Faculty Disclosures:

Dr. Crecelius has no relevant disclosures
Managing Dementia Care

- Most dementia patients have co-morbidities requiring active management
- Other diseases affected by dementia
- Behavioral disturbances, neurologic symptoms often complex
- Histories require additional work, can be complex
- Physicals often difficult, require multiple systems
- Decision making often complex
- Risks can be high
Be Smart Coding Dementia Care

- Know what diagnosis to use
- Understand what codes to use
- Know how to document
- Understand medical necessity
- Know how to incorporate ancillary & specialist services
Common Misunderstandings

• CMS views a dementia code differently
• Dementia can only be billed at a low level as it is not complex issue
• Dementia care can only be billed once a month
• It is not possible to bill for comprehensive services provided
• It is difficult to bill for common complications of dementia
Understanding CMS

• CMS wants to know services provided
  – CPT Codes
  – Diagnosis (ICD-9)
  – Procedures
  – Documentation
• CMS is supporting primary care
  – New annual exam and TCM codes
• CMS tends to review outliers
Primary Dementia Diagnosis

- Alzheimer’s disease 331.0
- Frontotemporal dementia 331.1 (1 Pick’s, 9 others)
- Senile degeneration of brain 331.2
- Dementia with Lewy bodies 331.82
- Cerebral degeneration in diseases classified elsewhere 331.7
- Cerebral degeneration, unspecified 331.9
- Hydrocephalus 331.3 or 4 (communicate/obstruct)
Primary Dementia Codes

- Cerebral atherosclerosis 437.0
- Late effects cerebrovascular disease (cognition) 438.0
- Parkinson’s dementia 331.82
- Multiple sclerosis 340
- Huntington’s chorea 333.4
- HIV 042
- Jacob-Creutzfeldt 046.1
- Dialysis (aluminum) 985.8
Secondary Dementia Diagnosis Codes

- Mild Cognitive Impairment  331.83
- 290.xx  Dementia with behavior disturbance
  First “x” type of dementia
  Second “x’ type of behavior disturbance
- 294.xx  Dementia in conditions classified elsewhere
  Nonspecific dementias due to other conditions
  Will not translate to ICD-10
Common complications

- Depression - use symptom which requires medical evaluation first as appropriate
  - Abdominal pain 789.09
  - Anorexia 783.0
  - Early Satiety 780.94
  - Fatigue 780.79
  - Insomnia 786.52
  - Weight loss 783.21
Common complications

• Symptom codes
  – Adult failure to thrive 783.7
  – Agitation 307.9
  – Apraxia or agnosia 784.69
  – Aphasia 784.3
  – Delirium 780.09
  – Dyslexia 784.61
  – Dysphagia 787.2
Common complications

• Symptom codes
  – Fecal incontinence 787.6
  – Gait abnormality 781.2
  – Hallucinations 780.1
  – Malaise and fatigue 780.79
  – Memory loss 780.93
  – Sleep disturbance 780.59
  – Urinary incontinence 788.3x
What Codes Apply to Dementia

• Annual Wellness Visit (AWV)
• Initial Preventative Physical Exam (IPPE)
• Transition of Care Management
• Traditional “Cognitive Codes”
  – Office, Asst. Living, Home Care, Nursing Home
  – Care Coordination (Home care certification)
  – In 2015 - Complex Care Coordination Code
Annual Wellness Visit & Dementia

• Acquiring Beneficiary History
  – Health Risk Assessment
    • Psychosocial risks, Behavior risks, Activities of Daily Living (ADLs) and Instrumental ADLs
  – Medical / Family History
    • Current diagnosis, medications, family history
  – Functional Abilities
    • ADLs, fall risk, hearing impairment, home safety
AWV & Dementia

• Begin Assessment
  – Assess Vitals; other measures as needed
  – Get names of other providers
  – Detection of cognitive impairment

• Counsel Patient
  – Written Screening schedule
  – List risk factors and intervention
  – Personalized health advise
Initial Preventative Physical Examination (IPPE)

Requirements similar for AWV except:

• End-of-life planning is a required service with beneficiary’s consent. End-of-life planning is verbal or written information provided to the beneficiary regarding:

• Ability to prepare an advance directive in the case the beneficiary becomes unable to make health care decisions, and

• Whether or not the physician is willing to follow the beneficiary’s AD wishes.
Tools for Cognitive Assessment

• Screening for Cognitive Impairment:
  – Minicog
    www.alz.org/documents_custom/minicog.pdf

• Quantitating Cognitive Impairment
  – Folstein Mini-mental Status Exam (FMMSE)
    Copyrighted
  – SLUMS
    http://www.elderguru.com/download-the-slums-dementia-alzheimers-test-exam/
Tools for Cognitive Assessment

• Assessing ADL / IADL Ability
  http://www.hospitalmedicine.org/geriresource/toolbox/howto.htm

• Depression
  – Geriatric Depressive Scale (GDS)
    http://www.stanford.edu/~yesavage/GDS.html

• Delirium
  – Months of the Year Backwards
  – Confusion Assessment Method (CAM)
As of January 1, 2013, Medicare pays for combined face to face and non-face to face physician and staff service of complex patients recently discharged from hospital, LTAC, or skilled nursing facility.

