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How we will live and die:

revising the International Classification of Diseases

I-r Dr Bedirhan Üstün with Professor Gwynnyth Llewellyn, Dean of the Faculty of Health Sciences, and Professor Richard Madden

The NCCH was delighted to host a seminar by Dr Bedirhan Üstün in February this year. Dr Üstün is the World Health Organization's Coordinator of Classifications, Assessment and Terminology (CAT) Team. He is a psychiatrist, epidemiologist and an international leader in health classifications. He coordinates the World Health Organization Network for the Family of International Classifications (WHO-FIC).

The family of classifications developed over the past ten years includes ICD, the International Classification of Functioning, Disability and Health (ICF) and a range of related classifications including International Classification of Primary Care (ICPC), International Classification of External Causes of Injury (ICECI) and the Anatomical Therapeutic Chemical Classification System (ATC). WHO-FIC includes interventions although there is no current intervention classification.

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Dr Üstün is currently focusing on the ICD and its revision. ICD-10 has been in place for 16 years and is in need of revision. Although, the second edition was released in 2004, there are regular updates. The ICD is scheduled for ten yearly periodic revisions to maintain the scientific currency and public health utility of the classification.

Key drivers for the revision of ICD

The key drivers for the ICD revision process are to address structural changes to the classification, introduction of electronic health records, identification of new diseases, changes in clinical knowledge and the impact of health terminologies. As well, improved compatibility of the classifications within WHO-FIC will be sought.

Dr Üstün stated, "We want to respond to consumer needs, be it clinicians, the administrators or data users. To keep up with new scientific knowledge, it is necessary to revise and update these classifications in a regular fashion. We want to shorten time required to improve knowledge management and make it accessible and available to users at all levels."

ICD revision work streams

The ICD revision will have three work streams. Dr Üstün said, "In each area of health care, the health information will be systematically reviewed in three interconnected mainlines:

1. Scientific stream
2. Clinical stream
3. Public health stream.

The work will be carried out by a core team of WHO investigators along with a group of international collaborators and advisors utilising a permanent Internet-based knowledge management and sharing portal.

These streams will ensure the ICD:

1. reflects the advances in medicine and all health sciences;
2. will be easy to use, support clinical decisions and management and have meaning for daily clinical practice in service of patients and care providers;
3. is useful to record mortality, morbidity and population health parameters, assist in public health policy and decision making for resource allocation and monitoring outcomes."

Dr Üstün is looking forward to as democratic and evidence-based a development process as possible for the revision. There will be a web-based revision platform, based on that now in place for the ICD-10 updating process. All proposals for change will be available there for comment and discussion prior to their formal consideration. As well, a testing process is envisaged, with input from as many potential users as possible.

An important early step will be gathering together the various clinical modifications from the countries that have prepared them. As well, relevant material from specialty adaptations will be collected. It is hoped to synthesise proposals from this material, after public input, using appropriate expert groups.

Resources will be a key issue for the revision. Dr Üstün is actively seeking support from interested countries and professional groups. Already the Japan Hospitals Association has pledged financial support. He hopes that collaborating centres such as Australia can provide resources and expertise, recognising that these will generally remain based in their home country. "A web-based process removes geographic boundaries and barriers" said Dr Üstün.

On his way to Japan from Australia, he concluded with the words of the master haiku poet Matsuo Basho, "Learn about pines from the pines, and about bamboo from the bamboo. Don't follow in the footsteps of the old poets, seek what they sought." The Japanese term *genchi genbutsu* – 'go to the source' – is Dr Üstün's guiding inspiration for the revision of the ICD.

The NCCH is most appreciative of the time and effort of Dr Üstün in providing this valuable insight into the revision program of the ICD.

ICD-10-AM/ACHI/ACS Fifth Edition is now available

The Fifth Edition volumes are now identified by their respective titles. The ICD-10-AM Tabular List and Alphabetic Index volumes are the disease classification. ACHI Tabular List and Alphabetic Index volumes are the interventions classification. ACS is the Australian Coding Standards.

Fifth Edition will be implemented across Australia from 1 July 06.
For further information and to order:
NCCH Sydney
Phone: + 61 2 9351 9461
E-mail: ncchsales@fhs.usyd.edu.au

10-AM Commandments

Chronic Obstructive Pulmonary Disease (COPD)

The Global Initiative for Chronic Obstructive Lung Disease Report (2005) defines chronic obstructive pulmonary disease (COPD) as "a disease state characterised by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lungs to noxious particles or gases".

COPD is a progressive disabling disease with serious complications. It is exacerbated by several different causes, including:

1. infection of the tracheobronchial tree

   The infection could be bacterial or viral and about a quarter of exacerbations are thought to be viral.

2. non-infectious conditions or factors such as:
   - left ventricular failure
   - pulmonary embolus
   - exposure to heavily polluted air.

However, the cause of about a third of severe exacerbations cannot be identified.

While COPD runs a chronic progressive course, the term 'acute exacerbation' is generally used for the short term (acute) increase in severity of symptoms (exacerbation). Acute exacerbations, usually infective, occur from time to time and may lead to a sharp deterioration in coping ability. A study of 173 patients with COPD reported an average of 1.3 (range 0–9.6) exacerbations annually (The Australian Lung Foundation and the Thoracic Society of Australia and New Zealand 2005).

Definitions of exacerbations in COPD are based on increase in symptoms such as dyspnoea, sputum volume and sputum purulence with or without symptoms of upper respiratory infection and/or increased health care utilisation (MacNee 2002).

Classification

Acute/infective exacerbation of COPD

J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified* and J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection* are indexed in ICD-10-AM Fourth Edition as follows:

Disease, diseased — *see also Syndrome*
- lung J98.4
- - obstructive (chronic) J44.9
- - - with
- - - - acute
- - - - - exacerbation NEC J44.1
- - - - - lower respiratory infection (except influenza) J44.0

This indexing has the subterms 'exacerbation' and 'lower respiratory infection (except influenza)' under the term 'acute'. Literature has shown that COPD is a progressive 'chronic' condition which worsens periodically due to infectious or non-infectious exacerbations of the disease. Such exacerbations are by nature acute and are characteristic of this chronic disease process. Terms such as 'exacerbation of COPD' and 'infective exacerbation of COPD' are commonly used when patients are hospitalised for treatment of hypoxia, carbon dioxide retention, acidosis or infection.

Therefore, when a patient is admitted for exacerbation/infective exacerbation of COPD, assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection* or J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified* even when the term 'acute' is not specified.

