coding matters

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

Volume 7 Number 3 **December 2000**

from the desk of the director

The second half of the year is traditionally filled with conferences, and of course the year 2000 has been no exception, despite an interlude for the Sydney Olympics.

NCCH took its new look display Instand to the Casemix Conference in Cairns (27–30 August), to the Health Informatics Conference in Adelaide (3–5 September) and to the International Federation of Health Records Organizations (IFHRO) Congress in Melbourne (2–5 October). It did not come with us to Rio de Janeiro. Instead I was accompanied by Kerry Innes and Sue Walker from NCCH with Richard Madden, director of AIHW heading the Australian delegation to the annual meeting of WHO Heads of Collaborating Centres (HOC) for Classification of Diseases (16–20 October).

Apart from exhibiting at the first three conferences, NCCH representatives presented papers ranging from issues to do with:

- Updating ICD-10 (Rosemary Roberts and Sue Walker at IFHRO)
- Development, implementation and maintenance of ICD-10-AM (Karen Peasley at IFHRO)

Sue Walker, Kerry Innes and Rosemary Roberts at the WHO meeting in Rio de Janeiro

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PRINT POST APPROVED PP224709/00038

- Post-procedural complications (Julie Rust at Casemix)
- PICQ and ACBA (Donna Truran and Lai-Mun Balnave at Casemix) and
- Comparison of electronic formats to hold ICD-10 (Sue Walker at HIC).

The conferences allowed NCCH to reveal new products and to discuss with coders and health information managers current issues in coding and terminology development. IFHRO brought new international contacts and refreshed old ones. Following the Congress, Linda Kloss from the United States and Deirdre Murphy from Ireland visited NCCH Sydney to discuss classification policy and practice in our respective countries (see photos).

The meeting in Rio was, of course, memorable and not only for the lime meringue pie. The HOC group is relatively small (20–30) but covers 11 centres and offices (some of the participants appear in the photo collage on page 3). It's

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National Centre for Classification in Health

NCCH (Sydney)

Faculty of Health Sciences, University of Sydney
PO Box 170 ph: 02 9351 9461
Lidcombe NSW 1825 fax: 02 9351 9603
Australia email: r.bernard@cchs.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 email: s.walker@qut.edu.au

NCCH Quality and Education Division

School of Public Health
La Trobe University ph: 03 9479 1135
Bundoora VIC 3086 fax: 03 9479 5657
Australia email: s.watts@latrobe.edu.au

Homepage http://www.cchs.usyd.edu.au/ncch/

Editor: Rodney Bernard
Typesetting: Rodney Bernard ISSN 1322-1922

Coding Matters *is the quarterly newsletter of the National Centre for Classification in Health (NCCH). NCCH (Sydney) is funded by the Casemix Program, Commonwealth Department of Health and Aged Care (Health). NCCH (Brisbane) is funded by the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the Queensland University of Technology.*

Linda Kloss, American Health Information Management Association (AHIMA) Executive Vice President/CEO

always a great opportunity to compare notes internationally, especially on the introduction of ICD-10, but also on clinical modifications, procedure classifications, education, electronic tools and the place of ICD in the WHO Family of Classifications. The Update Reference Committee met during the week to review recommendations for change to ICD-10 from the Collaborating Centres. I now chair this committee, which I could not do without support from Kerry Innes and Michelle Bramley who do much of the hard work associated with international communication and screening and dissemination of suggested updates. This year, 64 recommendations were considered, with 30 being supported, 11 rejected, 10 held over for further work and 13 referred back to WHO. Those that are accepted are posted on the WHO website for introduction in subsequent years, depending on the designation of the change as Major (every three years) or Minor (every year).

Other International Visits

For four weeks during September, Megan Cumerlato undertook a WHO consultancy in the Cook Islands, teaching ICD-10 and TENDON for the Western Pacific Regional Office of WHO. Meanwhile, Sue Walker and Debbie Abbott were working in the Kingdom of Tonga fulfilling a contract for AusAID in a training program again for ICD-10, medical documentation and terminology. These and other teaching commitments in the region continue to demonstrate the recognised expertise in Australia in ICD-10 and health information management.

Coding Standards Advisory Committee

This group met on 20 November in Sydney. On the agenda were issues relating to ICD-10-AM Third Edition including outcomes from the Classification Update Forums and public submissions.

General Practice

As mentioned in the last edition of *Coding Matters*, the GP Coding Jury has recommended that ICD-10-AM be the Australian standard for general practice coding, at least in the short

Postcard from Rio

l-r Lynn Bracewell, Rosemary Roberts, Donnamaria Pickett, Kerry Innes, Michael Schopen and Arun Nanda

Rio hosts Ruy Laurenti and Cassia Buchalla, WHO Collaborating Centre for Classification of Diseases

Christ the redeemer impression by Richard Madden, Director AIHW

term (five years). A seminar to discuss the implications of the decision was to have been held in early November but has now been delayed. Meanwhile NCCH, in conjunction with relevant organisations, is seeking funds to support fine-tuning of ICD-10-AM content and format for application in general practice.

Quality and Education

NCCH Sydney is not quite the same without Karen Peasley who has ventured south to help establish the Quality and Education Division of NCCH at La Trobe University in Melbourne. Karen's move has triggered the merger between quality and education, as well as the appointment of a Quality and Education Coordinator who will also be based at La Trobe. NCCH is extremely pleased to welcome Shannon Watts to this position, commencing late November. Although Karen will maintain her title as Quality and Education Manager, she will carry out this role for only one fifth of her life, the other four fifths being devoted to the Monash University National Centre for Coronial Information (MUNCCI). At MUNCCI, Karen will fill a newly created position of Quality Officer to implement the quality assurance plan for data supplied to the National Coroners Information System.

Irene Kearsey will continue to work half time in the division, on secondment from the Department of Human Services, Victoria. The injection of new staff to the division comes with the release of the electronic version of ACBA (ACBA 2000™) and PICQ 2000™ which now has about 100 indicators and a comprehensive user guide. The division will provide consulting and education services to users of PICQ and ACBA and help strengthen the cycle which identifies problems using quality measures and addresses the results through education.

Professional Relativities Study

The Professional Relativities Study, part of the Relative Value Study being carried out by NCCH for the Medicare Schedule Review Board, is drawing to an end. A draft report has been prepared for the November Board meeting and it is expected that the project will be completed by the end of this calendar year. Richard Juckes, on secondment from the Department of Health and Aged Care, Patricia Saad and Imelda Noti have formed an impressive team at NCCH, supported with statistical input from George Rennie and OR Systems in Melbourne. The project has lasted for over three years, so it is a real milestone to be able to bring it to a close.

National Centre for Classification in Health
(in conjunction with Clinical Coders' Society of Australia)

the language of health

7th Biennial Conference

1–3 April 2001
Landmark Parkroyal,
Sydney, New South Wales

INVITATION TO ATTEND

The NCCH staff and CCSA board members are pleased to invite you to attend the 7th Biennial NCCH Conference (in conjunction with CCSA) in Sydney, New South Wales.

Conference Theme

The conference theme, 'the language of health' will focus on issues such as the emergence of the electronic health record, terminologies and vocabularies, data quality, health information and classification technologies, clinical coder workforce and education issues.

Conference Structure

The conference will employ a range of formats including keynote address from Dr Chris Chute (Health Science Research, Mayo Clinic and Foundation, Rochester, USA), plenary sessions and a practical workshop.

Conference Schedule

Program and registration material published	**December 2000**
Conference	**1, 2, 3 April 2001**

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.

