


<b>Name of Policy:</b>	<b><u>Internal Guidelines for Coding Other (Additional) Diagnoses</u></b>	
<b>Policy Number:</b>	3364-105-507	
<b>Department:</b>	Health Information Management	
<b>Approving Officer:</b>	Chief Operating and Clinical Officer	
<b>Responsible Agent:</b>	Director, Health Information Management	
<b>Scope:</b>	Health Information Management	
		<b>Effective Date:</b> 11/1/2018
		Initial Effective Date: April, 1998
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy		<input checked="" type="checkbox"/> Minor/technical revision of existing policy <input type="checkbox"/> Reaffirmation of existing policy

**(A) Policy Statement**

The reporting of codes for other additional diagnoses shall be based on hospital data purposes; on conditions that affect the whole body system; on any diagnoses that place a bearing on the management of the patient; on any conditions that are not associated with the integral disease process; and on any physician documentation of abnormal findings that are of clinical significance to the patient’s care.

**(B) Purpose of Policy**

To ensure our commitment to practice the ethical, accurate and consistent reporting of codes for other additional diagnoses.

**(C) Procedure**

The guidelines described below shall be followed while performing the coding function:

1. The definition of other 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. Diagnoses that relate to an earlier episode of care which have no bearing on the current hospital stay are to be excluded.” We shall code other additional diagnoses only when affecting the patient’s care. The requirements for reporting will be in terms of clinical evaluation, therapeutic treatment, diagnostic procedure, extended length of hospital stay, and/or increased nursing care and/or monitoring.
2. The coding staff shall only code family and personal history codes when pertinent to the patient’s current stay.
  - A. We shall not code any contradictions in histories between resident/resident and/or attending/attending. If a resident states a history of something is negative and the attending documents it is positive, we shall code the history code if it is pertinent to that current case. The attending physician’s documentation shall over-write a resident’s documentation.
  - B. Personal history of cancer shall be coded on all patient types.
  - C. Family history of malignancy will be coded if the patient has a current condition of suspected cancer, cancer and/or personal history of the same cancer site.
3. All systemic conditions, such as hypertension, Parkinson’s disease, and diabetes mellitus shall be coded. These conditions need to be monitored continuously. Any conditions that are system specific, such as atrial fibrillation, cholelithiasis or seizure disorder, shall be coded if there is active intervention (medication given, nursing observation, clinical evaluation, and diagnostic procedures performed, or extended the patient’s length of hospital stay). The only system specific condition that shall be coded with no evidence of intervention is chronic obstructive pulmonary disease (COPD). This condition is chronic and may exacerbate at any time during the hospital stay.

