Chapter 6
Coding and DRG Assignment

All coders must be ready to make decisions. The ICD-9-CM codebook contains approximately 13,000 diagnostic terms, but the Alphabetic Index recognizes more than 120,000 such terms. Additionally, physicians use thousands of terms not included in the Alphabetic Index and the coder must decide how to translate them into numeric designations. Although some coding discrepancies will inevitably occur, errors can be kept to a minimum if coders adhere to recommendations and guidelines found in American Health Information Management Association’s (AHIMA’s) Standards of Ethical Coding (AHIMA HOD 2008) and the practice brief entitled “Developing a Coding Compliance Policy Document” (Bielby et al. 2010). Some of those recommendations include the following:

- Use the complete health record as the coding source document.
- Employ qualified coding professionals with ongoing education and training in coding systems.
- Develop written coding policies that conform to the Uniform Hospital Discharge Data Set (UHDDS) definitions and the Cooperating Parties’ official coding guidelines.
- Establish quality control procedures to monitor the consistency and completeness of code assignment.

Finally, persons who assign and report codes should always remember that it is unethical to manipulate codes to maximize reimbursement in ways that do not conform to the UHDDS definitions or guidelines.

The ability to review a health record and accurately assign the appropriate ICD-9-CM codes is a skill developed over an extended period of time. To become an expert at coding, one must have an understanding of disease processes and treatment. For accuracy and compliance in coding, the coder must rely on the documentation provided by physicians involved with the care of the patient, including both the attending physician and any consultants he or she deems necessary to assist with patient care. This chapter discusses the basic parts of a health record, what the coder should look for in each part, and the steps in a record review that coders should follow to determine principal diagnosis.
Circumstances of Admission

The guidelines indicate that the circumstances of inpatient admission always govern the selection of the principal diagnosis. The circumstances of the admission are determined by reviewing the documentation contained in the health record.

The health record entries made at the time of admission should be reviewed carefully to identify why the patient was admitted. For patients admitted through the emergency department, the coder should identify the symptoms, findings, and/or diagnoses recorded in the emergency department record. Often the emergency department record will clearly identify the diagnosis necessitating admission. In other health records, however, the documentation may not be so clear and it may be necessary to review additional sources of information, such as:

- The admitting diagnosis listed on the face sheet
- The physician’s conclusions recorded in the history and physical examination
- The patient’s chief complaint as recorded on the nursing assessment, history, and physical examination
- The initial and subsequent progress notes
- Reports by consultants who saw the patient soon after admission
- The initial orders to identify the focus of treatment. (Most hospitals require that the admission diagnosis be recorded as part of the admission order, although this diagnosis may be quite vague.)

Progress note documentation is especially relevant for patients admitted with symptoms or physical findings that require further study to identify underlying causes. In the progress notes, the physician records the results of studies being performed, assesses the patient’s status, and draws the conclusion when all studies are performed.

Data recorded at or near the time of admission are more useful in identifying the circumstances of the admission than the discharge summary or final progress notes because these documents contain information related to the patient’s condition at the time of discharge. Thus, the physician may focus on the most significant diagnosis in terms of implications for the patient’s health, medical care, and use of the hospital. If death occurs, the physician may record the cause of death instead of identifying why the patient was admitted.

In most instances, it is possible to identify the principal diagnosis with a high degree of certainty after carefully reviewing health record documentation. However, there may be problems with ambiguous, incomplete, or conflicting documentation. In such instances, documentation deficiencies should be queried, according to facility policy, with the physician or the appropriate medical staff committee.

Identifying the Sections of the Health Record

Every health record is composed of five basic sections:

1. An initial database
2. Consultations
3. Diagnostic tests
4. Therapeutic procedures
5. Daily documentation

**Initial Database**

The initial database consists of the emergency department record (if applicable) and the patient’s history and physical examination. This initial information will provide a key to the potential principal diagnosis.

**History and Physical Examination**

The history and the physical examination need to be reviewed for two types of information. The first type of information can influence identification of the principal diagnosis and includes the following:

- The chief complaint
- The history of present illness
- Current medications
- Presenting physical signs and symptoms

The second type of information can influence the number and types of additional diagnoses, which are considered secondary diagnoses. This information may include identification of potential complications to the principal diagnosis. For example, a review of the patient’s current medications may make it possible to identify stable conditions that are presently under treatment and that should be reported as secondary diagnoses, such as acute diastolic heart failure, acute exacerbation of chronic obstructive pulmonary disease (COPD), type I or type II diabetes, hypertension, or peptic ulcer disease. Any diagnosis identified in this review must be confirmed by physician documentation in the final diagnostic statement. If questions arise about whether a diagnosis should be reported, the physician should be consulted for confirmation.

