

Diagnosis—diagnosis/procedure/intervention classification type, code XXX[XXXX]

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Diagnosis—diagnosis/procedure/intervention classification type, code XXX[XXXX]

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Diagnosis/Procedure/Intervention classification type
Synonymous names:	DIA_TYPE_CODE_1; DIA_TYPE_CODE_2; DIA_TYPE_CODE_3
METEOR identifier:	573182
Registration status:	WA Health , Standard 19/03/2015
Definition:	The code that identifies the classification system used to assign a diagnosis, procedure or intervention code in a patient's medical record.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Diagnosis—diagnosis/procedure/intervention classification type
METEOR identifier:	572934
Registration status:	WA Health , Standard 19/03/2015
Definition:	The classification system used to assign a diagnosis, procedure or intervention code in the patient's medical record.
Object class:	Diagnosis
Property:	Diagnosis/Procedure/Intervention classification type

Value domain attributes

Identifying and definitional attributes

Value domain:	Diagnosis/Procedure/Intervention classification type code XXX[XXXX]
METEOR identifier:	573087
Registration status:	WA Health , Standard 19/03/2015
Definition:	A set of alphanumeric characters that identifies the classification system used to assign a diagnosis, procedure or intervention code in a patient's medical record.

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	XXX[XXXX]	
Maximum character length:	7	
Permissible values:	Value	Meaning
	ICD9CM	International Classification of Disease (ICD) ninth edition - Canadian modified (AU)
	ICD10AM	International Classification of Disease (ICD) tenth edition - Australian modified
	HIC	Health issue code

Data element attributes

Collection and usage attributes

Guide for use:

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the official system of assigning codes to diagnoses and procedures associated with hospital utilisation in the United States. It is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9).

ICD-9-CM consists of:

- a tabular list containing a numerical list of the disease code numbers in tabular form
- an alphabetic index of the disease entries
- a classification system for surgical, diagnostic and therapeutic procedures (alphabetic index and tabular list).

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services are the US government agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

ICD-10-AM

International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM) includes Australian extensions of the World Health Organization codes in ICD-10 and some specific Australian disease codes. Also included is a classification of procedures based on the Commonwealth Medicare Benefits Schedule (MBS) of fees for health services.

ICD-10-AM uses an alphanumeric coding scheme for diseases and external causes of injury. It is structured by body system and aetiology, and comprises three, four and five character categories.

It is the standard classification scheme now used for reporting diagnoses in all Hospital statistical collections, including the National Minimum Data Set and the Hospital Casemix Protocol.

ICD-10-AM consists of:

- a tabular list of three character codes with some expansion to four and five character codes
- an alphabetic index of diseases.

The alphabetic index comprises three sections:

- Section I is the index of diseases, syndromes, pathological conditions, injuries, signs, symptoms, problems and other reasons for contact with health services.
- Section II is the index of external causes of injury. The terms included here refer to descriptions of the circumstances in which the violence occurred rather than medical diagnoses.
- Section III is the index of drugs and other chemical substances giving rise to poisoning or other adverse effects (also known as the Table of drugs and chemicals).

The National Centre for Classification in Health (NCH) as the lead organisation of the Australian Consortium for Classification Development (ACCD) is the Australian body responsible for preparing, updating and publishing new editions of ICD-10-

AM.

ICPC-2 PLUS

International Classification of Primary Care, Version 2 (ICPC-2) PLUS is a coding system that allows health professionals to record symptoms, diagnoses (problem labels), past health problems and processes (such as procedures, counselling and referrals) at the point of care. It can be used in age-sex disease registers, morbidity registers and full electronic health records in primary care.

ICPC-2 PLUS is primarily used in Australia. General Practitioners from a mix of both rural and urban practices use it in their electronic health records. ICPC-2 PLUS is also currently implemented across a number of primary health care settings including software packages used by Aboriginal medical services, prisoner health, community health and allied health.

A mapping system has been developed, which enables the terms used in ICPC-2 PLUS to be matched to ICD-10-AM codes.

The ICPC-2 PLUS terminology is maintained and regularly updated by the Family Medicine Research Centre (FMRC), at the University of Sydney.

Relational attributes

Implementation in Data Set Specifications:

[WA Health Non-Admitted Patient Activity and Wait List Data Collection \(NAPAAWL DC\) 2013-14](#)

[WA Health](#), Standard 19/03/2015

[WA Health Non-Admitted Patient Activity and Wait List Data Collection \(NAPAAWL DC\) 2014-15](#)

[WA Health](#), Standard 24/04/2015