NIS: A user's guide

NCCH is proud to announce our new online interactive information system. NIS is available now and will offer a number of services to our web users.

What is NIS?

NIS is the NCCH Information System, a web-based information system delivering services to our clients and for supporting NCCH operations in classification management.

NIS will allow you to register for workshops, conferences and other NCCH events. You can also subscribe to *Coding Matters*, catalogues, maintain your contact details, download software and information as they become available. The NCCH, via the NIS, can keep you informed of events, training and products.

How to get access to NIS

To access NIS, you are required to register via the NCCH web page. This article will provide step-by-step directions to set up your account and how to maintain it.

New users registering for the first time

New users must register with NIS to create a user name. Firstly, go to the NCCH website, *http://nis-web.fhs.usyd.edu.au/ncch_new/* and click on 'Register' at 'Log in / Register' in the 'Quick Links' panel on the right of the website. If you are an existing *Coding Matters* subscriber with a valid e-mail address, you need to check whether you have been registered with NIS by clicking 'Lost your NIS ID?' and then provide

Use the 'Log In/Register' in Quick Links to enter NIS

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Registration page for new users

NCCH Information System Registration

Please complete the required fields (in red).

Field	Value
NIS ID:	Marge123
Title:	Mrs
Given Name:	Marge
Surname:	Simpson
Job Type:	Clinical Coder
Job Title:	Clinical Coder
Organisation:	Springfield Hospital
Address Type:	Work
Address:	Building M Level 5
Address (cont.):	Faculty of Science
Address (cont.):	75 East Street
City/Suburb:	Lidcombe
State/Province:	NSW
Zip/Post Code:	2141
Country:	
Telephone:	(02) 93519461
Fax:	(02) 93519603
Mobile:	0435123123
Primary Email Address:	msimpson@springfield.com.au
Secondary Email Address:	msimpson@yahoo.com.au
Password:	••••
Re-type Password:	••••

A valid e-mail address is necessary

Please enter the characters in the image in the text box (case sensitive).

Randomly generated security characters must be entered

Please make sure all required fields are completed before you press the Submit button.

Submit   Cancel

Sign In to NCCH Information System

If you are already registered with NCCH please sign in with your NIS ID and password below. Otherwise, please sign up here.

NIS ID:	
Password:	

Login

Lost your Password?

Lost your NIS ID?

Sign in to NIS if you have an account or use 'Lost your NIS ID' to check if you are registered

your e-mail address and your name. NIS will notify you if you have been registered by sending an e-mail with your NIS ID and password. This will avoid duplication of your NIS ID.

All mandatory fields indicated by red text must be filled to successfully register. On completion of your details a randomly generated distorted security code (image) must be entered before you click on the submit button. Your registration will be confirmed via e-mail and you can then proceed to use the NIS website.

If you have already registered, use 'Log In' to go directly to your account by entering your NIS ID and password.

Remember to log off when you have finished your NIS session. If you forget to log off your session will expire after 30 minutes of inactivity and you need to log in again.

What if I lose my password?

Don't panic! Your user identity and password are linked and both are required for you to successfully log in. You can retrieve a lost or forgotten password, or NIS ID by clicking on either 'Lost your Password?' or 'Lost your NIS ID?'. Your forgotten details will then be sent to your registered e-mail address immediately.

If you do forget your NIS ID or password, please do not register again as a 'new user' as this creates unnecessary duplication of accounts.
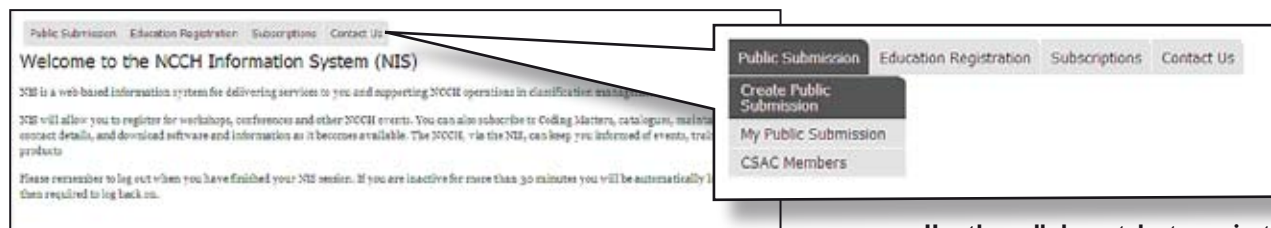
Public submissions

Public submissions regarding ICD-10-AM/ACHI/ACS can be made in your account by choosing 'Public Submission' and clicking on the tab, illustrated above. A new screen will provide a number of options for you to choose and make a submission. Please note that the public submission area is not a coding query forum. See *Coding Matters* Volume 15 Number 1 for further details on how to make a submission. The guidelines for making public submissions can also be accessed by using the hyperlinks on the NCCH website.

Registering for NCCH conference or workshops

You can use your NIS account to register for conferences or workshops when they are offered. For workshops, it will allow you to select your preferences for dates, locations and special requirements. The online registration, most of all, helps us reserve your seat quicker for one of these events. Please note that 2009 workshop registration is now closed.

Subscriptions

NIS will enable you to edit and maintain your subscription details for *Coding Matters* and other NCCH publications. A number of options are available to allow you to choose how you would like to receive the newsletter, by print or e-mail.

Future enhancements to NIS

In response to user demand, NCCH is considering an online education program for ICD-10-AM/ACHI/ACS Seventh Edition. It would provide user-pay interactive web-based training for registered NIS users. It would include a forum for education users to discuss the changes made to the classification and post comments back to the NCCH for a response.

