NARA Fall Conference 2022

Maintenance Therapy Jitters:

Understanding "Right Place, Right Time" and How to Document Maintenance Appropriately

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Learner Outcomes

- Describe when maintenance is a covered Medicare benefit and explain the Medicare regulatory difference between maintenance therapy and rehabilitative therapy.
- Identify differences between skilled maintenance and non-skilled maintenance.
- Explain when it's appropriate to create a skilled maintenance program.
- List elements needed in the documentation to support skilled maintenance.

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Jimmo Settlement Agreement (January 2013)

Glenda Jimmo, et al. vs. Kathleen Sebelius

- Upheld right of patients to continue to receive reasonable and necessary care to maintain condition or prevent or slow decline
- Determinant factor is not whether the Medicare beneficiary will improve
- Covers nursing and therapy services provided under both inpatient and outpatient settings

https://www.cms.gov/Center/Special-Topic/Jimmo-Center

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Medicare Benefit Policy Manual

Outpatient Therapy (Chap 15)	"Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care."
SNF (Chap 8)	"Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care."
HH (Chap 7)	"Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care."

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Medicare Regulations

Where can Maintenance Therapy be performed?

- All inpatient and outpatient settings EXCEPT Inpatient Rehabilitation Facilities (IRFs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs).
  - IRF: 42 CFR § 412.622
  - CORF: 42 CFR Part 410 Subpart D

Who can provide Maintenance Therapy?

- As of 2021, Therapists and Assistants can provide Maintenance Therapy in all settings (where allowed).

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Terminology

- ***Rehabilitative Therapy:*** Skilled therapy provided by a therapist or assistant. **Goals are written to improve function and/or underlying impairments.** The services or the patient must be so complex that only a licensed therapist or therapy assistant (under the supervision of a therapist) could provide.

- ***Skilled Maintenance (Maintenance Therapy):*** Skilled therapy provided by a therapist or assistant. **Goals are written to maintain or slow the decline in function.** The services or the patient must be so complex that only a licensed therapist or assistant (under the supervision of a therapist) could carry out the treatment interventions necessary to maintain or slow the decline in function.

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Terminology

- ***Non-skilled Therapy:*** Therapy or other activities provided by the patient themselves, any caregiver, family member, or even therapists. Goals may be to improve function, maintain function, or slow the decline. Either the patient or the therapy service provided is not at a level of complexity or sophistication to require the judgment, knowledge, and skills of a qualified therapist. Exercises/activities are generally repetitive with little variation from day to day, or over time. Increases in repetition or complexity of task may occur as the recipient shows improvement in a predictive manner. **Does not require the unique education or knowledge of a therapist.**

Understanding the Terminology

	Rehabilitative Therapy	Maintenance Therapy/ Skilled Maintenance	Non - Skilled Therapy
Who Performs?	**Must be performed by a therapist or therapist assistant.**	**Must be performed by a therapist or therapist assistant.**	**May be performed by the patient, nurse, nurse's aid, caregiver, family member. Could even be performed by a therapist or therapist assistant.**
Goals	**Improve function or underlying impairments**	**Maintain or slow the decline of function**	**Varied based on situation or possible state Medicaid requirements**
Requires the skills of a therapist?	**Yes**	**Yes**	**No**
Requires potential for improvement?	**Yes**	**No**	**No**

Understanding the Terminology

	Rehabilitative Therapy	Maintenance Therapy/ Skilled Maintenance	Non - Skilled Therapy
Reimbursement	Per CPT code, visit code, part of per diem rate	Per CPT code, visit code, part of per diem rate. Some payors may not reimburse.	May affect Case Mix Index in some states or may have no direct reimbursement.
Setting	• Acute Hospital (IP and OP) • Inpatient Rehab (IRF) • Skilled Nursing Facility (A&B) • Home Health (A&B) • OP - Rehab Agency, Therapists in both Private and Group Practice, CORF	• Acute Hospital (IP and OP) • Skilled Nursing Facility (A&B) • Home Health (A&B) • OP - Rehab Agency, Therapists in both Private and Group Practice (NOTE: Not covered in IRF or CORF)	Any location

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What is skilled therapy?

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What does Medicare say about therapist skill?

- "A therapist's skills may be documented…by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs…"
- "…skilled therapy services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified…therapist."
- "Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition."

What does Medicare say about therapist skill?

