

***ICD Coding Newsletter
Special Edition
June 2000***

Hospital Distribution List

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

.....

.....

.....

The *ICD Coding Newsletter* supports the clinical coding function performed in Victoria by Health Information Managers and Clinical Coders, by providing relevant information for these professionals 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, and
- 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).

Should you have any queries or comments regarding the *ICD Coding Newsletter*, contact:

Shannon Watts or Wendy Dickins.

HDSS Help Desk:

Telephone 9616 8141
Fax 9616 7629
Email PRS2.Help-Desk@dhs.vic.gov.au
Website www.dhs.vic.gov.au/ahs/hdss

- *This document can be accessed electronically at:*
www.dhs.vic.gov.au/ahs/hdss/newslett.htm or
www.dhs.vic.gov.au/ahs/hdss/clincode.htm
- *Notification of change of address or requests regarding the mailing list may be directed to any of the above contacts.*

Contents

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 2000, VAED changes - especially the introduction of ICD-10-AM 2nd edition and Version 4.1 of the AR-DRG grouper.


| | |
|--------------------------------------------------------------------------------------|----|
| 1 July 2000 Information Updates..... | 1 |
| Coding | 1 |
| Coding Classification..... | 1 |
| DHS ICD-10-AM Library File, Version 2 (2000—2001) | 1 |
| ICD-10-AM Refresher Course - La Trobe University..... | 2 |
| Report on ICD-10-AM/NCCH Workshops | 3 |
| Victorian Additions to Australian Coding Standards for 1 July 2000 | 5 |
| Summary of Victorian Additions (from 1 July 2000) | 5 |
| ICD-10-AM Code Book Annotations for Victorian Additions | 11 |
| Deleted Victorian Additions (from 1 July 2000) | 12 |
| ‘Deleted Victorian Additions’ - Advice that remains effective from 1 July 2000 | 15 |
| Victorian ICD Coding Committee Queries | 18 |
| Volume, Multiple Sources and Timing of Implementation of Coding Advice ... | 19 |
| Grouping | 23 |
| Grouper Version..... | 23 |
| VIC-DRGs in 2000—2001 | 23 |
| Australian Refined Diagnosis Related Groups (AR-DRG) Classification..... | 26 |
| Publications and References | 32 |
| Texts | 32 |
| Relevant DHS Correspondence..... | 32 |
| Websites..... | 33 |
| Useful Contacts and Committees..... | 33 |
| Coding Features..... | 35 |
| Additional Diagnoses | 35 |
| Anaesthetics | 38 |
| Electroconvulsive Therapy (ECT) | 38 |
| General Anaesthetic..... | 38 |
| Sedation | 39 |
| Assigning Code Prefixes | 40 |

| | |
|-----------------------------------------------------------------------------------------------|-----------|
| Blood Transfusions | 42 |
| Intra-operative | 42 |
| Blood salvaged in theatre and re-infused | 42 |
| Cancelled Surgery | 42 |
| Chemotherapy | 42 |
| Diabetes with diarrhoea | 43 |
| Place of Occurrence | 43 |
| Screening for Specific Disorders..... | 44 |
| Sequencing Guidelines | 45 |
| Tracheostomy..... | 47 |
| Unacceptable Obstetric Diagnosis Combination | 47 |
| | |
| Reporting to the VAED..... | 48 |
| Extra Diagnosis Record | 48 |
| VAED Schedule Requirements 2000—2001..... | 50 |
| | |
| Alphabetic Index to Victorian ICD-10-AM Coding Advice: July 1999 - June 2000 | 54 |
| | |
| Abbreviations..... | 60 |

1 July 2000 Information Updates

Coding

Coding Classification

 All separations on and after 1 July 2000 must be coded using ICD-10-AM 2nd Edition (and relevant errata) and the Victorian Additions to Australian Coding Standards, effective 1 July 2000.

Note: There are many small changes in the 2nd Edition, for example index amendments, therefore it is extremely important that coders look up codes in the 2nd Edition index rather than assigning codes from memory.

DHS ICD-10-AM Library File, Version 2 (2000—2001)

The 2000—2001 file (in Excel format) and the description of the file structure, have been loaded on to the HDSS web page at:

www.dhs.vic.gov.au/ahs/hdss/vaed.htm,

under the 'Selected Reference Files' section.

ICD-10-AM Refresher Course - La Trobe University

La Trobe University (School of Public Health), in conjunction with the Department of Human Services, is currently conducting a Coding Refresher Course for people wishing to regain basic coding and abstracting skills in ICD-10-AM (2nd Edition). This is particularly targeted at people who are not currently coding, or who are coding in a very narrow casemix. The course is being conducted over a six week period:

Saturday 17 June 2000

Friday 7 July 2000

Friday 23 June 2000

Saturday 15 July 2000

Saturday 1 July 2000


Friday 21 July 2000


Content includes:

- ICD-10-AM development and use in Australia, differences with previously used classifications
- Structure of classification system
- Selection of disease codes
- General standards for diseases and procedures
- All body systems
- Injury, poisoning and certain other consequences of external causes
- Review of standards specific to paediatric coding
- AN-DRGs and AR-DRGs, Coding in a casemix environment
- Standards for ethical coding.

Participants are required to complete a take-home examination as a hurdle requirement for a certificate of course completion.

If you are interested in undertaking such a course in the future or know of anyone who would be interested, please notify Dianne Williamson at La Trobe University:

 9479 5846

 9479 1783

 D. Williamson@latrobe.edu.au

Report on ICD-10-AM/NCCH Workshops

Ten Victorian ICD-10-AM/NCCH Workshops were held across four weeks in May and June, five in Melbourne and five in country areas: Ballarat, Bendigo, Geelong, Traralgon and Wangaratta. The workshops were conducted by members of the Coder Educator Network with NCCH staff attending on several days.

The sessions were very well attended and feedback has been positive with many participants stating they found the two days of education very beneficial. Thank you to the Coder Educator Network (CEN) members and the NCCH for a lot of hard work and a job well done.

Various queries were raised at the workshops and responses to these queries have been included as *Coding Features* within this newsletter. (Refer to *Coding Features*, page 35.)

Department of Human Services representatives provided an overview of the Victorian Additions to the Australian Coding Standards that will or will not apply and the coding related changes to the Victorian Admitted Episodes Dataset (VAED) from 1 July 2000. Copies of the information presented may be obtained by contacting the HDSS Help Desk.

Video of the ICD-10-AM 2nd Edition Workshops

The NCCH has developed a video of the ICD-10-AM 2nd Edition Workshops.

The video is approximately 3 hours in length and includes all the major revisions to the codes and indexing between the 1st and 2nd editions of ICD-10-AM as well as new and revised Australian Coding Standards (ACS). The material covered in the video is exactly the same as that presented at the face-to-face workshops.

Areas covered include guidance in the coding of procedural complications, anaesthetic coding, the new Place of Occurrence and Activity codes, revised Allied Health chapter and the revisions to the classification of diabetes mellitus.

The video package includes the video, a workbook with scenario exercises, an exercise answer booklet and feedback form and can be purchased from NCCH at a cost of \$130. The workbook and answers can be purchased separately at a cost of \$50.

The video should be available to purchase by the end of June and will be advertised in the June edition of *Coding Matters* and will also be a new item on the June product order form.

The video is predominantly aimed at those coders who were unable to attend the face-to-face workshops due to either financial, timing or distance constraints, but would also be useful to those coders who would like a refresher of the 2nd Edition changes.

Contact the NCCH for more information.

Victorian Additions to Australian Coding Standards for 1 July 2000

Note: The Victorian Additions distributed with this newsletter should be glued into Volume 5 of the Australian Coding Standards (2nd Edition). Contact the HDSS Help Desk if you require additional copies (see enclosed order form), alternatively you can access this document at:

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

Summary of Victorian Additions (from 1 July 2000)

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

Vic Prefix.1 Prefixes for Diagnoses

A diagnosis must meet the criteria specified in ACS 0001 *Principal diagnosis*, page 2 or ACS 0002 *Additional diagnoses*, page 5 in order to be coded. The following instructions advise on the assignment of the prefix of a condition that should be coded.

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.

Primary and associated diagnoses are conditions present at time of admission (or when the episode of care commenced), or are a direct consequence of a condition present at admission, 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*, page 5.

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).

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*, page 33.

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 33.

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], must have **Z51.0 Radiotherapy session** assigned as an additional diagnosis.

This Victorian Addition *overrides* the ‘multi-day’ component of ACS 0229 *Radiotherapy*, page 69.

Vic 0233 Morphology

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

This Victorian Addition *supplements ACS 0233 Morphology*, page 69.

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.)

Vic 2104 Rehabilitation

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

This Victorian Addition *supplements ACS 2104 Rehabilitation*, page 247.

ICD-10-AM Code Book Annotations for Victorian Additions

This list has been compiled to facilitate the annotation by coders of their ICD-10-AM 2nd Edition Tabular Lists (Volumes One and Three) to indicate codes to which a *Victorian Addition to an Australian Coding Standard* applies.

