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## Back to the Basics: Coding Secondary Diagnosis

## What is the definition of Secondary/Additional Diagnosis?

- **Answer:** The UHDDS defines Additional diagnoses is, "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay."
- **Secondary Diagnosis:** In the CMS Official Guidelines for Coding and Reporting (OCG), "Other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring 1 or more of the following:
  - Evaluation
  - Treatment
  - Diagnostic procedure
  - Increased nursing care or monitoring
  - Extended length of stay

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- Coders must adhere to established guidance provided in the Uniform Hospital Discharge Data Set (UHDDS), when assigning secondary diagnosis codes.
- ICD-10 guidelines state that the entire medical record should be thoroughly reviewed to determine the specific reason for the encounter and the conditions treated.
- Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded, per Coding Clinic.

- **Some Key Consideration before coding Secondary Diagnosis:**
  - Physician's documentation should support assignment of the diagnosis

- Chronic conditions that are not addressed at the time of the encounter may be coded if the condition is active and affects overall patient care treatment or management.
- ICD-10 Guidelines state- "Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. **Do not code conditions that were previously treated and no longer exist.**
- History Codes may also be used as secondary codes if the historical condition has an impact on current care or influences treatment". The existence of these historical conditions increases the complexity of the patient.
- Abnormal findings :(laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to query the provider whether the abnormal finding should be added.
    - **Remember:** This directive is unique to Inpatient Coding. Coding practices in the outpatient setting differ for coding encounters for diagnostic tests that have been interpreted by a provider.
- 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", 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 short-term, acute, long-term care and psychiatric hospitals.

*Happy Coding!*

## References


- ICD-10-CM Official Guidelines for Coding and Reporting
- Uniform Hospital Discharge Data Set (UHDDS)
- Coding Clinic, 1st Quarter, 2005 Guidelines for Reporting Additional Diagnoses


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.**