DEMENTIA NEWSLETTER FOR PHYSICIANS

A Publication of the Ontario Dementia Network

Vol. 1, No. 1 | INAUGURAL ISSUE | Fall 2010

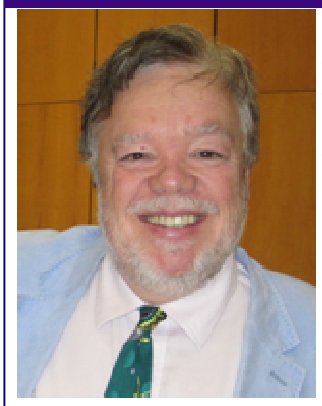
In This Issue ...

- **Guide to Scheduling and Billing for Family Physicians**
  - Dr. Leslie Anne Bailliu
  - Dr. Bill Dalziel
- **Mild Cognitive Impairment**
  - Dr. Andrew R. Frank
- **About the Ontario Dementia Network**

For more information

Alzheimer Society of Ottawa and Renfrew County
Tel: 613-523-4004
Fax: 613-523-8522
Email: info@asorc.org

Office Assessment of Dementia
A Guide to Scheduling and Billing for Family Physicians



Dr. W.B. Dalziel, FRCP(C), Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital, Associate Professor, Department of Medicine, University of Ottawa

Dr. Leslie Anne Bailliu, B.SC.P.T., CCFP (CoE), Medical Director, Geriatric Rehabilitation Services, Hopital Elizabeth Bruyere, Bruyere Continuing Care

The appropriate assessment of dementia can be a complex and time intensive activity in the fee for service office environment. However, dividing the assessment into multiple, shorter, focussed, billing friendly visits can facilitate the process.

The first **"visit"** is usually 1 of 3 scenarios:

1. screening high risk but asymptomatic elderly
2. assessing a "complaint" (usually by family) of a "memory" problem
3. you or your staff "noticing" a red flag problem (self neglect, non-compliance, "confusion", vagueness etc).

Cont'd on page 2

WEBINAR FOR FAMILY PHYSICIANS

Alzheimer Knowledge Exchange — Online Event
Linking People, Resources & Ideas

Topics: 1) Practical Safe Driving Checklist
2) A Guide to Dementia-Related Billing in Ontario

Presenter: Dr. W.B. Dalziel, FRCP(C), Regional Geriatric Program of Eastern Ontario

Date/Time: Monday, January 24, 2011 from 12 to 1 p.m.

Register Now!

Complete the online registration form at http://www.surveymonkey.com/s/VHRWLDW

Technical Requirements:

Visual Support — The presentation will be accessible via an Internet connection. This connection can be any web-enabled laptop or desktop computer of your choice.

Audio Support — Audio support for the presentation will be provided through your telephone via a toll-free line.

You will receive a confirmation email 24-48 hours prior to the session. Thank you, we look forward to your participation!

(cont'd from page 1)

Office Assessment of Dementia
A Guide to Scheduling and Billing for Family Physicians *(as of October 1, 2010)*

First Visit		
1) **Scenario 1** – Screening (high risk by age/vascular risk factors)	Memory Quickscreen 3 item recall [failure is 0 or 1/3, odds ratio 3.1] 4 legged animals in 1 minute [failure is <15, odds ratio 20.2] clock drawing [abnormal, odds ratio 24.0] and questions about cognition/function/behaviour changes	**A007 $33.10 or part of an annual review**
2) **Scenario 2** – memory complaint by family or patient (R/O depression) **or** **Scenario 3** – red flag symptoms	Full review of ABC symptoms with patient and caregiver A = Activities of Daily Living B = Behaviour C = Cognition physical exam, order lab and CT head (if appropriate)	**A003 $71.25**

Could also consider, depending on circumstances:

3) **K002****	Interview with relatives to obtain history/make decision on treatment on behalf of a patient who can't because of illness, incompetence	**$58.35 per unit**
4) **K005**	1° mental healthcare (needs to be more focussed on behaviour or neuropsychiatric symptoms)	**$58.35 per unit**

Second Visit Neurocognitive Assessment

If a Folstein MMSE plus other cognitive tests are done, A007 can be billed. However, it is recommended that you consider the neurocognitive assessment code K032*** (minimum 20 minutes: tests of memory, attention, language, visuospatial and executive function). The MoCA (Montreal Cognitive Assessment www.mocatest.org) plus animal naming, trails A & B (useful for driving) is suggested. If another problem is assessed at the same visit, another code can be billed (eg A007).

