

coding matters



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

Volume 6 Number 2 **September 1999**



**from the
desk of
the director**

ICD-10-AM

This is the first edition of *Coding Matters* following the national implementation of ICD-10-AM. I want to use this opportunity to recognise the efforts of everyone who has been involved in this major change to a new health classification system, and an Australian one at that. I know that many of you have been using ICD-10-AM since 1998, but now all Australian states and territories are on standard gauge, and I'm sure that all data users look forward to uniform coded morbidity data in ICD-10-AM.

NCCH staff have worked long and hard at creating the classification itself, presenting it in the best possible way, educating clinical coders and other users of the classification and addressing issues of quality of data. Without input from clinicians and expert clinical coders the ICD-10-AM classification and the Australian Coding Standards would have been neither possible nor credible.



Kerry Innes, Stuart MacAlister, Vin Lal and Rosemary Roberts celebrate national implementation of ICD-10-AM

But these activities were really only the beginning. The actual implementation process has involved members of the ICD-10 Implementation Committee, ICD-10 Implementation Coordinators, members of the Coding Educators Network, ICD-10-AM Education Working Party, state and territory ▶

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coding committees, not to mention clinical coders, health information managers and IT directors in hospitals, networks and health departments. Above all, I wish to thank the Commonwealth Department of Health and Aged Care for providing the initial positive response to recommendations to change to ICD-10, their willingness to develop an Australian modification of the international disease classification and our own procedure classification, and of course to meddle with the code foundations of the Australian casemix system, which has required major mapping exercises to ensure flexibility of the coding/casemix system nexus during the changeover from ICD-9-CM so that grouping stability could be maintained.

To mark the national implementation of ICD-10-AM, NCCH celebrated with a cocktail party to coincide with a meeting of the Coding Standards Advisory Committee (CSAC) on 26 July 1999.



Julie Rust, Nicole Boyens, Fran Brownlow, and Gay Lysenko



Irene Kearsey, Andrea Groom and Kay Bonello



Christine Thorpe and Karen Peasley celebrate national implementation of ICD-10-AM

The major investment of energy and resources required for ICD-10-AM development and implementation has reanimated the domain of health classification in Australia. Not only has it given us expertise in developing classifications, it has brought the realisation that coding decisions do make a difference – not only in regard to casemix grouping but in demonstrating what hospitals do and the ‘burden of disease’¹ in Australia. It has allowed us to contribute to international discussions in the World Health Organization (WHO) and International Organization for Standardization (ISO) on health classifications, and to use our efforts on ICD-10-AM as a foundation for work on Australian clinical terminologies.

**coding
matters**



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In regard to the place of health classification systems in international exchange of information about health, I refer readers to a most useful publication entitled "Barriers to a Global Information Society for Health"². This book summarises the positions in the G7 nations and Australia and makes 26 recommendations for international action including two relating to international terminologies and standards. It is important to note that these recommendations relate to international agreement on structures, models and frameworks rather than content of classifications or terminologies.

NCCH/CCSA Conference

The international theme is being carried through to the 1999 NCCH/CCSA Conference to be held in Hobart from 22-24 September. Karen Peasley, Education Manager, not allowed to rest after the Post Implementation Education (PIE) Workshops, is again organising the conference with administrative support from Linda Maleszka. We look forward to hearing our keynote speaker, Dr Bedirhan Üstün from WHO, and I hope you will join us in demonstrating to him and to each other the classification work occurring in Australia.

NCCH Staff



Gay Lysenko

NCCH staff seems to keep increasing, particularly with the imminent production of ICD-10-AM 2nd edition. New faces in Coding Services include Allison Lawer and Fran Brownlow, with Emily Ridgway providing database support until the end of 1999. Elizabeth Azel has joined the Publications Division for desktop publishing functions relating to preparation of the new publication. Gay Lysenko is also with us until the end of the year to manage the Performance Indicators for Coding Quality (PICQ) project and coordinate with Irene Kearsley who is working on PICQ development at NCCH Quality Division, La Trobe University. Linda Maleszka has returned to NCCH, her place as Administrative Assistant,

Professional Relativities Study (PRS), being taken now by Imelda Noti. Margie Luke is also doing project work on theatre times for PRS.



***Tina Stanhope
and Nicole***



Catherine Stanhope

Tina Stanhope, currently on maternity leave, has a beautiful daughter, Nicole Leslie (see photo). Tina's sister, Catherine Stanhope (Cath) (see photo), is filling her place as administrative assistant and rapidly making herself indispensable in dealing with the orders and generally keeping us in order too.

A most welcome addition to our team during June and July was Nicola Hunt, a 3rd year health information management student on placement from La Trobe University (see photo). We would like Nicola to have stayed and know she will have much to contribute to the HIM profession on graduation. ▶



***Coding Services made sure Nicola was
gainfully employed***

NCCH Strategic Plan

NCCH staff and Executive Committee have been heavily involved in developing specifications and letting a tender for the NCCH Strategic Plan, supported by the Commonwealth Department of Health and Aged Care. The successful tenderer is Healthcare Management Advisors (HMA) whose consultants will be interviewing staff and stakeholders and preparing the plan for the end of October 1999. The results of this exercise will be used in the short term by NCCH Executive and the Commonwealth Department of Health and Aged Care in negotiations on NCCH Sydney contract post June 2000. NCCH is also looking to the plan to provide long term direction for the centre now that it is nearing its sixth birthday.

National Health Information Management Group (NHIMG)

At its meeting of 22 June 1999, NHIMG made some important decisions for the future of NCCH in its role in maintaining and producing ICD-10-AM. Firstly, it agreed to consider changes for ICD-10-AM 2nd edition for endorsement following acceptance of those changes by CSAC. It also agreed to implement the 2nd edition as the national standard from 1 July 2000 and endorsed the recommendation from the NHIMG Health Classification Strategy Working Group that new editions of ICD-10-AM be produced on a two yearly basis. This means that all states and territories will move together to the 2nd edition in July 2000 and that the 3rd edition will be prepared for implementation in July 2002.



Olafr Steinum recently in Australia took the opportunity to visit the NCCH

Coding Queries

NCCH has now responded to over 1,000 coding queries which, as you know, are posted regularly on NCCH website. Dealing with these queries in Coding Services have been Tiffany Chan, Megan Cumerlato, Julie Rust, Allison Lawer, Fran Brownlow, Judith Hooper and Michelle Bramley (oh and I forgot Kerry Innes). Code-L, the NCCH listserver, seems to be well used not only in Australia but in New Zealand and Singapore, with regular contributions from our colleague Olafr Steinum in Sweden.

ICD-10-AM Database

Work on the database by our contractors, Essential Software, and by staff in Coding Services (Judith Hooper) and Publications (Chantel Garrett), is nearing completion. The prospects offered by this new format are limitless and will provide projects for all NCCH staff lifetimes! However, its immediate use will be for producing the new publication, for maintaining the classification and as a basis for the ICD-10-AM clinical terminology.

Terminology Developments

A proposal to the National Health Priorities and Quality Branch of the Commonwealth Department of Health and Aged Care for inclusion of ICD-10-AM in the Unified Medical Language System (UMLS) of the National Library of Medicine has been funded and work commenced. This is a feasibility study which will involve a mapping of terms in ICD-10-AM to the Concept Unique Identifiers (CUIs) in UMLS and allow translation of terms in ICD-10-AM to those in other classifications, especially Australian classifications such as ICPC2+ but also other classifications included in the UMLS Metathesaurus.

I represented NCCH at the Health IT Infrastructure Meeting held in Melbourne on 28-29 July by the Commonwealth Department of Health and Aged Care National Health Priorities and Quality Branch and participated in the working group on Health Concept Representation. This followed my involvement in a similar working group at the ISO Meeting held in Berlin last April. The Australian meeting considered work proposals from the ISO Technical Committee on Health Informatics and made recommendations to the meeting of IT/14 held in Melbourne on 30 July. IT/14, the Australian Health Informatics Committee, is currently resurrecting IT14/2, subcommittee on

Vocabulary and Semantic Issues, where again I will be representing NCCH.

Community Health

NCCH has responded to a request from NSW Health to provide advice on the Australian community based health services code set. NCCH has arranged for Mr Alex Canduci to be seconded to NSW Health from his position as health information manager at the Royal South Sydney Community Health Complex and for classification advice to the project from Michelle Bramley, NCCH.

