

ICD Coding Newsletter

Special edition June 2006

Distribution List

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

The ICD Coding Newsletter supports the clinical coding function performed in Victoria by 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 9096 8141

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HDSS web site is:

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

An electronic coding query form can be completed at:

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

An index to Coding Newsletters can be found at:

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

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1 July Information updates

Coding classification

All separations on or after 1 July 2006 must be coded using ICD-10-AM/ACHI Fifth Edition (and relevant errata) in accordance with the current Australian Coding Standards effective 1 July 2006, 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://www3.fhs.usyd.edu.au/ncch/>).

Library file for 2006-07

The 2006-07 library file (in Excel format) and the description of the file structure are available on the HDSS webpage at:

<http://www.health.vic.gov.au/hdss/reffiles/2006-07/vaed/libfil06.htm>

Software suppliers and hospitals are advised to download the new version of the ICD-10-AM/ACHI library file. Any updates to the file during 2006-07 will be published in the HDSS Bulletin.

The Excel file has been zipped and password protected using the same password as last year. If you do not have, or have forgotten the password, please contact the HDSS help desk.

Our licence agreement only permits DHS to release our ICD-10-AM/ACHI Library File within Victoria to hospitals and software vendors. The Victorian library file is a modification of the National ICD-10-AM/ACHI ASCII files, which are produced by the National Centre for Classification in Health (NCCH). If you are not authorised to receive the Victorian library file you may contact the NCCH on (02) 9351 9461 or email at ncchadmin@fhs.usyd.edu.au.

NCCH advice

Coders are reminded that information provided on the NCCH query database should be followed for coding in Victoria. This database may be referenced during patient data audits. The NCCH is committed to incorporating all of their advice into the latest version of their classification. If you are aware of information provided on the NCCH query database, in Coding Matters or via another NCCH source that has not been incorporated into the most recent publication of ICD-10-AM/ACHI please notify the secretary of the Victorian ICD Coding Committee (Carla.Read@dhs.vic.gov.au) Include in your notification the following information:

- 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').

Grouper version and mapping

For 2006-07, DHS will map ICD-10-AM/ACHI Fifth Edition codes to ICD-10-AM Fourth Edition codes for input to the AR-DRG Version 5.1 Grouper.

Information about AR-DRG Version 5.1 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 5.1 Definitions Manual.

Mapping tables from ICD-10-AM/ACHI Fifth Edition to Fourth Edition have been incorporated into the 2006-07 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 <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-casemix-grouper-bugform.htm>.

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 2006-07

The *Victoria —Public Hospitals and Mental Health Services Policy and Funding Guidelines 2006-07 (Technical information)* contains detailed information regarding Victorian modifications to AR-DRGs. This is reproduced below for your information with a link to the guidelines.

<http://www.health.vic.gov.au/pfg/index.htm>

In 2006–07, hospitals will assign diagnoses and procedure codes using the 5th edition of the ICD-10-AM/ACHI classification. For funding purposes, these codes will be mapped back to 4th edition codes and then grouped using AR-DRG Version 5.1.

As in previous years, some adjustments are to be made to the original AR-DRG5 (Version 5.1) grouping utilising the VIC-DRG5.1 field, prior to the calculation of WIES13. The AR-DRG Version 5.0 adjustments that applied in WIES12 will continue to apply in WIES13, except where changes have been routinely included within the AR-DRG5.1 structure.

Most VIC-DRG5.0 changes introduced for WIES12 in 2004–05 will continue in 2006–07, namely:

- the extension of A40Z to contain a broader range of high cost life support procedures
- splitting of D06Z into D06A Mastoid Procedures and D06B Other Sinus and Complex Middle Ear Procedures
- the ICD-10-AM diagnosis code Z71.3 *Dietary counselling and surveillance* will not be recognised as a complication and/or comorbidity code for the purpose of grouping to VIC-DRG51.

1.1 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-DRG51 of L61Y *Admit for peritoneal dialysis*.

1.2 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-DRG51 of R64Z *Radiotherapy* will be assigned for nonsurgical episodes that include a radiotherapy diagnosis code, except for episodes with the following AR-DRG5.1s: B61A and B61B; and pre-MDC AR-DRG5.1s: A40Z, A41A, A41B, W60Z, W61Z, S65A, S65B, S65C, B60A, and B60B.

