Practice Issues Forum:
Does Medicare Really Cover Maintenance Therapy?

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Objectives:
1. Describe the peripheral and central benefits of exercise for persons with chronic conditions.
2. Discuss the class action "Improvement Standard" lawsuit (Jimmo vs Kathleen Sebelius) and its impact on physical therapy practice.
3. Describe patient cases that have benefitted from the change in local coverage determinations associated with the "Improvement Standard" lawsuit.
4. Describe strategies for documenting maintenance care to facilitate reimbursement.

CENTRAL AND PERIPHERAL BENEFITS
OF EXERCISE

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Chronic and Progressive Conditions:
Need for Ongoing, Skilled Intervention

- Central and Peripheral nervous system benefits
- Potential for exercise to slow progression or induce neuroprotection

CENTRAL BENEFITS OF INCREASED PHYSICAL ACTIVITY

Central Nervous System Changes with Exercise

- Activity-dependent CNS plasticity can optimize motor recovery
- Plasticity can be measured with fMRI, non-invasive brain stimulation, and brain-derived neurotrophic factor (BDNF)
**Aerobic Exercise: Central Benefits**

- **Following stroke, aerobic exercise increases BDNF**
  - Greater neuroplasticity by facilitating long-term potentiation/connection between neurons
  - Improved cognitive function (2-3x/week for 12 weeks at mod. intensity combined with resistance training) Kluding PM et al, 2011
  - Improved motor learning of motor sequence task following 8 week cycling program; mod intensity 3x/week for 45' however gains were lost at 8 weeks=need for persistent training Quaney BM et al, 2009

- **Improved cognition**
  - Information processing and motor learning:
    - Patients with chronic CVA: Cycling (45', 3x/wk, 8wks) (Quaney BM et al, 2009)
    - Improved information processing speed following intervention; gains in info. processing not retained at 8 wk f/u implying need for ongoing exercise
    - No change in executive function
  - Executive function
    - Patients with PD (Yareda K et al, 2009, Cruise KE et al, 2011)
    - Alertness, verbal learning and recall
    - Patients with MS (Behrin S et al, 2014)

- **Increased BDNF production:**
  - facilitate LTP and dendritic branching, but aerobic exercise alone is not capable of inducing these neuroplastic processes.
  - To have meaningful and lasting effects it likely needs to be paired closely in time with sufficient and meaningful practice or experience that is consistent with the desired behavioral change.

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**PERIPHERAL BENEFITS OF INCREASED PHYSICAL ACTIVITY**
Aerobic Exercise-Peripheral Benefits

- VO2
  - Treadmill training:
    - Chronic stroke (also ↑ walking efficiency) (Macko R et al 2005)
    - PD: low and high intensity (Shulman LM, 2013)
  - Bicycle Ergometry
    - Patients with MS (Briken S et al 2014)

Resistance Exercise: Peripheral Benefits

- Strength:
  - Chronic CVA: ↑ LE strength; greater improvements when combined with cardiovascular ex. (Veerbeek J et al, 2014)
  - PD:
    - Strength, mitochondrial function, and shift to less fatigable muscle fiber type (Kelly NA et al, 2014)
  - MS:
    - Strength: (Systematic review: Kjolhede T et al, 2012)
    - Improved MVC but gains lost after period of detraining (Medina-Perez C et al, 2014)

Resistance Training: Function and Participation

- PD: (Lima L et al 2013; Systematic review)
  - ↑ walking capacity (6MWT), sit to stand time in patients with mild/moderate disease severity
- MS: (Goddard K et al, 2011)
  - QOL and fatigue but no change in walking ability and gains were lost after the study period
- CVA (chronic): (Mack S et al, 2012; meta-analysis)
  - Improved walking speed and endurance

Multi-Modal Training

- Postural control
  - CVA (chronic): resistance + treadmill
    - ↑ BBS particularly in patients with low balance ability (Al-Jarrah M et al, 2014)
- Gait
  - MS: resistance + aerobic + balance
    - ↑ MS Walking Scale 12, gait speed and functional amb. profile score

Co-Morbidities

- Co-morbid conditions or factors that affect activity tolerance
  - Diabetes
  - Cardiovascular
  - DJD/pain
  - Obesity
  - Cognitive impairment
  - Fatigue, heat sensitivity

BARRIERS TO EXERCISE FOR PATIENTS WITH DISABILITIES: WHY PT OVERSIGHT IS NECESSARY
Condition-Specific Variables

- Low level of function affects type of exercise
  - ↑ need for family/caregiver support
  - Limited access to appropriate equipment or resources for exercise
- Cognitive impairment:
  - Impacts ability to progress an exercise regimen safely
  - Limited insight into impairments (↓ safety)

