

Coding rules! NCCH conference 2005



Coding rules! – the 2005 NCCH conference was conducted in Perth, Western Australia, 16 – 18 March. The two-day conference (17 –18 March) was preceded by an optional ICD-10-AM Fourth Edition post implementation coding workshop.

Participants' feedback about the conference is overwhelmingly positive. Despite Mother Nature's best effort (a cyclone off WA's northern coast that provided some challenges – winds and power failures) the 200-plus delegates have indicated that the event met their needs and expectations particularly in terms of educational benefits. >>>

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Conference highlights

Among many excellent and relevant presentations, a large percentage of delegates commented about the informative and sometimes highly moving nature of presentations made by Dr Fiona Wood and Anne Roberts – ‘Burns: the Bali experience’; and Dr Didier Palmer – ‘Bali – the first 72 hours’. Professor Aleksandar Janca’s keynote opening address – ‘Classification is a way of seeing life’ successfully set the tone for the conference.



L-r Sue Walker, Dr Fiona Wood, Anne Roberts

Fiona and Anne revisited the challenges faced by the burns team at Royal Perth Hospital to treat and assist people injured in the 2002 Bali bombing. Fiona’s willingness to share the clinical aspects and challenges of treating people, coupled with the immense emotional impact of injuries for the patients, their families and the treatment teams, imparted a lasting message for participants. Fiona also described the development of CellSpray® – “a cultured epithelial autograft suspension that is sprayed onto injured skin in order to provide a rapid epidermal cover, promote healing and optimise scar quality” (<http://www.cellspray.info/>) which she co-pioneered. Anne’s contribution about the challenges and logistics of coordinating the coding of injured people’s records struck a meaningful chord with many. Dr Fiona Wood is the Director of Royal Perth Hospital’s Burns Unit and 2005 Australian of the Year. Anne Roberts is Clinical Coding Coordinator at RPH.

Dr Didier Palmer’s retelling of the impact of the Bali bombing on the emergency department at Royal Darwin Hospital was significant in the lessons learned, disaster planning tested as well as the human impact. Didier’s honesty and straightforwardness about the successes of clinical teamwork in the face of disaster, coupled with images from the event, provided an insight into an area of clinical practice not often experienced by clinical coders. Dr Didier Palmer is Director of Emergency Medicine at Royal Darwin Hospital.

For many conference participants, the social program also provided highlights.

Initial concern that the logistics and costs of travelling to Perth may have deterred some peoples’ attendance has been dispelled. The roll-up was one of the biggest – 246 people registered to attend the event over 2 days (some were day-only registrants).

Workshop

Previous conference experience indicated that hands-on coding workshops are one of the most popular features of NCCH conferences – and the 2005 event backs this up. Previous participants’ feedback was analysed and helped to determine both the scope and optimum workshop size. The initial maximum figure of participants was revised up to 90 places in response to strong registration demand.

The conference workshop will be repeated in a series of workshops in all Australian states and territories between August and November 2005. Expressions of interest are now being accepted (see pages 23–24 this edition for more information).

Breakfast discussion meeting

Initial conference program planning included a session to discuss additional diagnosis coding issues. The number of abstracts received in response to the call for papers meant that in order to include as many of these presentations as relevant and practical, the additional diagnosis session was transformed into a breakfast discussion meeting held before the workshop.

The breakfast meeting was judged a success by participants, although feedback indicates that some expected finite outcomes to be presented about this issue.

Participants’ feedback

We received completed evaluations from 97 participants (39.4% response rate). In a nutshell, here’s what participants had to say about the conference:

- 51% thought the conference was excellent and 42% thought it was good
- 44% said that the program was excellent, and 43% responded that it was good
- 61% said there were excellent opportunities to network
- 59% indicated that the program presented good new ideas
- 65% said the venue was excellent and 72% thought the location (Perth) was also excellent

Participants told us that their expectations in attending were about:

- networking
- innovation exposure
- knowledge, learning, education, professional development activities
- clinical updates
- inspiration, motivation, fun

76% of people said that their expectations were met fully.

What participants said about the conference

These are a few comments from evaluations provided by participants:

- Good variety of speakers
- Great. Some issues with speaker style and content. Variety of topics does work. How about something on personal responsibility (next time)?
- My role **is** important
- Not enough emphasis on how coding can be used to provide data to improve quality and safe practice
- Totally amazing experience
- This was a fabulous conference – extremely relevant and gave a well needed injection of energy and vitality to keep working hard to improve practice. Thank you!
- I found value in every presentation...

**What did I get out of the conference?
A sense of where I fit as a small cog
(WA rural coder) in a big wheel!**

A large part of participants' feedback about the most valuable aspect of the conference focussed on clinical updates – both clinical updates (burns and orthopaedic surgery) – were very favourably received. Other aspects people liked are:

- the program's information scope and content
- networking opportunities
- international and interstate perspectives
- rural and isolated coding issues discussion
- the workshop
- question time at the conclusion of sessions

Less valuable aspects commented about relate to:

- limited access to software demonstrations during breaks
- being unable to secure a place in the workshop
- relevance of state-specific information

Participants sent us some strong messages about their preferences including:

- presentation of more clinical updates by clinicians
- that the conference format should not be changed
- there should be more space allocated for the exhibition
- provision of more places at conference workshops



l-r Dr Olafur Steinum, Jenny Hargreaves, Kerry Innes

Social program

The feedback has been overwhelmingly positive about the conference's social program. Providing the option of a bus transfer between the conference and dinner venue (King's Park) was enthusiastically received (one response suggested that the bus trip should be retained for all conferences!) as was the catering, venues and entertainment. The photographs published here tell only part of the story – clinical coders love the opportunity to dance! More photographs are published at <http://www3.fhs.usyd.edu.au/nccch//8.3.htm>

Our thanks to...

The NCCH is deeply grateful to the presenters (and their employers and families), participants, venue staff and suppliers for helping to ensure a positive conference outcome. We would also like to acknowledge and thank the dedicated team of volunteers from WA who assisted with advice, local knowledge and lots of muscle.

Next NCCH conference

A decision has yet to be made about the next conference's location and timing. All Australian states and territories have now been locations for NCCH conferences.

10-AM Commandments

Trauma during pregnancy

The NCCH has recently received a number of queries asking for advice about coding trauma during pregnancy. This article summarises advice provided by the NCCH in response to the queries received.

There are two excludes notes which are important in the coding of trauma during pregnancy:

1. The excludes note at the beginning of Chapter XV *Pregnancy, childbirth and the puerperium*:

Excludes: injury, poisoning and certain other consequences of external causes (S00–T98).

This excludes note indicates that when coding trauma occurring during pregnancy, childbirth and the puerperium (excluding obstetric trauma), a code from S00–T98 should be assigned to reflect the condition. A code from Chapter XV may still be assigned to provide further details if required, for example if the patient delivers or has other obstetric complications.

2. The excludes note at O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*

Excludes: injury, poisoning and certain other consequences of external cause (S00–T98)

This excludes note indicates that the injury itself should be classified to another chapter and that a code from O99 should not be assigned. This note is reinforced by the listing of the codes from other chapters which are relevant to each code in O99. For example, in the code O99.8:

O99.8 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium

Conditions in C00–D48, H00–H95, M00–M99, N00–N99, Q00–Q99 and R00–R99

Note: There is no mention of the code range S00–T98 in this inclusion term.

Additionally, in the official WHO updates for ICD-10 (2005), to be included in ICD-10-AM Fifth Edition, there are revised and improved code ranges for the indexing of 'Pregnancy, complicated by, conditions in' in the Alphabetic Index with associated changes in the Tabular List. Codes from Chapter XIX *Injury, poisoning and certain other consequences of external causes* are not included in these index entries.

