ICD Coding Newsletter

Fourth quarter 2005-06

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Department of Human Services

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The ICD Coding Newsletter supports the clinical coding function performed in Victoria by providing relevant information to Health Information Managers, Clinical Coders, and their associates.

The newsletter, prepared by the Victorian ICD Coding Committee in conjunction with the Department of Human Services, seeks to:

- Ensure the standardisation of coding practice across the State
- Provide a forum for resolution of coding queries
- Address topical coding education issues, and
- Inform on national and state coding issues from the Victorian perspective.

The scope of the newsletter includes coding feature articles, selected coding queries and responses, and various information updates including feedback on the quality and uses of coded data (as reported to the Victorian Admitted Episodes Dataset).

If you have any mailing list changes or queries or comments regarding the ICD Coding Newsletter, contact the HDSS Help Desk:

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Coding features

NCCH Coder education

The NCCH coder education package has been available for some time. By now all coders should have taken the opportunity to work through this package in preparation for the introduction of ICD-10-AM fifth edition on 1 July 2006.

If you have not yet had time to peruse the whole package the following may help you focus on some of the more significant changes.

There are four new standards in fifth edition:

ACS 0304 *Pancytopaenia*
- Codes should be assigned for the specific blood disorders rather than the default code for pancytopaenia
- Details can be found on page 58 of the education package.

0942 *Banding of haemorrhoids*
- When a banding/ligation of haemorrhoids is performed with no documentation regarding the type of haemorrhoids, assign a diagnosis code for internal haemorrhoids
- Details on page 135 of the education package

1551 *Obstetric perineal lacerations/grazes*
- Instructions for the coding of 'episiotomy extended by laceration' and 'laceration extended by episiotomy'
- Details on page 157 of the education package

2009 *Mode of pedestrian conveyance*
- Any subsequent fall after a pedestrian conveyance collision is included in V00 - V09
- When pedestrians collide and are both on foot, these are classified to W03 or W51
- Any fall involving a pedestrian conveyance for example, roller skate or skateboard **not in collision** with another pedestrian conveyance are classified to W02 Fall involving ice-skates, skis, roller-skates, skateboards and other pedestrian conveyances
- Category V00 Pedestrian injured in collision with pedestrian conveyance includes collisions where either or both parties are on a conveyance. However, the **fifth character subdivision at V00 only identifies the mode of pedestrian conveyance used by the counterpart (that is, the other party involved)** at the time of the accident
- Details on page 27 of the education package

World Health Organisation (WHO) updates have resulted in the following changes:

- *New chapter*: **Chapter 22 Codes for special purposes (U00-U99)**:
    - This chapter is not located in alphabetical order, but at the end of the other chapters. The only codes that will be utilised in this section on an international basis are those in the code range U00-U49. Therefore, there will be no overlap with the ICD-10-AM activity codes already assigned (U50 – U73)
    - New code in this chapter: U04.9 Severe acute respiratory syndrome [SARS], unspecified

- *New codes:*
    - Autonomic dysreflexia
    - Hypoxic ischaemic encephalopathy [HIE] of newborn
    - Severe acute respiratory syndrome [SARS]
    - Barrett's oesophagus
    - Acute pancreatitis by aetiology
    - Fibromyalgia
    - Tendency to fall
    - Drug induced fever
    - Exposure to tobacco smoke – ***not to be used***
    - Microscopic polyangiitis
    - Personal history of chemotherapy for neoplastic disease
    - Preterm labour with/without delivery
    - Influenza due to identified avian influenza virus

- *Inactivated codes:*
    - P91.81 *Neonatal encephalopathy*
    - P91.89 *Other specified* disturbances of cerebral status of newborn

- *Deletion* of ACS 0624 *Autonomic dysreflexia*
- *Improved indexing for*:
    - Eisenmenger's syndrome, defect and complex
    - Extrasystoles
    - Arthrodesis status

- *Coding practice issues:*
    - A number of changes that were approved by WHO and have been incorporated in ICD-10-AM **are not to be followed by Australian coders** as a national coding policy has yet to be decided:
        - Z58.7 *Exposure to tobacco smoke*: A review of ACS 0503 *Drug, alcohol and tobacco use disorders* is to be undertaken. In the meantime coders are **not** to use Z58.7.
        - New includes and excludes notes at categories Y60-Y69, Y70-Y82 and Y83-Y84: Coders are to follow the guidelines outlined in ACS 1904 *Procedural complications* until this standard is revised in line with these changes.

Details for all these changes can be found on pages 60, 74, 75 and 129 of the education package.

MBS updates
Examination and recording of wave forms of peripheral and carotid or vertebral Vessels: New codes
Administration of thyrotropin alfa-rch: New includes notes and index entries
Catheter based intravascular brachytherapy: New code.
Closure of abdomen with reconstruction of umbilicus: New code
Excision of axillary sweat glands: Revised code title
Per anal excision of rectal tumour via stereoscopic rectoscopy: New code
Insertion of seton with or without excision of anal fistula: New codes and inclusion terms
Percutaneous transluminal coronary rotational atherectomy(PTCRA): New codes
Ocular transillumination: Revised code title
Radiofrequency ablation of liver: New code
Ultrasound of urinary bladder: New code

Changes to pharmacotherapy coding

- Addition of inclusion terms to 90560-00 [1552] *Administration of agent into soft tissue, not elsewhere classified* for the injection of botulinum toxin (Botox) for local effect. Updating of the index to ensure correct code assignment for local effect
- Amendments to the codes in Block 1921 *Loading of drug delivery device* to enable the use of the pharmacotherapy drug type extensions. New five character codes have been introduced to avoid overlap with existing codes in Block 766 *Vascular infusion device and pump*

Other changes

There are many new inclusions, include notes, exclude notes and index entries, and definitions as well as some new codes not mentioned in this document.

Coders must take the time to check for changes in all aspects of the classification when they use the new edition for the first time. Use the index!!

References

ICD-10-AM/ACHI/ACS Fifth Edition Education.

List of selected ICD-10-AM coding queries

#1892 ACS 0940 and Acute myocardial infarction

ACS 0940 *Ischaemic heart disease*, section title Acute myocardial infarction (Classification) pg 153. The third paragraph of this section states 'codes from category I21 *Acute myocardial infarction* should be assigned for an infarction in both the first hospital to which the patient is admitted for treatment and any other acute care facility to which the patient is transferred within four weeks (28 days) or less from onset of the infarction'.

