BEGIN WITH THE END IN MIND

- What we (and insurers) want for our patients:
  - Fewer re-hospitalizations
  - Fewer regressions
  - Improved quality of life
  - Achievement and maintenance of highest level of function
  - The ability to remain in the most independent location along the continuum
  - Decreased cost

BACKGROUND

- **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**

RECENT UPDATE: 8/18/2016

- **Judge orders Medicare Agency to comply with settlement in "Improvement Standard" case and provide more education.**
- The order requires CMS to remedy the Educational Campaign, which was a cornerstone of the settlement agreement.
- The goal continues to be ending the practice of denying coverage to tens of thousands of Medicare beneficiaries by replacing the illegal "Improvement Standard" with a maintenance coverage standard.

UPDATE: 2/16/2017

- Corrective Action Statement provided by CMS was approved by the courts. It includes:
  - Per ruling, training for Medicare contractors and adjudicators must be implemented by 9/4/2017.
  - New web page dedicated to Jimmo is available on the CMS website.

CMS WORDS

- **No "Improvement Standard" is to be applied when determining Medicare coverage for maintenance claims that require skilled care.**
- **Restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.**

CMS WORDS

- **A service is not considered a skilled therapy service merely because it is furnished by a therapist.**
- **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 the therapist furnishes the service.**

CMS WORDS

- **Coverage for skilled maintenance depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves.**
- **If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services.**

NEW YORK TIMES


The New York Times

HEALTH

Failure to Improve Is Still Being Used, Wrongly, to Deny Medicare Coverage

NEW YORK TIMES

Medicare beneficiaries often hear such rationales for denying coverage of skilled nursing, home health care or outpatient therapy: “They’re not improving. They’ve reached a plateau.” They’re “stable and chronic” or have achieved “maximum functional capacity.”

Deanna Kirby wasn’t buying it. “I knew they couldn’t refuse you, even if you’re not improving,” she said.

She’s right. A federal judge last month ordered the federal Centers for Medicare and Medicaid Services to do a better job of informing health care providers and Medicare adjudicators that the so-called improvement standard was no longer in effect.

WHAT IS SKILLED MAINTENANCE?

Glenda Jimmo, et al. vs. Kathleen Sebelius (Jan 24, 2013)

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.

IN THE WORDS OF CMS

CMS MANUAL TRANSMITTAL 179; *PAGE 5/118,* DATED: 1-14-2014

- ***"No 'Improvement Standard' is to be applied in determining Medicare coverage for maintenance claims that require skilled care."***
- ***"…restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.*** *Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."*

CMS SUPPORT- BASED ON CMS MANUAL TRANSMITTAL 179 DATED: 1-14-2014

- **A service is not considered a skilled therapy service merely because it is furnished by a therapist.** If a service can be safely and effectively furnished by an unskilled person, without the direct supervision of a therapist, the service cannot be regarded as a skilled therapy service even when a therapist actually furnishes the service.
- **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 the therapist furnishes the service.**

CMS SUPPORT

- Coverage for skilled maintenance depends not on the beneficiary's restoration potential, but on **whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves.**

CMS SUPPORT (CONTINUED)

If the services **required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services**. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of a maintenance program.

CMS SUPPORT- BASED ON CMS MANUAL TRANSMITTAL 179

- …establishing that a maintenance program's services are reasonable and necessary **would involve regularly documenting the degree to which the program's treatment goals are being accomplished.**

In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness is achieving its goal. When the maintenance program is intended to slow further deterioration of the patient's condition, the efficacy of the services could be established by documenting that the natural progression of the patient's medical or functional decline has been interrupted…

SKILLED MAINTENANCE

Rehab Focus

- Identification of patients
- Provision of service
- Development of transition plan
- Training of caregivers

Outcomes

WHAT AREAS OF REHAB PARTNERSHIP ARE EVIDENT IN YOUR PROGRAMMING?

- Quality of care
- Quality of life
- Prevention of rehospitalization
- Maintenance of function or slowing of decline

SOME RULES:
WHO MAY PROVIDE SKILLED MAINTENANCE

- **Therapist ONLY:**
  - SNF Part B
  - Home Health
- **Assistant may provide:**
  - SNF Part A

Applying the maintenance concept to the OT framework

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OCCUPATIONAL THERAPY

Achieving health, well - being and participation in life through engagement in occupation.

