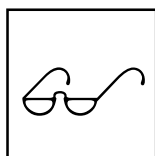


Coding Matters

Newsletter of the National Coding Centre

Volume 3 Number 2
October 1996



FROM THE DESK OF THE DIRECTOR

Clinical Coders' Society of Australia (CCSA)

A highlight of this issue of *Coding Matters* is the announcement from Health Information Management Association of Australia (HIMAA) of the creation of the new Clinical Coders' Society of Australia (CCSA). This is a truly significant achievement for coders and for the HIMAA and also for the Chair of its Establishment Committee, Janelle Craig, known to us as National Coding Centre (NCC) Education Manager, but also Vice-President of HIMAA. The NCC looks forward to close cooperation with CCSA and welcomes the society as a forum for coders to discuss many issues relating to their function, education, workforce planning and coding. It is in relation to coding that we expect the greatest degree of overlap with CCSA, as the codes and standards and education in those standards is the central role of the NCC. It will be extremely helpful to the NCC to have a society representing the views of clinical coders – our main customers.

Congratulations to CCSA and to members of its Establishment Committee, to HIMAA, to Janelle and to Barbara Levings, the first president of CCSA. Other members of the new executive are listed on page 10 of this newsletter and you should have already received your form to apply for membership. CCSA will also have its own newsletter, so you may find some refocussing of *Coding Matters* material to reflect coding issues while the CCSA newsletter will carry information relevant to coders.

ICD-10-AM

As the deadline for content completion approaches, the attention of the NCC in the last few months has been on production of ICD-10-Australian Modification (ICD-10-AM). Not the least of these deadlines is the production of an Addendum to ICD-10 to present to the meeting of World Health Organization (WHO) Heads of Collaborating Centres for Classification of Diseases to be held in Tokyo in October 1996. Representing Australia will be Dr John Donovan, Australian Institute of Health and Welfare (AIHW),

Casemix and coding booklets now available

– see page 12

Ms Sue Walker, (Director, National Reference Centre for Classification in Health) and myself. Of greatest importance to WHO are recommendations for change at the third and fourth character level, of which there number 20 from Australia. At the fifth character level, nations developing their own versions have more freedom. The NCC, in collaboration with its network of specialist clinician and coding advisers, has produced many additions to ICD-10. These will be submitted to WHO for information, but not for approval as with the third and fourth character changes. The Coding Standards Advisory Committee (CSAC) has reviewed and approved all recommended additions to the Tabular List of Diseases, and by the time this issue of *Coding Matters* reaches you, we will have completed the additions to the Index of Diseases.

In regard to the new procedure classification – MBS-Extended – most of the clinical consultation is complete, ►

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and the specialty areas are now being amalgamated to form what you are accustomed to using as a procedure classification – a tabular list structured according to site and procedure type with an alphabetic index. Thanks to all those hospitals and clinical coders who assisted with the pilot study of the specialty specific procedures. The total procedure classification will be trialled in October 1996 so that any changes can be incorporated before the end of the year.

A working group of the National Health Information Management Group (NHIMG) has been consulting with the NCC to fulfil the Australian Health Ministers' Advisory Committee (AHMAC) requirement that NHIMG endorse the NCC's methods of producing the procedure classification. The National Committee for Implementation of ICD-10 in Australian Hospitals met in August and reviewed progress on disease and procedure classification.

Progress has been made on creation of additional allied health intervention codes, both through communication with professional organisations and the National Allied Health Reference Standards Project. Outcome of the proposal to the Department of Health and Family Services (DHFS) for funding for the ICD-10 Education Strategy is not yet known. However, a teleconference of educational representatives on the original ICD-10

education group was held on 13 September 1996, and preliminary plans made for educating coders and data users in ICD-10-AM.

Shahn Campbell, on secondment to the NCC from the Victorian Department of Human Services, has been assisting Janelle Craig in preparing the ICD-10-AM Implementation Kit for Australian hospitals and health services.

Casemix & Coding Specialty Booklets

The first two booklets in the NCC series of specialty publications (Respiratory Medicine and Thoracic Surgery, and Oncology and Haematology) are now available from the NCC. Congratulations to Simone Lewis (Publications Assistant) and the Publications team for this most impressive production, and thanks to coders and clinicians who contributed, as well as to the Australian Casemix Clinical Committee (ACCC) for financial support for Simone's position (*see page 11*).

Coding Standards Advisory Committee (CSAC)

CSAC met on 2 August 1996 in Sydney with 100% attendance! CSAC members continue to provide major input to the work of the NCC, including ratification of the Australian modification of ICD-10.

Two subgroups of CSAC were formed – one to develop a coder satisfaction questionnaire for completion by coders during the second pilot of ICD-10-AM (Jo Raw, Lisa Quick and Sandy Juriansz); and another composed of state representatives to look at the possible standardisation of coding edits across states (Irene Kearsey from Victoria to convene).

Also discussed was a table prepared by the NCC demonstrating wide variation in number of diagnosis and procedure fields accepted by state and territory morbidity data collections (*see insert*). The issue has been referred to the National Health Data Committee (AIHW) for discussion on standardisation, particularly as the number of diagnoses and procedures coded is increasing in all states.

Integrated Quality Management Model

Lauren Jones has been working closely with the Australian Council on Healthcare Standards (ACHS) Care Evaluation Program to choose clinical indicators in obstetrics and gynaecology which are appropriate for hospitals to test the feasibility of extracting indicator data as a by-product of the clinical coding process. Three hospitals, Wimmera Base (Victoria), Royal Women's Hospital (Melbourne) and Campbelltown Hospital (NSW) are to pilot the definitions using ICD-9-CM logic and make comparisons with data extracted from usual sources of indicator material.

