

# coding matters



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

Volume 7 Number 2 **September 2000**



**from the  
desk of  
the director**

## **Contract, NCCH Sydney**

The big news from NCCH for this first issue of *Coding Matters* for the financial year is that we have finalised the contract for NCCH Sydney between The University of Sydney and the Commonwealth Department of Health and Aged Care. The contract, providing for core functions of NCCH Sydney, is for three years, and brings the 'life' of NCCH Sydney in line with that of NCCH Brisbane – ie until the end of June 2003. While this has meant that individual staff contracts have now been renewed, we are still seeking additional funds from various sources for 'new work', particularly relating to conversion of the terms in ICD-10-AM into an Australian Clinical Vocabulary. We also need to build on the foundation of the Access database for ICD-10-AM so that it can be maintained efficiently and form the basis of electronic and hard copy products.



**NCCH management  
at the planning day in July**

## **NCCH Executive**

The NCCH Executive has a new chair, Mr Peter Williams. Peter represents the National Health Information Management Group on the Executive, and has many contacts with NCCH in his role as Director, Information and Data Services, NSW Health. Dr Margaret Dean, Medical Advisor, Public Health Division, Department of Health and Aged Care, has left the Department and the Executive, and I wish to acknowledge the important contribution that Maggie has made to NCCH in focussing our attention on the use of coded datasets for public health purposes. Maggie steered the Centre through the strategic planning process and ►

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helped in strengthening our relationships with a range of divisions and branches within the department. Her place on the Executive has been filled by Mr Phil Hagan, Assistant Secretary, Information and Research Branch of the Portfolio Strategies Division. His branch, and Phil himself, have been closely involved in *Health Online*, a *Health Information Action Plan for Australia*, developed for the National Health Information Management Advisory Council.

Also departing from the Executive was Mr Peter Gray, Director, Case Payments, Acute and Co-ordinated Care Branch, Department of Health and Aged Care. Peter has been the NCCH contact person in the department for many years, and we will miss his knowledge, experience and understanding of NCCH as it has evolved since 1994.

The Executive met on 15 August in Brisbane and discussed a range of issues relating to the NCCH and its future, especially in relation to the Report by the National Electronic Health Records Taskforce<sup>1</sup>.

### National Health Online Summit

This meeting, held in Adelaide on 3-4 August 2000, was an extremely important one for NCCH and for anyone involved in health informatics or health information management. The Electronic Health Records Taskforce released the report mentioned above, and *HealthConnect*, a health information network for all Australians, was discussed. There were approximately 250 participants from a range of government, clinical, health information, consumer and software industry organisations.

NCCH was represented by Rosemary Roberts, Sue Walker and Donna Truran. A paper on *Using and Managing National Administrative Data* (Rosemary Roberts) was presented and I understand that all papers from the meeting will be published as Proceedings. NCCH expects that it will be further involved in work on the health information network through the use of codes and terms as building blocks for the electronic health record.

### IT 14/2 Health Informatics Subcommittee on Health Concept Representation

Michelle Bramley represents NCCH on this committee, which is convened by Standards Australia and has recently been reformed under the chairmanship of Heather Grain. It met in June and August 2000 and provides Australian input to international work of the International Organisation for Standardization Health Informatics Committee on Health Concept Representation (ISO TC 215 WG3). It is particularly concerned with Australian standards for health terminologies and vocabularies.

### Expert Group on Health Classifications

Following recommendations from the Electronic Health Records Taskforce and endorsed by Australian Health Ministers in July, the National Health Information Management Group (NHIMG) has established an Expert Group on Health Classifications which will include representation from NCCH. The group, which is yet to meet, will report to the NHIMG and the National Community Services Information Management Group. Its objectives are:

## coding matters



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- To identify those areas of activity where a national classification or codeset is required;
- To promote the co-ordinated development of consistency, quality and compatibility of classifications to support health and related data collections in Australia at both State and Commonwealth levels; and
- To co-ordinate and oversee Australian contributions to international health classifications work.

## General Practice Coding Jury

Recommendations from the GP Coding Jury on choice of a coding system were announced at the National Health Online Summit on August 4. In the short term, it was recommended that 'ICD-10-AM, with the addition of specific and essential general practice terms, be adopted as the coding system to be used in general practice in Australia for the next five years.' In the long term, the Jury considered that SNOMED-CT would be the dominant reference terminology of the future and recommended that Australia be in a position to take advantage of international advances.

These recommendations have important implications for NCCH scope and workplan. The move to ambulatory classifications and terms builds on NCCH input to the community health codeset for the Community Health Information Model. A teleconference to progress the recommendations of the jury is planned for the beginning of September 2000.

## Planning day

Following the NCCH strategic planning exercise completed at the end of 1999, NCCH senior staff met on 21 July to identify and discuss specific issues. Some of the key outcomes of the planning day related to the structure of NCCH and our need to establish an Intranet for communication between sites in Sydney, Brisbane and Melbourne. We believe there is an urgent need for NCCH to be closely involved in terminology development, given the Electronic Health Records Taskforce deliberations and findings of the General Practice Coding Jury. To do this, we require particular expertise in morbidity and mortality coding as well as health informatics, semantics and health concept representation.

## ICD-10-AM

The second edition of ICD-10-AM, printed from the Access database for the first time, was

introduced in acute care hospitals in all Australian states and territories on 1 July 2000. It is now available in hard copy (5 volumes), as an ASCII list, as an Access database and as a browser.

## Specialty books

With the help of Ann Jones, a spate of specialty books has been produced in the last few months. There are now 14 completed books, with a further four to finish the series. Of these four, two (Respiratory and Cardiovascular) are being updated to ICD-10-AM from existing ICD-9-CM specialty books. The two in production are *Obstetrics and Gynaecology* and *Neonatology and Paediatrics*. NSW Health has purchased the PDF files of the specialty books for their intranet to educate clinicians and clinical coders about coding and casemix.



## Coding Standards Advisory Committee

CSAC met in Canberra on 21 August. It continues to provide expert input to the Australian Coding Standards and their interpretation for publication in Coding Matters. Recommendations from the Public Submission process are being considered, as well as those from the Classification Update Forums.

## Classification Update Forums (CUFs)

Additional funding received from the Department of Health and Aged Care in the last financial year supported the first two of these specialty meetings. As mentioned in the last issue of *Coding Matters*, the CUF for Neonatology and Paediatrics was held on 26-27 May and that for Oncology on 29 June 2000. ►

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



CLINICAL CODERS'  
**CCSA**  
SOCIETY OF AUSTRALIA

# the language of health

**7<sup>th</sup> 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 7<sup>th</sup> 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

General notification and call for papers	<b>September 2000</b>
Final date for receipt of abstracts	<b>3 November 2000</b>
Notification of abstract selection for presentation	<b>November 2000</b>
Program and registration material published	<b>December 2000</b>
Conference	<b>1, 2, 3 April 2001</b>

### 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](http://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

Inclusive of the registration fee will be the Welcome Reception and the Conference Dinner.

### Sponsorship and Display

Enquiries regarding sponsorship and display opportunities at the NCCH 7<sup>th</sup> Biennial Conference should be directed to Karen Peasley and/or Rodney Bernard on the contact details noted below.

### Further Information

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**the language of health**



Further topics include diabetes, mental health, injury, cardiovascular disease, anaesthetics and adverse events. One outcome from the Oncology CUF was a meeting held on August 22 with representatives from the Australian Institute of Health and Welfare (AIHW) and Australian Association of Cancer Registries to discuss the dual use of ICD-10-AM and ICD-O in Australian Cancer Registries.

### **Mental Health Subset**

Following negotiations with the Mental Health Branch of the Department of Health and Aged Care, funding has been allocated under a contract with The University of Sydney to develop a mental health subset of ICD-10-AM for community mental health. Agreement has been received from WHO to access files of relevant publications to use as a basis for the Australian version. NCCH plans to develop the subset, including procedures and relevant Australian Coding Standards for publication in parallel with the third edition of ICD-10-AM for implementation in July 2002.

### **WHO Heads of Collaborating Centres Meeting and Update Reference Committee for ICD-10**

NCCH staff, particularly Michelle Bramley and Kerry Innes, have been preparing for the Annual Meeting of Heads of Centres for Classification of Diseases to be held in Rio de Janeiro from 16-20 October 2000. Abstracts from the Western Pacific Collaborating Centre include:

- Annual Report of the Western Pacific Collaborating Centre
- Report of the Centre Heads Update Committee (Roberts R)
- Report of the Centre Heads Links with other Classifications Committee (Madden RC)
- Iatrogenic Injury in Australia (Hargreaves J and Madden RC)
- Modifying ICD-10-AM External Cause Codes to Improve Adverse Event Reporting (Roberts R, Innes K et al)
- Using Adverse Events Data to Improve Patient Safety (Runciman W et al)
- Electronic Maintenance of Clinical Classifications (Stahl C et al)
- Effect of Query Action (Wood M, Steward J)
- Development of an Encoder for Perinatal Mortality Coding – an Australian Experience (Wood M)

- Quality Information: A Prerequisite for Good Decision Making (Balnave LM, Truran D et al)
- International Classification of Health Interventions (Roberts R, Innes K)

Australian representatives at the Rio de Janeiro meeting include Dr Richard Madden, A/Prof Rosemary Roberts, Sue Walker and Kerry Innes.

