AAVBC

American Academy
of Value Based Care

AAVBC Dementia/Major Neurocognitive Disorder

Quick Reference Guide

2026

AAVBC Dementia/Major Neurocognitive Disorder Quick Reference Guide

1. CLINICAL SNAPSHOT

Definition: Dementia is an umbrella term for a clinical syndrome caused by underlying brain disease(s) that leads to a progressive decline in mental ability, characterized by cognitive function loss beyond normal aging. These changes affect memory, thinking, and functional abilities, ultimately interfering with activities of daily living and independence.[1-3]

Note: According to the updated DSM-5 criteria, Dementia is now called Major Neurocognitive Disorder (MND). As the term "dementia" is widely used in both societal and medical contexts, this topic will refer to the condition as Dementia.

ICD-10 Codes:[4,5]

As of 2024, ICD-10-CM dementia codes use a structured modifier system to capture both severity and behavioral features:

ICD-10 Codes	Severity (4th character)	Behavioral/Psychiatric Features (5th character)
F01 – Vascular dementia **F02** – Dementia in other diseases **F03** – Unspecified dementia	.A – Mild dementia .B – Moderate dementia .C – Severe dementia	.X0 – Without behavioral disturbance .X1 – With agitation .X2 – With psychotic disturbance (e.g., hallucinations, paranoia) .X3 – With mood disturbance (e.g., depression, apathy) .X4 – With anxiety .X18 – With other behavioral disturbance (e.g., wandering, disinhibition)

Etiology and F-codes: G30 Alzheimer's Disease (G30.0 early onset, G30.1 late onset, G30.8 other Alzheimer's Disease, G30.9 Alzheimer's unspecified); Lewy Body Dementia G31.83; Frontotemporal Dementia G31.09; Pick's Disease G31.01. Simply documenting G30.1 is **insufficient** to capture the RAF. Must include clinical evidence supporting "Mild," "Moderate," or "Severe" to justify the F02.A/B/C code used for HCC mapping.

Example: F03.B1 = Unspecified dementia, **moderate**, **with agitation** F02.C3 = Dementia in other disease, **severe**, **with mood disturbance.**

HCC/RAF V28 Mapping:[4, 5] **HCC 125** (Dementia Severe) F01.CX, F02.CX, F03.CX, with RAF (0.341); **HCC 126 (**Dementia Moderate) F01.BX, F02.BX, F03.BX, with RAF (0.341); **HCC 127** (Dementia Mild or Unspecified) F01.AX, F02.AX, F03.AX, with RAF (0.341).

Prevalence:[3,6]

- **Dementia (all-cause)** rises sharply with age: Approximately **1 in 9** people (11%) aged 65 and older has Alzheimer's dementia[6]
- Estimated **7.2 million U.S. adults ≥65 live** with Alzheimer's dementia
- Significant health disparities exist; Older Black Americans are about **twice as likely** to have Alzheimer's or other dementias as older White Americans
- ~5% of Americans 65–74, 13% of those 75–84, and 33% of those ≥85 have Alzheimer's dementia[6]
- Women are disproportionately affected – nearly **two-thirds** of Americans with Alzheimer's dementia are women (approximately 12% of women ≥65 vs 10% of men)

Cost Burden:[3,6,7]

- Total annual payments for health care, long-term care, and hospice for Americans ≥65 with dementia are **$384 billion in 2025**
- Significantly increases per-patient Medicare spending **(nearly 3× vs without dementia)**
- The individual lifetime cost to care for an individual with dementia was nearly $200,000 more than an individual without dementia

Dementia is a progressive, functional-impairing syndrome that affects over 7.2 million US seniors. Due to its high prevalence (1/3 of adults 85+) and the associated 3x higher Medicare costs, early and accurate diagnosis is essential. Identifying the condition early and in the primary care setting ensures patients are directed toward timely intervention, robust care planning, and supportive community resources, which are the fundamental elements of a high-value care system.[3,6,7]

2. RECOGNITION & DIAGNOSIS

Early recognition of dementia in patients ≥65 is essential. Value-based clinicians should leverage Medicare's screening benefits, identify subtle signs, and differentiate dementia from other conditions. Prompt diagnosis (using standardized criteria) enables timely intervention, proper coding, and alignment with care quality metrics.

Medicare and DETeCD-ADRD 2025 Screenings (≥65yr, at-risk population)[2,8,9]

- **DETeCD-ADRD: D**iagnostic **E**valuation, **Te**sting, **C**ounseling, and **D**isclosure for **A**lzheimer's **D**isease and **R**elated **D**ementias 2025[2]

Test / Workflow	Purpose / When To Use	Who Covers /Endorses	CPT Code(s)	Notes
Annual Wellness Visit (AWV)	Brief cognitive screen/Annually (12-month interval)	CMS	G0438 (initial) G0439 (subsequent)	Includes required detection of cognitive impairment. May use Mini-Cog, GPCOG, etc...

