

***ICD Coding Newsletter***  
***November 2002***

**Distribution List**

- Health Information Manager/s (HIMS)
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The ICD Coding Newsletter supports the clinical coding function performed in Victoria by providing relevant information to Health Information Managers, Clinical Coders, and their associates.

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

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

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

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

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

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# ***Coding Features***

## **Emergency admission time and assignment of principal diagnosis**

Author: Jennie Shephard, HDSS, Department of Human Services

A query has been raised in relation to patients who attend the Emergency Department (ED) and are subsequently admitted - in particular, the impact the time of admission for these episodes has on the principal diagnosis decision.

In such episodes it is the decision to admit, and when this occurs, which is critical in determining principal diagnosis, rather than the official time of admission. To clarify:

1. When a patient attends the ED and is subsequently admitted, the admission starts when the patient was first treated by doctor or nurse, whichever is the earlier. Below is an extract from the VAED Manual, 12<sup>th</sup> Edition, July 2002, page 3-39.

*Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care. For example, when a patient is admitted from the Emergency Department, then the admission time is the time treatment was started in the Emergency Department. That is, when the patient was first treated by a nurse or doctor, whichever comes first, rather than the time the decision is taken to admit the patient. In this context, 'treatment' includes commencement of baseline observations by a nurse and assessment of the patient by a doctor.*

2. The principal diagnosis will be assigned in accordance with the Australian Coding Standard 0001 *Principal Diagnosis*. The definition of Principal Diagnosis is:

*The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).*

*National Health Data Committee (2001). National Health Data Dictionary, Version 10, AIHW.*

3. The condition that brings a patient to the ED will not always be the condition that is the reason for the admitted patient episode of care.

The examples outlined below demonstrate these points:

### **Example 1.**

A patient presents to emergency following a minor motorcar accident. A laceration on his forehead is sutured. He subsequently experiences an anterior myocardial infarct and a decision is made to admit him to CCU.

Principal Diagnosis: Anterior myocardial infarct

Additional Diagnosis: Laceration to forehead with appropriate external cause codes

Procedures: Suture of laceration

*Comment:* The principal diagnosis is the infarct as it is the condition that was chiefly responsible for occasioning the admitted patient episode of care. The admission time is the time of the commencement of treatment in the emergency department. As the laceration is treated and therefore meets additional diagnoses criteria for the episode, it is coded.

### **Example 2**

A patient presents to emergency complaining of abdominal pain and is diagnosed with a urinary tract infection. The patient is elderly and the UTI has caused confusion, which makes it difficult for the patient to cope at home. A decision is made to start antibiotics, and admit the patient until she is stable. After two days of antibiotics the patient is judged to be stable and is sent home.

Principal Diagnosis: UTI

Additional Diagnosis: Confusion, if it meets ACS 0002 criteria

Procedures: Nil

*Comment:* The UTI meets the definition of principal diagnosis – ‘the condition after study that was chiefly responsible for occasioning the episode of care’. Although the confusion is the presenting problem, the underlying condition (UTI) is identified during this episode of care, and is therefore the principal diagnosis. If the confusion meets ACS 0002 criteria it should be coded.

### Example 3

A patient presents to emergency with increasing confusion over the preceding few days and a UTI is diagnosed. This patient also suffers from CCF and hypertension, both of which have destabilised because of the UTI. A decision is made to admit to stabilise the CCF and the hypertension, and to treat the UTI at the same time.

Principal Diagnosis:        Either CCF or Hypertension

Additional Diagnosis:     UTI

                                 Either CCF or Hypertension (whichever is not px dx )

                                 Confusion, if it meets ACS 0002 criteria

Procedures:                Nil

*Comment:* According to the documentation provided in this scenario, the principal diagnosis is either the CCF or the Hypertension, depending on the 'circumstances of admission, diagnostic work-up and/or therapy provided'. If neither condition meets these criteria during the episode of care, the condition listed first by the clinician, on the discharge summary, is coded as principal diagnosis. The UTI will be an additional diagnosis as it will meet ACS 0002 criteria. Confusion will be an additional diagnosis if it meets ACS 0002 criteria.

### Example 4

A patient presents to emergency complaining of dizziness, nausea and vomiting. The patient is treated with anti-emetic and IV fluids. While trying to get up from the trolley the patient falls and fractures his wrist. The patient is then admitted for open reduction and fixation of the fractured wrist.

Principal Diagnosis:        Fractured wrist

Additional Diagnosis:     Dizziness, nausea and vomiting

Procedures:                Open reduction and fixation of fractured wrist

*Comment:* The principal diagnosis is the fractured wrist as it is the condition that was chiefly responsible for occasioning the admitted patient episode of care. The dizziness, nausea and vomiting can be coded as additional diagnoses as the time of admission is the time of commencement of treatment in the emergency department, and the conditions meet additional diagnosis criteria.

### **Example 5**

A patient presents to emergency complaining of dizziness, nausea and vomiting. The patient is diagnosed with gastroenteritis, treated with anti-emetic and IV fluids. A decision is made to admit the patient overnight to continue the treatment and observe. While transferring to a wheel chair for transfer to the ward, the patient falls and sustains a Colles' fracture. The patient is taken to theatre later that day for a reduction of the fracture.

Principal Diagnosis: Gastroenteritis

Additional Diagnosis: Colles' fracture

Procedures: Closed reduction and fixation of fractured wrist

*Comment:* In this scenario the decision to admit the patient for observation and treatment of the gastroenteritis has already been made when the patient falls and sustains a Colles' fracture. Therefore the gastroenteritis is what 'occasions the episode of care in hospital' and will be listed as principal diagnosis. The Colles' fracture occurs after the patient has been admitted, and is treated. It therefore meets additional diagnoses criteria and will be coded, prefixed with 'C'.

### **Example 6**

A patient presents to the Outpatient Department where skin lesions are excised. Following the removal of the lesions the patient collapsed and was taken to Emergency. In Emergency a decision is made to admit the patient for further investigations. These investigations result in a diagnosis of Complete Heart Block and a pacemaker is inserted.

Principal Diagnosis: Complete Heart Block

Additional Diagnosis: Skin lesions

Procedures: Insertion of pacemaker

Excision of skin lesions

*Comment:* The complete heart block is the condition that 'occasions the episode of care' and is therefore the principal diagnosis. As the admission time is taken from the time of treatment in the Outpatient Department, the skin lesions meet additional diagnoses criteria and are also coded.

# Underlying Condition as Principal Diagnosis

Author: Jennie Shephard, HDSS, Department of Human Services

Victorian ICD Coding Committee has received several queries that reflect difficulties coders experience in applying the 'underlying condition' aspect of Australian Coding Standard 0001 *Principal Diagnosis*, reproduced below.

## Assignment of the underlying condition as principal diagnosis

When a patient presents with a problem, and during the episode of care the underlying condition is identified, then the underlying condition is assigned as the principal diagnosis code and the problem should not be coded.

### EXAMPLE 2:

Patient presents with seizures. The patient had not previously been treated for seizures. CT scan revealed a large brain tumour.

Principal diagnosis: Brain tumour

Additional diagnosis: Nil

If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code.

### EXAMPLE 3:

A patient is admitted for treatment of recurrent seizures caused by a brain tumour diagnosed 3 months previously.

Principal diagnosis: Seizures

Additional diagnosis: Brain tumour

It seems that coders are often confused by the terms 'secondary to' and 'due to', and have difficulty applying the Principal Diagnosis definition when these terms are used. Clinicians may also use the terms interchangeably.

It may be helpful to refer to the dictionary meanings of 'secondary' and 'due'. The following quotes are taken from the Cambridge International Dictionary of English (online).

## **secondary** (COMING AFTER)

\* **developing from something similar that existed earlier**

*The drug is not very effective against AIDS, though it may be used to treat secondary viral infections.*

## **secondary** (LESS IMPORTANT)

\* **less important than related things**

*Her health is what matters - the cost of the treatment is secondary*

## **due** (RESULTING)

\* **due to, as a result of, caused by; because of**

And from Dorland's Illustrated Medical Dictionary:

## **Secondary**

*\* second or inferior in order of time, place or importance, derived from or consequent to a primary event or thing.*

From these definitions it may appear that documentation of 'secondary to' in the record means 'coming after', while documentation of 'due to' means 'resulting from'.

'Secondary to' describes the development of a new condition or a quantum leap in the severity of progress of an existing condition.

'Due to' means a problem that arises from an existing condition, and would be an expected or normal development for a patient with that particular condition.

These definitions are difficult to apply consistently and so it may be better to think of these terms in the following way:

**'secondary to'** = a phrase that refers to two or more independent conditions that are inter-related in this particular patient, one having been exacerbated by, and 'coming after' the other.

**'due to'** = a condition that could not have occurred without the other condition having existed first in this particular patient. One is a direct result of the other.

When these terms are used, it is important that coders consider the conditions independently of each other. The patient has two or more conditions, which one is the principal diagnosis?

**It is not a question of which came first, it is a question of which one *occasioned* the episode of care in hospital (ACS 0001).**

Examples:

The following examples represent the documentation that appears in the medical records. The terms 'due to' and 'secondary to' have been used interchangeably by the clinicians but the interpretation has been made in light of the definitions described above.

- *Renal failure secondary to gastroenteritis* = coming after. The renal failure is 'coming after' the gastroenteritis. This is not renal failure with an underlying condition of gastroenteritis. It is a patient who had gastroenteritis and now has renal failure (and has probably has dehydration as well). Even though the gastroenteritis came first, the renal failure occasioned the episode of care.

*Principal Diagnosis:* Renal failure

*Additional Diagnoses:* Gastroenteritis only if it meets criteria for additional diagnoses

- *Ascites due to liver disease* = resulting from, a direct result, caused by. This is clearly a patient with a condition that is a direct result of another condition, and that would not have occurred without the underlying condition being present – a presenting problem with an underlying cause.

*Principal Diagnosis:* Ascites (presuming that the liver disease is not treated)

*Additional Diagnoses:* Liver disease in accordance with ACS 0001 *Principal diagnosis*, underlying condition

- *Obstructive jaundice due to liver metastasis* = resulting from, a direct result, caused by.

This is clearly a patient with a condition that is a direct result of another condition, and that would not have occurred without the underlying condition being present – a presenting problem with an underlying cause.

*Principal Diagnosis:* Obstructive jaundice (presuming that the liver metastasis is not treated)

*Additional Diagnoses:* Liver metastasis in accordance with ACS 0001 *Principal diagnosis*, underlying condition

- *Vasovagal secondary to ear pain* = coming after. This patient has two problems. The ear pain came first but did not occasion the episode of care. The vasovagal attack came second but was actually the condition that occasioned the episode of care.

*Principal Diagnosis:* Vasovagal

*Additional Diagnoses:* Ear pain only if it meets criteria for additional diagnoses.

- *Addisonian crisis/hypoglycaemia due to gastroenteritis* = coming after. Again this patient has two problems – the gastroenteritis came first but did not occasion the episode of care. The Addisonian crisis/hypoglycaemia came second and was the condition(s) that occasioned the episode of care.

*Principal Diagnosis:* Addisonian crisis/hypoglycaemia

*Additional Diagnoses:* Gastroenteritis only if it meets criteria.

Whichever of the first two conditions is not sequenced as principal diagnosis

- *Oesophageal obstruction due to carcinoma of oesophagus* = resulting from, a direct result, caused by. This is clearly a patient with a condition that is a direct result of another condition – a presenting problem with an underlying condition.

*Principal Diagnosis:* Oesophageal obstruction (presuming that the carcinoma of the oesophagus was not treated)

*Additional Diagnoses:* Carcinoma of oesophagus in accordance with ACS 0001  
*Principal diagnosis, underlying condition*

- *CCF due to AMI* = coming after. There are two conditions co-existing in the same patient, one has exacerbated the other, however they could have existed independently of one another.