### **WHO Collaborating Centre for Classification of Diseases**

Dr YC Chong, Regional Adviser in Health Information, World Health Organization, Western Pacific Regional Office, visited NCCH on 17 July. The Head of the Collaborating Centre, Dr Richard Madden, was present, as well as Catherine Sykes from AIHW and Johanna Westbrook from The University of Sydney, School of Health Information Management.



*I-r Phyllis Watson, YC Chong and Johanna Westbrook*



*I-r Rosemary Roberts, Hal Kendig and Richard Madden*

### **WHO student placement**

Dr Wu Hong, visiting fellow from the WHO Collaborating Centre in Beijing, China, visited NCCH from 29 June to 7 July. Dr Wu's principal interest was in the introduction of ICD-10 in China. She is currently at La Trobe University ►



**Hong Wu presented Rosemary Roberts with a traditional Chinese gift**

School of Public Health undertaking courses in health information management, consulting with relevant staff and visiting hospitals.

### **World Medical Assembly**

NCCH was invited to submit a paper to the 52<sup>nd</sup> World Medical Assembly to be held in Edinburgh in September 2000. The paper was entitled *A World Medical Language? Creating a clinical vocabulary from an international disease classification*.

### **NCCH Quality and Education Division**

Performance Indicators for Coding Quality (PICQ 2000<sup>TM</sup>), an electronic coding quality measurement tool, has been tested in a range of hospital and department sites with excellent and encouraging feedback from all users. PICQ will be released at the International Federation of Health Records Organizations (IFHRO) Congress to be held in Melbourne 2-6 October 2000. It contains 100 performance indicators based on the Australian Coding Standards and ICD-10-AM coding conventions. The project has been a collaborative one, with input from NCCH Quality Division at La Trobe (Irene Kearsey), OR Systems in Melbourne and NCCH Sydney (Gay Lysenko, Nicole Schmidt, Donna Truran and staff of the Classification Support and Development Division).

The Singapore Ministry of Health has given approval for NCCH to develop a version of PICQ in ICD-9-CM. NCCH staff met to discuss details with representatives from Singapore at the Casemix Conference in Cairns from 28-30 August 2000.

An electronic version of the Australian Coding Benchmark Audit (ACBA 2000<sup>TM</sup>) is in parallel development with PICQ and will be co-released with PICQ at IFHRO. This development has been made possible by the use of contracted

programmers and a project consultant, Lai-Mun Balnave. In July 2000, the previous version of ACBA was used at NCCH Brisbane as part of an education program for WHO SEARO students.

PICQ and ACBA are being developed as complementary clinical coding audit tools. They provide standards for the assessment of coded data quality and in this sense are invaluable for data cleaning at hospital, state and territory and national levels. NCCH is developing a marketing strategy for PICQ and ACBA reinforcing the nexus between the two products.

Negotiations have been underway between NCCH Brisbane, NCCH Sydney and the Monash University National Centre for Coronial Information (MUNCCI) concerning the secondment of a staff member (Karen Peasley) from NCCH to implement the National Coroners Information System quality assurance plan. NCCH is planning to contract these services and to integrate the secondment with the Quality Division work program. NCCH staff have met with representatives from La Trobe University and proposed a combination of the NCCH education and quality functions at La Trobe, with the appointment of a quality and education officer to work with Karen Peasley. Karen would retain her position as manager, but amalgamate the education and quality functions as well as fulfilling the contract with MUNCCI.

In regard to core funding for NCCH quality functions, the NCCH Advisory Committee has recommended that the centre should prepare a further proposal to the NHIMG for support for data quality activities. A paper is being prepared for the November meeting of NHIMG.

### **Conclusion**

As you can see, NCCH activities are as hectic as usual. There are a number of conferences during this second half of the year at which NCCH will be presenting papers and/or exhibiting. This exposure is essential for us to inform users of the classification of our activities and to generate interest in our products. I hope we will see many of you during these opportunities to meet face to face and hear your news and views.

► **Rosemary Roberts**  
Director

- 1 A Health Information Network for Australia. Report to Health Ministers by the National Electronic Health Records Taskforce. July 2000. Commonwealth of Australia



# vital signs

## ACBA training in Brisbane

NCCH Brisbane hosted a training course in the use of the Australian Coding Benchmark Audit (ACBA) for students from the WHO South East Asia region, between 10–14 June. Andrea Groom, a member of the Coding Educators Network (CEN) International, conducted the course. Eleven participants were involved – five from Thailand (led by Dr Krissada Raungarereerat), four from Sri Lanka (led by Dr Sunil Senanayake), Dr Myint Htwe from India and Caroline Stahl, NCCH's intern from Germany. Dr Htwe is the new Regional Adviser in the Evidence for Health Policy unit of WHO/SEARO, replacing the previous incumbents Dr Miroslav Wysocki and Ms Candy Longmire.

The students were taught the basics of ACBA utilising the first edition of the product. They then used it to evaluate the coding in a series of medical records brought with them from their home countries. This proved somewhat challenging, given that the documentation in the records was somewhat sparse and variously written in English, Thai and Sri Lankan!

The final few days of the course provided students with the opportunity to try out their new

skills on some de-identified Australian records donated to QUT for students to practise their coding. Andrea worked especially hard during this period, pretending to be 'Coder A' for all of the records utilised. The students were also given the opportunity to visit the Australian Bureau of Statistics (ABS) to view the Automated Coding System and enjoyed a social dinner at the Kangaroo Point Hotel on the Thursday evening.

The contract signed by the participating countries with WHO required the cohort of students to subsequently visit hospitals in both Sri Lanka and Thailand to trial ACBA under real auditing conditions. We are currently eagerly awaiting the report of their experiences, which is intended to outline areas where it is felt that ACBA may need modification to make it more suitable for international use. Being 'classification neutral', NCCH is hoping to be able to market the product overseas and there is certainly a lot of interest in it. NCCH Brisbane thanks Andrea for her contribution to the training program and for her assistance in making it such a success.

## International news

During the week following the international training course, we hosted a visit by Dr YC Chong, from the Western Pacific region of WHO. Dr Chong had several meetings during his two days in Brisbane, including discussing future training courses with the NCCH staff and visiting the School of Public Health at Queensland University of Technology (QUT) and the Australian Bureau of Statistics.

Further on the international front, another CEN International member, Megan Cumerlato, is currently conducting a four-week training program in the Cook Islands. Carried out for WHO/WPRO, this course encompasses ICD-10, some basic medical record concepts and a report to WHO regarding potential improvements in data collection, coding and processing in the Islands.

NCCH Brisbane is currently finalising a contract for an AusAid In-Country Training Course in the Kingdom of Tonga, also being conducted in September. This two week program, being carried out by Sue Walker and Debbie Abbott, ►

### *ACBA students from the WHO South East Asia region*







**I-r Peng Bi, Tahnee Maker,  
Sue Walker and YC Chong**

consists of five days of medical terminology training, two days for clinical documentation requirements for clinicians, two days of introductory coding and one day of techniques for analysing coded data. We are also negotiating with WHO for a further two week ICD-10 training course in Bangladesh which, we anticipate, will be conducted in October or November.

Our final international work to report on in this edition of *Coding Matters* is the contract that we have signed, along with QUT, to provide medical terminology and introductory and advanced ICD-9-CM clinical coder training in Singapore. The work is being conducted for the Singapore Ministry of Health, representing public sector coders, and Parkway Healthcare, an employer of private sector coders.

The Health Information Management Association of Australia has been subcontracted to provide the first two subjects through its distance education program, with the advanced coding subject currently being developed by Andrea Groom, with assistance from Sue Walker and Jenny Nicol (from QUT). Forty-three students are enrolled, almost evenly spread between the medical terminology and clinical coding subjects. QUT is discussing the possibility of offering a further three subjects – mainly health sector management and casemix – to Singapore.

In the last few months, Sue Walker has participated in several (late night) teleconferences of the WHO Mortality Reference Group, along with Maryann Wood (representing ABS). NCCH has been involved in the proposed revision of several of the WHO rules for mortality coding. Sue Walker is also negotiating with IFHRO regarding a WHO Heads of Centres recommendation that a suitable international organisation be found with which to affiliate mortality coders. With the advent of the automated coding system, experienced

mortality coders are becoming rare and it is felt that a support network may be of value for these specialised positions.

