Infobite

Statistical Services Branch

What is a principal diagnosis?

A principal diagnosis is 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 a health care establishment, as represented by a code.

For the Queensland Hospital Admitted Patient Data Collection (QHAPDC), the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) is used.

(Source Queensland Health Data Dictionary, Identifier: QH 041644).

A principal diagnosis in a hospital admission is also known as PD, PDX or PDx and is collected via the QHAPDC.

A principal diagnosis can be:

- **determined by information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination.**

A principal diagnosis *cannot* be:

- **a diagnosis code identified in Australian Coding Standard 0050 *Unacceptable principal diagnosis code***
- **a neoplastic morphology (M8000/0 – M9999/9)**
- **an external cause, activity or place of occurrence (U50-U73, U90, V00-Y98)**
- **a supplementary code for chronic condition (U78-U88).**

Notes:

The Australian Coding Standards used to assign diagnosis codes during the clinical coding process can affect the assignment of the principal diagnosis code for specialties such as obstetrics and trauma.

The principal diagnosis may not be the most "resource intensive" condition that the patient either presents with or experiences during their episode of care. It is the main reason for this leading to admission to the hospital.

Data definitions and further information can be found in the QHAPDC Manual.

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