Medicare coverage for maintenance therapy in the post-acute world has been unclear, causing improper documentation and reimbursement for home health agencies, skilled nursing facilities (SNF), outpatient therapy, and rehabilitation facilities.

This guide contains both regulatory information and analysis as well as hands-on, practical advice for care and documentation. Advice given is specific to each post-acute care setting. The guide also features tips from consultants, downloadable materials, and sample forms and worksheets for easy comprehension of information.

This book contains tips, tools, and resources on:

- Identification of maintenance candidates
- Goal writing strategies
- Compliance with reassessment expectations
- Care planning for the maintenance patient
- Documentation auditing

A specific scenario is used throughout to demonstrate key concepts. To enhance knowledge application, a practice scenario is provided as well.
The
POST-ACUTE CARE GUIDE
to
MAINTENANCE THERAPY

Diana L. Kornetti, PT, MA
Cindy Krafft, PT, MS

HCPro
a division of BLR
# Table of Contents

About the Authors ................................. vii

Foreword .............................................. ix

Chapter 1: Are We Providing Maintenance Therapy? ........................................... 1
  Self-Assessment .................................. 1
  Current Perceptions of ‘Maintenance’ ................................................................. 2
  Changing the Vantage Point ............................................................... 2
  Identifying the Disconnect .............................................................. 3
  Single Therapy Visit Plan .................................................. 4
  Charting a New Course ............................................... 4

Chapter 2: Defining Key Terms and Concepts ................................................... 5
  Current Audit Environment ................................................ 5
  How to Decrease Denial Risk .................................................. 6
  Removal of the ‘Improvement Standard’ ........................................ 6
  Addicted to Improvement ................................................... 8
  Rehabilitation Potential and ‘Improvement’ ........................................... 9
  Defining ‘Skilled Care’ ........................................... 10
  Being ‘Reasonable’ ........................................... 11
  Is Therapy ‘Necessary’? ........................................... 11
  Tools in the Toolbox ........................................... 13

Chapter 3: Understanding the Regulations ....................................................... 15
  Regulations and Clinical Practice ........................................... 15
# Table of Contents

Lay of the Land ............................................................................................................................ 16

Call to Action ............................................................................................................................... 25

Chapter 4: Identifying Patients for Maintenance Therapy ............................................................... 27
  Shifting From Regulation to Reality ......................................................................................... 27
  Diagnosis and Maintenance Therapy ....................................................................................... 28
  Functional Limitations and Maintenance Therapy ................................................................. 29
  Chronic Diseases and Maintenance Therapy ............................................................................ 31
  Identifying Candidates for Maintenance .................................................................................. 35

Chapter 5: Assessments and the Maintenance Patient .................................................................... 37
  Operationalizing the Regulations ............................................................................................. 37
  Clinical Decision-Making ........................................................................................................ 39

Chapter 6: Goals: Capturing the Impact of Therapy ..................................................................... 49
  Expectations and Misunderstandings ....................................................................................... 49
  Goal-Writing Guidelines ......................................................................................................... 51
  Focus for Maintenance Therapy ............................................................................................... 55

Chapter 7: Care Planning With a Maintenance Focus ................................................................. 63
  Care Plan Development ........................................................................................................... 63
  Focus for Maintenance Therapy ............................................................................................... 69

Chapter 8: Defending Medical Necessity on Routine Visits ......................................................... 79
  Elements of Defensible Documentation .................................................................................. 79
  Focus for Maintenance Therapy ............................................................................................... 85

Chapter 9: Reassessments and Maintenance Therapy .................................................................. 93
  Are Reassessments Mandatory? ............................................................................................. 93
  Focus of Reassessments .......................................................................................................... 94
  Focus for Maintenance Therapy ............................................................................................... 96

Chapter 10: Tips for Identifying Maintenance Patients ............................................................... 105
  Decision-Making Tools ........................................................................................................... 105
  Starting Out Small .................................................................................................................. 107
# Table of Contents

