Healthcare service costing: Pricing perspectives and case studies for life care planners

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Abstract

For forty years, one goal that all life care planners have had is the measurement of future costs projections. The discussion of damage calculations dates back to the work of Dr. Paul Deutsch with the introduction of principles in life care planning. Embedded within current day standards are reference to associated costs for services identified in a life care plan. The growing availability of healthcare pricing databases has the potential to improve aggregated charge data access to support future cost projections. This paper provides guidance to the life care planner in determining costs for these goods and services through use of commonly used costing databases. It describes steps by which a life care planning practitioner, by following a structured methodology which utilizes these healthcare pricing databases, can make reasonably reliable cost estimates of professional and facility-based medical services. Case examples will provide further illustration for a professional service and a facility based service.

An accurate life care plan seeks to fully capture the specific needs of the injured party over their lifetime. Life care planning has emerged as an effective method for identifying and outlining future care needs and costs (Weed & Berens, 2018). The life care plan addresses the changing needs and expenses of an individual with long-term, often severe or chronic health care needs. According to the International Association of Rehabilitation Professionals (2021), life care planners are involved in the evaluation of individuals with disabilities or chronic health conditions to prepare a life care plan to document the needs created by the disability.

Historically, to prepare a life care plan, the life care planner made telephone calls to hospitals to collect pricing information. Today, pricing databases on the internet provide another opportunity to understand the prices of medical goods and services. The introduction and availability of such tools has led life care planners to follow a structured process that can withstand scrutiny, as, for example, the kind of scrutiny undertaken during a legal deposition. It is important for the life care planner to provide appropriate basis for their opinions and be able to articulate the costing methodology or process used. A five step life care plan costing methodology framework is described below.

The availability of master databases and sophisticated look-up programs which access these databases have influenced the task of life care planning over the last two decades. Rapid increases in availability of such tools and pricing information may lead some industry professionals to mistakenly believe that these tools can fully substitute for the experience-based judgment of a seasoned life care planner, and that the task of life care planning can be reduced to mere clerical activity. This is far from true. The power of healthcare pricing databases derives from the billions of claims providers submit annually, but there are limits that must be addressed by the experienced life care planner. These limits include a reduced sufficiency of claims when very narrow geographic regions are being searched (e.g., down to the zip code level), as well as the need to judge the coding intensity associated with complications and co-morbidities of the medical service being provided, which will manifest itself in the spread of prices captured (e.g., percentiles).

The term "coding intensity" measures the level of monetary risk against the level of care involved with various diagnostic and procedures codes. Within healthcare reimbursement, healthcare services are associated with a risk factor. The more complex the care and the condition, the higher the utilization of healthcare services, which results in higher reimbursement. The life care planner should rely on their understanding of a health care condition to develop a life care plan while also understanding that other factors are included in final prices. Specifically, the amount of resources involved to treat a particular condition will impact the services to support the condition (Kronick & Welch, 2014).

A methodology meeting these requirements of accuracy and reproducibility was put forward by (Busch, 2018a) and included five steps:

Step 1) Define the health condition and scope of the life care plan.

Step 2) Identify the data necessary to support the life care plan.

Step 3) Determine parties to be interviewed.

Step 4) Conduct analysis to prepare the life care plan with services designated.

Step 5) Define market comparisons, analysis, and generate life care plan report.

As this paper focuses on the utilization and impact of health care pricing databases, it will only briefly describe steps 1, 2, 3, and 5, and concentrate on Step 4.

Steps 1-3) – Define health condition, scope, necessary data, and environmental information sources

The essential starting point for any life care plan, steps 1-3 involve collecting all historical medical information and adding direct observations by the life care planner. While the life care planner is not seeking to make any medical judgments, they are adding the perspective that the evaluee's environment is a critical element in determining how the evaluee will progress with their illness or injury. This environmental review includes all aspects of their home, their workplace, and the family and friends who will play a large role in the evaluee's convalescence.