Historically, ICD-10 was developed for single condition coding, that is, only one code was assigned for each condition and therefore it was important to capture as

much information as possible by one code assignment. The codes in category O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* reflect this concept as they capture the fact that the patient is pregnant and that they have another condition (classifiable elsewhere) that is reflected in the code title. For example, in the code O99.5 *Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium*, if only one code is assigned, both the fact that the patient has a respiratory condition and that it is complicating the pregnancy is captured. In Australia however, for morbidity coding, we follow the logic of multiple coding, as outlined in ACS 0027 *Multiple coding* and ACS 1521 *Conditions complicating pregnancy* and assign an additional code for the specific condition, **where that condition is within the code range listed in the inclusion terms under each code.**

Classification

When a pregnant woman is injured and there are problems with the pregnancy as a result of the trauma, assign:

- a code/s from the injury chapter (with appropriate external cause, place of occurrence and activity codes) to describe the trauma to the mother and
- a code/s from the obstetric chapter to describe the obstetric condition

Example 1:

Patient, 29 weeks pregnant, involved in high speed car accident with splenic rupture. Patient was assessed by an obstetrician and an ultrasound and CTG monitoring was performed. Investigations showed mild hydrocephaly and subdural haematomas of the fetus.

Code:

S36.04 *Massive parenchymal disruption of spleen*

Appropriate external cause, place of occurrence code (Y92.-) and activity code (U50–U73)

O35.8 *Maternal care for other (suspected) fetal abnormality and damage*

In the above example, O35.8 *Maternal care for other (suspected) fetal abnormality and damage* describes the care of the mother related to fetal injuries from the accident. The pathway in the Alphabetic Index of Diseases is:

Maternal care (for) (known) (suspected)

- fetal
- - abnormality O35.9
- - - specified NEC O35.8

or

Pregnancy (single) (uterine)

- management affected by
- - abnormal, abnormality
- - - fetus (suspected) O35.9
- - - - specified NEC O35.8

When a pregnant woman is injured and there are no problems with the pregnancy as a result of the trauma, but obstetric care is received (for example, CTG monitoring or ultrasound) assign:

- A code from the injury chapter (with appropriate external cause, place of occurrence and activity codes) and
- Z34.- Supervision of normal pregnancy or Z35.- Supervision of high risk pregnancy

Example 2:

Patient, 31 weeks pregnant, presents with abdominal pain/strain following seatbelt injury. The patient is assessed by the obstetrics team and a CTG is performed. No further problems or abnormalities found, patient discharged home.

Code:

S39.8 *Other specified injuries of abdomen, lower back and pelvis*

Appropriate external cause, place of occurrence code (Y92.-) and activity code (U50–U73)

Z34.- *Supervision of normal pregnancy*

Example 3:

Patient, 27 weeks pregnant, presents to A&E with abdominal bruising due to being kicked in the abdomen by husband during an argument. The patient is assessed by the obstetrics team and a CTG is performed. No further medical problems although the patient was assessed by a social worker. The obstetric team noted on discharge that the patient is considered high risk due to social situation.

Code:

S30.1 *Contusion of abdominal wall*

Appropriate external cause, place of occurrence code (Y92.-) and activity code (U50–U73)

Z35.7 *Supervision of high risk pregnancy due to social problems*

When a pregnant woman is injured and there are no problems with the pregnancy as a result of the trauma and no obstetric care is received, assign:

- a code from the injury chapter (with appropriate external cause, place of occurrence and activity codes) and
- Z33 *Pregnant state, incidental*

Example 4:

Pregnant woman admitted with fractured shaft of metacarpal (jammed hand in door).

Code:

S62.32 *Fracture of shaft of other metacarpal bone/s*

W23.- *Caught, crushed, jammed or pinched in or between door*

Appropriate place of occurrence code (Y92.-) and activity code (U50–U73)

Z33 *Pregnant state, incidental*

(ACS 1521 *Conditions complicating pregnancy*, Example 4)

When a pregnant woman is **not injured** but obstetric care is received, assign:

- Z04.3 *Examination and observation following other accident* and
- Z34.- *Supervision of normal pregnancy*

Example 5:

Patient admitted to the antenatal ward for observation after fall from ladder whilst painting nursery. No obvious injury. Observation for 24 hours, CTG performed.

Code:

Z04.3 *Examination and observation following other accident*

Z34.- *Supervision of normal pregnancy*

Appropriate external cause, place of occurrence code (Y92.-) and activity code (U50–U73)

Use of external cause codes with obstetric codes

The majority of codes in Chapter XV *Pregnancy, childbirth and the puerperium* relating to complications do not require an additional external cause code as the concept is bundled within the disease code.

However, there is no convention in ICD-10-AM prohibiting the use of an external cause code with some codes in Chapter XV *Pregnancy, childbirth and the puerperium*.

Therefore, the use of an external cause code with obstetric code/s is acceptable if it provides further specificity.

Example:

During caesarean section, the initial incision extended into upper cervix resulting in cervical laceration.

Code:

O71.3 *Obstetric laceration of cervix*

Y60.0 (*Unintentional cut*) *During surgical operation*

Y92.22 *Health Service Area*

Venous lakes

Venous lakes are a type of vascular ectasia or vascular dilation which includes spider angiomas and telangiectases. They occur when superficial blood vessels dilate resulting in a single bluish or red/blue, soft, painless nodule which is compressible under the skin. The exact cause of venous lakes is unknown, but they are believed to be related to chronic sun exposure and damage. Venous lakes are more prevalent in people aged over 50 years.

Venous lakes differ from varicose veins in a number of ways. Notably, venous lakes have a different appearance to varicose veins and present mostly on the face, lips, ears and neck. Varicose veins commonly present on the lower limbs and may involve multiple vessels.

Classification

Documentation of 'venous lake' should be classified as:

178.1 *Naevus, non-neoplastic*

O60 Preterm delivery

The NCCCH has received a number of queries relating to the use of O60 *Preterm delivery*. This has been covered in Australian Coding Standards 1530 *Premature delivery* and 1550 *Discharge/transfer in labour*. In late 2004, WHO ICD-10 Update Reference Committee approved a proposal regarding preterm delivery. The code title of O60 will change to *Preterm labour* with fourth character subdivisions to indicate the delivery outcome. The changes will be incorporated in ICD-10-AM Fifth Edition.

Classification

O60 *Preterm delivery* should be assigned according to the guidelines in ACS 1530 and 1550. In cases of preterm labour without delivery, the index pathways in the Alphabetic Index of Diseases are:

Contraction/s, contracture, contracted

- preterm without delivery O60

Labour – see also Delivery

- early onset (before 37 completed weeks of gestation) O60

Labour – see also Delivery

- premature or preterm O60

Albumex transfusion

The NCCCH received a query regarding the assignment of procedure codes for transfusion of Albumex. Albumex is a natural plasma component prepared from pooled human plasma and is used as a plasma volume expander in the treatment of shock due to blood loss. Other indications are therapeutic plasmapheresis, cardiothoracic surgery, burns, paracentesis of ascites in cirrhosis patients and haemodialysis.

The classification of drugs in ICD-10-AM is according to their class and not their therapeutic indication. Plasma volume (blood) expander is classified as a type of blood product in ICD-10-AM. Therefore, transfusion of Albumex should be classified according to the guidelines in Australian Coding Standard 0302 *Blood transfusions*.

Classification

For documentation of transfusion of Albumex, assign 92062-00 [1893] *Transfusion of other serum*.

Administration of surfactant to newborn

A query was received asking whether administration of surfactant to premature babies should be coded. Surfactant (Survanta) may be given as a prophylactic treatment to babies at a high risk of developing respiratory distress syndrome (RDS) or as therapeutic treatment to babies that have been clinically confirmed as having RDS.

Classification

Surfactant administration is inherent in the standard treatment of babies at high risk of developing RDS as well as those clinically confirmed as having RDS and therefore does not require coding in ICD-10-AM.