Chapters 11: Tools and Tips for the Therapist ................................................................. 109  
  Moving From Concept to Reality .................................................................................... 109  
  Assessments/Goals ........................................................................................................ 109  
Chapters 12: Tips for the Quality Review Process .......................................................... 115  
  Assessing Therapy Documentation ................................................................................ 115  
  Use of a Standardized Audit Tool .................................................................................. 117  
Appendix A: CMS *Jimmo v. Sebelius* Settlement Agreement Fact Sheet ....................... 119  
Appendix B: The CMS MLN Matters: Manual Updates to Clarify Post-Acute Coverage Pursuant to *Jimmo v. Sebelius* ......................................................................................... 123  
Appendix C: *Jimmo v. Sebelius*, the Improvement Standard Case FAQs ....................... 129  
Appendix D: Self-Help Packet for Skilled Nursing Facility Appeals ............................... 135  
Appendix E: Self-Help Packet for Home Health Care Appeals ....................................... 149  
Appendix F: Self-Help Packet for Outpatient Therapy Denials ....................................... 163  
Appendix G: Notification on *Jimmo* and Medicare Advantage Plans ........................... 213  
Appendix H: Center for Medicare Advocacy: About Us .................................................. 215
About the Authors

Diana Kornetti

Diana Kornetti, a physical therapist for 30 years, is a past administrator and co-owner of a Medicare-certified home health agency. Kornetti now provides training and education to home health industry providers through a consulting business, Kornetti & Krafft Health Care Solutions, in Citrus Springs, Florida, with her business partners Cindy Krafft and Sherry Teague. Kornetti serves as chief operations officer.

Kornetti is a nationally recognized speaker in the areas of homecare, standardized tests and measures in the field of physical therapy, therapy training, and staff development in the home health arena. She is the immediate past editor of the Quarterly Report, a publication of the American Physical Therapy Association’s (APTA) Home Health Section, as well as a member of the Home Health Section’s Practice and Education Committees. She currently serves the Home Health Section’s Program Chair for annual conference educational activities. She has been an active member in good standing in the APTA since 1986. She is also the president of the Association of Homecare Coding and Compliance, and a member of the Association of Home Care Coders Advisory Board and Panel of Experts.

Kornetti is a published researcher. You can find her research on the Berg Balance Scale. She has co-authored Home Health Section resources related to OASIS, goal writing, and defensible documentation for the practicing therapist.

Kornetti received her B.S. in physical therapy from Boston University’s Sargent College of Allied Health Professions, and her M.A. from Rider University in Lawrenceville, New Jersey. Her clinical focus has been in the area of gerontology and neurological disease rehabilitation.

Cindy Krafft

Cindy Krafft, PT, MS, is CEO of Kornetti & Krafft Health Care Solutions in Citrus Springs, Florida. She brings more than 20 years of home health expertise ranging from direct patient care to addressing operational and management issues. Spending years in the homes of patients has solidified her view
that home health is the best setting to focus on functionality and the specific challenges faced by each patient. Krafft believes that providing care in the home environment is different than any other setting—a fact that becomes clearly evident in both training and consultation activities.

For nearly 10 years, Krafft has been a nationally recognized educator in the areas of documentation, regulation, therapy utilization, and OASIS. She is on the editorial board for *Home Healthcare Now* and has been an active participant with several Technical Advisory Panels for CMS. She is part of specific work groups with The Joint Commission and National Government Services (NGS), a CMS intermediary.

Krafft is also president of the Home Health Section of the American Physical Therapy Association (APTA). She works with APTA and CMS to clarify regulatory expectations and address proposed payment methodologies to ensure the long-term participation of therapy services in home health. Krafft has published two books: *The How-to Guide to Therapy Documentation* and *An Interdisciplinary Approach to Homecare*. 
Foreword

As one of the lead attorneys in Jimmo v. Sebelius, I am delighted with The Post-Acute Care Guide to Maintenance Therapy. It is the perfect therapists’ companion to the Jimmo settlement and the revised Medicare policies that resulted from the settlement. My colleagues and I can insist Medicare coverage rules follow the law, and advocate for patients when they don’t follow the rules, but only therapists can ensure that the promise of Jimmo becomes reality. Only therapists can open doors that have been closed to physical, occupational, and speech therapy for people with long-term and chronic conditions. As the authors write:

“Rehabilitation potential” is not synonymous with “improvement” but is meant to indicate that the individual has the potential to benefit in a meaningful way from interaction with a skilled therapist. This may result in improvement, but the ability to prevent decline must carry equal value to the therapists themselves.

