Coding Matters

Newsletter of the
National Centre for Classification in Health

Volume 5 Number 2
October 1998

FROM THE DESK OF THE DIRECTOR

Staff

Readers of *Coding Matters* will share with NCCH staff the major impact of Dr Karen Luxford's departure following her resignation from the position of Publications Manager to take up a new job as Evidence Based Medicine Manager at the National Breast Cancer Centre. Karen was one of the pioneer members of NCCH (in fact, there was a time when the then NCC was just Karen and me!). She has been Publications Manager Supremo, and will be sorely missed by all of us at the NCCH. Apart from editing *Coding Matters* and producing each issue on time, Karen has been responsible for the major task of publishing the Australian Versions of ICD-9-CM and more recently ICD-10-AM. Her functions have also included marketing and publicity and, before the appointment of Christine Erratt, contract and licence negotiation. She has also managed compilation of other products and publications such as education material, reports and the specialty booklets , *Casemix, DRGs and Clinical Coding*. The staff of the Publications Division has grown under her guidance, both in size (not girth) and function, and much of the preparation of our publications is now done in-house, although there has also been a major task in liaison with contracted typesetters and printers. Karen has instilled discipline into our mailing lists (now a contacts database) and guided all NCCH staff in moving towards electronic developments of products and internal systems.

If Karen is to be remembered for only one cause, I think it will be her contribution towards the promotion of the electronic patient record, not only as it relates to the coding function and NCCH, but for health information managers and clinical coders throughout Australia. Karen has been our ambassador overseas, especially in Southeast Asia, and it was due to Karen's negotiations that early links were made with the US producers of the ICD-9-CM publication, enabling Australia to base its modifications on work already available from the National Centre for Health Statistics and St. Anthony Publishing. Karen's basic training was as a scientist, and her scientific approach to problems has helped us all. She has been manager, mentor and friend to all of us at the NCCH and moulded the position of Publications Manager into one of the important cornerstones of the centre. Karen has demonstrated that organisations such as ours are built on people. Although we plan to replace Karen, the NCCH will not be quite the same. However, we wish Karen every good luck in her new venture, and know that she will bring to that position all her energy, intellect and creativity.

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Megan Roach (aka Megan Stargazer, Kirsty Wannabe, Tom Excelsior) is also moving to another position – this time as Systems Officer at the Powerhouse Museum. Megan has been restless since her study leave in the USA, and we congratulate her on her success in progressing to this more senior position. Megan too will be greatly missed – for her computer and database skills, general trouble shooting for the centre, organising distribution of our products, and above all for her laugh (and the occasional practical joke). Good luck Megan!!

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National Centre for Classification in Health

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NCCH Sydney has two new members of staff – Ms Nicole Schmidt (Database Administrator) and Ms Monica Komaravalli (Project Officer responsible for specialty booklet preparation). Both fill existing positions, the latter being a twelve month project funded by the Australian Casemix Clinical Committee (ACCC). Nicole and Monica are already proving to be highly valued staff members!

Ms Karen Peasley has been appointed as Education Manager having been acting in the position since Janelle Craig's maternity leave and subsequent resignation. Congratulations Karen! A position for a research officer has been created to add a research dimension to the work of NCCH Sydney by assisting existing staff to do research, preparing research proposals for funding and carrying out independent research relating to NCCH functions. The successful applicant was Donna Truran, who joined the NCCH in late September.

Ms Kerry Innes, Coding Services Manager, has been in North America, having been invited to present a paper on 'Development of ICD-10-AM' at an International Coding Collaborative 'Global Perspectives on Data Quality and Coding' in Washington DC. Reports are that Kerry was brilliant and a superb representative of NCCH and Australian progress in coding and classification.

Ms Monica Komaravalli, Project Officer (left) and Ms Nicole Schmidt, Database Administrator

Clinical Coding and Classification Groups

NCCH has been collaborating with the Department of Health and Family Services (DHFS) Acute Care Financing and Analysis Branch to reestablish the Clinical Coding and Classification Groups (CCCGs) which advise the ACCC and NCCH. Coders from most specialties responded to our call for expressions of interest and membership of the groups was finalised at the ACCC meeting of 5 September 1998 (see page 26). These groups will assist NCCH with preparation of the second edition of ICD-10-AM, with expert advice on specialty booklets and other issues (especially queries) requiring clinician and clinical coder input.

Coding Services Division

Talking about coding queries for ICD-10-AM and the temporary arrangements for directing queries to NCCH, you may like to know that approximately 400 queries have been received to date, of which over 70% have been answered. The remainder are in the process of consultation with CCCG members or research within NCCH.

Further work has been done with DHFS and the state ICD-10-AM Implementation coordinators on the mappings between ICD-9-CM and ICD-10-AM. Revisions have been made to the original maps for Version 4.0 of the AR-DRG grouper for use with AN-DRG v3.1. This latter set of maps has been published separately for use by those states and territories using ICD-10-AM from July 1998.

Coding Services has prepared guidelines for public submissions for update of ICD-10-AM. These guidelines are currently with the Coding Standards Advisory Committee and will be published in time for submissions to be received in February 1999. Recommendations for update to WHO ICD-10 have been sent to Heads of WHO Collaborating Centres for consideration at the Paris Meeting in October 1998.

Meetings have been held with allied health representatives about allied health intervention codes and development of codes for Indication for Intervention. A decision has been taken to revise the allied health intervention codes to make these codes provider neutral for the Second Edition of ICD-10-AM. Coding Services staff participated in the Allied Health Workshop to be held in conjunction with the Casemix Conference in September 1998 as well as the ICD-10-AM coding workshop at the same conference.

Publications Division

Subsequent to funding received from the DHFS, Health Services Outcomes Branch for development of an electronic database for ICD-10-AM, tenders were let in late July for a twelve month project to commence in September/October 1998. The successful tender was from Essential Software. NCCH staff will be working closely with the developers of the databases and look forward to this exciting new phase to streamline NCCH functions and provide electronic products for code and software users in hospitals, health services and state and national morbidity collections.

Orthopaedics and *Injury* specialty booklets are now available with those for *General Medicine* and *General Surgery* expected in the near future. The NCCH Annual Report is completed and will be ready for distribution within the next few months.

Education Division

Mastering Ten was completed and distributed in early June, and the first printing is almost sold out! A report on the successful completion of the ICD-10-AM Workshops held from April to June 1998 is on page 11. 1,010 participants attended 32 workshops. An education strategy for the 1999 workshops is being developed in conjunction with the states implementing next year.

As a follow up to the New Zealand train-the-trainer workshops conducted by NCCH staff, the Education Division is releasing visual material and workbooks for use in the New Zealand ICD-10-AM workshops.

The education material for clinicians has been created by NCCH staff with input from Lisa Quick and Dr Ralph Hanson. The material will soon be available on the NCCH website.

The NCCH Conference in Alice Springs has proved popular, as did its accompanying workshop. See page 14 for a full report.

The NCCH has contributed to several conferences with presentations, workshops and exhibiting through the NCCH booth. These include the Health IT Workshop (Sydney, August), the Tenth Casemix Conference (Melbourne, September), the HIMAA Conference (Brisbane, October) the Patient Classification Systems/ Europe (Manchester, October) and Heads of WHO Collaborating Centres for Classification of Diseases (Paris, October).

Quality Division

Staff of the NCCH Quality Division have been concentrating on developing and marketing the *Australian Coding Benchmark Audit* (ACBA) and Performance Indicators for Coding Quality (PICQ) as well as holding workshops on standards for ethical coding and for the coding service. See Quality Concerns on page 6 for more detail. Readers of *Coding Matters* will be interested in a recent report of a clinical coding audit in Western Australia. See Stevens, S., Unwin, C.E. & Codde, J.P. 1998, 'A review of hospital medical record audits: Implications for funding and training', *Australian Health Review*, vol. 21, no. 3, pp. 78–97.

Conclusion

Despite the staff movements reported above, the NCCH maintains its commitment to progress in health classification systems. Work at NCCH Brisbane on the Australian Clinical Thesaurus is one indication of the future direction of coding systems which will support coordinated care and tracking of patients across episodes of care.

❖ **Rosemary Roberts**
Director

VITAL SIGNS

In this edition of *Coding Matters*, I would like to report on the successful trainer program in basic medical record practice run for students from South-East Asia. The program, held over three weeks in June–July, was developed primarily by Joy Smith with assistance from Melissa McBride, Sue Walker and Maryann Wood. You will recall information in a previous edition of *Coding Matters*, which related Joy's experiences in Myanmar and Sri Lanka during her fact-finding missions to those countries. This work was conducted under contract to WHO Regional Office for South-East Asia.

The aims of the consultancy were twofold:

- to develop baseline educational materials relating to the delivery of a medical record/health information service in South-East Asia region (SEAR) countries
- to deliver a three week program in Brisbane for representatives from SEAR countries to familiarise them with the training materials, to assist them in developing teaching skills and in making the baseline materials relevant to their own national situations, and to facilitate the development of training courses for the countries of the region.

There were 11 participants in the program, nominated by their respective countries:

- Dr Hla Myint, Assistant Director, Department of Health, Myanmar
- Dr Thein Win Naing, Deputy Divisional Health Director, Myanmar
- U Tin Than, Statistician, Myanmar
- Dr U S H Gamage, Medical Officer, Sri Lanka
- Dr G N L Silva, Registered Medical Officer, Sri Lanka
- Ali Shareef Mohamed, Deputy Director, Ministry of Health, Republic of Maldives
- Fathmath Azeema, Medical Record Officer, Republic of Maldives
- Dr A Roy Bertrus Perera, Registered Medical Officer, Sri Lanka
- Choeki Gyeltshen, Medcial Record Officer, Bhutan
- Pravin Prasad Shreshta, Assistant Medical Recorder, Nepal
- Anil Thapa, Statistical Officer, Nepal.

In addition, U Soe Myint, Medical Record Officer from Myanmar, helped to facilitate the conduct of the course. Candy Longmire from the SEARO office, attended the final week of the course and subsequent debriefing.

A manual of training materials was developed by Joy, encompassing the following topics:

- the medical record
- medical record service
- medical record systems
- quality assurance in medical records
- information technology
- medical terminology
- clinical classification systems
- data management
- role of the medical record manager.

The materials have been developed in modular format to allow individual courses to be tailored for the specific needs of participants. The ICD-10 training materials previously developed by the NCCH can also be utilised in a training course if required.

During the three weeks the students were in Brisbane, they were given formal lectures based on these materials, plus informal workshops and discussions, video screenings, personal and group study time and visits to local hospitals and health services. Participants were also expected to complete some individual study and preparation during the evenings. The course modules were reviewed by the participants using the following criteria: structure, content, pitch, time allocation, teaching aids required, relevance to their own situations, tutorial requirements, modifications needed to improve the content and whether they felt sufficiently competent to teach the materials themselves. Opportunities to customise the materials were given and the students were required to present several seminars. These sessions were videotaped to give each student the chance to evaluate his or her own presentation style and to identify strengths and weaknesses in their performance.

Evaluations of the course by the students indicated a high degree of satisfaction with their experiences in Brisbane. The teachers, facilities and resource materials were all rated either very good or excellent. We were delighted with comments such as *'The training course is excellent. It is well done and best opportunity for the future'*. Weaknesses identified included the need for more time for the training (some suggested three months, rather than three weeks!). Many of the students felt that they needed to actually be taught the materials in order to understand them fully. This latter point reflected the variety in backgrounds of the participants, as not all of them were familiar with hospital medical record practice.

