

Get educated! NCCH continuing education program 2004–2005



The continuing education program has been devised based upon feedback received from the clinical coder and HIM community. Sources include the 2002 Coder Workforce Survey¹, conducted by the NCCH together with the Health Information Management Association of Australia Ltd (HIMAA) and the Clinical Coders' Society of Australia (CCSA); as well as evaluation comments and suggestions provided at recent events, and anecdotes from staff who have provided education.

The 2002 Coder Workforce Survey results provide strong indications that coding staff is generally not receiving – but desire – access to continuing professional education. ►►►

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Other important information elicited from the survey includes confirmation that there are limited education options available to people outside the major and capital cities; that most people prefer face-to-face activities and hot topics for education include clinical updates and procedure reviews.

The big news

Education activities will be offered at least twice each year. Activities will include:

ICD-10-AM Fourth Edition education program

Details are now available. See *Coding Matters* 10(4): March 2004 or www.fhs.usyd.edu.au/ncch

March 2005 NCCH Biennial Conference

The conference will be held in Perth, Western Australia. The call for papers appears on page 17 of this edition, more details will be published later in 2004. The conference will be conducted over two days, and an optional workshop will be offered.

Ideas in development

A number of other events are in the development pipeline. These include:

- **ICD-10-AM Fourth Edition post implementation workshops** – A series of one-day workshops will be conducted Australia-wide. Workshop scope will be based upon feedback from the Fourth Edition education program. Details about these workshops will be published in late 2004
- **Clinical update seminars.** These are planned to allow clinicians to present current and emerging clinical developments at half-day seminars. These are likely to be conducted on an *ad hoc* basis

- **Clinical and coding update seminars.** These one-day workshops will feature clinical updates being presented during morning sessions, followed by coding updates in afternoon sessions. Topics, dates and venues are presently being investigated and developed, and will be promoted widely as soon as plans are finalised
- **Documentation workshops for clinicians.** These workshops will be developed specifically for clinicians and will cover similar content to that in the NCCH *Good Clinical Documentation Guide*
- **Using morbidity data workshops.** Half-day workshops for clinical coders, HIMs and data managers are being considered for national presentation. The scope would address national and international morbidity data use.

Help us to help you

Many of these activities are in development, and your suggestions and feedback will help to ensure that most people's needs are met. Please send your comments and suggestions to

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National Centre for Classification in Health
The University of Sydney
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e-mail ncchadmin@fhs.usyd.edu.au

Reference

¹ McKenzie K & Walker S (2003) *The Australian Coder Workforce 2002: A report of the National Coder Survey*, National Centre for Classification in Health, Sydney.

NCCH Prize for Clinical Coding

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



QUT prize giving: l-r Dr Mary-Lou Fleming, Acting Head of the School of Public Health, Sue Walker, Associate Director, NCCH Brisbane and award recipient, Bridget Allison

2003 NCCH Prize for Clinical Coding recipients are:

Bridget Allison
Queensland University of Technology

Carolyn McCallum
Curtin University

Kathryn Markwick and Robin Boudville
The University of Sydney

Holley Oppy
*Health Information Management
Association of Australia Ltd*

Graham Evans
*Open Training and Education Network
– Distance Education*

The 10-AM Commandments

Removal of subcutaneous implanon

Implanon is a progestogen only contraceptive implant effective against pregnancy for three years. It consists of a small plastic rod about the size of a matchstick. It works by releasing a progestogen hormone slowly into the bloodstream from an implant under the skin.

Classification

Removal of a subcutaneous implanon contraceptive hormone/implant should be assigned 92202-00 [1908] *Removal of therapeutic device, not elsewhere classified*.

Ultrasonic thrombectomy

Ultrasonic thrombectomy uses an ultrasound device to direct acoustic energy down a wire to fragment material causing blockage in the arteries. The resulting tiny pieces are then absorbed by the body.

Classification

'Ultrasonic thrombectomy' should be classified as:

- Thrombectomy, artery, by site
- 55054-00 [1949] *Intraoperative ultrasound of other site*

The NCCH will consider a new code for this procedure for a future edition of ICD-10-AM.

Relocation of tissue expander valve

ICD-10-AM does not currently include a code for 'relocation of tissue expander valve' The NCCH will consider creating a new code for adjustment/relocation of tissue expander valve for a future edition of ICD-10-AM.

Classification

In the interim, documentation of a procedure to relocate a tissue expander valve should be classified as 90676-00 [1660] *Other procedures on skin and subcutaneous tissue*.

Sliding scale insulin

The NCCH was queried about whether documentation of 'sliding scale insulin' in the clinical record could be assumed to indicate uncontrolled diabetes.

The use of 'sliding scale insulin' regimens is historically a widely used method of controlling blood sugar levels for inpatients with diabetes.

Clinical advice received by the NCCH indicates that the use of a sliding scale insulin regimen does not imply 'uncontrolled diabetes'.

There must be documentation in the clinical record of 'unstable', 'for stabilisation', 'poorly controlled' or 'poor control' before E1-.65 * *Diabetes mellitus with poor control* can be assigned (see ACS 0401 *Diabetes mellitus and impaired glucose regulation, Diabetes for stabilisation*).

Chemotherapy/radiotherapy during stem cell transplantation

During the transplant phase of stem cell transplantation, a patient receives high dose chemotherapy, with or without radiation treatment according to an established protocol. Upon completion of the chemotherapy and/or radiation treatment, the previously collected stem cells are transplanted into the patient by infusion (ACS 0301 *Stem cell procurement and transplantation*).

Chemotherapy and radiotherapy are not inherent in the stem cell transplantation codes in block [802] *Bone marrow/stem cell transplantation*. Therefore, when chemotherapy and/or radiotherapy is performed with stem cell transplantation, appropriate codes should be assigned for each of these procedures.

The NCCH will consider rewriting ACS 0301 *Stem cell procurement and transplantation* for a future edition of ICD-10-AM to clarify this issue.

Radiofrequency ablation of osteoid osteoma

There is currently no code available in ICD-10-AM for ablation of bone lesion.

Classification

Documentation of (radiofrequency) ablation of a bone lesion should be coded by following the index at:

Excision
- lesion
- - bone

The NCCH will consider the introduction of a new code for this procedure for a future edition of ICD-10-AM.

Clinical update

Laparoscopic adjustable gastric banding for the treatment of obesity

This article was researched, written and published by

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) as part of its *Consumer summary* series, June 2002.

ASERNIP-S is a program of the Royal Australasian College of Surgeons (RACS).

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www.surgeons.org/asernip-s

The NCCH wishes to gratefully acknowledge ASERNIP-S' kind permission to amend and republish this report. Sections directly relating to patient information have been omitted or amended. The coding and classification information has been added by NCCH.

Laparoscopic adjustable gastric banding (LAGB) is a surgical technique that has been developed for the treatment of obesity. ASERNIP-S has reviewed the available published evidence to assess the safety and effectiveness of this procedure.

What is obesity?