NIS is a work in progress; therefore, more features will be developed to provide more services to you. NCCH will announce new features via NIS, *Coding Matters* and the NCCH website as they become available.

Australian Refined Diagnosis Related Groups (AR-DRG)

Version 6.0

AR-DRG is a classification scheme based on ICD-10-AM/ACHI/ACS codes. It provides a way of grouping episodes of care in a hospital according to clinical characteristics and resource use.

AR-DRG Version 6.0 incorporates ICD-10-AM/ACHI/ACS Sixth Edition codes.

AR-DRG definition manuals are published by the Australian Government Department of Health and Ageing and distributed by the NCCH.

For further information and to order:

NCCH Sydney
Telephone: +61 2 9351 9461
E-mail: fhsNCCHsales@usyd.edu.au

The **10-AM** Commandments

Combination drug coding

How should poisoning/adverse effect due to combination drugs be coded? For example, *Mersyndol*, which is a combination of 3 drugs; *codeine, paracetamol* and *doxylamine succinate*.

If a combination drug is documented as the cause of a poisoning/adverse effect – and no individual component is identified as being responsible for the poisoning/adverse effect, assign a code for each of the components.

> **Example 1:** Patient admitted with poisoning by *Mersyndol (codeine, paracetamol and doxylamine succinate)*. No individual component of the *Mersyndol* was identified as the cause of the poisoning.
>
> **Table of Drugs and Chemicals:**
> Codeine…T40.2
> Doxylamine…T45.0
> Paracetamol…T39.1
>
> **Assign:**
> T40.2 *(Poisoning by) Other opioids*
> T45.0 *(Poisoning by) Antiallergic and antiemetic drugs*
> T39.1 *(Poisoning by) 4-Aminophenol derivatives*
>
> With a code for any significant manifestation that meets the criteria in ACS 0002 *Additional diagnoses*, plus appropriate external cause, place of occurrence and activity codes.

If a combination drug is documented as the cause of a poisoning/adverse effect – and one of the components is **identified** as causing the poisoning/adverse effect, assign a code for that drug only. Code(s) for the other components of the combination drug are not required.

> **Example 2:** Patient admitted with bronchospasm due to ingestion of *Mersyndol (codeine, paracetamol and doxylamine succinate)* – taken as directed on the packet, for menstrual cramps. The codeine was documented as the cause of the bronchospasm.
>
> **Table of Drugs and Chemicals:**
> Codeine…Y45.0
>
> **Assign:**
> J98.0 *Diseases of bronchus, not elsewhere classified*
> Y45.0 *(Drugs …causing adverse effects in therapeutic use) Opioids and related analgesics*
>
> With appropriate place of occurrence code.

See also ACS 1901 *Poisoning* and ACS 1902 *Adverse effects.*

Complications of surgical and medical care

a. Headache due to anaesthesia

How do you code headache due to anaesthesia (other than spinal and epidural anaesthesia)?

To code headache due to anaesthetic drugs or anaesthesia in ICD-10-AM Sixth Edition, follow the guidelines in ACS 1904 *Procedural complications* and ACS 1902 *Adverse effects, Drugs.*

For headache due to anaesthetic drugs, follow the index pathway:

Headache
- drug induced NEC G44.4

and assign G44.4 *Drug-induced headache, not elsewhere classified* with an external cause code to identify the drug.

If the headache is specified as due to anaesthesia, but not specifically the anaesthetic drugs, follow the index pathway:

Complications
- anaesthesia, anaesthetic NEC *(see also Anaesthesia, complication or reaction NEC)* T88.5

and assign T88.5 *Other complications of anaesthesia* with R51 *Headache* as an additional diagnosis to complete the clinical picture.

b. Leaking gastrostomy tube

What is the correct code assignment for leaking gastrostomy tube?

To assign a code for leaking gastrostomy tube follow the guidelines in ACS 1904 *Procedural complications:*

> "Firstly, check the Alphabetic Index under the main term which best describes the complication, for the subterm of 'procedural' or 'postprocedural'…
>
> In some cases, rather than the generic term 'postprocedural', the subterm may directly describe the procedure involved."

Therefore, the correct code to assign is T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts* by following the index pathway:

Leak, leakage
- device, implant or graft
- - gastrointestinal (bile duct) (oesophagus) T85.5

with Y83.3 *Surgical operation with formation of external stoma* and Y92.22 *Health service area.*

c. Postprocedural bile leak

What is the correct code assignment for postprocedural bile leak?

When *postprocedural/anastomotic bile leakage* is documented but trauma or mechanical complication (conditions listed in T82.0) due to gastrointestinal implant is not specified, assign K91.8 *Other postprocedural disorders of the digestive system, not elsewhere classified*, following the index pathway:

Complication
- digestive
- - postprocedural
- - - specified NEC K91.8

K83.8 *Other specified diseases of biliary tract* may be assigned as an additional code to specify the site of the postprocedural/anastomotic bile leak.

Where there is documentation that the postprocedural/anastomotic bile leak is due to trauma or mechanical complication (conditions listed in T82.0), assign the appropriate codes from Chapter 19 *Injury, Poisoning and Certain Other Consequences of External Causes* (S00–T98) as per the guidelines in ACS 1904 *Procedural complications*. For example, for a postprocedural/anastomotic bile leak due to:

- **operative trauma** – assign T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* with the appropriate injury code (S code) to identify the site of the trauma.

- **mechanical complication** (conditions listed in T82.0) due to a gastrointestinal implant – assign T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts*.

In addition, assign external cause of injury and place of occurrence codes as appropriate.