Following the course, NCCH staff formulated a series of recommendations for WHO for the future of the medical records short course. In these recommendations, we noted that the trainer program had been intended to allow participants to place materials in context, rather than taught the whole curriculum. Because of the variety of skills and knowledge, we identified those students who seemed to have the ability to teach the materials effectively but whom we thought needed to obtain more content expertise. We recommended that these students be enrolled in the first full course, which we hope will be run in Myanmar in November/December 1998. The NCCH will participate in this, and future, courses but eventually will pull back from teaching all the materials in favour of the South-East Asian trainers. Ultimately it is hoped that our materials will be used to form the basis for more formal courses in medical record practice in existing training institutions in the region.

❖ **Sue Walker**
Associate Director, NCCH Brisbane

THE TENTH CASEMIX CONFERENCE IN AUSTRALIA

The NCCH was well represented at the very successful Tenth Casemix Conference held at the Melbourne Convention Centre from 6th to 9th September.

Karen Peasley, Education Manager and Judith Hooper, Coding Services Coordinator presented the *ICD-10-AM Implementation Workshop.*

Eric Schulz, Research Fellow presented two papers titled *Coding in the information age: ICD-10-AM goes electronic* and *Introducing an Australian clinical thesaurus* and co-authored another paper titled *Four possible coding systems for Australian general practice: A formal evaluation* presented by Peter Scott, postgraduate student at NCCH Brisbane.

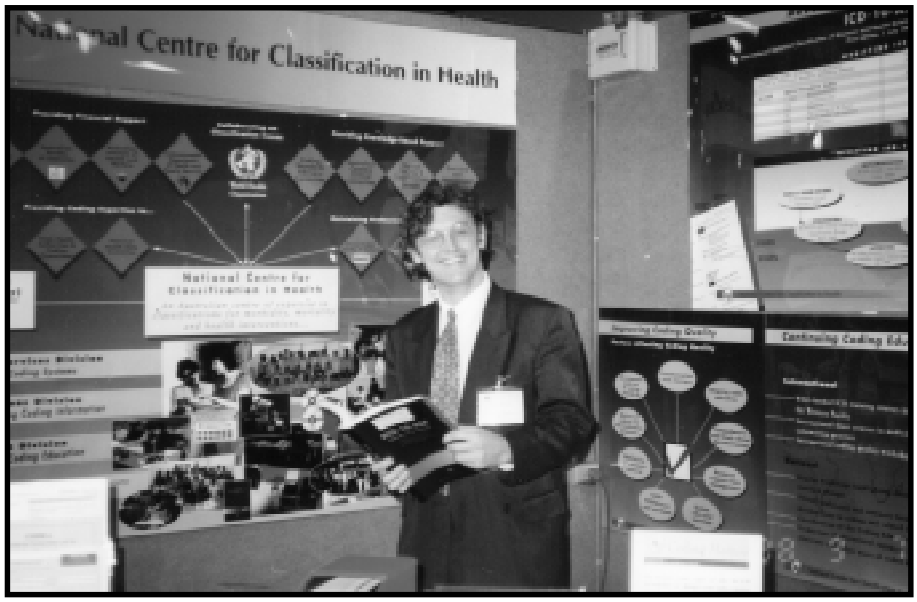
Andrea Groom, Quality Officer presented a paper titled *Developments in coding quality measures.*

Monica Komaravalli, Project Officer presented a paper titled *Casemix education for clinicians and clinical coders: Moving forward together*, authored by Karen Luxford.

Michelle Bramley, Senior Classification Officer presented a paper titled *Painting the Harbour Bridge: Maintenance of ICD-10-AM.*

Associate Professor Rosemary Roberts, Director chaired the session on ICD-10-AM and presented a paper titled *Evaluating the impact of ICD-10-AM*.

In addition, the NCCH sponsored a display booth in the very popular conference exhibition area.



Eric Schulz from NCCH (Brisbane) 'persoining' the NCCH Booth at the Tenth Casemix Conference in Australia.

QUALITY CONCERNS

ACBA

We are now receiving ACBA results from South Australia, Tasmania, New South Wales, and Victoria. As well, healthcare facilities in Queensland, Northern Territory and the ACT have reported that they are using ACBA but have not yet provided their results. We now need some involvement from the west to make this a national activity! There are also groups of facilities which are getting involved: all of the hospitals in two states/ territories have agreed to use ACBA on a regular basis, and we believe that the regional hospitals from one state, the private hospitals in another state, and the hospitals of a large metropolitan network have made a similar commitment. The Northern Hospital uses the ACBA process on a regular basis and you will find some comments on their experience on page 10.

The Feedback Forms are providing us with an important source of information to aid in the ongoing development and improvement of the ACBA tool, so please complete these forms and send them with your results. One of the advantages of ACBA is the detail on the cause of coding errors which it provides as the basis for Continuous Quality Improvement activities and we are very interested to know what changes healthcare facilities have implemented as a result of their ACBA audits. Please let us know of your ACBA success stories.

Commencing in this issue of *Coding Matters* is a new column for ACBA users, 'On the ACBA Audit Trail'. This column will provide hints and tips for users and answer commonly asked questions. We've had some calls from users of the ACBA kit's updated disk to tell us how easy it is to use; thank you for this feedback. If you have not yet acquired your new disk see *Coding Matters*, July 1998, page 5, or phone NCCH Sydney on 02 9351 9603. If we can help you with any queries on the use of ACBA, please give us a call on 03 9479 5788. Other contact details are on the inside cover of *Coding Matters*.

National Minimum Edits

In 1996, NCCH's Coding Standards Advisory Committee established a Working Party to develop and publish a set of National Minimum Edits (NME) applicable to ICD-10-AM. The CSAC representatives of Australian health authorities committed their respective States and Territories to apply edits *at least as strong* as the NMEs to their own data while the Commonwealth agreed to provided the resources and expertise needed for the project. Discussions were mainly teleconferences but some meetings were possible in conjunction with the quarterly CSAC meetings. Stuart McAlister (Department of Health and Family Services) and Irene Kearsey (CSAC representative of the Department of Human Services, Victoria) were joint convenors while the bulk of the work at the Commonwealth was done by Joan Lonergan, without whose expertise the project would not have progressed.

When work on the edits started in late 1996, the classification was still being prepared which made life difficult, trying to define edits for codes that were still being revised. However, the expected national implementation date for ICD-10-AM was 1 July, 1998 and it was not possible to wait until the classification was finalised. Even starting in late 1996, the Working Party had to limit itself to just *age* and *sex* edits for the first version of ICD-10-AM (in the knowledge that the AN-DRG grouper software applies some other types of edits). Edits would be either rejections or warnings.

Each Working Party member was provided with an Excel file of a section of the codes and entered their suggested edits. These were consolidated and re-distributed for review as a whole. With the thousands of codes to consider, and the number of interested parties, it is not surprising the deadline arrived before the Working Party had finished and, where agreement could not be quickly reached, a code was left without edit. However, a set of edits was handed over to the Commonwealth and later distributed to the ICD-10-AM coordinators.

The four '10' states each enhanced the set for their own purposes: tightening age limits, adding age or sex edits to more codes, adding different types of edits.

During 1998 and 1999 the NCCH Quality Division will consolidate and compare these State enhancements, preparing a revised set of edits for CSAC's consideration. This process will be undertaken each year, incorporating improved edits as consensus can be reached. New codes will also be considered for possible edits: as new codes are published, appropriate edits will accompany them.

NCCH would like to acknowledge and thank all who contributed to the development of the National Minimum Edits, another of the components in the immense task of developing and implementing the Australian classification. (Irene Kearsey sincerely apologises if any name has been omitted).

Joan Lonergan, Stuart McAlister, Josephine Raw – Dept of Health and Family Services

Irene Kearsey, Shahn Campbell – Dept of Human Services, VIC

Sandy Juriansz, Don Barr – Queensland Health

Jonnette McDonnell – Australian Institute of Health and Welfare

Rhonda Pfeiffer – SA Health Commission

Lisa Quick, Mary-Ellen Vidgen – NSW Dept of Health

Sue Stevens – WA Dept of Health

Lynette Lee – representing ACCC

Judith Hooper, Karen Peasley, Joanne Chicco – National Centre for Classification in Health

Vin Lal, Judy Redmond – ACT Community Care

Peter Mansfield – TAS Dept of Community & Health Services

Standards for Ethical Coding* and *Standards for the Coding Service

Appendices B & C, ICD-9-CM (1996) Volume 4,
Appendices C & D, ICD-10-AM (1998) Volume 5

The Quality Division is responsible for updating the *Standards for Ethical Coding* and *Standards for the Coding Service*. As a prelude to their revision, the NCCH Quality Division has been collating information regarding the current use and applicability of these two standards.

Several 'focus groups' to identify and discuss issues arising from these standards have been conducted. These have involved HIMs and clinical coders working in psychiatric, non-acute, country, metropolitan public and private sectors in Victoria, Tasmania and Queensland. Contact has been made with individuals, hospital network Chief HIMs in metropolitan Melbourne, and clinical coders from other States via health authority representatives. A 'call for comments' has also been placed in *Codelink* (CCSA newsletter), *Dataline* (HIMAA Vic newsletter) and Code-L. Thank you to the more than 120 people who have participated in focus groups or provided individual comments on these standards.

Emerging themes

From the feedback thus far received, the overall impression is that these standards are valuable to coders and coding service managers but they need updating.

Some of the themes to emerge include:

1. The Standards need to widen their focus to include areas whose needs are different such as isolated, non-acute, non-casemix funded and mental health services.
2. *Standards for Ethical Coding* encourage coders to behave ethically by setting ground rules and supporting the decisions made, especially if there is pressure from elsewhere for practice which may be considered unethical such as upcoding to increase casemix reimbursement.
3. Ethical obligations include coding accurately, according to *Australian Coding Standards*.
4. Ethical problems around coding for in-house and health authority use versus requirement for billing (e.g. health funds).
5. Some areas raised ethical coding issues in coding for rehabilitation, compensable cases, elderly medical patients and psychiatric patients.
6. Discussion of *Standards for the Coding Service* have raised queries about whether these should be a minimum standard that must be achieved or a 'best practice' standard, that is, something to aim for.
7. There is concern about the ability of healthcare facilities to provide resources such as internal education, coding literature, auditing and supervision.
8. It is felt that the *Standards for the Coding Service* need to be more specific, e.g. to define 'sufficient' office space, 'adequate' number of staff, 'regular' auditing. They could also incorporate additional information on related topics such as ergonomics, Occupational Health and Safety issues and Coder Competency Standards.
9. The reference to an 'adequate number of clinical coders for the size of the facility' brought about much discussion. There were many comments about having a coding rate per hour or day, and much discussion as to how the NCCH Quality Division will be promoting the use, and supporting the implementation, of the revised standards.

- **Dianne Williamson**
  Manager, NCCH Quality Division
- **Catherine Perry**
  Team Leader, *Standards for the Coding Service Project*, NCCH Quality Division
- **Andrea Groom**
  Team Leader, *Standards for Ethical Coding Project*, NCCH Quality Division
- **Irene Kearsey**
  Team Leader, *Performance Indicators for Coding Quality*, NCCH Quality Division

ON THE ACBA AUDIT TRAIL

On the ACBA Audit Trail is a new column by Andrea Groom, Quality Officer with the NCCH Quality Division which will provide useful hints and tips for ACBA users.

I've done an ACBA audit and I think my error rate is high. Should I send the results to NCCH Quality Division?

