coding matters

Newsletter of the **National Centre for Classification in Health**

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WHO Collaborating Centres meeting

The Australian Collaborating Centre for the Family of International Classifications (WHO-FIC) was proud to host the annual meeting of the WHO Collaborating Centres in Brisbane from 14-19 October 2002. Held at the Royal on the Park Hotel, the meeting attracted over 80 delegates for a week of meetings, presentations and discussions relating to ICD-10, the International Classification of Functioning, Disability and Health (ICF) and other WHO classifications. NCCH Brisbane staff, Sue Walker and Garry Waller, were involved as part of the organising committee for the meeting, in collaboration with colleagues from the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). As the 'locals', Sue and Garry helped arrange the venue, social events, show bags for delegates (containing sunscreen, water bottles, NCCH yoyos, tourist information and recommendations for restaurants, shopping and travel), meet-and-greet for international participants at the airport and a host of other activities and necessities.

NCCH (Brisbane) team members I-r Sue Walker, Melanie Spallek, Garry Waller and Kirsten McKenzie

The meeting began on Monday morning with a welcome from Richard Madden, Director of the AIHW and head of the Australian Collaborating Centre. Prior to arrival in Brisbane, there had been a two-day meeting of Centre Heads in Sydney to discuss and refine a strategy and work plan for the WHO-FIC Centres and this was presented to the meeting. During the next five days, meetings of the various committees and working groups considered this document and developed actions to progress the work plan over the next twelve months. Much of the collaborative work of the WHO-FIC Centres is conducted through various committees consisting of representatives of the Centres and WHO regional offices and headquarters. The committees are:

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- The **Family Development Committee**, chaired by Richard Madden (Australian Centre). The role of this group is to develop and implement protocol for acceptance of new classifications into the WHO 'Family of International Classifications' and to promote data comparability for countries using these classifications. The Family consists of the various health classifications that are published by the WHO. During the meeting, two new classifications were accepted as alpha versions for testing and evaluation – the Australian Classification of Health Interventions – Adapted for International Use (ACHI-I) and the International Classification of External Causes of Injury (ICECI). Work will also progress on the possibility of augmenting the ICD-10 for broader primary care use (in conjunction with WONCA, the World Organization of Family Doctors), investigating uses of WHO-FIC classification in casemix systems, investigations of links between classifications and vocabularies, assessment of comparability of hospital discharge data.

- The **Implementation of ICD-10 Committee**, chaired by the Pan American Health Organization (PAHO) and the WHO Regional Office for Africa. As its name suggests, the focus of this group is on promoting the implementation of ICD-10 internationally. To this end, work will be undertaken on 'WHO-FIC in a Box', a resource of guidelines, educational materials, tools and useful information to assist countries who are planning for the introduction of members of the Family, in particular the ICD-10 for morbidity and mortality reporting. Over the past few years, the Committee has also carried out a survey to assess the degree to which ICD has been implemented internationally, and this will be updated in 2003. A roster of experts who are available to assist countries who are considering implementation is being developed, as are plans for closer liaison with the United Nations Statistical Division in relation to strengthening of vital registration systems.

- The **Subgroup on Training and Credentialing** is a subcommittee of the ICD-10 Implementation Committee, chaired by Marjorie Greenberg from the North American Collaborating Center. Given that this group is focussed on the development of a core curriculum for ICD-10 education and a benchmarking process for mortality and morbidity coders, during the 2002 meeting it was determined that a similar group is required for ICF. A recent needs assessment survey, which identified existing training materials and the capacity for ICD education, is to be updated and a parallel survey developed for ICF. A brochure is also to be developed to showcase the work of the WHO-FIC Centres, in particular relating to the work of the Training and Credentialing subgroup. Continued work with the International Federation of Health Records Organizations (IFHRO) on the development of a credentialing scheme for coders will be facilitated through a meeting in the US in April 2003.

- The **ICD-10 Update Reference Committee**, chaired by Rosemary Roberts, is the committee that makes recommendations to the Heads of Centres for updates to ICD-10. During the Brisbane meeting, it was reported that 34 submissions for update had been received from the international community over the past year, with 22 of these being recommended and agreed to by the Centre Heads. Further discussions related to the international morbidity coding e-mail forum, established by the NCCH on behalf of the Update Reference Committee (URC), the need for consultation with WHO clinical specialty groups and other relevant international bodies (such as the International Agency for Research on Cancer) and the proposal that all changes to the classification be ratified by the URC. This is particularly relevant given that the meeting was informed that consideration is being given to updating Chapter V Mental and Behavioural Disorders, to ensure compatibility with the new version of the Diagnostic and Statistical Manual (DSM-V). Of particular note was the reiteration by the Committee of the need for an electronic copy of ICD-10 and plans for the development of this, in conjunction with the Electronic Tools Committee.

- The **Mortality Reference Group**, chaired by Lars Age Johansson from the Nordic Centre, is responsible for considering queries and making recommendations to the Update Reference Committee for changes to ICD-10 from the point of view of those that use the classification for mortality coding. The Group considered the latest batch of questions abstracted from the Mortality Forum, an e-mail discussion group hosted by the Nordic Centre. Discussions were also held about options for quality assurance of mortality

data, with a session to be devoted to this at next year's meeting.

- The **Electronic Tools committee** is chaired by Michael Schöpen from the Deutches Institut für Medizinische Dokumentation und Information (DIMDI – the German Institute for Medical Documentation and Information). This committee considered the urgent need for an electronic copy of the ICD-10 and developed a strategy for its development in English, French and Spanish using XML. The Committee also discussed interest in developing a metadatabase of ICD-10 modifications – unofficially called ICD-10-XM – to assist with the future refinement of both the international classification but also for countries wishing to adapt it for local use so that work done by colleagues in other countries can be considered.

Throughout the meeting, a number of sessions were devoted to discussions about the International Classification of Functioning, Disability of Health (ICF), the WHO's second flagship classification which is designed to complement the ICD-10. A work plan encompassing education and training, development of coding guidelines, validation and implementation aspects was developed to guide work of the Centres over the coming year.

The meeting also included the opportunity for the host Centre to showcase some of the contemporary activities relating to health information in Australia. Presentations were given by Richard Madden, regarding the work of the AIHW; Dennis Trewin, the Australian Statistician regarding activities of the Australian

The Royal on the Park, Brisbane provided an international welcome to WHO visitors

Lori Moskal (Canada) and Lindy Best (NCCH)

Bureau of Statistics; and Ian Ring, on issues relating to indigenous health. A further invited speaker was Dr Harry Rosenberg, recently retired Head of the Mortality Statistics section of the US National Center for Health Statistics. Harry spoke about his experiences in national and international work relating to mortality statistics, including his work towards implementing both ICD-9 and ICD-10 in the US.

The hard work during the week of the meeting was relieved by several social events, to take account of the fabulous weather that Brisbane put on for delegates. The official opening of the meeting was held on Monday evening at the Queensland Parliamentary Building, preceded by a tour of the building and including indigenous performers dancing and playing the didgeridoo. On the Wednesday night, the meeting dinner was a casual BBQ held at the RiverCanteen on Brisbane's Southbank. It was a beautiful tropical evening and delegates enjoyed the Brisbane River reflecting the lights of the city. Finally, a river cruise and trip to Lone Pine Koala Sanctuary on Friday afternoon proved a highlight for many participants, in particular, for those who got to hold a koala and feed a kangaroo!

Overall, the meeting was most enjoyable. It is always an invigorating experience to participate in such meetings and one returns to work with renewed enthusiasm, having benefited from learning of recent activities in coding and classification, and having enjoyed a great feeling of camaraderie amongst international colleagues.

Sue Walker

Associate Director NCCH (Brisbane)

Classification corner

The development of ICD-10-CM in the United States

The United States has been using ICD-9-CM (Clinical Modification) for morbidity coding since 1979. ICD-9-CM was designed for morbidity. It has been expanded annually to keep pace with changes in health care, and most users in the US are comfortable using the classification. When ICD-10 was released in the early 1990s a decision to continue using ICD-9-CM or to switch to ICD-10 for morbidity coding was needed. The US is committed to converting from ICD-9 to ICD-10 for mortality coding.

In determining which morbidity classification to use several factors were considered:

- did the US want to burden the public with converting to a new classification
- would it be acceptable to use ICD-9-CM for morbidity while using ICD-10 for mortality,

and most importantly

- would ICD-10 be a better classification for morbidity than ICD-9-CM?

In 1994 a Technical Advisory Panel (TAP) composed of health information professionals was convened by the National Center for Health Statistics (NCHS). The NCHS is the US government agency responsible for the maintenance of the ICD. NCHS is the site of the World Health Organization's (WHO) North American Collaborating Center for ICD. The TAP was charged with determining whether the ICD-10 was a significantly better morbidity classification than ICD-9-CM to warrant implementation in the US.

After study the TAP concluded that due to the extensive revisions made to ICD-9-CM over the years that ICD-10 was not a better morbidity classification. The TAP did not recommend the replacement of ICD-9-CM with ICD-10. However, it did recommended that a clinical modification of ICD-10 incorporating ICD-9-CM improvements and other enhancements that could not be achieved in ICD-9-CM would be worth implementing in the US. The TAP provided a draft version of a clinical modification to ICD-10 and titled it *ICD-10-CM*.

In keeping with the fact that ICD-10-CM is exclusively a morbidity (diagnosis) classification, the most important changes in this first version were that codes representing procedures, such as the delivery codes in chapter 15, as well as codes deemed strictly mortality, such as decapitation, were removed (deactivated). No ICD-10 code that was deactivated from ICD-10-CM will ever be reused in any future expansion to the ICD-10-CM.