Coding Matters



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Volume 3 Number 2

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Coding in ambulatory settings

At the end of July 1996, I attended a meeting in Melbourne of the national reference group of the National Institution Based Ambulatory Modelling Project (NIBAM), organised by NSW Health for NHIMG. NIBAM is modelling information needs and information flows for outpatient clinics and emergency departments. NCC's input has been to the possible coding of issues (reasons for visit) and interventions in these settings.

The NCC is also being consulted by the project being carried out by the Family Medicine Research Unit, University of Sydney, to test the feasibility of the International Classification of Primary Care Plus (ICPC+) in community health services. Marianne Carter has been seconded from Central Western NSW to act as Project Officer for the project for three months and is working with Ms Julie Bargaquast, Dr Graeme Miller and Dr Helena Britt.

Conferences, seminars and visits

Because my message in the last issue of *Coding Matters* was largely devoted to my European visit, I neglected to bring you up to date with Australian activities. The

NCC has been most fortunate to be included in a wide range of educational activities in the last few months. Exposure to health professionals working in clinical areas helps keep us in touch with the real world, and gives us the opportunity to disseminate information about the work of the NCC.

Welcome Joanne Chicco – the NCC's new Quality Manager.

The Royal Australasian College of Physicians held a Workshop on Casemix in conjunction with their

Annual Scientific Program in Canberra in early May 1996 and asked me to participate in a panel to discuss issues of documentation, coding and casemix classification. On May 23, the Australian Private Hospitals Association (APHA) invited me to speak at their Casemix Conference on 'Clinical Coding Audits: A Strategy for Private Hospitals'.

On 1 August 1996, I visited the Melbourne Clinic to discuss coding for mental health, work on ICD-10-AM and application of allied health intervention codes in mental health settings. Also in early August, Dr John Holmes (Chairman of the ICD-10 Implementation Committee) and I met with Dr Michael Crampton (Assistant Secretary General, The Royal Australian

Nicole Boyens (left) and Karen Peasley are the latest additions to the NCC's team of project officers.

College of General Practitioners) to discuss the relevance of ICD-10-AM to coding systems in general practice.

A meeting initiated by Vicky Stanley to discuss coding in rehabilitation was held at Mt. Wilga on August 19. Present were Vicky Stanley, Kathryn Le-Gay-Brereton, Helen Dawson, Kerry Innes and myself. It was decided to plan a joint workshop early in 1997 to raise issues for rehabilitation coding and to include in the workshop organisation the AIHW and a representative of the private sector. The aim of the workshop is to discuss needs for coding in rehabilitation, describe classification systems available and provide advice to the NCC on direction of rehabilitation coding development – diagnostic, functional and interventional.

Several NCC staff attended the 8th Casemix Conference in Sydney in September 1996 with presentations from Janelle Craig, Karen Luxford and Michelle Bramley. On September 15, Michelle also spoke at the Allied Health and Casemix Conference on allied health intervention coding.

It was wonderful to see so many of our readers at the NCC exhibition booth at the Casemix Conference. We were also very pleased to hear the announcement of Andrew Podger (Secretary, DHFS) in the conference opening address stating that the operations of the NCC were considered to be core functions of the Casemix Development Program and consequently support for the NCC by the Commonwealth would be ongoing until at least June 2000.

I was fortunate to be able to attend the 'Patient Classification Systems – Europe' conference immediately following the Casemix Conference, to catch up with coding and classification progress in Europe and North America. ▶

Staff changes

NCC staff had protracted sad farewells to Leisa Shorrocks (Administrative Assistant) who is in training to be Constable Shorrocks – so watch out! We were also sorry to lose Jocelyn Lee who has made a major contribution to the development of ICD-10-AM (diseases).

Welcome to:

- ✧ Connie-Rae Ballhause
(Administrative Assistant)
- ✧ Karen Peasley – HIV and ICD-10-AM (diseases) (Project Officer)
- ✧ Nicole Boyens – ICD-10-AM (procedures) (Project Officer)
- ✧ Shahn Campbell (on secondment from Victorian Department of Human Services)
- ✧ Joanne Chicco (Quality Manager)
- ✧ Chris Erratt (returning from maternity leave).

Projects, reports

- NSW Health – Waiting List exclusions – code list. Issue referred to National Health Data Committee (NHDC) to standardise waiting list exclusions with explicit lists of ICD-9-CM codes.
- Submissions to DHFS for ACCC Review and Review of Casemix Development Program.
- Anaesthesia coding – Prof Bill Runciman, Adelaide.
- Medicare Schedule Review Task Force – Consultancy to map MBS to overseas schedules (Rosemary Roberts, Sue Walker, Joy Smith and NCC staff).
- NSW Health – HIV Coding (Karen Peasley).

Visitors

Paul Fahey (Health Services Research Group, University of Newcastle) and Dr Alireza Abady (Iranian Ministry of Health and Education) met with staff from the NCC in July 1996 to discuss issues of data quality review.

Twenty members of a Thai delegation, headed by Dr Pichai Tangsin (Director of Health Information Division, Health Policy and Planning Bureau, Ministry of Public Health, Thailand), visited the NCC on 24 July. The visit was coordinated by Paul Long, NSW Health, and delegates were accompanied by Lisa Quick from NSW Health.