A Yes. We are interested in receiving all ACBA audit results – not just the 'good' ones. The audit is about improving coding quality. It is not a competition to see which healthcare facility is 'best' but a way of seeing how and why errors are made and doing something about it. If you take action on your errors (as highlighted in the comments column of the Scoring Tool Form), your results will improve! It is important for us to know the national range of error rates and the causes too. All results are treated confidentially.

Can more than one reporting category be allocated for an error?

A One category per error should be allocated except for reporting category 7 '*Unclear or inconsistent documentation*'. Experience to date has found that this category is not useful on its own. Therefore it is necessary to classify the **effect** of unclear or inconsistent documentation in addition, e.g. unclear documentation causing missing code, assign categories 4a '*Missing code*' **and** category 7. Category 7 errors are not counted in the 'total' column, so this will not artificially increase your error rate. Otherwise select the most appropriate category for the error.

How do I decide on the period to be audited?

A It is recommended that the cases to be audited come from one month's separations. The records to be audited must have already been coded, so the coding for the period chosen must be complete. However, the chosen month should be recent and in the current coding system period (that is, not after a change to a new edition). This will result in maximum educational benefit to your healthcare facility, as these cases reflect the coder's current knowledge (so you are not correcting something they have already discovered), are coded in the current system to the current standards, and it is more likely that the coder is still employed by the healthcare facility.

What should I write in the 'Comments' column on the Scoring Tool Form?

A The comments column is vitally important to enable your healthcare facility to take action on causes of coding problems. It should be used to provide feedback to coders, management, etc and to plan relevant CQI activities. The comments will also enable the NCCH to identify and take action to reduce particular errors, e.g. target coder education, amend or make new *Australian Coding Standards*, add includes or excludes notes.

A sample Scoring Tool Form has been included in this issue of *Coding Matters* on page 9. The sample helps to highlight the type of information that should be recorded in the comments column. Two helpful hints are:

1. The comments need to be meaningful without reference to the clinical record. For example, gastroscopy with biopsy was coded, but no biopsy was done. The cause of error was 'operational report not checked'.

2. The amount of text required may be reduced by making reference to the reporting category number. For example, '4a. smoker' means the same as 'missing smoker code', as category 4a means 'missing code'.

Why doesn't ACBA collect information on DRG changes?

A Whilst DRG change is not a reporting category in ACBA, this information can still be collected if it is useful for your healthcare facility. We suggest entering the information on DRG changes into the comments column of the Scoring Tool Form, and making a separate report of these changes later if required. The NCCH Quality Division is not collecting this information because of the different systems in different states, and also because casemix is only one of the reasons why coding accuracy is important.

❖ **Andrea Groom**
Quality Officer, NCCH Quality Division

Hospital name: Quality Hospital					**Audit period: March, 1998**	
Results Category	**Number Reported**		**Percentage**		**% Distribution**	
Baseline data			**%**		*Formula*	*Formula* (h)
Total number of records audited	40		_		_	_
Total number of ICD codes coded by Person A	168		_		_	_
Total number of ICD codes coded by Person B	176		_		_	_
Aggregated results by code						
ICD codes with error (categories 1,2,3,5,6,7)	14		8%		(a)	61%
ICD codes missed (category 4)	9		5%		(b)	39%
Total	23		13%		(c)	100%
Results by category type	**(C)**	**(S)**				
1a [C] Incorrect sequence P Dx, coder misinterpreting	0		0%		(d)	0%
1b [S] Incorrect sequence, ambiguous P Dx		1	1%		(d)	5%
2 [C] Incorrect P Dx, rule not followed	1		1%		(d)	5%
3 [C] Incorrect Additional Dx/Proc, rule not followed	6		4%		(d)	30%
4a [C] Missing code, coder misinterpreting	9		5%		(d)	45%
4b [S] Missing code, late information		0	0%		(d)	0%
5a [S] Optional code, added by Person A		0	0%		(d)	0%
5b [S] Optional code, added by Person B		1	1%		(d)	5%
6 [C] Unjustified additional code, no evidence	2		1%		(d)	0%
7 [S] Unclear documentation *		3	2%		(d)	15%
Results by error type						
Total coder error [C]	18		11%		(e)	90%
Total system error [S]		2	1%		(e)	10%
Total	20		12%		(e)	100%
Aggregated results by record						
Records with error	11		28%		(f)	-
Records without error	29		73%		(g)	-
Total records	40		100%			
* Category 7 errors are also counted under another category as appropriate, and do not contribute to the total.						
Formulas used to calculate error percentages						
(a) Total codes with error divided by total ICD codes coded by Person B, expressed as percentage.						
(b) Total codes missed divided by total ICD codes coded by Person B, expressed as percentage.						
(c) Aggregated errors (ie, *all* categories) divided by total ICD codes coded by Person B, expressed as percentage.						
(d) Error divided by total ICD codes coded by Person B, expressed as percentage.						
(e) Error divided by total ICD codes coded by Person B, expressed as percentage.						
(f) Records with a coding error (category 1-6) divided by number of records reviewed, expressed as percentage.						
(g) Records without a coding error divided by number of records reviewed, expressed as a percentage.						
(h) Total of that line as a percentage of the total for that analysis.						

The Northern Hospital Experience with ACBA

The Northern Hospital (formally the Preston and Northcote Community Hospital) is a 225 bed acute care hospital located in the outer suburbs of Melbourne with approximately 2,000 separations per month. At the Northern Hospital we are heavily committed to coding quality, auditing an average 13% of our separations per month. These coding audits are varied and include; targeted DRG audits, unit audits (conducted with clinicians and HIM), ICU cases, neonate weight audit and high outlier DRGs.

Due to the impact of Casemix funding in Victoria, most of our coding audits have focused on DRG variation rather than variation at ICD code level. ACBA has an emphasis on individual code assignment and has therefore provided us with a better method of identifying our actual coding error rate rather than just DRG errors.

To date we have conducted three ACBA audits (in ICD-9-CM) with encouraging results. ACBA does not measure DRG and associated weight variations, however we decided to collect this additional information using the comments column. Rather than have one sole auditor we felt that it would be more worthwhile for all coders to be involved. We did, however, elect a 'preparer' who assumed responsibility for obtaining the recommended 5% random sample, distributing the coding lists, setting a completion date, collating the Scoring Tools and producing the final written report.

All results were reviewed at monthly coding meetings and any problem areas were highlighted. The major coding variation encountered related to the coding of associated conditions such as atrial fibrillation and chronic obstructive airways disease, particularly for short stay admissions. This has resulted in our coding policy being updated. Cases identified with inadequate documentation for coding were referred to our established unit audits for clarification by the clinicians.

Outcomes

- Previous coding audits conducted at the Northern Hospital had focused on DRG assignment, whereas the ACBA audit has an emphasis on individual coding variation.
- During previous coding audits, coders have been more likely to verify codes rather than actually re-coding the record. ACBA requires coders to re-code the record without reference to the previous codes, thus ensuring a blind study. Less experienced coders are also not intimidated by the previous coding.
- Results have generated many discussions and highlighted coding areas that have required attention i.e. coding associated conditions and documentation deficiencies.
- ACBA has provided us with the opportunity to benchmark our coding error rate with similar organisations in Australia.
- ACBA requires records to be randomly selected which therefore provides an unbiased sample and a sample that accurately reflects the activities of the hospital.
- As we have a standard error rate with ICD-9-CM we now have the basis to compare the coding quality impact of ICD-10-AM.

Difficulties

We cannot say that we did not have a few hiccups in the beginning, especially when calculating the results. The NCCH Quality Division, however, has recently updated the two collection spreadsheets, which simplifies calculating the results and in fact does most of the work for you. We suggest that hospitals undertaking the audit obtain the updated files from the NCCH Quality Division to assist with the process.

We found conducting the ACBA audit more time consuming than other coding audits due to the detailed re-coding process of selecting random samples and preparing the record for the blind study.

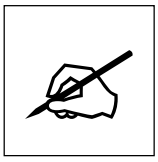
It was sometimes unclear whether a code is 'optional' or 'missing', which in turn made it difficult to assign the most appropriate reporting category.

Conclusion

We found ACBA to be a worthwhile exercise and aim to include it formally into our Quality Assurance Program on an ongoing basis. We plan to conduct the audit on a monthly basis and continue to use the recommended 5% sample.

Although it may seem time consuming to begin with, the results far outweigh the effort and we encourage organisations to jump on board. The full value of ACBA depends on the participation of clinical coders throughout the country, so please become involved and help the NCCH establish national benchmarks.

❖ **Jackie McLeod and Patricia Fini**
The Northern Hospital
Health Information Management Unit



EDUCATIONAL MATTERS

Clinical coders tell us how they felt about the ICD-10-AM workshops and the NT gives the NCCH conference delegates a true outback welcome...

ICD-10-AM Education Workshop Evaluation

During April, May and June 1998, there were 32 workshops held throughout New South Wales, Victoria, Northern Territory and the Australian Capital Territory. These workshops provided training in ICD-10-AM for 1010 clinical coders, health information managers and other data users.

Evaluation forms were supplied to all participants with a return rate of 78%.

There were five questions on the evaluation forms, three were free text and two included a rating scale. In this summary, only the most common free text comments have been included. All the comments made on these evaluation forms will be considered when planning for future educational activities, in an effort to continue to improve the format and content of the educational sessions that the NCCH provides.

The first question aimed to assess the expectations of the participants and whether these expectations were met or not. The general feeling was that the expectations of most participants were to gain an insight into the major differences between ICD-9-CM and ICD-10-AM and that these expectations were met and met well. Many noted that 'their fears were allayed', 'less stressed about the changes', 'pleasantly surprised that ICD-10-AM was not as hard as imagined' and 'unveiled the mysteries of ICD-10-AM'.

Other positive comments were that the sessions were informative and educational, a valuable learning experience, well presented, well formatted and presented at a good working pace and that the workshops were interesting and challenging.

However, many participants felt that the material presented was very rushed and suggested that the sessions could have been better presented over more than a two day period.

Participants were asked to rate the overall workshop program as an educational experience. A rating of 'very good' was the highest with 48% respondents. 25% reported the program as good, 20% as excellent, 6% as fair and 1% as poor.

Four questions were asked of the participants relating to the content and format of the workshop. These again used a rating scale of excellent, very good, good, fair or poor.

How was the ratio of lecture to discussion?

79% of participants felt that the ratio of lecture to discussion was good to excellent, 17% felt it was fair and 4% felt the ratio between lecture and discussion was poor. Comments related to this question were that some participants felt that discussion was lacking and that some educators did not encourage enough discussion. Another participant would have appreciated more discussion on tips for coding.

How well were the sessions kept alive and interesting?

81% of participants felt that the sessions were kept alive and interesting. 17% felt that the sessions were only moderately interesting and 2% thought that the sessions were not kept alive and interesting at all. Some comments and suggestions included the need to add some humour to the sessions as the topic can be dry so that it is difficult to maintain a level of interest over a long period of time. Others felt that the structure of each session was logical and that the educators were very positive towards the introduction of ICD-10-AM.

How well were major points identified and clarified?

90% of participants felt that the major points were well identified and clarified, 10% rated this question as fair to poor. Many participants commented that the workbook was an excellent reference and learning tool, however more work could have been provided on the *Australian Coding Standards* (ACS). The inclusion of identified documentation issues was appreciated.

How well did the scenario exercises help to reinforce the classification changes?

