

Codefile

Quarterly Newsletter of the Queensland Coding Committee

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ICD-10-AM 4th Edition

The National Centre for Classification in Health (NCCH) came to Queensland in May and June to deliver ICD-10-AM 4th edition education workshops. This year the education program for ICD-10-AM 4th edition included a web-based (or CD-ROM) interactive self paced learning tool covering the ICD-10-AM changes and the face to face workshops. The workshops helped to consolidate the material learnt through the self paced learning tool and covered the major changes to ICD-10-AM 4th edition including:

Diabetes

- ☆ Concept of 'with'
- ☆ Personal history of long term use of other medicaments, insulin
- ☆ Pre existing impaired glucose regulation in pregnancy
- ☆ With renal disease
- ☆ Insulin resistance
- ☆ Fatty liver
- ☆ Fibrous breast disease
- ☆ Muscle infarction

Obstetrics

- ☆ Pregnancy with advanced maternal age
- ☆ Labour without delivery
- ☆ Obstructed Labour
- ☆ Breastfeeding problems

Anaesthetic/pain management

- ☆ Local Anaesthetic
- ☆ Pain Management

- ☆ Intradiscal electrothermal therapy (IDET)

- ☆ Neuraxial blocks

Drug Administration

- ☆ Drug administration terminology
- ☆ Pharmacotherapy
- ☆ Multi drug use
- ☆ Chemotherapy

Cardiology

- ☆ Acute Coronary Syndrome
- ☆ STEMI and NSTEMI
- ☆ Testing defibrillator
- ☆ Biventricular pacemakers
- ☆ Electrodes

Dermatology

- ☆ Body Piercings
- ☆ Pressure Ulcers
- ☆ Skin tears/frail skin
- ☆ Standardisation of tumour/lesion terminology

In June the NCCH published the first errata for ICD-10-AM 4th edition for the ICD-10-AM hardcopy books. The NCCH have advised that the first eBook update incorporating the first errata is currently being published. The NCCH will notify facilities that have purchased the eBook, when the file is available for downloading.



NCCH Website

The NCCH website has been redeveloped. Users accessing the NCCH website will be automatically directed to the new URL. The NCCH website is located at: <http://www3.fhs.usyd.edu.au/ncchw/site/>.

The following topics can be accessed from the NCCH home page under quick links:
ICD-10-AM Fourth Edition

Fourth Edition Education Program

Coding Matters

Query Database

Catalogue

Public Submissions

NCCH Events

Get it fast/downloads.

The NCCH query database can also be found by clicking on ICD-10-AM, ICD-10-AM Queries Database.

The NCCH query database was last updated in February 2004.

AIHW's Classification and Terminologies Working Party

In May, Queensland Health hosted a visit by the AIHW where stakeholders from across the department were invited to discuss their needs, present and future, with regard to classifications and terminologies in the health sector. The aim of the workshop was to gather Queensland's needs to form a national integrated approach to classifications and terminologies.

Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2004-2005

The 2004-2005 QHAPDC Manual was distributed to facilities in June. This year the manual was distributed via CD and hardcopy. Previously the manual was distributed in hardcopy only.

The QHAPDC Manual can be found on the QLD Health Intranet site at: <http://qheps.health.qld.gov.au/hic/home.htm> and on the QLD Health Internet site at: <http://www.health.qld.gov.au/hic/default.asp>.

Below is a summary of changes to the 2004-2005 Queensland Hospital Admitted Patient Data Collection:

Sex Data Item

The category '3 – Indeterminate' of the Sex data item description has been modified to '3 – Indeterminate/Intersex'. Intersex refers to patients who, because of a genetic condition, have been born with reproductive organs or sex chromosomes that are not exclusively male or female.

Morbidity Coding

From 1 July 2004 all morbidity coding is to be supplied using ICD-10-AM 4th edition.

The range of block codes for which a procedure date must be provided has been updated as a result of ICD-10-AM 4th edition changes. In particular blocks 1780 to 1785 have been deleted from the ICD-10-AM classification and replaced with blocks 1920 to 1922.

