Coding *Matters*

FROM THE DESK OF THE DIRECTOR

With the results of the National Coder Workforce Issues Project (NCWIP) coder questionnaire recently analysed, I now know that I am addressing about 1,000 clinical coders with every issue of *Coding Matters*. Our distribution is actually over 3,800, an indication of the number of non-coders interested enough to want to know more about the coding world! It is a great advance to have an understanding of the size of the clinical coder workforce, and of the many details describing issues for coders provided through your completion of the NCWIP questionnaires. The NCWIP project team is to be congratulated for their efforts in the analysis of the questionnaire which has added substantially to our knowledge of the coder workforce. The National Coding Centre (NCC) is represented on the NCWIP Competency Project and continues its input through Janelle Craig (Coding Education Manager) to the NCWIP Education Strategy and preparation of coders for accreditation.

Also worthy of note is the inaugural meeting of the establishment committee of the Clinical Coders Society of Australia (CCSA). This meeting, called by the Health Information Management Association of Australia (HIMAA) and chaired by Janelle Craig, was held in Sydney on 28 August 1995 with representation from coders in all states and territories. It was an honour to be involved in such an historic occasion - I know how strongly coders have felt about the need for such a group, and the Establishment Committee will work with HIMAA to ensure that CCSA has a solid foundation and maintains its grassroots focus.

Since our last issue in July, the NCC has held its Second Annual Seminar in the Senate Chamber of Old Parliament House, Canberra (8 - 9 September 1995). We were overwhelmed with the response

Coding Tips
on pages 11 - 12

and delighted that so many coders find our seminar a useful forum for education and enjoyment. Janelle Craig is to be congratulated for once again organising such a successful gathering and our thanks to all those who contributed by presenting, chairing and taking part in discussion.

Another Canberra gathering was the first meeting of the National Committee for the Implementation of ICD-10 in Hospitals on 29 August 1995. The group, chaired by Dr. John Holmes (Director, Professional Services Review) and member of the Australian Casemix Clinical Committee (ACCC), includes representatives of the Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), National Reference Centre for

IN THIS ISSUE

Classification in Health (NRCCH), HIMAA, Private Sector Casemix Unit (PSCU), Department of Human Services and Health (DHSH) (Classification and Payments Branch, Medicare Benefits Branch), state health authorities (Queensland and Victoria) as well as the NCC. The role of the committee is to oversee the introduction of ICD-10 and a companion procedure classification by 1 July 1998 and to guide the NCC in planning for the implementation of the new classifications, including education of coders. It will report progress to the NCC Management Committee, DHSH, AIHW and ABS and ensure system links between the use of ICD-10 for morbidity and mortality as well as monitoring the change-over in statistical reporting from ICD-9-CM to ICD-10. At its first meeting, it was decided that the Committee would also make recommendations about the ongoing maintenance and updating of the classifications post introduction and review epidemiological and statistical uses of ICD-10 data. Meetings are to be held quarterly so that the NCC will be accountable for the time lines put forward in its workplan.

Talking of our plan for the introduction of ICD-10, work has commenced on forward and backward mappings of ICD-9-CM to ICD-10. Help has been sought from coding and classification experts outside the NCC. A mapping protocol and database have been established by the NCC so that uniformity will be maintained by all those involved. Collaborative efforts such as this will allow us to meet the extremely tight time lines leading up to production of "Australian Version" books by 1998. We have been considering too the educational needs of planners, trainers, supervisors, coders and students in health information management (HIM) and clinical coding programs. A special meeting to plan the ICD-10 and Medicare Benefits Schedule - Extended (MBS-Ext) education strategy will take place during the HIMAA 16th Conference in Perth in October 1995.

Although we are in the throes of planning for the introduction of ICD-10, our immediate concern is with the next instalment of new Australian codes and standards for ICD-9-CM to be introduced in July 1996. Work is proceeding with the Clinical Coding and Classification Groups (CCCG) to meet the October 1995 deadline. A new development has been direct contact between the

NCC and allied health professional groups to agree on a limited number of procedure codes (around 10 - 12) for each profession. These codes are slated for 1996 to allow allied health professionals and coders to become accustomed to documenting and abstracting allied health interventions before the Australian procedure classification is introduced in 1998.

New NCC Staff Member
Christine Erratt
(Classification Project Officer)

On 8 September 1995, the NCC welcomed a new member of staff, Christine Erratt, who will be the Classification Project Officer responsible for the new Australian procedure classification. Christine has moved to Sydney from Canberra, where she was located in the Classification and Payments Branch of DHSH as Executive Officer to the ACCC. Christine's appointment completes the ICD-10 staff triad managed by Kerry Innes (Coding Services Manager) with Michelle Bramley (Senior Classification Officer) primarily responsible for the disease classification and Christine for procedures. We are hoping to appoint a project officer to assist the group and may need further expert assistance from our "network". Please let us know if you would be available for secondment or contract work - particularly on the procedure classification! (*see page 3*)

Anne Marks, School of Health Information Management, University of Sydney, and Serena Cheng, Royal North Shore Hospital, will be assisting the NCC with coding queries from State Coding Committees which have created a bit of a coding backlog in the NCC! Elizabeth Watson is also helping with specific projects. Input such as this is extremely valuable to us, not only for the extra hands and brains but for connections with worlds other than our own. Kerry Innes has also been teaching Clinical Classification III in the School of HIM,

University of Sydney, while Janelle Craig (Coding Education Manager) and Michelle Bramley have continued teaching Medical Terminology I.

An important initiative arising from Karen Luxford's interest in electronic patient records was an informal meeting held on 4 September 1995 with interested parties. The aim of the meeting was to discuss ways and means of promoting electronic patient records in Australia. It was decided to formalise the group, develop a mission statement, call for representation from relevant organisations (including Standards Australia, AIHW, HIMAA, Health Informatics Society of Australia, private sector, and hospital associations) and seek support for the group for a 12 month period.

Presentations by staff of the NCC include those at the 7th Australian Casemix Conference in Adelaide 1995 (Michelle Bramley on the new procedure classification, Karen and I in the pre-conference session on classification systems); to the Casemix Measurement Systems Overview Workshop held at University of Sydney on July 20-21, 1995; to NSW Health Community Health Information Steering Committee on ICD-10 implementation strategy; and to Private Hospitals Associations of NSW and Victoria Rehabilitation Sub-Committee on Coding for Rehabilitation. To round out our involvement in "specialty coding", the NCC was invited to join the clinical and technical advisory committee to oversee the work program of the National Mental Health Strategy.

