Life Care Planning Cost Techniques: History, Methodology, and Literature Review

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Abstract

The following paper summarizes a presentation given on May 13, 2022, at the 2022 Life Care Planning Summit. In this presentation, we discussed the origin and evolution of costing techniques used by the life care planner to include a contemporaneous overview of the methods currently used in the specialty practice. We also sought to understand the origin of "associated costs" as a component of a life care plan, as per the 1998 definition. Another goal was to learn how life care plan costing methods have evolved and reviewed how various articles and published in literature have contributed to an understanding of life care plan costing techniques to date. This article will discuss the history of costing and its evolution to life care planning today. It will include a review of who prepares life care plans and what their credentials and associations require when costing, the definition of a life care plan in its first inception, and what the body of literature published on costing reveals about techniques.

History

Identifying costs for people with illnesses or disabilities has its roots in rehabilitation counseling. McGowan (1967) discussed the role of the rehabilitation counselor as a coordinator of care. They described that the Vocational Rehabilitation Act Amendments of 1943, Public Law 113, 78th Congress, tasked rehabilitation counselors with identifying services needed by individuals with disabilities and authorizing funding for these services. They stated, "Under this act, money could be spent only for a specific list of services." These services included:

1. Corrective surgery or therapeutic treatment necessary to correct or substantially modify within a reasonable length of time a static physical condition which constitutes a substantial handicap to employment.

2. All hospitalization, for up to 90 days, which is necessarily connected with the above surgery or treatment.

3. Transportation, occupational licenses, and customary occupational tools and equipment.

4. Such prosthetic devices as are essential to obtaining or retaining employment.
5. Maintenance during training, including the cost of any necessary books and other training materials. 1967

In Section 12 titled Planning and Provision of Services, McGowan (1967) further describe services offered by the rehabilitation counselor, including:

> Physical restoration, training, maintenance, transportation, placement, provision of tools, equipment and licenses, establishment of and management services for small business enterprises, and other goods and services necessary to render a handicapped individual fit to engage in a gainful occupation. (McGowan, 1967)

Physical restoration services are defined as

> medical and medically related services which are necessary to correct or substantially modify within a reasonable period of time a physical or mental condition which is stable or slowly progressive." More specifically, physical restoration services include (1) Medical or surgical treatment by general practitioners or medical specialists, (2) psychiatric treatment, (3) dentistry, (4) nursing services, (5) hospitalization (either inpatient or outpatient care) and clinic services, (6) convalescent, nursing, or rest home care, (7) drugs and supplies, (8) prosthetic devices essential to obtaining or retaining employment, (9) physical therapy, (10) occupational therapy, (11) medically directed speech or hearing therapy, (12) physical rehabilitation in a rehabilitation facility, (13) treatment of medical complications and emergencies, either acute or chronic, which are associated with or arise out of the provision of physical restoration services, or are inherent in the condition under treatment, and (14) other medical or medically related rehabilitation services (Regulations, 1966, sec. 401.1(p)). The services provided a client should not only meet his present needs, but insofar as possible encompass future needs. 1967

Maintenance payments are supplementary to the other vocational rehabilitation services. Maintenance means

> payments to cover the handicapped individual's basic living expenses, such as food, shelter, clothing, health maintenance, and other subsistence expenses essential to achieving the individual's rehabilitation potential or to achievement of his vocational rehabilitation objective" (regulations, 1966, sec. 401.1(k)). . . . as part of maintenance, amounts to cover the cost of short periods of medical care for acute conditions arising in the course of vocational rehabilitation.
>
> Transportation is considered to mean the necessary travel and related costs in connection with transporting handicapped individuals for the purpose of providing diagnostic or other vocational rehabilitation services under the State plan. Transportation includes costs of travel and subsistence during travel (or per diem allowances in lieu of subsistence) for handicapped individuals and their attendants or escorts, where such assistance is needed. (regulations, 1966, sec. 401.38) (McGowan, 1967)