Grouping

For separations from 1 July 2004, all DRGs (where supplied) must be grouped using AR-DRGs version 5.0.

Sub and Non-Acute Patients (SNAP)

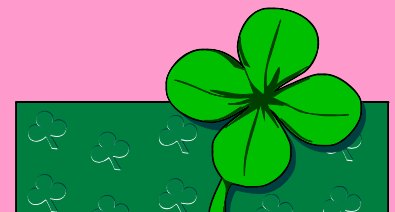
For Public facilities with designated SNAP units, all of the ADL scores collected in a SNAP episode will be provided. Previously, DSU only received the first recorded ADL score.

Country of Birth

The Standard Australian Country Classification was revised to incorporate the dissolution of the Federal Republic of Yugoslavia in 2003. Code 3213 "Yugoslavia, Federal Republic of" has changed to "Serbia and Montenegro". Private hospitals should ensure that their reference file is updated accordingly to reflect this change. For public hospitals, BAS will update HBCIS accordingly.

Visit to DSU by staff from The Economic and Social Research Institute of Ireland

In June, the DSU hosted a visit of Irish delegates from The Economic and Social Research Institute of Ireland. Ireland will implement ICD-10-AM 4th edition (currently using ICD-9-CM) and version 5.0 AR-DRGs from 1 January 2005. Our visitors were keen to hear what Queensland learnt when ICD-10-AM was first implemented in 1999. As Ireland's health network is a similar size to Queensland, they were also interested to know how our QHAPDC data are processed and the associated coding initiatives. While their visit was short, the DSU enjoyed their interest in 'how we do it in Qld'. On a more lighter note, our visitors loved Tim-Tams and were taking back to Ireland packets for their family and friends!



QHAPDC Validation Process

Garry Thorne, Data Services Unit provided an overview of the validation process for the QHAPDC at the May QCC Meeting. The scope of the QHAPDC is to collect data relating to demographic and clinical information on all admitted patients separated from the acute public hospitals, public psychiatric hospitals, private hospitals and day surgeries.

