

# Farewell Rosemary



January 14 2005 will be a landmark day in the life of the NCCH. This is Rosemary Roberts' last day of full time employment. Rosemary is joining the ranks of the post-fulltime work brigade, albeit, with a rosy future in consultancy potentially ahead of her. Life, both for Rosemary and the centre's staff, will be very different after she leaves us.

Rosemary has been an inspiration to many people. She is a critical thinker and an advocate for change. Some of Rosemary's traits are well known to the many people she has met and worked with during her Directorship. She is committed, capable, distinguished and erudite – but also curious, creative, entrepreneurial and energetic ►►

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in her pursuit of better clinical classification and improved health care. She has always valued the importance of research in all its forms and has encouraged personal and professional development. Her wicked sense of humour is not always completely camouflaged by her elegant presentation to the world.

Never one to shirk a challenge, Rosemary has moulded the NCCH into the well-respected organisation it is today. Ten years ago, an Australian Modification of ICD seemed a little like reaching for the moon.

Today, it is not only a mature classification system; it is applauded internationally and locally for its clinical relevance, thoroughness and innovation.

Rosemary's gift to us all has been that she has always been able to see the biggest of pictures and has not wavered in her determination to lead, build and provide tools that turn the wheels of better health services through best-practice clinical classification.

We are sure that all our readers will join in wishing Rosemary well as she enters the next phase of her life.



## Au revoir

Eleven years and 44 issues of *Coding Matters* later, it's time for me to hang up my hat as NCCH director and say au revoir to readers of the NCCH quarterly newsletter. This stage of my life has been extremely rewarding, although I know that for all of us it has also been a time of enormous change and adjusting to that change. However, we have together made a lot of progress, and I wish to thank you all for the contributions you have made to the growth of NCCH, for your input to its products and for the feedback you have provided over the years. Without informed and receptive users of our classifications, education and other products and services, the NCCH team would not have been able to respond to your needs.

This is an opportunity as well for a public thank you to all the members of the NCCH team that have so creatively and consistently 'produced the goods'. Australian health classifications have earned a world wide reputation for excellence, and it is very gratifying for me to have been involved in this joint endeavour.

Au revoir!

A handwritten signature in dark ink, appearing to read 'Rosemary', written in a cursive style.

Rosemary

# 10-AM Commandments

## Minimally invasive injectable graft (MIIG)

MIIG is a bone void filler paste. It is injected into osseous defects (either surgically created or traumatic). The paste cures in situ then resorbs and is replaced with bone during the healing process. The cured paste provides a temporary support media for bone fragments during the surgical procedure but does not provide structural support during the healing process (Wright Medical Technology nd).

### Classification

'Injection of MIIG' is usually performed in conjunction with another procedure, such as reduction of a fracture. Therefore, it is not necessary to assign a separate code for insertion of the MIIG.

## Squamous metaplasia of cervix

Squamous metaplasia is a normal physiological change in cervical tissue which has no sinister significance (Oats; Pepperell, 2004). Squamous metaplasia of the cervix may lead to cervical dysplasia, an abnormal growth of the epithelial tissue on the surface of the cervix (Glickman 2004).

### Classification

Documentation of squamous metaplasia of the cervix as an incidental finding does **not** require coding. Cervical dysplasia should be coded as N87 *Dysplasia of cervix uteri*.

## Torted appendix epiploicae sigmoid colon

The NCCH received a query regarding a diagnosis of torted appendix epiploicae of the sigmoid colon. The histology report detailed 'fatty tissue, necrotic and inflamed'. The torted appendix epiploicae was removed laparoscopically.

An appendix epiploicae is a pouch of visceral peritoneum filled with fat, attached in rows along the entire length of the colon (excluding the rectum). Torsion of the appendix epiploicae results in infarction, calcification of the fat contents and pedicle atrophy (Takada et al, 1998, pp441–442).

Documentation of torsion of the appendix epiploicae should be coded to K55.0 *Acute vascular disorders of intestine*.

Laparoscopic removal of the torted appendix epiploicae should be coded as 'epiploectomy':

96189-01 [989] *Laparoscopic omentectomy*

## Autologous blood transfusion

Perioperative (intraoperative or postoperative) autotransfusion of blood involves the use of various blood conservation/salvage techniques and devices, such as the bellovac drain.

An example of a blood conservation technique is 'cell saver', where blood is collected intraoperatively, mixed with an anticoagulant, concentrated/washed, and reinfused back into the patient ([www.perfusion.com.au/CCP/Details%20in%20perfusion%20technique/Autotransfusion.htm](http://www.perfusion.com.au/CCP/Details%20in%20perfusion%20technique/Autotransfusion.htm)). The purpose of autotransfusion is to recycle blood that is usually lost and discarded during or after surgery and can minimise or eliminate the need to use donor blood (BloodBook.com 2001, Ley 1996).

### Classification

Documentation of these types of autologous blood transfusion should be coded as 92060-00 [1893] *Transfusion of autologous blood*. 'Intraoperative blood salvage' is an inclusion term at this code.

## Excisional debridement of multiple burns

The logic in Australian Coding Standard 1911 *Burns* regarding 'dressing of burns' should be applied to excisional debridement of burns. That is, only one code should be assigned for multiple excisional debridement of burns performed during one operative episode. If a burns patient has excisional debridements of multiple sites, a code should be assigned to reflect the total body surface area debrided:

30017-01 [1627] *Excisional debridement of burn, < 10% of body surface area excised or debrided*

30020-00 [1627] *Excisional debridement of burn, ≥10% of body surface area excised or debrided*

## External cause codes – car trailers

The NCCH received a query regarding the external cause code for:

- a pedestrian severely injured in a collision with a trailer being towed by a car
- a person injured by a trailer that has broken free from a car or caravan

A trailer attached to a car should be considered a part of the car. This logic parallels that for trailers attached to or towed by other vehicles as described in the 'Definitions related to transport accidents' in Chapter XX *External causes of morbidity and mortality, Accidents, Transport accidents (definitions j, l and s)*.

The NCCH submitted a proposal to the WHO ICD-10 Update Reference Committee for revision of the definition of a car, to include a trailer attached to a car. This was accepted at the WHO-FIC meeting in October 2004. Definition (car) will be modified accordingly in ICD-10-AM Fifth Edition.

A trailer that has broken free from a car, caravan or similar should be coded as a 'non-motor' vehicle.

### Classification

Where an accident is documented as having been caused by a trailer attached to a car, an appropriate code should be chosen from the Table of Land Transport Accidents in the Alphabetic Index of Diseases, Section II External Causes of Injury (indexed under *Accident, Table of land transport accidents*) for a 'car (automobile)'.

Where an accident is documented as having been caused by a trailer that has broken free from another vehicle, an appropriate code should be chosen from the Table of Land Transport Accidents for 'other non-motor vehicle including animal-drawn vehicle'.

## Silastic patch to orbital floor fracture

A silastic patch (sheet) is a temporary implant that is applied to a fracture site and removed in a separate procedure at a later date.

### Classification

Reconstruction of a fracture of the orbital floor and implantation of a silastic patch should be coded to 45590-01 [1716] *Reconstruction of orbital cavity with implant*.

The following codes should be assigned for removal of the silastic patch:

90083-00 [229] *Other procedures on orbit*

92202-00 [1908] *Removal of therapeutic device, not elsewhere classified*

## Aspiration of sperm for IVF

The NCCH received a query regarding code assignment for male patients admitted for aspiration of sperm for IVF. Z31.3 *Other assisted fertilisation methods* should be assigned for these cases. Assign also an appropriate procedure code, as per documentation.

## References

Bloodbook.com (2001) Guide to blood transfusion: what to do if you need blood. Accessed 28 June 2004: <http://www.bloodbook.com/trans-guide.html>

Glickman J (2004) Health Science Report. Squamous metaplasia of the cervix. Accessed 28 June 2004: <http://www.health-science-report.com/cervical-dysplasia/treatment-for-cervical-dysplasia/squamous-metaplasia-of-the-cervix.html>

Ley SJ (1996) Intraoperative and postoperative blood salvage. *AACN Clinical Issues*. 1996 May, 7(2):238-48. Accessed 28 June 2004: [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=8718386&dopt=Abstract](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=8718386&dopt=Abstract)

Oats J. *Personal communication*, 28 April 2004

Pepperell R. *Personal communication*, 28 April 2004

Takada A, Moriya Y, Muramatsu Y and Sagae T (1998) A case of giant peritoneal loose bodies mimicking calcified leiomyoma originating from the rectum. *Japanese journal of clinical oncology* 28 (7):441 Accessed 11 May 2004: <http://ijco.oupjournals.org/cgi/content/fu//28/7/441>

Wright Medical Technology (no date) MIIG Minimally invasive injectable graft (product information) Accessed 28 June 2004: [http://www.wmt.com/Literature/docs/128801-2\\_Eng.pdf](http://www.wmt.com/Literature/docs/128801-2_Eng.pdf)

# ICD-10-AM

## Early Parenting Manual

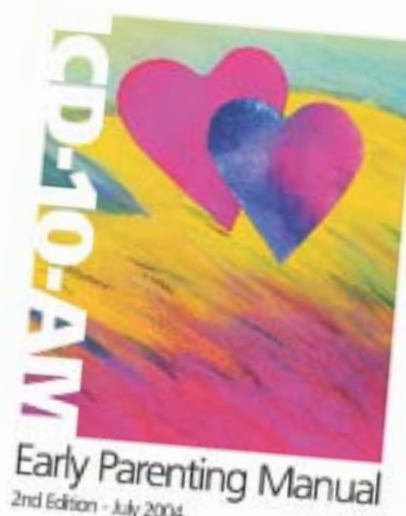
2nd edition

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.

