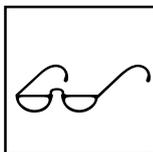


Coding *Matters*

Newsletter of the
National Centre for Classification in Health

Volume 5 Number 4
April 1999



FROM THE DESK OF THE DIRECTOR

The Move!

The desk of the director, and most other NCCH desks, moved to a new location at the Cumberland Campus of the University of Sydney in late January. We are now on Level 4 of T Block (great views!) and settling well into our new accommodation. NCCH staff members are to be congratulated on the smooth team work that lessened the pain of the transition and our thanks to the University of Sydney staff who prepared the new offices and provided physical and moral support. The aim of the move was to bring NCCH closer to the School of Health Information Management which is in the same block, albeit on the next level. As you can imagine, the move was a great opportunity for culling our four years accumulation of debris – so much for the paperless office! Phone, fax, post and email addresses have not changed.

New Editor

This is the first issue of *Coding Matters* edited by the recently arrived Publications and Technology Manager, Rodney Bernard. So be prepared for a new look in the near future!

Rodney's experience and expertise are most welcome at NCCH where we are so reliant on maintaining contact with our readers and receiving feedback from you.

The Second Edition

As you know, NCCH is preparing for the second edition of ICD-10-AM. Codes and coding standards are being reviewed, and we are currently reviewing the results of our first call for public submissions. Work on the database of the classification is proceeding and the finished product will form the backbone of future NCCH classification development and publication. While waiting to take up a new position at NSW Health, Jennifer Mitchell provided some valuable input to the Australian Coding Standards, and Coding Services staff Kerry Innes, Judith Hooper, Michelle Bramley and Tiffany Chan have been consulting with clinical coders and clinicians



**The new NCCH national headquarters – Building T
– we've allowed for some wishful thinking
and artistic license**

before changes are ratified by the Coding Standards Advisory Committee. Megan Cumerlato and Julie Rust are now each working three days a week for NCCH. This extended contribution is much appreciated in both Coding and Education Services.



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Education

As I write, Karen Peasley has commenced *Train the Trainer* sessions for members of the Coding Educators' Network in those states introducing ICD-10-AM in 1999 – Western Australia, South Australia, Tasmania and Queensland. These sessions are in preparation for NCCH workshops for clinical coders in those states in April and May. NCCH is fortunate in having the assistance of Lindy Best for some of the CEN workshops as well as NCCH 'agents' in the states concerned. Post implementation education is under way in states and territories already using ICD-10-AM and the NCCH Conference to be held in Hobart from September 22–24, 1999 is taking shape. Please note our call for papers on page 21.

Mapping

Several 'fixes' to the mapping between ICD-9-CM and ICD-10-AM have been introduced following input from users of the new classification, especially Victoria. South Australia is doing forward mapping from ICD-9-CM to ICD-10-AM and notifying NCCH of issues which might affect the present mappings. Work on these problem areas is being done by the staff of Coding Services and Christine Erratt, NCCH Executive Officer.

Specialty Books

NCCH specialty books, masterminded by Monica Komaravalli, are rolling off the presses. Ten have already been prepared with current issues carrying information in ICD-10-AM as well as data in ICD-9-CM. *Mental Health* and *Neurosciences* books are near completion with coding information provided in ICD-10-AM.

Community Health

NSW Health, lead agency in the development of the Australian Community-based Health Services Codeset, have invited NCCH to assume responsibility for maintaining the community health codeset. Those involved in negotiations have been Kerry Innes from NCCH Sydney and Erich Schulz, NCCH Brisbane. Erich has also included this codeset in the Australian Clinical Thesaurus which can be accessed through the NCCH homepage.

NCCH Homepage

Chantel Garrett has been improving the presentation and content of our homepage. You will find there the education material for clinicians and users of ICD-10-AM as well as up to date information on the centre's activities and personnel. Just recently, Chantel placed on our site samples of the classification to demonstrate its content to potential users. The resources and links listed on the homepage have just been reviewed, so if there is anything we've missed, please let us know. NCCH customers can now access our order form through our homepage at <http://www.cchs.usyd.edu.au/ncch/orderform.htm>.

Quality Division

Following requests to the states for financial support of the NCCH Quality Division at La Trobe University, the Victorian Department of Human Services has agreed to continue the secondment of Irene Kearsey half time to NCCH Quality Division until 2001. This generous contribution from Victoria will allow Irene to continue her valuable work on Performance Indicators for Coding Quality (PICQ) for which databases are being created with the help of Simon Clarke and Nicole Schmidt at NCCH Sydney.

Coding Matters

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Research

Donna Truran is making a substantial impact on NCCH through her skill in preparation of research and consultancy proposals. Donna now has her own column where she will provide details of her activities and results of the recent coders survey (*see* page 20).

Work Experience

Joanne Fitzgerald, a third year student from the School of Health Information Management, University of Sydney, recently completed her specialised placement at the NCCH. During her two week stay, she began work on a mental health subset for ICD-10-AM and helped in the analysis of the ICD-10-AM Implementation



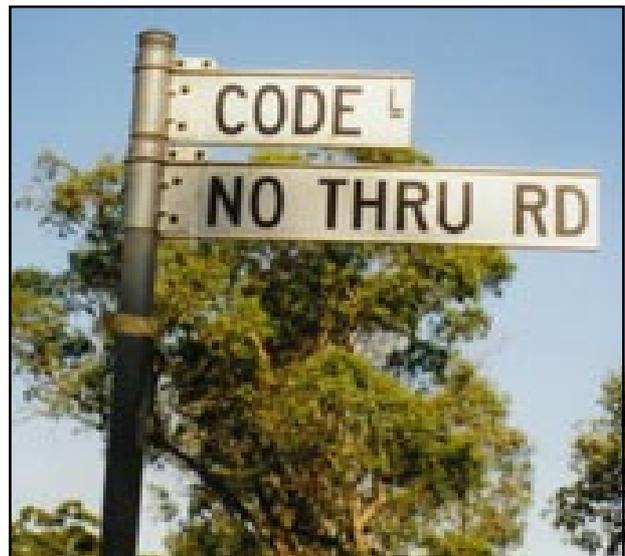
Joanne Fitzgerald

Evaluation – Clinical Coder’s Survey. Despite her busy timetable, she also attended the Coding Standards Advisory Committee meeting at Prince of Wales Private Hospital, Randwick on the final day of her placement.

International Affairs

NCCH international presence has been maintained by NCCH Brisbane through its recent training for WHO/SEARO and hosting of Fijian representatives at QUT to learn about ICD-10-AM. NCCH understands that Fiji is planning to adopt ICD-10-AM in 2000.

I have been nominated by NSW Health to be Australia’s representative on the International Standards Organisation Technical Committee 215 Working Group 3 (Health Concept Representation). Standards Australia IT/14/2 (Vocabulary and Semantics Subcommittee) is meeting early in March to prepare Australia’s position for the international forum. Much work pertaining to this area was done during the Commonwealth Department of Health and Aged Care National Workshop to Identify Strategic Requirements for Health IT Standards held in Sydney last August. I will keep you posted on developments.



Code-L

Recently spotted, by Andrea Groom, off the McIvor Highway near Bendigo. Of course the opposite is true of our Code-L.

Code-L is the Internet forum for Clinical Coders and HIM’s to help each other with coding problems.

Subscribe by sending an e-mail to:
majordomo@listserv.cchs.usyd.edu.au

- leave the subject blank, remove e-mail signature if you use one.
- Include the message text: subscribe code-l

If you have any questions email the List Administrator, Simon Clarke: owner-code-l@listserv.usyd.edu.au

General NCCH Activity

In all its activities, NCCH is dependent on input in time, expertise and goodwill of clinicians and clinical coders who form part of the NCCH network. The centre does not take this contribution for granted, and is most grateful for the continued support of the centre from its many stakeholders, from clinical coders and other users of the ICD-10-AM classification.

