Agenda

Working Interdisciplinary Network of Guardianship Stakeholders

August 20, 2014
12:00 to 2:00 p.m.

Administrative Office of the Courts
Scott M. Matheson Courthouse
450 South State Street
Judicial Council Room, Suite N31

Welcome and approval of minutes		Brent Johnson
Update on the Social Security Administration and WINGS conference calls	Tab 1	Mickie Douglas Mary Jane Ciccarello Karolina Abuzyarova
Feedback from Medicaid representatives on Dr. Foster's paper "Paying for the medical evaluation in guardianship proceeding"	Tab 2	Mary Jane Ciccarello Karolina Abuzyarova
Report from Education Subcomittee: "Planning Ahead: Guardianship Alternatives"; telenovela format		Mary Jane Ciccarello Kent Alderman
WINGS Facebook page: name of the page, information to be include in description		Karolina Abuzyarova

Committee webpage: www.utcourts.gov/howto/family/GC/wings

Tab 1

Social Security Administration and WINGS conference call update

We meet once a week to create an all-inclusive training package that SSA could provide the State WINGS members on representative payee topics. We'd like to have a draft of the training guide ready for our next WINGS call in September 2014.

Below is the master list of topics suggested for the WINGS Training Guide. If you are a subject matter expert (SME) in any of these areas (or work with someone in your area that is a SME), please annotate and send this list back to SSA, Attn: Kori Rabida, Project Manager for the Deputy Commissioner for Operations kori.rabida@ssa.gov, 410-965-7779.

Also, send any information on the topics below so we can discuss during our bi-weekly WINGS Training calls. Next meeting: August 21, 11am-12pm, and every two weeks on Thursday, until October 2, 2014.

Topics

- Disclosure
- Conserved Funds with Public Administrators
- Terminology of Conservator/Guardian/Executor
- Data Exchange between SSA/State
- Fee for Services
- Fraud/Misuse Reporting
- Oversight of Representative Payees/Organizational Payees
- Representative Payee Accounting
- Best Practices/Lessons Learned from SSA/State

Attendees

SSA		State	
Kori Rabida	Operations	Erica Wood	ABA Commission on Law and Aging
Maria Fernandez	Operations	Terry Hammond	Hammond Law & Associates
Hellen Savoy	Operations	Erica Costello	Indiana State Rep
Courtney White	Missouri SSA Rep	Becky Pryor	Indiana State Rep
Brandi Keeth	Oregon SSA Rep	Fred Steele	Oregon State Rep
Mickie Douglas	Utah SSA Rep	Karolina Abuzyarova	Utah State Rep
Rosanne Carey	Policy	Mary Jane Ciccarello	Utah State Rep
Kristina Cohn	General Counsel		

Tab 2

Paying for the Medical Evaluation in Guardianship Proceedings

Norman L. Foster, MD[1], Robert Denton, JD[2]; Kent Alderman, JD[3]; and Karolina Abuzyarova[4]

[1]Center for Alzheimer's Care, Imaging and Research, Division of Cognitive Neurology, Department of Neurology, University of Utah norman.foster@hsc.utah.edu (801) 587-7236

801-585-9983

[2]Managing Attorney Disability Law Center RDenton@disabilitylawcenter.org (801) 363-1347

[3]Attorney at Law, Lewis Hansen, LLC kalderman@lewishansen.com (801) 536-6715

[4]Program Coordinator Court Visitor Volunteer Program karolinaa@utcourts.gov (801) 578-3925

To be submitted to: *Utah Medical Association Bulletin*

Physicians are increasingly asked to provide medical evidence for court guardianship procedures, but this is an aspect of practice for which they are not trained and there is little guidance about what is needed. Another major barrier is uncertainty about who and how to bill for these activities. As a result, physicians often are not appropriately reimbursed for their medical evaluations relevant to this important aspect of their patient's care. Courts and lawyers for their part complain about the inadequacy of the information they are provided and find it difficulty to identify qualified physicians willing to provide the court evidence. In this paper we will describe how to perform a medical evidence examination and bill for these medical services.

Insurers reimburse medical services for their beneficiaries based upon whether they are deemed medically necessary. Insurers have specific procedures to determine what they consider medically necessary, but it remains subjective and open to interpretation. While some situations are so routine that there is little question of coverage, denials and their subsequent appeal procedures often hinges on disagreements about medical necessity in a specific individual or situation.