Available **NOW**

Fully revised and updated: aligns with ICD-10-AM Fourth Edition





# Use of injury codes

## with complication of medical/surgical care code

There are no conventions/includes/excludes notes in ICD-10 or ICD-10-AM that preclude the use of an injury code to further describe a complication of medical/surgical care. However, Australian Coding Standard 1904 *Procedural complications* states that...

*"an additional code from Chapters I to XVIII may be assigned to provide further specification of the condition".*

When this standard was written, it was assumed that in most cases a 'disease' code would further describe the complication rather than an 'injury' code. However, as Australia uses the convention of 'multiple coding' to fully describe the clinical picture (as per ACS 0027 *Multiple coding*), there is no reason why additional codes from Chapter XIX may not be assigned.

The NCCH also sought international advice on this issue via the WHO-FIC Update Reference Committee (URC) forum. Feedback confirmed that the addition of injury codes to further describe complications of medical/surgical care is common practice in other countries using ICD-10 or clinical modifications of ICD-10.

Following discussion at Coding Standards Advisory Committee (CSAC) in June 2004, there was general agreement to assign injury codes to further describe a complication. The use of injury codes with complication of medical/surgical care codes may provide further specificity by better translating the medical statement into code. A good example is in cases of laceration, perforation and/or nerve damage. An injury code could identify the specific organ or nerve involved.

### Example 1:

A patient suffers brachial plexus bruising due to surgery and requires treatment with physiotherapy.

#### Assign:

G97.8 *Other postprocedural disorders of nervous system*

S14.3 *Injury of brachial plexus*

(with appropriate external cause codes and procedure codes)

### Example 2:

A patient is admitted for removal of inguinal hernia mesh. During the procedure, the femoral vein is lacerated. The mesh is removed, the femoral vein is repaired and the patient is discharged home.

#### Assign:

T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts*

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

S75.1 *Injury of femoral vein at hip and thigh level*

(with appropriate external cause codes and procedure codes)

Therefore, when assigning a code for a complication of medical/surgical care (a code from T80-T88 or a 'postprocedural disorder' block, as specified in ACS 1904 *Procedural complications*), an additional code from **Chapters I to XIX** may be assigned to provide further specification of the condition.

The NCCH will amend ACS 1904 *Procedural complications* for a future edition of ICD-10-AM. The range of chapters from which an additional code may be assigned, will be extended to include Chapter XIX *Injury, poisoning and certain other consequences of external causes*.



# Clinical update

## Dynamic graciloplasty for the treatment of faecal incontinence

This article was researched, written and published by

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) as part of its Consumer summary series, October 2001.

ASERNIP-S is a program of the Royal Australasian College of Surgeons (RACS).

For further information about ASERNIP-S contact

ASERNIP-S  
PO Box 688  
North Adelaide SA 5006  
Ph (08) 8239 1144

The NCCH wishes to gratefully acknowledge ASERNIP-S' kind permission to amend and republish this report. Sections directly relating to patient information have been omitted or amended. The coding and classification information has been added by NCCH.

**Dynamic graciloplasty is a surgical technique that has been developed for treating faecal incontinence. ASERNIP-S has reviewed the available published evidence to compare the safety and effectiveness of this procedure with colostomy, an alternative surgical treatment for this condition.**

### What is faecal incontinence?

The anus is the opening at the end of the bowel through which faeces passes from the rectum to the outside of the body (Figure 1). Two sets of muscles control the passage of faeces: the anal sphincter, and the pelvic floor muscles. Bowel control also depends on:

- the mental function of the individual
- the stool size and thickness
- the normal action of the bowel and rectum
- anorectal sensitivity
- anorectal reflexes

When sphincter or pelvic floor muscle tone is lost through damage, or is lacking at birth, the person may be unable to adequately manage bowel control. If this happens more than twice a month the person is considered to be suffering from faecal incontinence.

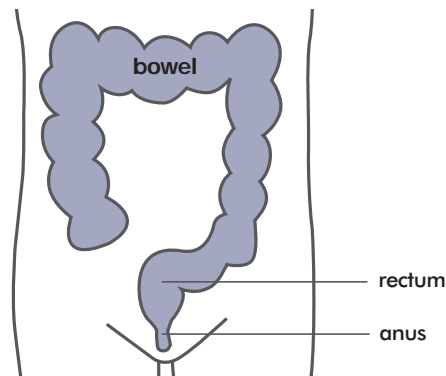


Figure 1: Anatomy of end of bowel

Even if the anal sphincter is working normally, this condition can develop if a patient has gastroenteritis resulting in diarrhoea. However, long-term faecal incontinence may be caused by:

- congenital anorectal malformations
- damage to the anal sphincters or perineal trauma either through direct trauma or during childbirth or surgery, such as anal fissures or haemorrhoids
- neurogenic faecal incontinence resulting from damage to the nerve supplying the pelvic floor muscles
- low-motor neuron lesions such as myelomeningocele or tethered cord syndrome

### Established treatments for faecal incontinence

Most patients can be treated using protocols such as:

- high-fibre diet
- enemas
- biofeedback

In biofeedback, the person learns how to squeeze and strengthen the anal sphincter muscles around a plug placed in the rectum. Patients must have an intact anal sphincter with nerve supply, strong motivation and maturity. This technique is not suitable for people with neurogenic faecal incontinence. Electrical stimulation of an anal plug has also achieved good results in patients with partial faecal incontinence.

In patients with a malformed or damaged anal sphincter, overlapping sphincteroplasty (surgical tightening of the sphincter) is the operation of choice. Post-anal repair has given good short-term results, but long-term full continence is rarely achieved. Post-anal repair fails to restore the anorectal angle (the angle between the rectum and the anus). Normally this angle

promotes faecal continence by encouraging the stool to remain in the rectum before expulsion to the outside of the body (Figure 2). However, when levatorplasty (surgical fixation of the pelvic floor muscles behind the anus) or the puborectal muscle is transposed to the anal canal, complete continence is achieved in two-thirds of patients.

When none of these treatments is successful, and the lower large intestine, rectum or anus is unable to function normally, a colostomy is performed.

In terms of safety, one study reported the risk of dying from colostomy to be 2%. Around half the patients who have a colostomy will experience a complication following surgery, most commonly paracolostomy hernia (21%) and skin complications (12%). One study found that the risk of hernia rose to about 37% ten years after the operation. One third of patients experience complications with their stoma. Constipation, however, was less of a problem for patients with stomas than without and reports on the use of bowel stabilising drugs varied between studies. The risk of re-operation for colostomy was reported at 13% and may increase with time after the operation.

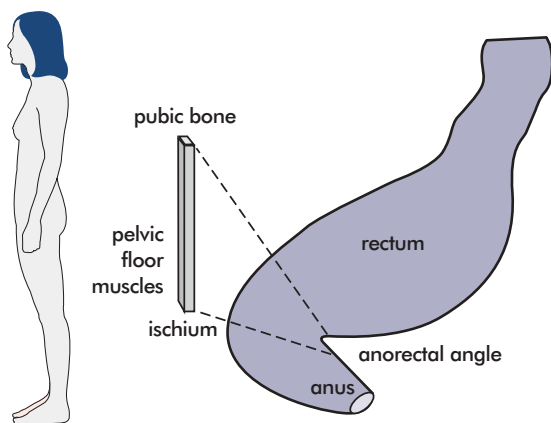


Figure 2: Anorectal angle (side view)

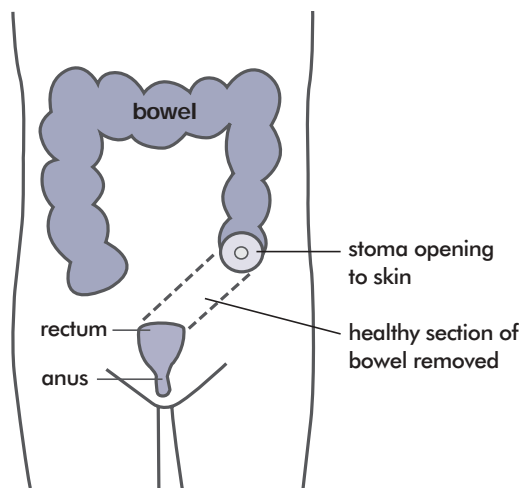


Figure 3: Colostomy

Psychosocial effects of colostomy were also examined, as the presence of the stoma inevitably distorts the patients' body image. One study found that patients with stomas are significantly more likely to report a poorer quality of life, with respect to bowel-related problems and psychological health for example, than patients without stoma.