Venue

Landmark Parkroyal Hotel, 81 Macleay Street, Potts Point, Sydney, New South Wales. The conference venue is located in the heart of cosmopolitan Potts Point and only a few minutes ride from the CBD of Sydney. Find out more at the website: www.parkroyal.com.au

Accommodation and Travel

SBT Business Travel Solutions will once again be handling all the travel and accommodation requirements. Reduced rates will be arranged for many flights with the two major airlines and a variety of accommodation options will be available.

Social Program

Included in the registration fee will be the Welcome Reception and the Conference Dinner.

Sponsorship and Display

Enquiries regarding sponsorship and display opportunities at the NCCH 7th Biennial Conference should be directed to Karen Peasley on the contact details noted below.

Further Information

Karen Peasley,
Quality and Education Manager
NCCH, Quality and Education Division
School of Public Health
La Trobe University
Bundoora VIC 3086
Ph: 61 3 9479 1135 Fax: 61 3 9479 5657
E-mail: k.peasley@cchs.usyd.edu.au
Website: www.cchs.usyd.edu.au/ncch/

the language of health

I-r PRS team Imelda Noti, Patricia Saad, Richard Juckes and Rosemary Roberts

Review of National Health Data Dictionary

Kerry Innes, Sue Walker and I were interviewed by John Lewis, KPMG Consulting, as part of the Review of the National Health Data Dictionary. A Draft Report was released in October.

NHIMG Expert Group on Health Classifications

As foreshadowed in the last edition of *Coding Matters*, this group has been established and will hold its first meeting in Canberra on December 14. Sue Walker, Kerry Innes and I will represent NCCH.

Conclusion

It seems far too early to be conveying good wishes for the holiday season. But they come with much warmth and thanks to all our readers for their contribution to and support of NCCH throughout this landmark year.

Rosemary Roberts
Director

PROFILE

ESRI

The Economic and Social Research Institute (ESRI) of Ireland is a non-profit organisation which was founded in 1960 as the Economic Research Institute with the help of a grant from the Ford Foundation of New York.

The fundamental aim of the organisation is to bring the latest thinking in economics and the social sciences to bear on the actual and potential problems of Irish society. The research program covers a broad range of topics including economic forecasting and modelling, public finance, the labour market, social exclusion, the environment, education and health.

The ESRI, in association with the Department of Health and Children, is engaged in the collection, processing and analysis of data for the Hospital In-Patient Enquiry (HIPE) which operates in all acute hospitals nationally. HIPE was started on a pilot basis in1969 and then expanded and developed as a national database of coded discharge summaries from the 1970s onwards. It is the only source of morbidity data available nationally for acute hospital services in Ireland

The HIPE Unit is responsible for:

- training of coders
- monitoring of data quality
- providing assistance and training to hospitals on the use of the HIPE software and production of reports
- development and management of HIPE National Files
- case mix classification of hospital activity data

I-r Rodney Bernard, Rosemary Roberts, Kerry Innes, Deirdre Murphy, Coding Manager, ESRI, and Karen Peasley

- providing data and statistics from the HIPE National Files to the Department of Health and Children and other relevant agencies nationally and internationally

HIPE is a computer-based discharge abstracting system designed to collect demographic, clinical and administrative data on discharges and deaths from acute general hospitals nationally. Each HIPE discharge record represents one episode of care.

All the data collected is coded in a standardised format for computer input and for subsequent analysis of the data. The most specialised aspect of this process is the coding of the diagnoses and procedures performed, using The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). A national database of all HIPE discharges is maintained by the HIPE Unit for each year since its inception.

Deirdre Murphy
Coding Manager, ESRI

vital signs

I have just returned from Rio de Janeiro where I attended the annual WHO Heads of Collaborating Centres for the Classification of Diseases meeting. NCCH Brisbane presented two papers at that meeting. One was written by Caroline Stahl which described two methods of maintaining ICD-10 electronically (the Microsoft Access database utilised by the NCCH and an SGML program used by the German Institute for Medical Documentation and Information). The second paper by Maryann Wood and Jamie Stewart from the ABS related to query action undertaken by the ABS to obtain good quality death certificate data to enable accurate coding of causes of death.

As well as the scientific papers, I participated in a meeting of the Mortality Reference Group, the ICD-10 Implementation Committee and the Training and Credentialling subcommittee. This latter subcommittee has established a joint working party with the International Federation of Health Records Organizations (IFHRO) to begin work on standards for international coding education for morbidity and mortality coders. Ultimately recommendations for an international certification or accreditation process will be made. I have been asked to co-chair this committee and to liaise between both groups. I also acted as one of two 'chief rapporteurs' with Susan Cole of Scotland. We ensured that the minutes of the meeting were available for review prior to the end of the meeting.

Debbie Abbott was interviewed by Tongan TV about the course

Medical terminology course participants and officials

Following the meeting Kerry Innes and I had a wonderful three-day holiday at Iguassu Falls – what an awesome place!

Training in Tonga

Before the WHO meeting, Debbie Abbott (a member of CEN International) and I spent two weeks in the Kingdom of Tonga, conducting a training course on behalf of AusAID. The course included one week of medical terminology, two one-day workshops on clinical documentation, and a four-day Introduction to ICD-10 program. The 74 students included medical record and health information department staff for the medical terminology and coding subjects and medical and nursing staff for the clinical documentation component. As well as Tongan students, we were delighted to welcome two students from Papua New Guinea to the course.

NCCH Brisbane has also recently nominated another member of CEN International – Kathy Baxter – to conduct an ICD-10 workshop in Bangladesh on behalf of WHO/SEARO. Negotiations for this course are continuing and it is hoped that it will be run in late November.

International Federation of Health Records Organizations (IFHRO)

In between overseas trips, I spent a week in Melbourne attending the Congress and associated Executive, Grand Council and Education committee meetings. NCCH was well represented on the congress program and I was delighted to meet up with several current and former NCCH international students. Jenny Nicol (from QUT) and I met with some of the current

Students from PNG, Ika Rouka and Iruna Veropo

Monika Ketu'u, coding clerk, Tongan Ministry of Health

cohort of Singaporean students to discuss phase II of our training program, which includes Introduction to Casemix, Casemix for Managers and Health Sector Management. It is planned to begin development work of this phase in early 2001. Current students are completing Medical Terminology and Introduction to Clinical Classification subjects, and will move on to Introductory or Advanced Clinical Classification respectively, assuming success in their examinations.

ACBA training results

In the last issue of *Coding Matters*, I reported on the quality assurance workshop held in Brisbane, with students from Thailand and Sri Lanka. Since then, ACBA audits have been carried out in both countries and reports sent to WHO and NCCH by team leaders Dr Krissada Raungarreerat (Thailand) and Dr Sunil Senanayake (Sri Lanka). The audit results from the four hospitals indicate relatively high error rates – ranging from 37.5% to 77.5%. Problems highlighted include missing codes due to coding from front sheets, rather than reviewing the entire medical record, and use of unjustified additional codes, such as signs and symptoms where a definitive diagnosis has been made.

Overall, ACBA was rated highly by both teams, with reports to the NCCH indicating that 'ACBA is fairly simple and a very sensitive auditing tool. It measures what it is intended to measure with a high degree of accuracy'. Recommendations from the project include adding an additional system error category for countries that only code a single condition and the translation of the programs and manuals into local languages. Periodic auditing of morbidity data has been recommended to the WHO regional office. It is hoped that an audit will be conducted to compare the quality of coding performed by NCCH-trained coders and others.

New staff

On 6 November, NCCH Brisbane was delighted to welcome Garry Waller as our new Senior Classification Officer. Garry, a qualified health information manager who graduated from QUT, has just returned from twelve months travelling around Australia with his wife.

