How to Debunk Myths and Misunderstandings about Maintenance Therapy

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Objectives

• Examine the key components of maintenance therapy in PPS regulations

• Analyze the similarities/differences between rehabilitative and maintenance therapy services in the home health setting

• Discuss documentation implications specific to maintenance therapy
Myth #1

“Maintenance therapy is not being done at my agency”

NO!

Does this look familiar?

- Therapy evaluation completed
- Expectation of improvement
- Plan created
- Visits made
- Goals achieved
- Patient discharged

RESTORATIVE

- Therapy evaluation completed
- At optimal level
- Concerned about decline
- Plan created
- Visits made
- Goals achieved
- Patient discharged

MAINTENANCE
Myth #2

“The need for maintenance therapy is determined by the patient diagnosis”

Therapy and Diagnosis

• “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
Inclusion of Therapy Services

• “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.”

Restorative
- PLOF Clear
- Chronic Disease Impacts
- Higher Frequency
- Shorter Duration

Maintenance
- PLOF Fluid
- Chronic Disease Drives
- Lower Frequency
- Longer Duration
New York Heart Association (NYHA)

<table>
<thead>
<tr>
<th>Class</th>
<th>Patient Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I (Mild)</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).</td>
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<tr>
<td>Class II (Mild)</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.</td>
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<tr>
<td>Class III (Moderate)</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea.</td>
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<tr>
<td>Class IV (Severe)</td>
<td>Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.</td>
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Myth #3

“In Home Health, patients can receive skilled OR maintenance therapy”
Defining Key Therapy Concepts

**Skill**

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

**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

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**What does Demonstrate “Skill?”**

- Complexity such that safety and/or efficacy of the intervention can only by 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
<table>
<thead>
<tr>
<th>Is there a Difference?</th>
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<tbody>
<tr>
<td>• Gait Training</td>
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<tr>
<td>• Transfer Training</td>
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<tr>
<td>• Monitored Exercises</td>
</tr>
<tr>
<td>• Trouble Shooting ADL issues</td>
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Which of these takes a therapist?

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<table>
<thead>
<tr>
<th>Myth #4</th>
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<tr>
<td>“Removal of the ‘improvement standard’ expanded the Medicare home health benefit”</td>
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</table>
Jimmo v. Sebelius

• Court ruling does not expand existing services
• Maintenance therapy has always been a component of the Medicare A Home Health benefit
• May draw greater attention to the need for therapists to clearly differentiate between rehabilitative and maintenance services in the home health setting
  • Use of appropriate G-code
    • PT – G0159
    • OT – G0160
    • ST – G0161

Jimmo v. Sebelius

• APTA Press Release:
  www.apt.org/Media/Releases/Legislative/2012/10/24
  • “This policy aligns with APTA’s long-held belief that determinations of whether physical therapy should be covered under Medicare should be based on the unique condition and individual needs of each patient.”
Conditions for Coverage of Therapy Services

Skills of a qualified therapist are needed to restore function

Patient's condition requires a qualified therapist to design or establish a maintenance program

Skills of a qualified therapist are required to perform maintenance therapy

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 |

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, Issued: 05-06-11, Effective: 04-01-11, Implementation: 05-05-11)
### 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 |

Ref: PPS-2011 Final Rule:
- Rehabilitative v/ Maintenance Therapy
- §409.44(c)(2)(H)(4)

### Condition #3: Maintenance

**What do the regulations say?**

| 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 | 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. |

Ref: PPS-2011 Final Rule:
- Rehabilitative v/ Maintenance Therapy
- §409.44(c)(2)(H)(4)
Understanding the Difference

Design or establish a maintenance program

- Qualified Therapist Responsibilities include:
  - 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.

Provide the maintenance therapy

- Qualified Therapist Responsibilities include:
  - 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.

Myth #5

“Tests and measures are not applicable to maintenance patients”
Initial Assessments

- 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.)

Making a Choice
Making a Decision

Therapy Assessment

Return to PLOF?  At Optimal Level?

Need Intervention?  Need Intervention?