Third Visit Diagnostic Disclosure/Family Conference		
K013**	Counselling (education, discussion re diagnosis, prognosis, treatment, driving, safety etc.) (3 units/year afterwards bill K033*** 34.05/unit	**$58.35 per unit**

Follow up Visit

If a patient is started on a cholinesterase inhibitor/memantine, the follow up visit at 3 months to determine benefit can also utilize the K032 (no limit), A007 codes as appropriate.

K035*** report on driving to Ministry of Transport	**$36.25**
K070*** CCAC application	**$31.75**
K071 acute CCAC supervision (advice to CCAC staff) max 1/week x 8 wks follow up CCAC admission	**$21.40**
K072 chronic CCAC supervision (maximum 2/month starting week 9 post admission to CCAC)	**$21.40**
K038 LTC application form	**$45.15**

* Unit = ½ hour or major part thereof (minimum 20 minutes)
** Must be pre-booked
*** Outside of the "basket" for FHT/FHO/FHN = full amount paid even for rostered patients

Mild Cognitive Impairment

Dr. Andrew R. Frank. B.Sc.H. F.R.C.P.(C)
Cognitive and Behavioural Neurologist, Memory Disorder Clinic, Elizabeth Bruyère Hospital, Ottawa, Ontario

Key Points:

- The diagnosis of MCI carries an increased risk of future worsening of symptoms, often towards dementia due to Alzheimer's disease.
- Cholinesterase inhibitor treatment of MCI can be considered on a case-by-case basis.

The past decade has seen a clear move toward clinical characterization of patients with mild cognitive concerns who appear to fall in the "grey zone" between cognitive normality and dementia.

While dementia represents cognitive deterioration causing loss of daytime functional independence, the diagnosis of "Mild Cognitive Impairment" (MCI) can be made earlier, in the presence of cognitive deterioration (confirmed by objective cognitive testing) without any clear loss of daytime functional independence[1,2].

Case Example: A 67 year-old man living with his wife has had a one-year history of increasing forgetfulness for details from recent conversations. On one occasion 2-3 months ago, the patient was clearly told to pick up his wife at the store, but he never did, denying vehemently he was ever asked to do so. The patient is fully independent for all daytime functioning such as taking medications and going shopping, and he drives safely. His past history is notable for hypertension, for which he is treated with ramipril. Family history is negative for any neurologic disease. Physical examination is normal, as are bloodwork and a CT scan of the head. Mini-Mental State Examination (MMSE) is 29 out of 30, but neuropsychological testing revealed delayed memory scores below the 8th percentile for age and gender. As the patient has cognitive concerns which are verified by formalized cognitive testing, but daytime functioning is intact, a diagnosis of Mild Cognitive Impairment (MCI) is made.

A diagnosis of MCI indicates a "warning state", carrying an increased risk of further cognitive deterioration towards dementia (i.e. MCI patients have a ~10-15% per year conversion to dementia, while a normal population has ~1-2% per year conversion to dementia[1,3]). MCI patients and their loved ones can be informed of this increased risk, and increased clinical follow-up can be arranged. Furthermore, patients with MCI represent an ideal target population for testing of novel "disease-modifying" therapeutics designed to slow the neurodegenerative processes of conditions such as Alzheimer's disease.

Indeed, the most common form of MCI is one in which short-term memory is primarily affected (i.e. amnestic MCI), which has an increased risk of progressing to dementia due to Alzheimer's disease (i.e. the abnormal accumulation of amyloid and tau in the brain). However, MCI involving other cognitive domains such as language, visuospatial, attention, or executive functioning (i.e. non-amnestic MCI), may progress to dementias due to other conditions, such as vascular disease, Lewy body disease, or Frontotemporal lobar degeneration[4,5].

The diagnosis of MCI involves a careful clinical history regarding the nature and severity of cognitive symptoms, focusing on the presence or absence of clear-cut daytime functional impairment. Investigations such as routine bloodwork (including thyroid function and vitamin B12 levels), as well as a CT or MRI scan of the brain, are routinely indicated.

