

ICD Coding Newsletter
November 2001

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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
- 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 the HDSS Help Desk:

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Notification of change of address or requests regarding the mailing list may be directed to any of the above contacts.

An electronic coding query form can be completed at:

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

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Coding Features

Procedural Complications

Jennie Shephard, Department of Human Services

The Victorian ICD Coding Committee has received several queries relating to the coding of procedural complications. These queries reflect a general confusion regarding the application of ACS 1904 *Procedural Complications*.

The following information may help coders apply this standard.

Background

Procedural complication coding is a particularly complex area and can be very easily misinterpreted. Changes to Australian Coding Standard 1904 *Procedural Complications*, have come about in an attempt by the NCCH to make this data more meaningful and therefore of more value to those organisations that make decisions based on it (AIHW, National Injury Surveillance Unit and others).

‘Procedural complication’ coding uses codes in the range T80 – T88, and the postprocedural disorder codes in the various body system chapters.

The coding of procedural complications should reflect only conditions that are known to occur as a result of a surgical/procedural intervention, **which also meet one of the following criteria:**

- Condition is more severe than would normally be expected (for example persistent urinary retention)
- Condition that, while an accepted ‘risk’ of surgery, is not expected to occur (for example haemorrhage or wound infection)

Conditions that are known to occur in some patients following certain surgical/procedural interventions, and that follow the expected pathway for that condition, are not coded as procedural complications. For example, atrial fibrillation will occur in some patients following cardiac surgery, and fever is a common occurrence following general anaesthetic. These conditions will be coded in their own right, if they meet ACS 0002 Additional Diagnoses criteria, and will be prefixed with a ‘C’. Thus,

they are considered complications in the episode of care but are not considered procedural complications.

Analysis of procedural complication coding should provide an accurate record of the number of adverse events that occur to Australian patients as a result of surgery. It does not need to reflect *everything* that happens to patients in the postprocedural period.

The fact that a condition does not meet the criteria outlined for procedural complications does not preclude that condition from being coded in its own right.

Victorian data analysts use the Victorian Prefixes to help them interpret the data. Coders must therefore take care to assign the correct prefix to their codes:

- Conditions occurring for the first time in the postprocedural period that do not meet the criteria for procedural complication coding (ACS 1904), but do meet criteria for additional diagnosis coding (ACS 0002), must be prefixed with a 'C' (Complication).
- If the reason for admission is a postprocedural condition (from a previous episode), it will be prefixed with a 'P' (Primary).

Coding Pointers

1. First consider ACS 0002 *Additional Diagnoses*

All conditions that occur in the postoperative period are initially subject to the criteria in ACS 0002 *Additional Diagnoses*. Coders must follow these four steps:

First Step

Decide whether the condition meets criteria ACS 0002 *Additional Diagnoses*.

Example: Anaemia may be documented postoperatively. If the patient does not display symptoms of the anaemia, no treatment is instituted, and the patient is discharged, the anaemia would not be coded, as it does not meet ACS 0002 criteria.

Second step

If ACS 0002 criteria are met, then decide how this condition should be coded according to ACS 1904.

Third step

If the condition does *not* meet ACS 1904 criteria for procedural complication coding, then it will be coded as a non-procedural complication and will be prefixed with a 'C'.

Example: If anaemia is documented postoperatively and the condition is investigated further, or meets other ACS 0002 criteria, then it will be coded. If no other underlying cause of the anaemia has been identified, the code for postoperative anaemia (D62) is accessed by the following index lookup:

Anaemia
- due to
- - blood loss
- - - acute D62

Fourth step

If the condition *does* meet ACS 1904, then it will be coded as a procedural complication.

2. Conditions described as 'postoperative'

Conditions that are described as 'postoperative' are simply conditions that have occurred during the postoperative period of time. Whether these conditions are coded as procedural complications, will depend on whether or not they meet the criteria outlined in ACS 1904. This is reflected by the statement printed in bold type at the bottom of page 217, Volume 5, ICD-10-AM, 2nd edition:

'Postprocedural' only appears in the index when the condition to which it relates meets the definition of a procedural complication.

Thus the postprocedural index entry can only be used when the coder has already decided that the condition is a procedural complication.

Example: Documentation of a postoperative ileus. Neither the description 'postoperative', nor the existence of an index entry for 'ileus, postprocedural', allows automatic assignment of code K91.3 *Post procedural intestinal obstruction*. In the absence of documentation definitively linking the ileus to the surgery (for example 'postoperative ileus secondary to right hemi-colectomy'), this should be coded to K56.7 *Ileus, unspecified*.

3. Transient conditions that commonly occur as a result of surgical/procedural intervention

Short-lived or transient conditions that can commonly occur as a result of specific surgical/procedural interventions are not coded as procedural complications.

'Transient' is defined as being of less than seven days duration or not still present on discharge of the patient. See page 218, Volume 5, ICD-10-AM, 2nd edition:

Transient conditions should not be coded as postprocedural complications...unless they are present at discharge or persist postprocedurally for at least seven days.

Example: 'Fever' recorded for two days postoperatively in a four-day stay, and meeting ACS 0002 criteria, would be coded to R50.9 *Fever unspecified*. The coder would *not* follow the index entry, 'Fever, postprocedural' to T81.4 *Infection following a procedure, not elsewhere classified*.

4. Non-transient conditions that commonly occur as a result of surgical/procedural intervention

Conditions that commonly occur as a result of specific surgical/procedural intervention that continue beyond being 'transient' should be coded as procedural complications unless some other underlying cause has been identified.

Example: Fever continuing for a period of seven days or more following a procedure, with no cause identified and with the patient receiving monitoring and/or treatment for the fever, would no longer be considered 'transient' and would be coded to T81.4 *Infection following a procedure, not elsewhere classified*, as per the index entry, 'Fever, postprocedural'. Likewise a patient still suffering from atrial fibrillation seven days or more postprocedurally, and receiving treatment, would be considered to have a procedural complication rather than a transient condition and this would be coded as I97.8 *Other postprocedural disorder of circulatory system, not elsewhere classified*, and I48 *Atrial fibrillation and flutter*, with appropriate external cause codes.

Those patients being discharged on ongoing treatment for a postprocedural condition should be considered to have a procedural complication.

Example: A patient with postoperative atrial fibrillation discharged on Digoxin, or a patient with postprocedural urinary retention discharged with an indwelling catheter in-situ.

5. Difficulty in deciding if the condition is transient or not

If the coder has difficulty deciding if the condition is transient or not, the default position is to code as transient. See page 218, Volume 5, ICD-10-AM, 2nd edition:

If it cannot be determined whether a condition is transient or persistent, then the condition should not be coded as a procedural complication.

Example: A patient suffering from acute renal failure postoperatively is admitted to ICU for one day. The patient recovers completely and the rest of the postoperative period is uneventful. This condition is life threatening, the resources used to treat it are considerable, and coders may consider that it therefore warrants coding as a procedural complication. However, there is no documentation linking this condition definitively to the surgery and it is short-lived. This condition would be coded to N17.9 *Acute renal failure* only, defaulting to the 'transient' position.

6. Patient admitted for treatment of a condition that is documented as 'postoperative'

When a patient is admitted with a condition that is documented as 'postoperative', the coder must use ACS 0001 *Principal Diagnosis* and ACS 1904 to assist in the determination of the Principal Diagnosis.

The issue of re-admission for a 'postoperative condition' is not addressed in ACS 1904. Coders need to apply the criteria set out in the standard in the same way as they do for 'postoperative' conditions for patients during the surgical episode.

Example: Patient re-admitted with 'postoperative vomiting' three days after discharge. The re-admission date is five days after the surgery. This condition is occurring within seven days of surgery and therefore qualifies as a 'transient' condition. The principal diagnosis would therefore be R11 *Nausea and vomiting*.

7. Disease process currently active in the patient

Conditions occurring in the postoperative period that can be considered to be due to an active disease process in the patient should not be coded as procedural complications. This is embodied in the definition of procedural complication, printed in bold towards the top of page 217, Volume 5, ICD-10-AM, 2nd edition:

A condition or injury, which is related to surgical/procedural intervention, rather than being related to the patient's disease process.

Example: If the patient had an abnormal coagulation profile due to a disease such as haemophilia or leukaemia and had a postoperative haemorrhage, the haemorrhage would be considered to be due to the disease, unless documented otherwise, and would be coded to 'haemorrhage by site' or R58 *Haemorrhage not elsewhere classified*.

A number of queries received by Victorian ICD Coding Committee have specifically requested advice regarding coding of postoperative haemorrhage in a warfarinised patient.

Coding Matters, Volume 7, Number 2, advises that code Z92.1 *Personal history of long term (current) use of anticoagulants* should be used for patients who are warfarinised, if that fact is significant for the current episode. This implies that patients with a 'normal' warfarin level are not considered to have an 'abnormal coagulation profile due to disease'. This same article states that, if a patient is admitted for treatment of an abnormal coagulation profile such as overwarfarinisation, assign D68.3 *Haemorrhagic disorder due to circulating anticoagulants*. This implies that a patient who is overwarfarinised is considered to have an abnormal coagulation profile.

Therefore, a 'postoperative haemorrhage' in a 'normal level' warfarinised patient, would be considered to be a procedural complication and would be coded as T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified*, because this patient's haemorrhage would not be considered to be due to a disease process.

However, if the patient was described as being over-warfarinised, the haemorrhage would be considered to be due to an 'abnormal coagulation profile' and could not be coded as a procedural complication. The haemorrhage would be coded as an adverse effect of the warfarin: D68.3 *Haemorrhagic disorder due to circulating anticoagulants*, Y44.2 *Anticoagulants causing adverse effect in therapeutic use*, Y92.22 *Place of occurrence, health service area*. A code for the site of the haemorrhage, if known and if a code exists, would be included after D68.3.

The following table summarises the appropriate code assignment for postoperative haemorrhage in warfarinised patients:

Current Warfarin level	Documentation of postoperative haemorrhage	Long term anticoagulant use, meeting ACS 0002 criteria
Normal	Assign: 1. T81.0, 2. External cause code, 3. Y92.22	Assign: Z92.1
Overwarfarinised	Assign: 1. D68.3, 2. Site code for haemorrhage if available 3. Y44.2, 4. Y92.22	Assign: D68.3

8. Pre-existing conditions

A condition that pre-exists in a patient is never coded as a procedural complication. Therefore, a patient with a history of atrial fibrillation and who had atrial fibrillation documented following surgery, would not be considered to have a procedural complication. Likewise a patient suffering from urinary retention due to prostatic hypertrophy, who continues to suffer from retention postoperatively, even for seven days, would not be considered to have a procedural complication.

9. Revised version of ACS 1904

ACS 1904 as printed in ICD-10-AM, 2nd edition supersedes any prior advice regarding procedural and postoperative coding issued by the NCCCH and the Victorian ICD Coding Committee.

Example: Coding of postoperative clot retention following a transurethral resection of prostate (TURP). The July 1996 *Victorian ICD Coding Newsletter* advised that this scenario should be coded as T81.0 *Haemorrhage complicating a procedure*, N99.8 *Other postprocedural disorders of genitourinary system*, R33 *Retention of urine* [codes converted from ICD-9-CM codes]. However, ACS 1904 was revised in the second edition of ICD-10-AM, substantially changing the coding of procedural complications. Thus the advice offered in 1996 is no longer applicable and coders should not be applying it. Unless the condition persisted for seven days, or was present on discharge,

clot retention following TURP would therefore be coded as N32.8 *Other specified disorders of bladder* (look up 'Clot, bladder') and R33 *Retention of urine*.

Conclusion

This standard is likely to continue evolving over the next few editions of ICD-10-AM. Coders are therefore advised that the advice contained in this article is accurate at the time of printing but may be superseded by future updates to the standard or by advice offered in *Coding Matters* by the NCCH.

Open Injury into Joint

Andrea Groom, Coding Educator, Southern Health

It is difficult to find a code in the Alphabetic Index for an open injury that penetrates into a joint. Clearly and obviously, the code must describe more than an 'open wound', but which codes to use?

The appropriate code for open injury of joint is a 'sprain and strain' code. Sounds funny doesn't it?! However, if you examine the Tabular List on page 375, 'laceration' is included as an injury type for 'dislocation, sprain and strain of joint capsule'. So, to find the appropriate code in the index, it is necessary to reference 'Sprain, by site'.

A code for an open wound of the site is also required to show that the joint injury was 'open', as is done when coding an open fracture.

An open injury of a joint may require lavage or washout.

Example 22 year old motorcyclist collided with a car, sustaining open wounds of his knee and wrist. On examination, a 5 cm jagged laceration was overlying the patellar region. There was also a deep wound on the ulnar side of the wrist, which exposed the bones of the wrist. Examination under anaesthesia of the knee laceration showed a connection to the knee joint. An arthrotomy and pulse lavage/washout of the knee joint was performed. Also at operation, the wound on the wrist was explored. The joint capsule had been torn and was noted as 'wrist wound extending into joint'. The wrist was treated with arthrotomy, pulse lavage/washout, debridement and closure of the joint.

Assign the following codes:

S83.6	<i>Sprain and strain of other and unspecified parts of knee</i>
S81.0	<i>Open wound of knee</i>
S63.50	<i>Sprain and strain of wrist, part unspecified</i>
S61.88	<i>Open wound of other parts of wrist and hand</i>
V23.4	<i>Motorcycle rider injured in collision with car, pick-up truck or van, driver injured in traffic accident</i>
Y92.4	<i>Place of occurrence, street and highway</i>
Y93.8	<i>Activity – other specified</i>
49500-03 [1496]	<i>Lavage of knee</i>
90574-01 [1561]	<i>Excision of joint, not elsewhere classified (debridement of wrist)</i>
92502-02 [1910]	<i>Intravenous and inhalational general anaesthesia</i>

Summary

Where there is an open wound communicating with an injury of the joint capsule, the following codes should be assigned and sequenced in this order:

1. A code for the sprain of the particular joint involved
2. A code for open wound of the anatomical site

It is suggested that you pencil an entry into your Alphabetic Index for:

Wound, open, communicating with a joint – see Sprain, by site

Casemix education tool – DRG Bell Curve diagrams

Catherine Perry, Manager, Health Information Services,
Goulburn Valley Health

At the weekly HIM meeting, one of the standing items is coding, which consists of discussion of outstanding coding figures. Once a month we also invite our Clinical Coder and discuss coding audits completed in the month, any coding queries, and an education session, provided by a clinician or an HIM. The DRG bell curves were developed for one of these education sessions, to ensure everyone was comfortable with the general terminology and concepts related to DRGs and were able to accurately calculate the DRG weight for any acute episode from the Victorian Cost Weight Tables. When developing the bell curves, we also knew we wanted to be able to adapt them for other educational purposes. Through feedback from the HIMs and others, such as Nurse Unit Managers, it became clear that different groups of people would require different levels of information. Even though some people need to understand the most complex diagrams, it was easier to start by presenting the more basic diagrams and finish by explaining the most complex one.

