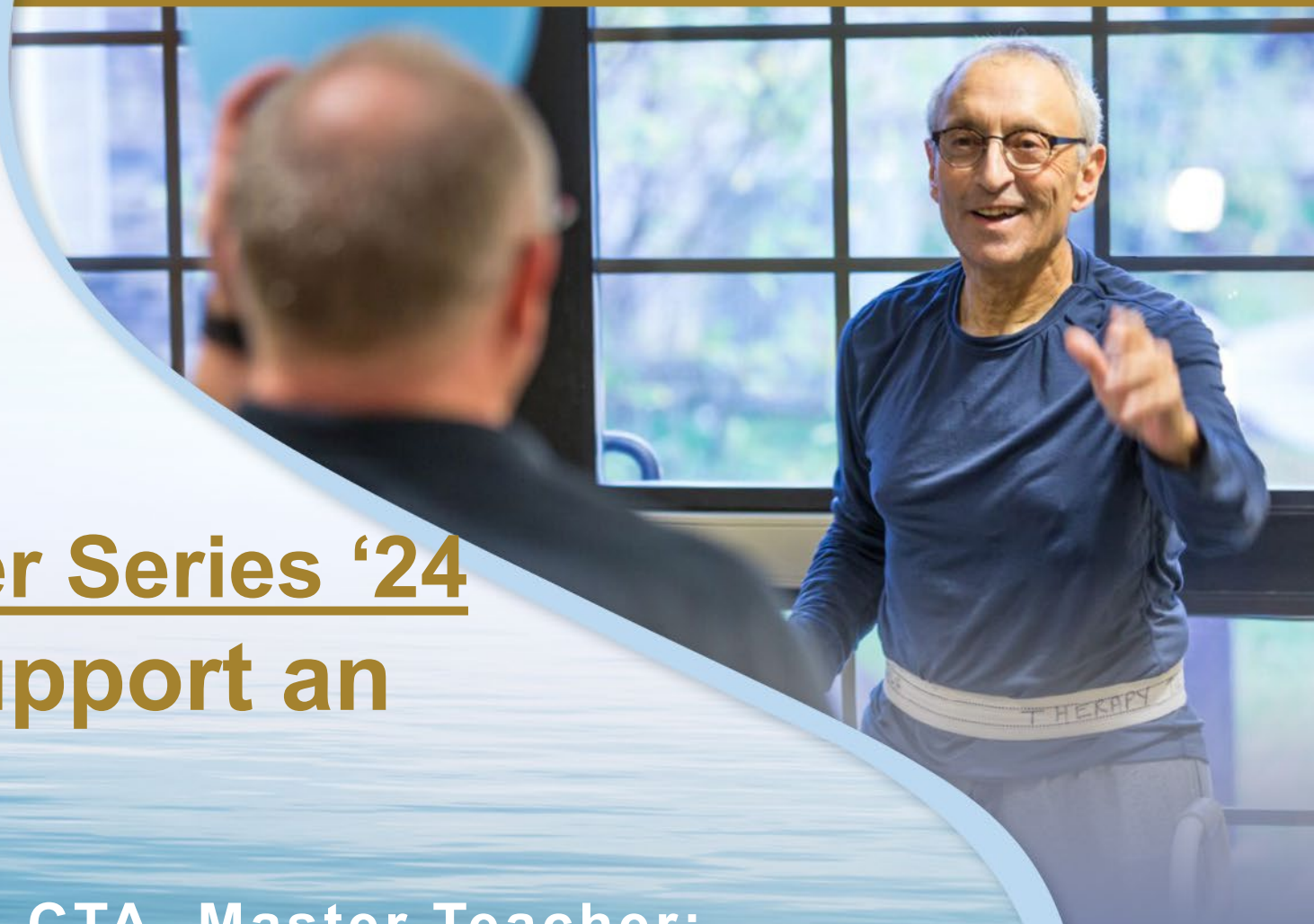
"A ***Knowledgeable*** and ***Compassionate*** partner"



