



**NEW COGNITIVE PROCEDURE CODING  
WHAT YOU NEED TO KNOW  
SESSION # 1075**

Presented by ASHA's Health  
Care Economics Committee  
2017 ASHA Convention  
Los Angeles, California  
November 9, 2017

# DISCLOSURES

## Dee Adams Nikjeh

Dee is contracted by the US Dept of Justice as an SLP expert witness. She is co-chair of the HCEC and the AMA RUC HCPAC, serves on the AMA RUC, and is reimbursed for HCEC and AMA RUC HCPAC travel.

## Shannon Butkus

Shannon owns a private practice, serves on the HCEC, and is reimbursed for HCEC related travel.

## Renee Kinder

Renee is paid a salary by Encore Rehabilitation, serves on the HCEC and the AMA RUC HCPAC, is reimbursed for HCEC and AMA RUC HCPAC travel, and received a complimentary conference registration for her participation in a Short Course.

## Mark DeRuiter

Mark DeRuiter is paid a salary by the University of Arizona, serves on the HCEC, is reimbursed for HCEC travel, and received a complimentary conference registration for his participation with the Research, Academic Town Meeting.

## Katie Holterman

Katie is paid a salary by Care One Management LLC, serves on the HCEC and on the AMA CPT Editorial Panel, and is reimbursed for HCEC and AMA CPT related travel.

## Tim Weise

Tim is contracted by Blue Cross Blue Shield of MI as an SLP Reviewer. He serves on the HCEC and is reimbursed for HCEC-related travel

# HEALTH CARE ECONOMICS COMMITTEE (HCEC)

## PURPOSE

- Assist Government Relations and Public Policy Board (GRPP) and cluster staff in determining current economic issues and develop goals for ensuring equitable coverage and reimbursement
- Develop recommendations for coding (procedural and diagnostic) and relative values of procedural codes
- Anticipate future socioeconomic needs of the professions and the consumers

# 2017 HEALTH CARE ECONOMICS COMMITTEE (HCEC)

## **SLP Members**

- Dee Adams Nikjeh, Co-Chair, SLP RUC Advisor
- Renee Kinder, SLP RUC Advisor, alternate
- Shannon Butkus
- Mark DeRuiter
- Katie Holterman, SLP CPT Advisor
- Tim Weise

Joan Mele-McCarthy, **VP Government Relations & Public Policy**

## **Audiology Members**

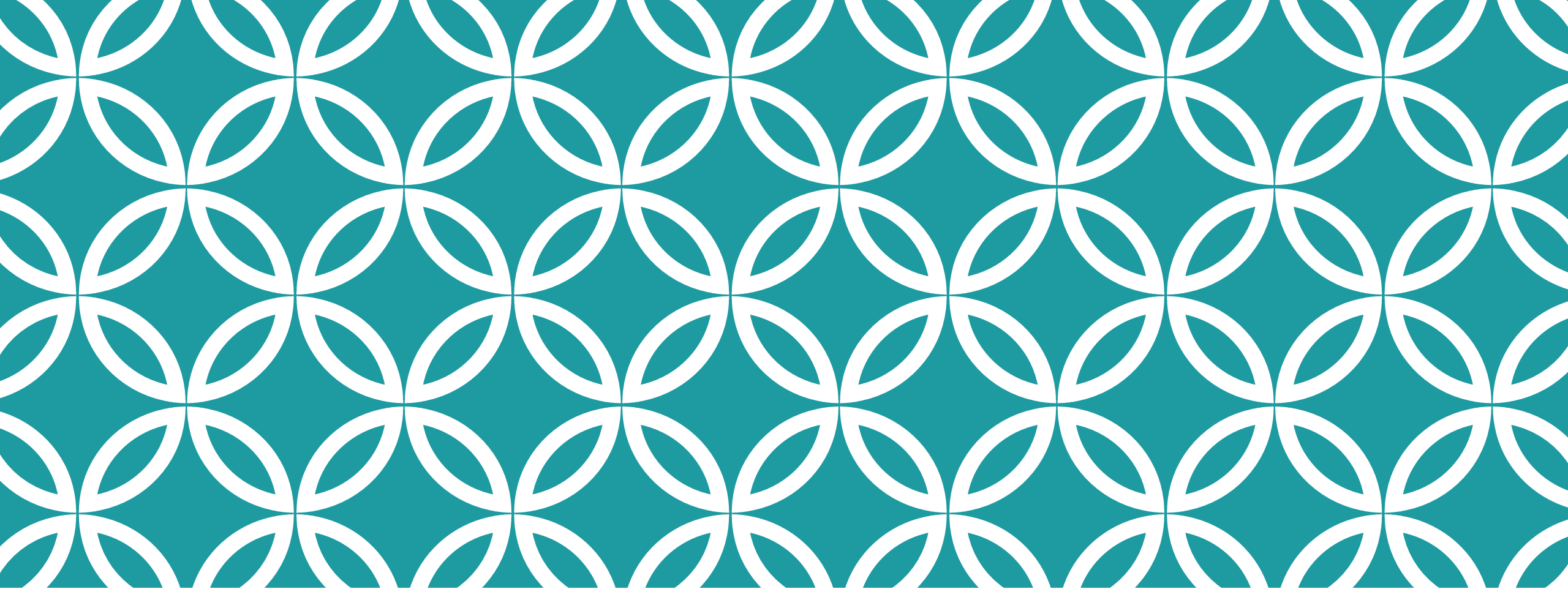
- Stuart Trembath, Co-Chair, AUD CPT Advisor
- Leisha Eiten, AUD RUC Advisor
- Bob Burkard
- Wayne Foster
- Mike Hefferly
- Lauren Mann

## **ASHA Staff**

- Tim Nanof, Ex Officio, Director, Health Care Policy & Advocacy
- Neela Swanson, Staff Liaison, Director, Health Care Coding Policy & Advocacy

# AGENDA

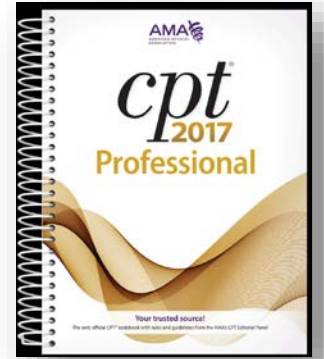
- Current Procedural Terminology (CPT) Codes
- International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) Codes
- Coding Options Based on Medical Diagnosis
- Practice Scenarios and Q&A



# **CURRENT PROCEDURAL TERMINOLOGY AKA CPT CODES**

Evaluation and Treatment of  
Cognitive Impairment

# CURRENT PROCEDURAL TERMINOLOGY (AKA CPT CODES)



- Every medical, surgical, and diagnostic procedure assigned a 5-digit code
- CPT codes are used to
  - Simplify the reporting of services
  - Ensure uniformity of communication
- Approximately 8,000 codes
- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Updated annually

# RELATIVE VALUE UNIT (RVU)

- Every CPT procedure or service has a *resource-based relative value*
- Payments for services are determined by the **resource costs** needed to provide them
- 3 Components of a relative value unit
  - Professional Work
  - Practice Expense
  - Professional Liability
- All procedures are ranked on this same relative value scale
- Standardized physician payment schedule



# CURRENT CPT CODE

## *CPT 96125 COGNITIVE PERFORMANCE EVALUATION*

### **Vignette**

Patient with diagnosed brain damage is referred for standardized cognitive performance testing.

