

Insider

Informative and educational coding information for providers

FOCUS ON: ALZHEIMER'S DEMENTIA



Dementia prevalence increases with age, from 5.0% of those aged 71–79 years to 37.4% of those aged 90 and older. Due to the aging of the baby boomers, the elderly population in the US is expected to double from 35 million today to more than 70 million by 2030.¹ Although Alzheimer's

dementia is not curable, there are treatment and care options available to manage symptoms, improve quality of life and delay time to nursing home placement.²

Cholinesterase inhibitors may improve quality of life and cognitive functions including memory, thought and reasoning. They are proven effective for people who are mildly to moderately affected by the disease, and are under evaluation in patients with Mild Cognitive Impairment and severe dementia. Therefore, the early recognition and diagnosis of Alzheimer's disease is important.²

The most widely used cognitive test in the US for dementia is the Mini-Mental® State Exam (MMSE). A total maximal score on the MMSE is 30 points. A score of less than 24 points is suggestive of dementia or delirium. Studies suggest that scores > 23 or <19 can be highly predictive in establishing competency from incompetency. Intermediate scores warrant a more detailed competency evaluation.

More recently, the 6 Item Cognitive Impairment Test (6CIT)³ has been shown to be administered more easily, is devoid of cultural biases, and correlates well with the MMSE but outperforms it in milder dementia. The 6CIT is a useful dementia screening tool for Primary Care.⁴

The test consists of six questions and takes 3-4 minutes to perform. Scoring: The 6CIT uses an inverse score and questions are weighted to produce a total out of 28.

- Scores of 0-7 are considered normal
- 8 or more significant for dementia

The test has high sensitivity without compromising specificity even in mild dementia. It is easy to translate linguistically and culturally.

ALWAYS REMEMBER...

- Document the type of dementia: presenile, senile, vascular (also any delirium, delusional or depressive features), alcohol-induced or drug-induced.
- Document any associated conditions: neurological condition, cerebral atherosclerosis, underlying physical condition or associated epilepsy.
- When documenting Alzheimer's disease or other cerebral degenerations, document any associated behavioral disturbance (e.g. wandering).

DOCUMENTATION AND CODING TIPS⁵

- "Senile dementia with Alzheimer's" is coded as 290.0 plus 331.0.
- "Dementia due to Alzheimer's disease" or "Alzheimer's dementia" is coded as 331.0 plus 294.1x.⁶
- "Alzheimer's disease" (without any mention of dementia) and "Alzheimer's sclerosis" are coded as 331.0.⁶
 - "Alzheimer's disease with dementia" is coded as Alzheimer's dementia.
- When coding Alzheimer's disease (331.0), use an additional code, when applicable, to identify dementia with behavioral disturbance (294.11) or without behavioral disturbance (294.10).
 - Behavioral disturbance is defined as: aggressive behavior, combative behavior, violent behavior or wandering off.
- Wandering is coded as V40.31 and requires that we code first the underlying disorder (e.g. Alzheimer's disease, autism, dementia, intellectual disabilities).
- Dementia, unspecified, with behavioral disturbance is coded as 294.21 in which case we would also code wandering, if applicable (V40.31).
- Dementia, unspecified, is coded as 294.20.
- Mild cognitive impairment is coded as 331.83.

Coding Example⁷

An elderly patient is seen for evaluation of violent behavior and episodes of wandering off. The physician documents Alzheimer's disease with dementia.

Three codes are required:

- 331.0 - Alzheimer's disease
- 294.11 - Dementia in conditions classified elsewhere with behavioral disturbance
- V40.31 - Wandering in diseases classified elsewhere

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 4 Brooke P, Bullock R; Validation of a 6 item cognitive impairment test with a view to primary care usage. *Int J Geriatr Psychiatry*. 1999 Nov;14(11). 936-40.
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