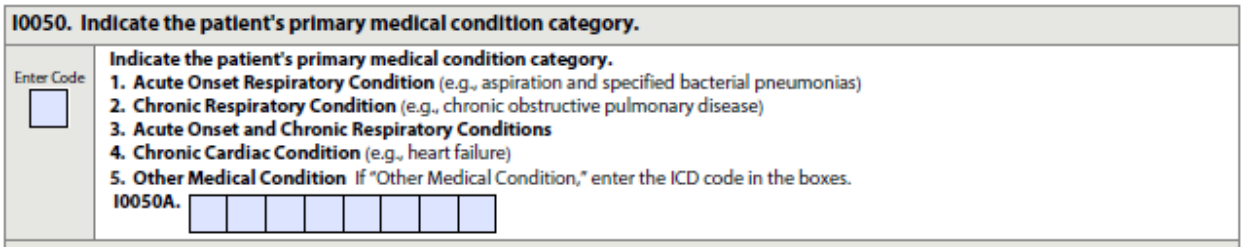
SECTION I: ACTIVE DIAGNOSES

Intent: The items included in this section are intended to indicate the presence of select diagnoses that influence a patient's functional outcomes, ventilator liberation outcomes, or a patient's risk for the development or worsening of pressure ulcers/injuries. This section captures active diagnoses that are associated with a patient's long-term care hospital (LTCH) stay. Active diagnoses include a patient's primary medical condition category and any comorbidities and co-existing conditions.

I0050. Indicate the patient's primary medical condition category



Item Rationale

- This item captures the primary medical condition category that resulted in the patient's admission to the LTCH.

Steps for Assessment

1. Identify a primary medical condition associated with the LTCH admission, and record the following primary medical condition category:
   - 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 International Classification of Diseases (ICD) code in the boxes

Coding Instructions

Complete only if A0250 = 01 Admission.

- Code 1, Acute Onset Respiratory Condition, if the patient's primary medical condition category is due to an acute onset respiratory condition. Examples include aspiration and specified bacterial pneumonias.
- Code 2, Chronic Respiratory Condition, if the patient's primary medical condition category is a chronic respiratory condition. An example is chronic obstructive pulmonary disease.

- Code 3, Acute Onset and Chronic Respiratory Conditions, if the patient's primary medical condition category is an acute onset and chronic respiratory condition.
- Code 4, Chronic Cardiac Condition, if the patient's primary medical condition category is a chronic cardiac condition. An example is heart failure.
- Code 5, Other Medical Condition, if the patient's primary medical condition category is not one of the listed categories. Enter the ICD code in I0500A.

Examples of Primary Medical Condition Category

1. Ms. K is a 67-year-old female who is admitted to the LTCH after an acute episode of respiratory failure secondary to pneumonia. Ms. K is on invasive mechanical ventilation. The admission diagnosis of acute episode of respiratory failure secondary to pneumonia is documented in the progress notes of the patient's medical record by the LTCH admitting physician.

   Coding: I0050, Indicate the patient's primary medical condition category, 1 – Acute Onset Respiratory Condition, would be checked.

   Rationale: The diagnosis of acute respiratory failure secondary to bacterial pneumonia is a primary medical condition category and is an active diagnosis for this patient as it will influence her health outcomes. The physician's progress note documents the diagnosis of acute onset respiratory condition secondary to bacterial pneumonia as the reason for the LTCH admission.

2. Mr. E is admitted to the LTCH for treatment of two non-healing sacral area stage 4 pressure ulcers. The LTCH physician documents Mr. E's primary medical condition as pressure ulcer of sacral region stage 4 in the patient's medical record.

   Coding: I0050, Indicate the patient's primary medical condition category, 5 -Other Medical Condition, would be checked. ICD-10 code L89.154 would be entered in I0050A.

   Rationale: The diagnosis of pressure ulcer of the sacral region stage 4 is the patient's primary medical condition and is an active diagnosis for Mr. E as it has a direct relationship with his medical treatment. Code 5 is checked and the ICD-10 code is entered as this diagnosis is not one of the listed primary medical condition categories.

