ICD Coding Newsletter

Special Edition

June 2005

Distribution List

- ❒ Health Information Manager/s (HIMs)
- ❒ Clinical Coders
- ❒ Information Technology (IT)
- ❒ Interested Others

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
- 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:
Telephone 9616 8141
Fax 9616 7743
Email PRS2.Help-Desk@dhs.vic.gov.au

HDSS web site is:
http://www.health.vic.gov.au/hdss/index.htm

An electronic coding query form can be completed at:
http://www.health.vic.gov.au/hdss/icdcoding/codecommit/icdquery.htm

An index to Coding Newsletters can be found at:
http://www.health.vic.gov.au/hdss/icdcoding/newslet/index.htm

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1 July Information Updates

Coding classification

All separations on or after 1 July 2005 must be coded using ICD-10-AM Fourth Edition (and relevant errata) in accordance with the current Australian Coding Standards effective 1 July 2004, Victorian Additions to the Australian Coding Standards and ICD Coding Newsletters issued by the department. Additionally, coders are expected to follow relevant and current advice published on the National Centre for Classification in Health coding query database (http://www3.fhs.usyd.edu.au/ncch/).

Library file for 2005-06

The 2005-06 library file (in Excel format) and the description of the file structure are available on the HDSS webpage at:
http://www.health.vic.gov.au/hdss/reffiles/2005-06/vaed/libfil05.htm

Changes from the previous library file for 2004-05 are limited to edit revisions only.

This file is password protected using the same password as last year. If you need to know the password, email the HDSS Helpdesk (prs2.help-desk@dhs.vic.gov.au) requesting this.

The department's licensing agreement with the NCCH only permits the release of this file to Victorian hospitals and software vendors with Victorian clients.

NCCH advice

Coders are reminded that information provided on the NCCH query database should be followed for coding in Victoria. This database may be referenced during patient data audits. See *Patient Data Audits* on page 16.
The NCCH is committed to incorporating all of their advice into the latest version of their classification. If you are aware of information provided on the NCCH query database, in Coding Matters or via another NCCH source that has not been incorporated into the most recent publication of ICD-10-AM please notify the secretary of the Victorian ICD Coding Committee (Sara.Harrison@dhs.vic.gov.au) Include in your notification the following information:

- Details of advice provided
- Where this information was provided (for example Coding Matters, NCCH query database, education session, other)
- When this information was provided (date/volume number)
- Why your coders are still following this advice (for example 'no further/more recent advice/information provided on this subject').

Grouper version and mapping

For 2005-06, DHS will map ICD-10-AM Fourth Edition codes to ICD-10-AM Third Edition codes for input to the AR-DRG Version 5.0 Grouper.

Information about AR-DRG Version 5.0 can be found on the website of the Commonwealth Department of Health and Ageing at http://www.health.gov.au/casemix/ardrg1.htm, and in the Australian Refined Diagnosis Related Groups Version 5.0 Definitions Manuals.

Mapping tables from ICD-10-AM Fourth Edition to Third Edition editions have been incorporated into the 2005-06 library file or can be accessed on the Department of Health and Ageing website at http://www.health.gov.au/casemix/mapdis1.htm#mapi10e34.

Notification of Grouper anomalies

The Department of Health and Ageing has developed a standard form for notification of grouper anomalies. This can be accessed at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-casemix-grouper-bugform.htm.

Please also notify the Victorian ICD Coding Committee of any anomalies. The State can, in many instances, influence a faster resolution of problems or make local adjustments to grouper software as required.

Victorian modifications to AR-DRGs for 2005-06

The *Victoria —Public Hospitals and Mental Health Services Policy and Funding Guidelines 2004-2005 (Technical information)* contains detailed information regarding Victorian modifications to AR-DRGs. This is reproduced below for your information with a link to the guidelines.
http://www.health.vic.gov.au/pfg/index.htm

1.1 AR-DRG modifications

In 2005–06, hospitals will assign diagnoses and procedure codes using the Fourth Edition of the ICD-10-AM classification. For funding purposes, these codes will be mapped back to Third Edition codes and then grouped using AR-DRG Version 5.0.

As in previous years, some adjustments are to be made to the original AR-DRG5 (Version 5.0) grouping utilising the VIC-DRG5 field, prior to the calculation of WIES12. The AR-DRG Version 4.2 adjustments that applied in WIES11 will continue to apply in WIES12, except where changes have been routinely included within the AR-DRG5 structure.
VIC-DRG5 changes introduced for WIES12 in 2004-05 will continue in 2005-06, namely:

- the extension of A40Z to contain a broader range of high cost life support procedures
- splitting of D06Z into D06A Mastoid Procedures and D06B Other Sinus and Complex Middle Ear Procedures
- addition of new VIC-DRG5 of 964Z Gender Reassignment-Conflict

- the ICD-10-AM diagnosis code Z71.3 Dietary counselling and surveillance will not be recognised as a complication and/or comorbidity code for the purpose of grouping to VIC-DRG5.