97% of participants felt that the scenario exercises in the workbook were good to excellent and assisted greatly in reinforcing the changes to the classification. 3% rated the exercises as only fair to poor in reinforcing the classification changes. Many participants commented that the exercises were very beneficial and were realistic and relevant. However, the majority of participants were in agreement that more time should have been provided for completion of the exercises.

As the NCCH is always on the lookout for feedback, the participants were asked to provide comments on what could have made the workshops more effective for their needs and what changes could be made for future educational sessions.

A major outcome from this question was the request for more education post implementation, approximately 3–6 months following the introduction of ICD-10-AM. This would be useful to clinical coders as problems with the use of the classification become clearer.

Other comments included a more interactive coding focus, possibly working in small groups or within particular speciality areas. Others felt that they would have gained more from the workshops had there been more detailed discussion and in depth analysis on the new changes as well as an optional day for review of the ACS. Many participants requested the answers for the exercises be provided within the workbook or they be provided with a take home question and answer workbook or that participants receive the workbooks prior to the session so that they may familiarise themselves with the material prior to attending the workshop. Another request was for more specific training for day procedure centres.

Although there were a few minor hiccups with the workshops (as is always expected), overall I felt that the workshops were a success and provided clinical coders with a solid base to commence preparation for the introduction of ICD-10-AM into their state or territory. As mentioned previously, all the comments and suggestions made will be reviewed and taken into consideration in planning future educational sessions and in preparation for the education of those states moving to ICD-10-AM in 1999.

NCCH 5th Annual Conference *(in conjunction with CCSA)*

I think there was some form of osmosis occurring in the Northern Territory (NT) in the last week of September. The laid back, relaxed, carefree and mellow surrounds seemed to permeate to all the delegates at the NCCH 5th Annual Conference being held in Alice Springs from the 23–25 September. When delegates starting turning up to sessions in t-shirts, shorts and sandals, I knew that the plan had worked to bring a group of people together to a location where they could be treated to a comprehensive and informative program while also letting the sun and surrounds do their work. This years theme, 'The Meeting of Two Centres–Coding in a Rural Setting', proved correct as many delegates greeted old friends and made new ones over the three day period, while learning about life in a rural town.

The conference commenced on Wednesday 23 September with a new innovation for the NCCH, the incorporation of optional site tours of the Alice Springs Hospital and the Royal Flying Doctor Service (RFDS) Base. Approximately 40 people spent an hour touring the Patient Services department, the hospital redevelopment plans and reviewing the Caresys computerised patient information system in use in the NT. The group then moved onto the RFDS for a very informative and educational guided tour of the operational base and museum. I would like to extend thanks to Janine Cassidy, Jill Burgoyne and Sandra Casey for their assistance in running the hospital tour.

During the afternoon the '10 Coding Circles Workshop' attracted approximately 65 participants. Broken into eight groups of eight people, the participants worked through sets of de-identified 'real' medical records. Each group had a facilitator to assist in guiding the groups in the abstracting and coding process. The majority of participants were from a state that had yet to implement ICD-10-AM and many agreed that they enjoyed sharing ideas with people with different levels of knowledge of the classification and the opportunity to exchange views about clinical coding. Many participants noted that they would have preferred a lot more time for the coding process and these comments will be considered when planning for the 1999 conference.

Due to the inclement weather the outdoor Welcome Reception was successfully transferred indoors with an outback theme provided by the Rydges Plaza Hotel staff. One hundred and twenty delegates gathered to the moving sounds of a didgeridoo, to eat, drink and be merry, while making friends and networking, with many delegates continuing to celebrate into the wee hours.

Barbara Arundell and Peter Whatley (St Vincents Hospital, VIC) and Karen Peasley (NCCH)

The NT team celebrate a successful home town conference

Waking to clear blue skies and bright sunshine, the main conference sessions commenced on Thursday 24 September with a variety of papers covering coding in a rural setting. The conference was jointly opened by Rosemary Roberts, Director of the NCCH and Joan Knights, President of CCSA. Jill Burgoyne provided an insight into the changes that have occurred in coding in the NT over the past twenty years and the challenges still to be faced, while Pam Hall provided a very moving story of her involvement in the Katherine floods and its affect on the people of Katherine and the local health care system. Richard Hayes explained why Tasmania is often thought of as a 'tropical' island and Julie Richards, our international guest speaker provided a detailed review of coding in a rural setting in Canada, how rurality is defined in Canada and how clinical coding practices and data collection methods in Canada differ in rural settings from those of urban settings.

After morning tea, renal medicine became the theme with Janine Cassidy and Dr Meshach Kirubakaran from Alice Springs Hospital providing an extremely informative clinical update on Renal Medicine. A full report of this paper will be available in the January edition of *Coding Matters*. Dr Paul Snelling and Kathryn Smith continued the renal theme with reports on the treatment of end stage renal disease in indigenous Australians and the dialysis casemix development project in NSW Health respectively.

A variety of delegates took on alter egos after lunch for their involvement in the hypothetical 'To Code or not to Code – is that the Question?' chaired by Dianne Williamson. This session was extremely thought provoking and entertaining and I am sure all the clinical coders in the audience appreciated the fact that the session concluded with the coder winning Lotto! A transcript of this session will be made available to interested persons upon request.

A range of papers followed providing some relevant information on coding in a health fund from Rhonda Kealy, and on the need for a coding qualification for clinical coders from Jennifer Mitchell, a humorous report from Kerry Innes on her attendance at the Global Perspectives on Data Quality seminar in the United States and an update on the implementation of ICD-10-AM from Western Australia, Tasmania, South Australia and Queensland.

The Thursday session closed with the CCSA Annual General Meeting, with Joan Knights being elected President and Peter Whatley, Vice President.

At 6.30pm that evening, almost 100 people boarded the coaches for the Bushmans Dinner at the Overlander Steakhouse in the town centre. Much conversation, laughter, eating, drinking, singing, dancing, wobble boarding, branding and riding of saddles ensued!!! The success of this dinner ensured that this night out is something to continue at future NCCH conferences.

Friday morning began with a review of the comparison study between ICD-10, ICD-10-AM and ICD-10-CM from Julie Richards and the planned introduction of ICD-10 in Canada. Sue Walker and Tiffany Chan spoke about the maintenance of ICD-10-AM and the remaining states and territories and the Commonwealth provided an update on the implementation of ICD-10-AM. Quality issues were covered by Catherine Perry and Andrea Groom in their papers on the Performance Indicator for Coding Quality (PICQ) project and the *Australian Coding Benchmark Audit* (ACBA) respectively. Jeremy Woodger provided a realistic and entertaining session on Peer Participated Performance Management or PPPM being undertaken at the Princess Alexandra Hospital in Brisbane.

International guest speaker, Julie Richards adding a personal touch to the rural theme

Two representatives from the CCSA Rural Advisory Subcommittee, Mary McKay and Lisa Timmins, updated delegates on the options paper on rural coding issues and Dr Richard Madden's paper provided some

enlightening information on the importance of good indigenous health information and how clinical coders can contribute to improving this information. Barbara Arundell closed the conference with a comprehensive summation of the previous three days.

Although this years conference was smaller in physical numbers, it was a most successful, informative and entertaining conference with a very high standard of papers. Clinical coders joined together to discuss the important issues facing all of us working in the health field and many new friendships were made across the nation. I would like to thank the board members of the CCSA for their assistance in the management of the conference, Rydges Plaza Hotel for providing a wonderful venue, SBT Business Travel Solutions for getting us all to and from Alice Springs and to all the NCCH staff members who assisted in the many tasks it takes in getting such a conference off the ground. For those people who were unable to attend the conference, full papers are available as Conference Proceedings at a cost of $20. Please refer to the Order Form in this edition to place your order.

So, with a sigh of relief it is on to thinking about 1999, a bigger and even better conference to be held in the beautiful state of Tasmania. Stay tuned for more information…

❖ **Karen Peasley**
Education Manager

▲ **Participants at the '10 Coding Circles' workshop give their facilitator their undivided attention**

◀ **Nina Messina (RPA Hospital), Alison Hollins (Concord Hospital) and Aisha Kattar (Blacktown–Mt Druitt Health) join in the party at the Bushmans Dinner**

▼ **Balloons and big smiles at the Welcome Reception (from left) Peter Whately (St Vincents Hospital, VIC), Wendy Baker (Royal Womens Hospital, QLD), Jonnette McDonnell (ACT Health), Kerry Innes (NCCH), Sandy Juriansz (QLD Health) and Mary-Ellen Vidgen (3M)**

During July and August, 1998, two third year students from the School of Health Information Management, Cecile Leung and Mervat Dawoud, visited the NCCH on their management placement. One of the projects that they undertook during their two weeks with us was a review of Code-L queries. As users of Code-L, we felt that the readers of *Coding Matters* would be most interested in the results of this study, so it is reproduced on the opposite page…

The Code-L Queries You Love Best

Cecile Leung and Mervat Dawoud

Background

Code-L is an internet subscriber list. It is an informal communication channel network provided by the NCCH for Australian clinical coders. Coders can get professional advice and information quickly and conveniently via electronic mail.

Purpose

The purpose of this report is to review replies and queries from Code-L and the ICD-9-CM query database for a six month period. This activity could provide an overview of the most commonly asked queries.

Method

A tally of the queries and number of replies from the period, 13/1/98 to 27/7/98 was generated. The top six queries are presented in a column graph. In addition, reasons for the replies and non-replies of queries were documented.

A comparison between the ICD-9-CM query database and queries on Code-L was also undertaken. Queries from Code-L that have appeared in the ICD-9-CM query database were matched, highlighting certain coding query areas which needs to be investigated.

Results

There was a total of 135 responses to the 75 queries submitted by different users of Code-L. 21 queries received no replies.

This may be due to several reasons:

- Answers should be known to the coders
- Answers to queries can be easily abstracted from the coding standards e.g. trephine of bone and cold injury syndrome
- Prioritising time to re-check codes
- Questions unrelated to coding area
- Questions which should be clarified by clinicians
- Rare and unknown diagnosis and procedures
- Replies are more likely to be made to known users
- Seeking definition which might be of an unknown origin
- Similar questions have been answered before therefore no replies were given
- Some coding areas does not interest other users
- Maybe the person has been blacklisted by other users!!!

The top six queries in terms of numbers of replies were:

- Follow up examinations[1]
- ICD-10-AM books[2]
- Grazed nipples
- Grovers Disease
- O&G and Neonatal
- Trial of void

The top six queries related to areas where:

- Many complications can occur e.g. obstetrics
- Coders need clarifications of standards
- Common coding problems occur at different hospitals
- Coding practice differences between countries or private/public sectors
- There is discussion about specific code for disease or procedure
- New issues need to be resolved e.g. ICD-10-AM books

Comparisons between ICD-9-CM query database and queries on Code-L

It has been found that there were certain coding query areas which have presented problems to coders, as they appeared on the ICD-9-CM query database, as well as Code-L.