School of HIM

NCC continues to work closely with the School of HIM, University of Sydney. Recent student placements

Thai delegation, headed by Dr Pichai Tangsin (Thai Ministry of Public Health), meets with NCC staff.

at the NCC have included Cu Cao and German students, Ulrike Langhorst and Stephanie Doppler. Janelle Craig has also been coordinating the third year HIM students in a research project to investigate coding in same day facilities.

Education

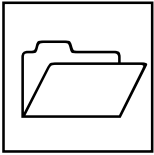
Together with HIMAA, the NCC (Janelle Craig) has undertaken a training program in ICD-9-CM coding for private health insurance companies. Two courses (Melbourne 4–6 September and Sydney 9–11 September) have now been completed and have helped to familiarise claims assessors with the process and implications of coding.

National Coder Workforce Issues Project (NCWIP)

The first Australian Coding Accreditation Exam has involved NCC staff in working with the Steering Committee of NCWIP (Janelle Craig and myself) and with the expert panel preparing the exam content and assessment methods (Kerry Innes). Best of luck to those 145 courageous pioneering coders who sat the first exam!

Who would have thought there could be so many changes to the coding world? It is most exciting to be part of the change process, and to manage it so that it works for you, the clinical coders. Please keep us in touch with your issues and concerns – there are now even more opportunities to do this, not the least of which will be through your membership of the CCSA, and attendance and presentations at the NCC Coding Seminar at Cooloom on 21st and 22nd November (*see back page*). I look forward to seeing you there!

✧ Rosemary Roberts



CODING TIPS

1. Suprapubic catheterisation

To further clarify the use of codes 57.17 *Percutaneous cystostomy* and 57.18 *Other suprapubic cystostomy* discussed previously in *Coding Matters*, Volume 2, No 3, the following advice is provided by Mr Douglas Travis (Nephrology/Urology Clinical Coding and Classification Group [CCCG]):

A percutaneous cystotomy (57.17) is a simple procedure that is performed either under local anaesthetic or at the end of an operative procedure where a needle of some form is introduced through the skin into the bladder. There are different variations depending upon the actual hardware used as to what happens next, but essentially a tube is placed down the track created by the needle into the bladder. The tube is on occasions sutured to the skin and that is the end of the procedure.

A suprapubic cystotomy (57.18) involves a formal operation through an incision in the lower abdomen. The bladder is formally exposed and surgically opened. The opened area of the bladder is then sutured to the skin creating a stoma. On occasions a formal stoma is not made rather the bladder once exposed has a tube placed in it via a stab incision and that is brought out through the wound.

Coding

Assign 57.17 *Percutaneous cystostomy* for operative descriptions such as “SPC” (suprapubic catheterisation) or “stab cystotomy” which usually follow an operative

procedure. Although the term “stab” may be used in relation to an open cystotomy (57.18) a procedure description of “stab cystotomy” should be interpreted as a percutaneous cystotomy (57.17). The terms *cystostomy* and *cystotomy* are used synonymously in this context.

2. Sympathectomy

Thanks to the Australian Pain Society for this insight into sympathectomy and its correct classification.

Category 05.2 *Sympathectomy* relates to **surgical sympathectomy** and is a formal operative procedure carried out under general anaesthesia involving exploration of the lumbar sympathetic chain extraperitoneally with division and resection of the lumbar sympathetic nerves.

A lumbar **chemical sympathectomy**, code 05.32 *Injection of neurolytic agent into sympathetic nerve*, is performed with the patient awake or under mild sedation and local anaesthesia. Using an image intensifier a needle is placed percutaneously in the region of the lumbar sympathetic chain. The current neurolytic agent is 10% phenol which has essentially the same effect as the open surgical sympathectomy.

Coders' note

No index entry exists for “Sympathectomy, chemical” so this should be noted in your index and tabular list.

❖ **Kerry Innes**

A ‘tail’ of confused digits!

Notice

To all coders (and those who enter the codes into a computer) who have, do or will in the future, **transpose digits!!!**

We recently had a query relating to the coding of 49.92 *Insertion of subcutaneous electrical anal stimulator* and consequently took a look at some national data, (again, kindly and expeditiously provided by the Classification and Payments Branch, DHFS) to see when this code was being used.

Amazing!!!

– Cases with a principal diagnosis code of 530.3 *Oesophageal stricture* had this procedure recorded!!

– Is this a new radical procedure for oesophageal stricture or is it because the digits have been transposed?

42.92 *Dilation of oesophagus* → 49.92 **BADBADBAD**

CLINICAL UPDATE

Lymphoma and myelodysplastic syndrome

Thanks are extended to our clinical consultant Dr Barry Dale for providing the following information on lymphoma and myelodysplasia.

The lymphomas

Malignancies arising in either the lymph nodes or other lymphoid sites in the body (e.g. spleen, bone, bone marrow, gastro-intestinal tract). The malignant change can arise from several different cellular origins, at different stages of differentiation. Lymphomas are broadly divided into:

- ✧ non-Hodgkin's lymphomas (NHL), and
- ✧ Hodgkin's disease (HD).

The classification of NHL is constantly being reviewed as understanding of the lymphoid system increases. Cell marker techniques, immunophenotyping, DNA analysis and functional studies are assisting in further sub-classification. There is continuing disagreement as to whether the best classification should be based on the cell of origin or on features which correlate with the clinical course of the patient.

Hodgkin's disease has its own characteristic clinical and pathological features which allow it to be specifically diagnosed and classified on its own.

Hodgkin's Disease

The cause is unknown and it most frequently affects young and middle-aged people. Usually present with enlarged lymph node(s) in the neck and/or in the mediastinum. The disease may initially progress by direct contiguous spread within the lymphatic system, but dissemination to non-lymphatic tissue may occur with advanced disease.