❖ **Rosemary Roberts**
Director



VITAL SIGNS

We are back into the swing of things here in NCCH Brisbane after a mercifully quiet Christmas and January period. At the moment, we are totally involved in ICD-10 and ICD-10-AM training courses – but this time, most are in Australia!

We are currently hosting two WHO Fellows from Fiji, who are studying ICD-10 for three weeks. Mr Ifereimi Tabuya is in charge of the Medical Record Department at the Colonial War Memorial Hospital in Suva. He manages the staff and the departmental systems, as well as undertaking some of the morbidity coding. Mrs Ruci Vuadreu works in the Ministry of Health in Suva. She is responsible for coding mortality and morbidity returns. As well as spending time in the classroom with Sue Walker, Ifereimi and Ruci will be visiting the Australian Bureau of Statistics (ABS), the Queensland Health department and several of Brisbane's public and private hospitals.



**Sue Walker with Mr Ifereimi Tabuya and Mrs Ruci Vuadreu
– WHO Fellows from Fiji**

Maryann Wood, Senior Classification Officer, is also teaching ICD-10. The ABS will be implementing the ICD-10 update to their automated coding software in the next couple of months and therefore NCCH is assisting them with training activities. The ABS is planning to begin coding its 1999 data in ICD-10 and will then backcode two or three years of mortality data in order to produce more robust code concordance and comparability tables and time series data.

Maryann is assisting Karen Peasley with the Queensland CEN refresher courses and ICD-10-AM training in Queensland. She is also about to jet off to Yangon in Myanmar to conduct an ICD-10 course there for WHO/

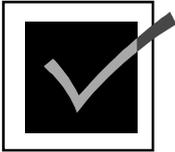
SEARO. We are also planning her trip to the Maldives for June or July where she will participate in a workshop on maternal mortality, as a coding expert.



**Maryann Wood with staff of the Health and Vitals section
of the Australian Bureau of Statistics**

Erich Schulz, Research Fellow, has reduced his hours with NCCH to one day per week so that he can concentrate on his work as a medical administration registrar at the Royal Brisbane Hospital and his sessions at a local medical practice. Erich is busy organising an informatics workshop to be held in Brisbane on 25 March. We have invited Dr Jim Warren from the School of Computer and Information Science at the University of South Australia to speak at the workshop along with Erich. Jim will talk about Care Plan On Line which is an intranet-based tool to support GPs in formulating care plans for the chronically ill. This tool supports GPs in their role as Care Coordinators in the SA HealthPlus Coordinated Care trials. He will also discuss his project Adaptive Data Entry for Primary Care. This involves exploring systems that 'anticipate' the symptoms, diagnoses and drugs that are most likely for a given patient.

❖ **Sue Walker**
Associate Director (Brisbane)



QUALITY CONCERNS



Irene Kearsey
Senior Quality Officer

The Department of Health (Victoria) has confirmed its support for the Quality Division by agreeing to continue the secondment of Ms Kearsey on a halftime basis until June 2000. The Australian Private Hospitals Association has provided financial support as well as Health Care of Australia. The activities of the Quality Division are dependent upon government support and we hope that other states and territories will provide additional funding. The Division is actively pursuing additional sources of financial support.

Activities for 1999 – 2000

The Quality Division has prepared a work plan for the next two years including the following activities:

- report and analysis of *Australian Coding Benchmark Audit (ACBA)* results and hospital Continuous Quality Improvement (CQI) activities
- provide ACBA support including advice to users, workshops and the conduct of hospital audits on a consultancy basis
- develop Version 2 of ACBA with provision for electronic submission of results
- develop, publish and promote revised *Standards for Australian Coding Services* and *Standards for Ethical Coding*
- act as a reference and resource centre on coding quality issues
- complete the Performance Indicators for Coding Quality (PICQ) dataset and process for analysis of databases.

Student education kits have been prepared for both ACBA and PICQ in Microsoft PowerPoint® and distributed to all the Australian health information management courses. Our aim is to ensure that all graduates of HIM programs are aware of both PICQ and ACBA thereby increasing the likelihood that they will use these products in the workplace. The universities have agreed in principle to incorporate this material into their 3rd year programs in 1999. The ACBA Student Education Program includes samples to enable students to practice assigning reporting categories and completing a tally form. The PICQ Student Education Program contains a list of obstetric episodes and their codes to enable students to derive the numerators and denominators of some basic ACS-based obstetric indicators. Another exercise will be to complete the numerator and denominator in codes, having been provided the indicator title, rationale, and narrative numerator and denominator, for a set of basic ACS-based trauma indicators. Answers to the exercises will be provided with the Student Education Kits. We are planning to conduct workshops on ACBA for clinical coders during 1999, and will provide more information as arrangements are confirmed.

Australian Coding Benchmark Audit (ACBA)

The Quality Division has prepared a strategic plan to facilitate the development of audit consulting services for individual hospitals and state/territory governments. Information on the hospital audit consultancy service will be available soon.

ACBA results have now been received from over 40 audits and Division staff are aware of many other audits which are being conducted. It is pleasing to see several hospitals repeating the audit process to monitor their progress.

Purchasers of the ACBA kit who have not submitted results were contacted in early 1999 with a short questionnaire to ascertain their need for ACBA support services. We are able to offer advice to facilities which indicate that they need additional support, and we will use the comments gained from the survey in preparing the next version of ACBA.

Preview of survey results:

Standards for Ethical Coding and Standards for the Coding Service

Thank you to those of you who completed the NCHC Quality Division's Questionnaire: *Australian Standards for Ethical Coding and Standards for the Coding Service*. Of the 269 questionnaires sent to a random sample of clinical coders throughout Australia, 173 were completed fully and a further 11 respondents who replied that they were not working as a clinical coder returned their questionnaires uncompleted, as requested. The response rate was a pleasing 68.4%. The following statistics are derived from the 172 completed responses. Results relating to the *Standards for Ethical Coding* will be discussed in a later issue of *Coding Matters*. It is planned that the new version of this document will be published in the second edition of ICD-10-AM.

Analysis of the clinical coder responses to the *Standards for the Coding Service* survey is underway. Early results indicate some interesting trends which might be of interest to readers. The following discussion addresses

three key issues, specifically: current awareness of the *Standards for the Coding Service*, how clinical coders have used them to date, and identification of the factors clinical coders believe affect their ability to code efficiently and effectively.

Considering that the *Standards for the Coding Service* are conveniently contained as an appendix in the ICD-9-CM and ICD-10-AM publications, it is surprising that not all coders were aware of their existence. One hundred and thirty respondents (75.1%) indicated that they were aware of the *Standards for the Coding Service* prior to taking part in the survey. Five respondents (2.9%) did not answer this question. Thus, some 20% of clinical coders are not aware of the existence of these standards.

Table 1 displays the responses to the question: How have you used these standards?

Table 1: Usage patterns of the *Standards for the Coding Service*

Options Supplied ¹	n	% ²
Not at all	88	54.0
As an explanation to others (e.g. clinicians, management) of the resources necessary to provide a coding service	60	36.8
When writing job descriptions	20	12.3
Other, please specify	17	10.4
When contracting staff	9	5.5
No response supplied	10	

¹ Respondents were able to select more than one answer if this was applicable to them.

² Percentages have been calculated after removing respondents who did not answer this question.

Interestingly, while 75.5% of the clinical coders surveyed are aware of the standards, 54.0% have not used them. This indicates that coders may not necessarily consider them to be of practical use. However, those clinical coders who refer to the standards have put them to a wide variety of uses. These include: as an explanation to others of the resources necessary to provide a coding service (36.8%), when writing job descriptions (12.3%) and contracting staff (5.5%). 'Other' uses of the standards include:

- Planning a new department
- Developing 'Quality' policy manual
- In working towards accreditation

- Justifying and restructuring MRA/HIM structure and casemix unit
- Explaining to coding services the scope of their potential services
- As part of performance management

Table 2 displays the responses to the question: What affects your ability to code efficiently and effectively?

