Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}

Exported from METEOR (AIHW's Metadata Online Registry)

Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Additional diagnosis
METEOR identifier:	333832
Registration status:	Health!, Superseded 05/02/2008
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 5th edn) ANN{.N[N]}

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th 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 4th edn) ANN{.N[N]}
Health!, Superseded 07/12/2005

Has been superseded by Episode of care—additional diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}
Health!, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN
Health!, Superseded 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2006-07
Health!, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
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.

Effective for collection from 01/07/2006

Admitted patient care NMDS 2007-08
Health!, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
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.

Effective for collection from 01/07/2006

Admitted patient mental health care NMDS
Health!, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
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 2007-08
Health!, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
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 2006-07
Health!, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
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.

Effective for collection from 01/07/2006

Admitted patient palliative care NMDS 2007-08
Health!, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
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.

Effective for collection from 01/07/2006

AROC inpatient data set specification
Health!, Recorded 18/07/2007
Implementation start date: 01/06/2007
DSS specific information:

Conditions or complaints either co-exisiting (comorbidities) with the principal diagnosis or arising during the episode (complications) are collected for each episode of medical rehabilitation. Due to coding issues in some facilities, this data is collected at point of care against an abreviated list of diagnoses that can be mapped to ICD10 at a later point in time.

Comorbidities

01	Ischaemic heart disease
02	Cardiac failure
03	Atrial fibrilation
04	Osteoporosis
05	Osteoarthritis
06	Upper limb amputation
07	Lower limb amputation
08	Depression
09	Schizophrenia
10	Drug and alcohol use
11	Dementia
12	Asthma
13	CAL/COPD
14	Renal failure
15	Epilepsy
16	Parkinson
17	CVA
18	Spinal cord injury/disease
19	Visual impairment
20	Hearing impairment
99	Other

Complications

01 UTI

02 Pressure area

03 Wound infection

04 DVT/PE

05 Chest infection

06 Significant electrolyte imbalance

99 Other

Residential mental health care NMDS 2006-07
Health!, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
DSS specific information: Effective for collection from 01/07/2006

Residential mental health care NMDS 2007-08
Health!, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

Implementation in Indicators:

Used as Numerator

National Healthcare Agreement: P22-Selected potentially preventable hospitalisations, 2010
Health!, Superseded 08/06/2011

National Healthcare Agreement: P41-Falls resulting in patient harm in hospitals, 2010
Health!, Superseded 08/06/2011

National Healthcare Agreement: P42-Intentional self-harm in hospitals, 2010
Health!, Superseded 08/06/2011