

Vic 0002 Additional Diagnoses education workshops

The Vic 0002 education workshops held on 19, 20, 21 December 2017 and 16, 17 and 23 January 2018 support the application of the Victorian Addition to Australian Coding Standard Vic 0002 *Additional diagnoses* effective for separations on or after 1 July 2017. As such, the information contained in this document is also applicable effective for separations on or after 1 July 2017. However there is no expectation that health services and hospitals retrospectively amend their data.

This document contains the key messages from the education workshops and answers to questions taken on notice at the workshops. This document should be read in conjunction with the education slides. It is important to note that the frequently asked questions have tried to capture the information discussed at the workshops but clinical coders also need to be guided by the spirit by which Vic 0002 has been developed, which is to reaffirm the concept of clinical significance when determining the assignment of additional diagnoses.

Key Messages

Data integrity

Vic 0002 was developed to reaffirm the principles of quality in the coded data; it was not developed to address a funding issue. The funding issue was addressed by funding model development and will be reviewed annually.

Vic 0002 seeks to increase confidence in the data by:

- Providing clear guidelines for coders to determine when a condition is considered to be clinically significant
- Providing a tool to help coders resist unrealistic expectations to assign codes for non-clinically significant conditions.

The end users of the data rely on the data being reliable, reproducible through the applicability of clear standards, accurate, complete and representative of the clinical truth as it applies to individual patients. Both public and private hospital data are used by the Department of Health and Human Services, the Victorian Agency for Health Information, Safer Care Victoria and national bodies.

It is important that coders assign codes for those conditions that are clinically significant as represented by the documentation in the record and that clarification of documentation should only occur where it is obvious that a condition exists. Retrofitting the documentation to justify coding of a condition that does not really exist is unethical and further destroys confidence in the data.

In terms of making a decision, coders need to be confident to make a decision that there is sufficient documentation to justify the coding or not. When there is not enough documentation it is correct to not assign a code – coders should not feel obliged to always find a way to assign a code just because it results in a better DRG/funding outcome.

Funding outcomes

It has been known for a long time that coders are under increasing pressure to achieve maximum funding outcomes and the recent events have made it obvious that this pressure impacts on the data quality dimensions mentioned above.

While clinical coders should provide optimal DRG outcomes for their organisation, they are not responsible for the financial viability of the organisation for which they work. By providing coded data that is accurate, complete and reliable and not skewed towards a funding outcome they will support all the work of their organisations and the jurisdictions to which their organisations report.

Private hospital applicability

Private hospital data is also used for multiple purposes and by multiple end users. From the data integrity point of view there is no difference in the significance of the data from private or public organisations. In Victoria, private hospitals are registered contingent upon them, among other things, reporting to the Department of Health and Human Services in accordance with specifications outlined by the department, and to that end, Vic 0002 applies equally to the private sector as to the public sector.

Questions and answers

Incontinence questions	
<p>1. Nurses will say that the care provided for these patients is beyond routine care. That is, it is care provided for these patients that is not provided for all patients. How do we identify/define significance for incontinence?</p> <p>2. Patient incontinent. Needed to take a urinary specimen to check for UTI. Unable to do so. Eventually a catheter was inserted to enable specimen to be collected. Does incontinence meet criteria for coding in Vic 0002?</p> <p>3. ACS 1808 provides a definition of clinically significant incontinence. Vic 0002 overrides this definition – is this correct? Why can't the specialty standard be followed?</p> <p>4. If doctor documents 'change pads every two hours' does this justify coding under Vic 0002?</p> <p>5. Incontinent patient reviewed by Occupational Therapist and a plan of care documented. Can the incontinence be coded?</p> <p>6. Smaller hospitals don't have access to specialist staff such as the allied health professional in the previous example. If the nursing staff assess the incontinence pads in terms of suitability for the patient, is this sufficient to meet Vic 0002?</p> <p>7. If a bladder scan is ordered for the patient would that meet criteria for coding?</p> <p>8. What if the bladder scan was ordered by a nurse? Does the incontinence still meet criteria for coding?</p> <p>9. Does Vic 0002 criteria need to be met as well as ACS 1808 Incontinence criteria?</p> <p>10. If incontinence is documented on a pathway can it be coded?</p> <p>11. What if the incontinence is present at discharge? Can it be coded as per ACS 1808?</p> <p>12. Patient with urinary incontinence. Indwelling catheter inserted on admission. Can the incontinence be coded?</p>	<p>Conditions which are managed through general nursing care do not meet the criteria for clinical significance outlined in Vic 0002. Therefore the routine changing of pads for an incontinent patient and the selection of a particular type of pads for the patient would not be considered clinically significant.</p> <p>In order to be coded based on the criteria of increased clinical care/management; a condition must have a documented plan of care or management. The fact that incontinence is documented on a clinical pathway does not represent a plan of care and would not justify coding.</p> <p>Interventions/documentation that would indicate clinical significance include:</p> <ul style="list-style-type: none"> • a urinary specimen was ordered or a bladder scan performed to investigate the incontinence i.e. a diagnostic procedure was performed • an indwelling catheter was inserted to manage incontinence • a continence nurse formulates a plan to manage a patient's incontinence • in health services where no continence nurse exists, a general nurse acting in that capacity formulates and documents a plan to manage the incontinence <p>ACS 1808 provides advice on the coding of incontinence which indicates that clinical significance is when incontinence is persistent prior to admission, is present at discharge or persists for at least 7 days. However these criteria cannot be applied until the condition first meets criteria in Vic 0002:</p> <ul style="list-style-type: none"> • See Vic 0002 flow chart provided on the HDSS web page (feature articles) • See Coding Rules TN1248 which advises that general standards must be applied before specialty standards

