codingmatters
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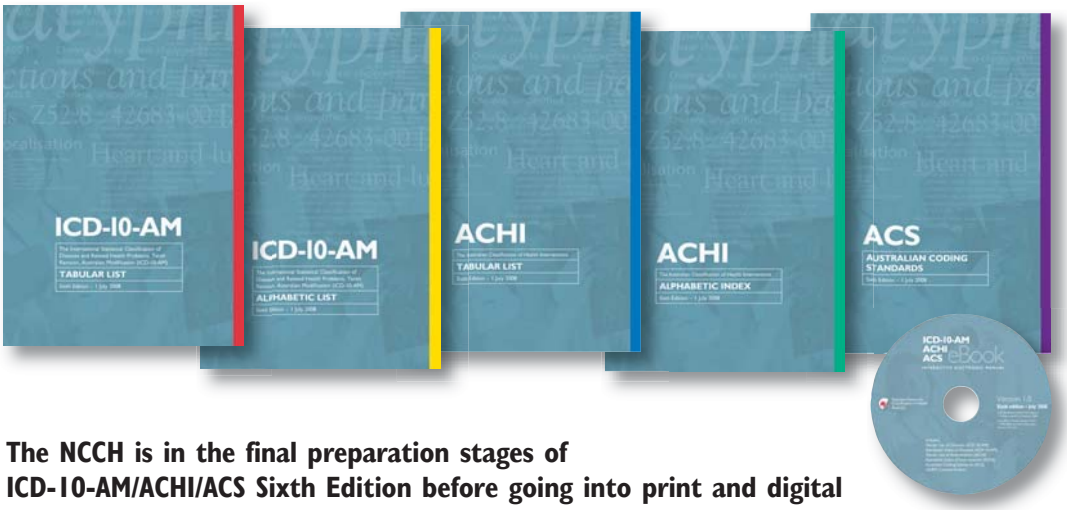
ICD-10-AM/ACHI/ACS Sixth Edition preview



The NCCH is in the final preparation stages of ICD-10-AM/ACHI/ACS Sixth Edition before going into print and digital production. The Sixth Edition has been prepared with input from Australian clinicians, health information managers and clinical coders. It includes changes derived from the foundation classifications: WHO ICD-10 and the Medicare Benefits Schedule (MBS).

NCCH has continued with its practice of seeking public submissions for changes to the classification. The centre acknowledges input from members of the Clinical Casemix Committee (CCC), Clinical Classification and Coding Groups (CCCG) and particularly from the NCCH's Coding Standards Advisory Committee (CSAC). CSAC has representation from Australian state and territory jurisdictions, New Zealand Health Information Service, the Health Information Management Association of Australia (HIMAA), the Australian Institute of Health and Welfare (AIHW), the Clinical Coders' Society of Australia (CCSA), the private sector, CCC and the Australian Government Department of Health and Ageing. The depth and scope of the scrutiny of changes emanating from both inside and outside the NCCH should guarantee the relevance of the classification as the Australian Standard for the next two years.

Following are the summary statistics regarding the number of new and deleted codes and a summary of the major changes in Sixth Edition.

Summary statistics

ICD-10-AM Sixth Edition

Total number of new disease codes 212

Total number of deleted disease codes 41

Australian Classification of Health Interventions (ACHI) Sixth Edition

Total number of new procedure codes 423

Total number of deleted procedure codes 242

Total number of new blocks 3

Total number of deleted blocks 6

Australian Coding Standards (ACS) Sixth Edition

Approximate number of new Australian Coding Standards 3

Approximate number of deleted Australian Coding Standards 5

Approximate number of modified Australian Coding Standards 56

WHO ICD-10 Updates

Proposals considered 192

Proposals included in ICD-10-AM Sixth Edition 129

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Summary of major changes

1. ICD-10-AM Sixth Edition

The modifications to the disease classification include a number of important improvements.

1.1 Major changes

Include, but are not limited to:

- Abortion, curettage and ectopic pregnancy
- Chronic kidney disease
- Diabetes Mellitus
- Drug and alcohol
- Effects of radiotherapy
- Postpartum anaemia
- Postprocedural complications
- Ruptured uterus

1.2 WHO ICD-10 updates

Recommendations for change to ICD-10 are made by the Update and Revision Committee of the WHO Family of International Classifications Network (WHO-FIC). ICD-10-AM Sixth Edition contains those recommendations ratified at the Tokyo (October 2005) and Tunis (October 2006) meetings of the URC.

The main changes include new codes for:

- Other infectious gastroenteritis and colitis
- Gastroenteritis and colitis of unspecified origin
- Acute viral hepatitis, unspecified
- Primary and secondary thrombophilia
- Vascular parkinsonism
- Indeterminate colitis
- Oesophageal varices, with and without bleeding, at the fourth character level
- Preterm labour without spontaneous delivery
- Immobility

New terminology in the area of:

- Decubitus ulcer and pressure areas
- Keratopathy following cataract surgery
- Ulcerative colitis
- Blindness and low vision
- Pneumocystis jirovecii

Change of classification for:

- Benign neoplasms of prostate (adenoma, fibroadenoma, fibroma and myoma)
- Stransky Regalia anaemia

1.3 External cause of injury codes

A submission was received by the Research Centre for Injury Studies (RCIS). Changes made as a result of this submission include the following areas:

- Bitten (pecked) or struck by birds
- Fall on and from stairs and steps
- Diving or jumping into water causing injury other than drowning or submersion
- Other fall from one level to another
- Contact with other powered hand tools and household machinery
- Moving objects
- Place of occurrence – home

Other changes made to the external cause of injury section as a result of other public submissions include:

- Town camps
- Activity codes

2. Australian Classification of Health Interventions (ACHI) Sixth Edition

The major modifications to the intervention classification include both changes made through public submissions as well as amendments based on the Medicare Benefits Schedule (MBS) changes from November 2004, May 2005, November 2005 and May 2006. The major changes include:

- Cardiac electrophysiology study (EPS) with radiofrequency ablation
- Cerebrovascular embolisation
- Electroconvulsive therapy
- Endoscopic procedures
- Laparoscopic hysterectomy
- Pacemakers and defibrillators
- Pharmacotherapy
- Ventilatory support

3. Australian Coding Standards (ACS)

3.1 Major amendments

There have been fifty-six ACS amended for Sixth Edition. Significant changes include:

- ACS 0002 *Additional diagnoses*
- ACS 0020 *Bilateral/multiple procedures*
- ACS 0503 *Drug, alcohol and tobacco use disorders*
- ACS 0936 *Pacemakers and defibrillators*
- ACS 1006 *Ventilatory support*
- ACS 1904 *Procedural complications*

3.2 Major deletions

With the changes incorporated into ICD-10-AM and ACHI with regard to the classification of pharmacotherapy, there has been a complete deletion of ACS 0045 *Drug delivery devices.*

3.3 Major additions

With final approval as a National Minimum Data Set (NMDS) item for collection effective July 2008, the Condition onset flag is a major addition to the ACS for Sixth Edition. Other major additions to the ACS include a standard on the coding of Chronic kidney disease (CKD) and Electroconvulsive therapy (ECT).

Publication information

ICD-10-AM/ACHI/ACS Sixth Edition will be published in March 2008, for implementation from July 2008. ICD-10-AM/ACHI/ACS Sixth Edition will be available as:

- five volumes in hard copy, with optional slipcases or sturdy polypropylene carry case
- enhanced electronic version, which can be used as a stand alone option or networked for your designated number of users. It includes useful features such as global notes, which allows an administrator to create or edit notes that can be seen by all users, and a personal notes field. Links make looking up Australian Coding Standards and the latest published information from 10-AM Commandments easy and fast.

  New to Sixth Edition is the split screen view (users can simultaneously view up to four components of the eBook).
- electronic code list – an ASCII comma delimited file

Ordering information is enclosed with this edition of Coding Matters and can be obtained from www.fhs.usyd.edu.au/ncch.

Sixth Edition education

- The model for delivery of Sixth Edition education will be similar to that used for Fifth Edition education. This will include online education via the web, CD-ROM for those without access to the Internet, and optional face-to-face workshops. See page 10 for further details.

The **10-AM** Commandments

Administration of Iron

Q. What is the correct code to assign for administration of iron?

Iron is an essential substance in the human body, transporting oxygen to tissues via haemoglobin in red blood cells and functioning as a co-factor in a number of enzyme systems. Iron deficiency is caused by a deficit in total body iron, resulting from iron requirements that exceed the iron supply. If iron deficiency is not corrected it will lead to iron deficiency anaemia with a significant impact on life, morbidity and mortality.

The World Health Organization estimates that as many as 2 billion people – more than 30% of the world's population – are anaemic, mainly due to iron deficiency.

Administration of iron using products such as Ferrum H® and Imferon® are commonly used for treatment of refractory iron deficiency anaemia where oral therapy is contraindicated. These supplements contain iron in a form that can be used by the body to build up iron reserves. They are administered either by injection into a muscle (intramuscular injection) or by infusion into a vein (intravenous infusion). Infusion is recommended only when the intramuscular route is impractical or unacceptable and when bone marrow shows no stored iron. Intravenous administration is only performed in a hospital.

When a patient is admitted specifically for administration of iron, for a day only episode of care, assign 96199-09 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent,* following the pathway:

Administration
- agent (to)
- - pharmacological
- - - intravenous 96199 **[1920]**

For multi-day episodes of care, an intervention code for the administration of iron is not required, as per point 5 *Drug treatment* in ACS 0042 *Procedures normally not coded.*

Charcot's Arthropathy

Q. What is the correct code assignment for Charcot's arthropathy due to diabetes or other causes?

In 1703, William Musgrave first described a neuropathic joint as an arthralgia caused by venereal disease. In 1868, Jean-Martin Charcot gave the first detailed description of the neuropathic aspect of the disease; hence, the condition is named after him. Charcot noted this disease process as a complication of syphilis. Syphilis was believed to be the most common cause of Charcot's arthropathy until 1936, when the condition was linked to diabetes. Diabetes is now considered to be the most common aetiology of Charcot's arthropathy. It also occurs, less commonly, as a result of syphilis, chronic alcoholism, leprosy, meningomyelocele, spinal cord injury, syringomyelia, renal dialysis and congenital insensitivity to pain. In fact, there are over twenty-four different diseases that have been demonstrated to develop this condition.

A Charcot joint is a progressive condition of the musculoskeletal system characterised by joint dislocations, pathologic fractures and debilitating deformities. This disorder results in progressive destruction of bone and soft tissues at weight-bearing joints and, in its most severe form, may cause significant disruption of the bony architecture. Charcot's arthropathy may occur at any joint; however, it occurs most commonly in the lower extremity at the foot and ankle.