Neuropsychological testing is very helpful in detecting the objective cognitive deterioration required to make a diagnosis of MCI. However, office testing involving tests such as the Montreal Cognitive Assessment (MoCA) can also provide evidence of cognitive impairment[6] (Note: The MoCA is freely available at www.mocatest.org). Referral to a cognitive specialty clinic can provide assistance in obtaining in-depth cognitive testing.

cont'd on page 4

Mild Cognitive Impairment (cont'd from page 3)

No pharmaceutical agent has been approved for the treatment of MCI, as clinical trials involving the cholinesterase inhibitors donepezil, rivastigmine, and galantamine have been negative[7,8,9]. However, in one trial, use of donepezil did delay conversion of MCI to Alzheimer's dementia by 6-12 months[7], though there was no sustained delay in conversion by the end of the trial at 3 years. Therefore, treatment of MCI with donepezil or other cholinesterase inhibitors is not routinely recommended unless patients are highly motivated to begin treatment, or there appears to be imminent conversion to the dementia stage, at which treatment with cholinesterase inhibitor therapy is indicated. Management of vascular risk factors is very likely of benefit in the prevention of decline in patients with MCI, as is the maintenance of mental, physical, and social activities in daily life[10].

Mild Cognitive Impairment (MCI) represents a clinical diagnostic framework in which patients with mild cognitive symptoms can be characterized. The diagnosis of MCI carries the warning of increased risk of future worsening of symptoms, and represents an ideal target population in which future disease-modifying therapies may be most beneficial.

References:

1. Petersen RC, Smith GE, Waring SC, et al. Mild cognitive impairment: clinical characterization and outcome. Arch Neurol 1999;56:303–8.
2. Winblad B, Palmer K, Kivipelto M, et al. Mild cognitive impairment—beyond controversies, towards a consensus: report of the International Working Group on Mild Cognitive Impairment. J Intern Med 2004;256:240–6.
3. Bennett DA, Wilson RS, Schneider JA, et al. Natural history of mild cognitive impairment in older persons. Neurology 2002;59:198–205.
4. Rasquin SM, Lodder J, Visser PJ, et al. Predictive accuracy of MCI subtypes for Alzheimer's disease and vascular dementia in subjects with mild cognitive impairment: a 2-year follow-up study. Dement Geriatr Cogn Disorder 2005; 19:113–9.
5. Meyer J, Xu G, Thornby J, et al. Longitudinal analysis of abnormal domains comprising mild cognitive impairment (MCI) during aging. J Neurol Sci 2002;201: 19–25.
6. Nasreddine ZS, Phillips NA, Bedirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. J Am Geriatr Soc 2005;53:695–9.
7. Petersen RC, Thomas RG, Grundman M, et al. Vitamin E and donepezil for the treatment of mild cognitive impairment. N Engl J Med 2005;352:2379–88.
8. Ferris S, Feldman H, Sfikas N, et al. Time to clinical diagnosis of dementia in MCI subjects receiving rivastigmine: a randomized, doubleblind, placebo-controlled study. International Psychogeriatrics 2005;17 (Suppl 2):S242–3.
9. Mayor S. Regulatory authorities review use of galantamine in mild cognitive impairment. BMJ 2005;330:276.
10. Gauthier S, Reisberg B, Zaudig M, et al. Mild Cognitive Impairment. Lancet 2006;367(9518):1262-70.

About the Ontario Dementia Network

The Ontario Dementia Network (ODN) is a coalition of regional dementia networks representing the 14 Local Health Integration Network areas around the province. Its mandate is to provide leadership to regional dementia networks in Ontario in the development of a comprehensive and well developed system of service delivery, education and public policy in the field of dementia.

The Co-Chairs of ODN are Dr. Bill Dalziel of the Regional Geriatric Program of Eastern Ontario and Ms. Kathy Wright, Alzheimer Society of Ottawa and Renfrew County Executive Director. One of the first provincial projects of the ODN is to publish a provincial dementia newsletter for physicians. An Editorial Committee consisting of several physicians across the province has been formed to look at topics of interest and expert contributors.

We welcome feedback regarding any aspect of this newsletter. Please send comments to the Alzheimer Society of Ottawa and Renfrew County at info@asorc.org or call 613-523-4004.

For previous articles published on dementia for physicians, go to:
www.champlaindementianetwork.org/en-resources.asp#PHYSICIANS