There are **four histological subtypes**:

- Lymphocyte predominant
- Nodular sclerosis
- Mixed cellularity
- Lymphocyte depleted.

Treatment

Extended field radiation therapy is the treatment of choice for stages I and IIA without bulky disease. Chemotherapy is the treatment of choice for stage IIB and stage IV disease.

The ideal treatment of stage IIB and IIIA disease remains controversial. Combined chemotherapy/radiotherapy is most frequently used but the incidence of complications rises.

Non-Hodgkin's Lymphoma

Classification depends on whether the tumour is arranged in nodular (follicular) fashion or diffuse pattern, the predominant cell(s) and the degree or otherwise of cell differentiation (maturation).

Staging

The staging system used with Hodgkin's disease is not as useful with NHL. Nevertheless, the same staging system is used with similar clinical correlation. Aggressive lymphomas tend to present with relatively localised disease whilst the less aggressive tumours tend to present with extensive disease (including bone marrow disease).

NHL has the peculiar tendency to primarily affect the gastro-intestinal tract – usually B-cell lymphoma but can involve T-cells. Skin involvement is also a feature of some cases and involves the T-cells:

- **Mycosis fungoides**
- **Sezary syndrome.**

Staging of lymphomas

Stage I	Involvement of one lymph node region or single localised site
Stage II	Involvement of two lymph node regions and/or localised extra-nodal site on same side of diaphragm
Stage III	Involvement of lymph node regions on both sides of the diaphragm and/or splenic disease
Stage IV	Disseminated involvement with extra-lymphatic disease

Sub-stages

- A no systemic symptoms
- B with systemic symptoms

Other important variants are:

- **Lennert's lymphoma**
– in which the pathology may resemble Hodgkin's disease.
- **Mantle zone lymphoma**
– an aggressive variant of follicular lymphoma.
- **Burkitt lymphoma**
– a high grade lymphoma.
- **Anaplastic large cell lymphoma**
– cells show either B or T-cell markers, and shows more frequent skin and less marrow involvement than most other lymphomas.

Treatment

✧ **Follicular or well-differentiated tumours**

Treatment choices lie between local radiotherapy, or single agent cytotoxics (e.g. chlorambucil or cyclophosphamide and/or steroids).

Myelodysplastic syndromes (MDS)

Myelodysplastic syndromes are haematologic disorders which occur predominantly in the elderly. They may prelude the later onset of classical leukaemia or behave as slowly evolving marrow failure syndromes.

Presentation is usually insidious with anaemia and, in some cases, persistent neutropaenia and/or thrombocytopaenia. Some patients present with an absolute monocytosis with or without splenomegaly and this condition has been designated 'chronic myelomonocytic leukaemia'.

The myelodysplastic syndromes are classified as:

1. refractory anaemia (RA)
2. refractory anaemia with ring sideroblasts (RARS)
3. refractory anaemia with excess blasts (RAEB)
4. RAEB in transformation (RAEBt)
5. chronic myelomonocytic leukaemia.

Diagnosis

Diagnosis is made from the combination of findings in the peripheral blood and bone marrow. The peripheral blood findings vary and include pancytopenia, an unresponsive macrocytic anaemia, neutropaenia, qualitative neutrophil or platelet defects, as well as thrombocytopaenia.

Clinically the patient presents with symptoms related to bone marrow failure:

- recurrent infective episodes
- bleeding episodes particularly muco-cutaneous
- recurrent anaemia. ►

✧ **Intermediate grade**

Usually requires combination chemotherapy such as CHOP (cyclophosphamide, vincristine, doxorubicin, prednisolone).

✧ **High grade**

Requires aggressive high-dose multi-agent chemotherapy using toxic protocols and often associated with the use of radiation therapy to areas of bulk disease and CNS prophylaxis.

Drugs more recently used in the treatment of NHL include:

- | | |
|--------------------------|-----------------|
| ▪ interferon alpha | ▪ fludarabine |
| ▪ 2-chlorodeoxyadenosine | ▪ cytarabine |
| ▪ etoposide | ▪ methotrexate. |
| ▪ mitoxantrone | |

Autologous bone marrow or peripheral blood stem cell transplantation following intensive dose chemotherapy is being applied to selected patients.

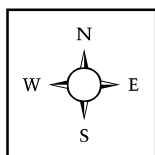
Patients may die from any one of these complications or progress to frank acute myeloid leukaemia. Apart from the peripheral blood abnormalities the bone marrow shows evidence of dysplastic changes affecting all three major cell lines, although initially in many patients one cell line may be predominantly affected. Chromosomal abnormalities affecting several chromosomes are common.

Treatment

Treatment is generally supportive only.

Blood transfusion is the mainstay of therapy particularly for those with symptomatic anaemia. Platelet transfusions are best avoided unless clinical bleeding occurs. Prompt treatment of any infections with broad spectrum antibiotics and the use of antifungals when indicated become important in those with significant neutropaenia.