At this point, in late 1995, NCHS staff sought physician and other health care provider input. It was strongly felt that full participation in the development process by all users was necessary to make the new classification as current and useful as possible. It would also help to ensure that users would support the ultimate change from ICD-9-CM to ICD-10-CM. Physician specialty groups were contacted, many of whom already assisted with annual changes to ICD-9-CM. The Worker's Compensation Insurance group, nursing groups, researchers in head and spinal cord injury and trauma care specialists were also contacted. All groups contacted have large memberships ensuring representation from throughout the US. The goal was to create a clinical classification that served all users in every setting.

Meetings with physicians and other user representatives were conducted between 1995 and 1997. The amount of detail that was requested was not possible with codes limited to 5 characters. Based on the requests from these groups it was decided to add a sixth character to each code. The first significant sixth character expansion was the addition of laterality to all applicable codes. This request was a priority for the Worker's Compensation group who have a strong interest in being able to identify the specific body part injured.

A new draft version of ICD-10-CM was posted on the NCHS web site in mid-1997. It included the addition of laterality to the codes as well as sixth digit expansions for some codes, primarily the injury codes. At this time a two-month open public comment period began.

Over 1,200 comments were received. Each comment was evaluated. The review of the comments took place between 1998 and 2000. Most requested even further expansion and detail to the codes. In order to accommodate the further detail requested it was decided that a seventh character extension would be allowed for certain codes. The seventh character identifies such things as the specific fetus in multiple gestation pregnancies, whether an injury is being seen for the first time or subsequent to the first encounter, or whether a fracture has a mal-union, non-union, or routine or delayed healing.

In addition to an extensive review and expansion of the injury codes, a full review of the external cause codes was done.
The redundancy inherent between the T codes and the X,Y, and Z codes was eliminated by expanding the T codes when possible to include the external cause. This change is most significant with the Poisonings and Toxic effect T codes that include the intent at the final character.

Since the end of the open comment period further refinements and changes have been made to ICD-10-CM. The guidelines for use have been written. A pilot test is being planned as well as the creation of a database and a cross walk between ICD-9-CM and ICD-10-CM. The current draft version is now posted on the NCHS website *http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm*. Following the pilot test additional changes will be made, any errors corrected. The final version of ICD-10-CM will be posted at that time. There are certain federal legislative requirements now under way to implement the ICD-10-CM in the US pending its completion.

Amy L Blum MHSA, RHIA, CTR

Medical Classification Specialist Data Policy and Standards Staff National Center for Health Statistics Centers for Disease Control and Prevention
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Stand by for Performance Indicators for Coding Quality (PICQ) ICD-10-AM Third Edition

As announced in *Coding Matters* (June 2002), PICQ for ICD-10-AM Third Edition is due for release in December 2002. Present PICQ users will receive letters of invitation to purchase the new version at a reduced rate. Prospective users will be notified about PICQ on Code-L (the NCCH coder discussion group), the NCCH web site *www.fhs.usyd.edu.au/ncch* and in forthcoming editions of *Coding Matters*.

The release will include:

- PICQ for ICD-10-AM First, Second and Third Editions
- updated *PICQ User Guide* and *About PICQ* documents.

In the interim, indicators that are considered invalid for ICD-10-AM Third Edition are available from *www.fhs.usyd.edu.au/ncch/* (follow the link to 'Downloads').

About the committee

NCCH ICD-10-AM Data Quality Sub-Committee and the NCCH ICD-10-AM Education Sub-Committee

NCCH ICD-10-AM Data Quality Sub-Committee

The ICD-10-AM Data Quality Sub-Committee was established by the Coding Standards Advisory Committee (CSAC) in response to a growing concern that data quality processes had been neglected, and that no method existed for assessing the effect of changes endorsed by CSAC.

Membership of the ICD-10-AM Data Quality Sub-Committee includes:

- the NCCH Director (Chair)
- the NCCH (Sydney) Associate Director
- the NCCH (Sydney) Research Officer
- the NCCH (Melbourne) Quality and Education Manager
- Australian Institute of Health and Welfare representative (AIHW)
- Coding Auditors Network representative
- Department of Health and Ageing representative
- States and Territories health departments representative (nominated by NHIMG)
- Clinical Coders' Society of Australia representative
- New Zealand Health Information Service representative.

Additional members will be co-opted as required.

The Committee's main function is the review of data quality for morbidity reporting, which will be achieved through:

- sharing information and providing advice to the NCCH on strategic directions for coded data quality in Australia
- receiving reports and making recommendations on data quality activities, products and priorities of the NCCH
- providing advice on sources of funding to support the data quality activities of the NCCH
- liaising with relevant authorities on morbidity coding related issues such as data edits, coding quality measurement, design of data collection systems
- reporting to and from organisations represented on this committee
- ensuring compatibility with national standards, such as concurrence with national data dictionaries
- encouraging and facilitating research within the NCCH.

The inaugural meeting was held 31 July 2002. Outcomes from the meeting included acceptance of the committee's terms of reference and an agenda for the first face-to-face meeting on 20 August 2002 at La Trobe University in Melbourne. Several data quality issues and activities were discussed at that meeting:

- a proposal from the Clinical Casemix Committee of Australia to undertake a project which aims to identify whether incomplete clinical documentation is resulting in under-reporting of patient comorbidities
- assessment of the impact of changes to ICD-10-AM using the national morbidity dataset from the AIHW
- feedback and discussion of the AIHW editing process
- PICQ and ACBA
- Coding Auditors Network.

The Committee plans to meet biannually, but will conduct additional meetings as required.

NCCH ICD-10-AM Education Sub-Committee

The ICD-10-AM Education Sub-Committee was established by the Coding Standards Advisory Committee (CSAC) to separate the education issues of NCCH from the general business of CSAC.

Membership of the ICD-10-AM Education Sub-Committee includes:

- the NCCH Director (Chair)
- the NCCH Associate Directors (Sydney) and (Brisbane)
- the NCCH (Melbourne) Quality and Education Manager
- a representative from the School of HIM (The University of Sydney)
- a representative of the Bachelor of HIM course (La Trobe University)
- a representative of the Bachelor of HIM course (Queensland University of Technology)
- a representative of the Bachelor of Science (HIM) course (Curtin University)
- Open Training and Education Network (OTEN) representative
- Health Information Management Association of Australia (HIMAA) Ltd Education Services representative
- Clinical Coders' Society of Australia (CCSA) representative
- Coding Educators Network (CEN) representative.

The committee's main function relates to advice on the development and delivery of education programs.

Terms of reference

- To share information and provide advice to the NCCH on strategic directions for coder education in Australia
- To receive reports and make recommendations on education work activities, products and priorities of the NCCH
- Provide advice on sources of funding to support the education activities of the NCCH
- Report to and from organisations represented on this committee
- Provide advice on education curriculum and training processes for entry level instruction
- Receive reports from NCCH and provide advice on international educational activities
- Encourage and facilitate research within NCCH.

The inaugural meeting was conducted on 20 August 2002. The terms of reference were accepted and the agenda for the first face-to-face meeting was established. Members subsequently met at The University of Sydney on 26 November 2002 to discuss a number of education issues and activities, including:

- national resources for coder training
- options to increase the number of CEN members
- using CEN members to provide increased education opportunities
- 2002 coder workforce survey
- practical coding experience for trainees
- description of education responsibilities
- nosology training program
- Coding Auditors Network (CAN)
- education in mortality coding.

The Committee will meet biannually (or more frequently if required) by teleconference and will conduct one face-to-face meeting each year.

Mental Health Manual

The *ICD-10-AM Mental Health Manual* is a classification of mental and behavioural disorders with glossary descriptions and diagnostic guidelines based on ICD-10-AM Third Edition.

The *Manual* is a diagnostic and coding tool that offers a common morbidity data language between the acute and community health sectors.

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ICD-10-AM

This regular feature provides guidance to clinical coders about frequently asked questions and aims to address those areas of coding which require immediate attention by clinical coders. Any major changes in practice (such as change of principal diagnosis sequencing for certain conditions) which may affect the integrity of state and national morbidity data collections will be flagged and should be introduced from the July following publication. If you find that any advice published in this section significantly changes your current practice, you should not do so until a suitable time in the collection year (January or July). You may feel it necessary in such circumstances to also seek advice from your state or territory health authority for a suitable date for implementation.

ICD-10-AM Third Edition Education Program
Frequently Asked Questions Part 2*

*Part 1 was published in *Coding Matters* 9(2): 8 –18 (2002) and at www.usyd.edu.au/ncch

The education program conducted prior to implementation of ICD-10-AM Third Edition encouraged participants to submit questions that came up from the course. These questions came from people who undertook the self-directed education program and from workshop participants. They have been answered by NCCH staff who worked on compiling the Third Edition.

The questions have been grouped by topic and appear as asked by education program participants.

A standard abbreviation of 'ACS' has been used throughout to stand for 'Australian Coding Standard'.

This information is also available from the NCCH web site: *http://www.fhs.usyd.edu.au/ncch/* under 'FAQs' and will be added to the queries database.

Anaesthesia

Where a patient attends the pre-admission clinic prior to admission for surgery and an ASA is documented, can that ASA be used for the surgery even if it is several days or weeks later?

No, the ASA score used to calculate the two-character extension of the anaesthesia code must be documented on an anaesthesia/ operation form at the same time the procedure took place.

Code 92513-xx [1909] Infiltration of local anaesthetic contains an excludes note which states 'that performed in conjunction with codes in blocks 1910 and 1333 – omit code' Please confirm that this only means when the code from 1333 has been used for anaesthesia not analgesia.

Yes, that is correct. A minor rewording change will be made to the tabular list of procedures in a future erratum to indicate this.

