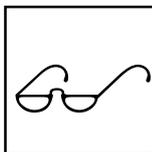




Coding *Matters*

Newsletter of the
National Centre for Classification in Health

Volume 5 Number 1
July 1998



FROM THE DESK OF THE DIRECTOR

ICD-10-AM Implementation

This short message is to recognise the historic nature of the forthcoming change to the Australian Modification of ICD-10 in July 1998 for hospitals in NSW, Victoria, ACT and NT. It feels a bit like the night before Christmas – the publication is finished and distributed, education material for coders and workshops has been completed and state and territory ICD-10 Implementation Coordinators are working at frenzied pace to ensure hospital and health department systems are ready to receive the new codes.

Even though only half the country will ‘change’ in 1998, the preparation has been a mammoth undertaking – for implementation coordinators, implementation committees, health information managers (HIMs) and above all, clinical coders. The staff of the National Centre for Classification in Health (NCCH) and NCCH advisors on the Coding Standards Advisory Committee (CSAC) and from the Clinical Coding & Classification Groups (CCCGs) have tackled overwhelming volumes of work to complete the classification and prepare for implementation. The mapping exercise has been an enormous one, with combined efforts from the Department of Health and Family Services (DHFS), the NCCH, the Australian Clinical Casemix Committee (ACCC) Acute Subcommittee plus those seconded from highways and byways to help in the initial work and then in checking and rechecking.

Kerry Innes has done outstanding work in coordinating the *Australian Coding Standards* and the new code development, Karen Luxford in organising and producing the hard copy and electronic publications and Karen Peasley in planning and presenting the education workshops and accompanying material. Each manager has been supported by teams of experts within NCCH as well as HIMs and clinical coders through our specialty adviser and coding educators networks. The contributions from individuals and groups has been astounding and has enabled NCCH to meet its contractual requirements with DHFS for production of ICD-10-AM by 1998.

Financial support for NCCH

As always, the NCCH is most appreciative of ongoing support from DHFS. Budgets and contracts have just been negotiated to enable NCCH to continue functioning until June 2000. As well as the core funding from Classification and Payments Branch, NCCH has received funding from Health Services Outcomes Branch for the development of electronic systems for ICD-10-AM at NCCH Sydney. Expressions of Interest to assist in this function were advertised in June 1998 in the national press. Further funding is being sought from the states for ongoing support of the Quality Division at La Trobe University. NCCH Sydney will subcontract work to NCCH Brisbane for work in Coding Services and Education, and NCCH Brisbane will again be supported by the Australian Institute of Health & Welfare (AIHW), the Australian Bureau of Statistics (ABS) and the Queensland University of Technology (QUT). Brisbane staff will be responsible for ICD-9-CM queries from Queensland, South Australia, Western Australia and Tasmania for 1998-99.



PRINT POST APPROVED PP224709/00038

In this issue

◆ ACBA	5
◆ PICQ	6
◆ 1998 NCCH Conference	9
◆ ICD-10-AM Workshop Q & A	13
◆ Coding Tips	15
◆ Publication Issues	23

ICD-10-AM Errata

The NCCH is gearing up for ICD-10-AM introduction by preparing procedures for dealing with queries and for updating the classification itself for the second edition for use in July 2000. There has been a great deal of feedback concerning the first errata for ICD-10-AM, specifically relating to its size and the amount of time required to insert changes in the books. Our main aim in producing the errata was to make the classification as current and accurate as possible for users in July 1998. Criteria for inclusion in future errata are issues relating to data quality and to grouping. The process of errata development also includes ratification by CSAC. We will try to minimise changes in future errata to stabilise the classification, although we recognise there may need to be further amendments such as those made to the *Australian Coding Standards* and typographical corrections as the classification is used. In response to those who have challenged the NCCH on the need for the first errata, we have analysed its content to provide some explanation for its size. The approximate proportion of errata changes were as follows:

The origins of Errata 1 content

Amendments have arisen from various sources

1)	WHO	29.8%
2)	MBS	28.6%
3)	NCCH	21.0%
4)	Correction of classification logic & typographical errors	20.6%

One common misconception stated in feedback received by the NCCH has been a belief that the errata consists only of 'errors'. As illustrated above, the vast majority of information in the errata (nearly 80%) is new material essential to maintaining the currency of the classification. As explained in a recent issue of *Coding Matters*, the NCCH has redefined 'errata' for the purpose of the release of new ICD-10-AM information post-publication. Another misconception appears to have been that the 17 typeset pages provided by the NCCH at the back of the errata were extra errata pages rather than an attempt by the NCCH to assist in the updating process.

Errata 2 (July 1998) is included in this edition of *Coding Matters* and contains a small number of essential changes to ICD-10-AM. The majority of CSAC members have supported the need for the release of Errata.

Education

As mentioned above, the education material for ICD-10-AM has virtually been completed, with publication of the Workshop booklets, *A Taste of Ten* and now *Mastering Ten*. The remaining task is to develop material for clinicians and epidemiologists. Lisa Quick (NSW Health) has been subcontracted to the NCCH to prepare this material, which we plan to make available on the NCCH homepage probably in June/July 1998. Clinicians and clinical coders will be able to download the material as required for personal use or for educating others. Other initiatives in regard to clinicians include a paper for the *Medical Journal of Australia* on ICD-10-AM for the forthcoming Casemix Supplement. As well, further issues in the series of Specialty Booklets for clinicians and clinical coders will be available within the next month or so (Orthopaedics, Injury, General Surgery and General Medicine).

Readers may be interested in the very positive book review of the Cardiology Specialty Booklet which appeared in the *Medical Journal of Australia* Vol 168, 1 June 1998 (page 541). Congratulations to those clinicians and coders who contributed to that particular booklet and to NCCH former staff member, Simone Lewis, for the effort which went into this (and all) the specialty booklet publications. The Australian Casemix Clinical Committee (ACCC) through DHFS has provided funds for a further 12 months to allow NCCH to produce

Coding Matters

July 1998

Volume 5 Number 1



National Centre for Classification in Health

NCCH (Sydney)

Faculty of Health Sciences, University of Sydney
PO Box 170 ph: 02 9351 9461
Lidcombe NSW 2141 fx: 02 9351 9603
Australia email: k.luxford@cchs.usyd.edu.au

NCCH (Brisbane)

School of Public Health, QUT
Victoria Park Rd ph: 07 3864 5809
Kelvin Grove QLD 4059 fx: 07 3864 5515
Australia email: s.walker@qut.edu.au

NCCH Quality Division

School of Public Health
La Trobe University ph: 03 9479 5846
Bundoora Vic 3083 fax: 03 9479 1783
Australia email: d.williamson@latrobe.edu.au

Homepage <http://www.cchs.usyd.edu.au/NCCH/ncch.html>

Editor: Karen Luxford

Typesetting: Karen Luxford

ISSN 1322-1922

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

booklets for the remaining specialties. The Publications Project Officer position for this function has recently been advertised and we hope it will be filled in the near future.

Staff

We have unfortunately lost one of our Information Systems Officers, Damian Hanrahan, who left NCCH to move to the banking sector. Damian made a major contribution to the smooth running of NCCH in his work on the NCCH/School of HIM network on which we have become so reliant and in his filling of orders for NCCH products. His position has been restructured and is to be filled by a database administrator. Megan Roach stays on as NCCH Information Systems Officer.

Community Health Codeset

NCCH staff (Michelle Bramley and Kerry Innes) have been involved through NSW Health in development of the national codeset for community based health services. NCCH was one of five primary contacts asked to validate the codeset with our main input to codesets for community health 'Issue' and 'Activity'. Results of this work will inform the final version of the codeset, the first module of which is due for release by NSW Health on 29 September 1998. ▶

Planning Day

The NCCH managers from University of Sydney, QUT and La Trobe University met to plan the future of NCCH on 11 June 1998, helped along by an equal number of canines at Kerry Innes' place! One of our main topics of discussion was the electronic developments for ICD-10-AM. This is seen as critical for internal maintenance of the classification within NCCH, for development of electronic products such as browsers and encoders and as a stand-alone product for embedding in software applications. As well, NCCH is being asked to prepare subset classifications of ICD-10-AM for specialty areas. Having our core files in a relational database will help streamline functions within the Centre and make more efficient the updating and navigating processes for codes and *Australian Coding Standards*.

Let me end by wishing clinical coders in NSW, Victoria, ACT and NT the best of luck for July 1. Remember, you are making history! Perhaps it will feel as if all your Christmases have come at once! I hope the classification we have developed withstands this testing crucible of real time use by real clinical coders. What I am sure about is that we will all learn from the experience and from reviewing the impact of ICD-10-AM. At least we are in a position in Australia to build on that experience and develop the classification, its format and education programs to suit your needs.

