Selection of Principal Diagnosis for Inpatient Admission

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Webinars
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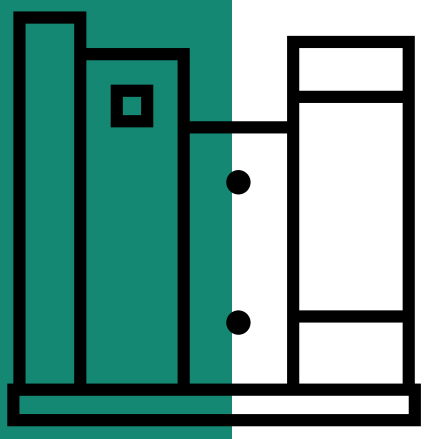

Sections of the ICD-10-CM Guidelines

- The guidelines are organized into sections.
- Section I includes the **structure and conventions** of the classification and **general guidelines that apply to the entire classification**, and **chapter-specific guidelines** that correspond to the chapters as they are arranged in the classification.
- **Section II includes guidelines for selection of principal diagnosis for non-outpatient settings.**
- Section III includes guidelines for reporting additional diagnoses in non-outpatient settings.
- Section IV is for outpatient coding and reporting.

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IMPORTANT STEPS TO CORRECT CODING

"The *entire record* should be reviewed to determine the *specific reason for the encounter* and the conditions treated."

- "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

Step 1: Find the condition in the alphabetic index by looking for the main term.
Step 2: Verify the code in the tabular list and identify the highest specificity.
Step 3: Review the chapter-specific coding guidelines. *Read and be guided by instructional notes that appear in both the Alphabetic Index and the Tabular List.*

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Conventions for the ICD-10-CM

Section I.A.

Conventions from ICD-10-CM Section I.A. must be taken into consideration along with guidelines for principal diagnosis.

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Terms of Reference Within Section I.A. Conventions for the ICD-10-CM

- Pay attention to terms such as:

- **"And"**
- **"With"**
- **"See" and "See also"**
- **"Code also"**
- **"Excludes 1 and 2 notes"**
- **"Code first"**
- **"Use additional code"**
- **"In diseases classified elsewhere"**

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Section I.A. Conventions

A. Conventions for the ICD-10-CM .....
1. The Alphabetic Index and Tabular List .....
2. Format and Structure: .....
3. Use of codes for reporting purposes .....
4. Placeholder character .....
5. 7th Characters .....
6. Abbreviations .....
a. Alphabetic Index abbreviations .....
b. Tabular List abbreviations .....
7. Punctuation .....
8. Use of "and" .....
9. Other and Unspecified codes .....
a. "Other" codes .....
b. "Unspecified" codes .....
10. Includes Notes .....
11. Inclusion terms .....

Section I.A. contents

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Section I.A. Conventions, continued

Section I.A. contents

12. Excludes Notes.....
    a. Excludes1.....
    b. Excludes2.....
13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes).....
14. "And".....
15. "With".....
16. "See" and "See Also".....
17. "Code also" note.....
18. Default codes.....
19. Code assignment and Clinical Criteria.....

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Code FIRST Does Not Mean Code as PRINCIPAL Diagnosis!!

- Be careful with "Code First" coding directive, as this only indicates an ***order of sequencing.***
- "Code First" and "Code as Principal" do not have the same meaning.
- "Code first" and "code as principal" may, in many cases, have the same result, but remember that a condition MUST meet the definition of "chief reason for admission" to be principal diagnosis.
- Make the distinction between "code first" and "code as principal diagnosis" since these two terms do have two different meanings.
- Auditors vs. Hospital Coders . . .

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Section I. B.

General Coding Guidelines

1. Locating a code in the ICD-10-CM
2. Level of Detail in Coding
3. Code or codes from A00.0 through T88.9, Z00-Z99.8
4. Signs and symptoms
5. Conditions that are an integral part of a disease process
6. Conditions that are not an integral part of a disease process
7. Multiple coding for a single condition
8. Acute and Chronic Conditions
9. Combination Code
10. Sequela (Late Effects)
11. Impending or Threatened Condition
12. Reporting Same Diagnosis Code More than Once
13. Laterality
14. Documentation *by Clinicians Other than the Patient's Provider*.
15. Syndromes
16. Documentation of Complications of Care
17. Borderline Diagnosis
18. Use of Sign/Symptom/Unspecified Codes
19. Coding for Healthcare Encounters in Hurricane Aftermath
    a. Use of External Cause of Morbidity Codes
    b. Sequencing of External Causes of Morbidity Codes
    c. Other External Causes of Morbidity Code Issues
    d. Use of Z codes

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Section I. C.

Chapter-Specific Coding Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Please also refer to Section II for guidelines on the selection of principal diagnosis when determining the chief reason for admission.

