



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

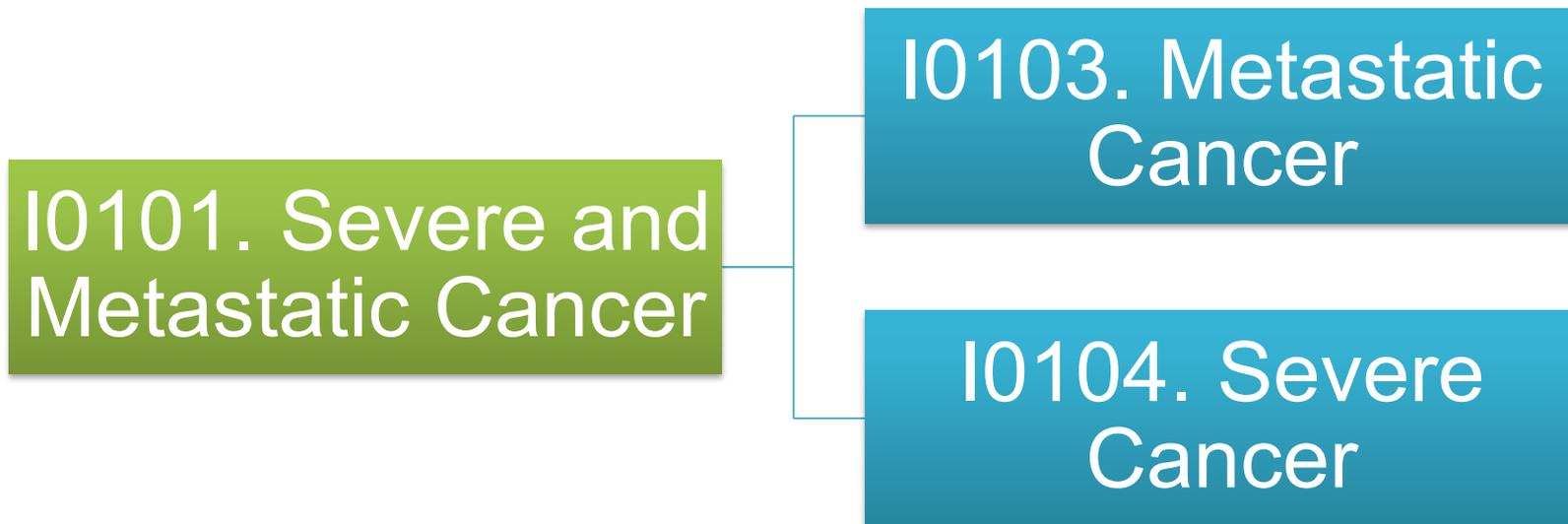
New Items and Changes

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.



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.

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.

10050 Item Rationale

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



10050 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.

