

ICD Coding Newsletter

(incorporating Special Edition features)

June 2002

Distribution List

- Health Information Manager/s (HIMS)
- Clinical Coders
- Information Technology (IT)
- Interested Others

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The ICD Coding Newsletter supports the clinical coding function performed in Victoria by providing relevant information to Health Information Managers, Clinical Coders, and their associates.

The newsletter, prepared by the Victorian ICD Coding Committee in conjunction with the Department of Human Services, seeks to:

- Ensure the standardisation of coding practice across the state
- Provide a forum for resolution of coding queries
- Address topical coding education issues
- Inform on national and state coding issues from the Victorian perspective.

The scope of the newsletter includes coding feature articles, selected coding queries and responses, and various information updates including feedback on the quality and uses of coded data (as reported to the Victorian Admitted Episodes Dataset).

If you have any queries or comments regarding the *ICD Coding Newsletter*, contact the HDSS Help Desk:

Telephone 9616 8141
Fax 9616 7629
Email PRS2.Help-Desk@dhs.vic.gov.au

Notify a change of address or a request regarding the mailing list to any of the above contacts.

HDSS's web site is:

<http://hdss.health.vic.gov.au>

An electronic coding query form can be completed at:

<http://hdss.health.vic.gov.au/icdcoding/codecommit/icdquery.htm>

Indexes to Coding Newsletters can be found at:

<http://hdss.health.vic.gov.au/icdcoding/newslet/qindex/index.htm>

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The purpose of this special edition of the ICD Coding Newsletter is to provide useful summary and reference information to readers on the 1 July 2002, VAED changes - especially the introduction of ICD-10-AM 3rd edition.

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1 July Information Updates

Reporting To The VAED

Coding Classification

All separations on and after 1 July 2002 must be coded using ICD-10-AM 3rd Edition (and relevant errata) and the Victorian Additions to Australian Coding Standards, effective 1 July 2002 (see page 8).

The 2002 – 2003 library file (in Excel format) and the description of the file structure, are available on the HDSS web page at:

<http://hdss.health.vic.gov.au/reffiles/index.htm>

Contact the HDSS Help Desk to obtain the password.

AR-DRG Modifications (2002-2003)

In 2002 -2003, hospitals will assign diagnoses and procedure codes using the 3rd edition of the ICD-10-AM classification. For funding purposes, these codes will be mapped back to ICD-10-AM 2nd edition codes, to enable grouping using AR-DRG Version 4.2.

Mapping tables from ICD-10-AM 3rd to 2nd editions can be accessed on the Commonwealth Department's website at:

www.health.gov.au/casemix/

Details of software availability are located at:

www.health.gov.au/casemix/grouper1.htm

As in previous years, some adjustments are to be made to the original AR-DRG4 (Version 4.2) grouping utilising the VIC-DRG4 field, prior to the calculation of WIES10.

The VIC-DRG4s for WIES9 for Peritoneal dialysis, Radiotherapy, Bone Marrow Transplants, Admission weight, Nasopharyngeal Intubation and Arteriovenous Fistula remain for WIES10.

Details are listed below:

Peritoneal dialysis

In recognition of cost differences between peritoneal and haemodialysis, episodes with a principal diagnosis of peritoneal dialysis (ICD-10-AM code Z49.2) are to be assigned a VIC-DRG4 of L61Y *Admit for peritoneal dialysis*.

Radiotherapy

Victorian Coding Standard 0229 states that non-same day patients receiving radiotherapy should have the malignant condition sequenced first, followed by the radiotherapy code (ICD-10-AM code Z51.0). Same day radiotherapy admissions, which follow the Australian Coding Standard, have Z51.0 assigned as the principal diagnosis followed by the malignancy code.

To maintain funding equity, a VIC-DRG4 of R64Z *Radiotherapy* will be assigned for non-same day, non-surgical episodes that include a radiotherapy diagnosis code (grouped as if the radiotherapy code is the principal diagnosis).

See also, Victorian Additions to the Standards, Vic 0229, Radiotherapy for guidance on coding of these cases.

Bone Marrow Transplants

In recognition of cost differences between allogeneic and autologous bone marrow transplants, AR-DRG4 A04Z *Bone marrow transplant* is split into VIC-DRG4 A04A *Allogenic bone marrow transplant* and A04B *Non-allogenic bone marrow transplant*. Any cases grouped to AR-DRG4 A04Z with ICD-10-AM 2nd edition procedure codes of 13706-00, 13706-06, 13706-09, or 13706-10 are allocated to VIC-DRG4 A04A and all other cases originally grouped into AR-DRG4 A04Z are allocated to VIC-DRG4 A04B.

Admission weight

In AR-DRG Version 4.2, admission weight must be between 400 and 9999 grams otherwise the episode will be assigned to AR-DRG 960Z Ungroupable. The Department has been notified of live births where the baby weighs significantly less than 400 grams.

Episodes with an admission weight between 125 and 399 grams are assigned an admission weight of 400 grams for grouping to an appropriate VIC-DRG4.

Nasopharyngeal intubation

For 2000-2001, new 2nd edition procedure codes were introduced for nasopharyngeal intubation (90179-02 *Nasopharyngeal intubation* and 90179-05 *Management of nasopharyngeal intubation*).

