

coding matters



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

Volume 6 Number 1 **June 1999**



from the desk of the director

Maryann Wood represented NCCH Brisbane at the two Canberra meetings and gave us an opportunity to say our farewells to Maryann who is moving to a newly created position at the Australian Bureau of Statistics in Brisbane. Maryann has provided sterling support to the Brisbane site of NCCH – we thank her for her major contribution to classification development and education in Australia and countries in the region, and wish her well for her new endeavours. ▶

NCCH has adjusted to its new workplace (accommodating up to 20 staff) and is forging ahead with a range of tasks, many of them related to the production of the second edition of ICD-10-AM. The NCCH Advisory Committee met recently in Canberra and discussed a series of issues affecting the future direction of NCCH policy. NCCH presented two papers at an Australian Institute of Health and Welfare (AIHW) conference on ICD and ICIDH held in Canberra on 3 May 1999.



*NCCH Advisory
Committee members at
the AIHW in Canberra*

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Coding Services Division

Katrina Chisholm has returned from the west and is again contributing to the work of Coding Services. Linda Best has also joined Coding Services for two days a week – it really is all hands on deck for the second edition of ICD-10-AM and you will have seen the ‘soliciting’ from Kerry Innes in the last edition of *Coding Matters* which has generated some additional interest.

At its meeting of 24th May, the Coding Standards Advisory Committee reviewed specific issues for the 2nd edition including coding standards for croup, anaesthesia, palliative care, female genital mutilation, postprocedural complication coding, blood transfusions and diabetes.

NCCH has placed over 1,000 coding queries on its website Coding Query Database; these can be downloaded as Excel files.

Publications and Technology Division

This division has been working closely with Coding Services in managing the subcontract to Essential Software to build a database for ICD-10-AM. Work on the database, due for completion in mid 1999, was demonstrated to members of the Advisory Committee on 4 April 1999 and to CSAC on 24 May 1999. New brochures are being drafted for NCCH, for ICD-10-AM and for the *Australian Coding Benchmark Audit*.

The Australian Casemix Clinical Committee has agreed to continue funding until June 2000 for our Project Officer, Monica Komaravalli, to continue publication of educational Specialty Books – we are delighted that Monica remains with us for another year and that we can proceed with publication of the remaining specialty books in the series.

Education Division

Karen Peasley has been managing the Post Implementation workshops and, in conjunction with members of the Coding Educators Network, has recently completed presentation of ICD-10-AM workshops in those states implementing in 1999. Staff of NCCH Brisbane contributed to preparation and presentation of course material for these workshops. NCCH (Rosemary Roberts and Karen Peasley) has been invited by the Singapore Ministry of Health to spend three days in Singapore in early September 1999 to educate Singapore coders in coding audit processes and to consult on clinical coder education and support requirements.

Quality Division

Work in this division is focusing on development of the Performance Indicators for Coding Quality (PICQ). This project is becoming a combined effort of NCCH Sydney and Brisbane and the Quality Division at La Trobe University. The *Australian Coding Benchmark Audit* is being applied for self audit in Australian hospitals and NCCH is offering supporting and consultative services.

Research and Consultancy

Research Officer, Donna Truran, has prepared proposals for evaluating the impact of ICD-10-AM. Work on this issue is proceeding in relation to clinical coder experiences which have been surveyed. Results are currently being analysed. The AIHW proposal for a concordance study

**coding
matters**

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National Centre for Classification in Health

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Chris Harasty and Young Tjoa of Essential Software in Canberra for the demonstration of the ICD-10-AM database to the NCCH Advisory Committee

between ICD-9-CM and ICD-10-AM has been approved for AHMAC funding.

NCCH has requested access to routine morbidity data from the states, the Commonwealth and AIHW. The Commonwealth and states that have responded so far have indicated their preference for the data to be made available through AIHW. NCCH intends to use this data to identify usage of newly introduced codes and compliance with Australian Coding Standards. It will also be used to review patterns of code use and inform development of new standards.

NCCH consultancy to carry out the **Professional Relativities Study** for the Medicare Schedule Review Board is still under way and is expected to be completed at the end of 1999.

International Organization for Standardization Technical Committee on Health Informatics

Rosemary Roberts was nominated by the Standards Australia IT/14 Health Informatics Committee as Australia's representative to Working Group 3 on Health Concept Representation for the Technical Committee on Health Informatics of the International Organization for Standardization (ISO/TC 215). The committee and its working groups met in Berlin from 12–15 April 1999. Support for the Australian representatives to attend the meeting was provided by the Department of Health and Aged Care National Health Priorities and Quality Branch. Australia was represented by Mr Peter Treseder, Standards Australia (Chair, TC 215), Mr Peter Williams (Chair, Working Group 1, Health Record and Modelling Coordination), Mr Peter White (Working Group 1), Mr Mark Mynott

(Working Group 2, Messaging and Communication), A/Professor Rosemary Roberts (Working Group 3, Health Concept Representation) and Mr John Lewis (Working Group 4, Security).

Preliminary work item proposals from Working Group 3 were accepted by the plenary meeting and will now be considered by the relevant organisations in the countries represented, for Australia this being IT14/2. These work item proposals related to standards for the terminologies themselves rather than for their content. That is, they proposed work on standard ways of describing terminologies and their structure and for evaluating terminologies and classifications against quality criteria.

As this was the first meeting of the Working Group on Health Concept Representation, it was a valuable opportunity to learn of existing work and for Australia to become involved in developing clinical terminologies in the context of international efforts.

Dr. Miriam Wiley

Dr. Miriam Wiley is Head of the Health Policy Research Centre and Senior Research Officer at the Economic and Social Research Institute, Dublin, Ireland. She was recently in Australia as a guest speaker at the symposium 'The Contribution of Research to Health Policy' in recognition of the career of Professor George Palmer.



Miriam Wiley with Rosemary Roberts and Kerry Innes

While in Sydney, Dr Wylie took the time to visit the NCCH. Although brief, her visit provided a valuable opportunity to compare and relate health information about our respective countries.

Dr Wylie is a leading national and international expert in health research. Her specific research interests include the financing of health and ►

hospital services and reform of approaches to health service funding, reimbursement, management, organisation and delivery. In addition, she has management responsibility for the Hospital Inpatient Enquiry (HIPE), the national discharge abstracting scheme that operates in all acute hospitals nationally and involves the collection, processing and analysis of data on close to 700,000 hospital discharges annually.



Speakers at the AIHW Conference included Kerry Innes, Rosemary Roberts, Mal Greig, Peter Gray, James Harrison, Jenny Hargreaves and Bill Runciman



AR-DRG V4.1 software is now available from **3M Health Information Systems**.

In Australia and internationally, 3M Health Information Systems has always set standards in Grouper software development and maintenance. The latest version of the grouper software, 3M AR-DRG V4.1, is now available in a number of platforms. In addition to this, 3M will provide the grouper through a number of major software vendors to the health care industry.

All our products have local clinical and technical support specialists contactable via a freecall number.

