

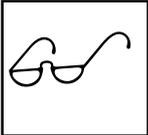


Coding Matters

Newsletter of the National Coding Centre

Volume 2 No. 4 April 1996

FROM THE DESK OF THE DIRECTOR



Pace of activity at the National Coding Centre (NCC) does not seem to have abated in 1996, despite the vague hope amongst most staff that there has to be a lull somewhere in the storm! I'm sure, however, that this situation reflects what everyone is facing in hospitals and health services around the country today. As this century draws to a close, expectations of what is possible seem to increase, not only in terms of productivity but in the application of growing expertise within Australia in a range of specialised fields. Coding is a good example of a function where expectations of achievements are soaring! And I mean coding throughput, coding accuracy, coding to reflect current clinical practice, code mapping to allow monitoring of disease trends over time and coding timeliness in relation to hospital separation. The codes themselves are being used more and more, not only for casemix measures, but for epidemiological and research purposes and to provide indicators of quality of care.

Although the staff at the NCC are immersed in input and process issues, especially preparation of the Australian modification of ICD-10 (ICD-10-AM), we try not to lose sight of the end use of the codes, and the amount of time that clinical coders in hospitals devote to getting the codes right and completed on time. It was heartening to meet the members of our Coding Educators Network at the train-the-trainer workshop held at University of Sydney in February this year. There is still an enormous amount of enthusiasm and freshness amongst our coding educators from around the country (as well as an amazing tolerance of the proliferation of *Australian*

Coding Standards!) with a general feeling of all pulling together to achieve a worthwhile goal. Congratulations to Janelle Craig (NCC Coding Education Manager) on another successful workshop. We hope to continue to provide a flexible format for these and other education programs, so that each can be tailored to the needs of the audience and the changing times.

"Coding is a good example of a function where expectations of achievements are soaring!"

Kerry Innes (NCC Coding Services Manager) has covered in her section in this issue the details of progress on the mapping from ICD-9-CM to ICD-10-AM and production of the Australian version of ICD-10 diseases and the MBS-Extended for procedures. At the time of writing, we are in the thick of consultation with clinicians concerning the first draft of both classifications, and as usual have had excellent support from the dedicated members of the Clinical Coding and Classification Groups (CCCGs), as well as other specialist clinical and coding colleagues. I must apologise for not mentioning in our previous newsletter that we have two Victorian staff contracted for the procedure mapping process - Andrea Groom and Paula Hallang (*see* photo page 9). Both have made vital contributions to the creation of codes in Plastic Surgery and Neurosurgery, despite having to communicate from a distance. Andrea and Paula have also spent some time in Sydney with the home-based team, including a meeting on 27 and 28 March, and have been joined in Victoria by staff from Sydney to discuss specialty specific issues with Melbourne-based clinicians.



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NCC staff is still growing (in number!). Welcome to Judith Hooper (Project Officer) who has replaced Anne Elsworth who left us for a permanent position at Mt. Druitt Hospital. Thank you Anne for your input to the Centre and the procedure classification. Jenny Smith has been seconded to the NCC two days a week from Prince of Wales Hospital, and both Judith and Jenny are doing valuable work on the development of the MBS-Extended procedure classification in the chapters of Obstetrics and Gynaecology, Paediatric and General Surgery. The obstetric section was particularly creative, as the Medicare Benefits Schedule (MBS) has very limited item numbers in this area. This whole process has been extremely educational for all of us, not only in classification design, but clinically. Dr Barry Dale, as mentioned in the January issue, is working with us on contract, and has assisted with disease and procedure coding in oncology and radiotherapy. Patricia DahDah has also joined the staff and is working with Jocelyn Lee on the disease mapping. Patricia is a Health Information Management (HIM) Honours Student (as is Natalia Alechna, also on our staff). Patricia's research project on codes for diagnoses identified in cross unit consultations and Natalia's on quality of coding for burns should both add to our knowledge on coding appropriateness and completeness. Lauren Jones, HIM Consultant, is consulting with the NCC on the injury section of ICD-10 and mapping to and from ICD-9-CM.

'The Mapping Crew', from the left, Lauren Jones (HIM Consultant), Patricia DahDah (NCC Project Officer), Jocelyn Lee (NCC Senior Classification Officer), and (seated) Natalia Alechna (Classification Officer, NCC).

I will be discussing issues of classification structure and classification standards with colleagues in Europe during my April visit to England, Scandinavia and Germany and will provide details of the outcome in the next issue of *Coding Matters*. The main purpose of the trip is to present a paper on activities and achievements of the NCC at the 12th International Health Records Congress in Munich from April 15 - 19. Janelle Craig will also attend the Congress, and has been invited by the International Federation of Health Records Organisations (IFHRO) to run a pre-conference workshop on coding quality education in ICD-10.

During my absence, NCC staff will be planning mini-trials of the new procedure classification in hospitals. Choice of hospital is being related to clinicians and coders who have input to various chapters, and will probably be limited to large teaching hospitals where we can test the classification against the widest possible range of procedural interventions. These real life trials must be done at this stage before the codes are set in stone. Further trials are planned for later in 1996 when the two classifications forming ICD-10-AM are completed.

The National Committee for Implementation of ICD-10 in Australian Hospitals (!) met again on 22 February 1996, chaired by Dr. John Holmes, Director, Professional Services Review. Membership of this committee has expanded, with representation now from all states and the Australian Hospitals Association as well as a representative from National Health Information Management Group (Dr John Donovan, Australian Institute of Health & Welfare). The meeting discussed the Australian Health Ministers' Advisory Council (AHMAC) ratification of the use of ICD-10 and a procedure classification based on MBS as the Australian national standard from 1998, as well as a mechanism for synchronising development of MBS-Extended with regular updates to the MBS. A press release and brochures on ICD-10

implementation are being prepared for wide distribution amongst Australian health services. The committee agreed to formally reconstitute the ICD-10 Education Committee as a sub-committee of the main ICD-10 Implementation Committee. Issues of membership, terms of reference, strategy and resources for this sub-committee are currently being explored.

Another important meeting was that of the NCC Management Committee held on February 16, 1996. This meeting was significant because of its input to the negotiations on the proposed merger between University of Sydney National Coding Centre (NCC) and the Queensland University of Technology National Reference Centre for Classification in Health (NRCCH). The merger is still on track for July 1996, with final details on contracts, staffing, budgets, functions at each site and last but not least, name of the combined centre, still to emerge. The merger is viewed in an extremely positive light by all parties, and should consolidate expertise in morbidity and mortality coding from the respective centres.

