

# Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training



## *Section I: Active Diagnoses*

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# Section I: Objectives

- Define Section I: Active Diagnoses.
- Explain new items and/or changes between LTCH CARE Data Set v2.01 and v3.00.
- Explain the intent of Section I.
- Discuss coding instructions and needed information for items.
- Accurately code scenario(s).

# Section I: New Items and Changes

## **NEW:**

- I0050
  - Admission Assessment
- I0500A
  - Admission Assessment

## **CHANGES:**

- The list of comorbidities and co-existing conditions has been expanded.

# Section I: Intent and Item Rationale

## **INTENT:**

Indicates the presence of select diagnoses that:

- Influence patient's functional outcomes.
- Increase a patient's risk for the development or worsening of pressure ulcers.

## **ITEM RATIONALE:**

- Disease processes can have significant adverse effect on an individual's health status and quality of life.
- Identifies active diseases or conditions associated with patient's LTCH stay.

# Section I: Definition

**ACTIVE DIAGNOSES:** 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 disease or conditions that have been resolved or do not affect the patient's current status as noted above.

# Section I: I0050. Indicate the Patient's Primary Medical Condition Category

## I0050. Indicate the patient's primary medical condition category.

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.

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*Applies to Admission Assessment only.*

# Section I: I0050. Indicate the Patient's Primary Medical Condition Category

## STEPS FOR ASSESSMENT:

- Identify diagnoses.
- Determine patient's **active** diagnoses. Include only diagnoses confirmed by the physician or other authorized licensed staff.
  - Transfer documents,
  - Physician progress notes,
  - Recent history and physical,
  - Discharge summary,
  - Medication records,
  - Physician orders,
  - Consults and official diagnostic reports,
  - Diagnosis/problem lists,
  - Other resources as available.

# **Section I: I0050. Indicate the Patient's Primary Medical Condition Category (cont.)**

## **STEPS FOR ASSESSMENT (cont.):**

- LTCH CARE Data Set reflects what was known and documented at time of assessment.
- Identify a primary medical condition associated with the LTCH admission and report the primary medical condition category.



# Section I: I0050. Indicate the Patient's Primary Medical Condition Category (cont.)

I0050. Indicate the patient's primary medical condition category.	
Enter Code <input type="checkbox"/>	<p>Indicate the patient's primary medical condition category.</p> <ol style="list-style-type: none"><li>1. Acute onset respiratory condition (e.g., aspiration and specified bacterial pneumonias)</li><li>2. Chronic respiratory condition (e.g., chronic obstructive pulmonary disease)</li><li>3. Acute onset and chronic respiratory conditions</li><li>4. Chronic cardiac condition (e.g., heart failure)</li><li>5. Other medical condition If "other medical condition", enter the ICD code in the boxes.</li></ol> <p>I0050A. <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p>

*Applies to Admission Assessment only.*

## CODING INSTRUCTIONS:

- Identify primary medical condition associated with LTCH admission:
  - Report primary medical condition category.
  - If "other medical condition" is selected, enter ICD code in the boxes.
- Proceed to Comorbidities and Co-existing Conditions.

# Section I: Comorbidities and Co-existing Conditions

Neurological	
<input type="checkbox"/>	I4501. Stroke
<input type="checkbox"/>	I4801. Dementia
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	I5000. Paraplegia
<input type="checkbox"/>	I5101. Complete Tetraplegia
<input type="checkbox"/>	I5102. Incomplete Tetraplegia
<input type="checkbox"/>	I5110. Other Spinal Cord Disorder/Injury (e.g., myelitis, cauda equina syndrome)
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)
<input type="checkbox"/>	I5250. Huntington's Disease
<input type="checkbox"/>	I5300. Parkinson's Disease
<input type="checkbox"/>	I5450. Amyotrophic Lateral Sclerosis
<input type="checkbox"/>	I5460. Locked-In State
<input type="checkbox"/>	I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain

# Section I: Comorbidities and Co-existing Conditions (cont.)

The list of comorbidities and co-existing conditions has been expanded:

- 8 Categories.
- 23 Diagnoses.
- 1 None of the Above.

## **CODING INSTRUCTIONS:**

- Check diseases or conditions that:
  - Have a documented diagnosis at the time of assessment.
  - 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 at the time of assessment).
- Check all that apply.

# Section I: Comorbidities and Co-existing Conditions (cont.)

**Check all that apply:**

**Cancers:**

I0101. Severe and Metastatic Cancers

**Genitourinary:**

I1501. Chronic Kidney Disease, Stage 5

I1502. Acute Renal Failure

**Infections:**

I2101. Septicemia, Sepsis, Inflammatory Response Syndrome/Shock

I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis

**Musculoskeletal:**

I4100. Major Lower Limb Amputation

**Nutritional:**

I5601. Malnutrition – replaced I5600 on v2.01

I5602. At Risk for Malnutrition

**Neurological:**

I4501. Stroke

I4801. Dementia

I4900. Hemiplegia or Hemiparesis

I5000. Paraplegia

I5101. Complete Tetraplegia

I5102. Incomplete Tetraplegia

I5110. Other Spinal Cord Disorder/Injury

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

**Metabolic:**

I2900. Diabetes Mellitus

**Heart/Circulation:**

I0900. PVD or PAD

# Section I: Coding Scenario (1)

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

**How would you code Section I?**

**What is your rationale?**

# Section I: Coding Scenario (1)

**CODING: I5450. Amyotrophic Lateral Sclerosis,** would be checked.

**RATIONALE:** Considered an active diagnosis because the physician progress note documents the amyotrophic lateral sclerosis diagnosis resulting in the need for ventilation.

# Section I: Coding Scenario (2)

Mrs. I underwent a below the knee amputation (BKA) due to gangrene associated with peripheral vascular disease (PVD). 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 PVD and left BKA.

**How would you code Section I?**  
**What is your rationale?**

# Section I: Coding Scenario (2)

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

**RATIONALE:** Both 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.



# Section I: Coding Scenario (3)

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.

**How would you code Section I?**

**What is your rationale?**

# Section I: Coding Scenario (3)

**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.

# Section I: Coding Scenario (4)

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.

**How would you code Section I?**

**What is your rationale?**

# Section I: Coding Scenario (4)

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

**RATIONALE:** Both considered active diagnoses because the physician's progress note documents the diagnoses of cancer and paraplegia.

# Section I: Summary

- Section I captures select diagnoses that could influence patients' functional outcomes or risk for pressure ulcers.
  - Physician or other authorized licensed staff (e.g., nurse practitioner) documents the patient's diagnoses on admission.
  - Determine if diagnosis is active.
- I0050 and I0050A are new to the Admission Assessment.
- Identify primary medical condition associated with the LTCH admission & report the primary medical condition category.
  - For item I0050A, if “other medical condition” is coded, enter the ICD code for other medical condition.
- List of comorbidities and co-existing conditions is expanded.
  - Check all that apply.

# Section I: Action Plan

- Review Section I intent, rationale, and steps for assessment.
- Review the importance and rationale of obtaining and documenting the patient's primary medical condition for admission and documentation of comorbidities and co-existing conditions.
- Reinforce the importance of including the needed information in the medical record to complete Section I.
- Practice coding a variety of scenarios with staff.