❖ **Rosemary Roberts**
Director

Seen here enjoying the Sydney Harbour views at the ICD-10-AM Book Launch (16 April 1998) were (from the left) Professor Brian Oldenburg (Head, QUT School of Public Health), A/Professor Rosemary Roberts (NCCH Director), and Ms Jo Murray (A/g Assistant Secretary of the then Classification and Payments Branch, Department of Health and Family Services) - see page 23....





VITAL SIGNS

On-route to the EHR congress, Sue Walker took the opportunity to visit the UK NHS CCC.....read on and all will be explained.....

I recently had the opportunity to travel to the United Kingdom to attend the European Health Records congress. Prior to arriving in Hull, where the congress was held, I visited the National Health Service (NHS) Centre for Coding and Classification (CCC) in Loughborough. Erich Schulz (NCCH Research Fellow) from the Brisbane office worked at the CCC for two years prior to arriving at the NCCH, and he was therefore able to facilitate my visit and ensure I met the relevant people in the limited time available. I spent half a day at the Centre, speaking with:

- the Coding Helpdesk operators, who log each query received by telephone, fax or email, into custom built software, which includes a clock which continually updates the time that each query has been active. Queries are forwarded to coding and clinical specialists for answers and it is hoped that all are answered within two weeks of receipt (it doesn't always happen like that!);
- coding educators, who manage the regional coding facilitators/educators throughout the UK and produce educational materials for clinical coders;
- the coding authors who work on new additions and revisions to the Read codes (Erich was one of these);
- the mapping people who work closely with the authors, providing maps between the Read codes and the ICD-10; and
- Ann Harding, who is the Head of the Centre and also of the WHO Collaborating Centre for the UK. We had a useful discussion about the WHO proposals for updating ICD-10 and the outcomes of the Collaborating Centres meeting in Copenhagen in 1997.

It was interesting to see how a Centre with similar goals and objectives to the NCCH works and to find that many of the frustrations - and the encouragements - are the same, despite the differences between countries. A/ Professor Rosemary Roberts (NCCH Director) has visited the CCC in the past as well and we hope to offer a reciprocal visit to our English colleagues should they manage to come to Australia.

Following my Loughborough visit, I travelled by train to Hull in the county of Yorkshire for the European Health Records congress, hosted by the Institute of Health Records Information and Management (IHRIM). During the Congress, Professor Phyllis Watson, former Head of the School of HIM at Sydney University, gave a presentation about coding activities in Australia. This generated a great deal of interest and I subsequently enjoyed a number of useful conversations with other delegates who wanted more information about the activities of the NCCH. There was particular interest in the ICD-10-AM and I wished I had managed to slip a set into my luggage!

Other papers delivered at the Congress highlighted achievements in the development of electronic patient records in the UK, the effect of changing legislation on the legal admissibility of electronic documents and retention schedules in Britain, telemedicine, the potential for use of the internet for healthcare communication and the changes on health records management brought about by the European union. I also attended a couple of meetings of the Executive of the International Federation of Health Records Organizations (IFRHO), held around the Congress, and these were terrific as well.

New Zealand training

A couple of weeks prior to my UK trip, I went to Wellington, New Zealand with Karen Peasley to conduct ICD-10-AM coder training for the NZ Health Information Service (NZHIS). This was held over a four day period, with Day 1 being an overview for staff of the NZHIS and attended by around 50 people. The other three days were train-the-trainer sessions for approximately 26 New Zealand clinical coders who will assist in training other coders throughout the country. I really enjoyed meeting the folks from the other side of the Tasman and the training seemed to go very well, although it was rushed as such sessions are often forced to be.

Other news

Maryann Wood is currently developing a detailed ICD-10 implementation plan for the Australian Bureau of Statistics (ABS), which is hoping to start coding mortality using the World Health Organization (WHO) version of the new classification from January 1999. This date is dependent on the arrival of the Automated Cause of Death coding software (ACOD) from America and the ability of the ABS to install and test it in time.

The ABS plans to recode a couple of years' past data in ICD-10 using the ACOD system to facilitate the coding. This will provide several years' of data with which to assess changing trends due to the new classification.

Erich Schulz and I have been having numerous discussions recently with a variety of organisations and groups about future developmental work on what is currently known as the 'Australian Clinical Thesaurus' (or ACT). We are hoping to gain funding to continue the developmental work already begun by Erich. The primary goal of the ACT is to facilitate the uptake of coding systems in health information software and electronic patient records. It will provide a stable electronic framework around which coding and reporting modules can be built. If anyone is interested in knowing more about the ACT, Erich can be contacted via email on <e.schulz@qut.edu.au>.

Joy Smith (NCCH Project Officer) has been beavering away working on the curriculum for the Medical Records Short Course train-the-trainer sessions, which are planned for 22 June–17 July 1998. We are anticipating around 10 students from 5 or 6 South East Asian countries and have developed a comprehensive social programme for them, in addition to the hard work they will be doing in modifying our materials to suit their own local needs. We have recently employed Melissa McBride, another HIM, to help Joy in the lead up to the course. You may have seen a request from Maryann Wood on Code-L recently, asking for the donation of old or unused textbooks and reference materials for the use of the students. There is a paucity of such material in many of the countries of the region and we would be delighted to receive donations (with an appropriate inscription from the donor if you wish) to pass on to the students. Donations can be forwarded to Maryann Wood or Joy Smith, NCCH (Brisbane), School of Public Health, Queensland University of Technology, Victoria Park Road, Kelvin Grove QLD 4059.

One of the things that has been occupying a large percentage of our collective minds in the past few weeks has been ensuring that the NCCH (Brisbane) continues past the end date of our current contract. We are delighted to have secured funding to enable us to continue to function for the next 3–5 years and wish to record our thanks to the following organisations for their support: the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, the Classification and Payments Branch of the Commonwealth Department of Health and Family Services and Queensland University of Technology.

❖ **Sue Walker**

Associate Director, NCCH Brisbane

Keep up with the latest on ACBA!

Hospitals that have used their copy of the *Australian Coding Benchmark Audit* (ACBA) will know that it comes with a disc comprising a set of forms to be used to record the audit:

- a 'front sheet' providing details of the hospital (Form E.1)
- two Excel spreadsheets for scoring and for summarising the audit results (Forms E.2 and E.3)
- a feedback sheet (Form E.4)

Further work on the files has produced a new version of the two spreadsheets which does some of the work for you:

- on Form E.2, columns add themselves up
- a new column checks the consistency between the various columns and points out where there is a discrepancy
- the whole of Form E.3 magically fills itself in, percentages and all

We have also taken the opportunity to add some items to the 'front sheet' to aid classification of hospitals into their benchmark groups.

Some notes will assist users where the forms are different from those shown in ACBA.

Any future purchasers of the ACBA kit will receive the new version of the disc files but we can also make this available to existing ACBA customers via:

- 1) The NCCH Homepage (call 02 9351 9344 for a password & have your Invoice No. handy!):

<http://www.cchs.usyd.edu.au/NCCH/ncch.html>

- 2) You can email NCCH (Sydney) on NCCHSales@cchs.usyd.edu.au to request that the updated files be emailed to you; after verifying your original purchase (please quote your Invoice No.), we will email the files to you

- 3) You can contact NCCH (Sydney) for a new disc to be posted to you (ph: **02 9351 9344**).

The NCCH Quality Division can also accept your ACBA results by email. Discuss this option with Andrea Groom on ph: 03 9479 5788.



QUALITY CONCERNS

ACBA

To date results from the *Australian Coding Benchmark Audit* (ACBA) have only been received from a few Australian sites, however, this has provided invaluable information on the use of ACBA (e.g. interpretation of reporting categories, calculation of error rates). Andrea Groom (NCCH Quality Division) has been working with several hospitals to support their implementation of ACBA. The method of calculating results has now been simplified and ACBA users can obtain the updated files to assist with this process (*see* page 5).

The change in coding system from ICD-9-CM to ICD-10-AM makes it even more important for hospitals to monitor coding quality so that documentation requirements and system bugs are identified quickly before coding errors become ingrained habits. Despite the pressure of change in the ICD-10-AM implementation states we look forward to receiving more results in the next few months. Please let us know if we can assist by providing advice and support for your first audit. We will not be able to provide any benchmark data until we have a database of results - so the potential value of ACBA depends on its usage by clinical coders in healthcare facilities throughout Australia.

Standards

A discussion paper is being prepared on the content and use of the existing NCCH *Standards for Ethical Coding* and *Standards for Coding Services*, and the need for revisions to be incorporated with the second edition of ICD-10-AM. Various methods of information collection are being used to gain comments on the standards: advertisements have been placed in several newsletters; several 'focus groups' are being organised to facilitate group discussion; and a questionnaire will be sent to a random sample of clinical coders.

Other news

A procedure for managing the development of coding edits has been introduced so that the appropriateness of edits is considered at the same time as new and revised codes are introduced.

Olga Goulas and Janine Pervanas, third year Bachelor of Health Information Management students from La Trobe University, are working with the Division for a five week placement period in May-June 1998 on several projects including PICQ, ACBA and the literature review.