There are many databases and several sets of codes to assist the life care planner. The difficult challenge is which ones to use. The fundamental process is to proceed from the description of the nature of the medical condition to diagnostic codes; from diagnostic codes to procedure codes; and from procedure codes to the Usual Customary and Reasonable (UCR) charges for the type of provider in the type of facility in the appropriate geographical region. Each of the various databases and code sets typically address only a subset of all possible

combinations of variables above. The life care planner must identify which are required for the specific case and allow for access to them.

Step 4 – Conduct analysis to prepare the life care plan with services designated.

Once the clinical requirements of the evaluee are determined by the life care planner, the life care planner, following the IALCP Standards of Practice (International Academy of Life Care Planners, 2015), needs to estimate the future healthcare costs through a deep understanding of several things: the specific services that are required as part of an individual's treatment and ongoing care; the types of medical professionals who will be involved; the geographic area where the services will be rendered; the type of facility required (e.g., inpatient or outpatient); and the medications or additional equipment required during or after the individual's ongoing care. In itemizing services within a life care plan, delineating services by procedure codes (when applicable) is helpful for finding relevant pricing benchmarks in the various databases.

The life care planner may access databases to obtain the UCR charges associated with a selected procedure or grouping code. A healthcare service or products procedure code selection should be:

- Usual if it is an in-scope service or procedure by an appropriately licensed and credentialed professional or facility (e.g., hospital)
- Customary if the level of planned activity, or coding that most professionals (CMS-1500) or facilities (UB-04, CMS-1450) in the geographic area perform for a given procedure
- Reasonable if it is clinically relevant and clinically justified. Any special condition (e.g., a difficult procedure) will be articulated based on current practice standards (Busch, 2018b).

These charges, and their sum, are the ultimate output of the life care planner's work, but even this look-up task requires experiential judgments as to whether the charges found fully capture the medical issues at hand. If not, modifications could be appropriate. Included in this last step might be selecting a higher or lower percentile price depending upon the Life Care Planner's sense as to whether the condition experienced by the evaluee is an "average" manifestation. The life care plan assessment should evaluate the potential for an outlier (e.g., higher intensity of service) case. Centers for Medicare and Medicaid Services has recognized that outlier cases exist and as a result allow for adjusted compensation. In one specific example, the average inpatient stay for wound debridement was 10 days, but extensive complications led to a stay of 60 days. It is not unusual for individuals with complicated conditions or traumatic injury to consume a higher intensity of service (CMS, 2022).

Step 5 – Define market comparisons, analysis, and generate life care plan report

Consistent with any scientific approach, the report must allow the reader to follow the logical path used by the life care planner. As such, the report should include an introduction; a statement of the scope of work; a list of the data sources utilized; methodology; the observational and analytical results; final conclusion; and any reference material that would allow the reader to further investigate.

The five-step process described above provides an overall structure to ensure the efficacy and sufficiency of data gathering in the preparation of the life care plan. The next section will narrow the knowledge gap that appears to exist in the use of price and costing data repositories in the final preparation of a life care plan.

Pricing portion of the life care plan

The life care plan lists professional and facility services required to care for the affected individual. (Note that this paper refers to provider and facility prices for inpatient services only. The application of the principles presented may vary for services that are categorized as dental, outpatient, durable medical equipment, and pharmaceuticals. These types of services are not covered in this paper. Database repositories contain details regarding the prices charged for millions of such professional and facility services. The bridge between the two is a set of standardized codes known as Diagnosis Codes (Optum 360°, 2021) and Current Procedural Terminology (CPT) (American Medical Association, 2019). Diagnosis codes (why the services were rendered) and CPT codes (what services were rendered) are not discretionary; they are common nomenclature used by healthcare providers to standardize the communication of what services were rendered. The databases aggregate prices by these same codes, allowing for the life care planner to move from the medical service codes embedded in the life care plan to their prices as found in the databases.

After performing an appropriate service for a patient, healthcare providers submit a claim, using form 1500/1450 from the Centers for Medicare and Medicaid Services (CMS). Among other data included on this claim form are procedure codes and a billed amount, also referred to as a "charged" amount or the "presenting" price. The pricing information is then collected and aggregated by CMS and others, such as Fair Health and Context 4 Healthcare, from these claim forms. All of the price information is aggregated by codes, allowing a broad look at what prices have been charged for the same standard procedure in millions of instances. A life care planner seeking benchmark market data for the price of a service in a prepared life care plan would select a service code, then look up the pricing data for that CPT code in a given geographic area (zip code) for a given year.

