Reimbursement for Dementia Care

In this module, learn about:
- effective use of primary and secondary ICD-9 codes
- coding E/M services appropriately
- performing appropriate documentation for higher level E/M codes

As every physician knows, reimbursement for clinical services depends on many factors, including a number that are out of our control. Dementia care is no different. It may seem as if telephone calls, discussions with caregivers, and the thoughtful untangling of emerging problems all add up to more time than the physician can bill for. But by becoming more familiar with the ins and outs of key aspects of the reimbursement scheme, the clinician can increase reimbursements while "playing by the rules."

This does not mean changing the way you treat your patients in order to get paid more – it is about getting paid for the work you are already doing. The central point is to document what you do and code based on that documentation. As a primary care physician, you are the heart of good care for patients with complex chronic illnesses like dementia. You deserve to be paid appropriately for the valuable work you do.

This module was developed to help physicians better understand the options they have for improving reimbursement for dementia care. Two main issues affect reimbursement for the care provided to dementia patients and their families:

1. Problems with the use of ICD-9 codes allowing reimbursement for medical services

2. Appropriate use of E/M codes to reflect the complexity of the work performed

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PROBLEMS WITH THE USE OF ICD-9 CODES

Certain ICD-9 codes are not regarded by CMS as regular medical codes. Thus they are not reimbursed at the usual rate, and sometimes not at all. The 290 to 319 codes are considered "mental health" codes, despite the fact that they include codes for dementia. "Mental health" codes are reimbursed at only 50% of the usual Medicare rate, and may not be paid at all to physicians who are not psychiatrists.

Therefore, guidelines for ICD-9 coding of dementia can be summed up in two rules:

- NEVER use a 290 code as a primary code
- For any dementia diagnosis *other than Alzheimer's disease*, use a 294.1x code as a *secondary* code.

⌘ When coding for dementia, do NOT use 290 codes as primary codes.

⌘ DO use a 294 code as a *secondary* code for diagnoses *other than* Alzheimer's disease, or 331.2 can be used for Organic Brain Syndrome when a clear diagnosis has not yet been determined and the patient is still being evaluated.

PRIMARY CODING FOR DEMENTIA

For primary care coding purposes, most dementia diagnoses will fall into the category of Alzheimer's. Let's look at the most common diagnoses used in primary care and how to code them:

- Alzheimer's. Alzheimer's disease is coded as 331.0
- Vascular dementia. The dementia diagnosis next most common in primary care is "vascular dementia." Before we look at how to code it, let's first acknowledge that most experts agree that this is over-diagnosed. Fewer than 10% of autopsies demonstrate primary vascular dementia, so our first

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step should be to reconsider this diagnosis. Consider whether Alzheimer's is a more accurate diagnosis (as well as easier to code).

However, if the cognitive deficits were clearly tied to vascular disease (both with documented infarctions and clear temporal correlation to cognitive changes), you may use:

- 438.0 "Late effects of cerebrovascular disease—cognitive deficits"

OR if the cognitive deficits are a complication of a procedure, like a CABG, you may consider using a complication code:

- 997.01 "Central nervous system complication—anoxic brain damage or cerebral hypoxia"

Note that this specifically excludes a cerebrovascular hemorrhage or infarction.

DO NOT USE 290.4 Vascular dementia as it is considered a "mental health" code, and will be reimbursed at the 50% rate, if at all. (See earlier explanation in the introduction to this section.)

- Other types Other types of dementia that you may see include:

  - 331.1 Frontotemporal dementia
  - 331.82 Dementia with Lewy Bodies (including dementia with Parkinsonism)
  - 331.83 Mild Cognitive Impairment, so stated.

  These specific dementia diagnoses require an accompanying 294.1x code as noted in italics in the ICD-9 Code Book. This would be in parentheses, following the primary code, as either:

  - 294.10 Dementia without behavioral disturbance OR
  - 294.11 Dementia with behavioral disturbance

- Undiagnosed. Finally, if you have just identified the patient as having memory problems but have not completed an evaluation of the cause, you can use 780.93 Memory loss. This code can also be used for those diagnosed with MCI (mild cognitive impairment).

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- Uncommon. Less common forms of dementia are not discussed here, but can be found in an ICD-9 codebook.

SECONDARY CODING FOR DEMENTIA VISITS

As is true for all other clinical problems, you should also include codes for the additional medical problems addressed on the visit being billed. These will help to support higher levels of E/M coding as discussed in the following section. For most elderly patients, co-morbid diseases are common.

⌘ Coding for dementia will usually be:

331.0 Alzheimer's dementia *with:*

294.10 Dementia without behavioral disturbance
or
294.11 Dementia with behavioral disturbance

APPROPRIATE USE OF E/M CODES

Physicians generally tend to under-code for complex office visits, and are therefore under-reimbursed. While this module is not intended to serve as a substitute for a full review of the CPT and E/M coding systems (see Resources in Table A), it highlights aspects of the evaluation and management of dementia patients that may increase the complexity of visits and thus qualify these visits for a higher E/M code:

1. Use counseling and coordination of care as a criterion for E/M coding

   Patients and families often need extensive counseling about the disease process, advance care planning, etc. along with coordination of care involving community resources (Module 5), paid caregivers, and consultations with other specialists.

