THE AMERICAN ASSOCIATION OF NURSE LIFE CARE PLANNERS

JOURNAL OF NURSE LIFE CARE PLANNING

aanlcp+

SUMMER 2025

vol XXV, no. 3

PSYCHOLOGICAL COMPLICATIONS

PEER-REVIEWED EXCELLENCE IN NURSE LIFE CARE PLANNING SINCE 2006

aanlcp

American Association of Nurse Lifecare Planners

SUMMER 2025

JOURNAL OF NURSE LIFE CARE PLANNING

TABLE OF CONTENTS

DEPARTMENTS

AMERICAN ASSOCIATION OF NURSE LIFE CARE PLANNERS
299 S. Main Street #1300-91732
Salt Lake City, UT 94111
PH & FAX: 801.274.1184
aanlcp.org

A Message from the President

Dear AANLCP Members and Friends,

As we wrap up summer and fall begins to peek around the corner, this Fall season can bring an energy shift. Just the other day, as I passed the school supplies aisle in a store, I noticed a child picking out supplies with equal parts excitement and dread—and honestly, I could relate. Transitions, even expected ones, may come with some added concern and weight.

The Summer Journal of Life Care Planning focuses on psychological complications—a reminder that the emotional and cognitive aspects of injury and illness are just as important as the physical ones. These aspects can be some of the most complex pieces of our work, requiring patience, insight, and compassion.

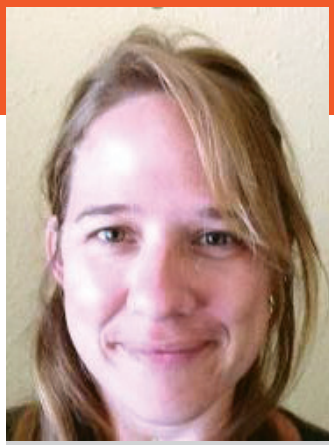
As summer comes to a close and we head into the fall, I hope this issue provides you with a moment to pause and reflect, and perhaps even offers a few tools or perspectives to take with you into your cases.

We are honoured to join forces with the American Association of Legal Nurse Consultants in contributing varied and valuable insights into the Journal.

Wishing you a wonderful rest of your summer and transition into fall.

Anne Gowing, RN, CRRN, CNLCP, and MSCC
President, AANLCP 2025 | president@aanlcp.org

From the Editor



Vanessa Richie
JNLCP Editor
journal@aanlcp.org

Happy End of Summer!

With the high-energy activities and heat of summer reaching its zenith, life can feel a bit chaotic. Many of us are squeezing out the last of our vacation time and relaxation with family and friends before going into the much more regimented schedule that comes with fall and winter. The long days are starting to get noticeably shorter, and the number of hours we can spend outside in the sun is waning, especially for those of us in the higher latitudes.

Being aware of how we are feeling mentally and emotionally is important because seasonal transitions can be jarring. It's just as important to keep this in mind while working on life care plans.

This issue of the journal provides a wealth of information on mental health considerations and monitoring for your life care plans. From the types of problems that may present themselves to the different codes associated with various forms of treatment, there is a lot of information to help you ensure mental health treatment is included in your life care plans.

This issue also has our first partnered article with the American Association of Legal Nurse Consultants, and the article is called "Prepared to Prevail: Expert Witness Preparation Tips from the Front Lines." We plan to offer different perspectives and types of articles with each issue in the future.

Have a spectacular rest of summer,

Vanessa Richie, Editor

Information for Authors

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. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication.

Text

- Manuscript length: 1500-3000 words
- Use Word© format (.doc, .docx) or Pages (.pages)
- 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)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must 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 must be submitted as a separate file, 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, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

Editing and Permissions

The author must accompany the submission with written release from:

- Any recognizable identified facility for the use of name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc. Note that images harvested online may be copyrighted.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.
- All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Submission indicates that the author accepts these terms. Queries may be addressed to the care of the Editor at: journal@aanlcp.org

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. 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.

Journal of Nurse Life Care Planning is the official peer-reviewed publication of the American Association of Nurse Life Care Planners. Articles, statements, and opinions contained herein are those of the author(s) and are not necessarily the official policy of the AANLCP® or the editors, unless expressly stated as such. The Association reserves the right to accept, reject, or alter manuscripts or advertising material submitted for publication. The Journal of Nurse Life Care Planning is published quarterly in spring, summer, fall and winter. Members of AANLCP® receive the Journal subscription electronically as a membership benefit. Back issues are available in electronic (PDF) format on the association website. Journal contents are also indexed at the Cumulative Index of Nursing and Allied Health Literature (CINAHL) at ebscohost.com. Please forward all emailaddress changes to AANLCP® marked "Journal-Notice of Address Update." Contents and format copyright by the American Association of Nurse Life Care Planners. All rights reserved. For permission to reprint articles, graphics, or charts from this journal, please request to AANLCP® headed "Journal-Reprint Permissions" citing the volume number, article title, author and intended reprinting purpose. Neither the Journal nor the Association guarantees, warrants, or endorses any product or service advertised in this publication nor do they guarantee any claims made by any product or service representative. In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work.

Contributors to this Issue

Sarah Schulze MSN, APRN, CPNP, PMHS

Sarah is a board-certified nurse practitioner who owns and works at a private practice where she specializes in adolescent mental health. She holds an MSN from the University of Illinois at Chicago and a BSN from Indiana State University. She earned an additional certificate in pediatric mental health after completing a fellowship at Ohio State University. She has 14 years of healthcare experience, and her professional interest centers on a family approach to building mentally well, resilient children. Sarah has also contributed to nursing education over the last 6 years, writing for and serving as a subject matter expert for a variety of continuing education and professional development platforms.

Lisa Gay, MSN, RN, FNP-BC, CLCP, CMC

Lisa is a nurse practitioner (NP), certified life care planner, and certified medical coder who lives and works in St. Croix in the US Virgin Islands. She practices as an NP in a multi-specialty clinic, working with patients of all ages, and was awarded the American Academy of Nurse Practitioners' State Award for Excellence for the US Virgin Islands in 2018. As a life care planner, she has experience in both pediatric and adult cases and accepts cases from both the Virgin Islands and throughout the states. She has a special interest in medical coding and enjoys helping other life care planners choose and apply the correct codes for different situations to strengthen their work.

Tommy Vaughn, MSN, RN, LNCC

Tommy Vaughn, MSN, RN, LNCC is a nurse expert and the Chief Nursing Executive at MedX Global Clinical Advisors. He specializes in life care planning, medical-legal consulting, and expert witness services for plaintiff attorneys nationwide. With over two decades of clinical experience and a focus on injury-related litigation, Tommy brings a pragmatic, ethics-driven approach to each case. He currently serves on the Board of Directors for the American Association of Legal Nurse Consultants (AALNC) and is a frequent contributor to education and professional development initiatives for nurse experts across the country.

Jack Korbutov, PharmD, RPh, FACA, FACVP

Jack Korbutov, PharmD, RPh, FACA, FACVP, is the President and Pharmacist-in-Charge of The Art of Medicine, a PCAB-accredited, USP-800 compliant compounding pharmacy in Philadelphia, PA. He founded the pharmacy in 2012 and has since grown it into a LegitScript Certified, VPP-inspected operation licensed in 45 states. Dr. Korbutov has dispensed hundreds of thousands of doses of Low Dose Naltrexone (LDN) and actively leads patient and provider education on its clinical applications. His passion for LDN stems from both emerging research and firsthand experience helping patients during the opioid crisis.

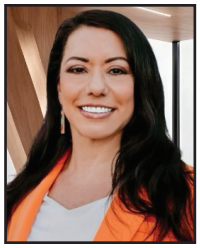
Contributors to this Issue

Kate Smith, BSN, RN, CNLCP, LCP-C

Kate Smith holds a Bachelor of Science degree in nursing from the University of Cincinnati. She has been a registered nurse since 2010 and worked in the acute hospital setting on the neurosurgical floor and intensive care unit for years before transitioning to outpatient pain management and same-day surgery. In 2022, Kate became certified as a nurse life care planner and is the owner of KLS Life Care Planning, LLC. She has a passion for traumatic brain injury and spinal cord injury, developing life care plans and medical cost projections for both plaintiff and defense.

Venus S. Victorino, BSN, RN, CCRN, CFRN, LNC, LCP-C, MCP-C

Venus S. Victorino, BSN, RN, CCRN, CFRN, LNC, LCP-C, MCP-C, is a Legal Nurse Consultant and owner of Lasting Costs, LLC in San Diego, California, specializing in life care planning, medical cost projections, and litigation support. She brings over 20 years of experience in critical care nursing across civilian, military, and austere settings. Her clinical background includes ICU care, aeromedical evacuation, and combat zone operations as part of the Air Force's Critical Care Air Transport Team and the Warrior Recovery Network's Mobile Surgical Resuscitation Team in East Africa.



Ilya E. Lerma, Esq

Ilya E. Lerma, Esq. is a nationally recognized trial lawyer, trial consultant, and Co-Council trusted by attorneys across the country. Founder of the Law Office of Ilya E. Lerma in Arizona and Past President of the Arizona Association for Justice, she has delivered record-setting verdicts and turned high-risk, high-value cases into wins for over 25 years. Her mastery in jury selection, case framing, and witness preparation transforms complex facts into stories jurors can't ignore. As a sought-after trial consultant and speaker, Ilya dismantles defense narratives and exposes the psychological tactics insurance companies use to sway juries. She's taken the stage at the most prestigious legal forums in the country, from AAJ's Weekend with the Stars to the National Trial Lawyers Summit. Known for her precision, strategy, and relentless pursuit of justice, she doesn't just prepare cases—she arms lawyers to win.

PSYCHOLOGICAL CONSIDERATIONS FOR THE LIFE CARE PLANNER

By Sarah Schulze MSN, APRN, CPNP, PMHS

Keywords: 1) Mental Health 2) Psychological Complications 3) Mental Health Support 4) Psychological Support 5) Depression 6) Anxiety

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1) Impaired resilience 2) Maladaptive coping 3) Post-trauma syndrome 4) Chronic pain 5) Readiness for enhanced coping 6) Depression 7) Anxiety

Care of clients with life-altering illness or injury is a complex and multifaceted process with coordination of many overlapping assessments and services. As life care planners guide clients through the many implications of living with a disability or chronic illness, it can be easy to focus on physical alterations and symptoms, integration of assistive devices, and tangible logistics of navigating the healthcare system. Tending to the physical needs of clients typically gets heavy emphasis, as that is where the changes are more obvious and where people will experience frequent disruptions to their routines. However, acknowledgment of the impact of these conditions on behavioral health should not be ignored. Clients with chronic illness or injury are at a greatly increased risk of psychological disorders, and failure to recognize and address this issue can negatively impact client outcomes and quality of life.

Life care planners are in a unique position of patient care and have a responsibility to be knowledgeable and comfortable handling the mental health concerns of their clients. The implications of proper mental health care are equally as important as meeting a patient's physical needs. Compassion and confidence when addressing mental health are a pillar of quality nursing care.

Risks and Prevalence of Mental Health Conditions

Mental health conditions do not discriminate and can affect anyone at any time. Data in recent years suggests that 1 in 5 Americans has a mental health diagnosis, and 1 in 20 has severe symptoms. Anxiety disorders are the most prevalent, affecting 19.1% of adults (NIMH, 2022a). Depression is the next most common, affecting 8.4% of adults annually (NIMH, 2022b). Other conditions like Post-Traumatic Stress Disorder

(PTSD) and bipolar disorder (BD) are experienced less often (3.6% and 2.8% prevalence, respectively), but still have significant implications (NIMH, 2022c).

There is some variation across demographics, with multiracial people being at the highest risk (35.8% prevalence), and non-Hispanic white individuals at the second highest risk (22.6%). Women are affected more often than men (25.8% vs 15.8%), and people who identify as LGBTQ have some of the highest rates of mental health disorders, at 47.4% (NHAMI, 2022).

Among some of the most at-risk people for mental health disorders are those suffering from chronic illness or disability following a catastrophic injury. As there is a wide variation in mechanism and extent of injury, it is difficult to determine prevalence on a broad scale, but much of the current data points to these individuals being at an increased risk of psychological disorders compared to the general population. This is further compounded in individuals who are at higher risk based on race, gender, and identity.

A 2021 study following individuals with general, significant injuries noted that 31% of people reported psychological symptoms 12 months after their injury, with nearly a quarter of those having never experienced any mental health symptoms previously (Richardson et al, 2021).

