

coding matters



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Australian coder workforce survey 2002 – managers' responses

In 1994–5, the Health Information Management Association of Australia (HIMAA) Ltd conducted a nation-wide survey of clinical coders working in Australian hospitals. The survey (National Coder Workforce Issues Project (NCWIP) funded by the then Commonwealth Department of Human Services and Health) provided baseline data about the coder workforce in terms of its size, the educational backgrounds of coders, circumstances relating to their employment and their needs in terms of continuing support and training. Importantly, the survey was conducted before casemix-based classification and funding had been implemented by all states and territories. It has now been nearly eight years since the original survey was conducted and casemix is in use in some form in all states and territories. Anecdotally, it is reported that the roles and responsibilities of clinical coders have changed significantly over this time period and that the workforce has grown in size and stature.



Vicki Andreopoulos coding at Royal North Shore Hospital

In 2002, the National Centre for Classification in Health, in collaboration with the HIMAA and the Clinical Coders' Society of Australia (CCSA), initiated a follow up survey to quantify these changes. By using some of the original questions from the 1994–5 survey, variations in the clinical coder workforce were measurable. Additional questions relating to anticipated changes in the health environment as a result of initiatives, such as electronic health records, facilitated the identification of on-going educational requirements for clinical coders. A parallel survey of the managers of clinical coding services elucidated strategic issues relating to clinical coder workforce.

This article is the first in a series that will report the major findings of the 2002 Australian Clinical Coder Survey. This report focuses on the manager survey and will highlight the significant findings from this survey. ▶

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Characteristics of respondents

Over one thousand two hundred (n=1277) facilities across Australia were contacted to participate in the survey and a total of 424 managers responded, representing a 33.2% response rate. Of these, 345 managers responded from hospitals, 61 from free standing day care facilities, 15 from multipurpose facilities, and 3 from early parenting clinics. The majority of the facilities (55.4%) were public. Metropolitan areas submitted the most responses (56.3%), 38% of responses were from rural areas and 5.7% of responses were from remote areas¹. The average number of beds per facility was 130 and the average number of separations for the 2001–2002 financial year was 11,468.

Coding workforce

Managers were asked whether they had any vacant positions for coders in their facilities at the time of the survey. No vacant positions for coders were reported in 383 (90.5%), and 40 (9.5%) responded that there were vacant positions available for coders. Managers were then asked how many full time equivalent (FTE) positions were available. Calculations from the data received showed there were 38.1 FTE coder positions available across Australia, with 25 of these vacant positions located in public metropolitan facilities, and nearly half of these 25 positions being located in New South Wales.

Managers also indicated if they were planning to create new coder positions in 2002. Again, the majority of managers (348 or 83.3%) stated that no new positions would be created for coders, 31 (7.4%) stated that new coder positions would be created, and 39 (9.3%) were not sure if they would create new coder positions. Managers were asked to specify how many new positions they were planning to create and the total number of hours per week for these positions. Calculations from the data received showed there were the 33 new coder positions to be created in 2002 across Australia, with a total number of hours of 944, being the equivalent of 23.6 new full time coder positions. The largest number of new coder positions to be created is in Victoria with a total of nine new full time positions.

Coding service responsibility

Managers were asked whether coding was part of the health information service/medical record department (HIS/MRD) in their facility.

In 337 (87.1%) facilities, coding was part of the health information service/medical record department, whereas in 50 (12.9%) facilities, coding was part of other sections. South Australia is the state least likely to code within HIS/MRD with 25% of South Australian managers stating that coding was undertaken in other sections. If coding was not part of HIS/MRD, coding was most likely to be performed by coders external to the hospital (eg contractors or coders in nearby hospitals) or within the financial/administration sections.

Coding quality

Managers were asked whether there were any activities used to assess coding quality in their facility. Coding quality was assessed in 270 (69.6%) facilities, while 118 (30.4%) stated that they did not assess coding quality in their facility. Approximately 75% of managers from public facilities and approximately 65% of managers from private facilities in metropolitan and rural locations stated that there were activities to assess coding quality. However, only half of the managers in public facilities in remote locations stated that they formally assessed coding quality. The quality activities described varied, but generally fell into the following six categories:

1. use of Australian Coding Benchmark Audit (ACBA) and/or Performance Indicators for Coding Quality (PICQ)
2. health department audits
3. error Diagnosis Related Group (DRG) audits
4. other internal audits and/or external audits
5. clinician-coder meetings
6. peer review.

Managers were then asked to consider a list of factors that have an impact on the accuracy, completeness, and timeliness of coding, and to indicate severity of each factor on a scale from no impact to an extreme impact. The factor most likely to affect coding quality according to managers was incomplete medical record content, with 72.2% of managers stating that this factor had an impact. This was closely followed by principal diagnosis not identified (65.8%), complications/comorbidities not identified (64.0%), illegible medical record entries (59.5% impact), performing multiple tasks (43.1%) (Figure 1). These top five reasons were similar across most subgroups (that is, public/private, locality and state/territory divisions).

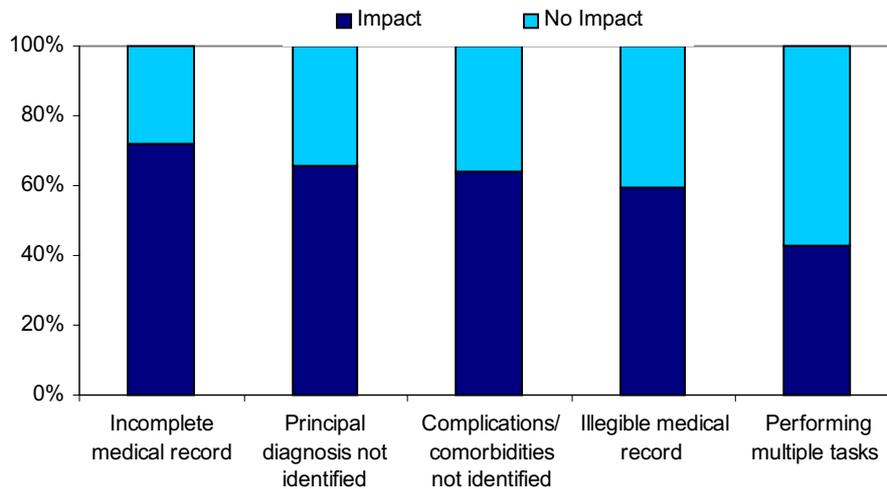


Figure 1: Impact of factors affecting coding quality

However, for some subgroups, other factors were also evident in the top five reasons for coding inaccuracy. These were:

- a lack of continuing education to update skills had an equal impact on coding quality as performing multiple tasks in remote areas and Queensland
- a distracting work environment and lack of training available for coders were rated equally as the fifth most important factors affecting coding quality in Western Australia.

Planned changes to coding services

Managers were asked whether they were planning to introduce any major changes to the way coding is carried out in 2002. No major changes were planned in 271 (69.1%), 64 (16.3%) were unsure of whether they were going to introduce any changes, and 57 (14.5%) stated that they were planning to introduce major changes. Distinct categories of change were identified from the managers' responses (Figure 2):

1. introducing or increasing the number of audits
2. introducing 3M Encoder software
3. increasing the number of hours of employment for coders and/or the number of coder positions
4. improving communication between coders and clinicians
5. introducing or increasing coding done at ward level
6. improving resources for coders (such as software/computers)
7. restructuring departments
8. changing coding deadlines
9. introducing ICD-10-AM Third Edition changes.

