MDS Alert

Item Focus: Follow These Steps for Stroke as Primary Dx

Hint: Where the resident has the stroke doesn't matter if it's during the lookback period.

With item I0200 (Indicate the resident's primary medical condition category) still feeling pretty new - and complicated by the various places within the MDS that a primary diagnosis may need acknowledgement - look to some basic Section I coding tenets.

"The point of these items is to determine if the diagnoses are active or not. Remember the MDS wants up-to-date diagnoses coded. All the items in Section I, between I0100 to I7900 (and I8000), are coded if the disease or condition is an active diagnosis," says **Jane Belt RN, MS, RAC-MT, RAC-CT, QCP,** curriculum development specialist at the **American Association for Nurse Assessment Coordination** (AANAC) in Columbus, Ohio.

Focus on Nuts and Bolts in Primary Dx

You may be dealing with a software snafu or other roadblock that is making you question the proper coding of these items; keep your head on straight by remembering that sometimes the Resident Assessment Instrument (RAI) Manual guidance really is as simple as it appears.

The RAI Manual explains the purpose of item I0200, saying on page I-1: "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."

For example, when considering a resident who's admitted to your facility because of a stroke, it's important to include the primary diagnosis as a stroke because it "influences the resident's functional outcomes," the RAI Manual says.

If the stroke didn't happen at the facility, look to the resident's clinical record, so you're certain of the exact disease process and can therefore code the MDS and care plan accordingly. "Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available," the RAI Manual says.

Note: The type of stroke doesn't matter; the RAI Manual lists "ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease" as examples of disease processes that qualify as stroke per the MDS. Similarly, even if the resident has been diagnosed with other conditions, such as Alzheimer's disease, focus on the reason for the resident's admission.

Code Stroke Later in Section I, Too

You'll need to address the resident's prior stroke in active diagnoses as well once you get to item I4500 (Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke), as well as any other diagnosed active conditions, such as Alzheimer's disease or diabetes, for example.

Important: There are two distinct look-back periods for this part of Section I, according to the RAI Manual, on page I-6:

- "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)."

So, when you are evaluating which conditions to note on the MDS, you are relying on the clinical record, particularly physician-documented diagnosis.

"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," the RAI Manual says.

What does that include? Progress notes, most recent medical history and physical, documents pertaining to transfer or discharge, diagnosis/problem list, or other resources all apply.

Caveat: Physician confirmation is key. "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," the RAI Manual says.

Once you've identified any viable diagnoses, you need to narrow your focus to what has been going on in the past seven days.

"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," the RAI Manual says

If the resident had a stroke within this active diagnosis look-back period, check I4500. Coding strokes appropriately can be tricky because of the multitude of complications that can follow, but if you focus on physician-confirmed clinical documentation in the appropriate lookback timeframes, you should be all set.