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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to *Jimmo v. Sebelius*
MLN Connects National Provider Call
Moderator: Leah Nguyen
December 19, 2013
2:00 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: Good afternoon. I am Leah Nguyen from the Provider Communications Group here at CMS, and I will be your moderator today. I would like to welcome you to this MLN Connects National Provider Call for providers and suppliers to discuss the recently released Medicare program manual updates to clarify skilled nursing facility, inpatient rehabilitation facility, home health, and outpatient therapy coverage pursuant to the *Jimmo v. Sebelius* settlement agreement.

MLN Connects Calls are part of the Medicare Learning Network. As part of the educational campaign contained in the settlement agreement, this MLN Connects Call for providers and suppliers will provide an overview of the recently released clarifications to the Medicare skilled nursing facility, inpatient rehabilitation facility, home health, and outpatient therapy program manuals. Before we get started, I have a couple of announcements.

You should have received a link to the slide presentation and MLN Matters article for today's call in previous registration emails. If you've not already done so, please download these materials from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select "National Provider Calls and Events." Then select the date of today's call from the list.

Second, pursuant to the settlement agreement, an audio recording and written transcript will be posted to the MLN Connects Call website for all interested stakeholders, including providers and suppliers unable to attend the call. An announcement will also be placed in the MLN Connects Provider eNews when these are available.

At this time, I would like to turn the call over to Jeanette Kranacs, Director of the Division of Institutional Post-Acute Care at CMS.

Presentation

Jeanette Kranacs: Thank you, Leah, and thank you to our callers participating with us today. If you refer to the slide set that Leah mentioned, there's an agenda on slide 4 that previews the topics I'm going to discuss today. My presentation will begin on slide 5.

Overview

If you turn to slide 5, we'll start with an overview. On January 24th, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the

case of *Jimmo v. Sebelius.* This settlement involves skilled care for the skilled nursing facility, home health, inpatient rehabilitation facility, and outpatient therapy benefits.

The agreement sets out specific steps for the Centers for Medicare & Medicaid Services to undertake, including issuing clarifications to existing program guidance and new educational material. The goal of the settlement agreement is to ensure that claims are correctly adjudicated in accordance with Medicare policy.

Settlement Agreement

On page 6, the settlement agreement includes language specifying that nothing in this settlement agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage.

Accordingly, any actions undertaken in connection with this settlement do not represent an expansion or contraction of coverage; rather, the changes serve to clarify the existing policy as follows:

When skilled nursing facility – excuse me. When skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of improvement or restoration potential. Conversely, such coverage would not be available when the beneficiary's care needs can be met safely and effectively through the use of non-skilled personnel.

To clarify, when we're discussing coverage we're primarily talking about the specific coverage requirement that the services rendered must be considered skilled services. Of course, all other coverage requirements for the individual setting must be met as well in order for the claim to be covered.

Improvement Standard

On page 7, our clarifications mean that no improvement standard is to be applied in determining Medicare coverage for maintenance claims that require skilled care. Skilled nursing or therapy services are covered where such services are necessary to maintain the patient's current condition or prevent or slow further deterioration. This means that the beneficiary must not only require maintenance care but must require skilled involvement in order for the needed care to be furnished safely and effectively.

Slide number 8. On the other hand, an improvement standard would be appropriate in situations where the treatment goal is restorative. In evaluating a claim for skilled services that are restorative—and by that I mean those for which the purpose is partially or completely reversing a previous loss of function—it would be appropriate to consider the beneficiary's potential for improvement from those services.

This standard applies for restorative skilled nursing or skilled therapy provided in the SNF, home health, or outpatient therapy settings. It would also be appropriate in the IRF

setting, where the goal is always to restore at least some measure of function or adaptation to impairment.

On slide 9, maintenance services are those that are necessary to maintain the person's condition or to prevent or slow further deterioration. Sometimes, even though no improvement is expected, a patient's special medical complications may require skilled personnel to perform a service that would otherwise be unskilled. Skilled involvement could also be required when the needed services are of such complexity as to require skilled personnel to perform them safely and effectively.

In evaluating a claim for maintenance services, coverage does not turn on the presence or absence of potential for improvement, but on the need for skilled care as well as the underlying reasonableness and necessity of the services themselves. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect this basic principle.

Settlement Agreement Activities

Revised Program Manuals

Slide 10. To clarify this policy, CMS published revisions to the relevant portions of the Medicare Benefit Policy Manual. As you can see on this slide, that includes Chapter 7, which is for the home health benefit; Chapter 8, the skilled nursing facility benefit; and Chapter 15, the outpatient therapy benefit. The revisions clarified that in the maintenance context, coverage of skilled nursing and skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement; rather, coverage turns on the beneficiary's need for skilled care.

On page 11, we also want to point out that CMS published revisions concerning the policy in the IRF setting. Those revisions happen in Chapter 1, Section 110 of the Benefit Policy Manual. And they clarify that coverage in the IRF setting should never be denied because a patient cannot be expected to achieve complete independence in the domain of self care, or because a patient cannot be expected to return to his or her prior level of functioning.

As previously mentioned, the maintenance coverage standards do not apply to services furnished in an IRF or a comprehensive outpatient rehabilitation facility, where the goal is always to restore at least some measure of function or, in the IRF setting, an adaptation to impairment.

Slide 12. In addition to clarifying the basic policy, the revised manuals now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations.

The presence of appropriate documentation is not explicitly addressed in the *Jimmo* settlement and is not, in and of itself, an element of the definition of a skilled service. However, such documentation serves as the means by which a provider would establish

and a Medicare contractor would confirm that skilled care is required and provided and that other coverage requirements are met.

On page 13, I'll get into the details of some of the clarifications. The manual revisions clarify that skilled nursing services which maintain the patient's current condition or prevent or slow further deterioration are covered under the SNF and home health benefits as long as an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed vocational or practical nurse, are necessary in order for the maintenance services to be safely and effectively provided. When the individualized assessment does not demonstrate such a need for skilled care, such services are not covered under the SNF or home health benefits.

On slide number 14, the manual revisions further clarify that skilled nursing care is necessary only when the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse, to perform a type of service that would otherwise be considered non-skilled, or when the needed services themselves are of such complexity that the skills of a registered nurse or licensed practical nurse are required to furnish the services.

Turning to therapy, on page 15, the manual revisions also clarify that skilled therapy services that maintain the patient's condition or prevent or slow deterioration are covered under the SNF, home health, and outpatient benefits-- as long as an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary to design or establish a safe and effective maintenance program or, as we'll discuss in the next slide, for the actual performance of such a program.

However, when the individualized assessment does not demonstrate such a need for skilled care, such maintenance services are not covered under the SNF, home health, or outpatient therapy benefits.

Slide 16. The manual revisions further clarify that skilled therapy is necessary for the performance of a safe and effective maintenance program only when the patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled, or the needed therapy procedures are of such complexity that the skills of a qualified therapist are needed to perform the procedure.

Under slide 17, now we'd like to present a few specific examples of maintenance coverage. The first one involves maintenance coverage for nursing services under the home health benefit. In this example, a patient with a CVA is expected to require an in-dwelling Foley catheter for urinary incontinence for a long and indefinite period.

Even though the patient is stable, periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper catheter care would be covered

as long as they're reasonable and necessary. However, the medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care, and at every home health visit there must documentation to describe the patient's current medical condition and support the need for continued skilled nursing services.

Next, we'd like to provide an example of maintenance coverage under therapy services in the SNF benefit. 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 the present level of function. This skilled physical therapy could include the initial evaluation of the patient's needs, the designing of a maintenance program appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, and the instruction of the patient or supportive personnel, such as aides or nursing personnel, in carrying out of the program. Again, this must be documented in the medical record.

Educational Campaign

In addition to clarifying the policy in the manuals, CMS is conducting a nationwide educational campaign for contractors, adjudicators, providers, and suppliers. CMS has disseminated a program transmittal, Medicare Learning Network Matters article, and updated 1-800-MEDICARE scripts. The links in the slides will take you directly to those articles that I just mentioned.

CMS will also conduct national conference calls with providers and suppliers as well as Medicare contractors, administrative law judges, medical reviewers, and agency staff.

Claims Review

In the next phase of the settlement agreement, to ensure that beneficiaries receive the care to which they're entitled, CMS will engage in accountability measures, including review of a random sample of SNF, home health, and outpatient therapy coverage decisions to determine overall trends and identify any problems.

