PRINCIPAL DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR — Section 97225

(a) For discharges occurring on and after October 1, 2015: The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-10-CM.

(b) Effective with discharges on or after July 1, 2008, whether the patient's principal 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.

DISCUSSION

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

PRINCIPAL DIAGNOSIS	**PRESENT ON ADMISSION**	
☐☐☐☐☐☐☐	☐	Y = Yes N = No U = Unknown W = Clinically Undetermined blank = Exempt from POA reporting

- A principal diagnosis must be reported for every discharge data record.
- 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.

- 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.

ICD-10-CM Codes:

Refer to the official guidelines for coding and reporting the principal diagnosis at https://www.cdc.gov/nchs/icd/icd-10-cm.htm