Although not all-encompassing, the list in table 6.1 represents common medications associated with typical secondary diagnoses.

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<th>Table 6.1. Examples of common medications associated with secondary diagnoses</th>
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<td>Diagnoses</td>
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<td>Hypertension</td>
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<td>Congestive heart failure</td>
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Consultations

If the attending physician requests consultations from specialists, their reports should be reviewed for support of the potential principal diagnosis, as well as significant secondary diagnoses. In some hospitals, diagnoses that are identified and treated by consultants are added routinely to the final list of diagnoses. However, the attending physician retains control of the patient’s care throughout the hospital visit and is responsible for reviewing the documentation provided by the consulting physician(s) and assessing its significance for the patient. Hospital coding guidelines should address this issue. The attending physician reviews the reports provided by the consulting physician and assesses and documents the significance of the findings.

When a patient is admitted for surgery, a medical consultation report for “surgery clearance” may be present. Frequently, this type of consultation identifies significant medical conditions for which the patient is undergoing treatment that may influence the surgical outcome or length of stay (LOS). Such conditions should be added to the diagnostic statement when documented by the attending physician. When a condition is identified, but not documented, a query process should be started.

Diagnostic Tests

This section of the health record may help justify a principal diagnosis or support the coding of a secondary diagnosis. For example, in the case of a patient with suspected sepsis, a positive blood culture present on admission or within several hours after admission will usually support sepsis as a principal diagnosis, particularly when the record identifies the focus of treatment as such. Negative or inconclusive blood cultures, however, do not preclude a diagnosis of sepsis in a patient with clinical evidence of the condition.

Repeated monitoring of laboratory values or abnormal values followed by a treatment order may suggest the presence of a significant secondary diagnosis that also may be a complication or comorbidity. For example, repeated tests for potassium levels followed by orders for a potassium supplement would suggest hypokalemia as a secondary diagnosis, if verified by the attending physician. However, coders should always be cautious in reviewing diagnostic tests. Even though a value may be abnormal, an additional diagnosis should not be added unless the related condition is treated or meets the criteria for inclusion as a secondary diagnosis. In unclear cases, the coder is obligated to consult the attending physician. The ICD-9-CM Official Guidelines for Coding and Reporting (section III, B) explain:

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the attending physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the abnormal finding should be added (NCHS 2009, 94).

Any cultures of body fluids also should be reviewed because they may assist in identifying bacterial infections that would influence the patient’s treatment. When these diagnostic tests indicate that a secondary condition may be present, the coder should review the progress notes for the attending or consulting physician’s comments for documentation of possible additional diagnoses. (Refer to the discussion of progress in the section below on daily documentation.)
**Therapeutic Procedures**

As the treatment pattern begins to emerge, therapeutic procedures may be used to correct particular problems. These procedures may or may not influence MS-DRG assignment. For example, a case of angina with a cardiac catheterization and subsequent coronary artery bypass graft (CABG) procedure will be assigned to a different DRG than a case of angina with only a cardiac catheterization.

Therapeutic procedures may be performed in an operating room or at the patient’s bedside and still have an impact on the DRG assignment. For example, different DRGs would be assigned for the following two patients:

**Example:** Patient A is admitted with decubitus ulcers. The ulcers are conservatively treated with intravenous antibiotics, repeat scrubbing, and topical medications.

Patient B is admitted with the same diagnosis, but the ulcers are debrided with a scalpel at the bedside.

Procedures such as the sharp débridement of skin ulcers using a scalpel to “bleeding” tissue at the patient’s bedside require close review of the progress notes because that may be the only method of identifying that the procedure was performed. Of course, these procedures also may be performed in the operating room.

**Daily Documentation**

One of the most important sections of the health record, daily documentation, usually includes the physician and allied health progress notes, physician orders, flow sheets for critical care, ventilator support, and ancillary records.

The physician orders will help identify the focus of treatment and support selection of the principal diagnosis. Here, the coordination of care can be located. It is important to coordinate the review of diagnostic tests and consultations to appropriately identify not only the principal diagnosis, but also significant secondary conditions. This is the place to find the patient’s current medications for “stable” types of chronic problems that might still affect patient management in the current episode of care.

