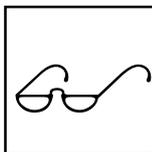




# Coding Matters

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

Volume 4 Number 1  
July 1997



## FROM THE DESK OF THE DIRECTOR

### **A budgetary first for medical records**

In a career spanning 35 or so years I've never known the words "patient records" or "medical records" to appear in the Australian federal Budget! To my surprise, the 1997-98 Budget includes a section on Information Technology (IT) under "Acute Health Care Initiatives to Stimulate Reform" which will establish "national standards and specifications for electronic formats for patient records and for electronic links between health service providers". It goes on to talk about the use of information technology to "integrate medical records, clinical decision support systems and provider links". As well, a section on Health Performance Information provides funding to refine indicators of hospital performance and treatment. The \$40 million over four years attached to these initiatives indicates the importance of health information and health records in our health care system.

Clinical coders should be aware of this groundbreaking recognition of the role of the patient record as the corner stone of health information systems. Not only should we watch with interest the developments which this financial support will foster, but participate in projects contributing to electronic patient record development and exchange of information through clinical codes.

### **ICD-10-AM IT workshops**

Another sign of the need for electronic systems to be at the forefront of our thinking was our meeting with IT colleagues at the first in the series of ICD-10-AM workshops. The meeting was very well attended, with evaluations indicating its success and warm response from participants to this sort of exposure. So much so that a second workshop was requested, and will be incorporated into the National Centre for Classification in Health (NCCH) Conference in Adelaide in November 1997.

In the private sector, the Australian Private Hospitals Association (APHA) "Caring with Skill" pre-conference IT workshop held on 16 April 1997 in Sydney included a

paper on ICD-10 implementation presented on behalf of the NCCH by Shahn Campbell, now back in Victoria following her secondment to the NCCH at the end of 1996.

### **ICD-10 Education program**

The ICD-10 Education Program is steaming ahead with the second Train-the-Trainer now being completed with 28 new members of the Coding Educators Network bringing the total to 50 around Australia. Congratulations to all those trainers who participated in those workshops to spread or receive the word.

The ICD-10 Education Working Party has met again (27 May) and continues to steer the education program in conjunction with the Coding Standards Advisory Committee (CSAC) and the National Committee for Implementation of ICD-10 in Australian Hospitals.

The NCCH has been asked by the National Committee to manage the Dual Coding Study aspect of the ICD-10-AM Impact Assessment. As I write, we are trying to come to terms with the enormity of this task, which is to be completed in August 1997 for reporting to the Australian Health Ministers' Advisory Council (AHMAC). ▶

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A sub-committee (!) of the ICD-10 Implementation Committee has been formed to steer the Dual Coding Study. Its aims are to:

1. Assess the impact on resource levels by measuring the time taken to code in ICD-9-CM and ICD-10-AM and identify factors which contribute to any difference in time.
2. Provide an indicative analysis of the concordance between ICD-9-CM and ICD-10-AM.
3. Provide information to assist in the assessment of the wider impact of the classification change (e.g. mapping, grouping, funding, population data).

## Executive and management meetings

The NCCH Executive held its second meeting and NCCH Management Advisory Committee its first meeting in Canberra on 5 May 1997. Both committees are chaired by Professor Brian Oldenburg from the Queensland University of Technology (QUT).

Of particular interest was the discussion of electronic coding systems which has resulted in a draft strategy paper prepared by Dr Erich Schulz (NCCH Research Fellow) of our Brisbane office. This paper is currently being examined by the two committees. Erich provides a new dimension to our profile, not only in gender balance but with his skills in medical informatics and electronic classification systems.

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*Because of the interest in ICD-10, NCCH is proposing ... that a workshop be held in Australia early in 1998 for all countries of the Western Pacific*

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Another issue on the Executive and Management Advisory Agendas was the NCCH plan of activities in the Western Pacific. You may know that Sue Walker (NCCH Associate Director, Brisbane) has recently spent three weeks in Thailand training trainers in ICD-10. Other initiatives in the Philippines, Malaysia, Hong Kong, China and Indonesia involve the NCCH, QUT and the School of Health Information Management (HIM), University of Sydney.

Because of the surge of interest in ICD-10, the NCCH is proposing to the World Health Organization (WHO) that a workshop be held in Australia early in 1998 for all countries of the Western Pacific, so that we can rationalise our resources and allow time for our own education programs as well.

## Committee representation

The NCCH is now represented by a Coding Advisor on the newly constituted Australian Casemix Clinical Committee (ACCC) which held its first meeting on 10 June 1997. An Acute Care Sub-committee will also have an NCCH member (Kerry Innes – Associate Director, Sydney). The NCCH has nominated Sue Walker as its new representative on the National Health Data Committee.

Another “new look” committee involving the NCCH is the Casemix Information & Development Exchange Meeting (CIDEX) (formerly the Casemix Applications and Development Advisory Committee and before that the Technical Reference Group!). CIDEX provides a forum for “exchange” on casemix matters between the states and commonwealth, the private sector, ACCC and NCCH.

## National allied health project

The National Allied Health Reference Standards Project has delivered its final report to the Department of Health & Family Services (DHFS). NCCH has been closely involved with this project and with the allied health professions in developing the allied health intervention codes. The next phase will be to develop

## Coding Matters



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“Indications for Intervention” for allied health. NCCH will tie in these initiatives with the Functional Coding Forum held on 17 July 1997.

### Medicare Benefits Schedule

A report to the Medicare Schedule Review Board on the feasibility of mapping between the Australian Medicare Benefits Schedule and the American Current Procedural Terminology was submitted by NCCH in March 1997. As a result, the NCCH has been asked to be responsible for project management of a 12 month study to determine resource based relative values for professional work relating to items in the Medicare Benefits Schedule.

This project commenced early in July 1997 with Lauren Jones as Project Manager and involvement of expert coders from the feasibility study including Joy Smith (Queensland), Jenny Shephard, Andrea Groom and Paula Hallang (Victoria).

### Coding Services developments

The Coding Standards Advisory Committee has been a great support with further input to ICD-10-AM, especially with the Australian Coding Standards which are the current focus of attention for Coding Services.

Also, from July 1997, Michelle Bramley (NCCH Senior Classification Officer) is to be seconded to NSW Health for 12 months to assist with development of code sets for “Issue” and “Activity” for the Community Health Information Model. Kerry Innes will also be involved in this project for one day a week.

For the NCCH, it represents an opportunity to branch out from our concentration on inpatient classification systems to those appropriate for ambulatory settings.