Coders are interpreting this standard differently. Some interpret this to mean if a patient is treated for their AMI, discharged home then re-admitted to another hospital (or the same one) a few days later, the AMI should be coded during the subsequent episode if it is less than 28 days since the AMI first occurred. Other coders are only assigning an AMI code during a subsequent episode of care if the patient is admitted for an initial episode of care for an AMI and subsequently transferred to another hospital within 28 days of the initial AMI (usually for treatment). Basically coders are placing emphasis on two different things:

- The 28 days or;
- The word transferred.

If a patient has an AMI, is treated, discharged home (within five days), referred to another hospital for PTCA and stent insertion and subsequently admitted to that hospital 10 days after discharge from the first hospital, should the AMI be coded by the hospital performing the PTCA and stent insertion?

If the AMI is coded, the episode groups to DRG F10Z *Percutaneous Coronary Angioplasty with AMI*, WIES 2.3343. If the AMI is not coded (and coronary artery disease is assigned as the principal diagnosis), the episode groups to DRG F15Z *Percutaneous Coronary Angioplasty without AMI with Stent Insertion*, WIES 1.871.

The NCCH has been consulted with regards to this complex query, and has responded as follows:

> Due to the complexity of this issue, the NCCH is withholding a decision on this query in order to seek advice from the Cardiovascular CCCG and CSAC. A task has been created to investigate this matter further.
>
> A final decision will be added to the query database when available.

In light of this, the VICC has decided to provide an interim response that can be followed until the NCCH is in the position to provide a definitive position. When the NCCH does provide a response to this query, the VICC will ensure to highlight this in an ICD Coding Newsletter to ensure that Victorian coders are aware of the decision. In the meantime, Victorian coders should adhere to the following advice:

For patients who have previously had an AMI who are admitted or transferred to your hospital, apply **ACS 0001** ***Principal Diagnosis*** and **ACS 0002** ***Additional Diagnoses*** to determine if the AMI should be coded.
Once you have determined that the AMI requires coding:

- If the patient is admitted (or transferred) to your hospital within 28 days of the AMI, use the code for a current AMI
- If the patient is admitted (or transferred) to your hospital more than 28 days following the AMI, use the code for an 'old' AMI

Each case will depend on the individual circumstances.

We acknowledge that **ACS 0940** ***Ischaemic heart disease-Acute Myocardial Infarction*** refers to 'transferred' patients, however we consider that this should also apply to patients separated from hospital and readmitted.

#2042 Conditions arising in the perinatal period

Please advise on the correct use of ACS in the following scenarios? My difficulty arises with the definitions contained in the ACS Chapter 16 Certain conditions originating in the perinatal period. ACS 1605 *Definition of Conditions Originating in the Perinatal Period* gives the definition of the perinatal period 'Commencing at 20 completed weeks and ends at 28 completed days after birth'. ACS 1607 *Newborn/Neonate* gives a definition for the neonatal period, as defined in Australia, which is similar to the perinatal period, in that it ends at 28 completed days after birth.
Infants who are still technically 'premature', who are over 28 days of age, as in the examples below, would seem to be excluded from the definitions within this chapter. Also ACS 1615 *Specific interventions for the sick neonate* states 'These standards will provide a valuable body of data which will assist in improving AR-DRG classification of neonatal conditions'. All the scenarios listed below group to 'neonatal' DRGs, should the criteria listed in ACS 1615 apply in these cases, as they are not classified as neonates. Also some conditions are not 'arising in the perinatal period', therefore should they be coded to P codes or not?

1. Infant transferred to our hospital at 30 days of age for ongoing care of prematurity. Admission weight 1789 grams. (Ex 27 week premature birth weight 700 grams, so now technically only 32 weeks). Infant documented as developing jaundice of prematurity, treated with phototherapy for 11 hours overnight. Codes assigned P07.22, P07.02, P59.0 and 90677-00 [1611] (following ACS 1618)
2. Infant transferred to our hospital at 63 days of age for ongoing care of prematurity, required one gavage feed only, then quickly progressed to bottle feeds. Admission weight 2081 grams. (Ex 26 week premature twin one, birth weight 880 grams. so now technically 35 weeks gestation) Codes assigned P07.22, P07.03 and 96202-07 [1920] (following ACS 1615)
3. Infant transferred to our hospital for ongoing care at 38 days of age from interstate, admission weight 1230 grams. (Ex 26 week premature triplet three, birth weight 706 grams. so now technically 31 weeks gestation). Problem list on discharge 1. Anaemia of prematurity - required top up transfusion. 2. Apnoea of prematurity. 3. Hyponatraemia - treated with IV infusion of electrolytes. 4. Oral candidiasis. Codes assigned P07.22, P07.02, P61.2, P28.41, E87.1, B37.0, 13706-02 [1893] and 96199-08 [1920].

The VICC referred this query to the NCCH who provided the following advice:

> The NCCH agrees with the VICC that the codes for neonates still apply to babies >28 days for babies who are still in the birth episode / continuous from birth.
>
> For patients who have been discharged (home) and then readmitted, neonatal codes may be assigned, if documentation indicates that their condition originated in the perinatal period. This is supported by advice in **ACS 1605 *Definition of conditions originating in the perinatal period***:
> 'Most conditions originating in the perinatal period disappear after a short time. Some, however, can persist throughout life and should be classified to the codes in this chapter (16) regardless of the patient's age'.
>
> The NCCH will consider amendments to the standards in **Chapter 16 *Certain conditions originating in the perinatal period*** of the ACS to clarify the above advice.

#2053 Sacral neuromodulation

Our hospital performs sacral modulation for faecal incontinence. This procedure is done in two phases. The first phase involves having electrodes implanted in the sacral nerves in a day surgery procedure, which are later connected to an external pulse generator. The second phase involves the implantation of a pacemaker about the size of a cigarette lighter, in the upper back or lower abdomen. The patient controls the pacemaker with an activator, thus enabling bowel control.

