

Back to basics

Fundamental guidelines to good clinical coding



The aim in coding is to translate clinical statements into code and accurately reflect the episode of care. By doing this, a picture is painted of why the patient was admitted and what care and treatment was provided during the episode of care.

Coding is not just selecting the correct code number. Abstracting the relevant and correct information from the clinical record is an important part of the coding process. Without the correct information the correct code will not be selected.

The primary source of clinical data for inpatient coding is the clinical record. Another source of information is the clinician. Coders should be prepared to consult clinicians if the information in the record is ambiguous, unclear, missing or confusing.

The clinician is responsible for documentation in the clinical record. If there are problems with interpreting the information in the clinical record, coders should seek the advice of the clinician who was generally responsible for the patient's care. The clinician should also be contacted if there is a discrepancy between the clinical documentation and investigation results.

Coding requires a good understanding of the classification as well as a sound knowledge of:

- medical terminology,
- disease processes,
- investigations and treatments
- content of the clinical record (knowing which forms to review to abstract information)

Coding is a three-step process and includes:

1. Abstraction – analysis of the record to determine which clinical statements to abstract.
2. Assigning codes for the clinical statements (refer to ACS section).
3. Correctly sequencing the codes.

The most challenging aspect of the coding process is the analysis and abstraction of the relevant information from the clinical record. This requires a good understanding of both disease processes and procedures so that symptoms and signs inherent in the disease or components of a procedure are not coded.

The following guidelines should help when coding from clinical records.



1. Read the front sheet for any diagnoses or procedures documented by the clinician.
2. Read the discharge summary for details and a summary of the patient's admission including any final diagnosis and procedures performed.
3. Compare diagnoses written on the front sheet with those on the discharge summary.
4. Read the history and physical examination of the patient to identify the reason for admission and any relevant coexisting conditions.
5. Identify any procedures or interventions that need to be coded.
6. Verify and code any diagnoses and procedures that you have found.
7. Review the entire record to make sure that you have found supporting documentation before coding the selected diagnoses and procedures.

ICD-10-AM

Structure of ICD-10-AM Tabular List

Fourth and fifth character subcategories

Fourth and fifth character subcategories are provided for extra specificity. The classification does not always list four and five character codes completely. Lists of fifth characters may be found at the beginning of a chapter, block or category. Always code to the most specific level.

The following annotations and symbols are found throughout the classification:

Text Boxes – identify if a code is valid or not

A **black reverse text box** indicates a three character code that is not valid. This means that it needs at least a fourth character to make it a valid code.

A **grey reverse text box** indicates a four character code that is not valid. This means that it needs a fifth character to make it a valid code.

A **box outline** is used to indicate that a three character code is valid.

Conventions used in the ICD-10-AM Tabular List

Symbols

† **Aetiology** (dagger)

This symbol describes the aetiology or the underlying cause of a disease. It is often called a “dagger” code and is usually paired with an “asterisk code”.

* **Manifestation** (asterisk)

This symbol describes the manifestation of the disease. It is often called an “asterisk” code. It must always be paired

with an aetiology code and is sequenced after the aetiology code.

▼ Australian Coding Standard

This indicates that there is an Australian Coding Standard (ACS) that applies to that section of the classification. The symbol may appear next to a single code, a category or a block and the relevant ACS number(s) will be either below or next to the symbol.

⊗ Australian code

This symbol is found next to codes that have been created for use in Australia. These codes constitute the Australian modification of ICD-10.

Instructional notations

Inclusion terms – are found at blocks, categories and codes and provide additional examples of diagnoses or terms that may be classified here. These lists of inclusion terms are not exhaustive. They provide a guide to the code content.

Exclusion notes – are found at chapter, block, category or code levels. They are a list of terms preceded by the word “Excludes” that may not be coded here.

Code also..... and **Use additional code.....** – are found throughout the classification where an additional code may be required to fully describe a condition.

Punctuation

Certain types of punctuation have specific meaning in coding:

- [] Square brackets are used to show synonyms, abbreviations or alternative words for a description or title.
- () Parentheses are used to provide additional information and to give examples of a code. They may also be used to enclose nonessential modifiers. These are terms that do not impact on the code selection. Their presence or absence makes no difference to the code selected.
- :
- A term in an inclusion or exclusion list followed by a colon means that the term is incomplete.
- }
- Braces link a series of terms, each of which is modified by the term to the right of the brace.

Words and abbreviations

Certain words and abbreviations have particular meaning when used in coding:

NEC – not elsewhere classified

Codes with NEC in their title are usually a last resort code. Coders need to make sure that there is not a more specific code available elsewhere in the classification before assigning a NEC code.

NOS – not otherwise specified

Codes with NOS in their title are used when there is not enough information to assign a more specific code. It is the same as saying 'unspecified'.

'And' in a code title

In the Tabular List of Diseases when the word 'and' is used it means and/or.

Structure of ICD-10-AM Alphabetic Index of Diseases

Each index (Alphabetic index of diseases, External Causes of injury and Table of Drugs and Chemicals) is organised by main (lead) terms. Subterms (also known as essential modifiers) are listed below the lead term at a one indent (hyphen) level. Subterms may also have their own subterms listed below at a two or more indent level. Lead terms and subterms may have further terms in parentheses after them. These are known as nonessential modifiers.

- Always check the number of indents when following an index list to make sure you are under the correct term.
- An essential modifier must be present in the clinical expression for code selection. A nonessential modifier may or may not be present in the clinical expression for code selection.

Lead terms, subterms and modifiers are always in alphabetic order, however the preposition 'with' takes precedence over other subterms. Other exceptions to sequencing are symbols, spaces, hyphens and numbers which come before alphabetic letters.

The lead terms in the Alphabetic Index of Diseases are related to disease or pathology rather than anatomical site. The terms in the External Causes of Injury index are descriptions of the circumstances that have caused the injury or trauma. The terms in the Table of Drugs and Chemicals are generic names of the drug or substance.

Some diseases are named after the person(s) that discovered them. These are called eponyms. Eponyms are used in the index, often as lead terms and are in alphabetical order.

Conventions used in the ICD-10-AM Alphabetic Index of Diseases

The spelling of medical terms in the classification is Australian not American (e.g. oesophagus not esophagus).

There are two types of cross-referencing directions you will find in the alphabetic index:

- **see** – means you must go to the term indicated. You will not find the condition you are looking for in this part of the index.
- **see also** – means that if you cannot find the condition you are looking for in this part of the index, then it may be under this other term.

When using the index you may come across incomplete codes where a dash has been used instead of a number. This occurs when more than one character (either at the fourth or fifth character level) can apply. Check in the Tabular List for the complete list of applicable fourth or fifth characters and select the correct one to make the code complete.

ACHI

Structure of the ACHI Tabular List of Interventions

Most of the chapters in ACHI are organised by body system rather than surgical specialty and wherever possible follow the chapter headings in the disease classification.

There are three axes (levels) used to organise the codes in ACHI:

Anatomical site is the main or principal axis within each chapter. It is structured by a 'head to toe' approach.

Procedural type is the secondary axis under each anatomical site. It is structured with the least invasive procedures first through to the most invasive procedure.

