Chapter 3: Uniform Hospital Discharge Data Set

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2

Uniform Hospital Discharge Data Set (UHDDS)

- Minimum set of items based on standard definitions to provide consistent data for multiple users.
- Required for reporting Medicare and Medicaid patients.
- Many other health care payers also use most of the UHDDS for the uniform billing system.

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UHDDS Required Data Items

- The UHDDS requires the following items:
  - Principal diagnosis,
  - Other diagnoses that have significance for the specific hospital episode, and
  - All significant procedures.
- Other items of general information regarding the patient and the specific episode of care:
  - Age, sex, and race of the patient,
  - Expected payer, and
  - Hospital's identification.

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UHDDS Application

- Originally developed for hospital reporting of inpatient data elements.
- Application of definitions expanded to all non-outpatient settings.
- Definitions and guidelines for selection of principal diagnosis and other (secondary) diagnoses apply to:
  - Acute care short-term hospitals,
  - Long-term care hospitals,
  - Psychiatric hospitals,
  - Home health agencies,
  - Rehabilitation facilities,
  - Nursing homes, and other settings.

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Principal Diagnosis—Definition

- The condition established after study to be chiefly responsible for admission of the patient to the hospital.

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Importance of Correct Selection of Principal Diagnosis

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

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Principal Diagnosis and “After Study”

- The principal diagnosis is NOT the admitting diagnosis, but the diagnosis found after workup or even after surgery that proves to be the reason for admission.
- The principal diagnosis is ordinarily listed first in the physician’s diagnostic statement, but this is not always the case.
- Always review the entire medical record to determine the condition that should be designated as the principal diagnosis.

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Selection of Principal Diagnosis

- The circumstances of inpatient admission always govern the selection of the principal diagnosis.
- Coding directives in the *ICD-9-CM* manuals, volumes 1, 2, and 3, take precedence over all other guidelines.
- Consistent, complete documentation in the medical record is important. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task.

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Admission Following Medical Observation

- A patient may be treated in a hospital's observation unit to determine if the condition improves sufficiently for the patient to be discharged. If the condition either worsens or doesn't improve, the physician may decide to admit the patient as an inpatient.
- Principal diagnosis: Report the medical condition that led to the hospital admission.

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Admission Following Postoperative Observation

- A patient undergoing outpatient surgery may require postoperative admission to an observation unit to monitor a condition (or complication) that develops postoperatively. If the patient doesn't improve, the physician may admit the patient to the same hospital as an inpatient.
- Principal diagnosis: Apply UHDDS definition of principal diagnosis—"that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

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Admission from Outpatient Surgery

- A patient undergoing outpatient surgery may be 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.

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Admission from Outpatient Surgery (cont.)

- 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.

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Guidelines for Selection of Principal Diagnosis

The following official guidelines for designating the principal diagnosis apply to all systems and etiologies.

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Two or More Conditions

- In the unusual situation in which two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of the admission and the diagnostic workup and/or therapy provided, either may be sequenced first unless the Alphabetic Index or the Tabular List directs otherwise.

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Two or More Conditions (cont.)

- When treatment is totally or primarily directed toward one condition, or when only one condition would have required inpatient care, that condition should be designated as the principal diagnosis.
- If another coding guideline (general or disease-specific) provides sequencing direction, that guideline must be followed.

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Comparable or Contrasting Conditions

- In the rare instance where two or more comparable or contrasting conditions are documented as either/or (or similar terminology), both diagnoses are coded as though confirmed and the principal diagnosis is designated according to the circumstances of the admission and the diagnostic workup and/or therapy provided.
- When no further determination can be made as to which diagnosis more closely meets the criteria for principal diagnosis, either may be sequenced first. Note: This does not apply to outpatient encounters.

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Symptom Followed by Contrasting/Comparative Diagnoses

- When a symptom is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. However, if the symptom code is integral to each of the conditions listed, no additional code for the symptom is reported.
- Codes are assigned for all listed contrasting/comparative diagnoses.

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Original Treatment Plan Not Carried Out

- When the original treatment plan cannot be carried out due to unforeseen circumstances, the criteria for designation of the principal diagnosis do not change.
- The condition that occasioned the admission is designated as principal diagnosis even though the planned treatment was not carried out.

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Other Diagnoses

- Those conditions that coexist at the time of admission or develop subsequently or affect patient care for the current hospital episode.
- Diagnoses that have no impact on patient care during the hospital stay are not reported even when they are present.
- Diagnoses that relate to an earlier episode and have no bearing on the current hospital stay are not reported.

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UHDDS Definition of Other Diagnoses

- Includes only those conditions that affect the episode of hospital care in terms of any of the following:
  - Clinical evaluation
  - Therapeutic treatment
  - Further evaluation by diagnostic studies, procedures, or consultation
  - Extended length of hospital stay
  - Increased nursing care and/or other monitoring

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Sequencing of Other Diagnoses

- No particular order is mandated for sequencing other diagnoses.
- The more significant diagnoses should be sequenced early in the list when the number of diagnoses that may be reported is limited.

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Reporting Guidelines for Other Diagnoses

The following guidelines and examples should be studied carefully in order to understand the rationale for determining other diagnoses that should be reported.

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Previous Conditions Stated as Diagnoses

- Physicians sometimes include in the diagnostic statement historical information or status post procedures performed on a previous admission that have no bearing on the current stay. Such conditions are not reported.
- 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.

