there was no change in his medical therapy.

On December 21, 2015, Robert DeLaPaz, M.D., obtained an MRI of Mr. ****t's lumbar spine from SimonMed and the study revealed the following:

- There were several ferromagnetic hardware artifacts at the L2 through S1 level secondary to bilateral transpedicular screw and posterior rod fixation hardware as seen on the previous X-ray and CT myelogram. Chronic central decompression laminectomy post-surgical changes at L2-L3 through L5-S1 levels were stable, although partially obscured by hardware paramagnetic artifact. The spinal canal remained widely patent and lumbar alignment was maintained within normal limits at the fusion levels with persistent 2 mm grade 1 retrolisthesis of L1 on L2 mid canal stenosis at L1-L2 level
- The severe ferromagnetic hardware artifact also obscured the post contrast image. No vertebral body or end plate enhancement, disc space enhancement, or para-spinous phlegm on epidural abscess or abnormal intra-thecal contrast enhancement was seen

- A stable mild bilobed disc bulge and moderate facet arthropathy at L1-L2 with mild canal stenosis without conus or cauda equina compression, Moderate neural foramen stenosis
- Severe disc desiccation was noted at L2-L3 level with widely patent thecal sac expanded into the laminectomy defect. Moderate neural foramen stenosis partially obscured by hardware artifact
- Mild disc desiccation was noted at L3-L4 level with widely patent thecal sac expanded into the laminectomy defect. Mild neural foramen stenosis partially obscured by hardware artifact
- Severe disc desiccation was noted at L4-L5 level with widely patent thecal sac expanded into the laminectomy defect. Moderate neural foramen stenosis partially obscured by hardware artifact
- Severe disc desiccation was noted at L5-S1 level with widely patent thecal sac expanded into the laminectomy defect. Moderate neural foramen stenosis partially obscured by hardware artifact

On January 07, 2016, Mr. ****t followed-up with Dr. Dohring for the complaints of pain and tightness in his low back, and legs associated with numbness and weakness especially in the left side. He reported the pain level in his low back as 6/10, and pain in his legs as 3-5/10. His lumbar Oswestry Disability Index score was 56%. On examination, he had difficulty performing heel and toe walk, especially on the left side because of weakness. He had tenderness in the left side of his low back. The movements of his low back had become restricted because of severe pain. Patella reflexes had decreased and his left Achilles reflex was absent. He had decreased sensation in the medial aspect of his left leg. Dr. Dohring stated that he was experiencing pain from the pseudarthrosis. The doctor stated that his leg pain was likely be related to arachnoidids, epidural fibrosis-induced nerve issue, or residual neuroforamina spinal stenosis. Diagnostic L3-L4 and L5-S1 facet injections were recommended. He was advised to pursue facet rhizotomy, if he had relief with the diagnostic facet injections. Bilateral L5 and S1 transforaminal epidural steroid injection was also recommended. Vicodin was prescribed. The doctor planned to refer him to physical therapy, if he had pain relief with the injections. He was advised to follow-up after the injection to consider physical therapy or surgery depending on the outcome of the injections.

On January 19, 2016, Allan Rowley, M.D., performed the following procedure at Surgcenter of Deer Valley for management of pain in Mr. ****t's low back:

Procedure:

- Bilateral L3-S1 facet joint posterior primary ramus and medial branch block under fluoroscopic guidance

On January 22, 2016, Dr. Rowley performed the following procedure for the management of pain in Mr. ****t's low back:

Procedure:

- Bilateral L5 and bilateral SI transforaminal epidural steroid injections under fluoroscopic guidance

On February 01, 2016, Mr. ****t followed-up with Dr. Dohring for the complaint of persistent pain in his low back and in the posterior aspect of his left leg associated with numbness and weakness. He stated that he had no relief with the injections. He presented for a discussion regarding his lumbar surgery. Dr. Dohring stated that he had left S1 radiculopathy according to the Electromyogram /Nerve Conduction Velocity study and his bone scan revealed primary low lumbar findings at L5-S1 with regard to pseudarthrosis, with possible pseudo arthrosis of L4-L5. Decompression and revision fusion surgery were recommended. The doctor stated that he had degenerative changes above his old fusion, but he did not appear to have significant pain. Unfortunately, his cardiac history and continuous cigarette-smoking could result in potential complications with the surgery. Therefore, the doctor recommended obtaining a surgical clearance from his cardiologist. Until then, he was recommended to continue supportive care with medications, home exercise, and sedentary duty.

