Vic 0002 Additional diagnoses

Education workshop slides

16 February 2018

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Welcome to the VIC 0002 education workshop.

My name is Carla Read and I'm the Acting Manager of the Health Classification and Coding Unit at the Victorian Agency of Health Information.

With me today is Andrea Groom who will be your educator for the workshop. Andrea is a Health Information Consultant and Director of Clinical Coding Services.

Andrea has been engaged by the Department and VAHI to provide this education as she has:
- extensive coding experience,
- is familiar with background to Vic 0002 and has current workplace experience.

Andrea works in both the public and private sectors and as this education applies equally to both sectors, the Department and the Agency do not consider that there is a conflict of interest engaging Andrea in this work.

Before I hand over to Andrea I would like to take a few minutes to go through the background that led VIC 0002 being implemented and some key messages.

Background to Vic 0002

Concept of clinical significance had been discussed at VICC for some time

➢ The number of queries regarding conditions meeting ACS 0002 had been increasing over the last year

Version 8.0 of the grouper was introduced in July 2016

➢ Complexity algorithm overhauled
➢ Adjacent DRGs that split on complexity up from 167 to 315
➢ Modelling of V8.0 uses historic data that were funded under V7.0
➢ Assumption was that coding would remain reasonably stable

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The concept of clinical significance had been discussed at VICC for some time as the types and number of queries VICC had been receiving indicated that coders needed clarity and direction in interpreting the term significance in ACS 0002.

VICC had therefore decided back in April to write a public submission to ACCD suggesting improvements to the ACS in the area of significance.

V8.0 of the grouper was introduced in July 2016.

As you are aware the complexity algorithm in V8.0 is completely different to previous versions of the grouper and the number of adjacent DRGs that split on complexity increased dramatically from 167 in V7 to 315 in V8.0.

The V8.0 WIES model used historic data that were funded under V7.0 and it was assumed that the coding would remain reasonably stable when transitioning from funding under DRG V7.0 to DRG V8.0

Background to Vic 0002

Modelling for 2017-18 funding model (WIES 24) identified:

➢ Significant increase in WIES activity that was not matched with a corresponding increase in admitted activity

➢ Significant increase in the assignment of some codes

The removal of the DCL on 44 codes was done to moderate the financial risk arising from changes in the coded data

➢ Deemed by the Chief Medical Officer of Safer Care Victoria to have a disproportionate effect on DRG outcome in relation to clinical significance

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In preparation for the 2017-18 funding model (WIES 24) the Department identified:

- A significant increase in WIES activity that was not matched with a corresponding increase in admitted activity, and

- Further analysis identified the significant increase in the assignment of some codes.

To deal with the immediate funding impact of this significant rise in WIES, the Department removed the DCL of 44 of the most frequently assigned codes that were deemed by the Chief Medical Officer of Safer Care Victoria to have a disproportionate effect in relation to clinical significance.

In other words the removal of the DCL from the 44 codes was done to moderate the financial risk arising from changes in the coded data.

Background to Vic 0002

VIC 0002 introduced in July 2017

➢ Reaffirms principles 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 clinical coders with the information they need to determine clinical significance for reporting purposes

So to reaffirm the principles of clinical significance to ensure ongoing the consistency, reliability and accuracy of the coded data, the Agency introduced VIC 0002 in July 2017 ahead of national changes to ACS 0002.

Key messages

Coded data has many purposes only one of which is to feed into the funding model

- ➢ Understand there is pressure to meet targets
- ➢ The funding model should not drive the coding
- ➢ The Department has other mechanisms to address funding issues

Cannot lose sight of clinical significance when coding

- ➢ Where clinically appropriate there is an expectation that the 44 codes continue to be reported
- ➢ The frequency of the reporting of these and other codes is now regularly monitored by the Department

Coded data has many purposes only one of which is to feed into the funding model.

We understand that there is pressure to meet targets.

However the funding model should not drive the coding.

The Department has other mechanisms to address funding issues.

Therefore we cannot lose sight of clinical significance when coding.

Where clinically appropriate additional codes including the 44 codes with their DCL removed need to continue to be coded.

The Department is now regularly monitoring the reporting of these and other codes.

Key messages

The Department and VAHI have an expectation that coded data is accurate and complete

Accuracy and completeness is critical:

- ➤ **To future funding decisions in this financial year and beyond**
- ➤ **For safety and quality monitoring**
- ➤ **For health service planning**
- ➤ **For research**

Accuracy and completeness applies equally to private sector

- ➤ **Regardless of reasons behind clarification, same messages re clinical significance, completeness and coding quality apply**

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The Department and the Agency have an expectation that coded data is accurate and complete as it is critical:

- To future funding decisions in this financial year and beyond

- For safety and quality monitoring which is the focus of the Agency's work with Safer Care Victoria

- For health service planning

- For research

Accuracy and completeness applies equally to private sector and therefore the same messages about clinical significance, completeness and coding quality apply to both sectors.

Purpose of today

Respond to sector confusion and concern with regard to VIC 0002 application

➢ CEO feedback to DHHS indicates ongoing confusion

Support clinical coders to ensure that episodes are coded completely and accurately

Restore the Department's and VAHI's confidence in the quality and completeness of the coded data

➢ Cannot have a repeat of significant shift in data that occurred 2016-17

Victorian Agency for Health Information

We understand that both sectors have expressed confusion and concern regarding the application of VIC 0002 so this workshop aims:

- To support clinical coders to ensure that episodes are coded completely and accurately, and

- To restore the Department's and the Agency's confidence in the quality and completeness of the coded data as we cannot have a repeat of the significant shifts in data that occurred 2016-17.

