

Maintenance Therapy


When and How to Integrate into Your Agency

Diana Kornetti, PT, MA, HCS-D
Cindy Krafft, PT, MS, HCS-O




Kornetti & Krafft
HEALTH CARE SOLUTIONS
Value Beyond The Visit

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 1: Regulations & Definitions

- Attendees will be able to:
 - Examine the myths and misunderstandings surrounding maintenance therapy
 - Define therapy in the areas of skilled, reasonable and necessary
 - Explore current regulations that pertain to maintenance therapy
 - Compare and contrast issues surrounding maintenance and restorative therapy
 - Discuss the impact of Jimmo v. Sebelius on home health therapy





Myths and misunderstandings surrounding maintenance therapy

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Myths and Misunderstandings

- Maintenance = never ending therapy
- Tests and measures do not apply in maintenance therapy
- Maintenance patients do not show progress
- Maintenance patients do not have goals





Myths and Misunderstandings

- If one discipline is providing maintenance, then they all have to
- Once in maintenance, always maintenance
- "Maintenance" OR "Skilled Care"
- Maintenance therapy is for patients with MS, ALS, Parkinson's disease





Jimmo v. Sebelius

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Jimmo v. Sebelius: Background

- January 24, 2013 – US District Court for the District of Vermont settlement agreement reached:
 - GOAL: ensure that claims are correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled
 - Specific steps that CMS must undertake (*to be completed by January 23, 2014*)
 - Issue clarifications to existing program guidance
 - New educational material on subject



Jimmo v. Sebelius: Transmittal 179

- Medicare Benefit Policy Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT_ Coverage Pursuant to Jimmo vs. Sebelius
- Transmittal Date: 12/13/13
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176BP.pdf>



Jimmo v. Sebelius: Transmittal 179

- **Summary:** Medicare Program manual revisions to clarify that coverage of skilled nursing and skilled therapy services "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."
 - To improve current condition
 - To prevent or slow further deterioration of condition



Jimmo v. Sebelius: UPDATE

- Federal Judge Ruling – filed Feb 2, 2017
 - "Confusion over the Improvement Standard persists," wrote U.S. District Court Chief Judge Christina Reiss in Vermont
- CMS deadline to file an objection – Feb 16
- All measures **MUST** be completed by Sept 4



Jimmo v. Sebelius: Settlement Details

- CMS will disavow the application of the so-called "Improvement Standard" as improper under Medicare policy for the SNF, HH, and OPT benefits
- CMS will publish on its website (cms.gov) a new webpage dedicated to the *Jimmo* settlement
- CMS will post on the forthcoming *Jimmo* webpage one set of Frequently Asked Questions (FAQs)
- CMS will include a message regarding the *Jimmo* settlement when it announces the publication of the *Jimmo* webpage to providers, adjudicators, contractors, and other stakeholders



Jimmo v. Sebelius: Settlement Details

- CMS will clarify the responses to questions posed and answers provided during the Dec. 16, 2013 *Jimmo vs. Sebelius* National Call for contractors and adjudicators
- CMS will issue a Technical Direction Letter to MACs directing them to conduct, within a specified timeframe, additional training on the *Jimmo* manual clarifications (CMS will provide materials)
 - Health Plan Management System memorandum to MAOs
- CMS will notify Plaintiffs once the Technical Direction Letter has been issued to MACs



Jimmo v. Sebelius: Corrective Statement

The *Jimmo* Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide. These regulations are set forth in the Medicare Benefit Policy Manual.



A review of key therapy concepts

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Defining Key Therapy Concepts

- Skilled Therapy Services (*ref: HH Benefit Policy Manual, Chapter 7, 40.2 – Skilled Therapy Services*)


Skill Belongs to the clinician.

- proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique

Progress

- advancement, development, growth, steady improvement

Progress does not equate to skilled therapy.



More on Skilled Therapy. . .

Specific Interventions do not equate to skilled therapy


- Just because the clinician does it during a visit, *doesn't* mean it **required** the skills/knowledge/abilities of a licensed professional . . .
 - Q: *What wouldn't have happened, been corrected, taught or modified if I didn't make this visit?*
- **Assessment** of patient response, program appropriateness, plan for next visit = SKILL



More on Skilled Therapy. . .

Patient improvement or progress does not mean it required a therapist

- The documentation should include:
 - Progress, not just change from previous status/visit
 - Measurable
 - It is "real" and can be reproduced
 - Relevance, or functional impact of progress
 - Meaningful to the patient



What does Demonstrate “Skill?”

