

# ICD Coding Newsletter

Special Edition

June 2004

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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:

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HDSS web site is <http://hdss.health.vic.gov.au>

An electronic coding query form can be completed at:

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

An index to Coding Newsletters can be found at:

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

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# Table of Contents

<b>1 JULY INFORMATION UPDATES-REPORTING TO THE VAED</b>	<b>1</b>
Coding classification	1
Grouper version and mapping	1
Notification of Grouper anomalies	1
Victorian modifications to AR-DRGs for 2004-05	2
VAED reporting schedule requirements for 2004-05	5
Victorian Additions to the Australian Coding Standards	9
<b>CODING FEATURES</b>	<b>18</b>
Changes in AR-DRGs Version 5.0	18
New VAED edits on diagnosis code prefixes	20
Admission Policy and the Australian Coding Standards	26
Proposed edits between procedure codes and criterion for admission	28
Updated Calendar of ICD Coding and DRG Grouping Systems used in Victoria	29
<b>CODING CORKBOARD</b>	<b>31</b>
'Old' NCCH advice	31
VICC Members as at 1 June 2004	32
Coding Committee Meeting Dates	32
References used in the production of this newsletter	33
Abbreviations	33



# 1 July Information Updates-Reporting to the VAED

## Coding classification

All separations on or after 1 July 2004 must be coded using ICD-10-AM Fourth Edition (and relevant errata) in accordance with the current Australian Coding Standards effective 1 July 2004, Victorian Additions to the Australian Coding Standards and ICD Coding Newsletters issued by the department. Additionally coders are expected to follow relevant and current advice published on the National Centre for Classification in Health coding query database (<http://www2.fhs.usyd.edu.au/ncch/>).

The 2004–05 library file (in Excel format) and the description of the file structure are available on the HDSS webpage at:

[www.health.vic.gov.au/hdss/reffiles/2004-05/vaed/libfil04.htm](http://www.health.vic.gov.au/hdss/reffiles/2004-05/vaed/libfil04.htm).

This file is password protected using the same password as last year. If you need to know the password, email the HDSS Helpdesk ([prs2.help-desk@dhs.vic.gov.au](mailto:prs2.help-desk@dhs.vic.gov.au)) requesting this.

The department's licensing agreement with the NCCH only permits the release of this file to Victorian hospitals and software vendors with Victorian clients.

## Grouper version and mapping

For 2004-05, DHS will map ICD-10-AM Fourth Edition codes to ICD-10-AM Third Edition codes for input to the AR-DRG Version 5.0 Grouper.

Information about AR-DRG Version 5.0 can be found on the website of the Commonwealth Department of Health and Ageing at <http://www.health.gov.au/casemix/ardrg1.htm>, and in the Australian Refined Diagnosis Related Groups Version 5.0 Definitions Manual.

Mapping tables from ICD-10-AM 4<sup>th</sup> to 3<sup>rd</sup> editions have been incorporated into the 2004–05 library file or can be accessed on the Department of Health and Ageing website at <http://www.health.gov.au/casemix/mapdis1.htm#mapi10e34>.

## Notification of Grouper anomalies

The Department of Health and Ageing has developed a standard form for notification of grouper anomalies. This can be accessed at [www.health.gov.au/casemix](http://www.health.gov.au/casemix).

Please also notify the Victorian ICD Coding Committee of any anomalies. The State can, in many instances, influence a faster resolution of problems or make local adjustments to grouper software as required.

## Victorian modifications to AR-DRGs for 2004-05

As in previous years, some adjustments are to be made to the original AR-DRG5 (Version 5.0) grouping utilising the VIC-DRG5 field, prior to calculation of WIES 12. The AR-DRG Version 4.2 adjustments will continue to apply in WIES 12, except where changes have been routinely included within the AR-DRG5 structure. New VIC-DRGs have been created for:

- Mastoid procedures
- Gender reassignment patients
- VAD and ECMO patients

### Peritoneal dialysis

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

### Radiotherapy

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

To maintain funding equity, a Vic-DRG5 of R64Z Radiotherapy will be assigned for non-same day non-surgical episodes that include a radiotherapy diagnosis code, except for episodes with the following pre-MDC AR-DRG5.0s: A40Z, A41A, A41B, W60Z, W61Z, S65A, S65B, S65C, B60A, B60B.

### Hysteroscopy Sterilisation

Vic-DRG4 (N11C) was created in 2003–04 to adequately cover the costs of hysteroscopy sterilization and will be continued for 2004–05. Patients allocated an AR-DRG5.0 of N09Z, N10Z, N11B, N08Z, or O05Z with an ICD-10-AM procedure code of 35688-01 *Sterilisation via vaginal approach* are allocated VIC-DRG5 N11C. For 2004–05 the weights for DRG N11C have been set using costing information for N11B, but increased to cover the prosthesis costs associated with this procedure.

## **Admission Weight**

In AR-DRG Version 5.0, admission weight must be between 400 and 9999 grams otherwise the episode will be assigned to AR-DRG 960Z *Ungroupable*. The Department has been notified of live births where the baby weighs significantly less than 400 grams.

Episodes with an admission weight between 125 and 399 grams are assigned an admission weight of 400 grams for grouping to an appropriate VIC-DRG5.

## **Extra Corporeal Life Support (ECLS)**

Episodes involving extra corporeal membrane oxygenation (ECMO) or a ventricular assist device (VAD) are allocated to a variety of DRGs. Analysis of the Victorian cost data indicates that costs for these episodes are significantly discounted by other episodes allocated to the same DRGs.