Mini-Cog	3-word recall + clock draw /at AWV or when concerns arise	CMS, DETeCD-ADRD	Included under AWV or 99483	No separate CPT; use within G0438/9 or 99483 visit documentation
Montreal Cognitive Assessment (MoCA)	Comprehensive mental screening tool / suspected MCI or early dementia	DETeCD-ADRD	under 99483	No separate CPT; may bill under cognitive assessment visit or E/M
Mini-Mental State Exam (MMSE)	Tracking moderate–severe decline / Staging or follow-up	DETeCD-ADRD	99483 or part of E/M	Often bundled; document use and time if under E/M
Ascertain Dementia 8 (AD8)	Caregiver-based brief screen/ When collateral info is available	DETeCD-ADRD	99483	Useful as part of cognitive visit or follow-up planning
Cognitive Assessment & Care Plan Visit	Full eval, testing, and plan /If cognitive impairment is detected	CMS	99483	50-min comprehensive visit: includes history, screening, decision-making, functional status, and ACP. Must document all elements
Depression Screening (PHQ-2/PHQ-9)	Rule out depression (dementia mimic)/At screening or eval	CMS, DETeCD-ADRD	G0444 or 99483	May bill separately (G0444) or under 99483. PHQ-2 ≥3 → PHQ-9
Functional Assessment (ADLs/IADLs)	Determine staging and safety needs. At diagnosis, then annually	CMS, DETeCD-ADRD	99483, part of AWV	Must assess basic and instrumental ADLs (e.g., bathing, finances
Hearing/Vision Screening	Rule out sensory mimics /Annually or PRN	CMS, DETeCD-ADRD	92551 (hearing) 99173 (vision)	Covered separately; essential part of cognitive eval
Brain Imaging (MRI/CT)	Rule out structural causes (e.g., stroke, tumor, NPH)/ New onset dementia, atypical or rapid decline	DETeCD-ADRD, CMS (if medically necessary)	70551 (MRI brain w/o contrast) 70450 (CT brain w/o contrast)	Not routine screening — must document clinical indication (e.g., recent cognitive decline, focal deficits). DETeCD recommends structural imaging in initial evaluation

Subtle Early Signs in Older Adults >65[2,3]

These symptoms are often mistakenly attributed to “normal aging” but should raise suspicion for early cognitive decline and prompt formal cognitive screening:

- **Short-term memory lapses**
  - Frequently repeating questions or stories
  - Forgetting recent conversations or appointments
  - Misplacing objects in unusual places
  - Word-finding difficulty or language lapses
- **Executive function changes**
  - Difficulty managing finances, paying bills, or keeping track of medications
- **Getting lost in familiar environments**
  - Navigational disorientation even in one’s neighborhood or home area

- **Loss of initiative or apathy**
  - Withdrawal from hobbies, social activities, or caregiving roles
- **Mood or personality changes**
  - New anxiety, irritability, or depressive features without clear external cause
- **Difficulty with familiar tasks**
  - Struggling to cook a usual meal, follow a recipe, or operate appliances
- **Poor judgment or decision-making**
  - Unsafe behaviors (e.g., giving away money, mismanaging medications)
- **Trouble planning or organizing**
  - Confusion managing multi-step activities like planning travel or shopping lists

Dementia Risk Factors in Older Adults[2,6]

Risk Factor	Risk Signal	Notes/Guidance
Age ≥65	Undisputed greatest risk factor; Risk doubles every 5 years	~33% of those ≥85 have Alzheimer's dementia
APOE-ε4 genotype	1 copy: 2–3× risk 2 copies: up to 12×	Strongest genetic risk for late-onset AD
Family history (first-degree)	Moderate risk	Shared genetic/environmental factors
Mid-life hypertension	~1.6× increased risk	BP control is key modifiable prevention target
Diabetes mellitus	~1.5× risk (esp. uncontrolled)	Promote glycemic control to slow decline
Untreated hearing loss	~2× increased risk	>60% of adults ≥70 don't use hearing aids
Late-life depression	~2× increased risk	Treat independently; may mimic dementia
Social isolation/loneliness	~1.5× increased risk	Associated with faster decline
Mid-life obesity	~1.8× increased risk	Physical activity improves cognitive resilience
Low education/cognitive inactivity	Earlier onset, faster progression	Encourage adult learning, stimulation
Polypharmacy (≥5 meds)	Increases delirium and cognitive load	Regular med review recommended
Multimorbidity (e.g., CHF, CKD)	Cumulative risk	Worsens frailty, functional reserve
Alcohol Use Disorder (AUD)	~3.3× increased risk	Associated with earlier onset and vascular dementia; screen with CAGE/DSM-5

Up to 45% of dementia risk may be modifiable with early identification and intervention.[2,6] Providers should assess and document these risk factors as part of AWVs, chronic care management, and dementia screening workflows.

RED FLAGS - URGENT ACTION[2,6]

These features suggest serious or reversible pathology and require urgent evaluation or referral:

- **Rapid onset or decline (weeks to months)**
  - Consider **delirium**, **autoimmune encephalitis**, or **prion disease**
  - Warrants urgent diagnostic workup
- **Focal neurologic signs**
  - E.g., unilateral weakness, visual field deficits, aphasia
  - Raise concern for **stroke**, **tumor**, or **subdural hematoma** (especially if trauma history)
- **Early gait disturbance + cognitive decline + urinary incontinence**
  - Classic triad of **normal pressure hydrocephalus (NPH)**
  - May be reversible with ventriculoperitoneal shunting
- **Young-onset dementia (<65 years old)**
  - Suggests **frontotemporal dementia**, **genetic causes**, or **autoimmune etiology**
  - Prompt specialist referral recommended
- **Rapid or extreme behavioral/personality changes**
  - Sudden onset paranoia, aggression, or disinhibition may indicate **FTD**, **toxic-metabolic**, or **infectious** causes
- **Acute confusion or fluctuating alertness**
  - Strongly suggest **delirium**, often superimposed on underlying dementia
  - Medical emergency: Identify and treat underlying cause (e.g., infection, medications, metabolic issue)