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Federal law in 1943 essentially outlined the categories of services to be considered in a life care plan today and tasked rehabilitation counselors with costing these services. In 1982, the concept of life care planning in litigation was introduced by Paul Deutsch, Ph.D, and Frederick Raffa (Deutsch & Raffa, 1981). Annual supplements were completed through 2020. According to these authors:

> 100.20 What damages can be measured in personal injury litigation "Damages in personal injury that can be measured objectively include 1) loss of diminution of earning capacity, 2) cost of rehabilitation and retraining, 3) cost of replacing household services the plaintiff can no longer perform, and 4) future medical expenses.
>
> In most cases, the damage is subject to economic assessment in a personal injury matter include the loss or diminution of an individual's earning capacity, the replacement of household services that the plaintiff can no longer perform, the cost of any vocational rehabilitation assistance or counseling, the cost of all required medical care (including annual medical evaluations, nursing care, therapy, treatment, medication, and future hospitalization), and the cost of all necessary personal attendant or nurse aide care.
>
> 100.24 Medical and Personal Care, Equipment and Related Services Individuals who sustain a personal injury may require ongoing medical care and services as well as have need of someone to assist them as a personal care attendant. The task of the expert damage witnesses, notably the rehabilitation specialist, would be to establish (with the help of expert medical testimony, if necessary) a standard of care that would be required by the plaintiff as a result of his or her injuries and, in turn, the base or current market cost of providing this care. 1981

On April 3, 1998, a combined definition of the University of Florida and Intelicus annual life care planning conference and the American Academy of Nurse Life Care Planners (now known as the International Academy of Life Care Planners) was presented at the Forensic Section meeting, NARPPS (now known as the International Association of Rehabilitation Professionals) annual conference, Colorado Springs, CO, and attendees agreed upon the following definition of a life care plan:

> 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, 1998)

Jurisdictional Variability

At the 2017 Life Care Planning Summit, the attending life care planners created a list of 29 different venues in which life care plans are utilized (Albee et al., 2017). Amongst these venues, life care plans used in litigation typically involve jurisdictional variability. This jurisdictional variability does not address how life care planners cost items but how they present costs (Matlock, 2013). Field et al. (2015) noted that the collateral source rule regarding damages related to litigation varies by jurisdiction. A review of the Matlock chart in appendix

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A of his article indicates the wide variance in how the collateral source doctrine is applied in each state. Field et al. (2015) also noted that the Affordable Care Act (ACA) mandate presents a new scenario covering individuals with health care benefits. While the ACA intends to provide universal health care insurance with a component that prevents excluding a "preexisting" condition, the life care planner should remain clear of incorporating changes to their work solely based on the ACA. It is unknown if and how this insurance program will impact life care planners. Lastly, "careful consideration by the life care planner may be warranted when consideration is given to incorporating collateral source data and set-asides" (Field et al., 2015, p. 9).

Credentials

Albee et al. (2017), Field et al. (2007), and C. B. Johnson et al. (2015) have outlined and updated over time the various credentials held by those who prepare life care plans. Life Care Planning is not a profession, but it is a function carried out by various professionals (McCollom, 1998). This statement from Patricia McCollum discusses the role of life care planning, recognizing the vast array of professionals who perform the task of life care planning.

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Table 1

Summary of Rehabilitation Certifications on Selected Variables

Credential	Independent Accreditation	Year Est	Minimum Education	Minimum Experience	Code of Ethics/ Standards of Practice	Exam Required	CEUs Required	Non-Profit
ABVE	No	1980	Yes	Yes	Yes	Yes	Yes	Yes
CCM	Yes	1993	Yes	Yes	Yes	Yes	Yes	Yes
CDMS	Yes	1984	Yes	Yes	Yes	Yes	Yes	Yes
CLCP	No	1996	Yes	Yes	Yes	Yes	Yes	No
CNLCP	No	1999	Yes	Yes	Yes	Yes	Yes	Yes
CPLCP	No	1980	Yes	Yes	Yes	Yes	Yes	Yes
CRC	Yes	1980	Yes	Yes	Yes	Yes	Yes	Yes
LCP-C	No	1980	Yes	Yes	Yes	Yes	Yes	No

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None of the credentials above speak to the technique of costing. Some of these credentials have affiliated associations that address the issue of costing in life care plans in their standards of practice.

Standards of Practice

Five weeks after the definition of a life care plan was agreed upon, the first proposed Standards of Practice for life care planners were published on May 15, 1998. Roger Weed, Ph.D., developed this first set of proposed standards after input from over two hundred participants at the 1997 Annual Life Care Planning Conference and other educational offerings for Life Care Planners (McCollom, 1998). The two standards that remotely spoke to costing were:

> 2.8.1. Written records will be maintained with regard to contacts, research, products, and/or services, and
>
> 2.8.2. Records will be accurate.

By 2000, the first edition of the Standards of Practice for Life Care Planners (SOP) was published by the IALCP (International Academy of Life Care Planners, 2000). Subsequent editions were reviewed and revised over time through an objective process and published in the Journal of Life Care Planning (JLCP). Currently, the 3rd Edition is utilized (International Academy of Life Care Planners, 2015). However, a 4th Edition is in the process of field review and revision.

Within the 3rd Edition of the SOP, the following areas related to costs and costing are noted: [need reference]

I.B Historical Perspective
An integrated plan that includes all disciplines and specific costs of care has become an increasingly important aspect of the health care process due to rapid growth in medical technology and an increased emphasis on the cost of care. This process of developing an integrated plan and delineating costs has evolved . . .

II.C. To specify services and the charges for those services needed by the evaluee.

IV. STANDARDS OF PRACTICE

4. STANDARD: The life care planner uses a consistent, valid, and reliable approach to research, data collection, analysis, and planning.
   MEASUREMENT CRITERIA:
   b. Researches appropriate options and charges for recommendations, using sources that are reasonably available to the evaluee.

   d. Uses a consistent method to determine available choices and charges.
6. The life care planner uses a planning process.
   MEASUREMENT CRITERIA:
   a. Follows a consistent method for organizing data, creating a narrative life care plan report, and projecting costs.

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b. Develops and uses written documentation tools for reports and cost projections.

c. Develops recommendations for content of the life care plan cost projections for each evaluee and a method for validating inclusion or exclusion of content.

10. STANDARD: The life care planner may engage in forensic applications. MEASUREMENT CRITERIA: If the life care planner engages in practice that includes participation in legal matters, the life care planner:

    a. Acts as a consultant to legal proceedings related to determining care needs and costs in the role of an impartial advisor to the court. 2015

A field review of the 4th Edition of the SOP was made available to all life care planners for their input. A methodology for determining the costs of future care recommendations is described in the SOP for the first time. In a review of the suggested changes, the following was noted about costing:

14. STANDARD: The life care planner uses a consistent, valid, and reliable approach to costs.
    PRACTICE COMPETENCIES:

    - Uses a consistent method to determine costs for various categories of available/needed services.
    - Uses geographically relevant and representative costs.
    - Follows a consistent method for organizing and interpreting data for projecting costs.
    - Cites verifiable cost data.

The authors also reviewed other associations' standards of practice for commentary regarding costs and costing techniques. According to the American Association of Nurse Life Care Planners (2015), the standards for costing accountability and transparency include:

> Nurse life care planners' expertise in researching costs, applying data regarding prognosis of medical conditions, and projecting future care needs will become more important. Legislative calls for more statutory requirements for pricing accountability and transparency in all aspects of healthcare grows louder with each budget year . . . Nurse life care planners will become increasingly valuable as their expertise assists stakeholders to make meaningful use of published cost data.

- Standard 4 (9th bullet): Includes an analysis of the economic effect on the healthcare consumer, family, caregivers, or other affected parties.
- Standard 4 (11th bullet): Provides alternatives, associated costs, and benefits.
- Standard 15 (4th bullet): Evaluated factors such as safety, effectiveness, availability, cost/benefits, technology, evidence, and efficiencies when considering life care plan component options with the same expected outcome.

