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

Exported from METEOR (AIHW's Metadata Online Registry)

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

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Additional diagnosis
Synonymous names:	Additional diagnoses
METEOR identifier:	746667
Registration status:	Health!, Standard 20/10/2021
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 attributes

Identifying and definitional attributes

Data element concept:	Episode of care—additional diagnosis
METEOR identifier:	356590
Registration status:	Health!, Standard 05/02/2008 Independent Hospital Pricing Authority, Standard 16/03/2016 National Health Performance Authority (retired), Retired 01/07/2016 Tasmanian Health, Standard 02/09/2016
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.
Object class:	Episode of care
Property:	Additional diagnosis

Value domain attributes

Identifying and definitional attributes

Value domain:	Diagnosis code (ICD-10-AM 12th edn) ANN{.N[N]}
METEOR identifier:	746696
Registration status:	Health!, Standard 20/10/2021
Definition:	The ICD-10-AM (12th edn) code set representing diagnoses.

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: Record each additional diagnosis relevant to the episode of care in accordance with the Australian Coding Standards (IHPA, 2022).

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.

An additional diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care.

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 or attendance at a health-care establishment. An additional diagnosis is classified from, and must be substantiated by, clinical documentation.

Comments: Additional diagnoses are conditions that significantly affect patient management in an episode of care in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic interventions
- increased clinical care.

These criteria are not mutually exclusive. Conditions must meet at least one of these criteria and be evidenced by clinical documentation. Further information on conditions which meet these criteria can be found in the Australian Coding Standards (IHPA, 2022) under ACS 0002 *Additional diagnoses*.

Certain chronic conditions that do not meet the above criteria may be recorded as an additional diagnosis if they meet criteria in the Australian Coding Standards.

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—additional 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—principal diagnosis, code (ICD-10-AM 12th edn) ANN{.N[N]}
Health!, Standard 20/10/2021

Implementation in Data Set Specifications:

Activity based funding: Mental health care NBEDS 2022–23
Health!, Standard 17/12/2021
Implementation start date: 01/07/2022
Implementation end date: 30/06/2023
Conditional obligation:

This data element is only required to be reported for patients with an admitted or residential mental health episode of care.

Admitted patient care NMDS 2022–23
Health!, Standard 20/10/2021
Implementation start date: 01/07/2022
Implementation end date: 30/06/2023
Conditional obligation:

This data element is only to be reported if the episode of care results in more than one diagnosis code being allocated.

DSS specific information:

An unlimited number of diagnosis 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.

Residential mental health care NMDS 2022–23
Health!, Standard 17/12/2021
Implementation start date: 01/07/2022
Implementation end date: 30/06/2023