Diagnostic Criteria for Major Neurocognitive Disorder (Dementia)

DSM-5/NIA-AA Diagnostic Criteria for Major Neurocognitive Disorder (Dementia), based on the 2025 DETeCD-ADRD guideline[2] and StatPearls MND summary:[3]

Criterion	Description	Notes/Guidance
1. Evidence of significant cognitive decline	Decline in **one or more cognitive domains:** Learning & memory, executive function, language, perceptual motor, complex attention, social cognition	Use **objective testing** or reliable informant/caregiver report
2. Interference with independence in daily activities	Cognitive deficits **impair ability to perform IADLs/ADLs** (e.g., managing meds, finances, cooking)	If patient remains fully independent, consider **Mild Neurocognitive Disorder** instead
3. Functional decline is progressive and persistent	Decline is not temporary or fluctuating	Assess changes from **prior baseline** using clinical history and functional scales
4. Deficits not better explained by delirium	Rule out acute, reversible cognitive disturbance (e.g., infection, drugs)	Use collateral info, review med list, and assess for **waxing/waning course**
5. Deficits not due to another mental disorder	Exclude **major depression,** schizophrenia, or anxiety as primary cause	Screen with PHQ-9, GAD-7; evaluate mood and behavior patterns

6. Objective documentation of impairment	Support diagnosis with bedside tools or formal testing	MMSE (<24), MoCA (<26), or neuropsych testing; adjust for education, language, and age norms

Clues to Dig Deeper[2,3]

Early clinician-facing signs suggesting underlying Major Neurocognitive Disorder (MND):

- **Subtle short-term memory issues**
  - Repeating questions, losing track of conversations, and forgetting recent events[2]
- **Functional slippage in IADLs**
  - Trouble managing finances, shopping, cooking — even when still fully independent[2]
- **Caregiver concern precedes patient recognition**
  - Family often notices confusion, withdrawal, or poor safety decisions before the patient does
- **Decline in judgment or risk awareness**
  - New driving incidents, unsafe medication use, or falling for scams[2]
- **Word-finding pauses or vague speech**
  - Struggling to retrieve names or describing familiar objects indirectly ("the thing you write with")[3]
- **Getting lost in familiar environments**
  - May present as late arrivals, directional errors, or travel avoidance[2]
- **Personality or mood change without trigger**
  - Apathy, new irritability, or emotional bluntness, especially if inconsistent with prior temperament[3]
- **Difficulty completing multi-step tasks**
  - Can't follow recipes, assemble tools, or manage medications without prompts[6]

Common Oversights[2,3]

Frequent attribution errors that delay dementia recognition:

- **Mislabeling early symptoms as "normal aging"**
  - 48% of the public — and many clinicians — believe memory loss is just part of aging
- **Delays in formal diagnosis**
  - Average time to diagnosis is 3.5 years; even longer for early-onset dementia
- **Underestimating patient distress or compensation**
  - High-functioning patients may mask deficits with lists, routines, or humor until quite advanced
- **Confusing sensory loss with cognitive decline**
  - Hearing or vision impairments can look like confusion or inattention; correction may clarify the picture
- **Assuming mood explains cognition**
  - Depression can mask or mimic cognitive symptoms, but may also co-occur with MND
- **Lack of collateral input**
  - Relying only on a patient's report underestimates impairment; always get family/caregiver perspective

Never accept “just aging” as a diagnosis without objective testing and functional review. Sensory correction, mood screening, and caregiver insight often reveal hidden decline.

Differential Diagnosis of Dementia-Like Symptoms in Older Adults[2,3,6]

Condition / Mimic	Key Clinical Clues	Recommended Evaluation	Notes
Delirium	Acute onset, fluctuating alertness, inattention, disorganized thinking	CBC, CMP, UA, vitals, infection screen, medication review	Often superimposed on dementia; medical emergency
Depression “Pseudodementia”	Apathy, slowed responses, "I don’t know" answers, variable effort	Geriatric Depression Scale (GDS), PHQ-9/PHQ-2	Treat and reassess cognition after mood improves
Vitamin B12 Deficiency	Neuropathy, fatigue, mood changes, slow cognition	B12, MMA, CBC	Reversible with supplementation
Hypothyroidism	Fatigue, cold intolerance, dry skin, cognitive slowing	TSH, free T4	Common mimic; treatable and often overlooked
Medication effects	Recent med changes, anticholinergics, opioids, sedatives, polypharmacy	Full med reconciliation	Deprescribing may resolve symptoms
Normal Pressure Hydrocephalus (NPH)	Gait disturbance + dementia + incontinence (“wet, wobbly, wacky”)	MRI brain, CT head, refer to neurology/neurosurgery	May be treatable with shunt
Subdural Hematoma	Trauma history, headache, focal signs, gradual decline	Non-contrast CT head	Common in elderly fallers; requires neurosurgery if large
Parkinson’s disease	Resting tremor, bradykinesia, shuffling gait, rigidity	Neurologic exam, DAT scan if unclear	Cognitive decline may emerge later (PDD)
Lewy Body Dementia	Visual hallucinations, parkinsonism, REM sleep disorder, fluctuating alertness	Clinical diagnosis; brain imaging supportive	Antipsychotic sensitivity is hallmark
Vascular cognitive impairment	Stepwise decline, focal deficits, CVA history, white matter disease	MRI brain (look for infarcts, small vessel ischemia)	Manage vascular risk factors to slow progression
Frontotemporal Dementia (FTD)	Personality change, apathy, disinhibition, language loss in <65yo	MRI (frontal/temporal atrophy), neuropsych testing	No memory loss early; misdiagnosed as psych disorder

