



Utilization Management Policy

Skilled Care Services

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Policy Statement

Optum* by OptumHealth Care Solutions, LLC considers eligible skilled care services to be medically necessary when they are required to fulfill any of the following patient needs:

- 1) To improve a patient’s current condition
- 2) To prevent or slow further deterioration of the patient’s condition
- 3) To help a person keep, learn or improve skills and functioning for daily living to maintain the patient’s current condition

AND

All of the following elements of the plan of care are documented in the health care record:

- The services are considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition
- The level of complexity or sophistication or the condition of the patient is such that the services required can be safely and effectively performed only by a qualified health care provider e.g., chiropractor, physical therapist, occupational therapist, or physician.
- The services including amount, frequency and duration are reasonable under accepted standards of practice.

Purpose

This policy has been developed as the clinical criterion that describes the position of Optum regarding the determination of skilled care services, when rendered by qualified health care providers.

Scope

This policy applies to all in and out of network programs, involving all provider types, where utilization review (UR) determinations are rendered. This policy serves as a resource for peer-to-peer interactions in describing the position of Optum on the clinical appropriateness and/or medical necessity of skilled care services.

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Key Question

What are the conditions/criteria needed to document the medical necessity of skilled rehabilitative, habilitative and/or maintenance care services?

Definitions/Descriptions

Unless otherwise specified, the following definitions and descriptions, which have been adapted from the Medicare Benefit Policy Manual [1], apply for the purposes of this policy:

Complexities: Complicating factors that may influence the need for skilled services. Complexities may be represented by diagnoses, age of the patient, severity of the condition, acuity of the condition, multiple conditions or co-morbid conditions, etc.

Custodial Care: Nonskilled personal care – such as help with activities of daily living e.g., bathing, eating, dressing, getting in/out of bed or chair, moving around, or using the bathroom. It may also include the kind of health care most people do for themselves e.g., using eye-drops or a hot pack.

Habilitative/Habilitation Services: Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services for people with disabilities in a variety of inpatient and/or outpatient settings [2].

Maintenance Program: A program established by a qualified health care provider that consists of activities, exercises and/or techniques that will assist a member 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. Maintenance programs are usually carried out by the member, family, or non-licensed personal. Skilled maintenance therapy may be reasonable and necessary when the particular patient's special medical complications or the complexity and sophistication of the therapy procedures indicated require the skills of a qualified health care provider.

Objective Evidence: Consists of serial standardized assessment tools/instruments, outcome measurements, and or measurable assessments of functional outcome used to quantify patient progress and support justification for continued treatment. Examples of objective evidence include:

- Functional assessment from standardized and validated outcomes instruments; or
- Functional assessment scores from tests and measurements that are validated in the professional literature, which are appropriate for the condition/function being measured

Physical measures e.g., range of motion, manual muscle strength testing are generally not considered to be 'objective evidence' of functional assessment.

Qualified Health Care Provider: An individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and reports a professional service. These providers are distinct from 'clinical staff' e.g., physical therapy aide, speech language assistant. A clinical staff member is a person who works under the supervision of a qualified health care provider and who is allowed by law, regulation and facility policy to perform or

assist in the performance of a specified professional service. Examples of qualified health care providers for the purpose of this policy include physicians, chiropractors, physical therapists, occupational therapists, physician assistants, nurse practitioners, physical therapy assistants, and occupational therapy assistants (please note this list is not all inclusive).

Rehabilitative (Restorative) Services: Are services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Improvement is evidenced by successive objective measurements whenever possible (e.g. impairments, pain, functional status, etc.). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary. Rehabilitative care must require the skills and level of sophistication of a qualified health care provider. Services that can be safely and effectively furnished by non-skilled personnel or caregivers are not rehabilitative care services.

Reasonable and Necessary: 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 only be performed safely and effectively by a qualified health care provider. Services that do not require the performance of a qualified health care provider are not skilled and are not considered reasonable or necessary.