### **Descriptor**

Standardized cognitive performance testing (eg, Ross Information Processing Assessment) *per hour* of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

# CPT 96125 COGNITIVE PERFORMANCE EVALUATION PROCEDURE SUMMARY

- Review pt history
- Interview pt and/or family/caregiver(s) to assess relevant cognitive demands
- Explain procedures and complete face-to-face administration of appropriate standardized test(s) to assess pt's ability to complete specific functional tasks applicable to the patient's environment
- Identify or quantify specific cognitive deficits (i.e., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning)
- Examine potential for effective compensatory behaviors, motivational barriers and facilitators
- Analyze and interpret data
- Determine plan of care
- Document findings and recommendations
- Discuss findings and tentative goals with patient and family/caregiver(s)

# CODING AND BILLING FOR CPT 96125

CPT 96125 is a *timed per hour* procedure code

**Medically Unlikely Edit (MUE)** applies

- CPT 96125 may be billed up to **2** units per evaluation
- Apply to Medicare & Medicaid, private payers may follow

Medicare **Multiple Payment Procedure Reduction (MPPR)** applies

- MPPR is per-day Medicare policy that applies across disciplines and settings
- MPPR applies to all procedure codes billed that day regardless of discipline (SLP, PT, OT)
- Code with greatest Practice Expense (PE) gets full payment and others have 50% PE reduced

# TIMED PROCEDURE CODES

Time documented must correspond to number of units billed on the claim

Time spent *must exceed halfway point* dictated by the code:

- **1-hour unit  $\geq$  31 minutes**
- **1/2 hour unit  $\geq$  16 minutes**
- **15-minute unit  $\geq$  8 minutes**

Subsequent timed-units may not be counted until the full value (first code) plus 1/2 of the value is exceeded (second code)

# CALCULATION OF REQUIRED TIME

## EXAMPLE FOR CPT 96125

A cognitive performance evaluation took 90 minutes with the patient and scoring, interpretation and documentation took an additional 20 minutes.

- CPT 96125 = 1 hour per each unit billed, max of 2
- To bill a second unit of 96125, 91 minutes must be documented on evaluation and report; (first hour + 1/2 of second hour + 1 min)
- In this case, 110 minutes are documented
- It is appropriate to bill 2 units of 96125

# EXAMPLE OF MPPR FOR CPT 96125

- Every CPT code value has 3 components
- Based on 2017 Medicare Physician Fee Schedule for CPT 96125 and the 2017 Conversion Factor ~ \$35.77
  - Professional Work = 1.70 → \$60.80
  - Practice Expense = 1.51 → \$54.00
  - Liability Insurance = 0.07 → \$ 2.50
- Reimbursement for CPT 96125 for first hour ~ \$117 per hour
- Additional hour reimbursement ~ \$117.00 - \$ 27.00 (%50 of PE) = \$90 for second hour
- Reimbursement from Medicare Part B for 2 hours is approx. \$ 207.00

# CPT 97532 COGNITIVE SKILLS DEVELOPMENT

*DELETED FOR 2018*

## **Old Vignette**

An older adult has a combination of depression and organic brain syndrome. Although she lives with her daughter's family, she is alone during the day at their home. She has difficulty remembering when to take her medicines and frequently forgets to eat the meals her daughter prepares for her. At times she exhibits disconnected language that impairs her conversational abilities. By analyzing the patient's home environment and daily routine, the practitioner develops a structured system that may include exercises to enhance attention, memory, and social interaction skills, by which the patient incorporates taking her medication and eating her meals into her daily activities.

## **Old Descriptor**

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

## **Procedure Summary**

Intraservice work includes services provided while practitioner is with patient and/or family

# DELETED 97532 COGNITIVE SKILLS DEVELOPMENT

## *PROBLEMS WITH THIS CODE*

- 15-minute timed code pulled thru Centers for Medicare and Medicaid Services (CMS) screen for High Volume Growth\*
  - 2005 utilization 66,680
  - 2010 utilization 158,301
  - 2015 utilization 308,359
- \*RUC Database (Medicare Part B)
- Used by multiple professionals for different purposes - psychology, occupational therapy, speech-language pathology
- 4 units (i.e., 60 mins) typical billing to Medicare Part B for SLPs
- Medicare Part A SLPs report less units per visit but report every day over longer period of time
- Billing abuse in the industry
- CMS wanted move from timed to untimed procedure codes
- Payment rationale for **value** of service, not time spent



# NEW CPT 97127 COGNITIVE FUNCTION INTERVENTION *UNTIMED PROCEDURE*

## **NEW Vignette**

A 30-year-old male presents with traumatic brain injury sustained in a vehicular accident resulting in memory problems, distractibility, depression, inappropriate social interaction, inability to self-monitor, and impaired organizational skills for executive function. He is seen for treatment.

## **NEW Descriptor**

Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks) (report 97127 **only once per day**) (Do not report 97127 in conjunction with 0364T, 0365T, 0368T, 0369T)

# NEW CPT 97127 COGNITIVE FUNCTION INTERVENTION

## *PROCEDURE SUMMARY*

Implement therapeutic activities that may include

- attention tasks (eg, gradually increasing levels of distracting background noise)
- memory tasks (eg, visualization and mnemonics; environmental adaptations)
- problem solving activities (eg, techniques to define a problem, set a goal, and organize an action)
- pragmatic activities to increase self-awareness of limitations and disabilities (eg, use of internal dialogue)
- Compensatory strategies
- Technology-assisted activities

**UNTIMED CODE, MAY ONLY BE BILLED ONCE PER DAY**

# SO, WHAT HAPPENED?

- Based on member surveys by ASHA and APA, AMA RUC HCPAC approved 1.5 RVU per treatment visit
- CMS was not happy and did not accept recommendation
- CMS labeled code INVALID and will not reimburse for Medicare Part B beneficiaries
- CMS created G code which is a temporary code based on the original 97532
- This is NOT related in any way to G-codes used for claims-based functional outcome reporting!!

# NEW G-CODE CENTERS FOR MEDICARE & MEDICAID SERVICES

What's a "G-code" ?

- Medicare develops G-codes for specific programmatic needs that can't be met with existing codes, such as the G-codes used for functional outcomes reporting.
- In this case, the G-code will be used just like a CPT code

