ICD Coding Newsletter

First quarter 2005-06

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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).

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Coding features

Cancelled Procedures

Coders should be aware of Query Number 2056 in the NCCH coding query database and apply this advice in conjunction with the Victorian Admission Policy.

Both the query and the relevant section from the Admission Policy are reproduced below for your information.

NCCH Query 2056
Cancelled procedures

This query relates to the advice given in Query 1932 *Chemotherapy cancelled* and how it relates to patients who have a Z code as Principal Diagnosis, for example, admission for elective circumcision Z41.2, which is cancelled due to unavailability of theatre. Prior to the Query 1932 we had been coding cancelled chemotherapy as Z51.1, neoplasm code, Z53.- and any reason if applicable. If the logic from this query is applied to other elective procedures, for example, admission for elective sterilisation, admission for A-V Fistula formation there is no obvious reason for the patient's hospitalisation except by the use of the Z code which indicates the reason for admission, for example, admission for ritual circumcision. What other code could be used as a Principal Diagnosis when this procedure has been cancelled.

This query will affect DRG assignment also, for example, malignancy as Principal Diagnosis instead of Z code.

ACS 0011 only provides examples of patients who are admitted for a particular diagnosis, not the many patients who have a Z code as their Principal Diagnosis. In the admission for elective circumcision which is cancelled what should the Principal Diagnosis be?

Could the chemo and other elective Z code admissions be included in ACS 0011 with examples.

Decision

Your query has highlighted an anomaly in the NCCH response to query 1932.

The original response to query 1932 did not allow for a differentiation between same-day admissions for administration of chemotherapy (Z51.1 'Pharmacotherapy session for neoplasm') and multi-day admissions, where the procedure (administration of the chemotherapy) was cancelled.

Where an admission is affected by the cancellation of a procedure, the diagnosis codes assigned should be the same as those that would be assigned if the procedure was performed. For example:

1. Admission of circumcision, procedure cancelled, assign:
   Z41.2 *Routine and ritual circumcision*
   Z53.- *Persons encountering health services for specific procedures, not carried out*

1. Same-day admission for chemotherapy for neoplasm, procedure cancelled, assign:
   Z51.1 *Pharmacotherapy session for neoplasm*
   Appropriate neoplasm codes
   Z53.- *Persons encountering health services for specific procedures, not carried out*
   (See also ACS 0044 CHEMOTHERAPY)

The NCCH will consider an addition to ACS 0011 ADMISSION FOR SURGERY NOT PERFORMED to include the above circumstances.

The information in the above query was also provided in coding Matters, Volume 12, Number 2, September 2005.

Victorian Admission Policy, Page 2-11 VAED Manual, 15th edition, July 2005
Cancelled Treatment

There will be occasions where a patient who is admitted, subsequently has their planned treatment cancelled:

- If the episode of care could be justified as extended medical treatment and supporting documentation is provided, it can be reported to the VAED. Even though this assessment needs to be made, the original Criterion for Admission should not be changed.
- If the episode of care could not be justified as extended medical treatment, the admission should be cancelled.

For example:

- Patient admitted on day of surgery, which was cancelled due to lack of available beds. Patient sent home without treatment. Admission should be cancelled.
- Patient admitted on day of surgery, which was cancelled as patient had a slight upper respiratory viral infection. Patient sent home without further investigation, to return to have the procedure when the virus is resolved. Admission should be cancelled.
- Patient admitted on day of surgery, which was cancelled as patient had a fever and cough. Patient underwent an x-ray, blood tests and was observed for five hours. Diagnosis of mild pneumonia, patient sent home, to return to have the procedure when pneumonia resolved. This episode should be reported to the VAED.

The level of same-day admissions involving cancelled procedures is continually monitored.

Until further notice, coders must first decide whether or not the admission is a legitimate admission according to the criteria discussed in the Admission Policy.

If the admission is legitimate, then the codes must be assigned according to the instructions contained in ACS 0011 *Admission for surgery not performed.*

If the admission is not legitimate, then the admission must be cancelled.

List of selected ICD-10-AM coding queries

#2031 Aftercare following a medical condition

In relation to ACS 2103 *Admission for convalescence/aftercare* paragraph 3 'If the aftercare follows medical (versus surgical) treatment of a condition, assign the code for the condition as an additional diagnosis'.

Could you please explain in what circumstances you would apply this standard when in relation to medical care?

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response.

The NCCH advises that **ACS 2103 *Admission for convalescence/aftercare*** paragraph 3 will be altered in a future edition of ICD-10-AM to read, 'If the convalescence follows medical (versus surgical) treatment of a condition, assign the code for the condition as an additional diagnosis'.

This advice can be applied immediately; therefore for episodes where this paragraph of **ACS 2103 *Admission for convalescence/aftercare*** applies, the principal diagnosis would be **Z54.x *Convalescence***.

#2034 Eradicated ulcers in diabetes

In regard to the changes to ACS 0401 *Diabetes Mellitus and impaired glucose regulation* page 103 'eradicated conditions in diabetes', there is a new note about an eradicated ulcer and how this is to be coded. This information is additional to that given in the 3rd edition FAQs, which only covered PVD and did not mention ulcers.

If the patient has diabetic foot (of which the ulcer is a part) and the foot is amputated or reconstructive vascular surgery allows the ulcer to heal, should we still code the patient as having diabetic foot (as per NCCH query #1746) or does the new advice on eradicated ulcers change this?

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response.

New advice regarding eradicated conditions supersedes the advice in NCCH Q1746.

Coding of these cases would depend on the condition at admission.

1. If the patient is admitted for diabetic foot for amputation, then code the diabetic foot.

2. If the patient has had a previous amputation for diabetic foot, then code E1-.51 and Z89.x unless other criteria for diabetic foot are met (presuming that PVD was the underlying cause of the ulcer).

The NCCH has advised that 'the query database is an historical document; therefore queries are never deleted from the database. The advice in query 1746 is relevant for ICD-10-AM Third Edition. A note has been added to the decision for query 1746 to alert coders that the advice was superseded in ICD-10-AM Fourth Edition'.

#2038 Repair of bilateral undescended testes

3 month old infant admitted for repair of bilateral undescended testes, one noted to be intra-abdominal and one inguinal.

