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Managing the Notion of UCR in a Life Care Plan

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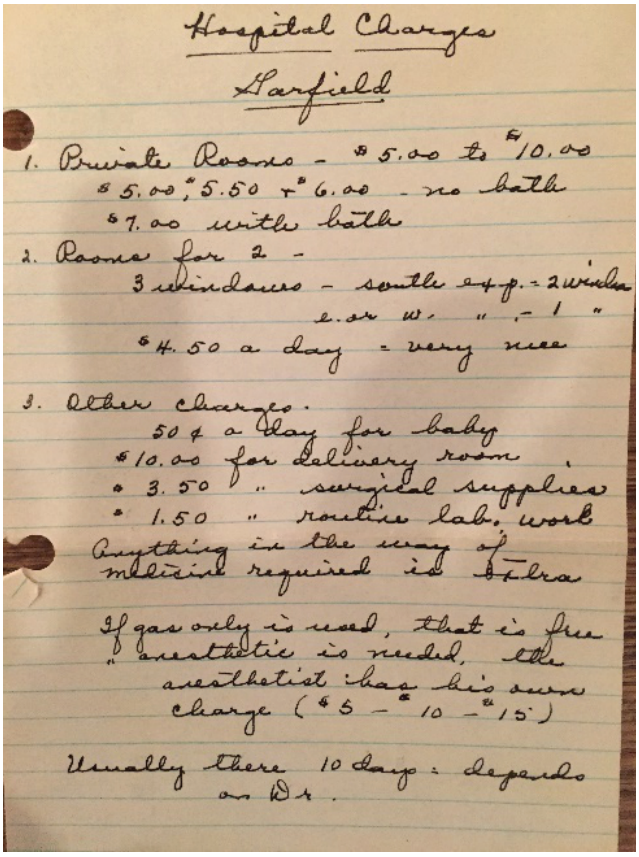
Abstract

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 his 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:

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.

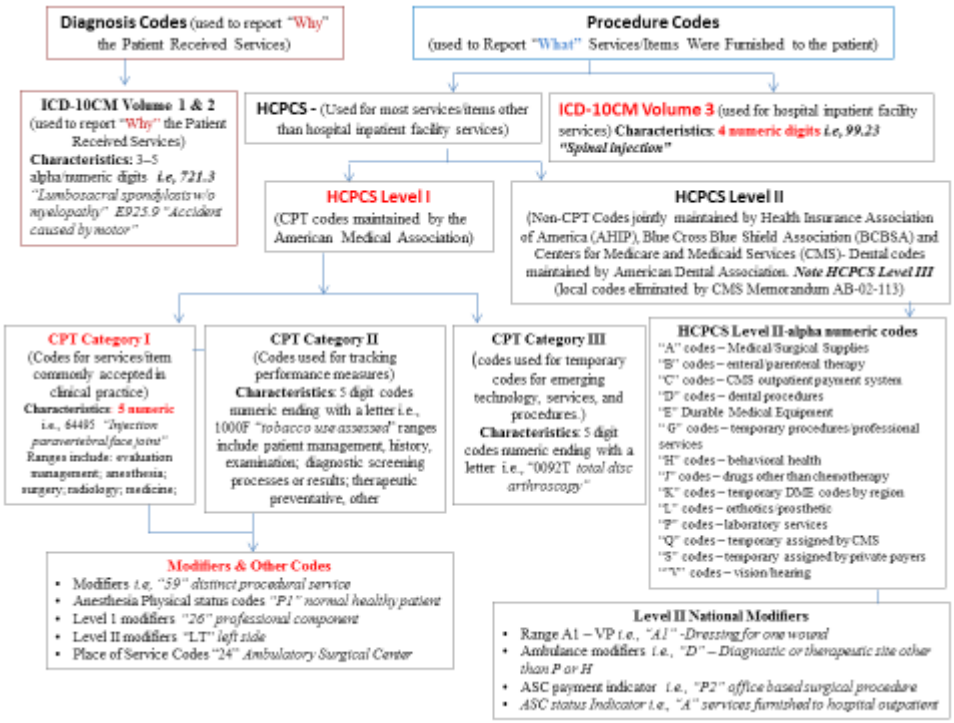
The concept of grouping services by a grouping method evolved from the inpatient facility into the ambulatory surgical setting. This prospective grouping system is referred to as Ambulatory Surgical Center (ASC) payment systems (Centers for Medicare & Medicaid Services, 2016d). The prospective payment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

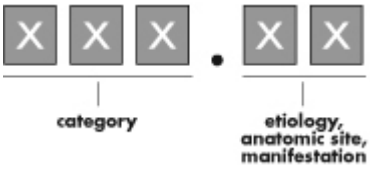
The International Classification of Diseases Clinical Modification (ICD-CM)

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 ninth revision (ICD-9-CM) Volume III (prior to 10/1/15) procedure codes consisted of four numerical digits with a decimal point separating the second and third digits.

