To: __________________________________________________________

Date: ______________________

(enter HCP name here)

Facility staff have identified that your resident may be experiencing symptoms of PD psychosis. The information below may be helpful in establishing a diagnosis.

**RESIDENT IDENTIFICATION**

Resident Name: ___________________________________________________ 
Room Number: _______________________

**HISTORY**

☐ The resident has been previously diagnosed with Parkinson’s Disease

Screened by: ________________________________________________ 
☐ G20 ICD code on chart

**POTENTIAL MOTOR SYMPTOMS**

☐ Bradykinesia

☐ Gait impairment

☐ Rigidity

☐ Rest tremor

**PROPOSED NINDS-NIMH DIAGNOSTIC CRITERIA FOR PARKINSON’S DISEASE PSYCHOSIS**

• Presence of at least 1 of the following symptoms:
  – Illusions – Hallucinations
  – False sense of presence – Delusions

• The above symptoms must be recurrent or continuous for at least 1 month and have occurred after the onset of PD

• PD psychosis may occur with or without:
  – Insight – Dementia – PD treatment

• Other potential medical and psychological causes of psychosis (eg, dementia with Lewy bodies, schizophrenia, schizoaffective disorder, delusional disorder, mood disorder with psychotic features, delirium) must be excluded before a diagnosis of PD psychosis is made

**SYMPTOMS OF PD PSYCHOSIS**

Problematic behaviors should be evaluated carefully to determine if they are in response to one or more of the following symptoms:

(check all that apply)

**Minor Phenomena**:

☐ Presence hallucinations: Feeling that someone is present when nobody is actually there

☐ Passage hallucinations: Sensation of a person or animal passing in the periphery

☐ Visual illusions: Misperception of a real stimulus

**Hallucinations**: Abnormal sensory perceptions when no real stimulus is present

☐ Olfactory: Smelling nonexistent odors/scents

☐ Tactile: Feeling something touching or moving on the skin

☐ Visual: Seeing people, animals, or objects that others don't see

☐ Auditory: Hearing sounds, such as music or people conversing

☐ Gustatory: Tasting chemicals or strong flavors in food

☐ Somatic: Feeling as if a part of the body is changing or distorting

**Delusions**: Strong false beliefs despite evidence that the belief is not true

☐ Persecutory: Belief that someone is trying to harm, steal from, or deceive them

☐ Jealousy: Belief that a spouse is being unfaithful

☐ Reference: Belief that an ordinary event has special or personal meaning (television program is speaking about them personally)

When/how often do these episodes happen per week? ____________________________________________________________

Descriptions of symptoms/impact on resident: ____________________________________________________________
DIAGNOSTIC CODES RECOGNIZED FOR PD PSYCHOSIS
Coding combinations that are recognized for PD psychosis include G20 (PD) plus one of the following ICD codes:

* F06.0 Psychotic disorder with hallucinations due to known physiological condition
* F06.2 Psychotic disorder with delusions due to known physiologic condition

WHEN INITIATING ANTIPSYCHOTIC THERAPY FOR A RESIDENT WITH PD PSYCHOSIS, CONSIDER THE FOLLOWING GUIDANCE FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES:

F757 and F758 address unnecessary drugs and psychotropic drugs

* To be considered necessary, an antipsychotic should:
  - Be clinically indicated to manage the symptoms of PD psychosis
  - Be appropriate for the resident’s clinical conditions, age, and underlying causes of symptoms
  - Be selected based on assessment of relative benefit and risks to, and preferences and goals of, the individual resident

F605 addresses chemical restraints

* To avoid being considered a chemical restraint, an antipsychotic for PD psychosis should:
  - Be the standard of practice for PD psychosis
  - Be the least restrictive alternative to treat the resident’s hallucinations and delusions associated with PD psychosis
  - Help the resident to function at the highest possible level

Coding must be to the highest level of specificity, and all coding decisions are ultimately the responsibility of each prescribing healthcare professional