Another type of surgical treatment for faecal incontinence involves the creation of a new anal sphincter using a synthetic sphincter or autogenous muscle. Two types of muscle can be used:

- type I, slow twitch, smooth muscle, which can continue a contraction without tiring
- type II, fast twitch, skeletal muscle, which cannot sustain contraction for long

Both types of muscle can be transplanted to the anus. Alternatively, the following type II muscles (not essential for movement or posture and originating near the anus) may be transposed to the anus:

- the **sartorius muscle** of the inner thigh is the least appropriate due to its complicated blood supply
- gluteoplasty – using the **gluteus maximus** to create a new anal sphincter – has been used successfully. However, incontinence due to spina bifida or myelomeningocele cannot be treated using this muscle. Further, it is an important muscle for running, walking, climbing stairs and rising from a seated position. Gluteoplasty is technically more complicated than that using the gracilis muscle because the nerve supplying the gluteus maximus is hard to find
- the **gracilis muscle** of the inner thigh is an adductor which may be used to create a new anal sphincter. However, contraction of all the adductor muscles in order to hold up stool will prevent the patient from moving to the toilet. While some patients have learned to contract the gracilis muscle alone, all day continence is rare because type II skeletal muscle is unable to sustain contraction for too long. Hence a tight loop has to be made in the muscle to achieve continence, keeping the anal opening closed all the time unless opened by straining during defaecation. Enemas are often required

## Recent developments in surgical treatments for faecal incontinence

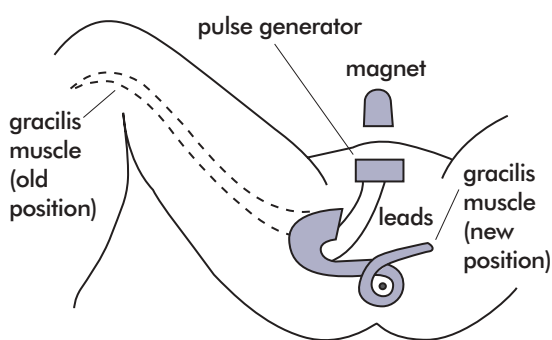
### Dynamic graciloplasty

In 1986 a new approach, called dynamic graciloplasty, was developed to treat this condition. In this treatment the type II gracilis muscle is converted to type I fatigue-resistant muscle through electrical stimulation of its obturator nerve. Thus the loop of muscle can be less tightly wound around the anal canal, which is closed by active sustained contraction by the patient.

This procedure is suitable for patients who have an external anal sphincter that is damaged beyond repair or a sphincter with severe neurogenic faecal incontinence damage, and individuals with a congenital disease like spina bifida. It should not be used for patients suffering from inflammatory bowel disease, those who are not motivated, or physically or mentally incapable patients. Careful evaluation of patients with cardiac pacemakers needs to be performed, because the gracilis electrical pulse generator can interfere with the sensing functions. The average patient accepted for dynamic graciloplasty has severe incontinence, is incontinent for many years, has had maximal conservative treatment, biofeedback training and one or more previous operations for restoration of continence.

This technique is performed after systemic antibiotics have been administered for 24 hours. In male patients a urinary catheter is introduced. Using one incision in the upper thigh and a smaller incision under the knee, the tendon connecting the gracilis muscle to the knee is cut. Two further incisions are made on either side of the anus to form three tunnels, which enable the gracilis muscle to be wrapped around the anal canal. The cut tendon is then attached to the pelvis or skin. No protective colostomy is created. Patients are encouraged to walk the next day and to wear an elastic stocking for several weeks.

At least 6 weeks after the first operation, the pacemaker and leads are put in the body. After another 24-hour course of antibiotics, an incision is made in the upper thigh and a flexible coil wire, the anode, is inserted, followed by the electrode and leads, which are passed under the skin to the lower abdominal wall and connected to a pulse generator (Figure 4).



**Figure 4: Dynamic graciloplasty**

Three days later, the training period begins. The pulse generator is stimulated to gradually increase the force of muscle contraction. At 8 weeks continuous stimulation is started and the patient is given an external magnet to turn the pulse generator off temporarily to allow defaecation. When there is a majority of type I, fatigue-resistant, muscle fibres, a sustained contraction can be achieved with a lower stimulation frequency.

### ***Double dynamic graciloplasty after removal of the lower part of the rectum***

After a part of the rectum is excised for low rectal cancer, normally a permanent colostomy is created. If the tumor has been successfully removed, and the patient is in good health, the individual is a candidate for a total anorectal reconstruction, during which a new pelvic floor and anal sphincter are created. A second gracilis muscle has been used to replace the pelvic floor muscles. The right muscle is passed behind the pulled-through bowel and sutured to the other side to recreate the anorectal angle. The left muscle is looped around the new rectum and sutured to the skin. Electrical stimulation prevents muscle wasting.

### **How does the dynamic graciloplasty procedure compare to the colostomy?**

Due to the lack of good quality evidence available on the dynamic graciloplasty and the colostomy, the following information should be treated with some caution, but may be used as a guide.

In terms of safety, the risk of dying for each procedure is roughly equivalent at around 2%. Although the risk of dying from dynamic graciloplasty ranged in the studies from 0% to 31%, this figure drops to 0% to 13%, or an overall rate of 2%, if patients suffering from rectal cancer (to which some of the deaths were attributable) are excluded.

With the dynamic graciloplasty procedure, the risk of patients experiencing a complication was higher than for the colostomy; results varied from one patient in seven in one study up to two complications experienced per patient in another. Complications can include infections (28%), problems with the pulse generator (15%) and leg pain (13%). Discharging of the battery, constipation, anal and body pain and damage to the gracilis muscle have also been reported in over 5% of cases.

Studies examining psychosocial effects showed that several quality of life measures, including anxiety, performance of tasks, social function, vitality and physical role, improved following a successful as opposed to an unsuccessful dynamic graciloplasty.

As an effective treatment for long-term faecal incontinence, the successful dynamic graciloplasty is clearly superior to the colostomy, which is completely incapable of allowing the patient to determine when and where faeces will be excreted. Unfortunately, the rate of failure amongst dynamic graciloplasties is quite high, with most studies reporting that less than 60% of patients achieve satisfactory continence.

The result of an unsuccessful graciloplasty is usually conversion to colostomy. The reported re-operation rate for this procedure was between one in seven patients and once per patient.



## What are the recommended procedures for treating faecal incontinence?

Due to the lack of good quality evidence, it is not possible to decide whether the dynamic graciloplasty procedure is as safe as the colostomy for treating faecal incontinence, although it has been found to be an effective alternative. As the result of an unsuccessful graciloplasty is usually conversion to colostomy, the patient and surgeon must weigh up whether the risks of complications and re-operation following dynamic graciloplasty outweigh the chance of an improved quality of life. The Royal Australasian College of Surgeons recommends that the dynamic graciloplasty be performed in the setting of a monitored trial or study and only in centers where the operation is routinely done.

**Important note:** The information contained in this report is a distillation of the best available evidence located at the time the searches were completed as stated in the protocol.

## Classification

ICD-10-AM Fourth Edition provides the following codes for dynamic graciloplasty:

90769-00 [940] Insertion of artificial bowel sphincter

32210-01 [940] Adjustment of gracilis neosphincter pacemaker

90769-02 [940] Removal of artificial bowel sphincter

32210-02 [940] Removal of gracilis neosphincter pacemaker

90769-01 [940] Revision of artificial bowel sphincter

32203-01 [940] Revision of anal or perineal graciloplasty

90770-00 [1859] Testing of implanted anal pacemaker

## CSAC state and territory representatives

		phone	fax	e-mail
NT	Jill Burgoyne	08 8951 7866/8951 7777	08 8951 7758	jill.burgoyne@nt.gov.au
NSW	Joanne Chicco	02 9391 9684	02 9391 9070	jchic@doh.health.nsw.gov.au
ACT	Vacant			
VIC	Sara Harrison	03 9616 7461	03 9616 7629	sara.harrison@dhs.vic.gov.au
TAS	Kirstie Mountain	03 6233 3765		Kirstie.Mountain@dhhs.tas.gov.au
SA	Rhonda Pfeiffer	08 8413 8261	08 8413 8222	rhonda.pfeiffer@dhs.sa.gov.au
QLD	Meegan Snell	07 32340123	07 3234 0564	Meegan_Snell@health.qld.gov.au
WA	Inge Young	08 9222 2472	08 9222 4408	inge.young@health.wa.gov.au

## Other CSAC members include:

Kay Bonello	Private sector	Linda Best	NCCH
Kate McKenzie	DoHA	Kerry Innes	NCCH
Vera Dimitropoulos	HIMAA Ltd	Sue Walker	NCCH
Terry Finnegan	Clinician, CCCA	Megan Cumerlato	NCCH
Andrea Groom	CCSA Ltd	Sue Wood	NCCH
Jenny Hargreaves	AIHW		
Deirdre Murphy	Ireland		
Mary-Ellen Wetherspoon	New Zealand		

## Alzheimer's disease

Several queries relating to *Performance Indicators for Coding Quality* (PICQ) indicator 100091 *Alzheimer's disease code without dementia code* have been received. PICQ indicator 100091 *Alzheimer's disease code without dementia code* has a fatal indicator degree, indicating that there is definitely an error. The rationale for this indicator is that:

This indicator identifies records containing the Alzheimer's code but no dementia code. Australian Coding Standard 0528 *Alzheimer's disease* states that dementia can always be assumed and coded.

