Diagnosis

Diagnoses made during utilization encounters.

This table lists all diagnoses associated with the encounters in the ENCOUNTER table. A record is a diagnosis code/original diagnosis code/diag provider combination unique to the index variable ENC_ID combination. The index variable ENC_ID uniquely identifies each encounter and is used to link the ENCOUNTER file to the both the DIAGNOSIS and PROCEDURE files. Include diagnoses from denied claims if the actual utilization occurred.

The PROVIDER variable is most useful for an outpatient visit. For an inpatient stay the major goal is that PROVIDER be consistent within an HMO. If possible, use the admitting physician. An inpatient stay has a single PROVIDER, even if multiple providers performed procedures.

Include diagnoses from professional and inpatient rounding services (outpatient providers who visit their patients in the hospital) in inpatient encounters. Identify the professional/inpatient rounding provider in the "diagprovider" variable.

Does not include the problem list as a source of diagnoses. Also, does not include admitting diagnosis for inpatient stays. Consider using the SAS compress option to reduce the size of the file and improve I/O processing.

Variable name	Variable Definition	Values	Comments
MRN	Identifier unique to an individual.	Character length unique to each HMO	Used to link across files
EncType	Encounter Type	Char (2)	Encounter Type. Valid Encounter Subtype values are in brackets "[]" **IP** = Acute Inpatient Hospital Stay: Inpatient stays, same-day hospital discharges, hospital transfers where the patient was admitted into the hospital. Includes acute inpatient psych and detox hospital stays. [Encounter_subtype=AI] **ED** =Emergency Department Encounter: Excludes urgent care visits. [Encounter_subtype=HA,OC] **AV**= Ambulatory Visit: Outpatient clinics, same day surgeries, observation beds, urgent care visits, and other same-day ambulatory hospital encounters. Excludes emergency department encounters). [Encounter_subtype= OC, OB, SD, HA, UC, RH, DI, OT] **TE** = Telephone Encounters: [Encounter_subtype=OT, HH]

			EM = E-mail Encounters: [Encounter_subtype=OT, HH] **IS**=Non-Acute Institutional Stays: Hospice, SNF, rehab, nursing home, residential, overnight non-hospital dialysis and other non-hospital stays. [Encounter_subtype=HS, SN, NH, RH,DI, OT] **OE**=Other Encounters (not overnight): Hospice visits, home health visits, SNF visits, other non-hospital visits. [Encounter_subtype=HS, HH, SN, RH, DI, OT] **LO**=Lab Only Encounter: Optional. Lab encounters that cannot be matched to another encounter. Include to link variables from utilization file to procedure file. [Encounter_subtype=OC,OT] **RO**=Radiology Only Encounter: Optional. Radiology encounter that cannot be matched to another encounter. Include to link variables from utilization file to procedure file. [Encounter_subtype=OC,OT]
ENC_ID	Encounter ID. Identifies unique encounters	Character. Length Unique to each health plan	Use to link across files. The encounter id must be unique for each encounter and should be permanently assigned (otherwise old and new versions of the files couldn't be joined). The encounter id can not contain PHI (such as MRN and dates). For EPIC/Clarity source data, recommend using the contact serial number. For other source data, sites should create a unique id that can be permanently assigned each unique combination of the following variables: MRN, Adate, EncType, Provider, Encounter_Subtype, Facility_Code and appointment time (if available). Suggest creating a separate crosswalk file between these variables and the encounter_id value. This crosswalk file would be updated with new encounters each time the utilization data is updated.
PROVIDER	Identifier unique to a provider	Character. Length unique to each HMO	Provider code for the provider who is most responsible for this encounter. Usually physician, nurse practitioner, physician assistant, optometrist, etc. For encounters with multiple providers, choose a single provider so the encounter can be linked to the diagnosis and procedure files. If there is no provider code for an encounter, then specify the value for provider as "UNK".
DIAGPROVIDER	Diagnosing Provider.	Character. Length unique to each HMO	Provider that made the diagnosis. If this provider is unknown, set equal to the provider variable.
ADATE		Numeric (4)	