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- Standard 15 (7th bullet): Assists the healthcare consumer and other relevant parties to understand costs, risks, and benefits of treatment, care, and other elements of the nurse life care plan. 2015

The International Commission on Health Care Certification (ICHCC), the corporation that owns the Certified Life Care Planner (CLCP) credential, reports in the ICHCC Practice Standards and Guidelines: Code of Professional Ethics that, "Certified Life Care Planners/Canadian Certified Life Care Planners are required to be thorough with competent research conducted for each identified category of need, and opinions and conclusions structured without regard for personal reimbursement resources" (International Commission on Health Care Certification, 2020).

The American Academy of Physician Life Care Planners (AAPLCP) publishes Practice Standards and costing is described under Standard 4: Quantification. Quantification describes the quantification of future medical requirements in a life care plan.

- When quantifying future medical requirements, physician life care planners reference/exhibit all variables used to perform their calculations."
- Physician life care planners describe the methodology used to perform all calculations so as to make their cost analyses independently replicable/disprovable.
- Physician life care planners quantify the total cost of the future medical requirements in their life care plans.
- Unless a physician life care planner is qualified as an expert to formulate present value analyses, Certified Physician Life Care Planners formulate the total cost of subjects' future medical requirements in nominal value, without accounting for inflation, discounts, or any other time value of money considerations.
- Physician life care planners, whenever possible/practicable, cite and/or reference all data sources from which they obtained cost data. (American Academy of Physician Life Care Planners, 2014)

Gamez et al. (2017) examined the AANLCP, ICHCC, and AAPLCP Standards of Practice and compared them to the original SOP by the IALCP. The authors noted,

> Life care planning standards and scope of practice are published for both educational and professional purposes. The goals of such documents are to maintain standards and consistency within the core of the profession and ensure best practices among those in the field. The standards of practice set forth within these three subgroups are similar, with overlap noted among the three professional life care planning standards of practice documents. 2017

Life Care Planning Summits since 2000 have developed Consensus and Majority Statements. C. Johnson and Preston (2009) reviewed and presented the life care planning consensus and majority statements derived from Life Care Planning Summits since 2000. C. Johnson and Preston (2012) first published the Consensus and Majority Statements derived from Life Care Planning Summits held in 2000, 2002, 2004, 2006, 2008, 2010, and 2012 in

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the Journal of Life Care Planning. C. Johnson et al. (2018) verified the relevance of all Consensus and Majority Statements derived from Life Care Planning Summits between 2000 and 2017 through a Delphi study in 2018. Through the Consensus and Majority Statements since 2000, the following statements are noted about cost and costing techniques:

- 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
- Life Care Planners shall utilize protocols for cost research.
- Life Care Planners shall gather geographically relevant & representative prices.
- Life Care Planners shall utilize protocols for using local versus national resources.
- Life Care Planners shall evaluate the cost effectiveness of life care plans.
- The cost of private-hire home care includes caregiver compensation and associated expenses. 2018

Life Care Planning Training Programs

Early training for life care planners came through programs including Kaplan, MediPro, Intelicus, and the University of Florida. A review of the modules revealed statements about costing in life care planning in Modules 1, 5, and 6:

- More than one source if possible.
- Care should be taken to document all needed equipment and supplies. Take into account maintenance and replacement cost for durable medical equipment. It is helpful to obtain costs for equipment and supplies from both catalog sources (noting retail, not wholesale, prices) and sources from the community in which the client resides. Listing a range of prices is helpful.
- For pediatric clients remember that provision of some goods and services may be covered by federal educational statute. The local school district may be helpful in identifying these.

Currently, there are five Pre-Certification Programs in place. These programs were surveyed to understand the costing methods taught. Questions asked were whether specific methods of costing are covered in their curriculum, and if so, what costing method (or methods) are taught. Table 2 illustrates the findings.