Analysis of Australian Institute of Health and Welfare (AIHW) national morbidity data indicates that in July to December 2000, there was a national error rate of approximately 9.4% for this indicator, which is very high for a fatal indicator.

ACS 0528 *Alzheimer's disease* states:

When only *Alzheimer's disease* is documented, rather than *Alzheimer's dementia*, the dementia component can be assumed and thus two codes should always be assigned, G30.- *Alzheimer's disease* and F00.-\* *Dementia in Alzheimer's disease*.

Additionally there has been a query relating to the occurrence of a more specific dementia, with Alzheimer's, such as delirium superimposed on dementia.

Regardless of whether extra information on the type of dementia is available, an F00 \* *Dementia in Alzheimer's disease* code must be used. This instruction is embodied in ACS 0027 *Multiple coding* which states that aetiology and manifestation (dagger and asterisk) codes must be assigned in the same sequence in which they appear in the Alphabetic Index, that is, the aetiology (dagger) followed by the manifestation (asterisk) code.

However, an additional code could also be added to further specify the dementia, if supported by the documentation.

It should be noted that the code F05.1 *Delirium superimposed on dementia*, is assigned only when the delirium develops in the course of a dementia, and is documented as such. When both these conditions are present, but there is no documentation of the aetiology of the delirium, they should be coded separately. (Reference: NCCH Query database, #1526).

## Coronary atherosclerosis

PICQ indicator 101535 *Coronary atherosclerosis code as principal diagnosis with angina code* has a fatal indicator degree, indicating that there is definitely an error. The rationale for this indicator is that:

This indicator identifies records with a coronary atherosclerosis code as principal diagnosis and an angina code. ACS 0940 *Ischaemic heart disease* states that angina should be sequenced before coronary atherosclerosis.

Analysis of AIHW national morbidity data indicates that in July to December 2000 there was a national error rate of approximately 8.79% for this indicator, which is high for a fatal indicator.

ACS 0940 *Ischaemic heart disease* states that the code for any type of angina should be sequenced before coronary atherosclerosis, if the patient is found to have this condition. This advice does not apply only to emergency admissions for angina. The patient does not have to be suffering angina pain at the time of admission to assign the code for angina.

Many coders have traditionally regarded angina as a 'symptom' of atherosclerosis and have incorrectly sequenced atherosclerosis as the principal diagnosis, that is, the underlying cause of angina. Although angina can be described as a symptom, it constitutes one of a group of symptoms which are significant in their own right.

Coronary artery bypass grafts are usually performed for angina, not coronary artery disease (CAD), that is, 'symptomless' CAD is not usually operated on. Therefore where the patient's history includes angina and CAD, sequence the code for angina before the code for atherosclerosis.

## Post-procedural care

A query relating to *Performance Indicators for Coding Quality* (PICQ) indicator 101593 *Surgical follow-up care without condition that required surgery* has been received. PICQ Indicator 101593 *Surgical follow-up care without condition that required surgery* has a fatal indicator degree, indicating that there is definitely an error. This indicator has been modified for PICQ 2004, Fourth Edition and the rationale for this indicator is now:

This indicator identifies records with surgical follow-up care as principal diagnosis but no other code that might indicate the condition that required surgery.

Analysis of AIHW data indicates that in July to December 2000 there was a national error rate of approximately 15.8% for this indicator, which is very high for a fatal indicator. Note that this indicator was incorrectly listed with a warning indicator degree in PICQ 2002.

An examination of the data reveals three main areas of error, which are now included in the rationale:

- Z48.8 *Other specified surgical follow-up care* should not be assigned alone. ACS 2103 *Admission for convalescence/aftercare* instructs that a code for the condition that required surgery should be assigned as an additional code
- The 'condition that required surgery' is not usually a Z code, for example osteoarthritis of hip is the condition that required surgery, not 'presence of hip implant'
- If the admission is for post-caesarean care, the postpartum code (Z39.0-) should be the principal diagnosis and the other specified surgical follow-up care code (Z48.8) is an additional diagnosis code (ACS 1519 *Delivery prior to admission*).

## ICD-10-AM eBook update

Over the last few months NCCH has been working on fixing some errors in the eBook. Examples of the kinds of corrections being made are:

### Code links in main window not working

Neuropathy, peripheral, with diabetes E1-.42 (has no link)

Neuropathy, peripheral, autonomic, with diabetes E1-.43 (no link)

### Navigation window doesn't have all the entries showing on the right-hand screen

Fall/falling, from/off – the first entries on the right-hand screen are not included in the navigation window.

NCCH realises that these are irritating errors but they do not interfere with correct code assignment because:

- in the case of the links not working, the correct code is still shown
- where text is missing in the navigation window the correct text is presented in the main window. Note that the navigation window bears this name because it is only for *navigation* to the main window therefore this should not affect code assignment

### Do not assign codes only from the navigation window without reference to the main window.

Setting the navigation window is done by hand which means that there will inevitably be transcription error when working with a large document full of indentations. We are working on improving the process for ICD-10-AM Fifth Edition so that these types of errors don't creep in. We apologise for the inconvenience some of the errors cause and ask for your patience while we fix them.

If you find an error in the printed books or eBook please take time to notify NCCH by e-mailing Linda Best at [l.best@fhs.usyd.edu.au](mailto:l.best@fhs.usyd.edu.au) so that we can include fixes in the regular eBook updates.

PICQ 2004



**incorporating PICQ for ICD-10-AM Fourth Edition**

### Performance Indicators for Coding Quality (PICQ)

is a set of predetermined performance indicators which identify records in data sets that may be incorrectly coded, based on Australian Coding Standards and coding conventions.

**PICQ 2004** contains a number of enhancements:

- 113 new indicators
- Upgraded internal data specifications for some indicators in PICQ for ICD-10-AM First and Second editions
- New and improved PICQ user guide

### For further information:

**NCCH Sydney**

**phone: + 61 2 9351 9461**

**e-mail: [ncchsales@fhs.usyd.edu.au](mailto:ncchsales@fhs.usyd.edu.au)**

## Asthma study

Following receipt of a public submission suggesting that asthma documentation in inpatient settings refer to patterns and severity of asthma, the NCCH is working together with the States to ascertain whether current ICD-10-AM asthma codes and disease indexing reflect the documentation of asthma in health records.

Asthma is a national health priority area and there is significant interest in capturing relevant detail about hospitalisations as a result of asthma. It is hoped that the study will answer the following questions:

- are patterns of asthma used widely and regularly documented in hospital records?
- if so, are there variations within these patterns of asthma?
- can patterns of asthma be applied to both children and adults?
- how regularly is asthma documented as mild, moderate or severe?
- are there other asthma terms used widely in hospital records that should be integrated into ICD-10-AM?

The answers to these questions will inform any changes to the ICD-10-AM codes J45x – J46 for Fifth Edition (2006). Hospitals asked to contribute data will be required to record asthma terms documented in health records for inpatient episodes with a principal diagnosis of asthma, as well as nominate some general hospital information, age group of the patient and the ICD-10-AM code applicable to the episode. The NCCH greatly appreciates the cooperation of all states and hospitals who participate in the study – it is a great opportunity to make a significant contribution to the review of asthma terminology for the fifth edition of the classification. Any queries about collection of data for the asthma study should be directed to state Coding Standards Advisory Committee (CSAC) representatives who are coordinating state responses.

## Additional diagnosis

The NCCH made a wording change to Australian Coding Standard 0002 *Additional diagnoses* in 2000 to reinforce the correct interpretation of additional diagnosis coding, achieve national comparability of coding of additional diagnoses and to enforce the

principle of coding diagnoses relating to an episode of care rather than diagnoses relating to a person's lifetime. The change to the wording of ASC 0002 was ratified through CSAC. The ACS applies the NHDD definition of additional diagnosis:

*"A condition or complaint whether coexisting with the principal diagnoses or arising during the episode of care or attendance at a health care facility".*

To quantify any effect of the wording change to ACS 0002 in 2000 the NCCH is currently analysing morbidity data pre and post July 2000. Results will be fed back to state CSAC representatives and will help to inform coder education and coding practice.

## PICQ 2004

*Performance Indicators for Coding Quality* (PICQ) is a set of performance indicators that identify coded records in morbidity data sets that may be incorrectly coded, based on Australian Coding Standards and coding conventions. PICQ is a useful quality tool for state health agencies and hospitals to help identify potential coding anomalies requiring corrective action, and to inform coder education. PICQ indicators analyse disease and procedure codes:

- in combination with other codes
- in combination with NHDD data items
- in a sequence
- for presence or absence of a code
- for code specificity

PICQ 2004 will soon become available and incorporates

- 118 indicators for ICD-10-AM First Edition
- 117 indicators for Second Edition
- 126 indicators for Third Edition
- 223 indicators for Fourth Edition

The product has been included in the product list attached to this edition of *Coding Matters* and orders are now being taken.

Any general enquires about these or other quality activities can be directed to Sue Wood (02 9351 9465).



NCCH conference

# Coding rules

16 – 18 March 2005, Perth

The NCCH is pleased to announce the final conference and arrangements for the conference.

## Program

The call for papers has yielded an excellent response, and the program features something for everyone – from leading edge developments and technology, to practical applications, and two of the extremely popular clinical update sessions. The final program is published in this edition and is also available from the NCCH web site.