To find out which products configuration best suit your requirements, contact Peter Walker on 1800 029 706 or via E-mail: pwalker@mmm.com.

ASERNIP-S

NCCH is represented on the Management Committee of the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). This is a 3 year pilot project of the Royal Australasian College of Surgeons (RACS) to determine a mechanism for using peer reviewed information from the literature to determine the safety and efficacy of new surgical procedures. A list of selected procedures has been chosen for review by specialist surgeons and ASERNIP-S staff including:

- Lung Volume Reduction Surgery
- Laparoscopic Live Donor Nephrectomy
- Laparoscopic-Assisted Resection of Colorectal Malignancies
- Minimally Invasive Parathyroid Resection
- Arthroscopic Subacromial Decompression using the Holmium:YAG Laser
- Intravaginal Slingplasty for Urinary Incontinence
- New Invasive Techniques for Relief of Bladder Outflow Obstruction
- Percutaneous Endoscopic Laser Discectomy
- Ultrasonic Liposuction

The Review Group analyses the literature and reports on the appropriate level of safety and efficacy of the procedure to the Management Committee which in turn makes recommendations to the RACS Council.

NCCH involvement allows identification of the procedure concept by existing ICD-10-AM procedure code or codes and early warning of need for new codes and their place in the classification hierarchy. This allows follow up of the use of the procedure when it is accepted in practice.

The project is funded by the Commonwealth Department of Health and Aged Care. ASERNIP-S is located at the RACS Offices in North Adelaide. Further details are available on the ASERNIP-S web site at <http://www.racs.edu.au/open/asernip-s.htm>

▶ **Rosemary Roberts**
Director



vital signs

As I write this column for *Coding Matters*, I am busy preparing for another two international training courses – this time in Fiji and Guam during May, on behalf of the Western Pacific region of WHO.

Don't let anyone tell you that this is a junket to exotic tropical countries – photos of hard-working NCCH staff will follow in future editions! The Brisbane office is delighted to be undertaking these consultancies, which represent NCCH's first experiences teaching in the Western Pacific region.

ICD-10 Training in Myanmar

During March, Maryann Wood conducted an ICD-10 training course in Yangon in Myanmar. This training course is a continuation of the work the NCCH has undertaken in recent years for the South East Asia Regional Office of the World Health Organization in clinical classification and medical record training. The course ran for two weeks with participants from five of the ten countries within the region. The 19 participants were from Myanmar, Bangladesh, Nepal, Bhutan and Sri Lanka and included statisticians, information technology specialists, clinicians and medical record technicians, many of whom had no previous knowledge of clinical classification.

Day one of the course began with the first of four power failures for the day (despite assurances that, although power failures are common – at least several times a week and usually only for half an hour – four in one day is exceptional). Imagine being totally prepared for teaching with overhead transparencies to highlight every main point – and the power goes off! Talk about having to think on your feet! Not to mention the temperature... around 35 degrees and humid!

Despite the power failures and students delayed through the need for government travel clearances, the course proved to be a great success. Given the lack of prior knowledge about clinical classification and the diverse backgrounds, the participants grasped the concepts of clinical classification relatively quickly. The course provided the opportunity not

only to gain an understanding of clinical classification but also to share ideas between countries and to develop networks of coders within the region. For the NCCH it was a further chance to witness a health information system in a developing country, and to renew old (and develop new) contacts. Three of the students from Myanmar we had taught in previous courses assisted Maryann with the conduct of this course, acting as tutors and facilitators.

ABS ICD-10 Implementation

The Australian Bureau of Statistics (ABS) mortality coders are currently completing the ICD-9 processing of 1998 deaths, in anticipation of coding 1999 deaths in ICD-10 from May, ►

ROYAL PRINCE ALFRED HOSPITAL

ASSISTANT MANAGER CLINICAL CLASSIFICATION Medical Record Manager - Grade 1

A challenging position is available for a motivated Health Information Manager interested in clinical classification, data management and production. The position assists the Clinical Classification Manager to ensure the timely production of accurate data. A commitment to staff management, development and education, service enhancement and quality data production is required.

Essential:

2 years coding experience in MRD, minimum 1 year experience in H.I.M or supervisory role, advanced clinical classification skills across a range of specialties, Ass. Diploma, Degree or recognised equivalent in H.I.M, excellent organisation and communication skills, demonstrated ability to implement E.E.O and O.H&S policies.

Desirable:

Knowledge of Encoder, knowledge of Patient Administration Systems, eligible for membership of H.I.M.A.A.

Applications and Enquires:

Miss Rachel West
Medical Records Department
Royal Prince Alfred Hospital,
Missenden Road,
Camperdown NSW 2050. Ph.(02) 9515 6100

Closing Date - July 2 1999

1999. Training in ICD-10 has been undertaken for all of the coders within the Cause of Death Unit by the NCCH Brisbane. The training has included transition courses for the experienced ICD-9 coders and more detailed training for a number of coders new to the area.

As mentioned in the previous edition of *Coding Matters*, the ABS are undertaking a bridge coding exercise to assess changing trends due to the new classification. Two years of data (1997 and 1998) will be back-coded using ICD-10, providing two years of data in both ICD-9 and ICD-10. To assist in this process 10 QUT HIM students have been employed, initially, to process the certificates through the SUPERMICAR phase, allowing the more experienced ABS coders to concentrate on the ACME/TRANSAX phase.

SUPERMICAR is the program which 'reads' the death certificates, comparing the diagnostic terms used with its dictionary and rejecting those records that it cannot understand. The students will be responsible for correcting spelling errors or entering alternative forms of words to clarify the meaning of the rejected certificates.

During the ACME/TRANSAX phase, the computer assigns ICD codes to the causes of

death mentioned on the certificates, determines the linkages between mentioned conditions (if any) and finally assigns the underlying cause of death.

Once the two years of dual coded data are available, it is planned to conduct a concordance study to determine the movements of diagnoses around the classification. For example, a pure mapping exercise will determine whether one ICD-9 code maps to one or more ICD-10 code(s). The concordance allows a calculation of the number of times (and percentage) each alternative code is used where there is a one-to-many relationship.

Staffing News

Maryann Wood has recently tendered her resignation from NCCH, effective from the beginning of June 1999. Whilst we are really going to miss Maryann's good humour and capacity for hard work, her expertise will not be entirely lost to us as she will be taking up a newly-created position as Manager of the Cause of Death Unit at the ABS. Congratulations Maryann! News of Maryann's replacement as Senior Classification Officer will be brought to you in the next edition of *Coding Matters*.

The Brisbane office is also currently interviewing for a Classification Officer to work with us on ICD-10-AM related matters. The successful candidate will assist both the Brisbane and Sydney offices in developing future educational strategies, as well as helping out with coding queries and the development of future revisions of the classification.

NCCH Brisbane is also advertising a two-three year research scholarship for an individual to undertake postgraduate study on a project related to the interests of the NCCH and its funding partners. More on this when we have a successful applicant!