Dementia questions

<ol style="list-style-type: none"> 1. Nurses will say that the care provided for dementia patients is beyond routine care. That is, it is care provided for these patients that is not provided for all patients. How do we identify/define significance for these conditions? 2. Patient with dementia. Understand that if the patient is wandering and needs to be re-directed the dementia does not meet Vic 0002. What if the patient absconds? Can the dementia be coded then? 3. Some hospitals provide a 'sitter' for some of their dementia patients. Would this represent clinical significance? 4. Dementia patient admitted the day before colonoscopy because won't drink the preparation at home – can the dementia be coded? 	<p>Conditions which are managed through general nursing care do not meet the criteria for clinical significance outlined in Vic 0002. Therefore general management of a patient with dementia would not normally meet criteria for coding under Vic 0002. General management might include redirecting a patient who has wandered into the incorrect ward, assisting a patient with meals etc.</p> <p>Interventions/documentation that would indicate clinical significance include:</p> <ul style="list-style-type: none"> • The patient has absconded and staff are deployed to find the patient • The patient is in the habit of wandering extensively and a plan is formulated and documented for 'frequent checks' on the patient • A 'sitter' is allocated to stay with the patient • The protocol for management of another condition is changed because the patient has dementia; for example, early admission in preparation for procedure, anaesthetic when one would not normally be required.
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Pressure injury questions

<ol style="list-style-type: none"> 1. Patient with pressure areas. Wound Specialist attention/wound chart etc. would justify coding. What if the hospital doesn't have a wound specialist – how would the pressure area ever meet Vic 0002? 2. Wound chart with regular monitoring documented. Is this enough to justify coding? Further discussion elicited that in some hospitals the establishment of a wound chart represents a different level of care for a pressure area i.e. only established when the pressure area is clinically significant; in other hospitals a wound chart is routinely established for all patients with a wound 3. Pressure area. If the dressing type is changed, does this represent clinical significance? 4. Small pressure areas would normally be coded and the nurse would also report this in the incident system. Why would they not be coded? 5. Why does the provision of an air mattress not meet Vic 0002 (slide 31)? 6. Does a wound chart represent a plan of care? 	<p>Conditions which are managed through general nursing care do not meet the criteria for clinical significance outlined in Vic 0002. Therefore if the nurse orders a pressure mattress/device or dresses a pressure injury this would be considered routine nursing care and does not justify the coding of pressure injury.</p> <p>Preventative care also does not justify the coding of a condition. Therefore if the management of a reddened area of skin to prevent the development of a pressure injury is undertaken, this would not justify the coding of pressure injury.</p> <p>However if there is a documented pressure injury, interventions/documentation that would indicate clinical significance include:</p> <ul style="list-style-type: none"> • A documented plan of care to support the management of the pressure injury, e.g. a regime of regular dressings • Referral to a wound specialist with a documented plan of care for the pressure injury • Documentation of discussion with a second nurse regarding management of the pressure injury with a documented plan of care • Application of vacuum dressing or other specialised dressing/device, not previously required for the pressure injury, to replace a conventional dressing.
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<p>7. What if the number or frequency of dressings changes – would this represent clinical significance?</p> <p>8. What would a plan of care on a wound management chart look like?</p> <p>9. Does management of a pressure ulcer meet point 3 i.e. increased clinical care and or monitoring?</p>	<p>A documented plan may be in the progress notes or on a wound management chart.</p> <p>A wound chart may also be routinely established for all potential wounds and coders therefore need to be confident that a plan exists on the chart for the management of the pressure injury.</p> <p>In health services where no wound specialist exists, a general nurse acting in that capacity formulates and documents a plan to manage the pressure injury.</p>
<p>Other additional diagnoses questions</p>	
<p>1. When Warfarin, administered for management of AF is ceased prior to surgery, does the AF meet criteria for coding under Vic 0002 point 1b i.e. the treatment plan for a pre-existing condition is altered?</p>	<p>The temporary cessation of a medication to allow surgery to be performed does not meet the criteria in Coding Rules Q2897 and Q3017, nor in Vic 0002. The Application of Vic 0002 document states that 'medication is ceased so the patient can have surgery' is an example of routine care.</p> <p>Also note the following question and answer where the Warfarin was adjusted and monitored.</p>
<p>2. Question raised at the ACCD/NCCH conference about Warfarin being ceased pre-surgery. NCCH comment was that the condition (AF in the case) should be coded. How does this fit with Vic 0002?</p>	<p>The example and response at the HIMAA/NCCH Conference was published in the ACCD Newsletter, December 2017:</p> <p>Question 5: Adjustment of warfarin in a patient with AF, why do we code the AF? If warfarin (for AF) is adjusted pre and post-surgery and monitored. Do we code AF?</p> <p>ACCD Response: Where a patient is on a specified medication as a result of having a clinical condition, and that specified medication has been altered during an episode of care, the clinical condition should be coded, as per the criteria in ACS 0002 <i>Additional diagnoses</i>; specifically dot point 1, 'commencement, alteration or adjustment of therapeutic treatment'.</p> <p>The concept of 'therapeutic treatment' does not mean that the condition is necessarily treated by the specified medication; the specified medication may be required to negate a manifestation or associated condition. Specific examples include the use of warfarin and aspirin in patients with atrial fibrillation.</p> <p>See also Coding Rule: ACS 0002 <i>Additional diagnoses and alteration to treatment</i> (published June 2015).</p> <p>NB. This example states the Warfarin was adjusted and monitored.</p> <p>As there is specific ACCD advice about the adjustment and management of warfarin, coders are instructed to follow the ACCD advice. This is consistent with the Vic 0002 education slides.</p>