Garry Waller

He has held positions as Deputy HIM at Lismore Base Hospital, HIM Consultant at the Royal Far West Children's Health Scheme and HIM/Clinical Coder for Prime Care Pty Ltd. Garry will be working primarily with the Causes of Death Unit at the ABS and the new Education and Quality Division staff. Welcome Garry!

Sue Walker
Associate Director, NCCH Brisbane

educational matters

The Education Division has been on the move, south of the border to Melbourne, to merge with the Quality Division to become the NCCH **Quality and Education Division**.

The new office is based at the School of Public Health, Faculty of Health Sciences, La Trobe University at Bundoora. I have expanded my current role and taken on the management responsibility of both the Quality and the Education divisions. I also commenced a secondment as the Quality Assurance Officer at the Monash University National Centre for Coronial Information (MUNCCI) four days per week. Irene Kearsey retains her current secondment position of Senior Quality Officer, five days per fortnight. The most recent appointment is Shannon Watts, in the newly created Quality and Education Co-ordinator position.

Shannon is a La Trobe-qualified health information manager who has worked in a regional HIM position in South Australia. Her most recent position was with the Victorian Department of Human Services. Shannon's tasks will overlap both the Education and Quality Divisions. Her first main role will be the continuation of the organisation of the NCCH 7th Biennial Conference. Over the next few months the NCCH Sydney office will be handing over all of the work related to the continuing development and maintenance of the ACBA and PICQ software products to the Quality and Education Division.

Khalis Mohammad Salleh, Hospital Universitit Kebangsaan Malaysia, winner of the NCCH backpack prize with Sue Walker at the recent IFHRO congress

Acknowledgement must be made of Professor Vivian Lin, Head of the School of Public Health and Kerin Robinson, Course Co-ordinator, Bachelor of Health Information Management, School of Public Health and other staff of the School, for their continued support of the NCCH and the Quality and Education Division.

The new contact details are as follows:

Phone: (03) 9479 1135
Fax: (03) 9479 5657
E-mail: k.peasley@latrobe.edu.au
i.kearsey@latrobe.edu.au
s.watts@latrobe.edu.au

NCCH Quality and Education Division
School of Public Health
Faculty of Health Sciences
La Trobe University
Bundoora VIC 3086

NCCH 7th Biennial Conference

The conference preparation is continuing full steam ahead. We have had a very encouraging response to the call for papers. Interested speakers have come from all regions of Australia, New Zealand, USA, UK and Germany. Coding practice, coding career issues, data analysis, audits, DRG issues, terminologies and electronic health records will be featured in the program. Clinical and coding updates on a variety of popular specialty areas will also be made, due to popular demand.

CCSA Coding Specialty Workshop

Although the format of this workshop is not finalised as yet, the Clinical Coders' Society of Australia (CCSA) plans on incorporating some medical input into the format of their previously successful masterclasses. The CCSA are planning on presenting two specialty topics, with the tentative format as follows:

- an initial introduction on diagnoses and procedures presented by a medical officer, and following,
- a specialty coding workshop, putting into practice the knowledge gained from the first part of the class.

The workshop will suit all levels of clinical coder, from beginner to experienced.

As usual, the conference social events will be the places to mingle, network and relax over good food and wine. The welcome reception will be held on the evening of Sunday 1 April at the Landmark Parkroyal. Expect a few surprises on April Fools' Day. The conference dinner will be held on the evening of Monday 2 April at the Watersedge Restaurant located at Pier One, offering spectacular views, in the historic Rocks precinct directly beneath the Sydney Harbour Bridge.

The conference will conclude with keynote speaker, Dr Christopher Chute. The full conference program and registration brochure will be mailed out to all readers of *Coding Matters* by the end of December. It will also be available to download from the NCCH website.

Monash University National Centre for Coronial Information (MUNCCI)

I commenced as the Quality Assurance Officer at MUNCCI on 13 November. MUNCCI is a consortium of the Victorian Institute of Forensic Medicine, the Monash University Department of Epidemiology and Preventive Medicine, and the Monash University Accident Research Centre. MUNCCI is based at the Victorian Institute of Forensic Medicine, which is co-located with the Victorian State Coroner's Office.

MUNCCI is responsible for the development and maintenance of the National Coroners Information System (NCIS). The NCIS will provide a national database of coronial information that is up to date, comprehensive and easily accessible by authorised users. The NCIS has been designed to assist coroners in their death investigation and prevention role. It will also be a valuable research tool for the identification of public health and safety risks and to inform prevention strategies.

The core data set for the NCIS consists of case demographics (name, date of birth, sex, occupation etc); incident information (time, location, circumstance and mechanism of death); cause of death; standard text reports (police notification, pathology, toxicology, post mortem etc). Development is planned for specialist modules to enhance the system on such areas as drug related deaths and water related deaths.

Key stakeholders include Australian coroners and coronial office staff; public sector agencies in areas of court administration, health, workplace safety, consumer product safety, road safety and research agencies with an interest in injury prevention studies and epidemiology.

I will be responsible for the development of methodology and processes for assessing and improving the quality and completeness of the data supplied to the NCIS. This will enable a systematic monitoring program to be put in place which will ensure the timely and continuous improvement of the quality of the NCIS data. I will also be working with the Team Leader, Systems Development at MUNCCI, on the finalisation of the Data Dictionary for the NCIS Core Data Items as well as the development of a coding manual for use by coronial clerks.

Educational Needs Survey and Workshop Evaluations

Apologies to those readers who may have been waiting for the results from the 2000 ICD-10-AM Second Edition workshop evaluations and the Educational Needs survey results.

Due to the upheaval of moving house and office in the past few weeks, the publication of these results has been held over until an early edition of *Coding Matters* for the new year.

Best wishes to all our readers for a very happy Christmas and a bright new year.

Karen Peasley
Quality and Education Manager

Specialty books

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Obstetrics and Gynaecology

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See order form distributed with Coding Matters or call 02 9351 9461 for further information about these books or other titles in the series.

classification support & development

Early parenting

The recoding and mapping study mentioned in *Coding Matters*, Volume 7, Number 1 has since been conducted and the results are now being analysed. This study examined medical records in nine Early Parenting Centres. Data extracted from the study was then analysed in terms of:

- Classifying diagnoses and procedures using ICD-10-AM and the draft Early Parenting Centres Classification produced by Angela Randall; and
- Identifying other clinical practices (nursing and allied health interventions) that are most often required by Early Parenting Centre patients, but not currently reflected in coded data sets.

Coding Standards Advisory Committee

The Coding Standards Advisory Committee met in November. The committee has been busy ratifying changes for ICD-10-AM Third Edition both during and between meetings.

Classification Update Forums (CUFs)

Another three CUFs have been run since the last edition of *Coding Matters* – mental health, diabetes mellitus and adverse events. Some decisions from the mental health CUF are included as new guidelines in this edition of the 10-AM commandments.

The adverse events CUF discussed a wide variety of issues including:

- *Using national morbidity data* (Jenny Hargreaves)
- *Existing adverse events data collections and international initiatives* (Professor Bill Runciman and Professor James Harrison)
- ICD-10-AM structure, concepts and coding practices in relation to adverse events.

The diabetes mellitus CUF delegates discussed further refinements to the classification of diabetes for ICD-10-AM Third Edition.

Kerry Innes
Associate Director

The University of Sydney
Faculty of Health Sciences

Project Officer

National Centre for Classification in Health

Reference D001027

The National Centre for Classification in Health (NCCH), Faculty of Health Sciences, The University of Sydney is seeking a Project Officer to assist the Coding Services Manager in the preparation of content of health classifications, particularly ICD-10-AM. The position also involves assisting in the management of new classification projects, production of subsets of ICD-10-AM for specific purposes and writing standards and guidelines. The position involves liaising with clinicians and clinical coders and data users.