AAVBC Recommendation: In all suspected dementia cases, recommended to obtain brain imaging (preferably MRI) to rule out structural or vascular mimics. Always review labs (TSH, B12, CBC, CMP), medications, and caregiver insights before final diagnosis.

Comorbidity Screening in Patients with Dementia[2,3,6]

Condition	Approximate Prevalence in Dementia	Recommended Screening / Evaluation
Depression	~30–50%	PHQ-2 or Geriatric Depression Scale (GDS); full PHQ-9 if positive
Anxiety	Up to 40%	GAD-7; ask about restlessness, sleep, and excessive worry
Sleep disorders (e.g., OSA, REM behavior disorder)	>50% report disrupted sleep	STOP-Bang screen for OSA; consider sleep study if high-risk
Hearing loss	~60–70% in adults ≥70	Handheld audiometry or referral to audiologist if impaired
Vision impairment	~25–40%	Snellen chart, annual dilated eye exam, cataract/glaucoma screening
Pain	Often underreported or misinterpreted	Use PainAD for non-verbal patients; inquire about chronic or new pain
Delirium triggers	Delirium in ≥30% of hospitalized dementia patients	Screen for UTI, dehydration, medication changes, and infection (UA, CBC, CMP)
Hypertension, AFib, diabetes	Highly prevalent; increase vascular dementia risk	BP, ECG for irregular rhythm, A1C at least annually (q6mo if diabetic)
Nutritional deficiencies (e.g., B12)	10–20% may have B12 insufficiency	Serum B12, MMA if borderline; folate/Vit D optional
Constipation /GI issues	Very common in frail elderly	Ask directly; assess for laxative overuse or inactivity
Alcohol use disorder (AUD)	Personality change, apathy, disinhibition, language loss in <65yo	CAGE questionnaire or AUDIT-C annually; consider DSM-5 criteria if indicated
Tobacco use	12–20% of adults ≥65 still smoke; ↑ risk for vascular dementia	Ask annually; document current, past, or never smoker; advise cessation
Illicit drug or prescription misuse	Often overlooked in older adults	Screen with DAST or brief interview (especially if behavior changes or sedation)
Obesity (BMI ≥30)	Mid-life obesity increases dementia risk ~1.8×	Record weight and height; calculate BMI annually at minimum
Diabetic control	>25% of dementia patients may have diabetes	A1C q6mo if diabetic; review meds for hypoglycemia risk and regimen complexity
Vaccination status	Often incomplete in dementia	Check influenza, COVID-19, pneumococcal, shingles; vaccinate as indicated

Dementia Staging Systems Overview

	CDR (Clinical Dementia Rating)	FAST (Functional Assessment Staging Test)	GDS (Global Deterioration Scale)	Clinical Notes
Stage 1	0 – No impairment	1 – Normal adult	1 – No cognitive decline	Normal; no deficits on testing or daily function
Stage 2	0.5 – Questionable impairment	2 – Normal older adult with forgetfulness	2 – Very mild decline	May describe subjective memory loss; no functional impairment
Stage 3	1 – Mild dementia	3 – Early functional deficit (IADLs)	3 – Mild cognitive decline	Impaired in work or complex tasks (e.g., finances, traveling); still independent; often where MCI is diagnosed
Stage 4	2 – Moderate dementia	4 – Needs help with complex tasks	4 – Moderate cognitive decline	Clear diagnosis of dementia; forgets recent events, difficulty with math, needs help managing meds or bills
Stage 5	–	5 – Needs help choosing proper clothing	5 – Moderately severe cognitive decline	Cannot live independently; disoriented to time/place; requires help with ADLs; corresponds to *ICD-10 F0.B*
Stage 6	–	6 – Needs assistance with dressing, bathing, toileting	6 – Severe cognitive decline	Major memory gaps; may forget spouse's name; incontinence and ADL dependence appear; ICD-10 F0∗.C
Stage 7	3 – Severe dementia	7 – Nonverbal, total dependence	7 – Very severe cognitive decline	Non-verbal, immobile, bed-bound; qualifies for hospice if progression continues

CDR is ideal for initial staging and caregiver interview; score of 1 = mild, 2 = moderate, 3 = severe dementia.[10]

FAST focuses on functional decline (ADLs); helpful for planning home health, OT, or hospice eligibility (Stages 6–7).[11]

GDS gives a global view of cognitive decline over time and correlates with Alzheimer's natural history.[2,11]

Mini-Mental State Examination (MMSE)

Score Range	Interpretation	Approximate Dementia Stage
25–30	Normal cognition or very mild impairment	May represent early MCI
19–24	Mild cognitive impairment/early dementia	Mild
10–18	Moderate cognitive impairment	Moderate
<10	Severe cognitive impairment	Severe

MMSE is a brief, standardized cognitive screening test used to assess overall cognitive function and track decline over time. Use alongside other assessments like or **FAST/CDR** for staging accuracy.[2,3]

Supports documentation for **MEAT** and **ICD-10 coding** (e.g., F02.A for mild, F02.B for moderate).

