



**Minimum Data Set (MDS) 3.0  
Instructor Guide**

# Section I

## Active Disease Diagnoses

### Objectives

At the conclusion of this unit, the student will be able to:

- State the intent of Section I Active Diagnoses.
- Describe how to determine an active and inactive diagnosis.
- Explain the purpose of each look-back period used in Section I.
- Code Section I correctly and accurately.



### **Methodology**

This lesson uses lecture and scenario-based practice.

### **Training Resources**

- Instructor Guide
- Slides 1 - 28

### **Instructor Preparation**

- Review the Instructor Guide.
- Review learning objectives for the lesson.
- Rehearse with slide presentation.

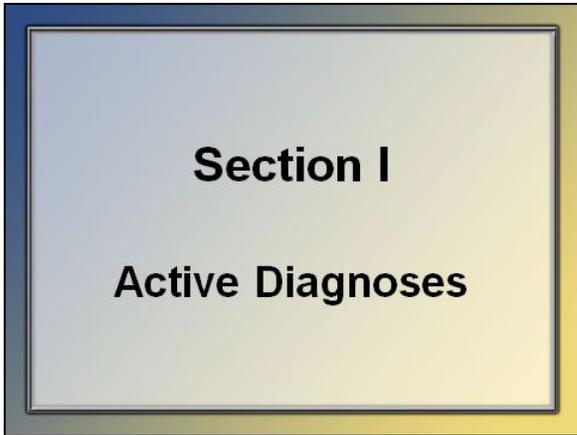


SLIDES	INSTRUCTIONAL GUIDANCE
<b>Instructor Notes</b>	
<b>Instructor Notes</b>	

**Instructor Notes**

Direct participants to turn to Section I in the MDS 3.0 instrument.

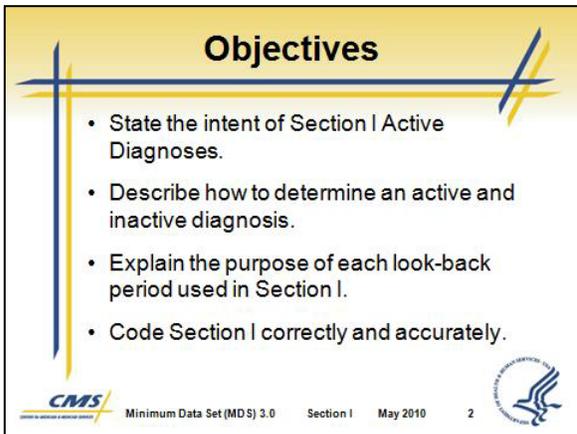
**Instructor Notes**



Slide 1

**I. Introduction/ Objectives**

- A. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident’s health status.



Slide 2

**B. Objectives**

- State the intent of Section I Active Diagnoses.
- Describe how to determine an active and inactive diagnosis.
- Explain the purpose of each look-back period used in Section I.
- Code Section I correctly and accurately.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section I Intent**

- Code diseases that have a relationship to the resident's:
  - o Current functional status
  - o Cognitive status
  - o Mood or behavior status
  - o Medical treatments
  - o Nursing monitoring
  - o Risk of death

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**Section I Importance**

- Disease processes can have a significant adverse affect on an individual's health status and quality of life.
- This section identifies **active** diseases and infections that drive the current plan of care.

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**Section I Conduct the Assessment**

1. Identify diagnoses.
  - o Requires a documented diagnosis.
  - o Use a **60-day** look-back period.
2. Determine diagnosis status.
  - o Determine if diagnosis is active or inactive.
  - o Use a **7-day** look-back period.

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C. Section I Intent

1. This section is intended to code diseases that have a relationship to the resident's:
  - a. Current functional status
  - b. Cognitive status
  - c. Mood or behavior status
  - d. Medical treatments
  - e. Nursing monitoring
  - f. Risk of death

D. Section I Importance

1. Disease processes can have a significant adverse affect on an individual's health status and quality of life.
2. This section identifies **active** diseases and infections that drive the current plan of care.

E. Section I Conduct the Assessment

Assessment consists of a two-step process.