Annotate the following codes "Vic 0030":

| ICD-10-AM 2nd Edition Diagnosis Code | ICD-10-AM 2nd Edition Procedure Code | ICD-10-AM 2nd Edition Block Numbers |
|------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------|
| Z00.5 | 42506-00 [161] | [173] |
| Z52.00 | 90065-00 [174] | [555] |
| Z52.01 | 42683-00 [254] | [659] |
| Z52.08 | 38438-03 [553] | [660] |
| Z52.1 | 90346-00 [953] | [801] |
| Z52.2 | 90317-00 [954] | [802] |
| Z52.3 | 90324-00 [981] | [978] |
| Z52.4 | 90669-00 [1634] | [1049] |
| Z52.5 | | [1057] |
| Z52.6 | | [1563] |
| Z52.7 | | [1637] - [1650] |
| Z52.8 | | [1861] |
| Z52.9 | | [1891] |
| | | [1892] |
| | | [1893] |

Annotate the following codes "Vic 0229":

| ICD-10-AM 2nd Edition Diagnosis Code | ICD-10-AM 2nd Edition Block Numbers |
|------------------------------------------------------------|-----------------------------------------------------------|
| Z51.0 | [1786] |
| | [1787] |
| | [1788] |
| | [1789] |
| | [1790] |
| | [1791] |
| | [1792] |
| | [1794] |
| | [1795] |

Deleted Victorian Additions (from 1 July 2000)

The deletion of a Victorian Addition may not necessarily mean a change in code assignment. For example, Vic 0401 *Diabetes Mellitus*. Diabetes with leg ulcer still requires an additional code for the ulcer as per ACS 0401 *Diabetes Mellitus*, page 81.

| Standard | Reason for deletion | Relevant ACS from 1 July 2000 |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Vic Prefix.3 <i>Prefixes for Rehabilitation Codes</i> | Prefixes should be applied as per Vic Prefix.1. | - |
| Vic Prefix.4 <i>Procedures</i> | Victorian Addition is superfluous. Prefix O (alpha) has not been required since 1 July 1998. | - |
| Vic 0001 <i>Principal Diagnosis</i> | Provides advice on applying the standard only. Covered by ACS. | ACS 0001 <i>Principal Diagnosis</i> , page 2. |
| Vic 0036 <i>Principal Procedure</i> | Victorian Addition is superfluous. The XXXX rule has not been applied since 1 July 1998. | - |
| Vic 0224 <i>Palliative Care</i> | Covered by ACS. | ACS 0224 <i>Palliative Care</i> , page 68. |
| Vic 0401 <i>Diabetes Mellitus</i> | The inclusion of additional codes for ulceration and/or gangrene does not influence AR-DRG Version 4.1. | ACS 0401 <i>Diabetes Mellitus</i> , page 81. |

| Standard | Reason for deletion | Relevant ACS from 1 July 2000 |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <i>Vic Athero Atherosclerosis with Ulceration and/or Gangrene</i> | The inclusion of additional codes for ulceration and/or gangrene does not influence AR-DRG Version 4.1. | - |
| <i>Vic Obstet Z code as Indicator of Type of Obstetric Episode</i> | Covered by ACS. | ACS 1517 <i>Outcome of delivery</i> , page 187 & ACS 1548 <i>Postpartum condition or complication</i> , page 194. |
| <i>Vic 0936 Replacement of Pacemaker or Pacemaker Components</i> | Not required for AR-DRG Version 4.1. | ACS 0936 <i>Pacemakers</i> , page 135. |
| <i>Vic 1505 Single Spontaneous Vaginal Delivery</i> | Provides advice on applying the standard only. Covered by ACS. The 'outcome of delivery' component is covered by ACS 1517. | ACS 1505 <i>Single Spontaneous Vaginal Delivery</i> , page 185. ACS 1517 <i>Outcome of Delivery</i> , page 187. |
| <i>Vic 1602 Neonatal Complications of Maternal Diabetes</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1602 <i>Neonatal Complications of Maternal Diabetes</i> , page 197. |
| <i>Vic 1607 Assignment of Principal Diagnosis in Newborns</i> | Covered by ACS. | ACS 1607 <i>Newborn/neonate</i> , page 198. |
| <i>Vic 1615.1 Jaundice in the Newborn</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific Interventions for the Sick Neonate</i> , page 201. |

| Standard | Reason for deletion | Relevant ACS from 1 July 2000 |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Vic 1615.2 <i>Feeding Problems in the Newborn</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific Interventions for the Sick Neonate</i> , page 201. |
| Vic 1615.3 <i>Hypothermia in the Newborn</i> | Move to AR-DRG Version 4.1. | - |
| Vic 1615.4 <i>Respiratory Illness in the Newborn</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific Interventions for the Sick Neonate</i> , page 201. |
| Vic 1615.5 <i>Hypoglycaemia in the Newborn</i> | Move to AR-DRG Version 4.1. | - |
| Vic 1615.6 <i>Disorders of Electrolytes, Hydration and Blood Volume in the Newborn</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific interventions for the Sick Neonate</i> , page 201. |
| Vic 1615.7 <i>Perinatal Infection</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific Interventions for the Sick Neonate</i> , page 201. |
| Vic 1615.8 <i>Maternal Illness/Incapacity to Care</i> | Move to AR-DRG Version 4.1 - Victoria is now following the ACS for all sick neonates. | ACS 1615 <i>Specific Interventions for the Sick Neonate</i> , page 201. |
| Vic 1917 <i>Tendon Injury with Open Wound of Same Site or Open Wound with Tendon Involvement</i> | Not required for AR-DRG Version 4.1. | ACS 1917 <i>Open Wounds</i> , page 234. |

'Deleted Victorian Additions' - Advice that remains effective from 1 July 2000

As noted on previous pages, many of the 1998 Victorian Additions have been deleted due to the 2nd Edition of the ICD-10AM classification and the change from Version 3.1 to 4.1 of the grouper. (Refer to *Deleted Victorian Additions [from 1 July 2000]*, page 12). However, many of these Victorian Additions contained useful information that still applies from 1 July 2000. The advice that remains effective has been reprinted in this newsletter for your information.

Jaundice and other conditions in the newborn normally treated by phototherapy

With the move to AR-DRG Version 4.1, Victoria is now following ACS 1615 *Specific Interventions for the Sick Neonate [phototherapy]*, page 201, hence Vic 1615.1 *Jaundice in the Newborn* has been deleted.

When coding jaundice and other conditions for admitted babies (in an admitted episode subsequent to the birth episode), where:

- the usual treatment is phototherapy, and
- the phototherapy was not provided for more than 12 hours, and
- there is no other diagnosis,

follow the table below for correct code assignment:

| Age | ICD-10-AM Diagnosis Code | DRG |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <29 days old | P59.x <i>Neonatal jaundice from other and unspecified causes</i> P55.x <i>Haemolytic disease of fetus and newborn</i> P57 <i>Kernicterus</i> P58 <i>Neonatal jaundice due to other excessive haemolysis</i> | P67D <i>Neonate, AdmWt >2499g w/o Significant O.R. Procedure, W/O problem</i> |
| >28 days old | R17 <i>Unspecified jaundice</i> | H63B <i>Disorders of Liver Excep Malig, Cirrhosis, Alcoholic Hepatitis W/O Cat/Sev CC</i> |

Note: Date of birth is counted as day 1 in Victoria, not day 0 as indicated in ACS 1607 Newborn/Neonate, page 198.

Prefixes for rehabilitation codes

Prefixes for rehabilitation should be applied as per Vic Prefix.1 *Prefixes for Diagnoses*, therefore Vic Prefix.3 *Prefixes for Rehabilitation Codes* has been deleted. The 'Admission for rehabilitation' examples that were provided in Vic Prefix.3 are now included in ACS 2104 *Rehabilitation*, page 247 with the exception of 'Other postoperative rehabilitation' which is reprinted below for your reference.

Admission for Other postoperative rehabilitation

- P Z50.x Rehabilitation
- P Reason for surgery code
- P Aftercare following surgery Z code
- P Z48.8 Other specified surgical follow-up care
- PAC Related or residual conditions
- PAC Other medical conditions
- Rehabilitation procedure codes

Single spontaneous vaginal delivery

Vic 1505 *Single spontaneous vaginal delivery* provided:

- Advice on applying ACS 1505 *Single Spontaneous Vaginal Delivery*, page 157 (1st Edition), and
- Duplicated information contained in ACS 1517 *Outcome of Delivery*, page 157 (1st Edition),

therefore this Vic Addition has been deleted. Coders should note however that:

- The use of MBS-E code 90467-00 [1336] *Spontaneous vertex delivery* in Victoria remains optional, and
- A Z37.- *Outcome of delivery* code must be coded for all delivery episodes (ACS 1517 *Outcome of Delivery*, page 187).

Z Code as Indicator of Type of Obstetric Episode

Vic Obset *Z Code as Indicator of Type of Obstetric Episode* is covered by ACS 1517 *Outcome of Delivery*, page 187 and 1548 *Postpartum condition or complication*, page 194, therefore this Vic Addition has been deleted.