In AR-DRG Version 4.2, these codes are valid only for MDC 22 Burns. These codes will be mapped to 92035-00 *Other intubation of respiratory tract*, so that episodes with either of these codes will group to an appropriate VIC-DRG4.

Arteriovenous fistula

In AR-DRG Version 4.1, procedure codes for surgical formation of arteriovenous fistula of lower limb (34509-00) and upper limb (34509-01), were not included in the lists of procedures relevant to MDC 11 *Diseases and disorders of kidney and urinary tract*. AR-DRG Version 4.2 has amended the allocation of procedure code 34509-01 *arteriovenous anastomosis of upper limb* but has not been amended for procedure code 34509-00 *arteriovenous formation of lower limb*. The procedure code for formation of arteriovenous fistula in lower limb (34509-00) will be mapped to 34509-01 *arteriovenous anastomosis of upper limb*, for grouping to an appropriate VIC-DRG4.

VAED Schedule Requirements 2002-2003

A hospital may transmit data via its nominated PRS/2 system as frequently as desired, but must meet requirements set out below according to hospital type.

Public hospitals

The following is extracted from the *Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003* in Section B: Conditions of Funding: Reporting. <http://www.health.vic.gov.au/pfg2002/index.htm>

Transmission of Admitted Patient Data

- 11.5.1 The hospital will transmit data to the VAED via PRS/2 according to the timelines detailed in clauses 11.5.1. (a) and 11.5.1(b).
- (a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the 21st day of the following month (see (d) below for processing schedule).
 - (b) Diagnosis and procedure and sub-acute details in any month are to be

transmitted in time for the VAED file consolidation on the 21st day of the second month following (see (d) below for processing schedule).

- (c) Data for the financial year should be completed in time for the VAED file consolidation on 21 August 2003. Any corrections must be transmitted before finalisation of the VAED database on 21 September 2003.
- (d) It is the hospital's responsibility to ensure that data are transmitted to the VAED to meet the processing schedule for inclusion in the Allegiance Systems file consolidation on the 21st of each month. VAED data (sent by modem) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disc) must be received by 12pm (noon) on the last working day on or before the 17th of the month.
- (e) WIES10, multi-purpose service and sub-acute payments will be:
 - (i) fully paid for data originally submitted in accordance with the deadlines specified in clauses 11.5.1.(a) and 11.5.1.(b) above, even if data is subsequently amended; or
 - (ii) paid at a reduced rate (50 per cent), or not recognised for payment, according to Schedules 2.1 and 2.2 located at the end of this section if the data has not been submitted in accordance with either deadline specified in clauses 11.5.1.(a) and 11.5.1.(b) above; or
 - (iii) not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses 11.5.1.(a) and 11.5.1.(b) above.

This clause applies to all account classes including DVA.

- (f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure details, the Hospital or MPS must write to the Department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for one-off late submission of data will generally only be considered for computer system problems that are beyond the control of the Hospital or MPS. (Hospitals or MPSs undertaking the PRS/2 data submission testing process are automatically exempted). Exemptions for late submission of admission and separation data will also be considered for staffing problems that are beyond the control of small rural hospitals and MPSs. Exemptions for late submission of admission and separation data will be automatically granted to hospitals or MPSs maintaining a consistently high level of timely data submission.

Private hospitals

Private hospitals are expected to adhere to the same timelines as Public hospitals (indicated above).

Schedule 2.1

Timelines for the Receipt of Admission and Separations Details (E2)

VAED Consolidation Date

Month of Separation 2002/2003	21 Aug	21 Sept	21 Oct	21 Nov	21 Dec	21 Jan	21 Feb
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate
January							Full Rate

VAED Consolidation Date

Month of Separation 2002/2003	21 Mar	21 Apr	21 May	21 Jun	21 Jul	21 Aug	21 Sep
December	Nil	Nil	Nil	Nil	Nil	Nil	Nil
January	Half Rate	Nil	Nil	Nil	Nil	Nil	Nil
February	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
March		Full Rate	Half Rate	Nil	Nil	Nil	Nil
April			Full Rate	Half Rate	Nil	Nil	Nil
May				Full Rate	Half Rate	Nil	Nil
June					Full Rate	Half Rate	Nil

Schedule 2.2

Timelines for the Receipt of Diagnoses and Procedure (X2, Y2) and Sub-Acute Details (S2)

VAED Consolidation Date

Month of Separation 2002/2003	21 Sept	21 Oct	21 Nov	21 Dec	21 Jan	21 Feb	21 Mar
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate

VAED Consolidation Date

Month of Separation 2002/2003	21 Mar	21 Apr	21 May	21 Jun	21 Jul	21 Aug	21 Sep
December	Half Rate	Nil	Nil	Nil	Nil	Nil	Nil
January	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
February		Full Rate	Half Rate	Nil	Nil	Nil	Nil
March			Full Rate	Half Rate	Nil	Nil	Nil
April				Full Rate	Half Rate	Nil	Nil
May					Full Rate	Half Rate	Nil
June						Full Rate	Half Rate

Notification of Grouper Anomalies

The Commonwealth Department of Health and Aging (DOHA) have developed a standard form for notification of grouper anomalies. It is now posted at the following web page:

www.health.gov.au/casemix

The Victorian ICD Coding Committee (VICC) would encourage any person sending an anomaly notification to DOHA, to also notify VICC through the PRS/2 Help Desk, as the State can in many instances either, influence a faster resolution of problems, or make local adjustments to the grouper software.

Victorian Additions to Australian Coding Standards

The latest edition of the Victorian Additions to Australian Coding Standards, effective 1 July 2002 (ICD-10-AM 3rd Edition) is available at:

<http://hdss.health.vic.gov.au/icdcoding/index.htm>

They are reproduced on the following pages for your convenience.

The following are the Victorian Additions to Australian Coding Standards, effective 1 July 2002 (supplementing ICD-10-AM, third edition, volume 5)

Each Victorian Addition that corresponds with an Australian Coding Standard (ACS) has been assigned the same reference number as the ACS, with the addition of a 'Vic' prefix.

Victorian Additions that do not relate to a particular ACS have an alpha or alpha-numeric reference that relates to the subject of the Addition.

The Victorian Additions should be added to the Australian Coding Standards (ACS) (ICD-10-AM 3rd Edition) for 1 July 2002.

Complete Summary of Victorian Additions:

<u>Vic Prefix.1</u>	<i>Prefixes for diagnoses</i>
<u>Vic Prefix.2</u>	<i>Prefixes for obstetric codes</i>
<u>Vic 0029</u>	<i>Coding of contracted procedures</i>
<u>Vic 0030</u>	<i>Organ procurement</i>
<u>Vic 0229</u>	<i>Radiotherapy</i>
<u>Vic 0233</u>	<i>Morphology</i>
<u>Vic 2104</u>	<i>Rehabilitation</i>
<u>Vic 2108</u>	<i>Assessment</i>

Vic Prefix.1 Prefixes for Diagnoses

A diagnosis must meet the criteria specified in ACS 0001 Principal diagnosis, or ACS 0002 Additional diagnoses, in order to be coded. Once a decision has been made to code a condition, Victorian standards require that a prefix be assigned. The following instructions advise on the assignment of the prefix to coded conditions. Note that only diagnosis codes require a prefix.

Codes do not have to be listed in groups according to the prefix assigned. With the exception of the principal diagnosis, which must always be sequenced first, all codes can be listed in any order regardless of whether the prefix is 'P', 'A', or 'C'.

Primary and associated diagnoses are conditions present at time of admission (or when the episode of care commenced), even if not diagnosed prior to this episode of care.

A secondary function of the A prefix is to suppress the code description for TAC and WorkCover certificates, generated by PRS/2.

Refer also to ACS 0002 *Additional Diagnoses* for guidance on whether or not a condition should be coded. However, be aware that many conditions that meet the criteria for additional diagnoses will be prefixed with 'P' rather than 'A', as they will receive active treatment during the episode of care. Some examples of conditions that would usually be prefixed with 'A' are Z72.0, *Tobacco use, current*, and Z22.52, *Carrier of viral hepatitis C*. These conditions would usually not be treated but there is a requirement to code them in Australian Coding Standards. Most cases would have very few if any codes prefixed with 'A'.

There is no direct relationship between the Australian Coding Standard 0002, Additional Diagnoses and the instructions relating to Associated Conditions contained in the Victorian Addition to the Standards, Vic Prefix 1, Prefixes for Diagnoses. Nor is there any relationship between the Australian Coding Standard 0001, Principal Diagnosis and the instructions relating to Primary Diagnoses contained in the Victorian Addition to the Standards, Vic Prefix 1, Prefixes for Diagnoses.

P - Primary Diagnosis

Primary diagnoses are those for which the patient received treatment or investigation during this episode of care. There can be more than one code prefixed P.

The first diagnosis code must be prefixed P and meet the definition for Principal Diagnosis (ACS 0001 Principal diagnosis, page 2).

Other diagnosis codes should be prefixed P if they do not meet the definition for A or C but:

- were other main conditions treated and/or investigated during the episode of care, or
- were the outcome of another P diagnosis code, or
- affected the treatment given and/or length of stay for the episode of care.

A - Associated Condition

An associated condition may be:

- the underlying disease (not treated) of a condition which was treated:

Example

A patient with metastatic carcinoma, being treated only for the secondary spread during this episode of care: prefix the primary neoplasm code with A.

- a condition or state which influenced the patient's health status or care during this episode of care, but which was not specifically treated:

Example

An autistic child who was admitted for dental treatment (rather than being treated as a non-admitted patient): prefix the autism code with A.

or,

- a condition or state which affected the treatment given and/or length of stay but which was not treated during this episode of care:

Example

A patient with a pacemaker, admitted for a valve replacement: prefix the pacemaker status code with A.

- conditions as defined in instructions 'use additional code...' in ICD-10-AM, if these conditions were present but not treated or investigated during this episode of care.

C - Complication

A complication is a condition that was not present at the time this episode of care commenced. A complication may be:

- a condition resulting from misadventure during surgical or medical care,
- an abnormal reaction to, or later complication of, surgical or medical care, or
- a condition which arose during this episode of care (that is, the condition was not present at the start of this episode of care).

Example

A medical patient admitted for treatment of ischaemic heart disease, who develops a UTI during the hospital stay.