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Table 2

Costing Methods Taught

Taught Component	IRET	FIG	Capitol University	Thomas Jefferson University	AAACEUs
Number of sources	multiple sources for costs	minimum of three costing databases	minimum of three private pay costs	three cost estimates	call three vendors
Resources	Local providers Fee Guides (i.e., Medical Fees, Physician Fee Reference), Databases (i.e., American Hospital Directory, Healthcare Cost and Utilization Project, VA Reasonable Charges, Context4Healthcare, FairHealth) Surveys (i.e., Genworth Cost of Care), Websites (i.e., Promatcher.com, Goodrx.com, medical equipment dealers)	Reference bills from providers (no more than 12 to 18 months old) Or default to costing databases (i.e., PFR, Medical Fees by PMIC, VA Tables, HCUP, FairHealth, Context4 Healthcare)	Medical Fees, Healthcare Cost and Utilization Project, VA Reasonable Charges, CMS database, Context4Healthcare, FairHealth, Goodrx.com, Reference bills from providers (no more than 12 months old), cold calling, websites including Goodrx and others, attendant care survey instrument and costing helper		Phone calls and databases including AHD, PFR, Medical Fees, etc.

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Table 2 – continued from previous page

Taught Component	IRET	FIG	Capitol University	Thomas Jefferson University	AAACEUs
Rates to use	Use UCR/actual charges/non-discounted charges rather than negotiated, discounted, or self-pay rates	Use a median of the costs	Database 75th to 80th Average		Average/ median costs
Other specifics taught	Suggest resources for locating local providers by specialty		Get geographically specific costs	regional costs	

Common themes amongst the training programs include the use of multiple methods, such as contacting local providers, using fee guides and databases, and obtaining geographically specific costs from a minimum of three providers.

The authors initially found the origin of using three costs in The Basic Tenets of Life Care Planning (Deutsch, n.d.). The fifth tenet reveals,

> Life care plans specify provisions throughout life expectancy and cannot depend on any one individual, service, or supplier for fulfilling plan recommendations. Always use at least three sources for the major cost items in the plan. Do not use negotiated rates because there is no guarantee that the cost will remain constant if the business/supplier should change hands; life care planners should not get into the habit of seeking discounted rates for repeat referrals. During the phase of plan development, costs should reflect real values of goods and services found within the patient's local market. Also, eliminate the outliers from the market analysis so that unrealistically low/high rates do not misrepresent the actual cost of an item.

We found subsequent sources that address the number of costs to obtain, including more than one cost, at least two, three, and multiple costs. The published materials aside from those previously mentioned include the Life Care Planning Survey 2001: Process, Methods, and Protocols (A. Neulicht et al., 2002), in which 58% of respondents reported that they typically obtain more than one cost quote (if available or accessible), 31% always obtain more than one cost quote, and 81% request private pay and/or retail cost quotes. Further, in 2014,

the Physician Life Care Planning (2014) prepared a white paper stating that a properly completed vendor survey contains multiple price samples (American Academy of Physician Life Care Planners, 2015). A Physician's Guide to Life Care Planning indicated that "an attempt is made to obtain at least three discrete costs from three discrete sources" (Gonzales, 2017, p. 148). The 1998 Supplement to A Guide to Rehabilitation noted that the life care planner should access at least two sources of information pertaining to costs (Deutsch & Sawyer, 1988). Finally, the AANLCP, A Core Curriculum for Nurse Life Care Planning recommends that three or more costs should be obtained from vendors if possible (Apuna-Grummer & Howland, 2013).

Handbooks

Handbooks have been used in pre-certification training and serve as a resource for the life care planner. The two most prevalent handbooks include the Life Care Planning and Case Management Handbook and the Pediatric Life Care Planning and Case Management Handbook.

The Life Care Planning and Case Management Handbook has published four editions beginning in 1999, with the latest Edition published in 2018 (R. O. Weed, 1998).

