Maintenance Therapy

When and How to Integrate into Your Agency

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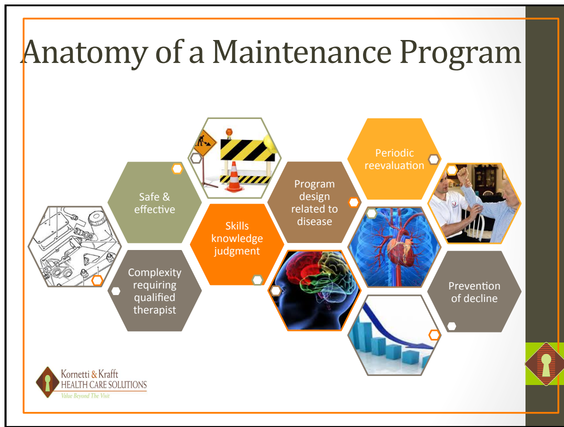
Course Objectives

- Examine the key components of maintenance therapy in PPS regulations
- Analyze the similarities/differences between restorative and maintenance therapy services in the home health setting
- Discuss potential factors that can impact the comprehensive management of a home health maintenance patient
- Discuss documentation implications specific to maintenance therapy
- Apply concepts of maintenance therapy to specific patient scenarios

Session 3: Reassessments and Routine Visits

- Attendees will be able to:
  - Practice documentation skills to support medical necessity for maintenance patients
  - Reality-based scenarios focused on:
    - Functional reassessments
    - Routine visits
  - Compare and contrast functional reassessments and routine visits for maintenance and restorative therapy

Anatomy of a Maintenance Program



Therapy Evaluation: Mrs. Q

- *Patient is a 79 year old female referred for HH PT & OT s/p recent hospitalization due to fall at home.*
- *PMHx: COPD x 17 years – **GOLD severity = moderate COPD**; O2 intermittent via NC @ 2L/min.; HTN; osteoporosis x 12 years with h/o compression fx – T vertebrae; (+) fall history (6 in last 12 months)*
- *SHx: lives alone in one-floor private residence, with 3 steps to enter/exit; supportive daughter lives 30 minutes away (works F/T) and checks on patient every evening; previously independent with ADLs; reliant on daughter of IADLs (transportation, shopping, laundry; receives Meals-on-Wheels x 3 years); walks with 4-wheeled rollator in home and short community distances*
- *Reason for Referral: recent ACH x 3 days for dehydration and UTI; patient found on floor by daughter (fell in AM and could not get up or to the phone) who came by on way home from work; patient spent 2 weeks in rehab following hospitalization prior to DC home with therapy*
- *Patient reports feeling 80% of prior /pre-hospital level of functioning.*

GOLD Spirometric Criteria for COPD Severity

I. Mild COPD	*FEV1/FVC < 0.7 * FEV1 > or = 80% predicted	patient is probably unaware that lung function is starting to decline
II. Moderate COPD	*FEV1/FVC < 0.7 *FEV1 50-79% predicted	Symptoms progress, with shortness of breath developing upon exertion.
III. Severe COPD	*FEV1/FVC < 0.7 *FEV1 30-49% predicted	Shortness of breath worsens and COPD exacerbations are common
IV. Very Severe COPD	*FEV1/FVC< 0.7 *FEV1 < 30% predicted or < 50% predicted with chronic respiratory failure	Quality of life at this stage is gravely impaired. COPD exacerbations can be life threatening.

Therapy Evaluation: Mrs. Q

- *Patient Goal: "I want to be able to get back to taking care of myself. I don't like relying on anyone if I don't have to."*
- *Physical Assessment:*

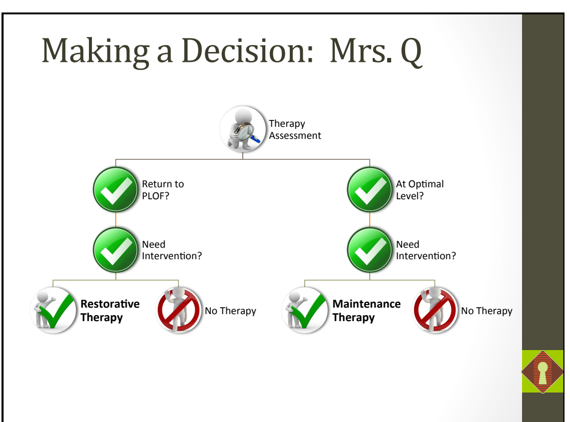
Assessment	Findings / Impairments	Score Interpretation	Functional Relevance
UE Strength Arm Curl Test	12 reps	WNL for age/gender norms (11-17 reps)	**None expected**
LE Strength 30-sec Chair Stand Test	5 reps	Below age/gender norms (10-15 reps) *LE strength is 50% of normal*	**Sit/stand transfers Toilet transfers Stair climbing**
Balance/Confidence Tinetti-POMA ABC	21/28 45%	POMA: (+) fall risk (medium); using 4WW Confidence: below normal ($\geq$ 80%)	**Ambulation Stair climbing Shower transfers**
Mobility Timed Up & Go	26 seconds	Moderate mobility impairment; (+) fall risk with score > 14 sec	**Ambulation Stair climbing Shower transfers**