## Optional workshop

The optional ICD-10-AM Fourth Edition post-implementation workshop provides opportunity to refine coding skills. As a special bonus activity, we are pleased to announce that there will be a breakfast discussion session for workshops registrants to examine the contentious question – how many diagnoses should you code? Participation in the breakfast discussion and the workshop is included in one price. There are preferential rates for those registering to attend both the workshop and the conference.

## Register to attend

There's still time to register for the conference. A copy of the registration form is provided in this edition, or you can obtain it from <http://www3.fhs.usyd.edu.au/ncch/7.9.htm>, as well as helpful information about accommodation, travel, and the delights Perth has to offer visitors.

Special early bird rates are available until 7 February 2005, and registration closes 9 March 2005. There are also special rates for day-only attendance and students.

## Social program

The social program will provide plenty of opportunities to meet and mix with colleagues from throughout Australia and overseas. Attendance at social events is included in full conference registration and participants are welcome to bring guests. See the registration form for details.

# NCCH conference program\*

This is a conference you can't afford to miss! The positive response to the call for papers has led to creation of a diverse and informative program relevant to all clinical coders, health information managers and casemix coordinators. And there's still time to register!

## Optional workshop Wednesday 16 March 2005

8.30 – 9.30am

**Breakfast session and discussion: How many diagnoses should you code?**

10.00am – 12.00pm

Coding workshop – ICD-10-AM Fourth Edition post implementation update  
Presenters – **Megan Cumerlato** and **Julie Rust**, NCCH

12.00 – 1.00pm

**Lunch**

1.00 – 4.00pm

Coding workshop – ICD-10-AM Fourth Edition post implementation update, continued

4.00 – 5.30pm

**3M Health Information Systems Customer Meeting**

6.00 – 8.00pm

**Welcome reception**

## Day 1

## Thursday 17 March 2005

9.00 – 9.30am

**Official opening**

**Welcome – NCCH Director**

**Keynote address and official opening – Professor Aleksandar Janca**

Head, University of Western Australia's Mental Health Epidemiology Unit;  
Consultant Psychiatrist Royal Perth Hospital; Director WHO Collaborating Centre in  
Perth; Professor UWA School of Psychiatry and Clinical Neurosciences, Perth, WA

### Session 1

9.30 – 10.30am

#### **Morbidity data use: How ICD-10-AM coded data are used**

**Elizabeth Sullivan**. Operations Director, AIHW National Perinatal Statistics Unit,  
Randwick, NSW

**Dr Tim Threlfall**. Director and Registrar, WA Cancer Registry, Perth, WA

**Associate Professor James Harrison**. Director, AIHW Research Centre for Injury  
Studies, Bedford Park, SA

10.30 – 11.00am

**Morning tea**

### Session 2

11.00am - 12.30pm

#### **Clinical update: Burns – the Bali experience**

**Dr Fiona Wood**. Plastic surgeon, Director Royal Perth Hospital Burns Unit,  
Director Clinical Cell Culture Limited, Perth, WA

**Anne Roberts**. Clinical coding coordinator, Royal Perth Hospital, Perth, WA

12.30 – 1.30pm

**Lunch**

12.45 – 1.15pm

**Clinical Coders' Society of Australia Ltd Annual General Meeting**

### Session 3

1.30 – 3.00pm

#### **Developments in EHR and data linkage**

**Dr Frida Cheok**. Manager, Clinical Information Project, Adelaide, SA

**Dr John Bass**. Senior Research Fellow, Centre for Health Informatics, Curtin  
University, Perth, WA

**Jenny Hargreaves**. Head, Hospital and Mental Health Services Unit, AIHW,  
Canberra, ACT

**Dr Olafr Steinum**. Infectious diseases physician, Uddevalla Hospital, Sweden

3.00 – 3.30pm

**Afternoon tea**

## Session 4

3.30 – 5.00pm

### Better coding

**Leanne Stokes** – *Coding rules in the private sector*. Health information consultant, Beachplace P/L, Mt Martha, VIC

**Corrie Martin** – *To creed or not to creed*. Acting coding manager, Princess Alexandra Hospital, Brisbane, QLD

**Jill Burgoyne** – *Coding improvement project*. Health information manager, Alice Springs Hospital, NT

**Mary McKay** – *Clinical coding within an indigenous population*. Patient services manager, Gove District Hospital, NT

**Conference dinner**

7.00pm – 12.00am

## Day 2

Friday 18 March 2005

## Session 5

9.00 – 10.30am

### Meeting the challenge

**Vera Dimitropoulos** – *HIMAA accredited clinical coder certification*. Lecturer, HIMAA Ltd, North Ryde, NSW

**Jennie Shephard** – *Education strategies for career development in clinical coding auditing*. Clinical coding auditor and Lecturer, La Trobe University, Bundoora, VIC

**Kay Richards** – *Meeting everyday challenges to obtain information on safety and quality*. Team Leader, Performance and Outcomes Service, Australian Council on Healthcare Standards, Sydney, NSW

**Carol Roughsedge** – *Rural and remote coders: The challenge of communication and education*. Casemix coordinator/FOI Officer, Whyalla Hospital and Health Services Inc, Whyalla, SA

**Morning tea**

10.30 – 11.00am

## Session 6

11.00am – 12.30pm

### Emergency issues

**Dr Didier Palmer** Director of Emergency Medicine, Royal Darwin Hospital, NT

**Other presentations to be confirmed**

**Lunch**

12.30 – 1.30pm

## Session 7

1.30 – 2.45pm

### Contributed papers

**Sameera Al Hashemi** – *Health care reform in the United Arab Emirates*. Coding and Statistics, Department of Medical Records, Shaikh Khalifa Medical Center, UAE

**Brian Stanley** – *Use of the encoder in Australian hospitals*. Lecturer, Curtin University, Perth, WA

**Jenny Seems** – *In record time*. Clinical Information Manager, Liverpool Health Service, Liverpool, NSW

**Andrew Wooding** – *PICQ and beyond: a stroll on the dark side of clinical coding*. Team leader, Clinical coding, Auckland City Hospital, Auckland, NZ

**Afternoon tea**

2.45 – 3.15pm

## Session 8

3.15 – 4.45pm

### Clinical update – Orthopaedic surgery

Presenters to be confirmed

4.45 – 5.00pm

**Official close**

\* The conference program is final but is subject to change due to any unforeseen circumstances

# Registration form

National Centre for Classification in Health Conference, 16–18 March, 2005 Perth

The University of Sydney ABN 15 211 513 464. This registration form can be used as a tax invoice. Please keep a copy.

One registrant per form. This form may be photocopied for additional registrations. This form is also available at [www.fhs.usyd.edu.au/ncch](http://www.fhs.usyd.edu.au/ncch)

Title (Prof/Dr/Mr/Mrs/Ms/Other)	Given name	Family name	
Preferred name for badge			
Position		Organisation	
Mailing address			
Town/suburb	State	Postcode	Country
Ph BH ( )	Fax ( )	Ph AH ( )	
Mobile	E-mail		
Special requirements			

Please tick the appropriate box. All prices are Australian dollars (\$AUD) All prices include GST

Full conference registration (includes attendance at social events)	Price
<input type="checkbox"/> Early bird – received and paid <b>before</b> 7 February 2005	\$ 616
<input type="checkbox"/> Standard – received <b>after</b> 7 February 2005	\$ 682
<input type="checkbox"/> Presenter <i>Presenter rate applies only to presenting authors. One person only per presentation</i>	\$ 550
<input type="checkbox"/> Student <i>Evidence of full time student status in a related discipline is required</i>	\$ 440

Day only registration (excludes attendance at social events)	
<input type="checkbox"/> Day registration	\$ 341
<input type="checkbox"/> Presenter <i>Presenter rate applies only to presenting authors. One person only per presentation</i>	\$ 275
<input type="checkbox"/> Student <i>Evidence of full time student status in a related discipline is required</i>	\$ 220

ICD-10-AM Fourth Edition post implementation education workshop registration	
<input type="checkbox"/> Full conference registrants	\$ 88
<input type="checkbox"/> All others	\$ 165
I will bring <input type="checkbox"/> ICD-10-AM bookset <input type="checkbox"/> ICD-10-AM eBook & laptop	

Social program (for day registrants and additional guests)	
<input type="checkbox"/> Welcome reception	\$ 60.50
<input type="checkbox"/> Conference dinner	\$ 121

**TOTAL** \$

If you have chosen full registration, please indicate if you will be attending the conference social events

- ☐ Yes! I will attend the welcome reception, Wednesday 16 March 2005  
☐ Yes! I will attend the conference dinner, Thursday 17 March 2005

## Payment

- ☐ I enclose my cheque (payable to NCCH) **Total \$** \_\_\_\_\_  
☐ Please charge my credit card **Total \$** \_\_\_\_\_ ☐ Bankcard ☐ Visa ☐ MasterCard

Card holder name \_\_\_\_\_ Expiry date \_\_\_\_\_ / \_\_\_\_\_

Card number

Signature \_\_\_\_\_



# ICD-10-AM Fourth Edition education program

The model created for Third Edition education activities in 2002 was refined and applied for Fourth Edition in 2004.

