FROM THE DESK OF THE DIRECTOR

The director is slightly overwhelmed with the state of her desk, so this will be a shorter than usual message. At least that is my intention!

Our big news is that 'the books' (ICD-10-AM) are now printed and available for distribution (*see* Order Form). Initial feedback on the book format and presentation has been excellent, so I hope you enjoy using them and tell us their good features as well as any errors or problems you encounter. You will be aware that an errata has been prepared for release in April for use with ICD-10-AM in July 1998 and that this contains new procedure codes resulting from the November 1997 update of The Medicare Benefits Schedule (MBS). The books will be launched following the Coding Standards Advisory Committee Meeting in Sydney on April 16 at Taronga Zoo. They are already selling well, so order early! Congratulations to all NCCH staff who worked on their content and production. It has been a major endeavour and it is most satisfying to have released on schedule this important 'First Edition' of ICD-10-AM, including the first Australian procedure classification (MBS-E).

Staff

Welcome back to Megan Roach, Information Systems Officer, who has returned from a year's study leave in the United States. Angela Abood is filling the Administrative Assistant position while Linda Maleszka is seconded to the Professional Relativity Study (Fiona McManus has returned to live in Darwin).

Education/Publications

Karen Peasley, Acting Education Manager, is working hard to coordinate the ICD-10-AM education program and accompanying education materials. Dr Karen Luxford and her staff in the Publications Division are managing the production and distribution of a new education title, in preparation by the Education Division, *Mastering Ten* (available early May 1998), as well as their work on the specialty booklets, where Christine Erratt (NCCH Executive Officer) is coordinating input to four specialty booklets at once! In regard to these

booklets, we are interested in some consumer feedback on their use and have included a questionnaire in this issue and on 'Code-L' to gauge whether the booklets are meeting users' needs (*see* Publication Issues).

A refresher Train-the-Trainer course for members of the Coding Educators Network (CEN) is planned for 23–24 March 1998. Workshops for clinical coders from the four jurisdictions implementing ICD-10-AM in July 1998 will be held from 20 April to 29 May 1998. These will be run by NCCH with the assistance of CEN members.

NCCH Sydney (Karen Peasley) and NCCH Brisbane (Sue Walker) are joining forces to provide ICD-10-AM training for the New Zealand Ministry of Health during the week commencing 30 March 1998.

Coding Services

The mechanism for updating ICD-10-AM has been considered by the Coding Standards Advisory Committee, the Executive Committee of NCCH and the National Committee for Implementation of ICD-10-AM in Australian Hospitals. One of the most important

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features of the mechanism is that there will be a call for public submissions for changes in February each year. **A copy of the timetable is included in this issue as a separate insert.** The intention of the NCCH is to update ICD-10-AM annually through publication of errata, release of updated ASCII lists as well as complete reprinting of hard copy ICD-10-AM.

You will see from the timetable (*see* insert) that the usual lead time for preparation of a new edition is 17 months to implementation or 12 months to publication. This means that NCCH would normally start preparing a new edition in February of the calendar year before the July implementation. NCCH does not have this lead time post-implementation in July 1998 so is proposing the publication of errata and ASCII lists in April-May 1999 as outlined above. The regular update timetable is organised to accommodate changes to WHO's ICD-10 (see *Coding Matters Vol 4(3)*) and to the Medicare Benefits Schedule.

At present, the NCCH is planning the following update timetable to 2000:

January 1998	First Edition ICD-10-AM
April 1998	First Edition Errata 1 (including new codes)
May 1998	1998 edition of ASCII list (First Edition ICD-10-AM plus Errata 1)
July 1998	First Edition Errata 2 (with *Coding Matters*)
October 1998	First Edition Errata 3 (with *Coding Matters*)
January 1999	First Edition Errata 4 (with *Coding Matters*)
April 1999	First Edition Errata 5 (including new codes)
May 1999	1999 edition of ASCII list (First Edition ICD-10-AM + Errata 1-5)
February 2000	Second Edition ICD-10-AM (Books plus Addenda)

ICD-10/ICD-10-AM UPDATE TIMETABLE — NCCH

Introduction

This timetable follows the processes required to implement changes to ICD-10 for mortality data and ICD-10-AM for morbidity data. Therefore, the timetable incorporates the WHO updating cycle for ICD-10 and the DHFS updating cycle for the Medicare Benefits Schedule.

Recommendations for modification to ICD-10-AM

The NCCH intends to introduce a public notice in February of each year, seeking recommendations for modifications to ICD-10-AM. The criteria for modifying the classification (based on WHO criteria) will be provided to respondents and recommendations will be ratified by the NCCH's Coding Standards Advisory Committee (CSAC) and the Australian Casemix Clinical Committee (ACCC).

Recommendations for modification to ICD-10

Recommendations will be received by the NCCH as part of the public notice for modifications to ICD-10-AM. The Brisbane office of the NCCH will manage the production of an addenda for ICD-10 in consultation with the Australian Bureau of Statistics (ABS). The ABS submits suggestions for changes to ICD-10 as part of the NCCH submission to WHO each March.

Submissions to WHO

Modifications made in ICD-10-AM are sent to WHO in March of each year.

Note: as WHO does not produce a procedure classification, modifications to the ICD-10-AM procedure classification are not submitted to the WHO updating process.

The NCCH/WHO contract in respect to the Australian version of ICD-10 requires that where modifications are necessary, the NCCH effects those modifications at the 5th character level whenever possible. Changes at the 3rd and 4th character level should be made only when absolutely necessary.

This requirement means that the 3rd and 4th character recommendations *may* go through a longer evaluation process through both the NCCH and WHO than do the 5th character changes.

An additional function of the NCCH is the maintenance of ICD-10 codes for mortality coding in Australia. These changes are referred to in the timetable as '*ICD-10 addenda*'.

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12 month cycle of updates

Recommendation for change   **Feb**
Year 1

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NCCH drafts addenda &submits to CCCGs   **Apr**
Year 1

↓

CSAC/ACCC ratify addenda   **Aug**
Year 1

↓

NCCH prepares final addenda   **Sept**
Year 1

↓

New edition of ICD-10-AM published   **Feb**
Year 2

↓

Implementation of new edition   **July**
Year 2

Coding query process

The NCCH is mindful of the need for a responsive query process with implementation of ICD-10-AM. It has requested funding from the Department of Health and Family Services for two additional staff to support queries in ICD-10-AM. Queries for ICD-9-CM will follow the existing mechanism through the State Coding Committees in those states still using ICD-9-CM in 1998–99. An outline of the proposal for managing coding queries is shown in here, in the next column. Implementation of this proposal is contingent on appropriate funding of the NCCH from July 1998. ▶

National Centre For Classification In Health

Proposal for managing ICD-9-CM & ICD-10-AM coding queries from 1998

ICD-9-CM queries

1. The NCCH will support coding queries in ICD-9-CM according to the existing protocol, however, no further changes to the ICD-9-CM classification will be made. Responses to queries will be returned to the enquirer and the appropriate state coding committee. Access to the NCCH query database may be possible through the internet, thereby potentially reducing the number of queries to the NCCH.

ICD-10-AM queries

Preimplementation

2. ICD-10-AM queries generated through the coding workbooks and subsequently, the training sessions in April and May 1998 should be forwarded to the NCCH for advice. If queries are received and answered at a state level, these question and answers should be forwarded to the NCCH to allow distribution to coders nationally.

The NCCH will distribute queries and answers generated from these sources through *Coding Matters*, CSAC members and state coding committees.

Implementation

3. Queries will be accepted at the NCCH directly from clinical coders by fax or through the 'Code-L' listserver from April 1998 until December 1999. This facility is provided due to the anticipated high demand for coding advice with this new classification (please be patient, as although we will be receiving queries pre-July, we will not be funded to do so until post 1 July 1998). This direct contact with the NCCH will alleviate the problem of state coding experts attempting to answer queries on a relatively unfamiliar classification.

4. The NCCH will forward selected queries to the CSAC committee via the Code-Q listserver for advice prior to response and distribution.

