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Welcome to the Spring 2012 issue of the Journal of Nurse Life Care Planning. We’ve had a number of requests for more information on coding and costing procedures, resources, and problems, so this issue steps back a bit from the clinical and offers some help and advice in those vital areas. Food for thought as you read through this issue: Why do you suppose there are no billing codes for nursing evaluation and management (E&M)? The answer is in one of these articles.

As I write this I have just returned from a multi-day conference with a task force charged with refocusing and rewriting the standards of practice and ethical standards for nurse life care planning to align them with American Nurses Association standards. These will be used as part of our application to the ANA in support of having nurse life care planning declared a bona fide nursing specialty.

Why should you care? Well, this is big news for many reasons. First, this resource will give guidance to both new and seasoned nurse life care planners. It will be our authoritative back-up when we are questioned about our methodology (the nursing process). Most compellingly, it will mean that in the future, any registered nurse performing life care planning activities will be held to them, regardless of certification, educational preparation, employment setting, or role.

It was inspiring to see our profession growing right before our eyes as this volunteer group of nurse life care planners push each other hard, challenging each other to define who we are, what we do, how it ought to be done, and then decide how to say it clearly. The end product is excellent. I am in awe.

We live in exciting times. Thank you all for what you do, and please join us in welcoming the newest CNLCPs listed on page 547.

Cordially,
Wendie Howland
Editor, Journal of Nurse Life Care Planning
whowland@howlandhealthconsulting.com
Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. **Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.**

**Text**

Manuscript length: 1500 – 3000 words

- Use Word® format only (.doc)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Set 1-inch margins
- Use Times, Times New Roman, or Ariel font, 12 point
- Use double-spacing, using the Word formatting feature
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association)

**Art, Figures, Links**

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

*Live links are encouraged.* Please include the full URL for each.

**Editing and Permissions**

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*All manuscripts published become the property of the Journal.* Manuscripts not published will be returned to the author. Queries may be addressed to the care of the Editor at: whowland@howlandhealthconsulting.com

**Manuscript Review Process**

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

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- Kathy Pouch BSN RN-BC CCM CNLCP LNCC
- Victoria Powell RN CCM LNCC CNLCP MSCC CEAS
Contributing To this Issue

Penelope Caragonne PhD (“Assistive Technology for One Hand”) has served persons with multiple disabilities for over 36 years. She has lectured extensively on long-term planning and case management as a model for comprehensive service delivery both within and outside a litigation context. She also provides long-term case management services to individuals with catastrophic injuries, assistive technology assessment, prescription, installation, training and repair services. Her company offers job site modification, educational access services, and forensic assessment, consultation, and testimony. She has served as Vice President of External Affairs, American Rehabilitation Economics Association, book review editor of The Earnings Analyst, Director of Research, International Association of Rehabilitation Professionals in the private sector and has authored multiple articles for the rehabilitation and forensic economics literature.

Liz Holakiewicz BSN RN CCM CNLCP (“Coding and Cost Research in the Life Care Plan”) has a nurse consulting practice in Carlsbad, CA (San Diego County). Practicing life care planning since the mid-1980s, she became certified as a CNCLP in 2000. She is also a certified case manager. She served 5 years on the AANLCP Certification Board and is currently President of the San Diego Chapter of American Association of Legal Nurse Consultants.

Marilyn Pacheco RN (“Coding and Cost Research in the Life Care Plan”) has been in the medical billing industry since 1986. Through the years she has gained a vast amount of experience, most notably in PM&R (physiatry) and contracting. Marilyn’s billing and consulting company, E&M Billing Service, has continued to grow and is recognized as an expert in the industry. Ms. Pacheco is also employed by Miller Children’s Subspecialty Group as an Executive Assistant for a 90+ physician pediatric subspecialty group. She is currently furthering her education and training in evaluation and management documentation.

Ann Maniha (“FAQs in Life Care Plan Pricing”) is a Registered Nurse who is a Certified Life Care Planner and Certified Medical Coder. Her background includes experience in life care planning, medical case management, research and specialty nursing care including, orthopedics, postanesthesia care unit, outpatient surgery, medical-surgical, substance abuse and psychiatry. Ms. Maniha has worked as a life care planner for over ten years. Her experience includes spinal cord injury, amputations, adult acquired brain injury, pediatric acquired brain injury, transplantation, chronic low back pain, cerebral palsy, birth-related injuries, and orthopedic injuries/complications.

Kathleen Pouch BSN RN-BC CCM CNLCP LNCC (“ICD-10 Update”) has been an active member of the AANLCP since 2000 serving as Executive Board Secretary, Editorial Chairperson, and 2005 Annual Conference Co-chairman. She is currently completing her MSN in Case Management. In 2011, she started her own case management company, Pouch Consulting LLC.

Keith Sofka (“Technology Corner”) is a principal of Caragonne and Associates, Ajijic, Jalisco, MX. He has practiced the provision of assistive technology services for the past 30 years. Mr. Sofka provides consultation to hundreds of companies, schools, Government Agencies and individuals. A major focus of Mr. Sofka’s work has been to provide recommendations for and implementation of school and workplace reasonable accommodation recommendations for individuals and organizations. This work typically includes housing and commercial building access as well as transportation, mobility and completion of daily living needs as well as modifications to the individual worksite. He has also taken training and practiced in other areas of assistive technology including custom seating and positioning for individuals with severe orthopedic involvement. His work has always been focused on ways to use technology to increase the independence of the individual.
Kudos
Over the last few years, the quality of the Journal of Nurse Life Care Planning has become increasingly outstanding. I look forward to each issue and am proud that our Journal is such a positive reflection of our Association.

Life Care Planning for the Cancer Patient by Cheryl Kaufman RN BScN CLCP CNLCP is well-written and clearly explains cancer concepts such as myelosuppression, biological response modifiers, and angiogenesis inhibitors. These are all new to this reader, but the author helps make them understandable. The author’s expertise in cancer care and curative cancer treatment options is evident. Her description of different treatment modalities, including complementary medicine, help make her discussion of treatment options comprehensive.

Even for those who are beyond the curative stage, I’m glad the author considered other alternatives and explained what multimodal treatments hope to accomplish.

“Although cure may not be an option, the goal of multimodality treatments is to provide an increased relapse-free and overall survival period with the fewest possible side effects compared to no treatment at all. This is a valid option, when requested by the patient.”

Inclusion of specific examples of nursing diagnoses applicable to cancer patients help make this a handy resource for planners. The resources in the text and the extensive bibliography make this a great article.

A big thank you and keep up the great work!

Linda Husted, MPH RN CNLCP LNCC CCM CDMS CRC
East Setauket NY
lindahusted@aol.com

Another excellent edition, flawless and loaded with lots of useful information. Kudos to you, the contributors, and the reviewers.

Joan Schofield RN BSN MBA CNLCP
Albuquerque NM
js@med-view.com

The journal looks great. It’s one of the nicest I’ve ever seen in terms of layout, etc. Your members are lucky to have such a nice one.

Chris Pasero MS RN-BC FAAN
El Dorado Hills CA
cpasero@aol.com

When I accept an assignment to produce or critique a Life Care Plan, the first place I research is the AANLCP Journal of Nurse Life Care Planning. I received my certification in Nurse Life Care Planning in 2007 and the Journal of Nurse Life Care Planning has consistently been my #1 resource for information. It is also my #1 resource for practical applications and common sense solutions to problems I encounter when writing a NLCP. The Winter 2009 Amputation and Winter 2010 Pain Management journals have been incredibly helpful to me in the past year.

Thank you for providing an excellent, consistent source of information regarding Nurse Life Care Planning.

Kristen Jones RN CLNC CNLCP
Alamo CA
kristenjones@sbcglobal.net

Pain management
As a pain management nurse reading through the articles, I realized what a specialty area this practice arena is, needing to be addressed carefully with practitioners well-rounded in the area of pain management. I was happy to see so much contributed to the arena of pain management and to see such a comprehensive compilation of what pain is, how it is diagnosed and how it is treated all in one area.

Moving from Passive Patient to Active Participant was a fabulous article. It would be a dream for a pain clinic to have patients be more active participants in the healthcare instead of bystanders. In today’s healthcare system there is not enough time or continuity of care for the patient to have all of the different modalities mentioned in one place, e.g., counseling, biofeedback, PT, nutrition, etc. As a pain management nurse I highly encourage the Life Care Planners to seek out treatment plans that include all modalities needed. Patients will definitely benefit from multimodal treatments.

As mentioned in Neuropathic Pain: Assessment and Pharmacologic Management, trial and error with medications is common practice. So many management challenges are involved with neuropathic pain. Patience is necessary and not just on the patient’s end but by the prescribing practitioner. Aging patients must be titrated at a slow pace to avoid undesirable side effects. Therapeutic levels in the elderly may be different due to slowed metabolism. Optimizing management of the patient’s pain through medication management and interventional techniques can give aging adults the tools needed to lead a happy life even with chronic pain.

Traci Corsones, RN-B C BSN CLNC
traci-rn@juno.com

Errata: Dr. Gokul Toshniwal’s name was misspelled in the previous issue. We regret the error; it was corrected.

Letters on any topic are welcome and may be sent to the Editor. Letters may be edited for brevity.
From the **CNLCP Certification Board**

**New Certifications and Reciprocity**

Congratulations to the thirty-eight RNs who achieved Certified Nurse Life Care Planner certification in 2011. For information on obtaining certification by examination or reciprocity, please go to the CNLCP Certification Board at [http://www.cnlp.org/page5.asp](http://www.cnlp.org/page5.asp)

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**Certification by Examination**

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Coding and Cost Research for the Life Care Plan

Liz Holakiewicz BSN RN CCM CNLCP
Marilyn Pacheco RN

Introduction
In the 1980s, the early days of life care planning, prices for care plan items were obtained solely by speaking with individual providers and facilities about the charges for a specific service or procedure. If the provider had other priorities or was otherwise just unresponsive, there were few or no other alternatives to consult.

Although today’s life care planner has more coding resource and database options, even cooperative outpatient facilities and physician offices now want codes to provide pricing information.

Coding systems can benefit life care planning practice because courts require a scientific process as the foundation for expert opinions and coding provides one: a standardized mechanism to conduct cost research and comparisons. This also makes it possible to compare the work of opposing life care planners.

