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Secondary Diagnoses

A secondary diagnosis is a condition that coexists at the time of admission, develops subsequently or that affects the treatment received and/or length of stay of the patient. Remember that secondary diagnoses support the severity of illness (SOI) and show that your patient is as sick on paper as they are in the bed.

Secondary diagnoses are defined as those conditions that consume one of the following hospital resources:

- Clinical evaluation
- Therapeutic treatment
- Further evaluation by diagnostic studies, procedures or consultation
- Extended hospital length of stay (LOS)
- Increased nursing care and/or other monitoring

For Example: If you are monitoring the blood pressure and continuing home oral anti-hypertensive medications, DO NOT document “history of HTN”. This scenario meets criteria for the secondary diagnosis of Hypertension and coders cannot code a “history of” and should be documented as such. The diagnosis of “hypertension” has much more impact on your patient’s severity of illness than “history of HTN”.

Please document all diagnoses that affect your patients’ care

Remember: Coders cannot code a “history of” a diagnosis. If you treat it, call it!
Get credit for the SOI of your patient.