Skilled Care Services: Services provided by a qualified health care provider that must require the expertise, knowledge, and clinical judgment/decision making abilities of a qualified health care provider that caregivers or the patient cannot provide independently.

Background

Overview:

Skilled care services are usually part of an overall management program that may also include a range of interventions (e.g., pharmacotherapy, splinting/supports, home-based nonskilled care, counseling, etc.) for the treatment of neuromuscular, skeletal or physical motion impairment disorders.

Skilled care may be necessary: 1) to improve a patient's current condition; 2) to prevent or slow further deterioration of the patient's condition; or 3) to help a person keep, learn or improve skills and functioning for daily living to maintain the patient's current condition. Thus, benefit coverage depends not on the patient's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves [1].

Skilled rehabilitative care services are part of a prescribed plan of treatment provided to improve or restore lost or impaired physical function resulting from illness, injury, neurologic disorder, congenital defect or surgery. These skilled care services are intended to enhance rehabilitation and recovery by clarifying a patient's impairments and functional limitations; and by identifying interventions, treatment goals and precautions. Rehabilitative services may be needed, and improvement in a patient's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. The fact that full or partial recovery is not possible does not necessarily mean that skilled services are 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 qualified health care provider, or whether they can be safely and effectively carried out by nonskilled personnel [1].

Unlike rehabilitative care services, which aim to recover capacities lost, habilitative services help people acquire, maintain, or improve skills and functioning for daily living. Skilled habilitative services may be reasonable and necessary, in particular, for individuals with intellectual or physical disabilities. The services and devices used in habilitation are often the same or similar as in rehabilitation, as are the professionals who provide these services, the settings in which the services and devices are provided, the individuals receiving the services, the functional deficits being addressed, and the improvement in functional deficits. The only meaningful difference is whether the services provided involve learning something new or relearning something that has been lost or impaired. [3].

Skilled services that do not meet the criteria for rehabilitative or habilitative care may be covered in certain circumstances under a maintenance program. Skilled maintenance therapy may be reasonable and necessary, when the particular patient's special medical complications or the complexity and sophistication of the therapy procedures indicated require the skills of a qualified health care provider [1]. The goals of a maintenance program would be, for example, to maintain functional status, or to prevent or slow further deterioration in function. Maintenance programs that are not considered skilled or do not require the skills of a qualified health care provider to render are usually carried out by the member, family or non-licensed personal [1].

Whether rehabilitative, habilitative or maintenance, skilled care interventions should be structured, systematic, goal-directed, and individualized in nature. The provider's clinical records must document the necessity for a course of skilled care through objective findings and subjective complaints. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a qualified health care provider, or whether they can be safely and effectively carried out by nonskilled personnel or caregivers [1].

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute skilled care services. Services provided by practitioners/staff who are not qualified health care providers are not skilled intervention services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed. Custodial care services for daily personal activities are nonskilled [1].

Medically Necessary and Reasonable

All eligible skilled care services must meet the criteria of "medically necessary and reasonable." Using available clinical evidence for guidance, the documentation in the patient's health care record – including plan of care and measurable outcomes – provides the basis for determining an individual's need for care, and whether a skilled care service is reasonable and necessary [1].

Each of the following elements of the plan of care is critical for assessing medically necessary and reasonable skilled services: [1]

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; and
- The level of complexity or sophistication or the condition of the patient is such that the services required can be safely and effectively performed only by a qualified health care provider; and
- The services, including amount, frequency, and duration, must be reasonable under accepted standards of practice.