### Visiting statisticians

With the merger between NCCH Sydney and Brisbane, relationships with the Australian Bureau of Statistics (ABS) are becoming closer. Sydney NCCH had a visit from John Alexander and David Jayne from ABS Brisbane at the end of May, so that we could better understand the interrelationship between coding for morbidity and mortality and the application of logic in the multiple cause of death coding now being used by the ABS.



**Dr Erich Schulz**  
Research Fellow – NCCH Brisbane

– see Erich’s biography on p4

### Continuing quality

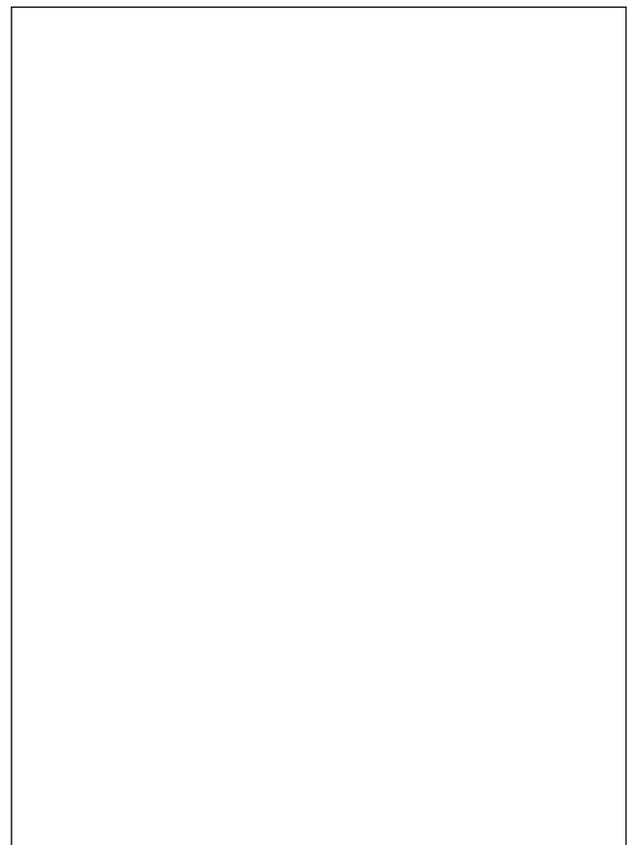
Adverse events are still in the news, and I was invited to speak on Clinical Coding and Quality Measurement at a Performance Indicators and Measurement of Quality Seminar held on the 19 June 1997 in Adelaide by the Hospitals and Health Services Association of South Australia and Department of Health and Family Services.

Lauren Jones has completed work on the pilot testing of Obstetrics & Gynaecology clinical indicators and ICD-9-CM and ICD-10-AM code translation of Australian Council on Healthcare Standards (ACHS) clinical indicators. Lauren has also compiled the results of the pilot testing of the Australian Coding Benchmark Audit which we plan to publish in the future in summary form with the *Australian Coding Standards* and as a separate NCCH product with details of method and data collection procedures.

An advertisement has been placed for our Quality Manager position, which we are hoping to fill in the near future either at NCCH Sydney or Brisbane or by subcontracting to an individual or organisation such as a state or territory health authority or university.

So, life has never been so busy! The ICD-10-AM building blocks are falling into place. We also have a new catch phrase to use with all our ICD-10-AM products including education programs: “*Towards the Perfect 10: ICD-10-AM*” (see page 16). Until next issue!

❖ **Rosemary Roberts**  
Director





## VITAL SIGNS

### Automated Cause of Death Coding

For all death registered from 1 January 1997, the Australian Bureau of Statistics (ABS) has been routinely classifying multiple causes of death. The adoption of multiple causes of death coding follows recognition of the need to capture information from the complete death certificate. Previously, the approach has been to only code the underlying cause of death (manually), which resulted in loss of information regarding intervening causes and some contributory causes of death. Coding of both the underlying cause and multiple causes has been made possible by the introduction of an automated coding system.

In the United States, the National Centre for Health Statistics (NCHS) has been developing a system of Automated Cause of Death (ACOD) coding over the past five to six years. The ABS has been given copies of parts of the system during this development process for evaluation purposes. The NCHS released the fully automated version two years ago. Once this fully developed system was received in Australia, the ABS began making adjustments to the system for Australian conditions. The system is now at the stage where processing of 1997 data is possible.

ACOD consists of four components, SuperMICAR, MICAR, ACME and TRANSAX. Each component assists in achieving the ultimate goal of assigning an underlying cause of death and coding all other conditions recorded on the certificate (multiple causes of death).

SuperMICAR is basically a text searching application. It is software which takes the "cause" text and splits it into separate causes ignoring noise words, such as "terminal" and "life threatening". Each cause is then analysed and a unique numeric code, an Entity Reference Number (ERN), is assigned for each accepted cause of death term. The ERNs represent a much more detailed classification than the various versions of the ICD.

The design of this system enables a smoother transition between versions of the ICD, as well as providing the opportunity of producing data for two versions of the ICD for the same year without repeating the SuperMICAR process. This will be particularly useful when ICD-10 is implemented for mortality coding in 1999 as differences in classification of diseases in the 9th revision compared with the 10th revision will be able to be quantified and analysed.

MICAR performs editing and validation functions by accessing logic rules, which are held in look-up files, together with its dictionary. These edits are applied to the ERNs assigned during the SuperMICAR process, to produce ICD codes.

ACME uses a number of look-up tables to allocate underlying cause codes appropriately. ACME makes implicit any linkages between multiple causes in assigning ICD codes for underlying cause. WHO has specific coding rules for identifying 'sequences' or causal relationships specified on a death certificate.

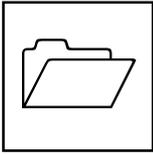
TRANSAX identifies the relationship between conditions mentioned on the death certificate, allowing a single ICD combination code to be assigned for any diseases which have a common aetiology.

The ACOD system provides several significant benefits for cause of death data. Firstly, the assignment of codes to all conditions recorded on the certificate, not just the underlying cause of death. This means that data on all intervening and contributory factors leading to death will be available for public health research. A second benefit is the consistency of the data produced by ACOD. Factors such as inexperience of staff and coder interpretation, which influence the assignment of codes, will be removed.

As data processing with ACOD has only begun within recent months we will keep you informed of developments that arise in the ABS coders' use of this new and innovative technology.