ACS 0031 Anaesthesia: if the progress notes are being used as the 'labour ward chart' and LA is documented for repair of tear, should the LA be coded? Also, a child with reduction of fracture under Bier's block (classified as LA) and done in emergency, documented in emergency department progress notes. Does ACS 0031 Anaesthesia mean that this is not coded? If so, we are missing a lot of procedures performed under anaesthesia.

Clinical advice received by the NCCH indicates that local anaesthesia should not be coded when it is documented in the progress notes of the clinical record.

A number of our anaesthetists have commented that a Bier's block is a regional block and not a local anaesthetic. In these cases I would assume that a regional block code would be used in preference to the infiltration code.

The classification in block 1909 *Conduction anaesthesia* is based on mechanism of action. Whilst a Bier's block will affect either the upper limb or lower limb, it is not an injection/infusion into a nerve and therefore should **not** be assigned to either 92511-xx [1909] *Regional block, nerve of upper limb* or 92512-xx [1909] *Regional block, nerve of lower limb.* Clinicians who advised the NCCH on the revision of the anaesthesia codes did not feel that a separate code was warranted for this procedure and that it met the criteria of a local anaesthetic, ie the effect is at localised tissue level.

If an anaesthetist notes two ASA scores, such as 2/3, which score should the coder default to?

An ASA score documented as 2/3 would indicate a misinterpretation of the correct use of ASA status. Such a score should be clarified with the anaesthetist, however, if this is not possible, then please assign the code representing the higher score. This is 3 in the case described.

Obstetrics, delivery episode of care. Pudendal block for pain relief for forceps extraction in labour (nerve block). Is this LA or neuraxial anaesthesia?

A pudendal block administered for forceps extraction is a type of anaesthesia (regional nerve block). Please assign 92510-xx [1909] *Regional block, nerve of trunk.*

ACS 0031 Anaesthesia: Bone marrow aspiration trephine (BMAT) performed under intravenous sedation in the ward, documented in progress notes. Do you code the IV sedation?

Intravenous sedation performed as anaesthesia for a procedure should be assigned 92515-xx [1910] *Sedation*, irrespective of where the sedation is performed.

Argon plasma coagulation (APC)

Indexing of argon plasma coagulation (APC) to stomach. Index – Coagulation, stomach does not give the choice for that by argon plasma, but it would appear that the code 30478-20 [1007] Panendoscopy to duodenum with other coagulation would be correct. It appears that only 'duodenum' has been indexed, even though the code title is 'to duodenum', indicating that it applies to all sites to the duodenum, although oesophagus has a different code (30478-19 [856] Oesophagoscopy with other coagulation). However, which code is to be used for a patient having an oesophagogastroduodenoscopy (OGD) with APC of oesophagus?

The correct code for argon plasma coagulation to stomach via OGD is 30478-20 [1007] *Panendoscopy to duodenum with other coagulation.* The index entry for 'Coagulation**,** stomach' will be amended to include 'by argon plasma 30478-20 [1007]' in a future errata. Although the term 'panendoscopy' in ICD-10-AM encompasses endoscopies of the digestive tract, oesophagoscopies are classified separately. Please refer to ACS 0024 *Panendoscopy* for further information. In the scenario described, please assign 30478-19 [856] *Oesophagoscopy with other coagulation* and 30473-00 [1005] *Panendoscopy*.

Arterial disease

ICD-10-AM Third Edition education program: Diseases – arterial disease exercises, page 4. What will the code I73.9 Peripheral vascular disease unspecified be used for now that documentation of 'peripheral vascular disease' without any further clarification is to be assigned a code of atherosclerosis.

While there are approximately 22,000 valid disease codes in the tabular list (Volume 1), there are approximately 56,000 entries in the alphabetic index (Volume 2). Consequently, there will usually be many more conditions classified to the one code than those that appear in the tabular list. In the case of I73.9 *Peripheral vascular disease unspecified,* there are 31 index entries for this code. Other conditions indexed to I73.9 *Peripheral vascular disease unspecified* include arteriospasm, vasomotor changes and angiospastic oedema.

Will the index entry for Claudication, intermittent I73.9 Peripheral vascular disease, unspecified be changed to I70.21 Atherosclerosis of arteries of extremities with intermittent claudication?

The NCCH is seeking further clinical advice to answer this query. Interim advice is conflicting and more work needs to be undertaken before we can provide a definite answer. In the meantime, please assign I73.9 *Peripheral vascular disease, unspecified* for documentation of 'intermittent claudication' without any further clarification.

ACS 0941 Arterial disease: what if the findings are documented as <50% and treatment is still initiated? Do you still code according to the instructions in the standard?

If there is documentation of 40% stenosis of a coronary artery and a coronary artery bypass graft is performed, then a code for atherosclerosis from I25.1 *Atherosclerotic heart disease* may be assigned. Please refer to ACS 0941 *Arterial disease* (Volume 5, p 156) under the heading of **Procedures performed for atherosclerosis** for further information. In cases where the clinician has documented 'coronary artery disease' or 'atherosclerosis' and treatment (medical/surgical) is initiated, however the results of investigations reveal <50% stenosis/obstruction, please assign the appropriate code for atherosclerosis.

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Where <50% stenosis/obstruction is a finding and medical treatment only is initiated, please seek clarification from the attending clinician for the correct diagnosis.

Bronchiolitis

The new index entries for bronchiolitis lead to codes for bronchitis. Please explain why.

There are some errors in the current index entries for bronchiolitis. The revised index entries will be published in the next errata, pending verification from the Coding Standards Advisory Committee (CSAC).

Diabetes mellitus

Are diabetes-associated conditions always to be coded even in same day cases? If NIDDM is coded on the basis of one BSL, then presumably there could be up to 6 or more additional codes for other conditions and eradicated conditions, even in a same day case (eg hypertension, obesity, eradicated cataract, presence of intraocular lens etc). We are concerned that routine assignment dilutes the usefulness of these codes. For example, if one patient stays overnight following colonoscopy, due to uncontrolled hypertension, there is actually no way to show the reason for the extended length of stay. This patient, from a coding point of view, will be indistinguishable from another NIDDM with hypertension who had an uncomplicated same day colonoscopy.

When should diabetes itself be coded? In the Third Edition education module, an example was given of a stable NIDDM having a same day colonoscopy. The diabetes was incidental but was included in the answer. We were informed at our education workshop that the rationale for including diabetes was that it met the ACS 0002 Additional diagnoses by virtue of the fact that one BSL was taken (normal).

Diabetes should be coded when it meets the criteria in ACS 0002 *Additional diagnosis*. If it meets ACS 0002 criteria, then all associated conditions need to be coded to capture the profile/severity of the diabetes.

Does the coding or non-coding of stable diabetes hinge on the performance of one BSL? If the intention is to capture all diabetic inpatient episodes, the exclusion on some diabetics on the grounds that no BSL was done (for whatever reason) seems arbitrary. We feel that rather than say outright that the intention is for universal capture, ACS 0002 Additional diagnoses is being stretched to its limits to allow some stable diabetics in, while at the same time opening the door for other chronic conditions.

Diabetes should be coded when it meets the criteria in ACS 0002 *Additional diagnosis*. Taking BSL's is one indication that diabetes mellitus meets ACS 0002 criteria.

In ACS 0401 Diabetes mellitus and impaired glucose regulation, does 'visceral fat deposition' mean conditions such as 'fatty liver'?

Visceral fat deposition is also known as intra-abdominal adipose tissue. The fat you can feel (that is, the old pinch test) is subcutaneous deposit. Visceral fat deposition is deposit of fat below the muscle layer, which is only found on imaging or during abdominal surgery. Fatty liver may result from visceral fat deposits because there is so much fat that it infiltrates the liver but there also may be other causes of fatty liver. Therefore, documentation of 'fatty liver' should not automatically be interpreted as visceral fat deposition.

At the workshops we were advised that although there is no code E10.72 (because type 1 DM cannot have features of insulin resistance), codes for hypertension and obesity are still required, however, the ACS does not include this advice.

In ACS 0401 *Diabetes mellitus and impaired glucose regulation*, (Volume 5, page 93), the classification box has a note that gives the instruction that when obesity, hypertension or other lipid disturbances are documented with either diabetes mellitus or impaired glucose regulation (IGR), then assign the appropriate diabetes mellitus or IGR code with these conditions as additional diagnoses. This note applies to both type 1 and type 2 diabetes mellitus and will be moved to a more appropriate position within ACS 0401 *Diabetes mellitus and impaired glucose regulation* in a future edition of ICD-10-AM.

Patient with maturity-onset diabetes of the young (MODY) has documented elevated fasting triglycerides and hypercholesterolaemia and a history of incipient nephropathy previously treated by a kidney transplant. My understanding was that the documentation of 'elevated fasting trigs and hypercholesterolaemia' was sufficient documentation for 'characteristic dyslipidaemia' – therefore I expected that you would code as per 'characteristic dyslipidaemia', for example, E78.6 Lipoprotein deficiency and E78.1 Pure hyperglyceridaemia, not E78.0 Pure hypercholesterolaemia and E78.1 Pure

hyperglyceridaemia. Also, if E78.0 and E78.1 are the correct answers, should these be coded to E78.2 Mixed hyperlipidaemia instead?

A The specific types of dyslipidaemia should be assigned the specific code from block E78 *Disorders of lipoprotein metabolism and other lipidaemias.* The documentation of elevated fasting triglycerides and hypercholesterolaemia is sufficient documentation to allow the assignment of E1-.72 **Diabetes mellitus with feature of insulin resistance*. Hypercholesterolaemia is not coded to the same code as depressed HDL cholesterol as they are not exactly the same lipid abnormality. The use of E78.2 *Mixed hyperlipidaemia* instead of E78.0 *Pure hypercholesterolaemia* and E78.1 *Pure hyperglyceridaemia* would not provide the specificity of the various types of lipids abnormalities involved, therefore it is preferred that the two separate codes are assigned.