Kerry Innes represented the NCC at Medinfo-95 held in Vancouver in July and came back bearing mountains of material on classification systems, terming, electronic records and new technologies for health information management.

Janelle Craig, apart from planning the NCC Annual Seminar and working with NCWIP on their education strategy, had a major input into workshops for coders in sameday facilities. These workshops, funded by DHSH and organised jointly by NCC, HIMAA and PSCU, were very well attended with positive feedback from participants at both NSW and Victorian workshops. Coding in sameday facilities was new territory for our educators and attempts

were made to prepare course material appropriate to casemix of those hospitals represented. We hope to repeat these workshops and/or to include coders in sameday facilities in future general training programs.

The ACCC continues to provide practical and moral support to the NCC for which we are most grateful. The practical support has most recently come in the form of educational resources to produce specialty publications for coders and clinicians and in conjunction with NRCCH to make an educational video for intern and resident orientation programs on issues relating to documentation for morbidity and mortality coding.

The work of the NCC is gathering momentum as the role of coders and importance of accurate coding become more widely recognised and valued. One indication of these advances was a recent invitation to join the Casemix Project Board and be involved with other relevant organisations and health authorities in policy issues relating to casemix. Our staff numbers are gradually expanding too, but we still need the benefit of your expertise, and for you to feel that what we do is a cooperative effort based on input from coders. Please use *Coding Matters* as a way of telling us what you think, of raising controversial issues, of suggesting better ways to do things. To borrow a phrase from the ABC - this is *your* NCC!

❖ *Rosemary Roberts*

☞ *Help us make coding history!*

We need experienced clinical coders who are available for secondment or contract work to help us prepare for the implementation of ICD-10. We particularly need assistance with the development of the procedure classification based on the Commonwealth Medicare Benefits Schedule. If you, or your staff, are available and would like to be involved, please contact either **Rosemary Roberts or Kerry Innes on ph: (02) 646 6461**.

☜

Clinical Coders' Society of Australia

For those of you who have been anxiously awaiting news of the coding society/forum, we are pleased to advise the first meeting of the Establishment Committee of the Coding Society/Forum was held on Friday 28 July 1995 in Sydney. A subsequent meeting has also been held via teleconference on Thursday 7 September 1995.

The role of the Establishment Committee is to oversee the establishment of the Society, to develop terms of reference of the Executive Committee of the Coding Society/Forum and prepare draft objectives by which the Society will function, as well as to develop a marketing strategy to publicise the Coding Society/Forum and to determine the name by which the Society will be known.

During the six month life of the Establishment Committee, many other matters will be addressed including determination of the role of the Society, membership issues and the relationship of the Society to the parent body, HIMAA.

If you would like to discuss the Clinical Coders' Society of Australia further you can do so by contacting me or your state/territory representative on the Committee. Members of the Establishment Committee are:

ACT Seija Graham, Calvary Hospital, Canberra
QLD Julie Turtle, Logan and Beaudesert Hospitals
NSW Lyn Lehman, John Hunter Hospital
NT Ann Shelby-James, Royal Darwin Hospital
SA Barbara Levings, Ashford Community Hospital
TAS Mark Ralston, North West Regional Hospital
VIC Kathryn Baxter, The Alfred Group of Hospitals
WA Joan Knights, St John of God Hospital, Subiaco

NCC Rosemary Roberts

HIMAA - DEP Louise Chester
HIMAA - NCWIP Debbie Abbott
HIMAA - Council Lisa Quick
Anne Irwin
Janelle Craig

Janelle Craig
Chair, Establishment Committee

Expressions of Interest to Develop Material for National Coder Workforce Issues Project - *Advanced Coding Workshops*

The Health Information Management Association of Australia (HIMAA) National Coder Workforce Issues Project (NCWIP) invites applications from interested parties to assist NCWIP Coding Educators develop and prepare educational material for *Advanced Coding Workshops* (to be conducted nation-wide in early 1996).

Specialities/clinical topics to be covered in these workshops are:

* **obstetrics/gynaecology**

* **oncology**

* **late effects, burns, suicide intent and injury & poisonings**

* **general surgery, surgical techniques, diagnostic testing and complications**
of **medical & surgical care.**

Applications are welcome from individual clinical coders, clinical coding units, private organisations, coding/HIM educators and relevant others who believe they have the skill and experience in any of the abovementioned areas. You may wish to express interest in the development of *any* or *all* modules. Renumeration to be negotiated based on experience and the ability to provide specified course material.

In the first instance, please contact **NCWIP Project Manager, Ms Leanne Holmes, on ph: (07) 3250 1533** to obtain details on specifications for course content. Applications thereafter close on Friday 3 November 1995.

EDUCATIONAL MATTERS

Second Annual NCC Seminar
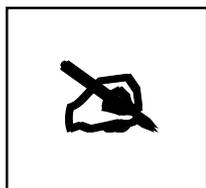
The impressive, red leather bound surrounds of the Senate Chamber at Old Parliament House Canberra provided the backdrop for the recent 2nd Annual Seminar of the NCC held on 8th & 9th September 1995. This year 250 registrants from throughout Australia and New Zealand joined us for a hectic two days of discussion and debate (not to mention fitting in time for a scrumptious lunch and cocktail party at New Parliament House). The theme of the seminar was '*Managing Coding*' through which issues such as managing coding services, managing with coded data and managing classification systems were explored.

The Keynote Address for the seminar was delivered by Professor Peter Baume, Chancellor of the Australian National University and Professor of Community Medicine at the University of NSW. Professor Baume's paper made us reflect on our role as clinical coders and the value we provide to the health care system. Professor Baume warned against a pre-occupation with 'correct' credentials, as opposed to skills acquisition.

The issue of communication was taken up by Professor John Hickie, Chairman of the Australian Casemix Clinical Committee, who focused on coder/clinician communication. Professor Hickie encouraged coders and clinicians to liaise closely in order to ensure coded data and consequently casemix information is as accurate and complete as possible.

