

The principles of principal diagnosis selection



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Recently I was reviewing a data sample investigating the root cause of DRG discrepancies between CDI and coding. More than half of the cases with a discrepancy were attributed to a difference in principal diagnosis selection.

One of the primary difficulties in achieving uniformity of code assignment is that, in some circumstances, selecting the principal diagnosis is believed to be up to the individual coder or CDI specialist. Let's take a closer look at the *Official Guidelines for Coding and Reporting* to understand whether this is really the case.

Section II.B

The *Guidelines* define the principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

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. In some instances, however, the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

We've all read these *Guidelines* at least once, but what do they really mean? When I've asked staff this question, they often summarize it as, “Both conditions were present on admission, so I can pick whichever one pays more.”

As a coder, I've always examined key words and phrases like “unless the therapy provided ... indicates otherwise.”

When I'm presented with two or more interrelated conditions potentially meeting the definition of a principal diagnosis, I always caution myself against immediately sequencing a particular condition first.

First, I ask myself if the therapy provided may indicate otherwise. The following questions help me make the decision:

- Was one condition treated with more therapies than the rest?
- Was one condition treated with a more invasive or resource-intensive therapy than the rest (continuous drip vs. intravenous medication versus oral medication, for example)?
- Was one condition treated with a therapy that represents an escalation of care (higher or more frequent dosage) vs. another condition being treated with a continuation of baseline therapy?

Section II.C

This section states: “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 guideline do not provide sequencing direction, any one of the diagnoses may be sequenced first.”

Once again, we are reminded to consider therapy provided as well as the diagnostic workup. We're also reminded that multiple diagnoses equally meeting principal diagnosis criteria will be an unusual occurrence. So now, in addition to the circumstances of the admission and the therapy provided, I ask myself whether the diagnostic workup may give me some sequencing direction. The following questions help me with this decision:

- Was one condition evaluated with more diagnostic tests than the rest?
- Was one condition evaluated with a more invasive or resource-intensive therapy than the rest (lab vs. radiology exam vs. endoscopic exam vs. surgical biopsy, for example)?

Section II.D

This section states: “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.”

Note that we’ve moved from unusual to rare. One of the reasons is the phrase “if no further determination can be made.” In most cases, one *can* make a further determination. CDI specialists and coders almost always have a way to gather the information they need through physician queries.

The best judge of the circumstances of admission is the physician or provider who admitted the patient. Similarly, the individual most qualified to determine which diagnosis should be principal is not the coder or CDI

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specialist, but the attending physician. If the attending doesn’t make it clear in the documentation, then it is critical that we ask.

I’ve received responses from physicians asking why such a query was necessary—after all, shouldn’t the principal diagnosis be chosen based on the diagnosis they listed first on the discharge summary? On the other hand, physicians have also sought me out and thanked me for issuing a query that demonstrated respect for their clinical judgment and medical decision-making.

As we know, these situations can go either way, or end up somewhere in between. However, CDI specialists and coders need to take every chance they get to provide

education and build rapport with physician stakeholders. We should not hesitate to take advantage of opportunities to make physicians better documenters and make ourselves better coders and CDI specialists.

Section II.H

This section states: “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.

This subsection of the *Guidelines* can also lend itself to misinterpretation or oversimplification. When I was a new coder, I remembered this one as, “Uncertain diagnoses are coded as confirmed on inpatients.” This is mostly right, but I skipped over the words “at the time of discharge” in my efforts to prove myself a proficient coder. It wasn’t until I was on the opposite side of an auditor’s findings that this concept became ingrained in my coding assessments forever.

If a patient is admitted with an uncertain diagnosis, or you see one pop up in subsequent progress notes, make sure it’s carried forward and documented as such at the time of discharge.

If it’s not, then the coder needs to issue a query to confirm that the diagnosis is still present at the time of discharge, or it might not be coded at all. I’ve also seen uncertain conditions coded even when they likely should not have been because they weren’t documented at time of discharge.

If it looks like an uncertain condition has been definitively ruled out, it’s good practice for it to be explicitly documented that way.

Even veteran coders and CDI professionals get complacent, thinking they’ve obtained a full understanding of principal diagnosis assignment.

A little review now and then, however, can reveal further nuances of this sometimes-tricky task and identify additional query opportunities for more accurate coding. 🌟

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