A 2024 study following significant orthopedic injury found that clients with lower extremity injuries experienced the following mental health conditions and prevalence rates: Major Depressive Disorder (MDD) 38%, Generalized Anxiety Disorder (GAD) 14%, and PTSD 7% (Chen et al., 2024). Individuals with spinal cord injuries have a comorbid mental health diagnosis 59.1% of the time (Peterson et al., 2022), and up to 45% of individuals with chronic pain experience comorbid depression (APA, 2020).

The often traumatic nature of a catastrophic injury can lead to lasting psychological effects, with no guarantee of symptom improvement over the passage of time. The U.S. Department of Veterans Affairs reports that in a 10-year study following people involved in a fireworks disaster with varying levels of injury, up to 6% of individuals still suffered from regular PTSD symptoms 10 years later. Of those,16.7% had symptoms rated as severe (USDVA, 2025).

Despite the high prevalence of psychological symptoms in the chronically injured population, attention to and utilization of mental health resources may be undervalued. In fact, a 2024 report from the University of Arizona indicated that a diagnosis of chronic pain actually led to a 40.3% reduction in utilization of mental health evaluation and treatment (Villareal, 2024). This data highlights the dire need to keep mental health at the forefront of patient assessment and planning for the life care planner. The foundation of this assessment begins with an understanding of common mental health conditions and their presentation.

Common Mental Health Conditions

Depression

Major Depressive Disorder (MDD), is among the most common mental health disorders that occur after a catastrophic injury. While persistently sad or flat mood is among the criteria for MDD, there are many other symptoms that clients may present with and, unless they express feelings of sadness to you, may be your only clues that a depressive disorder is present (NIH, 2022a). Criteria, as outlined by the Diagnostic and Statistical Manual for Mental Disorders (DSM-5), include at least 5 of the following symptoms for at least 2 weeks:

- Sad, depressed, flat, or detached mood for the majority of the day
- Anhedonia: a lack of interest or pleasure in activities or leisure
- Appetite changes, particularly a decrease in appetite or weight loss without intent
- Slowed movements and thought processes, noticeable by others
- Low energy or fatigue most days, regardless of adequate sleep
- Feelings of worthlessness or guilt
- Poor concentration or decision-making abilities
- Recurrent thoughts of death, with or without a plan (NIH, 2022a)

Symptoms must be severe enough to impact functionality in day-to-day life to qualify as MDD. People with depression may also have increased general complaints like headaches or abdominal pain, yet nothing is found to be wrong if they undergo evaluation by a medical provider. MDD can occur as a single episode or recurrent episodes that come and go every few weeks to months.

Particularly in the case of a loss or catastrophic injury, it is important to separate depression from grief, which is a response to loss with many overlapping symptoms with depression. With grief, feelings of sadness or hopelessness are typically intermittent and mixed with feelings of peace or joy, and clients often want to be near loved ones to share in comfort or healing. In depression, mood is persistently low and does not alternate with peace or joy. Clients may withdraw from loved ones or feel isolated, and thoughts center around feeling worthless or like death is the only escape (NIH, 2022a).

Anxiety

Anxiety disorders occur when people experience worries or stress beyond the normal frequency or intensity, to a point that it interferes with the ability to function at work, school, or in relationships. There are several different anxiety disorders, each with a slightly unique trigger or presentation. However, all types of anxiety center around excessive worry, repetitive thoughts, and any overly sensitive fight-or-flight response (NIH, 2022b). The DSM-5 criteria for Generalized Anxiety Disorder (GAD) include the following:

- Excessive apprehension or worry most days for at least 6 months
- Clients find it difficult to ignore or control the worry
- Clients experience 3 or more of the following issues:
- Restlessness or feeling on edge
- Easily fatigued
- Poor concentration
- Feeling irritable
- Muscle tension
- Sleep disruption (NIH, 2022b)

Some anxiety disorders may progress to panic level, where clients experience extreme physical symptoms like racing heart, chest pain, shaking, shortness of breath, feelings of dread or doom, and even dissociation, are feeling separate from reality. Panic attacks may occur with no obvious trigger. These attacks include a rising sense of discomfort or fear, resulting in a feeling of loss of control. These can be nearly debilitating, and the worst cases may result in the client ending up at a hospital.

Anxious clients may have many questions and may seem difficult to reassure or comfort. They may seek extreme detail and organization in caring for chronic illness or injuries and may have a low frustration tolerance (NIH, 2022b). This hypervigilance or even irritability should be recognized as a projection of the anxiety that comes with an extreme loss of control in the presence of catastrophic or chronic injury. Rather than taking a difficult attitude personally, this can be added to a client's assessment data and monitored for changes throughout care.

Post-Traumatic Stress Disorder

Clients who have experienced a particularly stressful, dangerous, or scary event, like a natural disaster, motor vehicle accident, workplace injury, shooting, or burns, may develop PTSD. Experiencing extreme fight-or-flight symptoms during a disaster is a normal response, but if clients are experiencing continued distress, fear, or anxiety days or weeks later, this may be suggestive of PTSD (NIH, 2022c).

To meet criteria for PTSD, symptoms must occur in response to an identifiable event, last 1 month or longer, and impact the ability to function in day-to-day life. Clients must also experience some of the following symptoms:

- 1 or more of intrusion symptoms
- Recurrent, intrusive, or disturbing memories of the event
- Recurrent and disturbing dreams
- Flashbacks or feelings like the event is happening again
- Intense distress when discussing or reminded of the event
- 1 or more of avoidance symptoms
- Actively avoiding thoughts, feelings, or memories of the event
- Actively avoiding place, people, or activities associated with the event
- 2 or more alterations in cognitive and mood
- Loss of memory of parts of the event
- Persistent negative self-thoughts
- Blaming oneself or others for the event
- Feeling detached or estranged from others
- Lack of interest or joy
- Poor concentration
- 2 or more alterations in arousal or reactivity
- Feeling irritable or angry often
- Sleep disruptions
- Reckless or self-destructive behavior
- Being easily startled
- Being hypervigilant (NIH, 2022c)

PTSD can occur as soon as 3 months after a traumatic event but may not develop until much later. Initially, the brain may suppress the trauma as a coping mechanism, but over time, new stressors may trigger old memories. If left untreated, PTSD can persist for years or even a lifetime. The nature of the trauma, support systems, individual resilience, and early identification of symptoms and access to treatment will all impact the duration and severity of symptoms (NIH, 2022c).

Suicidal Ideation

One of the most severe complications of mental health problems is suicidal ideation or suicide attempts. People may begin thinking about suicide if they feel worthless, hopeless, like a burden, or even if they feel death is the only escape from chronic pain.

Suicidal ideations are thoughts or plans related to taking one's own life. These thoughts can sometimes be passive,

where clients do not have a desire to end their life, but feel things would be easier if they did not wake up. A suicide attempt is any self-injurious behavior a patient engages in to attempt to end their life (NIH, 2022d).

It is important to be familiar with warning signs of suicidal ideation, such as withdrawing from others, increasing substance use, researching suicide methods, giving away possessions, or getting their affairs in order, or explicitly stating they are having thoughts of suicide. Clients with a sudden, extreme improvement in depressive symptoms should also raise red flags, as sometimes clients who have decided to end their life feel a large sense of relief (NIH, 2022d).

Additional Considerations

It is also important to consider that many people who have experienced a catastrophic injury or live with chronic illness may suffer from symptoms of any of the above conditions, but do not actually have the severity or number of symptoms required to meet criteria for the diagnosis. While the treatment plan and resources they utilize may vary, these clients could still benefit from adjustment sessions, and the impact of their condition on mental health still needs to be considered. Not meeting criteria for a disorder is not the same as being symptom-free or mentally well.

Impact of Chronic or Catastrophic Injury on Mental Health

When considering the implications of a client's particular condition, it can be easy to think in terms of symptoms, physical differences, or necessary medications, therapies, or assistive devices. But the impact of disease goes far beyond these details and includes significant social and emotional consequences. Integration of a client's unique injury with risks and presentation of mental health conditions is where life care planners can really implement a holistic, individualized assessment and plan of care.

Physical Limitations

Physical limitations resulting from muscle weakness, paralysis, fatigue, or pain may reduce a person's autonomy or require dependence on others for personal care, mobility, and transportation. The need for assistive devices can further reduce independence and accessibility to common aspects of daily life.

This can lead to difficulty maintaining careers, engaging in recreational activities, and maintaining social relationships. All of these factors contribute to frustration, reduced self-esteem, hopelessness, and a profound loss of freedom and identity. Limited physical activity also has the potential to become a vicious cycle as reduced mobility contributes to deconditioning and further dependence on others as time goes on.

Work and Career Challenges

Employment is often a cornerstone of adult identity, providing not only financial security but also social interaction, purpose, and routine. Physical limitations and demands of complex medical care mean clients may experience job loss, demotion, or missed opportunities for promotion, all of which negatively impact self-worth and confidence.

According to the U.S. Department of Labor, adults with chronic health conditions are more likely to be unemployed or underemployed than their healthy peers (2025). Even when employed, clients may feel isolation, discrimination, or bias from coworkers and supervisors who do not fully understand their condition or capabilities. Workplace accommodations (such as flexible scheduling, remote work, or medical leave) can help, but not all employers are able or willing to provide these options.

Navigating employment and education laws such as the Americans with Disabilities Act (ADA) the Family and Medical Leave Act (FMLA), and the Individuals with Disabilities Act (IDEA) requires time, energy, and often legal or advocacy support. These needs further add to the burden experienced by these clients and their caregivers.

Social Isolation

Clients with difficulty participating in work, hobbies, or social gatherings due to physical symptoms or fatigue commonly experience feelings of isolation. Visible disability, such as physical deformity or the use of assistive devices, can also increase the risk of stigma or social exclusion. This limitation in social participation can be a sudden and profound loss for people with previously rich and active social lives, and they may experience grief, anxiety, and depression.

Emotional and Self-Esteem Challenges

Living with persistent symptoms, grappling with physical differences, managing complex treatment regimens, and confronting an uncertain future comes with significant changes to self-image and identity. Clients may experience frustration, anxiety, or depression as they grieve the loss of their previous life and adjust to their new one. Body image concerns related to scarring, weight changes, muscle wasting, or medical devices can further erode self-esteem. Sexual dysfunction can alter intimacy expectations and impact relationships. The need for lifelong treatment, dietary restrictions, or assistive technologies can trigger feelings of hopelessness or resentment.

Family and Caregiver Strain

The implications of chronic illness or disability do not stop with the affected individual. Spouses, children, and other family members often experience a reordering of family roles, routines, and financial status. Balancing employment with caregiving duties can lead to burnout and resentment

for family members who take on a heavily involved caregiver role. Financial strain from healthcare expenses or changes in employment may add to anxiety or depression as families adjust to an altered standard of living.

Children of chronically ill adults may feel neglected or take on adult responsibilities prematurely. Couples may experience a shift in intimacy and communication, and families may become socially isolated if others cannot relate to or accommodate their situation. The emotional impact of witnessing a loved one suffer or losing shared experiences can create grief and strain family dynamics

Implications for Life Care Planners

Given the high prevalence of mental health conditions in the population that life care planners serve, it is imperative that they implement structured, ongoing mental health surveillance and integrate mental wellness into every aspect of planning. This involves using validated screening tools, creating safety protocols, making appropriate referrals, and ensuring clients' emotional needs are met alongside their physical ones.

Screening Tools

Routine screening for mental health conditions should be standard practice for life care planners. Screenings should be included during initial evaluations, annual plan reviews, or when any notable change in the patient's condition, behavior, or life circumstances occurs. There are a variety of evidence-based screening tools available, and screenings should be conducted at baseline, every 6 to 12 months, and whenever symptoms emerge or worsen. These questionnaires typically consist of a few subjective questions or statements that clients rate on a Likert scale, the total score indicating the severity of symptoms. A positive screening is not diagnostic for a disorder but rather indicates the need for further evaluation or referral. The following are a few of the most common standards:

- Patient Health Questionnaire-9 (PHQ-9): This 9-question tool screens for depression. A score of 10 or higher indicates moderate depression.
- Generalized Anxiety Disorder-7 (GAD-7): This 7-question screening is for anxiety symptoms. A score of 5 or higher indicates a mild anxiety disorder, and ≥10 indicates moderate to severe anxiety.
- Primary Care PTSD- 5 (PC-PTSD-5): This 5-item tool screens for PTSD. A score of 3 or higher suggests possible PTSD.
- Columbia-Suicide Severity Rating Scale (C-SSRS): Use immediately upon any concern of self-harm or suicide, and periodically for high-risk or severely depressed clients.

Documentation of these screenings should be integrated into the care plan. Any abnormal result should trigger immediate follow-up action, such as referral to appropriate mental health professionals (Medline Plus, 2022).

Holistic and Mental Health-Centered Planning

Mental health should be treated as a core component of rehabilitation and life planning, not as a separate or optional focus. As such, psychological services should be routinely included in the plan of care, including outpatient therapies like cognitive behavior therapy or group therapy, psychiatry services for medication management, and peer support groups.