PICQ

A new project currently being undertaken by the NCCH Quality Division has been given the title *Performance Indicators for Coding Quality* (PICQ) - yes, another acronym to add to your list - and considerable developmental work has been undertaken. Catherine Perry and Irene Kearsey are presently working on this project.

Each indicator describes a coding error, such as 'Episodes with a diagnosis code indicating a delivery without an outcome of delivery code'. To enable consistent selection of records, each indicator is specifically defined using ICD-10-AM codes. However, just identifying problem records is not the whole picture: you need to know the *size* of the problem and PICQ provides a method of calculating this. The indicator itself is the numerator and, for each indicator, PICQ provides a relevant denominator (being the total number of records which could have had the error described by the indicator).

Take the indicator 'Episodes with a diagnosis code indicating a delivery without an outcome of delivery code' for example: the total of error records is the numerator, and the denominator would be 'All episodes with a diagnosis code indicating a delivery'. In this way, the percentage calculated is relevant to the total of *possible* error records, rather than to the total of *all* records. Say two hospitals, one a general hospital that does some obstetrics and the other a specialist maternity hospital; both had 1,000 total separations in the year. Using this indicator, both hospitals found 10 error records: a crude error rate for both of 1%. But the denominator would identify that the general hospital had 100 records with a delivery code while the maternity hospital had 900 such records, giving the general hospital a 10% error rate and the maternity hospital a 1.1% error rate on this indicator.

As the indicators will be useful to facilities other than hospitals, they need to be indexed in a number of ways to permit any user to select the indicators that will be most useful for their purposes. For example, a data collector (say, for a State morbidity collection) might want to test for adherence to the *Australian Coding Standards*: all indicators testing Standards are indexed by Standard number. Researchers are another group of possible users who should test data before making their analysis and drawing any conclusions: all indicators are indexed according to the type of coding problem: for

example, completeness (missing codes), redundancy (unnecessary codes), specificity and sequencing. Indicators are also indexed according to the ICD-10-AM chapter numbers (diagnosis and procedure) relevant to the topic. The indicators will be a resource for software suppliers who can select indicators suitable to incorporate as edits into hospital systems.

This demonstrates that the indicators will have different uses at different times: if incorporated as edits, coding errors may be prevented; if run periodically on 'live' data, corrections can be made before data transmission; if run on data collections, data quality reports can be provided to hospitals; and if run on research collections, data can be assessed for its quality.

While final details of the project's format are yet to be worked out, it is envisaged that an accompanying text will be published, with the indicators recorded in a database format. An objective is for users to be able to download the lists of codes without further data entry. Because each indicator is exactly specified, results can be compared across time and across facilities for true benchmarking.

So far, our sources of indicators have included work performed by previous NCCCH staff Leanne Clavarino and Joanne Chicco and a trawl through the *Australian Coding Standards* and other literature. Examples of indicators:

Asterisk code used as the principal diagnosis.

Secondary neoplasm site code, without a primary site code or personal history code.

Old stroke code, without any manifestation code.

Acute tonsillitis code with tonsillectomy code.

Open wound communicating with a fracture code, without a fracture code.

The next job is a review of the tabular lists for any instructions which can be tested. We are also developing indicators from procedure codes for specific conditions/injuries. Ideas will also arise from the consideration of the existing edits used by states and territories. Currently, we have developed more than 500 indicators but the possibilities are endless! Readers of *Coding Matters* are invited to suggest indicators. What problems have you found in your own data that can become indicators? The problem records must be able to be clearly defined in codes. Send your ideas for indicators to: C.Perry@latrobe.edu.au

❖ **Dianne Williamson**
Manager, NCCCH Quality Division

A CHANCE TO HAVE YOUR SAY

Comments regarding the 'Australian Standards for Ethical Coding' and the 'Australian Standards for the Coding Service' (*ICD-10-AM, Volume 5, Appendices C & D*) are being sought by the NCCCH Quality Division.

Do you use these standards? Are they relevant to your type of facility? Are there issues or problems not covered? Are the ethical issues different for a clinical coder compared to a supervisor? Do you have examples of ethical problems you have faced?

We are currently undertaking a data gathering process to identify issues relating to the current standards and would like your feedback. Note that all information will be treated as confidential. At no stage will comments be identifiable as originating from a particular person or institution. We are planning to follow up this process with a detailed questionnaire sent to a random sample of clinical coders.

If you would like to have your say, please contact either Andrea Groom or Catherine Perry on:

mail: Quality Division, NCCCH

School of Public Health

La Trobe University

Bundoora Vic 3083

phone: (03) 9479 5788

fax: (03) 9479 1783

Australian Coding Benchmark Audit

(ACBA)

 Do you have any queries about how ACBA works?

Are you about to use ACBA or have just finished an ACB Audit?

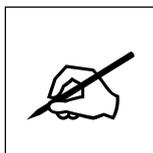
Would you like to make comments on it?

If so, call the ACBA 'Hotline' on

ph: 03 9479 5788

Don't forget to send your results to us!

Note that you can now send your results directly to NCCCH Quality Division by mail, fax or email (see page 2 for NCCCH Quality Division contact details).



EDUCATIONAL MATTERS

After just recovering from a whirlwind round of workshops, the NCCH Education Manager launches full swing into planning the 1998 Conference in the Red Centre!

ICD-10-AM Workshops

As you read this my feet are at last well back on terra firma after coordinating the NCCH ICD-10-AM Education Workshops held throughout NSW, Victoria, ACT and NT during April, May and June 1998.

The workshops were very well patronised with a total of just under 1000 participants attending 32 workshops. There were nineteen workshops held in NSW (eight in metropolitan Sydney) with 544 participants, eleven workshops held in Victoria (six in metropolitan Melbourne) with 372 participants and one workshop each in Darwin (12 participants) and Canberra (42 participants).

The workshops were a huge undertaking and could not have been conducted without the much valued assistance received from the state and territory ICD-10-AM Implementation Coordinators and their respective health departments and as always, support from the Department of Health and Family Services. Recognition must also be made of the efforts of the twenty three members of the Coding Educators Network (CEN) who presented the workshops on behalf of the NCCH.

The overall feeling gained from the workshops was that they were successful in providing an overview of the major changes between ICD-9-CM and ICD-10-AM and a basic understanding of the new and revised *Australian Coding Standards*. Many people have noted that they now face the implementation of ICD-10-AM with less trepidation. A review of the evaluation forms is currently underway and a full report will be available in the October 1998 edition of *Coding Matters*.

If there are any clinical coders, health information managers or other health professionals who missed out on attending one of these workshops due to work commitments, illness etc, please contact myself or Angela Abood (Administrative Assistant) at the NCCH. We will be maintaining a register of people who still require training and assessing the need for repeat workshops within the next six to twelve months.

Mastering Ten

Mastering Ten finally reached fruition in the second week of June 1998 and I would like to apologise again for the lateness of this material. I hope that many of you have now commenced the exercises in the workbook as practice before 'going live' with ICD-10-AM.

Education for clinicians and others

The educational material for clinicians and other health professionals is nearing completion and will be available from the NCCH homepage in July 1998. The original plan for a hard copy version of the material was revised and it was felt that accessibility to the material was paramount and thus the decision was made to place the material on the internet for down loading by interested parties. The material can be viewed on the NCCH homepage (<http://www.cchs.usyd.edu.au/NCCH/nccch.html>). The material is divided into speciality so that either all material or only that for selected specialities can be down loaded. The material is to be used as a self education tool for clinicians and other health professionals and also by health information managers and clinical coders for presentations to their relevant clinicians at hospital orientation sessions and clinical meetings.

1998 Conference

The NCCH/CCSA Conference planning is well underway and the registration form/program can be found in this issue of *Coding Matters* as an insert. Please contact me (ph: 02 9351 9461) if you do not receive the registration form/program or you require additional forms. The Conference is shaping up to be a highly interesting and entertaining event and I look forward to seeing many new and old faces joining us in the Red Centre.

❖ **Karen Peasley**
A/Education Manager

Unfortunately, due to the voluminous size of the 'Coding Services' section in this issue (and we all know how much you love those 'tips'), we have had to hold over the Coding Educators Network (CEN) member profiles until the October 1998 issue. Apologies!

**Attendees at the NZ
ICD-10-AM Coder
Training Workshop
conducted for the NZ
Health Information
Service (NZHIS), 31
March–3 April 1998**



Heading for the Centre - Fifth Annual Conference

The Fifth Annual NCCH Conference is rapidly approaching. This year we are also offering Sponsorship packages for the first time. An exciting rural theme program has been scheduled. We look forward to you joining us in the Red Centre!!

