Maintenance/Custodial Care

Optum Health Solutions Musculoskeletal (MSK)

Utilization Management Policy
Policy Number: 449

Effective Date: 04/25/2024

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Policy Statement

Maintenance or custodial care is considered to be unproven and not medically necessary for the treatment of disorders typically managed by chiropractors, physical and occupational therapists.

The role of maintenance/custodial care has not been established in scientific literature. A beneficial impact on health outcomes, e.g., prevention of recurrences and/or the sustainability of optimal health status has not been established.

Purpose

This policy describes the efficacy of maintenance or custodial care in the context of in-office services rendered by chiropractors, occupational and physical therapists.

Scope

This policy is limited to those services that take place within an in-office setting e.g., manual therapies, and is applicable to all in and out of network programs involving all provider types, where utilization review determinations about benefit coverage are rendered.

Out of Scope: Preventive screening measures as described by the U.S. Preventive Services Task Force and Medicare Preventive Services.

Definitions

CMS defines chiropractic maintenance therapy as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

CMS defines a physical therapy/occupational therapy maintenance program as one that maintains the patient's current condition or prevents or slows further deterioration.

CMS indicates custodial care:

- Consists of any non-medical care that can reasonable and safely be provided by non-licensed caregivers
- Involves help with daily activities like bathing, dressing, and help with household duties such as cooking and laundry

Description

For the purposes of this policy services are defined as *Maintenance/Custodial Care* when any of the following are satisfied:

- Treatment that seeks to prevent disease, promote health, and prolong and enhance quality of life
- A specific regime (usually at regular intervals) designed to provide for the patient's well-being or maintaining the optimum state of health
- Services that can be carried out by nonskilled persons e.g., passive exercises to maintain range of motion, distribution of educational pamphlets, etc.
- Treatment following a course of care, where a condition is symptomatically and/or functionally stationary, that seeks to preserve the patient's present level of symptoms/function and prevents regression of those symptoms and/or function

- Treatment that is intended to maintain a gradual process of healing or to prevent deterioration or relapse
- Treatment solely to improve physical performance e.g., endurance, strength, distance, proprioception, etc.
- Treatment directed towards biomechanical goals e.g., sagittal spinal curve correction in the absence of operant, and achievable therapeutic goals i.e., pain reduction, increased function
- A general exercise program to promote overall fitness
- Treatment that is intended to provide diversion or general motivation
- Services rendered solely for the comfort and convenience of the patient

Clinical Evidence

Chiropractors, physical and occupational therapists are regularly consulted for the treatment of chronic or recurrent disorders. It is understandable that, once improvement has been achieved, clinicians attempt to prevent new events or maintain patients at their optimal level. In the clinical domain of physical medicine and rehabilitation (inclusive of chiropractic), this type of care is typically termed maintenance or custodial care. In the context of public health, this type of care management is described as secondary or tertiary prevention. *Secondary prevention* is aimed at preventing subsequent events (episodes); whereas *tertiary prevention* means that improved patients, who have incurable conditions, are maintained at the best possible level. Additionally, individuals may elect to receive care that may mitigate the development of a disorder. This is termed *primary prevention*.

There does not seem to be consensus on a uniform definition of maintenance/custodial care. A search of electronic databases yielded a number of definitions of maintenance care reported in healthcare policies, guidelines, descriptive surveys, reviews, commentaries, and texts.

In spite of the general lack of consensus on a singular evidence-based definition for maintenance/custodial care, the concept seems to be firmly ensconced in the chiropractic profession. While the evidence is sparse, respondents to surveys appear to heavily favor maintenance or wellness care for at least some patients (93%), for the ‘average’ patient (98%), or for the asymptomatic patient (92%). (Boline, 1990; Jamison, 1991; Jamison, 1991) The conclusions from these surveys, however, are suspect due to low response rates, a focus on the prevention of non-musculoskeletal disorders, and possible changes in professional beliefs over time (these data are ~20 years old). More recently, a survey of 129 members of the Swedish Chiropractors’ Association indicated that 98% of respondents seem to support the concept of maintenance care. (Axen, 2009)

A 2007 “practice analysis” by Russell & Searcy (compiled by the Federation of State Boards for Physical Therapy) did not include maintenance/custodial care as a measurable component of clinical knowledge or practice characteristics. An additional literature search failed to identify any empirical or observational data pertaining to the occupational and physical therapy professionals on their beliefs or prevalence of use, or factors associated with the use of maintenance/custodial care.

