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:	4
Metadata type:	DATA ELEMENT		
Registration Authority:	NHIMG	Admin status:	SUPERSEDED
		Effective date:	14-NOV-03

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 form:	CODE
Representation layout:	ANN.NN
Minimum Size:	3
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: supersedes previous data element Additional diagnosis - ICD-9-CM code version 3
is used in the derivation of Diagnosis related group version 1
supplements the data element Principal diagnosis version 3
relates to the data element Diagnosis onset type version 1
has been superseded by Additional diagnosis version 5

Administrative Attributes

Source Document: Current edition of International Classification of Diseases, Tenth Revision, Australian Modification.

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

Comments: Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patients to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified Additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

External cause codes, although not diagnosis or condition codes, should be sequenced together with the additional diagnoses codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

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 01-Jul-98 to 14-Nov-03
NMDS - Admitted patient mental health	From 01-Jul-98 to 14-Nov-03

care

NMDS - Admitted patient palliative care From 01-Jul-00 to 14-Nov-03