COPD with pneumonia

Clinically, pneumonia may not always exacerbate COPD. It is often the case that clinical documentation is unclear whether pneumonia exacerbates COPD. From a classification point of view, the presence of COPD **with** pneumonia is sufficient to assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*. This is similar to diabetes mellitus coding where the 'with' rule applies and it is not necessary for clinical coders to ascertain a cause and effect relationship between the conditions.

When there is unclear documentation of the principal diagnosis, such as *COAD/Pneumonia or pneumonia* + COPD coders should find documentation in the clinical record or seek clinical advice on which condition meets the criteria in ACS 0001 *Principal diagnosis*. If not available, the section on ACS 0001 *Principal diagnosis*, *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* should be applied.

Example 1:

Discharge summary documented PDx as COAD/ Pneumonia.

Code:

Principal diagnosis	J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*
Additional diagnosis	J18.- *Pneumonia, organism unspecified*

Example 2:

Discharge summary documented PDx as Pneumonia +COPD exacerbation.

Code:

Principal diagnosis	J18.- *Pneumonia, organism unspecified*
Additional diagnosis	J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

Vaginal hysterectomy with tubal or ovarian procedures performed vaginally

The NCCH received a query asking for the correct assignment of procedure codes when unilateral salpingectomy, oophorectomy or ovarian cystectomy are performed vaginally at the time of vaginal hysterectomy without laparoscopic assistance. There are codes for these procedures when done laparoscopically or via laparotomy but none when done vaginally.

Classification

Clinical advice confirmed that the above procedures can be performed vaginally at the time of vaginal hysterectomy although it is uncommon. As there are no specific codes available, the NCCH suggests the default codes as per index:

Vaginal hysterectomy with unilateral ovarian cystectomy

35657-00 [1269] *Vaginal hysterectomy*

35638-04 [1244] *Laparoscopic ovarian cystectomy*

The index pathway is as follows:

Cystectomy — *see also Excision, cyst*
- ovary (laparoscopic) (para-ovarian) (unilateral) 35638-04 [1244]
- - bilateral (laparoscopic) 35638-05 [1244]
- - - via laparotomy 35717-00 [1244]
- - via laparotomy 35713-04 [1244]

Vaginal hysterectomy with unilateral oophorectomy

35657-00 [1269] *Vaginal hysterectomy*

35638-02 [1243] *Laparoscopic oophorectomy, unilateral*

The index pathway is as follows:

Oophorectomy
- unilateral (laparoscopic) (total) 35638-02 [1243]
- - via laparotomy 35713-07 [1243]
- wedge (laparoscopic) 35638-00 [1243]
- - via laparotomy 35713-05 [1243]

Vaginal hysterectomy with unilateral salpingectomy

35657-00 [1269] *Vaginal hysterectomy*

35638-09 [1251] *Laparoscopic salpingectomy, unilateral*

Although there is no default code for unilateral salpingectomy in the index, the laparoscopic code is considered the 'best fit' for consistency.

The index pathway is as follows:

Salpingectomy
- unilateral
- - laparoscopic (total) 35638-09 [1251]
- - - for removal of ectopic pregnancy (tubal) 35678-01 [1256]
- - - partial 35638-07 [1251]
- - via laparotomy (total) 35713-09 [1251]
- - - for removal of ectopic pregnancy (tubal) 35677-05 [1256]
- - - partial 35713-08 [1251]

Salpingo-oophorectomy — see block [1252]

The NCCH will review this area for a future edition of ACHI.

Spinal stabilisation methods in spinal surgery

The NCCH has received queries regarding which procedure codes to assign for the various stabilisation devices and systems used in spinal surgery such as DIAM spacer, Wallis stabilisation system, etc.

Classification

As these devices and systems are used for stabilisation of the spine, assign 48678-00 [1390] *Simple internal fixation of spine*. Where it is documented as stabilisation of second cervical vertebra, assign 40316-00 [1390] *Odontoid screw fixation*.

Gastric antral vascular ectasia (GAVE)

GAVE or watermelon stomach is a form of gastrointestinal vascular malformation where oozing haemorrhages, resembling red watermelon stripes, are seen in the gastric antrum on endoscopy. They usually cause chronic upper gastrointestinal blood loss and are often responsive to local endoscopic ablative therapy. Vascular ectasia can also occur in the duodenum.

Classification

There is no specific diagnosis code for gastric antral vascular ectasia in ICD-10-AM Fourth Edition. The NCCH had advised using K31.88 *Other specified diseases of stomach and duodenum* in previous queries. Recent clinical advice recommends that vascular ectasia of stomach and duodenum be classified to angiodysplasia of the stomach and duodenum.

For vascular ectasia of stomach and duodenum without haemorrhage, assign: K31.81 *Angiodysplasia of stomach and duodenum without mention of haemorrhage*. For vascular ectasia of stomach and duodenum with haemorrhage, assign: K31.82 *Angiodysplasia of stomach and duodenum with haemorrhage*.

This updated advice supersedes the previous NCCH response in regards to GAVE.

Venous ulcers

Venous ulcers develop when blood flow through the legs is reduced, causing blood to pool in the leg veins. The increased pressure in the veins and capillaries causes fluid to leak from the blood vessels into surrounding tissue resulting in swelling, thickening and damage to the skin. The damaged skin may eventually break down to form an ulcer.

Any disorder that causes blood to pool in leg veins (stasis) can cause a venous ulcer. A varicose vein or a vein blocked by a blood clot (deep vein thrombosis) can become damaged, causing blood to pool. Heart failure can also cause blood to pool in veins.

Classification

When venous ulcer is documented in the medical record without further specification, I83.0 *Varicose veins of lower extremities with ulcer* should be assigned by following the index pathways:

Ulcer, ulcerated, ulcerating, ulceration, ulcerative
L98.4
- varicose (lower limb, any part) I83.0

Stasis
- ulcer I83.0

NCCH will forward a submission to WHO Update and Revision Committee regarding indexing of these terms.

References

MacNee, W (2002), Acute exacerbations of COPD. [Online]. Available: http://www.rcpe.ac.uk/publications/articles/journal_32_2/Supplement%20PDFs/macnee.pdf [13 January 2006]

The Australian Lung Foundation and the Thoracic Society of Australia and New Zealand (2005), The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease 2005. [Online]. Available: http://www.copdx.org.au/guidelines/documents/COPDX_June2005.pdf [10 January 2006]

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) (2005), The pocket guide to COPD diagnosis, management and prevention. [Online]. Available: http://www.goldcopd.org/Guidelineitem.asp?l1=2&l2=1&intId=1116 [18 December 2005]

Correction

The NCCH would like to acknowledge the following error published in ***Coding Matters Volume 12 Number 4*** (March 2006).