The literature search identified only sparse information on the general indications for maintenance care by chiropractors and no information by physical or occupational therapists. A survey of 658 North American chiropractors (Rupert, 2001) suggests that there is a common understanding about the purposes of maintenance care. Over 80% of respondents either agreed or strongly agreed that its purpose was to minimize recurrence or exacerbation, maintain or optimize health status, prevent conditions from developing, provide palliative care for “incurable” problems, and to determine and treat subluxation. A small majority (56.2%) of chiropractors surveyed also agreed the purpose of maintenance care was to prevent subluxation. Jamison (2001) subsequently conducted a survey of 138 Australian chiropractors. The results obtained parallel the levels of agreement found with chiropractors in North America.

There appears to be lesser concordance on the body systems/conditions that can be helped by maintenance/custodial care. Both Rupert and Jamison found surveyed respondents who agreed (>80%) that maintenance care was appropriate for musculoskeletal conditions and stress. There was less agreement on the value of maintenance care for conditions directly related to the respiratory, gastrointestinal, cardiovascular, and reproductive systems.

The concept of “maintenance physiotherapy” has been described. The criteria list developed from a consensus definition, however, was analogous to the concept of “supportive care” (see policy # 84 – Determination of Maximum Therapeutic Benefit and policy # 486-Application of Skilled Care Services). The criteria emphasize consideration of other options, significant residuals (decreased function and quality of life) at maximum improvement, the application of standardized clinical outcomes measures, a self-care component, and consideration of eventual discharge.

There appears to be no common convention on the frequency of treatments and duration of the maintenance treatment program. Thus it is not known if patients on maintenance care are coerced to partake in a program of frequent treatments over a long period of time, or if they are actively involved in designing their own individualized treatment program.

Iben et al (2019) performed a systematic review of the literature on chiropractic maintenance care. The authors indicated an episode of spinal pain may be an acute event but the condition may often exist throughout the life of the patient. In the chiropractic profession, maintenance care has been described as preventative in order to maintain the health of the patient or continued care to treat chronic or recurring conditions. An official evidence-based definition of “maintenance care” is lacking. One objective of this systematic review was to define the term “maintenance care” and address indications for its use. Fourteen medical articles from 2008-2018 met the authors’ inclusion criteria and included both qualitative and quantitative studies. No studies were identified that evaluated the cost-effectiveness of maintenance therapy. The available literature described maintenance therapy as a secondary or tertiary preventive concept and when provided, occurred at a frequency of every one to three months. Although the indications varied, the patients identified as appropriate for maintenance therapy were those who experienced persistent or episodic pain and had experienced a positive benefit to the initial treatment. The randomized controlled studies included in this review did not provide an accurate depiction of the usefulness of maintenance care. Additional studies are required to identify the appropriate patients for maintenance care and the efficacy of the maintenance treatment for various spinal conditions.

A comprehensive literature review of maintenance/custodial care was conducted by Furlan et al (2015). A total of six studies were extracted for quality appraisal. A single randomized clinical trial (RCT) was identified that investigated manipulative therapy for the prevention of chronic neck pain. Four studies that evaluated the preventive effects of manipulation for chronic/recurrent low back pain, disability, or recurrence of disability were subjected to formal appraisal. A single RCT reporting on the preventive effect of manipulation for hamstring injuries was identified. With the exception of the RCT conducted by Eklund et al, all the appraised studies were judged to have a high risk of bias. The overall quality of evidence was rated very low to low across outcomes for pain intensity, disability, and work status; Evidence quality was judged to be moderate for the outcome of LBP bothersomeness.

Eklund et al (2018) conducted a pragmatic randomized controlled trial (RCT) to assess the efficacy of chiropractic maintenance care, as a prevention approach for individuals having recurrent or persistent low back pain (LBP). The authors sought to integrate the current state of the evidence with the clinical decision-making process and maintenance care approach typically employed by chiropractors. Thirty-five chiropractic clinics in Sweden identified patients, who met initial eligibility criteria and demonstrated an early (by the 4th visit) favorable response to treatment. A total of 328 patients were randomized to receive either symptom-guided/usual care (UC) or maintenance care (MC), with visits planned at 1-3 month intervals. Patients receiving scheduled chiropractic care at <1 month intervals were excluded from the study. MC visits typically included manipulative therapy (94%). The primary outcome for the trial was the number of days with bothersome LBP, which was reported via weekly text

messages through the 52-week study period. Compared to those receiving UC, the MC group had 12.8 days fewer (95% CI 10.1 to 15.6 fewer) of bothersome LBP. The efficacy of MC was not supported; however, as the relative effect (13% difference favoring MC) did not meet the prespecified clinically meaningful difference between groups of 20% for acute LBP and 30% for chronic LBP.

