

Care Type Supplement

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Inside this Supplement

2

Acute – Care Type 01

4

Rehabilitation – Care Type 21, 22, 23

6

Palliative - Care Types 31, 32, 33

8

Newborn – Care Type 05

11

Organ Procurement – Care Type 07

13

Boarder – Care Type 08

14

Geriatric Evaluation & Management – Care Type 09

15

Psychogeriatric – Care Type 10

16

Maintenance – Care Type 11

17

Other – Care Type 06

From 1 July 2000 the valid care types are as follows:

- 01 - Acute
- 21/22/23 - Rehabilitation
- 31/32/33 - Palliative
- 05 - Newborn
- 06 – Other
- 07 - Organ Procurement
- 08 - Boarder
- 09 – Geriatric Evaluation and Management;
- 10 - Psychogeriatric; and
- 11 – Maintenance (including respite)

All definitions provided here have been taken from the Queensland Health Data Dictionary, and the Queensland Hospital Admitted Patient Data Collection Manual (July 2005).



An episode of care is the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. An episode of care refers to the phase of treatment rather than to each individual patient day and there may be more than one episode of care within the one hospital stay period. Each episode is reported to the DSU on its completion. An episode of care ends when the principal clinical intent of care changes or when the patient is formally separated from the hospital. (QHAPDC Manual 2005-2006)

Acute – Care Type 01

DEFINITION

Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of an illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or
- perform diagnostic or therapeutic procedures.

Principal Diagnosis

The principal diagnosis is defined as ‘the diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care in hospital (or attendance at the health care facility). [ACS 0001]

Additional Diagnoses

A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility. [ACS 0002]

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

- Therapeutic Treatment
- Diagnostic Procedures
- Increased Nursing Care and/or monitoring [ACS 0002]

Procedures

Interventions as appropriate.

EXAMPLES

Example 1

Patient presents with seizures. The patient had not previously been treated for seizures. CT scan revealed a large brain tumour.

PD	C71.9	Brain, unspecified
M	M9400/3	Astrocytoma NOS

Example 2

A patient is admitted for treatment of recurrent seizures caused by a brain tumour diagnosed 3 months previously. A CT scan with contrast is performed.

PD	R56.8	Other and unspecified convulsions
OD	C71.9	Brain, unspecified
M	M9400/3	Astrocytoma NOS
PR	56007-00	Brain CT scan with contrast

Example 3

A woman was admitted to hospital on Monday for delivery of her baby on Tuesday. She had a spontaneous vaginal delivery with an episiotomy. She had gestational hypertension but there were no complications with the delivery. She had a baby boy!

PD	O13	Gestational [pregnancy-induced] hypertension without significant proteinuria
OD	Z37.0	Single live birth
PR	90472-00	Episiotomy with primary repair

EDITS

- The diagnosis codes Z50.0-Z50.9 must not be used for acute care types.
- The diagnosis codes Z38.x or Z76.2 must not be used in an acute care type.
- The diagnosis codes Z53.0 *Procedure not carried out because of contraindication*, Z53.1 *Procedure not carried out because of patients decision for reasons of belief or group pressure*, Z53.2 *Procedure not carried out because of patients decision for other and unspecified reasons*, Z53.8 *Procedure not carried out for other reasons* or Z53.9 *Procedure not carried out, unspecified reason* must not be used as a principal diagnosis.
- The diagnosis codes Z37.0-Z37.9 must not be a principal diagnosis. The principal diagnosis must be related to the delivery.
- The diagnosis codes O09.0-O09.9 must not be a principal diagnosis. The principal diagnosis must be related to reason for admission.
- The diagnosis codes T31.00-T31.99 must not be a principal diagnosis. However, they must be an additional diagnosis for codes in the T20.0-T25.3 or T29 range.
- Any codes listed as principal diagnosis from the AR-DRG 961Z, are unacceptable as a principal diagnosis. Diagnosis codes included in this AR- DRG are listed in the AR-DRGv5.0 definitions manual volume 1.
- The diagnosis codes Z91.1 *Personal history of non-compliance with medical treatment and regimen* must not be a principal diagnosis. (ACS 0517)
- The diagnosis codes O090 – O099 are required to be coded with Pregnancy Condition codes.
- The diagnosis codes Z51.0 and Z51.1 must only be used as a principal diagnosis if occurring during a same day admission for this care type.
- The diagnosis codes Z51.0 and Z51.1 must not be used as an additional diagnosis for this care type.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Rehabilitation – Care Types 21, 22, 23

DEFINITION

Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames, which are evaluated by a periodic assessment using a recognised functional assessment, measure. It includes care provided:

- 21** in a designated rehabilitation unit,
- 22** in a designated rehabilitation program or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation, or
- 23** under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation.