The NCC and clinical coders have had major input through the CCCGs and through representation on the Australian Casemix Clinical Committee (ACCC) and Casemix Applications and Development Advisory Committee (CADAC) to the refinements to AN-DRG Version 3. Changes to codes decided in 1995 have been included in the Official NCC Addendum, effective 1 July 1996. The addendum has been circulated to state and territory health authorities, private sector and other relevant organisations. Any coder who has not yet seen the addendum should consult with their state health authority. Code changes in the addendum will be included in the Second Edition of the NCC *Australian Version of ICD-9-CM*, 1996. You will have received your customised order form for this set of new and improved coding books, which will include again as Volume 4 the revised *Australian Coding Standards* effective in July 1996. Dr Karen Luxford (NCC Publications Manager) has been working hard and long to ensure that this version of the code books will better meet coders' needs. Orders are already flooding in, so be sure to send yours in as soon as possible.

Working with Karen, Simone Lewis (Publications Assistant) has been assembling material for consultation with clinicians and coders for the first three specialty booklets (Respiratory, Oncology & Haematology and Geriatrics & Rehabilitation) due for publication mid-year. Simone has mastered the intricacies of the coding/casemix nexus, and will soon be consulting with relevant individuals on the draft publications.

The second annual round of the Australian Coding Standards Workshops will take place in May and June. You should have already received your brochure including registration form (*see* page 4) and again should submit as early as possible. Workshops will be shorter this year (one day), and again our policy will be presentations by members of the Coding Educators

Network in conjunction with the NCC, if geography permits.

Other forums where the NCC has been represented are the Clinical and Technical Advisory Committee of the Mental Health Classification and Costing Project (national project to develop casemix measure and associated costs in mental health - both inpatient and community); February meeting of the Society of Hospital Pharmacists concerning the coding implications of Pharmgroups (casemix management tool developed by and for pharmacists); Health Informatics Association of NSW annual conference in Bowral; National Health Data Committee; Casemix Implementation Project Board; and National Coder Workforce Issues Project (NCWIP) Steering Committee. Congratulations to NCWIP on significant achievements with competency standards for clinical coders! *See* page 6 for an update.

On the horizon is the involvement of the NCC on a Quality Management Coordinating Team headed by Dr Duncan Stuart of HONI (Healthier Outcomes Network International). Dr Stuart was successful in tendering to the former Federal Department of Human Services & Health for a consultancy for the development of an integrated quality management model in acute care hospitals under the National Hospital Outcomes Program. Through this project, we hope to identify adverse events which are 'codeable' and to refine codes and coding standards to enable collection of quality of care outcome information from coded data.

This quick sketch of where we are up to in the NCC would not be complete without acknowledging the energy and dedication of all NCC staff, consultants and committee members. The School of HIM, University of Sydney, and especially Professor Phyllis Watson, is always a great strength and support. The arrival of Professor Beth Reid to the University of Sydney is an added bonus, and we expect even greater interaction between the School and the Centre, knowing Beth's special interest in clinical classification and research. Thank you to all of you for your superb team work, for your congratulations on my new title, and for responding with such brilliance to the ever-increasing demands on those involved in the coding community.

❖ *Rosemary Roberts*



P.S. Social News:

Chris Erratt has a daughter - Tamsin.
Congratulations to Chris and Andrew!

CLINICAL CODERS'
C C S A
SOCIETY OF AUSTRALIA

Update

The Establishment Committee of the Clinical Coders' Society of Australia (CCSA) has been extremely busy since we reported on its activities in the last edition of *Coding Matters*.

Significant activities undertaken include:

- ◆ development of **Ethics and Practice Standards** for CCSA members
- ◆ distribution of a **Marketing brochure** announcing the formation of the CCSA. An overwhelming number of people have registered interest in the Society and requested their details be placed on the CCSA mailing list
- ◆ development of a **Membership kit** to be used for the recruitment of members
- ◆ circulation of a **Press release** advertising the formation of the CCSA to members of other professional associations and to the wider health community
- ◆ finalisation of the **Constitution** which will guide the operation of the Society.

The next issues to be addressed are the incorporation of the CCSA as a company. It is anticipated this will take place by May 1996, after which formal membership will be available. Stay tuned for more news!

For further information, please contact your state/territory representative:

ACT	Seija Graham	(06)	201 6281
NSW	Lynn Lehmann	(049)	213 404
VIC	Kathryn Baxter	(03)	9276 3021
QLD	Julie Turtle	(07)	3299 8596
SA	Barbara Levings	(08)	375 5233
WA	Joan Knights	(09)	382 6921
TAS	Mark Ralston	(004)	306 527
NT	Ann Shelby-James	(089)	228 635

Janelle Craig
Chair, Establishment Committee

Australian Coding Standards Workshops

Aim:

These workshops are designed to educate coders on the use and interpretation of the *Australian Coding Standards*, effective 1 July 1996.

Content:

Workshops will cover standards in the 2nd Edition of the *Australian Coding Standards* (1996), with particular emphasis on new or updated standards. In addition, an introduction to ICD-10 will be included.

Participants:

Clinical coders, health information managers, consultants, relevant staff from cancer registries, state health authorities and universities.

Registration Fee:

Nil, **except** for workshops conducted in NSW, Queensland and Tasmania. For workshops in these states, the registration fee is \$50 per person. Please make cheques payable to the National Coding Centre and send the cheque and a copy of this registration form to: National Coding Centre, PO Box 170, LIDCOMBE NSW 2141.

Travel and Accommodation:

Travel and accommodation expenses incurred through attendance at the workshops should be met by the participant or their employer/organisation.

What to bring:

Your 1996 *Australian Version of ICD - 9 - CM*, 2nd Edition, including Volume 4, the *Australian Coding Standards* (available from the NCC from early May '96).

