

# Episode of admitted patient care—diagnosis onset type, code N

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# Episode of admitted patient care—diagnosis onset type, code N

## Identifying and definitional attributes

<b>Metadata item type:</b>	Data Element
<b>Short name:</b>	Diagnosis onset type
<b>METEOR identifier:</b>	270192
<b>Registration status:</b>	<a href="#">Health</a> , Superseded 05/02/2008
<b>Definition:</b>	A qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care, as represented by a code.
<b>Data Element Concept:</b>	<a href="#">Episode of admitted patient care—diagnosis onset type</a>
<b>Value Domain:</b>	<a href="#">Diagnosis onset type code N</a>

## Value domain attributes

## Representational attributes

<b>Representation class:</b>	Code
<b>Data type:</b>	Number
<b>Format:</b>	N
<b>Maximum character length:</b>	1

	<b>Value</b>	<b>Meaning</b>
<b>Permissible values:</b>	1	Primary condition
	2	Post-admit condition
<b>Supplementary values:</b>	9	Unknown or uncertain

## Collection and usage attributes

<b>Guide for use:</b>	CODE 1 Primary condition
	<ul style="list-style-type: none"><li>a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status. In the case of neonates, the condition(s) present at birth.</li><li>a previously existing condition not diagnosed until the current episode of care in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage</li></ul>
	CODE 2 Post-admit condition
	<ul style="list-style-type: none"><li>a condition which arises during the current episode of care and would not have been present on admission</li></ul>
	CODE 9 Unknown or uncertain
	<ul style="list-style-type: none"><li>a condition where the documentation does not support assignment to 1 or 2</li></ul>

## Data element attributes

## Collection and usage attributes

<b>Guide for use:</b>	<p>Assign the relevant diagnosis type flag to all of the ICD-10-AM disease codes recorded in the hospital morbidity system. Specific guidelines for correct assignment of diagnosis flag type are in the ICD-10-AM Australian Coding Standards.</p> <p>The following rules only apply to:</p> <ul style="list-style-type: none"> <li>• diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s).</li> <li>• hospital morbidity data.</li> <li>• 'episode of care' refers to hospital or day procedure episodes of care.</li> </ul> <p>Explanatory notes:</p> <p>The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.</p> <p>The flag on morphology codes should match that on the corresponding neoplasm code.</p> <p>Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.</p>
<b>Collection methods:</b>	A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.
<b>Comments:</b>	Improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring.

## Source and reference attributes

**Origin:** National Centre for Classification in Health

## Relational attributes

**Related metadata references:** Has been superseded by [Episode of admitted patient care—condition onset flag, code N](#)  
[Health](#), Superseded 07/02/2013

Is re-engineered from  [Diagnosis onset type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.1 KB)  
*No registration status*