5. The NCCH will distribute all queries and answers on a regular basis (with possible internet query database access) to:
* the enquirer
* Coding Educators Network
* each state/territory coding committee
* state/territory Coding Standards Advisory Committee (CSAC) representatives
* Education Centre of the Health Information Management Association of Australia
* Schools of HIM

6. The NCCH will publish selected queries and answers in the NCCH newsletter *Coding Matters*.

Quality Division

The Education Division worked with new members of the Quality Division to plan the 'Quality Matters' Seminar at La Trobe University on January 23 1998. It was a most successful occasion, with 120 delegates attending, mostly from Victoria. Seminar visuals and associated notes presented at the conference have been compiled into a booklet available from NCCH (*see 'Quality Matters'* on Order Form). Professor Stephen Duckett (Dean, Faculty of health Sciences, La Trobe University) launched the *Australian Coding Benchmark Audit*, for which we have just received our first hospital results. Members of the Quality Division are Ms Dianne Williamson (Manager) supported by three part time staff: Ms Irene Kearsey, Ms Catherine Perry and Ms Andrea Groom. Work is proceeding at full tilt on the audit, coding quality indicators, an update of the annotated bibliography of coding audit literature and other issues relating to coding and data quality. As well, the Quality Division is working with other organisations interested in using coded morbidity data to reflect quality of care.

CCCG membership

The newly formed Australian Casemix Clinical Committee is reviewing with NCCH membership of the Clinical Coding and Classification Groups (CCCG). Please see page 19 for Expressions of Interest in clinical coder membership of the CCCGs.

Functional Coding

Discussions were held in February between NCCH and representatives of the Australian Institute of Health and Welfare (AIHW) concerning work being contracted by AIHW on comparison between *ICD-10* and the *International Classification of Impairments, Activities and Participation (ICIDH): A Manual of Dimensions of Disablement and Functioning*. These discussions followed the Functional Coding Forum held by NCCH in July 1997. Other outcomes of the Forum have been consideration by CSAC of the Australian Coding Standard for Rehabilitation and definition of principal diagnosis in rehabilitation which is also to be discussed by the National Health Data Committee. The NCCH is attempting to devise a way of conforming with requirements for coding of rehabilitation episodes for AN-SNAP (The Australian National Sub-Acute and Non-Acute Patient Classification) using the United States UDS (Uniform Data Set) Functional Impairment Codes or by mapping to the Impairment Codes from ICD-10-AM diagnostic codes.

IT/14 Health Informatics - G7 Subcommittee

In February, I attended a meeting called by Standards Australia to meet representatives from the UK of the secretariat of the Enabling Mechanisms Subproject for the Group of Seven Countries (G7) Health Theme Project.

As a result, NCCH was asked to join an e-mail discussion group to prepare a report and recommendations to the Subproject relating to terminology, classification and coding. Nominees from NCCH were Dr Karen Luxford, Dr Erich Schulz and Mrs Sue Walker.

ASERNIP-S

I represent NCCH on the Management Committee of this exciting project of the Royal Australasian College of Surgeons (RACS) launched in Adelaide on 24 February 1998 by the Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Family Services. ASERNIP-S is the 'Australian Safety and Efficacy Register of New Interventional Procedures – Surgical', a three year pilot project funded by the Commonwealth Department of Health and Family Services to establish a systematic and ongoing evaluation and documentation of safety and efficacy of new technologies and surgical techniques as they are being introduced and/or before they are widely accepted in to the Australian health care system. The project is located at the RACS in Adelaide and is headed by Professor Guy Maddern. The NCCH is involved to provide advice on coding and documentation of new procedures and will benefit in early warning of new procedures for inclusion in ICD-10-AM. Other members of the Steering Committee include representatives of the RACS, Project staff, Australasian Cochrane Centre, Consumers Health Forum and Australian Council on Healthcare Standards.

HIANSW

Dr Karen Luxford and I attended the annual conference of the Health Informatics Association of NSW (HIANSW) held in Leura NSW from 28 February–1 March 1998. The excellent program contained many presentations of interest to clinical coders and health information managers in regard to IT applications and coding systems. Victoria Sheldon and Vladimir Stevanovic from the NZ Ministry of Health presented a paper on Quality Improvement of Health Information at the New Zealand Health Information Service, describing a centralised electronic method of audit of coding quality applying edits, Australian Coding Standards and coding quality indicators. Copies of the proceedings are available from HIANSW for $10 (contact HIANSW President, Jo Holman, e-mail: joholman@ozemail.com.au).

See page 6 and the NCCH Hompage for a list of upcoming conferences of interest. I look forward to seeing many of you at these meetings throughout the year.

❖ **Rosemary Roberts**
 Director
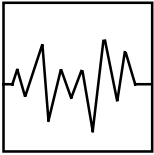
VITAL SIGNS

The job description read.....*"You must be prepared to spend two weeks visiting South-East Asia at the outset of the project"*. Some employers make it so difficult to decide whether to accept a position by imposing such conditions!

However, I bit the bullet and agreed to become involved in a project driven by the World Health Organization's (WHO's) Regional Office in India in which NCCH would develop a Short Course in Medical Record Practice for administrative staff in member states of the South-East Asian Regional Organization (SEARO) - Maldives, Sri Lanka, Bangladesh, Bhutan, Myanmar and Thailand.

The project was outlined in this column in the last issue of *Coding Matters* (Vol. 4 No. 3). I would now like to give a very brief overview of what I saw in the hospitals of Myanmar. My visit was for just 7 days and my itinerary was planned so that I could have an opportunity to visit hospitals of a variety of sizes and facilities, to give me some understanding of current health information systems employed and training needs. I spent the first few days in the capital, Yangon (Rangoon), then travelled north to Upper Myanmar to visit regional and rural hospitals in the Mandalay Division.

The health care system is primarily provided by the State, although some private clinics now also operate and there are currently 724 public hospitals. In 1995, malaria was the leading cause of both morbidity (15.9%) and mortality (20.23%).

All inpatient data is targeted for the national morbidity collection, but outpatient statistics are based on data taken on three specific days of the year (one per season - summer, rainy and winter). Except for Yangon General Hospital, clinical coding (by ICD-9 and now ICD-10) is performed centrally in the Ministry of Health, based on forms submitted monthly by medical record office staff or those with responsibility for medical records.

In general, records of inpatients in Myanmar hospitals are kept separately from those of outpatients unless an attendance leads to admission. Patients hold booklets into which details of health conditions and treatment given are transcribed. English is the written language used in medical records, particularly in doctors' notes, although printing on forms may include both English and Burmese and some contributions, such as observations, may be in the local language.

Serial numbering of medical records by admission (usually on an annual cycle) is most often employed,

and in most cases there is no effort made to link the admissions of a patient. Master patient indexes are rare and the level of technology in use is very low.

Each record is a small, delicate bundle of forms of various sizes and quality of paper which are attached by whatever means are available, sometimes staples but often by a length of tape or string threaded through the top left corner of each page and tied. Records are commonly bundled by date of discharge, again using whatever resources are available, which may even be a length of narrow tubing (similar to that which we usually see attached to IV fluid bags).

The officer in charge of the medical record service has, as a very important aspect of the position, the duty to collect data on patients as well as hospital administrative and operational information for submission to the DHP in Yangon (as part of the national morbidity collection) and for production of the hospital's own annual health profile brochure.

I visited quite a number of hospitals during my stay in Myanmar, from teaching hospitals in Yangon to township hospitals in the centre of the country, in Mandalay Division. They varied considerably in size and facilities. What I found to be consistent was the acute lack of resources available and the great ingenuity and determination employed to overcome it. For example, with office paper often hard come by, medical record forms are printed on locally recycled paper sometimes so thin you could almost see through it. At Yangon General Hospital (YGH), the MRO has carefully used and re-used the same set of medical record folders for decades (with up to 10 patients' records in each, at a time), although this is really for support and protection in the filing bays, not for containing the records when in use!

Clearly, the main purpose for patient medical records in Myanmar has been for communication between participants involved in an episode of care and as a source of data for central statistical purposes. Previous medical records are very rarely requested for later patient care, amounting to 0.84% in 1996 at YGH, which I believe would be higher than at other hospitals. Only a small proportion of records are used for forensic or other medico-legal purposes.

The advantages of increasing the quality and utility of medical records and the need to develop health information systems to serve a range of purposes (in particular, local service management and evaluation of

care) and which can be integrated to form an effective national system is recognised by the Ministry of Health in its *National Health Plan (1996-2001)*. The resources needed to achieve this, such as finances for staffing and stationery requirements, training and technology, to name only some, are enormous. The scope for development in systems and practices to a level that we in Australia are familiar with (and perhaps complain about!) mean that, even with will and determination, it will take a considerable time to achieve. However, I hope it does happen and am pleased that the NCCH will have played a part in facilitating the achievement.

Now that the trekking has finished and the Advisors have returned home, the next step in the project is to develop the course material based on the curriculum we have together established. This is likely to keep us busy for the next few months by which time we will also need to develop a program for enabling representatives from the SEARO countries to administer the course locally. This will involve participants visiting Brisbane for about four weeks, probably in July 1998.

In the next edition of *Coding Matters*, we hope to provide an update of this project, and also my impressions of the health care system and medical record practice in Sri Lanka. Until then.....