❖ **Maryann Wood** and **Sue Walker**  
Senior Classification Officer      Associate Director

**introducing** **Dr Erich Schulz** graduated in medicine from the University of Queensland in 1991. He was a junior hospital doctor at Rockhampton Base Hospital for two years, before working as a locum anaesthetic SHO in the UK for six months. He then joined the UK NHS Information Management Group as a Medical Coding Author, and then Senior Medical Coding Consultant. While there, he helped in the development of the UK's Read Code system. He has recently returned to Australia, and is now a Research Fellow at the National Centre for Classification in Health (Brisbane). His goal is to become a career medical informatician while pursuing a clinical interest in palliative care. Email: e.schulz@qut.edu.au



## CODING SERVICES

In this issue, Kerry Innes (Associate Director, NCCCH Sydney), addresses queries relating to the coding of hypertension, non-excisional debridement, colonoscopy, hypoglycaemia, neoplasm morphology codes, and anaphylactic reactions.

### Coding tips

#### 1 A refresher on coding types of hypertension

The categories 401 *Essential hypertension*, 402 *Hypertensive heart disease*, 403 *Hypertensive renal disease* and 404 *Hypertensive heart and renal disease* can be confusing, so without reiterating Australian Coding Standard ACS 0925 (page 86, Volume 4), here are a few tips on how to assign these codes correctly:

- I. These codes are mutually exclusive, i.e. you can assign **only one of them to one episode of care**.

##### Example

##### Hypertensive congestive cardiac failure

- Correct coding

402.91 *Hypertensive heart disease, unspecified, with congestive cardiac failure*

- Incorrect coding

402.91 *Hypertensive heart disease, unspecified, with congestive cardiac failure*

401.9 *Essential hypertension unspecified*

##### – This code is unnecessary

- II. 401.x *Essential hypertension* should be assigned only when there are no documented conditions related to the hypertension.
- III. Categories 402, 403 and 404 are used when there is a **documented causal relationship between the hypertension and the condition**. Examples of how this causal relationship could be documented in the record are:

“*Hypertensive heart disease*”

“*Hypertensive renal disease*”

“*Hypertensive heart and renal disease*”

“*Renal disorder due to hypertension*”

“*Malignant hypertension with associated nephropathy and CCF*”

- IV. It is not necessary to assign an additional code for categories 402, 403 or 404 to indicate the condition related to the hypertension.

##### Example

*Diagnosis:* Hypertensive cardiomegaly

*Code:* 402.90 *Hypertensive heart disease, unspecified, without congestive heart failure*

The code for cardiomegaly (429.3) is not necessary as this condition is included in code 402.90 (see Index: “Cardiomegaly, hypertensive”).

#### ICD-10-AM

#### Good news about hypertension from ICD-10-AM

ICD-10-AM does not have the fourth character breakdown for “benign”, “malignant” or “unspecified”!!

The new look ICD-10-AM hypertension codes are shown on page 7.

#### 2 Colonoscopy with ileal biopsy

There is no specific code for this procedure in ICD-9-CM. The index will lead to two codes, one for the colonoscopy (45.23 *Colonoscopy*) and one for the closed biopsy of the small intestine (45.14 *Closed [endoscopic] biopsy of small intestine*).

The incongruity of these two codes is clear, in that the biopsy of ileum is classified to a code which is normally associated with **upper** gastrointestinal endoscopy (namely, gastroscopy).

When coding “colonoscopy with ileal biopsy”, assign only the code 45.25 *Closed [endoscopic] biopsy of large intestine*. Note that the subterms at 45.25 includes “colonoscopy with biopsy”.

## HYPERTENSIVE DISEASES (I10–I15)

**Excludes:** complicating pregnancy, childbirth and the puerperium (O10–O11, O13–O16)  
involving coronary vessels (I20–I25)  
neonatal hypertension (P29.2)  
pulmonary hypertension (27.0)

**I10**

### Essential (primary) hypertension

High blood pressure  
Hypertension (arterial)(benign)(essential)  
(malignant)(primary)(systemic)

**Excludes:** involving vessels of:  
• brain (I60-I69)  
• eye (H35.0)

**I11**

### Hypertensive heart disease

**Includes:** any condition in I50.-, I51.4-I51.9  
due to hypertension

I11.0 Hypertensive heart disease with  
(congestive) heart failure  
Hypertensive heart failure

I11.9 Hypertensive heart disease without  
(congestive) heart failure  
Hypertensive heart disease NOS

**I12**

### Hypertensive renal disease

**Includes:** any condition in N18.-, N19.- or  
N26.- with any condition in I10  
arteriosclerosis of kidney  
arteriosclerotic nephritis  
(chronic) (interstitial)  
hypertensive nephropathy  
nephrosclerosis

**Excludes:** secondary hypertension (I15.-)

I12.0 Hypertensive renal disease with renal  
failure  
Hypertensive renal failure

I12.9 Hypertensive renal disease without  
renal failure  
Hypertensive renal disease NOS

**I13**

### Hypertensive heart and renal disease

**Includes:** any condition in I11.- with any  
condition in I12.-  
disease:  
• cardiorenal  
• cardiovascular renal

I13.0 Hypertensive heart and renal disease  
with (congestive) heart failure

I13.1 Hypertensive heart and renal disease  
with renal failure

I13.2 Hypertensive heart and renal disease  
with both (congestive) heart failure and  
renal failure

I13.9 Hypertensive heart and renal disease,  
unspecified

**I15**

### Secondary hypertension

**Excludes:** involving vessels of:  
• brain (I60-I69)  
• eye (H35.0)

I15.0 Renovascular hypertension

I15.1 Hypertension secondary to other renal  
disorders

I15.2 Hypertension secondary to endocrine  
disorders

I15.8 Other secondary hypertension

I15.9 Secondary hypertension, unspecified

### ICD-10-AM

#### Design Conventions made easy ...

You will notice above the use of black reverse text boxes on the three character codes (e.g. I12). When you see these black boxes in the final publication of ICD-10-AM, they should be interpreted to mean “this code requires additional digit/s”. Exceptions of course exist where three character codes are in fact intended to be used, and hence we have denoted these with a box outline (e.g. I10 above).

This design concept is carried through to the MBS-E Procedure Classification (see page 10), where black boxes are used on “block” numbers, which are not valid codes and can **never** be used.

Therefore, in general Black box = don't use!