BROAD RIVER REHAB

BRR Insiders™ Summer Series '24

Documentation to support an active diagnosis

Joel VanEaton, BSN, RN, RAC-CTA, Master Teacher:
Executive Vice President of PAC Regulatory Affairs and Education

ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 0.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 30 days

Learning Objectives

Documentation to support an active diagnosis

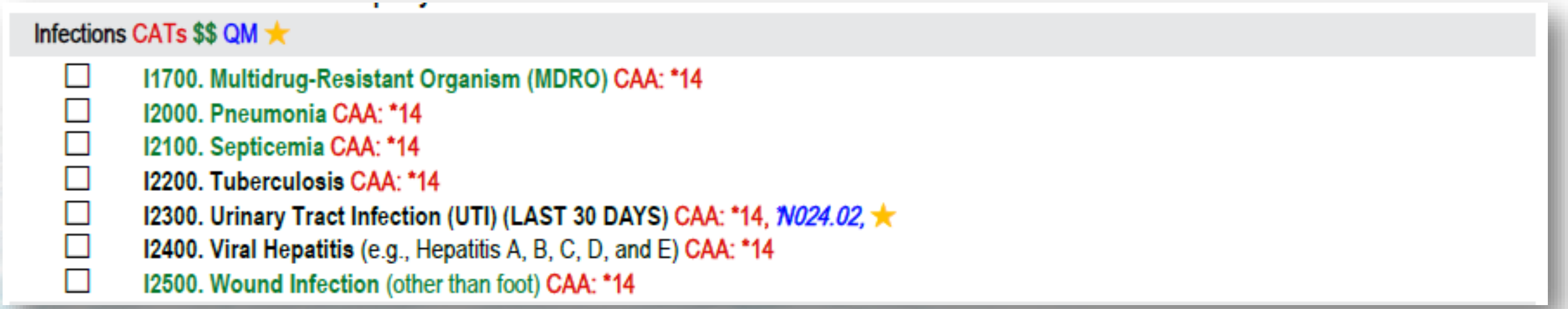
- Understand the definition of an active diagnosis
- Know the timeframes for accurate and supporting documentation
- Identify unique documentation requirements for UTI
- Recognize when documentation supports an active diagnosis.

Supporting an active diagnosis

- **Documentation to support an active diagnosis**
  - Documentation to support an active diagnosis on the MDS is crucial to accurate MDS coding.
  - Diagnoses coded in section I of the MDS affect **care planning, reimbursement**, and **quality measures**.
  - The RAI Manual requires specific documentation to support these areas.
  - The intent is to generate an updated, accurate picture of the resident's current health status.
  - Coding conventions must be followed using both the Tabular List and Alphabetic Index of ICD-10-CM. The science of ICD-10 is specificity!

Supporting an active diagnosis

- **Impact areas example**


Infections CATs $$ QM ★

- ☐ I1700. Multidrug-Resistant Organism (MDRO) CAA: *14
- ☐ I2000. Pneumonia CAA: *14
- ☐ I2100. Septicemia CAA: *14
- ☐ I2200. Tuberculosis CAA: *14
- ☐ I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) CAA: *14, *N024.02,* ★
- ☐ I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) CAA: *14
- ☐ I2500. Wound Infection (other than foot) CAA: *14

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **CAA 14 - Dehydration/Fluid Maintenance**

CAT Specifications: 14 Dehydration/Fluid Maintenance

Triggering Conditions	MDS 3.0 Item	Description	Response Values
1. Constipation present as indicated by:	• H0600	Constipation	= 1
2. Infection present as indicated by:	• I1700	Multidrug-Resistant Organism (MDRO).	= Checked OR
	• I2000	Pneumonia	= Checked OR
	• I2100	Septicemia	= Checked OR
	• I2200	Tuberculosis	= Checked OR
	• I2300	Urinary tract infection (UTI) (LAST 30 DAYS)	= Checked OR
	• I2400	Viral hepatitis (includes type A, B, C, D, and E)	= Checked OR
	• I2500	Wound infection (other than foot)	= Checked OR
	• M1040A	Infection of the foot	= Checked