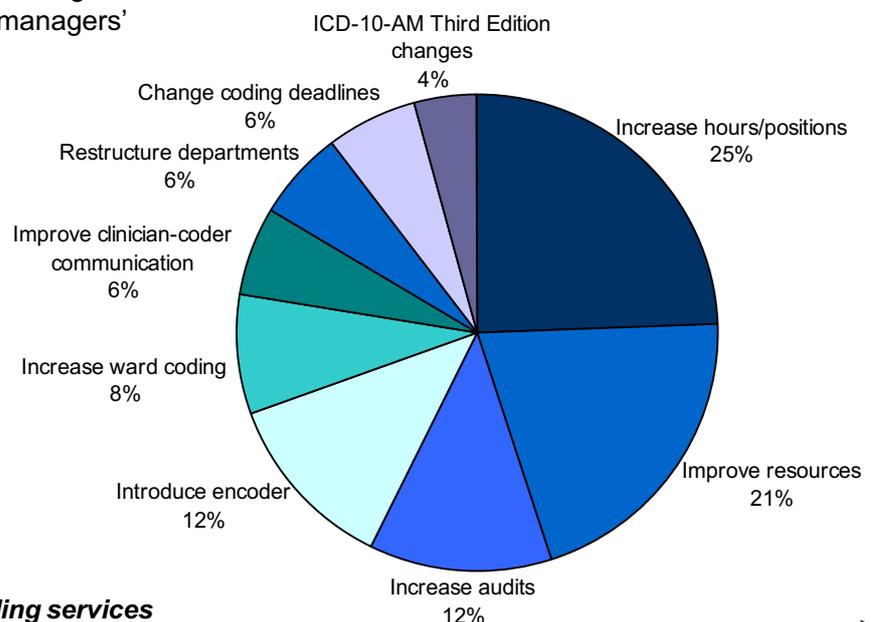


Figure 2: Planned changes to coding services

Coder education

Managers were asked about the educational opportunities for coders in their facility. The first question relating to education asked managers what in-house educational opportunities were available to coders in their facility.

Managers were asked to tick all the relevant categories from a list and to specify any additional in-house educational opportunities that were not part of the list provided.

Managers were able to specify as many educational opportunities as were available at their hospitals. In 38.7% of facilities, managers stated that coders are able to attend area coding meetings, in 33.7% of facilities coders are able to attend departmental coding meetings, in 26.4% of facilities coders are able to attend clinician-coder meetings. Medical science updates are available to coders in 11.3% of facilities, and library sessions can be attended by 1.9% of coders (Figure 3).

Sixty-seven (67) managers listed other in-house educational opportunities that were available to coders in their facility. These educational opportunities could be categorised into:

- feedback from audits
- attendance at ward rounds
- self education (including use of the internet, *Coding Matters*, Code-L etc)
- other external updates/workshops.

Managers were asked whether they were involved in organising and/or conducting continuing education for coders in their facility, and if so, what percentage of their work time they spent doing this. In over 50% of cases (n=215, 55.8%), managers stated that they

were not involved in organising and/or conducting continuing education, while 170 (44.2%) were active in these duties. Metropolitan public facilities had the highest level of manager involvement in continuing education with over 60% of managers stating their involvement in continuing education. A smaller number of managers (45%) in metropolitan private facilities stated that they were involved in continuing education. Nearly 40% of managers in both public and private rural facilities reported involvement with educational activities, however less than 20% of managers from remote public facilities were involved in continuing education.

The majority of managers (n=120, 69.4%) spend less than 5% of their work time organising and/or conducting continuing education for coders, 41 (23.7%) spend 5–10% of their work time on continuing education for coders, and less than 10% of managers (n=12, 6.9%) spend greater than 10% of their work time on organising and/or conducting continuing education for coders.

Managers' comments

Managers were invited to provide free text responses in two parts of the survey. They were asked:

1. What do you see as the role of the clinical coder in the future, and do you feel the profession is prepared for any changes you envisage?
2. What do you see as the impact of electronic health records on coding practices in the future?

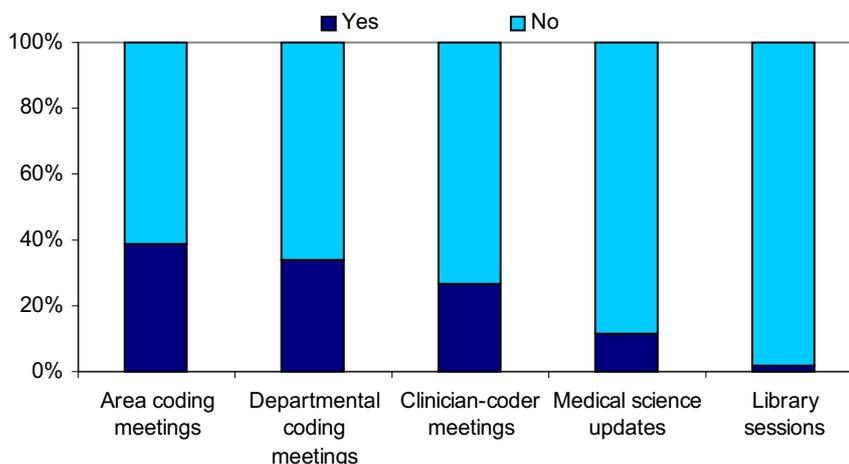


Figure 3 : Educational opportunities available to coders

Role of clinical coders in the future

There were six major themes to emerge from the managers' comments in relation to the role of clinical coders in the future, with 218 managers (51.4% response rate) providing comments on the future role of the clinical coder. In order of importance, these themes were categorised as:

1. involvement in financial issues/funding/casemix
2. involvement in quality assurance activities
3. use of electronic health records
4. increased involvement in computing/IT
5. interaction with clinicians/medical staff
6. specialisation of coders.

Approximately 30% of managers who commented on the role of clinical coders in the future stated that the role of the clinical coder will be more important as hospitals are increasingly funded through casemix.

These managers stated that clinical coders will be vitally important in revenue raising and more involved in the financial and/or management sections of the hospital. It was suggested that clinical coders will become casemix experts/advisors and will be involved in the interpretation of data and ramifications of data for hospital funding.

According to managers the second most important role of clinical coders in the future is in the data quality area. Twenty-two percent of managers who commented on the future role of clinical coders stated that the analysis and assurance of data quality is becoming an increasingly important task for clinical coders. Managers believed that clinical coders will become data managers and data auditors, and that these roles will comprise more of their time than would clinical coding in the future. These managers suggested that clinical coders will also have a greater role in the education of clinicians to ensure data accuracy.

Closely related to the previous point was the discussion of electronic health records (EHR), with 13.8% of managers who responded to this question stating the EHRs will change the role of clinical coders from a coding role to a data managing/auditing role.

The influence of technology on the role of the clinical coder was raised by 12.4% of managers in response to this question. These managers indicated that it will become increasingly

important for clinical coders to possess information technology skills and to be computer literate, with a move towards greater automation in the coding process.

Over one in ten managers believed that there will be a stronger liaison between clinical coders and clinicians/medical staff in the future. With casemix-based funding, these managers stated that clinicians are becoming increasingly aware of the importance of coding and the role of the clinical coder. As a result, there is a move toward a greater involvement of coders in the education of clinicians/medical staff on coding issues.

Finally, a small number of managers (6.4%) believed that the role of the clinical coder will become more specialised in the future. With a need for greater specificity in coding, there will be a growing need for clinical coders to become specialists in particular areas and continually update their education in their area of speciality.

Impact of electronic health records (EHRs)

Seven distinct themes are identifiable in the managers' responses to the impact of electronic health records, with 278 managers (65.5% response rate) providing comments on the impact of electronic health records. In order of importance, these themes have been categorised as:

1. easier and faster access to data/greater availability of information
2. data quality issues
3. increased need for computing/IT skills
4. greater legibility of records
5. need for training/education in EHR
6. greater involvement of clinicians in medical record documentation
7. greater flexibility in the location of coding (that is, off-site/work from home/centralised coding office).

A large number of manager responses to the impact of electronic health records referred to easier access to information and a greater availability of information, with 38.1% of managers raising these as benefits of EHRs. These managers believed that the easier access to off-site information and greater availability of information would result in coding using EHRs being less time consuming than using paper-based records.

Nearly 18% of managers raised data quality issues in their comments about EHRs, with the majority of these comments (82%) stating the EHRs will improve data quality. Reasons for improved data quality included more readily available information and greater legibility of records. Reasons given for poorer data quality related to the increased involvement of clinicians in the coding process and the automation of coding.