How and When to Register:

If you have not received a registration form as yet please contact:

**Leisa Shorrocks, National Coding Centre,
ph: (02) 646 6461, fax: (02) 646 6603.**

NB: Workshops conducted in metropolitan centres are limited to a maximum of 50 participants. As places are limited, please register early. At press, some workshops were already full (as indicated on the next page). Please note that all workshops are of one day's duration ■

Locations/Venues/Dates

➡ NEW SOUTH WALES

SYDNEY

- i) Westmead Hospital (Auditorium, Education Block) - 3 June or 11 June, 9.30-3.30
- ii) Prince of Wales Hospital (Edmund Blackett Theatre) - 4 June, 9.30-3.30
- iii) Concord Hospital (Conference Room) - 13 June, 9.30-3.30
- iv) Northern Sydney Education Centre, Wicks Road, North Ryde (grounds of Macquarie Hospital) - 15 June, 9.30-3.30

ORANGE

Bloomfield Hospital (Conference Room 3, Staff Development Centre) - 29 May, 9.30-3.30

WAGGA WAGGA

Wagga Wagga Base Hospital (Schofield House) - 14 June, 9.30-3.30

LISMORE

Coraki Conference Centre (Rayner Room), The Campbell Hospital, Coraki - 17 June, 9.30-3.30

TAMWORTH

Rural Health Education and Research Centre (Conference Room 2), Dean Street, Tamworth - 5 June, 9.30-3.30

NEWCASTLE

David Maddison Building (Main Lecture Theatre) Royal Newcastle Hospital - 4 June, 9.30-3.30

SHELLHARBOUR

Illawarra Area Health Service (Resource Centre), Pioneer Drive, Shellharbour - 2 July, 9.30-3.30

➡ NORTHERN TERRITORY

DARWIN

Royal Darwin Hospital (Staff Development Centre, Block 4) - 17 June, 9.00-4.00

➡ AUSTRALIAN CAPITAL TERRITORY

CANBERRA

Woden Valley Hospital (Seminar Room 2, Level 3, Building 2) - 30 May, 9.00-4.00

➡ TASMANIA

“The Grange” (The Studio), Midlands Highway, Campbelltown - 18 June, 9.00-4.00

➡ QUEENSLAND

BRISBANE

All three Brisbane workshops at:
Mater Public Hospital (Des O’Calligan Auditorium)

- i) 5 June, 9.00-4.00
- ii) 7 June, 9.00-4.00
- iii) 15 June, 9.00-4.00

TOWNSVILLE

Kirwan Hospital for Women (Meeting Room) - 4 June, 9.30-3.30

ROCKHAMPTON

Rockhampton Base Hospital (Conference Room B, Yangulla Centre) - 6 June, 9.30-3.30

TOOWOOMBA

Toowoomba Base Hospital (Suite 1, Freshney House) - 5 June, 9.30-3.30

➡ WESTERN AUSTRALIA

PERTH

All four Perth workshops at: Department of Health of WA (Seminar Rooms), 189 Royal Street, Perth

- i) 7 June, 9.00-4.00
- ii) 14 June, 9.00-4.00
- iii) 21 June, 9.00-4.00
- iv) 28 June, 9.00-4.00

➡ SOUTH AUSTRALIA

ADELAIDE

All three Adelaide workshops at:
AMA House, 80 Brougham Place, North Adelaide

- i) **22 MAY** (Private Sector Coders) 9.00-4.00
- ii) **23 MAY** (Public Sector Coders) 9.00-4.00
- iii) **24 MAY** (Public Sector Coders) 9.00-4.00 **FULL**

NB: The dates in the original flyer were incorrect. The workshops will be conducted in **May** and not June.

➡ VICTORIA

MELBOURNE

All five Melbourne workshops at:
Olympic Park Function Centre (Olympia Room), Swan Street, Melbourne

- i) 19 June, 9.00-4.00 **FULL**
- ii) 20 June, 9.00-4.00 **FULL**
- iii) 22 June, 9.00-4.00
- iv) 25 June, 9.00-4.00
- v) 26 June, 9.00-4.00

TRARALGON

La Trobe Regional Hospital (Lecture Hall, Education Centre, Traralgon Campus) - 27 June, 9.00-4.00

WANGARATTA

Wangaratta District Base Hospital (Conference Room) - 17 June, 9.00-4.00

BENDIGO

Anne Caudle Centre (Banksia Room), 100-104 Barnard Street, Bendigo - 18 June, 9.00-4.00

GEELONG

Grace McKellar Centre (Alan David Hall, “The Hub”), 45-95 Ballarat Road, North Geelong - 21 June, 9.00-4.00

National Coder Workforce Issues Project (NCWIP) Update

This article gives health information managers and clinical coders an update on the current activities of the National Coder Workforce Issues Project.

✓ **Coder Workforce Survey**

A report on the review of the coder workforce entitled "The Australian Coder Workforce" was submitted to the Commonwealth Department of Human Services and Health in October 1995. The report was based on a national coder workforce survey of all hospitals and freestanding daycare facilities carried out in late 1994 and early 1995. The report sought to provide a comprehensive profile of the Australian coder workforce, and reported on the coding workforce, coding quality, the coder population and job profiles, coders' background and experience, perceived educational needs, salary and industrial conditions, factors affecting coding quality and other issues. This report is available for purchase from the HIMAA Resource Centre, PO Box 1458, PARRAMATTA, NSW 2124.

✓ **Clinical Coder National Competency Standards (CCNCS)**

On the 7th March 1996 the competency standards were endorsed by the National Community Services & Health Industry Training Advisory Board. They are now at the final stage in the competency standards endorsement process and expect to receive final approval from the Standards and Curriculum Council in coming weeks. The standards package will then be available for purchase through the HIMAA Resource Centre, for use as an in-house assessment tool.

These standards have been developed with the aim of determining the baseline competency levels of the coder workforce. The main objectives of undertaking this process were to:

- ensure standardisation of good coding practice
- recognise competency of clinical coders
- ensure entry level coders meet competency standards
- provide a mechanism for assessment of coders in the workplace
- ensure future curricula development meets minimum industry standards.

✓ **Educational Program**

The National Coder Workforce Issues Project is now offering an "Advance Your Coding Skills" program. This activity has been planned to advance the skills of clinical coders in the specialty areas of:

- obstetrics/gynaecology
- oncology
- late effects, burns, suicide intent and injury and poisonings
- general surgery, surgical techniques, diagnostic testing and complications.

Each specialty will be packaged in a separate module adapted for self-paced learning. A fax helpline service will be provided as part of this educational activity.

Clinical coders who choose to register for the accreditation examination will find this activity of assistance in their preparation for the accreditation examination.

✓ **Industrial Issues**

Another activity of the project is to address the industrial and workforce issues in relation to the introduction of coder accreditation. A document entitled "*Workforce and Industrial Issues for Clinical Coders - A Discussion Paper*" has been written and circulated to a range of relevant bodies including state health authorities, HIMAA State branches, coding educational organisations, industrial unions, employer organisations and health insurance organisations.

This discussion paper has attempted to raise many issues and concerns in relation to the introduction of coder accreditation in Australia. It has been developed to stimulate discussion amongst these groups rather than make formal recommendations.

Based on the responses received from the discussion paper, an options paper will be developed. It is hoped that the issues raised in the options paper will be referred to the relevant industrial and employer groups.

A final report based on this discussion paper and the responses received will be submitted to the Commonwealth Department of Health and Family Services in May 1996.



