# DIAGNOSING DEMENTIA AND USING THE MEDICARE DEMENTIA CARE PLANNING CODE

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## OBJECTIVES

List the common types of Dementia and discuss work up and assessment tools

Describe the elements of a Dementia Care Plan

Define the CPT Code 99483 and use it in your practice

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# KEY POINTS ON DIAGNOSING DEMENTIA

Non-dementia causes of cognitive impairment should be considered and ruled out.

There are several brief validated tests that can detect dementia.

Dementia is not a part of normal aging.

Early diagnosis of dementia and its underlying causes allows for appropriate medical management, access to resources and clinical trials, and future planning with input from the persons living with dementia.

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# CAUSES OF COGNITIVE IMPAIRMENT

Dementia

Delirium

Depression

Vitamin deficiencies

Endocrine disorders

Infections

Drug/alcohol abuse

Sleep disorders

Brain tumors/lesions

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# CONDITIONS AFFECTING COGNITION

*Dementia mimics*

Delirium

Depression

*Sensory impairments affecting cognitive assessments*

Hearing Loss

Vision Loss

*Level of Education*

Low Education

High Education

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# 'REVERSIBLE DEMENTIA'

Drug Toxicity

Metabolic changes

Thyroid Disease

Subdural hematoma

Normal pressure hydrocephalus

**Account for 2-5% of cases**

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# DELIRIUM

Also known as…

Acute mental status change

Acute confessional state

Altered mental status

Toxic or metabolic encephalopathy

*Disorder of attention and awareness that develops acutely and tends to fluctuate.*

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# CAM – CONFUSION ASSESSMENT METHOD

1. Acute change in mental status or fluctuating course
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness

**Diagnosis with 1 *and* 2 + either 3 *or* 4**

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## CAUSES OF DELIRIUM

Delirium is typically caused by the sum of predisposing and precipitating factors.

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## PREDISPOSING FACTORS

Advanced age

Dementia

Functional Impairment

Medical Comorbidity

History of Alcohol Abuse

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# PRECIPITATING FACTORS

**D**rugs

**E**lectrolyte disturbances

**L**ack of drugs (Withdrawal / Uncontrolled pain)

**I**nfection

**R**educed sensory input (loss in hearing/vision)

**I**ntracranial (stroke, infection, hemorrhage)

**U**rinary, fecal (urinary retention, fecal impaction)

**M**yocardial, pulmonary (MI, COPD/CHF exac., Hypoxia)

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# DRUGS THAT AFFECT THE BRAIN

**Alcohol**

**Anticholinergics**

**Anticonvulsants**

**Antidepressants (anticholinergic only)**

**Antihistamines (anticholinergic only)**

**Anti-inflammatory (including prednisone)**

**Antiparkinsonian agents**

**Antipsychotics**

**Barbiturates**

**Benzodiazepines**

**Cardiovascular (dig, anti-HTN, diuretics)**

**Chloral hydrate**

**H2-blocking agents**

**Non-benzodiazepine hypnotics**

**Opioid analgesics (esp. meperidine)**

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# DELIRIUM AND DEMENTIA

Dementia is a risk factor for delirium

Previously intact patient who develop delirium should be monitored closely for developing cognitive impairment

Delirium can bring to light previously unrecognized cognitive impairment

Delirium in a patient with established dementia is associated with accelerated cognitive decline

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# DEPRESSION AND DEMENTIA

Patients with primary dementia

commonly experience symptoms of depression

may minimize cognitive losses

Patient with primary depression

Demonstrate decreased motivation during cognitive testing

Express cognitive complaints that exceed measured deficits

Maintain intact language and motor skills

Symptoms often overlap, which can present diagnostic challenges.
Continue to monitor these patients as ~50% of those with reversible cognitive deficits due to depression progress to dementia within 5 years.