## Workshops

ICD-10-AM Fourth Edition workshops were offered as optional self-education activities following completion of the education package. The NCCH education team provided 33 ICD-10-AM Fourth Edition education workshops for 1,036 participants throughout Australia between April–June 2004. (1,286 people registered for the self-guided education program – 948 used information online and 338 requested the CD-ROM version).

The workshops are designed to provide education and information to clinical coders about changes to the classification, with particular emphasis on new and complex changes to the classification. Participants benefit from the opportunity to engage with other coders – many of whom share similar learning needs and challenges – and to learn from educators who are also the major architects of changes to ICD-10-AM. Many participants feedback that one of the most important – and hard to acquire – benefits is networking with other coders through workshop participation.

## Workshops data

State/territory	# workshops	# participants
NSW	12	335
Victoria	5	196
Queensland	6	189
Western Australia	3	91
South Australia	4	132
Tasmania	1	28
ACT	1	51
Northern Territory	1	14
<b>TOTAL</b>	<b>33</b>	<b>1,036</b>

## Workshops comments

Some comments about the workshops from participants include:

- Great initiative to have the on-line material before the workshops as it makes the day less daunting as information is already known
- Workshop handouts and answers great, allowed participants to refer to the answers after the exercises without having to madly write the answers down

- More use of diagrams needed to help clarify material being taught
- Quiz is a good way to get the brain ticking
- Set aside time to ask questions about changes not covered in the workshop
- Body piercing was extremely helpful – my teenager will be impressed with me!
- More workshops needed
- Hold workshops closer to implementation date
- Smaller workshops are more effective
- Appreciated the added clinical detail and background to changes

## Post implementation workshops planning

The feedback received from the workshops is being used as the basis for the development of material for the post implementation education program for 2005. The first post implementation workshop will be held 16 March 2005 in Perth before the NCCH conference.

Content for the workshop includes case scenarios and clinical record abstracts based on the major discussion areas gleaned from the Fourth Edition education program as well as queries generated since implementation. Topics include:

- anaesthesia
- injuries, obstetrics
- pain management
- and more

Participants will be required to code the case scenarios and clinical record abstracts prior to attending the workshop in order to gain the most benefit from attending.

Overall the education process for each new edition of ICD-10-AM continues to be beneficial for clinical coders. The process of providing this information to coders has been improved over the years with the opportunity for coders to meet face to face continuing to be a positive aspect. Logistic issues regarding the on-line material continue to be reviewed and further developed. Clinical coders overall felt that when the on-line material is combined with a workshop it provided a sound education program.

# International ICD-10

## course comes to Brisbane



Garry Waller teaching use of decision tables

From 16–27 August, fifteen hardy international students gathered at the Queensland University of Technology in Brisbane for an introductory training course in ICD-10. Regular *Coding Matters* readers know that the NCCH Brisbane team often conducts similar programs overseas, mainly in developing countries, but – for the first time – it was determined to run a course at home and invite participation from the Asia-Pacific region. We were delighted to welcome participants from:

- Palau – two representatives from the Ministry of Health in Koror
- Tonga – two participants from the Ministry of Health in Nuku'alofa
- Malaysia – two representatives of the National Heart Institute and one from the Ministry of Health in Kuala Lumpur
- Kiribati – one student from the Ministry of Health and Medical Services in Tarawa
- Japan – a representative from the Japan Hospital Association's HIM distance training program and a Japanese interpreter who is a doctoral student at the University of Queensland
- Papua New Guinea – two students from the Department of Health
- Indonesia – four students in total, from the National Institute of Health Research and Development, Jakarta, Rumah Sakit (Hospital) Cengkareng, the Provincial Health Department in Jakarta and the district health office in Surakarta, Central Java.

In addition to the ICD-10 education program, which was conducted by Garry Waller and Sue Walker, the students were able to visit the Australian Bureau of Statistics' Causes of Death Unit and the Health Information Services team at Queensland Health. A weekend cultural visit to Lone Pine Koala Sanctuary preceded by a boat trip along the Brisbane River was enjoyed by all.

The dynamics of such a diverse group and their various experiences made this course a very interesting and enjoyable two weeks for the NCCH folks. A review of the student

evaluations showed that they also found their time in Brisbane valuable, with over 80% rating the course content as very good or excellent, over 90% reporting similar results for course presentation and all students indicating that they enjoyed the chance to meet coders from other countries and discover that many of the problems experienced at home are common across the world.



The class with Sue Walker



Garry Waller and students in class

**This short report provides an update on the work of the WHO-FIC Education committee over the past twelve months with particular emphasis on the work progressed during a three day meeting in Prague, Czech Republic in May and at the annual WHO-FIC Network meeting in October 2004.**

The rationale for the Committee's work is the shared belief that there is a need for improvements in the quality of coded morbidity and mortality data and for upgrading the status of ICD coders, in particular in the so-called 'information paradox' countries. The WHO-FIC Network recognises that those regions of the world which have the greatest health problems are also those which have the poorest health information systems, hence the 'paradox' analogy. WHO believes that good health outcomes depend critically on the availability and use of good health information<sup>1</sup>.

The education committee is focusing its initiatives on:

- provision of standardised educational material
- promotion of opportunities for training
- development of recognition and certification processes
- advancement of best practices, and
- engagement and support of the international coding community

Work towards these plans was progressed at the Prague meeting taking advantage of a number of members of the education committee being in that city for a workshop run by the International Collaborative Effort on Automated Mortality Coding and a subsequent meeting of the WHO-FIC Mortality Reference Group. The Committee was able to discuss the initial results of an international needs assessment survey auspiced by the group.

In early 2004, the WHO-FIC Education Committee distributed a survey to WHO member states to request information about the international coder workforce. Designed to collect data about morbidity coders and mortality coders separately, the survey included questions about the implementation and use of ICD-10, perceived barriers to implementation, characteristics of people who perform the coding function, coders' roles and responsibilities, educational backgrounds of coders and how coding training is obtained, proficiency levels, views about the development of an international credentialing process for coders and additional support required to promote coding in each country. The surveys were distributed

and returned in English, French, Spanish and certain other official WHO languages. The final results of the survey, presented at the 2004 WHO-FIC Network meeting in Reykjavik, Iceland, are being used in the further refinement of the education committee's work.

Substantial progress was also made during the Prague meeting on defining core curricula for underlying cause-of-death coders and morbidity coders and on developing a business plan for standardised ICD-10 training and international certification. It was determined that a full credentialing program is beyond capacity of the education committee but a workable solution for standardising recognition of coder education and skills was developed. The basic building blocks of the certification program are:

- development of a recognised pool of approved coding trainers. It is proposed that trainer qualifications be assessed by a joint WHO-FIC/IFHRO committee currently being established. It was noted that the trainer may be affiliated with an existing educational institution or may be an individual
- identification of approved training materials. The joint committee is to finalise criteria for the assessment of training materials, based on the core curricula requirements developed by the education committee. Training materials identified as meeting this gold standard will form the basis for the certification program, with coders who have completed training which is conducted using such materials being eligible for the international certification. The core curricula are grouped into related modules and training materials will be assessed according to the degree to which they meet the requirements of each module. It will not be mandatory for coders to study all modules from a single educational institution or individual trainer, although this may be advantageous. Coders will be at liberty to select different approved modules from different educational suppliers, depending on their circumstances. It is anticipated that there will be multiple sources around the world for education based on the gold standard materials
- to be eligible to receive the award of the international certificate, coders will need to submit evidence of completion of the full curriculum (that is, of each of the required modules) to an assessment committee, which is yet to be established
- the target date for awarding of the first international certificates is 2007, hopefully to coincide with the next IFHRO congress to be held in Seoul, Korea



The purpose of the business plan developed in Prague was for presentation to the Grand Council meeting of the International Federation of Health Records Organizations (IFHRO) before the IFHRO Congress in October 2004. The WHO-FIC Network sought cooperation and collaboration from IFHRO in the development of the international certification program and gained positive feedback from the Grand Council on the venture. It is hoped that IFHRO will also be able to provide an organisation with which coders can affiliate, particularly in countries where there are no local HIM or clinical coder associations. The WHO-FIC education committee is excited by the prospect of working with IFHRO, because it is felt that the organisations which represent IFHRO member countries have closer links to coders and health information managers than the Education committee does. These links will be vital in promoting the certification program and in encouraging participation by coders.

The education committee terms of reference also include identifying groups requiring education and training in the proper completion of source documents (such as death certificate, health record). During the meeting, it was agreed that there needs to be a curriculum for training the people who provide the mortality and morbidity information that is coded (for example, certifiers of cause of death, clinician who document in hospital records). This idea was progressed in Reykjavik, with several papers presented regarding local experiences in educating data suppliers. Further work on this aspect will be developed during 2005.

