Section I

Active Diagnoses

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.

Section I Intent

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

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.

Section I Conduct the Assessment

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

Identify Diagnoses Assessment$_1$

- 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.

Identify Diagnoses Assessment$_2$

- 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.

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**.

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

Active Diagnoses Guidelines$_1$

- 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.

Active Diagnoses Guidelines$_2$

- Other indicators of an active diagnosis:
  - Recent onset or acute exacerbation indicated by a positive study, test or procedure, hospitalization for acute symptoms and/ or recent change in therapy .
  - Symptoms and abnormal signs indicating ongoing or decompensated disease.
  - Symptoms must be specifically attributable to a disease.
  - Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potential adverse effects.

Active Diagnoses Guidelines$_3$

- Listing a disease/ diagnosis on the resident's medical record problem list is **not** sufficient for determining active or inactive status.
- To determine if arthritis is an active diagnosis, check for:
  - Notation of treatment of symptoms of arthritis pain
  - Doctor's orders for medication for arthritis
  - Documentation of therapy for functional limitation due to arthritis

Urinary Tract Infections (UTIs)[1]

- 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**.

Urinary Tract Infections (UTIs)$_2$

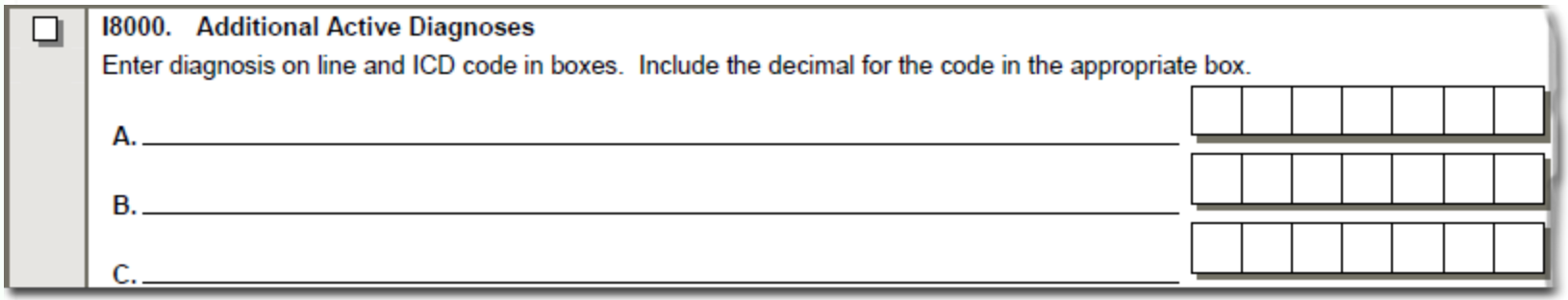
- Code for a UTI only if all of the following criteria are met:
  - Diagnosis of a UTI in last 30 days
  - Signs and symptoms attributed to UTI
  - Positive test, study, or procedure confirming a UTI
  - Current medication or treatment for UTI

Section I Coding Instructions

- Check off each active disease.
  - Diagnoses listed by major category.
  - Examples are provided for each category.
  - 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.

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.



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.

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.

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
☐	**I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
☐	**I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☑	I0700. Hypertension
☐	I0800. Orthostatic Hypotension
☐	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

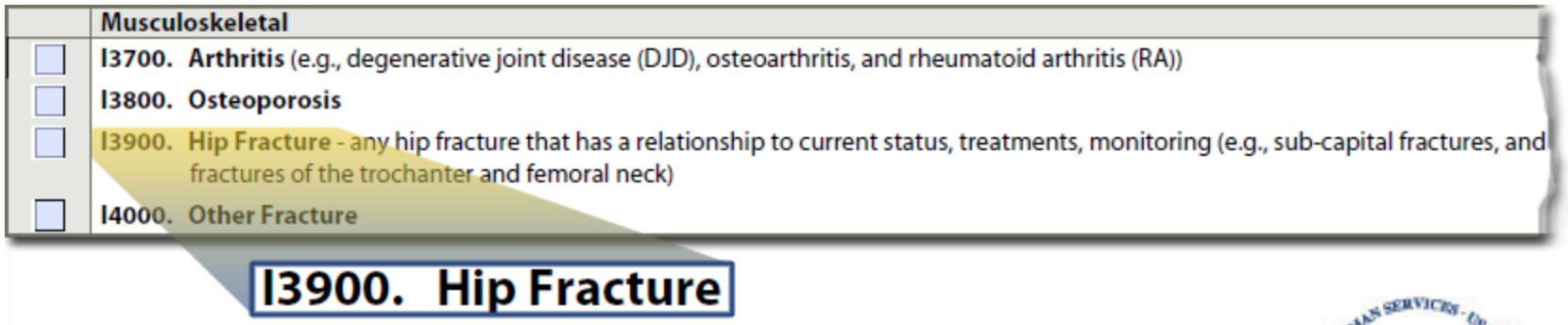
☑	**I0700. Hypertension**

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.