Q *ACS Diabetes mellitus and impaired glucose regulation (Volume 5, p 92) indicates that insulin resistance 'goes' with impaired glucose regulation (IGR), type 2 and "many specific types of diabetes". How do we know which specific types of diabetes should be coded with the insulin resistance code (when they meet the criteria)? Is it all types that are classified to E13 Other specified diabetes mellitus? Does it also apply to gestational diabetes? I note however, that on p 89 of the same standard, it states that maturity-onset diabetes of the young (MODY) has "minimal or no disorder of insulin resistance" – which seems to indicate that MODY will not have features of insulin resistance, therefore the insulin resistance classification does not apply to this condition?*

A Please follow the alphabetic index and tabular list in order to assign the correct code. If there is a '.72' (features of insulin resistance) breakdown for that condition and the criteria for insulin resistance are met then it is correct to assign a code for insulin resistance. Therefore, in the case of gestational diabetes, it is not coded because there is no '.72' breakdown. As pointed out in the query, ACS 0401 *Diabetes mellitus and impaired glucose regulation* states that 'MODY has minimal disorder of insulin resistance' however this does not indicate that MODY will not have features of insulin resistance only that it is rare.

Q *What is the appropriate diabetes code when a patient has a past history of below knee amputation (BKA) for diabetic foot ulcer, no further information available? Would this change depending on what other information is available? For example, past history of BKA for diabetic foot ulcer, originally performed due to ulcer with neuropathy. Or past history of BKA for diabetic foot ulcer, originally performed due to ulcer with 'loading' deformity (foot drop).*

A Both scenarios meet the definition of 'diabetic foot'. Advice received from the NCCH consultant endocrinologist indicates that an amputation does not eradicate the overall 'condition' of diabetic foot or the underlying causation, such as neuropathy. Therefore, in the scenarios described, E1-.73 *Diabetes with foot ulcer due to multiple causes* together with the appropriate codes for the specific complications, including amputation status, are assigned.

Q *Patient admitted with type 2 diabetes mellitus, elevated fasting triglycerides, suppressed HDL cholesterol and hypertension (stable on treatment). Is the hypertension coded?*

A Yes, the hypertension is coded. In this scenario, the patient meets the criteria for diabetes with features of insulin resistance. For further information, please refer to the classification box on p 93 (Volume 5) in ACS 0401 *Diabetes mellitus and impaired glucose regulation*.

Q ACS 0401 *Diabetes mellitus and impaired glucose regulation. A diabetic with cataract, one previously extracted, admitted for removal of other cataract. Do you code E1-.39 *Diabetes mellitus with other specified ophthalmic complication, H26.- *Cataract and Z96.1 Presence of intraouclar lens (assuming there was an IOL placed)? If it was a diabetic cataract, do you code E1-.36 *Diabetes mellitus with diabetic cataract, E1-.39 *Diabetes mellitus with other specified ophthalmic complication, Z96.1 Presence of intraocular lens?*

A If a diabetes complication still exists then the appropriate code for the diabetes and associated complication needs to be assigned. In cases where a condition can occur bilaterally, and one side has been eradicated but not the other, then the complication will still be current. In both the scenarios you have described, the codes provided are correct.

Q *A diabetic patient has an infected foot ulcer and a history of amputation of a toe. No other diabetic complications exist. Is it the intention of the standard that this patient should be classified as a diabetic foot? According to the instructions under 'diabetic foot' (Volume 5 p 99) no criterion is given regarding the need to*

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consider the reason for the previous amputation when applying the rule. Could you please comment?

Yes, this patient would be classified as having diabetic foot. The reason for the previous amputation does not have to be related to a diabetic complication. The amputation status may cause excessive loading (similar to the conditions listed in point 4, p 100 of ACS 0401 *Diabetes mellitus and impaired glucose regulation*).

Diagnosis selection in same day endoscopy

ICD-10-AM Third Edition education program: Procedures, anaesthetics – exercises p 3. The principal diagnosis is constipation rather than polyp. Doesn't polyp satisfy the requirement for principle diagnosis standard?

In summary, this scenario is of a 56 year old male presenting for a same day colonoscopy with constipation and a family history of colonic polyps. Findings at colonoscopy were diverticular disease and a benign polyp of the caecum. ACS 0046 *Diagnosis selection for same-day endoscopy* instructs that where a causal link between the symptoms and one of the findings is neither established or ruled out, then apply the Clinical Coders' Creed to determine the principal diagnosis. In this case, with the information supplied, it was deemed that there was not enough evidence to definitely link the constipation with the diverticular disease or the polyp, therefore the constipation was assigned as the principal diagnosis.

Hospital in the home (HITH)

With hospital in the home patients, what is the place of occurrence if an injury/accident occurs in their own home, such as a fall from bed. Is it hospital or home?

For national morbidity data collection purposes, hospital in the home (HITH) patients are considered to be standard admitted patients. 'Hospital in the home' is a data element concept in the National Health Data Dictionary (NHDD) Version 10, 2001, and the criteria for inclusion in this category include:

- without hospital in the home care being available, patients would be accommodated in the hospital
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the admitted patient data element concept)
- the hospital medical record is maintained for the patient
- there is adequate provision for crisis care.

Therefore, if an injury/accident occurs in the patient's home while they are classified as HITH, Y92.22 *Health service area* should be assigned as the place of occurrence.

Malignant neoplasm of jaw

Category C41.0 Bones of skull and face has inclusion terms of 'maxilla' and 'orbital bone'. These inclusion terms belong under C41.02 Maxillofacial bones and C41.01 Craniofacial bones respectively. Also, how does the excludes notes at C41.0 Bones of skull and face and C41.1 Mandible fit with the index entry in the Neoplasm table for Neoplasm, jaw, carcinoma C76.0 (Malignant neoplasm of) Head, face and neck?

The inclusion terms of 'maxilla' and 'orbital bone' are listed under C41.02 *Maxillofacial bones* and C41.01 *Craniofacial bones* respectively. They will be removed from category C41.0 *Bones of skull and face* in ICD-10-AM Fourth Edition. The excludes notes at C41.0 *Maxillofacial bones* and C41.1 *Mandible* are consistent with the index entry in Volume 2. They advise that carcinoma of any type (of jaw) should not be assigned to the codes in category C41.0 *Bones of skull and face* or C41.1 *Mandible*. Carcinoma is a malignant neoplasm comprised of epithelial cells and as such, the point of origin is unlikely to be the bone of the jaw. The index and these excludes notes therefore advise that the correct code assignment is C76.0 *(Malignant neoplasm of) Head, face and neck.*

Neonatal sepsis

ACS 1617 Neonatal sepsis/risk of sepsis, p 224. The final paragraph of this ACS provides different advice to that originally published in Coding Matters 5(2). That is, the ACS now instructs to assign a code from category Z29 Need for other prophylactic measures rather than from Z03 Medical observation and evaluation for suspected diseases and conditions when prophylactic treatment is given. However, the neonate still has 'risk of sepsis' and the addition of the procedure code per ACS 1615 Specific interventions for the sick neonate will indicate the treatment given. Why has this advice been changed?

For neonates with a diagnosis of 'risk of sepsis' and no documented condition, where prophylactic treatment is given, please continue

to assign the appropriate code from category Z03 *Medical observation and evaluation for suspected diseases and conditions.* A code from Z29 *Need for other prophylactic measures* may be assigned as an additional diagnosis. ACS 1617 *Neonatal sepsis/risk of sepsis* will be amended in a future erratum to reflect this advice.

Non-invasive ventilation

The patient is a newborn; respiratory distress is noted at birth. Bag and mask ventilation for three minutes. Also written as 'IPPB'. Is this coded as per index, Ventilation, non-invasive, mask ventilation (NIMV) 92040-00 [568] Intermittent positive pressure breathing or is part of the resuscitation at birth and not coded?

This is considered part of resuscitation at birth and is not coded.

At our hospital patients are admitted overnight for sleep studies when diagnosing obstructive sleep apnoea. These patients may have a subsequent overnight admission for further sleep studies plus CPAP. Should we be coding the CPAP in these patients?

Clinical advice confirms that non-invasive ventilation is not to be coded when performed for periods of <24 cumulative hours.

Obstetrics

When an episiotomy has been performed but the perineum then tears, extending to a first or second degree tear, is the code 90481-00 [1344] Suture of first or second degree tear of perineum the correct one to use to cover both procedures performed? If not could you please provide some specific scenarios where it would be used?

As per the advice given in the NCCH specialty book (*Casemix, DRGs and Clinical Coding – Obstetrics and Gynaecology*) the laceration should be coded to a first, second, third or fourth degree tear according to the documentation. The repair of the laceration is also coded with the appropriate code from block 1344 together with 90472-00 [1343] *Episiotomy*. The clinical reasoning is that in these cases the tear is usually more severe, and in some cases may involve the sphincter (third and fourth degree tears). Therefore the repair of the tear will be more extensive than the episiotomy.

ACS 1518 Duration of pregnancy: The range of codes for abortion that need a code from O09 Duration of pregnancy includes O08 Complications following abortion and ectopic and molar pregnancy. However in the tabular, the category O08 does not have the symbol for ACS 1518 or the 'use additional code' note. Should code O09 be added when coding O08?