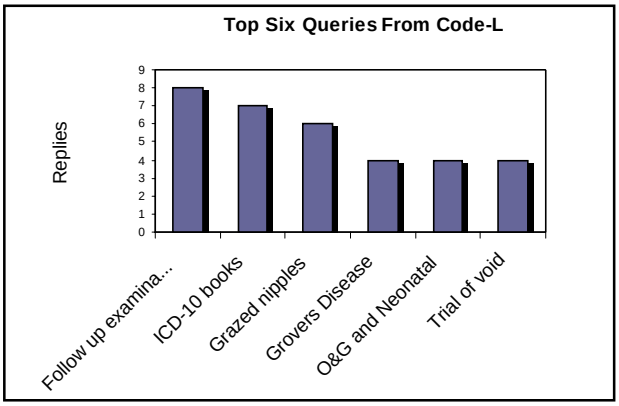
Such coding query areas include:

- Complications concerning post abortion/termination
- Envenomation of snake bites codes
- Grazed nipples with breast feeding difficulties
- Grovers Disease with the principal diagnosis code
- Helicobacter and the intestinal tract
- Inclusion of IVF principal diagnosis and additional code
- Urinary incontinence in stroke patients

Future Recommendations

A comprehensive research on the coding queries concerning ICD-9-CM and ICD-10-AM in the future will help to:

- Create an agenda for future publications e.g. specialty booklets
- Direct future developments of coding procedures and standards. e.g. in subsequent editions of ICD-10-AM.
- Measure the quality of coding
- Prioritise areas for educational services
- Provide support to clinical coders and associated health professions to discuss issues.



[1]Follow up examinations queries involves allocating codes for a patient who was admitted for follow-up of a diagnosis from a previous episode of care e.g. follow up of bladder cancer previously treated by radiation therapy with no recurrence of malignancy.

[2] Enquires relating to the issues of ICD-10-AM books and new coding standards

Profiles of Coding Educators Network (CEN) members

Gayle Smith (Tasmania)

I joined the Coding Educators Network (CEN) in May 1997. At that time Tasmania did not have a representative on this network and as we are often left off the map, I felt this need not be the case in this instance. It also provided an enormous opportunity to be actively involved with the introduction of ICD-10-AM from the outset. Being a member of the CEN, I attended a Train the Trainer workshop, participated in the Dual Coding Study and more recently, the ICD-10-AM CEN refresher course.

My background is in nursing and in 1993 I began working with medical records, about the time when the casemix debate was beginning to be taken seriously by hospital management and the threat of episodic payments seemed imminent. Five years down the track, casemix based payments are still threatening but the use of casemix information as a management tool is much more widespread. This would not be possible without clinical coders and coded information.

I completed the Distance Education Coding Course (HIMAA) in 1994 and am currently a member of the Tasmanian ICD-10-AM Implementation Working Party. Tasmania has elected not to introduce ICD-10-AM until July 1999 and whilst I was initially disappointed that there wasn't to be an Australia wide implementation date, I am now hopeful that Tasmania will learn from the experience of the states moving to ICD-10-AM in 1998.

Joan Knights (Western Australia)

I commenced my life in Clinical Coding using ICD-9 in 1986, when the manager of the Medical Record Department had the foresight that 'casemix' was coming to the West and coding was the career to be in. How right she was and what a journey it has been up to now!

I was appointed Coding Development Officer to St John of God (SJOG) Health Care in western Australia in 1996 and in this role one of my responsibilities is the ongoing education of SJOG Health Care (WA) Clinical Coders. This is an area of great interest to me and has proved to be extremely challenging.

My commitment to coding, in addition to my involvement with the Health Department of Western Australia (HDWA) State Coding Committee, the 'birth' of the Standards and other coder education aids such as regular sessions with various specialists and doctors, have all enabled me to achieve a very high standard in coding. This has been further enhanced by continuous education from the HDWA, the National Centre for Classification in Health (NCCH) and the Health Information Management Association of Australia (HIMAA).

In 1993 I became a HIMAA Distance Education Instructor and enjoyed meeting students who had come from various backgrounds, eager to establish a new career for themselves in clinical coding.

I took the opportunity to join the staff at Curtin University in 1994, enabling the Health Information Management (HIM) third year coding students to put into practice the coding methods they had been taught for themselves in the preceeding two years of their course.

I joined the NCCH Coding Educators Network in late 1995 and since then I have made many fine coder friends from all over the country where we have shared coders' fears, ideas, problems and future plans. These have been invaluable relationships to me.

I have had exposure to ICD-10-AM by taking part in the Dual Coding Study and the Train the Trainer sessions undertaken in 1997 and 1998. I believe I have acquired an extensive knowledge of the future classification and I am eagerly awaiting its implementation in WA on 1 July 1999 and the new stimulus and challenges it will bring.

Leonie Marskell (NSW)

Upon my return to the Health Information Management profession I decided it was imperative I ensure I was fully informed on all aspects of ICD coding. What better way than to become a Coder Educator? To clarify this statement my background includes graduating as a Medical Records Administrator in 1988, working as an MRA in various hospitals, diversifying my career and regrouping in 1995.

During my diversifying career episode I spent 2 years as a Medical Representative for a pharmaceutical company. This experience taught me a great deal about education and dealing with clinicians.

Education has always been a high priority for me with regards to ensuring that my staff and I are up to date with current practices. I have in the past developed and taught medical terminology courses at both TAFE and in-house hospital education.

In 1991 I was fortunate to be employed at the newly opened John Hunter Hospital in a staff training/education role.

In 1995 I moved interstate to South Australia, to be confronted with casemix based funding. My interest in coding quality and education escalated. It was in 1997 that I decided to apply to become a Coder Educator. I have since returned to NSW (the beautiful Hunter Valley) and am currently employed as the Casemix and Coding Services Manager, Lower Hunter Sector, Hunter Area Health Service. My CEN partner in crime has been Lynn Lehmann (*Coding Matters*, April 1998). Having conducted two very successful ICD-10-AM Workshops with Lynn, I am confident that all clinical coders will rise to the challenge of ICD-10-AM.

GREENSLOPES PRIVATE HOSPITAL

CLINICAL CODER (Administrative)

Greenslopes Private Hospital is Australia's largest private teaching hospital, owned and operated by Ramsay Health Care. With 350 beds, 24 hour Emergency Centre, and a wide range of on-site medical, surgical, psychiatric, diagnostic and allied health services, Greenslopes Private Hospital is considered to be one of Australia's finest and most comprehensive hospitals.

A unique opportunity exists within the Patient Record Service for an experienced Clinical Coder interested in working in a progressive and rewarding team environment.

The successful applicant will possess:

- At least one year industry experience;
- Ability to code to a high standard using ICD-9-CM;
- High level of motivation;
- Excellent communication skills;
- Ability to use patient management computing applications;
- Understanding of quality improvement principles.

Greenslopes Private Hospital will be moving to ICD-10-AM from 1 July 1999.

Please contact Shan Riddel, Manager - Patient Record Service, Greenslopes Private Hospital on (07)3394 7246 or riddels@ramsayhealth.com.au for further information.

CODING SERVICES

Some coding tips, some questions and answers, and some words of wisdom from Coding Services...
'He [or she] who asks is a fool for five minutes, but he who does not is a fool for ever'

As time goes by...

(MJA, Vol 168, 2 February 1998, page 137, editorial)

This editorial summary of a Western Australian study (reported in the Lancet 1997; 350:1752) should interest clinical coders. In the study seven general surgeons were asked to mark conclusions from 260 selected abstracts published in the journal *Surgery, Gynaecology and Obstetrics* between 1935 and 1994 as being true or false. The researchers found a linear relationship between time and the number of conclusions found to be true; the rate of loss of truth was 0.75% per year. The researchers suggested that the half-life of 'truth' for clinical statements in the surgical literature is 45 years, where truth represents our factual knowledge at the present time.

Medical Science Tip

Inflammation describes the reaction of tissue to injury.

Infection describes the state in which the body, or a part of it, is invaded by an infectious agent.

Inflammation does not necessarily mean there is associated infection

For example, about 45 years ago it was 'true' that in patients with cancer, prefrontal lobotomy usually altered patients' reactions so that no anxiety, fear or concern over their impending death was manifest. It was also 'true' that the detection of a gastric ulcer was a strong indication for immediate operation.

Extrapolating from their results, the authors believe that our current era of 'open' surgery will extend from 1904 to 2038, representing the time from abdominal surgery gaining public respectability through to the ascendancy of minimally invasive procedures and the preference for medical over surgical management.

Coding tips

Short gestation and low birth weight

More than one code from category P07 *Disorders related to short gestation and low birth weight, not elsewhere classified* can be assigned for an episode of care. For example: P07.3 *Other preterm infants* can be assigned with P07.1 *Other low birth weight.*

Admission for in vitro fertilisation (IVF)

When an admission is specifically for IVF procedures, and the principal diagnosis is 'IVF' or 'infertility', Z31.2 *In vitro fertilization* should be assigned as the principal diagnosis code. An additional code from N97x *Female infertility*, for the type of infertility may be assigned if known, including N97.4 *Female infertility associated with male factors.*

In contrast, when an admission is for investigation or treatment of infertility (either male or female), a code from N97.x *Female infertility* or code N46 *Male infertility* should be assigned as principal diagnosis.

Neonatal sepsis

Definition

Neonatal sepsis may be defined as an invasive bacterial infection occurring in the first 28 days of life. **Early-onset neonatal sepsis** is clinically apparent within 6 hours of birth in > 50% of diagnosed cases; the great majority present within the first 72 hours of life. **Late-onset neonatal sepsis** usually presents after 4 days of age and includes nosocomially acquired infections.

Risk factors for invasive neonatal infection include:
- preterm labour
- premature rupture of membranes
- signs of maternal infection
- multiple birth with delay in delivery of subsequent infant(s)
- prolonged rupture of membranes
- maternal carriage of group B streptococcus infection
- previous baby with invasive group B streptococcal disease

▶

Neonates who have one or more of the above risk factors but no symptoms may have a diagnosis of 'risk of sepsis' or '? sepsis' and be treated with antibiotics or kept in hospital for further observation, depending on their clinical profile.

Classification

For those neonates who have a specific infection , such as neonatal sepsis, assign the appropriate diagnostic code, from P36x *Bacterial sepsis of newborn* together with any associated intervention codes (as per ACS 1615 *SPECIFIC INTERVENTIONS FOR THE SICK NEONATE*). An additional code from category P00–P04 *Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery* may be assigned if the infection is a result of a maternal condition.

For those neonates with a diagnosis of 'risk of sepsis' or '? sepsis' and **no documented condition**, the following rules apply:

Neonate is observed only and treatment for sepsis is not initiated, assign Z03.8 *Observation for other suspected diseases and conditions*.

If the neonate is given antibiotic treatment, assign Z03.8 *Observation for other suspected diseases and conditions*, together with the appropriate intervention code (as per ACS 1615 *SPECIFIC INTERVENTIONS FOR THE SICK NEONATE*).

Haemodialysis

13100-00 [1059] Haemodialysis

In haemodialysis, the blood, laden with toxins and nitrogenous wastes, is diverted from the patient with renal disease to a dialyser where the blood is cleansed and returned to the patient. The process involves:

- *diffusion* whereby the toxins and wastes move from the area of greater concentration (the blood) to the area of lesser concentration (the fluid in the dialyser i.e. the dialysate),
- *osmosis* whereby excess water moves from the area of greater pressure (the patient) to the area of lesser pressure (the dialysate), and
- *ultrafiltration* which facilitates water removal by creating a negative pressure between the blood and the dialysate.

13100-01 [1059] Intermittent haemofiltration

Haemofiltration is used to remove excess fluid.

Intermittent haemofiltration treatments are given three times per week using highly permeable haemofilters. The theoretical advantage of intermittent haemofiltration is a higher removal rate of larger molecular weight substances which are removed poorly by dialysis.

