Diagnosis onset type

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:	000773	Version number:	1
Metadata type:	DATA ELEMENT		
Registration Authority:	NHIMG	Admin status:	SUPERSEDED
		Effective date:	01-MAR-05

Definition: A qualifier for each coded diagnosis to indicate the onset and / or significance of the diagnosis to the episode of care.

Context: Health services:
Improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring.

Relational and Representational Attributes

Datatype: Numeric

Representational form: CODE

Representation layout: N

Minimum Size: 1

Maximum Size: 1

Data Domain:

1	Primary condition
2	Post-admit condition
9	Unknown or uncertain

Guide For Use: 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 current edition of ICD-10-AM Australian Coding Standards.

The following rules only apply to:
- 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).
- hospital morbidity data - 'episode of care' refers to hospital or day procedure episodes of care

1 Primary condition
- 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.
- 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

2 Post-admit condition
- a condition which arises during the current episode of care and would not have been present on admission

9 Unknown or uncertain
- a condition where the documentation does not support assignment to 1 or 2

Explanatory Notes:-
The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code.

Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.

Collection Methods: A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.

Related metadata: relates to the data element External cause - admitted patient version 4
relates to the data element Additional diagnosis version 4
relates to the data element Place of occurrence of external cause of injury version 5
relates to the data element Activity when injured version 2
relates to the data element Principal diagnosis version 4

Administrative Attributes

Source Document:

Source Organisation: National Centre for Classification in Health.

Data Element Links

Information Model Entities linked to this Data Element

NHIM Request for / entry into service event

Data Agreements which include this Data Element