- "…the services shall be considered under accepted standards of medical practice."
- "…may include…Continued assessment and analysis during implementation of the services at regular intervals."
- "…may include…Instruction leading to establishment of compensatory skills"

What is skilled therapy?

The services provided must be so complex and sophisticated that they could ONLY BE PROVIDED by licensed rehab professionals and could not be replicated by an unskilled caregiver.

- What is skilled today may not be skilled tomorrow. Repetitive tasks or exercises are generally not considered skilled.
- A service provided by a skilled therapist or therapist assistant does not automatically make it a skilled service. If a service could be completed by an unskilled person or safely self-administered, it would not be considered skilled.
- At times, the patient's condition may be so complex that activities that could otherwise have been performed by unskilled caregiver must be performed by a therapist. These complexities must be evident in the documentation.

Why is skill so hard to nail down?

There isn't a defined list of skilled tasks:

- ADL Performance
- Safe Swallowing
- Assisted Gait/Mobility
- Therapeutic Exercise

Variance between:

- What the therapist did with the patient that was skilled

-vs-

- What the therapist documented about their skilled involvement with the patient

Why is skill so hard to nail down?

As therapists, we tend to focus all our attention on THE PATIENT.

What can the patient do? What can they not do? How much assistance do they require? These are the details we're most accustomed to documenting.

But SKILL talks about what WE (the therapists) are doing, thinking, analyzing, and planning. We spend so much of our day looking outward, we forget to also look inward and document those details too.

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What is skilled service?

The skill comes from what you, the therapist, are doing and thinking about during the treatment. NOT a description of what the patient is doing.

Some Action Words That Reviewers Like To See:

Analyzed	Inhibition
Assessed	Instruction in (specific task
Adjusted	segment)
Modified	Modeled
Adapted	Normalized
Instructed	Facilitated
Upgraded	Reduced
Progressed	Anticipate
Incorporated	Level of progress was not as
(Specific) compensatory training	anticipated (vs No progress or
Fabrication	Plateau)

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Skill is Situational but NOT Subjective

While skill is situational, it's not subjective. Determine if a service is skilled by answering four questions.

Are the skills of a therapist required to safely:

- **ASSESS** the patient's underlying impairments and functional deficits?
- **DEVELOP** a patient and point-in-time-specific treatment plan for medically necessary services?
- **ANALYZE** performance during interventions?
- **MODIFY and/or PROGRESS** the interventions in response to the analysis?

If ALL FOUR questions above can be answered with a YES, the task/activity/intervention is skilled.

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Factors That DO NOT Contribute to Skilled Need

- Patient/caregiver non-compliance with program
- Caregiver unavailability
  - "…The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service." (CMS)
- Patient/caregiver preference

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UNSKILLED –
But important

Patient ambulated 50’ feet with wheeled walker and minimal assistance.

SKILLED

Manual facilitation to stabilize right pelvis/hip during stance phase and verbal cueing for right toe clearance during swing phase. Required MIN assist to amb. 50’ w/FWW.

?

Could an AIDE do/document this?

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Is this a skilled service or a teachable service?

- Tasks/exercises/techniques that will continue to benefit the patient but can be safely taught (because their performance doesn’t require our skill), should be taught.
- Once comprehension of the instructions and mastery of the teachable task/exercise/technique has been demonstrated, it can be transitioned to an independent or supervised HEP or to a caregiver program (RNP/FMP).
- Intermittent reassessment of that taught program can and should occur (as needed throughout the episode of care) to assess continued appropriateness and to make modifications or to progress if needed.

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Is this a skilled service or a teachable service?

- When determining if a task is teachable, one must consider:
  - The complexity/variability of the task --AND--
  - The complexity/variability of the patient's clinical presentation

If you determine that something isn't teachable, consider this question: WHY ISN'T IT TEACHABLE? Answering that question and documenting the details of the answer will *likely* assist you in explaining WHY IT IS SKILLED.

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Can repetition be skilled?

Your patient has performed the same exercises under your instruction every day this week. Is that skilled?

Maybe yes…but sometimes no…

How do we know when it is and when it isn't?