In some cases a trial of chemotherapy may be indicated such as low dose cytosine arabinoside or maturation factors such as retinoic acid. Haematopoietic growth factors such as G-CSF, GM-CSF, IL-3 and erythropoietin have been used in various trials singly or in combination but the number of patients showing clinically relevant and sustained responses remains disappointingly low. The patients are in a delicate balance and whilst they remain free of serious infections and bleeding they may remain well for long periods of time ■



AUSTRALIAN CODING STANDARDS WORKSHOPS

May – June 1996

Having recently driven 2800 km in 10 days to conduct workshops throughout country Victoria and NSW, it's nice to be sitting down in one place to write this report to you! In previous months we have been extremely busy conducting the annual Australian Coding Standards workshops at 24 locations throughout Australia. We thought coders would appreciate some feedback on the workshops, so based on your verbal comments and responses to workshop evaluation forms the following information can be reported:

- ✧ 36 one-day workshops were conducted nationally between 22 May – 2 July 1996.
- ✧ 22 members of the NCC's Coding Educators Network assisted in the presentation of the workshops (working with an NCC staff member) or conducted the workshops on behalf of the NCC; one educator assisted in the development of additional resource material for educators; two members of the network assisted in the development of the quiz exercises.
- ✧ 1235 people were registered for the workshops, with the vast majority of registrants attending the workshops. The background of participants was predominantly that of clinical coders and health information managers from the public and private sector, as well as coders from sameday facilities and health authorities and staff from insurance companies.
- ✧ Participant involvement at a state/territory level being:

NSW	381	VIC	329
QLD	204	SA	143
WA	102	TAS	28
ACT	40	NT	8
- ✧ 917 responses were received on workshop evaluation forms, which accounts for 74% of all workshop participants.
- ✧ 74% of respondents rated the overall education experience as excellent or very good, and 98% responded that the workshops would help them to do a better job as a clinical coder/supervisor of coding services.
- ✧ The most common responses to free-text questions were that:
 - ♦ workshops (presentation/format/content) were better than last year
 - ♦ one day format is more manageable than two days
 - ♦ a large amount of material to cover in one day
 - ♦ some participants would have liked to cover more (if not all) standards
 - ♦ Saturday sessions (Syd/Melb/Bris) sessions were well patronised
 - ♦ smaller group numbers (particularly in Syd/Melb/Bris) were better and helped to facilitate group discussion
 - ♦ regional/country workshops were greatly appreciated
 - ♦ quiz exercises were considered to be a valuable learning tool and generally assisted in reinforcing standards (although not every question was perfect!)
 - ♦ not all participants felt it was necessary to code out all quiz questions
 - ♦ not enough time was allocated to undertake the quiz and discuss answers
 - ♦ query forms were a useful way to deal with unresolved queries raised at the workshops
 - ♦ feedback about the 1996 coding books indicated coders consider they are a big improvement on last years books
 - ♦ some participants (particularly those attending the earlier workshops) experienced difficulties receiving the books prior to the workshops and expressed disappointment in this.
- ✧ Feedback from workshop query forms (i.e. regarding standards addressed at the workshop or standards not covered at the workshops) revealed 111 queries, these being further divided into 95 queries about standards, five about quiz questions/answers and 11 relating to coding practice issues. The NCC has undertaken to respond personally to those people who raised a query on the workshop query form, as well as collate these queries at a state/territory level and provide feedback to the respective state or territory health authority/coding advisory committee.
- ✧ Frequently raised queries related to allied health standards, drug & alcohol dependence/use disorder and COAD. Because a large number of course participants raised issues relating to these topics, the appropriate responses are addressed on page 9.

Each year considerable effort is put into the planning, organisation and conduct of the Australian Coding Standards Workshops. Special thanks are extended to state and territory health authorities who subsidised and/or participated in the actual program, to members of ►

the NCC's Coding Educators Network who assisted in the delivery of the workshops and to all at the NCC, including Kerry Innes and Michelle Bramley, who assist greatly in preparation of material for the workshops.

In 1997, it is unlikely that the NCC will be 'on the road' conducting education sessions on Australian Coding Standards. Rather in 1997, the focus of education will be on ICD-10 and will address the education needs of health professionals who provide the codes (i.e. clinicians and clinical coders), those who make use of the resulting information (i.e. researchers, epidemiologists, health authorities) and those who are affected by the change to ICD-10 (e.g. software vendors).

In the meantime, we will be busy (along with HIMAA) conducting training courses in ICD-9-CM coding for staff from Private Health Insurance Companies and Sameday Hospital Facilities, as well as conducting our third Annual

**Shahn Campbell
(on secondment from
the Victorian
Department of Human
Services) will assist
with the preparation
of the ICD-10
Implementation kit.**

NCC Seminar at the Hyatt Regency, Coolum, Queensland on 21& 22 November (*see* page 16).

❖ **Janelle Craig**

Feedback on queries from the Australian Coding Standards (ACS) Workshops

ACS 0032 Allied Health

Q "Our hospital has staff who do not have an official allied health degree or qualification (e.g. a lifestyle educator who undertakes occupational therapy tasks), but who perform activities as described in the allied health standard. Do we code interventions performed by such staff or not?"

A Allied health interventions, if not performed by an allied health professional should not be coded at this stage. It must be a qualified allied health professional in the relevant allied health discipline to apply the appropriate code. It is planned for MBS-Extended in 1998 that codes for allied health professions will be generic an not discipline specific.

Q "Do we code allied health interventions once or as many times as they are performed. What happens if more than one allied health professional is involved?"

A As per advice in the coding of multiple/bilateral procedures (ACS 0020, p19) "any procedure from Chapter 16 of Volume 3, ICD-9-CM need only be coded once". However, if different procedures within the same allied health discipline are performed (e.g. an occupational therapist performs occupational therapy assessment and sensory motor occupational therapy), or if allied health professionals from more than one allied health discipline are involved in the care of the patient (e.g. a physiotherapist and a social worker), than codes for each appropriate discipline specific intervention can be applied.