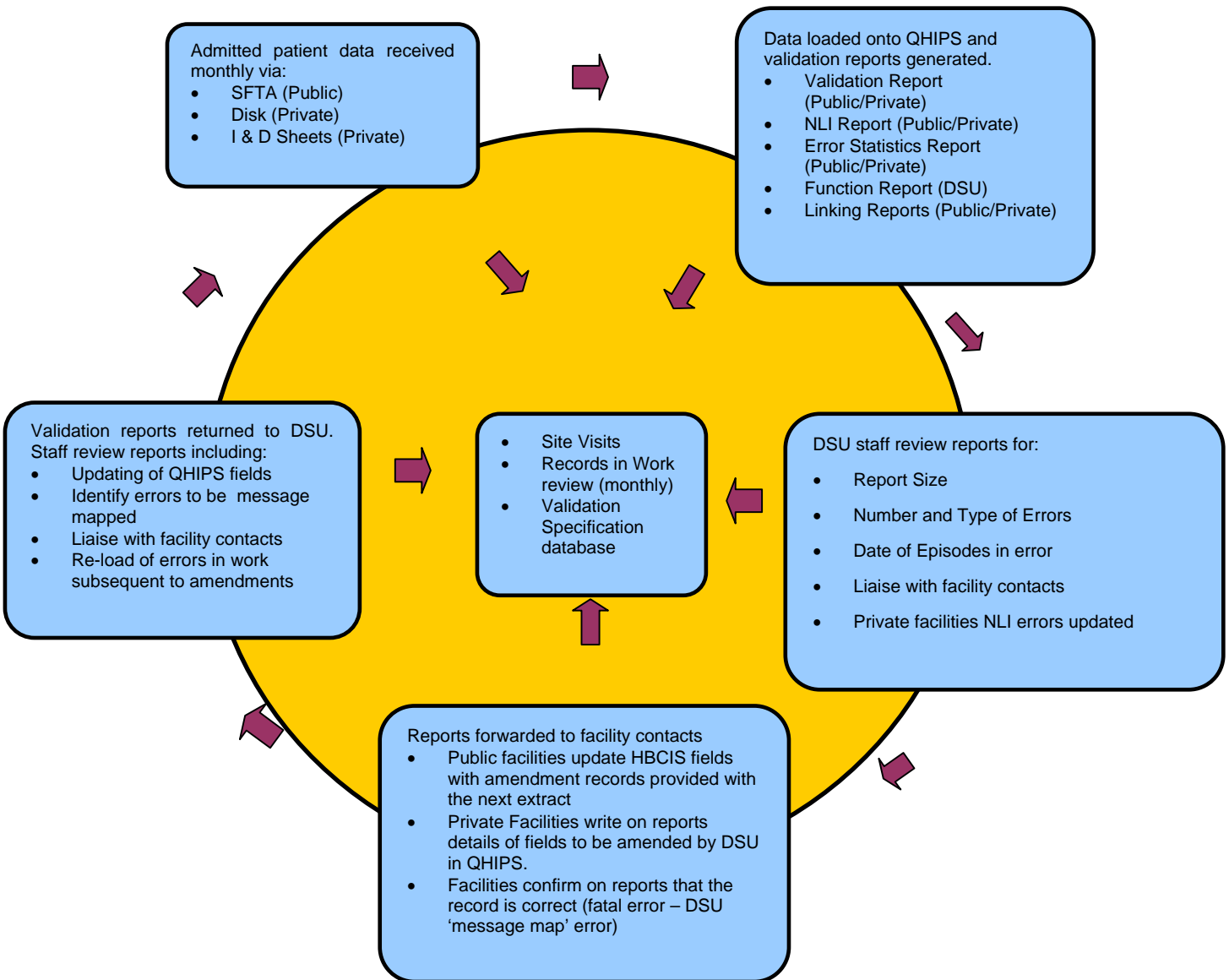
When data are received in DSU from facilities, they are loaded into the Queensland Health Inpatient processing system (QHIPS), the data are then validated and as a result a number of validation reports are produced.

Staff from the DSU, review the validation reports prior to distribution to facilities. Each facility receives the following reports: Validation report, NLI report, Error Statistics report, and Linking report. It is then the responsibility of each facility to work through the errors and amend records where necessary.

For any record that requires amendment, the correct data are to be updated and included on the report under the message to which it relates. If the data generating a fatal error are deemed to be correct please write 'message map' under the record to which it relates. On receipt to DSU, the report is reviewed and the data are updated and mapped accordingly.



Queensland Hospital Admitted Patient Data Collection Validation Report



Procedures requiring a Procedure Date

With the introduction of ICD-10-AM Fourth Edition, the range of block codes for which a procedure date must be provided has changed. In particular blocks 1780 to 1785 have been deleted from the ICD-10-AM classification and replaced with blocks 1920 to 1922. Mandatory block ranges requiring procedure codes follow:

1	to	59
67	to	559
561	to	737
739	to	1059
1062	to	1062
1064	to	1089
1091	to	1579
1602	to	1759
1828	to	1828
1886	to	1886
1890	to	1891
1909	to	1912
1920	to	1922

Please contact DQSTD@health.qld.gov.au if you have any queries or concerns regarding the procedure code blocks requiring dates.



Queensland Coding Committee Website

The QCC minutes, queries and coding quality presentations have been updated on the QCC Intranet and Internet site. The DSU is currently reviewing both websites to ensure that all information is current, easily identifiable and locatable.



Responses from NCCH to QCC Queries

Following is a list of NCCH responses to QCC queries (by QCC ID number) that have been received recently. Responses will be added to the QCC website in the near future.