The default index entry which assigns Charcot's arthropathy to A52.1† *Symptomatic neurosyphilis* M14.6* *Neuropathic arthropathy* assumes that syphilis is the most common aetiology of Charcot's arthropathy. However, if Charcot's arthropathy is not documented as being due to syphilis, assign G98† *Other disorders of nervous system, not elsewhere classified* and M14.6* *Neuropathic arthropathy* following the pathway:

Arthropathy
- Charcot's (tabetic)
- - nonsyphilitic NEC G98† M14.6*

Where Charcot's arthropathy is documented as being due to diabetes follow the index pathway:

Arthropathy
- Charcot's (tabetic)
- - with diabetes E1-.61
- - nonsyphilitic NEC G98† M14.6*

and assign all three codes in the following sequence to complete the clinical picture:

E1-.61 *Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication*

G98† *Other disorders of nervous system, not elsewhere classified*

M14.6* *Neuropathic arthropathy*

The indexing of Charcot's arthropathy will be reviewed for a future edition of ICD-10-AM.

Colonic/Rectal Stents

Q. What is the correct procedure code to assign for endoscopic placement of a colonic or rectal stent?

A. Following successful application of stenting in blood vessels and the upper gastrointestinal tract, stenting has in recent years been adopted for the relief of malignant colorectal obstruction. The value of the stent placement is as a minimally invasive alternative to open surgical techniques, such as resection or stoma creation. The stent is advanced to the obstruction in a collapsed state, and, once deployed, it slowly opens to its maximum diameter under its own force. This achieves patency of the obstructed anatomy. Stenting may be performed as a definitive palliative measure, or can be used as a 'bridge-to-surgery' to allow stabilisation of the patient's condition before surgery is carried out as an elective procedure at a later date.

Specific codes for colonic and rectal stents have been created for ACHI Sixth Edition. In the interim, assign 32094-00 [917] *Endoscopic dilation of colorectal stricture* by following the pathway:

Dilation
- colorectal
- - stricture (endoscopic) 32094-00 **[917]**

Conjunctival Intraepithelial Neoplasia

Q. What is the correct code assignment for conjunctival intraepithelial neoplasia?

Corneal and conjunctival intraepithelial neoplasia (CIN) is a precancerous lesion of the ocular surface. It is typically found in Caucasian men aged in their mid 60s.

CIN is composed of dysplastic and thickened epithelial cells, with increased cell proliferation and irregularity of the individual epithelial cells. Histopathological changes are graded as mild, moderate or severe. A lesion is termed 'carcinoma in situ' when it shows full thickness epithelial involvement. Finally, when tumour cells invade the epithelial basement membrane, the lesion becomes an invasive squamous cell carcinoma (SCC) and the patient is at risk of metastatic disease.

Excessive ultraviolet light exposure has been identified as a major risk factor in the development of CIN. Other causative factors may include petroleum products, heavy cigarette smoking, light-coloured hair and ocular pigmentation, living in an equatorial region and viral infection – including herpes simplex type 1, human papillomavirus (HPV) and HIV. HPV types 16 and 18 have been associated with intraepithelial neoplasia of the uterine cervix. DNA from HPV types 16 and 18 has been demonstrated in both benign and malignant cervical and conjunctival lesions, giving strong evidence for an aetiologic role of HPV in the development of CIN.

The correct code to assign for conjunctival intraepithelial neoplasia is H11.8 *Other specified disorders of conjunctiva.* Assign also B97.7 *Papillomavirus as the cause of diseases classified to other chapters* if HPV is documented.

Improvements to the index for this condition will be considered for a future edition of ICD-10-AM.

Indwelling Catheters (IDC)

Q. When should the code for an IDC be assigned?

Assign 36800-00 [1090] *Bladder catheterisation* if an indwelling catheter has been left in situ on the patient's discharge, irrespective of whether or not it has been placed postprocedurally.

Bladder catheterisation should also be coded as per ACS 1436 *Trial of void.*

ACS 0042 *Procedures normally not coded,* point 14, has been amended for ACS Sixth Edition and the term postprocedural has been deleted.

Noninfectious Colitis in Children

Q. ACS 1120 *Gastroenteritis* advises that if gastroenteritis is not stated as infectious it should be coded as A09 *Diarrhoea and gastroenteritis of presumed infectious origin in children (15 years and under).*

Can a noninfectious colitis code be assigned where colitis in a child is documented in association with inflammatory bowel disease or cryptitis or when such conditions as 'disuse colitis' or 'diversion colitis' are documented?

In the circumstances described, where colitis is not due to an infectious cause, it would be appropriate to assign a code from K52 *Other noninfective gastroenteritis and colitis.* ACS 1120 *Gastroenteritis* gives advice for when there is no indication in the clinical record to indicate if the colitis is infectious or noninfectious.

This area has been revised for ICD-10-AM Sixth Edition.

Polycythaemia

Q. What is the correct code to assign for polycythaemia, unspecified?

Polycythaemia is a condition in which there is a net increase in the total number of red blood cells in the body. The overproduction of red blood cells may be due to a primary process in the bone marrow (a so-called myeloproliferative syndrome), or it may be a reaction to chronically low oxygen levels or, rarely, a malignancy.

Primary polycythaemia is a rare condition, often called polycythaemia vera (PCV), polycythaemia rubra vera (PRV) or erythraemia. It occurs when excess red blood cells are produced as a result of an abnormality of the bone marrow. Often, excess white blood cells and platelets are also produced. Polycythaemia vera is classified as a myeloproliferative disease.

Secondary polycythaemia refers to elevated numbers of red blood cells not caused by bone marrow abnormalities. Usually, anything that reduces the amount of oxygen available to the body prompts the increased production of red blood cells. Some of the factors that may cause secondary polycythaemia include:

- cigarette smoking
- lung disease
- heart disease
- high altitudes
- certain tumours

The current index default in ICD-10-AM for polycythaemia (not otherwise specified) assigns D45 *Polycythaemia vera* (and M9950/3 *Polycythaemia vera*) with *primary, rubra* and *vera* listed as non-essential modifiers. However, D45 *Polycythaemia vera* should be assigned only in those cases where *polycythaemia (rubra) vera* or *primary polycythaemia* is documented. In the absence of this documentation and where no further information is provided, assign D75.1 *Secondary polycythaemia.*

The indexing of polycythaemia will be reviewed for a future edition of ICD-10-AM.

Reactive Airways Disease

Q. What code should be assigned for reactive airways disease?

The terms *reactive airways* and *reactive airways disease* have in recent years been used by doctors as synonyms for asthma. *Reactive airways disease* is a general term and does not indicate a specific diagnosis. It may be used to describe a history of coughing, wheezing and shortness of breath due to an undetermined cause. These signs and symptoms may or may not be caused by asthma.

Use of the term in part, reflects the difficulty with establishing a diagnosis of asthma in some situations and most particularly in children. In very young children, the diagnosis of asthma is problematic because histories and good quality pulmonary function tests are difficult to obtain. Asthma is also a diagnosis that carries a negative connotation for patients. Hence, this nonspecific term may be used in clinical contexts ranging from asthma, to wheezy bronchitis, to viral bronchiolitis or even to pneumonia.

In adults, the term is sometimes popular in instances where a physician obtains a history of wheeze, sputum production or inhaler use but a formal diagnosis of asthma is not in the patient record. A formal diagnosis of asthma requires documentation of reversible airway obstruction or airway hyperactivity in the setting of a typical history of asthma. If this information is missing, or elements of a typical asthma history are missing, the physician may document reactive airways disease to convey that the patient has some sort of airway problem.

The most appropriate code to assign for reactive airways disease in the absence of a diagnosis of asthma or another acute respiratory condition is J98.8 *Other specified respiratory disorders.*

Velamentous Insertion of Cord

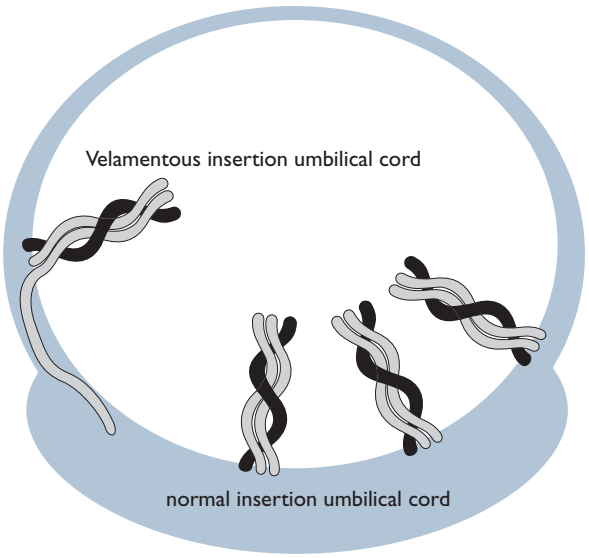
Q. What is the correct code to assign for velamentous insertion of cord?

Normally, veins run from the middle of the placenta via the umbilical cord to the fetus. The umbilical cord inserts on the placental mass in about 99% of cases, with the insertion site varying from the centre of the fetal surface to the border of the placenta. Velamentous insertion is used to describe the condition in which the umbilical cord inserts on the chorioamniotic membranes rather than on the placental mass.

The incidence of this condition is about 1.1% in singleton gestations and 8.7% in twin gestations. The incidence of velamentous insertion is even higher in early pregnancy: in spontaneous abortions it has been estimated to be 33% between the ninth and twelfth weeks and 26% between the thirteenth and sixteenth weeks.

The most significant problem arising from a velamentous insertion of the umbilical cord is vasa praevia, a dangerous condition in which the velamentous umbilical vessels traverse the fetal membranes in the lower uterine segment below the presenting part. In 6% of singleton gestations with a velamentous insertion, vasa praevia is a coexisting condition. These unprotected vessels may rupture at any time during pregnancy, causing fetal haemorrhage and death.

The picture below shows a velamentous cord insertion.



For velamentous insertion of cord, where care or intervention is required before the onset of labour, assign O43.1 *Malformation of placenta* following the pathway:

Insertion
- cord (umbilical) lateral or velamentous O43.1

or

Pregnancy
- complicated by
- - abnormal
- - - placenta, placental (vessel) O43.1

Where the abnormality is first diagnosed during labour, or requires care and/or intervention during labour, assign O69.8 *Labour and delivery complicated by other cord complications* following the pathway:

Delivery
- complicated (by)
- - velamentous insertion of cord O69.8

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NCCH Conference – Coding Rules

l-r Lori Moskal, Richard Madden, Sue Walker and Robert Jakob

The 2007 NCCH Conference was held on July 25–27 in Brisbane at the Hilton Hotel. Professor Stephen Duckett, Executive Director of Queensland Health, officially opened the conference on Thursday welcoming the 284 registered delegates. The first session set the scene for a wide ranging and informative conference including two clinical updates.

Conference highlights – Thursday

The first session, entitled ICD and WHO, featured invited presenters Lori Moskal and Dr Robert Jakob, both leading world authorities on ICD. Their presentations focused on the ICD now and in the future. First, Dr Jakob, an ICD Officer with the WHO in Geneva, detailed the future direction of the ICD, the need for revision of ICD-10 and the work towards the implementation of ICD-11.

Robert's presentation outlined the plans for the revision of the ICD. The revision process was launched in April 2007 and is led by a Revision Steering Group chaired by Professor Chris Chute from the Mayo Clinic. The revision process will make maximum use of the content of the various national modifications of the ICD, notably ICD-10-AM, and includes a range of Topic Advisory Groups. The group on External Causes and Injuries is led by Associate Professor James Harrison, Director of the AIHW National Injury Surveillance Unit at Flinders University. The aim is to have a first version of ICD-11 for comment in 2010. After testing, the target date for adoption is 2014.