Deep inferior epigastric perforator (DIEP) flap for breast reconstruction

What is the correct code to assign for a DIEP flap for breast reconstruction?

The correct code to assign for a DIEP flap for breast reconstruction is 45530-00 [1756] *Reconstruction of breast using myocutaneous flap*. Even though a DIEP flap does not use myocutaneous tissue, myocutaneous is a nonessential modifier in the Alphabetic Index, despite being specified in the code title.

The NCCH will review the code title of 45530-00 [1756] for a future edition of ACHI.

Duodenoscope assisted cholangiopancreatoscopy (DACP)

What is the correct procedure code to assign for duodenoscope assisted cholangiopancreatoscopy?

Duodenoscope assisted cholangiopancreatoscopy (DACP) allows direct visualisation of the biliary and pancreatic ducts. It is beneficial in circumstances where direct ductal visualisation is helpful in clarifying a diagnosis or providing targeted treatment that is not possible with conventional fluoroscopic imaging.

The procedure was first described in the mid-1970s when endoscopic retrograde cholangiopancreatoscopy (ERCP) was in its infancy. The procedure involves a small calibre cholangiopancreatoscope (daughter scope or baby scope) being passed through the accessory channel of the duodenoscope and is used to cannulate the ampulla of Vater and obtain images of the bile duct and then the pancreatic duct. The technique, however, was not widely accepted due to expensive and inadequate instruments which suffered frequent breakage, poor optics, etc.

However, in recent years technological improvements have overcome the inadequate equipment of the past and DACP may expand management options for pancreaticobiliary disorders in the future.

The correct code assignment for DACP is:

30442-00 [957] *Choledochoscopy*

and

30473-00 [1005] *Panendoscopy to duodenum*

Elevated prostate specific antigen (PSA)

What is the correct principal diagnosis selection for a day stay urology admission where 'elevated PSA' alone is documented as the principal diagnosis on the discharge summary and as the indication on the operation report but where the histopathology report received after discharge indicates adenocarcinoma?

Prostate specific antigen (PSA) is a protein that is secreted into ejaculate which helps to nourish the sperm. Normally, only tiny amounts enter the bloodstream. However, cancer cells and other conditions can interfere with proper functioning and cause large amounts to enter the blood. It is currently the most widely used method to screen for prostate cancer.

It is acknowledged that elevated PSA is also an indicator of other conditions such as benign prostatic hyperplasia (BPH), urinary tract infections and prostatitis. For the scenario cited, where histopathology has confirmed a diagnosis of adenoacarcinoma, this should be assigned as the principal diagnosis. The adenoacarcinoma should be coded as a finding that adds specificity to the diagnosis of 'elevated PSA' as per the guidelines in ACS 0010 *General abstraction guidelines, Test Results*.

Clinical advice has confirmed that R79.8 *Other specified abnormal findings of blood chemistry* is the correct code to assign for elevated PSA.

Excisional debridement

Should an additional code for suture of wound be assigned with 30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage* as it does not contain an includes note for suture of wound as in 30023-00 [1566] *Excisional debridement of soft tissue?*

30023-00 [1566] *Excisional debridement of soft tissue* has the following note:

'*Includes:* suture of wound'

This has led some coders to assume that as there is no similar note at 30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage*, that any suture of the wound should be assigned as an additional code for this procedure as it does not contain the same includes note.

However, in these circumstances the guidelines in ACS 0016 *General Procedure Guidelines – Procedure Components* apply and it is unnecessary to assign an additional code for suture of wound performed with excisional debridement. It is a component of the procedure.

The 'includes' note at 30023-00 [1566] will be reviewed for a future edition of ACHI.

Fall while water skiing

What is the correct external cause code to assign for fall causing injury (other than drowning/submersion injury) while water skiing?

The correct external cause code to assign for fall from water skis causing injury (other than drowning/submersion injury) is W02.2 *Fall involving water ski* following the index pathway:

Fall, falling (accidental)
- involving
- - conveyance, pedestrian
- - - not in collision with pedestrian
- - - - ski(s)
- - - - - water W02.2

Water ski accidents may be classified as a pedestrian conveyance or water craft accident depending on the circumstances of the accident. However, clinical advice from the National Injury Surveillance Unit (NISU) confirmed that W02.2 *Fall involving water ski* describes this accident more specifically than the residual code V94.7 *Other and unspecified water transport accidents, water skis* and should, therefore, be assigned in this instance.

Human immunodeficiency virus (HIV) in pregnancy

Should a code from Chapter 15 *Pregnancy, Childbirth and the Puerperium* be assigned in addition to a code for human immunodeficiency virus [HIV] disease (B20–B24) for HIV complicating pregnancy, delivery or the puerperium?

There is no index entry specifically for HIV complicating pregnancy and there is an exclusion note for 'human immunodeficiency virus [HIV] disease (B20–B24)' at O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*. Therefore, it is unnecessary to assign a code from Chapter 15 *Pregnancy, Childbirth and the Puerperium* in addition to a code from B20–B24 for HIV complicating pregnancy, childbirth or the puerperium.

Z33 *Pregnant state, incidental* may be assigned as an additional code for episodes of care where a patient is admitted for HIV and is pregnant as per the advice in ACS 1521 *Conditions complicating pregnancy, Incidental pregnant state.*

Incontinence

Please clarify ACS 1808 *Incontinence* below in relation to the following:

> ### 1808 INCONTINENCE
> Incontinence is clinically significant when the incontinence:
> - is not clinically considered to be physiologically normal,
> - is not clinically considered to be developmentally normal, **or**
> - is persistent in a patient with significant disability or mental retardation.