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| Features | Dementia | Delirium | Depression |
|---|---|---|---|
| Memory problems | Yes (storage and recall) | Yes (storage and recall) | Yes (recall) |
| Onset | Gradual | Acute | Gradual |
| Mood disturbance | Possible | Possible | Yes |
| Disorientation | Possible | Yes | No |
| Sleep disturbance | Possible | Yes | Yes |
| Fluctuating symptoms throughout day | Yes | Yes | No |
| Progression | Gradual | Fast | Either |
| Somatic complaints | Possible | No | Yes |
| Apathy or anhedonia | Yes | Yes | Possible |

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# OVERVIEW OF TYPES OF DEMENTIA

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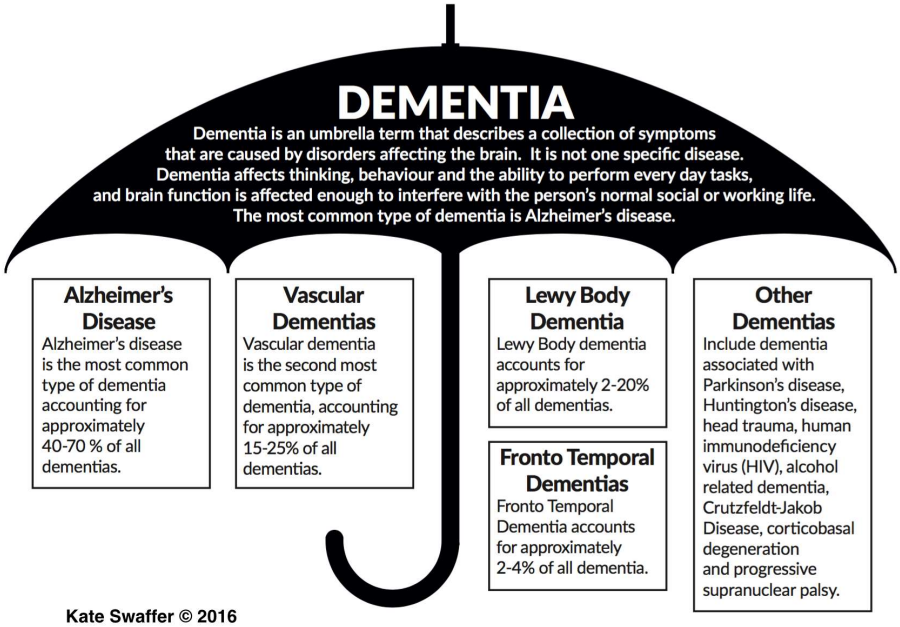


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# ALZHEIMER'S DISEASE

Short term memory loss
- **most common initial symptom*

Difficulty learning new information

Poor judgement

Language and difficulty speaking / communicating

Personality and behavior changes

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## VASCULAR DEMENTIA

A clinically diagnosed stroke is followed by dementia OR

Vascular brain injury is identified on brain imaging in a patient with cognitive decline without a clinical history of stroke

Impaired Executive Functioning

Confusion

Disorientation

Trouble speaking and understanding

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## DEMENTIA WITH LEWY BODIES

Cognitive symptoms present before motor symptoms

Visual hallucinations

Fluctuations in cognition and levels of alertness

Rapid eye movement (REM) sleep behavior disorder
- I.e. acting out dreams

Motor symptoms (falls, unstable gait, stiffness)

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## PARKINSON'S DISEASE DEMENTIA

Motor symptoms present before cognitive symptoms

Memory loss

Inability to pay attention

Poor judgement

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## FRONTOTEMPORAL DEMENTIA

Behavior Variant Frontotemporal Dementia
- Lack of inhibition, apathy, obsessive compulsive, lack of empathy, overeating, impulsive behaviors

Primary Progressive Aphasias
- Problems understanding language, inability to write, read, or speak
- Word finding difficulty, word usage, word comprehension

Frontotemporal Movement Disorders
- Muscle rigidity, stiffness, difficulty with balance, walking, swallowing and restricted eye movements

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# DIAGNOSING DEMENTIA

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## MOST COMMON TYPES OF DEMENTIA

- 1. Alzheimer's disease,
- 2. Vascular dementia,
- 3. Dementia with Lewy bodies
- 4. Parkinson's disease dementia
- 5. Frontotemporal degeneration
- 6. Mixed dementia