The 1st Edition states,

> Once a life care plan has been completed it is common for the planner to research the cost of treatment, medication, supplies, and equipment. There are occasions where catalogs will provide the necessary resource, particularly for products that are commonly available through mail order or for locations where the services or products are limited. In some states, depending on the jurisdiction (e.g., civil litigation, Worker's Compensation, long-term disability, etc.), there may be a need to identify collateral sources. (1998, p. 9)

On page 389, from the 23rd chapter,

> A Defense Attorney's Perspective on Life Care Planning," it is stated that, in most instances, the plaintiff's life care planner will attempt to place a current cost for each aspect of the plan. Defense counsel will review the plan carefully to determine the reasonableness of each of the base cost assumptions . . . It is not unusual to be able to demonstrate that the annual cost for hourly services is more than double the cost of negotiated contract rates. (1998, p. 389)

The 27th chapter includes life care planning resources, Acumyn(™) Resource is identified as a database of providers for home health care with potential access to costs (R. O. Weed, 1998, p. 461). On page 460, there is a discussion from Julie Kitchen regarding using a database to store contacts and costs.

In the Life Care Planning and Case Management Handbook 2nd edition (R. O. Weed, 2004), much of the 1st Edition is reprinted. However, Chapter 30 has 20 pages under resources and includes an area cost analysis request form. Also, beginning on page 727 is a discussion of the art of obtaining information by telephone.

The Life Care Planning and Case Management Handbook 3rd edition (R. O. Weed & Berens, 2010) continues with a repeat of the information contained in the two prior editions, but also on page 749 is a discussion of the common issue of life care planning in the

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methodology of research conducted related to identifying costs for the needs identified in the document. It is stated that

> it is common for facts and data on which the author of the life care plan relies will come from a variety of sources such as physicians, allied health care professionals, consultants, catalogs, suppliers, pharmacies (actual patient records, online, and brick and mortar), and others. It is also common for the author of the life care plan to employ or subcontract a qualified individual who completes the necessary research. One caution is that the life care plan author should provide specific direction to the person and supervise the research methodology so the document is reliable and can be effectively communicated by the author of the life care plan within a litigation context. 2010

In the most recent 4th edition of The Life Care Planning and Case Management Handbook (R. O. Weed & Berens, 2018), Maniha and Watson (2019) discuss utilizing databases for research. They note, "In addition to contacting a resource by telephone or e-mail, one may opt to utilize a reliable database available either in online subscriptions or published resources. When using databases, medical coding typically is required..." (Maniha & Watson, 2019, p. 744).

Information is provided in this chapter about medical coding and billing software subscriptions and resources and charts of reputable databases for facility, physician/other health care professionals, DME, anesthesia, and dental are included (Maniha & Watson, 2019, p. 744). The Standards of Practice for Life Care Planners, 3rd Edition, and the Consensus and Majority Statements Derived from Life Care Planning Summits Held in 2000, 2002, 2004, 2006, 2008, 2010, 2012, and 2015 are reprinted in Appendix I and Appendix II in the handbook.

The Pediatric Life Care Planning and Case Management Handbook has been published in two editions (Riddick-Grisham & Deming, 2018). The guidance for costing is presented under The Role of the Life Care Planner in Pediatric Life Care Planning: Research Costs, stating, "when possible, determine private pay costs using local vendors' catalogs, flyers, and the Internet" (p. 58) in Table 4.1, which has been reprinted from Life Care Planning and Case Management Handbook 1st Edition.

Literature Review

The authors of this article did a literature review to identify published material regarding life care plan costing techniques. The following themes related to costing emerged: reliability issues in gathering cost data, use of scientific methodology, descriptions of various costing techniques including usual, customary and reasonable, databases, healthcare bills, and phone calls, use of coding systems, and the need to identify collateral source offsets in certain jurisdictions.