Insurers may not agree or provide consistent guidance about medical necessity, however intent of the interaction is critical. An insurance or disability examination is generally not considered medically necessary and payment is provided through the insurance company. A medical examination performed for purposes of a lawsuit, often in preparation of expert witness testimony, also is not considered medically necessary and payment is provided through either the plaintiff or defendant's lawyer. In these cases, medical necessity is not met, because they are optional on the part of the patient and not required for medical care. By contrast, medical examinations performed for court guardianship procedures are a necessary part of coordination of medical care. Successfully providing medical care outside a physician's office or hospital may require guardianship if the patient is unable to adequately participate in the care plan because of incompetency or physical limitations. Consequently, a physician providing continuing care can reasonably bill such an examination as an evaluation and management (E&M) service billed through CPT codes 99201-99245. When a guardianship proceeding is uncontested, it usually is sufficient for a doctor to briefly summarize findings from a recent medical examination in a letter as described along with a recommended template that can be used in Appendix 2. It is interesting to note that insurers recognize that preparing letters and completing reports are part of E&M services for care coordination and consider that payments for a visit includes these activities. By

contrast, if the guardianship is contested, the physician needs to collect much more information and offer a medical judgment and advice. Consequently, a separate visit is required to meet the needs of the court and this is the situation in which payment arises.

As physicians recognize, E&M billing can be based upon individual components or, when >50% of a visit is spent on counseling and care coordination, based upon time. Because components relevant to guardianship evidence don't map well to those for typical E&M services, it is usually more appropriate for the physician to bill for time and consider the information collected to be required for counseling and care coordination. In order for visit to provide medical evidence for guardianship to reasonably be considered an E&M service, the following characteristics should be fulfilled:

1) The visit should be an established patient for whom the physician is providing recommendations for continuing care. The visit can be with the patient's primary care physician, or a specialist consulted for medical care.
2) The documentation should accurately indicate the purpose of the visit, e.g. to provide medical evidence for guardianship as part of the patient's medical care plan, and the content should reflect this goal. This is described along with a recommended template in Appendix 3.

Origin and Verification of this Guidance

This guidance was developed by the Utah Working Interdisciplinary Network of Guardianship Stakeholders (WINGS) and has been reviewed and approved by insurers, including Utah Medicaid, and by representatives of the Utah legal profession and courts.

Appendix 1. The Utah Working Interdisciplinary Network of Guardianship Stakeholders (WINGS) – Origins and Motivation

Utah is experiencing the greatest increase in the number of people with Alzheimer's disease of any state[1]. The growing proportion of our population that is elderly and most subject to dementing diseases along with the increase in Utah's population and improvements in medical care that allows the prolonged survival of those with developmental disabilities and more frequent recovery of those with traumatic brain injury, have changed the complexion of guardianship. The added caseload is increasing the strain on our judiciary and causing a new level of sophistication in assessing medical evidence. Furthermore, these changes have exposed deficiencies and ambiguities in guardianship procedures that demand attention. The Utah State Plan for Alzheimer's Disease and Related Disorders passed by the State Legislature in February 2012 (S.J.R. 1) recognized the critical role and unmet challenges of guardianship. It identified the need to partner with a broad array of stakeholders to establish legal protections with the goal of assuring health and dignity for those with dementia and those at risk. Furthermore it called for training on guardianship as one strategy to attain the goal of a dementia-competent workforce.

With these motivations, the Utah State Courts organized a Working Interdisciplinary Network of Guardianship Stakeholders (WINGS), funded in part through a grant from the National Guardianship Network developed through the initiative of the Conference of Chief Justices and the Conference of State Court Administrators. The goal of WINGS is to provide leadership in adult guardianship reform. Although the principles of guardianship are universal, the relevant legal framework varies from state to state, requiring a review of guardianship issues focused on Utah. A working group was established to review the medical evidence of incapacity required for guardianship and to improve the collaboration between the medical and legal communities that is necessary to collect and review this evidence. The working group provides a mechanism to increase communication and discuss practice guidelines to improve cooperation and mutual understanding. This report summarizes the proceedings of this working group and the outcome of discussion of a larger community of stakeholders during the Utah Guardianship Summit held in Salt Lake City on November 6, 2013. Although we found the perspectives, motivations, and training of stakeholders differ, agreement was reached to improve the quality of evidence and facilitate clinical and judicial decision-making.