QCC Query No.	Query Description
0803-02	Chemotherapy/Aredia
0903-03	Removal Subcutaneous Implanon
0903-04	Incidental Endoscopic Findings
1003-01	Error in Procedure Index
1203-04	Pleural effusions in pleural mesothelioma
0204-01	ACS0604 Stroke
0204-03	Default code for Positron Emmission Tomomography (PET)
0204-06	External Cause code for bite injury to tongue
0204-07	Autologous blood transfusion
0204-09	Index entry for Elevated PSA
0204-10	Squamous metaplasia
0204-12	Index for Z86.0 Personal History of Other Neoplasm
0204-13	IDC Traumatically removed
0304-04	Torted Appendix Epiptoicae Sigmoid colon
0304-05	Personal History of Stroke

The Use of R69 in Queensland

For some time now, DSU has been aware of a number of hospitals using the code **R69 Unknown and unspecified causes of morbidity** as the principal diagnosis (PD) for "missing charts" to ensure a complete month of separations are submitted to DSU. While DSU recognises the need for such a practice, any record sent that uses the code R69 as the PD or OD from 1 July 2004 will receive a fatal validation error.

It is permissible that this error message be carried from one month to another until the medical record is found. However, at the close of the reporting period, usually the financial year, each error message will need to be flagged by hospital staff to their respective DSU contact to ensure the message is mapped and acknowledgment of the error message will be recorded by DSU for any further reference.

Queensland Coding Committee

Terms of Reference

The QCC terms of reference have been reviewed in light of DSU becoming the business owner of the QLD Health code assignment tool, and the development of coding quality initiatives. The QCC endorsed the revised terms of reference at the June 2004 QCC meeting and are summarised below:

- Resolution of coding queries;
- Provide advice on the interpretation of Australian Coding standards and ICD-10-AM
- Disseminate coding information to clinical coders throughout Queensland;
- Establish and maintain a statewide register of clinical coders;
- Liaise with the coder network in relation to ongoing education requirement, training and workforce issues;
- Consult fellow clinical coders on matters relating to the national coding standards advisory committee;
- Involvement in the QCC publication 'Codefile';
- Recommend coding quality tools;
- Provide an avenue to raise AR-DRG grouping issues
- Promote and provide clarification of coding ethics and practice standards;
- Liaise with coders statewide in the preparation of public submissions to the National Centre of Classification in Health (NCCH) for changes and additions to ICD-10-AM
- Liaise with collaborate with the following organisations in relation to ICD-10-AM coding standards, policies and practices;
 - NCCH
 - Health Information Management Association of Australia;
 - Queensland Health
 - Coding Standards Advisory Committee
 - National Health Data Standards Committee
 - Statistical Information Management Committee
- Provide information to coders on quality initiatives in the collection of morbidity data
- Review national and state edits, specifically age, sex and rare edits in line with the biannual edition updates of ICD-10-AM
- Provide a mechanism where all coders in QLD both public and private have equity in access to all state coding resources, such as the QCC Website and the NCCH Website

- Endorse any state specific documentation on the use of ICD-10-AM codes for particular practices eg care type supplement

Clinical Coder Survey

The Clinical Coder Survey is in the process of being distributed. The survey will enable the QCC to maintain a current list of all coders in the state. An accurate, current register of clinical coders will allow publications of interest to be disseminated such as: The QCC Minutes and Queries, ICD-10-AM education material, the QCC newsletter 'Codefile' and the DSU Ebulletin. The survey will be posted on the QCC intranet and internet sites by the end of July.

If coders and HIMS details change the survey can be downloaded, completed and forwarded to the: QCC Convenor, Data Quality and Standards Unit, Queensland Health, GPO BOX 48, BRISBANE 4001 or Email: DQSTD@health.qld.gov.au

Quality Corner

The following articles summarise the QCC Quality Hour presentations for Quarter 2, 2004.

Month	Presenter
April	Julie Turtle- Good Clinical Documentation Guide, QEII Hospital
May	Dr. P Scott- Clinical Termer, NCCH, Brisbane
June	Corrie Martin- Spinal Procedures PA Hospital

Clinical Termer Presentation

At the May Meeting, the QCC welcomed a presentation from Peter Scott, a practising clinician from the National Centre for Classification in Health (NCCH) Brisbane on the Clinical Termer.

