# POSTette: Cognitively Impaired Patients: SLP Considerations

Reference: Medicare Benefit Manual Chapters 8 & 15, Local LCD's, ASHA Position Statements

Cognitively impaired patients are described as those whose skills and abilities they had before their accident or medical problem are now either absent or have some defect that compromises their ability to function. Cognitive impairments can be caused by head trauma, neurological conditions, Dementia, anoxia, encephalopathy, etc.

**According to ASHA Practice Standards**

Cognitive-Communication Treatment

*Intervention services are provided to individuals with cognitive-communication disorders, including problems in the ability to perceive, attend to, organize, and remember information; to reason and to solve problems; and to exert executive or self-regulatory control over cognitive, language, and social skills functioning.*

**Diagnostic Codes**

**When a Medical Diagnostic Code does not exist:**

When a Medical DX code is not required on the SLP eval/POC (Part A Payers); there still must be a DX code in the medical record to support SLP services for services. The physician will need to be consulted to add new medical diagnoses to the record based on the evaluation clinical findings reported by the SLP.

- The SLP can request eval and treat orders based on findings to warrant SLP intervention (i.e. screens, nursing documentation, etc.)
- The SLP will complete a standardized assessment to establish the patient's cognitive performance level.
- The SLP will share the evaluation / standardized test scores with the MD and ask the MD to review for the addition of a DX code.
- When waiting for the Med Dx code to be clarified, temporarily use the treatment code for both Med and Tx in order to complete the eval/POC. Once the code is clarified the Med Dx can be updated in the clinical documentation per organization practice.

**Treatment Codes**

- Cognitive Communication Deficit (R41.841): This code is the most descriptive for cognitive-linguistic intervention.
- Symbolic Dysfunction (R48.8) is sometime used for treatment– but is not as descriptive as Cognitive-Communication Deficit.

**Evaluation Considerations**

SLP scope of practice allows for assessment of cognitive/ cognitive-linguistic impairments. It is important to clearly identify how the assessment results will tie into the need for SLP intervention.

- SLP Cognitive-Linguistic standardized tests are conducted to identify and describe:
  - Underlying strengths and weaknesses related to cognition, language, and social/behavioral factors (see Signs and Symptoms) that affect communication performance
  - Effects of cognitive-communication impairments on the individual's activities and participation in ideal settings, everyday contexts, and employment settings;
  - Contextual factors that serve as barriers to or facilitators of successful communication and participation for individuals with cognitive-communication impairment;
  - The impact on quality of life for the individual and the impact on his or her family/caregivers
- Standardized Test considerations:
  - The SLUMs or Addenbrook may be a good initial diagnostic tool to determine the level of neurocognitive performance but should not be the only diagnostic tools used.
  - Select comprehensive standardized tests to further determine the cognitive-linguistic deficits and areas for targeted intervention.
  - Complete NOMs scoring for national data outcomes collection.
- Review and include relevant case history, including medical status, education, occupation, and socioeconomic, cultural, and linguistic background
- Review of auditory, visual, motor, cognitive, and emotional status
- Patient/client and family reports of goals and preferences, as well as domains and contexts of concern
- Clarification of patients PLOF as it related to need for cognitive-communication intervention. Specify specific performance of PLOF compared to baseline data collected.


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- Observation and description of the individual's processing of various types of information under ideal conditions and in the context of various activities and settings (e.g., ability to attend to, perceive, organize, and remember verbal and nonverbal information to reason and to solve problems)
- Observation and description of the individual's executive or self-regulatory control over cognitive, language, and social skills functioning (e.g., ability to set goals, plan, initiate and inhibit, self-monitor and self-evaluate, solve problems, and think and act strategically)
- Identification of the support competencies of relevant people in the environment and possible facilitative effects of modification of their support behaviors;
- Identification of the individual's potential for effective compensatory behaviors and associated motivational barriers and facilitators

- Assessment identifies the specific deficits along with preserved abilities and areas of relative strength in order to maximize functional independence and safety, and to address the deficits that diminish the efficiency and effectiveness of communication.

**Establishing Goals**

Goals may be focused on improving safety during functional tasks and structuring care to allow the patient to perform at their best functional ability consistently during activities.

