Myth Busters: Dementia and Aging

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Course Objectives

- The participant will identify 5 common myths in aging and dementia.
- The participant will analyze evidence-based practices for use in patients with dementia.
- The participant will generate 3 functional therapy ideas to meet the needs of the aging patient.
- The participant will appraise documentation of functional therapy to demonstrate skill and medical necessity.

Disclosure

- Dr. Heape has relevant financial relationships to disclose:
  - Salaried employee of PruittHealth, a post-acute care company
  - Receives travel stipend or honoraria for presentations
- Dr. Heape has relevant non-financial relationships to disclose:
  - ASHA SLP Advisory Council member for SC
  - ASHA State Advocate for Medicare Policy for SC

- According to ASHA, dementia is defined as "a group of symptoms related to memory loss and overall cognitive impairment."

Retrieved from http://www.asha.org/public/speech/disorders/dementia/
Image: http://www.jphotostyle.com/handwriting/images/dementia.jpg

Myth #1: Dementia is a normal part of aging….

Myth #1: Dementia is a normal part of aging….

- Dementia is characterized by abnormal changes in symptoms. These symptoms may include:
  - Confusion
  - Occupational difficulties
  - Getting lost in familiar surroundings
  - Difficulty with IADLs (finances, medication, housekeeping, grooming)
  - Personality changes
  - Depression
  - Memory loss
  - Difficulty following simple directions
  - Declining communication abilities
  - Dysphagia

Retrieved from http://www.asha.org/public/speech/disorders/dementia/

Myth #2: Alzheimer's disease and dementia are the same thing.

Categories of Dementia

- 2 primary categories
  - Reversible
  - Non-Reversible
    - Non-Progressive
    - Progressive

Reversible Dementias

- Drug-related (polypharmacy, toxicity, overdose)
- Psychiatric disorders
- Metabolic disorders
- Sensory impairments
- Nutritional deficits
- Tumors
- Infection
- CAD (Coronary Artery Disease-arteriosclerosis)
- Hydrocephalus
- Post-Operative Cognitive Dysfunction (POCD)
- Hypothyroidism (underactive thyroid)
- Vitamin B Deficiency
- Hypercalcemia (too much calcium)

Non-Progressive Dementias

- Traumatic Brain Injury
- Anoxia
- Vascular (single CVA)

Non-Reversible, Progressive Dementias

- Parkinsons
- Multi-Infarct
- Fronto-temporal
- Lewy Body
- Huntington's Disease
- Creuxfeldt-Jakob
- Korsakoff Syndrome
- Normal Pressure Hydrocephalus
- Alzheimer's Disease
- Chronic Traumatic Encephalopathy
- AIDS Dementia Complex (ADC)
- Neurosyphilis

Parkinson's Disease (PD) Related Dementia

- 50-80% of people with PD will experience related dementia.
- Stress is #1 trigger for Parkinson's Dementia.
- Average time from onset of PD to development of dementia is 10 years.
- Neuro-hallmark is beta-amyloid plaques and tangles.
- Symptoms:
  - Slowness
  - Rigidity
  - Stooped posture
  - Shuffling gait
  - Depression

(Alzheimer's Association, 2016)

Multi-Infarct (Vascular) Dementia

- 2nd most common type of dementia
- Can co-exist with Alzheimer's
- Most common in men over 70
- Remains underdiagnosed
- Caused by reduced or blocked blood flow to the brain (CVA or TIA).
- Symptoms similar to Alzheimer's Dementia, difficult to distinguish
- Some experts refer to "vascular cognitive impairment (VCI)" instead of dementia, because of the broad range of impairment severity.

(Alzheimer's Association, 2016)

Fronto-Temporal Dementia (Pick's disease)

- Progressive nerve loss primarily in frontal and temporal lobes
- Onset to death is 2-12 years
- Caused primarily by a tau or TDP43 protein
- Characterized by:
  - marked changes in personality and mood
  - Communication and motor disruption highly prevalent
  - Impaired judgement
  - Patient often unaware of decline in function
- Younger onset, with quick disease process

(Alzheimer's Association, 2016)

Lewy Body Dementia

- 3rd most common type (10-25% of cases)
- Neuro hallmarks similar to PD (possibly with or without plaques and tangles)
- Symptoms:
  - Emotionally/physically labile
  - Hallucinations
  - Confusion varies widely from one day to the next
  - Shuffling gait and stooped posture
  - Depression
- These are the patients you see shuffling, looking at the floor, and mumbling.

