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

Exported from METEOR (AIHW's Metadata Online Registry)

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Registration status:	Health, Superseded 28/06/2004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 **separation**, 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 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:

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).