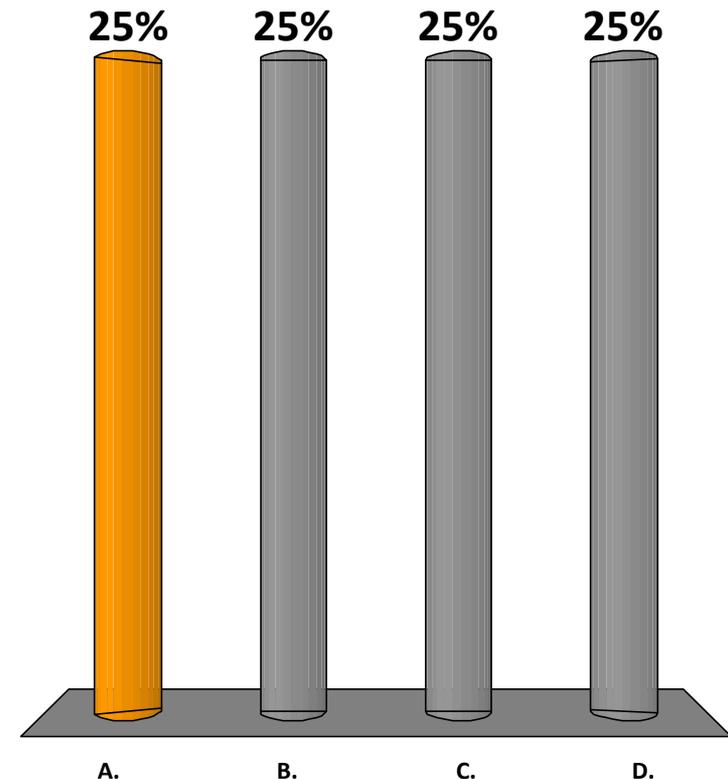
Practice Coding Scenario 1

- 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.

How would you code I0050?

Indicate the patient's primary medical condition category.

- ✓ A. Code 1, Acute Onset Respiratory Condition.
- B. Code 2, Chronic Respiratory Condition.
- C. Code 3, Acute Onset and Chronic Respiratory Conditions.
- D. Code 4, Chronic Cardiac Condition.



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Practice Coding Scenario 1 (cont.)

- **Coding: I0050. Indicate the patient's primary condition category, would be coded as 1, Acute Onset Respiratory Condition.**
- **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.

Comorbidities and Co-existing Conditions

Comorbidities and Co-existing Conditions	
↓ Check all that apply	
Cancers	
<input type="checkbox"/>	I0103. Metastatic Cancer
<input type="checkbox"/>	I0104. Severe Cancer
Heart/Circulation	
<input type="checkbox"/>	I0605. Severe Left Systolic/Ventricular Dysfunction (known ejection fraction \leq 30%)
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
Genitourinary	
<input type="checkbox"/>	I1501. Chronic Kidney Disease, Stage 5
<input type="checkbox"/>	I1502. Acute Renal Failure
Infections	
<input type="checkbox"/>	I2101. Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
<input type="checkbox"/>	I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis
Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM)
Musculoskeletal	
<input type="checkbox"/>	I4100. Major Lower Limb Amputation (e.g., above knee, below knee)

Applies to Admission Assessment only.

Comorbidities and Co-existing Conditions (cont. 1)

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"/>	I5455. Other Progressive Neuromuscular Disease
<input type="checkbox"/>	I5460. Locked-In State
<input type="checkbox"/>	I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain
<input type="checkbox"/>	I5480. Other Severe Neurological Injury, Disease, or Dysfunction

Applies to Admission Assessment only.

Comorbidities and Co-existing Conditions (cont. 2)

Nutritional	
<input type="checkbox"/>	I5601. Malnutrition (protein or calorie)
<input type="checkbox"/>	I5602. At Risk for Malnutrition
Post-Transplant	
<input type="checkbox"/>	I7100. Lung Transplant
<input type="checkbox"/>	I7101. Heart Transplant
<input type="checkbox"/>	I7102. Liver Transplant
<input type="checkbox"/>	I7103. Kidney Transplant
<input type="checkbox"/>	I7104. Bone Marrow Transplant
None of the Above	
<input type="checkbox"/>	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.