Active Diagnoses

Comorbidities and Co-existing Conditions

Comorbidities and Co-existing Conditions	
↓ Check all that apply	
Cancers	
☐	**I0103. Metastatic Cancer**
☐	**I0104. Severe Cancer**
Heart/Circulation	
☐	**I0605. Severe Left Systolic/Ventricular Dysfunction** (known ejection fraction ≤ 30%)
☐	**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**
☐	**I5455. Other Progressive Neuromuscular Disease**
☐	**I5460. Locked-In State**
☐	**I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain**
☐	**I5480. Other Severe Neurological Injury, Disease, or Dysfunction**

(continued)

Nutritional	
☐	**I5601. Malnutrition** (protein or calorie)
☐	**I5602. At Risk for Malnutrition**
Post-Transplant	
☐	**I7100. Lung Transplant**
☐	**I7101. Heart Transplant**
☐	**I7102. Liver Transplant**
☐	**I7103. Kidney Transplant**
☐	**I7104. Bone Marrow Transplant**
None of the Above	
☐	**I7900. None of the above**

Item Rationale

- These items capture the patient's comorbidities and co-existing conditions.
- 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 health outcomes.

Steps for Assessment

1. **Identify diagnoses:** Review the medical record to determine the patient's active diagnoses. Medical record sources include, but are not limited to, transfer of health documents, prior hospital discharge summary, physician orders and progress notes, recent history and physical, medication administration records, consults, diagnostic reports, diagnosis/problem list(s), and other resources as available.
2. **Determine whether diagnoses are active:** Once a diagnosis is identified, determine whether the diagnosis is *active.*

DEFINITION

ACTIVE DIAGNOSES
Diagnoses (conditions or diseases) 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.

- 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.
- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must always, when possible, 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.
- Only active 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.

- The LTCH CARE Data Set should reflect the patient's known and documented primary medical condition category and co-existing conditions and comorbidities that were present during the 3-day assessment period. If information regarding active diagnoses is learned after the Assessment Reference Date, which is the end-point of the assessment period for the LTCH CARE Data Set assessment record, the LTCH CARE Data Set should not be revised to reflect this new information. 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.*

DEFINITION

NURSE MONITORING

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

Coding Instructions

Complete only if A0250 = 01 Admission.

Code co-existing conditions or comorbidities 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 I0103, Metastatic Cancer, if the patient has an active diagnosis of metastatic cancer. Examples include prostate cancer with metastasis to pelvis, stage IV bladder cancer with metastasis to the lung, and extensive small cell lung cancer stage IV.
- Check I0104, Severe Cancer, if the patient has an active diagnosis of severe cancer. Examples include hepatocellular cancer, glioblastoma multiforme, liver cell carcinoma, and chronic myeloid leukemia.

Heart/Circulation

- Check I0605, Severe Left Systolic/Ventricular Dysfunction (known ejection fraction ≤ 30%), if the patient has an active diagnosis of severe left systolic/ventricular dysfunction.
- 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, and 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 I5455, Other Progressive Neuromuscular Disease, if the patient has an active diagnosis of other progressive neuromuscular disease. Examples include progressive supranuclear palsy, generalized myasthenia gravis, and spinocerebellar ataxias.
- 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.
- Check I5480, Other Severe Neurological Injury, Disease, or Dysfunction, if the patient has an active diagnosis of other severe neurological injury, disease, or dysfunction that are not listed. Examples include neuroleptic malignant syndrome, and Guillain-Barre Syndrome.

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.

Post-Transplant

- Check I7100, Lung Transplant, if the patient has had a lung transplant.
- Check I7101, Heart Transplant, if the patient has had a heart transplant.
- Check I7102, Liver Transplant, if the patient has had a liver transplant.
- Check I7103, Kidney Transplant, if the patient has had a kidney transplant.
- Check I7104, Bone Marrow Transplant, if the patient has had a bone marrow transplant.

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.

