

The **10-AM** Commandments

Renal failure unspecified with diabetes mellitus

The NCCH received a query on the correct code assignment for unspecified renal failure with diabetes mellitus.

Classification

Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign:

E1-.23 *Diabetes mellitus with advanced renal disease*

N18.90 *Unspecified chronic renal failure*

The NCCH will consider the addition of index entries for unspecified renal failure under 'Diabetes, diabetic (controlled) (mellitus)' to a future edition of ICD-10-AM.

Botox injections into salivary gland

The NCCH received a query asking about the code assignment for botox injection into salivary gland to reduce drooling in a child with cerebral palsy.

Classification

Assign 90560-00 [1552] *Administration of agent into soft tissue, not elsewhere classified* for botox injection into salivary gland.

The index pathway is:

Injection (around) (into) (of) – see also *Administration*

- botulinum toxin (Botox) (Botoxin) NEC (see also *Injection, by site*) 90560-00 [1552]

IV Mabthera for non-Hodgkin lymphoma

For coding purposes, chemotherapy is defined as the administration of any therapeutic substance (usually a drug), excluding blood and blood products (ACS 0044 Chemotherapy). The NCCH received a query asking to confirm whether Mabthera, a manufactured monoclonal antibody used

to treat non-Hodgkin lymphoma, should be regarded as chemotherapy and not a blood product.

Classification

Mabthera is the brand name of Rituximab which belongs to a group of cancer drugs known as monoclonal antibodies. Rituximab is classified in the ICD-10-AM Table of Drugs and Chemicals as an antineoplastic agent and, therefore, should be classified as pharmacotherapy using antineoplastic agent. A same-day case involving treatment with IV Mabthera for non-Hodgkin lymphoma should be assigned the following codes:

Z51.1 *Pharmacotherapy session for neoplasm*

C85.9 *Non-Hodgkin lymphoma, unspecified type*

M9591/3 *Lymphoma, non-Hodgkin NOS*

96199-00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*

Code descriptors for morphology codes M8480/3 and M8480/6

In ICD-10-AM, the code descriptor for M8480/3 is *Mucinous adenocarcinoma*. The NCCH was asked to clarify whether the code descriptor of M8480/6 *Pseudomyxoma peritonei*, should be mucinous adenocarcinoma, metastatic.

Classification

The code descriptors of M8480/3 *Mucinous adenocarcinoma* and M8480/6 *Pseudomyxoma peritonei* are consistent with WHO ICD-10 and ICD-Oncology codes and code descriptors.

Recently, the NCCH has received clinical advice which recommends the code descriptor of M8480/6 be amended to M8480/6 *Mucinous adenocarcinoma, metastatic* [*Pseudomyxoma peritonei*].

NCCH will forward a submission to WHO Update and Revision Committee and appropriate changes will be made to a future edition of ICD-10-AM.



Assignment of Chapter 17 Congenital malformations, deformations and chromosomal abnormalities codes (Q00–Q99) as additional diagnoses

The NCCH was asked to clarify if Q codes should be assigned as additional diagnoses to indicate the genetic nature of a disease in conditions such as otosclerosis, familial adenomatous polyposis (FAP), hereditary non-polyposis colon cancer (HNPCC) and cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL).

The issue of genetic links to specific conditions is complex and controversial. Debate on this issue is ongoing at the World Health Organization within the revision work on ICD-11.

A congenital condition is one that is present at or before birth. Congenital conditions may be inherited. For example, osteogenesis imperfecta is a genetic disorder that is present at birth.

Some congenital conditions are acquired due to the impact of environmental factors on the developing fetus. These conditions are not inherited. For example, congenital syphilis is caused by *Treponema pallidum*, passing through the placenta. It should be noted that some congenital conditions, although present at birth, may not be detected for some years.

A genetic condition occurs due to defective genes and tends to run in families. Genetic disorders may be present at birth (and hence are also congenital) or they may occur at any time throughout life. An individual may carry a defective gene and never exhibit the characteristics of that disease.

