

alzheimer's association desert southwest chapter

Medical Scientific Advisory Committee Newsletter

August 2007 • Volume 2 • Issue 2

Correct Coding of Alzheimer's and Other Types of Dementia

by

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Coding of dementia and Alzheimer's disease represents yet another challenge in the management of AD and dementia. Classifying correctly the different dementias will help us understand the true prevalence and help with research. Aside from dealing with the complex issues of dementia care, we as clinicians want to and deserve to be reimbursed for our time and effort. Incorrectly coding a visit can result in less reimbursement or a rejected claim. Here is our best effort to parse out what is applicable.

780.93 memory loss

331.0 Alzheimer's disease (avoid using the terms 'probable' or 'possible' AD)

Add modifier [294.10] for dementia without behavioral disturbance or [294.11] for dementia with behavioral disturbance. Use these modifiers with all dementia diagnoses

331.83 Mild Cognitive Impairment

331.82 Dementia with Lewy Bodies

332.0 is Parkinson's disease.

For PDD use 332.0 and in brackets 294.10 or 294.11

331.3 Normal Pressure Hydrocephalus

331.19 Frontotemporal lobe dementia

331.11 Picks disease

094.9 (294.10 or 294.11) dementia due to neurosyphilis

331.2 Senile Dementia of the Brain

331.89 Other cerebral degeneration (for dementias related to conditions such as cortical basal degeneration or Progressive Supranuclear Palsy)

The 290 codes have been assigned as mental health diagnoses and have been subject to lower Medicare reimbursement. However, according to Medicare Claims Processing Manual, 290 codes are no longer reimbursed at a lower rate. Nevertheless, it is better to use these as secondary codes.

290.0 Senile dementia uncomplicated

291.2 Alcoholic dementia

290.40 Vascular dementia. You may want to add 438.0 (Late effects of cerebrovascular disease, cognitive deficits)

Some of these codes may need to be clarified with your billing department. Also, check the ICD-9 codebook every fall, as the codes can change yearly. For example, 331.83 (MCI) is a new code.



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This newsletter is provided as a source of information, courtesy of the Alzheimer's Association Desert Southwest Chapter. Information contained herein is neither an implicit nor explicit endorsement of treatments or care providers.

ETHICAL ISSUES IN ALZHEIMER'S DISEASE: Telling the Truth in Diagnosis

by

Alzheimer's Association Desert Southwest Chapter

BACKGROUND INFORMATION

Telling a patient the truth about a diagnosis of progressive dementia caused by probable Alzheimer's disease or some other dementia-causing disease should be the usual practice. Doing it sensitively and in a way that avoids unnecessary despair requires more focused attention than it has currently received. Disclosure should usually mention the probable disease by name; expectations for the future; and the fact that while the condition cannot be cured, its effects can be treated.

Many experienced health care professionals have experienced the agonizing discussions of the family about whether to tell the patient about a diagnosis of Alzheimer's only to have the patient say, "That's what I've thought all along." The discovery of inheritance patterns, emerging cognitive-enhancing drugs that are best applied early in the course of disease, the general public awareness of Alzheimer's, and the interest in advance financial and medical planning all contribute to a noticeable swing toward diagnostic truth telling.

ASSOCIATION POSITIONS

The Association asserts that, in general, so long as a person retains his or her competence to understand, it is important to tell the truth in a supportive manner. The Association's key statement on this issue, entitled Ethical Considerations: Ethical Issues in Diagnostic Disclosure (1997), includes the following remark: Disclosing the diagnosis early in the disease process allows the individual to continue to live a quality of life and play an active role in planning for the future. If disclosure of the diagnosis is made after the dementia has advanced, it may no longer be warranted or meaningful.

Truth telling in diagnosis enables the person with Alzheimer's to take several beneficial measures:

- 1 - Plan for optimal life experiences in remaining years of intact capacities
- 2 - Prepare legal documents concerning care in more advanced stages of the disease
- 3 - Consider possible enrollment in research programs
- 4 - Participate actively in Alzheimer support groups

The Association's statement includes the important argument that disclosing the diagnosis early in the disease process allows the person to "be involved in communicating and planning for end-of-life decisions." Diagnostic truth telling allows an individual to prepare legal documents, called advance directives, that stipulate care preferences for late in the disease when he or she is Diagnosis and Treatment not capable of making such decisions. One such document, a durable power of attorney for health care, allows a trusted loved one to make any and all treatment decisions once the person with Alzheimer's becomes incompetent. This advance directive can be effectively coupled with a living will, which allows the person to express a decision on the use of artificial life-support systems and other end-of-life care issues. Without these legal documents, there is a greater chance that an individual will be placed on life-support systems, whether or not such care meets the presumed wishes of the patient or the stated wishes of the family.