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Not All Repetition is Bad

(PROBABLY) NOT SKILLED

- Repetition by design
- Repetition of task/technique with no significant patient complexity requiring ongoing skilled analysis
- Repetition because caregiver isn't available/willing to perform program
- Repetition because the patient is non-compliant with their program
- Repetition because the patient like/prefers working with us

(PROBABLY) SKILLED

- Repetition because analysis reveals that progression is not yet appropriate and patient and/or caregiver can't yet perform task/technique independently
- Repetition of task/technique, but the complexity of the patient requires ongoing skilled analysis
- Repetition of concept (e.g., ROM) with different techniques needed day-to-day depending on skilled analysis of patient presentation

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Medicare Denial Language Example: Skilled Services

The PT, OT, and ST services furnished to the beneficiary do not qualify as skilled services. That is, these services are no longer at a **level of complexity and sophistication** that they require the **unique skills and judgment of a licensed professional** for the safe and effective delivery of care. Specifically, the notes for the review period have described only repetitive services, encouragement, and support **without furnishing any patient-specific detail that only a licensed professional would be equipped to provide**.

Documentation does not support that further skilled therapy services were reasonable and necessary for physical therapy. **The plan of care was well established** and additional therapy to increase endurance, safety, and monitoring **does not require the skills of a therapist**. **Routine, repetitive services** do not contain the **complexity or sophistication** requiring the **skills of a licensed therapist. Non-skilled personnel are qualified to provide functional maintenance programs**.

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Skilled
Maintenance Set-Up

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Skilled Services

Skilled Therapy:

- Must be provided with the expectation, based on restoration potential, that the condition will improve materially in a reasonable and predictable period of time;
- OR the services must be necessary for the establishment of a safe and effective maintenance program;
- OR the services must require the skills of a therapist to perform the maintenance program.

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Maintenance Therapy Set-Up — How much skill is needed?

- Potential reduction in re-hospitalizations: Injury with falls is a serious risk to the patient and often results in hospitalization. A maintenance program to address balance and strength can reduce the risk of falls. However, some patients have conditions that require the skilled oversight of a maintenance program. For example, patients with highly variable muscle tone can require a different approach from day to day, or even from hour to hour. ***The skills of a therapist may be required to alter the approach to compensate for this variability.***
- Potential reduction of, or slowed loss of function, associated with some chronic conditions: Patients with progressive conditions, such as Parkinson's disease, sometimes present in ways that are highly variable from day to day ***requiring the oversight and/or performance of all or some of their maintenance programs by skilled personnel.***

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Maintenance Therapy Set-Up — How much skill is needed?

- Enhanced collaboration with caregivers: Some maintenance therapy programs involve a component of oversight of restorative program delivery. In some cases, ***the maintenance program is so sophisticated that it requires oversight by skilled rehab personnel. Caregivers may be conducting the program, but only with regular oversight by rehab.*** This type of oversight enhances the communication between caregivers and rehab and can result in subtle regressions being noted and addressed more quickly, before true functional loss can occur.

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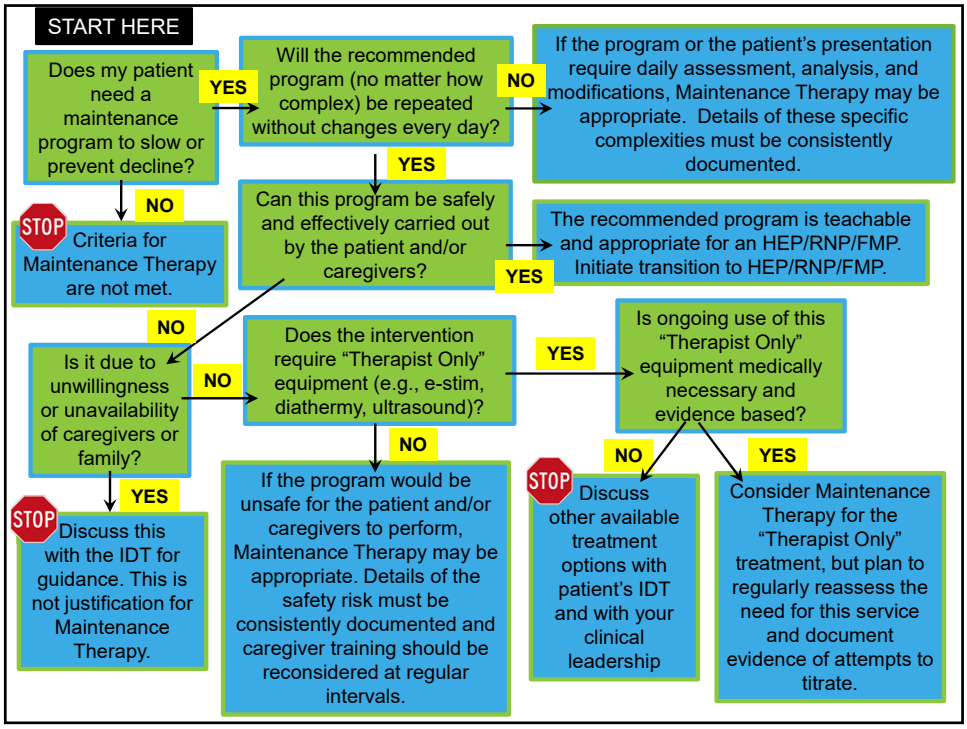