Maryann Wood demonstrates the dreaded 'coders claw' to clinical coders at a recent ICD-10-AM workshop

► **Sue Walker**

Associate Director, NCCH Brisbane

	6TH Annual NCCH Conference <i>(in conjunction with CCSA)</i> 22nd to 24th September 1999 Hotel Grand Chancellor, Hobart, Tasmania.
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on the **ACBA** **audit trail**

What is ACBA?

ACBA is the *Australian Coding Benchmark Audit*.

ACBA is a method of coding audit which involves re-coding a sample of hospital inpatient episodes recording results in a uniform manner. It is a simple, user-friendly audit tool, which can be conducted using clinical coder auditors already employed by the healthcare facility, by auditors contracted from external sources or even by arranging a 'swap' of auditors between facilities.

Why should I Audit?

The *International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM)* contains over 10,000 classes and over 120,000 diagnostic terms in the alphabetic index. Clinical coders must decide from this extensive range of possibilities which diagnoses or procedures to code, which codes to allocate and the sequence of codes.

Traditionally, clinical coding is performed within the healthcare facility's medical record department. The medical record is reviewed after patient discharge to obtain relevant data about the episode of care. This data including diagnoses, procedures and external cause or injury, is used as a basis for research studies, for casemix grouping and funding purposes and for the continuing care of patients. The use of coded data for casemix grouping has given new prominence to the need for data accuracy.

Errors – 'coder' or 'system'?

Clinical coders are faced with an array of decisions when confronted with the complex process of coding. There may be no direct match between the clinical record and the alphabetic index of the ICD, records may be incomplete at the time of coding, there may be conflicting information within a record and often illegible handwriting. Errors can also be made by not following the convention of ICD coding or that of the Australian Coding Standards.

This culminates in clinical coders having to use their judgment in the choice of code for a particular diagnosis or procedure. It is essential that any tool used to measure the quality of ICD coding should be able to distinguish errors in coder judgement from errors due to the system or quality of documentation on which they are dependent.

ACBA is a standard method of selecting and re-coding a random sample of records, identifying discrepancies in coding practice and identifying the cause of coding errors, as either 'system' or 'coder' errors. Because it is a standard method, these results can be compared across facilities and across time.

The whole system of clinical coding audit includes measuring the accuracy of the codes being selected, feeding back results to the clinical coding staff, identifying the reasons for variation and implementing systems to prevent those situations from recurring.

National Benchmark

The NCCH will calculate a national benchmark of audit results by hospital type to provide a national standard against which healthcare facilities can compare their own performance. Notification of results to NCCH is not mandatory but is essential to enhance the usefulness of benchmark data. Hospital identity will not be disclosed in the benchmarking process.

How to order ACBA

ACBA is available as a kit that includes comprehensive instructions, examples, and reporting and data collection forms necessary for recording audit results. The forms are also supplied on disk included with the kit.

You can order a copy of ACBA by using the form included with *Coding Matters* or by visiting our website: <http://www.cchs.usyd.edu.au/ncch/> and downloading it, call (02) 9351 9461 if you would like more information.



educational **matters**

The end is nigh... well at least for the completion of the initial educational strategy for the introduction of ICD-10-AM into Australian hospitals...

Bidding a fond farewell to the coders of Western Australia (last cab off the rank), I returned home to Sydney, fairly well satisfied that the 1500+ clinical coders that had participated in the 49 NCCH ICD-10-AM Education Workshops since their inception in April 1998, were well placed to embark upon the use of the new classification.



Participants at the Townsville workshop on 29–30 April

The initial feedback from the workshops conducted throughout Queensland and SA since April 1999 has been extremely positive. Considering that Tasmania, WA and these other states had an additional twelve months preparation time and most chose to undertake their own coding training sessions during this time, the NCCH workshops have complimented this training well. A common thread seems to be that at the conclusion of the NCCH workshops, clinical coders did not find the use of ICD-10-AM so daunting and as one participant noted "I was surprised that it (ICD-10-AM) wasn't as 'scary' as I anticipated." A full report of the evaluations from these workshops will be available in the September edition of *Coding Matters*.

Once again a big thanks goes to the Department of Health and Aged Care and the individual state health departments for their continued support and commitment to the education of clinical coders across Australia.

And just for your information, I alone have travelled almost 15,000 air miles during the conduct of these workshops in 1998/1999.



Robyn Rooney and Anne Darby, Bundaberg Base Hospital at the Noosa workshop on 27–28 April'



Joanne Webster, Wesley Park Haven Private Hospital and Jane Watson, Townsville General Hospital at the Townsville workshop on 29–30 April

I didn't even want to begin to include the travel mileage undertaken by other NCCH staff members and the members of the Coding Educators Network (CEN).

Preparations for the 6th Annual NCCH/CCSA Conference continue and more information about the conference, including registration costs can be found on page 24. Registration brochures will be distributed to all readers of *Coding Matters* in early July and will be available to download from the NCCH website at this time also. If you require additional forms or want to add your name to the distribution list please contact the NCCH asap.

▶ **Karen Peasley**
Education Manager

1998 Awards Ceremony School of Public Health, Curtin University

The National Centre for Classification in Health (NCCH) sponsored for the first time a prize for Clinical Coding for each of the University Health Information Management Programs and for the distance programs offered by HIMAA and OTEN. This prize is to be awarded to the top final year student in clinical classification.

This year the Department of Health Information Management, Curtin University, took advantage of the graduating students and their families being on campus for the Division of Health Sciences Graduation ceremony, to hold a high profile awards Ceremony prior to the Graduation Ceremony. Dignitaries joined members of the profession, students, past recipients of awards and academic staff in attending the formal presentation.

Professor Ian Rouse, Adjunct Professor in the School of Public Health, presented the NCCH's prize for Clinical Coding to Kate Harrison. In addition, Dr Pam Allen, Deputy Director of Clinical Services at Royal Perth Hospital, presented the Royal Perth Hospital's Award of



**Graduates from left to right
Paula Dalzell, Anita Cornish and
Kate Harrison**

Excellence jointly to Paula Dalzell and Kate Harrison. The final announcements made at the Ceremony were that Kate Harrison and Anita Cornish, who both shared the same top semester weighted average, would jointly appear on the Health Information Management Honour Board for 1998.

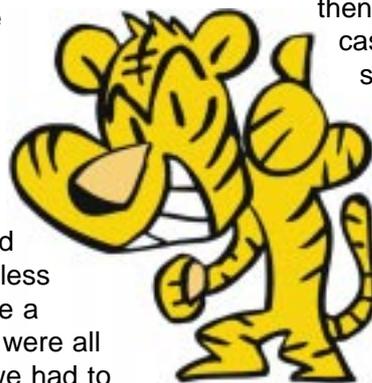
▶ **Barbara Postle**
Head, Department of
Health Information Management
Curtin University, WA

ICD-10-AM Education Made Fun in WA

It's been a challenge, enticing Clinical Coders (CC's) to spare time from their busy work schedules to attend ICD-10-AM work shops and ensure they come back for more education. There is so much to learn, and for Western Australia, it is a logistical nightmare to have them all in one place at the same time.

