Episode of admitted patient care—procedure, code (ICD-10-AM 3rd edn) NNNNN-NN

Exported from METEOR (AIHW's Metadata Online Registry)

Episode of admitted patient care—procedure, code (ICD-10-AM 3rd edn) NNNNN-NN

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Procedure
METEOR identifier:	269932
Registration status:	Health, Superseded 28/06/2004
Definition:	A clinical intervention represented by a code that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Episode of admitted patient care—procedure
METEOR identifier:	269450
Registration status:	National Health Performance Authority (retired), Retired 01/07/2016 Health, Superseded 05/10/2016 Tasmanian Health, Superseded 10/07/2017
Definition:	A **clinical intervention** that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Context:	This metadata item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.
Object class:	Episode of admitted patient care
Property:	Procedure

Value domain attributes

Identifying and definitional attributes

Value domain:	Procedure code (ICD-10-AM 3rd edn) NNNNN-NN
METEOR identifier:	270605
Registration status:	Health, Superseded 28/06/2004
Definition:	The ICD-10-AM (3rd edition) code set representing procedures.

Representational attributes

Classification scheme: [International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 3rd edition](#)

Representation class: Code

Data type: Number

Format: NNNNN-NN

Maximum character length: 7

Data element attributes

Collection and usage attributes

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM (3rd edition) Australian Coding Standards. Procedures are derived from and must be substantiated by clinical documentation.

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

Source and reference attributes

Origin: National Centre for Classification in Health

National Health Data Committee

Relational attributes

Related metadata references: Has been superseded by [Episode of admitted patient care—procedure, code (ICD-10-AM 4th edn) NNNNN-NN](#)
[Health](#), Superseded 07/12/2005

Is used in the formation of [Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA](#)
[Health](#), Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN](#)
[Health](#), Superseded 22/12/2009

Is re-engineered from [Procedure, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.7 KB)
No registration status

Implementation in Data Set Specifications: [Admitted patient care NMDS](#)

      [Health](#), Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
DSS specific information:

As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and state and territory information systems.

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.

Record all procedures undertaken during an episode of care in accordance with the ICD-10-AM (3rd edition) Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.