We feel that the appropriate codes for this procedure are:
Phase 1:
39130-00 [43] *Percutaneous insertion of epidural electrodes*
Percutaneous:
• burying }
• replacement}
• revision} of epidural electrodes
• threading}
• tunneling }
Includes: trial of dorsal column stimulator
Excludes: that with subcutaneous implantation of spinal neurostimulator device (39130-01 [43])

Phase 2:
39134-00 [43] *Subcutaneous implantation of spinal neurostimulator device/receiver*
Replacement of subcutaneous spinal neurostimulator device
Revision of subcutaneous spinal neurostimulator device
Subcutaneous implantation of:
• spinal pulse generator
• spinal radiofrequency (emitting) device/receiver
Excludes: that with insertion of epidural electrodes (39130-01, 39139-01 [43])

With a diagnosis code of R15 *Faecal Incontinence*, this groups to a 901Z *Extensive O.R. Procedure Unrelated To Principal Diagnosis.*

However, there is a code for insertion of anal electrode at 32206-00 [929] *Insertion of gracilis neosphincter pacemaker*, which may be more appropriate.

This query was referred the NCCH who provided the following advice:

> The NCCH supports the codes selected by the enquirer for the case cited. However, clinical advice states that phase 1 (implantation of electrodes into sacral nerves) may be performed as an 'open' procedure. If documentation indicates that phase one is an open procedure, assign:
> **39139-00 [43] *Insertion epidural electrodes by laminectomy***
>
> MBS contains item numbers that may be more appropriate for this procedure. NCCH will consider adding them to a future edition of ACHI.
>
> The NCCH and clinical advice support the assignment of K59.2 'Neurogenic bowel, not elsewhere classified' for documentation of 'neuropathic faecal incontinence'.

There is an index error at Insertion, electrode, anal, directing coders to assign:
32206-00 [929] *Insertion of gracilis neosphincter pacemaker*. This code is actually in Block [940]. The NCCH is aware of this and has amended it in fifth edition.

#2069 Pressure area

I have two related questions:

1. At one of the fourth edition education sessions it was stated by the NCCH presenter that ACS 1221 *Decubitus [pressure] ulcer* could be applied to documentation of 'pressure area'. 'Ulcer' or 'sore' did not have to be documented. However, this is not clearly stated in the ACS, and I am unsure whether to follow this advice. Under 'definition' in ACS 1221 it mentions 'a pressure ulcer is an inflammation, sore or ulcer', but does not mention 'area'.
   I have a patient with documentation on the care plan/action record of 'pressure area outer aspect R heel - duoderm prn' and another patient with the documentation of 'sacral pressure area'. Can I code L89.x *Decubitus [pressure] ulcer* from this type of documentation? I have another patient with 'pressure area' documented by nursing staff on the progress notes, and this is qualified on the wound chart as 'pressure area stage II. Do coders have to have qualification of 'pressure area' to code it?

2. I believe that sometimes 'pressure area' is used to mean a 'pressure sore' even if there is no actual ulcer or skin break, as in L89.01 *Decubitus ulcer stage 1*. However, 'pressure area' also appears to be used for cases where a patient needs turning or to use a pillow under their limb because there is a pressure area but once pressure has been relieved, the condition is no longer present.

How are coders to differentiate between these terminologies?

This query was referred to the NCCH who provided the following advice:

The original proposal for changes to the pressure ulcer section of ICD-10-AM was the result of a public submission received in February 2002 from a Clinical Nurse Consultant requesting an expansion of L89 to provide more specificity.

Further information was received to support this request from a CCCA member and a representative from QIEP Pressure Ulcer Management Project Team QLD Health Department regarding the classification stages. Information was also obtained from the Australian Wound Management Association to further clarify the various stages of a pressure ulcer. Subsequent to this the changes were made to the classification.

The turning of patients to reduce pressure on various areas of the body (that is, pressure care) is a preventative measure and constitutes normal nursing care. However, when these areas become 'a defined area of persistent redness' and require further treatment for example, application of duoderm and therefore meet the criteria of ACS **0002 *Additional diagnoses***, **L89.0 *Decubitus [pressure] ulcer, Stage 1***, may be assigned.

The NCCH acknowledges that the term 'decubitus' is not relevant in current clinical practice. ICD-10-AM is based on ICD-10 and under contractual agreement with WHO changes cannot be made to code titles at the third character level. This issue was explained during Fourth Edition education workshops.

In answer to specific concerns cited:

- If 'pressure area' is documented and not further qualified, and it meets **ACS 0002 *Additional diagnoses*** a code from **L89.x *Decubitus [pressure] ulcer*** may be assigned.
- A pillow under a limb is routine, preventative nursing care to relieve limb pressure and therefore does not meet **ACS 0002 *Additional diagnoses***.
- Stage 1 defines the level of severity of a 'skin ulcer' and at this level it is 'limited to erythema only' as per the definitions supplied in the original proposal, therefore the indexing is correct.

Please note, the term 'ulcer' within this classification does not infer that there is a breakdown of skin surface.

#2079 Surgery during pregnancy

Where a pregnant patient is admitted for a surgical procedure or other diagnosis unrelated to the pregnancy and receives obstetric care and observation, the episode groups to an antenatal DRG due ACS 1521 *Conditions complicating pregnancy* indicating we code an O94-O99 *Other obstetric conditions* as the Principal diagnosis.

A specific example is a pregnant woman admitted for laparotomy and removal of right ovarian cyst. We have coded O99.8 D27 M8441/0 35713-04 [1244]. The DRG is O65B *Other antenatal with moderate/ no complicating diagnoses*, 0.4494 WIES. If we delete O99.8 and code D27 as the principal diagnosis, the DRG is N07Z *Other Uterine & Adnexa Procedures for Non-Malignancy*, 1.3217 WIES.

Therefore we are currently receiving insufficient funding for the procedure.

Should the ACS 1521 be reviewed in requiring O94-O99 code for all obstetric observation or care admissions? Or should the grouper be adjusted and group to the procedure, not the principal diagnosis?