Comments like 'the room's too big, we at the back can't see and hear' or 'the room's too cramped, it's suffocating' or 'I'm finished the exercises quickly and am getting bored waiting for the less experienced to catch up' or 'I take a little more time – don't rush me!' were all legitimate comments, and I felt we had to do something about them... so I took them to the zoo!

Setting up six educators at picnic tables around the zoo grounds, and breaking the CC's into groups of four with a timetable to visit each educator throughout the day, gave us the opportunity to expand the classroom size, but dramatically shrink the class numbers. No, the CC's didn't have to drag their books around the



zoo, the educators had two sets each and all the paperwork the CC's needed. A clipboard and pen were the order for the day.

Each educator covered a pre-prepared case for one chapter to be coded at their table. They then had a captive audience to discuss the case and the standards particular to that specialty.

Moving between educators, the CC's could enjoy the surroundings. There is a new cheetah and the lion has L65.9. I also took the opportunity to test the CC's on the application of some of the standards and documentation issues for which they each had four worksheets to hand in at the end of the day.

And the decision at the end of it all was a resounding thumb's up: from the educators as well as the CC's. "Where will it be next?" was the question. I am yet to decide.

▶ **Viktoria King**
State Educator – Clinical Coding
Health Department of Western Australia



coding services

Profile of Kerry Innes

Kerry is the fount of all NCCH knowledge about codes and coding standards. She was a jump ahead of all of us right from the beginning, having contributed to the 1992 Australian Coding Standards which resulted from the Eagar and Innes Report of the National Patient Abstracting and Coding Project. Since then, Kerry has been the linch pin that keeps the NCCH wheels on.

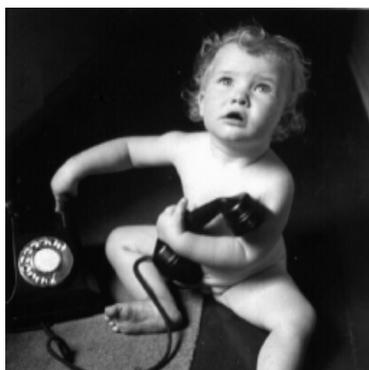
As Coding Services Manager, she has guided her own staff in developing successive editions of the Coding Standards, she has worked closely with clinicians and clinical coders in developing and revising codes, and more recently Kerry has compiled reports for WHO on Australian recommendations for change to ICD-10 itself.



extremely onerous and repetitive task of developing and maintaining a health classification. When she's not running Coding Services, Kerry functions as Associate Director, NCCH Sydney. In this capacity too, Kerry is indomitable and always brings a new perspective (and a laugh) to policy and procedural issues. It's sometimes hard to have a serious conversation when the barnyard on Kerry's computer decides to vocalise. Not many of us are irreplaceable – but high on my list is Kerry Innes (or Keri Ines, Kerrie Inniss, Cary Inners etc.)... I should also mention that Kerry

is a candidate for the first bionic implant of a telephone receiver.

An early photo of Kerry phoning a change to Coding Matters



Without Kerry we would never have had an Australian procedure classification, not to mention the Australian modification of ICD-10 diseases. Not many people working in coding and classification can lay claim to having actually created a classification. Kerry and her team have done just that – an enormous undertaking requiring vision, an appreciation of the possible and enormous amounts of dedicated and devoted hard work (as long as she is fed). Kerry is a foodie, loves dogs, can't go past a stray (animal or human) and entertains us all in what is sometimes an

▶ **Rosemary Roberts**
Director



Kerry will explain ICD-10-AM to almost anyone who will listen (Flipper, Arthur and Spike)

the 10-AM commandments

This regular section (previously 'Coding Tips') is intended to provide ongoing guidance to coders on commonly asked questions and aims to address those areas of coding which require immediate attention by 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 change practice 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/territory health authority regarding a suitable date for implementation.

Additional diagnoses – July 99 implementation

As mentioned in the last edition of *Coding Matters*, ACS 0002 *Additional diagnoses* has been revised. The new standard should be implemented for separations from 1 July 1999. See Errata 6 in this edition for a copy of the standard.

Note: *this modified standard is provided to reinforce good coding practice, and therefore may not have any effect on the way you code now.*

Remission in malignant immunoproliferative diseases and leukaemia – July 99 implementation

This standard is provided to assist in determining when to assign the fifth characters for 'in remission' and 'without mention of remission' for categories *C88 Malignant immunoproliferative diseases*, *C90 Multiple myeloma and malignant plasma cell neoplasms* and *C91–C95 Leukaemia*. It also provides guidance in the distinction between the concepts of 'in remission' and 'history of' in relation to these conditions. A definite cure, and therefore assignment of a 'history' code, may vary greatly from disease to disease and can only be applied retrospectively. The distinction therefore, after clinical consultation, is made on the basis of continuing treatment of the malignancy, rather than a set time-frame.

Definition

Complete remission – no evidence of signs or symptoms of the malignancy.

Partial remission – reduction in the signs or symptoms of the tumour by >50% but evidence of active disease exists.

Where documentation is incomplete and the only information is 'in remission', it is advisable to seek further clarification from the clinician.

Classification

This standard relates only to the following categories:

- C88.~ *Malignant immunoproliferative diseases*
- C90.~ *Multiple myeloma and malignant plasma cell neoplasms*
- C91.~ *Lymphoid leukaemia*
- C92.~ *Myeloid leukaemia*
- C93.~ *Monocytic leukaemia*
- C94.~ *Other leukaemias of specified cell type*
- C95.~ *Leukaemia of unspecified cell type*

with 5th characters:

- 0** *without mention of remission*
(includes partial remission)
- 1** *in remission* (complete remission)

Without mention of remission ('0')

A 5th character of 0 (without mention of remission) should be assigned when

- It is the first presentation and diagnosis of the disease, or
- It is clear from the documentation that even if there has been a reduction in the disease, active disease still exists.

In remission ('1')

A 5th character of 1 is assigned when:

- the clinician has documented in 'remission' with no further information on the stage or history of the disease and clinical advice is unavailable or,
- the patient is still receiving treatment for the inactive malignancy or for side-effects of therapy (i.e. surgery, chemotherapy, other drug treatment, etc.)

and

it is clear from the documentation that this is a complete remission (i.e. no evidence of signs or symptoms of the malignancy)

Z85 Personal history of malignant neoplasm

In cases where complete remission is documented and there is no evidence of the patient receiving any form of treatment for the malignancy or for side-effects of therapy, a code for 'history of malignancy' should be assigned, when it is relevant to the current episode of care (as per ACS 0002 *Additional diagnoses*). The possible 'history of malignancy' codes are:

Z85.6 *Personal history of leukaemia*

Z85.7 *Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues*

Neoplasm coding and sequencing – July 99 implementation

ACS 0213 *History of malignancy* and ACS 0236 *Neoplasm coding and sequencing* have been revised to clarify coding of cases where the episode of care relates to treatment of metastasis from a primary malignancy previously resected. See Errata 6.

