Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-01-135 **Date: SEPTEMBER 25, 2001**

CHANGE REQUEST 1793

SUBJECT: Medical Review of Services for Patients with Dementia

Contractors may not install edits that result in the automatic denial of services based solely on the ICD-9 codes for dementia.

Dementia is the general loss of cognitive abilities, including an impairment of memory, and may include one or more of the following: aphasia, apraxia, agnosia, or disturbed planning, organizing, and abstract thinking abilities. Dementia excludes the loss of intellectual functioning caused by clouding of consciousness**.** Advances in diagnostic techniques, including neuropsychiatric testing, currently enable physicians and psychologists to diagnose some dementias when the patient's disease is at its earliest stages. Throughout the course of their disease, patients with dementia may benefit from pharmacologic, physical, occupational, speech-language, and other therapies.

Contractors may not use ICD-9 codes for dementia alone as a basis for determining whether a Medicare covered benefit was reasonable and necessary because these codes do not define the extent of a beneficiary's cognitive impairment. For example, a claim submitted with only a diagnosis of Alzheimer's Disease (ICD-9 code 331.0) may entitle a beneficiary to evaluation and management visits and therapies if the contractor determines that these therapies are reasonable and necessary when reviewed in the context of a beneficiary's overall medical condition.

Because dementia is a diagnostic term with broad clinical implications, it may not support the medical necessity of a Medicare covered benefit when used alone. For this reason, contractors should continue performing routine data analysis to identify aberrant billing patterns on claims for Medicare covered services provided to beneficiaries with dementia. They should also instruct providers to enter the primary diagnosis or condition as well as secondary diagnoses or conditions that most closely reflect the medical necessity of the billed service on line 21 of Form HCFA-1500. For example, a provider using physical therapy to treat a patient with an unsteady gait due to Alzheimer's dementia may enter either ICD-9 code 331.0 *(Alzheimer's Disease)* or ICD-9 code 781.2 *(Abnormality of Gait)* as the primary diagnosis. If the provider enters ICD-9 code 331.0 as the primary diagnosis, then he or she should include ICD-9 code 781.2 as the secondary diagnosis to support the medical necessity of the physical therapy service.

When a beneficiary with dementia experiences an illness or injury unrelated to their dementia, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 Code V43.64 *(Hip joint replacement by artificial or mechanical device or prosthesis)* as the primary diagnosis, not ICD-9 code 331.0 *(Alzheimer's Disease)*.

Contractors should continue their routine practices to identify aberrant billing patterns using data analysis. When a Contractor identifies aberrant billing patterns, they should obtain probe samples and follow-up using the principles of progressive corrective action.

The *effective date* for this Program Memorandum (PM) is September 1, 2001.

The *implementation date* for this PM is September 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after August 31, 2002.

If you have any questions, contact Dr. Kevin Gerold at (410) 786-9587.