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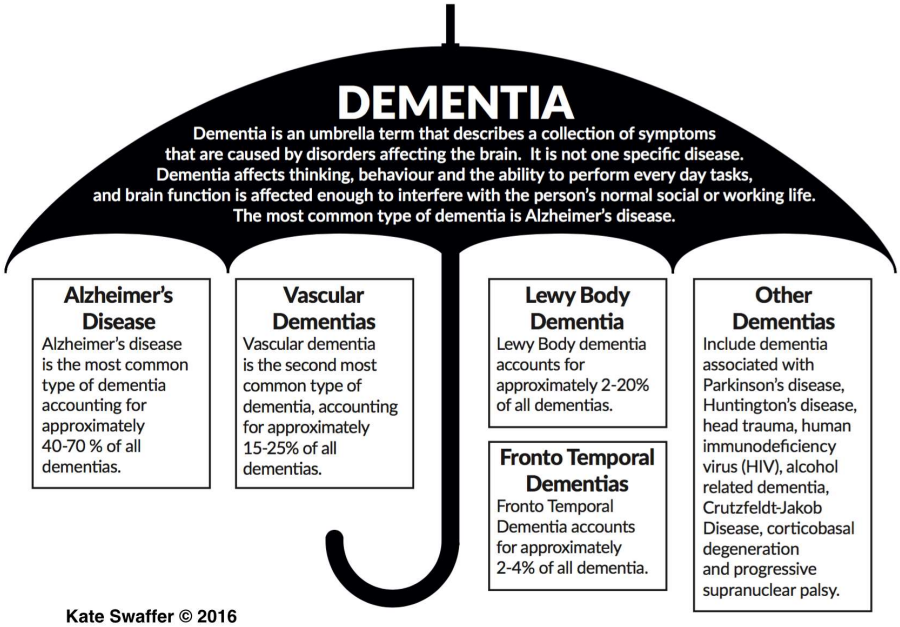


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# DEMENTIA HISTORY AND PHYSICAL

**Brief Cognitive Screen**
- **Mini Cog**
- **Rapid Cognitive Screen (RCS)**
- **Mini Mental State Exam (MMSE)**
- **St Louis University Mental Status Exam (SLUMS)**
- **Montreal Cognitive Assessment (MOCA)**

**Screen for Depression**
- **Geriatric Depression Scale (GDS)**
- **Patient Health Questionaire (PHQ 2 or PHQ 9)**

**Review of past medical and surgical histories**

**Functional Status**
- **Activities of Daily Living**
- **Independent Activities of Daily Living**

**Review medications**

**Collateral history from caregiver or family**

**Complete physical exam**

**Vision & Hearing**

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# TESTS FOR DEMENTIA WORK UP

**Medication Review**
- **check drug levels where applicable (Dig, Lithium)**

**Neuroimaging**
- **CT**
- **MRI**
- **MRI with NeuroQuant**

**Routine Lab**
- **CBC**
- **BMP - Renal/Electrolyte Panel**
- **TSH**
- **B12**

**Optional Lab**
- **Folate, homocysteine, methylmalonic acid (MMA)**
- **Chem Liver**
- **Infectious - HIV, syphilis/RPR**
- **Urine / Toxicology**

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# TESTS NOT TO WORRY ABOUT

Genetic Testing – NOT recommended

CSF levels of tau and beta-amyloid – NOT recommended

Specialty scans and repeat neuroimaging (one brain scan is recommended, but repeated imaging and specialty imaging are typically not needed)

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# ADVANCED NEUROIMAGING

FDG-PET scans approved by Medicare for atypical presentation or course of Alzheimer's Dementia in which Frontotemporal Dementia is suspected

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# ADVANCED NEUROIMAGING

Brain beta-amyloid PET imaging can detect amyloid beta protein plaques, which are one of the defining pathological features of AD.

- Brain amyloid plaques are associated with AD, but can also be seen with aging and other brain disorders.
- A negative brain amyloid PET scan can rule out AD.
- Three FDA-approved radioactive tracers are available for brain amyloid PET scans.

Medicare does not cover.

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# TOOLS FOR DIAGNOSING DEMENTIA

Ascertain Dementia (AD8)

Mental Status Questionnaire (MSQ)

Mini-Cognitive Assessment Instrument (Mini-Cog)

Saint Louis University Mental Status (SLUS) exam

Rapid Cognitive Screen (RCS)

Short Blessed Test (SBT)

Short Test of Mental Status (STMS)

Short Portable Mental Status Questionnaire (SPMSQ)

Six Item Screener (SIS)

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# RESOURCES FOR COGNITIVE ASSESSMENT TOOLS

**AAFP**

- https://www.aafp.org/patient-care/public-health/cognitive-care/cognitive-evaluation.html

