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Maintenance Therapy in Home Health Revisited: Part 2

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1

Learning Outcomes

Upon completion of this course, participants will be able to:

1. Explain Medicare regulations pertaining to therapy provision in the home health setting
2. Describe the difference between restorative and maintenance therapy
3. Describe the home health G-codes for therapy billing and related EMR service codes
4. List documentation criteria for maintenance care in home health
5. Identify OASIS data to justify maintenance level therapy provision

2

Review of Part 1

3

OASIS, Functional Reassessments and Maintenance

Q. Do I still have to perform functional reassessments on maintenance cases?

A. **YES**. All reassessments (restorative and maintenance) are to determine **effectiveness** of the plan of care for the established goals.

Q. Do we still need to complete OASIS Assessments?

A. **YES.** Nothing has changed regarding home health agency requirements for OASIS submission at SOC, ROC, Transfer, Follow up and DC.

4

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Home Health Therapy Coverage

- Medicare Part A – CHHA
- 3 options for coverage once COP's and eligibility criteria are met.
  - Homebound criteria, Medical Necessity, Reasonable and Necessary, Under the care of a physician, Intermittent need for services. (Medical Necessity Resource available for free from Home Health Section of APTA website…www.homehealthsection.org).

1. Restorative – Expectation for material improvement.
2. Maintenance - When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury.
3. Maintenance - Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program.

5

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Maintenance – 2 options

CMS Expectation is to be completed on the last visit to the home and if not, why not?

- When designing or establishing a maintenance program, the qualified therapist **must teach the patient or the patient's family or caregiver's** necessary techniques, exercises or precautions as necessary to treat the illness or injury.

Must be inherently complex and can only be performed by a therapist (not an assistant).

- Maintenance - Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and **skills of a qualified therapist ("skilled care") are necessary for the performance** of a safe and effective maintenance program.

6

Utilization of Maintenance Therapy

- PT maintenance – 2017 – 0.72%
- OT maintenance – 2017 – 0.75%
- SLP maintenance – 2017 – 0.48%

- *data provided by Poltilove J. Home Health Line. Home health agencies' use of maintenance therapy 2013-2017. Decision Health. June 18.2018 Vol 43. Issue 25.

- Why so low?
- Two possible reasons – Impact on STAR Ratings and Value Based Purchasing Program

7

Who provides maintenance therapy?

- Only PT's, OT's and SLP's are allowed to provide maintenance therapy visits as each visit consists of an ongoing assessment of the patient's condition.

- PTA's and COTA's are not allowed to perform maintenance therapy by CMS regulations in home health.

8

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Frequency and Duration

- The amount, frequency, and duration of the services must be reasonable.
- Not specifically defined by CMS.
- However, general consensus is less total visits with lower frequencies.
  - For example, 1-2x per week x 1 week then taper to 1x per week to 1x every 2 weeks.

9

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Billing G codes - Restorative

- **G0151** – Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes;
- **G0152** – Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes;
- **G0153** – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes;
- **G0157** – Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes; and
- **G0158** – Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

10

CONTINUED

Billing G codes - Maintenance

- **G0159** – Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes;
- **G0160** – Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes; and
- **G0161** – Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

11

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Service Codes

- Be clear to explain service codes to staff:
  - **Restorative Therapy Visit**
  - Connected to G0151, G0152, G0153, G0157, G0158
  - **Maintenance Therapy Visit**
  - Connected to G0159, G0160, G0161
- Billing and IT must be involved in setting up billing and EMR – point of service – codes

12

CONTINUED

Patient Selection – Scenario 1

- Patient is an 75 year old female referred for home care with Dx of pneumonia.
- Upon completion of the 30 day functional reassessment for performing restorative care, the PT realizes that the patient has not made any significant progress in therapy.
- The patient lives alone and has intermittent help with meals, shopping, laundry and housekeeping by family.
- Functionally, she is at a supervision level in her apartment for ambulation and transfers.
- She gets dyspneic with ADL's.

13

CONTINUED

Patient Selection – Scenario 1

- How do we decide if she is appropriate for maintenance?
  - 1st. Is the patient at risk for deterioration (due to a disease state, illness, medical condition? (Or is it decline related to aging)?
    - If aging related – is this deterioration? Probably not…
  - 2nd. Determine if care you are considering to provide is considered skilled or custodial in nature?
    - Maintenance option 1. Train caregiver/beneficiary in maintenance program.
    - Maintenance option 2. Provide the maintenance program yourself. (What is inherently complex that you need to provide the program?)
  - 3rd. If yes to question 1 and 2, discuss the case with your supervisor for further direction.