❖ **Joy Smith**
   Project Manager, NCCH Brisbane

Forthcoming conferences

● HIC'98. HISA Conference. *Working Together for an Electronic Patient Record*. July 26–28 1998, Carlton Crest Hotel, Brisbane.

● The Tenth Casemix Conference in Australia (in conjunction with the 1998 Annual AHA Conference). *Looking Back, Moving Forward*. 6–9 September 1998. Melbourne Convention Centre, Melbourne.

● NCCH/Clinical Coders' Society of Australia. *The Meeting of Two Centres. Coding in a Rural Setting*. 23–25 September 1998. Rydges Plaza Hotel, Alice Springs.

● 19th Conference of the HIMAA. 21–23 October 1998. Brisbane Convention and Exhibition Centre.

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QUALITY ASSURANCE AT THE CENTRAL CANCER REGISTRY

Last year I had the good fortune to undertake a year long secondment at the NSW Central Cancer Registry (CCR) to develop and implement a quality assurance plan. The eventual outcome of my stay was a series of pilot audits which evaluated the completeness and validity of CCR data, including both internal and external quality control checks. The results and recommendations from these pilots are currently being reviewed by the CCR management.

The NSW CCR was established in 1971 as a population-based cancer registry, with data collection beginning from 1 January, 1972. Hospitals, nursing homes, outpatient departments, radiotherapy departments and day procedure centres notify cases of cancer by completing and mailing a paper form (Schedule 13A) or by providing similar details in electronic format on magnetic tape or DAT tape. Pathology laboratories send copies of their pathology reports of cancer.

The objective of the first pilot study was to evaluate the accuracy of processing of incoming notifications on paper

The objective of the first pilot study was to evaluate the accuracy of processing of incoming notifications on paper. Our initial strategy was to undertake 'blind' reprocessing of paper form registrations at the NSW CCR and to compare the data entered onto the database during reprocessing with that entered at initial processing.

Of more immediate interest is the second pilot audit with the objective of evaluating the accuracy and completeness of data received by the NSW CCR from reporting hospitals in NSW. The validity of registry data depends on the accuracy of the source documents and the level of skill and care applied in abstracting data from them. The accuracy of abstraction of data from source documents is one of the key factors for quality Registry data. Completeness of notification of cases is important to ensure the accurate reporting of cancer incidence and mortality rates within the NSW population.

Our initial strategy was twofold: Part 1 was to undertake 'blind' reabstraction onto paper forms of cases notified from source hospitals and compare them with the original paper form or electronic notifications on file at the NSW CCR; and Part 2 was to determine the level of completeness of cancer notifications from notifying hospitals by searching all possible sources within the hospital for missed notifications. Part 2 was certainly a challenge for the Auditor and a test of her detective skills!

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Results of the pilot reabstraction audit (sample size: 11 hospitals, 597 forms) were as follows:

Data Item	Major Error (%)	Minor Error (%)
Family Name	1.0%	N/A
Given Names	0.2%	6.8%
Sex	0.5%	N/A
Postcode	4.0%	N/A
Date of Birth	0.67%	0.84%
Country of Birth	4.0%	0.2%
Primary Site	6.3%	4.0%
Histological Type	9.5%	1.5%
Method of Diagnosis	15.4%	0.3%
Degree of Spread	32.83%	13.74%

Given Names - the majority of minor errors were due to a missing second name. This was three times more likely to occur if the hospital notified via paper rather than electronically.

Sex - all the errors (3 in number) were due to missing information and all occurred in paper notifying hospitals.

Country of Birth - the majority of errors were due to this information not being present on the 13A form. Paper notifying hospitals had three times as many errors as electronically notifying (EN) hospitals (i.e. 6.0% Vs 2.0%).

Primary Site - Over 50% of all major errors were due to this information not being present. EN hospitals had more than four times as many errors as paper notifying hospitals and the majority of these errors were due to this information not being present. The current electronic Cancer Registration system allows 'forms' to be sent through without a primary site.

Histological type - 28% of all major errors were due to this information not being present. As well, 28% of all major errors were due to the original notifications giving 'Carcinoma NOS' whereas the Auditor was able to ascertain more detail. There also appears to be still some confusion with the abbreviation **SCC - this is to be used for Squamous Cell Carcinoma only** and not Small Cell Carcinoma. EN hospitals had nearly twice as many errors as paper notifying hospitals and the majority of these errors were due to this information not being present. The current electronic Cancer Registration system allows 'forms' to be sent through without an histological type.

Method of Diagnosis - 29.35% of all major errors were due to this information not being present. The Method of Diagnosis options for EN hospitals are Histology 'Yes/No'. If 'No', then it is coded to 'Clinical'. Paper notifying hospitals have the additional option of 'Cytology'. EN hospitals had more than twice as many major errors compared with paper notifying hospitals. 32.31% of the EN errors were due to this information not being present.

Degree of Spread - This data item is not included on the electronic Cancer Registration system but can, in some instances, be extrapolated from the secondary diagnosis codes provided. The EN hospitals had twice as many errors as paper notifying hospitals (i.e. 43.8% Vs 22.0%). 96.92% of EN major errors were due to this information not being present. Of the major errors by paper notifying hospitals, 40.90% were where the original notifier had given 'Not Known' whereas the Auditor was able to ascertain more detail and 13.64% were where the original notifier had given 'Localised to tissue of origin' whereas the Auditor said 'Invasion of Adjacent Organs'. For instance, if the primary site is colon and the pathology report states that the malignancy has invaded through to the pericolic fat then that is regarded as 'Invasion of Adjacent Organs'.

A working party has been formed by NSW Health to review the concerns of both the Registry and users about the quality of information supplied via the current electronic cancer notification system.

❖ **Christine Erratt**
Executive Officer

Coding Educators Network (CEN) members at the Refresher Course held in March 1998. Read more about this course and others on page 11...

QUALITY CONCERNS

The NCCH Quality Division is now up and running! The division was established at the beginning of 1998, following a contractual arrangement between NCCH Sydney and La Trobe University in Melbourne. Division staff, located within the School of Public Health at the Bundoora campus of the University, provide the NCCH with a Melbourne base.

A group of four enthusiastic health information managers have been appointed to work in the Division:

Dianne Williamson	Manager, Quality Division	0.2
Irene Kearsey	Senior Quality Officer	0.5
Andrea Groom	Quality Officer	0.4
Catherine Perry	Quality Officer	0.4

Irene and Dianne have been seconded on a part-time basis from the Department of Human Services (Vic) and La Trobe University respectively. Andrea and Catherine are experienced and accredited clinical coders who are members of the Coding Educators Network (CEN).

The 'Quality Matters' Seminar *(see report on next page)* held on 23 January 1998 was the first major activity of the Division and highlighted the importance of coding quality and introduced the *Australian Coding Benchmark Audit* (ACBA) as a quality improvement tool for hospitals.

Much of the Division's activity over the next few months will focus on providing support and encouragement to hospitals who are interested in using the ACBA. Congratulations to the clinical coders at Northern Hospital (previously PANCH) in Melbourne, Victoria who were the first to provide results of an ACBA audit to the Division. Northern Hospital found ACBA easy to use and intend to repeat the audit process on a monthly basis.

Congratulations to the clinical coders at Northern Hospital (previously PANCH) in Melbourne, Victoria who were the first to provide results of an ACBA audit to the Division.

The Division will be developing a database of results so that national benchmarks based on facility type and casemix can be calculated, enabling participating hospitals to compare their performance. ACBA also provides useful information for hospitals to feedback to clinical coders and clinicians so that individual or system problems which have been identified can be addressed as part of a Continuous Quality Improvement process.

The Division is also developing a set of Coding Quality Indicators which will enable organisations such as NCCH, hospitals and health authorities to evaluate coding quality by targeting specific issues. For example: the use of 'unspecified' codes; unexpected diagnosis and procedure combinations; the use of coding standards and conventions. The indicators could also be of use to software suppliers in the development of system edits and warning messages.

Review of the *Standards for Coding Services* and *Standards for Ethical Coding* are also the responsibility of the Division, and we will be working closely with clinical coders and the Coding Standards Advisory Committee (CSAC) to evaluate the current standards and develop revised editions for publication with the 2nd edition of ICD-10-AM.

The Quality Division is keen to work with clinical coders on these activities and we would be pleased to hear from people interested in participating in focus groups on quality issues.

We can be contacted by......