1.3 Hysteroscopy sterilisation

Based upon clinical advice on emerging clinical practice, a VIC-DRG51 (N11C) has been created to adequately cover the costs of hysteroscopy sterilization. Patients allocated an AR-DRG5.1 of N09Z, N10Z, N11B, N08Z, or O05Z with an ICD-10-AM 4th edition procedure code of 35688-01 are allocated to VIC-DRG51 N11C.

WIES13 cost weights for DRG N11C have been set using costing information for N11B, but increased to cover the prosthesis costs associated with this procedure.

1.4 Mastoid procedures

Analysis of the Victorian cost data indicated that mastoid procedures allocated to D06Z 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 WIES13, D06Z will be split into:

- D06A Mastoid Procedures
- D06B Other Sinus and Complex Middle Ear Procedures.

Patients will be allocated to VIC-DRG51 of D06A where they are initially grouped to ARDRG5.1 of D06Z and have one or more of the following ICD-10AM 4th edition procedure codes: 4154500, 4155100, 4155400, 4155700, 4155703, 4156000, 4156300, 4156400, 4156600, 4156601, 4156602. All other patients allocated to AR-DRG5.1 of D06Z will be allocated to VIC-DRG51 of D06B.

1.5 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 AR-DRG5.1 of A01Z,

A03Z, or A05Z and with one or more of the ICD-10-AM 4th edition procedure codes 90225-00, 38615-00, 38615-01, 38618-00 are to be allocated the VIC-DRG51 of A40Z.

1.6 Dietary counselling and surveillance

In AR-DRG version 5.1 the ICD-10-AM diagnosis code *Z71.3 Dietary counselling and surveillance* has a clinical complexity level (CCL) of two, for both medical and surgical DRGs. Even where Z71.3 is coded appropriately, the department feels this CCL value is inappropriate for a code of this nature and has created an AR-DRG 5.1 modification where Z71.3 will be allocated a CCL value of 0 before grouping to VIC-DRG51.

Victorian Additions to the Australian Coding Standards

The following are the *Victorian Additions to Australian Coding Standards*, effective 1 July 2006 (supplementing Australian Coding Standards, Fifth Edition). These should be applied for separations on and after 1 July 2006.

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 2006.

For 1 July 2006 there are changes as follows:

- **Vic 0002 Additional diagnoses - new**
- **Changes to the prefixing of obstetric codes**

Summary of Victorian Additions for 2006–2007

Vic Prefixes	<i>Prefixes for diagnoses</i>
Vic 0002	<i>Additional 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.

- ❖ Z codes related to outcome of delivery (Z37.-), 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 is prefixed with A

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 (complication code, 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 (complication code, organism code if applicable, 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.

Obstetric patients

For obstetric patients the following instructions apply:

Prefix with P:

- The principal diagnosis will be prefixed with P even if it is a condition that occurs post admission
- In delivered obstetric cases, the P prefix will apply to all conditions arising from the beginning of labour to the end of second stage, that is, until the baby is born.
- Z codes related to the outcome of delivery, and post partum care will be prefixed with P
- When in doubt about the correct prefix, apply the hierarchy of prefixes (see additional instructions).

Prefix with C:

- Any conditions arising after the end of the second stage of labour
- Any conditions arising after admission in a non delivered obstetric episode.

Prefix with A:

- Any conditions that must be coded but do not meet criteria for P or C.

The following definitions from the American Pregnancy Association may aid with prefix allocation.

First stage: Begins from the onset of true labour and lasts until the cervix is completely dilated to 10 cm.

Second stage: Continues after the cervix is dilated to 10 cm until the delivery of your baby.

Third stage: Delivery of placenta

Example 17

A woman is admitted for induction of labour due to post dates. During delivery she suffers a 1st degree tear that is sutured and a post partum haemorrhage. The baby is born alive with the cord wrapped around its neck. Codes and prefixes are assigned as follows:

PO48 Prolonged pregnancy (principal diagnosis)

PZ37.0 Outcome of delivery

PO70.0 First degree perineal laceration during delivery

PO69.2 Labour and delivery complicated by other cord entanglement

CO72.1 Other immediate post partum haemorrhage

Procedure codes

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:

Primary condition (**P**)

Complication (**C**)

Associated condition (**A**)

Example 18

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 19

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 20

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 21

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 2006

Vic 0002 Additional diagnoses

This Victorian Addition to the Australian Coding Standards represents the Victorian interpretation of ACS 0002. Victoria is currently working with the NCCH on amendments to the national standard to address some of the difficulties in application of the current version. Meanwhile Victorian coders should be guided by the following in addition to the criteria outlined in ACS 0002.

