Breaking up is Hard to do: Ethics of maintaining vs. ending care

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Clinical Professor, Marquette University
WPTA Ethics Committee Member

Learning Objectives

- Compare and contrast the **business vs. professional** aspects of the provision of health care services
- Review concepts of **medical necessity, skilled therapy**, and **maintenance** in the context of ongoing provision of rehab services
- Identify legal documentation and ethical principles related to reimbursement with a particular focus on the **Jimmo vs. Sebilius case**
- Apply the concepts presented in this course to case discussions and conflicts in one's own practice

Getting Down to Business

Home Care Agencies Often Wrongly Deny Medicare Help To The Chronically Ill

January 17, 2018 · 5:00 AM ET

SUSAN JAFFE

FROM KHN KAISER HEALTH NEWS

Home health firms sometimes turn away Medicare beneficiaries with chronic health problems by incorrectly claiming Medicare won't pay for their services.

Incentives intended to combat fraud and reward high quality care are driving some home health agencies to avoid taking on long-term patients.

Collin Campbell, 58
ALS x8 yrs

Federal law requires Medicare to pay indefinitely for home care — with no copayments or deductibles — if MD ordered, and pts can leave home only with great difficulty. They must need intermittent RN, PT, other skilled care that only a trained professional can provide. They do not need to show improvement.

Ruth Purtilo, PT, PhD, FAPTA

Director and Professor,
Creighton Univ. Center for Health Policy and Ethics

- Today's health care environment has forced us to look at ourselves more closely.
- We must grapple with how we fit into the current environment and how we differ from businesses that are driven strictly by market forces.
- How do we remain true to our basic identity as purveyors of an essential human service?

2000

Finding a Balance

Profession

Business

Professions

- Profession = service beyond self
  - Health care has one goal, business another
- Covenant = a promise the profession makes to the public that it will remain true to its moral center
  - Basis on which pts trust their health care provider
  - Grounds for the public's continued respect and reliance on our profession
- Economic theory is based on self-interest

Kassirer '07; Churchill '07

The Hegemony of Money

- Hegemony = Greek for "leadership" or "dominance"
- Power of money in medicine
  - Dominates measures of "good practice", reducing them to industrial efficiency and profitability
  - Also dominates other measures of professional self-understanding and satisfaction
- Money creates dual loyalties
  - To ourselves; to our employers
  - To those to whom we provide services
    - Fiduciary duty to our pts

Churchill '07

Payers / family / colleagues

Rights, entitlements

Provider (you)

Duties, integrity

Health care as a commodity

- Medicine has become a commercial activity
  - Do the principles and practice of commerce fit?

- "Commerce" = the exchange of products or services
  - Emphasis on tangible profit / success
  - Communication is key → truth telling, trust
    - Informed consent or let the buyer beware?
  - Customers have the freedom to select = autonomy
    - Value is in the eye of the beholder

Jonsen '07

Changed relationships

- Health care services = commodities
  - Seeing a therapist (provider) is purchasing a service
    - Pts need to comparison shop
    - The customer is always right; customer satisfaction is a goal
  - Increasing expectation that if they can pay for it, they should be able to get / have it
    - Our relationship with pts is much more complex; more responsibilities than service provider / consumer
    - Our fiduciary duty toward pt welfare should not be coerced

Andereck '07

Business model benefits…

Markets

- Supply broad choices
  - Cater to aspects of freedom, liberty, and personal choice
- Promote innovations
- Reward efficiency
- Produce higher quality

Managed Care

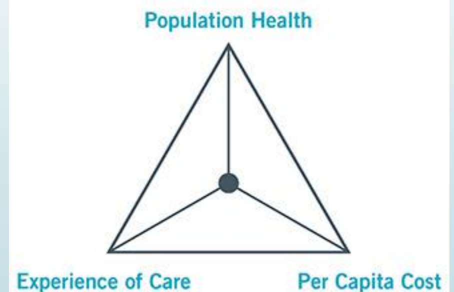
- Control costs through more efficient health care delivery
  - Eliminate choices that are wasteful, harmful, or expensive
- Financial rewards / penalties to influence provider decisions
- Benefits
  - Focus on dz prevention
  - Integration of services to minimize inefficiency
  - Restrict health care costs

Churchill '07, Lundy '06

"The Payment Squeeze in Post acute Care"