For the purpose of pricing the life care plan, the "billed" or "charged" amount within the data repository is most often utilized, avoiding the use of paid amount, discounted amount, or contractual amount. (Note: Collateral source rule is changing and in many jurisdictions, life care planners may be directed to only include the paid amount. That is now going to be jurisdictional; this is a deviation from how things have been in the past and how life care planners were trained.)

Federal laws and regulations require hospitals to maintain uniform electronic charge transmissions. What a hospital actually receives in payment for care, however, varies and can be impacted by many factors. For example, a hospital may choose to become a Medicare or Medicaid provider and accept the payment beneficiary rate for that program. Private insurance companies may negotiate discounts. Evaluees may be responsible for the entire bill, regardless of what their benefit plan covers but tax-exempt healthcare providers may be expected to pursue assistance for those individuals who are eligible for public assistance. It is common practice for providers to submit total billed charges for each service provided, no matter if circumstances like those above strongly influence the amounts received. In fact,

even those databases that have the "amount paid" information from the provider may not include all the financial consideration received by the provider.

Other factors may impact the amount a provider is paid for services rendered. Medicare providers may receive additional remuneration upon review of the Medicare Cost Report, specifically disproportionate share income payments. Private payers may have other carve outs (portion of a bill not considered or paid separately) or remuneration (additional payments/incentives) reconciliations at year end. Because the life care planner is not privy to such transactions, the billed amount is the one typically be used.

The hospital data repository payment system is referred to as the Inpatient Prospective Payment system (IPPS). Under the IPPS, each inpatient encounter is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare individuals in that DRG (CMS Centers for Medicare & Medicaid Services, 2021a). A key part of IPPS is the categorization of medical and surgical services into DRGs. The DRGs "bundle" services (labor and non-labor resources) that are needed to treat an individual with a particular disease. The DRG payment rates cover most routine operating costs attributable to individual care, including routine nursing services, room and board, and diagnostic and ancillary services (U.S. Department of Health and Human Services, 2001). The life care planner needs to select the appropriate DRG based on inpatient services along with the intensity that is clinically required. DRG information can also be found in claims data (CMS 1450). The life care planner can use the DRG information to find appropriate pricing data.

Pricing Professional Resources

(This article will illustrate several data sources for case study purposes only. It is not an endorsement of any particular source nor is it a literature review of all potential sources that exist.) The pricing data can be ascertained by using different databases and resources. The key point of any data source is to understand the format and the ability to isolate appropriate pricing data by various established coding systems (ICD, CPT, HCPC). The rules of how to properly present a service by coding language should parallel the presentation of the service on a life care plan. For example, if a surgeon performs a surgical procedure, the CPT code will access pricing data for that procedure. The life care planner should recognize that the surgeon will perform the procedure in a facility, therefore, the life care plan will have a facility charge next to the professional charge. If the service is an office visit exam, the life care plan should recognize that the office examination does not require an inpatient facility to perform the exam and a different outpatient facility fee may best represent the office visit.

The following databases will be utilized to show select pricing in the illustrative case example. An explanation of how to use each data base will include:

- Optum 360 National Fee Analyzer Charge Data for Evaluation Fees Nationally
- Context4 Healthcare Medical Fee Directory UCR & Medicare Fees 2021 publication
- Optum data at Illinois Workers Compensation Commission (www.iwcc.il.gov)
- FairHealth data base (also collected through Ingenix which is associated with Optum)

Life care planners can access pricing information from subscriptions (Context4 Healthcare, Fair Health), books available for purchase (Optum 360 National Fee Analyzer Charge Data for Evaluation Fees Nationally, discontinued after 2020, and Context4 Healthcare) or can be obtained from public sources (Illinois Workers Compensation Commission – Optum data) or public use file with various Departments of Health.