## **Staff changes**

In late July, NCCH Brisbane was sorry to farewell Tahnee Maker from her position as Senior Classification Officer. Tahnee has moved to a newly created position in Queensland Health. Applications for Tahnee's job have now closed and we look forward to introducing a new staff member in the next edition of *Coding Matters*. We were sorry to lose Tahnee's capacity for hard work and her bubbly personality and we wish her well.

Unfortunately, our research associate, Peng Bi, has also recently submitted his resignation to accept a position as an infectious disease epidemiologist. We will also miss Peng's dedication when he leaves us in September. NCCH is currently discussing the possibility of a joint research appointment with the QUT Centre for Public Health Research.

On the topic of farewells, Caroline Stahl's six-month internship with the NCCH Brisbane is almost up and she returns to Germany in mid-September. It has been great having Caroline working with us and we hope that she tells others of her experiences here and encourages more students to explore the possibility of doing their clinical placements in Australia. Caroline is keen to return some day and we would certainly welcome her back with open arms. We look forward to hearing of her experiences as Germany moves to adopt AR-DRGs in the next few years.

Sunny Chan, the NCCH's PhD student, is just about to submit his second stage application to QUT – a requirement prior to the confirmation of his candidature. Sunny has recently sent out an international survey regarding the management processes and statistical techniques employed by our overseas colleagues in the changeover to ICD-10. He will also be surveying Australian institutions and individuals and hopes to develop a model of best practice to assist data collectors, coders, data users and researchers who confront future classification changes.

So, as you can see, it is a busy time for the Brisbane office and likely to only get busier as we move towards the end of the year. We look forward to reporting to you again in the next edition of *Coding Matters*.



### **Sue Walker**

Associate Director, NCCH Brisbane





# educational matters

## NCCH 7<sup>th</sup> Biennial Conference

As reported in previous issues of *Coding Matters*, due to the change to the production schedule of ICD-10-AM and the cluster of other conferences scheduled for the second half of each year, it was decided to move the NCCH annual conference to become a biennial conference (ie held every two years).

I can now announce that the **NCCH 7<sup>th</sup> Biennial Conference** will be held on **1–3 April 2001** at the **Landmark Parkroyal Hotel, 81 Macleay Street, Potts Point, Sydney, New South Wales.**

The conference will once again be an excellent avenue for the continuing education of clinical coders and health information managers. Features of the conference will be practical workshops, clinical updates and presentations addressing a range of current and future classification issues such as terminologies and electronic health record advancements. Our invited keynote speaker will be Dr Christopher Chute, Health Sciences Research, Mayo Clinic, Rochester MN USA.

A call for papers can be found on page 24 and an invitation to attend is on page 4. We would like to encourage all readers of *Coding Matters* to consider a presentation submission, to ensure that the news about your work and advancements in your domain are spread far and wide.

Conference registration programs will be mailed out with the December 2000 edition of *Coding Matters*.

## ICD-10-AM Second Edition Workshops Video

The ICD-10-AM second edition education workshops were held from March to June 2000. There were 40 workshops held across the length and breadth of Australia, reaching almost 1300 clinical coders and health information managers. The workshops' aim was to prepare clinical coders for the introduction of the second edition of ICD-10-AM on 1 July 2000.

Work is currently underway to enter the 1000 plus workshop evaluations into a database. A

full report will be made available in an upcoming edition of *Coding Matters*. General verbal feedback and *ad hoc* comments to date have been very positive. While we will attempt to consider all suggestions for improvements to the educational programs, we may have a little difficulty in satisfying one unidentified clinical coder who suggested that the workshops may have been more effective if we had included... 'male go-go dancers in cages'.

For those clinical coders who may have missed attending the second edition workshops or who feel they need a refresher, the video package of the workshop is still available to purchase (see the enclosed order form).

## Educational needs survey

A survey seeking feedback on clinical coders' educational needs was sent out as part of the June edition of *Coding Matters*. The survey was designed to assess the educational needs and preferences of clinical coders and users of the ICD-10-AM classification and other NCCH products. A big thank you to those 120 plus people who took the time to complete and return the survey. Your contribution to your continuing education is appreciated. Responses are currently being collated and analysed by Donna Truran and a full report will be published in *Coding Matters*.

To close, more probing into the minds of clinical coders through responses to the 'expand the abbreviation section' from the workshop 'Essential Pursuit' quiz...

**HNPCC** could stand for 'has not passed coding course'; **LTB** could stand for 'long tall bladder' or 'large T bone' or even 'little time bomb'. **FLK** caused much consternation with such responses as 'floppy loose knees', 'fat ladies club', 'full length knickers' and poetic licence with 'fancy looking (K) coders'

► **Karen Peasley**  
Education Manager

Correct answers:  
HNPCC – Hereditary Non Polyposis Colon Cancer; LTB –  
Laryngotracheobronchitis; FLK – Funny Looking Kid.



# classification support & development

The Classification Support and Development Division has had some staff changes since the last edition of *Coding Matters*. Unfortunately Francine Brownlow decided to resign, and we reluctantly said goodbye to her on 18 August. We wish Francine well for the future. The good news is that our recent advertisement for a person to cover Judith's and Tiffany's maternity leave resulted in the employment of Sheree Gray (pictured). Sheree moved to Sydney from Perth at the end of August and joined the NCCH team on 4 September. Sheree will be using the ICD-10-AM database to assist in development of new products and the creation of ICD-10-AM third edition.



These forums have proved valuable in gathering expert advice on areas which are important for a number of users of morbidity data. NCCH is indebted to DHAC for its support for these meetings, which are crucial for maintaining credibility of the classification.

## Summary of new queries received since *Coding Matters*, Volume 7 Number 1

These are some of the queries that have been received since *Coding Matters*, Volume 7, Number 1. These queries and answers can be viewed in the queries database on the NCCH website:

[www.cchs.usyd.edu.au/ncch/](http://www.cchs.usyd.edu.au/ncch/)

## Classification Update Forums

The Neonatology/Paediatric and Oncology Classification Update Forums (CUFs) were conducted in May and June respectively. These forums discussed a range of topics with approximately 20 participants attending each.

The topics on the agenda of the Neonatology/Paediatric forum that provoked most discussion were birth asphyxia, intraventricular haemorrhage and hypoxic ischaemic encephalopathy.

This forum also discussed intractable seizures, asthma, haemolytic uraemic syndrome, classification of perinatal and childhood deaths, post haemorrhagic hydrocephalus of newborn, persistent hyperinsulinaemic hypoglycaemia of infancy, coding of malformations, history of prematurity, and sepsis.

Topics for the Oncology forum included chemotherapy, morphology codes, tumour recurrence, contiguous sites, gliomas, malignant ascites, staging, familial adenomatous polyposis and hereditary non-polyposis colon cancer.

## Queries relating to Australian Coding Standards

- Insertion of ureteral stent
- Premature rupture of membranes
- Amputation of toes
- Patent processus vaginalis
- Admission for training in self-catheterisation

## Other queries

- Coronary artery disease
- Wallgraft endoprosthesis
- Head injury with fracture of external auditory canal
- Bankart lesion
- Antenatal care following kick to abdomen
- Anterior chest wall sinus
- Malignant hyperthermia
- Spinal anaesthesia in labour
- Benign giant cell tumour of tendon sheath

## Mental health subset of ICD-10-AM

The NCCH is currently developing a subset of ICD-10-AM for use in community-based mental health services. This initiative is in response to a need for a specific set of codes for community-based mental health and diagnostic criteria. This project will:

- create a morbidity classification which is acceptable to the national community-based health services sector
- develop a portable, accessible subset of ICD-10-AM
- produce a coding and diagnostic tool which will create a common morbidity data language between the acute and community sectors
- improve the coding of diagnoses and procedures carried out during non-admitted episodes in mental health services
- provide a nexus between mental health coding in the acute and community sectors.

The subset will feature:

- mental health diagnoses
- diagnostic criteria
- disorders and symptoms relevant to psychiatry but not part of the ICD-10-AM mental health chapter
- Australian Coding Standards relevant to mental health
- intervention codes relevant to mental health services
- codes consistent with the third edition of ICD-10-AM

Importantly, the project also includes an education program for community-based mental health professionals in the use of the ICD-10-AM subset.

The subset is scheduled for publication in early 2002.

▶ **Kerry Innes**  
Associate Director



## ICD-10-AM Second Edition workshop video

The video package comprises a three hour video of the NCCH ICD-10-AM Second Edition workshops. Included in the package is the video, workbook with practical scenario exercises, exercise answer booklet and feedback form.