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❖ **Dianne Williamson**
Manager, Quality Division

'Quality Matters' Seminar Report

We were delighted that over 120 seminar participants were able to attend the half-day *Quality Matters: Coding and Data Quality* seminar held at La Trobe University on 23 January 1998. The title of the Seminar was chosen to reflect the concept that quality coding is important and the large audience representing all Australian states and territories as well as New Zealand demonstrated support for this concept. Participants also represented the interests of hospitals, health authorities, coding educators, registries, the Clinical Coders' Society of Australia, software suppliers, the Australian Institute of Health and Welfare and NCCH.

The papers presented by ten speakers covered the development and implementation of the *Australian Coding Benchmark Audit* (ACBA), the importance of quality data for use in research, funding and planning activities, and other issues relating to coding quality. Copies of the Seminar presentation visuals and notes are available from NCCH (*see* order form).

The Seminar was opened by A/Professor Rosemary Roberts (NCCH Director) who provided us with information on the establishment and role of the Quality Division. Rosemary emphasized the importance of the quality activities of NCCH, the need for credibility of data contributed by clinical coders, and for best use of existing data. Location of the Quality Division within the School of Public Health at La Trobe University would provide a more national focus for NCCH and support a scientific basis for the activities of the Division. The functions of the Division and relationships with external organisations and professionals were also described.

Mr Ric Marshall (Manager, Information & Performance Evaluation, Department of Human Services, Vic) presented a paper which gave a statewide perspective on coding quality issues, emphasizing the importance of accuracy for demographic as well as clinical data to support the functions of planning, research and funding. Activities of the Department to ensure data quality include testing of software used by hospitals to supply data, editing of data received and coding audits.

Three papers presented by Joanne Chicco (Consultant, CSC Healthcare), Natalie McIntosh (Medical Record Manager, Albury Base Hospital) and Dianne Williamson (Manager, NCCH Quality Division) described the development and piloting of ACBA and described the Continuous Quality Improvement philosophy behind the design of the Audit. Joanne emphasized the value of distinguishing between coder errors (such as failure to follow coding conventions) and systems errors (such as supplementary clinical information becoming available after coding had been completed). The processes involved with using ACBA were described by Natalie who supported the development of a national and consistent method hospital based audit. Dianne described the role of the Quality Division in the implementation of ACBA, the development of a database of results, and the potential uses of the national database.

Professor Bill Runciman (Department of Anaesthesia and ICU, Royal Adelaide Hospital) provided a researcher's perspective on coding quality. His work with the monitoring of adverse events was used to illustrate quality issues associated with data collection, coding and analysis. The implications of coding accuracy in hospital morbidity data collections in relation to public health research were discussed by Dr Raina ▶

Professor Stephen Duckett (Dean, Faculty of Health Sciences, La Trobe University) launching the new NCCH Quality Division and the ACBA

Quality Matters Seminar attendees Sharon Gibbons (HIM, The Canberra Hospital), Andrea Groom (now NCCH Quality Officer) and Linda Best (Education Officer, HIMAA)

McIntyre (Public Health Research Fellow, Victorian Infectious Diseases Service). Raina described a project which evaluated data submitted by Victorian hospitals to the Victorian Inpatient Minimum Database and provided an analysis of coding errors and their effect on AN-DRG assignment.

A presentation by Ms Jenny Hargreaves (Head, Patient Morbidity & Services Unit, AIHW) provided an overview of the use of coded clinical data in the presentation of national health statistics. She described the content of the National Hospital Morbidity Database and a variety of projects being undertaken by the Institute using data from hospitals and other sources. The final paper for the Seminar also gave a national perspective on data collection and usage. Ms Rachel Portelli (Project Officer, Care Evaluation Program, Australian Council on Healthcare Standards) described the development of Clinical Indicators and the role of the Care Evaluation Program. A project to explore the usefulness of ICD-9-CM codes to identify clinical indicators was described.

At the close of the seminar, Professor Stephen Duckett (Dean, Faculty of Health Sciences, La Trobe University) spoke on data collection and quality issues and formally launched the *Australian Coding Benchmark Audit*. Over lunch, participants raised their glasses of champagne to celebrate the launch of the ACBA and the establishment of the NCCH Quality Division. The feedback from the Quality Seminar was very positive, with the majority of participants rating the venue and administration as 'very good' and presentation content as useful, informative and relevant. We look forward to receiving more input to and feedback on the work of the NCCH Quality Division in the future. Until next issue!

❖ **Dianne Williamson**
  Manager, Quality Division

Professor Stephen Duckett, Dianne Williamson (Manager, NCCH Quality Division) and A/Professor Rosemary Roberts (NCCH Director) raise their glasses to the new NCCH division at La Trobe University
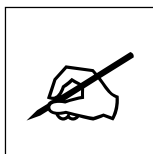
EDUCATIONAL MATTERS

Education for the introduction of ICD-10-AM is in full swing in both Australia and New Zealand.
Planning for the 1998 Conference in the Red Centre is also already well underway!

Educational material

The 'Taste of Ten' educational booklet set has proven to be a very popular publication (we are on our 3rd reprint!) and is being utilised by many health facilities in providing clinical coders with a solid basis of knowledge on ICD-10-AM prior to the NCCH education workshops. The follow up publication 'Mastering Ten: ICD-10-AM Exercise Workbook' has been a little late in production and is now not anticipated to be available until early May 1998. 'Mastering Ten' is highly recommended as an excellent resource for either 'pre-workshop' or 'post-workshop' education, and can be used to re-inforce workshop exercises. The booklet is a combination of points which highlight the major changes between ICD-9-CM and ICD-10-AM and practical exercises and answers (*see* Order Form).

CEN Refresher

On the 23rd and 24th March 1998, thirty three hardy souls spent two days more about ICD-10-AM in preparation for passing this information onto the clinical coders of Australia. Members of the Coding Educators Network (CEN) from New South Wales (NSW), Victoria, Australian Capital Territory (ACT) and Northern Territory (NT) and other invited guests received a refreshing look at ICD-10-AM (diseases & procedures) and the Australian Coding Standards (ACS). This course was based on the format of the upcoming ICD-10-AM educational workshops to enable the CEN members to become familiar with the presentations.

With the ICD-10-AM books having been available for about two months, much discussion ensued about the changes to the clinical classification, the differences (both positive and negative) from ICD-9-CM and the effect that the introduction will have upon the clinical coder workforce. A problem-based learning approach was taken with emphasis on practical exercises and open discussion.

This CEN refresher training course is to be repeated in mid March 1999 for those CEN members who reside in Queensland, Tasmania, South Australia (SA) and Western Australia (WA).

ICD-10-AM Education Workshops

All readers of *Coding Matters* from a public or private health care facility in NSW, Victoria, ACT or NT should have already received a registration form for attendance at the 1998 ICD-10-AM Education Workshops. If not and you are a clinical coder from any of these states/ territories, please contact the NCCH immediately for a registration form (call Angela Abood on ph: 02 93519461).

The workshops are to be held over a two day period commencing on the 20th April, 1998 and concluding on the 29th May 1998. As a lot of information is to be incorporated into a short period of time, the NCCH has

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NCCH staff involved in the CEN Refresher course, from the left, Kerry Innes (Associate Director, Sydney), Judith Hooper (Coding Services Coordinator), Julie Rust (HIM Consultant) and Karen Peasley (A/g Education Manager)

CEN Members with their heads stuck in the books....ICD-10-AM that is!

decided to exclude the majority of the ICD-10-AM background and developmental information from the training and thus to ensure that attendees have an understanding of the theory behind ICD-10-AM, attendees will be expected to be familiar with NCCH education material including:

● Familiarity with the contents of the *ICD-10-AM Implementation Kit* (issued April 1997) **or**

● Completion of one or more of the set of six *'Taste of Ten'* educational booklet series (issued December 1997) **or**

● Completion of *'Mastering Ten'* educational workbook (if available prior to the workshops in early May 1998)

These educational workshops will be repeated in April-May 1999 for the remaining four states, Queensland, Tasmania, SA, and WA. A full report from the workshops will be provided in the July 1998 edition of *Coding Matters*.

Educational material for clinicians and other health professionals

The NCCH is undertaking discussions with various people to develop a package of educational material for clinicians, nursing staff, allied health professionals, public health personnel and epidemiologists on the introduction of ICD-10-AM.

The material will take the form of a booklet which will provide basic information on the introduction of ICD-10-AM along with issues relevant to clinical health professionals and be supplemented by a disk containing a Microsoft Powerpoint presentation which can be used for presenting to clinical staff at meetings and orientation sessions.

NCCH 5th Annual Conference (in conjunction with Clinical Coders' Society of Australia (CCSA))

We are pleased to announce that the NCCH conference (in conjunction with the CCSA) will be held on 23–25th September 1998 at the Rydges Plaza Hotel in Alice Springs. The theme for this years conference is 'The Meeting of Two Centres - Coding in a Rural Setting'.