On February 05, 2016, Mr. ****t followed-up with Dr. Surdakowski for cardiac evaluation. He was compliant with his treatment, and the doctor advised him to follow-up as needed.

On February 11, 2016, Antony Pozun, D.O., performed the following procedure:

Procedure:

- Left heart catheterization with left ventriculography
- PTCA and stent placement to the RCA
- PTCA and stent placement to the LAD
- PTCA of the circumflex due to in-stent restenosis
- Angio-seal deployment right common femoral

Findings:

- Left maim is large, giving rise to the LAD and left circumflex. There is minimal disease
- The left anterior descending artery is large, arid, extends to and wraps around the apex. There is a 99% occlusion in the mid LAD, just near the takeoff of a large diagonal, which has no disease in it. The mid to distal LAD is free of disease
- Left circumflex is moderate to large and there is a stent in its proximal portion; which reveals 80% in-stent restenosis in the proximal half of the stent. There is also a stent in the more distal OM, which is larger than the lumen of the vessel, but is free of disease. There is a 50% stenosis before the stent, but this vessel is too small for intervention
- The right coronary artery is very large and there is a stent in the mid segment just after this; there is a 90% stenosis near a bend, flow-limiting, with TIMI 2 flow to the PDA
- LV function reveals mild global hypo-kinesis; ejection fraction is 40% to 45%

On February 19, 2016, Mr. ****t followed-up with Dr. Surdakowski for cardiac evaluation. He was compliant with his treatment. As bare metal stents were placed, Dr. Surdakowski stated that he should not have his back surgery for the next two to three months. He was recommended to obtain a Card-ECG and advised to follow-up in 2 months.

On March 03, 2016, Mr. ****t followed-up with Dr. Dohring for the complaint of persistent pain and weakness in his back and left leg. He stated that a cardiac stent was placed after angioplasty. He continued to take Plavix. He was not cleared for back surgery. He was taking Hydrocodone for pain. Dr. Dohring stated that he had permanent partial impairment of 13% and 10% impairment because of his prior injury. He was recommended to pursue modified work duty with restrictions of maximum lifting of 15 pounds, postural changes every ninety minutes, bending and twisting not more than 15 times an hour. Supportive care such as medication and one series of injections were recommended for the management of pain flare-ups. The doctor stated that the case would be re-opened for surgical work-ups, once his cardiologist cleared him for surgery. He was advised to continue conservative treatment and follow-up in four to six weeks for re-evaluation.

On April 12, 2016, Mr. ****t followed-up with Dr. Dohring for the complaint of persistent pain in his back and left leg associated with numbness. A cardiac evaluation was scheduled to determine if he was fit for surgery. He continued to use a cane for ambulation. He was taking Vicodin for pain flare-ups. He was instructed to make a phone call after his cardiac evaluation, and was advised to follow-up as needed.

On April 18, 2016, Mr. ****t followed-up with Dr. Surdakowski for a cardiac evaluation. He was stable and required no change in medical therapy. Dr. Surdakowski advised him to follow-up in three months for a re-evaluation.

On September 01, 2016, Mr. ****t followed up with Dr. Ames for the complaint of persistent pain in his low back. He stated that his surgeon wanted to perform the procedure but his cardiologist refused to provide a cardiac clearance given his high risk of peri-operative cardiac event. On examination, his had a slow and deliberate gait.

Assessment:

- Low back pain potentially associated with radiculopathy

Hydrocodone/Acetaminophen was provided, and he was advised to follow-up in six months.

On September 21, 2016, Mr. ****t presented to Ankit Chander, M.D., at Arrowhead Health Centers Glendale for evaluation of pain in his neck, and entire back. Walking caused increase in pain.

Assessment:

- Back pain
- Atherosclerotic heart disease of native coronary artery without angina pectoris

Hydrocodone/Acetaminophen was prescribed for pain. Physical medicine and rehabilitation consultation was recommended for evaluation of low back pain. He was also referred to a chronic pain specialist for further management.

