CODEX

CODING DECODED

UNIFORM HOSPITAL DISCHARGE DATA SET (UHDDS)

Reporting Standards for Diagnoses and Procedures

Medical Coding Training Notes

CODING DECODED

1. What is UHDDS?

The Uniform Hospital Discharge Data Set (UHDDS) is a standardized data collection system used to collect and report patient information to ensure reliability and consistency in reporting inpatient hospital data. It was established by the National Committee on Vital and Health Statistics (NCVHS) and is required for all hospitals that participate in Medicare and Medicaid programs.

Key Data Elements Collected in UHDDS

- Patient Identification (e.g., age, gender, race)
- Diagnoses (e.g., principal diagnosis, secondary diagnoses)
- Procedures (e.g., surgical procedures, diagnostic tests)
- Admission and Discharge information (e.g., discharged to home, transferred to another facility)
- Provider information (e.g., Attending Physician, operating physician, etc.)
- Payer information (e.g., Medicare, Medicaid or Private)

2. Sections of the Health Record

A medical health record is a comprehensive document that contains essential patient information, clinical findings, treatments, and follow-up plans. Below is a structured list of the key sections typically found in a medical record.

1. Patient Information (Demographics)

- Full Name
- Date of Birth (DOB), Gender
- Medical Record Number (MRN)
- Insurance Information
- Emergency Contact Details
- Address & Contact Information

2. Admission and Discharge Details

- Date & Time of Admission
- Reason for Admission (Chief Complaint)
- Admitting Diagnosis
- Date & Time of Discharge
- Discharge Summary

3. Chief Complaint (CC)

- Patient's main reason for seeking medical attention

4. History of Present Illness (HPI)

- Detailed account of symptoms and progression: onset, duration, severity, associated symptoms

5. Past Medical History (PMH)

- Chronic illnesses (e.g., diabetes, hypertension)
- Past infections
- Allergies (drug, food, environmental)
- Hospitalizations

6. Past Surgical History (PSH)

- Previous surgeries
- Year of procedure
- Complications, if any

7. Family History (FH)

- Health conditions in immediate family members
- Hereditary diseases (e.g., cancer, diabetes, heart disease)

8. Social History (SH)

- Smoking, alcohol, and drug use
- Occupational history
- Exercise, diet, and living conditions

9. Review of Systems (ROS)

- A checklist covering all body systems
- Common systems included: General (fever, weight loss), Cardiovascular (chest pain, palpitations), Respiratory (cough, shortness of breath)

10. Vital Signs

- Temperature
- Heart rate (pulse), respiratory rate
- Blood pressure
- Oxygen saturation

11. Physical Examination (PE)

- General appearance
- HEENT (Head, Eyes, Ears, Nose, Throat)
- Cardiovascular (heart sounds, murmurs)
- Respiratory (lung sounds, wheezing)
- Abdomen (palpation, tenderness)
- Neurological (reflexes, mental status)

- Skin (rashes, lesions)

12. Laboratory and Diagnostic Tests

- Blood tests (CBC, BMP, LFTs)
- Urinalysis
- Microbiology reports (blood culture, sputum culture)
- Radiology reports (X-ray, CT, MRI, ultrasound)
- Pathology reports (biopsy results)

13. Diagnoses

- Admitting diagnosis (initial suspected condition)
- Final diagnosis (after workup is complete)
- Secondary diagnoses (comorbid conditions)

14. Medications

- Home medications (before admission)
- In-hospital medications (prescribed during admission)
- Discharge medications (new or continued post-discharge)

15. Procedures & Surgeries

- Date and time of procedure
- Type of procedure
- Surgeon and anesthesiologist names
- Operative notes

16. Physician Notes

- Progress notes (daily updates on condition)
- Consultation notes (input from specialists)
- Pre-operative and post-operative notes

17. Nursing Notes

- Shift assessments
- Medications administered
- Patient observations

18. Treatment Plan

- Medications and therapy
- Lifestyle modifications
- Follow-up recommendations

19. Discharge Summary

- Final diagnoses
- Summary of hospital stay
- Medications at discharge
- Instructions for follow-up

3. Principal Diagnosis

> ***The principal diagnosis is defined in the UHDDS as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."***

Example

Clinical Scenario: A 65-year-old male is admitted to the hospital with shortness of breath and chest pain. After evaluation, he is diagnosed with acute congestive heart failure due to longstanding hypertension. He also has a history of type 2 diabetes and chronic kidney disease.