## 3 Non-excisional debridement

ACS 1203 **Debridement** states “code debridement only if excisional”. This standard was developed to address the fact that the default code in the index was 86.28 *Nonexcisional debridement of wound, infection, or burn* when in the majority of cases, debridement is excisional. The default has been changed in the index to 86.22 *Excisional debridement of wound, infection, or burn* which better reflects procedural practice.

Some coders have queried why 86.28 *Nonexcisional debridement of wound, infection, or burn* is still included in Volume 3 of ICD-9-CM. The reason is that there will be some instances where nonexcisional debridement is performed, and therefore it would be premature to remove it from the book.

**Amended ACS 1203 DEBRIDEMENT**

If “nonexcisional debridement” is documented or the surgeon confirms that the debridement was “nonexcisional” assign 86.28 *Nonexcisional debridement of wound, infection, or burn* .

This standard should be interpreted to include the following points:

- **most** debridements are excisional
- check with the clinician if unsure
- use the nonexcisional code (86.28) if documentation/ clinical advice supports its use.

## 4 Hypoglycaemia in a newborn of a mother with gestational diabetes

A recent question on the listserv ‘Code-L’, raised an issue relating to ACS 1602 **Neonatal complication of maternal diabetes**, page 137 of Volume 4. The question was whether code 775.0 *Syndrome of “infant of a diabetic mother”* could be used when the mother has **gestational** diabetes rather than diabetes mellitus.

Further reading in ACS 0401 **Diabetes mellitus**, page 58, indicates that “gestational diabetes cannot be differentiated from Type II diabetes diagnosed during pregnancy”. Therefore, for the purposes of classifying the effect on the infant, 775.0 should be used when the mother has gestational diabetes or classical diabetes mellitus.

**Note:** it is not sufficient reason to use 775.0 if it is noted in the record that the mother has diabetes – the effect of the maternal diabetes on the baby must be documented.

## ICD-10-AM

**ICD-10-AM will include the following codes:**

- P70.0 *Syndrome of infant of mother with gestational diabetes*
- P70.1 *Syndrome of infant of a diabetic mother*

## 5 Morphology coding refresher

Thanks to Dr Bruce Armstrong, Director, Cancer Control Information Centre and Noreen Panos, Data Manager, NSW Central Cancer Registry for providing these concise notes on the meaning and application of the one-digit behaviour codes, in particular /1 and /2, of the morphology codes.

The morphology code numbers consist of five digits:

- the first four identify the histological type of the neoplasm
- the fifth indicates its **behaviour**.

**The one-digit behaviour code is as follows:**

- /0 Benign
- /1 Uncertain whether benign or malignant  
Borderline malignancy★
- /2 Carcinoma in situ  
Intraepithelial★  
Noninfiltrating★  
Noninvasive★
- /3 Malignant, primary site
- /6 Malignant, metastatic site  
Secondary site
- /9 Malignant, uncertain whether primary or metastatic site

★Note these important inclusion terms

Important principle in assignment of the behaviour codes

The introduction of the morphology chapter in Volume 1 of ICD-9-CM, page 371, states:

*“the morphology code numbers include the behaviour code appropriate to the histological type of neoplasm but this behaviour code should be changed if other reported information makes this necessary”.*

For example, “chordoma” (M9370/3) is assumed to be malignant in ICD-9-CM. However, if the pathologist states a behaviour different from the usual behaviour as given in ICD-9-CM, code as the pathologist indicates.

### /1 Uncertain whether benign or malignant

*Uncertain whether benign or malignant* and *Borderline malignancy* are synonymous terms. Please use behaviour code /1 if any of these terms are used in a pathology report to describe a neoplasm **even though the index may not include all these terms**.

### /2 Carcinoma in situ

*Carcinoma in situ*, *intraepithelial carcinoma*, *noninfiltrating carcinoma* and *noninvasive carcinoma* are synonymous terms. Assign behaviour code /2 if any of these terms are used in a pathology report to describe a neoplasm **even though these terms may not appear as subterms for the morphological type in the index of ICD-9-CM**. If both in situ and invasive cancer are present in the same lesion, assign behaviour code /3.

Examples of coding to the documented morphology

### Example 1

Pathology report states “noninvasive squamous cell carcinoma of cervix”

**Code** to 233.1 M8070/2

(Note: ICD-9-CM description for M8070/2: *squamous cell carcinoma in situ NOS*)

**Example 2**

Pathology report states “noninfiltrating transitional cell carcinoma of bladder”

**Code to 233.7 M8120/2**

(Note: ICD-9-CM description for M8120/2: *Transitional cell carcinoma in situ*)

**6 HIV – cytomegalovirus (CMV) retinitis**

Care should be taken when coding HIV with CMV retinitis as three codes are required to accurately code this condition. The codes are:

HIV	042	<i>Human immunodeficiency virus [HIV] disease</i>
Retinitis	363.20	<i>Chorioretinitis, unspecified</i>
CMV	078.5	<i>Cytomegaloviral disease</i>

Sequencing will depend on the circumstances of the admission – see ACS 0102 **HIV/AIDS**, page 31.

**7 Duration of pregnancy codes with early onset of delivery**

The V23.6x codes are intended for use only with high risk pregnancies (e.g. abortion, threatened premature labour) as stated in ACS 1518 **Duration of Pregnancy**. However, from July 1997 V23.6x *Duration of pregnancy* codes can be assigned with 644.21 *Early onset of delivery*.

**8 Anaphylactic reaction to food**

The NCCCH has received a number of queries in regard to the use of 995.6x *Anaphylactic shock due to adverse food reaction* and the accompanying external cause code. The following points should be noted:

- I. Anaphylaxis is an allergic hypersensitivity reaction of the body to a foreign protein or other substance. Substances most likely to produce anaphylaxis include:
  - drugs, particularly antibiotics, local anaesthetics and codeine
  - drugs prepared from animals, such as insulin, adrenocorticotrophic hormone and enzymes
  - diagnostic agents, such as iodinated X-ray contrast media
  - biologicals used to provide immunity, such as vaccines, antitoxins and gamma globulin
  - protein foods
  - venom of bees, wasps and hornets
  - pollens, moulds and animal dander.

**Anaphylaxis is not a poisoning**

- II. The exclusion note at E865 *Accidental poisoning from poisonous foodstuffs and poisonous plants* reads:

**Excludes:** anaphylactic shock due to adverse food reaction (995.6)  
 food poisoning (bacterial) (005.0–005.9)  
 poisoning and toxic reactions to venomous plants (905.6–905.7)

This note means that E865 cannot be used for anaphylactic shock due to adverse food reaction (995.6) because 995.6 is not an accidental poisoning. The same logic applies to food poisoning (005.0–005.9) and poisoning and toxic reactions to venomous plants (905.6–905.7). Note also the addition of “poisonous” to the category title (addendum 1996) which serves to reinforce the intention for this code to be used only for poisonings, not anaphylaxis.