This year the invited guest speaker is Ms Julie Richards from the Canadian Institute for Health Information (CIHI) who will be presenting on the comparison project that Canada is conducting on ICD-10 (WHO), ICD-10-CM (American version) and ICD-10-AM (Australian version). Julie will also be providing a perspective on clinical coding in Canada.

The conference will be preceded by an optional tour of the Royal Flying Doctor Service base in Alice Springs and a tour of the Alice Springs Hospital. This will be followed by a pre-conference workshop to be conducted by the CCSA.

On the social front, in addition to the traditional cocktail party being held on the Wednesday evening, we will be offering an optional 'bushmans' dinner on the Thursday evening.

A call for papers can be found on page 23 of this edition of *Coding Matters*. Conference registration forms will be included in the July 1998 edition of *Coding Matters*. Any enquires can be directed to Karen Peasley, A/Education Manager on (02) 9351 9648.

We encourage all health professionals to attend the conference as an information sharing and educational venture and to experience the spirit of the Australian outback!

New Zealand ICD-10-AM Education Sessions

The New Zealand Ministry of Health has confirmed that New Zealand will be moving to ICD-10-AM on 1 January 1999, with a window period of implementation from October 1998 to March 1999. To prepare for this implementation, Sue Walker from NCCH (Brisbane) and myself crossed the Tasman in late March to participate in the first of the training for New Zealand. The training was held in Wellington and consisted of a one day session on the 30th March and a three day training session from the 31st March to 2nd April.

The one day session was an overview of the introduction of ICD-10-AM, its development, the structure of the classification, implementation and transition issues, information technology update and the status of the mappings and the grouper. This session was attended by approximately 40 people from the New Zealand Health Information Service (NZHIS) including clinical coders, auditors, programmers, analysts and account managers.

The three day session was a 'train-the-trainer' workshop for a select group of approximately 20 clinical coders and health information managers from across New Zealand. The session covered all areas of the changes between ICD-9-CM and ICD-10-AM (including MBS-E) along with the revised *Australian Coding Standards*. This training was conducted to enable an expert group of trainers to conduct the ICD-10-AM educational workshops throughout New Zealand in August–November 1998.

The training was a very successful venture and continued to strengthen the ties between the NCCH and the NZHIS.

APHA conference presentation

The Australian Private Hospitals Association recently held their annual conference — 'Caring with Skill' 6–9 April 1998 on the Gold Coast. The NCCH was represented by Julie Rust, HIM Consultant, who presented a paper on 'Managing Clinical Data with ICD-10-AM'.

As you read this, most of you from those states and territories implementing ICD-10-AM in 1998, will have already registered for the ICD-10-AM Education Workshops. I trust that those attending will benefit greatly from the workshops and take away increased knowledge and skills and be able to approach the implementation of ICD-10-AM with a little less trepidation and much more enthusiasm.

❖ **Karen Peasley**
   A/g Education Manager

Profiles of Coding Educators Network (CEN) members

Tanya Drake (SA)

In 1993, I graduated from La Trobe University, Victoria, with a of Bachelor Applied Science Medical Record Administration (Honours). Moving interstate appealed to my sense of adventure and I was employed first at the Royal Adelaide Hospital and then as the Coding Manager at the Adelaide Women's & Children's Hospital. Being a relatively new graduate, employment at these teaching hospitals opened my eyes to the intricacies of coding with exposure to trauma, burns, coronary surgery, intensive care, obstetrics, paediatric and gynaecological coding, to name a few.

In 1995, I became an instructor for the Health Information Management Association of Australia (HIMAA) Education Services' Coding Course and commenced in my current position as Regional Health Information Manager Coordinator with the SA Health Commission. In this position, I form part of the Regional Health Information Advisory Service and coordinate the technical work of four Regional HIMs in the provision of advice to 65 country hospitals. Working with a team of HIMs is very rewarding and facilitates a good working environment to enable us to provide advice in the areas of: health information systems and services; medical record management; coding; casemix; accreditation and data quality. At this time, I also took on the role as the State Liaison Officer for the HIMAA Education Services' Coding Course, organising and conducting coding workshops for SA coding students.

In May 1997, I attended the NCCH ICD-10-AM Train-the-Trainer II workshop and joined the CEN. Being a

member of the CEN is an extension of both my current roles and is a means of providing timely and thorough education to the South Australian coder workforce, particularly those in rural locations.

It will be interesting to see other states implement ICD-10-AM, with SA taking on the challenge next year. I'm looking forward to working with a dedicated team of CEN members to make the transition to ICD-10-AM as smooth as possible for clinical coders.

Pauline Strauch (Vic)

I am currently employed by the Department of Human Services, Victoria as the Victorian ICD-10-AM Coordinator. This is a relatively recent appointment, commencing September 1997. Ensuring Victorian coders are well educated in ICD-10-AM is obviously a major focus of my role, so being a member of the Coding Educators Network is a valuable coincidence.

I have performed coding from the commencement of my career in 1989 at the Royal Children's Hospital. In my last year at the Children's, I coordinated the coding function and was a member of the Victorian ICD Coding Committee. In 1993, I left Australia to travel Europe and a little to my surprise, ended up working as the Coding Manager at a large London hospital. England were, at that time, still using ICD-9, however, in April 1995 we implemented ICD-10. It was quite an experience to take a step back and then a step forward within the space of 18 months. I was responsible for training my coding staff in ICD-10, a task we spread over 3–4 months, for 4 hours per week. I also trained a clincial coder from scratch as there was no English equivalent of a HIM course and most coders were trained on the job. This took about 6 months. I really enjoyed doing the training and took much pride in the achievements of my 'students'. Upon returning to

Australia, I took up the position of Coding Coordinator at The Alfred. Here, again, I was responsible for the education of the coding staff, particularly new graduate coders.

Finding training in coding enjoyable and challenging, and feeling an urge to contribute, lead me to join the Coding Educators Network. I look forward to participating in the ICD-10-AM Workshops in April/May 1998 and the implementation in July, which will be very hard work but a great challenge for clinical coders.

Lynn Lehmann (NSW)

After holding various positions in the hospital system ranging from Nursing to Accounts, I decided to venture

into the field of medical records. I completed the Medical Records Practice (Clerical) course in 1989 and commenced my new career in 1990 at the Health Statistics Collection Unit with the NSW Department of Health, Sydney. After commuting to Sydney from Newcastle every day, I breathed a sigh of relief when I was accepted as the first clinical coder at the newly opened John Hunter Hospital in Newcastle. During my time there, I became experienced in coding cardiac surgery, obstetrics, neonatology and paediatrics to name a few specialities. I was also fortunate to be involved in a number of projects such as the 'Paediatric Coding: Getting it Right' booklet. I am currently employed at Maitland and Kurri Kurri hospitals. As a Coding Instructor with the HIMAA Distance Education course from 1993 the natural progression was to join the Coding Educators Network in 1996. I am on the board of the Clinical Coders' Society of Australia (CCSA) and the editor of 'Codelink', the CCSA newsletter. Participation in the Dual Coding Study gave me a 'taste of ten' and I look forward to meeting the challenge and imparting the knowledge I gain to other clinical coders. I must be a frustrated teacher!

A Taste of Ten

E R R A T A

'COMMON MEDICAL CONDITIONS' BOOKLET

p6		**Example**	

Patient was admitted with left sided hemiplegia and aphasia. Investigations revealed an intracerebral haemorrhage within the cerebellum.

Principal diagnosis:	Intracerebral haemorrhage in cerebellum	I61.4
Other diagnoses:	Hemiplegia	G81.9
Revise	Aphasia	R47.0

p14 **3. PNEUMONIA**

Clinical background

Add The inflammatory process may involve all or part of a lobe; all or parts of more than one lobe; and lobes in different lungs. Note that pneumonia described as 'lower lobe' does not necessary mean that the pneumonia is 'lobar'.

Revise **Lobar pneumonia** means consolidation of the **entire** lobe ~~in any of the five lobes of the lung,~~ and is **rarely** seen. However, the term 'lobar' may be used loosely to mean involvement of part of a lobe/s.

Structural changes in ICD-10-AM

Revise In ICD-9-CM, a diagnosis of lobar pneumonia with no further specification would lead to a code of pneumococcal pneumonia. In ICD-10-AM, ~~it has been included under category J18 *Pneumonia, organism unspecified* as code J18.1 *Lobar pneumonia, unspecified*~~ this term should be clarified with the clinician before assignment of code J18.1 *Lobar pneumonia, unspecified*.