Classification

Codes from Chapter 17 *Congenital malformations, deformations and chromosomal abnormalities* (Q00–Q99) should only be assigned for a condition by following the correct pathways in ICD-10-AM Alphabetic Index. An exception is the assignment of a code from Q87.- *Other specified congenital malformation syndromes affecting multiple systems* as detailed in ACS 0005 *Syndromes*.

For otosclerosis, assign a code from H80 *Otosclerosis*. Research indicates that genetic susceptibility is only one of a number of risk factors that may cause the condition. Other risk factors include gender, pregnancy, race, non-fluoridated water or viral infections. The exact cause is often unknown. Although otosclerosis may be caused by genetic susceptibility, it is not generally present at birth (and is therefore not a congenital condition).

Similarly, although FAP and HNPCC are caused by defective genes, affected individuals are not born with colon disease and some may never develop colon disease (refer to ACS 0246 *Familial adenomatous polyposis* and ACS 0247 *Hereditary non-polyposis colon cancer*).

CADASIL is a rare syndrome caused by mutations in the Notch3 gene. This inherited condition affects small blood vessels, mainly in the brain. The resulting blood vessel damage can lead to migraines, emotional and mental disorders, stroke-like episodes, dementia and other impairments of normal brain function. CADASIL is hereditary but not congenital with onset between 30 and 50 years of age.

There is no specific code for CADASIL in ICD-10-AM. Q87.- *Other specified congenital malformation syndromes affecting multiple systems* (refer to ACS 0005 *Syndromes*) should not be assigned as CADASIL is not a congenital syndrome. Q93.8 *Other deletions from the autosomes* may be assigned as an optional additional diagnosis code to the specific manifestations of CADASIL.

Admissions for colonoscopy with no underlying symptoms or family history

The NCCH received a query on principal diagnosis assignment when no abnormalities are detected in a patient admitted for colonoscopy with no underlying symptoms or family history. The query specifically related to cases where colonoscopy is performed due to age or anxiety, such as anxiety about death of a friend from colon cancer.

Classification

ACS 2111 *Screening for specific disorders* should be followed in these cases. Assign an appropriate screening code (Z11, Z12, Z13) as the principal diagnosis. Assign Z71.1 *Person with feared complaint in whom no diagnosis is made* as an additional diagnosis.

Example 1:

Patient admitted for colonoscopy due to anxiety from death of a close friend with colon cancer. No abnormalities were detected on colonoscopy.

Codes: Z12.1 *Special screening examination for neoplasm of intestinal tract*

Z71.1 *Person with feared complaint in whom no diagnosis is made*

32090-00 [905] *Fibreoptic colonoscopy to caecum*

Follow-up examinations with detection of new conditions

The NCCH received a query asking what code should be assigned as the principal diagnosis when a new condition is detected that is unrelated to the specific disorder being 'followed-up'.

Classification

ACS 2113 *Follow-up examinations for specific disorders* should be followed in these cases. Assign an appropriate follow-up code (Z08, Z09) as the principal diagnosis. Assign the newly detected condition as an additional diagnosis only if it meets the criteria of ACS 0002 *Additional diagnoses*. Coders should also be aware that ACS 0046 *Diagnosis selection for same-day endoscopy* does not apply to follow-up examinations.

Example 1:

Patient admitted for follow-up of familial adenomatous polyposis excised one year ago. A hyperplastic polyp, confirmed on histopathology, was removed during colonoscopy.

Codes: Z09.0 *Follow-up examination after surgery for other conditions*
Z86.0 *Personal history of other neoplasms*
K63.58 *Other polyp of colon*
32093-00 [911] *Fibreoptic colonoscopy to caecum, with polypectomy*

A polyp or tumour of a different histopathology should not be regarded as a residual condition or recurrence unless there is clinical advice to the contrary.

Example 2:

Colonoscopy performed for follow-up of familial adenomatous polyposis, excised one year ago. Diverticulosis found; no treatment was given.