Societal/Social Barriers

- Lack of accessible equipment or fitness facilities
- Cost
- Fear of exercise facilities expanding support for those with disabilities (concern over liability)

References


References


References


Improvement Standard Lawsuit and its Impact on PT Practice

Roshunda Drummond-Dye, JD
Director, Regulatory Affairs
American Physical Therapy Association
Improvement Standard Lawsuit

Glenda Jimmo, et. al vs. Kathleen Sebelius

Case was filed on January 18, 2011
Proposed settlement agreement filed in Federal District Court on October 16, 2012
Preliminary Order to Approve Settlement filed November 20, 2012 (Contingent upon fairness hearing)
Fairness hearing held January 24, 2013 and final approval was given on that date

Issue Synopsis

- Contractors interpretation: “Improvement Standard” provider must show a “material improvement” in patient’s condition over a determined period in order to establish medical necessity
- 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
- Decision covers nursing and therapy services provided under both inpatient and outpatient settings

Medicare Statute

- Basis of medical necessity under the Medicare program

Social Security Act §1862(1) states in part, “payment may not be made under [Medicare] part A or part B for any expenses incurred for items or services — which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Reasonably and Necessary Summary

Services must be:
- Safe, effective, not experimental
- Appropriate in duration and frequency;
- Furnished in accordance with accepted standards of medical practice for the condition;
- In an appropriate setting
- Ordered and furnished by qualified personnel
- Appropriate to meet the need, but does not exceed the need
- Potential for improvement in response to therapy

Medicare Coverage Policies

- Local Coverage Determinations – issued by Medicare Administrative Contractors, Carriers and Fiscal Intermediaries
  - 90 % of Medicare coverage
  - Specific coverage requirements for your local area
  - Cannot conflict with national Medicare regulations
  - Examples: outpatient physical therapy services
- National Coverage Determinations – issued by CMS on a national basis
  - 10 % of Medicare coverage
  - Examples: cardiac and pulmonary rehabilitation and urinary incontinence

Making the Case for Coverage

42 CFR § 409.32 Criteria for skilled services and the need for skilled services (SNFs)

(a) (c) The 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.
Making the Case for Coverage

- 42 CFR §409.44(b)(3)(iii) Skilled Services Requirement (Home Health)
- "(iii) There must be an expectation that the beneficiary’s condition will improve materially in a reasonable (and generally predictable) period of time based on the physician’s assessment of the beneficiary’s restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program.

Regulatory Clarifications

- Medicare Home Health Prospective Payment System Calendar Year 2011 final rule
- Clarifies that therapy coverage criteria has always been based on the inherent complexity of the service which the patient needs
- "The unique clinical condition of a patient may require the specialized skills of a qualified therapist to perform a safe and effective maintenance program required in connection with the patient’s specific illness or injury. When 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... by the therapist... 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"

Standard for Coverage

- Is skilled professional needed to ensure nursing or therapy is safe and effective?
- Is a qualified nurse or therapist needed to provide or supervise the care?
- Regardless of whether the skilled care is to improve, maintain, or slow deterioration

First Step: Manual Revisions

- Transmittal 179
- Clarifications contained in the Medicare Claims Processing and Benefits Policy Manual (chapters applicable to home health, IRF, SNF and outpatient therapy)
- No rule of thumb application – care depends on whether skilled care is required (reasonable and necessary criteria), not restoration potential
- Inclusion of examples and documentation guidelines for each setting

IRF Manual Revisions (admission predicated upon restoration potential)

- IRF claim cannot be denied based on:
  - Patient could not achieve complete independence in the domain of self care
  - Patient could not return to prior level of functioning

Coverage of skilled therapy in the SNF does turn on the presence or absence of the potential for improvement

- Rather is based on the need for skilled care
- Does not exclude PTAs from providing skilled maintenance therapy


Coverage of maintenance therapy is not solely based on potential for improvement – rather for skilled care

- Covered when demonstrated that the skills, knowledge and specialized judgment of the qualified therapist is needed
- Based on individual condition of the patient and complexity
- Services must be provided by the PT (not PTA)

Outpatient Therapy

Program established by therapist to assist patient in maximizing or maintaining progress during therapy/prevent or slow decline

- A service is not considered skilled therapy merely because it is furnished a PT/PTA (or under direct or general supervision)
- Services must be provided by the PT (not PTA)

Example

- "A patient with Parkinson's disease may require the services of a physical therapist to determine the type of exercises that are required to maintain his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy and must be documented in the medical record."