14

Patient Selection – Scenario 1

- Is the patient at risk for deterioration (due to a disease state, illness, medical condition)?
  - Yes, the patient is at risk for deterioration due to medical condition. Patient has COPD. Chronic disease.
    - Justify decision by determining what level of COPD patient has using other tests, pulmonary function testing results, etc.?
    - Auscultation reveals abnormal breath sounds.
  - If the patients regression would be slow and related to aging process, this would not be covered.

15

Patient Selection – Scenario 1

- Determine if care you are considering to provide is considered skilled or custodial in nature?
  - Yes, it is considered skilled care and program can be taught to patient/caregiver.
    - Breathing exercises, postural awareness and training to maintain present status, postural drainage, oxygen management, pacing, energy conservation, teaching patient to monitor for decompensation.
  - Or, Yes it is considered skilled care that only the PT can provide the patient.
    - Chest PT, percussion, vibration.

16

The past is a predictor of future results

- Look at the patient's more recent history.
  - Prior hospitalizations? How many? When did they occur?
  - Is there already a pattern of deterioration?
    - What is deteriorating? ADL's? Increasing frequency of falls? Medication errors? Ability to transfer?
    - Use risk stratification tools available in the EMR
    - Review OASIS M1033 for risk factors for rehospitalization
  - Partner with Performance Improvement dept. for trends (provide the bird's eye view) to assist in documentation.
    - Rehospitalization risk/rates.

17

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

OASIS Risk Factors - Rehospitalization

18

Justifying your decision – Use the Potentially Avoidable Event List

- Emergent Care for Injury caused by fall
- Emergent Care for Wound Infections, Deteriorating Wound Status
- Emergent Care for Improper Mediation Administration, Medication Side Effects
- Emergent Care for Hypo/Hyperglycemia
- Development of UTI #
- Increase in Number of Pressure Ulcers
- Substantial Decline in 3 or More ADL's
- Substantial Decline in Management of Oral meds
- Discharged to the Community Needing Wound Care or Medication Assistance
- Discharged to the Community Needing Toileting Assistance

19

Comparing apples to apples – Risk Adjustment

What risk factors are used in adjustment?

- OASIS data items, including factors such as age, patient living situation, diagnoses, wounds, dyspnea, urinary incontinence, sensory impairments, dependence in bathing, pain, etc.
- The risk factors are based on the start or resumption of care assessment and therefore represent baseline patient status for the episode of care.

20

Let's get back to maintenance…

21

Patient Selection – Scenario 2

- Patient is a 45 year old male with MS x 7 years with severe spasticity and hypertonicity in LE's – adductors, knee flexors, neurogenic bladder with multiple UTI due to urinary retention. New to self-catheterization.
- Non-ambulatory and requires Hoyer lift for transfers due to excessive flexion in B knees.
- Look again at the potentially avoidable event list.

22

Potentially Avoidable Event List– Patient Selection – Scenario 2

- Emergent Care for Injury caused by fall
- Emergent Care for Wound Infections, Deteriorating Wound Status
- Emergent Care for Improper Mediation Administration, Medication Side Effects
- Emergent Care for Hypo/Hyperglycemia
- **Development of UTI #**
- **Increase in Number of Pressure Ulcers**
- **Substantial Decline in 3 or More ADL's**
- Substantial Decline in Management of Oral meds
- Discharged to the Community Needing Wound Care or Medication Assistance
- **Discharged to the Community Needing Toileting Assistance**

23

Patient Selection – Scenario 2

- Is the patient at risk for deterioration?
- Would care provision be considered skilled?
- Can the care be transferred/taught to caregiver?

24

Scenario 2

- You decide. Yes and Yes to Questions 1 and 2
- The patient is at risk for deterioration and the care provided is skilled.
- Additionally, you decide that the care must be performed by therapist.
- What is next?

