Assigning the First-Listed Diagnosis

First Things First

Medical coding is a kind of story telling. The codes of the ICD-10-CM are a quick way of presenting an answer to the question, “Why did the patient come to the healthcare practitioner for treatment?” There are really two answers to this question. One is, what was the problem that motivated the patient to go to the doctor or nurse, and the other is, what would the healthcare practitioner say was the underlying problem?

The problem that brings the patient to the doctor is sometimes called the chief complaint. Physicians and nurses may abbreviate this as CC. It is the patient’s reason for the encounter or event. It may also be called the presenting problem, presenting complaint, or reason for encounter.

When the healthcare practitioner establishes what the main underlying issue in the medical event was, this is the first-listed diagnosis. This is called the principal diagnosis in the inpatient setting, but it is called the first-listed diagnosis for hospital-based outpatient care and physician-based office visits. The first-listed diagnosis is the most important one, not the one that the healthcare provider discovered first in the examination.

As the medical coder, how do you figure out which diagnosis should be the first-listed diagnosis?

Chief Complaint

In many medical visits, the best choice for the first-listed diagnosis is the patient’s chief complaint. If there is no other diagnosis, or if the only other diagnosis is a chronic condition that was part of the patient’s medical history, this will be the first-listed diagnosis.

The ICD-10-CM Official Guidelines state: "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider."

You can find many, but not all, of the symptom codes in Chapter 18 of the ICD-10-CM.
External Cause Codes

There is a list of External Causes in Chapter 20 of the ICD-10-CM. These are not medical conditions or diseases, but instead are types of accidents, violence, or mishaps that can cause injuries. The External Cause codes are never used as a first-listed diagnosis. Should you encounter a patient who has been hurt in a bombing or an assault, you may get to use these codes—but they are not intended for diagnosis.

Z Codes

Codes for factors influencing health status and contact with health services are listed in Chapter 21 of the ICD-10-CM. These are called Z codes. In the Z code section, you will find the codes for when circumstances other than a disease or injury are recorded as diagnosis or problems. These include the codes for routine health screenings (Z00-Z13).

Many of the Z codes are about the personal or health history of the patient. If the patient has an allergy to medication, an amputation, or has been exposed to illness and needs inoculation, the codes are in Chapter 21. Z codes, as the ICD-10-CM Official Guidelines explain, “indicate the reason for an encounter”. Even though they are not diagnoses, they can be used as a first-listed diagnosis code where appropriate.

Example

A patient presents with a sprained right ankle. When the physician orders an x-ray, there is no break visible. The patient has a history of asthma, but is not experiencing any symptoms of it now.

The first-listed diagnosis is S93.401, Sprain of unspecified ligmanet of the right ankle.