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	*Prefixes for diagnoses*
Vic 0002	*Additional diagnoses*
Vic 0029	*Coding of contracted procedures*
Vic 0030	*Organ procurement*
Vic 0229	*Radiotherapy*
Vic 0233	*Morphology*
Vic 2001	*External cause code use and sequencing*
Vic 2104	*Rehabilitation*
Vic 2108	*Assessment*

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
Principal diagnosis ACS 0001	✓	X	X	X
Additional diagnoses 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:

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