The VICC interpretation of **ACS 1521 *Conditions complicating pregnancy*** is to:

1. Assign **Z33 *Pregnant state, incidental*** when there is NO obstetric care;
2. Assign **Z34.x *Supervision of normal pregnancy*** when there IS obstetric care but the condition has NOT complicated the pregnancy, aggravated the pregnancy nor the pregnancy is the reason for care;
3. Assign **Oxx *Obstetrics conditions*** when there IS obstetric care AND the condition has complicated the pregnancy, aggravated the pregnancy or the pregnancy is the reason for care

This interpretation was confirmed by the NCCH who provided the following information:

1. **ACS 1521** states: If a patient is admitted for a condition that:
    - is not pregnancy-related
    - neither complicates the pregnancy nor is aggravated by the pregnancy AND requires no obstetric observation or care…assign Z33 *Pregnant state, incidental* as an additional diagnosis (with the code for the condition being treated assigned as principal diagnosis).

   The key point, as has been correctly pointed out, is 'requires no obstetric observation or care'.
2. **Z34 *Supervision of normal pregnancy*** should be assigned by following the following index entries:

   Antenatal
   - care
   Pregnancy
   - supervision
   - - normal
   Prenatal
   - care

   The terms 'care' and 'supervision' imply that obstetric observation or care has been required during the episode. 'Normal pregnancy' in the code title implies that the patient is not being treated for any condition that has complicated or aggravated the pregnancy.
3. Any condition that is complicating pregnancy or is complicated by the pregnancy must have a code from **Chapter 15 *Pregnancy, Childbirth and the Puerperium***:
    - Codes from blocks O20-O29 are specific codes for common conditions that are known to complicated pregnancy.
    - To code other conditions complicating pregnancy (or being aggravated by the pregnancy or that are the main reason for obstetric care), a code from O98 or O99 is assigned together with an additional code from another chapter to identify the specific condition.

The NCCH will consider amending **ACS 1521** to clarify the information contained in the standard.

The VICC advises that the options for groupings cited in the query are correct. Note that 35713-04 [1244] *Ovarian cystectomy, unilateral* is not a valid OR procedure in MDC 14 *Pregnancy, childbirth and the puerperium*.

#2090 Systemic lupus erythematosus

We have recently conducted an audit on patients with SLE. The index entry under 'Lupus, erythematosus, systemic, with …' contain only entries for 'with lung involvement' or 'renal tubulo-interstitial disease'. However, there are many other parts of the body affected by lupus, and many of these conditions are dagger/asterisk combinations which are indexed under the specific condition, such as Pericarditis, in SLE - M32.1† I32.8*, but not indexed under Lupus. Others include:

F02.8* Dementia
G05.8* Encephalitis
G63.5* Polyneuropathy
G73.7* Myopathy
I32.8* Pericarditis
I39.x* Libman-Sacks disease
I68.2* Cerebral arteritis
J99.1* Respiratory disorders
N08.5* Nephritis
N16.4* Renal tubulo-interstitial disorders

Also if you look up 'Systemic, lupus, erythematosus' the code M32.9 *Systemic lupus erythematosus, unspecified* is given, and there are no further options for any of the dagger/ asterisk combinations. Symptoms of lupus include arthritis, skin rashes, hair loss, sun sensitivity and fatigue. Body systems affected by lupus include kidneys, lungs, central nervous system, blood vessels, blood, and heart. The documentation on three of our patients is as follows:

Patient one:
Well 17 year old admitted as an overnight patient for IV cyclophosphamide for SLE. Medical history: SLE diagnosed 1998, cerebral lupus 1998, epilepsy and lupus nephritis – WHO class 4-5 interstitial fibrosis.

Patient two:
12 year old admitted with SLE for steroid injections into arthritis in the elbow and wrist both arms. SLE – initially diagnosed in 02.03 when patient presented with pneumonia, pericarditis and pleural effusion, now presents with joint symptoms for treatment.

Patient three:
15 year old with SLE for IV cyclophosphamide. Medical history: SLE diagnosed 1994. Complicated by nephritis, osteoporosis, and vasculitic rash.

Should all conditions documented as having a relationship to SLE be coded because they are dagger/asterisk combinations, even if past history? What does 'lung involvement' under the 'Lupus' entry include?

This query was referred to the NCCH who provided the following advice:

> Clinical advice indicates that patients documented with a history of severe manifestations of SLE would have advanced SLE. However, many complications do resolve and become inactive. Therefore, NCCH suggests that only current conditions should be classified when documented with SLE (if they meet the criteria in **ACS 0002 *Additional diagnoses***).
>
> In answer to question two, 'Lung involvement' indexed under 'Lupus, erythematosus, systemic' is classified to **J99.1* *Respiratory disorders in other diffuse connective tissue disorders***. This code includes any respiratory disorder classifiable to **Chapter 10 *Diseases of the respiratory system.***

Therefore the VICC advises that if a condition is chronic and irreversible such as lung fibrosis it would be coded as a dagger/asterisk combination. Conditions such as pneumonia or pericarditis that are resolved prior to the episode of care would not be coded.

The VICC has asked the NCCH to give consideration to including the asterisk conditions listed in the query in the index under SLE.

#2093 Abnormal limb movement

Patient had abnormal limb movements, due to a particular drug.

Following the index under Abnormal, movement, it takes me to a G code disorder; being a non-essential modifier. However, the correct code seems to be an R code. Should disorder be an essential modifier?

The VICC received the following updated advice from the NCCH:

After further review, NCCH supports the assignment of ***G25.9 Extrapyramidal and movement disorder, unspecified*** for the case cited in the query (abnormal limb movement, due to a drug).

Follow the index pathways:
Abnormal
- movement (disorder) (see also Disorder, movement) G25.9

Disorder
- movement G25.9
- - treatment-induced G25.9

This advice supersedes advice published in the Third Quarter 2005-06 ICD Coding Newsletter.

#2099 Biopsy male perineum

There are indexing inadequacies and code title problems with procedure codes to do with the perineum. All procedures appear in the gynaecological section but can be performed on males as well.

For example, a male patient had a biopsy of a perineal recurrence of Ca Rectum. There is no look up in the index for any such procedures for the perineum, and the word perineum appears in the block titles (vulva & perineum) but not in the actual code titles, except for incision which is both indexed and included on the code title 90446-00 [1290] *Other incision of vulva or perineum.*

For the case mentioned above, I have coded 30071-00 [1618] *Biopsy of skin and subcutaneous tissue.*

Please review the use of codes for perineal procedures and advise the correct codes to use for perineal procedures for males?