1. Step 1: Identify any diagnoses applicable to the resident.
  - a. A diagnosis must be documented by a physician or other licensed, authorized staff as permitted by state law.
  - b. Identify any diagnoses made in the last **60 days**.
2. Step 2: Determine if the diagnosis(es) are active.

## SLIDES

## INSTRUCTIONAL GUIDANCE

**Identify Diagnoses Assessment<sub>1</sub>**

- Requires documented diagnosis by authorized licensed staff as permitted by state law.
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
- Include **only** diagnoses identified in the last 60 days.

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**Identify Diagnoses Assessment<sub>2</sub>**

- Review medical record sources.
  - Progress notes
  - Most recent history and physical
  - Transfer documents
  - Discharge summaries
  - Diagnosis/ problem list
  - Other resources as available
- If a diagnosis/ problem list is used, enter only diagnoses confirmed by a physician or other authorized, licensed staff as permitted by state law.

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- a. Determine if the diagnosis is active or inactive over the **7-day** look-back period.

## F. Identify Diagnoses Assessment

1. This requires a documented diagnosis from authorized, licensed staff as permitted by state licensure laws.
  - a. Physician
  - b. Physician assistant
  - c. Nurse practitioner
  - d. Clinical nurse specialist
2. Include **only** diagnoses in the last 60 days.
3. Review medical record sources.
  - a. Progress notes
  - b. Most recent history and physical
  - c. Transfer documents
  - d. Discharge summaries
  - e. Diagnosis/ problem list
  - f. Other resources as available
4. If diagnosis/ problem list is used, only diagnoses confirmed by the physician or other authorized, licensed staff as permitted by state law should be entered.

**SLIDES**

**Identify Diagnoses Guidelines**

- Document diagnoses communicated verbally in the medical record to ensure follow-up.
- Document diagnostic information to ensure validity and follow-up.
  - Include past history obtained from family members and close contacts.
- Look-back period to identify a diagnosis is **60 days**.

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**2. Determine Diagnosis Status**

- Once a diagnosis is identified, determine if the diagnosis is **active** or inactive in the **7-day** look-back period.
- Review the medical record.
 

◦ Transfer documents	◦ Nursing assessments
◦ Physician progress notes	◦ Nursing care plans
◦ Recent history and physical	◦ Medication sheets
◦ Recent discharge Summaries	◦ Doctor's orders
	◦ Consults and official diagnostic reports
	◦ Other sources as available

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**INSTRUCTIONAL GUIDANCE**

G. Identify Diagnoses Guidelines

1. Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is essential that diagnoses communicated verbally be documented in the medical record to assure follow-up.
2. In addition, diagnostic data obtained from family members must also be documented in the medical record by the physician or authorized, licensed staff as permitted by state law to assure validity and follow-up.
3. The look-back period for this step is **60 days**.

H. 2. Determine Diagnosis Status

1. Once a diagnosis is identified in Step 1, determine if the diagnosis is active in the **7-day** look-back period.
2. Active diagnoses have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.
3. Check information sources in the medical record to identify active diagnoses.
  - a. Transfer documents
  - b. Physician progress notes
  - c. Recent history and physical
  - d. Recent discharge summaries

## SLIDES

## INSTRUCTIONAL GUIDANCE

**Active Diagnoses Guidelines<sub>1</sub>**

- The look-back period for this step is **7 days**.
- Do not include conditions that have been resolved.
- Do not include conditions that no longer affect the resident's functioning or plan of care.
- Check for specific documentation by physician or other authorized, licensed personnel as permitted by state law.