The four diagrams are entitled:

- DRG Basic Components
- DRG Basic Components with Definitions
- Calculating DRG Weight for a particular Episode
- Calculating DRG weight for example DRG I04A: *Knee Replacement and Reattachment with Catastrophic complication and/or co-morbidity*

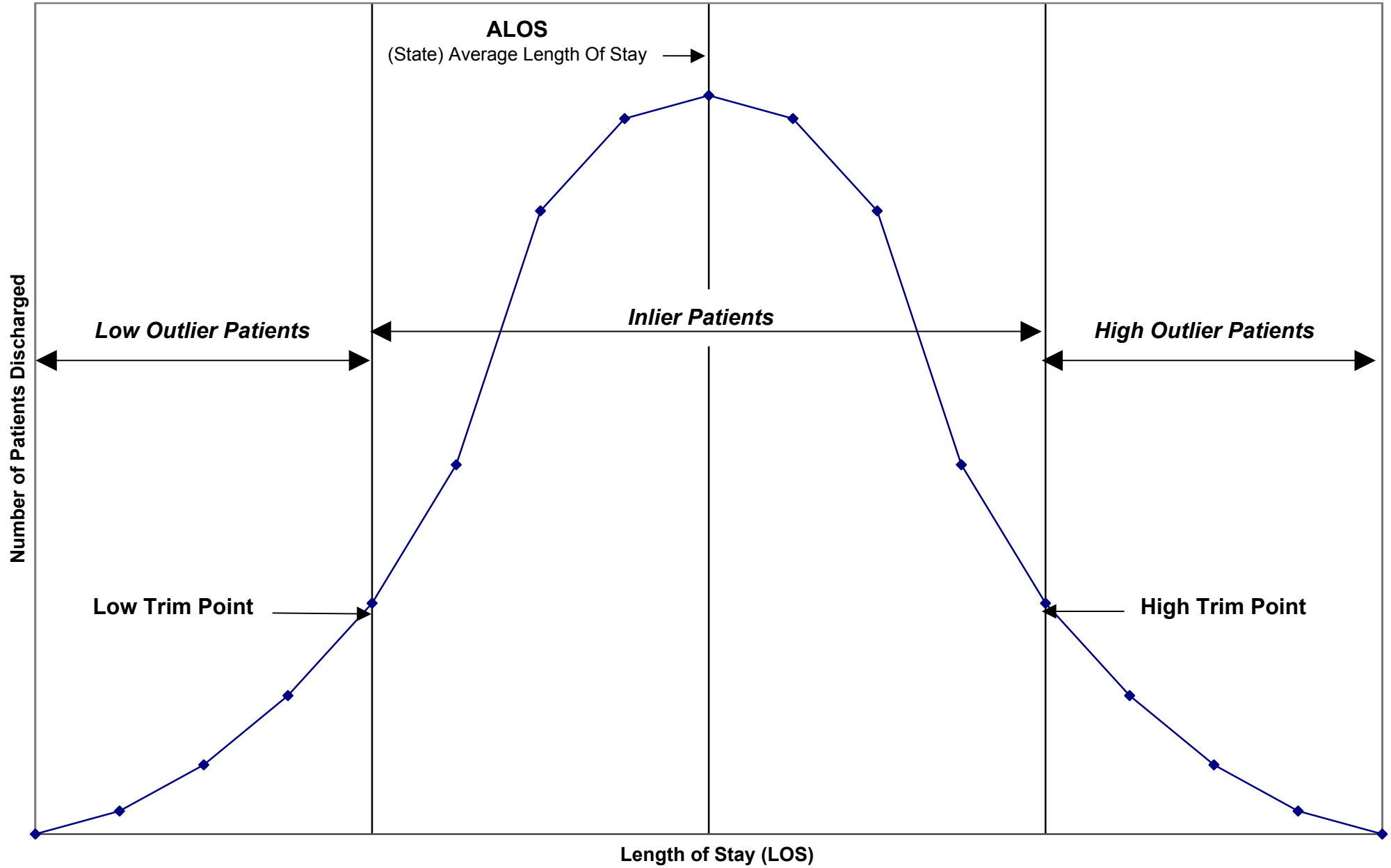
When reviewing the third diagram, bear in mind that not all DRGs have a meaningful low boundary point (for low outlier patients): check the Cost Weights table in the *Policy and Funding Guidelines* for the relevant year for (as each applies) the Same Day Weight and the One Day Weight.

Since their development, we have used the diagrams for a range of purposes, including:

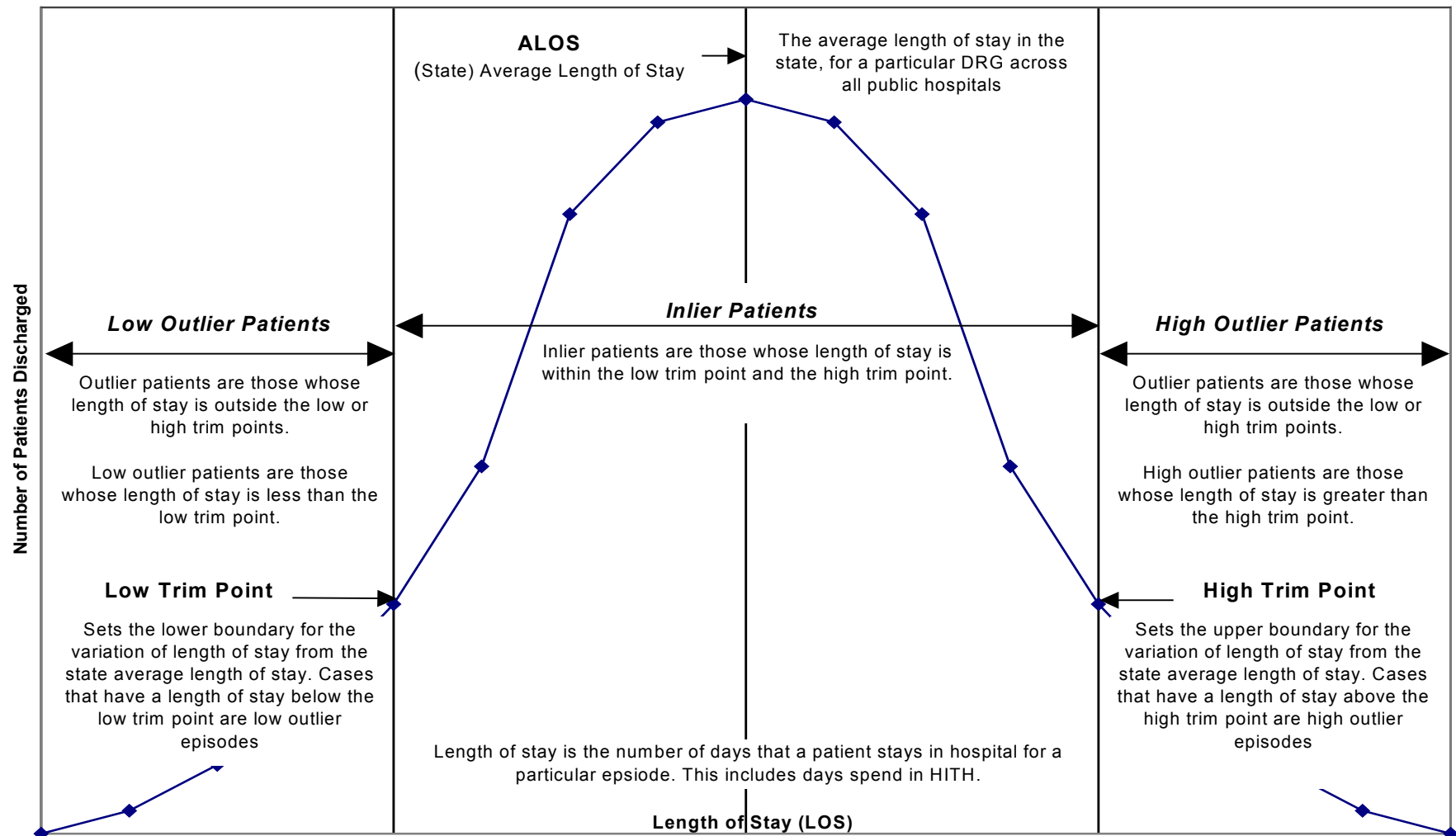
- Nursing Unit Manager (NUM) education
- Nursing Refresher Course Sessions
- Nursing Graduate Lectures
- Staff Information sessions at smaller regional hospitals (with attendance by personnel ranging from kitchen staff to doctors)
- Provision to other HIMs in the region for their own use
- Provision to La Trobe University (who are always grateful for teaching materials)

During our most recent DHS audit, the auditor felt that other HIMs and Clinical Coders could use these diagrams and perhaps add information specific to their own hospital. We are happy to share this information and if you would like an electronic copy, please email me on perryc@gvbh.org.au and I would be happy to send it to you.