This query was referred to the NCCH who provided the following advice:

The NCCH agrees with the code suggested for biopsy of male perineum:
30071-00 [1618] *Biopsy of skin and subcutaneous tissue*

#2103 Vaginoplasty

58 year old female admitted with a recurrent genital prolapse and a mid vaginal constriction, undergoes a laparoscopic sacrocolpopexy and a vaginoplasty to improve the vaginal capacity.

Please advise on the correct coding of the procedure 'vaginoplasty' which is performed for conditions such as vaginal stenosis/constriction, narrowed introitus and tightening of the vaginal muscles. It is often done at the same time as a repair of prolapse and other urogynaecology procedures on postmenopausal women.

Following the index, the only codes available for vaginoplasty are:
Vaginoplasty
-for
--ambiguous genitalia
---with clitoroplasty 37848-00 [1298]
--congenital adrenal hyperplasia 37851-00 [1298]
--mixed gonadal dysgenesis 37851-00 [1298]

We do not believe that these codes are appropriate for the above cases. Currently we use code 35567-00 [1286] *Other repair of vagina*.

This query was referred to the NCCH who provided the following advice:

A task has been created to review this request. Please note that NCCH agreed with the code suggested by the enquirer and supported by VICC **35567-00 [1286]** ***Other repair of vagina***.

The MBS item number relevant to this procedure (35567) is being deleted from MBS. NCCH will propose an appropriate replacement and index it as the default.

#2111 Aspergillus for IV antibiotics

53yo lady admitted to Oncology Day Stay unit with aspergillus post bone marrow transplant for Chronic lymphocytic leukaemia for intravenous antibiotics. On clarifying with nursing staff, they have said that the aspergillus is a lung infection and she is more likely to get it because she is immunosuppressed because of her post transplant status for CLL.

Do we code:

Z51.1	Pharmacotherapy session for neoplasm
C91.10	Chronic lymphocytic leukaemia, without mention of remission
M9823/3	B-cell chronic lymphocytic leukaemia/small lymphocytic lymphoma
96199-00 [1920]	Intravenous administration of pharmacological agent, antineoplastic agent

as per ICD-10-AM 4th edition training (pharmacotherapy); or

B44.9	Aspergillosis, unspecified
C91.10	Chronic lymphocytic leukaemia, without mention of remission
M9823/3	B-cell chronic lymphocytic leukaemia/small lymphocytic lymphoma
96199-02 [1920]	Intravenous administration of pharmacological agent, anti-infective agent

as per example two (clarification of the use of extension -00 in block [1920] Pharmacotherapy, E Books, ICD-10-AM commandments, Volume 11, Number 2, September 2004).

This query was referred to the NCCH who provided the following advice:

ACS 0236 *Neoplasm coding and sequencing* states: assign the primary malignancy as a current condition if the episode of care is for treatment of another nonmalignant condition, when the malignancy is a comorbidity that has an effect on the episode of care as per **ACS 0002 *Additional diagnosis***.

For the scenario cited, the specialist nursing care provided in the Oncology Day Stay Unit indicates that the CLL should be coded for this case.

Therefore, for the scenario cited, assign:

B44.x	***Aspergillosis***
C91.10	***Chronic lymphocytic leukaemia, without mention of remission***
M9823/3	***B-cell chronic lymphocytic leukaemia/small lymphocytic lymphoma***
96199-02 [1920]	***Intravenous administration of pharmacological agent, anti-infective agent***

Note: As the antibiotics are for treatment of a condition (aspergillus) that is the result of chemotherapy treatment (not a neoplasm or neoplasm-related condition):

- **Z51.1 *Pharmacotherapy session for neoplasm*** is not assigned
- -02 anti-infective agent is assigned with the pharmacotherapy code, not -00 antineoplastic agent.

The VICC advises that coding decisions should not be based on where the patient's treatment is provided.

In this scenario, it may be appropriate to assign **D89.8 *Other specified disorders involving the immune mechanism, not elsewhere classified*** to describe the patient's immunosuppressed status. It may also be appropriate to assign **Z94.8 *Other transplanted organ and tissue status*** and **D84.9 *Immunodeficiency, unspecified*** if these are documented in the notes and meet **ACS 0002 *Additional diagnoses.***

Note that aspergillus is a fungal infection and there are specific codes for pulmonary aspergillus.

#2121 Complications of treatment of neoplasms

ACS 0236 *Neoplasm coding and sequencing* dot point one states that you should use the neoplasm code as principal when coding a complication of the cancer. However, it does not tell you what to do if the complication is a complication of treatment given for the cancer.

VICC query #1958 in example one suggests that you cannot use the cancer as a principal and you should not use it as an additional diagnosis (unless it meets criteria of ACS 0002 *Additional Diagnosis*).

Why does the standard not clearly state that complications of treatment (vomiting or diarrhoea following chemotherapy for instance) are excluded?

Is this coding query #1958 still valid? Is there something that I have missed which clearly sets out what to do with a complication of treatment for malignancy?

The VICC notes that dot point one in **ACS 0236 *Neoplasm coding and sequencing*** relates to the assignment of current condition not principal diagnosis.

This query was referred to the NCCH who provided the following advice:

> **ACS 0236 *Neoplasm coding and sequencing*** states: assign the primary malignancy as a current condition if the episode of care is for treatment of another nonmalignant condition, when the malignancy is a comorbidity that has an affect on the episode of care as per **ACS 0002 *Additional diagnosis***.

The VICC therefore advises to only assign a code for the neoplasm where there is documentation that the neoplasm is impacting on the episode of care.

VICC query #1958 published in the February 2004 ICD Coding newsletter is still current except for those cases covered by NCCH query Q1982 (18/10/2004).

#2137 Wegener's granulomatosis

Patient admitted with 'infective exacerbation of airways disease secondary to pulmonary involvement from Wegener's granulomatosis.' I looked this up in the index under 'granulomatosis' and was led to code M31.*3 Wegener's granulomatosis*. When trying to code the lung involvement I noticed that there is nothing in the Tabular List Of Diseases under code M31.3 to indicate that a dagger/ asterisk combination exists for with lung involvement. The dagger/ asterisk combination for 'with lung involvement' is indexed correctly under 'Wegener's' and 'syndrome, Wegener's,' however we feel that code M31.3 in the Tabular List needs to have a reference to also code J99.1 *Respiratory disorders in other diffuse connective tissue disorders* in cases of lung involvement.