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Whenever more than half the visit is spent in "counseling and coordination of care," the time spent on the visit becomes a criterion for coding.

a. Document the time spent counseling and the total time of the visit, as well as the reason for and content of the counseling (e.g., "I spent 25 minutes with Mr. and Mrs. Anderson, with 15 minutes of that time discussing the placement options for her, because of the safety concerns mentioned above" – an automatic 99214 regardless of the other documentation).

b. The total time is based on face-to-face time in the office setting (and time on the unit in the hospital or nursing facility). To use time as the basis for a code, you must spend a minimum of the amount of time associated with the reported E/M code (15 minutes for 99213 and 25 minutes for 99214, with 40 minutes for 99215). This time includes that in which the physician obtains the history, performs the exam, evaluates the problem/s, and provides counseling, IF *over half* of the time was spent in counseling and coordination of care.

c. The counseling can be directed not only to the patient but also to family members or others who have responsibility for the patient (e.g., paid private caregivers, assisted living staff). However, for billing anywhere except the hospital, the patient must be present as well. "Face-to-face" time with the patient is the time measured in this type of coding.

d. Keep in mind that counseling in this context means discussion of proposed tests, diagnostic results, risks and benefits of treatment, prognosis, management instructions, follow-up plans, patient and family education, etc. It does *not* mean psychotherapy.

2. Diagnose over time

The work can be spread over a series of visits. This may have advantages for office flow as well as possible reimbursement. Most primary care offices are no longer able to accommodate lengthy patient evaluation visits. One model often laid out for dementia assessment is:

a. First visit—obtain history and perform physical exam, excluding cognitive testing; explain plans for further evaluation

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b. Second visit—test cognitive function and order appropriate diagnostic studies

c. Third visit— discuss findings and implement a treatment plan; establish follow-up plans.

3. Use the "-25" modifier

   When you see the patient for one problem and also do a procedure for another problem. Two separate diagnoses must be made. For example, if you remove a skin lesion and also assess and address a new problem behavior related to dementia, bill the procedure plus an appropriate level visit for the separate problem. Obviously, if you only address the problem for which the procedure is done, then only bill for the procedure. However, dementia patients more often than not present more than one problem at most visits.

4. Code office visits at appropriately high levels

   Use more 99214 codes for established patients. The increase in RVUs, and accordingly in reimbursement, for higher level visits is significant:

E/M Code (Established patients)	99212	99213	99214	99215
RVUs	0.604	0.887	1.465	2.361

   The 99214 or Level IV established patient visit is defined in the CPT as one that includes at least <u>two</u> of the following:

   1. a detailed history
   2. a detailed examination
   3. medical decision making of moderate complexity.

   The requirement of only two of the three key components means that the coding can be based on: the extent of the history and medical decision making only; on the examination and medical decision making only; or on the history and decision making only. For example, you don't necessarily

have to worry about adding up the body systems or exam elements to justify a 99214 visit if the visit has included a detailed history and decision making of moderate complexity.

⌘ Many coding experts believe that the 99214 code is the most under-used code in primary care, and that we should be coding visits at this level more often.

A more detailed review of the three components of E/M coding for a 99214 may be useful in thinking about your coding:

(1) History

The requirements for a "detailed" history are simple:

- At least four elements in the HPI (history of present illness) or three chronic conditions (very common in most dementia patients)
- An ROS (review of systems) for at least 2 systems, AND
- An update of at least one component of the PFSH (the patient's past medical history, family history or social history).

Given that most dementia patients have other co-morbidities and chronic conditions, it is common for visits to meet the HPI criteria for a 99214. Also the number of routine questions for a dementia patient or the caregiver, can easily exceed four elements for HPI – incontinence, nutrition, sleep problems, depression, hallucinations, etc. The relevant ROS for dementia readily includes at least two organ systems – the neurological and psychiatric ROS, along with a GI ROS for those on cholinesterase inhibitors, is routine. And an update of one component of PFSH is almost certainly part of each visit - the CPT considers the review of a patient's medications to be a component of the past history, so you will almost always have done that. A review of medication allergies, as well as past medical history, is a routine part of the medical assistant's work in many offices. And smoking status is often another routine update, considered part of the social history.

You can meet the criteria for "detailed" history by simply doing the following:

- Document in some detail the circumstances or conditions that brought the patient to your office, including at least four elements or three chronic conditions (and note that comorbid conditions are very common in elderly patients)

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- Document responses to a review of the two affected systems – neurological and psychiatric, along with any others that are relevant.
- Document your medication review, smoking status, allergies, or some other relevant aspect of the PFSH.

⌘ Many visits with dementia patients easily meet the requirement for the "detailed history that a level-IV visit requires.