- Complexity such that safety and/or efficacy of the intervention can only be achieved under the supervision of a skilled clinician.
- Development, implementation, management and evaluation of a care plan
- Management and periodic reevaluation (of plan as well as patient)

This applies to both restorative and maintenance programs for therapy





Is it “skilled” or isn’t it?

- Instructing patient in individual exercise program
 - **What isn’t:** completion of program if able to train lay (unskilled) individual to carry out
- Walking for increasing (progressive) distances
 - **What is:** development of a walking program for aerobic capacity rebuilding
- Completion of ADLs to determine DME needs for bathroom safety
 - **What isn’t:** ADL assistance/supervision that can be completed by a lay (unskilled) individual



Defining Key Therapy Concepts

Reasonable and Necessary Therapy Services (ref: HH Benefit Policy Manual, Chapter 7, 40.2 – Skilled Therapy Services)

Reasonable

- governed by or being in accordance with reason or sound thinking; not excessive or extreme

Necessary

- Absolutely essential; needed to achieve a certain result or effect; requisite

Therapy services must be in accordance with sound judgment and be essential, requisite for the patient.



More on Reasonable & Necessary Therapy

Just because an intervention was completed does not mean it was either reasonable or necessary

- Is there evidence of *clinically accepted standards of practice*?
- Does the care plan reflect interventions that focus on those conditions/illnesses/ diagnoses driving referral to home health?
- Are the services provided *indispensible* to the patient and their recovery?



Medicare Benefit Policy Manual – Chapter 7



- **20.3 - Use of Utilization Screens and "Rules of Thumb" (Rev. 1, 10-01-03) A3-3116.3, HHA-203.3**

- Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.




What CMS has to say ...





- "We believe that rehabilitation professionals, by virtue of their education and experience, are typically able to determine when a functional impairment could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities."
- "We expect rehabilitation professionals to be able to recognize when their skills are appropriate to promote recovery."




What CMS has to say . . . 

- Regarding therapy coverage based on patient diagnosis(es):
 - "A prescriptive definition of these sorts of conditions, such as a listing of specific disease states that provide subtext for these descriptions is impractical, as each patient's recovery from illness is based on unique characteristics."
 - *No assumptions can be made about the skilled need, reasonable and necessary status of a patient because they present with diagnoses that typically receive therapy*
 - i.e., stroke, orthopedic conditions or surgeries, progressive neuromuscular diseases (Parkinson's)



 Is it "**reasonable & necessary**" or isn't it?

- Pain management with chronic, non-operative bilateral knee osteoarthritis
 - **What isn't:** *solely obtaining a subjective report of pain by patient on 0-10 Visual Analog Scale*
- Gait training in tertiary (end stage) Parkinson's disease
 - **What is:** *teaching compensatory strategies for safe mobility*
- UE/LE strengthening program
 - **What isn't:** *for < 5/5 MMT scores that don't contribute to a functional impairment for the patient*






Conditions for coverage of therapy services
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The American Occupational Therapy Association, Inc.




Three Conditions for Coverage of Therapy Services: The Home Health Benefit

 <p>Skills of a qualified therapist are needed to restore function</p>	 <p>Patient's condition requires a qualified therapist to design or establish a maintenance program</p>	 <p>Skills of a qualified therapist are required to perform maintenance therapy</p>
Restorative	Maintenance	Maintenance

Condition #1: Restorative

What do the regulations say?

Must be reasonable & necessary for the treatment of the patient's illness or injury	To the restoration or maintenance of function affected by the patient's illness or injury within context of his/her unique medical condition	Must be inherently complex = safely and/or effectively performed only by or under general supervision of a skilled therapist	Must be consistent with the nature and severity of the illness/injury and patient's particular medical needs	Must be considered specific, safe, and effective treatment for the patient's condition
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Ref: PPS-2011 Final Rule
 *40.2 - Skilled Therapy Services (Rev. 1, 10-01-03) A3-3118.2, HHA-205.2
 *40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech Language Pathology Services, and Occupational Therapy (Rev. 144, Issue: 05-06-11, Effective: 04-01-12, Implementation: 05-05-12)

Condition #2: Maintenance

What do the regulations say?

Patient is responding to therapy and can meet the goals in a predictable period of time	The maintenance program must be established by a qualified therapist (and not an assistant)	The unique clinical condition of a patient may require the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient's specific illness or injury	Must include the program design, instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a PT, SLP, or OT is required
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Ref: PPS-2011 Final Rule:
 *Rehabilitative v/ Maintenance Therapy
 *§409.44(c)(2)(H)(4)

Condition #3: Maintenance

- Skills of a qualified therapist are needed to **perform** maintenance therapy
- What do the regulations say?