CURRENT MEDICAL CARE

CURRENT MEDICAL CARE:

- He follows-up with Victoria Tweedy, C-NP, MSN at Arrowhead Health Center once a month for pain medication
- He follows-up with his cardiologist, Dr. Surdakowski, three to four time a year
- His primary care physician has left practice, and he is currently looking for a new primary care physician

CURRENT MEDICATIONS:

- Hydrocodone 5/325 mg, three time a day (Weekends: Two tablets a day)
- Plavix 75 mg, once in the morning
- Lisinopril 10 mg, once in the morning
- Metoprolol tartrate 25 mg, once in the morning
- Digoxin 0.125 mg, once in the morning
- Simvastatin 40 mg at bedtime
- Aspirin 81 mg, at bedtime

EQUIPMENT:

- Cane for ambulation
- Shower chair
- Grab bar in the bathroom

HISTORY AND BACKGROUND INFORMATION

PERSONAL INFORMATION:

- Mr. ****t is 5.5 feet tall and weighs 144 pounds. He uses glasses while driving, and reading. He worked as a Maintenance Worker at Maricopa Hospital. His current source of income is from State retirement and workers' compensation

ADDRESS:

- He lives at 3825 W. Vogel Avenue, Phoenix 85051

TYPE OF HOME:

- He lives in a 3 bedroom, and 1.5-bathroom house

FAMILY INFORMATION:

Spouse:

- Deceased

Children:

- He is currently living with his daughter and two grandchildren

INJURIES SUSTAINED:

- Low back pain associated with left leg radiculopathy

ADDITIONAL SYMPTOMS OR SEQUELAE:

- Radiating pain, numbness, and weakness in left leg
- Positional pain
- Functional limitations
- Sleep difficulty

ENVIRONMENTAL INFLUENCES:

- He reported increased pain with humidity and changes in barometric pressure

OTHER PAIN RELIEVING AND AGGRAVATING FACTORS

- Other than medication he reports that lying flat on his back in bed for 15-20 minutes and/or hot shower relieves pain to a certain extent
- He stated that he had tried TENS unit and the equipment caused increased pain

CURRENT SYMPTOMS

(As reported by Mr. ****t)

Head:
- No abnormalities

Neck:
- No abnormalities

Shoulders:
- No abnormalities

Arms:
- No abnormalities

Upper and mid back:
- He reported pain in his upper back with increased movements

Low back:
- He reported significant tension like pain in his low back with movements
- His low back pain radiated to his entire left leg till his toes. He described the radiating pain as pins and needles

Bowel and bladder:
- He has no problems with bowel
- He stated that he has been noticing increased urination with increased movements. He stated that he gets up 3 to 4 times every night to urinate

CURRENT FUNCTIONAL STATUS

(As reported by Mr. ****t)

FUNCTIONAL LIMITATIONS:

- He cannot bend over or twist his back because of his lumbar fusion. He has difficulty finding a comfortable position while sitting and lying down
- He is unable to reach out for heavy things. He is unable to lift or carry objects weighing more than 15 pounds. He reported severe stabbing pain in his low back while lifting objects weighing more than 15 pounds

- He is unable to sit for more than 30 minutes. He needs to get up and move around to relieve pain

- He is unable to stand in one position for more than 10-15 minutes and will need to sit down

- He is unable to walk slowly for more than a block with his cane

- He has difficulty getting up from a seated position. He uses a cane to support himself inside and outside his house. When he is at home, he usually sits in his recliner which has an arm rest at a convenient height to support him while getting up

- He has difficulty ascending the stairs. He is unable to climb more than one flight of stair without difficulty

ACTIVITIES REQUIRING ASSISTANCE:

- He stated that he receives assistance from his daughter and grandchildren for activities around the house, but he has been self-proficient with his activities

FUNCTIONS PERFORMED WITHOUT DIFFICULTY:

- He can manage positional pain during the day time, as he can to feel pain at its start and move around before it become bad
- He can reach light weight objects without difficulty
- He can sit for 30 minutes
- He can stand in the same position for 10 to 15 minutes
- He can walk a block distance using his cane
- He can ascend only a flight of stair without difficulty. He has no issues while descending the stairs. He stated that descending seems to help pain

COGNITIVE AND EMOTIONAL PROBLEMS:

- He has difficulty finding a comfortable position while lying down. He has sleep problems due to positional pain. He is unable to stay in one position for more than 2 hours. He experiences significant pain and tension in his back, if he moves wrong while sleeping. He needs to get up and walk around to relieve symptoms. If walking fails to reduce symptoms, he then needs to take a hot shower. He stated that he takes 15 to 45 minutes to fall asleep again after his shower. He also reported increased urination with increased movements, and he stated that he gets up 3 to 4 times every night to urinate

LIMITATION IN HOBBIES/LEISURE ACTIVITIES:

- He is unable to pursue his love of working with wood. He has a complete cabinet shop in his garage.
- He is unable to taking care of home. He stated that he built a gazebo a few years ago, but he is unable to work on the interior and exterior of his house
- He is unable to go fishing
- He is unable to travel continuously. He stated that he recently travelled by road with his family for 2 ½ hours, and during the ride, he had to stop the vehicle 3 time just to get out and walk in order relieve pain in his low back and left leg

CURRENT HOBBIES/LEISURE ACTIVITIES:

He is currently pursuing the following activities during his leisure time

- Pie baking
- Cooking and preparing barbeque dinner
- Going and sitting up at the lake
- In the morning, he takes his dog for a walk. He sits outside and turns on the sprinklers to water the back yard
- He does paper work, and reads newspaper regularly

According to the National Vital Statistics Reports, Vol. 66, No. 3, April 11, 2017; Table 2. Life table for Males: United States, 2013; the Statistical Life Expectancy of Mr. ****t (DOB: August 1, 1945) a 72-year-old man is 13.1 years.

LIFE CARE PLAN RECOMMENDATIONS AND COST PROJECTION

The attached tables will detail the recommendations for Mr. ****t's future care needs. A life care plan is a preventative plan; therefore, recommendations for prevention, early detection, and minimizing complications are included.

Clinical practice guidelines are systematically developed documents which are published to provide specific recommendations to standardize the process of diagnosis and treatment of common clinical disorders for clinicians, patients, and healthcare practitioners. The following clinical practice guidelines related to lumbar injury were consulted for foundation and support of the recommendations noted in the attached tables.

http://www.owcc.state.ok.us/PDF/Guidelines%20for%20Treatment%20of%20the%20Lumbar%20Spine,%20eff%2008-15-2009.pdf
https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/motor-accident-disputes/guidance-material-for-medical-assessors/MAA_Permanent_Impairment_Guidelines_1_October_2007final_1.pdf

Routine Medical Evaluations- Table 1

- Mr. ****t has been following-up with Victoria Tweedy, C-NP, MSN at Arrowhead Health Center once a month for pain management. He will need to continue pain management consultations because of the chronic nature of his injury until discharged
- Mr. ****t will need to follow-up with his cardiologist periodically to monitor his cardiac function and to obtain surgical clearance for the lumbar fusion as recommended by Dr. Dohring
-
- On September 21, 2016, Dr. Chander recommended a physical medicine and rehabilitation consultation for the evaluation of low back pain.
- Mr. ****t stated that his primary care physician has left practice and he needs a new primary care physician. An allowance for family doctor will be required to receive routine health check-ups, medication refills, and appropriate referrals

Therapeutic Evaluations- Table 2

- Mr. ****t is anticipated to require surgical intervention for the management of pain in his low back. Post-operative rehabilitation may be required to regain strength, motion, and functionality and will be recommended by his treating surgeon.
  http://www.sosmed.org/protocols/pt-protocols/LUMBAR-FUSION-AND-DEBRACING.pdf

- Mr. ****t reported sleep difficulty because of pain in his back and left leg. Depression related to chronic back pain is common secondary to sleep problems, functional difficulties, and persistent pain. A will need psychological evaluation is recommended to determine strategies to promote sleep hygiene, and to manage psychosocial problems
  https://www.spine-health.com/conditions/depression/depression-and-chronic-back-pain

Therapeutic Modalities- Table 3

- Mr. ****t continues to have chronic low back pain and frequent flare-ups. An allowance for physical therapy modalities is included along with a program of home exercises for the management of pain exacerbations
  https://www.physio-pedia.com/Chronic_Low_Back_Pain

Diagnostic Testing – Table 4

- Based on the below clinical guideline, Mr. ****t will need periodic X-rays and/or CT scans of his lumbar spine to evaluate the progress of his low back injuries
  http://www.laworks.net/Downloads/OWC/Bibliography_CervicalSpine.pdf

Equipment and Aids- Table 5

- Mr. ****t is anticipated to need home exercises to maintain his functionality at baseline. The treating therapist will most recommend appropriate exercise equipment for home use
- Mr. ****t stated that he has been using a cane, grab bar, and a shower chair for assistance. Since this equipment is subjected to wear and tear, he will need to replace the cane once in every two years, the shower chair once in five to seven years, and the grab bars at least once in his life time

Pharmacology – Table 6

- Mr. ****t stated that he was taking Hydrocodone 5/325 mg, three times a day for pain. He will need continuous pharmacological intervention in conjunction with medical care under the supervision of his treating specialists.