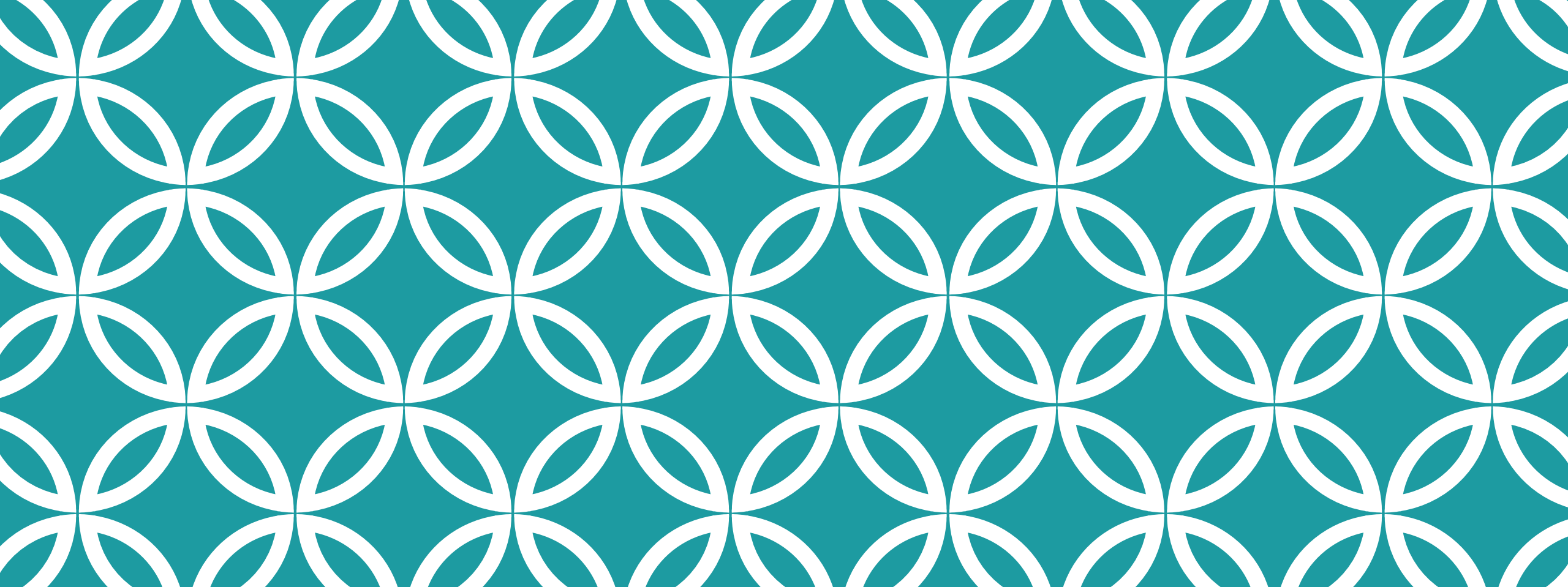
**G-code: G0515**

**Descriptor:** Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, **each 15 minutes**

**Vignette:** An older adult has a combination of depression and organic brain syndrome. Although she lives with her daughter's family, she is alone during the day at their home. She has difficulty remembering when to take her medicines and frequently forgets to eat the meals her daughter prepares for her. At times she exhibits disconnected language that impairs her conversational abilities. By analyzing the patient's home environment and daily routine, the practitioner develops a structured system that may include exercises to enhance attention, memory, and social interaction skills, by which the patient incorporates taking her medication and eating her meals into her daily activities.

# 2018 RECOMMENDATIONS FOR CPT CODING OF COGNITIVE FUNCTION INTERVENTION

- If Medicare is the payer, use G-code G0515 for 15-min procedure and same payment
- CCI edits still apply! Do not bill the new G-code on the same day as 92507
- If payer source is private insurer, Medicare Part C, or Medicaid,
  - CHECK with the payer to see which code they are accepting
  - Negotiate fee with payer based on your average treatment costs and overhead expenses
    - Medicare rates could be used as a starting point when calculating your fees
- If you feel payers are implementing the new code incorrectly, email ASHA for assistance: [reimbursement@asha.org](mailto:reimbursement@asha.org)

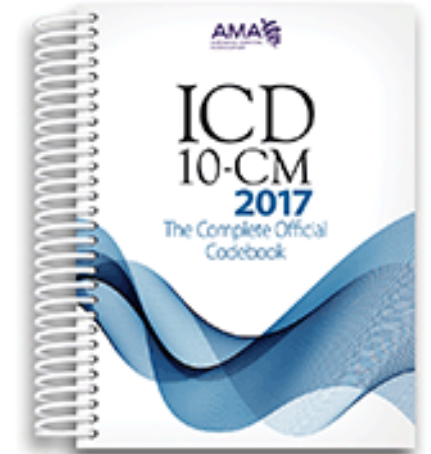


**INTERNATIONAL CLASSIFICATION OF DISEASES,  
10TH REV, CLINICAL MODIFICATION  
AKA ICD-10-CM**

ICD-10-CM Codes Related to  
Cognitive Impairment

# ICD-10-CM BEGAN OCTOBER 1, 2015

- ICD-10 includes approx 160,000
  - ICD-10-CM diagnosis codes for all settings
  - > 68,000 codes in Clinical Modification
  - ICD-10-PCS procedure codes for hospital inpatients
- Chapters based on body systems (e.g. nervous, circulatory, respiratory, digestive)
- 3-7 alphanumeric characters instead of current 3-5 digits
- Owned by the World Health Organization (WHO)
- Required for everyone covered by the [Health Insurance Portability and Accountability Act \(HIPAA\)](#)
- Does NOT affect CPT coding



# EXAMPLES OF ICD-10-CM THAT MAY BE ASSOCIATED WITH COGNITIVE INTERVENTION PROVIDED BY SLPS

**F80.1** Expressive language disorder

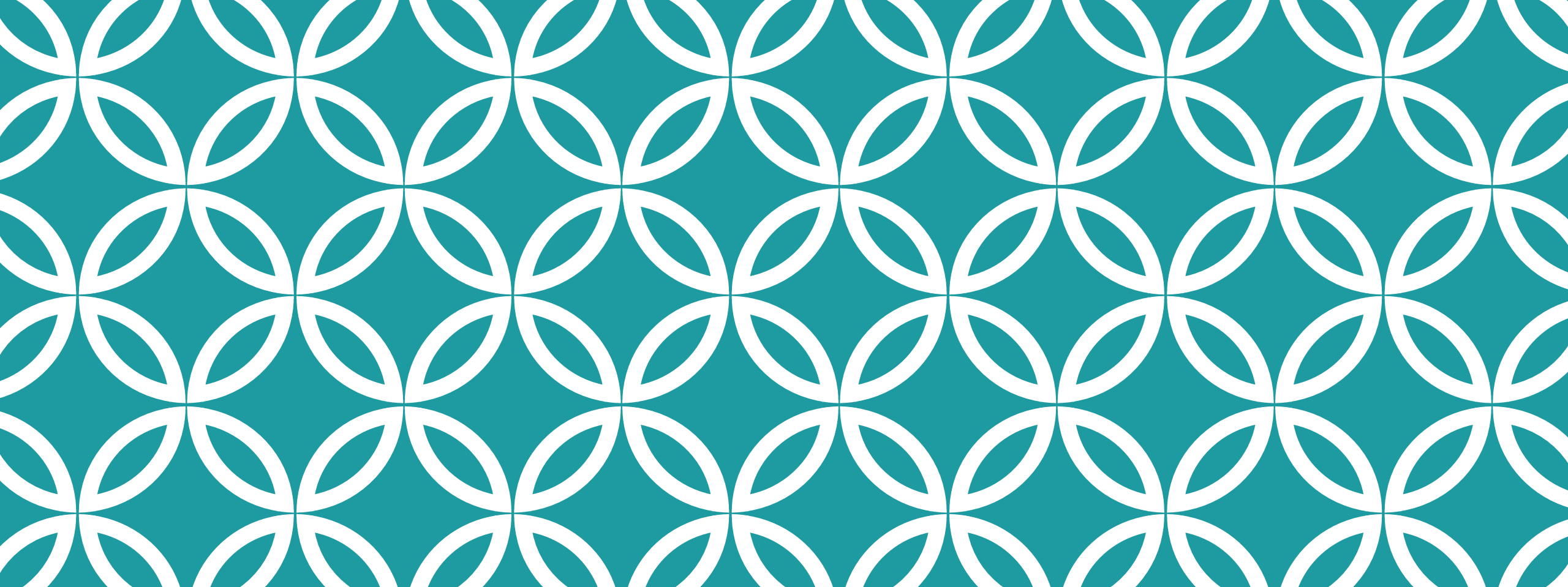
**F80.82** Social pragmatic communication disorder

**I69. series** Codes that replaced and expanded previous cognition codes 169.01 to 91 associated with cerebral infarct, hemorrhage, and disease

**R48.8** Other symbolic dysfunctions

**R48.841** Cognitive communication deficit





# CLINICAL PRACTICE SCENARIOS

Coding Issues  
SLP Evaluation and Treatment of  
Cognitive Impairment

# CASE SCENARIO

## BILLING MULTIPLE UNITS QUESTION

The evaluation for cognitive status using standardized measures took 50 mins with the patient. The interpretation and report writing took 30 mins and was documented in the medical record.