Reference

Australian Red Cross Blood Service.com (2005) Resource Library: Transfusion Medicine Manual. Accessed 17 February 2005 http://www.transfuse.com.au/ResourceLibrary/TMM_ch15_Plasma.asp

Clinical update

Radiofrequency ablation for the treatment of liver tumours

This article was researched, written and published by

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) as part of its Consumer summary series, October 2002.

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

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

Introduction

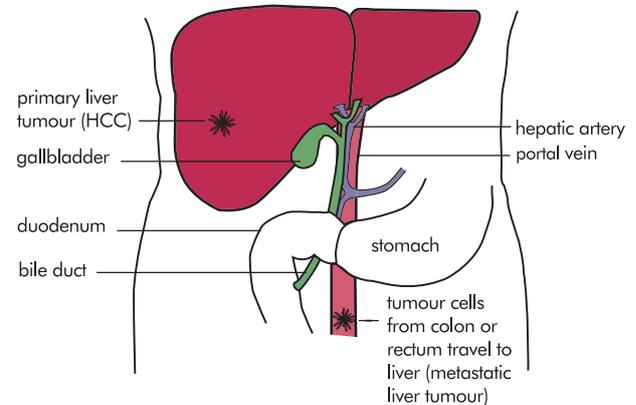
The following information deals with a new surgical technique called radiofrequency ablation, which has been developed to treat liver tumours. ASERNIP-S has reviewed the available published evidence to compare the safety and effectiveness of this procedure with the other surgical and non-surgical techniques currently in use.

What are liver tumours?

The liver lies behind the ribs on the right side of the abdomen. The liver produces bile, helps to metabolise food, and filters harmful substances, or toxins, from the blood.

A tumour is an abnormal growth of cells in the body. Liver tumours consist of either liver cells (called primary liver tumours) or other tumour cells that originated elsewhere in the body and travelled to the liver (metastatic liver tumours). A tumour is malignant if it invades other tissue or organs.

Liver tumours



Hepatocellular carcinoma (HCC) is the most common form of primary liver cancer. HCC is usually associated with cirrhosis of the liver, caused by hepatitis B or C, or alcohol. In most cases HCC is only picked up at an advanced stage. If left untreated, patients may live as short a period as six months from the time of diagnosis, but many live much longer. Metastatic liver tumours are often associated with cancer originating in the colon or rectum (primary colorectal carcinoma) and also reduce patients' life expectancy to an average of six months.

Conventional treatments for liver tumours

1. Surgical

Resection

It is generally accepted that the surgical removal or resection of a liver tumour is the only treatment that currently offers any possibility of cure. During resection, the tumour and the surrounding one centimetre of tissue should be removed for the surgery to have any chance of success. The five-year survival rate of patients after this operation is 20–40%. Unfortunately, only one fifth of patients are suitable to undergo this procedure. In other patients there may be too many tumours, or tumours in places that are difficult to reach. Patients may also have other diseases in or outside of the liver which preclude surgical removal of the tumour.

As so few patients with liver tumours are eligible for surgical resection, a number of alternative treatments have been developed.

Hepatic artery infusion chemotherapy

With this procedure, chemotherapeutic drugs used to treat liver tumours are delivered directly to the liver through a tube (catheter) that is surgically inserted in the hepatic artery (as opposed to traditional chemotherapy). The hepatic artery is the main pathway through which liver tumours receive their blood supply. This procedure enables a high concentration of the drug to reach the liver tumour, and limits the amount of the drug reaching outside tissues.

Cryotherapy

With cryotherapy, a probe delivers liquid nitrogen to the site of the tumour. The cells of the tumour freeze and then are allowed to thaw. Repeated cycles of freeze and thaw destroy the tumour cells.

Microwave coagulation therapy

This procedure requires the placement of an electrode into the tumour. A high-frequency electromagnetic wave generates heat and destroys tumour cells.

Laser therapy

In this procedure, a needle with flexible thin optic fibres is inserted through the skin and into the liver tumour. A laser beam delivered through the fibres generates heat and destroys tumour cells.

2. Non-surgical

Ethanol injection

A needle inserted through the skin injects ethanol into the liver tumour. The cells in and around the tumour are destroyed.

Radiofrequency ablation

A new procedure called radiofrequency ablation (RFA) has been developed to treat liver tumours. An electrode is placed in the tumour in one of three ways: through the skin using a local anaesthetic; by inserting a laparoscope through the abdomen; or through a wider cut made during an open operation under general anaesthetic. The electrode delivers a high-frequency current that produces heat and destroys the tumour and surrounding cells. The three types of electrode used for RFA are produced by RITA Medical Systems, Radiotherapeutics and Radionics.

How does RFA compare with the other treatments for liver cancers?

ASERNIP-S looked at all the articles published on studies comparing the safety and effectiveness of these treatments.

RFA versus surgical resection

Safety

- No comparative information was available

Effectiveness

- It is hard to compare surgical resection and RFA as these procedures are usually performed on different groups of patients. However, the one available study suggested that tumours removed by RFA were more likely to recur (39% of patients), than those removed by surgical resection (24% of patients). It also indicated that recurrences of tumours also tended to appear more quickly after RFA. These data suggest that surgical resection, when possible, may be more successful than RFA at controlling tumour growth

RFA versus hepatic artery infusion chemotherapy (HAIC)

Safety

- Very limited data suggested that fewer complications occurred after RFA compared to HAIC. In the one study available, which had only 20 patients, 4 out of 10 patients treated with HAIC died, while no deaths were reported for the RFA group during the short study period. No complications were reported for RFA, but 2 patients treated with HAIC developed major complications, with one of these patients dying 4 months after the procedure

Effectiveness

- It was not clear whether RFA was more successful than HAIC at controlling tumour growth

RFA versus cryoablation

- No studies were available that compared these two procedures

RFA versus microwave coagulation therapy (MCT)

Safety

- In one study, there was no statistically significant difference in the rate of major complications between RFA and MCT. Minor complications appeared to be more common in MCT patients (1 out of 36 patients in RFA treatment group; 4 out of 36 patients in MCT treatment group)

Effectiveness

- In one study, treatment was completely effective in 96% of RFA treated nodules and 89% of MCT treated nodules
- In another study, more tumour cells were destroyed in RFA treated nodules than in MCT treated nodules

RFA versus laser

Safety

- In one study (32 RFA patients, 14 laser patients), complications (such as fistula between the arteries and the portal vein, death of liver tissue through disturbed blood supply, wasting away of liver, and collection of fluid in and around the liver) occurred more often in the group of patients treated with laser than RFA. Damage to the portal vein occurred in 2 RFA treated patients. Other complications occurred at low levels for both groups

Effectiveness

- In one study, treatment times were longer for laser therapy than RFA
- In one study, tumour tissue remained in 76% of laser treated nodules and 35% of RFA treated nodules
- No studies compared the amount of tumour tissue completely destroyed in the two groups

RFA versus ethanol injection

Safety

- Very limited data showed that post-operative fever and pain appeared to be worse, and the use of drugs to relieve the pain was more common for RFA patients than for patients who had the procedure involving ethanol injection, and that
- RFA patients stayed in hospital for a shorter length of time

Effectiveness

- Very limited data showed that fewer RFA sessions appeared to be needed to completely destroy the tumour compared to the ethanol injection procedure, and that
- at follow-up, fewer recurrent tumours were found after RFA compared with ethanol injection

What is the recommended procedure for treating HCC or liver metastases?

The evidence was limited by the small number of studies available and the short follow-up times. Furthermore, the units of measurement used were not identical in all studies, making comparisons between studies difficult.

This limited evidence suggested that RFA for the treatment of liver tumours was at least as safe as the comparator procedures (surgical resection, hepatic artery infusion chemotherapy, ethanol injection, microwave coagulation therapy and laser). However, the efficacy of RFA for the treatment of liver tumours could not be determined.

