Eli's Rehab Report

Clinical Examples Can Help Clarify New Cognitive Skills Development Code

As reported in the December 2000 Physical Medicine & Rehab Coding Alert, a new CPT code for cognitive skills development (97532, 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) was added to the **physical medicine** and rehabilitation (PM&R) section of CPT 2001. Clinical examples of how this code will be used can help your PM&R practice prepare for its use. Although most insurers have not yet established review policies outlining reimbursement guidelines and applicable diagnoses for 97532, the following information from practicing therapists offers a more thorough understanding of its proposed importance.

Purpose of Cognitive Skills Development

There are three categories of cognitive impairment: attention, short-term memory and problem solving. Cognitive skills training allows individuals with these types of impairments to live independently, return to work and function safely in their environments. Patients with diagnoses such as psychiatric disorders, brain injury and cerebrovascular accidents (CVA) may require cognitive skills development to help them regain many of their prior abilities.

Any patient who comes in with a neurological impairment requires a cognitive assessment, during which well determine whether the patient would benefit from further cognitive skills development training, says **Tammy Miller, OTR,** an occupational therapist with Integrated Health Services, an inpatient/outpatient skilled rehab and skilled nursing facility in Gainesville, Fla. Many of the patients with cognitive problems suffer from CVAs (436) or may have a combination of symptoms, such as problems taking their medication or malnutrition. They may need help establishing a routine to achieve all of their daily goals, and teaching them cognitive skills can help with that.

Kim Warchol, OTR/L, president of Dementia Care Specialists Inc., an occupational therapy private practice outside of Chicago specializing in dementia care, education and products, says that treatment and evaluation occur simultaneously with the patients therapy. She introduces modified activities and conditions to the patient, assesses their effectiveness, and either continues the therapy or alters it, depending on the patients outcomes. Therefore, she says, 97532 is occasionally billed when a patient is being assessed and trained at the same time.

Both Miller and Warchol perform their therapy in functional contexts, such as therapy houses (an area in the therapy setting designed to look like an actual house) or in the patients home or nursing facility. Warchol says the best outcomes are achieved when training occurs in the environment where the patient will most likely be expected to function.

For example, a 65-year-old female patient suffering from Addisons disease (255.4) also suffers from associated dementia (294.8). Due to steady doses of corticosteroids, the patients condition is stabilized while at the rehab facility. After the patient returns to her home, however, she still experiences problems with short-term memory loss, causing her occasionally to forget to take her medication, which could be life threatening.

The therapist goes to the patients home and observes the patients activities during dinner, which is her normal medication time. As the therapist watches the patient, he or she assesses the patients cognitive function level to determine the best way to help improve her cognitive function skills. The therapist then shows the patient a series of routines so she can incorporate the medication administration into her daily dinner schedule. The therapist also works with the patient on activities to improve her short-term memory, such as showing her how to pre-plan her activities, incorporate them into her schedule and backtrack if she discovers that she has forgotten any important steps in her day. This would be billed as 97532, with the appropriate number of units, depending on how long the therapist is with the

patient (see more on billing 97532 in the shaded box More Information on Billing the New Time-based Therapy Codes at the end of this article).

Cognitive Skills Development vs. ADL

Cognitive skill development training in the example above will help the patient strengthen her ability to set and maintain a routine, but differs from standard activities of daily living training (ADL, 97535). It would be difficult to bill cognitive skills development as ADL because, with cognitive skills, were assessing new problem-solving skills as well as new learning abilities, and that occurs on an ongoing basis, Miller says. Were really looking at new learning with a functional task, and it may not be a task related to basic ADL or self-care.

Warchol agrees that there is a fine line between cognitive skills development training and ADL. I may choose to use the new code (97532) if I had the client engaged in some training to improve cognitive functioning, if the cognitive disability was reversible and could be improved, or if I had the client engaged in an activity that was for the primary purpose of assessment/probing for change and improvement in function.

I would use the ADL code (97535) if I was providing caregiver training as a part of a functional maintenance plan, Warchol says. For example, if a stroke patient suffering from right-side paralysis was leaving a nursing home and returning to the community, the therapist might take the patient into a mock-up of a house and show him how to bathe, dress and feed himself using only his left side. This would most likely be billed as ADL.

I have been taught to always look at the outcome of the intervention to best decide which CPT code to use, Warchol says. If the therapy has helped improve the patients cognitive skill level, 97532 may be the best choice. Conversely, if the patient is learning new ways to function in his daily life, the ADL/self-care code is often a good, safe choice, Warchol explains.

More Information on Billing the New Time-based Therapy Codes

Although no specific billing criteria have been outlined by HCFA regarding 97532 (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) or 97533 (sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct [one-on-one] patient contact by the provider, each 15 minutes) as of press time, there are several important factors to consider for both codes: First, these codes replace the previous therapy code 97770 (development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct [one-on-one] patient contact by the provider, each 15 minutes), which has been deleted and should no longer be used. The American Occupational Therapy Association (AOTA) requested codes for sensory integrative and cognitive skills training in 1994, but only one code (97770) was introduced in CPT 1995. Because both procedures were incorporated into 97770, AOTA again appealed to the CPT editorial panel, this time to split the procedures into their own codes, which resulted in this years issuance of 97532 and 97533.

The Correct Coding Initiative (CCI) has not yet published any edits for 97532 or 97533, but most coders will recall that a CCI edit prohibited billing 97770 with the physical therapy and occupational therapy re-evaluation codes, 97002 and 97004, as well as most of the evaluation and management codes. Therapists, however, were able to bill for initial evaluations (97001 for physical therapists; 97003 for occupational therapists) with 97770, and the same rules will likely apply to 97532 and 97533.

Significantly, these are time-based codes, like many other therapeutic procedures and modalities. Because of confusion regarding Medicares rules for billing time-based codes, says **Laureen Jandroep, OTR, CPC, CCS-P,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J., Medicare issued a program memorandum in March 2000 outlining the following guidelines for determining the number of units to bill:

1 unit eight to 22 minutes
2 units 23 to 37 minutes
3 units 38 to 52 minutes
4 units 53 to 67 minutes
5 units 68 to 82 minutes
6 units 83 to 97 minutes
7 units 98 to 112 minutes
8 units 113 to 128 minutes

Any services lasting less than eight minutes should not be billed, Jandroep says. Coders should note that this is a HCFA guideline, and third-party payers may deviate from it and use their own interpretation of how the 15-minute time units should be billed.

According to HCFAs guidelines, Jandroep says, if the therapist performs cognitive skills development (97532) for 10 minutes and therapeutic exercise (97110) for eight minutes, they would add that time, totaling 18 minutes of therapy, and bill it as one unit of 97532, instead of one unit each of 97532 and 97110, because you do not want to report more units than the actual total time. You would use the 97532 instead of the 97110 because that code dominated the treatment time.

As with all codes, state licensing laws dictate which practitioners can bill 97532 and 97533, so you should contact your carrier before billing the new codes to ensure that they have their review policies in place and are recognizing the code. This will help your practice reduce unnecessary denials and speed the claims process.