Classification (*see also* ACS 1004 PNEUMONIA)

Delete ~~If an organism is not identified for lobar pneumonia, assign code J18.9 Pneumonia, unspecified.~~

'OBSTETRICS' BOOKLET

p18 *Delete* ~~**Delusions** (paranoid) - *see* Disorder, delusional~~
~~**Labium leporinum** (*see also* Celft, lip) Q36.9~~

Add **Hypertension, hypertensive** (accelerated) (benign) (essential) (idiopathic)
(malignant) (primary) (systemic)
- complicating pregnancy, childbirth or puerperium O16
- - with
- - - albuminuria (and oedema) (*see also* Pre-eclampsia) O14.9
- - - - severe O14.1
- - - heart disease O10.1
- - - - and renal disease, pre-existing O10.3
- - - oedema (mild) (*see also* Pre-eclampsia)
- - - - severe O14.1
- - - renal disease, pre-existing O10.2
- - affecting fetus or newborn P00.0
- - essential (benign), pre-existing O10.0
- - - with superimposed proteinuria O11
- - - malignant, pre-existing O10.0
- - malignant, pre-existing O10.0
- - - with superimposed proteinuria O11
- - pre-existing O10.9
- - - with superimposed proteinuria O11
- - - malignant O10.0

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- - pregnancy-induced O13
- - secondary to renal disease, pre-existing O10.4
- - transient O16
- due to
- - endocrine disorders I15.2
- - pheochromocytoma I15.2
- - renal disorders NEC I15.1
- - - arterial I15.0
- - renovascular disorders I15.0
- - specified disease NEC I15.8
- encephalopathy I67.4
- gestational (pregnancy-induced) *see also* Hypertension, complicating pregnancy) O13

p40	*Revise*	**3.**	O13 look up hypertension, complicating pregnancy, childbirth or puerperium, pregnancy-induced

'PROCEDURES' BOOKLET

p36	*Revise*	**8**	Procedures: Left internal mammary artery to left anterior descending Saphenous vein to 1st diagonal
	Revise	**9**	48 year old male... Risk factors included high cholesterol.

p41

Insertion
- electrode(s)
- - heart (cardiac)
- - - temporary

Delete	- - - - transvenous
Delete	- - - - - atrium 38256-00 **[647]**
Delete	- - - - - - with ventricle 38256-02 **[647]**
Delete	- - - - - dual chamber 38256-02 **[647]**
Delete	- - - - - ventricle 38256-01 **[647]**
Delete	- - - - - - with atrium 38256-02 **[647]**
Delete	- - intracranial - *see also* Insertion, neurostimulator, intracranial
Delete	- - - for epilepsy, via
Delete	- - - - burr holes 40709-00 **[26]**
Delete	- - - - craniotomy 40712-00 **[26]**
Delete	- - scalp (fetal) 16514-00 **[1341]**
Delete	- - spinal - *see* Insertion, electrodes, epidural
	- electromagnetic hearing device 41557-02 **[321]**
Add	- pacemaker
Add	- - cardiac
Add	- - - permanent 38253-00 **[652]**
Add	- - - - dual chambered device
Add	- - - - - DDD 38253-10 **[651]**
Add	- - - - - DVI 38253-09 **[651]**
Add	- - - - - VAT 38253-07 **[651]**
Add	- - - - - VDD 38253-08 **[651]**
Add	- - - - single chambered device
Add	- - - - - AAI 38253-05 **[650]**
Add	- - - - - AAT 38253-06 **[650]**
Add	- - - - - AOO 38253-04 **[650]**
Add	- - - - - VOO 38253-01 **[650]**

p64	*Revise*	**4.**	90664-05 **[1625]**	look up *excision...*
	Revise	**5.**	95153-02 **[2067]**	look up *physiotherapy, evaluation*
	Revise	**6.**	34509-01 **[765]**	look up *formation...*
	Add	**11.**	38253-10 **[651]**	look up *insertion... cardiac, permanent, dual chambered device, DDD*
	Add		38259-00 **[648]**	look up *insertion... transvenous, dual chamber*
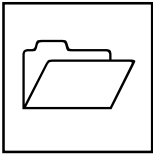
CODING SERVICES

Errata, addenda, addenda, errata.......all is made clear!! Plus a sneak preview of a topic from of the upcoming NCCH 'Orthopaedics' casemix and clinical coding specialty booklet.....

Coding in postnatal care centres

Angela Randall, a Health Information Manager from Victoria, is embarking on a Masters of Public Health. Her thesis will be on a standardised classification system for early parenting centres such as Tressillian, Karitane, etc. The services of such centres have traditionally been difficult to code, due to the nature of the care and also the fact that often the mother, father, baby and siblings can be admitted into these centres. We wish Angela well and will keep our readers informed about the outcome of Angela's work.

The updating process for ICD-10-AM

The NCCH has produced a draft updating timeline for ICD-10-AM (*see* insert). Part of this draft policy is a process whereby members of the public may submit recommendations for modification to ICD-10-AM. Key organisations and individuals with an interest in the classification will be targeted by the NCCH to make submissions. This opportunity to suggest modifications to ICD-10-AM will be available to anyone, beginning in February 1999. Although no draft document is available as yet, the system will be similar to that of the USA, the key features being:

•The NCCH will issue an official notice by way of a press release, providing an overview of the centre and its functions, with contact details for those wishing to submit a suggested modification.

• Those wishing to make a submission will be provided with documentation describing the criteria for changing a classification to ensure that their submission proposes a modification which is consistent with the structure and intention of ICD-10-AM.

• The NCCH will evaluate each submission against the established criteria in conjunction with clinicians and clinical coders from the Clinical Coding and Classification Groups (CCCGs) and relevant organisations and specialists as appropriate. Some things to consider when making a submission are that:

• each code has a unique definition

• the concept is clinically current and relevant

• the terminology used is meaningful

• the hierarchical structure of the classification is maintained

• the modification is justified because advances in medical knowledge or surgical techniques has made the code assignments outdated

• a current code is lacking necessary specificity

Questions to consider when making a submission include:

• Is the problem identified due to lack of knowledge of the classification rather than the classification itself?

• Is the proposed modification due to a need for information about a rare or unique concept?

• Is the problem experienced with the classification a result of data collection methods rather than the classification itself?

Please note that this preview of the updating process is provided for those readers who may wish to make a submission in February 1999. This forewarning will provide ample time for some initial thoughts about ICD-10-AM and preparation of a submission if desired.

ICD-10-AM — the *errata* and *addenda* — what are they?

Traditionally, these two documents are different in that an errata generally includes corrections of errors of a typographical nature and an addenda includes many types of changes, in particular new and deleted codes. The NCCH has blended the content of these two types of documents and now provides, below, a description of how the **errata** and **addenda** are used in the updating process of ICD-10-AM:

An **errata** has been produced for the first edition of ICD-10-AM which includes both corrections of typographical errors and also revised codes, code descriptors, inclusion/exclusion notes and coding standards. Because the errata now contains both typographical as well as code changes, an errata is distinguished from an addenda by the fact that ***the content of the errata must be added to the coding books to make them current.*** (e.g. *ICD-10-AM Errata 1 (April 1998)* contains material arising from new codes introduced by WHO, MBS and NCCH as well as typographical errors).

An **addenda** contains similar information to an errata but the difference is that *the content of an addenda is that which is to be included in the next edition of the classification* (e.g. the new information contained in a 2nd edition publication).

Coding Tips

In this edition of 'Coding Tips', we give you a sneak preview of the upcoming 'Orthopaedics' casemix and clinical coding specialty booklet.

Rotator cuff injuries and repair

Clinica background

Tears and rupture
The 'rotator cuff' refers to an amalgamated structure composed of four tendons (supraspinatus, infraspinatus, subscapularis and teres minor) and the superior portion of the shoulder joint capsule. Most orthopaedic and upper limb surgeons consider 'rotator cuff' to refer mainly to the four tendons running over the top of the shoulder capsule and inserting into the greater tuberosity of the humerus.

In older patients, most rotator cuff tears are degenerative in nature and are not associated with instability or injury (although both these conditions may cause rotator cuff tears). In younger patients, they usually follow severe trauma (including injuries of the shoulder without fracture or dislocation, anterior glenohumeral dislocation, and fracture dislocation) or chronic overuse syndromes.

Rotator cuff rupture is synonymous with rotator cuff tear. Rotator cuff tears can be either partial or full thickness tears.

1. Partial tears are either intratendinous or on the under surface of the rotator cuff tendons.

2. Full thickness tears expose the humeral head. The supraspinatus tendon is most commonly torn while the subscapularis is rarely torn.