Codes: Z09.0 *Follow-up examination after surgery for other conditions*
Z87.12 *Personal history of colonic polyps*
32090-00 [905] *Fibreoptic colonoscopy to caecum*

Example 3:

Patient admitted for follow-up of TCC bladder excised six months ago. A benign bladder tumour confirmed on histopathology was excised during cystoscopy.

Codes: Z08.0 *Follow-up examination after surgery for malignant neoplasm*
Z85.5 *Personal history of malignant neoplasm of urinary tract*
D30.3 *Benign neoplasm of bladder*
Appropriate morphology code
36839-04 [1100] *Endoscopic resection of a single lesion of bladder ≤2cm or tissue of bladder*

References

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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 was implemented across Australia on 1 July 2006.

For further information and to order:

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ICD-10-AM/ACHI/ACS

Fifth Edition education program

Workshops

ICD-10-AM/ACHI/ACS Fifth Edition workshops were, as in previous years, offered as optional self-education activities following the completion of the pre-workshop education material. A total of 37 workshops were held nationally for 1157 participants between May and June 2006. 1222 people registered for the web based training via a PDF document, 20 requested the CD-ROM version and 78 a hardcopy. Completion of the pre-workshop education material was mandatory for coders attending the workshops.

The workshops were designed to supplement the pre-workshop education material and focused on the more complex changes made to the classification which the NCCH thought would be beneficial to discuss in a workshop situation. Practical exercises and a quiz were offered to help apply and comprehend the changes.

Workshop data

State/territory	Workshops	Participants
NSW	13	348
Victoria	8	277
Queensland	6	202
South Australia	4	140
Western Australia	3	111
Tasmania	1	28
ACT	1	36
Northern Territory	1	15
TOTAL	37	1157

Workshop comments

Some comments from participants about the workshops include:

- Provides a good forum for discussion of changes and the reasoning behind them.
- Good pace, plenty of time for exercises and discussion.
- The quiz was fun. Needed more time to code activities. Good to have shorter learning session in afternoon.
- Would suggest the pre-workshop material be on paper rather than electronic.
- Handout of slides is informative but some of the text is too small to read.
- It is great to get out and meet others in the industry and learn in a fun environment.
- Going through the answers was dull. We should have just been given time to do activities and a chance to go through answers and then if anyone didn't agree or had issues to raise them and just discuss those points.
- Thank you for choosing the venue – as a HIM/coder we are the last people in the hospital to be considered in terms of working environment. At this venue I felt that I was valued and people 'cared' enough to take this into consideration.
- This was my first workshop and I found it very helpful and educational. Presenters presented information very well and there was sufficient worksheets etc to assist with learning.
- The background information provided on the WHO/URC process was fascinating.
- Invaluable resource for country coders. Please keep these 'face to face' workshops available. Country coders usually work on their own and don't get the opportunity to network with others.
- Suggestion to have a clinical component, probably not realistic but this is generally the one and only forum that coders attend and it would be great to try to include an educational (clinical) component.
- Could the photocopy of the power point slides be larger so I can read them.
- These educational opportunities assist HIM's and coders to cement their understanding of coding standards and processes. These workshops are the only opportunity that many clinical coders have to do continuing education. It enables them to feel their skills base is valued when they have education to attend which the hospital will pay for due to the cost containment. Keep up the good work!!

ICD-10-AM ACHI ACS eBook

INTERACTIVE ELECTRONIC MANUAL

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Frequently Asked Questions – Part 1

The following FAQs were asked at the recent ICD-10-AM/ACHI/ACS Fifth Edition education workshops and have been grouped by specialty. The standard abbreviation of 'ACS' has been used throughout for 'Australian Coding Standard'.

This information is also available from the NCCH website: www.fhs.usyd.edu.au/ncch/ under 'FAQs'.