This query was referred to the NCCH who has advised the suggestion will be considered for a future edition of ICD-10-AM.

#2217 Management of tracheostomy

72 year old male with a past history of squamous cell carcinoma of the larynx had a total laryngectomy, tracheoesophageal fistula and permanent tracheostomy performed. He was later admitted with aspiration due to persistent leakage of his tracheoesophageal fistula.

Diagnosis codes assigned were:

T17.9	Foreign body in respiratory tract
W44	Foreign body entering into or through eye or natural orifice
T81.8	Other complications of procedures not elsewhere classified
Y83.8	Other surgical procedures
Y92.22	Health service area
U73.9	Unspecified activity

In this admission the tracheostomy is continually cleaned and suctioned due to sputum plugs and the tracheostomy tube is used to prevent further aspiration by inflating and deflating the cuff. To reflect the extra care needed for this patient's tracheostomy 90179-06 [568] *Management of tracheostomy* was coded however this groups into A06Z *Tracheostomy or ventilation >95 hours* which impacts quite considerably on the WIES.

Without the management of tracheostomy code the DRG is E75B *Other Respiratory System Diagnosis A>64/+CC*. The inlier weight for this DRG is usually 0.5851 however there are four high outlier days which makes the cost weight for this episode 1.3427. (0.5851 + (0.1894 x 4 days)) = 1.3427

With the management of tracheostomy code added the DRG is A06Z *Tracheostomy Or Ventilation>95*. The inlier weight is usually 16.5318 however this episode is a low outlier, which makes the cost weight for this episode 11.8525. (1.8235 + (0.6686 x 15)) = 11.8525

There is a WIES variance of 10.5098. Why does management of tracheostomy (which includes tracheostomy toilet) change the DRG to A06Z? Is this a grouping problem?

The VICC agrees with the procedure code assigned by the enquirer in this scenario:
90179-06 [568] *Management of tracheostomy*

This query has been referred to the Commonwealth for investigation.

#2222 Suspensionoplasty of thumb

Please confirm that 46324-00 [1468] *Arthroplasty of carpal bone* is the correct code for suspensionoplasty of thumb as there is no index entry for suspensionoplasty.

I note that the inclusion note includes 'synovectomy and tendon transfer and realignment.' However our operation notes consistently refer to a tendon harvest that is used as a graft.

In these cases should we also code 90583-00 [1569] *Tendon graft, not elsewhere classified* and 90578-00[1564] Procurement of tendon for graft?

The VICC agrees with the procedure code assigned by enquirer in this scenario:
46324-00 [1468] *Arthroplasty of carpal bone*

The inclusion underneath the code title describes the procedure performed:
Replacement of carpal bone using adjacent tendon or other soft tissue
Resection arthroplasty of carpal bone

The includes note means that you don't have to add additional codes for these procedures as they are included in this procedure code:
Includes: synovectomy
tendon transfer or realignment

Therefore in this scenario, no other procedure codes need to be assigned.

#2224 Ecstasy

The index provides two different codes for Ecstasy:
T40.9 *Other and unspecified psychodysleptics [hallucinogens]*
T43.6 *Psychostimulants with potential for use disorder Methylenedioxyamphetamine*

I note that Methamphetamine and Amphetamine are both indexed to T43.6.

MDMA (3-4 methylenedioxymethamphetamine) is a synthetic, psychoactive drug chemically similar to the stimulant methamphetamine and the hallucinogen mescaline. Street names for MDMA include Ecstasy.

Which code is correct?

These are two different drugs and the code assigned would depend on the documentation in the record.

If Ecstasy is documented, code to **T40.9 *Other and unspecified psychodysleptics [hallucinogens]***

If MDMA is documented, code to **T43.6 *Psychostimulants with potential for use disorder***

If both are documented interchangeably, follow the excludes note under **T43 *Poisoning by psychotropic drugs, not elsewhere classified*** and assign:
T40.9 *Other and unspecified psychodysleptics [hallucinogens]*

#2226 Injection of botox

Please confirm the correct code to use for 'injection of botox into salivary gland'? Patients with excessive salivary production will often be admitted for injection of botox to help control the excessive drooling.

We have been using the advice regarding injection of botox into muscle/tendon and coding these patients to;
90560-00 [1552] *Administration into soft tissue, NEC*

Or should we code it to;
90140-00 [399] *Other procedures on salivary gland or duct*

The second code groups the patients into a higher weighted DRG.

The following advice regarding injection of botox into muscles and tendons NEC was published in Coding Matters Volume 11 Number 4, March 2005:

> Query 1428 advises coders to assign 92193-00 [1885] *Injection or infusion of other therapeutic or prophylactic substance* for 'injection of botox into tendons' (ICD-10-AM Second Edition). This code was inactivated for ICD-10-AM Fourth Edition and the concept mapped to block [1920] Pharmacotherapy. Index entries for 'Injection, botulinum toxin', direct coders to assign a code from block [1920] Pharmacotherapy with an extension of -09. The index entries are incorrect and will be rectified.
>
> The intention of block [1920] Pharmacotherapy is to classify 'systemic' drug administration. This is highlighted by the exclusional term at the beginning of the block:
> Excludes:
> - local effect (see Index: Injection, by site or Injection, by type, by site)
>
> Classification
> In cases that describe injection of Botox into muscles and / or tendons NEC assign:
> **90560-00 [1552] *Administration of agent into soft tissue, not elsewhere classified***
>
> The lookup pathway in the Alphabetic Index of Procedures is:
> Injection (around) (into) (of) – see also Administration
>
> -muscle NEC 90560-00 [1552]
>
> -tendon NEC 90560-00 [1552]
>
> Note that this is an NEC code. If the muscle / tendon injection is specified by site and / or condition, follow those index entries (e.g. 'Injection, toxin botulinum, for, strabismus' and 'Injection, toxin botulinum, vocal cord').
>
> The NCCH is currently reviewing this area of the classification and will make improvements in ICD-10-AM fifth edition.

Therefore, the VICC advises that because the botox acts on the muscle to reduce the muscular activity of the salivary gland, assign procedure code:
90560-00 [1552] *Administration of agent into soft tissue, not elsewhere classified*.

#2227 Long QT syndrome

There is a query on the NCCH queries database (Q658 Q-T interval prolongation) that advises coders to use R94.3 *Abnormal results of cardiovascular function studies*. This query however doesn't refer to this condition as a syndrome. We have had a few cases where the documentation mentions that this condition is in fact a syndrome/inherited condition. I have discussed this with our cardiologists and they have informed me that LQTS is characterised by prolonged QT intervals on an ECG (usually detected in early childhood) and the syndrome causes abnormalities in the electrical system of the heart. The patient's heart may spontaneously go into VT or VF which is potentially life threatening and requires an insertion of an AICD. The syndrome is also characterised by frequent LOC and syncopal episodes and the patients usually have a family history of sudden death. This syndrome is also called Ramano-Ward Syndrome or Jervell and Lange-Neilsen syndrome. As there isn't a specific code for this syndrome, should we apply ACS 0005 *Syndromes* and code the manifestations plus the Q87.89 *Other specified congenital malformations syndromes*?

Manifestations of Long QT syndrome are acute, not permanent therefore should only be coded if present. The coding will depend on the documentation in the medical record.

If coding an elective admission and there are no manifestations, assign:
R94.3 ***Abnormal results of cardiovascular function studies***
Q87.89 ***Other specified congenital malformation syndromes, not elsewhere classified***

If manifestations such as VT are present, assign:
A code for the manifestation
Q87.89 ***Other specified congenital malformation syndromes, not elsewhere classified***
Do not assign codes for the symptoms.

#2228 Feeding problems of newborn

Baby born at Hospital A at 36/40 gestation, birth weight 3640 grams. Transferred two days later to Hospital B due to cardiac and intestinal complications. Baby treated and transferred back to Hospital A on day 33 for further management and to establish feeding. Main problem here was poor feeding (breast and bottle) with other issues of ileostomy management, hyponatraemia, and small head circumference. Babe discharged home 19 days later.
Codes assigned:
Z51.88 *Other specified medical care*
P07.32 *Other preterm infant, 32 or more completed weeks but less than 37 completed weeks*
Z43.2 *Attention to ileostomy*
E87.1 *Hypo-osmolality and hyponatraemia*
M89.28 *Other disorders of bone development and growth, other*
Q25.1 *Coarctation of aorta*
Q21.00 *Unspecified ventricular septal defect*
This has been coded according to scenario three in coding query #1720 Transferred neonates, ICD Coding newsletter May 2002.

We are confused as to when you would apply P92.X *Feeding problems of newborn* as the principal diagnosis?

The code Z51.88 *Other specified medical care* includes establishment of breastfeeding.

Why you would use P92.X *Feeding problems of newborn*? According to ACS 1618 *Prematurity and low birth weight* under prematurity, Z51.88 is the principal diagnosis with P07.XX *Disorders related to short gestation and low birth weight, not elsewhere classified* as an additional diagnosis.

In accordance with **ACS 1618 *Prematurity and low birth weight***, where a babe is re-admitted to Hospital A to establish feeding and babe is >28 days old and >2500 grams, assign:
Z51.88 *Other specified medical care* as the principal diagnosis.

If however, babe is re-admitted to Hospital A with feeding problems as the diagnosis, the principal diagnosis to assign would be:
P92.x *Feeding problems of newborn* as per the second paragraph of the standard under prematurity.

In the case you describe, it appears that the feeding problem has developed post admission therefore **P92.x *Feeding problems of newborn*** can be included in your string of codes.

#2229 Type 1 and Type 2 respiratory failure

Doctors at our hospital are using the terms Type 1 and Type 2 respiratory failure regularly instead of acute or chronic. A respiratory registrar advised that Type 1 refers to low oxygen levels. Type 2 refers to high levels of carbon dioxide. As there is no specific index entry to this term do we code to unspecified or refer back to doctors for clarification of acute or chronic. There is no code for specified Not Elsewhere Classified.

The difference between Type 1 and Type 2 respiratory failure is very complex and clinicians actually differ in their interpretation of acute and chronic respiratory failure.

Clarification from the clinician is vital to determine whether the failure is acute, chronic or acute on chronic.

In the absence of clinical clarification, assign the default code:
J96.9 *Respiratory failure, unspecified*

#2230 Microdiscectomy

Some time ago we were advised by our surgeon to code microdiscectomies as rhizolysis with laminectomy. We are now receiving typed op reports and I now believe we should be using a discectomy code as well.

The procedure is as follows:
1. The back muscles (erector spinae) are lifted off the bony arch (lamina) of the spine. They are moved as opposed to cutting.
2. The surgeon is then able to enter the spine by removing the membrane over the nerve roots called the ligamentum flavum. This is done in order to visualize the nerve root.
3. Often a small portion of the inside facet joint is moved to facillitate access to the nerve root and to relieve pressure over the nerve
4. The nerve root is then moved aside and disc material is removed.

Almost all the joints, ligaments and muscle are left and therefore the mechanical structure of the spine remains unaltered.

Back surgery is complex however codes should be assigned according to the documentation, not on what the doctor advises because often clinicians definitions are based on MBS and can be quite different to the ACHI classification.

If there is documentation of microdisectomy, follow the lead term discectomy in the index (because there is no lead term for microdiscectomy) and assign a code accordingly.

40330-01 [54] ***Spinal rhizolysis with laminectomy*** should only be assigned if there is documentation to support the assignment of the code.

#2233 Non-multiresistant methicillin resistant Staphylococcus Aureus

One of our pathologists gave a presentation about infections and infectious organisms. He advised us that NMMRSA is non-multiresistant methicillin resistant Staph aureus and should be coded to Z06.32 *Methicillin resistant agent*. MRSA is multi-resistant methicillin resistant Staph aureus and should be coded to Z06.8 *Agent resistant to multiple antibiotics*.

This conflicts with ACS 0112 *Infection with drug resistant organisms,* which states that MRSA is methicillin resistant Staph aureus (coded to Z06.32).

NCCH query 1702 advises to code both NMMRSA and MRSA to Z06.1 *Infection with multidrug resistant Staph aureus.*

Coding Matters Volume 9 Number 2 advises MRSA is Methicillin resistant Staph aureus and is the same as NMMRSA and both should be coded to Z06.1.

According to **ACS 0112** ***Infection with drug resistant microorganisms***, MRSA means Methicillin Resistant Staphylococcus Aureus and should therefore be coded to **Z06.32** ***Methicillin resistant agent***.

