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Thriving in Skilled Nursing: Part I

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Session Description

Providing skilled speech therapy services to geriatric Medicare beneficiaries begins with having an adequate understanding of regulatory requirements .

This session will describe services which meet the criteria for reasonable and necessary services per the Medicare Benefit Policy Manual, clarify documentation requirements related to baseline versus prior level of function, and outline key differences between restorative versus maintenance based interventions.

Objectives

1) Define "reasonable and necessary" per the Medicare Benefit Policy Manual

2) Describe essential documentation requirements for documenting functional change between baseline and prior level of function for justification of services.

3) Discuss best practices for developing and documenting "restorative" and "maintenance" based plans

OBRA 1987

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) dramatically changed the way Skilled Nursing Facilities (SNFs) approached resident care, radically modifying nursing home regulations and the survey process.

- The federal government established a requirement for comprehensive assessment as the foundation for planning and delivering care to nursing home residents.

- Mandated that facilities "provide necessary care and services to help each resident attain or maintain their highest practicable physical, mental, and psychosocial well-being." and "ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process."

(Code of Federal Regulations [CFR] Title 42, Part 483.25.

Key Facility IDT Members

- Administrators, Owners. May be "in-house" or contract therapy
- Therapy Providers- PT,OT,ST; PTA and COTA, note that Medicare does not recognize SLPAs as providers
- Nursing- Director of Nursing, RN, LPN, CNAs
- Dietary- Registered Dietician, Dietary Manager, Dietary Assistants
- Social Worker

Residents. Family Members.

Speech Pathology- Reasons for Referral

- Coughing, throat clearing, watery eyes and/or runny nose at meals
- Decreased PO intake
- Weight loss/dehydration risks
- Increased time to complete meals/SOB at meals
- Refusal to eat/painful swallowing

- Decreased ability to respond to ?'s, ability to communicate needs, decreased vocal loudness, and/or ability to follow commands
- Increased forgetfulness
- Poor attention to task, problem solving and/or safety awareness

Determining Need for Skill

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

Evidenced Based Practice

- *The services shall be considered under **accepted standards of medical practice** to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:*
  - *Medicare manuals (such as this manual and Publications 100-03 and 100-04),*
  - *Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd and*
  - *Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Complexity and Sophistication

- *The **services shall be of such a level of complexity and sophistication** or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist*
- *Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.*
- *If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Medical Diagnoses

- *While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a **beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled**. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Frequency and Duration

- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and*
- *The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.*

Treatment: "Skilled Procedures"

- Analysis of actual progress toward goals.
- Establishment of treatment goals specific to dysfunction and designed to specifically address each problem identified in initial assessment.
- The selection and initial training of a device for augmentative or alternative communication systems.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family must begin at the time of evaluation.

Limitations: "Not Skilled"

- Non-diagnostic, non-therapeutic, routine, repetitive and reinforcing procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat.
- Procedures which may be effectively carried out with the beneficiary by any non-professional (family or restorative aide) after instruction is completed.

Rehab Therapy Defined

- *Rehabilitative/Restorative therapy includes services designed to address recovery or improvement in function and, when possible,* ***restoration to a previous level of health and well-being (i.e. PLOF)****.*
- *Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment.*

Maintenance Programs Defined

- *MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.*

Individuals with Chronic Conditions

- *Rehabilitative* therapy may be needed, and improvement in a patient's condition may occur, even *when* a chronic, *progressive, degenerative,* or terminal condition exists.
- For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full **(full movement from baseline to plof)** or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition *or to maximize his/her functional abilities.*
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel.

Dysphagia per Medicare Manual

- *Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death.*
- *Most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies.* ***For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment***. (MBPM, 2015)

Case Studies: Rehab or Maintenance?

- Mr. Jones is referred for bedside swallow evaluation secondary to significant weight loss of 5% in 30 days. Significant Medical History includes dementia and CVA s/p 5 years.
- Mrs. Smith was admitted following acute care stay resultant from fall and subsequent TBI in the home environment. ST referral secondary to reduced awareness and impulsivity with ADL tasks.

