TABLE OF CONTENTS

15 2017 Life Care Planning Summit Proceedings
Tracy Albee, RN, LNCC, CLCP, FIALCP
Jamie N. Gamez, MA
Cloie B. Johnson, MEd

26 Guardianship and Its Impact on a Life Care Plan
Shay Harlan Jacobson, RN, MA, NMG, LNCC, CNLCP®
Anne Margaret George, LCSW, CCM, MSCC, CMRS

35 Managing the Notion of UCR in a Life Care Plan
Rebecca Mendoza Saltiel Busch
RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA

48 Implementation of a Life Care Plan After the Development by a Nurse Life Care Planner
Rebecca Mendoza Saltiel Busch
RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA

DEPARTMENTS

3 From the Editor

4 Information for Authors

6 A Message from the President

8 Contributors to this Issue

10 Aging and Costing and Coding Resource List

12 Dear Carole

58 Issue Index
If all goes as planned, this issue should reach your inbox about the time you are completing your final travel preparations to attend the Association’s 2018 annual conference in St. Petersburg, Florida: The Art of Life Care Planning. In addition to providing an opportunity to share knowledge and experiences of our life care planning practices with one another, attendees can join in the fun as the Association’s 20th anniversary is celebrated. I look forward to seeing you there!

This issue on costing and coding contains the 2017 Life Care Planning Summit Proceeding by Albee, Gamez and Johnson. Various AANLCP members represented the organization at the summit and were part of the panelist for this multi-organizational forum. In addition to having a shared presence among the life care planning community, through the group work AANLCP attendees played an active role in the formulation of further defining what are the life care plan’s “associated costs”. The write up is filled with other pertinent costing and coding information that should be helpful for all practicing life care planners.

The Jacobson and George article on Guardianship and Its Impact on a Life Care Plan provides information on guardianships and how to approach the incorporation of the costs into a life care plan. The types and criteria for guardianship are outlined along with the standards of practice, ethical considerations, and the typical costs.

An overview and evolution of healthcare reimbursement is touched on as the lead in of Busch’s The Notion of UCR (usual, customary and reasonable) in a Life Care Plan. The article addresses various definitions of UCR, and provides a costing methodology for life care planners to consider in the course of developing a life care plan. Other considerations are discussed in Busch’s Implementation of a Life Care Plan After the Development by a Nurse Life Care Planner. Noted are how Florence Nightingale’s insights are embodied into today’s nursing practice standards and AANLCP standards. The article also articulates that the foundational principles of nursing supports the discipline of life care planning as a core competency and the role that nurses have in the life care planning process and case management.

As always, the Journal Committee welcomes your feedback and input. Please send your comments to the Editor. The committee welcomes issue themed topics and member interest in the opportunity to become involved in any aspect of the Journal’s production. Whether your forte is personal communication, networking, critiquing, writing, or editing, the Journal Committee has a role where your talent can shine, and your expertise grow.

May you have safe travels. See you in Florida!

Mariann F. Cosby, DNP, MPA, RN, PHN, CEN, NE-BC, LNCC, CLCP, CCM, MSCC
Editor, JNLCPP
smfc@surewest.net
AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

### Text

Manuscript length: 1500 – 3000 words
- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Use Times New Roman 12 point font
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association 6th Ed)

### Art, Figures, Links

All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi. Each table, figure, photo, or art should be on a separate page, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003) Live links are encouraged. Please include the full URL for each.

### Editing and Permissions

The author must accompany the submission with written release from:
- Any recognizable identified facility for the use of name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.

All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript. Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Manuscripts not published will be returned to the author. Queries may be addressed to the care of the Editor at: smfc@surewest.net

### Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and the nursing profession. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

---

Journal of Nurse Life Care Planning is the official peer-reviewed publication of the American Association of Nurse Life Care Planners. Articles, statements, and opinions contained herein are those of the author(s) and are not necessarily the official policy of the AANLCP® or the editors, unless expressly stated as such. The Association reserves the right to accept, reject, or alter manuscripts or advertising material submitted for publication. The Journal of Nurse Life Care Planning is published quarterly in spring, summer, fall and winter. Members of AANLCP® receive the Journal subscription electronically as a membership benefit. Back issues are available in electronic (PDF) format on the association website. Journal contents are also indexed at the Cumulative Index of Nursing and Allied Health Literature (CINAHL) at ebscohost.com. Please forward all email address changes to AANLCP® marked “Journal-Notice of Address Update.” Contents and format copyright by the American Association of Nurse Life Care Planners. All rights reserved. For permission to reprint articles, graphics, or charts from this journal, please request to AANLCP® headed “Journal-Reprint Permissions” citing the volume number, article title, author and intended reprinting purpose. Neither the Journal nor the Association guarantees, warrants, or endorses any product or service advertised in this publication nor do they guarantee any claims made by any product or service representative. In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work.
A CORE CURRICULUM
for
NURSE LIFE CARE PLANNING

American Association of Nurse Life Care Planners

Dorajane Apuna-Grummer
Wendie A. Howland
Editors
Dear Colleagues and Friends,

I am humbled, honored, and privileged to assume the role of President of the American Association of Nurse Life Care Planners (AANLCP) for 2018-2019. I am deeply grateful to my predecessor, Denise Wrenn, for her leadership and outstanding contributions to AANLCP during her presidency. To the members of the 2017-2018 Executive Board, I extend my sincerest thanks and am truly inspired by their commitment to and achievements for AANLCP. Our growth has been propelled collectively by these individuals, and all the past presidents and previous members of the AANLCP Executive Board. I look forward to continuing this important work toward fulfilling our mission.

2018 Membership Enhancements

AANLCP’s membership enrollment began February 1, 2018. In a continuous effort to provide our members with relevant resources, the Executive Board reviewed the results of the 2017 membership survey. Your voice has been heard, and a few resource changes have been made.

First, we have retired EBSCO access as a member benefit. As an added enhancement, we have upgraded Find-A-Code to complete facility licenses (including DRG Grouper/Payment Calculator for Inpatient Facility codes/fees, APC Packager/Price for Outpatient Facility codes/fees, ASC Payment Calculator for Surgical Facility codes/fees, plus all Professional coding/fees already included). See www.findacode.com/pricing for full details.

Industry standards place the value of these tools in the $3,000 to $7,000 per user per year range; normal retail pricing is $1,296/yr. Another enhancement made available to members is an a la carte option for Find-A-Code, ODG, and PMIC. Purchase the resources that are most important to you and your practice while omitting the resources that are not. It’s a win-win!

These resource enhancements affect membership levels as follows:

Premier members have access to the following resources:
- Crash Cart
- Find-A-Code
- Find A Nurse directory
- ODG
- PMIC eBook
- Free front row seat to all webinars hosted by AANLCP

Deluxe members have access to the following resources:
- Crash Cart
- Find A Nurse directory
- ODG

There is no change to Basic membership resources. To see the value of these membership benefits, be sure to tune in to our resource-centered webinar series Know Your Resources that are on this page: Go to Resource->Education->Member Resource Webinars

The Art of Life Care Planning 2018 Conference!

Join us March 16-19 in St. Petersburg, FL for an artful conference that is sure to help you cultivate your skills as a life care planner. More than that, it is a wonderful time to network, connect with dear colleagues, and develop new lasting friendships.

This year’s conference focus on the art of the life care planner will incorporate unique topics such as evidence-based practice, pediatric life care planning, therapies to consider in the development of life care planning, and published countless peer-reviewed journals consisting of noteworthy articles by authors from around the country. Through this work, AANLCP has helped to define what it means to be a life care planner. Building on this strong foundation, we will continue the work to effectively meet our mission.

20th Anniversary!

AANLCP just celebrated 20 years as an organization (1997-2017) and has achieved so much along the way. As an organization, AANLCP has created strong outreach and education programs, hosted national conferences that bring together the best minds in life care planning, and published countless peer-reviewed journals consisting of noteworthy articles by authors from around the country. Through this work, AANLCP has helped to define what it means to be a life care planner. Building on this strong foundation, we will continue the work to effectively meet our mission.
Networking, and identifying those resources that will grow your business and ensure your success, can be found among colleagues, speakers and vendors attending the conference.

Don’t miss out! We are excited to see you there!

The Power of Being a Volunteer

“Volunteers don’t get paid, not because they’re worthless, but because they’re priceless.” – Sherry Anderson

We life care planners, as members of the human race, volunteer for many reasons, from aiding in disaster relief, to improving health care, to advancing education standards. The list of ways we use our expertise to improve the lives of others is long. Within AANLCP, there are wonderful and meaningful opportunities to volunteer and strengthen us as an organization.

Life care planning is a process of creating a future plan for an individual with a catastrophic injury or chronic disability. However, nurse life care planning brings a vital approach to this practice through the incorporation of the nursing process, as well as our established and internationally-recognized nursing diagnosis. As an organization, AANLCP has added this to the published Scope and Standards of Practice for Nurse Life Care Planning.

Become an AANLCP volunteer, and help us make a powerful impact in the world of life care planning!

Core Curriculum for Nurse Life Care Planning

Nurse life care planning is a fast-growing entity within the life care planning industry. In 2013, AANLCP released a core curriculum text, for which the 2nd edition is currently under development. Working with the registered Certified Nurse Life Care Planner (CNLCP®) Certification Board, this upcoming edition will be a powerful resource not only for developing strong life care plans, but also as a study guide in preparation for the CNLCP® exam. The Core Curriculum for Nurse Life Care Planning offers something for everyone, new and seasoned. The release of this much-anticipated curriculum will occur at the 2019 AANLCP conference.

I am deeply thankful for each and every one of you. Here is to an exciting 2018!

Most Sincerely,

Lori Dickson, MSN, RN, MSCC, CLCP, CNLCP®
Contributors

TRACY ALBEE, RN, LNCC, CLCP, FIALCP
Tracy Albee is a Registered Nurse practicing in Tracy, CA. She is a past Chair of the International Academy of Life Care Planners. Ms. Albee is a Legal Nurse Consultant Certified, Certified Life Care Planner and holds Fellow Status with the IALCP. She served as a volunteer at the 2017 life care planning summit.

REBECCA MENDOZA SALTIEL BUSCH, RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA
Rebecca Busch is President of Medical Business Associates, Inc., a minority, woman-owned Medical Data Auditing and Healthcare Consulting firm. Ms. Busch developed and implemented a unique analytical workflow process that identifies critical tasks, conditions and standards to promote a stable, dynamic and scalable healthcare business.

JAMIE N. GAMEZ, MA
Jamie N. Gamez is a bilingual Certified Rehabilitation Counselor, Certified Case Manager, and Certified Disability Management Specialist. She provides vocational assessments, case management, and life care planning services at OSCVocational Systems, Inc. in Bothell, Washington. Ms. Gamez has been in practice since 2010 and served on the 2015 and 2017 Life Care Planning Summit Committee.

Ms. Busch has authored five books. Her latest, Patient’s Healthcare Portfolio: A Practitioner’s Guide to Providing Tools for Patients, was published April, 2017. Recognized as an expert in her field, Ms. Busch developed data management practice standards for emerging Chief Data Officers and auditors that ultimately support and defend complex issues impacting the bottom line.
to this issue

SHAY HARLAN JACOBSON, RN, MA, NMG, LNCC, CNLCP®

Shay Jacobson is a registered nurse with bachelor’s and master’s degrees from the University of Iowa and is a Certified Nurse Life Care Planner. She holds the designation of Master Guardian through the Center on Guardianship Certification, a designation held by less than 70 individuals nationally. She has served in the capacity of staff nurse, clinical nurse specialist, nurse manager, home care administrator, and nursing home administrator. She is the founder and president of Lifecare Innovations, a care management company, for over twenty years. Ms. Jacobson is a member of the American Association of Nurse Life Care Planners and National Guardianship Association, where she served on the National Board for two years. Ms. Jacobson has extensive experience in working with attorneys, fiduciaries, and the court systems in multiple Illinois County Courts, as well as in the court systems of various other state jurisdictions. She has served as an expert witness in matters involving life care plans, cost of care, and development of appropriate care plans.

ANNE MARGARET GEORGE, LCSW, CCM, MSCC, CMRS

Anne George is a licensed clinical social worker who has served primarily in case management roles. As a Lifecare Manager at Lifecare Innovations, she oversees a case of diverse clients and creates and implements individualized plans of care. As a Licensed Clinical Social Worker and Certified Case Manager, Anne is skilled and experienced in provision of advocacy and direct services for individuals with disabilities of all ages. She has applied these skills and others to contribute to the Life Care Planning program by performing records analyses, cost research, medical bill reviews, and other processes in the development of Life Care Plans and cost projections. Anne is also a Medicare Set-aside Certified Consultant and a Certified Medical Reimbursement Specialist and has demonstrated knowledge of the development and application of Medicare set-aside trust agreements as well as navigating claims, medical coding concerns, and other related responsibilities. She is an active member of the National Association of Social Workers, the Case Management Society of America, and the American Medical Billing Association.

CLOIE B. JOHNSON, MEd

Cloie B. Johnson, is a Rehabilitation Counselor and Case Manager at OSC Vocational Systems, Inc. Ms. Johnson has been in practice since 1987 when she began serving in the US Army. She is a past Chair of the International Academy of Life Care Planners, the Life Care Planning Section of IARP. Ms. Johnson has authored, presented and mentored many in Rehabilitation Counseling and Case Management, including Life Care Planning. Her multiple chairing events of Life Care Planning Summits since 2006 in the US and Canada along with other volunteer activities led to her receiving the 2016 Lifetime Achievement Award as presented at the International Symposium of Life Care Planning, by the FLCPR, ICHCC, IARP, IALCP, and The Care Planner Network.
Aging and Costing and Coding Resource List

Compiled by:
Kelly K. Campbell, RN, BSN, CP, CLNC, CLCP

1. ADEAR Center- is a current, comprehensive, unbiased source of information about Alzheimer’s Disease. The ADEAR Center is operated as a service of the National Institute on Aging.  
   https://www.nia.nih.gov/health/alzheimers

2. American Bar Association Commission on Law and Aging – Provides contact information by state  
   www.abanet.org/aging/


4. GovBenefits.gov -This site is the official government benefits website. It is a free, confidential tool that helps individuals find government benefits they may be eligible to receive. https://www.benefits.gov/


7. Long-Term Care Ombudsman Resource Center www.ltcombudsman.org

8. National Center on Elder Abuse – Lists phone numbers to report suspected abuse cases by state  
   https://ncea.acl.gov/resources/state.html

9. Nursing Home Compare -The primary purpose of this tool is to provide detailed information about the past performance of every Medicare and Medicaid certified nursing home in the country.  
   https://www.medicare.gov/nursinghomecompare/search.html?

10. Pension Rights Center- The U.S. Administration on Aging’s Pension Counseling and Information Program currently serves 30 states. Free legal assistance is available to individuals experiencing a problem with their pension, profit sharing or retirement savings plans. http://www.pensionrights.org/find-help

KELLY K. CAMPBELL, RN, BSN, CP, CLNC, CLCP

Kelly K. Campbell earned her Bachelor of Science degree in Nursing from Penn State University in 1996 and a certificate of Perfusion from Texas Heart Institute in 1998. In 2013 she earned her Legal Nurse Consultant certification and in 2014 she completed her Life Care Plan education from Capital University Law School. She recently served as the Journal Committee Co-Chair for the Journal of Nurse Life Care Planning, and is an author for the upcoming AALNC Principles and Practice 4th Edition. Her specialty interests include Medical Device, Brain Injury, Amputation, Chronic Pain and Cardiac.
Show Them The Evidence

Evidenced-based practice begins with research.
If you write life care plans you already do research.
No fear! Lighten the load! Strengthen the practice!

Come join us as we find the evidence to support our practice!

Are you...

... curious about how and why the nursing process supports our specialty practice of Nurse Life Care Planning? Are you in a formal education/practice program and need ideas for a research project and paper? Let’s talk!

Your Research Committee is currently studying how and why Nurse Life Care Planners put case management services into life care plans. We need help doing literature reviews and identifying tools to determine variables in using case management services.

... already working on research in a formal advanced education/practice program? Did you know that AANLCP would love to know about your research project?! Tell us about it!

~ Colleen Manzetti, DNP, RN, CNLCP, CNE
Chair, AANLCP Research Committee

Together we can learn the scoop 
share knowledge 
build a body of evidence 
by life care planners 
for nurse life care planners

Participate:
email cmanzetti@aol.com
Phone 732-261-1761
What is the Best Format for Report Writing?

Report writing is one of the steps in managing the case referral. There are a number of forms that are needed in the business of life care planning and it is the report format that is one of the most important. Others include: intake form, invoice, contracts, request for medical information, letter of referral acceptance, retainer letter, records needed for review letter, etc, etc.

The time to actually start the file work by review of the medical documents is when the retainer has been paid. Very often the actual records are forwarded by someone in the attorney’s office and that person becomes your more frequent contact and is a better contact to resolve any delayed payment issues. Some people create a chronology of the records and use that document to create the medical history of the client. I personally don’t do that when services have been retained by the defense as I know a medical history will be done by the life care planner retained by the plaintiff attorney. Having said that often the best history on the impact of the medical issue is obtained during the client interview…but we are getting ahead of the issue here.

Once the records are reviewed, the life care planner will need to decide if any critical records are missing and request those records. Each life care plan will need to state the reason for the referral in an opening paragraph as well as provide the demographic information about the client. While reviewing the medical records it is important to capture all the diagnoses and not just the major one that resulted in the need for a life care plan.

The intake interview is consistent and not dependent on the attorney or the side that retained your services. It will be helpful to create a companion intake format that outlines an area for current medications with dosage, purpose and frequency, activities of daily living, cognitive function, “a day in the life”, durable medical equipment, the make and model number for equipment, any care provider, and what care is completed with what frequency. Weight and height are important as well as any unrelated treatment needs.