The progress notes provided by the physician and allied health team will document the patient’s response to treatments. Moreover, they serve as backup documentation for various diagnostic and therapeutic procedures until a dictated report is provided. The coder should review the notes carefully to determine whether LOS was affected by secondary diagnoses or whether a complication developed postoperatively. For example, it may be possible to identify a postoperative complication of urinary retention by noting whether the patient had to be recatheterized or whether he or she received diuretics to restart the passage of urine after surgery. The complication must be documented by the physician or the coder may query for the cause-and-effect relationship.

**Reviewing the Health Record**

Each section of the health record serves a separate purpose. When reviewed correctly by the clinical coding professional, the sections taken together will support or justify the principal diagnosis and any secondary conditions that might affect reimbursement. It is important to
remember that, in order to be coded, these conditions must be appropriately documented by the physician. When the documentation is incomplete, ambiguous, or conflicting, a physician query is in order. See appendix B for a sample physician query form.

A suggested sequence of review follows. The coder should:

1. Determine if an emergency department record is attached and, if so, review physician documentation and any comments from the ambulance report for pertinent information.
2. Review the admission orders to confirm any suspected principal diagnosis and/or to support the admitting diagnosis.
3. Read the history and physical examination to determine admitting diagnoses that may be categorized as the principal diagnosis and to identify potentially codeable secondary diagnoses.
4. Read the consultation reports from specialists that may further support or refute the potential principal diagnosis and/or potentially codeable secondary diagnoses.
5. Read all progress notes and develop a sense of the focus of treatment, progression of signs, and symptoms to diagnoses.
6. Verify any potential secondary diagnoses with laboratory, radiology, or other ancillary tests, progress notes, and physician orders and identify need to query.
7. Read the operative reports, pathology reports, discharge summary, and/or special procedures or reports to confirm primary and secondary diagnoses and procedures and identify need to query.
8. Identify the principal diagnosis and, when necessary, confirm appropriateness with the attending physician.
9. Develop a list of secondary diagnoses to be reported and, when needed, verify with the attending physician to ensure accuracy.
10. Code all relevant diagnoses following ethical coding standards and the UHDDS official guidelines.

**Querying the Physician**

As stated throughout this chapter, there are times when documentation is incomplete or insufficient to support the diagnoses found in the chart. It is for this reason that facilities should establish a physician query policy. Coders and physicians need to be familiar with the policy and procedures to ensure that this process works as smoothly as possible. The most common way of querying the physician is through the use of a query form.

**Query Forms**

Query forms should be developed and used with care and should only be used as tools to facilitate communication between coder and physician. The facility should develop a standardized form with input from both coders and physicians. Usually, the query form is not considered part of the official legal medical record. AHIMA recommends that facilities choosing to incorporate
the form into their medical record should do so only under guidance from legal counsel and the compliance department in order to avoid problems.

The coder should keep to factual/clinical information (clinical indicators) and should not “lead” the physician toward a particular answer. Questions asked should remain open-ended to allow the physician to improve documentation. The physician should be guided toward clarifying any discrepancies in the body of the documentation, rather than just replying on the query form. This can be accomplished through use of an addendum to the discharge summary or progress notes.

According to Sue Bowman, AHIMA’s director of coding policy and compliance, organizations should establish a process for “ensuring that the physician documents in the health record any clarification or additional information resulting from communication with coding staff. Communication tools between coding personnel and physicians, such as coding summary sheets, attestation forms, or coding clarification forms (e.g., physician query forms), should never be used as a substitute for appropriate physician documentation in the health record (Prophet 2002).”


The facility should ensure that its query policy follows Medicare, Joint Commission, and facility documentation guidelines, as well as official coding guidelines. Coders should be encouraged to query the physician when the documentation is unclear or ambiguous; however, coders should not use the process to diagnose or question the physician’s medical judgment.

Clinical Documentation Improvement Program

Over the years, many facilities have struggled over when to begin the coding process. Traditionally, the chart is coded after the patient’s encounter or episode of care is complete. If documentation is clear and complete, then the coder should have all the information needed to accurately assign codes to the patient’s diagnoses and procedures. However, if information is missing or ambiguous, obtaining answers to coding queries is difficult and time-consuming once the patient has been discharged and the clinician has moved on to treating other patients.

