

coding matters



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

Volume 9 Number 2 **September 2002**

Emergency department classifications update

The NCCH's Coding Standards Advisory Committee (CSAC) has recommended that the NCCH develop a standardised set of diagnosis/problem codes for the Emergency Department Information System (EDIS).

Of the variety of information systems presently used in emergency departments, EDIS is the most common. These information systems allow clinicians at the point of care to select a diagnosis/condition from either a drop-down pick list, or a menu driven option, with various levels of granularity to allow users to further specify the condition. When clinicians select diagnoses/problems a code is allocated by the system. These codes are derived from either ICD-9-CM or ICD-10-AM and are usually a truncated version taken from the original classification.



These hybrids have been developed at state level to meet local needs, but without national consultation. ICD is being used as part of EDIS but there is no Australian standard for coding in emergency departments using either EDIS or other classification systems.

CSAC's recommendation came at a time when the Commonwealth Department of Health and Ageing is also working towards developing nationally consistent data for non-admitted hospital inpatient care. Development of an emergency department minimum dataset is a well-developed part of this project. The NCCH sees an opportunity to feed the work on an EDIS classification into this national agenda.

The NCCH envisages the EDIS classification (and potentially a fully national product) as being a subset of ICD-10-AM. This subset, developed in conjunction with users in Australian emergency departments, would be ►

Ambulatory care edition

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significantly smaller and simpler than the parent, with the potential of many concepts being reduced to a single code (such as 'Asthma' being coded to J45.9 only, regardless of the type). It is planned that these codes will comprise the EDIS classification and will be selected based upon a set of principles which can be applied to most, if not all emergency departments. These are that:

- The list is to form the basis of the 'Principal reason for presentation' – single code selection only.
- Emergency department visits last (generally) no more than 4 hours.
- Tests are not usually back by the time patient is discharged or transferred.
- Acute conditions (or chronic with a current acute phase) are the most common presentations.
- Trauma conditions are usually diagnosed with greater specificity.
- Conditions in pregnancy, newborn and other specific situations, which are referenced elsewhere in ICD-10-AM, should not be duplicated.

Beyond the EDIS classification development, and looking at emergency department data collection needs at a national level, there is one item of contention. Whilst the Commonwealth has recognised that a set of codes for emergency departments is desirable, data

elements for emergency department presenting problems, diagnoses and procedures are not part of the proposed National Minimum Data Set for Emergency Departments. Determining what data needs to be collected is the cornerstone of any classification development. Therefore, a number of questions about the key data element need to be resolved when building an emergency department classification. Some of these are:

Is it a principal diagnosis?

Is it the reason for visit?

Is it the clinician's view of the problem, or is it the patient's?

The NCCH has proposed a definition for capturing at least one of the most meaningful and appropriate data items which we have called the Principal Reason for Visit to an emergency department:

The diagnosis, condition, or problem which, after observation, is chiefly responsible for occasioning the patient's presentation to the emergency department

This definition is very similar to the Principal Diagnosis definition for inpatient care, as defined in the National Health Data Dictionary. The definition will provide the basis for collection of clear information which is necessary to examine reasons why patients attend emergency departments, and will provide a focus to examine resource use.

Development of nationally consistent data for emergency department care

The Commonwealth Department of Health and Ageing in collaboration with states and territories and other stakeholders is progressing the standardised collection of non-admitted data in accordance with the current Australian Health Agreements. An Emergency Department National Minimum Data Set (ED NMDS) is currently being developed.

'Presenting problem' and 'diagnosis' have been identified as important national data elements that require development for the NMDS. They were not included in the initial specification, due to difficulties in collection and national data consistency.

Stakeholders have agreed to a pilot study to develop national data domains for 'presenting problem' and 'diagnosis'. The aim of the pilot is to test the feasibility of the collection and the utility of the proposed national data set.

The pilot test will continue until October 2002. These codesets will be added to the NMDS at a later date.

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Classification corner

About the Australian Community-Based Health Services Codeset

The Australian Community-Based Health Services Codeset (ACBHSC) is the culmination of a project designed to produce tools that reflect the activities and support the information management requirements of all types of health services delivered in a community based setting.

Most of the data that are currently available to measure activity/workload and outcomes of health services come from the institutional or hospital sector. The gaps within community health data have inhibited both state and Commonwealth authorities from gaining a clear picture of total health service delivery. ACBHSC is a tool to describe the client base, activities, resource use and outcomes provided by community-based health care services in a consistent and meaningful way. The Codeset is designed to cover the spectrum of health service delivery for community-based health.

ACBHSC is composed of a hierarchical set of classification schemes and their component values. It is made up of 550 classification schemes and 5,100 code values. Each scheme and value is allocated an alphanumeric code, used to determine its place within the hierarchy, thus providing some structure to the classification. It is structured around 10 high level domains:

1. **Party (A)** – client and service provider demographics
2. **Activity type (B)** – activities, procedures, interventions performed by the service provider
3. **Communication related data items (C)** – how a service contact was performed, the reasons for the contact, etc.
4. **Issue type (D)** – the reason for the client's presentation
5. **Event type (E)** – the cause of the issue or activity
6. **Location type (F)** – the location of the service delivery or event
7. **Management plan related data items (G)** – allows the creation of electronic management plans
8. **Outcome type (H)** – the client focused outcomes to be achieved
9. **Physical resource type (I)** – the physical resources used
10. **Program related data items (J)** – data about the health programs being run

All of the schemes and values in each chapter have an alphanumeric scheme attached. Because of the depth of ACBHSC, these codes can be quite extensive, so the user is provided with the codes's text, rather than the code itself. The code becomes an identifier used by information systems to identify each unique concept within ACBHSC.

Each code has an alphabetic prefix, indicating the classification in which certain schemes and values lie ('A' for Party type, 'B' for Activity...). The hierarchy is then split into detailed schemes and values each represented by two digits.

For example, **D012401020106 (Pulmonary embolism)** is derived from:

D	=	Issue type
01	=	Issue nature (<i>scheme</i>)
24	=	Physical health issue (<i>value</i>)
01	=	Physical health issue type (<i>scheme</i>)
02	=	Cardiovascular issue (<i>value</i>)
01	=	Cardiovascular issue type (<i>scheme</i>)
06	=	Pulmonary embolism (<i>value</i>)

The role of NCCH as custodian of ACBHSC is to provide continuing management and maintenance to ensure consistency of application and coordination of further development on behalf of all stakeholders nationally. The Centre is working on the project in conjunction with the Australian Institute of Health and Welfare (AIHW) whose responsibility is for National Minimum Data Set (NMDS) coordination and creation of business rules. NCCH has inherited the codeset developed by Doll Martin Associates.

The NCCH will review ACBHSC and provide recommendations about ways to modify it, as required. These reviews will primarily focus on the role of ICD-10-AM and how it may be integrated into ACBHSC, such as mappings, or adoption of the classification with a specific community chapter. ►

Future NCCH activities include the promotion of ACBHSC into the wider community, with ongoing discussions with the relevant community-based health groups, which will be used as the basis for ongoing review and modification of ACBHSC.


Other issues that will be explored are the creation of a set of clinical terms for community based health, that will have links to both ACBHSC and ICD-10-AM.

The following is an example from the Issue chapter of the Codeset

ISSUE NATURE	D01
Family and other relationships issue	D0126
FAMILY and OTHER RELATIONSHIPS ISSUE TYPE	D012601
Family continuity issue	D01260101
FAMILY CONTINUITY ISSUE TYPE	D0126010101
Access to children	D012601010101
Adoption of overseas children	D012601010104
Identity of birth parents issue	D012601010108
Return of child issue	D012601010112
Primary relationship issue	D01260102
PRIMARY RELATIONSHIP ISSUE TYPE	D0126010201
Conflict over children	D012601020101
Impact of pregnancy on relationship	D012601020104
Incompatibility of goals and directions	D012601020105
Infidelity	D012601020106
Parenting issue	D01260103
PARENTING ISSUE TYPE	D0126010301
Child rearing practices	D012601030101
Grandparenting issue	D012601030103
Multiple birth parenting	D012601030105
Sole parenting issue	D012601030110

ICD-10-AM

Early Parenting Manual



The *ICD-10-AM Early Parenting Manual* provides guidelines to help ensure codes for diagnoses and interventions specific to early childhood care are appropriately selected and assigned.

The *Manual* provides a common link between the language and terms used by clinicians, nurses, coders and early parenting centres staff.

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Clinical update

Non-Invasive Ventilation

Non-invasive ventilation (NIV) is provided to individuals with respiratory failure to assist their breathing. The difference between non-invasive and invasive ventilation is that non-invasive ventilation is conducted without tracheal intubation. Consequently, this type of ventilation is provided through a soft, fitted mask that fits over the nose (nasal ventilation) or nose and mouth together. It may be provided in an intensive care unit, in a hospital ward or emergency department.

The assistance provided to breathing can be in several forms:

- CPAP (continuous positive airway pressure)
- BiPAP (bi-level positive airway pressure).

CPAP has been established for some time to be effective in the management of sleep-disordered breathing. It is prescribed for individuals with obstructive sleep apnoea and other sleep disorders, where continuous positive airway pressure is applied, usually through a nasal mask, to prevent the upper airway obstruction that occurs in sleep. To implement such therapy, an individual with sleep disorders usually presents to a hospital department where they have an overnight sleep study. If the sleep study is abnormal, CPAP may be prescribed. Some individuals undergo a second sleep study to ascertain the efficacy of CPAP. Frequently, Sleep Units are performing “split sleep studies” where the diagnosis is made in the first part of the night and CPAP trialed if indicated later during the night. People with sleep-disordered breathing will then use this treatment overnight at their home long term.

More recently, non-invasive ventilation has been used in the management of acute respiratory failure. It has been shown to be of benefit in individuals with acute respiratory failure and acidosis secondary to COPD^{1 2 3}. In such settings NIV has been shown to reduce hospital stay and improve survival. In these circumstances individuals will usually be admitted with an emergency presentation with respiratory failure due to chronic lung disease. Non-invasive ventilation may be trialed in order to avoid the greater morbidity associated with endo-tracheal intubation which necessitates intensive care admission.

It is also used to support patients with very severe pre-existing lung disease who have hypercapnia and acidosis. In such instances, non-invasive ventilation may be the preferred treatment rather than invasive ventilation as survival from endo-tracheal intubation is unlikely. Such patients are likely to be stabilised on nasal bi-level positive pressure breathing (Bi-PAP). Usually a carefully fitted nasal or facial mask will be strapped onto the patient and the breathing support provided through a portable ventilator. The pressure levels for each patient will be worked out individually by the person setting up the ventilation, often a specialist nurse or respiratory scientist. The treatment prescription will usually involve an inspiratory positive pressure as well as an expiratory positive pressure that can improve oxygenation. Once a patient has been stabilised on NIV, it is likely that they will continue such support for a few days. In these cases the support will likely involve a prescription for the amount of time on the ventilator (for example 3 hours in every 4) so that the patient can eat and drink or move out of bed. ▶

Patient connected to CPAP machine



Patients may have respiratory failure for reasons other than chronic lung disease. NIV can also be used for respiratory failure in neuromuscular disease where it has been shown to improve symptoms and possibly prolong survival.⁴. NIV may also be utilised in severe chest wall abnormalities where ventilation is compromised acutely or chronically. In some patients with extremely severe lung disease, NIV may be also be used to support the patient until a lung transplant becomes available. In such cases NIV may be stabilised whilst the patient is an inpatient and continued following the acute incident as outpatient therapy, so patients may be stabilised as a hospital inpatient on non-invasive ventilation that they can use at home.

The new DRG category for non-invasive ventilation (NIV) is to permit people treated for exacerbations of respiratory failure to be coded into a category to enable appropriate recognition of the severity of disease and intensity of care required in this critically ill group of patients.

In ICD-10-AM Third Edition, codes for NIV are located in block [568] *Airway management* and include:

- 92038-00 *Continuous positive airway pressure [CPAP]*
- 92039-00 *Bi-level positive airway pressure [Bi-PAP]*
- 92040-00 *Intermittent positive pressure breathing [IPPB]*
- 92041-00 *Continuous negative pressure ventilation [CNP]*

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References

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- 2 Keenan SP, Kernerman PD, Cook DJ, Martin CM, McCormack D, Sibbald WJ. (1997) Effect of non-invasive positive pressure ventilation on mortality in patients admitted with acute respiratory failure: a meta-analysis. *Crit Care Med* 25: 1685-92.
- 3 Plant PK, Owen JL, Elliott MW. (2000) Early use of non-invasive ventilation for acute exacerbations of chronic obstructive pulmonary disease on general respiratory wards: a multicentre randomised controlled trial. *Lancet* 355 1931-5.
- 4 Annane D, Chevrolat JC, Chevret S, Raphael JC. (2002) Nocturnal mechanical ventilation for chronic hypoventilation in patients with neuromuscular and chest wall disorders. (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2002. Oxford: Update Software.

AR-DRG version 5

The Australian Refined Diagnosis Related Groups

(AR-DRG) version 5.0 is now available. Copies may be purchased from the NCCH. See enclosed order form for details.

Alex's Conundrum

To which 2 body parts does the term *phrenic* refer and why?

phrenic from Greek *phren* = diaphragm and brain.