At the beginning of the interview narrative document, note that you stated the purpose of the interview and that you have advised the client that you have not established a long term relationship but rather the interview is a onetime assessment. This introduction will be dependent on your other national certifications so be sure to review your code of conduct before deciding what information you need to state at the start of the interview.
Another topic area is life expectancy. Use the most recent CDC life tables to establish a baseline life expectancy. It is helpful to state in this area that no adjustment has been made in the life expectancy and that the reader will need to seek adjustment by an economist.

In the conclusion–after the introduction, list of records reviewed, narrative of the interview, life expectancy and conclusion– you will want to state your impressions. This should include the plan of care based on nursing diagnosis, the details you have collected in the interview and the review of the medical record, and any personal communication with a current provider.

Before turning our attention to the schedules let me make a couple of comments on the narrative portion. Avoid superlatives and you will avoid language that will trigger questions during the deposition. For example, stating that a person is “severely” disabled is not a nursing diagnosis, it is a personal opinion. Stating that the client was “massively injured” in a motor vehicle accident is not specific to convey the depth of the injuries. Avoid stating that the client “suffered” an XYZ as a result of this event. You are inferring what the client experienced not the exact nature of the loss. Instead, itemize the injuries and how they impact independence instead of using none specific superlatives.

It is also helpful to avoid language that infers your personal perceptions. For example, persons using a wheelchair for mobility are not “wheelchair bound”. The wheelchair is an asset not a liability for that individual. It is a slippery slope when the word choices you make in the narrative reflect your opinions. Early on in your work as a life care planner these errors will make you squirm in the chair during testimony….save yourself that experience.

The schedules need to be competed with an eye toward completeness and these are best organized by category rather than a long list of services/equipment/care needs etc. On the top of each of the schedule there are categories for each item that will be listed on that schedule. For example, the item, the start date, the duration, the cost per unit, the number of years and if it is an annual or a onetime expense. If the item costs $100.00 and will be renewed every 5 years, the annual cost will be $20.00 for the life expectancy of the client. There are many examples of great formats out in the public domain and once you find the best one for your style you will feel confident in your report development and be able to defend it with skill and ease.

DISCLAIMER: The content of this column in intended as a brief introduction to general business concepts and has no legal or accounting expertise implied or suggested. The members of the journal committee and the invited contributors recommend the readers seek their own legal counsel and financial advisor for guidance on their business requirements.

Please keep the questions coming to: DearCaroleColumn@gmail.com

Carole Uzman, RN, MA, CCM, CRC, CDMS/R, CNLCP®

Carole is a registered nurse and master prepared rehabilitation counselor. She founded and managed Chesapeake Disability Management, an outcome driven medical and vocational rehabilitation company in 1991 at her dining room table. That organization eventually grew to a staff of 20 in multiple states on the East coast. In the past she served as a board member and chaired the Commission for Certification of Case Managers (CCMC). She currently serves on the Book of Knowledge editorial board for CCMC and held a board member position on a charter school in Baltimore City, Maryland in the past. She loves the ocean, her husband and life.
Coming!
Summer 2018

Core Curriculum for Nurse Life Care Planning
2nd edition

To contribute, contact
AANLCP
801-274-1184
2017 Life Care Planning Summit Proceedings

Tracy Albee, RN
Jamie N. Gamez, MA
Cloie B. Johnson, MEd

Life care planning is an advanced specialty practice performed by a diverse community of professionals in various health care fields. Due to the diversity of professional backgrounds in life care planning and because this specialized practice continues to grow and develop, it is vital that a coordinated effort with standardized approaches be promoted. Education of emerging and experienced practicing professionals is a key aspect of fostering the advancement of the field. While process and standards of practice for life care planning have been established and published, consensus and unity in this diverse field is an evolving process. Through life care planning Summits, life care planners have the opportunity to examine relevant issues, contribute to the resolution of these issues, and be involved in the evolution of the specialty practice. (Johnson, 2012; Johnson and Gamez, 2015; Johnson and Gamez, 2017).

Life care planning Summits are historically biennial events attended by life care planning practitioners with the goal of exploring the current state and future direction of life care planning. Since 2000, over 600 life care planners have participated in Summits, demonstrating a commitment to addressing cutting-edge issues affecting the life care planning community.

Published Summit results are generally accepted and relied upon by life care planning practitioners. The Best Practices and Consensus and Majority Statements derived from past Summits (Johnson 2015; Preston and Johnson, 2012) serve as reinforcement for the work of the life care planner. Summits are unique, in that their proceedings are developed by practicing life care planners, for life care planners and about life care planning. At the 2017 Summit, consensus was achieved in several key areas.

2017 Life Care Planning Summit

On May 19-20, 2017, the tenth life care planning Summit was held in Denver, Colorado. The summit was attended by 102 life care planners from diverse backgrounds and geographic locations. Past Summit locations and dates include:

- Dallas, TX – April 12, 2000
- Chicago, IL – May 18-19, 2002
- Atlanta, GA – April 24-25, 2004
- Chicago, IL – May 6-7, 2006
- Los Angeles, CA – May 15-16, 2008
- Atlanta, GA – April 17-18, 2010
- Toronto, ON – June 3-4, 2011
- Dallas, TX – May 5-6, 2012
- Scottsdale, AZ – September 18, 2015

This article includes 2017 Summit proceedings, including submissions by organizational representatives and panelists from IALCP, AANLCP, ICHCC and FLCPR. The content was reviewed by the Summit committee and presented to attendees for their review to ensure that the contents accurately reflect the events of the 2017 Summit proceedings.

The 2017 Summit was sponsored by the International Association of Rehabilitation Professionals (IARP) and the Life Care Planning Section/International Academy of Life Care Planners (IALCP) with support and representation from the International Commission on Health Care Certification (ICHCC), the American Association of Nurse Life Care Planners (AANLCP) and the Foundation for Life Care Planning Research (FLCPR). The IALCP took the leadership role in chairing the Summit, with collaboration and support from various associations and organizations within the life care planning community. The 2017 summit was chaired by Cloie B. Johnson and Susan Grisham. The planning committee included Tracy Albee, Debbie Berens, Jamie Gamez, Sherry Latham, Karen Preston, Patricia Rapson, Evelyn Roberts and Denise Wrenn. There were also numerous volunteers who contributed to the success of the Summit. Practicing life care planning professionals in attendance included nurses, rehabilitation counselors, physicians, social workers, physical therapists, occupational therapists and speech language therapists.

Pre-Summit Workshop: May 12, 2017

Prior to the Summit, twelve facilitators and recorders of the nominal group process were identified by the program chairpersons to assist in the coordination of Summit activities. Facilitators were Tracy Albee, Reg Gibbs, Karen Preston and Steve Yuhas and recorders were Debbie Berens, Brook Fecerrick, Carol Hyland, Jody Masterson, Linda Olzack, Dana Penilton, Patricia Rapson and Laura Woodard. These individuals were qualified practicing life care planning professionals. On May 12, 2017, a Pre-Summit workshop was held via video conference call with the facilitators and recorders to allow them the opportunity to participate in Summit sessions. During this Pre-Summit, Cloie Johnson served as facilitator and John Cary and Laura Stajduhar served as recorders. Participant responses collected during the workshop were incorporated into the second day of Summit proceedings. During this workshop, these individuals also received training on their Summit duties from Cloie Johnson.

Reprinted from Journal of Life Care Planning, Volume 15, Number 3; Albee, Gamez, & Johnson; 2017 Life Care Planning Summit Proceedings; pages 19-29, Copyright (2017), with permission from Elliott & Fitzpatrick and the International Association of Rehabilitation Professionals
Summit Day One Proceedings: Friday May 19, 2017

On the first day of the Summit, all event attendees were assembled in a general session for presentations and panels explaining the purpose of the 2017 Summit. The goal of the 2017 summit, to further define “associated costs”, was presented. Topics included how costs are derived and methods to determine and utilize collateral sources. A presentation covering a review of past Summits and a specific look at where “associated costs” were already referenced within the current Consensus and Majority Statements (Johnson, 2015; Preston & Johnson, 2012) and the Standards of Practice for Life Care Planners (IARP, 2015) was conducted.

Practicing life care planning professionals in attendance actively participated in this review, which set the stage for the remainder of the Summit. During the general session on May 19th, the focus was on providing a foundation of knowledge for the nominal group process, which would unfold during the second day of the Summit in the breakout sessions and the large group discussion.

Life Care Plan Venues

A closer look into venues where life care plans are utilized was undertaken. As a group, attendees generated 29 venues or applications in which a life care plan may be developed by a qualified professional. These are outlined in Table 1 below.

<table>
<thead>
<tr>
<th>Life Care Planning Venues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil litigation to include personal injury, general liability and medical malpractice</td>
</tr>
<tr>
<td>Trust funds</td>
</tr>
<tr>
<td>Wealth management</td>
</tr>
<tr>
<td>Setting reserves</td>
</tr>
<tr>
<td>Vaccine cases</td>
</tr>
<tr>
<td>Worker’s compensation cases</td>
</tr>
<tr>
<td>Structured settlements</td>
</tr>
<tr>
<td>Private hire</td>
</tr>
<tr>
<td>Medicare Set-Asides (MSA)</td>
</tr>
<tr>
<td>Marital dissolution proceedings</td>
</tr>
<tr>
<td>Discharge planning</td>
</tr>
<tr>
<td>Business dissolution</td>
</tr>
<tr>
<td>Specialized injury compensation funds</td>
</tr>
<tr>
<td>Veteran’s disability</td>
</tr>
<tr>
<td>Veteran’s independent living assessments</td>
</tr>
<tr>
<td>Estate planning</td>
</tr>
<tr>
<td>Pre-litigation settlement</td>
</tr>
<tr>
<td>Deceased/replacement costs</td>
</tr>
<tr>
<td>Conservatorships/guardianships</td>
</tr>
<tr>
<td>Victim’s assistance programs</td>
</tr>
<tr>
<td>American Civil Liberty Union (ACLU) matters</td>
</tr>
<tr>
<td>Pre-nuptial agreements</td>
</tr>
<tr>
<td>Fundraising support</td>
</tr>
<tr>
<td>Case management</td>
</tr>
</tbody>
</table>

Collateral Sources

Day one also provided a review of results from the 2017 Collateral Source Survey (Pomeranz, N.d.) which was sent to all known life care planners in March 2017, prior to the 2017 Summit. A total of 187 life care planners from 26 states responded to the survey. A total of 47% of the respondents reported being asked to include collateral sources in life care plans, while 53% had not. Of the respondents, 59% reported never having included collateral sources in the development of a life care plan, 39% sometimes include collateral sources and 2% reported always including collateral sources in life care plans. When asked who instructs them to include collateral sources in the development of a life care plan, respondents answered: The referral source (57%), federal rulings (4%), state rulings (6%) or done at my discretion (34%). When asked what specific collateral sources they had included in the development of life care plans, the following were reported: Medicaid (35%), Medicare (41%), Tricare (16%), VA Benefits (22%), Medicaid Waivers (13%), Federal/State mandated Vocational Rehabilitation Services (20%), Federal/State mandated Blind Services (14%), Federal/State mandated Deaf Services (8%), ACA or other private health insurance (35%) and Other (47%). Respondents included collateral sources in the following types of cases: Litigated Plaintiff Cases (38%), Litigated Defense Cases (59%), Trusts (17%), Vaccine Cases (16%), Dissolution Cases (8%), Direct Hire from Family (18%) and Other (25%).

The following survey question was posed: When including collateral sources in the development of life care plans, do you verify and document the limitations? (Examples: Waiting lists for Medicaid Waivers or if Medicaid is a payer source, one can only go to physicians who accept Medicaid). The following answers were given: Always (49%), Sometimes (21%) and Never (29%).

Professional Organization Input

A working lunch was held during the first day of the Summit proceedings. During this lunch, updates were provided by organizations which offer support, certification, education and/or guidance to life care planners. Presentations were made by representatives of the ICHCC, IARP, IALCP, FLCPR and AANLCP. The American Academy of Physician
Life Care Planners (AAPLCP) was invited, however, declined attendance. Below is a summary of remarks made by representatives of each involved organization.

**International Commission on Health Care Certification.**

Ms. Sherry Latham provided an update for the International Commission on Health Care Certification. The International Commission on Health Care Certification assumed the responsibility to provide the first specialty certification for life care planners, the Certified Life Care Planner (CLCP) credential, in 1996. The CLCP was developed out of a growing need for professionals to demonstrate competency, qualifications, and professional expertise in the role as a life care planner.

Ms. Latham stressed that all representatives of the ICHCC are available to assist life care planners with questions about the certification itself, approved educational programs as preparation for the Certified Life Care Planner (CLCP) certification, the standards of the CLCP, ethical dilemmas, approved continuing educational programs or any other matters associated with the field of life care planning.

The ICHCC has been actively pursuing accreditation for the CLCP through the National Commission for Certifying Agencies (NCCA), and continues to strive to fulfill the stringent requirements. An important factor in obtaining accreditation is the need for statistical information demonstrating a comprehensive analysis of the certification practices providing valid and reliable information. The ICHCC currently has surveys available to life care planners to address those needs. There are two surveys, the role and function study and a report writing survey, which can be located on their website, www.ichcc.org. It is vital that the Commission collect as much information for the best representation of statistical information. Four CLCP CEU’s can be obtained for completing each survey. Another component of accreditation is the statistical information involving a Beta test, which will be posted soon on the ICHCC website. A post will be sent out on the list-serves when available and the ICHCC encourages everyone to participate in this vital component of the accreditation process.

**Foundation for Life Care Planning Research.**

Dr. Debbie Berens provided an update for the Foundation for Life Care Planning Research. First, appreciation was extended for allowing the Foundation for Life Care Planning Research to provide an update on the organization. Dr. Paul Deutsch, who typically provides the update, was instrumental in forming the FLCPR in 2002 and continues to champion its mission. Unfortunately, Dr. Deutsch has had some medical issues that have resulted in his retirement from his practice and his primary Foundation leadership responsibilities. Dr. Deutsch sounds well and he wants everyone to know that even though he has retired from his active life care planning practice, he continues to follow what is going on in life care planning and remains very interested in the progress, leadership, and future direction of our specialty practice. Susan Riddick-Grisham who led the Foundation for many years as Chair of the Board, rolled off the Board over the summer and appreciation of her tremendous work for the Foundation was expressed. In 2016, Dr. Debbie Berens was named co-President with Dr. Deutsch and since his retirement, she has served as President of the Foundation.

The Foundation is a nonprofit research group with the primary mission of supporting research on the process of life care planning, including research on the reliability and validity of the life care planning process. Several years ago, the Foundation made the decision to shift away from sponsoring or co-sponsoring educational conferences (mainly the International Symposium on Life Care Planning/ISLCP) to focus on the Foundation’s primary mission of supporting research related to life care planning. Over the past 15 years of funding research, the Board has broadened the scope of its mission to consider any well-developed research design in life care planning that advances the field and/or makes a significant contribution to the population of individuals with disabilities who life care planners seek to serve.

The Foundation reported that it is currently funding a research project designed to replicate and expand a study published in 2006 regarding replacement values of durable medical equipment (DME). Results of the current study are expected to enhance and advance the field in the area of recommended replacement schedules, frequency and maintenance costs of some of the most commonly recommended DME included in life care plans. While other studies relevant to life care planning also are currently being conducted, all are invited to consider submitting a proposal to the FLCPR for a research grant. One suggested project is to update the Bibliography of Life Care Planning and Related Publications, originally published in the inaugural issue of the *Journal of Life Care Planning* in 2002. The bibliography has not been updated since that time and it is believed there are life care planning and related publications over the past 15 years that could be added to it. For anyone interested in conducting research and how the FLCPR may be able to help, please go to the Foundation’s website, www.flcpr.org.

**International Association of Rehabilitation Professionals.**

Mr. Steven A. Yuhas, IARP President-Elect, provided an update on IARP activities. Appreciation was given of everyone’s attendance at the IARP 2017 Summit and of the 2017 Summit conference committee, Cloie Johnson, Susan Riddick Grisham, and Tracy Albee. Appreciation was noted of IARP/ IALCP Section leadership, its members and ongoing contributions with recognition given the past and present IALCP Board members in attendance.
An overview of IARP was provided noting they were comprehensively striving to serve life care planners and the rehabilitation community. Kim Bailey was announced as IARP’s new Executive Director. The ISLCP/ IARP Conference will be held in St. Louis in October 2017. Noted appreciation was also given to Susan Riddick Grisham for her more than 20 years contribution with ISLCP. The ISLCP 2017 RFP’s received to date were also shared with Summit attendees.

International Academy of Life Care Planners (IALCP).
Debbie Marcinko, IALCP Immediate Past Chair provided an updated of IALCP. The IALCP (formerly the American Academy of Life Care Planners) became a section of the International Association of Rehabilitation Professionals (IARP) in 2006. The association with IARP has afforded greater networking and sharing of resources of the various professional disciplines and experts in rehabilitation. They have chaired and co-sponsored the Life Care Planning Summits since 2000, and the annual Symposium of Life Care Planning (since 1994) including the Symposium of Life Care Planning conference combined with the IARP annual conference in 2016. Their first Standards of Practice were published in 2000 and are now in the 3rd Edition (IARP, 2015). The Journal of Life Care Planning was introduced in April 2002. As a member of the IALCP Life Care Planning IARP Section, members receive a subscription to the Journal of Life Care Planning and the Rehabilitation Professional, access to live and pre-recorded webinars, the annual conference, access to networking and discussion groups of all IARP sections, and access to affinity programs such as FairHealth, American Hospital Agreement, AAACEUs, and liability insurance coverage.

The Fellow designation (FIALCP) was established in 1996 (through the IALCP) and continues under IARP. The purpose of the fellow program is to recognize expertise, experience and contribution to the field of life care planning. The program recognizes those life care planners who have achieved a high level of skill and who use their skills and knowledge to promote the advancement of life care planning. IALCP promotes relationships with other organizations for education, coalition, and collaboration in the promotion of life care planning.