Further data are required to complement the scant evidence available. In particular, long-term follow-up of patients is needed in order to establish the long-term implications of RFA. For this reason, the Royal Australasian College of Surgeons has recommended that surgeons practising RFA for primary hepatocellular carcinoma or metastatic colorectal liver carcinoma should participate in an audit of their outcomes of RFA, preferably at a national level.

Classification

Where radiofrequency ablation of liver lesion (tumour) is documented in the clinical record, assign 90299-00 [956] *Other destruction of liver*. 'Radiofrequency ablation of liver tumour' is an inclusion term at this code.

Index lookup:

Ablation

- lesion

- - liver, by radiofrequency 90299-00 [956]

MBS (Medicare Benefits Schedule) introduced an item number for this procedure in November 2003. A new procedure code will be added to ACHI Fifth Edition as part of the MBS updates.

Growing new nipples in a petri dish

Australian scientists have created nipple-coloured skin to reconstruct nipples following mastectomies and other breast surgeries.

The new "pigmented skin construct" is made up of

patients' keratinocytes – cells that produce the skin protein, keratin, with melanocytes – cells that produce skin pigment, to create fade-resistant cultured skin. The new technique artificially alters the natural ratio of keratinocytes and melanocytes.

Present nipple reconstruction options include cosmetic tattooing in the reconstructed breast or transplanting pigmented skin from another skin area, both of which can fade over time.

The technique is still in development and has not yet been trialled on patients.

Source: ABC Science Online. Judy Skatsoon, 5 April 2005. http://www.abc.net.au/science/news/health/HealthRepublish_1328801.htm. Accessed 18 April 2005

NCCH prize for clinical coding 2004

The NCCH prize for clinical coding is awarded annually to outstanding graduate students who have completed health information management and clinical coding courses.

Recipients of the 2004 NCCH prize for clinical coding are:

Amanda Gorman	<i>Queensland University of Technology</i>
Amanda Oliver	<i>Curtin University</i>
Catherine Richardson	<i>The University of Sydney</i>
Emily Dunnings	<i>La Trobe University</i>
Gwen (Narelle) Stanford	<i>Health Information Management Association of Australia Ltd</i>
Jigna Shah	<i>Open Training and Education Network – Distance Education</i>



QUT prize giving: l-r Dr Mary-Lou Fleming, Acting Head of the School of Public Health; award recipient Amanda Gorman; Sue Walker, Associate Director, NCCH Brisbane



Emily Dunnings – La Trobe University's award recipient

HIMAA clinical coder certification

The HIMAA advanced clinical coder certification process is not based totally on an exam. There are two components:

1. The completion of six advanced coding assignments (worth 30% of assessment)
2. A two hour examination paper consisting of copies of de-identified medical records (worth 70% of assessment)

The candidate must complete the assignments and examination in the same edition of ICD-10-AM and will receive certification with a mark of 80% or more when combining both components 1 and 2.

To assist in preparation for the advanced coding assignments, HIMAA has developed an optional preparation package consisting of 29 de-identified medical records with coding answers. This package is already available.

Candidates will also have the opportunity of maximising their assignment grade average by choosing to complete another assignment for any one assignment with a mark below 80% in their assessment. These second assignments will be known as 'B' assignments and will be available from September 2005. When B assignments are completed, Part 1 of the assessment

will be re-calculated using the higher assignment mark for each assignment (whether in A or B)

Coder certification will be perpetual. However, to maintain currency, an online quiz updated to reflect edition changes and other vital advice as published in *Coding Matters* '10-AM Commandments' will be developed and placed on the HIMAA website. A Certificate of Currency will be issued for a quiz result of 80% and above. A certified clinical coder who has been out of the workforce for a period of time, or who is not currently coding a varied casemix will also find this a useful tool. Failure to pass the quiz indicates that some continuing education through HIMAA may be required before undertaking the quiz again. Condensed preparation packages to help a previously certified clinical coder will be developed to cater for these cases.

For more information on coder certification, visit the HIMAA website: www.himaa.org.au or contact Denise Johnston, Registrar, Education Services, phone 02 9887 5898.

Vera Dimitropoulos
Lecturer
HIMAA Advanced ICD-10-AM Coding Course
April 2005

International

Visit by delegation from the Kingdom of Saudi Arabia

The NCCH was pleased to welcome a delegation from the Kingdom of Saudi Arabia in March 2005. The delegation visited Australia with the aim of investigating implementation of ICD-10-AM in the Kingdom, as well as developing links with education providers, health insurance organisations and other health sector services providers.



l-r Julie Rust, Dr Rashid Sulaiman Alhmaid, Kerry Innes, Mr Ziad Hisham Arnaout, Mr Saleh Nasser Alomair & Megan Cumerlato

The delegation members:

- Mr Saleh Nasser Alomair, President, National Center for Health Insurance Standards (NCHIS)
- Mr Ziad Hisham Arnaout, Executive Manager, NCHIS
- Dr Rashid Sulaiman Alhmaid, Secretary General, Cooperative Health Insurance Council

met with representatives from:

- The University of Sydney
- Royal North Shore Hospital
- St John of God Health Care (Subiaco)
- Australian Government Department of Health and Ageing
- Health Insurance Commission
- AusHealth International
- 3M Australia Pty Ltd
- Health Information Management Association of Australia Ltd

during the visit. Delegates also attended the NCCH conference in Perth.

The Kingdom is presently reviewing options to implement a national, standardised health classification system and to develop a Saudi national coder workforce.

Chinese WHO Fellowship recipients visit NCCH Brisbane

A four-member delegation from Guizhou Province in China, who are recipients of WHO Fellowships on Health Information Management, Primary and Community Health Care, visited NCCH Brisbane and QUT in April 2005.

A program reflecting the delegates' areas of interest was developed and provided. NCCH Brisbane staff gave presentations relating to HIM and coding in Australia and internationally.

Even though China has its own WHO Collaborating Centre for the Family of International Classifications, it is such a large country with such a huge population that the Chinese Centre struggles to meet the needs of every province.

The delegates were very interested in the NCCH presentation about coding and had an animated discussion about its applicability in their local hospitals.



Front row: l-r Dr Hou Xiang-Yu, Dr Zu Zhengming, Dr Li Xiaosong, Dr Wang Yalin. Back row: l-r Dr Cynthia Cliff, Sue Walker, Grant Warren (School of Public Health Health Services Management academic), Dr Zheng Hong, Jenny Nicol, Dr Mary-Lou Fleming

International

Statistical issues in small nations, New Caledonia, 2005

Sue Walker attended the *Statistical Issues in Small Nations* meeting hosted by the Secretariat of the Pacific Community (SPC) in association with the International Association for Official Statistics, in Noumea, New Caledonia, in March – April 2005. This meeting was a satellite of the 55th International Statistics Institute Session held the following week in Sydney.

Approximately 60 people attended including national statistics officers from 22 Pacific island country members of the SPC, as well as the founding member nations – Australia, France, NZ and USA. The head of the UN Statistical Division, Paul Cheung, and representatives from the World Bank, UNESCO, the International Monetary Fund, AusAID, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare attended. Most delegates were people who see the statistical output from health departments and who are sometimes responsible for the coding staff that process and code mortality data.

It was enlightening to hear that there are similar issues to those we see in morbidity and mortality data collections with many of the other major international and national statistical data collections, such as finance, labour force, occupational data, fisheries. To some extent, all suffer from a lack of quality and timeliness, not enough effort in providing environments conducive for the production of quality data, difficulties of getting developing countries involved in creating international classifications and difficulties in ensuring that internationally mandated classifications also meet local needs.

Of particular interest was the discussion regarding the collection of data relating to the Millennium Development Goals (MDGs), in particular, the role of the MDGs in providing a framework for developing statistical skills in small countries and islands. Endorsed by the United Nations in 2000, the MDGs “commit the international community to an expanded vision of development, one that vigorously promotes human development as the key to sustaining social and economic progress in all countries, and recognises the importance of creating a global partnership for development. The goals have been commonly accepted as a framework for measuring development progress.”
(www.developmentgoals.org/About_the_goals.htm).