From this word, *phrenic*, which dates back to the time when the heart was thought to be the seat of emotions, two series of terms have been derived. From its first meaning, heart or diaphragm, we get the name of the phrenic

nerve. On the other hand, from its second meaning for brain, we get phrenology and several compound terms ending in 'phrenia', such as schizophrenia. The heart continues to be thought of as the seat of the emotions only in amorous affairs, in which the mind plays a little part.

Perry Pepper, OH *Medical etymology: The history and derivations of medical terms for students of medicine, dentistry, and nursing.* <http://ancienthistory.about.com/cs/roots> Accessed 24 July 2002.



About the committee

Expert Group on Health and Health Related Classifications

The Expert Group on Health and Health Related Classifications has been established by the National Health Information Management Group (NHIMG) pursuant to the recommendation from the Electronic Health Records Task Force¹ and endorsed by Australian Health Ministers in July 2000.

Membership of the Expert Group includes:

- an independent Chair
- representatives from the NHIMG and the National Community Services Information Management Group (NCSIMG)
- the Head of the WHO Australian Collaborating Centre for the Family of International Classifications
- the Director of National Centre for Classification in Health (NCCH)
- one representative each from:
 - Australian Bureau of Statistics
 - HealthConnect Program Office
 - General Practice Computing Group
 - Medicine Coding Council of Australia
 - IT 14 Standards Committee
- two representatives from the Commonwealth Department of Health and Ageing
- two representatives from the Commonwealth Department of Family and Community Services
- experts in specific classifications:
 - ICD NCCH Brisbane
 - ICD-10-AM NCCH Sydney
 - ICPC-2 Family Medicine Research Centre
 - ICF Australian Institute of Health and Welfare (AIHW)
 - ICECI National Injury Surveillance Unit
- an agreed national standard set of classifications for use in all health care settings in Australia, that is, an 'Australian family of health and related classifications' (taking the WHO family of classifications as a starting point)
- a recommended sustainable process to facilitate the maintenance of the family of health and related classifications including an indication of resources required for implementation
- a national mechanism (including an indication of resources required) for the assessment and accreditation of members of the family of classifications. The proposed national mechanism will operate within the National Health Information Agreement between the Commonwealth and all States and Territories
- advice on the key requirements of, and potential mechanisms for implementation of, any national standard health terminologies which may be acquired, in order to support and integrate with the family of health and related classifications.

To date, the Expert Group has developed a framework for an Australian Family of Health and Related Classifications which has been endorsed, in principle, by NHIMG and is now working on a protocol for consideration of classifications for membership of the 'Family'.

▶ Catherine Sykes

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The tasks of the Expert Group are to provide:

- an annotated overview diagram outlining the scope, context and relationships between all types of terminologies (including classifications, vocabularies and combination systems) with definitions and examples²

References

- 1 A Health Information Network for Australia. Electronic Health Records Task Force July 2000.
- 2 The diagram is anticipated to be high-level, together with annotations and attachments where appropriate. Definitions and examples (no more than three or four are required) are intended to help non-experts to understand the purpose of and relationships between the terminologies. It is anticipated that these examples could be based on the flow of information from primary care settings through to the national classification of health information.

the 10-AM commandments

This regular feature provides guidance to clinical coders about frequently asked questions and aims to address those areas of coding which require immediate attention by clinical coders. Any major changes in practice (such as change of principal diagnosis sequencing for certain conditions) which may affect the integrity of state and national morbidity data collections will be flagged and should be introduced from the July following publication. If you find that any advice published in this section significantly changes your current practice, you should not do so until a suitable time in the collection year (January or July). You may feel it necessary in such circumstances to also seek advice from your state or territory health authority for a suitable date for implementation.

ICD-10-AM Third Edition Education Program Frequently Asked Questions

The education program conducted prior to implementation of ICD-10-AM Third Edition encouraged participants to submit questions that came up from the course. These questions came from people who undertook the self-directed education program and from workshop participants. They have been answered by NCCH staff who worked on compiling the Third Edition.

The questions have been grouped by topic and appear as asked by education program participants.

A standard abbreviation of 'ACS' has been used throughout to stand for 'Australian Coding Standard'.

This information is also available from the NCCH web site: <http://www.fhs.usyd.edu.au/ncch/> under 'FAQs' and will be added to the queries database.

Adult and child abuse

ACS 1909 Adult and child abuse – in the case of a victim with an injury occurring as a result of maltreatment, the ACS advises to code the injury and the external cause according to the mechanism of the injury. Should a code from T74 Maltreatment syndromes also be assigned to signify that this is more than just an assault?

There is a note at the beginning of T74 Maltreatment syndromes which indicates to "code first the current injury, if applicable". A code from T74 Maltreatment syndromes may also be assigned where there is clear documentation that the injury is the result of one of the types of maltreatment listed in T74.

Amputation status

Why has the ACS for amputation status been removed? Does it now not meet the additional diagnosis standard? In what circumstances apart from diabetes should it be used?

ACS 2110 Amputation status was deleted and this condition is only to be assigned when it meets the criteria in ACS 0002 Additional diagnosis.

Anaesthetics

Which ASA score should be used as a default when a different ASA score for the same procedure is recorded on an Anaesthetic Pre-Op form and an Operation Sheet?

Use the score recorded by the anaesthetist on the anaesthetic/operation form (see Coding Matters 8(3):13).

In the ICD-10-AM Third Edition education program exercise 'Sepsis and Septicaemia', the general anaesthesia is coded as 92514-29 [1910] General anaesthesia. The ASA score is 2, indicating a patient with mild systemic disease. In the text for the exercise there was no mild systemic disease mentioned. Should the disease be coded if it impacts on the ASA classification for a general anaesthetic?

The general anaesthesia code has an extension of '29' as it is stated in the exercise that the patient's ASA score is '2'. There is no indication of emergency status, hence the default to '9'. If the anaesthetist has documented an ASA score of '>1' and there is no mention of any systemic disease, that score must still be assigned as directed at the beginning of blocks [1333] Analgesia and anaesthesia during labour and caesarean section, [1909] Conduction anaesthesia and [1910] Cerebral anaesthesia. The assignment of disease codes will depend on the documentation in the clinical record.

In the ICD-10-AM Third Edition education program exercises for anaesthetics (p3 of 3), why is Z83.7 Family history of diseases of the digestive system necessary?

Z83.7 *Family history of diseases of the digestive system* is assigned because it provides a clinical picture of the reason for admission. The family history of colonic polyps relates specifically to why the patient is being investigated.

In order to assign a code for postoperative analgesia, ACS 0031 Anaesthesia states that the neuraxial or regional block must be maintained via continuous infusion. Does this also include bolus injections?

The main criteria when deciding to assign these codes is that the neuraxial or regional block must have been initiated in the operating suite (theatre or recovery) and there is documentation of continuing administration of analgesia (either infusion or bolus injection). ACS 0031 *Anaesthesia* will be edited to include this advice.

Given the instructions in ACS 0031 Anaesthesia, point 4 p43, should the excludes note under 92513-xx [1909] Infiltration of local anaesthetic also exclude the use of that code with any other code from block 1909?

The excludes note at 92513-xx *Infiltration of local anaesthetic* could possibly include block [1909], however the hierarchy concept is more fully explained in ACS 0031 *Anaesthesia* point 1, p42.

Is a code for local anaesthesia performed for repair of obstetric tears assigned, when an epidural has been administered during the labour for pain relief?

The local anaesthesia for this procedure is normally noted within the labour ward record and, is separate from the continuation notes. The epidural performed in this scenario has been administered for pain relief, not as anaesthesia for repair of the tear. Therefore, a code should be assigned for local anaesthesia in this case. The wording of ACS 0031 *Anaesthesia* point 4, p43 will be amended to 'on a specialised form (eg anaesthetic/procedural/labour ward chart)'.

ASA is documented for epidural in labour. The patient then has a tear repaired under local anaesthesia with no ASA documented. Can the same ASA be applied to the local anaesthesia too?

In the case described assign the filler digits of '9'. The exercise in the ICD-10-AM Third Edition Education program will be amended to reflect this advice.

A patient has an epidural inserted for postoperative analgesia (inserted in theatre) but it falls out on day 2 and is replaced with a PCA (assumed intravenous). Assuming that my hospital wants to code the post-op PCA, does

the hierarchy of ACS 0031 Anaesthesia part 5, p43 apply?

If your facility wishes to assign a code for the postoperative PCA, then the hierarchy within block [1912] *Postprocedural analgesia* will not apply.

ACS 0031 Anaesthesia – where an epidural is inserted in theatre but infusion was not started until some hours after return to ward, can this still be considered 'initiated in theatre'?

Yes.

In block [1912] Postprocedural analgesia; the note says 'initiated in operating suite (theatre or recovery)'. An epidural continuing for caesarean section is not 'initiated in OR' but we still code. Does this note need amendment?

An amendment will be made to this note to indicate that neuraxial blocks continued for caesarean section (and therefore initiated prior to theatre) and maintained postprocedurally are to be assigned a code from [1912] *Postprocedural analgesia*.

Arterial disease

Advice given at the ICD-10-AM Third Edition workshops not to include cerebrovascular disease in ACS 0941 *Arterial disease* (p156) raised the following queries:

There was discussion at the workshop about the relationship between I65.2 Occlusion and stenosis of carotid artery and I67.2 Cerebral atherosclerosis and whether one (in which case which one) or both should be used for patients who have carotid stenosis due to underlying atherosclerosis. There is advice on the NCCH database (Q182, Q1290) which seems contradictory. How should these codes be used?

The advice provided in Q182 and Q1290 is not contradictory. In summary, in ICD-9, the assumption was that atheroma of the precerebral arteries was synonymous with occlusion. This assumption changed in ICD-10 for carotid, basilar and vertebral arteries, that is, there may be other causes of the occlusion/stenosis that are not due to atheroma. However, if atheroma/atherosclerosis of these precerebral sites is documented, then I67.2 *Cerebral atherosclerosis* is the correct code to assign. If it is clear from the clinical documentation that the stenosis/occlusion is due to atheroma, then only the atheroma needs to be coded.

ACS 0941 Arterial disease states that 'over 50% stenosis of other arteries that is not documented as due to another cause, is to be assigned the appropriate atherosclerosis code'. There was a coding example at the workshop which specified 70% carotid stenosis. Would the

removal of cerebrovascular disease from ACS 0941 Arterial disease mean that in the case of a 70% stenosis of the carotid artery, atherosclerosis could not be assumed?

Yes, as stated in the workshops, the classification guidelines relating to the conditions outlined in ACS 0941 *Arterial disease* should not be applied to cerebral and precerebral arteries. In these cases, follow the Alphabetic Index to assign the correct code.

Debridement

In Example 1 of ACS 1217 Repair of wound of skin and subcutaneous, 30023-00 [1566] Excisional debridement of soft tissue is assigned for the wound debridement. However, the wording in the example does not indicate whether the debridement took place within the soft tissue or just at skin level, for example, to neatly oppose ragged skin edges prior to suture. Couldn't the terminology used in example 1, wound debrided, mean either soft tissue level or skin level or both?

The terminology used would usually be applied to both levels. Further clarification would be found on the operation report.

ACS 1203 Debridement: Can the code 30023-01 [1566] Excisional debridement of soft tissue involving bone or cartilage be used to capture a debridement of an amputation site? For example, patient amputated the distal tip of a finger. Operation sheet states 'debridement of distal phalanx and V-Y flap'. Do we assign the above code and a code for the flap, or do we code to debridement of open fracture, code 90580-00 [1566] Debridement of open fracture site with the flap code, or do we code 46396-02 [1449] Osteotomy of finger with the flap code? Can this new code for bone debridement be used to capture debridement of bone alone or does the soft tissue have to be debrided as well? We tend to see a lot of cases where only debridement of bone is done. How would a debridement of only 'bone' be coded?

In the case cited if documentation indicates that only a debridement of the amputation together with a V-Y flap is performed assign 30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage* and a code for the V-Y flap. If any other orthopaedic procedure is performed, such as reduction of open fracture or osteotomy, the debridement code is omitted. If the procedure involves debridement of the fracture site (with no reduction etc) assign 90580-00 [1566] *Debridement of open fracture site*.

Following clinical advice, if a bone debridement alone is performed this will usually be in

conjunction with another orthopaedic procedure therefore follow the index entry and 'omit' code.

Diabetes

In ICD-10-AM Third Edition if the aetiology/manifestation coding has been modified what will then happen when coding multiple microvascular complications eg retinopathy, nephropathy etc if the whole diagnosis is captured in the diabetic code so a code from other chapters isn't needed. In coding multiple microvascular complications we need the codes from other chapters to show what body system is affected. We may though end up with one code E1-.71 Diabetes mellitus with multiple microvascular complications and nothing else.*

In ICD-10-AM Third Edition the aetiology/manifestation convention that has been modified is the use of dagger and asterisk codes. A review was done on dagger and asterisk codes that had the same titles. Where the use of a dagger and asterisk combination did not give any more information (ie the two codes had the same information in the code titles), one of the codes was deleted from the classification. This does not have any affect on the coding of diabetes as dagger and asterisk codes are not involved. Specifically when coding multiple microvascular complications, ACS 0401 *Diabetes mellitus and impaired glucose regulation* must be followed and all appropriate codes assigned.

