Principal diagnosis - ICD-9-CM code

Identifying and Definitional Attributes

Data Dictionary:	NHDD		
Knowledgebase ID:	000136	Version number:	2
Metadata type:	DATA ELEMENT		
Registration Authority:	NHIMG	Admin status:	SUPERSEDED
		Effective date:	30-JUN-99

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

Context: Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	CODE
Representation layout:	ANN.NN
Minimum Size:	3
Maximum Size:	6
Data Domain:	NOVAL ICD-9-CM

Guide For Use: The classification is revised annually. The version current for the collection period is required. Australian editions of ICD-9-CM were published by the National Centre for Classification in Health in 1995 and 1996.

Although this data element has been superseded by Principal diagnosis - ICD-10-AM, Version 3, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification Rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:
- start with a digit or a V

- be reported as per coding guidelines

Some diagnosis codes cannot be used, and will result in a fatal error. These relate to Diagnosis Related Groups 951, 955 and 956, which are too imprecise to be acceptable as principal diagnosis. A list of diagnosis codes grouped under these three Diagnosis Related Groups is available from the Diagnosis Related Group Development Section, Classification and Payments Branch, Health Services Development Division, Department of Health and Family Services.

Diagnosis codes starting with an E, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis

Diagnosis codes starting with an M are morphology codes, cannot be used as principal diagnosis and will result in a fatal error.

Collection Methods: A principal diagnosis should be recorded for each episode of patient care. Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital inpatients), 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.

Related metadata: supersedes previous data element Principal diagnosis version 1
relates to the data element Additional diagnosis - ICD-9-CM code version 3
is a qualifier of Principal procedure version 1
is a qualifier of Principal procedure version 2
is a qualifier of Principal procedure - ICD-9-CM code version 3
relates to the data element Additional procedures - ICD-9-CM code version 3
relates to the data element External cause - major external cause version 3
relates to the data element External cause - human intent version 3
relates to the data element Place of occurrence of external cause of injury - admitted patient - ICD-9-CM version 3
relates to the data element Place of occurrence of external cause of injury - non-admitted patient version 3
relates to the data element Diagnosis related group version 1
is used in the derivation of Major diagnostic category version 1
is an alternative to Nature of main injury - non-admitted patient version 1
is an alternative to Bodily location of main injury version 1

relates to the data element External cause - admitted patient - ICD-9-CM code version 3
has been superseded by Principal diagnosis version 3

Administrative Attributes

Source Document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source Organisation: National Health Data Committee, National Coding Centre and National Data Standard for Injury Surveillance Advisory Group

Comments: This item is updated annually according to advice received from the National Coding Centre and is consistent with the Australian Coding Standards (Volume 4, Australian Version of ICD-9-CM (1995)).

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-93 to 30-Jun-98
NMDS - Admitted patient mental health care	From 01-Jul-97 to 30-Jun-99