Establishing Skilled Care

Step 1: Order Received
Step 2: Screen
Step 3: Evaluate and Determine if Skilled Intervention is Necessary
Step 4: Establish POC
Step 5: Write Clarification Order
Step 6: Get POC Certified
Step 7: Re Eval as appropriate
Step 8: Recertify when necessary

Plan of Care (POC) Requirements

- ✓ **Order or Referral**
- ✓ Clear distinction for **Evaluation/Re-evaluation or Screening**
- ✓ Beneficiary's **History** and the **Onset or Exacerbation Date** of the current disorder.
- ✓ **History in conjunction current symptoms** must establish support for additional treatment.
- ✓ **Prior Level of Functioning** should be documented
- ✓ **Baseline** abilities should be documented
- ✓ PLOF + Baseline establish the basis for the therapeutic interventions.
- ✓ **Plan, Goals** (realistic, long-term, functional goals)
- ✓ **Duration** of therapy, **Frequency** of therapy, and definition of the **Type of Service.**
- ✓ **Diagnostic and assessment testing** services to ascertain the type, causal factor(s) should be identified during the evaluation.
- ✓ Clarify if plan is anticipated to be **rehabilitative/restorative or maintenance based**

STEP 1: Order/Referral

- Needed for initial evaluation
- MD signature on POC acts as certification/clarification of services after evaluation
- New signature/certification needed for:
  - Any significant updates to POC affecting LTG (will require re-eval or recertification)
  - Addition of new interventions not included on initial plan.
    - Example-ST begins services for dysphagia alone, as resident progresses with laryngeal function further eval is warranted for voice and motor speech.
  - Recertification of POC

STEP 2: "Screening"

- Screening assessments are non-covered and should not be billed.
- The initial screening assessments of patients or regular routine reassessments of patients are not covered.

Think….. Screening Tells you Eval or Not Eval
No Clinical Judgments or Skilled Recommendations Should be Made from Screen Alone

Screening FAQs

- Nursing gave me a screen for swallow, however the true breakdown is cog related at meals. Do I need 2 screens?
  - Answer: No, complete screen clarifying need for eval orders in appropriate area.
- Can I screen to change a diet and recommend swallow strategies?
  - Answer: No, any significant changes requiring hands on assessment would require evaluation. Plan for strategies alone would be **Maintenance Based** in nature.

STEP 3: Evaluation

- The order or referral for the evaluation and any specific testing in areas of concern should be designated by the referring physician in consultation with the therapist.
- The documentation of the evaluation or re-evaluation by the therapist should demonstrate that an actual hands-on assessment occurred to support the medical necessity for reimbursement of the evaluation or re-evaluation.

DETERMINES NEED FOR SKILL

Evaluation Defined

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated ***based on objective measurements and subjective evaluations of patient performance and functional abilities (BASELINES).***

Evaluation is warranted e.g., for a ***new diagnosis (change from plof).***

These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

✓Medical History

Onset or Exacerbation Date

- Onset/Exacerbation Date: the date of the functional change which as a result of dx indicated the need for skilled care
- Chronic Conditions: May not be the date of dx for condition, however related to exacerbation of dx process
- New Conditions: CVA/TBI will be date of new insult

In conjunction current symptoms

- Provide correlation of why new onset has resulted in symptoms requiring your unique skilled services.

Step 4: Establish POC

Establish POC :
- Goals
- Frequency
- Duration
- Comparison of PLOF and Evaluation Baseline
- Deficits that require skilled care MUST have goals
- No Goal = No Treatment Can Occur

Baseline

The initial assessment establishes the **baseline** data necessary for evaluating expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals.

Methods for obtaining **baseline** function should include objective or subjective baseline diagnostic testing (standardized or non-standardized) followed by interpretation of test results, and clinical findings.

Goals should not be created for areas which do not have documented baseline measures, hence "DNT" or "Will not be addressed during POC" should not be used for target areas