As Medicare and other payers look to improve patient care and provide more accurate payment based on the patient’s documented severity of illness, organizations are retooling their coding process.

One such alternative to the retrospective querying process is commonly known as a Clinical Documentation Improvement (CDI) program. Coders work together with nursing staff and/or case managers to help ensure that clinical documentation is sufficient to support the patient’s medical care. This process is designed to enhance patient care through better documentation. It also allows for a smoother coding process because any documentation issues are identified in real time instead of days or weeks after the patient has been treated.

Clinical documentation specialists (CDSs) are coding professionals and nurses who work on the patient floors or alongside the physicians in the clinic setting. Although some facilities may choose nursing staff for this position, coding professionals also are excellent candidates. It is imperative that the CDS has a mixture of coding and clinical knowledge and possesses the communication skills necessary to query physicians and other clinicians when questions arise regarding the medical documentation. In the physician clinic setting, the CDS may also review inpatient chart documentation to facilitate correct coding for the physician’s professional services. This task also requires a strong working relationship between the hospital and physician practice (Scott 2008).
Present on Admission

Portions of this section are adapted from Present on Admission (Garrett 2007).

With the implementation of the Uniform Bill-04 (UB-04) billing form in 2007, an additional field was added to allow for indication of whether each diagnosis was present on admission (POA). Reasons for the addition of the POA indicator are included in the MEDPAC Report to the Congress (2005, 191):

Currently, a diagnosis recorded on the discharge summary that may have been present on admission cannot be distinguished from one that developed during the hospital stay. This additional information would significantly enhance the ability to identify which complications are avoidable. It would improve risk-adjustment of mortality and complications measures. Several quality organizations have supported this concept, and it should not significantly increase hospital burden.

The POA indicator is required to be addressed on all short-term inpatient admission claims. It is designed to identify conditions that are diagnosed prior to admission and conditions diagnosed during admission that were clearly present but not diagnosed until after admission occurred. Any condition that was present at the time the order for inpatient admission occurs, including conditions that develop during an outpatient encounter, such as in an emergency department, during observation, or in outpatient surgery, are considered as POA.

The POA indicator is assigned to the principal and secondary diagnoses and the external cause of injury codes except where exempt from reporting. Appendix I was added to the Official Coding Guidelines to define and explain proper usage of the POA indicator (NCHS 2009, 100–112). According to these guidelines, POA is not intended to replace any coding guidelines in the main body of ICD-9-CM Official Guidelines for Coding and Reporting and is not to provide guidance on when a condition should be coded.

Short-term acute care hospitals began reporting the POA for each diagnosis code on October 1, 2007, by using one of four indicators:

1. Y = Yes, the condition was POA
2. N = No, the condition was not POA
3. W = Clinically undetermined (the provider is unable to clinically determine if the condition was POA)
4. U = Unknown. This indicator shows that the chart documentation is insufficient to determine whether or not the condition was POA. The U indicator should not be used much because it should serve to prompt the coder to query the physician for additional information.

To further facilities down the path of pay for performance (P4P), CMS was required by law to select at least two conditions that will be excluded from the payment calculations if they are acquired during the hospitalization. These hospital-acquired conditions (HACs) will result in a decrease in reimbursement to hospitals if the condition is a complication or comorbidity (CC) or major complication or comorbidity (MCC) and occurred after the patient was admitted to the hospital.

Section 1886(d)(4)(D) of the Act addresses certain hospital-acquired conditions (HACs), including infections. By October 1, 2007, the Secretary was required to select, in consultation with the Centers for Disease Control [and Prevention] (CDC), at least two conditions that: (a)
are high cost, high volume, or both; (b) are assigned to a higher paying MS-DRG when present as a secondary diagnosis (that is, conditions under the MS-DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence-based guidelines. The list of conditions can be revised, again in consultation with CDC, from time to time as long as the list contains at least two conditions (CMS 2009, 43782).