Future Aggressive Care/Surgical Intervention – Table 7

- On February 01, 2016, Dr. Dohring recommended decompression and revision lumbar fusion surgery for the management of pain in his low back and left leg. According to the office visit dated September 01, 2016, Mr. **** was recommended back surgery but his cardiologist refused to provide a surgical clearance.

Home care/home services – Table 8

- Following the surgical procedure, Mr. **** will require assistance with activities of daily living and instrumental activities of daily living. To replace the services of his daughter, a live in attendant is recommended for 30 days post operation then reduced down to 15 hours per week for up to 3 months. The attendant will perform assistance with bathing and grooming activities, meal preparation and household tasks as well as provide transportation to medical and therapy appointments until he is cleared to drive.

Vocational Considerations

At the time of the event, Mr. ****t was earning $47,736.00 per year and was working beyond retirement age. Therefore, it is statistically difficult to determine his work life expectancy. However, people are working longer in life and it will be up to the triers of fact in this case to determine how long Mr. ****t would have earned $47,726.00 per year. He was an active individual and worked full time. There is no indication he would not have been able to continue working until he was physically unable secondary to the effects of aging.

SUMMARY AND CONCLUSION

Donald ****t, present age 72, was injured on August 06, 2015. Since the event, he has been experiencing persistent pain in his low back associated with radiating pain, numbness, weakness, and tingling in his left leg. He has not been able to participate in physical therapy because of pain. He is anticipated to require revision surgery for low back pain but is unable to proceed with the intervention because of cardiac issues. He continues to require supportive care to maintain his symptoms at baseline.

After you have had a chance to review the narrative report and the attached Life Care Plan, please do not hesitate to contact me should you have further questions.

Opinions expressed in this evaluation are based upon the information at the time of authorship. Should new information become available that would alter the opinions herein, the right is reserved to author addendum report. The methodologies applied in this evaluation are considered to be within an industry standard, and to a degree of vocational Life Care Planning probability.

Respectfully Submitted,

ATTACHMENTS: Appendix A - Life Care Plan

Appendix A

Total Expenditures for Donald ****t

Table Number	Table Title	Total Cost Projection
1	Routine Medical Evaluations	$42,397.00
2	Therapeutic Evaluations	$2,992.00
3	Therapeutic Modalities	$16,000.00
4	Diagnostic Testing	$10,740.00
5	Equipment and Aids	$1,337.65
6	Pharmacology	$2,179.96
7	Future Aggressive Care/Surgical Intervention	$175,000.00
8	Home Care/Home Services	$9600.00
	Total Cost Projection	$260,246.61

Routine Medical Evaluations- Table 1

Routine Medical Evaluations	Start year	End Year	Years	Frequency (Per Year)	Cost Per Visit	Annual Cost	Lifetime Total	Comments
Pain Management Consultation	72	85.1	5	12	$300.00	$3,600.00	$18,000.00	Ongoing care
Cardiology Consultation	72	85.1	13.1	4	$400.00	$1,600.00	$20,960.00	Ongoing care
Neurosurgery Consultation	72	85.1	1	1	$437.00	$437.00	$437.00	Initial evaluation for surgery
Additional Specialist as needed	72	85.1	5	2	$300.00	$600.00	$3,000.00	As per Dr. Chander

TOTAL: **$42,397.00**

Source:
The Physicians Fee Reference 2017

CPT codes:
99204, 99213, 99214 (established patient)

*Additional Specialists May Include Primary Care Physician & Physical Medicine Rehabilitation

Therapeutic Evaluations- Table 2

Therapeutic Evaluations	Start year	End Year	Years	Frequency (Per Year)	Cost Per Visit	Annual Cost	Lifetime Total	Comments
Physical Therapy Evaluation	72	85.1	5	2	$272.00	$544.00	$2,720.00	Assess status, home program and equipment needs
Psychological Evaluation	72	85.1	1	1	$272.00	$272.00	$272.00	Initial Evaluation
					TOTAL:			**$2,992.00**