1.2 Peritoneal dialysis

In recognition of cost differences between peritoneal and haemodialysis, episodes with a principal diagnosis of peritoneal dialysis (ICD-10-AM code Z49.2) are to be assigned a VIC-DRG5 of L61Y Admit for peritoneal dialysis.

1.3 Radiotherapy

Victorian Coding Standard 0229 states that non-same day patients receiving radiotherapy should have the malignant condition sequenced first, followed by the radiotherapy code (ICD-10-AM code Z51.0). Same day radiotherapy admissions, which follow the Australian Coding Standard, have Z51.0 assigned as the principal diagnosis followed by the malignancy code.

To maintain funding equity, a VIC-DRG5 of R64Z Radiotherapy will be assigned for nonsurgical episodes that include a radiotherapy diagnosis code, except for episodes with the following pre-MDC AR-DRG5.0s: A40Z, A41A, A41B, W60Z, W61Z, S65A, S65B, S65C, B60A, AND B60B.

1.4 Hysteroscopy sterilisation

Based upon clinical advice on emerging clinical practice, a new VIC-DRG5 (N11C) has been created to adequately cover the costs of hysteroscopy sterilization. Patients allocated an AR-DRG5.0 of N09Z, N10Z, N11B, N08Z, or O05Z with an ICD-10-AM Third Edition procedure code of 35688-01 are allocated to VIC-DRG5 N11C.

WIES12 cost weights for DRG N11C have been set using costing information for N11B, but increased to cover the prosthesis costs associated with this procedure.

1.5 Mastoid procedures

Analysis of the Victorian cost data indicated that mastoid procedures allocated to D06Z were significantly more costly than other D06Z procedures. These procedures were largely performed at the Royal Victorian Eye and Ear Hospital resulting in a relative funding disadvantage within this DRG. Consequently for WIES12, D06Z will be split into:

- D06A Mastoid Procedures
- D06B Other Sinus and Complex Middle Ear Procedures.

Patients will be allocated to VIC-DRG5 of D06A where they are initially grouped to ARDRG5.0 of D06Z and have one or more of the following procedure codes: 4154500, 4155100, 4155400, 4155700, 4155703, 4156000, 4156300, 4156400, 4156600, 4156601, 4156602. All other patients allocated to AR-DRG5.0 of D06Z will be allocated to VIC-DRG5 of D06B.

1.6 Admission weight

In AR-DRG Version 5.0, admission weight must be between 400 and 9999 grams otherwise the episode will be assigned to AR-DRG 960Z Ungroupable. The Department has been notified of live births where the baby weighs significantly less than 400 grams. Episodes with an

admission weight between 125 and 399 grams are assigned an admission weight of 400 grams for grouping to an appropriate VIC-DRG5.

1.7 Extra Corporeal Life Support (ECLS)

Episodes involving extra corporeal membrane oxygenation (ECMO) or a ventricular assist device (VAD) are allocated to a variety of DRGs. Analysis of the Victorian cost data indicates that costs for these episodes are significantly discounted by other episodes allocated to the same DRGs.

In recognition of these cost differences, episodes not allocated to an AR-DRG5.0 of A01Z, A03Z, or A05Z and with one or more of the ICD-10-AM 3rd edition procedure codes 90225-00, 38615-00, 38615-01, 38618-00 are to be allocated the VIC-DRG5 of A40Z.

1.8 Diagnosis or procedure codes incompatible with sex

In AR-DRG version 5.0 a patient's sex must be compatible with recorded diagnosis and procedure codes, else the episode will be assigned to AR-DRG5.0 960Z Ungrouped. However, episodes with incompatible codes can occur when gender reassignment or clarification is performed, or when patients who have retained their biological sex-specific organs require a form of treatment.
To resolve this potential grouping anomaly, episodes initially grouped to an AR-DRG5.0 of 960Z (i.e. diagnosis and procedure codes incompatible with sex) and with one or more additional diagnoses of E25.0, E25.8, E29.1, E34.5, F64.0, Q56.0, Q56.1, Q56.2, Q56.3, Q56.4, Q99.0, or Q99.1 (that is, explanations of why the diagnosis or procedure is assigned against the sex) will be assigned to VIC-DRG5 of 964Z Gender Reassignment-Conflict. This VIC-DRG5 will be assigned an initial WIES value of 0 (zero), and payment will be applied by assessing all diagnosis and procedure codes in order to determine the most appropriate ARDRG5.0. This is necessary because previous data standards and VAED edits have excluded these episodes from the Victorian cost data used to determine WIES12 cost weights.