Essential: Experience in report writing. Extensive experience in ICD-9-CM coding. Excellent written and oral communication skills. Recent experience in coding using ICD-10-AM. Demonstrable computer skills, particularly Microsoft Word and Access.

Desirable: Experience in answering coding queries and writing coding guidelines/standards. Excellent skills in Microsoft Word, Excel and Access.

The position is available for a fixed term of one year, subject to the completion of a satisfactory probation period for new appointees. The current occupant of this position is on maternity leave and has the right to return to this position on expiration of leave or sooner giving four weeks notice. Membership of a University approved superannuation scheme is a condition of employment for new appointees.

Enquiries and further information: Kerry Innes, Associate Director, Phone (02) 9351 9461; Fax (02) 9351 9603 or email: *k.innes@cchs.usyd.edu.au*

Remuneration package: $53,746 - $58,553 p.a. (which includes a base salary Level 7 $45,416 - $49,478 p.a., leave loading and up to 17% employer's contribution to superannuation)

Closing: 2 January 2001

Applications should quote the reference no., address the selection criteria, include a CV, the names, addresses, e-mail, fax and phone number of two confidential referees and should be forwarded to: The Personnel Officer, College of Health Sciences, Cumberland Campus (C42), The University of Sydney, PO Box 170, Lidcombe NSW 1825.

The University is a non-smoking workplace and is committed to the policies and principles of equal emplyment opportunity and cultural diversity. The University reserves the right not to proceed with any appointment for financial or other reasons. See http://www.usyd.edu.au/

the 10-AM commandments

This regular section provides ongoing guidance to clinical coders on 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 change practice 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/territory health authority regarding a suitable date for implementation.

Congestive heart failure

Congestive heart failure (CHF/CCF) is a syndrome in which the heart is unable to pump at an adequate rate for the body's metabolic requirements. This causes signs and symptoms of volume overload or manifestations of impaired tissue perfusion such as oedema, fatigue and decreased exercise tolerance. It is not necessary to code volume (fluid) overload in a patient with CHF.

Heart failure usually begins with the left ventricle not working efficiently (left ventricular failure – LVF), which results in congestion of the lungs. Assign I50.1 *Left ventricular failure.*

Failure of the pumping action of the right ventricle (right ventricular failure) is most commonly caused by prior left ventricular failure and results in congestion in veins and capillaries around the body. Therefore, if both LVF and CHF are documented, only I50.0 *Congestive heart failure* is assigned.

Acute pulmonary oedema (APO) is a life-threatening manifestation of acute left ventricular failure secondary to sudden onset of pulmonary venous hypertension forcing fluid out of the pulmonary veins and into the pleural cavity (pleural effusion). If it is documented that the patient has APO and CHF, assign only I50.0 *Congestive heart failure* (see also ACS 0920 *Acute pulmonary oedema*). It is not necessary to code pleural effusion unless specific treatment (eg drainage) is required.

Postoperative pain

ACS 1807 *Pain diagnoses and pain management procedures* relates to the current episode of care during which the surgery was performed and states 'When a patient is suffering postoperative pain or pain directly associated with another condition, assign only the code(s) for the which the surgery was performed or the condition(s) causing the pain'. For example, if a patient is admitted for a tonsillectomy and suffers from postoperative pain during the same episode of care, only a code for the condition (ie tonsillitis) should be assigned.

For patients readmitted for postoperative pain the following guidelines apply:

- If it is not documented that the pain arose as a complication of the initial surgery, only the pain needs to be coded.
- Where it is clearly documented that the postoperative pain arose as a complication of the initial surgery ACS 1904 *Procedural complications* should followed.

Example:

Patient is admitted for postoperative pain due to complication of previous tonsillectomy. Assign

T81.8	*Other complications of procedures, not elsewhere classified*
R07.0	*Pain in throat*
Y83.6	*Removal of other organ (partial)(total)*
Y92.22	*Health service area*

Urethral warts

Benign anogenital warts (*Condylomata acuminata*) are caused by the human papillomavirus (HPV) and are venereally transmitted. Urethral warts are also venereally transmitted and are of the same aetiology as other anogenital warts. ACS 1408 *Human papilloma virus* also applies to urethral warts: assign N36.8 *Other specified disorder of urethra* followed by A63.0 *Anogenital (venereal) warts.*

Mental health issues

The Mental Health Classification Update Forum (CUF) was held 8 September 2000. A number of decisions from the CUF are presented here as guidelines.

a) Mental retardation and intellectual disability/intellectual impairment

The terms **'intellectual disability'** and '**intellectual impairment'** are not indexed in ICD-10-AM and a number of requests have been received by the NCCH to clarify how these terms should be classified.

Intellectual disability

Clinicians advised that the term **intellectual disability** is used interchangeably with **'mental retardation'** and therefore when this term is documented, an appropriate code from categories F70-F79 *Mental retardation*, should be assigned. Bear in mind that F79.9 *Unspecified mental retardation, without mention of impairment of behaviour* should be used as the last resort. More information should be sought from the treating clinician to determine the extent of the impairment.

Intellectual impairment

In regard to the term **intellectual impairment**:

- If the condition is ***congenital***, then a code from category F70-F79 *Mental retardation* can be assigned (endeavour to obtain the extent of the impairment from the treating clinician).
- If the condition is ***acquired***, seek a more definitive diagnosis (ie dementia) from the clinician.

The NCCH will consider improvements to the index for ICD-10-AM Third Edition.

b) Cognitive impairment

The NCCH has received a number of queries about how to code **cognitive impairment**.

Clinicians were asked to consider whether F06.7 *Mild cognitive disorder* is the most appropriate code for this diagnosis.

The clinicians advised that clinical coders should be wary of such a diagnosis, particularly if this is the only diagnosis recorded for the episode of care.

If *cognitive impairment* is recorded, further clarification as to the extent of the impairment (ie mild memory disturbance or loss following organic brain damage, dementia) should be sought from the clinician. If this is not possible, then R41.8 *Other and unspecified symptoms and signs involving cognitive functions and awareness* should be assigned.

F06.7 *Mild cognitive disorder* should be assigned only when terms supporting the diagnosis are documented. The index pathways for F06.7 are:

Change, cognitive, due to or secondary to general medical condition

Disorder, cognitive, mild

Disorder, mild, cognitive

Disturbance, memory, mild, following organic brain damage

Lack of, memory, mild, following organic brain damage

Loss (of), memory, mild, following organic brain damage

Memory disturbance, **lack or loss,** mild, following organic brain damage

Please note that this advice supersedes the advice given in the Casemix, DRGs and clinical coding specialty book: Mental Health, Drugs and Alcohol (page 19).

c) Drug overdose – selection of principal diagnosis

The selection of the principal diagnosis in cases of drug overdose with an associated psychiatric diagnosis generated considerable discussion on Code-L recently. It is often difficult to establish the principal diagnosis in these admissions when two different treatment patterns occur:

1. Acute intervention for the drug effect – this is often only a day or two in ICU
2. Psychiatric treatment for any associated psychiatric disorder – this may be days or weeks.

In many hospitals, the episode of care is treated as one acute episode which creates difficulties

when assigning the principal diagnosis in these cases. The discussion on Code-L revealed national inconsistencies in applying the principal diagnosis definition in cases such as these.

Participants at the Mental Health CUF were asked to consider this issue. The possibility of a change of episode type, at the time the care focuses on the psychiatric condition, was discounted because the care type remains acute[1]. The possibility of basing the principal diagnosis selection on the type of treatment delivered to the overdose and the psychiatric condition was also discounted because treatments are too variable to be reliable as the criteria for assignment of the principal diagnosis.