Urinary and faecal incontinence codes (R32 *Unspecified urinary incontinence*, R15 *Faecal incontinence*) should be assigned only when the incontinence is persistent prior to admission, is present at discharge or persists for at least seven days.

a. Should coders use the information in the first paragraph of the ACS to determine if the incontinence is 'clinically significant' before following the classification advice in the second paragraph or is this paragraph for information only?

b. When following the classification advice in the second paragraph, would a code for incontinence be assigned for any patient, with any length of stay (including same day) admitted for any condition who was incontinent once only, providing it was on their day of discharge. That is, would you assign an additional code for incontinence for a same day admission of an elderly patient where voluminous incontinence is noted but is not the principal reason for admission?

c. Does this ACS cover all types of urinary incontinence or only those classifiable to R32 *Unspecified urinary incontinence?*

R32 *Unspecified urinary incontinence* and R15 *Faecal incontinence* should be assigned if they meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

Additionally, advice in ACS 1808 *Incontinence* should be followed. Therefore, in answer to part (a) of this query, the first paragraph is for information only.

In answer to part (b), coders should apply the advice in the second paragraph where the intent is to code 'persistent' faecal and/or urinary incontinence. So, for a same day episode of care, the advice to assign a code for incontinence present at discharge should only be followed where the documentation confirms that incontinence is a persistent problem.

Lastly, in answer to part (c), the advice in ACS 1808 is for urinary incontinence classifiable to R32 *Unspecified urinary incontinence*, only. It does not apply to other types of urinary incontinence e.g. overflow, stress incontinence etc.

Intercostal neuralgia

What is the correct code assignment for intercostal neuralgia?

The current index entries under Neuralgia and Neuritis do not include a subterm for intercostal. This may lead coders to assign G58.8 *Other specified mononeuropathies.* However, the index entry for *Neuropathy* has a subterm for intercostal, which assigns G58.0 *Intercostal neuropathy*, which is the correct code assignment for intercostal neuralgia.

Indexing improvements to this area of ICD-10-AM have been made for Seventh Edition.

In vitro fertilisation (IVF)

Please clarify the advice under In vitro fertilisation (IVF) in ACS 1437 *Infertility* concerning the assignment of an additional code from N97 *Female infertility*.

> 1437 INFERTILITY
>
> In vitro fertilisation (IVF)
>
> When a female is admitted specifically for IVF procedures, and the principal diagnosis is 'IVF' or 'infertility', Z31.2 *In vitro fertilisation* should be assigned as the principal diagnosis code. An additional code from category N97 *Female infertility*, for the type of infertility may be assigned if known, including N97.4 *Female infertility* associated with male factors.

The intent of the advice in the above paragraph is that female patients admitted specifically for 'IVF' with documented 'infertility' should have Z31.2 *In vitro fertilisation* assigned as the principal diagnosis. A code classifiable to N97 *Female infertility* should be assigned as an additional code to specify the type of infertility, including N97.9 *Female infertility, unspecified* for female infertility NOS. It is not necessary to assign a code from category N97 if the reason for the IVF is not specified or it is performed for another reason.

Ischaemic fingers

Ischaemic fingers due to occlusion of blood vessel secondary to injecting crushed benzodiazepine tablets into the ulnar artery.

What is the correct code assignment for the above scenario?

The correct codes to assign for this scenario are:

T42.4 *Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs, Benzodiazepines*

I77.8 *Other specified disorders of arteries and arterioles*

and the appropriate external cause of injury codes.

Assign a more specific code if the type of blood vessel occlusion is specified e.g. I74.2 *Embolism and thrombosis of arteries of upper extremities* for thrombosis of ulnar artery.

Neonatal withdrawal due to maternal use of prescribed medication.

What is the correct code to assign for a neonate suffering withdrawal due to maternal use of prescribed pain medication during pregnancy?

The correct code to assign for the neonate in this scenario is P96.1 *Neonatal withdrawal symptoms from maternal use of drugs of addiction* following the index pathway:

Reaction
- drug NEC
- - withdrawal
- - - newborn P96.1

The assignment of this code is not affected by whether or not the mother is drug dependent.

Parafoveal telangiectasia

What is the correct code assignment for parafoveal telangiectasia treated by Avastin® injection into retinal blood vessels?

Parafoveal or perifoveal telangiectasia, also known as macular telangiectasis, is a peculiar retinal vascular disorder that affects the central portion of the macula. Dilated retinal capillaries occur around the temporal aspect of the foveal area, eventually encircling it completely causing progressive loss of vision.

The correct code to assign for parafoveal telangiectasia is H35.0 *Background retinopathy and retinal vascular changes* following the pathway:

Disease, diseased
- retina, retinal
- - vascular lesion H35.0

or

Lesion
- retina, retinal
- - vascular H35.0

Avastin® (Bevacizumab) works by blocking a substance known as vascular endothelial growth factor (VEGF). Blocking or inhibiting VEGF helps prevent further growth of blood vessels. Initially, the drug was approved for the treatment of metastatic colorectal cancer to block blood vessels that the cancer needs to continue growing.

More recently ophthalmologists have injected Avastin® into the posterior chamber of the eye to treat age related macular degeneration and other eye conditions that cause loss of vision due to abnormal growth of blood vessels in the back of the eye, such as parafoveal telangiectasia. The drug was used because research indicated that VEGF is one of the causes for the growth of the abnormal vessels that cause these conditions.

The correct code to assign for Avastin® injection into abnormal retinal blood vessels is 42740-03 [209] *Administration of therapeutic agent into posterior chamber* following the index pathway:

Injection
- posterior chamber (by paracentesis) (eye) (therapeutic agent) 42740-03 [209]

The NCCH will consider improvements to the index for this condition and procedure for a future edition of ICD-10-AM/ACHI.