The following is a step-by-step illustration of determining Usual, Customary, and Reasonable prices (UCR) for prospective professional healthcare services contained within a life care plan. Consider an individual who has sustained an orthopedic knee crushing injury as a result of a motor vehicle accident. As part of ongoing care, the evaluee typically follows up with a physician for their knee injury and the treating physician anticipates that the individual will require a knee replacement surgery in the future. This article shall illustrate how to determine pricing for one professional service and one facility charge using different pricing resources.

First, the life care planner needs to determine the life expectancy of the individual as it will impact the number of visits and procedures required as part of the individual care. Sources like the Centers for Disease Control and Prevention (2022) provides reliable data on population health and mortality in the United States.

The life care planner determines the services required for the evaluee by evaluating the medical records, consulting with healthcare professionals and using their experience and clinical judgement. Historically, life care planners have relied on the healthcare professional recommending the service for the CPT code, the healthcare professional's business office staff, or a coding expert resource. The life care planner can gain knowledge by obtaining a CPT manual (or online reference tool) and learn to search the name of the procedure. Often a list of codes to reflect that service is listed. The life care planner can use that list in their discussions with healthcare providers or a coding specialist to finalize the most appropriate code. After selecting the appropriate CPT code, the life care planner needs to consider the geographic area where the service will be rendered. The life care planner should consider the evaluee's zip code to collect service pricing data unless a specific provider (such as a prior claim form/billing statement for similar services) is identified. CPT code charges vary based on geographic area and time period (year). Depending on the resource, a geographic adjustment factor may need to be applied to the price to calculate the adjusted fee (at a present cash value). (For a contrary example, FairHealth geo zip is applied at time of query, so no Geographic Adjustment Factor would be necessary).

A data repository provider, such as FairHealth, usually provides pricing information for different percentile amounts (Optum 360°, 2020). A given percentile refers to the percent of total observations falling at or below the average.

The final life care planning assessment determines that the evaluee is expected to require an annual orthopedic follow-up office visit by the treating physician. Further, the annual orthopedic visit was confirmed through consultation with the provider and interview of the individual. The code 99213 was determined by the life care planner because the individual requires an office visit to follow up for focused examination with their treating physician. This article illustrates how to find the pricing information for the office visit (Professional Service CPT Code 99213: Established individual office or other outpatient visit, 15 minutes) using different pricing resources (pricing data repositories). Regardless of pricing data source, the life care planner should understand the life care plan data required and how the

life care plan data can be obtained to calculate future healthcare expenses.

Pricing Professional Service Using National Fee Analyzer

The life care planner needs to select the appropriate CPT code for the service required. In this case, the life care plan assessment confirmed the use of CPT Code 99213 by the review of the claim form. It is evident that the individual's treating physician has billed this CPT (99213) for a price of $255 and the service was rendered in the year 2020 (The pricing information for this service is $255 and this information was noticed while examining the medical bills). The life care planner needs to consider the geographic area and find the Geographic Adjustment Factor (GAF). GAF are aligned with national average percentiles amounts found in National Fee Analyzer with local fees (Optum 360°, 2020). According to National Fee Analyzer, the geographic adjustment factor for the zip code 60559 is 0.982 (Optum 360 National Fee Analyzer Charge Data for Evaluation fees nationally 2020). This resource only provides weighted geographic adjustment factor. As discussed earlier there are different national percentiles (50, 75, 90th percentiles), which will impact the pricing data for the CPT code.

Table 1

CPT Code 99213 Pricing using National Fee Analyzer

Year	**2020**
Geographic Adjustment Factor (GAF)	0.982
50th percentile Price (CPT price * Geographic adjustment factor)	($139 * 0.982) **$136.50**
75th percentile Price (CPT price * Geographic adjustment factor)	($176 * 0.982) **$172.83**
90th percentile Price (CPT price * Geographic adjustment factor)	($220 * 0.982) **$216.04**

If the condition (coding intensity) of the evaluee indicates that 90th percentile price for the given CPT code at the given geography is appropriate, then the relevant price is $216.04. In evaluating the cost, the life care planner may take into consideration the annual inflation rate. To illustrate, the inflation rate for the United States is 7% for the 12 months ended December of 2021 (US Inflation Calculator, 2022). Adjusting for inflation, the price for the CPT code is $247 (2021 adjusted). This charge is determined to be Usual Customary and Reasonable (UCR) price. The life care planner further evaluates that the provider's current fee schedule of $255. This amount is within 20% of the cost data and therefore the life care planner may select the current provider charge of $255 for the cost of CPT code 99213. However, in the absence of a known provider of care fee, the use of the determined UCR price ($247) would be appropriate.