It was agreed that in such cases, the overdose should be sequenced as the principal diagnosis because it is 'chiefly responsible for occasioning the patient's episode of care in hospital'.

In cases where a patient is admitted for treatment of a drug overdose, and the patient subsequently receives treatment for an associated psychiatric condition in the same episode of care, the overdose code should be sequenced as the principal diagnosis.

[1] Note that in Victoria the care type can be changed to 'psychiatric care'. Victoria's care type data domain differs from the NHDD care type data domain.

d) Cluster B personality disorder

The NCCH has received a number of coding queries about how to code **cluster B personality disorder**.

The term cluster B personality disorder is a classification axis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and this may explain its appearance in medical record documentation. In contrast, in ICD this term relates to a group of personality disorders: antisocial, borderline, histrionic, or narcissistic (more commonly, borderline or antisocial personality disorder). The predominant personality disorder should be coded first, together with any other documented personality disorders.

Whenever a diagnosis of cluster B personality disorder is documented, without identification of the predominant personality disorder, seek clarification from the clinician.

e) Coding of suspected conditions in mental health

The NCCH has a standard for coding suspected conditions (ACS 0012). However, this standard is difficult to apply in mental health because the clinical coder cannot reliably select symptoms to code due to the complexity of the conditions.

The clinicians described the difficulties in diagnosing certain disorders. There may be a number of admissions before a definitive diagnosis can be determined, and this was especially true for adolescents.

Coding symptoms was not considered helpful or practical. One suggestion was to look at the treatment provided, however, this would vary greatly depending on the suspected disorder and a coding guideline would be difficult to develop.

There was general discussion on the possible inflation of estimates of hospitalisations for these conditions. Such an inflation may occur and, because confirmed and suspected cases cannot be distinguished from each other, the data may not be very useful for epidemiologists and others with an interest in hospitalisations for confirmed conditions. Alternatives for identifying suspected conditions remains an issue – a long term solution is required for coding suspected conditions in all specialties.

The clinicians agreed that in mental health, the suspected condition should be coded as a definitive diagnosis. If more than one suspected condition is documented, and it is not clear which suspected condition is the principal diagnosis, apply ACS 0001 *Principal Diagnosis, Two or more diagnoses that equally meet the definition for principal diagnosis* (Vol 5 page 4).

Amendments will be made to the existing Standard (ACS 0012) for ICD-10-AM Third Edition.

Newborns affected by maternal causes

ICD-10-AM contains a range of codes to indicate that a newborn has been affected by a maternal condition:

P00 *Fetus and newborn affected by maternal conditions that may be unrelated to present pregnancy*

P01 *Fetus and newborn affected by maternal complications of pregnancy*

P02 *Fetus and newborn affected by complications of placenta, cord and membranes*

P03 *Fetus and newborn affected by other complications of labour and delivery*

P04 *Fetus and newborn affected by noxious influences transmitted via placenta or breast milk*

ACS 1609 *Maternal causes of perinatal morbidity and mortality* provides guidance on the use of these codes. Note that the ACS mark in the tabular list appears next to code P03.4 but the Standard applies to the *full range* of the above codes.

To be able to assign one of these codes, the record must contain documentation of the newborn's problem (the effect) and a note that it was caused by one of the maternal conditions or a complication of pregnancy, labour or delivery. Therefore there will always be *two* codes: the problem and the cause. Always sequence the code for the problem first, followed by the code for the cause. A code from P00-P04 will *never* be the newborn's principal diagnosis code.

Codes from P10-P15 *Birth trauma* indicate that there has been some trauma during delivery and, as such, are likely to have an additional code from P03 *Fetus and newborn affected by other complications of labour and delivery* assigned. However, the cause and effect must be documented before a P03.- code can be assigned.

If the mother has a condition or complication of labour or delivery that does *not* cause any adverse effect to the baby:

- do *not* assign a code from P00-P04 on the baby's record
- if the maternal cause has necessitated provision of more health services than is usual for a newborn, it may be appropriate to assign Z76.2 *Health supervision and care of other healthy infant and child* (for example, in the case of post-caesarean observation) or Z03.8 *Observation for other suspected diseases and conditions*.

There is no time limit for the use of codes from P00-P04. For example, a 25 year old patient presenting with vaginal clear cell adenocarcinoma due to intrauterine exposure to DES (diethylstilboestrol) would be assigned the cancer codes followed by P04.1 *Fetus and newborn affected by other maternal medication*. See also ACS 1605 *Definition of conditions originating in the perinatal period*.

Example 1

Single newborn with injury to the face (requiring suturing) as a result of caesarean section.

Code	P15.4	*Birth injury to face*
	P03.4	*Fetus and newborn affected by caesarean delivery*
	Z38.0	*Singleton, born in hospital*

Example 2

Single newborn stated to be 'small for dates'. Mother noted to be hypertensive. (No relationship between SFD and hypertension documented in the record.)

Code	P05.1	*Small for gestational age*
	Z38.0	*Singleton, born in hospital*

Example 3

Single newborn delivered by caesarean section, admitted to special care nursery for post-caesarean observation. (No problem documented.)

Code	Z76.2	*Health supervision and care of other healthy infant and child*
	Z38.0	*Singleton, born in hospital*

ICD-10-AM Second Edition Browser

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EXPRESSIONS OF INTEREST

NOSOLOGY COURSE/PROGRAM

The national schools and departments of health information management in Australia are seeking people interested in undertaking postgraduate courses or development programs in nosology.

Nosologists are specialists in the science of health classification. They are also experts in the application, analysis, presentation and interpretation of coded data. Study of nosology would ensure your premier position in the creation, maintenance and use of clinical languages and codes.

At this stage it is anticipated that a nosology course/program would be available from early 2002 (this is dependent on the level of interest). If you are interested in this exciting opportunity to specialise please contact:

Jenny Nicol
Queensland University of Technology
Ph: 07 3864 5807
E-mail: j.nicol@qut.edu.au

Kerin Robinson
La Trobe University
Ph: 03 9479 5722
E-mail: K.Robinson@latrobe.edu.au

Barbara Postle
Curtin University
Ph: 08 9266 7363
E-mail: bpostle@health.curtin.edu.au

Professor Beth Reid
The University of Sydney
Ph: 02 9351 9494
Email: B.Reid@cchs.usyd.edu.au

CLINICAL UPDATES

Clinical coders' guide to dental services – Part 2

This is the second part of a two part series to provide dental procedures coding guidance. This section provides information on the types of procedures performed and the codes that can be assigned. The procedure codes have been listed in numerical order within the table and no sequencing has been implied.

The NCCH would like to thank:

Dr Robert Butler
Executive Director
Australian Dental Association, St Leonards

Dr Ian Jacobi
Deputy Director of Dental Services
United Dental Hospital, Sydney

Jenny Kok
Health Information Manager
ACT Department of Health and Community Care

for their input into the development of this clinical update.

Common definitions

In the following section, tables are provided to enable quick reference for those procedures commonly performed or terminology used. For further explanations on specific procedures refer to *An Australian Schedule of Dental Services and Glossary*, Sixth Edition, 1999.