National Centre for Classification in Health
(in conjunction with the
Clinical Coders' Society of Australia)
5th Annual Conference

Dates: Wednesday 23rd–Friday 25th September 1998

A pre-conference workshop will be held on the Wednesday along with an optional tour of the Royal Flying Doctor Service and Alice Springs Hospital

Venue: Rydges Plaza Hotel, Alice Springs,
Northern Territory

The Plaza Hotel is located approximately five minutes by car or fifteen minutes by foot from Alice Springs town centre and backs onto the Alice Springs Golf Course. Alice Springs is a central venue for touring the surrounding outback in the Northern Territory.

Theme: 'The Meeting of Two Centres - Coding in a Rural Setting'

Cost: The cost for attendance at the conference will range between \$315–\$380, dependent upon the number of days attendance and optional tours chosen.

Sponsorship: The conference organiser is pleased to invite interested parties to participate as sponsors for the conference. If you or your organisation would like to be involved in sponsorship, an information package is available from Karen Peasley.

Registration: Brochures distributed in July 1998.

Contact: Ms Karen Peasley
Conference Organiser
A/Education Manager, NCCH
PO Box 170, Lidcombe NSW 2141
Ph: (02) 9351 9461
Fax: (02) 9351 9603
Email: k.peasley@cchs.usyd.edu.au





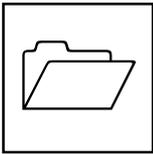
**Let the ICD-10-AM Workshops commence!
North Ryde, Sydney
(20–21 April 1998)**



Linda Best (NCCH Educator, CEN) answers the questions at the North Ryde Workshop



**Workshop attendees at La Trobe University with their heads in the books
(29–30 April 1998)**



CODING SERVICES

The Coding Services segment this issue is **so** large it nearly deserves its own newsletter!!
AR-DRGs, art and science, sports, query processes, ICD-10-AM workshop questions and answers and plenty of coding tips

Important notice about ICD-9-CM invalid codes

In *Coding Matters*, Vol. 4, No. 2, page 11 (April 1996) we advised in a 'stop press' article that the fifth digit of '9' should not be used for codes 800.x, 801.x, 803.x and 804.x. It has come to our attention that not everyone implemented that change. We have deleted these codes from our list of valid codes (in the 'ASCII list'), but because of a deadline for Version 4 grouper development, these codes will still appear in the forward mapping tables of ICD-9-CM to ICD-10-AM.

DON'T USE CODES 800.x9, 801.x9, 803.x9 or 804.x9

BY MAKING THIS CHANGE TO YOUR
ICD-9-CM CODING BOOKS:

FRACTURE OF SKULL (800-804)

The following fifth-digit subclassification is for use
with the appropriate

codes in categories 800, 801, 803, and 804:

DELETE ~~9 with concussion, unspecified~~

The difference between Versions 4.0 and 4.1 of the Australian Refined Diagnosis Related Groups classifications.....

Version 4.0 of AR-DRG

- available May 1998
- accepts ICD-9-CM codes
- incorporates the clinical recommendations accepted by the Commonwealth
- revised cc codes and logic
- new DRG numbering
- separate mapping software needed to map ICD-10-AM codes to ICD-9-CM

Version 4.1 of AR-DRG

- available November 1998
- no mapping needed, accepts ICD-10-AM codes
- same logic as AR-DRG 4.0
- concordance of maps with codes/data may cause volume variation in DRGs compared with Version 4.0

The art and science of clinical coding

Many of the queries we receive at the NCCH are related to the fundamental skills of clinical coding. Some of the issues raised recently prompted me to revisit the skills of the clinical coder:

- A clinical coder has a thorough, working knowledge of medical science and terminology.
- A clinical coder understands the structure and use of a statistical classification.
- A clinical coder can read the clinical record and make decisions about the appropriate codes to assign, based on the clinical documentation.

No mean feat!

The important features of these three points are **medical science, make decisions** and **structure**.

Medical science is complex and forever changing.

Structure of the classification is static.

Decision making is subjective.

Although new codes are introduced regularly, on the whole the classification structure remains constant over time. Codes and coding standards need to change to try and keep pace with medicine, but ultimately, clinical coders will often need to make decisions which are based on their **experience and common sense** as well as the resources available to them.

When you look at what you do objectively, you assign numbers from a structured, classification system to complex, ever-changing medical concepts which are not documented in a standardised way - no wonder its difficult!

My point is, no matter how much we hope there will be hard and fast rules to solve all our coding problems, it remains that no amount of rules will ever replace the educated judgements that clinical coders make about specific cases based on the.....

Clinical Coders Creed

As a clinical coder, I believe these things are the fundamentals of the art and science of clinical coding:

- Clinical documentation
- Communication with clinicians
- Coding standards
- Conventions
- Classification experience
- Common sense
- sScience of medicine

All this serves to highlight the considerable and often forgotten skills of clinical coders.

Make decisions in coding based on **Sailing the Seven Cs with the Clinical Coders Creed** and you'll come up with a code that is as good as possible - the work of a competent clinical coder.

Collection of sports activity in ICD-10-AM

Some of you may have noticed that although ICD-10-AM has a new 5th character for external cause codes called 'Activity', the activity code '0' *While engaged in sports activity* does not provide the level of detail available in ICD-9-CM code E889 *Type of sporting activity*.

The NCCH has been lobbying key stakeholders over the last year in an attempt to find other means of collecting at least the number of sports available in ICD-9-CM. Some state and territory health authorities may consider providing the 10 sports from E889 as a further option when clinical coders assign an activity of '0'.

The NCCH has recommended to the National Health Data Committee that this issue needs to be addressed in order to maintain some continuity in the changeover from ICD-9-CM to ICD-10-AM. This information is used for injury surveillance research and its unavailability would be a significant setback to such research. The National Injury Surveillance Unit of the Australian Institute of Health and Welfare (AIHW) is assisting us

in developing a comprehensive list of sports which may form part of a new external cause code structure currently being investigated by a working party of the NCCH Coding Standards Advisory Committee (CSAC).

One of the issues this working party will be examining is the possibility of removing the 4th and 5th characters of Place of Occurrence and Activity (respectively) and making these two separate codes. This would provide more scope within the classification to expand the place of occurrence and activity codes and also leaves these two characters free for expansion of the external cause codes themselves.

Needless to say, there is a lot of work involved in reviewing the external cause chapter and we will be looking not only to the CSAC working party members for assistance but also to our colleagues in Canada and USA, the USA having already made considerable changes to their version of ICD-10 (ICD-10-CM). There is also some interesting work being done by the World Health Organization Working Group for Injury Surveillance Methodology Development in its production of a draft International Classification of External Causes of Injuries (ICECI). The ICECI is a multi-axial codeset which captures aspects of injury such as place of occurrence, activity, intent of injury and victim-perpetrator relationship and is based on ICD. It is hoped the ICECI will be used as a companion guide to ICD allowing more detailed data capture in areas such as emergency departments and in ad hoc studies and surveys.

The National Injury Surveillance Unit at the Research Centre for Injury Studies (AIHW) has played a major role in these developments. The developments in ICECI will provide guidance for future modifications of the external causes chapter of ICD-10-AM.

ICD-10-AM Coding Queries

The coding query process published in *Coding Matters*, Vol . 4 No. 4 has been slightly revised consequent to the last Coding Standards Advisory Committee (CSAC) meeting. The changes are:

- The Code-L listserver will not be used for query submission, however, **queries can be sent by email, fax or mail.**
- The NCCH has developed an electronic query form which will enable email queries to be entered directly into a standard format. This form is available on the NCCH homepage and will be posted on Code-L.

**Email queries should be addressed to:
NCCHquery@cchs.usyd.edu.au**



- The NCCH will circulate draft answers to State Implementation Coordinators for comment prior to responding to the original enquirer. Selected queries/answers will also be forwarded to CSAC members when necessary.

- In the event that a query needs to be forwarded to the Clinical Coding and Classification Groups (CCCGs), the initial response to the enquirer will be an interim one.

- The coding query form is included as an insert in this edition of *Coding Matters*.

Please ensure that all queries are accompanied by the appropriate documentation

Please use a separate form for each query

ACS annotations in ICD-10-AM, Volume 1

Many clinical coders have notified the NCCH that codes in Volume 1 do not have annotations which indicate that an associated coding standard exists. At the time of printing of ICD-10-AM, only a few of the possible codes were annotated due to time constraints. These will be updated in the second edition of ICD-10-AM in 2000. Until then, feel free to add an annotation where you find this helpful.

Questions and answers from the ICD-10-AM workshops

Q1. What activity code should be used for suicide?

A. Activity code '8 *While engaged in other specified activities*' should be assigned for suicide to indicate the activity of the injured person at the time the event occurred.

Q2. What activity code should be used for child playing?

A. Activity code '8 *While engaged in other specified activities*' should be assigned to indicate child playing at the time the event occurred.

Q3. If a patient is playing on a school basketball court out of hours, is this place of occurrence .2 or .3?

A. Assign place of occurrence '3' because sports and athletic areas are excluded from '2'.

Q4. If a professional golfer is injured whilst playing golf, is this activity code .0 or .2?

