Inpatient Rehabilitation Facilities
Quality Reporting Program Provider Training

Section I:

Active Diagnoses

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Today's Presenter

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INPATIENT REHABILITATION FACILITIES
POST-ACUTE CARE PROGRAM

Section I: Objectives

- Illustrate a working knowledge of Section I: Active Diagnoses.
- Articulate the intent of Section I.
- Interpret the coding options for each item and when they would be applied.
- Apply coding instructions in order to accurately code practice scenarios.

Section I: Changed Items

- Items in Section I are **consolidated.**
  - **I0900,** Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
  - **I2900,** Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy).
  - **I7900,** None of the above.
- Section I is assessed on admission.

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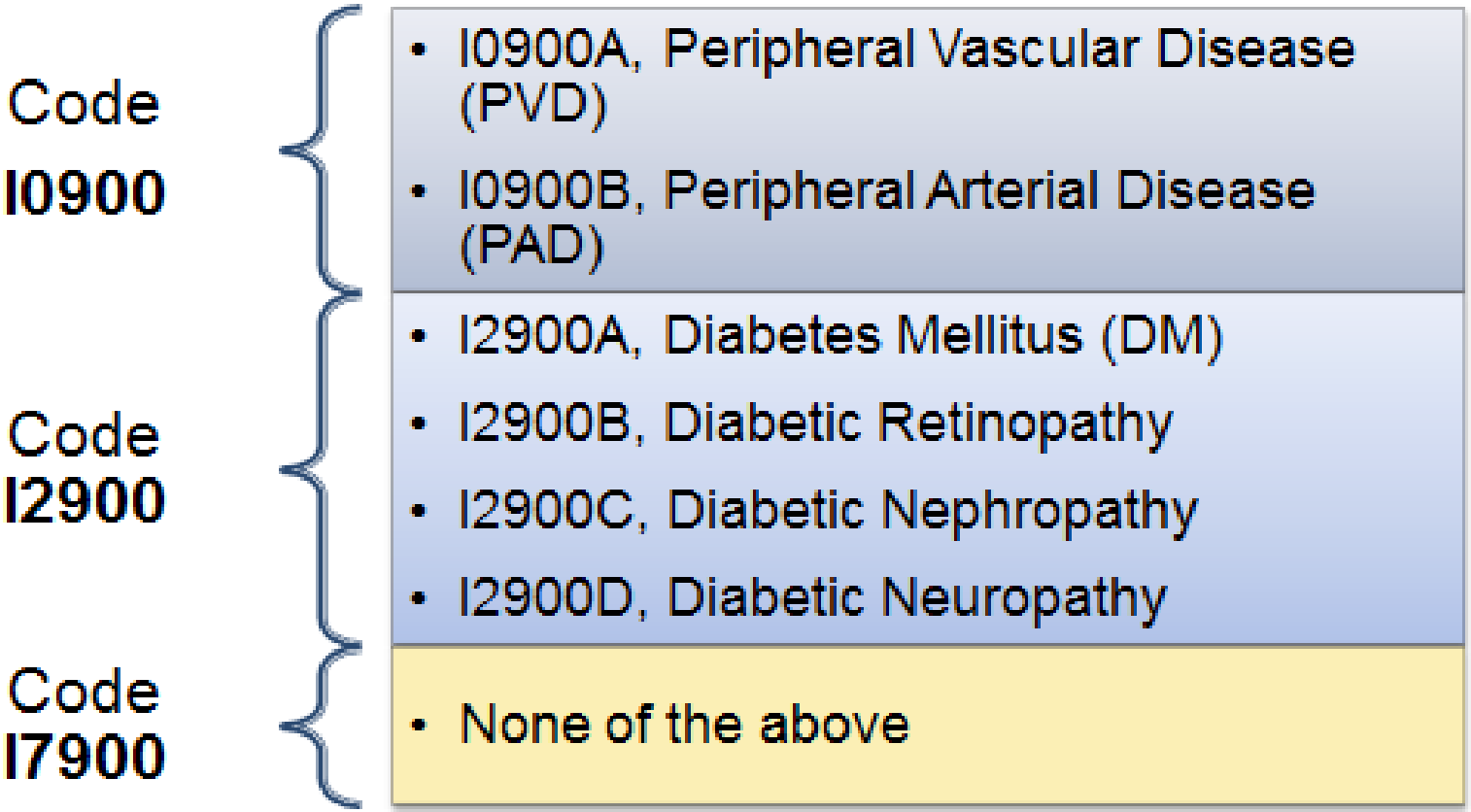
Section I: Overview of Changes