- PTinMOTION, Feb 2018

- MedPAC (independent congressional agency) is calling for a unified post acute care payment system to be in place by 2021
  - better aligning payment with pt characteristics rather than setting
  - increasing equity of payment across conditions
- Disconnect therapy volume and reimbursement



Move toward value-based payments

P4P

- **"Pay for Performance"** rewards doctors, hospitals, and other health care providers for attaining targeted service goals, like meeting health care quality or efficiency standards

MIPS

- **"Merit-based Incentive Payment System"** providers earn a payment adjustment based on evidence-based and practice-specific quality data.
- PT/OT/SLP not officially eligible yet but maybe as early as 2019

Additional changes

"Devolution" of health care

- Health care increasingly provided outside of hospitals – who is overseeing?
- More non-hospital tools & technology
  - Available and marketed direct-to-consumer
- Clinical services are being provided increasingly by less skilled providers (including caregivers, aides, techs)

OT Code of Ethics

- 1H: terminate services in collaboration w/ pt when no longer beneficial
- 2F: avoid dual relationships, conflicts of interest, situations creating unclear professional boundaries or objectivity
- 2I: avoid exploitation
- 2J: avoid bartering for services if potential for exploitation or conflict of interest
- 3D: establish collaborative relationship for shared decision-making
- 4B: assist in securing access to services
- 4M: bill and collect fees legally and justly
- 6C: avoid conflicts of interest

PT Code of Ethics

- 2A: act in the best interests of the pt
- 2D: collaborate w/ pts to empower them in their health care decisions
- 3A: demo independent and objective professional judgment in pt's best interest
- 4B: shall not exploit
- 7B: seek remuneration as is deserved and reasonable
- 7F: refrain from arrangements that prevent fulfillment of professional obligations to pts
- 8B: advocate, improve access, address health, wellness & preventive needs
- 8C: be responsible stewards & avoid over- or underutilization of PT

SLP Code of Ethics

- Principle I, Rule O: Individuals shall not charge for services not rendered, nor misrepresent services rendered, products dispensed…
- Principle III, Rule B: Individuals shall not participate in… activities that constitute a conflict of interest
- Principle III, Rule C: Individuals shall refer… solely on the basis of the interests of those being referred, not on any personal interest, financial or otherwise
- Principle III, Rule D: Individuals shall not misrepresent… services rendered, products.. or effects…
- Principle III, Rule E: Individuals shall not defraud…
- Principle IV, Rule C: Individuals shall not engage in …fraud…

Navigating the Regulatory Environment: Ensuring Compliance While Promoting Professional **Integrity**

APTA CE course (2 hrs)

Types of therapy Medicare/Medicaid fraud and abuse violations

- **This is one of the top compliance issues in therapy**

- Billing for services when the service was **unskilled** and **did not constitute PT/OT/SLP**
  - Unqualified personnel billing for services
  - Billing for services that are **not covered as PT/OT/SLP services** under Medicare
- Billing for therapy that was not performed or **not medically necessary**
- Providing & billing for rehab services w/o a license or w/o appropriate supervision as required by law
- Billing the incorrect code for treatment

APTA

Improper payments (Medicare)

- **Medically unnecessary (51%)**
- Incorrect coding (21%)
- Insufficient documentation (20%)

APTA

Back to basics: who are we and what are our skills?

- What are the "specialized judgment, knowledge, and skills of a qualified therapist"?
  - Anything done by someone with a SLP license?
  - Anything a person with a OT license is paid to do?
  - What are PT-specific skills? What are PT goals?

OT Code of Ethics

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WI State PT Practice Act 448.50
(updated Jan 1, 2018)

4(a) **"Physical Therapy"** means any of the following:

- Examining, evaluating or testing individuals with mechanical, physiological, or developmental impairments, functional limitations related to physical movement and mobility, disabilities, or other movement-related health conditions, in order to determine a diagnosis, prognosis, or plan of therapeutic intervention or to assess the ongoing effects of intervention.
- Alleviating impairments or fxnl limitations by instructing in or designing, implementing, or modifying **therapeutic interventions**
- **Reducing risk** of injury, impairment, functional limitations, or disability including by promoting **or maintaining fitness, health, or quality of life** in all age populations

WI State PT Practice Act 448.50
(updated Jan 1, 2018)

6 **"Therapeutic intervention"** means the purposeful and skilled interaction between a PT, patient, and if appropriate, individuals involved in the patient's care, using physical therapy procedures or techniques that are intended to **produce changes** in the patient's condition and that are consistent with the dx and prognosis

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American Physical Therapy Association

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Prevention, Wellness, and Disease Management

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Prevention, wellness, and disease management has moved into the forefront of health over the past decade as research continues to show the significant benefits of lifestyle changes on health. Lifestyle changes, including increased physical activity, can lead to health benefits in those with chronic disease, prevent or manage a number of noncommunicable diseases, and lead to an increased quality of life.