Technology concerns were an issue for 14.7% of managers commenting on the impact of EHRs. These managers stated that there would be a need for coders and clinicians to possess IT skills and to be computer literate. They also suggested that computing and IT infrastructure and support would be necessary to ensure the efficiency of EHRs.

On a positive note, 12.9% of managers believed EHRs would be beneficial in improving the issues associated with the legibility of medical records.

The increased need for training and education in relation to EHRs was raised by 12.9% of managers who commented on this question. These managers stated that training and education would be a twofold process, with both clinicians and coders needing training on the EHR, and with clinicians needing education on the process of coding.

Related to the previous point, 12.2% of managers who responded to this question stated that there would be an increasing involvement of clinicians in the coding process with the introduction of EHRs. These managers stated that clinicians would be increasingly involved in medical documentation and coding.

Finally, a small number of managers (5.7%) stated that EHRs would enable greater flexibility in the locality of coding, with coders able to complete their coding off-site either in centralised coding sections or working from home.

Reference

- ¹ Classification of the Rural, Remote and Metropolitan Area (RRMA) was based on information available from the Australian Institute of Health and Welfare website www.aihw.gov.au.

Further information

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Dr Kirsten McKenzie is a research fellow at NCCH (Brisbane) and was responsible for the collection, collation and statistical analysis of the coder workforce survey.

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Part 2 featuring responses from clinical coders will be published in the June 2003 edition of *Coding Matters*.

A comprehensive report summarising all findings will be published as part of the NCCH monographs series in September 2003.



Goodbye volume 9... hello volume 10

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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.

Perineal laceration/tear with episiotomy

There have been a number of queries recently regarding the classification of perineal lacerations/tears that occur in conjunction with an episiotomy. The two main scenarios are:

Episiotomy extended by laceration

The episiotomy originally performed extends during the delivery of the baby. The extension results in spontaneous perineal trauma and may include the surrounding structures, such as anal sphincter and mucosa.

Laceration extended by episiotomy

There may be an initial small laceration of the perineum which requires an extension via episiotomy for the baby to be delivered.

Classification

Episiotomy extended by laceration

A diagnosis code from *O70 Perineal laceration during delivery* should be assigned for the laceration. Two procedure codes are required; 90472-00 [1343] *Episiotomy* together with the appropriate code from block [1344] *Postpartum suture* for the repair of the laceration.

An additional code is required for the repair of the laceration because in this scenario the laceration is usually more severe and occasionally may involve the sphincter (third and fourth degree tears).

Laceration extended by episiotomy

A diagnosis code from *O70 Perineal laceration during delivery* should be assigned for the laceration. Only one procedure code, 90472-00 [1343] *Episiotomy*, is required as the repair of the initial laceration is inherent in the episiotomy code.

The NCCH will review both the tabular list and alphabetic index of the Australian Classification of Health Interventions (ACHI) to see if amendments are required to reflect this advice.

Acute coronary syndrome

In recent years there have been significant changes in both the terminology and classification of acute coronary disease. The term 'acute coronary syndrome' encompasses a number of clinical signs and symptoms suggestive of acute myocardial infarction (AMI) or unstable angina pectoris (UAP). A myocardial infarction is now often described as a ST segment elevation MI (STEMI) or a non ST elevation MI (NSTEMI).

The NCCH has received a public submission requesting changes in ICD-10-AM classification of acute coronary syndrome and myocardial infarction. This has been included in our work program for the Fourth Edition. In the meantime, where there is documentation of 'acute coronary syndrome' with no evidence of an acute myocardial infarction, please assign I20.0 *Unstable angina*. Further information on the classification of unstable angina may be found in ACS 0940 *Ischaemic heart disease*.

Intestinal metaplasia

Metaplasia is the replacement of one adult tissue by another occurring in postnatal life. Typically, intestinal metaplasia is seen in the stomach in chronic gastritis and represents the conversion of gastric type mucosa to a mucosa that may closely resemble intestine, usually the small intestine. It is generally considered to be an acquired condition in response to a non-specific injury and inflammation such as in reflux.



Classification

Where intestinal metaplasia is documented in conjunction with other findings/diagnoses/symptoms, assign a code(s) for those conditions, as appropriate. Do not code the intestinal metaplasia. In cases where intestinal metaplasia is the only condition documented, please refer to ACS 0013 'Other' and 'unspecified' codes, for correct code assignment. For example, if the metaplasia is in the oesophagus, search the index for 'Disease, oesophagus, specified NEC, which indicates code K22.8 *Other specified diseases of oesophagus*.

Transfer in labour

Women may begin their labour at one hospital, and then be transferred to another hospital for the delivery of the baby. The reasons for the transfer may be:

Clinical – a medical condition of the mother or baby or both

Administrative – lack of obstetric services, lack of obstetric beds, patient choice

Classification

For the purposes of coding the initial (undelivered) admission, assign the following codes:

Clinical – the medical (obstetrical) condition that necessitated the patient's transfer.

Administrative – the appropriate code from category 'O47 *False labour*', together with the duration of pregnancy code if applicable and 'Z75.3 *Unavailability and inaccessibility of health care facilities*' if applicable.

The NCCH has received a public submission on admission and transfer (without delivery) of women in labour. This has been included in our work program for ICD-10-AM Fourth Edition.

Acute respiratory distress syndrome (ARDS)

Acute respiratory distress syndrome (ARDS), also known as adult respiratory distress syndrome, is a type of lung failure that may result from any disease or acute process that causes large amounts of fluid to collect in the lungs. Causes include sepsis, pneumonia, aspiration of gastric contents, direct chest trauma, prolonged or profound shock, burns, fat embolism, near drowning, massive blood transfusion and smoke inhalation. Although sometimes termed 'adult', this syndrome also occurs in children.

Classification

J80 *Adult respiratory distress syndrome* should be assigned for patients of any age (excluding neonates) with a diagnosis of ARDS (acute or adult). Please refer to ACS 1614 *Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency* for further information on the classification of respiratory distress in neonates.

Fall involving scooter

In ICD-10-AM Second Edition, advice was provided to assign W02 *Fall involving ice-skates, skis, roller skates or skateboards* for falls involving non-motorised scooters. This code was subsequently expanded in ICD-10-AM Third Edition, however, there is no specific code for falls involving a scooter. The NCCH has received a public submission which includes a recommendation to review the classification of 'fall involving scooter' in ICD-10-AM.

In the meantime, assign W02.1 *Fall involving skateboard* where there is documentation of a fall involving a scooter. The type of scooter involved in the accident will be captured by one of the following activity codes:

U66.40 *Folding non-motored scooter, or*

U66.49 *Other and unspecified non-motored scooter*

Non-invasive ventilation (NIV)

A number of queries have been received regarding the calculation of hours of NIV in patients other than neonates, where two or more types of NIV have been used and they meet the criteria of cumulative hours as outlined in ACS 1006 *Respiratory support*.

Classification

In cases such as these where the cumulative hours are ≥ 24 , assign a code for each type of NIV administered. For example, a patient has 18 hours of CPAP and 14 hours of BiPAP cumulatively. Both 92038-00 [568] *Continuous positive airway pressure (CPAP)* and 92039-00 [568] *Bi-level positive airway pressure (BiPAP)* are assigned to reflect the two different types of NIV administered.

Postprocedural analgesia

The neuraxial and regional block codes in block 1912 *Postprocedural analgesia* should be assigned only for **management** (continuing infusion/bolus injection) of blocks that were

administered in the operating suite. The initial insertion of the neuraxial/regional block is not inherent in these codes, and should be represented by the appropriate code from block 1909 *Conduction anaesthesia*.

The NCCH will review the wording of ACS 0031 *Anaesthesia* and the note at block 1912 *Postprocedural analgesia* to reinforce this advice.

Advanced Breast Biopsy Instrumentation (ABBI)

Since 1995 the Advanced Breast Biopsy Instrumentation (ABBI) system has been available for the management of radiologically detected breast lesions. ABBI is a stereotactically guided procedure able to precisely locate and excise in a single step non-palpable breast lesions found on mammogram.