Question 1:
We assigned the code Q53.29 *Undescended testicle, bilateral, other specified site* following the index then assigned the fifth digit of .9 as there does not appear to be a combination code. An alternative would be to assign two codes, one for unilateral, intra-abdominal and one for unilateral, inguinal. Which code/s is correct?

Question 2.
It would not appear to be correct to assign Q53.xx *Ectopic testis* with the 5th digits for canalicular, inguinal or intra-abdominal, as these are the sites the testis normally progresses through in the descending process. Also it would not appear to be correct to assign Q53.1,2 or 9x Undescended testis with the 5th digit of 9 (Other specified site) as the movement of the testis is from the intra-abdominal cavity down through the inguinal canal to the scrotum, and all the other sites are normal positions of the descending testis.

Question 3.
Should there be a 5th digit for multiple sites?

Answer 1:
In this case it is appropriate to assign two separate codes to accurately describe the position of each of the undescended testes:
Q53.13 ***Undescended testicle, unilateral, intra-abdominal***
Q53.12 ***Undescended testicle, unilateral, inguinal***

Answer 2:
This will be forwarded to the NCCH for advice.

Answer 3:
A fifth character subdivision for multiple sites would not be appropriate, as this would not reflect the specific information provided in the record.

#2044 False labour

A patient was admitted in false labour before 37 weeks gestation. The patient was observed overnight and the next day was discharged home. She had pains and tightening, but VE showed a closed cervix. I have coded the record:
O47.0 *False labour before 37 weeks*, and O09.5 *34-36 completed weeks of gestation*. This grouped to O64A *False labour before 37 weeks or W catastrophic CC*

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response.

The enquirer's coding is correct. **ACS 1550 *'Discharge/transfer in labour'*** is applied when the patient is in true labour.

There has been some confusion about the application of this ACS, mainly due to the inclusion of information about false labour. The VICC has prepared a submission to the NCCH requesting that ACS 1550 be reworded to remove any confusion around this issue.

The information in the June 2004 Victorian ICD Coding Newsletter referred to women who's labour is induced, rather than those presenting in false labour. This information is reproduced here. 'Specifically, where patients are admitted for induction and are subsequently sent home to wait for established labour, they should be put on leave (as you are expecting the patient to return within seven days), rather than be separated with a new admission recorded when they return.'

#2047 Injection of Enteryx

74 year old male admitted for endoscopic injection of Enteryx for gastro-oesophageal reflux. Enteryx is a co-polymer injected into lower oesophageal tissue, used to bulk up the tissue to help against reflux. The item number used by the doctor is 30490.

Options for coding the procedure:
K21.9 *Oesophageal reflux*
30490-00 [853] *Endoscopic insertion of oesophageal prosthesis*

K21.9 *Oesophageal reflux*
30476-00 [851] *Endoscopic administration of agent into non-bleeding lesion of oesophagus*

K21.9 *Oesophageal reflux*
90301-00 [869] *Other procedures on oesophagus*
30473-00 [1005] *Panendoscopy to duodenum*

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response.

The VICC noted that Enteryx is considered a prosthesis in Schedule 5 ' Benefits Payable in Respect of Surgically Implanted Prostheses, Human Tissue Items and other Medical Devices', and the NCCH supports the assignment of:
30490-00 [853] ***Endoscopic insertion of oesophageal prosthesis.***

#2055 Diabetes with obesity

28 year old patient admitted with a diagnosis of obesity, for gastric stapling. The patient is an IDDM diagnosed at age 6. There were no other complications recorded, particularly no diabetic manifestations. Codes assigned:
E10.9 *Type 1 diabetes mellitus without complication*
E66.9 *Obesity, unspecified*
Gastric reduction code and G.A.

I have applied ACS 0401 *Diabetes Mellitus and Impaired Glucose Regulation* page 88 Classification which states 'When unqualified obesity (E66.x) ...is documented with Type I diabetes mellitus, assign the appropriate diabetes code with these conditions as additional diagnoses'. This was also in the standards for Third Edition, but in a different place and not so specifically written. This would be a change of coding practice to code in the above way, and I am unsure if this is the intent of this particular part of the standard.

This query was referred to the NCCH for advice.

> The NCCH agrees with the interpretation of this section of **ACS 0401 *Diabetes mellitus and impaired glucose regulation***. When unqualified 'obesity' (E66.-) or hypertension (I10) is documented with Type I diabetes mellitus, assign the appropriate diabetes code with these conditions as additional diagnoses.

#2056 Malpresentation of fetus

I believe ACS 1506 *Malpresentation, disproportion and abnormality of maternal pelvic organs* page 202 'Presentations regarded as abnormal' lists 'persistent occipito-posterior position' as being the same as 'face to pubes'. However, in the Alphabetical index of diseases these are listed separately and have different codes assigned.

Is the index entry incorrect, or the ACS? I have always believed them to be the same condition but cannot understand why the Index entries are now different.

This query was referred to the NCCH for advice.

> The NCCH acknowledges the error in the Alphabetic Index of Diseases. The correct codes and pathways should be as follows:
>
> **Malpresentation**
> -face
> --to pubes O32.3
> -persistent occipitoposterior (position) O32.3
>
> **Presentation**
> -face
> --to pubes O32.3
> -persistent occipitoposterior (position) O32.3
>
> The NCCH will amend the error in a future edition of ICD-10-AM.

To ensure that face to pubes presentation is coded accurately, apply this advice from the NCCH immediately rather than wait for this to be amended in a future edition of ICD-10-AM.

#2060 Herpes simplex conjunctivitis

The alphabetic index appears inadequate for coding herpes simplex conjunctivitis. Using the index for Herpes, conjunctivitis leads to

B02.3 Zoster ocular disease

Zoster:

- blepharitis† (H03.1*)
- conjunctivitis† (H13.1*)
- iridocyclitis† (H22.0*)
- iritis† (H22.0*)
- keratitis† (H19.2*)
- keratoconjunctivitis† (H19.2*)
- scleritis† (H19.0*)

There is no additional entry for herpes simplex conjunctivitis. Also look up under herpes simplex there is no index entry for conjunctivitis. Yet in the Tabular list, code H13.1* Conjunctivitis in infectious and parasitic diseases classified elsewhere, includes Conjunctivitis (due to) herpesviral [herpes simplex] (B00.5†).