(Alzheimer's Association, 2016)

Huntington's Disease

- Largely based on heredity
- If parent carries defective gene, child has 50% chance of developing
- Affects younger people (30-40)
- Symptoms:
  - Confusion
  - Diminished coordination
  - Fidgety movements
  - Behavior changes
  - Memory loss
  - Hallucinations

(Alzheimer's Association, 2016)

Creuxfeldt-Jakob Disease (CJD)

- aka Mad Cow Disease
- Infectious form of Dementia (from exposure to infected bovine products or tissue transplantation)
- Characterized by prion protein that changes cells into abnormal shapes and rapidly destroys.
- Rare (1 in 1 million people annually)
- Symptoms progress rapidly with no known treatment
  - motor symptoms
  - confusion
  - agitation
  - memory loss
- 90% of patients die within 1 year of onset

(Alzheimer's Association, 2016)

Korsakoff's Syndrome

- Most common in patients with a history of EtOH abuse
- Often preceded by Wernicke Encephalopathy- acute reaction to severely low thiamine
- Symptoms:
  - Motor- staggering, stumbling
  - Confabulation (making up information but believing it)

(Alzheimer's Association, 2016)

Normal Pressure Hydrocephalus

- Characterized by excessive accumulation of CSF in the ventricles.
- However, excess fluid does not often present during lumbar puncture
- Diagnosed by MRI or large volume spinal tap
- Symptoms:
  - difficulty walking
  - decreased executive functioning
  - loss of continence

(Alzheimer's Association, 2016)

Alzheimer's Disease

- Most common type of dementia (60-80% of cases)
- Progressive, and not a "normal" part of aging
- Characterized by memory difficulty, especially newly learned information
- Can be diagnosed pre-mortem now
- One neuro-hallmark is abnormally high numbers of beta-amyloid plaques and tangles.
- Primary neuro-hallmark is "wasting away" of the brain
- Current research focus is attempting to slow or prevent AD
- Symptoms differ by stage

(Alzheimer's Association, 2016)

Chronic Traumatic Encephalopathy

- May be called dementia pugilistica
- Most notably in the news due to prevalence in boxers and football players
- May also affect those with military background
- Thought to be caused by repetitive brain trauma (symptomatic or asymptomatic of concussion)
- Characterized by degeneration of brain tissue, including a buildup of tau protein
- Symptoms include:
  - Impulsivity
  - Erratic behavior
  - Aggression
  - Depression
  - Balance impairment
  - Impaired judgment

AIDS Dementia Complex

- May develop rapidly (in a matter of weeks)
- Usually develops in later stages of HIV
- Most definitive diagnosis is with CSF analysis
- Symptoms include:
  - Reduced concentration and inattention
  - Slow processing and movement speed
  - Clumsiness and Ataxia
  - Apathy, agitation
  - Mutism in later stages
- Has a Staging Scale (AIDS Dementia Complex Staging) http://hivinsite.ucsf.edu/InSite?page=kb-04-01-03

Neurosyphilis

- More prevalent prior to invention of penicillin
- May develop approximately 10-20 years after untreated or advanced Syphilis
- Symptoms include:
  - Hypo-reflexivity
  - Sensory impairment
  - Vertigo
  - Pupillary changes
  - Paranoia
  - Low muscle tone
  - Classic dementia symptoms

http://emedicine.medscape.com/article/1169231-overview#a4

Myth #3: If a patient has memory loss, they have dementia.

Definitive diagnosis…

- Characterized by a loss of function in at least 2 areas of function
  - Language
  - Judgment
  - Memory
  - Spatial ability
  - Visual ability
- Must be made by the MD
- Usually involves neuroimaging
  - Some studies suggest that neurological changes occur up to 9 years prior to diagnosis due to clinical manifestations (Amieva et al., 2005; Bennett et al, 2006)

What About Mild Cognitive Impairment?

- Cause is not completely understood at this time
- Cognitive and memory changes are noticeable to others, but are not severe enough to seriously interfere with ADLs.
- People with MCI ***may get better***
- Compensatory activities may slow decline or assist in progress
- ***May*** lead to AD
- Experts recommend re-evaluation every 6 months to diagnose improvement/decline.

(Alzheimer's Association, 2016)

Why is Early Identification of MCI Important?