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- e. Nursing assessments
- f. Nursing care plans
- g. Medication sheets
- h. Doctor's orders
- i. Consults and official diagnostic reports
- j. Other sources as available

- I. Active Diagnoses Guidelines
  1. The look-back period for this step is **7 days**.
  2. Do not include conditions that have been resolved.
  3. Do not include conditions that no longer affect the resident's functioning or plan of care during the 7-day look-back period.
  4. There may be specific documentation of active diagnosis in the medical record by a physician, nurse practitioner, physician assistant, clinical nurse specialist, or other authorized, licensed staff as permitted by state law.
    - a. A physician or other authorized, licensed staff as permitted by state law may specifically indicate that a condition is active.
    - b. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

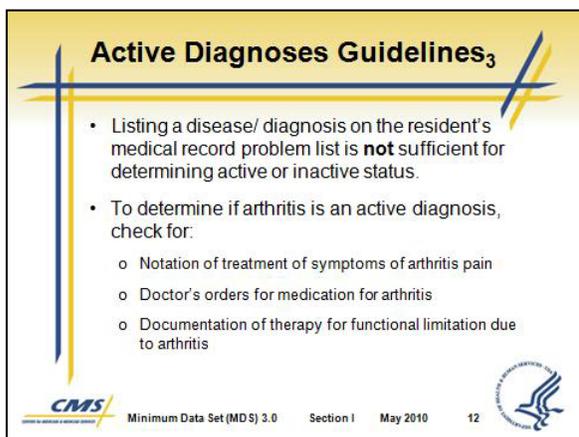


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- c. For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications.
  - d. This would be sufficient documentation of active disease and would require no additional confirmation.
5. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease.
- a. Recent onset or acute exacerbation indicated by a positive test or procedure, hospitalization for acute symptoms and/ or recent change in therapy in the last 7 days
  - b. Examples of a recent onset or acute exacerbation include the following:
    - New diagnosis of pneumonia indicated by chest X-ray
    - Hospitalization for fractured hip
    - Blood transfusion for a hematocrit of 24
  - c. Sources may include radiological reports, hospital discharge summaries, doctor’s orders, etc.
  - d. Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.

SLIDES	INSTRUCTIONAL GUIDANCE
	<ul style="list-style-type: none"><li data-bbox="980 260 1354 499">e. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease.</li><li data-bbox="932 522 1365 663">6. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes.</li><li data-bbox="932 686 1360 785">7. Therefore, a symptom must be specifically attributed to the disease.<ul style="list-style-type: none"><li data-bbox="980 808 1373 1058">a. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician or other authorized, licensed staff as permitted by state law.</li><li data-bbox="980 1081 1354 1255">b. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.</li></ul></li><li data-bbox="932 1278 1305 1528">8. Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor for potential adverse effects.<ul style="list-style-type: none"><li data-bbox="980 1551 1365 1871">a. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.</li></ul></li></ul>

SLIDES	INSTRUCTIONAL GUIDANCE
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- b. This includes medications used to limit disease progression and complications.
  - c. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.
9. Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is **not** sufficient for determining active or inactive status.
- a. For example, to determine if arthritis is an "active" diagnosis, check progress notes (including the history and physical) during the 7-day look-back period.
    - Notation of treatment of symptoms of arthritis
    - Doctor's orders for medications for arthritis
    - Documentation of physical or other therapy for functional limitations caused by arthritis

## SLIDES

**Urinary Tract Infections (UTIs)<sub>1</sub>**

- The look-back period for UTI differs from other items.
  - Look-back period to identify a diagnosis is **60 days**.
  - Look-back period to determine an active diagnosis of a UTI is **30 days**.

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**Urinary Tract Infections (UTIs)<sub>2</sub>**

- Code for a UTI only if all of the following criteria are met:
  - Diagnosis of a UTI in last 30 days
  - Signs and symptoms attributed to UTI
  - Positive test, study, or procedure confirming a UTI
  - Current medication or treatment for UTI

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## INSTRUCTIONAL GUIDANCE

## J. Urinary Tract Infections (UTIs)

1. The look-back period for an active diagnosis of a UTI [I2300 Urinary tract infection (UTI)] differs from other items.
2. The look-back period to identify a diagnosis is still **60 days**.
3. The look-back period to determine an active diagnosis of a UTI is **30 days**.
4. Code for a UTI only if all of the following criteria are met:
  - a. Diagnosis of a UTI by physician or other authorized, licensed staff as permitted by state law in the last 30 days
  - b. Signs and symptoms attributed to UTI which may include but are not limited to fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, or change in character of urine (e.g., pyuria)
  - c. Significant laboratory findings (the attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained)
  - d. Current medication or treatment for UTI in the last 30 days

**SLIDES**

**Section I Coding Instructions**

- Check off each active disease.
  - o Diagnoses listed by major category.
  - o Examples are provided for each category.
  - o Diseases to be coded not limited to examples.
- Check all that apply for the resident.
- If a diagnosis is a V-code, another diagnosis for the primary condition should be checked or entered.