Coding for rehabilitation categories (21, 22 or 23) should be carried out in strict numerical sequence, (i.e. the first appropriate category of care type should be coded). (see QHAPDC manual 2005-2006)

The treating clinician must nominate the most clinically appropriate sub or non-acute care type for the patient when there is an admission or a change in care type. The sub and non-acute care types currently available for use are Palliative Care, Rehabilitation, Geriatric Evaluation and Management (GEM), Psychogeriatric or Maintenance.

As this is a clinical decision please assign the appropriate care type as defined by the treating clinician. All morbidity codes associated with the admission should be coded.

Principal Diagnosis

Diagnosis codes Z50.0-Z50.1 or Z50.4-Z50.9 should be assigned as the principal diagnosis. [ACS2104]

Additional Diagnoses

The condition which led to the patient being in the rehabilitation facility. [ACS 2104]

External cause codes, Place of Occurrence and Activity Codes as appropriate.

Any other conditions being managed. [ACS 0002]

Procedures

Rehabilitation procedure codes.

For drug and alcohol problems, procedure codes from [1828] *Alcohol and drug rehabilitation and detoxification* should be used.

Where multiple rehabilitation procedures are performed, Z50.9 *Care involving use of rehabilitation procedure, unspecified* should be assigned and the details of the specific procedure should be indicated by the procedure codes. [ACS 2104]

EXAMPLES

Example 1

Rehabilitation for a patient hit by a car while jogging. They have a fractured spine resulting in a nerve injury requiring physical therapy.

PD	Z50.1	Other physical therapy
OD	T14.4	Injury of nerve(s) of unspecified body region
EX	V03.1	Pedestrian injured in collision with car, pickup truck or van (traffic accident)
EX	Y92.41	Sidewalk
EX	U56.1	Jogging and Running
PR	95550-03	Allied health intervention, physiotherapy

Example 2

A patient who had primary osteoarthritis requiring bilateral knee replacement surgery three weeks ago is remaining in hospital for rehabilitation. The patient is undergoing occupational therapy and physiotherapy.

PD	Z50.9	Care involving use of rehabilitation procedure, unspecified
OD	M17.0	Primary gonarthrosis, bilateral
OD	Z96.65	Presence of knee implant
PR	95550-02	Allied health intervention, occupational therapy
PR	95550-03	Allied health intervention, physiotherapy

EDITS

- The diagnosis codes from Z50.0-Z50.1 or Z50.4-Z50.9 must be used as the principal diagnosis in this care type.
- The rehabilitation care type must have a principal diagnosis in the ranges Z50.0 – Z50.1 or Z50.4 – Z50.9.
- The diagnosis codes Z50.0-Z50.1 or Z50.4-Z50.9 must only occur in rehabilitation care type.
- All episodes in the rehabilitation care type must have a valid morbidity code in position two (i.e. following the principal diagnosis).
- The diagnosis codes Z50.2 *Alcohol rehabilitation* and Z50.3 *Drug rehabilitation* must not be assigned for inpatient episodes of care. Use the codes listed in block [1972] *Alcohol and drug rehabilitation and detoxification* for appropriate treatments with a diagnosis code relating to the condition. [ACS 0525].
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Palliative – Care Types 31, 32, 33

DEFINITION

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- 31** in a designated palliative care unit
- 32** in a designated palliative care program, or
- 33** under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, where the principal clinical intent of care is palliation.

Coding for palliation categories (31, 32 or 33) should be carried out in strict numerical sequence, (ie, the first appropriate category should be coded). (QHAPDC manual 2005-2006)

The treating clinician must nominate the most clinically appropriate sub or non-acute care type for the patient when there is an admission or a change in care type. The sub and non-acute care types currently available for use are Palliative Care, Rehabilitation, Geriatric Evaluation and Management (GEM), Psychogeriatric or Maintenance.

As this is a clinical decision please assign the appropriate care type as defined by the treating clinician. All morbidity codes associated with the admission should be coded.

Principal Diagnosis

A principal diagnosis should be assigned which reflects the diagnosis resulting in the relatively shortened prognosis. [ACS 0224]

Additional Diagnoses

Z51.5 Palliative Care [ACS 0224]

Any other conditions or social circumstances being managed.