The procedure is performed under local anaesthesia and combines the placement of a wire marker and retrieval of a specimen into one minimally invasive procedure. It requires both radiological and surgical skills.

Using stereotactic imaging technology, the lesion is located and the area numbered with a local anaesthetic. A marking needle (guide wire) is inserted to mark the precise location of the lesion. Using the ABBI system, the surgeon inserts a cannula into the breast to obtain a specimen. The small opening is closed with a few stitches.

The main difference between the ABBI procedure and the traditional core biopsy is that the ABBI procedure removes one specimen in one pass. A vacuum assisted core biopsy device such as a mammotome can take multiple biopsies with one pass but cannot remove an entire lesion intact.

Classification

30363-00 [1743] *Core biopsy of breast*

30361-00 [1740] *Localisation of lesion of breast*

90720-00 [1759] *Other procedures on breast*

It is proposed that a new code will be introduced in ICD-10-AM Fourth Edition for the stereotactic component of this procedure.

About the committee

IT 14-2 Health Concept Representation

IT14-2 is a subcommittee of the IT-14 Health Informatics committee of Standards Australia. NCCH representatives on IT14-2 are Kerry Innes and Peter Scott.

It usually meets every second month by teleconference. Stakeholders include Government, NCCH, National Health Information Management Group (NHIMG), Family Medicine Research Centre (FMRC), the private and non-government sector and the Consumers' Health Forum.

The stated mission of the parent committee IT-14 is as follows:

The mission of the IT-14 committee is to coordinate, develop, disseminate and promote Standards for Health Informatics in Australia and New Zealand and contribute to international Health Informatics standards development.

www.committees.standards.com.au/COMMITTEES/IT-014/TOR/IT-014-TERMS.HTM

IT 14-2's role is to develop national standards for the representation of health concepts. This has often meant that the committee acts as a body of review for relevant ISO TC215 international standards. The current work is to produce a normative Australian standard for the 'terminology of terminology' as well as to produce a guide for parties interested in developing new data elements.

Further, representation on ISO TC215 Working Group 3 has been undertaken by Michelle Bramley of NCCH, and most recently by Kerry Innes, NCCH Associate Director.

► Peter Scott

Project Officer NCCH (Brisbane)

Clinical update



Functional Endoscopic Sinus Surgery

Definition

Functional endoscopic sinus surgery (FESS) is a minimally invasive technique which aims to restore sinus function by removing localised disease, opening blocked sinus outflow tracts and permitting a return to normal mucociliary drainage patterns. The term 'functional' was introduced to distinguish this type of surgery, using a rigid endoscope, from nonendoscopic, 'conventional' procedures. Although this type of surgery has been practised in Europe since the 1920s, it is only in the last 20 years that the concept has been widely introduced.¹

Functional endoscopic sinus surgery is a different procedure from older destructive sinus surgery that focused on stripping of all mucosa and did not include enlarging the natural outflow tracts of the osteomeatal complex. FESS is similar to other types of minimally invasive surgery in that it is designed to combine an excellent outcome with minimal patient discomfort. Other advantages are that scars and damage to the nerve supply of the teeth are avoided and the use of an endoscope permits a better view of the surgical field.²

Anatomy

The paranasal sinuses are small air pockets lined by mucosa in the facial bones. There are four pairs of sinuses:

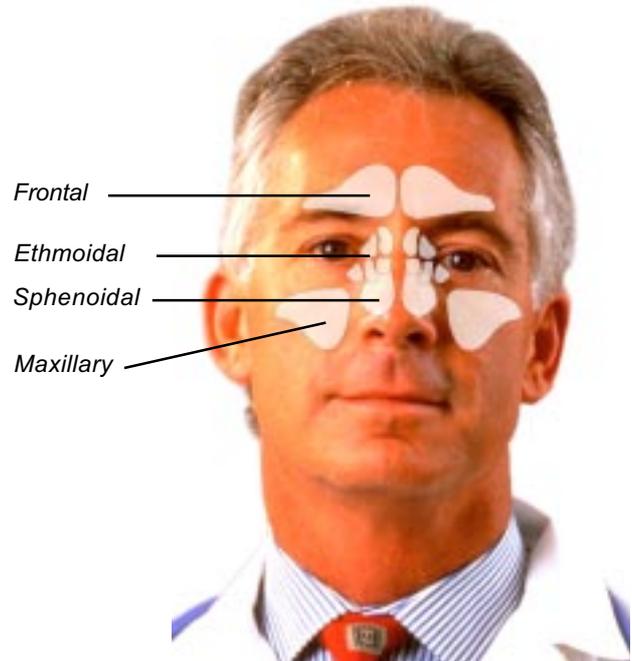
The **frontal** sinuses, located in a large cavity above the eyebrows in the frontal bone, each communicating with the middle nasal meatus on the same side.

The **sphenoidal** sinuses, in the body of the sphenoid bone, located behind the nose almost in the centre of the skull.

The **ethmoidal** sinuses, consisting of several air spaces or 'cells', located between the eyes.

The **maxillary** sinuses, located in the body of the maxilla on either side of the nose.

All of the paranasal sinuses drain into the one area, known as the osteomeatal complex. Under normal circumstances, air will pass through the sinuses, draining fluid into the nose. Sinusitis (inflammation of the sinuses) is caused by an allergy or infection, and will often follow a respiratory infection or cold. When inflammation occurs, sinus openings and drainage tracts



Paranasal sinuses

become blocked, the sinus lining becomes inflamed and the sinus fills with infected fluid, resulting in pain. Consequently, drainage is inhibited, causing a build up of fluid and further pain. It is therefore the disease in the nose that spreads into the paranasal sinuses despite the fact that the symptoms may be predominately sinus in origin. Physical abnormalities such as a deviated nasal septum may also predispose to sinus problems. Sinusitis generally occurs as an acute episode, and is classified as chronic if the episodes are frequent or pain is ongoing.^{1 3 4}

Indications

Surgical intervention is reserved for patients in whom medical management fails to control recurrent active or chronic infective sinusitis. The goal of surgery is to open up the osteomeatal complex and then allow the sinuses to drain by the natural motility of the cilia in the lining of the sinuses, sweeping the mucous from the sinus to the natural ostium of that particular sinus.¹ This avoids the need for radical surgical procedures on the frontal and maxillary sinuses.

The pre-operative assessment usually involves the use of a fiberoptic endoscope to examine the nose thoroughly from the anterior nares to

the postnasal space. This procedure requires only local anaesthetic and may be performed in the clinician's rooms. CT scanning is always performed before FESS in order to outline the diseased areas in relation to the key anatomic structures (orbital contents, optic nerve and carotid artery) and provide a surgical plan.²

Technique

Currently any intranasal surgery on the sinuses is performed with the endoscope alone or is an endoscopically assisted procedure. This allows access, via the use of specialised instruments, to the natural ostium of the maxillary antrum, the frontal sinus and the sphenoid sinus.¹

The most common procedure involves opening the middle meatal drainage area by removing the uncinate process, opening one or more of the anterior ethmoidal air cells and enlarging the natural maxillary sinus ostium, via a middle meatal antrostomy. This provides increased drainage for the maxillary, frontal, sphenoid and anterior ethmoidal sinuses. Where the disease has progressed into the posterior ethmoid sinuses, further surgical treatment may be required. In most cases however, the inflammation is confined to the osteomeatal complex and the anterior ethmoids.²

Other sinuses, the pituitary gland and the nasolacrimal duct can also be operated on using FESS. Complications of FESS that may arise are cerebrospinal fluid leak and damage to the contents of the orbit or to the optic nerve. These are very unusual. The careful follow-up usually with endoscopes to clean the nose and sinus area and promote healing is equally as important in achieving a successful result.

The current Australian Coding Standard (ACS) 0807 *Functional Endoscopic Sinus Surgery*, notes that functional endoscopic sinus surgery (FESS) is a term describing a range of procedures performed for the surgical treatment of sinus disease. It provides a list of codes from the Australian Classification of Health Interventions (ACHI) representing a variety of procedures, in any combination, which may be performed as 'FESS' (see below). Clinical coders are advised that where 'FESS' is documented, to check the operation report and assign only the appropriate code(s).

