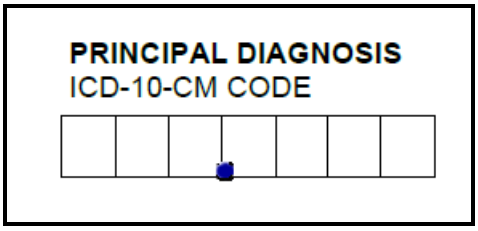
PRINCIPAL DIAGNOSIS — Section 97258

(a) For encounters occurring on and after October 1, 2015: The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care, shall be coded according to the ICD-10-CM.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission:



Reporting Requirements:

- A principal diagnosis must be reported for every encounter record.
- Fill from the left-most position and do not skip fields.
- Diagnoses shall be coded according to the International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM). For additional information see https://www.cdc.gov/nchs/icd/icd-10-cm.htm
- Duplicate diagnosis codes will not be accepted on the same encounter data record.
- Conditions should be coded that affect patient care in terms of requiring:
    - Clinical evaluation
    - Therapeutic treatment
    - Procedures
    - Increased nursing care and/or monitoring

- The following coding systems are not accepted by HCAI:
    - SNODO
    - DSM-IV
    - Morphology

- 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, HCAI will remove them during the standardization process when the data is made available to the public.