The average weight of Australians has increased over the past 40 years. This is attributed to an increase in the quantity of food available and a decrease in the amount of exercise in daily life. Obesity occurs when a person stores more energy in the form of fat than their body needs to function normally. This extra weight increases the person's risk of developing illnesses such as diabetes, hypertension, osteoarthritis and heart disease, particularly in men with increased fat around the stomach, as well as psychological problems like depression, which is more likely to be experienced by obese women. Other health issues such as infertility, liver dysfunction, sleep disturbance, difficulties in breathing while sleeping and alterations in the level of fats in the blood have also been associated with obesity. When a person's body mass index (BMI), calculated by dividing weight in kilograms by height in metres squared, becomes greater than 35, morbid obesity is said to occur. This means that the person has become so overweight that their health is affected.

Conventional treatments for morbid obesity

The following treatments are available:

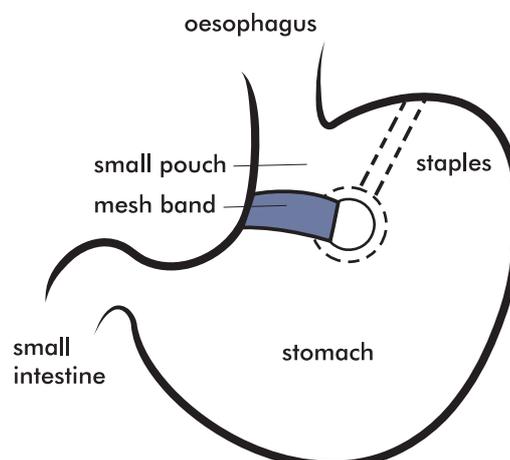
- **Dietary advice.** A weight-reducing diet is planned for the patient. The patient will lose weight when the energy intake in food (measured in calories) becomes less than the energy the person uses up. However, different individuals respond in varying degrees to the same weight-reducing diet. Furthermore, keeping the weight off is often a problem
- **Behaviour therapy.** The patient is required to change or modify certain behaviour patterns, such as the amount of exercise undertaken. This means that the person can use up excess energy stored in fat by increasing physical activity
- **Medication.** Drugs are prescribed that take away appetite or reduce the body's absorption of food. This means that a person can either reduce the amount of food they eat, or use laxatives to shorten the time food stays in the intestine and is absorbed
- **Surgery.** At the present time, surgery remains the only effective option for the management of morbid obesity

1. Limiting the capacity of the stomach for food.

Sections of the stomach can be stapled off so that the patient feels full after eating smaller quantities of food. Procedures include:

Vertical banded gastroplasty (Figure 1) The stomach is stapled to create a small pouch linking with the rest of the stomach through an opening, which is reinforced with a mesh band or collar to prevent expansion. When the small pouch fills with food, the person feels full.

Figure 1: Vertical banded gastroplasty

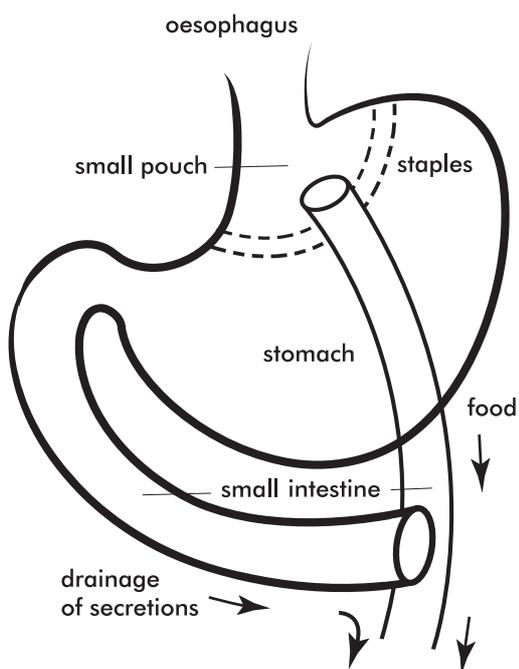


However, the size of the pouch and opening must be just right. If it is too small, food cannot pass by easily and vomiting may result; if it is too big, weight loss will not occur. Another problem is that weight can be regained later, due to stomach stretching (as more food can be eaten at one time), or if patients increase the amount they eat by snacking more frequently.

2. Reducing absorption of food. Bypassing sections of the gut reduces absorption of food and results in weight loss. Procedures include:

Roux-en-Y gastric bypass (Figure 2). Staples across the top of the stomach create a small pouch, which can contain only a limited amount of food. The small intestine is cut, and the far end is attached directly to the small pouch. The other end is reconnected to the small intestine to allow drainage of secretions from the rest of the stomach. Digestion and absorption of food is reduced as it bypasses parts of the stomach and small intestine.

Figure 2: Roux-en-Y gastric bypass



However, procedures affecting the absorption of food may lead to an increased risk of malnutrition and vitamin deficiencies. Restrictive procedures are associated with significantly less long-term nutritional risk.

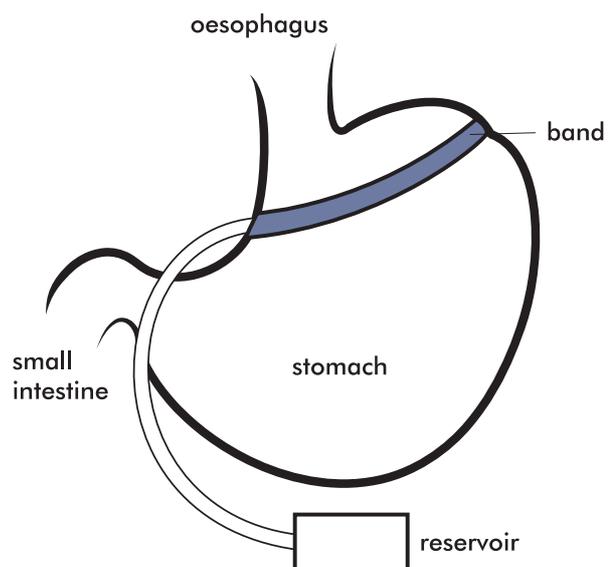
What is the laparoscopic adjustable gastric banding technique?

Laparoscopic adjustable gastric banding (LAGB) was developed to prevent the problems associated with the

conventional procedures. In this procedure, the stomach is partitioned off using bands such as the Lap-band™ or the Swedish Adjustable Gastric Band (SAGB) (Figure 3).

The LAGB technique is performed under general anaesthetic. A laparoscope is inserted into the abdomen through a small incision. Other small incisions (usually four) are made in order to pass the surgical instruments and an inflatable silicone band to the site. The procedure is less invasive than the conventional methods, as smaller incisions are used. Pain after the operation is reduced and the patient can return to normal activities more quickly. The silicone band is placed around the fundus of the stomach, creating a small pouch above the band. A tube connects the band to a reservoir. Fluid can be injected into, or removed from, this reservoir to adjust the tightness of the gastric band so that it will cause weight loss and not vomiting. The reservoir is placed under the skin on the abdominal wall through a cut just below the ribs. The LAGB procedure is fully reversible as the normal functioning of the stomach and intestine is not interfered with.

Figure 3: Laparoscopic adjustable gastric banding



How does laparoscopic adjustable gastric banding compare to other surgical treatments for obesity?