American Association of Nurse Life Care Planners (AANLCP).
Denise Wrenn provided an update of activities in AANLCP. On January 2, 2017, Denise Wrenn assumed the role of president of AANLCP®. In 2017, the AANLCP® executive board held their annual strategic planning meeting in Reno, Nevada. The association selected Annie Wiest, KAMO Management Company as Executive Director and Mariann F. Cosby, accepted the position as the new journal editor. During the 2017 conference, Colleen Manzetti Research Committee Chair presented the findings from a research project completed in 2016.

The Association continues to offer tier memberships, which allow not only registered nurses interested in nurse life care planning, but an associate membership to individuals in other health care professions. The association is on schedule to complete an update to A Core Curriculum for Nurse Life Care Planning, an essential knowledge resource for the practice. The 2018 release date has yet to be determined.

The association mission in 2017 continues to focus on supporting the nursing community’s efforts to achieve excellence in the practice of nurse life care planning. During the planning sessions, the board identified five drivers of organizational performance with goals designed as a strategic alignment to move the association closer to the vision, mission, and values of the association over the next three to five years. The five strategic domains are: Membership, finance, education, research and practice management and these domains are to become the pillars of the association in 2017 and beyond. The domains support the organization’s mission and the focus on action and define the specific strategies to attain crucial goals.

In March 2017, the annual education conference was held in Scottsdale, Arizona. The association hosted keynote speaker JR Martinez, ‘Dancing with the Stars’ 2011 Season 12 winner, and a world-renowned motivational speaker, actor, best-selling author and U.S. Army veteran. The conference committee put together a rock-star line-up of speakers who motivated, informed, and inspired all who attended. The 2018 education conference, The Art of Life Care Planning will be held in St. Petersburg, Florida on March 16-19. They are expecting to repeat the excitement experienced in Scottsdale.

Ethics Workshop.
On day one of the life care planning Summit, an Ethics Workshop was held. During the workshop, a review of the various credentials for those who prepare life care plans was shared. It is well-known that life care planning is a specialty practice, in which a variety of professionals, holding various licensures and certifications, participate. A review of the various credentials for those who prepare life care plans was shared with historical background for each. The credentials explored include American Board of Vocational Experts (ABVE), Certified Case Manager (CCM), Certified Disability Management Specialist (CDMS), Certified Life Care Planner (CLCP), Certified Nurse Life Care Planner (CNLCP), Certified Physician Life Care Planner (CPLCP) and Certified Rehabilitation Counselor (CRC). The analysis of each credential included identifying if there was independent accreditation, the year established, minimum education and experience requirements, code of ethics/standards of practice, requirement for examination and continuing education units (CEU) as well as non-profit status. This information is presented in Table 2 below and was originally published in Field, Choppa, Johnson,
Fountaine & Jayne (2007), which was updated in Johnson, Lacerte and Fountaine (2015) and most recently updated in 2017. It is illustrative of the historical nature, background and requirements of each credential.

### Table 2

<table>
<thead>
<tr>
<th>Credential</th>
<th>Independent Accreditation</th>
<th>Year Est.</th>
<th>Minimum Education Required</th>
<th>Minimum Experience Required</th>
<th>Code of Ethics/ Standards of Practice</th>
<th>Exam Required</th>
<th>CEUs Required</th>
<th>Non-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABVE</td>
<td>No</td>
<td>1980</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CCM</td>
<td>Yes</td>
<td>1993</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CDMS</td>
<td>Yes</td>
<td>1984</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CLCP</td>
<td>No</td>
<td>1996</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>CNLCP</td>
<td>No</td>
<td>1999</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CPLCP</td>
<td>No</td>
<td>2014</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CRC</td>
<td>Yes</td>
<td>1975</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The presentation included aspects of various credential codes of ethics, followed by small and large group discussion surrounding a variety of applicable ethical dilemmas. Participants were asked to contemplate and propose resolutions to various ethical dilemmas.

**Panel Presentation – Charges.**

After the working lunch, two panel presentations filled the remainder of Summit day one. The first panel was made up of four speakers: Lan Lieverse of Healthcare Financial Consultants; Dr. Robert Meier of Amputee Services of America; Cassandra Smith of Yavapai Professional Medical Billing and Coding; and Ray Agostinelli of FairHealth. The following questions were posed to panel participants:

- How do providers set their charges?
- Is there a commonly accepted definition of “usual and customary”? What other terms are used? What do these terms really mean? Do providers ever expect to get paid their full billed amount?
- Do providers have a single charge for each CPT code or do they have a variety of charges for a variety of circumstances? For example, self or private pay v. insurance v. lien rates
- What can you tell us about providers that do not accept any insurance or have a concierge practice?
- What is the best terminology to use when we call to get cost information?
- Is there an accepted concept that charges/contracts for cash

The presentation included aspects of various credential codes of ethics, followed by small and large group discussion surrounding a variety of applicable ethical dilemmas. Participants were asked to contemplate and propose resolutions to various ethical dilemmas.

**Panel Presentation – Charges.**

After the working lunch, two panel presentations filled the remainder of Summit day one. The first panel was made up of four speakers: Lan Lieverse of Healthcare Financial Consultants; Dr. Robert Meier of Amputee Services of America; Cassandra Smith of Yavapai Professional Medical Billing and Coding; and Ray Agostinelli of FairHealth. The following questions were posed to panel participants:

- How do providers set their charges?
- Is there a commonly accepted definition of “usual and customary”? What other terms are used? What do these terms really mean? Do providers ever expect to get paid their full billed amount?
- Do providers have a single charge for each CPT code or do they have a variety of charges for a variety of circumstances? For example, self or private pay v. insurance v. lien rates
- What can you tell us about providers that do not accept any insurance or have a concierge practice?
- What is the best terminology to use when we call to get cost information?
- Is there an accepted concept that charges/contracts for cash

The following is a summary of the panel presentation. The statements are the product of each panelist and not an endorsement by the attendees of the Summit, planning committee or any organization involved in the Summit. The summary statements below were developed from the presentations given and were reviewed by each individual panel participant.

**Lan Lieverse of Healthcare Financial Consultants**

Usual, Customary and Reasonable Fee (UCR) is the charge or range of charges evaluated against another provider for similar services in a geographical area. Usual, Customary and Reasonable Fees are not set for the healthcare industry, by Medicare, or any third-party payer, although payers may choose to define how much they will pay. Databases can show the range of charges for the same or similar services by the same or similar medical provider in a comparable geographic area. Usual, Customary and Reasonable Fee (UCR) calculations must include the geographical location. There is a difference between the amount charged and the amount that will be paid, with payments ranging from 0 to 140% of the gross charges. The amount providers are paid...
change every day, therefore, trying to estimate what will be paid is completely speculative.

Charges are determined by the provider identifying the cost to provide a service and dividing it by the number of those services they are expected to deliver. There are direct costs and indirect costs. This process is simply a budget. The goal of the insurance company is to set premiums high and buy services low. There are patients who would rather pay 100% of a medical bill than to run it through their insurance, which happens frequently in affluent areas of the country (e.g. famous people who do not want their insurance charged, as it opens them up to lack of confidentiality).

An explanation of capitation contracts was undertaken. A provider may get more than 100% of their billed charges if the insurance pays a flat amount monthly, regardless of the charges incurred. If the patient is not seen at all in the hospital in any given month, the provider is still paid the contracted amount.

Databases are absolutely needed to look at historical charges within a geographical area. These databases prove whether charges are falling within the UCR range. When doing a past cost analysis, Mr. Lievense typically uses two or three (or more) databases. Mr. Lievense does not change the databases but does ask the database vendors how each program handles charge outliers. He agrees that a provider can charge anything that they want and the provider can accept any payment that they want; however, there is legislation coming soon that may change that. A properly managed medical office/provider will have only one fee schedule and the amount of payment they accept may vary depending on business situations, contracts and social considerations (i.e. many medical offices write off copy amounts for clergy.) Payments from insurance companies include more than what is on a bill. For example, a provider may receive 80% of the bill on paper, but then receive a balloon payment at the end of the contract. This will not show up on a patient invoice or explanation of benefits. Providers with a concierge practice may charge a flat fee or they may have a charge structure. For example, the provider may charge an application fee, an enrollment fee, an annual charge for being a member of their practice, and a published fee schedule for the services provided. Concierge practices do not accept insurance or do third party billing. Concierge practices are not required to release their financial information, unless to a potential client who needs to know this before deciding to join the practice. There is a current trend for providers to move towards a concierge practice and these charges are not included in the standard databases. It is unknown how the industry will handle these new practice concepts.

Mr. Lievense recommends looking up “cost shifting” to find a remarkable amount of information on how providers make money. Cost shifting is a methodology used in all businesses, including healthcare. When Medicare or Medicaid decreases their payments, the provider generally needs to increase their charges. In order to stay in business, a provider must get 100% of their operating costs through billed charges. This does not happen by the entire patient population, but rather by the case-mix. If a provider only considers one payer source as a valuation of their medical services, then they are only considering a small portion of what their cost of service really is.

**Dr. Robert Meier of Amputee Services of America.**

Usual, Customary and Reasonable Fee (UCR) is most consistently defined by the “Medicare allowable” and represents the profit beyond the cost to provide the service. A physician group can charge whatever they please, but that does not mean that is what they will be paid. Payments are very much regionally based. Life care planners need to go to an authoritative source to get the charges for certain services. For example, if you have a patient with a spinal cord injury, should you go to a local provider or should you go to a place like Craig Hospital? Life care planners need to get their costs from the experts in any particular field. This is a reason not to use databases in some circumstances.

**Cassandra Smith of Yavapai Professional Medical Billing and Coding.**

Ms. Smith shared that she agrees with Mr. Lievense regarding the definition of UCR; however, in reality the UCR varies based upon zip codes, formularies of the insurance companies, and the payments based on any given contract. Every insurance plan pays a different amount with hundreds of factors involved in each contract. The UCR really means nothing and it is often just a way for insurance companies to get out of paying a bill. Providers know that when they accept a particular insurance contract, they will get what they get and it is a “take it or leave it” system. She noted prices are typically set around any given provider’s current contracts and the provider may also determine a non-insurance pricing model. Insurance, whether a provider takes it or not, typically guides the billing practices. Retail pricing is, more likely than not, a multiplication of the Medicare allowable fee schedule. For example, the industry standard is to set the charges at 300 to 400% of the Medicare fee schedule. Providers do not expect to be paid their retail price, but this is the base pricing. Providers are lucky if they receive 50% of their billed amount, with average payment being 20% to 50% of the charge, when the patient is out-of-network. However, they may receive 0 payments for out-of-network patients as well. If the patient is in-network, the provider may get 90% to 100% of the billed amount, as defined by the contract. A provider could bill for the same services for 20 patients, all with the same contract, and could receive 20 different reimbursements.

Physicians who work for corporations have no control over their charges, so if a life care planner is trying to obtain the charge for a service, they must get to the practice manager. Most physicians do not have any understanding of
how their own charges are determined. Often it is the biller who decides what to bill, not the providers themselves. There are different rates for different payers, such as self-pay, liens and insurance.

A provider must be careful how they disclose their different rates for different payers due to antitrust laws that may apply. If a provider is caught giving out different rates to different payers, they risk losing their insurance company contracts. Ms. Smith’s company advises providers to have one charged rate for everybody, but that it is okay to accept the insurance payment and then to bill the balance to the patient, if this is allowed by the contract. When asked about the concept of providers charging some patients more to make up for those payers who pay too little, this is not allowed. There are three types of payers: In-network, out-of-network, and private pay. A provider must take a balanced approach and look at what percentage of their patients are Medicare, Medicaid, insurance and private pay. That is the only way to offset losses.

Ray Agostinelli of FairHealth.

FairHealth was founded in 2009. They have 60+ contributors, including private payers, TPAs and self-insured employer plans. There are now 23 billion claims included in their data, reflecting over 150 million covered lives. It is geographically specific with over 500 geographical zip codes. FairHealth’s benchmark products array billed charges across a range of percentiles (50th to 95th) reflecting the distribution of market rates for healthcare services in specific geographic areas. Many payers use the benchmark products in developing fee schedules, including plans that reimburse out-of-network providers based on a percent of usual and customary rates. When asked about whether a life care planner should ask for charges or expected payments, he agreed with other panelists that the actual paid amount can vary greatly based on a variety of factors and opined that a database based on billed charges will provide less variability in those numbers. Providers who do not accept insurance must set their fee schedule, which they do by using a database or they may set their charges on a percentage of the Medicare fee schedule. If providers will not disclose their fees, this is a practice management issue.

Panel Presentation – Collateral Sources

The second panel of the day included Tony Choppa, Joan Schofield, Amy Sutton, Ray Agostinelli and lan Lievens. The theme of this panel was “Associated Costs and Collateral Sources – Understanding the various payer sources which impact life care plans combined with court rulings that also direct the inclusion or exclusion of payer sources or billed versus paid amounts in various jurisdictions.” A summary of the panel presentation is found below. The statements are the product of each panelist and not an endorsement by the attendees of the Summit, planning committee or any organization involved in the Summit.

Panelist 1: Tony Choppa.

Mr. Choppa provided a brief review of the presentation by himself, Dr. Timothy Field, and Cloie Johnson who authored The Collateral Source Rule and the ACA: Implications for Life Care Planning, originally presented at the 2015 International Symposium on Life Care Planning (ISLCP). There is an increasing friction among life care planners and attorneys about how to handle collateral sources. This is a state-by-state issue, but life care planning standards are not based on case law.

Mr. Choppa referred to the Matlock Chart, used in a prior presentation, which was based on 2013 data. The Matlock Chart has not been updated, despite the case law that has evolved, since its publication. There are three categories of statutes: Those that reduce the verdict solely on the collateral sources; those that eliminate collateral sources altogether; and those that require consideration of collateral sources. Case law is the driving force.

Prior Life Care Planning Consensus Statements (Johnson, 2015; Preston & Johnson, 2012) require the life care plan to be objective and consistent (#51); life-long and flexible (#52); transparent and reproducible (#82) and use non-discounted and market rates (#98). Standards and Consensus Statements must allow the flexibility for life care planner to meet the legal precedents of a specific jurisdiction. There is nothing that prohibits the providing of a variety of information, but how this is done while staying within standards and ethics is the challenge. Footnotes to the life care plan can be added to the life care plan for accuracy and ensuring compliance with standards of practice.

Motions-in-limine are usually about the methodology of how a life care planner arrives at the opinion they hold, not the opinion itself. The trier of fact, not life care planners, decides what the right cost is or who should pay.

Panelist 2: Joan Schofield.

Ms. Schofield uses Medicaid Waiver collateral sources within her practice when pricing support services are not generally available. In her area (New Mexico), up to 50% of the population qualifies for government benefits / healthcare. She uses the Waiver programs within her state and can find fee schedules on the government websites. The providers who accept government funding may provide care to a person who does not have government funding and ask for same amount in reimbursement that they would have collected from the government (i.e. they do not mark up the care for cash payers). This provides value of these services based upon the public agency fee schedule.
Panelist 3: Amy Sutton.

Ms. Sutton provides a choice of prices. Her goal is to assure that the individual will have funds to purchase the services, but if asked to consider a different scenario (such as what the Medicare or Medicaid reimbursement would be), she will do so. She takes case law into consideration. The definition of “non-discounted rates” does not imply that cash rates are “discounted”. Discounted rates are ones that have been negotiated for an entity and are not available to the general public.

Panelist 4: Ray Agostinelli.

Mr. Agostinelli expressed his opinion that it is important for life care planners to understand the rules and statutes of the states where they work. FairHealth’s data includes worker’s compensation fee schedules. Because FairHealth is used for dispute resolution (in New York), they often must defend their methodology. The level of their consistency makes their database defensible. FairHealth updates their benchmarks two to four times per year and they are released within one to two months of the data becoming available. FairHealth database was not developed for life care planners; however, the repository of the data is an asset to life care planners. FairHealth is a window into the market.

Panelist 5: Lane Lievense.

Mr. Lievense emphasizes that he is not attorney and no statement may be regarded as legal advice. The only valid test to predict the future costs of care is today’s charges. Collateral sources are speculative because: There is no guarantee that the plaintiff will be eligible for an insurance; that the insurance will cover the services; or that there will be medical providers in the plaintiff’s geographic area accepting a specific insurance. There are two pending litigated cases where the plaintiff received an award based on collateral sources and now that collateral source is not available and the plaintiff does not have enough money to purchase the care.

Discussion of Howell v. Hamilton (2011) and Corenbaum v. Lampkin (2013) was undertaken. In Howell, the California Supreme Court ruled that an individual was entitled only to the economic damages in the amount that they or their insurers paid/will pay for medical services, not the difference in what is billed and what is paid. The Howell case did not affect the reality of the healthcare financial industry because the underlying direct and indirect costs of healthcare services remained unchanged but resulted in an increase in attorneys encouraging plaintiffs to get their healthcare on a lien instead of using their insurance or applying for insurance(s) for which the plaintiff may be eligible. The healthcare industry cannot force a patient to use existing insurance if the patient wishes to pay in other ways including cash or lien arrangements.

This is part of what generated Corenbaum v. Lampkin (2013) where the court held that billed amounts were irrelevant and inadmissible if treatment was covered by insurance and that non-economic damages and expert testimony could use unadjusted bills when determining damages. These rulings resulted in defense attorneys arguing that a plaintiff has the responsibility to mitigate their own damages.

Summit Day Two Proceedings

The second day of the Summit began with a review of the group nominal process. Each participant was assigned to one of four groups comprised of life care planners with a mix of experience, training and knowledge. Each attendee rotated through all focus groups and participated in discussions of all topics. The modified nominal group technique was used within each group, gathering information in an organized format, aimed to reduce the influence of any overly verbal or assertive participants, on the outcome. The nominal group technique is described below.