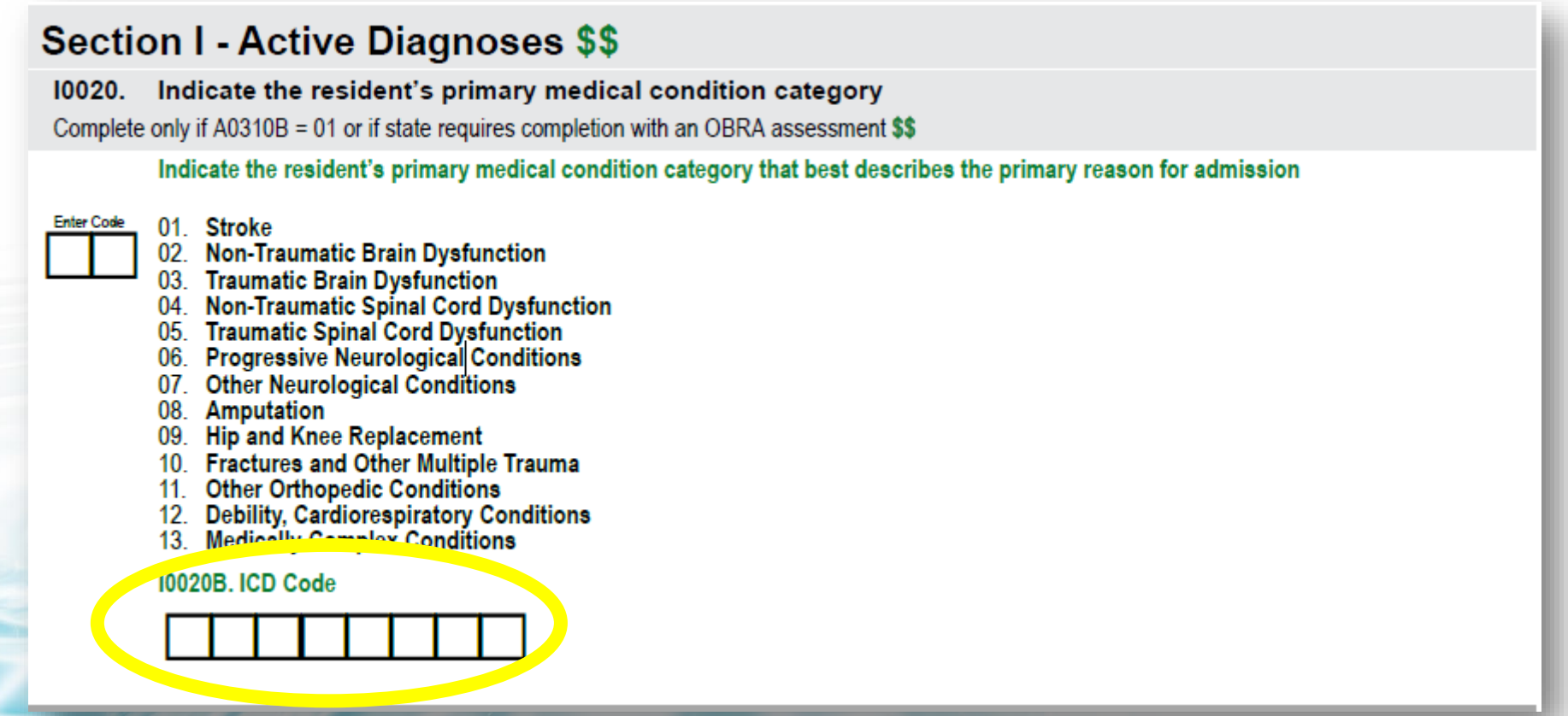
Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **CAA 14 - Dehydration/ Fluid Maintenance**