- Goals need to be based on the documented deficits identified in the evaluation (standardized, objective, observations, performance levels)
- Goals should not be created for areas which do not have documented baseline measures. "Did Not Test" or "will not be addressed during plan of care" should not be used for target treatment areas.
- Goals need to relate meaningfully to the abilities the patient requires in their discharge setting, or are a clear step that leads to the LTG.
- The cognitive communication goals for a patient going home will be very different that the goals going to LTC.
- Goals are the steps (STG) to get the patient back to their PLOF (LTG)
- Goals set the focus of skilled intervention. Treatment needs to tie back to the goal.
- If the goal is to improve working memory then treatment needs to target that type of memory.
- Goals need to be captured in way to easily show progress and/or support the need for skilled intervention.
- Make sure the goals don't have too many components or target areas. Break each area down into its own component and single goal.
- Progress reporting is frequent. Consider establishing STGs that will be addressed for each treatment week.

**SLP Goals Examples**

- Patient will engage in an adapted meaningful functional conversational activity with set up and cuing provided by a trained caregiver / family member for 10 minutes with 20% verbal / tactile/ visual cues (Target: 2 weeks)
- Pt. will improve selective attention with 80% accuracy in order to decrease distractions during needed ADL situations (2 weeks)
- Pt. will sequence (1-5 units of information) with 80% accuracy in order to process complex instructions as needed for independent living. (4 weeks)
- Pt. will formulate solutions with 80% accuracy in order to perform safely in current environment. (2 weeks)

**Skilled Intervention Considerations**

**Remember:** The responsibility is on the SLP to demonstrate the need for intervention in the documentation and to show that the deficits being treated would not simply resolve on their own without SLP services.

- Intervention is tailored to the unique needs of the individual (avoid too many electronic documentation "builds")
- If pt. is instructed in task, include documentation that cognitive ability to learn is present
- Ensure skilled interventions provided tie back to the goals.

**Skilled SLP Interventions:**

- Cognitive training to improve language function
  - Attention training (is the type of attention specified?)
  - Memory/recall (is the type of memory specified?)
  - Organization / Sequencing
  - Planning
  - Judgment/safety
  - Orientation
  - Problem solving / Reasoning
- Improving the processing of varied types of information, including verbal, non-verbal, and social cues.


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- Developing compensatory memory strategies, formal problem-solving strategies and their application to functional activities, and improving attention at various levels of complexity.
- Training basic skills to build up to more complex processing
- Training complex skills to strengthen underlying basic skills
- Spaced Retrieval
- Instruction in compensatory strategies for impaired cognition
- Caregiver training in compensatory strategies

**Note: For CPT coding tips refer to SLP Logging Minutes POSTette**

**Skilled Documentation Considerations**

- Use terminology that reflects the clinician's technical knowledge and skilled intervention techniques used during treatment sessions.
- Indicate the rationale (how the service relates to functional goal), type, and complexity of activity.
- Report objective data showing progress toward goal
  - accuracy of task performance
  - speed of response/response latency
  - frequency/number of responses or occurrences
  - number/type of cues
  - level of independence in task completion
  - physiological variations in the activity
- Specify feedback provided to patient/caregiver about performance *(i.e. Trained spouse to present two-step instructions in the home and to provide feedback to this clinician on patient's performance)*
- Explain decision making that result in modifications to treatment activities or the POC.
  - Explain how modifications resulted in a functional change
  - Explain advances based on functional change
  - Indicate additional goals or activities
  - Indicate dropped or reduced activities
  - Indicate changes in target activities or response criteria
- Evaluate patient's/caregiver's response to training

**Progress Reports**

- Progress reports need to show improvement or support skilled services provided.
- Are the goals captured in way to easily support and demonstrate patient's progress? Do they need to be revised?
- Is it medically necessary for an SLP to continue to provide services to the patient to attain the goals?
- If there isn't any change of status on a goal, there must be documentation why that goal or that plan is continuing.

**Justification Statement Examples**

- Due to documented cognitive impairments, he benefits from environmental modifications and use of multi-sensory cuing techniques in order to facilitate his best ability to function
- Training provided to activity staff regarding the modification of functional / meaningful activities to meet the cognitive capacity of the patient. Instruction was also provided on effective cueing techniques and environmental modifications / set-up to promote function.
- Pt. preparing to discharge to home setting with cognitive demands of money management, medication management and community reintegration for medical appointments, arranging transportation, shopping, and household management that are not at the level required for this discharge setting. Continued SLP will focus on....

**Remember**: Describing how the medical history impacts current functional status helps determine the circumstances that led to the need for skilled intervention.

The need for skilled intervention must make sense; support medical necessity and tie back to the goals. It is important to ask what could happen if skilled rehabilitation services were not initiated, such as safety risks and possible further decline.

The skills and techniques that can be taught to this population will not only improve the quality of their functional abilities but also improve their quality of life.

**Additional Resources:**

- Abilities Care / Dementia POSTettes
- Abilities Care / Dementia Clinical Programming
- Ensign U Cognitive-Communication Courses for SLPs
- ASHA.org


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