Note: Adjust scores for **education**, **language**, and **cultural background.**

3. M.E.A.T Documentation Essentials

In risk-adjusted value-based care, simply listing "dementia" in the chart is not enough. Providers must document M.E.A.T. – how they Monitored, Evaluated, Assessed, or Treated the dementia to substantiate the diagnosis for coding and audits. Complete documentation ensures dementia is recognized as an active, managed condition, securing appropriate HCC credit while guiding patient care.

Monitor: Describe how you are monitoring the dementia – e.g. "Monitoring memory decline and safety: MMSE 18/30 today vs 20/30 last visit, daughter reports more wandering." Key observations to document for Dementia care include changes in behaviour, daily living skills (ADLs), cognitive ability and medication.

Evaluate: Document evaluation of test results or symptoms – e.g. "Reviewed labs (B12 normal) and CT head – no acute changes; evaluated medication adherence and patient's response to donepezil." Record finding from physical exams related to the patient's dementia, such as gait changes or neurological signs. ("ADL score 4/6, declined from 6/6"). Evaluate the effectiveness of current medications or treatments.

Assess: State your clinical assessment/impression (severity + control + context) of the condition – e.g. "Assessment: Moderate Alzheimer's dementia with stable behaviors, some worsening short-term memory." This can include referencing records or counseling – e.g. "Discussed disease progression with family, advance care planning addressed." Acknowledge: Document the status and level of the condition, noting if it is stable, progressing, or causing behavioral issues.

Treat: Document treatments, interventions, or plans – e.g. "Continued donepezil 10mg daily, added memantine for advancing symptoms; referral to neurology for driving evaluation; caregiver given strategies for sundowning." Record any referrals to specialists, such as a neurologist, geriatrician, or mental health provider. Plan: Outline the ongoing management plan, including future appointments, specific care goals, and medication reviews.

Clinical Documentation Elements

Reflecting cognitive severity, functional impact, and ongoing clinical engagement.

- **Document diagnosis status annually:** face-to-face or telehealth encounter to reflect ongoing clinical assessment
- **Diagnostic specificity** (e.g., "Alzheimer's disease with moderate dementia")
- **Functional impact and care linkage:** Document how dementia affects daily functioning and link findings to care actions when appropriate (eg, impact on ADLs prompting home health, caregiver support, or safety planning)

- **Avoid vague terms** like "memory loss"
- **Include a clear plan of care** (e.g., medication changes, referrals, safety interventions)
- **Documentation integrity:** Notes should be signed, dated, and reflect individualized clinical judgment; Primary documentation should appear in the Assessment and Plan rather than relying solely on the problem list
- **Personalize templated language** to the patient; avoid copy/paste
- **Update diagnosis severity as the condition progresses** (e.g., F02.A → F02.B)

Reframing Common Documentation Pitfalls

Avoid…	Prefer documenting…
"Memory loss"	"Alzheimer's dementia, moderate severity; progressive short-term memory impairment affecting medication management"
"History of dementia"	"Alzheimer's dementia, moderate; actively managed"
Problem list only	"Assessment: Alzheimer's dementia, moderate. Plan: caregiver education provided; home health initiated for ADL support"
Generic templated text	Patient-specific cognitive, functional, and safety details
Outdated severity	Updated staging as condition progresses (eg, mild → moderate)
Unsigned note	Signed and dated encounter documentation

4. TREATMENT & REFERRAL QUICK GUIDE

Therapy Escalation Criteria[2,3]

The decision to escalate therapy involves three main axes: Cognitive Decline, Behavioral Symptoms, and Disease-Modifying Therapy (DMT) Eligibility.

Domain	Threshold for Escalation/Change	Recommended Action	Supporting Rationale (VBC)
Cognitive Management (Cholinesterase Inhibitors/Memantine)	**Initial Diagnosis (Mild-to-Moderate AD):** Confirmation of Major Neurocognitive Disorder (Dementia) due to Alzheimer's Disease (AD)	**Start:** Cholinesterase Inhibitor (Donepezil, Rivastigmine, or Galantamine)	Symptomatic treatment offers moderate short-term benefit for cognition and function, delaying long-term care need
	Progression to Moderate-to-Severe AD: Decline in function (e.g., FAST Stage 5 or 6) or loss of efficacy on monotherapy	**Add:** Memantine (NMDA antagonist) to the existing Cholinesterase Inhibitor (Combination therapy)	Memantine is FDA-approved for moderate-to-severe AD. Combined use provides better symptomatic relief