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**INSTRUCTIONAL GUIDANCE**

**K. Section I Coding Instructions**

1. Check each active disease.
  - a. Diagnoses are listed by major disease category.
  - b. Examples of diseases are included for some disease categories.
  - c. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples.
  - d. For example, **I0200, Anemia**, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).
2. Check all that apply for the resident.
3. If a diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked or entered.

**L. I8000 Additional Active Diagnoses**

1. If a disease or condition is **not** specifically listed, check the “Other” box (I8000).
2. Write in name and the ICD code for the diagnosis.
3. Right justify the ICD code (begin with the right-most space).
4. Make sure the decimal is provided in a separate, unique space.

**I8000 Additional Active Diagnoses**

- Check I8000 Additional Active Diagnoses if a disease or condition is not specifically listed.
- Write in the name and ICD code for the diagnosis.

I8000 - Additional Active Diagnoses  
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.								
B.								
C.								

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## SLIDES

## INSTRUCTIONAL GUIDANCE

**Section I Scenario #1**

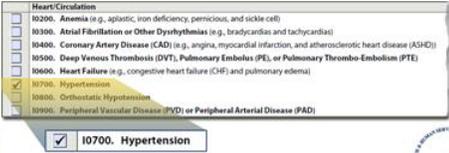
- A resident is prescribed hydrochlorothiazide for hypertension.
- The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen.
- Physician progress note documents hypertension.

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**Section I Scenario #1 Coding**

- Check I0700 Hypertension.
- This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.



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5. Specifications are set so that the computer will automatically adjust the code if the decimal is listed in a unique space.

## M. Section I Scenario #1

1. A resident is prescribed hydrochlorothiazide for hypertension.
2. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen.
3. Physician progress note documents hypertension.

*How should Section I be coded.*

4. Section I Scenario #1 Coding
  - a. Check I0700 Hypertension.

*Point out coding in graphic.*

- b. This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section I Scenario #2**

- Mr. J. fell and fractured his hip 2 years ago.
- At the time of the injury, the fracture was surgically repaired.
- Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices.
- Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker.
- He also needs help with lower body dressing because of difficulties standing and leaning over.

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N. Section I Scenario #2

1. Mr. J fell and fractured his hip 2 years ago.
2. At the time of the injury, the fracture was surgically repaired.
3. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices.
4. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker.
5. He also needs help with lower body dressing because of difficulties standing and leaning over.

*How should Section I be coded?*

6. Section I Scenario #2 Coding
  - a. Do not check I3900 Hip Fracture.

*Point out lack of coding in graphic.*

- b. Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period.
- c. Hip Fracture would be considered inactive.
- d. This information would be captured in the section for ADLs Section G.

**Section I Scenario #2 Coding**

- Do not check I3900 Hip Fracture.
- Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period.
- Hip Fracture would be considered inactive.

Microtraumatization  
 I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))  
 I3800. Osteoporosis  
 I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral head)  
 I4000. Other Fracture

**I3900. Hip Fracture**

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## SLIDES

### Section I Practice #1

- A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis.
- The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

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### How should Section I be coded?

- A. Check I1200 Gastroesophageal Reflux Disease (GERD) or Ulcer.
- B. Check I3700 Arthritis.
- C. Check both I1200 and I3700.
- D. Check neither I1200 and I3700.

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### Section I Practice #1 Coding

- Arthritis would be considered an active diagnosis because of the need for medical therapy.
- Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive; therefore, PUD would not be coded as an active disease.