In 2002, the Australian Coders Workforce survey identified that documentation practices affected coding quality in regards to incomplete documentation and lack of specificity in documenting the principal diagnosis.

Peter Scott, in conjunction with Margaret Campbell are developing an application known as the Clinical Termer. The aim of the Clinical Termer is to improve coding in an acute setting by aiding doctors with terms and guidelines for documentation. The application will assist doctors to provide specific and relevant diagnosis information by utilising terms that they would commonly use and match these terms to the terms from the ICD-10-AM classification to aid the coding process. The Clinical Termer is an Access database holding approximately 5000 terms from ICD-10-AM 3rd edition, all the modifiers have been stripped from the classification, leaving only naturalised terms. Upon entering a term, a number of terms are displayed from the search result along with the documentation guidelines. To aid doctors with diagnosis specificity and documentation the NCCH have incorporated the good clinical documentation guide for relevant body systems. The Clinical Termer has the ability to fit into current practices upon discharge from hospital when doctors are completing the electronic discharge summary, referrals and or front sheets. The Clinical Termer is currently being trialed at the Mater Misericordiae Hospital to assess the coding quality. ♦

Spinal Procedures

At the June meeting the QCC welcomed a presentation from Corrie Martin titled show a little backbone. The presentation provided the QCC members with an overview of the anatomy and physiology of the spine, some interesting facts about the backbone and the procedures used to treat vertebral disorders such as: vertebroplasty, Intradiscal Electrothermal Annuloplasty (IDET), the insertion of interbody cages and artificial disc replacement.. As new technology emerges we could potentially see new procedures such as Transforaminal lumbar interbody fusions (TLIF), endoscopic spinal techniques, robotic assisted spinal operations to treat spinal disorders.

These presentations will appear shortly on the QCC website under the 2003-2004 QCC Calendar.

Coding Standards Advisory Committee (CSAC) Report

The most recent meeting of the CSAC was held in Melbourne on the 28 June 2004.

4th Edition Education

The NCCH reported that Queensland had 189 participants attend the recent 4th Edition ICD-10-AM Education Workshops. A total of 6 workshops were held in Qld. Some other interesting facts provided at the meeting are tabled below. The NCCH have asked that any coding queries related to the 4th edition education material should be submitted to the QCC.

Table 1: Coding queries sent to the NCCH, by State July 03 – June 04

State	No. of queries
Qld	22
Vic	45
SA	22
WA	13
NSW	11
Tas	9
NT	8
ACT	0

Table 2: Public Submission Received by the NCCH for ICD-10-AM 5th edition, by State

State	No. of submissions
Qld	3
Vic	4
SA	1
WA	2
NSW	1
Tas	-
NT	-
ACT	1

NCCH Query Database

The NCCH query database and its role in Coding Audits was also discussed at CSAC. The NCCH have previously stated in Coding Matters Vol 10 No 3 December 2003 that, "The coding queries database is a tool to answer specific coding questions referred to the NCCH by state and territory coding committees. The database is an additional coding resource with options for reviewing or down loading via the NCCH web site. The NCCH provides this database for clinical coders to regularly review coding questions and answers. The NCCH selects information from the database for publication as 10-AM Commandments. Coding advice published in 10-AM Commandments is incorporated into the Australian Coding Standards to become part of ICD-10-AM classification. It is not the

NCCH's expectation that the database be used for auditing purposes because only advice in the Australian Coding Standards and Coding Matters are ratified by the Coding Standards Advisory Committee."

After a very lengthy discussion at CSAC, coders are asked via their State Coding Committees to identify any queries currently on the database that require further clarification. Examples of such clarification may include whether the advice should apply to the current edition of ICD-10-AM and/or if the advice should be developed into an Australian Coding Standard or appear in the Ten Commandments for further clarification.