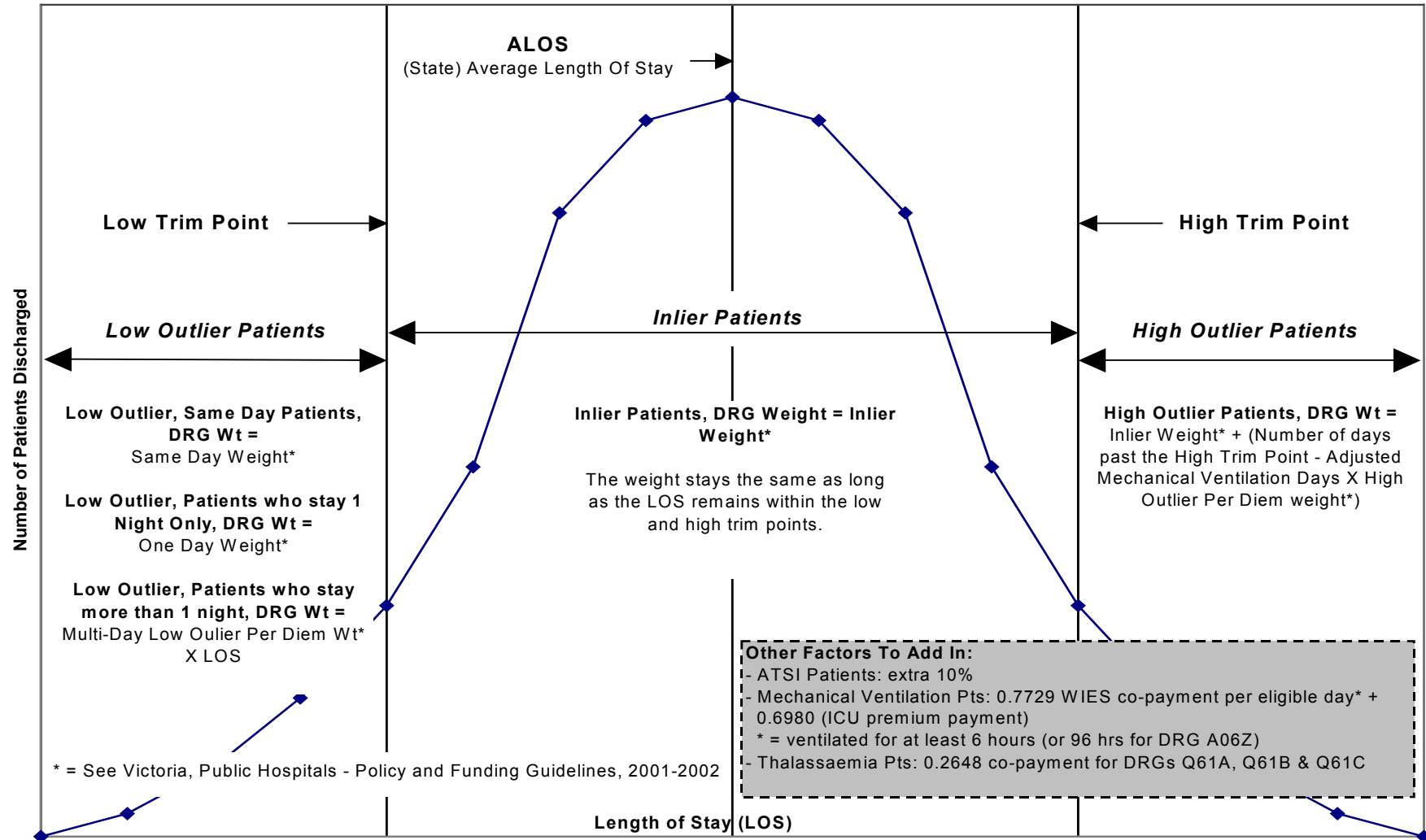
DRG Basic Components



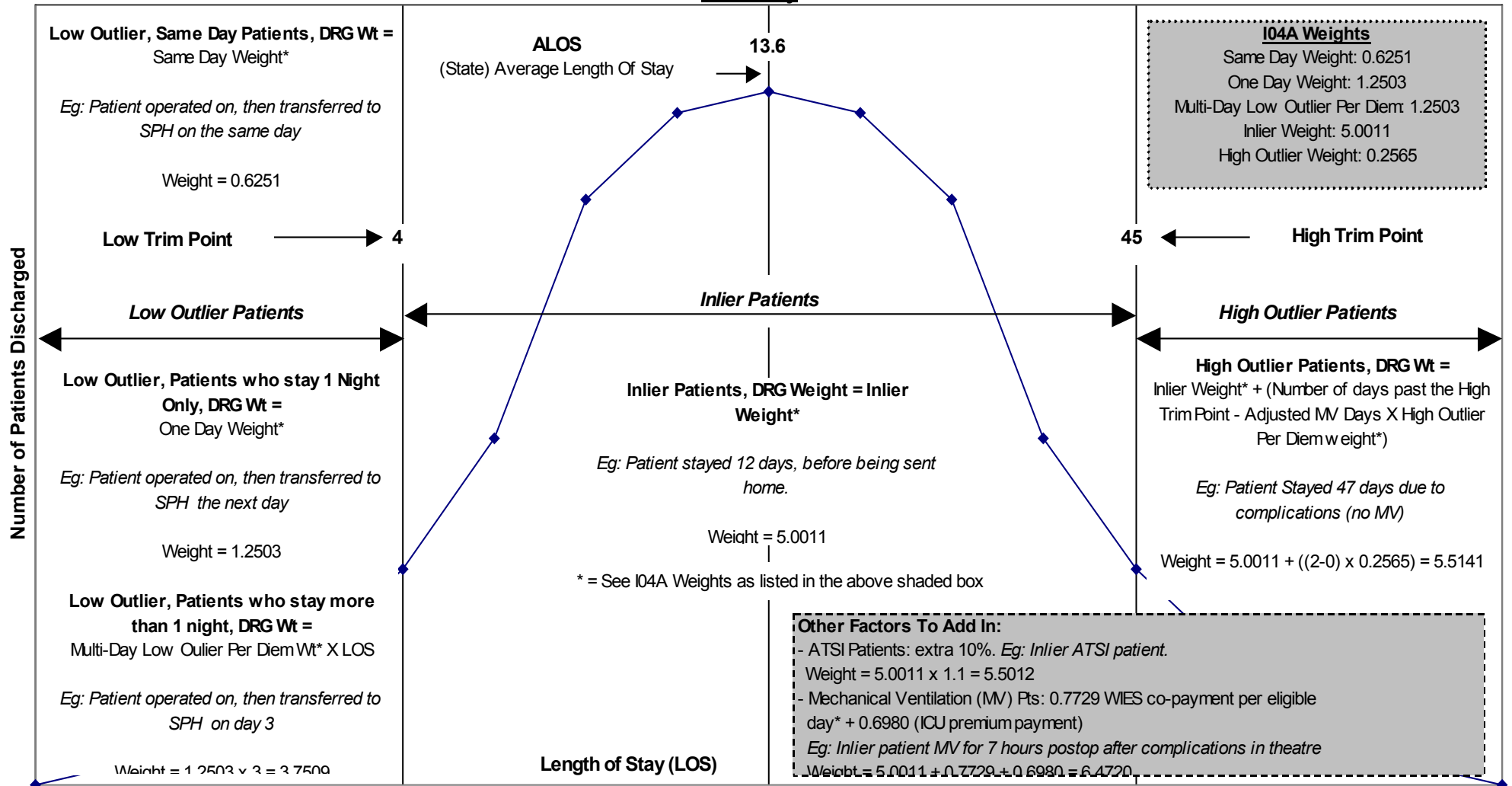
DRG Basic Components With Definitions



Calculating DRG Weight For A Particular Episode



Calculating DRG Weight For I04A: Knee Replacement And Reattachment With Catastrophic Complication And/Or Comorbidity



List of Selected ICD-10-AM Coding Queries

The ICD Coding Committee is an advisory body to Victorian clinical coders and the Department of Human Services. The Committee does not have the authority to establish coding standards but offers advice, based on the combined knowledge and experience of the members and/or the NCCH, in response to individual coding queries. The Committee's advice printed in this section of the newsletter can be adopted immediately unless an introduction date is stated. The implementation of this guidance is advisable as it sets a precedent for good coding practice. Unless otherwise stated, there is no expectation that coders should go back to similar episodes already coded differently and change the coding. It is acknowledged that this might result in a year's data containing episodes coded in a non-standard way.

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Amended/Expanded Advice

Some amendments and explanations are necessary to previous *ICD Coding Newsletters*. Where necessary, please annotate previous copies or paste these answers over previous answers.

This query (raising questions on an NCCH answer to a query on the NCCH database) was published in the February 2000 *ICD Coding Newsletter*, page 16. However, NCCH later amended the advice on their database.

#1468 *ACS 0234 Contiguous sites and ACS 0237 Recurrence of primary malignancy (NCCH query 884)*

Patient had cancer of the sigmoid and it was resected a number of years ago. Now presents with recurrence – rectal. I am concerned that NCCH response # 884 contradicts *ACS 0234 Contiguous Sites* and *ACS 0237 Recurrence of primary malignancy*. To me, recurrence is the same neoplasm that has come back, and in this case to a contiguous site.

NCCH's initial and amended responses:

26/03/99 Initial response: In this case, the stated site is rectum, therefore C20 *Malignant neoplasm of rectum* should be assigned. The NCCH acknowledges the difficulties in accurately reflecting recurrence versus a new primary.

03/11/00 Subsequent response: It is the role of the clinician to determine whether a cancer is recurrent or a new primary. The term 'recurrence' does not mean a new primary, it may refer to metastases or local invasion. If a tumour is documented as a recurrence it should be coded back to the original primary site (unless a new/different primary site is documented). Therefore, in the case cited please assign C18.7 *Malignant neoplasm of sigmoid colon*.

The Committee agreed that the crucial elements of this question are that the term 'recurrence' is misleading and the clinician's advice should be sought.

This query (summarised below) was published in the August 2001 *ICD Coding Newsletter*, page 18. However, the following advice from NCCH supersedes the previous answer.

#1690 **Autogenous bone marrow and OP-1 putty**

Please advise how to code this procedure, which I believe may be a new procedure:
Autogenous bone marrow and OP-1 putty.

NCCH response #1446:

Transplantation is defined as 'the transfer of living organs or tissue from one part of the body to another or from one individual to another...transplantation and grafting mean the same thing...' (Miller and Keane 1997). OP-1 is a type of osteogenic protein, which induces bone formation.

ICD-10-AM procedure codes describe the procedure performed and do not always have breakdowns according to the extent, size, number etc. involved.

In the case cited, assuming that the procedure was performed on the femur, assign both:

48200-00 [1488] *Bone graft to femur*

13700-00 [801] *Procurement of bone marrow for transplantation*

This query (summarised below) was published in the August 2001 *ICD Coding Newsletter*, page 18. However, the following advice from the NCCH (with Coding Committee comment) supersedes that answer.

#1725 Infective exacerbation of asthma

2nd edition of ICD-9-CM contained a direct index entry for Asthma – infective, which lead to 493.1- *Intrinsic asthma*. However, there is no such index entry in ICD-10-AM nor any ACS that directs coders how to code intrinsic asthma.

We also note a previous Victorian coding Query #1208 *Asthma, infective exacerbation*.

17/07/01 NCCH query #1454:

In answering [earlier] query #1261 *Exacerbation of asthma – infective*, the NCCH sought expert clinical advice from a member of the respiratory CCCG. In summary, there is no such clinical condition as ‘infective asthma’. In the past (ie, at the time of ICD-9-CM), infection was thought to be important in intrinsic asthma, which is also called ‘late-onset asthma’. However, the link with internal infection was disproved and is now an out of date concept.

Therefore, where asthma has been exacerbated by an upper respiratory tract infection, the codes assigned are J45.9 *Asthma, unspecified* and J06.9 *Acute upper respiratory infection, unspecified*.

The Committee also sought advice from several clinicians and received conflicting responses about the concept of infective exacerbation of asthma. As ‘infective’ asthma is not indexed in ICD-10-AM, the Committee agreed with NCCH’s advice to assign J45.9, with an additional code of J06.9 where URTI is documented.

This query was published in the August 2001 ICD Coding Newsletter, page 28. A subsequent query (#1761) raised a point of clarification, which has been included in the revised response.

#1715 Associated diagnosis – Atrial Fibrillation (regarding Change of standard treatment protocol)

81 year old male is admitted with anaemia for investigation. The patient has a past history of atrial fibrillation. Before the patient was transfused with 3 units of packed cells, his Warfarin was ceased. Is it justified to code atrial fibrillation as an associated condition in this case due to the patient's medication being altered?

Similarly, we have been advised not to code atrial fibrillation when a patient is admitted solely for stabilisation of their INR levels, as the atrial fibrillation is not being specifically treated. Should this reasoning be applied to the first mentioned case?

When a patient is admitted solely for stabilisation of their INR levels, use code:

D68.3 *Haemorrhagic disorder due to circulating anticoagulants*

The patient's problem with warfarinisation is their reason for admission. The atrial fibrillation was not treated at this episode and therefore is not coded. You cannot use Z92.1 *Personal history of long-term (current) use of anticoagulants* as a principal diagnosis (see *Coding Matters* volume 7, number 2, September 2000, page 15).

The coding of cases like the anaemia patient is more complex. Under ACS 0002 *Additional diagnoses*, a condition can be coded if there is a change in treatment during the episode. However, the change in this patient's treatment (ceasing Warfarin) was not because the patient had atrial fibrillation: the change in treatment was necessary because this patient was warfarinised and needed to cease being warfarinised before being transfused for their anaemia.

Therefore, the Committee advised the correct codes for the anaemia patient are:

D64.9 *Anaemia*

Z92.1 *Personal history of long-term (current) use of anticoagulants*

13706-02 [1893] *Transfusion of packed cells*

The Committee felt it important to clarify the distinction between:

- The need to change the standard treatment protocol for a condition because a particular patient has an *additional* condition - it is the additional condition that necessitates the change and the code for the additional condition would be added.

Examples:

1. A patient has a spinal anaesthetic rather than a general anaesthetic because he suffers from COAD – assign a code for the COAD.
 2. A patient may have a general anaesthetic rather than a local anaesthetic because he suffers from severe anxiety – assign a code for the anxiety.
- The need to change the normal treatment for one condition because a particular patient is to have medical/surgical treatment for a second condition.

Examples:

1. A patient may be admitted earlier than normal for ceasing of Warfarin before undergoing surgery for a hip replacement – assign a code for warfarinisation (do not assign a code for the underlying condition such as atrial fibrillation).
2. A patient may be admitted for laparoscopy rather than have an MRI for investigation of abdominal mass because he has a cardiac pacemaker (and cannot have an MRI) – assign a code for the presence of pacemaker (do not assign a code for the underlying condition such as complete heart block).

Coders must refer to ACS 0002, 'If a co-morbid condition changes the treatment protocol for a particular procedure, then that condition should be coded as an additional diagnosis', and take care to correctly identify the 'co-morbid condition' that is having an impact on the current treatment of the patient. Is it the atrial fibrillation or the warfarinisation? Is it the complete heart block or the presence of pacemaker? Is it the amputee status of the patient or the peripheral vascular disease?

Coders must also be guided by documentation in the record and where this is inadequate, the coder has a responsibility to consult with the appropriate clinician.

Diabetic Coding Queries

#1630 Diabetes with past history of osteoarthritis

In coding patients with diabetes and past history of osteoarthritis (OA), should this be:

E11.61 *Type II diabetes mellitus with diabetic musculoskeletal and connective tissue complication?*

Or does a patient have to be described as having an 'arthropathy' before this is coded?

NCCH response #1450:

Diabetes with a history of osteoarthritis should not be coded to 'E1x.61 *Type _ diabetes mellitus with musculoskeletal and connective tissue complication*'. This code will be altered in ICD-10-AM 3rd edition to indicate that only specific conditions should be classified there. These specific conditions will be indexed.

This information was published in *Coding Matters*, September 2001, Volume 8, Number 2, page 10.

Victorian additional note: If a diabetic patient has osteoarthritis (OA) and the OA meets the criteria for coding based on ACS 0002, it would be coded separately.

#1635 Diabetic bone changes

What is meant by the Index entry:

Diabetes, diabetic

- *with*

- - *bone change* **E1-.61**

Does this include a patient with osteoporosis, osteopenia, etc, with diabetes?

NCCH response #1408:

Due to confusion arising from this particular index entry, this will be deleted in ICD-10-AM 3rd edition. Only specific conditions that are indexed should be classified to:

E1-.61 *Diabetes mellitus with diabetic musculoskeletal and connective tissue complication*

The Committee suggests that you cross through this entry in the Alphabetic Index immediately.

#1639 Diabetic patient with chronic renal impairment

If a diabetic patient has chronic renal impairment, the correct code can be found only if you look up - Impairment, renal, chronic, with diabetes. Is it an error that it is not indexed under the Diabetes with... lookup?

Also if a diabetic patient is just documented to have renal impairment which is not qualified, should we code:

N18.91 *Chronic renal impairment*

Or

E1-.23 *Type _ diabetes mellitus with end-stage renal disease [ESRD]*

I have checked the NCCH query database and not found anything.

NCCH response #1411:

An index entry under 'Diabetes, with' for chronic renal impairment will appear in ICD-10-AM 3rd edition. If 'renal impairment' associated with diabetes is documented without further qualification, assign:

E1-.23 *Type _ diabetes mellitus with end-stage renal disease [ESRD]*

N18.91 *Chronic renal impairment*

N18.91 *Chronic renal impairment* is required as an additional code, because the title of E1-.23 *Type _ diabetes mellitus with end-stage renal disease [ESRD]* does not fully describe the patient's clinical condition.

#1653 Proteinaemia with diabetes

The Index contains an entry but without a code:

Proteinaemia

- with diabetes

Under Diabetes, only proteinuria is listed, not proteinaemia. Is there meant to be a code

for 'proteinaemia with diabetes'?

NCCH response #1414:

Please note that 'with diabetes' under the lead term 'Proteinaemia' was listed as a deletion in Errata 3.

Diabetes with proteinaemia does not have a specific code in ICD-10-AM. Complications of diabetes not listed under the main term 'Diabetes' in the index do not require a 'diabetes with' code unless:

- a) the condition is indexed to one of those codes; or
- b) where there is a documented association between diabetes and a condition classifiable to one of the 'other' or 'unspecified' categories.

As neither of these criterion apply in the case cited, please assign the following additional code, with the relevant code for the diabetes:

R77.9 *Abnormality of plasma protein, unspecified*

#1657 Acute renal impairment in a diabetic patient

For chronic renal impairment in a diabetic patient, the Index leads to

E11.23 *Type 2 diabetes mellitus with end-stage renal disease [ESRD]*

Can we assume then that acute renal impairment in a diabetic patient can be assigned the single code:

E11.23 *Type 2 diabetes mellitus with end-stage renal disease [ESRD]*

or would we also assign:

N18.91 *Chronic renal impairment*

NCCH response #1417:

Clinical conditions associated with rapid (days to weeks), steadily decreasing renal function are termed 'acute renal failure' (ARF). The term 'acute renal impairment' (ARI) refers to the mildest form of acute renal failure. Therefore, acute renal impairment NOS associated with type 2 diabetes should be assigned:

E1-.29 *Diabetes with other specified renal complication*

N17.9

Acute renal failure, unspecified

Coders should follow the index look-up:

Failure

- renal

- - acute N17.9

#1721 Diabetic foot

During the coding session of a HIMAA – Victorian branch Education seminar, it was noted that **E1-.71** *Diabetes with multiple microvascular complications* is listed as a condition that can form part of ‘diabetic foot’.

