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MDS Alert

Diagnosis Coding: 4 Tips Take The Guesswork Out Of Dementia Coding

Dementia for those over 65 isn't necessarily senile.

The diagnostic maze for coding dementia can put you in a daze. Not only do you have several diagnosis coding options, but physician documentation may not provide all the details you need to select the one that best fits the resident.

Our experts offer tips to help you choose the right dementia diagnosis code every time.

Where to find the basics: You'll find dementia ICD-9 codes in categories 290-294 (Organic psychotic conditions) of your ICD-9 coding manual. Here, you'll notice that there are five basic types of dementia: senile dementia, vascular dementia, alcoholic dementia, drug-induced dementia, and dementia caused by other diseases such Alzheimer's disease or Huntington's chorea.

1. Nail Down The Specific Cause.

There are plenty of specific dementia codes, but getting the background information about what is causing the dementia is probably the biggest problem in coding it accurately, says **Donna Smith, RHIA**, director of health information management for **Ethica Health and Retirement Communities** in Gray, GA.

Problem: Physicians often don't document the cause of dementia, and if it's not documented, you can't code for it.

Reason: Some physicians will not clarify a specific type of dementia because it can only be determined by specific testing or after a resident dies. So what should a coder do when she just can't get any more details? Often, more definitive testing to determine the cause of the dementia isn't warranted or desired, says **Charlotte Lefert, RHIA**, an independent health information management consultant based in Madison, WI, and coding strategy facilitator of the LTC Community of Practice for the **American Health Information Management Association** (AHIMA).

If it's the physician's clinical judgment the resident has dementia and that is all you have documented, 294.8 (Other persistent mental disorders due to conditions classified elsewhere or Dementia NOS) is the right code, says Lefert.

Coding example: You have a telephone order for Risperdal for agitated dementia manifested by constant calling out. The diagnosis is dementia with agitation.

List 294.8 for the dementia and 307.9 (Other and unspecified special symptoms or syndromes, not elsewhere classified) for the agitation, Lefert says.

What to do: If you think there is more information available or you don't have the appropriate diagnosis documented, contact the physician for clarification, Lefert says.

Tip: If you have a psychiatrist treating people in the facility, the psychiatrist's diagnosis may be more accurate and specific than the attending physician's, Smith says. Check for a psychiatrist's evaluation in the record, she says.

2. Don't Automatically Use 290.0.

When your patient population is over 65 years old, don't assume that you can list a senile dementia diagnosis code such as 290.0 (Senile dementia, uncomplicated). Don't code the dementia as senile unless the doctor documents that the resident has old- age dementia, says Smith. People used to think that as you got older you got dementia but that

thinking has changed, she says. You don't necessarily get dementia because you get older -- it has some other cause.

For example: Your resident keeps having little strokes and gets more and more confused. The strokes, rather than his old age, are the cause of his dementia. The physician diagnoses him with vascular dementia with confusion. Code for this resident with 290.41 (Vascular dementia with delirium).

3. Scan The Note For Delusion, Paranoia Details.

Physician documentation may help you navigate to a combination code for certain types of dementia.

For example: If the diagnosis is senile dementia with delusions, you would report 290.20 (Senile dementia with delusional features), Lefert says. But if the physician doesn't state that the resident's behavior is paranoid or delusional, it's not appropriate to use this code. Instead, you should assign 290.0. With less detailed documentation, you'll often end up coding paranoia and delusional features separately from the dementia.

For example: If your diagnosis is dementia with delusions, you would assign 294.8 for the dementia and 297.9 (Unspecified paranoid state) for the delusions, Lefert says.

4. Support Antipsychotics With Specifics.

Facilities often prescribe anti-psychotics to treat residents' dementia-related behavioral or psychotic symptoms. And OBRA rules allow facilities to use anti-psychotics to treat dementia-related psychotic or behavioral symptoms if the symptoms are causing the person functional impairment or distress, endangering him or others -- or interfering with essential care.

Tip: For residents who are receiving an anti-psychotic, make sure the physician documents the specific diagnosis for dementia-related psychotic or behavioral symptoms in the medical record, advises **Christine Twombly, RNC**, chief clinical consultant with **Reingruber & Co.** in St. Petersburg, FL. "Then record the ICD-9 code in Section I3 of the MDS," she adds.