In recognition of these cost differences, episodes not allocated to an ARDRG5.0 of A01Z *Liver transplant*, A03Z *Lung transplant*, or A05Z *Heart transplant*, and with one or more of the ICD-10-AM procedure codes 90225-00 *Extracorporeal membrane oxygenation [ECMO]*, 38615-00 *Insertion of left ventricular assist device*, 38618-01 *Insertion of right ventricular assist device*, or 38618-00 *Insertion of left and right ventricular assist device* are to be allocated to the Vic-DRG5 of A40Z.

## **Mastoidectomy**

Analysis of the Victorian cost data indicated that mastoid procedures allocated to ARDRG D06Z *Sinus, Mastoid and Complex Middle Ear Procedures* were significantly more costly than other D06Z procedures. These procedures were largely performed at the Royal Victorian Eye and Ear Hospital resulting in a relative funding disadvantage within this DRG. Consequently for WIES 12, AR-DRG5.0 D06Z will be split into D06A mastoid procedures, and D06B Other sinus and complex middle ear procedures.

Patients will be allocated to Vic DRG5 D06A where they are initially grouped to AR-DRG5.0 D06Z and one or more of the following procedure codes:

41545-00 *Mastoidectomy*,

41551-00 *Mastoidectomy by intact canal wall technique with myringoplasty*,

41554-00 *Mastoidectomy by intact canal wall technique with myringoplasty and ossicular chain reconstruction*,

41557-00 *Modified radical mastoidectomy*,

- 41557-03 *Incision of mastoid,*
- 41560-00 *Modified radical mastoidectomy with myringoplasty,*
- 41563-00 *Modified radical mastoidectomy with myringoplasty and ossicular chain reconstruction,*
- 41564-00 *Modified radical mastoidectomy with obliteration of mastoid cavity and eustachian tube and closure of external auditory canal,*
- 41566-00 *Revision of intact canal wall technique mastoidectomy,*
- 41566-01 *Revision of modified radical mastoidectomy, or*
- 41566-02 *Revision of radical mastoidectomy*

### **Diagnosis or procedure codes incompatible with sex**

In AR-DRG version 5.0 a patient's sex must be compatible with recorded diagnoses and procedure codes, else the episode will be assigned to AR-DRG5.0 960Z *Ungroupable*. However, episodes with incompatible codes can occur when gender reassignment or clarification is performed, or when these patients have retained their biological sex-specific organs and require treatment relating to them.

To resolve this potential grouping anomaly, episodes initially grouped to an AR-DRG5.0 of 960Z (i.e. diagnoses and procedure codes incompatible with sex) and with one or more additional diagnoses of E25.0, E25.8, E29.1, E34.5, F64.0, Q56.0, Q56.1, Q56.2, Q56.3, Q56.4, Q99.0 or Q99.1 (i.e. explanations of why the diagnosis or procedure is assigned against the sex) will be assigned to VIC-DRG5 of 964Z *Gender Reassignment – Conflict*. **This Vic-DRG5 will be assigned a WIES value of 0 (zero), and payment will be applied by assessing all diagnosis and procedure codes in order to determine the most appropriate AR-DRG5.0. This is necessary because previous data standards and VAED edits have excluded these episodes from the Victorian cost data used to determine 2004-2005 cost weights.**

## VAED reporting schedule requirements for 2004-05

A hospital may transmit data to the VAED as frequently as desired, and must meet requirements set out below.

### Metropolitan Health Services, hospitals and Multi-Purpose Services

The following information is taken from *Victoria-Public Hospitals and Mental Health Services Policy and Funding Guidelines 2004-2005* in General Conditions of Funding.

#### 6.5 Transmission of admitted patient data

- 6.5.1 The hospital will transmit data to the VAED via PRS/2 according to the timelines detailed in clauses 6.5.1. (a) and 6.5.1(b).
- (a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the 17th day of the following month (see (d) below for processing schedule).
  - (b) Diagnosis and procedure and sub-acute details in any month are to be transmitted in time for the VAED file consolidation on the 17th day of the second month following (see (d) below for processing schedule).
  - (c) Data for the financial year should be completed in time for the VAED file consolidation on 17 August 2005. Any corrections must be transmitted before finalisation of the VAED database on 17 September 2005.
  - (d) It is the hospital's responsibility to ensure that data are transmitted to the VAED to meet the processing schedule for inclusion in the Allegiance Systems file consolidation on the 17th of each month. VAED data (sent by modem) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disc) must be received by 12pm (noon) on the last working day on or before the 17th of the month.
  - (e) WIES12, multi-purpose service and sub-acute payments will be:
    - fully paid for data originally submitted in accordance with the deadlines specified in clauses 6.5.1.(a) and 6.5.1(b) above, even if data is subsequently amended; or
    - paid at a reduced rate (50 per cent), or not recognised for payment, according to Schedules 1 and 2 located at the end of this section if the data has not been submitted in accordance with either deadline specified in clauses 6.5.1(a) and 6.5.1(b) above; or
    - not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses 6.5.1(a) and 6.5.1(b) above.
    - This clause applies to all account classes including DVA.
  - (f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure details, the

Metropolitan Health Service, hospital or MPS must write to the department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for one-off late submission of data will generally only be considered for computer system problems that are beyond the control of the Metropolitan Health Service, hospital or MPS. (Metropolitan Health Services, hospitals or MPSs undertaking the PRS/2 data submission testing process are automatically exempted). Exemptions for late submission of admission and separation data will also be considered for staffing problems that are beyond the control of small rural hospitals and MPSs. Exemptions for late submission of admission and separation data will be automatically granted to hospitals or MPSs maintaining a consistently high level of timely data submission.