Articles were identified by performing a search using Google Scholar, PubMed, ProQuest, JSTOR, The Journal of Life Care Planning, starting with the inaugural issue in 2002, The Journal of Legal Nurse Consulting, starting with the first issue in 2003, and The Journal of Nurse Life Care Planning, starting with the first issue available online in 1998.

Issues of reliability in life care plan costing are addressed starting the first year the Journal of Life Care Planning was published. An article by Rosenblatt (2002) discussed is-

sues of accuracy and consistency in gathering cost data, noting "the determination of medical costs can be a less than exact process that has the life care planner traversing many paths" (p. 169). Further, "accuracy is always going to be difficult to determine because hospitals and data vendors have their own methodologies for aggregating and reporting data." This continues to be an issue today.

The use of scientific methodology as a way to increase the reliability of costing and ensure that costs are admissible in court is addressed in the literature. Busch (2002) suggested a five-step scientific approach to streamlining the costing methodology of a life care plan when gathering, reviewing, and analyzing data. Some key points related to costing in this method are to use a methodical approach to ensure accuracy and comprehension of facts, to identify and utilize reliable databases, and to ensure the numbers are understood and make sense.

A recent article by Barros-Bailey et al. (2022) introduced a survey methodology for costing attendant care, which is typically the highest lifetime value category in a life care plan. The authors indicated that this methodology is not recommended for all items in a life care plan because it would be time and resource prohibitive. Specific steps regarding costing are provided, including determining whether to use a census versus a sample; if using a sample, deciding whether to use a random or non-random sample, selecting who to call to avoid bias, and deciding how many sources to contact; constructing and testing the survey instrument; and collecting the data face-to-face, by phone, by mail, online, etc.

Literature was reviewed regarding the use of usual, customary, and reasonable (UCR) as a methodology for pricing in a life care plan. According to Busch (2018), there are different definitions among different agencies, but in general, usual equates to the fee usually charged by an individual provider, customary speaks to whether the fee is within the range of usual fees charged by similar professionals or facilities in that area, and reasonable means that the fee is justifiable. For example, if a fee is in the 80th percentile, 80 percent of the fees are at or below this amount. Insurers use the concept of usual, customary, and reasonable to determine healthcare reimbursement/allowable amounts by analyzing data regarding fees charged by medical providers. To set UCR fees, health plans use a percentile rank which is a position in a distribution of values below which a specified percentage of the values fall (Maniha, 2012, 2020).

The use of databases for life care plan costing was addressed in the literature. According to the 2009 life care plan survey, the primary databases used to research costs, in rank order, were Medical Fees, Physicians' Fee Reference, American Hospital Directory, Healthcare Common Procedure Coding System, Healthcare Cost, and Utilization Project, Red Book and National Fee Analyzer (A. T. Neulicht et al., 2010).

Woodard et al. (2017) compare different databases for costing surgery and discuss how to evaluate the data to determine whether it is current, geographically specific, and based on billed rather than reimbursed charges, as per standards of practice and consensus statements. There are databases available to help insurers and providers establish UCR, and life care planners also use these databases for costing.

Coding systems used to obtain costs include Current Procedural Terminology (CPT) codes, which include services such as physician visits, labs, diagnostic tests, and therapies, Diagnosis-Related Group (DRG) codes, which classify inpatient hospital care into groups with similar hospital resource use, Healthcare Common Procedure Coding System (HCPCS) codes,

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used to code and identify drugs and durable medical equipment, International Classification of Diseases (ICD) codes, which identify a diagnosis or condition), and Ambulatory Surgical Center (ASC) codes. Sources for coding, including coding software subscriptions, reference books, and crosswalks, are provided in the literature (Holakiewicz & Pacheco, 2012; Maniha, 2020; Maniha & Watson, 2019). When using databases, medical coding typically is required.