For example, in this section you will find chapter-specific guidance for conditions, including guidance on (but not limited to):

- Infectious diseases
- Neoplasms
- Diseases of circulatory system P codes, Q codes, R codes, Z codes
- Complications/Adverse Effects/Injuries

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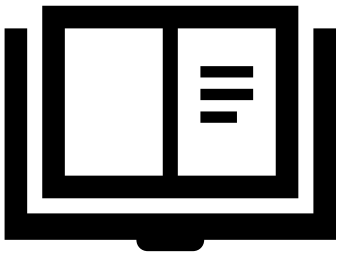
ICD-10-CM Official Guidelines Section II: Selection of Principal Diagnosis

Section II of the Official Coding Guidelines is titled Selection of Principal Diagnosis. ***"In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines.*** **(See Section I.A., Conventions for the ICD-10-CM.)"**



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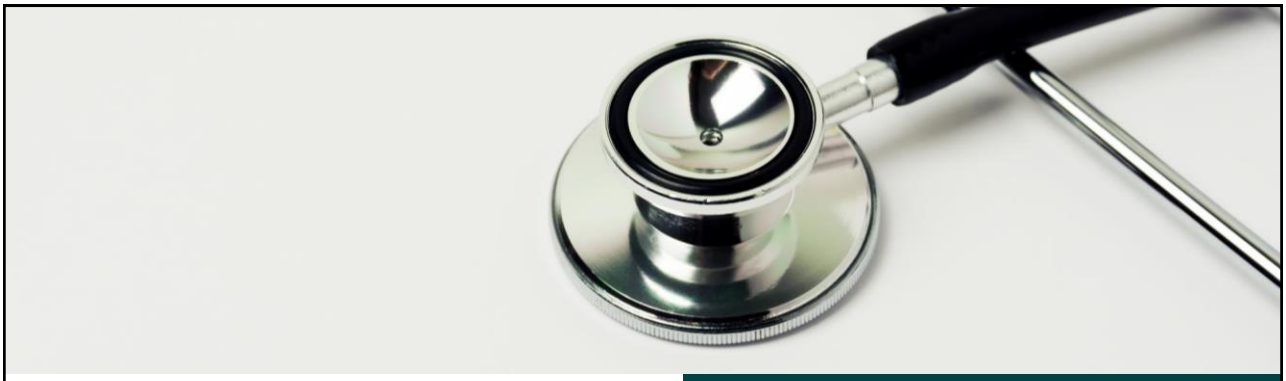

Principal Diagnosis Defined

- *What exactly do these phrases mean??*
- Circumstances of admission?
- Condition after study?
- Occasioning the admission?

- **The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."**

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What is the meaning of "Circumstances of Admission"?

What is the state of affairs/incidents/events that are relevant? Consider the entire context surrounding the need for inpatient admission.

Consider the setting from which the patient is being admitted (surgery, observation, emergency room, home, etc.)

- Consider events preceding the presentation to hospital and changes from the patient's usual condition.
- Consider the chief complaint and clinical findings.
- What did the physician document on presentation, and on or around time of admission?
- Consider what acute condition(s) of the patient necessitated an inpatient admission. Even if the patient has another condition relevant to the admission, not all the patient's conditions are acute and require inpatient care.
- Consider findings "after study" that may not have been fully apparent at time of presentation or even at the time of admission, but that in context of the admission, are associated with clinical signs that were present on admission. The chief reason for admission may in some cases not be documented on admission, but only defined after study.

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What is the meaning of "occasioning"?

A specific "something vital" that caused this admission.

"Occasion" as noun

- A particular time, especially as marked by certain circumstances or occurrences.

"Occasion" as verb

- To cause something.
- Oxford Dictionary states an example: "Something vital must have occasioned this visit"

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What is the meaning of "After Study"?

A definitive (or suspected) diagnosis is identified by the physician after the work up is complete (after study).

"After study" can also apply for the coder/auditor to mean "after study of the entire record of the admission." Review the entire record to ensure knowledge of the complete context before reporting a diagnosis as the chief reason for admission.

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Don't Be Confused By Terminology!

Principal Diagnosis vs.

Admitting diagnosis – Primary Diagnosis – Reason for Admission – Indication for Admit – Admit to Inpatient Diagnosis – Observation diagnosis – Discharge Diagnosis

? ? ?

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Admitting Diagnosis vs. Principal Diagnosis

Admitting Diagnosis

- Admitting diagnosis is defined by the Joint Commission of Hospitals as “the ICD-10-CM code associated with the diagnosis established at the time of the patient’s admission to the hospital”.