## **6.9 Patient Data Audits**

- 6.9.1 The Metropolitan Health Service, hospital or MPS will provide sufficient access to data and records to allow an audit of patient records, patient coding and data transmitted to the VAED.
- 6.9.2 If the audit shows a difference in assignment of DRGs and/or other data items that alter the allocation of WIES, or that patients fail to meet admission criteria, then the number of weighted inlier equivalent separations and/or throughput payments to the Metropolitan Health Service, hospital or MPS may be adjusted to take account of those differences.
- 6.9.3 Where the audit indicates that a Metropolitan Health Service, hospital or MPS has been consistently erroneous in the application of admission criteria and/or coding standards, the department will adjust or suspend the relevant throughput payments until such time as the issue is resolved to the satisfaction of the department.
- 6.9.4 The department also reserves the right to undertake supplementary audits to confirm an issue and/or monitor improvement; the cost of which is to be borne by the Metropolitan Health Service, hospital or MPS.
- 6.9.5 Access to data and records for interstate patients transmitted to the VAED will also be required should State or Territory Health Authorities request an independent audit to verify information on DRG weighted separations.
- 6.9.6 The Metropolitan Health Service, hospital or MPS will also provide sufficient access to data and records to allow an audit of patient records and data transmitted via AIMS as part of VACS.

6.9.7 Access to data and records for emergency department patients and persons on waiting lists will also be required should this department or the Commonwealth require an audit to verify information used for funding calculations either at the hospital or State level.

## Schedule 1

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

### VAED consolidation date

Month of Separation 2004-05	17 Aug	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate
January							Full Rate

### VAED consolidation date

Month of Separation 2004-05	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Nil	Nil	Nil	Nil	Nil	Nil	Nil
January	Half Rate	Nil	Nil	Nil	Nil	Nil	Nil
February	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
March		Full Rate	Half Rate	Nil	Nil	Nil	Nil
April			Full Rate	Half Rate	Nil	Nil	Nil
May				Full Rate	Half Rate	Nil	Nil
June					Full Rate	Half Rate	Nil

## Schedule 2

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

### VAED consolidation date

Month of Separation 2004-05	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb	17 Mar
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate

### VAED consolidation date

Month of Separation 2004-05	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Half Rate	Nil	Nil	Nil	Nil		
January	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
February		Full Rate	Half Rate	Nil	Nil	Nil	Nil
March			Full Rate	Half Rate	Nil	Nil	Nil
April				Full Rate	Half Rate	Nil	Nil
May					Full Rate	Half Rate	Nil
June						Full Rate	Half Rate

## Victorian Additions to the Australian Coding Standards

The following are the *Victorian Additions to Australian Coding Standards*, effective 1 July 2004 (supplementing ICD-10-AM, Fourth edition, volume 5). These should be applied for separations on or after 1 July 2004.

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

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

The Victorian Additions should be added to the ACS for 1 July 2004.

For 1 July 2004 there are changes to:

- *Vic Prefixes* and
- *Vic 2104 Rehabilitation*

Coders should pay particular attention to these two amended 'Vic Additions'.

### Summary of Victorian Additions for 2004–2005

Vic Prefixes	<i>Prefixes for diagnoses</i>
Vic 0029	<i>Coding of contracted procedures</i>
Vic 0030	<i>Organ procurement</i>
Vic 0229	<i>Radiotherapy</i>
Vic 0233	<i>Morphology</i>
Vic 2001	<i>External cause code use and sequencing</i>
Vic 2104	<i>Rehabilitation</i>
Vic 2108	<i>Assessment</i>

## Vic Prefixes

In Victoria a prefix is assigned to each diagnosis code.

The accepted prefixes are:

- **P** – Primary condition
- **C** – Complicating condition occurring after admission
- **A** – Associated condition not treated in this episode
- **M** – Morphology

Codes do not have to be listed in groups according to the prefix assigned. Whilst the principal diagnosis must be sequenced first, with a prefix of P, the order of the other codes should be in accordance with coding convention and/or Australian Coding Standards (ACS).

Do not confuse:

- Principal Diagnosis (ACS 0001) with the P prefix (primary condition)
- Additional Diagnosis (ACS 0002) with the A prefix (associated condition)

There is no direct relationship between the ACS and the prefixes. The following table may be a useful way of conceptualising the application of prefixes to ICD-10-AM codes.

	Possible prefixes			
	P - Primary	C - Complication	A - Associated	M - Morphology
<i>Principal diagnosis</i> ACS 0001	✓	X	X	X
<i>Additional diagnoses</i> ACS 0002	✓	✓	✓	X
Morphology code	X	X	X	✓
Procedure codes	X	X	X	X

## P - Primary Condition

Primary diagnoses are present at the time of admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with P if they required:

- Treatment, *or*
- Diagnostic procedures, *or*
- Increased nursing care and/or monitoring, *or*
- Active evaluation.

There can be more than one code prefixed P.

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

The P prefix will be assigned in the following circumstances:

- ❖ A previously existing condition that was not diagnosed until after the episode of care started.

### Example 1

Diabetes newly diagnosed during the current episode of care, and requiring treatment, further investigation or additional nursing care, is prefixed with P.

- ❖ A previously existing condition that is exacerbated during this episode of care.

### Example 2

Atrial fibrillation usually controlled on digoxin that becomes uncontrolled after surgery requiring treatment is prefixed with P.

### Example 3

Asthma usually controlled on Ventolin prn that becomes uncontrolled during admission requiring treatment is prefixed with P.

### Example 4

Hypertension usually controlled on Minipress that becomes uncontrolled during admission requiring treatment is prefixed with P.

- ❖ For consistency and ease of application, all obstetric codes (O codes) must be prefixed with P.

#### **Example 5**

An obstetric patient who is induced for 'post dates' (O48) and whose puerperium is complicated by grazed nipples (O92.2-) will have both these codes prefixed with P.

- ❖ Z codes related to outcome of delivery (Z37.0-), place of birth (Z38.-) and post partum care (Z39.-) are considered primary codes and must be prefixed with P.

