Maintenance Therapy

EVIDENCE-BASED APPROACHES TO DOCUMENTATION TO ENSURE PAYMENT

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Bio

- BS in PT June, 1991, from NU, Boston, MA
- MDiv (Masters of Divinity- pastoral degree) from Southern Seminary, Louisville, KY
- APTA Board Certification for Geriatric Clinical Specialist (GCS)
- Multi-site clinical management and DOR experience
- Clinical and Compliance Specialist
- Home Health therapist
- Course presenter for multiple geriatric related courses
- Married with 6 biological and 6 adopted children (from Ukraine)

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Disclaimer

- Medicare reviewers are people, too – they make mistakes with regulations and application of the *Jimmo v. Sebelius* ruling.
- No amount of good documentation can guarantee prevention of denials.
- Medicare auditors are generally nurses, and as such may miss elements of medical necessity in reviewing a therapist's documentation.
- While the presenter is well-experienced in preventing denials, the audience should review the teaching today, Medicare regulations, and their individual patient needs to determine whether the *Jimmo* case decision applies.

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Objectives

By the end of this seminar, the attendee will understand:

- How maintenance therapy came to be.
- What maintenance therapy means.
- How to prove medical necessity for any patient.
- How to specifically apply medical necessity to maintenance therapy patients.
- Medicare's minimal documentation requirements.
- Helpful tips in documentation to support maintenance therapy.

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Where do we begin?

- There are no changes (from restorative therapy to maintenance therapy) related to the normal coverage criteria for part A or part B.
- There are no fancy tricks to documentation that demonstrates medical necessity of maintenance therapy vs. restorative therapy .
- *All the same principles* of documentation that prove medical necessity in restorative therapy also prove medical necessity of maintenance therapy.

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There are NO changes to the Jimmo decision because of new payment models…

- "Nothing in this Settlement Agreement (Jimmo agreement) modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."
  - CMS Transmittal 179, January 2014
- Medicare has made it clear that new payment models are not expected to impact the *Jimmo* decision.
  - "Final Rule" 83 Fed. Reg. 39162, 39187

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Standards of Coverage "Bibles"

For standards of coverage criteria, refer to the following chapters in the "Medicare Benefit Policy Manual" on CMS.gov:

Home Health – chapter 7

SNF – chapter 8

Outpatient – chapter 15

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Most regulations are the same for Restorative and Maintenance Therapy, ***Except***…

"The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy…"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

However…

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New Ruling in Effect 1/1/2020

- PTAs/COTAs will be allowed to perform maintenance in home health setting.
  - https://www.federalregister.gov/documents/2019/07/18/2019-14913/medicare-and-medicaid-programs-cy-2020-home-health-prospective-payment-system-rate-update-home

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Restorative/Rehabilitative vs. Habilitative vs. Maintenance Therapy

- **Restorative/Rehabilitative** - Goals and treatment are geared towards
  - ***Improving*** the patient's underlying impairments,
  - Helping the patient get better with function by teaching them to ***compensate*** for impairments, or
  - ***Training others*** (non-therapists) to address the patient's functional deficits so that you may ***transition the patient off*** expensive ***therapy services***.
- **Habilitative** – Patient instructed in functions which he/she never had the capability of performing previously (most likely approach for peds patients)
- **Maintenance** – Goals and treatment are geared towards
  - ***Maintaining*** or ***slowing/preventing*** deterioration of the patient

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Ethics of Performing "Maintenance Therapy"

- APTA Ethics Standards – Principles of Ethical Conduct
  - "2A. **Physical therapists** shall adhere to the core values of the profession and **shall act in the best interests of patients/clients over the interests of the physical therapist**." (insert phrase "…over interests of the healthcare organization.")
  - "8C. **Physical therapists** shall be responsible stewards of health care resources and **shall avoid overutilization or underutilization** of physical therapy services."
- Neglect
  - Oxford Dictionary (legal definition):
    "Breach of a duty of care which results in damage."
- A lot of debate exists about whether healthcare is a "right."

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Let's assume Healthcare is a right… since it is treated as such and implied by the *Jimmo* decision.

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Background

- 2011 – Glenda Jimmo and several other plaintiffs sue HHS
- Suit alleged that Medicare following a policy of paying on an "improvement standard"
- 2012 - U. S. District Court for the District of Vermont agrees to settle case
- January 24, 2013 court rules in favor of Jimmo

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What did the Jimmo Decision force Medicare to acknowledge?

- "Medicare has long recognized that there may be situations in the ***SNF, home health, and outpatient therapy*** settings where, even though no improvement is expected, skilled nursing and/or therapy services *to prevent or slow a decline in condition are necessary because of the* ***particular patient's special medical complications*** *or the* ***complexity of the needed services***."
- "…such ***coverage depends*** not on the beneficiary's restoration potential, but ***on whether skilled care is required***, along with the underlying reasonableness and necessity of the services themselves."

https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf

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Setting of Coverage

- SNF
- Home Health
- Outpatient (this would include part B coverage in a LTC setting, HH, or an outpatient clinic)
- Medicare ***does not cover skilled maintenance therapy*** in a Comprehensive Outpatient Rehabilitation Facility (***CORF***):
  - "…because the statute [conditions of participation for CORF settings] specifies that CORF services are ***rehabilitative***." (emphasis mine)
    - Medicare Benefit Policy Manual Chapter 15, section 220.2

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What was supposed to happen as a result of the decision?

- Education of the following groups was mandated by the federal court:
  - Beneficiaries (patients)
  - Providers (therapists, etc.)
  - Auditors (reviewers of the claim)
- "Revise the Medicare Benefit Policy Manual ***to eliminate any suggestion*** that a beneficiary must show a potential for improvement, and to confirm that a need for skilled care is the determinative factor, regardless of whether the skilled care is needed to improve or maintain the individual's condition."
  - https://www.medicareadvocacy.org/march-2016-back-to-court-in-jimmo-litigation-update-other-issues-2/

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Legal Rights to "Maintenance" Therapy

- OBRA 1987 – "Long term care facilities wanting Medicare or Medicaid funding are to provide services so that each resident can "attain and maintain her highest practicable physical, mental, and psychosocial well-being."
  - https://www.ncmust.com/doclib/OBRA87summary.pdf
- ACA 2010 – "…end lifetime limits on the care consumers may receive."
  - Patient Bill of Rights – CMS
- Jimmo case – helped establish the coverage of services for maintaining patients in SNF, HH, and outpatient

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Medicare found wanting in its education efforts

- "On March 1, 2016, the Center (for Medicare Advocacy) and it co-counsel, Vermont Legal Aid, filed a Motion for Resolution of Non-Compliance with the Settlement Agreement. The filing comes after three years of urging the Centers for Medicare & Medicaid Services (CMS) to fulfill its obligation to end continued application of an 'Improvement Standard' by Medicare providers, contractors and adjudicators to deny Medicare coverage for skilled maintenance nursing and therapy."
  - https://www.medicareadvocacy.org/march-2016-back-to-court-in-jimmo-litigation-update-other-issues-2/

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Proving necessity of "maintenance therapy"= Documentation

- "While the presence of appropriate documentation is not, in and of itself, an element of the definition of a 'skilled' service, such *documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case*."
  - https://www.cms.gov/center/special-topic/jimmo-settlement/faqs.html

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What your documentation needs to prove

"In the case of maintenance therapy, the ***skills of a therapist*** are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the ***services cannot be safely and effectively carried out by the beneficiary personally***, ***or*** ***with the assistance of non-therapists, including unskilled caregivers***."

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf

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So the reverse is true…

- ***If*** what you are doing can be safely and effectively performed by
  - The patient or
  - Another person who is not a therapist,
- ***Then*** it cannot qualify as maintenance therapy.
- ***Also,***
  - Just because someone lacks a non-skilled caregiver to assist them in a task/intervention that *could* maintain them, it does not mean the task/intervention is skilled because only a therapist is available.

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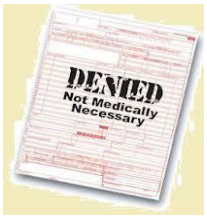
Proving Maintenance Therapy is Needed



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Skilled Necessity= "reasonable and necessary"

- **Reasonable**-
  - Weighing costs with benefits, care is generally predictable in duration and intensity, based upon best clinical practice and research. http://www.nejm.org/doi/full/10.1056/NEJMp1208386
- Outcome-based payment models attempt to determine the most ***reasonable*** payments by diagnostic groups and some other personal factors.

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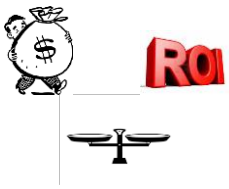
Reasonable Care = cost/benefit balance



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Necessary Care

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Necessary – defined by Medicare

"The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent **complexity** of the service is such that it can be performed **safely** and/or **effectively** only by or under the general supervision of a skilled therapist. "

- General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy, CMS

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What Complexity/Safely/Effectively Mean

- ***Complexity-***
  - Of the **patient**- co-morbidities, acuity, personal factors
  - Of the **evaluation** and **plan**
  - Of the **interventions**- proven by assessments, analysis, clinical judgment
  - Of the **clinical presentation** of the patient
    - Stable – (likely) not demonstrating a necessity of maintenance therapy, although Medicare denies this. (see next slide)
    - Evolving – think ongoing adjustments needed to care for
    - Unstable – think unpredictable, perhaps each visit, perhaps making it ***potentially dangerous*** to have a non-skilled person working with the patient.

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Clinical Presentation of the Patient - Stable

"A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. *Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is* ***stable****."*

- *https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r179bp.pdf*

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Clinical Presentation

in that category. The PT must determine whether the patient's condition or "Factors that ***may be*** considered in determining the clinical presentation ***might include***, but are ***not limited to***, vital sign response; continuous, intermittent, or changing levels of pain; and varying levels of awareness or cognitive performance."

"There is no 'definition' of an unstable clinical presentation, nor a list of conditions that would put a patient characteristics are stable, evolving, or unstable."

- http://www.apta.org/EvalCodes/FAQ/ClinicalDecisionMaking/#constitutes

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Clinical Presentation - continued

"The ***patient's clinical condition*** requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a ***maintenance program***, related to the patient's illness or injury, in order to ensure the ***safety*** of the patient and the ***effectiveness*** of the program…"

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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Safety – a determining factor of medical necessity of therapy

- Some things we do are potentially dangerous if administered by non-skilled personnel.
- Some interventions are never considered safe for non-therapists to administer (US or SWD)
- Medicare has examples about safety examples for maintenance care:
  - ROM – if the patient has significant complications related to risk of pathological bone fractures, then even PROM may be covered.
  - A patient has an unstable fracture – the knowledge of things such as the anatomy and kinesiology would potentially prevent the safe performance of the service by a non-skilled person.
  - Patient with Parkinson's and RA – the initial training of a program, and periodic adjustment by a therapist to maintain a patient might be necessary due to the evolving characteristics or lack of stability of the patient.

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Effectiveness – determines medical necessity

- ***Effectively- Evidence-based (EBP)- ties into word "reasonable" as well***
  - Researchers
  - 3rd party payers
    - Medicare – LCDs and definitions of CPT codes are evidence-based approaches for interventions.
  - You – this is the absolute most valuable proof of medical necessity (and effectiveness more specifically)

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When would maintenance not be covered?

- When the patient just won't work with a non-therapist
- When a caregiver is just not available
- Because nursing is short staffed
- ***Routine*** maintenance exercises and ***repetitive*** practice
- When goals are ***retroactively*** changed to maintenance goals instead of restoration goals

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Diagnosis codes – what they say about complexity

- "…a patient's diagnosis or prognosis *should never be* the sole factor in deciding that a service is or is not skilled."
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- However, code to the highest levels of
  - Specificity
  - Complexity

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Showing complexity through measures

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Standardized Tests/Assessments

- "Standardized"
  - Evidence-Based
  - Psychometric parameters (examples)
    - Test-retest reliability
    - Minimal Detectable Change (MDC)
    - Construct Validity
    - Age Normative Data
    - Etc…
- ***Best*** **way to track baselines, ensure maintenance and prove effectiveness** ***(reasonableness)*** **of treatment**

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Standardized Tests - continued

- Must provide ***interpretation*** of the data
  - What does score mean?
  - Why is my therapist's brain needed to make sense of this ***and*** address this?
  - Examples –
    - patient does the TUG in 22 seconds – means high fall risk, but what else does it mean?
    - Patient scores a 55/100 on the Barthel, which indicates moderate impairment, but what is behind the measure?
    - Patient scores a 142/200 on the MASA, indicating moderate dysphagia, but can you break that down?
- "John Adamson, The Rehab and Documentation Guru" YouTube channel – some tests with information concerning interpretation

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https://www.sralab.org/rehabilitation-measures

- Shirley Ryan Ability Lab
  - Over 400 standardized tests
  - Many tests for all functional areas that PT/OT/ST address
  - Many tests are free
  - The psychometrics are provided

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The Problems with Medicare's Reporting Tools

- Functional Limitation Reporting (G codes)
  - Wasn't sensitive enough to capture the value-basis of therapy intervention
  - Therapists compliance with g coding diminished drastically as the episode of care progressed
  - Therapists were not accurately capturing data consistent with g coding
    - Diane U. Jette, Mary Stilphen, Vinoth K. Ranganathan, Alan M. Jette, Are CMS G-Code Functional Limitation Severity Modifiers Responsive to Change Across an Episode of Outpatient Rehabilitation?, Physical Therapy, Volume 95, Issue 12, 1 December 2015, Pages 1650–1659, https://doi.org/10.2522/ptj.20150003

- Section GG
  - Requires interdisciplinary approach to coding, but often nursing simply abdicating to therapy, which may cause errors in coding.
    - https://www.aanac.org/Information/Section-GG/post/no-1-sign-of-gg-dysfunction-therapy-runs-the-show-alone/2019-02-20

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Other Measures

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Functional Deficits

- measurable (min assist, % disability,etc.)
- *Generally* observable by all people.
- Addressed possibly by > one discipline
- **3rd party payers expect functional decline to be treated**
- Compare PLOF to CLOF
- **Answers "WHAT" is going on?**

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Underlying Impairments

- Measurable (e.g.-special standardized tests, ROM, strength, balance, coordination, cardio-pulmonary measures, effusion/ edema, joint play, etc.)
- Not measurable by all people **safely** and **effectively** because of the **complexity**.
- Could be addressed by >1 discipline, but needing skill.
- ***Cause the functional deficit, prove (in part) the need for skilled services, form the basis for goals and analysis, and demonstrate the need for (most) chosen interventions (CPTs)***.
- **Answer "WHY" is this going on?**

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Documenting Goals

- *SMART…*
  - Specific- area of function- be specific- allows for determination of
  - Measurable- if it is not measurable, you cannot address
  - Attainable- is it something we can achieve- ties into prognosis
  - Relevant- does it have bearing on patient rights? PLOF? Our scope of practice?
  - Time-constrained- There is a end in sight- may not impact "maintenance therapy" *per se*

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Medicare says… *Maintenance* Therapy necessitates *Maintenance* Goals!

- **M**aintain Impairments- the goal is simply maintenance of function (assuming skills of therapist are necessary to maintain)
  - "Patient will ***maintain*** -70 degrees knee extension bilaterally **(UI)** to prevent posterior pelvic tilting in wheelchair, to allow sitting 2 hours without repositioning for meals and activities **(FD)** by (DATE)."
  - "…the documentation must establish that the patient needs the unique skills of a therapist to ***maintain***, prevent or slow further deterioration of functional status." CMS

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Analysis

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The Blueprint for a Solid *Maintenance* Analysis

1) Comparison of remaining ***functional deficits*** and ***underlying impairments***
2) Discussion of positive ***impact*** outside of therapy (patient/caregiver reports)
3) Related to number 3- any new underlying impairments? Show impact.
4) Necessity of ongoing therapy –
   a) Why would it be neither ***safe*** nor ***effective*** to discharge the patient at present?
   b) Why is continued therapy reasonable and necessary?
   c) Why could a non-skilled person not continue treatment and achieve maintenance?
   d) What are barriers to discharge? **(think complexities/diagnoses/underlying impairments)**

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Skilled Analysis- starter phrase for progress

"Patient has ***maintained*** (ENTER functional area) due to skilled interventions impacting (ENTER underlying impairments). Patient/caregiver has noted (ENTER) benefit as a result of therapy. Analysis reveals (ENTER specific) clinical characteristics which demonstrate an (ENTER evolving or unstable) clinical presentation, necessitating re-assessment of clinical approach each visit. D/C at this time and/or transition off skilled services is neither safe nor effective due to (ENTER the rationale for non-skilled persons being unable to address patient's needs)."

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Analysis statement = *Parable*

An easy to follow story, but with a ***deeper*** meaning that a non-therapist ***could not*** have come up with on their own…

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Analysis words to avoid

- "Patient is ***stable*** in clinical presentation."
  - It's generally not the medical clinical presentation that a therapist is worried about, ***but*** may be.
- "Patient tolerated treatment well…"
- "Patient is ***not compliant***…"

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Skilled Interventions

Charges entered by therapist as CPTs CPT-Current Procedural Terminology (CPT) is a code set that is used to report medical procedures and services to entities such as physicians, health insurance companies and accreditation organizations. (http://searchhealthit.techtarget.com/definition/Current-Procedural-Terminology-CPT)

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What skilled intervention means…

It is not a description of the activity ***by itself*** (though this may be part of it):

- "Patient performed 3 sets of 10 reps shoulder flexion with 3# weighted dowel."
- "Performed OME with min cues."
- "Educated in use of long-handled ____..."

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What skilled interventions should look like…

- CPT Code:
- Action Verb:
- ***Target*** of the action:
- "Special" Techniques:
- ***Functional*** Reason to address code:
- Response to care:
- ***Adjustments over time of treatment***:

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Examples of skilled statements

"NMRE/***97112***: ***Therapist inhibited*** increase in ***tone of hamstrings*** with ***manual pressure*** to the ***biceps femoris*** and ***semitendinosis*** insertions, ***utilizing contract/relax*** of ***hamstrings*** and ***varying*** static stretch to prevent increase in tone ***due to*** limited knee extinction ROM causing posterior pelvic tilting in wheelchair. ***Adjustments*** to techniques for effectiveness included _____, due to ***erratic*** nature of patient's increased tone."

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Adjustments to Care- more specifically

- Should reflect…
  - Analysis of change in functional status/lack of change
  - Past success/failure of interventions delivered to date
  - Patient's medical status at time of assessment
  - Any additional underlying impairments
  - Complexity of the patient at time of assessment for adjustment
- Think GOALS (yes, even maintenance patients need adjustment to goals and TREATMENT APPROACH

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Example of Adjustment to care approach for the Maintenance Patient

- Altering frequency- ***lowest possible*** to maintain
- Altering Intensity- ***lowest possible*** to maintain
- Changing Interventions- if they stay the same, a non-skilled person could eventually likely perform
- ***Constant*** justifications to demonstrate non-skilled person ***could not*** be trained in maintenance

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Medicare Examples for Maintenance Therapy: (Medicare Benefit Policy Manual, Chapter 15)

Example 1:

"A patient with Parkinson's disease is ***nearing the end*** of a ***rehabilitative*** physical therapy program and requires the services of a therapist during the ***last week(s) of treatment*** to ***determine*** what type of exercises will contribute the most ***to maintain function or to prevent or slow further deterioration*** of the patient's present functional level following the cessation of treatment. In such situations, the ***establishment*** of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the ***instruction*** of the patient or family members in carrying out the program, and such ***reassessments*** and/or reevaluations as may be required ***may constitute covered therapy*** because of the need for the skills of a qualified therapist."

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Example 2

"A patient with ***multiple sclerosis*** needs a ***maintenance*** program to slow or prevent deterioration in communication ability caused by the medical condition. Therapy services from a qualified speech-language pathologist ***may be covered to establish a maintenance program*** even though the patient's current medical condition does not yet justify the need for individual skilled therapy sessions. ***Evaluation, establishment*** of the program, and ***training*** the family or support personnel may require the skills of a therapist and would be covered. **NOTE:** In this example, the skills of a therapist are not required to actually carry out the maintenance program services and, as a result, are not covered,"

What would cover this would make this maintenance therapy is an MS patient of such complex clinical presentation that a therapist would need to be involved the safely and effectively adjust/modify the program to prevent decline or slow deterioration.

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Example 3

"Where there is an unhealed, ***unstable*** fracture that requires regular exercise to maintain function until the fracture heals, the skills of a therapist may be needed to ensure that the fractured extremity is ***maintained*** in ***proper position and alignment*** during ***range of motion exercises***. In this case, since the skills of a therapist may be required to ***safely*** carry out the maintenance program given this particular patient's special medical complications, therapy services would be covered."

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Example 4

"A patient with a ***long history*** of Multiple Sclerosis has difficulties transferring in and out of the wheelchair and ***maintaining*** range of motion (ROM) of the lower extremities (LEs) due to ***increased spasticity*** muscle tone since the most recent exacerbation episode of her Multiple Sclerosis. The beneficiary is unable to walk but is independent with the use of her wheelchair. The beneficiary needs to be able to ***safely*** transfer in and out of her wheelchair by herself or with the assistance of a family member or other caregiver(s). After an individualized assessment by the physical therapist, and given the patient's overall medical and physical condition, the skills of the physical therapist are required to instruct the patient and/or caregivers in proper techniques of wheelchair transfers and LE stretches due to the special medical complications from the progression of Multiple Sclerosis. ***When*** the physical therapist determines that the patient can carry out the transfers and stretching activities safely and effectively, either alone or with the assistance of the caregivers, the skills of the physical therapist are no longer necessary to furnish the maintenance therapy; and, the patient is discharged from PT."

Can you think how this patient may require ongoing therapy under the maintenance provision without discharge?

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Example 5

"A patient who has a ***progressive*** degenerative disease is performing the activities in a maintenance program established by a therapist with the assistance of family members. The program needs to be re-evaluated to determine whether assistive equipment is needed and to establish a new or revised maintenance program to maintain function or to prevent or slow further deterioration. ***Intermittent*** re-evaluation of the maintenance program would generally be covered as this is a service that requires the skills of a therapist. Should the therapist conducting the re-evaluation determine that the program needs to be revised, these services would generally be covered."

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Notice a common theme in Medicare's examples? What are they saying?

- They generally do not expect therapy to continue ***ad infinitum*** for maintenance patients.
- Their scenarios assume the presence of a willing, available, and capable patient/caregiver.
- In the event that a patient does not have a willing/available/capable caregiver, and is unable to assume responsibility for a maintenance program, there is not really guidance for whether maintenance therapy is a covered service.

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In Summary…

- Maintenance Therapy is a legitimate and covered patient approach.
- Regardless of the changes ahead as a result of the ACA, maintenance therapy is still covered.
- It is an ethical responsibility to provide maintenance therapy if our agency has therapists to cover maintenance cases and has the necessary services.
- If it is not going to be safe and effective for a non-licensed person to work with the patient to maintain the patient's level of function at time of discharge, then we must assess for maintenance therapy needs.
- No changes to the conditions of participation with Medicare occur in a maintenance therapy claim.
- Solid documentation is the key to getting paid for maintenance therapy.

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Thank you!

For follow-up:

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"The Rehab Documentation Guru" YouTube channel

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