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

For documentation of 'herpes simplex conjunctivitis' assign:
B00.5 ***Herpesviral ocular disease***
H13.1* ***Conjunctivitis in infectious and parasitic diseases classified elsewhere***
by following the index pathway:
Conjunctivitis
-herpes (simplex) (virus) B00.5† H13.1*

The NCCH will consider amendments to ICD-10-AM Alphabetic Index under the lead term ' Herpes, herpetic' to clarify code selection for this condition.

The code selection for the index pathway:
Herpes, herpetic
-simplex
--eye B00.5† H58.8*
B00.5 ***Herpesviral ocular disease***
H58.8* ***Other specified disorders of eye and adnexa in diseases classified elsewhere*** is correct and supported by ICD-10 WHO Alphabetic Index:
Herpes, herpetic
-eye
--simplex B00.5† H58.8*

Note however, that where a specific eye condition is documented with herpes simplex (for example conjunctivitis, iritis, keratitis etc), a code for this condition should be assigned as the asterisk code in preference to H58.8.

The Victorian ICD Coding Committee suggests that coders refer to the specific condition in the index when coding eye complications of herpes.

#2080 Division of adhesions, uterovesical pouch

Laparoscopic division of adhesions of the uterovesical pouch and left and right ovarian fossa. I have coded:
90369-00 [1127] Exploration of perivesical tissue once
30393-00 [986] Laparoscopic division of abdominal adhesions twice
Can you please confirm if this is correct?

The Victorian ICD Coding Committee suggests coding division of adhesions only once. This is based on **ACS *0020 Multiple/Bilateral procedures*** Exceptions (b) which notes 'Procedures which are inherently bilateral or have a code provided in ICD-10-AM that denotes the multiple or bilateral aspect in the code title or inclusion terms, should only have one code assigned per operative episode'.

The code title for **30393-00 [986] *Laparoscopic division of abdominal adhesions*** indicates division of adhesions (plural), and therefore this code is required only once to reflect the division of adhesions in the left and right ovarian fossa.

If **90369-00 [1127] *Exploration of perivesical tissue*** is the correct code for division of adhesions of uterovesical pouch, one code is required for this procedure as well. As we don't have your operation report, we are unable to confirm the validity of the code

#2112 Cancelled procedure

43 year old female patient was admitted to hospital for D&C and hysteroscopy for post menopausal bleeding. On admission she was found to have right middle lobe pneumonia and therefore the procedure was cancelled. The patient then subsequently remained an inpatient for six days with the pneumonia, which was treated via IV antibiotics. According to ACS 0011 *Admission for surgery not performed*, the reason for admission, in this case the postmenopausal bleed, should be coded as the principal diagnosis with Z53.0 and J18.1 as associated diagnoses.

However, our query relates to the fact that the patient remained in hospital for six days due to the pneumonia and was treated for this condition and not the postmenopausal bleed. Hence the patient was not discharged on the same day as admission. The standard does not direct coders how to code in these circumstances.

In this case should the principal diagnosis be the post menopausal bleed with the pneumonia and cancellation as additional diagnoses:
N95.0 *Postmenopausal bleeding*
Z53.0 *Procedure not carried out because of contraindication*
J18.1 *Lobar pneumonia*

Or should the pneumonia be coded as a principal diagnosis with the postmenopausal bleed and cancellation as additional diagnoses:
J18.1 *Lobar pneumonia*
N95.0 *Postmenopausal bleeding*
Z53.0 *Procedure not carried out because of contraindication*

The Victorian ICD Coding Committee recognises that **ACS 0011 *Admission for surgery not performed*** does not address coding of patients who are admitted for a procedure that is cancelled and then the patient remains in hospital overnight for treatment of a different condition. While acknowledging that this is problematic, the VICC advises the enquirer to follow the ACS 0011.

ACS 0001 *Principal Diagnosis* 'Original treatment plan not carried out' advises to sequence as the principal diagnosis the condition which after study occasioned the admission to the hospital even though treatment may not have been carried out due to unforseen circumstances (see also ACS 0011 *Admission for surgery not performed* and Coding Matters Volume 12, Number 2, September 2005).

In this case code:
N95.0 *Postmenopausal bleeding*
Z53.0 *Procedure not carried out because of contraindication*
J18.9 *Pneumonia*

Please note that middle lobe pneumonia is not lobar pneumonia (per ACS 1004 *Pneumonia*).

#2128 Postoperative care versus convalescence

We are a regional country hospital and have quite a number of patients transferred back following complex operations at other hospitals. It is difficult to differentiate from the standards definitions the difference between someone who is receiving 'active treatment' versus 'convalescence', and the example gives no detail either as to what could be considered active treatment versus convalescence. (It also seems odd that convalescence gives a higher weight than active care). I have provided the following examples:

Example 1:
78 year old man transferred back from teaching hospital post burns treatment (he received skin debridement and skin grafts at the teaching hospital). Treatment at our hospital involved dressing of burns repeatedly, continuing of prophylactic antibiotic therapy. Patient suffered some chest pain during stay, ECG showed no changes. Had dietetic and physiotherapy referral during stay. After a week patient discharged for further dressings to be received from district nursing.

Example 2
65 year old man transferred back post stents put in at teaching hospital. BP monitored, no real complications. Patient is a diabetic, seen by dietitian, discharged after two days.

Based on the information provided there does not appear to be documentation of convalescence or aftercare, therefore **ACS 2103 *Admission for convalescence/aftercare*** may not apply. The correct principal diagnosis in the first example is the burns as the patient received ongoing treatment for this condition. In the second example, based on the limited information provided, the committee cannot provide a definitive code.

It is important to note that **ACS 2103 *Admission for convalescence/aftercare*** does not apply to all transfers and this standard should only be applied when there is documentation of 'postoperative care' or 'convalescence'. The Victorian ICD Coding Committee suggests that these types of cases be referred back to the treating clinician for clarification of principal diagnosis whenever possible.

