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DEMENTIA

CLINICAL OVERVIEW

Dementia is a disease of advancing age, and 1 in 10 older Americans suffer from it. The lifetime risk of developing dementia is 17.2% in women and 9.1% in men. **Alzheimer's Dementia**, a neurodegenerative condition which causes 60-70% of dementia cases, is now is the 6th leading cause of death. An estimated 5.7 million Americans of all ages were living with Alzheimer's dementia in 2018; followed by **Vascular Dementia**, which is the most common non-neurodegenerative condition. Dementia is one of the leading causes of disability and dependency among older adults. It can be overwhelming not only for the people who have it, but also for their caregivers and their families.

Risk factor for developing dementia include advance age, female gender, a family history of first degree relatives with dementia, low socioeconomic status, cardiovascular risk factors such as hypertension, hyperlipidemia, and diabetes, and history of mild cognitive impairment.

Diagnostic criteria for mild cognitive dysfunction and dementia was updated in DSM-5 and the terminology was changed to major and minor neurocognitive disorders.

Criteria for dementia or major neurocognitive disorder:

- There is a significant decline in at least one area of cognition: learning and memory, language, executive function, complex attention, perceptual-motor or social cognition.
    - The decline is reported subjectively by someone close to the patient and,
    - The decline is found objectively through testing
- The impairment interferes with independence and normal activities of daily living
- The impairment is not due to delirium or another mental disorder

Criteria for mild cognitive impairment or minor neurocognitive disorder is the same as above except:

- The impairment is modest and does not affect daily function, but rather causes the patient to take more time and effort.

When there is a concern about memory and cognitive decline, utilize a brief screening tool such as the Mini-Cog, Memory Impairment Screen and General Practitioner Assessment of Cognition. If the results are abnormal, proceed with a more in-depth assessment tool such as the Montreal Cognitive Assessment, Saint Louis University Mental Status (SLUMS) Examination or the Mini-Mental State Examination.

When dementia criteria has been met, the initial work-up should include:

- Complete history obtained from a close family member or friend who knew the patient well before the cognitive changes started, including education, onset of issues and speed of progression
- Review of medications which can affect cognitive changes
- Discuss any alcohol or drug use
- Complete physical exam
- Screen for depression
- Neuroimaging with an MRI or CT scan to rule out treatable causes

Treatment and care:

There is no treatment currently available to cure dementia or to alter its progressive course. Numerous new treatments are being investigated in various stages of clinical trials. However, much can be offered to support and improve the lives of people with dementia and their caregivers and families. The principal goals for dementia care are:

- Early diagnosis in order to promote early and optimal management
- Optimizing physical health, cognition, activity and well-being
- Identifying and treating accompanying physical illness
- Detecting and treating challenging behavioral and psychological symptoms
- Providing information and long-term support to caregivers

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DOCUMENTATION & CODING TIPS

- Always remember to document the type of dementia

TYPES OF DEMENTIA	
G30._	Alzheimer's Disease
G31.83	Dementia with Lewy bodies or Parkinsonism
G31.09	Frontotemporal Dementia
G31.01	Picks Disease
F01.50	Vascular Dementia ***without*** behavioral disturbances
F01.51	Vascular Dementia ***with*** behavioral disturbances
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.97	Alcohol use, unspecified, with alcohol-induced persisting dementia
F02.80	Dementia in other disease classified elsewhere ***without*** behavioral disturbance
F02.81	Dementia in other disease classified elsewhere ***with*** behavioral disturbance
F03.90	Unspecified dementia ***without*** behavioral disturbance
F03.91	Unspecified dementia ***with*** behavioral disturbance

TIP: *When coding Alzheimer's disease, use an additional code to identify dementia with behavioral disturbance (F02.80) or Dementia without behavioral disturbance (F02.81).*

TIP: *ICD 10 –CM provides codes for memory loss without dementia. If the memory loss is a normal part of aging, code age related cognitive decline (R41.81). For patients experiencing more decline than expected for their age, code mild cognitive impairment (G31.84).*

- Always remember to document any behavioral disturbances which can include:

TYPES OF BEHAVIORAL DISTURBANCES
Aggressive
Violent
Combative
Wandering (use additional code to identify wandering Z91.83)

- Always remember to document any associated conditions: neurological condition, cerebral atherosclerosis, underlying physical condition such as malnutrition, or associated epilepsy.

  Example: Patient brought to the ER because of aggressive behavior at the site of a motor vehicle accident.

  - Admitted and diagnosed with Alzheimer's

CORRECT CODING	RATIONALE
G30.9	Alzheimer's disease unspecified
F02.81	Dementia in disease classified elsewhere with behavioral disturbance

References:

Katzman R. The prevalence and malignancy of Alzheimer disease: A major killer. Arch Neurol 1976;33(4):217-8.

B.L. Plassman, Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study.

Neuroepidemiology Knopman DS, DeKosky ST, Cummings JL, et al. Practice parameter: diagnosis of dementia (an evidence-based review). Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2001; 56:1143.

Caselli RJ. Current issues in the diagnosis and management of dementia. Semin Neurol 2003; 23:231.

Knopman DS, Boeve BF, Petersen RC. Essentials of the proper diagnoses of mild cognitive impairment, dementia, and major subtypes of dementia. Mayo Clin Proc 2003; 78:1290.