

To Sing or Not to Sing: Music Therapy, Managed Care, and Therapeutic Relationship

Fran Felton, MT-BC, NMT
Platteville, WI USA
fnkywmn@tds.net and

Karen Kwok, MT-BC
Toronto, Ontario CANADA
karenkca@yahoo.com

As music therapists, we often find the value of therapeutic relationship indisputable; however, it is not often reimbursable, especially within the U.S managed health care system. This creates a difficult conflict when time is needed to establish rapport with a client before treatment and progress can occur. This session will present the case studies of two women, both with a diagnosis of CVA with aphasia, who were discharged from speech therapy due to lack of progress under Medicare. One of the women had not received formal rehabilitation services for 3 years following discontinuation of speech therapy, and experienced severe decline in her functional speech. The other woman was consistently resistant to treatment, frequently refused cares and medication, and required 2 months to complete a music therapy assessment due to refusal of visits. Given time to develop a therapeutic relationship, both women demonstrated success in achieving speech goals in music therapy. Family members, frustrated by discontinuation of therapy due to lack of progress, were very appreciative of the music therapist's efforts and opportunities to achieve progress. Considering Music Therapy's quest to become a reimbursable and billable therapy, the conflict between outcome-based treatment and therapeutic relationship will be discussed. Also, music therapy reimbursement success within Canadian and U.S. medical models will be compared and contrasted.

Building Blocks of the Therapeutic Relationship

Roger Smeltekop, MM, MT-BC, Michigan State University

1. Motivation: reasons for engaging in the therapeutic process (therapist and client)
2. Communication: receptive and expressive
3. Contract: the understanding and agreement on the responsibilities and purposes of the therapist, client and the therapy
4. Empathy: in-depth understanding and appreciation for another's point of view.
5. Mutual Respect: regard for one another's full humanity
6. Trust: the belief and confidence in the reliability or constancy of certain traits of another.

Third-party reimbursement for healthcare in the U.S.:

- Medicare: the federal health insurance program for people age 65 and older, people of any age with End-Stage Renal Disease, and people under age 65 with certain disabilities. (detailed discussion below)

- Medicaid: a program co-financed by the federal and state governments (administered by the states) that provides medical assistance to individuals with low incomes and resources.
- Private Insurance, other state and county government subsidies.

The U.S. Medicare program has two parts:

“Part A” (Hospital Insurance) is free to most Americans and is financed mostly through Social Security payroll deductions/Medicare taxes.

“Part B” (Supplemental Medical Insurance) is a voluntary program financed through monthly premiums paid by the individual enrolled (the beneficiary).

Coverage:

Medicare Part A

Inpatient hospital services
 Skilled Nursing Facility Care
 Hospice Care
 Home Health Care

Medicare Part B

Doctor’s Care
 Outpatient Care
 Durable Medical Equipment
 Ambulance Services

Medicare Part A pays for a maximum of 100 days of nursing home coverage. After the first 20 days, the beneficiary pays a co-payment. As soon as a person’s condition no longer requires daily skilled care services, Medicare Part A coverage stops. When Medicare Part A stops paying, Medicare B will continue to pay for Part B services. Once the individual reaches a plateau in progress, Medicare coverage ends.

Since 1994, music therapy services have been eligible for Medicare coverage when provided as part of a partial hospitalization program (PHP). In order for successful reimbursement, there needs to be a “reasonable expectation that the client will improve with the intervention, not simply maintain current level of functioning” (The Centers for Medicare and Medicaid Services (CMS), *Medicare Benefit Policy Manual*, 2003).

Coverage for other rehab services under Medicare:

According to the Centers for Medicare and Medicaid Services (CMS), to be covered, PT, OT and SLP services must relate directly to an “active written treatment regimen” established by a physician (or practitioner) and must be “reasonable and necessary” to the treatment of the individual’s illness or injury.

To be considered “**reasonable and necessary**,” the following terms must apply:

- 1) Services must be considered, under accepted standards of medical practice, to be an effective treatment for the patient’s condition, and must also be of a level of complexity only to be performed by a qualified therapist. Services which do not require the performance or supervision of a therapist are not considered reasonable and necessary *even if* they are performed by a qualified (skilled) therapist.

- 2) Diagnosis and prognosis should never be the sole factor in deciding that a service is required to be skilled. The key is whether skilled services are needed to treat the illness or injury, or if the services can be provided by non-skilled personnel.
- 3) There must be the expectation that the patient's condition will improve significantly in a reasonable (and predictable) period of time, based on assessment of the patient's restoration potential, or services must be necessary for the establishment of a safe and effective maintenance program.
- 4) Amount, frequency, and duration of services must be reasonable under accepted standards of practice.

Plan of Treatment Requirements:

- 1) Plan is established before treatment is begun.
- 2) Content prescribes the type, amount, frequency and duration of services to be furnished, including diagnosis and anticipated goals.
- 3) A certification statement must be obtained at the time the treatment plan is established (or as soon thereafter as possible) and must be signed by the therapist and physician. It must basically state that the individual needed services, and services were provided under the plan of treatment.
- 4) Re-certification statements are required at least every 30 days and must be signed by the physician reviewing the treatment plan. It must indicate continuing need for services and estimate how long services will be needed.

Considerations of Music Therapy being a reimbursable service:

If we were to consider MT in terms of these kinds of guidelines for reimbursement, it may cause us to re-define how we approach our practice. We as a field, especially in long-term care, are not necessarily accustomed to predicting duration of care. Furthermore, our standards of practice do not have a specific time frame in which assessments need to be completed due to the varying types of facilities where MT services are provided.

Benefits and limitation of reimbursement/managed care in music therapy:

Benefits:

- Provide services for little or no cost to clients
- Gain credibility/comparability with other rehab therapies/medical profession
- Standardize practice of documentation (for reimbursement purposes)

Limitations:

- May need to discontinue services prematurely due to discontinuation of reimbursement, or limit scope of services provided under reimbursement
- Guidelines are complicated and cumbersome

Other considerations will be discussed regarding how music therapy is best approached as a reimbursable service, including discussion of the termination process in music therapy.

Nicholas Cummings in the 1993 American Journal of Psychotherapy states a basic treatment contract:

“It is my responsibility not to abandon you as long as you need me, and not to ask you to do something until you are able. In return, I ask that you join me in a partnership to make me as obsolete as soon as possible.”

Bibliography

AMTA. *Reimbursement Fact Sheet: Introduction to CPT Codes* (revised 3/02).

AMTA. *Standards of Clinical Practice, Standard VI*.

Bruscia, K.E. (1989). *Defining Music Therapy*. Spring City, PA: Spring House Books. 72-73.

Kwok, K. (2003). Unpublished Case Study, Western Michigan University.

McGuire, M. and Smeltekop, R. (1994). The Termination Process in Music Therapy: Part I – Theory and Clinical Implications. *Music Therapy Perspectives*, 12. 20-27.

Medicare (website). www.aahsa.org/public/medicbkqd.htm

Simpson, J. and Burns, D. (2004) *Music Therapy Reimbursement: Best Practices and Procedures*, Silver Spring, MD: American Music Therapy Association, Inc.

Smeltekop, R. and Merrill, T. (2003) *Side By Side: Functions of Music in the Formation, Activation, and Maintenance of the Therapeutic Relationship*. Unpublished Manuscript, Michigan State University.

Wisconsin Physician Service Medicare Policy webpage. (3/1/03).
www.wpsic.com/medicare/policies