Principal Diagnosis: Acute congestive heart failure (ICD-10-CM Code: I50.9)

UHDDS Definition Applies to All Non-Outpatient Settings

- Acute Care Inpatient Hospitals — General medical and surgical hospitals providing short-term treatment.
- Long-Term Care Hospitals (LTCHs) — Facilities for patients requiring extended hospital stays (usually over 25 days).
- Inpatient Psychiatric Facilities — Specializing in the treatment of mental health conditions on an inpatient basis.
- Inpatient Rehabilitation Facilities (IRFs) — Hospitals or units that provide intensive rehabilitation services to inpatients.
- Skilled Nursing Facilities (SNFs) — Inpatient stays when patients are admitted under Medicare Part A for skilled nursing care.
- Critical Access Hospitals (CAHs) — Small facilities providing limited inpatient and outpatient hospital services in rural areas.
- Inpatient Hospice Care Facilities — Providing 24-hour end-of-life care in a residential setting.
- Inpatient Units in Specialty Hospitals — Including cancer centers, children's hospitals, and cardiac specialty hospitals.
- Inpatient Observation Stays — If converted to inpatient status (patients initially placed under observation who are later admitted as inpatients).

4. Guidelines for Selecting Principal Diagnosis

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis

When a patient has two or more related conditions that could qualify as the principal diagnosis, either condition can be chosen as the principal diagnosis. However, the final choice should follow the specific admission reason, treatment given, and guidance from the ICD-10-CM Tabular List or Alphabetic Index.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or other coding guidelines does not provide sequencing direction, then any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions

In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed. The diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

F. Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80–T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

G. 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,” “compatible with,” “consistent with,” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases 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.

H. Admission from Observation Unit

Admission Following Medical Observation: When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

Admission Following Post-Operative Observation: When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the UHDDS definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

I. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is 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.
- 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.

J. Admission/Encounters for Rehabilitation

- When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed.
- For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

5. Principal Procedure

According to Uniform Hospital Discharge Data Set (UHDDS) guidelines, the principal procedure is defined as:

> ***The procedure that is performed for definitive treatment rather than for diagnostic or exploratory purposes, or that is necessary to treat a complication.***

> ***It is directly related to the principal diagnosis, meaning it is the procedure most closely associated with resolving or managing the condition responsible for the patient's admission.***

Selection of Principal Procedure

Follow these sequential guidelines when selecting the principal procedure, particularly when multiple procedures are performed:

1. Multiple Definitive Treatments

When procedures treat both principal and secondary diagnoses, select the procedure most related to principal diagnosis.

2. Mixed Definitive and Diagnostic Procedures

If both definitive and diagnostic procedures are performed for principal and secondary diagnoses, prioritize the definitive treatment most related to principal diagnosis.

3. Diagnostic Principal, Definitive Secondary

When diagnostic procedure is for principal diagnosis and definitive treatment is for secondary diagnosis, select the diagnostic procedure as it relates to principal diagnosis.

4. No Principal Diagnosis Procedures

When no procedures relate to principal diagnosis but treatments exist for secondary diagnoses, select the definitive treatment for secondary diagnosis as principal procedure.

6. When to Report Past Medical History as Secondary Diagnosis

According to ICD-10-CM Official Guidelines for Coding and Reporting, past conditions should only be coded when meeting specific criteria during the current admission:

Clinical Evaluation

Condition is actively evaluated during the current visit through physical examination or diagnostic testing.

Treatment & Monitoring

Condition requires ongoing treatment or monitoring during the current admission.

Impact on Resources in Patient Care

Condition affects patient care through medication adjustments, additional testing, or extended stays.

Increase in Care

Condition requires increased nursing care or specific interventions.

Note: Past medical conditions that are not addressed, evaluated, or treated during the encounter should not be coded as secondary diagnoses.

Worked Examples

Scenario	Secondary Dx?	Why?
Hypertension (HTN) listed in Past Medical History (PMH), but no meds given or monitoring done	No	Condition was not treated, monitored, or clinically

Scenario	Secondary Dx?	Why?
		relevant during this stay.
Patient has CKD Stage 3 (documented in PMH) and creatinine levels are monitored	Yes	Even if CKD was not the primary focus, it impacts kidney function and care.
Type 2 Diabetes listed in PMH, but no glucose monitoring or insulin adjustment during stay	No	If diabetes did not impact treatment, it should not be coded.
CHF documented in PMH, but BNP was ordered, diuretics given, and fluid restriction implemented	Yes	CHF affected the patient's management, so it should be coded.

Key Rule: Just because a condition is documented in the history does NOT mean it should automatically be coded. It must have impacted care, treatment, or monitoring during the encounter.