WELCOME TO CODING ROUND TABLE WEBINAR 135: Selection of Principal Diagnosis

The webinar will begin shortly

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Round Table 135

Selection of Principal Diagnosis

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Principal Diagnosis

Principal Diagnosis Selection

- The principal diagnosis is defined as the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care

"After study" examples:

1. The patient presented to the ED with painful arthritic pain in her knee. The patient was noted to have tachycardia and EKG showed AFIB with RVR.   The patient admitted to telemetry. The patient required IV antiarrhythmics for rate control. Pain was also managed with PO pain meds. She was instructed to follow-up with orthopedic surgeon for orthopedic management.

2. The patient presented with SOB. The patient was noted to ST elevations on EKG and was admitted to rule out MI. Final Diagnosis: AMI

3. Patient was admitted for elective knee replacement for OA. The patient experienced CP in pre-op holding and was ruled in for MI. The patient was transferred to cath lab and underwent emergent stenting.

4. Patient presents to ED with a fall of the curb after getting dizzy and has pain in her hip after the fall. The patient is noted to have a hip fracture and needs ORIF to repair the fracture. The patient was found to be dehydrated and given IV fluids in ED. She undergoes an uneventful ORIF and is transferred to a SNF for SAR.

What diagnosis was significant enough to warrant inpatient admission?

Principal Diagnosis Selection Guidelines

Section II. Selection of Principal Diagnosis

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."

In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines.

Example 1: Patient admitted with Diastolic CHF exacerbation and has a hx of HTN. Patient admitted to telemetry and Treated with IV lasix

Example 2: Patient admitted with Systolic CHF exacerbation and Hypertensive emergency. Patient admitted to telemetry and Treated with IV Lasix and IV antihypertensives

Example 3: Patient is admitted with acute HFrEF due to severe ischemic cardiomyopathy. Patient PMH includes HTN and CKD. Patient admitted to telemetry and Treated with IV Lasix

What are possible Principal diagnosis options for these scenarios?

Coding conventions, Tabular List and Alphabetic Index

What are possible Principal diagnosis options for these scenarios?

Example 1: Patient admitted with Diastolic CHF exacerbation and has a hx of HTN. Patient admitted to telemetry and Treated with IV Lasix
Possible Principal Diagnosis:
I11.0 Hypertensive heart disease with heart failure
~~I50.33 Acute on chronic diastolic (congestive) heart failure.~~ This is not a possible PDx per sequencing rules , so we can not use as the PDx

Example 2: Patient admitted with Systolic CHF exacerbation and Hypertensive emergency. Patient admitted to telemetry and Treated with IV Lasix and IV antihypertensives

Possible Principal Diagnosis:
I110 Hypertensive heart disease with heart failure DRG 293 RW ..6526
I16.1 Hypertensive emergency DRG 304 RW 1.0956
~~I50.23 Acute on chronic systolic (congestive) heart failure~~ This is not a possible PDx per sequencing rules , so we we have I110 and I16.1 for possible PDx options

Example 3: Patient is admitted with acute HFrEF secondary to severe ischemic cardiomyopathy. Patient PMH includes HTN and CKD. Patient admitted to telemetry and Treated with IV Lasix
Possible Principal Diagnosis:
I50.21 Acute systolic (congestive) heart failure This is our only option for PDx assignment as the CHF was specifically stated to be due to ICM so the link was broken between CHF and HTN. This is the only possible PDx assignment ~~I25.5 Ischemic cardiomyopathy~~ This is not an option for PDx as it was not the reason for admission and did not require specific treatment during the stay
~~I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease~~
~~N18.9 Chronic kidney disease, unspecified~~

Principal Diagnosis Selection Guidelines

Codes for symptoms, signs, and ill-defined conditions

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.

Example 1:

Patient is admitted with dysphagia and FTT which was thought to be due to his known Base of tongue cancer. The patient will require a peg tube, teaching, and nutritional consult for TF's for impending malnutrition because he is unable to eat at the present time. The patient also received scheduled radiation while in the hospital.

Possible Principal Diagnosis:

- ~~R13.10 Dysphagia, unspecified~~ This would not be a valid PDx as it is a code from Chapter 18 and related to a definitive diagnosis of BOT cancer.
- C01 Malignant neoplasm of base of tongue

Principal Diagnosis Selection Guidelines

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

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 1:
Patient admitted from ED with SOB, Leukocytosis, tachycardia, wheezing and LLL infiltrate on x-ray. After study the patient to have COPD exacerbation and Pneumonia. Treatment consisted of O2, nebulizers, IV steroids, and IV antibiotics.

Possible Principal Diagnosis:
J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation DRG 190, RW 1.1239
J18.9 Pneumonia, unspecified organism DRG 194 RW .863
J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection DRG 190 RW 1.1239

Principal Diagnosis Selection Guidelines

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

Example 2:

Patient admitted from ED with SOB, Leukocytosis, tachycardia, wheezing and LLL infiltrate on x-ray. Patient oxygen saturations were in the low 70's and started on BIPAP. The patient was admitted for of Acute respiratory Failure due to COPD exacerbation and Pneumonia. Treatment consisted, nebulizers, IV steroids, and IV antibiotics. The patient required BIPAP and was weaned to oxygen during the hospitalization. The patient was set up with home oxygen on discharge.

