

TEXT

CALIFORNIA CODE OF REGULATIONS
TITLE 22, DIVISION 7, CHAPTER 10, HEALTH FACILITY DATA
ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS
Sections 97225, 97226, 97227.

97225. Definition of Data Element for Inpatients—Principal Diagnosis and Present on Admission Indicator.

(a)(1) For discharges occurring up to and including September 30, 2014: 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-9-CM.

(2) For discharges occurring on and after October 1, 2014: 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 ~~or~~ at the time of inpatient admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~or~~ at the time of inpatient admission ~~or not~~.
- (5) (blank) Exempt from present on admission reporting.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97226. Definition of Data Element for Inpatients—Other Diagnosis and Present on Admission Indicator.

(a)(1) For discharges occurring up to and including September 30, 2014: 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-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

(2) For discharges occurring on and after October 1, 2014: 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 ~~on~~ at the time of inpatient admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~on~~ at the time of inpatient admission ~~or not~~.
- (5) (blank) Exempt from present on admission reporting.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97227. Definition of Data Element for Inpatients—External Causes of Morbidity and Present on Admission Indicator.

(a)(1) For discharges up to and including September 30, 2014: The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable. An E-code is to be reported on the record for the first episode of care

reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the discharge record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

(2) For discharges occurring on and after October 1, 2014: The external causes of morbidity shall be coded using the ICD-10-CM External Causes of Morbidity (V00 – Y99). The external cause of morbidity that resulted in the injury or health condition shall be listed first. Additional cause of morbidity codes shall be reported if necessary to describe the mechanisms that contributed to, or the causal events surrounding, the injury or health condition.

(b) For discharges on or after July 1, 2008, whether the patient's external cause of injury 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 ~~on~~ at the time of inpatient admission.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~on~~ at the time of inpatient admission ~~or not~~.

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

Note: Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.