It is the expectation of Queensland Health and the Queensland Coding Committee that clinical coders in Queensland should follow the ACS and any advice in the Ten Commandments. The purpose of providing access to the database (via the NCCH website) is to ensure that all coders in Qld have equity in access to coding resources and that it be used for its intended purpose, that is, it be used as a tool to provide further clarification should it be needed. Coders are not expected to know the details of every single query on the NCCH database. As per the advice above, if coders find queries on the NCCH database that are outdated or conflicting, these queries should be sent to the QCC. When coding audits are performed, these details regarding the status of the use of the database should be explicitly stated up front with the auditor.

Clinical Classification Management Project (CCMP)

The Deputy Director General Policy and Outcomes approved in June 2004 the project submission for the CCMP. The project aims to adopt two core strategies aimed at advancing the quality of coded morbidity data. The first strategy involves a comprehensive enterprise wide coding audit program. The second strategy entails an ongoing education program for clinical coding, administrative and clinical staff.

The funding has been approved for 24 months and the Data Services Unit will manage the project.

The positions will be advertised late July – August. The positions have been through the JEMS process and have been evaluated as the following:

AO6 Senior Project Officer – CCMP
AO5 Clinical Coding Auditor/Educator

When the positions are advertised, the DSU will distribute the advertisement to all those on the QCC

minutes distribution list and/or DSU E-bulletin mailing list.

For further details, please contact Meegan Snell, 07 3234 0123 or at Meegan_Snell@health.qld.gov.au



Comments, Queries and Suggestions

All Codefile comments, queries and suggestions can be forwarded to:

The Convenor, QCC
Health Information Centre
GPO BOX 48
BRISBANE QLD 4001
Telephone: (07) 3234 1318
Facsimile: (07) 3234 0564
Email: DQSTD@health.qld.gov.au

Australian Refined Diagnosis Related Groups (AR-DRG)

Definitions Manual overview

This article has been re-produced with permission by the original author, Jennie Sheppard, Department of Human Services, Victoria.

This article has been modified by Samantha Daly, Principal Policy Officer, Pricing Strategy Team, Queensland Health.

The introduction of Version 5.0 AR-DRGs into Queensland Public Hospitals on 1 July 2004 provides an impetus for all coders to do some self-education about AR-DRGs. The Version 5.0 AR-DRG Definitions Manual consists of a set of 3 books and CD-Rom that contain the logic of grouper software. Every coder should know how to access the Definitions Manual in order to understand the impact of a new grouper version, and to be able to problem solve DRG issues in their own workplace.

This article will serve as a tutorial to help you develop those skills, if you don't already have them. You will need to read this article with the Definitions Manual accessible so that you can refer to it regularly.

Although this article relates specifically to the Version 5.0 AR-DRG Definitions Manual, the concepts are the same for all versions. Once you have mastered the Version 5.0 Definitions Manual you should be able to apply these skills to all Definitions Manuals.

The Definitions Manual is available from the National Centre for Classification in Health (NCCH) for a cost (currently) of \$165.00. The Version 4.2 AR-DRGs Definitions Manual consists of a four-volume set of books, Volumes 1-3 being Version 4.1 and Volume 4 being an addendum to update it to Version 4.2.

Volume 1

Contents page: This includes the contents for all three volumes and is repeated in Volume 2 and Volume 3.

Figures and Tables: This is a list of the figures and tables for all volumes and only appears in Volume 1. This list is very useful as a quick reference for finding significant information throughout the manual.

Contents of CD-ROM: If you want to manually calculate the Patient Clinical Complexity Level (PCCL) for your set of codes you will need to learn to use some of the tables provided on the CD. This is a complex activity and not recommended if you are just familiarising yourself with the manual. However becoming familiar with the contents of the CD and how

to use the matrices contained there helps enormously to understand the concepts involved in assigning Complication and Comorbidity Level (CCL) values to codes and PCCL values to cases.

Acknowledgements: This short narrative helps to put the development of AR-DRGs into perspective. For those who wish to explore the development of AR-DRGs further, information is available on the Commonwealth Department of Health and Ageing website <http://www.health.gov.au/casemix/>.

