Additional diagnosis

Important note: This is an archived metadata standard from the AIHW Knowledgebase. For current metadata standards and related information please access METeOR, the AIHW's Metadata Online Registry at http://meteor.aihw.gov.au

Identifying and Definitional Attributes

Data Dictionary: NHDD

Knowledgebase ID: 000005 Version number: 5

Metadata type: DATA ELEMENT

Registration NHIMG Admin status: SUPERSEDED

Authority: Effective date: 01-MAR-05

Definition: A condition or complaint either coexisting with the principal

diagnosis or arising during the episode of admitted patient care,

episode of residential care or attendance at a health care

establishment.

Context: Additional diagnoses give information on factors which result in

increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).

Relational and Representational Attributes

Datatype: Alphanumeric

Representational CODE

form:

Representation ANN.NN

layout:

Minimum Size: Maximum Size: 6

Data Domain: NOVAL ICD-10-AM - disease codes from ICD-10-AM

current edition.

Guide For Use: Record each additional diagnosis relevant to the episode of care

in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional

diagnosis codes. In some data collections these codes may also be

copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Collection Methods: An additional diagnosis should be recorded and coded where

appropriate upon separation of an episode of admitted patient care

or the end of an episode of residential care. The additional diagnosis is derived from and must be substantiated by clinical

documentation.

Related metadata: is used in the derivation of NHDD Diagnosis related group version

1

supersedes the data element Additional diagnosis version 4 relates to the data element Diagnosis onset type version 1 supplements the data element Principal diagnosis version 4

Administrative Attributes

Source Document: Current edition of International Classification of Diseases, Tenth

Revision, Australian Modification (ICD-10-AM).

Source Organisation: National Centre for Classification in Health (Sydney).

Data Element Links

Information Model Entities linked to this Data Element

NHIM Physical wellbeing

Data Agreements which include this Data Element

NMDS - Admitted patient care From 14-Nov-03 to

NMDS - Admitted patient mental health From 01-Jul-04 to

care

NMDS - Admitted patient palliative care From 14-Nov-03 to

NMDS - Residential mental health care From 14-Nov-03 to