If there is documentation of Multi-resistant MRSA, this should be coded to:
Z06.8 ***Agent resistant to multiple antibiotics.***

If there is documentation of Non-multiresistant MRSA, this should be coded to:
Z06.32 ***Methicillin resistant agent.***

For the purposes of coding, pathologist's definitions should not be applied.

Note that NCCH Q1702 and advice in Coding Matters Volume 9 Number 2 have been superseded by **ACS 0112 *Infection with drug resistant microorganisms***.

#2237 Medical imaging

Can you please provide some advice regarding the coding and reporting to PRS/2 of medical imaging procedures?

We routinely code CT's, MRI's and other nuclear imaging as we have (had) a hospital run and owned imaging business but the imaging department has now been sold to a private company, and we are not sure if this impacts the coding/reporting.

Can you please advice what we should be doing now our hospital no longer owns the imaging department?

Medical imaging procedures performed in privately owned radiology departments are only coded if the hospital pays for the procedure.

If you wish to collect information on the procedures performed locally, you may code the procedures and suppress transmission to the VAED.

#2238 ACS 0112 Infection with drug resistant microorganisms

ACS 0112 *Infection with drug resistant microorganisms* instructs coders to assign a code from Z06.*x Bacterial agents resistant to antibiotics* when a clinician has documented the infection as being resistant to an antibiotic.

At our hospital the pathology reports will often document that the infection is resistant to an antibiotic however the clinician will not have documented it in the record. Can we apply the same logic we do when coding the type of organism and assign a code from Z06.x when it is documented only on the pathology report (that is, patient has UTI and no organism is documented, however a urine result indicates E Coli we can code it directly from the path report). Or must it be documented by a clinician in the record?

If there is documentation of infection in the clinical notes, then the organism recorded on the microbiology report can be coded. However the resistance to the organism should not be coded unless it is documented in the clinical notes as being a resistant organism, not just resistance to a drug (as per ACS 0112 Infection with drug resistant microorganisms).

This advice is consistent with NCCH advice published in Coding Matters Volume 9 Number 2 September 2002.

#2239 Rectal haemorrhoids

Should haemorrhoids in the rectum be coded to internal?

Do we need documentation of internal before assigning I84.2 *Internal haemorrhoids without complication*?

If you follow the index there is no option for rectum. Can we use our clinical knowledge to assume that the rectum is an internal organ?

The VICC considers that rectal haemorrhoids are internal. This is supported by the following the index entry:

Varicose
- vein
-- rectum - *see haemorrhoids, internal*

and the includes note at I84 Haemorrhoids:

I84 Haemorrhoids
Includes: piles
varicose veins of anus and rectum

In the case citied, if you have documentation of rectal haemorrhoids, follow the index and assign:
I84.2 *Internal haemorrhoids without complication*.

#2240 Laparascopic liver biopsy (wedge)

I have coded laparoscopic liver biopsy (wedge) to:
30409-00 [953] *Percutaneous [closed] liver biopsy*
30390-00 [984] *Laparoscopy*
Is this appropriate?

NCCH query database, Q672 and Q1012, contains old advice; the codes are no longer available. NCCH states amendments will appear in ICD-10-AM, second edition, which obviously didn't happen then or since. Will there be a procedure code in fifth edition?

The VICC agrees with the procedure codes assigned by the enquirer and note that the advice in NCCH queries Q672 and Q1012 no longer applies.

There is no procedure code for laparoscopic liver biopsy in fifth edition.

Coding Corkboard

Victorian ICD Coding Committee activities

The contents of this page provide a brief overview of the current activities undertaken by the Victorian ICD Coding Committee (VICC). Victorian coders are welcome to contribute to any discussion highlighted here. Please contact Carla Read, Convener and Secretary Victorian ICD Coding Committee (Carla.Read@dhs.vic.gov.au) if you would like to have your views considered.

ICD-10-AM fifth edition

NCCH has conducted workshops for Victorian coders. The education package is available on the NCCH website and should have been completed by all coders who attended the workshops. Significant aspects of the education have been summarised on page 4 of this newsletter.

Special edition newsletter

The special edition newsletter will be released shortly. This annual publication contains all details relevant to the various editions and versions to be used from 1 July of each financial year. This newsletter can be used a reference document throughout the year regarding:

- ICD-10-AM edition
- AR-DRG version
- Library file amendments
- Vic DRGS
- Victorian additions to the Australian Coding Standards

Victorian Clinical Coders contact list

The purpose of this list is to clearly identify the number of coders working in Victoria, where they are located and the circumstances of their employment. It is considered that this will help with the planning of future education programs and with the effective dissemination of information to the workforce.

We would like to thank all the coders who provided their details at the coding workshops. If you have not had an opportunity to add your name to the list, you can still be included. Simply complete the form on our web site at: http://www.health.vic.gov.au/hdss/icdcoding/index.htm and email to jennie.shepheard@dhs.vic.gov.au or fax 03 9096 7743.

Victorian ICD Coding Committee members as at June 2006

Jennie Shepheard	Human Services (Chair)
Carla Read	Human Services (Convener, Secretary)
Sara Harrison	Human Services (Victorian CSAC representative)
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Hancock	The Austin Hospital
Susan Peel	Southern Health
Maree Thorp	Peninsula Health
Kathy Wilton	3M
Diana Cheng	La Trobe University representative
Kylie Holcombe	Ballarat Health Services
Hayley Salter	The Royal Children's Hospital
Patricia Savino	The Northern Hospital
Pamela Williams	Eastern Health

Victorian ICD Coding Committee meeting dates

Tuesday 18 July	DHS, 10:00am, 18th floor 50 Lonsdale Street, Melbourne
Tuesday 15 August	DHS, 10:00am, 18th floor 50 Lonsdale Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
ADx	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CC	Complication or Comorbidity
CCCG	Clinical Classification and Coding Groups
CCL	Complication or Comorbidity Level
CSAC	Coding Standards Advisory Committee
DHS	Department of Human Services
DRG	Diagnosis Related Group
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
LOS	Length Of Stay
MDC	Major Diagnostic Category
NCCH	National Centre for Classification in Health
PDx	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
PCCL	Patient Clinical Complexity Level
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee
WHO	World Health Organisation