<p>3. Patient with stent inserted for kidney stone; biochemistry results noted in record which would indicate acute kidney injury (AKI) but AKI not documented; entry in record 'kidney function improved post stent insertion'. Does this represent an additional set of observations and therefore would also represent 'increased monitoring' to code AKI?</p>	<p>The documentation of 'kidney function improved post insertion' appears to be an observation based on routine assessment after the stent insertion rather than indicative of increased monitoring.</p> <p>However, if there was documentation that the biochemistry tests were taken to assess the patient's kidney function and a diagnosis of AKI was documented as a result, this would meet Vic 0002, diagnostic procedure performed.</p>
<p>4. Patient presents with toxicity post chemotherapy for neoplasm. CT result = disease progression. Patient notes = Disease progression, cease chemotherapy. Can the neoplasm be coded because increased monitoring has taken place?</p>	<p>An investigation has been undertaken with respect to the neoplasm and a management plan documented. So yes the neoplasm can be coded.</p>
<p>5. Slide 21 (re 'new medication on medication chart but no documented condition in a treatment plan'). Patient with AF on aspirin. Doctor wanted to start Clexane but patient has lung metastases which contraindicate for Clexane. Can the lung metastases be coded?</p>	<p>Yes lung metastases can be coded because that is the condition that contraindicated the use of Clexane as per VIC #3224. In other words, the lung metastases are significant in the management of this patient</p>
<p>6. Slide 21. Drug A first choice for treatment of patient but drug B prescribed because of co-morbidities. Can the co-morbidities be coded?</p>	<p>Yes, the specific co-morbidities documented as the reason for the need to choose a different drug can be coded because they are documented as the reason for a change of treatment, i.e. they are significant in the management of the patient</p>
<p>7. Patient documentation says 'no further care required' following assessment of a suspected condition. Does the condition meet Vic 0002 criteria for coding?</p>	<p>Yes, the suspected condition can be coded as the patient has been assessed and a documented plan exists for the management of the patient's suspected condition. NB. The suspected condition must also meet the criteria in ACS 0012 Suspected condition.</p>
<p>8. Oxygen therapy provided by a nurse following decreased oxygen saturations noted – does this meet Vic 0002 criteria for coding?</p>	<p>The decreased saturations are noted and a nurse provides oxygen. At this point this is only an action and possibly routine nursing care. If a plan is documented for ongoing oxygen, then the decreased saturations can be coded</p>
<p>9. Patient with a pre-existing diagnosis of Schizophrenia. The relapse is described as 'due to drug use'. Can drug use be coded as the underlying cause?</p>	<p>If the documentation describes a condition as having an underlying cause, then the underlying cause can be coded in accordance with that part of ACS 0002 – Vic 0002 does not apply to the coding of underlying conditions</p>
<p>10. Patient with PTSD 'on a background' of psycho-social issue(s). Can the psychosocial issue be coded?</p>	<p>See VICC #3207 and #3210 about 'on a background of' which states that this is not the same as 'underlying cause'.</p> <p>The psychosocial issue must be documented as the underlying cause of the PTSD before it can be coded under ACS 0002 – Vic 0002 does not apply to the coding of underlying conditions, but</p>