✓	**Diseases and conditions** that predispose to limitations in maintaining normal fluid balance	**Supporting Documentation**
☐	• Infection (I1700–I2500, *M1040A*)	
☐	• Fever (J1550A)	
☐	• Diabetes (I2900)	
☐	• Congestive heart failure (I0600)	
☐	• **Swallow problem (K0100)**	
☐	• Malnutrition (I5600)	
☐	• Renal disease (I1500)	
☐	• Weight loss (K0300)	
☐	• Weight gain (K0310)	
☐	• New cerebrovascular accident (I4500)	
☐	• Unstable acute or chronic condition	
☐	• Nausea or vomiting (J1550B)	
☐	• Diarrhea	
☐	• Excessive sweating	
☐	• Recent surgery (*J2000, J2100,* I8000)	
☐	• Recent decline in *functional abilities*, including body control or hand control problems *(GG0115A)*, inability to sit up, etc. (*GG0130, GG0170*)	
☐	• Parkinson's or other neurological disease that requires unusually long time to eat (I4200–I5500)	
☐	• Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, (J1550B)	

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **Reimbursement – PT, OT, SLP**



Section I - Active Diagnoses $$

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment $$

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

Enter Code

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

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **Reimbursement – Special Care High**

CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0520B2 or K0520B3 Feeding tube*
K0520A2 or K0520A3	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories OR

(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to the Special Care Low Category now.

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **Quality Measurement – Percent of Residents Who Newly Received an Antipsychotic Medication**

Table 2-10
Percent of Residents Who Newly Received an Antipsychotic Medication (SS)
(CMS ID: N011.03) (CMIT Measure ID: 1183) [9]

Measure Description
This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.

Measure Specifications
Numerator
Short-stay residents for whom one or more assessments in a look-back scan (*not including* the initial assessment) indicates that antipsychotic medication was received. This condition is defined as follows:
1. For assessments with target dates on or after 10/01/2023: (N0415A1 = [1]).[10]
Note that residents are excluded from this measure if their initial assessment indicates antipsychotic medication use or if antipsychotic medication use is unknown on the initial assessment (see exclusion 3, below).
Denominator
All short-stay residents who do not have exclusions and who meet all of the following conditions:
1. The resident has a target assessment, *and*
2. The resident has an initial assessment, *and*
3. The target assessment is not the same as the initial assessment.
Exclusions
1. The following is true for *all* assessments in the look-back scan (excluding the initial assessment):
1.1. For assessments with target dates on or after 10/01/2023: (N0415A1 = [-]).[10]
2. *Any* of the following related conditions are present on *any* assessment in a look-back scan:
2.1. Schizophrenia (I6000 = [1]).
2.2. Tourette's syndrome (I5350 = [1]).
2.3. Huntington's disease (I5250 = [1]).

[9] This measure is used in the Five-Star Quality Rating System
[10] For assessments with target dates before 10/01/2023, please refer to the MDS 3.0 Quality Measures User's Manual Version 15.

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **Quality Measurement – Discharge Function Score**

Covariates

Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF Stays.

1. Age group
2. Admission function – continuous form[c]
3. Admission function – squared form[c]
4. Primary medical condition category
5. Interaction between admission function and primary medical condition category
6. Prior surgery
7. Prior functioning: self-care
8. Prior functioning: indoor mobility (ambulation)
9. Prior functioning: stairs
10. Prior functioning: functional cognition
11. Prior mobility device use
12. Stage 2 pressure ulcer/injury
13. Stage 3, 4, or unstageable pressure ulcer/injury
14. Cognitive abilities
15. Communication impairment
16. Urinary Continence
17. Bowel Continence
18. History of falls
19. Nutritional approaches
20. High BMI
21. Low BMI
22. Comorbidities

See covariate details in *Table RA-5* and *Table RA-10* in the associated Risk-Adjustment Appendix File.