1.9 Dietary counselling and surveillance

In AR-DRG version 5.0 the ICD-10-AM diagnosis code Z71.3 Dietary counselling and surveillance has a clinical complexity level (CCL) of 2, for both medical and surgical DRGs. Even where Z71.3 is coded appropriately, the Department feels this CCL value is inappropriate for a code of this nature and has created an AR-DRG 5.0 modification where Z71.3 will be allocated a CCL value of 0 before grouping to VIC-DRG5.

Victorian Additions to the Australian Coding Standards

Victorian Additions to the Australian Coding Standards (supplementing ICD-10-AM, Fourth Edition, volume 5) remain the same for 2005-06 as they were for 2004-05.

They are reproduced here for your information.

Each Victorian Addition that corresponds with an Australian Coding Standard (ACS) has been assigned the same reference number as the ACS, with the addition of a 'Vic' prefix.

Victorian Additions that do not relate to a particular ACS have an alpha or alpha-numeric reference that relates to the subject of the Addition.

These Victorian Additions should be printed and inserted into Volume 5 ICD-10-AM for use from 1 July 2004.

Summary of Victorian Additions for 2004–05 and 2005-06

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

Vic Prefixes

In Victoria a prefix is assigned to each diagnosis code. The accepted prefixes are:

- **P** – Primary condition
- **C** – Complicating condition occurring after admission
- **A** – Associated condition not treated in this episode
- **M** – Morphology

Codes do not have to be listed in groups according to the prefix assigned. Whilst the principal diagnosis must be sequenced first, with a prefix of P, the order of the other codes should be in accordance with coding convention and/or Australian Coding Standards (ACS).

Do not confuse:

- Principal Diagnosis (ACS 0001) with the P prefix (primary condition)
- Additional Diagnosis (ACS 0002) with the A prefix (associated condition)

There is no direct relationship between the ACS and the prefixes. The following table may be a useful way of conceptualising the application of prefixes to ICD-10-AM codes.

	Possible prefixes			
	P - Primary	C - Complication	A - Associated	M - Morphology
Principal diagnosis ACS 0001	✓	X	X	X
Additional diagnoses ACS 0002	✓	✓	✓	X
Morphology code	X	X	X	✓
Procedure codes	X	X	X	X

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P - Primary Condition

Primary diagnoses are present at the time of admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with P if they required:

- Treatment, *or*
- Diagnostic procedures, *or*
- Increased nursing care and/or monitoring, *or*
- Active evaluation.

There can be more than one code prefixed P.

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

The P prefix will be assigned in the following circumstances:

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

Example 1

Diabetes newly diagnosed during the current episode of care, and requiring treatment, further investigation or additional nursing care, is prefixed with P.

❖ A previously existing condition that is exacerbated during this episode of care.

Example 2

Atrial fibrillation usually controlled on digoxin that becomes uncontrolled after surgery requiring treatment is prefixed with P.

Example 3

Asthma usually controlled on Ventolin prn that becomes uncontrolled during admission requiring treatment is prefixed with P.

Example 4

Hypertension usually controlled on Minipress that becomes uncontrolled during admission requiring treatment is prefixed with P.

❖ For consistency and ease of application, all obstetric codes (O codes) must be prefixed with P.

Example 5

An obstetric patient who is induced for 'post dates' (O48) and whose puerperium is complicated by grazed nipples (O92.2-) will have both these codes prefixed with P.

- Z codes related to outcome of delivery (Z37.0-), place of birth (Z38.-) and post partum care (Z39.-) are considered primary codes and must be prefixed with P.

A - Associated Condition

An associated condition must be present at the time of admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with A if they are:

- The underlying disease (not treated) of a condition which was treated
- A condition or state which affected the treatment given, or length of stay, during this episode of care, but which does not meet the definition of a primary condition
- Conditions that are coded because of 'use additional code...' or similar instructions in ICD-10-AM, or because of a specialty standard (listed in ACS 0002) directing the coder to assign additional code(s), if these conditions were present on admission but do not meet the definition of a primary condition.

Example 6

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

Example 7

A child who was admitted for dental treatment (rather than being treated as a non-admitted patient) because they were autistic would be assigned a code for the autism and it would be prefixed with A.