	the condition, e.g. PTSD, must meet ACS/Vic 0002.
11. Patient admitted with eating disorder and has documented metabolic disturbance (dehydration, hypo-osmolality, hyponatraemia etc.). Treated with fluid replacement which treats all the metabolic issues. Can the metabolic disturbances be coded?	<p>The eating disorder may be the 'diagnosis after study' and in that case the metabolic disturbances would not be coded unless they were important conditions in their own right (as per the Note at Chapter 18 of ICD-10-AM) and met Vic 0002 criteria, such as if there is a treatment plan specifically addressing the metabolic disturbances.</p> <p>As the treatment for the eating disorder is likely to be mental health treatment rather than medical treatment, it is likely that the metabolic disorders are being specifically addressed by the fluid replacement. But there must be documentation to support this.</p>
12. Three conditions documented for the patient and underneath is a note that represents a treatment plan but nothing linking this to one or other or all of the conditions. Can they be coded?	<p>Where the conditions and the treatment plan are documented in the same note in the record then the conditions can be coded. For example, the conditions of 'pneumonia, acute kidney injury and oesophagitis' are documented with a treatment plan in the same note as 'for antibiotics, IV fluids and repeat eGFR, and start Pantoprazole' – in this case, pneumonia, acute kidney injury and oesophagitis can be coded.</p> <p>However, this would not apply to a finding, observation etc. that is just documented within the note. For example, 'seen by physio post-op lap chole, observations normal, CXR – atelectasis, patient feels well, plan: mobilise, DB&C'. As per ACS 0010, the significance of the CXR result and relationship between the result and a condition has not been demonstrated, so atelectasis cannot be coded - in this case, this may be routine post-op physio rather than physio for the atelectasis.</p>
13. How do coders understand what is 'standard treatment protocol'?	Be guided by documentation. The coder doesn't need to know what is standard but documentation that indicates that the protocol needed to be adjusted would indicate that the standard or preferred protocol could not be followed.
14. Tobacco dependence assessment form completed by Pharmacist. Is this enough to code tobacco dependence?	<p>Tobacco dependence coding is subject to ACS 0503 which says that tobacco use is always coded when documented (see step one of flow chart).</p> <p>The completion of a tobacco dependence assessment form does not represent documentation of dependence. See also Coding Rules Q3204 (Dec 2017) Nicotine dependence tests.</p> <p>Coders need to be confident that tobacco dependence has been documented as a diagnosis before dependence can be coded.</p>

<p>15. Patient with DRAM documented by Physiotherapy post-delivery. Exercises to be completed at home documented. Is this a plan that justifies coding of DRAM?</p>	<p>Physiotherapy attention is often provided routinely post-delivery, e.g. in a post-natal check, and DRAM will often be documented.</p> <p>In order to code DRAM, the exercise regime needs to be clearly linked to treatment of DRAM rather than being a general regime for recovery post-delivery.</p>
<p>16. When a nurse goes to a HITH patient's home to change a VAC dressing and documents 'necrosis debrided', does this represent general nursing care and would therefore not allow the coding of 'necrosis' or does it represent a plan of care?</p>	<p>If a patient has a VAC dressing then the patient must have a significant wound which is likely to have necrotic tissue. VAC dressings have a debriding action so the necrotic tissue would also likely be routinely debrided as part of the dressing of the wound.</p> <p>However, if documentation exists of 'necrosis debrided', and this is not documented as part of the dressing itself, then this treatment would represent clinical significance of the necrosis.</p>
<p>17. Coding Rules Q2897 (Sept 2015) deals with adjustment of medication. If a patient on regular medication for hypertension presents with septic shock and is therefore hypotensive, and the hypertension medication is ceased for a period of time, can the hypertension be coded? That is, does the adjustment of medication have to be a permanent adjustment or can a temporary adjustment such as in this scenario, justify coding under Vic 0002?</p>	<p>Adjustment of medication does not have to be a permanent adjustment in order for it to be used to justify code assignment. In the scenario cited a code for the hypertension can be assigned</p>
<p>18. Slide 26 re conditions may meet Vic 0002 when documentation states the condition requires 'full nursing care'... What is meant by full nursing care? How would a coder differentiate between full nursing care and general nursing care?</p>	<p>General nursing care is the care provided routinely to patients – administration of medication, checking of vital signs, dressing of surgical wounds, assistance with mobilisation, etc.</p> <p>Full nursing care is where the patient requires assistance with all facets of their care throughout the day, i.e. assistance with all mobility, toileting, and activities of daily living.</p> <p>Full nursing care would be documented as part of a plan of care.</p>
<p>19. Slide 29 re cerebral palsy patient admitted with pancreatitis. With respect to the physio's notes, is the first paragraph ("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") sufficient to justify coding?</p>	<p>It is acknowledged that a cut down version of the notes was used in the slide.</p> <p>The point is that the coder needs to be confident that a second health professional has been engaged in the patient's care for a particular condition. When this has happened, and there is a plan of care documented, the condition can be coded.</p>
<p>20. Slide 29 re cerebral palsy patient admitted with pancreatitis and is referred to physiotherapist for assessment of cerebral</p>	<p>The documentation needs to link the physiotherapist referral to the cerebral palsy. When this is done the cerebral palsy has been</p>