### **A - Associated Condition**

An associated condition must be present at the time of admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with A if they are:

- The underlying disease (not treated) of a condition which was treated
- A condition or state which affected the treatment given, or length of stay, during this episode of care, but which does not meet the definition of a primary condition
- Conditions that are coded because of 'use additional code...' or similar instructions in ICD-10-AM, or because of a specialty standard (listed in ACS 0002) directing the coder to assign additional code(s), if these conditions were present on admission but do not meet the definition of a primary condition.

#### **Example 6**

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

#### **Example 7**

A child who was admitted for dental treatment (rather than being treated as a non-admitted patient) because they were autistic would be assigned a code for the autism and it would be prefixed with A.

#### **Example 8**

A patient with COAD who has a spinal anaesthetic rather than a general anaesthetic because of the COAD would be assigned a code for the COAD and it would be prefixed with A.

#### **Example 9**

Hypertension coded when it is present with a diagnosis in the range I20-I25.

#### **Example 10**

When a code for smoking status is assigned only because of instructions provided in ACS 0503 *Drug, alcohol and tobacco use disorders*, this code is prefixed with A.

#### **Example 11**

ACS 0401 *Viral hepatitis* instructs coders to assign code Z22.52 for *Carrier of hepatitis C*; if it does not meet the definition of a primary condition this code will be prefixed with A.

A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS2 for Work Cover patients.

## C – Complicating condition

A complicating condition is not present at the time the admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with C if they are:

- A condition that arose during this episode of care
- A condition resulting from misadventure during surgical or medical care in the current episode of care
- An abnormal reaction to, or later complication of, surgical or medical care occurring during the current episode of care.

### Example 12

A medical patient admitted for treatment of ischaemic heart disease who develops pneumonia during the hospital stay will have the code for the pneumonia prefixed with a C.

### Example 13

A patient who sustains a fracture due to fall from bed will have all the codes that are assigned for the fracture (injury, external cause, place of occurrence and activity) prefixed with a C.

### Example 14

An accidental laceration of blood vessel occurring during surgery will have all codes relating to the laceration (injury code, external cause, and place of occurrence) with a C.

### Example 15

An adverse drug reaction occurring during the current episode of care will have all codes relating to the adverse effect (adverse effect code, external cause, and place of occurrence) prefixed with a C.

### Example 16

A wound infection following surgery during the current episode of care will have all codes related to the wound infection (injury code, external cause, and place of occurrence) prefixed with a C.

## M – Morphology

Prefix morphology codes with an M (to distinguish these from musculoskeletal codes). The M prefix is optional for data entry but must be applied to morphology codes for transmission to PRS/2.

## Additional instructions

External cause, place of occurrence and activity codes must be assigned the same prefix as the diagnosis code to which they relate.

All other 'groups' of codes must have a prefix assigned for each code according to the prefix definitions provided in this document.

When a code potentially meets the definition for more than one prefix definition, assign the prefix according to the following hierarchy:

1. Primary condition (**P**)
2. Complication (**C**)
3. Associated condition (**A**)

### Example 17

A Type II diabetic patient develops lactic acidosis post operatively. The code E11.13 must be assigned. As the diabetes is pre-existing, and therefore a primary condition, and the lactic acidosis develops after admission, either Prefix P or Prefix C applies. Following the hierarchy above, assign Prefix P for this code.

### Example 18

A patient who suffers from COAD has an acute exacerbation of the COAD after admission to hospital. The acute exacerbation meets the criteria for assigning the prefix C. However, as the COAD is pre-existing and is treated it meets the criteria for assigning the prefix P. In this case assign prefix P in accordance with the hierarchy above.

### Example 19

A patient admitted for treatment of an adverse effect of a drug will have the code for the adverse effect, and the codes for external cause, place of occurrence and activity assigned the prefix P.

### Example 20

A patient admitted for treatment of uncontrolled Type II diabetes who also has peripheral neuropathy, and who develops acute renal failure later in the admission will be assigned prefixes as follows:

P E11.65 Type II diabetes with poor control  
P E11.71 Type II diabetes with multiple microvascular complications  
C N17.9 Acute renal failure, unspecified  
A G62.9 Polyneuropathy unspecified.

In this example, the 'multiple microvascular' aspect of the diabetes developed after admission, meeting the definition of a C prefix. However as the diabetes is also a pre-existing condition, the 'hierarchy' takes effect and E11.71 is prefixed with P.

*Issued 1 July 1993, Modified 1 July 2004*

## **Vic 0029 Coding of Contracted Procedures**

If the procedure is performed at another hospital under contract to this hospital, add a suffix to the procedure code (eighth character of the procedure code field).

Valid suffixes are:

- **F**-procedure performed at another hospital on an admitted basis, *or*
- **N**-procedure performed at another hospital on a non-admitted basis.

Refer to Department of Human Services, 2004, 'Procedure Codes' *VAED Manual* 14<sup>th</sup> Edition for further details on the use of these codes.

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

*Issued 1 July 1998*

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## **Vic 0030 Organ Procurement**

An episode for organ procurement is not yet included in the *National Health Data Dictionary* or in the Victorian Admitted Episodes Dataset (VAED); therefore the following two sections of Australian Coding Standard 0030 *Organ Procurement and Transplantation* do not apply in Victoria:

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

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

The following sections of ACS 0030 *Organ Procurement and Transplantation* are to be applied in Victoria:

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

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

*Issued 1 July 1998*

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## **Vic 0229 Radiotherapy**

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

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

*Issued 1 July 1998, Modified 1 July 2001*

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## **Vic 0233 Morphology**

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

This Victorian Addition supplements ACS 0233 *Morphology*.