Example 8

A patient with COAD who has a spinal anaesthetic rather than a general anaesthetic because of the COAD would be assigned a code for the COAD and it would be prefixed with A.

Example 9

Hypertension coded when it is present with a diagnosis in the range I20-I25.

Example 10

When a code for smoking status is assigned only because of instructions provided in ACS 0503 *Drug, alcohol and tobacco use disorders,* this code is prefixed with A.

Example 11

ACS 0401 *Viral hepatitis* instructs coders to assign code Z22.52 for *Carrier of hepatitis C;* if it does not meet the definition of a primary condition this code will be prefixed with A.

A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS2 for Work Cover patients.

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C – Complicating condition

A complicating condition is not present at the time the admission (or when the episode of care commenced).

Diagnosis codes should be prefixed with C if they are:

- A condition that arose during this episode of care
- A condition resulting from misadventure during surgical or medical care in the current episode of care
- An abnormal reaction to, or later complication of, surgical or medical care occurring during the current episode of care.

Example 12

A medical patient admitted for treatment of ischaemic heart disease who develops pneumonia during the hospital stay will have the code for the pneumonia prefixed with a C.

Example 13

A patient who sustains a fracture due to fall from bed will have all the codes that are assigned for the fracture (injury, external cause, place of occurrence and activity) prefixed with a C.

Example 14

An accidental laceration of blood vessel occurring during surgery will have all codes relating to the laceration (injury code, external cause, and place of occurrence) with a C.

Example 15

An adverse drug reaction occurring during the current episode of care will have all codes relating to the adverse effect (adverse effect code, external cause, and place of occurrence) prefixed with a C.

Example 16

A wound infection following surgery during the current episode of care will have all codes related to the wound infection (injury code, external cause, and place of occurrence) prefixed with a C.

M – Morphology

Prefix morphology codes with an M (to distinguish these from musculoskeletal codes). The M prefix is optional for data entry but must be applied to morphology codes for transmission to PRS/2.

Additional instructions

External cause, place of occurrence and activity codes must be assigned the same prefix as the diagnosis code to which they relate.

All other 'groups' of codes must have a prefix assigned for each code according to the prefix definitions provided in this document.

When a code potentially meets the definition for more than one prefix definition, assign the prefix according to the following hierarchy:

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

Example 17

A Type II diabetic patient develops lactic acidosis post operatively. The code E11.13 must be assigned. As the diabetes is pre-existing, and therefore a primary condition, and the lactic acidosis develops after admission, either Prefix P or Prefix C applies. Following the hierarchy above, assign Prefix P for this code.

Example 18

A patient who suffers from COAD has an acute exacerbation of the COAD after admission to hospital. The acute exacerbation meets the criteria for assigning the prefix C. However, as the COAD is pre-existing and is treated it meets the criteria for assigning the prefix P. In this case assign prefix P in accordance with the hierarchy above.

Example 19

A patient admitted for treatment of an adverse effect of a drug will have the code for the adverse effect, and the codes for external cause, place of occurrence and activity assigned the prefix P.

Example 20

A patient admitted for treatment of uncontrolled Type II diabetes who also has peripheral neuropathy, and who develops acute renal failure later in the admission will be assigned prefixes as follows:

P E11.65 Type II diabetes with poor control
P E11.71 Type II diabetes with multiple microvascular complications
C N17.9 Acute renal failure, unspecified
A G62.9 Polyneuropathy unspecified.

In this example, the 'multiple microvascular' aspect of the diabetes developed after admission, meeting the definition of a C prefix. However as the diabetes is also a pre-existing condition, the 'hierarchy' takes effect and E11.71 is prefixed with P.

Issued 1 July 1993, Modified 1 July 2004

Vic 0029 Coding of Contracted Procedures

If the procedure is performed at another hospital under contract to this hospital, add a suffix to the procedure code (eighth character of the procedure code field).
Valid suffixes are:

- **F-**procedure performed at another hospital on an admitted basis, *or*
- **N-**procedure performed at another hospital on a non-admitted basis.

Refer to Department of Human Services, 2004, 'Procedure Codes' *VAED Manual* 14th Edition for further details on the use of these codes.