*Principal Diagnosis:* *CCF, if the AMI had occurred, was diagnosed and treated previously.* If both are new diagnoses in this admission, choice of principal diagnosis depends on circumstances of admission (treatment etc), in accordance with ACS 0001 *Principal diagnosis*

*Additional Diagnoses:* The condition which is not principal diagnosis if it meets additional diagnoses criteria.

#### **Direction For Coders:**

When the terms 'secondary to' or 'due to' are used, consider the conditions as two or more separate conditions and apply principal diagnosis definition.

It is important to remember that clinicians may use these terms interchangeably and there will be circumstances when applying the following guidelines as strict rules, will result in incorrect coding. The coder must also apply the Clinical Coder's Creed to help in making a good coding decision. See Appendix D, page 293, Volume 5 ICD-10-AM.

#### ***In most scenarios, however, coders will be able to apply the following guidelines:***

When a condition is 'secondary to', the coder ***should not apply*** the underlying condition part of the principal diagnosis standard. The decision for principal diagnosis should simply be based on the condition that occasioned the episode of care.

When a condition is 'due to', the coder ***should apply*** the underlying condition aspect of the principal diagnosis standard and assign the presenting condition as principal diagnosis if the underlying condition is already identified and not treated during the current episode of care.

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# Intra Ocular Lenses Revisited

Author: Evelyn Robinson, Peninsula Health

Below is an expanded version of the feature last published in *November 2000* on intra-ocular lenses. Many thanks to those people who have contacted HDSS when they have discovered a new lens being used in their facility.

ICD-10-AM codes for insertion of intra-ocular lens specify whether the lens is *foldable*, or *rigid*. The following list provides brand names and model numbers, and advises whether each lens is rigid or foldable. Note that some brands produce both types of lenses, thus it is important to check the model number as well as the brand name.

<b>RIGID LENSES</b>			
<b>Brand</b>	<b>Model number</b>	<b>Brand</b>	<b>Model number</b>
Alcon	CP10BG	Alcon	MZ60MD
Alcon	CVCIU	Alcon	MZ60PD
Alcon	CZ70BD	Alcon	SK61CM
Alcon	LC80BD	Allergan*	AC51
Alcon	LX10BD	Bausch & Lomb	95BUV
Alcon	LX90BD	Chiron	SP38UB
Alcon	MC50BD	Chiron	6441B
Alcon	MC50BM	Chiron	6741B
Alcon	MC51BM	Chiron	C31UB
Alcon	MC60BD	Pharmica	722C
Alcon	MC60CM	Storz	P359UV
Alcon	MTA3U	Storz	P525UV
Alcon	MTA4U	Storz	68UV
Alcon	MTA4UO	Storz	95BUV
Alcon	MTA5U	Storz	121UV
Alcon	MZ20BD	Storz	121BUV
Alcon	MZ30BD	Storz	P359BUV
Alcon	MZ60BD		

<b>FOLDABLE LENSES</b>			
<b>Brand</b>	<b>Model number</b>	<b>Brand</b>	<b>Model number</b>
Alcon	MA30AC	Alcon	SA60AT
Alcon	MA30BA	Allergan*	All models except AC51
Alcon	MA50BM	Bausch & Lomb	C11UB
Alcon	MA60AC	Chiron	C11UB
Alcon	MA60BM	Chiron	LI61U
Alcon	MA60MA	Staar	All models
Alcon	MZ30	Storz	H60M
Alcon	SA30AL		

<b>ALL LENSES</b>					
<b>Brand</b>	<b>Model number</b>		<b>Brand</b>	<b>Model number</b>	
Alcon	CP10BG	Rigid	Alcon	MZ60MD	Rigid
Alcon	CVCIU	Rigid	Alcon	MZ60PD	Rigid
Alcon	CZ70BD	Rigid	Alcon	SA30AL	Foldable
Alcon	LC80BD	Rigid	Alcon	SA60AT	Foldable
Alcon	LX10BD	Rigid	Alcon	SK61CM	Rigid
Alcon	LX90BD	Rigid	Allergan*	AC51	Rigid
Alcon	MA30AC	Foldable	Allergan*	All models except AC51	Foldable
Alcon	MA30BA	Foldable	Bausch & Lomb	95BUV	Rigid
Alcon	MA50BM	Foldable	Bausch & Lomb	C11UB	Foldable
Alcon	MA60AC	Foldable	Chiron	6441B	Rigid
Alcon	MA60BM	Foldable	Chiron	6741B	Rigid
Alcon	MA60MA	Foldable	Chiron	C11UB	Foldable
Alcon	MC50BD	Rigid	Chiron	C31UB	Rigid
Alcon	MC50BM	Rigid	Chiron	LI61U	Foldable
Alcon	MC51BM	Rigid	Chiron	SP38UB	Rigid

<b>ALL LENSES</b>					
<b>Brand</b>	<b>Model number</b>		<b>Brand</b>	<b>Model number</b>	
Alcon	MC60BD	Rigid	Pharmica	722C	Rigid
Alcon	MC60CM	Rigid	Staar	All models	Foldable
Alcon	MTA3U	Rigid	Storz	121BUV	Rigid
Alcon	MTA4U	Rigid	Storz	121UV	Rigid
Alcon	MTA4UO	Rigid	Storz	68UV	Rigid
Alcon	MTA5U	Rigid	Storz	95BUV	Rigid
Alcon	MZ20BD	Rigid	Storz	H60M	Foldable
Alcon	MZ30	Foldable	Storz	P359BUV	Rigid
Alcon	MZ30BD	Rigid	Storz	P359UV	Rigid
Alcon	MZ60BD	Rigid	Storz	P525UV	Rigid

\* Allergan is also now known as Advanced Medical Optics.

This list will be updated and republished as required. Please send the brand name/s, model number/s and identify whether the lens is foldable or rigid, for any additional lenses not currently listed, to the HDSS Help Desk.

# ICD-10-AM eBook, 3M Codefinder and other electronic tools: Referencing the VICC Coding Newsletter

Author: Catherine Perry, HDSS, Department of Human Services

NCCH has released a new product, the 'ICD-10-AM Third Edition eBook', which is the browser with additional features comprising the *Coding Matters* '10-AM Commandments'. Codes are hyperlinked to relevant articles.

Another feature of the ICD-10-AM e-Book is a facility for users to attach relevant documents or to add their own comments. The eBook has been designed to allow notes and attachments to be transportable as ICD-10-AM eBook updates are issued.

3M Codefinder also has the ability for you to add your own notes. Once you have added your text message to a code, block number or Coding Standard, the software flags this for future reference. The ability to print out the notes you have added will assist in maintaining the notes.

One source of additional material that Victorian users could incorporate into the ICD-10-AM eBook and/or 3M Codefinder is the *Victorian Coding Newsletter*. Coders will already be aware that recent editions of the *Victorian Coding Newsletter* are available on the web at:

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

## How to add information from the Victorian Coding Newsletters

These files are in PDF format. Use the following instructions to cut and paste from PDF files to other documents:

- 1 Open the file from which you wish to take information.
- 2 Go to the section that you wish to copy the information from. Click on the 'Text Select Tool' button.
- 3 Use the mouse to highlight the area you wish to copy. Right click to select copy.

This block of information can then be either:

- Pasted directly into the desired program, such as the ICD-10-AM eBook or 3M Codefinder, or
- Used to create a separate document pertaining to a specified subject, which can be hyperlinked or referenced, in one of these applications. This may be a better approach where there is a large amount of information.

## **Guidelines when using references in electronic tools**

When adding references in tools such as the ICD-10-AM eBook and the 3M Codefinder, the following minimum guidelines should be followed to ensure consistency of use amongst users at a site, and for later data abstraction:

- Cite reference (eg May 2002 Vic Coding Newsletter), date, and initials of person adding the reference.
- Ensure where networked, that all users are aware when new information is added. Note that the ICD-10-AM eBook cannot be networked.
- When there are changes to ACS, State or National library files or version of DRGs and the like, ensure that references are checked and either amended or noted to be no longer valid. (If removing references, keep a register of when particular rules were applicable, in case required for abstraction of data at a later date).

# ***List of Selected ICD-10-AM***

## ***Coding Queries***

The Victorian ICD Coding Committee (VICC) 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, in response to individual coding queries. The Committee's advice printed in this section of the newsletter should be adopted immediately unless an alternative introduction date is stated. Unless otherwise stated, there is no expectation that coders should review similar episodes already coded. It is acknowledged that this might result in a year's data containing episodes coded in a non-standard way.

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## #1646      **Dissection of coronary artery during angioplasty**

Which code sequence is appropriate to describe scenarios where the dissection occurs *during* the angioplasty and requires multiple stent insertions to 'fix' the dissected segment of the vessel?

Possible codes discussed are

**T81.8**                    *Other complications of procedures, not elsewhere classified*

**T81.2**                    *Accidental puncture and laceration during a procedure, not elsewhere classified*

Or

**T81.7**                    *Vascular complications following a procedure, not elsewhere classified*

With

**I99**                      *Other and unspecified disorder of circulatory system*

**Y65.8**                    *Other specified misadventures during surgical and medical care*

**Y92.22**                    *Health Service Area (Place of Occurrence)*

This query was referred to the NCCH for consideration. Their response was:

As the dissection meets the definition of a misadventure (occurring during medical or surgical care), it is classified using a diagnosis code from T80-T88 *Complications of surgical and medical care, NEC* and an external code from block Y60-Y69 *Misadventures to patients during surgical and medical care* (as per ACS 1904 *Procedural complications*). A code from block Y70-Y82 *Medical devices associated with misadventures in diagnostic and therapeutic use* is not appropriate as it is not clear whether the device or the operative technique caused the dissection.

In view of the above, the most appropriate codes for this scenario are:

T81.7    *Vascular complications following a procedure, not elsewhere classified,*

Y65.8    *Other specified misadventures during surgical and medical care* and

Y92.22    *Health service area.*

The VICC agreed with the advice provided by the NCCH, which is in accordance with ACS 1904 *Procedural complications*.

## #1655 Diabetes with Renovascular Disease

For diabetes with renovascular disease and chronic renal failure, should we code:

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

**I12.0**                    *Hypertensive renal disease with renal failure*

Or is this double coding?

If the record demonstrates that the renal failure is due to the diabetes, or if no aetiology is documented, code:

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

**I12.0**                    *Hypertensive renal disease with renal failure*

If the renal failure is due to the renovascular disease, then it cannot be attributed to the diabetes. There is no index entry for Diabetes, with, renovascular disease or hypertensive renal disease. Therefore coders should use the following codes:

**I12.0**                    *Hypertensive renal disease with renal failure*

**E11.9**                    *Type 2 diabetes without complication*

## #1706 Donor lymphocyte infusions

We have patients admitted on a day stay basis for Donor Lymphocyte Infusions (DLI), and are unsure what procedure code to use.

We found advice on the NCCH query database that quoted the submitting hospital's Oncologists who advised the use of the following code as the product is donated to the patient in order for it to grow/multiply etc. The analogy was made that classification of such cases is similar to stem cell transplantation.

**13706-00 [802]**                    *Allogeneic bone marrow or stem cell transplantation, matched related donor, without in vitro processing*

NCCH acknowledged that a code did not exist in ICD-10-AM first edition, and that this would be reviewed for the 2nd edition. There still does not seem to be an appropriate code to use.

Using the above code groups to a Bone Marrow Transplant DRG, albeit with a same day weight.