The 10-AM Commandments contained an item titled ***Sequencing of asterisk and morphology codes for episodes of care requiring neoplasm codes***. The code sequencing listed in the classification section was incorrect. The NCCH suggests the following sequence:

- Dagger code (Neoplasm codes C00-D48)
- Morphology code
- Asterisk code (eg. M36.0* *Dermato(poly)myositis in neoplastic disease* (C00–D48†))

The NCCH apologises for any inconvenience caused by this error.

Calling all clinical coders!

Do you want to be involved in a national research project to develop and enhance the quality of external cause morbidity data?

Researchers at the NCCH at QUT, National Injury Surveillance Unit, and Injury Prevention and Control Australia are seeking to develop and enhance the quality of national external cause of injury data in hospital records.

To find out more, read the participant information sheet and complete the survey go to:
www.hlth.qut.edu.au/ph/ncch/survey-participant-information.html

For more information contact Dr Kirsten McKenzie.
E-mail: k.mckenzie@qut.edu.au
or phone 07 3864 9753

PICQ2006

Performance Indicators for Coding Quality

The NCCH is pleased to announce the forthcoming release of PICQ 2006, incorporating 223 indicators for Fourth Edition and 248 for ICD-10-AM/ACHI/ACS Fifth Edition.

PICQ 2006 and coding quality

PICQ 2006 is a series of indicators that analyse admitted patient morbidity data coded with ICD-10-AM and the Australian Classification of Health Interventions (ACHI) and is based on Australian Coding Standards (ACS) and coding conventions. Users link their coded data to the PICQ database and the records are then compared to the predetermined indicators that test coding quality. The indicators identify records that contain a coding error (or possible coding error) in diagnosis and intervention codes or National Health Data Dictionary (NHDD) fields, such as age. The indicators are categorised according to the type of problem the indicator seeks to identify.

PICQ 2006 includes 25 new indicators for ICD-10-AM/ACHI/ACS Fifth Edition in relation to:

- ACS 0102 HIV/AIDS
- ACS 0301 Stem cell procurement and transplantation
- ACS 0401 Diabetes mellitus and impaired glucose regulation
- ACS 0520 Family history of mental illness
- ACS 0942 Banding of haemorrhoids
- ACS 1008 Chronic Obstructive Pulmonary Disease (COPD)
- ACS 1335 Biomechanical lesions NEC
- ACS 1607 Newborn/Neonate
- The use of two codes simultaneously, that contravene excludes notes at the rubric level
- Application of other miscellaneous coding conventions

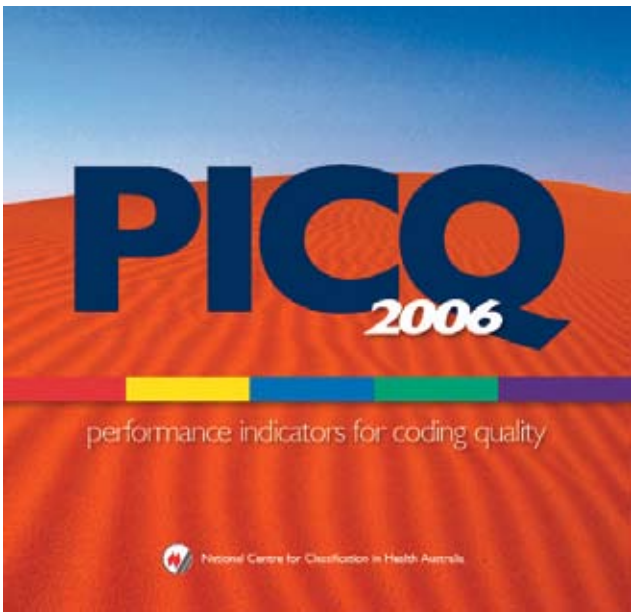
PICQ 2006 is able to perform a number of data quality checks. PICQ 2006 can:

- identify actual coding errors and possible coding problems
- identify specific records for correction, if necessary suggest possible problem causes
- suggest possible corrections
- measure data accuracy against particular indicators
- measure data quality over time
- provide continuous review and amendment of coded data
- provide feedback to individual coders and assist coder education
- benchmark results with similar hospital or health organisation
- complement existing coding audit activities.

New in PICQ 2006

As part of ongoing product improvement there have been some changes. These include:

- Indicator logic and other elements for some indicators incorporated in PICQ 2006 for ICD-10-AM Fourth and Fifth Edition (including action taken to rectify problems notified by users).
- Access 2000 and 2003 versions of the PICQ Database (Access 1998 versions have been discontinued).
- One indicator has been retired: 100290 Chronic bronchitis code with age <12 years (Fifth Edition only).



Indicators where the logic (code unseen by the user) has changed from PICQ 2004

- 100076 DKA (ketoacidosis) with other than Type I diabetes mellitus or long term use of insulin
- 100242 Bladder neck obstruction code as principal diagnosis followed by benign prostatic hypertrophy code
- 100253 Delivery, possible, without outcome of delivery code
- 100347 Impaired glucose regulation code with diabetes code
- 100369 External cause code required but not present with examination following accident/injury code
- 100854 Abortion, threatened abortion, threatened premature labour or pre-term delivery code without duration of pregnancy code (Fifth Edition only)
- 101386 Obstetric laceration third/fourth degree without third/fourth degree repair
- 101412 Prophylactic pharmacotherapy session as additional diagnosis with HIV/AIDS code when same day stay
- 101414 Prophylactic pharmacotherapy session as principal diagnosis with HIV/AIDS code when not same day stay
- 101415 Cardiopulmonary bypass procedure without cardiothoracic surgery (Fifth Edition only)
- 101440 Elevated blood glucose level (hyperglycaemia) code with diabetes or impaired glucose regulation code
- 101529 Radiotherapy session for neoplasm code as principal diagnosis without neoplasm code
- 101595 Termination of pregnancy procedure code without medical abortion code
- 101654 Re-operation for other cardiac procedure NEC code as only cardiac procedure code (Fifth Edition only)
- 101983 Adjustment and management of non-implantable vascular access device (VAD) without appropriate procedure code (Fifth Edition only)
- Most relative indicators relating to the use of 'unspecified' or 'other' diagnosis codes as principal diagnosis compared to all diagnosis codes in the chapter as principal diagnosis.