Coders should note that the following advice still applies:

| Type of episode | Additional code requirement |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Antepartum and postpartum conditions with delivery | Assign Z37.x <i>Outcome of delivery</i> . Do not assign Z39.0x <i>Postpartum care and examination after delivery</i> . |
| Antepartum condition with delivery | Assign Z37.x <i>Outcome of delivery</i> . |
| Antepartum condition, without delivery | No additional Z code required. |
| Delivery | Assign Z37.x <i>Outcome of delivery</i> as additional code to identify the delivery episode. |
| Delivery with postpartum condition | Assign Z37.x <i>Outcome of delivery</i> . Do not assign Z39.0x <i>Postpartum care and examination after delivery</i> . |
| Postpartum | Assign Z39.0x <i>Postpartum care and examination after delivery</i> as an additional code to identify the postpartum episode. |

Victorian ICD Coding Committee Queries

ICD-10-AM 2nd Edition queries should continue to be sent directly to the Victorian Coding Committee (not the NCCH) from 1 July 2000. Prior to submitting a query, coders are reminded to:

- Check ICD-10-AM 2nd 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* has been revised (refer to the proforma at the back of this document), to prompt you to include background information/details, to enable all queries to be answered appropriately. This in turn will ensure that:

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

Not only will this save the Committee's time, but also the enquirer's, if the answer can be found prior to submission. If you believe that your research answers your query, but would like confirmation from the VCC or wish to share your findings with others, please forward your query.

If you would like an electronic copy of the query form (to email), please contact the HDSS Help Desk. Queries can also be submitted electronically:

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

Volume, Multiple Sources and Timing of Implementation of Coding Advice

Reprinted below is a letter sent by DHS to Associate Professor Rosemary Roberts, Director, National Centre for Classification in Health (NCCH), on 20 April 2000 requesting an Agenda Item to consider the volume, multiple sources and timing of implementation of coding advice at the forthcoming NCCH Advisory Committee meeting. This meeting was held on 16 May 2000. The issue was subsequently discussed at the Coding Standards Advisory Committee (CSAC) meeting on 22 May 2000.

Dear Prof Roberts

**Item for Meeting of NCCH Advisory Committee on 16 May 2000:
Volume, Multiple Sources and Timing of Implementation of Coding Advice**

The first large scale audit of Victorian ICD-10-AM data was conducted last year by Healthcare Management Advisors Pty Ltd. This audit examined 7,004 separations, from December 1998 to February 1999 inclusive, across 50 randomly selected Victorian public hospitals of various size, in both metropolitan and rural locations. While the results were pleasing, the final audit report identified a number of issues to be addressed by coders, hospitals and this Department, some of which have relevance to other states, and at the national level.

Issues which warrant the consideration of the NCCH Advisory Committee are the numerous sources of coding advice, the currency of advice, and the difficulty for coders in determining when each piece of advice should be implemented. The latter issue has repercussions for data users, when there is lack of consistency of application across sites and states.

The volume of advice on ICD-10-AM coding has been high, no doubt influenced by the introduction of this new classification, and by the higher profile of coding and the greater emphasis placed on coding accuracy. This is especially so in jurisdictions where funding is determined, at least in part, by the codes assigned for the episode. Perhaps the volume of advice emanating from the various sources will diminish somewhat as coders become more familiar with ICD-10-AM and the classification itself is enhanced.

Coders and auditors have commented that there are too many different sources of advice. From the NCCH alone there are Coding Matters, ICD-10-AM errata, coding query database, specialty booklets, and verbal advice provided at conferences and workshops. This is further complicated by unofficial advice emanating from the NCCH-auspiced Code-L. In addition, most if not all states issue coding newsletters of their own. Multiple sources of advice create a considerable problem in terms of duplication of effort and the consequent expense incurred. Auditors report a range of measures employed by hospital coders to consolidate the advice: these include card indices and in-house publications, but have a common requirement of constant attention to ensure currency.

A more recent issue has been the retention on the NCCH's coding query database of advice which is conflicting, and of other advice which relates to the 1st edition of ICD-10-AM but has been:

- resolved in the 2nd edition; or
- superseded by different coding arrangements (eg change in ACS, or codes themselves) in the 2nd edition; or
- superseded by differing advice printed subsequently in Coding Matters.

'Serial' queries, where a response to a query generates a clarification, which is itself then treated as another query, further complicate the database. The database also contains queries where supporting descriptions or documentation are referred to in the query, but this material is not accessible through the database, diminishing the value of the response.

Coders are expected to implement advice or decisions, but where there is no clear implementation date, coders have an excuse to prevaricate. Possible solutions include appending an implementation date to each item of advice, or employing regular implementation dates, e.g. 6 monthly as advocated in the '10-AM Commandments' segment of Coding Matters. This would be appropriate where the advice represents a change in coding practice. However, where advice is merely a clarification of existing practice, a specific implementation date may not be appropriate. In addition where that clarification represents a change in practice for an individual coder, a set implementation date may imply that they should continue to code incorrectly until the implementation date.

Circulating draft advice in a timeframe which allows each jurisdiction to assess any impact on its funding arrangements prior to implementation by coders, would also be a step forward. Some advanced information is received via our CSAC representative however it is acknowledged that it is not possible for CSAC to be consider all coding advisory decisions.

These issues are raised in the hope that a solution to the problems can be identified for implementation from the beginning of the 2000—2001 financial year, to benefit all parties. The resolution of these issues will not be simple, with no remedy guaranteed to be universally successful. However it is clear from the results of our current auditing process that there must be a serious attempt, preferably involving all jurisdictions working together, to improve the situation. I look forward to discussing this issue at the NCCH Advisory Committee meeting on 16 May.


Yours sincerely

**MARK GILL
MANAGER
HEALTH DATA STANDARDS & SYSTEMS
ACUTE HEALTH**

During consideration of this issue at the two national meetings, NCCH have indicated that they will investigate the feasibility and resource implications of including cross references to *Coding Matters* advice on the query database, routinely listing new queries in *Coding Matters*, and including a disclaimer on Code L indicating that the views expressed on Code L are not necessarily those of the NCCH. Associate Professor Roberts has indicated that NCCH will formally respond to the letter. Once that correspondence is received the issue will be further considered by the Victorian Coding Committee and DHS.

Grouping

Grouping Version

 Once transmitted to PRS/2, ICD-10-AM 2nd Edition data will be mapped back to ICD-10-AM 1st Edition and grouped using AR-DRG Version 4.1.

VIC-DRGs in 2000–2001

In 2000–2001 hospitals will assign diagnoses and procedures codes using the 2nd Edition of the ICD-10-AM classification. For funding purposes these codes will be mapped to their 1st Edition ICD-10-AM equivalents for grouping in AR-DRG Version 4.1. This mapping is contained in the 2000–2001 Library File which is now available to software suppliers through the Department's website.

As in previous years, a number of adjustments will be made to the original AR-DRG4 (version 4.1) grouping by utilising the VIC-DRG4 field, prior to the calculation of WIES8. Some of the AN-DRG3 adjustments applied in WIES7 (Cerebral Infarction, Neonates, Transvascular Percutaneous Cardiac Intervention (Stents) and Chemotherapy) are no longer required as the modification has been included within AR-DRG4. VIC-DRG4s are still required for Peritoneal Dialysis, Radiotherapy and Bone Marrow Transplants.

In addition VIC-DRG4s will be derived for significant anomalies identified in Version 4.1 software (the Commonwealth Department will rectify these anomalies in Version 4.2). In some cases this involves additional mapping of ICD-10-AM 2nd Edition codes (over and above the mapping in the ICD-10-AM 2nd Edition Library File).

VIC-DRGs to overcome identified Version 4.1 anomalies

- **Arteriovenous fistula**

In **AR-DRG Version 4.1**, the procedure codes for surgical formation of arteriovenous fistula of lower limb (34509-00) and upper limb (34509-01) are not included in the list of procedures for MDC 11 *Diseases and disorders of kidney and urinary tract*.

As these procedures are commonly performed for treatment of end stage renal disease, 34509-00 and 34509-01 will be mapped to 34512-00 *Construction of arteriovenous fistula with graft of vein*, so that episodes with either of those procedure codes will group to an appropriate **VIC-DRG4**.

- **Bilateral hip replacement and bilateral knee replacement**

In **AR-DRG Version 4.1**, episodes with a bilateral hip or knee procedure will not group to DRG I01 *Bilateral or multiple major joint procedures of lower extremity*.

Where an episode contains a bilateral hip or knee procedure code (49319-00, 49519-00, 49521-01, 49521-03, or 49524-01) a **VIC-DRG4** of I01 will be assigned.

- **Hook needle localisation of breast lesion**

In **AR-DRG Version 4.1** procedure code 30361-00 *Localisation of lesion of breast*, is listed as a major OR procedure. This causes cases to group to a major OR procedure DRGs, whereas they should group to a minor OR procedure or medical DRG.

To address this anomaly, this code will be deleted when grouping to a **VIC-DRG4**. The likely presence of at least one other procedure code will ensure that episodes with procedure code 30361-00 group to an appropriate DRG.

- **Retained placenta and membranes without haemorrhage**

In **AR-DRG Version 4.1**, the diagnosis codes for retained placenta and membranes without haemorrhage (O73.0 and O73.1) have been omitted from the lists for DRGs O04 *Post partum and post abortion diagnosis with OR procedure*, and O61 *Post partum and post abortion diagnosis without OR procedure*. This means that some episodes with these diagnosis codes may be inappropriately grouped to delivery DRGs.

Diagnosis codes O73.0 and O73.1 will be mapped to O72.2 *Other immediate post partum haemorrhage*, so that episodes with either of those diagnosis codes will group to an appropriate **VIC-DRG4**.