	Loss of Functional Independence: Patient declines rapidly, requires maximum assistance (e.g., FAST Stage 7), or benefits no longer outweigh risks (BPSD/side effects)	**Consider Discontinuation (Deprescribing):** Tapering symptomatic medications, focusing exclusively on comfort and BPSD	Deprescribing high-risk drugs aligns with quality goals and reduces cost/side effect burden in end-stage disease. (CPT 99483 component)
Behavioral & Psychiatric (BPSD) (Agitation, Psychosis, Aggression)	**First Line Failure:** Behavioral symptoms (Agitation, Sleep Disturbance) cannot be managed by **Non-pharmacological Interventions (NPIs)** for 4-6 weeks	**Document NPI Failure:** Initiate behavioral strategies (e.g., identifying triggers, environmental change, caregiver training) and document lack of efficacy first. (Alzheimer's Assoc. CPG)	NPIs are the gold standard due to black box warnings on psychotics. Documented NPI failure justifies the high-risk drug
	Escalation Trigger: Behavioral symptoms are **severe, dangerous,** or **significantly distressing** to the patient or caregiver (e.g., immediate threat, self-harm, severe psychosis	**Start/Escalate Pharmacotherapy:** Atypical Antipsychotics (e.g., Risperidone, Brexpiprazole) for specific symptoms (agitation, psychosis) at the **lowest effective dose** for the shortest duration	Value-based care must prevent hospitalization, violence, and institutionalization. Pharmacological intervention is warranted only when safety is compromised
Disease-Modifying Therapy (DMT)	**Diagnosis of Mild Cognitive Impairment (MCI) or Mild Dementia:** Confirmation of AD pathology (Amyloid-positive status) via biomarkers (PET/CSF/Plasma) + meeting clinical trial inclusion criteria	**Refer to Specialist/Infusion Center:** Initiate Amyloid-targeting monoclonal antibodies (e.g., Lecanemab, Donanemab) with strict adherence to **Appropriate Use Criteria (AUC)**	DMTs are a massive cost center but represent the highest potential value by slowing progression. Adherence to AUC is critical for appropriate utilization and VBC cost control

Non-Rx Treatment Documentation

Non-drug therapies are first-line, especially for dementia-related behaviors and for overall cognitive health. Always document these interventions to show comprehensive care. Non-pharmacological intervention examples: Exercise and activity, routine and environment, behavioral/cognitive therapies, caregiver education, home safety, nutritional support.

Cognitive stimulation therapy (e.g., puzzles, reminiscence activities, music therapy)

Type/Description of intervention: "Music therapy: Listen to familiar music from the 1950s to reduce anxiety and improve mood during transitions." **Duration and frequency**: E.g., "15-minute session, three times per day." **Implementation details**: How the intervention is delivered. For example, "Use a personal music player with headphones to play a patient's custom playlist."

Medicare GUIDE Model alignment:[13]

- Capture caregiver support, coordination, and community resource linkage

Documentation of non-drug care fulfills value-based metrics for person-centered dementia management.

When to Refer[2,3,13]

Specialty / Service	Referral Triggers	Recommended Timing / Follow-Up	Documentation Notes
Neurology/Memory Clinic	Atypical presentation (early-onset, rapid decline, focal deficits); uncertain diagnosis; considering advanced therapies (e.g., monoclonal antibodies for early Alzheimer's)	At diagnosis or when symptoms progress beyond primary care scope	"Referred to neurology for evaluation of rapidly progressive dementia to exclude prion disease"
Geriatrics/Cognitive Disorders Specialist	Complex comorbidities, frailty, or overlapping syndromes (e.g., delirium vs dementia)	Early referral for baseline co-management	Helps with medication optimization and geriatric syndromes
Neuropsychology	Mild or uncertain cases; discrepancy between clinical impression and cognitive screening; legal or functional capacity questions	Early (baseline) or when diagnostic clarification needed	"Referred for formal cognitive testing to establish baseline and assist with staging."
Psychiatry/Geriatric Psychiatry	Severe behavioral disturbance, depression, or psychosis; considering antipsychotics or mood stabilizers	As symptoms emerge; follow every 3–6 months if medicated	"Referred to geriatric psychiatry for agitation management after non-pharmacologic strategies insufficient"
Occupational Therapy (OT)	Decline in ADLs, home safety risks, or caregiver strain; early-stage rehabilitation	Early to moderate stages; reassess annually or with functional decline	"OT referral for home safety assessment and cognitive retraining."
Physical Therapy (PT)	Falls, mobility decline, or gait instability; post-hospitalization	Moderate stage onward; after hospitalization or new weakness	"PT referral for gait and fall-prevention training."
Driving Rehabilitation/OT Driving Evaluation	Any question of driving safety or recent accidents	Mild–moderate stage; re-evaluate annually if still driving	"Referred for driving assessment due to family safety concerns."
Social Work /Caregiver Support Services	Caregiver burnout, financial stress, or care coordination needs	At diagnosis and whenever caregiver distress increases	"Referral to Alzheimer's Association for caregiver education and GUIDE Model resource enrollment."
Palliative Care /Hospice	Advanced dementia (FAST 6–7), recurrent infections, or weight loss	Moderate–severe stages; initiate goals of care discussion early	"Initiated palliative care referral to address comfort and feeding concerns."

Follow-up Timing:

- **Mild, stable dementia:** every **6 months** (earlier if new symptoms)
- **Moderate dementia or on meds:** Every **3–4 months** for titration and monitoring
- **Advanced dementia or new interventions:** Every **1–2 months** or as needed
- **Facility-based patients:** Coordinate with staff; see **quarterly** at minimum
- **After medication change:** Re-evaluate in **1 month** (e.g., tolerance, behavior)
- **At each visit:** Reassess weight, caregiver stress, safety, and function
- **Tie visit frequency to clinical stability** — shorter intervals for instability or rapid decline
- **Quality metrics:** Annually confirm advance care planning, pain, and fall screening (HEDIS COA)
- **Document reason for interval** (e.g., "Follow up in 3 months for cognitive monitoring and med review")

Patient Education & Adherence

Cognitive impairment, a core feature of dementia, negatively impacts adherence, making it crucial to simplify medication plans, leverage supportive technologies, and involve family members to help patients manage their care.

