

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
CALIFORNIA INPATIENT DATA REPORTING MANUAL,  
MEDICAL INFORMATION REPORTING FOR CALIFORNIA, SEVENTH EDITION**

**PRINCIPAL DIAGNOSIS AND PRESENT ON ADMISSION  
INDICATOR**

**Section 97225**

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

*(2) 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.*

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
CALIFORNIA INPATIENT DATA REPORTING MANUAL,  
MEDICAL INFORMATION REPORTING FOR CALIFORNIA, SEVENTH EDITION**

**DISCUSSION**

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 up to and including September 30, 2015:

<p><b>PRINCIPAL DIAGNOSIS CODE</b></p> <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 20%;"></td> </tr> </table>						<p><b>PRESENT ON ADMISSION</b></p> <table border="1" style="width: 40px; height: 25px; border-collapse: collapse; margin-bottom: 5px;"> <tr> <td style="width: 100%;"></td> </tr> </table> <p>Y = Yes N = No U = Uncertain W = Clinically Undetermined (blank) = Exempt from POA reporting</p>																			
<p><b>OTHER DIAGNOSES</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px;">a.</td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> </tr> <tr> <td>b.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	a.					b.					c.					d.					<p><b>PRESENT ON ADMISSION</b></p> <table border="1" style="width: 40px; border-collapse: collapse;"> <tr> <td style="width: 100%;"></td> </tr> <tr> <td></td> </tr> <tr> <td></td> </tr> <tr> <td></td> </tr> </table>				
a.																									
b.																									
c.																									
d.																									

**Principal Diagnosis:**

**Reporting Requirement:** A principal diagnosis must be reported for every discharge data record.

**Psychiatric Reporting:** All psychiatric facilities are to report the principal diagnosis as the chief cause for admission for every discharge data record. The first listed diagnosis (in Axis I, II, or III) would be the principal diagnosis, if that is the reason for admission to the psychiatric facility. This includes medical conditions (in Axis III). In order to comply with the State's reporting requirements to OSHPD, these medical conditions should be reported. The medical conditions are listed as ICD-9-CM codes in Appendix G of DSM-IV codebook.

**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.

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
CALIFORNIA INPATIENT DATA REPORTING MANUAL,  
MEDICAL INFORMATION REPORTING FOR CALIFORNIA, SEVENTH EDITION**

ICD-9-CM Codes:

Refer to the official guidelines for coding and reporting the principal diagnosis in *Coding Clinic for ICD-9-CM*.

[http://www.cdc.gov/nchs/icd/icd9cm\\_addenda\\_guidelines.htm](http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm)

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E000-E030, E800-E999) will never be reported in the principal diagnosis code field. Such codes must only be reported in the External Causes of Injury code fields.

Italicized codes will never be the principal diagnosis.

**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-9-CM Official Guidelines for Coding and Reporting.

[http://www.cdc.gov/nchs/icd/icd9cm\\_addenda\\_guidelines.htm](http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm)