coding matters

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

Volume 8 Number 4 **March 2002**

ICD-10-AM Third Edition Education

Education for Australian users of ICD-10-AM Third Edition has been developed as an interactive, self-learning tool that will be available from the Internet and on CD-ROM. The education activities will help to prepare ICD-10-AM Third Edition users about disease, procedure and Australian Coding Standard (ACS) revisions before the classification is implemented in all Australian states and territories on 1 July 2002.

Education for users of the classification is being provided electronically in response to survey feedback from participants who attended education activities carried out prior to the implementation of ICD-10-AM Second Edition in 2000.

The aim of providing electronic self-learning educational material is to allow learners to work at their own pace and at convenient times and locations. This was a clearly articulated preference made by Second Edition workshop participants.

Education Edition

- Clinical Update: Anaesthesia and postoperative analgesia II 7
- Classification Corner: ICD-O, Third Edition 12
- Queensland Trauma Registry 18
- The Abbreviated Injury Scale (AIS) 19
- ICD-10-AM Mental Health Manual Education Strategy 21

To participate in on line education, participants need access to:

- an Internet connection ***or***
- a CD-ROM facility ***and***
- the ICD-10-AM Third Edition book set or browser.

Many participants will also find *Coding Matters* volume 8, numbers 2, 3 and 4 which contain information about Third Edition changes (copies can be downloaded from the NCCH web site http://www.fhs.usyd.edu.au/ncch) useful to refer to during the activity.

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There will be no charge for participants to access the electronic education material. Participants who do not have access to the Internet will be provided copies on CD-ROM, also at no charge.

Before starting the course, participants will need to register by using the form available at http://www.fhs.usyd.edu.au/ncch. Participants who do not have access to Internet connections are invited to contact the NCCH Quality and Education division to arrange to receive a registration form by e-mail or fax.

Information from registered participants will be used to report the number and distribution of classification users who have undertaken on line education, and to monitor the progress and satisfaction of participants. Participants will receive login information and a password to access the material after registration.

The education material is divided into four main areas:

1. user guidelines
2. changes to the disease classification
3. changes to the procedures classification
4. changes to the Australian Coding Standards (ACS).

Where relevant and appropriate, information about the reasons and background for changes to the index, tabular and their related Australian Coding Standards are provided. Challenge exercises have been integrated so participants can self-assess their progress topic by topic.

Participants who have queries about classification changes are invited to document the question (on a query form, which will be available in the learning package) and send it to the NCCH Quality and Education Division before 12 April 2002. Responses to queries will be collated and established as a frequently asked questions (FAQ) page at the NCCH web site before workshops are commenced.

ICD-10-AM Third Edition Workshops

Many users of the classification will satisfy their educational needs about ICD-10-AM Third Edition by using the on-line material. For others, face-to-face workshops will be offered as an additional educational option. Attendance is not mandatory, but completion of the on-line education is a pre-requisite to attend workshops. NCCH staff and members of the Coding Educators Network (CEN) will conduct the one-day workshops.

The workshops will address the complex and difficult areas of change in the Third Edition, which will be defined from on-line learners' feedback. Practical exercises will be conducted to help apply and comprehend changes.

Proposed workshop dates are:

Australian Capital Territory	
Canberra	17 May
New South Wales	
Sydney	2, 3, 31 May (3 workshops)
Orange	7 May
Coffs Harbour	9 May
Tamworth	19 June
Newcastle	21 June
Northern Territory	
Darwin	17 June
Queensland	
Brisbane	3, 4, 6 June (3 workshops)
Toowoomba	5 June
Cairns	7 June
Tasmania	
Hobart	7 June
Victoria	
Melbourne	16, 31 May, 5 June (3 workshops)
Bendigo	27 May
Western Australia	
Perth	22, 23, 24 May (3 workshops)
South Australia	
Adelaide	12, 13, 14 June (3 workshops)

Register to attend workshops by 26 April 2002

Venue information will be publicised on Code-L, at the NCCH website and through state and territory health departments.

Registration to attend workshops costs $125 (inlcuding GST). Participants will need to negotiate for subsidies from their employer organisation, state or territory health department, or be prepared to self-fund attendance at the workshops.

For further information about education for the implementation of ICD-10-AM Third Edition, please contact the NCCH Quality and Education Division qed@latrobe.edu.au phone 03 9479 1135 or 03 9479 1811.

The following examples provide a detailed account of two areas of change that will be effective with ICD-10-AM Third Edition. They are the result of continuing feedback, from the public submission and query processes, and feature a similar level of information to that provided in the ICD-10-AM Third Edition educational material.

Postnatal depression

The NCCH received a public submission for changes to be made to the classification of postnatal depression. In ICD-10-AM Second Edition, coders are advised to assign a code from F32 *Depressive episode* for patients who are diagnosed with depression in the postnatal period **and** the depression is specified and classifiable to this category. A code from category F53 *Mental and behavioural disorders associated with the puerperium, not elsewhere classified* is assigned only when the type of depression is not documented or not able to be classified elsewhere and it originates within the postnatal period. The main concern expressed in the public submission was being unable to distinguish those patients suffering from a specified depressive episode that originated in the postnatal period.

There are three types of depression that can occur after childbirth:

1. Postnatal or maternity 'blues' are very common and involve a brief period of the mother feeling 'down', irritable and tearful in the week after the baby is born. The 'blues' is a transient state and generally disappears within a few days.
2. Postnatal depression is when the mother becomes seriously depressed in the first four months following the baby's birth. It can be distinguished from the baby 'blues' by two important factors: the length of time for which symptoms persist and the severity of the symptoms.
3. Postnatal psychosis (postpartum psychosis) involves symptoms of psychosis associated with changes in mood, depression or mania (an extremely high mood), and develops within three weeks following delivery. The clinical features of this disorder tend to be the same as those seen in bipolar affective disorder.

Following clinical consultation with members of the Mental Health and Obstetric Clinical Classification and Coding Groups it was agreed that the classification of the specific type of depression is important and the fact that it occurs in the postnatal period is secondary. This formed the basis for the changes to this area of classification for ICD-10-AM Third Edition.

A fifth character subdivision has been added to category F32 *Depressive episode* to indicate whether the depression occurred during the postnatal period. This enables the two components of this complex disease to be captured:

F32 **Depressive episode**

The following fifth-character subdivision is for use with category F32:

- 0 not specified as arising in the postnatal period
- 1 arising in the postnatal period

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Category F53.8 *Other mental and behavioural disorders associated with the puerperium, not elsewhere classified* has also been modified to include common terms associated with postpartum depression.

F53.8	Other mental and behavioural disorders associated with the puerperium, not elsewhere classified Postpartum: • blues • dysphoria • mood disturbance • sadness	NOS

Australian Coding Standard 0505 *Mental illness complicating pregnancy* has also been revised to reflect these changes. The main points in classification guidelines of this standard are now:

- Postnatal depression is a nonspecific diagnosis referring to any depression arising in the period of 42 days after confinement (the postnatal period)
- If the type of depression is specified and classifiable to the mental health chapter, the appropriate code should be assigned in preference to a code from F53.0 *Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified*
- If a code to specify the type of depression is assigned from category F32 *Depressive episode*, a fifth character will indicate whether the depression arose during the postnatal period.

Destruction/excision of skin lesions

In ICD-10-AM Third Edition, a number of diagnostic statements have been deleted from procedure code titles, in line with the principle that a procedure classification should describe only the procedure performed.

Consequently, one major area of change involves the procedure codes that deal with skin lesions. In ICD-10-AM Second Edition, reference was made to the morphology type in a number of the code titles, for example, 31255-03 *Excision of basal/squamous cell carcinoma of lip*. As this diagnostic information is captured in the disease and, in some cases, morphology codes, it was proposed that these terms be removed from the procedure classification. The decision was made to have two categories only. One encompasses all **destruction** of skin lesions by the number of lesions treated (single or multiple) and the method of destruction (cryotherapy, laser etc).

Another category includes all **excision** of skin lesions by site. No distinction is made on the basis of morphology.

