

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that 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. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

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	
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
<input type="checkbox"/>	Heart/Circulation
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
<input type="checkbox"/>	Genitourinary
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
<input type="checkbox"/>	Infections
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
<input type="checkbox"/>	Metabolic
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	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)
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	Neurological
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	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											
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis										
<input type="checkbox"/>	I5000. Paraplegia										
<input type="checkbox"/>	I5100. Quadriplegia										
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)										
<input type="checkbox"/>	I5250. Huntington's Disease										
<input type="checkbox"/>	I5300. Parkinson's Disease										
<input type="checkbox"/>	I5350. Tourette's Syndrome										
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy										
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)										
Nutritional											
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition										
Psychiatric/Mood Disorder											
<input type="checkbox"/>	I5700. Anxiety Disorder										
<input type="checkbox"/>	I5800. Depression (other than bipolar)										
<input type="checkbox"/>	I5900. Manic Depression (bipolar disease)										
<input type="checkbox"/>	I5950. Psychotic Disorder (other than schizophrenia)										
<input type="checkbox"/>	I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)										
<input type="checkbox"/>	I6100. Post Traumatic Stress Disorder (PTSD)										
Pulmonary											
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)										
<input type="checkbox"/>	I6300. Respiratory Failure										
Vision											
<input type="checkbox"/>	I6500. Cataracts, Glaucoma, or Macular Degeneration										
None of Above											
<input type="checkbox"/>	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.											
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I. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
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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).

1. **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.

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

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-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

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-8 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 and 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.)

- 15800, depression (other than bipolar)
- 15900, manic depression (bipolar disease)
- 15950, psychotic disorder (other than schizophrenia)
- 16000, schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- 16100, post-traumatic stress disorder (PTSD)

Pulmonary

- 16200, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- 16300, respiratory failure

Vision

- 16500, cataracts, glaucoma, or macular degeneration

None of Above

- 17900, none of the above active diagnoses within the past 7 days

Other

- 18000, 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.
- **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.

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/>

Examples of Active Disease

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.

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.

2. 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.

3. 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.

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.

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

Examples of Inactive Diagnoses (do not code)

1. 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.

2. 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.

3. 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.

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, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.