- **Birthweight**

In **AR-DRG Version 4.1**, admission weight must be between 400 and 9999 grams otherwise the episode will be assigned to the ungroupable DRG 960Z. During 1999—2000, there have been instances of live births, where the baby weighs less than 400 grams.

Episodes with an admission weight between 255 and 399 grams will be assigned an admission weight of 400 grams for grouping to an appropriate **VIC-DRG4**.

It is important that hospitals notify the HDSS Help Desk of any mapping and/or grouping anomalies they identify. Anomalies will be assessed from a Victorian funding perspective and a decision taken on appropriate action. This will include notifying the Commonwealth so that they can be considered in the development of later versions of the grouper.

Australian Refined Diagnosis Related Groups (AR-DRG) Classification

Based on extracts from the *Australian Refined Diagnosis Related Groups, Version 4.1 Definitions Manual*, Commonwealth Department of Health and Aged Care, 1998 (originally printed in the February 1999 edition of this newsletter).

The AR-DRG classification represents a major overhaul of the AN-DRG classification. All MDCs have been affected. This feature summarises the important differences between AR-DRGs v4 and AN-DRG v3.1.

Two changes affect the whole classification:

- Revised numbering system and
- Incorporation of a new system of measurement of severity.

These are described in detail later in this article.

Individual changes are as follows:

- Extensively modified MDCs:
 - 02 *Diseases and Disorders of the Eye*,
 - 17 *Neoplastic Disorders*,
 - 21 *Injuries, Poisonings and Toxic Effects*, and
 - 22 *Burns*.
- Some new DRGs have been created, while other DRGs have been merged, resulting in a fall in the total number of DRG classes from 667 to 661. New DRGs include percutaneous coronary angioplasty, microvascular tissue transfer, endoscopic procedures for bleeding oesophageal varices, same day HIV admissions, and opioid use disorder and dependence.
- Some restructured DRGs (including tracheostomy, AMI, stroke, head injury, hip replacement, shoulder and elbow procedures, skin disorders and after-care).
- The majority of paediatric age splits have been changed from ten to three years.

- Some surgical hierarchies have been re-ordered, particularly those in MDCs:
 - 06 *Diseases and Disorders of the Digestive System*,
 - 08 *Diseases and Disorders of the Musculoskeletal System and Connective Tissue*,
and
 - 09 *Diseases and Disorders of the Skin, Subcutaneous Tissue and Breasts*.

- Parallel DRGs have been created for prostatectomy in MDCs 11 *Diseases and Disorders of the Kidney and Urinary Tract* and 12 *Diseases and Disorders of the Male Reproductive System*.

- Modified and new variables:
 - Intended same-day has been replaced by actual same day,
 - Diagnosis codes incorporating neonatal birth weights are no longer recognised for DRG grouping purposes, only the actual weights,
 - The acceptable range for actual admission weight values has been modified so that it is now 400 to 9999 grams (NB. episodes with an admission weight between 255 and 399 grams will be assigned an admission weight of 400 grams for grouping to an appropriate VIC-DRG4 and VAED edit 325 will be changed to accept up to 9999 grams), and
 - Mental health legal status, a variable that identifies whether the patient was treated on an involuntary basis under State and Territory mental health legislation, has been added to severity splits in MDC 19.

Several features of the classification have remained unchanged. Like AN-DRGs, AR-DRGs are organised in terms of MDCs and are generally based on hierarchies of diagnoses and procedures distributed between surgical, medical and other partitions.

The AR-DRG numbering system

The format of each AR-DRG number consists of four alphanumeric characters organised in terms of 'ADDS', where:

- A** Is an alphanumeric character which indicates the broad group (usually the MDC) to which the DRG belongs,
- DD** Is a two-digit numeric code which identifies the adjacent DRG within the MDC, and the partition (medical, surgical or other), to which the adjacent DRG belongs, and
- S** Is a split indicator that ranks DRGs within adjacent DRGs on the basis of resource consumption.

For the first character, different letters of the alphabet have been used to signify the broad group to which the DRG belongs, while the number '9' has been used to identify 'Error' DRGs.

For example

- B01Z** relates to the nervous system,
- Z01A** relates to factors influencing health status, and
- 901Z** is an Error DRG.

The second and third characters of each AR-DRG number, that is the **DD**, identify the adjacent DRG grouping. DRG numbers that begin with the same letter and share the same middle digits, may be taken to relate to the same adjacent DRG.

Adjacent DRGs (ADRGs) consist of one or more DRGs, generally defined by the same diagnosis or procedure code list. DRGs within adjacent DRGs have differing levels of resource consumption, and are partitioned on the basis of several factors, including complicating diagnoses/procedures, age, and/or the patient clinical complexity level (PCCL).

For example

- B69A**, **B69B** and **B69C** relate to the same adjacent DRG.

The second and third characters of each AR-DRG number also identify the partition to which the adjacent DRG belongs, with three separate ranges used to indicate surgical, other and medical partitions.

| | |
|---------------|--------------------|
| Range 01 - 39 | Surgical Partition |
| Range 40 - 59 | Other Partition |
| Range 60 - 99 | Medical Partition |

For example

P67D is within the Medical Partition,
I09B is within the Surgical Partition, and
O40Z is within the Other Partition.

The fourth character of each AR-DRG identifies the relative importance of DRGs within an adjacent DRG in terms of resource consumption. The range of values used is:

- A** Highest consumption of resources within the adjacent DRG,
- B** Second highest consumption of resources,
- C** Third highest consumption of resources,
- D** Fourth highest consumption of resources, and
- Z** No split for the adjacent DRG.

The meaning of this split indicator may be gathered from the DRG titles.

For example

B69A *TIA and Precerebral Occlusion W Catastrophic CC*
B69B *TIA and Precerebral Occlusion W Severe CC*
B69C *TIA and Precerebral Occlusion W/O Catastrophic or Severe CC*

In general, both the DRGs within an adjacent DRG, and the adjacent DRGs within the surgical and other partitions, are organised hierarchically on the basis of resource consumption.

Measurement of severity

It is important for DRG classifications to recognise and measure (variation in the) severity of illness. The Complication and Comorbidity Levels (CCL) Refinement Project, which was undertaken as part of the ACCC's review of AN-DRG v3.1, resulted in the adoption of a radically different approach to severity measurement.

Two types of severity measures are used:

- Complication and comorbidity levels (CCL)
- Patient clinical complexity level (PCCL)

Complication and comorbidity levels (CCLs) are severity weights given to *all* additional diagnoses. These have been developed through a combination of medical judgement and statistical analysis. CCL values can vary between adjacent DRGs, and range from '0' — the code is not a complication or comorbidity, to '4' — the code is a catastrophic complication or comorbidity (surgical DRGs only).

Patient clinical complexity level (PCCL) is a measure of the cumulative effect of a patient's complications and comorbidities, and is calculated for each episode. The calculation is complex, and takes account of multiple CCL values on the patient's record, and has been designed to prevent similar conditions from being counted more than once.

The CCL Refinement Project also resulted in greater emphasis being given to PCCL for severity splits of adjacent DRGs. Between AN-DRG v3.1 and AR-DRG v4.0 the number of adjacent DRG splits based on complications and comorbidities alone increased from 81 to 126, while the number based on age alone decreased from 20 to 8. The level (CCL or PCCL) used for a number of these splits has changed from that used in AN-DRG v3. To a large extent, this shift in emphasis reflects a major revision to the meaning and measurement of CCs.

Abbreviations used in this article

| | |
|--------|----------------------------------------------|
| ACCC | Australian Casemix Clinical Committee |
| ADRG | Adjacent Diagnosis Related Group |
| AN-DRG | Australian National Diagnosis Related Groups |
| AR-DRG | Australian Refined Diagnosis Related Groups |
| CC | Complication and Comorbidity |
| CCL | Complication and Comorbidity Level |
| MDC | Major Diagnostic Category |
| NCCH | National Centre for Classification in Health |
| PCCL | Patient Clinical Complexity Level |

Bibliography and Recommended further reading

Development of the Australian Refined Diagnosis Related Groups Classification Version 4, Volume 1 Summary of Changes for the AR-DRG Classification V4.0
Commonwealth Department of Health and Aged Care.

Australian Refined Diagnosis Related Groups, Version 4.1 Definitions Manual
Commonwealth Department of Health and Aged Care, 1998.

Acknowledgment

This article was compiled with the assistance of Naarilla Hirsch, Commonwealth Department of Health and Aged Care (originally printed in the February 1999 edition of this newsletter).

Publications and References

The following list of publications, websites and contacts relating to 1 July 2000 changes are not definitive but may assist you to build your information base. You are invited to add to the list by contacting the HDSS Help Desk with your suggestions. Additional items will be published in future editions of this newsletter.

Texts

- *Australian Refined Diagnosis Related Groups, Version 4.1, Definitions Manual*, (Volumes One, Two and Three), Commonwealth Department of Health and Aged Care, 1998.
- National Centre for Classification in Health (Sydney). *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) 2nd Edition*. Faculty of Health Sciences, University of Sydney, NSW, 1998.
 - Including relevant errata, and
 - *Victorian Additions to Australian Coding Standards Effective 1 July 2000*, should be glued into Volume 5 of the above publication.