Please note the following paragraph from Coding Matters Volume 10 Number 3 December 2003 (article titled ACS 2103 *Admission for convalescence/aftercare*):

> The NCCH has received a number of queries concerning the application of **ACS 2103 *Admission for convalescence/aftercare***. The intent of this standard is to provide guidance for clinical coders when specific documentation is written in the clinical record regarding 'convalescence' and 'postoperative convalescence' when the patient may still be receiving treatment. It was not intended for this ACS to be applied to all cases where patients are transferred between hospitals. The term 'transfer' does not imply that all subsequent episodes of care are 'aftercare'.
>
> Classification
> Clinical coders should make the most appropriate decision regarding code assignment by:
> - applying the clinical coders creed by assessing each case individually
> - referring to clinical documentation
> - using appropriate coding standards

Cost weights are driven by historical clinical costing and coded data and are reviewed annually. Code assignment should not be determined by reference to cost weights.

#2136 Vaginal vault prolapse and cystocele after hysterectomy

A recent coding workshop instructed us to code cystocele after hysterectomy to N99.3 *Prolapse of vaginal vault after hysterectomy.* I am aware of the exclusion notes at the start of block N81. However I have it on (informal) clinical advice that 'vaginal vault prolapse' and 'cystocele' (and for that matter all other female genital prolapses such as enterocele or rectocele) are in fact separate conditions, even though they are often found in the company of each other. Vaginal vault prolapse is more common in women post hysterectomy.

The way the exclusion note reads does not indicate to me that all female genital prolapses (post hysterectomy) should be coded to N99.3, just prolapse of the vaginal vault.

Please advise on the correct code selection for cystocele, rectocele and enterocele post hysterectomy.

The correct codes to assign are:
N81.1 ***Cystocele***
N81.6 ***Rectocele***
N81.5 ***Vaginal enterocele***

N99.3 ***Prolapse of vaginal vault after hysterectomy*** should only be assigned when there is documentation of vaginal vault prolapse after hysterectomy.

The Victorian ICD Coding Committee has forwarded a suggestion to NCCH to consider revising the index entries for N99.3.

#2138 Reduction of sternal dislocation

Trauma patient admitted with a dislocated sternoclavicular joint following a fall from a building. The patient is taken to theatre for an open reduction of the dislocation.

There are no codes for reductions of sternal dislocations. Should we be coding to: Reduction of fracture of sternum, or reduction dislocation Clavicle or are there any other suggestions?

The correct procedure code to assign is:
47006-00 [1402] ***Open reduction of dislocation of clavicle***.

It is noted that this results in the episode grouping to 901Z *Ungroupable*. The Victorian ICD Coding Committee has forwarded a request to the NCCH for the creation of two new procedure codes for:

- Reduction, dislocation, clavicle, sterno-clavicular; and
- Reduction, dislocation, clavicle, acromio-clavicular.

#2139 Waterskiing accident external cause code

Which code should be used for a waterskiing accident? We assume V94.7 would be correct, with W02.2 exclusion note 'excludes into water'.

When you would use W02.2 in this case?

The Victorian ICD Coding Committee acknowledges the difficulties associated with coding waterskiing accidents. There are changes being made to these codes for ICD-10-AM Fifth Edition, which may resolve these issues when coding water skiing accidents in the future. Until then, it is correct to assign either:

W02.2 ***Fall involving water ski***
or
V94.7 ***Other and unspecified water transport accidents involving water skis***.

#2141 Baby of a chemically dependent mother

A full term baby of a mother on methadone was sent to Special Care Nursery for NASS scoring as per our hospital protocol, where all babies born to a chemically dependent mother are admitted to SCN for seven days monitoring. Some babies have severe symptoms, which warrant the code P96.1 *Neonatal withdrawal symptoms from maternal use of drugs of addiction*. In this instance, the baby suffered no effects from the drugs and is only monitored. The principal diagnosis used was P04.4 *Fetus and newborn affected by maternal use of drugs of addiction*.

ACS 1609 *Newborns affected by maternal causes and birth trauma* specifies that a code from P00-P04 will never be a newborns principal diagnosis code. Is it possible to code the *Z03.79 Observation for other suspected newborn condition* as the principal diagnosis (the effect) and the P04.4 to specify what the baby was being observed for the cause?

It is not correct to assign **P04.4** ***Fetus and newborn affected by maternal use of drugs of addiction*** as the baby was not affected by the maternal condition. Rather, the baby was monitored for a suspected condition that was not found. Coders should apply
ACS 1609 ***Newborns affected by maternal causes and birth trauma***.

Therefore in this scenario the correct codes to assign are:
Z03.79 ***Observation for other suspected newborn condition***
Z38.0 ***Singleton, born in hospital***

#2143 Epidural in labour

All patients who have perineal lacerations are given local anaesthesia prior to suturing. If a patient is given an epidural in labour and has perineal lacerations, which are sutured under a local anaesthesia but still under epidural, should the epidural be coded to:
92506-xx [1333] *Neuraxial block during labour* or
92507-xx [1333] *Neuraxial block in labour and delivery procedure*?
There is no mention that the epidural has been topped up prior to suturing the perineum.

The epidural is only removed prior to the patient being transferred from delivery suite to the postnatal ward in all cases of vaginal deliveries.

This query also relates to a NVD, which proceeds to either vacuum extraction, or forceps delivery where the epidural was administered for analgesia during the course of labour, however, there is no mention of the epidural being topped up for the vacuum or forceps delivery. We would only use 92507-xx [1333] if the intent of the epidural was as an anaesthetic rather than an analgesic in the above cases. Is this correct?

The only indication of the epidural being topped up is when the labour proceeds to a caesarean in which case we would code the epidural to 92507-xx [1333]

ACS 0031 *Anaesthesia* states that **92507-XX [1333] *Neuraxial block during labour and delivery procedure*** may also be assigned where, following a vaginal delivery, the same neuraxial block is continued for postpartum procedures such as removal of retained placenta and/or repair of obstetrical trauma.

The 'note' under **92507-XX [1333] *Neuraxial block during labour and delivery procedure*** in the tabular list of procedures states:

> This code is to be assigned for those patients who have a neuraxial block for pain relief in labour and the neuraxial block is continued for anaesthesia during delivery procedure.

Therefore the correct code to assign in these scenarios is
92507-XX [1333] *Neuraxial block during labour and delivery procedure*.

This code can be assigned in accordance with point 3 **ACS 0031 *Anaesthesia*** on page 43 of the Australian Coding Standards.