The following information provides a variety of resources to guide you in using these strategies to decrease risk and improve the overall health in the patients and clients you see.

Are prevention, wellness and disease management the same as “maintenance” or “fitness”?

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Physical Fitness for Special Populations (PFSP)

- *PT services that impact physical fitness include interventions that affect cardiovascular/pulmonary endurance, muscle strength, power, endurance & flexibility, relaxation, and body composition.*
- *When providing PT services for physical fitness for individuals or groups, in either traditional or nontraditional settings, the components of client management that define the practice of PT still apply.*
- *All services provided as PT to patients or clients should consider & appropriately address the 5 components of client management: examination, evaluation, diagnosis, prognosis, and intervention*

APTA position statement:

PT's ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE & DISABILITY

For their role in management of disease and disability, physical therapists:

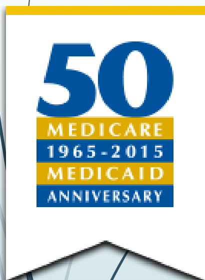
- 3. Apply best available evidence in selecting, prescribing, and using intervention and measurement strategies to establish exercise prescription for individuals to help them prevent primary, secondary, and tertiary conditions or optimize functional mobility
- 4. Apply best available evidence in planning programs to educate populations to help them prevent primary, secondary, and tertiary conditions or restore functional mobility

HOD P06-16-06-05

Is this skilled therapy?

- Running a PD exercise group / class
- Cash-based practice with a particular emphasis on fitness & wellness
- Providing PROM to a patient in a coma / PVS
- A neighbor asks you for advice about her high school daughter on the swim team who is having shoulder pain
- Seeing someone weekly1.5 yrs post TBI to play cards and board games for cognition.

Medicare: background



- Medicare is the national health insurance program established in 1965 by Title 18 of the Social security Act to which all Social Security recipients ≥ 65 or are permanently disabled are eligible.
  - Goal: protect the health & well-being of millions of families, save lives, and improve the economic security of the nation
- **Part A** = Hospital ins **Part B** = Medical ins
- **Part C** = Private Medicare plans / "Medicare Advantage" (MA) plans
- **Part D** = prescriptions

- www.cms.gov
- www.medicare.com
- http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

Medicare is a partnership

- Medicare = Government program, but decisions to pay claims are made by PRIVATE COMPANIES
  - This was a compromise made in 1965 to get Medicare passed

Ex: "MAXIMUS," = a Medicare administrative contractor
- for-profit company that helps state, federal and foreign governments administer programs

http://www.medicareadvocacy.org/33-medicare-is-a-private-public-partnership/

Original Jimmo case: the involved parties

Glenda Jimmo

76yo w/ diabetes

- National MS Society
- Parkinson's Action Network
- Paralyzed Veterans of America
- Alzheimer's Association
- United Cerebral Palsy
- National Committee to Preserve Social Security and Medicare (advocacy group)

Kathleen Sebelius

Former Secretary of HHS

Improvement standard = "covert rule of thumb"

- The Plaintiffs alleged that they were denied services through Medicare because they did not show improvement and that such denial of services was a violation of Medicare's obligation.
- The lawsuit included any Medicare beneficiary who received skilled **nursing or therapy** from a SNF, home health, or outpatient provider and was denied services for lack of progress on or after January 18, 2011.

Decision

- The plaintiffs joined with the Secretary of Health and Human Services Kathleen Sebelius, in asking the federal judge to approve the settlement of the case.
- The settlement was finalized 1-24-13, in favor of the Plaintiffs. The DHHS agreed to:
  - Revise the Medicare Benefit Policy Manual to reflect the **allowance of skilled care** to maintain function or prevent further decline.
  - Educate providers and carriers about the change.
  - Allow re-review of a denied claim for reasons of lack of progress. This led to two classifications of services: **Restorative/Rehabilitative** and **Maintenance.**

Have you been denied skilled nursing or therapy by Medicare because your condition is not improving?