Relevant DHS Correspondence















- HDSS Bulletin, Issue 8, 24 December 1999 (*Item 8.4, AR-DRG 4.1 - 1 July 2000*).
- HDSS Bulletin, Issue 10, 26 April 2000 *ICD-10-AM Version 2 to Version 1 mapping in AR-DRG V4.1 Grouper Software*.
- *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1.7.2000*.
- *Victoria - Public Hospital Policy and Funding Guidelines 2000—2001*.


This document will be distributed to CEO's.

Websites

| | |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| Australian Department of Health and Aged Care | www.health.gov.au |
| Health Data Standards & Systems Unit, Department of Human Services, Victoria | www.dhs.vic.gov.au/ahs/hdss |
| Health Information Management Association of Australia | www.himaa.org.au |
| National Centre for Classification in Health (NCCH) | www.cchs.usyd.edu.au/ncch |

Useful Contacts and Committees

- *Department of Human Services
HDSS Help Desk*
 9616 8141
 9616 7629
 PRS2.Help-Desk@dhs.vic.gov.au
 - *Victorian ICD Coding Committee*
 Department of Human Services
 17th floor
 555 Collins Street
 MELBOURNE VIC 3000
 9616 8141
 9616 7629
 PRS2.Help-Desk@dhs.vic.gov.au
 - *National Centre for Classification in Health (NCCH)*
 Faculty of Health Sciences, University of Sydney
 PO Box 170
 Lidcombe NSW 1825
 (02) 9351 9416
 (02) 9351 9603
 c.garrett@cchs.usyd.edu.au
 - *Clinical Coders Society of Australia (CCSA)*
 PO Box 203
 North Ryde NSW 1670
 (02) 9887 5001
 (02) 9887 5895
 shashis@himaa.org.au
- Coding Standards Advisory Committee (CSAC)*
- *Health Information Management Association of Australia (HIMAA)*
 Locked Bag 2045
 North Ryde NSW 1670
 (02) 9887 5001
 (02) 9887 5895
 - *HIMAA Victorian Branch*
 PO Box 12
 North Melbourne VIC 3051

 himaa@himaa.org.au

Coding Features

Additional Diagnoses

Background

The re-definition of ACS 0002 *Additional Diagnoses*, page 8 (1st Edition), effective 1 July 1999, involved the removal of the following three statements from the standard:

- ‘Clinical evaluation’,
- ‘Extended length of hospital stay’, and
- ‘Certain conditions such as hypertension, Parkinson’s disease, and diabetes mellitus are examples of systemic diseases that ordinarily should be coded even in the absence of documented intervention’.

The National Centre for Classification in Health (NCCH) advised in the June 1999 edition of *Coding Matters* that “this modified standard is provided to reinforce good coding practice, and therefore may not have any effect on the way you code now”. The HDSS Bulletin Issue 2 (July 1999) confirmed that the purpose of the change was to reinforce the essential principles of coding additional diagnoses and expressed the view that “The majority of Victorian coders will find that the revision of this standard will make little or no difference to the manner in which additional diagnoses were coded prior to 1 July 1999”.

Following further advice from NCCH and Victorian coders, it has become apparent that ACS 0002 is not being consistently applied in Victoria and that much clearer instruction is required.

Decision

From 1 July 2000, Victorian coders are instructed to strictly adhere to Australian Coding Standard (ACS) 0002 *Additional Diagnoses*, page 5 (ICD-10-AM 2nd Edition). This is likely to mean a change of coding practice for most Victorian coders.

Coders must make a conscious decision whether or not to code every condition in every case, rather than simply coding all chronic systemic conditions as a matter of course. The coder must be able to justify each code assigned. The advantages of this decision are that it will:

- Provide greater consistency in the coding of additional diagnoses,
- Coincide with the implementation of the 2nd Edition of ICD-10-AM,
- Coincide with the implementation of Version 4.1 of the AR-DRG grouper,
- Reinforce Victoria's commitment to follow national standards and therefore reduce multiple sources of coding advice to facilitate consistency in coded data,
- Curb routine, ill-considered coding of diagnoses which may be inconsequential to the episode of care, and
- Provide a more accurate reflection of the resources used during the episode of care, which will in turn provide more accurate cost weights.

There are no long term benefits in delaying strict application of ACS 0002. As there is a two year lag between coding and cost weight development, the sooner codes are assigned strictly in accordance with ACS 0002, the sooner cost weights will reflect that approach.

Issues

Education

Coders require education to ensure successful implementation of this standard. Education will be provided by the Department and made available to all coders by the middle of July, to ensure that the standard can be applied to all separations from 1 July 2000.

It is believed that workshop style education would not be effective due to the large number of potential participants, therefore the following alternatives will be utilised:

- Distance education, hard copy and web based, and
- Dedicated 'Help Desk' facility (staffed where possible by members of the Coders Educator Network).

Suggestions for other methods of education are invited. Please contact the HDSS Help Desk.

Effect on WIES

DHS acknowledge that it is of great concern to coders and hospital management (particularly public hospitals), that many of the conditions which would not necessarily be coded under the revised standard, act as complicating factors. It is suspected that strict application of ACS 0002 will result in a significant number of episodes grouping to 'non-CC' DRGs, when previously they would have been grouped to 'with CC' DRGs. As Victoria is moving to a new grouper with different CC logic, it is not possible to accurately estimate the effect on WIES in 2000—2001 from existing data.

DHS will assess the impact of adopting the standard with selected hospitals undertaking dual coding studies during 2000—2001 to provide 'before' and 'after' coding and grouping. This exercise will also measure the impact of the revised ACS 1904 *Procedural Complications*, page 217. The hospital studies, to be funded by DHS, are expected to provide an average WIES reduction figure which will be factored into the annual assessment of hospital performance against target. Hospitals interested in being involved in the study of the impact of applying ACSs 0002 and 1904, should notify Mark Gill immediately (Mark.Gill@dhs.vic.gov.au).

The VAED audit process will recognise that there may be a short transition period as coders become more experienced with a stricter application of ACS 0002.

Anaesthetics

The following information provides advice to be noted when applying ACS 0031 *Anaesthesia*, page 35.

Electroconvulsive Therapy (ECT)

ECT is coded according to the number of treatments per admission:

93340-00 [1907] *Electroconvulsive therapy [ECT] ≤8, or*

93340-01 [1907] *Electroconvulsive therapy [ECT] >8.*

Where these treatments are performed under general anaesthetic an anaesthetic code must be assigned for every visit to theatre (ACS 0031 *Anaesthesia*, page 35). For example, during one episode of care a patient receives 6 separate sessions of ECT, each performed under a general anaesthetic. Code assignment would be:

ECT 93340-00 [1907]

GA 92502-02 [1910]

GA 92502-02 [1910]

GA 92502-02 [1910]

GA 92502-02 [1910]

GA 92502-02 [1910]

GA 92502-02 [1910]

General Anaesthetic

Version 4.1 of the grouper uses general anaesthetic codes for grouping to the following DRGs:

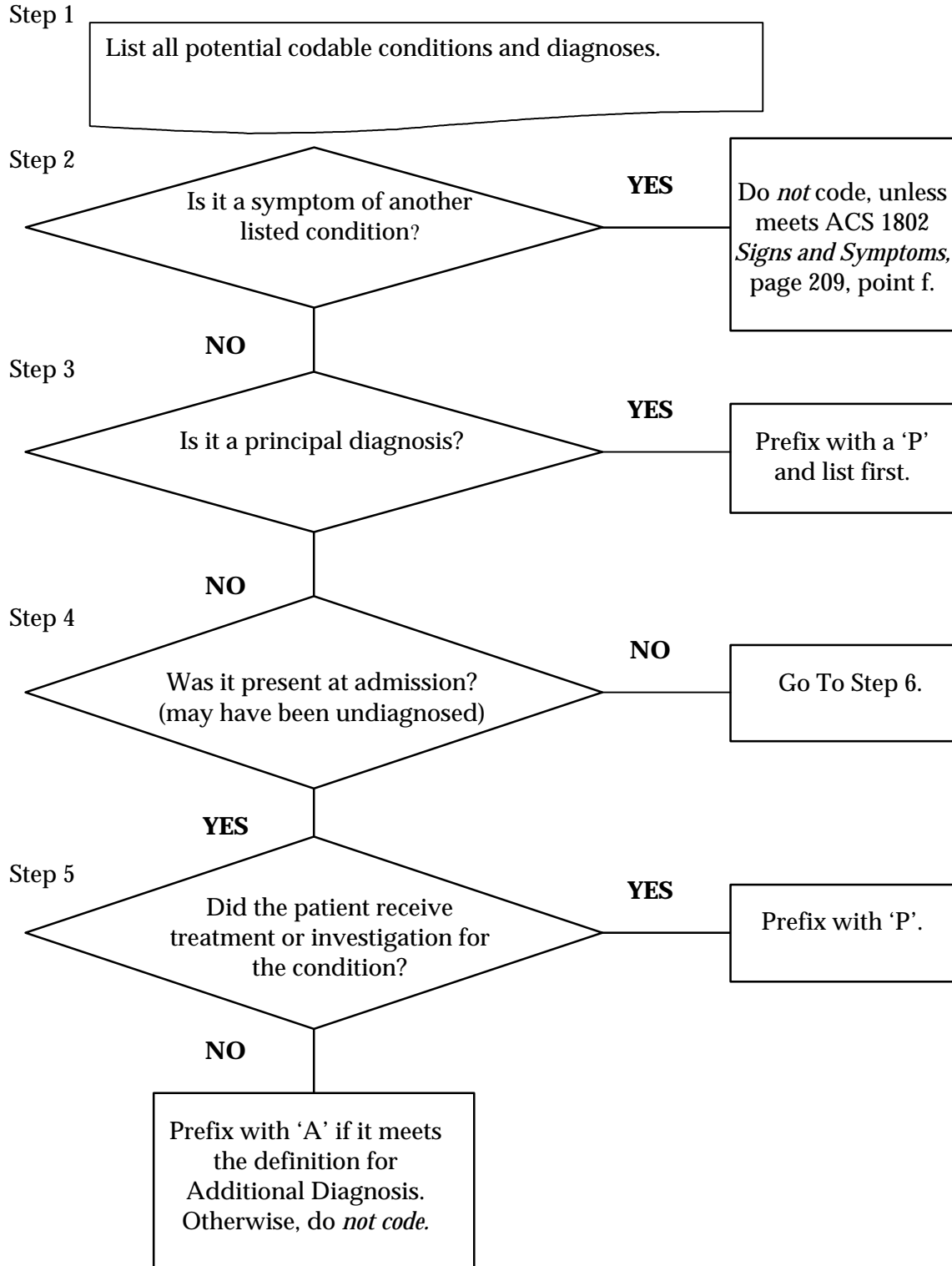
- F42A *Circulatory Disorders W/O AMI W Invasive Cardiac Inves Proc W Complex DX/Pr*
- G40A *Cmplx Therapeutic Gastroscopy for Mjr Digestive Dis W Cat or Sev CC/Comp Pr*
- G44A *Other Colonoscopy W Catastrophic or Severe CC or Complicating Procedure.*