Procedures

Intervention as appropriate.

EXAMPLES

Example 1

An elderly woman is admitted for five days of care of her intraductal papillary adenocarcinoma and medullary carcinoma. She is given palliative chemotherapy.

PD	C50.2	Malignant neoplasm of breast upper inner quadrant of breast
M	M8510/3	Medullary Carcinoma
OD	Z51.5	Palliative Care
PR	96199-00	Intravenous administration of pharmacological agent, antineoplastic agent

Example 2

Patient is admitted for care of extensive adenocarcinoma of caecum and bronchus. The patient is given palliative chemotherapy.

PD	C34.0	Malignant Neoplasm of main bronchus
M	M8140/3	Adenocarcinoma NOS
OD	C18.0	Malignant Neoplasm of Caecum
M	M8140/3	Adenocarcinoma NOS

OD Z51.5 Palliative Care
PR 96199-00 Intravenous administration of pharmacological agent, antineoplastic agent

EDITS

- The diagnosis code Z51.5 must only be an additional diagnosis in a palliative care type.
- The diagnosis code Z51.5 must not appear as the principal diagnosis in a palliative care type or in any other care type.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Newborn – Care Type 05

DEFINITION

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- Newborns who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- Newborns who turn 10 days of age and require clinical care continue in the newborn care type until they are separated.
- Newborns aged less than 10 days and not admitted at birth (eg, transferred from another hospital) are admitted with newborn care type.
- Newborns aged greater than 9 days not previously admitted (eg, transferred from another hospital) are either boarders or admitted with an acute care type.

Within a newborn care type, until the baby turns 10 days of age, each day is deemed to have a qualification status of either acute or unqualified. A newborn has an acute qualification status when it meets at least one of the following criteria:

- The newborn is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
- The newborn is admitted to an intensive care facility in a hospital, being a facility approved by the Australian Commonwealth Health Minister for the purpose of the provision of special care, or
- The newborn is admitted to or remains in hospital without its mother.

Information on the calculation of age can be found in the 2005-2006 QHAPDC manual.

A baby nine days of age or less **must** always be admitted as a Newborn episode of care (with a qualification status of acute or unqualified) and only varies on turning ten days of age. This is regardless of whether they were born in the hospital or were transferred in, and whether they were a single birth or in a multiple birth. On turning ten days of age they can continue as a Newborn (if qualification status is acute) or change to a Boarder (if qualification status is unqualified) depending on their condition and circumstances.

Newborns nine days of age or less can be assigned to a qualification status of either acute or unqualified depending on their circumstances and can change between acute and unqualified qualification status during this time. Once they turn ten days of age, a newborn can only be assigned an acute qualification status.

If the newborn is still in hospital on turning ten days of age but does not qualify for an acute qualification status, they must be separated from the Newborn care type and registered as a Boarder care type.

Newborns who are waiting for adoption and turn ten days of age, remain in hospital without their mother, and require **no** clinical care/treatment, should be formally separated and then registered as boarders (on and before nine days of age, they are classified according to the normal rules).

Also note, stillborn babies **are not** admitted.

Further information regarding the Newborn care type and qualification status, including the calculation of age, can be found in section 4.5 of the 2005-2006 QHAPDC manual.

Principal Diagnosis

1. A diagnosis code from the category Z38.x *live –born infants according to place of birth* should be sequenced as the principal diagnosis when the newborn is completely well.

2. Any morbid condition arising during the birth episode should be sequenced before the diagnosis code Z38.x *Live-born infants according to place of birth*.
3. The diagnosis code Z38.x codes cannot be used when treatment is being provided in second or subsequent admissions.

Additional Diagnoses

Any other conditions as appropriate. [ACS 0002]

Infant/liveborn (Z38.x) code if it cannot be sequenced as the principal diagnosis.

Procedures

Procedures should be coded as appropriate.

EXAMPLES

Example 1

A single healthy baby born into hospital. Mother is in hospital with the baby.

Care type – **05** Newborn.

Qualification Status – **U** Unqualified

PD Z38.0 Singleton, born in hospital.

Example 2

Single Newborn, born at home, no morbidity, vaginal delivery. Mother is in hospital with the baby.

Care type – **05** Newborn.

Qualification Status – **U** Unqualified

PD Z38.1 Singleton, born outside hospital

Example 3

Single Newborn, born in hospital, with hypoglycaemia, vaginal delivery. Mother is in hospital with the baby.