Digit 1 & 2	Digit 3 & 4
Type of procedure	Procedure details

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.

Character 1	Character 2	Character 3	Character 4
Section or category	Body System	Root Operation	Body Part

Character 5	Character 6	Character 7
Approach	Device	Qualifier

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.

I. 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.

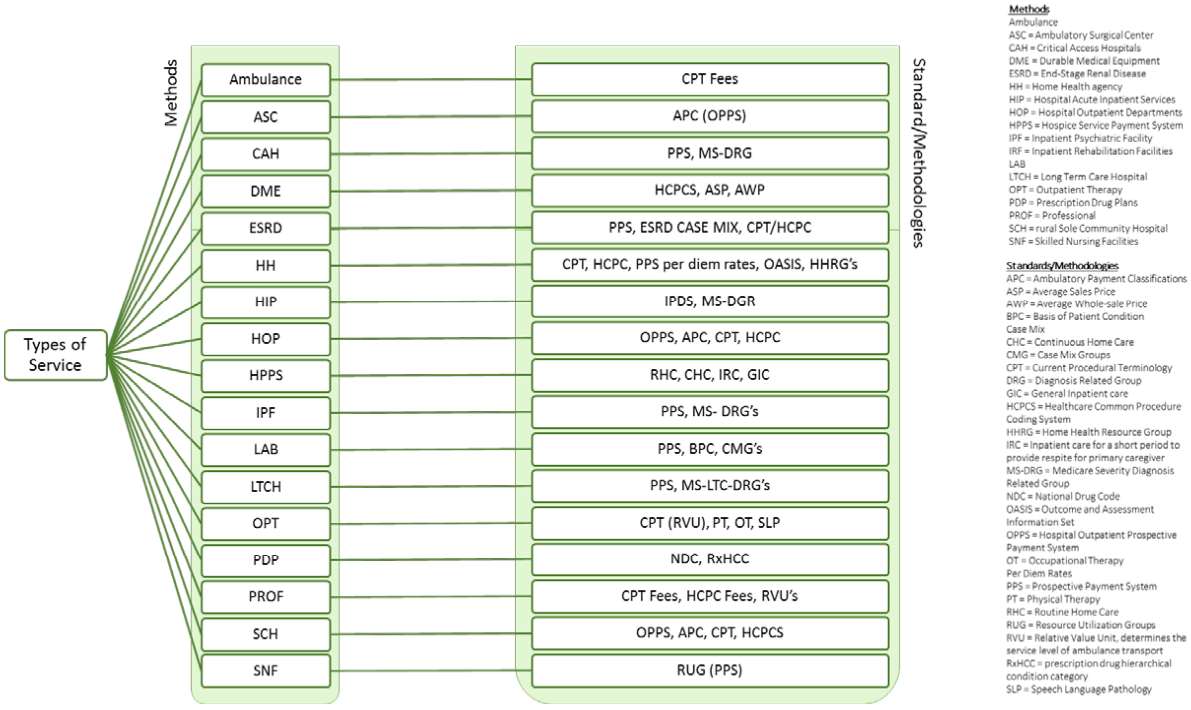
- Modifiers document extenuating circumstances involved with a service or additional definitive information. The modifier may or may not impact pricing. The practice standards and rules tells us how we are allowed to communicate the "what" and the "why".

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)
- **CPT –** Current Procedural Terminology (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 (HIAA) (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 of 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, formulary 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.

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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

• American Health Information Management Association www.ahima.org

• American Medical Association www.ama.org
Current Procedural Terminology: CPT Manual

• Centers for Medicare & Medicaid Services. General practice standards
National Correct Coding Initiative (CCI Edits) www.cms.gov-correctcodinginitiative

• Health Common Procedure Coding System (HCPCS) procedure codeshttps://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/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
-HIPAA for professionals https://www.hhs.gov/hipaa/for-professionals/index.html

• HHS OIG Compliance Program Guidance Documents
- for Individual and Small Group Physician Practices (65 Fed. Reg. 59434; October 5, 2000)
- for Third-Party Medical Billing Companies (63 Fed. Reg. 70138; December 18, 1998)

• ICD-10-CM Official Guidelines for Coding and Reporting FY 2016 https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf

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

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

• State Department of Insurance Illinois Department of Insurance.http://insurance2.illinois.gov/HealthInsurance/Usual_Customary_Fees.asp

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

• World Health Organization.
http://www.who.int/classifications/icd/en/