The following are the major changes that have been made to the classification of skin lesions:

Destruction procedures of skin lesions

Deleted blocks (and codes contained therein):

1613	**Destruction of premalignant skin lesion**
1614	**Destruction of malignant lesion of skin or cartilage**

Renamed block:

1612	**Destruction of benign lesion of skin**

has been renamed as

1612	**Destruction of lesion of skin or cartilage**

Changes to codes:

Appropriate changes have been made to the code titles within block 1612 *Destruction of lesion of skin or cartilage*, for example 30195-02 *Laser to benign lesion of skin, single lesion* has been renamed as *Laser to lesion of skin, single lesion*.

Excision procedures of skin lesions

Deleted blocks (and codes contained therein):

1621	**Excision of giant hairy or giant compound naevus**
1622	**Excision of basal cell or squamous cell carcinoma of skin**
1623	**Excision of other malignant lesion of skin and subcutaneous tissue**
1624	**Excision of residual or recurrent basal cell or squamous cell carcinoma of skin**
1625	**Excision of lesion of skin and subcutaneous tissue, not elsewhere classified**

Renamed block:

1620	**Excision of benign lesion of skin and subcutaneous tissue**

has been renamed as

1620	**Excision of lesion of skin and subcutaneous tissue**

Changes to codes:

Appropriate changes have been made to the code titles within block 1620 E*xcision of lesion of skin and subcutaneous tissue*, for example 31230-00 *Excision of benign lesion of skin and subcutaneous tissue of eyelid* has been renamed as *Excision of lesion of skin and subcutaneous tissue of eyelid*.

the 10-AM commandments

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

Arterial disease

The article on arterial disease in the 10-AM Commandments, *Coding Matters* (8)1:13, June 2001 prompted a number of queries requesting further clarification on the coding of peripheral vascular disease and conditions involving the cerebral and precerebral arteries.

The following information is provided to assist clinical coders in correct code assignment.

- The original article indicated that documentation of peripheral vascular disease (PVD) or 'chronic ischaemic leg' without further specification should be assigned I70.2_ *Atherosclerosis of arteries of the extremities*. The Alphabetic Index (Volume 2) of ICD-10-AM Third Edition will be amended in a future erratum to reflect this directive.
- **The information contained in the article does not apply to cerebrovascular disease.** Please follow the Alphabetic Index (Volume 2) of ICD-10-AM Second Edition in order to assign the correct code for these conditions (eg carotid stenosis, occlusion of cerebral artery). Changes will be made to the new Australian Coding Standard (ACS) 0941 *Arterial disease* to reflect this directive in a Third Edition erratum.

Excision lesion/tumour

In the procedure classification of ICD-10-AM, there are a number of instances where the terms used in the alphabetic index will not identically match those in the corresponding code title in the tabular list. This does not preclude correct code assignment. For example, if the look up for 'Destruction, lesion, bladder, by diathermy, multiple' is followed, the code assigned is 36845-01 [1096] *Endoscopic destruction of multiple bladder tumours*. Clinical coders should be reminded that the terms 'tumour' and 'lesion' are interchangeable in the Alphabetic Index of procedures (Volume 3). There is a direction under 'Excision, lesion' to 'see also Excision, tumour'. The index instructions should be followed to arrive at the correct code, regardless of the term used in the code title.

Positron emission tomography (PET) using Flurodeoxyglucose (FDG)

Positron emission tomography (PET) provides information about cell function, as distinct from the structural information provided by conventional imaging studies. When fluorine-18 is attached to a glucose molecule it produces a radiopharmaceutical called Flurodeoxyglucose (FDG) which contains a positron emitter whose energy can be recorded on a crystal outside the patient. A radiopharmaceutical is a radioactive pharmaceutical used for diagnostic or therapeutic purposes. In a whole body study using FDG, the recorded emissions provide a three-dimensional map of how glucose is used throughout the body. Cancer cells most often use glucose more rapidly than normal cells and can be highlighted as brighter areas on the map.

The codes in block 2012 *Whole body nuclear medicine imaging study* do not contain information on specific radiopharmaceuticals; they are subdivided according to which radioisotope, a radioactive form of an element, is used. Where a PET whole body study using FDG is documented, please assign 61434-00 [2012] *Whole body study using cells labelled with technitium with tomography.* The NCCH plans to discuss nuclear medicine codes with the appropriate Clinical Classification and Coding Group to investigate the need for expanded codes in this area.

Same day endoscopy standard

Following the publication of the same day endoscopy standard (*Coding Matters* 8(1):15, June 2001) there have been a number of queries about the scope of this standard. To reiterate, these guidelines apply to those patients who are admitted for endoscopic investigation of any body system (eg colonoscopy, bronchoscopy, ERCP) and who are also:

- same day patients, that is, admitted and discharged on the same date, or
- patients who are discharged on the day after admission but the intention was for same day admission, or
- patients who are admitted the day before the procedure because a day only admission is not possible or practicable for them (eg elderly patients, those who live in a remote location).

These patients may present with a number of symptoms for investigation, any one of which may be the cause of their problem. In these cases, it is important to capture all the conditions to reflect the complete clinical picture, particularly where there is no indication of causal links and/or a final diagnosis.

These guidelines do not apply to:

- cases where the patient is presenting for follow-up investigations. These cases are coded in accordance with ACS 0213 *History of malignancy* or ACS 1124 *Healed gastric ulcer*
- patients having endoscopies to further investigate a known condition, such as carcinoma of the stomach (these cases will be coded in accordance with ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*), or those presenting with a problem related to a known condition (these will be coded in accordance with ACS 0001 *Principal diagnosis* and ACS 0207 *Complications associated with neoplasms*)
- patients admitted for screening, who are to be coded in accordance with the current revision of ACS 2111 *Screening for specific disorders* (See *Coding Matters* 7(1):10, June 2000).

In the cases mentioned above, the patient is admitted for a specific purpose and incidental findings are therefore only coded when they meet the criteria of an additional diagnosis.

Diabetic foot

The code E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes* should be assigned only when a patient has diabetes mellitus with an ulcer or infection of the **foot** and peripheral and/or neurological complications and/or other distinct clinical factors (as per ACS 0401 *Diabetes mellitus*).

Whilst the code titles listed under point 1 in the 'Diabetic foot' section of the standard contain references to 'limb' or 'lower limb', the actual condition must be of the foot to qualify for the criteria of 'diabetic foot'.

An ulcer of the buttock or hand, for example, would not qualify for the assignment of E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes*.

Documentation of 'ulcer of ankle' in a patient who meets the other qualifying criteria for diabetic foot, should be clarified with the treating clinician as to whether the diagnosis of 'diabetic foot' is appropriate.

Breast reconstruction

Reconstruction of the breast may be performed at the same time the breast is removed or at a later date.

An admission specifically for post-mastectomy breast reconstruction will have a principal diagnosis code of Z42.1 *Follow up care involving plastic surgery to breast*. The malignancy (or history of) will be coded as an additional diagnosis; whether to use the current malignancy code(s) or Z85.3 *Personal history of malignant neoplasm of breast* is dependent on the circumstances of the episode of care.

Further detailed guidance on when to code malignancies as current is contained in the revised version of ACS 0236 *Neoplasm coding and sequencing*, ICD-10-AM Third Edition.

Suicide ideation/risk

The NCCH discussed the issue of suicidal ideation/risk at the Mental Health Classification Update Forum. Members of the forum agreed that the concept of 'history of suicidal ideation' is not useful and Z91.5 *Personal history of self-harm* is not always appropriate. The clinicians explained that suicidal ideation is an important symptom, however it is not an entity in its own right. Suicide ideation exists against a background of an underlying psychological disorder.

The NCCH submitted a proposal to World Health Organization (WHO) for a new code for suicidal ideation/risk. WHO agreed to adding 'suicidal ideation (tendencies)' as an inclusion term at R45.8 *Other symptoms and signs involving emotional state* to the Official Updates to ICD-10. The NCCH has added a new code R45.81 *Suicidal ideation* to ICD-10-AM Third Edition, with an important excludes note, 'suicidal ideation constituting part of a mental disorder (F00-F99)'.

In the meantime, when 'suicidal ideation/risk' is documented, please seek clarification from the treating clinician as to the underlying psychological disorder. When documentation is incomplete and clinical advice is unavailable, please assign R45.8 *Other symptoms and signs involving emotional state*.

Clinical update

Anaesthesia and postoperative analgesia II

The second* of a two-part clinical update on anaesthesia and postoperative analgesia

This clinical update includes information on:

- conduction anaesthesia
- anaesthesia/analgesia in labour and caesarean section
- postoperative/postprocedural analgesia.