Appendix 2. Background about Guardianship

Guardianship is one of many methods available to help ensure that the needs of an individual with limited mental capacity are met. Advanced health directives, and durable powers of attorney are other legal options that do not require judicial intervention unless they are the subject of a dispute, but the instrument must be established during a time of mental competence. Usual convention requires two medical practitioners to indicate inability to make decisions to active an advanced health directive or durable power of attorney, but this is intentionally designed to require less rigorous evidence than a legal hearing for declaring incompetency or guardianship. By far the most common method used to provide the needs for a patient with limited consent are informal arrangements of family and friends. The law recognizes a hierarchical order of relatives who can make decisions for a person whose wishes have not been specified in a legal document. However, when incapacity becomes too great, the required judgments too significant, or the responsibilities ambiguous or contested, then judicial intervention is required to obtain guardianship and/or conservatorship. Other than possibly civil commitment, guardianship is the most drastic option. A court finding of incapacity and the appointment of a guardian result in the loss of freedom to direct one’s life and make basic choices. Because of the significant impact it can have on one’s life, it is crucial that competent, persuasive evidence is presented to the judge regarding the individual’s incapacity.

Guardianship can be temporary or permanent and can be limited or essentially unlimited depending upon the circumstances. While the least restrictive guardianship is preferred, the incapacity is most often static or progressive and incapacity is usually severe by the time of judicial intervention. Consequently, with the exception of psychiatric disorders, guardianship is usually permanent and limited only by required judicial oversight of the appointed guardian. Capacity is about decision-making. Many disorders can impair one’s cognitive and mental capacity to make decisions. Developmental disabilities are both life-long and permanent. Guardianship becomes an issue when the individual reaches majority and parents are no longer legally responsible for their offspring. Traumatic brain injuries and strokes usually cause a static level of incapacity. More challenging for both medical and judicial judgments are mental illness that has fluctuating incapacity and dementing diseases such as Alzheimer’s disease where incapacity is progressive. There are long-standing procedures for psychiatric commitment and judging social incapacity for mental illness. Less clear are the

circumstances for dementing diseases that are often complicated by medical co-morbidities and for which it is difficult to draw a clear line for incapacity in a gradual progressive illness. Furthermore, it is typical in dementing diseases to incapacity that differs for specific cognitive domains. For example, in Alzheimer's disease social skills are often preserved long after memory and understanding are severely deficit. In comparison, judgment and social skills are generally an early and prominent deficit in frontotemporal degeneration even while memory is preserved. These distinctions can be difficult for non-specialist medical practitioners and incomprehensible without detailed explanation for individuals without medical training. Medical evidence of incapacity may require different kinds of examinations and test results for each condition. Not only may different information be required, but different kinds of expertise and consequently different kinds of health care practitioner may be needed to provide conclusive medical evidence. The only way the mission of the judicial proceeding can be achieved is with an unusual degree of collaboration between the legal and health care systems. Ultimately, incapacity (incompetency) is a legal, not a medical determination.

Before a guardian can be appointed for an individual, a court must find that they are incapacitated. Incapacity is legally defined:

> *"Incapacitated" or "incapacity" is measured by functional limitations and means a judicial determination after proof by clear and convincing evidence that an adult's ability to do the following is impaired to the extent that the individual lacks the ability, even with appropriate technological assistance, to meet the essential requirements for financial protection or physical health, safety, or self-care: (a) receive and evaluate information; (b) make and communicate decisions; or (c) provide for necessities such as food, shelter, clothing, health care, or safety[2].*

Until 2013, a finding of incapacity required that the individual have a "mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause" for their inability to "make or communicate responsible decisions" [3]. Now there is no statutory requirement to prove a physical or mental cause for incapacity. The focus is solely upon the individual's functioning. However, evidence of a physical or mental basis for the alleged incapacitated person's functional limitations should be available to the judge, particularly if the issue of capacity is contested. Since incapacity must be proven by clear and convincing evidence, a judge may be less willing to make a find of incapacity when there is no identified cause for the

limited functional abilities. The strongest case of incapacity will include proof of a physical or mental impairment, functional limitations that arise specifically from those impairments, and that those functional limitations directly render the individual unable to receive and evaluate information, make and communicate decisions, or provide for necessities such as food, shelter and clothing.

