JNP

Dementia Diagnosis Coding

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ABSTRACT

Dementia is not a specific disease. Instead, dementia describes a group of symptoms affecting thinking and social abilities severe enough to interfere with daily functioning. There are many causes of dementia. Without an in-depth patient history, it may be difficult to identify a specific type of dementia. More than 1 type of dementia can be coded, if it is supported by the medical record. Remember to look at the Excludes notes and to code with proper sequences.

Keywords: coding, dementia

Dementia is not a specific disease. Instead, dementia describes a group of symptoms affecting thinking and social abilities severe enough to interfere with daily functioning. Typical signs of dementia are a loss of cognitive abilities, behavioral and emotional changes, and inability to perform activities of daily living. By definition, dementia is not caused by major depression or schizophrenia. There are many causes of dementia.

Diagnosing dementia normally involves a Mini-Mental State Examination (MMSE), which consists of questions to gauge a person's mental abilities, memory abilities, and language. There is no specific *Current Procedural Terminology* code to report an MMSE. According to the 1997 Documentation Guidelines for Evaluation and Management Services,[1] a "brief assessment of mental status including: orientation to time, place and person; recent and remote memory; mood and affect (e.g., depression, anxiety, agitation)" is part of the examination elements for a general multisystem examination. The MMSE usually takes less than 10 minutes to complete. *Current Procedural Terminology* 96116, a code for neurobehavioral status examination, is more extensive testing and should not be used for the MMSE.

For a thorough evaluation, it is important to interview the patient along with a family member or close friend. The clinician should ask about deficits with judgment, language, learning elementary tasks, reduced activity interest, handling finances, and memory problems. Additional documentation, in addition to the physical examination, should include behavioral disturbances such as sleep, agitation, delusion, aggression, hallucination, and wandering. A written plan of care and follow-up should complete the assessment.

General coding guidelines from the Centers for Disease Control and Prevention for all diagnoses have the same general requirements. Diagnosis codes are to be used and reported at their highest number of characters available. Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification. Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.[2]

In *International Statistical Classification of Diseases, 10th Revision* (*ICD-10*) coding, there are Excludes1 and 2 notes.[3] An Excludes1 note is a pure excludes note. An Excludes1 note indicates that the excluded code should never be used with the code above the Excludes1 note. The 2 conditions cannot occur together. An Excludes2 note means a condition is not included in the code. An Excludes2 note indicates that the excluded condition is not part of the condition the code represents, but a patient may have both conditions simultaneously. When an Excludes2 note appears under a code, both the code and the excluded code may be coded together when appropriate.[2]

Certain conditions have both an underlying etiology and multiple body system manifestations because of the underlying etiology. For such conditions, the *International Statistical Classification of Diseases, 10th Revision, Clinical Modification* has a coding

convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases, the manifestation codes will have in the code title "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed following the underlying condition[2] as follows:

1. F02: dementia in other diseases classified elsewhere. Code first the underlying physiological condition, such as
   a. G30: Alzheimer disease
   b. A81.0x: Creutzfeldt-Jakob disease
   c. G31.83: dementia with Lewy bodies
   d. G40.0x: epilepsy and recurrent seizures
   e. B20: human immunodeficiency virus disease
   f. G10: Huntington disease
   g. G35: multiple sclerosis
   h. A52.17: neurosyphilis
   i. G20: Parkinson disease
   j. M32.x: systemic lupus erythematosus
   k. S06.x: traumatic brain injury
2. Use additional codes to identify the following:
   a. F02.81: dementia with behavioral disturbance
   b. F02.80: dementia without behavioral disturbance
   c. Z91.83: wandering in dementia in conditions classified elsewhere
3. Excludes2: these conditions can occur separately from the above diagnoses, so they may be coded in addition to the above codes.
   a. F10-F19, with .17, .27, .97: dementia in alcohol and psychoactive substance disorders
   b. F01.5x: vascular dementia

Dementia usually is preceded by mild cognitive impairment (MCI), which describes the normal forgetfulness that occurs with aging, depression, or severe stress. Not everyone with mild cognitive impairment will progress to dementia. At this point, patients may still be living independently but require some adjustments with their hygiene and social activities may be impaired. MCI is a middle ground between normal aging and dementia. This is memory loss without dementia. People with this condition are at risk for developing dementia, but not all people with mild cognitive impairment will progress to dementia.

1. G31.84: MCI, so stated
   a. Includes
      1. Human immunodeficiency virus—related cognitive impairment
   b. Excludes1: these codes should never be included with MCI codes above because the 2 conditions cannot occur together.
      1. Age-related cognitive decline (R41.81)
      2. Altered mental status (R41.81)
      3. Cerebral degeneration (G31.9)
      4. Change in mental status (R41.82)
      5. Cognitive deficits after (sequelae of) cerebral hemorrhage or infarction (I69.01-, I69.11-, I69.21-, I69.31-, I69.81-, and I69.91-)
      6. Cognitive impairment caused by intracranial or head injury (S06.-)
      7. Dementia (F01.-, F02.-, and F03)
      8. Mild memory disturbance (F06.8)
      9. Neurologic neglect syndrome (R41.4)
      10. Personality change, nonpsychotic (F68.8)

Ann Jones, a 78-year-old patient comes into your office. You have been seeing her for the last 5 years. She takes no medications, and prior medical history is noncontributory. She lives alone. At today's visit, she states that she is having trouble completing crossword puzzles, which she has done daily for years. She has no trouble with bathing, eating, or other activities of daily living. You diagnose her with MCI using the *ICD-10* code of G31.84. The code R41.81 altered mental status cannot be used as well because it is an Excludes 1 note; the 2 conditions cannot occur together.

Alzheimer disease is the most common form of dementia among older people. People may not