**How many units of CPT 96125 (1 hr/ea unit) may be billed for this evaluation?**

# CASE SCENARIO

## BILLING MULTIPLE UNITS ANSWER

**CPT 96125 is a timed code** and may be billed in 1-hour units of time for a maximum of two units. To bill a second unit **of 96125, 91 minutes (first hour + 1/2 of second hour + 1 min)** must be documented for the evaluation, interpretation, and report.

In this case 80 mins are documented in the record. It is appropriate to bill only **one unit of CPT 96125**.

# CASE SCENARIO

## CPT CODING QUESTION

I am treating an 11-year old who has been diagnosed with ADHD and is struggling in the classroom because of poor attention and memory skills. I work directly on memory enhancing techniques (e.g., chunking) and compensatory strategies.

Can I bill for **cognitive treatment**?

# CASE SCENARIO

## CPT CODING ANSWER

- It may depend on your payer:
  - If cognitive treatment is **not a covered benefit**, do not bill the payer.
  - If the focus of treatment is on cognitive communication and goals are **language-based** and the primary focus of treatment, CPT 92507 may be appropriate.
  - If CPT 97127 or G0515 is not recognized BUT cognitive treatment is a covered benefit, check with the payer. They may recommend billing CPT 92507 (speech and language therapy)
- You may NOT use both on the same date
- Do NOT switch billing to 92507 if cognitive treatment is provided, but is not a covered service, or has been denied by the payer

# CASE SCENARIO

## ICD-10 CODING QUESTION

The patient has been diagnosed by the physician with “dementia in other diseases classified elsewhere”(F02) and Alzheimer’s disease (G30). SLP treatment focuses on improvement of cognitive skills.

- Which ICD-10 code may I use?
- Which CPT procedure code may I use?

# CASE SCENARIO

## ICD-10 CODING ANSWER

Given recent change in ICD edit (i.e., change from Excludes 1 to Excludes 2 for R40-R46) indicating that R40-R46 codes *MAY* be combined with F01-F99 codes, ICD-10 codes for cognitive treatment for patients with Alzheimer's disease:

- **R41.841** Cognitive-communication deficit
- **G30** Alzheimer's disease

CPT Code?

Does POC support treatment of cognition (CPT 97127) or language skills (CPT 92507)? Use CPT code that represents your POC and reflects treatment provided.

# CASE SCENARIO

## ICD-10 CODING QUESTION

A 25-year-old was referred to SLP for evaluation of cognitive skills status-post automobile accident with concussion. ICD-10 code from the physician was S06.3 Focal traumatic brain injury and R41.841 Cognitive Communication Deficit. Evaluation of cognitive function was completed and abilities were within normal limits. What is the correct ICD-10 code for the evaluation?

- A. R41.841 Cognitive Communication Deficit
- B. X62.0 Normal
- C. I69.219 Unspecified symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage

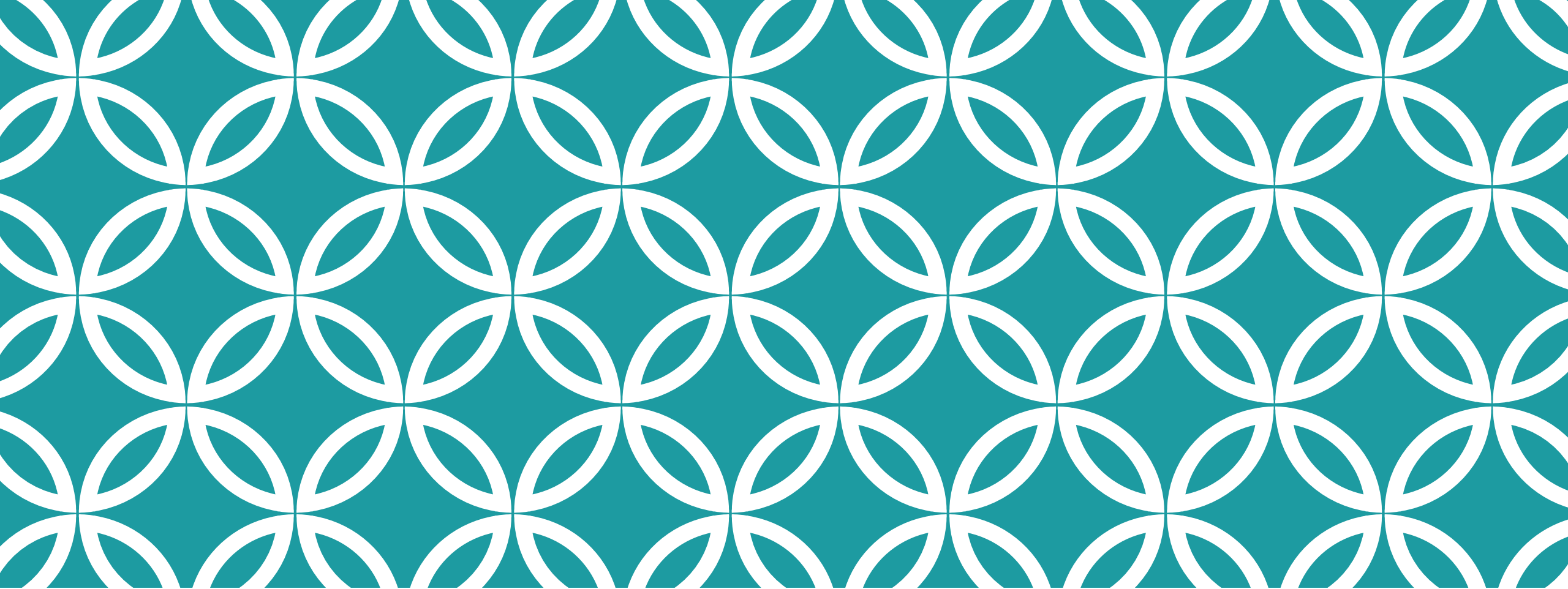


# CASE SCENARIO

## ICD-10 CODING ANSWER

Answer is: **A** (R41.841 Cognitive Communication Deficit)