The depth of medical evidence needed generally depends upon whether the issue of capacity is contested or uncontested. A minimal amount of evidence demonstrating incapacity must be in the petitioner's hand at the initial court hearing when the parties find out whether the matter is contested or not. In a contested case, the medical evaluation will need to be more detailed, setting forth the health care professional's testing process and observations which lead the their final conclusion. In either case, there should be sufficient evidence to demonstrate in what areas of life the individual needs a substitute decision-maker. The law prefers a limited guardianship. A petitioner must be able identify the specific needs the individual is not able to meet because of their limited capacity. Areas of decision-making authority could include medical, financial, residential and prevocational/habilitation among others. The medical and functional evidence should prove decision-making deficits in each of the areas the petitioner wants to be included in the guardianship. The more areas of decision-making authority the petitioner asks for, the more involved an evaluation of capacity should be.

The medical evidence subgroup at the Symposium identified three issues that are most critical and problematic in relation to the guardianship court process: (1) the minimum information necessary for the court to make a decision on the issue of capacity; (2) reimbursement for appropriate and high quality medical evidence and its transmittal to the court; and (3) identifying critical decision points and the resources available from when the need for a guardian is first identified through the conclusion of the court proceedings to appoint a guardian. This final issue is particularly important when an event or circumstances place the alleged incapacitated person at greater risk of harm.

Minimum Information Needed by the Court

There is a presumption among lawyers and judges that the medical profession can give definitive information on whether an individual is incapacitated as defined by the law. Medical professionals look to

attorneys to define for them what must be proven in court to find that an individual is incapacitated. This a more complicated relationship than one might assume. The medical professionals are not necessarily clear about the type of information that is most useful to the judge. They often do not know when this information is presented, what form it should take and who submits it. Attorneys representing the parties in guardianship proceedings often do not know which type of health care professional is the best source of medical information addressing the incapacity of the proposed ward and how the health care professional will be reimbursed for the cost of preparing the necessary information. There is nothing specific in the law about the type of information a health care professional should provide to the court.

At the symposium the health care professionals talked about various difficulties they have in writing an evaluation of an individual's decision-making capacity. They do not always understand the legal terminology involved in guardianship proceedings. There can be inconsistencies between the legal terminology and the medical terminology they use on a daily basis. On the other hand, attorneys representing the parties may not be as familiar with the medical terminology relevant to conditions that might render an individual incapacitated. The two professionals need to work together to make sure there is a clear understanding of the medical/legal relationships. This is particularly true when the health care professional has not treated the alleged incapacitated person, but is asked by the parties of the judge for an evaluation. Some guide for both in blending the medical and legal would be helpful. This could be done by a well crafted evaluation form or a set of guidelines for both attorneys and the health care professionals to use.

Often the alleged incapacitated person's condition is declining. This presents greater challenges to both attorneys and health care professionals evaluating the individual. Given the strong preference in the law for limited guardianship, the focus must be on what the alleged incapacitated person can currently do, or will likely be able to do in the near future. Trying to structure a guardianship to anticipate the inevitable decline while at the same time maintaining the individual's fundamental right to make decisions about important parts of their lives is tricky. Health care professionals can assist with this by projecting, to the extent possible, a timeline for the decline. This could be an important part of any evaluation of capacity. With this, changes to the guardianship can be a relatively simple matter. At the same time, prognosing this timeline cannot be speculative.

At least one health care professional was unclear on his role when conducting the evaluation. Are they supposed to be advocates for the alleged incapacitated person or provide an objective, neutral opinion? Even when the health care provider has not treated the alleged incapacitated person there may be a tendency to be supportive of the person, either as an advocate protecting their fundamental rights, or as a protector of their best interests. One way for the health care professional to meet their need to be an advocate would be for her to include in her evaluation a consideration of resources that could be available to the individual that would lessen the need for a guardian, or reduce the scope of the guardianship needed. A list of resources typically available to individuals with different types of mental impairments would help the evaluator in some cases.

One part of the discussion was surprising. The subgroup panelists assumed that there is a need not to burden health care providers by asking for too much information about the alleged incapacitated person's medical condition, and to avoid submitting too much information to judges. The responses of the health care professionals and judges at the symposium was unexpected – some of the health care providers feel that they cannot adequately address an individual's capacity in less than a ten to twelve page report. The judges felt that too much information is better than too little.