Indicators by topic

Some indicators are identified as having a particular topic and PICQ 2006, for ICD-10-AM/ACHI/ACS Fifth Edition, now includes 11 topics:

- Unacceptable principal diagnosis
- Procedure code assigned more than once
- Use of psychoactive substance with specific related disorder
- Diagnosis code assigned more than once
- Use of 'unspecified' diagnosis codes compared to use of all other codes in the chapter
- Use of 'other specified' diagnosis codes compared to use of all other codes in the chapter
- Use of 'unspecified' diagnosis codes as principal diagnosis compared to all diagnosis codes in the chapter as principal diagnosis
- Use of 'other' diagnosis codes as principal diagnosis compared to all diagnosis codes in the chapter as principal diagnosis
- External cause code required but not present
- Unusual route of administration of pharmacological agent
- Mutually exclusive codes assigned together.

How to order PICQ 2006

PICQ 2006 can be purchased using the NCCH order form. The order form can be downloaded from the NCCH website. Purchase price remains the same as PICQ 2004.

International

Ireland and ICD-10-AM

Happy anniversary ICD-10-AM in Ireland

January 2006 marked the first anniversary of Ireland implementing ICD-10-AM Fourth Edition, and what a fantastic implementation they had. The Economic and Social Research Institute (ESRI) are in the enviable position of being responsible for coding education (from beginner coders through to advanced coding courses), data collection (for the admitted dataset, including the coded information), conducting coding audits and other data quality activities, as well as involvement in data analysis. This allows many advantages, including access to up-to-date coded information each month, and the development of a standard interface for hospitals to send in their data for national reporting. All this is done with a small number of staff, including two Australian HIMs.

The smooth implementation of ICD-10-AM was the result of thorough planning, including a pilot study, and included three phases of education, one of which NCCH staff were involved with in January 2005. During 2005, ESRI had more than 1000 attendees at their different coding courses (this figure includes the same person attending more than one course).

ESRI manage a coding query process for Ireland's coders and, by November 2005, had answered more than 800 questions sent in by hospitals. Coding queries that cannot be resolved are forwarded to NCCH, similar to Australian jurisdictions. They also have a representative on the Coding Standards Advisory Committee (CSAC), so are in touch with the update process and changes accepted for future editions of ICD-10-AM.

Hospital benchmarking

In November 2005, Catherine Perry, while on secondment from the Department of Human Services, Victoria to the NCCH, was invited to Dublin to participate in a meeting of the Teaching Hospitals Benchmarking Club for Clinical Coding Resources, which includes hospitals from the UK.
As well as the regular attendees, all of Ireland's public hospitals were invited to attend. It was a good day, in which many common issues were discussed, including how many records should be coded per day, how to measure coding quality, and how to analyse coded data for use by others.

5th Irish Casemix Conference

In April 2006, Catherine also attended the 5th Irish Casemix Conference, held in Malahide, Dublin. It was here that the Hospital In-Patient Enquiry (HIPE) unit's HIPE Coding Audit Toolkit© was launched. This software was developed to provide both a tool for ESRI staff to use when they audit hospital coding, and for hospitals to use themselves. It covers the whole audit process, from identifying the population that is to be audited, through sample preparation, preparing the dataset, re-entering the cases, analysing the data, and providing a template for report writing, without jeopardising the 'live' national data. This is a fantastic tool that takes full advantage of having only one system in use nationally, which is readily accessed by the ESRI staff.

Other highlights of the conference were the international launch of the AR-DRG Casemix Family of Users; and the conference dinner, where there was an inspiring address by the *An Tánaiste* (Deputy Prime Minister of Ireland) and Minister for Health and Children, Mary Harney, TD. As well as the Irish attendees, there were representatives from Slovenia, UK, Germany and Australia for these events. It was very encouraging to see so many coding staff at the conference who gained a good insight into many of the uses of the data that they spend so much time producing.

Ireland plan to implement every second edition of ICD-10-AM, with the only changes in the intervening period being WHO changes as considered necessary. For example, they have chosen to implement the new code for Avian Flu, in the event that it is needed in Ireland. Additionally they plan to establish Irish Coding Standards, which will complement the ACS.

NCCH look forward to a continuing close relationship with ESRI, and congratulate them on their ongoing commitment to coder education and data quality.

Research

Developing and Enhancing the Quality of National Injury-Related Hospital Morbidity Data

Researchers at the NCCH at Queensland University of Technology, the National Injury Surveillance Unit, and Injury Prevention and Control, Australia, are seeking to develop and enhance the quality of national external cause of injury data in hospital records. The researchers successfully submitted a grant proposal to the Australian Research Council (ARC) in November 2003. The grant proposal sought funds to enable a research project to investigate the quality of national injury-related hospital morbidity data. The research project commenced at the beginning of 2005.

External cause data quality

Injury prevention and control organisations rely on accurate data on the circumstances surrounding hospitalised injury events, with injuries representing major direct and indirect costs to the Australian healthcare system. The quality of external cause data using ICD-10-AM is affected by the quality of the health classification system, the comprehensiveness of medical documentation, the clinical coding process and the interpretation and reporting practices of injury data users.

Research aims and benefits

The research project will benefit clinical coders, clinicians and injury researchers generally, by providing an evaluation of the quality of current external cause of injury codes, and assisting to develop better quality data for the future.

The specific aims of this research are to:

- examine the utilisation patterns of external cause codes in national hospital morbidity data
- ascertain the reasons for a lack of use/lack of specificity in code usage
- identify how coded external cause data is currently being used by injury researchers
- design and implement an educational program for clinicians, coders and injury data users to improve specificity of external cause coding in hospitals and therefore enhance the quality of national data.

Research progress

Stage One of the project, an analysis of the precision of external cause of injury data in the national hospital morbidity dataset, was completed in early 2006. Several presentations and publications have been written and submitted for conferences and academic publications. The findings have provided the researchers with a good insight into particular areas of external cause data that will require further attention in the latter stages of the research project.

Stage Two, a national clinical coder survey, aims to assess clinical coders' views of the reasons for a lack of utilisation/specificity of external cause codes. It will seek their views on challenging areas such as ambiguous codes and areas where no suitable codes exist. There will be particular focus on parts of the classification deemed to be problematic in terms of specificity as identified in the first study. The survey specifically relates to the significant changes introduced in ICD-10-AM Third Edition.

Calling all clinical coders

An important phase of this research is working with clinical coders to understand the factors affecting external cause coding and data quality. The national survey of coders commenced in May, with national distribution through email and discussion lists. The survey is largely conducted electronically, with coders completing and returning the survey online.

Clinical coders are invited to complete the survey by first visiting the participant information webpage www.hlth.qut.edu.au/ph/ncch/survey-participant-information.html. The survey can be found at www.hlth.qut.edu.au/ph/ncch/survey.html.

Further information

For further information on any aspect of the research project please contact
Dr Kirsten McKenzie, k.mckenzie@qut.edu.au,
phone 07 3864 9753 (Mon-Wed).