**Alzheimer's Association "Cognitive Assessment Toolkit"**

- https://www.alz.org/professionals/health-systems-clinicians/cognitive-assessment

**NIH**

- https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals

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# DIAGNOSING DEMENTIA

Evidence of impairments in at least 2 of the following domains that interfere with the ability to function at work or socially:

- The ability to acquire and recall new information
- Reasoning and handling of complex tasks
- Poor judgment - such as impairments in instrumental activities of daily living (IADL)
- Visuospatial ability
- Language function
- Changes in personality, behavior, or comportment

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# DIAGNOSING DEMENTIA

Person Living with Dementia generally have memory impairment and one of the following:

- **Aphasia**: loss of ability to understand or express speech, caused by brain damage.
- **Apraxia**: inability to perform particular purposive actions, as a result of brain damage.
- **Agnosia**: inability to interpret sensations and hence to recognize things, typically as a result of brain damage.
- **Impaired executive function**

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# COMPREHENSIVE ASSESSMENT WHEN SCREENING IS POSITIVE

If dementia is suspected, the person should undergo a full evaluation.

- Neurocognitive testing (when possible)
- Laboratory tests and imaging studies to rule out secondary causes

In some cases, care partner/informant may be administered a screening test such as the Neuropsychiatric Inventory to provide information about the person living with dementia.

Typically, neurological and physical exams are normal unless focal deficits from stroke or Parkinsonism

Persons with atypical presentations (such as Down syndrome or other intellectual disability) and/or are under the age of 65 require additional evaluation by a specialist.

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# DEMENTIA EVALUATION IN THE SETTING OF INTELLECTUAL DISABILITY

Preliminary screening information can be obtained from family- or staff- administered screen instrument (for example, the NTG-EDSD- National Task Group on Intellectual Disabilities and Dementia Practices, Early Detection Screen for Dementia)

Follow-up evaluations include comparing the patient to him or herself over time

Request longitudinal data (screening forms and visual digital record of function) from family or staff

Identify any extrinsic events that may be contributing to behavioral change, which may exclude dx of dementia

- Check for drugs, reactive depression (changes in family, friends or staff), physical effects (pain, GI, hearing)

Seek consult with clinician who is familiar with intellectual disability and aging-related neuropathologies

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# DIAGNOSING DEMENTIA IN PRIMARY CARE

Choose a brief cognitive assessment to use in your office

Assess patient's overall functioning

Obtain collateral histories

Assess for confounding factors and rule out non-dementia cause of cognitive impairment (Depression, Delirium, Drugs)

Order basic lab and neuroimaging

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# CPT 99483

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## CPT 99483

Code 99483 provides reimbursement to physicians and other eligible billing practitioners for a comprehensive clinical visit that results in a written care plan for individuals with Dementia.

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## WHAT'S A CARE PLAN?

A care plan provides direction on the type of care the individual or family may need. The main focus of a care plan is to facilitate standardized, evidence-based and holistic care. A care plan contains information about the individual's diagnosis and goal for treatment. Care plans provide direction for individualized care of the patient. A care plan is created from the patient's unique diagnoses and should be organized to address the patient's specific needs.

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## ELEMENTS OF A CARE PLAN

Anticipatory rather than reactive discussions about patient care

Defining roles and tasks among team members, including the patient/family

Negotiating agreements that facilitate care within and across organization

Supporting patients to manage their own health

Promoting shared decision making

Promoting care that is consistent with scientific evidence and the patient's preferences

Care plans and care planning in long term conditions: a conceptual model
J Burt, J Rick, T Blakeman, J Protheroe, M Roland, P Bower
Prim Health Care Res Dev. 2014 Oct; 15(4): 342–354.

