Victorian Additions to the Australian Coding **Standards**

health

1 July 2014

The following are the Victorian Additions to Australian Coding Standards, effective 1 July 2014 (supplementing Australian Coding Standards, Eighth edition). These should be applied for separations on and after 1 July 2014.

Each Victorian Addition that corresponds with an Australian Coding Standard (ACS) has been assigned the same reference number as the ACS.

The following changes have been made to this document for 2014-15:

Vic 2104 *Rehabilitation* has been modified to emphasise that the assignment of codes from Z50 range are independent of Care Type.

Vic 2108 *Assessment* has been deleted as the instruction in this standard is now redundant.

Summary of Victorian Additions for 2014-15

Vic 0048	***Condition onset flag***
Vic 0029	***Coding of contracted procedures***
Vic 0233	***Morphology***
Vic 2001	***External cause code use, sequencing and flagging***
Vic 2104	***Rehabilitation***

Vic 0048 Condition Onset Flag

In Victoria, prefixes are assigned to diagnosis codes to indicate condition onset.

The Victorian prefixes are mapped by the Department of Health to the national values in ACS 0048 for reporting to the Commonwealth as follows:

Victorian value		**National Value**	
P	Primary	**2**	Condition not noted as arising during the episode of admitted patient care
C	Complication	**1**	Condition with onset during the episode of admitted patient care
A	Associated	**2**	Condition not noted as arising during the episode of admitted patient care
M	Morphology	The same value as the preceding neoplasm code	

Coders must follow the instructions in ACS 0048 *Condition onset flag* to determine whether or not a condition was present at the beginning of the episode of admitted patient care and assign Victorian prefixes accordingly.

Coders must also ensure that the M prefix is assigned to morphology codes.

As per the above table, the accepted prefixes for use in Victoria are:

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

Every diagnosis code must be flagged with one of the acceptable prefixes.

Prefixes do not influence the sequencing of clinical codes which must be sequenced in accordance with coding convention and/or the Australian Coding Standards.

Do not confuse:

Principal Diagnosis (ACS 0001) with the P prefix (primary condition)

Additional Diagnoses (ACS 0002) with the A prefix (associated condition)

With the exception of ACS 0048 *Condition Onset Flag*, 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**	✓	Only for neonates in the birth episode*	X	X
Additional diagnoses **ACS 0002**	✓	✓	✓	X
Morphology code	X	X	X	✓
Procedure codes	X	X	X	X

*Refer to ACS 0048 *Condition Onset Flag* for further information.

The Victorian prefix C (complicating condition) is mapped to condition onset flag 1 Condition with onset during the episode of admitted patient care.

C – Complicating condition

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

Refer to ACS 0048 Guide for use point 6, if you have difficulty deciding if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode.

The Victorian prefixes P (primary) and A (associated) are both mapped to the condition onset flag 2 (Condition not noted as arising during the episode of admitted patient care). In order to determine which prefix to assign coders must note the following distinctions.

P – Primary condition

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

Diagnosis codes for conditions present at the time of admission should be flagged with the P prefix if they required:

- Commencement, alteration or adjustment of therapeutic treatment *or*
- Diagnostic procedures, *or*
- Increased clinical care and/or monitoring.

There can be more than one code flagged with the P prefix.

Z codes relating postpartum care (Z39.0-) are considered primary codes and must be flagged with a P prefix.

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 flagged with an A prefix 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 an instruction in a specialty standard (examples are listed in ACS 0002 *Additional Diagnoses*) 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.

When in doubt about whether to assign Prefix P or Prefix A for a condition present on admission, the P prefix should be assigned.

The following are examples of assignment of prefixes P and A:

A diagnosis code will be flagged with a P prefix 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 flagged with a P prefix.

- ❖ 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 flagged with a P prefix.

A diagnosis code will be flagged with an A prefix in the following circumstances:

Example 3

A woman who is admitted in labour at 35 weeks gestation must have the duration of pregnancy code assigned and it will be flagged with an A prefix.

Example 4

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

Example 5

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 flagged with an A prefix.

Example 6

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 flagged with an A prefix.

Example 7

Hypertension coded only because it is present with a diagnosis in the range I20-I25 is flagged with an A prefix

Example 8

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 flagged with an A prefix.

Example 9

ACS 0104 *Viral Hepatitis* instructs coders to assign code B18.2 for *Chronic Viral Hepatitis C* when documented; if it does not meet the definition of a primary condition this code will be flagged with an A prefix.

Example 10

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* instructs coders to assign code/s from E09-E14 for *diabetes or intermediate hyperglycaemia* when documented; if it does not meet the definition of a primary condition (or a complicating condition) these codes will be flagged with an A prefix.

The Victorian prefix M (morphology) does not have an equivalent condition onset flag in ACS 0048 *Condition Onset Flag.* Therefore the M prefix is mapped to the same value as the value of the preceding neoplasm code.

M – Morphology

Flag morphology codes with a M prefix (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.

Issued 1 July 1993. Modified 1 July 2006. Modified July 1 2007. Modified July 1 2008. Modified July 1 2010. Modified July 2013

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.

Contracted procedure code - NHDD definition:

> 'Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.'

Therefore the following instructions apply to the contracting hospital (Hospital A):

- Where a procedure that should only be coded once is performed at the contracting hospital (Hospital A), the procedure should not be assigned a *Procedures performed under contract at another agency* flag.
- Where a procedure that should only be coded once is performed at the contracted hospital (Hospital B), the procedure should be assigned a *Procedures performed under contract at another agency* flag.
- Where a procedure that should only be coded once is performed at the contracting hospital (Hospital A) and the contracted hospital (Hospital B), the procedure should not be assigned a *Procedures performed under contract at another agency* flag.
- Where a procedure is partially performed at both the contracting hospital (Hospital A) and the contracted hospital (Hospital B), such as mechanical ventilation, code according to the ACS and do not assign a 'Procedures performed under contract at another agency' flag.

Refer to Department of Health, Data element 'Procedure Codes', Section 3, *VAED Manual* 24th Edition for further details on the use of these codes.

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

Issued 1 July 1998. Modified November 2006. Modified 1 July 2007

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, sequencing and flagging

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.

Where multiples of the same external cause codes, place of occurrence codes and/or activity codes apply and there are different prefixes applicable, they should be repeated in the string of codes flagged with the appropriate prefix.

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

Issued 1 July 2002. Modified 1 July 2005. Modified 1 July 2007

Vic 2104 Rehabilitation

The assignment of external cause codes for injuries or complications of care for which the patient is receiving rehabilitation is mandatory in Victoria.

If a patient is admitted **'for rehabilitation'** regardless of the admitted Care Type, ACS 2104 *Rehabilitation* applies. However, if a patient is admitted to a rehabilitation Care Type but has no documentation supporting that they were admitted 'for rehabilitation', ACS 2104 does not apply.

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 Care Type 4 (which includes acute).

This Victorian Addition supplements ACS 2104 *Rehabilitation*.

Issued 1 July 1998, Modified 1 July 2001, Modified 1 July 2004, Modified 1 July 2014