Claims & Underwriting

Plan of Care, Easy as 1, 2, 3



16th Annual Intercompany Long Term Care Insurance Conference

Purpose



- To consider different approaches to the development of the Plan of Care
- To discuss Needs Based versus Benefits Based Plan of Care



Session Objectives



- To present several cases for discussion about the Plan of Care
- To provoke some thought about the approaches an Insurance Carrier can take toward the Plan of Care development



Needs Based vs Benefits Based POC



- Needs based plan of care is based solely on ADL/IADL deficits
 - Accurate picture of care needs
 - Can lead to unexpected out of pocket expense for insured
- Benefits based plan of care is a combination of ADL/IADL deficits and daily benefit (to reduce out of pocket)
 - Can reflect lower care needs than actually required
 - Must provide rate in order to establish
 - (to ensure it is within daily benefit)
 - Limits out of pocket expense for insured



Insurance Carrier Responsibilities



- Case Manager's responsibilities
 - Review reported care needs and diagnosis and recommend appropriate plan of care
 - Identify any community resources/DME that may be beneficial
- Adjudicator's responsibilities
 - Determine if approved provider is appropriate to render care and is covered by the policy
 - Review ongoing bills/care notes to verify services billed fall within plan of care



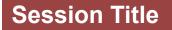


- 51 year old female
- Dx: Schizoaffective disorder, Anxiety, Depression, HTN
- Suffers from overwhelming fear and anxiety which is almost paralyzing, has suicidal ideations
- MMSE score 30/30
- Bathing verbal cues
- Dressing verbal cues
- Toileting independent
- Transfers independent
- Continence independent
- Eating independent
- Mobility supervision outdoors, independent indoors
- Home filthy, cluttered, unkempt





- 64 year old female
- DX: Stage 4 Pancreatic cancer with bone mets
- Lives at home with spouse, hospice services in place for end of life care
- Bathing Hands on assist
- Dressing Hands on assist
- Toileting Stand by assist
- Transfers Stand by assist
- Continence Independent
- Mobility Stand by assist
- Eating Independent
- Dependent for all IADLs







- 86 year old female with Tax Qualified policy
- DX: S/p fall with hip fx 8/10/15, partial replacement 8/13/15-it is noted that insured was somewhat deconditioned due to prior TKR 4/2015
- Fell while in rehab resulting in hematoma but discharged home 9/6/15 with the following care needs:
 - Bathing- hands on assistance
 - Dressing- hands on assistance
 - Transfers- standy by assistance
 - Continence- independent
 - Toileting- independent
 - Ambulation- independent
 - Eating- Independent







- Based on acute diagnosis insured was not expected to meet Chronically III Criteria, however, she was re-admitted to the hospital 9/20/15 due to infection. Insured was discharged home 10/8/15 with the need for long term antibiotics and below care needs:
 - Bathing- hands on assistance
 - Dressing- hands on assistance
 - Transfers- hands on assistance
 - Continence- independent
 - Toileting- hands on assistance
 - Ambulation- stand by assistance
 - Eating- Independent







- Insured determined to be Chronically III due to multiple acute conditions complicated by deconditioning and comorbidities of DM and CAD
- POC of 24/7 effective 10/8/15 recommended
- CM contacted insured on 10/20/15 and verified following care needs:
 - Bathing- hands on assistance
 - Dressing- hands on assistance
 - Transfers- stand by assistance
 - Continence- independent
 - Toileting- independent
 - Ambulation- independent
 - Eating- Independent
- POC of 12/7 recommended





- CM contacted insured on 11/5/15 and verified following care needs:
 - Bathing- hands on assistance
 - Dressing- hands on assistance
 - Transfers- independetnt
 - Continence- independent
 - Toileting- independent
 - Ambulation- independent
 - Eating- Independent
- POC of 8/7 recommended





- CM contacted insured on 12/5/15 and verified the following:
 - discharged from PT after plateauing. Continued to require assistance with multiple ADLs, therapist documents that it is unlikely for insured to return to baseline due to limited progress and comorbidities
 - Bathing- hands on assistance
 - Dressing- hands on assistance
 - Transfers- independent
 - Continence- independent
 - Toileting- independent
 - Ambulation- independent
 - Eating- Independent







 POC of 6/7 recommended, CM will follow up in 3 months to verify ongoing care needs and if no changes at that time, active CM may be discontinued as conditions appear to be chronic





- 91 year old male
- DX: Lewy Body Dementia, GERD, BPH, Anxiety, Insomnia
- Resides in locked memory care unit
- MMSE score 1/30
- Behaviors:
 - reportedly physically aggressive in the morning
 - urinates in public areas (ie: in the trash can, behind couch) instead of the restroom
 - wanders around memory care unit
 - becomes combative when staff or family try to assist with bathing or dressing
 - appears agitated, restless, was cursing during assessment
 - insured stated his wife was "a man" and did not know her name



Example 4 - cont



- Bathing verbal cues
- Dressing verbal cues (would wear the same clothes for several days if not cued to change)
- Toileting verbal cues
- Transfers verbal cues
- Continence verbal cues
- Eating verbal cues
- Mobility stand by for safety
- Assist needed for all IADLs





- 90 year old female
- Dx: OA, DM, HTN, Hyperlipidemia, Anemia, GERD, Peripheral Neuropathy, CAD
- MMSE score 26/30
- Resides in ALF
- Bathing hands on assist
- Dressing hands on assist
- Toileting independent with equipment
- Transfers stand by assist
- Continence independent
- Eating independent
- Mobility stand by outdoors, independent indoors
- Assist needed for all IADLs except phone use