*Issued 1 July 1998*

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## **Vic 2001 External Cause code use and sequencing**

When an External Cause code requires both a *Place of occurrence* code and an *Activity* code, sequence the *Place of occurrence* code before the *Activity* code.

This Victorian Addition supplements (fourth paragraph) ACS 2001 *External Cause code use and sequencing*.

*Issued 1 July 2002*

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## **Vic 2104 Rehabilitation**

Victorian coders are instructed to assign external cause codes for rehabilitation episodes of care as they would for any other episode of care.

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

If a patient is admitted for **treatment** of a condition but also receives rehabilitation before separation (regardless of bed or designation), the principal diagnosis must be the condition and the rehabilitation should be indicated by the appropriate allied health procedure codes. Z50.- *Care involving use of rehabilitation procedures* should not be added. Such episodes will normally be Type 4 (which includes acute).

This Victorian Addition supplements ACS 2104 *Rehabilitation*.

*Issued 1 July 1998, Modified 1 July 2001, Modified 1 July 2004*

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## **Vic 2108 Assessment**

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

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

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

This Victorian Addition supplements ACS 2108 Assessment.

*Issued 1 July 2001*

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# Coding Features

## Changes in AR-DRGs Version 5.0

This summary is taken from the Commonwealth Department of Health and Ageing, 2002, *Australian Refined Diagnosis Related Groups, Version 5.0, Definitions Manual*, Volume 1, p 4. (Reproduced with permission.)

Version 5.0 is the result of a comprehensive review of AR-DRG Version 4.2 using ICD-10-AM patient-level cost data. Statistical guidelines were revised to accommodate episode total cost as the dependent variable and these were applied to analyses of data from Rounds 3 and 4 of the National Hospital Cost Data Collection (1998-2000).

Version 5.0 incorporates the Third Edition of ICD-10-AM within the basic structure of version 4. However, the Adjacent DRG numbering sequence is no longer contiguous, and may not reflect the surgical hierarchy in some MDCs. New features are summarised below, and details of all recommendations for Version 5.0 are available on the Department's (of Health and Ageing) casemix internet site ([www.health.gov.au/casemix](http://www.health.gov.au/casemix)).

- New Adjacent DRGs: Respiratory Systems Diagnosis with Non-invasive Ventilation (E41); Knee Reconstruction or Revision (I29\_); and Major Breast Reconstruction (J14).
- Same-day DRGs for Glaucoma and Complex Cataract Procedures (C15); Lens Procedures (C16); Oral and Dental Disorders (D67\_); Skin Ulcers (J60); Major Skin Disorders (J68); Minor Skin Disorders (J67); Non-Surgical Spinal Disorders (I68); Cystourethroscopy in MDC 11 (I41); Antenatal and Other Obstetric Admission (O66); and Other Factors Influencing Health Status (Z64).
- Multiple Organ Transplant (A02) has been removed from the classification, and Renal Transplant (L01) has moved from MDC 11 to Pre-MDC (A09).
- Two adjacent DRGs for allogenic bone marrow transplant procedures (A07) and autologous bone marrow transplant procedures (A08) replace Adjacent DRG A04.
- Glaucoma procedure DRGs (C06 and C07) and lens procedure DRGs (C08 and C09) in MCD 02 appear as two Adjacent DRGs, C15 and C16 respectively.
- Adjacent DRGs for salivary gland procedures (D07) and mouth procedures (D08) in MDC 03 appear as one Adjacent DRG (D14).
- Complex Gastroscopy incorporates a test for gastroscopy and colonoscopy performed in one admission (G46 replaced G40 and G41).
- Cholecystectomy DRGs now distinguish between open and laparoscopic cholecystectomy (H07 and H08 replace H03 and H04).
- Fractures of pelvis and femoral neck appear as two Adjacent DRGs (I77 and I78 replace I62).
- Lower limb surgical DRGs in MDC 09 have been restructured (J12 and J13 replace J02 to J05).

- MDC 14 has been rewritten to perform PCCL grouping for deliveries, based on new CC and CC-exclusion lists for obstetric diagnosis codes. DRG 962Z Unacceptable Obstetric Diagnosis Combination has been removed from the classification-outcome of delivery codes (Z37.-) now have a central role in grouping episodes to delivery DRGs. The new structure includes a DRG for uncomplicated delivery to assist in obstetric benchmarking and a same-day DRG for antenatal admissions.
- DRGs for overnight HIV episodes have been combined into one Adjacent DRG (S65) with PCCL partitioning.

For further information regarding specific details of these changes, coders should view the recommendations for version 5.0 on the Department of Health and Ageing website. Note that these include all recommendations, not just the accepted ones.

## New VAED edits on diagnosis code prefixes

In 2004-05, HDSS will commence editing ICD-10-AM diagnosis codes (excluding morphology codes) against the prefix assigned to each code. (There is already an edit that ensures that morphology codes are prefixed with M). The new edits have been listed in the *Specifications for revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2004 – Appendix A, HDSS Bulletin 68*, and are reproduced at the end of this article.

Coders may not be aware that DHS and many other users of the data, make use of the prefixes in combination with ICD-10-AM codes, and therefore we wish to make sure that the combinations are as accurate as possible. To enable us to achieve this we have:

- Updated the 'Vic Prefixes' section in the *Victorian Additions to the Australian Coding Standards* for 1 July 2004.
- Developed edits that check the combination of ICD-10-AM diagnosis code and the assigned prefix.

### Nature of edits in the VAED

There are three different types of input edits generated by PRS/2, sent back to hospitals for investigation, and correction when appropriate. These edits are:

#### **Warning**

An edit message number prefixed by a W is a *warning*. That is, if there are no rejection edits, the record has been accepted but something needs to be checked and possibly corrected. If you take no action, the transaction will remain as reported.