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

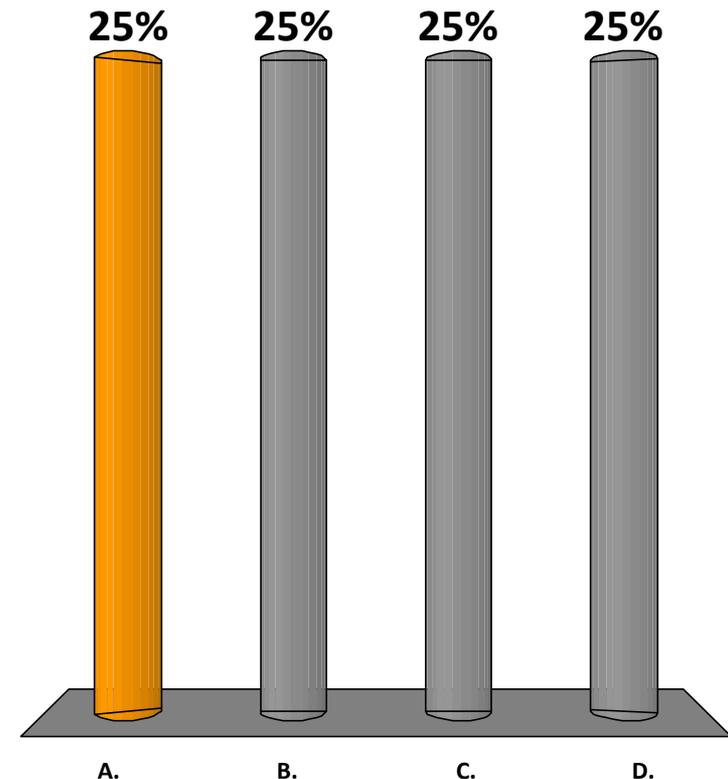
Practice Coding Scenario 2

- 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).

How would you code I0050?

Indicate the patient's primary medical condition category.

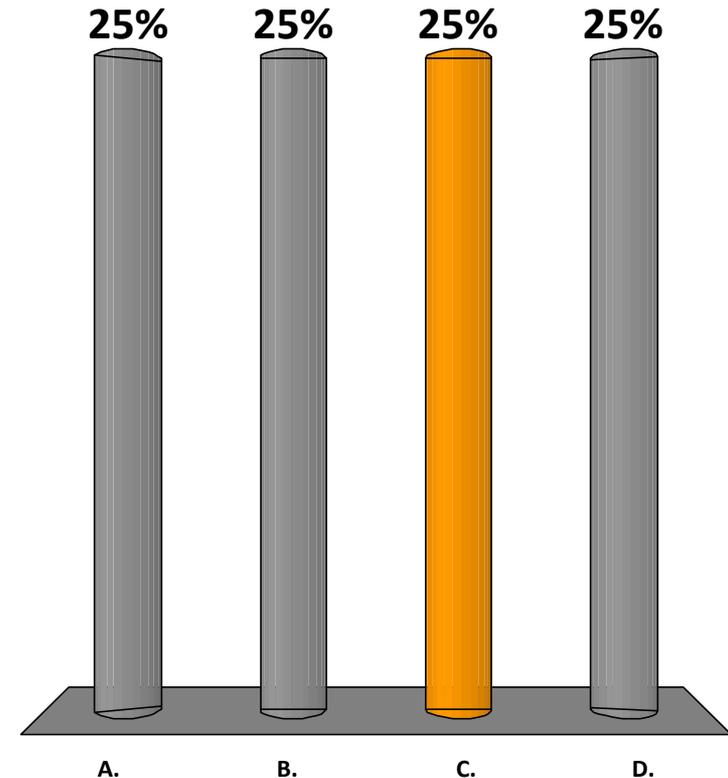
- ✓ A. Code 1, Acute Onset Respiratory Condition.
- B. Code 2, Chronic Respiratory Condition.
- C. Code 3, Acute Onset and Chronic Respiratory Conditions.
- D. Code 4, Chronic Cardiac Condition.



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Which Comorbidity and Co-existing Condition would you check?

- A. Check **I2900**, Diabetes Mellitus (DM).
- B. Check **I4501**, Stroke.
- ✓ C. Check **I5455**, Other Progressive Neuromuscular Disease.
- D. Check **I7900**, None of the above.



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Practice Coding Scenario 2 (cont.)