- MCI is a transitional phase between normal aging and dementia (Burgeois & Hickey, 2009)
- Individuals are generally at greater risk of developing dementia
- Interventions are possible to slow decline (Qualls, 2005)

Myth #4: There's nothing you can do to "slow dementia down."

What Might the MD Do?

- Medications
  - Aricept (1997)- most common prescribed of AD medications. One dose taken at night.
  - Reminyl (2001)- Used with vascular and mixed dementia. Once (extended release) or twice per day doses. Linked to renal and liver issues.
  - Exelon (2000)- Adds acetylcholine in the brain. Taken once or twice per day. Titration required and potential for GI problems.
  - Namenda (2003)- Regulates glutamate activity (related to learning and memory) Often used as a 2nd drug in a "cocktail" approach to pharmacological treatment.
  - Cognex

Can You Slow Decline?

- The American Academy of Neurology produced a study in 2009 that suggests that people who are "destined to develop dementia" can delay the onset of accelerated memory decline by doing brain exercises.
  - Reading
  - Writing
  - Crossword Puzzles
  - Board Games
  - Card Games
  - Group discussions
  - Music
  - Current events recollection
- Participants who didn't do these type of activities lost their memory 3 times as quickly as those who did cognitive exercises 7 days per week.

Physical Exercise to Limit Decline

- Regular physical activity reduces risk of cognitive decline
- Aerobic exercise may reduce Tau protein in patients with MCI
- Exercise = increased blood flow and oxygen!

https://www.alz.org/aaic/_downloads/thurs-1130am-exercise.pdf

Myth #5: If a patient has dementia, it is unethical to treat them

Jimmo vs. Sebelius

- Approved January 24, 2013
- Prior to the Jimmo settlement, Medicare's "Improvement Standard"- a resident had to show improvement for therapy to be covered.
- Now, the determining issue is whether the skilled services of a professional are needed, not if the patient will "improve"
- Intervention includes, establishing a RNP, modifying a program, preventing decline
- Important for patients with progressive disease processes

ASHA's Practice Portal

- Clinical guidelines for assessment, screening, treatment, and service delivery for patients with (or without) a dementia diagnosis displaying symptoms of cognitive-communicative impairments

http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935289&section=Treatment

Systematic Review of Existing Literature in Speech-Language Pathology

Found that:

- Patients with mild and moderate dementia may be able to learn new facts and procedures using cognitive intervention strategies. Less evidence with moderate to severe dementia.
- Memory techniques, specifically Spaced Retrieval, are successful in facilitating recall.
- Therapy tasks should be functional and valid to the patient.
- Some question about the carryover between learned items and overall cognition. Specific tasks and information do not always affect the general cognitive functioning.
- You should consider all areas of the patient (social, educational, cultural, etc.) when determining strategies and considering outcomes.

(Hopper, T., Bourgeois, M., Pimentel, J., Qualls, C. D., Hickey, E., Frymark, T., & Schooling, T. (2013). An Evidence-Based Systematic Review on Cognitive Interventions for Individuals With Dementia. *American Journal of Speech-Language Pathology, 22*(1), 126-145. doi: 10.1044/1058-0360(2012/11-0137)

Evidence-Based Interventions Recognized by ASHA:

- Cognitive Stimulation
- Validation therapy (errorless learning)
- Graphic and written cues
- Montessori- based interventions
- Memory training programs (spaced retrieval training)
- FOCUSED caregiver training program
- Computer-Assisted Cognitive Interventions (CACI's)

Cognitive Stimulation

- Improves
  - Cognitive function
  - Well-being
  - Quality of life
- Seems to be most effective for early to mid-stages
- Empirical evidence on specific activities is limited

Literature on Cognitive Stimulation

Activities for Cognitive Stimulation:

- Memory training
- Problem solving
- Use of mnemonic devices
- Multisensory stimulation
- Word games
- Puzzles
- Social activities
- External memory aids

Logsdon, R. G., McCurry, S. M., & Teri, L. (2007). Evidence-Based Interventions to Improve Quality of Life for Individuals with Dementia.*Alzheimer's Care Today*, *8*(4), 309–318.

