Victorian Additions to the Australian Coding Standards

health

1 July 2012

The following are the *Victorian Additions to Australian Coding Standards*, effective 1 July 2012 (supplementing Australian Coding Standards, Seventh edition). These should be applied for separations on and after 1 July 2012.

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 2012-2013:

Vic 0030 Organ and tissue procurement and transplantation has been deleted as it is no longer required with the introduction of a posthumous organ procurement episode in the VAED from 1 July 2012. Coders are instructed to follow ACS 0030 Organ and tissue procurement and transplantation from 1 July 2012.

Examples 5 and 13 specifically relating to prefixing of diabetes have been added to VIC 0048 Condition onset flag.

Example 23 in VIC 0048 Condition onset flag has been updated in line with updates to ACS 0401 Diabetes and intermediate hyperglycaemia for 1 July 2012.

Summary of Victorian Additions for 2011-2012

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 2108	***Assessment***

Vic 0048 Condition Onset Flag

Prefixes have been used for some time in Victoria and were unchanged following the introduction of the Australian Coding Standard 0048 Condition Onset Flag. In order to maintain alignment with national standards the prefixes are mapped, by the Department of Health, to the national values for reporting to the Commonwealth as follows:

Victorian value		**Commonwealth 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 corresponding condition code	

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

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

Codes do not have to be listed in groups according to the prefix assigned. Whilst the principal diagnosis must be sequenced first, flagged with prefix 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)

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**	✓	X	X	X
Additional diagnoses **ACS 0002**	✓	✓	✓	X
Morphology code	X	X	X	✓
Procedure codes	X	X	X	X

P – Primary condition

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

Diagnosis codes 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.

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

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.

  Example 3

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

  Example 4

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

  Example 5

  Type 2 diabetes mellitus usually controlled but develops hypoglycaemia during admission requiring treatment is flagged with a P prefix.

- Z codes related to outcome of delivery (Z37.-), place of birth (Z38.-) and post partum 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.

Example 6

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 7

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 8

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 9

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 10

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

Example 11

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 12

ACS 0104 *Viral Hepatitis* instructs coders to assign code Z22.52 for *Carrier of 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 13

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 these codes will be flagged with an A prefix.

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

C – Complicating condition

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

Diagnosis codes should be flagged with a C prefix 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 14

A medical patient admitted for treatment of ischaemic heart disease who develops pneumonia during the current episode of care will have the code for the pneumonia flagged with a C prefix.

Example 15

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

Example 16

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

Example 17

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) flagged with a C prefix.

Example 18

A wound infection following surgery during the current episode of care will have all codes related to the wound infection (complication code, organism code if applicable, external cause, and place of occurrence) flagged with a C prefix.

Example 19

A woman is admitted for induction of labour due to post-dates. During delivery she suffers a 1st degree tear that is sutured and a post partum haemorrhage. The first degree tear and the post partum haemorrhage will be flagged with C prefix.

M – Morphology

Flag morphology codes with an 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.

Additional instructions

- External cause, place of occurrence and activity codes must be flagged with the same prefix as the diagnosis code to which they relate.
- Codes in all other 'groups' of codes must be individually flagged with a prefix according to the prefix definitions provided in this document.
- When a code could potentially be flagged with more than one prefix, assign the prefix according to the following hierarchy:

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

Example 20

A Type 2 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 the P prefix or the C prefix applies. Following the hierarchy above, flag this code with the P prefix.

Example 21

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

Example 22

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 flagged with the P prefix.

Example 23

A patient admitted for treatment of uncontrolled Type 2 diabetes who also has peripheral neuropathy, and who develops acute renal failure later in the admission which requires treatment will have codes flagged with prefixes as follows:
P E11.65 Type 2 diabetes mellitus with poor control
P E11.29 Type 2 diabetes mellitus with other specified kidney complication
P E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
P E11.71 Type 2 diabetes mellitus with multiple microvascular and other specified nonvascular complications
C N17.9 Acute renal failure, unspecified

In this example, the renal failure developed after admission meeting the definition of a C prefix. However as the code for diabetes mellitus with other specified kidney complication contains the diabetes concept which was present on admission, the code is flagged with a P prefix as per the hierarchy above.

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

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* 21st 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

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), Australian Coding Standard 2104 Rehabilitation 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 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

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