The VICC forwarded this to the NCCH. Their response was:

If a patient who has had an allogeneic bone marrow transplant has a relapse, with return of the original disease, they may be given lymphocytes from the original stem cell donor. This procedure, called donor lymphocyte infusion requires that the original donor undergo a leukopheresis procedure unless the donor's lymphocytes were previously taken and stored at the time of the allogeneic bone marrow transplant. Donor leukocyte infusions have been used for a variety of haematologic malignancies, including most prominently chronic myeloid leukaemia, but also acute myeloid leukaemia, acute lymphocytic leukaemia, multiple myeloma, myelodysplastic syndromes, chronic lymphocytic leukaemia, Hodgkin's disease, and non-Hodgkin's lymphoma.

The advice given in NCCH Query 796 is still valid; the correct code for this procedure is 13706-00 [802] *Allogeneic bone marrow or stem cell transplantation, matched related donor, without in vitro processing*.

## **#1729      Insertion of CVCs**

Should we be routinely coding insertion of a Central Venous Catheter (CVC)? There is inconsistency amongst us, so no doubt amongst all coders!

Is the decision different according to where it is inserted, eg in ICU; in ED (perhaps by the Trauma Team consisting of an anaesthetist and ICU staff); in the ward; in theatre? What if it needs an anaesthetic?

ACS 0045 *Drug delivery devices* tells you how to code them, but not when.

The insertion of central venous catheters and similar drug delivery devices (eg peripherally inserted central catheters) should be coded once only per episode of care, unless an anaesthetic is administered to perform the procedure, or the procedure involves two or more sites.

The advice is in accordance with revisions to ACS 0020 *Multiple/Bilateral Procedures for ICD-10-AM Third Edition*. [Query submitted whilst using 2<sup>nd</sup> edition].

## #1734      **Radical excision of intra-oral tumour**

62 year old male with Squamous Cell Carcinoma - floor of mouth.

Operation Report: excision of floor of mouth lesion, R & L supra-oro-hyoid neck dissection.

Findings: 2x2 cm lesion in midline undersurface tongue/FOM. Tumour not extending to gingiva.

Procedure: Intra-oral excision of lesion with 1cm margin all around clinically. Primary closure – small area left raw. R&L supra-hyoid neck dissection – levels I, II & III dissected. Preservation of SCM, IJV, digastric, carotids R&L. Good haemostasis. Closure 3/0 Vicryl/staples over 2x10F drains.

Histopathology confirms SCC of floor of mouth. No metastases in 12 lymph nodes from R neck. No metastases in 11 lymph nodes from L neck.

### **30275-00 [403]      *Radical excision of intra-oral tumour***

The above code appears to cover the whole procedure. The 'includes' note states 'resection of lymph node' (although this is singular).

The index gives no indication under Excision, lymph node, neck, nor the tabular under the lymph node excision blocks that 30275-00 includes the LN excision.

For codes C04.9 and 30275-00, the DRG assigned is D08Z *Mouth procedures*. This has a range of 0-4 days and an inlier weight of 0.5549. This patient stayed 4 days and had no complications.

If 30328-00 [806] Radical excision of lymph nodes of neck is added to the above codes, the DRG assigned is D02B *Head and neck procedures*, with trim points of 0-10 days and inlier weight of 1.1063.

MBS 30275 has a fee of \$1,271.50 in the 1994 Medicare Benefits Schedule Book. Other MBS items in DRG08Z include e/o cyst of mouth (\$147.65); biopsy of tongue/soft palate etc (\$108); closure of fistula of mouth (\$183.20).

My issues are:

- 1 Is 30275-00 [403] the only code required and the correct code for this procedure?
- 2 Could the index and tabular be improved for the lymph node component of this code?
- 3 If 30275-00 [403] is the only code required, could its DRG placement be reviewed?

Committee noted that there appears to be a typographical error in the includes note for:

### **30275-00 [403]      *Radical excision of intra-oral tumour***

Although the notes refers to the singular 'resection of lymph **node**', the term **nodes**, being plural, is in the Index and would therefore be the correct code to assign in the above scenario.

Index look-up:

**Excision**

- tumour
- - intra-oral
- - - malignant 31400-00 [421]
- - - radical (with excision of lymph nodes of neck) (with resection of mandible) 30275-00 [403]

**Answers**

- 1 Yes, 30275-00 [403] is the correct and only code required for this procedure.
- 2 The NCCH has been asked to improve the index and tabular text, for the lymph node component of the above code and to further define the degrees of lymph excision.
- 3 The Commonwealth will be asked to review the DRG placement for the above code. The suggestion of D02B *Head and neck procedures* is probably correct.

**Exerpt from NCCH Response**

Please note, the Commonwealth will be asked to review the DRG placement for the above code, suggesting that D02B Head and neck procedures is probably correct. The other suggestions regarding the index entry and description for this code have been noted and will be included in the work programme for ICD-10-AM Fourth Edition.

**#1748 Revision/re-operation of vascular procedures**

- 1 Can ACS 0934 *Cardiac Revision/Re-operation Procedures* be applied to peripheral vascular revision/re-operation procedures?
- 2 Patient admitted for redo femoral-popliteal bypass in May 2001 with a diagnosis of ischaemic leg secondary to thrombosed/blocked bypass graft. The original bypass surgery was done in 1994. Should the principal diagnosis be an 'I' code or a 'T' code?

- 1 ACS 0934 *Cardiac revision/re-operation procedures* may only be applied to *cardiac* procedures. Please refer to the previous NCCH query and response (Q1370), which addresses this same issue, and confirms that the guidelines in ACS 0934 *Cardiac revision/re-operation procedures* will not always apply in the case of vascular disease of other sites. These guidelines were developed by the Cardiothoracic surgeons on the Cardiovascular CCCG and apply only to cardiac revision procedures and not to vascular grafts other than coronary.
- 2 If there is a causal relationship documented between the condition and the previous vascular surgery involving peripheral vessels, then the condition should be coded as a complication, otherwise it should be coded as progression of the disease. (The time frames suggested in ACS 0934 *Cardiac revision/re-operation procedures* do not apply in the case of peripheral vascular revision procedures.)

## #1755 Post-caesarean babies

This query relates to ACS 1609 *Maternal Causes of Perinatal Morbidity and Mortality*.

Do we have to use code:

**Z76.2**                    ***Health supervision and care of other healthy infant and child***

for all post-caesarean babies, because:

**Z38.0**                    ***Singleton, born in hospital***

does not indicate at all that the baby was a caesarean birth.

The Committee notes when coding episodes of babies admitted to Special Care Nursery (SCN), including those admitted post-caesarean, a **warning** edit (403) is triggered in PRS/2 when Z38.0 is the only Diagnosis Code entered.

December 2000 *Coding Matters*, page 14, contains an explanation of codes from the following range: P00-P04 *Newborn affected by maternal causes*. See below for excerpt.

‘If the mother has a condition or complication of labour or delivery that does *not* cause any adverse effect to the baby:

- do *not* assign a code from P00-P04 on the baby’s record
- if the maternal cause has necessitated provision of more health services than is usual for a newborn, it may be appropriate to assign Z76.2 *Health supervision and care of other healthy infant and child* (for example, in the case of post-caesarean observation) or Z03.8 *Observation for other suspected diseases and conditions*.’

To answer the query fully:

Z76.2 *Health supervision and care of other healthy infant and child* should be assigned for those babies who are in the SCN for post-caesarean observation with no other diagnosis. It should not be added routinely for *every* baby who is delivered by caesarean section. There is no need to specify this on the baby’s record.

## #1762      **Autopsy findings**

While coding a deceased diabetic patient's record, the Autopsy Report noted a number of findings, including arteriosclerosis. The patient's diabetic status was known prior to death but the arteriosclerosis was only found on autopsy.

Should codes be assigned in accordance with ACS 0401 *Diabetes Mellitus*? We are unsure if it is correct to assign diabetic complication codes when the conditions are found at autopsy, only documented on the Autopsy Report, and not documented on the Discharge Summary or in the body of the admission notes?

This same patient developed shortness of breath during the admission and this was coded; however, the Autopsy Report revealed a pulmonary embolism (PE) and that this was one of the causes of death. PE was documented in the record as a differential diagnosis amongst other diagnoses including respiratory failure secondary to pneumonia. The patient died soon after the shortness of breath developed.

Should I not code shortness of breath and code PE based on the autopsy finding?

Would I code the PE, rather than shortness of breath, if the PE were not documented as a differential diagnosis?

To code a condition noted in an Autopsy Report, it should still meet the criteria set by ACS 0002 *Additional diagnoses*. However, if the Autopsy Report provides further specificity to a condition where the full record already justifies coding, then the Autopsy Report information can be used in selecting the appropriate code.

In the example provided:

- The autopsy finding of arteriosclerosis can be used in assigning the appropriate detailed diabetes code.
- The autopsy finding of pulmonary embolism can be coded as it was in the list of differential diagnoses. That is, it was a query diagnosis confirmed by investigation and documented as cause of death.

## #1766      **Fat graft with spinal surgery**

Patient 41 years of age with sequestered intervertebral disc. Lumbar discectomy, rhizolysis and subdermo fat graft harvested and sutured to fascia to prevent migration was performed.

A majority of these patients do not have the fat graft performed and the admission will group to v4.1 DRG I10B *Other Back and Neck procedures w/o Catastrophic or Severe CC*

When this graft code is included:

**45018-01 [1668]      *Dermofat graft***

the episode groups to v4.1 DRG *I02B Skin graft w/o Catastrophic or Severe CC, excluding hand*

I have been unable to obtain any further information from the treating VMO regarding the appropriateness of the fat graft code, but decided to include it, as usually it is not performed in discectomy patients at our hospital.

The I02B DRG seems inappropriate, given that the patient would normally be grouped to the back procedures DRG, when fat graft is not performed. Please advise if the correct graft code has been used, and if so, your opinion regarding the allocated DRG.

A fat graft is performed at the time of spinal surgery to prevent scarring over the nerve root. The fat may be harvested through the incision used for the laminectomy, or from a separate site remote from the original incision. The information obtained by the Committee indicated that a fat graft is a routine component of spinal surgery - approximately 50% of surgeons routinely perform a fat graft with spinal surgery - therefore, it is not necessary to code the graft itself as a separate procedure.

In cases where the fat is harvested from a separate site, please assign the following code as an additional code.

**30168-00 [1666]      *Lipectomy, 1 excision***

## #1768      **Prefixing Chronic Conditions**

Please clarify the prefixes to be assigned:

Patient was admitted with haematemesis and melaena. He has a history of COAD. Approximately 7 days after admission, he developed an acute exacerbation of COAD requiring treatment (Ventolin nebs, CXR, then finally intubation and ventilation).

How should the acute exacerbation of COAD be prefixed – 'C' or 'P'?

The COAD should be prefixed with a 'P' because the condition was present on admission. An exacerbation of the condition has occurred during the admission but is still prefixed with a P.

## #1772      **Insertion of Artificial Anal Sphincter**

We have started performing a new procedure: insertion of an artificial anal sphincter for chronic faecal incontinence. It involves a prosthesis which is activated by a pump placed under the skin (abdomen) which is patient controlled.

I have spoken to the unit head and he has suggested using the code below, which most closely describes the procedure (except that this uses muscle rather than the prosthesis).

**32209-00 [946]**      *Anal or perineal graciloplasty with insertion of stimulator and electrodes*

The unit head also mentioned there was no MBS code available. The procedure was performed under a spinal anaesthetic.

Is it acceptable to use this code until a specific code is developed?

An appropriate code for this procedure does not exist in the second edition of ICD-10-AM [when query was first submitted].

In the meantime use code

**90316-00 [950]**      *Other procedures on anus*

There is no code in third edition either. Coders should continue using the code suggested until a specific code is provided.

## #1782      **Abscess from injection**

An abscess of left cubital fossa 2° to IV drug use (Heroin). Site of abscess consistent with injection from drug use. Abscess was drained in theatre.