Mental Health

The specialty book '*Casemix, DRGs and clinical coding, Mental Health, Drugs and Alcohol*' has just arrived from the printer. Congratulations to Monica Komaravalli and the team providing input to this publication for their achievement! NCCH has now completed nine of these specialty books with another nine to go, so the series now looks (and reads) as a substantial contribution to education and reference material for casemix and clinical coding.

International Classification of External Causes of Injuries (ICECI)

Coding Services Division has offered to participate in the testing of ICECI and has subcontracted this project to NCCH Brisbane. ICECI is being developed by the WHO-Working Group for Injury Surveillance Methodology Development whose lead agency is the Consumer Safety Institute in The Netherlands.

Quality Division

As mentioned above, work is proceeding on the PICQ indicators. Irene Kearsy from Melbourne has visited NCCH Sydney several times in recent months, with Dr Erich Schulz from NCCH Brisbane contributing to the discussion on the PICQ database and logic statements. We now have a 'PICQ team' comprising Irene, Gay Lysenko, Erich, Donna Truran, Nicole Schmidt and a representative from Coding Services, (usually Kerry Innes) and Publications (Rodney Bernard).

Apart from input from the Victorian Department of Human Services, funding for the Division at La Trobe is not yet assured and awaits the outcome of the NCCH Strategic Planning exercise. This does not reflect any lack of NCCH interest in coding quality. In fact, it highlights for us how much we need to examine quality of

coded data to assess the impact of what we do with codes and to indicate areas where education is needed or where the classification itself needs expansion or clarification.

Research and Consultation

Donna Truran has been instrumental in preparing research and consultancy proposals for NCCH, including specifications for the NCCH Strategic Plan and proposal for inclusion of ICD-10-AM in UMLS. She is also analysing results of surveys, writing papers for publication and supporting the other NCCH Divisions in researching the literature in regard to ICD-10-AM code and standard proposals.

Under the project management of Lauren Jones, work is progressing on the Professional Relativities Study for the Medicare Schedule Review Board. Patricia Saad, seconded from Coding Services, is an integral member of the ►

MATCHING SERVICE FOR CLINICAL CODERS

Queensland Health Staff Search has started a matching service for Clinical Coders. We manage an employment service for Clinical Coders interested in working in the state's public and private hospitals.

As a Coder you need to ensure that the coding of diseases and procedures in hospitals is clinically appropriate, efficient, accurate, and timely.

With the implementation of ICD-10-AM, some facilities may require additional coding resources. So, if you have experience or accreditation as a Coder and are:

- Seeking employment or a job change
- Wanting to return to the workforce
- Looking to increase your hours

**Register on our Coder
database today!**

**Hotline:
1 800 068 380**



QUEENSLAND
GOVERNMENT



TMP: K03309

PRS team and has acquired impressive expertise in statistical and spreadsheet PC applications.

NCCH Coding Prize

The NCCH Coding Prize is awarded for high achievement in clinical coding to highlight the importance of studies in this area and encourage students to aim for excellence. 1998 was the first year that the NCCH sponsored a prize for clinical coding for each of the University Health Information Management programs and for the distance education offered by HIMAA and OTEN.

Belinda Tilley, School of Public Health, La Trobe University (Bachelor of Health Information Management) was the 1998 recipient of the La Trobe University NCCH Coding prize.

Congratulations Belinda!



Belinda Tilley, recipient of the La Trobe University NCCH Coding Prize with Rosemary Roberts



Conclusion

Having spent five years now at NCCH, and with the current Strategic Planning exercise and clinical terminology developments, I feel that the centre is entering a new phase, where the emphasis will be on electronic coding products and extracting morbidity and procedure data from electronic patient records. The challenge for us is to think carefully about how we might hasten progress in these areas rather than waiting for the demand to arise. Whatever happens, we will also be producing books for a while yet, and hope we can achieve for clinical coders the right balance of stability and continuity with what we have against adventure and experimentation with the new. I guess what I'm trying to say is personified in the theme of this year's NCCH/CCSA conference:

- C Collaborating Centres
- O Observing Outcomes
- D Diversifying Developments
- E Evolving Episodes

I look forward to seeing you in Hobart!

▶ **Rosemary Roberts** Director

- 1 Murray CJL, Lopez AD (eds). *The Global Burden of Disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* World Health Organization. 1996.
- 2 Rogers R, Reardon J. *Barriers to a Global Information Society for Health. Recommendations for International Action. Report from the project G8-ENABLE.* IOS Press. Oxford. 1999.

Wanted Wanted Wanted

Coding Educators Network

The NCCH is seeking clinical coders and health information managers who are interested in joining either the Coding Educators Network (CEN) or CEN International.

For more information regarding either CEN or CEN International see the detailed advertisements on pages 12 and 21.



vital signs

Things have been reasonably quiet in the Brisbane office since my last report for *Coding Matters*. As I mentioned last time, NCCH Brisbane has been involved in several more international training courses conducted for the World Health Organisation. This time I was fortunate enough to teach students from the Western Pacific region in two two-week courses held in Suva, Fiji and Agana, Guam.

Both courses were very successful and it was interesting to hear stories of students who are the only coders on their island or the only coder in the whole country. One student related how he had to wait until pathology reports were sent by small boat from the main island (where the only pathology laboratory was located) to his remote island for inclusion in his health centre's medical records before he was able to complete coding. This meant that his timeframe for completing a weeks' coding was dependent on the weather!

Another student noted that mortality coding had been stopped in her country because it was felt that the certificates belonged to dead people and that there was nothing that could be done for them anymore – so what was the point?!

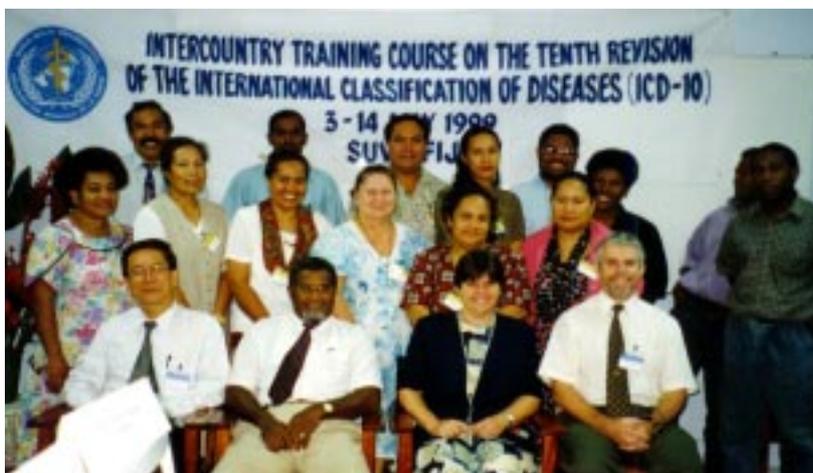
During the two courses, we had useful discussions about coder support, the need for further training and potential quality assurance



Students on the Coral Coast of Fiji on a Saturday outing

projects (including the use of a modified version of Australian Coding Benchmark Audit – ACBA). We talked about the development of a coder email discussion group within the Western Pacific region to enable resolution of difficult coding issues and to begin the development of region-wide standards.

NCCH hopes that one of the countries represented will take the lead on further involvement of this proposal. During both courses, we had the opportunity to visit local hospitals and to view their medical record departments and coding units. In Fiji, we visited the Colonial War Memorial Hospital where we ►



Students at official opening of ICD-10 course in Fiji. In front row are (L to R): Dr YC Chong, WHO Manila; Dr Tuqa, Ministry of Health, Fiji; Sue Walker; Dr Mike O'Leary, Acting WHO Representative for the South Pacific



Students at official opening of ICD-10 course in Guam. In the back row are Dr Gauden Galea, WHO Epidemiologist/Non Communicable Diseases specialist from WHO office in Suva, and Dr YC Chong

were shown around by Ifereimi Tabua, one of the WHO Fellows who had visited NCCH earlier in the year.

Ifereimi has now implemented ICD-10 in his hospital and the Fiji Ministry of Health hopes to use his knowledge (and that of the other WHO Fellow, Ruci Vuadreu) to conduct ICD-10 courses for other coders in the near future. Fiji is also considering the implementation of ICD-10-AM under the guidance of Jo Ravono, a past student of the School of HIM at the University of Sydney and the current head of the Health Information Unit in Suva.

In Guam, we had a site visit at the Guam Memorial Hospital. Guam is a protectorate of the USA and therefore its health system is based on that in America. The admission clerk 'admitted' one of the students and had to complete seventeen different computer screens' of data before the admission process was completed! Guam currently uses the US version

of the ICD-9-CM but is planning to move to ICD-10-CM around 2001. Interestingly, several of the managed care companies that operate in Guam have offices co-located in the hospital and coders often get visits from them to query principal diagnoses or other codes assigned.