Epilepsy

The terminology (and the basis of the classification) used for epilepsy in ICD-10-AM in G40 *Epilepsy* is a mixture of that recommended by the International League Against Epilepsy (ILAE) and terms such as 'grand mal' and 'petit mal' (first used in 1838). 'Grand mal' and 'petit mal' are not regarded by clinicians as appropriate terminology today but have been retained in ICD-10-AM because of their continued use by some clinicians and patients. A separate 3 character category is provided for status epilepticus (G41 *Status epilepticus*).

Following the current ILAE classification, the codes in G40 identify epilepsy according to aetiology (idiopathic or symptomatic) and whether it is localization-related or generalized. Within the localization-related, symptomatic codes, there is a split for simple and complex partial seizures (G40.1 and G40.2). This arrangement is shown in the table below.

The difference between idiopathic and symptomatic is:

Idiopathic: no known cause for the epilepsy

Symptomatic: a known cause exists for the epilepsy (e.g. space occupying lesion, congenital malformation of the brain, metabolic disorder, trauma, vascular disease, infectious disease). The literature suggests that the differentiation between idiopathic and symptomatic is rapidly disappearing as researchers are finding more causes for epilepsy. For example, research into mitochondrial disorders has identified some 'causes' for epilepsy (e.g. myoclonus epilepsy with ragged red fibres (MERRF)).

SITE	AETIOLOGY			
	Idiopathic	Symptomatic		Unspecified
Localisation	G40.0	Simple	G40.1	
		Complex	G40.2	
Generalised	G40.3	G40.4 G40.5		
	G40.6 Grand mal seizures G40.7 Petit mal seizures			
Undetermined				G40.9

In ICD-10-AM, in both the Tabular List of Diseases and the Alphabetic Index of Diseases, coders are directed towards the codes based on the ILAE classification rather than the use of the more imprecise and inappropriate terms such as 'grand mal' and 'petit mal'. This is why the Index lists G40.3 *Generalized idiopathic epilepsy and epileptic syndromes* as the code for 'Epilepsy - - petit mal'.

To reinforce that the terms and codes for 'grand mal' and 'petit mal' should be avoided if at all possible, notes have been included in ICD-10-AM under G40.6 *Grand mal seizures, unspecified (with or without petit mal)* and G40.7 *Petit mal, unspecified, without grand mal seizures* in Volume 1. See Errata 6.

Ovarian cysts

Cysts of the ovary can be classified as either:

1. Normal physiologic 'cysts'

A developing follicle starts off as a very small cystic structure 3-4 mm in diameter. Because it is selected to be the dominant follicle it increases in size progressively so that by the time of ovulation, this particular "cyst" actually ruptures and releases the egg. It is not a cyst in the true sense of the word, but a cystic developing follicle, which actually reaches a diameter of 20-25 mm immediately prior to rupture.

Under these circumstances the cysts are really physiological structures which do not need to be coded.

2. Abnormal physiological mechanisms resulting in cysts.

Three types of cystic structures can exist where the physiology has become abnormal:

i. **Follicular cysts** where the diameter of the cyst exceeds 2.5 cm. These are commonly seen around the time of the menarche, or the menopause, but can occur at any time in the reproductive life.

Coded to: N83.0 *Follicular cyst of ovary*

ii. **Corpus luteum cyst.** This is where the corpus luteum itself becomes much larger and cystic. This is a common feature in early pregnancy, especially where the patient has received forms of ovulatory stimulation.

Coded to: N83.1 *Corpus luteum cyst*

iii. **Polycystic or multicystic ovaries.** With the use of ultrasound ovaries can be clearly

identified, containing large numbers of very small cystic structures within them. The classical feature of a polycystic ovary is where 15-20 small follicles, 2-5 mm in diameter, are present in the subcortical region of the ovary. Where the cystic structure is slightly bigger than this, many reproductive endocrinologists refer to this as a multicystic ovary. Under these circumstances the size of the cysts themselves are always small, and much less than those of a normal follicle immediately prior to ovulation.

Coded to: E28.2 *Polycystic ovarian syndrome*

3. Pathologic cysts

The other form of cystic structures is that of the pathologic structures which are clearly defined by pathologists into benign and malignant variety.

Thanks to Professor Roger J Pepperell (Obstetrics & Gynaecology CCCG) for providing this information.

Chemotherapy in HIV/Kaposi's sarcoma

In the event that a patient is being treated with cytotoxics on a same day basis for Kaposi's sarcoma associated with HIV/AIDS, assign Z51.1 *Chemotherapy session for neoplasm*, rather than Z51.2 *Other chemotherapy* because the focus of treatment is the neoplasm rather than the HIV/AIDS.

Retained products of conception

The coding of retained products of conception has been clarified in Errata 6, with a modification of ACS 1544 *Complications following abortion and ectopic and molar pregnancy* and minor changes to the tabular list and index.

Anaemia in neoplastic disease

Code D63.0* *Anaemia in neoplastic disease* should be assigned when anaemia occurs in, due to or with a neoplastic condition. The specific code for the neoplasm should be assigned when known, as indicated by the inclusion term:

D63.0* Anaemia in neoplastic disease
Conditions in Chapter II (C00–D48).

Note that according to ACS 0207 *Complications associated with neoplasms*, the condition which is the focus of the care should be sequenced as the principal diagnosis. Therefore if a patient is being treated as a same day patient for blood transfusion for anaemia (with underlying leukaemia), the principal diagnosis would be

anaemia. However, because ICD-10-AM has the aetiology/manifestation rule for anaemia in neoplastic disease, the dagger/asterisk sequencing takes priority over the standard.

It is not necessary to assign another code in addition to D63.0* to indicate the type of anaemia.

History of sexual abuse in childhood

Z61.8 *Other negative life events in childhood* should be assigned for documentation such as 'history of sexual abuse' not otherwise specified. If the perpetrator of the sexual abuse is known, Z61.4 *Problems related to alleged sexual abuse of child by person within primary support group* or Z61.5 *Problems related to alleged sexual abuse of child by person outside primary support group* should be assigned instead of Z61.8. Due to the sensitive nature of this issue, coders should be especially cautious in assigning Z61.4, Z61.5 or Z61.8 and codes from T74.~ *Maltreatment syndromes*. Codes from T74.~ *Maltreatment syndromes* should be assigned only when the episode of care relates to a current suspected abuse case (e.g. 'child at risk'). An external cause code from Y07.~ *Other maltreatment syndromes* should also be assigned to indicate the relationship of the perpetrator to the victim. If the perpetrator is not known, assign Y07.99 *Other maltreatment syndromes by unspecified person, during unspecified activity*.