☑ **Coder Accreditation Examination**

Accreditation is the process whereby coders are assessed for their expertise against a pre-determined standard. Coder accreditation is seen as the final stage in the competency ladder with accredited coders demonstrating superior skills in abstraction and coding of health data. An individual who sits and passes the accreditation examination will be recognised as meeting a national benchmark. They will be recognised as an Accredited Clinical Coder (ACC). The coder examination is voluntary, will be administered by HIMAA, and will use simulation methodologies, primarily comprised of coding of medical records, together with a theory component.

Leanne Holmes
Project Manager, NCWIP

STOP PRESS...

***CODER ACCREDITATION
EXAMINATION DATE*** 

The date of the inaugural coder accreditation examination has now been set for **Saturday 21st September 1996**. The examination will be held in major cities and towns throughout Australia, with locations to be based on demand.

It is anticipated that coders will not be required to travel more than 150 km from their homes to take the examination. Special arrangements will be made for coders in remote areas and those with particular needs.

☞ For further details on the examination date, or on any of the activities of the National Coder Workforce Issues Project, telephone Leanne Holmes, Project Manager on: **(07) 3250 1533**.

**AUSTRALIAN CASEMIX REPORT
ON HOSPITAL ACTIVITY
1993-94**

The *Australian Casemix Report* is a unique publication in that it is the only printed source available for comprehensive national casemix data on hospital activity in Australia. This fact alone makes it essential reading for anyone with an interest in casemix developments.

The 1993-94 Casemix Report has been produced by the Commonwealth Department of Health and Family Services on behalf of the Australian Health Ministers' Advisory Council. It consists of a 250-page hard copy report, and includes two floppy disks containing the equivalent of 900 A4 pages of tables.

The 1993-94 Casemix Report is rich in detail. It includes user-friendly accounts of:

- ◆ the usage patterns of public and private hospital systems;
- ◆ the Australian National Diagnosis Related Groups (AN-DRG) classification;
- ◆ public hospital separations and bed days by AN-DRG over the period 1991-92 to 1993-94;
- ◆ the casemix of public and private patients in public hospitals;
- ◆ the casemix of private hospitals;
- ◆ the casemix complexity of patient flows between States/Territories;
- ◆ detailed clinical profiles for 31 selected AN-DRGs; and
- ◆ State/Territory use of ICD-9-CM diagnosis and procedure codes.

The addition of an electronic component has made it possible to give details of separations, bed days, same day separations, average length of stay and costs (where available) for every AN-DRG (Version 3.0) for the public hospital systems in each State or Territory, and for each of the three years 1991-92 to 1993-94.

The *Australian Casemix Report on Hospital Activity, 1993-94* is available from the first week of April, and has a recommended retail price of \$24.95. Details on how copies may be purchased are found in an advertisement on the back cover of this issue of *Coding Matters*. For further information on the contents of the Report, please contact Bill Nichol:

⇒  ph: (06) 289 8611, or  fax: (06) 289 7360.

CODING SERVICES UPDATE

The Coding Services division of the NCC is expanding rapidly both in number of projects and staff. Two major projects are in full swing:

- 1) *Mapping project*, and
- 2) *Development of a new procedure classification (to accompany ICD-10) which will replace ICD-9-CM procedures from July 1998.*

① Mapping project

The term “mapping” refers to the process of finding an “equivalent” code between two classifications which enables data users to interpret old and new data across the different classifications. Mapping is particularly important for time series data analysis and when using AN-DRG grouper software which is developed on a specific set of ICD-9-CM codes. However, time series data analysis may require use of various sets of codes to be analysed by the DRG grouper software.

Mapping is not a new concept. For some years, state health authorities have undertaken mappings between different versions of ICD-9-CM. For example, currently in NSW the latest ICD-9-CM codes are implemented each July but the AN-DRG grouper being used is Version 1.0 (the current version is Version 3.0) which was built on 1992 ICD-9-CM codes. Therefore, to use the Version 1.0 grouper using 1995 ICD-9-CM codes, a new code needs to be mapped back to an equivalent code from 1992 (e.g. the new codes 170.01 and 213.01 map back to 170.0 and 213.0 respectively).

Mappings between ICD-9-CM and ICD-10 are needed to facilitate a smooth transition between these two classifications in July 1998. These mappings will enable ICD-10 coded data to be grouped in the AN-DRG grouper which is built on 1996 ICD-9-CM codes. Similarly, it will enable a grouper version developed in ICD-9-CM to appear in ICD-10 codes.

There are some important terms used in mapping, which are explained below. They are:

- Forward mapping
- Backward mapping
- Logical mapping
- Historical mapping.

Forward mapping is where a code from a previous year’s data set is mapped to a new code in a subsequent year’s data set because the previous code is

now invalid. For example, HIV codes 042.0, 042.1, 042.2 and 042.9, which became invalid in 1995, would be forward mapped to 042, the valid code in 1995. Forward mappings are used when it is desirable to group old data using a new AN-DRG grouping system. As mappings have until now been created between different updates of ICD-9-CM, it is only those codes that change which require mapping. However, in the mapping project all codes in ICD-9-CM need to be mapped to ICD-10. The forward mappings from ICD-9-CM to ICD-10 will be primarily used by the NCC to elucidate those areas where ICD-9-CM is more specific than ICD-10. ICD-10 may therefore need to be modified to accommodate levels of specificity in ICD-9-CM.

"Mapping is particularly important for time series data analysis"

Backward mapping is where a new code from the current year’s data set is mapped to an older code from a subsequent year’s data set in order to use a previous version of the grouper. For example, the new 1995 code for HIV, 042, would be mapped back to 042.9 in order to group new data using an old version of the grouper. Backward mapping has been used over the last few years to analyse new codes using an old version of the AN-DRG grouping software. It will be used in 1998 to convert all ICD-10 codes into the “equivalent” ICD-9-CM codes in order that grouping can occur using the 1998 version of AN-DRG which will also be effective in July 1998.