Life care planners should anticipate barriers to mental health care like stigma, transportation, and cost, and assist clients with navigating the healthcare system and accessing the necessary services. Special care should be taken to collaborate with trauma-informed and culturally competent professionals to ensure clients can fully engage in their care. Consider local disability-specific support groups, Veterans Affairs programs, or National Alliance on Mental Health chapters that may be accessible in your area (Modi, 2022). Integration of complementary and alternative practices (such as acupuncture, yoga, and meditation) may be beneficial to include in routine care planning as well.

The exact number of disability adjustment sessions needed is going to vary widely based on the nature and extent of injury. Research indicates that a higher frequency of sessions is correlated with more positive outcomes, and the inverse is true for less frequent sessions, so priority should be placed on making sure patient encounters are occurring at regular intervals (Tiemans et al., 2019). Early on, clients may benefit from every 1 to 2 weeks, as needs and information about the condition can change rapidly. As time progresses, visits can be spaced out to once a month and then even less frequent check-ins over time. For mental health concerns, no more than 4 months should pass between visits. Engagement with other therapies, such as psychotherapy, may need to occur more frequently (even as frequently as once per week), for extended months or years. The specific resources and frequency recommendations will vary both by client scenario and the scope of the life care planner based on credentials and state regulations. Adjustments for those factors should be used accordingly.

Suicide Risk Assessment

When assessing clients with mental health concerns, it is important to be direct about assessing for suicidal ideations. All clients should be asked about this at baseline and regular intervals or with any symptom exacerbation. Talking about suicide will not give clients this idea, and often, people

considering death want to be asked about this, as they do not know how to bring it up themselves. Steps in a suicide assessment are as follows:

- Do you have thoughts of suicide or wanting to end your life?
- Do you have a plan?
- Can you share the details of that plan with me?
- Do you have the means to enact that plan?

These questions are checking for thoughts, intent, and the accessibility of lethal means, as well as helping determine the level of risk this patient is at for actually making a suicide attempt. Clients with intent, a plan, and access to the plan are at crisis level and need emergency evaluation by a crisis team (NIH, 2022d).

Safety Planning and Crisis Intervention

Life care planners must be prepared to act swiftly in the event of a mental health crisis or suicidal ideation. For clients with thoughts of self-harm, a personalized safety plan can be a useful tool and is easy to develop with clients. Typical safety plans include the following:

- **Early warning signs:** These can be patient-described triggers, thoughts, or feelings that often precede negative, intrusive thoughts or thoughts of self-harm.
- **Coping strategies:** Have clients list activities or practices that help them reset or move past self-harm thoughts. This will be unique to the individual, but common choices are going for a walk outside, caring for a pet, calling a friend, engaging in exercise, or journaling.
- **Means restriction:** Discuss with clients and caregivers ways that the home environment can be made safer (such as removal of knives, weapons, or firearms) or locking up medications, as well as having someone with the patient at all times until the crisis has passed.
- **Safe contacts:** There should be people available to help talk to clients when they are at risk.
  - Clients should list the names and phone numbers of identified loved ones or peers who are available to talk or help if the initial coping mechanisms are not helping.
  - Contacts should include a list of local mental health resources (such as crisis teams or hospitals) and national crisis lines (such as 988).

Much of this information may seem obvious or silly for clients to record when they are not in a crisis frame of mind. However, having a concise list of these measures can be very grounding in a crisis situation and becomes much more useful when clients are dysregulated or unsure what to do (AAP, 2023).

Referral Pathways and Resource Navigation

Life care planners should maintain an active referral network and be familiar with local mental health clinics and specialists (including psychiatrists, psychologists, and trauma therapists), telehealth providers who can meet accessibility and transportation needs, substance use programs, and vocational rehabilitation.

Follow-up on referrals and crises is essential. All referrals should be tracked to completion, and progress reports from teams or services should be integrated into planning where applicable.

Family Support

Life care planners also have the opportunity to help families. Referrals for family therapy should be facilitated when family dynamics are strained or role shifts are causing distress.

Health insurance is often overwhelming to handle and, for many people, comes with a steep learning curve about utilizing coverage, obtaining necessary prior authorization, and determining out-of-pocket costs. Clients may also be unaware of their legal rights or access to assistive services with a qualifying disability. Concepts like ADA, IDEA, or FMLA may be completely new to them. Connecting clients with medical case managers to help navigate the legal and insurance side of things can be an essential part of care.

Conclusion

Care of clients with significant injuries or disabilities is a complex and multimodal process. Adding one more facet may seem too difficult or time-consuming, but the importance of incorporating mental health care into life care planning cannot be overstated.

By proactively screening, coordinating, and advocating for mental health care, life care planners can ensure a more complete, person-centered approach that recognizes the full scope of human experience following catastrophic injury or illness. Addressing mental health is not only compassionate—it is essential for sustainable recovery and long-term quality of life.

REFERENCES

American Academy of Pediatrics. (2023). *Safety Planning*. AAP. Retrieved on April 15, 2025, from https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/brief-interventions-that-can-make-a-difference-in-suicide-prevention/?srsltid=AfmBOoq5yDp6W71ngE0__7wKgzPSQaoRFhamzFK8D2Z5cusN5LS96NWR.

American Psychiatric Association. (2020). *Chronic Pain and Mental Health Often Interconnected*. APA Newsroom. Retrieved on April 15, 2025, from https://www.psychiatry.org/news-room/apa-blogs/chronic-pain-and-mental-health-interconnected.

Chen, K., Hynes, K. K., Dirschi, D., Wolf, J. M., and Strelzow, J. A. (2024). "Depression, anxiety, and post-traumatic stress disorder following upper versus lower extremity fractures," Injury, 55(3). Retrieved on April 15, 2025, from https://doi.org/10.1016/j.injury.2023.111242.

https://www.nimh.nih.gov/health/topics/depression.

Medline Plus. (2022). *Mental Health Screening*. National Library of Medicine. Retrieved on April 15, 2025, from https://medlineplus.gov/lab-tests/mental-health-screening/.

Modi, H. (2022). *Exploring Barriers to Mental Health Care* in the U.S. Association of American Medical Colleges. Retrieved on April 15, 2025, from https://www.aamcresearchinstitute.org/our-work/issue-brief/exploring-barriers-mental-health-care-us

National Health Alliance on Mental Illness. (2022). Mental Health by the Numbers. NAMI. Retrieved on April 15, 2025, from https://nami.org/mhstats?gclid=Cj0KCQiAiJSeBhCCARIsAHnAzT8YJyMwaR4nXArETaLvF6OceJ3q4QTHQXR9lbSLAyH6zitldFr5orUaAra4EALw_wcB.

National Institute of Mental Health. (2022a). *Anxiety Disorders*. NIH. Retrieved on April 15, 2025, from https://www.nimh.nih.gov/health/topics/anxiety-disorders.

National Institute of Mental Health. (2022b). *Depression*. NIH. Retrieved on April 15, 2025, from National Institute of Mental Health. (2022c). *Traumatic Events and Post-Traumatic Stress Disorder (PTSD)*. NIH. Retrieved on April 15, 2025, from https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

National Institute of Mental Health. (2022c). *Traumatic Events and Post-Traumatic Stress Disorder (PTSD)*. NIH. Retrieved on April 15, 2025, from https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

National Institute of Mental Health. (2022d). *Suicide*. NIH. Retrieved on April 15, 2025, from https://www.nimh.nih.gov/health/statistics/suicide

Peterson, M. D., Meade, M. A., Lin, P., Kamdar, N., Rodriguez, G., Krause, J. S., and Mahmoudi, E. (2022). "Psychological morbidity following spinal cord injury and among those without spinal cord injury: the impact of chronic centralized and neuropathic pain," *Spinal Cord*, 60, 163–169. Retrieved on April 15, 2025, from *https://doi.org/10.1038/s41393-021-00731-4*.

Richardson, A.E., Derrett, S., Samaranayaka, A., and Wyeth, E.H. (2021). "Prevalence and predictors of psychological distress following injury: findings from a prospective cohort study." *Injury Epidemiology* 8:41. Retrieved on April 15, 2025, from https://doi.org/10.1186/s40621-021-00337-7.

Tiemens, B., Kloos, M., Spijker, J., Ingenhoven, T., Kampman, M., & Hendriks, G. J. (2019). "Lower Versus Higher Frequency of Sessions in Starting Outpatient Mental Health Care and the Risk of a Chronic Course; A Naturalistic Cohort Study," *BMC Psychiatry*, 19(1), 228. Retrieved on April 15, 2025, from https://doi.org/10.1186/s12888-019-2214-4.

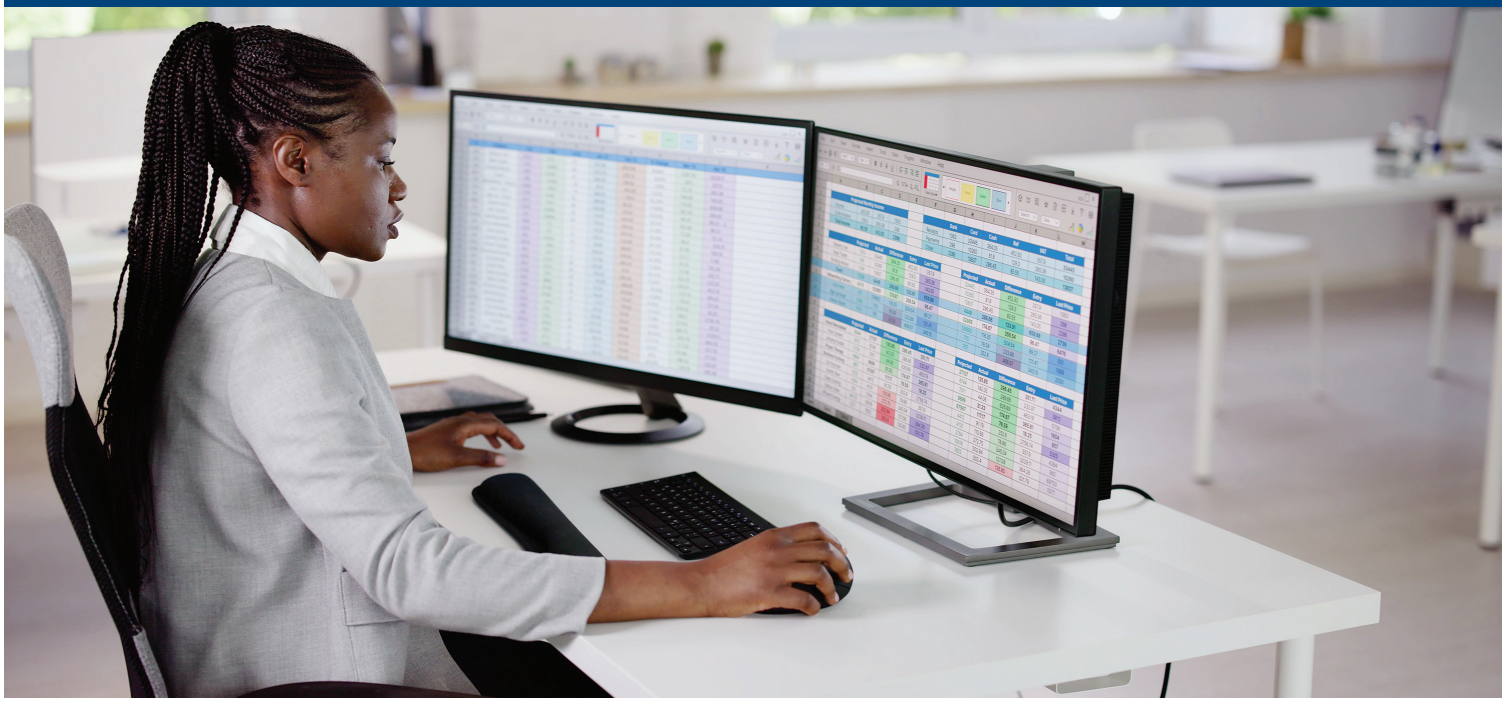
United States Department of Labor. (2025). "Persons with a Disability: Labor Force Characteristics – 2024," *News Release, USDOL Bureau of Labor Statistics*. Retrieved on April 15, 2025, from https://www.bls.gov/news.release/pdf/disabl.pdf.

United States Department of Veterans Affairs. (2025). *PTSD: National Center for PTSD*. USDVA. Retrieved on April 15, 2025, from https://www.ptsd.va.gov/disaster_events/for_providers/mental_health_impact.asp.