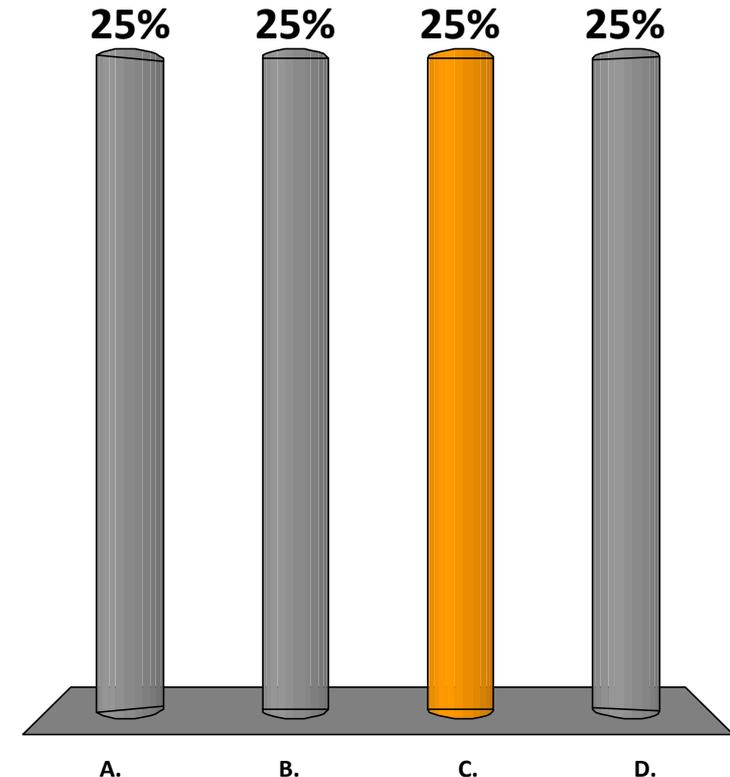
- **Coding:**
 - I0050. Indicate the patient's primary condition category, would be coded as **1, Acute Onset Respiratory Condition**.
 - **I5455, Other Progressive Neuromuscular Disease**, would be checked.
- **Rationale:**
 - The patient is admitted for care following an acute event (aspiration pneumonia) due to dysphagia.
 - Multiple system atrophy 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.

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.

Which Comorbidity and Co-existing Condition would you check?

- A. Check **I0104**, Severe Cancer.
- B. Check **I7102**, Liver Transplant.
- ✓ C. Check **I7104**, Bone Marrow Transplant.
- D. Check **I7900**, None of the above.



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Practice Coding Scenario 3 (cont.)

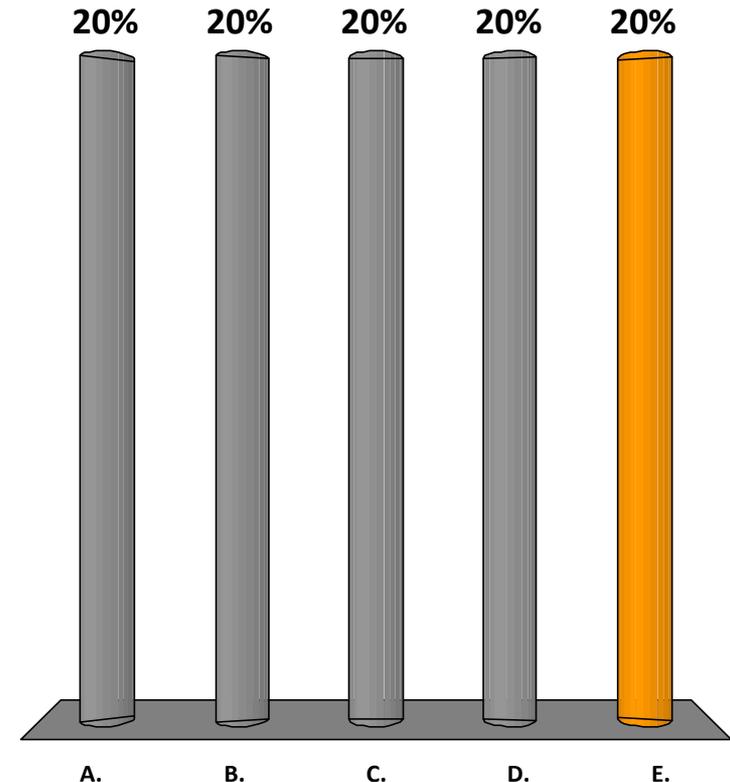
- **Coding: I7104, Bone Marrow Transplant,** would be checked.
- **Rationale:**
 - Mrs. P's current nursing monitoring and medical treatments are directly related to the bone marrow transplant.
 - The hospital transfer record includes a signed discharge summary.