Diabetes mellitus

Diabetes mellitus as the principal diagnosis

When the principal diagnosis is recorded as 'diabetes mellitus' the coder should check for further information about the nature of the diabetes mellitus which occasioned the episode of care. As indicated in ACS 0401 *Diabetes mellitus*, 'diabetes mellitus for stabilisation' should be assigned a fifth character of .1 *stated as uncontrolled*. The record should be thoroughly checked for information about any complications, and the appropriate fourth character assigned. When no further information is available, a code from E10–E14 should be assigned with a fourth character of .9 *without complications*. It is important that coders do not assume that the diabetes mellitus is complicated because it is recorded as the principal diagnosis. Remember, that if you make this assumption without documented evidence (of complications) in the clinical record and assign .6 *with other specified complications*, you will be

coding in contravention of the Australian Standards for Ethical Coding (see ICD-10-AM, Volume 5, page 229, point 3).

Diabetes with multiple complications

The fourth character of E10–E14, '.7' *with multiple complications* should be assigned when more than one of the fourth characters are applicable in a particular case. This E1~.7 code is then followed by the appropriate complication codes.

Example

Diagnosis: Non-insulin-dependent diabetes mellitus with nephropathy and polyneuropathy

Codes: E11.70 *Non-insulin-dependent diabetes mellitus with multiple complications, not stated as uncontrolled*

N08.3* *Glomerular disorders in diabetes mellitus*

G63.2* *Diabetic polyneuropathy*

Intubation without ventilation

Intubation may be performed without associated ventilation for cases such as adults admitted after an overdose or children (<16yrs) admitted for asthma, croup or epilepsy. In such cases a code for intubation can be assigned.

Remember:

intubation should never be coded when it is performed in association with ventilation for a patient >15 years of age.

CPAP via nasopharyngeal intubation

Patients may receive CPAP via nasopharyngeal intubation attached to a continuous-flow mechanical ventilator designed for neonates or a suitably equipped multipurpose ventilator set in the CPAP mode. In such cases assign the appropriate code(s) for CVS from block [569] *Continuous ventilatory support*. 92035-00 [1848] *Other intubation of respiratory tract* should also be assigned for patients <16 years of age.

Decompression laminectomy and discectomy

The codes for decompression laminectomy and discectomy in ICD-10-AM are being reviewed for the second edition. Until the second edition is released, the following guidelines may assist in alleviating some of the confusion in this area.

Definition

Spinal (vertebral) column The column formed by the vertebra is comprised of various levels: cervical (7), thoracic (12), lumbar (5), sacral (5) and coccygeal (4). The 5 sacral vertebra are

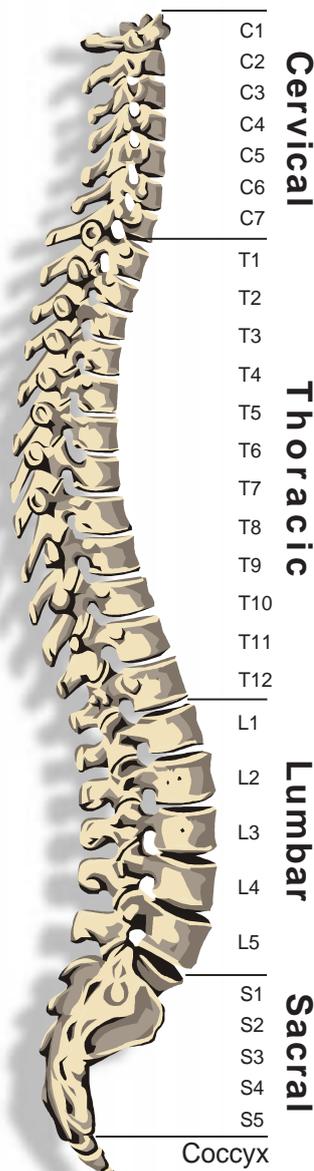
fused to form the sacrum, and the 4 coccygeal vertebra form the coccyx. The spinal column encloses the spinal cord and meninges.

Spinal cord Extends from foramen magnum (within the skull) to the upper part of the lumbar region. Note there is no spinal cord beyond the 1st lumbar vertebra.

Spinal nerve roots There are 31 pairs of spinal nerves. They emerge as paired nerve roots from the anterior and posterior spinal cord. Each nerve is then formed by the union of the paired roots.

Effects of Spinal Injury

Nerves run from the spinal column to specific areas of the body. By noting where a person has weakness, paralysis, or other loss of function (and therefore nerve damage), a neurologist can trace back and pinpoint where the spinal column is damaged.



Level of Nerve Injury	Effect*
C1 to C5	Paralysis of muscles used for breathing and of all arm and leg muscles; usually fatal.
C5 to C6	Legs paralyzed; slight ability to flex arms.
C6 to C7	Paralysis of legs and part of wrists and hands; shoulder movement and elbow bending are relatively preserved.
C8 to T1	Legs and trunk paralyzed; eyelids droop; loss of sweating on the forehead (Horner's syndrome); arms relatively normal; hands paralysed. <i>Note C8 refers to nerve root – there are 7 cervical vertebrae and 8 cervical nerve roots.</i>
T2 to T4	Legs and trunk paralyzed; loss of feeling below nipples.
T5 to T8	Legs and lower trunk paralyzed; loss of feeling below the rib cage.
T9 to T11	Legs paralyzed; loss of feeling below umbilicus.
T12 to L1	Paralysis and loss of feeling below the groin.
L2 to L5	Different patterns of leg weakness and numbness.
S1 to S2	Different patterns of leg weakness and numbness.
S3 to S5	Loss of bladder and bowel control; numbness in the perineum.

* Loss of bladder and bowel control can occur with severe injury anywhere along the spinal column.

Information sourced from *The Merck Manual of Medical Information – Home Edition 1997 Second Edition*

Level Certain spinal procedures require the specification of the level at which the procedure is being performed. The level of the vertebra is the numbered vertebra, e.g. L4 is the 4th lumbar vertebra. As intervertebral discs lie between vertebrae, documentation of 'L4/5' means the disc is between L4 and L5, that is one vertebral interspace or one disc level.

Decompression is releasing pressure either from the spinal cord or spinal nerve roots. It is necessary to read the procedural notes to determine what is being decompressed.

Laminectomy is removing some of the lamina (a bony plate which makes up part of the vertebral arch).

Rhizolysis is synonymous with decompression of the spinal nerve roots. This may be done by freeing tissue or removing some of the lamina. Some codes in block [46] *Decompression of cervical spinal cord* have the words 'with involvement of nerve roots'. This is the same as rhizolysis.

Discectomy is removal of an intervertebral disc which is a cartilaginous structure between each vertebra. Many disc prolapses can be excised with removal of a minimal amount of bone. A full laminectomy is usually only required for a large disc prolapse.

Classification

Discectomy

Cervical

- anterior approach:
assign 40333-00 [52] *Anterior cervical discectomy, 1 level* or 40333-01 [52] *Anterior cervical discectomy, ≥2 levels*.
- posterior approach, via laminectomy or laminotomy:
assign 40300-00 [52] *Discectomy, 1 level* or 40300-01 [52] *Discectomy, ≥2 level*.
- for recurrent disc lesion:
assign a code from block [51] *Discectomy for recurrent disc lesion*.