The Post-Acute Care Guide provides critical information to help therapists identify when skilled maintenance therapy is needed and how to document the therapy to support Medicare coverage. This will be key to changing the culture for therapists and Medicare decision-makers. Most importantly, The Post-Acute Care Guide will help get therapy to people who need it to maintain their conditions or slow deterioration.

—Judith Stein, Executive Director/Attorney
Center for Medicare Advocacy
www.MedicareAdvocacy.org
Chapter 1

Are We Providing Maintenance Therapy?

Self-Assessment

Before jumping in to the content of this book, it is important that the reader does a self-assessment specific to this topic area. This will help set the stage for tackling one of the most misunderstood components of the Medicare benefit: the provision of maintenance therapy.

Interacting with groups of clinicians throughout the country reveals a clear consensus that maintenance therapy is not being utilized to any significant degree. Unofficial polling to determine who is providing this level of care typically sees an affirmative response from 2 or 3 of every 50 people present, and many times not a single hand is raised. Those who do acknowledge using this part of the Medicare benefit often look concerned that by doing so they just volunteered for an audit or have done something they were not supposed to do.
Current Perceptions of ‘Maintenance’

The mere mention of the work “maintenance” can trigger visibly uncomfortable reactions from therapists, nurses, and leadership-level staff, giving the impression that even speaking the word is tantamount to swearing in a church. The following are a few examples of real-life comments made by clinicians when asked about a maintenance approach to care:

- “When I have stopped trying, I put the patient on a maintenance program”
- “These patients would all be seen three times a week for 10 years”
- “Maintenance patients don’t have goals; they are not going to get better”
- “If we provided maintenance therapy, there would be more LUPAs [low-utilization patients], and our agency doesn’t want those”
- “You can’t use tests and measures for maintenance patients”
- “I don’t want to get stuck forever with these patients”
- “I could use maintenance therapy as a way to keep patients longer so they don’t go to another agency”
- “Maintenance therapy would be a great way to keep patients who keep getting their doctor to order more therapy when they don’t really need it”

The current message is clear: Maintenance therapy is not skilled, not covered, and does not represent appropriate use of therapy services. But is that an accurate assessment of the situation?

Changing the Vantage Point

For purposes of discussion, and the reality of the anxiety level provoked by the word itself, put the term “maintenance” to the side for a moment and look at a couple clinical examples in Figure 1.2.

<table>
<thead>
<tr>
<th>Figure 1.2: What Is Considered Maintenance Therapy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist completes a thorough evaluation of the patient and clearly identifies functional issues. He concludes that there is the potential for material improvement so establishes a plan of care focused on progress toward regaining the prior level of function.</td>
</tr>
<tr>
<td>The therapist completes a thorough evaluation of the patient and clearly identifies functional issues. He concludes that the patient is currently at an optimal level given the disease process. He has concerns that the patient will decline without follow-up and establishes a plan of care focused on stabilization.</td>
</tr>
</tbody>
</table>

The first example should feel very familiar, as it represents the approach to therapy that is most often seen. Therapists have embraced their role as a “fixer,” a healthcare professional focused on improving the patient from where they are today. Nearly all marketing of therapy services promotes care from that mind-set, and the value of therapy has been linked to the ability to show patient progress.
Are We Providing Maintenance Therapy?

The second example, although not seen as often as the first one, should also resonate with therapists. Many times, the initial assessment reveals specific issues that do not fall in the “fixable” category. The concern shifts to assisting the patient and/or caregiver to put strategies in place to prevent the situation from worsening. This plan of care often takes the shape of a home exercise program, equipment recommendations, caregiver education, or environmental changes that focus on preventing a decline. What many clinicians fail to realize is that this approach to care is the very essence of maintenance therapy. There is tremendous skill involved with establishing a program addressing patient-specific concerns in these situations. The very same people who moments earlier did not acknowledge providing maintenance therapy will confirm they have created and implemented plans of care that mirror the second example.