Now I'll hand over to Andrea who will go through some scenarios.

Notes

Covering areas believed to have caused confusion

Any additional examples raised in today's workshop will be ratified and incorporated into a final version of the workshop slides

➢ such examples are not to be referenced in the meantime

We are not covering all areas of Vic 0002 but those areas believed to have caused confusion.

So there might be additional examples raised. If so, even if they are answered, we will document the queries and review to ensure consistency of the response. They will then be incorporated into a final version of the workshop slides which will be distributed.

As such, until any additional examples can be reviewed after the workshops, these examples should not be referenced.

There will be a Q&A document published as there have been many queries asked, including ones not about Vic 0002.

Queries after the workshop should be directed to VICC.

ACS 0002 and "significant"

The national morbidity data collection is not intended to describe the current disease status of the inpatient population, but rather the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring

"significant" was added to ACS 0002 in Sixth Edition (2008).

"significant" has been referenced in several Coding Rules since.

It isn't a new concept, but perhaps a forgotten concept.

VICC has been receiving queries on whether conditions meet ACS 0002 intent for many years, but particularly in the last year with the introduction of v8 grouper and more codes potentially affecting the DRG. Queries indicated the uncertainty coders felt of what they should code but also what they were being asked to code/query, and felt uncomfortable to do so – "we wouldn't have coded that before".

Vic 0002

Victorian additions to the ACS supplement (not override) the ACS advice

Vic 0002 seeks to clarify the term 'significant' in relation to the three dot points in ACS 0002

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

Coding Rules TN1248 ACS Mutual exclusivity

➢ Apply general ACS before specialty ACS

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Firstly, a few points about Vic 0002:
Victorian additions to the ACS supplement (not override) the ACS advice
Vic 0002 seeks to clarify the term 'significant' in relation to the three dot points in ACS 0002.

We have also considered Coding Rules TN1248 (Tenth Edition FAQs Part 1) re ACS mutual exclusivity
Mutual exclusivity does not apply to coding standards; however, multiple standards may apply to a particular case.
Apply first the general standards for diseases and interventions.
For example, ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses*, ACS 0010 *General abstraction guidelines* (see also the list of *General standards for diseases* in the ACS) and ACS 0042 *Procedures normally not coded.*
The apply the guidelines in the specialty standards on a case by case basis.
(Coding Rules for implementation 1 October 2017)

"Significant" – Vic 0002

Documented:

➢ **Plan of care**

➢ **Condition delayed discharge**

➢ **Required diagnostic procedure**

➢ **Variation from treatment plan in response to change in patient's condition**

➢ **Greater than routine care**

Vic 0002 defines 'significant' as conditions/symptoms that meet any of these criteria, ie only one criteria needs to be met for a condition to be considered significant.

Think about a plan of care rather than an action; everyone has been justifying coding based on an action being performed but it needs to be more than an action; more than "but they did something for it" for it to be more than routine care.

A few years ago we had IV complications (falling out, being a bit red etc) and wound ooze, and these conditions were being coded for the nurse putting ice on or changing the dressing – all really routine care but coded as complications of care. We used to call it the "level of coding" – where you didn't code the "minutiae", the small or trivial details of something, but over time, these conditions/symptoms had become almost routinely coded.

We acknowledge that a coder's view of 'significance' may be different to a clinician's view of 'significance' – we might think a condition is not significant but it is; conversely we might think it is significant, but it isn't. An example of this could be the 'tidying up' at the end of a procedure, e.g. diathermy of bleeders – it might read like it's significant but a clinician may say it's routine care to ensure there are no bleeding points left at the end of the procedure.

We are not asking coders to make a clinical decision; we are asking coders to judge 'significance' based on the documentation in the clinical record – that is all we can do and that is what coders do each and every day.

As more examples are raised and discussed, everyone will gain more confidence in what is significant compared to routine care.

Clinical documentation

"The responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder"

(Introduction to ACS)

Clinician refers to treating medical officer, but also refers to other clinicians, so documentation from other clinicians can be used for coding where it is appropriate to the clinician's discipline (and the condition meets Vic 0002 criteria)

➤ **Dysphagia by speech pathologist**

➤ **Postpartum haemorrhage by midwife**

➤ **Skin ulcer by wound care nurse**

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The introduction to the ACS states that the responsibility for recording diagnoses and procedures, lies with the clinician not the coder.
The introduction also defines clinician as being treating medical officer but also other clinicians, where the condition is appropriate to the clinician's discipline.

Areas of coder concern

Treatment / nurse-initiated medication

Increased clinical care/monitoring

Other sections of ACS 0002 that may apply

Documentation queries

Based on the scenarios received from coders and queries sent to VICC, the most common areas of concern are:

Treatment / nurse-initiated medication

Increased clinical care/monitoring

Other sections of ACS 0002 that may apply

Documentation queries

Commencement, alteration or adjustment of therapeutic treatment

Treatment plan/plan of care means, for example:

➢ Order in progress notes linked to the condition

➢ Medication commenced on medication chart linked to the condition

➢ Order for transfusion linked to the condition

"Plan" does not apply to nurse-initiated medication

Section 1 of Vic 0002 is commencement, alteration or adjustment of therapeutic treatment.
The treatment plan or plan of care used in this section means, for example, where there is an order for treatment in the progress notes, where a medication is commenced on a medication chart (ie new medication), or where an order for transfusion is documented, perhaps on a Blood Bank form.