There is little good quality evidence on the comparative safety and effectiveness of the laparoscopic adjustable gastric banding (LAGB) and other surgical procedures for treating obesity. However, the following may be used as a guide. >>>

Safety

In terms of safety, the limited data indicated that the short-term risk of dying during or shortly after this procedure was around 0.05% of patients, compared to 0.31% for vertical banded gastroplasty and 0.50% for Roux-en-Y. Complication rates were also difficult to assess, but appeared to be similar for the new and conventional procedures; around 11.3% of patients experienced complications after LAGB, compared to 25.7% following vertical banded gastroplasty and 23.6% after Roux-en-Y. The most common types of complication for LAGB were stretching of the small gastric pouch above the band (4% of patients) and slipping of the band (1.6% of patients). Vomiting is a side effect (as for conventional procedures), with one comparative study reporting a significantly lower rate for the SAGB compared to the Lap-band™. Injury to organs of the body occurred as a result of surgical errors in less than 1% of all procedures, but was more likely during LAGB than other procedures.

Effectiveness

In terms of effectiveness, it was difficult to compare rates of weight loss following these procedures due to the lack of longer-term data. However, it is clear that all three produced considerable weight loss in patients, over the maximum four year follow-up in the case of LAGB, and for at least ten years for the conventional procedures. Limited comparative data suggested that the Roux-en-Y operation was most likely to lead to the greatest weight loss, with LAGB and vertical banded gastroplasty more or less equivalent two years after the operation (although LABG may not be as effective regarding weight loss up to eighteen months postoperatively).

Studies suggested that all three procedures led to improvements in illnesses related to the patient's obesity, such as asthma, diabetes or high blood pressure. However, there was no significant difference between the procedures in this respect, nor was there evidence to clearly show that the improvements were due to the operations concerned.

There was no significant difference in the time taken to complete the Lap-band™ and vertical banded gastroplasty procedures. Conversion from LAGB to open surgery, which requires larger incisions in the abdomen, was required in about 5% of patients in most studies, with a range of zero up to 25% of patients overall. Although little reliable comparative data was available, there did appear to be a lower risk of reoperation (for example to repair or remove bands)

for patients who were fitted with the LAGB compared to those undergoing other procedures, with the highest risk recorded for vertical banded gastroplasty. Most studies reported that 8% or less of LAGB patients required a further operation for band removal, except for one small study, which recorded a level of around 67%. This last figure is not representative of the majority of studies.

Postoperative hospital stay reported after LAGB ranged from around 1 to 12 days. Once again it was difficult to compare the procedures in this respect because of limited data. In one study patients were asked to rate the effect of the operation on their quality of life; patients who had undergone Roux-en-Y gave more favourable responses than those from the other two groups. Similarly, one comparative study showed that people who had the Roux-en-Y procedure were more likely to have satisfactory psychological outcomes than after the gastric banding operation; that is, the patients were less obsessed with food and had a positive evaluation of surgery.

What is the recommended procedure for treating obesity?

The ASERNIP-S review group concluded that laparoscopic adjustable gastric banding was at least as safe as the comparator procedures for up to four years after the operation. For the first two years, LABG was as effective as vertical banded gastroplasty but less effective than gastric bypass in producing weight loss. However, longer-term data is required before a true comparison between the procedures can be made. It is important, therefore, for both the patient and the surgeon to weigh up all factors before choosing which operation may offer the best possible outcome for each individual patient.

Classification

Documentation of laparoscopic adjustable gastric banding in the clinical record is classifiable to a new ICD-10-AM Fourth Edition code:

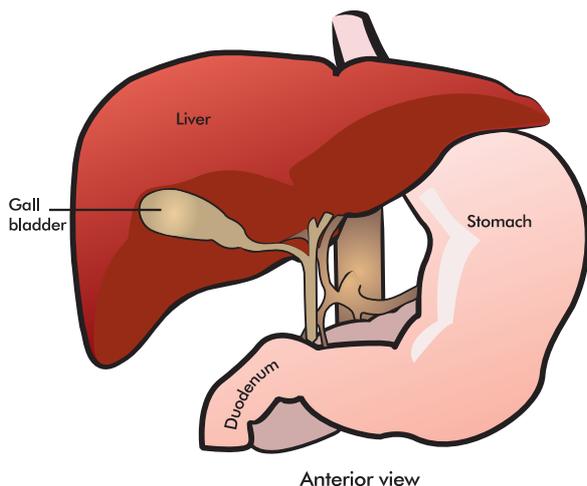
30511-01 [889] *Laparoscopic gastric reduction*

December edition...

Dynamic graciloplasty for the treatment of faecal incontinence

How it works – Gallbladder

The gallbladder is a 7–10cm long, 3cm wide, hollow, muscular, pear-shaped, slate coloured organ that stores and concentrates bile. It is located below the right lobe of the liver. Bile is produced by the liver, stored by the gallbladder and transferred to the duodenum where it helps to break down ingested fats. The gallbladder stores about 30–50ml of bile at any time, and daily throughput is about one litre.



The gallbladder is generally perceived to be a vestigial organ. Over 100 years of data indicates that there are generally no long-term harmful effects for people who have undergone cholecystectomy. Bile production continues at normal levels and the bile duct enlarges to assume the bile-storing role following cholecystectomy.

The gallbladder made up of three major component areas:

- the **fundus** is the expanded end which projects downward
- the **body** projects upward and back, and
- the **neck**, which becomes the cystic duct, is about 4cm long and joins the common hepatic duct to become the bile duct.

Bile is a thick yellow or greenish-brown liquid containing:

- bile acids (cholates, chenodeoxycholate, deoxycholate)
- bile salts
- electrolytes
- bilirubin
- cholesterol
- fats and fatty acids (phospholipids)
- lecithin
- water

The principal function of bile is to help break down and digest ingested fats. Bile assists excretion of cholesterol by emulsifying fats to make them soluble. An increase in cholesterol or decrease in bile salts can cause insoluble salts and minerals to crystallise, forming biliary calculi – gallstones.

Bile in the liver flows through a network of narrow channels – bile canaliculi – that connect with bile ductules, which conduct bile to the bile ducts. Bile is collected from the bile ducts via the right and left hepatic ducts. The hepatic ducts join to form the common hepatic duct, which exits the liver. Bile in the common hepatic duct has two flow options. The first option allows bile to flow through the common bile duct and empty into the duodenal ampulla. In the second option, bile enters the cystic duct, which leads to the gallbladder for storage.

The hepatopancreatic sphincter, also called the sphincter of Oddi, surrounds the lumen of the common bile duct, pancreatic duct and duodenal ampulla. A hormone – cholecystokinin (CCK) – stimulates the sphincter to regulate secretion of bile and pancreatic juice into the duodenum, commencing emulsification of ingested fats. Contraction of the smooth muscle of the gallbladder expels bile into the cystic duct, the common bile duct and small intestine. Once digestion is complete the hepatopancreatic sphincter closes. Bile then flows back into the cystic duct and gallbladder for storage.