palsy. Can the cerebral palsy be coded?	subjected to a second health professional being involved in the management of the condition, and if there is also a documented plan of care, it then meets criteria for coding in Vic 0002
21. When observations are changed from every 60 minutes to every 30 minutes, for example, would this be increased clinical care? Example, for a dementia patient, normal observations would be every 60 minutes but may be changed to every 30 for a particular patient.	Departures from normal protocol represent increased clinical care but must be documented as a plan in order for the condition to be coded.
22. Can Jittery baby be coded when there is documentation of 'abstinence syndrome' and also documentation of 'monitor jitteriness'?	Jitteriness is a common symptom of abstinence syndrome in a neonate and would not be coded in addition to abstinence syndrome unless it was an important condition in its own right (as per the Note at Chapter 18 of ICD-10-AM) and met Vic 0002 criteria.
23. Patient with chronic/general medical condition such as COPD also has cancer. If oncologist reviews the patient and documents 'no change to the current treatment' can the cancer be coded?	The cancer has been reviewed by a second health professional and a plan has been documented albeit a 'no change to current treatment'. Therefore the cancer can be coded.
24. With respect to nurse initiated medication; if a midwife initiates medication, can the condition be coded?	If the condition is appropriate to the midwife's discipline, e.g. obstetrics, then yes a midwife initiated medication can be coded because the nurse is a specialist nurse. For example, for a patient with PPH requiring midwife-initiated Ergometrine, the PPH meets Vic 0002 criteria and should be coded. However, there is no requirement, nor would it be in the spirit of ACS/Vic 0002, to assign a code for midwife-initiated Panadol for pain or for midwife-initiated Ural for dysuria post-delivery where there is no plan of care, investigation etc.
25. Can PPH that just needs to be monitored, be coded?	If a plan is documented for management of a condition it can be coded. Therefore if PPH is documented and the plan of care is documented as 'monitor the PPH' then it can be coded. If there is no plan documented, then the PPH cannot be coded as it is not considered significant if it does not need specific ongoing attention.
26. Incidental findings: If a second health professional reviews the patient and documents a plan to review in outpatients, can the condition be coded. Examples are incidental finding of hernia, incidental finding of PFO in a child	If a second health professional reviews a specific condition and documents a plan of care, then this condition is not an incidental finding and would meet Vic 0002. If during the review of another condition, the second health professional notes an incidental finding and documents that the condition is only for review post-discharge, then this is an incidental finding. In this case, ACS 0002 <i>Incidental findings and conditions</i> needs to be followed first as per the Flow Chart and Coding Rules TN1248 Mutual exclusivity, and the incidental finding would not meet ACS 0002 and

	then cannot meet Vic 0002.
27. If a plan is documented to change the medication for a condition but the patient goes home before the change can be implemented, can the condition be coded?	<p>Changes to medication can be used to justify coding in circumstances such as:</p> <ul style="list-style-type: none"> • Patient gone home before plan actioned • Patient has a contraindication for the medication (see VICC #3224) • Patient refuses treatment (see VICC #3224) <p>However in circumstances where the medication is ordered for PRN administration and it is never administered the condition should not be coded, unless other aspects of Vic 0002 are met.</p>
28. If a doctor documents 'daily changes' for a dressing, can the wound be coded?	<p>If this documentation follows review of the wound by a doctor and the documentation represents a treatment plan, then the wound can be coded, for example, an open (traumatic) wound. If this was an uncomplicated surgical wound requiring dressings, there would be no condition to be coded.</p> <p>See also the Pressure injury section above if the wound is a pressure injury.</p>
29. If a doctor documents 'continue current treatment', can the condition be coded?	<p>This depends on the circumstance of the doctor's review, for example, if this was of a condition documented during a clinical assessment (as per <i>Assessments</i> section of ACS 0002), then the condition would not be coded.</p> <p>But if the doctor reviews a patient's condition and documents 'continue current treatment', a treatment plan has been documented. Therefore the condition can be coded.</p>
30. Patient with acquired head injury presents with epilepsy and has ongoing seizures. The physiotherapist adjusts the patient's helmet to prevent injury. Can the acquired head injury be coded??	<p>If the documentation describes a condition as having an underlying cause, then the underlying cause can be coded in accordance with that part of ACS 0002 – Vic 0002 does not apply to the coding of underlying conditions. In this example, no link between the acquired head injury and epilepsy is stated.</p> <p>The physiotherapist being a second health professional with a documented plan of care may support the coding of the acquired head injury.</p>
31. Patient with increased suicidal ideation and depression due to past history of sexual abuse. Can the sexual abuse be coded?	<p>If the documentation describes a condition as having an underlying cause, then the underlying cause can be coded in accordance with that part of ACS 0002 – Vic 0002 does not apply to the coding of underlying conditions.</p> <p>Personal history is not routinely coded as per ACS 2112 Personal history.</p>
32. A paraplegic patient following a motor car accident 10 years ago; 2 nurses required to move the patient. Does this represent clinical significance?	<p>Routine nursing care would involve a nurse assisting or turning a patient to prevent pressure areas developing, for example. The paraplegia would not meet Vic 0002 if the only documentation was that two nurses moved the</p>

