I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

Item Rationale

Health-related Quality of Life

Disease processes can have a significant adverse effect on residents' functional improvement.

Planning for Care

Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.

Steps for Assessment

Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

I0020: Indicate the resident's primary medical condition category (cont.)

Coding Instructions

Complete only if A0310B = 01 or 08

Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.

When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.

Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

Code 01, Stroke, if the resident's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

Code 02, Non-Traumatic Brain Dysfunction, if the resident's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.

Code 03, Traumatic Brain Dysfunction, if the resident's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

Code 04, Non-Traumatic Spinal Cord Dysfunction, if the resident's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

Code 05, Traumatic Spinal Cord Dysfunction, if the resident's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.

Code 06, Progressive Neurological Conditions, if the resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

Code 07, Other Neurological Conditions, if the resident's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.

Code 08, Amputation, if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.

I0020: Indicate the resident's primary medical condition category (cont.)

Code 09, Hip and Knee Replacement, if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.

Code 10, Fractures and Other Multiple Trauma, if the resident's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

Code 11, Other Orthopedic Conditions, if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

Code 12, Debility, Cardiorespiratory Conditions, if the resident's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.

Code 13, Medically Complex Conditions, if the resident's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

Examples of Primary Medical Condition

Resident K is a 67-year-old *individual* with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in *Resident* K's history and physical by the admitting physician.

Coding: I0020 would be coded **01, Stroke.** I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage).

Rationale: The physician's history and physical documents the diagnosis stroke as the reason for *Resident* K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

I0020: Indicate the resident's primary medical condition category (cont.)

Resident E is an 82-year-old *individual* who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents *Resident* E's primary medical condition as total hip replacement (THR) in *their* medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

Coding: I0020 would be coded **10, Fractures and Other Multiple Trauma.** I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).

Rationale: Medical record documentation demonstrates that *Resident* E had a total hip replacement due to a hip fracture and required rehabilitation. Because *they were* admitted for rehabilitation as a result of the hip fracture and total hip replacement, *Resident* E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Resident H is a 78-year-old *individual* with a history of hypertension and a hip replacement 2 years ago. *There were* admitted to an extended hospitalization for idiopathic pancreatitis. *They* had a central line placed during the hospitalization so *they* could receive TPN (total parenteral nutrition). *They* also received regular blood glucose monitoring and treatment with insulin when *they* became hyperglycemic. During *their* SNF stay, *they are* being transitioned from being NPO (nothing by mouth) and receiving *their* nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into *Resident* H's SNF medical record.

Coding: I0020 would be coded **13, Medically Complex Conditions.** I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).

Rationale: *Resident* H had hospital care for pancreatitis immediately prior to *their* SNF stay. *Their* principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of *their* central line does not change *their* care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

I: Active Diagnoses in the Last 7 Days

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ **I0100. Cancer** (with or without metastasis)

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)**

Gastrointestinal

- ☐ **I1100. Cirrhosis**
- ☐ **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ **I1400. Benign Prostatic Hyperplasia (BPH)**
- ☐ **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ **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 neck)
- ☐ **I4000. Other Fracture**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

I: Active Diagnoses in the Last 7 Days (cont.)

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

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. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

I: Active Diagnoses in the Last 7 Days (cont.)

Item Rationale

Health-related Quality of Life

Disease processes can have a significant adverse effect on an individual's health status and quality of life.

Planning for Care

This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

There are two look-back periods for this section:

Diagnosis identification (Step 1) is a 60-day look-back period.

Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period)

Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the **last 60 days.**

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.

Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

DEFINITIONS

ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a

I: Active Diagnoses in the Last 7 Days (cont.)

Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-12 for specific coding instructions for Item I2300 UTI.

Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: 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, and other sources as available.

Coding Instructions

Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-12 for specific coding instructions.)

Document active diagnoses on the MDS as follows:

Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.

Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia,** includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).

Check off each active disease. Check all that apply.

If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.

Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code's decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes end on the left.)

If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

Cancer

I0100, cancer (with or without metastasis)

I: Active Diagnoses in the Last 7 Days (cont.)

