Emergency department stay—principal diagnosis, code X(18)

Exported from METEOR (AIHW's Metadata Online Registry)

Emergency department stay—principal diagnosis, code X(18)

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	ED principal diagnosis
METEOR identifier:	447914
Registration status:	Independent Hospital Pricing Authority, Superseded 31/10/2012
Definition:	The diagnosis established at the conclusion of the patient's attendance in an **emergency department** to be mainly responsible for occasioning the attendance following consideration of clinical assessment, as represented by a code.
Data Element Concept:	Emergency department stay—principal diagnosis
Value Domain:	Diagnosis code X(18)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	X(18)
Maximum character length:	18

Collection and usage attributes

Collection methods: The code set can be represented by the following :

ICD-10-AM - 1st edition to 7th edition

International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian Modification. ICD-10-AM is a classification of diseases and health related problems. ICD-10-AM diagnoses codes contain three core character codes with some expansion to four and five character codes. The format for ICD-10-AM diagnoses codes is ANN{.N(N)}

ICD-9-CM - 2nd edition

International Classification of Diseases - 9th Revision - Clinical Modification. ICD-9-CM is a classification of diseases. ICD-9-CM diagnoses codes contain four character codes with some expansion to five character codes. The format for ICD-9-CM diagnoses codes is NNN.N(N)

EDRS-SNOMED CT-AU

Systematized Nomenclature of Medicine - Clinical Terms - Australian version (Emergency Department Reference Set). SNOMED CT-AU is a clinical terminology which uses a structured vocabulary to describe the care and treatment of patients. There is a subset for Emergency Department care. The format for EDRS-SNOMED CT-AU diagnoses codes is NNNNNN(NNN).

Other term sets or code sets developed for use specifically to record diagnosis in an emergency department setting.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

An emergency department care episode ends when either the patient is admitted, died or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

The phrase 'at the conclusion' in the definition refers to evaluation of findings interpreted by the clinician available at the end of the emergency department episode. This may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, surgical procedures and pathological or radiological examination.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Has been superseded by Emergency department stay—principal diagnosis, code X[X(8)]
Health!, Superseded 13/11/2014
Independent Hospital Pricing Authority, Standard 31/10/2012

See also Emergency department stay—diagnosis classification type, code N.N
Independent Hospital Pricing Authority, Superseded 31/10/2012

Implementation in Data Set Specifications:

Emergency department care activity based funding DSS 2012-2013
Independent Hospital Pricing Authority, Superseded 31/10/2012
Implementation start date: 01/07/2012
Implementation end date: 30/06/2013
Conditional obligation:

The reporting of this data element is optional for those attendances where the emergency department principal diagnosis is not likely to be ascertained for patients who:

- Did not wait
- Dead on arrival
- Left the Emergency Department - treatment not complete.