Classification pointers, which highlight changes to coding practice in ICD-10-AM Third Edition, are provided at the end of each topic.

Conduction anaesthesia

Conduction anaesthesia is achieved when drugs are used to block nerve impulses before they reach the central nervous system (CNS). This is in contrast to general anaesthesia, which relies on the action of drugs within the central nervous system to produce unconsciousness and depress responses to painful stimulation.[1]

The term 'conduction anaesthesia' in ICD-10-AM Third Edition, includes neuraxial block, regional blocks and infiltration of local anaesthetic. The codes for these procedures are included in block 1909 *Conduction anaesthesia.*

Neuraxial block

Neuraxial anaesthesia or block is a term used to describe three types of anaesthesia: epidural anaesthesia, spinal anaesthesia, and caudal anaesthesia. All involve the injection of a local anaesthetic drug into the back in between the vertebrae and are administered to provide motor and sensory block to the areas affected.

Epidural anaesthesia

Epidural anaesthesia involves the deposition of local anaesthetics, either used alone or in combination with painkilling drugs, into the epidural space. The epidural space is the space between the dura and the bony spine. The dura is one of the three meninges – the protective membranes that surround the brain and spinal cord – and is the third and outermost layer. The epidural space contains the nerves that enter and leave the spinal cord. Once these drugs are in the epidural space, they diffuse across the membranes of the spinal cord and act by anaesthetising the nerves supplying the lower body.[2]

Most epidural anaesthetics are introduced via a catheter that is inserted into the epidural space. Intermittent or continuous infusion of local anaesthetics can then be administered through the epidural catheter and anaesthesia can be maintained for as long as the catheter remains in place. An epidural may be either used by itself for pain relief and/or anaesthesia in patients who are conscious, such as during labour, or combined with a general anaesthetic for some patients undergoing surgery.

Spinal (intrathecal) anaesthesia

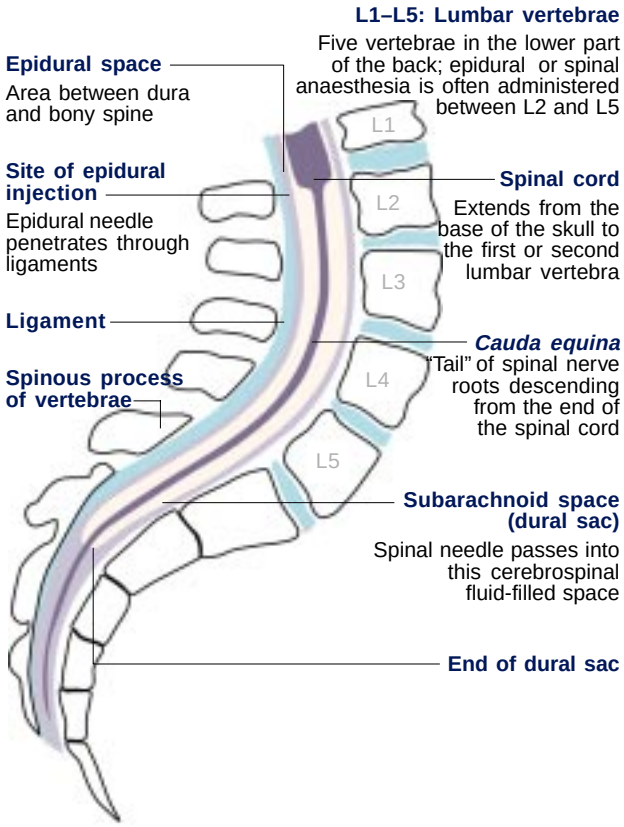
Spinal anaesthesia involves the injection of a local anaesthetic drug through the dura and directly into the subarachnoid space – the fluid-filled cavity surrounding the brain and spinal cord. The fluid within this space is the cerebrospinal fluid (CSF). The spinal needle is inserted between any two spinous processes of the second to fifth lumbar vertebrae. The spinal cord ends above this region, tapering down to the cauda equina. The subarachnoid space is therefore more easily and safely accessed here. The subarachnoid space is fluid-filled unlike the epidural cavity and it has a much smaller capacity thus a smaller volume of local anaesthetic is required. Spinal anaesthesia produces a dense block of rapid onset and is particularly useful for surgical procedures below the waist, including caesarean section, transurethral resection of the prostate and orthopaedic procedures on lower limbs.[3]

Caudal anaesthesia

Caudal anaesthesia is a type of epidural anaesthesia, mostly done for anorectal or perineal surgery. It involves a different method of approach, with the needle inserted at a 45 degree angle to the skin into the epidural space at the base of the spine.

*** The first part was published in *Coding Matters* 8(3):11-13, December 2001.**

Figure 1: Epidural and spinal anaesthesia



Regional nerve block

A regional nerve block involves the administration of anaesthetic agents in the area of single nerves or groups of nerves to numb (anaesthetise) the extremities or other parts of the body. It is a useful technique when dealing with injuries to limbs and may be used in conjunction with general anaesthesia (to prevent movement when the anaesthetic ceases or provide pain relief postoperatively) or sedation.

Intravenous regional anaesthesia

This technique consists of the intravenous injection of a local anaesthetic drug into the blood vessels of a limb, usually the arm, that is isolated from the circulation by an arterial tourniquet. This is also known as retrograde perfusion of limb or Bier's block. An intravenous cannula is inserted into the vein at the back of the hand and the arm is drained of blood by elevation or by the use of a special bandage. A double-cuff tourniquet is applied to the upper arm and inflated to 100mm Hg above the systolic blood pressure to prevent the blood vessels refilling. A solution of local anaesthetic is slowly injected through the cannula into the blood vessels and is absorbed by the surrounding tissue. The cuff must not be deflated under 30 minutes as this may allow release of the local anaesthetic in the general circulation. This technique is commonly used in emergency departments to reduce fractures of the wrist.[4]

Local anaesthesia

Local anaesthesia is frequently used in emergency departments for procedures that do not need a general anaesthetic but require a numbing action, such as stitching wounds, draining abscesses and inserting chest drains. An anaesthetic agent is generally injected under the skin, but may also be applied as a cream, paste, gel, spray or suppository.

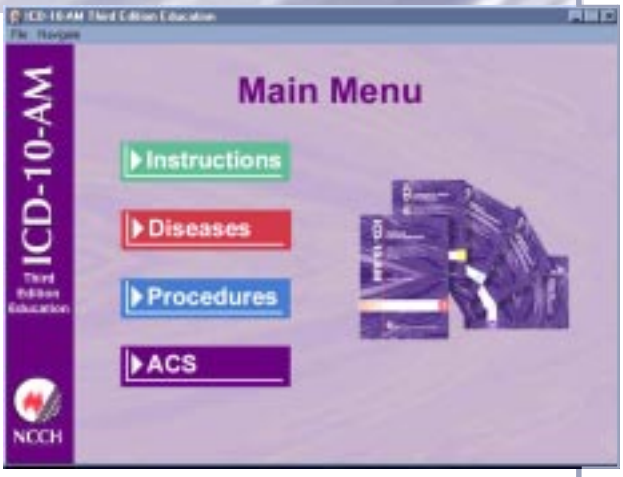
For the purposes of ICD-10-AM, local anaesthesia may be divided into two main categories:

Topical anaesthetics

Some of the different formulations of topical anaesthesia include:

- EMLA (eutectic mixture of local anaesthetic) cream, that contains lignocaine and prilocaine, may be applied to the skin under an occlusive (airtight) dressing. This is useful for needle-shy children or for insertion of intravenous cannulas and catheters.

Web-based education in addition to face-to-face training will be available for the **ICD-10-AM** Third Edition



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- Anaesthetic sprays/gels may be used to numb the surface of the mucosal lining of the nose, gums, throat and trachea before a tube or instrument is inserted.
- Cocaine paste is sometimes used to anaesthetise the side wall of the nasal cavity before passing a cannula into the maxillary sinus for a sinus washout.
- Anaesthetic suppositories inserted into the anal canal and rectum will ease pain due to an injury or disorder and allow minor procedures to be undertaken in comfort.
- Anaesthetic eye drops are sometimes used during ophthalmological surgery such as cataract extraction.[5]

Injected anaesthetics

A local anaesthetic is injected into the skin and subcutaneous tissue and by moving the point of the needle, the solution infiltrates the appropriate area. This technique is mainly used for minor surgery and stitching a wound.

