

SECTION I: ACTIVE DIAGNOSES

Intent: For the October 1, 2012 release of the LTCH CARE Data Set, Version 1.01, only three items (I0900: Peripheral Vascular Disease or Peripheral Arterial Disease; I2900: Diabetes Mellitus; and I5600: Malnutrition) are included in this section. These items are intended to code select diagnoses that increase a patient's risk for the development or worsening of pressure ulcer(s). However, if warranted by additional quality measures finalized by CMS for the LTCHQR Program through future rule-making cycles, CMS may add additional items to this section that document other active diagnoses.

Active Diagnoses

For this section, indicate the presence of the following conditions, based on a review of the patient's clinical records at the time of assessment.	
↓	Check all that apply
<input type="checkbox"/>	Heart/Circulation
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	Metabolic
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM)
<input type="checkbox"/>	Nutritional
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition

Item Rationale

- Some disease processes and conditions can increase a patient's risk for development or worsening of pressure ulcer(s).
- This section identifies *active* diagnoses (diseases or conditions) that are associated with the risk of developing or worsening of a pressure ulcer.

DEFINITIONS

ACTIVE DIAGNOSIS

Physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.

Steps for Assessment

- Identify diagnoses:** The diseases and conditions in this section require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.

Medical record sources for physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) diagnoses include, but are not limited to: transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and official diagnostic reports, diagnosis/problem list(s), and other resources as available.

- Although open communication regarding diagnostic information between the physician and other clinical staff is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) to ensure follow-up and coordination of care.

- Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) to ensure validity, follow-up, and coordination of care.
- Only diagnoses confirmed and documented by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) should be considered when coding this section.

DEFINITIONS

NURSE MONITORING

Nurse monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it is critical to determine if the diagnosis is *active*.

- Active diagnoses are 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.
- Medical record sources to identify *active* diagnoses at the time of assessment include, but are not limited to those listed under **1. Identify diagnoses**.
- Only diagnoses confirmed by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) and are active should be coded on the LTCH CARE Data Set.
- If information regarding active diagnoses is learned after the ARD, the LTCH CARE Data Set should not be revised to reflect this new information. The LTCH CARE Data Set should reflect what was known and documented at the time of the assessment. If, however, it comes to light that a **documented** active diagnosis but it was not indicated on the LTCH CARE Data Set, the LTCH should modify the LTCH CARE Data Set in accordance with the instructions in Chapter 4, pp. 4-5 through 4-7 under *Correcting Errors in LTCH CARE Data Set Assessment Records That Have Been Accepted into the QIES ASAP System*.

Coding Instructions

Complete only if A0250 = 01 Admission; A0250 = 10 Planned Discharge; or A0250 = 11 Unplanned Discharge.

Code diseases or conditions that have a documented diagnosis at the time of assessment and are active, i.e. 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 active diagnoses that apply.

Heart/Circulation

- Check I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) if the patient has an active diagnosis of peripheral vascular disease, or peripheral arterial disease.

Metabolic

- Check I2900, Diabetes Mellitus (DM) if the patient has an active diagnosis of diabetes mellitus (e.g., diabetic retinopathy, nephropathy, neuropathy).

Nutritional

- Check I5600, Malnutrition if the patient has an active diagnosis of malnutrition, or is at risk for malnutrition (protein or calorie).

Coding Tips

The following tips may assist staff in determining whether a disease or condition should be coded as an active diagnosis on the LTCH CARE Data Set.

- **There may be specific documentation in the medical record by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) of an active diagnosis.**
 - The physician (nurse practitioner, physician assistant, or clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active. Specific documentation areas in the medical record may include but are not limited to: progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
 - The physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws), for example, documents at the time of assessment that the patient has inadequately controlled diabetes and will adjust the medication regimen. This would be sufficient documentation of an active diagnosis and would require no additional confirmation because the physician documented the diagnosis, and also confirmed that the medication regimen needed to be modified.

Example of Active Disease

- A patient is prescribed insulin for diabetes mellitus. The patient requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. Physician progress note documents diabetes mellitus.

Coding: **I2900, Diabetes Mellitus**, would be checked.

Rationale: This would be considered an active diagnosis because the physician progress note documents the diabetes mellitus diagnosis and because there is ongoing glucose monitoring.