Historical mapping refers to the selection of a code map which achieves the most appropriate coding and clinical meaning. **Logical mapping** refers to the selection of a code map which achieves the appropriate AN-DRG assignment. Logical and historical maps are usually the same but do occasionally differ. For example, the new ICD-9-CM code 70.42 *Radical vaginectomy* to be introduced in July 1996 maps **historically** to 70.4 *Obliteration and total excision of the vagina*, i.e. 70.4 is the code that would have been assigned by coders prior to July 1996 for the procedure “radical vaginectomy”. However, because this code was introduced to make a distinction between “vaginectomy” and “radical vaginectomy”, the **logical** map will be 71.5 *Radical vulvectomy* because this code will result in the correct allocation of the AN-DRG 650 *Pelvic evisceration & radical vulvectomy*. In contrast, the logical and historical maps for 70.41 *Vaginectomy* are the same, i.e. 70.4 which groups to MDC 13, AN-DRG 658 *Female reproductive system reconstructive procedures*. ➤

Jocelyn Lee, NCC Senior Classification Officer, and previously Data Manager for the Colorectal Program at Concord Hospital, Sydney, is coordinating the mapping project. Jocelyn is very ably assisted by Natalia Alechna and Patricia DahDah (HIM honours students), Lauren Jones and some very accessible and much appreciated clinicians from the Clinical Coding and Classification Groups.

Creation of a classification is a new venture for Australia and has drawn on the skills of a number of health information managers whom we are proud to have sharing this very exciting and ground-breaking work with us. They are:

★ Paula Hallang and Andrea Groom from Melbourne - alias the "dynamic duo" - are creating the Plastic Surgery chapter of MBS-E, and

★ Judith Hooper, Judy Redmond, Gay Lysenko and Jenny Smith from Sydney.

'Procedures - Towards 2000' Standing (from left) are: Gay Lysenko, Judith Hooper, Paula Hallang, Andrea Groom and Jenny Smith. Seated (from left) are: Judy Redmond, Kerry Innes and Michelle Bramley.

② Development of a new Australian procedure classification - Towards 2000

Michelle Bramley (A/g Classification Project Officer) is coordinating this project which involves creation of a new procedure classification based on the Medicare Benefits Schedule (MBS) to be known as:

MBS-Extended
(or MBS-E for short)

This new classification will:

- come into effect from July 1998
- encompass procedures and interventions that are currently practised in Australia
- be concise and comprehensive, utilising the best features of ICD-9-CM and MBS
- replace ICD-9-CM Volume 3
- not replace the Commonwealth MBS, but will be mapped to MBS and ICD-9-CM
- be published as a book
- have a numeric, eight character code, the first five digits relating to MBS and the last two digits allocated by the NCC to describe certain procedural concepts embodied in the original MBS description. The new code will be in the following format: 32567-00

We are currently meeting with surgeons and proceduralists from the Clinical Coding and Classification Groups (CCCGs) in order to refine our first draft, which will be trialled by coders during April and May 1996.

For more information about the future of the Australian procedure classification see *"Beyond 2000"* on page 11.

Clinical Insights

Laparoscopic appendicectomy

The following article by Laurie Palmer was published in the *Journal of the American Health Information Management Association (AHIMA)* and is reproduced here for the interest of coders:

"Although laparoscopic appendectomies generally take longer to perform than the traditional open appendectomy, patients undergoing the laparoscopic surgery have a significantly shorter recovery time. According to the American Medical Association's *Archives of Surgery*, the laparoscopic procedure could become the new 'gold standard.' Michael Heinzelmann, MD, and colleagues from the University of Zurich, Switzerland, reviewed the cases of 306 patients who had appendectomies performed at the University of Zurich between 1991 and 1994; 102 patients underwent the laparoscopic approach and 204

Continued top of next column...

patients underwent the open technique. The researchers found that laparoscopic appendectomies averaged 83 minutes in duration while open appendectomies averaged 64 minutes. But patients undergoing laparoscopic appendectomies resumed their normal diets in an average of 2.6 days compared to 4.1 days in the control group. Also, hospital stays averaged 5.6 days for the laparoscopic group and 7.5 days for the open appendectomy group. There was no significant difference in the complication rate between the two groups.

Laparoscopy is also more useful for investigating suspected appendicitis, and postoperative lesions occur less often with that technique.

Although the study authors acknowledged that the costs of laparoscopic appendectomies are higher than for the conventional procedure, This expense could be offset by an earlier return of patients to normal, productive lives.”[1]

[1] Palmer, L. (1995) Laparoscopic appendectomy gaining ground. *Journal of the American Health Information Management Association (AHIMA)* **66** (10): 38.

In their recent Australian study, Cox et al [2] supported the American view that diagnostic laparoscopy is useful in reducing the rate of unnecessary appendectomy (41% to 9%). The authors claimed that the use of laparoscopy as a diagnostic tool also provides a more accurate diagnosis. Appendectomy can be performed, if necessary, at the time of diagnostic laparoscopy, with no further risk than generally associated with an open procedure. Although the study did not evaluate the costs of laparoscopic appendectomy versus laparoscopy followed by open appendectomy, the authors estimated that the operating times are similar. Complication rates were low overall, making laparoscopic appendectomy a safe procedure. Important advantages of the procedure were reduced wound infection, shorter postoperative stay and more rapid return to normal activities. This study also suggested that if a macroscopically normal appendix is found at laparoscopy, it should not be removed.

[2] Cox MR, McCall JL, Padbury RTA, et al. (1995) Laparoscopic surgery in women with a clinical diagnosis of acute appendicitis. *Medical Journal of Australia* **162**: 130-132.

OTHER CLINICAL NEWS

This is another interesting snippet from the *Medical Journal of Australia*, which summarises an article in the *Lancet* (1995) **346**: 1179-1184.

“Heartache

Patients with multivessel coronary artery disease who have percutaneous transluminal coronary angioplasty (PTCA) are more likely to require reintervention and to have clinically significant angina at one year than those who have coronary artery bypass grafting (CABG), according to the first report of a landmark European study. The Coronary Angioplasty versus Bypass Revascularisation Investigation (CABRI) group said their multinational, multicentre randomised study involving 1054 patients was the largest trial as yet reported that compares CABG with PTCA in multivessel coronary artery disease. The study group’s report of their first-year results also showed that in symptomatic patients with multivessel coronary disease the two procedures had an equivalent risk of death or myocardial infarction.”[3]

[3] (1995). “In other journals”. *Medical Journal of Australia* **164**: 50.

HISTORY OF GROUPER AND CODING VERSIONS

The following table may be a useful quick reference tool, although you should keep in mind that there are variations in implementation dates across the Australian states and territories.

AN-DRG GROUPER AND ICD-9-CM			
GROUPER VERSION	SOFTWARE RELEASED	ICD-9-CM COMPATIBILITY	SEPARATION DATA RANGE
AN-DRG 1.0	Jul-92	Oct-91	1 July 1992 - 30 June 1993
AN-DRG 2.0	Jul-93	Oct-92	1 July 1993 - 30 June 1994
AN-DRG 2.1	Jul-94	Oct-93 + 1994 Aust. codes	1 July 1994 - 30 June 1995
AN-DRG 3.0	Jul-95	1995 Aust. ICD-9-CM	1 July 1995 - 30 June 1996
AN-DRG 3.1	Jul-96	1996 Aust. ICD-9-CM	1 July 1996 - 30 June 1997

STOP PRESS...
NCC OFFICIAL ADDENDUM FOR
ICD-9-CM JULY 1996

The following two important points should be noted when reading the Addendum:

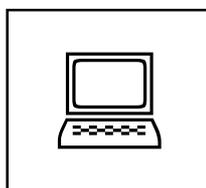
❶ Where existing annotations (e.g. *c/c* for comorbidities and complications, or for nonspecific principal diagnosis) do not appear next to a code in the Addendum, this does not mean that they no longer apply; it means that no change has been made to the annotations for those particular existing codes. The annotations will appear in the new edition of the *Australian Version of ICD-9-CM* (Second Edition, 1996). The annotations that do appear in the Addendum are those which apply to new codes to be introduced in July 1996.

❷ The fifth digit of "9" should be deleted for codes 800, 801, 803, 804.

Copies of the 1996 Addendum are now available from your state/territory health authority, if you have not already received one. ☒

The following article is a report by Kerry Innes (NCC Coding Services Manager) on the Medinfo'95 Conference. Apologies that this has not appeared sooner, but space limitations have prevailed in recent newsletter issues. We thought that *Coding Matters* readers would still like an update on world developments in medical informatics and coding. So here goes!

Beyond 2000 - Report on
MEDINFO '95, Vancouver, Canada



In July 1995 I attended the International Medical Informatics Association's (IMIA) Eighth World Congress on Medical Informatics (Medinfo '95) in Vancouver, Canada. Elizabeth Moss from the

Australian Institute of Health and Welfare (AIHW) joined me for a very full and interesting week. As this was our first visit to Canada, Elizabeth and I spent a week prior to the congress travelling across British Columbia into Alberta visiting some of those famous places, such as Lake Louise and Banff.

Elizabeth and I tried to attend different sessions at Medinfo '95 to ensure we gained as much information as possible. I went to Medinfo '95 with the intention

of gaining some knowledge of how informatics could assist the National Coding Centre in its aim of producing a computerised procedure classification to replace ICD-9-CM.

The scientific program followed a number of streams:

- * Education and training
- * Decision support systems
- * Health information systems
- * Medical language and coding
- * Informatics in dentistry
- * Nursing informatics
- * Image and signal processing
- * Telemedicine and communication
- * Primary care
- * Security, legal and ethical issues.

The scientific program was complemented by scientific demonstrations, workshops and case studies and experiences in health information technology.

While I attended the 'medical language and coding' stream and the related workshops, Elizabeth attended sessions on Health Level 7 (HL7), SNOMED, a universal patient identifier, medical concepts representation and standards in health care telematics and informatics.

"Kerry Innes reports on informatics, nomenclature, standards and the future of coding"

A number of different nomenclatures and classifications were discussed at Medinfo '95, including:

- Unified Medical Language System (UMLS) - the USA National Library of Medicine has developed the Unified Medical Language System which is a complex collection of terms, concepts, and relationships derived from standard classifications.
- Read Clinical Classification system - a system of recording clinical information using clinical terms, designed for use in primary care.
- Systematised Nomenclature of Human and Veterinary Medicine (SNOMED) International - published in 1993 by the College of American Pathologists. A multiaxial nomenclature designed for indexing, storing and retrieving the medical information of an electronic medical record.



Papers presented at the medical language and coding stream dealt predominantly with two areas:

- ◆ Methods of natural language processing of disease descriptions and, to a lesser extent, descriptions of procedures in medicine, and
- ◆ Medical concept representation.

Medical concept representation can be simply explained by the example of the term “fingernail” which can be conceptualised as “part of the lower arm”. In order to computerise the documentation of medical descriptions, the terms need to be “taken apart” and put into a structured model which a computer can then classify. However, it was acknowledged that some medical language is much harder to conceptualise than this example of “fingernail”, particularly that of psychiatry. Although there was general agreement amongst the presenters that “structure” is essential to computerise medical descriptions, there was a difference of opinion about how that structure is achieved. Some say that doctors must be able to freely use their natural language, which should then be subsequently managed by computers; others believe that the only way to computerise medical language is to enforce the use of a more structured language by doctors.

The most important message coming out of these papers on medical language and coding is the need for international standardisation in the development of procedure classifications. To that end, many countries (particularly in Europe) are looking to the work of the European Committee for Standardisation’s (CEN) Technical Committee 251. TC251 is developing a standard structure for the classification and coding of surgical procedures. Without going into too much detail, this “structure” relates to the concept fields within surgical procedures:

■ **Surgical deed** - Deed which can be done by the operator to the patient’s body during the surgical procedure.

to open	to create	to destroy
to close	to connect	to loosen
to remove	to dilate	to restrict
to clean	to examine	to pass through

■ **Human anatomy** - organ system or anatomic region.

■ **Pathology** - Abnormal macroscopic morphology.

Traumatic abnormality (dislocation, fracture, rupture, scar, wound)

Developmental malformation (cyst, polyp, neoplasm)

Inflammatory abnormality (abscess, fistula, adhesion)

Abnormal deposition (stone, thrombus)

Abnormal morphology resulting from previous procedures (stoma, anastomosis)

Unspecified pathology (lesion)

■ **Interventional equipment** - medical device for use in surgical procedure.

Surgical prostheses (implant, pacemaker, prosthetic valve)

Surgical instruments (drill, needle, scissors)

Fixation devices (nail, screw, plate)

Tubular devices (catheter, drain, tube)

Imaging devices (endoscopy, microscope, X-ray, ultrasound equipment)

Surgical agents (electricity, liquid nitrogen, laser)

■ **Modifiers** - expressions referring to characteristics that can be added to a superordinate concept to form a subordinate concept in a generic relation.