Axen et al (2008) proposed a dual model, “symptom-guided” vs. “clinical findings-guided”, as the fundamental means by which chiropractors determine treatment in terms of maintenance care. The authors incorporated this model within a small survey. Nine case scenarios were presented to 100 Swedish chiropractors. The 59 respondents selected one of six clinical management strategies for each scenario. The “symptom-guided” model was preferred for patients who presented with the following two vignettes: 1) An acute attack of LBP of two days’ duration and no previous history of LBP. The pain is completely gone after two visits. The patient is very worried that the pain will come back again. The patient asks if he could come back regularly to make sure this will not happen; 2) An acute attack of LBP of one week’s duration. The patient has had several similar attacks over the past 12 months. The pain is completely gone after two weeks of treatment. The “clinical-findings-guided” paradigm also received significant favour.

Sandnes et al (2010) authored what appears to be the most comprehensive investigation of the patterns of intervals between treatments for patients receiving and not on maintenance care, as well as who decides on the next treatment. Data were collected on 868 patients from 28 Danish and Norwegian chiropractors using trained observers and standardized recording methods. For patients on maintenance care, the most common interval between the current and previous visit was 2-4 weeks. The most common interval for the next maintenance care appointment was between two weeks and three months. In contrast, active or acute care intervals between appointments were usually less than one week. The decision on the interval between maintenance care visits was mainly made by the chiropractor. Beyond these broad conceptual approaches there does not appear to be a consensus on the clinical application of maintenance/custodial care.

Martel et al (2011) investigated the effect of high velocity/low amplitude cervical and thoracic manipulation for the tertiary prevention of chronic neck pain. Following randomization, 98 adult subjects received 10-15 sessions of spinal manipulative treatment (SMT) over a five to six week time period. Subjects were then allocated into three groups. One group attended the clinic once/2 months for assessment but no treatment (attention-control). The second and third groups received monthly SMT. The third group received home exercise instruction in addition to SMT. Serial outcomes were assessed every two months for up to ten months. Overall, SMT with or without exercise did not yield significant advantages when compared to the no treatment strategy. There were no significant between-group differences for the primary and secondary outcome variables.

The effect of “health maintenance care” on the recurrence of work disability (secondary prevention) was investigated in a single retrospective claims data analysis by Cifuentes et al (2011). Workers’ compensation claims data (894 cases), encompassing a single carrier in six states, were analyzed using an explicit methodology. Analysis was performed from the perspective of provider type (chiropractor, physical therapist, or physician). “Health Maintenance Care” was defined as the period after the initial disability episode had ended and the person had returned to work for >14 days. After controlling for demographics and severity indicators, only those receiving primarily physical therapy showed significantly greater recurrence rates than chiropractic care. The recurrence rate between those individuals receiving chiropractic care during the health maintenance care period and those not receiving any services was essentially the same. Calculation of the number needed to treat (NNT) showed that 96 patients would need to be treated over the course of 1-year to prevent one recurrence.

A shared-decision making approach between patient and clinician seems appropriate when considering secondary or tertiary prevention options such as maintenance care. Sandnes et al (2010), however, reported the decision on the interval between maintenance care visits was mainly made by the

chiropractor. A long-term care program such as maintenance care, when imposed on patients, may become more of a passive ritual, removing the responsibility for keeping well from the patient to the treatment program. A passive coping strategy may be detrimental to a patient's prognosis.