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Other Diagnosis with No Documentation Supporting Reportability

- If the physician has included a diagnosis in the final diagnostic statement, it should ordinarily be coded.
- If there is no supporting documentation in the medical record, however, the physician should be consulted as to whether the diagnosis meets reporting criteria; if so, the physician should be asked to add the necessary documentation.
- Reporting of conditions for which there is no supporting documentation is in conflict with UHDDS criteria.

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Chronic Conditions That Are Not the Thrust of Treatment

- Chronic conditions (e.g., chronic obstructive pulmonary disease) that are not the thrust of treatment and possibly not treated specifically are reported because they also required evaluation and monitoring.

- Criteria for selection of these chronic conditions to be reported as “other diagnoses” include:
  - The severity of the condition,
  - The use or consideration of alternative measures,
  - An increase in nursing care,
  - The use of diagnostic or therapeutic services,
  - The need for close monitoring, and
  - Modifications of nursing care plans.

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Conditions That Are an Integral Part of a Disease Process

- Conditions that are an integral part of a disease process should not be reported as additional diagnoses, unless otherwise instructed by the classification.
  - Example: A patient was admitted with nausea and vomiting due to infectious gastroenteritis. Nausea and vomiting are common symptoms of infectious gastroenteritis and are therefore not reported.
  - Example: A patient was seen in the physician's office complaining of urinary frequency and was diagnosed with benign prostatic hypertrophy. Although urinary frequency is a symptom of BPH, both conditions are reported because of the instructional note in the Tabular List under code 600.01.

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Conditions That Are Not an Integral Part of a Disease Process

- Conditions that are not an integral part of a disease process should be coded when present.
  - Example: A 5-year-old boy was admitted with a 104-degree fever associated with acute pneumonia. During the first 24 hours, the patient also experienced convulsions due to the high fever. Both the pneumonia and the convulsions are reported because convulsions are not routinely associated with pneumonia. Fever is commonly associated with pneumonia, however, and no code is assigned for it.

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Abnormal Findings

- Categories 790–796 for nonspecific abnormal findings (laboratory, radiology, pathology, and other diagnostic results) should be assigned only when the physician has not been able to arrive at a related diagnosis but indicates that the abnormal finding is considered to be clinically significant by listing it in the diagnostic statement.
- This differs from outpatient setting coding of diagnostic tests interpreted by a physician.
- Codes should never be assigned on the basis of an abnormal finding alone.

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Abnormal Findings (cont.)

- When findings are clearly outside the normal range and the physician has ordered other tests to evaluate the condition or has prescribed treatment without documenting an associated diagnosis, it is appropriate to ask the physician whether a diagnosis should be added or whether the abnormal finding should be listed in the diagnostic statement.
- Incidental findings on X-ray should not be reported unless further evaluation or treatment is carried out.

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Admitting Diagnosis

- The admitting diagnosis is not an element of the UHDDS.
- It must be reported for some payers and may also be useful in quality-of-care studies.
- Ordinarily, only one admitting diagnosis can be reported.

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The Inpatient Admitting Diagnosis

The inpatient admitting diagnosis may be:

- A significant finding (symptom or sign) representing patient distress or an abnormal finding on outpatient examination,
- A possible diagnosis based on significant findings (working diagnosis),
- A diagnosis established on an ambulatory care basis or during a previous hospital admission,
- An injury or poisoning, or
- A reason or condition not actually an illness or injury, such as a follow-up examination or pregnancy in labor.

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Admitting Diagnosis Code

- The code should indicate the diagnosis provided by the physician at the time of admission.
- The admitting diagnosis might not agree with the principal diagnosis on discharge.
- The admitting diagnosis should not be changed to conform with the principal diagnosis.

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Procedures

- The UHDDS requires that all significant procedures be reported. The UHDDS definitions of significant procedures and other reporting guidelines are discussed in chapter 7 of this handbook, along with other information on coding operations and procedures.

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Relationship of UHDDS to Outpatient Reporting

- The UHDDS definition of principal diagnosis does not apply to outpatient encounters.
- In contrast to inpatient coding, no “after study” element is involved 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.

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Ethical Coding and Reporting

- Medicare reimbursement depends on:
  - The correct designation of the principal diagnosis,
  - The presence or absence of additional codes that represent complications, comorbidities, or major complications or comorbidities as defined by the MS-DRG system, and
  - Procedures performed.
- Other third-party payers may follow slightly different reimbursement methods, but the accuracy of *ICD-9-CM* coding is always vital.

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Ethical Coding and Reporting (cont.)

- Accurate and ethical *ICD-9-CM* coding
  - Depends on correctly following all instructions in the coding manuals, official guidelines, and *Coding Clinic for ICD-9-CM*.
  - Requires the correct selection of conditions that meet the criteria set by the UHDDS and the official guidelines.
- Over-coding and over-reporting is unethical and may be considered fraudulent.
- Failure to include all diagnoses or procedures that meet reporting criteria may result in financial loss for the health care provider.
- Coders should abide by the AHIMA Standards of Ethical Coding.

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Ethical Coding and Reporting (cont.)

- Medicare identifies certain codes as unacceptable as the principal diagnosis.
- Third-party payers may question or deny payment.
- It is important to code correctly, and then make whatever adjustment is required for reporting. Otherwise, the coder runs the risk of developing incorrect coding practices that will distort data used for other purposes.
- A facility may collect nonreportable diagnoses or procedures for internal use if the information is maintained outside the external reporting system.

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38