Our international speaker, Ms Katrina Chisholm from the Hospital Authority (Hong Kong) discussed coding and data collection in Hong Kong and explored the benefits of clinical information as a management tool.

Given the venue for the seminar was a cauldron for dialogue and interjection in its previous life,

it seemed a fitting setting to conduct of series of debates on controversial issues in coding. Certainly the session 'Controversy Corner - Great Debates in Coding' was one of the highlights of the seminar. Who could forget for example 'Dr Andrea Griffin' (alias Andrea Griffin from the Mater Children's Hospital, Brisbane!!) going head-to-head with Professor Don Hindle (Director, Private Sector Casemix Unit) in the debate to determine who should do the coding: clinicians or clinical coders?; or for that matter, Kathy Eagar (Director, Centre for Health Services Development, University of Wollongong) battling angry tigers, sleeping dogs, sitting ducks and dark horses in her pursuit for meaning regarding whether we need a principal diagnosis.

In true senate style, seminar participants had the opportunity to provide feedback on each of the debate topics, by voting for the argument they considered won the debate. For those who weren't present, you may be interested in the result of the vote:

> **Who should do the coding?**
> Medical Officers = 49 votes vs
> Clinical Coders = 161 (3 abstainers)
>
> **Centralised vs decentralised coding.**
> Centralised = 43 votes vs
> Decentralised = 170 votes
>
> **Professional indemnity for coders.**
> Agree = 74 vs Disagree = 139
>
> **Do we need a principal diagnosis?**
> Yes = 77 vs No = 136

As with the inaugural NCC Seminar in Sydney last year, coders commented favourably on the opportunity the seminar offered them to meet colleagues and make new contacts. This friendly atmosphere, combined with a strong clinical program helped to produce a successful and beneficial seminar. For those who were unable to attend the seminar, proceedings are now available for purchase from the NCC (***please refer to the order form on page 15 of this issue***). Planning for next year's seminar is currently underway, so hopefully you will join us in November 1996 for the 3rd Annual NCC Seminar.

NCC 2nd ANNUAL SEMINAR
SEPTEMBER 1995
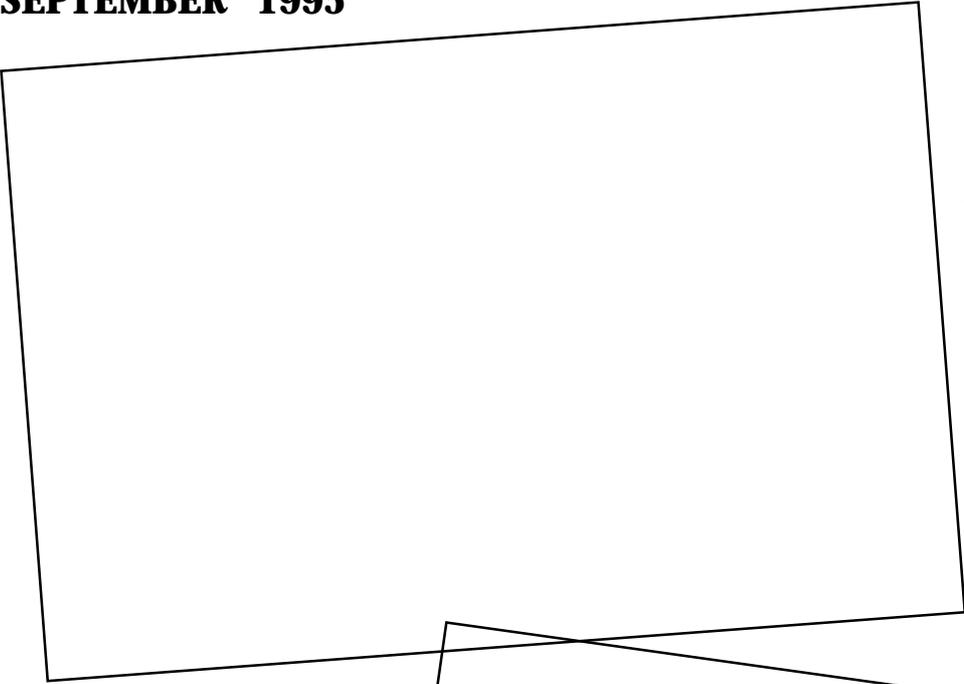
It's not parliament in session (although it looks like it at a glance!), it is the 1995 NCC Seminar, held in the Senate Chamber of Old Parliament House, Canberra