CPT, APC, DRG and ICD-9 codes (see Key to Abbreviations, next page) have the same goal regardless of origin: standardized classification. Codes are definitely required to use most databases. Therefore, life care planning requires basic understanding of the CPT, APC, DRG and ICD-9 CM coding systems. (Ed. Note: Soon to be ICD-10, see page 563)

This article includes a case example to help the reader understand the subject.

Coding Systems for Outpatient Procedures

Current Procedural Terminology (CPT) codes were first developed and published by the American Medical Association in 1966 to

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Marilyn Pacheco has been in the medical billing industry since 1986. Through the years she has gained a vast amount of experience, most notably in PM&R (physiatry) and contracting.
standardize documentation sent for billing. By 1983 CPT codes were adopted by Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), as part of the Health Care Common Procedure Coding System (HCPCS) to report services for Medicare Part B and in the Medicaid Management Information System. A few years later CMS required CPT codes for reporting outpatient hospital surgical procedures.

In 2000 the Health Insurance Portability and Accountability Act (HIPAA) began to require CPT codes for physician services, PT, OT, radiology services, laboratory testing, diagnostic procedures, hearing and vision services and transportation services, e.g., ambulance. *All health care plans and providers who transmit information electronically must use these standard code sets.*

The 5-digit CPT codes are organized in the following broad categories: evaluation and management (E&M), anesthesia, surgery, radiology (70001-79999), pathology and laboratory (80047-89398) and medicine. Providers, insurance carriers, and others use this 5-digit code language to talk about anticipated procedures, approval, billing, care planning, or associated fees.

**How to use it:** Publications such as *Medical Fees in the United States* give national fees in the 50th, 75th and 90th percentile by CPT code. Regional fee variation is anticipated by providing geographical adjustment factor formulas (included). The life care planner should use percentiles consistently, i.e., the same one, in all parts of a given care plan.

The most efficient way for the nurse life care planner to get accurate data for coding a given procedure recommended by a surgeon is to speak to the surgeon directly. This is the best source for extensive details, e.g., anticipated number of levels for continued next page.
a spinal fusion, the type of hardware, surgical approach, type of graft material, use of assistant(s), and operative time. The physician may be able to provide the codes directly. If not, the physician’s coder/biller can verify codes if provided the detailed description of the procedure.

Modifiers clarify details about given procedures. A modifier is a two-position alpha or numeric code appended to the CPT code, adding more information, e.g., anatomical site. Modifiers provide a way to change the service code without changing the procedure code.

Modifiers also help to eliminate the appearance of duplicate billing and bundling. Table 1 shows some modifiers frequently used by physiatrists.

Ambulatory Payment Classifications (APC) are used by Medicare to track and pay for facility outpatient services. These codes are part of the outpatient Prospective Payment System (OPPS) and resemble DRGs for hospital inpatient services (below).

Hospitals submit CPT codes to Medicare on a claim form. Medicare groups these CPT codes by clinical intensity, resource utilization, and cost into specific APC codes and then assigns a prospective payment for each APC once a year. These are fixed payments; the facility assumes the financial risk.

The government created APCs to have hospitals share the financial risk of providing outpatient services. In turn, this motivates hospitals to provide economical, efficient and profitable outpatient services, ultimately resulting in savings to Medicare.

APCs are only applicable to hospitals or facilities and have no impact on physician payment. APCs are continued next page

Table 1. Commonly-used PM&R modifiers. Marilyn Pacheco

22: Increased procedural service: when the work required providing a service is substantially greater than typically required.

25: Significant, separable identifiable evaluation and management service by the same physician on the same day of the procedure or other service: the physician may need to indicate that on the same day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided.

50: Bilateral Procedure: Unless otherwise identified in the listings, adding this modifier to the CPT code should identify bilateral procedures that are performed at the same session.

51: Multiple Procedures: When multiple procedures, other than E/M services, are performed in the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending this modifier. The additional procedure(s) are paid at a reduced rate. 1st procedure at 100% of allowed charges, 2nd procedure (s) at 50% of allowed charges and 3rd procedure(s) at 25% of allowed charges.
used for outpatient surgery, outpatient clinics, emergency department services and observation services. They also apply to outpatient testing (e.g., radiology, nuclear medicine imaging), and therapies (e.g., certain drugs, intravenous infusion therapies, blood products). If a patient is admitted through the Emergency room or hospital clinic, APCs are not used to obtain payment; DRGs are used.

The American Hospital Directory (AHD) (www.ahd.com) and other references use CPT and APC codes to outline cost data for outpatient procedures. They get their data from the hospital OPPS Limited Data Set. However, there are limitations: facilities only report data for groups of more than 10 patients, and the data only include Medicare patients. This means that there is little to no information on many uncommon or pediatric procedures.

How to use it: If a procedure is not commonly provided at a local facility, expand the search. One choice is to find a larger facility that performs it more often. Another is to use APC codes.

AHD provides listings of the APC codes directly under the title block for “Statistics for the Top 20 Ambulatory Payment Classifications” in a live PDF or Excel link. These links are downloadable at http://www.ahd.com/data_sources.html. Look for a broad category of services matching the needed procedure, if a specific procedure cannot be located by CPT code. For instance, you can find a price for APC 0040 Level II Arthroscopy if one is not able to find the price for CPT 29843 for a wrist arthroscopy.

Charge, Cost, and Payment

Use the “Average Charge,” not the “Average Cost” (to the hospital) or the “Average Payment” (by Medicare) to avoid discounting costs. It is important to understand these distinctions when referencing the AHD tables in deposition, as questioning is likely to focus on why one option was chosen over the other. Should cost data not be available for a procedure with specific facilities with AHD, the net will need to be cast over a wider area, by using state wide databases (e.g., www.orpricepoint.org) or national data. The general process, however, should be to use local geographic resources specific to the injured party first and then expand to a broader geographic area.

There are excellent resources on these coding topics in the CMS Medicare Learning Network for further reference. (https://www.cms.gov/MLNGenInfo/)

continued next page
Coding Systems for Inpatient Services

Diagnosis-related group (DRG), like APC, is designed to classify hospital care into one of approximately 500 groups expected to have similar hospital resource use. Criteria used include ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities are screened and clustered by a computer program, ultimately assigning a DRG. The assigned DRG determines how much Medicare pays a hospital, since patients within each category are clinically similar and are expected to use the same level of hospital resources.

ICD Codes

The International Statistical Classification of Diseases (ICD) and Related Health Problems is published by the World Health Organization as a means to classify diseases, symptoms and procedures. Each health condition is assigned to a unique category and given a code, up to six characters long. Such categories can include a set of similar diseases. This system is designed to promote the ability to compare statistics about health, morbidity and mortality in the international community. It is used across the world to obtain reimbursement and automate decision-making. HIPAA requires using ICD-9 codes for inpatient hospital services.

On October 1, 2013 ICD-10 will become mandatory for use across all of health care. (Ed. note: The compliance date of ICD-10 will be delayed from October 1, 2013 to a yet-to-be-determined date. The World Health Organization plans to release a new draft of ICD-11 in May 2015.) ICD-9-CM contains more than 17,000 codes and ICD-10 contains more than 141,000 codes and accommodates a host of new diagnoses and procedures. The number of diagnostic codes under ICD-10-CM will swell from 13,500 ICD-9 codes to 69,000 with ICD10, and inpatient procedures will jump from 4,000 codes to 71,000 codes. The ICD is currently the most widely used statistical classification system for diseases and procedures in the world. It consists of tabular lists of causes of death percentiles and code, alphabetical index to diseases, injury, drugs and chemicals and descriptions, guidelines and coding resource. ICD 9 codes have categories for diagnoses as well as for procedures.

**How to use them:** DRGs and ICD-9 codes are keys that can unlock cost data. AHD uses the Medicare Provider Analysis and Review (MedPAR) file, which contains IPPS billing records for Medicare beneficiaries. AHD uses the broader category of DRGs to provide cost information for inpatient charges at specific facilities. Healthcare Cost and Utilization Project (HCUP) of the Agency for Health Care Research and Quality ([http://www.ahrq.gov/data/hcup/](http://www.ahrq.gov/data/hcup/)) uses ICD-9 codes and can search statewide and nationally for charge information for a procedure with a variety of options such as metro versus rural, or teaching versus non-teaching facilities. Since the HCUP data is not purely Medicare data, pediatric services can also be researched with this resource.

*continued next page*
Other Sources
In addition to coding resources and databases, the life care planner can also contact manufacturers of devices or pharmaceutical providers to aid in the pricing of items in a care plan. Many manufacturers of the devices provide medical providers with detailed information on how to code their product for optimal reimbursement. These same data are incredibly helpful to the life care planner, as both inpatient and outpatient facility codes and all relevant CPT codes are identified for their particular device.

The primary databases used to research costs in the Neulicht et al. (2009) survey of life care planners for their methodology, process and practice, in order, were:

- Medical Fees In the United States
- Physicians Fee Reference
- American Hospital Directory
- Healthcare Common Procedure Coding System
- Healthcare Cost and Utilization Project
- Red Book: Pharmacy’s Fundamental Reference
- National Fee Analyzer

This same survey found that most respondents did not use cost information older than one year. The number of cost estimates varied based on the availability of a current vendor or provider, nature of the time or service, recent experience, cost of the item, time frame required, and database availability. A majority of respondents do not use negotiated fees or an established fee schedule. This means that most life care planners surveyed used market rates for services, not discounted rates. Geographic specificity to the client is important in plan development.

Using a search engine to inquire about the procedure code or relevant CPT code for a surgery is remarkably efficient in directing the nurse life care planner to resources for coding as well as some of the other resources noted in this article. For the case example, below, the author was able to identify an INGENIX coding companion for podiatry. There is also a series of books, Orthopaedic Pocket Procedures, published by McGraw Hill that shows orthopedic procedures, identifies applicable CPT and ICD-9 codes, and defines alternative treatment considerations. These reference books cover a variety of different areas in orthopedics by a variety of different authors.

Case Example
Mr. C is a 25-year-old man with traumatic C5 incomplete spinal cord injury from a gunshot wound 5 years ago. Following incarceration, where he was essentially bed-bound for 4 years, he completed an inpatient rehabilitation program. Since the injury he has been taking oral baclofen (10 mg, 4 times daily) to control spasticity. He has bilateral plantar flexion contractures, which impair weight bearing activities such as transfers.