Villareal, P. (2024). "Study finds large gaps in mental health care for people with chronic pain," *University of Arizona Health Sciences*. Retrieved on April 15, 2025, from https://healthsciences.arizona.edu/news/releases/study-finds-large-gaps-mental-health-care-people-chronic-pain.

Choosing the Correct Code: PSYCHIATRIC/PSYCHOLOGICAL SERVICES

By Lisa Gay, MSN, RN, FNP-BC, CLCP, CMC



Keywords: 1) Coding 2) Mental Health 3) Psychology

Many of the costs used for medical services in a life care plan are determined based on a medical code that corresponds to a service. Current Procedural Terminology (CPT®) codes are dictated by the American Medical Association (AMA) and are intended "for reporting medical services and procedures performed by physicians and other qualified health care professionals. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians and other qualified health care professionals, patients, and third parties" (AMA, 2024). As a life care planner, it is important to understand the intricacies of CPT codes to choose the correct code and, therefore, include the accurate cost of the service that an evaluee is anticipated to require.

At the heart of coding for medical services are the evaluation and management (E/M) services and codes. E/M codes represent services provided by a physician or other qualified healthcare professional and include codes 99202 to 99499. They are divided into categories primarily based on where the service is provided, and then subcategories, which typically reflect whether the visit is a new patient/initial visit or an established patient/subsequent visit. The appropriate code is determined based on either visit duration or complexity of medical decision making (MDM), place or type of service, and content of the service. For more information on outpatient office E/M codes and how they are determined based on MDM, see the following table from the American Medical Association: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

CPT Codes for Psychiatry Services

Per the AMA (2024), "psychiatry services include diagnostic services, psychotherapy, and other services to an individual, family, or group." Coding for psychiatry services is determined by the type of provider and the service provided. Psychiatry services are provided in all care settings, and, except for the use of E/M codes, their codes do not change with regard to the setting where the service is provided.

E/M codes can be used by medical providers, such as physicians, nurse practitioners (NPs), and physician assistants (PAs), to report some psychiatric services instead of using psychiatric-specific codes or in addition to psychiatric codes.

These circumstances will be discussed in more detail in the following sections.

Diagnostic Evaluations

The AMA (2024) defines a psychiatric diagnostic evaluation as "an integrated biopsychosocial assessment, including history, mental status, and recommendations." A diagnostic evaluation is done at the initiation of care with a patient and may be utilized again for a new episode of illness (e.g., evaluating anxiety when the individual was previously receiving care for depression) or when someone is re-admitted to a hospital or facility. There are two categories of psychiatric diagnostic evaluations:

- 90791: A psychiatric diagnostic evaluation would be performed by a qualified mental health professional, including clinical psychologists, licensed counselors, licensed marriage and family therapists, licensed clinical social workers, psychiatrists, and psychiatric NPs and PAs.
- 90792: A psychiatric diagnostic evaluation with medical services that can (but does not have to) include a medical assessment, physical examination, prescribing of medication, and ordering and/or review of laboratory or other diagnostic studies. This code would be used by providers licensed to provide medical services, such as psychiatrists and psychiatric NPs and PAs. These providers could choose to utilize an evaluation and management code for their diagnostic evaluation instead of (but not in addition to) using 90792.

Psychotherapy

According to the AMA (2024), "psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development." Psychotherapy codes are chosen based on time spent face-to-face with the patient and may include an informant on the patient's behalf, however the patient must be present for the majority of the service. Psychotherapy services provided by a mental health professional are coded using:

- 90832: Psychotherapy, 30 minutes with patient
- 90834: Psychotherapy, 45 minutes with patient
- 90837: Psychotherapy, 60 minutes with patient

When psychotherapy services are provided by a psychiatrist or psychiatric NP or PA, in conjunction with a medical E/M service on the same day, an add-on code is used to reflect this service. Add-on codes cannot be used alone; they must be used along with a primary service, in this case, the medical management visit. The E/M code would be chosen by the provider based on the level of their medical decision making, and the psychotherapy code would be chosen based on the time spent on psychotherapy alone.

- 90833: Psychotherapy, 30 minutes with patient when performed with an E/M service (add-on code)
- 90836: Psychotherapy, 45 minutes with patient when performed with an E/M service (add-on code)
- 90838: Psychotherapy, 60 minutes with patient when performed with an E/M service (add-on code)

An example of the use of these add-on codes would be an NP seeing a patient for a follow-up visit in which they provide psychiatric medication management, along with 30 minutes of individual talk therapy. They would then use CPT codes 99213 or 99214 for the medication management (depending on the variables that went into their medical decision making), as well as 90833 for the psychotherapy provided during the same visit.

It is worth noting that Cognitive Behavioral Therapy (CBT), which is often recommended in life care plans, is primarily coded using the psychotherapy codes listed above (90832-90834, 90836-90838). CBT is provided by licensed mental health care providers and would also be broken down based on whether it is provided alone or with a medical service. While situations will occur that require an alternative approach, such as CBT focused on a specific condition like insomnia or neurocognitive rehabilitation, the CBT recommended most often in life care plans is straightforward and coded based on the time spent with the patient in therapy. The technology now exists for CBT providers to monitor their patients' progress remotely using apps or wearable devices. Remote monitoring codes should be included in a life care plan when the service is specifically recommended to accompany CBT therapy and/or is already being provided to the individual. These services are typically coded using the following :

- 98980: Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
- 98981: Remote therapeutic monitoring, used with CPT 98980 for each additional 20 minutes during the calendar month (add-on code)

Additional Psychotherapy Codes

- 90845: Psychoanalysis, per session. For more information on psychoanalysis, see the International Psychoanalytical Association: https://www.ipa.world/IPA/Dev/About_Psychoanalysis/What_is_Psychoanalysis.aspx.
- 90846: Family psychotherapy (without the patient present), 50 minutes. This code is intended to represent therapy directed toward the treatment of the patient who is not present, rather than the family members who may have stressors related to the patient's illness.
- 90847: Family psychotherapy (conjoint psychotherapy, with patient present), 50 minutes. This code would be used

for therapy for any configuration of two or more family members to discuss their struggles, family members acting as caregivers (such as the parents of a child with a disability), couples therapy, and other types of family group therapy.

- 90849: Multiple-family group psychotherapy, per session. This code would be used when bringing together several families experiencing similar stressors for a therapy session.
- 90853: Group psychotherapy (other than a multiple-family group), per session. Used when bringing together several individuals experiencing similar stressors for a therapy session.

Psychiatric and psychological services can be provided via telemedicine by either audio/video or audio-only modalities. The rules and laws regulating telehealth services have changed multiple times since the COVID-19 pandemic increased their use in 2020. It is recommended that a life care planner double-check any code intended to represent telemedicine services before use. Psychiatric diagnostic evaluations (90791, 90792) can be provided remotely, as well as psychotherapy services, chosen by length of the visit (90832-90834, 90836-90838). Family psychotherapy services (with or without the patient present) can also be conducted through telemedicine (90846, 90847). A modifier should be used to indicate the modality of service:

- 95: Modifier to indicate a video/audio service
- FQ: Modifier to indicate an audio-only visit

Telemedicine can also be used to provide psychiatric/medical visits, with or without psychotherapy. As of the writing of this article, the Medicare rules regarding coding for these visits vary from the general coding guidelines, and the life care planner must choose which code set is most logical for their needs. On January 1, 2025, the AMA introduced codes 98000 to 98007 for telemedicine audio/video visits and 98008 to 98015 for audio-only visits. These codes are chosen based on the patient being new or established and the length of the visit (Robeznieks, 2025). Currently, Medicare does not reimburse for these codes but does continue to recognize outpatient E/M codes 99211 to 99215 for mental health telemedicine visits conducted by qualified medical professionals when the appropriate modifier (95 or FQ) is used (Health Resources and Services Administration, 2025).

Other Psychiatric Services or Procedures

- 90863: Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (add-on code). This code can be added onto psychotherapy codes 90832,90834, and 90837. It is to be used by mental health providers who have prescriptive authority in their state but are not physicians or psychiatric NPs or PAs. Physicians, NPs, and PAs should instead utilize E/M codes when providing pharmacologic management along with the add-on codes for psychotherapy services (90833, 90836, 90838) (AMA, 2024).
- 90865: Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital [Amytal] interview). The American Psychological Association (2018) defines narcosynthesis as "a treatment technique that involves the administration of narcotic drugs to stimulate recall of emotional traumas, followed by 'synthesis' of these experiences with the patient's emotional life through therapeutic discussions in the waking state."
- 90867: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, monitor threshold determination, delivery, and management. This code should be reported only once per course of treatment. For more information on TMS, see the following: https://www.ncbi.nlm.nih.gov/books/NBK568715/.
- 90868: TMS, subsequent delivery and management sessions, per session.
- 90869: TMS, subsequent motor threshold re-determination with delivery and management sessions, per session.
- 90870: Electroconvulsive therapy (includes necessary monitoring), per session. For more information on electroconvulsive therapy, see the following: https://www.ncbi.nlm.nih.gov/books/NBK538266/.
- Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight-oriented, behavior-modifying, or supportive psychotherapy). "Psychophysiologic therapy comprises a set of 'self-regulation' techniques that are specifically targeted at particular symptoms or body systems. Biofeedback involves taking one or more physiologic measures that are thought to have a very specific relationship to the patient's problem, and teaching the patient to control these measures voluntarily, by watching them change in real-time on a computer screen and thereby developing a personal strategy for controlling them" (Katsamanis et al., 2011). Visits are coded by time:
  - 90875: 30 minutes
  - 90876: 45 minutes
- 90880: Hypnotherapy, per session. Psychology Today (2022) describes hypnotherapy as "a therapeutic practice that uses guided hypnosis to help a client reach a trance-like state of focus, concentration, diminished peripheral awareness, and heightened suggestibility" and continues that "a trained clinical hypnotherapist can help clients in this state relax and turn their attention inward to discover and utilize resources within themselves that can help them achieve desired behavioral changes or better manage pain or other physical concerns."

Special Situations

The need for the following specialty services is harder to predict, and therefore, they are less likely to be used in a life care plan related to psychological care. However, there are situations where an individual's history and/or severity of their mental health issues indicate that there is a high likelihood of instability in the future, in which case, inclusion of these codes may be warranted.

An add-on code to indicate "interactive complexity" can be used to indicate "specific communication factors that complicate the delivery of a psychiatric procedure," such as "more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients" (AMA, 2024). This code can be used along with the codes for psychiatric diagnostic evaluations (90791, 90792), psychotherapy (90832 to 90834, 90836 to 90838), and group psychotherapy (90853). The American Psychological Association provides more information at the following link: https://www.apaservices.org/practice/reimbursement/health-codes/2022-reporting-interactive-complexity.

- 90785: Interactive complexity (add-on code)

Crisis codes for psychotherapy are intended for use when an individual is experiencing a mental health crisis, including feeling overwhelmed or unable to cope with a situation or event. This psychotherapy "provides immediate, short-term help to patients who experience a situation or event that produces emotional, mental, and behavioral distress. Psychotherapy is focused on the immediate situation, minimizing the stress of the event, providing emotional support and developing coping strategies to deal with the crisis. Therapy may also include reassurance and psychotropic medications aimed at decreasing the patient's anxiety and improving coping abilities" (Find-A-Code, 2025). Visits are coded by time:

- 90839: Psychotherapy for crisis, first 60 minutes
- 90840: Psychotherapy for crisis, each additional 30 minutes (add-on code)

When mental health services are provided in the emergency department and hospital setting, the typical E/M codes would be reported for the type of visit or stay:

- 99281-99285: Emergency department visit
- 99221-99223: Inpatient or observation care, initial, per day
- 99231-99233: Inpatient or observation care, subsequent, per day
- 99234-99236: Inpatient or observation care, admission and discharge on the same date
- 99238-99239: Inpatient or observation care, discharge day management
- A Diagnosis Related Group (DRG) code as applicable for the primary diagnosis related to the inpatient hospital stay

In addition to the E/M code(s) and a DRG code (if applicable), additional codes may be reported specifically for mental health care, including a consultation code for a psychiatrist (99242 to 99245 or 99252 to 99255), a psychiatric diagnostic evaluation (90791, 90792), psychotherapy for crisis (90839, 90840), and/or psychotherapy services (90832 to 90834, 90836 to 90838).

Care at a psychiatric residential treatment center is coded using the same E/M codes used for a nursing facility when provided by a medical provider, such as a psychiatrist or psychiatric NP or PA. Any applicable psychiatric diagnostic evaluation (90791, 90792) and/or psychotherapy service codes could also be used and may reflect psychotherapy provided alone or in conjunction with the E/M service (90832 to 90834 or 90836 to 90838).