	<p>patient, however if there was documentation of a plan of care for the paraplegia, i.e. that the patient requires two nurses for all assists this would meet Vic 0002.</p>
<p>33. Paraplegic patient requiring full hoist to assist with movement. Can paraplegia be coded?</p>	<p>If management of the patient's condition is documented as requiring the use of significant special equipment, such as the use of lifting devices, then the condition requiring that equipment can be coded. (Slide 26) Significant special equipment would not include equipment such as a wheelchair, shower chair or equipment to assist the patient to get dressed.</p>
<p>34. Quadriplegic and paraplegic – when do these conditions meet Vic 0002? Should coders look for physiotherapy notes?</p>	<p>If significant specialist equipment (e.g. hoists) are required and documented for the quadriplegia or paraplegia, this meets Vic 0002 criteria.</p> <p>If additional staff are required to manage the patient or a physiotherapist is involved, this may represent significance. The coder needs to look for documentation of a plan of care for the condition. This means that quadriplegia and paraplegia would not necessarily be coded in every applicable patient as it is dependent on the documentation.</p>
<p>35. Can an admission form completed by the nurse at the time of the patient's admission be used as part of the evidence for justifying code assignment?</p>	<p>Yes, the nurse's admission form forms part of the admission notes for the episode of care and can be used for coding purposes.</p>
<p>36. Can the patient completed pre-admission form be used for coding purposes?</p>	<p>With the exception of smoking status, any information contained in this form needs to be confirmed in patient episode notes (see also VICC #3230, Dec 2017).</p>
<p>37. A patient with diabetes: the nursing notes list retinopathy and other complications of the diabetes. Can these be coded?</p>	<p>Follow ACS 0401 to assign 'diabetes, with' codes, e.g. diabetes with retinopathy. Codes for the conditions themselves can only be assigned when they meet the criteria in Vic 0002. See also Coding Rules TN428 (June 2012).</p>
<p>38. A patient admitted for repair of hernia requires ICU admission because of co-morbidities. Do the co-morbidities meet criteria for coding under Vic 0002?</p>	<p>Yes, the co-morbidities can be coded because they are the reason for admission to ICU (see Slide 25).</p>
<p>39. Cystocele and rectocele are noted on hysteroscopy performed for investigation of PV bleed. Can they be coded?</p>	<p>If this is a same day or intended same day episode, follow same day endoscopy standards (ACS 0051 and 0052) to assign codes for these incidental findings.</p> <p>If this is not a same day or intended same day episode, the cystocele and rectocele would need to meet Vic 0002 criteria to be coded. Codes cannot be routinely assigned for findings.</p>
<p>40. Can you code an ulcer if the patient has diabetes?</p>	<p>Follow ACS 0401 to assign 'diabetes, with' codes, e.g. diabetes with ulcer. Codes for the conditions themselves can only be assigned</p>

	when they meet the criteria in Vic 0002.
41. Can a condition which caused delayed discharge/increased length of stay be coded?	<p>A condition that causes delayed discharge or increased length of stay would normally be significant.</p> <p>However it is important that documentation exists to link the condition with the delayed discharge/increased length of stay. Documentation such as 'delay discharge until xxx condition has improved...' would represent a treatment or management/care plan.</p>
42. Patient transferred from one hospital to another and treatment continued for a condition i.e. no change of treatment. Can the condition be coded (when it is not the principal diagnosis)?	<p>If the condition is assessed and documentation of 'continue current treatment' is provided then this represents a plan and the condition can be coded.</p> <p>However if medication is continued and administered as per routine nursing care, then this condition would not meet criteria in Vic 0002. This also applies to patients within the same health service who change care type, i.e. commence a new episode of care.</p>
43. Patient with Atrial septal defect and Down's Syndrome. Can the Down's Syndrome be coded as an underlying cause?	<p>If the documentation describes a condition as having an underlying cause, then the underlying cause can be coded in accordance with that part of ACS 0002 – Vic 0002 does not apply to the coding of underlying conditions.</p> <p>However if no link is documented between the two conditions coders cannot assume that one is the underlying cause of the other.</p>
44. Documentation of 'please repeat bloods to monitor CKD (chronic kidney disease)'. Can CKD be coded?	Yes, documentation to repeat bloods for monitoring represents a plan of care and the CKD can be coded.
45. Can the Z codes be used to identify issues that trigger exacerbation of mental health conditions, for example, history of abuse?	Conditions (or experiences) that are documented as the underlying cause of a current condition in the patient can be coded in accordance with the underlying condition aspect of ACS 0002 (Vic 0002 does not apply). Otherwise, the issue needs to meet Vic 0002 in its own right.
46. When do interventions during surgery become more than routine care and justify coding as a complication of care?	<p>Many interventions during surgery are routine components of the surgery and care must be taken not to code these as complications of the surgery inappropriately.</p> <p>Coders need to be confident that the documentation in the record represents a clinically significant situation that is easily interpreted as a complication of care before assigning codes for these conditions. When in doubt, a code should not be assigned.</p> <p>A clinician query may be sent but it should be very clear to the clinician as to what will be coded</p>