Thoracic, thoracolumbar and lumbar

- assign 40300-00 [52] *Discectomy, 1 level* or 40300-01 [52] *Discectomy, ≥2 levels*.
- for recurrent disc lesion:
assign a code from block [51] *Discectomy for recurrent disc lesion*.

- for percutaneous lumbar discectomy:
assign code 48636-00 [52] *Percutaneous lumbar discectomy*.

Decompression of spinal cord with/out discectomy

Cervical

- Decompression laminectomy with or without discectomy:
assign a code from block [46] *Decompression of cervical spinal cord*.

Thoracic, thoracolumbar and high lumbar

Assign a code according to the approach used, e.g. 40345-01 [47] *Decompression of thoracic spinal cord with involvement of nerve roots, via costotransversectomy*.

Note that as the spinal cord ends at the 1st lumbar vertebra, there are only codes for decompression of high lumbar spinal cord.

Decompression of spinal stenosis

Codes in block [48] *Decompression for spinal stenosis* should be assigned only when decompression is performed for spinal canal stenosis, that is bony disease causing spinal cord compression. In such cases these codes should be assigned instead of codes from the blocks mentioned above.

Spinal rhizolysis

The term spinal rhizolysis relates to decompression of spinal nerve roots as opposed to decompression of the spinal cord.

- Spinal rhizolysis without laminectomy:
assign 40330-00 [49] *Spinal rhizolysis*.
- Spinal rhizolysis with laminectomy:
assign 40330-01 [54] *Spinal rhizolysis with laminectomy*.

Combined procedures

Decompression of nerve roots with decompression of spinal cord (with or without laminectomy)

Cervical

assign one of the following codes from block [46]:

- 40331-01 [46] *Decompression of cervical spinal cord with involvement of roots, 1 level*
- 40332-01 [46] *Decompression of cervical spinal cord with involvement of nerve roots, with anterior fusion, 1 level*

40334-01[46] *Decompression of cervical spinal cord with involvement of nerve roots, ≥2 levels*

40335-01[46] *Decompression of cervical spinal cord with involvement of nerve roots, with anterior fusion, ≥2 levels.*

Thoracic

40345-01 [47] *Decompression of thoracic spinal cord, with involvement of nerve roots, via costotransversectomy*

In some cases it may be necessary to code more than one spinal surgery code to capture the procedures performed, e.g. anterior decompression of high lumbar spinal cord and spinal rhizolysis would be assigned codes:

40351-00 [47] *Anterior decompression of thoracolumbar spinal cord*
AND

40330-00 [49] *Spinal rhizolysis.*

Checklist of important issues for coding from 1 July 1999	
Additional diagnoses	(Errata 6)
Chemotherapy flowchart	(Coding Matters, vol.5 no.4)
Neoplasms – anaemia in	(Coding Matters, vol.6 no.1)
– assignment of primary site versus ‘history of’ codes	(Coding Matters, vol.5 no.4 and Errata 6)
– remission in malignant immunoproliferative diseases and leukaemia	(Coding Matters, vol.6 no.1)
Chronic renal failure with diabetes mellitus	(Coding Matters, vol.5 no.4 & vol.5 no.3)
Retained products of conception	(Errata 6)
Epilepsy	(Errata 6)

DRG Grouping from July 1999

The NCCH is developing standards and codes which are aligned with the most current version of DRGs available, namely AR-DRG v4.1. If your state requires morbidity data grouped in AN-DRG v3.1, any queries you have in relation to grouping should be directed to your state health authority, not to the NCCH. It is very difficult for the NCCH to effect any remedial action for AN-DRG v3.1 as all efforts are focussed towards evaluation of AR-DRG v4.1 in preparation for AR-DRG v5.0. There is no firm date for implementation of AR-DRG v5.0 but it is expected that it could be implemented in about 5 years time.

Questions and answers from the Coding Query Database

The Coding Services Division is working towards a deadline of July 1999 for the content of the second edition of ICD-10-AM. Due to this commitment some delays may be experienced in answering coding queries. I apologise for any inconvenience this may cause but we will do our best to keep the turnaround as short as possible.

▶ **Kerry Innes**
Associate Director



publication issues

Welcome to the new look June issue of *Coding Matters*! I've been reliably informed that a successful 45587-00 [1675] has been performed on this issue – you'll have to work it out. Donna's crossword will help you limber up.

I would also like to welcome and thank our guest contributors to this issue.

Thank you to all who responded to the Readers' Survey. The results of this survey will greatly assist us in preparing a newsletter that meets the specialised needs of our readers. Regardless of formal surveys your comments are always welcome.

Coding Matters via email

Coding matters is available by email to all who would like it delivered in this manner. The benefits include early delivery, saving the life of a tree or two and glorious colour. You can also forward it to anyone who would like a copy.

Coding Matters is sent as an Adobe Acrobat PDF which means it looks the same on screen as it does in print with the additional benefit of a linked contents and the ability to copy and paste sections you're interested in.

If you would like to receive *Coding Matters* by email please send your email details to Chantel Garrett: C.Garrett@cchs.usyd.edu.au