The content of the video includes all the major revisions to the codes and indexing for the second edition of ICD-10-AM as well as new and revised Australian Coding Standards (ACS).

Topics covered include guidance in the coding of procedural complications, anaesthetic coding, the new place of occurrence and activity codes, the revised Allied Health codes and the revisions to the classification of diabetes mellitus.

*Video and workbook also available separately, see the NCCH order form for details.*

*Further queries about the video can be directed to Karen Peasley, Education Manager, NCCH on (02) 9351 9461 or via email [k.peasley@cchs.usyd.edu.au](mailto:k.peasley@cchs.usyd.edu.au)*





# the 10-AM commandments

**T**his 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.

## 1. Procedures for fractures of the fibula

Fractures of the shaft of the fibula generally occur in conjunction with fractures of the shaft of the tibia. This relationship is demonstrated in the procedures index and the inclusion note in the procedures tabular under blocks 1509 *Closed reduction of fracture of shaft of tibia* and 1510 *Open reduction of fracture of shaft of tibia*.

Fractures of the lower (distal) end of the fibula generally occur in conjunction with fractures of the ankle and are classified to blocks 1537 *Closed reduction of fracture of ankle or toe* and 1539 *Open reduction of fracture of ankle or toe*. This relationship is also demonstrated in the procedures index.

Fractures of the shaft of the fibula can occur in isolation, however this is rare. In most cases these fractures would be treated by cast immobilisation – 47576-00 [1495] *Immobilisation of fracture of fibula*. Reduction of these fractures is rarely indicated and so no MBS item exists for such a procedure. If a reduction procedure is performed, assign a code from blocks 1509 *Closed reduction of fracture of shaft of tibia* or 1510 *Open reduction of fracture of shaft of tibia* as appropriate. The diagnosis code will distinguish these cases from fractures involving the shaft of the tibia.

## 2. Anaesthetic coding

The following are some guidelines for areas of anaesthetic coding where there have been queries or concerns raised by clinical coders since the implementation of the second edition of ICD-10-AM.

### 'Omit code' instruction for anaesthetics

The MBS-E tabular list and alphabetic index still retain the notes 'omit code' for operative anaesthesia (eg see Volume 4 p125 – *Infusion, spinal canal, for operative anaesthesia* or Volume 3 p9 excludes note under block 36). As explained in the recent workshops, these notes were not removed due to time constraints in the publication of ICD-10-AM second edition and, as the coding of anaesthetics is new, there may be many more changes made in the future. For the moment, these notes are overridden by the Standard (ie the notes are to be ignored and the Standard followed).

### Dental/general anaesthetic codes

When a dental procedure is performed in conjunction with a non-dental procedure, and either sedation or general anaesthetic is administered, assign only the appropriate non-dental anaesthetic code/s.

### Terminology of 'regional'

A regional anaesthetic blocks the nerves that lead to and from a specific area. Regional techniques may include epidural, spinal and caudal injections/infusions, plexus or nerve blocks, field blocks (eg eye block) and intravenous regional blocks (Biers block). Epidural, spinal and caudal are known as 'major regional' anaesthetics. The title and excludes note at block 1909 *Regional anaesthesia* in the procedures tabular list is confusing and will be amended for ICD-10-AM third edition.

## Intravenous sedation

Sedation is a type of anaesthesia administered to make a patient more comfortable during a procedure but does not involve loss of consciousness or loss of protective reflexes. When administered intravenously (usually with benzodiazepines) it produces relaxation, relieves anxiety and has a marked amnesic effect. Intravenous sedation with benzodiazepines does not provide pain relief, which, if needed, must be achieved by other means such as local anaesthetic or intravenous analgesics.

Some common uses of intravenous sedation include:

- short-lived uncomfortable procedures where local anaesthetic is impractical, eg gastrointestinal endoscopy, musculoskeletal manipulation, insertion of ETT, and cardiac catheterisation.
- unpleasant procedures without autonomic side effects, eg wisdom tooth extraction, toenail operations, vasectomy. A local anaesthetic may be used in conjunction with sedation for these procedures.

For some of the procedures mentioned, the anaesthetic is administered by the clinician and not by an anaesthetist. In these cases, a code from block 1911 *Sedation* is still assigned, even though the code title states 'anaesthetist controlled'. Oral or intramuscular sedation is not coded.

## 3. Premature rupture of membranes and long labour/delivery

### Background

There have been a number of queries regarding the use of codes in categories O42 *Premature rupture of membranes*, O63 *Long labour* and O75 *Other complications of labour and delivery, not elsewhere classified*.

There is confusion regarding the assignment of codes from these categories as some codes appear not to be mutually exclusive. The following is a listing of the various categories and codes with notes below to explain their usage.

<b>O42</b>	<b>Premature rupture of membranes</b>
O42.0	Premature rupture of membranes, onset of labour within 24 hours
<b>O42.1</b>	<b>Premature rupture of membranes, onset of labour after 24 hours</b>
O42.11	Premature rupture of membranes, onset of labour between 1-7 days later
O42.12	Premature rupture of membranes, onset of labour more than 7 days later
O42.2	Premature rupture of membranes, labour delayed by therapy
O42.9	Premature rupture of membranes, unspecified

Codes from category O42 should be assigned when spontaneous rupture of membranes occurs before the start of labour. The terminology of 'premature' used in these code titles refers to 'before the onset of labour' and **not** the length of gestation of the pregnancy.

Clinicians appear to use the terms 'premature' and 'prolonged' interchangeably, which can be confusing. However, the use of the term 'prolonged' usually means the time interval between membrane rupture and the **start** of labour, not the length of labour itself. Consultation with the clinician is essential where there is any doubt about the meaning of the diagnosis 'prolonged rupture of membranes'.

### Transfers

The discharge/transfer time should be used to calculate the period of membrane rupture in cases where the patient is discharged/ transferred after membrane rupture but before labour commences.

<b>O63</b>	<b>Long labour</b>
O63.0	Prolonged first stage (of labour)
O63.1	Prolonged second stage (of labour)
O63.2	Delayed delivery of second twin, triplet etc.
O63.9	Long labour, unspecified Prolonged labour NOS

Codes from the category O63 should be assigned for documentation such as 'prolonged first stage', 'delayed first stage', ►

‘delayed second stage’, and ‘prolonged labour’. They would be assigned in cases where once labour has commenced, there is a delay in either a stage of the labour or the whole labour. The use of these codes has no relationship with the codes for premature rupture of membranes, ie they identify two different entities:

O42 category – membranes rupture, **start** of labour delayed by certain time, regardless of how long the actual labour is.

O63 category – long (prolonged) labour, irrespective of

1. when the membranes rupture or
2. any delay in the **start** of labour

Therefore, codes from O42 *Premature rupture of membranes* and O63 *Long labour* could be assigned if both conditions are present.

<b>O75</b>	<b>Other complications of labour and delivery, not elsewhere classified</b>
O75.5	Delayed delivery after artificial rupture of membranes
O75.6	Delayed delivery after spontaneous or unspecified rupture of membranes

**O75 is a NEC category** and should be used rarely as there will usually be other conditions documented which cause delay of delivery, eg uterine inertia, obstruction, delayed second stage etc. Such conditions should be coded in preference to a code from O75.

O75.5 should be assigned where there is a delayed delivery **NOS** (either onset of labour is delayed or the labour itself may be long) **following artificial rupture of membranes**. The rupture could be either before labour (induced, ARM) or during labour (augmentation). **This code should be used rarely**, as in most cases a combination of methods, both surgical and medical, will be used to induce and/or augment labour.

O75.6 should be assigned rarely and only where there is a delayed delivery **NOS** (either onset of labour is delayed or the labour itself may be long).

#### 4. Conditions occurring in neoplastic disease

Certain conditions occurring in neoplastic disease have a dagger/asterisk relationship in

ICD-10-AM. A public submission received by the NCCH emphasised the need to ensure that a specific neoplasm code is assigned where possible and not D48.9† *Neoplasm of uncertain or unknown behaviour, unspecified*, as the aetiology (dagger) code for these conditions.

Example of the index:

##### **Anaemia D64.9**

- in neoplastic disease NEC (M8000/1)  
(see also *Neoplasm*) D48.9† D63.0\*

##### **Fracture**

- pathological (cause unknown) M84.4-  
- - due to neoplastic disease NEC (M8000/1)  
(see also *Neoplasm*) D48.9† M90.7-\*

As indicated by the inclusion of ‘NEC’ in these index entries, D48.9† *Neoplasm of uncertain or unknown behaviour, unspecified*, should be assigned only when the type of neoplasm is unknown. When the type of neoplasm is known, follow the ‘see also *Neoplasm*’ note and assign the appropriate neoplasm code instead of D48.9† *Neoplasm of uncertain or unknown behaviour, unspecified*.