ACS 0401 Diabetes mellitus and impaired glucose regulation: The general classification principles in diabetes mellitus are: only conditions indexed... can be classified to 'with complication' categories in E10-E14. Does the instruction in ACS 0401 Diabetes mellitus and impaired glucose regulation contradict the advice given in NCCH database query 1371?

Query 1371 related to ICD-10-AM Second Edition and the question asked was whether diabetes with cellulitis should be coded to E1-.62* *Diabetes mellitus with skin and subcutaneous tissue complication*. The response was as follows:

'Cellulitis is not always associated with diabetes. If the clinician has documented clearly that the cellulitis is related to the diabetes you should use E1-.62 and a code for the cellulitis. If there is no documented direct relationship between the diabetes and cellulitis then the index should be followed. Cellulitis is not indexed under diabetes, so you should assign an unspecified diabetes code (dependent upon other conditions present) and the appropriate cellulitis code'.

The ACS 0401 *Diabetes mellitus and impaired glucose regulation* does not contradict the

advice in query 1371. If a clinician clearly documents a causal relationship between diabetes and a specific condition then this condition must be coded as a complication of diabetes whether or not the index links them. In cases where the clinician has not documented a causal relationship, then the coder checks the index to see if the index links the specific condition with diabetes and codes according to the index.

In reference to the index entry in Volume 2, 'Diabetes, with arthropathy (Charcot's) E1-.61 Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication': Could you please clarify which condition/s the term 'arthropathy' used in E1-.61 is meant to represent? 'Charcot's' is in brackets so presumably this means there are other conditions which may go here? Given that 'Arthropathy' in the index (p37) says 'see also Arthritis', E1-.61 could be interpreted to mean that any of the conditions listed in the index under these terms is included in the code. Advice was given in Coding Matters (8(2):10) which said that E1-.61 should not be used for osteoarthritis and that the index would be changed for ICD-10-AM Third Edition. Whilst the confusing term 'with bone change' has been removed from the list of complications under Diabetes, I feel the term 'arthropathy' may still cause me similar confusion and can only presume that the advice in Coding Matters is still meant to be applied. Is the index still correct? Could you explain this for me?*

The advice published in *Coding Matters* is correct. The index entry at Arthropathy to 'see also Arthritis' does not mean that arthropathy is the same as arthritis. It is an alternative look up for conditions that may not be under arthropathy but are under arthritis. They are not necessarily the same thing. Under 'Arthropathy' there is a subterm entry for 'with diabetes' but no such entry appears under 'Arthritis'.

I can't find 'eradicated' in Volume 2 under 'Diabetes, condition, eradicated, previous disease'. Please explain how I find this condition in Volume 2?

There are no specific index entries for eradicated conditions in diabetes. This is a new convention and ACS 0401 *Diabetes mellitus and impaired glucose regulation* provides the direction on how to apply this convention. Codes will vary according to the individual cases.

A patient with diabetes and peripheral vascular disease (PVD) has had a femoro-popliteal bypass. Is the PVD classified as an eradicated condition?

No, PVD with bypass is an attempt to control the symptoms, it is not a cure for the disease. The diseased vessels are still present, but the most adversely affected sites are bypassed. Therefore the PVD is coded as a complication and not as an eradicated condition.

ACS 0401 Diabetes mellitus and impaired glucose regulation classification box (Vol 5 p92) lists different fifth characters to that in the Tabular List. Which is correct and will this be an errata change?

The correct fifth characters are those listed in the ICD-10-AM Third Edition Tabular List (Vol 1 p296). The classification box in ACS 0401 *Diabetes mellitus and impaired glucose regulation* (p92) will be amended.

The note in the classification box (Vol 5 p93) of ACS 0401 Diabetes mellitus and impaired glucose regulation states that "when unqualified obesity, hypertension or other lipid disturbance is/are documented with diabetes mellitus or impaired glucose regulation (IGR) and none of the above criteria are met, assign the appropriate diabetes or IGR code with these conditions as additional diagnoses." In ICD-10-AM Second Edition, ACS 0401 Diabetes mellitus is clear. It emphasises when either unqualified obesity or essential hypertension is documented with diabetes mellitus (and other criteria are not met) then insulin resistance is not coded. The inclusion of 'is/are' in ICD-10-AM Third Edition means that one or more of the stated conditions could be documented with diabetes. If the unqualified obesity and hypertension are both documented, then point 5 applies and insulin resistance is coded. The intention of ACS 0401 Diabetes mellitus In ICD-10-AM Second Edition to advise coders not to assume insulin resistance if only one of these two conditions is documented is now confused by the choice of 'is/are' in ICD-10-AM Third Edition. There was also some confusion over what codes are implied in other lipid disturbance (E78.- Disorders of lipoprotein metabolism and other lipidaemias).

The terminology 'is/are' in ICD-10-AM Third Edition was included due to there being a number of different types of lipid disturbances, none of which meet the criteria for the type of dyslipidaemia in insulin resistance (that is, elevated fasting triglycerides and depressed HDL-cholesterol). The following changes will be published in a future errata:

Note: When either unqualified obesity (E66.-) or hypertension (I10) or other lipid disturbance (E78.-) is documented with diabetes mellitus or IGR and none of the above criteria are met, assign the appropriate diabetes or IGR code with these conditions as additional diagnoses. ►

If coding dyslipidaemia with no further information, what E78.- code should be assigned?

Dyslipidaemia means 'abnormal lipids in the blood'. Category E78 *Disorders of lipoprotein metabolism and other lipidaemias* contains various types of dyslipidaemia. If no further information is given on the specific type of dyslipidaemia, assign E78.9 *Disorder of lipoprotein metabolism, unspecified*.

Point 4 of the classification box (p93, Vol 5) of ACS 0401 Diabetes mellitus and impaired glucose regulation, seems to be superfluous. Point 3 directs the use of a diabetes/impaired glucose regulation with features of insulin resistance code regardless of whether the patient has hypertension. Are we missing a vital point?

Your comment is valid and we will review this point for ICD-10-AM Fourth Edition.

Coding exercise 4 in the diabetes section of ICD-10-AM Third Edition education program required the use of two codes for dyslipidaemia – the components of the definition in the standard. Is the term 'hyperlipidaemia' synonymous with dyslipidaemia? Can E78.5 Hyperlipidaemia, unspecified be used alone with the diabetes/impaired glucose regulation with features of insulin resistance code or must the pathology be checked against the definition of dyslipidaemia and codes E78.1 Pure hyperglyceridaemia and E78.6 Lipoprotein deficiency be applied if applicable?

No. E78.5 *Hyperlipidaemia, unspecified* is not sufficient for classification of diabetes mellitus with features of insulin resistance. Dyslipidaemia is a general term that means abnormal lipids in the blood. Hyperlipidaemia is a specific type of abnormal lipids in the blood (that is, hyperlipidaemia is a specific type of dyslipidaemia). The codes for the specific types of dyslipidaemia should be applied, as they are not all covered by E78.5 *Hyperlipidaemia, unspecified*.

Please clarify how same day admissions for people with diabetes are to be coded. I have two scenarios:

- 1. A diabetic patient is admitted for same day treatment of diabetes related cataract (E11.39) and insertion of an intraocular lens (IOL). Should we code all the other diabetic conditions this patient may have as additional diagnoses?*
- 2. A diabetic patient is admitted as a same day case for treatment of non-diabetes related condition (laparoscopy for abdominal pain). Should this patient's diabetic status be coded? Blood sugar levels (BSL) are not*

always monitored. If so, do all other diabetic conditions this patient might have as additional diagnoses need to be coded?

The following information applies to both same-day and multi-day admissions:

In scenario 1, all diabetic complications need to be coded to profile the patient's diabetes.

In scenario 2, code the diabetes only if it meets the criteria in ACS 0002 *Additional diagnoses* (for example, when BSLs are monitored). If it does meet the criteria, code all complications to show the profile of the patient's diabetes.

In ACS 0401 Diabetes mellitus and impaired glucose regulation under 'circulatory complications in diabetes' the subheading 'atherosclerosis' has been removed. In the disease index, the entry for diabetes with atherosclerosis E1-.59 Diabetes mellitus with other specified circulatory complication has been removed. This change does not seem to have been identified in the training module, yet it is a significant one, presumably meaning that arteriosclerosis in diabetes should only be captured if the specific form of arteriosclerosis is indexed under the heading of diabetes.*

This is correct. Further modifications have been made to the index for diabetes in ICD-10-AM Third Edition to emphasise which conditions are linked with diabetes.

In the ICD-10-AM Third Edition education program, there is an exercise on page 4 of the diabetes section – patient with type 2 diabetes mellitus, foot ulcer, peripheral angiopathy. In previous workshops the answers have been E11.73 Type 2 diabetes mellitus with foot ulcer due to multiple causes then I73.9 Peripheral vascular disease, unspecified. If we have more specific information that the patient has arteriosclerotic disease of the extremities could you please confirm whether it is then correct to use E11.73 followed by I70.23 Atherosclerosis of arteries of the extremities with ulceration (when as above the patient has a foot ulcer)?

Always code to the most specific code you are able to use with the documented information. The answer to this exercise and the example in ACS 0401 *Diabetes mellitus and impaired glucose tolerance* (Vol 5, p100) will be amended to I70.2- *Atherosclerosis of arteries of the extremities*.

Can you assign Z71.8 Other specified counselling if the patient has diabetic education during an inpatient stay whilst admitted for something else?

No. ACS 0401 *Diabetes mellitus and impaired glucose regulation* states "For **admission for diabetes education**, assign a principal

diagnosis code from E10-E14 Diabetes mellitus and an additional code of Z71.8 Other specified counselling.”

Can the diabetes education code, Z71.8 Other specified counselling, be assigned for patients with gestational diabetes who are admitted for education regarding the use of insulin etc?

If the patient is admitted specifically for diabetes education assign the appropriate code from O24.4 Diabetes mellitus arising in pregnancy, with Z71.8 Other specified counselling as an additional code.

Can a code from E10-E14 (diabetes mellitus) be assigned, together with the appropriate complication codes, with a code from category O24 Diabetes mellitus in pregnancy or is this an exclusion?

The codes O24.0, O24.1-, O24.2- and O24.3- from the category Diabetes mellitus in pregnancy capture that the patient is pregnant and has pre-existing diabetes. If the patient has diabetic complications, then a code from E10-E14 (diabetes mellitus) should be assigned in addition to indicate those complications. E10-E14 with a fourth character of .9 (without complication) would not be assigned in addition, as it adds no further information than the appropriate O24.- code. A code from E10-E14 is not assigned in addition to O24.4 Diabetes mellitus arising in pregnancy as these patients have gestational diabetes, not the type of diabetes classified to E10-E14. Refer to ACS 0401 Diabetes mellitus and impaired glucose regulation, Vol 5 p91 for further information.

Diabetes is still listed as a specialty standard in ACS 0002 Additional diagnoses. Will this be changed/clarified given advice that diabetes must now meet ACS 0002 Additional diagnoses before being coded?

The inclusion of ACS 0401 Diabetes mellitus and impaired glucose regulation in the list of specialty standards in ACS 0002 Additional diagnoses does not imply that diabetes mellitus itself is to be coded in all situations. It is included in this list as within ACS 0401 Diabetes mellitus and impaired glucose regulation, there are instructions to code other conditions when present with diabetes in certain instances, such as obesity, hypertension and so forth.

ACS 2104 Rehabilitation – example 5 gives E10.51 Type 1 diabetes mellitus with peripheral angiopathy, without gangrene and I79.2 Peripheral angiopathy in diseases classified elsewhere. I cannot find I79.2* indexed as a dagger/asterisk pair with diabetes. Should this code be I70.2- Atherosclerosis of arteries of the extremities instead? Do we actually need any*

additional code because neither I79.2 or I70.2- add any further information anyway?*

An additional code is not required in example 5 (that is, I79.2 or I70.2-) as the concept is covered in the code title of E10.51 Type 1 diabetes mellitus with peripheral angiopathy, without gangrene. I79.2* Peripheral angiopathy in diseases classified elsewhere will be deleted from this example in a future errata.

Duration of pregnancy

We are confused re the term '37 completed weeks'. Please define 'completed' and give some examples. We have been told that the tabular description of code O09.5 34-36 weeks is going to be changed to 34-<37 completed weeks, and that they mean the same, but <37 completed weeks seems to indicate that 37 weeks, 6 days gestation would be premature. However, we were also told that 36 weeks, 6 days gestation is premature but 37 weeks is not. Please clarify.

The NCCH will be reviewing the title of O09.5 Duration of pregnancy, 34–36 completed weeks for the next edition. The terminology used in obstetrics may be confusing at times as 'completed' may be used, or they may describe the patient is being in her '37th week (which really means that she is 36 weeks + ?days). Any time frame of less than 37 completed weeks is deemed to be premature, that is, 36 weeks and 5 days is premature. Remember, 37 completed weeks = 36 weeks + 7 days, not 37 weeks + 7 days.

Enteral infusion

ACS 1615 Specific interventions for the sick neonate: if you code enteral infusion because it meets the criteria, should you code feeding problems with a disease code (even if not documented)?

