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Long-Term Care Hospital
Quality Reporting Program Provider Training

![LTCH Long-Term Care Hospital Quality Reporting Program]

Section I:

Active Diagnoses

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Acronyms in This Presentation

- International Classification of Diseases (ICD)

- Long-Term Care Hospital (LTCH)

- LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set)

Overview

- Define Section I: Active Diagnoses.

- Explain the intent of Section I.

- Describe new items and/or changes between Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v3.00 and v4.00.

- Discuss coding instructions and needed information for items.

- Review practice coding scenarios.

Objectives

- State the intent of Section I.

- Articulate the purpose of the item and coding options for each of the existing, revised, and new items.

- Apply coding instructions to accurately code practice scenarios.

Intent

- Indicate the presence of select diagnoses that influence a patient's:
  - Functional outcomes.
  - Ventilator liberation outcomes.
  - Risk for the development or worsening of pressure ulcers/injuries.

Section I: Active Diagnoses

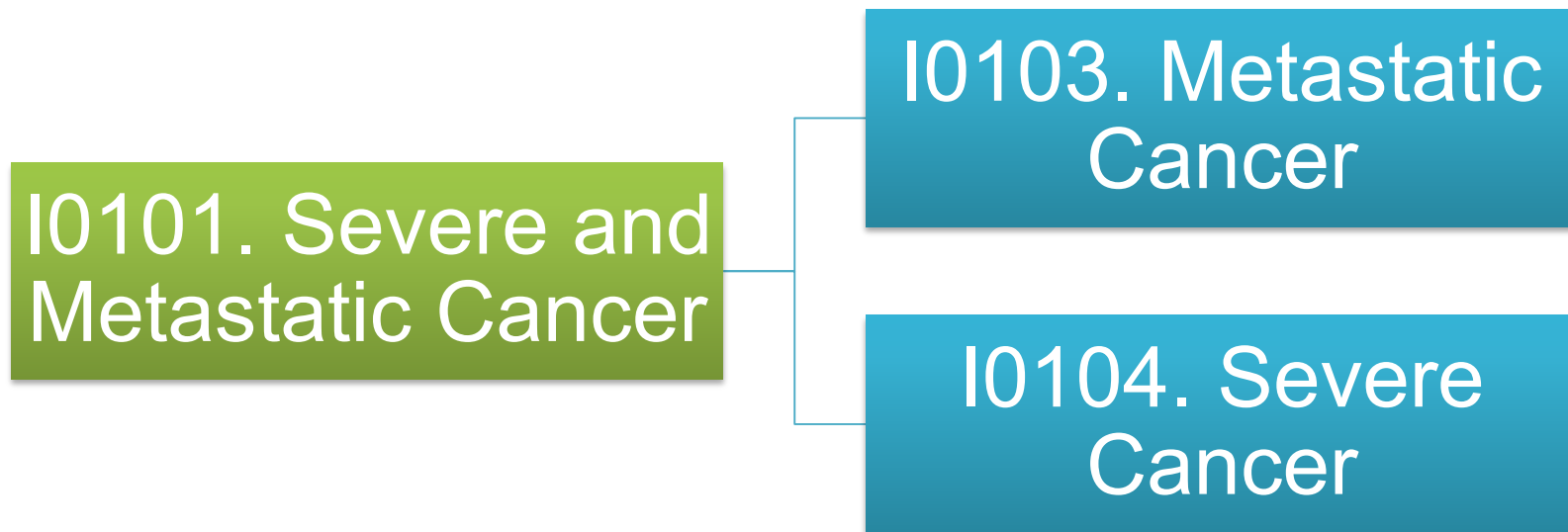## Changes Between LTCH CARE Data Set v3.00 and v4.00

New Items and Changes

New (Admission Assessment only):

- I0103. Metastatic Cancer
- I0104. Severe Cancer
- I0605. Severe Left Systolic/Ventricular Dysfunction
- I5455. Other Progressive Neuromuscular Disease
- I5480. Other Severe Neurological Injury, Disease, or Dysfunction
- I7100. Lung Transplant
- I7101. Heart Transplant
- I7102. Liver Transplant
- I7103. Kidney Transplant
- I7104. Bone Marrow Transplant

New Items and Changes (cont.)

- Changes:
  - Item I0101 replaced by I0103 and I0104.

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I0101. Severe and          ┌──  I0103. Metastatic
Metastatic Cancer  ───────┤          Cancer
                           └──  I0104. Severe
                                      Cancer
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Section I: Active Diagnoses

Coding Guidance and Practice Scenarios

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 diseases or conditions that have been resolved or do not affect the patient's current status as noted above.

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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.

Applies to Admission Assessment only.

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I0050 Item Rationale

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

I0050 Steps for Assessment

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

I0050 Coding Instructions

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. ☐☐☐☐☐☐☐☐

Applies to Admission Assessment only.

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

Practice Coding Scenario 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.

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)

Applies to Admission Assessment only.

Comorbidities and Co-existing Conditions (cont. 1)

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

Applies to Admission Assessment only.

Comorbidities and Co-existing Conditions (cont. 2)

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

Applies to Admission Assessment only.

Comorbidities and Co-existing Conditions (cont. 3)

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

LTCH CARE Data Set v3.00

- 8 categories.
- 23 diagnoses.
- 1 none of the above.

LTCH CARE Data Set v4.00

- 9 categories.
- 32 diagnoses.
- 1 none of the above.

Comorbidities and Co-existing Conditions 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.

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Comorbidities and Co-existing Conditions Steps for Assessment

- **Identify diagnoses:** Review the medical record to determine the patient's active diagnoses.

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

Comorbidities and Co-existing Conditions Coding Instructions

- Check diseases or conditions that:
  - Have a documented diagnosis at the time of assessment.
  - Are active (e.g., 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.

Comorbidities and Co-existing Conditions Coding Instructions (cont.)

Check all that apply:

Cancers:
I0103. Metastatic Cancer
I0104. Severe Cancer

Heart/Circulation:
I0605. Severe Left Systolic/Ventricular Dysfunction
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, Inflammatory Response Syndrome/Shock
I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis

Metabolic:
I2900. Diabetes Mellitus

Musculoskeletal:
I4100. Major Lower Limb Amputation

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
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

Nutritional:
I5601. Malnutrition
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:
17900. None of the above

Practice Coding Scenario 2

- Mr. F is admitted to the LTCH for medication administration, pulmonary assessment, and speech-language pathology 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).

Practice Coding Scenario 3

- 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.

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Practice 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.

Practice Coding Scenario 5

- 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, as he is at risk for malnutrition. The patient has right-sided hemiparesis and neglect identified in the transfer report from the hospital.

Practice Coding Scenario 6

- 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 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.

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Summary

- Section I captures active diagnoses that could influence patients' functional outcomes, ventilator liberation outcome, or risk for pressure ulcers/injuries.

  - A physician or other authorized licensed staff (e.g., nurse practitioner) documents the patient's diagnoses on admission.

  - Determine if the diagnosis is active.

Summary (cont.)

- Identify the primary medical condition associated with the LTCH admission and report the primary medical condition category.
  - For item I0050A, if "other medical condition" is coded, enter the ICD code for other medical condition.

- The list of comorbidities and co-existing conditions has been expanded.
  - Check all that apply.

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 members.