It will not be surprising to clinical coders that inadequate or insufficient clinical documentation rates as the most frequent factor that affects coding (73.2%). This is followed by the interruptions associated with completion of activities other than coding (55.5%). This may indicate that coders work in a disruptive atmosphere,

Table 2: Factors that affect the ability to code efficiently and effectively

Options Supplied ¹	n	% ²
Inadequate or insufficient clinical documentation	120	73.2
My job includes doing duties other than coding	91	55.5
Complexity of cases	49	30.0
My physical environment is not suitable for coding	31	19.0
Lack of access to educational activities, reference materials, etc	29	17.7
Other. Please specify	29	17.7
Insufficient numbers of coders for the number of separations	28	17.1
Lack of access to a computer at the point of coding to enable entry of codes	15	9.1
Nothing	13	7.9
No response supplied	9	

¹ Respondents were able to select more than one answer if this was applicable to them.

² Percentages have been calculated after removing respondents who did not answer this question.

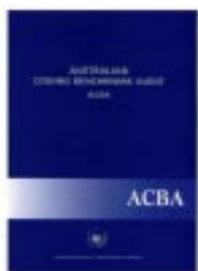
and possibly one where the need to complete coding competes with other priorities. Other factors which impede coders' ability to code efficiently and effectively, which directly contravene the *Standards for the Coding Service*, include a physical environment which is unsuitable for coding (19.0%), lack of access to educational activities and materials (17.7%), insufficient coders for the numbers of separations (17.1%), and the lack of a computer at the point of coding (9.1%). This supports the need for standards, one of the current primary uses of which is to define and explain to others the resources necessary to provide an adequate coding service (36.8%) It is a little surprising that the standards have not been used more widely for this purpose. 'Other' factors cited as affecting coding included:

- Pressure to code a large number of separations per hour (especially at deadlines)
- Deadline pressures which force coders to code without a front sheet or summary diagnosis
- Insufficient trained coders in rural areas
- Insufficient funding
- An inadequate computer system with insufficient edits and checks
- Interface problems between computer packages
- The absence of a suitable database or reference file that registers all decisions on coding practice at local, state, and national level

- Difficulty in accessing clinicians for clarification of cases
- Clinicians not wanting to explain episodes of care fully if there is a problem
- The existence or absence of peer support: Code-L has helped this to an extent
- The absence of reports and pathology results

The above results will be of great interest to clinical coders and, of course, to the NCCH. Further analysis will be completed on a state by state basis. A priority of the NCCH will be to address the perceived notion that the standards are not of practical use, even if coders are aware of their existence and content. The identification of factors which clinical coders believe affect their ability to code efficiently and effectively is a priority of the NCCH. This feedback will be used to drive the redevelopment of the *Standards for the Coding Service* to provide a more 'user-friendly' and practical document. This revision is one of the key projects of the Quality Division in 1999. The revised standards will be expanded and become a separate publication, rather than simply being incorporated into the second edition of ICD-10-AM. We will keep you informed of developments as they occur.

❖ **Dianne Williamson**
 Manager, NCCH Quality Division
Andrea Groom
Irene Kearsey
Catherine Perry



ON THE ACBA AUDIT TRAIL

Things you've always wanted to know about ACBA...
...and weren't afraid to ask!

Do you have any suggestions for obtaining the services of an arbitrator?

A

An arbitrator (Person C) is only required when the original coder and auditor (Persons A and B) cannot agree on code allocation, therefore an arbitrator may not be required for each audit. An arbitrator needs to be an

experienced clinical coder. The arbitrator may be:

- your Coding Services Manager
- another coder at your facility who was neither original coder nor auditor
- a coder from another facility (with whom you can offer to 'swap' arbitrator roles)
- an organisation, such as your state coding authority.

The arbitrator does not have to be on-site. The query may be able to be addressed by sending either a description of the coding issue or a de-identified photocopy of the relevant pages from the clinical record in question to the arbitrator.

On the Scoring Tool Form should the 'Number of codes in MRNs without error' be the same for Persons A & B?

A

Yes. Records without error must mean that the auditor (Person B) and the original coder (Person A) have exactly the same codes. If after recoding, the auditor notes that they have missed a condition or procedure that the original coder had coded, the auditor may add that code to their code string if they agree with the code allocation. If the two sets of codes are now exactly the same, the case would become a 'MRN without error'.

When should I conduct an ACBA audit?

A

NCCH recommends ACBA be performed six monthly. Points to consider in deciding on the audit period should include avoiding external deadlines (e.g. reporting deadline for your health authority), accreditation, changes in software systems, staff changes or holiday periods.

What factors should I consider before performing an ACBA audit?

A

The healthcare facility should consider how to provide the auditor (Person B) with appropriate facilities, for example a desk to work at in a quiet location, and the provision of coding books, if they are an external auditor. Sufficient time should be allocated for the recoding process, as well as the allocation of reporting categories for errors. In addition, the facility should allow time at the end of the audit for discussion between the auditor and the original coder (Person A), and commit themselves to resolve any issues which are identified through the audit. Clinical coders whose work is being reviewed should be assured that the spirit of ACBA is an audit based on a collaborative, educative and CQI process, rather than a disciplinary or threatening one.

I've heard there will be a Version 2 of ACBA. When will this happen?

A

The Quality Division has been liaising with ACBA users to identify changes that will make ACBA more user friendly. This refinement has resulted in a need for an updated version – Version 2. Version 2 is proposed for release by the end of 1999. The method and reporting categories between Version 1 and 2 will be compatible so healthcare facilities, NCCH and other users of the data will still be able to use and compare results obtained by the use of Version 1. So, please don't sit back and wait for Version 2 before you give it a try.

❖ **Andrea Groom**

Quality Officer, NCCH Quality Division



EDUCATIONAL MATTERS

By the time you commence reading this edition of *Coding Matters*, the final leg of the NCCH ICD-10-AM educational strategy will be underway.

There are 17 workshops to be held throughout Queensland, South Australia, Western Australia and Tasmania from now until mid June 1999. A full report from these workshops will be available in a future edition of *Coding Matters*. So by the end of June, the NCCH will have educated over 2000 clinical coders in the use of ICD-10-AM.

This includes an additional 400 clinical coders from NSW, ACT, NT and Victoria who participated in the Post Implementation Education workshops (affectionately known as the PIE workshops) during March. These workshops were not a part of the original educational work plan for the NCCH but came about through a survey conducted in late 1998 to assess the educational needs of clinical coders following implementation in July 1998. Clinical coders expressed a need for clarification on particular areas within the classification, so the workshops incorporated a lecture and discussion session in the morning followed by break-out 'coding circle' groups, where participants worked through five case studies.



1999 ICD-10-AM CEN Refresher Training WA representatives. From left: Barbara Campbell, Sue Stevens, Kavia Cheng, Joan Knights and Viktoria King.

In February, I spent two weeks in Perth, Adelaide, Hobart and Brisbane conducting a refresher course for the Coding Educators Network (CEN) members within those states moving to ICD-10-AM in 1999. Fourteen CEN members were trained in readiness for conducting the education workshops on behalf of the NCCH from April to June. The enthusiasm and commitment with which these CEN members face the challenge of educating their state clinical coders was very encouraging. This little sojourn brought home to me some of the practical issues confronted by coders, such as WA based Viktoria King's rather unfortunate allergic reaction to the paper and ink within the ICD-10-AM books, which now requires her to follow in Michael Jackson's footsteps and wear one white glove



1999 ICD-10-AM CEN Refresher Training SA representatives.

From left: Karen Peasley (educator), Nicole Parrent, Andrea Smart, Linda Best (educator), Lesley Ward, Anita Walker, Andrew Coshan and Tanya Drake.

on her left hand when coding. Kerri Chalmers from Far North Queensland lamented the loss of some of her most valued ICD-9-CM codes with the quote 'someone has stolen my codes...'