ACS 0503 Alcohol and Drug Dependence Disorder/Use Disorder

Q "The new terms for codes are ambiguous. Doctors never say 'harmful use' or 'tobacco dependence'."

A The new codes for harmful use of alcohol and drugs have been introduced to improve the reporting of these 'states' as

the impact of alcohol and drugs on the health of the community is significant and generally under reported. Although some coders may have difficulty in abstracting the appropriate descriptions, perseverance is essential to the long-term improvement in the collection of this information. Coders are encouraged to liaise closely with their clinicians in order to promote usage of new terminology.

ACS 1008 Chronic Airway Limitation (CAL)

There were numerous queries about this standard, particularly regarding the sequencing of pneumonia and COAD/CAL. The NCC concedes that the example in our workbook did not fully highlight the issue being made in the standard, that being that where both conditions are to be coded, guidance in the sequencing of the principal diagnosis should be provided by the clinician.

Given the volume of queries raised in relation to this general subject area (asthma, bronchitis and emphysema coming into question as well), the NCC thought it was worth conducting a special clinical coding update session on Respiratory Medicine at the upcoming NCC Seminar. To this end, Dr Christopher Clarke, clinician representative on the Respiratory CCCG, will be addressing the Seminar, together with supplementary sessions on the coding of respiratory diseases for morbidity and mortality purposes.

To assist Dr Clarke and our other speakers in the preparation of their material, we would be pleased to receive your input as to additional clinical information you require about respiratory disease processes and common dilemmas you face when coding respiratory cases. Queries/questions should be forwarded to Janelle Craig (fax: 02 9351 9603) prior to 8th November. If you are unable to attend the NCC seminar don't despair! This segment of the program will be video taped and made available for sale (ordering details available from the NCC in December 1996, phone 02 9351 9461).



After months of reporting on the activities of the Establishment Committee of the CCSA, it gives us enormous pleasure to report that the Clinical Coders' Society of Australia (CCSA) has now been formally incorporated as a company and is ready to commence operations and recruit members.

Readers of *Coding Matters* will be aware that members of the Establishment Committee have agreed to continue on and form the first (interim) Board of the CCSA. The CCSA Board have held their first Director's meeting and undertook election of office bearers, the results of which were:

President: Barbara Levings (SA)

Vice President: Joan Knights (WA)

Honorary Secretary: Peter Whatley (VIC)

Honorary Treasurer: Julie Turtle (QLD)

Members: Lynn Lehmann (NSW)

Mark Ralston (TAS)

Seija Graham (ACT)

Mary Derkley (NT)

Janelle Craig (HIMAA, ex-officio)

The CCSA Board have also conducted a strategic planning exercise aimed at determining the future direction of the CCSA in the next 12 months. This exercise has helped to identify the need for:

- ♦ special interest groups to address key issues (e.g. contemporary issues, education, etc)
- ♦ a regular newsletter to keep members up to date with coding issues (the first edition of which will be distributed to CCSA members in late October).

The Board of the CCSA met for the first time in August 1996 to plan the Society's direction for the coming year.

The CCSA Board is also keen to obtain input from members as to their needs. To this end, the Board have developed a membership needs survey which will assist in planning future CCSA activities. This survey will be distributed with the first edition of the newsletter.

Membership kits, including a membership brochure, membership form and a code of ethics/practice standards document have been distributed to *Coding Matters* readers and also with the recent edition of the HIMAA Journal. If you have not received a membership kit as yet, please contact your state/territory representative.

Remember, membership of the Society is open to all clinical coders, health information managers and those with an interest in coding. Annual membership fees are \$50.00, with an initial joining fee of \$30.00. Membership fees are tax deductible.

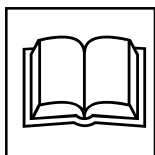
If you would like more information on the CCSA or about becoming a member, please contact:

- ♦ your state/territory representative on the CCSA
- ♦ HIMAA Executive Officer on ph: (02) 9887 5001
- ♦ or myself on ph: (02) 9351 9345 or email: j.craig@cchs.usyd.edu.au

Congratulations to all Australian coders!!!

❖ **Janelle Craig**

HIMAA representative, CCSA Board



PUBLICATION ISSUES

Several exciting pieces of news to announce in this our 10th issue of *Coding Matters*!

Casemix and Coding – two booklets now available

The first two booklets in the series '*Casemix, DRGs and Clinical Coding*' are now available and the feedback from all quarters has been very positive to date. Interest has been expressed from a wide range of organisations and orders have been flowing in! Reasonably priced at \$10 each, the first two booklets cover the specialty areas of:

- ✧ Respiratory Medicine and Thoracic Surgery
and
- ✧ Oncology and Haematology.

Order Now!

See page 13 for the
Specialty Booklet order form.

Congratulations to Simone Lewis (NCC Publications Assistant) for her excellent coordination of this project and for the production of such professional booklets. May she produce many more!!

Since the last issue of *Coding Matters*, new developments have occurred with the planned third booklet in this series. After much consultation with various interest groups, it was decided to split the proposed topic areas into two separate booklets, respectively entitled 'Geriatric Medicine' and 'Rehabilitation'.

The Rehabilitation booklet will now be held over until later in 1997, following the second report of the Sub-acute and Non-acute Patient (SNAP) classification project. The NCC is now proceeding with the Geriatric Medicine booklet, with expanded content, and it is anticipated that this publication will be available in December 1996.

Apologies to all those keenly awaiting the release of the third booklet. We are determined to make our casemix and coding publication series as useful and applicable as possible!

Along with the refinement of the Geriatric Medicine booklet, the upcoming specialty areas to be addressed will include 'Cardiovascular medicine and surgery', 'Burns' and 'ENMT'.

