CCAQ Coding Advice

Voluntary Assisted Dying – Q0331

Query:

QCAEC have been asked to provide a response by DOH, SSB and various working groups on how to capture voluntary assisted dying (VAD) in coding when it is implemented in QLD in January 2023. There is an expectation that some of patients will choose VAD whilst in hospital or will specifically be admitted to hospital for VAD.

Currently, voluntary assisted dying is not covered under any classifications or standards for clinical coding. The QCAEC's view (awaiting CCAQ confirmation) is that coders will reflect the underlying disease, illness, or medical condition for which the person is accessing voluntary assisted dying however we are unable to provide specific coding for VAD.

Some examples and coding issues are listed below:

Scenario 1

- Max is admitted to hospital for treatment of adenocarcinoma of the sigmoid colon with liver and lung metastases. While admitted, Max makes a first request for voluntary assisted dying. A first assessment for voluntary assisted dying is completed by Dr Smith, an oncologist with the healthcare facility. Would the coding only include the adenocarcinoma of the sigmoid colon with liver and lung metastases? There is currently no code available to indicate a VAD assessment has been completed.

Scenario 2

- Linh has hypertensive congestive heart failure and kidney failure (CKD stage 5). She has been found eligible for voluntary assisted dying and has made a practitioner administration decision. Linh prefers to die in hospital. Linh is admitted to hospital for administration of the voluntary assisted dying substance. Mr Brown, a nurse practitioner at the healthcare facility and authorised voluntary assisted dying practitioner, administers the VAD substance to Linh in the cardiology ward. There is currently no code available as a principal diagnosis or a procedure code for this scenario – would we just code the underlying medical reason for the VAD?

Coding and reporting issues and questions for VAD:

- There is no specific ICD-10-AM diagnosis or ACHI procedure code to identify and/or code for VAD patients i.e., no way to identify this cohort of patients in current coding practices for patients who decide during their stay or patients who are admitted specifically for this purpose.
- Is an acute care type (01) accurate for this type of patient – should there be a separate care type for VAD patients (who are solely admitted for this purpose)?
- What are other states/IHACPA doing? I spoke to HIMs from 4 different states and IHACPA representatives – they are not capturing this data at all, just coding underlying condition. They are relying on individual state VAD reporting systems.

- Is there a need for a “new” emergency use code in ICD-10-AM to identify this cohort of patients – if there was a specific code – if admission for VAD, then this could be used as the principal diagnosis or as an additional code if VAD was enacted during the stay (this would easily identify this cohort of patients). Speaking to IHACPA representatives at recent HIMAA Conference - no interest as very small numbers and these types of patients can be collected via other systems.

Evidently, our current coding practices are not able to identify VAD patients and their intervention. I would like CCAQ's view on this issue so that our State Educator can provide some guidance when VAD is introduced in January 2023.

Advice:

Effective: 1 December 2022 - Advice is CURRENT

First review: 1 December 2022 as CCAQ query 03-1222. ICD-10-AM/ACHI/ACS 12th Ed.

Voluntary assisted dying in Queensland gives eligible people diagnosed with a life-limiting condition, who are suffering intolerably and dying, an additional end-of-life choice by allowing them to choose the timing and circumstances of their death.

It involves the administration of a substance prescribed by a medical practitioner, with the purpose of bringing about the person’s death. It is instigated by the person’s voluntary request and follows a process of requests and assessments (Queensland Voluntary Assisted Dying Handbook – Version 1.0).

The Queensland Voluntary Assisted Dying Handbook states “Coding should reflect the underlying disease, illness, or medical condition for which the person is accessing voluntary assisted dying”.

The delivery of voluntary assisted dying in Queensland will be supported by the Queensland Voluntary Assisted Dying Information Management System (QVAD-IMS). The QVAD-IMS will enable data collection and reporting to support the functions of the VAD Review Board.

Voluntary assisted dying is an end-of-life choice and is distinct from palliative care (Queensland Voluntary Assisted Dying Handbook – Version 1.0), therefore a palliative care type may not be appropriate for an episode of care involving voluntary assisted dying.

The care type assigned to an episode of care will be the care type that best describes the primary clinical purpose or treatment goal. There may be more than one episode of care within the one hospital stay period (QHAPDC Manual 2022-2023 Collection Year v1.0).

Refer to the QHAPDC for definitions of the care types available for an admitted patient and assign the care type that best describes the primary clinical purpose or treatment goal.

For the scenarios in the query, assign the following codes:

Scenario 1

A patient admitted for treatment of adenocarcinoma of the sigmoid colon with liver and lung metastases. While admitted, the patient makes a first request for voluntary assisted dying and a first assessment is completed by the doctor and documented in the progress notes.

Principal diagnosis

C18.7 *Malignant neoplasm of sigmoid colon*

M8140/3 *Adenocarcinoma NOS*

Additional diagnoses

C78.7 *Secondary malignant neoplasm of liver and intrahepatic bile duct*

C78.0 *Secondary malignant neoplasm of lung*

M8140/6 *Adenocarcinoma, metastatic NOS*

An intervention code for the VAD assessment is not assigned.

Scenario 2

A patient admitted with hypertensive congestive heart failure and kidney failure (CKD stage 5). The patient has completed the request and assessment process and has made a practitioner administration decision. The patient prefers to die in hospital and is admitted for administration of the voluntary assisted dying substance.

Principal diagnosis

I13.2 *Hypertensive heart and kidney disease with both (congestive) heart failure and kidney failure*

An intervention code for administration of the VAD substance is not assigned.