As the admission is for treatment of the abscess, should the coding be in line with ACS 1210 *Cellulitis*? This would mean the PDx is the abscess.

Should there be an injury code also assigned? If it is considered to be a puncture, puncture is indexed to Open Wound.

What external cause code should be assigned? 'Needle' comes under W27 *Contact with nonpowered handtools*, but is that for a sewing needle not a hypodermic needle?

Patients can have episodes with abscess or cellulitis from insulin injection sites. Would these have a different external cause code because it is 'medical care'?

While the injury is described as 'self inflicted' it is doubtful, given the scenario provided, that the intention was to cause self harm. Therefore a code from categories X60-X84 *Intentional self-harm* is inappropriate. Following the external cause index trail, Contact - with - - needle W27.-, assign external cause code W27.-- *Contact with nonpowered handtool*.

Coding of abscess of injection site will differ depending on whether the injection has been a therapeutic or other injection.

Coding of abscess of injection site following medical care (regardless of whether the injection was self administered or administered by a health professional).

**T81.4**                      ***Infection following procedure NEC***

**L02.-**                      ***Abscess***

**Y84.8**                      ***Other medical procedures***

**Y92.22**                    ***Place of Occurrence***

Coding of abscess of injection site following other injection (illicit, recreational, other non-therapeutic drug use).

**L02.-**                      ***Abscess***

**xx.xx**                      ***Open wound of site***

**W27**                      ***Contact with non-powered hand tool***

**Y92.-**                      ***Place of Occurrence***

**Y93.8**                      ***Activity***

## **#1783            Obstetric perineal laceration/tear & episiotomy**

If a patient has both an episiotomy and a perineal laceration/tear (which is subsequently repaired), should the tear (O70.- *Perineal laceration during delivery*), repair of tear and episiotomy all be coded?

Is the decision affected by whether the episiotomy has been extended by a tear or if the tear is extended by the episiotomy?

I have spoken to the NUM of delivery suite who stated the following:

- Episiotomy extended by tear is more common than tear extended by episiotomy
- Episiotomy extended by tear happens when episiotomy is not large enough (usually because baby is bigger than thought to be)
- Both are relatively uncommon
- It is not any harder to repair a tear than an episiotomy
- The same technique is used to repair a tear as an episiotomy

It is stated in the NCCCH specialty booklet (Casemix, DRGs and Clinical Coding – Obstetrics and Gynaecology) p46 that:

If episiotomy is extended by laceration, the laceration needs to be coded to a first, second or third degree tear, depending on the documentation. Similarly, the repair of the laceration is also coded, together with the episiotomy.





## #1791 Infection of tongue stud

We are unsure how to code infected tongue stud and removal of same. The procedure was performed by an oral/maxillofacial surgeon. The operation report states:

Operative diagnosis: Infected tongue stud. Operation performed: R/O FB tongue.

Details of operation: Tongue bolt undone and removed, irrigated.

Specimen to Pathology: No

Please comment on the following:

*D08Z Mouth Procedures* [Vicwt 0.56 ALOS 1.3 Lt 0 Ht 4 Sdwt 0.56 Hioutl wt 0.31, PCCL 0 – SDX is not a CC.....]

<b>S01.54</b>	<b><i>Open wound of tongue and floor of mouth</i></b>
<b>T89.02</b>	<b><i>Open wound with infection</i></b>
<b>K14.0</b>	<b><i>Glossitis</i></b>
<b>Y84.8</b>	<b><i>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</i></b>
<b>Y92.9</b>	<b><i>Place of occurrence</i></b>
<b>90137-00 [394]</b>	<b><i>Other procedures on tongue</i></b>
<b>92502-02 [1910]</b>	<b><i>Intravenous and inhalational general anaesthesia</i></b>

The VICC agreed on the following codes:

<b>S01.54</b>	<b><i>Open wound of tongue and floor of mouth</i></b>
<b>T89.01</b>	<b><i>Open wound with foreign body (with or without infection)</i></b>
<b>K14.0</b>	<b><i>Glossitis</i></b>
<b>W49</b>	<b><i>Exposure to other and unspecified inanimate mechanical forces</i></b>
<b>Y92.9</b>	<b><i>Unspecified place of occurrence</i></b>
<b>Y93.8</b>	<b><i>Other specified activity</i></b>
<b>92078-00 [1897]</b>	<b><i>Removal of foreign body from mouth without incision</i></b>
<b>92502-02 [1910]</b>	<b><i>Intravenous and inhalational general anaesthesia</i></b>

An additional code to describe the infective organism should be assigned where documented.

## #1797      **Vertebroplasty**

Please advise on the following. Advice on coding vertebroplasty was published in Coding Matters Vol 8 (3). The recommendation was to code

**90589-00 [1571]      *Repair of bone, not elsewhere classified***

We are coding this procedure as:

**47684-00 [1381]      *Immobilisation of fracture/dislocation of spine***

This query was referred to the NCCH, and the following advice received:

Vertebroplasty is a relatively new technique that is being used to treat vertebral compression fractures. The procedure involves the injection of a cement-like material (polymethylmethacrylate - PMMA) into the vertebral body to stabilise and strengthen collapsed or crushed bone. Vertebroplasty is a non-surgical procedure performed using fluoroscopic guidance. There is no specific code for this procedure in ICD-10-AM.

A public submission has been received by the NCCH for the creation of a new code for vertebroplasty. This task is currently underway and will be completed for the Fourth Edition of ICD-10-AM.

In the meantime, please assign

***90589-00 [1571]      Repair of bone, not elsewhere classified***

## #1799 Documentation appropriate to clinical discipline

The standards state ‘...in order to assign a code associated with a clinician’s documentation, the documented information must be appropriate to the clinician’s discipline.’ (Introduction to ACS, p xx.)

It is sometimes difficult to determine if certain documentation is appropriate to a clinician’s or health professional’s discipline, especially where medical diagnoses are concerned. Take for example, a patient with hypototassaemia. A nurse documents the hypototassaemia, biochemistry results indicate hypototassaemia, and the patient is commenced on Slow K. According to Coding Query #1735, Coding Newsletter Nov 2001, p32, hypototassaemia is codeable.

However, in a similar scenario, a nurse documents pneumonia, which is supported by X-ray evidence and is treated with appropriate antibiotics, yet most coders would deem the pneumonia as not codeable on the basis that it must be documented by a doctor.

What makes the hypototassaemia codeable, but pneumonia not?

Are there any guidelines that would assist us in deciding which conditions can be deemed codeable when, although not documented by a doctor, are documented by another health professional and which are supported by test results, and by the commencement of treatment? I realise that it is not feasible to provide a list of correlated disciplines and conditions, but any guidance would be appreciated.

In a similar vein, is it possible that some conditions documented by specialty nurses/health professionals may be coded (eg CCU nurses documenting ‘AF’), which would not be codeable when documented by ‘unspecialised’ nursing staff?

The VICC did not agree that, in your scenario, pneumonia would not be coded, without considering other factors.

The Committee feels that a few points need to be made in order to satisfactorily answer this query:

- It is well recognised that, as coders, we are constantly required to make decisions based on unclear and inadequate documentation, and as such, have to draw on other resources in order to make difficult decisions.
- As stated previously (and by the inquirer), it is not feasible to provide a list of correlated disciplines and conditions.
- The term ‘clinician’ is now used in a broader sense than just meaning ‘doctor’ and can be expanded to include other health professionals.
- Coders should apply the Clinical Coders Creed, found in Appendix D of the Australian Coding Standards.

Therefore, if the condition is documented clearly as a diagnosis, and all knowledge and skills have been applied, with consideration of the above points, the condition should be deemed codeable.

## #1801 Anaemia with Tubular Adenoma

A patient undergoes a colonoscopy for the investigation of anaemia. One of the findings includes a polyp of the sigmoid colon, which is snared and sent to anatomical pathology. The pathology result shows that the polyp is actually a tubular adenoma. No findings are reported to have caused the anaemia.

What is its correct code assignment?

**D12.5**                    *Benign neoplasm of sigmoid colon*

**M8211/0**                *Tubular adenoma NOS*

**D63.0**                    *Anaemia in neoplastic disease*

Or

**D64.9**                    *Anaemia, unspecified*

**D12.5**                    *Benign neoplasm of sigmoid colon*

**M8211/0**                *Tubular adenoma NOS*

We believe the first option to be correct, in accordance with the aetiology and manifestation convention, which includes anaemia in neoplastic disease. However, it would seem that the polyp is an 'incidental finding' and therefore a relationship should not be assumed in this scenario.

The Committee acknowledged that anaemia is unlikely to be related to a *benign* neoplasm, and referred this issue to the NCCH, suggesting a review of the use of D63.0 *Anaemia in neoplastic disease*.

NCCH's response was:

This case is a good example of where the Clinical Coders Creed (Volume 5, p 293, Third Edition) should be applied. ACS 0046 *Diagnosis selection for same-day endoscopy* provides guidance on the selection and sequencing of codes for same-day endoscopy patients. In cases, such as the one described, where a causal link between symptoms and findings is neither established nor ruled out, coders are asked to apply the Clinical Coders Creed. The Victorian Coding Committee has done this as per the statement "the Committee acknowledges that anaemia is unlikely to be related to a benign neoplasm". The correct codes in this case are:

**D64.9**                    *Anaemia, unspecified*

**D12.5**                    *Benign neoplasm of sigmoid colon*

**M8211/0**                *Tubular adenoma NOS*

The code D63.0\* *Anaemia in neoplastic disease* with the inclusion term of 'Conditions in Chapter II (C00-D48)' has not been modified from ICD-10. It encompasses all

neoplasms (malignant, in-situ, benign and uncertain or unknown behaviour) as it is feasible that in some cases, a neoplasm other than a malignant neoplasm, may be linked to anaemia. It would therefore be impossible for the NCCH to list under the code D63.0\* *Anaemia in neoplastic disease* each neoplasm to which this code applied in all scenarios or to change the advice in ACS 0207 *Complications associated with neoplasms* to cover all circumstances.

## #1803 Heterotopic bone

For 'Heterotopic' bone the index instructs 'see also Malposition, congenital'.

Our surgeons say that when they write heterotopic bone, they mean heterotopic ossification of bone. This is an acquired condition that is *almost* the same as Myositis ossificans (M61.5x).

Do you consider the use of M61.5x to be appropriate in these cases? Any other suggestions?

Initial research indicated that heterotopic bone is an overgrowth of bone developing in the joint space, often occurring following bone surgery.

The index entry for 'heterotopic' does not provide for this condition. The Committee thought that 'Ossification' would be a suitable alternative, but referred this query to the NCCH, who provided the following advice:

Heterotopic ossification (HO) is the abnormal formation of bone within extraskeletal soft tissues. Historically, many diseases that shared this feature were classified under the category of myositis ossificans. This term is not commonly used now by the medical profession because primary muscle inflammation is not necessarily a precursor and ossification does not always occur in muscle tissue. It may also occur in fascia, tendons and other soft tissues. There are a number of different causal factors including post-traumatic, postprocedural and neurogenic.

This condition is a good example of the changing nature of medical vocabularies. The NCCH will include a task for the updating of terminology related to heterotopic ossification for a future edition of ICD-10-AM.

The NCCH agrees with the [following] advice given by the Victorian Coding Committee for the interim.