Blocks make up the tertiary axis and are located under the procedural type. This axis provides greater specificity to the type of procedure and may include more detail about specific sites of the procedure, technology being used, or the technique of the procedure.

Blocks are in numerical order and provide the way to locate a specific code within the Tabular List, as the codes within the Tabular List are not in numerical order.

Conventions used in the ACHI Tabular List

Many of the conventions used in the ACHI Tabular List of Interventions are the same as those used in the ICD-10-AM Tabular List of Diseases. Includes, excludes and instructional notes are the same, as are symbols and punctuation.

Includes in the ACHI Tabular List indicate the procedural components or equipment used that is inherent in a code or block description and they may also define a site.

'And/or' in a code title

In ACHI 'and' means 'and' and 'or' means 'or'. This is different to ICD-10-AM where 'and' means 'and/or'.

Structure of the ACHI Alphabetic Index

The structure of the ACHI Alphabetic Index is similar to that of the ICD-10-AM Alphabetic Index.

Lead terms, subterms and modifiers are always in alphabetic order, however the prepositions 'as', 'by', 'for', 'with' and 'without' take precedence over other subterms.

Numbers are sequenced numerically before alphabetic characters.

Conventions used in ACHI Alphabetic Index

Block numbers are printed in bold, inside square brackets, after the code. This allows the code in the Tabular List to be located.

Instructional notations

Omit code – this instruction indicates that certain procedures are not coded separately when they are part of a particular procedure. This instruction applies mostly to procedures that form the operative approach or are part of a more extensive procedure.

Cross references

- ‘– see’ means you must go to the term indicated, you will not find the procedure you are looking for in this part of the index.
- ‘– see also’ means that if you cannot find the procedure you are looking for in this part of the index, then it may be under this other term.
- ‘see block [xxxx]’ means you must go to the Tabular List to look for further information or specific site references.

Australian Coding Standards (ACS)

The Australian Coding Standards are standardised national guidelines for how to apply and interpret ICD-10-AM and ACHI. Coders should always have the ACS within easy access whenever coding.

There are 2 sections of general standards – one for diseases and one for interventions. The rest of the standards are known as specialty standards and are categorised by site and or system according to the specialty to which the diagnosis or procedure relates.

The standards provide coders with a variety of information that includes:

Coding rules – information on what you should code and how it should be set out.

Definitional information – definition of medical terms or phrases.

Classification information – how to code a disease or a procedure.


Medical science information – descriptions of disease and intervention.

There are three appendices and all relate to the quality of coding:

Appendix A - Basic Coding Guidelines

Appendix B - Code of Ethics for Clinical Coders

Appendix C - Clinical Coders' creed



The image displays the covers of the ICD-10-AM, ACHI, and ACS Sixth Edition books, along with a CD-ROM. The books are arranged in a row, with the ICD-10-AM book on the left, followed by the ACHI book, and the ACS book on the right. The CD-ROM is placed on top of the ACS book. The covers are blue with white text and a red spine. The CD-ROM is blue with white text.

ICD-10-AM/ACHI/ACS Sixth Edition

ICD-10-AM/ACHI/ACS Sixth Edition is now available in printed volumes and as eCompress® desktop software. For further information and to order:
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Important ACS to follow:

ACS 0001 Principal diagnosis

An essential part of accurate coding is selecting the correct principal diagnosis. The starting point for principal diagnosis selection is the front sheet or discharge summary.

The principal diagnosis (Pdx) is defined as:

'The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.'

(Health Data Standards Committee (2006), *National Health Data Dictionary*, Version 13, AIHW).

'After study' means after the patient has been evaluated, tested, maybe undergone surgery and the clinician has established what is wrong with the patient. The patient may have been admitted with certain symptoms but these are not necessarily the Pdx. The Pdx is the cause of the symptoms and this will only be known after the patient has been tested and investigated.

Underlying conditions may cause problems when deciding what to put as the Pdx. The ACS explains that if the patient comes in with a problem and a previously unknown condition is found to be the cause of the admitting problem, then code the newly found condition as the Pdx. If the patient comes in with a problem that is known to be caused by a previously diagnosed condition, then assign the problem as the Pdx and the known condition as an additional diagnosis

Signs and symptoms should not be coded when a related definitive diagnosis is known. The exception to this is when symptoms become important medical conditions in their own right and are treated. Then they are coded.

If **two or more** interrelated conditions equally meet the Pdx definition and it is not possible to get further clinical advice, assign the first mentioned diagnosis or condition.

ACS 0002 Additional diagnoses

An additional diagnosis is defined as:

'A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.'

(Health Data Standards Committee (2006), *National Health Data Dictionary*, Version 13, AIHW).

The important point to remember is any condition that affects patient management during an episode of care needs to be coded as additional diagnoses. Ask yourself the following questions:

Did the condition require any commencement, alteration or adjustment to therapeutic treatment?

Did the condition require any diagnostic procedures?

Did the condition require any **increased** clinical care and/or monitoring?

If the answer to any of these questions is YES then that condition meets the criteria for additional diagnosis and should be coded. Another point to remember is that risk factors should not be routinely coded and are only coded if they meet the criteria above or another standard indicates they should be coded.

The purpose of the Admitted Patient Care National Minimum Data Set is to collect information about care provided to admitted patients in Australian hospitals.

The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the condition that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

When there is uncertainty about whether a condition meets the additional diagnosis criteria, the Clinical Coders' Creed and Code of Ethics for Clinical Coders should be used to make a decision. (These can be found as appendices in the Australian Coding Standards.)

Source:

'Fundamentals of Morbidity Coding using ICD-10-AM,ACHI and ACS Fifth Edition' NCCH 2008

ICD-10-AM/ACHI/ACS Sixth Edition

The **IO-AM** Commandments

ACS 1521 Conditions Complicating Pregnancy

- a. ACS 1521 and adequate documentation to determine that a condition has complicated a pregnancy

In the following scenario a pregnant female is admitted with a diagnosis of cholestasis but there is no documentation to suggest that cholestasis has complicated the pregnancy except for a note on discharge which states 'for antenatal clinic review next week with repeat LFTs and increased CTG monitoring,' is this adequate documentation to determine the condition has complicated the pregnancy?

A condition in pregnancy such as in the scenario cited above which requires increased CTG monitoring is sufficient documentation to indicate the condition has complicated the pregnancy.

Therefore the appropriate code from category O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* or O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* should be assigned for conditions such as those in the scenario above, together with an additional code from the other chapters of ICD-10-AM to identify the specific condition, as per ACS 1521.

- b. ACS 1521 and the postpartum period
Does the logic in ACS 1521 *Conditions complicating pregnancy* apply to the postpartum period?

ACS 1521 states:

'Chapter 15 *Pregnancy, childbirth and the puerperium* contains two blocks of codes for complications related to pregnancy, O20–O29 *Other maternal disorders predominantly related to pregnancy* and O94–O99 *Other obstetric conditions, not elsewhere classified*. Conditions that are known to occur commonly in pregnancy have specific codes in O20–O29. To code other conditions complicating pregnancy (or being aggravated by the pregnancy or that are the main reason for obstetric care), a code from O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* or O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* is assigned, together with an additional code from the other chapters of ICD-10-AM to identify the specific condition.'