Sedation

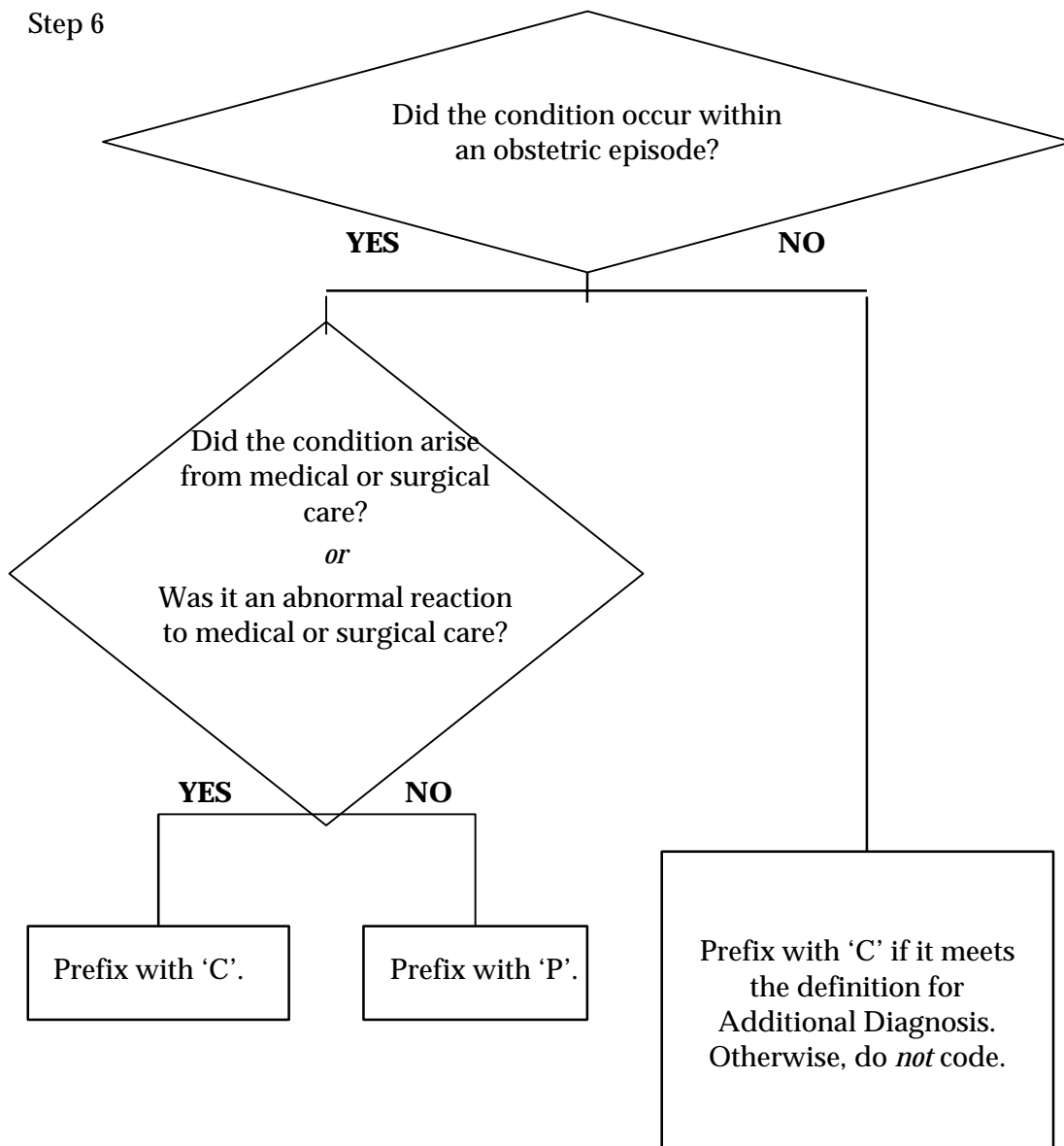
- Only *intravenous* sedation is coded (not oral).
- Code 92503-00 [1911] *Intravenous sedation, anaesthetist controlled*, suggests that intravenous sedation must be performed by an anaesthetist, however NCCH advice is that this code should also be assigned when the sedation is administered by a clinician, who is not an anaesthetist.

Assigning Code Prefixes

(This (revised) chart was originally published in the 1993 Victorian Coding Standards and reprinted in the June 1998 edition of this newsletter.)



Step 6



Some hospitals may wish to record conditions and procedures for later research purposes which, according to the Australian Coding Standards, should not be coded. There is no limitation on what hospitals may record for internal purposes; however, such codes and code 'embroidery' must be removed before data is transmitted to the VAED.

Blood Transfusions

Intra-operative

ACS 0302 *Blood Transfusions*, page 78, indicates that all blood transfusions should be coded. This includes intra-operative blood transfusions, (i.e. intra-operative blood transfusions should be coded whenever performed).

Blood salvaged in theatre and re-infused

The closest code available in ICD-10-AM (2nd Edition) for blood salvaged in theatre and re-infused, is that for autologous transfusion:

92060-00 [1893] *Transfusion of previously collected autologous blood.*

Cancelled Surgery

Coders should note that for ACS 0011 *Admission for Surgery Not Performed*, page 8, to be applied, the episode must first meet the 'criteria for admission' (for transmission via PRS/2 to the VAED), as detailed in the PRS/2 Manual and Acute Health Division Circular 15/98—*Reporting Admitted Patient Episodes to the Victorian Inpatient Minimum Database (VIMD)*, 26 August 1998.

Chemotherapy

Issue 6 of the HDSS Bulletin (13 October 1999) *Coding: Admission for Chemotherapy* remains effective from 1 July 2000. That is, the standard should be applied when the intent of the admission is for chemotherapy and the patient is treated with drugs as listed in the standard.

Diabetes with diarrhoea

Coders will note the index entry for diabetes with diarrhoea, which instructs them to assign:

E1-43 "...diabetes with diabetic autonomic neuropathy".

This code will be assigned to patients with 'diabetic diarrhoea' and also to those with diabetes and diarrhoea, where no cause and effect relationship is documented.

Coders should apply their Clinical Coders Creed and where it is obvious that the diarrhoea is due to another cause (such as gastroenteritis or food poisoning), then the diabetes and the diarrhoea should be coded separately.

Place of Occurrence

ACS 2003 *Place of Occurrence of External Cause of Injury*, page 243, indicates that the *Place of Occurrence* code should indicate the **place** where the injury or poisoning (external cause) occurred.

Accommodation Type should not influence the assignment of Place of Occurrence codes. Therefore, Hospital in the Home (HITH) patients who suffer injury or poisoning should not automatically be assigned a Place of Occurrence of 'Home' (Y92.0), rather the Place of Occurrence code should be assigned according to the examples illustrated in the table below:

| Scenario | Place of Occurrence |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| Patient with HITH <i>Accommodation Type</i> for the entire episode injured/poisoned whilst at home. | Y92.0 <i>Home</i> |
| Patient who changes between HITH and shared room <i>Accommodation Type</i> within the one episode, injured/poisoned: <ul style="list-style-type: none">whilst accommodated in the shared roomwhilst at home. | <ul style="list-style-type: none">Y92.22 <i>Health service area</i>Y92.0 <i>Home</i> |
| Patient with HITH <i>Accommodation Type</i> for the entire episode, injured/poisoned whilst walking down the street. | Y92.4 <i>Street and highway</i> |

Screening for Specific Disorders

Screening codes Z11, Z12 and Z13 will group to an 'unacceptable' DRG when used in accordance with the ACS 2111 *Screening for Specific Disorders*. This issue has been addressed by the NCCH and advice will appear in the June edition of *Coding Matters*.