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

Issued 1 July 1998

Vic 0030 Organ Procurement

An episode for organ procurement is not yet included in the *National Health Data Dictionary* or in the Victorian Admitted Episodes Dataset (VAED); therefore the following two sections of Australian Coding Standard 0030 *Organ Procurement and Transplantation* do not apply in Victoria:

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

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

The following sections of ACS 0030 *Organ Procurement and Transplantation* are to be applied in Victoria:

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

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

Issued 1 July 1998

Vic 0229 Radiotherapy

Multi-day admissions (that is, patients separated on a subsequent date to the admission date), receiving a radiation oncology procedure from blocks [1786] to [1792], [1794] or [1795], **for treatment of a malignant condition**, must have Z51.0 *Radiotherapy session* assigned as an additional diagnosis. The malignant condition receiving radiotherapy will be the principal diagnosis.

This Victorian Addition *overrides* the 'multi-day' component of ACS 0229 *Radiotherapy*.

Issued 1 July 1998, Modified 1 July 2001

Vic 0233 Morphology

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

This Victorian Addition supplements ACS 0233 *Morphology*.

Issued 1 July 1998

Vic 2001 External Cause code use and sequencing

When an External Cause code requires both a *Place of occurrence* code and an *Activity* code, sequence the *Place of occurrence* code before the *Activity* code.

An external cause code is required to follow any S or T code in all circumstances in Victoria.

This Victorian Addition supplements ACS 2001 *External Cause code use and sequencing*.

Issued 1 July 2002. Revised July 2005

Vic 2104 Rehabilitation

Victorian coders are instructed to assign external cause codes for rehabilitation episodes of care as they would for any other episode of care.

If a patient is admitted **'for rehabilitation'** (even if the patient is in a bed other than a designated Rehabilitation bed or if the hospital does not have a designated Rehabilitation program), standard 2104 applies.

If a patient is admitted for **treatment** of a condition but also receives rehabilitation before separation (regardless of bed or designation), the principal diagnosis must be the condition and the rehabilitation should be indicated by the appropriate allied health procedure codes. Z50.- *Care involving use of rehabilitation procedures* should not be added. Such episodes will normally be Type 4 (which includes acute).

This Victorian Addition supplements ACS 2104 *Rehabilitation*.

Issued 1 July 1998, Modified 1 July 2001, Modified 1 July 2004

Vic 2108 Assessment

If a patient is admitted specifically for **evaluation and management** by a geriatrician (even if the patient is in a bed other than a designated GEM program), the principal diagnosis must be the condition (or the major condition) that requires evaluation and management. If some rehabilitation is started during the evaluation and management episode, assign the appropriate Z50.- *Care involving use of rehabilitation procedures* code as an additional diagnosis. Allied health procedure codes should also be added.

If a patient is admitted for evaluation of a condition (even if the hospital does not have a designated GEM program), the principal diagnosis must be the condition (or the major condition) that requires evaluation. If some rehabilitation is started during evaluation episode, assign the appropriate Z50.- *Care involving use of rehabilitation procedures* code as an additional diagnosis. Allied health procedure codes should also be added.

The instruction to add the Z50.- *Care involving use of rehabilitation procedures* for patients admitted for evaluation or evaluation and management will help identify problems with bed allocation for these patients.

This Victorian Addition supplements ACS 2108 Assessment.

Issued 1 July 2001

Updates to VAED reporting

VAED edit types and descriptions

Rejection Edits
An Edit Message number prefixed by an *R* signifies a *rejection*. That is, PRS/2 does not retain a record of the transaction. The record must be checked, corrected and re-transmitted. If there are no rejection edits, the record has been accepted. However, fatal, notifiable and warning edits still indicate that something needs to be checked and possibly corrected.

Fatal Edits

- An Edit Message number prefixed by an F signifies a *fatal* edit. Fatal edits are those where the combination of data, including combinations between two different episodes for a patient, is definitely incorrect. However the data combination has been accepted to accommodate the PRS/2 logic in the update process.
- Where this data has not been corrected, HDSS will periodically notify each hospital and ask them to do so. Records must be checked, corrected and re-transmitted. Note: Fatal edits will not appear routinely on PRS/2 reports; rather the first notification of these edits will be from HDSS. If these episodes are not corrected they will be removed from the end of year VAED consolidated file. Public hospitals will receive no funding for removed episodes.

Notifiable Edits

- An Edit Message number prefixed by an N signifies a *notifiable* edit. Notifiable edits are those where the data would, in the majority of cases, be incorrect. For a very small number of episodes per year statewide, the combination of data items may be correct. The record is accepted by PRS/2 but something must be checked and possibly corrected.
- If data are wrong and have been corrected, no further action is required by the hospital. However, if data are correct, hospitals will need to confirm this with HDSS. To confirm the data as correct, contact the HDSS Help Desk via email at PRS2.Help-Desk@dhs.vic.gov.au or telephone 03 9616 8141. Where the data has not been corrected nor confirmed as correct, HDSS will periodically notify each hospital and ask them to do so.