The following criteria were applied to select the final list of conditions:

1. **Coding:** Easily identified by unique ICD-9-CM codes
2. **Burden:** High cost, high volume, or both
3. **Prevention guidelines:** Could reasonably have been prevented through the application of evidence-based guidelines
4. **CC/MCC:** Assignment of a case to an MS-DRG that has a higher payment when the code is present as a CC or MCC
5. **Considerations:** How condition meets statutory criteria in light of potential difficulties that CMS would face if the condition were selected

Beginning in FY 2009 (Oct. 1, 2008), cases with the following conditions were not paid at a higher rate unless the conditions were POA:

- Catheter-associated urinary tract infection
- Pressure ulcers
- Object left in body during surgery
- Air embolism
- Delivery of ABO-incompatible blood products
- Vascular catheter-associated infections
- Mediastinitis after CABG surgery
- Falls and fractures, dislocations, intracranial and crushing injury, and burns

Although these CMS requirements have shifted the focus of attention to assigning these indicators to Medicare claims, it is important to note that the POA requirement is described in the Official Coding Guidelines, as stated earlier. POA is not just to be addressed for Medicare patients only. The POA indicator should be added to all claims for all diagnoses that meet the criteria as established in the Official Coding Guidelines.

### Other Guidelines for Reporting Diagnoses

When patients have multiple diagnoses, it is sometimes difficult for the coding professional to find clear evidence of the one that best meets the definition of principal diagnosis. When questions arise, the Official Coding Guidelines provide examples and instructions to assist in the appropriate selection of principal diagnosis. There are also specific instructions found to assist the coding professional in assignment of secondary codes.
Chapter 6

**Symptoms, Signs, and Ill-Defined Conditions**

Manifestations are characteristic signs or symptoms of an illness. Signs and symptoms that pertain to a given diagnosis and primarily affect a specific body system are assigned to categories in chapters 1 through 15 of the Tabular List in the ICD-9-CM codebook.

**Examples:**

- 276.2 Acidosis
- 578.0 Hematemesis

ICD-9-CM chapter 16 (categories 780–799) includes symptoms and signs that point to two or more diseases or two or more systems of the body, abnormal results of laboratory or other investigative procedures, and ill-defined conditions in which no diagnosis classifiable elsewhere is recorded. These codes should not be used to identify a principal diagnosis when a related definitive diagnosis is available.

A sign or symptom code may be used instead of a diagnosis code and may possibly constitute the principal diagnosis in the following instances:

- No more specific diagnosis can be made at the time of discharge or outpatient encounter.
- The transient nature of the signs and symptoms makes it impossible to identify the cause.
- The patient does not return or expires before evaluation permits complete workup.
- The patient is referred elsewhere before a diagnosis is made.
- A more precise diagnosis is unavailable.
- The adverse reaction a patient experiences to a drug is a symptom code.
- The symptom or sign is a sequela related to a late effect of an illness or injury.

When the cause of a symptom or sign is stated in the diagnosis, the coder should report the code identifying the cause. An additional code may be assigned to further identify the symptom or sign when it represents an important problem in medical care on which data may need to be tracked.

**Example:**

- Brain metastasis, 198.3
- Coma, 780.01

Comatose patients require extra care, so this symptom is reported in addition to the cause.

**Example:**

- Leukocytosis, nausea, and vomiting due to acute appendicitis

Only the acute appendicitis would be coded (540.9) because the symptoms specified are signs and symptoms of appendicitis. There is no need to maintain data on these signs and symptoms unless they persist following surgery.

In some circumstances, the symptom may be the sole reason for admission. When a patient is admitted for the purpose of treating the symptom, and there is no treatment or further evaluation of the underlying disease, the symptom can be designated as the principal diagnosis. Often the symptom represents an acute problem caused by a long-standing chronic condition that
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does not justify hospital admission. In all cases, sequencing of the diagnoses depends on the circumstances of the current admission or encounter.

Example: Back pain management due to chronic lumbosacral strain
Because the treatment is specifically for back pain, it would be coded as the principal diagnosis, even though the pain is a symptom of a chronic condition.

Reporting of Other (Additional) Diagnoses

A joint effort between the attending physician and coding professional is essential to achieve complete and accurate documentation, code assignment, and diagnosis and procedure reporting. To assist both the physician and coder, the Cooperating Parties developed and approved specific guidelines for identifying which diagnoses to report in addition to the principal diagnosis. Hospitals may record other diagnoses, as needed, for internal data use.

UHDDS definitions are used by short-term acute care hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985 Federal Register (HHS 1985).

UHDDS item #II-b defines “other diagnoses” as (HHS 1985):

All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

General Rule

For reporting purposes, the definition of “other diagnoses” is interpreted as additional conditions that affect patient care by requiring any of the following:

- Evaluation
- Therapeutic treatment or diagnostic procedures
- Extended LOS
- Increased nursing care, increased monitoring, or both

The following guidelines are to be applied in designating other diagnoses when neither the Alphabetic Index nor the Tabular List in the ICD-9-CM codebook provides direction.