How can a skilled maintenance program achieve this?

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- Encompasses a variety of occupations within different contexts and settings
- Pertains to physical, process and social interaction skills
- Includes a variety of body functions and skills
- How can you advocate for maintenance within your practice setting?

PROCESS

- Client centered goals are identified for maintenance.
- Eval – analysis helps determine the focus.
- Intervention needs to be implemented, then reviewed based on outcome.

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MAINTENANCE INTERVENTIONS

Can be occupations and activities

Can be preparatory tasks and methods that support occupational performance

Can be education and training

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ELEMENTS USED IN CLINICAL REASONING

Relevance to client

Objects that are essential to the task

Space and social demands

Sequencing

Actions needed , body structures and functions involved

Purposeful occupation

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APPROACHES FOR SKILLED MAINTENANCE

- Create and promote
- Maintain
- Modify
- Prevent

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ADDITIONAL SUPPORT FOR SKILLED MAINTENANCE

- Development of secondary conditions
- Presence of co-morbidities in those with disabilities and multiple chronic conditions
- Maintaining health and well-being in community-dwelling older adults
- Conditions with fluctuating presentation.

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PATIENT EXAMPLES

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MULTIPLE EPISODES

- Many patients receive multiple episodes of OT each year.
- Is it possible that some (especially if seen for the same medical diagnosis) would have been good candidates for skilled maintenance?

2 OT EPISODES IN 2.5 MONTHS

MEDICAL DX: HISTORY OF CVA

- 1st episode: 1/22/16-2/5/16
  - **Carry-over program**: *W/C modification with photos*
  - **Overall function at d/c**: *Cushion prevents sliding and falls out of w/c.*
  - **Reason for d/c**: *Goal to improve w/c positioning to decrease sliding and falls achieved.*
- 2nd episode: 3/15/16-4/1/16
  - **Overall function at SOC:** *Patient complaining w/c is uncomfortable and she can't move it.*
  - **Carry-over program followed?** *It appears cushions are still in use.*
  - **Overall function at d/c:** *Moving chair with supervision and is comfortable.*
  - **Type of carry-over program:** *Not mentioned.*

WOULD BRIEF SKILLED MAINTENANCE HAVE HELPED?

- What might make it skilled?
- What do OTs see when we change positioning vs. what everyone else sees?

ADDITIONAL PATIENT EXAMPLE

- Mr. Brown was a 67-year-old outpatient following surgical rotator cuff repair at an outpatient ambulatory care surgery center. The surgeon noted that the tissue did not hold sutures well and feared that the unstable soft tissue supporting the joint would tear again without careful monitoring and slow, systematic rehab progression.
- Skilled rehab at an outpatient clinic for 2 weeks led to the OT's establishment of a ROM exercise program.

TRANSITION TO SKILLED MAINTENANCE

- Mr. Brown's ROM exercise program had become a routine program, but skills of a therapist were needed to maintain joint alignment and closely monitor performance of the ROM program to assure patient stayed within established ROM guidelines to allow compromised tissue to heal. Therapist also assessed patient's pain level and reported to the surgeon on a regular basis.
- Mr. Brown continued on skilled maintenance with the therapist 3x/week for 3 weeks and then 2x/week for 3 weeks.
- After this (8 weeks post surgery), Mr. Brown was able to initiated skilled rehab again to begin gradual strength training.

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CLINICAL DECISION-MAKING

- **Skilled maintenance is a clinical thought process and decision like any other.**
- We ask a series of questions throughout the episode of care:
  - What changed and why?
  - What are the impairments and their measures?
  - How much time will this take?
  - What is the discharge plan and long-term goal?
  - What skills did I provide and what needs to change next week?
  - Has the long-term goal been met?
- <u>But are we missing something?</u>