In the last several months he has noticed his spasticity worsening. The muscles of his trunk and lower extremities go into severe extension when he transfers to or from his wheelchair, which puts him at high risk for falls. Self-catheterization has become difficult, because heightened tone in the adductor muscles of his

continued next page
lower extremities causes close approximation of his thighs. Transfer to a commode is also hindered by spasticity. The physical medicine physician recommends trial of a baclofen pump and botulinum (Botox, Myobloc) injections for the life care plan. Mr. C has been referred for orthopedic consultation for tendon release, as recommended by the physiatrist. The next pages illustrate coding and costing for the botulinum and baclofen.

**Botox or Myobloc injections**  
*Marilyn Pacheco*

Since Botox injections are administered in the physician office, in this instance, the only needed codes are those for the site of the injection, the EMG guidance and the medication. Fees for these CPT codes can then be researched with Medical Fees in the United States or a similar database. In this example, injections are administered in San Diego, CA. For 2012 the Geographical Adjustment Factor (GAF) for San Diego is 1.072.

**HCPCS is used to identify drugs**

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<tr>
<td>J0587</td>
<td>Myobloc</td>
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**CPT codes for procedures:**

- **64612**: Chemodenervation of muscle(s); muscle(s) enervated by facial nerve (e.g., for blepharospasm, hemofacial spasm)
- **64613**: Destruction of neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (e.g., for spasmodic torticollis)
- **64614**: Extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
- **64640**: Destruction by neurolytic agent; other peripheral nerve or branch
- **95870**: Electromyography, limited study of muscles in one extremity

**CPT 64614, injection into extremity**  
Medical Fees in the United States, 2012, 75th percentile is:  
$680 \times 1.072 = $728.96

**CPT 95870, EMG guidance**  
Medical Fees in the United States, 2012, 75th percentile is:  
$211 \times 1.072 = $226.19

**ICD-9 Codes that support medical necessity for Botox or Myobloc injections:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>333.6</td>
<td>333.7</td>
<td>333.81</td>
<td>333.82</td>
</tr>
<tr>
<td>333.83</td>
<td>333.89</td>
<td>334.1</td>
<td>340</td>
</tr>
<tr>
<td>341.1</td>
<td>341.8</td>
<td>341.9</td>
<td>342.11</td>
</tr>
<tr>
<td>378.9</td>
<td>478.75</td>
<td>478.75</td>
<td>530.0</td>
</tr>
<tr>
<td>723.5</td>
<td>728.85</td>
<td>351.8</td>
<td></td>
</tr>
<tr>
<td>343.0-334.4</td>
<td>343.8-343.9</td>
<td>378.00-378.03</td>
<td></td>
</tr>
<tr>
<td>378.10-378.18</td>
<td>378.20-378.24</td>
<td>378.30-378.35</td>
<td></td>
</tr>
<tr>
<td>378.40-378.45</td>
<td>378.50-378.56</td>
<td>378.60-378.63</td>
<td></td>
</tr>
<tr>
<td>378.71-378.73</td>
<td>378.81-378.87</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*continued next page*
Intrathecal Baclofen Therapy  Marilyn Pacheco

Intrathecal baclofen therapy (ITB) is used to reduce severe spasticity associated with cerebral palsy, stroke, brain injury, multiple sclerosis and spinal cord injury.

**HCPCS is used to identify drugs**

J0475  baclofen

**CPT codes for procedures:**

**62311:** Screening Test, Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrasts (for localization or epidurography), or therapeutic substance(s) (including anesthetic antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

**95991:** Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), administered by physician

**62367:** Electric analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming

**62368:** Electric analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

**ICD-9 Codes that support medical necessity for implantable baclofen pump:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>340</td>
<td></td>
</tr>
<tr>
<td>344.4x</td>
<td></td>
</tr>
<tr>
<td>343.3</td>
<td></td>
</tr>
<tr>
<td>344.89</td>
<td></td>
</tr>
<tr>
<td>344.3x</td>
<td></td>
</tr>
<tr>
<td>438.21</td>
<td></td>
</tr>
<tr>
<td>438.40</td>
<td></td>
</tr>
<tr>
<td>438.52</td>
<td></td>
</tr>
<tr>
<td>781.3</td>
<td></td>
</tr>
</tbody>
</table>

*X indicates a fifth digit required on the CPT code:

0 – affecting unspecified side
1 – Affecting dominant side
2 – Affecting non-dominant side

Although this is not relevant for the purposes of cost research, if the fifth digit is not present, the claim will be denied when submitted for reimbursement. The tables on the following page demonstrate the details of charges for a medication pump using the coding reference from the manufacturer along with the resources discussed in this article to obtain pricing.

*text continued page 557*
## Pump Charges

Prepared by Liz Holakiewicz, RN, BSN, CCM, CNLCP

### Physician charges for refills in the office per Dr.

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pump Refill kit</td>
<td>84.00</td>
</tr>
<tr>
<td>Pump Programming</td>
<td>252.00</td>
</tr>
<tr>
<td>Pump Programming</td>
<td>350.00</td>
</tr>
<tr>
<td>Medication: about $2.50 per 10 mg units (J code 2275) Based on October 2011 Medicare Fee structure +5%</td>
<td>$1,032.00</td>
</tr>
</tbody>
</table>

**TOTAL average per visit**

$560.00

The pump is not reprogrammed at every visit but interrogation at each visit does occur.

The pump is refilled about every 45-60 days depending on the concentration of the drug and the rate. This would be approximately 7 times per year or an annual cost of (not including medication charge):

$3,920.00

### Outpatient Facility fee not including the pump, Heights Surgery Center:

$6,924.00

Dr. obtains the Pump Total for this option would be $68,924

**Total Outpatient Placement @ Heights**

$68,924.00

Outpatient Facility fee which includes the pump:

$47,000

**Average Outpatient Fee**

$57,962.00

**Inpatient Facility Fee based on data from Agency**

$102,179

### Physician Fees utilized in calculation of procedure, as taken from Medical Fees in the United States 2012 using a geographical factor of 1.032 for "the rest of California"

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Med Fees 75%</th>
<th>GAF</th>
<th>Price for SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>62350</td>
<td>Implantation, revision or repositioning of tunneled intrathecal catheter for pump w/o laminectomy</td>
<td>$2,322.00</td>
<td>1.032</td>
<td>$2,396.30</td>
</tr>
</tbody>
</table>

CPT 62351: Implantation, revision or repositioning of tunneled intrathecal catheter for pump w/ laminectomy

$2,846.00 1.032  $2,937.07

**TOTAL Cost for Trial:** includes average outpatient facility charge from Heights, average of CPT 62319 and 62311, average of 72275 and 77003 with related professional fees and 99144

$8,638.18

**TOTAL Cost for Placement:** includes average inpatient and outpatient facility fee, CPT 99144, average of 72275 and 77003, and the related professional fees, average of CPT 62350 and 62351, and CPT 62362

$85,725.86

**TOTAL Cost for Replacement:** includes average inpatient and outpatient facility fee, CPT 99144, average of 72275 and 77003, and the related professional fees, and CPT 62362

$84,671.16
In this instance, there were no data available from local community hospitals for pump insertion.

Charges for the specific ICD-9 code (pump insertion, 86.06, for the State of California) were found on HCUPnet. Outpatient facilities were contacted to obtain related fees directly from the provider for outpatient charges. This author uses an average of charges obtained for a given procedure, often showing details for research conducted. It should be noted that there are facilities whose prices are outliers, either significantly lower or higher than norms for the community. These locations should be eliminated from averaging unless specifically relevant to the treatment of the individual for whom the life care plan is being developed.

**Tendon Release**  
Three charges should be addressed in pricing out a procedure: the facility, the surgeon’s and the anesthesiologist. The surgeon’s actions during a procedure are assigned a CPT code for reimbursement. This same code may also be used to describe outpatient facility charges. An ICD-9 code or DRG for the facility services is used if an inpatient procedure is anticipated. A CPT code is also used for anesthesiology.

In our example we could use CPT 27606, percutaneous tenotomy of the Achilles tendon, under general anesthesia. One then uses this code to research the price in Medical Fees in the United States. One of three percentiles is selected by the nurse life care planner and then the geographical adjustment factor is applied to specify the charges to the area where the procedure will be performed.

The ICD-9 Procedure code for this procedure is likely 83.11, Achillotenotomy. Since this is not a procedure commonly performed on Medicare recipients the researcher may find that there is not enough data for inclusion in AHD hospital locations. Using the ICD-9 procedure code of 83.11 to search HCUP yields 62 discharges in California for an average charge of $29,892.

Finally, the related anesthesia charges need to be included in the total charges for this procedure. Decision Health (telephone 877-602-3835) offers a resource entitled *Anesthesia Average Time and Charge Benchmarks* which identifies fees for anesthesia services, base units and average minutes of anesthesia for that particular code, the average charge, and the average Medicare rate. In this case, CPT 01470, Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot, not otherwise specified, would apply. For the State of California, these charges in 2010 would be $564.61. This resource is for sale by specific geographical location throughout the country so a geographical adjustment factor is not necessary.

**Summary**

Use of CPT, APC, DRG and ICD-9 codes has become the normal process for conducting cost re-

*continued next page*
search in life care planning, either to access information from local providers or when using databases and fee structures. The example given illustrates one of many possible approaches to cost research in life care planning. The nurse life care planner must have a basic understanding of the use of these codes to research costs and access databases for corresponding pricing. The nurse life care planner’s understanding of these systems and the implications for use of different data sets is critical later as testimony is provided and explored.

References
Abraham M et al., CPT Professional Edition 2012, Chicago, IL 2011
Agency for Health Care Research and Quality Health care Cost Utilization Project, http://hcupnet.ahrq.gov/HCU/Pnet.app
Anesthesia Average Time and Charge Benchmarks, Decision Health, 2010
Medtronics, Intrathecal Baclofen for Severe Spasticity worksheet. Medtronics, Minneapolis MN
World Health Organization website http://www.who.int/en/
FAQs in Costing and Pricing

Ann Maniha, RN CLCP CMC

It is important to know the distinct differences between three terms when developing charges associated with codes, billing, and reimbursement.