Conservative treatment of rotator cuff tear, including physiotherapy and exercise, is usually attempted first. However, if conservative treatment fails, treatment by surgery (including acromioplasty, bursectomy or tendon repair) may be beneficial. The major indications for surgery, besides failure to improve with conservative treatment, are pain and persistent functional disability.

Rotator cuff syndrome
Rotator cuff syndrome is a diagnosis used when the patient presents with symptoms relating to a rotator cuff tear/rupture, however, there may be no other evidence to indicate that a tear has occurred. The syndrome may also be due to subacromial bursitis which often accompanies rotator cuff degeneration. The principal clinical feature is a painful arc on abduction.

Coding pointers

The ICD classification differentiates rotator cuff according to a 'traumatic' or 'nontraumatic' axis. Therefore, partial (incomplete) and full-thickness (complete) descriptions will not be reflected by different codes.

ICD-9-CM
With a diagnosis of rotator cuff syndrome, the operation sheet should be checked to see if a tear was found, and if so, code to tear (either 727.61 or 840.4, nontraumatic and traumatic respectively). If no definite diagnosis can be obtained from the operation sheet, code to 726.10 *Disorders of bursae and tendons in shoulder region, unspecified.* The same coding principle applies to a diagnosis of supraspinatus syndrome.

727.61 *Complete rupture of rotator cuff* should be assigned for rotator cuff tear (partial or full-thickness) of nontraumatic origin.

840.4 *Sprains and strains of rotator cuff (capsule)* should be assigned for rotator cuff tear (partial or full-thickness) of traumatic origin.

726.10 *Disorders of bursae and tendons in shoulder region, unspecified* should be assigned for a diagnosis of 'Rotator cuff syndrome' or 'Supraspinatus syndrome'.

ICD-10-AM
With a diagnosis of rotator cuff syndrome, the operation sheet should be checked to see if a tear was found, and if so, code to tear (either M75.1 or S46.0, nontraumatic and traumatic respectively). If no definite diagnosis can be obtained from the operation sheet, code to M75.1. The same coding principle applies to a diagnosis of supraspinatus syndrome.

M75.1 *Rotator cuff syndrome* should be assigned for:
- *rotator cuff tear of nontraumatic origin*
- *rotator cuff syndrome*
- *supraspinatus syndrome*

S46.0 *Injury of tendon of the rotator cuff of shoulder* should be assigned for rotator cuff tear (partial or full-thickness) of traumatic origin.

S43.4 *Sprain and strain of shoulder joint* should be assigned only when the rotator cuff injury is stated to involve the 'shoulder capsule only'.

❖ **Kerry Innes**
    Associate Director (Sydney)

EXPRESSIONS OF INTEREST

CLINICAL CODERS

The Australian Casemix Clinical Committee (ACCC) and the National Centre for Classification in Health (NCCH) are looking for interested clinical coders to provide expert clinical coding advice to the ACCC and NCCH through the newly reformed Clinical Coding and Classification Groups (CCCGs). Your advice would provide input into decisions on new codes, coding impact and DRG refinement and coding standards development.

The CCCGs comprise the following specialties:

- Anaesthesia and Intensive Care
- Cardiovascular
- Endocrinology
- Gastroenterology & Hepatobiliary
- Injury
- Mental Health, Drugs and Alcohol
- Neurosciences
- Obstetrics and Gynaecology
- Ophthalmology
- Paediatrics
- Respiratory

- Burns
- Dermatology
- Ear, Nose, Mouth and Throat (ENMT)
- Geriatrics and Rehabilitation
- Immunology, Rheumatology and Infectious Diseases
- Nephrology and Urology
- Neonatology
- Oncology and Haematology
- Orthopaedics
- Plastic Surgery

The CCCG Terms of Reference are:

❶ To make recommendations to the ACCC on modifications to Australian casemix classifications (such as AR-DRGs). Such recommendations to be based on clinical evaluation following consideration by the clinical professions.

❷ To provide clinical input to and make recommendations to the ACCC concerning developmental work on new casemix classifications (such as ambulatory, sub-/non-acute and mental health classifications).

❸ To provide clinical input to the NCCH on coding matters (such as ICD-10-AM and the coding specialty booklets).

❹ To assist the NCCH in relation to issues that relate directly or indirectly to the development and implementation of classification systems.

❺ To liaise with other specialty CCCGs concerning matters where appropriate.

❻ The CCCG's should end their term at the end of the ACCC term (i.e. April 2000).

The clinician members of the CCCGs are being organised through the ACCC.

The NCCH invites nominations from interested clinical coders with good communication skills and one or more of the following qualifications:

- an accredited coder; or
- meet the criteria for the Health Information Management Association of Australia's Clinical Coder National Competency Standards; or
- be a Coding Educators Network (CEN) member; or
- have three or more years of hands on experience in clinical coding in the specialty area(s) nominated.

Please send your resume, including your area(s) of clinical coding expertise, by **Friday 22nd May 1998**, to:

Ms Kerry Innes fax: 02 9351 9603
Coding Services Manager email: k.innes@cchs.usyd.edu.au
NCCH (Sydney)
PO Box 170 LIDCOMBE NSW 2141
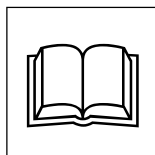
PUBLICATION ISSUES

ICD-10-AM: the books, the bookset box, the errata, the launch! Victorian HIM students have given us positive feedback on our Homepage and now we ask you to provide us with your thoughts on the *Casemix, DRGs and Clinical Coding* booklet series..........

ICD-10-AM

By now most readers who have placed orders will have received their ICD-10-AM books. Thank you to those who have sent in words of congratulations, they are greatly appreciated by the NCCH staff who have devoted much time (sweat & tears) to making this new publication possible. Damian Hanrahan (NCCH Infomation Systems Officer) has been in a whirl wind of activity aiming to process the hundreds of orders that flooded into the NCCH (Sydney) as quickly as possible in the last few months. Thanks to Damian! Apologies to customers who have experienced any delays.

ICD-10-AM Bookset Box

The NCCH has just released another new product, a custom-made, open-faced box specifically designed for the upright storage/display of your five volume ICD-10-AM bookset. Display your books on your desktop or book shelf! We have designed this box to assist you with displaying your bookset conveniently in an upright position. This new ICD-10-AM product will be available in late April (*see* Order Form).

ICD-10-AM Errata 1 (April 1998)

The first Errata for ICD-10-AM was released in early April 1998 and one copy sent free of charge to each purchasing organisation/individual who had to date purchased ICD-10-AM. The changes in this Errata can be added to your books immediately, ready for implementation. Thanks to Chantel Garrett for a lovely job on the Errata production and for preparing an additional 17 typeset pages for large replacement sections that can just be pasted straight into your books. I am assured by NCCH Coding Services staff that Errata 2 will be nowhere near as large!

ICD-10-AM Book Launch

As this edition of *Coding Matters* goes to press, we are preparing for the much awaited ICD-10-AM Book Launch to be held on 16 April 1998. The launch will be at the function centre at Taronga Zoo, Sydney, with the guest speaker of the evening being Dr John Holmes (Chair, ICD-10 Implementation Committee and Director, Professional Services Review). We look forward to raising our champagne glasses to celebrate the arrival of a new classification after several years of preparation!

NCCH Homepage

The NCCH Homepage is constantly being updated by Chantel Garrett and we were most gratified that it was voted by Victorian Health Information Management students as the site most useful to students and health information managers [Gill K, Wischer J (1997). *Helpful Internet sites for HIMs*. Health Information Management;27(3):137-141]. *Coding Matters* can now also be downloaded directly from the homepage!We shall try to maintain the standard and introduce new features as often as possible (http://www.cchs.usyd.edu.au/NCCH/ncch.html).

Welcome back Megan Roach

A warm welcome back to Megan Roach (NCCH Information Systems Officer) from one year's leave during which she studied (and travelled!) in the USA. Once more, the sound of Megan's laughter echos throught the NCCH (Sydney) offices! Megan is currently responsible, amongst other things, for database design and IT trouble shooting. She is assisting the NCCH Quality Division with the development of databases for the performance indicators for coding quality. Maybe Megan 'Stargazer' will also return to the pages of *Coding Matters*....who knows....

Specialty Booklet Customer Questionnaire

We are currently conducting a survey of customers of the NCCH booklet publication series *Casemix, DRGs and Clinical Coding* to investigate the uses of these educational booklets.We will be sending out questionnaires directly to customers and posting the questions on 'Code-L'. We have also included a copy of the questionnaire here on page 21. If you have encountered these booklets, we would greatly appreciate your feedback as it will help us to refine and appropriately market this series. You can photocopy the questionnaire page and fax it back to us on: 02 9351 9603.