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.

Which Comorbidities and Co-existing Conditions would you check?

- A. Check **I0103**, Metastatic Cancer.
- B. Check **I0104**, Severe Cancer.
- C. Check **I5000**, Paraplegia.
- D. Both A and C.
- ✓ E. Both B and C.



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Practice Coding Scenario 4 (cont.)

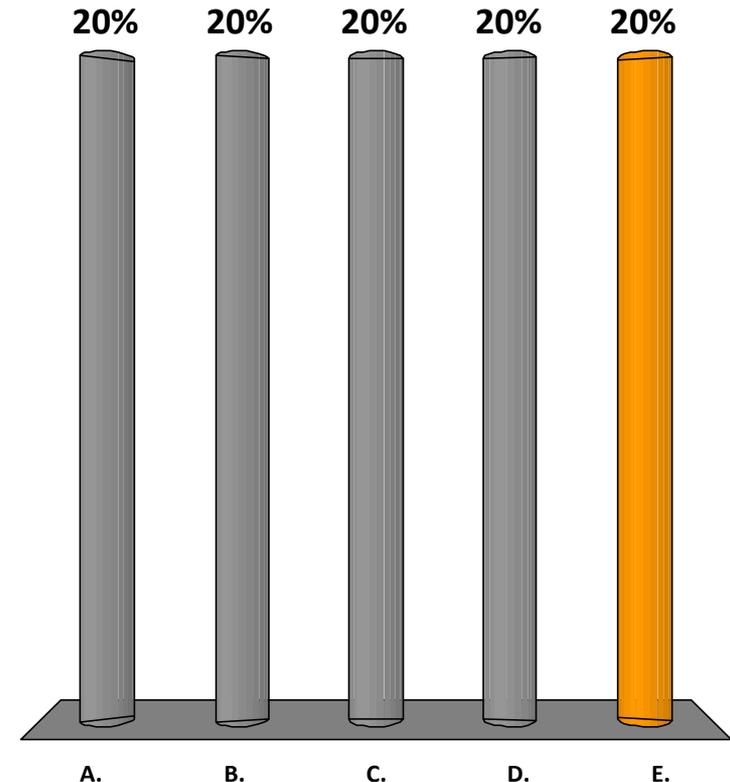
- **Coding: I0104, Severe Cancer and I5000, Paraplegia** would be checked.
- **Rationale:** These would both be considered active diagnoses because the physician's progress note documents the diagnoses of cancer and paraplegia.

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.

Which Comorbidities and Co-existing Conditions would you check?

- A. Check **I4501**, Stroke.
- B. Check **I4900**, Hemiplegia or Hemiparesis.
- C. Check **I5602**, At Risk for Malnutrition.
- D. Check **I7103**, Kidney Transplant.
- ✓ E. All of the above.



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Practice Coding Scenario 5 (cont.)

- **Coding:**
The following comorbidities and co-existing conditions would be checked:
 - **I4501, Stroke.**
 - **I4900, Hemiplegia or Hemiparesis.**
 - **I5602, At Risk for Malnutrition.**
 - **I7103, Kidney Transplant.**
- **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.