Professor Richard Madden, NCCH Director, followed Dr Jakob with the Australian perspective of ICD-11 revision and the NCCH's role in the revision process. Richard also spoke about the effects of the revision on future editions of ICD-10-AM. As a member of the Revision Committee, Richard was able to discuss the implications of the revision, both for future editions of ICD-10-AM and for the transition to ICD-11. ICD-10-AM contains material on a range of topics that will be of use in the revision, notably diabetes, kidney disease, external causes of injury and postprocedural complications.

During the revision process, the emphasis at NCCH will shift progressively from updates of ICD-10-AM to the planned morbidity version ('view') of ICD-11. The aim will be to incorporate as much material from ICD-10-AM into ICD-11, including anticipated ICD-11 material into ICD-10-AM, to allow a smooth a changeover to ICD-11 as soon after its adoption as possible. Most likely, Australia will still seek to modify ICD-11 for Australian purposes, but the less modification needed for its implementation, the easier the transition will be.

Lori Moskal from the Canadian Institute of Health Information then concluded the first session with an informative and engaging presentation on the successes and challenges of the WHO-FIC Update and Revision Committee and how it works. Lori is the Secretary of the WHO-FIC Update and Revision Committee. Canada took on the support of this Committee in 2005, succeeding NCCH which had supported it from its inception.

Lori outlined the success to date of the updating process, and the impact those updates will have in reducing the workload on the revision process. The number of proposed updates has expanded over time. A web platform is now in place to manage the burden this increased workload presents. The Committee will be working closely with the Revision Steering Group as the revision process accelerates.

Thursday's sessions were completed with four presentations each on the topics of using and improving coded data and what's new in coding here and overseas, including a highly anticipated presentation of the forthcoming changes for ICD-10-AM/ACHI/ACS Sixth Edition.

Conference highlights – Friday

The final day of the conference featured presentations on classification and patient safety and coding at the coalface. Of particular interest for coders in the DRG environment was an entertaining presentation by Swedish delegates, Olafr Steinum and Gunnar Henriksson, on the advantages for morbidity coding of a reversal of the dagger-asterisk convention.

There was also an informative session on SNOMED CT by two international guest speakers, Dr Geraldine Wade of Hewlett-Packard Information Management (USA) and David Markwell of the Clinical Information Consultancy (UK). David provided an excellent introduction to SNOMED CT, and its relationship to electronic records, and went on to discuss the confluence of SNOMED and ICD in the future. Geraldine spoke about Migrating Legacy Data to SNOMED CT and the big picture – transforming legacy data to interoperability. Both speakers provided the audience with insights into the possible future impact of SNOMED CT on ICD and its application to coding.

Clinical updates

The highly regarded clinical updates were presented on each day of the conference. The first was on Chronic Kidney Disease (CKD) by Dr Timothy Mathew, National Medical Director, Kidney Health Australia, and Margaret Cook (NCCH). The second clinical update was on Arthritis by Dr Lynn March, Department of Rheumatology, Royal North Shore Hospital (RNSH) Sydney. Both clinical update sessions were well attended and delegates were presented with a comprehensive description of both disease processes. An insight into the proposed classification changes for chronic kidney disease in ICD-10-AM Sixth Edition was also provided.

Conference workshop

The NCCH held the pre-conference workshop on Wednesday 25 July with 100 registrants. Past workshops have proved a popular feature of the conference and the 2007 workshop was no different. Hands-on coding continues to be the most favourable continuing education approach for coder training. This workshop was then offered nationally in all Australian states and territories (see the workshop report in this issue of Coding Matters).

Social program

The Conference commenced with an informal cocktail party held poolside at the Hilton Hotel to welcome the delegates to Brisbane, with approximately 200 delegates attending. The cocktail party followed the workshop and provided an opportunity for delegates to catch up with their interstate and international colleagues.

The conference dinner was held at the beautiful Hillstone St Lucia golf course on Thursday night. The evening commenced with drinks and canapés on the terrace overlooking the golf course and concluded with a dance exhibition by some of the NCCH staff. Those who left on the earlier buses certainly missed some rockin' dance floor moves!

Conference facts and figures

The NCCH conference attracted 284 registered delegates with a small number electing to attend either the Thursday or Friday sessions only. All the sessions were well attended over the two days and the challenge in hosting a conference for more than 250 delegates is that it is difficult to please all the delegates all of the time. Instead, the NCCH aimed to please most of the delegates most of the time! We feel that we achieved this as 61% of delegates who were surveyed agreed their expectations were met.

l-r Peter Hibbert, Margaret Cook and Timothy Mathew

l-r Marla Tun, Yukiko Yukobori and Ikuko Takatsuka

Overall, the conference was a success with 82.86% of delegates surveyed agreeing that the conference was enjoyable and 76.84% of delegates claiming it to be a valuable professional development opportunity.

This year we tried a few new things, the major one being engaging a company, Conference Logistics, to manage the registration process and organise the conference. This included an online registration process which 92% of the delegates surveyed said was excellent or good. The experience of working with Conference Logistics was very positive for the NCCH and we appreciated their knowledge, experience and calm manner during unexpected difficulties. Many thanks must go to Renae and Jane for their fantastic service! We thoroughly recommend Conference Logistics to anyone who is looking for a professional conference management company.

Many thanks should go to all the presenters for their thought provoking presentations, to the delegates for continuing to support our conference, and finally to the NCCH staff who did a fantastic job in making the 2007 NCCH Conference a great success.

Next NCCH conference

Looking to the future we received a lot of great feedback about what did and didn't work and we will use this to make the upcoming 2009 conference the best one yet. While we haven't yet finalised the location of the next conference, the money is on either Darwin or Adelaide so, as we say, stay tuned!

ICD-10-AM/ACHI/ACS

Sixth Edition education program

From 1 July 2008, ICD-10-AM/ACHI/ACS Sixth Edition will be implemented nationally. In order to familiarise clinical coders and other users with the changes that have been made to the classification, an education program (web and workshop based) will be offered to coders from March 2008.

Education program

Education material containing all the changes that have been made to ICD-10-AM/ACHI/ACS Fifth Edition to create the Sixth Edition will be provided via:

- a downloadable PDF file via the web – the education material can be worked through at your own pace and includes all major and minor changes that have been made to ICD-10-AM/ACHI/ACS with exercises to help reinforce some of these changes. (This document is >400 pages in length and will therefore take considerable time to work through in detail).
- optional (recommended) two day face-to-face workshops that will be conducted in all capital cities and many regional centres.

How to access the education program material

The education material can be accessed by:

- download from the NCCH website via a PDF file
- ordering a CD-ROM
- ordering a hard copy of the PDF file

Access to the PDF file via the NCCH website will be provided using a secure user name and password which will be issued once you have registered for the education program by using the form available at www.fhs.usyd.edu.au/ncch. Registrations will be taken from January 2008 onwards to secure a place in a workshop, but will not be processed or access provided to the PDF file until mid February.

To complete the exercises in the education material, access to ICD-10-AM / ACHI / ACS Sixth Edition is recommended.

ICD-10-AM/ACHI/ACS Sixth Edition workshops

Optional (but recommended) two day face-to-face workshops will be offered to Australian coders between April and June 2008 in all state and territory capital cities, as well as major regional areas. **Completion of the education material is mandatory for coders attending the workshops.**

Educators will reinforce some of the more complex changes to the classification outlined in the education material and there will also be the opportunity to complete coding exercises and a quiz to further highlight these changes. These workshops provide valuable opportunities for users of the classification to learn and discuss aspects of coding with Sixth Edition.

The workshops will commence at 9.00am and conclude at approximately 4.00pm each day and often fill very quickly so book early to secure your place. It is important that registrations are forwarded to the NCCH well in advance of a selected workshop in order that room bookings and catering arrangements can be made.

Attendance at workshops is optional, but provides an opportunity for coders to consolidate their learning and to also network with other ICD-10-AM/ACHI/ACS users. A fee will be charged for attending the workshops.

Maximum places offered for a workshop is fifty with the minimum being twenty. If the minimum quota for registrations is not reached (exception being the Northern Territory and some regional areas) the workshop may be cancelled.

The workshop will focus on the following areas which were considered more complex or new to the classification and topics will include:

- additional diagnoses
- chronic kidney disease
- condition onset flag
- drug and alcohol
- multiple/bilateral procedures
- obstetrics
- postprocedural complications
- ventilation

What you'll need to bring to the workshop

- a set of ICD-10-AM/ACHI/ACS Sixth Edition books or
- eBook installed on your own laptop computer and
- writing equipment

Workshops are operated on the assumption that all participants have completed the education material before attending. Educators are unable to retrospectively review information covered in the education material at workshops.

Cost

Users must register to access the Sixth Edition education program material. Costs are:

Downloadable PDF file via web	Free
CD-ROM	$ 55*
Hardcopy	$110*
Workshop	$440*

*All costs include GST

You must register and complete the education material to be eligible to attend workshops.

Workshop places are limited. To avoid disappointment you must register as soon as possible to secure a place and so that venues can be booked.

Cancellations received with more than 10 working days notice before a workshop will be refunded, less an administration fee of $50.00. No refunds are available for cancellations received within 10 working days of a workshop.

How to register

- Use the form on page 12 to order the education material and register to attend workshops (NB: due to alternative funding arrangements, South Australian coders are to complete a separate form, see insert for details)
- Send completed forms to Fax: 02 9351 9603
- The form is also available from www.fhs.usyd.edu.au/ncch where it can be completed and e-mailed online.

Please send cheques (payable to the University of Sydney) or credit card details (MasterCard or VISA) with the registration form to:

National Centre for Classification in Health
The University of Sydney
PO Box 170 Lidcombe NSW 1825

Workshop schedule

Please note: The NCCH reserves the right to cancel, reschedule or relocate workshops if target numbers are not reached

NSW

Bankstown
Tues 8 & Wed 9 April
Thurs 10 & Fri 11 April

Dubbo
Thurs 10 & Fri 11 April

North Ryde
Tues 29 & Wed 30 April
Thurs 1 & Fri 2 May

Albury
Thurs 1 & Fri 2 May

Coffs Harbour
Tues 6 & Wed 7 May

Newcastle
Tues 13 & Wed 14 May
Thurs 15 & Fri 16 May

Penrith
Tues 10 & Wed 11 June

Wollongong
Thurs 12 & Fri 13 June

Tamworth
Wed 11 & Thurs 12 June

Lismore
Wed 25 & Thurs 26 June

Queensland

Toowoomba
Tues 29 & Wed 30 April

Brisbane
Thurs 1 & Fri 2 May
Tues 20 & Wed 21 May
Thurs 22 & Fri 23 May

Rockhampton
Wed 21 & Thurs 22 May

Townsville
Thurs 15 & Fri 16 May

Tasmania

Hobart
Tues 24 & Wed 25 June

Northern Territory

Darwin
Mon 12 & Tues 13 May

ACT

Canberra
Tues 3 & Wed 4 June

Western Australia

Perth
Tues 27 & Wed 28 May
Thurs 29 & Fri 30 May
Wed 18 & Thurs 19 June

South Australia

Adelaide
Tues 27 & Wed 28 May
Thurs 29 & Fri 30 May
Tues 3 & Wed 4 June
Thurs 5 & Fri 6 June

Victoria

Melbourne
Mon 5 & Tues 6 May
Wed 7 & Thurs 8 May
Tues 17 & Wed 18 June
Thurs 26 & Fri 27 June

Geelong
Thurs 19 & Fri 20 June

Bendigo
Tues 24 & Wed 25 June

More information…

will also be published at www.fhs.usyd.edu.au/ncch, via Code-L, in the March edition of Coding Matters and by direct mail to previous workshop registrants.