CMS will also review individual claims determinations that may not have been made in accordance with the principles set forth in the settlement agreement.

Concluding Remarks

On page 21, I'd now like to finish with some concluding remarks. In conclusion, the *Jimmo* settlement does not change any existing Medicare coverage requirements. It only serves to clarify that in the context of maintenance services, coverage does not turn on the presence or absence of potential for improvement, but on the need for skilled care.

Accordingly, the goal of this settlement is to ensure that claims are correctly adjudicated consistent with the existing policy, and that Medicare beneficiaries receive the full coverage to which they're entitled.

In the remaining time, we'd like to open this session up to your questions. However, before we do, I'd just like to note that the purpose of this session is to explain the basic coverage principles that are currently being clarified under the terms of the *Jimmo*

settlement rather than to address their specific application to individual beneficiary claims, something that would require access to the beneficiary's full medical record.

If individual questions like this are asked, we will instruct you to follow the link on the Q&A session webpage to your local contractor, who could have access to your entire medical record and be able to advise you more appropriately.

At this time I'd like to turn it back over to Leah.

Keypad Polling

Leah Nguyen: Thank you, Jeanette. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there'll be a few moments of silence while we tabulate the results.

Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Ms. Leah Nguyen.

Question-and-Answer Session

Leah Nguyen: Thank you, Victoria. Our subject-matter experts will now take your questions. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please clearly state your name and the name of your organization.

In an effort to get to as many as your questions as possible, we ask that you limit your questions to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right, Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question is from Linda McCauslin.

Linda McCauslin: Hi, this is Linda McCauslin. I'm calling from Medical Facilities of America, located in Virginia. My question is that usually when CMS is talking about a qualified therapist, they are referring to either a therapist or an assistant, understanding that State regulations can trump that.

In the manual changes that came out, I noticed that in the home health section, it talked about – it specifically said "therapists" and then in parenthesis it said "not an assistant," but I did not see that language anywhere else, so I wanted to know if there were any clarifications on what can be done by a therapist and what can be done by the assistant, and if that has changed under these new rules. Thank you.

Leah Nguyen: Could you hold on for one moment?

Linda McCauslin: Pardon?

Leah Nguyen: Thank you for holding.

Jeanette Kranacs: One of the reasons why we wanted to hold is we are talking, as you indicated, about multiple settings, where the requirements may be a little bit different. One thing that I can say in general for the SNF and home health settings is that we haven't changed those requirements. It's still as it appears in regulation and what your State licensure allows.

I'll now let Pam West give the response specific to outpatient therapy benefits.

Pamela West: Thanks, Jeanette. I just want to clarify that, for outpatient maintenance programs, that it is the therapist and not a therapist assistant that must establish all maintenance programs and where it's necessary to provide that therapy as part of a maintenance program, that must also be done by a therapist.

Leah Nguyen: Thank you.

Operator: Your next question is from Robert Weiss.

Robert Weiss: Yes. So far only one LCD for outpatient physical therapy has been retired, which had improvement standard clauses in it. There are still outstanding about a half a

dozen or a dozen LCDs that have – have clauses having to do with improvement standard. Will those be modified or withdrawn also?

Jeanette Kranacs: At this point in time, there were things that were specifically listed in the settlement agreement that were our first priority for clarifications and so we have changed the Benefit Policy Manual. We've now been able to educate the contractors; we had a call with them on Monday. And we expect to see that, after they've been educated, for that information to sort of trickle down, and anything else that we see that is inconsistent with the improvement standard will be corrected.

Robert Weiss: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Deborah Beards.

Deborah Beards: This is Deborah Beards from House of the Good Shepherd. I'm trying to understand when you say skilled services whether you are referring to nursing or therapy, both, either/or?

Jeanette Kranacs: We refer to both. As we've indicated here in the slides, there are separate slides for skilled nursing services and separate slides for skilled therapy services. Of course the skilled nursing service does not apply to the outpatient therapy benefit, but the requirements are much the same for maintenance services.

If you notice that these slides parallel each other in the requirements that in order for maintenance services to be covered that the patient be either medically complicated, or that the procedures that they must receive be medically complicated, in order for maintenance to be covered, and that's parallel in both for nursing services and therapy services.