Acceptable practices for skilled care services are found in:

- Health Plan benefit coverage and medical policies
- Medicare manuals and publications
- Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd>)
- Guidelines and literature pertaining to the professions of physical therapy, occupational therapy and chiropractic.
- Evidence-informed utilization review policies

A representative example of acceptable practice standards has been published by the American Physical Therapy Association (APTA) [4]. The criteria include the following regarding the plan of care:

- based on examination, evaluation, diagnosis, and prognosis
- identifies goals and outcomes
- describes the proposed intervention, including frequency and duration
- includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care

These practice standards state that the interventions are “consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.” The criteria include the following notations regarding the interventions:

- based on the examination, evaluation, diagnosis, prognosis, and plan of care
- provided under the ongoing direction and supervision of the physical therapist
- altered in accordance with changes in response or status
- provided at a level that is consistent with current physical therapy practice

Regarding discharge and discontinuation of services, the practice standards includes the following criteria:

- The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.
- The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

Standards of practice for occupational therapy have also been published [5]. Guidelines for chiropractic quality assurance and practice parameters were published in 1993 [6]. More recently, at least one state has published minimum practice standards for chiropractic [7].

While an individual’s particular medical condition is a valid factor in making decisions about health care, the diagnosis or prognosis cannot be the sole basis in deciding that skilled care services are reasonable and necessary. The key judgment is whether the skills of a qualified health care provider are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel [1].

Skilled care services are not required to effect improvement or restoration of function, when a patient suffers a transient and easily reversible loss or reduction of function, which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Skilled care services furnished in such situations are not considered reasonable and necessary for the treatment of the individual’s illness or injury [1].

Regardless of the expectation of improvement, reasonable and necessary skilled care services must be provided by a qualified health care provider and require a high level of complexity and sophistication or the condition of the patient is such that the services can be safely and effectively performed only by a qualified health care provider. Services that do not require the performance or supervision of a qualified health care provider are not skilled and are not considered reasonable or necessary services, even if they are performed

or supervised by a qualified professional. Therefore, if a service can be self-administered or safely and effectively furnished by an unskilled person or caregiver, without the direct or general supervision of a qualified health care provider, the service cannot be regarded as a skilled even if a qualified professional actually furnishes the service. Further, the unavailability of a competent person to provide a non-skilled service, despite the importance of the service to the patient, does not make it a skilled service when a qualified health care provider furnishes the service [1].

The CMS has provided guidance to inform judgments about whether skilled care services are reasonable and necessary:

1. Treatment should be consistent with the nature/severity of illness/injury
 - Is this a new or acute problem?
 - May need intensive focused care e.g. reduce pain and/or work on a specific impairment or functional loss
 - Is this an old or chronic condition that needs retraining, or has there been a change in condition status?
 - May need to update or modify program
 - Is this an exacerbation of a condition?
 - May have to modify treatment or change assistive devices as the condition deteriorates
 - Are there other conditions (e.g. medical diagnosis) that are the underlying problem?
2. Cognitive performance can impact care
 - What is the individual's ability to retain newly learned information (cognitive function)?
 - What is the individual's ability to participate and benefit from skilled care services?
3. When assessing objective measurable gains for rehabilitation or habilitative therapy, look at:
 - Changes in the level of assistance required to perform functional tasks
 - Changes in the types of functional activities/ tasks
 - Changes in the types of assistive devices
 - Improvement in rating of reported pain levels and changes in the ability to perform tasks given the reduction of pain (e.g., Ability to sit for a duration of time as a result of pain reduction)
4. Considerations:
 - Did the provider consider the patient's goals?
 - Were the provider's and patient's goals realistic based on the nature of the condition; and
 - For rehabilitation or habilitative therapy did the provider change goals/treatment plan in response to improvement or lack of improvement in the person's condition?
 - Were there objective, measurable clinically relevant changes using standard scales and assessment tools?
 - What was the individual's response to treatment?
 - Did this change over time?
 - Was it sustained?

Documentation

In addition to the documentation requirements referenced in Optum's Guideline for Record Keeping (policy No. 474), it is the qualified health care provider's responsibility to provide clear documentation of the medical necessity and reasonableness for skilled care services. This includes: progress or lack of

progress, medical condition, functional losses, and treatment goals. Similarly, the length of time skilled care services will be considered reasonable and medically necessary is generally determined by the individual's needs as documented in the health care record [1].