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. 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. This area of the classification is currently under revision as part of an overall review of obstetric coding being undertaken both nationally and internationally.

O80 *Single spontaneous delivery* as per ACS 1505 *Single spontaneous delivery* –

'is intended for single spontaneous vaginal deliveries:

without abnormality/complication classifiable elsewhere in Chapter 15 *Pregnancy, childbirth and the puerperium* **and**

without manipulation or instrumentation.'

The issue of how you determine whether a nonobstetric condition complicates or is aggravated by the pregnancy in the delivery episode of care (including the postpartum period) is problematic as past clinical advice indicates that even clinicians are unable to clearly define this. It is unlikely, therefore, that documentation will indicate whether a nonobstetric condition is complicating or aggravating the pregnancy in the delivery/postpartum episode of care. The rule of thumb for many coders appears to have been to assign a code from O98 or O99 as appropriate for nonobstetric conditions in this period and then to assign a code for the condition based on ACS 0027 *Multiple coding*.

We advise that this practice should continue as per the following scenarios where there is a nonobstetric condition in the postpartum period of the **delivery episode of care**.

- I. Multigravida, normal vaginal delivery (NVD), nil complications but on day three develops dysuria. Seen by RMO who advises Ural and to see GP after discharge from hospital.

Principal Diagnosis

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

Additional diagnoses

R30.0 *Dysuria*

Z37.- *Outcome of delivery*

2. Primigravida, NVD, small tear not requiring suturing, who develops acute appendicitis on day two post delivery (documentation states has had abdominal pain for five days, but attributed to irritable uterus by GP). Went on to have laparoscopic appendicectomy, discharged on day six.

Principal diagnosis

O99.6 *Diseases of the digestive system complicating pregnancy, childbirth and the puerperium*

Conditions in K00–K93

Additional diagnoses

K35.9 *Acute appendicitis, unspecified*

Z37.- *Outcome of delivery*

and appropriate procedure codes.

3. Primigravida, NVD, has haemorrhoids noted on day two and was given medication and advised to follow up with GP on discharge.

Principal diagnosis

O87.2 *Haemorrhoids in the puerperium*

Additional diagnosis

Z37.- *Outcome of delivery*

4. Primigravida, NVD, no complications, but develops pulmonary embolus on day three (family history of pulmonary embolus).

Principal Diagnosis

O88.2 *Obstetric blood clot embolism*

Additional Diagnosis

Z37.- *Outcome of delivery*

NB: We have assumed these diagnoses have all met either ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. See also 10-AM Commandments, Vol 12, No 1, *Trauma during pregnancy*.

Anaesthetic Coding

Where intubation for an anaesthetic is indicated by terms such as LM3, PM3, LMA4 or laryngeal, but ventilation was spontaneous (i.e. not controlled) should it be coded as a general anaesthetic or sedation?

Where documentation is unclear as to the type of anaesthetic being administered follow the guidelines in ACS 0031 *Anaesthesia*. For classification purposes in ACHI and the ACS 'general anaesthesia' is indicated by the use of an artificial airway, such as an endotracheal tube, laryngeal mask or Guedel airway (see ACS 0031 *Anaesthesia, point 2, Sedation*).

ACS 0031 *Anaesthesia* will be reviewed for a future edition of the ACS.

The **Good Clinical Documentation Guide** helps clinicians to recognise critical elements they need to document to reflect the patient care process, to communicate, report and provide clear data for research and quality of care monitoring.

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Your guide to the best medical records

Anticoagulation therapy pre and post surgery

What is the correct code assignment for patients admitted prior and post surgery for anticoagulation therapy when the surgery is performed at another hospital?

The correct code assignment for a patient admitted for anticoagulant stabilisation prior to surgery to be performed at another hospital is:

Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*

Z92.1 *Personal history of long term (current) use of anticoagulants*

The correct code assignment for a patient admitted for anticoagulant stabilisation post surgery performed at another hospital is:

Z48.8 *Other specified surgical follow-up care*

Z92.1 *Personal history of long term (current) use of anticoagulants*

See also ACS 2103 *Admission for convalescence/aftercare*.

NB: If there is a contractual arrangement existing between the two hospitals in the scenario cited then the guidelines within ACS 0029 *Coding of contracted procedures* should also be followed.

Chronic Suppurative Lung Disease (CSLD)

What is the correct code to assign for CSLD?

Clinical advice indicates that 'CSLD is often called bronchiectasis.' Research further specified 'The term CSLD is used to describe a diagnosis where there are clinical symptoms of bronchiectasis without High Resolution Computed Tomography (HRCT) evidence of bronchiectasis. The dominant symptom of CSLD is the presence of excessively prolonged moist cough. Other than the lack of HRCT features, the symptoms of CSLD is otherwise identical to that of bronchiectasis.' Chang et al (2008).

Therefore, the correct code to assign for this condition is J47 *Bronchiectasis*.

Epstein-Barr Virus (EBV) hepatitis

How do you code Epstein-Barr Virus (EBV) hepatitis?

The Epstein-Barr virus, also called *Human herpesvirus 4* (HHV-4), is a virus of the herpes family (which includes *Herpes simplex virus*) and is one of the most common viruses in humans. Most people become infected with EBV, which is often asymptomatic but commonly causes the clinical syndrome known as infectious mononucleosis or glandular fever.

Epstein-Barr virus infections can also be associated with hepatocellular hepatitis. The frequency of this association varies with age. It is estimated to be in 10% of young adults and 30% in the elderly where it presents itself as an anicteric viral hepatitis.

The correct codes to assign for EBV hepatitis are:

B17.8 *Other specified acute viral hepatitis*

B27.0 *Gammaherpesviral mononucleosis*

by following the index pathways:

Hepatitis

- viral, virus
- - specified type (with or without coma) NEC B17.8

and

Epstein-Barr virus (gammaherpesviral mononucleosis) B27.0

It is incorrect to classify EBV infections to category B00 *Herpesviral [herpes simplex] infections*. Although Epstein-Barr virus is a herpesviral infection, it is not a Herpes simplex infection and the excludes note for gammaherpesviral mononucleosis in B00 directs coders to B27.0 *Gammaherpesviral mononucleosis*, where mononucleosis due to Epstein-Barr virus is classified.

Failed/difficult intubation

When should a code for difficult intubation be assigned?

Difficult intubation is poorly defined in literature. It is sometimes described as repeated attempts at intubation, the use of bougie or other intubation aid.

The American Society of Anesthesiologists in their article entitled *Practice Guidelines for Management of the Difficult Airway*, *Anesthesiology*, V98, No 5, May 2003 state:

'A standard definition of the difficult airway cannot be identified in available literature. For these Guidelines, a difficult airway is defined as the clinical situation in which a conventionally trained anesthesiologist experiences difficulty with face mask ventilation of the upper airway, difficulty with tracheal intubation, or both.'

