

# Focus on Dementia

November is National Alzheimer's Disease Awareness Month



## Quick Facts

- Prevalence of dementia increases with age, from 5% of those aged 71–79 years to 37.4% of those aged 90 and older. With the elderly population expected to double from 35 million to 70 million by 2030, dementia is regarded as the #1 health challenge of the 21st Century.<sup>1</sup>
- Dementia with Lewy bodies (DLB) is increasingly recognized as the second most common degenerative dementia after Alzheimer's disease.<sup>2</sup>
- There is some clinical imperative to diagnose DLB, as optimal treatment choices — for best efficacy and limitation of significant side effects — are specific to DLB.<sup>2</sup>
- Distinctive clinical features of DLB include: dementia, visual hallucinations, parkinsonism, cognitive fluctuations, autonomic dysfunction, sleep disorders and neuroleptic sensitivity.<sup>2</sup>
- Cognitive impairment in vascular dementia may be quite distinct from Alzheimer's disease, especially early in the disease. Prominent deficits in executive dysfunction causing significant disability may be seen, even while memory impairment is quite mild and before the patient reaches criteria for dementia.<sup>3</sup>

## 10 Warning Signs of Dementia<sup>4</sup>

1. Memory loss that affects job skills
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation to time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood or behavior
9. Changes in personality
10. Loss of initiative

## Documentation Tips

- Document the type of dementia.
- Document any associated neurological condition, cerebral atherosclerosis, underlying physical condition or associated epilepsy.
- When documenting dementia, Alzheimer's disease or other cerebral degenerations, document any associated behavioral disturbance.

## Coding Highlights<sup>7</sup>

- Vascular dementia, uncomplicated is coded as 290.40. Use code with appropriate 5th digit to report vascular dementia with: delirium (290.41), delusions (290.42) or depressed mood (290.43). Use additional code to identify cerebral atherosclerosis (437.0).
- Dementia is coded as 294.20, Dementia, unspecified, without behavioral disturbance.

- Dementia with aggressive, combative or violent behavior is coded as 294.21,\*\* Dementia, unspecified, with behavioral disturbance.
- Mild memory disturbances not amounting to dementia are coded as 310.89.
- Alzheimer's dementia, Alzheimer's disease and Alzheimer's sclerosis are coded as 331.0\* (Alzheimer's disease with dementia is coded as Alzheimer's dementia.)
- Dementia due to Lewey bodies is coded as 331.82.\*
- Mild cognitive impairment, so stated, is coded as 331.83.\*

\*Use an additional code to identify dementia in conditions classified elsewhere: without behavioral disturbance (294.10) or with behavioral disturbance (294.11\*\*).

\*\*Use additional code to identify wandering in conditions classified elsewhere (V40.31).

## Evaluation of Dementia<sup>4,5</sup>

Be alert to cognitive impairment in your patients and screen for dementia if suspected. The initial step in the evaluation of a patient with suspected dementia should focus upon the history. Family members or others who know the patient well are invaluable resources for providing a history of cognitive and behavioral changes.

## Screening for Dementia<sup>6</sup>

- The most widely used cognitive test in the United States for dementia is the Mini Mental Status Exam (MMSE). A total maximal score on the MMSE is 30 points. A score of less than 24 points is suggestive of dementia or delirium. Studies suggest that scores > 23 or < 19 can be highly predictive in establishing competency from incompetency. Intermediate scores warrant a more detailed competency evaluation.
- More recently, the Six Item Cognitive Impairment Test (6-CIT) has been shown to be administered more easily, devoid of cultural biases and possibly more accurate than the MMSE.
- Screening for B12 deficiency and hypothyroidism is recommended for patients being evaluated for dementia.
- Screening for depression in patients with dementia is recommended because depression is a common, treatable comorbidity that may also masquerade as dementia.
- Consider structural neuroimaging with either a noncontrast head CT or MRI in the initial evaluation of all patients with dementia.

<sup>1</sup> B.L. Plassman, Prevalence of Dementia in the United States: *The Aging, Demographics, and Memory Study*, *Neuroepidemiology* 2007;29:125–132.

<sup>2</sup> Ann Marie Hake, MD. *Clinical features and diagnosis of dementia with Lewy bodies*. UpToDate, Waltham, MA, Martin R Farlow, MD, Section Editor.

<sup>3</sup> Wright, CB. *"Etiology, clinical manifestations, and diagnosis of vascular dementia"* UpToDate, Waltham, MA.

<sup>4</sup> *"Detection, Diagnosis and Management of Dementia."* American Academy of Neurology. Web. 01 Aug. 2010. <[http://www.aan.com/professionals/practice/pdfs/dementia\\_guideline.pdf](http://www.aan.com/professionals/practice/pdfs/dementia_guideline.pdf)>.

<sup>5</sup> Shadlen, Marie-Florence, Larson, EB. *"Evaluation of cognitive impairment and dementia."* In: UpToDate, Basow, DS (Ed), UpToDate, Waltham, MA, 2009.

<sup>6</sup> Boustani, Malaz et al. Research Triangle Institute/University of North Carolina Rockville (MD): June 2003.

<sup>7</sup> World Health Organization, *Professional: ICD-9-CM for Physicians—Volumes 1 & 2*. 2012. Alexandria, VA: Ingenix, 2011, October. Print.