The records should justify the skills of a qualified health care provider are required. Services must not only be provided by the qualified professional, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a licensed professional that assistants, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a professional by actively participating in the treatment of the patient during each progress report period. In addition, a provider's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task [1].

“Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.”[1] Factors that contribute to individual patient need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability.

The documentation should also establish through objective measurements and functional reporting that the patient is making progress toward goals. “Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.”[1]

The entire health care record is considered when assessing the documentation for medical necessity. The absence of an individual item of documentation does not negate the medical necessity of a service, when the documentation as a whole indicates the service is necessary [1].

Policies/Positions of Other Health Care Organizations

Other organizations have established positions/policies about skilled care [therapy] services [8- 9]. They also follow the guidance provided by the Centers for Medicare and Medicaid Services (CMS) [1].

A joint consensus statement from the AOTA, American Speech-Language-Hearing Association (ASHA) and the APTA reported that the skilled nature of the care provided must be clearly expressed in the supportive documentation, and a connection between services provided and how they addressed the patient's goals must be made [10].

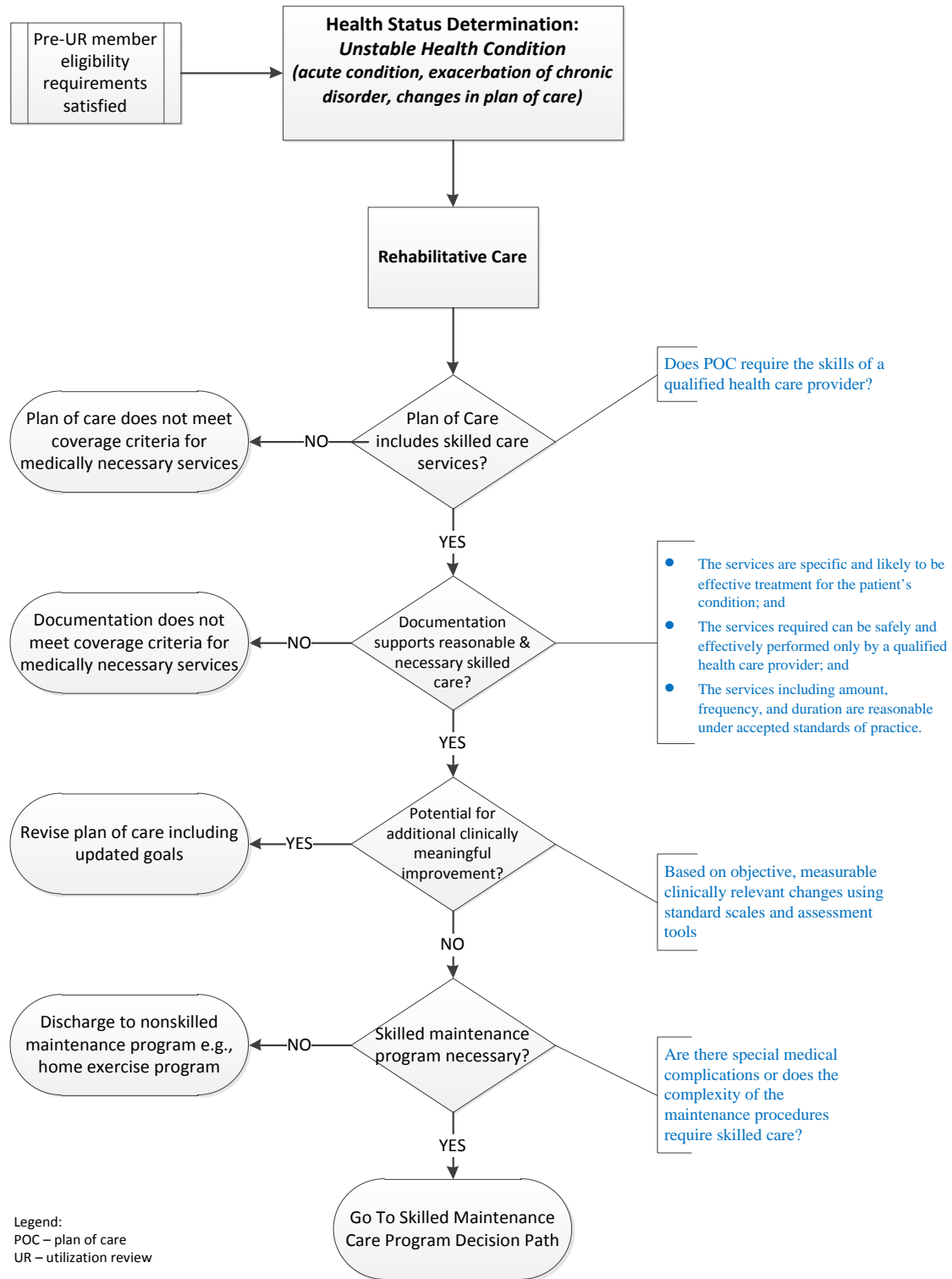
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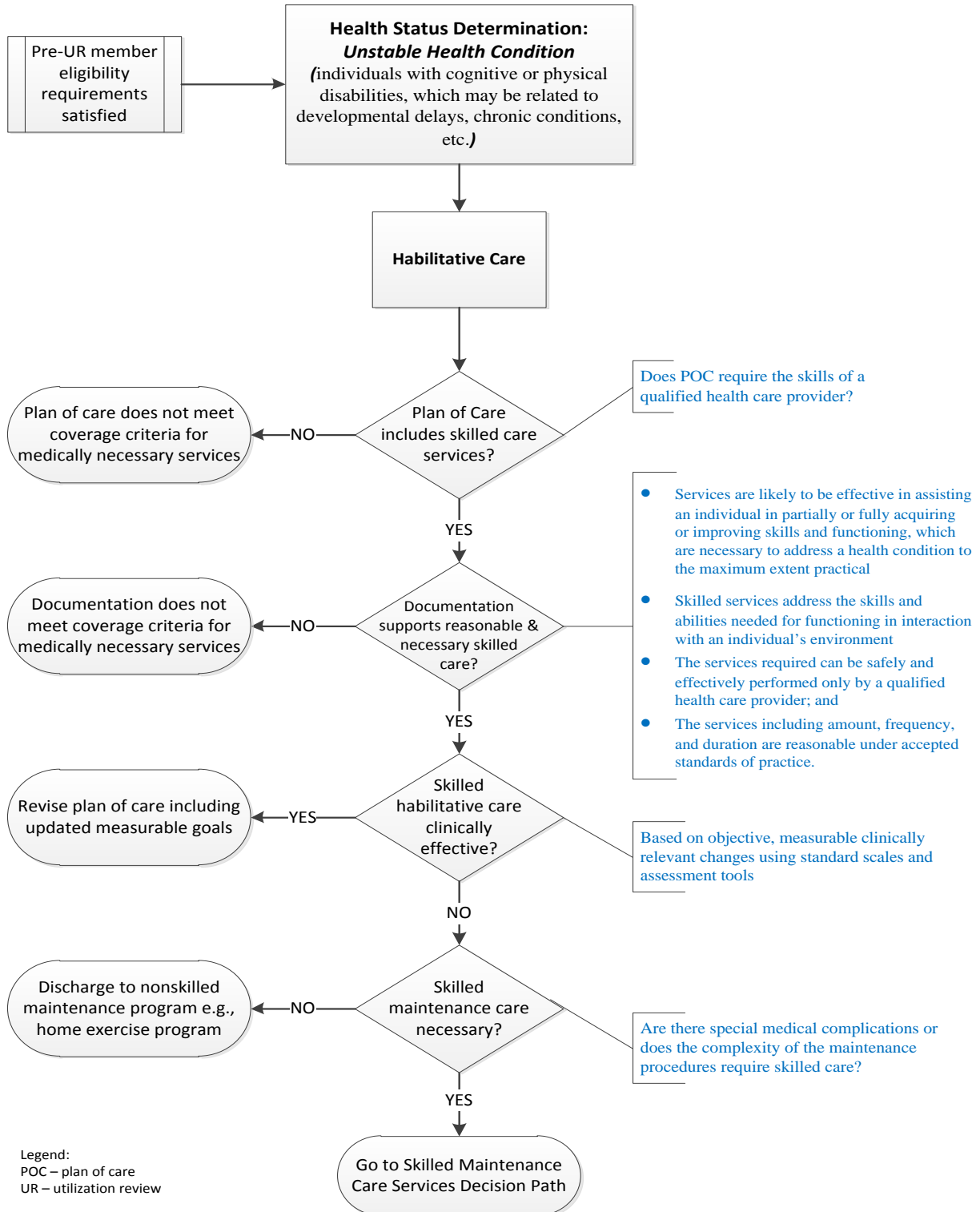
Appendix**Decision Support Tools**