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Documenting Skilled Maintenance at Start of Care

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Documenting Skilled Maintenance at Start of Care

"Coverage is based on individualized assessment of the patient's condition and the need for skilled care to carry out a safe and effective maintenance program...Skilled maintenance therapy is covered in cases in which needed therapeutic interventions require a high level of complexity."

"It is not necessary to establish rehabilitation or restorative therapy prior to the maintenance program, as long as the documentation justifies the need for skilled therapy to maintain function or prevent or slow deterioration."

(APTA's "Skilled Maintenance Therapy Under Medicare")

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Documenting Skilled Maintenance at Start of Care

Scenarios that might warrant skilled maintenance at start of care:

- Patient has a chronic progressive diagnosis and requires the specific expertise of licensed therapists to slow further deterioration
- Patient has already had one or more episodes of care for this condition and patient/caregiver have demonstrated inability to effectively perform maintenance program independently

The diagnosis is not the predictor for skilled maintenance. Rather, the need for the skills of a therapist is the predictor.

"While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled." (CMS)

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Documenting Skilled Maintenance at Start of Care

A SKILLED MAINTENANCE plan of care should:

- Be different than a rehabilitative assessment—goal is not for restoration or rehabilitation
- Highlight the complexity of the patient
- Identify purpose for skilled maintenance
  - Maintain current condition
  - Slow further deterioration
- Clearly state and support the need for skilled services to achieve purpose

"We note that the manual revisions do not require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although some areas of the Medicare Benefit Policy Manual do identify certain vague phrases like 'patient tolerated treatment well,' 'continue with POC,' and 'patient remains stable' as being insufficiently explanatory to establish coverage)." (CMS)

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Documenting Skilled Maintenance at Start of Care

Reason for Referral

- The Reason for Referral (RFR) is the most important element of the therapy evaluation for supporting medical necessity
- Identify patient's recent functional changes **–OR—** new or increased risk (relevant to evaluating discipline)
- Explain how the functional change or risk came about. The condition that caused the functional change/risk should align with the medical diagnosis
- Clearly connect how the above details support that THIS PATIENT'S needs can ONLY BE MET through the delivery of SKILLED maintenance services

Tests and Measures

- Detailed functional and underlying impairment assessment should support the complexity of the patient via tests and measures
- Note that there is NO DIFFERENCE between assessment expectations for rehab patients vs. skilled maintenance patients

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Documenting Skilled Maintenance at Start of Care

Goals

- Objective goals should be established to maintain or to prevent/slow decline—not progress

Plan

- Only include those interventions that specifically require the skills of a licensed therapist
- Note that there is no defined frequency for maintenance therapy. The frequency should be based on clinical judgment, documented as to why that frequency was chosen, and outlined in the plan of care
- It is advised intermittent attempts be made and documented to move the care, or least titrate it, to the patient, nursing staff or other caregivers

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Documenting Skilled Maintenance Throughout Episode of Care

What stays the same?

- Timing of therapist visits, progress notes, and reassessments does not change
- Criteria for documenting medical necessity (why the patient needs the services) and skilled services (why these services could only be provided by a therapist) does not change
- Services provided must be patient-specific and effective
- Focus of treatment can be patient or caregiver focused

What is different?

