Episode of care—additional diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]}

Exported from METEOR (AIHW's Metadata Online Registry)

Episode of care—additional diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]}

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Additional diagnosis
METEOR identifier:	333830
Registration status:	Health!, Superseded 07/12/2005
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:	Episode of care—additional diagnosis
Value Domain:	Diagnosis code (ICD-10-AM 4th edn) ANN{.N[N]}

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 4th 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 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: National Centre for Classification in Health

Relational attributes

Related metadata references:

Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}
Health!, Superseded 28/06/2004

Has been superseded by Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}
Health!, Superseded 05/02/2008