The eight MDGs build on agreements made at several United Nations conferences in the 1990s and represent commitments by the international community to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

The eight goals aim to:

- 1 Eradicate extreme poverty and hunger
- 2 Achieve universal primary education
- 3 Promote gender equality and empower women
- 4 Reduce child mortality
- 5 Improve maternal health
- 6 Combat HIV/AIDS, malaria, and other diseases
- 7 Ensure environmental sustainability
- 8 Develop a global partnership for development

Each goal has various targets to be met, and indicators that are used to measure progress towards the targets. Three of the eight goals (and eight of the 16 related targets and 18 of the 48 indicators) are directly about health issues. Health is also an important contributor to several of the other goals. The significance of the MDGs lies in the linkages between them: they are a mutually reinforcing framework to improve overall human development (<http://www.who.int/mdg/en/>).

Sue’s presentation *Issues in the application of the WHO International Classifications in small nations* was well received. The focus of the presentation was on the results of an international need assessment survey conducted in mid-2004 by the WHO-FIC Education committee. The survey elicited information about which countries currently use ICD-10 for morbidity and/or mortality coding, reasons why countries have not begun using this classification if they have not yet adopted it, a profile of people who do the coding and their educational and support needs. Many of the issues regarding the costs of implementing major classifications, problems with retaining skilled coding staff, inadequate source documentation and the difficulties in getting expert advice and training were recognised by participants as issues in their own countries. Sue also discussed the potential for future NCCH coding support for Pacific island nations.

International

WHO ICD-10 Update Reference Committee

The NCCH works closely with the Australian Institute of Health and Welfare (AIHW) to fulfill its function as a WHO Collaborating Center for the Family of International Classifications (WHO-FIC). As part of this role, the NCCH has been actively involved in the Update Reference Committee (URC), which recommends modifications to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) to WHO and develops policy on and mechanisms for updating ICD-10. Since its inception in 1999, Rosemary Roberts has been the Chair of the URC, and Michelle Bramley and Julie Rust have both provided Secretariat services.

At the annual WHO-FIC network meeting in Reykjavik in October 2004, it was decided that the positions of Chair and Secretariat of the URC should be rotated on a 5–6 year basis. The North American Center agreed to assume this responsibility, with Mea Renahan and Lori Moskal of the Canadian Institute for Health Information (CIHI) taking on the roles of Chair and Secretariat respectively.

The work involved in running the URC is considerable and in order to provide a smooth transition, the NCCH prepared detailed documentation of all procedures, prior to Julie Rust traveling to the headquarters of CIHI in Toronto, Canada, to affect the handover. The three day meeting was attended by Caroline Heick, Director, Data Quality and Classifications; Mea Renahan and

Lori Moskal all from CIHI; together with Dr Bedirhan Üstün, Coordinator, WHO-FIC, and Can Celik, Programmer/analyst from WHO in Geneva. Policies and procedures of the URC were discussed with some promising initiatives from WHO regarding web based electronic tools to assist with streamlining the updating process. A project of the URC for 2005 is for a number of Collaborating Centers to revise specific clinical topics as a pilot study for an overall revision of ICD-10. A teleconference, including other members of the URC, was held during the visit to discuss the progress to date and future directions of this project.



Back row l–r: Dr Bedirhan Üstün, Can Celik. Front row l–r: Julie Rust, Lori Moskal, Mea Renahan

Immediately following the handover meeting in Canada, Marjorie Greenberg, Head of the North American Collaborating Center for WHO-FIC hosted a two day meeting on evaluation of the ICD-10 implementation and updating process, as part of the revision process for ICD-10. Julie Rust represented the Australian Center at this meeting which was held at the National Centre for Health Statistics, CDC, Maryland USA. The facilitator for this meeting, Tom Chapel, Health Scientist at the Centers for Disease Control and Prevention (CDC), challenged all participants, by using a global logic model, to describe the current ICD-10 implementation and updating process and then to formulate the types of questions to be asked in an evaluation, methods employed and the uses to be made of the information gathered. It was an interesting exercise and the results will be used to inform further work on the evaluation process.

Overall, this visit to North America was extremely rewarding for the NCCH and we have full confidence in our Canadian colleagues to continue the important work of the Update Reference Committee and to face the challenges ahead in the revision of ICD-10.

HIMAA consultants' register

HIMAA's consultants' register is a web-based service developed to help find candidates to assist HIMAA Ltd to undertake consulting assignments. The register is open to both individuals and organisations. Fees apply.

For more information about the HIMAA consultants' register visit <http://www.himaa.org.au/consultants/index.htm>

International

Terminology and the Danish Health System Conference, Odense, Denmark

Denmark has a similar health system to Australia, with primary and acute sectors, a public health care system and a casemix funding model. It differs from Australia in some important respects: there are no state jurisdictions, it has implemented electronic health records (EHRs) for the last four years, and it is integrating a national reference terminology (SNOMED CT) with existing classification systems and the structure of the EHR.

NCCH Brisbane Health Informatician, Dr Peter Scott, attended and presented at a conference devoted to terminology and the Danish health care system in the city of Odense in late March 2005.

Points of interest for Australian HIMs and clinical coders are:

- The existing Danish classification, known as SKS, is considered inadequate for computer assisted clinical care
- The Danes recognise that they need a reference terminology to make their EHRs interoperable
- Denmark has assessed their vocabulary needs and determined a set of over 200,000 clinical, procedural and demographic/administration terms that need to be translated and attached to unique SNOMED CT concept codes
- The people doing this are based in a new organisation known as Sundterm ('healthterm'), within the Danish Health Department. Many on the team have classification backgrounds.



Hans Christian Andersen's memorial photographed on the day before his 200th birthday, in front of St Knud's Church in his birthplace, Odense, Denmark

Philippines coding and classification team visit NCCH Brisbane

The NCCH has recently welcomed Florinda (Froy) Tuvillo, Medical Records Adviser at the National Center for Health Facility Development at the Philippines Department of Health and Dr Guillerma (Emma) Manigbas, Acting Dean, Institute of Continuing Education in the Health Professions, De La Salle University Health Sciences Campus, Philippines. Froy was sponsored as a WHO Fellow in HIM and ICD-10 coding and Emma was supported by her university. Emma and Froy were in Brisbane for four weeks in March, followed by two weeks in Sydney hosted by the School of HIM at the University of Sydney.

During their time in Brisbane, Froy and Emma participated in various undergraduate HIM units with regular on-campus students to enable them to experience the teaching style and materials used by Australian academic staff. They spent considerable time at the NCCH, discussing their coding training needs and updating training materials and HIM policy and procedure manuals with assistance from NCCH staff. A series of site visits enabled Froy and Emma to see hospital and district health information services, a hospital casemix unit and various parts of Queensland



l-r Dr Cynthia Cliff (Projects Manager, QUT Faculty of Health), Jenny Nicol (lecturer, QUT School of Public Health HIM), Froy Tuvillo, Sue Walker, Professor Ken Bowman (Dean, QUT Faculty of Health), Dr Emma Manigbas, Dr Mary-Lou Fleming (Head, QUT School of Public Health)

Health corporate office. They were also able to participate in the Queensland Health HIM reference group meeting and a coding meeting at one of the local hospitals.

It is hoped that further collaborative work can be arranged between the Department of Health in Manila and the university sector in that country.

International

ICD-10-AM training in Ireland

Ireland officially adopted *The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, Fourth Edition (ICD-10-AM Fourth Edition)* for use in collecting morbidity data on 1 January 2005. Megan Cumerlato and Linda Best conducted four ICD-10-AM Fourth Edition 2-day workshops over 2 weeks in Ireland at the end of January. About 200 Irish coders attended workshops in Dublin, Cork and Galway. Some of the major topic areas covered included diabetes, anaesthetics, obstetrics, external causes and procedure coding. Ireland previously used ICD-9-CM.