The treatment needs to be linked to the condition, and the linking may need to be clarified through a documentation query.

Concept of a treatment plan or plan of care does not apply to nurse initiated medication, ie even if it is documented as a plan, nurse initiated medication does not meet Vic 0002

Nurse-initiated medication

Nursing documentation provides evidence of all care to patient

  ➢ An 'action' does not necessarily mean that a condition should be coded

Nurses can administer certain drugs

If nurse-initiated medication needed to continue, a doctor would be involved

  ➢ Number of times nurse initiated is irrelevant

Nursing documentation is expected to provide evidence of all care given to the patient. However, for coding purposes, not all care will meet the definition of ACS or Vic 0002 and 'significance' and so conditions documented by nurses may not be coded from nursing documentation alone.

A nurse can administer certain drugs for some conditions, however these are often 'over-the-counter' medications that can also be self-administered by patients outside of hospital. Also, if a nurse initiated medication is to continue, it would need to be ordered by a medical officer.

Examples of nurse-initiated medication

Nursing progress notes:

……given meds as charted. Magnesium replaced, orally given ii Magmin…..

Med chart:

Once only, pre-medication and nurse initiated medicines

27/7/17   Magmin   PO   ii   signed/name   1445

➢ Does not meet Vic 0002
  ➢ Nurse-initiated medication only

In this example, the nursing progress notes state given meds as charted. Magnesium replaced, orally given ii Magmin.
And the medication chart, in the 'once only, pre-medication and nurse initiated medicines' section, states the date and time of the administration of the Magmin.

In this example, there is no mention of consultation with doctor. No evidence that not nurse initiated. Therefore do not code.

This is probably a documentation issue – as would expect that a doctor was involved.

Example

Pt with CCF.

Panadol given by nurse for hip pain and stiff neck

- ➢ Does not meet Vic 0002
  - ➢ Nurse-initiated medication only
  - ➢ Routine, general nursing care to keep patient comfortable

In this example, the patient was given Panadol by the nurse for hip pain and stiff neck.

The hip pain and stiff neck do not meet Vic 0002 as the Panadol was nurse initiated medication, and it is routine, general nursing care to keep the patient comfortable.

Significant conditions would usually require doctor or specialist nurse or allied health attention/intervention

Nursing documentation

Do not ignore nursing notes

Example:
Nursing progress notes:

Phoned Dr re K+ 3.0, Slow K ordered, Dr to sign in morning

➢ Does meet Vic 0002
  ➢ Doctor involved
  ➢ Plan of treatment

But conditions documented by nurses should not be ignored as they may flag a diagnosis that the medical officer inadvertently failed to document, for example, where the doctor has documented to commence a medication on the medication chart, but not written it in the notes, the nurse may have documented "Slow K commenced as charted".

Also, where a medical officer is not in attendance, they may provide telephone orders, e.g. after-hours. This information exchange (of the reason for contacting the doctor, any diagnosis and treatment order made by the doctor) would be documented by the nurse and can be used by the clinical coder.

Therapeutic treatment

Ensure treatment is therapeutic, not prophylactic or preventative treatment

For example:

➢ **Biochem results – K+ above 3.5 throughout episode**

➢ **Administration of Slow K to keep K+ level above 4.0 in a cardiac patient = preventative**

The dot point in ACS/Vic 0002 is "therapeutic" treatment, not prophylactic or preventative, so coders need to ensure that the treatment they are considering using as the reason for meeting Vic 0002 is appropriate

Ensure treatment is carried out

ACS 0002, point 1 and VICC #3224

➢ Code only when treatment is commenced, altered or adjusted

    ➢ Unless refused by patient or documented contraindication

For example:

➢ Post-op patient noted to have low Hb, diagnosed with iron deficiency anaemia, patient declined iron infusion during admission so none administered, discharged home on oral iron replacement

    ➢ Patient refused treatment so still meets Vic 0002

Coders need to ensure that treatment is carried out.

ACS 0002, dot point 1, states: commencement, alteration or adjustment of therapeutic treatment so a treatment needs to be carried out.

However, VICC 3224, Documented plan not carried out, states that if treatment has been refused by the patient or there is a documented contraindication, then it is still considered to have been commenced.

But if there is no documentation as to why medication not given, then we don't know that it was refused or contraindicated so cannot meet the exclusion criteria so do not code.

Also, if medication was ordered as PRN and not given, then treatment has not been commenced.

"Application of Vic 0002" document

Section: Examples of conditions that are not clinically significant

- 'New medication on medication chart but no documented condition in a treatment plan'
  - This point in Vic 0002 is no longer relevant after ACCD's Clarification on the application of the "*Standards for ethical conduct in clinical coding*" (example 3)

In the 'Application of Vic 0002' document, the second last dot point in the "examples of conditions that are not clinically significant" section, stated:
"new medication on medication chart but no documented condition in a treatment plan".

In light of the ACCD's 'Clarification on the application of the standards for the ethical conduct in clinical coding' which was released in late October 2017 and was after the release of the Vic 0002 'application' document, the point "New medication on medication chart but no documented condition in a treatment plan" is no longer relevant.

Meaning that a new medication on a medication chart can be considered clinically significant.

"Vic additions to ACS" document

Section: Increased clinical care / monitoring
Original wording:

3a) A second health professional is engaged in determining the clinical care resulting in a documented change of treatment plan / management for the condition. Consultation by a second health professional is often routine care and should only be used to justify code assignment when a change of plan of care results from the consultation

Change to:

3a) A second health professional is engaged in determining the clinical care resulting in a documented ~~change of~~ treatment plan / management for the condition. [end of point 3a)].