**Identifying the Disconnect**

The disconnect between the term and clinical practice raises a very real question: If this level of care is, in fact, being provided, then why are therapists so against the use of the correct term to identify it? Many wonder if this current environment has led to underreporting of the provision of maintenance therapy, which can have long-range implications from a payer source perspective. Following the adage “If you don’t use it, you lose it,” what entities such as Medicare decide to include in their coverage criteria will be influenced by current utilization practices.

As an example, in home health therapy there is a specific G code for maintenance therapy that is put on the claim to identify the focus of the visit. Data analysis reflects that many organizations have not used that code even once since it was implemented in 2011. Some have chosen to not allow the code to be used and have made it inaccessible in the electronic medical record out of concern someone may try to select it. The payer source expectation is that the claims are accurately reflecting clinical practice. The nearly negligible use of the maintenance G code by home health agencies would mean that this part of the coverage criteria is really not needed often in this setting. Given the increase in the complexity of both the clinical and functional presentation of individuals served by this part of the healthcare continuum, this low utilization does not appear to make logical sense.

A close cousin of underreporting maintenance therapy is misidentifying it as care focused on improvement. Continuing with the home health example, the only other G code options are tied to a restorative or improvement model of therapy care planning. If the patient is being clearly identified as not a candidate for improvement and a care plan is created and completed with a focus on preventing decline but the visits themselves are coded as “restorative,” is there a risk in terms of successfully passing an external review? The documentation content would reflect the skilled care focused on stabilization of function with no traditional improvement expected by the therapist, yet the code indicates something very different. If the claim is stating improvement was expected by virtue of the visit code selected and progress toward this end does not occur, it is within reason to see the risk for denial increase regardless of the fact that a maintenance approach was implemented.
Chapter 1

**Single Therapy Visit Plan**

Review of therapy documentation reveals a clear indicator specific to maintenance therapy. Organizations have created their own terminology for the single therapy evaluation visit. Often referred to as “Eval Only” or “One and Done,” the documentation created on these one-time-only visits consistently indicates that education was provided, home programs were issued, equipment was recommended, or specific strategies related to functional tasks were given. The decision to do so is based on the findings of the assessment and not random follow-up comments given to all patients. If the need for these interventions to be done is clear, why is there no follow-up plan of at least one additional visit to confirm that the information provided actually is effective for this specific patient situation?

After many conversations on this very issue, it can safely be inferred that the hesitancy to provide additional visits is actually driven by therapists who believe that if the patient does not have the potential to improve, then there is no “rehab potential” and more visits cannot be provided. The ability for the therapist to determine the effectiveness of the interventions by reassessing both the patient and the plan of care is an appropriate part of ensuring the quality of care being provided. The skill is not in simply repeating activities completed on previous visits but in evaluating their intended impact. “Rehabilitation potential” is not synonymous with “improvement” but is meant to indicate that the individual has the potential to benefit in a meaningful way from interaction with a skilled therapist. This may result in improvement, but the ability to prevent decline must carry equal value to the therapists themselves.

**Charting a New Course**

In order to navigate the myths and realities specific to maintenance therapy, clinicians need to empower themselves with information. Review of regulations creates the foundation upon which to create an efficient and effective model of care that becomes tangible through the operationalization of key concepts. The process will challenge aspects of care delivery that have long been held as truths that need to be dusted off and evaluated with fresh eyes. The end result deepens the spectrum of services that can and should be provided by therapists to those who need them the most.

Let the journey begin.
Medicare coverage for maintenance therapy in the post-acute world has been unclear, causing improper documentation and reimbursement for home health agencies, skilled nursing facilities (SNF), outpatient therapy, and rehabilitation facilities. This guide contains both regulatory information and analysis as well as hands-on, practical advice for care and documentation. Advice given is specific to each post-acute care setting. The guide also features tips from consultants, downloadable materials, and sample forms and worksheets for easy comprehension of information.

This book contains tips, tools, and resources on:

- Identification of maintenance candidates
- Goal writing strategies
- Compliance with reassessment expectations
- Care planning for the maintenance patient
- Documentation auditing

A specific scenario is used throughout to demonstrate key concepts. To enhance knowledge application, a practice scenario is provided as well.