Pricing Professional Service Using Context4 Healthcare

As an alternative, the life care planner can perform a similar process with another database, for example Context4 Healthcare. This data source is available in a cloud-based format and is accessible from any web-based platform. This resource will provide information

on UCR pricing for medical and dental services. Parameters such as procedure code, service date, zip code, and percentile must be entered by the life care planner and the C4 Reference-Based Pricing Online Fee Viewer will return pricing for that service (based upon 2021 pricing data) (Context 4 Healthcare, 2021).

Context4 Healthcare Medical Fee resource provides several potential adjustment factors. These adjustment factors impact specific cost factors contributing to the intensity of the service and reimbursement rate. In essence, the following categories provide healthcare providers additional consideration for higher reimbursement. The consideration are already included in the price listed in the data resource. One is the Geographic Practice Cost Index (GPCI) for the work component of the procedure or service; another is the GCPI for the Practice Expense component; a third is the geographic factor for component of malpractice expense. Finally, the source provides weighting factors from the CMS report of review of alternative GPCI payment locality structures. The weighted average is the same from both resources; however, this calculation is using the geographic factor to illustrate additional cost the provider may incur.

Table 2

CPT Code 99213 Pricing using Context4 Healthcare

Year	**2021**
Geographic Adjustment Factor (GAF)	1.871
50th percentile Price (CPT price * Geographic adjustment factor)	($139 * 1.871) $260.07
75th percentile Price (CPT price * Geographic adjustment factor)	($175 * 1.871) $327.43
90th percentile Price (CPT price * Geographic adjustment factor)	($224 * 1.871) **$419.10**

As noted above, the 90th percentile price for the given CPT code is $419.10.The provider's current fee schedule of $255 is supported by data abstracted found within the data repository. Therefore, the life care planner may consider the use of the currently known physician price as an acceptable data point in the life care plan.