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## INSTRUCTIONAL GUIDANCE

## O. Section I Practice #1

1. A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis.
2. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

3. How should Section I be coded?  
*Give participants time to answer the question.*
  - a. Correct answer is B. Check I3700 Arthritis.

4. Section I Practice #1 Coding
  - a. Arthritis would be considered an active diagnosis because of the need for medical therapy.
  - b. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and, therefore, PUD would not be coded as an active disease.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**Section I Practice #2**

- The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior.
- The resident is on aspirin and has physical therapy and occupational therapy three times a week.
- The physician's note 25 days ago lists stroke.

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**How should Section I be coded?**

- Check I4500 Cerebrovascular Accident, Transient Ischemic Attack, or Stroke.
- Check I4800 Dementia.
- Check I6500 Cataracts, Glaucoma, or Macular Degeneration.
- Check both I4500 and I6500.
- Check neither I4800 and I6500.
- Check 17900 None of the above diagnoses with the last 7 days.

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**Section I Practice #2 Coding**

- The correct coding is to check I4500 Cerebrovascular Accident, Transient Ischemic Attack, or Stroke.
- Physician note within last 60 days indicates stroke.
- The resident is receiving medication and therapies to manage continued symptoms from stroke.



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P. Section I Practice #2

1. The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior.
2. The resident is on aspirin and has physical therapy and occupational therapy three times a week.
3. The physician's note 25 days ago lists stroke.

4. How should Section I be coded?

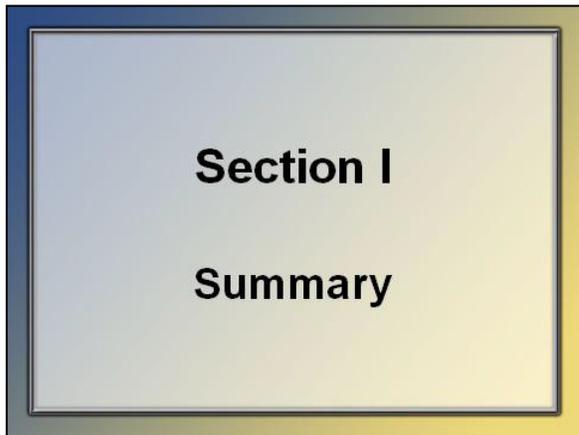
*Give participants time to answer the question.*

- a. Correct answer is A. Check I4500 Cerebrovascular Accident, Transient Ischemic Attack, or Stroke.

5. Section I Practice #2 Coding

- a. The correct coding is to check I4500 Cerebrovascular Accident, Transient Ischemic Attack, or Stroke.
- b. The physician note within the last 60 days indicates stroke.
- c. The resident is receiving medication and therapies to manage continued symptoms from stroke.

## SLIDES

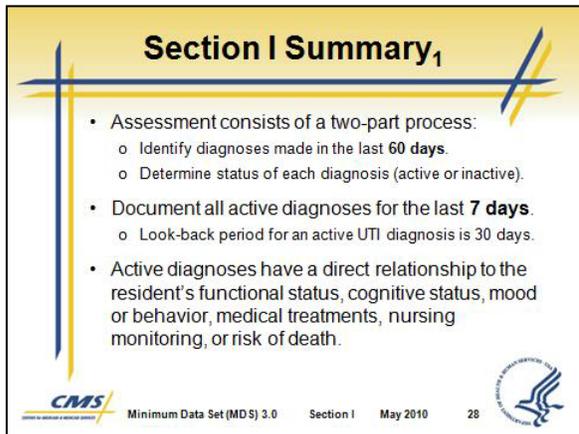


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## INSTRUCTIONAL GUIDANCE

## II. Section I Summary

- A. Look-back periods for diagnosis and active diagnosis
- B. Definition of an active diagnosis



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- C. Assessment consists of a two-part process:
  1. Identify diagnoses made in the last 60 days.
  2. Determine status of each diagnosis (active or inactive).
- D. Document all active diagnoses for the last 7 days.
- E. The exception to this look-back period is UTIs. The look-back period for an active UTI diagnosis is **30 days**.
- F. Active diagnoses have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