Second Step: National Education Campaign

- Special Provider Outreach call – December 19th at 2pm
- Target Audience: Skilled Nursing Facilities; Inpatient Rehabilitation Facilities; Home Health Agencies; and providers and suppliers of therapy services under the Outpatient Therapy Benefit.
- http://www.eventsvc.com/blh/technologies
- CMS Fact Sheet: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf

Third Step: Accountability

- Re-review of previous denials
- Retroactive January 2011
- Appeal rights lie with beneficiary
- Claims review through established protocol of sampling of QIC claims
- Bi-annual meeting with plaintiffs counsel on claims review findings
- Expedited review and resolution of errors and denials
### What Happens When Services Are No Longer Medically Necessary?

**Rights of the patient**
- Periodically meet with your health care providers (i.e. therapist, physician, SNF) to understand treatment options
- Can continue to receive services and pay out of pocket
- Seek aid through local assistance programs (national Elder Locator program 800.677.1116)
- Right to appeal denied Medicare claims

**Rights of the provider**
- Furnish patient with an ABN
- Establish a maintenance program to be carried out by non-skilled individuals
- Can continue to collect payment out of pocket
- Coordination of services with physician and other health care providers to ensure a consistent message to the patient
- Right to appeal Medicare denied claims

### Medicare Appeals Process
- Redetermination (contractor)
- Reconsideration (qualified independent contractor QIC)
- Administrative law Judge (ALJ) Hearing
- Medicare Appeals Council (MAC) Review
- Federal Court

### Medicare Resources
- Medicare Therapy Services webpage: [http://cms.gov/Medicare/Billing/TherapyServices/index.html](http://cms.gov/Medicare/Billing/TherapyServices/index.html)

### APTA Resources
- APTA Medicare Coverage Page [http://www.apta.org/Payment/Medicare/CoverageIssues/](http://www.apta.org/Payment/Medicare/CoverageIssues/)
  - Technical briefs on lawsuit and settlement
  - Summary of manual provisions
  - Tips and highlights for physical therapists
  - Podcasts: overview of manual provisions and documentation
  - Setting specific tools and clinical application resources

### Questions?
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### CASE STUDY: PARKINSON'S DISEASE: OUTPATIENT SETTING

Mike Studer, PT, MHS, NCS, CEEAA, CWT, CSST  
President  
Northwest Rehabilitation Associates Inc.
Patient profile: JH

- An 85 y.o. male referred to PT for dizziness and imbalance.
- Present with festinating gait, forward-flexed ambulating without an assistive device. Unable to ambulate backwards. No episodes of freezing.
- LUE tremor: Restricted facial movement and trunk ROM
- Social hx: Lives with spouse in 1 story home; spouse is retired and has her own cardiac conditions as well as obesity.

Environmental and personal variables

- JH is not currently driving. His access to PT is dependent on his wife's availability and ability.
- JH is highly educated and receptive to the new diagnosis of PD.
- Physician receptive and initiates a successful trial of dopamine replacement therapy

Evaluation

- Gait: 2 min walk test 268'
  - Timed 10' retro = 13.38 seconds and unable to stop himself.
- Posture: Occiput to wall = -9.25''

Management and therapy goals

- Communicated plan of care to address frequency of falls
- Communicated suspicion of PD
- Re-assessment after 1 month of PT (5 visits) and home exercise program. Objective measures reveal improvement. No falls.
- Progress exam plan of care details plan for 1 month HOLD. Patient returns for re-exam

Skilled care transition to maintenance

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Rationale for maintenance care

- Treatment Diagnosis: ICD9: 332.0 Paralysis Agitans (Parkinsons Disease) and 781.2 Abnormality of Gait
- Severity: Mobility: Walking & Moving Around
- Current Status: G8978: 42% Impairment Level CK: At least 40 percent but less than 60 percent impaired, limited or restricted
- Projected Goal Status: 15% Impairment Level CI: At least 1 percent but less than 20 percent impaired, limited or restricted
Documenting skilled care past Medicare cap ($1920)

- SKILLED PT is required to frequently reassess patient’s function and adjust home exercise efforts OR resume regular care.
- Goals to keep patient safe and functioning at high levels in posture, gait, coordination, balance, and fall frequency. Degenerative disease, quarterly reassessment.