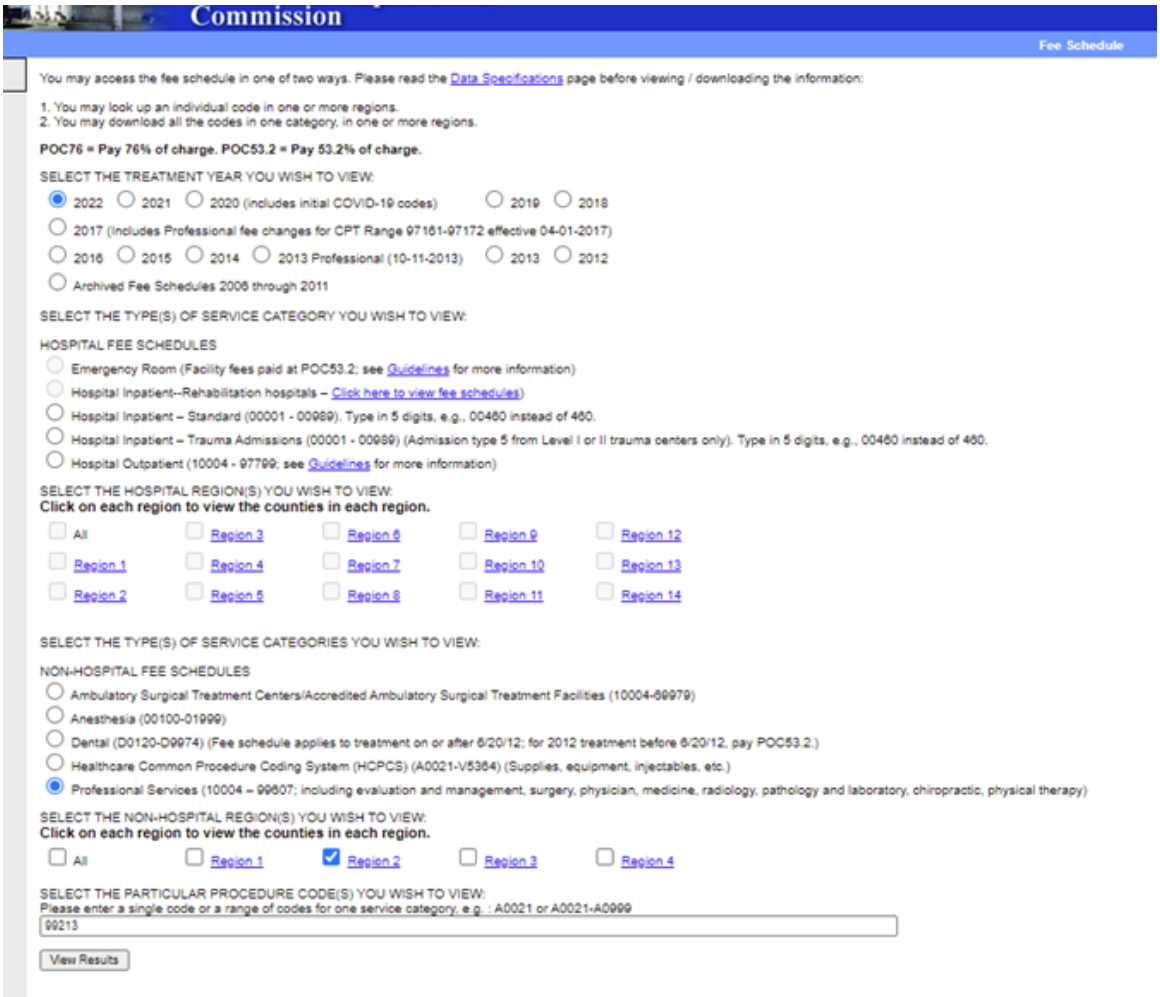
Currently none of the databases provides guidance in selecting a percentile - it is left for the user of the data to make this determination. The coding intensity of the health condition being evaluated or treated should be considered when selecting a percentile to use.

Pricing Professional Service Using Illinois Workers Compensation Commission (Optum Data)

In order to find the pricing information using this database, the life care planner needs to follow these steps: **Step 1:** Thoroughly and carefully read the instructions on the data source. In using this data repository, like all others, it is important to understand the context and condition of any data source, which includes the published disclaimers and the definitions. The life care planner should consider this understanding with utilizing any database (Illinois Workers' Compensation Commission, 2021b). Acknowledge that the life care planner (or the reader) has agreed, understands and abides by the website's terms and

Figure 1

Workers compensation Data from Optum



conditions. The website also states that this information is proprietary to Optum and certain restrictions apply. Once the life care planner accepts the terms and conditions, the webpage will look like figure 1.

This data source does not present data in percentile format. Further, it uses the unique term POC, defined as percentage of charge. By Illinois state law, whenever the Commission is unable to calculate a fee for a procedure, payment defaults to POC. If the fee schedule states POC76, the price is anticipated at 76% of the provider's charge. If the fee schedule states POC53.2, price is anticipated to be 53.2% of the provider's charge.

Step 2: Select the appropriate treatment year to view. In this case, the life care planner can select the year as 2022 in order to obtain the most recent available data.

Step 3: Select the service category. The life care planner will notice that there are five different types of service category:

- Emergency Room (Facility fees paid at POC53.2; see Guidelines for more information)

Figure 2

Hospital Region

- Hospital Inpatient–Rehabilitation hospitals
- Hospital Inpatient – Standard (00001 - 00989). Type in 5 digits, e.g., 00460 instead of 460.
- Hospital Inpatient – Trauma Admissions (00001 - 00989) (Admission type 5 from Level I or II trauma centers only). Type in 5 digits, e.g., 00460 instead of 460.
- Hospital Outpatient (10004 - 97799; see Guidelines for more information) (Illinois Workers' Compensation Commission, 2021a)

The follow-up office visit is categorized under "**Hospital Outpatient**".

Step 4: The Hospital Region is categorized based on the geographic area (County). The life care planner can click on the Region to find the different counties under each region.