- 99304-99306: Initial nursing facility care, per day (once per stay per provider)
- 99307-99310: Subsequent nursing facility care, per day
- 99315-99316: Nursing facility discharge management

Related Services

There are related services that are commonly seen in a life care plan, but they are outside of the scope of this article. The following are some additional resources for these services.

Coding for psychological and neuropsychological testing is very dependent on the individual and their situation. See the American Psychological Association's 2024 Psychological and Neuropsychological Testing Billing and Coding Guide for more information: https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding.pdf

Applied behavior analysis (ABA) assessments and therapy are often recommended for children with autism. Information from the ABA Coding Coalition can be found at the following link: https://abacodes.org/codes/

Conclusion

The majority of the codes for mental health services used in a life care plan are straightforward. It is important to distinguish if the provider is delivering medical services and/or psychotherapy services and to choose the appropriate corresponding code(s). Remember that the codes for psychiatry services can be applied without regard for the setting; however, any related E/M codes will be specific to the location of services. Choosing the correct code ensures that the life care planner can obtain the correct associated cost and provide the most accurate plan for the individual needing services.

REFERENCES

ABA Coding Coalition. (n.d.). *Billing Codes*. Retrieved on June 5, 2025, from https://abacodes.org/codes.

American Medical Association. (2024). *CPT Professional Edition* 2024. AMA Press.

American Medical Association. (n.d.). *CPT E/M Office Revisions Level of Medical Decision Making (MDM)*. Retrieved on June 5, 2025, from https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

American Psychological Association. (2018). *APA Dictionary of Psychology*. Retrieved on June 5, 2025, from https://dictionary.apa.org/narcosynthesis

American Psychological Association. (2024). *2024 Psychological and Neuropsychological Testing Billing and Coding Guide*. Retrieved on June 5, 2025, from https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding.pdf.

American Psychological Association. (2022). *2022 Guidelines for Reporting Interactive Complexity*. Retrieved on June 5, 2025, from https://www.apaservices.org/practice/reimbursement/health-codes/2022-reporting-interactive-complexity

Find-A-Code. (2025). *CPT® Code 90839 in section: Psychotherapy for crisis*…. Retrieved on June 5, 2025, from https://www.findacode.com/code.php?set=CPT&c=90839

Health Resources and Services Administration. (2025). *Telehealth for Behavioral Health Care: Billing for Telebehavioral Health*. Retrieved on June 5, 2025, from https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-behavioral-health/billing-for-telebehavioral-health

International Psychoanalytical Association (n.d.). *What is Psychoanalysis*. Retrieved on June 5, 2025, from https://www.ipa.world/IPA/Dev/About_Psychoanalysis/What_is_Psychoanalysis.aspx

Katsamanis, M., Lehrer, P. M., Escobar, J. I., Gara, M. A., Kotay, A., & Liu, R. (2011). "Psychophysiologic treatment for patients with medically unexplained symptoms: a randomized controlled trial," *Psychosomatics*, 52(3), 218–229. Retrieved on June 5, 2025, from https://doi.org/10.1016/j.psym.2011.01.015

Mann S.K. & Malhi N.K. (2023). "Repetitive Transcranial Magnetic Stimulation," *StatPearls*. StatPearls Publishing. Retrieved on June 5, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK568715/

Psychology Today. (2022). *Hypnotherapy*. Retrieved on June 5, 2025, from https://www.psychologytoday.com/us/therapy-types/hypnotherapy#:~:text=Hypnotherapy

Robeznieks, A. (2025, February 4). *How the AMA Meets Need for New Telehealth CPT Codes. American Medical Association*. Retrieved on June 5, 2025, from https://www.ama-assn.org/practice-management/cpt/how-ama-meets-need-new-telehealth-cpt-codes

Salik, I. and Marwaha, R. (2022). "Electroconvulsive Therapy," *StatPearls*. StatPearls Publishing. Retrieved on June 5, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK538266/.

AALNC

LEGAL NURSE VOICE:
Insights from a Legal Nurse Consultant

Prepared to Prevail:
Expert Witness Preparation Tips from the Front Lines

By Tommy Vaughn, MSN, RN, LNCC

Whether you are retained as a Nurse Life Care Planner or Legal Nurse Consultant, stepping into the role of expert witness demands more than clinical knowledge. It requires strategic preparation, polished communication, and the ability to teach complex medical concepts with clarity and composure to those who have little to no medical knowledge.

Mastery in the courtroom is developed long before a deposition or trial begins and starts with a comprehensive understanding of your scope of review. Look over every medical record, deposition, and relevant document for your case, not just those directly related to your area of expertise, as context matters. For example, if you're a life care planner, understanding the mechanism of injury, the pre-injury status, and any prior related diagnoses is essential to ensure your plan isn't inadvertently overreaching, or worse, underestimating long-term needs.

Build timelines and chronologies, cross-reference data, and highlight inconsistencies or gaps early. This not only strengthens your report but arms you with critical insights should opposing counsel challenge your assumptions.

This sounds basic, but nurse expert witnesses often get into trouble drifting outside their area of expertise or scope of practice. Avoid making causation statements, as a nurse life care planner, unless you're specifically qualified to do so. If you're a standard of care expert, don't speculate on long-term prognosis unless supported by medical authority.

Be clear with retaining counsel—and yourself—about what you can and cannot opine on. Courts (and juries) value credible humility over unfounded confidence.

Mock depositions are invaluable. Ask a trusted colleague or attorney to conduct a rehearsal session, focusing on common areas of attack: methodology, bias, credentials, scope of review, and literature reliance. However, avoid memorization as jurors and attorneys alike are skilled at detecting rehearsed answers, which may come off as disingenuous or evasive. Instead, aim for a conversational, confident tone that demonstrates command of your subject matter. Another step is to ensure trial preparation with the attorney for the case. This will aid in your ability to identify and neutralize potential traps that may occur at trial.

Depositions aren't trials, but they can determine whether your testimony ever makes it to court. Opposing counsel may try to provoke you, confuse you, or box you into binary answers. Don't take the bait. Pause before answering and always clarify confusing questions. It is perfectly appropriate to say, "I'd need to refer to the record," or "That's outside the scope of my opinion." Some examples of confusing questions that might be used at a deposition or trial are listed below.

The Compound Question: "Did you personally evaluate the plaintiff and also consult with their treating physician before creating the life care plan?"

Response Strategy: "Counselor, that's actually two separate questions. I'd like to address each one individually to give you accurate answers."

The Assumption Trap: "Since you agree the plaintiff exaggerated their symptoms, wouldn't you say your life care plan overestimates future costs?" (when you never agreed the plaintiff exaggerated their symptoms)

Response Strategy: "I need to clarify something first. I don't agree that the plaintiff exaggerated their symptoms. Let me explain what I actually found in my review..."

The False Dichotomy: "So either you're saying the plaintiff will never improve and needs lifelong care, or you're admitting your plan is speculative and unreliable, which is it?

Response Strategy: "That's not an either/or situation. The plan reflects current clinical findings and includes provisions for reassessment as the patient's condition evolves. It's based on established methodology and medical input, not speculation."

The Literature Mischaracterization: "This study you cited says nurses should check patients every hour, but the defendant only checked every two hours, correct?"

Response Strategy: "Let me refer to the actual study. [Pause to review] The study recommends hourly assessments for patients with specific conditions. I'd need to verify whether this patient met those criteria before drawing that conclusion."

Never agree with characterizations of your testimony. Break down compound questions into components when possible and correct misstatements of your opinions immediately. Use phrases like "Let me clarify" or "That's not quite accurate" when correcting misstatements. It is appropriate to say, "I'd need to review my notes to answer that precisely."

Remember: Opposing counsel's job is to create doubt, not necessarily to understand your opinion. Stay focused on the facts, maintain your professional demeanor, and don't let rapid-fire questioning pressure you into imprecise answers. Never speculate, and if you don't know something, say so-and resist the urge to fill in silence.

Your opinions must be grounded in a reliable methodology. For life care planners, this means demonstrating adherence to professional standards like those outlined in the International Academy of Life Care Planners (IALCP, 2025) or AANLCP guidelines (AANLCP, 2025). For nurse experts evaluating the standard of care, cite evidence-based practices, facility protocols, and relevant position statements.

It is important to keep a copy of every article or guideline you reference. If it's cited in your report, you should be prepared to explain and defend its applicability during cross-examination. Opposing counsel will often probe your professional affiliations, prior testimony history, and percentage of work for plaintiffs vs. defense. This is not inherently problematic, but you must be ready to address it with transparency.

If you predominantly work on one side of the aisle, be prepared to explain why that aligns with your clinical background or ethical comfort zone, but also emphasize your commitment to objectivity and truth over advocacy.

You may be questioned on many aspects of your career. In order to be prepared, have the following items reviewed and ready if needed:

- Ensure your CV or resume is current, accurate, and consistent with public databases.
- Disclose any licenses, certifications, employment history, and testimony history for at least the past four years, or as required by the court or jurisdiction.
- Keep a running testimony log with dates, case names (where permissible), jurisdictions, and whether you were deposed or testified at trial.

All of these proactive precautionary measures make future disclosures much easier and prevent unpleasant surprises.

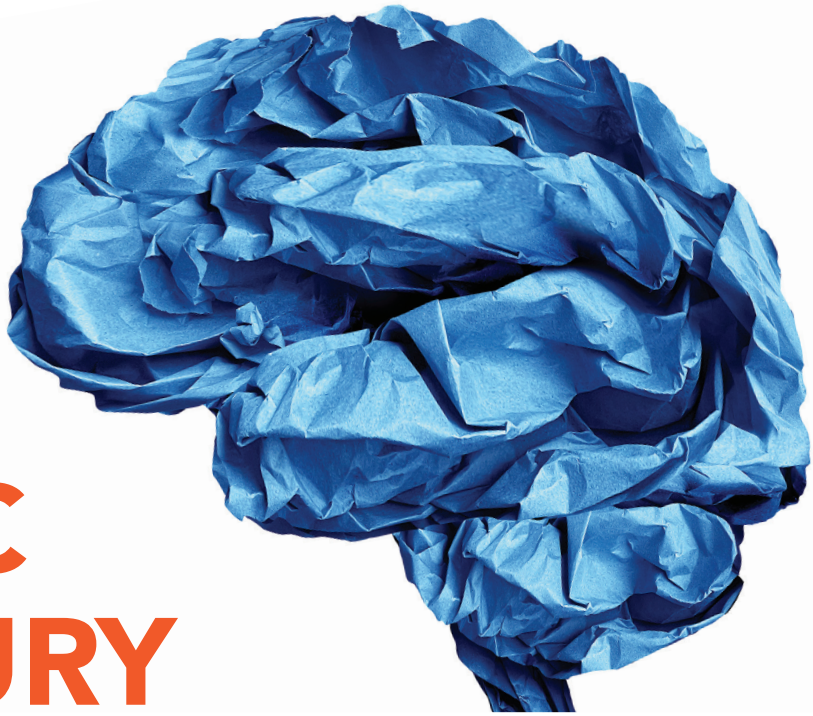
Expert witness work can be deeply rewarding as it allows nurse professionals to apply clinical insights in new ways and elevate the standard of medical-legal practice. It also comes with scrutiny, stress, and the responsibility to get it right. Preparation is your armor, whether you're testifying to a life care plan's rationale or dissecting deviations from standard nursing care, your credibility begins long before your name is called. Stand prepared, speak clearly, and always remember: your integrity is your most persuasive credential.

REFERENCES

American Association of Nurse Life Care Planners. (2025). *Nurse Life Care Planning Standards of Practice*. Retrieved on June 20, 2025, from https://www.aanlcp.org/nurse-life-care-planning-standards-of-practice/.

International Association of Rehabilitation Professionals-Life Care Planning (2025). *Scope and Standards of Practice*. Retrieved on June 20, 2025, from https://connect.rehabpro.org/lcp/about/scopeandstandards.

LIFE CARE PLANNING AFTER TRAUMATIC BRAIN INJURY



By Venus S. Victorino, BSN, RN, CCRN, CFRN, LNC, LCP-C, MCP-C
and Kate Smith, BSN, RN, CNLCP, LCP-C

Keywords: 1) Traumatic brain injury 2) Rehabilitation 3) National TBI Resources

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1) Impaired Memory 2) Ineffective Coping 3) Interrupted Family Processes

Traumatic Brain Injury (TBI) refers to damage to the brain caused by an external physical force. It can result from a sudden blow, jolt, or penetrating injury to the head or body. Common causes include falls, motor vehicle accidents, military trauma like blast injuries, and sports-related injuries (CDC, 2024). TBIs are categorized as mild, moderate, or severe based on the injury's intensity and effects on brain function. More than 75% of all TBIs are mild. But even mild TBIs (mTBIs) can cause significant and long-term issues. People with a mTBI may have trouble returning to their daily routines, including being able to work. Moderate and severe TBIs can develop significant and long-term health issues (Cleveland Clinic, 2024).

