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

## Exported from METEOR (AIHW's Metadata Online Registry)

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

## Identifying and definitional attributes

| | |
|---|---|
| **Metadata item type:** | Data Element |
| **Short name:** | ED principal diagnosis code |
| **METEOR identifier:** | 497490 |
| **Registration status:** | Independent Hospital Pricing Authority, Standard 31/10/2012<br>Health!, Superseded 13/11/2014 |
| **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[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

## Collection and usage attributes

**Guide for use:**

An emergency department stay 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:**

Supersedes Emergency department stay—principal diagnosis, code X(18)
Independent Hospital Pricing Authority, Superseded 31/10/2012

Has been superseded by Emergency department stay—principal 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:***

The reporting of this data element is optional for those attendances where the value recorded for non-admitted patient emergency department service episode - episode end status is reported as:

- 4 - Did not wait to be attended by a health care professional;
- 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- 7 - Dead on arrival, emergency department clinician certified death.

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:***

The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode —episode end status* is reported as either:

Code 4 - Did not wait to be attended by a health care professional;
Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or
Code 7 - Dead on arrival, emergency department clinician certified the death of the patient.

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:***

The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode —episode end status* is reported as either:

Code 4 - Did not wait to be attended by a health care professional;
Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or
Code 7 - Dead on arrival, emergency department clinician certified death.

Non-admitted patient emergency department care NMDS 2014-15
Health!, Superseded 13/11/2014
***Implementation start date:*** 01/07/2014
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The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode —episode end status* is reported as either:

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Code 7 - Dead on arrival, emergency department clinician certified the death of the patient.