

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
CALIFORNIA INPATIENT DATA REPORTING MANUAL, EIGHTH EDITION

OTHER DIAGNOSES AND PRESENT ON ADMISSION
INDICATOR

Section 97226

(a) For discharges occurring on and after October 1, 2015: The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-10-CM. ICD-10-CM codes from External Causes of Morbidity (V00-Y99) shall not be reported as other diagnoses.

(b) Effective with discharges on or after July 1, 2008, whether the patient's other diagnosis was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine if the condition was present at the time of inpatient admission.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

(5) (blank). Exempt from present on admission reporting.

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Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on and after January 1, 2019:

PRINCIPAL DIAGNOSIS		PRESENT ON ADMISSION		
	<input type="checkbox"/>	<input type="checkbox"/>	Y = Yes	
	<input type="checkbox"/>	<input type="checkbox"/>	N = No	
	<input type="checkbox"/>	<input type="checkbox"/>	U = Unknown	
	<input type="checkbox"/>	<input type="checkbox"/>	W = Clinically Undetermined	
	<input type="checkbox"/>	<input type="checkbox"/>	blank = Exempt from POA reporting	
a.	<input type="checkbox"/>	<input type="checkbox"/>	m.	<input type="checkbox"/>
b.	<input type="checkbox"/>	<input type="checkbox"/>	n.	<input type="checkbox"/>
c.	<input type="checkbox"/>	<input type="checkbox"/>	o.	<input type="checkbox"/>
d.	<input type="checkbox"/>	<input type="checkbox"/>	p.	<input type="checkbox"/>
e.	<input type="checkbox"/>	<input type="checkbox"/>	q.	<input type="checkbox"/>
f.	<input type="checkbox"/>	<input type="checkbox"/>	r.	<input type="checkbox"/>
g.	<input type="checkbox"/>	<input type="checkbox"/>	s.	<input type="checkbox"/>
h.	<input type="checkbox"/>	<input type="checkbox"/>	t.	<input type="checkbox"/>
i.	<input type="checkbox"/>	<input type="checkbox"/>	u.	<input type="checkbox"/>
j.	<input type="checkbox"/>	<input type="checkbox"/>	v.	<input type="checkbox"/>
k.	<input type="checkbox"/>	<input type="checkbox"/>	w.	<input type="checkbox"/>
l.	<input type="checkbox"/>	<input type="checkbox"/>	x.	<input type="checkbox"/>

Reporting Requirements

- Up to twenty-four other diagnoses may be reported to OSHPD. Discharge data becomes increasingly useful and valuable for research when all diagnoses that indicate risk factors are reported. Please report all relevant diagnoses.
- 1 or E will not be accepted in the POA field on and after January 1, 2019.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-10-CM Codes:

Refer to the official guidelines for coding and reporting the other diagnoses in *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*

<http://www.cdc.gov/nchs/icd/icd10cm.htm>

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Duplicate diagnosis codes on the same inpatient discharge data record will not be accepted.

If ICD-10 HIV test results Z21 and R75 are reported in your data, they will receive a warning edit flag. The California Health and Safety Code prohibits the disclosure of any HIV test results –whether positive, negative or inconclusive – without the patient’s written authorization for each disclosure.

Please note that if these HIV test result codes are not removed from the data by the facility, OSHPD will remove them during the standardization process when the data is made available to the public.

Conditions should be coded that affect patient care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- 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.

Parameters for Reporting Present on Admission on or after July 1, 2009:

Follow the reporting requirements in the Appendix “Present on Admission Reporting Guidelines” in the ICD-10-CM Official Guidelines for Coding and Reporting.

<http://www.cdc.gov/nchs/icd/icd10cm.htm>