Periductal mastitis

What is the correct code to assign for periductal mastitis?

The *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM), used in the United States, assigns periductal mastitis to mammary duct ectasia while ICD-10-AM makes no such link.

A literature review reveals that periductal mastitis has been confused with and called duct ectasia. However, duct ectasia is almost certainly a separate condition affecting an older age group and characterised by subareolar duct dilatation and less pronounced and less active periductal inflammation. Current evidence suggests that smoking is an important factor in the aetiology of periductal mastitis but not in duct ectasia.

Therefore, the correct code to assign for periductal mastitis is N61 *Inflammatory disorders of breast* following the index pathway:

Mastitis (acute) (infective) (nonpuerperal) (subacute) N61

Poisoning

ACS 1901 *Poisoning* states that 'In addition to the code for poisoning, an additional code should be assigned to indicate any significant manifestation (e.g. coma, arrhythmia).'

In a scenario where a patient is transferred to an Intensive Care Unit (sedated/ventilated) from another hospital following carbon monoxide poisoning/benzodiazepine overdose and it is noted that an arrhythmia was treated at the scene, can this ACS be applied (i.e. can a code for the arrhythmia be assigned) at the receiving hospital where the condition is no longer present?

ACS 1901 *Poisoning* intends to provide guidance on the sequencing of code assignment for poisoning episodes of care. It highlights that in addition to a code from the poisoning chapter an additional code may be assigned for any 'significant manifestations.' It was not intended to expand the interpretation of 'significant manifestations.'

Coders should follow the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* to determine if a code for a manifestation of poisoning should be assigned.

Pyelonephritis with renal calculus and hydronephrosis

What is the correct code assignment for pyelonephritis with renal calculus and hydronephrosis?

The correct code assignment for pyelonephritis with calculus and hydronephrosis is N13.2 *Hydronephrosis with renal and ureteral calculus obstruction* following the pathway:

Pyelonephritis
- with calculus
- - - with hydronephrosis N13.2

If the condition is documented with an infection, N13.6 *Pyonephrosis* may also be assigned with an additional code (B95-B97) to identify any infectious agent, to complete the clinical picture. See also ACS 0027 *Multiple coding* and ACS 0033 *Conventions used in the tabular list of diseases.*

Soft tissue injuries (STIs)

Can you clarify ACS 1331 *Soft tissue injuries*, particularly in relation to contusions which are classified as superficial injuries rather than soft tissue injuries?

Soft tissue injuries include damage to muscles, ligaments and tendons. They usually fall into one of the following:

- contusions (bruises)
- sprains
- strains

A **contusion** is an injury to soft tissue often produced by a blunt force such as a kick, fall or blow.

A **sprain** is an injury to a ligament and is often caused by a wrench or twist.

While a **strain** is an injury to a muscle or tendon and is often caused by overuse, force or stretching.

ACS 1331 *Soft tissue injuries* advises that where a more specific injury is documented (e.g. contusion, sprain or strain), these should be coded rather than following the index pathway 'Injury, site.'

Where soft tissue injury is the only description documented for an injury, assign a code by following the index pathway 'Injury, site.'

ICD-10-AM, as per ICD-10, classifies 'contusion' as a superficial injury, however, this does not alter the classification advice above.

The NCCH will review ACS 1331 *Soft tissue injuries* for a future edition of the ACS.

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Influenza A/H1N1 (swine influenza)

Clinical information

H1N1 (previously referred to as 'swine flu') is a new influenza virus causing illness in people. This new virus was first detected in people in April 2009 in Mexico and the United States of America (USA). Other countries, including Australia, New Zealand and Canada, now have confirmed cases of the disease.

The virus was originally referred to as 'swine flu' because laboratory testing showed that many of the genes in this new virus were very similar to influenza viruses that normally occur in pigs in North America. However, further study has shown it to contain two genes from flu viruses that normally circulate in pigs in Europe and Asia, avian genes and human genes. Scientists call this a "quadruple reassortant" virus. Further information may be found on the websites of the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC):

http://www.cdc.gov/h1n1flu/swineflu_you.htm

http://www.who.int/csr/disease/swineflu/en/index.html

Classification advice for ICD-10 and ICD-10-AM

As this type of influenza is a newly identified disease, there is no unique code in the WHO *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10). Following advice received from the Update and Revision Committee (URC) of the WHO Family of International Classifications and the Australian Coding Standards Advisory Committee (CSAC),

the following codes should be assigned for laboratory confirmed cases of Influenza A/H1N1 in Australia:

J09 *Influenza due to identified avian influenza virus*

Z29.0 *Isolation*

For cases described as 'suspected' or 'probable', but not confirmed by laboratory testing, assign:

J11.1 *Influenza with other respiratory manifestations, virus not identified*

Z29.0 *Isolation*

It is envisaged that further development of category J09 *Influenza due to identified avian influenza virus*, will be undertaken by the URC in 2009, to widen the scope of the category at the three character level, and to develop unique codes at the fourth character level to identify these emerging strains of influenza virus.

NCCH prize for clinical coding

The NCCH prize for clinical coding is awarded annually to outstanding graduate students who have completed health information management courses. The NCCH 2008 award was presented to Nicole Anne Dawson at The University of Sydney, Faculty of Health Sciences awards night on the 21st May 2009. Nicole was also awarded the Hilda Roberts Memorial Prize from the Health Information Management Association of Australia (HIMAA). The awards were presented by the Dean, Professor Gwynnyth Llewellyn.