(2) Exam

The requirements for the detailed exam are a bit more complex. A detailed exam can be either an examination of at least five organ systems/body areas or the documentation of at least 12 specific exam elements in at least two systems or areas. Here is an example of each for a dementia patient:

- The first approach (5 organ systems/body areas) is often easier because the information is less detailed. It could be as simple as: "Pt alert with calm affect; lungs CTA; heart sounds distant but normal; abdomen soft and non-tender; no pedal edema; DTRs 2+ and symm."
- The second approach (12 specific elements) might be used when a more thorough psychiatric and neurologic exam is appropriate (for example, in the diagnostic stage of dementia): "Pt is alert and responds appropriately to yes-or-no questions; not able to recall any specifics about medications or side effects; affect is flat; pupils equal and reactive to light; cranial nerves II-XII intact; DTRs 2+ and symmetrical; no motor weakness or sensory deficits detected; gait nl; Romberg negative; no tremor noted.

Don't forget that when your history and medical decision making are going to support a 99214 level of service, you need not spend time performing or documenting the exam beyond whatever is clinically appropriate. All abnormal findings should be clearly documented, but details about normal findings in organ systems outside the area of focus are not necessary for the purpose of documenting your level of service.

⌘ The physical exam need not be "detailed" to meet the criteria for a 99214 visit.

⌘ A "detailed" exam is not unusual in the care of patients with dementia.

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(3) Medical decision making

Level IV visits require medical decision making of "moderate complexity," which is determined by three factors:

- The number of diagnoses or management options being considered
- The amount and complexity of data involved
- The risk to the patient of either the presenting problem or the planned interventions.

Only two of the three need to be at a moderate level for the decision making to qualify as "moderate complex."

The 99215 or Level V visit is a very comprehensive evaluation. It is rarely done in most primary care practices except in a patient ill enough to warrant hospital admission. It requires two of the three following components: a comprehensive history, a comprehensive physical exam, and medical decision making of high complexity. Although this level of visit is rare for established patients in most practices, it may occur -- especially in the initial evaluation of complex new-onset dementia or with significant major changes in condition.

Use this code if you are sure it is appropriate, but be sure you can demonstrate the 'medical necessity' to justify its use. It should always have "high complexity" decision-making status, and it is NOT a code for an annual exam. If there is any question about its appropriateness, it is probably best to take the view that it is not worth an audit.

Primary care physicians often underestimate the complexity of their medical decision-making. Key points to consider in assessing complexity are:

- The extent of your differential diagnosis
- The potential seriousness of the problem
- The presence of multiple medical problems
- The level of uncertainty in the assessment.

Each of these factors can raise the level of the decision making to "moderate." The number of diagnoses considered in the differential diagnosis for dementia is substantial, and the problem is quite serious. And either two or more ongoing chronic conditions (very common in dementia patients), or one chronic condition

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with acute exacerbation and prescription drug management, is considered to represent “moderate” risk.

Primary care physicians care for complex dementia patients, often with multiple other medical problems, and are often the first to evaluate new problems or complications. Even a visit for bronchitis in a dementia patient may require moderately complex decision making if problem behaviors have increased with the illness or when the patient’s inability to give an adequate report of symptoms makes the severity of the illness more complex to evaluate. It is quite easy to miss giving yourself appropriate credit for the complexity of your medical decision making.

⌘ Primary care physicians often underestimate the complexity of their medical decision-making.

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TABLE A

Resources for Further Information on CPT and E/M Coding

Most primary care physicians can access excellent materials for this task through their professional organizations – the American Academy of Family Physicians www.aafp.org and the American College of Physicians www.acp.org.

American College of Physicians Practice Management website has a section on billing and documentation http://www.acponline.org/pmc/coding.htm?hp. Many of these resources require membership to access.

American Academy of Family Physicians has numerous resources, all open access at www.aafp.org. The "Family Practice Management Toolbox" at http://www.aafp.org/x20091.xml#c1 includes resources on:

- Time-based coding
- Documentation requirements
- Sample forms and templates
- 99214 visits
- A host of other coding and documentation tools

The Michigan State Medical Society and the Michigan Osteopathic Association also offer many practice management resources, ranging from courses to web-based resources. More information at www.msms.org and www.mi-osteopathic.org.

In addition, most health care systems have compliance officers who offer considerable expertise and resources on coding and documentation.

Center for Medicare/Medicaid Services website has information about E/M Codes and Guidelines (both the1997 and 2002 versions) at www.cms.hhs.gov

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GLOSSARY OF TERMS

ICD-9 International Classification of Diseases Version 9. This disease classification system was originally developed for epidemiologic purpose. It came into clinical use in 1989 when Medicare began to require ICD-9 codes for billing use. The material covered in this module is based on the 2005 version of ICD-9. Changes occur regularly, and clinicians should seek sources of information to learn about changes as they occur.

CPT Current Procedural Terminology. Five digit codes for billing all professional services, both procedural and non-procedural, services rendered as the attending or a consultant, and in all settings including inpatient, outpatient, home, and nursing facilities.

> **E/M codes**—Evaluation and Management codes. Five digit codes for billing non-procedural professional services. These billing codes were last revised in 2003, and further changes have been on the horizon since then.
>
> **Procedure codes**. Five digit codes for billing procedural professional services

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