Preventative Dental Services

Procedures/terms	*Definition*	*Code*
Fissure sealing	Sealing of non-carious pits, fissures or cracks in a tooth to prevent development of dental caries at the site	97161-00 **[455]**
Odontoplasty	Modification of the contour or the anatomy of the crown of a tooth to provide an improved contour	97171-00 **[455]**
Bleaching	Treatment to modify the colour of a tooth by chemical and/or physical agents	97117-00 **[453]** 97118-00 **[453]** 97119-00 **[453]**

Periodontics

Procedures/terms	*Definition*	*Code*
Gingivectomy	A surgical procedure to remove the soft tissue wall of the periodontal pocket or swollen gum tissue	97231-00 **[456]**
Periodontal flap surgery	Incision and raising of a flap of gingival tissue to enable removal of inflammatory or granulation tissue	97232-00 **[456]** 97238-00 **[456]**
Osseous graft	A surgical procedure in which a piece of bone or a synthetic substitute is used to replace or repair alveolar bone	97234-00 **[456]**
Osseous surgery	Re-shaping and modifying defects and deformities in the bone supporting and surrounding teeth	97233-00 **[456]**
Gingival graft	Transference or transplanting gingival or other soft tissue from a donor area in the patient's mouth to an area around a tooth or implant to remedy a gingival deficiency	97235-00 **[456]**

Endodontics

Procedures/terms	*Definition*	*Code*
Pulpotomy	Removal within the pulp chamber of part of the vital pulp of a tooth. The remaining pulp is then covered with a protective dressing or cement	97414-00 **[462]**
Obturation	The phase of a root canal treatment that creates a fluid tight seal along the length of the root canal system	97417-00 **[462]** 97418-00 **[462]** 97457-00 **[464]**
Extirpation of pulp	Removal of pulp, or necrotic debris of a pulp from a tooth's root canal system	97415-00 **[462]** 97416-00 **[462]** 97419-00 **[462]**
Post	Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration	97597-00 **[469]** 97452-00 **[464]**

Restorative Types

Procedures/terms		*Definition*	*Code*
Inlay/onlay		Construction and insertion into a tooth of a restoration which may be metallic, resin-based or porcelain	See Block 468
Pin retention		Small pins are inserted into the tooth to provide extra retention of the filling material	97575-00 **[469]**
Cast core for crown		A post and core fabricated accurately to the dimension of a prepared root canal to provide a foundation for an artificial crown	97625-00 **[470]**
Crown	Temporary crown	Construction of a temporary restoration usually made from a resin to protect the underlying tooth prior to construction of a permanent crown	97573-00 **[469]**
	Full crown – non-metallic	An artificial crown or full veneer constructed of resin-based or porcelain material restoring a natural tooth	97613-00 **[470]**
	Full crown – veneered	An artificial crown or full veneer constructed with a metallic base veneered with resin-based or porcelain material restoring a natural tooth	97615-00 **[470]**
Bridge	Pontic	That part of a bridge which replaces clinical crowns of missing teeth	97642-00 **[471]** 97643-00 **[471]**

Prosthodontics

Procedures/terms		*Definition*	*Code*
Complete denture		A removable dental prosthesis constructed to replace all missing teeth and tissues	97711-00 **[474]** 97712-00 **[474]** 97719-00 **[474]**
Partial denture		A denture provided for a dental arch in which one or more natural teeth remain	97721-00 **[474]** 97722-00 **[474]** 97727-00 **[474]** 97728-00 **[474]**
Partial Denture Components	Retainer	Metal clasp carefully designed to fit round a tooth. Its main purpose is to hold the denture in place.	97731-00 **[474]**
	Occlusal rest	A unit of a partial denture that rests upon a tooth surface to provide support for the denture	97732-00 **[474]**
	Wrought bar	A wrought bar joining sections of a partial denture	97738-00 **[474]**
Overlay		An extension of a denture covering the occlusal surface of remaining teeth	97734-00 **[474]**
Immediate replacement of tooth		This procedure involves the addition of one or more teeth to a denture	97736-00 **[474]**
Denture Maintenance	Relining	Replacement of the tissue fitting surface of a denture to improve its accuracy and fit	97737-00 **[474]** 97743-00 **[475]** 97744-00 **[475]** 97751-00 **[475]** 97752-00 **[475]**
	Remodelling	Replacement of the resin base of a denture to improve its accuracy and fit. It is different from rebasing in that it also permits rearrangement of teeth	97745-00 **[475]** 97746-00 **[475]**
	Rebasing	This involves the removal and replacement of a denture base	97754-00 **[475]**

Other prosthodontic service

Procedures/terms	*Definition*	*Code*
Splints	An appliance constructed from either acrylic resin or metal designed to hold or maintain mobile teeth in their predetermined position	97772-00 **[477]** 97773-00 **[477]**
Obturator	A prosthesis constructed to close a congenital or acquired opening in the palate. Usually attached to a partial or complete denture	97774-00 **[477]**
Denture characterisation	This process involves the staining and carving of the outer surfaces of the denture	97775-00 **[477]**
Dental impression	A negative imprint from which a reproduction or cast can be made	97776-00 **[477]**
Denture identification	Provision of a patient's identification on the base of the denture	97777-00 **[477]**

Orthodontics

Procedures/terms		Definition	Code
Removable orthodontic appliance	Passive removable appliance	An appliance designed to maintain the position of the teeth	97811-00 **[479]** 97812-01 **[479]**
	Active removable appliance	As opposed to the passive appliance, an active appliance exerts force on teeth or arches to achieve tooth or dental arch movement	97821-00 **[479]** 97822-01 **[479]**
Fixed orthodontic appliance	Banding	The application of bands and/or brackets to correct tooth position or arch form	97829-00 **[480]** 97831-00 **[480]** 97842-00 **[480]**
Extraoral appliance		Extra-oral head gear connected to a intra-oral appliance which makes use of the support of the back of the head and neck to transmit extra-oral force which is then distributed to the teeth	97851-00 **[481]**

General Dental Services

Procedures/terms		Definition	Code
Occlusal therapy	Occlusal splint	An appliance made of acrylic resin which is designed to relieve abnormal pressures exerted on the temporalmandibular joint (TMJ) and other supporting structures	97965-00 **[489]** 97966-00 **[489]** 97968-00 **[489]** 97972-00 **[489]**

Amendments

Amendments to Clinical coders' guide to dental services – Part 1 published in *Coding Matters* Vol 7 No. 2 September 2000 pages 18-19.

Figure 1

Canine (cuspid) teeth – revise 'The third tooth from the *centre of the* dental arch.'

Add to bottom of box 'Ref: *An Australian Schedule of Dental Services and Glossary, Sixth Edition, page 14, 1999.*'

Figure 2

Above Quadrant 1 add *Right* and above Quadrant 2 add *Left.*

Revise wording under figure 2 accordingly:

'Hence, from the chart in figure 2, the upper *left* first molar…'

'…indicates that the tooth is in the upper *left* quadrant.'

Common definitions – revise the following:

Endodontics – That part of restorative dentistry concerned with the *treatment of the root canal and related areas of the tooth.*

Prosthodontics – *A branch of dentistry that deals with the complex restoration of individual teeth and the construction of fixed and removable prostheses to replace missing teeth. It also deals with abnormalities of the temporomandibular joint.*

Bridges – '…which are joined to *fixtures in* adjacent teeth..'

'…receive cast metal *or non-metallic* restorations.'

Materials commonly used in restoration – revise the following:

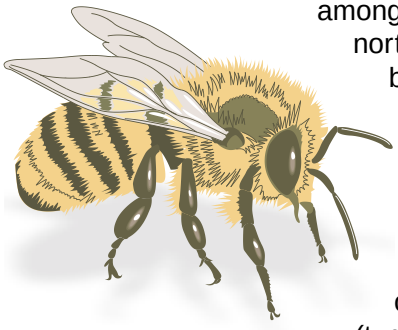
Amalgam – '*A filling material for posterior teeth made of an alloy of mercury with other metals including silver, tin and copper.*'

FEATURE

Hornets, bees and wasps: Modifications to the ICD-10-AM coding for external causes of injury due to venomous bites and stings

Kenneth D Winkel and James Harrison

Stings by bees and wasps are quite common. While most stings are no more than briefly painful, the consequences are sometimes severe, occasionally fatal. Bees differ from wasps in behaviour, composition of venom and in their distribution in Australia. Recent research shows marked differences in patterns of mortality from bee and wasp stings, but very little is known about patterns of morbidity. Better information on this, via hospitalisation data, would inform prevention and treatment.