Supporting an active diagnosis

- **Impact areas example (cont.)**
  - **Quality Measurement – Discharge Function Score**

Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock (HCC2)
Metastatic Cancer and Acute Leukemia (HCC8)
Lymphoma and Other Cancers (HCC10)
Colorectal, Bladder, and Other Cancers (HCC11)
Diabetes: Diabetes with Chronic Complications (HCC18) or Diabetes without Complications (HCC19)
Other Significant Endocrine and Metabolic Disorders (HCC23)
Intestinal Obstruction/Perforation (HCC33)
Dementia: Dementia With Complications (HCC51), Dementia Without Complications (HCC52)
Mental Health Disorders: Schizophrenia (HCC57), Major Depressive, Bipolar, and Paranoid Disorders (HCC59), Reactive and Unspecified Psychosis (HCC58), Personality Disorders (HCC60)
Tetraplegia (excluding complete tetraplegia) (HCC70) and paraplegia (HCC71)
Multiple Sclerosis (HCC77)
Parkinson's and Huntington's Diseases (HCC78)
Angina Pectoris (HCC88)
Hemiplegia/Hemiparesis (HCC103)
Aspiration, Bacterial, and Other Pneumonias: Aspiration and Specified Bacterial Pneumonias (HCC114), Pneumococcal Pneumonia, Empyema, Lung Abscess (HCC115)
Dialysis Status (HCC134), Chronic Kidney Disease, Stage 5 (HCC136)
Chronic Kidney Disease - Stages 1-4, Unspecified: Chronic Kidney Disease, Severe (Stage 4) (HCC137), Chronic Kidney Disease, Moderate (Stage 3) (HCC138), Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified) (HCC139)
Major Head Injury (HCC167)
Amputations: Traumatic Amputations and Complications (HCC173), Amputation Status, Lower Limb/Amputation Complications (HCC189), Amputation Status, Lower Limb/ Amputation Complications (HCC189)

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - 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.).

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - There are two look-back periods:
    - Diagnosis identification: **(Step 1)** is a 60-day look-back period.
      - 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, etc.
      - If a diagnosis/problem list is used, **only diagnoses confirmed by the physician** should be entered.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - 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.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - There are two look-back periods:
    - 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).
      - 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.
      - 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, etc.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - 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.
    - Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
    - 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.

Supporting an active diagnosis

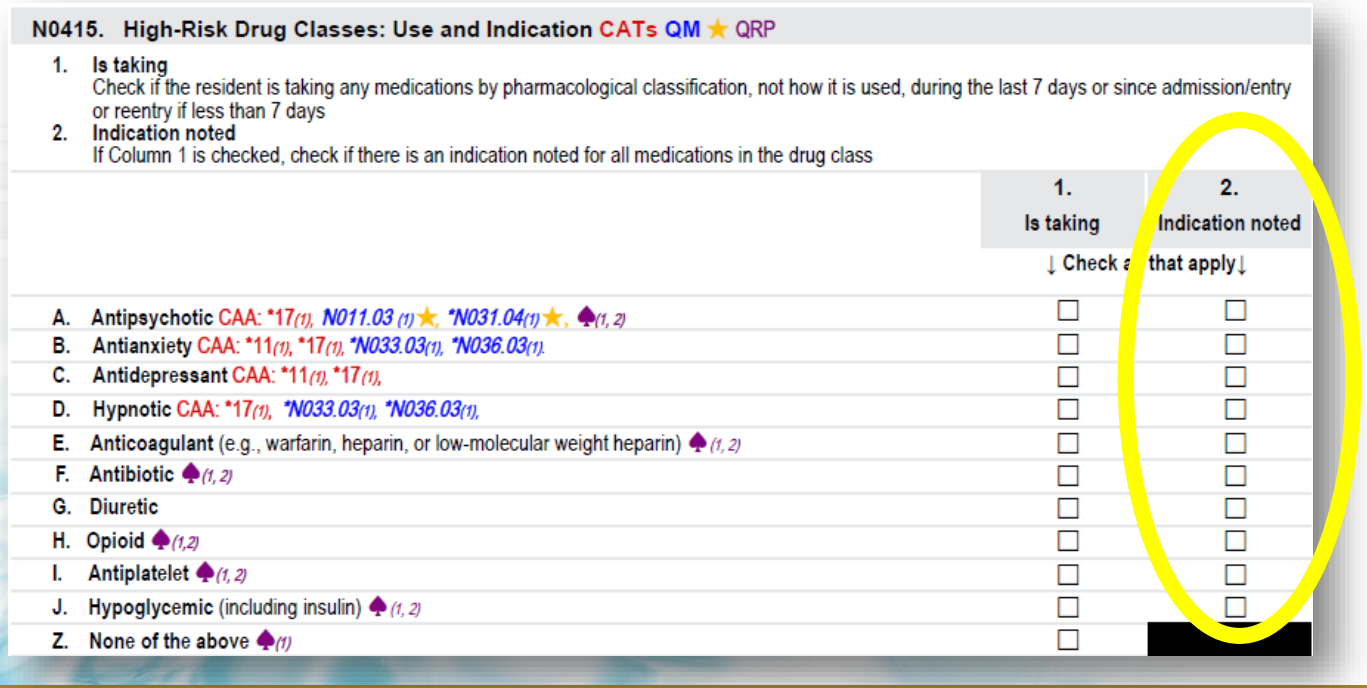
- **Definition of an active diagnosis**
  - Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list **is not sufficient** for determining active or inactive status.
  - It is expected that nurses monitor all medications for adverse effects as part of usual nursing 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.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - 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.
    - **Example:** 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 and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.
    - **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, of the resident's mental, physical, psychosocial, and functional status and persistent behaviors for the time period required.