A previously existing condition that was not diagnosed until after the episode of care started is not a complication.

M - Morphology

Prefix morphology codes with an M (to distinguish them from musculoskeletal codes). The M prefix is optional for data entry but must be applied to morphology codes for transmission to PRS/2. Refer to the *PRS/2 Manual* for further information.

Vic Prefix.2 Prefixes for Obstetric Codes

In an obstetric admission, all codes relating to pregnancy, delivery and the puerperium are classified as primary conditions, except:

- a condition resulting from misadventure during surgical or medical care (classify as a complication),
- an abnormal reaction to, or later complication of, surgical or medical care (classify as a complication),
- incidental conditions, unrelated to the birth process (classify as an associated diagnosis).

Effective July 1 2002

Vic 0029 Coding of Contracted Procedures

If the procedure is performed at another hospital under contract to this hospital, add a suffix to the procedure of:

- F** - if performed on an admitted basis, or
- N** - if performed on a non-admitted basis.

Refer to the *PRS/2 Manual*, for further details on the use of these codes.

This Victorian Addition *supplements* ACS 0029 *Coding of Contracted Procedures*.

Effective July 1 2002

Vic 0030 Organ Procurement

An episode for organ procurement is not yet included in the *National Health Data Dictionary* nor in the Victorian Admitted Episodes Dataset, therefore the following two sections of ACS 0030 *Organ Procurement and Transplantation* do not apply in Victoria:

- **2b** *In the procurement episode after the initial episode and following brain death*
- **2c** *Patients resuscitated in Emergency and subsequently ventilated for possible donation following brain death*

Until a procurement episode is introduced, these details cannot be captured in the Victorian collection.

The following sections of ACS 0030 are to be used in Victoria (see ACS 0030 *Organ Procurement and Transplantation*, page 33 for details):

- **1** *Live donors*
- **2a** *Donation following brain death in hospital: in the initial episode during which the patient dies*
- **3** *Patients receiving the transplanted organ*

This Victorian Addition *supplements* ACS 0030 *Organ Procurement and Transplantation*, page 39.

Effective 1 July 2002

Vic 0229 Radiotherapy

Multi-day admissions (i.e. patients separated on a subsequent date to the admission date), receiving a radiation oncology procedure from blocks [1786] to [1792], [1794] or [1795], **for treatment of a malignant condition**, must have **Z51.0 Radiotherapy session** assigned as an additional diagnosis. The malignant condition receiving radiotherapy will be the principal diagnosis.

This Victorian Addition *overrides* the 'multi-day' component of ACS 0229 *Radiotherapy*, page 76.

Effective July 1 2002

Vic 0233 Morphology

The assignment of morphology codes, where appropriate, is mandatory in Victoria.

This Victorian Addition *supplements* ACS 0233 *Morphology*, page 76.

The Victorian Library File contains morphology codes that are indexed in the ICD-10-AM Alphabetical Index to Diseases (Volume Two), but not listed in the ICD-10-AM Tabular List of Diseases (Volume One, Appendix A). (Refer to the DHS Library File 2000-2001 for a complete list of valid Morphology codes.)

Effective 1 July 2002

Vic 2104 Rehabilitation

In rehabilitation episodes following injury, do not assign external cause codes for the injury receiving rehabilitation.

If a patient is admitted '**for rehabilitation**' (even if the patient is in a bed other than a designated Rehabilitation bed or if the hospital does not have a designated Rehabilitation program), standard 2104 applies.

If a patient is admitted for **treatment** of a condition but also receives rehabilitation before discharge (regardless of bed or designation), the principal diagnosis must be the condition and the rehabilitation should be indicated by the appropriate allied health procedure codes - *Z50.- should not be added*. Such episodes will be normally be acute Care Type.

This Victorian Addition *supplements* ACS 2104 *Rehabilitation*, page 273.

Effective July 1 2002

Vic 2108 Assessment

If a patient is admitted specifically for **evaluation and management** by a geriatrician (even if the patient is in a bed other than a designated GEM program), the principal diagnosis must be the condition (or the major condition) that requires evaluation and management. *If some rehabilitation is started during the evaluation and management episode, assign the appropriate Z50.- code as an additional diagnosis*. Allied health procedure codes should also be added.

If a patient is admitted for evaluation of a condition (even if the hospital does not have a designated GEM program), the principal diagnosis must be the condition (or the major condition) that requires evaluation. *If some rehabilitation is started during evaluation episode, assign the appropriate Z50.- code as an additional diagnosis*. Allied health procedure codes should also be added.

The instruction to add the Z50.- for patients admitted for **evaluation** or **evaluation and management** will help identify problems with bed allocation for these patients.

This Victorian Addition *supplements* ACS 2108 *Assessment*, page 276.

Effective 1 July 2002

Coding Features

Continuous Ventilatory Support (CVS) and Non-Invasive Ventilation (NIV)

As of 1 July 2002, Non-invasive ventilation (NIV) hours need to be both recorded in a separate field, and coded using ICD-10-AM Third Edition. In the August 2002 Coding Newsletter there will be a comprehensive coding feature, adapted and revised from a similar article in August 2000 Victorian ICD Coding Newsletter, which will also incorporate NIV.