Refer to ACS 0401 *Diabetes mellitus*

- Peripheral vascular disease and diabetes (page 88)

- - Diabetic foot

- - - Peripheral neuropathy

- - - - Diabetes with multiple microvascular complications E1-.71

Seminar participants and presenter did not feel the multiple microvascular complications code belonged under the section of peripheral neuropathy, as the patient doesn’t necessarily have peripheral neuropathy in order to assign a multiple microvascular code.

NCCH response #1452:

[In ACS 0401, page 88] E1-.71 is included in category 3 under diabetic foot because patients with multiple microvascular complications may have neuropathy as part of that complex. Therefore, if the patient has a condition listed under category 1 in diabetic foot and multiple microvascular complications, which includes neuropathy (E1-.4-), then E1-.73 would be assigned. In ICD-10-AM 3rd edition, an additional note will be included under the neuropathy category to clarify this point.

This information was published in *Coding Matters*, September 2001, Volume 8, Number 2, page 10.

#1743 **Diabetic complications**

When coding patients with diabetes, should we code all documented complications that exist with, or due to, the diabetes, or do we apply ACS 0002 and code only conditions that were treated, monitored or required diagnostic procedures?

For example, a patient admitted for a hernia repair, but also suffers from NIDDM, retinopathy and Peripheral Vascular Disease (PVD). Do we code the diabetes to a without complication code (E11.9), as the retinopathy and PVD do not meet ACS 0002? Or do we code out the diabetic retinopathy and PVD (E11.31 and E11.51)?

The NCCCH 2000 Education Workshop Handbook, with answers, indicated specific diabetic complications should be coded out.

Yes, all diabetic complications should be coded out in each episode. Refer also to HDSS Bulletin 13, 19 July 2000 and the Diabetes Quiz provided in the November 2000 *ICD Coding Newsletter*.

#1747 **Diabetes in pregnancy (gestational and pre-existing)**

When a patient is admitted with gestational diabetes, we currently assign only:

O24.4- (or .9) *Diabetes mellitus arising in pregnancy*

If a patient is admitted with pre-existing diabetes during her pregnancy, do we code both to reflect that the patient has pre-existing diabetes (or is this over-coding?):

O24.- *Diabetes mellitus in pregnancy*

E1-.- *Diabetes*

In reference to the Standards, a clear statement is not provided. However, in the tabular list, O24.- is within an exclusion note under both E10.- and E11.-.

For O24.0 to 24.3 *Pre-existing diabetes mellitus in pregnancy*, a diabetic E chapter code would be assigned as an extra code only if a patient had a complication of their diabetes. The E1-.- would then be providing further information to explain the clinical statement.

As gestational diabetes is not Type I or II, assign one of the following codes alone, without any further diabetic code:

O24.41 *Diabetes mellitus arising in pregnancy, non-insulin-requiring*

O24.42 *Diabetes mellitus arising in pregnancy, insulin-requiring*

Only if it were not known whether the diabetes was gestational or pre-existing would you assign:

O24.9 *Diabetes mellitus in pregnancy, unspecified*

#1752 Use of multiple Diabetes codes

If a NIDDM patient has a complication such as peripheral vascular disease and also has hypertension or obesity, do we add I10 *Hypertension* or E66.9 *Obesity, unspecified* to:

E11.9 *Type 2 diabetes mellitus with unspecified complication*

Or do we just add the I10 or E66.9 after a complicated diabetes code such as:

E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*

Coders should simply add the relevant I10 or E66.9 below the E11.51 (or other complicated diabetes code). E11.9 must not be used with any other diabetic code.

#1753 Acute on chronic renal failure in diabetic patient

Patient admitted with acute on chronic renal failure and diabetes (type 2).

Not sure how to code this or how to sequence codes.

Here are two of our suggestions. Are either correct?

E11.29 *Type 2 diabetes mellitus with other specified renal complication*

N17.9 *Acute renal failure, unspecified*

E11.23 *Type 2 diabetes mellitus with end-stage renal disease [ESRD]*

N18.90 *Unspecified chronic renal failure*

Or

E11.23 *Type 2 diabetes mellitus with end-stage renal disease [ESRD]*

N17.9 *Acute renal failure, unspecified*

N18.90 *Unspecified chronic renal failure*

The first string of codes suggested by the enquirer is correct:

E11.29 *Type 2 diabetes mellitus with other specified renal complication*

N17.9 *Acute renal failure, unspecified*

E11.23 *Type 2 diabetes mellitus with end-stage renal disease [ESRD]*

N18.90 *Unspecified chronic renal failure*

Assuming that there is no separate specific cause of the patient's acute renal failure, in the above scenario, coders following the disease index would assign these two pairs of codes.

Other (non-diabetes) Coding Queries

#1631 Paraurethral cyst

Female patient, age 45, overnight stay.

Diagnosis - Paraurethral cyst. Following the direct index entry - Cyst, paraurethral.

We coded:

N36.8 *Other specified disorders of urethra*

Procedure as identified through a direct index entry - Excision, cyst, paraurethral:

35557-00 [1282] *Excision of lesion of vagina*

92502-02 [1910] *Intravenous and inhalational general anaesthesia.*

The above codes appear to be correct. However, the codes are grouping to:

902Z *Non-extensive OR procedure unrelated to Principal Diagnosis*

Is this a grouping anomaly or a mapping problem?

Based on the information provided, the Committee agreed with the code assignment, but noted that the diagnosis code is assigned to MDC 11 *Diseases and disorders of the kidney and urinary tract* and the procedure code is not recognised in this MDC.

The Australian Refined Diagnosis Related Groups Version 4.1 Definitions Manual (volume 1, page 11) provides clarification of DRG assignment for 'clinically atypical' cases:

'Hospital records that contain clinically atypical or invalid information are assigned to one of seven Error DRGs in AR-DRG v4.1.'

In the above case, the resulting DRG does not represent an 'error', but should be reviewed for accuracy.

NCCH response #1410:

The paraurethral glands are located where the female urethra opens into the vestibule of the vulva. DRG 902Z *Non-extensive OR procedure unrelated to Principal Diagnosis* is allocated due to the difference in the anatomic site to which paraurethral cysts are classified in the ICD-10-AM disease (urethra) and procedure (vagina) classification. This grouping anomaly will be referred to the Commonwealth Department of Health and Aged Care.

#1703 **Infected IV site: T80.2 or T82.7**

Can you explain the difference between these codes:

T80.2 *Infections following infusion, transfusion and therapeutic injection*

T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts?*

If a patient has an infected IV site, we have been using T82.7 with:

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.*

But perhaps we should be using T80.2?

Also, if using T82.7, it seems as if it should be accompanied by:

Y83.1 *Surgical operation with implant of artificial internal device as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.*

With T80.2, it would seem to need Y84.8. However, Y84.8 seems a better choice for infusion of IV agents. Can you please comment?

NCCH response #1433:

Infections related to intravenous access may be described as localized or systemic. Localised infections will be indicated by erythema, oedema, purulent discharge, pain and possibly pyrexia. Systemic infections associated with intravenous access devices may be difficult to recognize, the patient may only present with low grade pyrexia and an elevated white cell count. Generally, localized infections are associated with the access device (ie insertion of the catheter) rather than the procedure of infusion, transfusion or injection.

The indexing under 'Infection, due to' provides guidance in this area. 'Infection, due to, infusion...' leads to T80.2 *Infections following infusion, transfusion and therapeutic injection*', whereas 'Infection, due to, device, catheter, infusion' leads to T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts*'. The insertion of an intravenous access device is not usually a surgical operation, therefore the correct external cause code in the case cited is Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or later complication, without misadventure at the time of the procedure*.

This information was published in *Coding Matters*, September 2001, Volume 8, Number 2, page 9.

#1722 **Unsuccessful angioplasty**

If a patient is undergoing a coronary angioplasty and it is unsuccessful, in that they are unable to cross the lesion with a guidewire, how are we to code this?

On advice from one of our cardiologists we have been coding the angioplasty, as it is a lot more involved than just a coronary angiogram. However, they have not actually finished the angioplasty.

There is a significant difference in DRG assignment; however, we also need some way of pulling out such cases for clinical research, statistics on the number of unsuccessful angioplasties.

The Committee noted that ACS 0019 *Procedure not completed or interrupted* states:

'If a surgical procedure was interrupted or not completed for any reason, code to the extent of the procedure performed.'

Unless the balloon catheter is used and inflated across the lesion, only an angiogram has been performed. If this **does** occur, then an angioplasty can be coded, even if the procedure is not successful. The cardiologist will always do at least one shot of the coronary artery to be treated with angioplasty, so a coronary angiography can be coded alone, even if they don't complete the angioplasty.

This advice would appear to be consistent with a response from the NCCH in query #1313 *Insertion of stent - ureter*, which advised that only the cystoscopy could be coded, when there was an unsuccessful ureteral stent insertion.

Therefore, in the current query, only a code for the angiogram should be assigned.

#1728 Postpartum cervical repair

35yr old female patient with lacerated cervix and cervical suture insitu, readmitted 13 days after preterm delivery (at 22.4 weeks) for removal of cervical suture and repair of cervix (laceration sustained during delivery in previous episode of care).

Our codes:

O71.3	<i>Obstetric laceration of cervix</i>
Z39.01	<i>Postpartum care after hospital delivery</i>
16571-00 [1344]	<i>Suture of current obstetric laceration of cervix</i>
16512-00 [1274]	<i>Removal of cervical suture</i>
92502-02 [1910]	<i>Intravenous and inhalational general anaesthesia</i>

These group to:

O02Z *Vaginal delivery with complicating O.R. procedure*

Is this a grouping anomaly or a mapping problem? The case should group to:

O04Z *Post partum and post abortion diagnosis with O.R. procedure*

The Z codes indicating delivery/postpartum cases do not always drive DRG assignment in Version 4.1 or 4.2 although Version 5 may have these Z codes driving assignment to ante/postpartum DRG. Codes currently group according to where the diagnosis code is 'most likely' to occur, ie, antenatally, during delivery or postnatally.

In this case, the Committee considered another principal diagnosis would be appropriate, the complete coding being:

O34.3	<i>Maternal care for cervical incompetence</i>
O71.3	<i>Obstetric laceration of cervix</i>
Z39.01	<i>Postpartum care after hospital delivery</i>
16512-00 [1274]	<i>Removal of cervical suture</i>
16571-00 [1344]	<i>Suture of current obstetric laceration of cervix</i>
92502-02 [1910]	<i>Intravenous and inhalational general anaesthesia</i>

This results in the following DRG (v 4.1), which the Committee considered appropriate:

#1730 Postoperative anaemia

In the *Victorian ICD Coding Newsletter* of January 1996, query # 1110 *Low Haemoglobin Levels and Post Operative Anaemia*, stated that postoperative anaemia could be assigned the code for acute posthaemorrhagic anaemia:

285.1 (9CM) *Acute posthaemorrhagic anaemia*

D62 (10AM) *Acute posthaemorrhagic anaemia*

Does this advice still apply given the changes to coding of procedural complications (ACS 1904)?

The answer to query #1110 is still valid.

'...*Acute posthaemorrhagic anaemia* can only be allocated if postoperative anaemia is documented by the clinician....'

Therefore, assign code:

D62 *Acute posthaemorrhagic anaemia*

No additional code for haemorrhage is assigned, as haemorrhage/blood loss can be expected in some cases. No external cause code is to be assigned to 'link' D62 to the procedure, as the anaemia is not a true procedural complication.

#1735 Arrows/plus signs/question marks as adequate documentation

What is the rule regarding coding of conditions documented with arrows or plus signs?

Some examples:

- 1 Nursing staff/Doctor documents ↓K in progress notes, patient is put on Slow K. Biochemistry results indicate hypopotassaemia.
- 2 Nursing staff/Doctor documents ↓K in progress notes, patient is put on Slow K. No biochemistry results available.
- 3 Nursing staff/Doctor documents ↓K in progress notes. Biochemistry results indicate hypopotassaemia

- | | |
|---|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4 | Nursing staff/Doctor documents patient's haemoglobin level – no arrows used. Blood transfusion is given. Haematology results support anaemia. |
| 5 | Nursing staff/Doctor documents patient's haemoglobin level – no arrows used. Blood transfusion is given. No haematology results available. |
| 6 | Nursing staff/Doctor documents patient's haemoglobin level – no arrows used. Haematology results support anaemia. No transfusion given. |
| 7 | Nursing staff document pain on urinating, offensive urine, frequent small amounts passed. Doctor orders MSU test. Result in record indicates urinary tract infection (UTI). Antibiotics ordered that correlate with sensitivities. UTI not documented in record by doctor or nursing staff. |

Clinical documentation does not necessarily have to be provided by a doctor. Please refer to the Coding Feature, 'Coding of Clinical Information Recorded by Clinicians other than Medical Officers' published in August 2000 *ICD Coding Newsletter*, page 50.

As with abbreviations, symbols may be interpreted as words, as long as the meaning/context is clear.

Coders should keep in mind the following Australian Coding Standards:

0002 *Additional diagnoses*

0010 *General Abstraction Guidelines*
 - *Abnormal findings*

0012 *Suspected conditions*

In the Scenarios, the answers to whether the condition would be coded are:

1. Yes. ↓K means hypotassaemia and according to the scenario, treatment was initiated.
2. Yes. ↓K means hypotassaemia and according to the scenario, treatment was initiated.
3. No, because no treatment was initiated.
4. No. Anaemia or low Hb must be documented to enable coding of the condition, so this would need to be clarified with the clinician. The transfusion procedure should be coded regardless of whether anaemia is coded or not (*ACS 0302 Blood Transfusions*).
5. No. Coders would need better documentation.
6. No. Coders would need better documentation.

7. No. Coders would need better documentation. UTI must be documented.

#1738 Acute renal impairment

Do you code acute renal impairment (ARI) to acute renal failure?

We currently code it (as directed by the index) to:

N18.91 *Chronic renal impairment*

I understand the Victorian Coding Committee has discussed this issue but I am unable to find any documentation of this. I am also aware of the NCCH query #931 Acute renal impairment:

Question: Acute renal impairment (due to drugs or illness). Does this go to acute renal failure or some other code?

NCCH Response: In the case cited, please assign a code from category 'N17 Acute renal failure', as appropriate.

I am reluctant to change the way we are coding ARI based on this comment alone. I have discussed this issue with other clinical coders at other hospitals and there appears to be two definite groups - those coding it to N17.9 and those coding it to N18.91.

Acute renal impairment (ARI) is the mildest form of acute renal failure (ARF). Therefore it is acceptable to code it as:

N17.x *Acute renal failure*

Refer to *Coding Matters*, June 2001, Volume 8, Number 1, pages 16-17, and the NCCH's Nephrology and Urology specialty booklet, for further clinical advice about acute renal impairment.