For Life Care Planners, understanding the clinical complexity of TBI and the range of support options available is essential. TBIs can cause long-term challenges that affect daily functioning and the lives of people of all ages. Anyone can experience a TBI, but there is data that suggests some groups are at greater risk of dying or experiencing long-term health problems afterward. Examples of groups who are more likely to be affected by a TBI include racial and ethnic minorities, service members and veterans, people who experience homelessness, people who are in correctional and detention facilities, survivors of intimate partner violence, and people living in rural areas (CDC, 2024). Life care plans benefit from going beyond a summary of past treatment, as they offer realistic, individualized recommendations based on known symptoms and expected future needs. These recommendations often involve collaboration with providers, caregivers, and support systems to accurately project care frequency and costs.

Common Causes and Real-World Examples

TBI can result from many types of events and vary widely in severity. Common causes of TBIs include falls, firearm-related injury, motor vehicle crash, and assault (CDC, 2024). Even seemingly minor incidents can lead to long-term complications. The following are examples of the types of incidents that could result in a TBI:

a. A high school soccer player sustains a mild concussion and seems fine at first. Over the next week, she develops sleep

issues and mood swings. With rest and monitoring, the symptoms are resolved.

b. A warehouse worker is hit in the head by a heavy box and experiences loss of consciousness, confusion, and post-traumatic amnesia. He's diagnosed with moderate traumatic brain injury. He has ongoing behavioral and cognitive complaints after being discharged from the hospital, requiring medications, psychotherapy, and caregiver support.

c. A veteran exposed to a blast is initially treated for physical injuries, but later develops sleep problems and emotional instability, leading to a diagnosis of mTBI.

d. A woman involved in a car accident sustains a severe TBI and enters a coma. Months of rehab follow, including speech, cognitive, and mobility therapy.

e. A toddler falls from a short distance and seems fine. Days later, vomiting and drowsiness persisted, leading to a diagnosis of mTBI.

Not all injuries look serious at first glance. These examples illustrate the diversity of TBIs. Early detection and flexible planning often make a critical difference.

Common Symptoms by Severity

When someone has a TBI, they typically present with one or more symptoms. The symptoms depend on which part of the brain gets injured. Not all symptoms are obvious initially, so it is important to monitor for potential issues over time. The severity of a TBI is often classified using the Glasgow Coma Scale (GCS), a neurological tool that assesses eye, verbal, and motor responses immediately after injury. Scores range from 3 to 15, with mild TBI classified as 13 to 15, moderate as 9 to 12, and severe as 3 to 8 (CDC, 2015).

a. Mild TBI (mTBI): headache, nausea or vomiting, fatigue or drowsiness, problems with speech, dizziness or loss of balance, sensory problems such as blurred vision, ringing in the ears, bad taste in the mouth or changes in ability to smell, sensitivity to light or sound, loss of consciousness for a few seconds to few minutes, no loss of consciousness, but a state of being dazed/confused/disoriented, memory or concentration problems, mood changes or mood swings, feeling depressed or anxious, difficulty sleeping or sleeping more than usual (Mayo Clinic, 2021).

b. Moderate to Severe TBI: can cause the same symptoms as mild TBI, plus any or all of these symptoms: loss of consciousness from several minutes to hours, persistent headache or headache that worsens, repeating nausea or vomiting, convulsions or seizures, dilation of one or both pupils, clear drainage from nose or ears, inability to awaken from sleep, weakness or numbness in fingers or toes, loss of coordination, profound confusion, agitation, combativeness or other unusual behavior, slurred speech, coma and other disorders of consciousness (Mayo Clinic, 2021).

Complications of TBI

Complications can occur immediately or soon after a TBI. The more severe injuries increase the risk of a greater number of, and more severe complications. It's important for the life care planner to be aware of these complications to anticipate future needs appropriately.

a. Physical complications: seizures, hydrocephalus, infections, blood vessel damage, headaches, vertigo, cranial nerve damage (which can result in facial paralysis or loss of sensation in the face, altered taste or smell, double vision or loss of vision, swallowing problems, dizziness, ringing in the ears, hearing loss)

b. Intellectual problems: memory loss, poor judgment, learning problems, attention and concentration, problems with problem-solving, multitasking, organization, planning, decision-making, or beginning or completing tasks

c. Communication problems: difficulty understanding, speaking, inability to organize thoughts, dysarthria, trouble reading cues or understanding nonverbal signals

d. Sensory problems: tinnitus, difficulty recognizing objects, impaired hand-eye coordination, double vision, taste/smell changes, balance or dizziness, paresthesia (Mayo Clinic, 2021)

Psychological Complications of TBI

Not all effects of TBI are visible. In many cases, the most disruptive symptoms are psychological. Mood instability, personality changes, anxiety, depression, anger, lack of empathy, insomnia, difficulty with self-control, verbal/physical outbursts, and poor self-awareness are some examples of psychological complications (Mayo Clinic, 2021). These can affect relationships, safety, quality of life, and independence. These complications often emerge gradually and may be overlooked without input from those who interact closely with the individual. Life Care Planners can assist by collaborating with families, behavioral health providers, and rehabilitation teams to identify risks and include long-term support in the plan. These behaviors are often the result of neurological changes that impact self-awareness, emotional regulation, and cognition.

Depending on the psychological complication, clients may benefit from a referral to a mental health specialist, counseling/psychotherapy, medication management, support groups, a daily schedule of structured activities and exercises, and/or cognitive rehabilitation (MSKTC, 2023).

Caregiver Support and Education

Caregivers (often family and friends) are frequently the first to notice slight shifts in mood, memory, or function that others who are unfamiliar with the patient may miss. In many cases, they're the main point of contact for providers, helping bridge the gap between formal care and daily life. Because caregivers are so closely involved, collaborating with them during client assessment can provide critical insight. Their perspective can inform both the care recommendations and the accuracy of frequency projections. Areas they are often well-versed in include the following:

a. **Observation and Communication:** Caregivers often notice early signs of regression, medication side effects, or emotional changes, allowing for timely adjustments.

b. **Care Coordination:** Families often help coordinate care, track changes, and keep things on course when multiple providers are involved.

c. **Emotional Support:** Their presence provides comfort and reassurance in moments of uncertainty or stress.

d. **In-Home Routines:** Caregivers are often intimately familiar with and may be able to provide information on medication routines, symptom management, and environmental modifications needed to complete tasks.

Challenges and Considerations

Life Care Planners often navigate more than just medical needs. Many clients face emotional and psychological hurdles that complicate recovery, and those challenges are not always easy to see on paper. Some of the most significant challenges emerge from psychological, behavioral, or cognitive shifts, which are difficult to quantify (MSKTC, 2023). Life Care Planners can anticipate these issues more effectively by working closely with clients, caregivers, and providers to identify subtle signs and include safeguards in the plan. Anticipating these moments early and working with others to plan around them can make a meaningful difference in long-term outcomes. The following are some examples of the challenges that clients with TBI may face:

a. A young adult injured in a motorcycle crash becomes withdrawn and avoids rehab appointments. By collaborating with therapists and case managers to include supportive counseling and peer mentoring, the care plan can better meet them where they are.

b. A parent recovering from a motor vehicle accident now avoids leaving home due to fear and anxiety. Working with providers to include community-based support or home-based therapies can reduce isolation.

c. An aging client recovering from a fall begins missing medications, but resists help. Caregiver input and regular check-ins can guide the inclusion of memory care and contingency planning.

Other common challenges difficult to quantify include provider shortages and transportation barriers in rural areas (CDC, 2015). Life care plans benefit from understanding common challenges to consider in the client population to remain realistic and responsive.

National TBI Resources

There are several national TBI resources that provide a range of support, education, and services to individuals and families living with TBIs, caregivers, as well as life care planners. Some examples of national TBI resources include:

a. **Model Systems Knowledge Translation Center (MSKTC)** – Offers fact sheets, caregiver education, and clinical tools that help validate recommendations and estimate care needs.

b. **Brain Injury Association of America (BIAA)** – Provides access to educational materials and advocacy tools useful for projecting long-term and vocational support.

c. **Brainline** – Shares personal stories, tools, and guides that reflect real-world challenges and help align planning with lived experiences.

d. **Centers for Disease Control and Prevention (CDC)** – Provides statistics, research, and public health guidance to help understand long-term prevalence and outcomes.

e. **Brain Trauma Foundation** – Publishes clinical guidelines that help structure follow-up care timelines and expectations.

TBI Specialty Clinics

Many academic and rehabilitation centers across the country offer TBI specialty care programs. Life Care Planners may reference these facilities' programs to establish benchmarks for care frequency, type, or facility-based pricing. Examples of TBI specialty clinics located around the country include:

a. **Oregon Health & Science University (Oregon)** – Integrated outpatient and neurorehabilitation programs.

b. **Craig Hospital (Colorado)** – Known for spinal cord and brain injury rehab.

c. **Spaulding Rehabilitation (Massachusetts)** – Offers structured neuro transition planning.

d. **Shepherd Center (Georgia)** – Vocational rehab and behavioral reentry focus.

e. **MossRehab (Pennsylvania)** – Cognitive rehab and assistive tech evaluation.

f. Rancho Los Amigos (California) – Large public hospital with extensive TBI services.

Department of Veterans Affairs - Affiliated Resources and Planning Considerations

While life care plans do not include services that are already covered or reimbursed by third-party payers, Department of Veterans Affairs (VA) programs remain vital for veterans recovering from TBI. Many individuals prefer to receive care within the VA system due to long-standing provider relationships, access to specialized services, and trust in VA-based support. In addition to providing care, the VA is a national leader in establishing clinical practice guidelines for TBI and related comorbidities (VA, 2021). Life care planners may collaborate with VA case managers to identify challenges, including waiting lists and unmet needs in the area, which can inform community-based recommendations and justify increased costs for travel and/or specialized program availability. Additionally, life care planners may use VA clinical practice guidelines to help shape accurate community-based recommendations and out-of-pocket projections. VA-Affiliated resources include:

a. Mental Illness Research, Education, and Clinical Centers (MIRECC) – Offers behavioral health and suicide prevention resources.

b. VA Polytrauma System of Care – Supports complex rehabilitation pathways for individuals with polytrauma.

c. VA TBI Clinics – Provide evaluations and interdisciplinary care planning.

d. VA Caregiver Support – Offers training and peer support for caregivers and their families.

Conclusion

TBI care is highly individualized. Recovery often unfolds over time and may involve shifting physical, emotional, and cognitive needs. Life care planners contribute by collaborating with caregivers, consulting with providers, and drawing from trusted resources to ensure recommendations reflect both current conditions and anticipated care requirements.

REFERENCES

Centers for Disease Control and Prevention. (2015). *Report to Congress on Traumatic Brain Injury in the United States: Epidemiology and Rehabilitation*. Retrieved on 29 June, 2025, from tbi_report_to_congress_epi_and_rehab-a.pdf.

Centers for Disease Control and Prevention. (2024). *Traumatic Brain Injury & Concussion: Data & Statistics*. Retrieved on July 1, 2025, from Site Index | Traumatic Brain Injury & Concussion | CDC.

Cleveland Clinic. (2024). Traumatic brain injury (TBI): *What it is, symptoms & treatment*. Cleveland Clinic. Retrieved August 2, 2025, from https://my.clevelandclinic.org/health/diseases/8874 traumatic brain injury.

Department of Veterans Affairs. (2021). *VA/DOD Clinical Practice Guideline for the Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury*. Retrieved on July 3, 2025, from VA/DoD_Clinical_Practice_Guideline_for_the_Management_and_Rehabilitation_of_Post-Acute_Mild_Traumatic_Brain_Injury.

Mayo Clinic. (2021). *Traumatic Brain Injury*. Retrieved on July 1, 2025, from https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

Model Systems Knowledge Translation Center (MSKTC). (2023). *TBI Resources and Factsheets*. Retrieved on July 1, 2025, from https://msktc.org/tbi.

LOW DOSE NALTREXONE (LDN):

A Promising Tool for Pain, Inflammation, and Autoimmune Disorders in Life Care Planning

By Jack Korbutov, PharmD, RPh, FACA, FACVP

Keywords: 1) Chronic pain 2) Inflammation 3) Long COVID 4) Low Dose Naltrexone 4)Brain Fog

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1) Chronic Pain Syndrome 2) Chronic Pain 3) Readiness for Enhanced Coping 4) Fatigue 5) Decreased Activity Tolerance 6) Impaired Comfort.