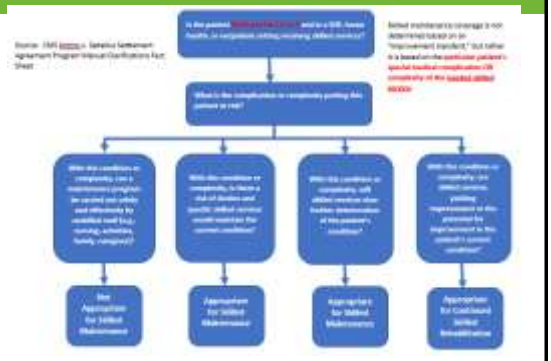
WE SHOULD ALSO BE ASKING

- My patient has completed rehab. <u>What is next?</u>
- What is needed to maintain this level or prevent regression?
- Am I sure this can be accomplished by the patient or his/her caregiver?
- If not, what is so skilled or sophisticated about it that requires me to do it or oversee it?
- This would be **SKILLED** maintenance.

WHAT ABOUT PROGRAMS THAT ARE NOT FOLLOWED?

- When programs are not followed do we naturally assume it is due to "no time," "no restorative," or "patient not compliant"?
- Should we be asking different questions:
  - What impairments are being addressed with this program? Can the caregiver really do this?
  - When caregiver says he or she just could not follow the program, do we honestly ask if it's because the program was too skilled for the caregiver?
  - Have we assessed if the carry-over program really does require either skilled oversight or skilled implementation?
  - Did this patient regress in the areas that the home exercise program was supposed to maintain?
  - Is there a recent rehab episode for the same diagnosis?

SKILLED MAINTENANCE DECISION TREE



WHY IS THIS IMPORTANT?

- Keep patient well longer.
- May lead to a shorter length of stay as an inpatient.
- Keep patients out of higher cost locations for longer periods of time.
- Insurers are expecting this.
- Isn't staying well what our patients deserve?

VOLUME TO VALUE

- We know CMS and other payers are moving from paying for volume to paying for value.
- Isn't keeping people well and maintaining their abilities a value proposition?
- If that maintenance can be directed only in a skilled fashion, that is VALUE.
- This reduces cost down the road.

WHAT ABOUT FREQUENCY?

- Decisions must be individualized, just like rehabilitative treatment.
- There are many possible scenarios. Not one size fits all.
- You may be:
  - Providing the program
  - Observing the program being provided
  - Some combination of the two
- You may, at some point, be satisfied that care-givers can carry out the program but keep patient on 1 time per month to assess status.

FREQUENCY OPTIONS

NOT AN INCLUSIVE LIST

- Due to risk and constant adjustment, you provide the skilled maintenance program 5 times per week.
- After 4 weeks, you begin to titrate down. You maintain frequency of 5 times per week with 2 of those sessions providing monitoring of caregiver ability to adjust as needed.
- At the end of 2 weeks of the above, you assess the patient and determine that you can safely reduce to 3 times per week: 1 time providing the program and 2 times monitoring the provision by caregivers.
- After 2 weeks of the above, you assess the patient and determine that status is being maintained.
- You decrease to 1 time per week for re-assessment of patient status for 4 weeks.

FREQUENCY OPTIONS (CONTINUED)

NOT AN INCLUSIVE LIST

- You provide the skilled maintenance program 3 times per week for 3 weeks.
- After 3 weeks your patient has maintained, so you reduce the program to 2 times per week.
- After 3 weeks of 2 times per week, your patient has begun to regress, so you increase back up to 3 times per week.

FREQUENCY OPTIONS (CONTINUED)

NOT AN INCLUSIVE LIST

- You see your patient for skilled maintenance 2 times per week.
- During sessions, the caregiver is providing the program. You are assessing the caregiver's ability to adjust as needed based upon patient presentation each day.
- After 2 weeks, it is clear the caregiver can adjust as needed.
- You decrease to 1 time per month to assess patient status for any regressions.
- After 2 months, patient has maintained and you discharge.

DOCUMENTATION

- You are not trying to restore function.
- The documentation must clearly articulate why the service MUST be provided by a therapist.
- The documentation must describe what is so complex or sophisticated about this case that the skills of a therapist are required to safely carry out or oversee the program.
- The plan should clearly indicate that this is a skilled maintenance situation.