Heart/Circulation

I0200, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)

I0300, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)

I0400, coronary artery disease (CAD) (e.g., angina, myocardial infarction, 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], pulmonary edema)

I0700, hypertension

I0800, orthostatic hypotension

I0900, peripheral vascular disease or peripheral arterial disease

Gastrointestinal

I1100, cirrhosis

I1200, gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)

I1300, ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

I1400, benign prostatic hyperplasia (BPH)

I1500, renal insufficiency, renal failure, or end-stage renal disease (ESRD)

I1550, neurogenic bladder

I1650, obstructive uropathy

Infections

I1700, multidrug resistant organism (MDRO)

I2000, pneumonia

I2100, septicemia

I2200, tuberculosis

I2300, urinary tract infection (UTI) (last 30 days)

I2400, viral hepatitis (e.g., hepatitis A, B, C, D, and E)

I2500, wound infection (other than foot)

Metabolic

I2900, diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)

I: Active Diagnoses in the Last 7 Days (cont.)

I3100, hyponatremia

I3200, hyperkalemia

I3300, hyperlipidemia (e.g., hypercholesterolemia)

I3400, thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Musculoskeletal

I3700, arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])

I3800, osteoporosis

I3900, hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)

I4000, other fracture

Neurological

I4200, Alzheimer's disease

I4300, aphasia

I4400, cerebral palsy

I4500, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke

I4800, dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)

I4900, hemiplegia or hemiparesis

I5000, paraplegia

I5100, quadriplegia

I5200, multiple sclerosis (MS)

I5250, Huntington's disease

I5300, Parkinson's disease

I5350, Tourette's syndrome

I5400, seizure disorder or epilepsy

I5500, traumatic brain injury (TBI)

Nutritional

I5600, malnutrition (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

I5700, anxiety disorder

I: Active Diagnoses in the Last 7 Days (cont.)

I5800, depression (other than bipolar)

I5900, bipolar disorder

I5950, psychotic disorder (other than schizophrenia)

I6000, schizophrenia (e.g., schizoaffective and schizophreniform disorders)

I6100, post-traumatic stress disorder (PTSD)

Pulmonary

I6200, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)

I6300, respiratory failure

Vision

I6500, cataracts, glaucoma, or macular degeneration

None of Above

I7900, none of the above active diagnoses within the past 7 days

Other

I8000, additional active diagnoses

Coding Tips

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS.

There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.

The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.

In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:

Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

I: Active Diagnoses in the Last 7 Days (cont.)

Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. 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. This includes medications used to limit disease progression and complications. 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.

It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice. For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.

In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

Item I2300 Urinary tract infection (UTI):

The UTI has a look-back period of 30 days for active disease instead of 7 days.

Code only if both of the following are met in the last 30 days:

It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

AND

A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

I: Active Diagnoses in the Last 7 Days (cont.)

In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.

Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.

If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is **not** necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.

When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

Resources for evidence-based UTI criteria:

Loeb criteria:
https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference

Surveillance Definitions of Infections in LTC (updated McGeer criteria):
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/

National Healthcare Safety Network (NHSN):
https://www.cdc.gov/nhsn/ltc/uti/index.html

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not

I: Active Diagnoses in the Last 7 Days (cont.)

recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTIs and many other issues related to infections in LTC.
http://www.cdc.gov/hai/

Item I5100 Quadriplegia:

Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.

Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.

Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

Examples of Active Disease

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.

Coding: Hypertension item (I0700), would be **checked**.

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

Warfarin is prescribed for a resident with atrial fibrillation to decrease the risk of embolic stroke. The resident requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

Coding: Atrial fibrillation item (I0300), would be **checked**.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

I: Active Diagnoses in the Last 7 Days (cont.)

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.

Coding: Arthritis item (I3700), would be **checked**.

Rationale: 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 and therefore PUD would not be coded as an active disease.

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.

Coding: Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke item (I4500), would be **checked**.

Rationale: The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

The admission history states that the resident had pneumonia 2 months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look back period.

Coding: Pneumonia item (I2000), would **not be checked.**

Rationale: The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.

The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

Coding: CAD item (I0400), would **not be checked.**

Rationale: The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

Resident J fell and fractured *their* 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 *them* to *their* previous ambulation status, which had been independent without any devices. Although *they* received therapy services at that time, *they* now require assistance to stand from the chair and uses a walker. *They* also need help with lower body dressing because of difficulties standing and leaning over.

Coding: Hip Fracture item (I3900), would **not be checked.**

Rationale: Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, *they have* not received therapy services during the 7-

day look-back period; thus, Hip Fracture would be considered inactive.

I: Active Diagnoses in the Last 7 Days (cont.)

The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

Coding: **Schizophrenia** item (I6000), would **not be checked.**

Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess *the management of pain,* the presence of pain, pain frequency, effect *of pain on sleep, and pain interference with therapy and day-to-day activities*. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.