The following codes

T88.4 *Failed or difficult intubation*

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*

Y92.22 *Health service area*

should only be assigned when the 'failed' or 'difficult' intubation meets the criteria in ACS 0002 *Additional diagnoses*. However, these codes should not be routinely assigned when 'difficult intubation' is documented.

Laser ablation of the lower ureter

What is the correct code to assign for laser ablation of the lower ureter?

Laser treatment is increasingly being used for a variety of urological procedures, including ablation of ureteric anastomotic and congenital strictures.

The correct code to assign for laser ablation of the lower ureter is 90358-00 [1088] *Other procedures on ureter*. Assign also the appropriate codes for endoscopy or stent insertion if performed.

Pelvic peritonitis secondary to pelvic inflammatory disease (PID) due to gonorrhoea

What are the correct codes to assign for pelvic peritonitis secondary to pelvic inflammatory disease due to gonorrhoea?

Pelvic inflammatory disease is a broad term encompassing a variety of upper genital tract infections such as salpingitis, salpingo-oophoritis, endometritis, tubo-ovarian inflammatory masses, and pelvic or diffuse peritonitis.

PID usually results from ascending infection from the cervix and is a common and serious complication of some sexually transmitted infections especially chlamydia and gonorrhoea. PID can damage the fallopian tubes and tissues in and near the uterus and ovaries. Untreated PID can lead to serious complications, including infertility, ectopic pregnancy, abscess formation and chronic pelvic pain.

The correct code assignment for pelvic peritonitis secondary to pelvic inflammatory disease due to gonorrhoea is:

A54.2† *Gonococcal pelviperitonitis and other gonococcal genitourinary infections*

N74.3* *Female gonococcal pelvic inflammatory disease*

by following the index pathway:

Gonorrhoea

- pelvis(acute)(chronic)
- - female pelvic inflammatory disease A54.2† N74.3*

Male sling procedure

What is the correct procedure code to assign for sling procedure for male stress incontinence?

Urinary incontinence is a significant problem in men who undergo prostate surgery. Persistent, long term incontinence (usually stress incontinence) in patients following radical prostatectomy is difficult to treat. There are a number of male sling procedures which use various techniques, including bone anchors, to support the bulbar urethra and help to achieve effective dynamic urethral resistance.

Following clinical advice the correct code to assign for male sling procedure is 37044-00 [1109] *Retropubic procedure for stress incontinence, male*.

Plasmapheresis

What is the correct code assignment for patients admitted for donor apheresis?

There are two types of patients admitted for donor apheresis. One type of donor is a patient with a known disease, such as a malignancy, admitted to donate their own cells for therapeutic reinfusion at a later date (autologous donation). In this scenario assign a code for the condition to be treated by the donated cells.

The other type of donor is a healthy donor, admitted to donate cells for infusion into another person (allogeneic donation). In this scenario, assign as the principal diagnosis Z51.81 *Apheresis*.

For patients admitted for therapeutic apheresis (eg plasmapheresis, leukapheresis etc.) assign as the principal diagnosis a code for the condition requiring treatment. It is unnecessary to also assign Z51.81 *Apheresis* as this information is specified by the procedure code.

See ACS 0301 *Stem cell procurement and transplantation*.

ICD-10-AM/ACHI/ACS



OF CHANGES FROM FIRST TO SIXTH EDITION

The Second Edition of the ICD-10-AM/ACHI/ACS Chronicle summarises the changes made from First to Sixth Editions. The Chronicle is an important electronic reference tool for those who need to interpret ICD-10-AM/ACHI coded morbidity data. Available July 2008. Visit the NCCH website for more information.

Plasmapheresis for Kidney Transplant

What are the correct codes to assign for plasmapheresis for ABO incompatible kidney transplant recipient?

Plasmapheresis in this scenario is one component of an immunosuppressant protocol for a patient who is to receive an ABO incompatible kidney transplant. Immune suppression reduces a normal immune response to prevent rejection of transplanted organs or cells.

The correct code to assign for same day prophylactic plasmapheresis for a patient who is to receive a kidney from an incompatible blood group donor is Z29.1

Prophylactic immunotherapy

Do not assign Z51.81 *Apheresis* as per the index entry 'Admission, plasmapheresis' as this is the code for a patient admitted for allogeneic donor apheresis (that is, a healthy donor admitted to donate cells for transplant into another person).

See also ACS 0301 *Stem cell procurement and transplantation*.

Ventilator associated pneumonia

What is the correct code to assign for ventilator associated pneumonia?

Ventilator associated pneumonia (VAP) is a hospital acquired bacterial pneumonia in patients who are on mechanical ventilatory support through an endotracheal tube or tracheostomy tube for at least 48 hours. Pneumonia occurs as a result of microbial invasion of the normally sterile lower respiratory tract, often where there is a defect in host defenses and/or a virulent or overwhelming invasion of organisms.

Contaminates may also enter the patient's lungs from condensation on the intubation drainage tubing or because intubation itself bypasses the natural barrier between oropharynx and trachea. Bronchoscopy, tracheal suctioning, manual ventilation, the supine position of the patient and the use of paralytic agents may also play a role in the development of bacterial pneumonia in these patients.

VAP complicates the course of up to 47% of intubated patients and may have a mortality rate as high as 50%.

Following the guidelines in ACS 1904 *Procedural complications* the correct code to assign for ventilator associated pneumonia (VAP) is J95.8 *Other postprocedural respiratory disorders* following the pathway:

Pneumonia

- postprocedural J95.8

Assign also an additional code for the type of pneumonia from the choices listed under the lead term Pneumonia, plus the following external cause codes:

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, Other medical procedures*

Y92.22 *Health service area*

Bibliography

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PICQ 2008

PERFORMANCE INDICATORS FOR CODING QUALITY

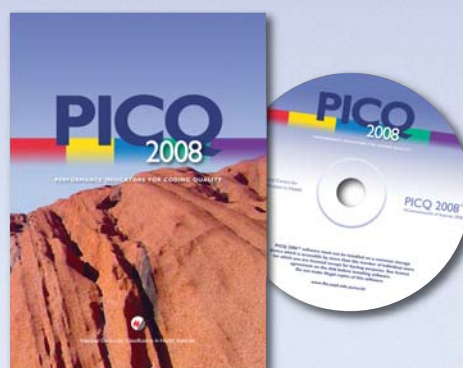
Performance Indicators for Coding Quality (PICQ)

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

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

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

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



PICQ 2008 and coding quality

PICQ 2008 is able to perform a number of data quality checks that includes:

- identifying actual coding errors and possible coding problems;
- identifying specific records for correction, if necessary;
- suggest possible problem causes and possible corrections;
- identifying areas where documentation may lead to the use of unspecified codes;
- measuring data accuracy against particular indicators;
- measuring data quality over time;
- identify areas for coder and clinician education;
- provide feedback to individual coders;
- provide results that can be benchmarked with other health care facilities; and
- complement existing coding audit activities.

New in PICQ 2008

- 70 new indicators in Sixth Edition;
- indicator logic and other elements for some indicators have been revised;
- the indicator degrees have been modified to better reflect the problem identified;
- two edit reports that identify and report on all import errors, allowing the user to correct the errors prior to re-importing; and
- the ability to process fields which are blank instead of null, e.g. unused diagnosis and intervention code fields.