Summary of Changes

- Requirement to assign one code only for the sum of all durations of Continuous Ventilatory Support (mechanical ventilation)
- Requirement to report Duration of Non-Invasive Ventilation for patients in NICU/SCN in VAED field
- Option to report Duration of Non-Invasive Ventilation for patients in ICU in VAED field
- Minimum time period required before assignment of Non-Invasive Ventilation code in non-neonates
- *No change* to rounding rules for Duration of Mechanical Ventilation VAED field (although originally specified in the *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2002*)

Admission for Chemotherapy

Queries sent to VICC over the past twelve months indicate that Victorian coders are still experiencing problems with the coding of chemotherapy patients.

NCCH and VICC are currently reviewing Australian Coding Standard 0044, Chemotherapy in order to provide greater clarity.

Until then DHS Bulletin (Number 6), October 1999 provides definitive advice for Victorian coders and should continue to be followed.

This article reinforces the instructions provided in the October 1999 Bulletin for the diagnosis coding of 'chemotherapy' patients and provides additional advice for the procedure coding.

These instructions should be applied for all admissions for 'chemotherapy' regardless of where the patient is admitted to within the hospital. There are no special coding standards or guidelines for patients admitted to chemotherapy day wards.

Diagnosis Coding

In Victoria, *Z51.1 Chemotherapy session for neoplasm*, or *Z51.2 Other chemotherapy*, should be coded when the patient is treated with either antineoplastic or cytotoxic therapy. Thus, chemotherapy diagnosis codes must be coded:

- If a patient with a neoplasm (either benign or malignant) is having antineoplastic therapy, **or**
- if a patient with either a neoplasm or a non-neoplastic disorder is treated with cytotoxic therapy.

It is suggested that coders consult with their pharmacy/clinician/MIMS to identify drugs as being either anti-neoplastic or cytotoxic.

Patients admitted for infusion/injection of substances that are not antineoplastic or cytotoxic should be coded either, according to an Australian Coding Standard specific to the condition or treatment occasioning the patient's admission (for example ACS 0214 Intragam), or according to ACS 0001, Principal Diagnosis and ACS 0002, Additional Diagnoses.

The 'Coding of Chemotherapy with Cytotoxics and Other Agents' flow chart, which was distributed at the Post Implementation Workshops, and published in Coding Matters Volume 5, number 4 (page 16), no longer applies.

Procedure Coding

Procedure codes for all patients admitted for antineoplastic or cytotoxic therapy, and therefore having diagnosis codes of either Z51.1 *Chemotherapy session for neoplasm* or Z51.2 *Other chemotherapy*, should be taken from one of the following:

Block [1780]	<i>Chemotherapy administration</i>
Block [1784]	<i>Instillation of cytotoxic agent</i>
Block [1256]	<i>Procedures for management of ectopic pregnancy</i>

Examples

Number 1 **Same day admission for infusion of cytotoxics for breast cancer (e.g. Cisplatin, Taxol, 5FU)**

Z51.1	<i>Chemotherapy session for neoplasm</i>
C50.-	<i>Malignant neoplasm of breast</i>
M-----/3	<i>Morphology code</i>
Block [1780]	<i>Chemotherapy administration one of the intravenous administration codes</i>

Number 2 **Patient with breast cancer admitted as a day patient for subcutaneous injection of Sandostatin (Octreotide).**

C50.-	<i>Malignant neoplasm of breast</i>
M----/3	<i>Morphology code</i>
92189-00 [1885]	<i>Injection of other hormone</i>

Sandostatin is a pituitary hormone, not a cytotoxic or antineoplastic agent, therefore the condition is coded as principal diagnosis, and the procedure code is assigned according to the substance administered.

Number 3 **Same day admission for administration of Aredia, for treatment of hypercalcaemia caused by bony metastases from breast cancer.**

- E83.5 *Disorders of calcium metabolism*
- C79.5 *Secondary malignant neoplasm of bone and bone marrow*
- M----/6 *Morphology code*
- C50.- *Malignant neoplasm of breast*
- M----/3 *Morphology code*
- 92193-00 [1885] *Injection or infusion of other therapeutic or prophylactic substance*

Aredia is an agent affecting calcium and bone metabolism, not a cytotoxic or antineoplastic agent, therefore the condition is coded as principal diagnosis, and the procedure code is assigned according to the substance administered.

Number 4 **Same day patient with rheumatoid arthritis admitted for administration of intravenous methotrexate**

- Z51.2 *Other chemotherapy*
- M06.9- *Rheumatoid arthritis*
- Block [1780] *Chemotherapy administration one of the intravenous administration codes*

Methotrexate is a cytotoxic agent therefore the principal diagnosis is Z51.2. It is administered intravenously therefore procedure code is taken from Block [1780].

Number 5 **Same day admission for infusion of methylprednisolone for multiple sclerosis**

- G35 *Multiple sclerosis*
- 92188-00 [1885] *Injection of steroid*

Methylprednisolone is neither an antineoplastic nor cytotoxic drug, and therefore this case is not coded as an admission for chemotherapy.