Supporting an active diagnosis

- **Section N – Indication for use.**
  - INDICATION: The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.



N0415. High-Risk Drug Classes: Use and Indication CATs QM ★ QRP

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking ↓ Check a	2. Indication noted ↓ that apply ↓
A. Antipsychotic CAA: *17(1), N011.03 (1)★, *N031.04(1)★, ♠(1, 2)	☐	☐
B. Antianxiety CAA: *11(1), *17(1), *N033.03(1), *N036.03(1).	☐	☐
C. Antidepressant CAA: *11(1), *17(1),	☐	☐
D. Hypnotic CAA: *17(1), *N033.03(1), *N036.03(1),	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) ♠(1, 2)	☐	☐
F. Antibiotic ♠(1, 2)	☐	☐
G. Diuretic	☐	☐
H. Opioid ♠(1,2)	☐	☐
I. Antiplatelet ♠(1, 2)	☐	☐
J. Hypoglycemic (including insulin) ♠(1, 2)	☐	☐
Z. None of the above ♠(1)	☐	

Supporting an active diagnosis

- **Definition of an active diagnosis exception - 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**:
    - 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**
    - 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.
  - 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.

Supporting an active diagnosis

- **Definition of an active diagnosis exception - UTI**
  - 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).

Supporting an active diagnosis

- **Definition of an active diagnosis Clarification - Quadriplegia**
  - Item I5100 Quadriplegia:
    - Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
    - Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
    - Functional quadriplegia refers to complete immobility due to severe physical disability or frailty.
    - Conditions such as cerebral palsy can also cause functional paralysis that may extend to all limbs. For individuals with these types of severe physical disabilities, their primary physician-documented diagnosis should be coded on the MDS and **not the resulting paralysis** from that condition.

Supporting an active diagnosis

- **Active Diagnosis or Not:**
  - **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.
    - This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.
  - **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.
    - The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would not be considered an active diagnosis.

Questions?

Don’t Forget!

BRR Insiders™ Summer Series

June 21 12:00 - 12:30 – Documentation to support section GG. (Gwen Pointer)

July 12 12:00 - 12:30 - Documentation to Support the Primary DX. (Shannon Hayes)

July 19 12:00 - 12:30 – Documentation to support Swallowing disorder, IV feedings and mechanically altered diet. (Amy Garrison)

August 2 12:00 - 12:30 – Documentation to support Shortness of Breath while lying flat, Isolation. (Cathy Wuest)

August 16 12:00 - 12:30 – Documentation to support not using the dash related to SNF QRP. (Joel VanEaton)