**PICQ 2008 is now available –
for further information and to order:**

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

WHOFIC – New Delhi, India

The annual meeting of the World Health Organization Family of International Classifications (WHOFIC) Network was held from 25–31 October 2008 in New Delhi, India. The meeting was hosted by the recently designated Indian Collaborating Centre and was attended by approximately 100 participants from 12 WHO Collaborating Centres and representatives from Ministries of Health or National Statistics Bureaux from 14 countries. Representing Australia were Gordon Tomes, Australian Institute of Health and Welfare (AIHW), Julie Rust, Megan Cumerlato, Belinda Saad and Garry Waller from the NCCH, and Ros Madden (ICF expert).

This report will concentrate on the areas of development of the International Classification of Diseases (ICD), both for the current classification, ICD-10, and on the revision process towards ICD-11. The final meeting report, containing detailed summaries of the meetings of the various committees and groups of the Network, will be available here: <http://www.who.int/classifications/network/meetings/en/index.html>

Update and Revision Committee (URC) for ICD-10

A total of 202 proposals were reviewed by the URC in 2008, with 133 proposals accepted as official updates to ICD-10 during the WHOFIC meeting. A number of these were public submissions received by the NCCH during the past two years, which required ratification by WHO before inclusion into the classification. They included:

- A new code for HELLIP syndrome
- Identification of microscopic colitis, tertiary hyperparathyroidism and non-alcoholic steatohepatitis
- Changed default code for polycythaemia
- Clarification of the coding of cord around neck, with and without compression

Dr Bedirhan Üstün (Coordinator, Classification, Terminology and Standards, WHO) and Dr Chris Chute (Chair of the Revision Steering Group (RSG)), addressed the second session of the URC on the progress of the

revision process towards ICD-11. It is envisaged that major updates will continue for ICD-10 for 2010, 2013 and if needed, 2016, with a possible relaxation of some conventions and structural principles. These updates will inform the work on ICD-11 in order to reduce the transition process. The writing of ICD-11 will commence in Geneva in September 2009, and the anticipated timeline is:

- 2010 alpha draft
- 2012 beta draft
- 2014 request approval from World Health Assembly
- 2016 adoption

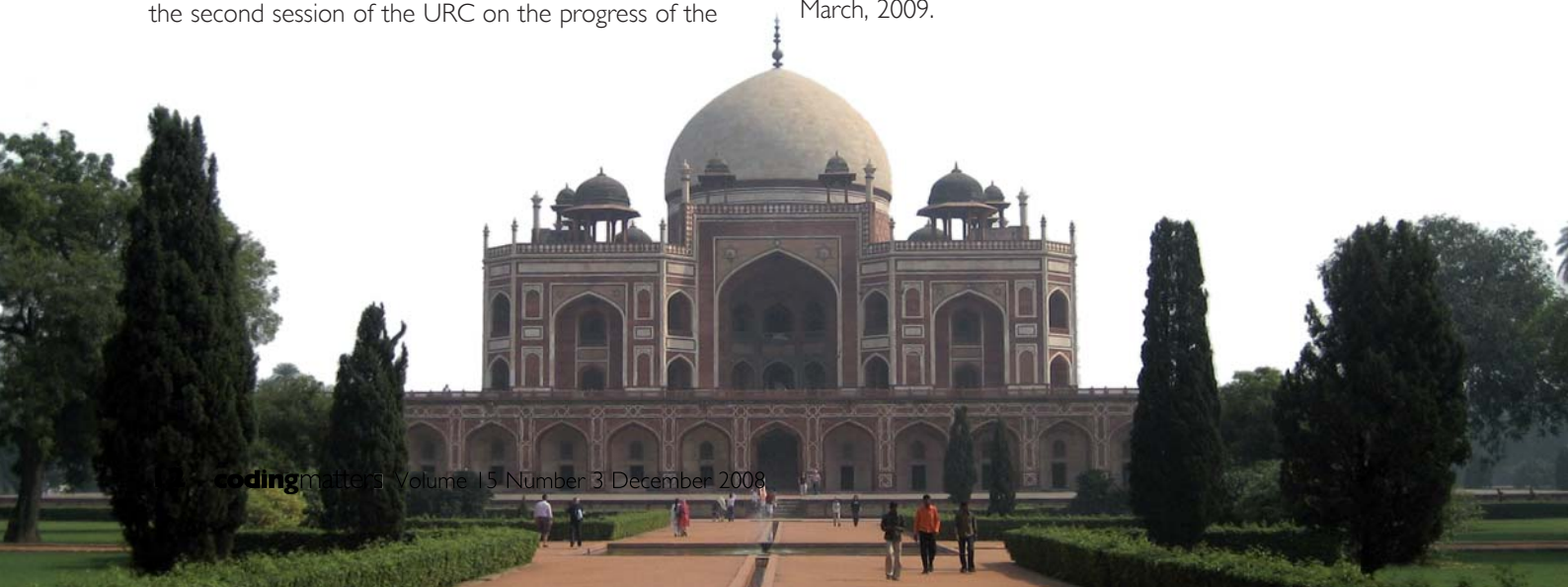
The terms of reference of the URC were reviewed, in light of the inclusion of the International Classification of Functioning, Disability and Health (ICF) into the updating process. An election of co-chairs was conducted and by acclamation Mea Renehan (North American center) was re-elected and Carlo Francescutti (Italian centre) elected.

Morbidity Reference Group (MbRG)

The Morbidity Reference Group (MbRG) met twice during the Network meeting and work continued on a number of key areas, with a focus on the development of ICD-11. Topics included:

- Conventions and rules for ICD-11
- Revision topics for the Topic Advisory Groups (ICD-11 development)
- Dagger and asterisk convention
- Definition of main condition
- Analysis of code frequencies in national data collections
- Use cases for ICD

An election of office bearers for 2008–2010 was called and Kerry Innes (Australian centre) and Olafur Steinum (Nordic Centre) were elected by acclamation. The mid year meeting of the MbRG will be held in Sydney, 16–18 March, 2009.



Frequently Asked Questions

Part 2

This is the second of a two part series on FAQs which were asked at the ICD-10-AM/ACHI/ACS Sixth Edition education workshops held during April – June 2008.

Part 1 was published in the September Edition of Coding Matters refer Volume 15 No.2.

For this article the FAQs have been grouped once again by specialty. The standard abbreviation of 'ACS' has been used throughout for 'Australian Coding Standard'.

Principal/Additional diagnoses

Q: Does the term 'infectious' need to be documented with gastroenteritis before A09.0 *Other gastroenteritis and colitis of infectious origin* can be assigned, regardless of the patient's age?

A: Yes, documentation should support the fact that the gastroenteritis is caused by an infectious organism before assigning A09.0. *Other gastroenteritis and colitis of infectious origin*, irrespective of the patient's age.