The *billed charge* is what the provider charges for the service(s) performed or item(s) provided, before any discount is applied. This may also be known as *billed amount, usual or customary, or retail.* The provider chooses this amount to cover costs and means of support. It is essentially the same process that any professional would use to determine professional fees. (Maniha, 2008)

*Cost* is the actual cost to perform the procedure, including overhead, materials, insurance, additional staff, education or expertise involved, and specialty training. This does not include any mark-up. (Maniha, 2008)

The *reimbursement amount* is what the payor pays the provider. This takes into account any specific rules, regulations, and contracts that apply to the payor source, e.g., a specific insurance company plan, Medicare, or workers' compensation, and the provider. (Maniha, 2008)

Life care planning uses billed charges, not cost or reimbursement rates. The life care planner should adhere to this methodology regardless of the referral source. If the life care planner is requested to identify specific reimbursement rates required by rules of a specific jurisdiction, then it is this author's opinion that a disclaimer should be included in addition to identifying this rate. Identifying the entity's allowable rate, also known as the *reimbursable amount,* can be as easy as adding an additional column to the life care plan charts. (Maniha, 2008)

In past years, one typically would ask for the "private pay charges." However, now there is wide variability in what "private pay" means and this may no longer be appropriate because facilities and physicians may apply a discount to the "private pay charges." Using any kind of discounted charges in a life care plan runs the risk of providing inadequate funding for lifetime appropriate care. It is critically important for the life care planner to develop a comfortable way to convey to the provider what the life care planner is actually requesting. (Maniha, 2008)

*Ann Maniha is a Registered Nurse who is a Certified Life Care Planner and Certified Medical Coder. Her background includes experience in life care planning, medical case management, research and specialty nursing care including, orthopedics, postanesthesia care unit, outpatient surgery, medical-surgical, substance abuse and psychiatry. She can be contacted at ann.maniha@att.net*
There are three questions that often arise when pricing out the life care plan. This article will address them in order.

1. Which percentile most accurately represents provider billed charges?

Two reputable databases, Medical Fees 2012 and Physicians’ Fee Reference 2012, gives fees for Medicare RVU (relative value unit) and Medicare National Fee; and usual, customary and reasonable (UCR) fee information by 50th, 75th and 90th percentile. UCR charges are determined by review of the local market charges in a specific geographical area for providers of similar services or supplies.

These databases assist physicians and providers to set their fees. An article in BC Advantage, a magazine for billing, coding, office and HIM professionals, noted that it is important for billing companies when reviewing physician fee schedules to set the fees at least at the 75th percentile and the author of that article noted that his company suggests the 90th percentile to their clients. (Feins, 2006) Large insurance groups such as Aetna or Arlen Group indicate they set their out-of-network provider allowable at the 80th percentile. Medical Fees 2012 indicates that HMOs and other managed care groups negotiate fees closer to the 50th percentile.

When the Veterans’ Administration developed “Reasonable Charges,” they chose the 80th percentile. Prior to developing this fee schedule the VA used average cost-based per diem rates to bill insurers. On continued next page

What is a percentile? What are median and mean?

### Table 1. Percentile illustration

<table>
<thead>
<tr>
<th>50th percentile</th>
<th>75th percentile</th>
<th>90th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% equal or below</td>
<td>75% equal or below</td>
<td>90% equal or below</td>
</tr>
<tr>
<td>50% above</td>
<td>25% above</td>
<td>10% above</td>
</tr>
</tbody>
</table>

Medical Fees 2012 defines a percentile as “a value on a scale of one hundred that indicates the percent of distribution that is equal to or below it.” (Davis, 2012) For example, if a fee for CPT 99213 is $75, and is in the 50th percentile, then 50% of all fees charged for 99213 are equal to or less than $75, or 50% are equal to or more than $75. If it is in the 90th percentile, then 90% are the same or below, or 10% are the same or above (see Table 1, above).

Remember that median and mean or average are not the same. The median, also known as the 50th percentile, is the middle/midpoint value; the mean is the average of all values.

Using the seven values as shown in Table 2, as an example, the median value of the group is 5; that is, there are three larger and three smaller. The mean is the average of the group; that is, the total amount divided by the number of values.
the VHA Chief Business Office website under Reasonable Charges (rates) Information, the following was noted, “Reasonable charges are based on amounts that third parties pay for the same services furnished by private-sector health care providers in geographic area.”

All that said, what percentile should the life care planner use to cite billed charges? It is this author’s opinion 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.

2. Do I use the private pay discount?
It’s a common misconception that all private pay, underinsured, or uninsured individuals receive discounts on their hospital billed charges. This is not always the case. Life care planning should use actual billed charges and not discounted charges. (Maniha, 2008)

The problem with discounts is that there is no guarantee they will remain in place over time. Using discounts will most likely not provide the required funds to care for that individual over their lifetime. (Maniha, 2008)

Another misconception is that no one pays actual billed charges. Once again, this is not always the case. Some hospitals have been known to charge the uninsured and underinsured at least 155% of hospital costs, while the insured are charged 50% less. When this became known, some states enacted laws to protect individuals from this practice. There are state hospital association websites that indicate that insured, underinsured, and uninsured are charged the same. Don’t forget that insurance carriers negotiate discounts off of these charges. (Reinhart, 2006)

3. Is Medicare pricing appropriate?
No. Experts in the field of practice management note that private and commercial provider fees are approximately 300% of the Medicare physician fee schedule. In other words, one would multiply the geographically adjusted Medicare fee by 3 to reflect actual billed charges. Medicare and Medicaid are collateral sources and not to be used in life care planning. This is because collateral sources are like discounts; there is no guarantee they will remain in place or unchanged over time.

Conclusion
Costing out items using billed charges is an important part of creating a life care plan. It is important to
use the full amount of billed charges and not use discounted schedules, including private pay discounts, because discounts of any kind may not be available to the consumer over time. Since the Medicare fee schedule is a set fee schedule, it does not represent billed charges, and using it would be the same as using a discount. Therefore, using it would do the individual a disservice as it would most likely not provide for funds to meet an individual’s lifetime needs. It is this author’s opinion that when relying on national databases the 75th and/or 80th percentile more accurately represents billed provider charges.

References
Davis, J. B. Medical fees 2012. (18th ed.). Los Angeles; Practice Management Information Corporation, 2012
Feins, F.. Setting provider fees. BC Advantage, 2006

Spring, First pitch
LaLecheur Park
International Classification of Diseases

ICD-10 Update

Kathleen Pouch  BSN RN-BC CCM CNLCP LNCC

While a life care planner refers to diagnosis and procedure codes, the life care planner does not assign them. Codes are assigned by coding and billing experts based upon the activity performed by the medical provider. This article will address the ICD codes.

The *International Classification of Diseases* is an international system used to classify diseases, conditions, circumstances, signs and symptoms, and causes of death for mortality statistics. The ICD has been revised ten times since 1900 to reflect and incorporate changes in the medical field (www.cdc.gov).

The current version, ICD-9, is used to classify and code mortality data for death certificates. The ICD-9 CM (Clinical Modification) assigns codes to diagnoses in hospital utilization in the United States. The ICD-9 PCS (Procedure Coding System) is used for identifying procedures or specific interventions.

On October 1, 2013 ICD-9 will be replaced with the ICD-10 (www.cdc.gov). (Ed. note: The compliance date of ICD-10 will be delayed from October 1, 2013 to a yet-to-be-determined date. The World Health Organization plans to release a new draft of ICD-11 in May 2015.)

ICD-10

The ICD-10 includes tabular lists of:
- cause and death titles and codes
- inclusion and exclusion terms for cause of death titles
- alphabetical index to diseases and nature of injury
- external causes of injury
- table of drugs and chemicals
- description, guidelines, and coding rules (www.cdc.gov)

ICD-10-CM has expanded on the ICD-9-CM with additional information on:
- ambulatory and managed care encounters
- expanded injury codes
- combination of diagnosis/symptom codes reducing the number of codes to describe a condition
- addition of sixth and seventh characters
- inclusion of general fourth and fifth character subclassifications
- laterality
- greater detail in code assignment (www.cdc.gov)

There are currently 19,817 codes in ICD-9; ICD-10 has 141,060 codes (Wollman, 2011). This expansion in codes allows for greater precision in identifying procedures and diagnosing in billing and coding.

Kathleen Pouch has been an active member of the AANLCP since 2000 serving as Executive Board Secretary, Editorial Chairperson, and 2005 Annual Conference Co-chairman. She is currently completing her MSN in Case Management. In 2011, she started her own case management company, Pouch Consulting LLC. She can be contacted at Pouch Consulting LLC, 2997 W. Centerline Rd., St. Johns, MI 48879, 989-224-8520, kathy@pouchrn.com
The ICD-10 includes both CM and PCS. (www.cms.gov/ICD10).

ICD-9 codes were generally three to five digits, e.g., 813 or 813.06. Both ICD-10 CM and PCS codes will now have 7 alphanumeric characters. In ICD-10-CM, the first character is alpha (a letter); second character is numeric (a number); and characters three through seven are alpha or numeric (Centers for Medicare and Medicaid [CMS], 2010). For example: the ICD-9-CM code 813.06 designates fracture of the neck of radius, closed. In ICD-10-CM the code becomes S52.131a a displaced fracture of the neck of right radius, initial encounter for closed fracture (CMS, 2010). The change in the code has enhanced the definition of the diagnoses. This information can be helpful to the nurse life care planner.

ICD-10-PCS has evolved from three to four characters to seven, with each either alpha or numeric (CMS, 2010). The letters “O” and “I” are not used to prevent confusion with the numbers zero and one (CMS, 2010). ICD-10-PCS code 0DHA4UZ designates an insertion of feeding device into jejunum, percutaneous endoscopic approach. The seven digit alphanumeric code for this procedure is:
- 0, medical surgical section
- D, gastrointestinal body system
- H, the operation (insertion)
- A, the body part (jejunum)
- 4, the approach (percutaneous endoscopic)
- U, the device (feeding tube)
- Z designates no qualifier (CMS, 2012)

This conveys more information than the former ICD-9-PCS code, 44.32: percutaneous endoscopic gastrojejunostomy.