Although endoscopy (sinoscopy) may be inherent in a number of these procedures, the code titles and includes notes of the codes do not always reflect this. Some of the procedures

listed here may also be performed as an open approach or during other open surgery. Therefore, where 'FESS' is documented, also assign 41764-01 [370] *Sinoscopy* to indicate the endoscopic nature of the surgery.

- 41716-01 [387] *Intranasal maxillary antrostomy, unilateral* (includes formation of an antral meatal window)
- 41716-02 [387] *Intranasal maxillary antrostomy, bilateral* (includes formation of an antral meatal window)
- 41716-00 [383] *Intranasal removal of foreign body from maxillary antrum*
- 41737-02 [386] *Ethmoidectomy, unilateral*
- 41737-03 [386] *Ethmoidectomy, bilateral*
- 41731-00 [386] *Ethmoidectomy, frontonasal approach*
- 41731-01 [386] *Ethmoidectomy with sphenoidectomy, frontonasal approach*
- 41737-09 [386] *Frontal sinusectomy*
- 41746-00 [386] *Radical obliteration of frontal sinus*
- 41752-01 [386] *Sphenoidectomy*
- 41716-05 [384] *Biopsy of maxillary antrum*
- 41752-04 [384] *Biopsy of sphenoidal sinus*
- 41737-07 [384] *Biopsy of frontal sinus*
- 41737-08 [384] *Biopsy of ethmoidal sinus*

Reference:

- 1 Kennedy, JT (2002) Functional endoscopic sinus surgery, background material provided to NCCH, Sydney.
- 2 Slack R, Bates G (1998) Functional endoscopic sinus surgery. *American Family Physician* (58) 3. Accessed October 2002 : http://www.aafp.org/afp/980901_ap/slack.html
- 3 National Centre for Classification in Health (2000) *Casemix, DRGs and clinical coding – Ear, nose, mouth and throat*. NCCH, Sydney.
- 4 Sacks R, Boustred N (1999) Endoscopic sinus surgery. Sydney Adventist Hospital Newsletter, June 1999.

Education program in Vietnam

Sue Walker, NCCH Brisbane Associate Director, visited Vietnam with Jenny Nicol, an academic staff member from Queensland University of Technology (QUT), as part of the QUT/Hanoi School of Public Health (HSPH) Curriculum Development Project during November – December 2002. The project, funded by Atlantic Philanthropies, is to develop an undergraduate curriculum in public health to be offered by the Hanoi School. Our visit had dual purposes: firstly to help with the health information management units being developed as part of the program, and secondly to teach the academic staff ICD-10 in train-the-trainer format.

Health management information systems

The subject *Health management information systems* is scheduled for first semester of year 3 of the Bachelor of Public Health program. It will be offered for the first time in September 2004. The subject has been broken down into eight modules of study:

- 1 Introduction to HMIS
- 2 Importance of health information in health care management
- 3 Population based health information systems
- 4 Hospital information systems
- 5 Other sources of health data
- 6 Health data management
- 7 Health data quality
- 8 Future developments in HMIS

During our time in Hanoi, we discussed each unit of study with the academic staff member who will be responsible for teaching the unit. The structure and objectives of each unit were clarified collaboratively. We then developed more detailed content for each unit, including making recommendations for relevant reference materials, tutorial activities, student

assessments, potential guest speakers and, where necessary, suggestions for more contextualisation to ensure the units include information of relevance to the Vietnamese situation. Details were reviewed with the relevant academic to clarify the needs for further unit development.

ICD-10

The ICD-10 unit is to be run in second semester of year 3. Academic staff at the HSPH indicated that the course outline and modular teaching materials used for ICD-10 short courses developed by the NCCH will form the basis for instruction in this subject.



I-r Pham Viet Cuong, Sue Walker, Tran Thi Hong and Jenny Nicol at HSPH

ICD-10 training

Although we had originally planned a five-day ICD-10 training program, we were asked to modify the length of the course to three full days of instruction, over a four-day period. We were therefore only able to provide introductory materials and the opportunity for some hands-on coding work to an average of eight students each day. A core group of four students attended each session with other students attending at different times.

We were challenged by a lack of coding books available for the course – in fact, we had two full sets in English and a Tabular List in Vietnamese. This meant students had to work in groups, rather than individually. Given that most of them lacked any background in medical terminology or medical science, and because the ability to work in English was limited for some students, this actually worked quite well.

During our time in Hanoi, we were also asked to give a presentation to the HSPH's regular Wednesday seminar series. We gave a 90-minute presentation titled *You can't manage what you can't measure: The role of health information management in health care*. We were told that this had been the first time that any discussion relating to health information had been held in the HSPH and that it would form the basis for future presentations about uses of health information, its quality and issues and difficulties arising from use of health data in Vietnam.

The fun stuff...

We had the opportunity to do some sight seeing on our free weekend – visits to Halong Bay (a World Heritage listed site – a huge bay dotted with limestone caves, peaks and outcrops) and the Perfume Pagoda, set amongst the tranquil hills of Huong Son 70 km outside Hanoi – were highlights. The visit to the Perfume Pagoda involved a two-hour trip up the Yen River in a sampan, energetically rowed by local women. We also managed some sightseeing in Hanoi and spent many after work hours in the Old Quarter, rummaging around little shops and stalls selling anything and everything – from headstones to toys to kitchen utensils to incense and temple offerings – not to mention souvenirs for gullible tourists. We were also delighted to have the opportunity to meet with two Masters of Public Health students who are currently studying at QUT, but back in Hanoi for holidays. Bich and Nga took us sightseeing one evening on the back of their motorbikes and fed us local lake snails for entrée. We also had dinner with My Linh, who was previously a project officer working with the QUT/HSPH project whilst also studying in Brisbane last year, and caught up with Dr Duong, who had been one of my interpreters when I was in Hanoi working for WHO in 2001.



Sue Walker and Jenny Nicol at Vietnam's Perfume Pagoda

Further work

The QUT/HSPH will continue over the next few years with other academic staff from QUT visiting Vietnam, various joint research projects underway or in development, and staff and student exchanges also happening. It's a great privilege to work on projects like this one, which has huge potential for improving the health and well-being of the local population.

► Sue Walker

Associate Director
NCCH Brisbane

FREE

with this edition



Evolution in classifying mortality statistics

the new title in the NCCH Monograph series

Copies also available for purchase

See order form for details



WHO Collaborating Centre for the Family of International Classifications for North America



The WHO Collaborating Center for the Classification of Diseases for North America (NACC) was established in 1976 to represent the United States and Canada in international activities related to study and revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD). In 1993, the Collaborating Center also assumed responsibility for work in North America on the *International Classification of Impairments, Disabilities and Handicaps*, now the *International Classification of Functioning, Disability and Health* (ICF). In 2002, the Collaborating Center received new terms of reference as a WHO Collaborating Center for the Family of International Classifications (WHO-FIC). The North American Collaborating Center (NACC) is located at the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention, in the US Department of Health and Human Services (DHSS), and works in close collaboration with the Canadian Institute for Health Information and Statistics Canada. Designation is in co-operation with the Pan American Health Organization.

The NACC hosted the annual Centre Heads meeting in Bethesda, Maryland, in October 2001, where the Family of International Classifications and the ICF were officially launched. Photographs of the participants and individual delegations were taken for use in national launchings of WHO-FIC and the ICF (see NACC home page at <http://www.cdc.gov/nchs/about/otheract/icd9/nacc.htm>). In addition, interviews were videotaped with participants about the role of the Centres, the need for training various professions in the use of the classifications, and applications of the classifications in clinical, survey, policy and program work. These interview tapes will be available in 2003 for use in national launchings, other promotional activities, and training materials. Eight staff from the US and Canada represented NACC at the 2002 Centre Heads meeting in Brisbane, Australia, and presented 17 papers on current activities.