First, group members write down their top three to five suggestions in order of priority and facilitators use flip charts to go around the group and write down suggestions, combining suggestions when possible. After the issues are recorded, the attendees are asked to “vote” on their top five of the suggestions listed. After the vote, the group facilitator assigns five points to the responses with the highest count, four points to the second highest, three points to the third choice, two points to the fourth choice and one point to the fifth choice. The facilitator adds up the score for each and the top scoring three to five recommendations represent the decisions for the group. When the large group reconvened, each small group contributed three to five recommendations for consideration by all participants. Theoretically, several overlapping recommendations should be made. The 2017 Summit, like previous Summits, utilized two recorders per facilitator, to allow one to record responses on the easel for all to review and one on a laptop computer to record the data in a formatted spreadsheet for verification and transport of data. Following the rotating group nominal process, results were collated and participants were reconvened into a general session where the results were discussed to determine consensus. On topics or recommendations where everyone agreed, consensus is achieved. If a majority agreed, the statement is considered “support by the majority” but not consensus. If fewer than one-half of attendees agreed, the decision reflects “minority viewpoint” or is removed from the list. Consensus is the goal. After lively discussion, the following results were obtained:

Consensus: A comprehensive and systematic review of the existing 102 statements from the life care planning Summits since 2000 through a multi-association process to determine if they are still appropriate and relevant is needed.

Consensus: Life care planners shall develop a position statement (white paper) regarding the presentation of charges and/or costs presented in the life care plan that provides guidance to life care planners for the variety of uses and jurisdictional requirements encountered by life care planners.
The paper:

a. Must take into consideration that “associated costs” are referenced in the definition of a life care plan and
b. Ensure the current geographically relevant monetary charges for a good and service are in the life care plan.

Consensus: There was a consensus to reaffirm prior Consensus and Majority Statements including #98, #86, #82 and #79, which were reaffirmed during the 2017 Summit proceedings. For reference, these items are outlined in Table 3 below.

Table 3

2017 Consensus Statements

#98, Best practices for identifying costs in Life Care Plans include:

• Verifiable data from appropriately referenced sources
• Costs identified are geographically specific when appropriate and available.
• Non-discounted/market rate prices.
• More than one cost estimate, when appropriate.

#86, Life Care Planners shall assess the reliability, validity and accuracy of data and methods.

#82 Life Care Planning products and processes shall be transparent and consistent.

#79 Life Care Planners shall follow generally accepted methodology

Consensus: In the future review of the statements, it will be necessary to look closely at #56 (applicability, relevance and the obligation of life care planner to know the integrity of our data versus only the sources of data) to consider the definition of “integrity”. It is noted that there was a consensus that the group did not want any statements specifically focused on the litigation aspect of the life care planning work.

Conclusion

In May 2017, the tenth biennial life care planning Summit was conducted as a cooperative effort with major life care planning organizations including the International Association of Rehabilitation Professionals, the American Association of Nurse Life Care Planners, the International Academy of Life Care Planners, the Foundation for Life Care Planning Research and the International Commission on Health Care Certification. This year’s topic focused primarily on the subject of pricing items contained in a life care plan. With over 100 Summit attendees from diverse healthcare backgrounds, a rich dialogue was held among seasoned life care planning professionals. As a result of the process, four consensus statements were issued. These statements, along with topics discussed during the 2017 Summit are designed to enhance the practice of all life care planners and serve as a guide for best practices in the field.

References

Howell vs. Hamilton Meats & Provisions, Inc. 52 Cal App. 4th 541 (California Supreme Court, 2011).

Attendees of the 2017 life care planning Summit:

Tracy Albee
Michele Albers
David Altman
Dorajane Apuna-Grummer
Jennifer Axelton
Dan Bagwell
Danny Beeman
Rebecca Bellerive
Debbie Berens
Harold Bialsy
Stephanie Birely
Nancy Bond
Jack Bopp
Kathy Bottroff
Kathlene Bracken
Susan Brooks
Diana Bubanja
Margot Burns
John Cary
Robynanne Cash-Howard
Tony Choppa
Dawn Cook
Alisa Cornetto
Aubrey Corwin
Mariann Cosby
Valerie Cummings
Shirley Daugherty
Elizabeth Davis
Ted Deshotels
Heidi Fawber
Brook Feerick
Ellen Fernandez
Carol Fricks
Jamie Gamez
Mary Geheb
Reg Gibbs
Bob Gisclair
David Goudelock
Cathy Gagg-Smith
Kerry Hanson
Walter Harrell
Cynthia Haseley
Stacey Helvin
Carol Hyland
Cloe Johnson
Elizabet Kattman
Jacqueline Kelly
Valerie Knaeflc
Mary Kay Kolar
Sarah Larsen
Sherry Latham
Joanne Latham
Veronica Leavitt
Leigh Anne Levy
Tracy Litzenburger
Lenora Maatouk
Ann Manha
Debbe Marcinko
Michael Martinez
Jody Masterson
Franny Maze
Mike McCord
Ruth McLeod
Andrew Melcher
Dorothy Miller
Teresa Millsap
Erin O’Connell
Linda Olzack
Dana Penilton
Geri Pennachio
Karen Preston
Anne Rappaport
Patricia Rapson
Rhonda Renteria
Susan Riddick-Grisham
John Roberts
Mary Ann Rogrig
Jan Roughan
Mary Salerno
Joan Schofield
Ronald Smolarski
Stella Spencer
Gil Spruance
Laura Stajduhar
Diane Steffy
David Stewart
Molly Struble
Amy Sutton
Nadene Taniguchi
Robert Taylor
Kirsten Thomas
Daniel Turner
Miranda Van Horn
Hope Wade
Lora White
Heidee White
Susan Wirt
Laura Woodard
Denise Wrenn
Steven Yuhas
David Zak
Steven Zimmerman

Author Note

Tracy Albic, RN is a Registered Nurse practicing in Tracy, CA. She is a past Chair of the IALCP. Tracy is a Legal Nurse Consultant Certified, Certified life care planner and holds Fellow Status with the IALCP. She served as a volunteer at the 2017 life care planning Summit. Jamie N. Gamez, MA, and Cloie B. Johnson, MEd are all Rehabilitation Counselors and Case managers providing vocational assessments and life care planning services at OSC Vocational Systems, Inc. in Bothell, WA. Jamie is a Certified Rehabilitation Counselor, Certified Case Manager and Certified Disability Management Specialist and has been in practice since 2010. She served on the 2015 Summit Committee and is back for the 2017 Summit Committee.
Cloie is a Certified Case Manager, Diplomat with the American Board of Vocational Experts and co-owner of OSC. She is a past Chair of the IALCP and has chaired or co-chaired the Summits in 2010, 2011, 2012, 2015 and 2017. Cloie received the 2016 Lifetime Achievement Award in the specialty practice of life care planning.

Author Acknowledgement
A special thank you to all the attendees; specifically those who assisted with coordinating, facilitating, recording and note taking.
Life care plans are essential tools that provide roadmaps for individuals facing challenges due to injuries or enduring conditions that impact their capacity to thrive (Weed & Berens, 2009). The foremost component of these complex plans is individualization designed to meet the person’s needs in accordance with their abilities. Injuries and conditions come in a wide variety of presentations with no two situations alike. Many of the circumstances are catastrophic in nature and it is not uncommon for the issue of mental capacity to come into play. Traumatic brain injuries, developmental disabilities, and anoxic events are just a few conditions that can impact cognitive functioning and processing skills. Those affected by cognitive dysfunction may need lifelong assistance with decision-making to protect them, guide and help them through life events, and allow them live to their fullest potential.

The life care planner must have a working knowledge of guardianship to appropriately identify clients who may need decisional capacity support. Additionally, the life care planner must understand the qualifications, responsibilities, and duties of the guardian(s); such as case coordinators and financial managers; to integrate the economic factors and avoid duplication of those services within the plan. Therefore, the aim of this article is for the life care planner to become familiar with various aspects of guardianship including: criteria for guardianship, types of guardianships, standards of practice and ethical considerations, and the costs associated with guardianship.

What is Guardianship and When is it Needed?

Freedom of choice and personal rights are a foundation of this country. In the United States, the question of competency is a legal one, and all adults are considered competent until adjudicated otherwise (Leo, 1999). For example, even children born with profound mental disabilities must go through the guardianship process when they become of legal age to have an alternate decision-maker. In the United States, removing the rights of an individual is done with due process, as guardianship limits a person’s rights to make choices for one’s self. The National Guardianship Association (NGA) describes guardianship succinctly in the following passage:

“Guardianship, also, referred to as conservatorship, is a legal process, utilized when a person can no longer make or communicate safe or sound decisions about his/her person and/or property or has become susceptible to fraud or undue influence. Because establishing a guardianship may remove considerable rights from an individual, it should only be considered after alternatives to guardianship have proven ineffective or are unavailable” (NGA, n.d., para. 1).

A guardian is appointed and supervised by the court. The court must be provided evidence and find
that the person or proposed ward is not competent. The evidence usually consists of a medical doctor's report that indicates an exam took place and determined the person is no longer able to understand options and make decisions. The capacity to manage one's affairs can be influenced by mental deterioration, illness, physical incapacity, developmental disability, chronic intoxication, or addictions such as gambling (Jacobson, 2013). Alternatively to guardianship such as case management, powers of attorney, and representative payee should be considered first as they do not result in the same rights restrictions as guardianship (NGA, 2013). For instance, a person under guardianship may not enter into contracts such as leases, credit cards, consent for medical procedures, or marriage.

People are individuals and courts are respectful of this. Guardianships are viewed on a sliding scale or spectrum, rather than seeing the persons in a clear-cut, black and white context. The cognitive skill set for managing functions of the person's life can be different from person to person. For instance, a ward may have the ability to make medical and social decisions, but the same person may be unable to manage the complexities of a $15,000,000 settlement. Therefore, guardianships are always divided into two parts: guardian of the person and guardian of the estate.

Additionally, there are many types of guardianships. It is up to the courts to determine which are most appropriate for the person after reviewing the evidence. Types of guardianships include:

- Temporary: used in emergency situations and lasting no more than 60 days;
- Plenary of the person: the guardian has broad ability to make decisions concerning the person; and
- Plenary of the estate: the guardian has broad ability concerning property and financial matters (Jacobson, 2013).

The court also has the role of overseeing the guardianship. Therefore, the court requires plans and reports from both the guardian of the person and guardian of estate. The guardian is always accountable to the court and must seek guidance when the circumstances require oversight. For instance, the guardian of the person needs court approval for electroshock therapy or sterilization. Additionally, the guardian of the estate is not allowed to invest nor disperse the assets without presenting a plan to the court (NGA, 2013, p. 18).

The goal of the court is to protect an individual and the person’s estate while maximizing the ward’s ability driven participation. Hence, the court is also responsible for evaluating changing circumstances. For example, has the ward improved to the point that the guardianship needs to be adjusted to restore some or all the rights of the individual?

**Standards of Practice and Ethical Considerations**

**Types of Guardians**

Family and friends frequently choose to petition to be the guardian for their loved one. These types of guardians are considered non-professional and usually do not charge for their services because the services are commonly viewed as a component of the personal relationship with the ward. Professional guardians are third-party entities or persons that are not related to the individual, such as a corporate, not-for-profit, or state entity. They charge fees to the estate, which must be an economic consideration in the life care plan.

The court will appoint the best guardian to act in the ward's interest, regardless of any familial relationship. Guardianship petitions are state specific, and contain questions related to age, legal status, felony convictions and other items concerning competence of the petitioner to act in the role as guardian. Illinois, as an example, outlines that a guardian must be at least 18 years old, mentally sound, a legal resident of the United States, and must disclose felony convictions (Illinois Legal Aid Online, 2018).

Laws and the standards of practice apply to both professional and non-professional guardians. The guardian performs duties and fulfills obligations in accordance with current state and federal law governing guardianships.

“The National Guardianship Association (NGA) supports and encourages the adoption and/or use of the NGA Standards of Practice (Practice Standards) and Standards of Practice for Agency and Programs Providing Guardianship Services (Agency Standards) by professional organizations, guardianship agencies and programs, guardianship associations, legislatures, courts or any other entity desirous of bringing excellence to the practice of guardianship” (NGA, 2016, p. 1).

To provide uniformity in executing duties as a guardian, there is a nationwide push for all guardians – professional and non-professional – to be certified (Center for Guardianship Certification [CGC], n.d.). There are two levels of certification: National Certified Guardian and National Master Guardian (CGC, n.d.). These certifications are knowledge and experience-driven processes that requires the person to pass a test for initial certification and continuing education for certification renewal.

**Plan of Care Development**

The guardian of the person is entrusted to treat each person as an individual and create a person-centered plan of care. The guardian of the person serves as the plan developer and coordinator, which encompasses the duty to consult with appropriate professionals to develop a comprehensive plan. If the case warrants, the guardian may consult with the treating physicians, therapists, educators, nurse case managers, and nutritionists to name a few. The NGA standards do not specifically address consulting with case management services but do encourage medical second opinions (NGA, 2013, p. 4-33).
Professional guardians of the person are compensated for their services and as a general practice do not request the additional expense of external case managers for more than consultation. NGA standard 22 specifically states, “The guardian shall bear in mind at all times the responsibility to conserve the person’s estate when making decisions regarding providing guardianship services and charging fees for those services” (NGA, 2013, p. 23).

There are exceptions to this. The court must assess the level of care the individual needs and the guardian’s ability to manage that care. The professional and non-professional guardians have the same responsibility of justifying all expenditures in behalf of the ward. The court ultimately oversees all expenditures and is diligent in preserving the assets for future needs and avoids replication of service.

For example, in a case where the mother was the non-professional guardian of her daughter and had some developmental challenges of her own, the court approved a case manager to assist in coordinating the health care of her daughter.

Another example was the case of a 50-year-old male with a traumatic brain injury from a bicycle accident whose wife was appointed as guardian of the person. The entire family was from Mexico with Spanish as their only language and an unretractable fear of any health care system. The judge approved a case manager to assist the wife with coordination of care, attending doctor’s appointments, and managing durable medical equipment.

The guardian of the person charges the estate fees for developing and coordinating the plan of care and must justify all expenditures. The judge—as an agent of the court—has the role of approving the guardian of the person, the fee schedule, and their proposed plan of care. The cause for the adjudication of disability is considered when a guardian is chosen. The judge appoints the guardian who is qualified as having the proper skill set to manage the wellbeing of the ward in a fiduciary responsible manner.

For instance, if the ward has a severe mental health challenge, the judge will encourage the parties to petition for a mental health professional as guardian. If there are medical complexities, the judge will gravitate toward a nurse, physician, rehabilitation specialist, or clinical social worker to act as guardian. If the judge feels a guardian is not performing in the role of developing a person-centered care plan for a specific individual, the judge—as an agent of the court—may direct that a substitute guardian is found.

The court has a role of preserving assets for future needs of the ward and is always on the alert for duplication of services. The guardian of the person may request a case manager to be approved by the court. However, since there cannot be two parties charging for coordination of care, the professional guardian accordingly reduces the time and associated costs for this service.

For example, a Public Guardian was named guardian of the estate and person. He was a lawyer with no health care background and his ward had uncontrolled back pain. With court approval, he hired a professional case manager to manage the care plan and did not charge any coordination fees for guardian of the person.

Values and Choices Consideration
It is important for the life care planner to understand that decisions made by the guardian of person or estate are not made on economics and care alone. Inclusion and adherence to incorporating the ward’s values and choices are required decision-making standards (NGA, 2013, pp. 7-8).

An example of this is a 99-year-old ward with a $9,000,000 estate who wanted to live at home regardless of the cost. She emphatically stated to the court that she did not want to preserve the assets for her daughter. Instead, she wanted to utilize all services that would allow her to remain in her home, providing for her comfort and health. The ward also expressed that she did not want her daughter as her guardian, as she feared her daughter would not follow or carry out her wishes.

The ward’s home-based care was complex and expensive, much costlier than a nursing home placement. The daughter’s repeated attempts to place her in the nursing home were rejected by the guardian who was supported by the court and the ward’s medical team. The guardian was obligated to execute decisions based on the premise of doing what the ward would decide if she was able to do so. It is important to note that the guardian in this case was being true to the ward’s wishes that she had expressed throughout her life.

According to the NGA’s Standards of Practice (2013), substituted judgement is “the principle of decision making that requires implementation of the course of action that comports with the individual person’s known wishes expressed before incapacity, provided the individual was once capable of developing views relevant to the matter at issue and reliable evidence of those views remains” (p. 30). The only time the guardian should invoke a different standard is when the ward’s personal choice could put the person or the estate at risk.

For instance, in the prior example, if the care provided in the home was not adequate to meet her health needs, the guardian would be faced with a different challenge. The principle of best interest; part IV of the NGA’s seventh standard of practice; would then be invoked to override a personal choice by the ward (NGA, 2013, p. 8).

State jurisdictions are very clear that the principle of least restrictive environment or least intrusive measure is followed for all wards (Georgia Council on Developmental Disabilities, n.d.; Missouri Protection & Advocacy Services, 2004; Montana Department of Public Health & Human Services, n.d.; Wisconsin Department of Health Services, 2011; Wyoming Department of Health, 2014). It is the guardian’s duty to ensure the ward is residing in the least restrictive environment that meets the person’s needs whenever possible.
The issue is not just one of economics, considering only the expenses related to placement; but is also the issue of ensuring the individual's freedoms, a sense of purpose, and quality of life. One must look at each situation to determine what the least restricted environment measure would be for the ward.