Preparations for the 6th Annual NCCH/CCSA Conference are continuing, with a call for papers located on page 21. Sponsorship information packages were distributed in early March and registration brochures will be distributed in mid July. Another exciting and innovative programme is taking shape with Dr Bedirhan Üstün from the World Health Organization (WHO) agreeing to participate as the keynote speaker. Dr Üstün is responsible for the areas of international classification systems at WHO. This year the NCCH has not allocated a distinct 'theme' but rather has chosen six words which aim to reflect what is happening within the coding world. These words are Collaborating centres, Observing outcomes, Diversifying developments, Evolving episodes. As this annual conference is an important component of the overall NCCH education programme and is aimed at providing a forum for the exchange of ideas and the updating of classification information, I hope to see lots of new and old faces in Hobart in September.

Once the rush of ICD-10-AM implementation slows a little, the Education Services Division will be looking onwards and upwards to ways of improving the NCCH educative process including making better use of new technologies such as videoconferencing and the Internet. Looking toward the new millennium should be a challenging and exciting venture for all clinical coders.

❖ **Karen Peasley**
Education Manager

Profiles of Coding Educators Network (CEN) members

Glenn Garside – Queensland

Formerly a psychiatric nurse, I switched to Health Information Management (HIM) because of 839.21's following an E814.75 or as translated into ICD-10-AM (S22.01 & S22.04 following a V03.12).

I graduated from Queensland University of Technology in May 1992 and the previous clinical experience often comes in useful. I have worked as a clinical coder at Greenslopes Repatriation General Hospital and as an HIM at Maryborough Base and Princess Alexandra Hospitals. I have just been appointed as the HIM and FOI Decision Maker for Bayside District Health Service, which involves a lot more hospital and community administrative work rather than direct coding.

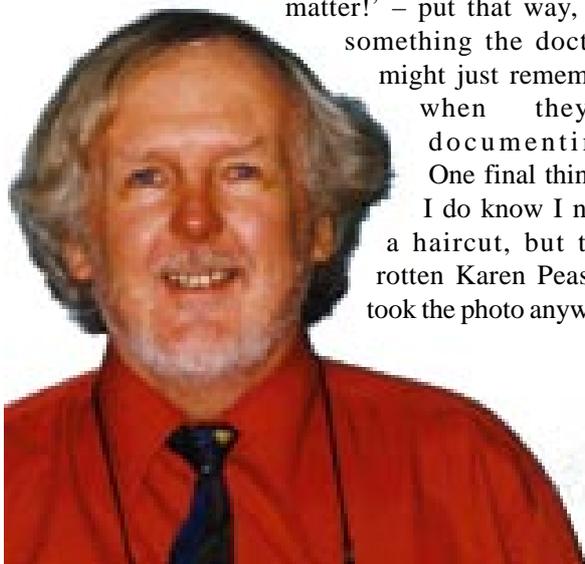
However, coding is my first love and I stay in touch through auditing, helping our staff undertaking the HIMAA course and the inevitable (but enjoyable) coding discussions. I have been a member of the Injury Clinical Coding Classification Group (CCCG) and the Queensland Coding Committee and I am the Industrial representative for the HIMAA Queensland Branch.

I have found that one of the best ways to learn something is to teach it (creates an amazing learning curve!) and since I wanted to learn ICD-10-AM, where better to start than with the Coding Educators Network (CEN) team and the Dual Coding Study? I do enjoy teaching and have a City and Guilds teacher's certificate from my 'former lifetime', so my progression to CEN membership was a natural step.

I think that, as much as possible, both work and learning should be fun, so for those of you yet to meet me, my Winnie the Pooh ties are a trademark. Similarly, my sense of humour can be a bit wicked, and I think the catch phrase for procedure coding in MBS-E is 'Size does

matter!' – put that way, it's something the doctors might just remember when they're documenting. One final thing –

I do know I need a haircut, but that rotten Karen Peasley took the photo anyway!



Nicole Parrent – South Australia

I graduated from La Trobe University, Melbourne in 1994, and commenced my HIM career at Monash Medical Centre, Melbourne, where my role was mainly coding.

In June 1995, I moved to Adelaide to take up the position of Coding Manager at the Women's and Children's Hospital. I found this a huge learning experience, and it certainly helped



improve my obstetrics coding! During this time, I acted as Manager Patient Information Services for 12 months. This was a huge challenge, but once again, a great experience, and an opportunity to be exposed to a very wide range of HIM-related projects.

In 1997, I joined the Coding Educators Network (CEN), along with quite a few other HIMs from South Australia. I found the CEN a great way to learn more about ICD-10-AM in its earlier stages of development, including the opportunity to participate in the Dual Coding Study. I have also improved my presentation skills and am looking forward to conducting a workshop in SA over the next few months.

I am currently working at Modbury Public Hospital as a clinical analyst, managing casemix. I have also recently taken over the management of Coding, Medical Records and Outpatients. No doubt, along with all HIMs involved with ICD-10-AM implementation, I will be kept extremely busy over the next few months!

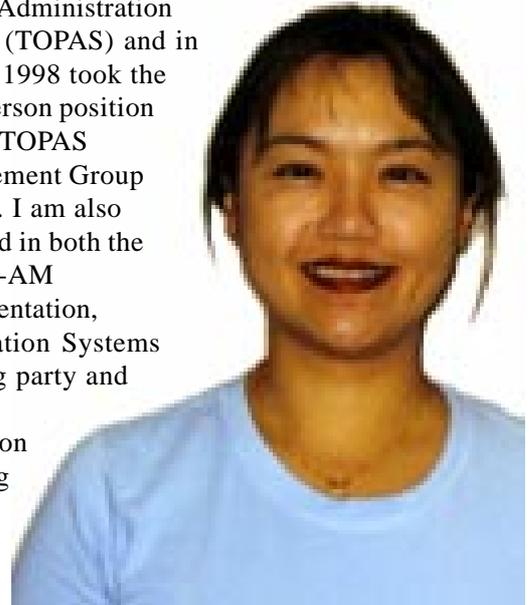
Kavia Cheng – Western Australia

I completed my Bachelor of Business-Health Administration (HIM) in 1991 and Bachelor of Business-Management in 1993 and am currently undertaking a Masters degree in Commerce majoring in Information Systems at Curtin University.

I worked at the Holy Spirit Hospital and Queensland Cancer Registry during my study and following graduation held the position as Health Information Manager at the Prince Charles Hospital where I was responsible for coding and development of number of clinical databases. I was also involved in the establishment of the Day Rehabilitation Unit where they commenced day rehabilitation coding for the Unit. With the introduction of casemix funding in Queensland, I also became involved in the casemix education of clinicians.

In 1995, I joined the National Coder Workforce Issues Project as a coding educator. During this period I travelled extensively across Australia delivering educational workshops. During this time I also made the decision to join the NCCH Coding Educators Network (CEN).

In September 1996, I accepted the position of Assistant Head of Department, Patient Information Management Services at Princess Margaret Hospital (PMH) and King Edward Memorial Hospital (KEM) in Perth and moved west. Since joining KEM/PMH, I have been the Project Coordinator for the implementation of The Open Patient Administration System (TOPAS) and in August 1998 took the Chairperson position for the TOPAS Management Group for WA. I am also involved in both the ICD-10-AM implementation, Information Systems working party and also the Education Working Party.

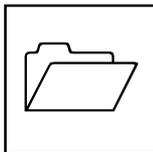


Expressions of interest

The NCCH is seeking expressions of interest from anyone with good coding, analytical and writing skills who would like to work for the Coding Services Division. The NCCH (Brisbane) is also looking for someone with these skills to work on a part-time basis.

Call Kerry Innes (NCCH Sydney) on 9351 9461 or Sue Walker (NCCH Brisbane) on (07) 3864 5873 if you would like an opportunity to work in this unique, rewarding and expanding field of health classification.