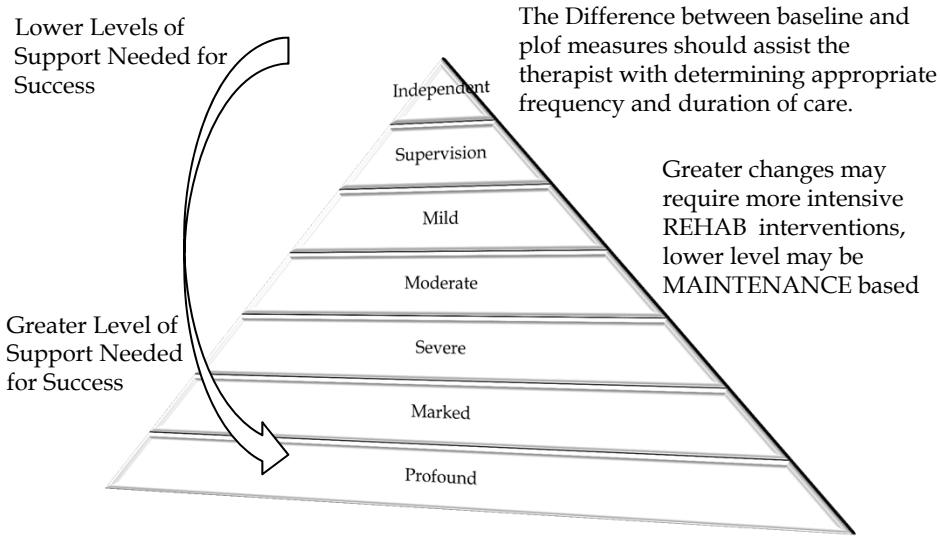
Diagnostic Testing

- Diagnostic and assessment testing services to ascertain the type, causal factor(s) should be identified during the evaluation.
- Includes standardized and non-standardized functional assessment tools.

Prior Level of Function

The residents' **prior level of function** refers to the functional level of independence prior to onset of decline which necessitated need for skilled therapy screening, and if deemed necessary, further evaluation and skilled intervention.

The Space Between



Goals/Treatment Measures

- REALISTIC/LONG TERM/FUNCTIONAL
- There should be an expectation of **<u>measurable functional</u>** improvement.

- Measureable component (percentile) needs to be attached to all short and long term goals
- Functional component (in order to…) needs to be attached to all short and long term goals.
- SUB-TASK functional impairment areas in order to measure more specific changes in function

How do Rehab vs. Maintenance goals differ?

- Rehab Goal for Auditory Comprehension
  - Patient will improve ability to follow multi-step commands with 90% accuracy in order to improve success with completion of activities of daily living
- Maintenance Goal for Auditory Comprehension
  - Patient will improve ability to follow multi-step commands with 90% accuracy and **use of visual signage** in order to improve ability to complete dressing tasks.
  - Levels of external support are often added in for maintenance

Frequency and Duration

- The **frequency** refers to the number of times in a week or # of visits over a specific time frame the type of treatment is provided.
- The **duration** is the number of weeks, or the number of treatment sessions, for THIS PLAN of care.

If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

Frequency and **Duration** should be patient specific, related to level of functional decline, and appropriate based on evidenced based practice patterns.

How does Frequency and Duration differ with Rehab vs. Maintenance?

- Considerations
  - Always individualize intensity of services
  - Wean frequency as patient progresses
  - Promote functional carryover for maintenance via verbal understanding and return demonstration of tasks.
  - Some plans will be **maintenance and rehab combined**

Step 5: Write Clarification Order

Patient to receive skilled (insert discipline) (insert frequency) (insert duration) in order to (insert reason)

Step 6: Certification of Eval/POC

- CERTIFICATION is the Physician's/Non Physician Practitioner's (NPP) approval of the plan of care (evaluation).
- Certification requires
  - Signature must be from the physician or NPP
  - **Timely certification occurs within 30 days**
  - A dated signature on the plan of care or some other document that indicates approval of the plan of care
  - When initial cert expires, a recert must then be completed certified within 30 days (needs MD signature and date which can be added as receipt date).

Step 7: Re-Eval as Needed

- *Re-evaluation may be covered if necessary because of a change in the beneficiary's condition. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.C)*
- *Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations*
- ***Covered only if the documentation supports the need for further tests and measurements after the initial evaluation.***
- *Indications for a re-evaluation include* ***new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.***
- *May be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.*
- *Focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services.*
- *Reevaluation requires the same professional skills as evaluation.*
- *The minutes for re-evaluation are documented in the same manner as the minutes for evaluation.*

Re- Evaluations Are NOT

- Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation.
- **A re-evaluation is not a routine, recurring service** but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services.

Step 8: Recertify When Necessary

Requires completion of recert document within Optima

Requires MD signature obtained in timely manner (30 days)

Additional clarification orders

Questions?