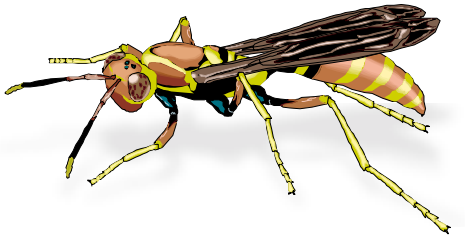
Australia has a diverse range of venomous creatures capable of causing severe morbidity and mortality. Whilst most attention has focused upon snake and spider bite-related fatalities, arthropods such as honey bees (*Apis mellifera*) and European wasps (*Vespula germanica*) can also inflict dangerous stings. Indeed, due to their widespread distribution, bee and wasp stings are a leading cause of bite and sting related mortality globally.

Despite their importance, little has been published on the circumstances and incidence of severe bee and wasp sting related injuries. For example, an analysis of Australian bee sting fatalities that occurred during 1960–81 was unable to obtain adequate clinical information regarding most of the fatalities during that period[1]. Coronial records were examined for only 1 of the 27 fatalities identified in that study. Unfortunately, despite the increasing abundance[2] of the introduced and aggressive European wasp (*V. germanica*), even less information is available regarding wasp sting related fatalities in Australia than for bee stings[3,4,5].

The European honey bee was introduced to Australia in 1822 and is now widespread. By contrast the European wasp only arrived in Tasmania in 1957 and on the mainland (in Victoria), in 1977. Ecological restrictions are more limiting of the distribution of *V. germanica* in Australia than for *A. mellifera*. Consequently, the epidemiology of bee and wasp sting mortality in Australia appears distinctive. For example, most wasp mortality is concentrated amongst farmers in Queensland and north-eastern NSW[5]. Fatal bee stings, by contrast, occur in all states and territories and are grossly over-represented amongst bee-keepers and their families[6].

Other findings of these mortality studies are that many deaths occur less than an hour after a sting (typically only one sting), and affect people with a history of allergic response to previous stings. Adrenaline and immunotherapy amongst bee and wasp venom allergy patients are likely to be effective treatments, but they seem to be under-used. To date there have been no published studies of national trends in bee and wasp sting related morbidity.

Unfortunately our efforts to better define the burden and determinants of bee and wasp sting related morbidity have been limited by the categories provided in the International Classification of Diseases[7]. Hornet, bee and wasp related injuries were all lumped under the same category (E905.3 in ICD-9-CM and X23 in ICD-10-AM). This effectively referred to bee and wasp stings only since there are no true hornets (genus *Vespa*) in Australia. No separate analysis of bee versus wasp sting related inpatient data is possible for separations prior to July 2000. Nevertheless the significance of bee and wasp stings can be gauged by the fact that they have, historically, constituted the second most common cause of hospitalisation due to ▶



venomous bites and stings in Australia[7,8]. They account for more admitted cases than snakes, and not quite as many as spiders.

Fortunately, the second edition of the clinical modification of ICD-10 developed for use in Australia (ICD-10-AM) uses an additional digit to provide separate coding categories to distinguish wasps and bees sting injuries. The new categories are shown in Table 1.

Table 1. Extended category X23 in ICD-10-AM Second Edition

X23	Contact with hornets, wasps and bees
.1	Contact with hornets
.2	Contact with wasps (includes yellow jacket)
.3	Contact with bees
.9	Contact with hornets, wasps and bees, unspecified

The usefulness of the new categories depends on whether the information necessary to distinguish bee stings from wasp stings can be found in available records. We found that this distinction could be made with reasonable certainty for most deaths[5,6]. However this required a careful examination of the clinical record. The most important clues were the initial visual identification of the creature by a witness as opposed to the (sometimes inaccurate) medical attribution, and the presence or absence of a sting retained at the sting site. Honey bees always leave a retained sting (though this is not always seen) but wasps never do.

While the availability of information in hospital records may differ from what we found for deaths, the following guidelines, based on our experience, are likely to help when applying the new codes to hospitalised cases.

1. If the stinging creature has been caught and identified as a bee or a wasp by a competent person, then code according to this assessment.
2. Bees leave their stinging organ embedded at the site of injury, while wasps do not. If there is mention of an embedded sting, then the case should normally be coded to X23.3 (bee).
3. Witnesses, including the patient, are likely to be at least as reliable at identifying the type of creature as most hospital personnel who did not see the event.

Fortunately, the number of bee and wasp stings resulting in admission to a hospital is not very large. For example, about 1,300 separations in 1997/98 included the Ecode value E905.3 Consequently, the additional distinction required by the extended version of X23 will not add greatly to the overall burden of coding.

We and others will use the more specific information about bee and wasp sting morbidity that will result from this change to help improve preventative strategies and treatment.

Kenneth D Winkel, MBBS, PhD, Director, Australian Venom Research Unit, Department of Pharmacology, University of Melbourne 3010 VIC.
Tel. 03 8344 7753 Fax. 03 9348 2048.
E-mail: *k.winkel@pharmacology.unimelb.edu.au*

James Harrison MBBS, MPH, Director, Research Centre for Injury Studies and AIHW National Injury Surveillance Unit, Flinders University, South Australia.

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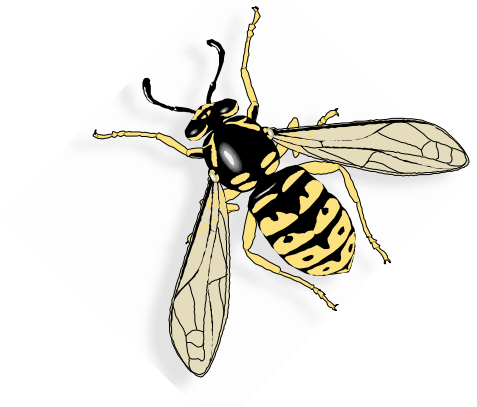

publication issues

Coding Matters mailing list

Coding Matters is freely distributed to hospitals, health professionals and clinical coders. Consequently, its mailing list has grown over the last few years, and so has the cost of postage. Therefore, we're seeking your help to clean up the subscriber list. Reducing production costs will aid in maintaining *Coding Matters* as a free publication.

Please use the form on the cover sheet to let us know if you wish to continue receiving *Coding Matters*. **The next issue will be the last sent to you if no response is received.** Alternatively, e-mail t.stanhope@cchs.usyd.edu.au

Coding Matters can also be delivered to you by e-mail file as a Portable Document Format (PDF) file and can be downloaded from the NCCH website: www.cchs.usyd.edu.au/ncch/

AR-DRG version 4.2: Addendum to the Definitions Manual

The Australian Refined Diagnosis Related Groups (AR-DRG) classification needs to be modified from time to time in line with changes to medical, surgical and coding practices. AR-DRG version 4.2 is a revision to the classification. It accommodates changes that occurred between the first and second editions of ICD-10-AM, and includes a number of 'fixes'.

The AR-DRG version 4.2 Addendum to the Definitions Manual provides details of what is new and different about AR-DRG version 4.2. It consists of a single volume, with a CD-ROM attached.

The AR-DRG version 4.2 Addendum to the Definitions Manual has a recommended retail price of $50 plus GST. Copies may be purchased from the NCCH.