ICD-10-AM/ACHI/ACS Sixth Edition education program

This registration form can be used as a Tax Invoice. Please keep a copy. The University of Sydney ABN 15 211 513 464. To avoid disappointment register as soon as possible to secure a place.

Registration details

Please print clearly. Business hours contact details only please. One registration per form only. Please copy the form for multiple registrations.

Name

Position/Title Department

Hospital/Organisation

Address

State Postcode e-mail

Telephone ( ) Fax ( ) Mobile phone

❑ Purchase order

Please check this box if a purchase order number is required for payment of invoices within your organization. Failure to check this box will result in an invoice raised by NCCH without a matching purchase order. If your order is duplicated due to YOU failing to inform NCCH of purchase order number requirements, YOU will be charged TWICE for this transaction. An administration fee may also be charged for any duplicated transactions.

Education preference (please tick options)

❑ PDF file via web - Free ❑ Hardcopy - $110* ❑ CD-ROM - $ 55* ❑ Workshop only - $440*

Total Amount Payable $_____ * Includes GST

Workshops are for Australian coders ***only*** and will be filled on a first come basis.
Cancellations received with more than 10 working days notice before a workshop will be refunded, less an administration fee of $50.
No refunds are available for cancellations received within 10 working days of a workshop.

Workshop location

First preference Dates

Second preference Dates

Books or eBook?

For seating and power allocation planning purposes, please indicate if you will be using

❑ ICD-10-AM/ACHI/ACS Sixth Edition book set **OR** ❑ ICD-10-AM/ACHI/ACS Sixth Edition eBook

Catering

Please list any special dietary needs:

Payment

Cheques and money orders are payable to: The University of Sydney – NCCH

Credit Card ❑ VISA ❑ Mastercard Amount $ _____

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date ☐☐/☐☐

Cardholder's name Signature

Direct debit

Payment can be made directly into the NCCH bank account by direct electronics funds transfer (EFT)

Bank details for EFT are:

Bank: National Australia Bank
Account name: The University of Sydney NCCH Account
BSB: 082 369
Account Number: 54 372 4531

Please e-mail **fhsNCCHadmin@usyd.edu.au** to confirm that you have paid by direct EFT.

Post or fax your registration to:

National Centre for Classification in Health
The University of Sydney
PO Box 170
LIDCOMBE NSW 1825 Australia
Fax: 02 9351 9603
Faxed on (date) ___ / ___ / ___

For further information from NCCH
phone **02 9351 9461**
or e-mail **fhsNCCHadmin@usyd.edu.au**

Cerebral Palsy

Cerebral palsy (CP) describes a group of disorders of the development of movement and posture that are attributed to non-progressive disturbances that occurred in the developing brain. It occurs in about two per 1000 live births.

Causes of Cerebral Palsy

CP is caused by damage to one or more parts of the brain occurring either during pregnancy, during delivery, or in early childhood. Some causative events include:

- Prenatal (75% of cases) eg developmental brain anomalies, congenital inter-uterine infections.
- Perinatal (8–10%) eg birth asphyxia, hypoglycaemia, untreated jaundice.
- Postnatal (10%) eg accidental injury, severe brain infection.

Cerebral palsy distorts messages from the brain to cause increased muscle tension (hypertonus) or reduced muscle tension (hypotonus). At times, this muscle tension may vary, becoming more or less obvious. Messages from the brain may also be untimely, sent to the wrong muscle, or not sent at all which, generally results in erratic movement of the muscles. It is, therefore, the message path between the brain and muscles which is affected, not the muscles themselves.

CP can be categorised into four main areas, according to the parts of the body it affects.

- **Quadriplegia** – all four limbs are affected and the muscles of the face and mouth may also be affected.
- **Diplegia** – all four limbs are affected, but legs more so than arms.
- **Hemiplegia** – one side of the body is affected.
- **Paraplegia** – both legs, but neither of the arms, are affected

There are four main types of cerebral palsy:

- **Spastic CP** is the most common type, characterised by stiffness or tightness of the muscles, which is most obvious when the person tries to move.
- **Athetoid CP** is characterised by uncontrolled movements and often leads to erratic movements.
- **Ataxic CP** is the least common type of cerebral palsy and is characterised by a lack of balance and coordination. It often presents as unsteady, shaky movements or tremors.
- **Mixed CP** may involve a combination of types of cerebral palsy.

Other disabilities, such as: hearing, sight or speech disorders, epilepsy or an intellectual disability, can sometimes also occur with CP.

There are many different factors involved in the cause of CP and each case is as individual as the person affected. The symptoms and severity of cerebral palsy can range from mild, barely noticeable effects, to severe, in which the individual has extremely poor motor skills and intellectual disability. In the more severe cases, children with CP will require substantial therapy and equipment as well as a range of support services. With treatment, most children can significantly achieve greater control over movement as they learn and practice motor skills. (See AIHW publication *Therapy and equipment needs of people with cerebral palsy and like disabilities in Australia* (2006) for an in depth study on needs for assistance.)

Classification

As the research suggests, each case of CP is as individual as the person affected. The symptoms or associated difficulties of CP can range from mild to severe, and over time, with treatment and continued practice of motor skills, persons with CP will achieve greater control over movement. Therefore, coders should be guided by the available clinical documentation within the episode of care and the ACS in determining whether CP and/or its associated conditions should be coded.

ACS 0002 *Additional diagnoses* allows coders, on a case by case basis, to decide whether CP along with any other associated condition(s) (eg intellectual disability, epilepsy, gastro-oesophageal reflux etc) meet the criteria for assignment as an additional diagnosis(es).

Apart from the initial diagnosis of CP it will very rarely be coded as the principal diagnosis (see example 1). More often than not, the patient will be admitted for treatment of an associated condition such as gastro-oesophageal reflux or epilepsy. In these cases, ACS 0001 should be followed for assignment of the associated condition as principal diagnosis, followed by the CP as an additional diagnosis (see example 2).

Where a patient with CP is admitted for treatment of a condition unrelated to CP, for example, fractured shaft of femur following a MVA, the CP and any other associated conditions should only be coded as an additional diagnosis(es) if the criteria in ACS 0002 is (are) met (see example 3). However, where a patient has a condition from categories F70–F79 *Mental retardation* and this condition meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses,* then the note on page 135 in the tabular list of diseases should be followed with regard to using an *additional code to identify associated conditions such as… …severe physical handicap*. In this instance, if the CP is documented as severe, it should be coded as an additional diagnosis.

ACS 0002 *Additional diagnoses* and 0001 *Principal diagnosis* are the guiding standards to assist in the coding of CP cases. However, the following examples may be used to clarify the coding of CP and its associated conditions.

Example 1:

2 year old boy with a neonatal history of seizures and hypertonia associated with birth trauma is admitted to hospital with muscle spasms and lack of coordination. A series of laboratory tests were performed that excluded progressive biochemical motor system disorders. A brain CT scan performed under sedation confirmed the diagnosis of spastic cerebral palsy. During the admission, the patient was seen by the physiotherapist for a biomechanical assessment.

Principal diagnosis:	G80.00 *Spastic cerebral palsy, unspecified*
Additional diagnoses:	Nil
Procedures:	56001-00 [1952] *Computerised tomography of brain*
	92515-99 [1910] *Sedation, (ASA-99)*
	95550-03 [1916] *Allied health intervention, physiotherapy*

Example 2:

13 year old girl with spastic quadriplegic cerebral palsy and associated epilepsy is admitted to the high dependency ward following an epileptic seizure. The patient had her epilum dosage monitored and altered. During the admission the patient was seen by the speech pathologist and physiotherapist for treatment associated with her cerebral palsy.

Principal diagnosis:	G40.90 *Epilepsy, unspecified, without mention of intractable epilepsy*
Additional diagnoses:	G80.03 *Spastic quadriplegic cerebral palsy*
Procedure:	95550-05 [1916] *Allied health intervention, speech pathology*
	95550-03 [1916] *Allied health intervention, physiotherapy*

Example 3:

26 year old male with mixed cerebral palsy and moderate intellectual disability is admitted to hospital for reduction of his fractured shaft of femur following a MVA. On admission he required sedation for a considerable behaviour problem. Once his agitation subsided he underwent closed reduction of his fractured femur under GA (ASA 2). Prior to discharge, he was seen by the social worker and occupational therapist with regard to home management of his cerebral palsy.

Principal diagnosis:	S72.3 *Fracture of shaft of femur*
Additional diagnoses:	*External cause, Place of occurrence and activity codes as applicable*
	F71.1 *Moderate mental retardation, significant impairment of behaviour requiring attention or treatment.*
	G80.8 *Other cerebral palsy*
Procedures:	47516-01 [1486] *Closed reduction of fracture of femur*
	92514-29 [1910] *GA (ASA 29)*
	95550-01 [1916] *Allied health intervention, social work*
	95550-02 [1916] *Allied health intervention, occupational therapy*

References:

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Cerebral Palsy Fact Sheet (2005). Centre for Developmental Disability Health Victoria. Available at: http://www.cddh.monash.org/assets/fs-cerebralp.pdf. Accessed: 20 November 2006

Cerebral Palsy Source (2005). Mild cerebral palsy. Available at: http://www.cerebralpalsysource.com/Types_of_CP/mild_cp/index.html. Accessed: 14 November 2006:

Disability online. Cerebral palsy – causes and implications. Available at: http://www.disability.vic.gov.au/dsonline/dsarticles.nsf/pages/Cerebral_palsy_causes_and_implications?OpenDocument. Accessed: 14 November 2006

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ICD-10-AM/ACHI/ACS

Fifth Edition coding workshops – 2007

The NCCH conference held in July 2007 once again presented an opportunity for participants to attend an ICD-10-AM/ACHI/ACS Fifth Edition coding tutorial. As this workshop is always very popular and only caters for 100 attendees, the same workshop was then offered nationally. 21 workshops for 723 participants were presented during the months of August–October 2007.

Workshop data

State/territory	# workshops	# participants
NSW	7	243
Victoria	4	177
Queensland	4	145
South Australia	1	23
Western Australia	2	60
Tasmania	1	28
ACT	1	34
Northern Territory	1	13
TOTAL	**21**	**723**

The material for the workshop this year focused mainly on coding cases related to diabetes mellitus. This was based on feedback received from state and territory coding authorities requesting further education in this area of the classification given the number of major changes that have been made to this section over the editions. Other topics included trauma, plastics, obstetrics and gynaecology.