The reason for enteral feeding cannot be assumed to be for feeding problems as other conditions in sick neonates may necessitate the neonate being fed via enteral infusion. Code only conditions that are documented.

In ACS 1615 Specific interventions for the sick neonate, for 'gastric gavage', how is 'only when administered multiple (>1) times within an episode of care' to be interpreted where a tube is placed and not removed for a period of time? Is the >1 related to placement of tube, or feeds given through tube?

The (>1) refers to the number of feeds given through the tube.

External causes

In the ICD-10-AM Third Edition education program exercises for external causes (p10 of 10), I coded U72 Leisure activity, not elsewhere classified rather than U73.9 Unspecified activity.

The activity applies to the baby not the mother and the baby was not involved in a leisure activity.

Which activity code should be assigned when someone is injured whilst working and their work involves one of the activities described in category U50-U72 While engaged in sports or leisure. An example would be a farmer injured during a fall from a horse whilst mustering sheep.

Where there is an overlap between work and sport, the sport code takes precedence only when the person is injured in their role as a professional sports person, such as a professional golfer or a first grade Australian rules football player. In other words, it is their 'paid work'. Other circumstances, such as where the activity (sport) is inherent in the job, but not the task for which the person is paid, should be assigned the appropriate code from U73.0 *While working for income*. For example, in the scenario provided, the farmer is paid for his animals/crops etc, not for riding the horse.

Which external cause code should be assigned when a person (usually elderly) is injured whilst riding on a gofer or motorised scooter (may be three or four-wheeled).

In ICD-10-AM Third Edition, a motorised scooter or wheelchair is defined as a pedestrian conveyance (see Vol 1 p451). If the accident meets the definition of a transport accident (such as a collision with a car), then assign the appropriate code from V01–V09 *Pedestrian injured in transport accident*. Where the injuries are sustained as the result of a fall from motorised scooter, then assign the appropriate code from W00-W19 *Falls*.

External cause index, place of occurrence, Vol 2, p456. The Index gives an essential modifier of indoor and outdoor for 'athletics and sports area'. However in the Tabular List pp503–4, these are non-essential modifiers. This difference was highlighted when discussing what to code if the patient was playing Australian rules football at the Colonial Stadium with the roof open or closed. Using the index, you have to choose indoor or outdoor first, but the Tabular List description of 'sporting grounds' (outdoor) appears more correct than 'sporting hall'.

Outdoor stadiums, such as Colonial Stadium and the Tennis Centre, which have moveable roofs, should still be assigned Y92.30 *Sporting grounds (outdoor)* regardless of whether the roof is open or closed when an injury occurs. Indeed, we would be most surprised if that level of detail was documented when reporting an injury.

Regarding the sequencing of place of occurrence and activity, all the workshop answers sequence the activity before the place of occurrence. Previously, it was the other way around. Is there a particular sequence for these codes?

There is no rule in ACS 2001 *External cause code use and sequencing* relating to the sequencing of activity and POO codes. Please follow your state/territory health morbidity collection guidelines.

Incidental findings at endoscopy

ACS 2111 Screening for specific disorders and 2113 Follow-up examinations for specific disorders. If there are incidental findings at an endoscopy that is done for screening or follow-up purposes, do you code the incidental findings? I assume not, because you cannot follow ACS 0046 Diagnosis selection for same day endoscopy as it specifically excludes endoscopy for screening or follow-up.

No. ACS 0046 *Diagnosis selection for same day endoscopy* specifically excludes cases where the patient is presenting for follow-up investigations or those admitted for screening. Refer to '10-AM Commandments', *Coding Matters* 8(4) for further information.

Infection with drug resistant microorganisms

ACS 0112 Infection with drug resistant microorganisms: Why is a non multi-resistant bug being assigned Z06.1 Infection with multidrug resistant Staphylococcus aureus?

There are different strains of Methicillin Resistant Staphylococcus Aureus (MRSA): hospital-acquired and community-acquired. The latter, also known as non multi-resistant MRSA, is less resistant to other antibiotics and is typically resistant to only methicillin and penicillin. This specific information is not always documented in the record, therefore, for the purposes of classification with ICD-10-AM, both strains of MRSA are to be assigned Z06.1 *Infection with multidrug resistant Staphylococcus aureus* in accordance with the instructions in ACS 0112 *Infection with drug resistant microorganisms*.

If a doctor notes staph infection in the medical record but MRSA comes back on the micro report and is not noted in the medical record, can the MRSA be coded or does it have to be documented?

New ACS 0112 *Infection with Drug Resistant Microorganisms* states “If the clinician has documented in the record that the organism causing the infection is resistant then the appropriate code from Z06.- *Infection with drug-resistant microorganism* must also be assigned”.

The presence of an infection (such as a wound infection, urinary tract infection, pneumonia etc) must be documented and meet the criteria for coding in accordance with ACS 0002 *Additional diagnoses*. If the condition is documented, the microbiology results may be used to ascertain the causative organism, which would be coded in addition to the condition, or combined code assigned (such as pneumococcal pneumonia).

The resistance of an organism must be documented in the clinical notes. This may take the form of documentation of MRSA or Vancomycin Resistant Enterococcus (VRE) which are the two most common or other documentation of multiple resistance. ACS 0112 *Infection with drug resistant microorganisms* was written to stop the indiscriminant use of Z06.- *Infection with drug-resistant microorganism* when ‘R’ (resistance to a particular drug) is recorded on a microbiology report.

Lavage of knee joint

I am trying to code “arthroscopic lavage of knee joint”. Under “Lavage, joint, knee, arthroscopic”. The index states “see arthroscopy, knee”. When I go to “Arthroscopy, knee” there is no entry for “lavage” or “washout”. Do I go to “Arthroscopic lavage of joint NEC” 90601-00 [1554], or use the codes “Arthroscopy, knee” 49557-00 [1501] plus “Lavage of joint NEC” 90601-01 [1554]? This may have DRG implications.

Clinical advice has confirmed that lavage is an inherent part of the arthroscopic procedure. The code 49557-00 [1501] *Arthroscopy of knee* should be assigned for arthroscopic lavage of knee joint. Changes will be made in a future errata of ICD-10-AM to reflect this.

Limb lengthening

There is an exercise in the ICD-10-AM Third Edition education program on limb lengthening where the principal diagnosis is a bony deformity of the tibia following severe osteomyelitis 6 months previously. Why are sequelae codes not assigned in this scenario?

Codes from the category B94 *Sequelae of other and unspecified infectious and parasitic diseases* are assigned to indicate conditions in categories A00-B89 *Certain infectious and parasitic diseases* as the cause of sequelae, which are themselves classified elsewhere. In this exercise, the type of osteomyelitis is not specified. It is only in cases where the osteomyelitis is of a type classifiable to A00-B89 that the sequelae codes from B94 *Sequelae of other and unspecified infectious and parasitic diseases* may be assigned.

External fixation with invasive device to bone. Can 50130-00 [1550] Application of external fixation device NEC for the application of the Ilizarov frame be assigned?

This code is to be assigned if the procedure cannot be classified elsewhere (NEC) and is not part of a correction of bone or joint deformity, reduction of fracture or a limb lengthening procedure. Note that limb lengthening is very different from a simple application of external fixateur, such as an Ilizarov frame. The application of an Ilizarov frame does not equate to limb lengthening. There must be documentation of a limb lengthening procedure to assign the limb lengthening code.

Multiple/bilateral procedures

If a patient has a fusion of four metatarsal joints of four toes through the one incision, is the the procedure coded four times?

Yes. ACS 0020 *Multiple/bilateral procedures*, indicates that if a procedure involves two or more sites, the procedure should be coded as many times as it is performed. If the index does not provide a bilateral or multiple site procedure code, and the procedure meets the other requirements as outlined ACS 0020 *Multiple/bilateral procedures*, then it must be coded as many times as it is performed.

ACS 0020 Multiple/bilateral procedures – ‘if a procedure involves 2 or more sites’ – if 2 lesions are removed from the same body part, such as the leg, is this coded twice?

Yes. ACS 0020 *Multiple/bilateral procedures* indicates that if a procedure involves two or more sites, or is performed under anaesthesia, the procedure should be coded as many times as it is performed. If a patient has three skin lesions removed from the leg, then assign 31235-03 [1620] *Excision of lesion of skin and subcutaneous tissue of leg* three times.

ACS 0020 Multiple/bilateral procedures: Does this change to ACS 0020 mean the excision of endometriosis from different sites, such as peritoneum, bladder, ovaries, uterus is coded as many times as it is performed?

Yes. The Standard indicates if the procedure involves 'two or more sites' it should be coded as many times as performed.

In the case of endoscopic bilateral ureteric stenting, is this assigned two codes or one? Coronary stenting has codes for multiple stents, same artery or > 1 arteries. It is not the norm to stent both ureters (calculus, obstruction don't usually affect both ureters, unlike female sterilisation where both sides must be done).

ACS 0020 Multiple/bilateral procedures indicates that if a procedure involves two or more sites, it should be coded as many times as it is performed. Therefore if an 'endoscopic bilateral ureteric stent' is performed this would be coded twice as there is no available 'bilateral' procedure code.

Old AMI

I am still having difficulty interpreting the standard ACS 0940 Ischaemic heart disease , particularly the sections relating to 'Old myocardial infarction' and 'Other forms of ischaemic heart disease'.

How am I to know whether or not a patient is still receiving care for their 'old' anterior myocardial infarction (AMI)? If a link is not documented which code should I use, I25.2 Old myocardial infarction or I25.8 Other forms of chronic ischaemic heart disease? Am I correct in assuming that the NCCH wants this standard to stop using I25.8 when the 'old' AMI does not qualify as an additional diagnosis? Does it mean that when the significance of the 'old' AMI is not stated I should be 'defaulting' to I25.2?

The presence of ischaemic heart disease with a diagnosis of 'old MI' may indicate that the MI occurred recently and may therefore meet the criteria for assignment of I25.8 *Other forms of chronic ischaemic heart disease*.

The intent of ACS 0940 *Ischaemic heart disease* is not for clinical coders to make assumptions as to whether there is a causal relationship between the old MI and the IHD, this information is rarely documented and clinical coders should not make this judgement

If the documentation includes 'old myocardial infarction (MI)', I25.2 *Old myocardial infarction* can be assigned if the condition has resolved but is directly relevant to the current episode of care. Amendments to the section within the standard relating to 'Old myocardial infarction' will be made in a future errata of ICD-10-AM.

Neoplasms and morphology/ICD-O-3

ACS 0207 Complications associated with neoplasms: Please clarify the principal diagnosis in the context of amended second paragraph "if a patient presents with a problem...and only the problem is being treated, then the problem should be principal diagnosis". Therefore, if a patient with a known brain tumour presents with seizures and during their episode of care is given chemotherapy for the tumour what will be the principal diagnosis in this scenario? (The seizures were of course treated).

A patient admitted with seizures on a background of a brain tumour, both of which are treated during the episode of care, would have a code for the brain tumour assigned as the principal diagnosis and the seizure as an additional diagnosis code.

A query arose from the workshops with regard to the assignment of a morphology code when it follows a lead term and the disease code is from another chapter.

There are instances in the index where there is a morphology code directly after a lead term and the disease code is from another chapter. The intent of this instruction in the workshops was to advise clinical coders that a morphology code could apply to any subterm below the lead term that does not have an alternative morphology code, eg Adenoma, prostate N40 + M8140/0. This example clearly illustrates that the assignment of a morphology code here is appropriate as the condition is neoplastic.

The NCCH has since identified some areas within the index where there are inconsistencies in applying this coding practice for example, tubal mole, this term may be used to indicate a tubal pregnancy and is not considered a neoplastic condition therefore the assignment of a morphology code in this instance would be inappropriate. A review of these index entries will be undertaken for a future edition of ICD-10-AM. In the meantime clinical coders need to be mindful that when following this coding practice that if the condition is non neoplastic a morphology code is **not** to be assigned.

Are there other new entries for specific sites where there is no reference to the neoplasm table?

There are no new entries for specific sites where the neoplasm table wouldn't be used. All new entries from ICD-O-3 have been included in the tabular and index with reference to the neoplasm table where appropriate.

Pacemakers

ACS 0936 Pacemakers: Is the use of the status code only applicable to patients admitted for surgery or does it need to be assigned for medical admissions as it is listed as one of the specialty standards?

The inclusion of ACS 0936 *Pacemakers* in the list of specialty standards in ACS 0002 *Additional diagnoses* does not mean that a status code for pacemaker is to be assigned in all cases. The second sentence of the section 'Specialty standards' should be read carefully. 'The following standards are examples of where the coder is instructed to code conditions which do not meet the additional diagnoses criteria'. In other words, there are instructions within these standards which direct the clinical coder to assign a code for a condition(s), in certain instances, which ordinarily may not meet the criteria for an additional diagnosis. The instructions in ACS 0936 *Pacemakers* direct the coder to assign Z95.0 *Presence of cardiac device* for all surgical cases.

Postnatal blues

ACS 0505 Mental illness complicating pregnancy- postnatal blues - does this have to be documented by a psychiatrist?) What if this is documented by a midwife?