Burns

Q: *How many times would you assign a procedure code for synthetic skin grafts to burns (90672-01 [1640]) as there is no split on body surface area (BSA)?*

A: ACS 1911 *Burns* does not address synthetic skin grafts to burns, therefore code(s) are assigned as per ACS 0020 *Multiple/bilateral procedures* which states that:

'Generally, if a procedure or procedures involves two or more sites, or is performed under anaesthesia, the procedure should be coded as many times as it is performed.'

Q: *If more than one burn site is debrided during one operative episode, how many procedure codes are assigned?*

A: One procedure code is assigned from block [1627] *Debridement of burn*. The code assigned will be based on the total body surface area debrided during that operative episode.

External causes of injury

Q: *What external cause code would be used if a patient is injured after walking through a glass door?*

A: Assign W13.2 *Fall out of or through glass door*. ICD-10-AM will be amended for a future edition to reflect this advice.

Q: *What external cause code would be assigned for a fall from a fence?*

A: Assign W13.8 *Fall from, out of or through other specified building or structure*. ICD-10-AM will be amended for a future edition to reflect this advice.

Q: *If a patient jams their finger in a trailer attached to the car, is this classified as a transport accident?*

A: No, see excludes note at V00–V99 *Transport accidents*. Any accident involving a vehicle, trailer/caravan not in motion is classified to W00–X59 *Other external causes of accidental injury*. In the case cited, assign W23.8 *Caught, crushed, jammed or pinched in or between other objects*.

Q: *If a child is injured while playing touch football with his friends in the local park, what activity code is assigned as this is not considered 'organised sport'?*

A: Assign U50.05 *Touch football*. As per the definition regarding Sport and Leisure found in the Diseases Tabular List – Activity (U50–U73):

'Sport' overlaps with 'Leisure' and sufficiently specific and generally accepted definitions for these activities, suitable for use in clinical coding, are not available. Most of the activities specified by codes U50–U71 are commonly recognised as sports, though they may also be engaged in as leisure. Residual categories have also been created for those sporting activities that cannot be classified to the more specific categories. U72 *Leisure activity, not elsewhere classified* is provided to enable coding of other leisure activities, not identified as sport.

When both a sport (U50–U71) and leisure (U72) code apply, assign the activity code for sport.

In the above scenario, the child doesn't have to be playing 'organised' sport for the activity code U50.05 *Touch football* to be assigned. If the activity meets the criteria for 'sport' or 'leisure', assign the specified sport activity code.

Falls

Q: *Can R29.6 Tendency to fall, not elsewhere classified, be assigned as an additional diagnosis?*

A: The WHO Update and Revision Committee introduced a number of changes in 2005, one of which was a new code R29.6 *Tendency to fall, not elsewhere classified*.

This incorporates an includes note 'Tendency to fall because of old age or other unclear health problems'.

ACS 1806 *Falls* should be interpreted as follows. If the injury is the reason for the admission and meets the criteria in ACS 0001 *Principal diagnosis*, then assign a code for the injury as the principal diagnosis. In episodes when the minor trauma would not ordinarily have necessitated the admission and the main reason for admission is for investigation of fall (for which no underlying cause has been found), R29.6 *Tendency to fall, not elsewhere classified* may be assigned as the principal diagnosis. Where the injury also meets the criteria for ACS 0002 *Additional diagnoses*, then assign the appropriate injury codes as additional diagnoses.

If a patient with a history of falls is admitted for an unrelated condition, and the cause of the falls is investigated during the episode of care, assign R29.6 *Tendency to fall, not elsewhere classified* as an additional diagnosis.

ACS 1806 *Falls* will be amended for a future edition of ICD-10-AM/ACHI/ACS to reflect this advice.

Obstetrics

Q: If a patient chooses not to have a perineal tear repaired, should a disease code still be assigned?

A: An appropriate code from O70.- *Perineal laceration during delivery* should be assigned together with Z53.2 *Procedure not carried out because of patient's decision for other and unspecified reason*. The Z code acts as a 'flag' to identify those patients who choose not to have their tear repaired. However, neither of these codes should be assigned in those cases where it has been **clinically determined** that a perineal graze/tear does not require suturing.

