In Brief
for Health Care Professionals

alzheimer's association®

800.272.3900 | alz.org®

Care Planning for Individuals with Cognitive Impairment

In this *In Brief*, we discuss the importance of a timely and disclosed diagnosis of Alzheimer's and other dementias, and how the cognitive assessment and care planning services code, CPT® code 99483, can be helpful in providing thorough care for your patients with cognitive impairment.

Importance of diagnosing Alzheimer's and other dementias

Currently, only 33 percent of seniors age 65 and older with Alzheimer's disease are aware of their diagnosis.[1] Studies have found that one of the reasons physicians do not diagnose Alzheimer's — or disclose a diagnosis — is a lack of time and resources to provide care planning.[2,3] However, a disclosed diagnosis is necessary to implement care planning, a crucial element in improving outcomes for the individual.

Early diagnosis and care planning offer many benefits for the patient and their family, including:

- Newly diagnosed individuals and their caregivers can learn about medical and non-medical treatments, clinical trials and support services available in the community that can help them maintain a high quality of life.
- Fewer hospitalizations and emergency room visits, and improved medication management.
- Better management of other conditions that can be complicated by Alzheimer's.

CPT 99483 cognitive assessment and care plan services

Effective January 1, 2018, CPT 99483, which replaces HCPS Level II G0505, is used to report cognitive assessment and care planning services for individuals who are cognitively impaired. (Reference: American Medical Association. 2018 Current Procedural Terminology.) Physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives can report services under code 99483.

Cognitively impaired individuals eligible to receive services under the code include those who have been diagnosed with Alzheimer's, other dementias or cognitive impairment. It also includes individuals without a clinical diagnosis who, in the judgment of the clinician, are cognitively impaired.

Code 99483 includes specific identification of a caregiver as well as an assessment of his or her knowledge, needs and ability to provide care. An independent historian is now required under code 99483, which allows caregivers to be included throughout each of the required service elements, including the creation of a detailed care plan for the person with cognitive impairment.

Service elements of CPT 99483

All elements under CPT 99483 must be provided face to face in a physician's office, outpatient setting, home, domiciliary or rest home. Service elements include:

- Cognition-focused evaluation, including a pertinent history and examination of the patient.
- Medical decision-making of moderate or high complexity (defined by the E/M guidelines).
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity.

- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDT]).
- Medication reconciliation and review for high-risk medications.
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s).
- Evaluation of safety (eg, home), including motor vehicle operation.
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of the caregiver to take on caregiving tasks.
- Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference. Development, updating or revision, or review of an Advance Care Plan.
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Reporting CPT 99483 and reimbursement

Experts have noted that care planning for individuals with dementia is an ongoing process and that a formal update to a care plan should occur at least once per year. Per CPT 99483, a single physician or other qualified health care professional should not report code 99483 more than once every 180 days. However, clinicians should review their local payer policies with respect to this code for any billing limitations.

Some service elements under 99483 overlap with services under E/M codes, advance care planning services and certain psychological or psychiatric service codes. As a result, code 99483 cannot be used along with the following codes: 90785, 90791, 90792, 96103, 96120, 96127, 96160-96161, 99201-99215, 99241-99245, 99324-99337, 99341-99350, 99366-99368, 99497, 99498, 99605-99607, G0506, G0181 and G0182.

Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location. Given those caveats, Medicare's national payment allowance for this service is $241.85. Payer policy should be consulted.

Tools to help you deliver cognitive impairment care planning

The Alzheimer's Association®, with the help of an expert task force, has compiled a comprehensive online toolkit with best practices and resources to help conduct a care planning visit under code 99483. The toolkit includes easy access to validated measures, such as the Mini-Cog™ and Dementia Severity Rating Scale, and newly designed assessment tools, including:

- **Safety Assessment Guide and Checklist:** Identify safety-related concerns and outline steps to keep the dementia patient safe.
- **Caregiver Profile Checklist:** Assess a caregiver's ability and willingness to provide care.
- **End-of-Life Checklist:** Screen to identify care preferences and legal needs.

To learn more about code 99483 and access the Cognitive Assessment Care Planning Toolkit, visit alz.org/careplanning.

References

1 Disclosure rates are based on calculations incorporating data from the 2008, 2009 and 2010 Medicare Current Beneficiary Surveys and Medicare claims data. Calculations and related analyses were performed under contract by Avalere Health, LLC.

2 Phillips J, Pond CD, Paterson NE, Howell C, Shell A, Stocks NP, et al. Difficulties in disclosing the diagnosis of dementia: A qualitative study in general practice. Br J Gen Pract 2012;62(601):e546–53.

3 Koch T, Iliffe S, project E-E. Rapid appraisal of barriers to the diagnosis and management of patients with dementia in primary care: A systematic review. BMC Fam Pract 2010;11:52

4 American Medical Association. 2018 Current Procedural Terminology Manual.