	as a result of the clinician's response. See also Clinician queries section below.
47. Serosal tears during surgery will be documented in operation notes but coders are confused about whether they should be coded.	If the tears require repair during the surgery, then they would be coded. Otherwise, the coder would need documentation that the tears require a plan of care representing care that is significantly beyond routine care for the surgery (as per ACS 1904).
48. Does alteration of MET call criteria meet Vic 0002 criteria. For example, MET criteria for extremely low or extremely high BP may be altered for a specific patient.	The MET call criteria is generally altered when the patient's normal readings, e.g. for blood pressure, fall outside of the normal MET criteria; this relates to the management of the MET call process rather than to the management of the patient and therefore does not meet Vic 0002.
49. Phone order taken by nurse, documented in progress notes with a diagnosis and plan of care and also documented on the medication chart. However doctor does not sign the medication order as required the next day – does this documentation still stand for coding purposes? Similarly, the doctor may document a medication order but fail to sign it. Can the condition for which the medication is ordered be coded?	The legal requirement for a doctor to sign medication orders is out of scope for coders; if all other aspects are met, i.e. a diagnosis linked to a treatment plan with evidence the medication was given etc. then the condition meets Vic 0002
50. Is a consultation that occurs over the phone considered to be a patient interaction? For example, a doctor is contacted for an opinion/advice/ consult but never actually sees the patient.	Provided the consultation via electronic methods, e.g. video/teleconferencing is documented in the patient's record it can be used for coding purposes. It may be documented by a nurse or another doctor for example.
51. VAED audit advice is to code all interventions during surgery because they represent increased resource use – is this correct?	Resource use, e.g. number of nurses or tests performed, is identified in cost data rather than in the clinical codes. Clinical codes must represent the clinical truth (significance) of the conditions relevant to the episode of care and follow coding conventions and standards, rather than trying to represent all the resources used during the episode of care.
Clinician queries	
1. Regarding documentation queries, is a query that leads to a yes/no answer OK	The ACCD's 'Clarification on the application of the Standards for ethical conduct in clinical coding' released in October 2017 provides five dot points of how clinician queries should be written. The points include that the query should enhance the clinical truth of the documentation, to allow clinicians to elaborate regarding significance and cause, and not to include leading questions. As a result, the question must be worded in such a way that the doctor understands clearly what condition will be coded as a consequence of

	<p>his/her response.</p> <p>The Clarification document also states that in some instances, a yes/no or multiple choice query makes sense, but this must include provision for the clinician to elaborate or add context around the response.</p>
2. Can coders take a result from pathology when you can also see the treatment in order to initiate a clinician query e.g. Slow K and then ask query	Yes this was an example in the ACCD's 'Clarification on the application of the Standards for ethical conduct in clinical coding'. It means that a new medication on a medication chart can be considered clinically significant.
3. When there is a link between treatment and the condition of increased BP in the notes and medication on chart, can clinician be queried for a diagnosis of hypertension?	Yes a query can be raised based on this evidence.
4. Slide 17. In the case of nurse administered Magmin, can a documentation query be raised?	As this was nurse-initiated medication with no evidence of a doctor's involvement, a query cannot be raised to ask if the doctor was involved.
5. Potassium administration documented on a medication chart but patient's potassium levels are within normal range. Can a clinical documentation query be sent?	There needs to be justification that a condition exists before you can send a query; a range reported with normal levels would not be indicative of a condition.
6. Can a clinical documentation query be answered by a doctor who did not treat the patient?	As per VICC #3198 (re difficult intubation), the documentation must be appropriate to the clinician's discipline so the treating clinician is the most appropriate clinician to answer a query. If the treating clinician is not available, it is appropriate to query another clinician provided that clinician is being asked a query appropriate to their discipline e.g. cardiologist for a cardiology query.
7. Can a clinical documentation query be sent to an ANUM to support coding of a condition? For example, if there is a lot of nursing notes about a condition but no actual plan?	<p>If the notes of a dementia patient include, for example, 'check patient each half hour', then this would represent more than general nursing care and would be a plan of management for that patient. Provided dementia was documented as the reason for the plan (in this case, increased checks), the dementia would meet Vic 0002 criteria. If dementia was not documented as the reason, it would be reasonable to query the reason for the plan. If the supporting documentation was appropriate to the clinician's discipline, e.g. the ANUM in relation to the nursing care of a patient with dementia, then an ANUM could answer the query.</p> <p>However, it would not be reasonable to query that this was a plan of care when there is only documentation of actions being taken.</p>
8. Can coders query for specificity of a diagnosis of pneumonia?	Yes, if the pneumonia meets ACS 0001 or Vic 0002 criteria for coding.

<p>9. Patient needs hoist to assist with movement but there is no documentation to say why – what should coders do?</p>	<p>If a patient requires significant use of equipment such as a hoist, a clinician query can be sent to establish a diagnosis.</p>
<p>10. What words can be used to query a clinician about whether bleeding during surgery is significant or if the care required was routine?</p>	<p>Care given for bleeding during surgery may be a routine part of the procedure, for example, tying off bleeders at the end of the procedure.</p> <p>ACS 1904 states that a condition can only be coded as a procedural complication when there is documentation of care or management that is significantly beyond routine care. A documentation query can be sent to the clinician where the coder is not certain that the care was significant for the bleeding.</p> <p>VICC will consider writing an example of a suitable query</p>
<p>11. Patient with multiple diagnoses listed as principal –can the coder query the clinician to determine which one to put first?</p>	<p>ACS 0010 states the coder must first verify the information on the summary against the body of the record.</p> <p>Once the listed diagnoses have been verified as all valid for selection as principal diagnosis, ACS 0001 states to code the first mentioned condition as principal diagnosis. See also VICC #3229.</p> <p>However, further information on querying the clinician when multiple diagnoses are listed and verified will be provided via a VICC query response.</p>