The NACC coordinates activities in three major aspects of classification: mortality, morbidity and disability and works with the other WHO collaborating centers and related offices to promote and coordinate ICD and ICF applications. A major activity regarding mortality data is the International Collaborative Effort (ICE) on Automating Mortality Statistics, which was established by NCHS in 1995 to promote the comparability of mortality statistics through the application of automation. Two plenary meetings of the mortality ICE, one in 1996 and the second in 1999, encouraged WHO to establish a number of working committees oriented to training and credentialing and to electronic products more generally. Under the ICE, NCHS has initiated an international training course on mortality medical coding oriented to automation. NCHS also has provided technical assistance in Egypt, Jordan and Jamaica.

The Head of NACC chairs the WHO Collaborating Centres Subgroup on Training and Credentialing, which has developed and circulated questionnaires on ICD-10 training materials, training capacity and needs assessment for ICD-10 mortality and morbidity coders. The results of the first two questionnaires can be found on the NACC home page. The next ICE Plenary is scheduled to take place in Washington DC 7-10 April 2003. In the preceding week, the Subgroup on Training and Credentialing will be meeting to develop a draft core curriculum on ICD-10 underlying cause mortality coding that can be refined for international endorsement and serve as a framework for the international credentialing process. The group also hopes to develop a plan for to progress similar curricular work for ICD-10 morbidity coders and multiple cause coders. Sue Walker, Associate Director, NCCH, is an active member of the Subgroup.

The Canadian Institute for Health Information (CIHI) is facilitating the implementation of a Canadian enhancement of ICD-10 (ICD-10-CA) and the Canadian Classification of Health Interventions (CCI) in acute care hospitals throughout Canada. Full implementation is

expected by 1 April 2004. NCHS also has developed a clinical modification of ICD-10 (ICD-10-CM), which is posted on the NCHS website (<http://www.cdc.gov/nchs/about/otheract/icd9/abtcd10.htm>). During 2003, NCHS will conduct testing on the more recent changes to ICD-10-CM as well as ICD-10-CM alpha version guidelines and training materials. Implementation of ICD-10-CM in the United States will be through the rulemaking process under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The National Committee on Vital and Health Statistics, the advisory committee to the Secretary of Health and Human Services, currently is supporting an impact analysis of the costs and benefits of transitioning from the clinical modification of ICD-9 (ICD-9-CM) to ICD-10-CM and ICD-10-Procedure Classification System (PCS). The latter would be used for reporting inpatient procedures.

NACC was very active in the revision process for ICF and has initiated a number of activities in the US and Canada to promote awareness and applications of ICF. The Eighth Annual North American Collaborating Center (NACC) meeting on ICF was held in Toronto, Canada in June 2002. The meeting was attended by more than 70 participants, with over 30 papers presented. The Ninth Annual NACC meeting on ICF will be held in St Louis, Missouri 17-19 June 2003. On 5 December 2002, the US Inter-agency Committee on Disability Research hosted a meeting on *The ICF: Potential influence on disability and rehabilitation in federal agencies*.

A NACC Clearinghouse on ICF has been launched, with over 250 participants who receive a monthly message on relevant ICF issues. Information on signing up for the Clearinghouse can be found on the NACC home page. An ICF expert is compiling information on use of ICF in university curricula in the US and Canada and developing a model course. Code ICF, a web-based training tool to familiarise persons with ICF as a classification and framework for functional status and disability, will be completed in early 2003. The DISTAB Group, representing six countries (Australia, Canada, France, Netherlands, South Africa and US, as well as the United Nations Statistics Division), continues to study ICF applications in population surveys. The Washington City Group has identified ICF as the framework for general measures of disability to be used internationally in surveys and censuses. The City Group, which

has been endorsed by the United Nations Statistical Commission, first met in February 2002 in Washington DC, and held its second meeting in Ottawa, Canada 9-10 January 2003; the next meeting is scheduled for October 2003 in Brussels, Belgium. More information is available on the NCHS website (<http://www.cdc.gov/nchs/citygroup.htm>).

Collaboration across mortality, morbidity and disability classification and statistics at the national and international levels will continue to be a major focus of the North American Collaborating Center.

▶ **Marjorie S Greenberg, MA**

National Center for Health Statistics,
Centers for Disease Control
and Prevention
Hyattsville, Maryland, USA

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
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- ▶ notes marker
- ▶ 10-AM Commandments full-text links
- ▶ user defined search facility.



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Australian DRG delegation to Europe

In late September, Stuart McAlister, Katrina Chisholm and Cathy Hales from the DRG Development Section of the Department of Health and Ageing visited Germany, Austria, Romania, Slovenia and Ireland.

In Meunster, Germany, the delegation met with Professor Norbert Roeder, who has been undertaking research in AR-DRGs and their application in the German health system, or G-DRGs, as they will be known. They also visited InEK, the German DRG Institute, in Siegburg, where they met the Director Dr Frank Heimig and staff. They have been given the task of the developing cost weights for G-DRGs, and the certification of the German DRG grouper.

After attending the PCS-E conference in Innsbruck, Austria (for a full report about the European casemix conference, see *CM* 9(3):21), we went to Slovenia to meet staff from the Ministry of Health. A World Bank project undertaken by the Australian Health Insurance Commission had proposed that the Australian classifications systems, ICD-10-AM and AR-DRGs, should be used as the basis for developing similar systems for Slovenia. During our short visit to this beautiful country, negotiations with Dr Tanja Mate and other members of her team took place to implement ICD-10-AM and AR-DRGs in Slovenia. We also met with the Head of the Centre for Health Care Organisation, Economics and Informatics, Dr Albreht, and learned more about morbidity data collection in Slovenia. Slovenian data collection breaks the episode of care into its components and codes each component of the episode. Thus, if the patient is transferred to another specialty or ward, each component has a principal diagnosis, which is coded. This enables a comprehensive picture of the care provided to the patient to be captured. The delegation fell in love with the very picturesque city of Ljubljana and would have enjoyed spending more time here.

Our next stop was in Bucharest, Romania. We had very fruitful discussions with the DRG project team, led by Dr Dana Burduja. We met

with Dr Ioana Pertache of the Romanian Institute of Health Statistics and with Dr Bogdan Martian and staff members at the Institute of Health Services Management. We were also very fortunate to be able to meet informally with the Secretary of State for Health.

In Ireland we were involved in further discussions about the pilot trial of ICD-10-AM and the potential use of AR-DRGs as a funding mechanism for that country.

It was very gratifying to see the high esteem held for Australian health classifications in these countries. We are delighted to announce that the major outcome from this visit was the recent signing of a contract to use ICD-10-AM and AR-DRGs in Slovenia and confirmation of an agreement for ICD-10-AM to be used in Romania.

► **Katrina Chisholm**

DRG Development Section
Department of Health and Ageing



Centre for Health Care Organisation, Economics and Informatics, Ljubljana, Slovenia

As it once was...

Parenting has always involved some contentious issues. This is how some of our mothers and grandmothers were informed about the trials and joys of parenting.

from
Sunday Guardian (Sydney) vol 1,
no 48, Sunday August 24 1930, p21



A MOTHER who plans the hours of the day, observes strict regularity in the foundation of a baby's daily habits, and trains her baby from the beginning to observe a certain discipline and routine in his little life, ensures the little person being a welcome addition to the household, instead of a trial and a worry to everybody.

On the other hand, the mother who will not make the initial effort of coping with the increased number of duties which must fall to her lot with the arrival of a child, who allows the baby to "rule the roost" and have every bit of his own way, and who will not adhere to a strict timetable in handling her baby, makes a rod for her own back, and upsets the entire household.

It is a wise mother, who, having worked out her scale of management of the household and the baby, goes ahead and carries it out, and will brook no interference, even from the most well-meaning of relatives.

I have seen mothers who have been seriously trying to train their babies, and who, because of the interference of a relative, sometimes living in the house, sometimes merely a frequent visitor, have given up the task in vain. There are some well-meaning and affectionate relatives who insist on "picking up the little darling just for a wee while," no matter what hour of the day or night they find their visit.