Therapy Evaluation: Mrs. Q

- *Physical Assessment: cont'd*

Assessment	Findings / Impairments	Score Interpretation	Functional Relevance
ADL/Self Care Barthel Borg RPE	*10*/20 15/20	Barthel: ↓ score = ↑ disability Borg: Hard/Heavy effort	**Shower transfers Self-care/ADLs**
Aerobic Capacity 2-Minute Step Test	32 steps	Below age/gender norms (68-100 steps)	**Stair climbing Self-care/ADLs Basic IADLs**
Gait Velocity 10 ft walk test	2.5ft/sec	Below age/gender norms (4.1 ft/second)	**Community mobility**
Borg RPE 6-20 Scale	Currently = 8/20; During Activity = 15/20	Very Hard rating of perceived exertion with ADLs/in-home mobilities	**Ambulation Stair climbing ADLs/Basic IADLs**
Cognitive MoCA	23/30	WNL for age >26/30; score indicates mild cognitive impairment	**Follow through w/education & training**

Making a Decision: Mrs. Q



Physical Therapy Goals: Mrs. Q

1. *Patient will increase LE strength to WNL for age/gender as evidenced by ≥10 reps in 30-second Chair Stand Test (CST) for reciprocal stair climbing/descent x 4 weeks.*
2. *Patient will increase balance as evidenced by Tinetti-POMA score ≥ 25/28 for reduced fall risk during gait and mobility activities x 4 weeks.*

Occupational Therapy Goals: Mrs. Q

1. *Patient will demonstrate improved endurance during completion of ADLs with pacing strategies employed as evidenced by Borg RPE score ≤ 12/20 x 6 weeks.*
2. *Patient will resume safe and independent showering as evidenced by Barthel Scale score ≥ 18/20 x 4 weeks.*

Therapy Utilization Parameters: Mrs. Q

- Determine Part A Home Health Benefit:
  - *Rehab or Maintenance?*
    - ***Begin with Rehab for short course then transition to maintenance***
- Frequency/Duration:
  - OT Orders: **4-5w1; 3w1; 2w2; 1qow x 4**
  - PT Orders: **3w3; 2w1; 1 mo 1**

DC PLAN: ***with stabilization of patient functional status and safe return to self-care/basic IADLs***

Reassessment and the maintenance therapy patient

THE MEDICARE PART A HOME HEALTH BENEFIT

Dispel The Myth .. .

- Are therapy re-evaluations at 30 days or visit 13 and 19 required for maintenance patients?
  - **A**: They are required at all three stages, though therapy maintenance case is unlikely to reach the 13th visit since frequency would be limited. Keep in mind, though, that a patient receiving PT maintenance also might be getting occupational and speech therapy. If so, the 13/19th visit could become a re-evaluation issue. In any case, the 30-day assessment would be required if the maintenance program, once established, extends beyond 30 days.

Source: CMS Q&As

Clarify What Constitutes a FRA

Guidance: *"At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof."*

Source: CMS Manual System – Pub 100-02 Medicare Benefit Policy: Transmittal 176 (Dec. 13, 2013). 40.2.1 – Section 1ii Reassessment at least every 30 days (performed in conjunction with an ordered therapy service).

Documentation Focus

Initial Assessment

- Measure impairments
- Determine functional impact
- Select interventions
- Establish goals
- Set frequency and duration

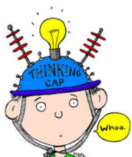
Reassessment

- Completion of intervention(s)
- Objective measurement(s) updated
- Interpretation of findings/ changes from baseline
- Clinical statement to support continued services (if continuing)
- Modifications to care plan/ goals
- Communication/input from physician

Documentation Concepts

The Maintenance Reassessment

- The challenge → operationalizing it!
- ***What should the reassessment read/look like***?