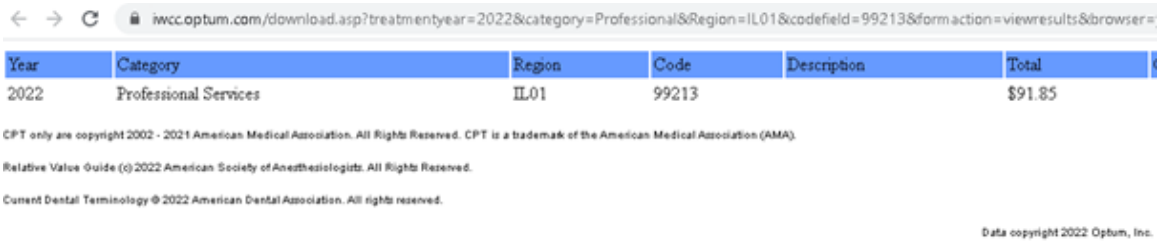
In figure 2, the life care planner can select Region 1, since the Zip code 60559 is included in Cook County.

Step 5: Select the appropriate CPT to view pricing information. For this case, the life care planner selects the CPT Code as 99213 and the year 2022.

CPT Price for 99213 is $91.85. * 1.468 = $134.76 plus market deflation of 30% = $173 figure 3: CPT pricing information

Figure 3

CPT pricing information



Based upon on the coding intensity of service expected, the price determination appears to be low. The known current provider current fee schedule of $255 can be considered for the life care plan.

Pricing Professional Service Using FairHealth database

FairHealth is another price look-up tool and it requires a subscription to use the pricing database. FairHealth data is also collected through Ingenix which is associated with Optum. If this process is repeated by using FairHealth database, the life care planner would complete the following process.

Once the life care planner logs into the website, they need to select the appropriate benchmark. This would include the current year of service and the selection of the appropriate zip code for the CPT code identified. Once the benchmark is selected, the life care planner inputs the first three digits of the zip code and the CPT. The website will automatically calculate the prices. The Fair Health lookup tool provides CPT Price information that takes into consideration the geographic adjustment factor and hence eliminates the need for the life care planner to make any further adjustment for that.

Table 3

CPT Code 99213 Pricing using FairHealth Database (Geozip 605)

Year	**2021**
50th percentile	$153
60th percentile	$157
70th percentile	$157
75th percentile	$157
80th percentile	$157
85th percentile	$165
90th percentile	$187
95th percentile	$200

Based on the expected intensity of service, the price determination appears to be low. The known current provider fee schedule of $255 could be considered for the life care plan.

Pricing Facility Services

This article has demonstrated how the price for professional services along with the proper CPT code identified by the life care plan can be derived by using multiple costing databases. The construction of a facility bill is different than a professional bill. Therefore, the costing databases are also different. In contrast to professional bills, where the procedure code drives the reporting of charges, on the facility side it is the diagnosis that drives the databases. Specifically, the combination of diagnosis and projected invasive procedure lead towards the selection of a DRG (Diagnostic Related Group) that will provide access to the costing data. The following is a step-by-step illustration of determining UCR pricing for a projected facility service contained within a life care plan. This illustration will introduce a source that is focused solely on facility charges and is publicly available.

Many facilities have a charge data master (CDM) that contains a list of charges with various data points. Each inpatient bill also lists a final DRG code (CMS Centers for Medicare & Medicaid Services, 2021a). The correct categorization of charges by revenue code and DRG are not discretionary and inpatient data that is collected by DRG is therefore considered reliable. Pricing information on inpatient stays may be obtained from the National Medicare Provider Analysis and Review (MedPAR) file (CMS Centers for Medicare & Medicaid Services, 2021b). This file contains records of Medicare-covered inpatient discharges in the United States. The records collected by the MedPAR file contain individual records with up to nine diagnosis codes, up to six procedure codes, claim costs and charges, the DRG, the length of stay, and many other admission-specific parameters. Data repositories also include claims information that contains the hospital's provider number, making it possible to correlate diagnoses with providers. MedPAR tracks discharges rather than individuals, making a distinct record available for each individual encounter. For example, if an individual is admitted and discharged in January and is again admitted and discharged in September, MedPAR will produce two records for this individual (CMS Centers for Medicare & Medicaid Services, 2021b). Be aware, however, that MedPAR also collects reimbursement data that should not be utilized because it excludes additional remuneration and consideration provided via the Medicare cost report. Further, the most current aggregated listing of charges by CMS is available from 2016. Consider inflation factors (or assistance from an economist) in bringing the rate forward to the relevant base year of your life care plan.