1. In Victoria '**active evaluation**' is recognised as a criterion for the assignment of additional diagnoses codes. The definition of 'active evaluation' is:
'Review of current, active conditions as evidenced by documentation in the medical record that is not simply part of routine admission/anaesthetic examination'.

This applies to:

- Conditions that develop during the course of the patient's episode that are evaluated and may or may not require ongoing care or investigation.
- Pre-existing conditions for which there is an active decision not to change the current treatment or not to investigate further.

Example 1

During the course of an episode of care for COAD, a patient develops a mildly painful toe. Evaluation of the toe reveals an ingrown toenail. As the patient is due to go home the next day, and has plans to visit his GP the following day, a decision is made to allow the GP to manage the condition.

In this case, a code is assigned for the ingrown nail because an active decision has been made regarding the condition.

Example 2

A patient is admitted to have a total hip replacement. During his stay he expresses concern about his heart failure medication. The doctor discusses the patient's heart condition with him, and decides that the medication is appropriate and recommends that no further action be taken.

In this case a code is assigned for the heart condition because it has been actively evaluated although not treated or investigated.

2. **Conditions noted on examination of the newborn.** Routine examination of the neonate is similar to the taking of an admission history. Therefore conditions noted during the examination are not routinely coded. Information regarding birth anomalies is collected in the Perinatal Data Collection and the coding of these conditions is therefore not required for 'public health' reasons. These conditions must meet ACS 0002 criteria before a code can be assigned for them.

Example 3

On examination of a newborn portwine naevus and clicky hip were noted. A decision was documented that the baby would be referred for a paediatric opinion regarding the clicky hips (active evaluation). Nothing further was done about the portwine naevus.

A code is assigned for the clicky hips because it has been actively evaluated although not treated or investigated, but not for the portwine naevus because it was simply noted incidentally on examination.

3. **Findings at histology examination.** All findings at histology are coded, as histology examinations provide definitive information that does not require clinical interpretation, and as, in many cases, any of the findings can be the cause of the patient's problem.

Example 4

A hysterectomy was performed for a diagnosis of menorrhagia. Histology revealed leiomyomata and endometritis.

A code is assigned for both the leiomyomata and endometritis.

4. **Placental abnormalities.** Placental abnormalities noted on routine examination of the placenta must be coded. This instruction is inconsistent with other instructions in this document. However as these have been routinely coded for many years, and there has been no definitive discussion regarding these conditions at a national level, the DHS decision is that they should continue to be coded until further notice.

Example 5

On delivery of the placenta during the third stage of labour 'placenta circumvallate' is noted. A code is assigned for this condition.

5. All **instructional notes** in the classification must be followed. In some cases this will result in the assignment of a code for a condition that does not meet the criteria outlined in ACS 0002.

Example 6

Code blocks I20- I25 and I60- I69 contain the following note: *Use additional code to identify presence of hypertension.* This note must be followed even if the hypertension does not meet additional diagnoses criteria.

6. Risk factors and related conditions are not coded unless they meet ACS 0002 criteria. However the NCCH has provided advice in queries 1386, 1711, and 2154 as follows: *When a patient is admitted for a cardiac condition, it is appropriate to assign a code for 'old MI' or 'history of CABGs' if this is documented in the patient's history. It would almost always be clinically relevant and affect the treatment of the cardiac condition for the current episode of care.*
- Coders should limit application of this advice to the scenarios outlined in the respective queries.

Example 7

A patient was admitted to have a coronary angiogram. Note was made of the patient's history of CABGs and his previous AMI 3 years ago. Codes may be assigned for these conditions. The same patient was readmitted three days later following a fall in the street. For this second admission codes for presence of CABGS and old AMI cannot be assigned unless these conditions meet additional diagnoses criteria.