#2144 Postcoital bleeding in pregnancy

A significant number of antenatal patients present to hospital with postcoital bleeding at various stages of pregnancy. The bleeding is from vaginal tissue and not from the placenta. The only code regarding haemorrhage from the obstetric chapter comes from O46 *Antepartum haemorrhage*.

We have used O99.8 *Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium* and N93.0 *Postcoital and contact bleeding* to code postcoital bleeding in pregnancy.

As per **ACS 1521 *Conditions complicating pregnancy*** and Coding Matters Volume 11, Number 4, if the postcoital bleeding is complicating the pregnancy and the patient receives obstetric observation, the correct codes to assign are:

099.8 ***Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium***
N93.0 ***Postcoital and contact bleeding***

If the postcoital bleeding is not complicating the pregnancy, but the patient receives obstetric observation, the correct codes to assign are:

N93.0 ***Postcoital and contact bleeding***
Z34.x ***Supervision of norma*l *pregnancy***

If the postcoital bleeding is not complicating the pregnancy, and the patient does not receive obstetric observation, the correct codes to assign are:

N93.0 ***Postcoital and contact bleeding***
Z33 ***Pregnant state, incidental***

#2145 GBS positive status in pregnancy

Is GBS positive status in pregnancy coded only in the delivery episode or in all antenatal admissions? Do we need to code GBS positive status in pregnancy in cases of elective/emergency LUSCS given that there is no vaginal delivery and antibiotics are not given?

ACS 1549 *Streptococcal Group B Infection/Carrier in Pregnancy* does not state otherwise.

ACS 1549 *Streptococcal Group B Infection/Carrier in Pregnancy* applies to 'obstetric patients with Strep B' regardless of whether the episode is for a vaginal delivery or LUSCS.

GBS positive status should be coded whenever it is documented in all obstetric admissions including antenatal and postnatal, regardless of whether the patient received antibiotics.

#2146 False labour

ACS 1550 *Discharge/transfer in labour* states that the cervix does not actually change in false labour whereas it does dilate and soften during true labour.

Patients often present with mild contractions, 50% cervical effacement and cervix is 1 or 2 cm dilated. The patients are seen and sent home to await a more established labour. Our clinicians have informed us that unless there is 100% effacement and at least 3 cms of cervical dilation, the patient is not in labour and that this should be coded as false labour. This information contradicts ACS 1550 *Discharge/transfer in labour*. Please advise as interpretation of the standard and our clinical advice is contradictory.

If a patient presents with a show, no contractions and no changes of the cervix, is this false labour? If this is not false labour, what code should be used for this antenatal admission?

ACS 1550 *Discharge/transfer in labour* overrides clinical advice.

It is important to note that this standard applies when there is documentation of labour and the patient is transferred or discharged home.

If labour is documented as false labour, then this should be coded to **O47.x *False labour***.

If not documented as false labour, the correct code to assign is **Z34.x *Supervision of normal pregnancy***.

Coders should assign codes based on the documentation in the record and the advice in **ACS 1550 *Discharge/Transfer in labour***

#2147 Hypothermia in newborns

When babies are newly born their body temperature is a little lower than normal and the babies are wrapped in blankets and or placed under heaters until the temperature is >=36.6. The body temperature normally stabilises with the first few hours after birth.

Although there is no documentation of hypothermia, can this be coded as hypothermia of newborn?

Hypothermia of newborn must be documented before a code for the condition can be assigned.

#2149 Fetal death in utero (FDIU) of one twin

37year old obstetric patient originally pregnant with twins however suffered FDIU of one twin at 17/40. Admission was for delivery of surviving twin. Should FDIU be coded in delivery admission that is, using codes O02.1, O09.2 or is this covered by using O31.2?

If I include these codes to complete the whole picture, the episode groups to a non-obstetric DRG O63Z, which is unacceptable, despite using an outcome of delivery code (Z37.3).

Is it acceptable to simply use O31.2 to reflect the complication?

The correct principal diagnosis to assign in this scenario is:
O31.1 ***Continuing pregnancy after abortion of one fetus or more***

O02.1 ***Missed abortion*** should not be assigned as per the 'excludes' note at the beginning of the O00-O08 chapter *Pregnancy with abortive outcome* which states:

> **Pregnancy with abortive outcome (O00–O08)**
> ***Excludes***: continuing pregnancy in multiple gestations after abortion of one fetus or more (O31.1)

In AR-DRG V5.0 this episode groups to **O60A** ***Vaginal delivery with catastrophic or severe CC*** when **Z37.3** ***Twins, one liveborn and one stillborn*** (or **Z37.0** ***Single live birth***) is assigned.

The Victorian ICD Coding Committee recommends use of **Z37.0** ***Single live birth*** because the death of a fetus at 17 weeks makes this an abortion, and not a birth per **ACS 1510** ***Pregnancy with abortive outcome***.

#2152 Anaemia and related descriptions

I wish to further clarify information regarding the coding of anaemia and related descriptions contained in Query #1944 ICD Coding Newsletter Second Quarter 2004-05. It has become common practice in our hospital for clinicians to document anaemia and its treatment in the following ways:

1. ↓ Hb Transfuse 2 units packed cells
2. ↓ Hb Transfusion given
3. Monitor Hb readings and when Hb <90 transfuse 2 units. Entries further along say 'Hb 85 patient received 2 units packed cells'

Prior to query #1944, we coded anaemia on the basis of a down arrow as per examples in VICC query #1735 (Nov 2001).

Queries back to the clinicians asking them to document anaemia are not always received graciously, rather the clinicians are puzzled that we need to ask for clarification as they consider a patient to be anaemic whenever transfusions are given. Can we code anaemia in the above examples?

The Victorian ICD Coding Committee agreed that a downward arrow can be interpreted as meaning 'low'. Low haemoglobin is indexed to **D64.9** ***Anaemia, unspecified***. Therefore for scenarios 1 and 2, anaemia can be coded. For scenario 3, there is no documentation indicating that the patient has anaemia, and therefore this cannot be coded.

Hopefully if your doctors are constantly made aware/reminded of the documentation requirements for coding anaemia (and other conditions) then this should eventually reduce the number of queries referred back to them when the documentation is lacking.

#2153 Suspected snakebite

14 year old male presents with suspected snakebite. He has two marks on his leg but VDK test is negative and there was no actual sighting of a snake.