Preparing to speak are (in the foreground, from the left): Leanne Holmes (Project Manager, NCWIP), Katrina Chisholm (Manager, Clinical Information, Hospital Authority, Hong Kong), and Professor John Hickie (Chair, Australian Clinical Casemix Committee)
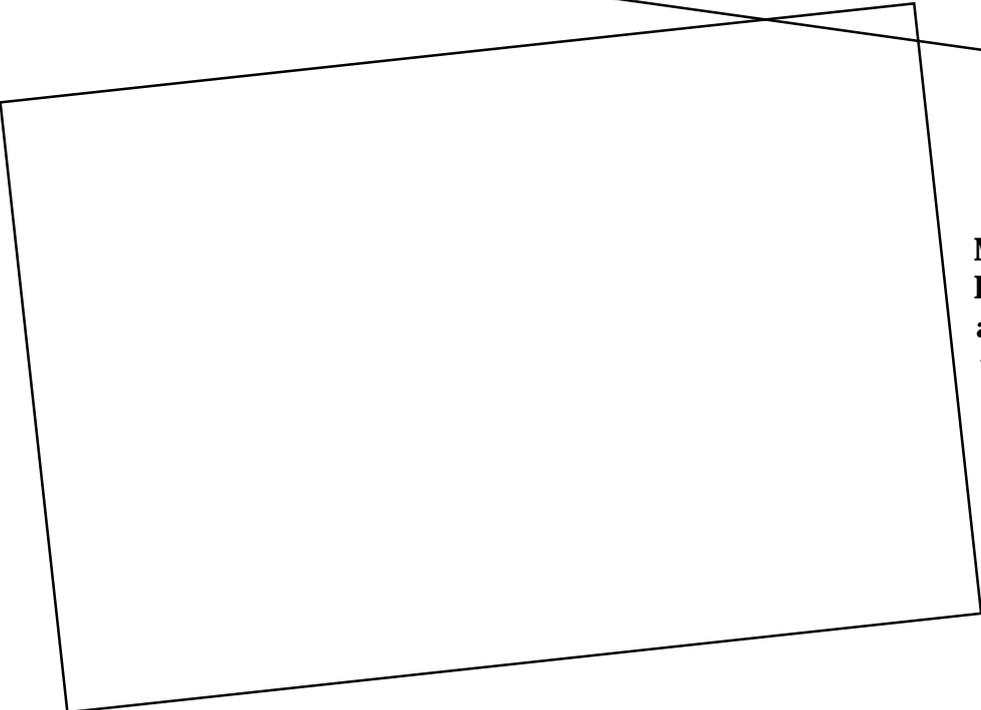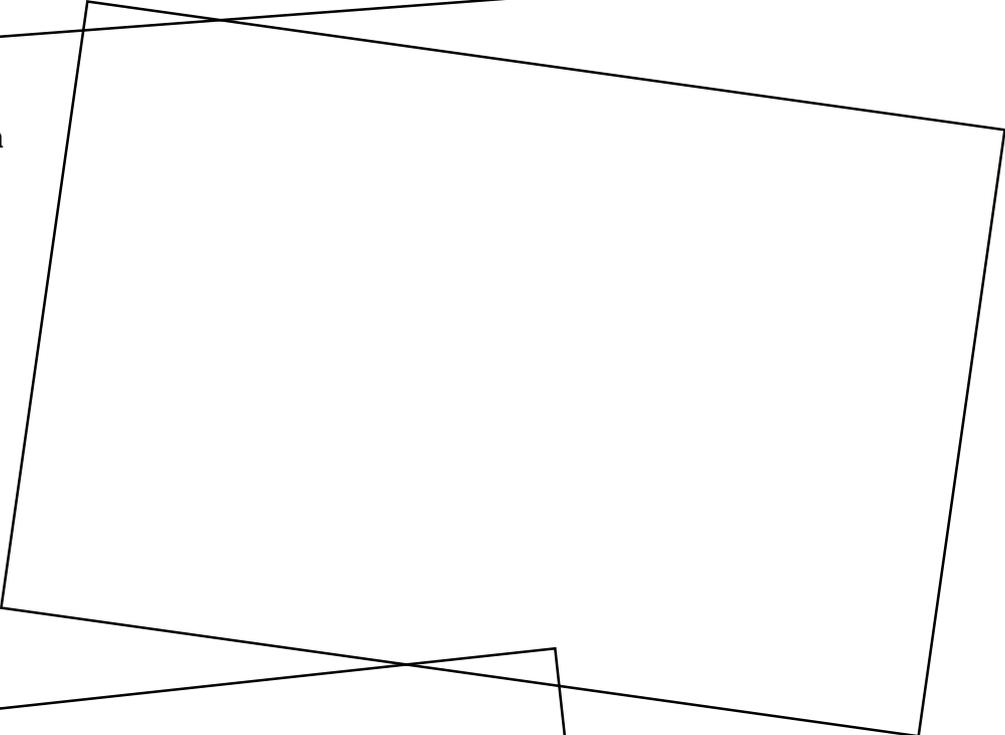
Multiskilled NCC Director, Rosemary Roberts, helping attendees to register for what proved to be an informative and enjoyable seminar