CMS WORDS

- **…establishing that a maintenance program's services are reasonable and necessary would involve regularly documenting the degree to which the program's treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness in achieving its goal. When the maintenance program is intended to slow further deterioration of the patient's condition, the efficacy of the services could be established by documenting that the natural progression of the patient's medical or functional decline has been interrupted…**

CMS WORDS

- **The documentation in the medical record must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:**
  - **"Patient tolerated treatment well"**
  - **"Continue with POC"**
  - **"Patient remains stable"**

DOCUMENTATION EXAMPLE 1

- **Reason for Referral**: Patient experienced an R humeral fracture which is unhealed and unstable. Surgery is not an option at this time. Maintenance of ROM and prevention of contractures in RUE is severely compromised until healing has occurred. OT is required to provide the ROM program to maintain the extremity in optimal anatomical position for healing, reduce potential for further injury and assess changes or symptoms of improper healing. Recruitment of specific muscle groups is contraindicated for healing, and this can only be monitored by OT.

DOCUMENTATION EXAMPLE 1 (CONTINUED)

- **STG:** Patient will maintain current AROM of R wrist, elbow and gravity eliminated shoulder abduction to allow for function once healing has occurred.
- **LTG:** Patient will maintain ROM of RUE throughout healing process of R shoulder.

DOCUMENTATION EXAMPLE 1 (CONTINUED)

- **Skilled Service:** Patient assessed for presence of increased edema in RUE. Goniometric measurements of all joints of RUE reveal no loss of ROM this week. Substitution noted during shoulder abduction movement. Patient requires stabilization and max cueing to avoid these potentially damaging movements. Results of sessions continue to be discussed with MD once per week.

DOCUMENTATION EXAMPLE 1 (CONTINUED)

- **Updates to Tx Plan:** Skills of a therapist remain medically necessary due to high probability of ineffective healing if exercise is not provided within the most optimal anatomical alignment possible. Observation for substitution remains necessary at each session.

EXAMPLE 2

- **Reason for Referral:** OT required for skilled maintenance of ROM of wrist and R hand. Changes in fluid retention, safety/integrity of skin, risk of pain with fluid retention, and potential for decline due to co-morbidity of diabetes require the skills of an OT to monitor. Patient has a long history of diabetes and currently receives dialysis 3 times per week. Prior ROM program is no longer effective due to increased extremity swelling and fluid retention. Nursing also notes ADLs now require assist of 2. Tolerance of edema management techniques fluctuates daily.

EXAMPLE 2 (CONTINUED)

- **STG:** Patient will maintain skin integrity of RUE and tolerate application of compression device.
- **LTG:** Maintain ROM in R wrist/hand to enable patient to assist with ADLs.

EXAMPLE 2 (CONTINUED)

- **Skilled Service:**
  - **Session 1**: Due to pain resulting from fluid retention, application of compression garment not viable on this date. Alternative edema strategies of positioning and massage utilized.
  - **Session 2**: Adjusted wearing schedule of UE splint due to increased redness noted in dorsal surface of R hand.
  - **Session 3**: Application of alternative compression glove trialed today. Alternative necessary due to improvement seen in levels of edema.
- **Progress Note**: Patient's level of edema and pain fluctuates daily. Daily adjustment of edema techniques is required as a result. Wearing schedule for splint has been adjusted due to redness noted in R dorsal hand.

EXAMPLE 2 (CONTINUED)

- **Updates to Tx Plan:** Due to high potential for skin related issues, will continue to monitor redness in R dorsal hand. Alternatives to splinting will be pursued if necessary. Continue daily monitoring of highly fluctuating levels of edema and pain.

CASE STUDIES

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CASE STUDIES
QUESTIONS TO ASK

- What factors demonstrate the complexity and sophistication of this program?
- What is being analyzed and adjusted in the plan from session to session in order to facilitate carryover?
- Why is OT still needed to provide this program and analyze the program for needed adjustments?

CASE STUDY
FUNCTIONAL DECLINE

- Seen for skilled OT treatment 5x/week for 4 weeks.
- OT then started skilled maintenance 1x/week
- Medical diagnoses impacting care: COPD, Parkinson's and schizophrenia.
- Treatment diagnosis: Muscle weakness

DOES THIS CONVEY THAT THE SKILLS OF A THERAPIST ARE NEEDED?