## 5. Diabetes

### 5.1 Diabetic diarrhoea

The following information is provided to assist coders in the assignment of E1-.43\**Diabetes with autonomic neuropathy* for diabetic diarrhoea.

“Diarrhoea is a relatively uncommon symptom of diabetic neuropathy, and is only rarely severe. Nocturnal exacerbations are characteristic but not invariable. Episodes last from a few hours to a few days, and then remit, with a normal bowel habit or even constipation between attacks. Once established, diarrhoea rarely remits completely but may continue intermittently for a decade or more, without necessarily worsening overall;...”<sup>2</sup>

“The diagnosis of diabetic diarrhoea must be established by confirming the presence of autonomic neuropathy, and excluding other causes of diarrhoea. Those affected mostly have long-standing IDDM, usually poorly controlled, with other evidence of autonomic and somatic neuropathy.”<sup>3</sup>

2 Clarke B F (1991). Textbook of Diabetes (2<sup>nd</sup> edition). (ed Pickup J, Williams G.) Vol 2 (chapter 61). Blackwell: Science Ltd.

3 Young R J (1991). Textbook of Diabetes (2<sup>nd</sup> edition). (ed Pickup J, Williams G.) Vol 2 (chapter 51). Blackwell: Science Ltd.



## Classification

When referencing the index entry 'Diabetes, with, diarrhoea' it should be noted that the title of the code given is '**diabetes with autonomic neuropathy**'. It should also be noted that '**diabetic diarrhoea**' is an inclusion term. The name of the code and the qualification of diarrhoea as diabetic is a good indicator that this code is for a particular type of diarrhoea peculiar to diabetes (and documented as such) – and not for diabetes with transient diarrhoea that does not meet the clinical picture outlined above.

When coding diabetes it is important to evaluate all the available information about a particular condition as well as the structure of the tabular list and index. Because of the complex nature of diabetes it is often difficult to fully reflect the complexity of the condition in the index. This is true for many conditions – which is why it is necessary to consult the tabular list to read inclusion and exclusion terms to confirm the index pathway.

### 5.2 Diabetes code sequencing

In many cases of diabetes it will be necessary to assign more than one code to fully describe diabetes and its associated complications. Although there are no dagger (aetiology) and asterisks (manifestation) associated with the diabetes codes in the second edition of ICD-10-AM, the intention is similar.

For example, a case of diabetic retinopathy should always have the diabetes code (E1-.31) sequenced first (similar to the dagger code) and the specific code for the retinopathy (H35.0) sequenced second (similar to the asterisk code).

The codes in block E10 – E14 represent the latest knowledge about the complications of diabetes. It is important that this sequencing rule be applied consistently to ensure that the complexities of this condition are as accurately reflected in code as possible.

## 6. ECT

The Coding Standards Advisory Committee (CSAC) recently discussed how anaesthetic codes should be assigned with ECT.

There are multiple options for resolving this issue and it was agreed that the following approach should be taken.

This issue will be further investigated for the third edition and reviewed at the Anaesthetic Classification Update Forum in the near future.

Electroconvulsive therapy is a procedure usually performed under general anaesthesia. ECT may be performed a number of times during one episode of care. The procedure code for ECT is split on the number of times the procedure is performed:

93340-00 [1907] Electroconvulsive therapy [ECT] ≤ 8 treatments

93340-01 [1907] Electroconvulsive therapy [ECT] > 8 treatments

ACS 0031 *Anaesthesia* directs coders to assign one anaesthetic code for each visit to theatre. That is, an anaesthetic code is assigned as many times as performed. ECT, on the other hand, is assigned only one code for multiple sessions.

Therefore, an ECT admission where a patient undergoes 5 separate sessions of ECT, with each being performed under an intravenous general anaesthetic, will be coded as follows:

93340-00 [1907] Electroconvulsive therapy [ECT] ≤ 8 treatments

92502-00 [1910] Intravenous general anaesthesia

92502-00 [1910] Intravenous general anaesthesia

92502-00 [1910] Intravenous general anaesthesia

92502-00 [1910] Intravenous general anaesthesia

92502-00 [1910] Intravenous general anaesthesia

## 7. Abnormal coagulation profile

Patients using anticoagulant agents often require admission to hospital for preoperative or postoperative stabilisation of anticoagulant (warfarin) levels. Similarly, when anticoagulant levels are not controlling a condition or if the anticoagulant levels require adjustment, an admission to hospital may be required.

### Classification

In cases where patients are admitted for stabilisation of anticoagulant levels (eg warfarin, heparin, clexane and fragmin) prior to surgery, ►

or when a patient's length of stay is extended for postoperative stabilisation, assign Z92.1 *Personal history of long-term (current) use of anticoagulants* as an additional code.

In cases where patients are admitted for treatment of abnormal coagulation profile (also known as unstable INR, overwarfarinisation, underwarfarinisation, prolonged bleeding time, abnormal bleeding time etc) assign D68.3 *Haemorrhagic disorder due to circulating anticoagulants*.

#### Example 1:

Diagnosis: Patient on long term anticoagulants, admitted one day prior to TURP for heparinisation.

Code: Z92.1 *Personal history of long-term (current) use of anticoagulants* (as an additional code)

#### Example 2: (see also ACS 1902 *Adverse effects of drugs*)

Diagnosis: Patient on warfarin for atrial fibrillation admitted with warfarin toxicity causing epistaxis.

Codes: D68.3 *Haemorrhagic disorder due to circulating anticoagulants*  
R04.0 *Epistaxis*  
Y44.2 *Anticoagulants causing adverse effects in therapeutic use*  
An appropriate place of occurrence code (Y92.-).

#### Example 3: (see also ACS 1901 *Poisoning*)

Diagnosis: Elderly gentleman admitted because he had taken incorrect dosage of warfarin resulting in overwarfarinisation.

T45.5 *Poisoning by anticoagulants*

Codes: D68.3 *Haemorrhagic disorder due to circulating anticoagulants*  
X44 *Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances*  
An appropriate place of occurrence code (Y92.-) and activity code (Y93.-).

#### Example 4:

Diagnosis: Patient with a history of DVT, treated with warfarin for the past 2 years is admitted for a CABG. Discharge was delayed while warfarin was stabilised post surgery.

Codes: Z92.1 *Personal history of long-term (current) use of anticoagulants* (as an additional code)

## 8. Consolidation of lung

Lungs are described as consolidated when the normal air-filled spaces distal to the bronchi are occupied by:

- blood
- pus
- water.

Consolidation is confirmed by radiographic imaging, usually X-ray.

Causes of lung consolidation include:

- pulmonary oedema
- cardiogenic/fluid overload
- adult respiratory distress syndrome
- inhalation of noxious gases
- drug abuse
- neurogenic disorders (including head injuries)
- trauma, such as fat embolus
- renal disease
- eosinophilic lung disease
- collagen vascular disease
- pneumonia
- radiation pneumonitis
- neoplasm
- haematological disorders
- contusion
- infarction
- idiopathic pulmonary haemorrhage (Goodpasture's syndrome)
- sarcoidosis
- alveolar proteinosis.

Consolidation of the lung is a symptom of an underlying condition or the result of injury or trauma. Often it is caused by pneumonia.

When the underlying condition is known, code only the underlying condition.

When the underlying condition is unknown, seek clinical advice.

In the case of injury, code only the injury which caused the consolidation.

**Note:** *the index entry at 'Consolidation, lung' currently leads to 'Pneumonia, lobar'. Until this is modified in the third edition, please follow the above advice.*

## 9. Old AMI

Currently in ICD-10-AM, the distinction between I25.2 *Old myocardial infarction* and I25.8 *Other forms of chronic ischaemic heart disease* is based on the presence of symptoms. However, there is some dissension about what constitutes a symptom. Therefore, the distinction between these two codes has undergone revision (see below) and is now based on the treatment given during the current episode of care rather than the presence of symptoms.

Please note that this guideline should be followed in addition to ACS 0940 *Ischaemic heart disease* (second edition) and supersedes the statement '...but currently presenting no symptoms' in the index entry for old (past) AMI.

### \* Other forms of chronic ischaemic heart disease (I25.8)

Myocardial infarction described as 'chronic' or with a duration of more than four weeks (28 days) from onset and for which the patient is currently receiving care (observation, evaluation or treatment) is classified to I25.8 *Other forms of chronic ischaemic heart disease*.