The court itself does not initiate guardianship procedures. The need of an individual for guardianship must formally be brought to its attention. The first critical decision point occurs when the need for guardianship is recognized. The general public is largely unaware of advanced health directives and durable powers of attorney and their value. Attempts to inform individuals and encourage their adoption at the time of hospitalization or nursing home admission have largely failed because institutions have not been willing to devote the necessary resources or time required for discussion and documentation. Likewise, perverse incentives mean that physicians often don't address advanced directives. Personal lawyers and financial advisors are perhaps most effective in completing such documents, but relatively few individuals utilize such resources and they may be expensive even though standard forms are widely available and legal advice may not be required.

Guardianship proceedings are usually initiated when a lawyer acting for a family member petitions the court. Unfortunately, even when families recognize the need for guardianship significant barriers exist. Even though family members can file a position themselves, they often do not understand how to obtain

guardianship, are intimidated by dealing with lawyers or the court or do not have the money to go through the process. It can be a long time between an incident indicating that a person is unable to make decisions and when a guardianship petition is granted.

In other situations, professionals may recognize the need for guardianship. A member of the community or health provider may initiate an investigation through adult protective services that uncovers the need for guardianship. Particularly when there a no engaged family members police officers or social agencies will identify individuals at risk, but they also face many barriers in seeking protection for a vulnerable adult. Representatives of law enforcement at the sessions described their frustration when they come upon a person in need of protection who clearly is not capable of making decisions necessary to keep themselves out of harm's way. Too often the individual does not have a guardian or even an identifiable relative, and there is no other alternative available to make sure that decisions can be made to meet the individual's needs. There only choices seem to be incarceration, transportation to an emergency room or not addressing the problem. Usually such individuals don't require acute medical or psychiatric hospitalization and are discharged back into the community with little change in condition or available supports. Such individuals become "frequent fliers" and drain resources from a variety of sources in a never-ending cycle of interventions. Sometimes, depending upon the individual's disability, it's difficult for safety officers to figure out where to bring people when they are in need of protection. What works for someone with a mental illness may not work if the cause is traumatic brain injury, developmental disability or dementing disease.

Guardianship is not always necessary to ensure that an individual's basic needs for food, shelter, clothing and medical care are met. There are alternatives that can be less expensive and allow the individual to retain greater freedom and independence. Advanced health care directives can identify a person to make medical decisions on behalf of the person who executes the directive if at some point they are unable to give informed consent to medical care. By a durable power of attorney, an individual can grant someone else the authority to make decisions and take various actions on their behalf in financial matters. The power of attorney can remain effective after the grantor no longer has the capacity to make informed choices on their own. Trusts are another vehicle through which an appointed person can take care of the financial affairs of another. Of course, none of these options are available when the individual has the type of mental impairment that has

prevented them from ever being competent, such as an intellectual disability. Likewise, an individual cannot name a health care advocate or durable power of attorney after becoming incapacitated. Consequently, advanced planning is required for this most effective option.

A court currently has the ability to grant an emergency temporary guardianship when circumstances warrant, or when a guardian is not performing their duties[5]. However, there is no definition of emergency. The judges attending the subgroup discussions did not feel constrained by the lack of a definition of "emergency." They did not think that the lack of a definition has lead to any abuse of the provision. Often situations arise when the alleged incapacitated person may be in need or greater support or intervention. The steps to take on their behalf may be short in duration. A temporary or time-limited guardianship may be sufficient to meet the individual's immediate critical need. At the same time, in the majority of these situations, the individual's incapacity will not be short lived. They will need a guardian long term. In these situations, the time-limited guardianship should be avoided.

The standards for civil commitment are different from guardianship. There must be a high degree of impairment before an individual can be committed. For an individual with mental illness, there must be a serious risk that the individual with mental illness will commit suicide, inflict serious bodily injury to himself or others or will suffer serious bodily injury because he or she is unable to meet their basic needs, such as food, clothing or shelter[6]. For an individual with an intellectual disability, he or she must pose an immediate danger of physical injury to self or others, lack the capacity to provide the basic necessities of life, such as food, clothing, or shelter, or be in immediate need of habilitation, rehabilitation, care, or treatment to minimize the effects of a condition which poses a threat of serious physical or psychological injury to the individual[7]. Commitment will not directly protect the individual's finances. It does not reach to all medical needs. For individuals with mental illness it reaches only one part of their overall medial need – mental health treatment. Commitment will last only as long as the risk remains. For people with mental illness, sometimes their condition is cyclical. For others, they may not pose the necessary risk while taking their medications. As a relatively short-term answer, commitment is little more than a mechanism for crisis management.