Source:
The Physicians Fee Reference 2017

CPT codes:
97001, 90792

Therapeutic Modalities- Table 3

Therapeutic Modalities	Start year	End Year	Years	Frequency (Per Year)	Cost Per Visit	Annual Cost	Lifetime Total	Comments
Home exercise	72	85.1	13.1	365	$0.00	$0.00	$0.00	Future care
Physical therapy modalities	72	85.1	5	16 sessions (at 2 sessions per week for 4 weeks twice a year)	$200.00	$3,200.00	$16,000.00	As recommended by the treating physical therapist

TOTAL: **$16,000.00**

Source:
The Physicians Fee Reference 2017
https://www.spine-health.com/treatment/physical-therapy/physical-therapy-passive-pt-modalities-back-pain

CPT codes:
97010, 97014, 97110, 97035, 97014

(Physical Therapy modalities include Hot/Cold Packs, Electrical Stimulation, Therapeutic Exercises, Ultrasound Therapy & Traction)

Diagnostic Testing – Table 4

Diagnostic Testing	Start year	End Year	Years	Frequency (Per Year)	Cost Per Item	Annual Cost	Lifetime Total	Comments
X-ray Lumbar Spine	72	85.1	5	2	$349.00	$698.00	$3,490.00	Follow-up evaluation of lumbar spine
CT Lumbar Spine	72	85.1	5	1	$1,450.00	$1,450.00	$7,250.00	Follow-up evaluation of lumbar spine
				TOTAL:				**$10,740.00**

Source:
http://health.costhelper.com/x-rays.html
https://www.newchoicehealth.com/procedures/lumbar-spine-ct

CPT codes:
72100, 72133

Equipment and Aids- Table 5

Equipment and Aids	Start year	End Year	Years	Frequency (Per Year)	Cost Per Item	Annual Cost	Lifetime Total	Comments
Exercise equipment for home	72	85.1	1	1	$500.00	$500.00	$500.00	Maintain strength
Grab bars in shower	72	85.1	1	1	$150.00	$150.00	$150.00	Safety during bathing
Cane	72	85.1	13.1	Replaced once every 2 years	$83.95	$83.95	$587.65	Safety during ambulation
Shower chair 1 per 5-7 years	72	85.1	2	1	$50.00	$50.00	$100.00	Safety during bathing

TOTAL: **$1,337.65**

Sources:

http://www.allegromedical.com/daily-living-aids-c519/reachers-c3622.html
http://www.adaptiveaccess.com/grab_bars_shower_tub.php
https://www.walmart.com/c/kp/walking-canes
http://www.medicalsupplydepot.com/Bathroom-Safety-Products-1/Shower-Chair-with-Arms-3/

Pharmacology – Table 6

Pharmacology	Start year	End Year	Years	Frequency (Per Year)	Cost	Annual Cost	Lifetime Total	Comments
Hydrocodone 5/325 m, 3 tablets a day	72	85.1	5	1095	$23.89 for 60 Tabs	$435.99	$2,179.96	(Medication, dosage, and frequency may change depending on the symptoms) Pain control

TOTAL: **$2,179.96**

Sources:
www.goodrx.com
www.cvspharmacy.com

Future Aggressive Care/Surgical Intervention – Table 7

Procedure	Start year	End Year	Years	Frequency	Cost	Annual Cost	Lifetime Total	Comments
Lumbar decompression and revision fusion surgery	72	85.1	1	1	$150,000.00		$150,000.00	As recommended by Dr. Dohring
Lumbar decompression and revision- additional level	72	85.1	1	1	$25,000.00		$25,000.00	As recommended by Dr. Dohring
					TOTAL:		**$175,000.00**	

Sources:
https://www.spine-health.com/.../herniated-disc/surgery-options-a-herniated-disc
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3864481/
http://health.costhelper.com/back-surgery.html

CPT codes:
63042, 22849

Cost of surgery will include implant cost, surgeon's fee, anesthesia fee, OR Room charges & post-operative rehabilitation.

Home care/home services – Table 8

Service	Start year	End Year	Years	Frequency (Per Year)	Cost Per Item	Annual Cost	Lifetime Total	Comments
Live in attendant for 1 month post operation	72	85.1	1	30 days	$200.00 per day	$6000.00	$6000.00	To replace the services of his daughter post op
Homemaker – 15 hours per week for 3 months @ $20.00 per hour	72	85.1	1	12 weeks	$300.00 per week	$3600.00	$ 3600.00	To replace the services of his daughter
							Total: $ 9600.00	

Source:

https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/118928AZ_040115_