### \* Old (healed) myocardial infarction (I25.2)

I25.2 *Old myocardial infarction* is essentially a 'history of' code, even though it is not included in the Z code chapter. It should be assigned as an additional code only if all of the following criteria apply:

- the 'old' myocardial infarction occurred more than four weeks (28 days) ago
- the patient is currently **not** receiving care (observation, evaluation or treatment) for their 'old' myocardial infarction
- the 'old' myocardial infarction has some significance for the current episode of care as documented by the treating clinician. For example, an old MI is considered significant in patients being treated for another cardiovascular condition.

## 10. Neurointestinal dysplasia

'Neurointestinal dysplasia' is also known as 'intestinal neuronal dysplasia'. These terms refer to an abnormality of intestinal innervation resulting in the dysfunction of colonic motility. The common comorbidities include intractable constipation and intractable encopresis (faecal incontinence).

Currently in ICD-10-AM there is no specific code for neurointestinal dysplasia or intestinal neuronal dysplasia. However, based on consultation with clinicians, K59.2 *Neurogenic bowel, not elsewhere classified* is the most appropriate code for this condition.

Index changes are proposed for the third edition which will make these conditions more easily accessible.

## ICD-10-AM

*Second Edition*

**now available**

ICD-10-AM Second Edition, effective from July 2000, includes:

- ▲ standards for coding anaesthesia
- ▲ modifications to incorporate changes in the Medicare Benefits Schedule
- ▲ improved codes for allied health procedure codes, cerebral palsy, sleep apnoea, firearm injuries and sporting injuries
- ▲ changes to diabetes mellitus with improved codes and a comprehensive standard for their application
- ▲ improved standards for coding postoperative complications



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## CLINICAL UPDATES

### Clinical coder's guide to dental services

Coding of dental procedures can be difficult if coders are unfamiliar with the terminology. This section has been prepared by the NCCH, based on a *Clinical coder's guide to dental services* produced by Jenny Kok (The Canberra Hospital). Its aim is to assist coders to understand some common terms and procedures used in dentistry. However, it is recommended that further clarification from the medical/dental practitioner is sought if a procedure documented in the medical record is not clear.

ICD-10-AM dental procedure codes are based on *An Australian Schedule of Dental Services* (sixth edition) published by the Australian Dental Association Incorporated.

This is a multi-part series. Procedure descriptions and codes will appear in *Coding Matters*, Volume 7, Number 3.

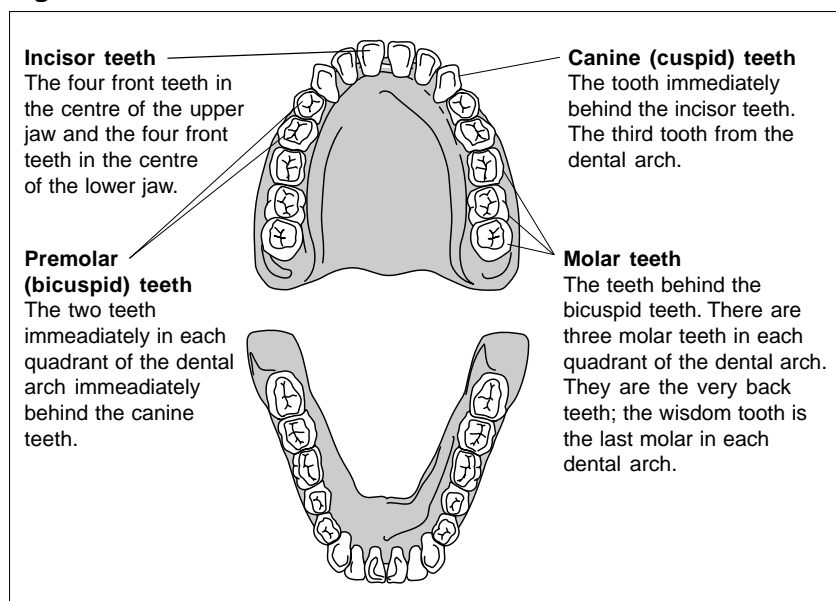
#### Dental arch

Figure 1 illustrates the maxilla (upper jaw) and the mandible (lower jaw).

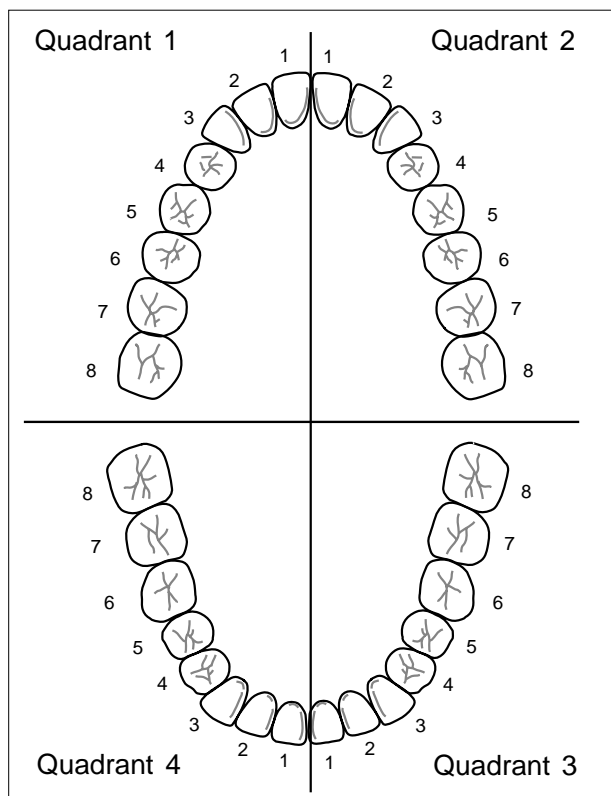
#### Teeth charting

Generally there are two ways in which the position of teeth are recorded. To understand this concept, an understanding of the dental arch is needed.

**Figure 1**



**Figure 2**



Hence, from the chart in figure 2, the upper right first Molar is either indicated as:

6 OR 26

6 and the 2 indicates that the tooth is in the upper right quadrant. The 6 denotes the first molar.

## Common definitions

- Endodontics** – That part of restorative dentistry concerned with the restoration of individual teeth.
- Periodontics** – The study and treatment of diseases of the tissues supporting the teeth.
- Orthodontics** – A branch of dentistry concerned with the diagnosis and treatment of malocclusion and irregularities of teeth.
- Prosthodontics** – A branch of restorative dentistry that deals with the construction of removable prostheses to replace missing teeth.

## Bridge

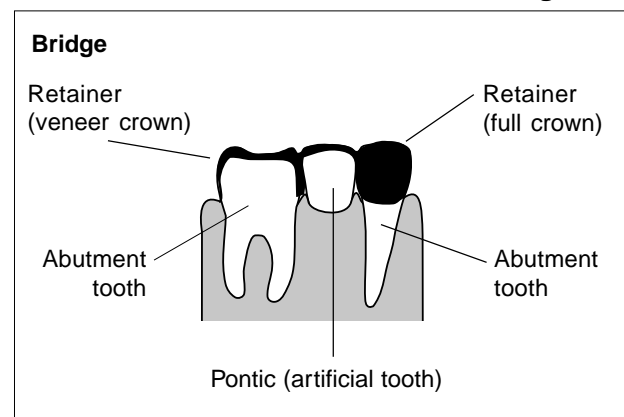
- A bridge is made up of pontics (replace missing teeth) which are joined to adjacent teeth on either side. These adjacent teeth are prepared to receive cast metal restorations.

## Crown

- Full/partial replacement of clinical crown that is attached to the remaining part of the tooth. Materials used include metal, resin and porcelain

Information and illustrations used in this article are based on *An Australian Schedule of Dental Services*, 6<sup>th</sup> edition; published by the Australian Dental Association Incorporated; 2000.

**Figure 3**



## Oral surgery

### *Surgical removal of teeth*

This requires an incision and reflection of the mucosa. Following the extraction of the tooth, suturing is necessary to close the wound.

### *Non-surgical removal of teeth*

'Forceps extraction' and 'extraction' commonly refer to non-surgical extraction of teeth.

## Restorative dental services

These services are concerned with the restoration of defective teeth as a result of caries or trauma. Restorative services range from simple fillings of defective areas to full construction of crowns and bridges.