During April, Maryann Wood submitted her resignation from NCCH to take up the newly created position of Manager, Causes of Death Unit at the Australian Bureau of Statistics (ABS). Whilst the Brisbane office misses her good humour and hard work, her expertise has not been entirely lost to us as we subcontracted ABS for her services to conduct a further ICD-10 course at the National Institute of Health Sciences (NIHS) in Kalutara, Sri Lanka during June and July.

The NIHS has been selected as the potential training site for future international courses in health information management and ICD-10, with past students of the NCCH courses as principal trainers. Eventually it is hoped that all Regional training for South-East Asia will be conducted at the NIHS, giving the Region its own training resource and reducing its reliance on external consultants.

Maryann's ICD-10 course was conducted in the middle of the first twelve week HIM course for Sri Lankan students, being taught utilising the materials developed by the NCCH last year. Twenty five national students attended both the HIM and the ICD-10 courses, with a further twelve international students participating only in the ICD-10 module. Later in 1999, the NIHS will conduct an international course in both HIM and ICD-10 and the abilities of the trainers will be formally assessed by the NCCH for WHO/SEARO. Although this means that NCCH will most likely soon reduce its South-East Asian training activities, we are delighted that our efforts have facilitated the development of self-sufficiency in these areas within the Region.



Sue Walker with Ruci Vuadreu, who was one of the Fijian students who came to NCCH Brisbane for ICD-10 training in March 1999. Ruci currently codes mortality in the Ministry of Health, Fiji

Coding Around the Western Pacific

Ever wondered what classifications are used in our nearest neighbour countries? As part of the WHO Collaborating Centre for the Classification of Diseases, NCCH undertook a fact finding mission during the recent ICD-10 training courses in Fiji and Guam. Here are the results – get out your atlases! Note that where it is indicated that no coding is undertaken, we are hoping that the courses NCCH conducted will lead to improvements in documentation practice and implementation of coding for morbidity and mortality.

Niue: no coding currently undertaken for morbidity or mortality, short list of diseases utilised to collect notifiable disease statistics.

Solomon Islands: no coding currently undertaken for morbidity or mortality although a doctor at the National Referral Hospital has developed his own classification for internal research purposes. Hoping to implement ICD-10 for morbidity reporting next year.

Tonga: ICD-10 implemented in early 1999, US version of ICD-9-CM used for procedures. There are currently two morbidity coders at the main hospital, the government statistics office codes mortality using ICD-9.

Cook Islands: only one coder who codes morbidity and mortality using ICD-9. ICD-10 to be implemented in 2000.

Vanuatu: morbidity data from five hospitals coded centrally in national statistical office, using ICD-9 for diagnoses and US ICD-9-CM for procedures. No mortality data is coded.

Fiji: morbidity currently coded in three general hospitals and three specialist hospitals using ICD-9; ICD-10-AM to be implemented in January 2000. Mortality coded by Ministry of Health also using ICD-9 but plans to use ICD-10-AM in 2000. Health Information Unit in the Ministry of Health is managed by Jo Ravono, who studied HIM at the University of Sydney.

American Samoa: because of ties with the USA, morbidity coding currently completed using ICD-9-CM by two coders at main hospital. Planning to use ICD-10-CM once it is approved for use by HCFA. Mortality data is also coded using ICD-9 by the hospital coders.

Samoa: networked health information system used to transfer data between five islands. Currently code hospital separations with ICD-10 and MBS-E utilising software from Prime Care. Mortality coding is done but unsure which classification is used.

Guam: another island which is a territory of the USA and therefore uses ICD-9-CM and the 3M Encoder for morbidity. Will implement ICD-10-CM in 2001. Mortality data is processed using ICD-9 by the Department of Public Health and Social Statistics.

Commonwealth of the Northern Mariana Islands: US version of ICD-9-CM used for morbidity, ICD-10 has recently been implemented for mortality.

Marshall Islands: patchy coding completed using ICD-9. Some contractors used to code diagnoses on an ad hoc basis.

Tuvalu: Morbidity data from nine island clinics forwarded to Princess Margaret Hospital on main island and coded using ICD-9. Mortality data also coded by hospital coder, Kilisimasi Setoga, who completed a short HIM course in Sydney.

Kiribati: Both morbidity and mortality data currently coded using ICD-9 by the Health Information Department, which is managed by loelu Tatapu (an HIM graduate from University of Sydney). ICD-10 to be implemented in January 2000.

Pulau: Three ICD-9-CM coders, two code morbidity at main hospital and one is located in Department of Public Health. Mortality coding is also undertaken but unsure whether ICD-9 or ICD-9-CM is utilised.

Federated States of Micronesia: four hospitals on four main islands in the group. Morbidity coding performed on site using ICD-9. Mortality coding performed centrally by Amato Elymore, who also studied in Sydney. ICD-10 to be implemented in January 2000 if new patient management software is ready.

Nauru: no coding currently undertaken at all. Health information procedures are being upgraded and consideration being given to need for coding for morbidity and mortality.

► **Sue Walker**
Associate Director, NCCH Brisbane



on the **ACBA** **audit trail**

Survey of Kit Purchasers

In January 1999 a survey was sent to hospitals which had purchased the ACBA kit prior to July 1998, but had not submitted audit results to NCCH. The aims of the survey were to identify:

- users who needed assistance with the implementation of the audit process
- plans for using ACBA
- usefulness of ACBA results
- need for education workshops

Despite a low response rate the respondents provided useful information to assist NCCH with the development of strategies to assist hospitals including an audit service and education workshops. Hospitals which had purchased the kit from July were not included as they would have had less opportunity to implement the audit process. The survey was not sent to hospitals who had submitted results of surveys to the NCCH Quality Division or to non-hospital purchasers (e.g. government departments).

Those hospitals which identified a need for assistance were contacted by NCCH Quality Division staff as the survey forms were received.

Responses to the survey are detailed below:

*1. If you **have** performed an ACBA audit, what were your reasons for not forwarding results to NCCH?*

Hospitals explained that they were waiting for a hospital or regional review of results before sending them to NCCH or that they had varied the methodology, so their results could not be used for external benchmarking. Two hospitals considered their first ACBA audit a 'trial' and indicated that they would submit results of future audits. Three hospitals chose not to submit their results.

*2. If you **have not** yet performed an ACBA audit, what are your plans to do one? When might you start?*

Nineteen respondents indicated that they planned to conduct an ACBA audit within the next year. Two hospitals had decided not to use

ACBA because they had a single clinical coder. One hospital indicated that they would like training before attempting to use the process.

3. Would you be interested in attending a workshop to learn more about ACBA?

66% of respondents were interested in an ACBA workshop. The remainder were either undecided except for 4 hospitals where a workshop wasn't necessary.

5. Would you like to speak with a Quality Division staff member about ACBA?

All positive respondents to this question have been contacted by a Quality Division staff member.

6. Other comments

Replies to this question included:

'I appreciate the efforts of NCCH in developing this tool and have set myself the goal of mastering it.'

'I am keen to collate our results (once the coder C makes the decisions) so we can see how we went. I will send the results to NCCH once collated.'

'I have purchased the ACBA tool, but as yet haven't had the time to start audit. Other facilities in my area have completed an audit using this tool.'

'This survey has been a good "reminder" for me to "get in and use" ACBA.'

'We are currently focusing on our EQUIP accreditation and preparing for ICD-10 so many projects are on hold at present.'

'Sound kit'

Thank you to the clinical coders and managers of health information services who took the time to provide feedback to the Quality Division by returning the survey. As a result of the survey ACBA users and potential users have been provided with individual support where this was requested.

▶ **Dianne Williamson**
Manager, NCCH Quality Division



educational matters

A summary of the results from the final instalment of the national ICD-10-AM educational strategy and future plans for clinical coder education...

Commencing on the 12th April 1999 in Brisbane the first of seventeen face-to-face ICD-10-AM education workshops were held throughout Queensland, South Australia, Western Australia and Tasmania. The final workshop concluded on the 11th June 1999 in Perth, with a total of just under 500 delegates participating across the four states.

The content of fifteen of the workshops was based upon those conducted in 1998, the remaining two workshops were a modified version adapted specifically for South Australian coders who had undertaken the HIMAA ICD-10-AM Intermediate Course.