*Skilled PT due to assessment and revision of POC

Patient requires skilled PT, resuming at 1x/week after quarterly reassessment reveals:
- Comorbid health changes (MI, falls) in the last 3 months
- Objective reduction in functional performance: balance, strength, gait as compared to his baseline.
- Reasonable expectation of improvement, given his past history and objective findings

“Improvement Standard”

- Documented objective improvements
- Documented need for skilled reassessment with progressive disease
- Documented plan for disease management with accountability and stewardship

Skilled to maintenance & back

- Reassessments and objective needs dictate intervention

- NOT: Medicare cap
- NOT: Diagnosis
- NOT: Census
- NOT: Time of year

CASE STUDY:
ALZHEIMER’S DISEASE: ASSISTIVE LIVING SETTING

Travis King
Vice President of Quality Assurance and Professional Development
Fox Rehabilitation

THE IMPROVEMENT STANDARD: PATIENT PROFILE

JS is an 85 year old female with a primary medical diagnosis of:
- Alzheimer’s type dementia
- Osteoarthritis
- History of pneumonia
THE IMPROVEMENT STANDARD:

PATIENT PROFILE

- History of Present Illness:
  - 3 falls in the last 3 weeks
  - Right knee pain
  - Increased difficulty with transfers and ambulation
  - Increased fall risk
  - New resident to memory care unit of assisted living environment

- Prior Level of Function:
  - Independent with transfers and ambulation for 2000 feet with no assistive device
  - Living in residential home with caregiver available 8 hours each day

- Functional Outcome Measures:
  - Timed up and Go: 16 seconds with no assistive device
  - 5 Times Chair Rise: 28 seconds with use of both upper extremities
  - 6 Minute Walk Test: 46 meters in 1 minute 48 seconds

THE IMPROVEMENT STANDARD:

Patient JS

The Plan of Care:

- 24 visits between February 18th to June 17th
- Primary Interventions:
  - therapeutic exercise
  - gait training
  - neuromuscular reeducation
  - therapeutic activities

THE IMPROVEMENT STANDARD:

Patient JS

Timeline of Key Clinical Decision Making Points:

- February 2nd: Initial evaluation
- March 6th: Identification of pneumonia via decreased Spo2 and abnormal breathing sounds – Home activity program was not being completed consistently
- March 13th: First progress note. Gains were good but progress slowed due to mild pneumonia
- March 18th – April 8th: Gains made in strength and balance begin to demonstrate more significant functional carry over and program advances to outdoor ambulation and ability for outings
- April 10th: Increased attention on home activity plan and caregiver education

THE IMPROVEMENT STANDARD:

Patient JS

Timeline Continued:

- April 15th: Flipped the switch to skilled maintenance
- Assessment:
  - Pt has continued to demonstrate consistent gains in strength, balance, and cv stamina, as shown by FOMS chair rise test, TUG, and 6MWT, which has allowed for decreased assist with I/R and increased amb and amb safety consistency. PT has involved caregiver and PT has begun training in HEP in order to begin to progress toward change of POC to 2x per month for skilled maintenance therapy due to pt's progressive diagnosis of dementia. At this time, pt continues to have balance impairment, requiring skill of PT to address with advanced balance activities and lack of cv stamina, requiring skill of PT to monitor during cv stamina training. However, some seated and standing TE no longer requires the skill of the PT, and is being trained to caregiver as HEP. Over the next few weeks, plan to progress program in this way, discharging aspects to caregiver as HEP which become unskilled, and eventually treating 2x per month to update/change/progress program based on pt's status.
- April 15th – June 17th: 6 visits occurred during this time period with the last visit and discharge occurring on June 17th
- Final visit: All outcome measures maintained from April 15th progress note

THE IMPROVEMENT STANDARD:

DOCUMENTING SKILLED MAINTENANCE

- Skilled care techniques used to justify medical necessity:
  - Use of music for compliance and cadence based on GDS level 6
  - Vital sign monitoring and lung auscultation
  - Redirection techniques (i.e. “we gotta get outta here, I just want to get out of here” response: “We need to wait for your son to arrive at the therapy room”)
  - Used prior leisure activity of dance as a catalyst to activity
  - Deep breathing techniques
  - Modification of activity based on patient response

- Goals:
  - Modified goals to reflect maintenance rather than progression

RATIONALE FOR MAINTENANCE CARE

What were the factors that contributed to the clinical decision, made on April 15th, to proceed with a skilled maintenance plan of care?

- Patient reached her maximal ability
- Dynamic plan of care needed based on behaviors associated with dementia (i.e. redirection, daily program modification)
- Presence of highly motivated and willing caregiver
- Skilled balance program was needed to maintain gains
- Skilled need for monitoring vital signs
- Began intense education on home activity plan
- Daily activity was a high priority due to predisposition for pneumonia
Value of Proper Use of the Improvement Standard

- Total Visits: 24
- Total Cost (based on fee schedule): $3,226.06

What if a maintenance plan of care, such as the one described here, could eliminate frequent functional declines?

