Principal diagnosis

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:	000136	Version number:	3
Metadata type:	DATA ELEMENT		
Registration Authority:	NHIMG	Admin status:	SUPERSEDED
		Effective date:	13-NOV-03

Definition: The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, and episode of residential care or an attendance at the health care establishment.

Context: Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes. Admitted patients: The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	CODE
Representation layout:	ANN.NN
Minimum Size:	3
Maximum Size:	6
Data Domain:	NOVAL Current edition of ICD-10-AM

Guide For Use: The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The second edition was published for use from July 2000 and the third edition for use from July 2002.

For the National Minimum Data Set for Community Mental Health Care and the National Minimum Data Set for Residential Mental Health Care, codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health in 2002.

Verification Rules: As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.
For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups, Version 4.
Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes, cannot be used as principal diagnosis.

Collection Methods: The principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients: 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.

Residents: The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

Related metadata: supersedes previous data element Principal diagnosis - ICD-9-CM code version 2
relates to the data element Diagnosis related group version 1
is used in the derivation of Major diagnostic category version 1
is used as an alternative to Nature of main injury - non-admitted patient version 1
is an alternative to Bodily location of main injury version 1
relates to the data element External cause - human intent version 4
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 External cause - non-admitted patient version 4
relates to the data element Procedure version 5
relates to the data element Diagnosis onset type version 1
has been superseded by Principal diagnosis version 4

Administrative Attributes

Source Document: Current edition of International Statistical Classification of Diseases and Related Health Problems - Tenth Revision - Australian Modification. National Centre for Classification in Health, Sydney.

Source Organisation: Health Data Standards Committee.
National Centre for Classification in Health.
National Data Standard for Injury Surveillance Advisory Group.

Data Element Links

Information Model Entities linked to this Data Element

NHIM	Physical wellbeing

Data Agreements which include this Data Element

NMDS - Admitted patient care	From 01-Jul-89 to 14-Nov-03
NMDS - Admitted patient mental health care	From 01-Jul-97 to 14-Nov-03
NMDS - Community mental health care	From 01-Jul-98 to 14-Nov-03
NMDS - Admitted patient palliative care	From 01-Jul-00 to 14-Nov-03