Maybe the child has just been put down and informed by a strict mamma that he must now go to sleep. Before the poor mite can carry out his very good intention, he is swooped upon and his attention distracted from the business of being drowsy and contented by

a series of "gooks" and gurgles. Of course, he will like the attention, and will respond with a smile and perhaps another gurgle. Then, having satisfied the craving expression of her affection, the fond relative returns him to his crib, and the baby, naturally, resents being thus treated. If this kind of thing is allowed to continue, even the best baby in the world will develop a fractious temper in time and will learn to make his demands on the entire family by lifting his voice for everything he wants, or only thinks he wants.

A child responds naturally and happily to discipline. He is far happier when his days and his hours are regulated for him, and he learns early in life that he must bend to a higher authority. Every human being is the better for discipline—and the younger they learn it the better for them.

Interference!

A young mother of my acquaintance, who manages her three small children with the minimum of fuss and the maximum of contentment for all concerned, decided to me how she kept the wheels of her household running smoothly in spite of the arrival of three babies in four years.

"When I was in bed with my last baby, I spent the time revising my programme of events for the day and making out a fresh timetable to fit in the new baby. It is just a matter of sliding the weeks forward for two to let in the third."

And, by adhering determinedly to her programme and allowing no one to interfere with the routine of her baby's day, she has half-reared how three of the bonniest kiddies—and happiest—I have ever seen. And there is peace and contentment in her home.—V.H.

ICD-10-AM

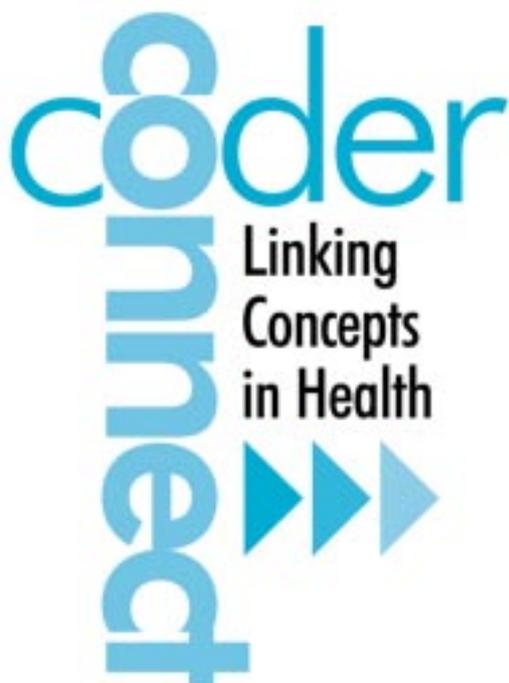
Early Parenting Manual

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.

NOW AVAILABLE

**National Centre for Classification in Health
8th Biennial Conference
26 – 28 March 2003
Hilton on the Park, Melbourne**



Conference preparation is well underway and you will have received the *Preliminary program and registration information with Coding Matters* in December 2002. Code-L subscribers have been advised that the final program is available from the NCCH web site <http://www.fhs.usyd.edu.au/ncch/> (follow the link to Conference 2003). Advice about program changes and other information will be posted at the website, so check it regularly.

Keynote presenters

The conference will include dual keynote addresses from Associate Professor Stephen Bolsin, Director of the Division of Perioperative Medicine, Anaesthesia and Pain, Geelong Hospital, and Christine Sweeting, Data Quality and Classifications Advisor, National Health Service Information Authority, UK.

Stephen and Christine have been involved in the Bristol Royal Infirmary paediatric cardiac surgery affair and the subsequent General Medical Council and public inquiries: Stephen as the clinician who first raised concern about unacceptably high mortality rates in some paediatric cardiac surgical procedures, and Christine as an analyst of clinical data presented at the inquiries. The outcomes of the Bristol inquiry have had profound effects upon the attitudes and administration of the NHS.

Tutorial day - Melbourne 26 March 2003

Two hands-on tutorials will be conducted on the Wednesday before the conference:

- **Introduction to health terminologies** will familiarise participants with the concepts of interface, reference and aggregating health terminologies. Participants will learn how these terminologies fit into the contemporary health informatics environment.
- **ICD-10-AM Third Edition coding tutorial** is designed for users of the classification and will be based upon frequently asked questions.

Poster display

An unprecedented number of excellent abstracts were received in response to the call for papers. Not all papers were able to be included in the conference program, so some papers will be presented as posters.

The poster display is planned to be available for delegates throughout the conference. The posters will be displayed in the trade exhibition area visited by delegates during breaks in the program. Poster presentations during breaks will allow small group interaction with the author who is on hand to describe and discuss the poster's content.

eBook demonstrations

NCCH eBook demonstrations will be conducted from 7.30–9.00am and 12.30–1.30pm on Thursday 27 March and Friday 28 March. Delegates will have the opportunity to gain hands-on experience in a relaxed environment.

The *ICD-10-AM Third Edition eBook* is an interactive, electronic version of ICD-10-AM Third Edition, which looks like the printed manuals on screen, with loads of additional features:

- **hyperlinks between volumes** provides fast and accurate navigation
- **periodic updates** (errata) that include revisions, additions and deletions are released during the two-year lifecycle of ICD-10-AM Third Edition and are sent electronically to registered users. No more cutting-and-pasting!
- **a personalised user notes field.** Notes can be created according to personal, area, state, research or other needs. Editing is easy using MS Word® or WordPad®. Portability is a feature: notes can be transferred as updates are released
- **a notes marker** shows entries where notes have been created
- **links to 10-AM Commandments** technical information published in *Coding Matters* helps to clarify and guide assignment of correct codes
- **a user-defined search facility.** Search for codes, parts of codes, words or strings of words
- **cut-and-paste text from the eBook** and retain formatting into most popular word processing programs

Social program

Attendance at the welcome reception and conference dinner is included in the full conference registration. The welcome reception will be held at the conference venue and the conference dinner at the award-winning Melbourne Aquarium's Function Cove. Kream, one of Melbourne's premier bands, will entertain guests playing hits from the 70s till now – don't miss it!

Program enquiries

Phone + 61 3 9479 1811
 Fax + 61 3 9479 5657
 e-mail S.Watts@latrobe.edu.au

*We look forward to seeing
 you in Melbourne at this
 stimulating conference*

Hurry! Hurry! Hurry! Register for Coder Connect now!

The program in a nutshell

Wednesday 26 March 2003

- Introduction to health terminologies tutorial
- ICD-10-AM Third Edition coding tutorial
- **Welcome reception
 Hilton on the Park, Melbourne**

Thursday 27 March 2003

- Official opening and keynote presentations
- Clinical update: Infections
- Coding in quality of care
- Coded data quality and auditing
- **Conference dinner
 Function Cove, Melbourne Aquarium**

Friday 28 March 2003

- Coder careers and education
- The changing face of coding
- Clinical update – Vascular access devices
- The classification/documentation link and close

Registration information and forms available from

www.fhs.usyd.edu.au/ncch

follow the links from Conference 2003

Phone + 61 2 9351 9461

Fax + 61 2 9351 9603

e-mail T.Stanhope@fhs.usyd.edu.au

National Centre for Classification in Health Coding Auditors' Network

The NCCH has continued to work with La Trobe University to develop coding auditors' course. This exciting new venture creates opportunities for coding audit certification, which is a criterion for participation in the NCCH Coding Auditors' Network (CAN). More details about the CAN will be published in the June 2003 edition of *Coding Matters*.

La Trobe University

Short course in coding auditing

La Trobe University is offering a short course in the second half of 2003 for people who undertake clinical coding or who manage clinical coding functions to acquire the specialised skills to be a coding auditor. Auditing skills acquired through the course of study can be used to apply for auditing positions with external agencies and to undertake or further develop internal audit programs within their own organisations.