The workshop was designed to allow participants to complete a workbook containing 12 case scenarios and 6 clinical record abstracts prior to attending. This allowed time for discussion of answers and review of the cases during the actual workshop.

Feedback from participants, via the evaluation process, confirmed the benefits of this approach and also provided the following comments:

- A great opportunity to refresh coding skills and a reminder to refer to standards more often.
- Always informative. Important for coding development and reinforce coding practice.
- Clinical slides excellent – found them very educational.
- It was encouraging to see that my coding skills are keeping up with changes and also that other coders have similar difficulties.
- Format of workbook was excellent. Format of answer booklet, with the 'hints' section was especially excellent.
- Enjoyed being able to go through the exercises prior to the workshop. We had enough time to go through the exercises and discuss the answers.
- Great networking opportunity a reinforcement of current coding standards.
- I just wish we could encourage more group discussion, everyone is too afraid of being 'wrong'. Not sure how to make people more comfortable with discussing differences in code assignment.
- I really enjoy hearing other coders' opinions and ideas on coding issues. It's also really great to hear from the presenters on the way they approach coding.
- I'm the only coder in my hospital so these workshops are brilliant for me in the fact that I get to meet with other coders and measure my ability and accuracy as a coder.
- It is great to get together and discuss current issues, as coders work under a lot of pressure and it is difficult to get the time to discuss and research 'grey' areas. I look forward to going back with new 'armed' information.
- It's nice to get a day away from the office, I enjoy asking questions that have bothered me. Great to have face to face definite answers.

Frequently Asked Questions

The following FAQs were asked at the recent ICD-10-AM/ACHI/ACS Fifth Edition 2007 continuing education coding workshops. The standard abbreviation of 'ACS' has been used throughout for 'Australian Coding Standard'.

This information is also available from the NCCH web site: www.fhs.usyd.edu.au/ncch/ under 'FAQs'.

Q: What is the most appropriate code to assign for an accident which has occurred in a 'motel' as seen in clinical record 6?

A: The correct place of occurrence code to assign for an injury occurring in a motel, is Y92.53 *Café, hotel and restaurant.* An inclusion term for 'motel' has been added to this category in ICD-10-AM Sixth Edition.

Q: Why was Y92.22 assigned as the place of occurrence for the adverse drug reaction in case scenario 1?

A: The definition for 'place of occurrence' according to both ICD-10-AM/ACHI/ACS Fifth Edition and the National Health Data Dictionary, Version 12, is the place where the external cause of injury, poisoning or adverse effect occurred. Accordingly, regardless of where and when the manifestation of that injury, poisoning or adverse effect occurs, the place of occurrence code *must relate to where the external cause occurred.*

For example: when a patient is admitted to hospital for treatment of an adverse effect of a properly administered (prescription or non-prescription) drug, the place of occurrence code will be Y92.22 *Health service area.* Since the drug has been properly used, it can be assumed that

the drug was obtained from a health service facility (eg GP, outpatient clinic and pharmacies, etc.).

In case scenario 1, although the rash may not manifest until after the patient has returned home, code Y92.22 *Health service area* would still be assigned for place of occurrence, as the medication was prescribed and/or dispensed from a health service provider.

Q: Should thrombocytopenia be coded as an additional diagnosis in case scenario 1?

A: Thrombocytopenia is a symptom of dengue fever (A90) and is more often seen in dengue haemorrhagic fever (A91). In the case cited, the thrombocytopenia was only treated symptomatically and the patient did not exhibit signs of the more severe dengue haemorrhagic fever. Therefore, A90 *Dengue fever [classical dengue]* is only assigned in this case following ACS 0002 *Additional diagnoses.*

ACS 1806 *Signs and symptoms* provides guidance on the coding of symptoms when a more definitive diagnosis exists. Point (f) states that:

f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

which indicates that some 'symptoms', because of their significance, require coding if they are significant in their own right and meet ACS 0002 *Additional diagnoses.*

Q: In case scenario 5 should a code be assigned for IVDU (intravenous drug use/user)?

A: In this case scenario, the abbreviation, 'IVDU' was noted with no other documentation. Before Z72.2 *Drug use* can be assigned, it needs to meet ACS 0002 *Additional diagnoses.*

In ACS 0503 *Drug, alcohol and tobacco use disorders*, coders are directed to assign codes for tobacco use/disorders for all cases. There is no such directive for alcohol or drug use/disorders. Therefore, when coding drug and alcohol use/disorders, they need to meet ACS 0002.

Q: Should a code for 'extensive' skin graft be assigned if the wound is large?

A: In case scenario 4, a split skin graft (SSG) was applied to the site where the latissimus dorsi free flap had been raised. There was no documentation as to how large this site was and hence how large the graft was that was used on this site. There needs to be some form of documentation to indicate 'extensive' before a code from Block 1646 *Other split skin graft, extensive* can be assigned.

Following the index:
Graft (repair)
- skin (autogenous) (free) (mucous membrane)
- - specified site NEC
- - - full thickness 45451-09 **[1649]**
- - - split thickness (small) 45439-00 **[1645]**
- - - - extensive 45442-00 **[1646]**

The code assignment is 45439-00 [1645] being the default. The index selection is reinforced by ACS 0038 *Procedures distinguished on the basis of size, time or number of lesions* which instructs coders that when there is no documentation in the clinical record and no further information can be obtained from the clinician and there is no default in the index, assign the code for the smallest size, the least duration or the least number of lesions as appropriate.

Q: Should E1-.65 **Diabetes mellitus with poor control** ***be assigned for documentation of 'erratic self monitoring, deterioration in glycaemic control, noncompliance with medication, low BSLs etc'?***

A: The determination of whether a patient's diabetes mellitus is poorly controlled or unstable needs to be made by the clinician who assesses the total picture of the patient's diabetes, both retrospectively and currently.

ACS 0401 *Diabetes mellitus and impaired glucose regulation* provides specific guidelines for the use of E1-.65. It states that there needs to be documentation of the terms 'unstable', 'for stabilisation', 'uncontrolled', 'poorly controlled' or 'poor control' before E1-.65 can be assigned.

Q: Can retinopathy be eradicated by laser treatment and therefore should not be coded as a current condition?

A: There is no cure for diabetic retinopathy. Laser treatment is the only way to stop the progression of the disease when it has reached the proliferative stage; therefore, a code for the current condition can still be assigned.

Q: Please explain the assignment of O24.9- **Diabetes mellitus in pregnancy, unspecified onset** ***versus O24.4-*** **Diabetes mellitus arising at or after 24 weeks gestation**

A: In case scenario 8, it was documented that the patient had 'diet controlled gestational diabetes mellitus'.

ACS 0401 *Diabetes mellitus and impaired glucose regulation* has a section on diabetes mellitus in pregnancy and gestational diabetes mellitus (page 93). The classification box in this section has caused some confusion for coders. It provides guidelines on the assignment of O24.9- when the time of onset of diabetes mellitus in a pregnant patient is unknown. Gestational diabetes is diabetes which has developed during pregnancy (gestation meaning pregnancy) so it is inappropriate to assign O24.9- for gestational diabetes as the time of onset is known – it is during the pregnancy.

This is reinforced by the index:
Diabetes, diabetic (controlled) (mellitus) E1-.9
- gestational O24.4-

And the inclusion term in the tabular list:

O24.4 Diabetes mellitus arising at or after 24 weeks gestation
Gestational diabetes mellitus NOS

ACS 0401 *Diabetes mellitus and impaired glucose regulation* will be amended for Sixth Edition to reinforce the code assignment of O24.4- for all cases of gestational diabetes mellitus.

Q: Should documentation of 'hypoglycaemia' always be coded?

A: As per ACS 0002 *Additional diagnoses*, for coding purposes, additional diagnoses 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.

Therefore, if a condition meets the criteria as per the ACS it should be coded.

Following the Conference workshop, information was sought from specialists on the Endocrinology CCCG requesting clinical information on 'hypoglycaemia'. Responses indicated the following:

'Hypoglycaemic attacks are often classed as minor and major or severe, the latter implying loss of consciousness and seizure and minor where minimal treatment is required (ie drink, lollies etc) and implies that the problem is dealt with before catastrophe occurs.'

Hypoglycaemia is classified in ICD-10-AM to:

E1-.64 *Diabetes mellitus with hypoglycaemia*
Diabetes mellitus with hypoglycaemia(ic):
- coma
- NOS
- seizure (convulsion)(fit)

This category captures minor and major types of hypoglycaemia as noted by the inclusion terms. The NCCH plans to do further work in this area of the classification. In the meantime, this code is to be assigned if it meets the criteria in ACS 0002 and by following the index pathway:

Diabetes, diabetic (controlled) (mellitus) E1-.9
- with
- - hypoglycaemia (coma) (convulsion) (fit) (seizure) E1-.64

Q: When is Z92.22 **Personal history of long term (current) use of other medicaments, insulin** *assigned?*

A: *Z92.22 Personal history of long term (current) use of other medicaments, insulin* is assigned for patients with diabetes mellitus (E11–E14) who are being treated by the use of insulin. This insulin treatment is ongoing (ie long term) not short term and it is the main form of treatment used to control the patient's diabetes.

Do NOT assign Z92.22 when:

- The use of insulin is started during the current episode of care
- Insulin is used to control the diabetes during an episode of care (eg postoperatively) and then stopped prior to the patient's discharge.
- Insulin is used to treat Type 1 diabetes mellitus

Q: Should a procedure code be assigned for diabetes education?

A: There is no specific procedure code in ACHI to capture 'diabetes education'. ACS 0401 *Diabetes mellitus and impaired glucose regulation* indicates that when an admission is specifically for diabetes education, assign a principal diagnosis code from E10–E14 *Diabetes mellitus* and an additional code of Z71.8 *Other specified counselling.*

In ACHI Sixth Edition a new code has been introduced to the classification specifically for diabetes education and this will be found in block 1916 *Generalised allied health interventions.*

Q: Under which circumstances is the fifth character of '1' assigned to indicate 'with mention of attachment difficulties' in category O92 **Other disorders of breast and lactation associated with childbirth?**

A: Attachment difficulties may result from problems the mother is having, problems the baby is having or problems both the mother and the baby are having.

The mother may have breast or nipple problems that result in her having attachment difficulties. In these cases a code from either block O91 *Infections of breast associated with childbirth* or O92 *Other disorders of breast and lactation associated with childbirth* with a fifth character of .1 should be assigned.

The baby may have problems attaching due to an anatomical condition (eg cleft palate) or other conditions (eg problem with sucking reflex). In these cases, assign Z39.1 *Care and examination of lactating mother* on the mother's record and the appropriate code for the neonatal problem on the baby's record.

In cases where both mother and baby have attachment difficulties assign the appropriate codes as described above on the relevant records.

Q: Should Z35.51 **Supervision of primigravida with advanced maternal age** *be assigned in all instances based on documentation of the age of the mother at the time of delivery?*

A: The codes Z35.5- *Supervision of pregnancy with advanced maternal age* should only be assigned when applicable, ie if they meet ACS 0002 *Additional diagnoses,* and not routinely coded based on the patient's age.