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Letters to the editor

The following letter has been forwarded by the Clinical Coders' Society of Australia, with the agreement of the author, for publication in *Coding Matters*.

8 September 2003

Secretary

Clinical Coders' Society of Australia Ltd

Dear Madam

I am writing in regards to the article entitled 'The Australian coder workforce survey 2002', published in *Coding Matters* 10(1) June 2003. It alludes to study results that state that hospital coders code four to five records per hour, with an 'average daily throughput requirement' of three to four records per hour (p 15). However, it does not clarify the type of records coded, their level of complexity, or the extent of experience possessed by the coders. In the real world, all of these factors affect the outcome of how many records actually get coded in a day. The publication of 'average results' is interesting information, but without acknowledging the variables that affect performance, it ignores the factors that acknowledge a coder as a skilled human being, rather than a mechanised automaton.

This is of concern to me, as I was recently placed on a performance plan, which used the results of this study as a benchmark. I would like to see the complete specs of the research, to evaluate whether the conditions under which the experiment was performed match those of the actual workplace. Indeed, if the specs had been published with the original article, then these findings could less easily be used as a cheap device for justifying sometimes unrealistic expectations. Being a union delegate, I can reliably inform you that this has become an issue for coders throughout Queensland. Managers are virtually bullying employees over this matter, and the duty of care to provide a safe and harmonious work environment is being overridden.

I therefore request two things of you. Firstly, that you [that is, NCCH, ed] be more thoughtful of your publication of data in future; and secondly, that you rectify the misconceptions caused by your truncated publication of these results, by *acknowledging in publication* the way in which such data can be misused or abused. In real-life conditions, the concept of a benchmark is both artificial and misleading.

I thank you for your cooperation in this matter, and your respect for my wish to remain anonymous in this matter.

Yours faithfully

Name withheld by request

Sue Walker and Kirsten McKenzie, chief investigators and authors of *Australian Coder Workforce 2002*, and the report summary articles published in *Coding Matters*, have been offered right-of-reply. Their response follows.

The NCCH believes that the issue of benchmarks for coding throughput is a very topical one and encourages other clinical coders to respond to this issue with their comments.

The NCCH recognises the difficulty in being able to adequately assess coding throughput in a standardised manner, because – as you have noted – there are a variety of factors that influence the work of coders and their ability to code a certain number of records in a specified time frame. The question we asked coders to respond to was 'Are you required to meet coding throughput targets?' If the answer to this question was positive, we asked the number of records that the coder was required to code per day or per week. The purpose of these questions was to try to ascertain whether benchmarks existed for hospitals of differing sizes or for different types of facility. We did not conduct any more rigorous research into this issue, but asked coders to report what is actually required of them in the workplace. The assumption must be made that managers who set throughput targets for their own staff are cognisant of the circumstances in which coders work and therefore take these into consideration, but we have no way of assessing this.

Our analysis has been reported in the coder survey monograph report, which has been published and is available from the NCCH. Our intention in reporting the results which were published in *Coding Matters* was not an attempt to misinform readers through publication of summaries of our findings, but more the chance to let readers know, in a timely manner, the sort of results that our analysis of survey submissions was highlighting. We are aware that there is a great deal of interest in the issue of benchmarks of coding throughput and our results were intended to show the range of throughput requirements that coders are being asked to meet. It was not possible for us to interpret the results to any greater extent, largely because of the issues identified by the author of the letter (ie differences in type and complexity of records to be coded, coders' experience, other tasks to complete in addition to coding). With these issues in mind, we did not make any attempt to create standard or recommended benchmarks from the data reported to us. We believed that this would have potentially yielded too simplistic an interpretation of the results that ignored many of the important aspects of the environment in which coders are required to operate.

If the results have been interpreted in this fashion for the performance plan noted by the writer, *without taking these other confounding factors into account*, we believe that this is a somewhat naïve interpretation of the results and may have produced misleading expectations of coding throughput potential. However, we do not back away from our decision to report the results in *Coding Matters* for the interest of readers.

The following is an extract of the relevant sections of the monograph that relate to this issue.

Extract from McKenzie K & Walker S *The Australian Coder Workforce 2002: a report of the National Clinical Coder Survey*. NCCH: Monograph Series No. 3, 2003

5.6.2 Coding throughput

Coders identified whether they were required to meet a coding throughput and if so, they specified the number of records they were required to code per day or per week (these were combined into a single variable indicating daily coding throughput). Figure 21 shows the percentage of coders who have to meet a coding throughput by state/territory.

Only 44% of coders indicated that they were required to meet a coding throughput. Of these, 333 reported the actual throughput targets. The average daily throughput requirement was indicated at 28 records per standard working day (3–4 records per hour). However, the coding throughput mode (most frequently reported) was slightly higher at 30–39 records per day (4–5 records per hour). The coding throughput requirements for freestanding day-care facilities and hospitals were as follows:

Free-standing day-care facilities:

- Average 28 records per day
- Minimum 3 records per day
- Maximum 100 records per day (this was an outlier, and the second highest coding throughput was 42 records per day).

Hospitals:

- Average 36 records per day
- Minimum 6 records per day
- Maximum 80 records per day (11 hospitals stated that their coding throughput requirements were greater than 60 records per day).

The new NCCH web site is up!!!

Visit www.usyd.edu.com.au/ncch to see it in all its technicolour glory

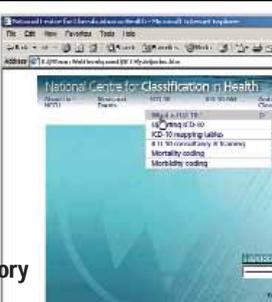
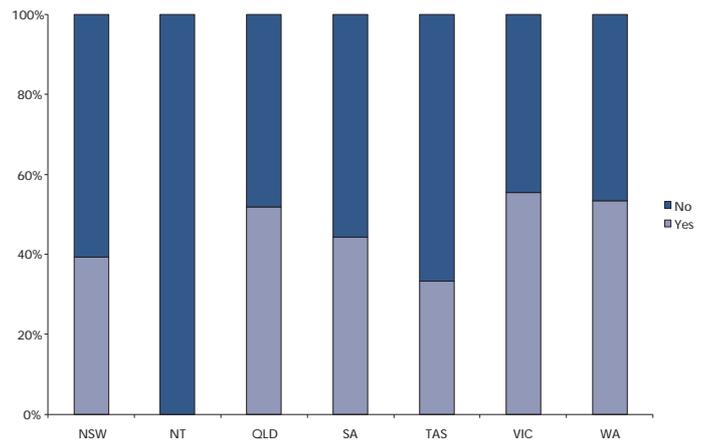


Figure 21: Coding throughput requirement by state/territory



Coders indicated that the average daily coding throughput requirement was 28 records, the equivalent of between 3–4 records per hour in a standard working day. However, the mode coding throughput was slightly higher at 30–39 records per day, the equivalent of between 4 and 5 records per hour in a standard working day. Coding throughputs were categorised into 6 groups: 1–19 records per day, 20–29 records per day, 30–39 records per day, 40–49 records per day, 50–59 records per day, and greater than 60 records per day. Table 48 shows the number of coders within each coding throughput category, Table 49 shows the number of coders within each coding throughput category by state/territory.