Chronic pain in the United States affects over 50 million adults and is a leading contributor to disability, lost productivity, and diminished quality of life (Dahlhamer et al., 2018). For decades, traditional pain management strategies and protocols resorted to opioids and non-steroidal anti-inflammatory drugs (NSAIDs), which come with a myriad of downfalls: dependency, tolerance, and systemic side effects. While they are and should be first-line for acute pain, providers and life care planners are typically faced with a lack of long-term options that are safe, sustainable, and aligned with individual health goals. A decades-old yet emerging therapy, Low Dose Naltrexone (LDN), offers a novel approach to both pain relief and immune modulation.

Naltrexone, an opioid receptor antagonist, was originally approved by the FDA in 1985 for the treatment of opioid and alcohol use disorders. At the commercially available 50 mg dose, naltrexone blocks the euphoric and addictive effects of opioids and reduces the cravings of alcohol dependence. Forty years later, it is still a top choice due to its efficacy and safety.

The connection to addiction treatment has significance for life care planners. For patients with a history of substance use disorder, LDN offers an alternative to highly addictive opioids. LDN has virtually no risk of addiction and does not cause the same euphoria that results from opioid use. This means it can be used as a tool for patients where safety and sobriety are paramount. It is truly one of a kind in its dual utility, as a therapy for addiction and a low-risk pain medication.

Overview of LDN Use

The development of LDN is a fascinating one, starting as a potential treatment for an entirely unrelated issue. Dr. Bernard Bihari, a physician treating HIV/AIDS patients, noticed a correlation between low endorphin levels and worsening autoimmune conditions. Having closely monitored the development of naltrexone, he hypothesized that selectively blocking opioid receptors may have an upregulatory effect on endorphins. He experimented with doses less than 10% of the commercially available dose, from 1 mg to 4.5 mg. The effects were astounding, as his patients experienced a 200% to 300% increase in their endorphin levels. This, in turn, alleviated pain and the rate of autoimmune progression.

Since then, hundreds of published studies, trials, and case studies have shown that LDN is an effective and well-tolerated treatment. In typical doses of 0.5 mg to 4.5 mg, it is increasingly being utilized in complex cases involving fibromyalgia, multiple sclerosis (MS), rheumatoid arthritis (RA), various cancers, and post-viral syndromes such as Long-COVID. Although compounded and typically not covered by insurance, one of the benefits of LDN is its low cost and availability across compounding pharmacies in the United States.

For life care planners seeking integrative approaches that address underlying inflammation, autoimmune, and neuroimmune dysregulation, LDN represents a compelling option for their patients and treatment teams to consider. With the growing body of evidence in support of LDN as a treatment option, increased awareness and education among providers, patients, and planners are essential to integrate it more widely in clinical practice.

Pharmacology and Mechanism of Action

Naltrexone has always been known as a competitive antagonist of opioid receptors, which makes it useful for opioid use disorder. In low doses (less than 10% of the commercially available dose), LDN operates via several distinct mechanisms. The most well-known of these mechanisms is the increase of endogenous opioids or endorphins. Through the temporary blockade of opioid receptors, the body upregulates beta-endorphins and enkephalins (Younger et al., 2014). This increase in endorphins helps increase pain tolerance and promotes a feeling of well-being, often related to a "runner's high."

A more recently discovered and intriguing mechanism of LDN is its antagonization of toll-like receptors (TLR) (Toljan, et al 2018). Specifically targeting TLR-4 receptors on microglia, the central nervous system's resident immune cells (Kučić et al., 2021). The activation of TLR-4 receptors is well-known as the initial step in many inflammatory marker cascades. This is why LDN, in some functional and integrative medicine circles, is deemed to be a "root cause" medication. Overactivation of TLR-4 receptors contributes to downstream chronic pain, brain fog, and fatigue. By dampening this response, LDN reduces inflammation. This unique dual action of promoting endorphin production and reducing inflammatory markers from the source positions LDN very uniquely, compared to traditional pain therapies that target downstream inflammation or pain control.

AN IMPORTANT NOTE: Unlike opioids or NSAIDS, LDN does not relieve pain immediately. Patients need to be in compliance with dosing for at least a few weeks to a few months for full effect. This wait may be extended if the patient is on a titration schedule to find the correct dose.

LDN in Chronic Pain Management

Since the mid-1980s, Naltrexone has been widely used for substance use disorders. At 50 mg and higher, its mechanism is to bind and block opioid receptors. Its effectiveness to this day keeps it a first choice for providers treating patients with opioid and alcohol addiction.

Several pieces of clinical evidence exist to support LDN's potential role in conditions such as fibromyalgia, complex regional pain syndrome, and some cancers. In a double-blind, placebo-controlled trial, Younger and Mackey (2009) found that fibromyalgia patients taking 4.5 mg of LDN nightly reported a 30% reduction in pain compared to those who took the placebo. Perhaps just as importantly, quality of life measures such as mood, sleep, and general satisfaction improved.

LDN's benefits appear particularly notable in central sensitization syndromes and conditions where the nervous system becomes hypersensitive to stimuli. Nurse life care planners frequently work with patients who are subject to polypharmacy and the dangers of opioid dependence. LDN should be considered for these patients as a well-tolerated alternative or in conjunction with conventional medications. It may not provide the immediate and nearly guaranteed pain relief of opioids, but it is a gentler and less risky option.

In care planning, LDN may reduce reliance on higher-risk medications, improve function, and potentially decrease costs related to long-term care due to unmanaged chronic pain. As a general rule of thumb, life care planners should monitor and document changes in pain levels, activity levels, and quality of life.

LDN in Autoimmune and Inflammatory Disorders

Due to its upstream TLR receptor antagonism, LDN shows immense promise in a large variety of autoimmune conditions. In multiple sclerosis, LDN has demonstrated

improvements in spasticity, fatigue, and overall quality of life (Sharafaddinzadeh et al., 2010)(Zogan et al., 2014). In a completely different system and autoimmune disorder, Crohn's disease, a small pilot study reported that 67% of patients achieved clinical response, along with a 33% remission rate (Smith et al., 2007).

The immune-modulating properties of LDN come from its ability to shift cytokine profiles away from pro-inflammatory markers such as interleukin-6 (IL-6) and tumor necrosis factor-alpha (TNF-**α**) (Younger et al., 2014). This anti-inflammatory effect makes it relevant in conditions such as lupus, Hashimoto's thyroiditis, and RA. While data remain limited at this time, anecdotal and observational evidence support its inclusion as a non-immunosuppressive intervention.

LDN presents life care planners and treatment teams with an opportunity to support symptom management in autoimmune diseases with the debilitating side effects associated with long-term corticosteroid or biologic use. Patient-reported outcomes, such as fatigue, joint pain, and gastrointestinal distress, may be positively impacted, enhancing quality of life. Regular reassessment is key to tailoring interventions to each patient's unique and evolving needs.

LDN and Long-COVID/Brain Fog

One of the most fascinating and emerging applications of LDN is in post-viral syndromes, specifically Long-COVID. Patients with Long-COVID typically present with persistent fatigue, cognitive impairment or "brain fog," joint pain, dysautonomia, and other reductions in quality of life. These are classic symptoms of chronic inflammation and autonomic nervous system disruption.

A recent publication in Brain, Behavior, & Immunity - Health noted that 74% of Long-COVID patients reported improvements in energy, pain, and mental clarity after initiating LDN (Isman et al., 2024). Although limited in scope, these findings further align with LDN's known effects on neuroinflammation and microglial activation.

Brain fog, a widespread and growing condition, may feel disabling and impair daily functioning. Life care planners may find LDN a valuable option worth discussing with providers in cases where cognitive dysfunction limits rehabilitation progress or return to work. Furthermore, LDN's potential to mitigate chronic fatigue and neuroinflammation may benefit individuals with other post-infectious syndromes.

Consideration for Nurse Life Care Planning

LDN's potential benefits, tolerability, ease of oral administration, and affordability make it a suitable option for long-term care plans. Most compounding pharmacies dispense LDN in a range from $30 to $60 per month. To get an accurate price, it's advised to contact your preferred compounding pharmacy. Keep in mind, however, that quality and service can vary just as much as price! There is no risk of addiction or withdrawal, and tolerability is not typically seen. There are typically no major side effects in studies, although vivid dreams and insomnia may occur in the first few weeks of therapy (Younger et al., 2014).

When should LDN be considered from a planning perspective? On one extreme, some providers in the functional/integrative space put nearly every patient on LDN as either therapy or a preventative, knowing that inflammation is the root cause of the majority of human diseases. If you are new to LDN, there are three areas to consider adding to treatment:

- When standard treatments have failed or caused intolerable side effects.
- In patients with central sensitization, autoimmune disease, or neuroinflammatory symptoms.
- As part of interdisciplinary approaches involving pain specialists, primary care, and rehabilitation teams.

LDN may also benefit patients with limited access to specialty care. Its oral administration (most often once daily) offers an easy option that supports symptom control while minimizing disruption to daily routines. Its inclusion in life care planning should be accompanied by regular follow-ups.

It is important to note that LDN is not FDA-approved for any of the indications listed. Since information can vary online, it is important to provide patients and providers with valid information and a trusted compounding pharmacy. If you are unsure about a compounding pharmacy to entrust, search for a PCAB-accredited pharmacy. These pharmacies go through a voluntary and rigorous inspection process to ensure that proper guidelines and quality control are met.

It is vital to notify patients that it may take several weeks to several months for the LDN to take full effect and that some side effects, like insomnia or vivid dreams, do dissipate. Although there are very few drug interactions, LDN is still an opioid receptor antagonist.

NOTE: Chronic opioid patients should not be initiated on LDN. Although there is anecdotal evidence and protocols to utilize Ultra Low Dose Naltrexone (ULDN) in these patients, that is a topic of its own.

Limitations and Future Directions

Due to its lack of patentability and the disinterest of pharmaceutical companies, LDN remains under-researched compared to traditional therapies. Most available studies are small, open-label, or pilot in nature. Larger, multi-center, randomized controlled trials are needed to fully validate its efficacy across the conditions listed.

However, with favorable safety and patient cost, LDN represents a low-risk intervention that may significantly improve the quality of life for several patients. Life care planners who maintain a holistic perspective and a patient advocacy role are well-positioned to raise awareness about LDN and facilitate its integration into care plans. Future directions include research into disease-specific dosing strategies, combination therapies, and identification of biomarkers that predict response to LDN.

Conclusion

LDN presents a promising alternative for managing pain, inflammation, and cognitive dysfunction in a range of chronic conditions. For life care planners, it offers a path of reducing reliance on high-risk medications while potentially enhancing patient function and autonomy. As research continues to evolve, LDN may emerge as a mainstay in life care planning strategies for chronic, inflammatory, and neuroimmune disorders. Its thoughtful inclusions in care plans, along with patient education, interdisciplinary collaboration, and ongoing monitoring, can foster empowerment, resilience, and improved outcomes.

REFERENCES

Dahlhamer, J., Lucas, J., Zelaya, C., Nahin, R., Mackey, S., DeBar, L., Kerns, R., Korff, M., Porter, L., and Helmick, C. (2018). "Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults - United States, 2016," *Morbidity and Mortality Weekly Report*, September 14, 67(36); 1001-1006. Retrieved on May 18, 2025, from https://www.cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm.

Isman, A., Nyguist, A., S:trecker, B., Harinath, G, Lee, V., Zhang, X., Sajad, and Zalzala, S. (2024). "Low-dose Naltrexone and NAD+ for the Treatment of Patients with Persistent Fatigue Symptoms after COVID-19," *Brain, Behavior, & Immunity* - Health, February 1, 3; 1007336. Retrieved on May 18, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC10862402/.

Kučić, N., Rački, V., Šverko, R., Vidović, T., Grahovac, I., and Mršić-Pelčić, J.(2021). "Immunometabolic Modulatory Role of Naltrexone in BV-2 Microglia Cells," *International Journal of Molecular Sciences*, 22(16):8429. Retrieved on June 2, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC8395119/#:~:text=Since%20TLR%2D4%20is%20usually,the%20present%20study%20as%20well.

Sharafaddinzadeh, N., Moghtaderi, A., Kashipazha, D., Majdinasab, N., and Shalbafan, B., (2010). "The Effect of Low-dose Naltrexone on Quality of Life of Patients with Multiple Sclerosis A Randomized Placebo-controlled Trial," *Multiple Sclerosis*, August 16(8): 964-969. Retrieved on May 18, 2025, from https://pubmed.ncbi.nlm.nih.gov/20534644/.

Smith, J., Stock, H., Bingaman, S., Mauger, D., Rogosnitzky, M., and Zagon, I., (2007). "Low-dose Naltrexone Therapy Improves Active Crohn's Disease," *The American Journal of Gastroenterology*, 102(4):820-828. Retrieved on June 2, 2025, from https://pubmed.ncbi.nlm.nih.gov/17222320/.