ACS 0002 *Additional diagnoses* states "... a condition which is the subject of a standard in this volume must meet the criteria for an additional diagnosis before it can be coded, unless indicated otherwise." In ACS 0002 there is a list of specialty standards where the coder is instructed to code conditions which do not meet the additional diagnoses criteria – ie exceptions to ACS 0002.

ACS 1524 *Advanced maternal age* provides guidelines for using Z35.5- indicating that these conditions should be coded when documented by an obstetrician/clinician/midwife and that if the criteria for the specific obstetric diagnosis is met, but the relevant diagnosis is not documented, consult the clinician before assigning a code. However, this standard is not listed in ACS 0002 as a specialty standard that is exempt from following ACS 0002 criteria.

Q: Please explain code assignment when an epidural has been 'topped up' in obstetric cases.

A: Epidurals can be used in three ways for obstetric patients.

1. An epidural may be used to provide only analgesia (ie pain relief) for an obstetric patient during labour. This epidural may be 'topped up' to provide continuing analgesia depending on how long the patient is in labour.

Code assignment for these types of epidurals is:
92506-XX [1333] *Neuraxial block during labour*

2. An epidural may be used to provide only anaesthesia for an obstetric patient. The most common scenario is an epidural given as anaesthesia to enable an elective caesarean section to be performed.

Code assignment for these types of epidurals is:
92508-XX [1909] *Neuraxial block*

3. An epidural may be used to provide **both** analgesia and anaesthesia for an obstetric patient. The epidural will initially be used to provide analgesia (ie pain relief) during labour. It then will be 'topped up' to provide anaesthesia to enable a procedure to be performed (eg caesarean section, manual removal of retained placenta).

Code assignment for these types of epidurals is:
95207-XX [1333] *Neuraxial block during labour and delivery procedure*

Care needs to be taken when there is documentation of 'top up'. This terminology is used when an epidural being used to provide analgesia is topped up to provide further or continued analgesia. The terminology is also used when an epidural providing analgesia is topped up to become a form of anaesthesia to enable a procedure to be performed.

In clinical record number five there was documentation that the epidural was 'topped up'. However, 95207-xx was not assigned in this case as the top up was given 2–3 hours prior to the delivery to provide analgesia (pain relief) and then a local anaesthetic was used for repair of the perineal tear.

Q: Should drug 'resistance' documented on microbiology reports be coded to Z06?

A: Z06.- *Bacterial agents resistant to antibiotics* should be assigned for multi, penicillin or methicillin resistance and is usually clearly documented in the record. This code should not be assigned based on documentation of 'sensitivity/resistance' on pathology results alone as this does not mean the same as 'multi' or 'MRSA' as per the intent of Z06.-.

ACS 0112 *Infection with drug resistant microorganisms* indicates that the presence of an infection (wound infection, urinary tract infection, pneumonia, etc) must be documented and coded in accordance with ACS 0002 *Additional diagnoses* before additional codes can be assigned for the organism, or the condition coded as being due to the organism. If the clinician has documented in the record that the organism causing the infection is resistant to an antibiotic, then the appropriate code from Z06.- *Bacterial agents resistant to antibiotics* must also be assigned.

Q: In case scenario four would it be more correct to assign* S81.88 Open wound of other parts of lower leg *instead of* S81.9 Open wound of lower leg, part unspecified, *given that there is documentation of injury to specified muscles which anatomically relate to the calf?

A: Documentation in case scenario four indicated 'lower leg' only. However, medical science and anatomy would indicate that the peroneal and posterior lateral compartment muscles make up the calf; therefore, S81.88 could be assigned.

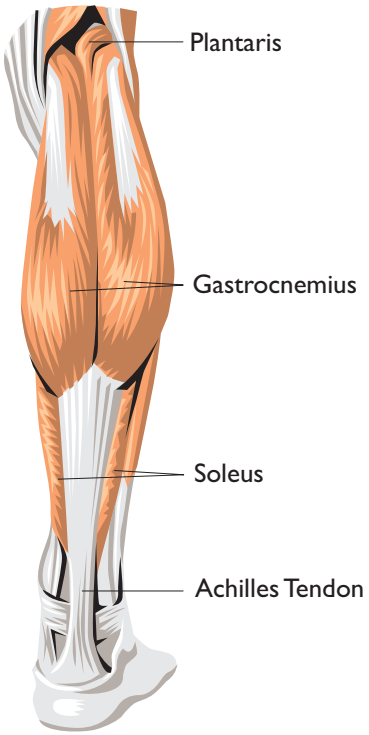
Lower leg muscles

The calf muscles

The gastrocnemius, soleus and plantaris muscles are known as the calf muscles. They form the superficial muscles of the posterior compartment of the leg. The deep muscles of the posterior compartment of the leg are the popliteus, tibialis posterior, flexor digitorum longus and flexor hallucis longus.

The posterior compartment

holds the large muscles that are most commonly known as the calf muscles (the gastrocnemius and soleus).



WHO-FIC Annual Network Meeting

Trieste 2007

The annual meeting of the World Health Organization Network for the Family of International Classifications (WHO-FIC) was held in Trieste, Italy, from 28 October to 3 November 2007.

The purpose of the meeting was to review all elements of the WHO Family of International Classifications and the work of the WHO-FIC Network, including Centres themselves and the various committees (Planning Committee; Implementation Committee; Education Committee; Update and Revision Committee; Family Development Committee; Electronic Tools Committee) and four reference groups (Mortality Reference Group (MRG), the Morbidity Reference Group (MbRG), the Functioning and Disability Reference Group (FDRG), and the Terminology Reference Group (TRG)).

The meeting was hosted by the newly designated Italian Collaborating Centre and was attended by 168 participants from ten WHO Collaborating Centres and representatives from Ministries of Health or National Statistics Bureaux from 27 countries. Representing Australia were Penny Allbon (Australian Institute of Health and Welfare (AIHW), Head of the Australian Collaborating Centre), Bill Dudley (AIHW), Catherine Sykes (AIHW), Ros Madden (ICF expert), Richard Madden, Sue Walker, Kerry Innes and Julie Rust from the NCCH, James Harrison (National Injury Statistics Unit of AIHW and a member of the ICD-11 Revision Steering Committee), Rosemary Roberts (consultant to the Western Pacific regional office of the WHO on a classification of East-Asian traditional medicine), and Michael Kidd (Sydney University, representing the World Organization of Family Doctors).

The work of the WHO-FIC Network is conducted through a matrix of committees and working groups. The final meeting report, containing detailed summaries of each of these parties, together with all the papers for the meeting, may be found at www.who.int/classifications/network/meetings/en/index.html.

The following topic areas provide an overview and highlights of some of work of this year's meeting.

International Classification of Diseases (ICD)

Both the Mortality Reference Group (MRG) and the Morbidity Reference Group (MbRG) develop and recommend proposals for change to ICD-10, which are then forwarded to the Update and Revision Committee (URC) for consideration.

Mortality Reference Group (MRG)

The MRG met 25-26 October in a pre-meeting, on 30 October during a breakout session of the WHO-FIC Network meeting, and on 31 October in a joint session with the MbRG and URC. Nearly 80 issues were discussed in the pre-meeting, ranging from those being presented for the first time to those requiring ratification for submission to the URC. In 2006/2007, 21 proposals were brought forward to the URC. Further progress was made on:

- drafting a unified perinatal death certificate
- clarifying Rule 1 used to select the underlying cause of death from a death certificate for coding and subsequently for statistical tabulation.
- work with the two existing automated coding software suites, ACME (Automated Classification of Medical Entities, coding program developed by the National Center for Health Statistics in the USA which automates the mortality coding rules published in the ICD-10) and IRIS (a newly developed program based on ACME but which facilitates the selection of the underlying cause of death based on text recognition using national language dictionaries)
- specific issues relating to deaths from sudden infant death syndrome and deaths due to self harm where intent is not documented
- mechanisms for improvement of cause of death information. The role of the MRG in the ICD-11 revision process and the need for statistical stability over the period of change were major discussion points during the pre-meeting and the break out sessions.

Morbidity Reference Group (MbRG)

The MbRG met on the 27th October in a pre-meeting and on 29th October during a breakout session of the WHO-FIC Network meeting.

The following technical issues were covered in the pre-meeting session:

- ongoing work on two draft papers: conventions for ICD-11 (including interesting options to clarify the definition of main condition) and revision topics for topical advisory groups (TAGs).
- alignment of domains in the International Classification of Functioning, Disability and Health (ICF) with items in ICD, concentrating on some of the ICD codes in Chapter 21, and the option of a risk factors classification.

- proposal of new and updated codes and terminology for sepsis, nosocomial infections, bacteria and patient safety concepts.
- consideration of a request from the Education Committee (EC) for a review/update of the morbidity coding guidelines in Volume 2 of ICD-10.

The MbRG submitted 12 proposals to the Update and Revision Committee (URC) in 2007, with nine accepted during this WHO-FIC meeting. These include some major changes in coding conventions, structure and terminology such as a relaxing of the dagger/asterisk rule, providing a definition of a primary neoplasm, a major update to the classification of leukaemia and lymphoma, and the replacement of the concept of 'chronic renal failure' with 'chronic kidney disease'.

Richard Madden stepped down as co-chair of the MbRG and, following an election, Kerry Innes was declared the new co-chair.

Update and Revision Committee (URC)

The past year was an extremely busy one for the URC, with 125 proposals considered during the year and 89 accepted as official updates to ICD-10 during the WHO-FIC meeting. A summary of these changes will be available on the WHO website: www.who.int/classifications/icd/icd10updates/en/index.html towards the end of January 2008.

There was discussion, both in the in-session meeting of the URC and a combined meeting of the URC, MRG and MbRG, on the best way to proceed with the parallel work of updating ICD-10 and the revision process towards ICD-11. It was agreed that the current updating process should continue, with the proviso that major updates to ICD-10 be deferred from 2009 to 2010. A final decision on the continuing updating of ICD-10 will be undertaken at that time (2010), once the progress on ICD-11 is clearer. The possibility of including ICD-11 material as updates in ICD-10 arose in discussion and will be further addressed.

Education Activities

The Education Committee met twice during the meeting week in addition to providing an orientation session at the beginning of the meeting for first time attendees. Papers presented during the sessions related to sharing of recent experiences in training coders internationally (presented by Sue Walker) and specific educational issues in Korea and Japan. Training issues relating to the use of the new French electronic death certificate and various papers relating to ICF education were also presented. Updates on the development of an electronic ICD-10 training tool, the work of the joint collaboration between the Education Committee with IFHRO and the joint educational program with the Functioning and Disability Reference Group were discussed.

ICD-11 Revision

The current state of the revision process, with an overview of the Topic Advisory Groups (TAGs), was presented by WHO and the Chair of the Revision Steering Committee, Professor Chris Chute from Harvard University, USA. WHO proposes that the ICD-11 revision will proceed in three phases:

- systematic review of scientific, clinical and public health evidence relevant to classification, taking into account the material already developed in national modifications
- creation of a draft ICD-11 and field testing
- development of meaningful linkages to standardised health care terminologies to facilitate communication, data processing and research.