Table 48: Number of coders within each coding throughput category

Records per day	n	%
1–19 records	28	8.4
20–29 records	45	13.5
30–39 records	101	30.3
40–49 records	87	26.1
50–59 records	48	14.4
60+ records	24	7.2

(respondents=333 missing=124)

Table 49: Number of coders within each coding throughput category by state and territory

Records per day	NSW	NT	QLD	SA	TAS	VIC	WA
1–19 records	6	0	3	4	0	12	0
20–29 records	1	0	3	11	0	22	2
30–39 records	23	0	9	7	1	16	11
40–49 records	29	0	20	1	0	9	11
50–59 records	14	0	10	2	0	5	0
60+ records	4	0	3	0	0	4	1
Total	77	0	48	25	1	68	25

(respondents=244 missing=213)

6.1.4 Separations per coder

Cases were selected where data was available on the coders' working hours and separation size of the facility to enable calculations that would establish coder workload in terms of separations per coder.

Three hundred and ten facilities comprised the sample (73% of the total number of respondents). The sum of separations in this selected sample was 2,951,537 (94% of all reported separations in the survey), and the number of FTE coders comprising this selected sample was 395 coders. Working on a 36.25 hour week and 48-week year for FTE coders, this resulted in the equivalent of approximately 7,467 separations per year per coder, being approximately 4.3 records per hour for the selected sample.

When focusing specifically on hospitals, rather than day-care facilities, the total sum of the separations reported in the survey was 2,872,258. The number of FTE coders available to code these separations in this sample was 370 coders, which results in the equivalent of approximately 7,790 separations per year per coder, being approximately 4.5 records per hour (working on a 36.25 hour week and 48 week year for FTE coders). As there were fewer FTE coders in private hospitals than public hospitals, private hospitals showed a higher coding throughput per coder than public hospitals, with nearly 5 records per hour in private hospitals compared to 4.3 records per hour in public hospitals. Metropolitan hospitals had a higher coding throughput per coder than rural or remote facilities, with 5.1 records per hour in metropolitan facilities, compared to 3.27 records in rural facilities and 2.33 records per hour in remote facilities. As rural and remote facilities

had a smaller number of total separations than metropolitan facilities, there were fewer separations to code per coder, resulting in a smaller coding throughput.

These results need to be interpreted with caution however, as there were some differences in the facilities where all of the information was available (ie, the facility was selected in the sample) and where all the information was not available (ie, the facility was not selected in the sample). Facilities in New South Wales and South Australia comprised a larger percentage of unselected facilities than selected facilities, while Victorian facilities comprised a larger percentage of the selected facilities. Metropolitan facilities and hospitals were represented to a larger proportion in the selected sample than the unselected sample. Only 14 of the 60 facilities in the unselected sample provided separation sizes, though it appears from this that a larger percentage of 'higher-activity' hospitals were represented in the selected sample, with 37% of selected hospitals having annual separations in excess of 10,000 compared to just 14% of unselected hospitals. From patterns identified in the selected sample, it is likely that the unselected respondents would have a lower coding throughput compared to the selected sample, with the higher proportion of free-standing day care facilities in non-metropolitan areas.

Sue Walker
Associate Director

Dr Kirsten McKenzie
Research Fellow

NCCH Brisbane

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- eBook can now be networked and is also available as a single user/installation option. eBook's features include:
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 - links to relevant 10-AM Commandments advice
 - links to Australian Coding Standards
 - your own notes. Notes can be saved between updates
 - administrator notes (multiple user licenses only). Share important information with all users simultaneously by posting global notes
 - cut-and-paste information in and out of ICD-10-AM
- electronic code list is an ASCII, comma delimited list of codes

See the enclosed order form or visit the NCCH web site
www.usyd.edu.au/ncch

The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) is developed by the National Centre for Classification in Health with the support of the Commonwealth Department of Health and Ageing, the Coding Standards Advisory Committee and Australian clinical coders and clinicians.

Letter to the editor

17 March 2004

Dear Team at NCCH

Much as I enjoy reading *Coding Matters*, as I am now retired, I probably should no longer be receiving it.

My 10 years association with NCCH since first starting the coding course in 1993 has been great.

Congratulations and sincere thanks for all the work you do and the assistance given to keep coders 'doing it well'.

Keep up the good work and again, many thanks.

Judy Jowett
Tallebudgera Valley

What is a Lewy body?

Lewy bodies are abnormal structures found within the cytoplasm of nerve cells. Frederick Lewy first described them in 1912, as a consequence of examining the brains of deceased patients who had Parkinson's disease. Initially they were thought to occur only in the mid-brain region but more recently researchers have found Lewy bodies in the cortex (outer layer of grey matter) of the brains of dementia patients. These latter occurrences are known as cortical Lewy bodies or diffuse Lewy bodies.

Clinical features of Lewy body disease (LBD)

It is thought that Lewy bodies play a role in a number of neurodegenerative conditions, depending on the site of Lewy body formation and associated neuronal loss. The three main manifestations are:

Dementia with Lewy bodies (DLB)

Dementia is usually the presenting feature of LBD and accounts for up to 20% of all cases of dementia in old age. Marked fluctuation in cognitive performance and level of consciousness are common early symptoms of DLB. Other features include:

- visual hallucinations
- impaired short-term (recent) memory, inattention, mental inflexibility and indecisiveness
- speech block, word finding difficulties
- anxiety and depression

Parkinson's disease

Onset of the clinical features of Parkinson's disease is the most common presentation of LBD in middle age. These features include a flexed posture, shuffling gait, rigidity, tremor and reduced spontaneous movement. It is important to note that people with LBD do not respond well to the medications prescribed for Parkinson's disease and their Parkinsonian features may even be worsened if they are given these drugs.

Primary autonomic failure

Lewy Body disease may also affect the autonomic nervous system, leading to postural hypotension and syncope and occasionally, urinary incontinence.

Diagnosis of Lewy body disease

Lewy body disease is often initially diagnosed (misdiagnosed) as either Alzheimer's disease or vascular dementia. LBD can be distinguished from Alzheimer's disease by the presence of striking fluctuations in cognitive performance and recurrent visual hallucinations that are typically well formed and detailed. In addition, the progress of the dementia in LBD may be more rapid than seen in other types of dementia.

Patients presenting with Parkinsonism may be diagnosed as having Parkinson's disease. In general, if a person who has been diagnosed with Parkinson's disease begins to show signs of dementia within 18 months, it is likely that they have LBD rather than Parkinson's disease.

Lewy body disease should also be considered as a differential diagnosis in the presentation of symptoms including episodic disturbances of consciousness, syncope, sleep disorders and unexplained delirium. There is no specific biological test or marker for this disease, although a brain scan may reveal brain degeneration. An accurate diagnosis is reliant upon careful history taking of the pattern of symptoms and mental state examinations. The presence or absence of Lewy bodies can be confirmed only by autopsy.

Treatment and prognosis

There is no specific treatment for LBD. Therapy is limited to managing the neuropsychiatric symptoms and movement disorders. Problems in management may occur as drugs for some features of the disease, such as neuroleptic therapy for dementia, can actually exacerbate or initiate movement disorder.