The NCCH congratulates Nicole and wishes her success in her career in health information management.

Professor Gwynnyth Llewellyn with Nicole Anne Dawson

Morbidity Reference Group

mid year meeting

The Morbidity Reference Group (MbRG) of the WHO Family of International Classifications Network (WHO-FIC) met in Manly, Australia, in March 2009. There were 22 participants, including 14 international members of the MbRG, representing 10 countries. With ICD-11 on the horizon, the agenda was very full and a number of important topics were covered during the three day meeting.

Two large papers in relation to the revision process were finalised; ICD-11 Conventions and Topics for Topic Advisory Groups (TAGs). The first paper provided the current views of the MbRG and Mortality Reference Group (MRG) on the rules, conventions and structure for ICD-11, including detailed work completed by the group on the analysis of the dagger/asterisk convention. The second paper was a summary, but by no means exhaustive, of the main areas within ICD-10 in need of revision from a morbidity perspective. Both of these papers have now been forwarded to the Revision Steering Group (RSG) of WHO-FIC.

Professor James Harrison, Chair of the Injury and External Causes TAG, was invited to provide an overview of work to date. He highlighted some of the clinical areas under review including traumatic brain injury, falls, suicide and intentional self harm and noted the importance of the input to date, and in the future, from the MbRG on both clinical and classification issues.

Following pilot testing of a draft proposal, members agreed in principle to a new definition of main condition for ICD-11. The group will further refine some of the decision points of this definition in papers for the forthcoming WHO-FIC meeting in Korea in October 2009.

A systematic review of ICD-10 volume 2 morbidity coding rules has been included on the workplan for the MbRG, in response to a request by the Education Committee, to underpin the establishment of international competency standards. Work will begin in this area in 2009.

A number of other issues were progressed such as guidelines for the coding of sepsis, discussion on the sequelae convention and collection of national morbidity information on code frequencies to inform the revision process.

NCCH Staff Changes

Professor Richard Madden, NCCH Director, recently announced staffing changes at the NCCH. Vera Dimitropolous has accepted the position of Assistant Director, Classification Development. Vera will be well-known to many of our readers through her work at HIMAA and The University of Sydney.

Julie Rust has accepted the position of Manager, International Classification Development while Megan Cumerlato, Manager Education, will continue to oversee the NCCH's education programs. Vera, Megan and Julie will work as a team to lead and manage the classification development program.

The NCCH also welcomed new staff members Irene Soo and Christine Erratt, and returning from maternity leave Dana Higgins and Yan Guo.

Vera Dimitropolous with Dr David Tanous and Richard Madden at the recent NCCH conference

NCCH Conference – Coding Rules

The 2009 NCCH Conference was held on March 11–13 in Sydney at Dockside, Darling Harbour. Professor Richard Madden, Director NCCH, officially opened the conference and welcomed the delegates on Thursday. The first session set the scene for a wide ranging and informative conference including two clinical updates.

Conference highlights – Thursday

The first session, entitled 'What's new here and overseas', featured invited presenters Dr Chien Earn Lee, Rosemary Roberts and Dr Ulrich Vogal. Dr Lee focused on the implementation process for classification and casemix in Singapore and the future directions. Rosemary provided an update on the work she is involved in on the development of a traditional medicine classification as a related member of WHO-FIC. Dr Vogal gave us an insight into the development and use of the German version of ICD-10.

l-r Dr Ulrich Vogal, Rosemary Roberts, Dr Chien Earn Lee and Professor Richard Madden

Conference highlights – Friday

The final day of the conference featured presentations about development work being conducted for ICD-11 in Australia, SNOMED information and updates, and coding quality in Australia. Professor Richard Madden gave us a revision update on ICD-11. Professor Gavin Andrews from the University of NSW provided a thought provoking presentation on mental health issues and ICD-11. And Professor James Harrison spoke about developments in injury and external cause classification for ICD-11.

Dr Kent Spackman from the USA and David Hislop from NeHTA spoke about SNOMED CT from development, adoption and implementation viewpoints.

The coding quality session provided coal-face views from clinical coding stalwarts Rhonda Carroll, Jennie Shepheard and Hayley O'Meara. Kylie Holcombe's presentation on an auditor's lot in life was a standout presentation and will perhaps inspire a number of attendees to pursue the 'Life in Cold Blood: The Auditor'.

Clinical updates

Clinical updates were presented on each day of the conference. The first was on Infectious Diseases by Dr Olafr Steinum, Expert Advisor, Nordic Centre for Classifications in Health Care, WHO-FIC Collaborating Centre in the Nordic Countries/Sweden and Dr Gunnar Henriksson, Consultant Surgeon, Skövde, Sweden. They presented a very entertaining feature on 'What is antibiotic resistance and why must we code it?' and 'Sepsis (and the man with 3 buttocks)'.

l-r Dr Gunnar Henriksson, Megan Cumerlato and Dr Olafr Steinum

The second clinical update was on cardiovascular procedures by Dr David Tanous, Cardiologist at Westmead and Auburn Hospitals. Dr Tanous presented a very informative and graphic presentation of the different vascular surgery techniques that are being used today.

Both clinical update sessions were well attended and delegates were presented with very informative and comprehensive descriptions of the various medical and surgical techniques used in these two areas.

Conference workshop

The NCCH held the pre-conference workshop on Wednesday 11 March with 100 registrants. Past workshops have proved a popular feature of the conference and the 2009 workshop was no different. Participants received a coding workbook consisting of 12 case scenarios and 6 clinical record abstracts which had to be coded prior to attending the workshop. Cases this year focused on chronic kidney disease, bilateral/multiple procedures, cardiovascular, spinal surgery and many more. Answers to the cases were then presented and discussed during the workshop.