Care type – **05** Newborn

Qualification status – **A** Acute if in a designated neonatal intensive or special care unit

U Unqualified if not in a designated neonatal intensive or special care unit

PD P70.4 Other neonatal hypoglycaemia

OD Z38.0 Singleton, born in hospital

Example 4

A woman is admitted to hospital for the caesarean delivery of twin girls. Both of the twins are healthy and do not require any clinical care. The twin newborn girls would be given the following care type, qualification status and morbidity codes.

Twin 1

Care type – **05** Newborn

Qualification status – **U** Unqualified

PD Z38.3 Twin, born in hospital

Twin 2

Care type – **05** Newborn

Qualification status – **A** Acute

PD Z38.3 Twin, born in hospital

Example 5

A baby (seven days old) accompanies its mother into hospital but does not require treatment. The baby's mother was discharged two days post-delivery. On the fifth day post-delivery, she developed a post partum infection and is admitted to hospital. As the baby is under 9 days of age it is admitted into a Newborn care type.

Care type – **05** Newborn

Qualification Status – **U** Unqualified

PD Z76.2 Health supervision and care of other healthy infant and child

Example 6

The same mother from example 5 above is re-admitted again eleven days post delivery. She is breast feeding her baby and the baby is brought to the hospital with her. As the baby is over 10 days of age it is registered as a boarder.

Care type – **08** Boarder

Qualification Status – not required, as the baby is not in a newborn care type.

PD Z76.3 Healthy person accompanying a sick person.

EDITS

- The diagnosis codes Z38.x or Z76.2 must only be in a newborn care type and must not occur in any other care type.
- The diagnosis code Z76.2 must only be a principal diagnosis.
- The diagnosis codes Z38.1, Z38.2, Z38.4, Z38.5, Z38.7 and Z38.8 must have a source of referral of '02' – Emergency Department, this hospital.

For HBCIS users the diagnosis codes Z38.1, Z38.2, Z38.4, Z38.5, Z38.7 and Z38.8 can have a source of referral code of 08 Outborn from September 2005

- The diagnosis codes Z38.0, Z38.3 and Z38.6 must have a source of referral as '09' – Born in hospital. Other diagnosis codes from the Z38.0-Z38.8 range, which have a source of referral, as '09' will raise an error at DSU.
- The diagnosis code Z38.0 must not be the principal diagnosis when the qualification status is acute.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Organ Procurement – Care Type 07

DEFINITION

This category is for the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead. This category should not be used for live donors. Live donors are treated essentially the same as an admitted patient for removal of an organ and are therefore assigned to an acute care type. This category has been developed for posthumous organ procurement. Posthumous organ donors must meet the following criteria:

- Brain death
- Consent for organ procurement received, and
- The patient is clinically eligible to donate organ/s.

In the procurement episode after the episode following brain death, assign as principal diagnosis the appropriate code from Z52.x *Donors of organs and tissues* and the relevant procedure code(s). It is not necessary to assign diagnoses from the preceding episode or cause of death as these will already have been coded in the initial episode. Only code patients who actually proceed to organ donation. [ACS 0030]

Note: Public Hospitals utilising HBCIS do not have the capacity to register patients to the organ procurement care type. The Organ Procurement Team that carries out the organ procurement will manually complete an Identification and Diagnosis sheet for that episode. This identification and diagnosis sheet will be forwarded to the Data Services Unit where it will be coded and entered onto the Queensland Hospital Admitted Patient Data Collection for inclusion in the data for that hospital in which the procurement episode took place.

EPISODE WHERE BRAIN DEATH OCCURS	ORGAN PROCUREMENT REGISTRATION
The episode of care where brain death occurs has the following: Care Type: relevant code; Source of Referral: relevant code; Mode of Separation: Died in Hospital (05).	The organ procurement registration has the following: Care Type: Organ procurement (07); Source of Referral: Organ procurement (20); Mode of Separation: Organ procurement (13)

Principal Diagnosis

The diagnosis code must be Z52.x.

Additional Diagnoses

Assign as additional diagnosis any additional code(s) from Z52.x Donors of organs and tissues.

Procedures

The procurement procedure code(s). [Please see ACS 0030]

EXAMPLES

Example 1

The family of a person who has been seriously injured in an accident and is now brain dead have agreed to donate the deceased's organs. The organ procurement team has procured the deceased's heart and both kidneys.