Extent - degree to which the deed is carried out (superficially, partially, etc)

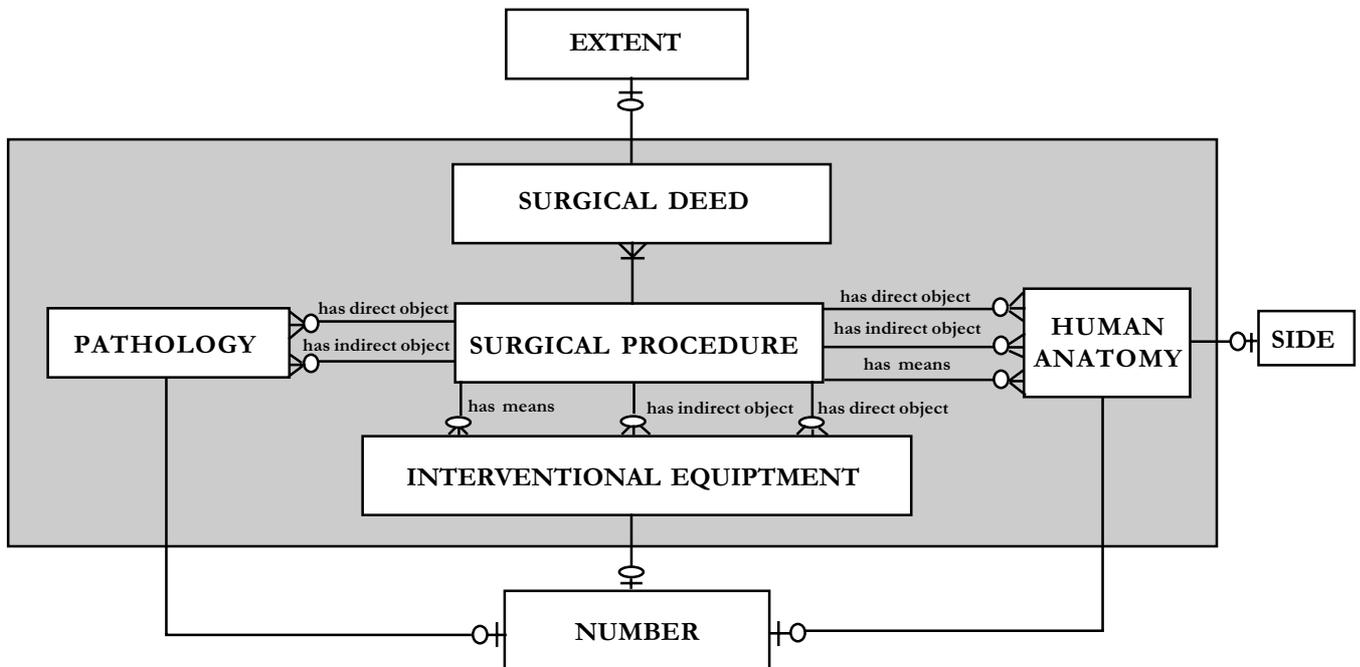
Side - half of the body involved in the deed (right, left, both, lateral, medial)

Number - how many specimens are involved in this action (two polyps)

TC251 explains the structure in terms of a concept diagram (*see* diagram, next page). Every surgical procedure concept involves at least one concept of the field “surgical deed”, and may involve any number of concepts of the fields “human anatomy”, “interventional equipment” and “pathology”.

One of our most valuable contacts made at Medinfo’95 was Dr Alan Rector, Project Administrator of The Generalised Architecture for Languages, Encyclopaedias and Nomenclatures in Medicine (GALEN). GALEN is a three-year research and development project based at the University of Manchester, England.

GALEN “will provide a foundation on which to build the next generation of clinical information and electronic patient record systems. ➤



Concept Diagram: Surgical procedures concept system. Structure for classification and coding of surgical procedures. TC251 - Medical Informatics. European Committee for Standardisation (CEN). 1994.

Clinical terminologies are large, complex, and diverse. For example, the detail required in a patient's medical record, which is used to support the daily care of the patient, is far greater than that needed for an epidemiological study or routine hospital statistics. Furthermore, different users in different clinical settings require different but consistent views of that information. To address the problems of clinical terminologies, GALEN is constructing a semantically sound *model* of clinical terminology.

This model comprises:

- elementary clinical concepts such as 'fracture', 'bone', 'left' and 'humerus';
- relationships such as 'fractures can occur in bones', that control how these may be combined;
- complex concepts such as 'fracture of the left humerus' composed from simpler ones." [1]

[1] (1994) *GALEN, Advanced terminological services to support integrated clinical information systems*. The GALEN Project Office, Department of Computer Science, University of Manchester, Manchester.

We have sought advice from the GALEN team on our preliminary work on MBS-Extended and Rosemary Roberts will be visiting Alan Rector, project administrator, during her overseas trip in April this

year. Lynda Dandie (HIM, previously of the Austin Hospital, Melbourne) has recently moved to England and will be joining Rosemary on her visit to the GALEN office, as the NCC's ambassador!

There is a myriad of reading material available from the Medinfo '95 proceedings covering natural language systems, conceptual graphs, etc and we will endeavour to pass on more information periodically through *Coding Matters*. Information on electronic data interchange (EDI) standards, such as HL7 and ANSI, can also be found on the NCC Homepage Resource Centre under the heading "EDI Standards Organisations".

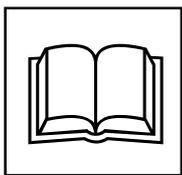
NCC homepage address again is:

<http://www.cchs.su.edu.au/NCC/ncc.html>

The initial work being done on MBS-Extended will form the basis of further development of our Australian procedure classification into a computerised, expandable, multiaxial, current and user-friendly system. We look forward to being involved with our colleagues in informatics both here and overseas to produce a procedure classification to take us *Beyond 2000!*

❖ **Kerry Innes**

PUBLICATION ISSUES



Feedback on the NCC homepage has been very positive to date! As we go to press, 474 people have visited our internet site since February 2, 1996. One such HIM 'net surfer' commented:

"Congratulations on the excellent NCC pages. I was most impressed with the Resource page and the excellent links to some resources my doctors were having difficulty finding. It is fantastic to see HIM going electronic!" (Bernadette Cranston, Qld)

Thank you for your words of congratulation. We will endeavour to keep up the standard! Subject to input from the State Coding Committees, we hope to soon also add State Coding Bulletin Boards to our homepage site. If you've forgotten our internet address, see bottom of previous page.

Apologies to Dot Muir, whose reply to our "Maggot Therapy" article was printed in the last issue of *Coding Matters* (Vol. 2, No. 3). I mistakenly listed Dot as being from Rockingham/Kwinana Health Service in "Qld"! Dot thought it was a little *too* far to travel, seeing her Health Service is actually in WA, but she says she'd love to swap the weather! 😊

Order your 1996 Australian ICD-9-CM Books now

Only \$50/set for existing customers (for the same quantity of sets as 1995) or \$200/set for new customers or additional sets. If you have not already received your order form, call Leisa Shorrocks on (02) 646 6461.