Abbreviations: This list provides the meanings of abbreviations used throughout the manual.

Introduction: Pages 1 to 15 of Volume 1 are essential reading for anyone wanting to understand AR-DRGs in general and Version 5.0 in particular. As well as general information about AR-DRGs and their development, this section provides detailed information about the Version 5.0 developments, the numbering system for DRGs, the CCL assignment, the process involved in assigning a DRG, the use of 'functions', error DRGs and detailed instructions in how to use the volumes. Points 4 'Grouping episodes to AR-DRG' and 5 'Guidance in the use of this Definitions Manual' are particularly informative.

List of Australian Refined Diagnosis Related Groups Version 5.0: Beginning on page 17 is a very useful list of DRGs ordered within Major Diagnostic Category (MDC). The 'partition' indicates that the DRG is medical (M), surgical (S), or Other (O). While this list is in numerical order, it does not accurately reflect the surgical hierarchy within each MDC. Version 5.0 is the first version in which the numerical order of DRGs does not necessarily reflect the surgical hierarchy.

MDC logic: Page 31 is the beginning of the first of several chapters that provide the logic used in each MDC. There are 24 'chapters' in total in the AR-DRGs. Chapter 1 relates to Pre-MDC logic, while the other 23 relate to specific MDC logic. The chapter for Pre-MDC logic and the chapters containing the logic for MDCs 1 to 8 are contained in Volume 1.

Each of these chapters has at the beginning a 'decision tree', which represents the decisions that the grouper makes when assigning a DRG within each MDC. This decision tree also reflects the surgical hierarchy for each MDC, which has resulted in the DRGs appearing in the tree out of numerical order in some cases.

Following the decision tree is a list of codes that are accepted as a principal diagnosis for the particular

MDC. When one of these codes in this list is assigned as a principal diagnosis, the episode is allocated to this particular MDC. This is the second dot point of Section 4.1 - Variables used for grouping, on page 8 of Volume 1 (MDC assignment).

After the list of principal diagnoses, all the DRGs for the MDC are listed. The alpha-numeric code of the 'adjacent' DRG (for example, B02 Craniotomy) is in a black reverse text box, while the code of a DRG (for example, B02A Craniotomy w Catastrophic CC) appears in a box outline. The title of the DRG is listed beside the code and under the title is the logic that pertains to that DRG. This logic may be a single item such as 'at least two procedures from TAB-I01-1' or it may be quite complex such as '(any Principal diagnosis in MDC 08 table TAB-M08-0 except TAB O02-1) and Procedure in table TABI02-2'.

Users of the Definitions Manual must read this logic carefully to fully appreciate which episodes have been included in this DRG.

Beneath each DRG and adjacent DRG are the tables that relate to the logic applied for an episode to be assigned to that DRG. Each of these tables has a number in brackets (for example, TAB-102-3). When reading the logic for the DRG assignment or adjacent DRG assignment you can reference these tables accordingly.

Volume 2

Contents page: This includes the contents for all three volumes and is repeated in Volume 1 and Volume 3.

MDC logic: Volume 2 contains chapters providing the logic for MDCs 9 to 23 set out as explained above. At the end of MDC 15, on page 163 you will find details about the logic used in assigning neonates to DRGs split on 'major problem' and 'multi major problem'. These are 'true' and 'false' decisions. If the neonate has one of the conditions on the major problem list it will be allocated to a DRG with a 'major problem' split. If the neonate

has at least two of the conditions on the major problem list it will be allocated to a DRG with a 'multi major problem' split. See logic printed under the headings 'Neonate major problem' and 'Neonate multiple major problems' on page 167.

Functions: Beginning on page 379 you can find the descriptions of two of the four 'functions' that occur in DRG assignment in AR-DRGs Version 5.0. The other two functions are the major problem list and the multi major problem list found in MDC 15 (see page 167 Volume 2).

