Best's Insurance Law Podcast

How Changes to Life Care Planning Could Impact Insurance Claims – Episode #190

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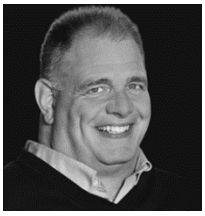

Hosted by: John Czuba, Managing Editor
Guest Expert: Dan Thompson of DeeGee Rehabilitation Technologies, Ltd.
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John Czuba: Welcome to "Best's Insurance Law Podcast," the broadcast about timely and important legal issues affecting the insurance industry. I'm John Czuba, Managing Editor of *Best's Insurance Professional Resources*.

We're pleased to have with us today expert service provider, Dan Thompson, president and CEO of DeeGee Rehabilitation Technologies with offices in Ontario, Canada, and Arizona. Dan has worked within the litigation arena for over 15 years.

He is a registered rehabilitation professional, registered vocational professional, and a certified life care planner. His company services include providing expert opinion to insurance carriers, attorneys, and medical professionals by assessing the needs and vocational capabilities for people with disabilities.

Dan, we're very pleased to have you with us again today.

Dan Thompson: Thanks for having me, John. I appreciate it.

John: Today's discussion is how changes to life care planning could potentially impact insurance claims. Dan, for our first question today; tell us: what is a life care plan, and what is its history and purpose?

Dan: Back in as far as I can tell, in 1976 was the first recorded litigation mention of setting up life care planning. Our grandfathers in the industry are Dr. Paul Deutsch and Roger Weed. What they did was they tried to come up with a system that will educate the court on what is reasonable and necessary, in terms of goods and services for an individual who sustained a catastrophic injury.

A catastrophic injury, of course, could be a brain injury, a spinal cord injury, amputation, severe burns, the whole gamut. It's supposed to work in a multidisciplinary approach, so in other words, work with treating doctors to come up with a foundation to justify, going forward, what would be needed for those individuals, as I indicated.

You're supposed to have, of course, other methodologies in place so that this can stand up in court to a Daubert or a Frye challenge, depending on the jurisdiction you're in. Some of the other criteria would be ensuring you have at least a minimum of three quotes not to prejudice the cost too high or too low.

We, as the damages experts, are supposed to be dispassionate. In other words, we're not supposed to be a plaintiff or a defense advocate. We are supposed to make our arguments based on the facts of the case. To make it reasonable and necessary, doesn't matter what jurisdiction you're in, those are some of the rules that we have to adhere to.

John: Dan, who does LCP, or credentials accrediting bodies, and how often is it done, and how is it done?

Dan: We as life care planners, we have our governing body, which is the International Commission on Health Care Certification. It's interesting, in Canada, there seems to be a real gravitation towards occupational therapists.

They seem to be the ones that are doing a lot of these life care planning and cost projections for individuals, whereas in the United States, it seems to be physicians. There are a lot of physician life care planners, a lot of nurse life care planners. There are psychologists and other healthcare professionals who are basically doing this.

In essence, to maintain our CEUs, that's our education credits, we have to maintain at least 80 credits during a five year period. That's when our renewal comes up. In essence, we have to make sure that we are adhering to the latest and greatest and what's happening in our field to make sure that we are current throughout our licensure and making sure that we keep that in place.

John: Dan, what are some of the problems that might arise from current LCPs, both in Canada and in the United States?

Dan: One of the biggest things is that in adherence to making sure that you are not prejudicing your cost too high or too low, there is a plethora of databases out there. For example, you could use Medicare's L codes when it comes time for projecting the cost for prosthetic devices.

In addition, in the United States, the nice thing is that there are huge databases such as FAIR Health that use the CPT codes for any medical procedure. That could be diagnostic testing, like MRIs or X rays. That could be for a physician visit. It could be for the actual operation that someone might need.

The nice thing is you have those benchmarks in which to drill down and ensure that you are accurately putting forth the right goods and services for that. What I find far too often, whether it be in Canada or the United States, is that people don't adhere to those methodologies that we are taught in the course.

As such, a lot of their opinions sometimes come down to, "Well, I've worked in this field for so long, and basically what I say is true." Even if they are a physician by background or by nature, they still have to adhere to the fact that it's the "treating doctors" that are least first in the pecking order and they should have the most weight.

We have to look at the holistic approach by also going by consulting physicians, or also going by the medical records themselves in which to come up with the projected costs. In Canada, because we have socialized medicine built into our healthcare infrastructure, there are legal issues that are based solely in Canada.

In the States, for example, there's clear cut rules, such as collateral source rules. We're supposed to assume that our projections don't take into consideration other potential sources, such as the insurance.

However, in some cases, the Affordable Care Act, it was supposed to basically help mitigate some of those costs, because the individual would qualify for those services, whether there's insurance or not. The key is to come up with "reasonable and necessary" projections going forward.

John: Dan, what should insurance carriers be aware of, and what's the potential impact on claims?

Dan: What they need to look at is, again, making sure that the individual who's coming up with these life care plans is going to be fair and impartial. Far too often, as I indicated before, a plaintive narrative is inserted into the equation.

There may be millions of dollars at stake to ensure that the individual's getting what's reasonable and necessary and not necessarily what they want. That's critical.

Also, you have to make sure that the individual followed the proper methodology so that they did work in collaboration with the individual's treating doctors to come up with their plans to ensure that the person is going to use these services in the future and to make sure that it is going to be reasonable and necessary going forward.

John: Dan, how do you see changes being implemented?

Dan: There needs to be constant reform. As I indicated before, Roger Weed had set up this infrastructure way back in 1976. That's four years before my injury, so there's forty years that has transpired. The best way to depict this is that my father was in the unions, and the reason he was in the unions is to make sure that people had proper conditions to which to work with. By the time he retired, John, he indicated that there was more management in unions than there was in management.

What's happened here is that because there are biases, both plaintiff and defense, it's imperative to ensure that things are adhered to and that there has to be more scrutiny on the part of perhaps the International Commission on Health Care Certification's part to make sure that people are putting together plans that are reasonable and necessary, and are based on the science involved to make sure that they can hold up to a Daubert and/or a Frye challenge, use those databases that we talked about before, such as Medicare's L codes, or using the CPT codes. This way, you know it is going to be a fair and impartial plan going forward.

John: Dan, what do you see for the future?

Dan: Life care planning is fairly new in its infancy. When you compare that to vocational rehab that was set up way back in the 1700s, clearly this is more of a fledgling industry. Through checks and balances on both sides of the fence, whether you're a plaintiff or a defense, there's going to be reform, there's going to be a need. Even right now, the International Commission on Health Care Certification is looking for accreditation through the American Standards Act, and that's a much higher standard than what we have already.

If and when that comes through, that will also ensure a better quality product going forward and ensure that, of course, that people are getting a fair shake on both sides of the fence, both now and in the future as well.

John: Dan, thanks very much for joining us again today.

Dan: Thank you very much for having me, and I look forward to the next one.

John: You've just listened to Dan Thompson, president and CEO of DeeGee Rehabilitation Technologies with offices in Arizona and Ontario. You can learn more about Dan's company at www.deegeerehab.com. Special thanks to today's producer Frank Vowinkel.

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I'm John Czuba, and now this message.

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