Victorian Additions to the Australian Coding Standards

Effective 1 July 2018

The following are the Victorian Additions to Australian Coding Standards, effective 1 July 2018 (supplementing Australian Coding Standards, Tenth Edition). These must be applied for separations on and after 1 July 2018.

Note that the Australian Coding Standards still apply and that the Victorian Additions are intended to provide further information and guidance where necessary.

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 2018-19:

Vic 0002 *Additional diagnoses*

There are no changes to the intent of Vic 0002 *Additional diagnoses*. Changes in wording are for clarification only.

Vic 0002 *Additional diagnoses* has been updated to incorporate the change to point 3a and creation of point 3c in line with the materials that were presented at the Vic 0002 *Additional diagnoses* education workshops.

The words 'and point 3' have been added to the first dot point 'Documentation of a plan of care for the condition (see point 1)'

The Vic 0002 education workshop slides and Q&A document both remain valid for separations on or after 1 July 2018. They can be found at https://bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/education

Summary of Victorian Additions for 2017-18

Vic 0002	***Additional diagnoses***
Vic 0048	***Condition onset flag***
Vic 0029	***Coding of contracted procedures***
Vic 0233	***Morphology***
Vic 2001	***External cause code use, sequencing and flagging***

Vic 0002 Additional diagnoses

Vic 0002 provides guidance to determine whether a condition is significant and therefore meets criteria for coding as per ACS 0002 Additional diagnoses. It is in keeping with the stated intent of ACS 0002 Additional diagnoses which says that:

- *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* (emphasis added) *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*

For classification purposes, a condition must be significant in order for a code to be assigned. Conditions are significant when at least one of the following is present in the clinical notes in the current episode of care.

- Documentation of a plan of care for the condition (see point 1 and point 3)
- Documentation that the condition delayed discharge
- Documentation that the condition required a diagnostic procedure (see point 2)
- Documentation of variation from a documented treatment plan in response to a change in the patient's condition
- Documentation by a treating clinician of greater than routine care (see point 3).

1. Commencement, alteration or adjustment of therapeutic treatment is significant when one of the following occurs:

    a) The treatment plan is commenced for a newly diagnosed condition following clinical consultation and documentation
    b) The treatment plan for a pre-existing condition is altered following clinical consultation and documentation
    c) A second health professional is engaged in determining the clinical care resulting in a documented change of treatment plan/management for the patient.

    Conditions resulting in nurse initiated administration of medications/drugs are not considered to be significant unless 1a), 1b) or 1c) above is met.

    Examples include but are not limited to:

- Administration of pain relief for a headache or sore shoulder
- Application of cream for nappy rash
- Administration of coloxyl and senna for constipation.

2. Diagnostic procedures can be used to justify code assignment only when:

   a) The procedure is being performed as a result of clinical documentation of a symptom or condition that needs to be investigated; or
   b) The patient receives ongoing treatment for the symptom or condition, even when a definitive diagnosis could not be made.

3. Increased clinical care and/or monitoring is more than what would be routinely provided in the care and management of the condition. This would occur when:

   a) A second health professional is engaged in determining the clinical care resulting in a documented treatment plan /management for the condition. This includes when the plan resulting from the review by the second health professional is 'no change to current treatment'.

   b) The intention to provide increased monitoring of a condition is documented by a treating clinician. For example, the presence of regular blood tests in pathology results does not represent increased monitoring unless specifically documented as such.

   c) A treatment plan for a pre-existing condition is documented and carried out. For example, a documented plan of care for a pre-existing pressure injury; formulation of a plan of care to provide increased monitoring of a dementia patient who is frequently wandering from the ward.

Assignment of a code for the condition would not be justified when the condition receives routine care; examples of routine care include but are not limited to:

- Replacement of IV catheters that have fallen out or regular re-siting of IV catheters
- Continuation of patients regular medication (even if administered by nursing staff instead of the patient)
- Advice given to the patient to purchase medication to manage a condition e.g. apply Zovirax for a cold sore
- Changing pads in a patient with known urinary incontinence
- Advice provided to the patient to drink more fluids as slightly hypotensive.

Documentation queries

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.

Issued 1 July 2017. Updated October 2017. Updated 1 July 2018.

Vic 0048 Condition Onset Flag

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

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

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

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

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

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

- P – Primary condition
- C – Complicating condition occurring after admission
- M – Morphology

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

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

Do not confuse:

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

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**	**M - Morphology**
Principal diagnosis ACS 0001	✓	Only for neonates in the birth episode*	X
Additional diagnoses ACS 0002	✓	✓	X
Morphology code	X	X	✓
Procedure codes	X	X	X

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

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

C – Complicating condition

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

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

Z codes relating to postpartum care (Z39.0-) may be flagged with a C prefix in episodes where a patient is transferred from hospital A to hospital B for delivery and returns to hospital A postpartum on the same day.

There can be more than one code flagged with the C Prefix.

The Victorian prefix P (primary) is mapped to the condition onset flag 2 (Condition not noted as arising during the episode of admitted patient care).

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. The underlying disease (not treated) of a condition which was treated
- 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
- Supplementary codes for chronic conditions (U78 – U88)

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

Z codes relating to postpartum care (Z39.0-) are considered primary codes and must be prefixed with a P prefix with the exception of the scenario described above.

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

- 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

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 a P prefix.

Example 4

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

Example 5

A child who was admitted for dental treatment (rather than being treated as a non-admitted patient) because they were autistic would be assigned a code for the autism and it would be flagged with a P prefix.

Example 6

A patient with COPD who has a spinal anaesthetic rather than a general anaesthetic because of the COPD would be assigned a code for the COPD and it would be flagged with a P prefix.

Example 7

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 a P prefix.

Example 8

A baby born at 38 weeks who develops jaundice on day 2 and requires phototherapy for 2 days would be assigned a code for the neonatal jaundice as principal diagnosis and it would be flagged with a C prefix.

Example 9

A patient who is admitted with a stage I pressure ulcer on the buttock which progresses to stage II on day three would have L89.15 Pressure injury, stage II, ischium assigned and it would be flagged with a P prefix

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

M – Morphology

Flag morphology codes with a M prefix (to distinguish these from musculoskeletal codes). The M prefix is optional for data entry but must be applied to morphology codes for transmission to PRS/2.

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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.

Contract procedure flag - METeOR definition states:

> *'*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 & Human Services, Data element 'Procedure Codes', Section 3, *VAED Manual* 27th 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.

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