Previous Conditions

According to the ICD-9-CM Official Guidelines for Coding and Reporting:

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy (NCHS 2009, 94).

However, history codes (V10–V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment (NCHS 2009, 94).
Diagnoses Not Listed in the Final Diagnostic Statement

When the physician has documented what appears to be a current diagnosis in the body of the record but has not included it in the final diagnostic statement, the coding professional should ask the physician to add the current diagnosis. However, according to guidance found in Coding Clinic, coders are allowed to code diagnoses from the body of the record (AHA 2000, 17–18):

When the documentation in the medical record is clear and consistent, coders may assign and report codes. If there is evidence of a diagnosis within the medical record, and the coder is uncertain whether it is a valid diagnosis because the documentation is incomplete, vague, or contradictory, it is the coder’s responsibility to query the attending physician to determine if this diagnosis should be included in the final diagnostic statement. All diagnoses should be supported by physician documentation. Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding.

Conditions That Are an Integral Part of a Disease Process

Conditions that are an integral part of a disease process should not be assigned as additional codes.

Conditions That Are Not an Integral Part of a Disease Process

Additional conditions that may not be associated routinely with a disease process should be coded when present. For example, when a patient is admitted with chest pain, but it is found after study that the patient had referred chest pain due to gastroesophageal reflux disease (GERD), the chest pain would be coded separately to justify the tests performed to evaluate the cause of this symptom, such as electrocardiograms (EKGs) and troponin levels.

Abnormal Findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not assigned or reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the attending physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate for the coder to ask the physician whether the diagnosis should be added.

Angina

When a patient is admitted for another reason but is taking medication for angina, the angina is reportable as an additional diagnosis. It is considered to be under treatment even though the condition is stable and the patient has no episodes during the current stay. The condition is reportable if the physician includes angina in the diagnostic statement. The physician may state that the condition is compensated or stable.

Congestive Heart Failure

When a patient with a history of congestive heart failure (CHF) is admitted for another reason and is currently taking medication for CHF (such as Digoxin and Lasix with a potassium
supplement), the CHF should be reported. The patient would continue on the medications during the current stay even if no signs of cardiac decompensation are present. The physician may describe this type of CHF as compensated, stable, or history of CHF. It is still reportable as an additional diagnosis. The coding professional should also review the medical documentation to determine if the heart failure is specified as acute vs. chronic and diastolic, systolic, or both diastolic and systolic. This specificity will impact the selection of the correct coding assignment and the MS-DRG assignment impacting reimbursement because CHF no longer counts as a CC.

**Frequently Overlooked Diagnoses**

Coders should examine the entire health record carefully for conditions and statements that may indicate additional diagnoses. Remember that in order to code these conditions, they need to be documented by the physician or the potential diagnosis should be queried. The following list is an example of clues for diagnoses that are frequently overlooked in reporting:

- **Anemia**
  - Faintness, dizziness, pallor, fatigue, thirst, sweating, blood loss (for instance, ulcer, trauma, hematemesis, or melena)
  - Low hemoglobin or hematocrit level
  - Administration of iron or blood components
- **Cardiac arrhythmias (especially in patients with acute myocardial infarctions)**
  - Palpitations, near-syncope, pallor, nausea, weakness, lightheadedness, fatigue
  - EKG findings confirmed by a physician as clinically significant
  - Cardioversion, digitalis, verapamil therapy, beta- or calcium blockers, pacemaker insertion
- **Dehydration (especially in patients with gastroenteritis or those who are eating poorly)**
  - History of diarrhea or vomiting, dry mucous membranes, poor skin turgor, weakness
  - Elevated blood urea nitrogen (BUN) level, electrolyte imbalance
  - Force fluids, intravenous rehydration (for instance, greater than 125 cc/hr)
- **Urinary tract infection (especially in postoperative patients and those admitted from nursing homes)**
  - Dysuria, urinary urgency and frequency, flank pain or tenderness, possible fever, chills, and general malaise
  - White blood cells, red blood cells, and bacteria on urinalysis; urine culture positive for organism causing infection (colony count greater than 100,000)
  - Antibiotic therapy, force fluids
- **Heart failure (especially in patients with respiratory disease or other cardiac conditions)**
  - Dyspnea, orthopnea, peripheral edema, rales
  - Positive chest x-ray (pulmonary venous congestion)
  - Lasix, Digoxin, low-salt diet, oxygen administration
• Gastrointestinal bleeding (especially in patients with severe gastritis or those taking large quantities of anti-inflammatory drugs)
  — Fatigue, pallor, dizziness, hematemesis, or melena
  — Low hemoglobin/hematocrit level, stool positive for occult blood, endoscopy confirmation, upper and lower gastrointestinal series
  — Blood replacement, nasogastric tube, special diet, antacid prescribed