- There is NO CODE to indicate normal
- Explain results in the documentation



# DECISION TREE

Cognitive Impairment vs  
Dementia Screening vs  
Evaluation

## COGNITIVE TREATMENT PLANNING DECISION TREE

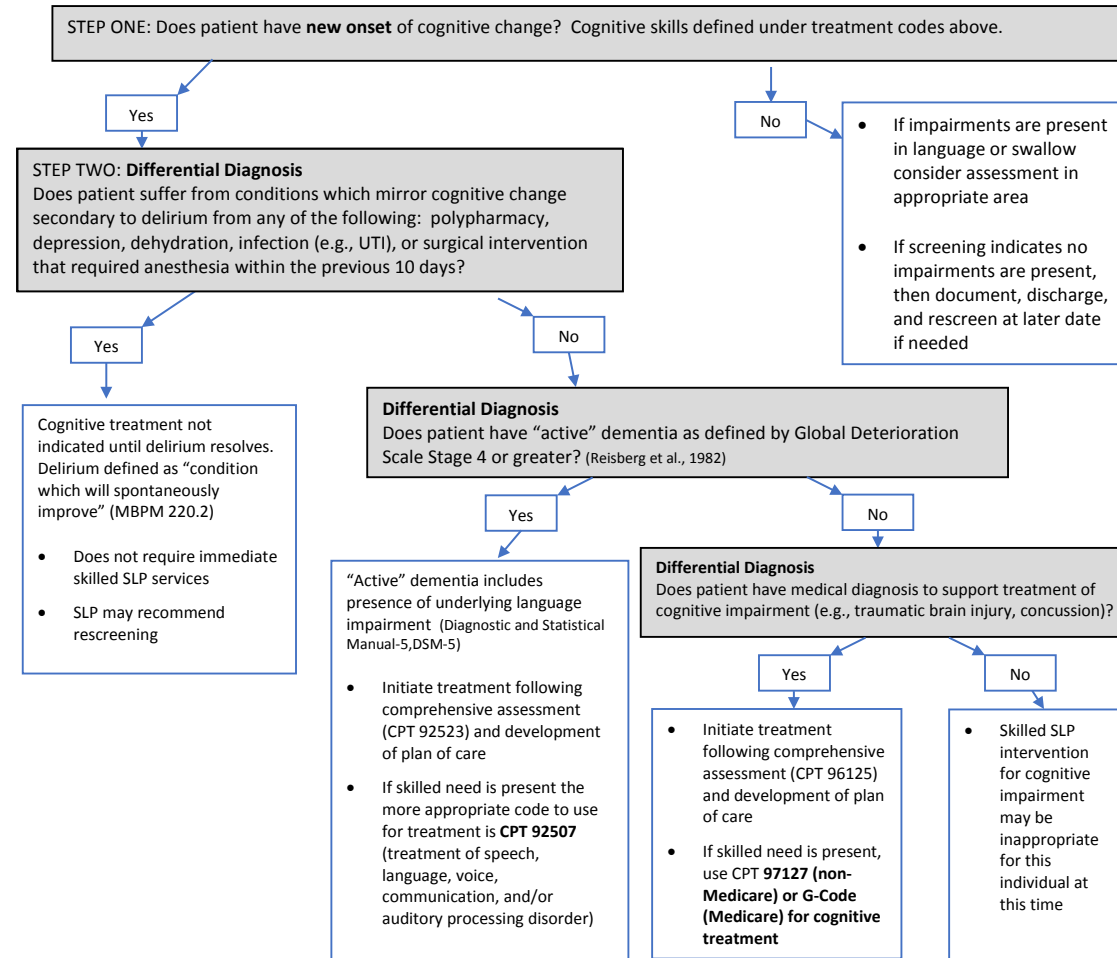
**Case Study: A physician order has been given to “eval/treat for cognitive function.” What do you do?**

### Evaluation Procedure Code

CPT 96125- Standardized Cognitive Performance **Testing** (eg, Ross Information Processing Assessment) *per hour* of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

### Treatment Procedure Codes

- G-code TBD (Medicare)-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**
- CPT 97127 (non-Medicare) – Cognitive treatment, **untimed procedure**; Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks)



# SCREENING VERSUS EVALUATION

- Screening Purpose
  - Does a problem exist?
  - Yes or No, Pass or Fail
- If yes, proceed to evaluation
- Clinical judgments and/or skilled recommendations should not be determined from only a screening
- Screening assessments are not covered by Medicare Part B

# EVALUATION VERSUS SCREENING

## EVALUATION

- Comprehensive service provided by a clinician
- Requires professional skills to make clinical judgments about conditions for which services are indicated
- Based on objective measurements and subjective evaluations of patient performance and functional abilities
- Establishes baselines of function
- Essential to development of the plan of care, short-term goals and selection of intervention strategies

## Evaluation is warranted when

- New diagnosis
- Change of status

Source: Medicare Benefit Policy Manual Chapter 15 Section 220

# CASE STUDY: I HAVE ORDERS

- Physician orders to “eval/treat for cognitive decline”
- What should you do?

## COGNITIVE TREATMENT PLANNING DECISION TREE

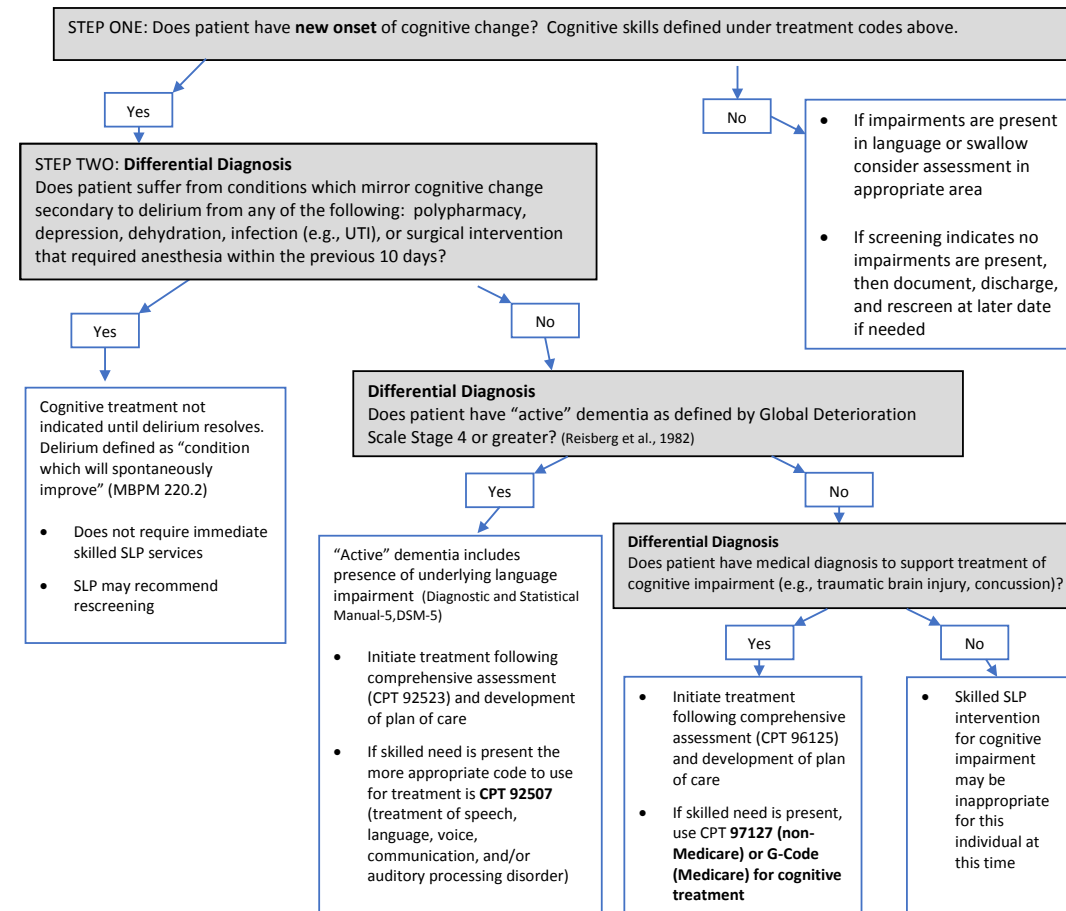
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# STEP ONE: IS THERE A COGNITIVE CHANGE?