Principal Diagnosis

- **May** or **may not be** the same as the admitting diagnosis but make the distinction between the terms “admitting diagnosis” vs. “principal diagnosis.”
- It is the diagnosis established after study to be responsible for the admission (should be clarified as POA in physician query if not clearly evident on admission).
- Consider circumstances of the admission.

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Key Points: Selection of Principal Diagnosis

- Principal diagnosis is the condition determined to be the chiefly responsible for occasioning the inpatient stay, established **after study**.
- Principal diagnosis must be clearly present on admission but might not be stated as a diagnosis on admission (may need to be queried for POA status if unclear).
- Principal diagnosis always considers the circumstances surrounding the admission.
- Principal diagnosis must be a condition that requires inpatient care (think “acute”).
- It *may* or *may not* be the same as the emergency room diagnosis, primary diagnosis, discharge diagnosis, or admitting diagnosis.
- It *may* or *may not* be the most resource intensive condition of the admission.

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Key Points: Selection of Principal Diagnosis

- Ideally, it should be noted as a diagnosis in the discharge summary or hospital course summary, but this does not always happen, and does not exclude a reported condition from being chief reason for admission.
- It is the first listed diagnosis in sequencing reported codes.
- Be aware of all coding conventions, sequencing rules, and chapter specific guidelines!!
- Sequencing can significantly impact reimbursement. Think critically!
- If there is a question in the coder's mind of any type: POA status, specificity, type, clinical criteria, etc., QUERY, QUERY, QUERY!!

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Section II Guidelines

Section II. Selection of Principal Diagnosis
- A. Codes for symptoms, signs, and ill-defined conditions
- B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.
- C. Two or more diagnoses that equally meet the definition for principal diagnosis
- D. Two or more comparative or contrasting conditions
- E. A symptom(s) followed by contrasting/comparative diagnoses
- F. Original treatment plan not carried out
- G. Complications of surgery and other medical care
- H. Uncertain Diagnosis
- I. Admission from Observation Unit
  - 1. Admission Following Medical Observation
  - 2. Admission Following Post-Operative Observation
- J. Admission from Outpatient Surgery
- K. Admissions/Encounters for Rehabilitation

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Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established. (Chapter 18: codes R00.0 - R99)

Guideline II.A. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes **when a related definitive diagnosis has not been established** (confirmed) by the provider.

Use of Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms (or unspecified codes) are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

EXAMPLE: Patient presents to the hospital with chest pain (R07.9). He is admitted with suspected NSTEMI. A full cardiac, infectious, GI workup is done as well as chest imaging. After study, no etiology is found, and he is discharged in stable condition. In this case R07.9 is an acceptable principal diagnosis. However, if a more definitive diagnosis is established for the chest pain, R07.9 is not an acceptable principal diagnosis.

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Section II. B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

Guideline

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

EXAMPLE

- *Patient presents with shortness of breath. Imaging confirms pneumonia and severe COPD. He is admitted and treated with IV steroids, IV antibiotics, nebulizers, oxygen, respiratory therapy, and discharged with oral antibiotics and Medrol dosepak. Diagnoses throughout the admission are pneumonia unspecified and COPD exacerbation or pneumonia superimposed on COPD exacerbation.*
- *These are inter-related diagnoses (J18.9 and J44.1) and either may be sequenced as principal diagnosis.*

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Section II. C. Two or more diagnoses that equally meet the definition for principal diagnosis.

Guideline

- In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

EXAMPLE

Patient presents with shortness of breath. Imaging confirms pleural effusion with probable pneumonia. He is admitted and treated with IV antibiotics for pneumonia with full infectious workup to determine type (blood/sputum cultures were gram-neg). A BNP and echo is performed which confirm acute systolic heart failure, and he is given IV Lasix. He is also on oxygen for both pneumonia and acute HF. Diagnoses throughout the admission are established as gram-neg pneumonia and acute systolic heart failure (no history of chronic HF). Gram-neg pneumonia and acute systolic heart failure are co-equal and either may be selected and reported as principal diagnosis.

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Section II. D. Two or more comparative or contrasting conditions.

Guideline

- In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed, and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

EXAMPLE

Patient presents with shortness of breath, cough, and leukocytosis, no known hx. Imaging suggests pneumonia vs. tuberculosis. Patient is placed in isolation, treated with IVAB, serial imaging performed, and patient is initiated on tuberculosis meds with follow-up as outpatient with pulmonology. The physician documents at discharge, “CAP vs. atypical pneumonia vs. tuberculosis”. If there are no sequencing directions, either J18.9 or A15.0 may be selected and reported as principal diagnosis.

