

## 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 ensure to 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.-), 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.

## **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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