## Reference

WHO: The Health Metrics Network, *Improving health information systems; Empowering local decision makers*.  
<http://www.who.int/healthmetrics/en/> accessed 23.11.04

## Example of the knowledge clusters to be included as modules in the core curriculum for morbidity coders

*This is not the final draft of the curriculum and may be subject to change as work progresses*

- biomedical sciences
  - medical terminology
  - basic anatomy and physiology
  - pathophysiology and disease processes
  - pharmacology
- legal/ethical issues relevant to the country in which coding is being performed
  - privacy and confidentiality
  - release of information
  - professional ethics
- users of morbidity data
- healthcare delivery systems
- healthcare data content and structure
  - content of the health record
  - documentation requirements
  - minimum data sets
  - source documents
- general uses of morbidity data
- specific uses of morbidity data
- the International Classification of Diseases
  - nomenclature and classification
  - international context, including the Family of International Classifications
  - standardisation and comparability
  - history of the classification
  - development of clinical modifications
  - structure of the classification
  - updating mechanisms
- how to code
  - ICD volumes
  - coding rules, instructions and conventions
  - coding guidelines or standards
  - sequencing
  - definitions
- quality assurance considerations and techniques



### Sharing solutions in the global community

To the beat of the drum, sound of the fife and presentation of flags, the IFHRO/AHIMA convention got underway in grand style at the Washington DC convention centre on Monday 11 October 2004. For the 400-plus attendees, this was an event to remember. The AHIMA was a gracious and welcoming host organisation and the convention had international experiences and educational opportunities for all. Having heard and read about AHIMA conventions for many years, this was my first chance to be part of one – and I wasn't disappointed. It was also my third IFHRO congress, following the very successful Melbourne experience in 2000 and the wonderful Munich assembly in 1996. Having such a variety of international colleagues present added a distinctly different flavour to discussions about HIM matters.

The convention week actually began for me the weekend prior to the convention, with the IFHRO General Assembly meeting conducted on Saturday. At the meeting, I was privileged to hear the strong support of IFHRO member countries for the work of the WHO-FIC Education Committee, following presentation of the business case for a proposed training and certification program by the chair of the committee, Marjorie Greenberg. I believe that the collaboration between IFHRO and the WHO-FIC Network is a natural alliance and will have mutual benefits. IFHRO representatives will bring the 'real life' perspective on health information collection and processing issues to the WHO-FIC and the WHO-FIC will provide the view of researchers, policy-makers and other users of the coded data.

On Sunday, I attended a day-long workshop, entitled 'Health information management education in a global community'. The discussions regarding the education of new generations of HIMs were interesting. The challenges of changing workforce requirements, shifting roles and responsibilities, reviews of higher education offerings, the need to increase research output, the challenges imposed by accreditation and certification of HIM professionals, the need for ongoing professional development and changes in career opportunities were all highlighted by panels of expert educators. Much of the focus was on the further development of educational programs in developed countries and, whilst there is an obvious need for this, it served to reinforce for me the differences in educational opportunities for practitioners in less well-resourced or developed countries. The chance to have informal discussions about such issues with fellow attendees was provided at a pleasant educators' reception, followed by an international reception that evening, hosted to welcome delegates from overseas.

From Monday to Wednesday, conference sessions – both plenary and breakout – were available and it was a difficult choice to decide which sessions to attend. Highlights for me included

- an update on the state of play in the US regarding the ten-year strategy for the adoption of EHRs from David Brailer, newly-appointed National Health Information Technology Coordinator
- an inspiring presentation from Dr Bernard Kouchner, the founder of Médecins sans Frontières, in which he challenged the audience to consider some form of global health insurance to ensure access to basic health services to everyone in the world, including the poor. His belief is that the most important code in the ICD-10 is Z59.5 *Extreme poverty* which he thinks represents the underlying cause of the majority of the world's leading health problems
- updates regarding ICD-10 implementation, or plans for implementation from a global perspective
- health informatics, technology and EHR updates
- a fabulous presentation regarding genomics and future of medicine from Dr Francis Collins, Head of the Human Genome Research Institute Project – including the singing of some of his own compositions about HIMs and genomics, self-accompanied on the guitar
- sessions regarding data quality
- a variety of educational tours

In addition to the educational sessions, an amazing exhibition with hundreds of vendors was a great attraction – particularly those vendors offering diamond bracelets or \$500 (in US dollars) as prizes for visiting their booths and listening to the spiel! Although I was not successful in winning such a lavish prize, it was fairly mind-blowing to wander through the exhibition floor to see the variety of offerings, from off shore transcription services to medical reference books to various IT systems to educational opportunities. The AHIMA booth was always busy, with a variety of HIM products and services available for sale. As those of you who know me well are aware, I'm a bit of an exhibition booth junkie and I came away with far too many freebies – stress balls, pens, note pads, sewing kits, post-it notes, balsa wood model planes, key-rings...

On the Tuesday evening, delegates were wined and dined at the President's Premier Celebration. Held at the Ronald Reagan International Trade Centre, the evening began with obligatory passport checks and bag searches – remember, this was just before ►►►

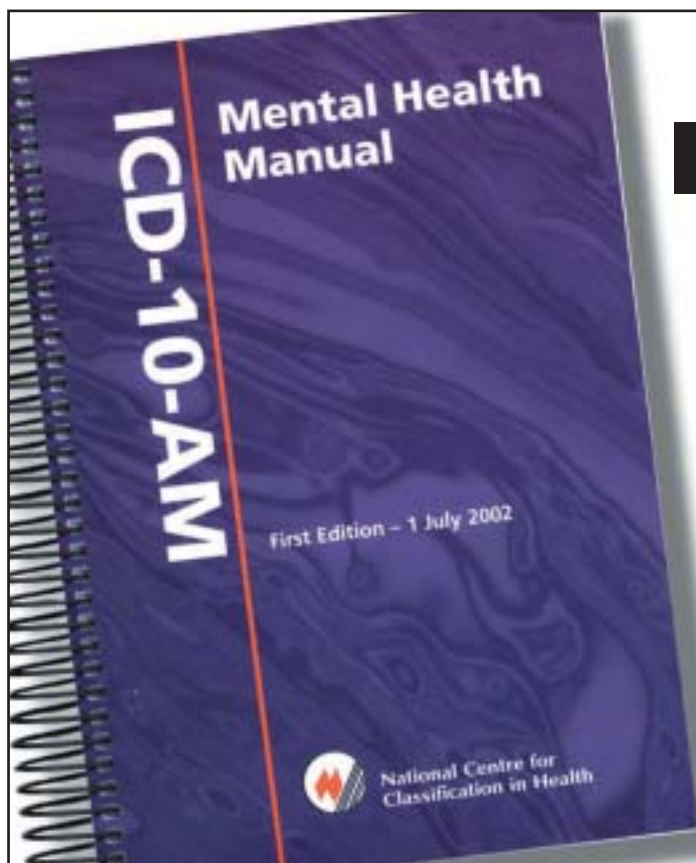
the US presidential elections and Washington was on high alert. Having passed that small obstacle, we were welcomed to a variety of international foods and the opportunity to mingle and chat with other attendees. This was followed by dancing on the large marble dance floor. The Australian contingent – around 10 of us – showed other folks what we were made of following a request to the DJ for Men at Work's 'Down Under'.

It wasn't all fun and games however. NCCH staff made several presentations during the week. Rosemary Roberts spoke on Monday as part of an international panel, giving the Australian experience with the implementation and use of ICD-10. On the same panel was Deirdre Murphy representing Ireland, explaining the decision to use ICD-10-AM in that country beginning in 2005. Lauren Jones, who is currently the Project Manager for CATCH, presented in a data quality breakout session, describing a pilot study which explored the accessibility and comparability of hospital morbidity data from several countries. My first presentation was a report of a comparative study of coder workforces in the US, Canada, the United Kingdom and Australia conducted by NCCH Brisbane in collaboration with AHIMA, the Canadian Institute for Health Information and the UK's National Health Service. Kirsten McKenzie was principally responsible

for the analysis for this study, but was unable to attend the congress. On the Thursday after the end of the congress, an Institute on Health Classifications and Vocabularies was held and both Rosemary Roberts and I were invited speakers. Many of our WHO colleagues were also presenters at the Institute, which provided sessions on the WHO international classifications and plans for future development, uses of classifications and terminologies in computerised information systems, how national classifications are developed and maintained, and how IFHRO and the WHO-FIC network are working together to support coders and data producers. The final hour of the Institute was devoted to general discussion providing the opportunity for brainstorming and exploration of ideas for upgrading HIM professional skills to ensure quality morbidity and mortality data.

Overall, the week was full-on and tiring but equally, stimulating and exciting. It reinforced the belief that Australia is one of the world leaders in the use of classifications and increasingly, in understanding the role of terminologies and vocabularies in communicating, sharing and using health information.

*Sue Walker*  
*Associate Director*  
*Brisbane*



## **ICD-10-AM**

### **Mental Health Manual**

The ICD-10-AM Mental Health Manual is a diagnostic and coding manual with WHO diagnostic guidelines and codes from the core classification ICD-10-AM

The Manual offers a common language for describing and coding mental health conditions and interventions wherever mental health services are provided

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# PCS/E conference

Budapest, Hungary 27 – 30 October 2004

**Patient Classification Systems – Europe (PCS/E) is the annual conference convened by the Association to share casemix-related information, experiences and to explore new concepts. The conference attracts participants from throughout Europe and the rest of the world.**

The Budapest conference was attended by about 250 people from 30 countries. An interesting statistic presented by PCS/E President, Céu Mateus, is that only about 40 participants were native English speakers. All conference presentations are made in English. The largest contingent – about 25 people – came from Sweden, with substantial contingents from Hungary, Romania, the Netherlands, Portugal, Slovenia, Denmark and Bulgaria. Eight Australians attended the conference. Kerry Innes and Ann Jones represented NCCH at the conference.