A total of 70 participants attended the two one day Adelaide based sessions in May. The evaluation forms had a 85% return rate. The style of these workshops differed from others in that the morning session was lecture discussion format focussing on changes to the classification since July 1998 and the afternoon session was breakout group coding circles using de-identified medical records. Most participants appreciated the chance to network and discuss coding issues with their peers and felt that the session had been a reinforcement of information and provided clarification of 'grey' areas.

Overall, 61% of the participants rated the workshop as very good or excellent. The majority of participants thought the group coding circle sessions were very useful to hear the input and interpretation of coding problems from coders with a varied background, skill level and working environment. Many participants rated it as a good learning experience, however a few participants who were new to clinical coding did not feel that the groups were of use as their coding skill level was not sufficient to partake in this type of session. Many participants suggested that handout theory material could be sent to all delegates prior to attendance at the session and that more specific material was required for those coders

employed in speciality clinical fields such as mental health.

The remaining workshop evaluations gleaned a return rate of 90%, with 38% of participants rating the overall programme as a very good educational experience.

The predominate expectation of the workshop was to learn about the ICD-10-AM conventions, changes, practical applications and to gain a better knowledge of the classification. Some participants were disappointed that there was not more discussion from the interstate experience and felt that more complex coding scenarios would have been useful for exercises. Overall, most agreed that there was a good mix between instructional theory and practical exercises and that the course was informative and useful in building confidence in preparation for the classification introduction.

57% of participants noted that the ratio of lecture to discussion was very good to good, however 3% felt that it was poor. Many participants felt the sessions were well paced across the two days, although there were a few requests for both longer courses (4-5 days) and shorter courses (1/2 day). 67% of participants felt that the sessions were kept alive and interesting, and the use of two presenters broke up the sessions and added variety and interest. 76% of participants agreed that the major points were well identified and clarified, but some participants requested more examples and explanation of the classification logic. Again 76% of participants agreed that the scenario exercises helped to reinforce the changes to the classification. Many participants suggested that there could have been more exercises and that they could have been more complex and challenging. It becomes difficult when educating a huge range of people who are all sitting at varying skill and knowledge levels to ensure that the practical work is at a suitable level for all, but this is certainly something that will be looked at for future workshops.

Those participants who work as clinical coders in speciality fields suggested that the workshops may have been more effective for them had there been specific workshops just dealing with one clinical area. A few participants requested ►

the inclusion of anatomical pictures and clinical examples to illustrate the topics being discussed. Others suggested that the exercises could be completed by breaking into small groups which would aid in discussion.

Overall the majority of participants felt that the workshops were helpful and informative providing them with a basis to commence use of the classification in July. Many noted that they felt more confident about the implementation and would utilise the workbooks for future reference.

As there seems to be a common thread of suggestions and comments coming through from these evaluations and those from the last year and the Post Implementation Education sessions, the NCCH Education Services team will review all of these comments when the time comes to commence preparation of the educational sessions for the introduction of the second edition of ICD-10-AM.

A quick visit to Singapore was made in early September with Associate Professor Rosemary Roberts to undertake a seminar and workshops for staff of the Singapore Ministry of Health, Health Corporation of Singapore and selected staff from local health care facilities. A full report from this sojourn will be available in the next edition of the newsletter.

For the remainder of 1999, I will be undertaking a review of the NCCH Coding Educators Network (CEN) in preparation for their involvement in the 2000 2nd Edition Update workshops. All current CEN have been informed of the changes and for those interested in joining the network, please see the advertisement on this page.

Innovative and interesting ways to continue the education of clinical coders within Australia and overseas is high on the agenda as the circuit continues into the year 2000.

▶ **Karen Peasley**
Education Manager

Wanted CEN Agents for the **Coding Educators Network**

The NCCH Coding Educators Network (CEN) was born in late 1994 and has been a continuing force for the past five years. The network still has many original members. The NCCH will be reviewing the role of the network over the next few months and is commencing this review with a call for clinical coders to join the network. All current CEN members will need to reapply through the normal processes as mentioned below.

So what is the CEN and what would your responsibilities be?

The CEN is a pool of clinical coders and health information managers from all states and territories in Australia who assist the NCCH in the development of material and the presentation of coding education programmes. The CEN member also becomes a liaison point in each state and territory for issues related to coding education.

Although the education is principally directed towards clinical coders, there is also a need to focus on education for other health care personnel such as clinicians, researchers/epidemiologists, IT vendors and other users of coded data.

A CEN member requires a commitment to the continuing education of clinical coders and other health care professionals and to the ongoing work of the NCCH. As a member of the CEN you become the "face" of the NCCH when you are conducting educational sessions. The work of the CEN member traditionally takes place in the first six months of the year, when train-the-trainer sessions and educational workshops are held prior to implementation of a new edition of ICD-10-AM.

However, some members may be called upon at other times to assist in various projects. For those members who are able to undertake it, some programmes will require some regional and/or interstate travel.

Expressions of interest are invited from coders who have experience and skills in ICD-10-AM coding (preferably currently undertaking some coding on a regular basis) and ideally who have had some experience in conducting coder training programs. Your background may be as either a clinical coder or a health information manager.

Although you may be currently employed, this does not exclude you from applying as the NCCH can negotiate involvement with the network with your employer. Training sessions for CEN members is provided by the NCCH prior to field work. The two major skills required of a CEN member are presentation/education skills and coding. Therefore, acceptance onto the network will be contingent on a satisfactory performance assessment in both these skills. Salary will be negotiated and based upon qualifications and experience.

A duty statement is available on request.

If you are interested in applying to join the CEN, please forward a written application, together with a current curriculum vitae before Friday 22nd October 1999 to:

Karen Peasley
Education Manager

NCCH, PO Box 170, Lidcombe NSW 1825

Phone: (02) 9351 9461 Fax: (02) 9351 9648

Email: k.peasley@cchs.usyd.edu.au



coding services

I would like to thank those people who responded to the call for expressions of interest in working at the NCCH (*Coding Matters*, Volume 5, No. 4). That process was a successful one, and as a result I can introduce our two new coding services staff members, Allison Lawer and Francine Brownlow.

There are many projects associated with the development of the third and subsequent editions of ICD-10-AM. Therefore, we again welcome expressions of interest from HIMs and clinical coders in working on specific projects for coding services (*see page 18*).

Allison was reluctantly, but supportively released from Port Macquarie Base Hospital and Port Macquarie Private Hospitals where she has worked since completing the Bachelor of Applied Science (HIM) at The University of Sydney in 1997.

Allison began work at the NCCH on 15 June and has been thrown in at the deep end of second edition preparation and is still afloat and still smiling.



Francine (Fran) comes to us from Hurstville Community Co-operative Hospital and President Private Hospital, both in the southern suburbs of Sydney. Fran has a background in nursing, coding and managing a medical record department.

She completed a degree in Health Services

Management (Information) through Charles Sturt University in 1998 and was trained in coding through the Distance Education Program, Health Information Management Association of Australia. Fran is working with us for two days per week, and continuing her employment with Hurstville Community Co-operative Hospital.



Fran's baptism of fire has been in preparing some of the guidelines in this edition of *10-AM Commandments*.

I am very pleased to welcome them both to coding services.

Development of ICD-10-AM Second Edition

The changes for the second edition of ICD-10-AM are almost complete and the task of typesetting and proofing has begun. The typesetting process is being conducted 'in-house' for this edition, a move which will streamline the publication process and improve the effectiveness of the typesetting /proofing process.

For those interested in knowing what will change in the second edition, make sure you attend the NCCH Conference in Hobart this month, where I will describe the most important changes.

Development of ICD-10-AM Database

A core function of the NCCH since 1996 has been the development and implementation of ICD-10-AM. The creation and revision of *ICD-10-AM* has been extremely time consuming and labour intensive as all the changes have to be entered into, and edited in, word processed documents. The database will streamline the editing process and reduce transcription errors. The database will also provide a platform for the development of electronic coding products, electronic 'browsers' of ICD-10-AM and will allow more detailed investigation, manipulation and improved synchrony between the terms or concepts that are used in ICD-10-AM and those used by clinicians.

The project was completed at the end of August 1999. NCCH project staff and Essential Software contractors are busily trying to locate and iron out the bugs as the database is put into service. The database will be used in providing export scripts for the production of the ICD-10-AM second edition books.

