Episode of care—principal diagnosis, code (ICD-10-AM 12th edn) ANN{.N[N]}
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Episode of care—principal diagnosis, code (ICD-10-AM 12th edn) ANN{.N[N]}

Identifying and definitional attributes

Metadata item type: Data Element

Short name: Principal diagnosis

METEOR identifier: 746665

Registration status: Health!, Standard 20/10/2021

Definition: The diagnosis established after study to be chiefly responsible for occasioning an

episode of admitted patient care, an episode of residential care or an attendance

at the health care establishment, as represented by a code.

Data Element Concept: Episode of care—principal diagnosis

Value Domain: Diagnosis code (ICD-10-AM 12th edn) ANN{.N[N]}

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health

Problems, Tenth Revision, Australian Modification 12th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Source and reference attributes

Origin: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use: The principal diagnosis must be determined in accordance with the Australian

Coding Standards (IHPA, 2022). Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding,

complaint, or other factor influencing health status.

As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of the *International statistical classification of diseases and related health problems, Tenth Revision, Australian Modification* (ICD-10-AM).

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as a principal diagnosis. Diagnosis codes which are morphology codes cannot be used as a

principal diagnosis.

Collection methods: A principal diagnosis should be recorded and coded upon separation, for each

episode of admitted patient care or episode of residential care or attendance at a health-care establishment. The principal diagnosis is derived from and must be

substantiated by clinical documentation.

Comments: The principal diagnosis is one of the most valuable health data elements. It is used

for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin: Independent Hospital Pricing Authority

Reference documents: IHPA (Independent Hospital Pricing Authority) 2022. Australian Coding Standards

Twelfth Edition. Sydney: IHPA.

Relational attributes

Related metadata references:

Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 11th edn)

ANN(.N[N])

Health!, Superseded 20/10/2021

Tasmanian Health, Standard 08/04/2019

See also Episode of care—additional diagnosis, code (ICD-10-AM 12th edn)

ANN(.N[N])

Health!, Standard 20/10/2021

Specifications:

Health!, Standard 17/12/2021

Implementation start date: 01/07/2022 Implementation end date: 30/06/2023 Admitted patient care NMDS 2022–23

Health!, Standard 20/10/2021 Implementation start date: 01/07/2022 Implementation end date: 30/06/2023

DSS specific information:

The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Community mental health care NMDS 2022–23

Health!, Standard 17/12/2021

Implementation start date: 01/07/2022 Implementation end date: 30/06/2023

Residential mental health care NMDS 2022-23

Health!, Standard 17/12/2021

Implementation start date: 01/07/2022 Implementation end date: 30/06/2023

DSS specific information:

Codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).