- PLOF is less of a factor (but should still be documented)
- Impact of the chronic disease (and its progression) is emphasized
- Duration of care is less predictable and typically lower frequency and potentially longer episode

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Documenting Skilled Maintenance Throughout Episode of Care

Commonly observed errors with skilled maintenance documentation:

- **Goals:**
  - Written to improve function
  - Written without clear "maintain" or "slow progression" language that may render a reviewer uncertain as to whether or not the goal was written to improve function
- Interventions described in a way that suggests that they did not require therapist skill
- "Fair" or "Poor" rehab potential
- Cloning details from one note to the next

"Claims for skilled care coverage must include sufficient documentation to substantiate that skilled care is required, that it was in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication." (CMS)

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Transitioning to Skilled Maintenance After Rehabilitative Therapy

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When a patient under rehabilitative therapy plateaus…

- Determine the cause of the plateau and update the treatment plan
- **It's NOT "skilled maintenance" when a patient plateaus under a treatment plan aimed at goals to improve**

"In regards to establishing treatment goals, the goals cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment restoration to maintenance. Instead, it would make such a change on a prospective basis only." (CMS)

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Common Transition Scenarios

Rehabilitative goals met or not achievable:

- Transition to therapist-developed program (carried out by patient/caregiver)
- Transition to therapist-provided skilled maintenance program

"A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel." (CMS)

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Transition to a Functional Maintenance Program (FMP)

Best practice is to develop and train the FMP (or HEP or RNP) while the final functional goals to improve are not yet met

- If rehabilitative functional goals have been met or are not achievable:
  - Discontinue the met/unachievable functional goals to improve
  - Add a goal related to training the FMP
- Adjust frequency/duration to reflect the time it is anticipated to take to train the FMP

Examples of FMP goal structure:

Patient will demonstrate (ENTER compensatory technique or action) with (ENTER % and Cue Type) in order to maintain (ENTER function/action and measure).

Caregiver(s) will demonstrate (ENTER the caregiver technique or action) with (ENTER % and Cue Type) to facilitate continued ability of patient to maintain (ENTER function/action and measure).

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Transition to FMP with Follow-Up Reassessment

If reassessment of trained FMP is planned:

- Discontinue the goal related to training the FMP
- Add a goal related to the expected outcome at the planned reassessment visit
- Adjust frequency/duration to reflect timing of the planned reassessment(s)

On (ENTER time frame such as in 3 week or bi-weekly) reassessment, patient's ability to (ENTER function) will be maintained at (ENTER measure) through (ENTER independent or caregiver provided) program.

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Transition to Skilled Maintenance

Therapist-provided skilled maintenance:

- Due to patient's complex current medical and clinical condition
- Due to complexity and sophistication of the services required to maintain function
- Never based on diagnosis alone

Complete an Updated Plan of Care (UPOC) / Functional Reassessment (FR):

- Explain the need for the therapist to provide skilled maintenance services
- Adjust STGs and LTGs to reflect maintaining or slowing decline in function

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Justifying Skilled Maintenance

Provide clinical reasoning to justify the skilled maintenance plan:

- Describe the specific medical conditions and clinical circumstances that make the patient complex
- Describe the complex and sophisticated treatments that will be needed
- Explain the risk if the service was not performed by the licensed therapist

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Justification

Example of justification structure:

The patient is no longer appropriate for a therapy program focused on making gains in functional ability because **(ENTER reason - such as goals met, no longer has potential to make functional gains).** Patient is being transitioned to skilled maintenance. Goals are being adjusted to reflect this change in treatment focus. This patient will require a therapist's skill to carry out these interventions because of the following conditions: **(ENTER specific and current complex medical and clinical conditions),** and the need for the skills of a therapist to safely and effectively carry out the complex treatment required including **(ENTER the complex analysis/monitoring that will be required when carrying out the services and why, and/or the complex treatment techniques required - that an aide couldn't provide)**. Without the skills of the **(ENTER PT/OT/ST)** in providing these necessary services, the patient would **(ENTER what would happen without PT/OT/ST providing these services or what would occur if the services were attempted by an aide and not carried out skillfully by a therapist).**

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Justification Example

Mr. Avery is no longer appropriate for a therapy program focused on making gains in functional ability because he has reached his current maximum potential. He is being transitioned to skilled maintenance. Goals are being adjusted to reflect this change in treatment focus. Mr. Avery will require a therapist's skill to carry out these interventions because of the following conditions: post-CVA with varying tone and spontaneous knee buckling affecting his ability to walk short distances safely within his room, such as to go to the bathroom. Because of the unpredictable nature of his tone and the impact it has on his walking ability, he requires the skills of a therapist to safely and effectively carry out the complex neuromuscular reeducation techniques required to manage varying tone levels to retain available ROM and allow functional weight shifting and swing phase completion during gait. Without the skills of the PT in providing these necessary services, the patient would experience persistent increases in tone, increases in knee buckling, increased fall risk, and a decline in ability to walk. Without further skilled therapy, it's likely that Mr. Avery would become completely wheelchair-bound.