Number 6 **Same day admission for Methotrexate injection for ectopic pregnancy, previously diagnosed.**

- Z51.2 *Other chemotherapy*
- O00.9 *Ectopic pregnancy, unspecified*
- O09.- *Duration of pregnancy*
- 35677-03 [1256] Fetotoxic management for removal of ectopic pregnancy

Methotrexate is a cytotoxic drug; therefore the principal diagnosis is Z51.2.

Number 7 **Same day patient admitted for administration of antibiotic for chronic MRSA wound infection**

- T81.41 *Wound infection following a procedure*
- B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*
- Z06.1 *Infection with multidrug resistant Staphylococcus Aureus*
- .-- *External cause code*
- Y92.22 *Place of occurrence: Health service area*
- 92186-00 [1885] *Injection of antibiotic*

The treatment is neither antineoplastic nor cytotoxic, therefore a code for the condition is assigned as principal diagnosis, and the procedure code for injection of antibiotics is assigned.

Number 8 **Same day admission for infusion/injection of gammaglobulin for treatment of hypogammaglobulinaemia.**

- D80.- *Hypogammaglobulinaemia*
- 92181-00 [1885] *Injection of gammaglobulin, or*
- 13706-05 [1893] *Transfusion of gammaglobulin*

Gammaglobulins (such as Intragam) are blood products and are therefore neither antineoplastic nor cytotoxic therapy. In addition, gammaglobulin is the subject of Australian Coding Standard 0214, Intragam, and this scenario is coded according to instructions contained in the standard.

Update of Calender of ICD and DRG versions (Updated June 2002)

Fin. Year July/ June	ICD version: (edition/release date) (a)	ICD version: Victoria	Coding Standards used in Victoria	Aust DRG version released	DRG version: Victoria (b)	Codes input to DRG version: Victoria (c)
02-03	AM 3 (Jul 2002)	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
01-02	No release	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.2	AR v4.2 *	AM 2
00-01	AM 2 (Jul 2000)	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.1	AR v4.1 *	AM 1
99-00	No release except Amendment list	AM 1	Aust Standards AM 1st ed. with some Vic Additions	AN v4.0	AN v3.1 *	Aust CM 2
98-99	AM 1 (Jul 1998)	AM 1	Aust Standards AM 1st ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
1.7.98	Victoria changed from ICD-9-CM to ICD-10-AM.					
97-98	No release	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
96-97	Aust CM 2 (Jul 96)	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AN v3.1	AN v3.1 *	Aust CM 2
95-96	Aust CM 1 (Jul 95)	Aust CM 1	Aust Standards CM 1st ed. with some Vic Additions	AN v3.0	AN v1.0 *	U.S. 8
94-95	U.S. 10 (Oct 93)	U.S. 10	Vic Guidelines Revised, incorporating National Coding Standards	AN v2.0	AN v1.0	U.S. 8
93-94	U.S. 9 (Oct 92)	U.S. 9	Vic Guidelines Revised, incorporating National Coding Standards	AN v2.0	AN v1.0	U.S. 8
1.7.93	Victoria introduced casemix funding					
92-93	U.S. 8 (Oct 91)	U.S. 8	Vic Guidelines 2nd ed (Revised)	No release	AN v1.0	U.S. 8
91-92	U.S. 7 (Oct 90)	U.S. 6	Vic Guidelines 2nd ed	AN v1.0	AN v1.0	U.S. 8
90-91	U.S. 6 (Oct 89)	U.S. 6	Vic Guidelines 2nd ed		HCFA v4	U.S. 2
89-90	U.S. 5 (Oct 88)	U.S. 5	Vic Guidelines 1st ed		HCFA v4	U.S. 2
88-89	U.S. 4 (Oct 87)	U.S. 2	Vic Guidelines 1st ed		HCFA v4	U.S. 2
87-88	U.S. 2 (Oct 86)	U.S. 2	(Victorian) VHSS guidelines		HCFA v4	U.S. 2
1.7.86	Victoria changed from ICD-9 to ICD-9-CM.					

- (a) U.S. = HICF ICD (release date in the USA)
Aust CM = Australian ICD-9-CM (release date in Australia)
AM 1 = ICD-10-AM
- (b) DRG version used in Victoria (pre 1.7.1993) for any published grouped data and (post 1.7.1993) for casemix funding purposes.
* = years Vic adjusted DRGs for funding purposes (details in relevant year's Public Hospital Policy and Funding Guidelines or equivalent publication).
- (c) If **ICD version: Victoria** and **Codes input to DRG version: Victoria** columns differ, ICD codes were mapped from **ICD version: Victoria** to **Codes input to DRG version: Victoria**.