Does the patient have new onset of cognitive change?

Yes, continue to step 2

No

- If impairments are present in language or swallow consider assessment in the appropriate area
- If no impairments are present, you may screen, discharge and rescreen at future time as needed



# STEP TWO: DIFFERENTIAL DIAGNOSIS

Does the patient suffer from conditions which mirror cognitive change secondary to delirium?

- polypharmacy
- depression
- dehydration
- infection such as UTI
- anesthesia within previous 10 days

If Yes, use evidence-based decision-making

- Medicare defines this as a “condition which will spontaneously improve” and therefore does not require a skilled level of care from an SLP
- Cognitive treatment not indicated until delirium resolves
- SLP recommends rescreening

If No, move to next decision

# STEP TWO: DIFFERENTIAL DIAGNOSIS

Does patient have “active” dementia as defined by Global Deterioration Scale Stage 4 or greater? (Reisberg et al., 1982) “Active” dementia includes presence of underlying language impairment (Diagnostic and Statistical Manual-5,DSM-5)

If Yes,

- Initiate treatment following comprehensive assessment (**CPT 92523**) and development of plan of care that may include a maintenance program
- If skilled need is present the more appropriate code to use for treatment is **CPT 92507** (treatment of speech, language, voice, communication, and/or auditory processing disorder)

If No, move to next decision

# GLOBAL DETERIORATION SCALE (GDS)

The Global Deterioration Scale (GDS), developed by Dr. Barry Reisberg, provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease. It is broken down into 7 different stages. Stages 1-3 are the pre-dementia stages. Stages 4-7 are the dementia stages.

# GDS STAGE 4: ACTIVE DEMENTIA

Global Deterioration Scale- Stage 4

Moderate cognitive decline (Mild Dementia)

Clear-cut deficit on careful clinical interview.

Deficits manifest in following areas: (a) decreased knowledge of current and recent events; (b) may exhibit some deficit in memory of ones personal history; (c) concentration deficit elicited on serial subtractions; (d) decreased ability to travel, handle finances, etc. Frequently no deficit in following areas: (a) orientation to time and place; (b) recognition of familiar persons and faces; (c) ability to travel to familiar locations.

Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations frequently occur.

# STEP TWO: DIFFERENTIAL DIAGNOSIS

Does patient have medical diagnosis to support treatment of cognitive impairment (e.g., traumatic brain injury, concussion)?

If Yes,

- Initiate treatment following comprehensive assessment (**CPT 96125**) and development of plan of care that may include a maintenance program
- If skilled need is present, use **CPT 97127 (non-Medicare)** or **G-Code (Medicare)** for **cognitive treatment**

If No, skilled SLP intervention for cognitive impairment may be inappropriate for this individual at this time

# OTHER TOOLS FOR DIFFERENTIAL DIAGNOSIS

## Repeat lab values

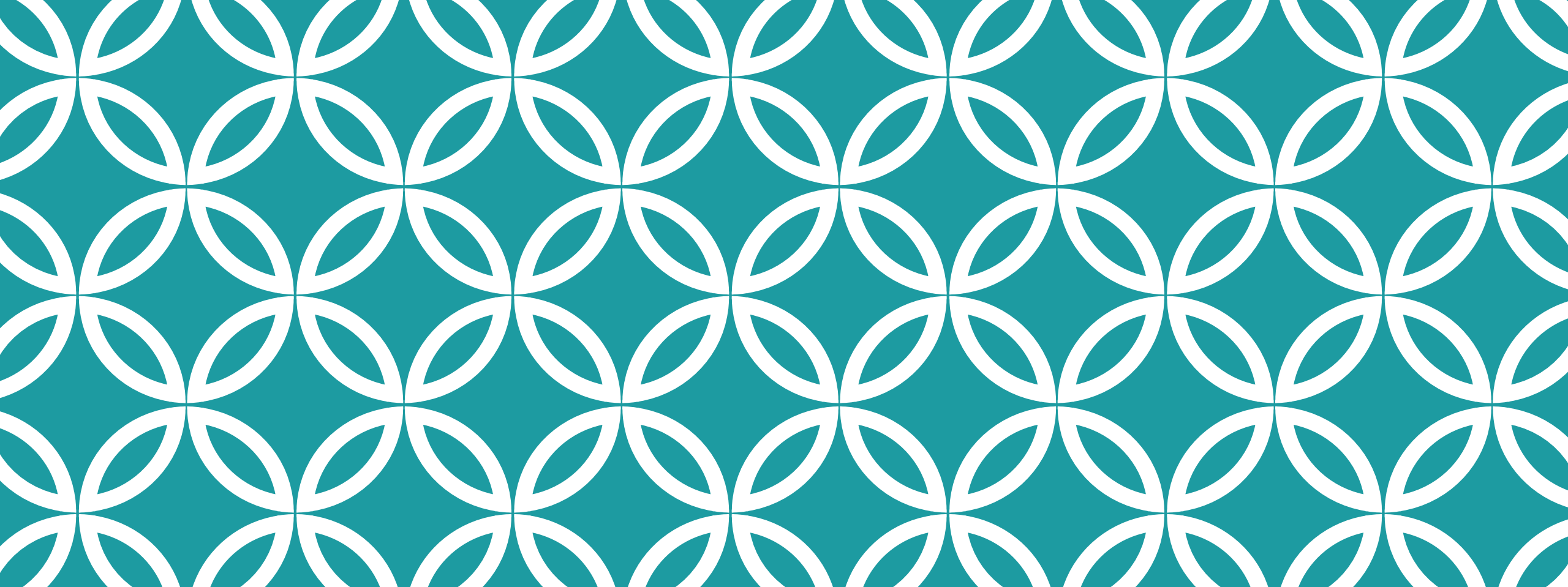
- Example - urinary analysis (UA) following active urinary tract infections

## Confusion Assessment Method (CAM)

- standardized evidence-based tool
- enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings.
- <https://consultgeri.org/try-this/general-assessment/issue-13>

## Tincture of Time

- Repeat SLP evaluation in 7 to 10 days



# CLINICAL PRACTICE SCENARIOS

SLP Evaluation and Treatment of  
Cognitive Impairment

# CASE SCENARIO: QUESTION

## MRS. RAY- FREQUENT FALLS

Mrs. Ray was referred for speech-language pathology services secondary to increased falls in her room. During initial patient interview, Mrs. Ray presents with decreased ability to verbally sequence steps for ADL tasks that she prefers to complete in her room including: transferring from her bed to the walker; completing denture care; and completing UB dressing tasks.

SLP determines the root cause of Mrs. Ray's impairments is based on decline of receptive and expressive language abilities that limit her ability to formulate thoughts and request assistance from caregivers.



# CASE SCENARIO: ANSWER

## MRS. RAY

Anticipated intervention coding: **CPT 92507** language based interventions appear to be most appropriate to meet her current needs.

# CASE SCENARIO: QUESTION

## MR. SMITH- FREQUENT FALLS

Mr. Smith was referred for speech-language pathology services secondary to frequent falls which occur in his room. He was admitted approximately one week ago status post TBI which occurred in the home environment.

Baseline measures during SLP evaluation reveal intact language abilities, however Mr. Smith presents with significant declines in cause-effect problem solving and short term memory tasks. Falls appear to be subsequent to overall decreased ability to negotiate obstacles in room environment when performing ADL tasks.