Avian influenza

– the disease in birds

Avian influenza is an infectious disease of birds caused by type A strains of the influenza virus. The disease occurs worldwide and, while all birds appear to be susceptible, some species are more resistant to infection than others. The common name for avian influenza is bird flu. Domestic birds, including poultry, may develop disease when infected by avian influenza viruses. The resulting disease in poultry may take two forms:

- a mild illness, with ruffled feathers, decreased egg production and mild respiratory symptoms
- sudden onset of severe disease, which is highly contagious, and results in death within 48 hours

The strains of avian influenza that cause the severe form of the disease are known as highly pathogenic avian influenza (HPAI), and all outbreaks to date have been caused by the H5 and H7 subtypes, in particular, the H5N1 strain.

Avian influenza viruses are highly contagious, spreading through bird faeces and contaminated water or dust. Carriers may include live birds, people (contaminated shoes and clothing) and contaminated equipment such as vehicles, feed and cages.

Countries with bird cases

Avian influenza was first identified in Italy in 1878. However, the H5N1 strain of the recent outbreaks was first recognised in Hong Kong in 1997, leading to large scale poultry infections and six human deaths. A slightly altered form of the 1997 virus reappeared in 2003 in a number of countries in Asia, and there have since been reported isolated cases in wild birds in some countries in Europe, together with extensive outbreaks in poultry farms in some other areas.

The disease in humans

The number of human cases worldwide has been small, relative to the number of outbreaks in birds. The evidence so far indicates that those affected all had close contact with dead or sick birds, including the slaughtering, defeathering, butchering and preparation for consumption of infected birds.

There is limited, if any, evidence to suggest the spread of the virus from one person to another.

However, the H5N1 strain of avian influenza virus presents greatest concern to human health for two main reasons:

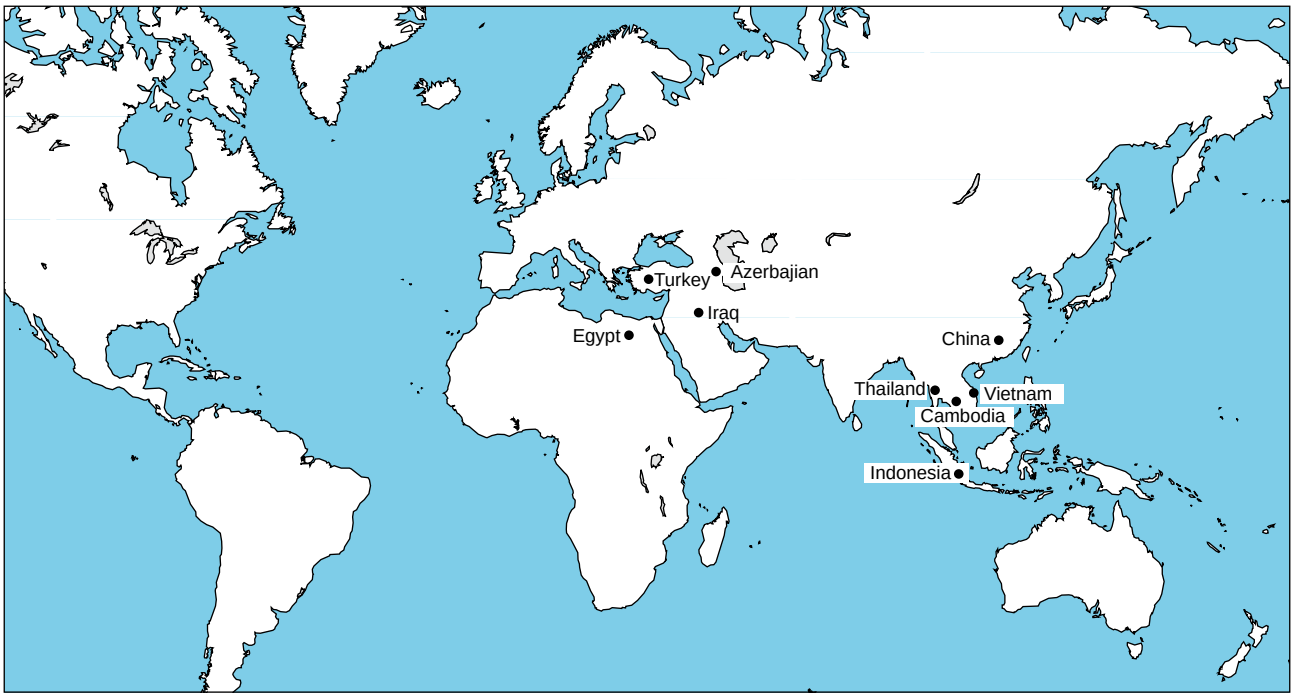
- it has caused the greatest numbers of severe disease and deaths and crossed the species barrier to infect humans on at least three occasions since 1997.
- it has the potential to improve its transmissibility among humans and start another influenza pandemic via two mechanisms; reassortment of genetic material and adaptive mutation.

Clinical features

Following an incubation period of approximately seven days, the initial symptoms include a high fever and 'flu-like' symptoms. Diarrhoea, vomiting, abdominal and chest pain, and bleeding from the nose and gums have also been reported in some cases. A common feature is the development of respiratory manifestations early in the illness, including difficulty in breathing, hoarseness, respiratory distress and bloody sputum. Almost all patients develop pneumonia, which does not respond to treatment with antibiotics.

Treatment

Some antiviral drugs, such as oseltamivir (Tamiflu), if administered within 48 hours of onset of symptoms, can limit disease progression and improve prospects for survival.



WHO confirmed human cases of H5N1 avian influenza since 2003

Countries with human cases

In the recent outbreak of avian influenza virus, human cases have been reported in six countries: Cambodia, Indonesia, Thailand, China, Vietnam and Turkey *(see map)*. All these cases have coincided with outbreaks of H5N1 avian influenza in poultry.

Classification of avian influenza

During the World Health Organization Family of International Classifications (WHO-FIC) annual meeting in Tokyo in October 2005, a proposal was presented to the Update and Revision Committee (URC) to create a unique code in ICD-10 for human cases of disease due to avian influenza virus, effective immediately. This proposal was agreed to by all URC members and, consequently, the following entry was created:

J09 Influenza due to identified avian influenza virus
Influenza caused by influenza viruses that normally infect only birds and, less commonly, other animals

As the final confirmation of the wording for this entry for ICD-10 was not received until March 2006 from WHO, the corresponding entry for ICD-10-AM Fifth Edition does not contain the inclusion term. This will be added in Errata 1, June 2006.