► **Kerry Innes**
Associate Director

the 10-AM commandments

This regular section (previously 'Coding Tips') is intended to provide ongoing guidance to coders on commonly asked questions and aims to address those areas of coding which require immediate attention by coders. Any major changes in practice (such as change of principal diagnosis sequencing for certain conditions) which may affect the integrity of state and national morbidity data collections will be flagged and should be introduced from the July following publication. If you find that any advice published in this section significantly changes your current practice, you should not change practice until a suitable time in the collection year (January or July). You may feel it necessary in such circumstances to also seek advice from your state/territory health authority regarding a suitable date for implementation.

1. Transcatheter embolisation of blood vessels

The NCCH has received a number of queries relating to embolisation of arteries or veins (NCCH query ID 342, 375, 501, 564, 614, 798, 1013).

The advice given here supersedes the advice given in those queries.

Transcatheter embolisation of blood vessels is performed to therapeutically block or occlude blood vessels. This may be performed to arrest a haemorrhage, treat vascular anomalies such as arteriovenous malformations (AVM) or fistulas or to block blood supply to a tumour. Embolisation can also be performed as a precursor to surgery, such as excision of tumour or clipping of AVM, as embolisation reduces the risk of haemorrhage or infarct.

The technique involves the delivery of an agent or device through a small catheter and is generally performed in X-Ray departments or catheter laboratories. Many agents or devices can be used to occlude blood vessels:

- Sponges - gelatin (Gelfoam) or plastic (polyvinyl alcohol)
- Balloons
- Wire coils (steel or platinum with or without polyester strands)
- Ethanol
- Glue
- Silastic pellets

For transcatheter embolisation of a cerebral blood vessel assign:

90226-00 [694] *Embolisation of cerebral artery for arteriovenous malformation.*

90226-00 [694] can be assigned for cerebral artery embolisations performed for reasons other than arteriovenous malformation. Note that the 'code also when performed' note under code 90226-00 is not correct, this note should not be followed and an amendment will appear in the 2nd edition of ICD-10-AM.

For transcatheter embolisation of other blood vessels assign:

35321-00 [694] *Percutaneous surgical peripheral arterial catheterisation with administration of agents to occlude arteries, vein or arteriovenous fistula or to arrest haemorrhage*

35321-01 [694] *Open surgical peripheral arterial catheterisation with administration of agents to occlude arteries, vein or arteriovenous fistula or to arrest haemorrhage*

Note that the index entries under Embolisation – arteriovenous, artery; vein are not correct and will be amended for the 2nd edition of ICD-10-AM.

2. ERCP, endoscopic sphincterotomy, stenting of biliary tract and choledochoscopy

The NCCH has received a number of queries relating to endoscopic retrograde cholangiopancreatography (ERCP), sphincterotomies and stenting of biliary tract (NCCH query ID 368, 612, 613, 633, 634).

The advice given here supersedes the advice given in those queries.

The codes and instructional terms in blocks 958, 959, 960 and 963 relating to ERCP, sphincterotomy (with and without extraction of calculus), insertion and replacement of biliary stent and choledochoscopy have been reviewed by the Gastroenterology /Hepatobiliary CCCG and revised for the 2nd edition of ICD-10-AM. In the interim, please follow this advice.

ERCP + Sphincterotomy

When **ERCP** is performed in conjunction **with a sphincterotomy** (with or without extraction of calculus) assign:

30485-00 [963] *Endoscopic sphincterotomy or*

30485-01 [963] *Endoscopic sphincterotomy with extraction of calculus from common bile duct.*

ERCP + insertion of biliary stent

When an **ERCP** is performed in conjunction with **insertion of a stent** into the biliary tract, assign:

30491-00 [958] *Endoscopic stenting of biliary tract.*

ERCP + replacement of biliary stent

When an **ERCP** is performed in conjunction with **replacement of biliary stent**, assign:

30451-00 [960] *Replacement of biliary drainage tube*

and

30484-00 [957] *Endoscopic retrograde cholangiopancreatography [ERCP].*

ERCP + sphincterotomy + stenting

When an **ERCP** is performed in conjunction with a **sphincterotomy** (with or without extraction of calculus) and **insertion or replacement of a biliary stent**, assign:

30485-00 [963] *Endoscopic sphincterotomy*

or

30485-01 [963] *Endoscopic sphincterotomy with extraction of calculus from common bile duct*

and

30491-00 [958] *Endoscopic stenting of biliary tract*

or

30451-00 [960] *Replacement of biliary drainage tube*

The term 'endoscopic' in these code titles above is indicative of an ERCP.

Choledochoscopy

There are three ICD-10-AM codes relating to interventions performed with a choledochoscope:

30452-01 [958] *Choledochoscopy with passage of stent*

30452-02 [959] *Choledochoscopy with removal of calculus*

30452-00 [971] *Choledochoscopy with balloon dilation of stricture*

A choledochoscope is a very small calibre endoscope introduced through the channel of the larger duodenoscope. Choledochoscopy can be performed in conjunction with open procedures, laparoscopic procedures or endoscopic procedures. The procedure is performed in a handful of centres in each State.

3. Arthroscopic chondroplasty of the ankle

A new code has been introduced for arthroscopic chondroplasty of the ankle in the second edition of ICD-10-AM. In the interim, assign:

90599-00 [1544] *Other repair of ankle*

and

49700-00 [1529] *Arthroscopy of ankle* ▶

4. Vascular access for drug delivery

The terms related to methods of giving drugs to patients via a vascular route are varied, and include:

- Vascular access device (VAD)
- Drug delivery device
- Central venous catheter (CVC)
- Central line
- Hickman catheter
- PICC (peripherally inserted central catheter)
- Port-A-Cath
- Infus-A-Port
- Reservoir
- Implantable pump
- External pump

This guideline is provided to assist in understanding the broad principles of these procedures:

- Catheterisation
- External or implanted device
- Pump

Catheterisation

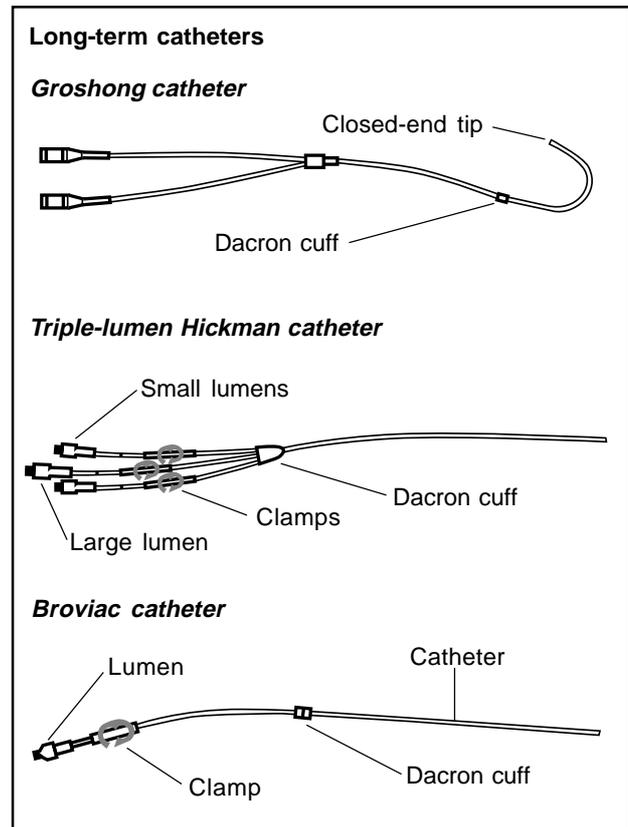
For long-term drug delivery catheterisation is usually **central**, as opposed to the more routine **peripheral** catheterisation for short term drug delivery (commonly documented as 'IV').