Intermittent haemofiltration is sometimes referred to as *intermittent ultrafiltration* which is most often used just prior to dialysis. A dialysis machine is used but dialysis solution is not circulated through the machine and a negative pressure is generated in the ultrafiltrate compartment, effecting ultrafiltration.

13100-02 [1059] Continuous haemofiltration

Continuous haemofiltration is a method of temporarily replacing kidney function.

It is used at the beside in *intensive care units* for patients whose kidneys are unable to handle their high acute metabolic or nutritional needs.

Blood is circulated through a small volume, low resistance filter by the patient's own arterial pressure rather than that of the blood pump used in haemodialysis. Blood flows from an artery, via an arteriovenous fistula or an arterial catheter, to a haemofilter where excess fluids, electrolytes and nitrogenous waste products are removed by ultrafiltration. The blood then returns to the patient's circulation via the venous arm of the arteriovenous fistula or a venous catheter. Intravenous fluids may be administered to replace fluid removed by the procedure.

The process is continuous and slow, making it particularly suitable for patients with unstable cardiovascular systems. Continuous haemofiltration should be specifically documented in the medical record to assign the appropriate code.

13100-03 [1059] Intermittent haemodiafiltration

Intermittent haemodiafiltration is a hybrid between haemofiltration and haemodialysis, combining diffusion and convection. Blood flow is accelerated to twice that of conventional dialysis; also called high-flux haemodiafiltration. Intermittent haemodiafiltration is performed approximately three times per week in patients with chronic renal failure.

13100-04 [1059] Continuous haemodiafiltration

The definition for continuous haemodiafiltration is the same as above, except that it is performed continuously, usually in intensive care units. Candidates for this type of treatment have acute renal failure with unstable cardiovascular systems.

Specific machines have been adapted for haemofiltration, haemodialysis and haemodiafiltration, they include:

CVVH: Continuous Veno-Venous haemofiltration, provides solute removal by convection, and patient fluid removal if desired.

CVVHD: Continuous Veno-Venous Haemodialysis, provides solute removal by diffusion, and patient fluid removal if desired.

CVVHDF: Continuous Veno-Venous Haemodiafiltration, provides solute removal by diffusion and convection simultaneously, and patient fluid removal if desired as per intermittent haemodiafiltration

13100-05 [1059] Haemoperfusion

Haemoperfusion is the continuous circulation of blood outside the body through a material such as charcoal for the removal of toxins from the blood stream. A dialysis machine is used for this procedure. Haemoperfusion is rarely performed.

Peritoneal dialysis

Peritoneal dialysis uses the lining of the abdominal cavity, called the peritoneal membrane, to clean waste from the blood. The peritoneal cavity is filled with dialysis solution via a catheter which is surgically placed. Over several hours, the solution draws waste out of the membrane's blood vessels as it is washed around the peritoneal cavity. The fluid is then drained out of the body and replaced with new fluid, starting the process over again.

There are two types of peritoneal dialysis:

i. Continuous Ambulatory Peritoneal Dialysis (CAPD)

This type of dialysis is performed continuously by the patient on an outpatient basis. Fluid is run into the abdomen, where it is left for four to eight hours (the dwell period). The drainage bag is clamped, folded and held in the person's clothing during this time. When the dwell period is over, the catheter to the drainage bag is unclamped and the dialysate fluid is drained by gravity. Generally 4 bag changes a day, 7 days a week are required. Continuous cycling peritoneal dialysis (CCPD) is similar to CAPD but takes place at night, using a machine to make several fluid exchanges automatically. The last exchange before the patient rises is allowed to dwell for the day, avoiding the interruption of daily activities for maintenance of the system.

As this dialysis is continuous, it allows for a freer diet and fluid allowance than other forms of dialysis.

ii. Intermittent Peritoneal Dialysis (IPD)

This involves the use of an IPD machine to which the patient is attached for about 12 hours, 3 times a week. The machine runs fluid in and out of the abdomen every 20 minutes. This treatment can be performed overnight whilst the patient is asleep.

Catheters

Central Venous Catheter (CVC) inserted percutaneously = PerQCath, PICC

CVC inserted by cutdown = Broviac, Cook, Groshong, Hickman, Leonards

Implantable Vascular Access Device (VAD) inserted percutaneously = Vascath

Implantable VAD inserted open = Infus-A-Port, Permacath, Port-A-Cath

Errata 3

You will find Errata 3 (October 1998) as a 2 page insert included in this edition of *Coding Matters*. If you have not received it, please call us.

❖ **Kerry Innes**
Associate Director (Sydney)

HOSPITALS AND AMBULANCE SERVICE DIVISION
ROYAL HOBART HOSPITAL

Position Title: Manager Clinical Coding
Position Numbers: E1500-001
Salary Range: $45,584 to $48,189 per annum
Special Comments: Permanent Full Time
Award: Community and Health Services (Public Sector) Award Administrative and Clerical Level 8
Location: Patient Information Management Service, Royal Hobart Hospital

Duties:
Manage the provision of a high level, effective and efficient clinical coding service with specific responsibility for timely completion of coding in compliance with reporting requirements; accuracy of clinical coding in compliance with relevant national standards; management of clinical coding personnel; liaison with hospital clinical, casemix and financial personnel; and development of appropriate policies and procedures relating to clinical coding. Implementation of ICD-10.

Qualifications:
Desirable:
- Tertiary qualification in Health Information Management.
- Sound knowledge of the three volumes of ICD-9-CM and the Australian Coding Standards.
- Experience in the use of the 3M-Encoder.
- Sound knowledge of the health system with particular emphasis on morbidity coding and casemix within a large health care service.

Enquiries: For position descriptions please contact Amanda Turner on (03) 6222 8258.
For any further information please contact Ms Marie Shea, Director Corporate and Support Services on (03) 6222 8261.

Applications to: The Manager
HUMAN RESOURCES DEPARTMENT
GPO BOX 1061L
HOBART TAS 7001
By 5.00 p.m. on 30 October 1998

Questions and answers from the ICD-10-AM workshops

Q1 ***As there are now many laparoscopic procedure codes but few 'laparoscopic converted to open' codes, shall we continue with the practice of using the open code + scope code for those cases where converted codes aren't available?***

A Yes, when an endoscopic procedure is converted to an open approach and no single code exists to encompass both the open procedure and the endoscopic approach, assign a code for the open approach followed by the appropriate endoscopic procedure code.

Q2 ***Does 30428-00 [953]*** **Lobectomy of liver for trauma** ***include 'intraoperative' trauma?***

A The terms 'trauma' or 'traumatic' are found in the code descriptors for the following procedure codes in ICD-10-AM:

90004-00 [16]	Corticectomy of brain for trauma
90004-01 [16]	Partial lobectomy of brain for trauma
30427-00 [953]	Segmental resection of liver for trauma
30428-00 [953]	Lobectomy of liver for trauma
30422-00 [954]	Repair of traumatic superficial laceration of liver
30425-00 [954]	Repair of traumatic deep, multiple lacerations of liver
36576-00 [1044]	Exposure and exploration of kidney for trauma

The reference to trauma in the above codes excludes intraoperative trauma. Intraoperative trauma procedures should be coded to the specific procedure performed.

Q3 ***Open wound with tendon injury: do you need to code the tendon injury and then the open wound code?***

A Yes. The tendon injury should be sequenced first followed by the open wound code. Refer to ACS 1908 *LACERATION WITH NERVE DAMAGE*.

Q4 ***Neoplasm of breast (male): is it the same code as female i.e. C50.9?***

A Yes, no distinction is made between neoplasm of the male or female breast.

Q5 ***Inferolateral myocardial infarction: from index can only code this specificity if also noted as transmural. Should I21.9*** **MI not otherwise specified** ***or I21.1*** **Inferolateral transmural MI be assigned?**

A When the term 'myocardial infarction' is qualified by a term describing the position of the infarction in the ventricular wall (for example, anterolateral myocardial infarction or inferolateral myocardial infarction) assume that the myocardial infarction is transmural. Myocardial infarctions are transmural, i.e. 'full-thickness' unless specified as non-transmural, non-Q wave or subendocardial. Assign the correct code by following the index trail:
- Infarct, infarction (of)
- - myocardium, myocardial (acute...)
- - - transmural

Q6 ***Patients with underlying neoplasm often come into hospital for treatment of anaemia. Example 3 of ACS 0207*** **COMPLICATIONS ASSOCIATED WITH NEOPLASMS** ***tells us to code this as 1. Anaemia 2. Neoplasm 3. Treatment. Does code D63.0**** **Anaemia in neoplastic disease,** ***affect ACS 0207?***

A Index entry under Anaemia, in neoplastic disease NEC, D48.9†, D63.0*, directs the coder to *see also* Neoplasm. (D48.9 is an NEC code). Therefore a more specific code for the type of neoplasm should be assigned with the manifestation code of D63.0*. In this case the aetiology/manifestation rule overrides the standard (ACS 0207 *COMPLICATIONS ASSOCIATED WITH NEOPLASMS*). Please follow the Index when assigning codes for anaemia in neoplastic disease. For guidance in assigning aetiology/manifestation codes please refer to ACS 0027 *MULTIPLE CODING*.

Q7 ***With reference to the allied health-specific codes, do the tasks have to be completed by the particular allied health worker i.e. social work discharge planning 95055-00 [2057] by a social worker? This is quite often completed by another health worker i.e. OT, nursing staff.***

A The allied health interventions in Chapter XXI must be performed by a qualified allied health professional in the relevant discipline to assign the appropriate code. It is hoped that codes for allied health interventions will be practitioner neutral in the second edition of ICD-10-AM. The NCCH is currently working with the National Allied Health Casemix Committee to redesign this chapter.

Q8 ***ACS 0234*** **CONTIGUOUS SITES** ***states to code to primary site only, however in the case of skin carcinoma to an internal organ i.e. orbit, it groups only to a skin (minor) DRG.***

Should ACS 0234 be amended to include an exception for skin carcinoma to internal sites?

A The instruction to 'code only the primary site if the spread is from a known primary site to an adjacent organ or site' in ACS 0234 *CONTIGUOUS SITES* should be applied even though the DRG outcome is not always favourable. The NCCH will refer this issue to the Oncology and Haematology CCCG.

Q9 ***When the size of the lesion is not specified on the operation report, can you use the histopathology report for size of the lesion?***

A Yes. When the size of the lesion is not stated on the operation report consult the histopathology. In the instance where the size of the lesion is not documented on the operation report or histopathology report, apply ACS 0038 *PROCEDURES DISTINGUISHED ON THE BASIS OF SIZE, TIME OR NUMBER OF LESIONS.*

Q10 ***What code should be assigned for day only admissions to a hospice for diversional therapy? An additional code would be their disease e.g. HIV, terminal cancer.***

A ICD-10-AM has provided more specificity in Chapter XXI *Factors influencing health status and contact with health services*. In the absence of more information regarding the intent of the diversional therapy, Z50.8 *Care involving use of other rehabilitation procedures* **may** be an appropriate code to assign, as may Z51.88 *Other specified medical care*.

Q11 ***Should newly diagnosed diabetes mellitus be coded to 'uncontrolled'?***

A Patients with newly diagnosed diabetes are often admitted for stabilisation. However, a fifth character of 'uncontrolled' should only be assigned when indicated by clinical documentation such as 'uncontrolled' or 'for stabilisation'. Do not automatically assign a fifth character of 'uncontrolled' for newly diagnosed diabetes mellitus. See ACS 0401 *DIABETES MELLITUS*.