In the Victorian additions to the ACS document, Vic 0002 ADX, Increased clinical care/monitoring section 3a), the wording that was published stated:
A second health professional is engaged in determining the clinical care resulting in a documented change of treatment plan / management for the condition. Consultation by a second health professional is often routine care and should only be used to justify code assignment when a change of plan of care results from the consultation

It is acknowledged that a review by a second health professional, e.g. a consultant, is an increase in clinical care, regardless of whether there is a CHANGE of treatment plan/management. There is still a requirement for there to be documentation of the consultation plan of care or management of the condition, even if that plan is "no change".

Therefore, the wording in section 3a) needs to have the words 'change of' and the whole of the second sentence deleted.

However, make sure the condition was not ruled out by 2nd health professional, ie if seen for 'x' condition but that specialist says the patient does not have that condition, then do not code it.

Example

Incidental finding of hernia during admission. Specialist reviewed hernia. Plan: not for surgery, for conservative management

➢ Meets Vic 0002 3a) A second health professional is engaged in determining the clinical care resulting in a documented treatment plan / management for the condition.

In this example, there was an incidental finding of hernia during admission. Specialist was called to review the hernia, and documented a plan of 'not for surgery, for conservative management'.

In this example, the hernia meets Vic 0002, section 3a) as a second health professional was engaged in determining the clinical care resulting in a documented treatment plan / management for the condition.

Increased clinical care / monitoring

Condition may meet Vic 0002 when documentation states the condition requires admission to higher acuity area of hospital

➢ **E.g. ICU/NICU/CCU/SCN**

Example: TURP for BPH. Planned ICU admission because of severe OSA and aortic stenosis and he had a GA

➢ **OSA and aortic stenosis meets Vic 0002**

Another way a condition may meet Vic 0002 is when documentation states the condition requires admission to higher acuity level of hospital.

In this example, the patient had TURP for BPH. The conditions OSA and aortic stenosis would have been considered risk factors (for surgery) and would not have met criteria for coding until they were documented as the reason for admission to ICU and therefore for increased clinical care. In this example, the OSA and aortic stenosis can be coded.

Increased clinical care / monitoring

Condition may meet Vic 0002 when documentation states condition requires:

➢ Clinical specialling / 'specialled'

➢ Full nursing care

➢ Significant special equipment, e.g. use of hoists

   ➢ Bariatric hoist for morbidly obese patient

Conditions may meet Vic 0002 if there is documentation that the condition required:
- **Clinical specialling or 'specialled'** – by definition, this means the patient has had increased nursing care, usually for a clinical condition but it can also be for a safety risk – need documentation of the condition that the patient is specialled for
- **Full nursing care** for a specific condition
- **Significant special equipment** for a specific condition, for example, the use of a bariatric hoist for a morbidly obese patient

Increased clinical care / monitoring

Condition would <u>not</u> meet Vic 0002 when documentation states condition only requires:

➢ General nursing care, for example,

  ➢ Turning / assisting in and out of bed / mobilising

  ➢ Washing

  ➢ Assisting with ADLs

  ➢ Directing

  ➢ Wound care – dressings / change of dressings

  ➢ Making patient comfortable

  ➢ Administering medications

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Conditions would not meet Vic 0002 if there was documentation that the condition only required general nursing care, for example, washing, directing, dressings etc.

In this slide and the previous slide, we've given the two extremes – there will be other levels of care that will still require coders to make a decision re 'significance' – we cannot define it for every condition – but coders make decisions for every episode they code, after reviewing the documentation.

Again this might highlight a documentation issue rather than a coding issue.

Example

Pt admitted with pancreatitis. Also has cerebral palsy.
Nursing progress notes:

Communicates verbally and with alphabet board

Assist x 1 – able to roll in bed

Washed with assist x 1

Can move in bed with assistance

Wheelchair bound

Physiotherapy notes:

Assessed normal level of function of CP – usually doesn't require any assistance but needs to be set up exactly how he is used to otherwise finds it difficult.

Pt unable to come from lying -> sitting, hoist transfer required; trialled standing with bar in front, unable to complete. Understands he is below pre-morbid level. Agreeable to go to rehab.

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In this example, the patient was admitted with pancreatitis and also has cerebral palsy.
The patient was referred to the physiotherapist because of their cerebral palsy.
(NB. This is a cutdown version of the actual notes.)

Example

Pt admitted with pancreatitis. Also has cerebral palsy.
Nursing progress notes:

Communicates verbally and with alphabet board

Assist x 1 – able to roll in bed

Washed with assist x 1

Can move in bed with assistance

Wheelchair bound

Physiotherapy notes:

Assessed normal level of function of CP – usually doesn't require any assistance but needs to be set up exactly how he is used to otherwise finds it difficult.

Pt unable to come from lying -> sitting, hoist transfer required; trialled standing with bar in front, unable to complete. Understands he is below pre-morbid level. Agreeable to go to rehab.

VAHI Victorian Agency for Health Information

Based on the nursing documentation alone, the cerebral palsy would not be coded as it is general nursing care to assist a patient with turning, washing, moving in/out of bed, etc.

Example

Pt admitted with pancreatitis. Also has cerebral palsy.