Central catheterisation will often be documented as a 'central line' or 'CVC' (central venous catheter). Insertion of a central line is a highly skilled procedure usually performed in intensive care or the operating theatre. The catheter is

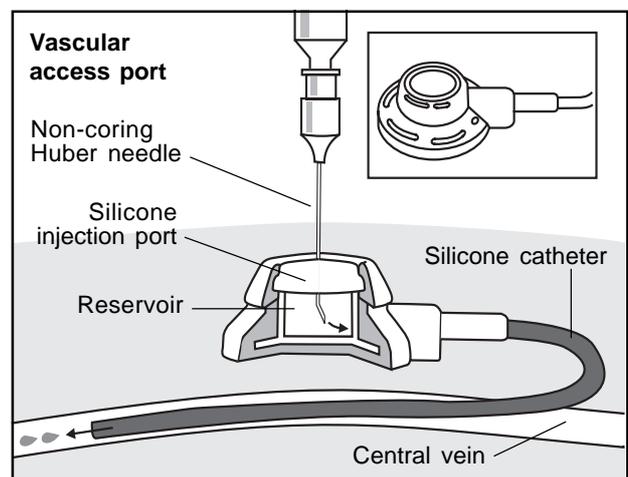
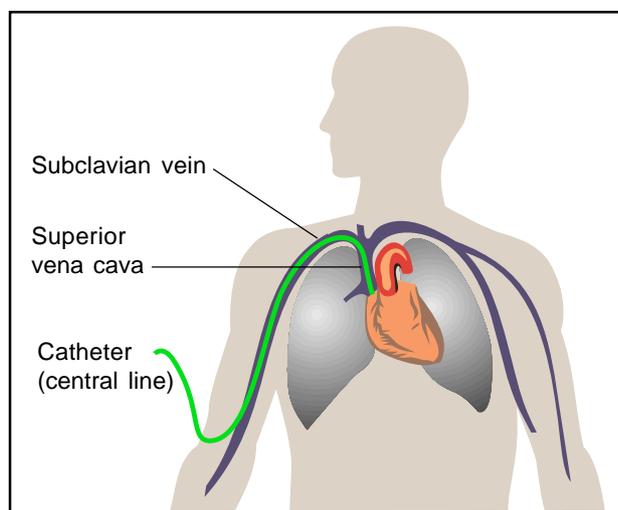
inserted into a vein and the tip of the catheter is guided through the vein until it rests in the right atrium of the heart, the inferior vena cava or the superior vena cava.

The device

External devices allow delivery of the drug through the end of the catheter which remains **outside the body**.



Implantable devices are where the drug is delivered to a small chamber (**port** or **reservoir**) implanted **under the skin**, which in turn is connected to the end of the catheter e.g. Port-A-Cath, Infus-A-Port



The pump

A computerised pump delivers a drug in a prescribed dose and rate. The pump may be:

External attached **outside the body** to the end of the catheter e.g. continuous ambulatory drug delivery (CADD)

Implant inserted **under the skin** (a combined pump and reservoir)

Classification

Code central catheterisation (blocks 694 *Arterial catheterisation*, 738 *Procedures for venous access* and 766 *Other procedures for vascular access*) **except:**

when associated with insertion of **implantable** device – code only the device insertion as the catheterisation is included in the device code.

Code attachment of an external pump (13942-00 [1783] *Loading and maintenance of ambulatory drug delivery device*) **except:**

when associated with insertion of **implantable** device – code only the device insertion as the attachment of an external pump is included in the device code.

Code loading of a drug/s into a device, (block 1783 *Loading of chemotherapy devices*) **except:**

when performed in conjunction with insertion of the device or attachment of a pump – code the insertion of the device or attachment of the pump only

Code maintenance (flushing) of the catheter, device or pump only when the patient is admitted for this procedure:

92058-00 [1858] *Irrigation of vascular catheter*

13942-00 [1783] *Loading and maintenance of ambulatory drug delivery device*

13939-00 [1783] *Loading and maintenance of implantable infusion pump or reservoir*

Don't code chemotherapy (block 1781 *Intravenous chemotherapy*) as well as loading:

loading of a device = administration of chemotherapy

5. Balloon thermo-ablation of endometrium

Endometrial ablation has been the treatment of choice since the late eighties for some women with heavy periods or post-menopausal women on hormone replacement therapy. The latest advance in endometrial ablation is called balloon thermo-ablation or thermal uterine balloon ablation. The basal layer of the endometrium is destroyed by heating, thus preventing the endometrium from regenerating during the next cycle, eventually bringing menses to a halt.

The hysteroscope, with a camera attached, is passed into the uterine cavity, giving the surgeon full view. A latex balloon attached to a catheter is inserted vaginally through the cervix and placed into the uterus and inflated with fluid. The fluid is then heated to 87° for 8 minutes, causing destruction of the endometrium.

For balloon thermo-ablation, assign:

35622-00 [1263] *Endoscopic endometrial ablation*

6. Chemotherapy

Following on from the article in *Coding Matters*, Volume 5, No. 4 it is important that the flow chart included in that article is **not interpreted as applying to every same day patient receiving any drug treatment**. Even though the word 'chemotherapy' technically means any drug treatment, in clinical use it is most often used for antineoplastic or cytotoxic treatment. The principle intention of the flow chart was to assist in coding the procedures in cases where there is documentation of 'chemotherapy'.

If 'chemotherapy' is not documented, the flow chart does not apply (*see ACS 0001 Principal diagnosis*).

Example 1

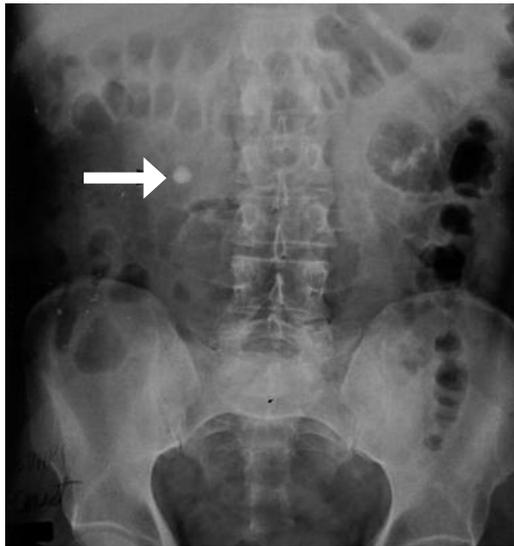
Diagnosis: Same day admission for methotrexate injection for ectopic pregnancy

Codes:

O00.9 *Ectopic pregnancy, unspecified*

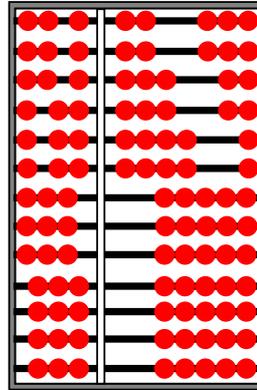
35677-03 [1256] *Fetotoxic management for removal of ectopic pregnancy*

In this example, Z51.2 is not assigned because 'chemotherapy' is not documented (even though methotrexate is a cytotoxic drug). ►



Did you know?

The word 'calculate' is from the latin 'calculi' meaning 'pebbles'. In the abacus the round balls were called 'calculi' – to count the calculi = 'calculate'.



The moral of the story:

Don't forget to calculate your calculi!

36540-00 [1043]
Nephrolithotomy with removal ≤ 2 calculi

35643-00 [1043]
Nephrolithotomy with removal of ≥ 3 calculi

Example 2

Diagnosis: Paget's disease of the hip, non malignant, for same day intravenous chemotherapy (methotrexate).

Codes:

Z51.2 *Other chemotherapy*

M88.95 *Paget's disease of the hip*

Code from block 1781 *Intravenous chemotherapy*

In this example, Z51.2 is assigned because 'chemotherapy' is documented.

► **Kerry Innes**
Associate Director

**calling all
coders**

NCCH is seeking a project officer (HIM/clinical coder) for Coding Services to assist with work on ICD-10-AM development, coding queries and term mapping. This work will involve use of the ICD-10-AM database. Please contact Kerry Innes on 02 9351 9461.

Now Available

Latest in the Casemix, DRG and clinical coding book series

Mental Health, Drugs and Alcohol

See order form distributed with *Coding Matters* or call 02 9351 9461 for further information about this book or other titles in the series.



quality concerns

PICQ put through its paces

La Trobe University HIM third-year student Anthea James did her practical placement at the Victorian Department of Human Services this year. As her main project, Anthea James ran a number of indicators from the Performance Indicators for Coding Quality (PICQ) collection against data in the Victorian Department of Human Services admitted patient collection. These separations were coded in ICD-10-AM. The database at that time contained about three-quarters of the year's data.

For this test, indicators were selected if they had been graded by NCCH as 'high priority' (meaning they were of *general* relevance), their definition was complete (that is, all codes were specified), and they did not refer to problems already prevented by Victorian editing.

Because this testing was done before the conversion of PICQ indicators into a computer language, Anthea programmed them using SAS, which was a very tedious process. However, when the PICQ product is available for sale, the user will merely select the relevant indicators by number.

After her initial analysis, Anthea documented the results for each indicator and presented them to a meeting of the Victorian Coding Committee. Members provided valuable comments on indicators to assist in refining the definitions. For example, one indicator tested for the presence of codes for both forceps and caesarean section *without* a diagnosis code for failed forceps.