ICD Facts and Figures

ICD Edition	Year	Number of Valid Diagnosis Codes	Number of Valid Procedure Codes	Total Number of Valid Codes	Comments
ICD-9-CM 1st Edition	1995	12475	3517	15992	
ICD-9-CM 2nd Edition	1996	12540	3624	16164	Total number of new codes introduced 1/7/96 = 272 - disease codes = 150 (Aus codes = 93) - procedure codes = 122 (Aus codes = 117)
ICD-10-AM 1st Edition	1998	33744	6328	40072	Number of valid disease codes = 12028 Number of valid external cause codes = 21066 Number of valid Z codes = 650 Number of valid Australian disease codes = 1126 - 3rd character level = 0 - 4th character level = 22 - 5th character level = 1104 (non-valid Australian disease codes at 3rd character level = 2) Total Number of new codes introduced 1/7/98 = N/A Total Number of deleted codes 1/7/98 = N/A
ICD-10-AM 2nd Edition	2000	14159	5945	20104	Number of valid disease codes = 12081 Number of valid external cause codes = 1418 Number of valid Z codes = 660 Number of valid Australian disease codes = 1271 - 3rd character level = 1 - 4th character level = 67 - 5th character level = 1203 (non valid Australian disease codes at 3rd character level = 2) (non valid Australian disease codes at 4th character level = 3) Total Number of new codes introduced 1/7/00 = 1668 - disease codes = 1314 (Aus codes = 301) - procedure codes = 354 Total Number of deleted codes 1/7/00 = 21636 - disease codes = 20899 (Aus codes = 55) - procedure codes = 737
ICD-10-AM 3rd Edition	2002	15927	5926	21853	Number of valid disease codes = 12358 Number of valid external cause codes = 2896 Number of valid Z codes = 673 Number of valid Australian disease codes = 3377 - 3rd character level = 3 - 4th character level = 324 - 5th character level = 3050 (non valid Australian disease codes at 3rd character level = 26) (non valid Australian disease codes at 4th character level = 61) Total Number of new and reactivated codes introduced 1/7/02 = 2560 - disease codes (new) = 869 (Aus codes = 852) - disease codes (reactivated) = 1309 (Aus codes = 1302) - procedure codes = 382 Total Number of deleted codes 1/7/02 = 472 - disease codes = 71 (Aus codes = 34) - procedure codes = 401

Data Quality

VAED Audit 2000-2001

The final report of the audit of 2000-2001 VAED data will be posted to the HDSS website within the next few weeks. It consists of a number of files, according to the sample type and report. Access will again be limited by password, with access details circulated to public hospitals.

Any queries about the VAED audits should be directed to Joanne McLachlan (9616 7710) or Mark Gill (9616 7456), rather than HMA or individual auditors.

Performance Indicators for Coding Quality (PICQ) and Australian Coding Benchmark Audit (ACBA)

To encourage hospitals to perform data quality activities, during the 2001/2002 HDSS has:

- Negotiated and met the cost of a statewide licence to use the National Centre for Classification in Health's (NCCH) two products:
 - Performance Indicators for Coding Quality (PICQ)
 - Australian Coding Benchmark Audit (ACBA)
- Started analysing the VAED data using PICQ

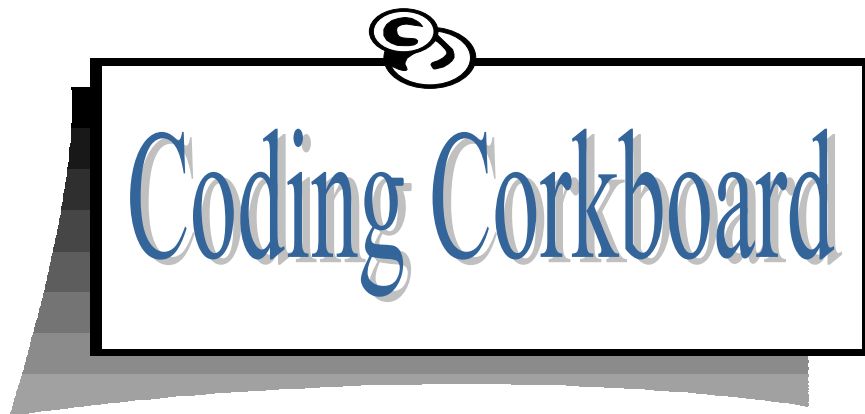
Information regarding gaining access to these products can be found at:

<http://hdss.health.vic.gov.au/picq/index.htm>

Please note that a version of PICQ supporting ICD-10-AM Third Edition will be released in December 2002.

HDSS has analysed statewide public hospital data from July 2001 to April 2002 (May and June yet to be completed). Records with possible errors have been returned to hospitals for comment and action where required. Through the valuable feedback from hospitals we have been able to provide constructive comment to NCCH regarding their product.

Thank you for your continuing support on this project.



Coding Newsletter Mailing List

DHS is still working towards phasing out the posting of hard copies of the Victorian *ICD Coding Newsletter* and we are again seeking your help to update our 'mailing list'.

The Newsletter is available via the Health Data Standards and Systems Unit website:

<http://hdss.health.vic.gov.au/icdcoding>

If you already receive your copy by email, you do not need to do anything.

If you would like to **start** receiving your copy by email, please email your request to:

PRS2.Help-Desk@dhs.vic.gov.au

If you have a special need to continue receiving a hard copy newsletter, **please re-confirm** this by emailing to the Helpdesk (above) or via fax to the Secretary, Victorian Coding Committee: 9616 7629

Victorian ICD Coding Committee

Victorian ICD Coding Committee (VICC) Queries

ICD-10-AM 3rd Edition queries should be sent directly to the VICC. Queries can be submitted:

- As a hard copy by fax or mail to The Secretary, VICC, Health Data Standards and Systems, Metropolitan Health and Aged Care Services Division, Department of Health, **or**
- Via email to, PRS2.Help-Desk@dhs.vic.gov.au, **or**

A coding query form should be completed, which can be found at:

www.dhs.vic.gov.au/ahs/hdss/icdquery.htm

Prior to submitting a query, coders are reminded to:

- Check ICD-10-AM 3rd Edition:
 - Index (Volume 2 and 4)
 - Tabular list (Volumes 1 and 3)
 - Australian Coding Standards (Volume 5)
- Refer to:
 - Victorian ICD Coding Newsletter (cumulative *Coding Advice* index)
 - Coding Matters
- Obtain a dictionary definition
- Seek clinical input
- Search the NCCH query database
- Discuss with a colleague
- Research other options that may assist in answering the query.