Example 1 on page 258 of standards says to use open wound code but the VDK test in this example has detected contact with a brown snake. My query is how to code the above scenario when the only evidence is two marks on leg that could be due to a branch, rock or anything?

The Victorian Coding Committee notes that the question is not about whether the snake was venomous or not, but rather whether this is in fact a snakebite. Therefore what is being coded is 'query' snakebite.

In this case, the principal diagnosis should be **Z03.8** ***Observation for other suspected diseases and conditions*** (as per **ACS 0001** ***Principal diagnosis*** Codes from the Z03.0-Z03.9 series, medical observation and evaluation for suspected diseases and conditions').

#2154 Admission for IVF involving males

Patient (male) admitted for PESA (Percutaneous Epididymal Sperm Aspiration) under GA as part of IVF procedure. The sperm obtained is sent to the IVF laboratory.

According to ACS 1437 *Infertility* the appropriate diagnosis code would appear to be Z31.2 *In vitro fertilisation*. However, system edits (at hospital level, Victorian DHS level and NCCH ASCII file level) prevent the entry of this diagnosis code for a male patient.

As PESA is a procedure carried out specifically for IVF, and the standard states 'either male or female' according to the standard when admission is specifically for PESA and IVF (or infertility) has been documented as the principal diagnosis, Z31.2 *In vitro fertilisation* should be assigned.

The NCCH database contains the following query, (Q1914) dated 15/03/2004:
Q. What code is used for Principal Diagnosis for males being admitted for IVF treatment?

A Male admitted for aspiration of sperm for IVF under LA. (Female admitted at same time for TVOR). If Z31.2 *In vitro fertilisation* is used it is ungroupable. Z31.2 appears the most appropriate code, but have only up to this stage tended to be assigned for the females only. A male infertility code is not appropriate as it is not treatment for the infertility, but IVF treatment. The NCCH suggests Z31.3 *Other assisted fertilisation methods* for the scenario cited.

In addition, Coding Matters Volume 11 Number 3 December 2004 states:
Aspiration of sperm for IVF
The NCCH received a query regarding code assignment for male patients admitted for aspiration of sperm for IVF. Z31.3 *Other assisted fertilisation methods* should be assigned for these cases. Assign also an appropriate procedure code, as per documentation.

We are following this advice from NCCH, but feel that Z31.2 *In vitro fertilisation* is the correct code for males admitted for IVF procedures according to the Standard and current code indexing.

Would VICC consider suggesting to NCCH either:
1. That indexing for Admission for IVF be amended to direct male admissions to Z31.3 and female admissions to Z31.2 and that ACS 1437 *Infertility* be amended to reflect that for IVF procedures, Z31.2 is appropriate for female patients and Z31.3 for male patients, in line with their advice in Coding Matters

Or

2. That the ASCII file be amended to enable Z31.2 to be used for both male and female patients where admission is for IVF (as ACS 1437 *Infertility* currently directs).

The Victorian ICD Coding Committee recognise the issues highlighted by the enquirer and has referred the enquirer's suggestions to the NCCH. In the meantime coders should follow the advice provided in Coding Matters Volume 11 Number 3 December 2004.

#2155 History of antepartum haemorrhage (APH)

Patient with multiple antenatal admissions for small APHs, presented and was induced on this occasion for this reason, although on admission no APH present. Admitted for Prostin, ARM and Syntocinon.

Would the Principal Diagnosis be APH or a Z code to show past history?

ACS 1513 *Induction* notes that induction of labour is performed for many reasons including for 'previous antepartum haemorrhage'. A patient admitted for induction of labour for previous antepartum haemorrhages, should be coded to **O46.x *Antepartum haemorrhage, not elsewhere classified***.

#2156 Gritty placenta

A 'gritty' placenta. Please advise what you would consider the appropriate code to describe this condition?

Some coders here use O43.1 *Malformation of placenta* and some O43.8 *Other placental disorders*

Clinical information obtained by the Victorian ICD Coding Committee indicates that gritty placenta is more common in post-dates pregnancies and has no clinical importance. (http://showcase.netins.net/web/placenta/placentaltriage101.htm).

The Committee advises that gritty placenta should not be coded.

#2157 Relapse of schizophrenia

Patient admitted with a relapse of schizophrenia. The symptoms included being distracted by voices. This relapse occurred when the patient ceased his Clozapine in a previous admission (due to physical health complications) and commenced Amisulpiride.

In the past I have simply coded these episodes to the principal diagnosis. However, I want to know whether we can find a code that shows that the relapse was due a change in medication. Maybe a Z code?

Suggestions:
F20.9 *Schizophrenia*, unspecified
Z76.8 *Persons encountering health services in other specified circumstances*
or
Z92.28 *Personal history of long term (current) use of other medicaments - other medicaments*

There are no codes to indicate that a change to the status of a condition is due to a change in medication, and no codes to indicate this are required.

For this scenario, code **F20.9 *Schizophrenia, unspecified***.

If there is a need at local level to collect this information then the Z codes mentioned above may be appropriate. However, coders must ensure that these codes, if assigned for this purpose, are not transmitted to VAED.

#2159 Diabetic foot with cellulitis of toe

50 year old male presented with diabetic foot with cellulitis of the toe with a LOS of 60 days. Debridement of the cellulitic toe was undertaken on the ward and the general surgeon documented in the progress notes (R) 5th toe bone nibbled back and tendon debrided indicating that the excisional debridement of the soft tissue involved the bone.

When I group the episode, it goes to 901Z *Extensive O.R. related to principal diagnosis* and the episode becomes an outlier as the high trim point 36 days. Alternatively, if I use the procedure code 30023-00 [1566] *Excisional debridement of wound of soft tissue*, the episode groups to K01Z *Diabetic foot procedures,* becomes an inlier and is more accurate. If I use both procedure codes, the DRG remains at K01Z.

Questions:

1. Does the documentation support the allocation of 30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage*?

2. If so, should both debridement codes be allocated to ensure that the episode groups to K01Z?

3. Or do adjustments need to be made to the DRG procedure code table to include 30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage*?

The information that you have provided supports the assignment of:

30023-01[1566] ***Excisional debridement of soft tissue involving the bone or cartilage***

30023-00 [1566] ***Excisional debridement of wound of soft tissue*** cannot be used in addition to this code because of the 'excludes' note at this code excluding 'excisional debridement of soft tissue including bone or cartilage'.