The literature also attempts to address the question of which percentile benchmark to use when using databases for costing. Maniha (2012) concludes that

> the 75th or 80th percentile more accurately represents billed charges. When the individual is under the care of a very specialized provider, it is not unreasonable to use the 90th percentile to more accurately represent charges." Maniha (2020) states that she elects to utilize the 75th or 80th percentile of billed charges. This method has been reviewed in the court system and deemed reasonable in the Cuevas v. Contra Costa (2017) court case. Lastly, Maniha and Watson (2018, p. 731) state that "usual and customary typically fall within the 75th or 80th percentile [and] the 75th or 80th percentile more accurately represents billed charges. When the individual is under the care of a very specialized provider, it is not unreasonable to use the 90th percentile to more accurately represent charges. (p. 561)

Maniha (2020) states that she elects to utilize the 75th or 80th percentile of billed charges. This method has been reviewed in the court system and deemed reasonable in the *Cuevas v. Contar Costa County* (2017) court case. Lastly, Maniha and Watson state that "usual and customary typically fall within the 75th or 80th percentile" (Maniha & Watson, 2019, p. 731).

Another technique life care planners use for costing is a review of healthcare bills and the literature provides some guidance in this area. It is stated that the life care planner should utilize the charges billed and not the cost or reimbursement rate (Maniha, 2008, 2012). Busch (2017) and Busch (2018) noted that the life care planner should review healthcare bills to assess if they are fair and reasonable using the concept of UCR, and if the bill is not an appropriate pricing source, the life care planner should use other options. Stajduhar et al. indicate that life care planners are qualified to review medical bills for costing purposes, stating that life care planners "possess a unique skill set that qualifies us to opine about costs of medical goods and services in the context of past medical charges" (Stajduhar et al., 2019, p. 55).

The literature also addresses the terminology used for obtaining costs. The billed charge, also known as "billed amount," "usual or customary," or "retail," represents the charge for the procedure or item before any discount or reduction is applied (Maniha, 2008, 2020). The term "private pay" may no longer be appropriate because there is wide variability in what this means and because most facilities and physicians apply a discount to the private pay charges.

The literature addresses how to present collateral source offsets when required. Stern and Rutherford Owen (2022) describe that a court's approach to the collateral source rule may affect the source of the cost data contained in the life care plan. It is not a deviation from standard life care planning methodology to use the adjusted cost in certain jurisdictions if that is what is required for the life care plan to be deemed admissible. This involves

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an additional step to identify collateral source offsets. Life care planners need to be able to explain the market rate amount and how the adjusted amount was derived. Maniha (2008) wrote that if rules require reimbursement rates of a specific jurisdiction, the life care planner should include a disclaimer and can add a column to the life care plan charts. Lastly, Field et al. (2015) provided that if a life care planner is asked to identify collateral source offsets, this must be performed transparently after the comprehensive assessment, data analysis, and research are completed.

Suggestions were obtained by the authors from Journal of Life Care Planning editors Dr. Aaron Mertes and Dr. Tanya Rutherford Owen regarding future research to consider. This might include:

- A comparison of charges obtained via phone calls and databases versus actual billed charges.
- An encyclopedia of commonly used costing tools.
- A comparison of various tools used for costing.
- Research into how insurance companies determine what percentile to use for reimbursement.

After reviewing the history, literature, and resources, there was no generally accepted or peer-reviewed method of obtaining costs outside the guidance provided in the SOP and Majority and Consensus Statements since 2000. There are several options for pricing data. However, it is the life care planner's responsibility to understand and articulate the data source, why the life care planner chose the source, and how it is reasonable, relevant, and reliable.

Additional Resources to reference for life care plan costing include the following citations. See references for full information. Albee et al. (2017), American Association of Nurse Life Care Planners (2019), American Association of Nurse Life Care Planners (AANLCP), Certified Nurse Life Care Planner (CNLCP) ((2014), Deutsch and Sawyer (1985), Gonzales and Zotovas (2014), Greenfield (2010), Howland (2012), C. Johnson (2012), May and Moradi-Rekabdarkolaee (2020), Patterson and Pyle (1991), Pomeranz et al. (2010), Research Planning Consultants (2021), and R. Weed and Rutherford-Owen (2018)

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