Non-coding questions

<p>1. In the VAED audit there is no opportunity to discuss code changes – only DRG changes. If the code changes are significant, they should be discussed at least at the closing meeting – can methodology be amended to include this discussion?</p>	<p>The VAED audit methodology does allow for any issue of significance to be discussed at the closing meeting. It is assumed that if the issue is significant it would warrant a recommendation and anything that attracts a recommendation must be discussed at the closing meeting. It is not possible to discuss all code changes but the audit data is provided to the hospitals for them to identify any particular code issues (although it is acknowledged that this would not necessarily be easy)</p>
<p>2. How do you distinguish between clinical significance and funding significance?</p>	<p>It is not the coder's responsibility to make a funding based decision. It is important to make an assessment that the DRG outcome (not the dollar outcome) reflects patient complexity, whilst acknowledging that version 8.0 is difficult in this respect; however it is also important that non-clinically significant conditions are not used to achieve this outcome, i.e. coders taking it upon themselves to restore historic levels of A DRG outcomes is not appropriate</p>
<p>3. VAED audits are WIES driven – this results in coding all this rubbish – is this message</p>	<p>VAED audits are to assess the integrity of the data submitted to the VAED. Only DRG changes</p>

<p>getting through to the CEOs? (but surrounded by funding issues).</p>	<p>are discussed due to time constraints.</p> <p>The Vic 0002 education workshops were provided so both coders and CEOs could be confident about additional diagnosis code assignment.</p> <p>The ACCD Standards for ethical conduct in clinical coding also aims to support coders to ensure the integrity of coded clinical data.</p>
<p>4. Will funding systems be taking into account Vic 0002 when looking at HAC funding?</p>	<p>The modelling for HAC funding has not yet begun but Funding Systems will be taking into account data integrity issues and monitoring shifts in code assignment on a regular basis from now on.</p>
<p>5. Coded data is reported nationally. Do other states have audit programs; concern about consistency of data nationally</p>	<p>As per the introduction to the Australian Coding Standards and the ACCD's Standards for ethical conduct in clinical coding, the coding and ethical standards have been developed to ensure the integrity of coded clinical data at a national level.</p> <p>However, there has always been some inconsistency between states and territories but there are escalation procedures for coding committees to follow where a query from one state contradicts that from another state.</p> <p>One of the stated aims of VICC query responses is that they follow the national coding rules / guidelines / conventions, regardless of the outcome. Where VICC is concerned about the code outcome, or where there is no answer within the classification, VICC sends the query to ACCD for a national decision.</p> <p>WA has a similar standard for ACS 0002 which has been in place since 2016.</p> <p>Other states/territories do not have the same level of audit that Victoria has had through the VAED program.</p>
<p>7. State based standards versus National standard for private sector – which should they follow?</p>	<p>Victorian private hospital registration requires that data are submitted in accordance with the requirements outlined by DHHS.</p> <p>Health fund contracts with private hospitals do not usually state that only national coding standards must be followed; in some cases they are explicit that state based standards must be followed.</p>
<p>9. We have mentioned 'ahead of national changes', when can we expect those changes?</p>	<p>Changes to ACS 0002 are being considered for Eleventh Edition – 1 July 2019</p>
<p>10. Coders are end users of the data! Only coders can identify issues and do anything about them!</p>	<p>This is not true. Many people analyse coded data and identify issues that need to be addressed. Coders however are the ones who</p>

	identify documentation issues and inappropriate DRG allocation and can act on these.
11. PICQ has indicators for rates of unspecified codes being assigned – is this indicative of a need to ask for more specificity?	The PICQ indicators identify those cases where unspecified codes have been assigned. If the rate of triggering these indicators is very high it may be indicative of a documentation issue. However the clinician may not have more specific information to provide.
12. With respect to version 9.0 of AR-DRGs; what plans are there to analyse the data and assess the potential impact of this new version.	Before a new version of AR-DRGs is implemented the historic data from the previous year(s) is grouped in the new version and an impact assessment made. However it is not possible to make an assessment of potential changes to coder practice in response to new grouping software. Coders should not change their practice in response to new grouping software.
13. Who decided on the 44 codes that have been removed from the grouper logic? How will this be managed in the future?	<p>The 44 codes were determined on advice from the Chief Medical Officer of Safer Care Victoria. The decision was based on a disproportionate impact on DRG outcome compared to the usual clinical significance of the condition, i.e. this was a funding decision but should not change the assignment of these codes where the documentation supports the code meeting the Vic 0002 criteria.</p> <p>A CEO funding group has been established and will manage any proposed changes from this point forward.</p> <p>The review of the DCL exclusion list, which includes some of the 44 codes, is on IHPA's work plan for AR-DRG version 10.0 development.</p>