A duration of pregnancy code (O09) is not to be assigned with category O08 *Complications following abortion and ectopic pregnancy*. There will be an erratum change to ACS 1518 *Duration of pregnancy* to indicate that the range of abortion codes applicable is O00 – O07 *Pregnancy with abortive outcome*.

Ultrasound

ICD-10-AM Third Edition education program: Procedures – MBS changes – exercises p 2. Ultrasound is in the list of procedures not to code. However, the exercises direct you to code an ultrasound of the elbow. Should we be coding this?

The exercises in this section were not in scenario format. There is a list of procedures and the corresponding code is requested. These exercises were simply to highlight changes to procedure codes brought about by the biennial update of the Medicare Benefit Schedule (MBS), where there are changes/revisions to certain item numbers and these are carried over to the Australian Classification of Health Interventions (ACHI), Volumes 3 & 4 of ICD-10-AM. The decision of whether to code an ultrasound of the elbow in an episode of care would still be guided by ACS 0042 *Procedures not normally coded.*

Parts 1 & 2 of the FAQs arising from ICD-10-AM Third Edition education are available from our website and have been integrated into the queries database

Report

Coding auditors course and Coding Auditors Network (CAN)

The NCCH has been investigating the establishment of a Coding Auditors Network (CAN) similar to the structure of the existing Coding Educators Network. Expressions of interest generated positive responses from clinical coders in Australia and New Zealand.

It was initially planned that the NCCH would develop both the auditing course and the network, but subsequent investigation revealed that the School of Health Information Management at La Trobe University (Melbourne) planned to develop an auditing education subject for practising auditors and clinical coders. Discussions between the School and the NCCH led to a decision that will see the course offered by the School of HIM at La Trobe University in collaboration with the NCCH. The NCCH will continue to develop the coding auditors network.

La Trobe University coding auditors course

The course:

- will be conducted in June 2003
- is likely to consist of interactive and face-to-face components, although an interactive web-based option only has not been ruled out. (If the course does have a face-to-face component it will be conducted on site at La Trobe University in Melbourne)
- will be open to all
- will offer an optional assessment at the conclusion to the course for those who wish to qualify as a coding auditor. The University will provide certificates reflecting the level of completion (either attendance or assessment based)
- will count as a credit towards the postgraduate HIM course at La Trobe University.

Further course details will be published in the March 2003 edition of *Coding Matters.*

The NCCH Coding Auditors Network (CAN)

The CAN remains a high priority with the NCCH. Requirements to become a CAN member will include:

- completion of the La Trobe University coding auditors course
- current experience as a coding auditor (criteria to determine appropriate experience are currently being ratified).
- successful completion of a coding competence assessment (either the HIMAA coder certification exam or similar level of competence).

The next phase of development will include operational guidelines for the CAN. Further updates will be published in *Coding Matters*.

Alex's conundrum

What is black jaundice?

Black jaundice is a synonym for Wiel's disease. The disease was quite common a century ago, especially near European mining communities, farms and untreated sewage. Wiel's disease is a bacterial infection of the liver carried by rats and secreted in their urine. Although not usually fatal to humans, it is fatal to dogs and cats, which can develop resistance and become carriers to pass the disease on to humans.

Since a symptom of Wiel's Disease is the skin becoming dark yellow, when this is compounded with the presence of coal dust and ultraviolet radiation from the sun, it can make skin very dark. Hence the label 'black jaundice'.

Since the disease affects the liver, alcohol consumption impedes recovery and aggravates the disease.

INTERNATIONAL

International classification centres update

The spirit of international collaboration in the world of health classifications and related areas is alive and well. Sue Walker, NCCH Associate Director (Brisbane) invited centres represented at the October 2002 World Health Organization Heads of Centres meeting to describe their activities.

Medical Classification at the German Institute for Medical Documentation and Information (DIMDI)

The German Institute for Medical Documentation and Information (DIMDI) is one of several institutes within the range of the German Federal Ministry for Health. It was founded in 1969 as a host service offering on-line access to life science databases in order to ensure information supply for the biomedical sciences. Over the years the tasks have grown so that at present 5 areas of work are covered:

- host services for many databases, including: MEDLINE, EMBASE and Current Contents
- Medical Devices Information System
- Information System on Drugs and Drug Regulatory Affairs
- medical classifications
- health technology assessment and evidence based medicine.

The Medical Classifications section is in charge of German translations of the ICD, the application of ICD. To Oncology (ICD-O), the International Classification of Functioning, Disability and Health (ICF), and other international vocabularies. DIMDI is also responsible for the German classification of medical procedures OPS-301. Within the area of classification work there has been active collaboration with the World Health Organization for many years and thus, DIMDI has applied to become a WHO Collaborating Centre for the Family of International Health Classifications. DIMDI is presently represented on the Update Reference Committee for ICD-10 and on the Mortality Reference Group. These committees are work groups of the network of the WHO Collaborating Centres for the Classification of Diseases. DIMDI chairs the Electronic Tools Committee, which supports WHO and the WHO Collaborating Centres to develop policies on electronic classification tools and their dissemination.

An area of special interest within medical classification work is the application of standards for electronic publishing to the international classifications. DIMDI maintains the German versions of the classifications in computer systems based in Standard Generalised Markup Language (SGML). This approach opens the classifications for multi-purpose applications ranging from book publishing, database integration and Internet based-classification access.

DIMDI acts as the office of the National Board for Classification in Health Care established in 1995 to advise the Federal Ministry of Health on the use of classifications in the German health care system. The board is composed of the major players in German health policy, including the statutory health insurers, the national board of physicians, the association of the German medical societies, the German hospital society, the association of the German pension insurance companies and the association of the German accident insurance companies.
The board meets about twice a year. Several working groups have been set up to treat special problems, such as ICD maintenance or procedure classifications. These groups meet more frequently.

For many years special emphasis has been given to terminology work and to the collaboration with the United States National Library of Medicine. DIMDI is in charge of the German translation of the Medical Subject Headings (MeSH) and has been contributing to the Unified Medical Language System (UMLS) by regular delivery of German source vocabularies. DIMDI has also developed a German counterpart to the UMLS Specialist Lexicon, a linguistic lexicon with a set of tools for medical language processing.

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The WHO Collaborating Centre for ICD in French

The WHO Collaborating Centre for ICD in French (Paris centre) commenced activities in 1968. It belongs to the French National Institute for Health and Medical Research (Inserm). This centre is located in the Centre for Epidemiology on Medical Causes of Death (CépiDc).

The main activities of the Paris centre are related to the implementation, use and improvement of ICD in French speaking countries both for mortality and morbidity. The Paris centre participated in the work on the tenth revision of ICD and to its publication in French. It organised several international training courses on ICD-10 in France, Haiti, Tahiti and New Caledonia. It helps ICD-10 users in relation to coding and analysis issues. It also collects propositions for updates from users.

The Paris centre is deeply involved with the CépiDc in the production of French mortality data. It participated to the design and development of the automated coding system Styx[1] used to code mortality data in France. On the basis of this experience, the centre collaborates with Tunisia and Algeria to implement new mortality information systems. The Paris centre also participated in ICD-10 implementation in the Canadian province of Quebec.

The Paris centre partakes in several projects of Eurostat, the Statistical Office of the European Commission. These projects deal with automated coding systems in mortality[2,3] and data quality[4]. The Paris Centre belongs to the planning committee of the NCHS International Collaborative Effort for mortality coding.

1 Pavillon G, Jougla E. The French automated coding system Styx. In : Proceedings of the International Collaborative Effort on Automating Mortality Statistics (vol 2), Centre for Disease Control and Prevention, Bethesda, Maryland, USA, 2001 :pp.50-51.

2 Pavillon G, Coleman M, Johansson LA, Jougla E, Kardaun J. Coding of causes of death in European Community. Final report. Eurostat, Project 96 / S 99-5761 / EN., june 1998 :p.190.

3 Pavillon G, Johansson LA. Production of methods and tools for improving causes of death statistics at codification level. Final report, European Commission, Eurostat, August 2001, p.108.

4 Jougla E, Rossolin F, Niyonsenga A, Chappert JL, Johansson LA, Pavillon G. Comparability and Quality Improvement of European Causes of Death Statistics - Final Report. European Commission, DG Sanco, July 2001: p.191.

WHO Collaborating Centre for the Family of International Classifications in Portuguese

The WHO Collaborating Centre for the Family of International Classifications in Portuguese, (also known as the Brazilian Centre [CBCD]) was established in 1976 under a tripartite agreement between the Pan American Health Organization (PAHO), the Brazilian Ministry of Health and the University of Sao Paulo.

The Brazilian Centre is part of the Department of Epidemiology at the School of Public Health of the University of Sao Paulo and some of the Centre's staff teaches in this department. The staff includes three physicians, a technician and a secretary. The team collaborates with many others including university professors, researchers, epidemiologists and government employees from other regions of the country. This helps to ensure development of a large number of activities in a country as big as Brazil.

The Centre's activities are supported by the Brazilian government through research projects from the Ministry of Health. The Brazilian Centre also has close contact with the Ministry of Health of Portugal, where we provide training for clinical coders, and through whom we have a collaborative agreement to translate the ICF.

As the Brazilian National Health System became decentralised, the CBCD developed a network of collaborators who participate as trainers. The Centre provides ICD morbidity and mortality training according to demand in Sao Paulo, other Brazilian sites and for other Portuguese speaking countries, such as Portugal. All of this training material is available from the Centre's web page.

To meet the needs of the large number of municipalities (more than 5,000) that need to train people to use ICD-10, the Centre has also developed a pilot version long distance course that is offered via the Internet.

One of the Centre's most resource intensive activities is responding to ICD user demands. Users consult the Centre by telephone, mail, fax or e-mail. Queries frequently relate to the selection of the underlying causes of death. Many of these queries are published in our newsletter BOLETIM and others are included in the FAQs at our web page.