- III. The inclusion note at E930–E949 *Drugs, medicinal and biological substances causing adverse effects in therapeutic use* reads:

**Includes:** correct drug properly administered in therapeutic or prophylactic dosage, as the cause of any adverse effect including allergic or hypersensitivity reactions.

This note and the category title indicate that **biological substances causing allergic or hypersensitivity reactions** are included in E930 – E949.

- IV. The index entry for “Anaphylactic shock” in the external cause index (Volume 2, page 548) indicates that E947.9 *Unspecified drug or medicinal substance causing adverse effects in therapeutic use* is the correct code assignment. The *see also* “Table of Drugs and Chemicals” note need not be followed as the entries in the Drug table for “Food, foodstuffs, nonbacterial or noxious” (page 501) relates only to **poisoning by the noxious substance eaten as food**.

The correct external cause code assignment for 995.6x is E947.9 *Unspecified drug or medicinal substance causing adverse effects in therapeutic use*.

- V. Anaphylactic reaction to food in ICD-10-AM

The same logic applies in ICD-10-AM for coding anaphylaxis due to food, i.e:

**T78 Adverse effects, not elsewhere classified**

T78.0 Anaphylactic shock due to adverse food reaction

**DRUGS, MEDICAMENTS AND BIOLOGICAL SUBSTANCES CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE (Y40–Y59)**

**Y57 Other and unspecified drugs and medicaments**

Y57.9 Drug or medicament, unspecified, causing adverse effects in therapeutic use

## Learning more about ICD-10-AM – Diseases

As you may know, ICD-10-AM will introduce the new feature of an alpha character to the disease code. The alpha characters usually relate to a specific chapter, e.g. O is the alpha character for *Chapter XV Pregnancy, childbirth and the puerperium*. The chapters of ICD-10-AM and the relevant codes for each chapter are detailed below. Note that chapters I, II, XIX and XX have more than one alpha in them while chapters II and III share the letter D and chapters VII and VIII share the letter H.

<b>I</b>	<b>Certain infectious and parasitic diseases</b>	<b>A00–B99</b>
<b>II</b>	<b>Neoplasms</b>	<b>C00–D48</b>
<b>III</b>	<b>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</b>	<b>D50–D89</b>
<b>IV</b>	<b>Endocrine, nutritional and metabolic diseases</b>	<b>E00–E90</b>
<b>V</b>	<b>Mental and behavioural disorders</b>	<b>F00–F99</b>
<b>VI</b>	<b>Diseases of the nervous system</b>	<b>G00–G99</b>
<b>VII</b>	<b>Diseases of the eye and adnexa</b>	<b>H00–H59</b>
<b>VIII</b>	<b>Diseases of the ear and mastoid process</b>	<b>H60–H95</b>
<b>IX</b>	<b>Diseases of the circulatory system</b>	<b>I00–I99</b>
<b>X</b>	<b>Diseases of the respiratory system</b>	<b>J00–J99</b>
<b>XI</b>	<b>Diseases of the digestive system</b>	<b>K00–K93</b>
<b>XII</b>	<b>Diseases of the skin and subcutaneous tissue</b>	<b>L00–L99</b>
<b>XIII</b>	<b>Diseases of the musculoskeletal system and connective tissue</b>	<b>M00–M99</b>
<b>XIV</b>	<b>Diseases of the genitourinary system</b>	<b>N00–N99</b>
<b>XV</b>	<b>Pregnancy, childbirth and the puerperium</b>	<b>O00–O99</b>
<b>XVI</b>	<b>Certain conditions originating in the perinatal period</b>	<b>P00–P96</b>
<b>XVII</b>	<b>Congenital malformations, deformations and chromosomal abnormalities</b>	<b>Q00–Q99</b>
<b>XVIII</b>	<b>Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</b>	<b>R00–R99</b>
<b>XIX</b>	<b>Injury, poisoning and certain other consequences of external causes</b>	<b>S00–T98</b>
<b>XX</b>	<b>External causes of morbidity and mortality</b>	<b>V00–Y98</b>
<b>XXI</b>	<b>Factors influencing health status and contact with health services</b>	<b>Z00–Z99</b>

Note that V will represent external cause codes for transport accidents (V for “Vehicles”). In our copious spare time at the NCCCH we try and think of associations between the letters and the chapters to make it easier to remember them. Perhaps you can think of some better ones – if so we would like to hear them!

Here are some of our suggestions:

Chapter IV	E for “Endocrine”
Chapter XII	L for “Lesion”
Chapter XV	O for “Obstetrics”
Chapter XVI	P for “Perinatal”

and my favourite:

Chapter I	“All the Bugs”
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### Good news from ICD-10-AM (diseases)

ICD-9-CM	ICD-10-AM
Fifth digits in obstetrics	Gone!!
Fifth digits for schizophrenia	Gone!!
Fifth digits on tuberculosis	Gone!!
Hypertension table	Gone!!
Fifth digit for non/dominant side in hemiplegia	Gone!!
No specific code for postpartum depression	New code in mental health chapter
Myelodysplasia codes inadequate	Six new codes for myelodysplasia

## Learning more about ICD-10-AM – Procedures (MBS-E)

### Conventions used in the tabular list to procedures – Format

#### • 1st level – anatomical site axis

MBS-Extended (MBS-E) has been structured with a principal axis of anatomical site. Within each chapter the anatomical site has been structured by a “superior” to “inferior” (head to toe) approach.

#### • 2nd level – procedural type axis

The secondary axis is procedure type, beginning with the least invasive procedure through to the most invasive procedure. Standardised procedural axes are:

Examination  
 Application, Insertion, Removal  
 Incision  
 Destruction  
 Excision  
 Reduction (only applicable to Musculoskeletal chapter)  
 Repair  
 Reconstruction  
 Revision  
 Re-operation  
 Other procedures

#### • 3rd level – block axis

The Medicare Benefits Schedule (MBS) is a fee schedule and has been structured according to specialty. As MBS-Extended is based on item numbers in the MBS and structured on an anatomical basis, the code numbers do not always appear in numerical order within the Tabular List.

