Name of Policy:	**Internal Guidelines for Coding Other (Additional) Diagnoses**
Policy Number:	3364-105-507
Department:	Health Information Management
Approving Officer:	Chief Medical Officer
Responsible Agent:	Director, Health Information Management
Scope:	Health Information Management

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 9/5/2023

Initial Effective Date: April, 1998

_____ New policy proposal
_____ Major revision of existing policy
_____ Minor/technical revision of existing policy
__X__ 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.

4. Any localized, non-acute conditions shall not be coded if they have no bearing on the current hospital stay at the time of admission. An example of this type of condition is the documentation of bunion as an incidental finding.

5. Any conditions that are an integral part of a disease process shall not be assigned as additional codes. Many symptom codes would be included in this category. An example would be nausea and vomiting secondary to infectious gastroenteritis; chest pain due to acute myocardial infarction.

6. Any additional conditions that may not be associated routinely with a disease process shall be coded when present. An example of this type of condition is when a patient presents with an acute CVA with coma and hemiparesis.

7. Abnormal findings on lab tests, radiology reports, pathology reports, or other diagnostic results shall not be coded and reported unless the physician documents the clinical significance of these abnormal values. The physician must document the diagnosis for the abnormal value in the progress notes for the coder to be able to code the condition. If no diagnosis is indicated but the physician documents the significance of the abnormal value, coders shall code from the nonspecific abnormal findings section.

8. Assign cause codes to specify the mechanism and place of occurrence for injuries. If the place of injury is unknown, do not assign a cause code.

Approved by:	**Review/Revision Date:**
/s/ _____ _____ Pamela Eaton — Date Director, Health Information Management _/s/ _____ _____ Michael Ellis, M.D. — Date Chief Medical Officer	1/2005 5/2007 7/2011 11/2012 11/1/2015 11/1/2018 11/1/2021 8/15/2023 **Next Review Date:** 09/05/2026
Policies Superseded by This Policy: 10-03	

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.