Participants in the Medical Evidence Conference Workgroup

Robert Denton Managing Attorney (Panelist) Disability Law Center

Kent Alderman Attorney at Law (Panelist, Reporter) Lewis Hansen, LLC

Karolina Abuzyarova Program Coordinator (Recorder) Court Visitor Volunteer Program

Norman Foster Director (Panelist) Director, Center for Alzheimer's Care, Imaging and Research, Department of Neurology, University of Utah

Lori Giovannoni Training Administrator (Facilitator) Division of Child and Family Services

Jackie Rendo Criminal Justice and Family Mentor National Alliance on Mental Illness

David Connors Judge Second District Court

Ron Bruno Crisis Intervention Teams Coordinator Salt Lake Police Department

Bill Heder Court Visitor/Elder law attorney Court Visitor Volunteer Program

Katy O'Banion Court Visitor/Psychologist Court Visitor Volunteer Program

Frederick Gottlieb, MD, Internist, Geriatric Specialist, Hospice & Palliative Care

Warren Walker Board Member Utah Healthcare Association

Kevin Duff Ph.D. Center for Alzheimer's Care, Imaging and Research, Department of Neurology, University of Utah

Martin Freimer Adjunct Assistant Professor Department of Psychiatry, University of Utah

Kimberley Price Medical Surgery Supervisor VA Salt Lake City Health Care System

Sally Hurme Project Advisor AARP, Education and Outreach

Kate Toomey Judge Third District Court

Citations

1. Hebert LE, Scherr PA, Bienias JL, Bennett DA, Evans DA. State-specific projections through 2025 of Alzheimer disease prevalence. Neurology 2004;62:1645.
2. Utah Code Annotated section 75-1-201(22)
3. Utah Code Annotated section 75-1-201(22) (amended Laws 2013, c. 364, section 11)
4. Utah Code Annotated section 75-5-304
5. Utah Code Annotated section 75-5-310
6. Utah Code Annotated sections 62A-15-602(14), 62A-15-631(10)(b)
7. Utah Code Annotated sections 62A-5-312(13)

Appendix 2: Template for a Letter Documenting Medical Evidence for a Legally Uncontested Guardianship Proceeding

INSTRUCTIONS: This template can be used to document medical evidence for court guardianship hearings **when the proceeding is uncontested**. The letter presumes that the opinion is based upon one or more recent evaluations performed in the context of providing medical care. Generally, practitioners are willing to provide such a letter for established patients at little or no charge. If the provider has not recently been involved in care, then a separate visit for a medical examination is necessary. Such a visit would be billed as usual to the patient and his or her medical insurance. For coordination of care, a copy of the letter should be entered into the patient's medical record and a copy sent to others involved in the patient's health care (care partners). Items listed in CAPS require entry and must be individualized. Implementing the template as part of an electronic medical record (EMR) allows posting of information to the letter from other parts of the EMR and can decrease the burden on the provider.

DATE

Re: PATIENT NAME, MEDICAL RECORD NUMBER

To Whom It May Concern:

I completed a comprehensive examination and evaluation for cognitive impairment on this patient at CLINIC NAME on DATE. The examination showed significantly diminished cognitive capacity with difficulty comprehending information and making logical judgments. Additional details are provided in the medical records. This disability is due to a progressive neurological condition and recovery is not expected.

Based upon these observations, I believe this individual is unable to manage daily affairs, including financial decisions. It is appropriate to activate an existing durable power of attorney or to seek guardianship. The details of my medical evaluation supporting these opinions are available in my other records about this patient.

Sincerely,

PROVIDER SIGNATURE AND CONTACT INFORMATION

CC: CARE PARTNERS AND THEIR CONTACT INFORMATION

Appendix 3: Template for a Medical Visit Documenting Medical Evidence for a Legally Contested Guardianship Proceeding

---

INSTRUCTIONS: This template is used to document a medical visit and the examiner's opinion for court guardianship hearings **when there is a contested proceeding**. In a contested proceeding the court requires more detailed evidence specific to legal judgments. Since the needed information is usually obtained during typical medical visits and it must be current, information solely from a prior medical visit is inadequate. If properly completed this template will significantly reduce the likelihood that in person testimony will be necessary.