#1741 Hypertension with unstable angina

Patient admitted with unstable angina, continued to take usual dose of antihypertensives (ie, hypertension not further assessed or investigated).

In the tabular list, Ischaemic Heart Disease (I20-I25) carries a note 'use additional code to identify presence of hypertension'. Does this override ACS 0002 *Additional Diagnoses*?

The Notes printed at I20-I25 *Ischaemic Heart Diseases* and I60-I69 *Cerebrovascular Diseases* do override ACS 0002.

Refer to Query 18 – *Instructional Notes* published in November 2000 *ICD Coding Newsletter*, page 6, as part of the Coding Feature on Additional Diagnoses – Queries and Responses.

#1745 Ventilation post transfer

In ACS 1006 *Respiratory Support*, there is instruction on how to code ventilation for a patient who has had surgery, stating that they must be ventilated for more than 24 hours post surgery to do so. There is also an instruction on coding a patient who is transferred in, already ventilated, which states to count from the time of arrival at the hospital.

What do we do for a patient who is transferred in, having had surgery at another hospital? Does the 24 hour rule still apply or does the fact that they have been transferred in, override this?

If a patient is transferred in post surgery elsewhere and no surgery will be performed at your hospital, the 24 hour rule does not apply. The ventilation procedure code should be assigned, even if less than 24 hours.

The ‘rule’ in the ACS is to differentiate between those patients whose Continuous Ventilatory Support (CVS) is associated with anaesthesia and is an integral part of surgery, from those whose CVS is not associated with surgery. The CVS the receiving hospital is providing in this query is not associated with surgery, therefore commence counting from the time of arrival at your hospital.

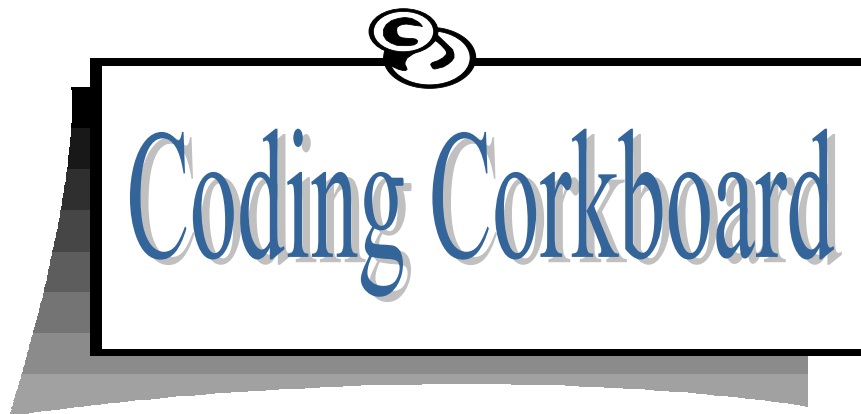
#1749 AMI – old or current

Patient admitted to Hospital A with initial inferior and anterolateral acute myocardial infarction (AMI). Patient remained in Hospital A for five days and was then transferred to Hospital B for coronary angioplasty. Patient returned from Hospital B for aftercare following angioplasty and remained in Hospital A for five days before being discharged home. Three days later, patient represented to Hospital A with supraventricular tachycardia (SVT). Patient remained in Hospital A for seven days before being discharged home. This scenario took place within 14 days.

If the patient represented to Hospital A with SVT after being discharged home, should the AMI be coded as current or old? Given that the patient has had an angioplasty and still remains within the 28 days for an initial AMI, we need some advice in coding this case.

SVT should be coded as principal diagnosis. The AMI would be coded as current if it meets the criteria in ACS 0002 in this episode.

The AMI should not be coded routinely if it occurred within the last 28 days. It would be coded if this episode were a continuation of the original episode (ie, the patient has been transferred from or back to the original hospital, as per ACS 0940 *Ischaemic Heart Disease*) or if it meets ACS 0002 criteria, in the case of a new episode of care for some other condition.



HIMAA abbreviations dictionary

The third edition of the *Australian Dictionary of Clinical abbreviations, Acronyms and Symbols* is now available for ordering from HIMAA. For prices and ordering details, please refer to the Publications List on the HIMAA website <http://www.himaa.org.au> or telephone Kerran Storey on: 02 9887 5001.

NCCH ICD-10-AM query database

Please be aware that the most recent posting of queries to the NCCH database was 27 August 2001. Coders have three options for viewing queries:

- downloading the searchable database in Microsoft Access 97 format
- viewing the whole database online
- searching the database online

Coding Matters

The September edition of *Coding Matters* contains a number of very useful references, including:

- List of Acronyms and Abbreviations used in the fields of health information, casemix and health informatics
- Clinical Coding Quiz (with answers)
- Call for Submissions for Modifications to ICD-10-AM

Current and previous editions of *Coding Matters* can be viewed and/or downloaded from the NCCH's website <http://www.cchs.usyd.edu.au/ncch>

Websites

The Visible Human Project	http://www.nlm.nih.gov/research/visible/visible_human.html
Telemedicine Information Exchange	http://www.tie.telemed.org/news/default.asp#item376
Lifeclinic.com: managing your health online	www.lifeclinic.com/
Health Communication Network (HCN)	http://www.hcn.net.au/
Victorian State Emergency Service - Online	http://www.ses.vic.gov.au/
Rural Health Home - An Australian Department of Health and Aged Care site	http://www.ruralhealth.gov.au/
Health Online: A Health Information Action Plan for Australia	http://www.health.gov.au/healthonline/actionp_2.pdf
Public Health Image Library	http://phil.cdc.gov/Phil/default.asp
IFHRO Home Page	http://home.soneraplaza.nl/qn/prive/jc.willem1/ifhro/ifhro.htm

Information Update

Final Consolidation of Financial Year Data for Victorian Admitted Episodes Dataset

2000 – 2001

On 21 September 2001, the VAED was closed for the 2000 – 2001 financial year. Data for the last financial year can no longer be added, deleted or corrected.

Thank you to sites that provided complete data before the VAED closure.

The following table compares, for 21 September 2001 and 21 September 2000, the number of separations in the VAED and those with diagnosis records outstanding:

CONSOLIDATION YEAR (as at 21 SEPTEMBER)		PUBLIC	PRIVATE
2000-2001	Total reported separations	1,065,572	580,416
	Outstanding Diagnosis Records	54	514
1999-2000	Total reported separations	1,041,835	519,838
	Outstanding Diagnosis Records	1,495	3,316

Hospitals that did not meet the consolidation deadline can expect to be closely monitored in the current financial year.

2001 – 2002

Hospitals must transmit data as per the Timelines detailed in the *Victoria – Public Hospitals Policy and Funding Guidelines 2001 – 2002* and reproduced in the June 2001 *ICD Coding Newsletter*, to ensure no financial penalties are incurred.

Summary of 2001-2002 funding formula issues relevant to HIMs

There was a late change to the Victorian public hospital Policy and Funding methods for 2001-2002 regarding Mechanical Ventilation: complete information is set out below, together with checks that public hospitals need to make to their WIES software and documentation. In addition, the other funding formula issues relevant to public hospital HIMs are summarised.

The complete *Victoria – Public Hospitals Policy and Funding Guidelines 2001-2002* document is available at: <http://www.dhs.vic.gov.au/ahs/pfg2001/index.htm>

The [P&FG] numbers shown for each section below refer to relevant sections in the *Policy and Funding Guidelines*.

Mechanical Ventilation Co-Payment (some revision for 2001-2002)

Only selected DRGs attract this additional payment that recognises mechanical ventilation (MV) as a surrogate for patient severity (excluded DRGs are those where MV is inherent to the episode of care).

For 2001-2002, the WIES formula was modified so neonates in the four hospitals with NICUs attract additional WIES depending on the length of MV. This payment provides a significant increase in funding for the sickest and/or smallest neonates and replaces the previous co-payments for episodes in DRGs P06A and P06B (*Neonate >2499g with Significant OR Procedure*). Also some specified grants associated with high outlier neonates have been subsumed into the WIES formula.

For 2001-2002, the WIES associated with the MV co-payment was increased to provide a premium for many ICU patients. This additional payment, set at 0.6980 WIES per eligible patient, maintains higher funding for an ICU 'turnover period' (a period where the hospital still incurs the costs associated with providing high level care without actually providing that care to a patient). This enables hospitals to run ICUs at lower occupancy without suffering financial penalty; however, this premium is subject to hospitals maintaining appropriate ICU bed availability.

[P&FG 15.3, 16.9]

Checks you need to make re the revision to MV formula

The revision to the MV formula regarding the additional 0.6980 WIES was included in the modelled budgets in the 2001-2002 *Policy and Funding Guidelines* and the formula is correct in the current **web** version of the Technical Specifications, Section C, 'Calculation of WIES9', Box 2a.

However, you need to make **two** checks:

First, you need to check the revision has been included in your WIES calculation software. To assist you, the revision is bolded in the extract below:

```
Select mv_elig
  case "D" then
    if (hours on mechanical ventilation > 6) and ICU hospital then
      Adjmvday = round((hours mechanical ventilation +12)/24)
      mv_copay = adjmvday x 0.7729 + 0.6980
.....
  case "N" then
    if (hours on mechanical ventilation > 6) and NICU hospital then
      Adjmvday = round((hours mechanical ventilation +12)/24)
      mv_copay = adjmvday x 0.7729 + 0.6980
.....
```

Second, if you have a printed copy of the *Policy and Funding Guidelines*, paste the complete Box 2a below over the one in your printed copy:

```
Box 2a:      Calculating Mechanical Ventilation Co-payments
Select mv_elig
  case "D" then
    if (hours on mechanical ventilation > 6) and ICU hospital then
      Adjmvday = round((hours mechanical ventilation +12)/24)
      mv_copay = adjmvday x 0.7729 + 0.6980
    else
      adjmvday = 0
      mv_copay = 0

    go to box 2b

  case "N" then
    if (hours on mechanical ventilation > 6) and NICU hospital then
      Adjmvday = round((hours mechanical ventilation +12)/24)
      mv_copay = adjmvday x 0.7729 + 0.6980
    else
      adjmvday = 0
      mv_copay = 0

    go to box 2b

  case "4" then
    if (hours on mechanical ventilation > 96) and (ICU hospital) then
      adjmvday = round((hours mechanical ventilation +12)/24) - 4
      mv_copay = adjmvday x 0.7729 + 0.6980
    else
      adjmvday = 0
      mv_copay = 0
    go to box 2b
  otherwise do
    adjmvday = 0
    mv_copay = 0
    go to box 2b
```

Higher Payment for Aboriginal & Torres Strait Islander Patients (no change for 2001-2002)

The formula continues to add 10 per cent to the usual WIES9 payment, as an incentive for hospitals to provide appropriate care and to ensure these patients are correctly identified in the VAED. [P&FG 15.2]

Thalassaemia Patients (no change for 2001-2002)

Each thalassaemia case in DRGs Q61A, Q61B and Q61C (*Red blood cell disorders*) continues to receive a co-payment of 0.2648 WIES. This recognises the additional resources needed for thalassaemia patients within their relevant DRG. [P&FG 15.4]

Victorian Maintenance Dialysis Program (VMDP) Patients (no change for 2001-2002)

Victorian maintenance dialysis services continue to be funded under the two-tier payment model, comprising a case payment and a program grant (because the weights for dialysis DRGs are not intended to cover all costs). Reporting is through the VAED and Information Management System (AIMS), and DHS intends to audit VAED maintenance dialysis episodes in late 2001-2002. [P&FG 15.6]

Records at the State Coroner's Office

Coders occasionally have problems when a patient's record is needed to meet a coding deadline but it has been sent, with the body, to the State Coroner's Office.

Ideally, the relevant sections of the record would be photocopied before the record leaves the hospital. Health Information Services (HIS) staff should ensure that ward and mortuary staff are aware of this. Ensure these staff members also know which sections of the record are relevant for photocopying, if you are unable to make the photocopies yourself. It may be possible for HIS staff to prepare an A4 sized poster that can be incorporated into manuals and put up on notice boards. The proforma on the following page could be the basis for your own poster.

Retrieving records from the State Coroner's Office

Advice to Health Data Standards and Systems from the State Coroner's Office is that any record sent to the Coroner's Office with a patient's body should be returned to the hospital within two weeks.

If the record has not been returned to you by then, and you need the record for coding or other purposes, contact the following officer to arrange the return of the record:

The Principal Registrar
State Coroner's Office
(03) 9684 4444
57 Kavanagh Street, South Melbourne 3205

If there is to be an inquest, this will occur some time after the post-mortem, when the State Coroner's Office will again request the record from the hospital.

If a hospital still experiences difficulty in retrieving a medical record, you should contact the HDSS Help Desk who will attempt to negotiate on your behalf: HDSS staff will need sufficient details to identify the case with the Coroner's Office (including hospital name, some form of case identification, relevant dates) together with details of contact already made with the Coroner's Office and the response you received.

[Adapt this proforma for your own use]

Information for Ward and Mortuary staff regarding patient records and the State Coroner's Office

When a body has to be sent to the State Coroner's Office, the deceased's hospital medical record must accompany the body.

Although the record should be returned to us within two weeks, the casemix funding system depends on prompt and complete coding by the hospital. Therefore it is important that the Health Information Services [**or insert appropriate Department name**] has the clinical information needed for coding.

Before allowing the medical record to be leave the hospital for the Coroner's Office: If the transfer occurs between the hours of [**insert your Department days/hours**], please telephone [**insert extension number**] and we will come immediately to make photocopies of relevant sections of the record before it leaves the hospital.

If the transfer occurs outside Health Information Services hours, *if at all possible*, please make photocopies of any of the following sheets that exist for the episode and send these copies (in a sealed envelope) to [**insert name and/or title of Chief Health Information Manager**]: [**edit list and amend form titles to suit**]

- Front sheet
- Any Discharge summary
- History
- Examination
- Body chart
- Investigation and Imaging reports
- Drug therapy charts
- Operation report
- Obstetric record (all sheets relevant to the delivery)
- Short stay record

Thank you for your co-operation!

[**insert appropriate names and contact information**]

Data Quality

PICQ - Performance Indicators for Coding Quality

Jennie Shephard, Department of Human Services

The Concept of PICQ

Performance Indicators for Coding Quality (PICQ) is a software package containing a set of indicators for identifying coding variation from Australian Coding Standards (ACS) or coding conventions in clinical datasets. PICQ identifies records that may be incorrectly coded, so that the causes can be investigated and corrective action taken, if required.