Hands-on coding continues to be the most favourable continuing education approach for coder training with positive feedback being received. This workshop was delivered nationally in all Australian states and territories during May and June 2009.

Social program

The Conference commenced with an informal cocktail party held at L'Aqua, Darling Harbour to welcome the delegates to Sydney, with approximately 180 delegates attending. The cocktail party followed the workshop and provided an opportunity for delegates to catch up with their interstate and international colleagues.

Delegates at the conference dinner

The conference dinner was held at Doltone House at Jones Bay on Thursday night. Drinks and canapés were held on the balcony overlooking Sydney Harbour followed by dinner. It was good to see the New Zealand contingent making use of the water taxi to make their arrival to the venue. Delegates were entertained by local band Jelly Bean Jam and were able to show off their dancing skills till close at 11.30pm.

Jelly Bean Jam provided the after dinner entertainment

Exhibition

This years conference featured a well supported exhibition with booths from 3M Health Information Systems, Rolls Filing Systems, HIMAA, Department of Health and Ageing, La Trobe University and The University of Sydney. The exhibition enabled delegates to view clinical coding relevant software, products and training. The NCCH thanks our exhibitors for helping to make this year's conference a success.

Conference facts and figures

The NCCH conference attracted 233 delegates with a small number electing to attend either the Thursday or Friday sessions only. All the sessions were well attended over the two days and the challenge in hosting a conference is that it is difficult to please all the delegates all of the time. Instead, the NCCH aimed to please most of the delegates most of the time! We feel that we more than met this goal as almost all of the delegates surveyed agreed their expectations were met.

Overall, the conference was a success with 83% of delegates surveyed agreeing that the conference was enjoyable and 77% of delegates claiming it to be a valuable professional development opportunity. Further evaluation feedback indicated that 89% of attendees would like to attend future NCCH conferences and 86% found it useful networking with their peers.

l-r Vera Dimitropoulos, Jennie Shepheard, Hayley O'Meara, Kylie Holcombe and Rhonda Carroll

NCCH was pleased to welcome the winners of our online registration competition, Val Klelociuk, a self-funded attendee from Tasmania and Michelle Swan from Figtree Private Hospital in NSW. Both attendees received free full conference registration. Congratulations to Lucy Kennedy from Queensland, the winner of a digital camera for the evaluation competition.

Many thanks go to all the presenters for their thoughtful presentations, to the delegates for continuing to support our conference, and finally to the NCCH staff who did a fantastic job in making the 2009 NCCH Conference a great success.

Next NCCH conference

Looking to the future we received a lot of great feedback about what did and didn't work and we will use this to make the upcoming 2011 conference the best one yet. While we haven't yet finalised the location of the next conference, we are considering either Darwin or Adelaide so, as we say, stay tuned!

Tissue Transplantation and Donation:

## Allogeneic and Autologous donation

What is apheresis?

Apheresis (also called pheresis) is a medical procedure that involves the removal of whole blood from a patient or a donor and separation of the blood into its components so that a specific component can be removed. The remaining blood is then transfused back into the patient or donor. Apheresis is used for the treatment of certain medical conditions and for harvesting cells for donation into another person (see below: *What is apheresis used for?*).

The component that is separated and withdrawn from the blood is reflected in the clinical terminology used, for example:

- Platelets / thrombocytes (plateletpheresis or thrombocytapheresis)
- Red blood cells / erythrocytes (erythrocytapheresis or erythropheresis)
- Plasma (plasmapheresis)
- White blood cells / leukocytes (leukapheresis, leukopheresis or leukocytapheresis)

How is apheresis performed?

Whole blood is drawn from one arm using a sterile needle and channelled through tubing into a single-use sterile collection kit within the apheresis machine. The blood is passed through the apheresis machine (also known as a cell separator) that separates the blood into its components: red blood cells (RBCs), white blood cells (WBCs) and plasma. The apheresis machine separates the blood by either a centrifuge or filtration process. After the separation, the required blood component(s) are removed and the remaining components are transfused back into the patient or donor. The process may take up to two hours to complete.
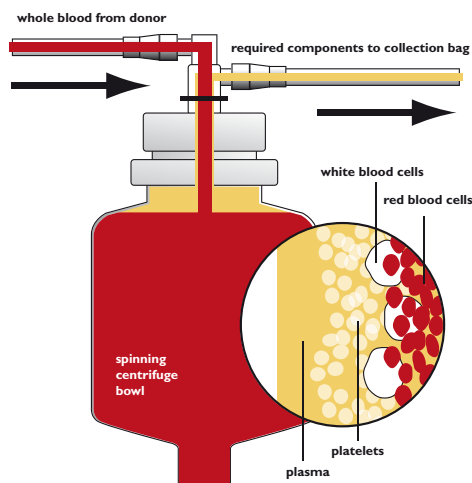
Apheresis machine separating whole blood into its components via centrifuge

What is apheresis used for?

Apheresis is performed for either a patient with a known condition for reinfusion at a later date (autologous donation) or for harvesting cells for donation into another person (allogeneic donation). Many medical treatments require apheresis donations and some forms of apheresis and their treatments include:

Plateletpheresis

Platelets are essential for blood clotting. Platelet transfusions are routinely needed to support patients undergoing cancer therapy, open-heart surgery, burns patients, organ and bone marrow transplantation, and for patients with bleeding disorders. Platelets have a very short shelf-life and must be transfused within five days of collection.

Erythrocytapheresis

RBCs carry oxygen to all parts of the body. Red cell transfusions are mainly required after major blood loss due to trauma or surgery, or to treat anaemia.

