

The following are the Victorian Additions to Australian Coding Standards, effective 1 July 2003 (supplementing ICD-10-AM, third edition, volume 5)

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 Australian Coding Standards (ACS) (ICD-10-AM 3rd Edition) for 1 July 2003.

Complete Summary of Victorian Additions:

Vic Prefix.1	<i>Prefixes for diagnoses</i>
Vic Prefix.2	<i>Prefixes for obstetric codes</i>
Vic 0029	<i>Coding of contracted procedures</i>
Vic 0030	<i>Organ procurement</i>
Vic 0229	<i>Radiotherapy</i>
Vic 0233	<i>Morphology</i>
Vic 2001	<i>External cause code use and sequencing</i>
Vic 2104	<i>Rehabilitation</i>
Vic 2108	<i>Assessment</i>

Vic Prefix.1 Prefixes for Diagnoses

A diagnosis must meet the criteria specified in ACS 0001 *Principal Diagnosis*, or ACS 0002 *Additional Diagnoses*, in order to be coded. Once a decision has been made to code a condition, Victorian standards require that a prefix be assigned. The following instructions advise on the assignment of the prefix to coded conditions. Note that only diagnosis codes require a prefix.

Codes do not have to be listed in groups according to the prefix assigned. Whilst 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 ACS. There is no requirement that codes be placed in groups according to prefix.

Primary and associated diagnoses are conditions present at time of admission (or when the episode of care commenced), even if not diagnosed prior to this episode of care.

A secondary function of the A prefix is to suppress the code description for TAC and WorkCover certificates, generated by PRS/2.

Refer also to ACS 0002 *Additional Diagnoses* for guidance on whether or not a condition should be coded. However, be aware that many conditions that meet the criteria for additional diagnoses will be prefixed with 'P' rather than 'A', as they will receive active treatment during the episode of care. Some examples of conditions that would usually be prefixed with 'A' are Z72.0, *Tobacco use, current*, and Z22.52, *Carrier of viral hepatitis C*. These conditions would usually not be treated but there is a requirement to code them in Australian Coding Standards. Most cases would have very few if any codes prefixed with 'A'.

There is no direct relationship between the Australian Coding Standard 0002, *Additional Diagnoses* and the instructions relating to Associated Conditions contained in the Victorian Addition to the Standards, Vic Prefix 1, Prefixes for Diagnoses. Nor is there any relationship between the Australian Coding Standard 0001, *Principal Diagnosis* and the instructions relating to Primary Diagnoses contained in the Victorian Addition to the Standards, Vic Prefix 1, Prefixes for Diagnoses.

P - Primary Diagnosis

Primary diagnoses are those for which the patient received treatment or investigation during this episode of care. There can be more than one code prefixed P.

The first diagnosis code must be prefixed P and meet the definition for Principal Diagnosis (ACS 0001 *Principal Diagnosis*, page 2).

Other diagnosis codes should be prefixed P if they do not meet the definition for A or C but:

- were other main conditions treated and/or investigated during the episode of care, or
- were the outcome of another P diagnosis code, or
- affected the treatment given and/or length of stay for the episode of care.

A - Associated Condition

An associated condition may be:

* the underlying disease (not treated) of a condition which was treated:

Example

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

* a condition or state which influenced the patient's health status or care during this episode of care, but which was not specifically treated:

Example

An autistic child who was admitted for dental treatment (rather than being treated as a non-admitted patient): prefix the autism code with A.

or,

* a condition or state which affected the treatment given and/or length of stay but which was not treated during this episode of care:

Example

A patient with a pacemaker, admitted for a valve replacement: prefix the pacemaker status code with A.

* conditions as defined in instructions 'use additional code...' in ICD-10-AM, if these conditions were present but not treated or investigated during this episode of care.

C - Complication

A complication is a condition that was not present at the time this episode of care commenced. A complication may be:

- * a condition resulting from misadventure during surgical or medical care,
- * an abnormal reaction to, or later complication of, surgical or medical care, or
- * a condition which arose during this episode of care (that is, the condition was not present at the start of this episode of care).

Example

A medical patient admitted for treatment of ischaemic heart disease, who develops a UTI during the hospital stay.

A previously existing condition that was not diagnosed until after the episode of care started is not a complication.

M - Morphology

Prefix morphology codes with an M (to distinguish them from musculoskeletal codes). The M prefix is optional for data entry but must be applied to morphology codes for transmission to PRS/2. Refer to the *PRS/2 Manual* for further information.

Vic Prefix.2 Prefixes for Obstetric Codes

In an obstetric admission, all codes relating to pregnancy, delivery and the puerperium are classified as primary conditions, except:

- * a condition resulting from misadventure during surgical or medical care (classify as a complication),
- * an abnormal reaction to, or later complication of, surgical or medical care (classify as a complication),
- * incidental conditions, unrelated to the birth process (classify as an associated diagnosis).

Issued July 1993, Modified July 1 2001

Vic 0029 Coding of Contracted Procedures

If the procedure is performed at another hospital under contract to this hospital, add a suffix to the procedure of:

- F** - if performed on an admitted basis, or
- N** - if performed on a non-admitted basis.

Refer to the *PRS/2 Manual*, for further details on the use of these codes.

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

Issued July 1 1998

Vic 0030 Organ Procurement

An episode for organ procurement is not yet included in the *National Health Data Dictionary* nor in the Victorian Admitted Episodes Dataset, therefore the following two sections of ACS 0030 *Organ Procurement and Transplantation* do not apply in Victoria:

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

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

The following sections of ACS 0030 are to be used in Victoria (see ACS 0030 *Organ Procurement and Transplantation*, page 33 for details):

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

This Victorian Addition supplements ACS 0030 *Organ Procurement and Transplantation*, page 39.

Issued July 1 1998

Vic 0229 Radiotherapy

Multi-day admissions (i.e. patients separated on a subsequent date to the admission date), receiving a radiation oncology procedure from blocks [1786] to [1792], [1794] or [1795], **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*, page 76.

Issued July 1 1998, Modified July 1 2001

Vic 0233 Morphology

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

This Victorian Addition *supplements* ACS 0233 *Morphology*, page 76.

The Victorian Library File contains morphology codes that are indexed in the ICD-10-AM Alphabetical Index to Diseases (Volume Two), but not listed in the ICD-10-AM Tabular List of Diseases (Volume One, Appendix A). (Refer to the DHS Library File 2003-2004 for a complete list of valid Morphology codes.)

Issued July 1 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.

This Victorian Addition *supplements* (fourth paragraph) ACS 2001 *External Cause code use and sequencing*, pages 265-267.

Issued July 1 2002

Vic 2104 Rehabilitation

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

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 discharge (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.- *should not be added*. Such episodes will be normally be acute Care Type.

This Victorian Addition *supplements* ACS 2104 *Rehabilitation*, page 273.

Issued July 1 1998, Modified July 1 2001

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.- 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.- code as an additional diagnosis.* Allied health procedure codes should also be added.

The instruction to add the Z50.- 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*, page 276.

Issued July 1 2001