The disease is relentless and progressive, with dementia becoming global and leading to complete dependence. The average survival time from diagnosis is seven years, with most patients dying from pneumonia or other intercurrent illness.

Classification

In response to a number of queries, both locally and via the ICD-10 Update Reference Group discussion forum, a new code has been created in ICD-10-AM Fourth Edition, G31.3 *Lewy body disease*. This code contains the instructions to also code the presence of dementia (F02.8* *Dementia in other specified diseases classified elsewhere*) or Parkinsonism (G22* *Parkinsonism in diseases classified elsewhere*) associated with Lewy body disease.

The new and revised codes are:

F02.8* Dementia in other specified diseases classified elsewhere

Dementia in:

- cerebral lipidosis (E75.-t)
- epilepsy (G40.-t)
- hepatolenticular degeneration (E83.0t)
- hypercalcaemia (E83.5t)
- hypothyroidism, acquired (E01.-t, E03.-t)
- intoxications (T36–T65t)
- Lewy body disease (G31.3t)
- multiple sclerosis (G35t)
- neurosyphilis (A52.1t)
- niacin deficiency [pellagra] (E52t)
- polyarteritis nodosa (M30.0t)
- systemic lupus erythematosus (M32.-t)
- trypanosomiasis (B56.-t, B57.-t)
- vitamin B12 deficiency (E53.8t)

G22* Parkinsonism in diseases classified elsewhere

Parkinsonism in:

- Lewy body disease (G31.3t)
- syphilis [syphilitic parkinsonism] (A52.1t)

★G31.3 Lewy body disease

Lewy body disease:

- cortical
- diffuse
- with:
- dementia† (F02.8*)
- Parkinsonism† (G22*)

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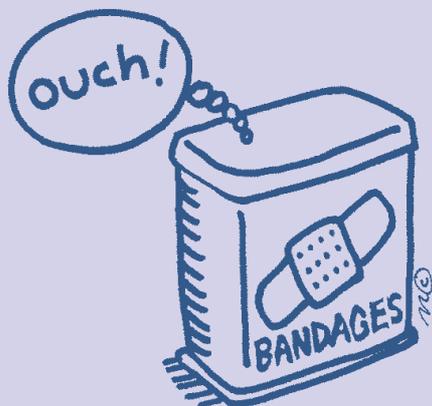
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What is pain?



Pain is

'A feeling of distress, suffering or agony, caused by stimulation of specialised nerve endings. Its purpose is chiefly protective; it acts as a warning that tissues are being damaged and induces the sufferer to remove or withdraw from the source'¹

The International Association for the Study of Pain has established three categories of pain:

Acute pain

'...caused by occurrences such as traumatic injury, surgical procedures or medical disorders; clinical symptoms often include increased heart rate, blood pressure and respiratory rate, shallow respiration, agitation or restlessness, facial grimaces or splinting'²

Chronic pain

'... pain that is persistent, often lasting more than six months; clinical symptoms may be the same as for acute pain, or there may be no symptoms evident'³

Cancer pain

'...pain associated with malignancies...can reach a level of great severity'⁴

Pain can also be classified as:

Nociceptive

'...arises from mechanical, chemical or thermal irritation of peripheral sensory nerves (for example, after surgery or trauma or associated degenerative processes such as osteoarthritis). Typically, the pain is described as sharp and is well localised'⁵

Neuropathic

'...is less well localised and is caused by damage to the peripheral or central nervous system (that is, in conditions such as post-herpetic neuralgia and painful diabetic neuropathy)⁶

References

1,2,3,4 Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing and Allied Health. Sixth Ed, (1997) WB Saunders and Co, Philadelphia.

5,6 Gouke R. (2003) The management of persistent pain, *Medical Journal of Australia*, www.mja.com.au/public/issues/178_09_050503/gou10286_fm.html Accessed February 2004.