Q: What code do you assign for a patient who is admitted for an elective caesarean section and is preterm but not in labour?

A: Australia has sent a proposal to WHO Update and Revision Committee requesting a new code to be included in this section of the classification to specify 'preterm delivery without labour'. In the interim, assign O60.1 *Preterm labour with preterm delivery*.

Q: Is there a rule regarding principal diagnosis selection for obstetric cases?

A: Chapter 15 of the ACS provides a number of standards which deal with principal diagnosis selection, in particular ACS 1515 *Antepartum condition with delivery* and ACS 1530 *Premature delivery*. If none of these standards apply, ACS 0001 *Principal diagnosis* should be followed. In obstetric cases, the reason for admission is for the safe delivery of the baby and, therefore, in most instances the principal diagnosis will be based on the sequence of events surrounding the delivery. However, there may be some exceptions to this, therefore, coders should follow ACS 0001 *Principal diagnosis* for code assignment. This issue is currently under review.

Suspected conditions

Q: Why do we need to assign Z75.3 for suspected conditions only – what is trying to be collected?

A: Z75.3 *Unavailability and inaccessibility of health-care facilities* is assigned as a 'flag' to identify patients transferred because of a suspected condition rather than a confirmed diagnosis. It is not necessary to assign Z75.3 for **all** transferred patients, as this is captured by the mode of separation data element in the national minimum data set.

10th NCCH Conference

25–27 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, 25–27 July 2007.

Visit the NCCH website for more information:
www.fhs.usyd.edu.au/ncch/

Extended final date for receipt of abstracts

The final date for abstracts to be submitted has been extended to **Friday 15 December 2006**.

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

Notification of acceptance

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

Submission of full papers and conference proceedings

Successful authors will be asked to prepare full papers for publication in the conference proceedings. Proceedings will be distributed to all registered conference delegates at the conference.

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

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/
Oct 17-19 2006	The Safety Show Sydney 2006	Sydney, NSW	www.thesafetyshow.com
Oct 19-20 2006	HIMAA eHR 2006 Symposium	Hobart, Tas	www.himaa.org.au
Oct 19-20 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 in 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
Nov 15-16 2006	11th Annual Conference & Scientific Symposium	Dublin, Ireland	www.hisi.ie
Nov 15-17	The Right to the Right Health Care	Sydney, NSW	www.cdds.med.usyd.edu.au/html/Conferences.html
Mar 21 2007	Health-e-Nation Conference and Exhibition 2007	Sydney, NSW	www.chik.com.au
May 15-18 2007	HIMSS AsiaPac07	Singapore	www.himssasiapac.org
July 25-27 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>

Attention clinical coders

The NCCH needs case scenarios or clinical record abstracts for possible use in future education workshops!

We would like to streamline future workshops to provide more relevant cases to suit participants' needs. Therefore, we need cases from you. If you have a case that can be used, please either send a de-identified copy to the NCCH or summarise the case and e-mail to us.



Contact Megan Cumerlato for further information on 02 9351 9449.

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Attention clinical coders

coding matters



Volume 13 Number 2 September 2006
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ISSN 1322-1922

Coding Matters is the quarterly newsletter of the National Centre for Classification in Health (NCCH). NCCH (Sydney) is funded by the Casemix Program, Australian Government Department of Health and Ageing. NCCH (Brisbane) is funded by the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the Queensland University of Technology.

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- + Publishing the Health-e-Directory - an online and in print listing of Australian eHealth product and service providers (www.health-e-directory.com.au)**
- + Carrying out Commissioned and Independent Research**
- + Hosting the Annual Health-e-Nation Conference (www.health-e-nation.com.au)**
- + Coordinating delegations to international Health ICT conferences**
- + Co-hosting annual HIMSS AsiaPac conferences & exhibitions (15-18 May 2007, Singapore)**

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