Long-Term Care Survey Alert

Section I: Differentiate Between Primary and Secondary To Code Section I Smoothly

Tip: Take a close look at the patient's plan of care.

If you are confused about which diagnosis is primary, there's help for you. Take advantage of expert tips from the **Centers for Medicare & Medicaid Services'** (CMS) recently released provider update video to properly code Section I Active Diagnoses.

1. Understand What 'Direct Relationship' Really Means

Understanding the concept of "direct relationship" is critical to accurately coding Section I, stressed **Jennifer Pettis, RN, BS, WCC**, consultant for the CMS Division of Nursing Homes, in the provider update presentation.

Definition: "A disease that drives the resident's plan of care is considered one that has a direct relationship to the resident's status, and therefore is considered to be an active diagnosis," Pettis explained. When coding Section I, you must identify the active diseases and infections that drive the current care plan and report them on the MDS 3.0.

2. Follow 2 Steps to Code Section I

To code Section I, you must take two steps with specific look-back periods, stated **Shelly Ray, RN, BSN**, with **CMS's Center for Clinical Standards and Quality**, in the provider update video. In the first step, you must identify diagnoses.

You can identify diagnoses by ensuring a physician-documented diagnosis in the last 60 days, Ray noted. Depending on your state licensure laws, you may also meet the physician-documented diagnoses requirement by a nurse practitioner, physician's assistant or clinical nurse specialist.

Remember: Any diagnoses that a physician or other health care practitioner communicates verbally must also be documented in the medical record to ensure follow-up, Ray cautioned. The physician must document and verify diagnostic information in the medical record, and staff must also document any past history obtained from family members and close contacts to ensure validity and follow-up.

Example: A resident's daughter communicates to the facility social worker that the resident has a long history of depression, Pettis illustrated. The daughter goes on to report specific signs and symptoms that the staff should be aware of, as these symptoms represent the need for the staff to take additional measures to avoid a potential recurrence of the resident's depression.

The social worker informs the physician of her discussion with the family, and the physician then contacts the resident psychiatrist who provides the history, Pettis continued. The physician then documents the diagnosis of depression in the resident's medical record.

Meaning: As long as the diagnosis is physician-documented in the last 60 days, you have met the first qualifier, Pettis noted.

For the second qualifier, let's say that the team was successful in obtaining supporting information from the resident's mental health provider and added this to the medical record, Ray said. Staff updated the care plan to include the information from the daughter and the mental health provider, including necessary monitoring and measures to take if the previously reported signs and symptoms of depression reoccur.

Taking all this information into account, this diagnosis is active for the resident and you've met both qualifiers for properly coding I5800 Depression (other than bipolar).

3. How to Determine Whether Diagnoses are Active

The second step of the two-step process is to determine whether the diagnoses are active, Pettis said. Active diagnoses are those that, during the seven-day look-back period, have a direct relationship to the resident's current:

- Functional, cognitive, or mood or behavior status;
- Medical treatments;
- Nursing monitoring; or
- Risk of death.

Mistake: Don't 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 seven-day look-back period," Pettis warned. These are not considered active diagnoses.

And don't expect the physician to always specifically indicate in the medical record that a diagnosis is active this doesn't happen often, Ray pointed out. You will usually need to look for other sources of information documenting a particular diagnosis.

4. Look for Documentation in These Places

To determine whether a diagnosis is active in the last seven days, you can look for information in the following places:

- Transfer documents;
- Physician's progress notes;
- Recent history and physicals;
- Recent discharge summaries;
- Nursing assessments;
- Care plans;
- Medication sheets;
- Doctor's orders;
- Consults; and
- Diagnostic reports.

This is not an exhaustive list, but rather just some of the potential places in the medical record where you might locate the information, Ray noted.

5. Don't Treat Section I Diagnoses as 'All-Inclusive'

Although Section I lists many diagnoses by major disease category and some diagnoses listed have examples of diseases included in those diagnoses, "it's important to note that these examples are not all-inclusive," Pettis warned. You will check off each active disease, being careful to check all that apply.

Options: You also have the option to check I7900 None of the above active diagnoses within the last 7 days, Pettis noted. Or you can check I8000 Additional active diagnoses, where you can enter the ICD code of any disease or condition not specifically listed in Section I.

6. Pinpoint the Primary Diagnosis

Additionally, proper Section I coding relies on specific, accurate documentation. "Facilities in general should work to clarify any nonspecific diagnoses as much as possible," Ray urged.

Nonspecific diagnoses, as well as confusion between a primary and a secondary diagnoses, can cause coding errors in Section I. One good example is coding I5100 Quadriplegia, which you cannot code as the primary diagnosis in Section I

when the quadriplegia is not caused by spinal cord injury, Ray noted.

Example: The resident has end-stage Alzheimer's disease and can no longer move any of her limbs, Ray illustrated. She is dependent on the facility staff to assist her with all of her activities of daily living (ADLs). So the resident has a severe debilitating diagnosis with a functional deficit that can render her functionally immobile.

"This functional immobility may seem comparable with what would be seen in a quadriplegic," Ray said. But you would code the diagnosis of I4200 – Alzheimer's disease and not I5100. Similarly, you would code I4400 – Cerebral palsy for a resident with a diagnosis of cerebral palsy, spastic quad type, and not under I5100.

But the primary diagnosis that's the cause for the secondary diagnosis is not always the correct item to code in Section I, particularly if the primary diagnosis is no longer considered active.

Another example: Consider a resident who has hemiplegia or hemiparesis secondary to cerebrovascular accident (CVA), or a stroke, which occurred two years ago. "The CVA is not considered the active diagnosis if the CVA itself has resolved," Pettis explained. This means that the resident is currently receiving no treatment to manage continued symptoms from the stroke.

In this case, if the current care plan is addressing deficits associated with hemiplegia or hemiparesis and all the requirements for coding the active diagnosis are met, you should code this for item I4900 – Hemiplegia or Hemiparesis, and not under I4500 – Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke.

7. Beware of Look-Back Exception for I2300

Although Section I specifies a look-back period of seven days, there is one exception: item I2300 – Urinary Tract Infection (UTI) has a look-back period of 30 days, Pettis stated. So don't let this different look-back period trip you up when you're coding Section I.

And not only does item I2300 have a 30-day look-back period, but also you must identify four elements to code this diagnosis, Pettis reminded:

1. The UTI must be present in the 30-day look-back period, with a diagnosis made by a physician or other authorized licensed staff according to your state law.

2. Identify at least one sign or symptom attributed to UTIs, such as fever, painful urination, urinary frequency, pain or tenderness, mental status changes like confusion, or changes in urine characteristics such as color or clarity.

3. Significant laboratory findings or urine culture, as the physician deems necessary.

4. Staff administered a medication or treatment for a UTI within the last 30 days.

Remember: The RAI User's Manual does not provide definitions of diagnoses for coding Section I, Pettis cautioned. "This was an intentional omission, as it's up to the physicians who must make a determination and document the active diagnoses for all residents in the facility according to their assessment of the resident."

Link: The video MDS 3.0 Provider Updates: Section I is available at www.youtube.com/watch?v=sZLjJMntcPQ&feature=youtu.be.