Classification pointers for ICD-10-AM Third Edition

- The codes in block 1909 *Conduction anaesthesia* require a two character extension to indicate ASA score (see *Coding Matters* 8(3):13 for codes and definitions).
- There is no distinction on the basis of the route of administration for the neuraxial block (infusion or injection) nor the type or combination of block (spinal, epidural or caudal). The type of drug (opioid, local anaesthetic or other therapeutic substance) administered is not required for assignment of the code.
- The codes for regional blocks are divided on the general anatomical area of the administration of the block, eg nerve of head or neck, nerve of trunk, nerve of upper limb, nerve of lower limb.
- If more than one type of anaesthesia is administered from block 1909 *Conduction anaesthesia* during a 'visit to theatre', assign only one code from this block, using the following hierarchy (listed from highest priority to lowest):
  1. neuraxial block
  2. regional block
  3. infiltration of local anaesthetic
- A code for local anaesthesia (any type) is assigned only when the anaesthetic is documented on an anaesthetic form and there is no other anaesthetic procedure documented on the same form.

Anaesthesia and analgesia in labour and caesarean section

The distinction between analgesia and anaesthesia becomes blurred when dealing with labour and delivery. A patient may request an epidural block for pain relief during labour, which may then be extended to a combined spinal/epidural or 'topped up' to provide anaesthesia during an emergency caesarean section. For this reason, the current separate block of codes in ICD-10-AM Second Edition, 1333 *Epidural injection during labour* is maintained for the Third Edition, the title has changed to *Analgesia and anaesthesia during labour and caesarean section* and two new codes were introduced to better reflect current clinical practice:

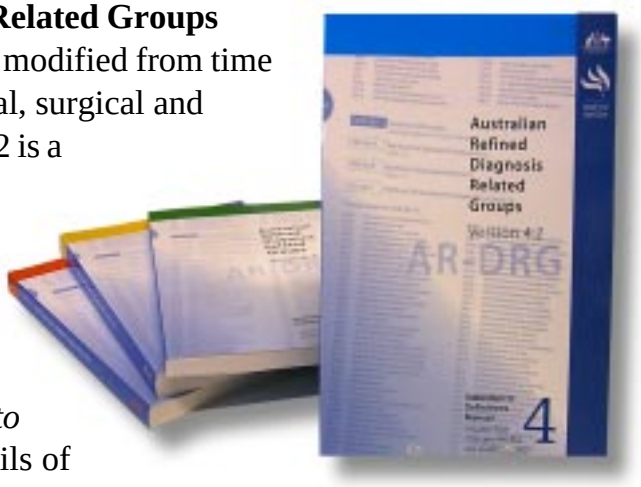
92506-xx	Neuraxial block during labour
92507-xx	Neuraxial block during labour and caesarean section

Classification pointers for ICD-10-AM Third Edition

- The codes in block 1333 *Analgesia and anaesthesia during labour and caesarean section* require a two character extension to indicate ASA score (see *Coding Matters* 8(3):13 for codes and definitions).
- There is no distinction on the basis of the drugs administered for the neuraxial block (local anaesthetic, opioid or other therapeutic substance) nor the type or combination of the neuraxial block (spinal, epidural or caudal).
- The distinction between the two codes in this block is on whether the neuraxial block administered for pain relief in labour is continued for anaesthesia during caesarean section.
- A separate code, from block 1912 *Postprocedural analgesia,* is assigned for **continuing** infusion of neuraxial block for pain relief following delivery.

AR-DRG V4.2: Addendum to the Definitions Manual

The Australian Refined Diagnosis Related Groups (AR-DRG) classification needs to be modified from time to time in line with changes to medical, surgical and coding practices. AR-DRG version 4.2 is a revision to the classification. It accommodates changes that occurred between the First and Second Editions of ICD-10-AM, and includes a number of 'fixes'.



The AR-DRG version 4.2 *Addendum to the Definitions Manual* provides details of what is new and different about AR-DRG version 4.2. It is a single volume, with CD-ROM.

The AR-DRG version 4.2 *Addendum to the Definitions Manual* is $50 plus GST. Copies may be purchased from the NCCH.

Postprocedural/postoperative analgesia

There are many and varied methods of pain relief for postprocedural pain, ranging from oral analgesia to continuous epidural infusion. The following techniques are those contained in block 1912 *Postprocedural analgesia*.

Neuraxial block

An epidural cannula may be left in situ following a procedure to allow a continuous infusion of local anaesthetic and other drugs for prolonged postprocedural analgesia. Local anaesthetics and opiates, alone or in combination, are administered through the epidural catheter as an infusion or a bolus to provide analgesia. In recent years, the use of continuous spinal local anaesthetics for postoperative pain has become popular. Subarachnoid administration of local anaesthetic and/or opioids has the advantages of simplicity, reliability and low-dose requirements. Both of the above methods may be delivered on a patient-controlled basis.

Patient Controlled Analgesia (PCA)

All of these methods of postprocedural analgesia may be delivered on a patient-controlled basis, which allows a patient to receive drugs on demand. The drugs are administered via a PCA pump when the patient pushes a button. The clinician determines the intermittent injection dose (the dose received when the patient pushes the button), the lockout interval (the minimal length of time that must elapse between consecutive doses) and may limit how much drug is injected in a limited time (1-4 hours). This allows continuous effective pain relief with minimal sedation and respiratory depression.[7]

This clinical update has been prepared in consultation with Dr Mervyn Cobcroft, member of the Classification Update Forum on Anaesthetics and Dr Richard Kelly.

Dr Cobcroft is currently Director of Anaesthetics, QEII Hospital, Coopers Plains, Qld. Dr Kelly is Head of Anaesthesia at Noarlunga Health Services, SA.

Our special thanks to Drs Cobcroft and Kelly for their support of the work of the NCCH.

Classification pointers for ICD-10-AM Third Edition

- Codes in block 1912 *Postprocedural analgesia* are to be used only when the procedure described is initiated in the operating suite (theatre or recovery) and there is documentation of continuous infusion occurring postprocedurally.
- Do not assign codes from this block where the infusion is initiated after leaving the operating suite (theatre or recovery). In these cases, refer to ACS 1807 *Pain diagnoses and pain management procedures* for guidance on correct code assignment.
- Codes for continuing infusion of neuraxial and regional blocks include those administered via patient-controlled analgesia.
- Codes for intravenous postprocedural analgesic infusion, administered either by continuous infusion or patient-controlled, may be assigned if data on such interventions is required at the local hospital level. Use of these codes is not mandatory for national morbidity data reporting.

1 Dobson M (2000) Anaesthesia at the district hospital. World Health Organization: Geneva

2 Inside the Human Body, Unit 37, sheet 9, Bright Star Publishing, London

3 Inside the Human Body, Unit 37, sheet 11, Bright Star Publishing, London.

4 Dobson M (2000) Anaesthesia at the district hospital. World Health Organization: Geneva

5 Inside the Human Body, Unit 3, sheet 36, Bright Star Publishing, London

6 European Society of Regional Anaesthesia and Pain Therapy website http://www.esraeurope.org/abstracts/abstracts 98/rawal 1.htm Patient controlled regional anaesthesia (PCRA) – accessed January 2002.

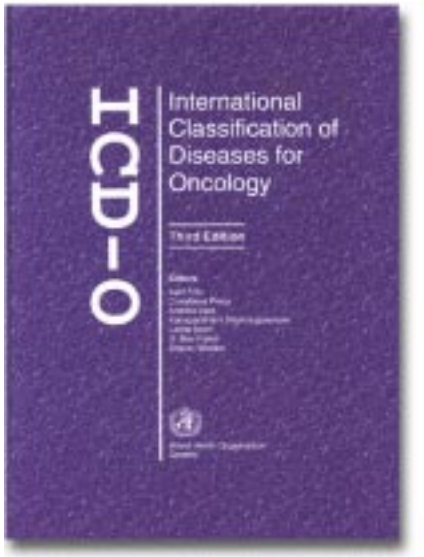
7 Burkitt G, Quick C & Gatt D (1998) Essential Surgery. (2nd ed) 1996 Churchill Livingstone: Edinburgh

Changes made to Part one - see *Coding Matters* 8(3) http://www.fhs.usyd.edu.au/ncch/

Classification corner

International Classification of Diseases for Oncology, Third Edition (ICD-O-3)

The *International Classification of Diseases for Oncology* (ICD-O) was first published in 1976 and was substantially revised in 1990. The third edition of the classification, ICD-O-3, has recently been published by the World Health Organization (WHO).