Diabetes

Q: In ACS 0401 *Diabetes mellitus and impaired glucose regulation – Eradicated conditions in diabetes* example 8 has assigned E11.29 *Type 2 diabetes mellitus with other specified kidney complication* with N18.3 *Chronic kidney disease, stage 3* as the patient has had a transplant, but if CKD is never eradicated (as per ACS 1438 *Chronic kidney disease - Kidney replacement therapy*) why not code it to the current condition i.e. E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy*?

A: Kidney replacement therapy in the form of a transplant or dialysis never eradicates chronic kidney disease as per ACS 1438 *Chronic kidney disease*. In this scenario assign E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy* and N18.3 *Chronic kidney disease, stage 3* to indicate that the patient still has CKD and diabetes, and Z94.0 *Kidney transplant status*.

Example 8 in ACS 0401 *Diabetes mellitus and impaired glucose regulation* will be amended in a future errata.

Q: The clinical information in ACS 0401 *Diabetes mellitus and impaired glucose regulation - Visceral fat deposition/obesity/overweight* indicates that:

The following BMI categories adopted by WHO only apply to Europid adults (> 18 years old), not to individuals from other ethnic backgrounds:

- Overweight (grade 1 obesity) is defined as a BMI of 25–29.9 kg/m²
- Obesity (grade 2) as BMI 30–39.9 kg/m²
- 'Morbid obesity' (grade 3) as BMI > 40 kg/m²

The classification guidelines then indicate:

E11.72, E13.72, E14.72 *Diabetes mellitus with features of insulin resistance or E09.72 Impaired glucose regulation with features of insulin resistance, as appropriate, should be assigned when one or more of the following is documented:

- acanthosis nigricans
- characteristic dyslipidaemia (elevated fasting triglycerides and depressed HDL-cholesterol)
- hyperinsulinism
- hypertension
- increased intra-abdominal visceral fat deposition
- 'insulin resistance'
- nonalcoholic fatty (change in) liver
- obesity (meeting recognised criteria or documented as "morbid obesity")

Does this therefore indicate that the three grades of obesity meet the criteria for features of insulin resistance?

A: Yes, to clarify this, clinical advice was sought and confirmed that 'obesity' (ie documentation of obesity grades 1, 2 and 3 or 'overweight', 'obesity' or 'morbid obesity') meet the criteria for features of insulin resistance in Europid adults. When BMI only, is documented seek clarification from the clinician. Amendments will be made to this section of the standard to better reflect this advice.

Q: If you have diabetes documented in the patient's medical history as:

Diabetes

- nephropathy
- retinopathy
- cardiomyopathy

can you assume that it is 'diabetic cardiomyopathy'?

A: As per ACS 0401 *Diabetes mellitus and impaired glucose regulation*:

Diabetic cardiomyopathy (E11.53)

A distinctive form of cardiomyopathy without significant atherosclerotic involvement of coronary arteries, may occur in diabetic patients and often causes cardiac failure. It is characterised by diastolic dysfunction confirmed by cardiac nuclear scanning and/or echocardiography.

Diabetic cardiomyopathy is indexed in ICD-10-AM as follows:

Cardiomyopathy (familial) (idiopathic) I42.9
- diabetic E1-.53

or

Diabetes, diabetic (controlled) (mellitus) E1-.9
- cardiomyopathy E1-.53

Clinical advice was sought on this topic which advised the following:

'Cardiomyopathy cannot be assumed to be 'diabetic' without confirmation involving the demonstration of diastolic ventricular dysfunction on nuclear medicine cardiac scanning. Additionally, the categorisation of cardiomyopathy as 'diabetic' excludes significant coronary artery disease with resultant cardiomyopathy (coded to I25.5) and other causes (coded to I42.6 – I42.7 and I43). In the absence of other apparent causes and specific confirmation on formal investigation, the cardiomyopathy should be coded to I42.9'

Therefore, in the scenario cited the form of documentation specified is not sufficient to assume diabetic cardiomyopathy as per the index and the clinical advice received. The other two conditions, nephropathy and retinopathy, are linked with diabetes in the index and it is sufficient for the appropriate diabetes codes to be assigned in this instance.

Drug and alcohol

Q: Why can't Y91.9 Alcohol involvement, not otherwise specified be assigned to indicate alcohol involvement in an injury/accident admission? In the past this code has been routinely assigned to identify that there has been alcohol involvement, although the patient may not have been intoxicated at the time they presented to hospital.

A: At some of the workshops coders indicated that the victim who is admitted to hospital is not the one who has actually used alcohol. It is often the perpetrator of the assault who was influenced by alcohol and therefore coders wanted to assign Y91.9 to reflect this. The classification was not designed to capture this level of detail and as indicated in ACS 0002 *Additional diagnoses*:

'the national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care'.

Also, as the title of category Y91 is 'Evidence of alcohol involvement determined by level of intoxication' the codes from this category cannot be assigned if the patient is not intoxicated at the time of admission to hospital. ACS 0503 *Drug, alcohol and tobacco use disorders* also indicates that these codes are not to be used for inpatient morbidity coding.

Q: When can Z72.1 Alcohol use be assigned?

A: The note in ICD-10-AM Tabular at category Z72 *Problems related to lifestyle* indicates that:

'hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user'.

Therefore this code can only be assigned if the clinician indicates there has been hazardous use of alcohol. It should be remembered that a code for alcohol cannot be routinely assigned, as we do with smoking, because of the subjective nature of its usage i.e. when looking at age, sex, weight issues etc. and that code assignment is still dependent on the condition meeting the criteria in ACS 0002 *Additional diagnoses*.

Q: If alcohol involvement has necessitated an admission to hospital for treatment of an injury but no blood alcohol level is documented, what code should be used?

A: Category Y91 *Evidence of alcohol involvement determined by level of intoxication* is not to be used for inpatient morbidity coding as per ACS 0503 *Drug, alcohol and tobacco use disorders*. In the scenario cited to indicate that alcohol was involved, Z72.1 *Alcohol use* may be assigned if the patient was affected by alcohol at the time of the injury and no blood alcohol level has been documented (see also Question 2 above).

Q: As the blood alcohol levels specified at Y90 Evidence of alcohol involvement determined by blood alcohol level do not always match what is documented in the clinical record or reported by hospital pathology laboratories, can the NCCH publish the mappings for this in Coding Matters?

A: The table below provides the equivalent laboratory ranges for blood alcohol level as reported in ICD-10-AM and may be used as a guide for code assignment:

Conversion of Blood Alcohol Readings for ICD-10-AM Sixth Edition

	mmol/L		mg/100mL		g/100mL	
Patient's Alcohol	10		46		0.05	
ICD-10-AM Sixth Edition code	mmol/L		mg/100mL		g/100mL	
	Lo	Hi	Lo	Hi	Lo	Hi
Y90.0		4.3	<	20		0.02
Y90.1	4.3	8.5	20	39	0.02	0.039
Y90.2	8.7	12.8	40	59	0.04	0.059
Y90.3	13.0	17.2	60	79	0.06	0.079
Y90.4	17.4	21.5	80	99	0.08	0.099
Y90.5	21.7	25.9	100	119	0.1	0.119
Y90.6	26.1	43.3	120	199	0.12	0.199
Y90.7	43.5	52.0	200	239	0.2	0.239
Y90.8	52.2		240	>	0.24	

Chronic kidney disease

Q: The default for 'diabetes with chronic kidney disease' is E1-.22 * *Diabetes mellitus with established diabetic nephropathy*, why isn't E1-.21 * *Diabetes mellitus with incipient diabetic nephropathy* assigned as this is the 'lesser' degree, or not have a default at all?