New Zealand attendees evidently also enjoyed the Seminar! From the left are: Audrey Grozef (Analyst, Ministry of Health), Margaret Frost (Senior Coder, Waitemata Health) and Olwen Minnitt (Clinical Coding Co-ordinator, Middlemore Hospital, South Auckland Health)
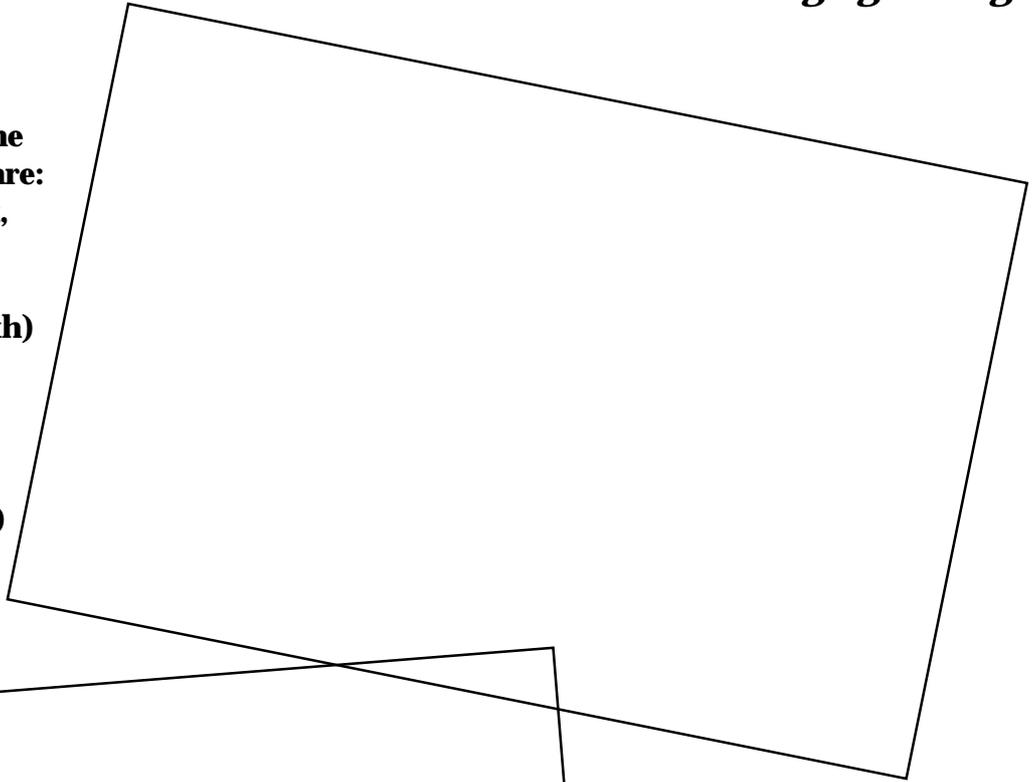
Professor John Hickie (Chair, Australian Clinical Casemix Committee) takes the floor in the Senate Chamber
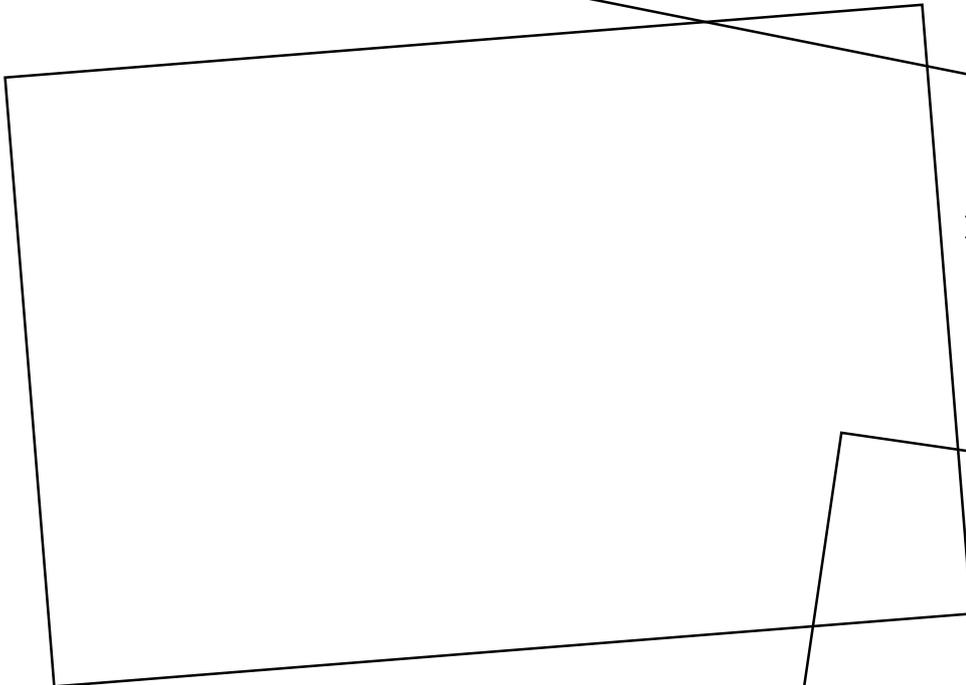
Seminar attendees listened to a joint presentation on *"Managing Using Coded Data"* by Annette Toohill (MRA), pictured here at right, and Jane Widdison (Acting Director/Project Officer, Hospital Support Unit), both speakers from the Royal Children's Hospital, Melbourne
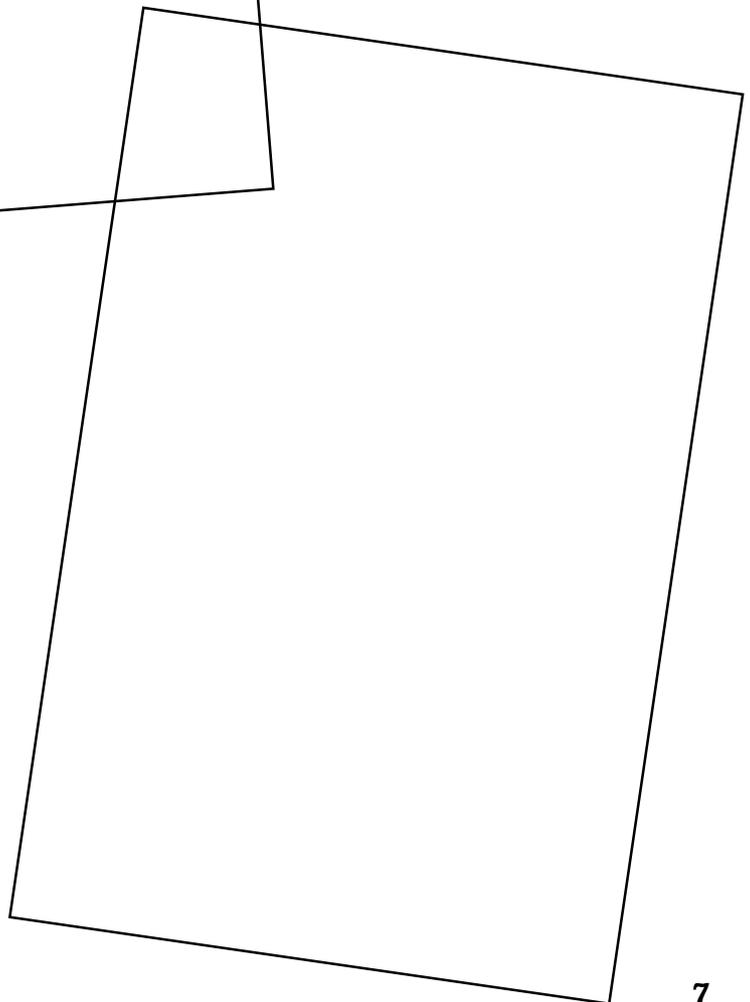
EXPRESSIONS OF INTEREST
CODING EDUCATOR NETWORK

In the October 1994 issue of *Coding Matters* (Vol. 1 No.2) expressions of interest were sought from clinical coders to become part of the NCC's Coding Educator Network. This network has been used extensively in 1995 to help with the *Australian Coding StandardsWorkshops* throughout Australia, and most recently to assist in delivery of course material as part of the *Sameday Training Program* (**see this page**).

The NCC is keen to increase numbers in the Coding Educator Network, particularly in states and territories which are not currently represented on the Network.

Applications would thus be welcome from clinical coders who have experience and skills in coding and ideally who have had some experience in conducting coder training programs. Your background may be as a Health Information Manager or as a Clinical Coder. Although you may be currently employed, this does not exclude you from applying, as the NCC can negotiate involvement with the Network with your employer and involvement will be required only when courses are being conducted in your respective state/territory. Salary to be negotiated based on qualifications and experience.

If you are interested in applying to join the Coding Educators Network, please forward a written application, together with a current Curriculum Vitae to:

Ms Rosemary Roberts
Director
National Coding Centre
PO Box 170
LIDCOMBE NSW 2141

Applications close by Friday 1 December 1995. Enquiries can be directed to **Janelle Craig, Coding Education Manager, on (02) 646 6345.**

Training Course for Coders from Private Sameday Hospital Facilities

In April, 1995 the National Coding Centre (NCC), the Health Information Management Association of Australia (HIMAA) and the Private Sector Casemix Unit (PSCU) tendered for and were subsequently awarded the contract to conduct a specialised training course to educate coders from private sameday hospital facilities in the classification system, ICD-9-CM. Reforms to the private health insurance industry, in the form of the introduction of a casemix payment system, mean that sameday hospital facilities who have contracts with health insurance funds will be required to provide financial information in a casemix-related format. Hence, the need for and importance of coded data.