The Victorian ICD Coding Committee will notify the Commonwealth of this grouping issue.

#2162 AICD/Pacemaker insertions

Doctors at our hospital have advised that all AICD units have both pacemaker and defibrillator functionality. One lead from the AICD unit performs both functions (pacing and defibrillating). This lead is placed into the right ventricle.

Depending on the pacemaker function required depends on the number of leads to be inserted.

The problem that coders face is how should we capture the fact that one of the leads doubles up to act as a defibrillator lead as well as a pacemaker lead? If we code each one out, it appears that an extra lead has been inserted when it hasn't.

A Biventricular AICD unit requires a lead to pace the atrium and a lead to both ventricles.

38524-00 *Insertion of automatic defibrillator generator*
38521-03 *Insertion of defibrillation electrodes (leads) for automatic defibrillator (1 electrode)*
38281-13 *Insertion of permanent triple chamber pacemaker*
90214-00 *Insertion of permanent triple chamber transvenous electrodes (3 electrodes)*

Looking at these codes it would appear that four wires have been inserted but in reality only 3 wires have been inserted. To code two pacing electrodes with a triple chamber pacemaker would not appear correct.

The same occurs with an AICD (VVI 40). This is a unit with one lead to the right ventricle. It both has a pacing threshold of 40 beats per minute (indicated by VVI 40) and a defibrillator coil.

To code the pacemaker VVI without an electrode would not follow the 'includes note' in the procedure code.

Therefore we have been coding:
38524-00 *Insertion of automatic defibrillator generator*
38521-03 *Insertion of defibrillation electrodes (leads) for automatic defibrillator (1 electrode)*
38281-02 *Insertion of permanent single chamber pacemaker, VV*
38278-01 *Insertion of permanent transvenous electrode into ventricle (1 electrode)*

Again this creates a picture that 2 electrodes have been inserted when in fact only one has been inserted.

Are we interpreting the errata and 'code also' notes correctly?

The Victorian ICD Coding Committee recognises the difficulties in assigning codes for these procedures and will prepare a public submission for NCCH requesting a review of AICD and pacemaker codes and coding standards. Until these codes can be reviewed and updated appropriately, assign a code for each component performed knowing that the end result will not precisely match the actual procedure performed. The codes that you have provided in your query are appropriate.

#2163 Breast exploration procedure

Patient was admitted for right breast pain, with the procedure documented as exploration. The patient has a breast implant, which was removed and reinserted after the cavity was irrigated. I am unsure whether to code just the breast exploration code or if I should include codes for the removal and insertion or the replacement of the prosthesis. The options we are considering;

1. 31551-00 [1742] *Incision and Drainage of Breast*

2. 31551-00 [1742] *Incision and Drainage of Breast*
   45548-00 [1758] *Removal of Breast Prosthesis*
   45524-00 [1753] *Augmentation mammoplasty, Unilateral*

3. 31551-00 [1742] *Incision and Drainage of Breast*
   45552-00 [1758] *Removal of breast prosthesis with complete excision of fibrous capsule and replacement of prosthesis.*

Options 2 & 3 are not ideal as they both imply a new implant is inserted. In the third option the excision of a fibrous capsule was also not performed.

Option 1, **31551-00 [1742]** ***Incision and Drainage of Breast*** is the appropriate code for this procedure. Removal of the prosthesis is a part of the operative approach to enable access for irrigation; therefore this is not coded separately.

#2164 Insertion of unispacer into knee

How do you code the insertion of a Unispacer into a knee joint? The Unispacer is a small metallic, kidney-shaped insert, which is held in place by its geometry and the surrounding soft tissue structures. It is used as an alternative to TKR in patients with low grade arthritis to provide a smooth surface for the bones to glide over and improve joint stability. It is also used to correct the deformity of a meniscectomy and relieve the consequent imbalance of forces after meniscectomy. Our Orthopaedic department suggested coding:
49517-00 [1518] *Arthroplasty, knee, partial*

This problem with the partial knee arthroplasty code is the index specifies 'for joint replacement'. As the 'Unispacer' insert is not for joint replacement it was thought this might not be appropriate.

An alternative code is 90598-00 [1520] *Other repair of knee* that is also not ideal.

The correct code to assign for this procedure is:
90551-00 [1496] ***Implantation of prosthetic device of leg***.

The index look up is:
Implantation
↓
-prosthesis, prosthetic device
--leg

#2165 Bladder scan for females

After AIHW has analysed data supplied by jurisdictions, they send back episodes to the jurisdictions that they confirmed, including what they believe to be mismatches in sex and procedure codes.

Feedback included episodes where 55300-00 [1943] *Transrectal ultrasound of prostate, bladder base and urethra* was coded for females. This data combination for 2004-05 results in a rejection, which hospitals must fix in order to submit their coding (in line with the ASCII).

Upon investigation it was noted that for all three episodes, the procedure that the coder was trying to reflect was a bladder scan. This procedure is used routinely to measure the volume of urine in the bladder to determine whether the patient may need to be catheterised. It is noted that this procedure should not normally be coded as per ACS 0042 *Procedures not normally coded*, however if a hospital does choose to code the procedure, there appears to some issues with the indexing of bladder scan. The current indexing is listed below:

Ultrasound
↓
-bladder (base)
--with prostate and urethra (transrectal) 55300-00 [1943]

We would like to suggest that the indexing be changed as listed below:

-bladder (base) 55038-00 [1943]
--with prostate and urethra, transrectal 55300-00 [1943]

55038-00 [1943] *Ultrasound of urinary tract* appears to be the best fit of the current codes, however there could be scope to create a new code.

Transrectal is currently a non-essential modifier, yet is in the title of the code, implying that it is required if the code is to be used.

In the ICD-10-AM Procedures classification 'and' means 'and' and not 'or' (per **ACS 0040 *Conventions Used in the Tabular List of Procedures***)

In this scenario, code **55038-00 [1943] *Ultrasound of urinary tract*** is the most appropriate code for this procedure.

55300-00 [1943] *Transrectal ultrasound of prostate, bladder base and urethra* cannot be coded for females, as all of these organs must be scanned before this code can be used.