Reality Orientation Therapy vs. Validation Therapy

- ROT-
  - Higher level patients
- Validation Therapy (Lower level patients)
  - The basic approach to this therapy is to validate what the person with dementia is saying or feeling, regardless of accuracy or factuality.
  - Suggests there is logic behind all behaviors. Therapists focus on understanding the feelings behind statements rather than the accuracy of them.
  - The approach teaches that rather than correcting or reorienting the person with dementia, the therapist or caregiver should give positive words or gestures that give validation to the patient's thoughts and feelings.
  - Use conversation to get the patient to do something else without them realizing they are actually redirected.

Graphic and Written Cues/ External Memory Aids

- This method of therapy involves providing written factual information and/or familiar photographs to facilitate communication with the client.
  - An example of this would be to make a book of photos of family members with their printed names labeling each person. The client would use these cues to be able to appropriately facilitate communication with family members.
- In a person with Alzheimer's dementia, the ability to read and recognition memory may be somewhat preserved throughout the main course of the disease. Graphic and written cues capitalize on these residual skills.
- Examples:
  - Activity calendars
  - Memo boards
  - Memory books/ memory wallets
  - Appointment cards
  - To-do lists

Montessori-based Interventions

- Uses rehabilitation principles including guided repetition, task breakdown, and progressing from simple to complex tasks.
- Principles of dementia interventions such as external cue usage and reliance on implicit memory are used. Shown to be effective in long term, short term care, and independent living.
- Operates on the premise that muscle memory (procedural memory) is often less damaged in people with dementia
- Use materials familiar to the individual
  - kitchen objects for word-finding
  - recipes for a patient who cooks often
- Begin with a simple task and progress to a more difficult task.
  - Focus on one step at a time
  - start with a 3-step sequencing task before progressing toward a 6-step task
- Use materials that are visible and easily recognized

Memory Training Programs

- Errorless Learning
  - As each skill is taught, the patient is provided with a prompt or cue immediately to decrease chance of incorrect response.
  - Patient only learns to respond correctly
  - Prompts removed until patient can respond correctly on their own
- Vanishing Cues
  - Similar to errorless learning
  - Reduction of cues as learning progresses
- Spaced Retrieval

Spaced Retrieval Training

- Patient is given a piece of information. The patient is then asked to recall the information or behavior in response to a stimulus question systematically over time.
- The main goal of the spaced retrieval technique is to teach a single functional piece of information or behavior that can be use in situations of everyday living.
- Examples could be caregiver names, transfer techniques, room number, or other basic ADL facts.
- This technique can be used for multiple pieces of information, but only one fact or behavior should be targeted at a time.

Recent Literature on Spaced Retrieval

- Oren, S., Willerton, C., & Small, J. (2014). Effects of Spaced Retrieval Training on Semantic Memory in Alzheimer's Disease: A Systematic Review. *Journal of Speech, Language, and Hearing Research, 57*(1), 247-270. doi: 10.1044/1092-4388(2013/12-0352)
- Benigas, J. E. (2015). Spaced Retrieval Training: 26 Years of Growth. *SIG 15 Perspectives on Gerontology, 20*(1), 34-43. doi: 10.1044/gero20.1.34

FOCUSED Caregiver Training

- Designed to be used with family members of people with dementia as well as their caregivers.
- The strategies of the acronym teach caregivers how to effectively communicate with the patient.
- The techniques of the FOCUSED program are:
  - F- Functional and Face-to-face communication
  - O- Orient to topic
  - C- Continuity of Topic (should be concrete- no why?)
  - U- Unstick communication blocks
  - S- Structure the conversation with yes or no questions or choices
  - E- Exchange conversation and encourage interaction
  - D- Direct conversation- use short, simple sentences

Ripich, D. N., Wykle, M., & Niles, S. (1995). Alzheimer's disease caregivers: the focused program. A communication skills training program helps nursing assistants to give better care to patients with disease. *Geriatr Nurs, 16*(1), 15-19.

FOCUSED Caregiver Training

- Studies have shown that FOCUSED Caregiver training may contribute to:
  - More successful conversation exchanges
  - Increased or decreased caregiver burden, depending on situation
  - Improved quality of life for the patient
  - Maintenance of language abilities of the person with dementia
  - Increased caregiver knowledge of dementia and understanding of communication breakdown
  - Increased caregiver satisfaction on communication competency

CACIs

- Train patients to perform "everyday tasks of functional relevance
- Therapists supplement CACI by providing instructions, redirection, or prompting to facilitate task completion
- Anticipated outcomes with CACI's:
  - Improved acquisition and retention of trained information and skills
  - Generalization of computer-trained tasks to real-word tasks
  - Enhanced ability to performed trained tasks in a lesser amount of time
  - Retention of trained information over several weeks after end of training
  - Little to no change with global cognitive function as measured by standardized test of memory or general cognition as a result of the training.
  - Outcomes judged on functional abilities
- Herrera and colleagues found that CACIs improved episodic memory and recognition, and that those skills were maintained 6-months post-study.