A. In this example, assign '0' because for injury prevention purposes knowing the 'sport' is more useful than 'engaged in work'.

Generally, when two codes are possible, assign the one higher in the list.

Note: The guideline below may be different from advice received at the recent ICD-10-AM workshops and overrides ACS 2006 *ACTIVITY CODE*.

(Reference: *National Data Standards for Injury Surveillance, Version 2.1, Australian Institute of Health and Welfare, January 1998*)

Q5. A patient has a lobe of her left lung removed in the first episode of care. She is re-admitted to have the remaining left lung removed. Is this second operation considered to be a 'pneumonectomy' or a 'complete lobectomy'?

A. This second procedure is known as a 'completion pneumonectomy' (the removal of the remaining portion of lung following previous lobectomy) and is classified to 38438-01 [552] *Lobectomy of lung*. Pneumonectomy is not appropriate for this procedure because it means complete removal of the lung which was the **outcome** of the completion pneumonectomy, but not the procedure actually performed.

Note: The left lung has three lobes and the right lung has two lobes.

The lead term Pneumonectomy in the index has indentations for bilateral and unilateral: **these should be ignored**. This section will be reviewed in the future.

Q6. Should code E89.0 *Postprocedural hypothyroidism* be on the list of codes not requiring an external cause code (Y code)?

A. No. The inclusion terms at E89.0 indicate that hypothyroidism can result from surgery or irradiation. Therefore, the addition of an external cause code to reflect the type of surgery or irradiation will add further information to the code assignment.

Q7. Z86.43 code description is 'personal history of tobacco use disorder' - coders were put off by the disorder component and felt this was more than just history of smoking.

A. In line with the existing ICD-9-CM convention, the term 'abuse' is replaced in ICD-10-AM with 'use disorder'. The original code description from ICD-10 was Z86.4 *Personal history of psychoactive drug abuse* and therefore all new codes at Z86.4 have had the term 'abuse' replaced with 'use disorder'. Use disorder is a very general term, and its inclusion should not dissuade clinical coders from assigning this code as indicated in ACS 0529 *TOBACCO USE DISORDER*.

Note the changes for code Z86.43 *Personal history of tobacco use disorder* in Errata 2.

Q8. Can a percentage BSA code (T31) be used with the sunburn codes (L55)?

A. For sunburn, if the percentage body surface area is documented, assign T31.xx *Burns classified according to extent of body surface involved*. Also, note that the external cause is inherent in the codes L55.x *Sunburn* and therefore the assignment of an external cause code is unnecessary. However, if you assign T31.xx you will also need to assign X32.xx *Exposure to sunlight*.

Q9. How do you code intramuscular injection for chemotherapy?

A. The NCCH is currently reviewing the procedure codes for chemotherapy and injection/infusions. In the interim, where an intramuscular injection for chemotherapy is performed, assign procedure code 92193-00 [1892] *Injection or infusion of other therapeutic or prophylactic substance*.

Q10. Which procedure code is to be used for an epidural injection/infusion done for back pain? Patient is admitted solely for an epidural to treat chronic lower back pain.

A. The NCCH is currently investigating this issue. In the interim epidural for back pain relief should be assigned one of the **preoperative** codes, such as:

18216-00 [33]
Epidural infusion of local anaesthetic, preoperative,

18216-03 [33]
Epidural infusion of opioid, preoperative, or

18216-06 [33]
Epidural infusion of other therapeutic substance, preoperative.

Q11. We use induction of labour for social reasons as a clinical indicator and have previously retrieved this information using the ICD-9-CM code 659.8 *Other specified indicators for care or intervention related to labour and delivery*. How can we distinguish this in ICD-10-AM?

A. In ICD-10-AM, when there is no reason for induction documented or the reason is social/elective and a normal vaginal delivery follows the induction, assign O80 *Single spontaneous delivery* with an accompanying induction procedure code. The absence of a diagnosis code indicating the reason for induction will signify the social/elective intent of the induction. Similarly, if another code from chapter 15 is assigned instead of O80 (e.g. perineal tear), the absence of a code indicating the reason for induction will signify the social/elective intent of the induction. Refer to ACS 1535 *REASON FOR INDUCTION* for examples of common reasons for induction of labour.

Q12. When do you use procedure block [1823] *Psychiatric consultation*?

A. Although consultation codes are provided in ICD-10-AM, it is not envisaged that these codes will be assigned in the inpatient setting. However, this does not preclude their use for specific purposes such as research.

Q13. Can we use all the procedure codes available in ICD-10-AM for inpatients?

A. Although procedure codes are provided for most interventions/procedures, it is not necessary to assign all available codes in the acute care setting. To assist in the selection of procedure codes to be assigned, the following list is provided. It includes procedures which **would normally not be coded. Note that this list is not exhaustive.**

**GUIDELINES FOR PROCEDURES
NOT TO CODE**

These procedures are normally not coded because they are usually routine in nature, performed for most patients and/or can occur multiple times during an episode. Most importantly, the resources used to perform these procedures are often reflected in the diagnosis. For example:

- X-ray and application of plaster is expected with a diagnosis of Colles' fracture.
- intravenous antibiotics is expected with a diagnosis of septicaemia.

That is, for a particular diagnosis there is a standard non-surgical treatment which is unnecessary to code.

Note:

- 1) where there is a specific need to code any of the listed procedures for research or other purposes, *these codes may be assigned*.
- 2) note that some codes on this list may be required in certain standards elsewhere in this document. In such cases, the standard overrides this list and the stated code should therefore be assigned as described in the relevant standard.

1. **Procedure components**
(see ACS 0016 *GENERAL PROCEDURE GUIDELINES*)

2. **Application of plaster**

Code if performed under general anaesthesia (e.g. for congenital dislocation of hips). See ACS 0031 *GENERAL ANAESTHESIA*.

3. Dressings

Code if performed under general anaesthesia. See ACS 0031 *GENERAL ANAESTHESIA or dressings specifically for burns (see ACS 1911 BURNS)*.

4. Electrocardiography (ECG)

5. Electromyography (EMG)

6. Ultrasound

7. X-rays without contrast [plain]

8. Primary suture of surgical and traumatic wounds

Do not code suture of surgical wounds during the course of a procedure and primary suture of traumatic wounds associated with a direct underlying injury (e.g. compound fracture).

9. Traction

Code if traction is the only procedure performed.

10. Cardiotocography (CTG)

11. Echocardiogram

Code transoesophageal echocardiogram.

12. Monitoring: cardiac, electroencephalography (EEG), pressure

13. Stress test

14. Intracranial pressure (ICP) monitoring

15. Postprocedural urinary catheterisation

Code if patient discharged with catheter in situ.

Code suprapubic catheterisation.

16. Intravenous antibiotics

Code if administered in the neonatal period.

See ACS 1615 *SPECIFIC INTERVENTIONS FOR THE SICK NEONATE*.

17. Nasogastric intubation

Stay tuned for the October 1998 issue of *Coding Matters* for more ICD-10-AM workshop questions and answers!

Coding tips

Repair of ectropion/entropion

Definition

An ectropion is an outward turning of the upper or lower eyelid so that the margin does not rest normally against the eyeball, but falls or is pulled away.¹

An entropion is an inward turning of the upper or lower eyelid so that the margin rests against and rubs the eyeball.¹

Classification

Block 239 *Procedures for ectropion or entropion* groups together procedures performed exclusively for repair of ectropion or entropion.

42581-00 [239] *Cauterisation of ectropion*

42581-01 [239] *Cauterisation of entropion*

Cautery is used to shrink the tissues of the eyelid margin to treat the everted/inverted lid.²

42866-00 [239] *Repair of entropion by tightening or shortening of inferior retractors*

42866-01 [239] *Repair of entropion by other repair of inferior retractors*

Correction of entropion is achieved by repairing the inferior 'retractors' (a term commonly applied to the eyelid movement mechanism).³

45626-00 [239] *Correction of ectropion or entropion by suture technique*

Absorbable sutures are used to correct the eyelid's malposition. No incision is required.²

45626-01 [239] *Correction of ectropion or entropion with wedge resection*

A wedge of tarsus and conjunctiva is excised (generally in the configuration of a triangle, diamond or rhomboid) to eliminate the ectropion or entropion. The incision is repaired with layered sutures.²

EXAMPLE 1

Operation report:

Diagnosis: Ectropion of (L) upper eyelid

Procedure: Wedge resection of (L) upper eyelid

Assign procedure code:

45626-01 [239] *Correction of ectropion or entropion with wedge resection*

Note that other procedures classified elsewhere in MBS-E may be performed to repair an ectropion or entropion, such as grafts and canthoplasty.

EXAMPLE 2

Operation report:

Diagnosis: (R) LL Cicatrical Ectropion

Procedure: 1. Lateral canthal tightening with 4/0 nylon
2. PAWG (post auricular Wolfe graft) (L) ear to (R) lower lid secured with 6/0 BSS with tie over 4/0 nylon to ear.