For example, a person with developmental disability or traumatic brain injury may have more freedom in a group home than a skilled nursing facility. In such an environment, the person can live more independently in a home-like environment and participate in day training or programming workshops that may not be available in other settings. The least restrictive environment concept is foundational across disciplines and should be taken into consideration when creating or reviewing life care plans (International Association of Rehabilitation Professionals, 2015; Nursing Home Care Act, n.d.).

Guardianship is State Specific

Guardianships are managed by the state courts. If a person is under a guardianship the plan should be congruent with the state specific requirements. For example, states can differ in the requirements and process to deem a person incapacitated that requires a guardian and the process of obtaining guardianship. The National Guardianship Society has always been concerned about the mobility of our society and to not put an undue burden and expense on the wards and their family when they want to change locations, particularly across state lines.

The Adult Guardianship and Protective Proceedings Jurisdiction Act (Uniform Law Commission, 2007) is designed to address “the issue of jurisdiction over adult guardianships, conservatorships and other protective proceedings, providing a mechanism for resolving multi-state jurisdictional disputes. The goal is that only one state will have jurisdiction at any one time” (Uniform Law Commission, 2017, para. 1). Although it is recommended that all 50 states adopt this legislation, the five states that have not yet enacted the Act are: Wisconsin, Texas, Florida, Kansas, and Michigan (Uniform Law Commission, 2017). The life care planner should use diligence when researching the state-specific rules in these states.

Guardianship Costs in a Life Care Plan

Guardianship adds additional costs for professional time to manage and care for a person with disabilities. Since it is the life care planner’s responsibility to incorporate and factor the costs of services over a lifetime, when applicable, the costs of guardianship also need to be included in the plan. It is important to consider all aspects of a guardianship including initial and ongoing court costs, attorney fees, and the guardian fees.

Legal Representation Fees

Guardians, both non-professional and professional, have the right to legal representation paid for by the estate. If the guardian of the person and the guardian of the estate are separate entities, they have the right to have separate representation. However, they will use the same counsel if there are no conflicts to preserve costs. The life care planner should examine local costs for attorneys and professional guardianship fees. Since fees vary from county to county, it is prudent to research costs in the county where the individual resides.

Guardian of the Estate

Fee Structure Options

The guardian of the estate is responsible for mapping out the resources and structuring expenditures to last the lifetime for the ward. The guardian of the estate is also responsible for property/asset management and for paying bills. A family member may be appointed in this capacity, but the court usually insists on the family member hiring a financial planner to assist in managing the estate and to provide professional reporting. This could be a financial planning organization or a bank trust department.

The costs of hiring such experts to assist the appointed family member do not vary significantly from directly appointing these entities to be the guardian of the estate. If a professional service is appointed in the guardian of the estate role, it is critical to avoid duplication of services. The planner should be aware of the qualifications of the guardian of the estate to evaluate if a professional financial planner is needed as an additional cost item.

For instance, the guardian of the estate could be an attorney who performs legal work and manages the funds and usually engages a financial planner for investment advice at an additional cost to the estate. Alternatively, banks that serve as guardian of the estate usually have a package price that includes both the financial advising and fund management but hires attorneys for the court costs and filings at an additional cost. Regardless of whether the guardian of the estate is an attorney or a bank, the sum of legal and financial management fees should be similar.

Managing the estate is much more straightforward than managing the person. Whether the family member assumes the role and hires a professional case manager or if the professional manager is directly appointed by the court, the case management costs should be comparable.

Guardian of the Person

Family Member Considerations

The guardian of the person is a role that family members frequently assume. The life care planner should discuss with the family if they want to maintain their role in the personal aspects of their loved one’s life. Turning this responsibility over to a professional is not common unless the family is ill-equipped to manage the ward’s personal life. The life care planner should ask the family questions that focus on challenges
Nursing Diagnoses To Consider

Ineffective health management (Domain 1, Health promotion, Class 2, Health management)
Deficient knowledge (Domain 5, Perception/cognition, Class 4, Cognition)
Interrupted family processes (Domain 7, Role relationship, Class 2, Family relationships)
Ineffective role performance (Domain 7, Role relationship, Class 3, Role performance)
Powerlessness (Domain 9, Coping/stress tolerance, Class 2, Coping responses)

they may have that prevent them from accepting the role. A few examples that may impair the person’s ability to meet the challenges of the role include:

- The family unit includes another child or spouse with disabilities and the person cannot devote the time.
- The person has been estranged for years, and the ward is not comfortable with the family member in charge.
- The ward’s mental state has resulted in family violence.
- The family member has been convicted of a felony, which may disqualify them.
- The family member has a drug addiction.
- The family member has a progressive disease such as multiple sclerosis.

Typically, a family member assumes this role without monetary compensation. The family member managing this role can be time-limited if the ward is younger than the guardian. Social Security projections should be used to estimate the retirement age for the chosen guardian (Social Security Administration, 2017). If another family member is not able to assume the role at the projected retirement age of the appointed family member, the life care planner may consider including conversion to a professional guardian of the person.

Care Coordination

The guardian of person performs the role of decision-maker and coordinator of care to ensure the health and well-being of the ward. Since these functions are similar to the work of case managers, duplication of services must be evaluated and avoided. Therefore, the life care planner should not list separate case management services and fees without an identifiable need that a guardian cannot reasonably be expected to manage the case without additional support.

As in case management, the qualifications of professional guardians are variable. The guardian of the person role includes consulting with appropriate professionals to determine what resources, specialists, procedures, and equipment are necessary to provide the best quality of life for the ward in the least restrictive environment. The court is involved in determining if the proposed guardian has the proper credentials and knowledge to create and manage a person-centered plan of care for the ward. The court has the responsibility to review the guardian’s annual reports to determine that the executed plan met the guardianship standards (NGA, 2013, pp. 4-5). Nurses, social workers, professional counselors, and other professionals frequently serve as guardian of the person and the court makes every effort to appoint the guardian who is best suited to meet the wards individual needs. For instance, the court may appoint a guardian who is a nurse to be guardian of a ward with medically complex needs.

Fees

An approach to projecting guardian of the person fees is to calculate the amount of case management time required to meet the ward’s care needs and include additional time for consulting with attorneys, creating reports for the court and court appearances. Most states require a minimum of an annual report and many require an annual appearance to present the report. More frequent reporting may be required if the case has medical complexities, familial discord, or changes in living arrangement such as placement in a facility.

The life care planner should include additional time for the guardian of person if the case so warrants. Based on the authors’ years of experience, it is reasonable to calculate guardian of the person expenses by doubling the time necessary for case management to cover the additional court reporting requirements and related tasks. However, cases vary in complexity and additional time may need to be included to best meet the needs of the ward.

Incorporation of Costs into the Life Care Plan

Guardianship is a process. The initial start-up fees should be outlined separately from the ongoing maintenance (see Table 1 for typical LCP costs). The costs for consideration are as follows

Start-up Fees

- Court costs which are county specific are usually several hundred dollars. Typically, there is one fee that covers the filings for both the person and estate. Absent of a conflict between the guardian of the estate and the guardian of the person, one fee for both is adequate; as it is customary to use the same attorney for filings.
- Attorney fees for setting up a guardianship—using the same attorney—can range from $2,000 to $10,000 depending on geographic location and complexity. If there is a conflict between the two guardians, this fee could be doubled as each guardian has the right for legal representation.
- Guardian of the person set up fees can range from 20 to 40 hours at the guardianship rate. It is important to research the fees that are allowed in the geographic location of the ward,
but generally, they can run from $75 to $150 per hour.

Ongoing Maintenance Fees
- Annual reporting and appearance in court. This again includes attorney fees and typically range from $2,000 to $5,000 per year. Absent of conflict between the guardian of the person and estate, one attorney can appear for both guardians. If conflict is present this fee could be doubled as each guardian has the right for legal representation.

- Ongoing guardian of the estate fees do not vary from the financial management fees except for reporting to the court and creating an annual accounting. A fee of $100 to $150 per hour averaging 2 hours a month is routinely adequate. If a family member assumes the role, there may be no cost.

- Ongoing guardian of the person fees—as noted previously—the role for guardian of person is similar to those of case management, but more time is needed for the guardian due to court reporting requirements. Case management fees should not be included when there is a professional guardian in place unless the there is an identified reason why the guardian cannot fulfill the duties of their role in planning or executing a plan of care. For instance, if a family member is guardian of person, case management fees may be warranted. For the majority of cases managing persons with disabilities, the guardian of person ranges from 4 to 10 hours a month on an ongoing basis. More complex cases with extensive medical needs or ongoing behavioral and psychiatric issues may require more time, as much as 20 hours per month.

Conclusion
Creating a life care plan that addresses an individual's needs is a monumental task. The individual's decisional capacity

<table>
<thead>
<tr>
<th>Table 1: Typical Guardianship LCP Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOME / FACILITY CARE</strong></td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Start up Court costs, to establish guardianships</td>
</tr>
<tr>
<td>Start up Attorney fees, to establish guardianships</td>
</tr>
<tr>
<td>Guardian of the person fees, professional, to establish guardianship</td>
</tr>
<tr>
<td>Court fees, ongoing</td>
</tr>
<tr>
<td>Attorney fees, ongoing</td>
</tr>
<tr>
<td>Annual reporting and court appearances for guardians</td>
</tr>
<tr>
<td>Guardian of estate fees, professional, ongoing</td>
</tr>
<tr>
<td>Guardian of the person fees, professional, ongoing</td>
</tr>
<tr>
<td><strong>TOTAL HOME / FACILITY CARE</strong></td>
</tr>
</tbody>
</table>

*This in an example and should be treated as such. The need for guardianship(s) is different case to case, and these services and numbers may vary.*
can alter the plan when the protection of a guardianship is necessary. Guardianship is overseen by the state courts. The Universal Guardianship Act provides some uniformity from state to state, but additional research is needed in the states that have yet to adopt the act.

Guardianship is ever-changing. It is important to look to the national organizations for current standards of practice and ethical principles as guidance. There are times when a professional guardian is requisite due to the unavailability of family willing and able to serve in the role. In such cases, cost research should include the cost of initiating a guardianship and the ongoing maintenance. Caution should be used to avoid duplication of services such as case management, financial services, and other services that are covered under the guardianship role.

REFERENCES


SHAY HARLAN JACOBSON, RN, MA, NMG, LNCC, CNLCP®
Shay Jacobson is a registered nurse with bachelor’s and master’s degrees from the University of Iowa and is a Certified Nurse Life Care Planner. She holds the designation of Master Guardian through the Center on Guardianship Certification, a designation held by less than 70 individuals nationally. She has served in the capacity of staff nurse, clinical nurse specialist, infusion specialist, nurse manager, home care administrator, and nursing home administrator. She is the founder and president of Lifecare Innovations, a care management company, for over twenty years. Ms. Jacobson is a member of the American Association of Nurse Life Care Planners and National Guardianship Association, where she served on the National Board for two years. Ms. Jacobson has extensive experience in working with attorneys, fiduciaries, and the court systems in multiple Illinois County Courts, as well as in the court systems of various other state jurisdictions. She has served as an expert witness in matters involving life care plans, cost of care, and development of appropriate care plans.

ANNE MARGARET GEORGE, LCSW, CCM, MSCC, CMRS
Anne George is a licensed clinical social worker who has served primarily in case management roles. As a Lifecare Manager at Lifecare Innovations, she oversees a case of diverse clients and creates and implements individualized plans of care. As a Licensed Clinical Social Worker and Certified Case Manager, Anne is skilled and experienced in provision of advocacy and direct services for individuals with disabilities of all ages. She has applied these skills and others to contribute to the Life Care Planning program by performing records analyses, cost research, medical bill reviews, and other processes in the development of Life Care Plans and cost projections. Anne is also a Medicare Set-aside Certified Consultant and a Certified Medical Reimbursement Specialist and has demonstrated knowledge of the development and application of Medicare set-aside trust agreements as well as navigating claims, medical coding concerns, and other related responsibilities. She is an active member of the National Association of Social Workers, the Case Management Society of America, and the American Medical Billing Association.
Join us as we take a closer look at the artistry and methodology of Life Care planning.

Register Now at www.aanlcpconference.com

Contact us at 801-274-1184 www.aanlcp.org
Managing the Notion of UCR in a Life Care Plan
Rebecca Mendoza Saltiel Busch
RN, MBA, CCM, CFE, CPC, CHS-IV, CRMA, CICA, FIALCP, FHFM

Abstract
This article provides a review of the Life Care Planning (LCP) process and the UCR (Usual Customary Reasonable) methodology in the course of developing a life care plan. The article will review associated Standards of Practice from several stakeholders. This article will address the current barriers to pricing methodology and the means of overcoming those barriers. Finally, in addition to specific references noted throughout the article, a list of suggested reading has been included.

Understanding Healthcare Reimbursement
Healthcare reimbursement has evolved significantly since the turn of the century. The term “fee for service” has always been customary. Figure 1, reflecting notes taken by an expecting mother documenting predicted hospital charges to deliver her baby, was taken from an archive of photos dating back to 1908 (Hamilton, private collection, 2017).

Figure 1 1908 Notes on Hospital Charges

Costs include:
• Private Room $5 to $10; the $5 to $6 range does not include a bath; the $7 charge includes a bath.
• Anesthesia “If gas only is used that is free; if anesthetic is needed, then the anesthetist has own charge ($5 - $10).”
• “Usually there (in the hospital) 10 days, depends on Dr.”

The 1908 adaptation would look like the following in 2017:
• Room and Board closer to $900 to $1,500 per day
• “Gas” is termed as conscious sedation (CPT code 99143) for approximately $800
• Anesthesia (CPT code 00600) for approximately $1,500

The progression of reimbursement models parallels the ongoing development of the medical bill audit functions. In the late 1970’s, medical auditing support services involved simply validating whether or not a service was performed, but the integrity of the service was seldom questioned. The validation of charges simply involved breaking down a bill and comparing it to the medical record. The evolution of medical auditing can be noted as follows:
• Reconciling the medical record with the itemized bill to
• Reconciling the medical record with the itemized bill and evaluating if the medical record documentation supports why a service was performed to
• Reconciling the medical record with the itemized bill and evaluating if the medical record documentation supports why a service was performed and if the value was received.

The next generation in auditing will reflect the new population health standards being developed. The focus of future audits will likely involve a review of the efficacy of an eco-system to effectively manage a defined population. This system places providers at risk financially as they may be held accountable for the outcome of the care provided.

Reimbursement models beyond fee-for-service, particularly various payment systems, have expanded significantly. A prospective payment system is a pre-determined rate for a specified service. They vary in methodology and pricing and are supported by statistical analysis of geographic data and claim form data analysis. The best resource to stay current on the variety and scope of reimbursement models may be found at Medpac.gov (payment basics). The following are examples of prospective payment systems:

Reprinted from Journal of Life Care Planning, Volume 15, Number 3; Busch, Managing the Notion of UCR in a Life Care Plan, pages 3-14, Copyright (2017), with permission from Elliott & Fitzpatrick and the International Association of Rehabilitation Professionals.
The Diagnosis-Related Group (DRG) coding system was developed by Yale University in the 1970’s to describe patients in an acute care facility by diagnostic categories. Their original study included newborns, pediatric, and the general adult population. The DRG system itself assigns a numeric representation along with a weighted value for the specified group. The weighted value is associated with the level of intensity to support the patient in the context of a particular set of conditions and procedures. The purpose and use of this system has evolved into data management, reimbursement consideration, comparability, benchmarking and other types of research. The DRG group components includes the title of the category, geometric mean length of stay, arithmetic mean of stay, relative weight, and the current version of ICD code volume I diagnosis codes and volume 3 procedure codes. The code number itself range from 1 to 5-digit number. In essence, a DRG group is a list of diagnosis (Volume 1 of ICD-CM of the relevant year of service), followed by a list of procedures (Volume 3 ICD-CM of the relevant year of service) that are related to each other and assigned to a specific group. A trained coder may manually walk through the proper identification of diagnosis and procedure codes to arrive at the appropriate DRG group. There are also available electronic programs referred to as “Groupers” that may facilitate the appropriate selection of a DRG group based on the defined diagnosis, conditions, procedures, and included complications.

In 1983 Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA) adopted the DRG classification system for use as an Inpatient Prospective Payment System (IPPS). Significant updates have been made to the classification system for inpatient acute care (American Health Information Management Association, 2017). Historically, CMS has captured charge related data by each DRG group. The charge capture data is available at CMS.gov (Centers for Medicare & Medicaid Services, 2017) and contains both the Medicare paid amount and the total charges submitted by providers by DRG group.

The most relevant modern application of DRGs to life care planning involves the use of the coding system to identify the relevant DRG group that would comprise the DRG assignment relevant to a future procedure. Once the correct diagnosis and procedures attested by the provider are identified, the life care planner may then select the relevant DRG group plus the average charge amount noted within the MedPAR data.

The concept of grouping services by a grouping method evolved from the inpatient facility into the ambulatory surgical setting. This prospective grouping system is referred to as Ambulatory Surgical Center (ASC) payment systems (Centers for Medicare & Medicaid Services, 2016d). The prospective payment system for skilled nursing facility care evolved into what is known as Resource Utilization Groups (RUGs) (Centers for Medicare & Medicaid Services, 2016e).

Ambulatory Surgical Centers (ASC) codes include Medicare reimbursement rates for surgical procedures provided in a singular freestanding or hospital operated ambulatory surgical centers (ASCs). The unit of payment in the ASC payment system is the individual surgical procedure. “Each of the approximately 3,500 procedures approved for payment in an ASC is classified into an Ambulatory Payment Classification (APC) group on the basis of clinical and cost similarity” (Medpac, 2016b). There are several hundred APCs. All services within an APC have the same payment rate. Likewise, hospitals utilize the Outpatient Prospective Payment System (OPPS). The ASC system uses the same APCs as the OPPS.