For many delegates, casemix is a relatively new concept, which in many cases, has been implemented to first meet financial management issues. In both casual conversation and in formal presentations, Australia was often cited as a major force in the development of casemix components. Many lessons learned in Australian implementation and development is now informing decisions about best casemix practice internationally.

Another major impetus for health system reform for many nations represented at the conference is political change. Romania, Slovenia, Bulgaria and Hungary, for example, have all experienced significant shifts from socialist to capitalist government structures in the late twentieth century. For other regions, the previously fragmented model is being unified.



## Hot topics

Some of the topics discussed during the conference included:

- coding audits
- coding standards
- coding quality
- who should code – clinicians or coders?
- international developments of procedure classifications
- up coding surveillance
- disease staging and its implications for casemix
- international DRG variants
- implementation of DRG systems internationally
- levels of invasiveness (LOI) and developing effective cost measures

## PCS/E General Assembly

At the General Assembly, Mr Chris Aisbett was elected Asia/Pacific representative on the PCS/E Executive Committee. Chris will take over from Dr Terri Jackson.

A proposal was made to amend the association's name to 'Patient Classification systems – International' (PCS/I) in order to better reflect the increasing globalisation.

## Forthcoming events

PCS/E will next be conducted in Ljubljana, Slovenia, 5-8 October 2005. Visit <http://www.pcse.org> for more information.

The 2005 casemix summer school will be conducted in Trieste, Italy, 6–10 June 2005.

The city of Budapest provides some visual clues about the level of reform the country has experienced and is continuing. The evidence of the wealth of the Austro-Hungarian Empire, although a little faded in some instances, is counterbalanced by Soviet era monuments and buildings. And through it all the Danube is still very much a working river, and not very blue in October.



## Japan Hospital Association meeting

In September 2004, Sue Walker was privileged to receive an invitation from the Japan Hospital Association (JHA) to give a keynote presentation at the annual meeting of the JHA, held in conjunction with the thirtieth anniversary of the Japanese Society of Medical Record Administration. The meeting was held in Chiba, just south-east of the centre of Tokyo. The invitation was extended because of the collaborative work being conducted by Sue, Yukiko Yokobori and other international colleagues for the WHO-FIC Education Committee. Yukiko is the head of the JHA's distance education program which has graduated nearly eight and a half thousand HIMs since it was first established in 1972.

Sue's presentation, before an audience of over 1,400, discussed the HIM profession in Australia, including education for HIMs, the work of the HIMAA in setting educational standards, employment opportunities and the diversity of prospects available to Australian HIM graduates. The majority of Japanese HIMs work in hospitals, with only a small percentage working in other data management roles or in computer companies. The recent adoption of a case-based

payment system known as the DPC (Diagnosis Procedure Classification) by the Japanese Ministry of Health has thrown the spotlight on HIMs and their coding skills, with nearly 40% of HIMs responsible for coding. Currently 57% of hospitals in Japan use ICD-10, as recommended by the JHA, 36% use ICD-9-CM and 7% use other classifications.

In addition to the presentation, Sue participated in a panel discussion with Dr Moriyo Kimura, Director of the ICD Office in the Ministry of Health, Labour and Welfare and Dr Shuzo Yamamoto, President of the JHA. This discussion related to the work of the WHO-FIC Education committee and the development of the international standard curriculum for educating clinical coders.

### Reference

Toshio Ohi, Yukiko Yokobori, Syuzo Yamamoto, Moriyo Kimura, *The results of questionnaire survey of health information manager in Japan* Paper # WHOFIC/04.086 WHO-FIC Network annual meeting, Reykjavik Iceland, October 2004





# The **Good Clinical Documentation** guide

Your guide to  
the best  
medical records

The **Good clinical documentation guide** helps clinicians to recognise critical elements they need to document to reflect the patient care process, to communicate, report and provide clear data for research and quality of care monitoring.

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The specialty chapters feature:

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- documentation pointers for each topic
- AR-DRG version 5.0 information where relevant
- examples of the impact documentation has on DRG assignment where DRG variances can be illustrated

The guide is provided as an Adobe® Acrobat® file on CD-ROM and features electronic navigation between topics and concepts. The guide is printer-friendly.

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e-mail [ncchsales@fhs.usyd.edu.au](mailto:ncchsales@fhs.usyd.edu.au)



from us all at the NCCH  
*Seasons  
Greetings!*

and a prosperous New Year



**coding  
matters**



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**National Centre for Classification in Health**

#### **NCCH (Sydney)**

Faculty of Health Sciences, The University of Sydney  
PO Box 170 ph: 02 9351 9461  
Lidcombe NSW 1825 fax: 02 9351 9603  
Australia e-mail: [r.bernard@fhs.usyd.edu.au](mailto:r.bernard@fhs.usyd.edu.au)

#### **NCCH (Brisbane)**

School of Public Health, QUT  
Victoria Park Rd ph: 07 3864 5809  
Kelvin Grove QLD 4059 fax: 07 3864 5515  
Australia e-mail: [ncch.brisbane@qut.edu.au](mailto:ncch.brisbane@qut.edu.au)

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La Trobe University  
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## CODING AUDITING – SHORT COURSE

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**Module five** - audit outcomes - reporting and strategic development

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# WHO-FIC meeting, October 2004, Reykjavik, Iceland



Lindy Best and friendly locals, Reykjavik



l-r Marjorie Greenberg, North American Collaborating Centre; Lindy Best & Rosemary Roberts, Australian Collaborating Centre



l-r Sue Walker, Rosemary Roberts and Richard Madden, skyline, Reykjavik



Cold? You bet. Sue Walker enjoying sub zero conditions at Gullfoss





# CONFERENCES 2005

13-17 February	HIMSS 2005 (Health Information and Management Systems Society)	Dallas, Texas, USA	<a href="http://www.himss.org/">www.himss.org/</a>
23-25 February	The 6th National Allied Health Conference	Melbourne, VIC	<a href="http://www.sapmea.asn.au/conventions/alliedhealth/">www.sapmea.asn.au/conventions/alliedhealth/</a>
25-27 February	14th Annual Conference on Health Informatics in NSW	Pokolbin, Hunter Valley, NSW	<a href="http://www.hisansw.org.au">www.hisansw.org.au</a>
9 March	Health-e-Nation	Sydney, NSW	<a href="http://www.health-e-nation.com.au/">www.health-e-nation.com.au/</a>
10-13 March	8th National Rural Health Conference	Alice Springs NT	<a href="http://www.nrha.net.au/nrhapublic/publicdocs/conferences/8thNRHCThemes.htm">www.nrha.net.au/nrhapublic/publicdocs/conferences/8thNRHCThemes.htm</a>
13-16 March	15th National Health Promotion Conference	Canberra, ACT	<a href="http://www.healthpromotion.act.gov.au/news/conferences/AHPA2005.htm">www.healthpromotion.act.gov.au/news/conferences/AHPA2005.htm</a>
16-18 March	NCCH Conference 2005	Perth WA	
18-20 March	2nd International Conference on Healthy Ageing and Longevity	Brisbane, Qld	<a href="http://www.longevity-international.com/">www.longevity-international.com/</a>
19-20 March	European Federation of Medical Informatics	Athens, Greece	<a href="http://ghia.nurs.uoa.gr/efmi%2Dsrc2005/index.asp?page=general_info">http://ghia.nurs.uoa.gr/efmi%2Dsrc2005/index.asp?page=general_info</a>
21-23 March	Healthcare Computing Conference	Harrogate, North Yorkshire, UK	<a href="http://healthcare-computing.co.uk/index.html">healthcare-computing.co.uk/index.html</a>
26-28 April	International Conference and Exhibition on Health Communication	Kuala Lumpur, Malaysia	<a href="http://www.aidcom.com/HealthCom05.htm">www.aidcom.com/HealthCom05.htm</a>
12-13 May	Ethics in Human Research Conference 2005	Canberra, ACT	<a href="http://www.communicationlink.com.au/ethics/main.aspx">www.communicationlink.com.au/ethics/main.aspx</a>
26-28 July	2005 General Practice & Primary Health Care Research Conference	Adelaide, SA	<a href="http://www.adgp.com.au/site/index.cfm?PageMode=indiv&amp;module=EVENT&amp;page_id=3629">http://www.adgp.com.au/site/index.cfm?PageMode=indiv&amp;module=EVENT&amp;page_id=3629</a>
30 - 2 September	8th Australian Palliative Care Conference 2005	Sydney, NSW	<a href="http://dcconferences.com.au/pinp2005/">dcconferences.com.au/pinp2005/</a>
25-28 September	36th Public Health Association of Australia Annual Conference	Perth, WA	<a href="http://www.phaa.net.au/">www.phaa.net.au/</a>
5-8 October	PCS/E	Ljubljana, Slovenia	<a href="http://www.pcse.org/">www.pcse.org/</a>
10-11 October	25th Annual APHA National Congress	Melbourne, VIC	<a href="http://www.apha.org.au/media_files/2378040505">www.apha.org.au/media_files/2378040505</a>

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

# Welcome Irish coders!

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