SECTION I: ACTIVE DIAGNOSES

Intent: The items included in this section are intended to indicate the presence of select diagnoses that influence a patient's functional outcomes or increase a patient's risk for the development or worsening of pressure ulcer(s).

I0050. Indicate the patient's primary medical condition category

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Enter Code ☐

Indicate the patient's primary medical condition category.
1. **Acute onset respiratory condition** (e.g., aspiration and specified bacterial pneumonias)
2. **Chronic respiratory condition** (e.g., chronic obstructive pulmonary disease)
3. **Acute onset and chronic respiratory conditions**
4. **Chronic cardiac condition** (e.g., heart failure)
5. **Other medical condition** If "other medical condition", enter the ICD code in the boxes.

I0050A. ☐☐☐☐☐☐☐☐

Item Rationale

- Disease processes can have a significant adverse effect on an individual's health status and quality of life. Some disease processes and conditions can influence a patient's functional outcomes.

  This section identifies active diagnoses (diseases or conditions) that are associated with a patient's LTCH stay.

Steps for Assessment

1. **Identify diagnoses:** The diseases and conditions in this section require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.

   Medical record sources for physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) diagnoses include, but are not limited to, transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and official diagnostic reports, diagnosis/problem list(s), and other resources as available.

   DEFINITION

   ACTIVE DIAGNOSIS
   Diagnosis (condition or disease) that has a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.

   - Although open communication regarding diagnostic information between the physician and other clinical staff is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) to ensure follow-up and coordination of care.

- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the medical record by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) to ensure validity, follow-up, and coordination of care.

DEFINITION

NURSE MONITORING

Nurse monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).

- Only diagnoses confirmed and documented by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) should be considered when coding this section.

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, determine whether the diagnosis is *active.*

   - Active diagnoses are diagnoses that have a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment. Do not include diseases or conditions that have been resolved or do not affect the patient's current functional, cognitive, or mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
   - Medical record sources to identify *active* diagnoses at the time of assessment include, but are not limited to, transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and official diagnostic reports, diagnosis/problem list(s), and other resources as available.
   - Only diagnoses confirmed by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) that are active should be coded on the LTCH CARE Data Set.
   - If information regarding active diagnoses is learned after the Assessment Reference Date, the LTCH CARE Data Set should not be revised to reflect this new information. The LTCH CARE Data Set should reflect what was known and documented at the time of the assessment. However, if, it is discovered that a **documented** active diagnosis was not indicated on the LTCH CARE Data Set, the LTCH should modify the LTCH CARE Data Set in accordance with the instructions in ***Chapter 4***, under *Correcting Errors in LTCH CARE Data Set Assessment Records That Have Been Accepted into the QIES ASAP System.*

3. Identify a primary medical condition associated with the LTCH admission, and report the primary medical condition category. The categories are

   - Acute onset respiratory condition (e.g., aspiration and specified bacterial pneumonias)
   - Chronic respiratory condition (e.g., chronic obstructive pulmonary disease)
   - Acute onset and chronic respiratory condition
   - Chronic cardiac condition (e.g., heart failure)

- Other medical condition. If “other medical condition” is selected, enter the ICD code in the boxes.

Active Diagnoses

Comorbidities and Co-existing Conditions

Comorbidities and Co-existing Conditions	
↓ Check all that apply	
Cancers	
☐	**I0101. Severe and Metastatic Cancers**
Heart/Circulation	
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
Genitourinary	
☐	**I1501. Chronic Kidney Disease, Stage 5**
☐	**I1502. Acute Renal Failure**
Infections	
☐	**I2101. Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock**
☐	**I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis**
Metabolic	
☐	**I2900. Diabetes Mellitus (DM)**
Musculoskeletal	
☐	**I4100. Major Lower Limb Amputation** (e.g., above knee, below knee)
Neurological	
☐	**I4501. Stroke**
☐	**I4801. Dementia**
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5101. Complete Tetraplegia**
☐	**I5102. Incomplete Tetraplegia**
☐	**I5110. Other Spinal Cord Disorder/Injury** (e.g., myelitis, cauda equina syndrome)
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5450. Amyotrophic Lateral Sclerosis**
☐	**I5460. Locked-In State**
☐	**I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain**
Nutritional	
☐	**I5601. Malnutrition** (protein or calorie)
☐	**I5602. At Risk for Malnutrition**
None of the Above	
☐	**I7900. None of the above**

Coding Instructions

Complete only if A0250 = 01 Admission.

Code diseases or conditions that have a physician documented diagnosis and are active (i.e., have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death).

Check all that apply.

Cancers

- Check I0101, Severe and Metastatic Cancers, if the patient has an active diagnosis of severe or metastatic cancer(s). Examples include: metastatic cancer and acute leukemia, lung cancer, multiple myeloma, and lymphoma.

Heart/Circulation

- Check I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), if the patient has an active diagnosis of peripheral vascular disease or peripheral arterial disease.

Genitourinary

- Check I1501, Chronic Kidney Disease, Stage 5, if the patient has an active diagnosis of chronic kidney disease, stage 5.
- Check I1502, Acute Renal Failure, if the patient has an active diagnosis of acute renal failure.

Infections

- Check I2101, Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock, if the patient has an active diagnosis of septicemia, sepsis, or systemic inflammatory response syndrome/shock.
- Check I2600, Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis, if the patient has active diagnoses of central nervous system infections, opportunistic infections, or bone/joint/muscle infections/necrosis. Examples include: bacterial, fungal, and parasitic central nervous system infections; viral and late effects central nervous system infections; and osteomyelitis.

Metabolic

- Check I2900, Diabetes Mellitus (DM), if the patient has an active diagnosis of diabetes mellitus.

Musculoskeletal

- Check I4100, Major Lower Limb Amputation, if the patient has an active diagnosis of major lower limb amputation (e.g., above knee, below knee).

Neurological

- Check I4501, Stroke, if the patient has a diagnosis of stroke. Examples include: cerebral hemorrhage, ischemic or unspecified stroke, late effects of cerebrovascular disease.
- Check I4801, Dementia, if the patient has an active diagnosis of dementia.
- Check I4900, Hemiplegia or Hemiparesis, if the patient has an active diagnosis of hemiplegia or hemiparesis.
- Check I5000, Paraplegia, if the patient has an active diagnosis of paraplegia. Examples include fracture of T1-T6 level with complete lesion of spinal cord, fracture of T7-T12 level with complete lesion of spinal cord.
- Check I5101, Complete Tetraplegia, if the patient has an active diagnosis of complete tetraplegia.
- Check I5102, Incomplete Tetraplegia, if the patient has an active diagnosis of incomplete tetraplegia.
- Check I5110, Other Spinal Cord Disorder/Injury, if the patient has an active diagnosis of other spinal cord disorder/injury. Examples include myelitis and cauda equina syndrome.
- Check I5200, Multiple Sclerosis (MS), if the patient has an active diagnosis of multiple sclerosis.
- Check I5250, Huntington's disease, if the patient has an active diagnosis of Huntington's disease.
- Check I5300, Parkinson's disease, if the patient has an active diagnosis of Parkinson's disease.
- Check I5450, Amyotrophic Lateral Sclerosis, if the patient has an active diagnosis of amyotrophic lateral sclerosis.
- Check I5460, Locked-In State, if the patient has an active diagnosis of locked-in state.
- Check I5470, Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain, if the patient has an active diagnosis of severe anoxic brain damage, cerebral edema, or compression of brain.

Nutritional

- Check I5601, Malnutrition, if the patient has an active diagnosis of malnutrition (protein or calorie).
- Check I5602, At Risk for Malnutrition, if the patient is at risk for malnutrition.

None of the Above

- Check I7900, None of the Above, if the patient does not have any of the active diagnoses listed above.

Coding Tips

The following tips may assist staff in determining whether a disease or condition should be coded as an active diagnosis on the LTCH CARE Data Set.

- There must be specific documentation in the medical record by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) of the disease or condition being an active diagnosis.
- The physician (nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active. Specific documentation areas in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer notes, and the hospital discharge summary.
- The physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws), for example, documents at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen. This would be sufficient documentation of an active diagnosis and would require no additional confirmation because the physician documented the diagnosis and also confirmed that the mediation regimen needed to be modified.
- For the purposes of the LTCH CARE Data Set, LTCHs should consider only the *documented* active diagnoses. A diagnosis should not be inferred by association with other conditions (e.g., “weight loss” should not be inferred to mean “malnutrition”).
- If there is documentation in the medical record that a patient has diabetes mellitus, check the I2900, Diabetes Mellitus. Item I2900, Diabetes Mellitus, also includes patients who have diabetes with complications such as diabetic retinopathy, nephropathy and neuropathy. Provided there is documentation that the patient has diabetes mellitus, item I2900 should be checked regardless of if the patient has diabetes mellitus or if the complication is linked to diabetes. If there is only documentation in the medical record of a complication such as nephropathy or neuropathy and there is no documentation that the patient has diabetes, it should not be assumed the complication is linked to diabetes and the item I2900, Diabetes Mellitus, should not be checked.

Examples of Active Diagnoses

1. Mr. A is prescribed insulin for diabetes mellitus. He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes mellitus.

   Coding: I2900, Diabetes Mellitus, would be checked.

   Rationale: Diabetes Mellitus would be considered an active diagnosis because the physician progress note documents the diabetes mellitus diagnosis, and because there is ongoing medication management and glucose monitoring.

2. Mrs. I underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The nurse practitioner's progress note documents peripheral vascular disease and left below the knee amputation.

   Coding: I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), and I4100, Major Lower Limb Amputation, would be checked.

   Rationale: These would both be considered active diagnoses because the nurse practitioner's note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.

3. Mr. O had an ischemic stroke and is unable to swallow safely. Neurologic checks are ordered every 4 hours. He requires total parenteral nutrition (TPN) through a central venous catheter. The physician's progress note documents stroke and risk of malnutrition.

   Coding: I4501, Stroke, and I5602, At Risk for Malnutrition, would be checked.

   Rationale: These would both be considered active diagnoses because the physician's note documents the stroke and need for neurologic checks and the need to provide TPN.

4. A patient with amyotrophic lateral sclerosis requires a ventilator to breathe. The physician's progress note documents the diagnosis of amyotrophic lateral sclerosis.

   Coding: I5450, Amyotrophic Lateral Sclerosis, would be checked.

   Rationale: This is an active diagnosis because the physician's progress note documents the amyotrophic lateral sclerosis diagnosis resulting in the need for ventilation.

5. Mr. E underwent a total knee replacement six months ago and developed a tibial infection. The total knee prosthesis was removed and a spacer was placed to maintain proper positioning of the limb. The physician progress note documents the diagnosis of bone infection and need for antibiotic therapy.

   Coding: I2600, Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis, would be checked.

   Rationale: This would be considered an active diagnosis of bone infection because the physician progress note documents the bone infection and the need for antibiotic therapy.

6. A patient had surgical removal of a spinal cord tumor at the level of T6 and a diagnosis of complete paraplegia. The physician's progress note documents the diagnosis of malignancy and the need for further treatment with chemotherapy and radiation.

   Coding: I0101, Severe and Metastatic Cancers, and I5000, Paraplegia, would be checked.

   Rationale: These would both be considered active diagnoses because the physician's progress note documents the diagnoses of cancer and paraplegia.