Resource Utilization Groups (RUGs) is a classification system to determine reimbursement levels for patients in Skilled Nursing Facilities (SNF). RUGs are based on “the number of minutes of therapy (physical, occupational, or speech) that the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy or specialized feeding); the presence of certain conditions (e.g., pneumonia or dehydration); and an index based on the patient’s ability to independently perform four activities of daily living (eating, toileting, bed mobility, and transferring)” (Medpac.gov, 2016a). “Patient’s characteristics and service use are determined by periodic assessments using the SNF patient assessment instrument, known as the Minimum Data Set” (Medpac.gov, 2016a).

The above payment methodologies are driven by a complex coding system. Figure 2 provides an overview landscape of “codes” that are utilized to communicate what service was provided to the patient and why. Tracking this information with respective charges on a provider bill is what drives reimbursement analytics. The two principal coding systems involve the ICD Index that is managed and updated by the World Health Organization (WHO). The Current Procedural Terminology (CPT) is managed and updated by the American Medical Association (AMA).
Figure 2 Overview of Coding Systems (Busch, 2016)

The following is a list of billing documents. It is important to understand how these bills are generated, the content contained within, and how to extract relevant information to conduct a UCR analysis.

**Professional / Durable Medical Equipment / Ambulance bills**

- **Claim Form (CMS-1500)**
  
  Most commercial insurance carriers require paper claims to be submitted on CMS-1500’s by physicians and suppliers, and in some cases, for ambulance services. Some providers now submit electronic CMS-1500 claim forms. These claim forms document professional fees from physicians, suppliers, ambulance services, physical therapy, nurse practitioners, physician assistants, etc. (Weed & Berens, 2010).

- **Charge sheet or equivalent** is typically an internal document maintained by the provider. The format and content will usually have a listing of procedure codes that are charged by the provider. This is not required if an actual claim form or equivalent has been provided.

- **Facility:**
  
  - **Claim Form (UB-04, CMS-1450)**
    
    The UB-04 Claim Form is for hospitals, clinics, or any provider billing for facility fees. The UB-04 Claim Form replaced the UB-92 Health Insurance Claim Form. Itemized billing statements are usually provided when medical bills are requested. The UB-04 Claim Form is generally not provided. There are inpatient and outpatient versions of the UB-04 Health Insurance Claim Form.

- **Charge Data Master (CDM)**
  
  The charge data master file is a listing of a provider’s itemized charge for products and services. Each itemized charge is assigned a revenue code that will be summarized on a universal billing claim form. In addition, relevant charges will be coded with applicable HCPC or CPT code imbedded within a unique service code alphanumeric number. The typical header file of a CDM may include charge description, service code number, procedure codes, payer billing code data, and unit price.

- **Product Sheets**
  
  It is important to obtain any relevant documentation of the DME product provided, note serial numbers and obtain information on any custom orders.

- **Understanding medications and pharmaceuticals:**
  
  - **Prescription Drug Claim Form**
    
    The Prescription Drug Claim Form provides a common format for reporting the prescribed medication purchased during the patient’s treatment.

- **Understanding a dental medical bill:**
  
  - **ADA (American Dental Association) Dental Claim Form**
    
    The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan (American Dental Association, 2012). ADA policy promotes use and acceptance of the most current version of the ADA dental claim form by dentists and payers (American Dental Association, 2012).

- **Systems used on the above billing forms**
Revenue Codes

Revenue Codes are 4-digit numbers that are used on hospital bills to identify specific accommodation and/or ancillary charges (Boston Medical Center Health Plan, 2015). It tells the insurance company where the patient was when they received treatment, or what type of item the patient received. Any provider billing on a UB-04 claim form, must bill a 4-digit Revenue Code to have the claim considered for payment.

Revenue Code Example

0110 Room & Board – Private

The International Classification of Diseases Clinical Modification (ICD-CM)

The United States uses a diagnostic coding system that dates back to 1893. At the time, the first attempt to track diseases resulting in death was referred to as the International List of Causes of Death, which was adopted by the International Institute in 1893 (International Association of Rehabilitation Professionals, 2017). The World Health Organization (WHO) established in 1948 took over responsibility for this list and published the 6th (ICD-6) edition for listing of diseases. The current version of ICD-10 was endorsed by WHO in May of 1990 at the 44th World Health Assembly. The purpose of the ICD is to track, trend, and study the identification of health occurrences globally (Foundation for Life Care Planning Research, 2015). Advancements and preparation are underway for ICD-11.

The World Health Organization has provided the US government and respective agencies permissions to create adaptions to ICD-10 only within the context of established WHO conventions. The ICD-CM coding system, as modified by the Centers for Medicare and Medicaid Services (CMS) for classification of procedures and the National Center of Health Statistics (NCHS) is utilized by healthcare providers to classify, code, and record diagnoses, symptoms, abnormal findings, complaints, social circumstances, and the external causes of injury or diseases (Health Care, 2013).

• The 10th revision (ICD-10-CM) (effective 10/1/15) diagnostic codes consist of 3-7 digits. The first digit is alphabetic, the second and third are numeric, and the fourth through seventh digits can be either alpha or numeric. A decimal separates the third and fourth digits (Gily, 2014).

• The ninth revision (ICD-9-CM) Volume I & II (prior to 10/1/15) diagnostic codes consisted of 3-5 digits. The first digit can be alpha or numeric and the second through fifth digits are numeric. A decimal separates the third and fourth digits (Gily, 2014).

The International Classification of Diseases Procedure Coding System (ICD-10-PCS)

ICD-10-PCS replaced ICD-9-CM Volume III as the coding system used by hospitals to record procedures performed in an inpatient facility setting only beginning 10/1/15. It is composed of seven numeric digits.

CPT

CPT (Current Procedural Terminology) codes (or procedure codes) are 5-digit codes assigned for reporting a procedure performed by the physician. The CPT code describes medical, surgical, and diagnostic services. They are used to tell insurance companies what kind of procedure or service was performed on the patient. They also denote pharmacy and supply items, as well as capture physician visit times. CPT codes must match up with diagnosis (ICD) codes in order to get claims paid.

The CPT code does not actually have to be a procedure. It can be what is known as an E&M-(Evaluation and
Management), or visit code, which denotes the time, place of service, or type of patient a physician has seen. It can also be a lab test, which is considered a procedure, even though sometimes the patient may not have been at the facility that took the sample (Medical Billing Answers, 2017).

CPT Code Example
20600 Arthrocentesis, aspiration and/or injection; small joint or bursa

HCPCS
HCPCS (Healthcare Common Procedure Coding System) Codes (often pronounced by its acronym as "hick picks") is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). HCPCS Codes begin with a letter followed by 4-digits.

HCPCS Code Example
J2270 Injection, morphine sulfate, up to 10 mg.

Modifiers
• “A service or procedure can be further described by adding a 2-digit modifier.” (Santa Clara County Medical Association, 2004). “Modifiers can be 2-digit numbers ranging from 21 to 99, two-character modifiers, or alphanumeric” (All Things Medical Billing.com, 2017). CPT code modifiers enhance the support associated with the procedure. More than one modifier may be used with a CPT code. CPT code modifiers are not applicable to every category of CPT codes. Some CPT code modifiers are used with a particular category (All Things Medical Billing.com, 2017).

MAA
Maximum Allowable Amount refers to the maximum amount an insurer will be willing to pay for a certain covered health service.

1. General Guidelines
The diagnosis code (ICD) is why we did something to a patient (as indicated by the medical practitioner). It documents what medical service was rendered.
• Modifiers document extenuating circumstances involved with a service or additional definitive information. The modifier may or may not impact pricing. The practice standards and rules tell us how we are allowed to communicate the “what” and the “why”.

Figure 3 identifies relevant components of the reimbursement model.

For example, to calculate a cost in a life care plan of a patient who needs a knee replacement, the following steps will be taken:
1. Isolate the appropriate DRG group to represent the knee replacement (do I select no complication, moderate complications or major?)
2. Based on the description of the surgeon, isolate the CPT codes to perform the surgery. Consider the use of the correct coding initiative rules when selecting codes.
3. If appropriate, identify the CPT code for a physician's assistant.
4. Include associated costs such as pre-op services (with all CPT codes) and post-op services (physical therapy, one round unless noted) and relevant medications if appropriate. Include both professional (readings) and technical (laboratory) components for diagnostic tests.

Figure 3: Cycle of Reimbursement by Type of Service & Methodology (Busch, 2013)
Case Example:

Medical Audit Methodology

- Identify the scope of work
- Identify and classify the type of bill
- Review the details of the bill
- Review relevant medical records
- Obtain any additional records or provider clarification if required
- Review relevant market standards, coding reference, geographic information, any applicable compliance requirements, applicable legislative requirement, and validate the provider’s NPI.
- Review the content in the bills as defined under UCR
- Review line item of each bill and then in its entirety
- Render an opinion

Review of prior medical bills

- Obtain copies of claim forms facility UB-04, CMS-1450 and professional claim form; CMS-1500 Billing statements
- Relevant medical records
- Validate Coding information
  - Review relevant practice standards
  - Review selection of diagnosis codes
  - Review selection of procedure codes
  - Any other relevant coding references
- Validate Demographic information
  - Basics – NPI and location
  - Validate contents of the claim form

Illustrative Resources

- HCPCS – Healthcare Common Procedure Coding System (CMS.gov)
- ICD – International Classification of Disease Index (CDC.gov)
- National Uniform Billing Committee (nubc.org)
- CCI – Correct Coding Initiative (CMS.gov)

Other Considerations

To determine UCR for healthcare services provided in an organization that does not generate bills, such as the Veterans Administration, the process is very similar to a life care plan. One should identify the services provided, apply the appropriate codes, and determine the price. One should follow the same procedure for international services performed; however, the pricing data should reflect the geographic location of where the patient will continue to receive services within the US.

Validity is Case Specific

As an example, a Chicago-based individual with paraplegia with no history of decubiti (pressure ulcers) requires a new power wheelchair, cushioning, and training regarding pressure release, skin inspection, and other methods to prevent the development of decubiti. The assumption is made that the basic materials for treatment would be included. That individual's life care planner should not include provisions for assumed risk of decubiti and subsequent surgeries. Once the list of services is determined, utilize the appropriate coding system to classify the service. Once the service is “coded”, utilize the most appropriate resource to project a price for that service. It is important to also document the medical condition associated with the services.

Services Required: Wheelchair, cushions, training, skin inspections

Services Pending: No pending surgery anticipated

ICD-9 Codes:
- G82.2 Paraplegia

CPT / HCPCS Codes:
- DME Wheelchair & Accessories
  - K0856-NU (Wheelchair) $7,132
  - 97542 (Fitting and Evaluation) $50.03
- Physical Therapy Training Gait
  - 97163 (PT Evaluation) $205.67
  - 97116 (Gait Training) $81.47
  - 97164 (PT Re-Evaluation) $112.17
- Evaluation Management for Skin Assessments
  - 99213 Evaluation and Management (E&M) $118.30

Note: Pricing per National Fee Analyzer (NFA) based on Chicago area geographic location.

However, let us assume that the patient does have a history of stage four decubiti with ongoing intervention. The individual had a full-time desk job with little mobility. The life care planner may project a future surgery by utilizing the DRG hospitalization data collected under MedPAR data (Medicare Provider Analysis and Review data) which is publicly available at CMS.gov. In addition, if the patient is located in a state that collects charge capture, data is available for workers’ compensation.

If a future procedure is needed for wound debridement, the life care planner can isolate the relevant diagnostic codes and utilize the MedPAR charge capture data to obtain hospitalization charge capture fees based on the DRG grouping system. The MedPAR data collects what Medicare paid in addition to what providers charged by DRG group. This data is aggregated by DRG group and not geographic location. Figure 4 and Figure 5 highlight the two standard claim forms that will provide relevant data points when evaluating the diagnosis codes, procedure codes, and charge information that may be collected during the review.

ICD-9 Codes:
- 707.04 Pressure ulcer, hip
- G82.2 Paraplegia

DRG (Diagnosis Related Group) for future Debridement:
- DRG 463: Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders
- Price based on Illinois Workers Comp Fee Schedule based on DRG Group 463 in Chicago zip code is for $131,412.35.
- Price based on MedPAR data for DRG 463 is
$132,303.66

The following section provides a detailed discussion on UCR along with published definitions. It is important to note the collective message of the depth and breadth of the UCR process as applied by various healthcare stakeholders. The life care planner should develop an understanding on how various market segments utilize the UCR concept within their respective market.

**Defining Usual, Customary and Reasonable (UCR) Charges**

Usual, Customary and Reasonable analysis is a term used in healthcare to evaluate the presentation of a healthcare bill in the context of the services provided and supported within the medical record. The bill is reconciled against relevant clinical and billing practice standards, geographic considerations, as well as any legislative requirements. The reconciliation of these attributes supports opinions and determination of UCR healthcare charges within a forensic setting.

A healthcare service(s) or product(s) charge is considered

- “Usual” if it is a professional charge(s) for an in scope of practice service/procedure by an appropriately licensed and credentialed professional or; If it is a facility (e.g. hospital, outpatient, nursing home, rehabilitation, long term care) for a defined facility based licensed scope of services/procedure, and

- “Customary” if it is within the range of fees, quantity, volume, and/or coding that most professionals (CMS-1500) or facilities (UB-04, CMS 1450) in the geographic area charge for a given procedure; if it is a facility within a ranges of fees, quantity, volume, and/or coding (UB-04, CMS 1450), in scope facility license; and

- “Reasonable” if it is usual and customary and/or if it is clinically relevant, with informed consent, and clinically justified. Any special condition (e.g. a difficult procedure) will be articulated based on current practice standards.

However, definitions of the term Usual, Customary and Reasonable (UCR) continue to vary across data sources. This can be seen below in definitions of UCR quoted from various data sources:

- **Healthcare.gov Definition** (2013) - UCR is “The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.” Note: This definition does not take into consideration other attributes, such as whether a provider is licensed or practicing within their scope. For example, a relevant UCR question is if the provider is following healthcare.gov’s coding initiatives.

- **HealthInsurance.org Definition** (1994) - UCR or covered expenses refer to “the amount customarily charged for or covered for similar services and supplies which are medically necessary, recommended by a doctor, or required for treatment.” Note: This definition implies that the review of diagnosis and procedure codes assigned by the provider to support the clinical condition is relevant to the UCR process.

- **Illinois Department of Insurance Definition** (2010) - UCR is the charge for healthcare that is consistent with the average rate or charge for identical or similar services in a certain geographical area. To determine the UCR fee for a specific medical procedure or service in a given geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the database profile set up by the Health Insurance Association of America (HIAA). Some insurers compile their own data using their own claim information and use these statistics to chart a range of fees for each geographical area in which services are provided. When a claim for a specific treatment or procedure is submitted the insurer pays all or part of the claim, depending on whether the amount of the claim is within the UCR allowance. Note: This definition introduces the use of statistical analysis in deriving an average dollar amount by similar services (procedure codes). Refer to the respective states’ Department of Insurance for any other defining considerations.

- **Bureau of Labor Statistics Definition** (2002) - UCR is defined as conventional indemnity plans that “operate based on Usual, Customary, and Reasonable (UCR) charges. UCR charges mean that the charge is the provider’s usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.” Note: An additional interpretation of circumstances includes appropriately licensed, professionally provided services under appropriate conditions. The analysis is driven by isolating the appropriate diagnostic and procedure codes that represent the services charged.

- **Office of Personnel Management Definition** (1996) – “UCR is defined as a widely-used method, which may vary from company to company, to determine benefit reimbursement levels.” The acronym of UCR simply means: **Usual**: The fee that an individual dentist most frequently charges for a given dental service. **Customary**: A fee determined by the insurance company based on the range of usual fees charged by dentists in the same geographic area. **Reasonable**: A fee is justifiable considering special circumstances of the particular care rendered. Note: This definition reflects the incremental process that is involved in
analyzing a healthcare bill.

- **The Government Accountability Office Definition** (2005) - “The UCR price is the price an individual without prescription drug coverage would pay at any retail pharmacy.” **Note:** This definition is placing the value at the price paid by the individual, assuming the patient. However, the actual value may not address the consideration that a benefit plan or the provider receives from other transactions. For example, rebates, shared savings and other incentive payments among the stakeholders.

- **The American Dental Association Definition** (2012) “The fee an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement. It is always appropriate to modify the fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.” (Defineterm.com, n.d.) **Note:** This definition focuses on the presenting charge versus any payer contractual relationship. Further, it does not consider what the market will typically pay for the service by geographic location.

The variations in definitions may contribute to the lack of understanding of the complexities of healthcare reimbursement. These complexities then contribute to flawed assumptions when reviewing healthcare billing practices. Flawed assumptions result from not being able to recognize other contributing factors in evaluating UCR, the context of proper coding, the scope of professional practice and other elements in the presentation of a healthcare services bill.

**UCR Analysis Process and Associated Standards**

To determine the Usual and Customary fee for a specific medical procedure or service in a specific geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the database profile set up by the Health Insurance Association of America (HIAAA) (Busch, 2017). Some insurers compile their own data using their own claim information. The insurers use these statistics to chart a range of fees for each geographical area in which services are provided. When a claim is submitted for a specific treatment or procedure, the insurer pays all or part of the claim, depending on whether the amount of the claim is within the usual and customary allowance. Please note, the current private payer contractual arrangements are moving away from the use of the term UCR. Many of their current agreements have shifted toward the use of the term “Maximum Allowable Amount” (MAA). This shifts the debate of what is UCR for a particular service is to what the plan is willing to pay.