**Coding Format**
The ICD-10-CM index is separated into an alphabetical list of terms with codes and a tabular list of codes containing categories, subcategories, and codes (CMS, 2012). Both lists are used when locating a code because the alphabetical index does not always provide the full code (CMS, 2012). Codes that identify diagnoses, symptoms, problems, syndromes, or complaints are located in A00.0 through T88.9 and Z00-Z99.8 (CMS, 2012). Codes that describe signs and symptoms, and not diagnoses, can be found in Chapter 18 and are used if the diagnosis has not been defined by the provider (CMS, 2012). An ICD-10-CM code may include multiple codes to describe a condition; both acute and chronic conditions; combination code of two diagnoses; sequela effect after the acute phase has terminated; and as the seventh digit, laterality to identify right, left, or bilaterally (CMS, 2012).

**Transitioning from ICD-9 to ICD-10**
After the compliance date, all Health Insurance Portability and Accountability Act (HIPAA) entities will be required to use the ICD-10 diagnosis and procedure codes for services provided, for reimbursement, including providers and payers that do

*continued next page*
not process Medicare claims (CMS, 2011, July). Claims without ICD-10 codes will not be processed. ICD-10 code sets may be obtained free of charge from the CMS website.

- ICD-10-CM at: https://www.cms.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp#TopOfPage
- ICD-10-PCS at: https://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp#TopOfPage

Additional References
Additional coding resources are available to assist the nurse life care planner in understanding the upcoming changes to ICD.

- www.ICD10data.com: 2012 ICD-10 medical coding website includes the ICD-10-CM and ICD-10-PCS indexes and a tool to convert ICD-9 to and from ICD-10
- https://www.cms.gov/ICD10/Downloads/ICD-10QuickRefer.pdf: CMS Quick Reference Information is a two page guide that explores the benefits of the ICD-10-CM and the similarities and differences between the two coding systems

Conclusion
The ICD-10 CM/PCS contains increased clinical information to measure health care services, conduct public health surveillance, document claims, refine grouping and reimbursement methodologies, identify fraud and abuse, design payment systems, and process claims (CMS, 2010). The information found within the code contains a wide-range of clinical impressions, identification of body parts, and patient encounters while avoiding umbrella codes in order to provide a unique code that identifies specificity in the coded data (CMS, 2010).

Every HIPAA covered entity will transition from ICD-9 to ICD-10 at a date to be determined. The nurse life care planner can be prepared to decode the ICD-10 using the resources discussed, and by accessing the Centers of Disease Control and Prevention website; www.cdc.gov.

References
Call for posters

October 12-15, 2012 ~ Albuquerque, New Mexico
“Rising to New Heights: Today, Tomorrow, & Beyond”

**Submission deadline for poster presentations: September 1, 2012**

Poster presentation submissions are encouraged as a way to share knowledge, skills and expertise with your colleagues. Posters will be on display throughout the conference. Poster presenters will be asked to prepare a five minute overview of their presentation to be delivered to the general session audience. Awards will be given to poster presenters. Poster presentations will be reviewed by the Journal of Nurse Life Care Planning for possible invitation to expand the subject matter into a full text article for publication. Posters of all subject matters pertinent to the field of nurse life care planning are welcomed.

**Potential poster topic ideas**

- A comparison of ways to incorporate nursing diagnoses in LCPs
- LCP examples that clearly demonstrate use of the nursing process
- A review of the literature related to a specific nursing diagnosis

Name, credentials, address, phone, email

Presentation Topic or Title and description

Please fax this form to 1-801-274-1535 or email to: sandigansel@gmail.com
Obtaining costs and charges is difficult and time-consuming. There are no short cuts. The nurse life care planner should have a good understanding of the procedure and be organized with questions in hand before contacting a provider or biller for assistance. Establishing relationships with medical professionals and staff is valuable for future assistance, and networking with peers promotes better practices in obtaining charges.

Participants at the 2011 Annual AANLCP conference in Kansas City were asked to submit billing and coding related questions for this issue of the Journal. The following questions were discussed by a random panel of experienced nurse life care planners. The following is a summary of their opinions. Opinions and sources are not endorsed by the AANLCP or the Journal of Nurse Life Care Planning.

Life care plans are individualized documents. Nurse life care planners also have individual approaches based on their experiences in obtaining costs and charges. There was consensus among the panel on many items, but not all (see box below). Your comments or questions on this Roundtable are welcome. Please direct them to the Editor.

Q. What resources or websites do you use for coding or billing issues in the development of a life care plan?

A. The panelists offered many suggestions.

• AHRQ (Agency for Healthcare Research and Quality)
  http://hcupnet.ahrq.gov Free health statistics, information on hospital inpatient and emergency department utilization. Queries on hospital stays throughout the nation or by specific state are available based on diagnoses or procedures from years 1997-2009 using ICD-9 procedure or diagnoses codes. Information the nurse life care planner may find helpful includes the mean length of stay and the mean hospital charges.
Not all of the nurses from the panel used AHRQ because the charges tend to be low and some felt it was outdated. AHRQ is used by the panel as a starting point when gathering charges for a procedure or diagnosis.

- **AHD (American Hospital Directory)**
  
  [www.ahd.com](http://www.ahd.com) Hospital statistics of Medicare inpatient and outpatient utilization and hospital profiles. Individual subscription fee $355 per year as of this writing.

Many on the panel used AHD pricing with the appropriate DRG (Diagnosis Related Group) code as a starting point in determining charges for inpatient and outpatient treatment.

- **Google** ICD-9 codes, CPT codes, DRG codes, and billing guidelines for procedures or treatments.

For example, a nurse life care planner looking for the charge of a cervical epidural steroid injection might search the following: “cervical epidural steroid injection billing guidelines.” This will yield approximately 87,000 results with information such as:

- specific medical insurance companies’ allowable CPT codes, ICD-9 diagnosis codes, and inclusions and exclusions
- billing coders’ general discussions regarding reimbursement for the service
- policy and guidelines for coverage determination; and articles on techniques for performing the procedure

The nurse life care planner needs to consider the source of the material before placing trust in the information provided. The nurse life care planner will have to determine if the information is credible, who sponsors the site, and if the information is trying to sell a product or service before relying on the material.

- **Medical Fees in the United States**, PMIC. Usual and customary medical procedure codes (surgery, laboratory, radiology, evaluation and management, therapy, etc.) at 50th, 75th, 90th percentiles, Medicare fees, geographical modifiers.

The nurse life care planner will need to know the CPT codes for the service or procedure to identify the corresponding charge.

The panel also advised the life care planner have knowledge of modifiers when obtaining charges. Modifiers are used if a physician performs multiple procedures during a surgery, the procedure is bilateral, the procedure occurs at the same time as an office visit, or the procedure has both a professional and technical component. An insurance company won’t pay for all procedures separately, but pays for the primary procedure and then the remaining portions of the surgery based on the assigned modifiers. The nurse case manager can identify the modifiers by asking the physician or office staff, “What is the CPT code used for this procedure, and will there be any modifiers used?”

*continued next page*
Medical Disability Advisor
www.mdguidelines.com and

Official Disability Guidelines
www.odg-twc.com  These are data sources for predicting disability duration, cost, treatment guidelines, and return to work. Access is by annual subscription.

Additional websites frequented by members of the panel for charge information included:

- Drugstore.com  Medications
- AllegroMedical.com  Equipment and supplies
- Pattersonmedical.com (Sammons Preston)  Rehabilitation equipment and supplies (ask for their catalog)
- Amazon.com  Equipment and supplies
- Spinlife.com  Wheelchairs, scooters, lifts
- Invacare.com  Wheelchairs, beds, rails, respiratory, patient transfer equipment
- RehabMart.com  Rehabilitation equipment
- ROHO.com  Pressure relief equipment

Q. How do you obtain treatment charges?
A. Panel members suggested the nurse life care planner request all available itemized bills. These will provide ICD-9 diagnoses codes applied to the patient’s condition, CPT procedure codes, number of units, and the total bill less what another payer source covered. It is essential to understand the difference between charge and cost. Charge is the amount the facility uses before any discounting to the patient bill is applied. Cost may reflect any insurance payments or write-offs that were applied to the patient bill.

If itemized bills are not available to the nurse life care planner, the panel recommends the following:
- Identify the procedure
- Perform basic research on the procedure technique, complications, indications

continued next page

There was consensus among the panel members on many items. The following were the exceptions:

- Using the Physician’s Fee Schedule / AHD / AHRQ
- Putting CPT codes in the life care plan
- Including anesthesia charges
- Using modifiers
- Asking the provider / facility if a cash discount is accepted (Ed.: see p. 559)
- Telephone call vs. personal visits
• Identify possible CPT codes and diagnosis codes
• Contact the treating physician for selection of the appropriate CPT codes and modifiers for the specific procedure. Ask how long the procedure will take. Ask how many days of hospitalization will be required. Is therapy needed post-operatively? Identify what preoperative testing will be needed. Ask what the physician charges for the procedure.

The panel suggested if the life care planner has the physician’s cooperation with this process, the information may be sent to the physician with a request to return signature to document collaboration.

If a treating physician is not available, contact a comparable physician practice for the corresponding CPT codes and modifiers based on the ICD-9 code for the above information.

If the nurse life care planner is working for the defense, discuss with the attorney the ability to rely on the defense expert for codes and charges.

• Using the CPT codes and modifiers, obtain the basic price information using Medical Disability Advisor, and/or Official Disability Guidelines.
• Contact the hospital or outpatient facility billing department for charges for the identified CPT codes. One member of the panel recommends a personal visit to the facility for this purpose. Identify the daily bed rate charge. Compare the charges provided by the facility against the basic information previously obtained (Medical Fees in the United States, AHRQ, AHD, Medical Disability Advisor, or Official Disability Guidelines).

• If the procedure is in an outpatient facility, the nurse life care planner will need to know how many units will be assigned to the procedure. Charges may be calculated with price per unit multiplied by number of units.
• Contact anesthesia to determine their charge for each 15 minutes of surgery time. Ask if there will be lines or post-op injections because these items could increase the anesthesia charges.

**Pearls**

The panel offered these suggestions.

• Keep it simple.
• Identify yourself using your title of nurse case manager.

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• Save a file of bills from other plans for reference.
• Use the word “trust” or “budget” when requesting charges.
• If a provider wants to use the amount the insurance company is paying as the charge, consider that even if insurance is currently paying the charge, a medical insurance company may demand return of its payments.
• Another rationale for requesting charges would be in the instance of a health savings account.
• Keep it light, use humor. Respect what people do; you are not a biller or office manager.
• Be organized before making the call or personal visit.