▶ **Rodney Bernard**
Publications and Technology Manager

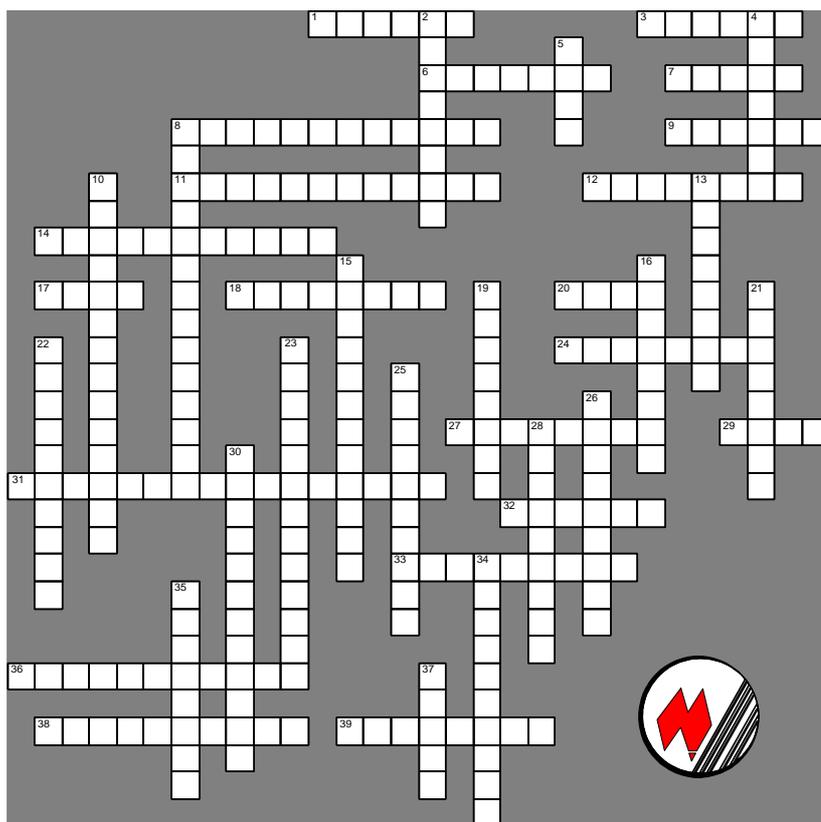
Truran's Teaser No.1

ACROSS

1. G25.5 (6)
3. [411] (6)
6. fetus or newborn injury from vacuum extraction (7)
7. T14.1 (5)
8. 30238-00 (12)
9. T14.9 (6)
11. arterial embolectomy or——(12)
12. praying at the porcelain altar (8)
14. open the window (11)
17. prescription for——(4)
18. R09.0 (8)
20. ——vocal cord J38.2 (4)
24. non-Hodgkin's—— (8)
27. mild mental illness (8)
29. use the sharp end of the stick (4)
31. enlargement of vaginal orifice (7, 9)
32. mycobacterium [A31.8; vol 2 p 238] (6)
33. bringing on by artificial means (9)
36. E06.9 (11)
38. operative approach (10)
39. malignant tumour of skin (8)

DOWN

2. cut it out! (8)
4. result of overexposure on Bondi Beach (7)
5. drinkers disease (Archaic) (4)
8. P50.9 (5,5,4)
10. ——Koch-Week's [H10.0] (14)
13. [1550] (8)
15. testicular dysfunction (12)
16. abnormal growth of tissue (8)
19. it was not on purpose (8)
21. far too sweet (8)
22. unable to read (noun) (10)
23. gall bladder problems (13)



25. suck it out (10)
26. —— of ankle or foot [1528] (9)
28. synonym for 2 down (9)
30. freezing point (12)
34. an imaging technique (10)
35. group of symptoms (8)
37. ——and corruption (5)

The solution to the crossword will be printed next issue.

*For those who cannot wait they can be found on our website.
Crossword created by Donna Truran.*

LIST OF ACRONYMS

Confused by the alphabet soup of acronyms abounding within the health information arena? *Coding Matters* will try to shed some light with a list of some commonly used acronyms.

AACR	Australian Association of Cancer Registries	HIMAA	Health Information Management Association of Australia
ABS	Australian Bureau of Statistics	HIRMAA	Health Insurance Restricted Membership Association of Australia
ACBA	Australian Coding Benchmark Audit	HISA	Health Informatics Society of Australia
ACBHSC	Australian Community Based Health Services Codeset	ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ACCC	Australian Casemix Clinical Committee	ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ACS	Australian Coding Standards	ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ACT	Australian Clinical Thesaurus	ICPC	International Classification of Primary Care
AHA	Australian Healthcare Association	ICPC 2 PLUS	International Classification of Primary Care, 2nd Edition Plus
AHIA	Australian Health Insurance Association	IFHRO	International Federation of Health Records Organizations
AHMAC	Australian Health Ministers' Advisory Council	MBS	Medicare Benefits Schedule
AIHW	Australian Institute of Health and Welfare	MBS-E	Medicare Benefits Schedule-Extended
AIS	Abbreviated Injury Scale	MRA	Medical Record Administrator
AN-DRG	Australian National Diagnosis Related Group	MSRB	Medicare Schedule Review Board
APHA	Australian Private Hospitals Association	NAHCC	National Allied Health Casemix Committee
AR-DRG	Australian Refined Diagnosis Related Group	NCCH	National Centre for Classification in Health
ASCII	American Standard Code for Information Interchange	NDARC	National Drug and Research Centre
ATOT	Australian Thesaurus of Ophthalmic Terminology	NHDC	National Health Data Committee
CAC	Coding Advisory Committee	NHDD	National Health Data Dictionary
CCCG	Clinical Coding and Classification Group	NHIM	National Health Information Model
CCSA	Clinical Coders' Society of Australia	NHIMG	National Health Information Management Group
CEN	Coding Educators Network	NIBAM	National Institution Based Ambulatory Modelling Project
CHID	Community Health Information Development Project	MRN	Medical Record Number
CHIME	Community Health Information Management Enterprise	OH&S	Occupational Health and Safety
CHIM	Community Health Information Model	OTEN	Open Training and Education Network
CHIS	Community Health Information System	PACHSNIM	Primary and Community Health Services National Information Model
CPT	American Medical Association Current Procedural Terminology	PICQ	Performance Indicators for Coding Quality
CSAC	Coding Standards Advisory Committee	PRS	Professional Relativities Study
DRG	Diagnosis Related Group	QUT	Queensland University of Technology
EPR	Electronic Patient Record	WHO	World Health Organization
HIC	Health Insurance Commission	WHO/SEARO	World Health Organization South East Asia Regional Office
HIM	Health Information Management/Manager	WHO/WPRO	World Health Organization Western Pacific Regional Office

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CLINICAL CODERS'
CCSA
SOCIETY OF AUSTRALIA

National Centre for Classification in Health

(in conjunction with Clinical Coders' Society of Australia)



6th Annual Conference

22nd – 24th September 1999
Hotel Grand Chancellor, Hobart, Tasmania

(The conference venue is ideally located right on the waterfront in central Hobart, only a stone's throw from the city and many tourist attractions)

Highlights of Programme:

A pre-conference clinical classification workshop (Masterclass) conducted by members of CCSA will be held on the afternoon of Wednesday 22nd September. Other activities will include the 3M 'Coding & Grouping' User Group Meeting and the CCSA Annual General Meeting.

The keynote speaker will be **Dr Bedirhan Üstün**, Group Leader of the Assessment, Classification & Epidemiology, Social Change and Mental Health division of the World Health Organization (WHO) in Geneva. Dr Üstün will be speaking on the WHO family of classifications and the WHO structures relating to disease classification and the role of collaborating centres.

Two clinical update sessions

- Cardiovascular diseases
- Colorectal surgery

and a variety of other papers relevant to the conference theme.

Social Events:

The Welcome Reception will be held on the evening of the 22nd September at Tasmania's newest attraction, 'Antarctic Adventure', only a short walk from the conference venue. While enjoying a fine selection of Tasmanian food and beverage, delegates will also be able to experience the entertaining, interactive and educational delights of the largest assembly of Antarctic Science in the Southern Hemisphere.

The conference dinner will be held on the evening of the 23rd September at the Elizabeth Pier Function Centre, located in the heart of Sullivans Cove, again

only a short walk from the conference venue. Fine dining will be supplemented by the music of a local bush band allowing delegates to relax and dance the night away.

Flights and Accommodation:

SBT Business Travel Solutions will again be handling all the travel and accommodation requirements for delegates. Reduced rates have been arranged for many flights with the two major airlines and accommodation rates will range from approximately \$97 to \$150 per night.

Cost:

2 day conference	\$450
Pre-conference workshop	\$50
One day registration	\$260

Reduced registration rates will be available for speakers.

Registration:

Registration brochures will be distributed to all readers of *Coding Matters* in early July 1999. Contact the NCCH to ensure you will be on the mailing list to receive a registration brochure.

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