The general elements involved in conducting a UCR analysis typically include collection of the following data points:

- Professional, dental, and/or prescription demographic, National Provider Enumeration Number (NPI) and licensure information;
- Facility demographic, licensure information, NPI number;
- Durable Medical Equipment (DME) demographic, licensure information, NPI number;
- Dental demographic, licensure information, NPI number;
- Prescription demographic, licensure information, NPI number;
- Relevant medical information to include clinical records that support information contained within the billing records;
- Relevant billing information that includes:
  - Contents of the bills (such as CMS-1500 professional bills; UB-04, CMS 1450 Facility Bills)
  - Date(s) of Service
  - Place of Service (POS)
  - Procedure codes (with modifiers)
  - Diagnosis codes
  - Quantities (includes volume, units, and time increments)
  - Rendering provider versus billing provider
  - Demographic analysis of all providers involved with an episode of care (Technical Components [TC] versus Professional Components [PC])
  - Correct Coding Initiative (CCI Edits)
  - Proper context and condition (is the procedure approved to be done in a particular setting)
  - Any specialty care coding system
- Relevant medical information that includes:
  - Clinical records that support information contained within the billing records.
- Any other relevant contractual, legislated, and/or court-ordered considerations. A court-ordered consideration may include a directive to “remove services associated with a condition” as irrelevant to the case in litigation. A legislated consideration may include the appropriate use of ICD and CPT codes as defined within HIPAA statutes. A contractual related consideration may include separation of wellness conditions within the body of the report.

**Life Care Plan Process and Associated Standards**

Life Care Planning has emerged as an effective method for identifying and outlining future care needs and costs (Weed & Berens, 2010). The Life Care Plan addresses the changing needs and expenses of an individual with long term, usually severe and chronic health care problems because of a personal injury. “Life Care Planners evaluate individuals with disabilities or chronic health conditions in order to outline the needs created by the disability. The Life Care Planner develops an integrated plan that includes items and services required, with their respective costs.” (International Association of Rehabilitation Professional, 2017) The Life Care Plan addresses both current and future needs and costs of the individual. The first formal definition of a Life Care
Plan was noted by Deutsch and Raffa:

“A consistent methodology for analyzing all of the needs dictated by the onset of a catastrophic disability through to the end of life expectancy. Consistency means that the methods of analysis remain the same from case to case and does not mean that the same services are provided to like disabilities” (Deutsch & Raffa, 1981; Deutsch & Sawyer 2002, p. 4).

An initial description of life care planning was offered by Deutsch and Raffa and with follow-up collaboration with leaders and organizations led to the following agreed upon definition:

“The life care plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs” (International Academy of Life Care Planners, 2009, p. 6).

The goals of a life care plan are to decrease the frequency and severity of medical complications, improve the patient’s quality of life, and effectively project anticipated cost. Considerations may include health/wellness, home and personal safety, educational support, ongoing care coordination support and legal and financial (Foundation for Life Care Planning Research, 2009, International Academy of Life Care Planners, 2017).

The American Association of Nurse Life Care Planners (AANLCP) established a research committee supporting the peer review practice with the goal of expanding the body of knowledge and theory specific to the practice of nurse life care planning (AANLCP, 2014). Most of the research used to “back up” recommendations comes from medical and disability research findings, which are available in a myriad of medical and disability related journals. The AANLCP practice standards establish the acceptable use of medical journals in addition to the documentation of current healthcare providers to support the foundation for recommendations contained within their life care plans.

**Costing Methodology for Developing a LCP**

Life care planners rely upon a scientifically based methodology to ascertain the components of their life care plan. Life care planners rely on a variety of methods for determining the monetary impact of care projected in a care plan. Costing methodologies vary in their approach, formula and comprehension. A five-step process is used to facilitate the development of a costing methodology for the life care plan that provides a comprehensive clinical and financial picture include:

- **Step 1**: Define scope of audit and review
- **Step 2**: Define data necessary for evaluation
- **Step 3**: Define parties to be interviewed
- **Step 4**: Prepare audit review and data analysis
- **Step 5**: Define market comparison, analysis, and financial report (Busch, 2016).

In step one, the life care planner defines the scope of audit and review. The life care planner and referring party discuss and agree upon the objectives of assignment prior to initiating development. This discussion should include the parameters and limitations set by expert testimony. The life care planner should establish a mitigation strategy for expert opinions or testimony when research demonstrates a conflict or results in a different opinion. With respect to actual data, it is important to discuss parameters and limitations that are set due to incomplete data. For example, how does the life care planner address missing medical records or an incomplete assessment of relevant injuries?

In step two, the life care planner defines data necessary for evaluation with an inventory for the materials obtained. If appropriate, index these materials by information to be reviewed and those relevant to the clinical issue in question versus those that are not. All materials should be reviewed and a professional judgement rendered as to its appropriateness and relevancy. Materials labeled as non-related may contain pertinent information that may influence a new understanding or etiology of a condition or have a possible impact on long-term care decisions. For example, if the patient has a progressive chronic condition such as arterial enteritis, which is unrelated to the damages claim of dementia from acute traumatic brain injury, long-term implication of support for activities of daily living maybe impacted. The primary care projections will include ongoing primary care management in which the relevant damages issue will require the same level of intensity as the non-damages claim. The life care plan may want to acknowledge the shared resources to address both the relevant and non-relevant healthcare delivery support. The driver of “relevant” and “non-relevant” should be driven by the diagnosis code attested to by the physician involved with the care.

In step three, the life care planner identifies parties to be interviewed. Provisions should be made for comprehension, accuracy, and further determination of additional experts (if required). A special note should be made regarding privacy regulations with the interviewer obtaining consent to acquire information. In an environment of changing laws with respect to the handling of health information as well as the privacy laws, it is suggested that legal counsel should be obtained when making a final determination of the appropriateness of any consent form.

In step four, the life care planner prepares audit review and data analysis. Review of materials should take a methodical approach to ensure accuracy and comprehension of facts. Clearly, a majority of time will be spent on completing this step of the process. Proprietary database software systems may be used to abstract health information into a relational database and facilitate the analysis and data mining of the health information. Regardless of the use of the software or narrative text of a report, the information in its entirety should be reviewed.

In step five, the life care planner conducts market comparison, analysis and prepares the final report. This step...
provides for conclusions, analyses, summaries and production of a final report. Looking at the “big picture,” does the overall plan reflect the total care required for this individual? Are any providers of care by category missing? For example, if a surgery has been projected, does the report include all the diagnostic testing and post-surgical care? The final report will indicate the sources of all financial information and formularies to determine current and future expenses. The life care plan may also make provisions for other emerging factors such as medical error rates, possibly from databases in development that will provide financial information on the monetary impact of medical errors.

In order to effectively project the monetary value of future services within a life care plan, the life care planner will consider the Usual, Customary, and Reasonable (UCR) price of a service. The pricing of services should parallel reliable market data that takes into consideration appropriate metrics. Other attributes beyond price should include the provision of services in an appropriate setting, by appropriate licensed personnel, and with necessary quantities and services. In some situations, a complication factor will be considered in individuals with known, expected complications such as patients recovering from severe burns. Data, in particular historical claims, would support that burn patients are at risk for infection. Another example would include hip replacement. If the manufacture suggests that the life span of a joint replacement is 15 years and the life expectancy projection is an additional 40 years, the life care plan may include two projected hip replacements. The life care plan would then project the future services needed by the patient and the UCR process incorporates the appropriate healthcare coding systems including diagnostic codes, procedure codes, place of service, and price.

Goals of UCR in the context of a Life Care Plan

The goal of the UCR analysis is to articulate anticipated expenses in their proper context, condition, and through the use of the correct diagnostic and procedure coding language. The opinions on pricing are based on what is reasonable considering the geographic location of the services. Finally, the healthcare services must support the life care plan and have a clinical and/or practice standard foundation. The life care planner may also be called upon to conduct a retrospective bill review for past medical events. Regardless, if the life care planner is not addressing prior medical bills as part of the work product, an understanding will enhance the future costing of the life care plan final projections. In order to be effective at costing services into the future, it is important to have a general understanding in how to evaluate prior medical bills. The review process for retrospective billing is the same as described for selecting price points for a life care plan.

Conclusion

This article provided a review of the process and the UCR (Usual, Customary, and Reasonable) methodology in the course of developing a life care plan. The associated standard practices were reviewed for life care plans and usual, customary, and reasonable determinations in addition to understanding the various industry segment definitions of UCR. This article provided support on the potential gaps and barriers faced with understanding UCR. With respect to pricing, it is important to understand context, condition, and any special formulary that may be relevant.

The processes presented in this article will facilitate the appropriate costing and/or pricing of the services being presented within the life care plan. The life care planners may apply these principles during the development of their life care plan. The foundation and support are illustrated by first understanding how healthcare is paid for, followed by how services are articulated within the coding language system. The coding system provides the opportunity for consistency in communicating services recommended, followed by a formal process to track expenditures as the life care plan is executed.
References

Suggested Reading
• American Association of Professional Coders www.aapc.com
• American Dental Association. http://www.ada.org/~/media/ADA/Member%20Center/Files/j430d_dental_claim_form_2012.ashx
REBECCA MENDOZA SALTIEL BUSCH, RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA

Rebecca Busch is President of Medical Business Associates, Inc., a minority, woman-owned Medical Data Auditing and Healthcare Consulting firm. Ms. Busch developed and implemented a unique analytical workflow process that identifies critical tasks, conditions and standards to promote a stable, dynamic and scalable healthcare business.

Ms. Busch has authored five books. Her latest, Patient’s Healthcare Portfolio: A Practitioner’s Guide to Providing Tools for Patients, was published April, 2017. Recognized as an expert in her field, Ms. Busch developed data management practice standards for emerging Chief Data Officers and auditors that ultimately support and defend complex issues impacting the bottom line.
Grow your career with FIG!

- Nurse Life Care Planning
- Medicare Set-Asides
- Medical Cost Projections
- Online classes-start anytime
- Onsite classes-every month
- Mentorship & brain storming-individual & group
- Preapproved CEUs
- Payment Plans
- AANLCP members receive discount

FIGeducation.com
Florence Nightingale saw first what subsequent research confirmed scientifically – that a holistic approach to patient care— including the caregiving environment, patient care recommendations, and financial considerations; are all essential to patient recovery. These original insights should be embodied in today’s nursing practice standards, specifically the role of nurses in the development of a life care plan (LCP). An effective LCP is demonstrated by another nursing role—the case manager—whose skill set is to ensure the appropriate execution of the plan. Nightingale’s insights to patient care are applied in the development of life care plans, implementation of the LCP, and ongoing case management are explored in this paper through real-life vignettes subtly modified to protect the identities of individuals and their families.

The Patient’s Surroundings

“What nursing has to do… is to put the patient in the best condition for nature to act upon him” (Nightingale, 1969). “Poor or difficult environments led to poor health and disease” (Nightingale, 1969).

Florence Nightingale, a pioneer in the field of modern nursing, believed that suffering is caused not only by the disease itself, but also by the patient’s surroundings. Nursing can significantly enhance the quality of care for patients by monitoring the health of the patient’s home. Homes that maintain low noise levels, fresh air, adequate light, as well as a healthy patient’s diet all promote recovery and reduce suffering.

These nursing practices do not require physician-driven medical diagnoses of the pathology of the patient. Instead, knowledge of how to make the patient’s surroundings and environment amicable to better deal with the symptoms of the disease – the domain of professional nurses – is essential. Moving beyond Nightingale’s environmental conditions, today’s nurses must consider the safety of the home environment and the emotional, cognitive, and physical support required by the patient from family and other care-givers. Applying the core competency of assessment followed by plan of care, Ms. Nightingale set the stage for the rapid evolution of modern era nursing practice in scope, depth, and breadth of practice.

Capturing this full range of surrounding conditions is assisted by the creation of a LCP. The LCP embodies knowledge gained through engaging the LCP client in personal interviews. Home visits should occur at a time that is most
convenient to assess the LCP client’s day-to-day environment and activities. Walking through the home and observing how the LCP client literally leaves the home could be necessary to identify the resources required to mobilize the LCP client.

Seasonal issues should also be addressed. Personal observations such as these, are important to assess what is not seen within the clinical setting and written within the medical record. The onsite visit may close the gap in understanding all the limitations that are being experienced by the LCP client. It is ideal to have present those parties who support the LCP client.

This practice supports the standard of the LCP “uses consistent, valid and reliable approach to research, data collection, analysis, and planning” (International Association of Rehabilitation Professionals [IARP], 2015, p.9). This practice is also reinforced by and consistent with the American Association of Nurse Life Care Planners (AANLCP) practice standards (Howland, 2015). The AANLCP Scope and Standards of Practice recapitulate the steps of the nursing process. The nursing process includes six singular and integrated actions of assessment: diagnosis, outcomes identification, planning, implementation, and evaluation (Howland, 2015). The case below illustrates the importance of involving all individuals assisting the LCP client when developing a LCP.

Case Profile: “The Bicyclist”

A high profile, 52-year-old investment trader was hit by a car while riding his bicycle. He was expected to never walk again. However, two years later he was using leg braces and a cane. The author conducted a follow-up interview and home inspection, observing all the activities of a typical day. The discussions that followed included the LCP client, his 45-year-old wife, attorney, and caregiver.

At first glance, all seemed to conform to the clinically determined prognosis. The LCP client could prepare simple meals, heating food in the microwave when required. The caregiver corroborated the LCP client’s care needs as documented within the medical records. However, more detailed observations that could only be achieved by a nurse’s physical presence, noted anomalies posing threats to the LCP client’s recovery. For example, uneven floor patterns raised the risk of falling. More dramatically, the author noted the wife cued her husband throughout the interview. She had a pattern of initially starting the answer to questions presented to her husband. He would take that cue and only then respond.

Seeing this, the author raised this subject with the wife without any other parties present. She broke down and started to cry. She stated that her husband’s memory had been greatly diminished. As an example, she spoke of how he would pay all the household bills and then she would subsequently correct the errors he made. Additionally, she had replaced all metal kitchen utensils with plastic to avert him from placing metal inside the microwave. She told the author that she had not shared this with his physician. The reason? She did not want to take away her husband’s remaining dignity as the family provider.

Life Care Plan Implications

This vignette illustrates the challenges present in obtaining all relevant information on the actual conditions of the LCP client. A physician’s clinical observations fall short in identifying how the emotional conditions of those surrounding the LCP client can restrict the flow of key information. Further, assumptions were made regarding the LCP client’s cognitive ability.

A proper LCP benefits from an environment conducive to subtle observations of a LCP client’s surroundings and the ability to pointedly and immediately follow-up with one-on-one interviews. Here the issue was not just one of the physical disabilities, but a cognitively compromised LCP client that the records had not thoroughly documented. The wife’s concern of allowing her husband to feel value in managing the home was such an emotional risk, she avoided sharing her concerns with his physician.

However, this dynamic impacted the consideration and level of independence that was really required to help manage his care. Further, it explained why the wife would never leave him alone unless a caregiver was at his side. The situation was not sustainable for the LCP client or his wife, and the physician was informed. During a provider’s follow up interview, the physician reported that she was not aware of any memory issues and would evaluate it during the next examination.

Therefore, keep in mind, the root cause of all errors, gaps, and failed milestones circle back to a data point that was unknown, misunderstood, misplaced, ignored, and or just simply not processed. The case manager can support the life care plan by facilitating the coordination of care and assurance that all relevant facts are under consideration in evaluating the most appropriate plan of care for the LCP client. The NLCP, in using the standards of practice, has the optimal skill set to ensure that critical data points within the home environment are not missed (Howland, 2015; IARP, 2015).

The Patient’s Environment

“Keep the air he breathes as pure as the external air, without chilling him”.

“Light has quite as real and tangible effect upon the human body...” (Nightingale, 1969b).

Nightingale pioneered the recognition that stale air or air fouled by odors emanating from a sick person’s body, extreme room temperatures, and inadequate sunlight all weakened patient healing. She ensured room ventilation, balancing cool, ventilated air with fire, and exposure to sunlight all became a standard part of nursing. Further, she saw that hygiene—cleaning the patient’s room, regularly replacing bed linens, giving regular baths, and
properly treating bodily wastes—was of paramount importance.

The home visit provides the opportunity to collect data, research, and to support the most appropriate recommendation in the home setting (IARP, 2015). It is necessary to have the LCP observe the patient’s environment to support the LCP client. This practice is reinforced and consistent with AANLCP standard 5B Health Teaching and Health Promotion (Howland, 2015) (See Table 1: The NLCP employs strategies to promote health and safety).

Case Profile: “The Mother/Daughter Challenge”

In a tragic role reversal, a 96-year-old mother must care for her 66-year-old daughter with a brain injury and subsequent Alzheimer’s disease. There were no other direct descendants to assist them in their small 2-bedroom home. The medical records noted the mother to be competent, alert, and not experiencing any dementia issues of her own.

The author in the role of a LCP planner developed an LCP for both mother and daughter which included the need for residential care based on their limitations for self-care. At the time, however, the family’s preference was to provide in-home care assistance. The accepted 2-year-old plan specified that meals were to be prepared and delivered by an outside service. Additionally, the plan included a caregiving services for 4 hours per day to support both women with activities of daily living, and ongoing case management to ensure the proper execution of the LCP. All arrangements had been implemented.

Since there were no conflicts in LCP and case manager role identified, the author, returned in the role of a case manager (Howland, 2015, p 50). She visited these women and discovered quite a different picture. The home’s atmosphere was somber with drawn shades, minimal lighting, and closed windows. The daughter wore adult incontinence undergarment that had not been changed in days. The family dog was spreading excrement throughout the house. The kitchen was filthy, the sink full of dishes. The mother appeared to be experiencing visual impairment. The mother’s cognitive functioning appeared compromised. She could not validate how often the caregiver came and the time being spent. The daughter, with known advanced dementia secondary to Alzheimer’s disease, could not be relied upon to confirm whether the prescribed care was being performed. According to neighbors who filed a complaint on an elder hotline, the caregiver was only checking in on Saturdays. The neighbors were concerned about the condition of the mother and the daughter.