Warning Edits
An Edit Message number prefixed by a W is a warning. Warning edits are those where the data is not usual, but possible. The record has been accepted but the data needs to be checked and possibly corrected.

Software edits
Ideally, the hospital's in-house software should have edits no less stringent than PRS/2's so that errors are detected before transmission to Mantrack Systems. The receipt of Edit Messages may indicate the transmission of invalid codes or faults in software logic. Contact your software supplier to initiate changes to your software to prevent these errors occurring.

VAED reporting schedule requirements for 2005-06

A hospital may transmit data to the VAED as frequently as desired, and must meet requirements set out below.

The following information is taken from *Victoria-Public Hospitals and Mental Health Services Policy and Funding Guidelines 2005-2006* in *General Conditions of Funding*.

6.5 Transmission of admitted patient data

6.5.1 The hospital will transmit data to the VAED via PRS/2 according to the timelines detailed in clauses 6.5.1. (a) and 6.5.1(b).

(a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the 17th day of the following month (see (d) below for processing schedule).

(b) Diagnosis and procedure and sub-acute details in any month are to be transmitted in time for the VAED file consolidation on the 17th day of the second month following (see (d) below for processing schedule).

(c) Data for the financial year should be completed in time for the VAED file consolidation on 17 August 2006. Any corrections must be transmitted before finalisation of the VAED database on 17 September 2006.

(d) It is the hospital's responsibility to ensure that data are transmitted to the VAED to meet the processing schedule for inclusion in the Allegiance Systems file consolidation on the 17th of each month. VAED data (sent electronically) must be received by 5pm on the 17th of each month, regardless of the actual day of the week. VAED (sent by disc) must be received by 12pm (noon) on the last working day on or before the 17th of the month.

(e) WIES12, multi-purpose service and sub-acute payments will be:

- fully paid for data originally submitted in accordance with the deadlines specified in clauses 6.5.1.(a) and 6.5.1(b) above, even if data is subsequently amended;
- paid at a reduced rate (50 per cent), or not recognised for payment, according to Schedules 1 and 2 located at the end of this section if the data has not been submitted in accordance with either deadline specified in clauses 6.5.1(a) and 6.5.1(b) above;

- not recognised for payment, if data has not been submitted in accordance with both deadlines specified in clauses 6.5.1(a) and 6.5.1(b) above.

  This clause applies to all account classes including DVA.

(f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure details, the Metropolitan Health Service, hospital or SHRS must write to the department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for one-off late submission of data will generally only be considered for computer system problems that are beyond the control of the Metropolitan Health Service, hospital or SHRS. (Metropolitan Health Services, hospitals or SHRSs undertaking the PRS/2 data submission testing process are automatically exempted). Exemptions for late submission of admission and separation data will also be considered for staffing problems that are beyond the control of small rural hospitals and SHRSs. Exemptions for late submission of admission and separation data will be automatically granted to hospitals or SHRSs maintaining a consistently high level of timely data submission.

Patient Data Audits

The following extract from the Policy and Funding Guidelines relates to auditing of patient data and is relevant for all coders.

6.10.1 The Metropolitan Health Service, hospital or SHRS will provide sufficient access to data and records to allow an audit of patient records, patient coding and data transmitted to the VAED.

6.10.2 If the audit shows a difference in assignment of DRGs and/or other data items that alter the allocation of WIES, or that patients fail to meet admission criteria, then the number of weighted inlier equivalent separations and/or throughput payments to the Metropolitan Health Service, hospital or SHRS may be adjusted to take account of those differences.

6.10.3 Where the audit indicates that a Metropolitan Health Service, hospital or SHRS has been consistently erroneous in the application of admission criteria and/or coding standards, the department will adjust or suspend the relevant throughput payments until such time as the issue is resolved to the satisfaction of the department.

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6.10.4 The department also reserves the right to undertake supplementary audits to confirm an issue and/or monitor improvement; the cost of which is to be borne by the Metropolitan Health Service, hospital or SHRS.

6.10.5 Access to data and records for interstate patients transmitted to the VAED will also be required should State or Territory Health Authorities request an independent audit to verify information on DRG weighted separations.

6.10.6 The Metropolitan Health Service, hospital or SHRS will also provide sufficient access to data and records to allow an audit of patient records and data transmitted via AIMS as part of VACS.

6.10.7 Access to data and records for emergency department patients and persons on waiting lists will also be required should this department or the Commonwealth require an audit to verify information used for funding calculations either at the hospital or State level.

