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Back to Basics:

Principal Diagnosis Selection

What is the definition of Principal Diagnosis?

Principal diagnosis is defined as the condition, *after study,* which occasioned the admission to the hospital, according to the *ICD-10-CM Official Guidelines for Coding and Reporting*.

We must remember that the principal diagnosis is not necessarily what brought the patient to the emergency room, but rather, what *occasioned the admission*.

The first step towards selecting the principal diagnosis is the beginning guideline at the initial part of Section II, which states that "the circumstances of inpatient admission always govern the selection of principal diagnosis." Reading the documentation revolving around the circumstances of admission is required and necessary:

--The reason for coming to the hospital, chief complaint, emergency room documentation

--H&P, initial signs and symptoms, initial assessment, and treatment plan

-- Initial tests ordered/results, and physician orders

The physician doesn't have to state the condition in the history and physical for the coder to be able to use it as the principal diagnosis. The presenting symptoms that necessitated admission must be linked to the final diagnosis by the physician. Coders cannot infer a cause-and-effect relationship. It is the condition

"after study" meaning we may not identify the definitive diagnosis until after the work up is complete.

Example

For example, a patient might present to the emergency room because he is dehydrated and is ***admitted for*** a urinary tract infection. UTI is the principal diagnosis in this instance.

Many people define it as the diagnosis that led the physician to decide to admit the patient. A good question for coders to ask when examining the record is: "What is the diagnosis that was significant enough to require inpatient care?"

Following the application of the "circumstances" and the "condition found after study," we then need to determine if there is other principal guidance to be followed. Certainly, the coding conventions in the ICD-10-CM, the Tabular List, and Alphabetic Index take precedence over these official coding guidelines.

What if more than one diagnoses meet the definition for Principal Diagnosis?

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.**

In most cases, the selection should then be the diagnosis that yields the highest-paying DRG.

Remember:

The UHDDS definition does NOT apply to outpatient encounters. When reviewing an inpatient record, review closely the treatment and plans to determine if the condition chiefly responsible for the admission was identified in the documentation. Sometimes the documentation will be not be specific and a query will be needed.

Happy Coding!

References

ICD-10-CM Official Guidelines for Coding and Reporting

AHA's *Coding Clinic,* Second Quarter 1984, pp. 9–10.

Uniform Hospital Discharge Data Set (UHDDS)

Section I.A., Conventions for the ICD-10-CM

Note: While the above education will assist the coder with accuracy each encounter may have specific variations of documentation for both diagnosis coding and/or procedure coding. Please note all encounters should be reviewed for possible query for clarification of **documentation in the health record for accurate code assignment.**