The Centre has finished work on the Portuguese version of the ICF and publication is

planned for early 2003. The content and scope of this classification and input from stakeholders about how it will be used were determined through consultation at congresses, seminars, panels and in specific meetings with representatives from social security, rehabilitation services, and so on.

The CBCD is currently running a three-year project to enhance Brazilian Health Statistics. The project aims to improve all aspects related to health data, from collection to analysis.

The Centre is also involved in many other projects such as: maternal mortality investigation (a sample of 4,000 female deaths that have been investigated in all state capitals); testing ICF in a rehabilitation service; and investigating multiple causes of deaths in AIDS patients. The Centre also plans to test new classifications such as the Australian Classification of Health Interventions – Adapted for International Use (ACHI-I), the Primary Care Classification, and others.

The Centre coordinates activities related to the development of software. One of these, the selection of underlying causes of death software – SCB – is part of the National Mortality Information System. Another is the PesqCid that allows an automatic search for a code. The Centre will also investigate the on-line versions of ICD-10 and ICF.

The Brazilian Centre publishes a wide range of resources, including BOLETIM, which periodically publishes issues on the classifications, news on courses, ICD-10 updates, results of the studies, coder queries and responses. We also publish a series of booklets related to health statistics and the use of ICD such as *The death certificate, ICD use in clinical research, Vital events registration: its importance for public health* and others.

Part of the Centre's activities relates to staff participation in various work groups, national committees, Secretariat's State Groups and Municipalities Health Advisers. The Centre's staff also regularly participates and presents results of studies at congresses, seminars and lectures

After 26 years of activities the Brazilian Centre is a reference centre for the Family of International Classifications, not only for Portuguese speaking countries, but also for all Latin American countries.

WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries

The WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries was instituted in 1987 by the Nordic Council of Ministers. The formation of the centre meant that the long-standing informal Nordic collaboration in health statistics and classification was given an institutional form. The centre is financed directly from the health administrations of Denmark, Finland, Iceland, Norway and Sweden and has a Board of Directors with representatives from these institutions.

The Nordic centre is located at the Department of Public Health and Caring Sciences at Uppsala University in Uppsala, Sweden. Uppsala University, founded in 1477, is the oldest university in the Nordic countries.

Professor Björn Smedby, Sweden, has been Centre Head since the formation of the centre. Dr Martti Virtanen, Finland, is to become the new Centre Head in 2003. The centre also engages advisers in various areas of expertise:

- Mr Lars Age Johansson of the Swedish National Board of Health of Welfare in the area of mortality statistics
- Dr Glen Thorsen from the Norwegian Centre for Medical Informatics for the classification of surgical procedures
- Dr Birthe Frimodt-Møller from the Danish National Institute of Public Health in the area of classification of external causes of injury
- Mrs Tóra Dahl, Denmark is a consultant in matters concerning classification of functioning and disability.

The main task of the centre is to coordinate medical and health related classification work in the Nordic countries. As a WHO Collaborating Centre, the Nordic centre represents the Nordic countries in international classification work. On the Nordic level, the centre collaborates closely with NOMESCO (Nordic Medical Statistical Committee), another Nordic body involved in collaboration in health statistics. This collaboration also plays an important part in centre activities aimed at providing support to the Baltic countries (Estonia, Latvia, Lithuania) in the area of medical classifications and health statistics.

The main areas of work for the centre that apply to international activities include participation in ▸

the WHO Collaborating Centre network. This work includes the annual updating of ICD-10 for mortality and morbidity applications and implementation and further development in ICF (International Classification of Functioning, Disability and Health). The Nordic centre administers an international discussion forum on mortality coding issues, the Mortality Forum. Other collaborative activities that the centre takes part in relate to work on introducing and developing other classifications for international use in areas such as surgical procedures, general practice/primary health care, accident and injury registration as well as nomenclature and medical informatics.

Important activities on the Nordic level concern the responsibility for maintenance and development of three Nordic classifications: NordDRG, the Nordic DRG system, the NOMESCO Classification of Surgical Procedures (NCSP) and the NOMESCO Classification of External Causes of Injuries (NCECI). This includes coordination of Nordic expert networks and electronic discussion fora as well as production of updated versions of these classifications.

A number of activities are aimed at improving the use of health related classifications in various settings and with different aims, such as mortality and health statistics, hospital activity analysis, and health services research in general. Staff from the centre regularly participates in projects aimed at exploring and improving the quality of health statistics, both national and international, that are used for comparative purposes. Other examples of activities are the Nordic-Baltic seminars for mortality coders and the Nordic-Baltic conferences on ICF arranged on a biannual basis.

WHO Collaborating Centre in China

The Chinese Centre is located in the Peking Union Medical College (PUMC) Hospital and is affiliated with the Chinese Academy of Medical Sciences (CAMS) and PUMC. The Centre was established in 1981 from a recommendation made by WHO and with the approval of the Ministry of Health (China).

In recent years, a major activity undertaken by Centre is to popularise and implement ICD-10 in China. Since 1996, three volumes of ICD-10 have been translated into Chinese and published. The Centre has conducted many ICD-10 training courses for both mortality and morbidity statistical coders and other medical workers around the country.

In 2000, the Centre commenced work to compile a software version of ICD-10 for clinical coders' self-study. The package includes the three volumes of ICD-10, codes for commonly occuring diseases, maps between ICD-9 and ICD-10 codes and clinical information relevant to the diseases and classification. More than 300 images of human anatomy are also included.

Japanese ICD office

The Japanese ICD office has a long history but it is not a WHO Collaborating Centre.
The Japanese ICD office is located in the centre of Tokyo, just in front of the Palace. The ICD office is in the Ministry of Health, Labour and Welfare, Minister's secretariat. The office's clients vary from lay people to Ministers of the Japanese cabinet.

The major activities undertaken by the Japanese ICD Centre include:

- education for physicians and coders
- classification development
- updating the automatic coding system
- epidemiological data publication
- translation services.

The Japanese ICD office takes care of all matters regarding ICD and related classifications, except ICF, and works in very close collaboration with other sections of the Japanese government.

Current issues being worked on include integration of DRGs into the electronic medical record system, which have been introduced recently. The office also maintains and controls ICD-10-JM (Japanese Modification).

INTERNATIONAL

Mauritius

The Republic of Mauritius has a long history of clinical coding of morbidity (hospital medical record) and mortality (death certificate) data. It has been using the International Classification of Diseases, Ninth Revision for both morbidity and mortality reporting since the early 1980s, and clinical coders are very familiar with its use. In hospitals, the ICD-9 is used in combination with two procedure classifications: the Office of Population Censuses and Surveys classification second revision (OPCS-2) from the UK, and Fascicle V of the International Classification of Procedures in Medicine (ICPM), which is a WHO publication.

The decision by the Ministry of Health and Quality of Life in Mauritius to implement ICD-10 provided the opportunity for the Ministry to also review methods of data capture and coding. In particular, consideration is being given to processes for improving the quality of the coding, through education for coders, and also through implementing improvements in medical records and death certificates, which form the source data for abstraction of diseases and procedures for coding. It is planned to begin using ICD-10 from 1 January 2003 and to also introduce the ACHI-I (the Australian Classification of Health Interventions – Adapted for International Use) for the coding of procedures. In May 2001, NCCH Director, Rosemary Roberts visited Mauritius to conduct a needs analysis, and subsequently NCCH Brisbane hosted a visit by Mr Nasser Jeeanody and Mr Sukhdeo Pem later in the year. Both of these visits were aimed at developing and refining plans for the implementation. The latest in the support activities provided to Mauritius was a training consultancy carried out by Sue Walker in August 2002, funded by the WHO Regional Office for Africa.

The two week program for my most recent consultancy included visits to Mauritian hospitals to view medical record departments and to evaluate the process for coding. Two training courses were also conducted. The first course (20-22 August) was aimed at medical record officers, clinicians and statisticians, and provided an overview of the coding process and the rules and conventions for coding, documentation requirements to support accurate and complete coding, coding quality techniques and an introduction to the International Classification of Functioning, Disability and Health (ICF). The second course (23-29 August) was for clinical coders and focused on coding using ICD-10 and ACHI-I, abstracting from medical records, coding quality techniques (including a session incorporating a modified ACBA audit) and use of INTERCOD, an interactive coder training software package for ICD-10 developed by the Pan American Health Organization. In Mauritius, the coding is performed by clerical staff in the medical record department, often with little or no formal training. Although the medical records viewed appeared reasonably comprehensive, the order of sheets within the records was a little haphazard and this meant finding the right information for coding a particular episode of care can be difficult. There is also a lack of adequate documentation of diagnoses by medical staff. The majority of clinical documentation is in English and the coders use English-language coding books. English is the official language in Mauritius, although French and Creole are also widely spoken. Some coders enter data directly into a dBase III database which contains the codes and code descriptions, with a word-matching algorithm used to select the correct codes. Other coders use the coding books. Coded data is then submitted to the Ministry of Health and Quality of Life on disk or CD-ROM. Some of the coders

Medical record officers, statisticians and clinicians attended the first training course

experience some difficulties, in particular as they share the coding work with a variety of other tasks and responsibilities. However, they are enthusiastic about their work and keen to begin using the ICD-10. Consideration is also being given to formalising a career structure for coders, including initial and continuing education. The two courses were conducted at the Mauritius Institute of Health in Pamplemousse, which is the organisation that conducts much of the nursing and paramedical education for the country. Discussions with the Executive Director, Dr JC Mohith, indicated that it might be possible for coder education to become part of the curriculum at the Institute.

l-r Ministry of Health officer, Jose Larhubarbe and Florise Roussety

The generosity of the staff of the Ministry of Health – in particular Ms Florise Roussety, Mr Jose Larhubarbe and Mr Nasser Jeeanody – in taking the time to show me around and introduce me to relevant people, and providing the impetus and the practicalities for the consultancy, were much appreciated. Mauritius is a beautiful country and I look forward to one day having the opportunity to visit it for a holiday, rather than for work!

