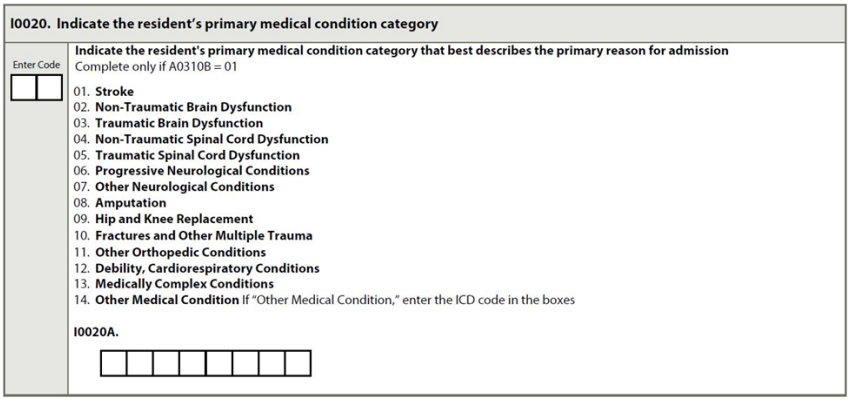
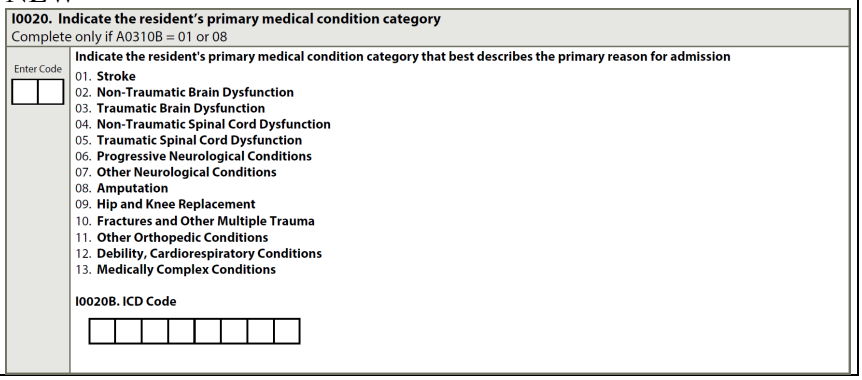
Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I0020– I8000	I-1– I-15	Page length changed due to revised content.
3	I0020	I-1	Replaced screenshot. OLD  NEW 

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Chapter	Section	Page	Change
3	I0020	I-1	**Planning for Care** • ~~This item identifies the primary medical condition category that resulted in the resident's admission to the facility and that influences the resident's functional outcomes~~Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. **Steps for Assessment** 1. ~~Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the SNF facility~~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.
3	I0020	I-2	***Complete only if A0310B = 01 or 8*** • ~~Enter the code that represents the primary medical condition that resulted in the resident's admission~~ 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. ~~If codes 1–13 do not apply, use code 14, "Other Medical Condition," and proceed to I0020A.~~ • While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.
3	I0020	I-3	~~**Code 14, Other Medical Condition,** if the resident's primary medical condition category is not one of the listed categories. Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.~~

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Chapter	Section	Page	Change
3	I0020	I-3	1. Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician. **Coding:** I0020 would be coded **01, Stroke.** I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage). **Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.
3	I0020	I-3	2. Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital. **Coding:** I0020 would be coded **10, Fractures and Other Multiple Trauma.** I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur). **Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

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Chapter	Section	Page	Change
3	I0020	I-4	~~3. Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis. The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician's discharge summary from the acute care hospital and are incorporated into Mrs. H's medical record.~~ ~~**Coding:** I0020 would be coded **13, Medically Complex Conditions.**~~ ~~**Rationale:** The physician's discharge summary from the acute care hospital documents the need for IV antibiotics due to urosepsis as the reason for Mrs. H's admission to the facility.~~
3	I0020	I-4	3. Mrs. H is a 78-year-old female with a history of hypertension and a hip replacement 2 years ago. She was admitted to an extended hospitalization for idiopathic pancreatitis. She had a central line placed during the hospitalization so she could receive TPN (total parenteral nutrition). She also received regular blood glucose monitoring and treatment with insulin when she became hyperglycemic. During her SNF stay, she is being transitioned from being NPO (nothing by mouth) and receiving her nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into Mrs. H's SNF medical record. **Coding:** I0020 would be coded **13, Medically Complex Conditions.** I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection). **Rationale:** Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of her central line does not change her care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

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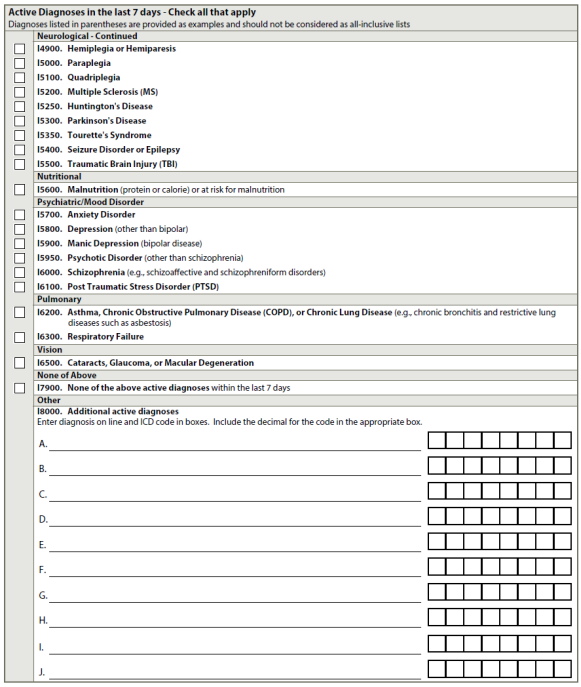
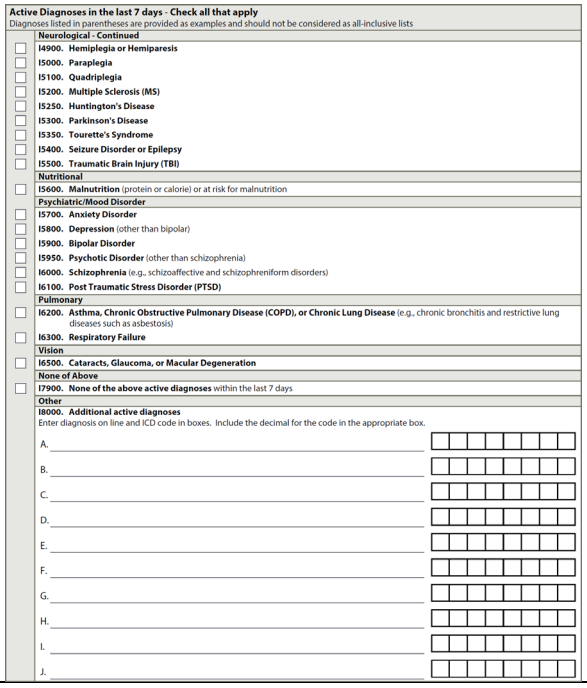
Chapter	Section	Page	Change
3	I4900–I8000	I-6	Replaced screenshot. OLD  NEW 

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
- 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. _____
I. _____
J. _____

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Chapter	Section	Page	Change
3	I4900–I8000	I-8	• Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-~~8~~12 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~~12 for specific coding instructions).*
3	I5900	I-11	• **I5900,** ~~manic depression (~~bipolar disorder~~disease)~~