

## ♣ Measure #133: Screening for Cognitive Impairment

### DESCRIPTION:

Percentage of patients aged 65 years and older who have documentation of results of a screening for cognitive impairment using a standardized tool

### INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

### **This measure is reported using G-codes:**

CPT service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

### NUMERATOR:

Patient's screening for cognitive impairment is documented

#### **Definitions:**

**Screening** – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.

**Standardized tool** – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of cognitive impairment screening tools include: Clinical Dementia Rating Scale, Mini Mental Status Examination (MMSE), Global Deterioration Scale, Short Portable Mental Status Questionnaire, Clock Drawing Test, Modified MMSE, Mini-Cog, Hopkins Verbal Learning Test, and 7-Minute Screen.

**Cognitive impairment** – Impairment of mental activities associated with thinking, learning, and memory.

**Not eligible/not appropriate** – A patient is not eligible/not appropriate if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Patient was referred with a diagnosis of cognitive impairment
- Patient has been participating in on-going treatment with screening of cognitive impairment in a preceding reporting period
- Patient is not appropriate for cognitive impairment screening due to physical capacity

**Numerator Coding:**

**Screening for Cognitive Impairment Documented**

**G8434:** Documentation of cognitive impairment screening using a standardized tool

OR

**Screening for Cognitive Impairment not Documented, Patient not Eligible/not Appropriate**

**G8436:** Patient not eligible/not appropriate for cognitive impairment screening

OR

**Screening for Cognitive Impairment not Documented, Reason not Specified**

**G8435:** No documentation of cognitive impairment screening using a standardized tool

**DENOMINATOR:**

Patients aged 65 years and older

**Denominator Coding:**

A CPT service code is required to identify patients for denominator inclusion.

**CPT service codes:** 90801, 90802, 96150, 97003

**RATIONALE:**

As many as 6.8 million people in the U.S. have dementia, and at least 1.8 million of those are severely affected. The U.S. Preventive Services Task Force (USPSTF) reported that Alzheimer's Disease and cerebrovascular ischemia (vascular dementia) are the two most common causes of dementia, with estimated economic costs of Alzheimer's Disease (AD) in the U.S. totaling at least \$100 billion annually. The National Institute of Neurological Disorders and Stroke contends that accurate diagnosis of dementia is important for patients and their families because it allows early treatment of symptoms.

**CLINICAL RECOMMENDATION STATEMENTS:**

The American Psychiatric Association (APA) states that the core of the treatment of demented patients is psychiatric management, through psychiatric, neurological, and general medical evaluations of the nature and cause of cognitive deficits, while the American Academy of Neurology (AAN) states there is good evidence to support the use of general cognitive screening instruments.

**Evidence Supporting the Criterion of Quality Measure:**

**Overall Evidence Grading:** SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved early detection and initiation of treatment for dementia that may delay further progression; reduced iatrogenic illness, unnecessary workups driven by vague symptoms, and inappropriate and costly utilization of hospital and emergency room care; and improved outcomes, but not consistently high quality evidence

American Academy of Neurology (AAN)

A guideline revised in 2004 includes the identification and monitoring of Mild Cognitive Impairment (MCI) patients for progression to Alzheimer's disease. It also states there is good evidence to support the use of general cognitive screening instruments.

In a second guideline developed in 2001, it states that general cognitive screening instruments, which include the Mini Mental Status Exam (MMSE), Kokmen Short Test of Mental Status, the 7-Minute Screen, or the Memory Impairment Screen, are useful for the detection of dementia when used in patient populations with an elevated prevalence of cognitive impairment either due to age or presence of memory dysfunction.

A third guideline developed in 2001 on the early detection of dementia included a review of the evidence on mild cognitive impairment. It reported that studies indicated that individuals characterized as being cognitively impaired, but not meeting clinical criteria for Alzheimer's disease (mild cognitive impairment), have a high risk of progressing to dementia or Alzheimer's disease. It further reported that, if the figures for incident Alzheimer's disease from the general population are used, one could see that the rates range from 0.2% in the 65-69 year age group to 3.9% in the 85-89 year age group. Finally, it reported that studies of mild cognitive impairment indicate that the rate of progression to dementia or Alzheimer's disease is between 6% and 25% per year.

Study quality level 2 (limited-quality patient-oriented evidence)

#### Geriatric Nursing Academic Institution

This 2003 guideline, developed by a group of nursing experts from across the country as a part of the Nurses Improving Care for Health System Elders (NICHE) Project, supports the use of standardized instruments for cognitive testing.

Study quality level 2 (limited-quality patient-oriented evidence)

Chow, T. W. (2001). "Quality indicators for dementia in vulnerable community dwelling and hospitalized elders." Annals of Internal Medicine 135: 668-676.

A review of 30 quality indicators for dementia resulted in 14 being judged to be valid by the expert panel process. These included five dealing with dementia screening and diagnosis. The cognitive and functional screening indicator states that, if a vulnerable elder is admitted to the hospital or is new to a physician practice, the multidimensional assessment of cognitive ability and assessment of functional status should be documented because screening for dementia can lead to early detection and initiation of treatment that may delay further progression.

Study quality level 2 (limited-quality patient-oriented evidence)

National Chronic Care Consortium (2003). Tools for the early identification, assessment and treatment for people with Alzheimer's disease and dementia. Bloomington, National Chronic Care Networks for Alzheimer's Disease initiative.

Dementia is very prevalent among the elderly, but is often overlooked even by skilled clinicians. Unrecognized dementia may lead to iatrogenic illness, unnecessary workups driven by vague symptoms, inappropriate and costly utilization of hospital and emergency room care, and poor outcomes. Improving our ability to recognize dementia is a key first step toward improving this widespread situation. The Chronic Care Networks for Alzheimer's disease early identification process uses two tools to identify people who may have dementia and should receive a full assessment. These tools include education and awareness materials/triggers and a family questionnaire.

Study quality level 2 (limited-quality patient-oriented evidence)

Kawas, C. H. (2006). "Alzheimer's and dementia in the oldest-old: A century of challenges."  
Current Alzheimer Research 3(5): 411-419.

Alzheimer's disease (AD) is the most common type of dementia in the U.S. and much of the world with rates increasing exponentially from age 65. Increases in life expectancy in the last century have resulted in a large number of people living to old age and will result in a quadrupling of AD cases by the middle of the century. Preventing or delaying the onset of AD could have a huge impact in the number of cases expected to develop. The oldest-old are the fastest growing segment of the population and are estimated to account for 12% of the population over 65.

Study quality level 2 (limited-quality patient-oriented evidence)