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Review and Approval History

Date	Description
3/07/2001	Original effective date
9/20/2002	Annual review and approval completed
11/11/2003	Annual review and approval completed
10/18/2004	Annual review and approval completed
2/14/2006	Annual review and approval completed
4/10/2008	Annual review and approval completed
10/09/2009	Policy revised. Added were: an updated and detailed literature review and Plain Language Summary
1/15/2009	Policy retitled (from Preventive/Maintenance Care to Maintenance/Custodial Care); Policy reformatted
4/30/2009	Annual review and approval completed
4/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to “OptumHealth Care Solutions, Inc. (OptumHealth)”
4/07/2011	Annual review and approval completed
10/13/2011	Policy revised to include recently published clinical trials and data produced by the Nordic Maintenance Care Program
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed
4/17/2014	Annual review and approval completed; Policy rebranded “Optum* by OptumHealth Care Solutions, Inc.”
4/16/2015	Annual review and approval completed
4/21/2016	Annual review and approval completed
4/20/2017	Annual review and approval completed. Legal entity name changed from “OptumHealth Care Solutions, Inc.” to “OptumHealth Care Solutions, LLC.”
4/26/2018	Annual review and approval completed: Updated Table 7 and associated references
4/25/2019	Annual review and approval completed; Revised Efficacy section and Tables 2, and 10. Added Tables 3 and 9; Updated associated references
4/23/2020	Annual review and approval completed

4/22/2021	Annual review and approval completed: Updated Table 10 and associated references
5/03/2022	Annual review and approval completed
6/29/2022	Updated legal entity name “OptumHealth Care Solutions, LLC.” to *Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
4/27/2023	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.
01/31/2024	Annual review completed. Transitioned to new template. No substantive changes to clinical criteria. Approved by Optum Clinical Guideline Advisory Committee
4/25/2024	Annual review and approval completed. Document content transitioned to new policy template. No significant changes made to the document.

Plain Language Summary

Maintenance/Custodial Care
Utilization Management Policy # 449

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 and/or guideline. These summaries are not a substitute for advice from your own healthcare provider.

What is maintenance/custodial care and what is known about it so far?

Musculoskeletal pain is a common experience for most people. Traditional nonsurgical treatments that are helpful for some patients with musculoskeletal pain include physical therapy, manipulation (chiropractic), exercise, and drugs (pain killers, anti-inflammatory drugs, and muscle relaxants). Most treatments reach a point where either patient complaints have resolved or no further improvement can be expected. It is understandable that, once improvement has been achieved, some patients choose to continue with periodic in-office care with an expectation of preventing recurrences or to keep a chronic condition from worsening. This type of care is termed Maintenance or Custodial Care.

Most healthcare benefit certificates do not include coverage for maintenance (custodial) care, when rendered in a chiropractic, physical therapy or occupational therapy office.

How was the maintenance/custodial care benefit evaluated?

A work group of clinicians was assigned to review the available research. The internet and journals were searched for policies and articles that provided information about 1) current descriptions and uses of maintenance/custodial care; 2) are there types of patients or conditions likely to benefit from maintenance (custodial) care; 3) what is/are the recommended treatment schedules for patients who elect to receive maintenance care; and 4) is there scientific literature confirming that either new episodes can be prevented or chronic symptoms can be kept from worsening?

After gathering and analyzing this information, a policy was presented to a series of committees that included independent health care practitioners.

What did the workgroup find?

The value of maintenance/custodial care is unclear

•The research regarding the use of maintenance/custodial care is limited and of very low quality that conclusions about the types of patients and/or conditions likely to benefit from regular maintenance/custodial care cannot be made

•Other health care organizations and governmental agencies have reached the same conclusions

•There is a need for additional research studies

What were the limitations of the information?

The majority of research related to maintenance/custodial care was performed by chiropractors. Much of this research is based upon opinion. There is little to no information about how this type of care is actually provided by physical and occupational therapists.

What are the conclusions?

Maintenance/custodial care is considered to be unproven and not medically necessary due to insufficient scientific evidence of benefit in the treatment of disorders typically managed by chiropractors, physical therapists and occupational therapists.

What are the options?

Once complaints have either resolved or no further improvement can be expected, the patient and treating provider may consider:

a)Discharge from scheduled in-office care with home-care recommendations

b)Discharge from scheduled in-office care; return for treatment only when complaints noticeably worsen in spite of self-care measures

c)Elect to pursue maintenance/custodial care, which is not a covered benefit.

- The patient may be required to sign a “Billing Acknowledgement Form” prior to receiving maintenance/custodial care.* (*not required in NJ)
- By signing this form, a patient assumes financial responsibility for maintenance (custodial) care.