References

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-avian_influenza-index.htm

http://www.who.int/mediacentre/factsheets/avian_influenza/en/index.html

ICD-10-AM Fifth Edition
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International

Republic of Marshall Islands consultancy

Garry Waller recently completed a three-week consultancy on behalf of the Republic of Marshall Islands (RMI) Ministry of Health (MOH) between 7 and 24 February 2006.

About the Republic of Marshall Islands

The Marshall Islands are located in the North Western Pacific Ocean. The population, of approximately 60,000, resides on five high islands and 29 low atolls that have a land area of only 180 km^2. The capital, Majuro, is spread over three islets, Delap, Uliga and Darrit, at the eastern end of Majuro Atoll. These and the other islets that make up the atoll of Majuro are connected by thin stretches of coral.

With a long history of administration by Spain, Germany, Japan and the USA, the RMI gained independence in 1989 when it entered into a Compact of Free Association with the United States.

The Marshall Islands enjoys a pleasantly warm climate all year round. Rainfall can occur throughout the year. The Marshall Islands boast magnificent coral and World War II wreck diving. The people of the Marshall Islands are friendly and laid back. The development of tourist facilities should ensure a strong future as a popular tourist destination.

The consultancy

The purpose of the consultancy was to provide training in morbidity and mortality coding using ICD-10. A situational analysis of medical records practice was undertaken prior to commencement of training to gain an understanding of local health information processes and practice. This review included a site visit to the Laura Community Health Clinic.

An initial meeting was held with heads of departments from the MOH and Majuro Hospital. As a result of this discussion, it was decided to conduct two training sessions for coders, one for morbidity and one for mortality coding, preceded by two days of introduction to ICD-10 for both groups. Such was the enthusiasm of participants that all but one actually attended both morbidity and mortality sessions.

It was also decided to conduct a short education session with clinical staff to discuss documentation quality and how this could enhance the quality of coded data for both inpatient episodes of care and on death certificates. During this session, Medical Officers voiced concerns regarding their limited ability to provide defined causes of death in cases where the deceased is unknown to them and has died outside of the hospital.

The assessment of the medical record, medical records service and health information systems was conducted by audit of medical records and interviews with medical record staff and other health officers from key areas of the health service.

Health care delivery

Delap is the site of the Majuro Hospital, the Ministry of Health and other Government offices. The only other hospital serving the Marshallese people is located in Ebeye on the atoll of Kwajalein, home of the Ronald Reagan Ballistic Missile Defence Test Site. Primary health care is delivered through community health centres located on most atolls in the RMI and on the Islet of Laura, at the western end of Majuro atoll. When necessary, clients are referred and transferred to Majuro Hospital. Major surgery and clinical tests are conducted off island, generally in Hawaii.

Morbidity coding

The Republic of the Marshall Islands currently codes inpatient episodes of care using the International

Garry Waller with the Marshall Islands course participants

Classification of Diseases, Ninth revision, Clinical Modification (ICD-9-CM) but has a strong desire to implement ICD-10. Morbidity coders have received no formal coding education, but are familiar with the use of ICD-9-CM.

The MOH has a strong desire to implement ICD-10 and nominated five MOH and Majuro Hospital staff to attend the NCCH Introduction to ICD-10 Morbidity and Mortality Coding Short Course in Brisbane in 2005 in preparation for implementation. Recognising a need for further and continuing coder education, the ministry engaged the NCCH to provide a total of 13 RMI MOH and Majuro Hospital staff with morbidity coding training.

Mortality coding

At the time of the consultancy, causes of death (COD) were not coded, tabulated or formally reported. The regular coding of death certificates has now commenced in the RMI, as from January 2006. COD are currently tabulated for local use only but it is planned to implement formal COD reporting to the WHO. There are approximately 300 deaths per year in the RMI and it is conceivable to back code previous years' deaths to further enhance historical cause of death data.

Death certificates are completed by doctors at the Majuro Hospital and forwarded to the Planning and Health Statistics section of the MOH where they are checked for completion, and now coded. A copy of the death certificate is forwarded to the Department of Internal Affairs who maintain births and deaths registration data. Copies of death certificates are then filed by year of death within the Planning and Statistics sections.

All death certificates that were reviewed appeared to be completed correctly with a high quality of documentation and detail in the COD. A high proportion of deaths are coded as unattended or ill-defined deaths as a result of the dispersed nature of the population.

Mortality coding training was delivered to 12 RMI MOH and Majuro Hospital staff, five of whom attended the 2005 ICD-10 introductory course in Brisbane and had the opportunity to further enhance their coding skills.

The training was well received by both the participants and the MOH. There is enthusiasm to implement ICD-10 for inpatient episodes of care and the ministry recognises the need to continue to build the skills and education of coding and medical records staff. I would like to thank all in the Marshall Islands MOH for their hospitality, enthusiasm and assistance in making this consultancy a success.

Attention Fifth Edition eBook users

The ICD-10-AM/ACHI/ACS Fifth Edition eBook includes periodic updates for the life of the edition. The updates contain the errata and amendments. Fifth Edition eBook users are notified by e-mail of the latest update and given directions on how to download it from the NCCH website.

A number of Fifth Edition purchasers using 'purchase orders' did not supply e-mail addresses. If you purchased the eBook in this manner, you will need to supply your email address to receive automatic notification of updates.

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Health in the media

Diabetes treatment using seaweed

The Sydney Morning Herald recently reported a revolutionary new treatment for Type 1 diabetes mellitus. Researchers at the University of New South Wales hope that the simple transplant treatment will mean an end to daily insulin injections for Type I diabetes mellitus sufferers. The procedure involves injecting around 200,000 insulin-producing cells, called islets, from a deceased donor into the abdomen of the recipient. It's not expected to totally replace insulin injections just yet but will certainly reduce them.

The key to the experimental transplant procedure is the tiny alginate capsules (a product made from seaweed), about 0.3mm in diameter, which protect the islets from being destroyed by the body's immune system. The alginate capsules have pores small enough to block immune cells getting in to destroy the islets but large enough to allow the entry of nutrients.

The alginate capsules overcome the need for patients to take immunosuppressive drugs to prevent the body rejecting the cells. Side effects of such drugs can include infection and cancer. Studies have shown the viability of the transplanted cells remained high at between 70 and 80 per cent in animals five months after the procedure.

The Australian pilot trial of the transplant procedure is expected to take several years to complete. The issue of supply is also a problem due to the limited number of donors compared to the high number of Type I diabetes mellitus sufferers.

The treatment may require two or three transplants for patients to achieve the ultimate goal of coming off their insulin altogether. Further research is required into eventually replacing the donor cells with insulin-producing stem cells or possibly even pig pancreatic cells.

