Eli's Rehab Report

Reader Question: Don't Confuse 'Maintenance Therapy' With Billable Services

Question: We all hear from CMS and private payers that we can't bill for "maintenance therapy." But where does a therapist draw the line? For example, suppose a patient successfully finished her rounds of therapy for a knee injury, and she returns two weeks later for therapy addressing the same problem.

Answer: If you show in your documentation that yes, you have stopped therapy, but that the patient has regressed or had a decline in function that brought her back to you, that may help support your claim.

Another thought to consider is, how often are you seeing this patient for this "maintenance" therapy? Three visits per week for several weeks may seem excessive, compared to one visit per week every couple of weeks. You can also back up your argument by checking on the patient's progress and making the appropriate adjustments in your plan of care -- and documenting this. On the other hand, if you are truly just performing therapy for "maintenance" -- doing the same routine day in and day out, two to three times per week over a period of time -- most insurance carriers at some point will deny it, especially if it's unskilled therapy.

Another possibility: The patient returned for therapy two weeks after discharge for the same diagnosis and now exhibits functional changes. This may not be maintenance therapy, but rather may require a re-evaluation and continued skilled therapy services.

Bottom line: Watch the frequency, duration and your rationale for the additional therapy. And as always, document the patient's history and prior status -- whether or not it's maintenance therapy.