# CASE SCENARIO: ANSWER

## MR. SMITH

Anticipated intervention coding **97127 (non-Medicare) or G-Code (Medicare)** to address cognitive impairments related to memory and problem solving

# CASE SCENARIO: QUESTION

## REFERRAL FOR GENERALIZED CONFUSION

- 86 year old male who was referred by nursing for “confusion.”
- Med hx significant for osteoarthritis
- No previous history of dementia or brain injury
- Admitted to SNF following surgery for hip fracture
- Patient lives alone and is expected to return home

Patient is confused and disoriented to place, date, and time. He is pleasant and cooperative. I'm concerned because if pt goes home alone will he be able to take care of himself given his confusion? Should I provide therapy to address cognitive deficits?

# CASE SCENARIO: ANSWER

## REFERRAL FOR GENERALIZED CONFUSION

There is no history of dementia or brain injury. If using the decision tree, consider if this a “new” condition.

If yes:

- Note that patient had a hip fracture. Using chart review, determine if surgery was performed for hip fracture. If surgery was less than 10 days ago, this patient may be suffering from post-anesthesia delirium with associated cognitive deficits which may clear given time. **Consider re-screening in one-two weeks to determine need for evaluation.**

# CASE SCENARIO: QUESTION

## PATIENT WITH HEARING IMPAIRMENT

- 73 year old female referred for cognitive therapy with “end stage dementia”
- Pt was diagnosed 5 months prior to admission with vascular dementia
- SLP evaluation suggests that patient has a hearing impairment that significantly affects her ability to follow directions. She refuses hearing aids.

Should patient receive language treatment, cognitive treatment, or no SLP treatment?

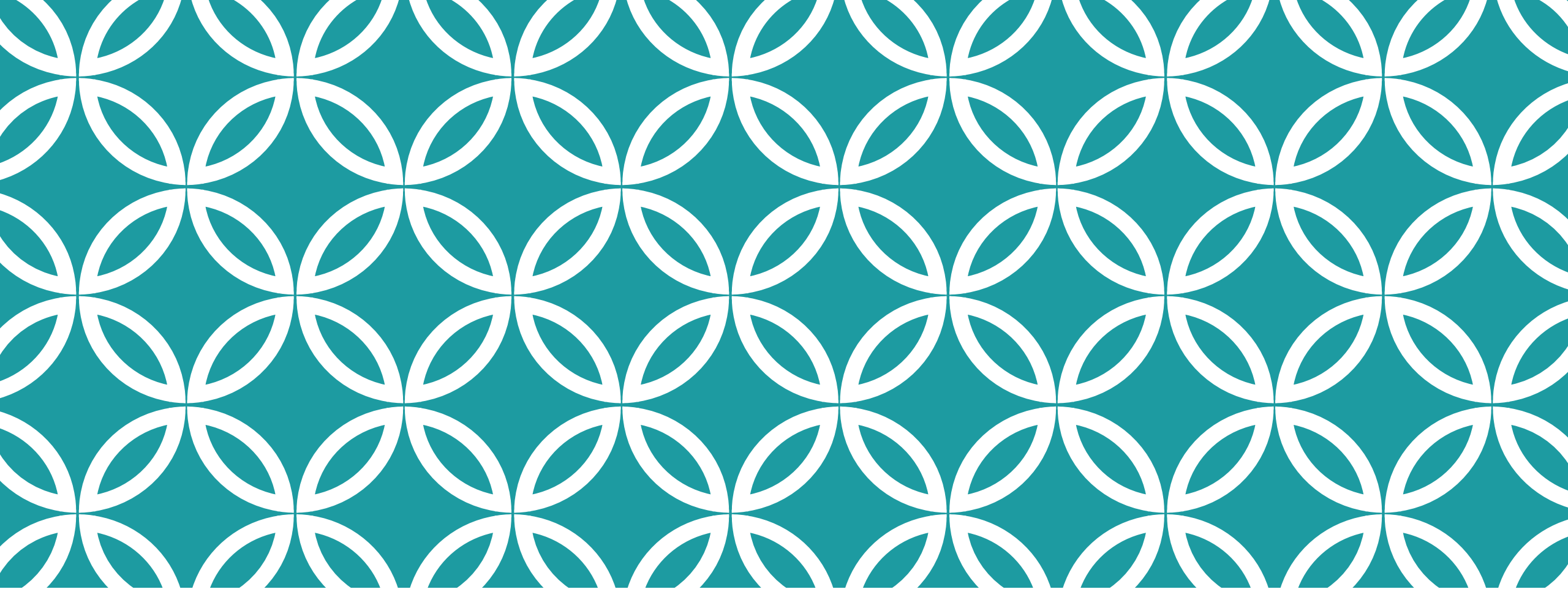
# CASE SCENARIO: ANSWER

## PATIENT WITH HEARING IMPAIRMENT

We must first consider whether patient is unable to follow directions due to hearing impairment, language impairment due to dementia, or both conditions. Review the evidence and involve family and/or caregiver.

- Has patient had a recent hearing evaluation? If no, recommend audiological evaluation.
- How does patient function at home?
- Try non-verbal cues/commands to evaluate comprehension without auditory component.

Cog perf testing adapted for significant hearing loss may indicate a true problem or no problem. A differential diagnosis is needed before proceeding to plan of care



# RESOURCES





# CODING RESOURCES

## New Codes for 2018

- New CPT Codes: [www.asha.org/practice/reimbursement/coding/new\\_codes\\_slp/](http://www.asha.org/practice/reimbursement/coding/new_codes_slp/)
- New ICD Codes: [www.asha.org/Practice/reimbursement/coding/New-and-Revised-ICD-10-CM-Codes-for-SLP/](http://www.asha.org/Practice/reimbursement/coding/New-and-Revised-ICD-10-CM-Codes-for-SLP/)

## CPT Codes for Speech-Language Pathologists

[www.asha.org/practice/reimbursement/coding/SLPCPT/](http://www.asha.org/practice/reimbursement/coding/SLPCPT/)

## ICD-10 Codes for Speech-Language Pathologists

[www.asha.org/Practice/reimbursement/coding/ICD-10/](http://www.asha.org/Practice/reimbursement/coding/ICD-10/)

## National Correct Coding Initiative: SLP Edits

[www.asha.org/practice/reimbursement/coding/CCI\\_edits\\_slp/](http://www.asha.org/practice/reimbursement/coding/CCI_edits_slp/)

## Medical Necessity for SLP & Audiology Services

[www.asha.org/practice/reimbursement/medical-necessity-for-audiology-and-SLP-services/](http://www.asha.org/practice/reimbursement/medical-necessity-for-audiology-and-SLP-services/)

## Medicare Coding Rules for SLP Services

[www.asha.org/practice/reimbursement/medicare/slp\\_coding\\_rules/](http://www.asha.org/practice/reimbursement/medicare/slp_coding_rules/)

# MEDICARE RESOURCES

Medicare Outpatient Fee Schedule for SLPs

[www.asha.org/Practice/reimbursement/medicare/feeschedule/](http://www.asha.org/Practice/reimbursement/medicare/feeschedule/)

Medicare Administrative Contractor Resources

[www.asha.org/Practice/reimbursement/Medicare/Medicare-Administrative-Contractor-Resources/](http://www.asha.org/Practice/reimbursement/Medicare/Medicare-Administrative-Contractor-Resources/)

Medicare Guidance for SLP Services in SNFs

[www.asha.org/Practice/reimbursement/medicare/Medicare-Guidance-for-SLP-Services-in-Skilled-Nursing-Facilities/](http://www.asha.org/Practice/reimbursement/medicare/Medicare-Guidance-for-SLP-Services-in-Skilled-Nursing-Facilities/)

Documentation of Skilled vs Unskilled Care for Medicare

[www.asha.org/Practice/reimbursement/medicare/Documentation-of-Skilled-Versus-Unskilled-Care-for-Medicare-Beneficiaries/](http://www.asha.org/Practice/reimbursement/medicare/Documentation-of-Skilled-Versus-Unskilled-Care-for-Medicare-Beneficiaries/)

# ASHA LEADER ARTICLES

*[HTTP://LEADER.PUBS.ASHA.ORG/](http://leader.pubs.asha.org/)*

New Cognitive Therapy Code Debuts in 2018

<http://leader.pubs.asha.org/article.aspx?articleid=2656663>

How Do You Code Executive-Function Services for Children?