Leah Nguyen: Thank you.

Operator: Your next question is from Jennifer LaBay.

Jennifer LaBay: Hi, this is Jennifer LaBay from Health Concepts in Rhode Island. Just a quick question on the Internet-Only Manuals and the revision dates. I just wanted to clarify that those revision dates would change with the effective date from the transmittal. Is that correct?

Jeanette Kranacs: Of course, the way that the CMS process works is that we put out a transmittal, and the transmittal reflects all of the changes, but the internet manual – or Internet-Only Manual itself doesn't get updated as a whole immediately upon us putting out that transmittal. So if you click on the IOM, you won't see the changes there. Your best bet at this point in time is to refer to the transmittal, which there is a link for in here.

And that will show all the changes until after the effective date when the entire manual and the IOM itself will reflect these changes.

Jennifer LaBay: Perfect, thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Heather Belcher.

Diane Bell: Hi there, this is Diane Bell calling you from Friendship Health & Rehab Center in Roanoke, Virginia. We're a skilled nursing facility. My question is in reference to what many therapists have talked about in regards to what the *Jimmo* case changed, and it appears—and I'm hoping that you can clarify—it appears that some patients may qualify for therapy indefinitely under this case, meaning that there may be patients who have a need for the level of complexity and sophistication of a therapist, and a therapist would not be able to then train another non-skilled worker to be able to handle that case. So it appears that there are certain cases, although I'm sure there are few, that therapy could potentially continue indefinitely. Is that what you're taking from this as well?

Jeanette Kranacs: The first thing I must reiterate is that, again, with regard to this is – the *Jimmo* settlement covers one of the coverage requirements, and that is the necessity of skilled services, and that's what we're clarifying today-- in what instance would maintenance services be considered skilled and therefore meet the skilled coverage requirement.

The additional – there are additional coverage requirements, and that's what I referred to at the beginning, as far as the whole claim being covered- you must also consider whether or not those services are reasonable and necessary; in the SNF setting whether or not the patient had a 3-day qualifying stay, whether they're getting those benefits or getting daily skilled services, which is a requirement. It also doesn't change the requirement that beneficiaries get 100 days of utilization. So that was what the purpose of my saying, "This doesn't change all of those requirements." They still must be met.

You have to look at the individual patient and continuously evaluate their need for skilled care as you're giving those services. Do they still meet that skilled care need? And if they do, you must also consider all of the other coverage requirements and whether or not they have been met.

In addition, I would say that the – as we mentioned, that the documentation should clearly lay out when the person – what the goals are for the person, and whether or not they're meeting those goals, and how they're reacting to those goals, and why skilled care is necessary; demonstrating that they're either complex or that the services are complex. I hope that answer helps.

Leah Nguyen: Thank you.

Operator: Your next question is from Sally Andrews.

Sally Andrews: Hi, this is Sally Andrews with East Texas Medical Center Home Health. And I was wondering if the Medicare replacement policies − if they can have additional interpretations or coverage stipulations regarding maintenance services?

Jeanette Kranacs: I'm sorry, I'm not sure that in this room that we're understanding exactly what a replacement policy is. Is it a Medicare Advantage organization plan?

Sally Andrews: Yes, yes, yes.

Jeanette Kranacs: OK. Well, from my understanding—and we're not experts in this room by any means—that you have to offer the same benefits at a minimum as they do under Medicare Part A. So the maintenance service definitions that we're defining here under Part A would also be a guideline to be used under the Medicare Advantage organizations.

Sally Andrews: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Diana Thomas.

Diana Thomas: Hi, this is Diana Thomas with HCR ManorCare. And I have a question regarding the documentation requirement for the SNF setting. Previously there – in the skilled nursing coverage, there weren't any specific guidelines on the frequency of documentation. And so we were going by the outpatient therapy guidance for what's required for a daily treatment note and the interims of the progress notes.

In the new policy that was clarified with the 30.2.2.1 section, it refers to a current visit documentation of the patient's response to skilled services. Does that – are we reading that correctly, in that there's now a requirement for a daily treatment note that includes that specific piece of information, the patient's response to treatment during the current visit on a daily basis?

Leah Nguyen: Could you hold on for a moment?

Diana Thomas: Sure.