A third level axis, called a **BLOCK**, has been introduced. Blocks are numbered sequentially in the Tabular List to assist coders in locating a specific code and have titles that relate specifically to the codes contained within the block.

### Good news from ICD-10-AM (procedures)

*New codes for:*

Uvulopalatopharyngoplasty  
 Laparoscopic cholecystectomy proceeding to open cholecystectomy  
 Laparoscopically assisted hysterectomy  
 Cardiomyoplasty  
 Instillation of cytotoxic agent  
 For those hospitals specialising in dental procedures: a ‘whole chapter’

There are certain chapters that are an exception to the general format. These include: Dental services, Obstetric procedures, Chemotherapeutic and radiation oncology procedures, Miscellaneous procedures, Imaging services and Allied Health Interventions.

### How is the MBS-E tabular list arranged?

#### Example 1

### CHAPTER III PROCEDURES ON EYE AND ADNEXA

**Eyeball** [1st level – anatomical site axis]

**Examination** [2nd level – procedural type axis]

**160 Examination procedures on eyeball** [3rd level – block axis]

42503-00 Ophthalmological examination under general anaesthesia

*Excludes:* that with any other procedure on the eye – omit code

#### Example 2

### CHAPTER XIV OBSTETRIC PROCEDURES

**Delivery procedures** [1st level]

**Caesarean delivery** [2nd level – procedural type axis]

**1340 Caesarean section** [3rd level – block axis]

16520-00 Elective classical caesarean section

16520-00 Emergency classical caesarean section

16520-00 Elective lower segment caesarean section

16520-00 Emergency lower segment caesarean section

### How is the MBS-E alphabetic index arranged?

#### Example

#### Suture

- obstetric laceration, current (tear) 90485-00 [1344]

-- 1st degree 90481-00 [1344]

-- 2nd degree 90481-00 [1344]

-- 3rd degree 16573-00 [1344]

-- 4th degree 16573-00 [1344]

-- bladder (and urethra) 90480-00 [1344]

❖ **Kerry Innes**  
Associate Director



## EDUCATIONAL MATTERS

Twelve months to go until the intended implementation of ICD-10-AM and the Education Services division is frantically planning, designing and organising for the education of more than one thousand clinical coders and health information managers, clinicians, allied health professionals, software vendors and many others, across Australia.

### Train the Trainer II

Since Janelle Craig's departure to the heavenly world of motherhood, we have undertaken various educational activities, the main being the ICD-10-AM Train the Trainer II sessions, otherwise affectionately known as "TTT 2". These sessions were held across Australia during May 1997 following on from Phase I of the Train the Trainer session held in February this year.

### Coding Educators Network

The aim of the TTT 2 sessions was to train members of the Coding Educators Network (CEN), both current and new members, along with representatives from the State Coding Advisory Committees, state health departments, 3M Healthcare and the Schools of Health Information Management. A total of 71 people attended the workshops nationally.

Those people that had applied to become new members of CEN were assessed on the first day of training, by preparing and presenting a chapter from the *ICD-9-CM Australian Coding Standards*. This process allowed the NCCH to determine the suitability of applicants for membership of the Network.

We would like to say a big thank you to all those who participated and would like to extend a big welcome to

the following individuals who have been accepted onto the NCCH Coding Educators Network:

#### New South Wales and ACT:

Nicole Boyens	Carmel Cheney	Elina Muljadi
Filippa Pretty	Denise Crowe	

#### Queensland:

Glenn Garside	Sally Harlen	Darren Sonter
Sharon Wiseman	Lisa Timmins	

#### Victoria and Tasmania:

Kylie Holcombe	Leanne Schoen	Gayle Smith
Pauline Strauch	Jennie Shephard	

#### South Australia and Northern Territory:

Andrew Coshan	Terry-Lee Dymmott	
Susan Edmonds	Tanya Drake	Andrea Smart
Heather Howse	Nicolle Parrent	Anita Walker
Cathryn Perry	Shannon Watts	Lesley Ward
Leonie Maskell		

#### Western Australia:

Viktoria King

An item about the Coding Educators Network will appear regularly in *Coding Matters*. In this issue, we present a profile of selected current members of the Network (*see* page 13). ►

**ICD-10-AM brings a smile to participants faces (??) as Julie Rust (centre) convenes the 12-13 May NSW/ACT TTT2 session**

The remaining two days of TTT 2 training were split into one day on ICD-10-AM diseases and one day on procedures (MBS-E). Some comments from the evaluations have been: “good to have access to the draft books”; “small groups, easy to discuss issues”; “alleviation of anxiety regarding MBS-E”.

The feedback from the majority of participants was positive with the Index to MBS-E being the most celebrated new addition and just to allay fears, the typeset and printed index to Diseases will be much easier to use than the draft!

At the conclusion of these sessions, Julie Rust and I moved straight onto the next phase of education planning, which is the development of educational material and activities for clinical coders and other health professionals.

This material is in preparation stage at present and will be available for distribution during September and October 1997. A sneak preview will be provided for those individuals who have nominated to attend the ICD-10-AM workshops at the 9th Casemix Conference in Brisbane in September.

### **Functional Coding Forum and Dual Coding Study**

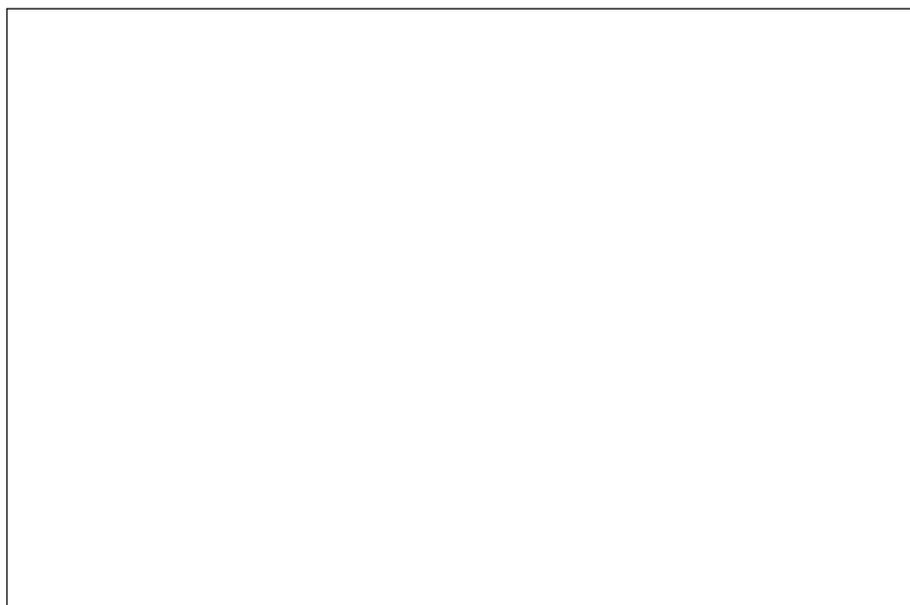
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The NCCH is participating in two education activities throughout the next few months. The first was the Functional Coding Forum, or “Revisiting Rehab”, which was held on 17 July 1997 at the Faculty of Health Sciences, University of Sydney. The forum was supported by the NCCH, Australian Institute of Health & Welfare and Alpha Healthcare.