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Prognostic Indicators

- Patients must have potential to achieve the goals to maintain or slow the decline in function
- Prognosis/Rehab potential: the likelihood that the patient will meet their established LTGs
- Prognostic indicator: positive attributes and conditions that the patient has in them or surrounding them that make the therapist believe that the patient will meet the LTGs

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Ongoing Skilled Maintenance

Skilled Analysis of Status Toward Goals

- Explain why the STGs to maintain were or were not met

Analysis and Adjustments

Highlight the Skilled Services Provided

- Highlight what has been introduced, modified, or adjusted during this Progress Reporting Period; OR
- Describe the treatment intervention in such a way that the complexity is evident and it's very clear that an unskilled caregiver or aide could not carry out the specific elements of the intervention; OR
- Document the variability in the patient's condition that had been previously present, was less variable this Progress Reporting Period, and as such, based on analysis, modifications or adjustments to the treatment were not needed. (This situation should not be ongoing as once frequent analysis and adjustments are not needed, then the care should be transitioned to an unskilled caregiver/aide)

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Keep in mind…

Repetitive activities, tasks, exercises, or cues are generally not considered skilled

Image from iStock

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Auditing Skilled Maintenance Documentation

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"Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist or by a qualified therapist assistant under the supervision of a qualified therapist because it could safely and effectively be accomplished by the patient or with the assistance of nontherapists, including unskilled caregivers, such maintenance services will not be covered." (CMS)

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Auditing Skilled Maintenance Documentation Quality *Evaluation*

1. Are the STGs and LTGs written to maintain or slow the decline in a specific function?

2. Is the patient's condition described in complex terms, or the treatment described in complex/sophisticated terms, to justify that the therapist's skills are needed to develop or carry out a skilled maintenance program?

3. Does the patient have a positive prognosis (generally good or excellent)?

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Auditing Skilled Maintenance Documentation Quality
Transition at UPOC/Functional Reassessment

1. Are the STGs and LTGs revised to maintain or slow the decline in a specific function?

2. Is the patient's CURRENT condition described in complex terms, or the treatment described in complex/sophisticated terms, to justify that the therapist's skills are needed to develop or carry out a skilled maintenance program?

1. Does the patient have a positive prognosis (generally good or excellent)?

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Auditing Skilled Maintenance Documentation Quality
Progress-Type Notes

1. Are the STGs and LTGs written to maintain or slow the decline in a specific function?

2. Did the patient achieve most maintenance STGs? If not, is there an explanation for why the patient is not achieving the goals to maintain/slow decline, and was the treatment plan updated?

3. Is there rationale for why the patient is or is not meeting their maintenance goals? Does the rationale make clinical sense?

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Auditing Skilled Maintenance Documentation Quality – *Progress-type Notes*

4. Is there a highlight of the skilled services provided?
   - Introduced new exercises, activities, interventions, types of cues with enough detail to make clear the changes
   - Focused on different, specific task segments and the related impairments
   - Trained new task elements, or specific strategies
   - Modifications or adjustments to the exercises/activities already in place based upon analysis. It may be that the modifications or adjustments are varying daily as a result of the patient's changing presentation, but typically are not in a progressive manner over time
   - Complex technique applied that an aide or caregiver couldn't do

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Skilled Maintenance Summary

- Skilled maintenance is a Medicare benefit
- **The services provided must be so complex and sophisticated that they could ONLY BE PROVIDED by licensed rehab professionals and could not be replicated by an unskilled caregiver**
- SKILLED MAINTENANCE plan of care should:
  - Highlight the complexity of the patient
  - Identify purpose for skilled maintenance
    - Maintain current condition
    - Slow further deterioration
  - Clearly state and support the need for skilled services to achieve purpose
- LTGs and STGs must relate to maintaining or slowing the decline in function. If the goals are to improve, then it's not a skilled maintenance program

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THANK YOU!

Questions?

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