The indicators have been developed by the National Centre for Classification in Health (NCCH) to serve as measures of aspects of coding quality. They can be used to monitor, evaluate, and facilitate coding quality improvements.

Indicators are based on individual ICD-10-AM Australian Coding Standards, coding conventions and previous Australian and overseas coding quality studies. When an indicator examines disease and procedure codes (sometimes in conjunction with particular National Health Data Dictionary items), it analyses them:

- In combination with others, and/or
- In a sequence, and/or
- For their presence or absence, and/or
- For their specificity.

The PICQ user

The PICQ user is able to download relevant data items from their hospital database and format this to PICQ specifications. The user can then select which indicators are relevant to their particular hospital and run the data against these. The results can then be analysed and appropriate action taken.

Statewide Licence for PICQ

The Department of Human Services has purchased a statewide licence for the use of PICQ. This enables PICQ to be used in two ways:

1. Victorian hospitals, both Public and Private, can use PICQ to identify quality issues in their own data.

The PICQ software is available to download from the PICQ/ACBA webpage:

<http://www.dhs.vic.gov.au/ahs/hdss/picq/index.htm>

Victorian public hospitals must complete the PICQ/ACBA Software Application form to apply for a password. This will enable the hospital to download the PICQ software for use in their own organisation. Implicit in the downloading of the software is agreement with the terms of the licence.

Victorian private hospitals also have access to the PICQ software via a password, but are required to sign a copy of the licence agreement and return it (fax or mail) to the Department.

Further information and downloading instructions can be found at www.dhs.vic.gov.au/ahs/hdss/picq/index.htm (for a limited time) and at our new website www.hdss.health.vic.gov.au.

Victorian hospitals that do not have access to the Internet, or do not have an adequate computer speed for downloading the software, can apply to obtain a CD version of the software from the Department.

An updated list of registered users of the Victorian statewide licence will be sent to the NCCCH regularly so that they are aware of legitimate users of the software.

Hospitals are encouraged to take advantage of this opportunity to establish a system of monitoring the quality of their own coded data. Clinical coders in particular are encouraged to see monitoring of the quality of their data as an integral component of their ethical responsibility to the hospital(s) they work for. The statewide licence has been purchased to facilitate this aspect of data collection in hospitals.

Any queries related to the downloading of the software and the use of the product should be addressed to the Department via email, to PICQ.ACBA@dhs.vic.gov.au.

2. The Department can run Victorian data through PICQ to identify quality issues.

A preliminary analysis of July 2001 data from public hospitals has already been undertaken. Each hospital was sent a copy of their results. Many readers will have either been the recipient of this information, or had access to it through another person in their organisation.

This information was sent to hospitals, to demonstrate the capacity of PICQ to identify issues with the quality of coded data and to give hospitals an opportunity to comment on its usefulness.

The Department is interested in feedback related to this process. The following issues are of particular interest:

- Are you in a position to facilitate the use of PICQ in your organisation? If not, can you supply the contact details of the person who would be more appropriate? Please send the correct email address for future contact, to PICQ.ACBA@dhs.vic.gov.au

- If the Department needs to send further data files to hospitals, who is the appropriate person to send this information to? Please send details to PICQ.ACBA@dhs.vic.gov.au

The Department will continue to apply PICQ to hospital data, in the interests of monitoring the quality of the coded data. It is expected that information obtained from this exercise will provide a focus for coder education and for the development of coding standards in future editions of ICD-10-AM. In addition the development of statewide benchmarks for each indicator will be possible and will aid hospitals further in determining the standard of their own data.

Audits of VAED data

Joanne McLachlan, Department of Human Services

2000 – 2001

The final site visits for the audits of 2000 – 2001 VAED data were completed in mid-September. Reports have been despatched to almost all of the 72 sites involved in this round of audits, and responses received from just over 30 sites. The final report for the 2000 – 2001 VAED audits is expected to be posted to the HDSS website during December.

In the interim, preliminary aggregated results for sites involved in Annual, Follow-up and Supplementary audits are as follows:

	%DRG change	Lowest DRG change	Highest DRG change	%WIES8 change	Greatest negative WIES8 change	Greatest positive WIES8 change
Annual	9.80	0.00	37.50	0.94	-18.17	11.40
Follow-up	16.01	10.00	17.87	-0.91	-2.47	0.44
Supplementary	12.43	4.00	24.00	1.20	-1.45	5.19

A special commendation goes to the five sites in the Annual audit group where no DRG change was reported.

As Annual sites were randomly selected from all hospital groups, the raw percentage DRG change for those sites provides the second statewide result in this three-year project. At 9.80%, this is a substantial improvement from the previous statewide result of 13.04%, derived from the audit of 1998 – 1999 data.

Due to the change in Australian Coding Standards introduced from 1 July 2000, data for July and August 2000 were not included in audit samples, except at one site, where there would otherwise have been insufficient separations to draw the required sample. Samples were drawn from separations reported by hospitals for the months from and including September 2000 to May 2001, satisfying the objective that data from all

quarters of 2000–2001 be audited. In all cases, the most recently reported data used for funding were sampled. The results in the table above do not include those for additional two sites audited using data from the final quarter of 1999–2000.

Some sites which had not previously been audited, or which had not been audited since the coding audits of 1993–1994 or 1995–1996 data, were included in the audit of 2000-2001 VAED data. All public hospitals with sufficient annual throughput to provide a minimum sample size of 40 separations have now been audited in this three-year project.

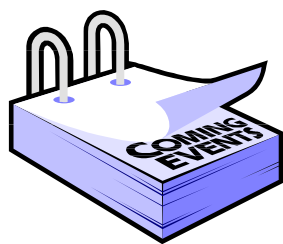
Again this year, the overwhelming majority of sites have treated their involvement in the audit as a positive experience, using the interaction with auditors, and their individual hospital report, as valuable feedback towards improving the accuracy of the data they contribute to the VAED, to the benefit of all data users.

2001 – 2002 and Beyond

Release of the final report of the audits of 2000-2001 VAED data will conclude the contract with HMA for the conduct of audits of VAED data for the three years 1998-1999 to 2000–2001 inclusive. A tender for VAED audits for subsequent years will be released in the next few months. Some changes are anticipated, but these are likely to be more of emphasis, than broad methodology, and will need to include the capacity to return repeatedly to sites where results remain above levels considered acceptable.

Queries

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



Coding Calendar of Events

Date	Event	Details
2-4 December 2001	2nd New Zealand/ Australian Health Services and Policy Research Conference	www.vuw.ac.nz/hsrc/conf/conference.htm Wellington, New Zealand
26-29 January 2002	CHIC Australian Mission to Arab Health 2002 Conference (United Arab Emirates)	www.arabhealthonline.com/page.cfm Dubai World Trade Centre, Dubai, United Arab Emirates
708 June 2002	Canadian Health Records Association Annual Conference 2001	Email: constance.wrigley@chra.ca Halifax, Nova Scotia, Canada CHRA Constance Wrigley
25-29 August 2002	European Conference on Health Records Dublin 2002	info@conferencepartners.com Trinity College Dublin Conference Partners in Ireland
21-26 August 2002	National Convention, American Health Information Management Association	E-mail meetings@ahima.org Moscone Convention Centre, San Francisco
March 2003	NCCH 8th Biennial Conference	Victoria

For a comprehensive list of health information events, see:

www.himaa.org.au/Calendar.html

Victorian ICD Coding Committee

Member Profile – Kylie Holcombe

Brief Work History

I completed the HIM course in 1989 and went straight into my first job at Repatriation General Hospital – Heidelberg, where myself and one other new graduate were responsible for all of the coding. From there I left to go to Fairfield Infectious Diseases Hospital, where I had a few happy years. While Acting Chief MRA there I left to go overseas for a year with the person I would later marry. I returned in 1994 to the position of Deputy Chief HIM at Frankston Hospital. After a year I left full-time work to spread myself part-time between The Angliss, The Alfred and Donvale Rehabilitation Hospital. I left the Angliss and took on some work at Waverley Private Hospital. I then left The Alfred and took on work at the Royal Melbourne Hospital. Currently I work at St. Vincent’s Hospital and have over the last couple of years been involved in the VAED audit in Victoria and as a member of the Coder Education Network (CEN).

Why did you join the Coding Committee?

I saw the Coding Committee as a challenge and an opportunity to expand my coding knowledge. It was not until I got involved that I realised how much work the Committee does and the influence that the Committee can have over the development of coding through feedback to the NCCH. I have made many great contacts through the Committee and really enjoy the healthy ‘debating’ that occurs at each meeting, as members are very passionate about coding and ensuring that answers are clinically correct.

What do you see as the challenges for the Coding Committee in the future?

Medicine and surgery is advancing so fast. There is at least one query at each meeting that involves a new technology that the current coding books do not cover. Each member has a duty to find out as much as they can about the queries prior to the meeting, relying on a vast range of resources including clinicians and the Internet. Diseases are also evolving and more is being learned about conditions and infectious agents. Keeping up to date with this is very challenging.

Name your most unusual possession

My most unusual possession(s) would be the 50 or so wombats that can be found around the house in various sizes, shapes and forms. I have a thing about wombats and can't help buying any I see. Our wedding cake was a wombat and on my honeymoon I visited a wildlife park in Tasmania where I was able to nurse a couple of baby wombats. (Heaven!!)

How do you cope with stress?

Anyone who knows me well will say that I do not really get stressed. I don't believe in worrying about what I can't control or what has happened in the past. I also believe in putting things into perspective and my troubles are nothing compared to what is going on in the world at the moment. I must admit though I am passionate about my work so I may show signs of stress if our coding numbers are blowing out.

What talent do you wish you had?

I wish that I had the talent of some of the working mums that I know who juggle busy work lives, children and still manage to enjoy life.

Who would you most like to sit next to on a plane?

I would say that first of all I would choose my husband, as it would mean that I was off on a holiday. In travelling around Europe and Scandinavia for a year together we found that we are compatible travellers. Otherwise I would chose Billy Connolly or Bill Bryson who would guarantee plenty of laughter so the time would pass quickly.

Family

I married my husband Darren last November after seven years together. We have two pugs Lois and Percy who are a delight most of the time and absolute terrors the rest of the time. We are expecting our first child in May next year.

Interests

My interests are reading (never without a book on hand), travelling, cooking, and music. Recently we have become involved with the Kintala Club with our two dogs, so most Saturday mornings are spent at dog school, which all of us really enjoy.

Members as at 1 November 2001

Irene Kearsey	Convener (Department of Human Services)
Lisa Basile	Peninsula Health
Moira Cameron	Cabrini Hospital
Rhonda Carroll	The Alfred Hospital
Andrea Groom	Southern Health
Sonia Grundy	St John of God, Geelong
Kylie Holcombe	St Vincent's Hospital
Susan Peel	Healesville and District Hospital
Evelyn Robinson	Peninsula Health
Fiona Rounds	Ballarat Health Services
Ruth Rundell	Barwon Health - The Geelong Hospital
Jennie Shephard	La Trobe University representative
Kathy Wilton	Royal Children's Hospital

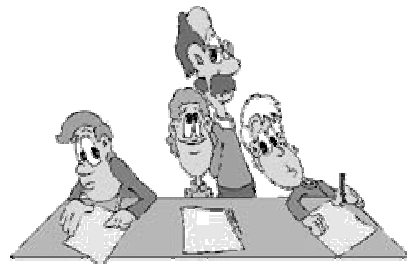
Please note: bold type indicates new members appointed in October 2001.

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

Next Meetings

- Tuesday 11 December 2001 Royal Children's Hospital
9.30 am, Flemington Road, Melbourne
- Tuesday 15 January 2002 Department of Human Services
10.00 am, 555 Collins Street, Melbourne

On a Lighter Note

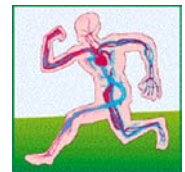


Quotes from primary school students' science exam papers:



❖ The body consists of three parts - the brainium, the borax and the abominable cavity. The brainium contains the brain, the borax contains the heart and lungs, and the abominable cavity contains the bowls, of which there are five - a, e, i, o, and u.

- ❖ When you smell an odorless gas, it is probably carbon monoxide.
- ❖ Three kinds of blood vessels are arteries, vanes and caterpillars.
- ❖ Blood flows down one leg and up the other.
- ❖ The alimentary canal is located in the northern part of Indiana.



- ❖ The skeleton is what is left after the insides have been taken out and the outsides have been taken off.
- ❖ For a nosebleed: Put the nose much lower than the body until the heart stops.

- ❖ To collect fumes of sulphur, hold a deacon over a flame in a test tube.
- ❖ For drowning: Climb on top of the person and move up and down to make artificial perspiration.



- ❖ To remove dust from the eye, pull the eye down over the nose.
- ❖ To prevent contraception: wear a condominium.
- ❖ For head cold: use an agonizer to spray the nose until it drops in your throat.
- ❖ H₂O is hot water, and CO₂ is cold water.