• Chronic obstructive pulmonary disease
  — Shortness of breath on exertion, dyspnea, chronic intermittent cough or wheezing
  — Positive chest x-ray, increased residual volume and decreased vital capacity on pulmonary function tests, abnormal blood gases, low theophylline levels
  — Treatment focuses on relieving symptoms and preventing exacerbations
  — Chest physiotherapy, bronchodilator, oxygen therapy, corticosteroids
  — Chronic condition vs. an (acute) exacerbation of the COPD

• Malnutrition (especially in patients admitted from nursing homes)
  — Low weight, lethargy
  — Poor appetite
  — Insertion of feeding tube, total parenteral nutrition, nutritional supplements

• Status or disabilities
  — Blindness, deafness, absence of limb, presence of colostomy requiring extra nursing time, pacemaker status, aortocoronary bypass status, transplant status (may require extra testing or increase the risk associated with other diseases and procedures)

Frequently Overlooked Procedures

Following is a list of tips for identifying procedures that are frequently overlooked by physicians and coders:

• **Excisional débridement:** The coder should look for pressure ulcers, diabetic foot ulcers, and/or cellulitis. Nursing and physical therapy notes also should be reviewed for documentation. Bedside procedures, such as excisional débridement, are frequently documented in the nursing notes. Moreover, physicians may perform this procedure during physical therapy. When this is the case, physical therapy notes should be reviewed to verify that the physician visited the patient during a session in the whirlpool and performed the débridement.

• **Adhesiolysis:** The coder should look for abdominal surgery on a patient with a history of previous abdominal procedures, hernia procedures on patients with a previous hernia procedure or a previous lower abdominal procedure, cholecystectomy procedures where the patient has a history of prior appendectomy, and/or a previous history of peritonitis or internal bleeding and ulceration. **Coding Clinic** requires documentation that the adhesiolysis was required in order to access the organ or site of the procedure.
• **Common bile duct exploration with cholecystectomy:** The coder should review the procedure dictation to find documentation that states the surgeon needed to explore the common bile duct for stones. This may be performed with open cholecystectomy procedures. An intraoperative cholangiogram is a diagnostic radiologic procedure to assess the bile ducts. Dye is injected into the bile ducts to assess for the presence of stones or other abnormalities. This is not the same as a common bile duct exploration; a common duct exploration can be performed open, transendoscopically via ERCP (endoscopic retrograde cholangiopancreatography) with endoscopic sphincterotomy, or laparoscopically, but it always requires an incision into the common bile duct to some extent.

• **Bone graft harvesting:** For certain spinal fusions or bone procedures for fracture non-unions, it may be necessary to harvest bone from one anatomic site for use in another. Frequently, the bone (or bone marrow) is harvested from the iliac crest. The bone graft harvesting is included with some ICD-9-CM codes, such as limb-lengthening procedures, but not with others. The coder must review the codebook carefully prior to assigning an additional code.

• **Repair of inadvertent lacerations:** The coder should review operative notes carefully to identify the repair of accidental lacerations. If the surgeon must repair the inadvertent tear, the additional code for the suture of the site of the tear should be added.

• **Pacemaker insertions:** The coder should review progress notes and emergency department notes for insertions of pacemakers. Insertion of both the device and the lead or leads is coded.

• **Mechanical ventilation:** The coder should review progress notes and emergency department notes to determine the start time of mechanical ventilation. Ventilator flow sheets usually accompany the health record of a patient on mechanical ventilation. In some facilities, coding professionals are responsible for calculating total hours of mechanical ventilation based on documentation in the patient’s record. Great care should be taken to follow ICD-9-CM instructions for counting both start time and stop time of mechanical ventilation.

• **Biopsies:** During the course of a major procedure, the surgeon may elect to take an unplanned biopsy of other structures. The coder should review the operative notes carefully to identify the additional procedure.