Injections into the pancreas is considered too risky because of the enzymes it also contains to help food digestion. Those enzymes potentially could ingest anything you inject. Animal testing is continuing to determine whether transplanting the cells in another area of the body, such as the spleen, will produce a better result.

- Sydney Morning Herald, 21 February 2006

Hot water bluebottle sting cure

The Medical Journal of Australia recently published a report on the use of hot water to treat the curse of summer beach-goers – the bluebottle sting.

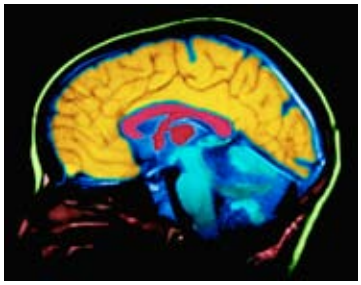
Current treatment uses the application of ice packs to manage the pain. Researchers at Newcastle's Mater Hospital have found using hot water works faster and better in treating stinger pain. The hot water trial was performed over a one and a half year period.

Hot water used in the study was fixed at 45^0C. The hot water treatment was based partly on previous animal research by one of the study's authors, Cairns biologist Jamie Seymour, who found heating venoms inactivated them. The other benefit of this treatment is the cost; hot water is a lot cheaper than ice packs or traditional pain-killers.

Research has begun in Darwin using hot water as a treatment for people who have received the far more painful box jellyfish sting.

- Medical Journal of Australia, 20 March 2006

Early detection of Alzheimer's using brain scans



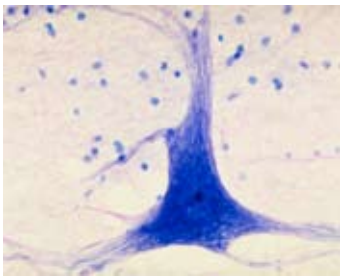
The US publication, Annals of Neurology, reported on a new study that has identified structural and metabolic brain changes that may predict dementia or cognitive decline in normal older adults. Using two imaging techniques – positron emission tomography or PET imaging and magnetic resonance imaging or MRI – researchers could identify predictors of dementia.

The trial was performed over a four year period using people with normal mental function who were between the ages of 60 and 100 years. Six of the subjects developed dementia, allowing researchers to identify the anatomical location of changes that suggested Alzheimer's disease pathology. The researchers concluded that the pattern of glucose metabolism, together with the location of brain regions, are predictive of Alzheimer's disease.

- Sydney Morning Herald, 2 February 2006

Reconnecting human nerves

A Newcastle University PhD student has discovered evidence that human nerve cells can form new connections. It may be possible that damage caused by strokes and spinal cord injuries may not be irreparable.



The discovery was made while researching the anatomy of macular degeneration in the eyes of elderly people. Macular degeneration is a major cause of blindness. Evidence of nerve cells in the retina responding to the disease by forming new connections with neurons linking the eyes to the brain were found in elderly human donors with macular degeneration.

This is the first time researchers have reported it in elderly humans, though previously, similar behaviour in the nerve cells of young animals has been noticed. The discovery provides hope for future therapies to repair damaged nervous tissue caused by stroke, or brain or spinal injury.

- Sydney Morning Herald, 23 February 2006

NCCH prize for clinical coding 2005

The NCCH prize for clinical coding is awarded annually to outstanding graduate students who have completed health information management and clinical coding courses.

Recipients of the 2005 NCCH prize for clinical coding are:

Keren Toomey	The University of Sydney
Natalie Mons	Queensland University of Technology
Nicholas Strohmeier	Curtin University
Christine Moje	La Trobe University

L–R MaryLou Fleming, Natalie Mons and Sue Walker

Barbara Postle and Nicholas Strohmeier

Russell Main and Susan Wagemakers	Health Information Management Association of Australia Ltd
Avril Parry	Open Training and Education Network – Distance Education
Judith Brennan	Joint Queensland Trauma Registry (QTR)/NCCH award.

The NCCH congratulates the award winners and wishes them success in their careers.

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10th NCCH Conference

July 2007, Brisbane, Queensland

Call for papers

The NCCH is pleased to invite prospective participants to submit abstracts for presentation at the NCCH conference in Brisbane, Queensland, July 2007.

Conference program scope

The following list provides suggested areas that contributors may wish to address:

- Professional development and education programs
- Innovation in clinical coding
- Communication strategies
- Quality issues
- Technology issues
- New ways of meeting everyday challenges
- Emerging opportunities and trends in health information management

Criteria for selection

The NCCH conference program committee will select papers for presentation on the basis of relevance to contemporary needs and interest, innovation, professional interest, novelty and timeliness. Presentations are 15 minutes.

What to include

Submitted papers should include:

- Working title of the presentation
- A 500 word abstract
- Authors' names, titles and organisational affiliations
- Presenter's name, title and organisational affiliation
- A 50 word biography for each contributing author
- Mailing address, telephone and fax numbers and e-mail address for the corresponding author

How to submit abstracts

Please send abstracts:

- as e-mail attachments (.RTF or .DOC files only) to Tina Stanhope t.stanhope@fhs.usyd.edu.au or
- by mail on floppy disk or CD-ROM (.RTF or .DOC files) to the mailing address below

Final date for receipt of abstracts

Abstracts are to be submitted by Friday 24 September 2006.

Notification of acceptance

Acceptance of abstracts will be made at the discretion of the NCCH conference program committee. Authors will be notified in writing of acceptance or otherwise before the end of October 2006.

Upon acceptance, authors will be advised about the session, date and time for the presentation.

Submission of full papers and conference proceedings

Successful authors are asked to prepare full papers for publication in the conference proceedings. Proceedings will be distributed to all registered conference delegates at the conference. Full papers are to be submitted before Friday 26 November 2006.

Cost

Successful presenters will be offered a reduced registration fee that will include attendance at the conference social events – welcome reception and conference dinner. This subsidy applies to presenting authors only.