Ensure Effective Communication

- Use clear, simple language and avoid jargon. Employ active listening, empathy, and non-verbal cues like body language and facial expressions to build trust and understanding

Simplify Medication Regimen

- Deprescribe & Consolidate: Review the Beers Criteria/high-risk list (part of CPT 99483). Aim for once-daily dosing where possible. Document: "Deprescribed Amitriptyline (Beers List); consolidated medications to morning/evening boxes"
- Reduces risk of falls, polypharmacy-related cognitive decline, and HEDIS measure failures

Leverage Technologies

- Pillboxes & Automatic Refills: Ask: "Do you use a weekly pillbox?" Document: "Pillbox management taught to caregiver; enrolled in 90-day mail-order refills"
- Directly supports medication adherence rates (a key HEDIS/Star metric) and reduces emergency refills

Involve the Care Team

- Required Independent Historian: Obtain medication and adherence history from the caregiver/spouse (mandatory for CPT 99483). Document: "Caregiver verbalized understanding of new titration schedule"
- Acknowledge and document the person responsible for adherence, which is vital for RADV/audit defense

Comorbidity Management[2,3]

Comorbidity	Medication Concern / Adjustment	Clinical Rationale	Documentation Example
Bradycardia/Heart block/Syncope	Avoid or lower dose of **cholinesterase inhibitors** (donepezil, rivastigmine, galantamine)	Can worsen bradycardia due to vagotonic effects	"Avoiding high-dose donepezil due to heart block — monitoring pulse and syncope risk."
Chronic Kidney Disease (CKD stage 4+)	Reduce dose of **memantine**	Drug is renally cleared; accumulation increases adverse effects	"Memantine reduced to 5mg BID due to GFR <30."
Parkinsonism /Lewy Body Dementia	Avoid typical antipsychotics (haloperidol, risperidone); consider **quetiapine or clozapine**	Sensitive to dopamine blockade → worsened rigidity and confusion	"Psychosis present — started quetiapine low dose due to Parkinsonism."
COPD/Asthma	Caution with **rivastigmine (inhalation exposure)** or **anticholinergics**	Cholinesterase inhibitors may cause bronchospasm; anticholinergics worsen cognition	"Avoiding inhaled anticholinergic agents; monitoring respiratory status."
Frailty/Weight loss/Poor appetite	Lower dose or discontinue **donepezil** if anorexia or GI distress occurs	GI side effects increase fall and weight loss risk	"Reduced donepezil to 5 mg due to appetite loss and frailty."
Polypharmacy /Beta-blocker use	Monitor HR if combined with **donepezil** or **galantamine**	Additive bradycardic effect; risk of syncope	"On metoprolol — monitoring for bradycardia while continuing donepezil."
History of falls /Orthostatic hypotension	Avoid sedatives, high-dose antipsychotics, or TCAs	Increased fall risk and confusion	"Avoiding sedatives and TCAs — reviewed fall precautions with the caregiver."

Always record the **rationale for medication adjustments**, to demonstrate individualized, risk-aware care, and support compliance with **HEDIS "Medication Review"** and **Care for Older Adults (COA)** quality metrics.

Cost-Smart Rx Options[2,3,14]

Medication / Class	Brand Example(s)	Cost-Smart Strategy	Clinical Rationale
Donepezil	Aricept®	Use generic (5–10 mg daily) instead of brand; avoid unnecessary high-dose (23mg) tablet	Equal efficacy at lower cost; 23mg adds minimal benefit, more side effects
Rivastigmine	Exelon® (capsule, patch)	Prefer oral generic over patch unless GI intolerance; verify formulary coverage	Patch 3-5× cost of oral; oral equally effective if tolerated
Galantamine	Razadyne®	Use generic ER once daily; avoid branded formulations	Equivalent efficacy; improved adherence and lower copay

Memantine	Namenda®	Use generic memantine; if on Namzaric®, prescribe components separately	Same efficacy; combination pill significantly more expensive
Donepezil + Memantine	Namzaric®	Avoid fixed-dose combo; use individual generics	Brand adds no benefit over separate agents; cost difference often >$500/month

Quality Metrics Tie-In[2,12,14,15]