The *Victorian ICD Coding Committee Query Form* prompts coders to include background information/details, to enable all queries to be answered appropriately. This in turn will ensure that:

- Inquirers have researched appropriately prior to submitting the query,
- The thought process behind the query (and therefore the response) is clearly documented, and
- If the query is forwarded to NCCH (or other agency) all relevant information will be included.

Still forward your query if you believe that your research answers your query, but would like confirmation from the VICC or wish to share your findings with others.

The following table outlines the current process of dealing with coding queries. This process can sometimes be very lengthy and we ask coders to please be patient. Meanwhile the VICC is investigating more efficient ways of handling the workload, with the aim of producing a more timely service for coders.

Who and When	What
<p><i>At least 10 days before Meeting</i></p> <p>Coder</p>	<ul style="list-style-type: none"> • Submits query (using query form) to DHS via fax, email or mail.
<p>VICC Secretary</p>	<ul style="list-style-type: none"> • Numbers and logs query • Formats and types query (if faxed)
<p><i>7 days before Meeting</i></p> <p>VICC Secretary to VICC Committee Members, Convenor</p>	<ul style="list-style-type: none"> • Emails new queries and queries requiring further consideration with the agenda • Faxes attachments (for example, operation reports) • Emails unconfirmed minutes of previous meeting and confirmed minutes for the meeting before that.

Who and When	What
VICC Members, Secretary, Convenor	<ul style="list-style-type: none"> • Research queries by checking: <ul style="list-style-type: none"> • Index & tabular entries and Australian Coding Standards • NCCH database • Dictionaries and other reference books • Previous Victorian queries • <i>Coding Matters</i> and NCCH 'Specialty' booklets • <i>ICD Coding Newsletters</i> • Other expert coders • Clinicians
<i>1st Meeting</i> VICC Members, Secretary, Convenor	<ul style="list-style-type: none"> • Consider each query in addition to other VICC work. At times there have been up to thirty queries to consider.
Secretary	<ul style="list-style-type: none"> • Prepares minutes including responses formulated at meeting
<i>2nd Meeting</i> VICC Members, Secretary, Convenor	<ul style="list-style-type: none"> • Minutes considered for confirmation • Resolved queries considered for possible inclusion in the Newsletter
<i>If query is resolved</i> VICC Secretary	<ul style="list-style-type: none"> • Sends response to enquirer • Collates and sends responses to HDSS staff member, for inclusion in the Newsletter
<i>If query requires further consideration</i> VICC Secretary	<ul style="list-style-type: none"> • Forwards query to appropriate organisation, for example NCCH • Adds query to agenda for next meeting (and cycle begins again)

Who and When	What
<i>Quarterly</i> HDSS Staff Member (A VICC member)	<ul style="list-style-type: none">• Collates the <i>ICD Coding Newsletter</i> including all answered queries.

Members as at 1 June 2002

Irene Kearsey	Convener (Department of Human Services)
Jenny Wischer	Secretary (Southern Health)
Catherine Perry	Coding Newsletter (Department of Human Services)
Lisa Basile	Peninsula Health
Moira Cameron	Austin and Repatriation Medical Centre
Rhonda Carroll	The Alfred Hospital
Andrea Groom	Southern Health
Sonia Grundy	St John of God Health Care, Geelong
Susan Peel	Healesville and District Hospital
Evelyn Robinson	Peninsula Health
Fiona Rounds	Ballarat Health Services
Jennie Shephard	La Trobe University representative
Kathy Wilton	Royal Children's Hospital
Kylie Holcombe (<i>on leave</i>)	St Vincent's Hospital
Ruth Rundell (<i>on leave</i>)	Barwon Health - The Geelong Hospital

Committee's representative on VACCDI: Pauline Cripps, Box Hill Hospital

Future Meetings

Tuesday 16 July	DHS, 10.00 am, 555 Collins Street, Melbourne, 16th floor
Tuesday 20 August	DHS, 10.00 am, 555 Collins Street, Melbourne, 13th floor
Tuesday 17 September	DHS, 10.00 am, 555 Collins Street, Melbourne, 16th floor

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACS	Australian Coding Standard
ADX	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CCCG	Clinical Classification and Coding Groups
DHS	Department of Human Services
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
HMA	Healthcare Management Advisors Pty Ltd
ICD-9-CM	International Classification of Diseases - 9th Revision – Clinical Modification
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IFHRO	International Federation of Health Records Organizations
LOS	Length Of Stay
MDC	Major Diagnostic Categories
NCCH	National Centre for Classification in Health
PDX	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee