

Principal Diagnosis/First Listed Diagnosis ICD-10-CM

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Let's go back to basics as we prepare for the implementation of ICD-10-CM and review the Guidelines for designation of the Principal Diagnosis for inpatient use and First Listed Diagnosis for outpatient use.

Principal Diagnosis

The definition of the Principal Diagnosis as defined in the Uniform Hospital discharge Data Set (UHDDS): "That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Why is it important to make the correct selection of the Principal Diagnosis?

- It is significant in cost comparisons, in care analysis, and in utilization review.
- It is crucial for reimbursement because many third-party payers (including Medicare) base reimbursement primarily on principal diagnosis.

The principal diagnosis is not necessarily the same diagnosis as the admitting diagnosis, but it is the diagnosis found after workup, or even after surgery, that is determined to be the reason for admission.

The principal diagnosis may, or may not, be listed first in the physician's diagnostic statement, but sequencing in the diagnostic statement or discharge summary cannot be the determining factor in establishing the Principal Diagnosis. Always review the entire medical record to determine the condition that should be designated as the principal diagnosis.

A review of the **ICD-10-CM Official Guidelines for Coding and Reporting FY 2016** to reestablish our knowledge of the Principal Diagnosis is always helpful. The guidelines may be downloaded at:

<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf>

ICD-10-CM Official Guidelines for Coding and Reporting FY 2016

Section II. Selection of Principal Diagnosis

A. 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.

B. 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.

C. 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.

D. Two or more comparative or contrasting conditions

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.

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

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014

F. 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.

G. 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.

H. 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”, 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.

I. Admission from Observation Unit

1. 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.

2. 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.”

J. 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.

K. 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 no longer present, report the appropriate aftercare code 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.

First Listed Diagnosis

The first thing to keep in mind when coding outpatient cases is that the UHDDS definition of principal diagnosis does not apply to outpatient encounters.

In contrast to inpatient coding, there is no “after study” component involved in the selection of the First Listed Diagnosis because ambulatory care visits do not permit the continued evaluation ordinarily needed to meet UHDDS criteria.

If the physician does not identify a definite condition or problem at the conclusion of a visit or encounter, report the documented chief complaint as the reason for the encounter/visit.

And now a review of the **ICD-10-CM Official Guidelines for Coding and Reporting FY 2016** to reestablish our knowledge of the First Listed Diagnosis.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2016

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis. When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain diagnosis

Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

See Section I.C.21. Factors influencing health status and contact with health services, Screening