Q12 ***Is there a specific code when a patient is admitted for staged procedures to replace the ICD-9-CM code V58.83*** **Encounter for planned second/subsequent stage procedure** ***in ICD-10-AM?***

A V58.83 was introduced into ICD-9-CM because staged procedures could not be introduced into the procedure classification. In ICD-10-AM staged and subsequent procedures are included in the procedure classification such as 45704-00 [1689] *Reconstruction of cleft lip using flap, 2nd stage* and therefore no diagnoses code equivalent to V58.83 is required. The diagnosis for such admissions will be the condition documented.

Q13 ***Workshop Exercise: This 29 year old male was admitted with a two month history of worsening mental state, hearing voices, hallucinations and suicidal ideation. He was admitted to the psychiatric ward and started on Haloperidol 2.5mg nocte to which he responded well. Head CT scan and the EEG were normal. Final diagnosis was schizophreniform disorder with recurrent depression. Additional diagnosis was 'recurrent depression' correct answer was given as F33.9. Could this be coded as: Disorder, depression, recurrent, current episode, severe with psychotic symptoms F33.3 (auditory and visual hallucinations)? Also, could you code the 'suicidal ideation' to Z91.5 as a risk factor?***

A The term 'severe' was not specified in this Coding Exercise. In any disorder, but particularly in Psychiatry, check with the clinician before making any judgements about severity. The classification of suicidal ideation is currently being referred to WHO for clarification.

Q14 ***Total splenectomy for trauma. Quite often a prolonged surgical procedure is performed trying to repair the spleen prior to the decision to remove it. This would not be reflected in the splenectomy code.***

A Because ICD-10-AM is a statistical classification not all scenarios or circumstances can be specifically reflected in the ICD-10-AM codes. Procedure codes are provided for 30596-00 [815] *Partial splenectomy for external trauma* and 30596-01 [816] *Splenorrhaphy for external trauma*.

Q15 ***Is there an ICD-10-AM code equivalent to the ICD-9-CM category V09*** **Infection with drug-resistant microorganisms*?***

A There is no equivalent code in ICD-10-AM that classifies infection with drug-resistant microorganisms. The usefulness of the ICD-9-CM codes (V09.~ *Infection with drug-resistant microorganisms*) and their applicability to ICD-10-AM is currently being investigated by the NCCH and the Infectious Diseases CCCG.

Q16 ***Do you code Continuous Positive Airway Pressure (CPAP) when performed in an adult but not associated with mechanical ventilation?***

A A code for CPAP should be assigned in these circumstances.

Q17 ***Can we use 13857-00 [569]*** **Continuous ventilatory support, initiation outside of intensive care unit** ***or 13879-00 [569]*** **Continuous ventilatory support, initiation in intensive care**

unit *alone to show that a patient may be ventilated less than 24 hours?*

A Mechanical ventilation less than 24 hours is not coded. Please refer to ACS 1006 *CONTINUOUS VENTILATORY SUPPORT*.

Q18 ***Does 13857-00 [569]* Continuous ventilatory support, initiation outside of intensive care unit *apply to neonates who had ventilation initiated in delivery suite or caesarean theatre rather then NICU? This is the usual management for babies < 30 weeks or so. I thought 13879-00 [569]* Continuous ventilatory support, initiation in intensive care unit *better applied, as I see the above places as extension of the NICU.***

A 13857-00 [569] *Continuous ventilatory support, initiation outside of intensive care unit* is the appropriate code for ventilation initiated in a delivery suite or operating theatre.

Q19 ***Does ACS 0104* VIRAL HEPATITIS AND VIRAL HEPATITIS CARRIER STATUS *indicate that 'carrier status' should never be assigned unless documented specifically?***

A Yes. Coders should clarify with the clinician to determine if the patient is actually a carrier when an ambiguous term is documented in the record.

Q20 ***Workshop Exercise: A 58 year old woman presented to A&E with breathing difficulty and acute exacerbation of her chronic obstructive airways disease. She also suffers from bronchiectasis and during this admission, haemoptysis was noted although no underlying cause could be detected. She had intensive physiotherapy however, despite all advice, she continued to smoke. Disease due to 'despite all advice, she continued to smoke'. Could the 'smoking' be coded as tobacco dependence? If not, why not?***

A There must be clear documentation to indicate that the patient was tobacco dependent before a code for tobacco dependence can be assigned. Please refer to ACS 0529 *TOBACCO USE DISORDERS*.

Q21 ***What is the correct code for sprain of lower back not further specified? T09.2* Dislocation, sprain and strain of unspecified joint and ligament of trunk, *S33.50* Sprain and strain of lumbar spine, unspecified *or S39.0* Injury of muscle and tendon of abdomen, and pelvis*?***

A T09.2 is for injury to unspecified site of the back and is therefore not appropriate. S39.0 relates to a sprain or other injury of muscle or tendon of the lower back and is therefore also not appropriate. The terminology 'sprain of lower back' does not provide the specificity to indicate whether the sprain relates to a tendon, muscle or ligament. Therefore, if further definition cannot be obtained from the clinician, follow the index (Sprain, back, lumbar region) and assign: S33.50 *Sprain and strain of lumbar spine, unspecified*.

Q22 ***Spontaneous vaginal delivery (SVD) code with normal pregnancy was not assigned in my facility with ICD-9-CM. Should we start using it with ICD-10-AM?***

A The assignment of 90467-00 [1336] *Spontaneous vertex delivery* duplicates the diagnosis code O80 and need not be used with this code. If the principal diagnosis is other than O80, the procedure code for spontaneous vertex delivery should be assigned if applicable.

Q23 ***The use of oral chemotherapy tablets (e.g. for breast cancer) is common in this Area Health Service. Would you use the appropriate oral chemo code for these instances (90760-00 [1780])?***

A Code 90760-0 [1780] *Chemotherapy, oral administration* is provided for those rare cases where an inpatient may be treated with oral chemotherapy. Please refer to ACS 0206 *CHEMOTHERAPY FOR NEOPLASMS*.

Q24 ***How do you code insertion of an arterial catheter for monitoring of arterial pressure when a patient is in ICU? It would appear the default code is to open arterial catheterisation. Is this correct?***

A The default for insertion of an arterial catheter is 34524-00 [694] *Open arterial catheterisation/cannulisation*.

Q25 ***Documentation of 'Hep A+' or 'Hep B+': should these terms be assigned a code or only when evidence of disease is obvious?***

A Coders should clarify with the clinician when ambiguous terms such as 'Hep A+' or 'Hep B+' is documented in the record. Hep A is never a chronic disease nor carrier state. Therefore if Hep A+ was documented it would have to be past history or obvious that the patient has acute hepatitis.

Q26 ***Should the terms 'Hep C' and 'Hep C+' be coded as 'chronic' Hep C unless specified further?***

A 'Hep C+ (positive)' can mean that the patient is a carrier or it can mean that the patient has a history of an acute infection. Ambiguous documentation such as Hep C+, should be clarified with the clinician in effort to obtain a more specific diagnosis.

When 'Hep C' is recorded, coders should check with the clinician to determine if the disease is at the acute or chronic stage. Where consultation is not possible, assign B18.2 *Chronic viral hepatitis C*.

Q27 ***I suggest we need a standard regarding calculation of BSA. The 'rule of nines' may need publishing, but we also need more guidance as to how to calculate part of those specified body categories. e.g. Burn of front of arms with grafts of both forearms. Should front of arms be calculated 4.5 + 4.5 = 9%? This issue will increase in importance with ICD-10-AM with procedure coding using BSA.***

A The calculation of body surface area involved and depth of burn should be calculated by the clinician. There are many variations of the 'Rule of Nines' and these can be obtained from your Burns Unit or other reference sources. Please refer to ACS 1911 *BURNS*.

Q28 ***If the dental surgeon gives only cleaning and restoration as the procedure with no mention of what substance they fill the teeth with what would be the default code for restoration and what code would be used for cleaning teeth?***

A Unclear documentation should be clarified with the dental surgeon as there are many types of dental restoration. Similarly cleaning may involve removal of plaque or calculus and this detail should be documented. Reference can also be made to the Australian Schedule of Dental Services and Glossary to clarify terms used in Chapter VI Dental Services (Vol 3, ICD-10-AM).

Q29 ***Is there a code to replace the 677 block in ICD-9-CM (late effects of pregnancy and childbirth)? This code was often used if a patient arrived 12 months later to have their obstetric tears repaired or vagina widened or for 'obstetric cardiomyopathy' which may occur years later, but was originally diagnosed as due to pregnancy. In ICD-10-AM, when you look up sequelae, obstetric cause, the coder is sent to O97 which is 'death', but the above patients are still alive. Would the best codes be O70.2 and Z39.~~? These codes specify care and exam immediately after delivery and are not really appropriate for a long term sequela.***

A It is not appropriate to assign a code from category O70 *Perineal laceration during delivery* or Z39.~~ *Postpartum care and examination* in this instance. There is currently no code in ICD-10-AM to replace the ICD-9-CM code 677 *Late effects of pregnancy and childbirth*. Therefore, assign a code for the residual condition, sequencing will be determined by ACS 0001 *PRINCIPAL DIAGNOSIS*. The NCCH is currently reviewing the use of 677 with the O&G CCCG for possible inclusion in the 2nd edition of ICD-10-AM.

Q30 ***Can there be a specific code for geriatric assessment in acute setting?***

A Codes relating to assessment, consultation and other similar interventions that can be performed by medical practitioners as well as nurses and allied health professionals are currently being reviewed by the NCCH.

Q31 ***How would you code refilling/loading of morphine pump? Insertion is 39128-00 [39] but I can't find refilling.***

A Appropriate index entries are:

Refill, refilling — *see* Loading
Loading (of)
- device
Maintenance (of)
- device

Q32 ***Could we have a default code for Radiotherapy, NOS? We sent our patient to another hospital for the procedure and there is no documentation back from the hospital about what kind of radiotherapy is given to the patient.***

A There is no default for radiotherapy procedures. Please check with the Medical Record, Imaging or Radiotherapy departments at the facility that performed the radiotherapy. In the above example, it is appropriate to request routine documentation from the facility performing the procedure. The NCCH recommends that coders seek advice from their state or territory health authority for guidelines on coding of contracted services.

Q33 ***If there is no documentation on what kind of agent is injected into nervous system, can we default it as anaesthetic agent?***

A The anaesthetic or operation forms should be consulted for the name of the agent used. MIMS will assist in establishing the type of agent used. Unclear documentation should always be clarified with the clinician.

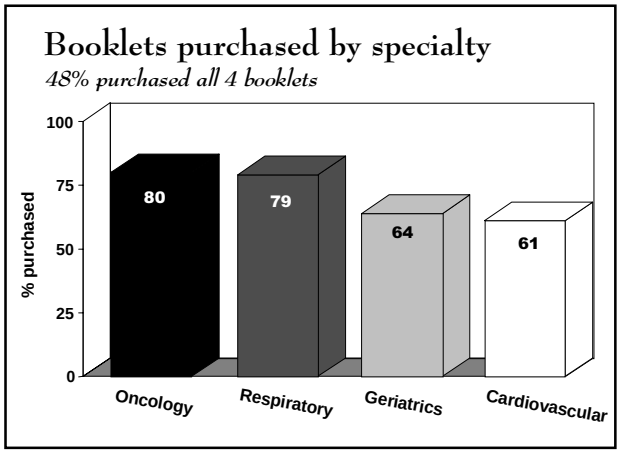
Q34 ***A common question on UTI to specify site. e.g. Urethra, ureter and in most cases for me it is unspecified. I usually have two codes: UTI of unspecified site and bacterial infection of unspecified site. Should I be using the A49 classification?***

A The site of a UTI is often not known. UTI, without further clarification, should be assigned N39.0 *Urinary tract infection, site not specified*. An additional code for 'bacterial infection of unspecified site' is unnecessary.