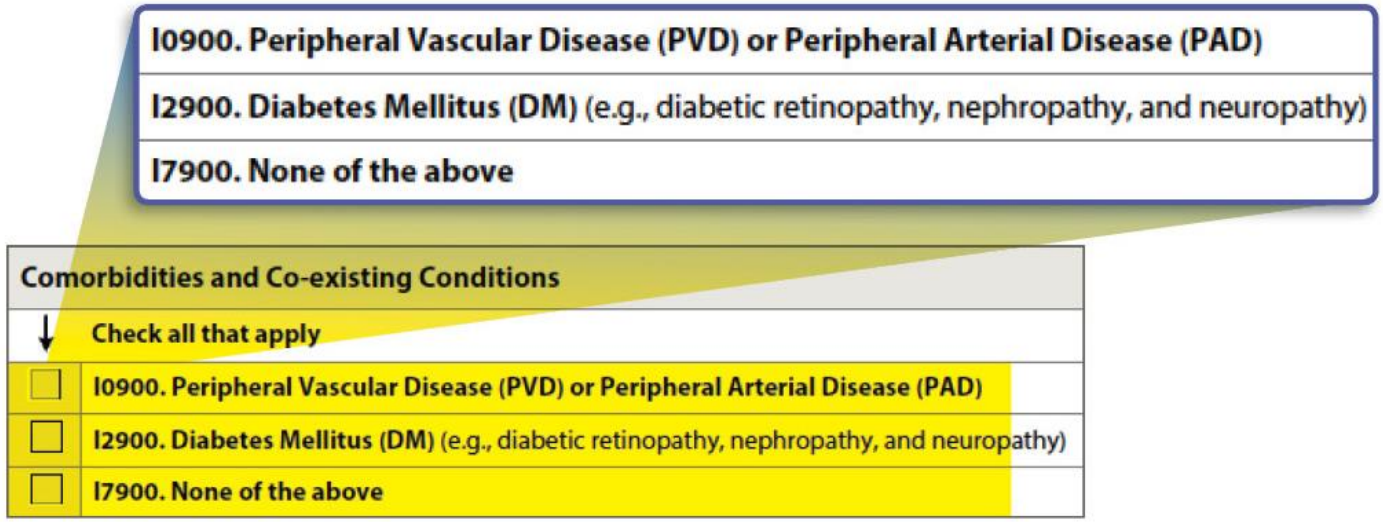


Section I: Intent

Indicate the presence of select diagnoses that influence a patient's risk for the development or worsening of pressure ulcer(s).

Coding Instructions

- Complete only at the time of admission.
- Code diseases or conditions that:
  - Have a documented diagnosis at the time of assessment.
  - Are active.
- Check all that apply.



INPATIENT REHABILITATION FACILITIES
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Identify Diagnoses Assessment

- There must be specific documentation in the medical record by authorized licensed staff as permitted by State law:
  - Physician.
  - Nurse practitioner.
  - Physician assistant.
  - Clinical nurse specialist.
  - Other authorized licensed staff.
- Authorized licensed staff may specifically indicate that a diagnosis is active.

Identify Diagnoses Assessment (cont.)

- Specific documentation areas in the medical record may include:
  - Progress notes.
  - Admission history and physical.
  - Transfer notes.
  - Hospital discharge summary.
- A diagnosis should not be inferred by association with other conditions.

Identify Diagnoses Assessment (cont.)

- IRFs should consider only the **documented active diagnoses.**
- Please note that Item #24, Comorbid Conditions, and Section I, Active Diagnoses, may not always align.

Identify Diagnoses Assessment (cont.)

***Example*:** The physician documents on the Post Admission Physician Evaluation (PAPE) that the patient:

- Has inadequately controlled diabetes.
- Requires adjustment of the medication regimen.

This would be sufficient documentation and would require no additional confirmation because the physician:

- Documented the diagnosis.
- Confirmed that the medication regimen needed to be modified.

Practice Coding Scenario (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 PAPE documents diabetes mellitus.
- Mr. A does not have PVD or PAD.

Practice Coding Scenario (2)

- Mrs. I underwent a below the knee amputation.
- She requires dressing changes to the stump and monitoring for wound healing.
- Peripheral pulse monitoring is ordered.
- The nurse practitioner's progress note documents peripheral vascular disease, left below the knee amputation, and uncontrolled diabetes.
- Blood sugars are being monitored, and insulin dosages are being adjusted.

Section I: Summary

- Section I is not new, just consolidated.
- Section I is only coded on admission.
- Must be specific documentation in the medical record by authorized licensed staff as permitted by State law.

Section I: Action Plan

- Review your current process and identify any opportunities for improvement.
- Evaluate current documentation to ensure terminology aligns with items in the IRF-PAI v1.4.
- Practice coding a variety of scenarios with staff.

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Questions?

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