❖ **Karen Luxford**
  Publications Manager

Specialty Booklet Questionnaire

H ere is your opportunity to provide us with feedback on the NCCH booklet series *Casemix, DRGs and Clinical Coding*. And have a chance to **win the next four booklets in the series** at the same time.

Just fill out this questionnaire (photocopy the page first) and fax it back to us on fax: **02 9351 9603** or mail to: NCCH, PO Box 170, Lidcombe NSW 2141. We will also be conducting a direct mail out to booklet customers as well as posting the questionnaire on 'Code-L'. One respondent will be drawn at random and will receive a copy of the next four booklets in the series when available. Entries should be returned by 8 May 1998, and the winner will be announced in the July issue of *Coding Matters*.

Questions: (tick a box to indicate your response)

Which booklets have you purchased? (tick as many as apply)

☐ Respiratory Medicine & Thoracic Surgery   ☐ Oncology & Haematology

☐ Geriatric Medicine   ☐ Cardiovascular Medicine & Surgery

When you purchased the booklets, who did you intend for them to be used by? (tick as many as apply)

☐ clinical coders/HIMs   ☐ senior managers/CEO

☐ clinicians   ☐ academics/lecturers

☐ casemix coordinators   ☐ others: _____

Are the booklets used for any of the following? (tick as many as apply)

☐ coder education   ☐ senior management education

☐ clinician education   ☐ student education

☐ administrative staff education (e.g. finance)   ☐ other: _____

Are the booklets used:

☐ in education courses?   ☐ meetings?   ☐ induction/intern sessions?   ☐ by individuals?

How useful have users found the information contained in the *Casemix, DRGs & Clinical Coding* booklets?

☐ Very useful   ☐ Useful   ☐ Somewhat useful   ☐ Not at all useful

Which booklet section have users found the most helpful? (tick as many as apply)

☐ Parts I–III: Casemix & coding introduction   ☐ Part IV: Common problem areas in documentation & coding

☐ Part V: Important DRG information

Which of the upcoming booklets will you purchase? (tick as many as apply)

☐ Orthopaedics   ☐ Injury   ☐ General Medicine   ☐ General Surgery

Do you have any general comments on the booklet series *Casemix, DRGs and Clinical Coding?*:

_____

_____

If you wish to enter in the competition for the next four *Casemix, DRGs and Clinical Coding* booklets, enter your details below (your comments remain confidential):

Name: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone: _____ Fax: _____

Postcard from Singapore

Singapore is designed for consumers – and I'm not just talking satay sticks! The city's services are efficient, its goods are convenient, and they keep the place so clean. Now Singaporeans and permanent residents also have the opportunity to create their own 'convenient' medical record on the Internet, making their clinical history available for reference by clinicians anywhere in the world, at any time. With the patient's consent of course.

Virtual records

The Virtual Medical Record (VMR) is a web-based repository for personal medical records, which may include immunisation and surgical histories, medication and allergy records, and progress notes entered by treating clinicians. Laboratory test results and clinical images may also be stored. One megabyte of storage space is initially available to each VMR user, and further space may be purchased as required.

VMR has been developed by Health Online, a subsidiary of the company that publishes the pharmacological bible, MIMS, with the collaboration of a local insurance company. It is one project in Health Online's series of web-based information services, which also includes CyberPharm, where over-the-counter pharmacy products can be ordered for home delivery, and the bilingual Traditional Chinese Medicine website.

The VMR service is available to the public via CD-ROM or the company's website, and is free to the insurance company's policy-holders. Each registrant must provide their name and identity card number (only Singaporeans and permanent residents have identity cards) then choose a password five to eight characters long. Virtual forms are provided for the user to complete and add to their 'folder'. It is recommended that the information be checked by, or entered with the assistance of, the treating clinician. The user may copy their forms to disk for their own reference.

Privacy and access

Medical records are only accessible using a smart card and the user's password. Clinicians who register with Health Online are issued with digital certificates, passwords, smart cards and a smart card reader. Digital certificates and smart cards are designed to verify the identity of each clinician, and will provide them with an identifying 'electronic signature' for all online activities, including VMR.

When a VMR user visits a doctor taking part in the project – participation is indicated by a sticker displayed at the clinic – the patient consents to the access of their online record by keying in their own password.

If the user forgets or loses their password, they must apply for a new one in person with their identity card or passport.

Several factors make the regulation of access to records and the enforcement of privacy easier to achieve in Singapore than, say, Australia. Not the least is the universal issuing of identity cards to nationals, which document all personal details and include a unique identifying number, photograph and barcode. The size of the population and the number of practitioners, as well as the use of smart cards and passwords, also contribute.

End of the paper record?

This web-based medical record is in a basic form, and is intended as a quick reference tool to support, not replace, the traditional paper record. For example, only the most relevant medical images would be stored in the user's VMR, in order to save storage space. VMR is a framework for data storage onto which, according to the developing company, more sophisticated tools (such as keyword searches) may be grafted in the future.

General practice and private clinics are the targeted settings at present, but a move into the hospital setting may be viable within a year of the launch.

Clinical coding, however, does not appear to be a feature of the Singaporean VMR......... yet.

For more information

To find out more about VMR and related projects, try these websites: http://www.vmr.org/

and http://www.hol.com.sg

❖ **Simone Lewis**
 Roving NCCH Correspondent
 & Ex-Publications Assistant

National Centre for Classification in Health
(in conjunction with Clinical Coders' Society of Australia)
5th Annual Conference

23–25 September 1998
Rydges Plaza Hotel,
Alice Springs, Northern Territory

Initial Announcement

A pre-conference workshop/forum will be held on the Wednesday along with an optional tour of the Royal Flying Doctor Service and Alice Springs Hospital.

Venue: The Plaza Hotel is located approximately five minutes by car or twenty minutes by foot from Alice Springs town centre and backs onto the Alice Springs Golf Course. Alice Springs is a central venue for touring the surrounding outback in the Northern Territory.

Theme: 'The Meeting of Two Centres - Coding in a Rural Setting'

Cost: The cost for attendance at the conference will range between $315–$380 dependent upon the number of days attendance and optional tours chosen.

Sponsorship: The conference organiser is pleased to invite interested parties to participate as sponsors for the conference. If you or your organisation would like to be involved in sponsorship, an information package is available upon request. Contact Karen Peasley for further information.

Registration: Brochures will be distributed in July 1998.

Contact:

Ms Karen Peasley, Conference Organiser

A/Education Manager, NCCH (Sydney)

PO Box 170, Lidcombe NSW 2141

Ph: (02) 9351 9461

Fax: (02) 9351 9603

Email: k.peasley@cchs.usyd.edu.au

Call for Papers

The NCCH and CCSA invites prospective participants to submit abstracts for presentation at their 5th Annual Conference. Abstracts from clinical coders, health information managers and readers of *Coding Matters*, which address the theme 'Coding in a Rural Setting' are most welcome.

Authors may wish to focus their paper on:
● Issues for isolated (rural and solitary) health professionals
● Innovations in communications for rural health settings
● Differences in the clinical classification role in rural and urban health settings
● Working with a new classification
● Developments in community health, mental health and rehabilitation classifications
● Clinical coders working in a varied environment

Papers will be selected on their relevance to the conference theme and their written clarity. Guidelines for those wishing to submit an abstract are as follows:
1. Please provide two copies of a typed abstract of the paper (maximum of 500 words).
2. The abstract should include the title of the paper, the author's name/presenter's name, title, position and organisation.
3. Provide abstract in a formatted copy (saved in Word 6 format onto an IBM formatted disk and labelled with author's name and organisation) or as an email attachment to address below.
4. More than one abstract may be submitted.
5. Abstracts should be submitted **before 15th May 1998**:
Ms Karen Peasley - A/g Education Manager
NCCH (Sydney)
PO Box 170, Lidcombe NSW 2141
or Email: k.peasley@cchs.usyd.edu.au

Authors of the abstracts will be notified in writing of the acceptance or otherwise of papers. The decision on acceptance of papers will be at the discretion of the NCCH.

For further information please contact Karen Peasely at the address above or:

Phone: (02) 9351 9461
Fax: (02) 9351 9603
Email: k.peasley@cchs.usyd.edu.au

ICD-10-AM *Bookset Display Box*

The NCCH is pleased to announce the release of a new product......the ***ICD-10-AM Bookset Display Box***.....a convenient custom-made box designed specifically for your ICD-10-AM bookset. Use the box to store or display your coding books on your desk or bookshelf.

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For only **A$25***

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See the **Order Form** *in this issue.*