Program / Measure	Focus Area	Documentation Requirement	Impact / Notes
HEDIS – Care for Older Adults (COA)	Annual **Functional Status, Pain Screening,** and **Advance Care Planning (ACP)**	Document each once per calendar year: - ADL/IADL status - Pain assessment - ACP discussion or directive	Meets Medicare Star measure for COA; supports person-centered care
MIPS #281 – Dementia: Cognitive Assessment	Annual **Cognitive and Functional Evaluation** with documented **Care Plan**	Record cognitive test results and care plan (e.g., MMSE, MoCA, or equivalent)	Required for full MIPS quality scoring under dementia measure set
CMS GUIDE Model (2024–2027)	**Coordinated dementia care** – caregiver support, care navigation, emergency planning	Document care coordination, caregiver education, and resource referrals	CMS reimburses participating practices; focuses on equity and caregiver well-being
Medicare Star Ratings	**Medication review, adherence, safety** for dementia patients ≥65	Perform and document **annual medication review** and avoidance of high-risk drugs	Affects plan quality bonuses and network ranking
CG CAHPS (Caregiver Experience)	**Caregiver satisfaction and communication**	Document engagement, education, and empathy in visits	Improves caregiver experience domain in Star ratings
High-Risk Medications in the Elderly (DAE)	Avoid **antipsychotics, benzodiazepines,** and other high-risk drugs in patients ≥65	Document justification if prescribing (e.g., severe psychosis, danger to self/others)	Reduces fall and mortality risk; directly tracked in Medicare Stars
Potentially Harmful Drug–Disease Interactions (DDE)	Avoid meds that **worsen dementia**(e.g.,anticholinergics, sedatives)	Document rationale or alternatives when these drugs are prescribed	Improves drug safety and adherence; linked to plan performance
Transitions of Care (TRC)	Timely **post-discharge follow-up** for hospital or SNF transitions	Document contact or visit within 7-30 days post-discharge	Reduces readmissions; dementia patients are high-risk for care gaps

Documenting **function, cognition, pain, medication review, and care coordination** annually satisfies multiple quality metrics (COA, MIPS, DAE, DDE, TRC) and supports **CMS GUIDE model compliance** for dementia care coordination. Always consider **exclusions** for patients whose primary care goal has shifted to comfort and end-of-life care.

5. CODING REMINDERS & CASE EXAMPLES

Specificity Requirements

- **Specificity is key:** Always code the **most specific dementia diagnosis** supported by your documentation. Include the type (if known) and severity in your note so the correct ICD-10 can be selected. For example, document "Alzheimer's disease with moderate dementia (F02.B0)" rather than just "memory loss" or "dementia"
- Use **ICD-10 codes with extensions**: .A/.B/.C to indicate mild/moderate/severe and add .0 or .1 for with/without behavioral disturbance (e.g. F03.C4 = severe dementia with anxiety)
- **Avoid unspecified codes** if specifics are known – e.g. if you know it's vascular dementia, code F01 not F03. If multiple etiologies, code each (e.g. Alzheimer's G30.9 + F02.x dementia, and cerebrovascular disease)
- Remember to **update codes as severity changes**; if a patient progresses from mild to moderate, use the new severity code going forward (and note the change in documentation)

Annual Clinical Review and Confirmation

Confirm dementia remains active, staged, and clinically managed.

- **Annual review**: Dementia must be reassessed once per calendar year via face-to-face or synchronous audio-video encounter, with MEAT documented by 12/31
- **Visit modality**: In-person or audio-video telehealth encounters qualify when cognitive status, functional impact, and care plan are addressed

Good documentation is Comprehensive Coding

Insufficient	Comprehensive
Vague diagnosis ("dementia" only)	Specify type and cause (e.g., Alzheimer's, vascular, Lewy body) "Probable Alzheimer's dementia — workup planned"
Missing MEAT documentation	"Dementia – stable, monitored" or equivalent in A/P.
"History of dementia"	Use "ongoing," "due to Alzheimer's," or list under **active problems**
Missing impact on daily function	Document ADL decline (e.g., bathing, dressing, feeding) and include caregiver input or physician letter
Insufficient medical evidence to justify diagnosis	Include MMSE/MoCA scores, neuropsych testing, and note progression over time
Cognitive focus only, no functional context	Link cognition to functional limitation and care needs in A/P section

EHR Tips

- EHR Tips: Exact tools (e.g., ".dmMEAT template, Problem list: flag HCC_REQUIRED, Annual Wellness Visit prompt: CHRONIC_CAPTURE")
- Every dementia entry should show **MEAT + function + evidence** to support chronic, progressive disease status

Brief Case Examples

Case 1 – Success (Proper Documentation): *Mrs. A, an 80-year-old with **moderate Alzheimer's dementia (F02.B0)**, seen today:* "**Dementia (moderate, HCC 126):** Patient's MMSE 20 → 18 in 6 months (Monitored). Reviewed home health aide notes – no falls, occasional sundowning (Evaluated). Assessment: stable weight, needs help dressing (functional decline noted). Continue donepezil 10 mg daily, added memantine for worsening memory (Treating). Discussed advanced directives with the daughter, will follow up in 3 months."

Takeaway: Documentation explicitly shows monitoring (MMSE trend), evaluation (notes review), assessment (status/progression), and treatment plan. It justifies the HCC code and provides a clear care plan, meeting both clinical and coding needs.

Case 2 – Pitfall (Poor Documentation): *Mr. B, 88, with known dementia, comes in for follow-up:* Provider documents under Assessment: "**History of senile dementia** – continue current management." **Problems:** Labeled as "history of," implying the condition is in the past. No evidence of MEAT (no current findings or plan specific to dementia).

Fix: The provider should document dementia as an active problem, include a brief status (e.g. "no change in memory, family managing meds") and management (even if no changes). Without that, this one-liner example would not pass a RADV audit.

Takeaway (Coding & Cases): **Capture dementia actively, and specifically** every year. Use the highest specificity ICD-10 codes (with type, severity), and ensure each code is backed by documentation (MEAT).

Avoid common pitfalls like "history of dementia" or incomplete notes. By using EHR tools and vigilant documentation practices, you'll secure your coding (and revenue) while illustrating quality care – as seen in the success case above.

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