ICD-O-3 contains codes for:

- topography (site of origin of primary cancer)
- morphology (histological cell type)
- behaviour (malignant, benign, etc)
- differentiation or tumour grade (the degree of aggression of the tumour).

Due to significant changes in pathological and diagnostic techniques in recent years (such as cytogenetic testing), and improvements in knowledge of neoplasms and their behaviour (particularly haematopoietic cancers), ICD-O-3 contains major changes in morphology codes compared with previous revisions.

Planning for the third revision began in 1998 when the International Agency for Research on Cancer was requested by WHO to prepare an update to ICD-O-2. A taskforce was established and surveys sent to cancer registries around the world to request input into the update process. It was determined that the ICD-O topography codes, being based on the 'malignant primary tumours' section of ICD-10 Chapter II, would not be considered for revision as these had already been subject to the WHO update process. The WHO also publishes a series entitled *Histological Typing of Tumours* (known to pathologists as the 'Blue Books') and it was resolved to ensure that ICD-O and the terminology used in the classification is compatible with these publications to assist in the coding process. Following developmental work and field trials (in which NCCH was a participant), the ICD-O-3 was released in mid 2001.

Information about ordering the publication is available at http://www.who.int/dsa/cat98/can8.htm or from the Australian WHO publications distributor, Hunter Publications.

What's new in ICD-O-3 compared with ICD-O-2?

Behaviour changes

The first thing to note is that some disease entities have changed behaviour type – in other words – the digit following the slash (/) at the end of the M code is different. This reflects current understanding of the behaviour of these neoplasms.

ACBA™ 2000

Health care decisions are dependent on good quality morbidity data. ***Australian Coding Benchmark Audit 2000*** **(ACBA)** provides a mechanism to assess quality of coded morbidity data. **ACBA 2000** is a coding audit method that involves re-coding a sample of hospital-admitted patient episodes and uniformly recording results.

ACBA

- ***identifies*** errors in coding practice
- ***automates*** results reporting

See order form distributed with Coding Matters or call 03 9479 1811 for further information.

Table 1. Terms that changed to malignant behaviour

ICD-O-2 Code	Primary term as it appeared in ICD-O-2	ICD-O-3 Code
8931/1	Endolymphatic stromal myosis (C54.1)	8931/3
9134/1	Intravascular bronchial alveolar tumor (C34._)	9133/3
9538/1	Papillary meningioma	9538/3
9950/1	Polycythemia vera	9950/3
9960/1	Chronic myeloproliferative disease, NOS	9960/3
9961/1	Myelosclerosis with myeloid metaplasia	9961/3
9962/1	Idiopathic thrombocythemia	9962/3
9980/1	Refractory anemia, NOS	9980/3
9982/1	Refractory anemia with sideroblasts	9982/3
9983/1	Refractory anemia with excess blasts	9983/3
9984/1	Refractory anemia with excess blasts in transformation	9984/3

Table 2. Terms that changed from malignant to borderline

ICD-O-2 Code	Primary term as it appears in ICD-O-3	ICD-O-3 Code
8442/3	Serous cystadenoma, borderline malignancy (C56.9)	8442/1
8451/3	Papillary cystadenoma, borderline malignancy (C56.9)	8451/1
8462/3	Serous papillary cystic tumor of borderline malignancy (C56.9)	8462/1
8472/3	Mucinous cystic tumor of borderline malignancy (C56.9)	8472/1
8473/3	Papillary mucinous cystadenoma, borderline malignancy (C56.9)	8473/1
9421/3	Pilocytic astrocytoma (C71._)	9421/1
9422/3	Spongioblastoma, NOS (C71._)	9421/1

Table 3. Terms that changed to or from borderline behaviour

ICD-O-2 Code	Primary term as it appears in ICD-O-3	ICD-O-3 Code
8152/0	Glucagonoma, NOS (C25._)	8152/1
8580/0	Thymoma, NOS (C37.9)	8580/1
8640/0	Sertoli cell tumor, NOS	8640/1
9506/0	Neurocytoma	9506/1
8261/1	Villous adenoma, NOS	8261/0
8361/1	Juxtaglomerular tumor (C64.9)	8361/0
8823/1	Desmoplastic fibroma	8823/0
9080/1	Mature teratoma	9080/0

ICD-10-AM Second Edition contained the morphology codes from ICD-O-2. The morphology codes in ICD-10-AM Third Edition are consistent with ICD-O-3.

New codes and terms

In the process of developing ICD-O-3, 220 new morphology codes were included and numerous synonyms and new terms have been added to the ICD-O index. The leukaemia/lymphoma section of codes was considerably revised. The terminology for these tumours has been updated, although older terminology has been retained in the Index and as inclusion terms for reference. Additional commonly used abbreviations have been added to the Index to assist in coding. Some new codes have been included that, although reflecting non-specific diagnoses, are commonly used on pathology or cytology reports such as M8046/3 *Non small cell carcinoma*, M9861/3 *Acute non-lymphocytic leukaemia*.

Lymphomas and leukaemias

A variety of classifications and terminologies are used by pathologists to describe haematopoietic cancers. ICD-O-2 was based mainly on the Working Formulation, which was a means of translating other classifications such as Kiel, Rappaport and Luke-Collins. In 1994, the REAL (Revised European-American Lymphoma) classification was published. This classification grouped blood and lymphatic tissues along their cell lines, rather than the physical characteristics of their cells. This major shift in diagnostic thinking resulted in publication of the *WHO Classification of Neoplastic Diseases of the Haematopoietic and Lymphoid tissues* in 1999, and this classification has been used as the basis for the development of ICD-O-3 for these cancers. One of the changes that was made as a result of the use of the underlying pathological classification was to identify and name leukaemias on the basis of the chromosomal changes in the cancer cells. Thus the code for *acute promyelocytic leukaemia* is M9866/3 with the suffix *t* (15;17)(q22, q11-12). '*t*' refers to a translocation of genetic materials between two chromosomes – in this example there has been a shift of genetic materials from chromosome 15 on the long arm (*q* means long arm) in region 22 to chromosome 17 in the region between 11 and 12.

What's not new but still important?

The Matrix Principle

Although there have been many additions of specific diagnoses and code-behaviour combinations, the matrix principle still applies.

The matrix principle is the rule that makes it permissible to change the behaviour of a reported diagnosis so that it reflects the diagnostic opinion of the pathologist. For example, if a pathologist reports a *malignant adrenal rest tumour*, the morphology code will be M8671, but the behaviour code should be altered from /0 as specified in the classification, to /3 to reflect the malignant status specified by the pathologist – thus the full code will be M8671/3.

International Classification of Diseases for Oncology Third edition (ICD-O-3) edited by A Fritz, C Percy, A Jack, K Shanmugaratnam, L Sobin, DM Parkin and S Whelan (2000) World Health Organization, Geneva. 240 pages, ISBN: 92 4 154534 8.

Available from: Hunter Publications, 58a Gipps St, Collingwood, 3066, ph 03 9417 5361. Cost is approximately $74.00 (depending on currency fluctuations) + GST.

Fritz A & Percy C (2001) Implementing ICD-O-3: Impact of the New Edition http://training.seer.cancer.gov/module_icdo3

Percy C, Van Holten V & Muir C (eds) (1990) *International Classification of Diseases for Oncology, Second Edition*. Geneva: World Health Organization.

Fritz A, Percy C, Jack A, Shanmugaratnum K, Sobin L, Parkin M, Whelan S. (eds) (2000) *International Classification of Diseases for Oncology, Third Edition*. Geneva: World Health Organization.

ICD-10-AM Third Edition
booksets include
the new CD-ROM Browser
Visit **http://www.fhs.usyd.edu.au/ncch/**
for ordering information

International

Bucharest, Romania

It's not often that you travel from bush fires at your back door and temperatures in the 30s to the ice and snow of midwinter in Eastern Europe (Bucharest, Romania) – but that was my good fortune in January of this year! And it was coding in ICD-10 that took me there.