Leah Nguyen: Thank you for holding.

Jeanette Kranacs: I apologize, we just wanted to get the manual in front us so that we were able to reference the section that you were talking about. We're not – I should say up front that we're not coming out and saying that there is any particular documentation requirement that we're now having versus what has existed before.

What we're saying with regards to documentation is that in order for a Medicare contractor to understand that you're meeting the skilled coverage requirements, that the description in the medical record should indicate that the treatment goals of the patient, that the person was, you know, complicated or that − the skills necessary to be provided to that patient are – are complex, but we're not requiring any particular frequency or any particular form in the SNF setting that you had referred to.

There are requirements under the outpatient therapy benefit that are specific to daily notes. But in the section that you referred to, there is no specific requirement. What we're asking you to do is give enough detail that a contractor would know that skilled – or skilled care is required.

Diana Thomas: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Shelley Schwaesdall.

Cindy Hasz: Hi, this is Cindy Hasz from Grace Care Management. We are geriatric care managers and patient advocates. And so my question is, in regards to our patients and their families who may be advocating for their loved ones, both in skilled nursing settings and in home health, do you have any recommendations to make for advocacy assistance? Are there organizations that you would refer them to? Because this is all very complex for people, even as professionals; I'm a geriatric care manager for many years and it's complicated for us. Our families and clients who are going to be advocating for their loved ones may need help.

And so my question is, do you have an organization that you can suggest to us, and a place to go also for us to provide easily understand – easy-to-understand materials for, for instance, skilled nursing and home health − that we are in the process of educating to advocate for our clients, and they've never heard of these things, and they are going to need some – we are going to need some tools to be able to help them understand what we're saying. So to recap, any advocacy organizations that you can recommend and any websites or toolkits for those of us that are advocating?

Jeanette Kranacs: Thanks. I appreciate the fact that a lot of people would be interested in this, and that you'll be getting a lot of questions about this. What I would do is refer you to the CMS Ombudsman's Office or the Long-Term Care Ombudsman who would take care of, you know, getting any type of information to you, whether or not they were just general coverage requirements or benefits or contacts. I think that's the best place to go, to the Ombudsman.

Cindy Hasz: Thank you.

Leah Nguyen: Thank you.

Operator: You next question comes from the line of Steven Young.

Steve Young: Hi, this is Steve Young from HealthConnect at Home in Fargo, North Dakota. It seems that the designation between restorative versus maintenance therapy care is important because of the skilled therapist requirements. And I'm wondering how it is that a provider should designate that their care plan is restorative versus maintenance, and is there anything under billing codes that would indicate what type of program is being provided?

Jeanette Kranacs: No, there's nothing specific on the claim where we're going to make a classification, you know, specifically outlining the services provided in this context. What we would say is that whether or not the services provided will come with a goal of restoration or a goal of maintenance should be indicated by the documentation in the record for the individual beneficiary.

The goal should be to either restore function or to maintain or prevent further deterioration, and that would be the indication of – what would indicate that. I say that generally, but I should say more specifically in the home health setting there are G-codes that could indicate that.

Steve Young: OK. One followup question then. If a restorative program should become maintenance after further assessment, should the restorative goals be discharged and new maintenance goals written?

Jeanette Kranacs: Yes, I think that's a natural progression of developing a treatment plan for a patient, to look at the goals, see how they're reacting to those goals, whether or not they're able to meet them, and whether or not they need to be changed. And it would be appropriate that perhaps you started out with restorative goals and that you determine at some point in time that the change is going to be maintenance. That should – those goals should be set up sort of *pro*spectively in nature and the treatment should then follow.

What we don't want to see happen is to – for somebody to get at the end of their treatment and say, "Well at this point in time restorative didn't work so we're going to call it maintenance." Again, the goals should be set out right up front and documentation should be provided about whether or not the patient is reacting well to those goals and whether the goals should be changed.

Steve Young: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Estelle Masiello.

Estella Masiello: Hi. I work for Homecare, and I'm confused about slide 6 a little bit, and I think it might be because it's written generally for all types of providers. The second sentence says, "Conversely, coverage in this context would not be available when the

beneficiary's care needs can be met safely using non-skilled personnel." And from my understanding of the home care regulations, a procedure is skilled whether a licensed professional is doing it or even if you've taught a family member.