Assign procedure codes:

1. 42590-00 [235] *Lateral canthoplasty*
2. 45451-00 [1649] *Full thickness skin graft of eyelid*

In the above example, the lateral canthus was tightened with sutures and a post auricular Wolfe graft was performed to repair the ectropion. Note the anatomic distinction between 45626-00 [239] *Correction of ectropion or entropion by suture technique* in which the eyelid is stitched and 42590-00 [235] *Lateral canthoplasty* in which the *canthus* (angle formed by the inner or outer junction of the upper and lower eyelids) is stitched.

References:

1. Cassin, B. and Solomon, S.A.B. (1990). *Dictionary of eye terminology*. (2nd ed). Triad Publishing Company. Florida.
2. Bernard, S. (Ed.). (1996). *Illustrated coding - The eye. Medicode. Salt Lake City.*
3. Dr. Michael Hennessy, Prince of Wales Hospital - Member of Ophthalmology Clinical Coding & Classification Group. [Personal communication].

Keratoacanthoma

The morphology code for keratoacanthoma is M8070/1. Note that this is the code used in ICD-9-CM. The NCCH is working on adding additional codes with behaviour codes not in ICD-10-AM, (such as M8070/1) into the ICD-10-AM ASCII. Until this work is completed for the second edition of ICD-10-AM, it should be noted that M8070/1 may not be included in state morbidity systems.

Asthma - ACS 1002

There has been some confusion about this ICD-10-AM standard. It was **not** the intention of the standard that all cases with a documented principal diagnosis of asthma should be assigned J46 *Status asthmaticus*. This rewording is intended to clarify this standard:

Patients with status asthmaticus (acute severe asthma) are usually suffering from a deterioration of their baseline condition and are not responding to usual medication. This definition applies to patients who are admitted to hospital with a principal diagnosis of asthma. Status asthmaticus (J46) should be assigned only if the asthma is documented as “acute severe”.

HIV

Categories B20–24 are provided for coding human immunodeficiency virus (HIV). In ICD-10, an optional fourth character is provided to indicate any associated condition. In ICD-10-AM, these fourth characters have been deleted with an additional code from other chapters required to indicate the associated condition. This departure from ICD-10 means that the index entries still reflect the fourth character B20–24 codes. The changes to the tabular list for HIV and a review of the index entries will be undertaken for the second edition of ICD-10-AM. In the interim you need to **ensure that ACS 0102 HIV/AIDS is followed and assign codes for all manifestations of the HIV infection** sequencing the principal diagnosis based on ACS 0001 *PRINCIPAL DIAGNOSIS*. The Note for categories B20–24 should also be consulted, ‘Use additional code(s) for categories B20–B24 to identify all manifestations of HIV infection’.

Glaucoma

In Errata 1, the term glaucoma was deleted from ACS 0002 *ADDITIONAL DIAGNOSES* and ACS 0711 *GLAUCOMA* was deleted. This previous advice to code glaucoma routinely has been rescinded based on clinical advice from the Australian Casemix Clinical Committee which states that only cases of ‘acute’ glaucoma should be assigned routinely as additional diagnoses. The **routine** assignment of chronic glaucoma as an additional diagnosis should be discouraged, particularly when the principal diagnosis is unrelated to glaucoma. The ideal solution to solve this problem would be to have specific codes for acute glaucoma and chronic glaucoma. However, this is not possible in ICD-10-AM. Therefore, a decision was made to prohibit the routine assignment of glaucoma as an additional diagnosis. This action serves to suspend any **routine** assignment of the glaucoma code, but **does not preclude the assignment of the code when it is warranted for a particular case**.

Readmitted for jaundice

ACS 1615 *SPECIFIC INTERVENTIONS FOR THE SICK NEONATE* states that the diagnosis of jaundice should only be coded when phototherapy is given for >12 hours. Clinical coders have asked us what to do in

the event that a patient is readmitted after the birth episode with a diagnosis of jaundice. This is a good example of where the clinical coder needs to use the ‘coders creed’ and use some common sense: if the clinician has diagnosed jaundice of the neonate as the principal diagnosis then the clinical coder should assign the appropriate code because if the standard is followed then no diagnosis code can be assigned! Standard 1615 deals only with the more common occurrence of jaundice occurring during the birth episode. The standard is designed to ensure that only the significant cases of jaundice (i.e. those treated with phototherapy) are captured in morbidity collections.

In the rare case that an infant is readmitted for jaundice and no phototherapy is given, jaundice should be coded as the principal diagnosis. When the infants age is <29 days, see Volume 2 Index Jaundice, - fetus or newborn. When the infants age is >28 days, see the main term Jaundice in the Index.

Chronic gastritis

Some questions have been raised about the absence of a fifth character breakdown for haemorrhage associated with chronic gastritis. The K29 *Gastritis and duodenitis* category is based on the International Nomenclature of Diseases of the Digestive System (Vol. IV) as are many categories in ICD-10-AM. In this nomenclature there is no concept of ‘chronic haemorrhagic gastritis’ whereas there is a distinct entity of ‘acute haemorrhagic (erosive) gastritis’. Therefore, if chronic gastritis is documented as being accompanied by haemorrhage, assign the appropriate code from K29 *Gastritis and duodenitis* with an additional code of K92.2 *Gastrointestinal haemorrhage, unspecified*.

Postpartum condition or complication

In cases where a postpartum condition or complication classifiable to the obstetrics chapter occasions an episode of care and the **patient has delivered prior to admission** (e.g. in hospital or at home), a code from Z39.0x *Postpartum care and examination immediately after delivery* must be assigned as an additional diagnosis. Z39.0x must never be assigned as the principal diagnosis in such cases (see ACS 1519 *DELIVERY PRIOR TO ADMISSION*, page 158 regarding Z39.0x as the principal diagnosis).

EXAMPLE 1

Patient admitted with puerperal pulmonary embolism after having delivered at another hospital 1 week ago.

Codes: O88.2 *Obstetric blood-clot embolism*

Z39.01 *Postpartum care after hospital delivery*

If the patient is treated for a postpartum condition during an episode of care in which delivery occurs, Z39.0x should **not** be assigned.

EXAMPLE 2

Spontaneous breech delivery of a single liveborn infant with pulmonary embolism post delivery.

Codes:

O32.1 *Maternal care for breech presentation*

O88.2 *Obstetric blood-clot embolism*

Z37.0 *Single live birth*

Postnatal depression

Given the number of questions raised at the workshops regarding postnatal depression, this interim guideline has been developed and overrides Errata 1 (April, 1998) changes to ACS 0505 *MENTAL ILLNESS COMPLICATING PREGNANCY*.

ICD-10-AM has a specific code for postnatal depression F53.0 *Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified*. This code, however, is a ‘not elsewhere classified’ code and special attention should be paid to the note under the category heading. The NCCH, together with the Obstetrics and Gynaecology CCG, is currently reviewing the classification of postnatal depression. In the interim, this guideline aims to provide clarity and consistency in the assignment of F53.0.

Classification

Only when the type of postnatal depression is **not documented** or **not able to be classified elsewhere** in Chapter V ‘Mental and behavioural disorders’ should F53.0 *Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified* be assigned.

The note at F53 *Mental and behavioural disorders associated with the puerperium, not elsewhere classified* states “This category includes only mental disorders associated with the puerperium (commencing within six weeks of delivery)...”. If, however, a diagnosis of *postnatal depression* is documented without further qualification, in any episode **up to one year post delivery**, the code F53.0 may still be assigned.

Delivery or puerperal episode of care**EXAMPLE 1**

Diagnosis: Patient delivered of a liveborn infant by spontaneous vaginal delivery. Diagnosis was postnatal depression. Further qualification of this term was sought, yet not able to be provided.

Principal Dx:

O80 *Single spontaneous delivery*

Additional Dx:

F53.0 *Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified*

Z37.0 *Single live birth*

Procedure:

90467-00 [1336] *Spontaneous vertex delivery (optional code)*

EXAMPLE 2

Diagnosis: Patient admitted at 36 weeks for bedrest and antidepressants for exacerbation of her major depression. During the same episode the patient delivered of a liveborn infant by spontaneous vaginal delivery at 39 weeks.

Principal Dx:

O99.3 *Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium*

Additional Dx:

F32.2 *Severe depressive episode without psychotic symptoms*

Z37.0 *Single live birth*

Procedure:

90467-00 [1336] *Spontaneous vertex delivery (optional code)*

Episodes of care (after delivery and puerperal episodes) up to one year post delivery**EXAMPLE 3**

Diagnosis: Patient admitted 6 months post delivery with postnatal depression. Discharged 4 weeks later. Further qualification regarding the type of depression could not be obtained.

Principal Dx:

F53.0 *Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified.*

EXAMPLE 4

Diagnosis: Patient admitted 6 months post delivery with a provisional diagnosis of postnatal depression and is subsequently diagnosed with major depression. Discharged 4 weeks later.

