

Episode of care—additional diagnosis, code (ICD-10-AM 9th edn) ANN{.N[N]}

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Episode of care—additional diagnosis, code (ICD-10-AM 9th edn) ANN{.N[N]}

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Additional diagnosis
METEOR identifier:	588981
Registration status:	Independent Hospital Pricing Authority , Standard 16/03/2016 Health , Superseded 05/10/2016 Tasmanian Health , Superseded 06/07/2017
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:	356590
Registration status:	Health , Standard 05/02/2008 Independent Hospital Pricing Authority , Standard 16/03/2016 National Health Performance Authority (retired) , Retired 01/07/2016 Tasmanian Health , Standard 02/09/2016
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.
Object class:	Episode of care
Property:	Additional diagnosis

Value domain attributes

Identifying and definitional attributes

Value domain:	Diagnosis code (ICD-10-AM 9th edn) ANN{.N[N]}
METEOR identifier:	588979
Registration status:	Independent Hospital Pricing Authority , Standard 16/03/2016 Health , Superseded 05/10/2016 Tasmanian Health , Superseded 06/07/2017
Definition:	The ICD-10-AM (9th edition) code set representing diagnoses.

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 9th 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.

Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. 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).

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 or attendance at a health care establishment. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Comments: Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.

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 of 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: Independent Hospital Pricing Authority
Australian Consortium for Classification Development

Relational attributes

Related metadata references: Supersedes [Episode of care—additional diagnosis, code \(ICD-10-AM 8th edn\) ANN{.N\[N\]}](#)

[Health](#), Superseded 13/11/2014

[Tasmanian Health](#), Superseded 02/09/2016

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

[Health](#), Superseded 25/01/2018

[Independent Hospital Pricing Authority](#), Recorded 04/08/2016

[Tasmanian Health](#), Superseded 08/04/2019

Is used in the formation of [Episode of admitted patient care—diagnosis related group, code \(AR-DRG v 8.0\) ANNA](#)

[Tasmanian Health](#), Superseded 11/01/2018

Implementation in Data Set Specifications: [Activity based funding: Mental health care DSS 2016-17](#)
[Independent Hospital Pricing Authority](#), Superseded 28/02/2017

Implementation start date: 01/07/2016

Implementation end date: 30/06/2017

Conditional obligation: This data element is required to be reported for episodes of care in an admitted or residential setting.

DSS specific information:

For admitted episodes of care it is mandatory for diagnosis to be reported in accordance with the Australian Coding Standards, and in ICD-10-AM 9th edition.

For ambulatory and residential episodes of care additional diagnosis is not mandatory. Provisional diagnoses should not be reported.

[Admitted patient care NMDS 2015-16](#)

Health, Superseded 10/11/2015

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation: This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated.

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 care NMDS 2016-17](#)

Health, Superseded 05/10/2016

Implementation start date: 01/07/2016

Implementation end date: 30/06/2017

Conditional obligation:

This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated.

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 2015-16](#)

Health, Superseded 19/11/2015

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation: This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated.

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 2015-16](#)

Health, Superseded 19/11/2015

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation: This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated.

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.

[Residential mental health care NMDS 2016-17](#)

Health, Superseded 17/08/2017

Implementation start date: 01/07/2016

Implementation end date: 30/06/2017

[Tasmanian Admitted Patient Data Set - 2016](#)

Tasmanian Health, Superseded 10/01/2018

Implementation start date: 01/07/2016

Implementation end date: 30/06/2017

**Implementation in
Indicators:**

Used as Numerator

[Australian Health Performance Framework: PI 3.1.5–Hospitalisation for injury and poisoning, 2019](#)

[Health](#), Superseded 13/10/2021

[National Healthcare Agreement: PB f–By 2014–15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions, 2018](#)

[Health](#), Superseded 19/06/2019

[National Healthcare Agreement: PB f–By 2014–15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions, 2019](#)

[Health](#), Superseded 13/03/2020

[National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2018](#)

[Health](#), Superseded 19/06/2019

[National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2019](#)

[Health](#), Superseded 13/03/2020

[National Healthcare Agreement: PI 27–Number of hospital patient days used by those eligible and waiting for residential aged care, 2018](#)

[Health](#), Superseded 19/06/2019

[National Healthcare Agreement: PI 27–Number of hospital patient days used by those eligible and waiting for residential aged care, 2019](#)

[Health](#), Superseded 13/03/2020

[Number of potentially preventable hospitalisations - chronic obstructive pulmonary disease \(COPD\) per 100,000 people of all ages, 2014-15 to 2017-18](#)

[Australian Commission on Safety and Quality in Health Care](#), Standard 27/04/2021

[Number of potentially preventable hospitalisations - chronic obstructive pulmonary disease \(COPD\) per 100,000 people of all ages, 2014-15 to 2017-18](#)

[Australian Commission on Safety and Quality in Health Care](#), Standard 27/04/2021