7. **Pregnancy related conditions** that are present on admission and that resolve post delivery must all be coded. Pregnancy related conditions that existed during the pregnancy but are no longer present are not coded.

Example 8

A patient was admitted for induction of labour. Conditions noted on admission included pregnancy induced hypertension and post dates. A code is assigned for both these conditions because they were present on admission.

There is also a note that the antenatal period was complicated by recurrent UTIs but no evidence that the patient is currently suffering from a UTI. No code is assigned for the pregnancy complicated by UTI because it is not present on admission.

Issued July 1 2006 (advice available on web site since 2000)

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, 'Procedure Codes', Section 3, *VAED Manual 15th Edition* for further details on the use of these codes.

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

Issued 1 July 1998

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

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

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

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.

An external cause code is required to follow any S or T code in all circumstances in Victoria.

This Victorian Addition supplements ACS 2001 *External Cause code use and sequencing*.

Issued 1 July 2002. Modified 1 July 2005

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

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

Updates to VAED reporting

VAED reporting schedule requirements for 2006-07

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

The following information is taken from *Victoria-Public Hospitals and Mental Health Services Policy and Funding Guidelines 2006-2007* in *General Conditions of Funding Chapter 6*.

6.5 Transmission of admitted patient data

The hospital will transmit admitted patient data to the Victorian Admitted Episodes Dataset (VAED) via PRS/2 according to the timelines detailed in clauses (a) and (b) below.

- 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 the processing schedule).
- b) Diagnosis and procedure and sub-acute details in any month must 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 must be completed in time for the VAED file consolidation on 17 August 2007. Any corrections must be transmitted before finalisation of the VAED database on 17 September 2007.
- 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 PRS/2 file consolidation on the 17th of each month. VAED data (sent electronically) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disk) must be received by 12pm (noon) on the last working day on or before the 17th of the month.
- e) WIES13, SRHS and sub-acute payments will be:
 - fully paid for data originally submitted in accordance with the deadlines specified in clauses (a) and (b) above, even if data is subsequently amended

- 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 (a) and (b) above, or
- not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses (a) and (b) above.

This clause applies to all account classes including DVA.

- f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure data, the Metropolitan health service, hospital or SRHS must write to the Manager, Health Data Standards and Systems, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule.

Occasional exemptions for late submission of admission and separation (E3) data may be granted to Metropolitan health services, hospitals or SRHSs maintaining a consistently high level of timely data submission.

Exemptions for late submission of admission and separation (E3) data will also be considered for staffing problems that are beyond the control of small rural hospitals and SRHSs.

Exemptions for late submission of diagnosis and procedure (X3) data will only be considered for circumstances beyond the control of the hospital. Software problems are, of themselves, insufficient justification for late submission of data. Hospitals are expected to have arrangements in place with their software vendor to ensure that statutory reporting requirements are met.

Metropolitan health services, hospitals and SRHSs undertaking the PRS/2 data submission testing process are automatically exempted for the applicable months of data.

6.6 Transmission of mental health data to the VAED

Metropolitan health services, hospitals and SRHSs must transmit data for admitted mental health patients to the VAED via PRS/2 according to the timelines and specifications outlined in this document, the VAED Manual and any amending documentation.

Where hospitals are non-compliant with the timelines and specifications the Department may apply a penalty for each non-compliant record no greater than the amount of the applicable notional bed-day rate published in Victoria–public hospitals and mental health services Policy and funding guidelines 2006–07.

↓

6.11 Patient data

The Metropolitan health service, hospital or SRHS will provide sufficient access to data and records to allow audits of patient records, patient coding and data transmitted to the VAED, VEMD, ESIS, AIMS and other data collection systems [including Victorian Ambulatory Classification System (VACS) data.]

If these audits show a difference in assignment of DRGs and/or other data items that alter the allocation of WIES or other funding, or that patients fail to meet admission or other eligibility criteria, then the number of weighted inlier equivalent separations and/or throughput payments and/or other funding payments to the Metropolitan health service, hospital or SRHS may be adjusted to take account of those differences.

Where these audits indicate that a Metropolitan health service, hospital or SRHS has been consistently erroneous in the application of admission criteria and/or coding standards and/or other eligibility criteria, the department may adjust or suspend the relevant throughput or funding payments until such time as the issue is resolved to the satisfaction of the department.