A: Patients who have CKD stages 1 - 2 are usually asymptomatic and an eGFR may not always be performed. Therefore if the patient has diabetes with CKD and the diabetes meets ACS 0001/0002 for code assignment a logical default in this instance is to E1-.22 * *Diabetes mellitus with established diabetic nephropathy*.

Obstetrics/Gynaecology

Q: Workshop Obstetrics exercise 3 – In our answers we have assigned the Spontaneous code (O71.11) assuming it was the forces of labour that caused the rupture of the uterus. The patient was given syntocinon and had an epidural during labour. Coders queried why not assign the unspecified code O71.10 or should this have been coded to O71.12 *Traumatic as drugs were used*?

A: For the scenario used in the workshop the most appropriate code to assign given the limited information provided was O71.11 *Spontaneous rupture of uterus during labour*, however, we understand that some coders may have wanted to assign O71.10 *Rupture of uterus during labour, unspecified* based on their interpretation of the case scenario and this is often difficult when the whole record is not available at the time of coding. Code assignment should be based on documentation of the rupture occurring 'spontaneously' or 'traumatically' if in doubt assign the code for unspecified rupture.

The NCCH will be reviewing data, when it becomes available, on the frequencies of these codes to ascertain whether it is appropriate to keep this level of detail in the classification.

Q: Hysterectomy has a code also instruction for debulking of uterus at blocks [1268] and [1269] – is this the same as morcellation?

A: Debulking is the removal of a major portion of the material that composes a lesion, such as the surgical removal of most of a tumour so that there is less tumour load for subsequent treatment by chemotherapy or radiation. Often with uterine tumours they need to be 'debulked' prior to a hysterectomy being performed.

This differs from morcellation where there is the division of solid tissue (such as an organ) into pieces, which can then be removed often laparoscopically.

If 'debulking' is documented in the operation report assign 35658-00 [1270] *Debulking of uterus preceding hysterectomy*.

Procedural complications

Q: In ACS 1904 Procedural complications – infected intravenous (IV) sites, the classification section provides advice on:

- Localised infection – due to device
- Systemic infection – due to procedure or infusion

What codes would be assigned if a systemic infection that has resulted from the device, i.e. starts as a local infection due to the device, and then progresses to a systemic infection e.g. seen in cancer pts who have a Hickman's who are more prone to developing an infection due to their low immune system?

A: If there is clear documentation in the clinical record that the infection was due to a device and it then becomes systemic assign T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts* and the appropriate sepsis code to capture that it is now a more systemic infection.

Q: The following issues were raised regarding the coding of procedural complications:

- Coding of CVAs, MI, haemorrhages, hypertension which occur during a procedure (ie intra-operatively) – are these classified to T81.8 *Other complications of procedures, not elsewhere classified* then the external cause being a misadventure or is the condition really a result of an existing condition and therefore just use the specific chapter code without an external cause code?
- If the condition doesn't meet the definition for a procedural complication then should the condition be coded in its own right and therefore a T code is not assigned?
- What codes should be assigned for an intra-operative haemorrhage? - a T code plus a Misadventure external cause code as per ACS 1904 *Procedural complications - Definition of a misadventure*.

A: If the intraoperative event e.g. haemorrhage, MI, CVA etc meets:

- the definition of an additional diagnosis as per ACS 0002 *Additional diagnoses* and
- the definition for a procedural complication as per ACS 1904, (ie is directly related to the surgical/procedural intervention)

then for the diagnosis code, apply ACS 1904 and follow the index lookups. This means that the first diagnosis code could come from either the end of chapter codes or the T code section.

The next code in the string will indicate the condition/problem ie MI, CVA etc and an external cause code will be assigned from Y60 – Y69 *Misadventures to patients during surgical and medical care*, refer to examples 17 and 18 in ACS 1904.

The definition of a 'misadventure' in ACS 1904 Procedural complications will be amended to remove the terms 'due to human intervention'.

Ventilation

Q: If a patient is intubated and ventilated for <1 hour and then transferred to another hospital what codes are assigned?

A: As per ACS 1006 *Respiratory support* hours of mechanical ventilation should be interpreted as **completed cumulative hours** (point 1 c.) and any method of intubation for ventilatory support is not coded (point 2 b.). For classification purposes if a patient is intubated and ventilated for less than one hour the intubation and ventilation are not coded. Amendments will be made to ACS 1006 to reflect this advice.

Q: If a patient, during one episode of care, has three theatre episodes with periods of post ventilation all of which are <24 hours and the three periods of ventilation (excluding the theatre time) add up to >24 hours, should the ventilation be coded as per the first dot point at point C in ACS 1006 *Ventilatory support* – *Classification section*?

A: No, point F in the classification section of ACS 1006 *Ventilatory support* should be followed. Each visit to theatre, where the patient is intubated and extubated, needs to be looked at individually and if the period of ventilation post surgery is ≤ 24 hours a code for ventilation is not assigned and not used cumulatively with other periods of ventilation in the episode of care.

Bilateral/multiple procedures

Q: In ICD-10-AM/ACHI/ACS Fifth Edition - ACS 0020 *Multiple/bilateral procedures* the 'exceptions' at point C read as follows:

(c) Procedures performed without anaesthesia should be coded once only (unless listed in ACS 0042 *Procedures normally not coded as a procedure not to code, or unless directed otherwise in another specialty standard*).

EXAMPLES:

Assign one code if multiple repetitions of the following procedures are performed without anaesthesia:

CT scans (of same site and type)

Blood transfusions (of same product type)

Pain management procedures

Allied health interventions

Haemodialysis

Does this still apply for the coding of CT scans or does the new classification point in ACS 0020 *Bilateral/multiple procedures* over ride this i.e. 'a procedure which is repeated during an episode of care should be coded as many times as performed'?

A: The NCCH acknowledges the fact that the coding of multiple CT scans was not addressed in the revision of ACS 0020 for Sixth Edition. Therefore if a patient has multiple repetitions of a CT scan performed during an episode of care assign one code only.

The NCCH is planning to review ACS 0020 *Bilateral/multiple procedures* and ACS 0042 *Procedures normally not coded* regarding the coding of radiological procedures for a future edition.

Attention!

Health Information Managers and Clinical Coders

The NCCH needs case scenarios or clinical record abstracts for possible use in future education workshops!

If you have a case that can be used, please either send a *de-identified* copy to the NCCH or summarise the case and email it...

E-mail:

m.cumerlato@usyd.edu.au

Address:

NCCH
The University of Sydney
PO Box 170 Lidcombe NSW 1825

ICD-10-AM/ACHI/ACS Sixth Edition

coding workshops for 2009

The 2009 workshops will feature case scenarios and clinical records which will be distributed to participants for completion prior to attending the event. At each workshop there will be opportunity to discuss the answers with basic coding tips and pointers also being provided.