Principal Dx:

F32.2 *Severe depressive episode without psychotic symptoms*

Exclusion notes

There are two types of exclusion notes in ICD-10-AM. The exclusion note meanings were developed by the World Health Organization (WHO). In the development of ICD-10-AM the exclusion notes remain unaltered from those appearing in ICD-10. This is an important point in understanding the two types of exclusion notes which are described simply by WHO as:

Exclusion Note Type 1

For single condition coding 'it' goes somewhere else.

Exclusion Note Type 2

You might think 'it' goes here but it doesn't.

Apart from understanding the ICD-10 principles involved in exclusion notes it is also essential that we revisit our main aim in coding:

To translate medical statements into code.

If the application of an exclusion note results in the medical statement not being fully represented by code/s, then you may need to re-examine the code assignments. A good way to test the appropriateness of your code assignments is **to translate the codes back to the medical statement.**

A simple example of translating code back to a medical statement:

Medical statement: Cholecystitis with cholelithiasis

Code translation: K80.10

Medical translation: Calculus of gallbladder with other cholecystitis, without mention of obstruction

This is a good code assignment because both the medical statement and the medical translation include inflammation of the gallbladder (cholecystitis) and calculus of the gallbladder (cholelithiasis).

Let's look more closely at the two types of exclusion notes

Type 1 exclusion notes (For single condition coding 'it' goes somewhere else)

These notes are based on the principle of single or multiple condition coding in ICD-10. The principle of single-condition coding is employed in some countries where only the main condition treated or investigated during the relevant episode of health care is reported - i.e. one code only to describe the episode of care. Obviously, single-condition coding will often result in valuable information being lost. In Australia, we use multiple-condition coding to provide the necessary specificity to fully describe the episode of care.

Again, the rule of thumb is to translate your codes back to the medical statement to check for completeness of code/s assignment.

EXAMPLE:

Diagnosis: Uncontrolled noninsulin dependent diabetes mellitus complicated by gangrene

For single-condition coding, this diagnostic statement would be coded to E11.51 *NIDDM, with peripheral circulatory complications, uncontrolled* because:

- E11.51 **includes** gangrene (*see* Tabular extract next column) and,
- R02 *Gangrene, not elsewhere classified* **excludes** gangrene in diabetes mellitus (*see* below).

Therefore, the excludes note at R02 means 'for **single condition coding** NIDDM with gangrene goes somewhere else (i.e. E11.51)'. ▶

DIABETES MELLITUS

(E10-E14)

Use additional external cause code (Chapter XX) to identify drug if drug-induced.

The following fourth-character subdivisions are for use with categories E10–E14:

.5 With peripheral circulatory complications

Diabetic:

- **gangrene**
- peripheral angiopathy† (I79.2*)
- ulcer

R02

Gangrene, not elsewhere classified

Excludes: gangrene in:

- atherosclerosis (I70.24)
- **diabetes mellitus (E10–E14 with common fourth character .5)**
- other peripheral vascular diseases (I73.-)
- gangrene of certain specified sites
 - *see* Alphabetical Index
- gas gangrene (A48.0)
- pyoderma gangrenosum (L88)

For **multiple-condition coding**, R02 would be used as an additional code to fully describe the diagnostic statement because the code E11.51 does not provide detail about the gangrene.

Type 2 exclusion notes (You might think 'it' goes here but it doesn't)

The conditions listed in these exclusion notes are those which are similar concepts to the rubric in which they are listed and therefore could be mistakenly classified to the rubric in question.

EXAMPLE:

Diagnoses: Chronic airway limitation and bronchiectasis

Chronic airway limitation is indexed to J44.9 *Chronic obstructive pulmonary disease, unspecified*

Bronchiectasis is indexed to J47 *Bronchiectasis*

The inclusion/exclusion notes for these two codes are: ▶

J44**Other chronic obstructive pulmonary disease**

- Includes:** chronic:
- . bronchitis:
 - . asthmatic (obstructive)
 - . emphysematous
 - . with:
 - . airways obstruction
 - . emphysema
 - . obstructive:
 - . asthma
 - . bronchitis
 - . tracheobronchitis
- Excludes:** asthma (J45.-)
 asthmatic bronchitis NOS (J45.9)
bronchiectasis (J47)
 chronic:
- . bronchitis:
 - . NOS (J42)
 - . simple and mucopurulent (J41.-)
 - . tracheitis (J42)
 - . tracheobronchitis (J42)
 - emphysema (J43.-)
 - lung diseases due to external agents (J60–J70)

J47**Bronchiectasis**

Bronchiolectasis

- Excludes:** congenital bronchiectasis (Q33.4)
 tuberculous bronchiectasis (current disease) (A15–A16)

The exclusion note at J44 means that ‘you might think bronchiectasis goes here but it doesn’t’. Also, J47 does not have an inclusion note which indicates that CAL with bronchiectasis would be classified to J47. Therefore, the correct code assignments are J44.9 *Chronic obstructive pulmonary disease, unspecified* and J47 *Bronchiectasis*.

The exclusion note doesn’t mean that CAL with bronchiectasis is coded to J47 only for these reasons:

1. If you translate J47 back to the medical statement it does not include CAL.
2. From the Coders Creed, your **sScience of medicine** knowledge confirms that bronchiectasis is different to CAL and would not be classified to J44 as the exclusion note indicates.
3. There is no inclusion note at J47 indicating that CAL is included there.
4. The index entry for ‘Bronchiectasis’ does not include any subterms relating to CAL or vice versa.

Meconium ileus

P75 *Meconium ileus* (E84.1†) is an asterisk code, which means that it should always be assigned in addition to E84.1† *Cystic fibrosis with intestinal manifestations*. Clinical advice to the NCCH is that there are instances of meconium ileus (5–10%) which are not related to cystic fibrosis. Based on that advice, the NCCH has recommended to the World Health Organization (WHO) that the asterisk be removed from this code in the update of ICD-10. Informal advice from WHO is supportive of this recommendation. While this recommendation is being considered by WHO, we recommend the following action:

In cases where meconium ileus is not associated with cystic fibrosis, assign P75 alone.

Family history codes (Z80-Z84)

Note: The following guideline may be different from advice received at the recent ICD-10-AM workshops.

The coding of examinations for family history of certain disorders will follow the same principles as that which operated in ICD-9-CM. In ICD-9-CM codes, such as V16.0 *Family history of malignant neoplasm* could be assigned as the principal diagnosis code when a patient was admitted for an examination because of a family history of a particular condition. In ICD-10-AM, there is an exclusion note at Z80–Z99 which reads:

Excludes: when family or personal history is the reason for special screening or other examination or investigation (Z00–Z13).

The following rules apply in conjunction with the change in the exclusion note:

PERSONS WITH POTENTIAL HEALTH HAZARDS RELATED TO FAMILY AND PERSONAL HISTORY AND CERTAIN CONDITIONS INFLUENCING HEALTH STATUS (Z80–Z99)

Excludes: follow-up examination (Z08–Z09)

When family or personal history is the reason for special screening or other examination or investigation (Z00–Z13).



SEE ERRATA 2 FOR THIS CHANGE ▶

In accordance with previous advice on coding **family history of certain conditions** in *Coding Matters*, Vol. 2 No.3, the following rules apply:

1) Investigation of a symptom

Assign the symptom code as the principal diagnosis if a condition is not found. Assign the appropriate code Z80–Z84 (*Family history of...*) as an additional diagnosis.

2) Investigation of a condition not found

Assign the appropriate code Z80–Z84 (*Family history of...*) as the principal diagnosis if the condition being investigated is not found.

3) Investigation of a condition not found, other condition found

Assign the appropriate code Z80–Z84 (*Family history of...*) as the principal diagnosis if the condition being investigated is not found. Assign a code for the other condition found as an additional diagnosis.

EXAMPLE

Diagnosis: Patient admitted for colonoscopy due to family history of colon cancer. Colonic polyps snared.

PDx: Z80.0 *Family history of malignant neoplasm of digestive organs*

Add Dx: K63.5 *Polyp of colon*

Proc: 32093-00 [911] *Fibreoptic colonoscopy to caecum, with polypectomy*

4) Investigation of a condition found

Assign as the principal diagnosis the code for the condition being investigated if this condition is found at examination. Assign the appropriate family history code as an additional diagnosis.

EXAMPLE

Patient admitted with family history of colon malignancy for endoscopy. Adenocarcinoma of the descending colon is found at endoscopy and biopsied.

PDx: C18.6 *Malignant neoplasm of colon, descending colon*

M8140/3 *Adenocarcinoma NOS*

Add Dx: Z80.0 *Family history of malignant neoplasm of digestive organs*

Proc: 32090-01 [911] *Fibreoptic colonoscopy to caecum, with biopsy*

Important: This rule does not apply for examinations for **personal** history of certain disorders. The excludes note at Z80–Z99 should be followed, i.e. a code from Z00–Z13 should be assigned as the principal diagnosis code followed by the appropriate personal history code from Z85–Z88.