The Coding Committee pointed out that, in the case of twins, one could be a forceps delivery and the other a caesarean delivery without trying forceps. In this way, the indicator definition was revised by defining it as applying only to *single* deliveries. All these enhancements have been incorporated into the PICQ database.

Many of the indicators showed the Victorian data to be very 'clean' which was pleasing for the Department and a credit to Victorian clinical coders. Where indicators did identify a number of problem records, analysis was then made by month of separation date to test whether

performance improved as coders became familiar with ICD-10-AM. This was not the case: the rate either fluctuated or remained fairly constant month by month. There were no gradual falls.

The next stage for Victoria is to analyse results by hospital. If problem records are concentrated in a few hospitals, lists of Unit Record Numbers could be sent to those hospitals. If problem records occur across the State, information could be published in the Victorian Coding Newsletter. The Department will also provide the results to NCCH. The indicators finding problem records may identify areas requiring some action (such as further education, clarification of a standard, or a new standard).

The test has confirmed the value of PICQ at the central data collection level.

Anthea James has become so involved with the PICQ project that she has continued the work after her practical placement ended, visiting the Department and the NCCH office at La Trobe University to refine and rerun indicators and perform further analyses. The Department and NCCH thank Anthea for her huge contribution to the development of PICQ.

Would you like to see some of these intriguing PICQs? At the NCCH conference in Hobart, visit the demonstration of the prototype! And watch out for an announcement of the launch of first edition of PICQ early next new year.

Nurturing new Clinical Coders

Reproduced, with permission, from the Victorian ICD Coding Newsletter, April 1998.

For any clinical coder, starting a new job is an exciting challenge. For the new graduate, it may also be a daunting challenge. For the hospital, there is also a challenge: how to enable the new employee to achieve their maximum capacity, particularly if the new employee is also a new graduate.

1. If the new coder is a new graduate, bear this in mind. There is much more for them to learn during their career. Don't have unrealistic expectations. ►

2. Conduct an orientation session to coding at your hospital:
 - Provide a copy of any notes on special aspects in coding at your hospital. Keep these in a display book with clear plastic pockets with space for future expansion. Over time this becomes an important reference tool for the coder.
 - Point out where to find all the reference resources.
 - Explain all additional elements of coding, for example, ICU and Mechanical Ventilation hours, Intention to Readmit (if entered by coders at your hospital), Birth Weight, and so on, as they relate to your software.
3. Go through a few records, discussing arrangement of the various sheets and where specific items of information can be found.
4. Maintain a coders' reference collection of useful journal articles and such material on any clinical specialty of your hospital. If appropriate, annotate the articles with relevant code numbers.
5. Make sure there are adequate reference resources for coders:
 - Complete set of current coding books
 - Medical dictionaries
 - MIMS
 - Collection of *Coding Matters*
 - Collection of Victorian *ICD Coding Newsletter*
 - Leaflets describing certain diseases/procedures
6. Start the new coder on a single (relatively uncomplicated) clinical specialty, selecting the records by doctor/surgeon. When the coder achieves competency in this specialty, add another, and so on until the coder can code the full range of cases. *However*, you need to ensure your other coders are not overloaded with difficult cases.
7. For each new specialty assigned to the new coder, show where specialised information can be found.
8. Review the new coder's work and discuss any discrepancies, pointing out the supporting documentation for *your* codes, such as the relevant Australian Coding Standard.
9. Do not give a new coder records of patients who have been in ICU as these are likely to be complex cases.

10. Select complex cases which have already been coded, review the coding and then discuss with the new coder.
11. Conduct internal coding workshops where all coders code a set of records and discuss the results.
12. When the new coder is gaining confidence and with appropriate guidance, involve them in related activities:
 - Coding meetings
 - Casemix discussions
 - Clinical meetings
 - Data quality, coding audits

Development of the revised Code of Ethics for Clinical Coders

A professional code of ethics aims to provide guidance on 'right' or 'good' conduct, in accordance with accepted principles of right and wrong, to members of a specific professional group. Clinical coders are increasingly accountable for the accuracy and timeliness of their output because of the multiple users of coded data and an increasing number of stakeholders (Robinson et al, 1998).

The need for ethical guidance is embodied in the *Clinical Coder Competency Standards* which specify that clinical coders 'Employ ethical conduct in coding practice' (*HIMAA* page 18, 1996). Discussions with clinical coders have indicated the usefulness of a code of ethics to support their decision making and discussions with stakeholders.

In 1998 the NCCH Quality Division, in conjunction with health information management staff of La Trobe University, commenced the process of reviewing current codes of ethics for clinical coders and the ethical issues with which clinical coders were involved. A wide range of codes was reviewed, but those of specific relevance were:

- *Australian standards for ethical coding* – National Centre for Classification in Health
- *Code of ethics and practice standards* – Clinical Coders' Society of Australia
- *Code of Ethics* – Health Information Management Association of Australia
- *Standards for ethical coding* – American Health Information Management Association

The review process has also included: twelve focus groups in which approximately 140 clinical coders and health information managers from a wide variety of workplaces were involved; a

detailed questionnaire which was completed by a national sample of clinical coders; and a literature search. Members of the Coding Standards Advisory Committee, representing stakeholders and clinical coders provided comments on the final drafts of the new code.

The revised *Code of Ethics for Clinical Coders* has now been finalised. The Code focuses on behavioural statements specific to clinical coders. General statements which may relate to members of any professional group (e.g. 'serve your employer loyally') have been excluded. Procedural directions which are included in the *Australian Coding Standards* have not been duplicated in the Code.

The Code will be available for purchase as a laminated wall poster. A detailed report on the national survey is being prepared for publication later this year. The Quality Division is indebted to all those who have participated in the review process.

► **Dianne Williamson**

Manager, NCCH Quality Division

American Health Information Management Association. Standards for clinical coding. At www.ahima.org/professional.support/guidelines/standards.html

Clinical Coders' Society of Australia. (1996). Code of ethics and practice standards. Sydney: CCSA.

Health Information Management Association of Australia. (1996) Clinical coder competency standards and assessment guide. Sydney: HIMAA.

Health Information Management Association of Australia. (1989). Code of ethics. Sydney: HIMAA.

National Centre for Classification in Health. (1998). Australian standards for ethical coding. In International statistical classification of diseases and health related problems – 10th revision – Australian modification. Vol. 5. Sydney: NCCH.

Williamson D. et al (1998) To code or not to code: Is that the question? NCCH Conference.

Robinson K. et al. (1998). Coding practice: What are the ethical issues? In Proceedings 19th National conference of the HIMAA. Sydney: HIMAA.

WANTED!! CEN International!

NCCH Brisbane is interested in hearing from Australian coders who would like to be part of our international training activities. Given that the Brisbane office is relatively small in terms of staff numbers, we would like to be able to call on the skills and knowledge of other coders and educators to help us out with ICD-10 and other training courses on an ad hoc basis.

We are looking for people with the following characteristics:

- Knowledge of ICD-10
(*Note: this may manifest as recent hands on experience with ICD-10-AM*) and its use for morbidity and mortality coding
- Ability to develop and conduct training courses for students whose first language may not be English
- Availability to conduct courses overseas for periods of 2-3 weeks at a time
- Previous experience in training activities
- Reliability, resourcefulness and open-mindedness
- Interest in international work, particularly for WHO and other aid agencies.

As with the 'domestic' CEN members, we will provide additional training as required, although this is likely to be less frequent than regular CEN ICD-10-AM training. As NCCH is approached to conduct international courses, we will consider the expressions of interest we have received and negotiate with prospective educators regarding timing, terms and conditions of employment and release from current duties (if applicable).

Please submit expressions of interest, including current CV, to:

**Sue Walker, NCCH Brisbane,
School of Public Health, QUT,
Victoria Park Road, Kelvin Grove Q 4059.**

Feel free to call if you have questions
– 07 3864 5873 – or email s.walker@qut.edu.au

Remember – it is possible to be a member of BOTH the regular CEN AND CEN International!



publication issues

Welcome to the NCCH Conference edition of *Coding Matters*! I'm looking forward to meeting some of our *Coding Matters* audience at the conference. Please feel free to discuss the newsletter and other publications with me in Hobart.

Publications and Technology Division is now entering the most intense phase of our publication year. The second edition of ICD-10-AM is our prime focus at present until it is published and distributed in January next year.

How did you go with Donna's crossword? Answers for Truran's Teaser No.1 are on the next page. Hopefully this will have prepared you for Truran's Teaser No.2! Donna assures me that she was being gentle with you with her first teaser, now the gloves are off.