Herrera, C., Chambon, C., Michel, B. F., Paban, V., & Alescio-Lautier, B. (2012). Positive effects of computer-based cognitive training in adults with mild cognitive impairment. *Neuropsychologia, 50*(8), 1871-1881. doi: http://dx.doi.org/10.1016/j.neuropsychologia.2012.04.012

Who is a candidate for CACIs?

- Patients with episodic memory impairments resulting from dementia, but relatively spared motor learning skills (procedural memory)
- Individuals with mild to moderate dementia and the ability to attend and participate in sessions
- Patients with hearing and vision within normal limits with adaptive equipment and hand-eye coordination to manipulate touch-screen or keyboard

Apps for Ipad/Ipod

- Tactus Therapy Solutions Apps (Free versions)
  - Language Lite
  - Visual Attn Lite
  - SRT
  - Category Lite
  - Conversation Lite
- Scrabble
- Memory!
- Just Say It!
- Sandwich Maker
- Unblock Me
- Ruzzle
- Brain Challenge HD
- Chain of Thought
- Fit Brains Trainer
- Word Warp
- Describe It
- déjà vu
- iMazing
- Conversation Starters- iTopics
- TherAppy Apps
- Story Creator
- MakeChange
- Answer Yes/No
- Text Twist
- Clockface Test

Myth #6: Documenting therapy for a patient with dementia is a losing battle….

Expectations and Goal Writing

- Would we expect a patient on GDS 5 to work on medication management?
- What should we do if a patient presents on a much lower GDS than prior level of function due to acute condition?
- Can a patient progress beyond their prior level of function?
- Can a patient with dementia learn?

Daily Notes Should…

- Justify billing codes being used.
- Demonstrate the skilled interventions of the therapist
- Must be linked to a goal.
- Demonstrate medical necessity.
- Demonstrate progression.

Documenting Daily Therapy Activities

- ALWAYS remember that your daily notes should convey why it was necessary to have this activity facilitated by a therapist!
- Remember Skilled Terminology!

Analyzed	Assessed
Decision Making	Demonstrated
Developed	Designed
Educated	Evaluated
Facilitated	Graded
Incorporated	Implemented
Inhibited	Instructed
Modeled	Progressed
Provided	Reviewed
Selected	Trained

Coding

- Why does it matter?
  - Paints a clear picture of the patient's condition that led to the decline.
  - Clearly delineates where the deficit is and why ST is treating the patient.
  - Serves as a means for achieving reimbursement for our services.
  - Improper coding can mean automatic denial of reimbursement.

One Code Fits All?

- Common misconception is that all patients should be coded using the symbolic dysfunction or cognitive communicative deficit code.
- Since October 1, 2015 and the initiation of ICD-10, the one-code-fits all mentality of using symbolic dysfunction has been scrutinized.
- Therapists need to understand that it's all a matter of lining up CPT coding with appropriate ICD-10 codes and corresponding goals for EACH individual patient.

But we ALWAYS do it ___ way….

- There are rarely any "always" or "never" situations.
- There are exceptions (codes that MACs or LCDs do not accept)
- No one code should be used for all cognitive communication disorders.
- Be familiar with your Medicare Fiscal Intermediary (FI) and get a copy of the Local Coverage Determination (LCD) manual to determine what acceptable coding is appropriate for your specific building.
  - Cahaba
  - Palmetto
  - WPS

One major exception

- R40-R46 codes (including the R41.841-Cognitive Communicative Deficit) cannot be used with any F codes (includes Dementia)
- These codes are excluded by rule. Any use of them in the same claim will be automatically denied.

But the patient has Dementia…..

Your very first step in the process is to ask:

1. What is the primary medical dx (what diagnosis triggered the decline in function?)
   - Just because the patient has underlying dementia does NOT mean that it is the trigger for the current decline. It may be exacerbated by the current condition, but that medical dx should be the acute condition.
   - You may state that the patient has dementia that has worsened in the Medical History tab.