For instructions on coding follow up for personal history of malignancy *see* ACS 0213 HISTORY OF MALIGNANCY - SEQUENCING, ICD-10-AM, Vol. 5, page 58.

Postoperative complications - DRAFT

At the NCCH ICD-10-AM workshops, we circulated a draft standard for coding of postoperative complications. The NCCH is working on improving the indexing of complications but this is a large task and will not be effective until the second edition of ICD-10-AM, in July 2000.

The draft standard is reproduced here for those of you who did not receive a copy:

CODING OF POSTOPERATIVE COMPLICATIONS - ICD-10-AM 23/4/98

IMPORTANT NOTICE

This guideline has been provided to address some inconsistencies in the index and tabular list for postprocedural/postoperative/postsurgical complications. The NCCH will be doing a full review of complication coding in ICD-10-AM but this will take some time. Therefore, this guideline should be used from July 1998 until further notice. Any comments about coding complications, particularly inconsistencies with the indexing of complications, should be forwarded to the NCCH on the NCCH ICD-10-AM coding query form.

This guideline specifically relates to conditions documented as having a causal relationship with a procedure or operation.

This causal relationship may be implicit in the diagnostic description, such as *postirradiation hypopituitarism* or documented in terms such as:

‘Postoperative...’ e.g. Postoperative wound infection

‘...due to’ e.g. Lymphoedema due to mastectomy

‘...caused by’ e.g. Infection caused by joint prosthesis

‘Postprocedural...’ e.g. Postprocedural anoxia

‘...following’ e.g. Atrial fibrillation following CABG

‘... from’ e.g. Cerebrospinal fluid leak from spinal tap ▶

Rule 1: ONE code required

If the condition is indexed to a **specific code in the postprocedural disorders** sections (*see* list in ACS 1904, Volume 5, page 204), assign only **the indexed code if the type of procedure is identified in the code title**.

Example 1: Postmastectomy lymphoedema

I97.2 *Postmastectomy lymphoedema syndrome*

Reason: Only one code is necessary because these codes fully describe the complicating condition (lymphoedema) and the external cause (postmastectomy) (*see* ACS 2001 for postprocedural disorder codes which do not require an external cause code).

Rule 2: TWO codes required

If the condition is indexed to a **specific code in the postprocedural disorders** sections (*see* list in ACS 1904, Volume 5, page 204), assign the indexed code and an external cause code **if the type of procedure is not implicit in the code title**.

Example 2: Postpancreatectomy hypoinsulinaemia

E89.1 *Postprocedural hypoinsulinaemia*

Y83.6 *Removal of other organ (partial) (total)*

Reason: Two codes are necessary because the diagnosis code does not fully describe the external cause (postpancreatectomy). ▶

Rule 3: THREE codes required

3.1 If the condition is indexed to a **‘.8’ code in the postprocedural disorders** sections assign the .8 code first, followed by the specific code from the appropriate main chapter and an external cause code as additional codes.

Example 3: Coronary artery bypass graft with postoperative atrial flutter

I97.8 *Other postprocedural disorders of circulatory system, not elsewhere classified*

I48 *Atrial fibrillation and flutter*

Y83.2 *Surgical operation with anastomosis, bypass or graft*

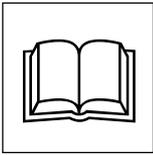
Reason: Codes ending in ‘.8’ in the postprocedural disorders sections do not fully describe the complicating condition or the external cause. Therefore, an additional code is required to fully describe the condition and also the external cause.

3.2 If the condition is indexed to a code in the block T80–T88 *Complications of surgical and medical care, not elsewhere classified*, assign three codes as described in paragraph 3.1.

❖ **Kerry Innes**
Associate Director (Sydney)



Dr John Holmes (Chair, ICD-10 Implementation Committee) entertained attendees at the ICD-10-AM Book Launch at Taronga Zoo (16 April 1998)



PUBLICATION ISSUES

In April 1998, NCCH staff and colleagues enjoyed the superb Sydney harbour views from Taronga Zoo for the ICD-10-AM Book Launch. We raised our glasses to all those who had assisted and supported the development and production of ICD-10-AM!

ICD-10-AM Book Launch

A lovely evening was had by one and all at the ICD-10-AM Book Launch at Taronga Zoo, Sydney on 16th April 1998. Dr John Holmes (Chair, ICD-10 Implementation Committee and Director, Professional Services Review) launched the publication (volume by volume!) and kept us all entertained with tales about casemix, clinicians, deadlines and launching boats. Dr Holmes talked about the underlying theories behind nomenclature and the concept that 'knowing the names of things gives power to those who know it'. Speeches were then given by Ms Jo Murray (A/g Assistant Secretary of the then Classification and Payments Branch, DHFS), A/Prof. Rosemary Roberts (NCCH Director), Professor Hal Kendig (Dean, Faculty of Health Sciences, University of Sydney) and myself. Thanks to all who attended and made this a night to remember for NCCH staff!

New Staff

Welcome to Nicole Schmidt, the NCCH new Database Administrator, who is replacing Damian Hanrahan in our Sydney office. Nicole comes to us from Wang Australia Pty Ltd will be primarily responsible for our publications orders. Welcome also to Monica Komaravalli, a graduate of the School of HIM, University of Sydney, who has been appointed as NCCH Project Officer to coordinate the production of the Casemix and Coding clinical specialty booklets. The NCCH gratefully acknowledges the continuing

A/Professor Rosemary Roberts (NCCH Director) (centre), NCCH Managers (from the left) Karen Luxford, Dianne Williamson, Karen Peasley, and Associate Directors, Kerry Innes and Sue Walker celebrate at the ICD-10-AM Book Launch



support of the ACCC for this position (*see* Order Form, this issue for the new booklets due to be released in late August '98).

New Advertising Policy

The NCCH is pleased to announce that we have changed our *Coding Matters* advertising policy as of 1 July 1998 and will now be accepting advertisements for commercial products. As previously, all submitted advertisements will be subject to editorial scrutiny and the NCCH retains veto rights. Advertisement inclusion is also subject to space availability. As with advertising in any publication, readers must recognise that the appearance of an advertisement in *Coding Matters* does not mean that a product is endorsed by the NCCH.

New advertising rates are:

- Quarter page \$400
- Half page \$600
- Full page \$800

Deadlines for advertising in future issues:

21 Sept 1998 (for Oct '98); 14 Dec 1998 (for Jan '99).

❖ **Karen Luxford**
Publications Manager

**HEALTH INFORMATION
MANAGER
GRADE 2 , FULL TIME**

An exciting and diverse professional role will stimulate an enthusiastic Health Information Manager wishing to work in a modern, well equipped 46 acute bed facility. The position encompasses maintenance of the Health Information Service, coding for 3500 separations, Freedom of Information Officer, and Clinical Indicator Coordinator. A strong commitment to EQulP is essential.

Kyabram Hospital is a major District Hospital serving a population of over 16,000. Kyabram is a township of 6,000 with excellent shopping, educational and recreational facilities. It is centrally located in the Goulburn Valley within easy access of the Murray River.

Remuneration and conditions of employment will be in accordance with the appropriate award.

To obtain a position description or make enquiries, contact Sue Balfour, HIM on ph: (03) 5857 0200.

Written applications including current CV and three referees should be forwarded to:

Mr Alwin Gallina
Chief Executive Officer
Kyabram & District Memorial
Community Hospital
PO Box 564
KYABRAM VIC 3619

by **Friday, 31 July 1998**

*KYABRAM HOSPITAL IS AN EQUAL
OPPORTUNITY EMPLOYER AND
HAS A NO SMOKING POLICY.*

**ICD-9-CM
Coding Queries**

- ICD-9-CM coding queries should be directed to your respective state/territory coding committees.

The NCCH (**Brisbane**) rather than the NCCH (Sydney) is now answering ICD-9-CM coding queries.

- No further changes to the ICD-9-CM classification will be made.
- Responses to queries will be returned to the enquirer and the appropriate state coding committee.
- All queries should be sent with supporting documentation.
- Your state/territory coding committee will consult with the NCCH (Brisbane) if they need our advice.

**Coding Committees should address
ICD-9-CM queries to:**

Sue Walker

Associate Director

NCCH (Brisbane)

Queensland University of Technology

School of Public Health

Victoria Park Road

Kelvin Grove QLD 4059



**Specialty Booklet Questionnaire
winner is.....**

**Annette Formosa
Health Information Manager
Lismore Base Hospital NSW**

Congratulations Annette, who will receive the next four booklets in the *Casemix, DRGs and Clinical Coding* series as soon as they are available! The results from the questionnaire were very positive and will be reported on in the October 1998 issue of *Coding Matters* and also at the 1998 Casemix Conference 