Sue Walker
NCCH (Brisbane) Associate Director

Ireland trialing ICD-10-AM

On 30 August 2002 Kerry Innes, NCCH (Sydney) Associate Director presented a paper at the first National Clinical Coding Conference in Dublin, Ireland. The conference was a great success and another is planned for 2003. The aims of the conference will be familiar to Australian coders – they were to:

- acknowledge and celebrate the work of clinical coders
- examine coding as a profession
- raise the profile of the coder's job
- launch a new society specifically for clinical coders.

Kerry presented a paper about ICD-10-AM and Deirdre Murphy from the HIPE (Hospital Inpatient Enquiry) Unit of the Economic and Social Research Institute (ESRI) in Dublin presented a paper about their evaluation of various health classifications for use in Dublin. Deirdre announced that ICD-10-AM would be trialed over the ensuing months with a view to making a final decision in early 2003.

NCCH wishes our colleagues in Ireland well with the trial and we look forward to hearing that ICD-10-AM and AR-DRGs are the classifications of choice for the Irish health system in the not too distant future.

Deirdre Murphy; Professor Brendan Whelan, Director, ESRI; Professor Miriam Wiley, Head, Health Policy Research Unit, ESRI; Kerry Innes; Anne Clifton, Manager, HIPE, ESRI

INTERNATIONAL

18th Conference of Patient Classification Systems Europe, Innsbruck, Austria, October 2-5 2002

This meeting is subtitled the 18th International Case Mix Conference, and it is, in fact, an international conference organised by PCS/E. The theme underlying this year's gathering was "There is gold in your data – for you and your patients". This was an inspiring start, as was the spectacular flight in to Innsbruck through snow covered alps, which dominated the city itself after the first snow falls of the season. However, more than 300 participants spent three days inside the magnificent Innsbruck Congress Centre 'digging for gold'. This process took the form of plenary and break out sessions relating to classification, costing and funding, data mining, information systems, clinical and change management and evaluation as well as exchange of information and experience on casemix systems in Austria, Netherlands, Central Europe and internationally. Australia was well represented with three participants from the Commonwealth Department of Health and Ageing (Stuart McAlister, Cathy Hales and Katrina Chisholm) together with Terri Jackson (Victoria), John Pilla (SA), Chris Aisbett, Deniza Mazevska, Leon Paff and myself (NSW).

Apart from presenting and chairing sessions, the Australians were able to renew old friendships and of course I was particularly keen to follow up recent NCCH connections with representatives from many countries including UK, Ireland, Germany, Romania, Switzerland and Slovenia. There is no doubt that for the duration of PCS/E, Australia becomes an honorary member of the European family. The discussions reinforced for me the importance of maintaining comparability of data at the level of ICD, which can then be grouped using a variety of casemix classifications. There is an amazing amount of international interest in ICD-10-AM and AR-DRGs. Apart from my paper co-authored with Kerri Chalmers on modelling ICD-10-AM, there were presentations comparing AR- with other casemix classifications (Germany, Singapore/USA), Katrina Chisholm on classification currency and credibility and John Pilla on casemix payments in the Australian private sector. Terri Jackson reported her work on Australian outpatient data collection, while Stuart McAlister represented Australia in the final day 'casemix systems around the world in eighty or so minutes'.

Highlights for me were the papers from Germany on implementation of DRGs (Nicole Schlottmann) (and adjusting of AR-DRG 4.1 (Michael Wilke)), modelling of rehabilitation treatment groups (Günter Neubauer), and XML schema of ICD-10 (Simon Hölzer from Switzerland and Ralf Schweiger from Germany). I also learnt about new casemix initiatives in Japan (Hideki Hashimoto and Yuichi Imanaka) and Thailand (Supasit Pannarunothai) and was brought up to date on the Romanian casemix implementation (Dana Burduja).

There was far too much high grade ore in the program to describe adequately in this short report. I understand that PowerPoint presentations from the conference will be available on the PCS/E website *(www.pcse.org)* and the summary of national progress in casemix will be published as usual as a book in the Studies in Health Technology and Informatics series. To reinforce the international focus of the conference, the next PCS/E will be held in Washington DC in October 2003.

Rosemary Roberts
Director NCCH

INTERNATIONAL

Coding in Saudi Arabia

NCCH was pleased to welcome Terry Dymmott to the Sydney team in July 2002. Terry's former position in Jeddah, Saudi Arabia offered her opportunities to develop professional expertise and to experience a different culture.

My new life in Jeddah started without a hitch…or so I thought. Arriving at my new home in the middle of the night didn't cause too many problems; I was too excited to sleep and making sure I was early for work wasn't going to be an issue.

'Home' was a compound that housed expatriate workers. Finding the bus stop within the compound wasn't too difficult. I then asked a woman if the bus coming down the driveway was going to the King Fahd Armed Forces Hospital (KFAFH)? She gave me a wry look then nodded so I got on the bus.

I thought I was looking pretty smart in my new summer wardrobe, wearing a calf length skirt, short sleeved shirt, 'office' make-up, simple jewellery and sedately painted toenails slipped into a moderate sandal. Nothing over the top. After sitting down for the journey I, in a nonchalant kind of way, checked out everyone else around me. My very confident attitude was soon deflated – it was so obvious that I was the new kid in town and didn't I know it? I was the only person on the bus wearing 'clothes'! Everyone else wore the standard issue laboratory coat or black *abaya*. These garments cover every inch of skin and devoid you of any body features.

I felt like the proverbial sore toe. Showing my forearms and ankles in public suddenly made me feel extremely naked. And to add insult to injury, I later learned I hadn't fluked a piece of good fortune catching the right bus. I was never in doubt of getting on the wrong bus. How could I when there was only one bus available?

Terry and her co-worker Najat at the King Fahd Armed Forces Hospital

Everyone blunders sometime in Saudi; learning to 'cover-up' became my first priority. It didn't take long for me to purchase my abaya which I wore everywhere as all females do to conform to the culture. It did hide a multitude of sins, especially on 'fat days' or 'bad hair days'.

All hospitals provide women with laboratory coats to be worn as a uniform. Nursing staff understandably wore trousers and smocks but the rest of us had shapeless, oversized coats.

Make-up and jewellery weren't permitted and hair had to be tied up. Definitely no ankles to be shown. Nevertheless, rules were rules and it didn't take long to get used to the dress code.

The Medical Record Department was one of the few services in the hospital that allowed men and women to work together. Keeping doors locked was virtually impossible. Therefore, anyone and everyone had access to the department.

The extensive Saudi Arabian royal family has special privileges, and it wasn't unusual for a prince to come into the department to collect documents. The distinguished visitors weren't apparent until after they had left. Tradition dictates that all Saudi men wear the thobe and guttra: there was nothing in the royal family's dress to distinguish members from other people in the community.

King Fahd Armed Forces Hospital is the main carer for the Saudi royal family, and is situated next door to the military base and the palace. Staff were sent to the palace daily and there was an official royal suite that was off limits to regular employees.

To begin with I was rather excited about having to deal with royalty but when there are approximately 9,000 members all claiming VIP

status it quickly becomes a difficult concept to manage.

The usual practice within the hospital was that if an area was short-staffed a 'coder' was sent as the replacement clerk, gradually depleting experienced coders. Staff training was a major priority. Introducing ICD-10 was a challenge but with a supportive Program Director and eager coders it quickly became a worthwhile venture.

The coders adapted extremely well, changing from ICD-9-CM to ICD-10 diagnoses and MBS-E Second edition procedures. I figured that if I was starting from scratch I might as well go the whole nine yards! However, I soon learned that speaking colloquially was not very prolific, neither was using long, complex or unusual words. I also had to learn basic Arabic and help students with basic English.

We were keen to do well as the whole Kingdom was watching us – King Fahd Armed Forces Hospital (KFAFH) was the first facility to begin coding in ICD-10. Changing classifications was very exciting.

Working Saturday to Wednesday (Thursday and Friday are Saudi weekends) and a 7-8 hour time difference made communication with Australia difficult. Support with issues often would take a week to sort out. If I sent an e-mail to Australia on a Wednesday I wouldn't see my response until the following Monday.

Other hospitals were anxious about our progress and communication lines started opening up. I supplied training material for other coding departments and helped with queries as much as I could. Previously coders were pretty much left alone to contend with problems themselves. The doctors do not supply information willingly and documentation within the health record isn't very descriptive.

The Saudi cancer registry also opened doors and being able to code in ICD-O-3 was very beneficial for me. However, the hardest thing about having a reputation is living up to it! I became responsible for all the Western Region Military Hospitals and luckily for me I had tremendous support from the National Cancer Registry (NCR) in Riyadh.

I thoroughly enjoyed my time spent at the KFAFH and the NCR. I worked with some fantastic people, argued with some fantastic people and include Majors and Brigadier Generals as honoured colleagues.

Did I make impressive changes? On a professional level, I like to think so. On a personal level I've learned that patience really is a virtue.

Terry Dymmott

NCCH (Sydney)
Project Officer
Classification Support
and Development Division

ICD-10-AM

Early Parenting Manual

The *ICD-10-AM Early Parenting Manual* provides guidelines to help ensure codes for diagnoses and interventions specific to early childhood care are appropriately selected and assigned.