Sequencing Guidelines

From 1 July 2000, Victorian hospitals can transmit up to 25 diagnosis codes and 25 procedure codes (by implementing the new Extra Diagnosis Record [Y2]). Alternatively, a hospital can continue to limit transmitted codes to 12 and 12 respectively. If the hospital implements the new Y2 record, the complete set of codes (that is, from both X2 and Y2 records) will be edited as a whole.

From 1 July 2000, some episodes will need more codes than previously: for example, an anaesthesia code must be added, where appropriate, and some External Cause codes will also require a Place of Occurrence and/or an Activity code.

Code according to the selection and sequencing instructions in the *Australian Coding Standards*. However, the following guidelines will assist when there are more codes than can be transmitted, either because they exceed what the hospital can transmit or what PRS/2 is capable of receiving. If necessary, delete or do not transmit diagnosis or procedure codes of lesser significance.

Sequence to ensure transmission of the following, if relevant to the episode:

Diagnoses

- Any code regarded as a complication or comorbidity if the episode groups to an adjacent DRG (i.e. one that splits depending on the presence or absence of a PCCL).
- Outcome of delivery code (*Z37.x Outcome of delivery*) or a Postpartum care and examination code (*Z39.x Postpartum care and examination*), to ensure correct grouping.
- Liveborn infant code (*Z38.x Liveborn infants according to place of birth*).
- Any code used in grouping to Vic DRGs or co-payments. For full details, refer to the Victoria—*Public Hospital Policy and Funding Guidelines 2000—2001*.

- External Cause* coding if the episode includes a diagnosis code (or set of diagnosis codes from the one event) requiring External Cause details. Sequence the External Cause* coding immediately after the relevant diagnosis code or last relevant diagnosis code (ACS 2001 *External cause code use and sequencing*, page 241). If necessary, 'bundle' diagnosis codes of less severe injuries (to multiple injuries of site/type) to ensure all injuries are captured before the external cause codes.
- External Cause* coding *for each event* if the episode includes more than one set of diagnosis codes (that is, the patient suffered more than one event) requiring External Cause details. Sequence each External Cause* code immediately after the respective relevant diagnosis code or last relevant diagnosis code. (ACS 2001 *External cause code use and sequencing*, page 241).

**External Cause coding includes, in addition to the External Cause code, a Place of Occurrence code (if diagnosis is V01-Y89) and Activity code (if diagnosis is V01-Y34).*

Procedures

- One anaesthetic code for each procedure (or set of procedures performed at the *same* time). Sequence immediately after the procedure code (or set of procedure codes) and select according to the following hierarchy if more than one anaesthetic was used (ACS 0031 *Anaesthesia*, page 35):
 - General anaesthesia combined with epidural, caudal or spinal anaesthesia
 - General anaesthesia
 - Epidural/caudal/spinal anaesthesia
 - Sedation (intravenous only).
- One anaesthetic code for each set of procedures if the procedures were performed at *different* times. Sequence immediately after the (last) procedure code in that set of codes and select according to the ACS 0031 *Anaesthesia*, page 35 hierarchy (above).
- If an anaesthetic is used during an endoscopy, one anaesthetic code (now used in some AR-DRG assignment).

Tracheostomy

In Version 4.1 of the grouper, patients under 16 years of age who fall into MDC 22 *Burns* and MDC 5 *Diseases and disorders of the circulatory system* are excluded from the Tracheostomy (DRG A06Z *Tracheostomy Any Age, Any Condition*) and Intubation (DRG A41Z *Intubation Age <16*) logic.

Unacceptable Obstetric Diagnosis Combination

Coders should be aware that obstetrical procedures (as listed in ACS 1505 *Single Spontaneous Vaginal Delivery*, page 185), reported in combination with a Principal Diagnosis code of O80 *Single spontaneous delivery* will group to DRG 962Z *Unacceptable Obstetric Diagnosis Combination* in Version 4.1 of the grouper.

Reporting to the VAED

Extra Diagnosis Record

(Note: Refer to the 'Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1.7.2000' document, distributed in April 2000, for more information).

There is only one 'coding related' revision to the VAED, and this is to add a new Transaction Record which will be known as the Extra Diagnosis Record or Y2.

The new Transaction Record (Y2) accommodates 13 extra diagnosis and 13 extra procedure codes for each episode. PRS/2 therefore is able to accept a maximum of 25 diagnosis and 25 procedure codes. (The Diagnosis Record accepts the first twelve of each.)

The development of this transaction record was initiated by the Victorian ICD Coding Committee principally because:

- AR-DRG grouper version 4.1 considers a maximum of 20 diagnoses and procedure codes when allocating a DRG.
- Alterations to the ACS, particularly external cause coding and anaesthetics will result in a significant increase in the numbers of codes assigned to many episodes from 1 July 2000.

The reporting of the Extra Diagnosis Record (Y2) is optional for both public and private hospitals.

The Extra Diagnosis Record (Y2) can be reported when:

- the episode has more than 12 diagnosis and/or 12 procedure codes, and
- a separation date has been reported in the corresponding Episode Record (E2).

The Extra Diagnosis Record (Y2) should be transmitted immediately following the corresponding Diagnosis Record (X2).

Both records will be edited each time they are transmitted. They will also be re-edited if their corresponding Episode Record (E2) is re-transmitted.

If the Episode Record (E2) is deleted, both Diagnosis Records (X2 & Y2) will automatically be deleted from PRS/2.

To correct or update an Extra Diagnosis Record (Y2), re-transmit the Diagnosis Record (X2) immediately followed by the updated Extra Diagnosis Record (Y2). This will overwrite all fields already recorded and re-assign the DRG.

If only an X2 update is sent when an X2 and Y2 are already held by PRS/2, only the X2 will remain. A warning message will inform you of this.

VAED Schedule Requirements 2000—2001

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 will be included in the *Victoria—Public Hospitals Policy and Funding Guidelines 2000—2001* in Section B: Conditions of Funding: Acute Health.

Transmission of Admitted Patient Data.

The hospital will transmit data to the Victorian Admitted Episodes Dataset (VAED) via PRS/2 according to the timelines detailed in clauses (a) and (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. Any corrections must be transmitted before finalisation of the VAED database on 21 September.
- 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. Because of the various methods of transmission used by hospitals, and Allegiance Systems' processing schedules, data must be transmitted by the PRS/2 feeder systems to the VAED by, at the latest, the 17th day of each month; however, weekends or public holidays may bring the effective deadline forward to the 14th day.

- e) WIES8 and sub-acute payments will be:
- 1) fully paid for data originally submitted in accordance with the deadlines specified in clauses (a) and (b) above, even if data is subsequently amended; or
 - 2) paid at a reduced rate (50 percent), 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 (a) and (b) above; or
 - 3) not recognised for payment, if data has not been submitted in accordance with *both* deadlines specified in clauses (a) and (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 must write to the Department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for late submission of data will generally only be considered for computer system problems that are beyond the control of the hospital. (Hospitals 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 the small rural hospitals. Exemptions for late submission of admission and separation data will be automatically granted to hospitals maintaining a consistently high level of timely data submission.
- g) Data should be reconciled after each transmission against the hospital's in-house computer or manual systems and against the Monthly Return-Admitted Patients and any required corrections transmitted with data for the subsequent period.

Private hospitals

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

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

VAED Consolidation Date

| Month of Separation 2000 | 21 September | 21 October | 21 November | 21 December | 21 January | 21 February | 21 March | 21 April |
|---------------------------------|---------------------|-------------------|--------------------|--------------------|-------------------|--------------------|-----------------|-----------------|
| July | Full Rate | Full Rate | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| August | Full Rate | Full Rate | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| September | | Full Rate | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| October | | | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| November | | | | Full Rate | Half Rate | Nil | Nil | Nil |
| December | | | | | Full Rate | Half Rate | Nil | Nil |
| January | | | | | | Full Rate | Half Rate | Nil |

VAED Consolidation Date

| Month of Separation 2001 | 21 March | 21 April | 21 May | 21 June | 21 July | 21 August | 21 September |
|---------------------------------|-----------------|-----------------|---------------|----------------|----------------|------------------|---------------------|
| 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 1999 | 21 September | 21 October | 21 November | 21 December | 21 January | 21 February | 21 March | 21 April |
|--------------------------|--------------|------------|-------------|-------------|------------|-------------|-----------|----------|
| July | Full Rate | Full Rate | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| August | | Full Rate | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| September | | | Full Rate | Half Rate | Nil | Nil | Nil | Nil |
| October | | | | Full Rate | Half Rate | Nil | Nil | Nil |
| November | | | | | Full Rate | Half Rate | Nil | Nil |
| December | | | | | | Full Rate | Half Rate | Nil |

VAED Consolidation Date

| Month of Separation 2000 | 21 March | 21 April | 21 May | 21 June | 21 July | 21 August | 21 September |
|--------------------------|-----------|-----------|-----------|-----------|-----------|-----------|--------------|
| 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 |

Alphabetic Index to Victorian ICD-10-AM Coding Advice: July 1999 - June 2000

ACS Australian Coding Standard
 CF Coding Feature
 HDSS M/YY HDSS Bulletin
 Vic Addition Victorian Additions to Australian Coding Standards