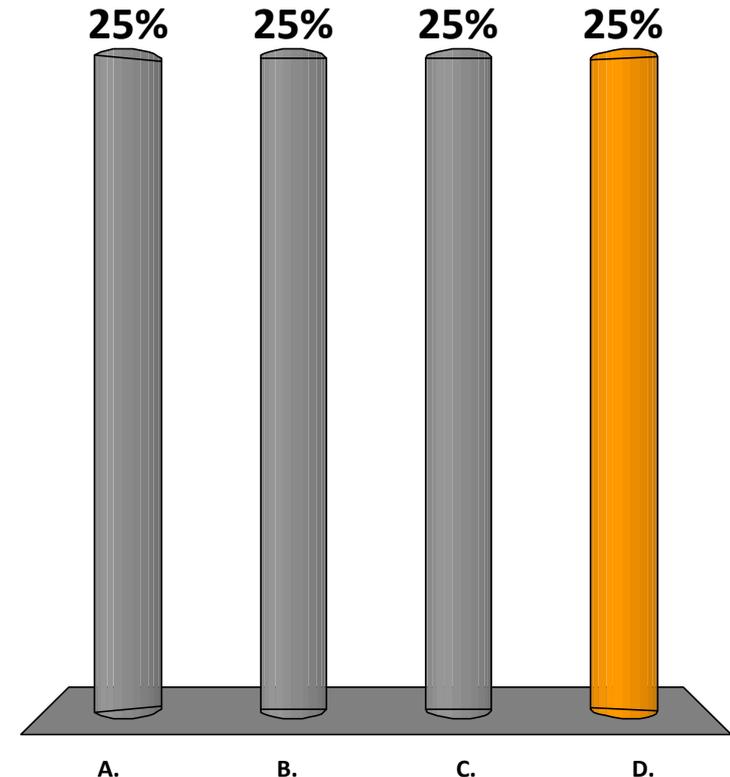
Practice Coding Scenario 6

- 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.

How would you code I0050?

Indicate the patient's primary medical condition category.

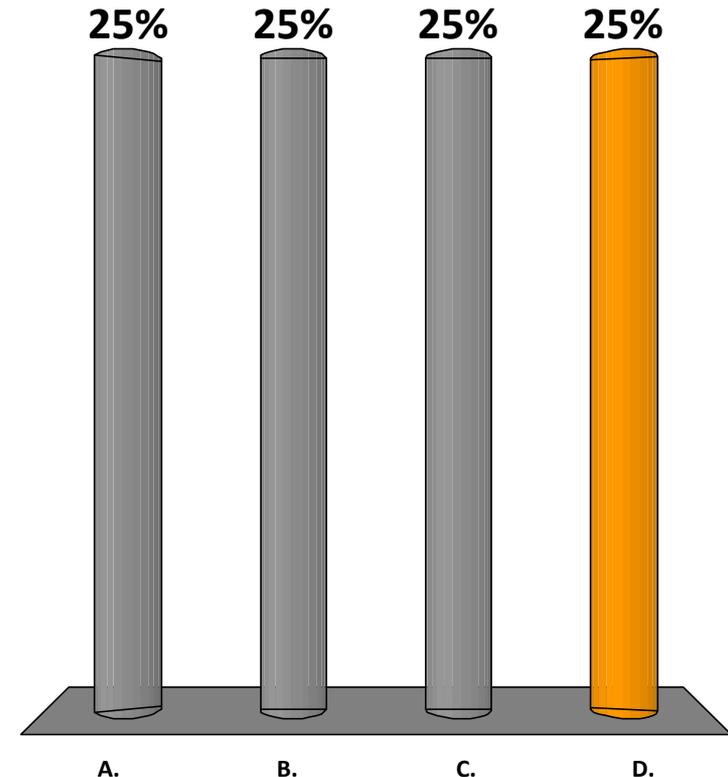
- A. Code 1, Acute Onset Respiratory Condition.
- B. Code 2, Chronic Respiratory Condition.
- C. Code 3, Acute Onset and Chronic Respiratory Conditions.
- ✓ D. Code 4, Chronic Cardiac Condition.



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Which Comorbidities and Co-existing Conditions would you check?

- A. Check **I0605**, Severe Left Systolic/Ventricular Dysfunction (known ejection fraction $\leq 30\%$).
- B. Check **I7101**, Heart Transplant.
- C. Check **I7900**, None of the above.
- ✓ D. Both A and B.



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Practice Coding Scenario 6 (cont.)

- **Coding:**
 - **I0050**. Indicate the patient's primary condition category, would be coded 4, **Chronic Cardiac Condition**.
 - **I0605**, **Severe Left Systolic/Ventricular Dysfunction (known ejection fraction \leq 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.

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.