If 'postnatal blues' is documented by an obstetrician/clinician/midwife it should be coded.

Postprocedural complications

ACS 1904 Postprocedural complications: If the clinician documents a transient condition as being 'postprocedural' do we code it to a postprocedural complication? When do you use D64.9, D62 or T81.0 in relation to anaemia?

If the clinician has documented that a transient condition is a complication of the procedure, then a postprocedural complication code may be assigned. The use of the term 'postprocedural' alone to describe the condition does not meet the criteria for a postprocedural complication, unless the condition is still present at discharge or has persisted postprocedurally for at least 7 days. Without clinical documentation of specific cases, we are unable to provide assistance on the correct code assignment for anaemia.

Reopening of operative site

In ACS 0039 Reopening of operative site, two new codes in block 746 Other destruction procedures on vascular sites are included. Do you need to have documentation to support the postoperative component (block [746]) for coding of the procedure and should you assign

in conjunction with diagnosis codes for postprocedural complication?

The codes mentioned in ACS 0039 *Reopening of operative site* (Vol 5 p46) are not new in ICD-10-AM Third Edition. They have been included in this standard because they are relevant to the information contained therein. They would be assigned in cases where an operative site required reopening (either intra-abdominal or extremity) due to bleeding/haemorrhage following a procedure. The assignment of a diagnosis code for a postprocedural complication would be dependent on the documentation in the particular case.

Sepsis and septicaemia

If septicaemia is not indicated by the attending clinician and the only documentation is 'sepsis', can A41.9 Sepsis, unspecified be assigned?

Where no further clinical advice is available and there is no documentation in the clinical record of the 'sepsis' referring to a localised infection, then A41.9 *Sepsis, unspecified* may be assigned.

Stroke

ACS 0604 Stroke: Re long standing deficits, specifically sequelae of stroke (hemiplegia etc). Do the changes to this standard mean these deficits are coded only when they meet the definition of an additional diagnosis?

These conditions should be coded only when they meet the criteria of an additional diagnosis as per ACS 0002 *Additional diagnoses*.

ACS 0604 Stroke: Example 2 p117, can you code the residual hemiparesis if no treatment/assistance is provided to the patient. All this says is that mobility is affected. Does this meet the additional diagnosis standard? Coders interpretation of documentation in the medical record could vary the coding of this in terms of patient assistance/treatment.

Patients who have had a previous stroke and are left with residual deficits should have these conditions coded when they meet the criteria for an additional diagnosis (ACS 0002 *Additional diagnoses*). In example 2 of ACS 0604 *Stroke*, it states that 'mobility' was affected, and therefore the condition would necessitate increased nursing care and/or monitoring.

ACS 0604 Stroke: Dysphagia – does this meet the additional diagnosis standard if treated by an allied health professional regardless of the 7 day rule or feeding program? Is this an expected outcome for someone who has a CVA and that is why we are not coding it if not persistent for 7 days?


Some neurological deficits will resolve spontaneously or without the need for ongoing treatment. Most stroke patients will usually have some form of dysphagia and criteria was therefore developed as guidance for coding this condition. As stated in ACS 0604 *Stroke*, 'dysphagia, urinary incontinence and faecal incontinence should only be coded when certain criteria are met'. Therefore, dysphagia, even when treated by an allied health professional, would not be coded unless it was present for more than 7 days and/or required nasogastric tube/enteral feeding.

ACS 0604 Stroke: Old CVA – does this meet the additional diagnosis standard? Does the application of this code have to be relevant to the reason for admission? If there is an anaesthetic risk, can you assign the code? Does it relate to the specialty standards (personal history)?

An 'old CVA' (I69.0 – I69.4) would be coded if the patient has residual neurological deficits still present and they meet the criteria for inclusion according to ACS 0002 *Additional diagnoses*. ACS 2112 *Personal History* indicates that codes in categories Z85 – Z87 (Personal history) are assigned only as additional diagnoses when the condition is completely resolved but is relevant to the current episode of care. Regarding anaesthetic risk, there would need to be clear documentation of the anaesthetic risk, and the way this changed the standard treatment protocol, before assigning a code for 'old CVA'.

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Suspected conditions

ACS 0012 Suspected conditions: Re the term 'probable diagnosis' in the paragraph before example 3. Does this apply to any of the terms listed at the start of the ACS (under 'Discharged home') such as suspected, possible or any other qualifying expression? Would it include 'viral illness'?

Yes. All synonyms of 'probable' that indicate uncertainty about the final diagnosis may be included.

Trial of void (TOV)

ACS 1436 Trial of void: Do you code trial of void (TOV) when the patient is not specifically admitted for TOV (procedure carried out as part of another admission)? What do you do if the episode had both successful and unsuccessful TOVs?

The information in ACS 1436 *Trial of void* is to be followed when patients are admitted specifically for a trial of void. A trial of void in a multi-day stay patient following a urinary procedure, for example, would not be coded. Unsuccessful followed by successful TOVs are most likely to be in a multi-day stay admission and are therefore not coded.

Urinary tract infection (UTI)

ACS 0010 General abstraction guidelines: Example 3 (p6) 'do not code UTI when only microbiology results show organisms...' Firstly, does this include when sensitivities to drugs are stated in microbiology?

Secondly, doctor queries whether patient has UTI and results come through after the patient goes home (doctor queries a number of probables, the UTI being just one of them) Do we code UTI in this instance?

In answer to your first question, microbiology results are used to specify the infecting organism/sensitivities once a UTI has been diagnosed and documented by the clinician.

In response to your second query, the coding of suspected conditions depends on a number of variables. Please refer to ACS 0012 *Suspected conditions* for further information.

Ventilation

ACS 1006 Respiratory support: Regarding completed cumulative hours; do you add the exact times, then round down to the completed hours? (Rather than round each, then add).

Add the exact times, then round down to the completed hours.

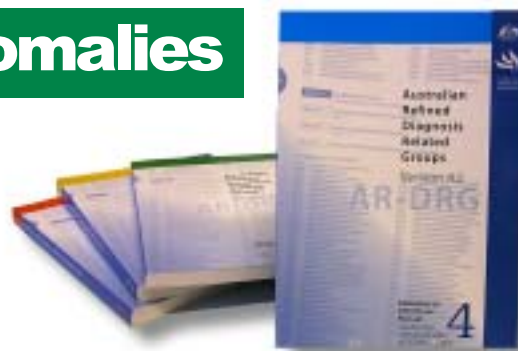
**More FAQs will be published in
Coding Matters December edition**

Reporting grouper anomalies

A new function has been added to the Commonwealth Department of Health and Ageing's casemix branch web pages to enable electronic reporting of grouper anomalies.

The DRG Development Section has copies of all the AR-DRG groupers and we ask that the form be completed, so that we can test the data against the software in use in your facility. DRG Development will test the problem and have a return answer to your query.

In the past, notifications of grouper anomalies have been sent via state and territory coding committees, state and territory health authorities, the NCCH or to the DRG Development section at DoHA. In most instances, changes have already occurred or may have been worked on in the latest version of the AR-DRG grouper. Often this may take time, following a rather circuitous route to get to DRG Development and then more time to analyse the problem and give a response. It is anticipated that responses should be received within three working days.



If it is a problem that has not been corrected in later versions of the AR-DRG classification, then it will go on file to be reviewed in the next version. DRG Development has already started to collect recommendations for change for version 6. A formal Public Submission process will be advertised in the press. This function can enable a rapid response to queries. One state has already notified its coders of this function and we have been able to respond by return email that problems have been corrected in AR-DRGv4.2 and AR-DRG v5.0. Hopefully, coders will appreciate that the classification does take time to prepare and implement.

This function is located on the main page of the Casemix web site www.health.gov.au/casemix

Corrections to Chapter XIII, volume 1, ICD-10-AM Third Edition

Some corrections need to be made to Chapter XIII, *Diseases of the musculoskeletal system and connective tissue* in volume 1 of ICD-10-AM Third Edition hard copies.

Replacement information has been published as stickers that can be affixed over the incorrect information on pages:

- 249 right column
- 250 left column
- 258 right column
- 260 left column
- 268 left column
- 454 left column

NCCH will send copies of the stickers to all purchasers of hard copies of ICD-10-AM Third Edition. Please amend your books with the correct information when you receive the stickers.

If you have not received the replacement page by the end of September, please contact Catherine Stanhope at NCCH Sydney phone: 02 9351 9768 or e-mail: c.stanhope@fhs.usyd.edu.au to arrange delivery. Copies of the corrected information is also available to download from the NCCH web site ICD-10-AM Third Edition page www.fhs.usyd.edu.au/ncch/

Users of electronic versions of ICD-10-AM Third Edition are not affected by these corrections.

Report

Recording general
practice information

We're all familiar with medical documentation and coding for inpatients. But there is a wealth of information about patients held by general practitioners, and to date, this information is not formally available to other clinicians in an electronic form. Some exchange of clinical information regularly happens between sectors but this is not efficient, standardised or grafted into electronic applications. The Commonwealth Department of Health and Ageing (DoHA) has been addressing the issue of recording health information from the primary care sector over the last few years.

The DoHA began by establishing a General Practice Coding Jury, who were charged with investigating and deciding the best method for implementing clinical coding for GPs. After considerable deliberation, the Coding Jury recommended that ICD-10-AM, with some augmentation of terms, be used for primary care coding in the short-term. They reserved their decision on the use of a coding system for the longer term, pending availability and investigation of SNOMED-CT.

Since the Jury's decision, it has been realised that there is an immediate need to provide GPs with a set of clinical terms that are relevant to their practice. These terms need to be familiar to GPs, and they must adequately describe the health conditions encountered in primary care. Many terms provided by ICD-10-AM will suit these purposes. But in its present form, it offers most benefit to GPs by acting as a reference system, rather than an interface system. Basically, the first step will be to provide GPs with a set of terms suitable for recording health information. Issue of coding those terms will be addressed in subsequent stages of the project.

The diagram shows how the use of clinical terms and concepts varies between input terms

(familiar to users, in this case GPs) and output terms (for aggregation and reporting purposes).

Initial work on the GP Term Project has begun, with a focus on building a controlled interface vocabulary. Dr Don Walker (University of Adelaide, Faculty of Medicine, Department of General Practice) is leading this project, and staff from the NCCH Classification Development Unit have been sub-contracted to provide nosological assistance. Dr Peter Scott from NCCH Brisbane is providing valuable help; as a GP he is familiar with the characteristic idiosyncratic use of clinical terms and the 'short-hand' descriptors of health problems often used by GPs.

Terms regularly used by GPs to record patient conditions have been gathered, and are now being examined and parsed to provide a set of terms that will meet the immediate needs of GPs for an interface vocabulary.

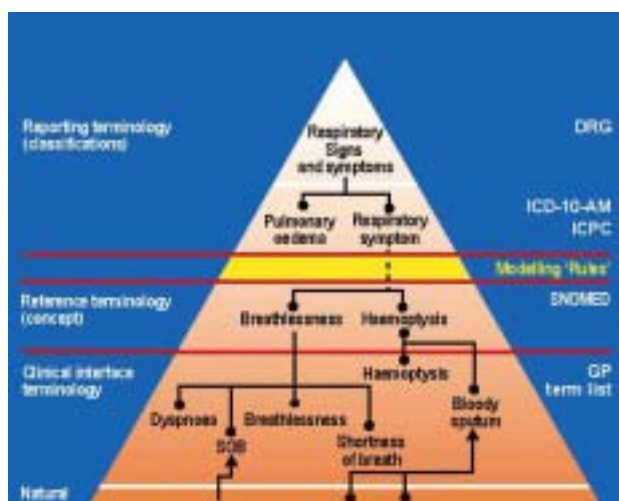
Parsing involves identifying the individual semantic components of GP terms. This process allows identification of domains (or 'buckets') such as symptom/sign/diagnosis/problem, severity, course, site, laterality, procedure, drug, etc, providing a standardised view of the term. That is, terms such as 'mild chronic hepatitis' are parsed into components that are attributed to the 'buckets': mild (*severity*), chronic (*course*), hepatitis (*diagnosis*). It serves to overcome problems raised by different methods of pre- and post-coordination of term phrases, for example:

Chronic ischaemic colitis

Colitis (*problem*)
Ischaemic (*morphology*)
Chronic (*course*)

Hepatitis vaccination

Vaccination (*procedure*)
Hepatitis vaccination (*drug*)
Hepatitis (*problem*)



Probable right bundle branch blockBundle branch block (*problem*)Bundle branch (*site*)Right (*laterality*)Probable (*certainty*)**Post op ingrown Gt toenail check**Ingrown toenail (*problem*)Post op (*time-related*)Gt Toenail (*site*)Check (*process*)

The parsing work will contribute a set of terms, meaningfully assigned to semantic type, which can then be used to construct a familiar GP interface term set. It is expected that this initial phase of the project will be complete by September 2002. Subsequent stages will focus on mapping these terms to ICD-10-AM terms and codes to provide a means of aggregating and reporting health information from GPs. This will also facilitate cross-sector communication.

