**Do both conditions truly meet the definition of principal diagnosis?**

The ICD-9-CM guidelines state that it’s unusual for two or more diagnoses to meet the definition of principal diagnosis. However, coders know this isn’t exactly true, as the scenario tends to occur frequently.

Pneumonia and heart failure is a common combination with which patients present to the hospital, says **William E. Haik, MD, FCCP, CDIP,** practicing pulmonologist and director of DRG Review, Inc. in Fort Walton Beach, Fla. “When you have pneumonia, it causes the pressure inside the lungs to increase, which sometimes causes the heart to fail,” he says.

Another example involves the combination of atrial fibrillation with rapid ventricular response and congestive heart failure, says Haik.

The question that coders must ask themselves is whether both conditions *truly* meet the definition of principal diagnosis. If they do—and no other sequencing rules or coding conventions take precedence—they can sequence either condition as the principal diagnosis.

The *ICD-9-CM Official Guidelines for Coding and Reporting* state the following:

“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.”

For example, a patient presents with acute Staphylococcal pneumonia and acute systolic heart failure. Both are present on admission. The physician treats both conditions with IV medications and lists both in the discharge summary. No guidelines provide sequencing direction.

“Regardless of the order in which they’re documented in the discharge summary, the hospital has the right to sequence either condition as the principal diagnosis,” says Haik.

In general, most hospitals sequence the condition that yields the higher-weighted DRG; however, doing so requires careful attention to details in the medical record, says Haik.

“It’s a difficult issue. It often comes down to a clinical determination,” says **Donna Didier, MEd, RHIA, CCS,** director of coding compliance at TrustHCS in Springfield, Mo. “If it’s obviously a tossup, then you can sequence either as the principal diagnosis. However, the Recovery Auditors [RA] are looking for findings. The record needs to be iron clad. If it’s not clear as to whether both conditions equally meet the definition, then coders should really have clinical back-up in the form of a query.”

Haik agrees. He says RAs often deny claims because documentation doesn’t clearly indicate whether both conditions clearly meet the definition of principal diagnosis or because one condition is an incidental finding—and not the reason for the admission. The decision is often subjective, which is why it’s important to ensure documentation accuracy, he adds.

Consider the following tips to ensure compliance:

**Tip #1: Know the definition of principal diagnosis.** The Uniform Hospital Discharge Data Set (UHDDS) defines 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.”

Applying the definition of principal diagnosis can sometimes parse out the condition that is truly the principal diagnosis, says Haik. For example, a patient presents with pulmonary edema. After study, a physician determines the patient has acute systolic heart failure. Thus, the acute systolic heart failure is chiefly responsible for the admission.

However, the definition is challenging. For example, a patient presents with encephalopathy. After study, a physician determines the patient has hepatic encephalopathy related to cirrhosis of the liver.

“Even though cirrhosis of the liver was found after study, it’s not an *acute* condition that required the patient’s hospitalization,” says Haik. “The hepatic encephalopathy would be the principal diagnosis.” See *Coding Clinic*, First Quarter 2002, p. 3 for more information.

Sometimes it’s helpful to distinguish between what brings the patient to the ED versus what condition—after study—actually prompts the change in level of care to inpatient status, says Didier. For example, if a patient presents with chest pain that a physician determines is due to an evolving myocardial infarction (MI), code the MI as the principal diagnosis. Likewise, if a patient presents with acute onset of gastrointestinal bleeding and anemia that a physician later determines is due to a bleeding gastric ulcer, report the gastric ulcer with hemorrhage as the principal diagnosis.

**Tip #2: Determine whether both conditions are POA.** Physicians may not be able to diagnose on admission every condition with which a patient presents. However, symptoms of the condition that is ultimately assigned as the principal diagnosis must have been present on admission, says Didier.