Nursing progress notes:

Communicates verbally and with alphabet board

Assist x 1 – able to roll in bed

Washed with assist x 1

Can move in bed with assistance

Wheelchair bound

Physiotherapy notes:

Assessed normal level of function of CP – usually doesn't require any assistance but needs to be set up exactly how he is used to otherwise finds it difficult.

Pt unable to come from lying -> sitting, hoist transfer required; trialled standing with bar in front, unable to complete. Understands he is below pre-morbid level. Agreeable to go to rehab

VAHI Victorian Agency for Health Information

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However, the patient had a Physio review for their cerebral palsy which is a 2nd health professional as per section (3a) of Vic 0002 and as a result of the review, there is a documented plan of care, so the cerebral palsy meets Vic 0002.

It is important to note that coders don't need to compare pre-admission care to post-admission care – we don't need to know whether the patient is usually needing a hoist at home, for example. Need to look at level of care provided in this episode and determine if that care is significant.

Example

Nursing progress notes:

Pt has new small pressure sore on sacrum. Cleaned and dressed. Pt now on air mattress.

> Does not meet Vic 0002
>> Action only, no plan of care
>> No wound care nurse/doctor review
> Stage 1 pressure injury / pressure area – may be dressed, perhaps bed cradle to keep weight of bedding off patient, pillow elevation, air or eggshell mattress ordered, pressure area care (PAC), skin checks

In this example, the nursing documentation stated "patient has a new small pressure sore on sacrum. Cleaned and dressed. Pt now on air mattress".

Cleaning and dressing of a pressure sore and ordering of pressure mattress are general nursing actions, which may be preventative. There is no documented plan of care, no wound care nurse or doctor review so the pressure sore does not meet Vic 0002.

Not every hospital will have specialist nurses such as wound care nurse, but would generally have another nurse (perhaps the NUM) that this would be referred to, if this was a significant condition.

We acknowledge that pressure injuries are an important indicator of quality of care but there is no 'always code' instruction for pressure injuries so they need to meet criteria for coding in the same way as other conditions do.

Also remember that there are other ways that pressure injuries are reported, for example, in incident management systems such as Riskman.

Pressure injuries should only be coded and included in our data if they meet Vic 0002 and significance criteria.

Example

Nursing progress notes:

Pt has new Stage 2 pressure injury near sacral region, aquacel soft was applied and pressure mattress ordered

Wound management chart commenced with plan for ongoing care

➢ Meets Vic 0002

    ➢ Plan of care – wound management chart

➢ Documentation of pressure injury is appropriate to nursing discipline

➢ Stage 2 pressure injury is likely to have a Wound treatment plan commenced

Documentation of pressure injury is appropriate to nursing discipline but dressing is routine care, and pressure mattress may be preventative.

In this case, the Wound management charts included a plan for dressings but not all similar charts do so need to check.

A stage 2 PI would normally be seen by a specialist wound nurse/clinician who then usually prescribes a course of treatment/dressing regime.

Example

Nursing progress notes:

Pt has pre-existing skin ulcer on leg. Cleaned and dressed.

- ➢ Does not meet Vic 0002
  - ➢ Does not meet 1a commencement of treatment, as same as had before
  - ➢ Does not meet 3 increased clinical care
  - ➢ Action only, no plan of care
  - ➢ No wound care nurse/doctor/specialist review

In this example, the nursing documentation stated: patient has a pre-existing skin ulcer on leg. Cleaned and dressed.

The pre-existing skin ulcer does not meet Vic 0002 as:
- Does not meet 1a commencement of treatment, as same as had before
- Does not meet 3 increased clinical care as dressing/cleaning is routine care
- Action only, no plan of care
- No wound care nurse/doctor/specialist review

In this example, the skin ulcer would not be coded.

Example

Nursing progress notes:

Pt has pre-existing skin ulcer on leg. Cleaned and dressed.
Wound care nurse review skin ulcer with plan of care documented.

➢ Meets Vic 0002

  ➢ Second health professional review – specialist in wound care

  ➢ Plan of care

In this example, the nursing documentation stated: patient has a pre-existing skin ulcer on leg. Cleaned and dressed.
Wound care nurse review skin ulcer with plan of care documented.

The pre-existing skin ulcer meets Vic 0002 as:
• Second health professional review – specialist in wound care, and
• There is a documented Plan of care

Example

Pt incontinent of urine for entire 10 night admission, pads changed daily as noted on nursing care plan.

Bed linen also changed twice during admission due to incontinence

- ➢ Does not meet Vic 0002
  - ➢ Routine nursing care
  - ➢ No plan of care

Incontinence needs to meet the criteria in ACS 0002 and Vic 0002, as well as ACS 1808: "persistent prior to admission, is present at discharge or persists for at least seven days."

Whilst ACS 1808 tells us that incontinence is significant in certain cases, the care provided for the incontinence still needs to meet the criteria for significance in Vic 0002.

In this example, patient incontinent of urine for entire 10 night admission, pads changed daily as noted on nursing care plan.
Bed linen also changed twice during admission due to incontinence

Incontinence does not meet Vic 0002 as it is routine nursing care to change pads and bed linen, and there is no plan of care

Example

Pt incontinent of urine for entire 10 night admission, pads changed daily as noted on nursing care plan.

Bed linen also changed twice during admission due to incontinence.

Bladder ultrasound performed to assess for any cause of ongoing incontinence

➢ **Meets Vic 0002**
  ➢ **Diagnostic procedure performed to investigate**

This same patient now has a bladder ultrasound performed to assess for any cause of ongoing incontinence

In this example, the incontinence meets Vic 0002 as there was a diagnostic procedure performed to investigate the incontinence

Example

Pt incontinent of urine for entire 10 night admission, pads changed daily as noted on nursing care plan.