PD Z52.7 Heart donor
 OD Z52.4 Kidney donor
 OD Z52.6 Liver donor
 PR 90204-00 Removal of donor heart for transplantation.
 PR 36516-06 Complete nephrectomy for transplantation, cadaver
 PR 36516-06 Complete nephrectomy for transplantation, cadaver
 PR 90346-00 Total hepatectomy

EDITS

- Organ Procurement patients LOS is usually under 24 hours. If the episode is greater than 72 hours a warning error will be generated by DSU.
- The diagnosis codes Z52.5, Z52.6 and Z52.7 must only be used in organ procurement care type and no other care type.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Boarder – Care Type 08

DEFINITION

A hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. When a hospital registers a boarder, the boarder should be allocated with a *Source of referral/transfer = 21*, a *Type of episode = 08* and a *Mode of separation = 14*. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients (care type – 05 newborn) with a qualification status of either acute or unqualified. For further information regarding the newborn care type, please refer to page 8 of this document.

If a boarder has been accommodated at a hospital and a change in his/her condition subsequently allows him/her to be an admission under the minimum criteria, this cannot be recorded as a change in status. As the hospital has previously 'registered' the person as a boarder (not an admitted patient), the patient must be admitted and treated as a first time admission. Do not use '06' - Episode Change for either the source of referral/transfer or mode of separation. If the person subsequently changes circumstances again, they should be formally separated prior to being registered as a boarder once more.

Examples of boarders may include:

- A two year old baby who does not meet the criteria for admission, accompanying his/her mother who is currently admitted.
- A mother accompanying her child who is admitted for a tonsillectomy.
- A baby who remains in hospital with its mother and does not require clinical care/treatment becomes a boarder when the newborn turns 10 days of age. Until this time, it would have been in a newborn episode of care.
- A baby waiting for adoption, remaining in hospital without his/her biological mother, does not require clinical care/treatment and is greater than 9 days of age.

Principal Diagnosis

The diagnosis code must be one of Z76.3 or Z76.4.

Additional Diagnoses

There should not be any other conditions. If there are any other diagnoses and/or procedures that warrant coding, the patient must satisfy the criteria for admission. The patient should be separated from the boarder registration and admitted with the appropriate care type.

Procedures

There should not be any procedures related to a Boarder. If there are any procedures, then the care type should be changed appropriately.

EXAMPLES

Example 1

A single healthy baby over 10 days of age accompanying mother who has mastitis.

PD Z76.3 Healthy person accompanying a sick person.

Example 2

A mother accompanying a child having a tonsillectomy.

PD Z76.3 Healthy person accompanying a sick person.

Example 3

A boarder not accompanying a sick person

PD Z76.4 Other boarder in health care facility.

EDITS

- A Boarder is identified through the use of the following codes: *Source of referral/transfer = 21*, a *Type of episode = 08* and a *Mode of separation = 14*. The principal diagnosis must be Z76.3 or Z76.4.
- A true boarder must not have any additional diagnosis recorded.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Geriatric Evaluation & Management – Care Type 09

DEFINITION

Geriatric Evaluation and Management (GEM) is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative timeframes.

Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and maintenance unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

The treating clinician must nominate the most clinically appropriate sub or non-acute care type for the patient when there is an admission or a change in care type. The sub and non-acute care types currently available for use are Palliative Care, Rehabilitation, Geriatric Evaluation and Management (GEM), Psychogeriatric or Maintenance.

As this is a clinical decision please assign the appropriate care type as defined by the treating clinician. All morbidity codes associated with the admission should be coded.

EXAMPLES

Example 1

A 74 year old lady is seen by the treating clinician who clinically decides to admit her to a GEM care type. She is being treated for her Parkinson’s disease, depression, orthostatic hypotension and constipation.

PD	G20	Parkinson’s disease
OD	F329	Depressive episode unspecified
OD	I951	Orthostatic hypotension
OD	K590	Constipation

Example 2

A 73 year old man is seen by the treating clinician who clinically decides to admit him to a GEM care type. He is being treated for his hyperplasia of prostate. He also has haematuria, dementia, and hypothyroidism and is depressed. While in hospital he is seen by the dietitian and social worker.

PD	N40	Hyperplasia of prostate
OD	R31	Unspecified haematuria
OD	F03	Unspecified dementia
OD	E039	Hypothyroidism unspecified
OD	F329	Depressive episode unspecified
PR	9555000	Allied Health intervention – dietetics
PR	9555001	Allied Health intervention – social work

EDITS

- DSU will generate a warning error if the patient’s age is under 65years, asking staff to check that the patient’s date of birth is correct.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Psychogeriatric – Care Type 10

DEFINITION

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatric care unit;
- in a designated psychogeriatric care program; or
- under the principal clinical management of a psychogeriatric physician or, in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

The treating clinician must nominate the most clinically appropriate sub or non-acute care type for the patient when there is an admission or a change in care type. The sub and non-acute care types currently available for use are Palliative Care, Rehabilitation, Geriatric Evaluation and Management (GEM), Psychogeriatric or Maintenance.

