MDS 3.0 SECTION I

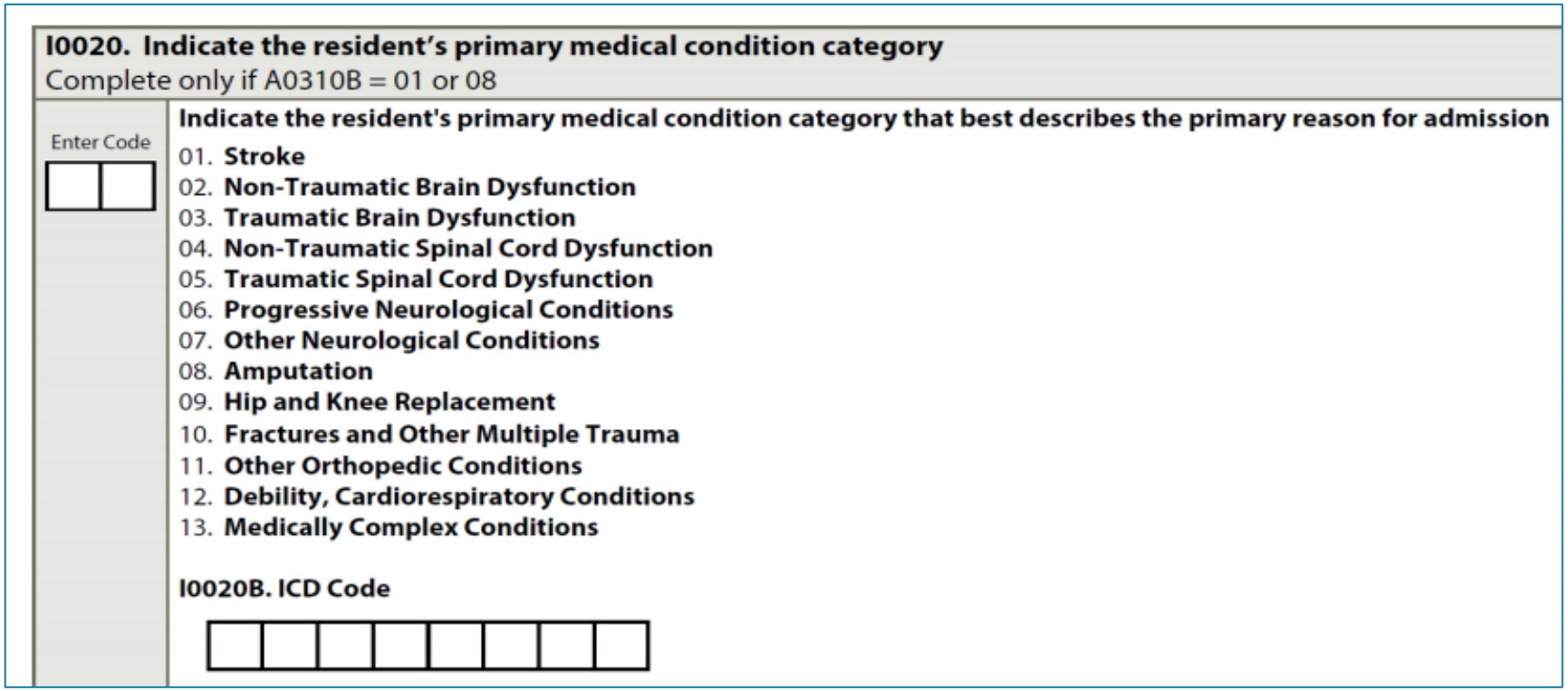
Active Diagnoses

Intent Section I

- Intent: the items in this section are intended to code diseases that have a relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

I0020: Primary Medical Condition

- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay or for state PDPM



I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or 08

Enter Code

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

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

I0020: Primary Medical Condition

Steps for Assessment

1. 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

Coding Instructions

- 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

Coding Instructions, Continued

- 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

Coding Instructions, Continued

- 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.

Coding Instructions, Continued

- 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.

I0020: Primary Medical Condition

- Read carefully the examples of each code in the RAI manual, pp. I-2 and I-3
- Note: if the hip and knee replacement is secondary to a hip fracture, code as 10, Fractures and Other Multiple Trauma
  - Example include hip fracture, pelvic fracture, and fracture of tibia and fibula
- If coding I0020B on an OBRA assessment that's not a Medicare assessment, think about the diagnosis that best represents the need for current NF care

Active Diagnoses - 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
- 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)

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 licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

Coding instructions for Section I0100 – I8000

1. Identify **all** diagnoses in the last 60 days* using required documentation by a physician, or by a nurse practitioner, physician's assistant or clinical nurse specialist as allowed by state licensure laws.

   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.

Coding instructions for Section I0100 – I8000

1. (Continued) 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.

Coding instructions for Section I0100 – I8000

2. Determine if the diagnoses in step 1 ***have been active in the last 7 days***. (Note: ItemI2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 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 for Section I

- 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

Coding Instructions for Section I

- 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

Items I 0100 to I 8000

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

	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. Dementia** (e.g. Non-Alzheimer's dementia such as 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 - 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. Manic Depression** (bipolar disease)
☐	**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. _____ ☐☐☐☐☐☐☐☐

Coding Tips

- 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.

Coding Tips, continued

- 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.

Coding Tips, continued

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

Coding Tips, continued

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

Coding Tips, continued

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

Coding Tips, continued

- 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.

I2300: Urinary Tract Infection

- 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:
  - 1. 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
  - 2. 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.
  - (NOTE: No mention if ATB in last 30 days)

I5100: Quadriplegia Clarifications

- Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, **caused by spinal cord injury**
- Coding I5100 is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition
- This differs from functional quadriplegia, which is 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 residents 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

Example of Active Diagnosis

- 4. 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 Diagnosis (Do Not Code on MDS)

- 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.

Examples of Inactive Diagnosis (Do Not Code on MDS)

- 4. 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 I – Critical Clinical Information

- Active diseases are coded on the MDS because they affect the plan of care
- Section I plays a major role in PDPM, which we discussed earler in the course
- Diagnoses from section I also are also used to risk adjust a variety of QMs
- Diagnoses should be reviewed with each assessment to determine which diagnoses continue to affect the plan of care, you can query the physician regarding appropriateness of adding new diagnoses or resolving existing diagnoses

I8000 and PDPM

- Some PDPM items require a specific ICD10 code to be present and do not look at MDS check box items
  - SLP comorbidities such as dysphagia, speech and language deficits
  - NTA conditions such as morbid obesity, cardio-respiratory failure and shock
- The IDT team should know the required source of PDPM items to ensure items are coded everywhere needed for full reimbursement
  - Example, J96.01 should be coded in I0020B if it is the primary reason for the SNF stay. Regardless of if it is coded in I0020B it is an active diagnosis and you should check I6300 for the nursing component and also record J96.01 in I8000 for the NTA component.

I8000 and PDPM

- There is only room for ten diagnoses in I8000 but a resident could have more than ten diagnoses, requiring you to pick which ones are entered into I8000.
  - You should prioritize capturing ICD10 codes that are required to capture appropriate reimbursement (SLP and NTA components).
  - In many EMR software systems, the ranking of diagnoses determine which get pulled into I8000, but this can be overridden or you can re-rank