Toljan, K. and Vrooman, B. (2018). "Low-Dose Naltrexone (LDN) - Review of Therapeutic Utilization," *Medical Sciences*, 6(4):82. Retrieved from June 2, 2025, from https://pubmed.ncbi.nlm.nih.gov/30248938/

Younger, J. and Mackey, S. (2009). "Fibromyalgia Symptoms Are Reduced by Low-dose Naltrexone: A Pilot Study," *Pain Med.*, 10(4); 663-672. Retrieved on May 18, 2025, from https://pubmed.ncbi.nlm.nih.gov/19453963/.

Younger, J., Parkitny, L., and McLain, D. (2014). "The Use of Low-dose Naltrexone (LDN) as a Novel Anti-inflammatory Treatment for Chronic Pain," *Clinical Rheumatol*, 33(4); 451-459. Retrieved on May 18, 2025, from https://pubmed.ncbi.nlm.nih.gov/24526250/.

Zagon, I and McLaughlin, P. (2014). "Endogenous Opioids and the Treatment of Multiple Sclerosis," *Journal of Neurology & Neurophysiology*. Retrieved from June 2, 2025, from https://www.iomcworld.org/open-access/endogenous-opioids-and-the-treatment-of-multiple-sclerosis-45952.html.

IN THE FORENSIC WORLD OF PERSONAL INJURY

By Ilya E. Lerma, Esq.

Keywords: 1) Expert Witness 2) Common Errors 3) Preparation

In the forensic world of personal injury, compelling expert work begins in the pre-litigation phase. This phase involves a series of critical tasks, including gathering and reviewing medical records, investigating the incident, interviewing witnesses, consulting with experts, developing case theories, and attempting early resolution through negotiations. Expert witnesses play a crucial role throughout pre-litigation, and their work must align with the goals and evidence as they evolve.

Common Errors Early in the Litigation Process

Unfortunately, critical errors are often made in the early stages. By understanding errors in the core tasks of the pre-litigation phase, both attorneys and experts can work together to ensure expert work remains credible, defensible, and strategically aligned with the overall case goals. The following are some common errors directly tied to mishandling pre-litigation tasks:

1. Forming opinions on incomplete or outdated evidence.
2. Failing to proactively disclose prior challenges and disqualifications. In the life care setting, for example, consider the situation where the court determines a single opinion is not based on a recommendation by a qualified physician and the life care planner is not a physician. A court order may state that the opinion may not be offered as it is outside the scope of the life care planner's expertise. A skilled cross-examiner may come in possession of this order in a different case and ask, "Have you ever been disqualified or had opinions limited for any reason?" An expert may be focused on the more severe disqualification and not be considering the part of the question where the testimony is limited. Yet, an answer of "No" is incorrect. The examiner might then produce a copy of a ruling as impeachment and proof that they offered opinions outside the scope in another case. It may be that there is a good explanation and rehabilitation available, but severe damage is done. As far as the jury and opposing counsel are concerned, the expert gave an untruthful response under oath. Thus, the expert must have a handle on motion practice involving their opinions and copies of minute entry rulings or orders involving their opinions. This ensures they can respond truthfully and accurately and discuss any such matters with counsel to ensure those past matters will not threaten the viability of the present case down the road.
3. Lacking understanding between the standards used in each state for the admissibility of expert testimony. Federal courts and most states apply Daubert but many states apply Frye or a modified standard. While these standards are primarily legal matters, a skilled opposing lawyer will drill down on the factors of each test and exploit any areas where an expert does not articulate their methodology in

accordance with the required standard. The expert must have good familiarity with the standard of the state where they are offering testimony.

4. Putting too much in writing, too soon. Drafting detailed emails or reports prematurely or too casually can create discoverable records that may be used against them later in the litigation.

5. Failing to ensure current opinions are consistent with prior published work or prior testimony.

6. Failing to advise the attorney on areas of evidence preservation. The attorney may be unaware of the types of important evidence within the expert's knowledge. If this evidence is not identified and affirmatively requested early in litigation, it can be altered, destroyed, or lost—sometimes permanently—through routine business practices like technology upgrades and routine storage purges. For example, in home health care, the life care planner may detect that caregivers used a digital platform exchange (i.e., "Slack") or a hardcopy written log (i.e., shift "hand-off") notebook to relay notes and informal or logistical data to other staff. These items are rarely produced for the attorney in routine record requests because many facilities regard these as ancillary to treatment and more operational in nature. Detected early, the lawyer may be in a position to send letters to preserve this information and related metadata, in the case of digital information. This information may bolster the expert's opinion and may also shed light on other issues important to the success of the case.

7. Poorly documented assumptions, methodology, or foundation.

8. Extensive text or email exchanges with counsel can lead to impeachment. Even harmless content may appear biased due to its informal tone or casual familiarity with counsel.

9. Disregarding opposing evidence contradicts signals and abandonment of the scientific method. Selective use of evidence from only one side indicates bias and speculation.

Anticipating and Minimizing Errors

Many errors can be minimized or avoided entirely by engaging reputable lawyers with substantial litigation or trial experience. Lawyers who do not try cases or who litigate infrequently may lack the sophistication or foresight to anticipate problem areas in early-developed opinions. In contrast, lawyers with substantial trial experience are adept at anticipating oppositional attacks and can plan accordingly. They also understand that expert opinions must be integrated with the other experts, witnesses, evidence, and aligned with goals of the case. They also know that ambiguous communication on possible challenges or bias can lead to the case falling into serious jeopardy.

Experienced litigators will take particular care to protect their expert. They will never put the expert in a position endorsing a tenuous position or force them "out on a limb" where the opinions are overstated. In life-care planning, for example, experts may be asked to challenge calculations on future care, but they should not be asked to challenge the underlying medical foundation for the recommendations unless they possess the appropriate medical qualifications to do so. A life care planner's judgment is not a substitute for medically supported opinions. Similarly, individual assessments and tailored recommendations are far more reliable than average life-expectancy tables or generic care protocols. Counsel can insulate experts from attacks by ensuring that the expert is adhering to the acceptable practice standards and best practices of the industry.

A Collaborative Effort

Collaborating closely through pre-litigation all the way through trial, the lawyer and expert ensure that no evidentiary gaps exist. For example, traumatic brain injury or significant pediatric injury can be missed if not carefully monitored, particularly during transitions from acute to post-acute care. A life care plan may need to account for delays in obtaining treatment and services lost as a child transitions into adulthood. Other areas where gaps in the life care setting often occur may exist in failing to account for secondary complications, such as care of pressure ulcers, urinary tract infections, or respiratory complications associated with spine injury cases, or insufficient cost projections for progression of needs as the patient ages. Another big area is in mental health support services or counseling for chronic pain and traumatic brain injury clients. For example, clients who have suffered a TBI are at risk of a wide range of mental health issues, something that could be overlooked when addressing the many potential physical issues. If unaddressed, such gaps are rife with material for cross-examination.

In patients where the duration of care presents a changing landscape, regular and coordinated communication between attorneys, medical experts, and the life care planner is essential. Regular collaborative meetings ensure that new developments are reflected in the life care plan and that transitions in care are accurately mapped out and executed where possible. Life care planning experts should continually review and update their work as new evidence emerges.

Tips for the Best Pre-litigation Results

As an expert witness consultant and trial lawyer, here are the top 10 tips for achieving the best outcomes in pre-litigation expert services.

1. Ensure as much complete information and documentation as possible is provided. If it appears something is missing, follow up with the hiring lawyer and engage their assistance in obtaining complete documentation or information from the client.

2. Do not assume accuracy or completeness in records. Verify and corroborate important details and identify discrepancies or missing elements.

3. Never omit relevant medical history or prior injuries.

4. Use visuals and demonstratives to simplify data and bring a report to life. Use photos of assistive devices, embed links with exemplar surgeries, and include these within the body of the report. Consider attending therapy sessions and obtaining a video of the injured person working through their injuries. Take pictures during a home visit to show limitations of the present environment or workarounds that may present hazards if their condition deteriorates. A past client once provided all of her old pain pill bottles, which filled 4 banker boxes by the time of trial. The visual impact of the years of narcotics to control pain was excellent leverage at settlement negotiations. When reliably sourced, these demonstratives can present a powerful visual impact at various stages of the case and, when used creatively by the life-care planner, will garner significant appreciation from retaining counsel.

5. Investigate the injured person's online presence for information that may contradict or support their claims. The legal team typically handles this, but it's best to ensure that it has been done as part of litigation preparation.

6. Maintain open communication with the hiring attorney. Regularly update them on your findings and address concerns. Too often, experts shy away from reaching out because they assume the lawyer is too busy, so they try not to interrupt the lawyer's work. However, expert work is vital to the case's success and requires that assumptions be minimized. A good lawyer will prefer to have too much information over information and evidentiary gaps.

7. Consider asking to be connected to other experts involved in the case. While this is often labeled as collusive by the opposition, a skilled lawyer is unafraid of building a team that works together. This multidisciplinary approach not only strengthens your conclusions but also demonstrates to the court that your opinions are well-supported and thoroughly considered, ultimately increasing your effectiveness as an expert.

This is especially true in areas such as brain injury, where treatment is multi-disciplinary, and a collaborative approach often yields the best outcomes in forensic work. A good lawyer will facilitate these encounters as needed.

8. Be vocal about suggestions for the attorney. We rely upon experts in the field to assist in navigating very complex fields of science and medicine. Do not assume we know what you know. Suggest articles, journals, scopes of practice, or even other experts who may be helpful. If the attorney hasn't addressed an important area, don't assume it is deliberate. Attorneys can suffer from the occasional blind spot, and they will appreciate the insight an expert can bring to the table.

9. Anticipate the opposition and suggest how the lawyer might strategize to get ahead.

10. Ask for testimony support. Great lawyers support good experts through preparation and go beyond the basics. They teach strategies to deal with aggressive cross-examination and listening skills that are critical to ensuring their testimony is not manipulated by a lawyer on the opposing side. If a hiring lawyer fails to provide you with adequate preparation, consider requesting that they hire a consultant to assist you. In some jurisdictions, this may be considered a case cost, or you may choose to hire a consultant independently. Though this is a skill needed more during litigation, a hiring lawyer will feel more comfortable knowing that you have the skills to defend expert opinions should the case need to head into the litigation phase.

Applying these expert witness tips can directly enhance the credibility of your opinions and the overall strength of your case. Identifying and addressing discrepancies, such as conflicting dates in medical records, the expert can clarify these issues in their reports, demonstrating diligence and reducing opportunities for opposing counsel to undermine opinions. Similarly, maintaining open communication with the hiring attorney allows the expert to stay updated on new evidence or shifting case priorities. If the attorney receives new imaging studies or witness statements, prompt communication ensures the expert analysis remains current and comprehensive, and time to adjust opinions and avoid being blindsided during cross-examination. These practices not only enhance the persuasiveness of expert testimony but also contribute meaningfully to the case's overall strategy and likelihood of a favorable outcome.

LOOKING AHEAD

2025

Autumn: Orthotics

2026

Winter: Methodology and Standards

Spring: Elder Care

Summer: Technological Advances and Costing

aanlcp
American Association of Nurse Lifecare Planners

Index of Past Issues

all past issues from 2009-present area available as PDFs for free download at www.aanlcp.org

2016

XVI.1 Pain
XVI.2 GI Issues
XVI.3 International LCP
XVI.4 Home Care

2017

XVII.1 Brain Injury
XVII.2 The Business of Life Care Planning
XVII.3 Back and Spine
XVII.4 Mobility and Extemity Function

2018

XVIII.1 Costing and Coding

2019

XIX.1 Presidents Issue
XIX.2 Licensure I Qualifications I Certifications
XIX.3 New Directions in Pain Management
XIX.4 Technology Updates

2020

XX.1 Spinal Cord Injury Updates
XX.2 Advances in Amputation
XX.3 Evidence Based Practice
XX.4 Durable Medical Equipment and NLCP

2021

XXI.1 Therapeutic Modalities
XXI.2 The Business of NLCP
XXI.3 Ages and Stages in Life Care Planning

2022

XXII.1 Expert Witnessing and Testimony
XXII.2 Pain Management Revisited
XXII.3 Orthopedics, Pain, and Research

2023

XXIII.1 Pediatrics
XXIII.2 Business of Life Care Planning
XXIII.3 Mental Health
XXIII.4 Interacting with Other Disciplines

2024

XXIV.1 Assistive & Durable Medical Equipment
XXIV.2 Nervous and Spinal Injury Considerations
XXIV.3 Ethics
XXIV.4 Delegation of Care and Caregivers

2025

XXV.1 Foundations in Life Care Planning
XXV.2 New Directions in Homecare
XXV.3 Psychological Complications