#### **Notifiable**

An edit message number prefixed by an N is a *notifiable*. Episodes that trigger notifiable edits fall into one of two groups:

1. Where the data would, in the majority of cases, be incorrect.

It is acknowledged that for a very small number of episodes state wide per year, the combination of data items is correct.

The record has been accepted by PRS/2 but something must be checked and possibly corrected.

To confirm the data as correct, contact the HDSS Help Desk via email (PRS2.Help-Desk@dhs.vic.gov.au) or telephone (03 96168141).

Where the data has not been corrected nor confirmed as correct, HDSS will periodically notify each hospital, and request that this be attended to.

2. Where the combination of data is definitely incorrect.

The edit has been made notifiable to accommodate the PRS/2 logic in the update process. If these edits were designated Rejection edits, the only way to update these episodes, once they had been accepted by PRS/2, would be to delete the episodes and then re-transmit them. Where this data has not been corrected, HDSS will periodically notify each hospital, and ask them to do so. If these episodes are not corrected they will be removed from the end of year VAED consolidated file.

[This type of notifiable edit does not apply to the prefix edits.]

**Rejection** An edit message number prefixed by an *R* signifies a *rejection*. That is, PRS/2 does not retain a record of the transaction. The record must be checked, corrected and re-transmitted.

### **Edits on the combination of prefixes and diagnosis codes**

The new edits relating to combinations of Prefixes and Diagnosis Codes are:

559 Prefix = P, Unusual Code Combination (*Notifiable*)

560 Prefix = P, Unusual Code Combination (*Warning*)

561 Prefix = C, Unusual Code Combination (*Notifiable*)

562 Prefix = C, Unusual Code Combination (*Warning*)

563 Prefix = A, Unusual Code Combination (*Notifiable*)

564 Prefix = A, Unusual Code Combination (*Warning*)

### **Current Status of the new edits**

At the request of the Victorian ICD Coding Committee:

- These edits have only been applied to code in the S-Z range
- Will currently only trigger Warning edits

This strategy has been adopted to allow coders time to adjust to the new form of editing, and the updated Prefix Victorian Addition to the Australian Coding Standard.

### **Future of the new edits**

During 2004-05 there will be incremental changes to the library file to tighten these edits. This will include:

- Expanding the range of codes that these edits apply to (that is, codes from the A-R chapter range). Examples include:
  - Obstetric codes (O00-O99) should always be prefixed with a P
  - Diabetes codes would almost always be prefixed with a P or A, as it would be rare for diabetes to develop during an episode. (Diabetes that was present but undiagnosed on admission should be prefixed with a P.)
- Tightening the degree of the edits that are in place. Examples include:
  - External cause codes such as being bitten by a snake, in combination with a C prefix is currently a warning. This may be made a notifiable combination.
  - An activity of swimming in combination with a C prefix is currently a warning. This may be made a notifiable combination.

The procedure for notifiable edits is that hospitals can either:

- Fix incorrect data, and resubmit to PRS/2, or
- If the data is correct, either provide HDSS with the details, including the Patient Identifier, Unique Key, and the documentation in the record that justifies the data, or wait until DHS asks for the data, and provide it then.

There is no plan to make any combination of prefix and diagnosis codes a rejection. This is in recognition that such an edit could compromise a hospital's ability to meet the DHS data timeliness requirements.

## ICD-10-AM 4<sup>th</sup> edition Library File

The Library File specification for Prefix editing has been expanded to accommodate the new edits, as listed below.

The specification for the Library File is:

Field	Column(s)	Comments
	M	<p>ICD-10-AM Diagnosis Code Prefixes:</p> <p>Space: no restraint</p> <p>1: NOTIFY if Prefix = A</p> <p>2: NOTIFY if Prefix = C</p> <p>3: NOTIFY if Prefix = P</p> <p>4: NOTIFY if Prefix = A or C</p> <p>5: NOTIFY if Prefix = P or C</p> <p>6: WARN if Prefix = A</p> <p>7: WARN if Prefix = C</p> <p>8: WARN if Prefix = P</p> <p>9: WARN if Prefix = A or C</p> <p>10: WARN if Prefix = P or C</p> <p>11: NOTIFY if Prefix = C, WARN if Prefix = P</p> <p>12: WARN if Prefix = A, NOTIFY if Prefix = C</p> <p>13: NOTIFY if Prefix = A, WARN if Prefix = C</p>

### 559 Prefix = P, Unusual Code Combination

*Effect* NOTIFIABLE

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with P *Primary Diagnosis*, however this combination is highly unusual.

[On Library File: column M, PREF, code 3 or 5]

*Remedy*

- HDSS acknowledge that for a small number of episodes this combination of data items is correct. Check Diagnosis and Prefix codes. If any are incorrect, amend as appropriate and re-transmit the X2/Y2. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. If you consider a prefix edit unjustified, the Victorian ICD Coding Committee will be notified, for possible future revision of the Library File. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

Refer to:

- Section 3: *Diagnosis Codes*.

## 560 Prefix = P, Unusual Code Combination

*Effect* Warning

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with P *Primary Diagnosis*, however this combination is unusual.

[On Library File: column M, PREF, code 8, 10 or 11]

*Remedy* Check Diagnosis and Prefix codes, amend as appropriate and re-transmit the X2/Y2.

- If you consider a prefix edit unjustified, notify the Victorian ICD Coding Committee via the HDSS Help Desk, for possible future revision of the Library File.

Refer to:

- Section 3: *Diagnosis Codes*.

## 561 Prefix = C, Unusual Code Combination

*Effect* NOTIFIABLE

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with C *Complication*, however this combination is highly unusual.