- Skilled Rehabilitative Care Services
- Skilled Habilitative Care Services
- Skilled Maintenance Care Services
- Plain Language Summary

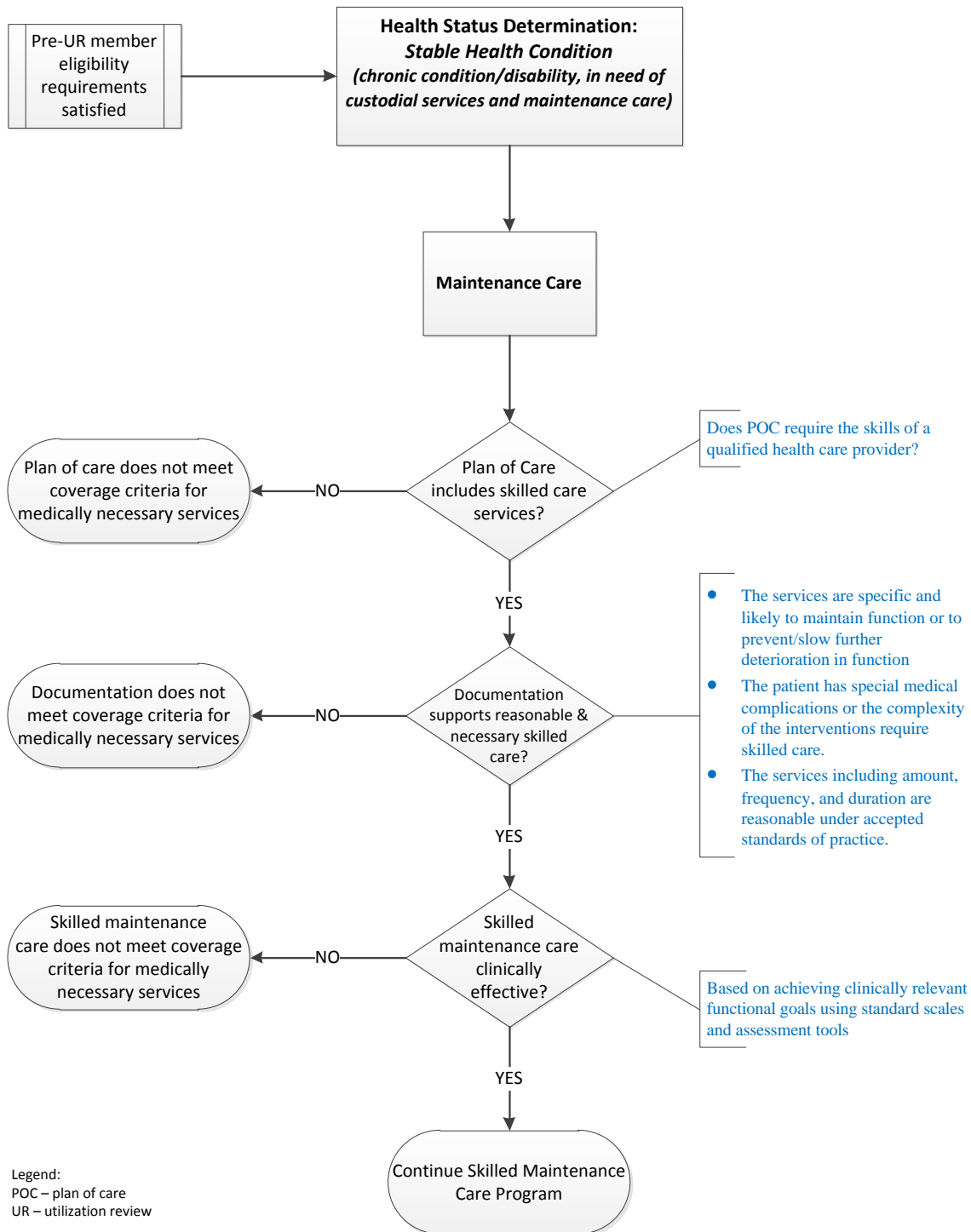
Skilled Rehabilitative (Restorative) Care Services