While there are other courses available that provide basic coder training, staff from sameday facilities felt strongly that their needs were somewhat different to clinical coders in other settings. Thus, the course designed sought to provide an introduction to ICD-9-CM and then allow participants to undertake modules covering different clinical specialities which were relevant to the casemix of their facility.

Registration

133 private, free-standing, sameday facilities throughout Australia were contacted by mail promoting the course and inviting facilities to register a participant.75 facilities initially registered a participant in the course, however with withdrawals this number decreased to a total of 70 facilities (52.6% of facilities canvassed).

Facilities registering participants were then offered the opportunity to send an additional one staff member to the course. 14 facilities took up this proposal, thus enrolling two students in the course. Prior to the commencement of Phase I of the course, a total of 92 participantswere enrolled.

Phase I

Phase I of the course was conducted from 10 - 12 July, 1995. Two workshops were held, one at The University of Sydney (Faculty of Health Sciences, Lidcombe campus) which catered for participants from NSW and the ACT, and the other in Melbourne at La Trobe University (Bundoora campus) to which participants from all other states attended. This phase of the course was designed to introduce participants to the ICD-9-CM classification system and to the general rules, conventions and standards relating to clinical coding (module 2).

Participant's understanding and knowledge of medical terminology was assessed by reviewing module 1 material (this material having been distributed to course participants at the time of registration). In addition, participants were familiarised with issues of current relevance (e.g. casemix and health insurance requirements) and to organisations involved in clinical classification (e.g. the National Coding Centre and the Health Information Management Association of Australia).

Phase II

Phase II of the course saw participants undertake modules in clinical specialities relevant to the casemix of their facility (this nomination process taking place during registration for the course and further clarified during the Phase I workshop). Each module consisted of medical terminology/anatomy and physiology, coding exercises/self assessment questions, as well as an assignment to submit to a central coding instructor for assessment. By far the most strongly demanded modules were those relating to the digestive system (63%) and skin & subcutaneous tissue (44%).

Phase III

Phase III of the course consisted of a one day workshop for all participants designed to revise material covered to date, to assess participant's skill and ability in the modules they nominated to undertake and to evaluate the course.

Participants who completed the training program have been presented with a Certificate of Attendance detailing modules successfully completed.

Course Evaluation

Generally participants were satisfied with the course, as 91% considered the course did adequately prepare them to code in their facility. Comments such as "the course provided valuable basic information on coding", "an insight into coding (especially the difficulty of the job)" and "the opportunity to network was beneficial" were common.

61% of course participants expressed interest in furthering their coding knowledge by undertaking additional studies (e.g. the HIMAA Distance Education Program). Some participants expressed interest in keeping up to date by attending NCC annual seminars and by reading its publication, *Coding Matters*.

As with any face-to-face educational activity, one of the positive aspects of this course was the opportunity for networking and peer support links to be established. A number of course participants felt this was a particularly beneficial aspect of the course. Many were reassured that clinical coders in other sameday facilities experienced similar dilemmas as themselves, and a number have now established communication channels to help resolve coding difficulties. Generally all course participants expressed the belief that they are more confident in their role as clinical coders and know where they can seek assistance if required.

Conclusion

The parties involved in the training program considered the course did fulfil its objectives in providing a training course appropriate for coders from sameday hospital facilities, which ensured a familiarisation to the classification system ICD-9-CM, and completion of modules reflecting the specialised casemix of the facility.

For further information about future training courses, please contact me on (02) 646 6345.

❖ *Janelle Craig*

PUBLICATION ISSUES
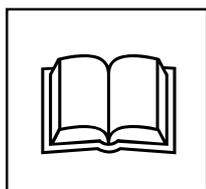
Following the last issue of *Coding Matters*, some of our readers suggested that we make our popular 'Coding Tips' column a discrete section. As you will see opposite, 'Coding Tips' now appears as a double-sided page so that, if you desire, you can either cut it out or copy it and keep these handy tips on file elsewhere for future reference. We hope this is helpful! Where possible in the future, we will endeavour to maintain 'Coding Tips' as a discrete section.

Feedback regarding the NCC's 1995 edition of the *Australian Version of ICD-9-CM* has been noted and is being used to improve future editions of our publication. Your letters and your comments received at the NCC 2nd Annual Seminar are appreciated and are being used to make this Australian publication better for you, the users. We are currently investigating ways of improving this publication and will keep you posted through *Coding Matters*.

As mentioned in Rosemary Roberts' column (*page 3*), the NCC has recently been granted funding by the ACCC to produce a series of specialty specific booklets covering the topics of coding, diagnosis related groups (DRGs) and casemix. The clinical and coding expertise of members of the CCCGs will be utilised to produce specialty booklets of relevance for both doctors and clinical coders.

The NCC is now working on developing an active homepage on the internet which will keep everyone posted on the changes afoot in coding and current projects being undertaken by the NCC. A resource centre for coders will be attached to the homepage which will contain information on relevant educational internet sites throughout the world. We will let you know the electronic address of our site in the next issue of *Coding Matters*!

Prior to the NCC's 2nd Annual Seminar, held in Canberra during September of this year, I had the opportunity to join in on a group tour of the Optical Disk System currently in use for medical records at Woden Valley Hospital. Headed by Louise Ali (Acting Director, Medical Records Department), a group of interested attendees were shown the computerised storage system which went live in the hospital in August 1994. The system contains imaged records that have been scanned in by the staff of the Medical Record Department. The juke box storage system used has a limited capacity and at the current rate of document scanning of new and old records it is estimated that a new juke box will be required after 3 years of usage. Although costly and time consuming, the scanning of documents will free up about 500 sq m of floor space that can be returned to the hospital for other uses.

Scanned medical records are now accessed through the 80 live workstations, however, not all of the hospital is on line as yet. Six levels of system access exist to ensure security and access is gained through the use of passwords.