• Never use more than 15 minutes of someone’s time when requesting charges.
• Keep a notebook with information about associates that are contacted often. “I remember them, and they remember me,” advises one panelist.
• Do not call an office on a Monday morning or Friday afternoon.
• Be humble and ask for assistance. If you are speaking with a nurse and ask for help, a nurse will help you.
• Physical and occupational therapy are examples of treatments billed in 15 minute increments. Know the limits associated with the CPT codes.
• Do not ask for procedure charges on an online list.

Spring, Maritime Academy

Mother and girlfriend, graduation day
This column will address easy-to-accomplish modifications for individuals with unilateral musculoskeletal-related conditions, such as Erb’s Palsy, weakness in one upper extremity, carpal tunnel syndrome without a good surgical outcome, injuries to the hand, wrist, fingers, or arm which have resulted in reduced grip strength, little or no fine-finger control, reduced pincer grasp, or just general loss or reduction of strength or function in one limb.

One only needs to think back to when someone we knew lost use of one finger, an arm or a hand to realize just how life-altering loss or limited use of an upper extremity can be. Tying your own shoes, and many other ADLs, go from automatic tasks to next to impossible. Work is difficult. Coping with these losses of function can be very hard. It can be even harder when others don’t recognize this, particularly when they compare them to more highly-visible injuries. Fortunately there are many assistive technology devices and modification strategies to help.

There are hundreds of helpful devices available. Many can be bought from specialty vendors; some are off-the-shelf consumer items; some are “do-it-yourself” items. It is important to be sure that any item you select for a client is useful and individualized to the specific person with whom you are working. This specific-to-the-person-assessment process is the purpose of an assistive technology evaluation.

The general availability of AT devices in catalogs may lull you into thinking that a “Chinese menu” approach to device identification is effective. This is incorrect. It is important to identify a specialist with experience and training in the area pertaining to the functional obstacles you have identified. For example, if you need recommendations pertaining to as-

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assistive technology for activities of daily living, an Occupational Therapist (OT/R) with ATP certification from RESNA (Rehabilitation Engineering Society of North America) would be a good place to start.

Specific recommendations cannot be made until detailed questions are asked and answered; everyone experiences their obstacles in a different way. There are usually many different ways to address an obstacle through technology. Deciding on the best solution requires that the ATP consider multiple factors. For example: Some people love technology; others abhor it. Cost, safety for the user and others, and possible funding sources must also be factored into a final recommendation. How much training will be required? How will the device be maintained and repaired if there is a breakdown? Will the person be able to get along without it during maintenance and repair periods? Who will pay ongoing costs? Do the long-term benefits of the device outweigh its costs? Are there cheaper and more reliable consumer devices that could be used? Is there a way to change how the task is performed or the need to perform the task that could eliminate the need for a device altogether? How does this device work with other devices the individual may have or also needs?

With these questions and observations in mind we invite you to explore the list of devices and modifications we have included below.

**Some Functions, Tasks and Hobbies That May Require Modification for Independence:** Bathing independently; fastening buttons; crocheting, embroidery; nail care: shaving; brushing teeth; eating; cutting food; getting in and out a tub; reaching for items on a countertop; reaching for items in a kitchen cabinet; fastening a bracelet; opening and closing jars; opening cans; dispensing toothpaste; zipping pants; drying hair after washing; applying makeup; fastening a bra; pulling on pants; rising from a chair; sitting down in a low chair; getting out a car; reaching for a seatbelt in the car; chopping food; stirring food; opening wine bottles; dispensing pills; holding a plate in one place; holding and lifting a pot.

Examples of ATP work-arounds or task modifications: Fastening a bra: front-fastening bras are available commercially as are devices that permit fastening a back-fastening bra with one hand. A button hook can be used to help with buttoning and unbuttoning a shirt. Velcro modifications can be used on tennis shoes, as can elastic shoelaces. A rocker knife and a cutting board with holding spikes can help with chopping and preparing a meal. A spork, “knork,” or bowl holder can be used to transfer food from one bowl to another. A grater with suction feet can hold the grater stable while cutting cheese. One-handed can openers support opening cans independently. Plate guards can be used to keep food from moving out of a plate. “Sticky keys” can be used for

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typing with one hand. One-handed typing lessons and one-handed computer keyboards are available; Word prediction software can reduce need for lengthy typing with one hand. Electric fishing reels allow a person to fish independently. Toilet paper roll holders are designed to permit easy placing of dual toilet rolls. An automated paper towel dispenser can reduce the need for tearing off multiple paper towels. Mouth sticks can be used for tasks that require stabilizing paper while you write. A bracelet holder can stabilize a bracelet on one end to permit closing with one hand.

Selected Devices Kitchen

Clean Cut Paper Towel Dispenser: 
http://www.dynamic-living.com/product/clean-cut-paper-towel-dispensers/#clear The CleanCut touchless automatic paper towel dispenser uses infrared technology and a "never dull" cutting blade to save paper, time, and space. It's easy to save paper with this great kitchen gadget. It dispenses only what you need. Simply place your hand in the "dispensation" infrared beam and the towels will roll out. Remove your hand from the beam and the dispensing stops. Swipe your hand across the "cutter" beam and the CleanCut blade slices off the exact amount you requested (regardless of the perforation) and holds it in place until you grab it. The CleanCut dispenser is perfect for anyone who needs single-handed accessibility or has limited arm strength, hand strength or range of motion.

One-Handed Cutlery Set
http://www.maddak.com/onehand-cutlery-set-p-28024.html A combination lightweight fork and knife that can be used with either hand. When pushed down onto food, the fork retracts up inside the three-sided box knife. The knife then cuts a bite-sized piece of food. When pressure is released, the spring-mounted fork with the cut food extends past the knife. A raised lip guard on the fork section protects lips from the knife edges. Can be disassembled for cleaning.

Chef'n EzSqueeze One-Handed Can Opener:  http://www.amazon.com/Chefn-EzSqueeze-One-Handed-Opener-Meringue/dp/B002XUUUSFC. The innovative, squeeze-to-open design makes opening cans quick, safe and ever so easy – open a can with just a few squeezes. Innovative, squeeze-to-open design makes opening cans quick, safe and easy. Stainless steel cutting blade; magnetic end allows for easy and safe removal of lids.

One-handed Can Opener:
http://www.freshfinds.com/index.cfm/fuseaction/productdetail/categoryID/4BB3E775-2A83-4828-8BAB-3EB992C62E4/productID/C9D625CB-4301-4C19-92D3-01721D576E0B One Touch™ Can Opener II needs no hands. Just place it on any can and it will “travel” around the lid, cutting the can open smoothly and neatly. There will be no sharp, jagged edges either since it cuts under the rim of the lid, not through the top. A handy built-in magnet holds lid off food, and provides for safe disposal. New and improved design has an easy-access battery chamber. Requires 2 AA batteries (not included).

Unscru Jar Opener:
http://www.dynamic-living.com/product/unskru-jar-opener/#clear Wedge the jar lid firmly between the metal grip post and the appropriate edge of the jar opener and twist. (The metal post can grip lids well because it has "teeth"). The white Un-Skru jar and bottle opener will open lids up to 4.75" in diameter. We tested several mounted jar openers before we settled in on this model. One of our single-handed customers tested them with us and found this product to work exceptionally well.

Maddapt Ubendit Fork, Spoon and Knife:  http://www.maddak.com/maddadapt-ii-utensil-set-teaspoon-soup-spoon-knife-fork-p-28036.html With built-up handles. For people with upper extremity weakness or reduced range of motion. These stainless steel utensils feature built-up handles for people with arthritis, weak grasps or other hand limitations. Their contoured shape makes them easier to hold and use.

Easy Butler Countertop Appliance Aid:
http://www.dynamic-living.com/product/easy-butler-countertop-appliance-aid/#name_tabsHref+clear Small appliances are easily at reach with the Easy Butler™. No installation necessary - simply sits on the countertop. Great for use with coffee makers, blenders, food...
Inner Lip Plates:
http://www.maddak.com/innerlip-plate-plastic-sandstone-p-27970.html  Designed to assist children, the elderly, people with limited muscle control and individuals with the use of only one hand. The deep inner lip keeps food from sliding off the plate. The user brings the fork or spoon to the edge of the plate and pushes the food onto the utensil.

One-handed soap mitt:
http://www.amazon.com/Maddawash-741320002-Medium-Terry-Soap/dp/B0007OZ2BQ  Terrycloth wash mitt provides a palm pocket to hold a bar of soap. Ideal for bathing or for washing dishes. Elastic at wrist and top of soap pocket assures a snug fit. The mitt can be used on either hand by turning it inside out.

Pot and Pan Holder/Stabilizer:
http://www.maddak.com/pot-and-pan-holder-p-28062.html  Prevents a pot from turning while stirring with one hand. Wide spread suction cup base creates greater stability and keeps the suction cups further from the heat than narrower based models. Plastic-coated steel, 16 x 4 ½" (41 x 11 cm).

Hot Hand Protector and Jar Opener:
http://www.maddak.com/hot-hand-protector-jar-opener-sky-blue-p-28069.html  Helps maintain a secure grip on hot, cold, or slippery items such as bottles, glasses and pans  • Works as a gripper to unscrew tight jars and bottle caps  • Maintains temperatures as high as 500 degrees F and as low as -7 degrees F Recommended as a precaution against burns for people with hands that have reduced sensation to heat. The gripping surfaces are studded with small suction cups. End pockets fit the thumb and fingers.

Solid Rocker Knife:
http://www.dynamic-living.com/product/solid-rocker-knife/#clear  This solid wood cheese knife is beautiful and comfortable to use. The built up handle does not aggravate arthritis and fits nicely in large or small hands. The wooden "blade" is beveled to make it easier to cut hard cheeses. The smooth wood blade edge won’t cut fingers, but glides through hard cheeses, like aged gouda and parmesan, as well as it slices through softer spreads, sandwiches and hors d’oeuvres or spread toppings onto crackers and bread. The wood is preserved with a food safe sealant and a linseed oil finish that leaves it virtually care-free.