When coding heterotopic ossification, coders should refer to the index under 'Ossification'. The site will determine the correct code assignment. For example, if the heterotopic bone involves ligament, assign

**M67.8-                      *Other specified disorders of synovium and tendon***

If the site is not specified under 'Ossification', look up 'Disorder' by site. For example, if the heterotopic bone involves soft tissue, assign

**M79.9-                      *Soft tissue disorder, unspecified***

## #1806      **Stabilisation / reconstruction of shoulders**

I am concerned when coding shoulder stabilisation/reconstructions, both open and closed. These patients mainly have a diagnosis of shoulder instability; however, surgeons will often document a reconstruction as opposed to a stabilisation. In addition to this, they use an MBS item number for stabilisation (although I note that there is no **open** shoulder reconstruction available to them). I have written to our surgeons asking them to modify their documentation; however, they regard stabilisation to be done by reconstruction anyway, hence I have had limited success getting correct documentation.

If I strictly follow the index, I feel that my data will be inaccurate.

In the case of shoulder instability (or a lesion causing instability) could we please be instructed to default to a stabilisation procedure code even if reconstruction is documented?

This brings me to my next dilemma of coding *open* stabilisation of shoulders. Once more I have sent numerous requests to please specify if stabilisation is for multi directional stabilisation or for recurrent dislocation. Could we please have a default when no further information is available? Apparently, if there is a capsular shift, then it is a multi directional stabilisation; also multi directional stabilisation seems to be the most common MBS item number used when the diagnosis involves a Bankart lesion. Do others find this too?

When a patient is diagnosed with shoulder instability, and the procedure is documented as 'stabilisation' of shoulder, coders should follow the index trail:

### **Stabilisation**

- joint (see also Arthrodesis) 50106-00 [1571]  
- - shoulder

There is no default at this point – however, the NCCH has confirmed that, where 'stabilisation of shoulder' is documented, with no further information, assign '48930-00 [1404] Stabilisation of shoulder for recurrent dislocation'.

- - - recurrent dislocation (anterior) (open) (posterior) 48930-00 [1404]

### **48930-00 [1404]      *Stabilisation of shoulder for recurrent dislocation***

If a patient is diagnosed with shoulder instability, and the procedure is documented as 'reconstruction' of shoulder (as opposed to 'stabilisation'), coders should follow the index trail:

### **Reconstruction**

- joint — see also Arthroplasty (if the procedure is not 'arthroscopic')  
- - shoulder  
- - - arthroscopic (closed) (with acromioplasty) (with resection of acromioclavicular joint) (with rotator cuff repair)  
48960-00 [1405]

### **48960-00 [1405]      *Arthroscopic reconstruction of shoulder***

**Arthroplasty** (see also Repair, joint) 50127-00 [1571]  
- shoulder NEC 90533-00 [1404]

**90533-00 [1404]      Other repair of shoulder**

## #1807      **Chondropathy of knee**

As the term chondropathy is often used in our arthroscopic knee reports, and is not well handled by the index, we sought advice as to its meaning. We were given the following definition of chondropathy of knee by an orthopaedic surgeon and have been coding this condition as follows:

Type I	chondromalacia M94.26 (excludes patella M22.4)
Type II	splits in cartilage M94.26
Type III	cartilage loss M94.26
Type IV	M17.1 (Osteoarthritis, underlying bone is visualised)

The first three types were considered to be varying degrees of chondromalacia.

As this does not strictly follow the index should we be using these codes? If not, following the definition codes provided by the index would be:

**M94.96                      *Unspecified disorder of cartilage***

Or

**M94.86                      *Specified disorder of cartilage***

Please advise us as to what code we should use.

From our research on the topic of 'chondropathy', it seems that there is no consensus amongst clinicians on the classification as proposed in your query.

Without further details of the type of chondropathy, reference should be made to ACS 0013 'Other' and 'unspecified' codes, p17:

'When a clinician uses terminology which cannot be found in ICD-10-AM, seek clarification for alternative terms which are available in ICD-10-AM. If no other description is provided then one of the following strategies should be employed.' (see Example 3)

**EXAMPLE 3:****Diagnosis:** Polyp of oesophagusCode: K22.8 *Other specified diseases of oesophagus*

In this example the main term 'Polyp' in the index does not include a sub-term of 'oesophagus'. To find the correct code assignment, next search the index for 'Disease, oesophagus, specified NEC', which indicates code K22.8 *Other specified diseases of oesophagus*.<sup>1</sup>

The correct codes as determined by consulting the index:

**Disease**

-cartilage M94.9-

--specified M94.8-

Therefore, the following code would be correct:

***M94.86***                      ***Other specified disorders of cartilage - knee***

## #1809      **Birmingham Hip Resurfacing**

Please clarify coding of a hip replacement using Birmingham Hip Resurfacing prosthetics. Our orthopaedic surgeons regard this as a total hip replacement, and since the procedure involves both acetabular and femoral components, we have coded it as a total hip replacement. Is this correct?

All the advice received and information sourced regarding this procedure indicates that it is appropriate to code it as a total hip replacement. Where 'Birmingham hip resurfacing' is documented, please assign either

**49318-00 [1489]**            ***Total arthroplasty of hip, unilateral***

Or

**49319-00 [1489]**            ***Total arthroplasty of hip, bilateral***

The NCCH will consider changes to block 1489 for the Fourth Edition of ICD-10-AM, in relation to this procedure.

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<sup>1</sup> Extracted from NCCH ICD-10-AM, July 2002, General Standards for Diseases.

## #1810 Drug, Alcohol & Tobacco Use Disorders

I need some assistance with the use of ACS 0503 *Drug, Alcohol and Tobacco Use Disorders*. ACS 0002 *Additional diagnoses* (3rd edition of ICD-10-AM) includes ACS 0503 *Drug, alcohol and tobacco use disorders* as a standard for which conditions are not required to meet additional diagnoses criteria.

My question is, when you have IV drug user ticked on an admission form, do you code it to **Z72.2 Drug use**, or even if it is stated on the history, do you code it to **Z72.2?** Or do we just code drug use disorder or drug abuse when these are documented in the record?

The section of ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* to which the inquirer is referring is as follows:

“The following standards are examples of where the coder is instructed to code conditions which do not meet the additional diagnoses criteria. Such instructions must be followed.

.....

- 0503 drug, alcohol and tobacco use disorders”

Coders must not mistake the titles of these standards listed on page 10 as an instruction to ‘always code’. The title must be viewed as an instruction to *consult* the standard, in order to decide whether conditions should or shouldn’t be coded.

In this specific case, ACS 0503 *Drug, alcohol and tobacco use disorders* should be consulted in order to decide on the coding of ‘drug use’. On page 106, under the subheading of ‘Tobacco Use Disorders’ it is stated that ‘these codes should be assigned as additional diagnoses for all cases where appropriate documentation is provided regarding tobacco consumption.’ This same statement is not made about drug or alcohol use disorders, and so these conditions must comply with ACS 0002 *Additional diagnoses*. A tick box, or simple statement ‘drug user’ would not meet these requirements.

## #1811 Infection/Cellulitis of IV site: Drug User

Patient admitted with cellulitis of forearm after self-injecting IV heroin. The IV site has become infected.

I have noted the Vic Coding Newsletter November 2001 #1703 Infected IV site: T80.2 or T82.7. However, this query explains infection of a therapeutic device, but not an IVDU site – heroin dependence.

1. Should we code cellulitis of forearm post IVDU to **L03.10 *Cellulitis of upper limb***, with the drug use code or another code?
2. How would you code the same scenario but only infected IV site (drug user) noted, where no cellulitis has developed?

### Answer to Question 1:

To determine principal diagnosis, refer to ACS 1210 *Cellulitis*.

If the principal diagnosis is determined to be cellulitis, the correct code assignment would be:

**L03.10**                      ***Cellulitis of upper limb***

**S51.-**                         ***Open wound of forearm***

**T89.0-**                        ***Complications of open wound***

**Y28.2\***                      ***Contact with hypodermic needle and syringe, undetermined intent***  
(ACS 2005 *Poisonings and injuries – indication of intent* instructs coders to use this code for self-inflicted injury, where there is no stated or implied intent.)

Or

**X78.2\***                      ***Intentional self-harm by hypodermic needle and syringe*** (where there is stated or implied intent to self-harm)

Or

**W27\***                         ***Contact with nonpowered hand tool*** (if injury is described as 'accidental')

**Y92.-**                        ***Place of Occurrence***

**U73.8**                        ***Other specified activity***

\* Choose appropriate external cause code.

Include code for drug use if meets ACS 0002 *Additional Diagnoses*.

**Answer to Question 2:**

**S51.-**                    ***Open wound of forearm***

**T89.02**                    ***Open wound with infection***

**Y28.2\***                    ***Contact with hypodermic needle and syringe, undetermined intent***  
(ACS 2005 *Poisonings and injuries – indication of intent* instructs coders to use this code for self-inflicted injury, where there is no stated or implied intent.)

Or

**X78.2\***                    ***Intentional self-harm by hypodermic needle and syringe*** (where there is stated or implied intent to self-harm)

Or

**W27\***                    ***Contact with nonpowered hand tool*** (if injury is described as 'accidental')

**Y92.-**                    ***Place of Occurrence***

**U73.8**                    ***Other specified activity***

\* Choose appropriate external cause code.

Include code for drug use if meets ACS 0002 *Additional Diagnoses*.

## **#1815      Pleural effusion**

When should pleural effusion be coded? Specifically, in a patient with pneumonia, should/can pleural effusion be coded?

In a *Coding Matters* article about Congestive cardiac failure (Volume 7, No. 3, page 11), it states that pleural effusion is not to be coded unless specific treatment, eg drainage, is required.

The Specialty book describes pleural effusion but offers no coding advice. There are no queries that I could find on the NCCH query database.

According to ACS 0002 *Additional Diagnoses*:

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- therapeutic treatment
- diagnostic procedures
- increased nursing care and/or monitoring

For example, if a pleural effusion is diagnosed on chest x-ray, and there is evidence of treatment specific to that condition, the pleural effusion should be coded. If pleural effusion is diagnosed incidentally on x-ray, when pneumonia is being investigated, and it is not specifically treated, then it should not be coded.

The Committee confirms that pleural effusion should be coded when the condition meets the criteria for additional diagnosis, which would include specific treatment being given, such as drainage.

## #1819      **Diabetes with Ischaemic Heart Disease**

Diabetes with Ischaemic Heart Disease (2<sup>nd</sup> edition code E11.59 *Diabetes with other specified circulatory complication*) code has disappeared from 3<sup>rd</sup> edition of the coding books.

What is the reasoning behind the removal of this code?

Diabetes is still linked with arteriosclerosis of extremities, but now we can no longer link arteriosclerosis and IHD with diabetes.

In ICD-10-AM, 3<sup>rd</sup> edition, ACS 0401 *Diabetes Mellitus and Impaired Glucose Regulation* has been further developed in accordance with increased clinical knowledge about diabetes, and in order to overcome past inadequacies in the disease index. Please follow this revised standard.

In addition to this, coders should refer to the FAQ page of the '3<sup>rd</sup> edition education' section of the NCCH web site:

[www.casino.cchs.usyd.edu.au/ncch/](http://www.casino.cchs.usyd.edu.au/ncch/)

There are many questions and answers about diabetes at this location, the most relevant to this query being:

Q: In ACS 0401 *Diabetes mellitus and impaired glucose regulation* under 'circulatory complications in diabetes' the subheading 'atherosclerosis' has been removed. Also, in the disease index, the entry for diabetes with atherosclerosis E1x.59 has been removed. This change does not seem to have been identified on the training module, yet it is a significant one, presumably meaning that arteriosclerosis in diabetes should only be captured if the specific *form* of arteriosclerosis is indexed under the heading of diabetes. Could you please comment.

A: Yes this is correct. In ICD-10-AM Third Edition, further modifications have been made to the index for diabetes to emphasise which conditions are linked with diabetes.

Please note, ACS 0401 *Diabetes mellitus and impaired glucose regulation*, page 87

***The general classification principles in diabetes mellitus are:***

.....