Further information

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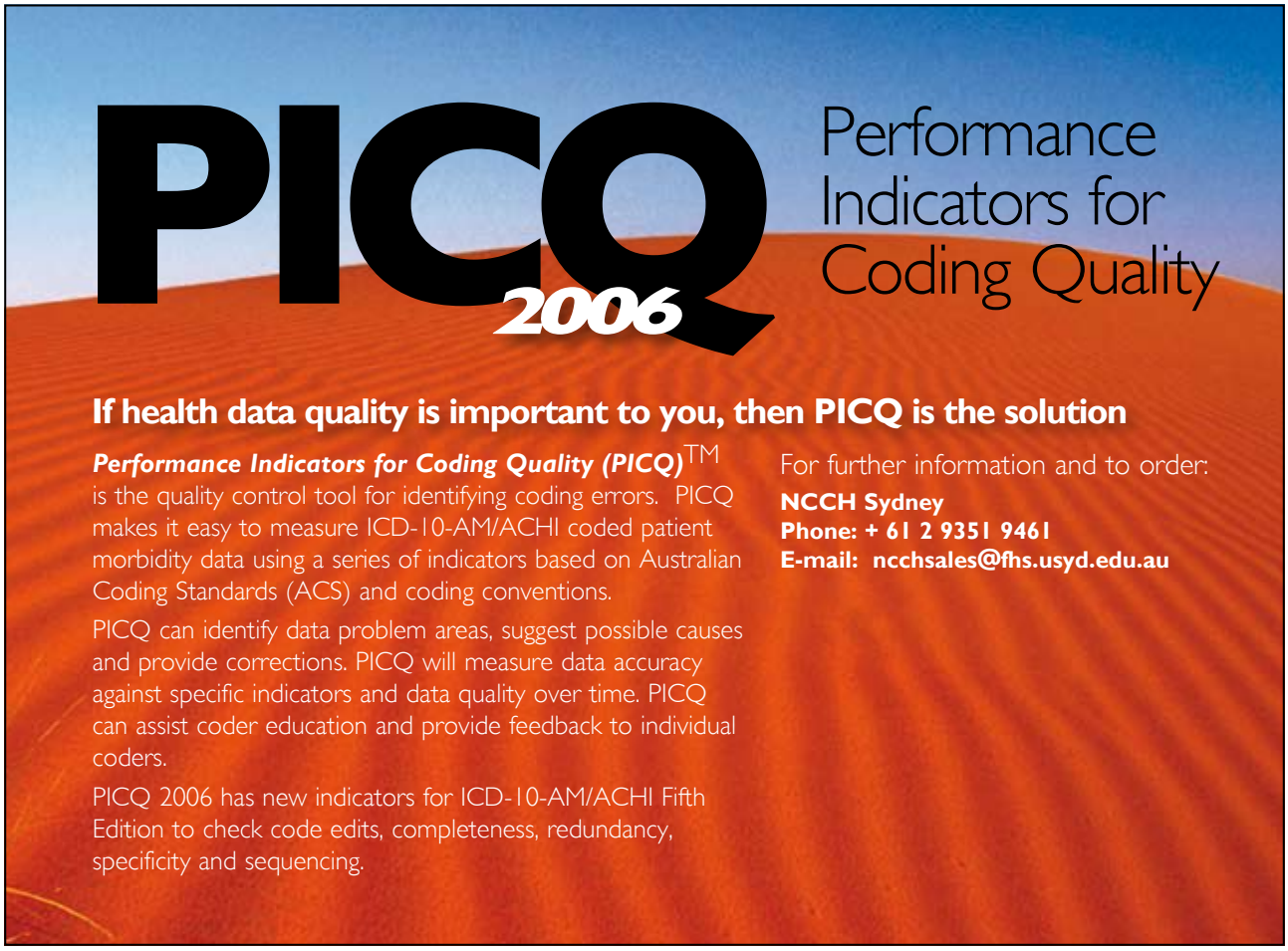
CONFERENCES 2006/7

June 21 2006	AIHW Australia's health 2006 conference	Canberra, ACT	www.aihw.gov.au
Jun 27-28 2006	Optimising Patient Flow Summit 2006: Innovative Strategies for Hospital Operational Excellence.	Sydney, NSW	www.iqpc.com
Aug 2-4 2006	Joint National Congress. Australian College of Health Service Executives and The Royal Australasian College of Medical Administrators.	Hobart, Tas	www.achse.org.au
Aug 20-22 2006	HISA Health Informatics Conference 2006	Sydney, NSW	www.hisa.org.au/
Aug 21-23 2006	4th Australasian Conference on Safety and Quality in Health Care	Melbourne, VIC	www.aaqhc.org.au/
Sept 13-16 2006	SARRAH (Services for Australian Rural and Remote Allied Health) Conference	Albury, NSW	www.ruralhealth.org.au/conferences/sarrah2006/home.htm
Sept 25-27 2006	37th Public Health Association of Australia Annual Conference	Sydney, NSW	www.phaa.net.au/
Oct 5-8 2006	RACGP 49th Annual Scientific Convention 2006	Brisbane, QLD	www.racgp.org.au/asc2006/
Oct 9-10 2006	26th Annual APHA National Congress	Gold Coast, QLD	www.apha.org.au/media_files/2378040505
Oct 11-14 2006	PCS/I Singapore	Singapore	www.pcse.org/.
Oct 13-15 2006	3rd International Conference on Healthy Ageing and Longevity	Melbourne, VIC	www.longevity-international.com/
Oct19-20 2006	National Institute of Clinical Studies: Using Evidence: Using Guidelines Symposium	Melbourne, VIC	www.usingevidence.com.au.
Oct 22-25 2006	23rd International Conference of The International Society for Quality Health Care	London, UK	www.isqua.org
Oct 29-Nov 4 2006	WHO-FIC meeting	Tunis, Tunisia	www.who.int/classifications/en/
Nov 14-16 2006	A Measure of Hospital Health: The Biennial Health Conference 2006	Sydney, NSW	www.health.gov.au/casemix
July 2007	10th NCCH Conference	Brisbane,QLD	www.fhs.usyd.edu.au/ncch
Aug 20-24 2007	Medinfo 2007	Brisbane,QLD	www.medinfo2007.org
Oct 8-10 2007	HIMAA National Conference	Auckland, NZ	www.himaa.org.au

Conference information is also published at the NCCH web site http://www3.fhs.usyd.edu.au/ncch/2.4.htm



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The Clinical Coders' Society of Australia Ltd was established in 1996 and is affiliated with the Health Information Management Association of Australia (HIMAA). The CCSA constitution states that the primary objective of the Society is to provide a forum, and also support, for clinical coders and those interested in the coding of health care data.

The CCSA aims to provide members with advice on workforce and professional issues, continuing education activities, coder accreditation support, and regular publications, in addition to helping to raise the profile of clinical coders and to promote the understanding of the value of coded data.

The constitution of the CCSA enables membership to be offered to clinical coders, health information managers and those interested in clinical coding.

The CCSA is managed through a Board of Directors comprised of a member from each state and territory and a HIMAA Board member who will act as an ex-officio director.

The membership fees are $60 annually (students $30) plus a one off $30 initial joining fee. These fees are tax deductible.

For further information contact:
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(membership information and forms online);

Your state or territory CCSA representative;
or
CCSA Membership
PO Box 203, North Ryde NSW 1670
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coding matters

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