The Irish coder education program included a number of face-to-face workshops that started in August 2004 and finished with the workshops conducted by the Australian trainers.



l-r Marie Glynn, Megan Cumerlato, Brian McCarthy, Linda Best, Jacqui Curley & Deirdre Murphy: Irish coding education program presenters

The response to the change from ICD-9-CM to ICD-10-AM has been very enthusiastic, with many coders reporting that they appreciated the additional specificity provided by ICD-10-AM Fourth Edition.

Ireland also made a decision to provide the eBook, electronic version of the classification, to all coders. As a result, special eBook training sessions were held in conjunction with the coding workshops. The feedback about eBook has been extremely positive from the coders. They reported especially liking the links provided between ICD-10-AM codes and the 10-AM Commandments.

Megan and Linda were made to feel very welcome during their time in Ireland and would especially like to acknowledge and thank the staff of ESRI and Ireland's coders for their warm welcome and enthusiasm to embrace new technology and classifications.



Megan Cumerlato and Linda Best at Blarney Castle

PICQ 2004

incorporating
PICQ indicators for
ICD-10-AM
Fourth Edition

Performance Indicators for Coding Quality (PICQ) is an electronic application that provides a series of indicators to analyse admitted patient morbidity data coded with ICD-10-AM it is based on Australian Coding Standards (ACS) and coding conventions

PICQ 2004 contains a number of enhancements:

- 111 new indicators
- Upgraded internal data specifications for some indicators in PICQ for ICD-10-AM Third Edition
- Indicators to check code edits, completeness, redundancy, specificity and sequencing
- New and improved PICQ user guide

For further information and to order:
NCCH Sydney

Phone: + 61 2 9351 9461

Email: ncchsales@fhs.usyd.edu.au

10 good reasons to use PICQ

- Identify actual coding errors and possible coding problems
- Identify specific records for correction, if necessary
- Suggest possible problem causes
- Suggest possible corrections
- Measure data accuracy against particular indicators
- Measure data quality over time
- Provide continuous review and amendment of coded data
- Provide feedback to individual coders and assist coder education
- Benchmark results with similar hospital or health organisation
- Complement existing coding audit activities

Coding quality analysis

Over the coming months the NCCH will be reviewing 2002–2003 data from the Australian Institute of Health and Welfare to check for compliance with Australian Coding Standards (ACS) and coding advice published in *Coding Matters*. In this issue, classification in three ACSs will be reviewed:

- ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes*
- ACS 1915 *Spinal (cord) injury*
- ACS 1917 *Open wounds*

ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes*

ACS 1912 instructs coders to first code the residual condition or nature of the sequelae followed by the cause of the late effect, that is, the sequelae code. The analysis reviewed the allocation of a sequelae code as principal diagnosis from the range T90–T98 *Sequelae of injuries, of poisoning and of other consequences of external causes*. Application of the ACS was very well adhered to with 99.9% of all sequelae records coded in the correct sequence (refer Table 1).

Sequelae Total	Sequelae code not as PDx		Sequelae code as PDx	
	Number	Rate	Number	Rate
19,111	19,092	99.90%	19	0.10%

Table 1 Sequencing for sequelae codes (ACS 1912)

ACS 1915 *Spinal (cord) injury*

ACS 1915 states that a spinal injury, in the initial phase post trauma, should include a code for type of spinal cord lesion (complete or incomplete) and a code for functional level of spinal cord lesion. Further, ACS 1915 states that coding of type of spinal cord lesion should precede coding of functional level of spinal cord lesion. Traumatic injury codes should only be used in the initial phase post trauma. Analysis centered on the presence and sequencing of codes for type of spinal cord lesion and functional level of spinal cord lesion.

The analysis was undertaken in two parts. Firstly, coded data that included a type of spinal cord lesion code from the range S14.1-, S24.1-, S34.1 *Other and unspecified injuries of cervical, thoracic, lumbar spinal cord* was interrogated to:

- check for the presence of a functional level of spinal cord lesion code

- check for adherence to the sequencing requirement when codes for both type of spinal cord lesion and functional level of spinal cord lesion were present

In total 1,090 records were reviewed and Figure 1 gives a graphical display of the results. Overall, 74% of records included codes for both type of spinal cord lesion and functional level of spinal cord lesion that were coded in the required sequence. A code for functional level of spinal cord lesion was absent in 26% of records, and coding of type of spinal cord lesion followed coding of functional level of spinal cord lesion in 3% of records. Absence of a functional level of spinal cord lesion code was highest for cervical type of spinal cord lesion, whilst incorrect sequencing was slightly higher for lumbar and thoracic types of spinal cord lesion.

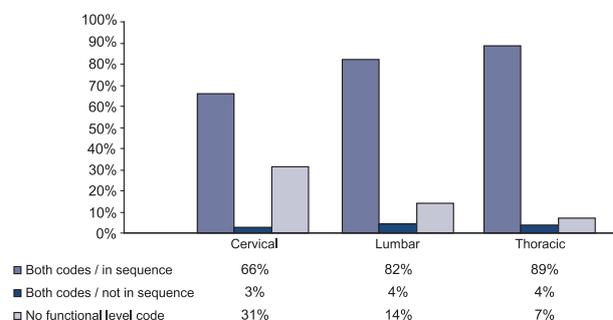


Figure 1 Incidence and sequencing of functional level of spinal lesion code

A second analysis of spinal cord injury was conducted on coded data which included a functional level of spinal cord lesion code from the range S14.7-, S24.7-, S34.7- *Functional level of cervical, thoracic, lumbar spinal cord injury* to ascertain absence of a type of spinal cord lesion code. Overall, 16% of records did not contain a type of spinal cord lesion code. Absence of a type of spinal cord lesion code was highest for functional level of lumbar spinal cord. Further details are presented in Figure 2.

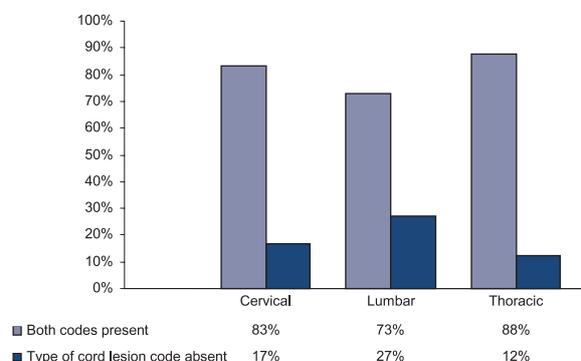


Figure 2 Incidence of type of spinal cord lesion code

Note – although multiple type and/or functional level of spinal cord lesion codes were present in many records, for the purposes of this analysis each record was only counted once.

ACS 1917 Open wounds

ACS1917 states that an open wound complicated by infection, foreign body or delayed healing or treatment should have a code assigned for open wound by site followed by a code for complication of open wound. Coded data that included a code from the range T89.0- *Complications of open wound* was analysed to:

- ascertain the presence of an open wound by site code; and
- when both codes were present, check the sequencing of codes for open wound by site and complication of open wound

In total, 87% of the 10,522 records that were reviewed contained a code for both open wound by site and complication of open wound that were in the correct sequence. Further details are shown in Figure 3.