	Outpatient encounter date or admit date		SAS date. Encounter date or admit date for an inpatient or institutional stay. If the encounter date or admit date is unknown from a claim, then use the first date of a claim.
DX	Standard Diagnosis codes	Char (8+) Sites may have local codes that are longer than the longest ICD Code. Truncation could occur on local codes.	Note the decimal point. Clean up site introduced suffixes and prefixes to match the ICD standard if possible. Use with the Dx_Codetype variable when new versions of the ICD coding system are implemented. ICD-9-CM Format ###.##, V##.##, E###.# ICD-10-CM Format A#@.@@@@ (3-8 characters - includes a decimal point (except for 3 digit codes)) First digit is alpha (A); Digit 2 is numeric (#); Digits 3-7 are alpha or numeric (@)
Dx_Codetype	ICD Coding Version	Char (2)	**0 7**='ICD-7-CM' (including 'ICD-7') **0 8** ='ICD-8-CM' (including 'ICD-8') **0 9** ='ICD-9-CM' (including 'ICD-9') **10** ='ICD-10-CM' (including 'ICD-10') **11**='ICD-11-CM' (including 'ICD-11') **OT**='Other'
ORIGDX	Original Diagnosis code from Source Data	Character. Length unique to each HMO	This is the actual diagnosis value from the source data
PDX (Replaced by Principal_Dx and Primary_Dx on 06/30/2012. Will be removed from the specs on 1/31/2014)	Primary Diagnosis flag (See Principal_Dx and Primary_Dx variables.)	Char (1)	**P** = primary diagnosis (the prinicipal diagnosis for hospital encounters or the primary diagnosis for any other encounter). Should have only 1 per encounter. For claims data, use the last facility bill for an encounter. **S** = secondary diagnosis (non-primary diagnoses) **X** = Unable to classify
Principal_dx (Scheduled to be added by 6/30/2012)	Principal Diagnosis Flag	Char (1)	**P**=Principal Dx **N**=Not Principal Dx **X**=Principal Dx Status not classifiable

			Assigned after discharge after review by the medical record department, the **principal** diagnosis is main reason why the patient was admitted to the hospital for care. This is the diagnosis on which the DRG is based. Note that the principal diagnosis is very different from the admitting diagnosis which is assigned at the beginning of the stay. For example, if a patient was admitted to a hospital with an admitting diagnosis of chest pain which was later diagnosed as a heart attack during the stay, the principal diagnosis would be heart attack. Specify principal diagnosis as defined by the site's institutional source data. It is expected that there should be one and only one principal diagnosis per hospitalization. For claims systems, the principal diagnosis may be found in the UB facility bill (field number 67 in UB 92 and UB 04 or "2300 HI01-2" on the electronic form) which should be the first diagnosis code listed. If there are multiple UB facility bills for a stay, identify the principal diagnosis from the final/last facility bill. If there are multiple final bills on the last date, use the one with the longest LOS. While the value "P" is expected to only be specified for inpatient and institutional stays, it is allowed for other encounter types if it is clearly identified in the source data. However in most typical cases for other encounters, the principal_dx should be set to "N". If the source data does not identify principal diagnosis (or not principal) for specific inpatient and institutional stays, then set Principal_dx to "X" for all diagnoses. Multiple principal diagnoses per hospitalization are allowed if the final/last facility bill can't be determined using the criteria above or if the principal diagnosis was a local combination code that has to be put into multiple records to have values within a standard coding system.
Primary_dx (Scheduled to be added by 6/30/2012)	Primary Diagnosis Flag	Char (1)	**P**=Primary Dx **S**=Secondary Dx **X**=Primary Dx Status not classifiable **Primary** diagnosis is the illness or injury that was the most serious/severe/life-threatening and/or resource intensive. From a claims perspective, it is the main reason for a provider's services being rendered (and billed/paid for).

			Specify primary diagnosis as defined by the site's institutional source data. For an outpatient encounter, it is expected that there should be one and only one primary diagnosis. For an inpatient stay, there can be multiple primary diagnoses, one for each provider claim during the stay. A provider may have multiple claims during a stay, each with a primary diagnosis. If multiple bills were submitted for a claim, choose the final/last professional bill. For claims systems, the primary diagnosis may be found in the HCFA professional bill (field number 21.1 in the HCFA 1500 or "2400 SV107-1" in the electronic form) which is the first diagnosis code listed. The other diagnoses on this bill should be identified as "S" (Secondary Dx). The values "P" (Primary Dx) and "S" (Secondary Dx) should only be specified for encounters where there's a clearly defined primary diagnosis in the source data. Thus, if the source data does not identify primary or secondary diagnosis for a specific encounter, then set all diagnoses for that encounter to "X" (Not Classifiable). If all diagnoses for an encounter are reported as secondary in the source data, then set primary_dx="S" (secondary). Multiple primary diagnoses are allowed if the final/last professional claim can't be determined using the criteria above or if the primary diagnosis was a local combination code that has to be put into multiple records to have values within a standard coding system.

The prior spec

Can be found here.

Please contact the VDW Utilization working group for questions and suggestions.

Related content
- Diagnosis (v2)
- Utilization QA Workplan

Comments (0)