A core group of experts with a background in rehabilitation services was invited to attend. Various issues, such as an update on current projects in the field of rehabilitation services (e.g. SNAP), advice on ICIDH, FIM, Barthel and other classification systems and their relationship with ICD-10-AM, coding standards for rehabilitation services and other allied health issues, were discussed.

A report on the outcome of this forum will be provided in the October edition of *Coding Matters*.

The second education activity is the dual coding study which forms part of the Impact Assessment Project being undertaken by the Commonwealth Department of Health



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### **Heads down for the WA TTT 2 session (28-29 May)**

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and Family Services. During the month of August, approximately 50 individuals from the Coding Educators Network will be closeted away undertaking the study.

### **Looking forward to 1998**

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The NCCH has received a number of enquiries from interested parties about the plan for the education thrust in 1998. We are still very much in the developmental stages, however, the ‘full-on’ hands-on training in ICD-10-AM is scheduled for the period March to May 1998.

The format and length of the sessions are yet to be decided and will be influenced by the results of other training sessions that have been held in the interim period. Keep your eyes on the October '97 and January '98 editions of *Coding Matters* which will supply you with more up-to-date information.

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*The ‘full-on’ hands-on training in ICD-10-AM is scheduled for the period March to May 1998*

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As always, the NCCH Education Services area is facing a busy six months to close the year and if anyone requires further information or has any useful contributions to the proposed education plan, please feel free to contact Julie Rust or Karen Peasley on (02) 9351 9461.

Don't forget – to catch up on further news regarding the implementation of ICD-10-AM, attendance at the NCCH Conference in Adelaide in November '97 is imperative!! (see page 15–16).

❖ **Karen Peasley**  
Project Officer  
Education Services

## Profiles of Coding Educators Network (CEN) members

### Linda Best (NSW)

A 1980 graduate of the Medical Record Administration course at the then Cumberland College of Health



Sciences in Sydney, my early career was varied with positions in coding review and research, oncology data management, management of medical record departments in hospitals and medical record consultancy.

The practical coding experience I have gained over the past 7 years, at public and private hospitals in Sydney and Auckland, is now being put to use in coder education.

I joined the NCCH Coding Educators Network in 1995 and helped present the Version 2 Australian Coding Standards Workshop. I have also lectured in clinical classification at the University of Sydney in 1996 and since January 1997, have been employed as an Education Officer in the Education Services division of HIMAA. I sat and passed the inaugural Accredited Clinical Coder Examination in 1996 and continue to code for the equivalent of two days a week at Westmead Hospital in Western Sydney.

I hope that through my involvement in coder education, I can pass on some of my experience and help other coders in their work.

### Janine Cassidy (NT)

Greetings from the Northern Territory! I have been the Health Information Manager at Alice Springs Hospital



since August 1994 and a member of the Coding Educators Network since 1995. I have a background in Nursing and obtained a degree in Health Information Management from the University of Sydney in 1991.

After much heart-ache and despair,

I also sat and passed the Accredited Clinical Coder Examination in 1996.

I attended the first Train-the-Trainer workshop in February 1995, where it was great to meet other coders from around Australia and learn about the similarities and differences in coding practice within each state.

In April 1995, I was a co-presenter at the Australian Coding Standards workshop held at Royal Darwin Hospital, where 10 coders from around the Territory attended. It was a wonderful opportunity to meet in person all the other coders in the Territory.

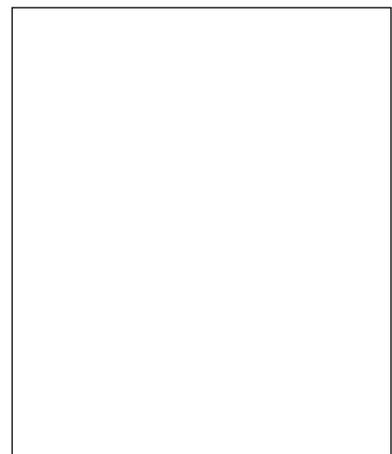
I have since presented the NCWIP Clinical Update Seminars and the 1996 Australian Coding Standards in Darwin. I enjoy presenting new information to a small but responsive and accepting audience. In May 1997, I attended the ICD-10-AM Train-the-Trainer II workshops in Adelaide.

I think the next 18 months will be very stimulating as ICD-10-AM and MBS-E are established in our coding consciousness.

### Barbara Levings (SA)

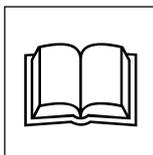
Following fifteen years in nursing, I moved into the medical records arena approximately five years ago.

I completed the HIMAA Distance Education Programme and have been working at Ashford Community Hospital in Adelaide since this time. I joined the NCCH Coding Educators Network in 1995 and am currently President of the Clinical Coders' Society of Australia (CCSA).



I am excited and rather challenged by ICD-10-AM, although I have been fortunate to be able to have some exposure to the classification whilst working with the Australian Patient Safety Foundation.

I have even contemplated having a dagger and asterisk tattoo to remind me of the order, as I wasn't coding when we last used them. I have also realised that I will have to relearn the alphabet, or alternately decorate the office with a child's alphabet chart! ■



## PUBLICATION ISSUES

### ICD-10-AM: where are we at?

It's heads down in the NCCH Publications Division as we work amongst a sea of proof pages for ICD-10-AM! The publication is proceeding through numerous proof stages and we aim to tender for the printing of the books in early August 1997. ICD-10-AM publication availability is on track for January 1998. We are very pleased with the design of the publication and have put much effort into making a "seamless" publication out of the new disease and procedure classifications (a simulated sneak preview of the type of style employed can be seen on page 6 along with some brief notes). Preparing draft ICD-10-AM coding manuals for use in the Dual Coding Studying has also allowed us to experience the "books-before-the-books".