Skilled Habilitative Care Services



Skilled Maintenance Care Services



PLAIN LANGUAGE SUMMARY

Skilled Care Services

Utilization Management Policy # 486

Plain Language Summaries are a service provided by *Optum*^{*} by *OptumHealth Care Solutions, LLC* to help patients better understand the complicated and often mystifying language of modern healthcare.

Plain Language Summaries are presented to supplement the associated clinical policy or guideline. These summaries are not a substitute for advice from your own healthcare provider.

What are skilled care services?

Skilled services are provided by a licensed health care professional (physical therapist, occupational therapist, physician, or chiropractor). These services include treatments, devices, strapping, etc. They require the abilities of a qualified health care provider that caregivers (aids, family members) or the patient cannot provide by themselves.

How were skilled services evaluated?

A work group of clinicians was assigned to review the available research. The internet was searched for guidance about skilled services. The work group independently examined the selected information. Broadly accepted standards were used. Additionally, the positions and guidelines of other professional and healthcare groups were evaluated.

Before it was approved, the policy was presented to a series of committees that included independent health care practitioners.

What did the work group find?

The health care provider's clinical records must document the necessity for skilled care.

The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a qualified health care provider, or whether they can be safely and effectively carried out by nonskilled individuals.

What are unskilled or nonskilled services?

Nonskilled services include personal care – such as help with activities of daily living like bathing, eating, dressing, getting in/out of bed or chair, moving around, or using the bathroom. It may also include the kind of health care most people do for themselves e.g., using a hot pack.

Services such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are unskilled care services.

Services provided by practitioners/staff who are not qualified health care providers are not skilled services.

Services that are regularly performed by the patient to help maintain function are not skilled services

What are the conclusions?

Skilled care services are medically necessary, when they are needed to:

1. To improve a patient's current condition
2. To prevent or slow further deterioration of the patient's condition
3. To help a person keep, learn or improve skills and functioning for daily living to maintain the patient's current condition

AND

- The services are considered to be an effective treatment for the patient's condition
- The services can only be safely and effectively performed by a qualified health care provider e.g., chiropractor, physical therapist, occupational therapist, or physician.
- The plan of care is reasonable under accepted standards of practice.



Utilization Management Policy

Policy History/Revision Information

Date	Action/Description
4/16/2015	Original effective date
4/21/2016	References updated; Annual review
4/20/2017	Annual review and approval completed; References updated; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
4/26/2018	Annual review and approval; references updated
4/25/2019	Annual review and approval; references updated

Contact Information

Please forward any commentary or feedback on OptumHealth Care Solutions, LLC (OptumHealth) Utilization Management policies to: policy.inquiry@optumhealth.com with the word "Policy" in the subject line.

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Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.

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