Dementia: An under-coded problem

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Abstract

Dementia imposes a significant challenge for healthcare systems, and can be under-coded in hospital patients. A review of coding in an Australian setting identified deficiencies which could impact on funding for dementia care, and for research. Further work is needed to clarify the impact of coding on decisions about funding for dementia care and research.

Keywords:

Dementia, Coding, Funding

Introduction

Dementia places a huge burden on health systems, and is an increasing problem for resource allocation. Australia has 250,000 cases of dementia, with a predicted threefold increase over the next 40 years [1]. Activity based hospital funding for the care of a disease group is based on ICD coded data about cost and workload. Fillit [2] noted that limitations of ICD-9-CM and failure to document created classification and coding issues for dementia; Australian Coding Standards may also lead to under-coding.

Method

The Wicking Dementia Research and Education Centre ran a pilot study in 2009 to improve collection and linkage of data about people with dementia. A study database supported service provision, and collected de-identified research data, and consent for future research. The hospital routinely coded admissions using ICD10-AM, and assigned a Diagnosis Related Group (AR-DRG 4.2).

Results

We studied dementia coding for 48 admissions (40 patients) by comparing ICD and DRG data for current and previous admissions with admission diagnosis, principal/primary diagnosis, additional diagnoses and inpatient assessments from the study database.

Only one of the 48 admissions listed dementia as the patient's principal diagnosis. Another eight had dementia as a documented diagnosis, or as a Diagnosis Related Group (DRG), giving a prevalence of 21%. The remaining 38 admissions had no mention of dementia among the recorded diagnoses, but included two patients with previously diagnosed dementia, and seven with assessments indicating a degree of cognitive impairment. These data suggest an overall prevalence of dementia of 25%, and possibly higher, and one in six patients with dementia who were not recognised as such at admission.

Conclusion

These results indicate that ICD coding may not reliably identify dementia in hospital patients, and hence activity based funding will not recognise additional costs for those patients. Australian Coding Standards limit use of ICD-10-AM dementia codes, particularly as a co-morbidity. Dementia can only be coded as a diagnosis if it is the reason for the admission, or actively affects the level of care required. This issue may be compounded by reluctance of clinical staff to "label" a patient as having dementia, since there can be some finality associated with the diagnosis.

This study identifies under-coding of dementia in a hospital setting, as a result of coding standards and coder decisions. Funders, clinicians and researchers may underestimate the extent of dementia in non-acute units. More work is warranted to fully map the impact of coding on episodes involving dementia.

References

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