[On Library File: column M, PREF, code 2, 4, 5, 11 or 12]

*Remedy*

- HDSS acknowledge that for a small number of episodes this combination of data items is correct. Check Diagnosis and Prefix codes. If any are incorrect, amend as appropriate and re-transmit the X2/Y2. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. If you consider a prefix edit unjustified, the Victorian ICD Coding Committee will be notified, for possible future revision of the Library File. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

Refer to:

- Section 3: *Diagnosis Codes*.

## 562 Prefix = C, Unusual Code Combination

*Effect* Warning

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with C *Complication*, however this combination is unusual.

[On Library File: column M, PREF, code 7, 9, 10 or 13]

*Remedy* Check Diagnosis and Prefix codes, amend as appropriate and re-transmit the X2/Y2.

- If you consider a prefix edit unjustified, notify the Victorian ICD Coding Committee via the HDSS Help Desk, for possible future revision of the Library File.

Refer to:

- Section 3: *Diagnosis Codes*.

## 563 Prefix = A, Unusual Code Combination

*Effect* NOTIFIABLE

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with A *Associated Diagnosis*, however this combination is highly unusual.

[On Library File: column M, PREF, code 1, 4 or 13]

*Remedy*

- HDSS acknowledge that for a small number of episodes this combination of data items is correct. Check Diagnosis and Prefix codes. If any are incorrect, amend as appropriate and re-transmit the X2/Y2. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. If you consider a prefix edit unjustified, the Victorian ICD Coding Committee will be notified, for possible future revision of the Library File. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

Refer to:

- Section 3: *Diagnosis Codes*.

## 564 Prefix = A, Unusual Code Combination

*Effect* Warning

*Problem* The X2/Y2 Diagnosis Record contains diagnosis code/s prefixed with A *Associated Diagnosis*, however this combination is unusual.

[On Library File: column M, PREF, code 6, 9 or 12]

*Remedy* Check Diagnosis and Prefix codes, amend as appropriate and re-transmit the X2/Y2.

- If you consider a prefix edit unjustified, notify the Victorian ICD Coding Committee via the HDSS Help Desk, for possible future revision of the Library File.

Refer to:

- Section 3: *Diagnosis Codes*.

## Admission Policy and the Australian Coding Standards

Please note that the following Australian Coding Standards (ACS) need to be applied within the context of the *DHS Hospital Admission Policy 2003-2004*. This policy can be accessed at <http://www.health.vic.gov.au/hdss/vaed/index.htm>.

### **ACS 0401     *Diabetes Mellitus and Impaired Glucose Regulation***

The following section of the ACS *0401 Diabetes Mellitus and Impaired Glucose Regulation* (p103) may imply that where patients undergo screening for diabetes, these episodes should be recorded as an admission.

#### **SCREENING FOR DIABETES**

The risk of developing Type 2 diabetes increases with:

- age
- obesity
- reduced physical activity

Screening for diabetes is often performed on:

- individuals with a family history of the disease
- members of high-risk racial/ethnic groups
- women with prior GDM or polycystic ovarian syndrome
- individuals with hypertension, dyslipidaemia or previously identified IGR or vascular disease

(See also ACS 2111 *Screening for specific disorders*)

#### **Classification**

Z13.1 *Special screening examination for diabetes mellitus* should be assigned as the principal diagnosis code when the patient is admitted specifically for screening when diabetes or IGR is excluded. In cases of screening prompted by a family history of diabetes an additional code of Z83.3 *Family history of diabetes mellitus* should be added.

Patients requiring 'screening for diabetes' should not be routinely admitted, as this is generally performed in pathology departments, and takes approximately two hours, most of which consists of waiting time in between testing. Admissions for screening for diabetes would need to meet the Type B or C Criterion for Admission.

## ACS 1550 *Discharge/Transfer in Labour*

The new ACS 1550 *Discharge/Transfer in Labour*, reproduced below, should be applied in the context of the VAED *Leave* concept definitions and *Length of Stay* business rules.

### Definition

False labour, also called Braxton Hicks contractions, are irregular tightenings of the pregnant uterus that begin in the first trimester and increase in frequency, duration and intensity as the pregnancy progresses. The crucial difference between false and true labour is that the cervix does not actually change in false labour whereas it does dilate and soften during true labour.

A woman may begin her labour at one hospital and then be transferred to another hospital for the delivery of the baby. The reasons for the transfer may be:

Clinical - a medical condition of the mother or baby or both

Administrative - lack of obstetric services, lack of obstetric beds, lack of neonatal services, patient choice

A woman may also be discharged home in labour to await more established labour before being readmitted for the delivery episode.

### Classification

For coding the undelivered admission, assign the following codes:

- Clinical – the medical (obstetrical) condition that necessitated the patient's transfer.
- Administrative/Discharged home:
  - for = 37 completed weeks of gestation assign the appropriate code from category 'Z34 *Supervision of normal pregnancy*' as the principal diagnosis
  - for < 37 completed weeks of gestation assign the appropriate code from category 'O60 *Preterm delivery*' as the principal diagnosis.

Specifically, where patients are admitted for induction and are subsequently sent home to wait for established labour, they should be put on leave (as you are expecting the patient to return within seven days), rather than be separated with a new admission recorded when they return.

## **Proposed edits between procedure codes and criterion for admission**

Many coders would be aware that the *Proposals for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2004* contained a proposal to edit between ICD-10-AM Procedure Code and Criterion for Admission. This proposal was not implemented, largely due to the need to clarify where some of the ICD-10-AM procedure codes 'fitted' into the *Day Only Procedures Manual*. We are continuing to liaise with the Commonwealth on these and related issues.

There have been several requests from HIMs in the field for us to release a list of the ICD-10-AM procedure codes with an indication of which codes are considered Type A, B and C codes, and which codes we believe should have no impact on the decision to admit (for example, the need for physiotherapy has no impact on whether the patient should be admitted or not). We are currently undertaking this work, and will publish it on the HDSS website in the near future. Due to ongoing negotiations with the Commonwealth, this work, even when released, will not be complete.

