REGULATORY TIPS

Denial Alert – April, 2019

Denials for cognitive re-training by speech therapy have started coming in fairly rapidly and will be addressed through the appeal process. But let's try to stem the flow!

While National Government Services (claim reviewer) includes communication and dysphagia in their local coverage determinations, it neither directly acknowledges nor directly disallows cognitive re-training.

NGs does not understand the benefit of providing cognitive retraining so documentation must capture it in such a way that there is no question that it was medically necessary to provide the service. In order to do so, documentation must be functional. Medicare is very functionally driven and if they don't see the the connection between deficits and function in the documentation, denials will continue. Make that connection for them.

FUNCTION must be evident in:

- Reason for Referral
- Prior Level of Function (PLF)
- Assessment
- Goals
- Treatment

REASON FOR REFERRAL

Decreased ability to perform "X".
- X = a specific, functional task

PLF

Was able to perform X.
(At what level?)

SPECIFIC FUNCTIONAL TASKS EXAMPLES

X- SNF
- Locate room
- Use call light
- Recall precautions
- Object use
- Y/N? For pain, hunger, etc.

X- HOME
- Money management
- Med management
- Sequence appliances
- Make/keep appts
- Problem solve emergencies

Add to these lists as you identify additional functional tasks affected by cognitive decline.

X in Goals

In knowing what the patient had been able to do at **home,** and by identifying their baseline deficits for problem solving, memory, object identification, reading comprehension, etc.- it will probably be quite clear that they could no longer be functioning as independently with tasks they had been completing in their home. For **SNF** residents, the nursing staff should be able to identify some functional declines they have observed such as a decreased ability to locate their room, forgetting to get dressed, etc. So you use these functional tasks, the Xs, to establish **short and long term goals** (in addition to traditional, but non-functional, baseline deficits identified in the evaluation process.) It is critical to include these functional tasks as short term goals so that they can be measured weekly and as long term goals to identify what the patient will be able to do once they have completed their course of treatment.

X in Assessment

While you probably don't have time to assess Xs during your evaluation, nor are these tasks included on the evaluation/POC, during your first treatment session, get out your money/med management tool boxes to get a baseline, assess the patient's ability to use their actual call light, etc.- and document it.

X in Treatment

In addition to working to improve component deficits, treatment should directly address the Xs, the specific functional tasks.

NGS does not believe that there is enough literary support for improvement of cognitive deficits for dementia. However, they are more likely to understand the use of strategies to compensate for cognitive declines such as environmental modification (e.g. red nail polish on call light button, picture of patient's dog outside their room, pictures of pills attached to pill sorter, etc.). Much like PT works on gait daily and OT works on their Xs, self-cares, daily so much ST work on the patient's specific functional tasks daily. Incorporate training for problem solving, memory, etc. into the actual task itself. This will allow Medicare to see the correlation between component deficits and functional deficits.