\*Only conditions indexed under 'Diabetes, diabetic' can be classified to 'with complication' categories in E10-E14.

## #1821 Non STEMI AMI

How is a non STEMI acute myocardial infarction (AMI) coded?

NSTEMI - Non-ST segment Elevation Myocardial Infarction is an acute process of myocardial ischaemia with sufficient severity and duration to result in myocardial necrosis. The initial ECG does not show ST-segment elevation and the majority of patients do not develop new Q waves, therefore are ultimately diagnosed as having had a non-Q wave AMI. [Reference NCCH Query 1521 (6/12/01)]

In accordance with ACS 0940 *Ischaemic heart disease*

### I21.4 *Acute subendocardial myocardial infarction*

is to be assigned for non Q-wave infarctions.

## #1823 Ureteric Calculus

Patient with a past history of renal stones 9 years ago now has a ureteric calculi seen on IVP after presenting with more than 3 weeks history of lower abdominal pain, dysuria, frequency and possible haematuria.

Patient is booked & subsequently admitted to hospital 2 months later for ureteroscopic extraction of calculus/lithoclast/JJ stent. History on presentation to Hospital was approx. 4/12 Hx Dysuria & R) loin pains (IVP – 6 mm stone R) lower ureter.

In theatre a ureteroscopy/RGP is done, no stone is seen & there are entirely normal findings.

What PDx do you code?

- 1 The ureteric calculus as the condition causing the admission to hospital and reason for operation? or
- 2 The symptoms (? patient still experiencing if stone is passed)? or
3. **Z03.8** *Observation for other suspected condition*

As the condition did exist (ie the stone was identified on imaging), it should be coded as the reason for admission. Therefore,

### N20.1 *Calculus of ureter*

should be assigned as the principal diagnosis (plus codes for ureteroscopy, and RGP).

### Z03.8 *Observation for other suspected diseases and condition*

would not apply, as the patient was being treated for a condition that existed, which had been confirmed on diagnostic imaging.

## #1826 Coding smoker/ex-smoker from tick box

I have noticed that many coders across my network code 'smoker' and 'history of smoker' from a tick box, usually preadmission sheet, but not always. Without further clarification, such as '5 a day' or 'stopped 2 weeks ago' my feeling is that these conditions should not be coded.

Coders have previously been instructed not to code conditions from tick boxes without further clarification. Even the term 'ex-smoker' needs to be coded with care - without further detail could it ever be coded?

A tick box is adequate documentation from which to code 'smoker'. Whilst acknowledging that the documentation of 'ex-smoker' may not be completely reliable in terms of the definition (non-smoker for > 1 month), the VICC's opinion is that, without further information, ex-smoker NOS should be coded to the default code

**Z86.43**                      *Personal history of tobacco use disorder*

## #1827 Pre-admission ASA Score

If an ASA score is written on a preadmission anaesthetic sheet, and nowhere else in the record, can this be used with the coding of anaesthetics when the patient is eventually admitted?

What if this assessment was 3, 4, 5 or 6 months ago? Is it still valid?

The anaesthetic form must be current, and must relate to the procedure in question.

The patient's ASA score from one procedure cannot be applied to subsequent procedures, as a patient's clinical status may deteriorate or improve in between times.

Coders should refer to the FAQ page of the '3<sup>rd</sup> edition education' section of the NCCH web site:

[www.casino.cchs.usyd.edu.au/ncch/](http://www.casino.cchs.usyd.edu.au/ncch/)

The following is from the NCCH's 3<sup>rd</sup> edition FAQs Part 2:

**Where a patient attends the pre-admission clinic prior to admission for surgery and an ASA is documented, can that ASA be used for the surgery even if it is several days or weeks later?**

No, the ASA score used to calculate the two-character extension of the anaesthesia code must be documented on an anaesthesia/operation form at the same time the procedure took place.

## #1832 Place Of Occurrence - Nursing Home

Patient had a fall at the Nursing Home in which they live, and is admitted for management of fractured ribs.

Looking up Nursing Home in the index under Place of Occurrence of External Cause, Residential Institution leads us to the new code:

### **Y92.14**                      *Aged Care Facilities*

In the tabular list, Nursing Home is included under the heading of this code. However, Nursing Home is also still included under the heading of code Y92.22 *Health Service Area*.

Should one of these Nursing Home entries be deleted from the tabular lists or are they both valid?

The NCCH confirmed that the reference to 'Nursing Home' will be deleted from the list under Y92.22 *Health service area* in the Disease Tabular of ICD-10-AM.

Therefore, the code for 'nursing home' as a place of occurrence is listed below:

### **Y92.14**                      *Aged care facilities*

## #1833 Drainage of fluid from Pouch of Douglas

Same day stay. 35 year old woman comes in with abdominal pain and has D&C, and laparoscopy. The operation notes state cystic ovary, 'drainage of fluid from Pouch of Douglas' which was sent for cytology, otherwise normal pelvis. Is it possible to code the drainage of fluid, and to which code?

References include NCCH query database no: 1042 (1st edition) which states to code aspiration of fluid from cul-de-sac to laparoscopy with biopsy - there was an includes note for biopsy, but this includes note is not present for 3rd edition. Can the committee advise why this 'includes biopsy' note under laparoscopy is no longer present?

Following the index:

### **Biopsy**

- cul-de-sac (closed) (open) (pouch of Douglas) (rectouterine pouch) 30075-37 [988]

Therefore, the appropriate procedure codes to be assigned in this scenario would be

**35640-00 [1265]**      ***Dilation and curettage of uterus [D&C]***

**30390-00 [984]**      ***Laparoscopy***

**30075-37 [988]**      ***Biopsy of peritoneum***

Note that, although this is a gastrointestinal system code, there is an 'includes' note for pelvic cavity.

The 'includes biopsy' note previously under laparoscopy no longer exists, because the 'female' laparoscopy code was deleted/combined, so that there is now only one laparoscopy code.

## #1835 Admission of newborn – not birth episode

New Account Class (NT) requires all newborns <10 days old to be admitted (use this Account Class for admissions subsequent to birth episode - usually to little country hospitals - healthy mother and baby, not yet ready to go home, but wanting to be closer to family/friends).

This was implemented as NHDD says (as part of Admitted Patient) a patient should be admitted if '... the patient is aged nine days or less'. In 'Care Type' it says 'Babies in hospital at aged 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified'.

Obviously, a code from Z38 is not appropriate (as not the first admission).

### **Z76.2** *Health supervision and care of other healthy infant and child*

- ACS 1609 indicates that this code should be used when 'the maternal cause has necessitated provision of more health services than is usual'. In our particular scenario, this is usually not the case. If the mother was unwell they would not usually be transferred out to these sites. Mother is usually a normal post-partum without CC.

### **Z76.3** *Healthy person accompanying sick person*

- As per above, the mother is not usually sick, just post partum. Library file: unacceptable Pdx (rejection).

### **Z76.4** *Other boarder in health-care facility*

- As per NHDD definitions, the baby is not a boarder. Library file: unacceptable PDx (rejection).

### **Z76.8** *Persons encountering health services in other specified circumstances*

- Is this appropriate? Library file: questionable PDx (warning).

What do you think? Obviously, if the baby did have another codeable condition, this would be used (eg attachment difficulties).

The opinion of the Committee is to code these babies to

### **Z76.2** *Health supervision and care of other healthy infant and child*

which would seem to be the most appropriate code that will not cause a rejection in PRS2, and which at least specifies 'infant'.

It is to be used only when there is no other condition to be coded.

## #1837 Multiple Procedures

- 1 When a patient is admitted overnight or longer and has an apheresis procedure more than once during the episode, is the procedure coded once, or the number of times performed?
- 2 When a patient is admitted overnight or longer for radiotherapy, is the procedure coded once, or the number of times performed?

Refer to ACS 0020 *Multiple/Bilateral Procedures*

....  
Exceptions:

- .....  
(c) Procedures performed **without** anaesthesia should be coded **once only** (unless listed in [ACS 0042](#) *Procedures not normally coded* as a procedure not to code, or unless directed otherwise in another specialty standard).

In both examples (apheresis and radiotherapy), code once only, as these procedures are performed without anaesthesia, and are not included in ACS 0042 *Procedures not normally coded*, or covered in a specialty standard. (ACS 0229 *Radiotherapy* provides guidelines on assigning diagnoses when patients are admitted for radiotherapy.)

## #1839 Interpretation of ACS 0031 Anaesthesia

When coding episodes where both general and local anaesthesia have been administered, I have found ACS 0031 Anaesthesia to be contradictory. Under 'Classification' 1.1, page 42, the standard indicates that it is possible to code both a general and a local anaesthetic. However, this is contradicted in point 4., page 43, which states that '*code 92513-XX [1909] Infiltration of local anaesthetic should be assigned only when the anaesthetic is documented on an anaesthetic form and there are no other anaesthetic procedures from blocks [1333] Analgesia and anaesthesia during labour and delivery, [1909] Conduction anaesthesia or [1910] Cerebral anaesthesia documented on the same form.*'

Although there is an exclusion note in the procedure tabular at 92513-XX [1909],

**'Excludes:** that performed in conjunction with codes in blocks [1910] and [1333] – omit code',

which confirms that point 4 overrides point 1 in the standard, I believe that this fact should be more clearly explained in the standard, rather than requiring the coder to rely on exclusion notes to clarify the 'rules'.

Please comment.

Coders should refer to the FAQ page of the '3<sup>rd</sup> edition education' section of the NCCH web site:

[www.casino.cchs.usyd.edu.au/ncch/](http://www.casino.cchs.usyd.edu.au/ncch/)

The following is from the NCCH's 3<sup>rd</sup> edition FAQs Part 1: (refers to these points (1 & 4) in ACS 0031 *Anaesthesia*.)

**Q: 'Given the instructions in point 4 p43 of ACS 0031 Anaesthesia, should the excludes note under 92513-xx [1909] also exclude the use of that code with any other code from block 1909?**

A: The excludes note at 92513-xx *Infiltration of local anaesthetic* could possibly include block [1909], however the hierarchy concept is more fully explained in point 1 p42 of ACS 0031 *Anaesthesia*.'

The VICC agrees that the standard is not clear on this point, and will send a comment to the NCCH, requesting that the standard be reworded.

## #1841 'Essure' sterilisation

Essure sterilization is a new method of sterilization performed at our hospital. A coil is placed into the fallopian tube via vaginal approach with hysteroscopy. The coil is made of macron and titanium and, once in place, is released from the probing tool and springs open.

After speaking with one of the gynaecologists from our service, he mentioned that there is no MBS number the procedure. He recommended that we use the code

**35688-00 [1257]      *Laparoscopic sterilisation***

as this is where 'Sterilisation, NOS' is indexed to.

Can we please have this code confirmed?

The following information is from: <http://www.essure.com.au/static/what.html>

Essure is a soft, flexible micro-insert designed and made by Conceptus, with the same materials used for years in heart valve replacements and blood vessel grafts. The worldwide introduction of Essure occurred in a clinical trial in Australia in 1998.

Essure is inserted vaginally by a trained gynaecologist using a visually guided method called hysteroscopy. A micro-insert is placed in each fallopian tube, where the body and the micro-insert work together to form a biological blockage that prevents sperm from reaching the egg.

Although a clinician may use a particular MBS code, it should not always be considered as the best choice from a coding perspective. In this example, a laparoscopic code should not be assigned, as this procedure is performed via vaginal approach.

From the index:

**Sterilisation**

- female
- - vaginal approach 35688-01 [1257]

**35688-01 [1257]      *Sterilisation via vaginal approach***

would be the correct code.