The main focus of this year's continuing education workshops will be on coding cases related to chronic kidney disease which was based on feedback received from state and territory coding authorities. Other topics will include:

- bilateral/multiple procedures
- cardiovascular
- diabetes mellitus
- obstetrics
- procedural complications
- spinal
- ventilation

Pre-Conference Workshop

The NCCH will be presenting the first of the continuing education coding workshops at the NCCH conference in March 2009. As always places are limited for this particular workshop. If you intend on coming do not delay in securing your place.

The NCCH will also run a series of national workshops during May and June for those coders who are unable to attend the NCCH pre-conference workshop.

National 2009 coding workshops

The dates and locations for these workshops are listed in the adjacent textbox and are subject to change but the NCCH will endeavor to keep to this timeline if possible.

Registration to national workshops will be \$198 (incl. GST). Participants will receive a 100+ page workbook with 12 case scenarios and 6 clinical records, to be completed prior to attending. The workbook will be sent to participants, at least two weeks prior to the nominated workshop date, for completion. An answer book will be provided on the day plus lunch, with tea and coffee being available throughout the day.

Participants will need their own copies of ICD-10-AM / ACHI / ACS Sixth Edition in hard copy or the eBook on laptop at the workshops plus your completed workbook.

Registrations will open from the end of January 2009 at <http://www.ncch.com.au>

The proposed workshop dates and locations* are:

NEW SOUTH WALES

5 May	Bankstown
6 May	North Ryde
7 May	Dubbo
12 May	Newcastle 1
13 May	Newcastle 2
14 May	Albury
18 May	Penrith
10 June	Tamworth
17 June	Coffs Harbour

NORTHERN TERRITORY

2 June	Darwin
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QUEENSLAND

12 May	Brisbane 1
13 May	Brisbane 2
14 May	Brisbane 3
4 June	Cairns
4 June	Rockhampton
18 June	Maroochydore

TASMANIA

2 June	Launceston
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SOUTH AUSTRALIA

26 May	Adelaide 1
27 May	Adelaide 2
28 May	Adelaide 3

WESTERN AUSTRALIA

26 May	Perth 1
27 May	Perth 2

AUSTRALIAN CAPITAL TERRITORY

20 May	Canberra
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VICTORIA

19 May	Bendigo
20 May	Melbourne 1
21 May	Melbourne 2
10 June	Melbourne 3
11 June	Melbourne 4
12 June	Geelong

*subject to change

NB: the minimum number of participants required for a workshop to be held is 15 participants (excluding NT) otherwise the workshop will be cancelled.

CONFERENCES 2009

Feb 3-5	Delivering ICT Capabilities Within Healthcare Services	Sydney, NSW	www.arkgroupaustralia.com.au/events-c054%20ICT%20Health.htm
Feb 24-27	HIMSS AsiaPac09	Kuala Lumpur, Malaysia	www.himssasiapac.org/
Mar 2-3	Australian Health Care Reform Alliance Summit 2009	Melbourne, Australia	www.healthreform.org.au/#
Mar 11-13	11th NCCH Conference and Workshop	Sydney, NSW	www.fhs.usyd.edu.au/ncch
April 4-8	HIMSS'09 Annual Conference and Exhibition	Chicago, USA	www.himssconference.org
April 14-16	6th Annual World Health Care Congress	Washington, DC, USA	www.worldcongress.com/events/HR09000/index.cfm?confCode=HR09000
May 5-7	HIMSS MiddleEast09	Manama, Bahrain	www.himssme.org/09/
May 17-20	10th National Rural Health Conference	Cairns, QLD	nrha.ruralhealth.org.au/?IntCatId=14
Aug 4-7	ACHSE 2009 National Congress	Surfers Paradise, QLD	www.achse.org.au
Aug 29-Sept 2	22nd International Congress of the European Federation for Medical Informatics	Sarajevo, Bosnia and Herzegovina	www.mie2009.org/
Oct 1-4	GP'09 - The conference for general practice 2009	Perth, WA	www.gpconference.com.au/
Oct 14-16	HIMAA National Conference	Perth, WA	www.himaa.org.au/

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

Australian Refined Diagnosis Related Groups (AR-DRG)

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

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

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

For further information and to order:

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Telephone: +61 2 9351 9461

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Version 6.0





The Director and staff of the **NCCH**
wish you a Merry Christmas and a
prosperous New Year

10-AM Commandments Sixth Edition **online now**



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10-AM Commandments Sixth Edition may also be viewed using the *Coding Matters* index and newsletter PDF documents also available on the NCCH website. The ICD-10-AM/ACHI/ACS Sixth Edition software version includes the Commandments using active hyperlinks to the relevant sections of the classification.

Visit ICD-10-AM Sixth Edition Commandments online at: www.fhs.usyd.edu.au/ncch

**coding
matters**



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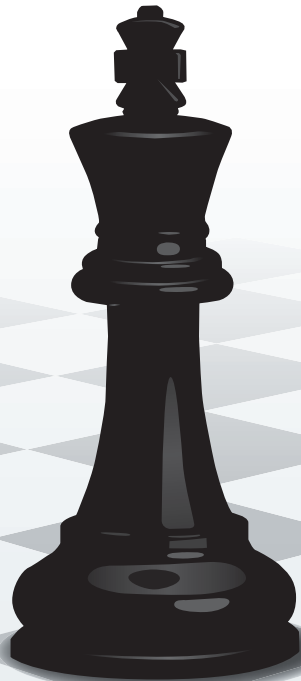
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CODING rules

11th NCCH Conference 2009

11–13 March 2009, Dockside, Cockle Bay, Sydney

The National Centre for Classification in Health is pleased to invite you to **Coding rules**, the eleventh NCCH conference and workshop, at Dockside, Cockle Bay, Sydney NSW, 11–13 March 2009.

The conference is designed to inform, educate and inspire users of ICD-10-AM/ACHI/ACS and other health sector professionals involved or interested in health data and information. **Coding rules** will provide abundant opportunities for ICD-10-AM/ACHI/ACS users and those from related work and interest areas to learn more about a broad range of core health classification and clinical terminology issues and associated skills, resources, planning, systems and management concepts.

The conference program provides a forum to exchange best-practice ideas, explore innovations and to be inspired by some of the country's best clinical classification and terminology practitioners, clinicians, researchers, health information and knowledge workers.

The conference will provide valuable information and opportunities for those with interests in clinical classification issues and health data and information management, including:

- ICD-10-AM/ACHI/ACS users
- clinical coders
- health information officers and managers
- health system administrators and managers
- casemix coordinators
- health service managers and planners
- health department personnel
- clinicians
- academics and researchers

The NCCH will once again be presenting a pre-conference coding workshop prior to the NCCH conference on Wednesday 11 March 2009. The workshop will provide continuing education to clinical coders on ICD-10-AM/ACHI/ACS. Places in the workshop are limited.

Register online at www.fhs.usyd.edu.au/ncch

We look forward to seeing you in Sydney!



National Centre for Classification in Health