So I'm not sure what you mean by non-skilled personnel there. Do you mean, like in the inpatient setting, an aide, or do you mean a, you know, a family caregiver? And if you mean a family caregiver, suppose there's none that's able and willing? Did I lose them?

Leah Nguyen: Could you hold on for a moment?

Estelle Masiello: Hello?

Leah Nguyen: Could you hold on for one moment, please?

Estelle Masiello: Sure.

Leah Nguyen: Thank you for holding.

Jeanette Kranacs: Yes, thank you. And one of the reasons that we did want to come off line and talk about this a little bit is, this is one of the cases where the slide is general in nature, but the distinctions across settings are slightly different. So I'm going to ask Randy Throndset to speak to the home health setting and then Pam West to follow up with a response for outpatient therapy setting.

Randy Throndset: Thanks, Jeanette. So in the home health setting, I mean, if the nature of the service is skilled, then it's a skilled service. So if the service is unskilled, then just because a therapist does it, doesn't make it skilled.

Estelle Masiello: Right, like if a family member does it, it doesn't make it unskilled either, right? The converse of that is also true as well, correct?

Randy Throndset: Well, but if we're talking about the services, if the services are able to be taught to a family member and they can provide it, then there's not a need for a skilled professional to provide it.

Estelle Masiello: But that would be because it's no longer reasonable and necessary, am I correct on that?

Randy Throndset: Correct.

Estelle Masiello: OK. But suppose there's nobody able and willing. Then it would be OK for the professional to go in and continue. Am I getting that – I'm trying to really *get* it.

Randy Throndset: Right. Well, this kind of goes to what Jeanette said earlier as far as if it's of a complicated nature such that the patient – you're saying that there's nobody there that can provide it and the patient can't do it themselves, and so the patient is complex

enough to where it takes – it needs a professional to be able to provide the skilled care, then the skilled professional could do it and be considered skilled.

Estelle Masiello: OK. All right, thank you.

Randy Throndset: Yes.

Pamela West: Hi, this is Pam West. And, to clarify, the outpatient policy is very similar to really what Randy has just said. So in the outpatient arena we're not typically seeing someone with such a complicated condition that, you know, because they're already living in the community. So, these folks who need the skills of a therapist in order to provide the maintenance program, as they are instructing a family caregiver or other non-skilled person to do the therapy, at such time when those services can be done by someone else, those are no longer skilled, and the services would no longer be covered.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Amy Dixon.

Amy Dixon: Yes, we wanted to know if there are any examples for the maintenance coverage for outpatient therapy benefit. You had examples for the home health as well as the skilled nursing.

Jeanette Kranacs: No. We pulled out just a couple examples to include in our slide presentation, but if you actually look at the manual revisions themselves, you'll see many more examples for all three settings.

Leah Nguyen: Thank you.

Amy Dixon: OK.

Operator: Your next question comes from the line of Heritage Ministry. Hello, your line is open.

Your next question comes from the line of Donna Benjamin.

Leslie Wizelman: Hello, this is Leslie Wizelman in Pennsylvania. And our question is whether – who ultimately decides whether it's restorative care or maintenance care? Is it the doctor or the therapist? Because we get – sometimes we get, you know, conflict here.

Leah Nguyen: Could you hold on for one moment?

Leslie Wizelman: Sure.

Jeanette Kranacs: I just wanted to clarify with everybody here that there has been no change on who orders the services, who determines the treatment plan, who determines

what therapy is given. That all remains the same, and there aren't any changes in the manuals for that. So if you refer to the current language that's in the manual, you'll see that it hasn't changed, and it will give you the proper direction.

Leslie Wizelman: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Nichole Robinson.

Nichole Robinson: This is Nichole Robinson from Mercy Memorial Hospital's rehab center, needing to know if the therapy cap for outpatient services still applies in regards to the maintenance therapy, and if there's a frequency in regards to how many times a week we're able to see someone.

Jeanette Kranacs: Again, this is one of those situations where I could – the clarifications here revolve only around the definition of skilled care. All those other coverage requirements—whether they be therapy caps, whether they be daily need for skilled services, or face to face—all of the other coverage requirements regarding the other settings are still in place, and they haven't changed at all.

Nichole Robinson: OK. Thank you.