<p>Where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant), or</p>	<p>The clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.</p>
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Ref: PPS-2011 Final Rule:
•Rehabilitative v/ Maintenance Therapy
•§409.44(c)(2)(H)(4)





Understanding the Difference

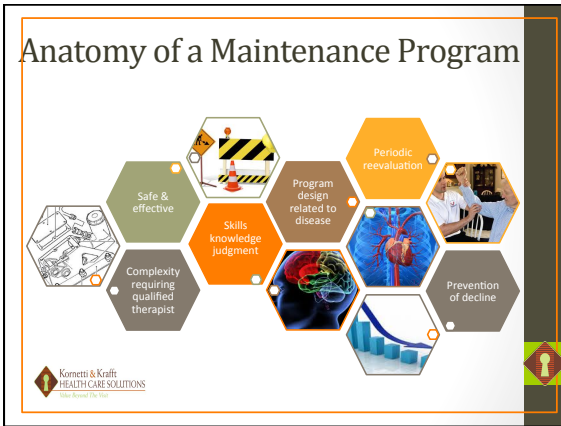
<p>Design or establish a maintenance program</p> <ul style="list-style-type: none"> • Qualified Therapist Responsibilities include: <ul style="list-style-type: none"> • Program connected to patient specific needs. • Program reflects acceptable standards of practice • Periodic reassessment of plan and patient to ensure program is safe and effective. 	<p>Provide the maintenance therapy</p> <ul style="list-style-type: none"> • Qualified Therapist Responsibilities include: <ul style="list-style-type: none"> • Condition 2 already in place. • Hands-on, in-person provision of the components of the program. • Clear support as to why the therapist has to be the one to complete the program with the patient.
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What About the Caregiver?

- The presence or absence of a caregiver DOES NOT define the intervention provided as "skilled"
- IF someone OTHER THAN a therapist can do the intervention THEN it would NOT be considered "skilled"



Knowledge Application Exercise

Match the therapy service to the correct coverage criteria

- Dementia patient with increased sedentary behaviors x 3 months
- Severe COPD with recurrent pneumonia, breathlessness with eating and airway clearance deficits
- Exacerbation of CHF with fluid overload/diuresis and recent ACH x 4 days

Coverage Criteria 1 – Restorative Therapy

Coverage Criteria 2 – Maintenance Program development and management

Coverage Criteria 3 – Maintenance Therapy Program performance

PT EXAMPLES for Coverage Criteria

Osteoarthritic patient who recently underwent elective total joint arthroplasty of knee

Restorative




Diabetic patient with peripheral neuropathy and retinopathy with reduced gait stability

Maintenance




CVA with tonal dominance including sustained PF clonus impacting transfers/gait

Maintenance

OT EXAMPLES for Coverage Criteria




 <p>COPD patient with recent deterioration in ability to bathe, dress, cook and do laundry following bout of pneumonia</p>	 <p>Psychiatric patient with depression and increased sedentary behaviors not completing self-care activities regularly</p>	 <p>Severe rheumatoid arthritic patient with weakness in UEs and inability to complete ADLs</p>
Restorative	Maintenance	Maintenance

ST EXAMPLES for Coverage Criteria

 <p>CVA patient with dysphagia and expressive aphasia</p>	 <p>Dementia patient with increased demonstration of repetitive behaviors interfering with daily function</p>	 <p>Severe COPD patient with recurrent pneumonia and breathlessness during eating, speaking</p>
Restorative	Maintenance	Maintenance


Rehab v. Maintenance Therapy

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Operationalize the Regulations

- **Rehabilitative: GOAL = recovery of function**
 - Recovery of function
 - Clear prior level of functioning (PLOF) with a reasonable expectation that beneficiary can return to/near to this level of ability
 - POSSIBLE with chronic disease processes – stage/level of condition + prognosis is relevant
 - Predictable period of therapy intervention to realize improvement
 - ↑ intensity
 - ↓ duration



