Victorian Additions to the Australian Coding Standards

The following are the *Victorian Additions to Australian Coding Standards*, effective 1 July 2009 (supplementing Australian Coding Standards, Sixth edition). These should be applied for separations on and after 1 July 2009.

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

There are no changes to this document for 1 July 2009.

Summary of Victorian Additions for 2009–2010

Vic 0048	*Condition onset flag*
Vic 0029	*Coding of contracted procedures*
Vic 0030	*Organ procurement*
Vic 0233	*Morphology*
Vic 2001	*External cause code use, sequencing and flagging*
Vic 2104	*Rehabilitation*
Vic 2108	*Assessment*

Vic 0002 Additional diagnoses

This Victorian Addition to the Australian Coding Standards has been deleted following updates to the Australian Coding Standard 0002 *Additional diagnoses*, effective 1 July 2008. Coders must apply only the criteria outlined in ACS 0002 *Additional diagnoses* from 1 July 2008.

Issued July 1 2006 (advice available on web site since 2000). Deleted 1 July 2008

Vic 0048 Condition Onset Flag

Prefixes have been used for some time in Victoria and will remain in use unchanged following the introduction of the Australian Coding Standard 0048 *Condition Onset Flag*. In order to maintain alignment with national standards the Vic Addition has been renamed, and the prefixes will be mapped, by the Department of Human Services, 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

Victorian value	Commonwealth Value
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 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.

- 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.

- In many circumstances the principal diagnosis for an obstetric case will be a condition that occurs after admission. This principal diagnosis code will be flagged with a P prefix.

Example 5

A woman is admitted in labour at 40 weeks. During delivery she suffers a first degree tear that is sutured. There were no other conditions requiring coding. The code for first degree tear is the principal diagnosis and is flagged with a P prefix even though this occurred after admission.

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 'use additional code...' or similar instructions in ICD-10-AM, or because of 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 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 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 flagged with an A prefix.

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 flagged with an A prefix.

Example 9

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

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 flagged with an A prefix.

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 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 12

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 13

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 14

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 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) flagged with a C prefix.

Example 16

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 17

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 18

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

Example 19

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 20

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 21

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 have codes flagged with 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 flagged with a P prefix.

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

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 Human Services, 'Procedure Codes', Section 3, *VAED Manual* 17th 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 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

This Victorian Addition to the Australian Coding Standards has been deleted. The Vic DRG Radiotherapy remains in place but the logic for creating it will be based on the procedure coding rather than the addition of Z51.0 *Radiotherapy session* to the diagnosis string. From July 1 2008, coders must apply ACS 0229 *Radiotherapy* when coding radiotherapy cases.

Issued 1 July 1998, Modified 1 July 2001 Deleted 1 July 2008

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
