

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”, or other similar terms indicating uncertainty, code the condition as if it existed or was established.

Note: This guideline is applicable only to inpatient admissions

- **“Possible” and “probable” diagnoses can be coded when suspected and documented by the provider in the inpatient record **if the diagnosis is documented as possible or probable at the time of discharge.****
- **Remember to carry this consistently through all daily progress notes and into the **discharge summary.****
- **If the diagnosis in question is confirmed, then drop the conditional terminology. If the diagnosis is ruled out, state that diagnosis X is ruled out and do not document it in future notes.**
- **If the diagnosis remains uncertain, the provider can document “possible” all the way through to the discharge summary.**

For example:

“Acute blood loss anemia due to a probable upper GI bleed”

“Will add Zosyn to treat a possible gram negative pneumonia”