# *Data Quality*

## **But that edit's only a Warning...**

Author: Irene Kearsey, previously HDSS, Department of Human Services  
Amanda Muggivan, HDSS, Department of Human Services

### **PRS/2 edits**

PRS/2 has two types of edits:

- **Rejections** you check, correct and re-transmit the record
- **Warnings** you check and, if necessary, correct and re-transmit the record

But is this what happens in your hospital?

Because the record has been accepted, staff checking a Control Report may be tempted to ignore a Warning edit because they're busy – 'it's only a Warning so it doesn't matter'. Such an approach is a mistake and this article explains why records receiving Warning messages *should* be checked. The Department expects that records receiving Warning messages *will* be checked.

### **Why does PRS/2 'Warn'?**

Fatal edits reject because an individual data item or a combination of data items *cannot* be correct. Warning edits cover individual or combinations of data items that are *unlikely* to be correct (although it is possible). Therefore, most records that receive a Warning edit will, in fact, contain an error. For example, reporting that the patient was born in Antarctica – possible, but highly unlikely.

The text for each Warning edit message (Section 8 of the *VAED Manual*) lists some possible scenarios where a record will be correct. If you find another scenario where data are correct, please send details to the HDSS HelpDesk ([PRS2.Help-Desk@dhs.vic.gov.au](mailto:PRS2.Help-Desk@dhs.vic.gov.au)).

If you consider a specific Warning edit is unjustified (that is, when checked, the majority of records are correct), please send details to the HDSS HelpDesk ([PRS2.Help-Desk@dhs.vic.gov.au](mailto:PRS2.Help-Desk@dhs.vic.gov.au)), and we will review that edit.

### **How often is a 'Warned' record incorrect?**

Before Final Consolidation of VAED for 2001-2002, HDSS selected eight potential data problems that are either Warning edits in PRS/2 or checks used by Australian Institute of Health and Welfare (AIHW). In all, 71 records were found that contained these potential problems. HDSS sent the reporting hospital's details of their respective records, and

asked them to check the relevant fields and report back. Because this was close to the time of Final Consolidation, some hospitals did not respond; thus, we do not know the outcome of 37 records (52%). Responses did cover 34 records (48%) and only 1 of those records (1.4% of the total) was reported to be correct. It would not be unreasonable to expect the 37 (unreported) records would have produced a similar result.

In other words, *most of these edit messages did find real errors.*

The edits that were followed up in this review are identified with an asterisk in the table below. Where a check originated from AIHW but is similar to a PRS/2 edit, that edit is asterisked.

## **New Rejection edits**

HDSS will consider some Warning edits for upgrade to Fatal (eg, edits 288 and 297).

Some new edits will be designed in the future to follow AIHW's specifications (eg, baby weighing less than 1000g at admission, staying less than 7 days in the hospital but the Separation Type is not Transferred or Died).

## **Follow up of Warning messages**

HDSS is planning to redesignate some Warning edits to a new category: Notifiable Warnings. These will have the same effect as Warnings at time of input (that is, the record will be accepted) but HDSS will periodically send lists of these records, asking for confirmation of the various data items (for instance, your assurance that the patient really does claim to have been born in Antarctica).

Think now of ways you can save yourself time when HDSS emails out lists of episodes. When you check a record receiving a Notifiable Warning message as part of processing a Control Report and find the record to be correct, perhaps you could keep a note of those records. If there is no way of flagging the record in your computer system, an exercise book could be used to jot down identifying details of the record (say, UR and Unique Key) and a brief note of why the record is correct. When you receive the list from DHS, you have the information immediately available: no need to pull records again to investigate.

## **Risks of ignoring a Warning edit message**

If you fail to correct an error by ignoring a Warning, your hospital data will contain incorrect information. This will always lower the value for data users in the hospital, and at state and national level. There may be other, more serious, ramifications.

The following table lists some of the Warning edits and the possible ramifications of letting an error through by not checking and correcting, when this is found necessary.

Asterisk = Edit (or similar check) in the recent HDSS review (see above)

Edits listed below are planned to be notifiable edits, except edit 354.

<b>Edit</b>	<b>Checking</b>	<b>Possible ramifications</b>
<b>069*</b>	Born today or yesterday but not in Australia	If Date of Birth incorrect: <b>Possibly incorrect DRG.</b>  (Perhaps Date of admission repeated in Date of Birth field.)  If Country of Birth incorrect: <b>Misleading statistics for hospital and Victoria.</b>
<b>080</b>	Sex Indeterminate	Sex incorrect: <b>Misleading statistics for hospital and Victoria.</b>
<b>228</b>	Unusual Country of Birth	If incorrect: <b>Misleading statistics for hospital and Victoria.</b>
<b>243</b>	Newborn in hospital more than 9 days	If Separation Date incorrect, with incorrect length of stay being too <i>long</i> : <b>Possibly claimed unjustified Outlier days.</b>
<b>288*</b>	Separation Barthel >000 but Separation Type = Died	If patient did die: <b>Barthel must be incorrect.</b>  If patient did not die: <b>PMI problems particularly if patient returns.</b>
<b>289</b>	Rehabilitation patient transferred in on the condition's Onset date	Unless at least one data item is incorrect: <b>Patient had no acute care for the problem needing rehabilitation.</b>
<b>290</b>	Care Type = Rehab and Admission Source = Statistical but Onset Date = Admission Date	Unless at least one data item is incorrect: <b>Your hospital appears to have caused the problem needing rehabilitation.</b>
<b>297*</b>	Separation RUG >00 but Separation Type = Died	If patient did die: <b>RUG must be incorrect.</b>  If patient did not die: <b>PMI problems particularly if patient returns.</b>

<b>Edit</b>	<b>Checking</b>	<b>Possible ramifications</b>
<b>324</b>	Stay in ICU but Account Class = NHT, or indicates Rehab, Psych, Same Day	If Account Class = NHT, time in ICU would, in most circumstances, justify an Acute episode: <b>Missed Statistical separation = hospital missed casemix payment.</b>  If Account Class indicates Rehab, Psych, or Same Day, time in ICU may justify an Acute episode: <b>Missed Statistical separation = hospital missed casemix payment.</b>
<b>325*</b>	Duration of MV but Account Class = NHT, or indicates Rehab, Psych, Same Day	To be reported, MV must be provided in ICU – therefore see note above on Edit 324.
<b>354*</b>	ICD code and Sex incompatible	If either is incorrect: <b>Possibly incorrect DRG.</b> [AIHW check looked only for vasectomy procedure code with female sex]
<b>358*</b>	Diagnosis rare in Australia	If incorrect: <b>Possibly incorrect DRG. Misleading hospital, state and national statistics.</b>
<b>403</b>	Qualified Newborn but no diagnosis to justify	If baby from interstate – <b>Other State will not reimburse Victoria.</b>
<b>406</b>	Rehab Care Type but not Rehab DRG	<b>Incorrect DRG assignment and payment.</b>
<b>412*</b>	<b>Admission Weight 1000-2499g but no equivalent ICD code</b>	<b>[AIHW checked for Weight &lt;1000 and length of stay &lt;7 days and Separation Type not Transferred or Died]</b>
<b>425*</b>	Separated to aged care or mental health residential facility but patient under 8 years	If Separation Type incorrect: <b>Misleading statistics for hospital and Victoria.</b>  If age (therefore Date of Birth) incorrect: <b>Possibly incorrect DRG.</b>
<b>448</b>	Time in ICU but episode is not Acute	Time in ICU would, in most circumstances, justify a new Acute episode: <b>Missed Statistical separation = hospital missed casemix payment.</b>
<b>449*</b>	Notifiable Disease ICD code	If the code is correct: <b>Ensure appropriate Notification is sent to Public Health. This is a statutory obligation.</b>

# ***VAED Data – Uses and Users***

Another in the series of articles about specific uses and users of your coded clinical information: your coding *does* matter!

## **Injuries**

Author: Irene Kearsey, previously HDSS, Department of Human Services

### **Victorian Injury Surveillance**

An extensive user of coded hospital data on injuries is the Victorian Injury Surveillance & Applied Research (VISAR) unit, part of the Monash University Accident Research Centre (MUARC). MUARC publishes a quarterly publication, appropriately called *Hazard*, which analyses injury data from a variety of sources, including the Victorian Emergency Minimum Dataset (VEMD) and the Victorian Admitted Episode Dataset (VAED).

You can find *Hazard* at:

<http://www.general.monash.edu.au/muarc/hazard>

The Autumn 2002 issue of *Hazard* was the 50th issue and included a tabulation of 50 Achievements. This table is an excellent demonstration of practical outcomes from using data. VISAR makes more use of VEMD data: its free text provides richer detail. Using VAED data *and* VEMD data together causes some problems in avoiding double-counting.

### **Australian Injury Surveillance**

Another user of coded hospital data on injuries is the Research Centre for Injury Studies (RCIS), Flinders University, which incorporates the National Injury Surveillance Unit (NISU). RCIS periodic journal is *Injury Issues Monitor*. These include details of articles on injury topics by Australian authors published in peer-reviewed journals (with internet addresses where available). Currently on the web site, you will find the last issue of the journal and details of publications that analyse hospital data:

<http://www.nisu.flinders.edu.au/>

# ***VAED Data – Easy Access***

These are some easy ways to use admitted patient data, either at state or national level.

## **Department of Human Services**

DHS provides Standard Datasets on CD. Each Standard Dataset contains a set menu of data items. Go to:

<http://hdss.health.vic.gov.au/vaed/vaedover.pdf>

Then look at Appendix 2 for what data items are included in each Standard Dataset and, at the start of that Appendix, instructions on how to order.

## **Australian Institute of Health and Welfare**

Some data immediately available from:

<http://www.aihw.gov.au/dataonline/index.html>

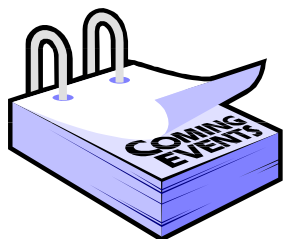
Publications are detailed at:

<http://www.aihw.gov.au/publications/health.html>

## **HealthWIZ**

HealthWIZ is the *National Social Health Database*, developed by Prometheus Information Pty Ltd for the Commonwealth Department of Health and Ageing as part of its commitment to providing easy public access to Australia's key health and welfare information. HealthWIZ brings together data from a wide range of sources across Australia. Check out:

<http://www.prometheus.com.au/healthwiz/hwiz.htm>



## *Coding Calendar of Events*

<b>Date</b>	<b>Event</b>	<b>Details</b>
8 – 11 December 2002	<b>TEHRE 2002: UK The 7th Annual European Conference and Exhibition on Electronic Health Records,</b>	E-mail inquiries: <a href="mailto:cust_service@medrecinst.com">cust_service@medrecinst.com</a> or call for Papers <a href="mailto:marcy@tepr.com">marcy@tepr.com</a>  New Connought Rooms, Covent Garden, Great Queens Street, London, United Kingdom.
18–20 February 2003	<b>National Health Summit 2003: Crisis, Reform &amp; Solutions</b>	<a href="http://www.pharma-rd.net/2003/health_AU">http://www.pharma-rd.net/2003/health_AU</a> Merchant Court Hotel, Sydney, Australia
26-28 March 2003	<b>NCCH 8<sup>th</sup> Biennial Conference</b>	“Coder Connect: Linking concepts in health” <a href="http://casino.cchs.usyd.edu.au/ncch//">http://casino.cchs.usyd.edu.au/ncch//</a>  Hilton on the Park, Melbourne
24 – 28 August 2003	<b>10th Asia Pacific Special Health &amp; Law Librarians Conference - Adelaide.</b>	Adelaide Convention Centre, Adelaide. Contact: Georgina Livissianos, Ph: (08) 8205 4487 E-mail: <a href="mailto:georgia.livissianos@fedcourt.gov.au">georgia.livissianos@fedcourt.gov.au</a>
14–17 September 2003	<b>Health Care In Focus Incorporating the 15th National Casemix Conference in Australia</b>	<a href="http://www.health.gov.au/casemix">www.health.gov.au/casemix</a>  Canberra, Australia
October 2003	<b>National Convention, American Health Information Management Association</b>	<a href="http://www.ahima.org/products/events/calendar.html">http://www.ahima.org/products/events/calendar.html</a>  Minneapolis
9-14 October 2004	<b>IFHRO 14th Congress - Washington, USA.</b>	<a href="http://www.ahima.org/products/events/calendar.html">http://www.ahima.org/products/events/calendar.html</a>

For a comprehensive list of health information events, see:

<http://www.himaa.org.au/Calendar.html>

The logo features the text "Coding Corkboard" in a blue, serif font with a drop shadow effect. The text is enclosed in a black rectangular border that has a slight 3D effect, with a grey shadow underneath. At the top center of the border, there is a small graphic of two interlocking gears.