CODING SERVICES

The Coding Services Division is busily preparing the updates to ICD-10-AM for the second edition release in early 2000. We are due to complete the addenda (the document which details all the changes made since the first edition was released) in July 1999. Over the last few months we have been extremely fortunate to have had assistance from two very experienced health information managers, Jennifer Mitchell and Katrina Chisholm. Jennifer has an intimate understanding of the needs of clinical coders through her extensive experience in education for the Health Information Management Association and for the NSW and Queensland programs of Health Information Management. She has superior writing and oral communication skills and has that most valuable ability of elucidating and succinctly describing



components of the most complex issues. We have not yet come to terms with her recent departure to take up a position at NSW Health – copious quantities of chocolate couldn't even tempt her to stay!

Jennifer Mitchell

Katrina Chisholm



Katrina Chisholm is setting a good example for Jennifer by returning to the NCCH after her first brief visit late in 1998. Katrina will be assisting us with some of many tasks in Coding Services from March to June 1999. Katrina also has

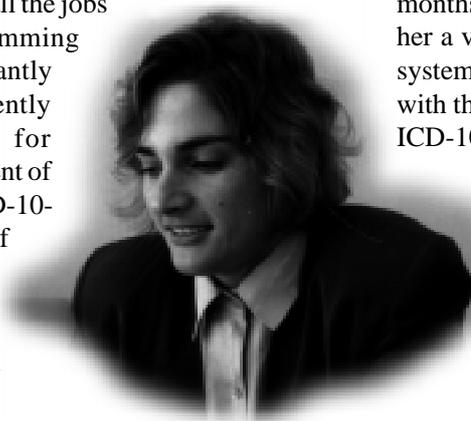
an impressive track record in coding and health information management, in particular having recently returned from working in Hong Kong for six years. While in Hong Kong, Katrina was responsible for introducing coding, medical record and data collection systems into a number of hospitals. Katrina was a member of the Standards Development Committee of the National Patient Abstracting and Coding Project in 1992. The work of that committee resulted in the first ever *National Coding Standards* which subsequently formed the basis for the standards we use today. Katrina also has the knack of 'cutting to the chase' with a practical, circumspect view of the coding function. We welcome Katrina back to the fold this month with lots of work (and laughs) ahead.

Coding Services – staff profile

Judith Hooper

Coding Services Coordinator – full time

Judith is conversant in all aspects of Coding Services having begun work here in March 1996. Judith is responsible for keeping all the jobs in Coding Services humming along and most importantly concluding. Judith recently took responsibility for managing the development of a database version of ICD-10-AM. The core work of producing a database from our word processing files is undertaken by our



contractor, Essential Software. This project will take a substantial chunk of Judith's time over the next few months. Judith's logical approach to her work makes her a valuable asset in construction of these electronic systems which is why she also has the task of working with the Publications Division in developing the CD of ICD-10-AM, Second Edition. Judith also spends eight hours per week coding in a large Sydney hospital, helps with coding queries, deputises for me, dabbles in mapping of various kinds and incorporates changes in MBS item numbers into ICD-10-AM. Judith's easy going way helps her remain 'cool' when the going gets busy.

Michelle Bramley **Senior Classification Officer – full time**



Michelle has primary responsibility for generating the errata and addenda, creating these from information provided from many sources but predominantly from the hands-on users of ICD-10-AM, the clinical coders. Michelle's perseverance and eye for detail are ideal skills for producing very large indexes and tabular lists. This work is extremely taxing and VERY IMPORTANT. When she's tired of staring at a computer screen she uses her classification talents and

reorganises our burgeoning library. She has a dedication to her work and the NCCH as a whole which makes her an extremely valuable member of staff. Michelle codes for four hours each week in a Sydney hospital. Michelle has an interest in community health classification which afforded her the opportunity to consult on the development of the Australian Community Based Health Services Codeset in 1998. She is also heavily involved in advising the National Allied Health Casemix Committee on classification issues and works tirelessly for the NSW Branch of the Health Information Management Association.

Tiffany Chan **Classification Officer – full time**

Tiffany is the newest member of this small and busy team. Tiffany's quiet way belies her ability. With a little less experience than her coworkers to draw on, Tiffany has managed to grasp the idiosyncrasies of the work we do and make a valuable contribution. Tiffany is primarily responsible for making sure your coding queries go into the database and



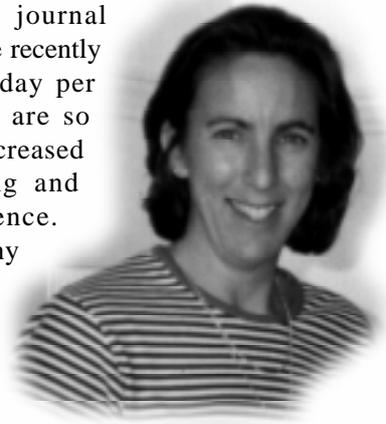
come out with an answer. Although Tiffany is responsible for the queries database we weren't mean enough to make her answer them all on her own. Coding queries are initially answered by any one of the Coding Services staff and checked by everyone before they are sent to the appropriate state coding coordinator.

Tiffany also helps Michelle and Judith with various jobs and she codes at a large Sydney hospital each week. Tiffany sits between Judith and Michelle which makes for a harmonious balance of personalities and styles.

Megan Cumerlato – Consultant – part time

Megan got sick of not being included on the journal circulation list so she recently increased her one day per week to three. We are so thankful for her increased injection of coding and education experience.

Megan helps Tiffany with the coding queries and anything else which needs her advice. Megan also helps the Education



Division when workshops are looming, both in writing the content and in presenting the material to clinical coders. When she's not at the NCCH Megan codes for a large Sydney hospital, lectures for the NSW School of Health Information Management and goes home to a family of six!

Julie Rust – Consultant – part time

Julie can put her hand to anything in Coding Services, do it with skill, a minimum of fuss and on time. Julie spends her too few hours with us, answering coding queries, presenting papers at conferences, writing education material, presenting workshops, organising meetings, attending meetings and writing coding standards. In the rest of the working week (which I am still trying to convince her she should spend with us) Julie works as a consultant, specialising in preparation for hospital accreditation, coding and clinical record management.



The Coding Services staff are truly a 'well oiled' team where everyone pitches in to get the job done. It's a pleasure working with them.

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

Coding tips

This regular section is intended to provide ongoing feedback to coders on commonly asked questions and aims to address those areas of coding which require immediate attention by coders. Any major changes in practice (such as change of principal diagnosis sequencing for certain conditions) which may affect the integrity of state data collections will be flagged and should only be introduced from the July following publication. If you find that any tips published in this section significantly change your current practice, you should seek advice from your state/territory health authority regarding a suitable date for implementation.

ACS 0002 ADDITIONAL DIAGNOSES

The NCCCH has made minor alterations to the wording of this standard to clarify which additional diagnoses should be coded and to minimise overcoding. The intent of the standard has not changed.

The revision of ACS 0002 ADDITIONAL DIAGNOSES has now been approved by the Coding Standards Advisory Committee (CSAC) and will be published in full in the June 1999 edition of *Coding Matters*.

The underlying concept in this revised version is to reinforce the practice of clinical coders reporting only those additional diagnoses which reflect morbidity during the current episode of care.

The main points of the revised standard are as follows:

- For coding purposes, additional diagnoses are conditions that affect patient management in terms of requiring either therapeutic treatment, diagnostic procedures or increased nursing care and/or monitoring.
- One or more of these factors will generally result in an extended length of stay.
- There are certain specialty standards in Volume 5 of ICD-10-AM that guide clinical coders to assign codes for conditions that do not meet the above criteria. These conditions generally fall into the following groups:
 - issues of public health concern e.g. smoking, drug and alcohol disorders
 - long-standing deficits e.g. paraplegia
 - obstetrics and
 - certain codes for health status e.g. carrier status, prosthetic status
- The importance of not ‘overcoding’ in same day procedure cases is highlighted.

Note: this modification to the standard is designed to **reinforce, not change** the essential principles of coding additional diagnoses. It is quite possible and acceptable, that this modification will have no impact on your current coding practice.

Update on the Clinical Update on Renal Diseases – *Coding Matters*, Volume 5 Number 3

The second example about ‘CRF due to NIDDM’ on page 14 created some confusion. The sentence appearing directly under the example relates to the example. This example therefore demonstrates that the principal diagnosis in cases of chronic renal failure due to NIDDM may be:

PD N18.90 *Unspecified chronic renal failure*

Add E11.20† *Noninsulin-dependent diabetes mellitus, with renal complications, not stated as uncontrolled*

N08.3* *Glomerular disorders in diabetes mellitus*

OR

PD E11.20† *Noninsulin-dependent diabetes mellitus, with renal complications, not stated as uncontrolled*

Add N08.3* *Glomerular disorders in diabetes mellitus*
N18.90 *Unspecified chronic renal failure*

Neoplasm Sequencing (excluding same day chemotherapy/ radiotherapy)

The NSW Central Cancer Registry has recently advised the NCCCH of an unusual number of enquiries from coders using the HOSPAS Cancer Notification Module. The enquiries relate to cases where a principal diagnosis code is for a metastasis and the clinical coders want to accompany it with a Z code for history of malignancy. The Cancer Registry does not accept Z codes. Although these code assignments are possible it is much more common for the metastasis code to be accompanied by the code for the primary site of the malignancy. Note in ACS 0236 NEOPLASM SEQUENCING the entry:

‘If the admission is for treatment of a metastatic neoplasm, then assign the metastatic neoplasm as the principal diagnosis code with additional code/s for the primary site/s if known, or C80 Malignant neoplasm without specification of site if the primary site is unknown.

The malignancy code should be sequenced as the principal diagnosis for each episode of care until

the treatment phase has ended. This includes episodes of care which follow surgical removal of a malignancy – although the malignancy has been resected the patient is still being treated for the malignancy.'

Therefore, if a patient is being treated for metastases, the primary malignancy code will be assigned as an additional diagnosis because the patient is being treated for a condition (metastases) which is a continuation of treatment of the primary malignancy.

Note in ACS 0213 HISTORY OF MALIGNANCY – sequencing: 'the codes in category Z85 *Personal history of malignant neoplasm* should be assigned only when the treatment phase has ended and should never be sequenced as the principal diagnosis.'

The NSW Central Cancer Registry only requires a notification when cancer is the principal or an additional diagnosis for the episode of care. A cancer notification is not required for a history of malignancy.

Note: If this changes your current coding practice, implement this advice from 1 July 1999.

Anterior cruciate ligament

Receipt of a number of queries and some recent discussion on Code-L about anterior cruciate ligament tears/ruptures has prompted the NCCH to revise its response to Query 112 and provide the following information.

Definition

The anterior cruciate ligament (ACL) of the knee is one of four principal knee ligaments. The ACL crosses from the back of the femur to the front of the tibia. Although it acts like a strong brace for the knee, the ACL is injured more often than the posterior cruciate ligament (PCL) because it is smaller and more susceptible to twisting.

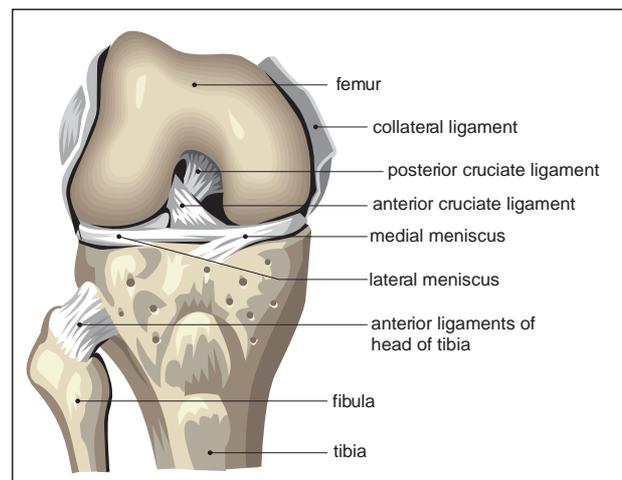
The ACL controls how far forward the tibia moves in relation to the femur. If the tibia moves too far the ACL

can rupture. This tearing of the ligament results in a loud 'pop' and instability in the knee.

The symptoms following a tear of the ACL are variable. Usually there is swelling of the knee within a short time following the injury due to bleeding into the knee joint from torn blood vessels in the ligament. The instability caused by the torn ligament leads to a feeling of insecurity and giving way of the knee, especially when trying to change direction on the knee.

The pain and swelling from the initial injury will usually resolve after 2 to 4 weeks, but the instability remains.

Anterior view right leg



Classification

If the injury is not described as current assign M23.5~ *Chronic instability of knee.*

For current ACL injuries follow the index at: **Rupture, Sprain or Tear.** Note the Errata 5 (contained in this issue) updates for tear of the anterior cruciate ligament. Further enhancements to the index will be published in the second edition of ICD-10-AM to ensure that entries under rupture and tear are consistent.

Important notice – ICD-10-AM query process

From 1 July 1999 coding queries will be accepted directly from QLD, SA, WA and Tasmanian clinical coders until 30 June 2000.

The Coding Standards Advisory Committee agreed at the meeting of 24 February 1999 that the NCCH will return the responsibility for ICD-10-AM coding queries to NSW, ACT, NT and Victorian coding committees from 1 July 1999. The process for handling coding queries in these states/territories

will revert to that which operated for ICD-9-CM. That process requires clinical coders to first seek assistance from their peers/local coding group and if a problem remains, a query should be sent to the state coding committee. The state coding committee will forward unresolved queries to the NCCH. The NCCH will return the answer to the state coding committee. The NCCH will include selected answers to state coding committee queries on the NCCH homepage.

Coding of chemotherapy with cytotoxics and other agents

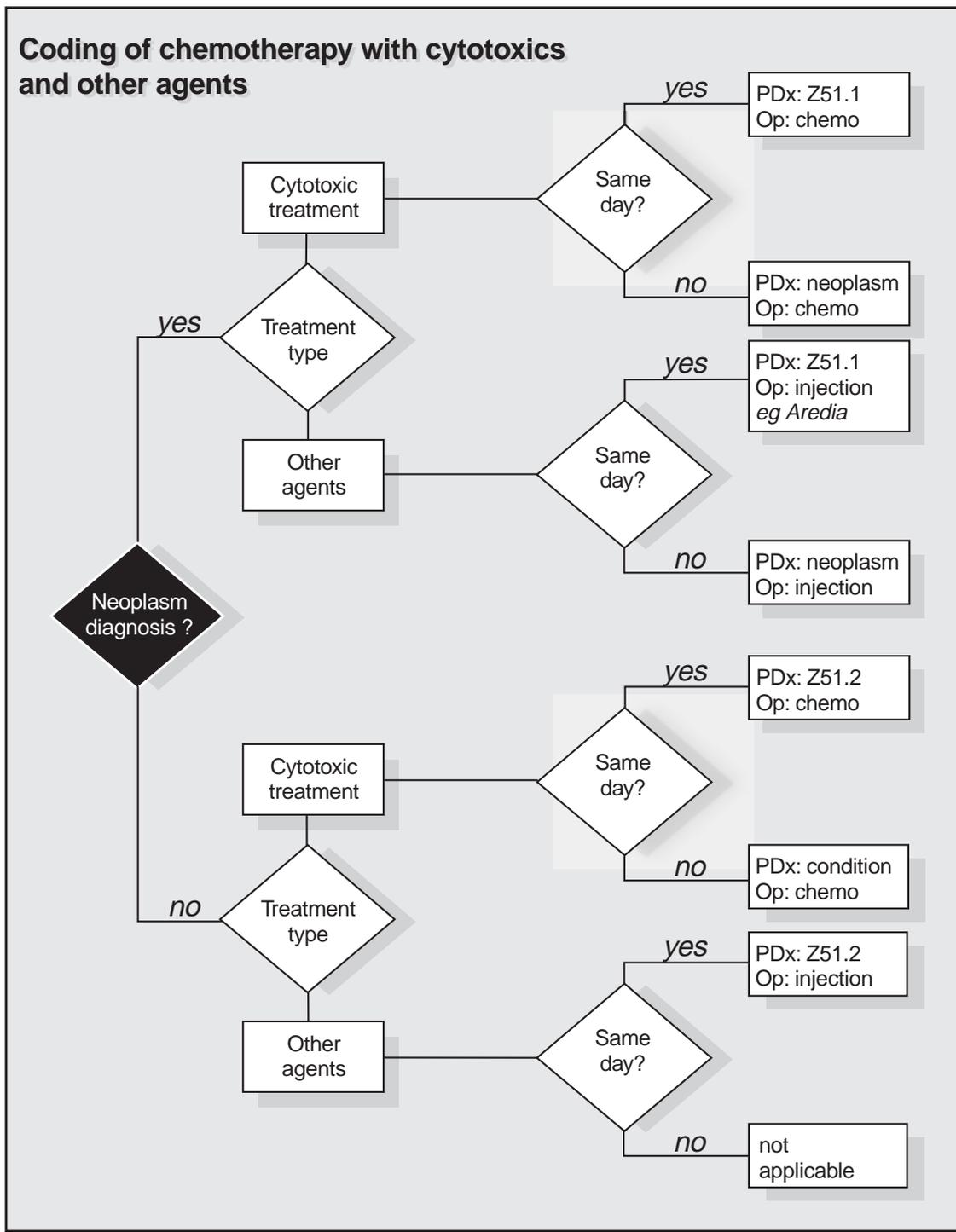
There is some confusion regarding the classification of certain drugs as ‘chemotherapy’ which has meant that some coders assign a code from blocks [1780 to 1784] *Chemotherapeutic procedures* and some assign 92193-00 [1892] *Injection or infusion of other therapeutic or prophylactic substance*.

The NCCH is currently reviewing the chemotherapy/injection/infusion codes in ICD-10-AM in preparation for the second edition release in July 2000. There are a

number of issues to consider in this area, some of which are:

- the cost of certain chemotherapy drugs
- the duration of the chemotherapy treatment
- whether the term ‘chemotherapy’ has a broad definition (including cytotoxics, antivirals, cytostatics, antibiotics) or whether it should, for the purposes of coding, refer only to cytotoxics.

In an attempt to standardise coding practice in this important area, the following guidelines should be implemented from 1 July 1999 until the second edition of ICD-10-AM becomes effective in July 2000.



Questions and Answers from the Coding Query Database

Q¹ Cervical dysplasia/cervical intraepithelial neoplasia (CIN)

I am seeking clarification of coding dysplasia of cervix/CIN. Previously severe dysplasia and CIN III were the same code. Now there is a separate code for severe dysplasia and CIN III. My understanding is that they are considered to be the same thing and clinicians at my hospital use the terms interchangeably. Please clarify the use of these two codes N87.2 and D06.~. If a clinician writes severe dysplasia do I need to seek clarification whether it is CIN III?

A The new code in ICD-10-AM for severe dysplasia (N87.2) excludes CIN III, with or without mention of severe dysplasia (D06.~). The synonymous use of the terms ‘CIN III’ and ‘severe dysplasia of the cervix’ is contentious. In ICD-10-AM, the term severe dysplasia is not interchangeable with CIN III. The following guideline may assist clinical coders:

Severe dysplasia of the cervix, documented, without mention of CIN III, assign N87.2 *Severe cervical dysplasia, not elsewhere classified*.

Severe dysplasia of the cervix, documented, with mention of CIN III, assign a code from category D06.~ *Carcinoma in situ of cervix uteri*, as appropriate.

Example

Histopathology report – diagnosis:

Endocervical biopsy showing fragments of squamous epithelium with features of severe dysplasia (CIN III). Assessment for invasion is not possible due to lack of underlying connective tissue.

Assign: D06.0 Carcinoma in situ of cervix uteri, endocervix.

Q² Chemotherapy

What codes do we use for patients who are admitted daily over the course of a week and each day have the vascular device reloaded with chemotherapy drugs, stay for a while and then go home? The drugs are administered over a period for > 6 hours, but the patient is not in hospital all this time.

Do we code:

a) 13939-00 [1783] alone (does this refilling include the gradual administration)?

b) 13939-00 [1783], 13915-00 or 13918-00 [1781] depending on how long the drugs are administered while the patient is an inpatient?

c) 13939-00 [1783], 13921-00 [1781] as drugs administered for period over < 6 hours even though the patient is not an inpatient the entire time?

d) Only one of the IV administration codes (13915-00, 13918-00, 13921-00 [1781])?

A On the basis of the scenario provided assign 13939-00 [1783] *Loading and maintenance of implantable infusion pump or reservoir* or 13942-00 [1783] *Loading and maintenance of ambulatory drug delivery device* as appropriate. The administration is inherent in the above procedures.

Q³ Dysphagia

Australian Coding Standards indicate that dysphagia is coded only if a person is receiving nasogastric/enteral feeding. Does this standard apply to a rehabilitation facility where the patient may not be receiving nasogastric feeding but is in the facility post stroke with dysphagia listed as one of the conditions present (see Australian Coding Standards, page 88)?

A In light of continuing concerns about such cases, the following guidelines may be applied: dysphagia present for more than 7 days after stroke may be coded if requiring allied health treatment (e.g. speech pathology) or nursing care WITH or WITHOUT nasogastric tube/enteral feeding.

Q⁴ Atypical pneumonia

In ICD-10-AM, atypical pneumonia is indexed to J15.7 Pneumonia due to mycoplasma pneumonia. I spoke about this to a clinician who said that there are other causes of atypical pneumonia such as psittacosis, and believed that a better code for atypical pneumonia NOS is J18.8, unless the organism has been identified.

A The meaning of the term ‘atypical pneumonia’ in Australia does vary from that of the WHO classification and therefore atypical pneumonia is not synonymous with ‘pneumonia due to mycoplasma pneumoniae’. Atypical pneumonia should be assigned code J18.9 *Pneumonia, unspecified*. An amendment to the index will appear in the second edition of ICD-10-AM.

Q⁵ Cystoscopy

Operation report says ‘cystoscopy: bladder and ureteric orifices NAD. Bilateral retrograde 5F catheters up to PUJ’. Could you please explain the difference between 36812-00[1088] Cystoscopy, 58715-01[1979] Retrograde pyelogram (which I

coded) and 36818-01[1065] Endoscopic ureteric catheterisation with fluoroscopic imaging of upper urinary tract, which the specialist recorded? Which is correct?

A The correct code for cystoscopy with bilateral retrograde pyelogram is 36818-01 [1065] *Endoscopic ureteric catheterisation with fluoroscopic imaging of upper urinary tract, bilateral*. Enhancements to the tabular (Volume 3) and index (Volume 4) of ICD-10-AM are planned.

Q⁶ Gestational diabetes
Gestational diabetes or haemorrhoids (puerperal). Is it incorrect to assign additional non obstetric codes to the ‘O’ codes where they give more detail, even in the absence of a ‘code also’ note? (a) Is it wrong to assign O24.4 and E11.90 for gestational diabetes? The E11.90 provides extra detail. (b) Is it wrong to assign O87.2 and I84.3 for haemorrhoids (puerperal)? The I84.3 provides extra detail.

A (a) The exclusion notes under categories E10–E14 *Diabetes mellitus* are type 1 exclusion notes (see *Coding Matters*, Volume 5, Number 1, July 98, Guideline on Exclusion Notes) and therefore a code from categories E10–E14 can be assigned with codes O24.0, O24.1, O24.2 and O24.3, particularly for the capture of the manifestations of diabetes such as diabetic nephropathy. However, this practice is under review. This guideline does not apply to O24.4 *Diabetes mellitus arising in pregnancy* as this code should not be assigned with a code from categories E10–E14.

(b) A code from category I84 *Haemorrhoids* can be assigned as an additional diagnosis to O87.2 *Haemorrhoids in the puerperium* to indicate the type of haemorrhoids.