Bed linen also changed twice during admission due to incontinence.

Continence nurse reviewed pt and documented plan of care

➢ **Meets Vic 0002**
  ➢ **Second health professional with treatment/care plan**

This same patient now has a Continence nurse review and document a plan of care.

In this example, the incontinence meets Vic 0002 as there was a second health professional involved with a documented treatment or care plan

Example

Pt with known hypertension. HT noted by nurse during admission. Nurse notes for BP to be monitored. Takes regular BP throughout admission

➢ Does not meet Vic 0002
  ➢ Routine, general nursing care to take BP
  ➢ No documentation of increased monitoring
  ➢ No doctor review required

In this example, the patient with known hypertension. HT noted by nurse during admission. Nurse notes for BP to be monitored. Takes regular BP throughout admission

The hypertension does not meet Vic 0002 as:
  • **Routine, general nursing care to take BP**
  • **No documentation of increased monitoring**
  • **No doctor review required**

Example

Pt with AMI. Known Parkinson's disease. Assist with ADLs, moving in/out bed

➢ **Does not meet Vic 0002**
  ➢ **Routine, general nursing care to assist patient**

In this example, the patient was admitted with an AMI. Has known Parkinson's disease and had assistance with ADLs and moving in/out bed.

The Parkinson's disease does not meet Vic 0002 as it is routine, general nursing care to assist patient.

Example

Midwife notes:

Normal vertex delivery of live male……

PPH requiring Ergometrine

➢ **Meets Vic 0002**

    ➢ **Midwife is specialist clinician for obstetric conditions**

    ➢ **Commencement of therapeutic treatment**

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In this example, the midwife has documented the delivery of the baby and then "PPH requiring Ergometrine".

The PPH meets Vic 0002 as a midwife is a specialist clinician for obstetric conditions, that is, a midwife has done specialised training, and there was commencement of therapeutic treatment for the PPH.

Other sections of ACS 0002

➢ **Underlying cause**

➢ **Assessments**

➢ **Multiple coding**

➢ **Incidental findings and conditions**

There are some other ways (than the 3 dot points and significance) of conditions meeting or not meeting ACS 0002 that also need to be considered.
Where the rules are not about the 3 dot point points, then Vic 0002 does not apply.

The 3 dot points is referring to ACS 0002:
- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

Other sections of ACS 0002

Underlying cause

If a problem with a known underlying cause is being treated, then both conditions should be coded (see also ACS 0001 *Principal diagnosis/Problems and underlying conditions*).

EXAMPLE 1:

Patient is admitted for a fractured hip and during the episode of care develops ascites due to known underlying liver disease. The ascites is drained.

Principal diagnosis:	Fractured hip
Additional diagnoses:	Ascites
	Liver disease
Procedure:	Drainage of ascites

The underlying cause does not need to meet ACS (or Vic) 0002 in it's own right

ACS 0002, Underlying cause section, states:
If a problem with a known underlying cause is being treated, then both conditions should be coded.

Underlying cause is not about the "3 dot points and significance" so the underlying cause (of a condition that does meet criteria for coding), can be coded, i.e. the underlying cause does not need to meet the 3 dot points or significance in it's own right

Example

Patient admitted with pneumonia. Has intellectual disability. Nursing staff assist with ADLs and prompting with cares

- Does not meet Vic 0002
  - Routine, general nursing care to assist patient

Pt readmitted 5 days later as non-compliant with medications due to intellectual disability

- Z91.1 for non-compliance
  - Underlying cause of intellectual disability so meets ACS 0002

In the first example, the patient was admitted with pneumonia and has intellectual disability. Nursing staff assist with ADL's and prompting, which is general nursing care for any patient.

However, in the second example, the patient was readmitted 5 days later as he was non-compliant with medications, documented as due to his intellectual disability.

In this example, the underlying cause of the non-compliance is documented as intellectual disability so intellectual disability meets the underlying cause section of ACS 0002 and can be coded. The underlying cause does not need to meet Vic 0002 as it is not about "3 dot points and significance"

Other sections of ACS 0002

"Assessments"

Documentation of a condition during a clinical assessment does <u>not</u> meet ACS/Vic 0002

➤ Unless dot point criteria and 'significance' met, or

➤ When condition changes standard treatment protocol

Example:

Cardiology review documents patient's chronic condition of Parkinson's disease

➤ Parkinson's disease <u>does not</u> meet ACS 0002

Procedure normally performed under spinal but given GA instead as cannot lie still because of Parkinson's disease

➤ Parkinson's disease <u>does</u> meet ACS 0002

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Documentation of current conditions during a clinical assessment, does not meet ACS 0002 criteria, unless the dot point criteria and 'significance' are met, or when the condition changes the standard treatment protocol for a particular procedure/condition.

The example in ACS 0002 re "a condition documented during a clinical assessment" is a pre-op assessment by an anaesthetist, i.e. listing the patient's conditions as part of the assessment, which does not make those conditions meet ACS or Vic 0002. Another example may be where the Cardiologist reviews the pt, e.g. for angina, and documents the pt's chronic condition of Parkinson's disease.
In this case, the Parkinson's disease does not meet ACS 0002 so "stop there" and do not code.