**Please refer to the original source for the page number of a query*

| Advice ID | Descriptor | Source |
|-----------|---------------------------------------------------------------------------------------|---------------|
| | -A- | |
| #1482 | Abscess, submandibular, incision and drainage of | May 2000 |
| #1494 | Abstraction guidelines, general ACS 0010 | February 2000 |
| #1479 | ACS 0002 Additional diagnoses | November 1999 |
| - | ACS 0002 Additional diagnoses (VAED) | HDSS 2/99 |
| #1494 | ACS 0010 General abstraction guidelines | February 2000 |
| #1529 | ACS 0012 Suspected Conditions | May 2000 |
| #1468 | ACS 0237 Recurrence of primary malignancy & 0234 Contiguous sites & (NCCCH query 884) | February 2000 |
| #1479 | Additional diagnoses, ACS 0002 | November 1999 |
| - | Additional diagnoses, ACS 0002 (VAED) | HDSS 2/99 |
| #1507 | Adjustment, ureteric memokath | February 2000 |
| #1472 | Alcohol dependence, past history | February 2000 |
| #1520 | Amputation and open fractures | May 2000 |
| #1517 | Amputation, distal 3 rd and 4 th fingers with reattachment | May 2000 |
| #1466 | Anaemia, post operative | February 2000 |
| #1490 | Apraxia, senile gait | May 2000 |
| | -B- | |
| #1470 | Biopsy, transjugular liver | May 2000 |
| #1499 | Brachytherapy and radiotherapy | November 1999 |

| Advice ID | Descriptor | Source |
|-----------|---------------------------------------------------------|---------------|
| #1480 | Brachytherapy, intraluminal | November 1999 |
| | -C- | |
| #1478 | Calciphylaxis | November 1999 |
| - | Chemotherapy - admission for | HDSS 6/99 |
| CF | Chemotherapy, intraperitoneal | August 1999 |
| CF | Coding idiosyncratic episodes | February 2000 |
| #1541 | Coffin-Lowry syndrome | May 2000 |
| #1532 | Conscious state, decreased | May 2000 |
| 0029 | Contracted procedures, coding of | Vic Addition |
| #1538 | COPD, infective exacerbation of, with emphysema | May 2000 |
| #1492 | Coronary artery disease in stent and transplanted heart | November 1999 |
| #1510 | Coroner's report/Post mortem coding | February 2000 |
| #1515 | Cystadenoma of ovary (borderline malignancy) | February 2000 |
| | -D- | |
| #1532 | Decreased conscious state | May 2000 |
| #1472 | Dependence, alcohol, past history | February 2000 |
| #1551 | Dependency, benzhexol | May 2000 |
| #1513 | Depression, postnatal | February 2000 |
| CF | Diabetes with multiple complications | August 1999 |
| #1548 | Diastasis recti post delivery | May 2000 |
| #1539 | Diathermy of penile wart | May 2000 |
| #1566 | Dimple, sacral | May 2000 |
| #1542 | Disorder, schizoaffective, hypomanic | May 2000 |
| | -E- | |
| #1538 | Emphysema with infective exacerbation of COPD | May 2000 |

| Advice ID | Descriptor | Source |
|-----------|----------------------------------------------------------------------------------------------------------------------------|---------------|
| | -F- | |
| #1520 | Fractures, open and amputation | May 2000 |
| #1540 | Fundoplication, Nissen (laparoscopic), revision of | May 2000 |
| | -G- | |
| #1489 | GAMP (ACS 1912 Sequelae of injuries, poisonings, toxic effects and other external causes and 1906 Current and old injuries | November 1999 |
| #1462 | Geriatric Evaluation and Management Program coding | November 1999 |
| #1501 | Group B strep. Status, (unknown) | February 2000 |
| | -I- | |
| #1500 | Impacted tooth, surgical removal | November 1999 |
| #1476 | Implant, breast, re-inflation of | May 2000 |
| #1495 | Implant, loop recorder | February 2000 |
| #1552 | Implant, nose (silicon), removal of | May 2000 |
| #1482 | Incision and drainage of submandibular abscess | May 2000 |
| CF | Infusion, isolated limb | November 1999 |
| | -L- | |
| #1475 | Lacerated bowel and bladder during LUSCS | May 2000 |
| #1504 | Lavage, arthroscopic, of shoulder | February 2000 |
| #1493 | LeFort Osteotomy | November 1999 |
| | -M- | |
| #1543 | Melanotic macule, lip-labial | May 2000 |
| #1545 | Metastatic spread | May 2000 |
| 0233 | Morphology | Vic Addition |
| #1473 | Myelodysplastic syndrome with anaemia | November 1999 |
| | -N- | |

| Advice ID | Descriptor | Source |
|-----------|-------------------------------------------------------------------------------------------|---------------|
| #1540 | Nissen fundoplication, laparoscopic, revision of | May 2000 |
| | -0- | |
| #1519 | Obstruction, upper airway | February 2000 |
| 0030 | Organ procurement | Vic Addition |
| #1496 | Overwarfarinisation/stabilisation of INR | February 2000 |
| | -P- | |
| #1486 | Photodynamic therapy (PDT) | May 2000 |
| #1510 | Post mortem/Coroner's report coding | February 2000 |
| #1527 | Pre-admission tests | May 2000 |
| Prefix.1 | Prefixes for diagnoses | Vic Addition |
| Prefix.2 | Prefixes for obstetric codes | Vic Addition |
| | -R- | |
| #1485 | Radiofrequency ablation of liver | November 1999 |
| 0229 | Radiotherapy | Vic Addition |
| #1499 | Radiotherapy and brachytherapy | November 1999 |
| #1518 | Reattachment of finger | February 2000 |
| #1517 | Reattachment, amputated distal 3 rd and 4 th fingers | May 2000 |
| #1468 | Recurrence of primary malignancy (ACS 0237) & 0234 Contiguous sites & (NCCH query 884) | February 2000 |
| 2104 | Rehabilitation | Vic Addition |
| #1476 | Re-inflation of breast implant | May 2000 |
| #1552 | Removal of silicon implant from nose | May 2000 |
| #1535 | Removal, bath drain from fingers | May 2000 |
| #1511 | Repair AAA with endoluminal bifurcation graft | February 2000 |
| #1516 | Replacement of progesterone 'IUD' | February 2000 |
| #1540 | Revision of a laparoscopic Nissen Fundoplication | May 2000 |

| Advice ID | Descriptor | Source |
|-----------|------------------------------------------------|---------------|
| | -S- | |
| #1542 | Schizoaffective disorder, hypomanic | May 2000 |
| #1544 | Schizophrenia, chronic | May 2000 |
| #1487 | Stenosis, lumbar spinal | November 1999 |
| #1506 | Stent, endobronchial | February 2000 |
| #1465 | Sternal wires | May 2000 |
| #1463 | Sudden cardiac death | November 1999 |
| #1529 | Suspected conditions, ACS 0012 | May 2000 |
| #1541 | Syndrome, Coffin-Lowry | May 2000 |
| | -T- | |
| #1553 | Tamoxifen for breast cancer | May 2000 |
| #1527 | Tests, pre-admission | May 2000 |
| #1486 | Therapy, photodynamic | May 2000 |
| #1503 | Thrombophlebitis, post operative | February 2000 |
| #1470 | Transjugular liver biopsy | May 2000 |
| | -U- | |
| #1501 | Unknown Group B. strep status | February 2000 |
| | -V- | |
| 0029 | VIC Addition - Coding of contracted procedures | Vic Addition |
| 0233 | VIC Addition - Morphology | Vic Addition |
| 0030 | VIC Addition - Organ procurement | Vic Addition |
| Prefix.1 | VIC Addition - Prefixes for diagnoses | Vic Addition |
| Prefix.2 | VIC Addition - Prefixes for obstetric codes | Vic Addition |
| 0229 | VIC Addition - Radiotherapy | Vic Addition |
| 2104 | VIC Addition - Rehabilitation | Vic Addition |

| Advice ID | Descriptor | Source |
|-----------|-------------------------------------------|----------|
| | -W- | |
| #1539 | Wart, penile, diathermy of | May 2000 |
| #1471 | Warts, vulval, vaginal and perianal warts | May 2000 |

Abbreviations

| | |
|-----------|------------------------------------------------------------------------------------------------------------------------|
| ACS | Australian Coding Standard |
| ADX | Additional Diagnosis |
| AN-DRG | Australian National Diagnosis Related Groups |
| AR-DRG | Australian Refined Diagnosis Related Groups |
| CC | Complication and Comorbidity |
| CEN | Coder Educator Network |
| DHS | Department of Human Services |
| HDSS | Health Data Standards and Systems |
| ICD-9-CM | International Classification of Diseases - 9 th Revision - Clinical Modification |
| ICD-10-AM | Statistical Classification of Diseases and Related Health Problems, 10 th Revision, Australian Modification |
| NCCH | National Centre for Classification in Health |
| PCCL | Patient Clinical Complexity Level |
| PDX | Principal Diagnosis |
| VAED | Victorian Admitted Episodes Dataset (name of the admitted patient data collection from 1 July 1999) |
| VCC | Victorian Coding Committee |
| WIES | Weighted Inlier Equivalent Separations |