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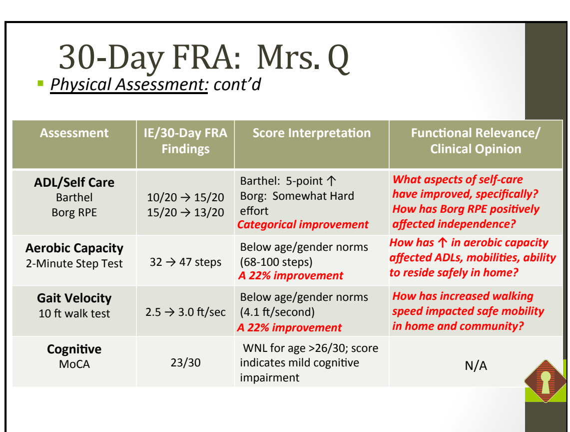
30-Day FRA: Mrs. Q

- *Patient Goal: "I want to be able to get back to taking care of myself. I don't like relying on anyone if I don't have to."*
- *Physical Assessment:*

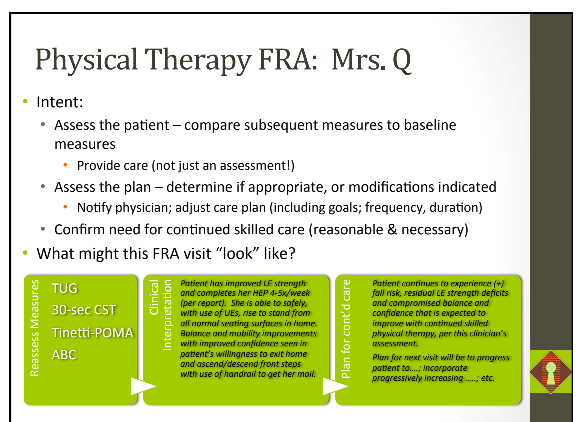
Assessment	IE /30-Day FRA Findings	Score Interpretation	Functional Relevance /Clinical Opinion
UE Strength Arm Curl Test	12 reps / 11 reps	WNL for age/gender norms (11-17 reps) ***UE strength remains WNL***	**None expected**
LE Strength 30-sec Chair Stand Test	5 reps / 8 reps	Below age/gender norms (10-15 reps) ***LE strength has ↑ to 80% of WNL***	***Has there been a change in ability to complete transfers with 30% ↑ in strength?***
Balance/Confidence Tinetti-POMA ABC	21/28 → 25/28 45% → 63%	POMA: ≥25/28 = low fall risk ***Categorical improvement*** Confidence: below normal (≥ 80%) ***Currently at 79% WNL***	***How has this ↑ in balance (from medium to low fall risk) and confidence affected function?***
Mobility Timed Up & Go	26 secs /19 secs	Mostly independent mobility; (+) fall risk with score > 14 sec ***Categorical improvement; a 27% improvement in time***	***How has this reduction in mobility impairment affected function?***



30-Day FRA: Mrs. Q

- *Physical Assessment: cont'd*

Assessment	IE/30-Day FRA Findings	Score Interpretation	Functional Relevance/ Clinical Opinion
ADL/Self Care Barthel Borg RPE	10/20 → 15/20 15/20 → 13/20	Barthel: 5-point ↑ Borg: Somewhat Hard effort ***Categorical improvement***	***What aspects of self-care have improved, specifically? How has Borg RPE positively affected independence?***
Aerobic Capacity 2-Minute Step Test	32 → 47 steps	Below age/gender norms (68-100 steps) ***A 22% improvement***	***How has ↑ in aerobic capacity affected ADLs, mobilities, ability to reside safely in home?***
Gait Velocity 10 ft walk test	2.5 → 3.0 ft/sec	Below age/gender norms (4.1 ft/second) ***A 22% improvement***	***How has increased walking speed impacted safe mobility in home and community?***
Cognitive MoCA	23/30	WNL for age >26/30; score indicates mild cognitive impairment	N/A



Occupational Therapy FRA: Mrs. Q

- Intent:
  - Assess the patient – compare subsequent measures to baseline measures
    - Provide care (not just an assessment!)
  - Assess the plan – determine if appropriate, or modifications indicated
    - Notify physician; adjust care plan (including goals; frequency, duration)
  - Confirm need for continued skilled care (reasonable & necessary)
- What might this FRA visit "look" like?

Reassess Measures

Barthel Index

2-MST

Borg RPE

Clinical Interpretation

Aerobic capacity improvement from 47% (baseline) to 69% of WNL, with reduced observation of SOB during self care; O2 sats remain > 90% during daily activities. Patient is able to complete ADLs with increasing independence (Barthel improved from 10/20 to 15/20), employing energy conservation strategies.

Plan for cont'd care

Patient continues to experience limited endurance verbalizing fatigue following bathing/dressing. She does confirm that she is "up doing more" each day, however, she has not returned to her PLOF, self-reporting feeling 80% at time of this reassessment.