GET THE FACTS

The *Jimmo* Settlement was approved on January 24, 2013. The Court agreed:

No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.

Coverage is available NOW.

Health care providers and advocates – find out more by visiting: http://goo.gl/j9F2As.

Beneficiaries needing assistance – get a self-help packet at: http://goo.gl/upyZzc.

Medicare Non-Compliance

- **2016:** The Center for Medicare Advocacy and Vermont Legal Aid, plaintiffs in the Jimmo v. Sebelius case of 2013, filed a motion for Resolution of Non-Compliance
- **2017 Corrective Action Plan**
  - CMS tasked with revising its Medicare Benefit Policy Manual and numerous other policies, guidelines and instructions
  - CMS to develop and implement a nationwide education campaign for all who make Medicare determinations
- The *Jimmo* standards apply to home health care, nursing home care, outpatient therapies, and, to a certain extent, for care in Inpatient Rehabilitation Facilities/Hospitals.

CMS in the transmittal announcing the *Jimmo* Manual revisions:

No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.

The important issue is whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will "improve."

Center for Medicare Advocacy

OP Therapy denials (Medicare advice to pts)

- **Expiration of MD orders**
- **Therapist no longer believes the therapy meets Medicare's coverage criteria**
- **You have reached the annual financial cap**

- All too often, Medicare claims are **erroneously denied**: these d/c's may be inappropriate, done too early and may endanger your long term health or limit your independence.
- It is your right as a Medicare beneficiary to appeal an unfair denial; we urge you to do so.
  - For additional assistance, contact your State Health Insurance Assistance Program (SHIP)

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

Additional Medicare advice to pts

- **Expiration of Orders:** Therapists follow MD orders, so if the MD only orders 3 sessions, the therapist will d/c you after 3 sessions. If you don't think you are ready for d/c, ask the physician to order more care.
- **Therapy caps:** If you continue to need skilled care after achieving the Medicare payment cap, ask your therapist to bill ongoing care through the *Exception Process*

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

Additional Medicare advice to pts

- **Reasonable and Necessary:** If your therapy is ending because your therapist believes you will not improve, but also thinks that continued care is necessary to maintain or slow the decline of your condition, give them a copy of the Jimmo settlement / read the CMS publications.
  - Ask your MD to give your therapist copies of research or clinical guidelines from professional sources supporting the medical benefit of maintenance for your condition.

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

REALLY?

Quick Screen: Medicare for OP therapy

- **PT/OT/SLP is covered by Med B if:**

- MD orders and periodically reviews the therapy regimen
- Therapy is **MEDICALLY NECESSARY**: It is **specific and effective** treatment for the patient's condition under accepted standards of medical practice
- Therapy can be **safely** and **effectively** performed **only by**, or under the supervision of, a **qualified therapist** because of the **complexity** of the therapy or medical condition of the patient.

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

Quick Screen: Medicare for OP therapy

- **"Restoration potential"** is **NOT required by law** and a **maintenance** therapy program **can be covered** if therapy performed by a skilled professional is necessary to prevent further deterioration or to preserve current capabilities

- Therapy that can **ordinarily** be performed by a **nonskilled person** can still be covered by Medicare if the pt's condition is **so medically complex** that it requires a skilled therapist to perform or supervise care

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

Skilled care and maintenance

- "**Skilled therapy services to maintain** the pt's current condition or **prevent or slow further deterioration are covered** as long as an individualized assessment… demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary to design or establish a safe and effective maintenance program or…for the actual performance of such a program."

Skilled care and maintenance

- **"Skilled therapy"** is necessary for the performance of a safe and effective maintenance program **only when:**
  - the particular pt's **special medical complications require** the skills of **a qualified therapist** to perform a therapy service that would otherwise be considered non-skilled
  - the needed **therapy procedures are of such complexity** that the skills of a qualified therapist are required to perform the procedure."

Does it apply to patients who have dementia?

Is maintenance therapy available for patients who are not weight-bearing?

Once a patient can walk a specified number of feet, does skilled PT end in…

Skilled Nursing?

Home Health?

Out Patient?

NOPE.
NOPE.
NOPE.

Are objective tests and measures appropriate for use with maintenance therapy patients?

Do maintenance therapy patients have goals?