The purpose of a visit to evaluate for guardianship differs in content from a typical medical visit for diagnosis and treatment. Nevertheless, it is still considered medically necessary since a medical opinion is required and must be documented in the medical record. If the patient's diagnosis and management have not already been established, a separate medical visit for this purpose should be arranged ahead of time; this information will be needed for the guardianship evaluation visit. The requirements of a visit to evaluate for guardianship are to review the patient's history (from multiple sources whenever possible), assess how cognition affects functional abilities and judgment in daily life, and review of medical examination and data to aid the court in its determinations. The medical information included in the note would vary based upon the specialty and training of the provider and the patient's medical or psychiatric condition. For example, if physical disability in addition to mental disability was significant, further details about endurance, strength and work capacity might be necessary to provide the court with a full understanding of the patient's limitations.

This template should meet the reimbursement requirements for an established patient visit when billed based upon time with >50% devoted to counseling and care coordination. The visit can be billed as usual to the patient and his or her medical insurance. The patient must be present to bill insurance. Requirements for reimbursement may differ based upon insurer and should be investigated ahead of time to minimize out-of-pocket charges and assure payment to the provider. For coordination of care, a copy of this note should be sent to others involved in the patient's health care (care partners). Implementing the template in an electronic medical record (EMR) allows posting of information to the note from other parts of the EMR, allows drop-down option entries and substantially decreases the burden on the provider.

If the visit is initiated by court appointment:

The letter should be sent to the District Court as indicated on the order. In this case a release of information from the patient is not needed, but the court order should be entered into the medical record. If the patient fails to appear for an appointment, then contact the attorney or judge.

If the patient, a family member (the petitioner) or the petitioner's representative initiated the visit:

The letter also should be sent to the patient. In this case if someone else needs to receive a copy of the report and that person is not involved in providing care, a written release of information is required and should be entered into the medical record.

Items listed in CAPS require entry and must be individualized. Alternative options are separated by "/"; choice only one.

Patient: PATIENT NAME

MRN: MEDICAL RECORD NUMBER

Date of Visit: DATE OF VISIT

Age: PATIENT'S AGE

Handedness: PATIENT'S HANDEDNESS

Judge NAME

DISTRICT COURT #

COURT ADDRESS

Dear Judge NAME,

PATIENT NAME is a AGE-year-old MAN OR WOMAN who presents in clinic today for CHIEF COMPLAINT.

Medical Qualifications of Examiner: I am qualified to perform this assessment because I am currently licensed to practice medicine in the State of Utah (License #, expiration date), I am board certified in SPECIALTY, and I have over X years experience in clinical practice.

Purpose of Visit: Evaluation for conservatorship and/or guardianship.

Encounter Diagnoses: LIST MEDICAL DIAGNOSES

Duration of Visit: NUMBER minutes, more than 50% spent in counseling and care coordination.

Source: The patient was accompanied by NAMES OF THOSE WHO ACCOMPANIED THE PATIENT TO THE VISIT. The history was obtained from all present.

Issues Relevant to Definition of Incapacity:

1. Does this patient have clinically significant cognitive impairment? YES / NO

2. What is the cause(s) of this impairment? (if dementia is present, what is the cause of the dementia?) DESCRIBE

3. What is the expected course of this impairment? TEMPORARY / REVERSIBLE / STABLE / PROGRESSIVE

4. Does the patient lack the ability, even with appropriate technological assistance to provide for necessities such as food, shelter, clothing, health care, or safety? YES / NO

5. If yes to item 4, which of the abilities are lacking? NOT APPLICABLE / DESCRIBE

6. Is the patient able to receive and evaluate information? YES / NO

7. Can the patient make and communicate decisions? YES / NO

8. Can the patient manage medications independently? YES / NO

9. To provide the court more information I recommend:

    a. A home visit by a social worker: YES / NO

b. Neuropsychological testing: YES / NO

c. A psychiatric evaluation: YES / NO

d. Other: NONE / DESCRIBE

Additional Information: The details of my medical evaluation supporting these opinions are available in my other records about this patient. These records include the patient's history and findings on examinations and my medical, financial, and environmental management recommendations. Further recommendations not otherwise available in the existing medical record are: DESCRIBE

Sincerely,

PROVIDER NAME AND CONTACT INFORMATION

CC: CARE PARTNERS AND THEIR CONTACT INFORMATION