These booklets are only as good as the input we receive from concerned parties (i.e. coders and clinicians). So if you are a clinical coder in a facility frequently coding any of the above episode types, your input is invaluable. Also, if you are approached to assist with booklet content, we would greatly appreciate your help. Or if you wish to have direct input on specific areas of concern for casemix and coding in cardiovascular, burns or ENMT, write now to:

Simone Lewis, Publications Assistant,
National Coding Centre, PO Box 170,
Lidcombe NSW 2141.

✧ Karen Luxford

new NCC publication

Australian changes to ICD-9-CM

The NCC is pleased to announce the publication of:

Changes '94 –'96: A chronicle of new Australian codes and changes to Australian Coding Standards

This document is a valuable reference tool for users of ICD-9-CM and those interpreting coded data. The publication summarises changes made to ICD-9-CM by the NCC in the period 1994-96, with emphasis on new codes and accompanying significant changes to the Australian Coding Standards.

Arranged in chapters according to body system, this new publication will be available from the NCC in late October 1996. To obtain an order form, contact Karen Luxford on:

- phone: 02 9351 9478 • fax: 02 9351 9603 or • email: k.luxford@cchs.usyd.edu.au

Order form

Casemix, DRGs and clinical coding

A series of specialty specific booklets for clinicians and clinical coders

Customer details

Name _____

Organisation _____

Address _____

Suburb/Town _____ State _____ Postcode _____

Phone _____ Fax _____ Email _____

Order

Product	Price [#]	Quantity	Cost
Casemix, DRGs and clinical coding: Respiratory Medicine and Thoracic Surgery <i>Available late August, 1996</i> Product code: SB0196	\$10.00		
Casemix, DRGs and clinical coding: Oncology and Haematology <i>Available early September, 1996</i> Product code: SB0296	\$10.00		
Postage and handling charges [#]			
[#] An additional charge of \$10 for postage and handling applies when ordering more than a total of 15 booklets.			Total cost:

Payment

Post your order to: National Coding Centre
Publications Division
University of Sydney
PO Box 170
Lidcombe NSW 2141 Australia

or fax: 02 9351 9603
faxed on (date) _____
For further information phone:
02 9351 9641

Please make cheques and money orders payable to: National Coding Centre.

Office use only

Customer no. _____

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CODE-L – electronic communication for coders

The NCC is pleased to announce the launch of a new forum for the discussion of coding issues. CODE-L is an electronic listserver, established by the NCC for Australian clinical coders, which can be accessed through your email. The list is free of charge. To receive or post messages on coding issues, you must join ('subscribe to') the list (*see this page*).

The 1995 Australian Coder Workforce report (NCWIP, HIMAA) revealed that 45% of coders are employed in non-metropolitan areas. With so many coders located outside major cities, the NCC believes that CODE-L will provide an ideal avenue of communication to link coders, particularly those coders located in rural and remote regions of Australia.

CODE-L is a site for the discussion of coding issues with your coding peers. We also hope that CODE-L will be used for the posting of bulletins/notices regarding upcoming local and national coding events. CODE-L is **not** a coding query line to the NCC, nor will the NCC screen messages before they are posted on the list (although we do expect that you will adhere to 'Netiquette' – internet etiquette – when sending messages!). When you join the list, you can post clinical

coding questions/comments to all subscribers and then draw on the valuable expertise of your Australian coding colleagues. Maybe even find a coding 'buddy' near your facility!

CODE-L is available now.

To join, just send an email to the following address:

- **Subscription address:**
MAJORDOMO@LISTSERV.CCHS.USYD.EDU.AU
- **Message:**
SUBSCRIBE CODE-L

Join today!

If you don't have email yet, now could be the time to get it! What better reason do you need?

See you in coding cyberspace...

❖ **Karen Luxford and Janelle Craig**
k.luxford@cchs.usyd.edu.au

CODING QUESTION – FOR CODERS!

We have noticed in the national data that code V42.8 *Other specified organ or tissue replaced by transplant* has a high frequency of use as an additional diagnosis in some DRGs, particularly in the following:

DRG		
728	Lymphoma & non-acute leukaemia w cc	728 cases
788	Acute leukaemia w/o major OR proc w non-major cc	661 cases
512	Malignant breast disorders >69 w/o cc or <70 w cc	463 cases
404	Chemotherapy	404 cases

We have a few ideas about why V42.8 is used as an additional diagnosis in these cases but thought that going to the source (i.e. coders) would give us the best insight into the usage of this code.

The information we obtain will inform us about any areas which may warrant new codes or change in text in the development of ICD-10.

Terms which index to V42.8 are:

Status

- transplant
- - blood vessel
- - bone marrow
- - intestine
- - organ NEC
- - pancreas

Let us know some examples of where you would code V42.8 as an additional diagnosis.

Fax your thoughts on this matter to:
02 9351 9603 **or write to:** Kerry Innes, Coding Services Manager, National Coding Centre, PO Box 170, Lidcombe NSW 2141.

NATIONAL CODING CENTRE

ERRATA 1996 – Part 2

1996 Australian Version of ICD-9-CM

Subsequent to the Errata published in July 1996, the following corrections need to be made to the *1996 Australian Version of ICD-9-CM*.