Anatomical position and directional terms

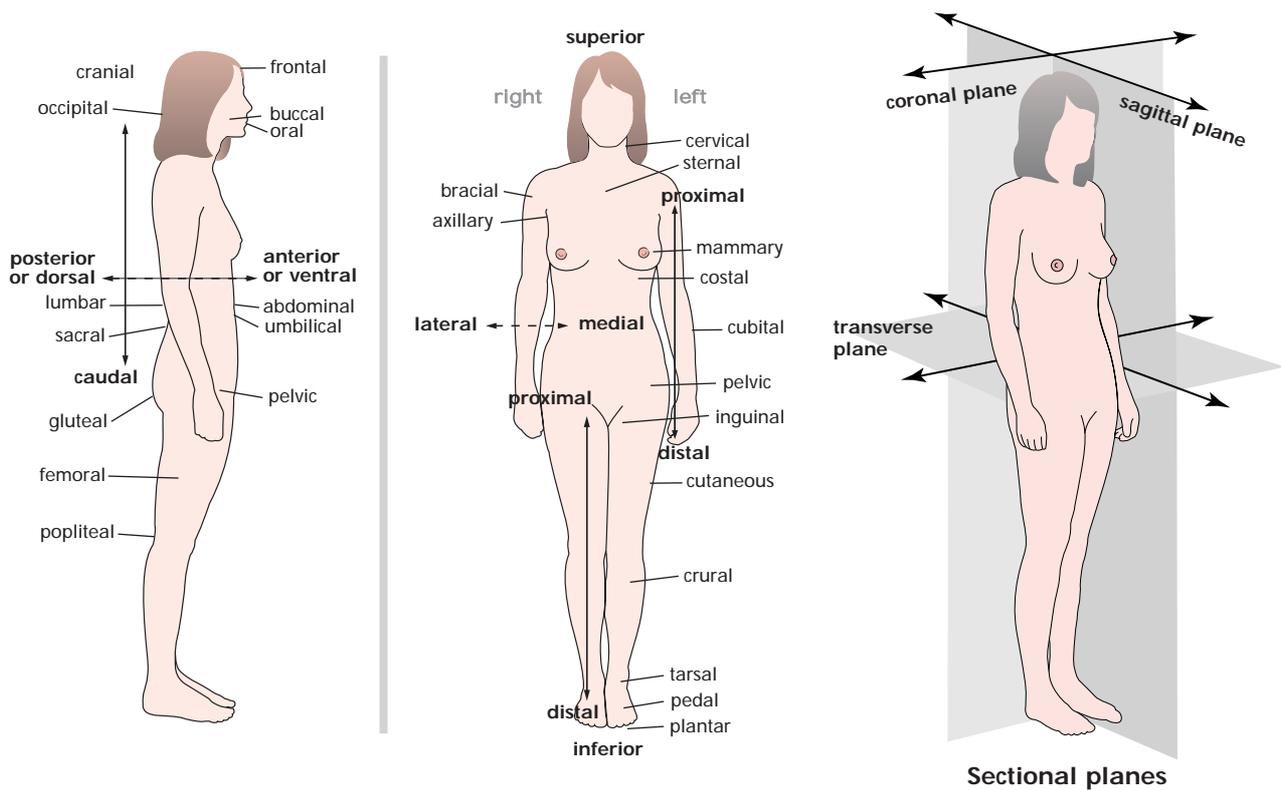


Table of terms

<i>Term</i>	<i>Region or reference</i>
Anterior	situated at or directed toward the front; before. Opposite of posterior
Caudal	pertaining to a cauda (tail), most frequently in people, this is the coccyx; away from the head of the body
Cranial	pertaining to the cranium or to the head of the body. Synonym of superior
Distal	further from a point of reference; remote
Dorsal	directed toward or located on the back surface
Inferior	situated below or directed downward; refers to the lower surface of a structure, or the lower of two similar structures
Lateral	located away from the body's longitudinal axis
Medial	pertaining to or situated at the midline
Posterior	directed toward or located at the back. Opposite of anterior
Proximal	nearest to a point of reference
Superficial	located on or near the surface
Superior	situated above or directed upward; refers to the upper surface of an organ or other structure, or to a structure occupying a higher position
Ventral	pertaining to the abdomen; situated on or directed toward the belly's surface. Opposite of dorsal

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International

ICD-10-AM and AR-DRGs for Ireland

Following a major review of the Irish health system, Mr Micheál Martin TD, Ireland's Minister for Health and Children, announced at the National Casemix Working Conference in Kilkenny that ICD-10-AM and AR-DRGs will be implemented in Ireland from 2005.

In his letter to conference delegates, Minister Martin summarised the review's major recommendations that include:

- The adoption of the Australian Casemix system as being the best for Irish patients while also being one of the most open, transparent, Government sponsored systems internationally
- Developing links with the State of Victoria in Australia who use Casemix for all acute sector funding and who have similar demographics to Ireland
- Moving to ICD-10-AM with the objective of bringing Ireland fully up-to-date in clinical coding
- Adapting the Australian systems, where required, to reflect the needs of Irish patients
- The incremental expansion of the Irish national Casemix programme to all acute hospitals in Ireland, and all areas of acute hospitals.

Ireland's Economic and Social Research Institute (ESRI) will lead the introduction of ICD-10-AM for coding clinical data collected by the Irish hospital discharge abstracting system (known as the Hospital In-Patient Enquiry (HIPE)). The ESRI's HIPE & NPRS Unit is responsible for all aspects of data collection for all discharges and births within the acute hospital system, including training clinical coders, developing data collection software, the production of data reports and maintenance of the national data file used to apply a case mix adjustment for hospital budget development (see www.esri.ie/hipe).



I-r Deirdre Murphy, Jacqui Curley and Marie Glynn demonstrated ICD-10-AM for delegates following the Minister's announcement at Ireland's National Casemix Working Conference, April 2004

As a result of a comprehensive evaluation and trial phase, some members of Ireland's clinical coding community have already had exposure to ICD-10-AM.

There are early indications of a high level of acceptance and enthusiasm for the change from ICD-9-CM from the coding community.

During the two or so years since Ireland's ESRI approached the NCCH about the possibility of implementing ICD-10-AM and AR-DRGs, a very fulfilling and supportive collaborative relationship has been forged. The NCCH team looks forward to welcoming the Irish implementation training team in mid-2004 when they will participate in train-the-trainer education. Perhaps in 2005, we will all enjoy the participation of Irish clinical coders in Code-L debates!

International

Vietnam revisited

For two weeks in February 2004, Sue Walker again visited the School of Public Health in Hanoi, Vietnam as part of a Queensland University of Technology (QUT) academic staff delegation. The Hanoi School currently has its first cadre of undergraduate public health students enrolled and this visit was to continue work on curriculum development for these students. The objectives for the visit were:

- provision of technical assistance to the staff of HSPH in the development of an appropriate curriculum relating to health management information systems, based on the unit outlines developed during our previous visit in December 2002
- writing of a workbook to be used for the teaching of undergraduate students
- provision of advice regarding tutorial activities and assessment methodologies.

The Health Management Information Systems subject will commence in September 2004, as will a unit focused on clinical classification. This latter unit is being taught using ICD-10 materials developed by the NCCH.



I-r Tran Thi Hong, member of the academic staff of the Department of Biostatistics & Computer (sic) in Hanoi, Jenny Nicol & Sue Walker

In addition to the workbook and assessment developments, Sue and QUT School of HIM academic, Jenny Nicol, met with Dr Duong from the Ministry of Health. Dr Duong is responsible for health information collections for the Ministry. Discussions were held about the potential for him, or members of his staff, to give some guest lectures or to provide practical experience for students undertaking the HMIS unit. Other guest speakers who represent collectors and users of Vietnamese health information, such as NGOs (for example, WHO and UNICEF) and other government departments (such as the Government Statistics Office) are also to be invited to participate in the unit's presentation.

Hanoi rooftops



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The cumulative index for volumes 1–10 is now available
www.fhs.usyd.edu.au/ncch

Coding rules

9th NCCH Conference

March 2005

Perth, Western Australia

Call for papers

The NCCH is pleased to invite prospective participants to submit abstracts for presentation at the NCCH conference in Perth, Western Australia, March 2005.

Conference program scope

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

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

Criteria for selection

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

What to include

Submitted papers should include:

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

How to submit abstracts

Please send abstracts:

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

Final date for receipt of abstracts

Abstracts are to be submitted by
Friday 24 September 2004.

Notification of acceptance

Acceptance of abstracts will be made at the discretion of the NCCH conference program committee. Authors will be notified in writing of acceptance or otherwise before the end of October 2004.

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

Submission of full papers and conference proceedings

Successful authors are asked to prepare full papers for publication in the conference proceedings. Proceedings will be distributed to all registered conference delegates at the conference. Full papers are to be submitted before **Friday 26 November 2004.**

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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PICQ 2002 FAO

Several queries relating to Performance Indicators for Coding Quality (PICQ) indicator 101586 Dependence on renal dialysis code with a dialysis procedure code have been received. PICQ indicator 101586 Dependence on renal dialysis code with a dialysis procedure code has a 'Fatal' indicator degree, indicating that there is definitely an error. The rationale for this indicator is that:

This indicator identifies records containing the dependence on renal dialysis code and a dialysis procedure code. The dependence on renal dialysis (dialysis status) code would only be used if a patient who is dependent on dialysis is not receiving dialysis during this episode but the patient dialysis status affects the care during this episode, meeting the definition for additional diagnoses.

Queries received indicate that some coders incorrectly use the Z99.2 *Dependence on renal dialysis* as an additional diagnosis for patients who receive renal dialysis during hospital admissions.

The Excludes Note at code Z99.2 *Dependence on renal dialysis* states that patients who are currently having 'dialysis preparation, treatment or session' should be coded to Z49.- *Care involving dialysis* instead. However, the use of the Z49 *Care involving*

dialysis codes is governed by ACS 1404 *Admission for renal dialysis*, which states that it is only if the intent for admission was for renal dialysis as a same-day episode that Z49.- *Care involving dialysis* would be an additional diagnosis. In all other cases, ACS 1404 *Admission for renal dialysis* states that dialysis is indicated by the procedure code and that Z49 codes are not required.