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Section II. F. Original treatment plan not carried out

Guideline

- Section II.F.: Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

EXAMPLE

- A very ill patient is admitted from a nursing facility and is found to be septic. The patient was hypotensive despite receiving IV fluid boluses, and the plan was to admit to ICU for antibiotics and pressors. However, the patient expires before the plan was carried out.
  - ➢ Sepsis is the appropriate principal diagnosis.
- Another scenario is the patient who leaves AMA before the treatment plan is carried out – the condition that originally occasioned the admission is still selected as principal diagnosis.

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Section II. G. Complications of surgery and other medical care

Guideline

- When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

EXAMPLE

A patient recently had a right total knee arthroplasty. He later developed a postoperative infection due to the hardware. In this case, the principal diagnosis would be classified to the T80-T88 series (T84.53XA Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter.) This code merely describes the infection. Only add an additional code for this condition if the T code does not fully capture the detail needed to describe the complication.

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Section II. H. Uncertain Diagnosis

Guideline

- If the diagnosis documented **at the time of discharge** is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the **diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach** that correspond most closely with the established diagnosis.

EXAMPLE

A patient is admitted with syncope and dehydration. There was a rise and fall of troponins. Workup was suggestive of demand ischemia. The provider reported “likely demand ischemia due to dehydration” throughout the record. In cardiology progress note on date of discharge, the physician documented “in setting of dehydration and hx CAD, probable demand ischemia.” Report code I24.8 (other forms of acute ischemic heart disease).

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Section II. I. 1. Admission from Observation Unit – Following Medical Observation

Guideline

- When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

EXAMPLE

An elderly patient is kept in observation because she has a fever, confusion, and UTI. She was going to be discharged back to nursing facility, but blood cultures returned positive, and she was admitted with bacteremia 2/2 UTI. After study she was found to have sepsis d/t UTI (physician queried/confirmed sepsis as POA). *In this case, coding conventions take precedence over PDx guidelines.* R78.81 is code from chapter 18; therefore, sepsis would be the principal diagnosis and not bacteremia. However, you are still guided by the condition established in observation to arrive at principal diagnosis.

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Section II. I. 2. Admission from Observation Unit – Following Post-Operative Observation

Guideline

- When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

EXAMPLE

A patient underwent repair of a knee fracture. In the PACU, he developed fever and chills and was admitted to observation. He was found to have infection as a surgical complication and was subsequently admitted to inpatient for treatment. In this case, a code from T80-T88 would be the chief reason for admission after study.

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Section II. J. Admission from Outpatient Surgery

Guideline

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission: *If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis. * If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis. *If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

EXAMPLE

A patient underwent repair of a knee fracture. After surgery, he developed significant hypotension that was unrelieved by fluids in PACU. He required inpatient admission to evaluate his hypotension, but hypotension resolved prior to initiating pressors. Shock was ruled out and physician query clarified that hypotension, while postoperative, was not a surgical complication. The reason for admission was documented as postoperative hypotension. A code from I95.- should be assigned. Post procedural hypotension (I95.81) could be the principal diagnosis here since this code does not describe hypotension as a complication; merely post procedural.

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Section II. K. Admissions/Encounters for Rehabilitation

1. When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed.
2. If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury.
3. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis.

- *See Section I.C.21.c.7, Factors influencing health states and contact with health services, Aftercare.*
- *See Section I.C.19.a for additional information about the use of 7th characters for injury codes.*

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Examples for Admission for Rehab

1. Is the purpose for admission **the condition for which the service was performed**? *Rehab after CVA:* for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first listed/principal diagnosis.
2. If a patient with severe degenerative **osteoarthritis** of the hip, underwent hip replacement and the **current encounter/admission is for rehabilitation**, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. (OA no longer present)
3. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur **fracture** (active treatment for INJURY), report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.

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Appendix 1: Present on Admission Reporting Guidelines

- Present on admission is defined as present at the time the order for inpatient admission occurs -- *conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.*

Y = present at the time of inpatient admission

N = not present at the time of inpatient admission

U = documentation is insufficient to determine if condition is present on admission

W = provider is unable to clinically determine whether condition was present on admission or not

- *There is no required timeframe as to when a provider must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. This does not mean the condition was not POA!*
- If at the time of code assignment, the documentation is unclear as to whether a condition was POA or not, it is appropriate to **query the provider for clarification**.

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- Remember that there are many steps to accurately code the principal diagnosis!
- Be guided by the UHDDS definition of principal diagnosis.
- Consider ALL components: Section IA Conventions, Section IB General coding guidelines, and Section IC Chapter specific GLs in addition to Section II which gives guidelines for principal diagnosis. Be familiar with "Present on Admission Coding Guidelines".

- DON'T FORGET TO QUERY FOR AMIBIGUOUS, CONFLICTING, UNCLEAR DOCUMENTATION INCLUDING POA STATUS!

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Thank you!

This concludes the presentation. Thank you for your time and attention!

Sara & Crysta

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