interRAI Long-Term Care Facilities (LTCF): Disease Diagnoses (I1) and Other Disease Diagnoses (I2)

Intent of sections I1 and I2

To document the presence of any diseases or infections that are relevant to the person's current activity of daily living (ADL) status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring or risk of death.

Steps for recording disease diagnoses

Step 1: Gather information

Consult the clinical record and the primary physician, or talk to the person and family and validate their statements with the physician.

Step 2: Complete Section I1 (Disease Diagnoses)

Select the most appropriate disease code for each diagnosis listed. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs. There can be more than one primary diagnosis coded to support and justify services being provided.

Step 3: Complete Section I2 (Other Disease Diagnoses)

Enter the diagnosis, the appropriate disease code and the ICD-10-CA code for diseases and infections that are not recorded in Section I1. You may also record more specific designations for general disease categories listed in I1. Do not include signs and symptoms that are manifestations of an underlying disease.

Example

A person is admitted with a diagnosis of Alzheimer's disease and severe rheumatoid arthritis. The reason for admission to long-term care is identified as "frailty" and "deconditioning," with loss of autonomy for completing self-care activities.

The assessor records the following primary diagnosis/diagnoses for the current stay:

- Section I1: *Alzheimer's disease*
- Section I2: *Rheumatoid arthritis, unspecified* (ICD-10-CA code M06.9)

Important: No ICD-10-CA code is recorded for "frailty" or "deconditioning," as these are manifestations of the underlying disease. Loss of functional autonomy is captured in Section G (Functional Status).

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Diagnoses that contribute to an output calculation

The table below lists diagnoses that should be captured in the interRAI LTCF assessment to ensure that the clinical outputs accurately reflect the person being assessed:

Diagnosis	ICD-10-CA code	Output impacted
I1c Alzheimer's disease	n/a	Cognitive Loss CAP, QI (Percentage of residents on antipsychotic without a diagnosis of psychosis)
I1d Dementia other than Alzheimer's disease	n/a	Cognitive Loss CAP, QI (Percentage of residents on antipsychotic without a diagnosis of psychosis)
I1e Hemiplegia	n/a	RUG-III, RUG-III Plus
I1f Multiple sclerosis	n/a	QI (Percentage of residents with indwelling catheters), RUG-III, RUG-III Plus
I1i Quadriplegia	n/a	QI (Percentage of residents in daily physical restraints), RUG-III, RUG-III Plus
I1q Schizophrenia	n/a	QI (Percentage of residents on antipsychotics without a diagnosis of psychosis)
I1r Pneumonia	n/a	RUG-III, RUG-III-Plus
I1u Diabetes mellitus	n/a	RUG-III, RUG-III Plus
Sepsis, unspecified (septicemia)	A41.9	RUG-III, RUG-III Plus
Huntington's disease (Huntington's chorea)	G10, G3080	QI (Percentage of residents on antipsychotics without a diagnosis of psychosis)
Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease)	G12.20	QI (Percentage of residents with indwelling catheters)
Cerebral palsy, unspecified	G80.9	RUG-III, RUG-III Plus

Notes
n/a: Not applicable.
CAP: Clinical Assessment Protocol.
QI: Quality indicator.
RUG-III: Resource Utilization Groups version III.
RUG-III Plus: Resource Utilization Groups version III Plus.

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