But where the condition has changed the standard treatment protocol, for example, Procedure normally performed under spinal but given GA instead as cannot lie still because of Parkinson's disease, then the Parkinson's meets ACS 0002 and would be coded

Other sections of ACS 0002

Multiple coding

MULTIPLE CODING

There are situations which require the assignment of additional codes to reflect the various components of a disease, which may themselves not meet the above criteria of an additional diagnosis (see also ICD-10-AM Tabular List: *Conventions used in the Tabular List of Diseases/Instructional notes/terms*).

Examples of common areas where multiple coding is used in ICD-10-AM include:

- aetiology and manifestations (see also ACS 0001 *Principal diagnosis*)
- local infections to identify the organism
- functional activity of neoplasms
- neoplasm morphology (see also ACS 0233 *Morphology*)
- underlying disease
- toxic agents
- nature of injury or cause of poisoning or adverse effect
- diabetes mellitus with complications
- postprocedural complications

The additional diagnosis code in a multiple coding situation does not need to meet ACS (or Vic) 0002 in it's own right

For some conditions, there is a need to assign an additional diagnosis code to reflect the various components of a disease as instructed by the Multiple coding section of ACS 0002, for example, adding a 'bug' or coding out diabetic complications.

These additional diagnoses do not need to meet the 3 dot point criteria and 'significance' as they meet ACS 0002 for other reasons

Other sections of ACS 0002

Incidental findings and conditions

…..However, where these findings or conditions are incidental to the episode of care and are only flagged for follow-up or referral post discharge they do not qualify for code assignment under ACS 0002 Additional diagnoses.

Example:

Finding of small pleural effusion on CXR; referred to Outpatients

➢ Does not meet ACS 0002

The incidental findings and conditions section of ACS 0002 states:
However, where these findings or conditions are incidental to the episode of care and are only flagged for follow-up or referral post discharge they do not qualify for code assignment under ACS 0002 Additional diagnoses.

If for example, the patient was found to have a small pleural effusion on CXR during the episode and was referred to Outpatients to follow it up, then the pleural effusion does not meet ACS 0002.

If a condition does not meet ACS 0002, it cannot meet Vic 0002

Coding Rules advice

Follow CR advice for application of ACS 0002

Example:

Q2897 ACS 0002 Additional diagnoses and alteration to treatment

…. conditions listed in the past history/background (congestive cardiac failure and atrial fibrillation) where medication to treat these conditions has been altered should be coded, as per the criteria in ACS 0002 Additional diagnoses; specifically dot point 1, 'commencement, alteration or adjustment of therapeutic treatment'…..

There may also be specific Coding Rules advice that still needs to be followed because there has been a specific instruction for the application of ACS 0002, for example:
Ref No: Q2897 | Published On: 15-Jun-2015 | Status: Current
ACS 0002 Additional diagnoses and alteration to treatment
Q:
Does a condition meet the criteria in ACS 0002 *Additional diagnoses* when the medication to treat the condition has been altered to manage an adverse effect or another condition, ...
A:
......the conditions listed in the past history/background (congestive cardiac failure and atrial fibrillation (in these particular examples)) where medication to treat these conditions has been altered should be coded, as per the criteria in ACS 0002 *Additional diagnoses*; specifically dot point 1, 'commencement, alteration or adjustment of therapeutic treatment'.
(Coding Rules, June 2015)

Steps to help - #1

1. **Is it a condition/symptom/status that is always coded as per a speciality ACS or another ACS instruction?**

   If yes, code it

   If no, continue to next step

Examples:

➢ **Viral hepatitis – yes, code it**

➢ **Smoking status – yes, code it**

➢ **Diabetes – yes, code it**

➢ **Underlying cause – yes, code it**

These steps may help decide whether a condition/symptom/status meets Vic 0002.
Step 1:
Is it a condition/symptom/status that is always coded as per a speciality ACS or another ACS instruction?

If yes, code it
If no, continue to next step

For example, in the case of diabetes, current conditions that are indexed under Diabetes, with, do not need to meet ACS or Vic 0002 "significance" criteria as they are covered by the 'always code' instruction in ACS 0401.

Steps to help - #2

2. Does the condition/symptom meet ACS 0002?

If yes, continue to next step

If no, do not code it

Example:

➢ Specialist comes to see patient re bleeding in ear, examined, observe for now – yes, meets ACS 0002 -> next step

➢ Patient referred to external provider to review skin lesions noted during admission – no, does not meet ACS 0002 -> do not code

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Step 2:
Does the condition/symptom meet ACS 0002?

If yes, continue to next step
If no, do not code it

Specialist comes to see patient re bleeding in ear, examined, observe for now – meets ACS 0002 – go to the next step.
Patient referred to external provider to review skin lesions noted during admission – this does not meet ACS 0002 due to change in advice incorporated into Tenth Edition – so go no further – if it doesn't meet ACS 0002, then it can't meet Vic 0002

Steps to help - #3

3. Does the condition/symptom meet the criteria for significance in <u>Vic</u> 0002?

If yes, continue to next step

If no, do not code it

Example:

➢ Dementia, patient with a plan for being specialled – yes, meets Vic 0002 -> next step

➢ Dementia, patient wandering and being redirected – no, does not meet Vic 0002 -> do not code

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Step 3:
Does the condition/symptom meet the criteria for significance in <u>Vic</u> 0002?

If yes, continue to next step
If no, do not code it

Dementia, patient with a plan for being specialled – yes, meets Vic 0002 -> next step
Dementia, patient wandering and being redirected – does not meet Vic 0002 – do not code.

Assigning the U code will assist with the identification of the impact of such conditions and the analysis that will be performed by ACCD to inform potential changes to the coding of chronic conditions for 11th Edition.