Suction Bowl Holder:
http://www.pattersonmedical.com/app.aspx?cmd=get_product&id=66867  One-handed can opener requires good grip strength. Mounting the jar opener will require assistance from another person. The reviewers of this 5-star product note that it is an excellent purchase for the person who loves to cook, but only has the use of one arm.

Fruit and Veggie Scrubber:
http://tinyurl.com/8a5b3up  Firmly attaches to any sink with 19 suction cups. Cleans away dirt, chemicals, and wax from fruits and vegetables, using only one hand. 1000 bristles gently scrub and clean, but do not damage the produce’s skin. Easier to use than a brush, and cleans with simple rinsing. Latex free.

Can Pop for Pull-Tab Libs on Soft Drinks and Beer:

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Graviti Salt and Pepper Mill:
http://www.dynamic-living.com/product/graviti-saltpepper-mill/#clear  Tilt the Graviti Pepper Mill to grind fresh pepper over your salad. Adjust the pepper grind size (finer or coarser) by turning the knob on top.

Battery Operated Sifter:
http://www.dynamic-living.com/product/battery-operated-sifter/#clear  This lightweight sifter does all the work with a touch of a button. Battery operated sifter. 3 cup capacity. Terrific for bakers with carpal tunnel or arthritis.

Single-Handed Cutting Board:
http://tinyurl.com/6n7zqtf  The Single Handed Cutting Board is a great cutting and food preparation board. A great work surface to make sandwiches, slice meats and chop vegetables. Three spikes hold tightly onto the food that you need to slice. Two raised corner pieces are perfect for holding bread in place as you spread toppings.

Under Counter Jar and Bottle Opener:

Medications

One-handed Pill Dispenser:
http://www.epill.com/medsmart.html  (You Tube Video at: http://www.epill.com/medsmartvideo.html)  E-pill electronic “pill” dispenser (MedSmart automatic medication dispenser / pill organizer / pill box / pill dispenser / 993019) and reminder system helps ensure that medications and vitamins are taken properly and on time.

Remote-Controlled Insulin Pump:
www.MyOmniPod.ca  GlaxoSmithKline Inc. announces that the OmniPod™ Insulin Management System - the first tubeless and wirelessly-controlled insulin pump - is now available in Canada. The OmniPod™ Insulin Management System offers people of all ages living with type 1 diabetes more freedom to do what they want, when they want, offering them increased freedom and more opportunities to enjoy life. Patients can participate in most physical activities while wearing the Pod, leaving the PDM in their gym bag, backpack, or purse.

Bathroom

One-handed soap mitt:
http://www.amazon.com/Maddawash-741320002-Medium-Terry-Soap/dp/B0007OZ2BQ  Terrycloth wash mitt provides a palm pocket to hold a bar of soap. Ideal for bathing or for washing dishes. Elastic at wrist and top of soap pocket assures a snug fit. The mitt can be used on either hand by turning it inside out.

Personal Hygiene Wand:  http://www.freedomwand.com  The FreedomWand® is a multi-task, multi-length tool; it holds an ointment pad, loofah or lightweight wash cloth, disposable shaver and the all-important toilet tissue. The FreedomWand can be used from 7-30” and comes with a cloth carry bag. It’s specifically designed for personal cleaning and hygiene for anyone with limited mobility. The easy to use slide button releases tissue into the toilet with little effort. The FreedomWand® is made from a polypropylene material, making it very durable and easy to clean. It is also designed with a rinse hole in the head to aid in easy cleaning.

Self-Wipe Bathroom Toilet Aid:  http://www.maddak.com/universal-hand-clip-p-27900.htm  Superior, smooth, rounded design provides more comfort than other devices and allows for accurate placement and pressure. Easy to travel with. Comfortable and easy to use hygiene aid helps people who have difficulty bending or limited use of their hands and arms to function independently when using the toilet. Toilet tissue is placed around the angled clamp on the lower portion of the device. After use the tissue is discarded by pressing an easy-to-use release button on the end of the handle. Made of sturdy plastic. Autoclavable.

Sure-Loc Toilet Duet:
http://www.dynamic-living.com/product/sure-loc-toilet-duet/#clear  The Sure-Loc™ Toilet Duet is a chrome toilet paper holder and magazine rack that keeps what you need within reach. Holds 2 rolls of toilet tissue, as well as books or magazines for reading. Chrome finish looks beautiful in your bathroom. Installs without tools. Perfect for apartment renters or individuals with a weakened grasp.

insulin pump that adheres to many places on the body; and the Personal Diabetes Manager (PDM), a hand-held remote that controls insulin delivery for the Pod, calculates insulin doses and has a built-in blood glucose meter. The OmniPod™ Insulin Management System allows people with type 1 diabetes more freedom to do what they want, when they want, offering them increased freedom and more opportunities to enjoy life. Patients can participate in most physical activities while wearing the Pod, leaving the PDM in their gym bag, backpack, or purse.

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Easy Out Tube Squeezerz:
http://www.maddak.com/easy-out-tube-squeezer-p-28082.html. Easily squeezes tubes flat from the bottom up. A unique feature allows the last drop to be squeezed from the nozzle of the tube after the tube has been expelled up to the collar. Ideal for toothpaste, lotions, salves, sili-
cones, and other household products.

Soap Dispenser:
http://www.dynamic-living.com/product/automatic-soap-di-
spenser/#clear. The Liquid Motion Soap Dispenser is the perfect solution for sanitary, hands-free dispensing of liquid soaps, hand sanitizers and more. No touch operation eliminates the spread of germs from pump or bar
soaps. Top buttons easily increase (or decrease) the amount of soap dispensed. Works with liquid soaps, hand
sanitizers or lotion. Great for care givers who need to use hand sanitizers frequently and individuals with limited arm mobility or arthritis in their hands.

Hair Dryer Holder:
http://www.dynamic-living.com/product/hair-dryer-holder/ #clear. Ideal for individuals with limited hand strength, limited coordination or the use of just one hand. Slip your hair dryer into the holder, position it and let go for hands free hair drying. The black Hair Dryer Holder has foam padding that will securely hold dryers with handles up to 2¼" in diameter. It also features a 17" flexible goose neck that will bend and pivot allowing you to position the hair dryer to the angle that best fits your needs. The Hair Dryer Holder won't take up a lot of sur-
face space, an important consideration for those with small counter space. Hands Free Hair Dryer Stand ad-
justs to any angle.

Grab Bars:
http://www.dynamic-living.com/product/kingsley-grab-bar-
s/#clear. This Moen® Grab Bar from the Kingsley™ Col-
lection will enhance your bathroom decor and provide strong support too. The Moen® decorative grab bars are only 1½" from the wall, meeting ADA requirements. The installation screws are concealed with flanges. Great for people who want the security of a grab bar to prevent falls.

Swivel Lotion Applicator:
http://www.maddak.com/swiveling-lotion-applicator-p-27957.html. Swivel feature moves with the contours of your body and allows you to apply lotions, oils and creams to those hard to reach spots without straining. 23" (58.42) long handle - reduces the need to bend, stretch or strain. The sponge head swivels to accommodate the unique contours of the body. The hypoallergenic odorless sponge will not flake, crumble or shed fibers. Can be rinsed and re-used.

Pistol-Grip Toe Nail Clipper:
http://www.maddak.com/pistolgrip-remote-toenail-clipper-
p-27959.html. This clipper is a valuable asset to preg-
nant women, overweight people, the elderly, people with back problems and anyone else with a limited range of motion. The long handle and pistol grip make clipping toenails possible with less bending. The trigger action provides increased leverage.

Dressing

Clip and Pull Pant Clip: http://tinyurl.com/8ym7zl. Simply clip the Pant Clip to opposite sides of the waistband of your underwear, shorts, skirt or pants and drop the clothing to the floor. Step into the open-
ings and pull up on the attached handle. Since the handle adjusts to up to 23" long, there's no need to bend. This Clips are very easy to open, even for individu-
als who find grasping difficult. If you're single handed, put your clothing on a table or bed and place the clips on one at a time. For individuals with weak hands or the inability to grasp, use the side of your hand to open the clip and put your clothing in with the other hand.

Pocket Dresser/One-Handed Dressing Aids:
http://www.dynamic-living.com/product/pocket-dresser/#cl-
ear. A great tool for maintaining independence while dressing. Tools include: a zipper pick, closed loop but-
toner, small button hook and a large button hook. Adjust-
able strap helps to hold device securely. Includes excel-
lent directions for the use of each tool. Small, portable design. The designers of this tool thought of nearly every-
thing. With four separate tools, the PocketDresser™ helps with pant buttons and zippers, shirt collar but-
tons, coat zippers, shoelaces and more. Limited gripping capability? No problem. The PocketDresser™ comes with an adjustable hand strap that can fit around your whole hand, wrist or arm. The instructions that come with

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the product are very clear. With the photos included, even a beginning dressing tool user can figure out how to manipulate their buttons into place.

**Bra Fastener:**

The Bra-Angel is designed by an Occupational Therapist to assist women who find it difficult to bring both ends of a bra together. Whether you are single-handed or have arthritis, the Bra-Angel can help. The one-size-fits-all Bra-Angel gives you an extra hand to help you close your bra. It works with most brassiere types, is latex free, light and durable. It is an indispensable dressing aid for women who cannot use both hands to complete this task.

**Easy to Close Belt:**

Looks like a standard brown belt. Uses a hook and loop closure rather than a buckle. Ideal for people who are single-handed or people who cannot manipulate a regular belt buckle. Plus the Myself Belt has a simple design and looks like a normal dress belt. Each belt is 1½" wide and made out of a handsome brown, leather-like vinyl.

**Button Hook:**
http://www.dynamic-living.com/product/button-hook/#clear

Insert the wire through the button hole and over the button, then pull through the hole. An indispensable dressing aid for one handed people or people recovering from a stroke.

**Bracelet Buddy:**

The Bracelet Buddy helps you fasten and unfasten bracelets with ease. Holds one end so you can work the clasp with your free hand. Great for anyone that wears bracelets.

**Cord Type Zipper Pull:**

Makes dressing easier by giving the user control of zippers. A split ring is attached through the hole in the zipper tab and the hook on the end of the pull engages the ring. When the zipper is fully closed or open, the hook is disengaged. Ten 1/4¨ (.7 cm) diameter split rings are included for hooking to zipper tabs. Made of sturdy nylon cord with a hand loop and metal hook 18¨ (46 cm) long.