The Improvement Standard: Patient Profile KM

- Pt is a 70 y.o. female with a primary medical dx of PPMS who presented to PT initially in 3/14/2014 s/p botox injections for L acquired torticollis due to spasticity and cervical dystonia
- PMH: MS dx in 2010, R CVA with L hemiparesis in 2000, osteoporosis, falls, HTN(stable on meds)

Environmental and Personal Variables

- Social hx: Lives with spouse in 2 story home
- Spouse is retired and has R UE carpal tunnel syndrome, limited with transfers and unable to perform HEP with pt
- Private duty aides 6 days/wk 6 hours per day
- Bedroom on 2nd floor; stairglide to get there
- Has to sleep in tilt in space wheelchair if no aide at night

Evaluation

- Sensation: light touch: impaired B plantar aspect of feet; proprioception: absent L UE; Impaired b/l feet
- Edema: B pitting LE +2 ankle to toes
- Tone: MAS: B adductors and ankle plantar flexors 2/5; bilateral quads 3/5
- Pain: c/o burning B feet 3/10; L neck and headaches 4/10 at worst
- ROM: WNL with following exceptions: B ankle DF 5 degrees from neutral; L elbow lacking 10 degrees of ext
- Strength/Volitional movement: Bilateral UE 2+/5, B LEs unable to isolate movement w/ext synergy influence noted; grossly <1/4 AROM against gravity t/o B LEs

CASE STUDY: MULTIPLE SCLEROSIS: HOME SETTING

Jennifer Brown, PT, DPT, GCS
President and Founder
Dynamic Home Therapy

Environmental and Personal Variables

- Access to therapy: limited based on scheduling of private duty aides;
- Ramp and stairglide to exit home; no outdoor covering on days with inclement weather
- Fatigues easily by early afternoon
- Works part time from home 2 days a week as a speech language pathologist
- Highly educated on her diagnosis
- Just received power w/c
Mobility/Balance

Transfers and Bed Mobility:
- Patient D to sit unsupported on edge of w/c
- Sit to stand transfer max A x 1 with retropulsion
- Standing tolerance 60 seconds with max A x 1 and B UE support
- Powered W/C Mobility: 50’ in home with min A on straightaways and verbal cues 50% of time for L sided visual field cut; D turns to L side
- Skin: redness on sacral region Stage I

Rationale for Initial POC

Treatment Diagnosis: CD9.780.7: malaise and fatigue, 368.40: Visual field defect, unspecified, 342.82: Other specified hemiplegia and hemiparesis affecting nondominant side
- Fatigue Severity Scale: 46 (cutoff 36)
- Severity: Primary Functional Limitation: Changing & Maintaining Body Position;
  - Current Status: G8981: CL, At least 60% but < 80% impaired, limited or restricted
  - Projected Goal Status: G8982: CK, At least 40% but < 60% impaired, limited or restricted

Documenting skilled care past Medicare cap ($1920)
Pt requires ongoing skilled PT 2x wk for 6 more wks due to multiple comorbidities including L sided hemiparesis from CVA, hemisensory loss L side, L visual field cut, onset of plantar fasciitis in L LE after PT SOC, new onset of B pulmonary embolisms; new areas of stage II on sacral region, recent fluctuation in BP requiring close monitoring with activity and possible seizures vs anxiety that are all affecting her mobility. Pt requires close monitoring and frequent reassessment and modifications in her program.

POC/Timeline of Services
- IE: March 2014: 2-3x wk for 12 wks
  - May 2014 new complications while on vacation: PE, new onset HTN w/ new meds, stage II sacral region, flare up of her MS, increased anxiety
  - Recert: June 2014: Pt met $1920 cap; added KX modifier; POC 2x wk for 6 wks, then decrease to 1x wk for 6 wks
  - Recert: Sept 2014: POC: 1x wk for 12 wks; new power w/c assessment with pressure mapping for stage II sacrum, assessment with neuroophthalmologist for possible prism glasses, recent phenol injections in gastroc with need for new AFO assessment
- Total 40 visits

Documenting skilled care past $3700
Pt requires ongoing skilled care 1x wk for the next 4 wks, then decrease to every other wk to reassess and modify/progress her HEP and new equipment needs, along with her changes in spasticity as this relates to function from recent botox injections in B adductors/L quad and phenol to R gastroc. Pt’s making slow, steady progress with PT; functional status fluctuates weekly based on fatigue, sleep, blood pressure, skin issues and intermittent pain.