Features of the coding audit course

- The course is being offered in electronic distance education mode
- Depending on the number and location of course participants, there is a possibility to offer one or more face-to-face sessions
- Students can choose assessment and award level to match present workplace needs and career planning aims. Options are:
 - to complete all course work requirements in preparation to undertake the final examination. A pass in the examination leads to the award of a certificate of pass. This certificate is particularly valuable to people planning careers as external auditors
 - or
 - to complete the course work requirements, but choose not to undertake the final examination, to be awarded a certificate of completion

Enrolment requirements

A qualification in clinical coding, a HIM degree or other recognised clinical coding qualification, is a prerequisite for enrolment. Competence using Excel® (or similar spreadsheets) will be valuable for people undertaking the course.

Further information

Contact Kerin Robinson K.Robinson@latrobe.edu.au or Jennie Shephard J.Shephard@latrobe.edu.au for further information about the course.

Course content

Key areas that relate to audits of coded data and management of audit functions will be taught including:

- principles of clinical coding, at a half-day, advanced coding workshop designed to assist students in making their decision whether to sit the optional examination at the end of the course
- principles of casemix funding and AR-DRGs
- introduction to auditing
 - types of coding audits
 - auditing methodologies
 - audit tools; data collection, entry and management
- analysis and interpretation of audit results
- the internal audit function and its management
- the external audit function
- strategies for dealing with audit outcomes
- interpersonal skills for auditors

NCCH bids au revoir to Michelle Bramley

NCCH long-time staff member, Michelle Bramley, has departed the Sydney office to take up a new career as an academic. Michelle's new post takes her away from the Sydney office, albeit not very far. She will be working in the University of Sydney School of Health Information Management, which is located on the same campus, teaching in both undergraduate and postgraduate courses.

Michelle has been with the NCCH almost from its beginning. She joined the team, initially as a project officer, directly after graduating from the University of Sydney's School of Health Information Management.

Michelle has been involved in many firsts as part of the Sydney team. She was a major contributor to the development of the ICD-10-AM procedure classification and fulfilled much of the work to create the *ICD-10-AM Mental Health Manual*.

In recent months, Michelle has been a major player in creation of the soon to be released *ICD-10-AM Chronicle* (a cross-indexed list of all changes made to the ICD-10-AM classification through all editions).

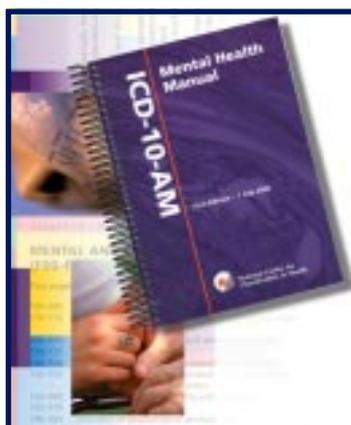
Michelle has also made a mark for the NCCH internationally by fulfilling much of the secretariat work for the World Health Organization's Update Reference Committee for ICD-10. She also represented the NCCH at the ISO TC 215 Health Informatics Working Group 3 in the development of a health language metavocabulary, and at Standards Australia IT-14-2 in health concept representation.

Michelle will remain in the affection of her NCCH colleagues for her meticulous attention to detail; developing the 'Bramley branch' of the University of Sydney libraries in her enthusiastic use of resources during research and development work; smiley faces; and her love of fine red wine.

Michelle's contributions have been great and many – she has left her mark of excellence on many systems, projects and products that have helped the NCCH to grow and continue to meet the needs of health classification users in Australia and internationally. We thank Michelle for her work that has often been above and beyond the call of duty, and wish her continuing success and fulfilment in her new role.



**Members of the
NCCH Sydney
team farewell
Michelle Bramley**



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.

Available NOW

ICD-10-AM

Alex's Conundrum



What was the *King's evil*?

King's evil is an old name given to scrofula (primary tuberculosis of the lymphatic glands in the neck). Scrofula is a disease of children and young adults, and it was a very common form of tuberculosis in the nineteenth century. Symptoms include enlarged rubbery lymph nodes in the neck, which are not painful, and which often drained onto the skin of the neck via the sinus tracts. This led to ulceration and skin abscesses. It could be a very chronic infection, that lasted for years before antibiotics offered a reliable way to treat tuberculosis.

In medieval France and England, scrofula was deemed capable of cure by the *royal touch*. The practice of 'touching' for the King's

evil in England originated from a legend about King Edward the Confessor. Legend says that he healed a young woman of scrofula, after she had dreamt that she was cured at the hands of the King. Later, the monarch maintained that the exclusive right of being anointed was in some manner responsible for the healing powers of the royal touch.

The public displays of this practice endured from the 1340s until 1714.

Identification of the tubercle bacillus as the causative agent in 1882 firmly established the infectious nature of scrofula and the development of sanatoria soon followed.

Source:
The 1911 Edition Encyclopedia, <http://19.1911encyclopedia.org>

The Australian Refined Diagnosis Related Groups (AR-DRG) version 5.0

Diagnosis Related Groups (DRG) is a patient classification scheme that provides a clinically meaningful way of relating the number and types of patients treated in a hospital to the resources required by the hospital. AR-DRG is developed and maintained by the Commonwealth Department of Health and Ageing.

AR-DRG version 5.0 builds on the foundation of version 4.2 and incorporates ICD-10-AM Third Edition.

AR-DRG version 5.0 consists of 3 volumes and includes a CD-ROM with supplementary tables.

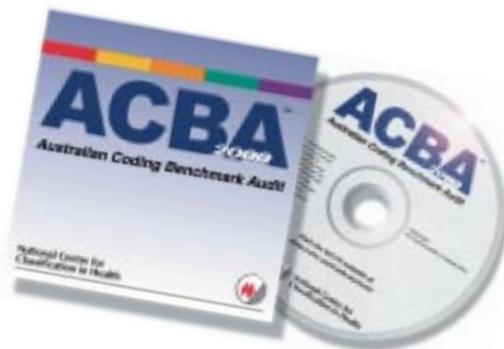
Copies may be purchased from the NCCH. Versions 4.0 and 4.2 are also available. See enclosed order form for details.



For more details
about AR-DRG version 5 visit:
www.health.gov.au/casemix

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ACBATM 2000



Health care decisions are dependent on good quality morbidity data. **Australian Coding Benchmark Audit 2000 (ACBA)** provides a mechanism to assess quality of coded morbidity data. **ACBA 2000** is a coding audit method that involves re-coding a sample of hospital-admitted patient episodes and uniformly recording results.

ACBA

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

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

2003 Conference & Event Calendar

26-28 March NCCH 8th Biennial Conference
Coder connect: Linking Concepts in Health
Melbourne, Australia
www.fhs.usyd.edu.au/ncch

14-16 July The First Australian Conference for Safety and Quality in Health Care
Safety and Quality – in Action!
Perth, Western Australia.
www.safetyandquality.org/

8-10 August HIMAA 2003
Health Information Management Association of Australia (HIMAA)
Sydney, Australia
www.himaa.org.au/2003/

10-12 August HIC 2003
Health Informatics Society of Australia (HISA)
Sydney, Australia
www.hisa.org.au

15th National Casemix Conference
Department of Health and Ageing
Conference 2002
Health Care in Focus
Canberra, Australia
www.health.gov.au/casemix/

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**Next
edition
June 2003**

Watch for the new look *Coding Matters* from June 2003: a new layout and some new features. Also included will be:

- A full report from the NCCH biennial conference *Coder Connect: Linking concepts in health*
- *Part 2 of the 2002 Australian Coder Workforce Survey – coders' responses*
- Index of clinical information presented in *Coding Matters* volume 9 2002 – 2003

The winner is...

In December 2002, a one-day research seminar *Mental health: La Trobe health sciences initiatives* was conducted at the Bundoora campus of La Trobe University.

Jason Fowler, a psychologist at Latrobe Regional Hospital, Traralgon, was the winner of a copy of the *ICD-10-AM Mental Health Manual* in a competition conducted by the NCCH at the seminar.

**coding
matters**



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

For further information:
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PICQ 2002 contains a number of enhancements:

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

An order form is enclosed with this edition of *Coding Matters*