Therefore, Z99.2 *Dependence on renal dialysis* should only be used if documentation indicates a patient is dependent on renal dialysis, but they do not receive dialysis during the episode of care, and the dialysis dependent status meets ACS 0002 *Additional diagnoses* criteria. In the majority of multi-day episodes dialysis dependence is likely to be reflected by the assignment of the code for end stage renal failure where it meets the criteria for coding as an additional diagnosis (ACS 0002).

The following sentence has been added to the rationale for PICQ 2004:

Note the code for 'Dependence on renal dialysis' excludes dialysis preparation, treatment or session, therefore a patient receiving dialysis during this episode should not have the 'Dependence on renal dialysis code' assigned.



Concerned about Grouping after June 30, 2004?

How will ICD-10-AM Fourth Edition Codes affect your AR-DRG Grouping Processes?

Your current Grouping Software does not include the new ICD-10-AM Fourth Edition Coding Classification. As well your Software may not include the AR-DRG V 5.0 Grouper Classification.
(Please refer to your Health Dept or related Health Fund to establish which Grouper Version you require.)

This means that from 30th June 2004 you **will not** be able to group using your existing Grouper Software and consequently be unable to forward the required patient information both to your health funds for payment and to your relevant health department.

How can 3M help?

In June 3M Health Information Systems will be releasing an update of the 3M™AR-DRG V5.0 Grouper Software which will accept both the new ICD-10-AM Fourth Edition and all previous ICD-10-AM Coding Classifications, including the relevant mappings to allow for grouping in AR-DRG V5.0, V4.2 and V4.1 groupers.

More Information?

Please contact our sales specialist, Peter Walker, by email pwalker@mmm.com or phone: 1800 029 706.

Note: The information above does not relate to 3M™Codefinder™ Software. This Software will incorporate new codes and mapping as part of the standard scheduled update.



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The Good Clinical Documentation guide

Your guide to the best medical records

The **Good clinical documentation guide** helps clinicians to recognise critical elements they need to document to reflect the patient care process, to communicate, report and provide clear data for research and quality of care monitoring.

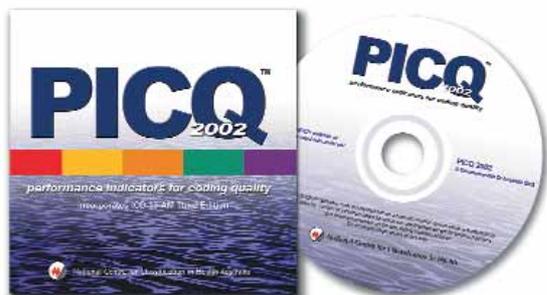
The **Good clinical documentation guide** provides general information about the requirements for good documentation, and the relationship between documentation, coding and Diagnosis Related Groups (DRGs). Specific information relevant to 22 clinical specialties helps guide and inform clinicians about important issues in documentation.

The specialty chapters feature:

- a range of clinical topics
- clinical profiles
- the top 5 principal diagnoses, procedures and complications and comorbidities (ICD-10-AM Third Edition) for each relevant specialty
- documentation pointers for each topic
- AR-DRG version 5.0 information where relevant
- examples of the impact documentation has on DRG assignment where DRG variances can be illustrated

The guide is provided as an Adobe® Acrobat® file on CD-ROM and features electronic navigation between topics and concepts. The guide is printer-friendly.

See the enclosed price list for purchasing details or contact NCCH Sydney
phone 02 9351 9461
e-mail ncchsales@fhs.usyd.edu.au



PICQ₂₀₀₂

incorporating PICQ for ICD-10-AM Third Edition

Performance Indicators for Coding Quality (PICQ) is a set of predetermined performance indicators which identify records in data sets that may be incorrectly coded, based on Australian Coding Standards and coding conventions.

PICQ 2002 contains a number of enhancements:

- PICQ for ICD-10-AM Third Edition has 13 new indicators
- Upgraded internal data specifications for some indicators in PICQ for ICD-10-AM First and Second editions
- New and improved PICQ user guide

For further information:
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coding matters



Volume 11 Number 1 June 2004
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Production and Layout: Peter Long & Rodney Bernard

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, Commonwealth 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.

CONFERENCES 2004

1 June	First International workshop on formal biomedical knowledge representation	Whistler, Canada	Stschulz@uni-freiburg.de
2-4 June	13th International Conference on Safe Communities Prague,	Czech Republic	safe@cbttravel.cz
2-4 June	International Congress on Medical and Care Compunetics	The Hague, The Netherlands	http://www.icmcc.com/
6-9 June	7th World Conference on Injury Prevention and Safety Promotion	Vienna, Austria	www.safety2004.info
22-23 June	Australia's Health 2004 Conference	Canberra	www.aihw.gov.au/conferences
29-30 June	EHR and E-Health Conference	North Sydney	http://www.iir.com.au
20-22 July	2004 ACHSE National Congress	Darwin	http://www.achse.org.au
23-24 July	National HIMAA Symposium	Brisbane	www.himaa.org.au
25-27 July	HIC 2004	Brisbane	www.hisa.org.au
9-11 August	AAQHC Quality in Healthcare Conference	Canberra	http://www.aaqhc.org.au
7-11 September	Medinfo 2004	San Francisco, CA USA	http://www.medinfo2004.org/
22-24 September	SNOMED International Users Group Meeting	Phoenix, AZ USA	http://www.snomed.org/
26 September – 1 October	HL7 18th Plenary and Annual Working Group Meeting	Atlanta, GA USA	meetinginfo@hl7.org
9-14 October	International Federation of Health Records Organizations Congress: Sharing Solutions in the Global Community	Washington, DC USA	http://cop.ahima.org/COP/Public/Events/
10-13 October	Health Care in Focus 15th Casemix Conference in Australia	Sydney	http://www.health.gov.au/casemix/conf.htm
11-12 October	Australian Private Hospitals Association National Congress 2004	Gold Coast	apha@consec.com.au
13-17 October	WONCA 2004	Orlando, FL USA	http://www.wonca2004.org/
15-17 October	Trauma Care 2004	Sydney	www.traumacare2004.com
21-23 October	PCS/E – Patient Classification Systems – Europe 2004	Budapest, Hungary	http://www.pcse.org/content.asp
13-15 December	International Conference on Knowledge Management	Singapore	http://www.icKM2004.org

Conference information is also published at the NCCH web site www.fhs.usyd.edu.au

Coding Matters is changing

Coding Matters as you know it has been renovated. NCCH will still publish four newsletters each year, with each alternate edition devoted only to 10-AM Commandments and quality issues. 10-AM Commandments will continue to be published in every edition.

2004–2005 publication schedule:

September 2004: 10-AM Commandments and quality issues

December 2004: *Coding Matters*, including 10-AM Commandments

March 2005: 10-AM Commandments and quality issues

June 2005: *Coding Matters*, including 10-AM Commandments

Coding Matters has just notched up 10 years' of publication, and as we begin our eleventh year of publication, the NCCH is confident that readers will continue to enjoy and benefit from the newsletter.

NCCH Editorial Committee