Application of Vic 0002 *Additional diagnoses*

Introduction

The Victorian ICD Coding Committee (VICC) published Vic 0002 *Additional diagnoses* as part of the Victorian Additions to the Australia Coding Standards (ACS), effective for separations on and after 1 July 2017.

Victorian additions to the Australian Coding Standards (ACS) **supplement** (not override) the advice in the ACS and apply to all Victorian coded data submitted to the VAED.

This article is intended to provide further information and background regarding Vic 0002 *Additional diagnoses*. VICC recognises that some aspects of Vic 0002 *Additional diagnoses* may result in a change of practice for some Victorian clinical coders.

The aim of Vic 0002 *Additional diagnoses* is to:

- Ensure that the admitted data collection (VAED) contains coded data that is fit for purpose
- Add clarity to ACS 0002 Additional diagnoses so that only those conditions which represent clinical significance for the patient are reported to the VAED
- Provide Victorian clinical coders with the information they need to determine clinical significance for reporting purposes.

Vic 0002 *Additional diagnoses* is in keeping with the stated intent of ACS 0002 Additional diagnoses. Emphasis has been placed on significance to provide greater clarity to coders in determining which conditions meet the definition of an additional diagnosis. Where it is unclear whether a code should be assigned according to ACS 0002 Additional diagnoses or Vic 0002 *Additional diagnoses*, do not assign the code.

Clarification of terms used in Vic 0002 *Additional diagnoses*

Clinician

Vic 0002 *Additional diagnoses* uses the same definition of the term 'clinician' as the 'How to use this document' section of the Introduction to the Australian Coding Standards, as follows:

The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline.

A treating clinician refers to someone who has been involved in the management/treatment/planning for that patient.

Nurse-initiated administration

The term nurse initiated administration relates to medications/drugs where a nurse has made the decision to administer the medications/drugs and the condition does not require any further management. The term 'nurse' has been used because it is typically a nurse who provides this type of treatment.

Clinical consultation

Clinical consultation is an interaction between the clinician and the patient, or between multiple clinicians, or involves the clinician reviewing the patient's results and determining a course of action, that results in documentation in the medical record. This documentation is evidence of clinical consultation. The documentation may take the form of medication or test orders, additions to progress notes, and/or a plan of treatment/care/management elsewhere in the medical record.

Treatment plan

A treatment plan is a plan of care that can appear in many parts of the medical record but would typically appear in the admission notes, the progress notes or on a care path. Treatment plans should be documented by a treating clinician including a diagnosis with a clear link to the planned treatment, or investigation.

Routine care

Routine care is the care that is expected to be provided to the patient in the normal course of their surgical management or their recovery from a medical condition. Documentation of an intervention does not automatically justify the assignment of a complication code, for example, replacement of an IV catheter that has fallen out does not justify the assignment of a code for complication of catheter.

Increased monitoring

Increased monitoring is that which is above the standard management for a condition. It must be evident in the current episode of care. The evidence must include that the increased monitoring is in response to an observation that is documented by a treating clinician, for example, 'Hb = xxx. Repeat blood test tomorrow'. This excludes documentation that is simply outlining the management of surgery or a medical condition, for example, 'please perform daily blood tests for three days'.

Examples

The following examples are provided in addition to those in Vic 0002 *Additional diagnoses*.

Examples of clinically significant conditions

- Clinical documentation that the patient has ongoing headaches with a CT brain performed to investigate
- Clinical documentation that the patient had seizures with MRI performed to investigate; no diagnosis of epilepsy made but plan to treat with ongoing medication
- Patient admitted with #NOF; also has pre-existing angina on regular medication; doctors review patient's angina which results in documentation of a plan to perform serial troponins
- Nurse documents reflux for Mylanta; gives Mylanta; doctor reviews next day and documents a plan for ongoing medication for reflux
- Nurse documents headache – Panadol given. Headache persisted – phoned Doctor: change from Panadol to Mersyndol – will sign in medication record tomorrow
- Medical officer documents in progress notes – CCF. Plan – Frusemide
- Documented by nurse in the progress notes: Phoned Doctor to report K+ 2.9 – told to start Slow K and repeat electrolytes after 12 hours
- Documented by medical officer in progress notes: Thigh abscess, incised and drained
- Continence nurse assesses patient's longstanding urinary incontinence and provides a plan of care
- Documented by midwife in progress notes: cracked nipples. Provided advice on positioning for feeds. Provided nipple shield and referral to lactation consultant. Recommended regular application of Lansinoh cream

Examples of conditions that are not clinically significant

- Finding of atelectasis from CXR performed post-op; no other related documentation
- Patient admitted with #NOF; also has pre-existing angina on regular medication; Current medications continued on the ward
- Nurse documents 'reflux, for Mylanta' in progress notes, nurse documents Mylanta on medication chart
- Nurse documents headache – Panadol given
- Nurse documents nappy rash on baby's transfer to SCN – Sudocrem applied. No other documentation related to the nappy rash or the Sudocrem
- Midwife advises the use of Lansinoh cream for cracked nipples on discharge of the patient
- New medication on medication chart but no documented condition in a treatment plan
- In progress notes: BNO - aperients. Evidence in the medication chart that Movicol was given. No other documentation

Examples of routine care

- Medication is ceased so the patient can have surgery
- Medication for chronic conditions that is not changed during the episode of care
- Change of bed linen post faecal incontinence
- Assistance with ADLs
- Change of existing dressing on surgical wound

Documentation queries

Refer to:

- ACCD Standards for ethical conduct in clinical coding (https://www.accd.net.au/Ethics.aspx)
- ACCD Tenth Edition education (https://www.accd.net.au/Education.aspx)
- Application of the ACCD Standards for ethical conduct in clinical coding feature article (https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/health-classifications/feature-articles)

A documented symptom or condition that does not meet any of the criteria for significance outlined in Vic 0002 *Additional diagnoses* should not be the subject of a documentation query.

The clinician should not be queried to obtain documentation that the type of care delivered is significant when there is no basis in the record to support clinical significance.