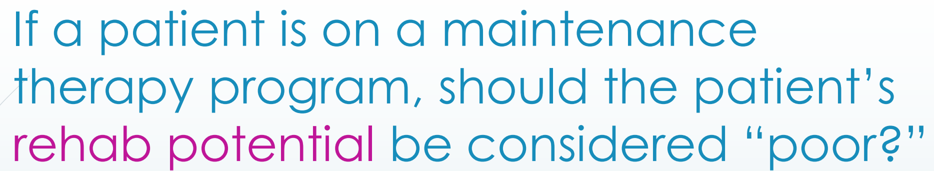
A patient who is receiving skilled therapy requires a discipline-specific, patient-centered care plan, including goal statements, developed by the qualified therapist and based on an assessment of the patient, reflecting the intent and scope of the skilled therapy.

Do maintenance therapy patients have to be reassessed?

Is it fraud for a SNF, HHA, or OP therapy provider to continue to provide skilled therapy services to a pt who is not improving?

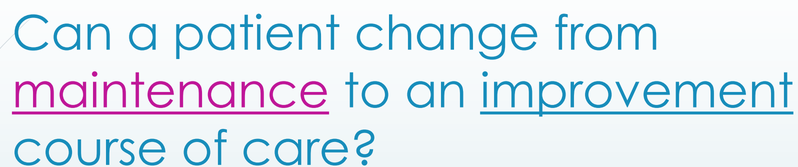
Can a patient change from an improvement course of care to a maintenance course of care?

If a patient is receiving maintenance services from one discipline, must all other disciplines also provide maintenance care?



Theoretically yes
but actually no

- "Rehab potential" is not a *prognosis* of the patient's underlying condition(s), but rather the qualified therapist's clinical assessment of the patient's **ability to progress/be responsive to the maintenance therapy program.**



If the patient has a progressive condition like PD, MS, or ALS, is it expected that the patient show "progress" when receiving maintenance services?

Actually, yes.

- **"Progress" is not synonymous with "improvement."** Progress in maintenance therapy would be the *responsiveness* of the patient to the established course of care. Maintenance therapy is intended to stabilize or slow the natural course of deterioration with a progressive condition, or to prevent potential sequelae that may occur due to the presence of that progressive condition.
- Progress, or responsiveness to therapy, would be determined by the patient's **capacity to function at an optimal level**, consistent with the stage or severity of the underlying progressive condition.

If a patient has plateaued, does Medicare coverage for skilled therapy services stop, unless the patient deteriorates?

NO

Can an IRH admit a functionally impaired pt whose function is deteriorating, in order to prevent further deterioration and teach them new skills?

Can an evaluation of an already-established maintenance plan be covered for a Medicare pt who needs to be assessed for assistive equipment and other therapies in order to prevent deterioration?

Can IPR continue for a Medicare pt if she has achieved an improvement in functionality & will soon be d/c'd, but is undergoing instruction & observation over the last few days of her stay?

If the patient does not improve at all over the entire period of his or her stay, must the entire stay be denied as a covered Medicare service?

not necessarily

As long as there was a reasonable expectation of improvement during the inpatient stay, **regardless of** whether there was **actual improvement** at any time, the stay can be covered as necessary and reasonable.

If a Medicare pt exceeds the therapy cap for OP therapy services and requires those services to maintain his or her current function, can Medicare coverage continue?

Seek an "exception" to the therapy cap to continue therapy services

Can an Inpatient Rehab Hospital continue to treat a pt if they have shown no improvement but the MD continues to believe there is a reasonable expectation that the pt will demonstrate measurable improvement?

If you d/c a Medicare pt from OP therapy because they have plateaued and are not expected to return to their prior level of function, can the MD prescribe additional therapy?

Can Medicare coverage continue for outpatient therapy if an MD prescribes therapy to prevent or slow further deterioration, even if the pt continues to deteriorate?

What are some appropriate goals for maintenance therapy?

- Preventing unnecessary, avoidable complications from a chronic or degenerative condition
  - Preventing deconditioning
  - Preventing muscle weakness from lack of mobility
  - Preventing contractures
  - Preventing skin breakdown
  - Reducing fatigue
  - Promoting safety
  - Maintaining strength and flexibility
  - Ensuring appropriate positioning

http://www.medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials/

What qualifies a patient for d/c when receiving maintenance therapy?