

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
CALIFORNIA EMERGENCY DEPARTMENT AND  
AMBULATORY SURGERY PATIENT DATA REPORTING MANUAL, FIFTH EDITION**

**OTHER DIAGNOSES**

Section 97259

*(a) For encounters occurring on and after October 1, 2015: The patient's other diagnoses are defined as all conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses shall be coded according to the ICD-10-CM. ICD-10CM codes from External Causes of Morbidity (V00-Y99) shall not be reported as other diagnoses.*

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on and after October 1, 2015:

OTHER DIAGNOSES ICD-10-CM CODE						
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Reporting Requirements:

- Fill from the left-most position and do not skip fields.
- Diagnoses shall be coded according to the International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modifications (ICD-10-CM).
- Duplicate diagnosis codes must not be reported on the same encounter data record.

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- Up to twenty-four Other Diagnoses, in addition to the Principal Diagnosis, may be reported to OSHPD.
- Conditions should be coded that affect patient care in terms of requiring:
  - Clinical evaluation
  - Therapeutic treatment
  - Procedures
  - Increased nursing care and/or monitoring
- For coding chronic conditions, please refer to the American Hospital Association's (AHA) Coding Clinic for ICD-10-CM.
- The following coding systems are not accepted by OSHPD:
  - SNODO
  - DSM-IV
  - Morphology