

Diagnosis array

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Diagnosis array

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METEOR identifier:	767940
Registration status:	Health , Standard 06/12/2023
DSS type:	Data Element Cluster
Scope:	The diagnosis array identifies: <ul style="list-style-type: none">• a condition (a diagnosis, symptom, injury, external cause or other factor identified using a <i>diagnosis code</i> from ICD-10-AM),• the onset of the condition (identified using the <i>condition onset flag</i>)• whether the condition relates to another diagnosis code (identified using a <i>diagnosis cluster identifier</i>)

Collection and usage attributes

Statistical unit:	Episode of care
Guide for use:	<p>The diagnosis array comprises data elements that provide information on the conditions reported to the admitted patient care data sets.</p> <p>Diagnosis cluster coding is a method that links related International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) codes together, evidenced by clinical documentation in the patient's health care record. The diagnosis cluster identifier (DCID) is recorded against all ICD-10-AM codes assigned to an episode of admitted patient care. Where two or more ICD-10-AM codes are assigned the same DCID value, these codes are considered to be 'clustered' and are related to one another.</p> <p>Reporting the diagnosis array is not contingent upon a system's ability to report the DCID for episodes of admitted care on and from 1 July 2025. Until the DCID is implemented in local systems, supplementary value 9 can be reported.</p>
Collection methods:	Information used to inform the diagnosis array is taken from clinical documentation of the health care record. Guidelines from the Australian Coding Standards determine whether a condition is present in the diagnosis array.

Source and reference attributes

Submitting organisation:	Independent Health and Aged Care Pricing Authority
Reference documents:	Australian Coding Standards (IHACPA, 2025)

Metadata items in this Data Set Specification

Seq	Metadata item	Obligation	Max occurs
No.			

Seq No.	Metadata item	Obligation	Max occurs
1	Episode of care—principal diagnosis, code (ICD-10-AM Twelfth edition) ANN{.N[N]} <i>DSS specific information:</i> The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories. Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), 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.	Mandatory	1
2	Episode of care—additional diagnosis, code (ICD-10-AM Twelfth edition) ANN{.N[N]} <i>Conditional obligation:</i> This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated. <i>DSS specific information:</i> An unlimited number of diagnosis codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 40 codes should be able to be collected.	Conditional	99
3	Injury event—external cause, code (ICD-10-AM Twelfth edition) ANN{.N[N]} <i>Conditional obligation:</i> This data element is only required to be reported if the episode of care contains a principal or additional diagnosis code that refers to an injury, poisoning, or other adverse effect.	Conditional	99
4	Injury event—place of occurrence, code (ICD-10-AM Twelfth edition) ANN{.N[N]} <i>Conditional obligation:</i> This data element is only required to be reported if the episode of care contains a principal or additional diagnosis code that refers to an injury, poisoning, or other adverse effect.	Conditional	99
5	Injury event—activity type, code (ICD-10-AM Twelfth edition) ANN{.N[N]} <i>Conditional obligation:</i> This data element is only required to be reported if the episode of care contains a principal or additional diagnosis code that refers to an injury, poisoning, or other adverse effect.	Conditional	99
6	Episode of admitted patient care—condition onset flag, code N	Mandatory	99

Seq No.	Metadata item	Obligation	Max occurs
7	Episode of admitted patient care—diagnosis cluster identifier, code X[X]	Mandatory	99

DSS specific information:

The diagnosis cluster identifier (DCID) is reported against *ICD-10-AM Thirteenth Edition* codes.

Health services that are not able to collect and report the DCID data element for episodes of admitted care on and from 1 July 2025 are able to report supplementary value 9 *Not reported* until their data management system is able to collect the data element.