Quality assurance activities at Monash University National Centre for Coronial Information (MUNCCI)

National Coroners Information System (NCIS) data quality is currently under review by the Quality Assurance Officer, Sue Wood. Quality assurance (QA) activity is focused on the implementation of the NCIS Quality Assurance Plan, which has specific quality targets, including the following:

- **Completeness** – the assessment of whether all reported cases are being transferred between local systems to the NCIS and also review of the data fields for completeness to ensure that there are no 'null' fields
- **Timeliness** – the data needs to be as up to date as possible so that coroners and third party users know that they are accessing current data; and
- **Validity and reliability** – the data is required to be true values and the information to be stable.

A preliminary analysis of NCIS data, has revealed four common deficiencies, namely inaccurate or incomplete data; incorrect coding of coronial cases; lack of supporting documents on NCIS; and a poor closure rate. It is likely that the identified deficiencies were in part caused by a lack of guidance to staff during the initial implementation of the NCIS; technical problems, including poor mapping when system changes have been introduced and occasional corrupt data transfer.

Reviews of Tasmania and Northern Territory are near completion and the results will be made available soon. In addition, Glebe metropolitan cases are currently in the early stages of QA review. Data correction and completion is being done on the local systems for those jurisdictions using MUNCCI designed systems. The changes are then being uploaded to the NCIS. NSW and Victorian QA can only occur on NCIS, as MUNCCI does not have access to their local systems. When NCIS does not hold the necessary documentation to allow the QA Officer to fix the data, staff from the relevant jurisdiction will be requested to provide the data or else to go back to the case(s) and complete or make corrections.

Data review has prompted the creation of a new monthly coding newsletter being provided to the jurisdictions named *Coding Tips*. The content of this newsletter comes from QA analysis, which has identified misconceptions or weaknesses in coding of coronial cases. It is hoped that the newsletter will reinforce and complement coding conventions stated in the NCIS data dictionary and coding manual, and therefore strengthen the quality of our data.

Reprinted with permission from *MUNCCI Talk* Winter Edition, Issue 22, 2002.

Report

ICD-10-AM Third Edition education program

In response to requests from participants at workshops conducted in the past, on-line education was provided for the first time. Evaluations received indicate that the majority of program users found the education program 'very good', although there were some glitches, and much has been learned that will help to plan education programs for Fourth Edition and beyond.

The NCCH wishes to thank on-line education program and workshops participants for their helpful feedback.

ICD-10-AM Third Edition on-line education feedback

On-line (and CD-ROM, for participants without convenient access to Internet connections) interactive self-paced learning material was developed to introduce coders to Third Edition changes before attending optional workshops.

The education material was provided for more than 1 400 people (800+ Internet and 600+ CD-ROM users). Hardcopies were prepared for state and territory health authorities to distribute to users without access to electronic resources.

The evaluation survey response rate was very low at 5.5%.

Media choices

81% of evaluations came from users of electronic versions. 71% of these people used the CD-ROM version, 21% used the on-line version and 8% used both. 19% of responses came from hard copy education material users.

Location choices

76% completed the course at work, 8% at home, and 16% used both home and work places.

On-line education satisfaction ratings

	Overall rating of program	Overall satisfaction	Speed	Design	Instructions	Navigation	Images	Content	Exercises
Poor	4%	1%	11%	5%	3%	6%	2%	1%	1%
Fair	6%	6%	0%	8%	3%	14%	8%	3%	5%
Good	24%	22%	28%	22%	19%	33%	27%	22%	22%
Very good	38%	42%	39%	38%	43%	22%	38%	45%	40%
Excellent	27%	29%	22%	27%	32%	24%	25%	29%	31%



Users satisfaction ratings of on-line education

The average rating of the on-line education was 'very good' in areas of speed, design, instructions, images, content, exercises, and overall satisfaction with the product. Navigation rated an average response of 'good'. A breakdown of ratings is presented in the table below.

Users expectations

37% of respondents expected to:

- gain knowledge of Third Edition changes
- learn about the Third Edition changes to disease and procedure codes
- be briefed about Australian Coding Standards (ACS) changes
- have presented information reinforced by completing exercises.

10% expected the tool to provide an easy, smooth introduction to the changes, and 8% expected an overview of the changes.

Over 60% of responses indicated that expectations were met or exceeded. 5% reported that their expectations were not met, mainly due to navigation and display problems.

Features on-line users liked most

23% made positive comments about the on-line education. Many expressed appreciation for the introduction of on-line education, which when combined with the workshop, provided a very effective education program. Feedback indicates that the on-line education allowed participants to be better prepared and to benefit more from the face-to-face workshops.

37% of participants were enthusiastic about the flexibility of the program. Users were particularly enthusiastic about being able to choose places, times and to priorities completion of sections according to interest, relevance and resources available.

Other positive comments were received about:

- product style
- navigation between screens
- challenge exercises
- images used
- content depth.

Aspects on-line users didn't like

14% of respondents reported that they were happy with the product and did not identify any aspect that they did not like.

Other comments about the limitations of the on-line education concerned:

- the volume of material (there was more than anticipated)
- time taken to complete the training (it took longer than anticipated)
- Internet down load problems
- inflexibility in data entry
- navigation issues such as being unable to go back to the previous screen (especially in the exercises)
- the style of the on-line product. Respondents indicated that the display window and font size were too small
- poor linkage to ACS changes
- that it was disadvantageous not to have a link between the education program and the browser version of ICD-10-AM Third Edition
- that people missed the face-to-face element that is a feature of the workshops and stressed that workshops should continue
- that receiving ICD-10-AM Third Edition books earlier would have allowed more time for completion prior to the workshops.

Suggested improvements

Recommendations for improvements largely reflect suggestions to resolve aspects that were least favoured, such as:

- improved navigation
- more exercises, especially those that resemble types of records coded in hospitals
- increasing the size of the display within available screen area
- improving the print function
- linking education material with the browser
- including more images
- including a print facility
- being able to save exercises
- providing prompts for incorrect exercise answers
- wider availability of paper copy to complement the online product.

On-line education and workshops

93% reported that the workshops added value to the on-line education.

90% were in favour of on-line education and would use it again in the future.

88% said that they wanted the workshops to continue.

74% felt that after completing the on-line material it was still important to attend a workshop.

23% did not feel the need to supplement the education with workshop attendance.

6% reported that they would not use interactive education again.

Positive comments for continuing workshops included:

- essential to build upon online education
- opportunity for discussion with NCCH staff and work colleagues
- reinforcement and clarification of on-line education
- the face-to-face aspect of the workshops
- clarification of issues from on-line education
- rural coders who appreciate opportunities to network with peers
- sourcing additional information which only presents itself in a face-to-face environment or was not included in the on-line education package.

A small number of users completed the on-line material in groups at their workplace and found that this was a positive experience. ►

Hard copy users comments

Hard copy users cited:

- access issues with CD-ROM and Internet use
- computers in general
- file download problems
- flexibility of hard copy
- personal choice

as reasons why interactive education was not a suitable option for them to use.

ICD-10-AM Third Edition workshops feedback

During May and June 2002, the NCCH conducted 27 workshops for 892 participants to provide education and information about ICD-10-AM Third Edition changes.

The workshops were planned as optional educational activities. Completion of the on-line program was required to attend workshops. Clinical coders were encouraged to attend workshops for the benefits of face-to-face discussions, clarification of queries and to exchange experiences with other clinical coders.

Participants expectations

93% of coders responded that their expectations about the workshops were met. Expectations included:

- an overview of the Third Edition changes
- clarification of issues emerging from the on-line education program
- discussions with peers and colleagues
- reinforcement of the on-line education program content
- education on specific topics.

Workshop features participants liked most

Aspects that workshop participants reported liking most include:

- the presentations
- the face-to-face aspect of the workshops
- the format of the workshops
- the balance between lectures and exercises
- that presenters were both confident and knowledgeable in their delivery of workshop material
- learning in an informal setting with educators who had a sense of humour and an easy going manner

- interacting with fellow coders
- interpretations of the Australian Coding Standards (ACS) and the discussion that ensued
- hearing others' views.

Respondents also reported that they felt less pressure attending the workshop as much of the complex education material had already been learnt from completing the on-line education prior to the workshop.

Many participants complimented the presenters and expressed appreciation of the time and effort spent by NCCH and the presenters in organising the workshops.

Most appreciated the education prior to the workshops and felt that this provided a thorough grounding about the impending ICD-10-AM changes. Participants also felt that a good balance between the two learning contexts was provided.

Aspects workshops participants didn't like

33% said that they enjoyed everything about the workshop. Venues and catering problems prompted negative feedback from 23% of respondents.

Other feedback included comments about:

- presentation quality (too rushed, too drawn out, poor quality visuals, extended breaks and wasted time)
- insufficient time to complete exercises and for discussion.

Suggested improvements

27% were satisfied with the workshops and did not recommend changes.

29% suggested that more time should be spent on specific topics. ('Diabetes' was identified in the overwhelming majority of responses to this question).

13% suggested that workshops should be extended.

Suggestions for improving workshops included:

- better control of time, slower pace
- using small group work for difficult or contentious topics
- using videos
- presenting complex issues during morning sessions
- conducting the quiz at the end of the workshop

- covering other topics (including the minor changes)
- prompt delivery of books (many coders reported that they did not have enough time to complete the on-line education prior to the workshop)
- conducting more workshops in rural areas
- holding workshops closer to implementation date
- holding single topic workshops for complex or controversial topics
- providing name badges for participants
- providing handouts of all questions with answers and rationales

- providing a summary handout of all Australian Coding Standard changes.

General comments

General education comments included suggestions that:

- NCCH should provide more publications
- establish a mentor system (especially guidance in training new coders in the country)
- NCCH should produce another diabetes video and more diabetes coding education.

Workshop satisfaction ratings

	Overall rating of program	Overall satisfaction	Quality of content	Major points	Practical exercises	Lecture: discussion ratio	Presenter style, pace & delivery	Venue facilities
Not completed	0%	0%	0%	0%	0%	1%	0%	0%
Poor	0%	0%	0%	0%	0%	0%	0%	0%
Fair	3%	2%	2%	3%	3%	4%	2%	6%
Good	23%	20%	23%	22%	18%	32%	20%	23%
Very good	52%	60%	59%	56%	55%	45%	50%	39%
Excellent	22%	18%	16%	19%	24%	18%	28%	32%

PICQTM 2000

Performance Indicators for Coding Quality (PICQ) is a set of predetermined performance indicators which identify coding variation in a defined dataset. When coding variations are identified, causes can be investigated and corrective action taken.



PICQ:

- **identifies** data problem areas
- **identifies** specific records for correction

See order form distributed with Coding Matters or call 03 9479 1811 for further information.

ICD-10-AM Third Edition eBook

The ICD-10-AM eBook is the interactive, electronic version of ICD-10-AM Third Edition, that looks like the printed manuals on screen.

The ICD-10-AM eBook features:

- ▶ hyperlinks between volumes
- ▶ personalised user notes
- ▶ notes marker
- ▶ 10-AM Commandments full-text links
- ▶ user defined search facility.

See the enclosed brochure for more information and technical specifications

Clinical coding and health information management in Romania



Sue Walker (l) and Shannon Watts in Bucharest, Romania

Sue Walker and Shannon Watts provided a consultancy in Romania, funded by USAID and World Learning Inc, from 27 May – 15 June 2003. This was the second visit to Romania by staff of the NCCH, following a needs analysis conducted by Associate Professor Rosemary Roberts in January 2002 (See *Coding Matters* 8(4):15).

Purpose of consultancy

The main reason for this trip was to conduct two training courses relating to ICD-10 coding in a casemix environment: one in Sibiu, Transylvania (home of Dracula!) and another in Bucharest (Romania's capital city). The main topic areas included coding with ICD-10, introduction to casemix, documentation practices and quality assurance techniques.

Approximately 80 clinicians and coders received training, with simultaneous translation of the sessions from English to Romanian.

All PowerPoint slides were also provided in Romanian, whilst we kept track of proceedings with the English versions. Although the time available for the training courses was limited, both workshops were successful.

The participants appeared interested in the materials presented and initiated useful discussions through comments and questions relating to casemix and coding.

Coding and DRG grouping

The Romanian health system has a long history of coding health data, however, the emphasis has previously been on coding for situation analysis and research, not for casemix management. This has meant that until the

genesis of the DRG Project in 2001, some coding quality issues, such as timeliness, had not been high priority areas. Various methods have been used at the hospital level to manage the coding process. The Romanian DRG project team has made significant progress toward standardising coding procedures in a very short time and, although much work remains to be done, have achieved a great deal already.

Coding in Romanian hospitals is performed primarily by clinicians using the Tabular List and Instruction Volumes of ICD-10 (volumes I and II). The third volume, the Alphabetic Index, is still being translated into Romanian. Coding is the responsibility of the specialty department from which the patient is discharged, and is performed when patients are discharged. Generally, either the treating doctor, or his or her registrar or resident, assigns the codes.

Although the use of ICD-10 appears to have been well accepted, there is an urgent (and well-recognised) need to review the classification used for coding medical and surgical procedures. Currently ICPM, the *International Classification of Procedures in Medicine* (WHO: 1978), is used. This classification is out of date, inconsistent with current clinical practice and the source of much frustration amongst hospital staff who find it does not reflect their work. A major recommendation of this consultancy was the need to move to a more relevant procedure classification.

