# MSHA March 4, 2017 Committee Reports for Consent Agenda

## COMMITTEE REPORT FOR COMMUNITY OUTREACH

ACTIVITY FOR OCTOBER 5, 2016-FEBRUARY 23, 2017:

11/10/16: $100.00 approved to Gemma Dodd for new ear molds for her BTE hearing aids. Requested by Leah Jacobsen.

Available balance in Community Outreach fund as of 2/23/17 is $82.47.

## STATE ADVOCATES FOR MEDICARE POLICY (StAMP)

## STATE ADVOCATES FOR REIMBURSEMENT (STARs)

March, 2017

STAMP:

I have received numerous questions about cognitive coverage from MSHA members. I am addressing this issue using the training from Liza Milliken, fellow StAMP member.

An important cognitive coding exception to be aware of is:

*(R40-R46) Symptoms and signs involving cognition, perception, emotional state and behavior*

***Excludes2:*** *symptoms and signs constituting part of a pattern of mental disorder (F01-F99)*

Coding rules for cognition and language deficits:

***Step 1: Answer the following questions:***

- What is the primary medical diagnosis Dx? (i.e., What Dx has triggered this decline in function?)
- What is the expected functional progress and the supporting rationale?
- What deficits were noted and then, what were the resulting goals?

Points to be aware of about G31.84

***Refer to the ICD-10 coding rules:***

**G31.84- Mild Cognitive Impairment**

**Excludes 1:**

age related cognitive decline (R41.81)

altered mental status (R41.82)

cerebral degeneration (G31.9)

change in mental status (R41.82)

cognitive deficits following (sequelae of) cerebral hemorrhage or infarction (I69.01,I69.11, I69.21, I69.31, I69.81, I69.91)

cognitive impairment due to intracranial or head injury (S06.-)

dementia (F01.-, F02.-, F03)

mild memory disturbance (F06.8)

neurologic neglect syndrome (R41.4)

personality change, nonpsychotic (F68.8)

- The next rule is to follow the Local Coverage Determination (LCD) of the respective Medicare Administrative Contractor (MAC). For NGS, this code is not listed as a covered Diagnosis. In other regions, (e.g., Novitas Solution) it is listed as a covered diagnosis, but only when

Used with an additional code to clarify the reason/diagnosis for SLP services.

Final consideration for cognitive codes:

- Make sure there is an objective cognitive assessment, to include deficits noted from prior level of functioning (PLOF) in the areas of: Problem solving, memory, executive function, etc. An assessment WITH the scores would be most recommended as well (Ex: SLUMS, RIPA-G subtests, MOCA, etc)
- Make sure cognitive goals are listed on the plan of care (POC). Remember that following 1-stage 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 aphasia.

STARs:

I brought forward the opening for a MSHA habilitation representative to ASHA at the MSHA fall conference in Helena and invited members to take the position. I will be the habilitation representative until a member volunteers.

I am going to include a quote from the ASHA Leader on what role the position plays for our members:

Habilitation – What it is And Why it Matters to You

January 4, 2012 By Amy Hasselkus

Most of us are familiar with the term rehabilitation and are comfortable with our role in providing “rehab” services. Habilitation, on the other hand, may be less common. I don’t know of many SLPs who consider themselves “habilitation providers.” Audiologists may be somewhat more comfortable with the term as providers of aural habilitation, but not in other contexts.

So, what is habilitation? Basically, we are talking about services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally. Still not clear? Contrast that with services that help a person improve skills that have been lost after a stroke, head injury, illness, or other cause. The latter is rehabilitation – regaining lost skills or functioning. Habilitation refers to services for those who may not have ever developed the skill, such as a child who is not talking as expected for his or her age. Adults can also benefit from habilitative services, particularly those with intellectual disabilities or disorders such as cerebral palsy who may benefit from services at different points in their life to address functional abilities.

Why the focus on distinguishing habilitation from rehabilitation? Anyone who has dealt with private insurance for a person needing habilitative services likely knows the answer. If you look closely at coverage descriptions for many insurance plans, you'll likely see language specifying that services like physical therapy or speech-language pathology will be provided when skills have been lost due to illness or injury. This language automatically restricts payment for services to those who haven't had a stroke or suffered an illness, including most children who don't have a specific diagnosis underlying their speech, language, swallowing, or hearing problems.

As we face more stringent documentation demands for reimbursement, the role of habilitation is a major factor to not only be aware of , but also be trained in to capture reimbursement, and continue the ongoing education of the business of speech/language pathology and audiology.

I plan to attend the ASHA connect in New Orleans and attend the STARs meeting.

Please feel free to contact me with questions.

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Committee Chair

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**Prevention Committee Report for the MSHA Board meeting.**

Prevention Committee

The Prevention Committee is watching the bill prohibiting smoking in vehicles with minors on board. Joan is going to get an update on its status. We are also continuing to feature awareness and prevention ideas each month on MSHA's Facebook page. Please check these resources/ideas out!

Respectfully Submitted,

Diane Simpson, Chairman Prevention Committee