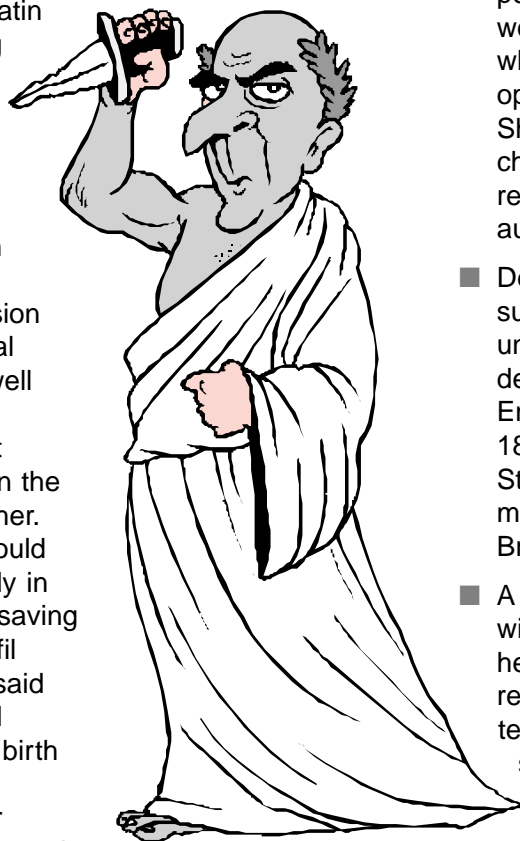
## Materials commonly used in restoration

<b>Materials</b>	<b>Definition</b>
Amalgam	A widely used filling material for posterior teeth made of an alloy of mercury with another metal, such as silver, tin and copper.
Glass ionomer/silicate	Cement type material that is more commonly used for the restoration of anterior teeth.
Composite resin	A ceramic-filled polymer restorative material used for restoring both anterior and posterior teeth.
Gold foil	Gold that has been rolled to a thickness of foil compacted into the cavity in increments.
Metal alloys	These are commonly used in construction of inlays or onlays.

## Did you know?

Caesarean section, or the surgical delivery of a child, is a term with an interesting etymology and lots of associated folklore. Greek myth had Apollo delivering his son, Aesclepius, by C-section. But by far the most pervasive legend regarding this operation is associated with its name.

Legend has it that Julius Caesar was surgically delivered, hence his name from the Latin *caesus*, meaning 'to have been cut'. This seems unlikely as Caesar's mother, Aurelia, survived his birth and lived to hear news of his invasion of Britain. Surgical deliveries were well known in Roman times, but almost always resulted in the death of the mother. The operation would be performed only in the slim hope of saving the child or to fulfil Roman law that said that mothers and children dying in birth should be buried separately. Other versions of the legend have a relative of Caesar's being surgically delivered and conferring the name upon his younger relation.



This origin of Julius's name is not certain, though. Pliny reported that the name derived from *caesaries*, or hair, as the future dictator of Rome was born with a full head of hair.

But did the term come from the legend, true or not, that Caesar or one of his relatives was surgically delivered? The Oxford English Dictionary thinks so (but it also accepts that Julius was a surgical delivery), as do many other authorities. Brewer's, however, believes that the etymology comes directly from the Latin *caesus*, with no allusion to the dictator. This seems plausible as late-medieval surgeons would have likely used Latin terms for their operations.

The term 'caesarean section' dates to at least 1615, used in Crooke's *Body of Man*.

Having nothing whatsoever to with etymology, the following are some interesting facts regarding C-sections:

- The first recorded C-section in which the mother lived was performed in 1500 by a Swiss pig-gelder, Jacob Nufer, who performed the operation on his wife. The woman had been in labour for several days when Nufer got permission to attempt the operation. Both she and the child survived. She subsequently gave birth to five other children, including twins. The story was not recorded until 1582, however, so its authenticity is somewhat questionable.
- Despite the long tradition of midwifery, surgical deliveries were the province of men until very recently. The first caesarean delivery performed by a woman in the British Empire was sometime between 1815 and 1821. It was performed by James Miranda Stuart Barry, who was masquerading as a man and serving as a physician with the British army in South Africa.
- A British traveller, R W Felkin, reported witnessing a surgical delivery by native healers in Uganda in 1879. The patient recovered. Felkin concluded from the technique and apparent expertise of the surgeon that the procedure was well established. Similar reports are to be had from Rwanda.
- In comparison, one estimate cited by the National Library of Medicine estimates that not one woman survived a caesarean in Paris in the years between 1787 and 1876.

The National Library of Medicine at the National Institute of Health web page, dated August 1994, was used as a source, as was the Compact Oxford English Dictionary, 2nd Edition; Oxford University Press; 1991; ISBN 0-19-861258-3. Including the Oxford English Dictionary Additions Series, Volumes 1-3; Oxford University Press; 1993 & 1997;

Brewer's Dictionary of Phrase & Fable, 15th Edition; Harper Collins; 1995.

Reprinted with permission from Dave Wilton's Etymology Page <http://www.wilton.net/etyma1.htm>





# publication issues

Welcome to the September issue of *Coding Matters*, another bursting with information for the clinical coder and health information manager. Thank you to all our contributors.

Publications and Technology Division has been extremely busy, not only with the production of publications and products, but also with distribution and coping with the implementation of GST.

ICD-10-AM second edition browser production has been delayed. We expect delivery early in October.

Germany's decision to use AR-DRG version 4.1 has provided a lot more work for the Division. Cath Stanhope's grasp of the German language is improving, although, I think our German customers may also be benefiting from Cath's colourful use of Australian English.

## NCCH display

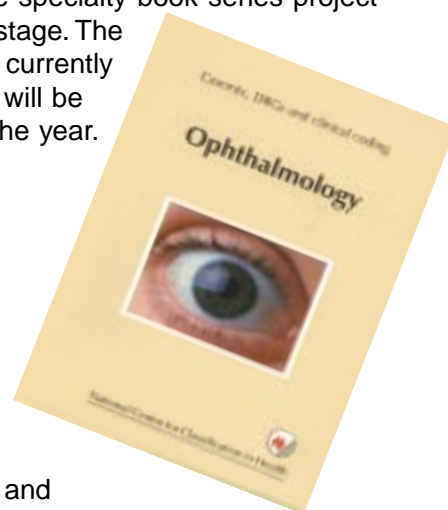
The NCCH recently purchased a new display system, a Vale Display Systems 'Instand', for use at conferences, exhibitions and seminars. The 'Instand' is a three metre collapsible wall with a series of colourful panels identifying the core

areas of the NCCH. The unit will provide a strong focal point to our displays in the future.

## Ophthalmology specialty book

The latest specialty book in the Casemix, DRGs and clinical coding series, *Ophthalmology*, is now available. The specialty book series project is now in its final stage. The last four titles are currently in production and will be available later in the year.

They include *Neonatology and Paediatrics* and *Obstetrics and Gynaecology* and the final two revised titles, *Respiratory Medicine and Thoracic Surgery* and *Cardiovascular Medicine and Surgery*, which will round off the series. Keep a look out for them on our order form and website: [www.cchs.usyd.edu.au/ncch/](http://www.cchs.usyd.edu.au/ncch/)



The specialty book series have also been further developed as electronic publications at the request of NSW Health. The books are published electronically as Portable Document Files (PDFs) using Adobe Acrobat.

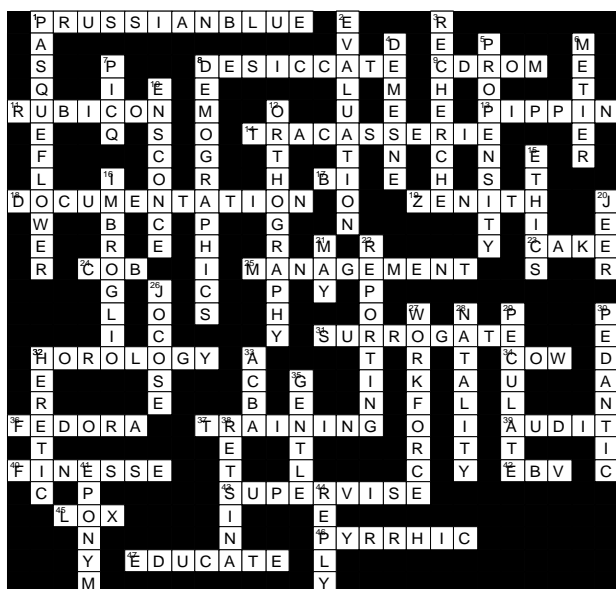
## Digital Coding Matters

All issues of *Coding Matters* are now available to view and download as PDFs at the NCCH website. They are also linked to the *Coding Matters* index and to the Coding Queries database. This will enable readers to cross reference information.

The NCCH website has recently been revamped to provide greater ease of navigation and provide a useful source of information to health information managers and clinical coders.

▶ **Rodney Bernard**  
Publications and Technology Manager

## Truran's Teaser No.4 solution



## INTERVIEW

Dr Wu Hong is a visiting fellow from the WHO Collaborating Centre in Beijing, China, who was based at La Trobe University for six months. During her visit to the NCCCH Sydney office, 29 June – 7 July, we took the opportunity to speak with her to satisfy our curiosity about health information management and clinical coding in China today.

