ICD-9-CM Coding Guidance for LTC Facilities. Appendix B: Reporting and Sequencing Diagnoses on the Health Record and UB-04 Claim Form

The "ICD-9-CM Official Guidelines for Coding and Reporting" is updated annually, thought it may be changed more frequently. Coders should be familiar with the guidelines and use the most current version.

The guidelines provide the following guidance for principal/first-listed and continued stay diagnosis:

Section I, "Conventions, General Coding Guidelines and Chapter Specific Guidelines Section I.B.15, "Reason for Admission for Rehabilitative Therapy": "

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis. Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter."

Section II, "Selection of Principal Diagnosis"

"The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as 'that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.'

"The UHDDS definitions are used by 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* (Vol. 50, No, 147), pp. 31038-40.

"Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

"In determining principal diagnosis the coding conventions in the ICD-9-CM, Volumes I and II take precedence over these official coding guidelines. *(See Section I.A., Conventions for the ICD-9-CM)*

"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task."

Section II.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 basis 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. Uncertain diagnoses are not coded in LTC facilities."

(This instruction (H) is also found in section III.C, "Reporting Additional Diagnoses, Uncertain Diagnosis.")

Section III, "Reporting Additional Diagnoses"

"For reporting purposes the definition for 'other diagnoses' is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring

"The following guidelines are to be applied in designating 'other diagnoses' when neither the alphabetic index nor the tabular list in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider."

Section IIIB, "Abnormal Findings"

"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 ask the provider whether the abnormal finding should be added."

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