# Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}

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# Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}

# Identifying and definitional attributes

Metadata item type: Data Element

**Short name:** Principal diagnosis

METEOR identifier: 270187

Registration status: Health, Superseded 28/06/2004

**Definition:** The diagnosis established after study to be chiefly responsible for occasioning an

episode of admitted patient care, an episode of residential care or an attendance

at the health care establishment, as represented by a code.

Data Element Concept: Episode of care—principal diagnosis

Value Domain: Diagnosis code (ICD-10-AM 3rd edn) ANN{.N[N]}

#### Value domain attributes

# Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health

Problems, Tenth Revision, Australian Modification 3rd edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

## Data element attributes

# Collection and usage attributes

**Guide for use:** The principal diagnosis must be determined in accordance with the Australian

Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint,

or other factor influencing health status.

As a minimum requirement the Principal diagnosis code must be a valid code from

the current edition of ICD-10-AM.

For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups, Version 4.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as

principal diagnosis.

**Collection methods:** A principal diagnosis should be recorded and coded upon <u>separation</u>, for each

episode of patient care. The principal diagnosis is derived from and must be

substantiated by clinical documentation.

**Comments:** The principal diagnosis is one of the most valuable health data elements. It is used

for epidemiological research, casemix studies and planning purposes.

# Source and reference attributes

Origin: Health Data Standards Committee

National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Reference documents: Bramley M, Peasley K, Langtree L and Innes K 2002. The ICD-10-AM Mental

Health Manual: an integrated classification and diagnostic tool for community-based mental health services. Sydney: National Centre for Classification in Health,

University of Sydney

#### Relational attributes

Related metadata references:

Has been superseded by Episode of care—principal diagnosis, code (ICD-10-AM

4th edn) ANN{.N[N]}

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 re-engineered from Principal diagnosis, version 4, DE, NHDD, NHIMG,

Superseded 01/03/2005.pdf (19.3 KB)

No registration status

Implementation in Data Set Admitted patient care NMDS **Specifications:** 

Health, Superseded 07/12/2005 Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

DSS specific information:

The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Admitted patient mental health care NMDS

Health, Superseded 07/12/2005

Implementation start date: 01/07/2005 Implementation end date: 30/06/2006

Admitted patient palliative care NMDS

Health, Superseded 07/12/2005 Implementation start date: 01/07/2005 Implementation end date: 30/06/2006

Community mental health care NMDS 2004-05

Health, Superseded 08/12/2004 Implementation start date: 01/07/2004 Implementation end date: 30/06/2005

Community mental health care NMDS 2005-06

Health, Superseded 07/12/2005 Implementation start date: 01/07/2005 Implementation end date: 30/06/2006

DSS specific information:

Codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health 2002.

Residential mental health care NMDS 2005-06

Health, Superseded 07/12/2005

Implementation start date: 01/07/2005 Implementation end date: 30/06/2006

DSS specific information:

Codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).