Hospitals will be notified of the availability of this document through the HDSS Bulletin. An article on the relationship between ICD-10-AM procedure codes and MBS codes will be published in the August ICD Coding Newsletter.

## Updated Calendar of ICD Coding and DRG Grouping Systems used in Victoria

Fin. Year July/June	ICD ed: (edition/ release date) (a)	ICD ed: Vic	Coding Standards used in Victoria	Aust DRG version released	DRG version: Vic (b)	Codes input to DRG version: Vic (c)
04-05	AM 4 (Jul 2004)	AM 4	Aust Standards AM 4th ed. with some Vic Additions	No release	AR v5.0 *	AM 3
03-04	No release	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
02-03	AM 3 (Jul 2002)	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	AR v5.0	AR v4.2 *	AM 2
01-02	No release	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
00-01	AM 2 (Jul 2000)	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.2	AR v4.1 *	AM 1
99-00	No release except Amendment list	AM 1	Aust Standards AM 1st ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
98-99	AM 1 (Jul 1998)	AM 1	Aust Standards AM 1st ed. with some Vic Additions	AR v4.1	AN v3.1 *	Aust CM 2
1.7.98	Victoria changed from ICD-9-CM to ICD-10-AM.					
97-98	No release	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AR v4.0	AN v3.1 *	Aust CM 2
96-97	Aust CM 2 (Jul 96)	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AN v3.1	AN v3.1 *	Aust CM 2
95-96	Aust CM 1 (Jul 95)	Aust CM 1	Aust Standards CM 1st ed. with some Vic Additions	AN v3.0	AN v1.0 *	U.S. 8
94-95	U.S. 10 (Oct 93)	U.S. 10	Vic Guidelines Revised, incorporating National Coding Standards	An v2.1	AN v1.0	U.S. 8
93-94	U.S. 9 (Oct 92)	U.S. 9	Vic Guidelines Revised, incorporating National Coding Standards	AN v2.0	AN v1.0	U.S. 8
1.7.93	Victoria introduced casemix funding					
92-93	U.S. 8 (Oct 91)	U.S. 8	Vic Guidelines 2nd ed (Revised)	No release	AN v1.0	U.S. 8
91-92	U.S. 7 (Oct 90)	U.S. 6	Vic Guidelines 2nd ed	AN v1.0	AN v1.0	U.S. 8
90-91	U.S. 6 (Oct 89)	U.S. 6	Vic Guidelines 2nd ed		HCFA v4	U.S. 2
89-90	U.S. 5 (Oct 88)	U.S. 5	Vic Guidelines 1st ed		HCFA v4	U.S. 2
88-89	U.S. 4 (Oct 87)	U.S. 2	Vic Guidelines 1st ed		HCFA v4	U.S. 2
87-88	U.S. 2 (Oct 86)	U.S. 2	(Victorian) VHSS guidelines		HCFA v4	U.S. 2
1.7.86	Victoria changed from ICD-9 to ICD-9-CM.					

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



## **'Old' NCCH advice**

To ensure that all NCCH advice followed by Australian coders is incorporated into a future edition of ICD-10-AM, the NCCH has undertaken to review advice previously provided to coders that may not have been incorporated into the next published version of ICD-10-AM. The Victorian ICD Coding Committee is asking Victorian coders to assist with this task.

If you or coders at your hospital follow any advice that has been previously issued by the NCCH but never incorporated into an Australian Coding Standard, please forward the following relevant information to Sara Harrison, Secretary Victorian ICD Coding Committee ([sara.harrison@dhs.vic.gov.au](mailto:sara.harrison@dhs.vic.gov.au)) by Monday 16 August 2004.

- Details of advice provided
- Where this information was provided (for example Coding Matters, NCCH query database, education session, other)
- When this information was provided (date/volume number)
- Why your coders are still following this advice (for example 'no further/more recent advice/information provided on this subject').

## **VICC Members as at 1 June 2004**

Jennie Shepheard	Human Services (Chair, Acting La Trobe University representative)
Carla Read	Human Services (Convener)
Sara Harrison	Human Services (Secretary)
Melinda Avram	Epworth Hospital
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Morrison	The Royal Women's Hospital
Jade Oliver	Austin Health
Susan Peel	Healesville and District Hospital
Catherine Perry	NCCH representative (Human Services CSAC representative)
Leanne Stokes	Beachplace Pty Ltd
Kathy Wilton	3M

## **Coding Committee Meeting Dates**

Tuesday 20 July	DHS, 10:00am, 16 <sup>th</sup> floor 555 Collins Street, Melbourne
Tuesday 17 August	DHS, 10:00am, 16 <sup>th</sup> floor 555 Collins Street, Melbourne
Tuesday 21 September	DHS, 10:00am, 16 <sup>th</sup> floor 555 Collins Street, Melbourne

## References used in the production of this newsletter

National Centre for Classification in Health, 2004 *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* Fourth Edition.

Commonwealth Department of Health and Ageing, 2002 *Australian Refined Diagnosis Related Groups, Version 5.0, Definitions Manual, Volume 1*.

Department of Human Services Victoria, 2004 *Victoria—Public Hospitals and Mental Health Services, Policy and Funding Guidelines*.

## 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
CC	Complication or Comorbidity
CCCG	Clinical Classification and Coding Groups
CCL	Complication or Comorbidity Level
CSAC	Coding Standards Advisory Committee
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
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
LOS	Length Of Stay
MDC	Major Diagnostic Category
NCCH	National Centre for Classification in Health
PDx	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
PCCL	Patient Clinical Complexity Level
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee
WHO	World Health Organisation