<http://leader.pubs.asha.org/article.aspx?articleid=2290894>

Capturing Cognition in Skilled Nursing Facilities

<http://leader.pubs.asha.org/article.aspx?articleid=2474068>

Diving into New ICD-10 for 2017 (I69 series of codes related to cognition)

<http://leader.pubs.asha.org/article.aspx?articleid=2578621>

# ASHA PRACTICE PORTAL TOPICS

*[WWW.ASHA.ORG/PRACTICE-PORTAL/](http://WWW.ASHA.ORG/PRACTICE-PORTAL/)*

Dementia

[www.asha.org/Practice-Portal/Clinical-Topics/Dementia/](http://www.asha.org/Practice-Portal/Clinical-Topics/Dementia/)

Traumatic Brain Injury in Adults

[www.asha.org/Practice-Portal/Clinical-Topics/Traumatic-Brain-Injury-in-Adults/](http://www.asha.org/Practice-Portal/Clinical-Topics/Traumatic-Brain-Injury-in-Adults/)

Pediatric Traumatic Brain Injury

[www.asha.org/Practice-Portal/Clinical-Topics/Pediatric-Traumatic-Brain-Injury/](http://www.asha.org/Practice-Portal/Clinical-Topics/Pediatric-Traumatic-Brain-Injury/)

Documentation in Health Care for SLPs

[www.asha.org/Practice-Portal/Professional-Issues/Documentation-in-Health-Care/](http://www.asha.org/Practice-Portal/Professional-Issues/Documentation-in-Health-Care/)

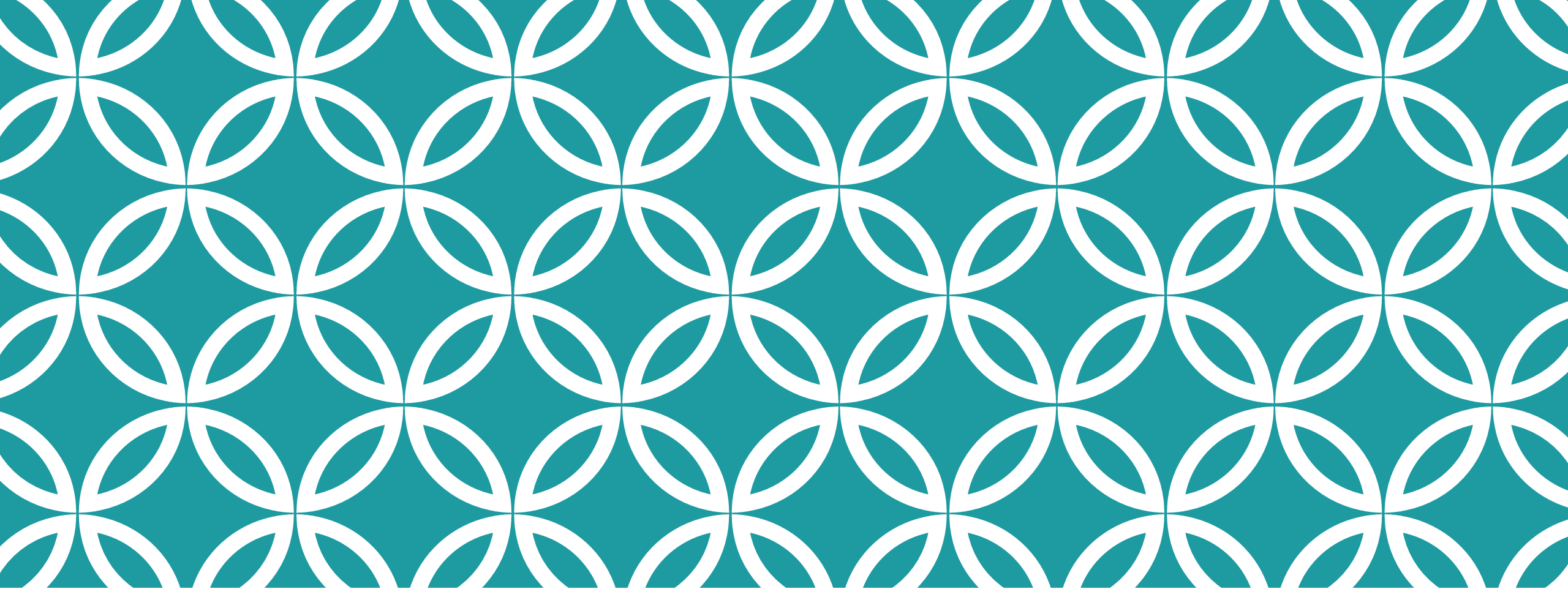
# RESOURCES DEVELOPED BY THE HCEC

## Speech-Language Pathology Medical Review Guidelines

- [www.asha.org/Practice/reimbursement/SLP-medical-review-guidelines/](http://www.asha.org/Practice/reimbursement/SLP-medical-review-guidelines/)
- provides an overview of the profession of speech-language pathology including qualifications, standard practices, descriptions of services, documentation of services, and treatment efficacy data

## Coding, Reimbursement, & Advocacy Modules

- [www.asha.org/Practice/reimbursement/modules/](http://www.asha.org/Practice/reimbursement/modules/)
- eight narrated modules provide an overview of important reimbursement and advocacy concepts



# ASHA PRESENTATIONS OF INTEREST

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## Thursday (Today!)

**6:30 - 7:30 pm** *Top Medicaid Challenges – Inquiring Minds Want to Know (Marriott, Gold 3)*

## Friday

**10:30 – 11:30 am** *Medicaid-Beyond the Basics-The Picture Expands (CC, 502A)*

**1:00 – 3:00 pm** *Teaching the Business of Our Professions: Empowering Our Students to Succeed in the Real World (Marriott, Platinum/F/G/H)*

**3:30 – 4:30 pm** *Get Ahead of 2018: Coding & Payment Update for Speech-Language Pathologists (Marriott, Diamond 4)*

# ASHA PRESENTATIONS OF INTEREST

## Saturday

**8:00 – 10:00 am** *Changing Landscape: Resources Members Need to Protect Their Services in Changing Healthcare/Education Environment (CC, 405)*

**11:00 am – 12:30 pm** *Top Ten List of Medicaid Challenges (You've Never Heard on David Letterman) (Poster, CC, West Hall A)*

**1:00 – 2:00 pm** *Politics and Professions: A Primer on ASHA-PAC and Advocating for Audiology and Speech-Language Pathology (CC, 403B)*

**2:30 – 3:30 pm** *Shift Happens: Advocating to Maintain SLP Services in Challenging Times (CC, Concourse 151)*