# Coding Corkboard

## ***Coding Corkboard***

### **Victorian *Coding Newsletter* mailing list**

Thank you to all who responded to our appeal with the August issue for updated information. Many people provided an email address for receiving their Newsletter electronically, with some electing to discontinue the paper copy. This and other tidying of the posting list reduced numbers by 13%, making a valuable saving. Even if you do not currently have email, remember to let us know when you do have access!

### **NCCH ICD-10-AM web site**

The most recent posting of queries to the NCCH database was 24 April 2002, however there are now 2 FAQs related to 3rd edition.

These, as well as current and previous editions of *Coding Matters*, can be viewed and/or downloaded from the NCCH's website:

<http://casino.cchs.usyd.edu.au/nch//>

### **Expressions of Interest – Part-time Employment**

In the past the Health Data Standards and Systems Unit (HDSS) has maintained a register of Health Information Managers or Clinical Coders who were available to work on a casual or consultancy basis.

This register is distributed upon request to Day Procedure Centres and Private Hospitals within Victoria requiring experienced personnel to assist in their transmission of admitted patient data to the VAED. Often these are newly registered sites unfamiliar with the concept of VAED, ICD Coding and patient management systems, therefore the work can involve more than coding and management of the transmission process.

In an effort to ensure that the lists provided to interested parties are as up to date as possible HDSS is seeking expressions of interests from HIMs or Clinical Coders who would like to be considered for such employment.

***Interested parties should contact Leanne Daking with the following information on the numbers or email listed below.***

Please note HDSS tenders no recommendations in regards to the register, we simply provide the listings to interested facilities for their own investigation.

- Name: \_\_\_\_\_
- Qualifications: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Preferred Locations: (ie: western suburbs, metro, rural north)  
\_\_\_\_\_
- Availability (preferred days, times)  
\_\_\_\_\_
- Relevant Information: (coding experience, PRS/2 experience, training)  
\_\_\_\_\_  
\_\_\_\_\_

Phone: (03) 9616 8022

Fax: (03) 9616 7629

Email: [leanne.daking@dhs.vic.gov.au](mailto:leanne.daking@dhs.vic.gov.au)

## **Advertisement: La Trobe University - Health Classification**

Are you interested in contributing to a quality education in Health Classification?

If so, we need your help! We are looking for current expert coders to form a committee that will work on upgrading the Health Classification workbook each year in readiness for the following year's students. This work would be undertaken under the supervision of the coordinator of the Health Classification subject, and would involve a minimum amount of work over a two to three week period at the end of each academic year. The aim of the work is to provide a workbook that is current in respect to both Australian (and Victorian) Coding Standards and clinical practice.

To be eligible you must be currently coding in a hospital and must have at least two years coding experience.

If you are interested, please contact Jennie Shephard on mobile phone number 0408 102277 or by email at [shephear@bigpond.net.au](mailto:shephear@bigpond.net.au)

# ***Victorian ICD Coding Committee***

## **Member Profile – Irene Kearsey (Part 2)**

The last Coding Newsletter featured a member profile on Irene Kearsey. As mentioned in this article, Irene has since retired – and is already sorely missed and fondly remembered. She will remain an icon in the minds of many Medical Record Administrators, Health Information Managers and Clinical Coders.

Reproduced below are two documents.

- The first is from 1978. It's the document that 'started it all' in terms of the Victorian ICD Coding Committee (VICC), as it is known today. (Younger coders may need some explanations: the health authority was then a Commission; Lincoln Institute provided MRA training before La Trobe University; Health Computing Services was the precursor to Allegiance, and the Victorian admitted patient data collection was due to start on 1.1.1979: up to that date, it was a hospital decision whether to code or not and, if the hospital did code, it could use whatever coding system it liked).
- The second is a little poem written by an 'anonymous coder' (Connie, alias Irene Kearsey) from the *Coding Newsletter Edition 21, July 1989*. (Younger coders may need some explanations: the references are to a much earlier version of DRGs; all Victorian hospitals changed to ICD9 on 1.1.1979 and to CM on or before 1.7.1986; we really were 'talking about ICD10' in 1989 but it took a little longer than expected to arrive; the health authority was then HDV; and you'll have to ask your parents about 'The Comedy Company', Aunt Marika and Uncle Con).
- The re-typing of these documents has reduced the effect of the originals, which were both typed on the conventional typewriter in courier (how quickly we forget)!

Both documents simultaneously remind us how far we have come since 1978, yet how similar some of the issues remain.

### **MEMORANDUM**

**29th November 1978**

To Dr Race [who forwarded it to Dr Patricia Wilkinson]  
From: Irene Kearsey  
Subject: INTERNATIONAL CLASSIFICATION OF DISEASES

With all hospitals starting to use ICD9 for the collection of morbidity statistics, it is important that coding practice is standardised so that final statistics are as accurate as possible.

With this in mind, I have proposed the Victorian Medical Record Association that a committee of reference be formed to advise on ICD9 coding. The Association reacted favourably and suggested that the committee be composed as follows:

- Convenor from the Commission
- One representative from Lincoln Institute
- One representative from Hospitals Computer Service
- Two representatives from large teaching hospitals
- One representative from a smaller hospital

Terms of Reference would be as follows:

1. To receive ICD9 coding queries and problems from coders in Victoria and to advise enquirers on correct or recommended codes.
2. To circulate advice on codes to all coders in Victoria by means of Commission circulars and in the journal of the Medical Record Association of Australia.
3. To consult expert coders in specialist areas when necessary.
4. To liaise with any other coding advisory bodies in Australia and encourage the establishment of such bodies in other states; to liaise with the Australian Bureau of Statistics.
5. To communicate with WHO regarding coding problems and to circulate advice received from WHO.
6. To promote the study of ICD9 and communicate with WHO suggestions for further revisions.
7. To promote the accurate use of ICD9 and ICD – based codes.

#### Recommendations

1. That the Commission approves the establishment of the ICD9 Coding Committee with the above Terms of Reference.
2. That a Commission circular be sent to all hospitals advising of the establishment of the ICD9 Coding Committee, its purpose as an advisory body for coding and its address at the commission.
3. That the Commission provides the method of circulating future information by Commission circulars.
4. That a Commission officer act as convenor of this committee and that Commission facilities are available for meetings.

[Signed] Irene Kearsey

[Annotated and initialled by Dr Race to Dr Wilkinson] PW: Would you prepare a Minute Sheet please? [Then, Minute Sheets were required to submit any business to the Commissioners and forming a new Committee required the Commissioners' approval].

## Connie The Coder

The coding's piling up to the sky.  
To get some done, I'll really try.  
The Chief is getting mad as a hatter.  
Though I say to her, "Doesn't matter!"

A coupla days, a coupla days,  
I'll get it done in a coupla days.

With ICD-8 I got along fine.  
But daggers and asterisks were hell in Nine.  
With CM I'm only just getting in the gen  
And now they're talking about ICD-10!

Have you seen the new books? How can I cope?  
Coloured patches and all! I haven't a hope.  
New operations and a rash of fifth digits.  
It 's all too much - it gives me the irrits.

A coupla Valium, a coupla Valium,  
I might just manage on a coupla Valium.

The CEO's nagging about our DRG weight  
'Cos my coding's all grouping to 468  
It's not my fault if only they'd see -  
I blame the bods at HDV.

It's no surprise I fall in a heap  
With CCs and ORs and DRG creep.  
I sit here each day with my head exploding.  
What am I doing? Coding, coding, coding.

I code and I code 'til it addles my brain.  
The pay isn't great but I no complain.  
I do my best - I'm very dutiful,  
But no-one ever says "Bee - yu-di-ful!"

When things get too much and I can't go on,  
I visit Aunt Marika and Uncle Con.  
He gives me apples and sends me home happily  
Saying, "You should be married and good luck to your family."

An apple a day, an apple a day.  
I close my eyes and it all goes away.

This poem (?) was submitted anonymously. It would appear to be from a Victorian Coder for three reasons:

- DRG 468 has a zero-weighting in Victoria; hospital managements therefore wish to avoid this DRG.

- On 1 July 1989, Victoria changed to the latest version of ICD-9-CM (introduced in USA from 1 October 1988) and requested all coding hospitals to purchase the new coding books; these have coloured patches and other devices to assist coders.
- The HDV's Consolidated File, from which DRG, and many other, reports are produced, is to be compiled on 1 October 1989 and for the 1988/1989 financial year's data. This is earlier than in previous years; resultant data, however, are being used more. The pressure is on!

## **VICC Members as at 1 November 2002**

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

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

## **Future Meetings**

Tuesday 17 December	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor
Tuesday 21 January	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor
Tuesday 18 February	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor
Tuesday 18 March	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor

# ***On a Lighter Note***

## ***Medical Chart Comments***

- Discharge status: Alive but without permission. The patient will need disposition, and therefore we will get Dr Blank to dispose of him.
- Healthy appearing decrepit 69 year-old male, mentally alert but forgetful.
- The patient refused an autopsy.
- The patient has no past history of suicides.
- The patient expired on the floor uneventfully.
- Patient has left his white blood cells at another hospital.
- Patient was becoming more demented with urinary frequency.
- The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days.
- She slipped on the ice and apparently her legs went in separate directions in early December.
- The patient experienced sudden onset of severe shortness of breath with a picture of acute pulmonary oedema at home while having sex which gradually deteriorated in the emergency room.
- The patient left the hospital feeling much better except for her original complaints.
- Between you and me, we ought to be able to get this lady pregnant.
- Since she can't get pregnant with her husband, I thought you might like to work her up.
- Occasional, constant, infrequent headaches.
- Patient was alert and unresponsive.
- Rectal exam revealed a normal size thyroid.
- Skin: Somewhat pale but present.
- The pelvic examination will be done later on the floor.
- Patient was seen in consultation by Dr. Blank, who felt we should sit on the abdomen and I agree.
- Large brown stool ambulating in the hall.
- Patient has two teenage children, but no other abnormalities.

### ***What A Choker...***

In Azerbaijan, an 11 year old girl called Matanet fell asleep in a field after picking tomatoes and woke up choking. She was rushed to a children's hospital in Baku and made to drink 3.5 pints of salt solution, after which she vomited up a two foot long Caucasian cat snake, which had crawled into her mouth while she slept. She left hospital an hour later feeling fine.

### ***One In The Eye***

Julian Fabricus was seven years old when he fell over while chasing butterflies in a field near Worcester, South Africa. When he returned home his left eye was inflamed and smarting, but the doctor gave him some eye-ointment, and the incident was soon forgotten. A year later Julian's eye began to itch and his vision began to suffer. Surgeons removed a white object from his cornea that turned out to be a flower seed which, after a year in his eye, had sprouted and grown an eighth of an inch long, with two little leaves. After the operation, Julian had perfect vision once more.

# ***Abbreviations***

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