Pricing inpatient facility service

The life care planner evaluates the medical records, physician notes and depositions. In this case, the treating physician states that the individual will require a knee replacement surgery and the life care planner should include the pricing information for this surgery. For the purposes of this hypothetical case, the individual will be admitted to the inpatient facility, although many knee replacement surgeries are performed in an outpatient setting today. It is a clinical judgment as to whether such surgeries should be performed in- or out-patient. The choice of inpatient surgery here is for illustrative purposes only. It is clear that inpatient facility bills will be assigned a DRG. Selecting an appropriate DRG is the basis to find pricing data for facility services. In the case of a replacement surgery, the life care planner can review the list of DRG groups and identify the most relevant grouping for the individual's condition. If new to the use of DRG groups, seek the consultation of an inpatient coder to narrow down

the list of appropriate DRG groups.

Considering the individual's condition, complications, and comorbidities, there are two possible DRG groups that can be assigned. **DRG 470** for Major Joint Replacement or Reattachment of Lower Extremity without MCC or **DRG 469** Major Joint Replacement or Reattachment of Lower Extremity with MCC. As discussed earlier, MedPAR consolidates Inpatient Hospital or Skilled Nursing Facility (SNF) claims data from the National Claims History (NCH) files into stay level records (CMS Centers for Medicare & Medicaid Services, 2021c).

Table 4

CPT Code 99213 Pricing using FairHealth Database (Geozip 605)

DRG	Total Charges	Total Days	Number of discharges	Average Total days
470	$41,677,370,579	1,919,949	712,398	2.7
469	$3,437,391,243	250,136	36,782	6.8

The life care planner can use the publicly available information (CMS, n.d.e) to calculate the DRG average rate and DRG per diem rate for DRG group 470. "DRG Average Rate" can be calculated "Total Charges"/Total Number of Discharges ($41,677,370,579 /7 12,398 = $58,503). "DRG Per Diem Rate" can be calculated by "Total charges"/ "Total days" ($41,677,370,579 / 1,919,949 = $21,708).

Similarly, DRG Average Rate and DRG Per Diem Rate for DRG group 469 can be obtained: DRG Average Rate ($3,437,391,243 / 36,782 = $93,453) and DRG Per Diem Rate ($3,437,391,243 / 250,136 = $13,742)

In this example, the care plan assessment concluded that the individual has significant co-morbidities, including an unstable traumatic injury and diabetes. A clinical judgment on the coding intensity (not a standard procedure for life care planners) could lead to the individual being coded into a higher weighted DRG group. Therefore, the individual is more likely to fall into DRG 469 group. The pricing data for DRG 469 is $93,454. The life care plan should list the facility fee along with the professional fee representing the surgical procedure within the life care plan.

Pulling It All Together

Life care planners recognize that accuracy in future cost projections is essential. Effective utilization of healthcare billing repositories requires the life care planner to understand the existing coding nomenclatures which communicate "what" was done to the evaluee and "why." As current healthcare practices already provide different codes for different intensity of service, and as current databases reflect difference prices for those different code/intensity levels, the life care planner can have confidence that they can find an appropriate price reference for the activity and its intensity that they are forecasting. The life care planner should continue to follow basic life care planning methodology to educate themselves about the individual (though interviews) and their medical conditions (through medical records) as a basis for projecting future disability-related needs. Once this is complete, the next job task to be completed by the life care planner is determining the associated costs

for the goods and services included in the life care plan. To do this, one may choose to use a variety of available healthcare databases. While multiple databases can be utilized, the life care planner must develop the requisite skill in making clinical decisions based upon their education, training and experience to provide accurate, and defensible cost projections.

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