A Revision Steering Group (RSG) has been established by WHO to oversee this process and each main area of revision will be worked through a TAG and multiple workgroups. A number of TAGs including mental health, rare diseases, external causes of injury, internal medicine and neoplasms have already met, and the chair of each group presented their work to date. WHO acknowledges that further TAGs may need to be established for remaining domains of diseases such as infectious diseases, diseases of the eye and ear, dental conditions, maternal and perinatal diseases, and paediatrics.

A detailed plan of the revision process may be found on the WHO website: http://extranet.who.int/icdrevision/help/docs/ICDRevision.pdf.

The International Classification of Functioning, Disability and Health (ICF)

The Children and Youth version of ICF (ICF-CY) was launched during a two day meeting in Venice. This derived version of ICF includes concepts relevant to the developing young person. The meeting focussed on applications of the ICF-CY in health, in education and for human rights monitoring.

Also launched was an international project to monitor the health of children world-wide, using the ICF. A demonstration project in Italy will pilot the materials, with projects in other countries following.

The Functioning and Disability Reference Group met on 27 October and during the meeting, and discussed the work of all its eight task groups. Particular emphasis was given to the updating process for ICF and to ICF education.

Papers on ICF education and training in South Africa and the USA and of Physical Therapists worldwide were presented to the Education Committee. A core curriculum for ICF education was agreed. Progress has been made on developing basic course materials.

The FDRG is keen to include representatives of non-governmental agencies and disabled peoples

organisations and is improving its communication through the development of an interactive website. A project undertaken by the Nordic centre looked at the relationship between terms in the ICF and terms in SNOMED CT.

Implementation Activities

The creation of the Asia Pacific Network within the WHO-FIC Network was discussed as a good example of how to support the implementation of the classifications across the world. Other regions are considering the development of networks.

Following the meeting, a useful discussion was held with the Health Metrics Network in Geneva and the two Networks are preparing to sign an MOU formalising a more collaborative relationship in the improvement of health information systems in developing countries.

WHO-FIC and Terminologies

The International Health Terminology Standards Development Organisation (IHTSDO) has recently been formed as an organisation whose role is to acquire, own and administer the rights to SNOMED CT and other relevant assets and to develop, maintain, promote and enable the uptake and correct use of terminology products. The WHO has agreed to establish a Harmonisation Board between WHO and the IHTSDO to work together on mapping of SNOMED CT to WHO-FIC members eg ICD, ICF. A preliminary meeting of the two organisations, to discuss the work of the Harmonisation Board, took place in Geneva after the WHO-FIC meeting. A series of workshops will be facilitated by the Australian Collaborating Centre over the next few months to discuss the implications of the introduction of terminologies and the challenges for stakeholders, including coders.

Development of the Family of Classifications

The Family Development Committee held two sessions during the WHO-FIC Network meeting where a number of topics were covered. Two new classifications, the International Classification of East Asian Traditional Medicine (ICTM-EA) and the International Classification of Nursing Practice (ICNP) were considered for inclusion in WHO-FIC. It was agreed in principle to include the alpha and beta versions respectively, as related classifications/ terminologies, pending further comment from network members.

During 2007, work had progressed on the background, need for and possible structure of the International Classification of Health Interventions (ICHI) and this was presented and discussed. The overall approach and suggested dimensions of the classification were supported and a broader group will progress this work in 2008.

The WHO Collaborating Centre for Drug Statistics Methodology provided an update on the Anatomical Therapeutic Classification (ATC). It was agreed that, together with WHO Collaborating Centre for International Drug Monitoring (Uppsala), a proposal for use of the ATC in ICD-11 would be developed for the Revision Steering Group in April .

There is to be collaborative work with the WONCA (an organisation made up of national colleges, academies or organisations concerned with the academic aspects of general family practice) Classifications Committee on Chapters 18 and 21of ICD-10 to align reason for encounter codes between ICD and ICPC, both of which are now under revision. In parallel, domains in these chapters and other parts of ICD which are also covered by ICF will be identified so that consistency between the classifications can be pursued.

The 'conceptual framework' for an International Classification of Patient Safety was presented to the Committee as a work-in-progress. At this stage, the classification does not include data domains but illustrates the types of information that would ideally be collected for patient safety events. Field testing is underway and the classification will be brought back to WHO-FIC Network when this is completed.

The next meeting of the WHO-FIC Network will be held in New Delhi, India from October 26 to 1 November 2008.

Enquiries about the work of the Australian Collaborating Centre should be directed to Barbara Levings – e-mail Barbara.Levings@aihw.gov.au.

Code-L server upgrade

NCCH's list server, Code-L, has new procedures for subscribing, unsubscribing and posting messages due to a server upgrade, :

- to subscribe to Code-L, you will now need to go to the following website http://mailman.ucc.usyd.edu.au/mailman/listinfo/fhs-code-l
- to unsubscribe from Code-L, you will need to also go to the website http://mailman.ucc.usyd.edu.au/mailman/listinfo/fhs-code-l and use your e-mail address to unsubscribe
- to send an e-mail to Code-L you will need to send to the following address fhs-code-l@mail.usyd.edu.au

Code-L instructions and further details can be found on our website www3.fhs.usyd.edu.au/ncch/.

Current subscribers will be automatically transferred to the new server. You are not required to re-subscribe.

If you have any questions or difficulties with the new server, please contact Dana Higgins (d.higgins@usyd.edu.au).

Workshop for International Users

of ICD-10-AM/ACHI/ACS

Workshop attendees with NCCH presenters and staff

As the Australian modification of ICD-10 is licensed to more countries, the NCCH has received many requests for training and implementation techniques. Given our position as the publisher of ICD-10-AM/ACHI/ACS, the NCCH feels that we have an obligation to provide these new ICD-10-AM/ACHI/ACS licensees with some training and/or implementation skills.

In the past, the question has always been what is the best way to meet this obvious need without depleting our resources? We recently decided to conduct a two week course on morbidity coding using ICD-10-AM/ACHI/ACS for international users based on a training program we developed for an international client a few years ago.

We had expressions of interest from over 10 different countries but, due to the difficulties of obtaining visas, we only had three participants attend. However, this was a blessing, allowing us to trial the program and get some great feedback!

Training commenced on Monday 15 October and concluded on Friday 26 October. The participants had sound medical terminology skills and had had previous exposure of varying degree to classification systems. The attendees included a computer operator and medical recorder from Tonga and a Health Information Management Consultant/Clinician from Turkey.

The program was very intensive and, even though it was conducted over a short period, it still provided participants with classification theory with detailed practical exercises, consisting of case scenarios and clinical records, in ICD-10-AM/ACHI/ACS.

Train-the-trainer skills were also provided to the participants highlighting the importance of presentation skills and different methodologies for coder training programs. The last day of the course was devoted to coding quality tools with a discussion on the importance of maintaining ongoing coder training and assessment.

Although there was no formal assessment of the participants, coding skills at the conclusion of the course, the application of coding standards and conventions were assessed through the completion of the exercises throughout the program. On the last day, participants were presented with a certificate of attendance by the Business Director, Lena Caruso, on behalf of the NCCH.

The course was evaluated by the participants and the following comment was made that perfectly summed up the intent of this course, 'we do not become experts but have learnt how to approach the classification'. The first ever international users workshop was a great success and we are now preparing to run another course in the middle of 2008. Details of future courses will be announced on the NCCH website and in Coding Matters.

Attention clinical coders

The NCCH needs case scenarios or clinical record abstracts for possible use in future education workshops!!!! It is anticipated that future workshops will be streamlined to provide more relevant cases to suit participants needs, therefore, we need cases from you. If you have a case that can be used. please either send a de-identified copy to the NCCH or summarise the case and e-mail it.

Contact Megan Cumerlato for further information:
Phone: 02 9351 9449
E-mail: m.cumerlato@usyd.edu.au
Post: NCCH, PO Box 170, Lidcombe NSW 1825

International

Chinese study tour to Australia

The NCCH hosted seven delegates from the China Health Economics Institute (CHEI) for three days, from 17 to 19 September, 2007.

Members of the Chinese delegation

Team leader

Mr. Yang, Hongwei – Deputy Director, China Health Economics Institute

Members

Ms. Zhu, Peihui – Project Officer, Division of Planning and Pricing, Department of Planning and Finance, Ministry of Health

Mr. You, Mao – Vice Dean, Division of Health Information, China Health Economics Institute, MoH

Mr. Shao, Xiaojun – Researcher, China National Health Economics Institute, MoH

Ms. Huang, Chunfang – Assistant Researcher, China Health Economics Institute, MoH

Mr. Lian, Leyao – Doctorial candidate, China National Health Economics Institute, MoH

Ms. Xiao, Yue – Communication Officer, China Health Economics Institute, MoH

The delegation was interested in looking at our healthcare system, in particular hospital management and the application of health classification systems and DRGs in hospitals.

During their Australian visit, they also toured both Sydney and Melbourne hospitals. In Sydney, Westmead Hospital provided the delegates with a tour of the Clinical Information Service and the Hospital's Clinical Coding staff and Area Casemix staff provided talks with specific reference to classifications and DRGs. Professor Richard Madden, Director of the NCCH, also accompanied them to Canberra where they visited the Department of Health and Ageing and were given an introduction to the Australian healthcare system and the development, planning, implementation and evaluation of AR-DRGs. Following is a brief outline of the objectives of the study tour.

The China Health Economics Institute (CHEI), founded in 1991, is a national research institution directly affiliated to the Chinese Ministry of Health (MoH). CHEI specialises in the development of health policy and research, and provides policy consultancy to the relevant ministries of the central government.

In 1998, CHEI was commissioned by the MoH to compile the National Classification of Clinical Interventions, which was published and implemented in 2001. In December of 2006, CHEI formally established the Project on the National Classification of Clinical Interventions and Payment System (with a primary focus on DRGs). During the project, the CHEI team realised the need to obtain advanced international experience and technical support.

Australia's experience and the achievements made in the development, implementation and continued improvement of the Australia Refined DRGs is internationally recognised. Therefore, CHEI organised a delegation to conduct a 10-day study tour to Australia. The main objective of the tour was to strengthen CHEI's research capacity and promote the implementation of the above-mentioned project through learning from the Australian experience and securing technical assistance from Australian partners.

The Chinese delegation with Professor Gwynnyth Llewellyn, Dean, Faculty of Health Sciences, Professor Richard Madden, NCCH Director, and NCCH staff

International training

Pohnpei, Federated States of Micronesia,

31 July–10 August 2007

Sue Walker with course attendees in Pohnpei

In July–August, Sue Walker conducted a 10-day training course in the use of the ICD-10 and ACHI for the Department of Health, Education and Social Affairs and the three participating State Health Departments from the Federated States of Micronesia (FSM).

Funding for the activity was provided by Asian Development Bank (ADB) through the Basic Social Services Project currently being conducted in Micronesia. Eighteen participants took part in the training, which covered the coding of both morbidity and mortality data, to facilitate the application of ICD-10 for hospital inpatient and outpatient data and to describe causes of death reported on death certificates.

There are differences in coding in the various island states, with some with closer affiliation with the United States of America utilising US patient administration software which contains ICD-9 codes. This is the case in Yap. Other states already use ICD-10 for the coding of their data, such as in Pohnpei. Certain states have recently adopted new Patient Administration software, to replace the aging WinPAS system sourced from New South Wales.