6.10.8 The department will have access to patient level cost data and to patient level data transmitted to the VAED, VEMD, and ESIS.

Schedule 1

Timelines for the Receipt of Admission and Separations Details (E2)

VAED consolidation date

Month of Separation 2005-06	17 Aug	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate
January							Full Rate

VAED consolidation date

Month of Separation 2005-06	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Nil	Nil	Nil	Nil	Nil	Nil	Nil
January	Half Rate	Nil	Nil	Nil	Nil	Nil	Nil
February	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
March		Full Rate	Half Rate	Nil	Nil	Nil	Nil
April			Full Rate	Half Rate	Nil	Nil	Nil
May				Full Rate	Half Rate	Nil	Nil
June					Full Rate	Half Rate	Nil

Schedule 2

Timelines for the Receipt of Diagnoses and Procedure (X2, Y2) and Sub-Acute Details (S2)

VAED consolidation date

Month of Separation 2005-06	17 Sept	17 Oct	17 Nov	17 Dec	17 Jan	17 Feb	17 Mar
July	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
August		Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil
November					Full Rate	Half Rate	Nil
December						Full Rate	Half Rate

VAED consolidation date

Month of Separation 2005-06	17 Mar	17 Apr	17 May	17 Jun	17 Jul	17 Aug	17 Sep
December	Half Rate	Nil	Nil	Nil	Nil		
January	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
February		Full Rate	Half Rate	Nil	Nil	Nil	Nil
March			Full Rate	Half Rate	Nil	Nil	Nil
April				Full Rate	Half Rate	Nil	Nil
May					Full Rate	Half Rate	Nil
June						Full Rate	Half Rate

Revisions to VAED for 1 July 2005

Feedback received from Victorian HIMs and coders via the Victorian ICD Coding Committee over the past few years has indicated that several PRS/2 edits were triggering large numbers of warning edits. Because of the large numbers involved, there was a perception that many of these warnings were being ignored in the review of transaction reports.

A review of the edits perceived to be the most problematic was undertaken at DHS with outcomes as outlined in the table below.

Edit Number	Edit name	Number of episodes triggered 04/05 April consolidation	Action taken	Outcome	Number of episodes remaining
W354	Code and sex incompatible - diagnosis	266	Edit removed from 36 codes	Reduction in triggered episodes by 223	43
W354	Code and sex incompatible - procedure	319	Edit removed from 20 codes	Reduction in triggered episodes by 313	6
W355	Invalid principal diagnosis	13,617	Edit removed from 10 codes.	Reduction in triggered episodes by 5400	8,217
W356	Non specific code	77,788	Edit deleted	Reduction in triggered episodes by 77,788	0
N358	Area code restraint	761	Edit removed from 4 codes	Reduction in triggered episodes by 294	467
N449	Notifiable - infectious disease coded	287	Edit removed from 2 codes	Reduction in triggered episodes by 255	32
W449	Warning - infectious disease coded	11,868	Edit removed from 12 codes	Reduction in episodes triggered by 10,701	1,167
W353	Code and age incompatible – diagnosis	5,718	No action taken as there is a requirement for more investigation of these restraints	Nil	5,718
W353	Code and age incompatible – procedure	812	No action taken as there is a requirement for more investigation of these restraints	Nil	812
		111,437			16,462

It is expected that instances of these edits triggering will reduce by approximately 85% for 2005-06 compared to 2004-05.

PRS/2 edits are developed with a view to creating high quality data. The Department therefore requires that all edits, including warnings, are followed-up as part of the review process.

Changes to reporting of NIV hours

The reporting of NIV hours has been made optional beginning July 1 2005.

Other changes to existing edits

- Edit 595 *Neoplasm Code Missing*: The library file has been updated to allow for several codes that may require a morphology code, but the morphology code may not be sequenced immediately after the condition code.
- Palliative care days must be reported to VAED for all episodes with Care Type 2,4,6,7,K, 8,9, and E, where the hospital campus is approved for Palliative Care.

Admission Policy

The current DHS Admission Policy can be accessed at http://www.health.vic.gov.au/hdss/vaed/index.htm.

Coders should be aware of the guidelines provided in this policy. Updates will be notified via DHS Bulletins as they become available.