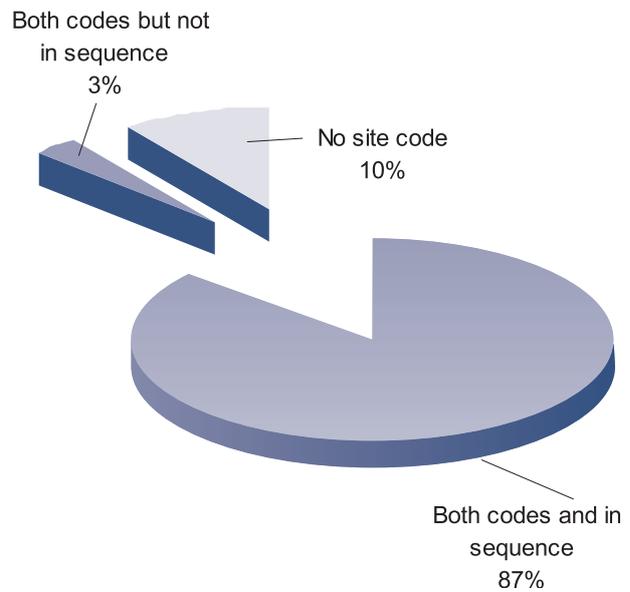


Figure 3 Analysis of complication of open wound code

Index of coding advice

Coding Matters Volume 11, numbers 1 to 4, June 2004 – March 2005

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- transport	11	2	4	- minimally invasive injectable graft (MIIG)	11	3 3
Administration, drug				L55 Sunburn	11	2 2
- multiple				Laparoscopic uterine nerve ablation (LUNA)	11	4 1
- - administrations of the same drug	11	2	3	Lewy body disease	11	1 11–12
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for neoplasm	11	2	3	Racz procedure	11	4 1
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NCCH's partnership

with Commission for Children Young People and the Child Guardian

In September 2004, NCCH and Child Death Review Team at the Queensland Commission for Children, Young People and the Child Guardian entered into an agreement whereby NCCH would provide the services of a health information manager (HIM) to the CCYPCG. This is a newly created position but was modelled on similar arrangements between NCCH Brisbane and Australian Bureau of Statistics and the Queensland Trauma Registry. The HIM is seconded three days a week to the Child Death Review team and works the other two days a week supporting NCCH Brisbane's research program. The current incumbent is Bridget Allison.

Bridget provides mortality classification, training and a data quality assurance program to the Child Death Review team. However, the position is not bound by these requirements. The HIM is also involved in the analysis of child deaths in Queensland, provides information on diseases and trauma processes and will be heavily involved in the future research program of the Child Death Review Team as this develops.

In 2003–2004 the Queensland Crime and Misconduct Commission (CMC) undertook an inquiry into the abuse of children in foster care, known as the 'Protecting Children Inquiry' (CMC, 2004).

An outcome of this inquiry was to implement a Child Death Review Team within the then Commission for Children and Young People. This recommendation by the CMC consolidated previous recommendations by the Queensland Ombudsman (Queensland Ombudsman, 2002, 2003) to review the deaths of children known to the Department of Family Services (now known as the Department of Child Safety (DCS)). The CMC report recommended that the Commission for Children and Young People expand its role to:

- maintain a register of deaths of all children in Queensland
- review the causes and patterns of death of children as advised by investigative agencies through a Child Death Review Committee
- review in detail all DCS case reviews, whether conducted internally or externally, regarding the deaths of children in care and those who had been notified to DCS, within the three years prior to their deaths
- conduct broader research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable
- prepare an annual report to the parliament and the public regarding child deaths (CMC, 2004: 166)

Changes to the *Coroners Act 2003*, the *Births, Deaths and Marriages Registration Act 2003* and the *Commission for Children and Young People Act 2000* were enacted to implement the recommendations by the CMC.

The Child Death Review Team was staffed from early 2004 and started receiving data August 2004; the HIM was employed from November 2004.

The Child Death Review Team receives notification and data of all children's deaths in Queensland from the Registrar of Births, Deaths and Marriages and the Queensland State Coroner. The Department of Child Safety also notifies the Child Death Review Team if any child that dies is known to the department within the three years prior to the child's death. The Department of Child Safety performs its own review of the child's death. An independent body known as the Child Death Case Review Committee reviews the Department of Child Safety's involvement with the child prior to the child's death. This committee comprises of the Queensland State Coroner, Chief Superintendent of Queensland Police, a social worker, a psychiatrist, a paediatrician, an Aboriginal representative and a Torres Strait Islander representative. The Child Death Review Team provides a secretariat role to this committee.

The agreement has allowed NCCH to further develop links and research opportunities with non-health related entities and to spread its expertise in data management and coding. Already there have been circumstances in which additional specificity in ICD-10 codes would be useful for Commission purposes and it is intended to feed recommendations and suggestions through to the WHO Update Reference Committee for consideration. Because of NCCH's existing links with the mortality coders at the Australian Bureau of Statistics, it has been possible to begin building a connection between the Bureau and the Commission.

Child Death Review is a relatively new concept in Australia. New South Wales and Victoria established Child Death Review Teams in the late nineties and other states are now in the process of implementing teams. This represents an interesting new field that other Health Information Managers may decide to explore in the future.

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Why Charles Darwin was stopped by a milkshake and Michelangelo was a loner



Recent research indicates that Charles Darwin was lactose intolerant and Michelangelo may have had Asperger's syndrome.

A recent report by researchers from Cardiff University published in the *Postgraduate Medical Journal* has unearthed evidence from Darwin's personal diaries and letters indicating that Darwin and his family probably lacked sufficient amounts of the enzyme lactase needed to break down the sugars in dairy products.

Darwin's reporting of his diet and health include frequent indication that within 2–3 hours of eating, he often had bouts of "...vomiting, stomach pains, severe tiredness, and depression". Despite visiting many doctors who suggested diagnoses including heart disease, arsenic poisoning, allergy to pigeons, and malaise following his mother's death, Darwin found his own solution by altering his diet.

He excluded dairy products and adopted 'hydrotherapy treatment' – an intervention that involved drinking significant amounts of water.

Further research shows that other members of the Darwin family, including his children, may have inherited lactose intolerance.

Darwin's condition frequently prevented his work on his theories of evolution and natural selection. He confessed that he kept his condition quiet so as to not jeopardise his voyage on the *Beagle*.¹

Irish and British experts in autism have published their findings in the *Journal of Medical Biography* hypothesising that Michelangelo may have had Asperger's syndrome, a form of autism. People with Asperger's syndrome often affect communication and social interface difficulties and may have a special talent, such as music, mathematics or art.

The researchers compared reported traits about Michelangelo with characteristics of Asperger's syndrome: he was aloof, a loner and according to one source "strange, without affect and isolated" and "preoccupied with his own private reality". It has also become apparent that Michelangelo's male relatives including his father, grandfather and brothers, also displayed characteristics associated with autism.

A differentiating aspect of Asperger's compared with other forms of autism is that people with this syndrome do not have delayed language development or skills.²

1. Charles Darwin had lactose intolerance. ABC Science Online, News in science www.abc.net.au/science/news/health/healthrepublic_1353681.htm Published 26 April 2005. Accessed 29 April 2005
2. Michelangelo may have been autistic. ABC Science Online, News in science www.abc.net.au/science/news/stories/s1120348.htm Published 1 June 2005. Accessed 29 April 2005



La Trobe University
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Module four: Statistical Analysis and Methodology

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Certificate of Internal Clinical Coding Auditing - International. This will be awarded to international students who complete all modules of the course and the major assignment.

Certificate of External and Internal Clinical Coding Auditing. This will be awarded to students who complete all modules, successfully complete the major assignment and pass a final examination.

NCCH puzzle

Find a word – words appear vertical, horizontal and oblique

R D Y E B H G I C F S A A X H N Y S D J
 Y W A U K N U H N P Z L A A Y O G D I I
 F S R M I O O M I F U N B N S I O I S F
 I N P N P L R R E T A P Q T T T L C E R
 S N W O E U I T S R P N P H E C O A A A
 E A G R T L T I S R O R T O R U N T S C
 Y R A R L U F A O N O U S S E D I N E T
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 B Y F I L S H I E C L I P O B M N D U L
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 B O T U L I S M K B M R D E B U A H I N
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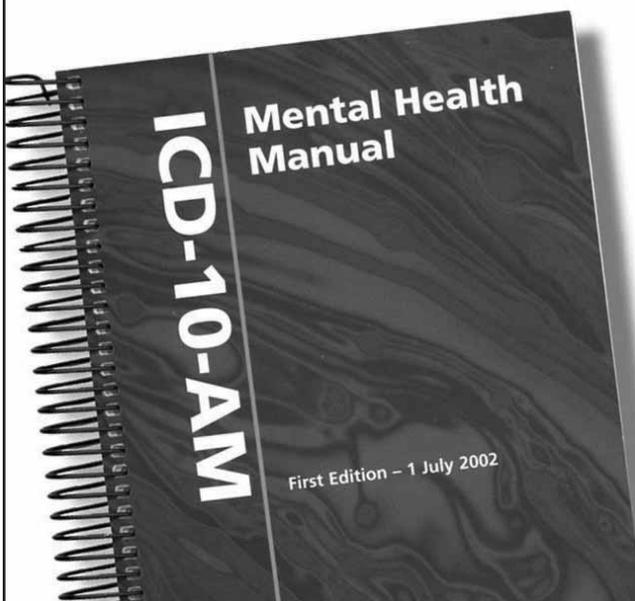
ACUPUNCTURE
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 PROCEDURE
 PROGERIA
 PUSTULE
 SCABIES
 SMEGMA
 SPIRILLOSIS
 SPLEEN
 SUNSTROKE
 TERMINOLOGY
 VERTEBRAE
 VITAMINS
 XANTHOSIS
 YAWNING

ICD-10-AM Mental Health Manual

The ICD-10-AM Mental Health Manual is a classification of mental and behavioural disorders with glossary descriptions and diagnostic guidelines based on ICD-10-AM Third Edition.

The Manual is a diagnostic and coding tool that offers a common morbidity data language between the acute and community health sectors.

Available **NOW**



Volume 12 Number 1 June 2005
National Centre for Classification in Health

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CONFERENCES 2005

JUNE

15 – 17	5th Annual Adverse Events 2005 Conference	Melbourne	www.iir.com.au
27 – 29	8th Annual E-Health and EHR Congress	Sydney	http://www.iir.com.au/conferences/conflist.html?cat_code=health&indexpage=index-health.html

JULY

11 – 13	3rd Australasian Conference on Safety and Quality in Health Care	Adelaide	http://www.sapmea.asn.au/conventions/aaqhc2005/index.html
26 – 28	2005 General Practice and Primary Health Care Research Conference The conference will showcase high-quality Australian primary health care research with a mix of international and Australian guest speakers, papers, posters, plenary sessions and workshops	Adelaide	http://www.adgp.com.au/site/index.cfm?PageMode=indiv&module=EVENT&page_id=3629
26 – 27	Australian Biotechnology Summit	Sydney	www.acevents.com.au/bio2005
27 – 29	2005 HIMAA National Conference The HIMAA national conference features: 27 July – Coding workshop conducted by the Victorian Branch of HIMAA 28-29 July – HIMAA Conference 2005. The theme is 'see change' reflecting the conference's emphasis on change and change management in health information management. The conference is a lead in to HIC 2005, which is being held in Melbourne	Geelong	http://www.himaa.org.au/2005/index.htm

31 July – 2 August	HIC 2005 - Improving Healthcare through Informatics The HIC program scope 31 July – Education sessions and welcome reception 1 August – Conference sessions and gala dinner 2 August – Conference sessions HIC is a major event on the Australian health conference calendar. Other features include a comprehensive trade exhibit (come and see NCCH – we'll be there!) and national and international keynote speakers to inform, challenge and inspire participants	Melbourne	http://websites.golden-orb.com/hic/default.php
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AUGUST

10 – 12	2005 ACHSE National Congress The Congress is an ideal opportunity to meet, network and form partnerships with key government and health industry leaders and be part of their future business decisions. This event is the major health management professional meeting offered across the Australian health sector	Adelaide	http://www.achse.org.au/frameset.html
30 Aug – 2 Sept	8th Australian Palliative Care Conference 2005	Sydney	http://www.pallcare.org.au/pca_conference.html

SEPTEMBER

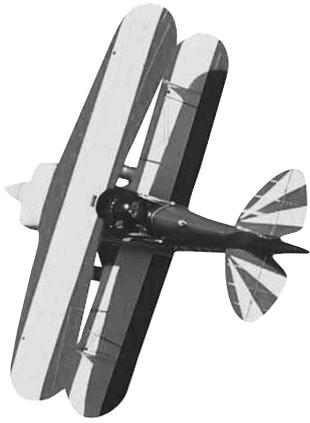
8 – 10	The 7th Annual SNOMED® International Users Group	Chicago	http://www.snomed.org/education/usersgroups.html
25 – 28	36th Public Health Association of Australia Annual Conference	Perth	http://www.phaa.net.au
22 – 24	10th International Symposium on Health Information Management Research (iSHIMR 2005) iSHIMR 2005 aims to bring together people who are carrying out, or are interested in, research in the general area of health information management and health informatics technology, and to provide a forum for the presentation and discussion of their research activities.	Greece	http://www.seerc.info/ishimr2005

29 Sept – 2 Oct	RACGP 48th Annual Scientific Convention	Darwin	http://www.racgp.org.au/document.asp?id=15589%20
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OCTOBER

5 – 8	Patient Classification Systems /International (PCS/I) New financial models for in- and out-patient treatment, cost calculations and weights, and risk adjustment are high on the agenda of many health care systems across the world. The conference is the biggest international casemix and DRG meeting point for exchanging experiences and contacts for future cooperation	Slovenia	http://www.pcse.org
10 – 11	25th Annual APHA National Congress	Melbourne	http://www.apha.org.au/media_files/2378040505
22 – 26	AMIA 2005 Annual Symposium	Washington DC	http://www.amia.org/meetings/annual/current
NOV – DEC 4 – 7 December	10th World Congress Internet in Medicine	Prague	http://www.medinfo.cz/MedNet2005/index.php

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



ICD-10-AM Fourth Edition post implementation coding workshops

In response to demand created by the ICD-10-AM Fourth Edition coding workshop presented at the NCCH conference in March 2005 opportunities to attend additional workshops are now being offered in all states and territories.

Workshops will feature case studies, discussions, coding tips and pointers. Workbooks will be distributed to participants before attending the event, and following registration & payment.

Register now!

Places filling fast

The proposed workshop dates and locations* are:

TASMANIA

25 August Launceston

VICTORIA

6 September Melbourne

7 September Melbourne

8 September Bendigo

WESTERN AUSTRALIA

3 August Perth

4 August Perth

SOUTH AUSTRALIA

23 August Adelaide

24 August Adelaide

NORTHERN TERRITORY

9 August Darwin

QUEENSLAND

11 August Townsville

20 September Rockhampton

21 September Brisbane

22 September Brisbane

AUSTRALIAN CAPITAL TERRITORY

13 October Canberra

NEW SOUTH WALES

5 October Sydney – Bankstown

6 October Sydney – North Ryde

11 October Dubbo

19 October Newcastle

26 October Tamworth

27 October Coffs Harbour

2 November Albury

* subject to change

The workshop will focus on topics from ICD-10-AM Fourth Edition classification queries received by the NCCH including:

- anaesthetics
- cardiology
- diabetes
- injuries
- obstetrics
- AICDS / pacemakers
- pain management

Participants will need their own copies of ICD-10-AM Fourth Edition in hard copy or the eBook on laptop at the workshops.

Already sent your expression of interest? Stand-by – you'll be contacted about your choice soon.

Registration fees include workshop materials and catering. Workshop registration fee is \$176.00 (including GST)

Please complete the ICD-10-AM Fourth Edition coding workshop registration form overleaf and send to:

**National Centre for
Classification in Health**
PO Box 170
LIDCOMBE NSW 1825
or fax 02 9351 9603

The form can also be completed and sent on line from <http://www.fhs.usyd.edu.au/ncch>