Goal: Caregiver(s) will demonstrate 100% accuracy of patient and caregiver body alignment as well as verbal cueing to facilitate continued ability of patient to complete safe functional transfers to and from her bed to wheelchair.

Goal: Patient will maintain her B UE shoulder ROM of WNL to allow for maintained ability to reach for her bed rail and complete basic grooming tasks with SBA.

- UE tremors, pain, and activity tolerance (related to Parkinson's, Arthritis and COPD) vary each day necessitating variable strategies to facilitate best performance.
- Patient's schizophrenia results in daily behavioral differences which require different types of cueing strategies to facilitate performance as well.
- 1x/week skilled maintenance is required to maintain effectiveness of carry-over programs and avoid regression due to highly variable function.

Weekly sessions focus on care-giver observation and instruction to compensate for variations in performance.

CASE STUDY
CONTRACTURE

- Seen for skilled OT 5 times per week for 2 weeks to implement a splinting plan for both elbows.
- OT then started skilled maintenance 5 times per week for 6 months at which time patient was discharged to acute hospital.
- Medical diagnoses impacting care: Contracture, hypoxic respiratory failure, persistent vegetative state.
- Treatment diagnosis: Contracture shoulders, elbows and hands.

DOES THIS CONVEY THAT THE SKILLS OF A THERAPIST ARE NEEDED?

Goal: Pt to tolerate BUE PROM with prolonged stretch with minimal facial grimace in pain.

Goal: Demonstrate PROM of B UE elbow extension of -60 degrees, improving ability for staff to perform elbow crease hygiene.

- E-stim is required to prevent worsening of contractures along with prolonged stretch and tapping techniques.
- Nursing staff unable to safely and effectively apply splints due to severe contractures, pain and variability from day to day.
- Staff report continued ability to perform hygiene as a result of continued OT involvement.

CASE STUDY
SITTING BALANCE

- Seen for skilled OT 3x/week for 2 months to implement seating system, improve forward reach and improve strength of core.
- Seen by OT for skilled maintenance 2x/week for 12 weeks for e-stim for strengthening of neck muscles and for observation of head control for meals and cares.
- Medical diagnoses: Multiple sclerosis, and anxiety impact this POC.
- Treatment diagnosis: Abnormal posture.

DOES THIS CONVEY THAT THE SKILLS OF A THERAPIST ARE NEEDED?

Goal: Improve sitting forward reach score to 7 inches resulting in min assist to perform self cares.

Goal: Patient will maintain neck/head control to allow for manual w/c use of 3 hours/day for meals/activities.

- Graded strengthening exercises were provided.
- E-stim for posterior neck muscles to maintain head positioning.
- Exercises to improve fine and gross motor coordination for joy stick use.
- Patient limited in what she could do in one day due to fatigue.

CASE STUDY
IMPROVEMENT OF SELF-FEEDING SKILLS

- Seen for skilled OT 5x/week for 8 weeks UE strengthening, training in adaptive feeding techniques and equipment, functional reach and coordination.
- Seen by OT for skilled maintenance 5x/week for at least 8 weeks for positioning and manual stretches.
- Medical diagnosis: Parkinson's
- Treatment diagnosis: Muscle weakness

DOES THIS CONVEY THAT THE SKILLS OF A THERAPIST ARE NEEDED?

Goal: Maintain LUE FM coord. At mildly impaired to allow for use during self-feeding.

Goal: Pt. will cont. to demo. L elbow 3+ and L shoulder 2+ strength to perform feeding and grooming with min assist.

- Strengthening exercises and coordination activities.
- Gentle ROM to head and neck.
- Caregiver training on proper alignment in w/c.

BEGIN WITH THE END IN MIND

- What we (and insurers) want for our patients:
  - Fewer re-hospitalizations
  - Fewer regressions
  - Improved quality of life
  - Achieve and maintain highest level of function
  - The ability to remain in the most independent location along the continuum
  - Decreased cost

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aegis
Angela Edney, OTR
Aegis Therapies
(954) 464-1176
Email: angela.edney@aegistherapies.com
www.AegisTherapies.com
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