- The patient's active diagnoses must be documented in the medical record applying the primary medical condition category code I0050 and/or comorbidities and co-existing conditions codes I0103–I7104 by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws).
- 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 documents in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer of health information notes, and the acute care 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 confirmed that the medication 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").
- For example, if there is documentation in the medical record that a patient has diabetes mellitus, check I2900, Diabetes Mellitus. This comorbidity/co-existing condition, also includes patients who have diabetes related complications such as diabetic retinopathy, nephropathy, and neuropathy. Provided there is documentation that the patient has diabetes mellitus, I2900 should be checked regardless of if the patient has diabetes mellitus or if the complication is associated with their 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 associated with diabetes, and 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's progress notes document diabetes mellitus.

   Coding: I2900, Diabetes Mellitus, would be checked.

   Rationale: Diabetes Mellitus would be considered an active diagnosis because the physician's 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 incision site and monitoring for wound healing. In addition, assessment of circulation, sensation, and motion 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 6 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: I0104, Severe Cancer 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.

7. Mr. B is admitted to the LTCH with the diagnoses of status post heart transplant for severe cardiomyopathy and end stage heart failure. The hospital discharge record includes an extensive cardiologist report, which documents an echocardiogram result of an ejection fraction of 15%, a diagnosis of severe left systolic dysfunction, and a long history of cardiomyopathy with end stage heart failure. The signed heart transplant surgical report is also included in the hospital transfer notes. Nursing care includes cardiopulmonary monitoring as well as post-transplant assessment.

   Coding: I0050, Indicate the patient's primary medical condition category, would be coded 4, Chronic Cardiac Condition. I0605, Severe Left Systolic/Ventricular Dysfunction (known ejection fraction ≤ 30%), would be checked. I7101, Heart Transplant, would be checked.

   Rationale: The clinician located the signed heart transplant surgical report and the cardiac consult, which included the diagnosis of severe left systolic dysfunction and cardiomyopathy. These are active diagnoses, having a direct relationship to the patient's current functional status, medical treatments, and nurse monitoring.

8. Mr. F is admitted to the LTCH for medication administration, pulmonary assessment and speech-language pathology (SLP) therapy post hospitalization for aspiration pneumonia due to dysphagia. Included in the physician's history and physical assessment is the diagnosis of Shy Drager disease (multiple system atrophy).

   Coding: I0050, Indicate the patient's primary medical condition category, would be coded 1, Acute Onset Respiratory Condition. I5455, Other Progressive Neuromuscular Disease, would be checked.

   Rationale**:** The patient is admitted for care following an acute event (aspiration pneumonia) due to dysphagia. Multiple System Atrophy (MSA) is an active diagnosis, because it is included in the physician's history and physical diagnosis list and has a direct relationship to this patient's current functional and medical status.

9. A patient is admitted to the LTCH after a stroke. The admitting physician has reviewed the record of the hospital course and performed and documented the history and physical indicating the stroke occurred in the postoperative period following a kidney transplant. He also writes the patient is receiving peripheral parenteral nutrition (PPN) as he is at risk for malnutrition. The patient has right-sided hemiparesis and neglect identified in the transfer report from the hospital.

   Coding**:** I4501, Stroke would be checked. I4900, Hemiparesis, would be checked. I5602, At Risk for Malnutrition, would be checked. I7103, Kidney Transplant, would be checked.

Rationale: This patient's functional status, medical treatments, and monitoring requirements are directly related to the diagnoses of stroke with right sided hemiparesis and post kidney transplant. All of these diagnoses are documented by the physician in the patient's medical record documentation.

10. Mrs. P is admitted to the LTCH after a bone marrow transplant. The hospital transfer record includes a signed discharge summary with a list of diagnoses including aplastic anemia and allogenic bone marrow transplant. She is receiving medication and is being monitored for signs and symptoms of transplant rejection and infection.

    Coding: I7104, Bone Marrow Transplant, would be checked.

    Rationale: Mrs. P's current nursing monitoring and medical treatments are directly related to the bone marrow transplant. The hospital transfer record includes a signed discharge summary.

[This page intentionally left blank.]