Possible Principal Diagnosis:

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation DRG 190, RW 1.1239

J18.9 Pneumonia, unspecified organism DRG 193 RW 1.3107

J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection DRG 190 RW 1.1239

J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia DRG 189 RW 1.2248

Principal Diagnosis Selection Guidelines

Acute respiratory failure as principal diagnosis

A code from subcategory J96.0, Acute respiratory failure, or subcategory J96.2, Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. **Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II, C.) may be applied in these situations**. If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification

Principal Diagnosis Selection Guidelines

Two or more diagnoses that equally meet the definition for principal diagnosis

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 1: An 84-year-old patient presented with s/p syncope and found to have a LT hip fracture from the fall that required surgical management. The patient syncope was thought to be related to dehydration from a recent bout of viral gastroenteritis. The patient was treated with IV fluids while clearing the patient for surgery. Once the patient was clear for the surgery the patient underwent a hip replacement. PT/OT recommended skilled rehab and the patient was discharged to a SNF for rehab.

Possible Principal Diagnosis:

S72002A Fracture of unspecified part of neck of left femur, initial encounter for closed fracture

~~E860 Dehydration~~

Based on the thrust of treatment the dehydration would not meet the definition of the principal diagnosis. The only option is the hip fracture.

Principal Diagnosis Selection Guidelines

Two or more diagnoses that equally meet the definition for principal diagnosis

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 2: The patient admitted with Afib with RVR rate that resulted in acute diastolic heart failure. The was treated with IV antiarrthymics and IV Lasix. The patient was also started on PO antibiotics for a UTI noted on urinalysis. On further questioning the patient did note mild burning on urination.

Possible DRG options:
I48.91 Unspecified atrial fibrillation DRG 308 RW 1.1993
I50.21 Acute systolic (congestive) heart failure DRG 292 RW .8951

AFIB and CHF are both viable options for PDx. Although, one caused the other does not mean either can't be used as the PDx. There are no instructional notes or sequencing rules for this specific scenario. Both required medical management and inpatient treatment. Based on Principal Diagnosis criteria they both were the reason for admission and required equal treatment. The UTI did not require inpatient care so it is not a viable option for PDx.

Principal Diagnosis Selection Guidelines

Two or more diagnoses that equally meet the definition for principal diagnosis

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 2a: The patient admitted with Afib with RVR rate that resulted in acute diastolic heart failure, Trops were elevated, Ruled out MI. After study, It was thought the patient had a Type 2 MI due to rapid afib and acute pulmonary edema due to heart failure. The patient had a stress test within the last year with no evidence of ischemia. The patient was treated with IV antiarrthymics and IV Lasix. The patient was also started on PO antibiotics for a UTI noted on urinalysis. On further questioning the patient did note mild burning on urination.

Possible DRG options:

I48.91 Unspecified atrial fibrillation DRG 280, RW 1.62

I50.21 Acute systolic (congestive) heart failure DRG 281 RW .9321

~~I21.A1 Myocardial infarction type 2~~ Based on sequencing rules Type 2 MI is not a viable option for the PDx

AFIB and CHF are both viable options for PDx. Although, one caused the other does not mean either can't be used as the PDx. There are no instructional notes or sequencing rules for this specific this scenario. Based on Principal Diagnosis criteria they both were the reason for admission and required equal treatment. The UTI did not require inpatient care so it is not a viable option for PDx. In addition, based on tabular and index acute pulmonary edema would not be assigned in addition to the heart failure code.

Principal Diagnosis Selection Guidelines

Two or more comparative or contrasting condition

- 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.
- **A symptom(s) followed by contrasting/comparative diagnoses**

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014

Example:
A 65 year old patient was admitted with change in mental status and falls. The patient has a PMH of epilepsy. A neuro consult for AED managmenet was ordered as well as blood and metabolic panels, blood and urine cultures, ammonia and AED drug levels. The patient was placed on fall and delirium precautions, telemetry (as AED's can cause AED induced arrythmia's), PT/OT. Patient's lacosamide level found to be supratherapeutic at15.9; After study it was thought his presenting symptoms were due to Toxic metabolic encephalopathy due to supratherapeutic AED level or post-itcal encephalopathy due to break-through seizures, no evidence to suggest syncope. The patient's medications were adjusted, and the patient was monitored for seizure activity. The patient's mental status improved over the course of a couple days. In this context, patient could be exhibiting side effect from a lacosamide dose that is too high. In decreasing his lacosamide dose, we will need to balance it with the need to provide adequate anti-seizure coverage. Additionally, patient would benefit from ambulatory EEG if he continues to have falls that blur the line between breakthrough seizure and medication dose effect. The patient did not experience any seizures while in the hospital.

Possible Principal Diagnosis:
G92 Toxic encephalopathy DRG 093 RW .7813
G40.909 Epilepsy, unspecified, not intractable, without status epilepticus DRG 100 RW 1.8736

Other Guidelines

Original treatment plan not carried out

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

Complications of surgery and other medical care

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.

Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” “compatible with,” “consistent with,” 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.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Admission Following Medical Observation

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

Admission Following Post-Operative Observation

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."

Other Guidelines

Admission from Outpatient Surgery

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

Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, 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 or principal diagnosis.

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. 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. For example, 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. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, 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

Summary

- Follow all coding guidelines and instructional notes when assigning codes and selection of Principal Diagnosis
- Eliminate any possible options that do not meet criteria for Principal diagnosis
  - Just because it was POA does not mean that is appropriate to assign as the PDx
  - The first question is what was the diagnosis that occasioned the admission? This is the diagnosis which occasioned the need for the inpatient bed.
    - Consider thrust of treatment in your thought process
      - If multiple choices, what is the diagnosis that utilized the most resources?
        - Eliminate an options based on guidelines and instructional guidelines that would not be applicable
- Take note of all remaining principal diagnosis options
  - If there are multiple possible choices based on the circumstances of admission, thrust of treatment, and correct sequencing, then we can look to optimize

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