Jeanette Kranacs: Thank you.

Operator: Your next question comes from the line of Marilyn Kirby.

Marilyn Kirby: Yes, I was wondering, with the example you gave regarding the CVA patient for home health care—they have incontinence, and my understanding is normally with incontinence, I wouldn't think there'd be a covered skilled service. Is it because they have the CVA and you're afraid they're going to break down or…? I'm not sure about that one.

Jeanette Kranacs: Yes. We thought …

Leah Nguyen: Hold on one moment, please.

Thank you for holding.

Jeanette Kranacs: I apologize; this is a little out of my league. It gets a little bit medically complex, so I had to refer to our medical officers. In this particular case, we consider the need for that changing of the catheter, of monitoring it, that would be considered a skilled service.

Marilyn Kirby: Why? If they're incontinent − because you can be incontinent; that doesn't make it a skill. That's my concern.

Crystal Simpson: Hi, this is Dr. Crystal Simpson. It's the medical complications. We had to make the examples to keep them short for you, but it's the fact that that patient does have the CVA along with it, and because of the complications from their CVA, they need – they need the skilled characteristics of a nurse to have the changing of the catheter, of the in-dwelling catheter.

Marilyn Kirby: OK. Because I was just thinking of neurogenic bladder or retention, not, you know, just incontinence. That's all I was getting at.

Crystal Simpson: No. I mean, we won't go into all the details, because when you look at each individual patient, you have to look at those particular characteristics, which were reviewed by the contractor. However, in this example, we concentrate on the fact that the CVA was leading to the medical – one of the factors contributing to the medical complications, which require the skilled need.

Marilyn Kirby: OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Joshua Cohen.

Joshua Cohen: Hi. This is Joshua Cohen from Mobile Rehab in North Carolina. My previous question was going to be, you know, what happens if they don't have any supportive personnel to help them carry out the exercises from physical therapy? But now I understand that you clarified that services are not skilled in the outpatient sense if someone else is able to perform them or help the patient with them. So, if that's correct in my understanding, then my followup question would be, how do we dispute denials based on this new clarification, and from what date would it be effective?

Jeanette Kranacs: Nothing has changed in the appeals process. This is a clarification of an existing policy, and so it's not as if there's a change in policy and it's now effective so, you know, contractors should change the way that they view things. The appeals process is the same as it's always been. So I would advise you to use that mechanism, and you don't have to look at a particular date.

Joshua Cohen: So there's no, like, retroactive deadline or anything like that?

Jeanette Kranacs: Yes. Again, there's not an effective date of a new policy, which sometimes happens. This is a clarification of an existing policy, and hopefully the contractors have been effectuating this policy the way that we're clarifying it.

Joshua Cohen: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Arthur D. Bergeron.

Arthur Bergeron: Hi. My name is Arthur Bergeron, I'm from a law firm in Worcester, Massachusetts, Mirick O'Connell. So my question is, I understood from the manual section dealing with home care that in the physical – for the physical therapists, that the development of the physical therapy plan regarding the person who is at home is considered to be a skilled service, although the individual physical therapy implementation may not be.

The question would be over the period of the plan, would the – would the occasional return of the physical therapist to the patient just to analyze whether or not the services being provided are having the appropriate effect—would that also constitute a skilled service in addition to the original development of that plan?

Jeanette Kranacs: I think this is like a lot of cases where somebody may be on a maintenance program, that you have to continuously look at that individual's medical record and what their needs are, what the goals are, are they meeting those goals, is a change in treatment plan necessary, are skilled services still needed, are they still reasonable and necessary? So, though all of those things would have to be considered when you look at, you know, whether or not the next visit or a particular person going out and providing services would be covered.

Arthur Bergeron: Thank you very much. That's a big help.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Gail Bagby.

Gail Bagby: Yes. In regards to skilled care or reasonable and necessary, a lot of times those terms are up for interpretation. Would it be appropriate to have the patient or the family member sign an ABN if you are looking at doing maintenance care?

Jeanette Kranacs: With regard to ABNs, we don't believe that it would be appropriate to make somebody sign an ABN on a routine basis. If you have specific ABN questions, you can certainly contact the office here at CMS and I can – if you send me an email, I can send you a contact for that. But typically ABNs aren't issued out of a routine nature for certain things because you anticipate maintenance services may end.