### Applying the Guidelines

The following case examples are designed to increase the understanding of, and ability to select, appropriate UHDDS principal and secondary diagnoses. The correct answers can be found at the end of the chapter.

#### Case 6.1

Patient A was admitted with shortness of breath and chest pain. He has a history of adenocarcinoma of the colon 5 years ago. At that time, he had a colonoscopy and biopsy with removal of malignant lesion, with no disease found in the resected colon. A chest x-ray revealed a large pleural effusion. A thoracentesis was performed to remove a large amount of fluid, after which the patient’s breathing and chest pain improved. Cytology revealed metastatic adenocarcinoma of the pleura. An oncology consultant examined the patient and thought that he was a candidate for
chemotherapy, initial treatment of 5-fluorouracil, methotrexate, and Cytoxan was given. The patient was discharged with a diagnosis of pleural effusion due to metastatic adenocarcinoma of the pleura.

**Answer:**
Principal Diagnosis: ______________________________________________________________
Secondary Diagnoses: ______________________________________________________________

**Case 6.2**

Patient B, an elderly female, was admitted from a nursing home with a history of poor appetite and marked weakness with lethargy for 2 days prior to admission. There was no history of diarrhea or vomiting. Mucous membranes were very dry and skin turgor was poor. The patient had no shortness of breath, chills, or fever. The nursing home BUN level was 65. Intravenous therapy was started for hydration and nutrition. With hydration, the BUN decreased to 30. The patient became more alert and responsive to stimuli, and began eating. She was discharged to the nursing home clinically stable with diagnoses of dehydration, mild malnutrition causing weakness, and elevated BUN.

**Answer:**
Principal Diagnosis: ______________________________________________________________
Secondary Diagnoses: ______________________________________________________________

**Case 6.3**

Patient C is admitted with acute bronchopneumonia unresponsive to outpatient treatment. She has been on chemotherapy for previously resected breast carcinoma of the upper-inner quadrant. She has been on an 8-week regimen that started after her breast surgery. In addition, she has axillary and lung metastases. The pneumonia responded slowly to intravenous antibiotic therapy, but when her lungs cleared, the patient was discharged to resume antineoplastic therapy in 1 week.

**Answer:**
Principal Diagnosis: ______________________________________________________________
Secondary Diagnoses: ______________________________________________________________

**Summary**

The practice of clinical coding requires a unique blend of coding and clinical knowledge, skill, and judgment. Responsible coding professionals are able to read and interpret documentation in health records, clarify questions with physicians, and apply official coding guidelines accurately, consistently, and completely in assigning principal and secondary diagnoses, procedures, and other applicable codes. The expert coder is one who is aware of and respects the ethical issues in coding compliance.

**References**

AHIMA House of Delegates. 2008 (Sept.). AHIMA Standards of Ethical Coding.


Answers to Case Studies

Case 6.1

Principal Diagnosis: 197.2, Secondary malignant neoplasm of pleura. After study, the principal diagnosis of malignant pleural effusion was found to have been the cause of the shortness of breath and chest pain. These symptoms are not coded because a definitive diagnosis was found.

Secondary Diagnoses: V10.05, History of colon cancer. The history of colon cancer is used because there is documentation that the colon cancer was resected and without evidence of recurrence.

Case 6.2

Principal Diagnosis: 276.51, Dehydration. The principal diagnosis is dehydration because, after study, that is what was identified as the underlying cause of the weakness, lethargy, and increased BUN. Her appetite improved when she became more alert.

Secondary Diagnoses: 263.1, Malnutrition of mild degree should be reported as a secondary diagnosis.

Case 6.3

Principal Diagnosis: 485, Bronchopneumonia, organism unspecified. The principal diagnosis is acute bronchopneumonia because therapy focused on this condition. The patient’s stay was complicated by the metastatic carcinoma, as antineoplastic therapy exerts a suppressive action on the immune mechanisms, thus making the pneumonia more difficult to treat and extending the stay.

Secondary Diagnoses: 174.2, Malignant neoplasm of upper-inner quadrant.
197.0, Secondary malignant neoplasm of lung.
196.3, Secondary neoplasm of axillary lymph nodes.

The breast cancer is reported as current even though it has been surgically excised because it appears that the patient has been on chemotherapy since the surgery and, therefore, it is currently being treated. The metastatic sites of the lymph nodes and lung should be reported.