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 SRHS.

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.

The department will have access to patient level cost data and to patient level data transmitted to the VAED, VEMD, and ESIS.

Editor's Note: An audit of VAED 2005-07 data will take place over the next two years.

Schedule 1

Timelines for the receipt of admission and separations details (E3)

VAED consolidation date

Month of separation 2006–07	17 Aug	17 Sep	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 2006–07	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 (X3, Y3) and sub-acute details (S3)

VAED Consolidation date

Month of Separation 2006–07	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 2006–07	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Half rate	Nil	Nil	Nil	Nil	Nil	Nil
January	Full rate	Half rate	Nil	Nil	Nil	Nil	Nil
February		Full rate	Half rate	Nil	Nil	Nil	Nil
March			Full rate	Half rate	Nil	Nil	Nil
April				Full rate	Half rate	Nil	Nil
May					Full rate	Half rate	Nil
June						Full rate	Half rate

Revisions to library file edits for 1 July 2006

In addition to the modification of the library file for Fifth Edition of ICD-10-AM/ACHI, the following changes have been made to the triggering of VAED edits:

N358 Area Code Restraint

Feedback received by HDSS suggests that many of the infectious diseases triggering this edit are of episodes of patients who are immunodeficient. HDSS has therefore once again reviewed the list of diagnosis codes and has reduced the number that trigger the edit on the PRS/2 report. We will however, as part of the notifiables process, send notifications to sites where an unusual infectious disease code has been assigned without diagnosis code *D84.9 Immunodeficiency*.

N595 Neoplasm Code Missing

The library file has been modified to trigger this edit if the morphology code has not been sequenced directly after the neoplasm code, in accordance with advice published in Coding Matters Volume 12 Number 4 March 2006, in the article titled *Sequencing of asterisk and morphology codes for episodes care requiring neoplasm codes*. The edit remains notifiable to accommodate neoplasms not classified in the neoplasm chapter that sometimes require a morphology code.

R600 Invalid Code

Fifth Edition diagnosis code *Z58.7 Exposure to tobacco smoke* will trigger this edit if it is assigned. This is in accordance with advice given at the NCCH Fifth Edition education workshops, and published in the education material.

The validity of the following diagnoses codes has been reverted to 'valid' but will trigger this edit if assigned for Victorian episodes:

Z38.2 Singleton unspecified as to place of birth

Z38.5 Twin unspecified as to place of birth

Z38.8 Other multiple unspecified as to place of birth

W355 Invalid Principal Diagnosis – Warning

This edit has been removed from diagnosis code *Z34.9 Supervision of normal pregnancy unspecified*, as in certain circumstances it is appropriate to assign this code as a principal diagnosis as per ACS 1550 Discharge/Transfer in Labour.

Admission Policy

The current DHS Hospital Admission Policy 2003-04 can be accessed at <http://www.health.vic.gov.au/hdss/vaed/admpol0304.pdf>

Coders should be aware of the guidelines provided in this policy. Updates will be notified via DHS Bulletins as they become available.

Care Type changes on the Admission or Separation Date

Coders will have noted the change to reporting arrangements for patients who, in the past, have been admitted to one Care Type and then changed to another Care Type later on the day of admission. From 1 July 2006, only one Care Type may be reported on the day of admission or the day of separation. This is to prevent the same day from being double counted as a patient day, and is an extension of the instruction not to report same-day episodes occurring during a multi-day episode of another Care Type.

Usually these are patients who present to the emergency department and receive treatment in the emergency department, and are then transferred to another Care Type (most often mental health). In 2005-06 (year-to-date) there were several same day episodes reported to the VAED where a transfer to another Care Type was recorded on the same day.

Hospitals are advised that when a patient is admitted as one Care Type and then changed to another Care Type in the same day, do not report the initial Care Type to the VAED.

The following coding feature, originally printed in the November 2002, has been reprinted (with updates to references) here to assist coders to determine the appropriate principal diagnosis in this scenario.

Emergency admission time and assignment of principal diagnosis

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, 15th Edition, July 2005, page 3-19.

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 (2003). National Health Data Dictionary, Version 12, 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.