But the patient has Dementia…..

2. What is the expected progress for this patient and the supporting rationale for treatment? Why therapy, why now?
3. What deficits exist (through objective assessment) and what goals will address these?

Then, we begin to write the plan of care!

	IF the Primary Dx is Dementia… (F03.90 or other)
Sample Medical Dx.	F01.5 Vascular Dementia F02.80 Dementia in other diseases without behavioral disturbance F02.81 Dementia in other diseases classified elsewhere, with behavioral disturbance.
Example of allowable tx codes for language/cognition…	Language-based goals: R47.01- Aphasia (see attached handout for further descriptives)
Exclusions: DO NOT USE on the same claim…	NO R40-R46 (cognitive) codes on this POC
Evaluation Code	92523
Treatment Code	92507
Important Notes:	Following commands, expression, recall of verbal information are all language-based goals.

- Difficulty speaking- R47.01
- Unintelligible Speech (Dysarthria)- R47.1
- Apraxia- R48.2
- Difficulty understanding spoken language (not attributed to CVA)- R47.01
- Difficulty understanding written language- R48.0 (Alexia)
- Difficulty writing (total Agraphia)- R48.8
- Difficult reading/writing- R48.0
- Difficulty remembering words- R47.01
- Difficulty Expressing thoughts- R47.01
- Difficulty processing information- R47.01
- Difficulty Following Directions- R47.01
- Word retrieval difficulties- R47.01
- Difficulty with word meaning- R47.01
- Difficulty with simple mathematical tasks (acalculia) R48.8
- Loss of ability to recognize objects, persons, sounds, shapes, or smells (Agnosia)- R48.1
- Difficulty processing visual information (visual agnosia) R48.3

	If the Primary Dx is neurological, not a CVA…
Sample Medical Dx.	G20: Parkinson's Disease G93.41 Metabolic Encephalopathy S06.5X0S Traumatic subdural hemorrhage w/o loss of consciousness, sequela (Most GXXX.X codes are neuro-related)
Example of allowable tx codes for language/cognition…	R48.8 (Other symbolic dysfunction)
Exclusions: DO NOT USE on the same claim…	No I60.xxx- I69.xxx codes on the POC (need recent neurological code)
Evaluation Code	92523
Treatment Code	92507

- Other Symbolic Dysfunction- R48.8

BUT, more specific deficit areas can be characterized by:

- Difficulty speaking- R47.01
- Unintelligible Speech (Dysarthria)- R47.1
- Apraxia- R48.2
- Difficulty understanding spoken language (not attributed to CVA)- R47.01
- Difficulty understanding written language- R48.0 (Alexia)
- Difficulty writing (total Agraphia)- R48.8
- Difficult reading/writing- R48.0
- Difficulty remembering words- R47.01
- Difficulty Expressing thoughts- R47.01
- Difficulty processing information- R47.01
- Difficulty Following Directions- R47.01
- Word retrieval difficulties- R47.01
- Difficulty with word meaning- R47.01
- Difficulty with simple mathematical tasks (acalculia) R48.8
- Loss of ability to recognize objects, persons, sounds, shapes, or smells (Agnosia)- R48.1
- Difficulty processing visual information (visual agnosia) R48.3

	If the Primary Dx is from surgery or illness….
Sample Medical Dx.	N39.0 UTI A41.9 Sepsis R29.6 Repeated Falls M62.82 Rhabdomyolosis
Example of allowable tx codes for language/cognition…	R41.841
Exclusions: DO NOT USE on the same claim…	No F0-F99 (dementia) codes on this POC
Evaluation Code	92523
Treatment Code	92507

	If the Primary Dx is a CVA….
Sample Medical Dx.	I63.412 Cerebral infarction due to embolism of L MCA I63.011 Cerebral infarction due to thrombosis of right vertebral artery I63.111 Cerebral infarction due to embolism of right vertebral artery ….or any other of the multitude of CVA codes
Example of allowable tx codes for language/cognition…	Examples: I69.xxx (look up applicable CVA code)
Exclusions: DO NOT USE on the same claim…	No R48.8 (symbolic dys) or R41.841 (cog comm deficit) on this POC
Evaluation Code	92523 or 96125
Treatment Code	92507 or 97532

CPT Codes 96125 and 97532

LCD Definition of 96125:

- (Cahaba) Standard cognitive performance testing (eg., Ross Informational Processing Assessment) per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.
  - a. These tests evaluate different aspects of neurocognitive ability **in patients who have compromised functioning due to acute neurological events such as traumatic brain injury or cerebrovascular accident (CVA).**
- (Palmetto) Evaluate abilities of executive (cognitive) function including: assessment of learning abilities, memory and working memory, abstract thought, language, and attention.