Romania has a long history of the use of the International Classification of Diseases for collection of statistics on cause of death and hospital morbidity. For some years it has used ICD-10 in full or abbreviated format. Volumes 1 and 2 of the classification have already been translated into Romanian. However, the main impetus of my visit, funded by USAID, was the introduction of casemix classification and funding in Romanian hospitals. Twenty-three pilot hospitals have been coding in ICD-10 (diseases) and the International Classification of Procedures in Medicine (ICPM) during 2001, grouping their data using the HCFA 18 grouper, which necessitates a mapping back to ICD-9-CM for grouping purposes. These hospitals are to be funded by diagnosis related group during 2002 (budget neutral). The remaining hospitals (about 150) will start coding and grouping during 2002, for funding by casemix in 2003.

As you can imagine, the introduction of coding using the full ICD-10 and grouping by DRG has sharpened the need for a disciplined approach to coding of diseases and procedures. While some guidelines have been developed, mainly based on ICD-10 conventions, I found a great deal of familiar controversy about definitions (eg principal diagnosis, acute care episode) and specific rules (eg coding of renal dialysis, multiple trauma, burns, angina).

Although there was formerly a group of coders (medical registrators) who undertook a two year training program, there has been more recent emphasis on physician coding. Some preliminary training has already been provided by the Romanian National Centre for Health Statistics for staff in the 23 pilot hospitals. The two day training which I undertook during the two week visit was designed to identify issues for a future trip by NCCH educators so they could develop coding education curricula customised for the current Romanian situation.

My recommendations included the urgent need to translate the alphabetic index of ICD-10 into Romanian and to develop definitions and standards, and especially to identify the clinical coder workforce. I stressed the value of a consistent approach to coding in a casemix environment, and the difficulties this might pose

if resident medical staff continue to perform many of the coding functions in the pilot hospitals. While many Romanian physicians displayed a great interest in and knowledge of DRGs, this does not necessarily mean that resident medical staff should actually code. Transferring the emphasis from physician coding to involvement of statisticians, medical registrators and IT personnel will help Romania to identify the clinical coder workforce for future training programs.

The speed of implementation of casemix classification and funding was extremely impressive, and I came away with an enormous respect for the progress that has already been made. Australia and NCCH have much to offer in sharing its work on development of rules (eg. the National Health Data Dictionary, the Australian Coding Standards) and the classifications themselves, especially the Australian procedure classification. Once this basic infrastructure of coding personnel and other resources is in place and data has been collected, further work on evaluation of groupers, including those based on ICD-10 or its modification, will undoubtedly follow. This is particularly important in highlighting the link between coded and grouped data so that physicians, clinical coders and those funding the health services can see the consequences of patient characteristics and treatment in the diagnosis related group and its related weight.

The DRG project team has already established validation mechanisms which act as edits for submitted data and staff are extremely conscious of the need to audit the quality of data. So many parallels exist between our two countries (population size and mix, emphasis on improving hospital efficiency, sense of humour) that I felt quite at home despite the language difference. I suppose speaking the language of ICD-10 and DRGs is always a wonderful foundation for the sort of bonds that come from international sharing of experience and tools. Thanks to my Romanian hosts for a warm welcome and to USAID for making the consultancy possible. No doubt we will hear more after 'Trip 2' (currently scheduled for May 2002)!

Rosemary Roberts
Director, NCCH

German Delegation to NCCH, 18 January 2002

The NCCH was pleased to welcome a delegation of health professionals from the German Hospital Federation (DKG) to the NCCH as part of their study tour in Australia. The DKG has responsibility under the Health Care Reform 2000 program to develop and implement a new system of payments for hospital services based on DRGs, the preparation of general recommendations for forms of "integrated care", the review of diagnostic and therapeutic procedures and the development of criteria for the appropriate and efficient provision of health care. The delegates visited NCCH and spent the afternoon with Kerry Innes, NCCH Associate Director, discussing:

The delegation from Germany visiting NCCH Sydney

- The history of the NCCH
- NCCH structure, staffing and funding
- NCCH role in AR-DRG development
- PICQ and ACBA
- the process of updating ICD-10-AM – what criteria are used to develop codes, which organisations and individuals are consulted and the role of the Australian Coding Standards in the use of ICD-10-AM.

Visit from Mauritians

NCCH has recently welcomed two visitors from the Ministry of Health in Mauritius. Mr Nasser Jeeanody, Acting Senior Medical Statistician, and Mr Sukhdeo Pem, Medical Records Organiser, were on a three-week study tour arranged by NCCH Brisbane for the WHO African Region.

Mr Jeeanody (left) and Mr Pem with Associate Director Sue Walker at NCCH Brisbane

During their first week, Mr Jeeanody and Mr Pem spent three days with Sue Walker at NCCH Brisbane learning about ICD-10, and then visited the Health Information Service at the Royal Brisbane Hospital and the Data Services Unit in Queensland Health.

The second week of the visit was spent at the Australian Bureau of Statistics Health and Vitals National Project Centre, where they trained in cause of death coding and the automated mortality coding software used by the Bureau was provided.

Visits to the NCCH Sydney office, NSW Central Cancer Registry, Westmead Hospital, the New Children's Hospital at Westmead and to the Australian Institute of Health and Welfare concluded the study tour.

The Ministry of Health and Quality of Life in Mauritius is planning to implement ICD-10 in 2002 or 2003, following recommendations made during a WHO consultancy conducted by Rosemary in early 2001.

Representatives of the All Japan Hospital Association visit NCCH Sydney

NCCH Director Associate Professor Rosemary Roberts, Sydney Associate Director Kerry Innes and Corporate Relations Officer Ann Jones met AJHA representatives Dr Hirotoshi Nishizawa, Dr Kazuo Sano, Dr Masayuki Iwai, Dr Shuhei Iida, Dr Tomonori Hasegawa, Dr Yo Moriyama and Yukali Armstrong

Representatives from Japan's largest private hospital association visited NCCH Sydney in February. The doctors from Tokyo, Okayama and Obihiro City, were taking part in a study tour investigating casemix and DRG issues. The delegates are contributing to a feasibility study of the introduction of service related groups (SRGs) and prospective payment systems (PPS) and are examining the role of benchmarking using clinical indicators to enhance healthcare quality.

Queensland Trauma Registry

In early 2001, NCCH Brisbane signed an agreement with the Queensland Trauma Registry (QTR, the Registry) relating to the employment of a Quality Assurance (QA) and Training Officer. Modelled on the existing arrangement that NCCH has with the Monash University National Centre for Coronial Information (MUNCCI), the QA & Training Officer is funded by QTR to work four days per week with the Registry and one day with NCCH.

The principal tasks are to develop and implement a quality assurance program for the Registry and to assist the Registry's data collectors to use the Abbreviated Injury Scale (AIS) classification by providing education, management of regular coding quality meetings and a coding advisory service. For the NCCH, exploring the potential for synergy between the ICD-10-AM and the AIS is a primary objective.

The Queensland Trauma Registry was established in 1998 to collect clinical data relating to patients admitted to the Princess Alexandra and Royal Brisbane Hospitals for treatment of moderate to severe injuries.

The scope of data collection has recently been expanded to include seven Queensland hospitals where data is collected and submitted to the Registry. Two major paediatric hospitals are included in the data collection and seven additional sites will be on line before the end of this year.

All patients who are admitted to one of the registry hospitals via the emergency department are included, except for those subsequently discharged from the emergency department or whose admission to hospital is for less than 24 hours. Patients admitted for treatment of injuries, who bypass the Emergency Department because their condition requires immediate ICU or surgical care, are also included. For the purposes of eligibility, the admission time includes time in the observation ward, admission at one of the included hospitals, and admission time at a hospital to which a patient is transferred from one of the hospitals where the Registry operates. Time in the emergency department prior to admission is not included.

Data for the Registry is abstracted from existing electronic and paper record systems by trauma nurse co-ordinators and health information managers and entered into the Sybase trauma database. This includes some basic demographic details:

- injury specific data
  - cause of injury
  - place of occurrence
  - means of referral
  - first vital signs
  - disposal from emergency department
  - injury outcome diagnosis (coded to AIS)
  - Injury Severity Score (ISS, calculated from other variables)
- additional information for major cases including
  - data about the pre-hospital phase of care
  - inter-facility transfers
  - emergency department observations
  - triage
  - complications
  - procedures
  - performance indicator data.