The new software is Access-based and enables the collection of ICD-10 and ACHI coded data for both inpatient and outpatient encounters; hence the need for training at this time to update to the new editions of both classifications in use in FSM.

Most of the participants showed an aptitude for morbidity coding and demonstrated skills in this task. The ones who found this type of coding most difficult were those who had no medical science or medical terminology knowledge and therefore lacked the capacity to understand the diagnoses and procedures they were being asked to code.

The mortality coding was found to be difficult by nearly all of the participants, most likely because of the lack of time devoted to this type of coding, the fact that it was new to most of them and the lack of medical knowledge. However, all participants except two managed to pass the exam conducted on the second last day of the training course which was gratifying.

Greater Noida, India

3–7 September 2007

This workshop was run by Sue Walker on behalf of the WHO South East Asia Regional Office. The overall objective of the workshop was to build skills in the teaching and use of the ICD-10, to review existing teaching activities and to create understanding of the underpinning requirements for production of high quality coded morbidity and mortality data. The specific objectives of the workshop were:

1. to review, discuss and share experiences on the current status and quality of implementation of the international classifications for coding of diseases and deaths,
2. to review existing training modules and demonstrate and test existing training techniques,
3. to adapt standard training modules for the region and recommend a sequence of applying ICD-10 and other classifications of the WHO Family of International Classifications for the coding of morbidity, treatment procedures, health interventions and functional disability, and
4. to draft outlines of country training plans for implementation of the classifications.

Twenty-one participants from nine member countries of the region attended the workshop. Also in attendance were workshop facilitators from the NCCH and WHO Headquarters, resource persons from Thailand, Myanmar, and staff of the SEARO Evidence and Health Information Unit.

The workshop was not planned to be a course in how to use ICD-10 and participants were supposed to have basic

Workshop participants Greater Noida

coding knowledge. However, many of them did not have this background, which meant the workshop was possibly not as successful as it could have been.

The workshop encompassed introductory sessions from participants about the status of ICD implementation in their countries, discussions about region-wide issues, a session about the importance of good clinical documentation, hands-on assessments of medical record documentation quality using records from some of the countries of the Region, provision of information about the WHO-FIC-IFHRO Training and Certification program and the sharing of training materials from various countries, development of plans for educating clinical staff about coding, and country plans for future ICD training.

The workshop was beneficial because it demonstrated to participants that many of the problems they face are not unique to their own situation. Regional solutions to training and the development of materials may assist in the implementation of the Family of Classifications, particularly in countries where available expertise is limited. It was particularly useful to have two representatives from Timor Leste (East Timor) in attendance and to hear of their struggles to make improvements in hospital record keeping with a highly mobile international health workforce. There is no history of coding at all in this new country.

The workshop concluded with recommendations identified from the five days of discussions amongst the participants. The recommendations were:

1. Engagement with private sector

- An advisory committee for ICD-10 implementation, including private sector representatives should be established
- Consider mandatory reporting as part of registration and licensing arrangements for private hospitals and health centres
- Consider beginning with collection of coded data from sentinel sites if national private sector data collection is not possible
- Invite involvement and participation in ICD training sessions to key representatives of the private sector
- Consider involvement by national medical and nursing associations as a way of encouraging interest amongst clinical groups

2. Coding workforce issues

- Obtain management support for coding and find local champions to advocate for coders
- Consider regional need for a standardised curriculum and training on documentation and coding
- Career development for coders – advocate for specific posts for coders, considering existing staffing patterns in Medical Record Departments
- Seriously consider who should code – doctors, nurses, non-medical coders – what training is required for each group?

3. Improvements in clinical documentation

- Establish documentation standards for medical records and death certificates
- Consider development of minimum data set and data standards – data collection processes and forms can be localised but all countries should collect same minimum data so comparable health information is reported
- Specify roles and responsibilities for documentation and coding
- Establish committees to guide and support documentation and coding standards

4. Uses of coded data

- Consider uses of health data – for example, who uses outpatient data and what is it used for? The uses made of coded data will inform the extent to which coding needs to be collected from all patients and at what level of specificity is necessary.
- Strongly encourage local and national use of the coded data and promote its benefits.

Help Us Improve the Complication Codes in ICD-10-AM

NCCH is now working on the development of ICD-10-AM Seventh Edition and would like your help in making improvements to the residual adverse effect code T78.1 and complication codes in section T80–T88 *Complications of surgical and medical care, not elsewhere classified.*

Analysis of the national morbidity data indicates that the following codes are heavily used in Australian hospitals, but because these codes indicate 'other' adverse effects or 'other' complications, we are unclear what conditions or circumstances are being assigned to these codes.

National morbidity data collection 2004–05

Code	Description	Count
T78.1	*Other adverse food reactions, not elsewhere classified*	837
T80.8	*Other complications following infusion, transfusion and therapeutic injection*	1560
T81.8	*Other complications of procedures, not elsewhere classified*	8593
T82.8	*Other complications of cardiac and vascular prosthetic devices, implants and grafts*	8150
T83.8	*Other complications of genitourinary prosthetic devices, implants and grafts*	2177
T84.8	*Other complications of internal orthopaedic prosthetic devices, implants and grafts*	4202
T85.81	*Other complications due to nervous system device, implant or graft*	676
T85.88	*Other complications of internal prosthetic device, implant or graft, NEC*	2870
T87.6	*Other and unspecified complications of amputation stump*	734
T88.5	*Other complications of anaesthesia*	1151
T88.8	*Other specified complications of surgical and medical care, not elsewhere classified*	701

If we can collect some data about why coders use these codes, we may be able to include some of these conditions in a revised classification in ICD-10-AM Seventh Edition (to be implemented in 2010). This will in turn provide greater clarity about complications in health care in the morbidity data collection.

We are asking for coders to contribute either via hardcopy or by entering responses on our website. We'd like coders to tell us what condition(s) you were coding when assigning one of the above codes. We are interested in receiving the words or phrases you found in the medical record which directly influenced your decision to use these codes. We do not want you to submit any patient information – just the clinical words.

The information we will require is on the forms inserted into this edition of Coding Matters. The website will be similar and can be viewed by following the links at: www.fhs.usyd.edu.au/ncch when you register online to participate in this survey. We encourage those of you who can complete the survey online to do so as it will allow you to view other submissions related to the adverse effect or complication code being reported. It will also allow you to save time by using the 'Me too' function to indicate frequency or repetition of your own or other submissions you agree with. This will allow the NCCH to gauge the extent of the problem. It will also be much easier for us to collate the survey results.

The survey will run from 1 January through to 31 October 2008.

General guidelines

When you register with us (whether hardcopy or online), we will require a contact number from you in case we need to clarify anything. We do not, however, intend to contact you about this survey unless absolutely necessary.

It IS NOT necessary to indicate the case ID, in fact, please don't – just list the codes and clinical words/phrases regardless of whether they are from one patient record or multiple records.

For hardcopy participants, if you find that you use a code for the same condition in many records, then indicate this in the comments so that you don't have to repeat the same information each time you use that code. For online participants follow the 'Me too' guidelines.

This isn't a rigorous investigation. We are just wanting your feedback on how you use the codes, and where possible, some indication of frequency. So, for hardcopy participants, we are not expecting you to keep repeating the same information for a particular code, but we would like you to tell us when the clinical words/phrases in the record, are different for a particular code.

We would also like to know something about the following external cause codes when you use them in conjunction with the study T codes:

Y70–Y82 *Medical devices associated with misadventures in diagnostic and therapeutic use*

Y83–Y84 *Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.*

The more information we have about the various types of conditions that a code is used for, and about the different ways that a condition or circumstance might be expressed, the easier it will be to build in all the possible index entries for a code.

So we anticipate that after a while, you may find that you have no new information arising from the records for a particular code(s) – then stop reporting on that code(s).

Hardcopy participation

Included in this edition of Coding Matters is a registration form and a data collection form. Complete the registration form and, using the data collection form supplied as a master copy, photocopy it as many times as required during the survey period. When you have completed the survey, send the completed registration form together with the data collected to Kerry Innes by fax (02 9351 9603) or by mail to:

The National Centre for Classification in Health,
The University of Sydney, Cumberland Campus
PO Box 170
LIDCOMBE NSW 1825

Website participation

To do the survey you will need to go to the NCCH website at www.fhs.usyd.edu.au/ncch and follow the links to the complication codes survey. Here, you will be required to sign into the NCCH Information System. If you have a NIS ID already then you can login and proceed to the survey page. However, you can register if you do not have an NIS ID yet. You will be able to then add your latest information at your convenience. We will make visible other submissions so participants can see what others are contributing. The data collection site allows you to click the 'Me too' field to minimise duplication and time but at the same time letting us know of the frequency of the problem. This is an anonymous process as only your submissions will be visible but none of your details .

If you decide to stop participating in the survey please let our contact person know.

Contact person at NCCH: Kerry Innes, 02 9351 9461, k.innes@usyd.edu.au. Please contact Kerry if you have any queries.

Thank you for giving some of your time to improve ICD-10-AM.

coding matters

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CONFERENCES 2008

Feb 20-21	Health Facility Design and Development 2008	Brisbane, QLD	www.iqpc.com/au
February 27-29	17th Annual Medico Legal Congress 2008	Sydney, NSW	www.iir.com.au/medicolegal
March 10-12	World Health Care Congress Europe 2008	Berlin, Germany	www.worldcongress.com/events/HR08015/index.cfm?confCode=HR08015
March 10-12	Diversity in Health 2008 Conference	Sydney, NSW	www.dhi.gov.au/conference/
March 11-12	Redesigning the Healthcare Workforce 2008: Implementing Innovative and Effective Recruitment, retention and Workforce Management Strategies	Sydney NSW	www.iqpc.com/au/healthworkforce
March 26-29	2008 World Congress of Health Professionals	Perth, WA	www.worldhealthcongress.org
April 1-2	Electronic Health Record and Data Management Conference	Sydney, NSW	www.iqpc.com/au/ehealth
April 16-18	Med-e-Tel – The International Educational and Networking Forum for eHealth, Telemedicine and Health ICT	Luxembourg	www.medetel.lu
May 20-23	HIMSS AsiaPac08	Hong Kong	www.himssasiapac.org
May 20-22	CeBIT Australia – showcasing the latest technology solutions for business	Sydney, NSW	www.cebit.com.au
July 7-9	Population Health Congress 2008 A Global World Practical Action for Health and Well Being	Brisbane, QLD	www.phaa.net.au
August 6-8	Australian College of Health Service Executives National Congress Health Services Management – Different Faces, Different Places	Alice Springs, NT	www.achse.org.au
Aug 31-Sept 2	HIC08 – The Person in the Centre	Melbourne, VIC	www.hisa.org.au/hic08
Sept 16-18	11th National Immunisation Conference	Gold Coast, QLD	www.phaa.net.au/conferences.php
Sept 25-26	HIMAA Symposium 2008	Canberra, ACT	www.himaa.org.au/2008/default.htm
Oct 26-Nov 1	WHO-FIC meeting	New Delhi, India	www.who.int/classifications/en/

Conference information is also published at the NCCH website http://www3.fhs.usyd.edu.au/ncch/2.4.htm