Note that there will be a new code in ICD-10-AM Fifth Edition for ultrasound of the bladder.

#2172 Osteoarthritis of spine

When looking in index for osteoarthritis (OA) of the L4-L6, for example, would you go straight to OA Spine in the index or follow the path of OA, Joint, Vertebral column, or alternatively go to OA, primary, vertebral column, or OA localised, vertebral.

The different codes in turn lead to a different DRG with a very different weight.

Osteoarthritis
↓
-spine (see also Spondylosis) M47.9-

is the appropriate index look up for this condition.

The subterms 'joint', 'primary' and 'localised' can only be used if these terms are documented in the patient's record.

The subterms 'joint' and 'primary' are also NEC entries and would only be used when a more specific sub term is not available.

The sub term 'localised' directs coders to M19.9- *Arthrosis unspecified* which has an 'excludes' note for spine.

#2173 Routine coding of additional diagnoses

What conditions/diseases are to be coded even if they do not meet the 'additional diagnosis criteria'? We understand that those conditions listed as specialty standards on page 10 of the ACS 0002 *Additional diagnoses* are coded routinely (do not have to meet associated criteria) or are we misinterpreting this instruction?

Query #2001 from the Third quarter 2004-2005 both the enquirer and the response implies diabetes must meet the additional criteria? We always code diabetes as an additional condition if present.

The list of specialty standards in **ACS 0002 *Additional Diagnoses*** indicates that these are standards that contain advice to code certain conditions that may not meet the criteria for coding as additional diagnoses. For example **ACS 0401 *Diabetes mellitus and impaired glucose regulation*** contains advice to assign codes for many conditions in addition to the code for diabetes. This standard does not state to 'always code' diabetes, therefore diabetes must meet **ACS 0002 *Additional Diagnoses*** before it can be coded. Thus, when diabetes does meet criteria outlined in **ACS 0002 *Additional Diagnoses***, there are certain conditions, for example hypertension and hypercholesterolaemia, that must be coded if they exist in the patient. These conditions do not have to meet additional diagnoses criteria in this circumstance.

The coder must refer to the advice in each of the listed ACS.

#2174 Fetal stress/distress

There is ongoing discussion amongst our coders regarding category O68 *Labour and delivery complicated by fetal stress [distress].*

Some coders tend to use code O68.8 *Labour and delivery complicated by other evidence of fetal stress*, arguing that the evidence of fetal distress is electrocardiographic which is the CTG, and that all heart rate information on the unborn baby is by CTG (or internal CTG).

Other coders use O68.0 *Labour and delivery complicated by fetal heart rate anomaly,* which includes bradycardia, tachycardia, heart rate irregularity. These coders argue that the CTG is simply the method of measuring the heart rate, and that fetal distress occurs when there is documented bradycardia, tachycardia, fetal distress or more commonly variable decelerations or other documented heart rate anomalies,

Because it could be argued that CTG is a measure of fetal heart rate when documentation such as non-viable CTG or non-reassuring CTG is noted, is this really just an indication of fetal heart rate anomaly/irregularity anyway?

The coders who use O68.8 also use this when non-viable CTG or non-reassuring CTG is documented, for the obvious connection regarding CTG in documentation. However for these cases when meconium is also documented, they revert to O68.1 *Labour and delivery complicated by meconium in amniotic fluid,* which suggests a perception that there is precedence for collecting information higher up at the 4th digit level.

Similarly with O68.3 *Labour and delivery complicated by biochemical evidence of fetal stress*. We don't use this as a method of diagnosis of fetal distress at our hospital but which would you code in a case where fetal distress is diagnosed by both CTG and biochemically?

We are querying whether a hierarchical system applies in category O68, based on the 4th digit.

There is no hierarchical system that applies to categories within **O68 *Labour and delivery complicated by fetal stress [distress]***. More than one code can be used if appropriate.

If there are specific fetal heart rate anomalies documented (for example bradycardia, 'heart rate irregularity', tachycardia) assign the specific code:
O68.0 *Labour and delivery complicated by fetal heart rate anomaly*

Note that this code excludes with meconium in amniotic fluid (O68.2). Therefore if there was meconium in the liquor and a specific fetal heart rate anomaly, assign only code:
O68.2 *Labour and delivery complicated by fetal heart rate anomaly with meconium in amniotic fluid*.

If you have documentation of 'abnormal CTG' or 'non-reassuring CTG' only as the reason for intervention (with no specific heart rate anomalies documented) assign the code:
O68.8 *Labour and delivery complicated by other evidence of fetal stress.*

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 Sara Harrison, Secretary Victorian ICD Coding Committee (Sara.Harrison@dhs.vic.gov.au) if you would like to have your views considered.

Coding queries

The committee continues to remain up to date with processing new queries coming to the committee. However at the last meeting there were still several queries awaiting feedback from NCCH. The committee expects to receive these responses in the next few months and will then be up to date.

Public Submissions to NCCH

NCCH will be receiving public submissions for modification to ICD-10-AM during the first half of 2006. Coders can be involved in this process. Details regarding how to submit a proposal can be found on the NCCH website under 'ICD-10-AM, Changes to ICD-10-AM'. If there are ways to improve the classification about which you feel strongly start preparing that submission now.

NCCH queries database

The database was last updated with new queries added on 7 September 2005. This database can be viewed online or downloaded from the NCCH web page at:
http://www3.fhs.usyd.edu.au/ncchwww/site/4.3.htm
We encourage all coders to access this database regularly.

Victorian ICD Coding Committee members as at 1 March 2005

Jennie Shepheard	Human Services (Chair)
Carla Read	Human Services (Convener)
Sara Harrison	Human Services (Secretary, Victorian CSAC representative)
Melinda Avram	Epworth Hospital
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Morrison	The Austin Hospital
Megan Morrison	St John of God Health Care Geelong
Susan Peel	Southern Health
Leanne Stokes	Beachplace Pty Ltd
Maree Thorp	Peninsula Health
Kathy Wilton	3M
Diana Cheng	La Trobe University representative

Victorian ICD Coding Committee meeting dates

Tuesday November 15th	DHS, 9:30am, 16th floor 555 Collins Street, Melbourne
Tuesday December 13th	DHS, 9:30am, 16th floor 555 Collins Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACS	Australian Coding Standard
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