In a Windows based enviroment, users can access several software applications and use enquiry facilities to search for relevant patient information. In the future, it is anticipated that the Woden Valley Optical Disk System will also incorporate X-rays and encoding and grouping functions. During the demonstration, Louise pointed out that the system has highlighted to clinicians the need to improve the quality of hand writing.

It was reassuring to hear from Louise that the introduction of what is essentially a static system had prompted some departments within Woden Valley Hospital to opt for going straight to direct input of information, rather than scanning. Louise acknowledged that a truly electronic patient record would be preferable in the future, however, she also felt that the Woden Valley system had helped to increase user acceptance of computer systems in general for maintaining and accessing patient information.

Thanks to Louise for a very informative guided tour and for dealing with all those tricky questions so gracefully!!

P.S. Subsequent to my message regarding the future of coding and electronic systems in the last issue of *Coding Matters* (Vol.2 No.1), a pertinent feature article entitled "Coding against an Uncertain Future" has appeared in the *Journal of AHIMA* (Vol.66 No.7, p41-42, July-Aug, 1995). I highly recommend it as interesting further reading!

❖ *Karen Luxford*

Coding Tips
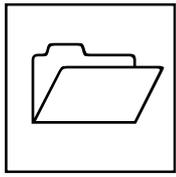
☐ Acute exacerbation of chronic airways limitation (CAL)

Coders should not assume that a chest infection is involved in this diagnostic statement. Only 496 should be assigned for this diagnosis. If the exacerbation is described as "infective" an appropriate code for the organism involved should be assigned as a secondary condition.

☐ Attention deficit disorder

Codes in category 314 can be used for adolescent or adult patients even though the title of this category *Hyperkinetic syndrome of childhood* would indicate otherwise. Attention deficit disorders (314.0) can be first diagnosed in an older patient even though the condition may have been present since childhood. ICD-10 does not include mention of "childhood" in this category which will make coding of these disorders less confusing in the future.

☐ Bladder neck suspension

Review of the national morbidity data reveals a significant number of code 57.89 *Other repair of bladder* reported with a diagnosis of stress incontinence. There are two points which are important for coders to note:

◆ Code 57.89 cannot be used with a diagnosis of stress incontinence, in accordance with the exclusion note under category 57.8, *Other repair of urinary bladder*, which reads:

> *Excludes: that for stress incontinence (59.3 - 59.79)*

◆ Bladder neck suspension and other similar procedures for the repair of stress incontinence are not classified well in ICD-9-CM. The NCC has been working with the Obstetrics & Gynaecology Clinical Coding and Classification Group to improve this section for introduction from July 1996. As an interim guide, the following list is provided:

59.3 Plication of urethrovesical junction

Kelly (-Kennedy) operation (urethrovesical plication)

Kelly-Stoeckel operation (urethrovesical plication) (stitch)
Plication of urethrovesical junction

59.4 Suprapubic sling operation

Cystourethropexy by suprapubic suspension
Goebel-Frangenheim-Stoeckel operation (urethrovesical suspension)
Miller operation by urethrovesical suspension
Millin-Read operation (urethrovesical suspension)
Oxford operation for urinary incontinence
Sling operation, urethra (suprapubic)
Urethrocystopexy by suprapubic suspension
Repair of stress incontinence by suprapubic sling
Repair of stress incontinence by urethrovesical suspension

59.5 Retropubic urethral suspension

Aldridge (-Studdiford) operation (urethral sling)
Cystourethropexy by retropubic suspension
Sling operation, urethra (retropubic)
Sling operation, urethrovesical (retropubic)
Urethrocystopexy by retropubic suspension
Marshall-Marchetti (-Krantz) operation (retropubic urethral suspension)
Repair of stress incontinence by retropubic urethral suspension
Suspension urethral (retropubic) (sling)
Suture periurethral tissue to symphysis pubis
Burch colposuspension
Bladder neck elevation
Fixation, urethrovaginal (to Cooper's ligament)

59.6 Paraurethral suspension

Pereyra operation (paraurethral suspension)
Repair stress incontinence by paraurethral suspension
Repair stress incontinence by periurethral suspension
Suspension, paraurethral
Suspension, periurethral

59.71 Levator muscle operation for urethrovesical suspension

Cystourethropexy by levator muscle sling
Pubococcygeoplasty
Repair stress incontinence by cystourethropexy (with levator muscle sling)
Repair stress incontinence by pubococcygeal sling
Repair stress incontinence by urethrovesical suspension, levator muscle sling

Repair stress incontinence by urethrovesical
    suspension, gracilis muscle transplant
Urethrocystopexy by levator muscle sling
Inglemann Sundberg

59.79 Other repair of urinary stress incontinence

Cystourethropexy (NOS)
Kaufman operation (for urinary stress
    incontinence)
Insertion Rosen prosthesis for urinary
    incontinence
Operation for anti-incontinence NEC
Raz-Pereyra procedure (bladder neck
suspension)   Stamey
                Tudor "rabbit-ear" (anterior
urethropexy)
Repair stress incontinence by anterior
    urethropexy
Urethrocystopexy

70.77 Vaginal suspension and fixation

Colpopexy
Fixation, vagina
Harrison-Richards operation (vaginal
suspension)
Norman-Miller operation (vaginopexy)
Suspension, vagina
Vaginofixation

❑   Epilepsy

Category 345 *Epilepsy* requires assignment of a
fifth digit to indicate with or without intractable
epilepsy for the fourth digits 0, 1 and 4 - 9. The
term "intractable" is defined as:

The occurrence of one or more seizures per
month with impairment of consciousness,
                or
Twelve or more seizures per year, despite
treatment with adequate doses of at least two
anti-
epileptic drugs, singly or in combination.

❑   Fracture dislocation

In cases where only fracture is documented, but
dislocation is also recorded on the X-ray report
both the fracture and the dislocation should be
coded, according to *Australian Coding Standard*
No. 1313.

❑   Intravenous neurolepsis

Children admitted for chemotherapy may have
intravenous neurolepsis as part of that treatment.
Assign 99.26 *Injection of tranquilliser* as a
secondary procedure code to the chemotherapy.

❑   Kaposi's sarcoma

It has been noted in the national data that the
unspecified code for Kaposi's sarcoma 176.9 is
more frequently used than the more specific
codes in this category 176. Coders should
attempt to abstract the exact site/s for this
condition.

