OTHER DIAGNOSES AND PRESENT ON ADMISSION INDICATOR **Section 97226**

(a) For discharges occurring on or after January 1, 2023: 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 the be excluded. Diagnoses shall be coded according to the ICD-10-CM. ICD-10-CM codes from Social Determinants of Health (Z55-Z65) shall be included if they are documented in the medical record. 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.

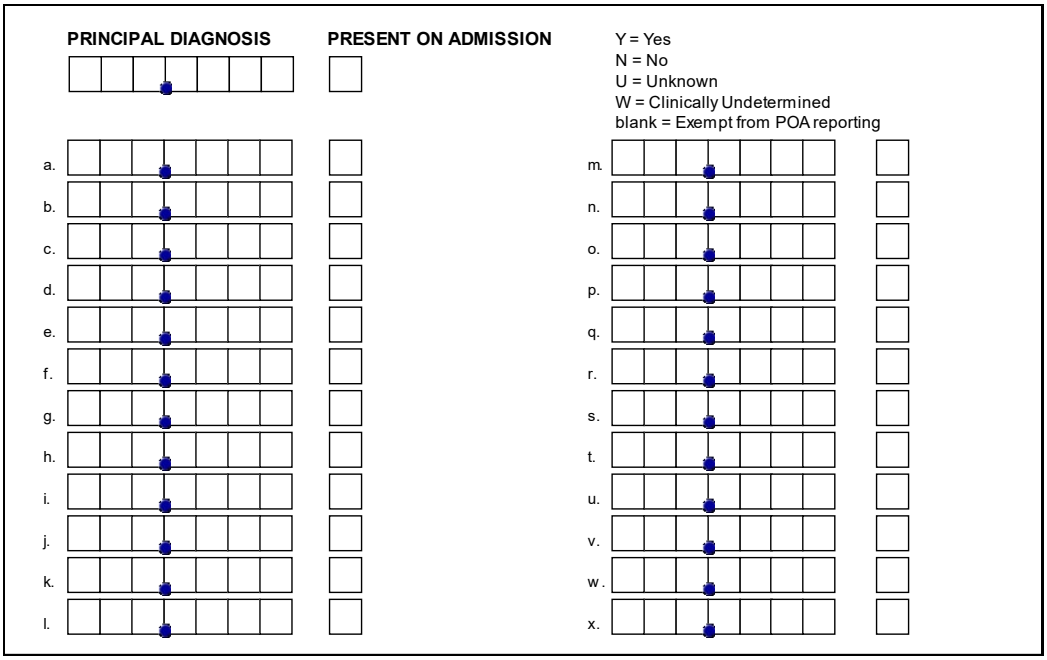
(2) N. No. Condition was not present at the time of inpatient admission.

(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.

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

- Up to twenty-four other diagnoses may be reported to HCAI. Discharge data becomes increasingly useful and valuable for research when all diagnoses that indicate risk factors are reported. Please report all relevant diagnoses.

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

- Parameters for Reporting Present on Admission:

    - 1 or E is not accepted in the POA field.

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

- 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

- 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.

- For coding deliveries: a principal diagnosis code from category Z38 is assigned only once, to a newborn at the time of birth. A code from category Z37, outcome of delivery, should be included on every maternal record when a delivery has occurred, and is always a secondary code.

- Other Coding Systems:

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

- Please refer to the American Hospital Association's (AHA) Coding Clinic for ICD-10-CM at https://www.cms.gov/Medicare/Coding/ICD10