At present, the HCFA 18 grouper is used at the central level by the Romanian DRG team. Hospitals do not presently have access to their own computerised groupers.

Records management

During our visit we had the opportunity to visit a hospital to learn about documentation practices in Romania. We also had a number of meetings with project team members and course participants about health information procedures.

The focus of medical record keeping in Romania is at specialty department level within hospitals. Few hospitals maintain patient-based medical records. This means that it is rare that original medical records accompany patients who are transferred between departments. Records remain in the originating department. A new record is commenced at the time of transfer. This has implications for good quality and completeness of coding for all episodes of care.

Another recommendation from this consultancy was that consideration be given to educating a new workforce of 'health information managers' for Romanian hospitals. The role of this group would be to assume responsibility for the maintenance of health information in the hospital setting, including maintenance of paper-based and electronic records, preparation of statistics and activity reports, coding and development of data quality initiatives and activities.

The ultimate aim would be the development of a patient-based medical record system, with one record per patient used for all admissions and attendances, stored in a specific department which is responsible for filing and retrieving records for research and patient care.

Conclusion

While Romania faces a challenging path in its bid to extend casemix funding from the initial 23 pilot hospitals to the remainder of the country, we are confident that an appropriate infrastructure to develop the project further has been established.



l-r Dr Petru Muresan, Ms Ioana Pertache, Sue Walker, Shannon Watts and Dr Traian Ionescu

The enthusiastic and committed Romanian project team has representation from the health system, including: the Ministry of Health and Family through the (Romanian) National Center for Health Statistics and the Institute for Health Services Management, National Health Insurance House, Ministry of Finance, College of Physicians and project funders USAID.

We enjoyed the opportunity to be able to share our knowledge and experience with members of the Romanian team through both formal training sessions and in general discussions and informal meetings. We thank the Romanian team for their warm welcome, support and willingness to communicate their experiences.

A Memorandum of Understanding (MoU) has been negotiated between the Romanian Ministry of Health and Family and NCCH. We look forward to many years of shared involvement in casemix and classification systems and the mutual benefit that this MoU will bring.



Sue Walker

Associate Director
NCCH Brisbane

Shannon Watts

Acting Manager
Quality and Education Division
NCCH Melbourne



Mental Health Manual

The *ICD-10-AM Mental Health Manual* is a classification of mental and behavioural disorders with glossary descriptions and diagnostic guidelines based on ICD-10-AM Third Edition.

The *Manual* is a diagnostic and coding tool that offers a common morbidity data language between the acute and community health sectors.

EDUCATION CD-ROM AVAILABLE NOW

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ICD-10-AM

ICD-10 Mortality and Morbidity Coding and Death Certification Practices Training Project in the Kingdom of Tonga

The Tongan Ministry of Health and AusAID requested further education in advanced morbidity and mortality coding for both clinicians and coding staff to be conducted in April 2002 from recommendations made at the conclusion of training workshops in Tonga by NCCH staff and consultants in September 2000.

NCCH Brisbane team member, Garry Waller, lead a series of workshops at the Vaiola Hospital on Tongatapu in April 2002 for 43 clinicians and village health officers from the main islands of Tongatapu, Vava'u, Ha'apai, 'Eua and coders from the Vaiola Hospital, attended the workshops.

The training included:

- Two one-day workshops on ICD-10 mortality coding rules and death certification that included an introduction to the WHO rules for selection of the UCOD (Underlying Cause of Death), death certification practices, common problems when coding UCOD from death certificates and practical exercises in applying the rules
- A three day workshop focussing on ICD-10 mortality coding rules for coders that provided detailed coverage of the WHO rules for selection of underlying cause of death and interpretation of the rules
- A three day workshop on ICD-10 advanced morbidity coding that allowed in-depth study of morbidity coding topics, selection of main condition and procedure, coding using ICD-9-CM Volume 3 Tabular List and Index of Procedures
- A one-day workshop that reviewed the paper-based version of the Australian Coding Benchmark Audit (ACBA), general auditing theory and hands on practice using ACBA.

Tonga is composed of about 170 volcanic and coral islands with a total land area of about 700k² and a population of nearly 100,000 people of Polynesian origin. Tonga is a constitutional monarchy and His Majesty King Taufa'ahau Tupou IV is Head of State. The national capital, Nuku'alofa, is located on the major island group Tongatapu. The other main



Officials from the AusAID Tongan Health Project, the Ministry of Health and the Civil Service Training Centre attended the Graduation ceremony at Vaiola Hospital. Pictured are Dr Litili 'Ofanoa Director of Health; Dr Siale 'Akau'ola, Acting Medical Superintendent; Mr Siale Puloka, Deputy Secretary of the Prime Minister's Office Training Centre; Mrs Olivia Tu'ihalamaka, member of the Tongan Health Project and Garry Waller with successful participants.

islands of the archipelago are Vava'u, Ha'apai, 'Eua and Niua.

The people of Tonga are Christian and Sunday activities are restricted to religious observance. Shops are closed, most transport is suspended, and sport is not encouraged. The police will actually ask you to leave the water if found swimming on Sunday. Islands close to the mainland provide relief for expatriates keen for a Sunday drink or a swim.

I had the opportunity to attend the Class of 2001 Nursing Graduation Ceremony at which the Queen of Tonga awarded successful candidates with their certificates and prizes. It was a wonderful ceremony with magnificent choral music. The Vaiola Hospital has a nurses choir and it is compulsory for student nurses to participate.

I was also interviewed by Tongan National News about the workshops and was greatly relieved to hear my nervous stuttering overdubbed in Tongan.

► Garry Waller

Senior Classification Officer
NCCH Brisbane

About the NCCH

CSDD

The Classification Support and Development Division, NCCH Sydney

Given the growth in staff numbers at NCCH Sydney over the last few years, it is timely to briefly describe the activities of the 16 people in the Classification Support and Development Division (CSDD).



Dana Merrin (l) and Kerry Innes

The CSDD is managed by Kerry Innes and is divided into two units: The classification support unit (CSU) and the classification development unit (CDU). Dana Merrin provides fantastic administrative support to the CSDD.

Classification Support Unit

Unit members:

Lindy Best
Tiffany Chan (currently on maternity leave)
Karyn Chen
Megan Cumerlato
Terry Dymmott
Christine Erratt
Sheree Gray (classification support coordinator)
Lisa Richmond
Julie Rust

The CSU looks after NCCH's core business of updating and maintaining ICD-10-AM. While this is easy to say in one sentence, the update and maintenance of ICD-10-AM is a huge task and forms the core of the work of the Classification Support and Development Division (as you can see from the number of staff in the support unit). The CSU has two new arrivals – Lisa Richmond joined the team in June and Terry Dymmott began work in July. Many of the



(l-r) Lisa Richmond, Megan Cumerlato, Lindy Best, Christine Erratt, Karyn Chen and Julie Rust

support unit staff also very involved in education, both material preparation and presentation, when new editions of ICD-10-AM are released.

The production of a new edition of ICD-10-AM involves a lot a research into diseases and procedures, and consultation with the Clinical Classification and Coding Groups.

Processing of public submissions and coding queries also forms a large part of the work in CSU. Both public submissions and coding queries help NCCH to keep abreast of the needs of users of ICD-10-AM and thus feed directly into the update of the classification.

The support unit also creates products derived from ICD-10-AM such as the *ICD-10-AM Early Parenting Manual* and the *ICD-10-AM Mental Health Manual*. Both of these Manuals are recent developments and we hope they will be useful tools for clinicians and coders and lead to other 'subsets' of ICD-10-AM for specific specialties.



Sheree Gray and Terry Dymmott

Who to contact in CSU about:

Project	Contact
ICD-10-AM Fourth Edition changes	Sheree Gray
Early Parenting Manual	Sheree Gray
Mental Health Manual	Sheree Gray Michelle Bramley
Coding queries	Julie Rust
<i>Coding Matters</i> articles about coding	Julie Rust Sheree Gray
Australian Classification of Health Interventions – general enquiries	Linda Best
Allied health interventions	Kerry Innes Megan Cumerlato
eBook	Sheree Gray
Chronicle of ICD-10-AM	Michelle Bramley Christine Erratt
Public submissions	Julie Rust Sheree Gray

Classification Development Unit

Michelle Bramley
Alex Canduci
Kerri Chalmers (currently on maternity leave)
Judith Hooper (currently on maternity leave)
Patricia Saad

The classification development unit (CDU) is also ably assisted by our research officer, Donna Truran, due to the overlap between research and development activities (however Donna is not officially part of this unit). Colin Spowart (systems manager), also not an official CSDD member, provides both CSU and CDU with support in terms of current software developments both nationally and internationally.

Alex Canduci is the manager for ambulatory classification development that, as the name implies, has responsibility for all the ambulatory classification developments – community, GP, emergency, outpatients. While Alex is the manager of ambulatory classification developments, his focus in the near future will be on the Australian Community-Based Health Services Codeset project for which NCCH has recently concluded contract negotiations with the Commonwealth Department of Health and Ageing. We are very pleased that work has begun on the ACBHSC. A great many years of development produced the codeset inherited by NCCH and we are keen to see it refined and ready for implementation as soon as possible.

Kerri Chalmers and Patricia Saad are both working on a GP terms parsing project. Patricia ably works on the GP parsing project as well as assisting Donna with research projects. A current project of interest to readers is the analysis of the use of 'other' and 'unspecified' codes. Why do we use them – is it because the classification is not specific enough or because information to classify to a more specific code is not available in the clinical record? This research will help NCCH to improve ICD-10-AM. The development unit is also evaluating a number of



(l-r) Michelle Bramley, Alex Canduci
and Patricia Saad

Who to contact at CDU about:

Project	Contact
Community codeset	Alex Canduci Michelle Bramley
ISO and IT14/2	Kerry Innes Michelle Bramley and Peter Scott, NCCH Brisbane
ICECI review	Michelle Bramley Kerry Innes
General practice parsing project	Alex Canduci Donna Truran Patricia Saad
SNOMED-CT and other terminologies NCCH Brisbane is also involved in these developments	Alex Canduci Kerry Innes Patricia Saad
WHO Update Reference Committee	Michelle Bramley Kerry Innes
Modelling ICD-10-AM	Alex Canduci Donna Truran Kerry Innes

products that will provide the means to *model* ICD-10-AM. Modelling refers to representing the ICD rules and conventions and the terms within the index and tabular list in a way that can facilitate their manipulation and mapping in an electronic environment. This is a long term project but will provide benefits not only to NCCH's internal ICD-10-AM management but also in the incorporation of ICD-10-AM concepts and rules into the future electronic health record.

Michelle Bramley is currently working with the support unit on production of the chronicle of ICD-10-AM (an electronic summary of changes made to ICD-10-AM through each edition) as well as her normal work in supporting the Update Reference Committee for the World Health Organization. Michelle is also doing a taxonomic review of the International Classification of External Causes of Injury (ICECI) in collaboration with the National Injury Surveillance Unit.

► Kerry Innes

NCCH (Sydney) Associate Director
and Manager, CSDD

CLINICAL CODERS' SOCIETY OF AUSTRALIA UPDATE

CCSA on the World Wide Web

CCSA has created its own web site after deciding to run its own from an independent Internet Service Provider, rather than through the HIMAA web site. This will ensure web site updates on a regular basis, and include items such as member only area that would be password protected. Visit our new home on the web <http://www.ccsofa.org.au>

Board of Directors

Debbie Solomon, a member from Tasmania has recently accepted a position on the CCSA Board of Directors. We will have a vacancy in the near future for a Victorian Representative to take up a position on the CCSA Board and also have a current vacancy for an ACT Board Member.

Mentor Program

The Mentor program is to be revised with new coordinators and we will keep you posted on its progress.

Masterclasses

CCSA Masterclasses are continuing successfully in SA and WA, and are planned to start this year in NSW.

Strategic Planning Day

Constitutional changes were made at the Strategic Planning Day in April 2002, which were then passed at CCSA's AGM, held in July 2002. These changes included increase in membership fees to \$60 per year, introduction of a student membership category (\$30 per year), and changes to the proposer process for membership.

NCCH Conference affiliation

The CCSA Board confirmed its commitment to provide continuing support to the NCCH for the pre-conference workshops at the NCCH biennial conferences. The next scheduled to be held in Melbourne, March 2003. The CCSA plans to conduct its Annual General Meeting and Strategic Planning Day during the NCCH conference to maximise CCSA members' ability to attend.

JOIN CCSA

Please send me an application form to join:

Mr/Mrs/Miss/Ms/Other (please circle) Family name:

Given name/s:

Address:

.....

City / Town: State: Postcode:

Telephone: () Mobile:

Fax: () E-mail:

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CLINICAL CODERS'
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Ten years ago...

We are ten years old! On 6 February 1992, the National Reference Centre for Classification in Health (NRCCH) opened at Queensland University of Technology (QUT) which was followed by an official inauguration ceremony on 10 March of that year. Funded by the Australian Institute of Health and Welfare, and with the support of QUT's School of Public Health, the Australian Bureau of Statistics and Queensland Health, NRCCH was originally established to assist the Institute in its role as a World Health Organization Collaborating Centre for the Classification of Diseases. Its initial Director was Jennifer Mitchell, who held a joint position with NRCCH and the School of Public Health. Jenny Nicol was the Centre's health information manager and only other staff member.