Updated Calendar of ICD Coding and DRG Grouping Systems used in Victoria

Fin. Year July/June	ICD ed: (edition/ release date) (a)	ICD ed: Vic	Coding Standards used in Victoria	Aust DRG version released	DRG version: Vic (b)	Codes input to DRG version: Vic (c)
05-06	No release	AM 4	Aust Standards AM 4th ed. with some Vic Additions	No release	AR v5.0*	AM 3
04-05	AM 4 (Jul 2004)	AM 4	Aust Standards AM 4th ed. with some Vic Additions	AR v5.1 (Oct 04)	AR v5.0 *	AM 3
03-04	No release	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
02-03	AM 3 (Jul 2002)	AM 3	Aust Standards AM 3rd ed. with some Vic Additions	AR v5.0	AR v4.2 *	AM 2
01-02	No release	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	No release	AR v4.2 *	AM 2
00-01	AM 2 (Jul 2000)	AM 2	Aust Standards AM 2nd ed. with some Vic Additions	AR v4.2	AR v4.1 *	AM 1
99-00	No release except Amendment list	AM 1	Aust Standards AM 1st ed. with some Vic Additions	No release	AN v3.1 *	Aust CM 2
98-99	AM 1 (Jul 1998)	AM 1	Aust Standards AM 1st ed. with some Vic Additions	AR v4.1	AN v3.1 *	Aust CM 2
1.7.98	Victoria changed from ICD-9-CM to ICD-10-AM.					
97-98	No release	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AR v4.0	AN v3.1 *	Aust CM 2
96-97	Aust CM 2 (Jul 96)	Aust CM 2	Aust Standards CM 2nd ed. with some Vic Additions	AN v3.1	AN v3.1 *	Aust CM 2
95-96	Aust CM 1 (Jul 95)	Aust CM 1	Aust Standards CM 1st ed. with some Vic Additions	AN v3.0	AN v1.0 *	U.S. 8
94-95	U.S. 10 (Oct 93)	U.S. 10	Vic Guidelines Revised, incorporating National Coding Standards	An v2.1	AN v1.0	U.S. 8
93-94	U.S. 9 (Oct 92)	U.S. 9	Vic Guidelines Revised, incorporating National Coding Standards	AN v2.0	AN v1.0	U.S. 8

Fin. Year July/June	ICD ed: (edition/ release date) (a)	ICD ed: Vic	Coding Standards used in Victoria	Aust DRG version released	DRG version: Vic (b)	Codes input to DRG version: Vic (c)
1.7.93	Victoria introduced casemix funding					
92-93	U.S. 8 (Oct 91)	U.S. 8	Vic Guidelines 2nd ed (Revised)	No release	AN v1.0	U.S. 8
91-92	U.S. 7 (Oct 90)	U.S. 6	Vic Guidelines 2nd ed	AN v1.0	AN v1.0	U.S. 8
90-91	U.S. 6 (Oct 89)	U.S. 6	Vic Guidelines 2nd ed		HCFA v4	U.S. 2
89-90	U.S. 5 (Oct 88)	U.S. 5	Vic Guidelines 1st ed		HCFA v4	U.S. 2
88-89	U.S. 4 (Oct 87)	U.S. 2	Vic Guidelines 1st ed		HCFA v4	U.S. 2
87-88	U.S. 2 (Oct 86)	U.S. 2	(Victorian) VHSS guidelines		HCFA v4	U.S. 2
1.7.86	Victoria changed from ICD-9 to ICD-9-CM.					

(a) U.S. = HICF ICD (release date in the USA), Aust CM = Australian ICD-9-CM (release date in Australia), AM = ICD-10-AM

(b) DRG version used in Victoria (pre 1.7.1993) for any published grouped data and (post 1.7.1993) for casemix funding purposes.
* = years Vic adjusted DRGs for funding purposes (details in relevant year's *Public Hospital Policy and Funding Guidelines* or equivalent publication).

(c) If coding version used (ICD version: Victoria) differs from that used by the grouper (Codes input to DRG version: Victoria), then the codes are mapped to that used by the grouper

VICC Members as at 1 July 2005

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

Coding Committee Meetings

The committee meets every 3rd Tuesday throughout the year. In order to be included on the agenda, queries must be submitted to the Secretary by the close of business on the Monday of the week before the meeting is to take place.

The form for submission of queries is available at:
http://www.health.vic.gov.au/hdss/icdcoding/codecommit/icdquery.htm

References used in the production of this newsletter

National Centre for Classification in Health, 2004 *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* Fourth Edition.

Commonwealth Department of Health and Ageing, 2002 *Australian Refined Diagnosis Related Groups, Version 5.0, Definitions Manual, Volume 1*.

Department of Human Services Victoria, 2004 *Victoria—Public Hospitals and Mental Health Services, Policy and Funding Guidelines*.

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-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
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