25

Patient Scenario 2 - Documentation

- Create the Plan of Care.
- Interventions and Goals
- If the therapy is maintenance then create maintenance goals

26

Interventions – Generic

- Therapist will perform maintenance ROM / strengthening / ADL program
- Instruct caregiver(s) in maintenance ROM / strengthening / ADL program
  - Therapist/CG will perform stretching exercises to appropriate extremities/trunk areas
  - Therapist/CG will perform bed mobility activities
  - Therapist/CG will perform transfer training & weight-bearing exercises
  - Therapist/CG will perform ambulation/locomotion activities
  - Therapist/CG will perform positioning to prevent contractures and skin breakdown
  - Therapist will perform joint mobilization techniques for pain management
  - Therapist will perform splinting to prevent contractures

27

Interventions –Therapists performs

- Therapist will perform maintenance ROM / strengthening / ADL program
  - Therapist will perform stretching exercises to appropriate extremities/trunk areas
  - Therapist will perform bed mobility activities
  - Therapist will perform transfer training & weight-bearing exercises
  - Therapist will perform ambulation/locomotion activities
  - Therapist will perform positioning to prevent contractures and skin breakdown
  - Therapist will perform joint mobilization techniques for pain management
  - Therapist will perform splinting to prevent contractures to hamstrings.

28

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Goals

- Caregiver to be competent in safely performing a stretching / strengthening program in order to maintain the patient's current ROM / strength and assist in safe ADLs
- Patient to maintain current ROM necessary for positioning to prevent pressure ulcerations
- Patient to maintain current ROM/strength to prevent further deterioration of ADLs
  - Caregiver will demonstrate safe & effective stretching techniques
  - Caregiver will demonstrate safe & effective strengthening exercises
  - Caregiver will demonstrate safe ADL activities with patient
  - Patient will maintain current level of bed mobility
  - Patient will maintain current level of transfer activities
  - Patient to maintain current level of ambulation/locomotion activities
  - Pain will be reduced/controlled

29

CONTINUED

Patient Scenario 2

- Interventions:
  - Therapist will perform maintenance ROM / strengthening / ADL program
    - Therapist/CG will perform stretching exercises to appropriate extremities/trunk areas
    - Therapist/CG will perform positioning to prevent contractures and skin breakdown
- Goals:
  - Patient to maintain current ROM necessary for positioning to prevent pressure ulcerations
  - Patient to maintain current ROM/strength to prevent further deterioration of ADLs
    - Patient will maintain current level of bed mobility
    - Patient will maintain current level of transfer activities

30

Patient Scenario 2 - documentation

- Document reason for deterioration:
  - Patient is at a high risk for developing UTI's, if adductor ROM and access to perineum is not maintained.
- Document skilled need:
  - Patient requires the skills of a therapist for safe stretching due to presence of spasticity and hypertonicity putting patient at risk for muscle injury during stretch by unskilled caregiver and patient is unable to stretch self.
    - Objectively measure
      - Use Ashworth Tone Scale. and record tonal level.
      - ROM – using goniometer in test positions

31

Practice

- Create a maintenance goal for a patient with end stage heart failure.
- Create a maintenance goal for a patient with Parkinson's disease.

32

Every visit must stand alone

- Must document ongoing medical need
- Reasonableness of care being provided
- Risk for decline
- Skill being provided
- Response to intervention

33

Maintenance therapy

- Is *NOT* considered a long term care program.
- It is not a given or assumed that care is provided indefinitely, although care may extend for an extended period of time.

34

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Case Scenario 3

- Hx. Cardiac, CA Hx, Kidney Issues, LT steroid use, oxygen, polyneuritis
  - Objective testing to document impairments
  - Prior Level of function
  - Prior hospitalizations
  - Is the care restorative or maintenance?
  - Is the care moving from restorative to maintenance?
    - If this is the case – maintenance option 1 – training caregiver – you must document why it cannot be completed at the last visit?

35

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Case Scenario 3

- Chronic weakness noted in LE's
- History of falls with injury
- Multiple hospitalizations for renal disease

- Discussion…
- Restorative care – look at Prior level of function
- Is maintenance indicated?

36

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Case Scenario 4

- Patient with MS receives 2 cert periods of therapy. Referred for PT one month after dc from 2nd episode of care.
- Evaluation indicates no difference in functional status from dc one month ago.
- Is this case appropriate for maintenance therapy?
- (+) functional impairments – Max A with amb 10 feet x 3 using RW.
- Could intervention be skilled (Y/N)?
- Is patient at risk for deterioration?

37

CONTINUED

Case Scenario 4

- What does the month without therapy mean when functional status is unchanged?
- Can maintenance be justified without deterioration?

38

Handling the "I'm Entitled…"

- Know the rules
- Know the details of the Jimmo Settlement
- Explain the rules
- Contact your supervisor/director for guidance
- Offer the ABN/NOMNC forms correctly and as appropriate to provide care not covered by Medicare

39

Thank You!

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40

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41

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42