As this is a clinical decision please assign the appropriate care type as defined by the treating clinician. All morbidity codes associated with the admission should be coded.

EXAMPLES

Example 1

A 74 year old man is seen by the treating clinician who clinically decides to admit him to a Psychogeriatric care type. He has vascular dementia and type 2 diabetes with no complications. He has essential hypertension, faecal incontinence and a malignant neoplasm of the prostate.

PD	F019	Vascular dementia
OD	E119	Type 2 diabetes mellitus without complication
OD	I10	Essential (primary) hypertension
OD	R15	Faecal incontinence
OD	C61	Malignant neoplasm of prostate
M	M80103	Carcinoma NOS

Example 2

A 64 year old lady is seen by the treating clinician who clinically decides to admit her to a Psychogeriatric care type. She has Alzheimer's disease, atypical dementia in Alzheimer's. She also suffers with epilepsy and orthostatic hypotension.

PD	G308	Other Alzheimer's disease
OD	F002	Dementia in Alzheimer's disease, atypical or mixed type
OD	G4090	Epilepsy unspecified
OD	I951	Orthostatic hypotension

EDITS

- DSU will generate a warning error if the patient's age is under 50 years, asking staff to check that the patient's date of birth is correct.
- The diagnosis code R69 must not be used as a PD or OD for this care type.
-

Maintenance – Care Type 11

DEFINITION

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting (eg, at home, or in a residential aged care service, by a relative or carer that is unavailable in the short term).

The treating clinician must nominate the most clinically appropriate sub or non-acute care type for the patient when there is an admission or a change in care type. The sub and non-acute care types currently available for use are Palliative Care, Rehabilitation, Geriatric Evaluation and Management (GEM), Psychogeriatric or Maintenance.

As this is a clinical decision please assign the appropriate care type as defined by the treating clinician. All morbidity codes associated with the admission should be coded.

Principal Diagnosis

The principal diagnosis should be related to the primary reason for admission.

Additional Diagnoses

Any other conditions.

Procedures

Procedures as appropriate.

EXAMPLES

Example 1

The daughter of an elderly lady is going on an overseas holiday with her family. Due to the mother's age and condition the family are unable to take her with them. She is going to hospital for care during their absence. She also suffers with dementia.

PD	Z75.5	Holiday relief care
OD	F03	Unspecified dementia

Example 2

A 90 year old man is currently waiting for admission to a nursing home. He requires assistance due to hemiplegia as a result of a cerebral infarct 18 months previously. He currently has a urinary tract infection, which has been determined as E. coli in origin.

PD	Z751	Person awaiting admission to adequate facility elsewhere
OD	G819	Hemiplegia, unspecified
OD	I693	Sequelae of cerebral infarction
OD	N390	Urinary tract infection, site not specified
OD	B962	Escherichia coli [E. coli] as the cause of diseases classified to other chapters

EDITS

- The diagnosis code Z75.5 must not occur in any other care type.
- The diagnosis code R69 must not be used as a PD or OD for this care type.

Other – Care Type 06

DEFINITION

The 'Other' admitted patient care type is a phase of treatment where the principal clinical intent does not meet the criteria for any of the previously defined care types.

Principal Diagnosis

The principal diagnosis is defined as 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility). [ACS 0001]

Additional Diagnoses

A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility. [ACS 0002]

Procedures

Interventions as appropriate.

EXAMPLES

Example 1

A patient was admitted into an acute care type for his chronic obstructive pulmonary disease with acute lower respiratory infection. His condition was treated as an acute care type with oxygen enrichment therapy and has since improved to a point where he is eligible for discharge. However, his normal residence is 300 kilometres from the hospital and he unable to return home for another two days. The patient still requires minimal nursing care for his COPD but the clinician has indicated that he is no longer an acute patient. He has an episode change from 'acute' to 'other' for the final two days. The 'other' care type episode would be coded as follows:

PD	Z59.8	Other problems related to housing and economic circumstances.
OD	J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection.

EDITS

- DSU will generate a warning error if the episode type 'other' is used, asking staff to check that the care type has been allocated correctly.

Comments, Queries and Suggestions

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

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