What about 96125 and 97532?

LCD Definition of 97532:

- (Cahaba)- Development of cognitive skills, as described by code 97532, seeks to improve attention, memory and problem solving, and includes compensatory training, which refers to training provided to make up for a deficiency or loss of cognitive skills. This is often indicated for adults with **diagnoses of psychiatric disorders, brain injuries and cerebral vascular accidents (CVAs).** Cognitive skill training may allow individuals with these types of impairments to live independently, return to work, and function safely in their environments. Cognitive impairments are broken down into three categories: Attentional Impairments, Short Term Memory Impairments and Problem Solving Impairments. As **the definition of the goal is "to improve"**, this service would not be expected to be used with maintenance therapy.
- (Palmetto) This is the developing or restoring of cognitive status (alertness, orientation, attention, memory, problem solving, recall, affect, reasoning, judgment, organization, and retention) and (informal assessment/ observation of cognitive abilities necessary for performing daily activities); with interpretation and report.
- (WPS) Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one-on-one) patient contact by the provider, each 15 minutes
  - 1. This procedure may be medically necessary for persons with acquired cognitive impairments resulting from **head trauma, or acute neurologic events including cerebrovascular accidents**. These services are not indicated for patients with chronic progressive brain conditions without reasonable potential for restoration.
  - 2. These procedure may be medically necessary when included in a patient's certified plan of care aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when expected outcomes that are attainable by the patient are specified in the plan.

Rehab Potential

- Many MACs (including Palmetto GBA) require patients with 97532 used to have "expected significant improvement." (not compensatory strategies, not education, no language-based activities for ADL independence)
- Brain injury or CVA are seen as appropriate 97532 diagnoses, not progressive neurological conditions

If you use "cognitive" only codes

- Make sure there is a standardized, normative referenced assessment, to include deficits noted from PLOF in the areas of: memory, executive function, etc. An assessment WITH the scores would be most recommended (RIPA-G subtests, etc)
- Make sure cognitive goals are listed on the POC, not language goals.

Cognitive Linguistic Therapy

- Remember that following 1-step commands and communication-expression goals are ***language goals***.
- If these are present, there should also be assessments related to each goal as well as additional treatment dx (such as the ones listed on the chart).
  - BCRS
  - MOCA
  - SLUMS
  - SAGE
  - Etc….

92507

The treatment/intervention, (e.g., prevention, restoration, amelioration, and compensation) and follow-up services for disorders of speech, articulation, fluency and voice, language skills and the **cognitive aspect of communication**)

In addition to "traditional therapy approaches," this could include:

1. Providing consultation, counseling, and making referrals when appropriate
2. Providing training and support to family members/caregivers and other communication partners of individuals with speech, voice, language, communication, fluency and hearing disabilities
3. Developing and establishing effective augmentative and alternative communication techniques and strategies, including selecting, prescribing and dispensing of aids and devices as identified by State Practice Acts; and training individuals, their family members/caregivers, and other communication partners in their use.
4. Developing compensatory techniques and instructing patient in their use.

Examples of Language-Worded Goals

- Recall information presented verbally
- Utilize written language to provide graphic cues for recall of information
- Follow auditory directions for ADL sequencing
- Verbally express potential safety hazards
- Verbally express solutions to problems for daily living scenarios
- Answer questions regarding safety

Documentation

- Should connect the dots! How decline occurred, what condition was major contributor, how this decline has affected patient's abilities, and why treatment is necessary.
- Should demonstrate the skilled nature of services provided by the therapist, not what the "patient did".
- Avoid:
  - Tolerated well
  - Continue POC
  - Plateau
  - Max potential
  - Patient completed …..(exercise, task, etc.)

Additional Organizational Resources

- Alzheimer's Association
- Alzheimer's Foundation of America
- Alzheimer's Society
- National Association of Certified Dementia Practitioners
- Dementia Research Center
- Fisher Center for Alzheimer's Research
- National Institute on Aging

Thank you for your time and attention!

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