The purpose of the trauma registry data collection is system-focused, with the data generally used in three ways:

- To support the work of Trauma Review Committees through the use of audit filters or quality indicators. Tripping of one of the indicators, which are built into the regular data collection system, identifies cases for detailed case record review by peer trauma clinicians. Recommendations for improvements in care for trauma patients are developed from this case review process.
- To assist with the development of statewide benchmarks from the analysis of aggregate data, to be used to judge the efficacy of trauma care within Queensland Health.
- To seek to establish statistics relating to the incidence of severe trauma in the state, causes of trauma, locations, other explanatory variables, treatment and outcomes.

The Abbreviated Injury Scale (AIS)

The Abbreviated Injury Scale (AIS) is an anatomical scoring system first developed in 1969 by the American Association for the Advancement of Automotive Medicine. Since that time, it has been regularly revised and updated as survival following major trauma has improved, so that it provides a reasonably accurate ranking of the severity of injury. The latest revision of the classification was published in 1990 and was subsequently updated in 1998.

The AIS is divided into nine body regions

1. head
2. face
3. neck
4. thorax
5. abdomen
6. spine
7. upper extremities
8. lower extremities
9. unspecified.

Within these, each injury is coded using a seven-digit code. Each digit within the code has a specific meaning, as follows:

1	general body region
2	anatomical structure within the body region (eg whole area, vessels, nerves, organs, skeletal, head (including loss of consciousness)
3 & 4	anatomical structure and nature of injury (eg within upper arm, skin abrasion, skin laceration, amputation, degloving)
5 & 6	severity level of the injury based on structure involved (eg within whole area - upper arm, codes are for amputation, arm or forearm, finger, hand/palm, skin not further specified)
7	AIS, overall severity of the injury

Abbreviated Injury scores are ranked on a scale of 1 to 6, with 1 being minor, 5 severe and 6 an untreatable injury for which the probability of death is extremely high. This code represents the 'threat to life' associated with a specific injury.

To illustrate the concept of severity, the AIS codes for injuries to cervical spine include:

640278.1	cervical strain
630299.2	brachial plexus injury, not further specified
640200.3	cord contusion, not further specified
640200.4	incomplete cord syndrome, not further specified
640221.5	complete cord syndrome, C4 or below
640229.6	complete cord syndrome, C3 or above

An Injury Severity Score (ISS) can also be calculated by computing an overall score for patients with multiple injuries using the following methodology. Each injury is assigned an AIS code and severity score and is also allocated to one of six body regions (head and neck, face, chest, abdomen, extremities (including pelvis), external). Only the highest AIS score in each body region is used to calculate the ISS. Where there is more than one injury within a body region with the same score, this score is used only once in the calculation. The most severe injuries within the body regions have their score squared and added together to produce the ISS score.

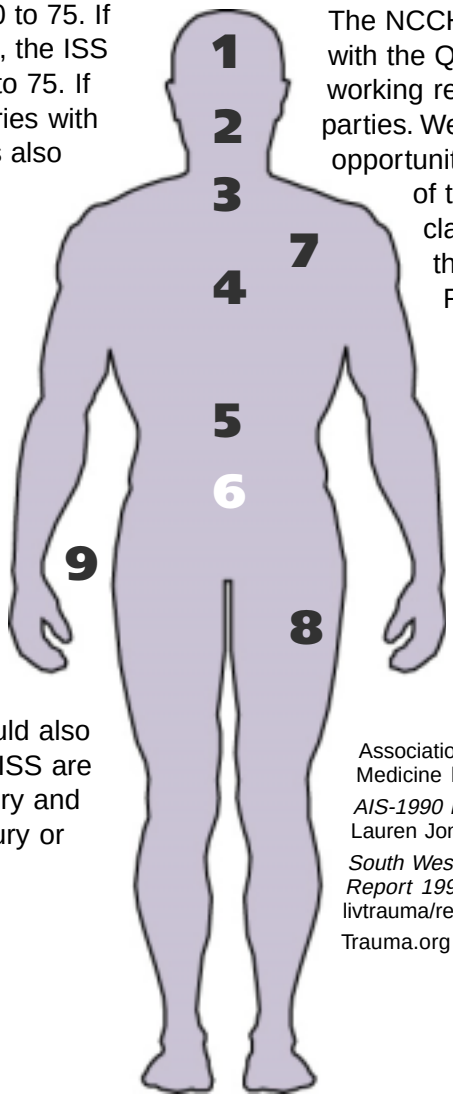
An example of the ISS calculation is shown below:

Body region	Injury description	AIS code	AIS severity score	Square most severe three injuries
Head & neck	Nil			
Face	Facial abrasions	210202.1	1	
Chest	Diaphragm rupture	440604.3	3	9
	Rib fracture	450212.1	1	
Abdomen/ pelvic contents	Minor liver laceration	541822.2	2	4
Extremity	Radius fracture, open	752804.3	3	9
	Femur fracture, shaft	851814.3	3	
External	Nil			
		Injury Severity Score		*22*

Reference: *South Western Sydney Regional Trauma Registry Report 1995 - 1999*, available at http://www.swsahs.nsw.gov.au/livtrauma/reg_stat/default.asp

The ISS score has values from 0 to 75. If an injury is assigned an AIS of 6, the ISS score is automatically assigned to 75. If there are three body region injuries with an AIS of 5, the maximum ISS is also assigned.

The ISS is associated linearly with mortality, morbidity, hospital stay and other measures of severity. Although a useful predictor of mortality, it should be noted that it has some limitations. For example, only an error in the AIS score of the most severe injury in a body region affects the ISS score. Many different injury patterns can yield the same ISS score and injuries to different body regions are not weighted. It should also be understood that the AIS and ISS are related to the severity of the injury and not the consequences of the injury or subsequent impairments.



The NCCH believes that its new affiliation with the QTR is an example of a successful working relationship with benefits to both parties. We are delighted with the opportunity to develop expertise in the use of the AIS and to use our classification knowledge to assist in the development of the Trauma Registry.

Sue Walker

Associate Director, NCCH Brisbane.

Dr Desley Kassulke

Senior Research Fellow and Manager, Queensland Trauma Registry.

Association for the Advancement of Automotive Medicine http://www.carcrash.org/ais90.html

AIS-1990 Injury Coding Manual (1990) developed by Lauren Jones on behalf of NCCH Brisbane

South Western Sydney Regional Trauma Registry Report 1995-1999, http://www.swsahs.nsw.gov.au/livtrauma/reg_stat/default.asp

Trauma.org http://www.trauma.org/scores/iss.html

Casemix, DRGs and clinical coding book series on CD-ROM

The ever-popular *Casemix, DRGs and clinical coding* series of specialty books is now available on CD-ROM.

The CD-ROM version includes all titles in the series in Adobe PDF format with a cumulative index.

The specialty book series provides an informative and useful resource of health information managers, clinicians and clinical coders.

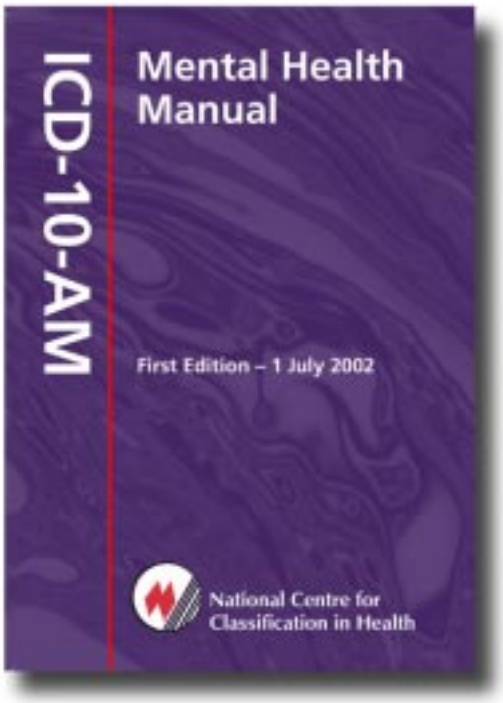
The cumulative index is also available from the NCCH website.

Book and CD-ROM versions of the series can be purchased by using the order form distributed with *Coding Matters* or by visiting our website: **http://www.fhs.usyd.edu.au/ncch/** and downloading the order form.