The first function relates to the assignment of DRG 'Unrelated OR procedures'. The decision tree for this function is on page 381. On the following pages are the lists of procedure codes that relate to a case being assigned to DRGs 901Z *Extensive OR Procedure Unrelated to Principal Diagnosis*, 902Z *Non-extensive OR Procedure Unrelated to Principal Diagnosis* or 903Z *Prostatic OR Procedure Unrelated to Principal Diagnosis*. This occurs when the procedure code is not recognised as a legitimate procedure in the MDC to which the case has been allocated on the basis of the principal diagnosis. Note that the list under 901Z is the same as the list under 902Z. However the logic listed under each of these DRGs is different. The logic for 901Z is any OR procedure except those in the list. The logic for 902Z is any procedure code on the list. When the grouper logic refers to 'OR procedure' this means all those procedures that the grouper recognises as being OR procedures. It does not mean all the procedures for which we have ICD-10-AM procedure codes.

The second function relates to the assignment of a 'Pacemaker' DRG. The tables for this function contain the valid combinations of codes that allow an episode to be assigned to the pacemaker DRG.

Note that the 'functions' are a 'true or false' decision that the grouper makes. If the pacemaker codes are a valid combination, this is 'true' for assignment to the pacemaker DRG. If the code combinations are 'false', the episode will not be assigned to the pacemaker DRG.

Volume 3

Contents page: This includes the contents for all three volumes and is repeated in Volume 1 and Volume 2.

Appendix A-Diagnosis code/MDC/DRG index: The first two pages of this index provide directions for the use of the rest of the index. Primarily disease codes, when used as a principal diagnosis, are allocated to one MDC. There are exceptions when the patient is a HIV patient, a multiple trauma patient, or the disease code is used in the definitions of a DRG even if not the principal diagnosis. DRGs 901Z, 902Z and 903Z are the result of the principal diagnosis code being allocated to an MDC that is in conflict with the MDC to which the procedure code(s) is allocated. Perusal of this index is therefore crucial to understanding the cause of these DRGs.

Appendix B-Procedure code/MDC/DRG index: This index is the same as Appendix A except that it deals with procedure codes rather than disease codes. The first three pages describe the logic involved in allocating procedure codes to MDCs and DRGs. This

index and the instructions at the beginning further explain the allocation of DRGs 901Z, 902Z and 903Z. Importantly, procedure codes can be allocated to several different MDCs, whereas disease codes are allocated primarily to one MDC.

Appendix C-CCs, the CC exclusions, CCL and the calculation of PCCL: It is important to understand the grouping process as explained in the introduction in Volume 1 before reading the introductory pages to this appendix. These pages provide specific details about the allocation of CCL values to codes and PCCL values to episodes. Note that obstetric and neonate episodes are treated differently to non-obstetric and non-neonate episodes (see bottom of page 213). The remainder of the appendix is dedicated to the Complication or Comorbidity (CC) list. This list provides the possible CCL value assigned to each CC. Note that the value varies between medical and surgical, and can be different within medical or surgical. This means that if the episode is allocated to a medical DRG, the CCL value of the codes listed for that episode might be different than if the episode was allocated to a surgical DRG. To manually calculate the CCL value of any CC you will need to use the CD provided with your Definitions Manual, and follow the steps provided in Appendix C.

Appendix D-Edits: This appendix provides details of the edits that the grouper checks before allocating a DRG. This is step one in the DRG assignment process (see Section 4.1 - Variables used for grouping, page 8 Volume 1). The tables on pages 261 and 262 (D.2 Demographic edits and D.3 Clinical edits) provide information about the acceptable entries for the various data items that are edited. The grouper allocates a status following grouping, the details of which are provided at D.5 Grouper status on page 264. The remainder of this appendix contains lists of codes that are used in 14 ICD Coding Newsletter-May 2004. These lists are valuable for problem solving when you have an error or edit DRG.

Glossary: Pages 305 and 306 have a glossary of terms related to AR-DRGs. This is very useful if you are providing education in your workplace, or if you are simply looking for a succinct and consistent way of understanding the jargon of AR-DRGs.