Restorative Therapy  No Therapy  Maintenance Therapy  No Therapy

The Devil is in the Details: Documentation

• So, what does a therapy “skilled” visit look like?
  • Answer the following questions:
    • What was taught? (and who was it taught to?)
    • What did the patient do?
      • Was there assistance required?
      • Was there cueing/supervision, etc. required?
      • If so, how much and for what?
    • How did the patient respond?
    • What is your clinical opinion (“assessment”) of the visit?
      • What improved? What didn’t? If not, why not?
      • What can patient now do (functional relevance)?
    • Clinical Plan:
      • What can’t the patient do and why does it continue to require a therapist to visit?
Documentation Concepts

*Rehab – Maintenance Assessments*

<table>
<thead>
<tr>
<th>Rehabilitative</th>
<th>Maintenance</th>
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<tbody>
<tr>
<td>Recovery of function</td>
<td>Optimize at current level of function</td>
</tr>
<tr>
<td>Clear prior level of functioning (PLOF)</td>
<td>PLOF relevance?</td>
</tr>
<tr>
<td>Role of chronic disease in course of recovery</td>
<td>Chronic disease – “front and center”</td>
</tr>
<tr>
<td>Predictable period of time for recovery and probable discharge</td>
<td>Potential role of CG’s</td>
</tr>
<tr>
<td></td>
<td>Less predictable period of time and discharge</td>
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</tbody>
</table>

Myth #6

“The care plan for a maintenance patient does not include specific therapy goals”
Goal Writing Template

• Five (5) necessary elements that all goals should include:
  • Who the goal pertains to
  • Objective measure
  • Score interpretation
  • Functional improvement/stabilization
  • Time frame
• “These guidelines are not exhaustive and should be considered a starting point for goal setting.”
• Source: Goal Writing Guidelines for Home Health Therapists, www.homehealthsection.org

Documentation Concepts

Rehab – Maintenance Care Planning

• Rehab: Goal Setting
  • Focus can be patient or caregiver(s)
  • Factors in prior level of functioning (PLOF)
  • Written for improvement:
    • In functional ability
    • From baseline objective measurement
Documentation Concepts

Rehab – Maintenance Care Planning

• **Maintenance**: Goal Setting
  - Focus can be patient or caregiver
  - Prior level of functioning (PLOF) not a factor
  - Written for prevention of deterioration or decline
    - In functional ability (e.g., bed mobility, transfers)
    - In body structures (e.g., ROM, strength)

**Myth #7**

“Maintenance therapy patients are exempt from mandatory functional reassessments”
Frequently Asked Questions

- 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.

Defining Compliance

- Full compliance requires equal attention in two critical areas:
  - Timing
  - Documentation
Reassessment Tips

**DO:**
- Be objective as possible
- Analyze findings
- Connect improvement in measures to functional relevance
- Clarify the need for more therapy

**DON’T:**
- Repeat the initial evaluation
- Use tests or measures because it’s “required”.
- Use unsupported phrases such as “continue therapy” or “continue per POC”

Functional Reassessment

*Rehab & Maintenance Therapy*

- Reassessment determination:
  - At mandatory time points
  - When clinically indicated by patient presentation
- Key components of any HH therapy reassessment visit:
  - Completion of intervention(s)
  - Objective measurement(s) redone
  - Interpretation of findings/changes from baseline
  - Clinical statement to support continued services (if continuing)
  - Modifications to care plan/goals
  - Communication/input from physician
Functional Reassessment
*Rehab & Maintenance Therapy*

- Counting expectations are identical in all cases with skilled therapy being provided.

- Challenge is making sure documentation supports ongoing need for therapy.

  = CLINICAL DECISION MAKING by the qualified therapist

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Reassessment Checklist

- **Were you**: As objective as possible?

- **Did you**: Analyze findings/interpret scores?

- **Did you**: Connect improvement in measures to functional relevance?

- **Did you**: Clarify the need for more therapy or provide rationale for discharge?
The Medicare Part A HH Benefit

Skilled
Reasonable
Necessary

Accept it!
Believe it!
Chart it!

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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