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.



I3900. Hip Fracture

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.

How should Section I be coded?

A. Check I1200 Gastroesophageal Reflux Disease (GERD) or Ulcer.

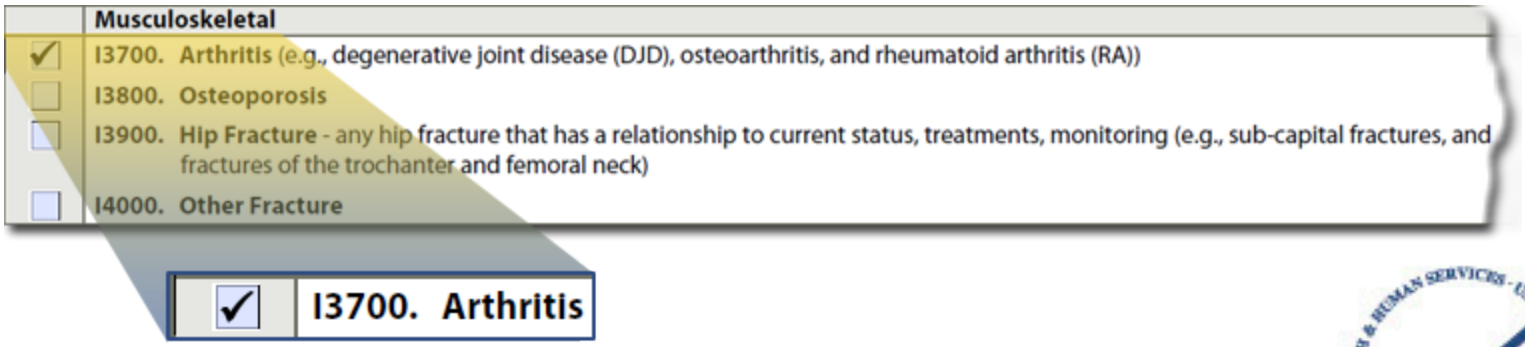
B. Check I3700 Arthritis.

C. Check both I1200 and I3700.

D. Check neither I1200 and I3700.

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.



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.

How should Section I be coded?

A. Check I4500 Cerebrovascular Accident, Transient Ischemic Attack, or Stroke.

B. Check I4800 Dementia.

C. Check I6500 Cataracts, Glaucoma, or Macular Degeneration.

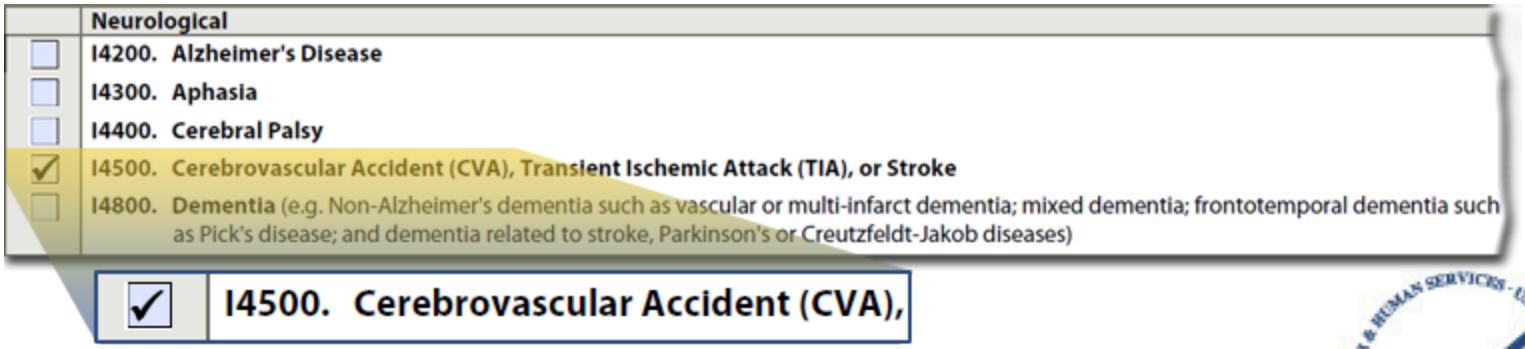
D. Check both I4500 and I6500.

E. Check neither I4800 and I6500.

F. Check 17900 None of the above diagnoses with the last 7 days.

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.



Section I

Summary

Section I Summary$_1$

- Assessment consists of a two-part process:
  - Identify diagnoses made in the last **60 days**.
  - Determine status of each diagnosis (active or inactive).
- Document all active diagnoses for the last **7 days**.
  - Look-back period for an active UTI diagnosis is 30 days.
- 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.