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## DEMENTIA CARE PLAN

Should reflect the diagnosis

Written in a language easily understood

Indicates who is carrying out action steps and outline follow-up

Consider use of a template

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# DEMENTIA CARE PLAN

*Patient Diagnosis*
- Specific characteristics of the cognitive disorder, treatment plan, stage, prognosis
- Comorbid medical conditions
- Prescription therapies

*Patient Needs*
- Mood and behavior symptoms and management plan
- Non-RX interventions to support the patient in maintaining a measure of independence

*Safety*
- What safeguards are needed to accommodate the effects of cognitive impairment
- Driving, finances, medication management, cooking, cleaning

*Caregiver Needs*
- Referrals to community-based programs for education and support
- Individual or family counseling
- Legal or financial counseling

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# 9 KEY ELEMENTS FOR CPT 99483

Cognition
Function
Staging / Severity
Decision-making
Neuropsychiatric symptoms
Medication Review
Safety
Caregiver needs
Advance Care Planning

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# 9 KEY ELEMENTS INTO A DEMENTIA CARE PLAN

*Patient Diagnosis*
- Cognition
- Staging / Severity
- Decision-making
- Medication Review

*Patient Needs*
- Neuropsychiatric symptoms

*Safety*
- Function
- Safety

*Caregiver Needs*
- Caregiver Needs
- Advance Care Planning

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# ADDITIONAL INFO ON CPT 99483

*Patients*

New or existing patient with signs or symptoms of cognitive impairment

Establishment of cognitive impairment diagnosis, etiology and severity

*Providers*

Any practitioner eligible to report E/M services can provide this service (DO, MD, PA, NP)

*Locations*

Outpatient, Home / Domiciliary, Assisted Living, Nursing Home

*Time*

Usually 50 minutes of face-to-face time with the patient and/or family/caregiver.

*Frequency*

No more often than once every 180day

*Assessments*

Can be done prior to the care planning visit, provided they remain valid

ALL REQUIRED ELEMENTS MUST BE PERFORMED, otherwise use a different E/M Code

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## 9 KEY ELEMENTS FOR CPT 99483

- Cognition
- Function
- Staging / Severity
- Decision-making
- Neuropsychiatric symptoms
- Medication Review
- Safety
- Caregiver needs
- Advance Care Planning

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## ADDITIONAL RESOURCES

Dementia Modules Available for further education at: https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum

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# EDUCATIONAL OPPORTUNITIES: PROJECT ECHO

Extension for Community Healthcare Outcomes (ECHO) model was developed by Univ. of New Mexico

Developing learning communities for **primary care providers** focused on improving care for patients in rural or underserved areas.

People need access to specialty care for their complex health conditions.

There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.

ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.

Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

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**UNTHSC Geriatrics ECHO** beginning February 2020

There is **no cost** associated with participating. **AMA PRA Category 1 CME credits are provided at no charge.**

The **UNTHSC Geriatrics ECHO** addresses patient care needs by:

- training community providers through HIPPA-compliant, **technology-enabled collaborative learning**
- conducting **regular sessions with community providers** to discuss specialized geriatric health care topics
- allowing **case-based learning** through patient case presentations by community providers to determine best treatment options

More information can be found at **www.unthsc.edu/ECHO**.

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## EDUCATIONAL OPPORTUNITIES: FREE ONLINE CONTINUING EDUCATION

Free, 1-hour modules provide training on geriatric topics and evidence based tools to advance health professional teamwork in the care of older adults.

Topics include advance care planning, Dementia therapies and interventions, Improving Safety and Quality of Life for Persons living with Dementia and their families, Safe Opioid Use in the Home Hospice Setting.

https://www.unthsc.edu/geriatrics

**(choose "Healthcare Professionals" and then CME)**

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## EDUCATIONAL OPPORTUNITIES: E-LEARNING MODULES

- Reynolds IGET-IT Program and NBOME Learning Platform
- Performance improvement modules for residents and practicing physicians
  - Fall Risk Education & Assessment
  - Elder Mistreatment
  - Advance Care Planning
  - Medication Management

Free CME credit is available on the NBOME Learning Center

**Available online at learn.nbome.org**

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## EDUCATIONAL OPPORTUNITIES: GERIATRIC PRACTICE LEADERSHIP INSTITUTE

- 9 month Leadership Institute in partnership with TCU Neeley Executive Education and Harris College of Nursing and Health Sciences
- Prepares teams of professionals from various healthcare sites to serve as leaders in their institutions to foster geriatric evidence-based practices and to improve outcomes for older adults

**Applications are available each Spring**

**More information and application online at**

**www.unthsc.edu/gpli**

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**Contact:**

**Geriatrics@unthsc.edu**

WE HAIL Website: http://www.unthsc.edu/wehail

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DEPARTMENT OF INTERNAL MEDICINE AND GERIATRICS

WE HAIL
Workforce Enhancement in Healthy Aging and Independent Living

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# Thank you

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