ICD-10 Coding
Clarifications for Hospice: Part 2

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Definition of Dementia (Mayo Clinic)

Dementia is not a specific disease. Instead, dementia describes a group of symptoms affecting thinking and social abilities severe enough to interfere with daily functioning. There are many causes of dementia.

Memory loss generally occurs with dementia, but memory loss alone does not mean a patient has dementia.

Symptoms of Dementia

- Memory loss
- Difficulty communicating
- Difficulty with complex tasks
- Personality changes
- Inability to reason
- Inappropriate behavior
- Paranoia
- Agitation
- Hallucinations
- Difficulty with planning and organization
- Difficulty with coordination and monitoring functions
- Problems with disorientation, such as getting lost
Vascular Dementia

Category F01, Vascular dementia, is a result of infarction of the brain due to vascular disease.

“**Code first** the underlying physiological condition or sequelae of cerebrovascular disease.”

F01.5 Vascular dementia
F01.50 Vascular dementia without behavioral disturbance
F01.51 Vascular dementia with behavioral disturbance

“Use additional code, if applicable, to identify wandering in vascular dementia (Z91.83)”

Example

G31.1, Senile degeneration of the brain, not elsewhere classified

– Unspecified code found in the Nervous System Chapter.
– Frequently used by physicians as the underlying physiological condition for vascular dementia.
– While this is an unspecified code, it is not included on the 2014 list of diagnoses that cannot be used as a principal diagnosis in hospice.

Other codes that are frequently coded as an underlying condition for vascular dementia are:

– I69.31 Cognitive deficits following non-traumatic cerebral infarction
– I69.398, F01.50 vascular dementia without behavioral disturbance as a sequela of a cerebral infarction
Dementia as Manifestation

F02.8- Dementia in other diseases classified elsewhere

“Code first the underlying physiological condition,” such as: Alzheimer’s, dementia with Lewy bodies, frontotemporal dementia, MS, Parkinson’s disease, Pick’s disease, etc. followed by the dementia code:

F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance

F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance

“Use additional code, if applicable, to identify wandering in conditions classified elsewhere (Z91.83)”

Case Example

Patient admitted with late onset Alzheimer’s dementia with aggressive behavior and sundowning and also vascular dementia due to a CVA 2 years ago. Patient is a wanderer.

M1021 Alzheimer’s Disease with late onset

M1023 Alzheimer’s dementia w/ behavioral disturbance

M1023 Delirium superimposed on dementia (sundowning)

M1023 Cognitive deficits following cerebral vascular disease/stroke

M1023 Vascular dementia w/ behavioral disturbance

M1023 Wandering in dementia

ICD-10-CM

G30.1

F02.81

F05

I69.31

F01.51

Z91.83
Case Example Discussion

Many patients have mixed dementia diagnoses as this example illustrates in which the patient has both Alzheimer’s dementia and vascular dementia as a residual from a stroke 2 years ago.

ICD-10-CM expanded code options for Alzheimer’s Disease

- Late onset Alzheimer’s is after age 60 (MD must verify Dx)
- Early onset Alzheimer’s is prior to age 60
- Progressive or end stage Alzheimer’s disease is coded to G30.9
- Coding Clinic direction: If a patient has a diagnosis of Alzheimer’s, the dementia in conditions classified elsewhere is automatically coded as the next code (MD does not have to verify the linkage).

Case Example Discussion

This case example also illustrates the use of F05, Delirium due to known physiological conditions.

- Includes sundowning, delirium superimposed on dementia, acute or subacute confusional state, acute or subacute brain syndrome
- F05 requires a code for the underlying physiological condition prior to the F05 code
Unspecified Dementia (continued)

F03 Unspecified dementia codes require a 5th character code from one of the following:

- F03.90, Unspecified dementia without behavioral disturbance
  [Dementia NOS]
- F03.91, Unspecified dementia with behavioral disturbance
  “Use additional code, if applicable, to identify wandering in unspecified dementia (Z91.83)"

Includes presenile dementia, presenile psychosis, primary degenerative dementia, senile dementia, senile dementia depressed or paranoid type, senile psychosis

Note: May be assigned as the primary diagnosis, except in hospice

Case Example 2

Patient with dementia fell and fractured her right hip and was referred to hospice.

- MD wanted the fractured hip as primary diagnosis since her dementia is not otherwise specified.
- Hospice staff wanted to use dementia as the principal diagnosis, followed by:
  - debility and decline.
  - history of falling/risk of falling
  - bed confinement
  - weight loss

Notes — It is recommended that a BMI be listed after weight loss, anorexia or other similar diagnoses
Case Example # 2

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Weight loss</td>
<td>R63.4</td>
</tr>
<tr>
<td>Other Unspecified dementia without behavioral disturbance</td>
<td>F03.90</td>
</tr>
<tr>
<td>Other Subsequent episode following fracture of the right hip</td>
<td>S72.001D</td>
</tr>
<tr>
<td>Other Debility &amp; decline</td>
<td>R53.81</td>
</tr>
<tr>
<td>Other History of falling/risk of falling</td>
<td>Z91.81</td>
</tr>
<tr>
<td>Other Bed confined</td>
<td>Z74.01</td>
</tr>
</tbody>
</table>

Rationale

Unspecified dementia is determined to be a contributory condition to her terminal status, but cannot be listed as a principal diagnosis because it is listed on the 2014 List of Hospice Invalid Principal diagnosis Codes.

The dementia has lead to increased feeding issues, confusion, and decline in functional ability which may have contributed to her recent hip fracture.

ICD-10 Coding Guidelines no longer includes codes for aftercare of fractures and all fractures are coded to the original fracture with a 7th character of D for subsequent treatment.

Debility is a non-specific code and although it cannot be the primary diagnosis, it can be coded as a secondary code if desired. Due to her age and bed confinement status, she will have increased risk for several complications.
Coder Question

Q. When only given dementia with no mention of behavioral status, however, other diagnosis listed are agitation, anxiety, depression, confusion, etc., can we assume they are causative relationship with the dementia with behavior?

Answer

A. The physician is ultimately responsible for verifying all diagnosis codes including symptom codes.
   – Behavioral issues are any situations that distress others or puts the patient or caregiver at risk.
   – Hospice clinicians are more likely to identify the presence of behavioral issues when they assess the patient and caregivers. Staff need to share these observations with the physician and recommend coding the dementia with behavioral disturbance as well as any comorbid conditions that will impact the patient’s care.
   – Conditions such as agitation, anxiety, and depression are potential comorbid conditions that complicate the care of the patient and should be coded based on their impact on the patient’s care with physician verification or agreement to the diagnoses.
Questions?

Thank you for attending!

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