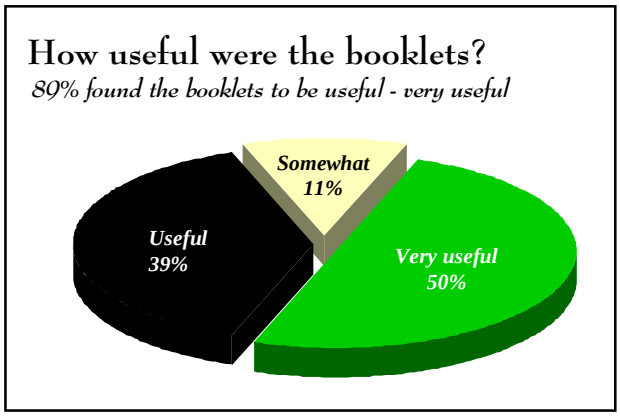
Results of the Specialty Booklet Customer Questionnaire

In the April issue of *Coding Matters* readers were invited to participate in a questionnaire on the NCCH booklet series *Casemix, DRGs and Clinical Coding*. The questionnaire was also circulated via direct mail and Code-L. We received 80 responses in total, the results of which are presented below…

- Whilst 48% of respondents had purchased all booklets released to date, 'Oncology & Haematology' proved the most popular with 80% of respondents purchasing this booklet. Other booklets purchased were 'Respiratory Medicine & Thoracic Surgery' (79% respondents), 'Geriatric Medicine' (64% respondents), and 'Cardiovascular Medicine & Surgery' (61%).



- Upon purchasing, the booklets had been intended for use predominantly by clinical coders/HIMs (88%) and clinicians (51%). The actual usage by clinical coders/HIMs mirrored the intended use (89%), however, more clinicians appeared to use the booklets (60%) than had initially been intended by the purchaser.
- The majority of purchasers used the booklets on an individual basis (89%), followed by use in meetings (31%), education courses (21%), and staff induction sessions (18%).
- Of all the respondents, 29% found all sections of the booklet useful. Part IV (Documentation and Coding) appeared to be the most useful section (78%), with Parts I–III (Introduction and Background) and Part IV (Important DRGs) both being rated as the most useful sections by 50% of respondents.
- All upcoming booklets appeared to be of high interest with 'Orthopaedics' (86%) rating as the most popular topic. Others included 'Injury' (73%), 'General Medicine' (85%) and 'General Surgery' (76%).



Some specific free-text comments included the following quotes:

'The series demonstrates that clinicians, coders, and HIMs can work together to provide quality information which will encourage good clinical documentation relevant to the casemix environment.'

'As a new clinical coder, I have found the books to be invaluable in assisting me in applying the coding standards thus helping to eliminate ongoing areas. It also provides valuable insight to clinical staff in helping to improve documentation.'

Conclusion

Feedback from the questionnaire indicates that the 'Casemix, DRGs and Clinical Coding' booklet series has been well received, with the majority of users finding the booklets very useful. The results suggest that the booklet contents, listing ways of improving documentation and coding practices, have the potential to improve data quality in healthcare settings.

PUBLICATION ISSUES

Dear readers,

By the time you receive this issue of Coding Matters*, I will be already relocated in a new job! So this is my farewell message as editor of the NCCH newsletter. It has been marvellous to see the newsletter develop over the years and I know that it will continue to go from strength to strength. Rosemary Roberts will be editor for this issue.*

I would like to take this opportunity to express my sincere thanks to all clinical coders and HIMs who made it so easy for me to feel at home in your world! You are a very welcoming and vibrant bunch. I have been immensely impressed by the level of professionalism I have encountered over the four and a half years that I have worked at the NCCH. You are right to feel proud of your profession!

Leaving the NCCH (and particularly a wonderful boss, Rosemary Roberts) has been very difficult, as I have made many good friends over the years. I feel that it may not be too easy to replace such wonderful colleagues and such excellent supporting staff. I wish all the best to the hard working NCCHer's and to the next Publications Manager!

Happy coding,

Clinical Coding and Classification Groups (CCCGs)

On the 5th September the Australian Casemix Clinical Committee (ACCC) endorsed the new CCCG membership. The NCCH congratulates the following people and looks forward to working with CCCG members on classification and coding issues. The terms of reference, in the relevant specialty area, are listed below.

1. To make recommendations to the ACCC on modifications to the Australian casemix classifications (such as AR-DRGs). Such recommendations to be based on clinical evaluation following consideration by the clinical professions.
2. To provide clinical input to and make recommendations to the ACCC concerning developmental work on new casemix classifications (such as ambulatory, sub-/non-acute and mental health classifications).
3. To provide clinical input to the NCCH on coding mattters (such as ICD-10-AM and coding specialty booklets).
4. To assist the NCCH in relation to issues that relate directly or indirectly to the development and implementation of classification systems.
5. To liaise with other CCCGs concerning matters where appropriate.
6. The CCCGs should end their term at the end of the term for the ACCC, i.e. April 2000.

Anaesthesia
Dr William Shearer
Ms Robyn Quinn
Dr Michael King
Dr Scott Germann
Dr Anthony Weeks
Prof David Fletcher* (ACCC)
Ms Lesley Ward (coder)

Burns
Dr Hugh Martin
Dr Fiona Wood*
Ms Linda Seghesio (coder)
Dr Michael Muellar
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Dr Renee Pols
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Ms Susanna Pang (coder)
Mr John Edwards (coder)

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Dr Sanjeev Bandi
Dr Timothy Mathew
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Mr Douglas G Travis
Ms Glenn Stewart
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Dr Leslie Reti
Ms Marylee Sinclair Vogt (AH)
Ms Wendy Baker (coder)
Ms Elaine Larwood (coder)
Ms Lisa Timmins (coder)

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Dr Guy Toner
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Dr Michael Barton
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Ms Joan Knights (coder)
Royal Australian College of Ophthalmologists
Prof M Coroneo
Dr M Hennessy
Dr J Playfair
Sr J Stretton
Dr L Robinson
Dr P Martin
Dr R Higgins
Dr D Colville

Orthopaedics

Dr Brett Courtenay
Miss Leonie Jane Lambert
Mr D Robert Dickens
Prof John Hart* (ACCC)
Ms Joanne Meldrum (AH)
Ms Debbie Abbott (coder)

Paediatrics

Dr Ian Alexander
Mr Hugh Martin
Ms Cyndy Stewart
Ms Jenny Jarvis
Dr Ralph Hanson* (ACCC)
Ms Cathy Hindmarsh
Ms Gayle Smith (AH)
Ms Nicole Rankin (coder)
Ms Sheree Gray (coder)
Ms Susan Travis (coder)

Pathology

Dr D Looke
Prof D Thomas
Dr D Gillis
Dr S Weinstein
Dr John Holmes* (ACCC)
Ms Jennie Shepheard (coder)

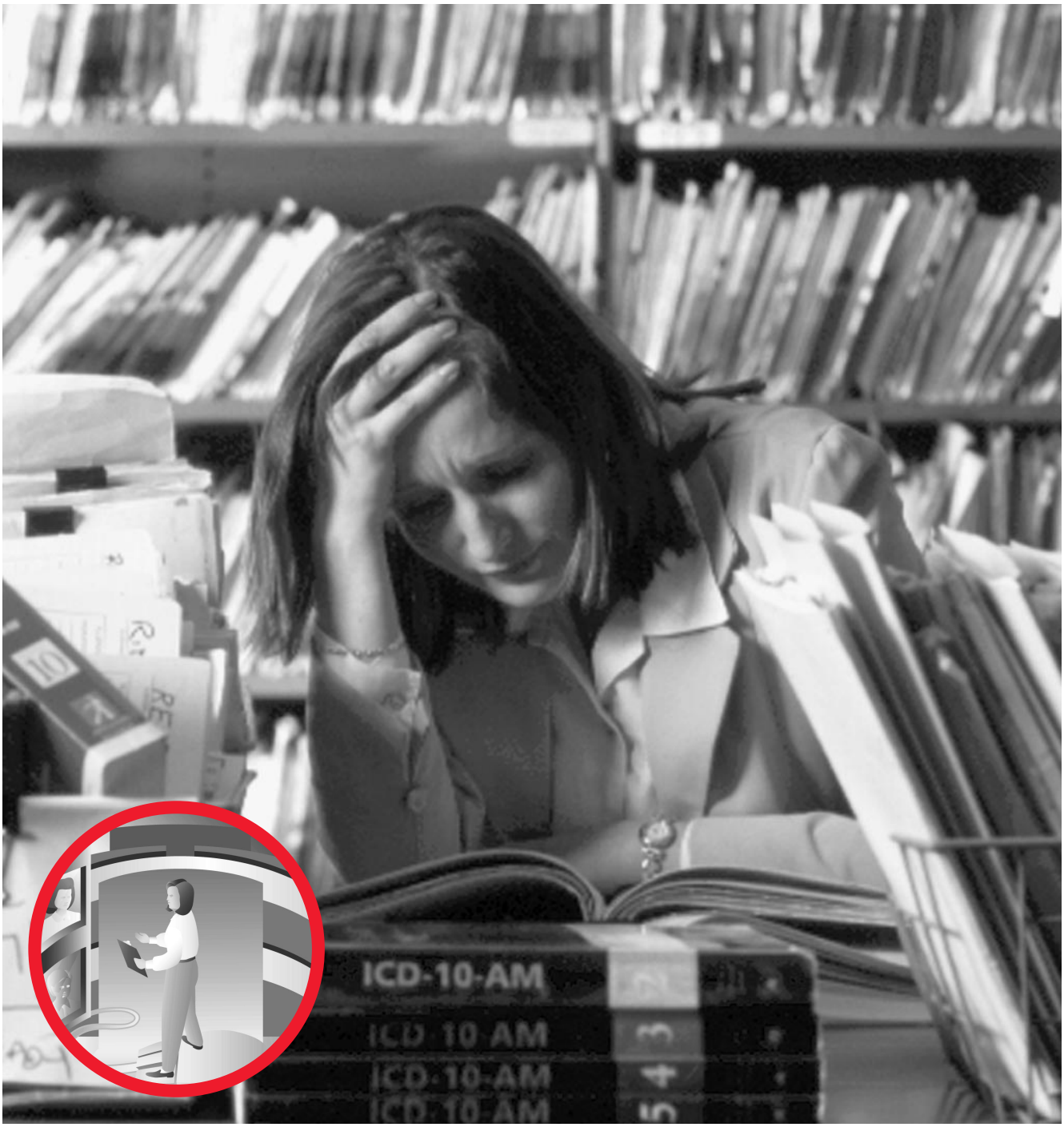
Plastic Surgery

Mr Bruce Johnstone
Mr John Hokin
Mrs Patricia Fini (coder)
Ms Lesley Ward (coder)
Prof John Hart* (ACCC)

Respiratory

Dr Andrew Veale
Dr Christopher Clarke
Dr Peter Frith
Ms Lyndall Maxwell
Dr Jo Douglass* (ACCC)
Ms Vivienne Woolfson (AH)
Ms Linda Seghesio (coder)
Ms Lisa Timmins (coder)

*convenor
(AH) allied health
TBA to be advised



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