The *Manual* provides a common link between the language and terms used by clinicians, nurses, coders and early parenting centres staff.

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Patient Safety in Australia: the role of the Australian Council for Safety and Quality in Health Care

The Australian Council for Safety and Quality in Health Care was established in January 2000 to lead national efforts to improve the safety and quality of health care provision in Australia. The Council has been allocated in-principle funding of $50 million to lead a five year national program of work, in addition to $5 million provided for operational and establishment costs.

The Council reports annually to all health ministers and it is supported by all jurisdictions. It works closely with other national bodies to ensure that its work program complements the efforts of others.

In order to further these activities and reduce the rate of adverse events the Council has identified five priority areas. They are:

1. supporting those who work in the health system to deliver safer patient care
2. improving data and information for safer health care
3. involving consumers in improving health care safety
4. redesigning systems of health care to facilitate a culture of safety
5. building awareness and understanding of health care safety.

Initially action is being taken to address safety issues and reduce the most common adverse events. Other activities include:

- facilitating the development of national standards and protocols on which to base decisions to support safer patient care
- supporting lead implementation sites so that tried and tested approaches to safety improvement are practically taken up throughout Australia
- promoting opportunities for consumers to actively participate in their health care.

The rate of adverse events in health care receives major coverage nationally and internationally. The actual rate of adverse events in Australia is difficult to determine but debates about the size of the problem are less important than taking action. One major study brought the issue of adverse event rates to the public notice in 1995.

The report from the Quality in Australian Health Care Study was published in the *Medical Journal of Australia* in 1995[1]. The objective of this study was to estimate patient injury (and its direct consequences) caused by health care in Australian hospitals. Episodes of patient injury were defined as adverse events.

An adverse event was defined as

"…an unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by health care management".

The study involved a retrospective review of over 14,000 admissions to hospitals in New South Wales and South Australia in 1992. Following the study the reviewers concluded that 16.6% of all of these admissions were associated with an adverse event.

The publication of the results caused great controversy because the rate of adverse events was higher than the rate of adverse events detected in studies in the United States. However, re-analysis of the studies following the methods of a similar study in the US found that the Australian rate of adverse events was likely to be 10.6% which suggests that Australia has a similar rate to NZ, UK and Denmark.

Retrospective case note analysis is not an ideal method of determining the rate of adverse events. It is resource intensive and not conducted frequently enough to provide regular estimates.

There is no single source of statistics that provides a reliable measure of frequency or nature of adverse events. Nor is there a repository or regular reporting system for these data in Australia or other developed countries. Most existing data collections have not been designed to collect data about incidents and adverse events in ways that are useful for improving safety and very few give any information about the factors that contribute to the occurrence of these events.[2]

Both Council and the National Centre of Classification in Health share an interest in determining the value of mortality and morbidity data coded with the ICD. Routinely coded mortality and morbidity data has been assessed as an alternative to retrospective casenote analysis to monitor the rates of adverse events. Although the data sets appear to usefully record a range of adverse events, their sensitivity for iatrogenic collections is limited and data validity is uncertain in their present form.[3]

In order to explore the value of these data Council is supporting a project which aims to determine:

1. the number and nature of adverse events identifiable in the routinely collected hospital morbidity data
2. the extent to which routinely collected hospital morbidity data can be used as a source of information about the occurrence and proximal causes of adverse events and the harm attributed to them
3. the kinds of changes required to the data collections to make them more useful for monitoring these aspects of adverse events.

This project has the potential to inform changes to improve the capacity of ICD codes to describe adverse events, and changes to data collections to improve the capture of adverse events. A working paper will be released in 2003.

More information about the work of the Council can be found at *www.safetyandquality.org*

References

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2. Australian Council for Safety and Quality in Health Care. Safety in Numbers – A technical options paper for a national approach to the use of data for safer health care. 2001.
3. Hargreaves J. Reporting of adverse events in routinely collected data sets in Australia Australian Institute of Health and Welfare. (Health Division Working Paper no3) 2001

The Australian Refined Diagnosis Related Groups (AR-DRG) version 5.0

Diagnosis Related Groups (DRG) is a patient classification scheme that provides a clinically meaningful way of relating the number and types of patients treated in a hospital to the resources required by the hospital. AR AR—DRG is developed and maintained by the Commonwealth Department of Health and Ageing.

AVAILABLE NOW

AR-DRG version 5.0 builds on the foundation of version 4.2 and incorporates ICD-10-AM Third Edition.

AR-DRG version 5.0 consists of 3 volumes and includes a CD-ROM with supplementary tables.

Copies may be purchased from the NCCH. Versions 4.0 and 4.2 are also available. See enclosed order form for details.

For more details about AR-DRG version 5 visit: *www.health.gov.au/casemix*

Community involvement

Katrina Chisholm, CCCA Executive Officer at the Department of Health and Ageing in Canberra, is well known to many HIMs in Australia and internationally through her work in hospitals, government and professional organisations. It is less well known that Katrina, who owns a property at Mt Fairy just outside Canberra, is a new member of the Mt Fairy/Boro Rural Bush Fire Brigade. Last summer's bushfires prompted Katrina to join her local brigade. Although she describes herself as very much a novice and is still undertaking training, Katrina is now busy preparing both her property and herself for the threat of bushfire as most of Australia faces a summer in the worst drought conditions for more than a century.

Do you have a story to share about your involvement in the community? Please contact the editor.

Katrina Chisholm and her alpaca D'Artagnan

Australian Coding Benchmark Audit (ACBA) update

In the spirit of continuous improvement, an ACBA Focus Group has been established to evaluate the electronic ACBA product. Membership includes ACBA users, NCCH project and IT staff. An enhanced product will be available in mid 2003.

Next Edition March 2003

- **Clinical Update: FESS**
- **2002 Coder workforce survey**
- **Classification corner: The Royal College of Paediatrics and Child Health adaption of ICD-10**

Next monograph in series *Evolution in classifying mortality statistics*
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2003 Conference & Event Calendar

15-16 February	Health Informatics Association of New South Wales (HIANSW) Annual Conference Pokolbin, NSW, Australia *www.hiansw.org.au/hiansw.htm*
18-20 February	National Health Summit 2003 *Crisis, Reform & Solutions* Sydney, Australia *www.pharma-rd.net/2003/health_au*
26-28 March	NCCH 8th Biennial Conference *Coder connect:* *Linking Concepts in Health* Melbourne, Australia *www.fhs.usyd.ed.au/ncch*
14-16 July	The First Australian Conference for Safety and Quality in Health Care *Safety and Quality - in Action!* Perth, Western Australia. *www.safetyandquality.org/*
10-12 August	HIC 2003 Health Informatics Society of Australia (HISA) Sydney, Australia *www.hisa.org.au*
14-17 September	15th National Casemix Conference Department of Health and Ageing Conference 2002 *Health Care in Focus* Canberra, Australia *www.health.gov.au/casemix/*
28 Sept-1Oct	35th Public Health Association of Australia Annual Conference *Essentials, Differentials and Potentials in Health* Brisbane, Australia *www.pha.org.au/*

Would you like to promote your conference? Please send the details to Rodney Bernard, Publications Manager – *r.bernard@fhs.usyd.edu.au*

ACBA™ 2000

Health care decisions are dependent on good quality morbidity data. ***Australian Coding Benchmark Audit 2000*** **(ACBA)** provides a mechanism to assess quality of coded morbidity data. **ACBA 2000** is a coding audit method that involves re-coding a sample of hospital-admitted patient episodes and uniformly recording results.

ACBA

- ***identifies*** errors in coding practice
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See order form distributed with Coding Matters or call 03 9479 1811 for further information.

coding matters

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coder connect

Linking Concepts in Health

National Centre for Classification in Health
8th Biennial Conference

26 –28 March 2003
Hilton on the Park, Melbourne

Invitation to attend

The NCCH is pleased to invite you to attend the 8th Biennial NCCH Conference in Melbourne, Victoria, 26-28 March 2003.

Conference theme

The conference theme, ***Coder Connect: Linking concepts in health*** will focus on issues such as, the relationship between clinical coding and health care planning, coding and research, health data and communication between health care sectors, terminologies and vocabularies, data quality, health information and classification technology issues.

Conference structure

The conference will employ a range of formats including dual keynote addresses from

- **Associate Professor Stephen Bolsin**, Director of the Division of Perioperative Medicine, Anaesthesia and Pain Management, Geelong Hospital, Victoria *and*
- **Ms Christine Sweeting**, Data Quality and Classification Adviser, NHS Information Authority, Southampton, UK.

Clinical Update sessions are also scheduled, with plenty of opportunity for registrants to present their original papers during themed sessions.

Who should attend?

Clinical coders, health information managers, data managers, casemix coordinators, clinicians, health service managers and planners, health department officers, information technology professionals, academics and researchers.

Tutorial day

Wednesday 26 March 2003 is tutorial day. On offer are:

- Introduction to health terminologies, hosted by Dr Peter Scott
- ICD-10-AM Third Edition post implementation education, presented by the NCCH in conjunction with the Clinical Coders' Society of Australia.

Venue

Hilton on The Park, Melbourne, a few minutes walk from Melbourne CBD, near the historic Melbourne Cricket Ground. There is easy access to the Domain Gardens and the main shopping and entertainment venues of Melbourne.

Accommodation and travel

Reduced rates are offered for many flights and a variety of accommodation options are available. The NCCH has appointed conference organisers *Convention & Incentive Services* to coordinate travel and accommodation bookings.

Social program

Attendance at the welcome reception and the conference dinner is included in the registration fee. The welcome reception will be held at the Hilton on the Park, and Melbourne Aquarium on the banks of the Yarra River is the venue for the conference dinner.

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