❑   Laminectomy

Laminectomy is a procedure which involves
fenestration <u>and disc excision</u> even though the
disc excision is often not specified by the
surgeon. Coders should ensure that this
procedure is assigned code 80.51 *Excision of
intervertebral disc* (as indicated by the exclusion
note) and not 03.09 *Other exploration and
decompression of spinal canal.* 03.09 should only
be assigned when decompression is documented
without laminectomy.

❑   Lennox-Gastaut syndrome

Although a patient with this syndrome may
suffer from a specific type of seizure (e.g. tonic,
tonic-clonic, akinetic), the type of seizure should
not be used to code these cases. Lennox-Gastaut
Syndrome is categorised in ICD-9-CM to 345.0
Generalised nonconvulsive epilepsy and is
appropriate and adequate to describe the
syndrome.

❑   Mechanical ventilation

◆   There have been a number of queries from
coders about whether to assign codes for
intubation when a patient is transferred into a
facility with intubation and ventilation in place.
There will be new codes to reflect these cases of
"management" of intubation and ventilation
rather than "initiation" of intubation and
ventilation in July 1996. Until then, coders
should assign the appropriate codes for
intubation and ventilation for these cases.

◆   "Mini tracheostomy" is used to keep the
airway clear and "aqua pack" is used for
humidification. "Swedish nose" is another form
of humidification. None of these types of
equipment should be coded.

❖ *Kerry Innes*

➤ CLINICAL UPDATE SEMINARS

A brochure has been sent to most of you in recent weeks outlining the range of education programs to be offered as part of the National Coder Workforce Issues Project. Clinical Update Seminars are currently being offered until mid December, 1995. These seminars will provide you with information on medical advances and will be helpful in increasing your understanding of specific clinical specialties. For those interested in undertaking the accreditation examination next year, this will be a golden opportunity to brush up on your knowledge in areas that you may not regularly encounter in your present work. There are still *vacancies* in all Clinical Update Seminars.

For further information, telephone Judith Tailby on (07) 3250 1533

or fax your registration form on (07) 3257 3933. ◀

Are you *moving*? Let us know too!

If you wish your mailing address for **Coding Matters** changed, please fill out the section below and **fax** a copy to us on (02) 646 6603 or **post** it to us at:
National Coding Centre, PO Box 170, Lidcombe NSW 2141.

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⬦ Maggot Therapy:
Can you code it ⬦

A bizarre new therapy has recently emerged overseas involving the use of maggots. We haven't received any coding queries as yet at the NCC regarding maggot therapy, so I think we can safely assume that it isn't in use yet in Australia. But what is it all about?

Currently, maggot therapy is being promoted by Oxford University entomologist, David Rogers, fellow entomologist Paul Embden and orthopaedic surgeon, Dr John Church. In a study of 10 patients published recently in *The Journal of Spinal Cord Medicine,* maggots were used to heal wounds that had defied medicine. All patients recovered within approximately one month of treatment, each patient requiring at least three batches of maggots.

One American clinician, Dr Ronald Sherman of the University of California, has been breeding maggots and using them to treat patients at a Long Beach Medical Centre for the past five years. Both Dr Sherman and Dr Church breed and use green-bottle flies, a common type of house fly.

The researchers believe that the maggots are effective due to their ability to devour necrotic tissue and bacteria within a wound, whilst avoiding healthy tissue. These proponents of maggot therapy also hope to unravel the key to the antibiotic properties of this unique treatment.

The Oxford team admits that there is one main problem that they currently face: user acceptability! Not many people savour the idea of having their wounds maggot-infested and flyblown. With flies and maggots traditionally associated with death and decay, it appears unlikely that patients will be easily convinced of their power to aid the healing process.

- AP

✸ Coderscope ✸

**Your horoscope
by
Dr Stargazer**

♎ *Libra   September 24 - October 23*
The next few months will see great pressures placed on you resulting in 308.3 and 307.3. Some of the polite conversations that you will take part in will actually make you experience 787.02. You will survive these trying times by keeping in mind that you will get some V66.9 in the tropics later in the year. Although typically indecisive, Libra, there is one thing you are sure of - you have a 301.7 and when on your holiday may engage in a bit of V69.2. Be safe!

♏ *Scorpio October 24 - November 22*
Mortgaging the house to fuel your V69.3 habit has left you with a V60.0. Keep a brave face, however, for in mid November, this very same habit will result in an unexpected financial windfall. Beware of adopting a life of total luxury as you may experience E865.1 and E860.0. Resist the temptation to have a 86.82 yet.

♐ *Sagittarius November 23 - December 22*
Your work mates will conclude you have a 301.4, whilst you think you are probably more a 301.82. Either way, you'll probably require a 86.64 due to your frustrated hair tugging. As Christmas approaches, watch out for a E827.0 when putting the decorations on your roof and a E880.0 when doing your pressie shopping.

➢

But you never know! One day a medical record may land on your desk with the principal procedure documented as "Maggot Therapy". *How would you code it?*
Fax me your ideas on (02) 646 6603.

❖ *Karen Luxford*

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☺ *And the Winner is.....*
Standards, Standards, Standards

Coder Bumper Sticker Competition

We couldn't decide which entry should win the *Bumper Sticker Competition* in the last issue of *Coding Matters,* so we asked you to pick a winner out of 8 entries. The winner was announced at the NCC Seminar in Canberra, 8-9 September 1995.

Your favourite entry was.. (and we checked the numbers twice...so, no, it wasn't rigged!)...

❶ **Coders do it to a national standard**

(Viktoria King, Fremantle Hospital)

The runner up was...

❷ **Old coders never die, their number is never up!**

(Dale McCurley, Nepean Hospital)

And we finally selected an NCC favourite entry.....

❸ **Come any closer and I'll code you!**

(Paul Hussein, Canterbury Hospital)

Thank you to all those imaginative coders who entered the sticker competition and joined in the spirit by having a little bit of fun! Congratulations Viktoria King, you will receive an NCC cap and stickers soon. Dale McCurley and Paul Hussein will receive a selection of stickers in the mail. **One of the above stickers has been randomly selected and included in your copy of this issue of *Coding Matters*.** We hope that you will display it with pride in a prominent location for all to see!!