New specialty books and index

The last four books in the *Casemix, DRGs and clinical coding* series are now available. The latest release includes the new titles:

- *Neonatology and Paediatrics*
- *Obstetrics and Gynaecology*;

and revised versions of

- *Cardiovascular Medicine and Surgery*
- *Respiratory Medicine and Thoracic Surgery*.

A cumulative index for all books has been produced and is included with purchases of the complete set of books. It can also be obtained as a PDF from the NCCH website.

ICD-10-AM Browser network version

The ICD-10-AM Browser is now available in a network version, which allows purchasers to nominate the number of users required. The Browser incorporates the first and second errata and enables users to have all ICD-10-AM volumes easily accessible from the desktop.

The network version of the Browser is available only by e-mail. Pricing details can be found on the NCCH order form. Please call Cath Stanhope, 02 9351 9768, for further information regarding your Browser networking requirements or visit the NCCH website for more information.

As this is the final *Coding Matters* for 2000, we wish you a happy and safe Christmas break.

Rodney Bernard
Publications and Technology Manager

Commonwealth Department of Health and Aged Care

CASEMIX

AUSTRALIAN CASEMIX

Public submission to modify AR-DRG version 4

The Australian Refined Diagnosis Related Groups (AR-DRG) inpatient classification system is developed and maintained by the DRG Development section of the Department of Health and Aged Care. The Department is inviting interested parties to submit proposals for change to the AR-DRG classification system for the next major update – version 5. Proposals for change are evaluated and analysed by the Department, then submitted to the Clinical Coding and Classification Groups (CCCGs) for clinical advice and to the Clinical Casemix Committee of Australia (CCCA) for arbitration and/or ratification.

Applications for Public Submission are available on the Department of Health and Aged Care internet site, *www.health.gov.au/casemix/pubsub1.htm* or by requesting a copy of the public submission document from DRG Development Section, Department of Health and Aged Care, PO Box 852, Woden ACT 2606 or by phone on 02-6289 7467.

Deadline for submission is 15 February 2001

quality concerns

PICQ 2000™ released

PICQ 2000 was released in October at the 13th International Federation of Health Records Organizations Congress held in Melbourne. NCCH staff demonstrated PICQ 2000. Here are some FAQs (Frequently Asked Questions) about PICQ 2000:

What is PICQ 2000?

Performance Indicators for Coding Quality (PICQ) provides a mechanism to assess quality of coded morbidity data.

PICQ is a set of predetermined performance indicators which identify coding variations in a defined dataset. When coding variations are identified the causes can be investigated and steps taken to rectify variations, or measured, according to the interests of the user.

What does PICQ 2000 do?

PICQ 2000

- identifies data problem areas
- identifies specific records for correction or measurement
- measures data accuracy against a particular indicator or indicators
- suggests possible problem causes and corrections.

PICQ can be applied at any stage of data collection:

- individual (coder, manager or researcher)
- unit
- hospital
- central morbidity collection (area, state, national).

PICQ 2000 analyses data using 122 indicators which check for compliance with Australian Coding Standards. It uses ICD-10-AM and National Health Data Dictionary items.

Indicators test adherence to Australian Coding Standards and coding conventions by identifying:

- presence or absence of codes
- incorrect combinations of codes
- incorrect code sequencing
- code specificity.

Coding indicators use fields such as:

- diagnosis (ICD-10-AM code)
- procedure (ICD-10-AM code)
- age or LOS

and NHDD items such as

- separation mode
- care type.

What's in the PICQ package?

The PICQ 2000 package is one CD-ROM containing:

- *About PICQ 2000* describes the program and gives information about adapting PICQ's features to meet specific needs
- *PICQ 2000 User Guide* provides technical information and instructions for using the program
- *PICQ 2000* software program – two versions are supplied for use with Microsoft Access 97 or Microsoft Access 2000
- *Sample data* to develop skills using the application. The application can be learned with a safety net of pre-formatted data.

What system requirements do I need to operate PICQ 2000?

A PC with Microsoft Access 97 or Microsoft Access 2000 is needed. Expertise with Access is not required. The *User Guide* provides step-by-step help about installation and operation.

A minimum of a 166MHz Pentium processor and 32MB of memory are recommended to ensure reasonable performance with medium-sized databases. The PICQ 2000 program occupies less than 5MB of disk space.

How is data linked with PICQ 2000?

PICQ 2000 requires data to be in a specific format. Section 3 of the *PICQ 2000 User Guide* provides details about formatting data.

After data are formatted according to the specifications in Section 3, the PICQ 2000 'inverts' and links the data to the program. This is an automated operation. Datasets of over 100,000 records have been used with PICQ 2000.

How do I select indicators?

PICQ 2000 allows the choice of any or all of the 122 indicators to run against selected data. View the list of indicators at the NCCH website http://www.cchs.usyd.edu.au/ncch/

What kinds of reports can PICQ 2000 produce?

PICQ 2000 can create four types of outputs:

1. Summary report	a overview of data quality
2. Detailed report	a standard report of episodes with coding variation
3. User-defined report	user can select fields for the detailed report
4. Export facility	details of episodes of variation can be exported as Microsoft Access file and manipulated to suit individual requirements

We don't have access to an IT person at my workplace. What do I do if I can't solve a problem?

Contact NCCH Quality and Education Division

Shannon Watts
03 9479 1135
s.watts@latrobe.edu.au

Irene Kearsey
03 9479 1135
i.kearsey@latrobe.edu.au

PICQ 2000 is available now.
Contact *NCCHsales@cchs.usyd.edu.au* for licence and order details.

Donna Truran
Research Officer

CALL FOR SUBMISSIONS

The University of Sydney

National Centre for Classification in Health (Sydney)

Modifications to ICD-10-AM

The National Centre for Classification in Health (NCCH) is inviting public submissions for modifications to the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)*. *ICD-10-AM* is a classification of diseases and procedures and is based on the World Health Organization statistical classification ICD-10. From 1 July 1999, *ICD-10-AM* became the Australian standard for morbidity classification in acute health services and day facilities. The third edition is due for national implementation from 1 July 2002.

The NCCH is an Australian centre of expertise in classifications for morbidity, mortality and health interventions and is responsible for the maintenance of *ICD-10-AM*. It is the intention of the NCCH to update *ICD-10-AM* biennially.

The main objectives of the public submission process are to ensure that *ICD-10-AM*:

- meets the needs of various users throughout the healthcare system
- continues to be a comprehensive and clinically meaningful classification.

The NCCH invites written submissions from interested members of the public and representatives of relevant agencies or organisations.

Written guidelines on the submission process can be obtained from

NCCH (Sydney), The University of Sydney,
PO Box 170, Lidcombe NSW 1825,

ph: 02 93519461
fax: 02 93519603
e-mail: NCCHAdmin@cchs.usyd.edu.au

or from the NCCH website:
http://www.cchs.usyd.edu.au/ncch/

Submissions must be lodged between 1 February 2001 and 28 February 2001

NCCH (Sydney) is funded by the Casemix Program, Commonwealth Department of Health and Aged Care.

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Enrolments in this distance education course is open to those with previous coding training &/or coding experience including all past Introductory ICD-10 or ICD-9 students, Health Information Management Graduates and OTEN Introductory Coding Course graduates.

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http://www.himaa.org.au/education.html or inquiries e-mail to *denisej@himaa.org.au* or phone Denise Johnston on (02) 9887 5898

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Health Information Management Association of Australia Ltd (HIMAA)
Locked Bag 2045, North Ryde NSW 1670
Telephone: (02) 9887 5001 Fax: (02) 9887 5895
E-Mail: *himaa@himaa.org.au*
Web site: *www.himaa.org.au*