Sales of the *ICD-10-AM Electronic ASCII Code List – Full Descriptors* are progressing at a steady pace! Don't forget to purchase your copy of the complete code list to get an advanced viewing of all the codes (*see* order form this issue). The abbreviated descriptor product is taking longer to develop than originally anticipated, however, we will keep you posted!

### Enter the Dragon

During a recent holiday, I had the pleasure of visiting the Chinese WHO Collaborating Centre for ICD in Beijing and meeting with staff Associate Professor Dong Jingwu and Mr Liu Ai-min. Established in 1981, the Centre is located in the Chinese Academy of Medical Sciences at the Peking Union Medical College Hospital.

The Centre aims to popularise the use of ICD in the People's Republic of China and in the mid-1980's published a translation of ICD-9. Currently in China, diseases are coded using ICD-9 and procedures coded using a 1992 translation of ICD-9-CM procedures. Dealing with both morbidity and mortality coding issues, the Centre is also responsible for conducting national and provincial level education workshops.

Shortly after the publication of WHO's ICD-10, the Chinese Centre began a translation of the text. The Disease Tabular translation (an impressive publication indeed!!) was published in late 1996 and during my visit staff were busy finalising the Disease Index publication. Having established term translations during work on the Tabular List, converting the Index proceeded swiftly with the aid of computers, although problems were encountered with some drug brand nomenclature.

The staff are well positioned to receive timely clinical advice regarding ICD-10, being conveniently located in one of Beijing's largest and oldest hospitals! The Centre will soon prepare practical ICD-10 coding guides and consequently staff were very interested in the Australian *Implementation Kit*. The People's Republic of China will continue to use ICD-9-CM procedure codes with ICD-10. Thanks to the Centre's staff – I thoroughly enjoyed the Beijing experience and dream of visiting again one day!

### Adieu!

Some sad news is that Simone Lewis (NCCH Publications Assistant) has herself caught the Asian fever and is off to live in Singapore! During her 19 months at the NCCH, Simone has proved to be an endearing and invaluable staff member. Amongst many other things, Simone has successfully launched the *Casemix and Clinical Coding Specialty Booklet* series, and will have completed four booklets by the time of her departure. We wish Simone the best of luck in her future endeavours!!

❖ **Karen Luxford**  
Publications Manager

Thanks to Assoc. Prof. Dong (left) and Mr Liu for their hospitality, during what was for them a very busy time, and also for their instruction in local cuisine!

## 1997 Annual Conference



## Invitation to attend

We invite you to attend our fourth annual conference to be held at the Stamford Grand Hotel in Glenelg, Adelaide, South Australia on **19–21 November 1997**.

## Call for papers

Abstracts from Clinical Coders, Health Information Managers and readers of *Coding Matters*, which address the theme **“The Future of Coding”** are most welcome. Authors may wish to focus their paper on:

- ✦ the changes in classification systems
- ✦ innovations in information technology for classification systems
- ✦ implications of changes for coders and other health professionals

Papers will be selected on their relevance to the seminar topic and their written clarity. Guidelines for those wishing to submit an abstract are as follows:

1. Please provide two copies of a typed abstract of the paper (maximum of 500 words)
2. The abstract should include the title of the paper, the author's name/presenter's name, title, position and organisation with address and telephone/facsimile numbers
3. More than one abstract may be submitted
4. Abstracts should be submitted to:

Ms Karen Peasley, Project Officer – Education Services  
National Centre for Classification in Health  
PO Box 170, Lidcombe NSW 2141  
or emailed to: [k.peasley@cchs.usyd.edu.au](mailto:k.peasley@cchs.usyd.edu.au)  
**by 5th September 1997**

Authors of abstracts will be notified in writing of the acceptance or otherwise of papers. The decision on acceptance of papers will be at the discretion of the NCCH.

For further information please contact the address above or:

Phone: (02) 9351 9461    Fax: (02) 9351 9603    Email: [k.peasley@cchs.usyd.edu.au](mailto:k.peasley@cchs.usyd.edu.au)

### National Centre for Classification in Health

#### Errata 1997 – Part II

#### 1996 Australian Version of ICD-9-CM, second edition

Volume 2 – Alphabetic Index of Diseases		Page	
Page		244	<b>Injury</b>
120	<b>Dermatitis</b>		- blood vessel NEC 904.9
	- seborrhoeic 690.10		- - axillary 903.00
Add	- - <u>capitis 690.11</u>	Revise	- - - artery <u>903.01</u>
	- - infantile 690.12		
Add	- - <u>specified type NEC 690.18</u>		<b>Volume 3 – Tabular List of Procedures</b>
		pi-29	<b>Estes operation...</b>
153	<b>Dysplasia</b>	Delete	<del><b>Etlander operation</b></del> (thoracoplasty) 33.34
Revise	- bone (fibrous) NEC <u>733.93</u>		<b>ESWL...</b>
Revise	- - monostotic <u>733.93</u>		<b>Ethmoidectomy</b> 22.63
			<b>Ethmoidotomy</b> 22.51
		Add	<b>Etlander operation</b> (thoracoplasty) 33.34

## 1997 Annual Conference



## Dates

.....  
 Wednesday 19th – Friday 21st November 1997

A short pre-conference workshop on ICD-10-AM will be held on 19th November (Attendance numbers will be limited)

## Venue

.....  
 Stamford Grand Hotel, Glenelg, Adelaide, South Australia

Glenelg is located 15 minutes from Adelaide's central business district and the Stamford Grand Hotel is located directly on the beachfront.

## Theme

.....  
 "The Future of Coding" to focus on:

- ✦ the changes in classification systems
- ✦ innovations in information technology for classification systems
- ✦ implications of changes for coders and other health professionals

## Cost

.....  
 Full registration (3 days – inclusive of workshop,  
 two day conference, catering & cocktail party) \$300 per person

Attendance at conference only \$280  
 (inclusive of catering & cocktail party)

Attendance at one day of conference only \$165

Attendance at workshop only \$50

## Registration

.....  
 Brochures will be distributed in mid September 1997

## Contact

.....  
 Ms Karen Peasley, Project Officer – Education Services

Phone: (02) 9351 9461

Fax: (02) 9351 9603

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

*Thank you to those who contributed entries in last issue's **slogan competition**. However, after lengthy deliberations and an independent vote, the slogan selected was one created by an NCCH staff member (who will remain of course anonymous!).*

Towards the Perfect  : ICD-10-AM