Alphabetic Index to Victorian ICD-10-AM Coding Advice: July 1999-November 2001

ACS	Australian Coding Standard
CF	Coding Feature
CT	Coding Tip
DQ	Data Quality Feature
HDSS # - MM/YY	HDSS Bulletin
Vic Add	Victorian Additions to Australian Coding Standards

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

A

AAA

- repair, with
- - endoluminal bifurcation graft #1511, Feb 2000

Abdominal muscle, rectus

- diastasis of #1713, Aug 2001

Abdominal wall

- abscess #1612, Nov 2000

Ablation

- percutaneous transluminal myocardial septal #1572, Aug 2000

- radiofrequency, liver #1485, Nov 1999

Abscess

- abdominal wall #1612, Nov 2000

- submandibular,

- - incision and drainage of #1482, May 2000

Abstraction Guidelines

- general ACS 0010 #1494, Feb 2000

Acoustic neuroma

- removal via middle fossa #1700, Aug 2001

- acute pulmonary oedema #1580, Nov 2000

Additional Diagnosis

- ACS 0002 #1479, Nov 1999

Item 13.1, HDSS Bulletin 13 - 07/00

(Replaces HDSS Bulletin2 - 07/99)

Additional procedures

- performed in conjunction with CABGs ACS 0909

- Adjustment #1691, Jun 2001

Adjustment

- ureteric memokath #1507, Feb 2000

Admission, for

- chemotherapy Item 6.1 HDSS 6 -10/99

- convalescence/aftercare #1662, Jun 2001

- IVF #1675, Aug 2001

- specific treatment for which there is a Z code

CF, Feb 2000

Adverse effects (and)

- poisoning CF, Aug 2000

Airways, upper

- obstruction #1519, Feb 2000

Alcohol dependence

- past history #1472, Feb 2000

AMI

- old or current #1749, Nov 2001

Amplatzer duct occluder

- insertion of #1564, Aug 2000

Amputation

- and open fractures #1520, May 2000

- distal 3rd & 4th fingers with reattachment

#1517, May 2000

Anaemia

- myelodysplastic syndrome #1473, Nov 1999

- postoperative #1466, Feb 2000

#1730, Nov 2001

Anaesthesia	
- ACS 0031	CF, Nov 2000
- LUSCS, with procedures	#1726, Aug 2001
- procedures	#1665, Jun 2001
Anaesthetics	CF, Jun 2000
Angina	
- post infarction	#1642, Jun 2001
- unstable, with hypertension	#1741, Nov 2001
Angiograms	
- CT	#1562, Aug 2000
Angiography	
- cardiac catheterisation and intervention	CF, Aug 2001
Angioplasty	
- unsuccessful	#1722, Nov 2001
Approach, middle fossa (for)	
- removal of acoustic neuroma	#1700, Aug 2001
Apraxia	
- senile gait	#1490, May 2000
Arthroscopic	
- lavage of shoulder	#1504, Feb 2000
Assigning code prefixes	CF, Jun 2000
Associated Diagnosis	
- atrial fibrillation	#1715, Aug 2001
Asthma	
- ACS 1002	#1622, Jun 2001
- infective exacerbation	#1725, Aug 2001
Atrial fibrillation	
- associated diagnosis	#1715, Aug 2001
Australian Coding Standard	
- 0002 Additional diagnosis	#1494, Feb 2000
Item 13.1, HDSS Bulletin 13 - 07/00	
(Replaces HDSS Bulletin 2- 07/99)	
- 0010 General abstraction guidelines	#1494, Feb 2000
- 0012 Suspected conditions	#1529, May 2000
- - perforation	#1689, Jun 2001
- 0031 Anaesthesia	CF, Nov 2000
- 0226 Prostatic cancer	#1659, Jun 2001
- 0237 Recurrence of primary malignancy & 0234 Contiguous sites & (NCCH Query 884)	#1468, Feb 2000
- 0909 Additional procedures performed in conjunction with CABGs	#1691, Jun 2001
- 1002 Asthma	#1622, Jun 2001
- 1912 & 1906 GAMP	#1489, Nov 1999
- 2103 Admission for convalescence/aftercare	#1662, Jun 2001
- 2107 Respite care	#1681, Aug 2001
- 2111 Screening	HDSS Bulletin 23.4
Autogenous bone marrow (and)	
- OP-1 putty	#1690, Nov 2001
(replaces #1690, Aug 2001)	
Autologous Chondrocyte	
- implantation (ACI)	#1654, Jun 2001

B

Bands	
-lap, gastric	#1530, Nov 2000
Benzhexol	
- dependence	#1551, May 2000
Biopsy	
- transjugular liver	#1470, May 2000
Birth episodes	
- coding of	DQ, Aug 2001
Birthweight	
- low	#1638, Jun 2001
Bladder & Bowel	
- lacerated during LUSCS	#1475, May 2000
Blood	
- transfusions	CF, June 2000
Bone changes	
- diabetic	#1635, Nov 2001
Bone marrow, autogenous	
- OP-1 putty	#1690, Nov 2001
(replaces #1690, Aug 2001)	
Bowel & Bladder	
- lacerated during LUSCS	#1475, May 2000
Brachytherapy	
- and radiotherapy	#1499, Nov 1999
- intra-coronary	#1585, Aug 2000
- intraluminal	#1480, Nov 1999
Branemark implants	#1712, Aug 2001
Breast	
- cancer, Tamoxifen (for)	#1553, May 2000
- implant, re-inflation	#1476, May 2000
- lesion, wide local excision of	#1615, Nov 2000
Bypass using vein	
- ilio-femoral (PTFE)	#1568, Aug 2000

C

Calciphylaxis	#1478, Nov 1999
Cancelled	
- chemotherapy	#1537, Aug 2000
- surgery	CF, Jun 2000
Cancer	
- breast, Tamoxifen (for)	#1553, May 2000
- site codes	#1601, Nov 2000
Capsulectomy (of)	
- shoulder	#1558, Aug 2000
Carbon fibre resurfacing	#1571, Aug 2000
Cardiac death	
- sudden	#1463, Nov 1999
Cardiac Catheterisation	
- angiography and intervention	CF, Aug 2001
Care, Respite	
- ACS 2107	#1681, Aug 2001
Carrier	
- pregnancy Strep. Group B	#1563, Aug 2000

Chemotherapy (and) #1589, Nov 2000
- admission for Item 6.1 HDSS 6-10/99
- cancelled due to URTI #1537, Aug 2000
- device loading #1648, Jun 2001
- intraperitoneal CF, Aug 1999
Chest pain
- musculoskeletal #1664, Jun 2001
Cholecystectomy
- laparoscopic to open cholecystectomy
with exploration of CBD #1651, Jun 2001
Chronic renal impairment
- in diabetic patient #1701, Aug 2001
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Chronic schizophrenia #1544, May 2000
COAD (and)
- pneumonia, sequencing #1624, Nov 2000
Cochlear
- implant procedure CF, May 2000
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- assigning prefixes CF, Jun 2000
- birth episodes DQ, Aug 2001
- cancer sites, morphology #1727, Aug 2001
- clinical information recorded by clinicians
other than medical officers CF, Aug 2000
- contracted procedures Vic Add 0029
- external cause, scooters #1669, Jun 2001
- GEM Program #1462, Nov 1999
#1702, Aug 2001
- I24.0 #1621, Nov 2000
- idiosyncratic episodes CF, Feb 2000
- laparoscopy #1677, Jun 2001
- minor trauma CF, Jun 2001
- morphology, cancer sites #1727, Aug 2001
- place of occurrence #1666, Aug 2001
- post mortem information #1510, Feb 2000
- selection of principal #1628, Nov 2000
Coffin-Lowry Syndrome #1541, May 2000
Colonoscopy
- investigation or finding #1636, Jun 2001
Combination, unacceptable
-obstetric diagnosis Item 14.3, HDSS 14 - 07/00
(Replaces CF, Jun 2000)
Complications
- diabetes, multiple CF, Aug 1999
- diabetic #1743, Nov 2001
- mechanical, ventricular shunt #1644, Jun 2001
- place of occurrence codes #1666, Aug 2001
- postprocedural #1650, Jun 2001
- procedural CF, Nov 2001
Conception
- retained products #1641, Jun 2001
Condition underlying #1682, Jun 2001
Conscious state
- decreased #1532, May 2000
Continuous ventilatory support CF, Aug 2000

Contracted procedures
- coding of Vic Add 0029
COPD (with)
- infective exacerbation of,
with emphysema #1538, May 2000
- smoking related #1658, Jun 2001
Coronary artery disease (in)
- stent and transplanted heart #1492, Nov 1999
Coroner's Report
- post mortem coding #1510, Feb 2000
CT
- Angiograms #1562, Aug 2000
Cyst
- liver, percutaneous ultrasound
guided drainage #1625, Nov 2000
- mullerian #1613, Nov 2000
- paraurethral #1631, Nov 2001
Cystadenoma (of)
- ovary [borderline malignancy] #1515, Feb 2000

D

Death
- cardiac, sudden #1463, Nov 1999
Decreased
- conscious state #1532, May 2000
Denver pleuro-peritoneal shunt #1711, Aug 2001
Dependence
- alcohol, past history #1472, Feb 2000
- benzhexol #1551, May 2000
- opioid #1618, Nov 2000
Depression
- post natal #1513, Feb 2000
Device loading
- chemotherapy #1648, Jun 2001
Diabetes CF, Nov 2000
- in pregnancy #1747, Nov 2001
- use of multiple codes #1752, Nov 2001
- with
- - acute on chronic renal failure #1753, Nov 2001
- - acute renal impairment #1657, Nov 2001
- - bone changes #1635, Nov 2001
- - chronic renal impairment #1701, Aug 2001
#1639, Nov 2001
- - diarrhoea CF, Nov 2000
- - features of insulin resistance #1702, Aug 2001
- - - E11.72, Type 2 #1702, Aug 2001
- - multiple complications CF, Aug 1999
- - past history of osteoarthritis #1630, Nov 2001
- - proteinaemia #1653, Nov 2001
- periungual telangiectasia #1597, Nov 2000
Diabetic complications #1743, Nov 2001
Diabetic Foot #1721, Nov 2001

Diagnosis

- associated, atrial fibrillation #1715, Aug 2001
- obstetric, unacceptable

Item 14.3, HDSS 14 - 07/00
(Replaces CF, Jun 2000)

- prefixes Vic Add Prefix.1

Diarrhoea

- with diabetes CF, Nov 2000

Diastasis, of

- recti, post delivery #1548, May 2000
- rectus abdominal muscle #1713, Aug 2001

Diathermy (of)

- penile wart #1539, May 2000

Dimple

- sacral #1566, May 2000

Disorder

- schizoaffective, hypomanic #1542, May 2000
- screening for specific CF, Aug 2000

Documentation

- adequacy of arrows/plus signs #1735, Nov 2001

Drainage

- cyst, liver, ultrasound guided (percutaneous) #1625, Nov 2000

Drugs

- poisoning and adverse effects CF, Aug 2000

Dysplasia

- otospondylomegaepiphyseal #1484, Aug 2000

E

E11.72, Type 2 diabetes

- with features of insulin resistance #1702, Aug 2001

Emphysema (with)

- infective exacerbation, COPD #1538, May 2000

Endobronchial

- stent #1506, Feb 2000

Endoluminal bifurcation graft

- AAA repair #1511, Feb 2000

Epidural

- during labour #1593, Nov 2000

Epigastric

- Hernia or ventral #1609, Nov 2000

Epilepsy (and)

- status epilepticus #1555, Aug 2000

Ethanol injection

#1685, Jun 2001

Exacerbation, infective

- asthma #1725, Aug 2001
- COPD with emphysema #1538, May 2000

Excision/Removal (of)

- osteophytes #1560, Aug 2000
- wide local, breast lesion #1615, Nov 2000
- wide, neoplasm #1584, Aug 2000

External Cause code

- scooters #1669, Jun 2001

F

Facial implant

- removal of #1546, Nov 2000

Failure, renal

- acute on chronic, diabetic patient #1753, Nov 2001

Family history

- retinoblastoma #1723, Aug 2001

Finding or investigation

- colonoscopy #1636, Jun 2001

Finger

- bath drain, removal of #1535, May 2000
- reattachment (of) #1518, Feb 2000

Fixation, internal

- osteotomies
- - bilateral maxilla & mandible #1693, Jun 2001

Follow-up

- gastroscopy #1676, Jun 2001

Foot

- diabetic #1721, Nov 2001

Fractures

- open and amputation #1520, May 2000

Fundoplication, Nissen (laparoscopic)

- revision of #1540, May 2000

G

GAMP

- ACS 1912 and 1906 #1489, Nov 1999

Gastric lap bands

#1530, Nov 2000

Gastroscopy

- follow-up #1676, Jun 2001

Geriatric Evaluation and Management Program

- coding (GEM) #1462, Nov 1999
- #1702, Aug 2001

Graft, endoluminal bifurcation

- AAA repair #1511, Feb 2000

Group B Strep

- carrier in pregnancy #1563, Aug 2000
- status, unknown #1501, Feb 2000

Group of

- laparoscopy codes #1677, Jun 2001

Guide

- Intraocular lens (replaces Aug) CF, Nov 2000

Guidelines

- sequencing CF, Jun 2000

H

Hemicolectomy (and)

- LUSCS #1578, Aug 2000

Hepatic portal vein (studies)

- pressure/post pressure #1599, Nov 2000

Hepatitis B

- vaccinations in newborns #1582, Aug 2000
- vaccine #1573, Aug 2000

Hernia

- ventral or epigastric #1609, Nov 2000

History, family

- retinoblastoma #1723, Aug 2001

Hypertension

- with unstable angina #1741, Nov 2001

Hypomanic

- schizoaffective disorder #1542, May 2000

Hysterectomy

- vaginal, laparoscopically #1623, Nov 2000

I**I24.0**

- use of code #1621, Nov 2000

Idiosyncratic episodes

- coding CF, Feb 2000

Ilio-femoral

- bypass using vein (PTFE) #1568, Aug 2000

Impacted tooth

- surgically removed #1500, Nov 1999

Impairment

- renal, acute #1738, Nov 2001
- renal, acute in diabetic patient #1657, Nov 2001
- renal, chronic in diabetic patient #1701, Aug 2001
- #1639, Nov 2001

Implant (implantation)

- autologous chondrocyte (ACI) #1654, Jun 2001
- Branemark #1712, Aug 2001
- breast, re-inflation of #1476, May 2000
- cochlear CF, May 2000
- facial, removal of #1546, Nov 2000
- iridium, insertion of #1569, Aug 2000
- loop recorder #1495, Feb 2000
- nose (silicon), removal of #1552, May 2000
- Silastic, thyroplasty #1579, Aug 2000

Incision and drainage (of)

- submandibular abscess #1482, May 2000

Infarction, post

- angina #1642, Jun 2001

Infected IV site T80.2 or T82.7

- #1703, Nov 2001

Infective exacerbation of

- asthma #1725, Aug 2001
- COPD with emphysema #1538, May 2000

Infusion (of)

- isolated limb CF, Nov 1999
- pump for pain management #1565, Aug 2000

Injection (of)

- ethanol #1685, Jun 2001
- Yttrium #1643, Aug 2001

Injury

- (open) into joint CF, Nov 2001
- of joint, open #1694, Aug 2001

Intravenous site

- infected #1703, Nov 2001

INR

- stabilisation, overwarfarinisation #1496, Feb 2000

Insertion (of)

- amplatzer duct occluder #1564, Aug 2000
- iridium implant #1569, Aug 2000
- pleuroperitoneal shunt #1598, Nov 2000
- transfemoral aortic stent #1567, Aug 2000

Insulin resistance

- features with diabetes #1702, Aug 2001
- - E11.72, Type 2 #1702, Aug 2001

Internal fixation

- osteotomies
- - bilateral maxilla & mandible #1693, Jun 2001

Intervention, (and)

- cardiac catheterisation, angiography CF, Aug 2001

Intra-coronary brachytherapy

- #1585, Aug 2000

Intraluminal brachytherapy

- #1480, Nov 1999

Intraocular lens guide (replace Aug)