Hong is involved in reviewing systems for the proposed introduction of ICD-10 into China in 2001.

*Coding Matters: What is your professional background?*

**Wu Hong:** I studied Clinical Sciences at the Capital University of Medical Sciences in Beijing. After an internship at Chaoyang Hospital, I worked in various areas in the hospital including surgery, general medicine, and the emergency centre. An interest in health information management grew from that hospital experience. After graduation an opportunity to work at WHO Collaborating for ICD in China came up.

*CM: How long have you been working at the WHO Collaborating Centre in China and what is your role at the centre?*

**WH:** Four years in charge of classification of diseases in hospitals in China.

*CM: What attracted you to visit Australia for your fact-finding mission?*

**WH:** China is in the same WHO western Pacific region and uses ICD-10 as the basis for health information. Australia has made great progress in HIM and ICD-10-AM and serves as a good model.

*CM: Can you provide me with some background to the health system in China at present?*

**WH:** There are over 311,000 health units in China and 15,413 hospitals serving a fifth of the world's population. Almost all hospitals are public. Most are general but some focus on specialty areas such as oncology or plastic surgery. Most hospitals are public funded.

All hospitals collect medical records, and their quality varies. Most large hospitals would have around three coders. HIMs as such don't exist in

China; clinical coders are made up of nurses, doctors and other hospital staff.

*CM: When is China due to implement ICD-10?*

**WH:** During 2001 as a staged progression. ICD-9-CM is used for procedures coding. ICD-10 is used for classifying diseases and for mortality data. I am in charge of training coders to use ICD-10 through the Ministry of Health.

*CM: What problems do you anticipate using different versions of classifications for procedures and diseases? What problems do you see given that ICD-9-CM procedure classification is a little out-dated in relation to current procedural concepts?*

**WH:** The suitability and cost of full ICD-10 implementation is too great at this stage. Using ICD-9-CM procedures will cause some problems that must be overcome. Eventually ICD-10 classification of diseases and procedures will be modified to suit the needs of China's health system.

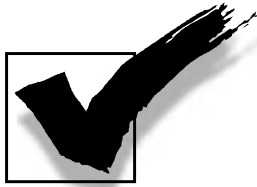
*CM: You have been in Australia since mid-May. What skills/knowledge have you picked up that will assist you and your team when your return to China?*

**WH:** I am familiar with Australian Coding Standards, and they provide a useful model to develop Chinese standards. Casemix or a similar funding system would improve coding quality. The health information systems in Australia are very good and could provide a model for China, especially features like bar coding systems. Education of specialist HIMs would be good for our hospitals.

*CM: What do you think of Australia? Have you had time for any leisure/sightseeing activities?*

**WH:** Australia is a beautiful country, green grass and clean air. People are very friendly. I have been to the Sydney Opera House, Darling Harbour, Taronga Zoo, and the Blue Mountains. I spent six weeks in Melbourne at La Trobe University and visited the Royal Botanic Gardens and Phillip Island. I also did some sightseeing on the Great Barrier Reef.





# quality concerns

## PICQ news

Gay Lysenko was contracted to work with NCCH over a year ago. Her brief was to manage the development, production and commercial release of the Performance Indicators for Coding Quality (PICQ) product – no small task! Gay has spent many long hours working on the development of indicators, liaising with the programmers, organising testing of the prototype product with users, analysing results, managing contracts and payments, writing user manuals and conference papers, and organising seminars.

With the release of PICQ in October Gay's contract with NCCH is coming to a close. This has given Gay the opportunity to relax in France during September. When she returns from her sojourn in Europe, Gay is returning to her consultancy work. The NCCH staff who have worked closely with Gay on the PICQ project have enjoyed her warmth, good humour, energy



*I-r Donna Truran, Gay Lysenko, Nicole Schmidt and Irene Kearsey*

and enthusiasm. While the credit for getting the product to sale is largely due to Gay, we're sure she will allow us all to share in her success. We'll miss her sunny smile and outrageous laugh. She leaves with our thanks and very best wishes.

► **Donna Truran**  
Research Officer



## The University of Sydney

### Quality and Education Coordinator

*National Centre for Classification in Health*

**Reference no: D000812**

This is a newly created position to assist the manager, Quality and Education Division, to carry out the quality and education functions of the National Centre for Classification in Health (NCCH).

The position is located at the NCCH Quality and Education Division, La Trobe University, Bundoora, Victoria. The successful applicant will be responsible to the Manager, Quality and Education Division, also located at La Trobe University. However, the quality and education coordinator will be a contracted employee of the University of Sydney, through NCCH (Sydney).

The position will be full time however, negotiation of hours will be considered. The position will also require some interstate travel.

Staff of the Quality and Education division (La Trobe University) will work closely with the Classification Support and Development, Publications and Technology and Research Divisions of NCCH (Sydney) located at The University of Sydney and NCCH (Brisbane) located at Queensland University of Technology.

The motivated individual we seek will be responsible for the planning, organising and presentation of education programs for clinical coders and users of coded data as well as the development of education material (in conjunction with the Senior Classification Officer, NCCH (Brisbane)). The position also involves the coordination of conferences and seminars and the coordination of the national coding educators network. The successful applicant will also assist with the implementation and maintenance of the Performance Indicators for Coding Quality

(PICQ) and Australian Coding Benchmark Audit (ACBA) marketing plan along with assisting the Senior Quality Officer in the maintenance of PICQ and ACBA. Other duties include the coordination of the PICQ and ACBA consulting and bureau service, providing assistance to sites in the implementation of PICQ and ACBA, establishing and managing a system for collation and comparison of PICQ and ACBA data and customer feedback and maintaining a data base of coding audit studies in the published literature.

**Essential:** Tertiary qualifications in Health Information Management or other health related discipline. Excellent skills in teaching and presentation and knowledge of coding audit methods. Excellent organisation and communication skills as well as good skills in word processing, Powerpoint, spreadsheets and database applications. Sound experience in classification of diseases and procedures and coding using ICD-9-CM and ICD-10-AM. Excellent knowledge of medical terminology, disease processes and surgical procedures. Knowledge of coding software and AR-DRG's.

The position will be for a fixed term to 30 June 2003, subject to the completion of a satisfactory probationary period for new appointees.

**Enquiries and further information:** Karen Peasley, Quality and Education Manager, Phone (02) 9351 9461; Fax (02) 9351 9603; Mobile 0418 116 723 or email: k.peasley@cchs.usyd.edu.au

**Remuneration package:** \$60,155 - \$67,844 p.a. (which includes a base salary Level 8 \$50,832 - \$57,329 p.a., leave loading and up to 17% employer's contribution to superannuation).

**Closing:** 6 October 2000

Applications should quote the reference no., address the selection criteria include a CV, the names, addresses, email, fax and phone numbers 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 employment opportunity and cultural diversity. The University reserves the right not to proceed with any appointment financial or other reasons.*

<http://www.usyd.edu.au>



# the language of health

## 7<sup>th</sup> Biennial Conference

1–3 April 2001

Landmark Parkroyal,  
Sydney, New South Wales

## CALL FOR PAPERS

The NCCH and CCSA Conference Committee are pleased to invite prospective participants to submit abstracts for presentation at the 7<sup>th</sup> Biennial Conference.

Within the context of 'the language of health' the themes to be explored are:

- ▼ electronic health records
- ▼ issues in clinical coder education
- ▼ current and future coding systems
- ▼ clinical coder workforce issues
- ▼ coding and health data quality management
- ▼ beyond acute classifications
- ▼ emerging issues in clinical classification
- ▼ classification, terminologies and vocabularies
- ▼ health information and coding technology

The criteria for the selection of papers will include relevance, professional interest and innovation. Selection of papers will be made by the NCCH/CCSA Conference Committee. The expected length of each presentation is 15-20 minutes.

The submitted paper should include:

- ▼ working title of the presentation
- ▼ preferred presentation length (in minutes)

- ▼ an abstract of not more than 500 words
- ▼ name of author(s) in bold, name of presenting author underlined, title, position, organisation
- ▼ full mailing address, phone, fax and email addresses

The abstract may be submitted via e-mail to [k.peasley@cchs.usyd.edu.au](mailto:k.peasley@cchs.usyd.edu.au). Attachments are to be formatted in MIME and saved as .RTF or .DOC

Alternatively, mail a formatted disk with files saved as either .RTF or .DOC and two hard copies of all documents to:

Ms Karen Peasley,  
Education Manager  
National Centre for  
Classification in Health  
PO Box 170  
Lidcombe NSW 1825

***All abstracts must be submitted by  
Friday 3 November 2000***

*Authors will be notified in writing of their acceptance or otherwise of papers. The decision on acceptance of papers will be at the discretion of the NCCH/CCSA Conference Committee.*

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the language of health