**Combination Dressing Stick:**
http://www.maddak.com/combination-dressing-stickshoe.htm

Use it for pushing and pulling drawers, retrieving clothing from floors, chairs, closets, etc.

**Dressing Stick with Hook:**

The 24¨ dressing stick assists in putting on jackets, pulling up slacks or skirts, or removing socks. Dressing stick can help you reach. The small hook on the opposite end aids in pulling zippers and shoelace loops. An essential for anyone who has difficulty bending, a limited range of movement, or the use of only one arm or one hand.

**King Tong Heavy Duty Reacher:**

The Raptor™ is a low cost, durable, lightweight, all plastic reacher with a contemporary design unlike other reachers. The jaw opens a full 2 ¼" (6.3 cm) and provides a tight grip on even the smallest items such as coins or bulky items like newspapers, clothing and cans. A hook-like extension on the front can be used as a dressing aid.

**Lace Locks for Tennis Shoes:**

Why struggle to tie shoelaces when Lace Locks will do all the work? They take just one hand to operate. Pinch and pull to loosen laces, reverse to tighten. Plastic. Set of 2. ¾"W x 1"L (2 x 2.5cm). Latex-free.

**Hobbies**

**Crochet Holder:**

This simple tool keeps yarn in the right place, with the proper tension while you crochet. Kroh’s Crochet Aid holds the yarn for you. Wonderful craft tool for people who have arthritis or MS.

**Stand Up Embroidery Hoop:**
http://www.dynamic-living.com/product/stand-up-embroidery-hoop/#clear

This Stand Up Embroidery Hoop has a suction cup base that stays in place while you work. Cross stitch or embroider single-handedly. Four suction cups hold the hoop in place on any smooth surface. Perfect for embroidery lovers who have the use of only one hand or who tire easily from holding a standard hoop.

**Clamp It Device:**
http://tinyurl.com/7e4fj8p

Suction cups hold the clamp securely to the table top. Ideal for avid hobbyists and for people who are single-handed or who have arthritis. Clamp-It is an adjustable clamping device that can be used to hold an item in a fixed position. It is a wonderful help when doing crafts - use it for holding a knitting needle or crochet hook. This is also a great tool for single handed people. Put your glasses in it when they need cleaning or adjusting, hold your nail file, magnifier, almost anything you need. Clamp-It is mounted on four suction cups for extra stability. The clamp bar can be used vertically or
horizontally. Adjust the clamp size simply by turning the two wing nuts. Maximum holding width is 1”.

Card Player Holder:
http://www.maddak.com/card-player-card-holder-p-27794.html Attractive, fan shaped playing card holder is perfect for anyone with limited finger strength and dexterity. Holds cards snugly and provides a clear view of cards. Can be held comfortably by a weakened or arthritic hand and can stand by itself on two non-skid legs. Cards will not fall out if tilted. The holder is also great for phone messages, recipes, shopping lists, coupons, receipts, reminders, etc. Molded of a durable rigid plastic. Measures 4 x 8” (10 x 20 cm). The company also distributes automatic card shufflers and a device that can hold playing cards.

Page Turner, Keyboard Aid/Wrist Cuff:
http://www.maddak.com/advanced_search_result.php?key words=Arthritis Features a soft foam rubber palm grip and 1” (2.5 cm) wide hook-and-loop adjustable wrist band. Measures 1 x 8” (2.5 x 22 cm). A foam rubber tip at the end of a curved wand helps people with limited hand function or dexterity easily flip through pages of books, newspapers, and magazines. The curve of the wand has a foam rubber pad for turning heavy coated paper and large sheets. Also handy on computer keyboards or phone pads. Measures 1 1/8 x 10¨ (3 x 2.5 cm).

Driving

Easy Reach Seat Built Handle:
http://www.dynamic-living.com/product/easy-reach-seat-belt-handle/#clear The Easy Reach Seat Belt Handle makes it easier for you to reach your seat belt, even if you have arthritis. The Easy Reach Seat Belt Handle offers an additional 6½” to grab on to. Ideal for individuals who have trouble reaching for the seat belt in their car.

Memory Foam Steering Wheel Cover:
http://www.dynamic-living.com/product/memory-foam-steering-wheel-cover/#clear Wheel Cover increases the diameter of your steering wheel to make it easier to grasp, while protecting your hands from heat and cold. Grasp the steering wheel with ease, even if you have painful arthritis. Comfortable memory foam and chamois cover feels great in your hands. Great in the summer or winter - protects your hands from a hot or cold steering wheel. Slips onto steering wheels that measure 14½” - 15” diameter.

General

Easy to Grasp Key Holder:
http://www.dynamic-living.com/product/easytograsp-key-holder/#clear With this key accessory, your key is positioned for maximum leverage to work the most stubborn lock. This key turner will hold up to 2 keys. Simply remove the screw, insert keys and tighten. Will hold household keys and car keys that are straight metal keys (it cannot handle the thickness of keys with plastic head covers). Keys fold in towards the curve for easy storage in a pocket or purse. The comfortable curved handle of the Key Turner can be held several ways to accommodate each individual's need. Either place fingers within the center or grasp around the outside.

Key Holder:
http://www.dynamic-living.com/product/key-lever/#clear With this key accessory, your key is positioned for maximum leverage to work the most stubborn lock. Even with two fingers. The 3” long, ¼” thick bar screws together in the center. The Key Lever can hold a key fob up to ¼” thick. To add or remove the key, there are holes in each side of the lever. If twisting is difficult for your fingers, slip pencils through these holes and twist to easily screw or unscrew. The 3 inch long bars screw together in the center. The key slips over the screw bar in the center. Then screw the bar back together. Easy to hold, easy to turn.

Great Grips Door Knob Adapter:
http://www.dynamic-living.com/product/great-grips-door-knob-adapter/#clear Great Grips are soft covers for round doorknobs and faucets. They have ridges for a comfortable grasp and a small protrusion on either side. These small protrusions are like a lever and let you turn the knob with the side of your hand, a finger or a fist. When your hands are full of packages, you can even open a doorknob with your elbow. Great Grips add a lever to round knobs to make them easier to turn. These latex free covers insulate your hand from touching hot or cold metal knobs. They also eliminate the static shock we sometimes get when the air is very dry. Each package contains 2 clear Great Grips.

Leveron Door Knob Adapters:
http://www.dynamic-living.com/product/leverbon-handle-doo r-knob-adapters/#clear If it is hard for you to grasp and turn a doorknob, this lever handle is a great alternative without removing your existing doorknob. This plastic door lever handle fits over most existing round doorknobs. An inexpensive way to retrofit doorknobs. Great alternative for people who cannot grip a door knob.

continued next page
Arthwriter Hand Aid:  
Gives you the extra reach sometime needed to zip up. Versatile tool helps people with hand or finger disabilities to eat, write, groom and perform other daily activities. Versatile tool helps people with hand or finger disabilities to eat, write, groom and perform other daily activities. Particularly beneficial for anyone with arthritis, missing fingers or an arm in a cast. Provides a comfortable grip on a pen, pencil, razor, toothbrush or other utensil and can be used with many control sticks on motorized wheelchairs. Particularly beneficial for anyone with arthritis, missing fingers or an arm in a cast. Provides a comfortable grip on a pen, pencil, razor, toothbrush or other utensil.

Universal Cuff, Adult and Pediatric:  
Ideal for children and adults with little or no hand strength. Comfortable utensil holder is fully adjustable to meet the user's particular condition and hand size. Holds eating utensils, toothbrushes or other small items. Can also be used to hold instruments in special needs music classes.

Universal Hand Clip:  
The perfect solution for people with arthritis or reduced hand strength. Spring action hand clip fits snug against the hand. Attaches to objects with strips of heavy-duty hook and loop. Can be used on phones, cups, bottles, hair brushes, etc.

Plastazote Tubing - 6mm (1/4") Bore for Built up Grips:  
http://tinyurl.com/85rtxf8  
This versatile closed cell foam tubing is ideal for adding a built up handle on household items such as toothbrushes, hairbrushes, cutlery and pens, making them easier to grip. Simply slip over the handle of the object. Supplied in 1 metre lengths, it can be cut to the desired length and is available in three inner bore sizes to fit various objects.

Homecraft Contour Tap or Knob Turner:  
www.abilitysuperstore.com/index.php/kitchen/washing-up/tap-turners/homecraft-contour-tap-or-knob-turner/2119  
This device is used to give good leverage for turning small difficult items such as gas or radiator taps. The head has a bed of sprung stainless steel rods, which when pressed around an object, retract, conform around its shape, and provide a grip around it when the handle is turned. The handle is a black plastic T-piece, which is easy to grip. It is small enough to be carried around in a pocket or handbag.

Arthro-Thumbs Up Without Lid:  
Functional and lightweight for people who have decreased grip strength, wrist pain, hand deformities or need to keep the wrist in a neutral position. The unique ergonomic design increases leverage of the hand and aids in raising the cup to the lips without wrist motion. The thumbs-on grip reduces the possibility of spilling due to trembling. The cup is double-walled to protect hands from heat or cold. It holds 8 ounces (237 ml), leaving 1¨ (2.5 cm) of free space above the liquid to reduce spillage. Liquid ounce and metric measures are marked inside. Top rack dishwasher and microwave safe.

Steady-Write Writing Instrument:  
Designed to help improve the handwriting of people with arthritis, Parkinson’s or other hand limitations. Triangular base balances and guides the hand as you write to smooth out shaky penmanship. Black ink.

One-handed Gripper:  
http://www.enasco.com/product/SB01889M  
A unique, silicone-rubber molded hand protector for safely gripping hot beakers, flasks, bottles, and similar objects. Withstands temperatures up to 500° F (260° C); useful for work with cold objects, retaining its flexibility down to -70° F (-57° C). The end pockets for thumb and fingers fit any size hand. Gripping surface is studded for positive grip. Convenient hole tabs for easy hanging. 3-7/8" x 7-1/2" (98 mm x 190 mm).

DYCEM:  
Dycem has been developed to produce the most effective non-slip material available. It is not sticky, but it grips dry, slippery surfaces such as worktops, trays, floors and tables to prevent movement. It may also be used to enhance grip on jars, handles, lids and so on. It can be cleaned in soft, soapy water to retain its properties but is not effective when wet.
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