Plasmapheresis

Plasma is the liquid portion of the blood and contains antibodies, clotting factors and other proteins. Plasma is used in the treatment of clotting disorders, bleeding and trauma. Plasma transfusions are used to treat patients with autoimmune disorders and coagulation factor deficiencies, such as patients with liver failure, and those patients with certain bleeding disorders. It can also be transfused into premature infants.

Leukapheresis

WBCs help defend the body against infectious diseases and foreign substances. WBC transfusions are used to treat patients with cancer and granulocytes (type of WBC) for transfusion therapy of infections unresponsive to antibiotics.

Classification of apheresis

There are two types of patients admitted for donor apheresis:

Autologous donation

An autologous donor is a patient with a known disease such as a malignancy who is admitted to donate their own cells for therapeutic reinfusion at a later stage.

In this scenario, assign a code for the condition that will be treated by the donated cells. It is unnecessary to also assign Z51.81 *Apheresis* as this information is specified by the procedure code.

Allogeneic donation

An allogeneic donor is a healthy donor, admitted to donate cells for infusion into another person.

In this scenario, assign as the principal diagnosis Z51.81 *Apheresis*.

References:

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HealthLine Networks, Inc. (2009). Pheresis – Health Article [online]. Available: http://www.healthline.com/galecontent/pheresis. [Accessed: 20 April 2009].

Lichtman, MA, Beutler, E, Kipps, TJ, Seligsohn, U, Kaushansky, K and Prchal, JT (2005). Williams haematology – seventh edition. McGraw-Hill Professional, New York.

MedicineNet, Inc. (2009). Apheresis (Haemapheresis, Pheresis) [online]. Available: http://www.medicinenet.com/hemapheresis/article.htm. [Accessed: 20 April 2009].

UCLA Health System (2009). UCLA Blood and Platelet Center: Apheresis Donations [online]. Available: http://gotblood.ucla.edu/body.cfm?id=22. [Accessed: 9 April 2009].

CONFERENCES 2009

Aug 4-7	ACHSE 2009 National Congress	Surfers Paradise, QLD	www.achse.org.au
Aug 19-21	CHIK's Health-e-Nation'09 Conference	Canberra, ACT	www.health-e-nation.com.au
Aug 19-21	International Swine Flu Conference	Washington, USA	http://new-fields.com/ISFC/
Aug 20-21	HIC'09	Canberra, ACT	www.hisa.org.au/hic09
Aug 29-Sept 2	22nd International Congress of the European Federation for Medical Informatics	Sarajevo, Bosnia and Herzegovina	www.mie2009.org/
Sep 20-23	26th International Records Management Association of Australasia (RMAA) Convention	Adelaide, SA	www.rmaa.com.au/natcon2009/
Sept 30-Oct 2	HINZ Conference and Exhibition	Rotorua, NZ	www.hinz.org.nz/page/conference
Oct 1-4	GP'09 — The conference for general practice	Perth, WA	www.gpconference.com.au/
Oct 7-9	AHHA 2009, AHHA and Australian Institute of Health Policy Studies	Hobart, TAS	http://healthpolicystudies.org.au/
Oct 11-13	Australian Private Hospitals Association (APHA) National Congress	Melbourne, VIC	www.apha.org.au/media_files/2378040505.html
Oct 12	2nd IFHRO SEAR Conference	Perth, WA	www.himaa.org.au/
Oct 14-16	HIMAA National Conference	Perth, WA	www.himaa.org.au/
Oct 20-23	Australian Association of Practice Managers (AAPM) National Conference The edge of practice management.	Melbourne, VIC	www.cdesign.com.au/aapm2009/
Oct 28-29	Software and Systems Quality Conference	Melbourne, VIC	www.sqs-conferences.com/au/index.htm
Nov 4-7	AGPN Forum, General Practice Network	Sydney. NSW	www.gpnetworkforum.com.au/site/index.cfm
Nov 10-12	Australian Health Insurance Association (AHIA) National Conference	Melbourne, VIC	www.ahia.org.au/events.php
Nov 14-18	American Medical Informatics Association (AMIA) Annual Symposium	San Francisco, USA	http://symposium2009.amia.org/
Nov 16-17	Australia's welfare 2009 conference	Canberra, ACT	www.aihw.gov.au/
Dec 2-3	Australasian Mortality Data Interest Group (AMDIG) 6th Understanding Mortality Data Workshop	Wellington, NZ	http://nis-web.fhs.usyd.edu.au/ncch_new/ AMDIG2009.aspx

Conference information is also published at the NCCH website www.fhs.usyd.edu.au/ncch

PICQ 2008

Performance Indicators for Coding Quality (PICQ)
is a set of pre-determined indicators which identifies records
in data sets that may be incorrectly coded based on Australian
Coding standards (ACS) and coding conventions

PICQ 2008 makes it easy to measure ICD-10-AM/ACHI coded
patient morbidity data using a series of indicators based on
Australian Coding Standards (ACS) and coding conventions.

PICQ can identify data problem areas, suggest possible causes
and provide corrections. PICQ will measure data accuracy
against specific indicators and data quality over time. PICQ
can assist coder education and provide feedback to individual
coders.

PICQ 2008 is now available, incorporating 245 indicators for
ICD-10-AM/ACHI/ACS Fifth Edition and 302 indicators for
ICD-10-AM/ACHI/ACS Sixth Edition.

PICQ 2008 is now available.
For further information on
how to order:
NCCH Sydney
Phone: +61 2 9351 9461
E-mail: fhsNCCHsales@usyd.edu.au