Sepsis *diagnosed* during the hospital stay is challenging for coders when it occurs simultaneously with other conditions that are POA. It’s something that RAs are targeting, says Didier, who previously worked for an RA contractor. It’s often unclear whether the sepsis was actually POA based on signs and symptoms, she says. Physician documentation and queries are important in terms of overturning any RA denials, she adds.

In general, RAs are looking at the POA indicator as they verify the principal diagnosis. Conditions listed as the principal diagnosis with a POA of N raise a red flag, says Didier.

**Tip #3: Consider medical necessity and treatment provided.** Generally, coders should review all progress notes, consults, and procedures to determine the clinical focus of treatment. This will help determine the principal diagnosis. Treatment may actually be clearly slanted more toward one of the two diagnoses, says Didier.

Identify whether one condition could have been treated on an outpatient basis, says Haik. For example, a patient presents with heart failure and a UTI, both of which are present on admission. A physician treats the heart failure with IV diuretics and the UTI with oral antibiotics. The UTI could have been treated on an outpatient basis, thus it doesn’t meet the definition of principal diagnosis that necessitates inpatient care, he says.

Also distinguish between medical and surgical treatment. If a surgical intervention is performed, the condition for which the surgery is performed is typically the principal diagnosis because that condition is more resource-intensive, says Didier.

However, don’t assume this is always true. For example, an elderly patient is admitted for pneumonia. While in the hospital, he or she falls and incurs a hip fracture that requires surgery. Even though the surgery is performed for the hip fracture, the pneumonia is what actually prompts the admission, says Didier.

“At the time of admission, the hospital didn’t even know that it would be performing a hip surgery. So the two conditions are not coequal,” she says. However, this is one of many scenarios that trigger MS-DRGs 981-983 (extensive OR procedure unrelated to the principal diagnosis)—a group of DRGs to which RAs are paying close attention, she adds.

All principal diagnoses should meet medical necessity criteria for inpatient care, says **Cheryl Ericson, MS, RN, CCDS, CDIP,** CDI education director at HCPro, Inc., in Danvers, Mass. “A chronic condition often will not support inpatient care. It’s the exacerbation of the chronic condition that supports the inpatient admission or defines the circumstances of the admission,” she says.

**Tip #4: Review the entire record.** Don’t stop at the ED notes, says Didier. Follow the patient’s entire story in chronological order through the progress notes, consult notes, and discharge summary to determine what condition—after study—actually led to the admission.

Coders also shouldn’t rely entirely on the discharge summary, she adds.

“Physicians could incorrectly state the sequence of events or blur some of the facts,” she says. “In some cases, a physician who wasn’t involved in the case early on might dictate the discharge summary. If the sequence of events regarding admission appears to contradict other evidence regarding the causes of admission, that would be a red flag to get additional clarification.”

**Tip #5: Beware of unintended bias in physician documentation.** Haik says this can occur when a physician has a particular interest in a specialty, such as cardiology, and then documents a patient’s heart failure treatment more voluminously than the treatment he or she provides for the patient’s pneumonia. Even though the physician may have treated both equally, it could appear as though the heart failure is the reason for the admission based on the biased nature of the documentation, he adds.

**Tip #6: Don’t be afraid to query.** Queries not only ensure compliance, but they also help appeal RA denials, says Didier. Consider the following query format: “Of the final diagnoses [insert diagnoses], please indicate which one—after study—is most clearly the cause of the inpatient admission?”

**Tip #7: Reviewing coding guidelines and *Coding Clinic*.** Coders should always review the ICD-9-CM guidelines and *Coding Clinic* before sequencing the principal diagnosis, says Didier. Consider the following relevant *Coding Clinics* that explain scenarios in which patients have multiple diagnoses on admission:

* *Coding Clinic*, 3rd quarter 2012, p. 22 (acute respiratory failure and acute myocardial infarction)
* *Coding Clinic*, 3rd quarter 2009, p. 14 (drowning or acute respiratory failure)
* *Coding Clinic*, 1st quarter 2008, p. 18 (acute respiratory failure and aspiration pneumonia)

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