ICD-10-AM Second Edition

Publications and Technology Division is currently working with Coding Services to prepare the second edition of ICD-10-AM. As mentioned earlier in this issue, Elizabeth Azel has joined us to help in typesetting the new volumes. Her expertise in using QuarkXpress is being put to good use.

Typesetting in-house also means that we can be more responsive to corrections and additions. Ultimately, this means that the books will have a higher rate of accuracy – a benefit that will be appreciated by all users of the classification.

Coding Matters via email

As mentioned in the last issue, *Coding Matters* is now available by email. Response is steadily increasing to receive it directly. Comments from our email readers have been very positive.

Readers who now receive it in this format have acknowledged the benefits. These include receiving it up to two weeks earlier than the printed version, colour and direct, personal delivery.

If you would like to receive *Coding Matters* by email please send your email details to Chantel Garrett: C.Garrett@cchs.usyd.edu.au

AR-DRG Version 4.1

The Australian Refined Diagnosis Related Groups Version 4.1, Definitions Manual (AR-DRG v4.1) is now available from the NCCH. AR-DRG v4.1 is Australia's first DRG classification to use ICD-10-AM rather than ICD-9-CM codes. It consists of three hard copy volumes and a CD-ROM. See the order form distributed with *Coding Matters* for more details.

Hot off the press!

Mental Health, Drugs and Alcohol, the latest in the specialty book series of *Casemix, DRG and clinical coding*, is now available.

The *Casemix, DRG's and clinical coding* books provide a valuable resource in understanding of coding in the casemix environment.

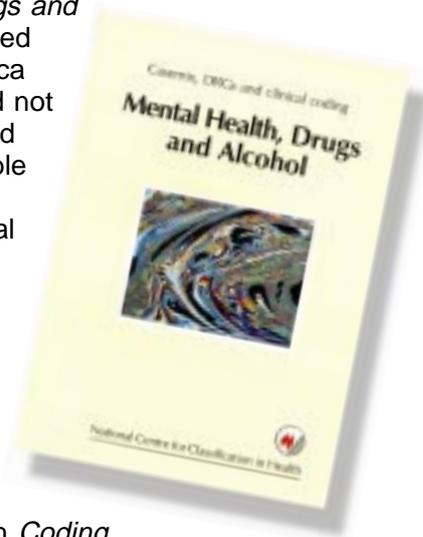
Mental Health, Drugs and Alcohol was produced and edited by Monica Komaravalli. It could not have been produced without the invaluable assistance of clinicians and clinical coders who supply the specialist input required.

Copies of *Mental Health, Drugs and Alcohol* can be purchased by using the order form distributed with *Coding Matters*.

Copies will be also available for sale at the NCCH Conference in Hobart.

The next book in the series *Neurology and Neurosurgery* will be available soon followed closely by *Gastroenterology/Hepatobiliary and Ear, Nose, Mouth and Throat*.

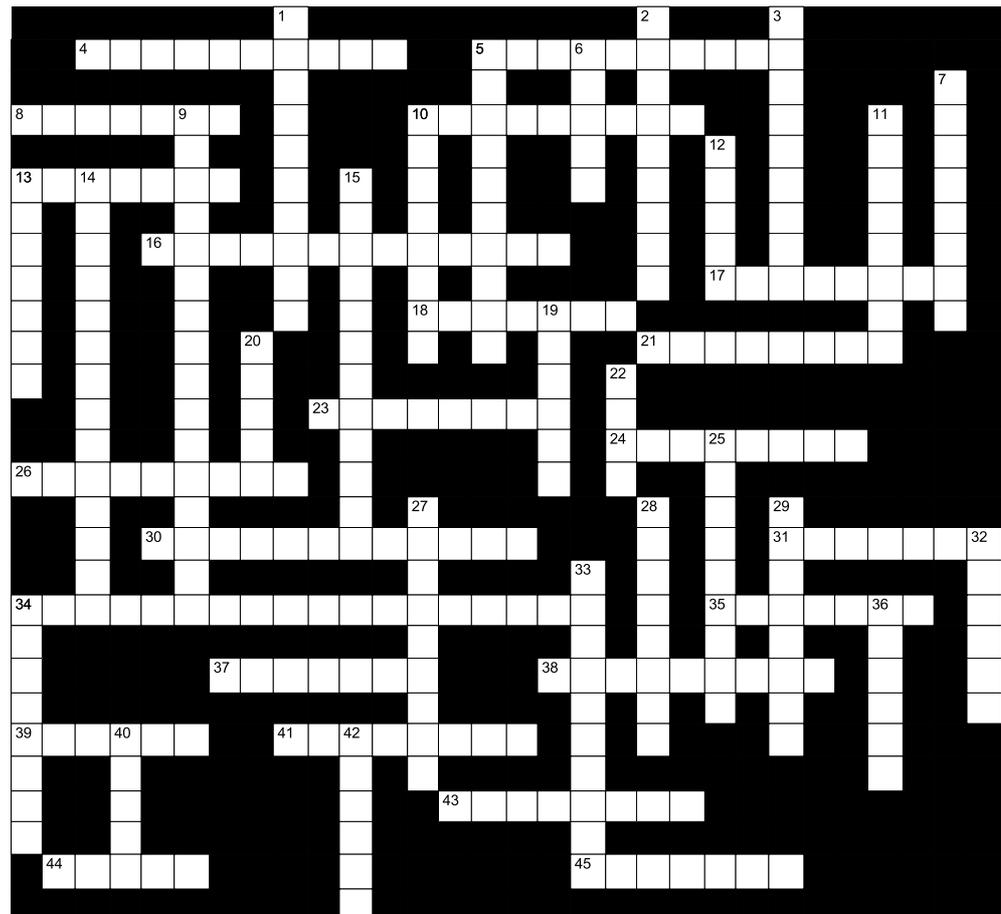
▶ **Rodney Bernard**
Publications and Technology Manager



Truran's Teaser No.2

ACROSS

4. delusions of personal beauty
5. body build or physique
8. having a tail
10. pertaining to both eyes
13. defective language function
16. barbiturate anticonvulsive, sedative hypnotic
17. a knot-like mass
18. one form of eating disorder, ___ nervosa
21. substance that has a calming effect
23. pertaining to tears
24. branch of medicine studying malignancy
26. condition of being distorted, flawed, malformed
30. brain inflammation
31. pertaining to the liver
34. inability to make quick, finely co-ordinated motor movements
35. contact point between two neurons
37. unable to produce normal speech sounds
38. curvature of the spine
39. produce vomiting
41. ringing in the ears
43. inflammation of mucous membranes of the nose
44. fourth letter of the Greek alphabet
45. pertaining to disease caused by fungus



DOWN

1. progressive, degenerative neurological disorder with tremor
2. chemical element, symbol K
3. female hormone
5. fusion of fingers or toes
6. mature, fully grown
7. directed away from the centre
9. hair removal, the hard way
10. cyanosis
11. branching that extends from the cell body of neuron

12. growing old
13. impairment in ability to manipulate objects
14. horny, scaly skin condition of newborn
15. slowness of the heart
19. he has a hierarchy of needs
20. one type of patient record
22. extension of nerve cell that conducts impulses away from neuron body
25. persistent preoccupation with a thought
27. cardiac glycoside
28. bronchodilator, albuterol
29. making cognitive effort
32. tooth decay
33. self love
34. substance promoting to production of urine
36. vocal communication
40. on anti-cancer drug, from the bark of the Yew tree
42. nerve cell

Solution to Truran's Teaser No.1

Across – 1.Chorea, 3. Biopsy, 7. Chignon, 8. Wound, 8. Fascioplasty, 9. Injury, 11. Thrombectomy, 12. Vomiting, 14. Ventilation, 17. Drug, 18. Asphyxia, 20. Node, 24. Lymphoma, 27. Neurosis, 29. Stab, 31. Fentons procedure, 32. Xenopi, 33. Induction, 36. Thyroiditis, 38. Laparotomy, 39. Melanoma.

Down – 2. Excision, 4. Sunburn, 5. Gout, 8. Fetal blood loss, 10. Traction, 13. Conjunctivitis, 15. Hypogonadism, 16. Neoplasm, 19. Accident, 21. Diabetes, 22. Illiteracy, 23. Cholecystitis, 25. Aspiration, 26. Osteotomy, 28. Resection, 30. Cryoablation, 34. Ultrasound, 35. Syndrome, 37. Graft.

*The solution to the crossword will be printed next issue.
For those who cannot wait they can be found on our website.
Crossword created by Donna Truran.*

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