NB: the star annotation/s used in the NCC ICD-9-CM publication only appear on new Australian codes (not on new codes developed in the USA)

Volume 1- Tabular List of Diseases

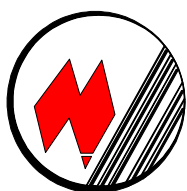
Page

273		INTERNAL INJURY OF CHEST, ABDOMEN, AND PELVIS (860-869)
	Amend	<i>Excludes: concussion NOS (850.1-850.9)</i>
	Delete	<i>flail chest (807.4)</i>
289		946 Burns of multiple specified sites
	Delete	● § 946.0
	Delete	§ 946.1 [Delete annotation for additional digit]
	Delete	§ 946.2
	Delete	§ 946.3
	Delete	§ 946.5
290		948 Burns classified according to extent of body surface involved
Amend		The following fifth-digit subclassification is for use with category 948 to indicate the percent of <i>body surface</i> with <u>full-thickness</u> burn; ...
290		949 Burn, unspecified
	Amend	● § 949.0
	Amend	● § 949.1 [Delete annotation for additional digit]
	Amend	● § 949.2 Add annotation for nonspecific principal]
	Amend	● § 949.3
	Amend	● § 949.5
317		V28.6 Screening for decreased foetal movements
	Amend	<i>Excludes: that with delivery, no underlying cause (656.81, 656.83)</i>
325		V67.51 Following completed treatment with high-risk medications, not elsewhere classified
	Delete	<i>Excludes: long-term (current) drug use (V58.61-V58.69)</i>

Volume 2 - Alphabetic Index of Diseases

16		Adhesion ...
	Amend	- periuterine <u>614.6</u>
17		Admission
		- for
		- - aftercare
		- - - removal of
	Amend	- - - - non-vascular catheter <u>V58.82</u>

172	Amend	Fasciitis - necrotising <u>728.86</u>
235	Amend	Infection, ... - Corynebacterium pseudodiphtheriticum <u>041.89</u>
471	Amend	Aminoglutethimide ... <u>963.1</u> <u>E858.1</u> <u>E933.1</u> <u>E950.4</u> <u>E962.0</u> <u>E980.4</u>
551		Collision (accidental) - motor vehicle ... - - and - - - landslide, ... Amend - - - - moving <u>E909.2</u>
Volume 3 -Index of Procedures		
pi-9:		Biopsy
	Delete	- artery (any site) 38.21
	Add	- - <u>temporal</u> 38.23
pi-22:		Destruction
		- lesion
		- - duodenum NEC 45.32
		- - - by excision 45.30
		- - - - endoscopic 45.30
	Add	- - - - - <u>by laser</u> 44.45
Volume 4 - Australian Coding Standards		
30	0032	ALLIED HEALTH
		10. Cardiorespiratory intervention - physiotherapy
	Amend	Cardiorespiratory rehabilitation <u>93.36</u>
47	0243	ADMISSION FOR STEM CELL OR BONE MARROW PROCUREMENT
	Amend	Admission of a donor for procurement of stem cells should have a principal diagnosis code of <u>V59.02 Donor, stem cells</u> with a procedure code of either ...
63	0503	ALCOHOL AND DRUG DEPENDENCE/USE DISORDER
	Amend	Criteria for harmful levels of alcohol consumption are ≥ 60 grams/day males, and ≥ 40 grams/day females. [Add in greater than or equal to [≥] symbols]
64	0505	MENTAL ILLNESS COMPLICATING PREGNANCY
		Post natal depression
	Revise	Post natal depression should only be coded when it <u>onset</u> occurs within the period ...
70	0604	CEREBROVASCULAR ACCIDENT (CVA)
	Amend	In (1), the appropriate code is <u>V12.50 Personal history of diseases of the circulatory system</u> .
88	0935	CARDIOMYOPLASTY
	Amend	Cardiomyoplasty is a relatively ... heart muscle. A <u>cardiomyostimulator</u> , usually implanted into the anterior ...



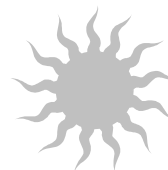
1996 NCC Annual Seminar

Date:

Thursday 21 and Friday 22 November, 1996





Venue:

Hyatt Regency, Coolumb, Queensland



Theme:

'Partnerships in Coding', to focus on:

-  clinical partnerships (whether between coders and clinicians, or coders and other health professionals)
-  partnerships with other organisations (relating to coding or the use of coded data)
-  partnerships with the Commonwealth (for example, the development of classification systems, grouper technology, encoding software)
-  international partnerships in coding

Cost:

Full registration (i.e. two days \$275 per person)

Registration:

Forms have been distributed in early October. If you have not received a registration brochure to date, please contact the NCC.

Contact:

Janelle Craig, Coding Education Manager

telephone: (02) 9351 9461

fax: (02) 9351 9603

email: j.craig@cchs.usyd.edu.au

AUSTRALIAN CASEMIX REPORT ON HOSPITAL ACTIVITY 1994-95

The *Australian Casemix Report on Hospital Activity 1994-95* will be essential reading for anyone with an interest in hospital casemix data. It will comprise a hard copy report of about 270 pages in length, and four 1.44 MB floppy disks containing the equivalent of about 3,000 pages of tables.

In contrast with past issues, which have focussed almost exclusively on the activity of public hospitals, the 1994-95 Casemix Report will give details for both public and private sectors and will facilitate public/private comparisons.

Special offer for advance orders...

The 1994-95 Casemix Report will be available for public release by late November 1996. Its recommended retail price will be \$29.95. However, persons placing orders by 22 October will be able to obtain copies at a special price of \$24.95 each.

If you wish to obtain further details of this special offer, please contact Bill Nichol, Classification and Payments Branch, Department of Health and Family Services, on phone: 06 289 8611 or fax: 06 289 7630.

New publication