Medicare will pay between $164 and $231, depending on the complexity of the patient, for care during the 29 days after the discharge date.
Transitional Care Management Services Code 99495

- 99495 - Moderate complexity patients
  - Requires physician / staff to make direct contact, by phone or electronically, with the patient or caregiver within 2 business days of discharge.
  - A face-to-face visit with the patient is required within 14 calendar days of discharge.
Transitional Care Management Services Code 99496

- 99496 - High-complexity patients
  - Requires direct contact with the patient or caregiver within 2 business days
  - Face-to-face visit within 7 calendar days

- Both codes billable by only one party (PCP or specialist) in the outpatient setting
- Requires medication reconciliation and any needed coordination of care
Transitional Care Management Services Codes (99495 and -96)

- Non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction:
  - Staff services: medication adherence, education of patients / caregivers e.g. self-management, HHA communication, facilitating access to care.
  - Physician services: discharge information review, diagnostic test follow up, community resources referrals, educating patients / families, interaction with other health professionals.
Proposed Payment Chronic Care Management Code

- CMS finalizing details, will pay in 2015
- Separate G codes covering 90 days, requires at least one hour
- Patient must have "multiple complex chronic conditions" lasting at least 12 months or until death, put them "at significant risk of death, acute exacerbation/decompensation, or functional decline."
Proposed Chronic Care Code

• Office based code
• Probable mandatory requirements:
  – Develop & update comprehensive care plan
  – Must receive yearly wellness exam
  – Use certified electronic health record system
  – Employment of a NP or PA
  – Offer complex chronic care management services on a 24/7 basis
  – Status as a medical home
What’s Important to Follow on Routine Visits

• Cognitive domains
  – Short/long term memory, language, praxis, agnosia, executive skills
• Psychosocial concerns, Function
• Medication efficacy
• Diagnostic testing
• Interaction on other health issues
• Prognosis, plans and family counseling
Frequency of Visits for Dementia Care

“Medical Necessity” is the standard

- No set definition
- CMS: Patients have “conditions of sufficient intensity to require frequent visits (e.g., once a week or once a day).”
- Must justify service as sound clinical practice, reflects reasonable and realistic goals, outcomes (community standards)
Documentation of Dementia Care

• Legible / Complete / Inclusive
• Medical Decision Making
  – primary determinant of level of service
  – Most important feature of note
• Billing based on time
  – Counseling/coordination of care >50% time
  – Consistent with the nature of the problem(s) and the patient's and/or family's needs
Can I bill for these services?

• Family counseling
  – Face to face patient interaction required
  – Patient & diagnosis oriented

• Phone calls
  – Not directly reimburged
  – May affect next service / care plan oversight

• Advance Beneficiary Notice (Form CMS-R-131-G) notice of non-coverage signed before service provided, still need to attempt bill
Coordinating Teamwork

- Medical Specialists
- Case Management
- Social Work
- Dementia Clinics
- Neuropsychological Testing
- Psychotherapy
- Education Resources
Case Management Services

- Conduct care-planning assessments to identify problems, and need for services.
- Screen, arrange, and monitor senior services.
- Act as a liaison to families at a distance.
- Offer counseling and support.
- Provide information, referral and placement.
- Offer crisis intervention and care management services.
Dementia Clinics

- Academic / private
- Subsidization
- Insurance; additional fees
- Physician, Geriatric nurse, social worker
  - Psychiatrist, dietician, geriatric case manager
- Continuity, Consultative
Psychotherapy in Dementia

- Higher functioning persons
- Insight, memory sufficiently preserved
- Past or new psychologic symptoms
- Most often requested by Psychiatry
- MS-SW or PhD-Psychology
- Medicare reimbursement 50% + private insurance ($70 per 40 min)
**Hospice and Dementia**

- One physician becomes primary doctor
- Paid by hospice if employed by them
- Others paid by Medicare B
  - GV modifier for hospice diagnosis and related conditions (e.g. dysphagia)
  - GW modifier for non-hospice diagnosis
  - Can be NP (can’t certify terminality)
  - Associates paid by primary doctor
Care Plan Oversight
HHC Certification / Recertification

- Home Health Care Supervision  G0181
  - Physician supervision of patient (not present), per calendar month, \( \geq 30 \text{ min} \) \~\$105
  - Complex/multidisciplinary, regular development & review care plans, status reports, labs, etc

- Home Health Patient Certification  G0180
  - Initial certification for HHC services \~\$53

- Home Health Patient Recertification  G0179
  - Recertifying HHC services \~\$41
Hospice Care Plan Oversight

• Physician supervision of patient (not present), per calendar month, \( \geq 30 \) min, \( \sim \$106 \)

• Complex / multidisciplinary, regular development & review care plans, status reports, labs etc

• GV modifier needed
Advanced Practice Nurse / PA

• Can provide excellent dementia service
• Bill “incident to” outside nursing home
• Bill at 85% PFS in nursing home
• Scope of practice determined by state
• Type and quality of service must be similar to physician
• If billing by time the problem complexity should be able to justify the time billed
Don’t Forget Educational Resources

• Web sites
  – www.alz.org
    Alzheimer’s Association
  – www.alzheimers.org
    Alzheimer’s Disease Education & Referral Center
  – alzheimer.wustl.edu (other regional centers)
    Washington University Alzheimer’s Disease Research Center

• Print  (The 36 Hour Day (Mace & Rabin))
Value Based Modifier

• Between 2015 and 2017 CMS will transition most providers to value based payments (base +/- incentive or penalty)
  – Based on quality (PQRS data), costs (Med A+B expenses) and severity of illness
• Stronger incentive to provide accurate diagnosis, prognosis, advance care planning, office based care
With knowledge of:
  – How codes work
  – What to document
  – Special circumstances
  – Use of resources

Successful dementia care is possible