Important considerations: While ordinarily it is presumed that the patient is expected to be the "autonomous" decision maker, there are some cultures in which the practice of truth telling for any serious medical diagnosis is considered a burden to the patient. Some cultures are less individualistic in their orientation to ethical decision making, and the preferred approach is for a group or family to make the decisions. In all cases the individual with dementia should be involved to the fullest extent possible, but in less individualistic cultures, the person's family or group should be approached rather than focusing solely on the individual. Generalizations about culture are not possible because cultures are quite internally diverse and individuals express their preferences and decisions in different ways within their own culture-based values and beliefs.

Even if diagnosis is withheld out of respect for an individual's cultural preferences, the person with dementia should be encouraged to make financial and legal plans for the future. If a living will is not considered appropriate because it hinges on the preferences of the individual, the option of a durable power of attorney for health care can still be offered.

FOCUS ON:

Behavioral Neuroscience and Alzheimer's Clinic at the University of Arizona

Geoffrey L. Ahern, M.D., Ph.D.
Professor of Neurology, Psychology, and Psychiatry

The Behavioral Neuroscience and Alzheimer's Clinic (BNAC) at the University of Arizona focuses on patients with:

- Alzheimer's Disease and other dementias
- Behavioral consequences of stroke, head injury, and seizure
- Adult learning disabilities
- Behavioral aspects of movement disorders (Parkinson's, Tourette's, etc.)
- Atypical psychiatric disorders

As an essential part of the evaluation process, the behavioral neurologist compiles a complete picture of the patient – including the evolution of the current problem, past medical history, medications, and social and family history. Mental status and neurological examinations are also performed. Based on the findings, a number of tests may be ordered, including brain imaging (CT, MRI, PET, SPECT), laboratory studies, neuropsychological testing, electroencephalogram (EEG), and neuropsychiatric evaluation. These tests help the physician formulate a diagnosis, and may also help to find a treatable cause of the neurobehavioral syndrome.



Geoffrey L. Ahern, MD, PhD

The Behavioral Neuroscience and Alzheimer's Clinic operates in close conjunction with the Memory Disorders Clinic at the University of Arizona Health Sciences Center. The BNAC also serves as the focal point of the University of Arizona's participation in the multi-site, NIA-funded, Arizona Alzheimer's Disease Core Center (ADCC).

Clinical research has been an essential part of the mission of the Department of Neurology at the University of Arizona, almost since its inception in 1967. The tradition continues today and particularly in the domain of cognitive disorders and dementia. We have participated in the trials leading to the development of agents such as donepezil (Aricept?) and galantamine (Reminyl? / Razadyne?). Aside from working with the pharmaceutical industry, we have also been members of the NIA-funded Alzheimer's Disease Cooperative Study (ADCS), led by Leon Thal, M.D., at the University of California, San Diego, and have participated in such studies as the Mild Cognitive Impairment / Aricept? / Vitamin E study. A number of trials are currently ongoing:

- A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Trial of Simvastatin to Slow the Progression of Alzheimer's Disease – ADCS (closed to new patients)
- High Dose Supplements to Reduce Homocysteine and Slow the Rate of Cognitive Decline in Alzheimer's Disease – ADCS (closed to new patients)
- A Double-blind, Phase II, Safety and Efficacy Evaluation of ONO-2506PO in Patients with Mild to Moderate Alzheimer's Disease – ONO Pharmaceutical Company (closed to new patients)
- A Randomized, Double-Blind, Placebo-Controlled Trial of Valproate to Attenuate the Progression of Alzheimer's Disease (AD) – ADCS (actively recruiting new patients)
- A Double-Blind, Randomised, Placebo-Controlled, Parallel-Group Study to Investigate the Effects of Rosiglitazone (Extended Release Tablets) on Cerebral Glucose Utilisation and Cognition in Subjects with Mild to Moderate Alzheimer's Disease (AD) – GlaxoSmithKline (actively recruiting new patients)

For more information on studies at the University of Arizona, please call Margie Baldwin, RN, BSN at (520) 626-4296.