Gail Bagby: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jody Larson.

Jody Larsen: I forgot what I was going to ask.

Operator: Jody Larson, your line is open.

Jody Larson: You know, I can't remember what I was going to ask, sorry.

Operator: Your next question comes from the line of Mary Kolodziej.

Mary Kolodziej: Hi. Can you hear me?

Leah Nguyen: Yes, we can.

Mary Kolodziej: My question was whether you see any application for the scenario that was described in the home health benefit with the individual with the CVA with the long-term Foley catheter. Do you see any application in skilled nursing facilities? I mean, we certainly have patients in skilled nursing facilities who, for a variety of reasons may need a Foley catheter, which was never historically a Medicare coverable benefit, but certainly require, you know, observation, you know, do need changes, irrigation. Do you see any application with this change in the interpretation of the guidelines?

Jeanette Kranacs: Yes. Yes. Thanks for your question. It was very difficult for us to determine what examples would be good and how to write up those examples, because when you look any of these cases, you really have to look at the entire person—I mean, we say in here "an assessment of the entire individual's medical record."

And so, it's hard to say, you know, just in a word or two, "Yes, this person would definitely be covered because they look complicated." We can't say a particular condition or a particular service is always covered. It really, on an individualized basis, must be assessed meeting the criteria that we've laid out, whether or not it's a skilled service, whether or not those services are reasonable and necessary, but we couldn't say generally yes, this would apply in the SNF setting or no, it wouldn't apply. It needs to be made on an individual basis.

Mary Kolodziej: OK. And just one other question. For a patient that, you know, perhaps had a brain tumor removed who then is left with longstanding hemiparesis, who has gone through some restorative therapy hoping that, you know, that he would improve to a significant level but really plateauing far from that, and then finding that, you know, then we need to continue a maintenance plan, and if skilled therapists were not involved, he deteriorated.

Now, you made a statement earlier that you would want to see documentation that, you know, ultimately we would be at a maintenance level with the skilled therapist involved and that you really didn't want to see, you know, it starting out as restorative and then, you know, "Oh gee, we're at the end," and all of a sudden this person is now maintenance. How would you then handle that?

Jeanette Kranacs: Yes. Again, I think when determining whether or not the goals for a particular individual are restorative or maintenance in nature and in evaluating whether or not any services should continue, it really requires the person to look at the individual medical record and determine whether or not – you know, what services need to continue,

how the plan of care should read, whether or not skilled services are necessary, whether or not the services are reasonable and necessary. And, you know, it would be hard for us to say one way or the other for any individual what would be appropriate.

Mary Kolodziej: No. I understand and, you know. I certainly appreciate that, you know, but my question is more, you know, you cannot always determine up front whether someone is going to require maintenance therapy. And earlier, unless I misunderstood you, I heard a statement that it would not be a good scenario if someone was receiving therapy under a restorative program and then at the conclusion of that, finding that the therapist must stay involved for maintenance to prevent decline. It sounded like you're almost asking, you know, like for a crystal ball to, you know, know up front from day one where this therapy is going to go, and that's not always, you know, realistic.

Jeanette Kranacs: What I had said earlier is that when you develop a plan of care and determine what services you're going to provide to an individual, you're going to set goals up front—"I'm going to provide therapy, and it's going to consist of this, and this is what I hope the therapy will achieve." And that should be documented in the record, when you're going to provide those services. And then you should be documenting responses to those services.

And it's possible that through your treatment plan, your goals might change. But then you should go ahead and in your treatment plan, change those goals. So you could have started out on – you know, with restorative goals—"we'd like to improve this person's function"—and then determine that, well, that's not going to work, what we'd like to do is, you know, set them up with a maintenance program and then allow them to go home.

So you would be changing the goals, but those goals should be clearly stated before you provide the services. What we don't want you to do is say, "I've got restorative goals," and then at the end, when the restorative goals aren't met or the services have already been provided, that you would say, "Well, we're now changing the goals and we're not providing any more services. We're changing the goals and the definition for the services that have already been provided."

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 23 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on program manual updates to clarify

SNF, IRF, home health, and outpatient therapy coverage pursuant to the *Jimmo v. Sebelius* settlement agreement. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

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