- CF, Nov 2000

Intraperitoneal

- chemotherapy CF, Aug 1999

Intravascular ultrasound

- #1575, Aug 2000

Investigation or finding

- colonoscopy #1636, Jun 2001

Iridium implant

- insertion of #1569, Aug 2000

Isolated limb

- infusion (of) CF, Nov 1999

IUD

- progesterone, replacement #1516, Feb 2000

IVF

- admission, for #1675, Aug 2001

J**Joint**

- open injury CF, Nov 2001
- #1694, Aug 2001

K**K+**

- low #1680, Jun 2001

L**Labour**

- epidural (during) #1593, Nov 2000

Labour, premature

- patient transferred	#1561, Nov 2000
Lacerated	
- bowel & bladder during LUSCS	#1475, May 2000
Lap bands	
- gastric	#1530, Nov 2000
Laparoscopic	
- cholecystectomy to open cholecystectomy with exploration of CBD	#1651, Jun 2001
- hysterectomy, vaginal	#1623, Nov 2000
Laparoscopy	
- codes, grouping of	#1677, Jun 2001
Lavage	
- arthroscopic, of shoulder	#1504, Feb 2000
LeFort Osteotomy	#1493, Nov 1999
Lens	
- Intraocular guide (replaces Aug)	CF, Nov 2000
Lesion	
- breast, wide local excision	#1615, Nov 2000
Ligation, tubal	
- pregnancy, following	#1583, Aug 2000
Limb, isolated	
- infusion (of)	CF, Nov 1999
Lip-labial	
- melanotic macule	#1543, May 2000
Liver	
- cyst, percutaneous ultrasound	#1625, Nov 2000
- transjugular biopsy	#1470, May 2000
Liquor	
- meconium in	#1600, Nov 2000
Loading	
- chemotherapy device	#1648, Jun 2001
Loop recorder implant	#1495, Feb 2000
Low	
- birthweight	#1638, Jun 2001
- K+	#1680, Jun 2001
Lumbar spinal	
- stenosis	#1487, Nov 1999
LUSCS (and)(during)	
- anaesthesia, with	#1726, Aug 2001
- hemicolectomy	#1578, Aug 2000
- lacerated bowel & bladder	#1475, May 2000

M

Macule, melanotic	
- lip-labial	#1543, May 2000
Meconium in liquor	#1600, Nov 2000
Mechanical complication (of)	
- ventricular shunt	#1644, Jun 2001
Melanotic macule	
- lip-labial	#1543, May 2000
Mesocaval shunt	
- thrombectomy of	#1587, Aug 2000
Metastatic spread	#1545, May 2000
Middle fossa, approach (for)	
- removal of acoustic neuroma	#1700, Aug 2001

Minor trauma	
- coding of	CF, Jun 2001
Morphology	Vic Add 0233
- coding cancer site	#1727, Aug 2001
Mullerian	
- cyst	#1613, Nov 2000
Multiple complications	
- with diabetes	CF, Aug 1999
Muscle, rectus abdominal	
- diastasis of	#1713, Aug 2001
Musculoskeletal	
- chest pain	#1664, Jun 2001
Myelodysplastic syndrome	
- with anaemia	#1473, Nov 1999

N

Neoplasm	
- wide excision of	#1584, Aug 2000
Nissen fundoplication	
- laparoscopic, revision of	#1540, May 2000
Nose (silicon) implant	
- removal of	#1552, May 2000

O

Obstetrics	
- prefixes	Vic Add Prefix.2
- principal diagnosis	#1661, Jun 2001
- unacceptable diagnosis	Item 14.3, HDSS 14 - 07/00 (Replaces CF, Jun 2000)
Obstruction	
- upper airways	#1519, Feb 2000
Occurrence, Place of	CF, Jun 2000
- complications, coding	#1666, Aug 2001
Oedema	
- acute pulmonary	#1580, Nov 2000
OP-1 putty (and)	
- autogenous bone marrow	#1690, Nov 2001 (replaces #1690, Aug 2001)
Open fractures	
- and amputation	#1520, May 2000
Open injury	
- (into) joint	CF, Nov 2001
- of joint	#1694, Aug 2001
Opioid	
- dependence	#1618, Nov 2000
Organ Procurement	Vic Add 0030
Osseous metaplasia (and)	
- solar lentigo	#1671, Jun 2001
Osteoarthritis (past history of)	
- with diabetes	#1630, Nov 2001
Osteophytes	
- excision/removal of	#1560, Aug 2000

Osteotomy (ies)	
- LeFort	#1493, Nov 1999
- with internal fixation	
- - bilateral maxilla & mandible	#1693, Jun 2001
Otospondylomegaepiphyseal	
- dysplasia	#1484, Aug 2000
Ovary	
- cystadenoma of	#1515, Feb 2000
Overwarfarinisation	
- stabilisation of INR	#1496, Feb 2000

P

Pacemaker	
- recall	#1620, Nov 2000
Pain Management	
- infusion pump for	#1565, Aug 2000
Palliative care	#1663, Jun 2001
Paraurethral cyst	#1631, Nov 2001
Past history	
- alcohol dependence	#1472, Feb 2000
Penile wart	
- diathermy of	#1539, May 2000
Percutaneous	
- transluminal myocardial septal ablation	#1572, Aug 2000
Perianal	
- vaginal, vulval wart	#1471, May 2000
Periungual telangiectasis (in)	
- diabetes	#1597, Nov 2000
Photodynamic therapy (PDT)	#1486, May 2000
Place of Occurrence	CF, Jun 2000
- complications, coding	#1666, Aug 2001
Pleuroperitoneal shunt	
- Denver pleuro-peritoneal	#1711, Aug 2001
- insertion (of)	#1597, Nov 2000
Pneumonia (and)	
- COAD, sequencing of	#1624, Nov 2000
Poisoning and adverse effects (of)	
- drugs	CF, Aug 2000
Post delivery	
- diastasis recti	#1548, May 2000
Post infarction	
- angina	#1642, Jun 2001
Post mortem / Coroner's report	
- coding of	#1510, Feb 2000
Post natal	
- depression	#1513, Feb 2000
Postoperative	
- anaemia	#1466, Feb 2000
	#1730, Nov 2001
- thrombophlebitis	#1503, Feb 2000
Postpartum	
- cervical repair	#1728, Nov 2001
Postprocedural	
- complications	#1650, Jun 2001

Potassium	
- low	#1680, Jun 2001
Pre-admission tests	#1527, May 2000
Prefixes	
- assignment of	CF, Jun 2000
- for diagnoses	Vic Add Prefix.1
- for obstetric codes	Vic Add Prefix.2
Pregnancy	
- carrier Strep. Group B	#1563, Aug 2000
- diabetes (in)	#1747, Nov 2001
- following tubal ligation	#1583, Aug 2000
Premature Labour	
- patient transferred	#1561, Nov 2000
Pressure/post pressure studies	
- hepatic, portal vein	#1599, Nov 2000
Principal Diagnosis (in)	
- obstetrics	#1661, Jun 2001
- selection of	#1628, Nov 2000
Procedural Complications	CF, Nov 2001
Procurement, organ	Vic Add 0030
Products, retained	
- conception	#1641, Jun 2001
Progesterone	
- 'IUD', replacement (of)	#1516, Feb 2000
Prostatic cancer	
- ACS 0226	#1659, Jun 2001
Proteinaemia (with)	
- diabetes	#1653, Nov 2001
PTFE	
- ilio-femoral bypass using vein	#1568, Aug 2000
Pulmonary oedema	
- acute	#1580, Nov 2000
Pump (for)	
- pain management infusion	#1565, Aug 2000

R

Radiofrequency ablation	
- of liver	#1485, Nov 1999
Radiotherapy	Vic Add 0229
- and brachytherapy	#1499, Nov 1999
Reattachment (of)	
- amputated distal 3 rd & 4 th fingers	#1517, May 2000
- finger	#1518, Feb 2000
Recall	
- pacemaker	#1620, Nov 2000
Rectus, abdominal muscle	
- diastasis of	#1713, Aug 2001
Recurrence (of)	
- primary malignancy(ACS 0238)	
0234 Contiguous sites & NCCH Query 884	#1468, Feb 2000
	Vic Add 2104
Rehabilitation	
Re-inflation (of)	
- breast implant	#1476, May 2000

Removal/excision (of)
- acoustic neuroma, middle fossa #1700, Aug 2001
- bath drain from fingers #1535, May 2000
- facial implants #1546, Nov 2000
- impacted tooth, surgically #1500, Nov 1999
- neoplasm, wide #1584, Aug 2000
- osteophytes #1560, Aug 2000
- silicon implant from nose #1552, May 2000

Renal impairment
- acute #1738, Nov 2001
- acute, in diabetic patient #1657, Nov 2001

Renal impairment, chronic
- in diabetic patient #1701, Aug 2001
#1639, Nov 2001

Repair (of)
- AAA with endoluminal bifurcation graft #1511, Feb 2000
- cervical, postpartum #1728, Nov 2001

Replacement (of)
- progesterone 'IUD' #1516, Feb 2000

Resistance, insulin
- features of with diabetes #1702, Aug 2001
- - E11.72, Type 2 #1702, Aug 2001

Respite Care
- ACS 2107 #1681, Aug 2001

Resurfacing
- carbon fibre #1571, Aug 2000

Retained products (of)
- conception #1641, Jun 2001

Retinoblastoma
- family history of #1723, Aug 2001

Revision (of)
- laparoscopic Nissen Fundoplication #1540, May 2000

S

Sacral
- dimple #1566, May 2000

Schizoaffective disorder
- hypomanic #1542, May 2000

Schizophrenia
- chronic #1544, May 2000

Scooters
- external cause coding #1669, Jun 2001

Screening for
- specific disorders CF, Aug 2000
- ACS 2111 Screening Item 23.4 HDSS 23-6/2000

Selection (of)
- principal procedure #1628, Nov 2000

Senile gait
- apraxia #1490, May 2000

Sequencing
- COAD and pneumonia #1624, Nov 2000
- guidelines CF, Jun 2000

Shoulder
- arthroscopic lavage of #1504, Feb 2000
- capsulectomy of #1558, Aug 2000

Shunt
- Denver pleuro-peritoneal #1711, Aug 2001
- mesocaval, thrombectomy of #1587, Aug 2000
- pleuroperitoneal, insertion of #1598, Nov 2000
- ventricular shunt
- - mechanical complication #1644, Jun 2001

Silastic implant thyroplasty #1579, Aug 2000

Silicon nose implant
- removal of #1552, May 2000

Site codes
- cancer #1601, Nov 2000

Smoking
- related COPD #1658, Jun 2001

Solar lentigo (and)
- osseous metaplasia #1671, Jun 2001

Specific treatment
- admission for which there is a Z code
CF, Feb 2000

Spinal lumbar
- stenosis #1487, Nov 1999

Spread
- metastatic #1545, May 2000

Stabilisation
- INR, overwarfarinisation #1496, Feb 2000

State
- conscious, decreased #1532, May 2000
- Strep. Group B unknown #1501, Feb 2000

Status epilepticus (and)
- epilepsy #1555, Aug 2000

Stenosis
- lumbar spinal #1487, Nov 1999

Stent
- coronary artery disease and transplanted heart #1492, Nov 1999
- endobronchial #1506, Feb 2000
- transfemoral aortic, insertion #1567, Aug 2000

Sternal wires #1465, May 2000

Strep. Group B
- carrier in pregnancy #1563, Aug 2000
- status unknown #1501, Feb 2000

Study
- pressure/portal pressure hepatic portal vein #1599, Nov 2000
- WADA #1559, Aug 2000

Submandibular abscess
- incision & drainage, of #1482, May 2000

Sudden cardiac death #1463, Nov 1999

Surgery, cancelled CF, Jun 2000

Surgically removed
- impacted tooth #1500, Nov 1999

Suspected conditions
- ACS 0012 #1529, May 2000
- perforation #1689, Jun 2001

Syndrome
- Coffin-Lowry #1541, May 2000

T

Tamoxifen (for)
- breast cancer #1553, May 2000
Telangiectasia
- periungual in diabetes #1597, Nov 2000
Tests
- pre-admission #1527, May 2000
Therapy
- photodynamic #1486, May 2000
Thrombectomy (of)
- mesocaval shunt #1587, Aug 2000
Thrombophlebitis
- postoperative #1503, Feb 2000
Thyroplasty
- silastic implant #1579, Aug 2000
Tracheostomy CF, Jun 2000
Transfusion
- blood CF, Jun 2000
Transfemoral aortic stent
- insertion (of) 1567, Aug 2000
Transjugular liver biopsy #1470, May 2000
Transplanted heart (with)
- coronary artery disease in stent #1492, Nov 1999
Tubal ligation
- pregnancy, following #1583, Aug 2000

U

Ultrasound
- guided percutaneous drainage
- - liver cyst #1625, Nov 2000
- intravascular #1575, Aug 2000
Unacceptable combination
-obstetric diagnosis Item 14.3, HDSS 14 - 07/00
(Replaces CF, Jun 2000)
Underlying condition #1682, Jun 2001
Unknown
- Strep. Group B status #1501, Feb 2000
Unsuccessful
- angioplasty #1722, Nov 2001
Upper airways
- obstruction #1519, Feb 2000
Ureteric memokath
- adjustment #1507, Feb 2000
URTI (due to)
- cancelled chemotherapy #1537, Aug 2000

V

Vaccine (vaccination)
- Hepatitis B #1573, Aug 2000
- Hepatitis B in newborns #1582, Aug 2000
Vaginal
- hysterectomy, assisted laparoscopically #1623, Nov 2000
- vulval and perianal wart #1471, May 2000
Ventilation
- post transfer #1745, Nov 2001
Ventilatory support
- continuous CF, Aug 2000
Ventral
- Hernia, or epigastric #1609, Nov 2000
Ventricular shunt
- mechanical complication #1644, Jun 2001
Vic Addition
- coding contracted procedures 0029
- morphology 0233
- organ procurement 0030
- prefixes for diagnoses Prefix.1
- prefixes for obstetric codes Prefix.2
- radiotherapy 0229
- rehabilitation 2104
Vulval, vaginal and perianal
- wart #1471, May 2000

W

WADA study #1559, Aug 2000
Wart
- penile, diathermy of #1539, May 2000
- vulval, vaginal and perianal #1471, May 2000
Wide excision (of)
- breast, local #1615, Nov 2000
- neoplasm #1584, Aug 2000
Wires
- sternal #1465, May 2000

X

Xanthelasma #1576, Aug 2000

Y

Yttrium
- injection #1643, Aug 2001

Z

Z Codes
- admission principally for a specific treatment
CF, Feb 2000

Abbreviations

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
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
NCCH	National Centre for Classification in Health
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee