

Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}

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Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Additional diagnosis
METEOR identifier:	333832
Registration status:	Health , Superseded 05/02/2008
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, as represented by a code.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Episode of care—additional diagnosis
METEOR identifier:	269656
Registration status:	Health , Superseded 05/02/2008
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).
Object class:	Episode of care
Property:	Additional diagnosis

Value domain attributes

Identifying and definitional attributes

Value domain:	Diagnosis code (ICD-10-AM 5th edn) ANN{.N[N]}
METEOR identifier:	333683
Registration status:	Health , Superseded 05/02/2008
Definition:	The ICD-10-AM (5th edition) code set representing diagnoses.

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th 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: Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. 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.

Comments: Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient 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 diagnosis codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references: Supersedes [Episode of care—additional diagnosis, code \(ICD-10-AM 4th edn\) ANN{.N\[N\]}](#)
[Health](#), Superseded 07/12/2005

Has been superseded by [Episode of care—additional diagnosis, code \(ICD-10-AM 6th edn\) ANN{.N\[N\]}](#)
[Health](#), Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care—major diagnostic category, code \(AR-DRG v5.1\) NN](#)
[Health](#), Superseded 22/12/2009

Implementation in Data Set Specifications: [Admitted patient care NMDS 2006-07](#)
[Health](#), Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
DSS specific information:

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.

Effective for collection from 01/07/2006

[Admitted patient care NMDS 2007-08](#)
[Health](#), Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
DSS specific information:

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.

Effective for collection from 01/07/2006

[Admitted patient mental health care NMDS](#)

[Health](#), Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

DSS specific information: 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.

[Admitted patient mental health care NMDS 2007-08](#)

[Health](#), Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

DSS specific information: 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.

[Admitted patient palliative care NMDS 2006-07](#)

[Health](#), Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

DSS specific information:

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.

Effective for collection from 01/07/2006

[Admitted patient palliative care NMDS 2007-08](#)

[Health](#), Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

DSS specific information:

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.

Effective for collection from 01/07/2006

[Residential mental health care NMDS 2006-07](#)

[Health](#), Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

DSS specific information: Effective for collection from 01/07/2006

[Residential mental health care NMDS 2007-08](#)

[Health](#), Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

**Implementation in
Indicators:**

Used as Numerator

[National Healthcare Agreement: P22-Selected potentially preventable hospitalisations, 2010](#)

[Health](#), Superseded 08/06/2011

[National Healthcare Agreement: P41-Falls resulting in patient harm in hospitals, 2010](#)

[Health](#), Superseded 08/06/2011

[National Healthcare Agreement: P42-Intentional self-harm in hospitals, 2010](#)

[Health](#), Superseded 08/06/2011