The initial focus of the Centre was to assist with the introduction of ICD-10 for mortality coding in Australia and the Western Pacific region. Little consideration was able to be given to the standardisation of coding practices in hospitals, and it was noted in the official report of the opening ceremony that "each state health department has its own guidelines within the broad framework of WHO and ABS requirements" (Inside QUT, April 1992). Jennifer and Jenny were able to take part in the very first ICD-10 training course run by WHO in Southampton in 1992 and Jennifer also



(l-r) Ian Ring, Len Smith, Jennifer Mitchell, Gary John, John Donovan and Ken Bowman: NRCCH gets off the ground

attended an early Collaborating Centres meeting in Beijing.

From these humble beginnings grew the NCCH as we know and love it today. In 1997, NRCCH joined forces with the National Coding Centre, which had been established by the Commonwealth two years after NRCCH was set up. This gave the Centre a focus on the use of the ICD for both morbidity and mortality reporting and consolidated the expertise of Australian classification and coding experts. Since that time, activities and staffing levels have increased and workloads have skyrocketed. We've come a long way in ten years!

► **Sue Walker**

NCCH (Brisbane) Associate Director

NCCH farewells Karen Peasley

Karen Peasley, NCCH's long-standing Quality and Education Manager, has been farewelled by her colleagues at the NCCH. Karen has resigned from the NCCH to take up a career opportunity at St Vincent's Hospital in Melbourne.

Karen was a pioneer for the NCCH in many ways. She set up the NCCH office in Melbourne (while also fulfilling a secondment at MUNCCI);



(l-r) Rosemary Roberts, Karen Peasley and Kerry Innes

completed several circumnavigations and crossings of Australia and New Zealand to deliver education workshops for various editions of ICD-10-AM; planned and managed several NCCH conferences; and contributed to development and maintenance of NCCH quality tools PICQ and ACBA in Australia and Singapore.

Karen will be remembered for many things, not least her passion for the Sydney Swans (AFL team) her superb organisational skills, meticulous attention to detail and willingness to go the extra mile.

It is anticipated that an Associate Director position will be created to manage the work of NCCH Melbourne, but in the meantime, Shannon Watts is Acting Manager of the Quality and Education division. Shannon is being supported by two new team members, Kylie Holcombe and Virginia Kalma, and by Andrea Groom.

Thank you Karen for your many years of hard work and devotion to the NCCH cause!

Answers to the ‘test your coding skills and knowledge about how famous people died’ quiz

Matching causes of death (and ICD-10-AM Third Edition codes) with famous people.

Congratulations to **Sue Fraser**, of Kalamunda Hospital in Western Australia who provided correct answers. Sue wins an ABC shop gift voucher and the enviable NCCH lifestyle pack including baseball cap, polo shirt and backpack.

<i>Famous person</i>	<i>Biography</i>	<i>Cause of death</i>	<i>ICD-10-AM Third Edition codes</i>
Eva (Evita) Peron	Argentine celebrity	Cancer of the uterus	C55 M8000/3
Rasputin	Siberian ‘Mad Monk’	Assassination: poisoned wine, poisoned food (potassium cyanide), shot (twice), drowned in freezing river	T65.0, X89.09, Y92.9, U73.2, T14.9, X95.99, Y92.9, U73.9, T75.1, X92.99, Y92.81, U73.9
David Niven	Actor	Motor neurone disease	G12.2
Ludwig van Beethoven	Composer	Cirrhosis of liver	K74.6
Maurice Ravel	Composer	Alzheimer’s disease	G30.9, F00.9
George Washington	US president	Acute epiglottitis	J05.1
Emperor Frederick III	German monarch	Laryngeal cancer	C32.9, M8000/3
Mata Hari	WWI spy	Murder: gunshot wound	T14.1, X95.99, Y92.9, U73.9
Henry VIII	British monarch	Syphilis	A53.9
Jimi Hendrix	Rock performer	Heroin overdose, leading to aspiration of vomitus	T40.1, Y12, Y92.9, U73.8, T17.9, W78, Y92.9, U73.9
Isadora Duncan	Dancer	Accidental strangulation: scarf entangled in motor vehicle’s wheel	T71, W76, Y92.49, U73.9
George II	British monarch	Porphyria	E80.2
Leon Trotsky	Russian revolutionary	Murder: blow from ice pick	T14.1, X99.8, Y92.9, U73.9
Rudolf Nureyev	Ballet performer	AIDS	B24
Karen Carpenter	Pop performer	Anorexia nervosa	F50.0
Francois II	French monarch	Mastoiditis	H70.9
Stevie Ray Vaughan	Blues guitarist	Helicopter crash	T14.9, V95.0, Y92.9, U73.9
Duane Allmann	Rock performer	Motorcycle accident	T14.9, V29.9, Y92.49, U73.9
Jumbo	Circus performer	Hit by train whilst crossing tracks. Train de-railed	No codes for veterinary science
Charles Lindbergh Jr	‘the Lindbergh baby’	Murder: Fractured skull	S02.9, X59, Y92.9, Y73.9
Joseph Stalin	Russian dictator	Cerebral haemorrhage	I61.9
Virginia Woolf	Author	Suicide, by drowning	T75.1, X71.9, Y92.9
Rudolf Valentino	Actor	Complications from surgery to repair a perforated gastric ulcer	T88.9, U73.8, Y83.8, Y92.22
John Banner	Actor	Abdominal haemorrhage	R58
Nero	Roman emperor	Suicide, by stab wound from sword	T14.1, X78.0, Y92.9, U73.8
Sylvia Plath	Poet	Suicide, oven gas inhalation	T58, X67.2, Y92.9, U73.8
Socrates	Philosopher	Suicide, drank hemlock	T62.2, X69, Y92.9, U73.8
Kingsley Amis	Author	Accidental, injuries sustained in a fall at home	T14.9, W19, Y92.09, Y73.9
Franklin D Roosevelt	US President	Congestive heart failure	I50.0
Dr Christiaan Barnard	Surgeon	Asthma attack	J45.9
Ingrid Bergman	Actor	Breast cancer	C50.9, M8000/3
Sonny Bono	Pop performer	Accidental, skiing injury – hit tree	T14.9, W22, Y92.9, U55.20
Yul Brynner	Actor	Lung cancer	C34.9, M8000/3
Richard Burton	Actor	Cerebral haemorrhage	I61.9
Jane Austen	Author	Tuberculosis	A16.9
King Herod	Judean monarch	Fournier’s gangrene	N49.8
Sir Harry Secombe	Actor	Prostate cancer	C61, M8000/3
Frank Zappa	Rock performer	Renal failure, due to metastatic prostate cancer	N19, C61, M8000/3, C80, M8000/6
Steve McQueen	Actor	Mesothelioma	C45.9, M9050/3
Attila the Hun	Despot	Nose bleed, while asleep (and drunk)	R04.0, F10.0
Francis Bacon	Author	Hypothermia (in an attempt to preserve a chicken by freezing it in snow)	T68, X31, Y92.9, U73.8
Aeschylus	Playwright	An eagle dropped a tortoise on his head	S09.9, W20, Y92.9, U73.9



How to use your ICD-10-AM Browser

Register your ICD-10-AM Browser

Before you can start to use the ICD-10-AM Browser you will need an authorisation key to install the software.

Put the CD-ROM, label side up, into the CD drive on your computer. A set up window will open, that asks for your user name and authorisation key. Close this box, open Windows Explorer and double click the left mouse button on the CD drive. A number of documents and folders will appear. Open the MS Word document called 'Browser registration form'. Complete the registration form and send it to the NCCH by:

- E-mailing it (as an attachment) to ncchsales@fhs.usyd.edu.au or
- Faxing it to 02 9351 9603 or
- Posting it to

The National Centre for
Classification in Health
The University of Sydney
PO Box 170
Lidcombe NSW 1825 Australia

Your authorisation key will be sent to you by e-mail (or fax if you prefer) within 5 working days. Once you have received your user name and authorisation key, put the CD-ROM into your computer's CD drive, and follow the instructions in the Setup box for installing the software.

How to use the Browser's tools


The Browser has 8 main functions on its tool bar.





1. Use the '**Search String**' box to type in a word, code, a string of words that you want to find in ICD-10-AM.

Example: Click on **1: Diseases Tabular** in the left frame. Type 'stroke' in the Search String box and click the Enter button. All occurrences of the term 'stroke' are shown in


the text of the right frame. A green marker also appears in the left frame to indicate where a search item can be found within the volumes. Select Search, Clear search, to clear the markers.

2.  The **Search Forward** button. Click this button to search for words in the Search String box from this point **forward** until the word is found. If your search doesn't find any matches a message will be displayed in the status bar at the bottom of the screen.



Example: Click on **2: Diseases Tabular, Tabular List of Inclusions and Subcategories, Circulatory** in the left frame. Type in 'stroke' in the String Search box and click the **Search Forward** button. The search will start in the 'Circulatory' chapter and will work through ICD-10-AM chronologically. All occurrences of 'stroke' will be highlighted in the right frame.

3.  The **Search Backward** button. This button does the same job as the Search Forward button, but backward from the starting point.
4.  The Copy button. Use the cursor the highlight text as you would in other applications such as MS Word. Click the copy button to copy the selected text onto the clipboard.


Example: You want to distribute Australian Coding Standard (ACS) 0604 *Stroke* prior to a meeting with clinicians. Select **5: Australian Coding Standards, Specialty Standards**, in the left frame. Type in '0604' (the number of the ACS) in the 'Search String' box and click on the Search Forward button. ACS 0604 *Stroke* appears in the right frame. Highlight the text you need and click on the Copy button on the toolbar. The text is copied to the clipboard with all formatting retained. You can then paste this selection into another application or document.

5.  The **Print** button. This button sends the current document or the selected text (if selected) to the printer.

Example: If you don't want to make another document (eg Word document) but simply print out a section of ACS 0604 *Stroke*, highlight the required text, click the Print button on the toolbar, select *Selection* and the text, with all formatting, can be printed.

6.  The **Backtrack to Master Table of Contents** (TOC) button. Click this button to return to the Master Table of Contents menu.
7.  The **Backtrack** button. This button takes you backwards along the steps you have followed to get to your current location. You can also go backwards along links by pressing the *Escape* key or by selecting *Backtrack* from the File menu.

Example: Follow the steps to ACS 0604 *Stroke*. Within the text of this standard there is a link to ACS 0002 *Additional diagnoses*. Double clicking on this link will bring ACS 0002 *Additional diagnoses* appears into the right frame. Click on the *Backtrack* button to return to ACS 0604 *Stroke*.

8.  The Zoom Control. Adjust the zoom setting to reduce or enlarge your view.

ICD-10-AM Third Edition CD-ROM Browser UPDATE AVAILABLE NOW

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for ordering information

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ACBA

- **identifies** errors in coding practice
- **automates** results reporting

See order form distributed with *Coding Matters* or call 03 9479 1811 for further information.

coding matters



Volume 9 Number 2 September 2002

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Production: Rodney Bernard
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ISSN 1322-1922

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

**National Centre for Classification in Health
8th Biennial Conference**

Coder Connect:

Linking Concepts in Health

**26 – 28 March 2003
Hilton on the Park, Melbourne**

CALL FOR PAPERS

The NCCH conference committee is pleased to invite prospective participants to submit abstracts for presentation addressing the 8th Biennial Conference theme
Coder Connect: Linking Concepts in Health.

Themes

- ▼ linking patient records
- ▼ electronic health records
- ▼ clinical updates
- ▼ international use of ICD-10-AM
- ▼ coding and health data quality management
- ▼ standards in health care
- ▼ links between clinical documentation and coding
- ▼ classification, terminologies and vocabularies
- ▼ health information and coding technology
- ▼ ambulatory and community care coding
- ▼ health data in primary care
- ▼ organisational links and liaison
- ▼ linking clinical coding with health research activities

Abstracts may be research, descriptive, opinion, review, scientific or case study in type. All work must be original and the author's own work, not previously presented or published.

Criteria for selection

The criteria for the selection of papers will include relevance, professional interest and innovation. The NCCH conference committee will select papers for presentation. The expected length of each presentation is 15-20 minutes.

What to include

The submitted paper should include:

- ▼ working title of the presentation
- ▼ indicate preferred presentation length (in minutes)
- ▼ an abstract of not more than 500 words
- ▼ name of author(s) in bold, name of presenting author underlined, title, organisation
- ▼ brief biography for each author
- ▼ full mailing address, telephone, fax and e-mail addresses

How to submit

Send abstracts (saved as .RTF or .DOC files) by e-mail to Shannon Watts s.watts@latrobe.edu.au, or by mail (contact details below)

Final date for receipt of abstracts

All abstracts must be submitted by
Friday 1 November 2002

Notification of acceptance

Acceptance of papers is at the discretion of the NCCH conference committee. Authors will be notified in writing of acceptance or otherwise of papers by the end of December 2002.

Upon acceptance, authors will be advised about the session, date and time for the presentation and submitting full papers for publication in the official Conference Proceedings.

Cost

Successful presenters will be offered a reduced registration fee which will include attendance at the Welcome Reception and Conference Dinner.

Further information

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