DEMENTIA

Physician Documentation

Dementia is a progressive decline in cognition along with short- and long-term memory loss due to brain damage or disease. It is always going to affect the health of the patient and should be documented for all encounters, as it affects care planning.

Documentation Tips

- **Documentation of mental health and decline** is an important concept in senior care. Note all counseling provided for driving alternatives, safety issues, neuropsychiatric referrals or interventions, end-of-life decisions, and medication changes. Note if the patient is accompanied by a caregiver.
- **Be as specific as possible** in describing the patient's mental capabilities, symptoms, or diagnosis. Document any violent or disruptive behavior, wandering, or sundowning. The chart below provides the language of ICD-10-CM for patients at risk for dementia.

Code(s)	Symptoms
G31.84	Mild cognitive impairment
I69.-	Cognitive deficit following stroke, specify deficit; note intracerebral/subarachnoid bleed vs infarct
R41.81	Age-related cognitive decline
R41.82	Altered mental status, unspecified
R41.841	Cognitive communication deficit
R41.844	Frontal lobe and executive function deficit
R90.82	White matter disease, diagnostic imaging, NOS
Z87.820	Personal history of traumatic brain injury

- **Dementia should be linked to any known etiology** with causal language (eg, "Dementia due to Parkinson's disease"). Often, two codes are required to capture the etiology and the dementia.

Code(s)	Dementia Etiology
E--. with .49	Diabetes
E75.-	Cerebral lipidoses
F01.5-	Vascular dementia
F03.9-	Unspecified dementia
F03.9-	Senile dementia, not otherwise specified
F10.97, F10.27	Alcoholic dementia, state dependence, abuse
G10	Huntington's disease
G20	Parkinson's disease
G30.-	Alzheimer's disease, state early or late onset
G31.01	Pick's disease
G31.09	Frontotemporal dementia
G31.83	Lewy body disease
G35	Multiple sclerosis
G40.-	Epilepsy

- **Document violent, combative, or aggressive behavior** to capture the extra work required in serving a patient with behavioral disorders in dementia. Document all related comorbidities, including any depression, malnutrition, or functional quadriplegia.
- **The age of onset of Alzheimer's disease** is pertinent to outcomes. Younger patients have a greater impairment in neocortical temporal function, affecting practical application of knowledge. Later onset results in greater impairment in limbic disorders affecting visual memory and orientation. Document the patient's Alzheimer's disease as early onset (before age 65) or late onset (after age 65).

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Coder Abstraction

A patient with dementia is going to have memory deficits. Over time, the patient typically becomes progressively confused. A caregiver or family member will usually accompany dementia patients to medical encounters and provide the patient's history and chief complaint.

Coding Tips

- **Report behavioral status for any patient with dementia.** The patient who is violent, aggressive, or uncooperative should be coded with behavioral disturbance. DSM-V states significant psychotic symptoms include mood disturbances, agitation, and apathy, which qualify as "behavioral disturbance." Query the physician if there are questions regarding a symptom.
- **In some cases, the behavioral disturbance, dementia, and etiology are captured with one code.** In other instances, it requires two codes to capture both.

Parkinsonism vs Parkinson's Disease

Parkinsonism is defined as tremor and abnormalities in movement. Patients with Parkinson's disease, a specific neurological disorder, have Parkinsonism, but not all patients with Parkinsonism have Parkinson's disease. Code these conditions as follows:

- **Dementia due to Parkinson's disease** G20, F02.80
- **Dementia with Parkinsonism** G31.83, F20.80

- **Wandering** is reported in addition to dementia with code Z91.83.
- **Sundowning** is reported in addition to dementia with code F05. Sundowning is not in the Alphabetic Index, but can be found as an inclusion term at code F05, *Delirium due to known physiological condition*.
- **Do not report Alzheimer's dementia** when the patient is elderly and the physician has documented only "dementia." Coders cannot assume etiology. Without a documented cause of the dementia, query the physician or report code F03.90, *Unspecified dementia without behavioral disturbance*.

Dementia due to Alcohol Dependence

ICD-10-CM assumes a link between dementia and alcohol dependence. Therefore, report code F10.27 whenever documentation states persistent dementia in a patient who is also noted to be alcohol dependent, unless the physician states otherwise.

- **Dementia is inherent to Alzheimer's, Lewy body, and Pick's disease.** If Alzheimer's is documented, report the Alzheimer's and report dementia in diseases classified elsewhere. In the Alphabetic Index, see Disease/Alzheimer's G30.9 *[F02.80]*, an indication that two codes are required, according to the ICD-10-CM guideline's etiology/manifestation convention. The Alphabetic Index also provides two codes for Disease/Lewy body G31.83 *[F02.80]*, and Disease/Pick's, G31.01 *[F02.80]*.
- **There is no time limit on when a late effect code** can be used to report a cognitive deficit from a stroke. Once the patient has been released from the hospital following an acute infarct or hemorrhage, the codes from category I69 may be used to report any cognitive deficits.
- **Delirium and other symptoms similar to dementia** may be present in an elderly patient who has a urinary tract infection or other malady. Do not make assumptions regarding the diagnosis; query the physician to answer any questions.
- **Code also any noted comorbidities** for dementia (eg, cachexia [R64], depression [F32.9], or frailty [R54]).