According to the billing records, the caregiver received payment for daily support services. Based on the condition of the home, it appeared that the neighbor’s reports of activities were consistent with the adverse condition of the home and not the services claimed on the billing documents. Upon further review, an enormous conflict of interest was discovered. The caregiver made a financial arrangement to inherit the home upon the death of the mother and daughter. However, if the daughter and mother were admitted to an assisting living facility, the value of the home would be necessary to finance the assisted living arrangements. Therefore, the caregiver had a strong self-serving incentive to keep the mother and

<table>
<thead>
<tr>
<th>COMPETENCIES: THE NURSE LIFE CARE PLANNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

daughter in their home, even if it led to substandard care.

**Life Care Plan Implications**

The deficiencies of the caregiver contributed to the development of an inferior environment that promoted rather than prevent disease. Further, ethical issues and perhaps criminal issues appeared to have arisen in this matter with respect to ownership of the home. This case example is further complicated by quality of care provisions that impacted the original effectiveness of the LCP.

Having a written LCP sets the stage for a case manager to validate the execution of the LCP. The documentation of patient care—content, context, and condition of the care being provided—must be verified. Again, in person, on-site visits by a case manager are key for ensuring proper implementation. This example supports the inclusion of case management support services within a LCP. Prior bills provide data to support diagnosis attested to by the physician and procedure codes with pricing to support inclusion of costs of future services.

Substantiated healthcare bills maybe considered as an appropriate source as a basis for costing in a LCP. Specifically, the amount of the presenting charge by the provider with the corresponding CPT level charge maybe considered as a basis for presenting an usual, customary, and reasonable amount. The use of the "paid amount" is specifically associated with a court specified order, a case involving Medicare Set-Aside's, or a specific Workers Compensation required fee schedule. General use of the paid amount is not appropriate because it involves a contractual analysis of contracts in which the full consideration of compensation is not known. These payer contracts are not in the public domain and are considered proprietary.

Further, the diagnosis code on a presenting bill is considered an attested to diagnosis by the physician. The LCP planner may rely on these diagnostic conditions if they are also documented within the supporting clinical records. The NLCP may consider healthcare presenting charges, the use of diagnosis codes, and the associated rules (refer to resources noted under understanding healthcare reimbursement) in order to provide a foundation for the use of pricing data in costing out future services (Busch, 2017a).

**The Patient’s Advocate – Transition of the LCP to a Nurse Case Manager**

"Wise and humane management of the patient is the best safeguard against infection" (Nightingale 1969b).

Through writings like Notes on Hospitals (1859) and Notes on Nursing: What It is and What it is Not (1969), Nightingale advocated for a patient's human rights; that is, patient care and patient self-care beyond the specific treatments for a specific illness that she felt were necessary for long-term health. Nurses were well equipped to educate patients on preventive actions against illnesses, to encourage patients to participate in rehabilitation, and to assist them in certain aspects of administering to their own needs. She believed, and these efforts were most efficaciously carried out by professional nurses.

Today, the implementation of a LCP by a case manager can take the form of assisting a person to navigate the extraordinarily complex patient-provider-administrator-payer environment which can impede the very care it is trying to provide. Complex cases may include the collaboration (IARP, 2015) and transition of the LCP to a nurse case manager. This notion is also supported and consistent with AANLCP Standard 5A Coordination of Care (Howland, 2015) (See Table 2: The NLCP provides for coordination of the planned care and services throughout the lifespan).

**TABLE 2**

**AANLCP Standard 5 A: Coordination of Care.**

The nurse life care planner provides for coordination of the planned care and services throughout the lifetime.

<table>
<thead>
<tr>
<th>COMPETENCIES: THE NURSE LIFE CARE PLANNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Organizes the components of the plan.</td>
</tr>
<tr>
<td>2 Recommends a nurse case manager and/or qualified other(s) to implement the plan, manage transitions of care delivery, and provide for dignified and humane care by the multidisciplinary team.</td>
</tr>
<tr>
<td>3 Assists the healthcare consumer in identifying options for alternative care.</td>
</tr>
<tr>
<td>4 Incorporates services that maximize safety, independence, and quality of life.</td>
</tr>
<tr>
<td>5 Advocates for the delivery of dignified and humane care by the multidisciplinary team.</td>
</tr>
<tr>
<td>6 Documents decisions and actions related to coordination of care.</td>
</tr>
</tbody>
</table>

The case profile below illustrates the complexity of some cases in which require a LCP and a nurse case manager to collaborate for the welfare of the client.

**Case Profile: “The Doctor Who Couldn’t Get Care”**

Dr. S and Dr. G are two retired physicians. Dr. S is managing ongoing issues with weight control, hypertension, and adult onset diabetes. Dr. G. is managing long-term complication of juvenile diabetes. The discussion between them ranged from the diminished connectivity between the healthcare provider and the LCP client. Concerns they covered included: 1) providers spend more time with technology than the LCP client engagement, 2) the impact of third-party activities, including policies that do not directly assess the LCP client but dictate LCP client care, and 3) the impact these factors have on healthcare decisions.

Dr. G was unable to obtain Medicare approval to amputate his left toe/foot which had been developing gangrene, due to his age and general medical condition. “My life has value,” he told Dr. S. “I do not need my foot to enjoy time with my grandchildren.” Without an amputation, he said, he was given a death sentence. In fact, Dr. G did die one month later from complications of gangrene secondary to lifelong issues associated with juvenile diabetes.

Dr. G needed an active case manager advocating for services –introduced by Nightingale as petty management– within our convoluted system to obtain approval for his surgery. The organization of details to ensure care is implemented efficiently and in a consistent manner is referred to as petty management. Nurse life care planners can support the administration of a LCP by providing options on available resources that case managers can implement. Time is often a crucial factor in matters of health wellbeing. Patient advocacy is at the heart of nursing.

**Life Care Plan Implications**

Any successful endeavor involves planning the work and assuring the plan works. Nurse life care planners are no exception. Working the plan includes identifying new developments affecting the LCP client’s health and actively supporting recommendations for the LCP client to overcome known obstacles. This may be more important now than even in Nightingale’s time, given the increasing noise of healthcare delivery. Modern day application of this core competency is reflected in AANLCP Standard 5 Implementation (Howland, 2015) (See Table 3: The NLCP provides for implementation of the plan).

**Money Matters**

A patient managing their health care was a concept embedded in Nightingale’s (1969b) concept of petty management and is now embedded in current nursing practice standards. Modern-day petty management ensures that the LCP will make provisions to effectively manage the

---

**Table 3**

**AANLCP Standard 5. Implementation.**

The nurse life care planner provides for implementation of the plan.

<table>
<thead>
<tr>
<th>COMPETENCIES: THE NURSE LIFE CARE PLANNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

---

LCP client’s needs both with and without direct provider support. As a result, LCP considerations in the future may address how care gets paid.

Busch (2008) identified the increasing significance of financial considerations 10 years ago: “Financial case management (FCM), the management of patient health from a financial perspective, is a new and emerging component of patient healthcare management” (p.45). The following vignette focuses on the importance of financial case management.

Case Profile: “Injured Cop”

A 45-year-old police officer (Mr. P) was injured during a car chase after a shooting and robbery. A resulting verdict awarded him a significant trust, and he now resides in a rehabilitation facility in a near-vegetative state. He has a significant brain injury, is unable to walk or communicate, and is ventilator dependent. The medical treatment aspect of the LCP was and is in place and fully active. Ongoing management of the care was being provided and adapted with discussions with the various healthcare provider stakeholders and family members. Mr. P’s father and brothers – all four police officers themselves–were active in providing excellent management of his care. So why this vignette? Because Mr. P’s care and finances were not equally considered by the provider.

Resource utilization groups (RUGs) is a prospective grouping system with 66 potential groups that are defined by the level of intensity and characteristics of the services being provided (Medpac, 2016). In essence, they specify different flat rates per day, inclusive of all services, based on the intensity of therapeutic support provided.

The facility treating Mr. P chose to ignore the traditional RUG Group pricing and took advantage of what was perceived to be a very large trust. Mr. P was instead billed $15,000 for services at 100% of itemized gross charges. Upon review of the active services being received by the patient, the appropriate category was equivalent to a much lower RUG-defined intensity of service. The variance in price was an upcharge of $7,000 per month.

**Life Care Plan Implications**

The life care planner should consider the use of case management within a LCP as an effective gatekeeper in the financial management of healthcare episodes (AHC Media, 2009; VanGelder & Coulter, 2013). It is important for both life care planners and nurse case managers to understand the complexity of costing methodologies from both a planning and monitoring perspective. Medpac.gov (under payment basics) provides the general principles of understanding other reimbursement formulas. In addition, a NCLP with a medical billing background or with the assistance of a medical billing specialist, should be able to evaluate if the products and services charges for a healthcare episode, are usual, customary, and reasonable (UCR).

A *Usual* if it is a professional charge(s) for an in scope of practice service/procedure by an appropriately licensed and credentialed professional or; If it is a facility (e.g. hospital, outpatient, nursing home, rehabilitation, long-term care) for a defined facility based licensed scope of services/procedure, and

- **Customary** if it is within the range of fees, quantity, volume, and or coding that most professionals (CMS-1500) or facilities (UB-04, CMS 1450) in the geographic area charge for a given procedure; if it is a facility within a ranges of fees, quantity, volume, and or coding (UB-04, CMS 1450), in scope facility license; and
- **Reasonable** if it is usual and customary and or if it is clinically relevant, with informed consent, and clinically justified. Any special condition (e.g. a difficult procedure) will be articulated based on current practice standards (Busch, 2017b, p. 9).

In this vignette, the nurse case manager was able to effectively use the pricing information documented within the LCP. By understanding the traditional forms of healthcare reimbursement, the nurse case manager was able to lower the monthly payments to $8000.00, the relevant RUG group for that facility.

**Putting it Together**

“The art of nursing, as now practiced, seems to be expressly constituted to unmake what God had made disease to be, viz., a reparative process” (Nightingale, 1969b).

Nightingale (1969b) stated that disease is a reparative process that nature institutes upon people who fail to continuously take proper care of themselves and immediately attend to any of their health-related concerns. This view may lack universality today, the scientific evidence showing the causal link between microorganisms and disease was just becoming widely accepted in Nightingale’s time. Even so, Nightingale’s insights that a patient’s surroundings, environment, and self-care play a role, is as relevant in the era of genetics as it was in the mid-nineteenth century.

Case Profile: “Familial Catastrophe”

A married, 38-year-old father of two young children suffered a horrific injury while at work on a road construction site. He was accidentally attached to a heavy-duty machine paver by a belt and unable to detach himself. The driver of the paver continued to pour hot asphalt without hearing his co-worker’s cries for help. The injury had a devastating impact on his appearance: he was on a ventilator, his condition stabilized through an induced coma, 70% of his skin degloved, and he had unrecognizable facial features.
This vignette illustrates the importance of many of Nightingale's nursing principles as described in this article: 1) the importance of a first-hand understanding of the patient's surroundings through on-site interviews and visits, 2) the importance of understanding the impact of the patient's health issues on the people around him or her, and 3) the benefit of untangling the financial consequences major illnesses create, including managing assets that are set aside for long-term.

Most importantly, is the critical role nurses play. Follow-up time should be included when nurse case managers are involved in the management of LCPs and updating the LCP. This vignette is not implying that life care planners have a direct responsibility or legal role with respect to creation or management of trusts. The referring attorney in this vignette did take measures to protect the patient legally. In the course of following up and checking on the status of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP the discovery that the wife left with the death benefit of an executed LCP.

The tragic consequences of this injury enveloped the worker and those around him in a cascading series of catastrophes. His 36-year-old wife committed suicide on the first evening after she had seen the startling condition of her husband. A divorced female friend of the family, who was a rehabilitation nurse with a 10-year-old son, stepped in to help. She took in the patient's children, received temporary guardianship, and became active in helping him recover. During the five-year litigation and subsequent settlement, the nurse and the patient eventually married.

Provisions to create a trust on the settlement were arranged such that in the event of death, the nurse and her child would receive 20% of the trust. The remaining portion would be held in trust for his own children. During his post management, the patient continued to have ongoing pain management issues. Two years into the post settlement time period, the patient died of an accidental opioid overdose. The second wife gave up his two children and received 20% as noted within the established trust and estate documents. The children went into foster care until formal arrangements could be made.

Nightingale effectively established the foundational nursing principles as a core competency of nursing; the ability to evaluate the subjects (patients) condition and what those conditions (care healing, health management) require. This is the practice for LCP, specifically: “The life care plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs” (IARP, 2015.)

The development of clinical and financial management of the patient is the blended outcome in the development of an LCP by life care planners and the implementation of the LCP by nurse case managers. Nurse life care planners have long established the ability to support their opinions within a LCP. The context and conditions including the healthcare diagnostics articulate and support the future healthcare requirements of the patient. The opportunity to further refine best practice standards is a contemporaneous process with a duty for professionals to participate and contribute to the literature, as demonstrated through the vignettes.

### Resources on Healthcare Reimbursement and Suggested Reading

- American Association of Professional Coders [www.aapc.com](http://www.aapc.com)
- American Dental Association. [http://www.ada.org/~/media/ADA/Member%20Center/Files/430d_dental_claim_form_2012.ashx](http://www.ada.org/~/media/ADA/Member%20Center/Files/430d_dental_claim_form_2012.ashx)
- Code on Dental Procedures and...
Nomenclature (CDT) - The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA). Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

- American Health Information Management Association
  www.ahima.org

- American Medical Association
  www.ama.org


- Centers for Medicare & Medicaid Services. General practice standards
  – National Correct Coding Initiative (CCI Edits) www.cms.gov/correctcodinginitiative
  – Physician query process to prevent the submission of an improper claim


- Health Common Procedure Coding System (HCPCS) procedure codes
  – https://www.cms.gov/Medicare/Coding/HCPCSGenInfo/index.html

- Health Insurance Portability and Accountability Act of 1996 (HIPAA),
  – Administrative Simplification provisions on electronic healthcare transactions and code sets https://www.cms.gov/Regulations-

and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html

- “Fraud is defined as knowingly, and willfully executes or attempts to execute a scheme...to defraud any healthcare benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by...any healthcare benefit program.” Health Insurance Portability and Accountability Act 1996 (18 U.S.C., Ch. 63, sec.1347).

- HIPAA for professionals https://www.hhs.gov/hipaa/for-professionals/index.html

- HHS OIG Compliance Program Guidance Documents
  – For Third-Party Medical Billing Companies (63 Fed. Reg. 70138; December 18, 1998)


- Health Care Common Procedure Coding System (HCPCS) - This code set, established and maintained by the Centers for Medicare & Medicaid Services (CMS), primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes. For more information, see the link in the Related Links inside CMS section below. This file does not contain the CPT-4 codes. CPT-4 codes can be purchased from the American Medical Association at 1-800-621-8335.

- Current Procedure Terminology (CPT) codes- The CPT-4 codes are used to describe medical procedures and physicians services, and is maintained and distributed by the American Medical Association. For more information on the CPT-4 codes, please contact the American Medical Association (AMA).

- International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

- International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) are maintained by CMS and are used to report procedures for inpatient hospital services.

- International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

- Medpac: http://medpac.gov/-documents/-payment-basics

- National Plan & Provider Enumeration System (NPI #s) https://npiregistry.cms.hhs.gov/


- Universal Billing Committee (www.nubc.org). The appropriate presentation and submission of healthcare services as published by the

1. National Drug Codes (NDC). The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers.

REFERENCES


Value of CNLCP® Certification

As healthcare has become more complex, it is increasingly vital to assure the public that healthcare professionals are competent. Individual State Registered Nurse (RN) licensure measures entry-level competence only; and, in so doing, provides the legal authority for an individual to practice nursing. It is the minimum professional practice standard.

Certification, on the other hand, is a formal recognition that validates knowledge, experience, skills and clinical judgment within a specific nursing specialty; and, as such, is reflective of a more stringent professional practice standard. It affirms achievement of proficiency beyond basic licensure.

The Certified Nurse Life Care Planner (CNLCP®) Certification Board is a separately incorporated entity that facilitates consumer health and safety through credentialing/certification of nurse life care planners. It ensures that their practice is consistent with established standards of excellence in the development and defense of the life care planning document.

Similar to consumers knowing to seek out certification status within other professions (e.g., dentists, pharmacists), certification within the field of nurse life care planning has become an important indicator that a certified nurse not only holds state licensure to practice nursing, but is qualified, competent and has met rigorous requirements in the achievement of the CNLCP® credential.

The policies and procedures used by the CNLCP® Certification Board to construct and review items and examination forms for the CNLCP® examination are consistent with guidelines recommended by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education (AERA, APA, NCME; 2014) as well as other industry standards such as: Standards for the Accreditation of Certification Programs (National Commission for Certifying Agencies, 2014) and Conformity assessment — General requirements for bodies operating certification of persons (ISO/IEC 17024).

AANLCP® supports certification through the CNLCP® Certification Board.

CNLCP® is a registered trademark of the CNLCP® Certification Board.
ISSUE INDEX

2012
XII.1 Coding and Costing
XII.2 Electrical Stimulation Technology
XII.3 Preconference / Brain Injury
XII.4 Veterans Administration

2013
XIII.1 LCP for Motor and Developmental Disorders
XIII.2 Ethical Topics in LCP
XIII.3 Preconference / Exemplars in NLCP
XIII.4 Home Modifications

2014
XIV.1 Technology Updates
XIV.2 LCP Across All Ages
XIV.3 Psych topics in LCP
XIV.4 LCP and the ACA

2015
XV.1 Topics in Transplantation
XV.2 Updates in Spinal Cord Injury
XV.3 Burns
XV.4 Perinatal / Childhood

2016
XVI.1 Pain
XVI.2 GI issues
XVI.3 International LCP
XVI.4 Home Care

2017
XVII.1 Brain Injury
XVII.2 The Business of Life Care Planning
XVII.3 Back and Spine
XVII.4 Mobility and Extremity Function

2018
XVIII.1 Costing and Coding