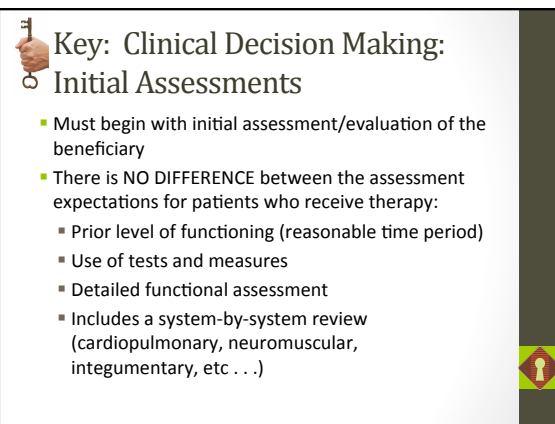
Operationalize the Regulations

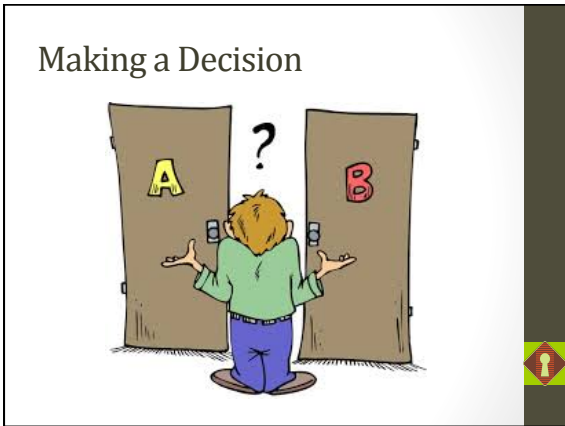
- **Maintenance: GOAL = optimal functioning**
 - Optimization of function – maximizing beneficiary safety and ability where they currently are
 - Frequently, a changing/fluctuating level of functioning (PLOF)
 - PROBABLE with progressive disease processes
 - Anticipation of future change/decline
 - LESS predictability of therapy intervention
 - ↓ intensity*
 - ↑ duration

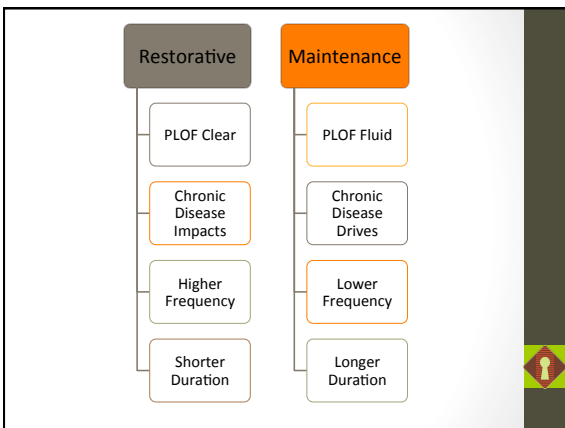


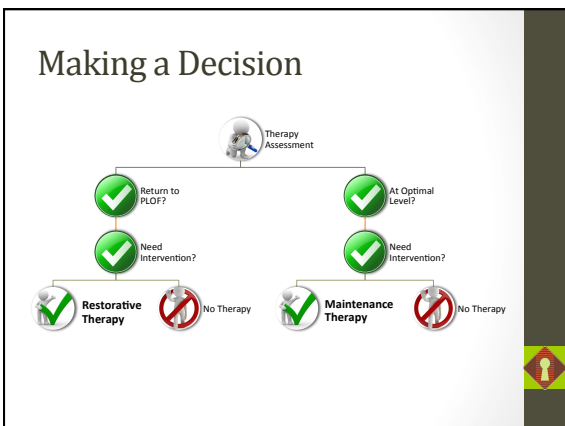
Key: Clinical Decision Making: Initial Assessments

- Must begin with initial assessment/evaluation of the beneficiary
- There is NO DIFFERENCE between the assessment expectations for patients who receive therapy:
 - Prior level of functioning (reasonable time period)
 - Use of tests and measures
 - Detailed functional assessment
 - Includes a system-by-system review (cardiopulmonary, neuromuscular, integumentary, etc . . .)











Key: Clinical Decision-Making

- Requires the therapist (1) know what chronic conditions are present, and (2) where the beneficiary is in the course of the disease(s)
 - i.e., CHF - NYHA Classification – The Stages of Heart Failure
 - Relates symptoms to everyday activities and quality of life
 - i.e., COPD – GOLD grading system
 - Defines the disease according to its severity; serves as a guide for initial approach to treatment




New York Heart Association (NYHA)

Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea.
Class IV (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.



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.



Assessments and Care






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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.



Dee Kornetti COO
kornetti@valuebeyondthevisit.com



Cindy Krafft CEO
krafft@valuebeyondthevisit.com