It is this clinician's professional judgment that . . . . based on chronicity of disease processes.

Reassessment Checklist

- ❑ ***Was*** the visit completed by a qualified therapist?
  - ❑ Was care provided, in addition to patient reassessment
- ❑ ***Were you***: As objective as possible?
  - ❑ Not required to complete *__all__* baseline measures
- ❑ ***Did you***: Analyze findings/interpret scores?
- ❑ ***Did you***: Connect stabilization (or improvement) in measures to functional relevance?
- ❑ ***Did you***: Clarify the need for more therapy __or__ provide rationale for discharge?

Therapy Parameters: Mrs. Q

- Possible Plan:
  - *Continue or discharge?*
    - **OT: maintenance**
    - **PT: continue restorative additional 2 weeks, then transition to maintenance**
- Frequency/Duration:
  - OT Orders: **1qow x 4**
    - **No changes to existing care plan**
  - PT Orders: **2w3, 1w1**
    - **Modify care plan freq/duration**
    - **Keep goals as established**
    - **In coordination with physician**

DC PLAN: **When patient has stabilized at an optimal functional level to be safe in her home.**

Regular visits and the maintenance therapy patient

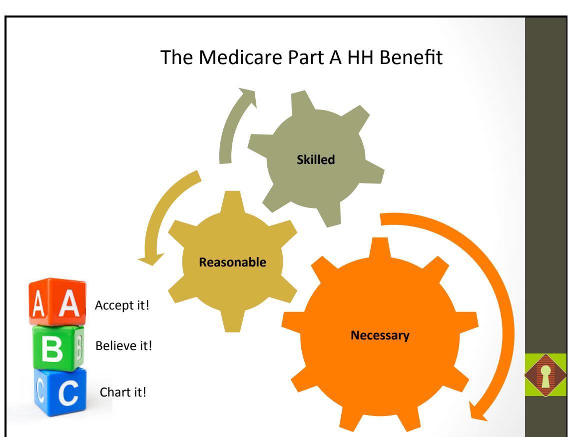
THE MEDICARE PART A HOME HEALTH BENEFIT

APTA — American Physical Therapy Association

AOTA — The American Occupational Therapy Association, Inc.

American Speech-Language-Hearing Association

The Medicare Part A HH Benefit



Visit Note Basics: The SOAP Note

- Subjective:
  - Patient reported ↑ or ↓, or change(s)
  - Current issues or complaints
- Objective:
  - Education, instruction
  - Specific intervention(s) by therapist
- Assessment:
  - Clinical overview of visit with decision-making and associated rationale
- Plan:
  - For next visit . . . Be specific!

Documentation Concepts
Identifying Skill, Reasonable & Necessary

- The challenge → operationalizing it!
- ***What should the documentation read/look like***?

Maintenance Visit: Mrs. Q

Note Category	Documentation	Skilled, Reasonable & Necessary?
Subjective	*Patient reports completing her HEP without difficulty; she reports, " I am not getting as tired as I was when I first came home. My daughter is still doing my shopping, but I am making my meals and doing my laundry now." Patient reports she "takes breaks" throughout the day when she gets fatigued. She reports no complaints of pain.*	
Objective	VS (pre): BP 128/78; P 82; R 18; O2 = 95% with O2 via NC at 2L/min; Borg 7/20 *Reviewed current aerobic/strengthening HEP and advanced as follows: unilateral PF exercises in standing x 8-12 reps; sit-stand exercises without use of UE's x 10 reps; walking program for 3-5 minutes, without seated rest break. Patient reports Borg RPE = 14/20; following seated rest x 5 minutes = 8/20. PT reviewed pacing activities with patient during completion of ADL and mobility activities. Patient able to walk for distance of 97 feet with rollator walker and supervision on level surfaces. PT instructed patient on ascending and descending 2 steps into garage to access washer/drier with assistive device.* VS(post): BP 134/72; P 88; R 21; O2 = 94% with O2 in use	□ Skilled: required a qualified therapist? □ Reasonable: consistent with evidence-based practice? □ Necessary: indispensable for patient?

Maintenance Visit: Mrs. Q

Note Category	Documentation
Assessment	*What is your clinical statement about interventions, education and patient?*
Plan	*What is your "next steps?"*

□ Have you clarified patient's homebound status? *(this will support a decision to continue)*

Next Steps

- Start small
- Monitor closely
- Build on success
- Expect changes
- Open communication

Are you concerned about protecting the revenue you have earned from providing therapy services?

Kornetti & Krafft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions in interdisciplinary, patient-centered care management to fortify your agency's fiscal security.

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