Steps to help - #4

4. Does the condition/symptom have an ACS with specific criteria that is met?

If yes, code it

If no, do not code it

Example:

➢ **Difficult intubation, ACS 1924**

Step 4:
Does the condition/symptom have an ACS with specific criteria that is met?

If yes, code it
If no, do not code it

An example, could be difficult intubation.
Might get through all steps of meeting ACS 0002 and Vic 0002, but then fail the criteria, for example, not have the Mallampatti score documented for a difficult intubation (in which case, can't code it)

Steps to help – summary

1. **Is it a condition/symptom/status that is always coded as per a specialty ACS or another ACS instruction?**
2. **Does the condition/symptom meet ACS 0002?**
3. **Does the condition/symptom meet the criteria for significance in Vic 0002?**
4. **Does the condition/symptom have an ACS with specific criteria that is met?**

Flow chart
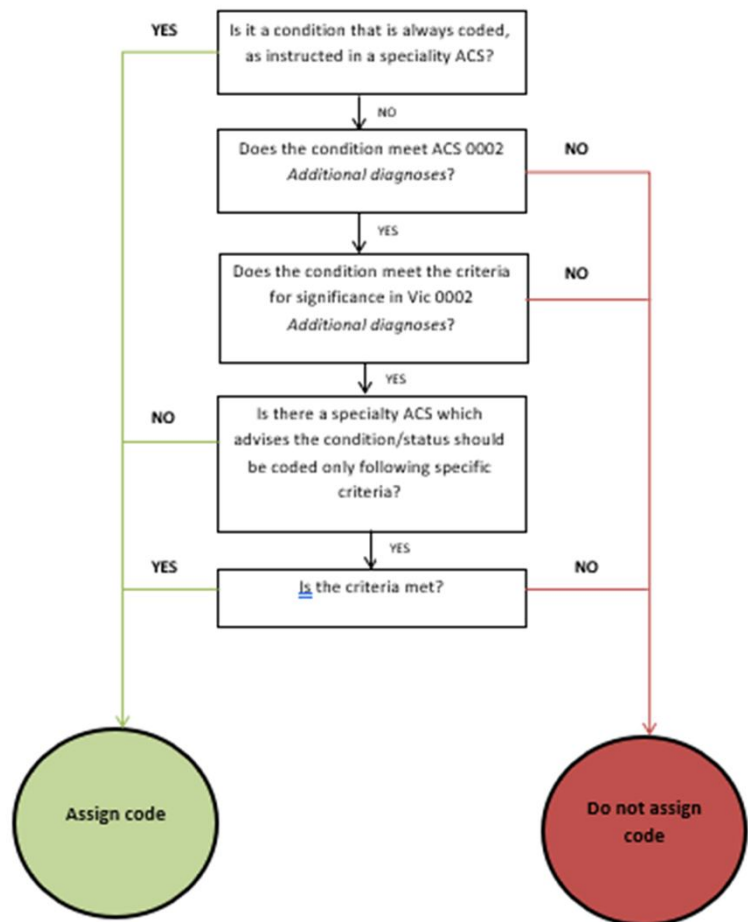
The Flow chart for ACS and Vic 0002 may also assist with explaining the interaction between ACS 0002 and Vic 0002 and stepping through the decisions.

The flow chart was emailed to all coder contacts by DHHS on 2 November 2017 but is also on the website in the Feature articles section.

Documentation queries re significance

Vic 0002 states:

"A documented symptom or condition that does not meet any of the requirements for significance outlined in this standard should not be the subject of a documentation query"

Means:

Don't query the clinician to obtain documentation that the type of care delivered is significant when there is no basis in the record to support clinical significance

Vic 0002 contains the statement: "A documented symptom or condition that does not meet any of the requirements for significance outlined in this standard should not be the subject of a documentation query".

This is like the Vic queries re IV complications or wound ooze, that also stated that you can't ask the clinician if, for example, icing the wound is significant because icing the wound was on the list of actions that were not considered to be significant.

Documentation queries

It is appropriate to query:

Treatment documented in progress notes but not linked to a diagnosis

Example: Dr writes "for iron infusion" in progress notes

Query reason for iron infusion

Further specificity

Example: anaemia meeting criteria for coding

Query type of anaemia

It is appropriate to query where treatment is documented in progress notes but not linked to a diagnosis
Example: Dr writes "for iron infusion" in progress notes, iron infusion given.
It is OK to query the reason for the iron infusion.

It is also appropriate to query for further specificity
Example: anaemia meeting criteria for coding
It is OK to query the type of anaemia, for example, to query blood loss anaemia if there is some evidence of blood loss.

Make a decision

If confident that there is sufficient documentation to support "significance", assign a code

If not sure, but there is evidence, consider a query

"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"
(VICC feature article, Application of Vic 0002, 4/10/17)

  ➢ i.e. if in doubt, leave it out

In summary, make a decision – that is what coders do all the time. How significant was this condition to this episode of care? Did it create a significant burden to the staff?

Many coding issues are because the documentation is not sufficient for coding purposes – querying conditions should assist.

Note that the Application of Vic 0002 document states "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" – i.e "if in doubt, leave it out", but if there is evidence, it is OK to query to clarify a condition.

If your episode is checked or audited by another coder and it is found that you have or haven't coded according to Vic 0002, use the opportunity to discuss with the other coder to find out what documentation they have used to make their decision. Don't fear any check/audit; it should be a learning process and a collaboration to get the data right.

Questions/comments/concerns?