

Emergency department stay—additional diagnosis, code X[X(8)]

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Emergency department stay—additional diagnosis, code X[X(8)]

Identifying and definitional attributes

| | |
|------------------------------|--|
| Metadata item type: | Data Element |
| Short name: | ED additional diagnosis code |
| METEOR identifier: | 497488 |
| Registration status: | Independent Hospital Pricing Authority , Standard 31/10/2012 Health! , Superseded 13/11/2014 |
| Definition: | The condition or complaint coexisting with the emergency department principal diagnosis during a patient's attendance to the emergency department, as represented by a code. |
| Data Element Concept: | Emergency department stay—additional diagnosis |
| Value Domain: | Diagnosis code X[X(8)] |

Value domain attributes

Representational attributes

| | |
|----------------------------------|---------|
| Representation class: | Code |
| Data type: | String |
| Format: | X[X(8)] |
| Maximum character length: | 9 |

Collection and usage attributes

| | |
|----------------------------|---|
| Collection methods: | This value domain allows reporting of diagnosis using different code sets. The code set can be represented by the following: ICD-10-AM - 6th edition, 7th edition and 8th 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] |
|----------------------------|---|

Source and reference attributes

| | |
|---------------------------------|--|
| Submitting organisation: | Independent Hospital Pricing Authority |
|---------------------------------|--|

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Supersedes [Emergency department stay—additional diagnosis, code X\(18\)](#)
[Independent Hospital Pricing Authority](#), Superseded 31/10/2012

Has been superseded by [Emergency department stay—additional diagnosis, code X\(X\(8\)\)](#)
[Health!](#), Superseded 05/10/2016

See also [Emergency department stay—diagnosis classification type, code N.N](#)
[Health!](#), Superseded 13/11/2014
[Independent Hospital Pricing Authority](#), Standard 31/10/2012

Implementation in Data Set Specifications: [Activity based funding: Emergency department care DSS 2013-2014](#)
[Independent Hospital Pricing Authority](#), Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

Only required to be reported when at least one additional diagnosis is present for the emergency department stay.

[Non-admitted patient emergency department care DSS 2014-15](#)

[Health!](#), Superseded 04/02/2015

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.

[Non-admitted patient emergency department care NMDS 2013-14](#)

[Health!](#), Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.

[Non-admitted patient emergency department care NMDS 2014-15](#)

[Health!](#), Superseded 13/11/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.