ICD-10-AM Mental Health Manual

a progress report on the NCCH educational strategy

The *ICD-10-AM Mental Health Manual* was conceived as a handbook for clinicians in community-based mental health services. Its purpose is to act both as a diagnostic tool and as a coding tool. The use of ICD-10-AM in community-based mental health services is an important step in establishing a common *language* in health – a vital part of the electronic health record environment.



NCCH's education strategy for the implementation of the *Manual* aims to emphasise the features of this *Manual* which make it primarily a diagnostic tool embodied in the national coding standard, ICD-10-AM. The target audience of the education program will be mental health clinicians rather than clinical coders.

The *ICD-10-AM Mental Health Manual* is endorsed by the Australian Health Ministers' Advisory Council's National Mental Health Working Group and National Mental Health Information Strategy Committee (ISC).

The National Health Information Management Group (NHIMG) has mandated the *Manual* for recording and coding principal diagnosis for the National Minimum Data Set - Community Mental Health Care.

Professor Aleksandar Janca, Professor of Psychiatry at the University of Western Australia and consultant to the World Health Organization, has been closely involved with the development of the *ICD-10-AM Mental Health Manual* along with representatives from each state and territory, the Department of Health and Ageing and specialist clinicians.

The education program will concentrate on the diagnostic tools in the *Manual*:

1. Diagnostic guidelines which appear with most codes
2. Symptom checklist
3. WHO Disability Assessment Schedule – Short (WHO DAS-S)
4. Multi-axial diagnostic formulation form.

The program's aim is to provide substantial assistance to clinicians using ICD-10-AM to code psychiatric conditions, particularly those who have traditionally used DSM-IV.

The program

It is proposed that community-based mental health professional representatives from all states and territories will undertake train-the-trainer education conducted by NCCH during April 2002. Both nominees and existing representatives from state and territory health authorities will undertake the train-the-trainer education sessions. Representatives will provide input at the session to help explain the authority's data collection guidelines and will provide information about practices in their region. The education strategy allows for both interactive learning using this train-the-trainer methodology or web-based, self-paced learning.

The educational package, *A Guide to the ICD-10-AM Mental Health Manual*, includes:

- Section A is an introduction to the *ICD-10-AM Mental Health Manual*, including aims and objectives, the practice of coding, uses of coded data, mental health coding and the benefits of introducing an ICD-10-AM mental health classification
- Section B provides an outline of the structure and content of the *ICD-10-AM Mental Health Manual*
- Section C guides the use of the *ICD-10-AM Mental Health Manual*, including conventions, application of diagnostic guidelines and clinical assessment tools, and outlines ICD-10-AM basic classification principles. Other areas covered are recording multiple diagnoses from Chapter One *Mental and Behavioural Disorders* (Chapter V of the parent classification) and how and when to apply the classification for other medical conditions, contextual factors and mental health interventions
- Section D gives case history exercises and practical examples in the use of the *ICD-10-AM Mental Health Manual* and its clinical assessment tools.

The NCCH wishes to thank Professor Aleksandar Janca and Danny Rock, Acting Deputy Director, Centre for Clinical Research in Neuropsychiatry, Western Australia, for their assistance in preparing the clinical component of the *Guide*. Both have extensive experience in the ICD-10 classification and developing clinical education programs based on ICD-10.

See *Coding Matters* 8(2):12-14, September 2001 for more information about the strategy. Contact Lisa Langtree, Project Officer, NCCH Melbourne: ph 03 9479 1811; L.Langtree@latrobe.edu.au for more information.

NCCH web site upgrade

After almost seven years of faithful service, the NCCH web site is being upgraded. All current features will be retained, but with improved navigation aids. The site will also be mirrored as a text-only option, which will help visitors who have access to slower Internet connections.

New features include:

- E-commerce facility. Visitors can purchase products on-line
- A quick-find function to search for topics at the site
- Site map
- Improved site architecture and lots more in-text links to help locate information.

Information is being revised, and new features added.

During 2002, features available will include:

- **ICD-10-AM Chronicle**. The Chronicle will be a browser format which contains all changes made to the ICD-10-AM classification since it was created and included Third Edition changes
- **ICD-10-AM Third Edition education** will be avilable on line. For more information, see the cover story in this edition
- Preliminary information about the **2003 NCCH Biennial Conference**, which will be held in Victoria.

The new site will be launched in May 2002.

The new URL is:
http://www.fhs.usyd.edu.au/ncch/

About the committee

National Health Information Management Group (NHIMG)

The NHIMG guides and directs work towards creating and maintaining consistent, reliable national health information. The implementation of the National Health Information Agreement (NHIA), signed by Commonwealth, state and territory health and statistical authorities, is the cornerstone of national health information development in Australia. The NHIA aims to ensure that the collection, compilation and interpretation of nationally relevant health information is appropriate and carried out efficiently. The parties to the Agreement are:

- Commonwealth Department of Health and Ageing
- New South Wales Department of Health
- Department of Human Services Victoria
- Queensland Health
- Health Department of Western Australia
- Department of Human Services, South Australia
- Department of Health and Human Services Tasmania
- Territory Health Services
- Department of Health and Community Care, ACT
- Australian Institute of Health and Welfare
- Australian Bureau of Statistics.

Proceedings are under way to include the Health Insurance Commission (HIC) in the Agreement.

The NHIMG comprises a representative from each of the signatory organisations and a Chair appointed by the Australian Health Ministers' Advisory Council (AHMAC). The New Zealand Ministry of Health has observer status. The current Chair is Ms Patricia Faulkner, Secretary of the Department of Human Services (Victoria).

The National Health Data Committee is the only standing committee of the NHIMG. Its primary role is to check compliance and consistency of data element definitions to go into the National Health Data Dictionary. The Dictionary is the authoritative source of national health data definitions and contains definitions of data elements and provides a national standard for collected health information.

The NHIMG blueprint, the National Health Information Plan (NHIP), guides nationally agreed health information management priorities. The NHIP has been developed for work through to 2005, as the NHIMG health Information Development Priorities. The Plan was presented to AHMAC in February 2002.

coding matters

Volume 8 Number 4 **March 2002**

National Centre for Classification in Health

NCCH (Sydney)

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2002 Conference & Event Calendar

26-28 March	**e-Health and IM & IT** Sydney, NSW *http://www.iir.com.au/conferences/confdetail.html?detail=L1020.html*
20-23 April	**eHealth 2002 - A New era of Health Care Delivery** Vancouver, Canada *info@e-health2002.com* *http://www.e-health2002.com*
11-16 May	**TEPR 2002: Proving the Electronic Healthcare Advantage** Seattle, USA *http://www.medrecinst.com/conferences/tepr/index.shtml*
16-17 May	**8th National Public Health Association of Australian Immunisation Conference** Melbourne, Victoria *conference@phaa.net.au* *http://www.phaa.net.au*
7-8 June	**Canadian Health Records Assoc. Annual Conference 2001** Halifax, Canada. Constance Wrigley *constance.wrigley@chra.ca*
4-6 August	**Health Informatics/HIMAA Conference** Melbourne, Victoria *www.hic.org.au/*
25-29 August	**European Conference on Health Records Dublin 2002** Dublin, Ireland *info@conferencepartners.com*
27-29 August	**2002 Linking Health Innovations and Management Congress** A national congress presented by The Australian College of Health Service Executives (ACHSE) Perth, Western Australia *www.linkinghealth.com/index2.html*
1-4 September	**14th National Casemix Conference** Department of Health and Ageing Conference 2002 *Health Care in Focus - Best Practice, Best Management, Best Measurement?* Melbourne, Australia *www.health.gov.au/casemix/*
21-26 September	**2002 AHIMA National Convention and Exhibit** San Francisco, CA, USA *www.ahima.org/*
25-27 September	**ADS/ADEA Annual Scientific Meeting 2002** *Australian Diabetes Society* Adelaide, South Australia *http://www.racp.edu.au/ads/news.htm*
5-9 October	**The Royal Australian College of General Practitioners 45th Annual Scientific Convention and AGM 2002** Western Australia Faculty *Living Better:* *Towards a Better Quality of Life* Burswood International Resort Perth, Western Australia Call for papers – Closing 26 April 2002 *http://www.congresswest.com.au/RACGP2002/*

Would you like to promote your conference? Please send the details to Rodney Bernard, Publications Manager – r.bernard@cchs.usyd.edu.au

Details of conferences and events will be listed on the NCCH website as information becomes available: *www.fhs.usyd.edu.au/ncch/*

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