◆ Specialty Booklets - Casemix & Coding

Simone Lewis (NCC Publications Assistant) has plunged into the preparation of draft publications for the specialty areas of Respiratory, Oncology & Haematology and Geriatrics & Rehabilitation. Simone is currently in the process of sending out this draft material to relevant clinical coders and clinicians, on the respective CCCGs, for consultation on content.

Simone Lewis
(NCC
Publications
Assistant)
*dives into
the topics of
casemix,
DRGs and
coding.*

The NCC would also now like to get your input on a specific query. If you are a clinical coder experienced in the fields **Respiratory, Oncology & Haematology or Geriatrics & Rehabilitation**, you may wish to help us out with the following:

◆ *What are the questions that clinicians most frequently ask coders regarding coding in the above specialties?*

List only 3 points per specialty. Please send your responses to Simone Lewis by 17 May 1996 on fax: (02) 646 6603 or by e mail: s.lewis@cchs.su.edu.au

The first three booklets are planned for publication mid-year 1996 and details of how to order booklets in this new informative series will appear in the next issue of *Coding Matters*.

Until next issue!

◆ **Karen Luxford**

1996 Electronic ASCII List of ICD-9-CM Codes Full Descriptors

📁 Now available from the NCC for \$200 📁

Ideal for database environments

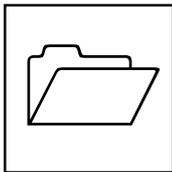
All codes effective from 1 July 1996

Includes 284 new codes (flagged with 1996 introduction date)

For Order Forms, contact Leisa Shorrocks on pb (02) 646 6461

[NB: All existing ASCII List customers will automatically be sent a form for the 1996 diskettes]

Coding Tips



This regular section is intended to provide ongoing feedback 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 data collections will be flagged and should only be introduced from the July following publication. If you find that any tips published in this section significantly change your current practice, you should seek advice from your state/territory health authority regarding a suitable date for implementation.

❑ Pruritic urticarial plaques of pregnancy (PUPP)

This is a distinct, not uncommon condition involving intensely pruritic, erythematous, urticaria-like papules and plaques, arising in the third trimester. The eruption usually resolves promptly after delivery and does not usually recur in subsequent pregnancies.

Code to: 646.8 *Other specified complication of pregnancy*, and
698.8 *Other specified pruritic conditions*

❑ Coloproctectomy

This term is not indexed in ICD-9-CM but an exclusion note exists under code 45.8 which has caused some confusion. It reads:

Excludes: coloproctectomy (48.41 - 48.69)

This exclusion note is incorrect, and should be ignored. Because ICD-9-CM differentiates between procedures on the colon and the rectum, coloproctectomy should be assigned two codes, namely:

45.8 *Total intra-abdominal colectomy*, and
48.5 *Abdominoperineal resection of rectum*

Continued top of next column...

**1996 NCC Seminar
- see back cover this issue...**

❑ Failed forceps and failed vacuum extraction

Disease and procedure coding varies for failed forceps/vacuum extraction due to the structure of ICD-9-CM.

Whenever a diagnosis of “failed forceps” or “failed vacuum extraction” is documented, assign 660.7x *Failed forceps or vacuum extraction, unspecified* with the appropriate procedure code.

If the procedure is failed forceps, assign 73.3 *Failed forceps* only. A code for the specific type of forceps is unnecessary. When using 73.3 ensure that a code for episiotomy is assigned if this is also performed. If the procedure is “failed vacuum extraction”, code to the appropriate vacuum extraction code (72.7x) as no specific code exists for “failed vacuum extraction”. In cases of failed forceps/vacuum extraction an additional code is required for any subsequent intervention e.g. caesarean.

❖ *Kerry Innes*

P.S. See insert this issue for Coding Tips Index!

Coderscope

Your horoscope
by
Megan Stargazer

♈ *Aries* *March 21 - April 20*

Time to wake up from 293.89 (see Index, Alice). Take yourself out in the fresh air, but be careful of random E920.4 and E805.

♉ *Taurus* *April 21 - May 21*

Your usual bluntness (Taureans are loved for this) could have you wearing a 744.81. You should resist the urge to be involved with E968.1 Be good to yourself, work towards a 780.03.

♊ *Gemini* *May 22 - June 21*

In line with your 10 year plan sometime after July 1998 you will meet a person with R46.1 who greatly changes your life. In your homemaking, avoid E920.2.

★ New Publication ★

**AUSTRALIAN CASEMIX REPORT ON HOSPITAL ACTIVITY
1993-94**

The *Australian Casemix Report* is the only printed source available for readers wanting comprehensive national casemix data on hospital activity in Australia. This fact alone makes it essential reading for anyone with an interest in casemix developments.

The 1993-94 Casemix Report will be available for sale from early April 1996. It consists of a 250-page hard copy report, and includes two floppy disks containing the equivalent of 900 A4 pages of tables. Details of its contents are given on page 7 in this issue of *Coding Matters* (coding excerpts from the 1993-94 Casemix Report can be found on the insert provided in this issue).

With a recommended retail price of \$24.95, the 1993-94 Casemix Report represents outstanding value for money!

☞ Copies may be purchased from the Australian Government Publishing Service in one of four ways:

1. over the counter from any one of 9 Commonwealth Bookshops;
2. AGPS mail order sales (AGPS, GPO Box 84, Canberra, ACT 2601);
3. AGPS phone shop, free call 132 447 (24 hour answering service), or 295 4861 for Canberra callers;
4. fax an order (06 295 4888, credit card and account customers only).

**News Flash!!!
3rd Annual NCC Seminar**

The National Coding Centre will be holding its 3rd Annual Seminar on 21 and 22 November 1996 at the Hyatt Regency, Coolumb, on the Sunshine Coast, Queensland. More details to follow in the next edition of *Coding Matters* ■

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National Coding Centre
PO Box 170
Lidcombe NSW
Australia 2141



Phone: (02) 646 6461
Fax: (02) 646 6603
email: k.luxford@cchs.su.edu.au

Editor: Karen Luxford

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DOCUMENTATION: A Matter of Life or Death

The NCC and NRCCH have received a number of enquiries as to the possibility of obtaining additional copies of the posters produced as part of this popular educational package. In response to these requests, we would like to make additional copies of the posters available at manageable rates.

Effective with this edition of *Coding Matters*, you can now order either 5 morbidity or 5 mortality posters for **only \$35.00.**

☞ Please telephone Leisa Shorrocks on (02) 646 6461 to obtain an order form for this product.

The National Coding Centre (NCC) is funded by the Casemix Development Program, Commonwealth Department of Health and Family Services. The NCC is an independent national body established by the School of Health Information Management, Faculty of Health Sciences, University of Sydney. ❖