Q⁷ Maltreatment
Can you please clarify the use of Y07.~ codes in light of its heading of maltreatment syndrome? Does it have to be documented as a syndrome in order to assign these codes? e.g. 35 year old women admitted with pneumonia and also facial contusion secondary to punching by husband. After J18.9, should we code S09.9 and Y07.0, even though the injuries were not described as a syndrome? Also, we are not sure when to use code Z63.0 in light of ACS 1909 wording – ‘code Z63.0... other than the victim or offender’. Does this mean you do not use this code for patients with relationship problems as they are the victim?

A If you follow the index to external causes (Volume 2) under the main term ‘Maltreatment’ you will notice that ‘syndrome’ is a non essential modifier and so a code from category Y07 *Other maltreatment syndromes* can be assigned when maltreatment is documented alone. Given the information

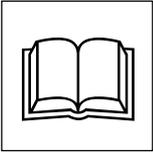
you have provided, maltreatment was not documented and should not be assigned. J18.9 *Pneumonia, unspecified* is the correct code assignment if you do not have more detailed documentation describing the type of pneumonia. For facial contusions, with no further documentation provided, assign S00.85 *Superficial injury of other parts of head, contusion*. (Follow the index, **Contusion** (see also Injury, superficial), **Injury** - superficial -- face NEC). ACS 1909 ADULT AND CHILD ABUSE provides guidance in the assignment of codes when adult and child abuse is documented. Z63.0 *Problems in relationship with spouse or partner* is assigned when counselling is provided to those affected by abuse, other than the victim or the offender. This does preclude the assignment of Z63.0 for the victim of abuse, because it adds no further information when coding from categories T74.~ *Maltreatment syndromes* and Y07 *Other maltreatment syndromes*.

Q⁸ Liveborn infant at 17 weeks
Patient admitted at 17/40 with placenta abruption. Fetus lived for 1.75 hours, weight 110g. Codes used are O03.9 Spontaneous abortion, O45.9 Premature separation of placenta, unspecified and O09.2 Duration of pregnancy 14–19 weeks. Should the liveborn infant be coded as for ACS 1511 TERMINATION OF PREGNANCY? Please clarify coding, and if possible perinatal guidelines.

A Given that the case cited is rare, the NCCH supports the assignment of a code from category Z37 *Outcome of delivery* as an additional diagnosis to indicate the liveborn birth. While it could be argued that codes from category Z37 are intended for ‘delivery’ and an abortion is clearly not a delivery, this is an exception to the rule and this exception will help distinguish cases such as these from other abortions. This decision may conflict with State/Territory Health Authority edits and you may need to contact your State/Territory Health Authority for their advice.

Q⁹ Percutaneous transluminal coronary angioplasty (PTCA) with thrombolytic agent
ICD-9-CM enabled us to code PTCA and ReoPro® to 36.02. What is the appropriate code for ICD-10-AM? Just PTCA [670] or 35321-00 [694] (although this is to occlude arteries) or 35317-00 [741] (although this can be done by bolus doses in catheter laboratory or by infusion)?

A In ICD-10-AM there is no distinction between PTCA with or without administration of a thrombolytic agent therefore, assign a code as appropriate, from block [670] *Transluminal coronary angioplasty*. There is no need to code the thrombolytic agent separately.



PUBLICATION ISSUES

Firstly, I would like to say thank you to all for the extremely warm welcome I've received to the NCCH. I'm impressed with the level of commitment and professionalism that I've witnessed. And I also like your sense of humour. I'm looking forward working to with you all.

Secondly, as the new editor of *Coding Matters* I believe I have the duty to uphold the good work of my predecessors. In this issue you will find a reader survey, details following. The survey will allow you, as its readers, to participate in its direction for the future.

Reader Survey

Coding Matters, as the voice of the NCCH, seeks your input and opinions to maintain and improve, where possible, its usefulness and quality. Publications such as *Coding Matters* only remain relevant if they provide the right mix of news and information. In this issue you will find a Readers' Survey form on page 23 (photocopy it if you don't want to damage your copy). Please send your response back by the close of business 21 May 1999.

The survey form also provides an opportunity for you to let us know of any changes in your mailing details. Alternatively, you can nominate to receive *Coding Matters* directly on its publication day by email.

Please fax your response (02) 9351 9603, fill it out on our website <http://www.cchs.usyd.edu.au/ncch/reader.htm> or post to: Coding Matters/Readers' Survey NCCH, PO Box 170 Lidcombe NSW 1825.

Letters to the Editor

In the next issue we plan to reinstate the letters to the editor column. It will enable you to air your views and concerns regarding health information issues. It will be a different forum, although, to Code-L which is more specific in its nature.

Letters will be published dependent on space available. Writers must give full name and address for verification. The views expressed in any letter published in *Coding Matters* are those of the individual writer and are not necessarily endorsed by the NCCH. Please note the publication dates are the same as those for advertising.

All correspondence should be addressed to:
The Editor, *Coding Matters*, NCCH, PO Box 170
Lidcombe NSW 1825
or email: r.bernard@cchs.usyd.edu.au

Advertising

Coding Matters is the ideal advertising medium to reach clinical coders and health information professionals. Don't miss the opportunity to reach this important market. Call or email me if you would like to discuss advertising and rates further.

The following are the advertising deadlines for 1999:

Volume 6 Number 1 – June 1999

Advertising due by: 30 April 1999

Volume 6 Number 2 – September 1999

Advertising due by: 4 August 1999

Volume 6 Number 3 – December 1999

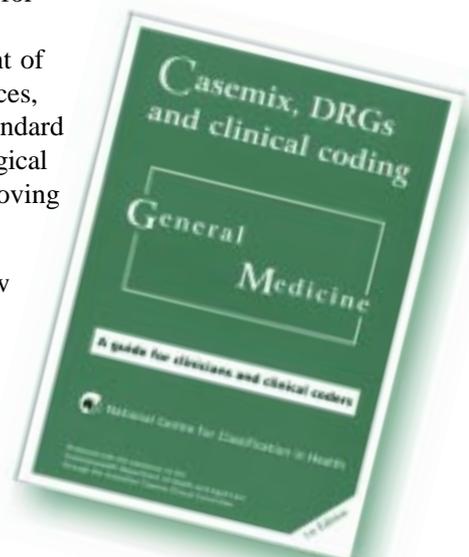
Advertising due by: 3 November 1999

General Medicine Specialty Book – Out Now

The latest specialty book in the *Casemix, DRG's and clinical coding* series is now available.

Based on ICD-10-AM, this series of books aim to promote a greater understanding of casemix and clinical coding issues. An understanding of these issues is vital for appropriate reimbursement of hospital services, raising the standard of epidemiological data and improving patient care.

Details of how to order *General Medicine* and other titles in the series are on the order form distributed with *Coding Matters*.



❖ Rodney Bernard

Publications & Technology Manager



RESEARCH REPORTS

ICD-10-AM Implementation Study

Several NSW hospitals have agreed to be involved in a small pilot study of the impact of ICD-10-AM implementation and have been in contact with the NCCH over the past few months. As well, other states and the Australian Institute of Health and Welfare (AIHW) have indicated their interest in conducting a concordance study between ICD-9-CM and ICD-10-AM.

Further project planning work will be done over the next few months to decide the scope and the methodology for both the impact and concordance studies.

The NCCH would welcome the interest and involvement of HIMs and coders and updates will be posted on the website when available.

Clinical Coder's Survey

A survey for ICD-10-AM users was included in the last issue of *Coding Matters*, and to date about 200 people have responded. Many thanks to those readers who have responded. The NCCH is still interested in receiving your responses, so continue to send in your completed surveys. A preliminary analysis of results has begun with the assistance of a HIM student on placement with the NCCH, Joanne Fitzgerald. Joanne has prepared a short report of some of the highlights of the survey responses and these are presented below (thanks Joanne!). A full and final report will appear in a later edition.

Contact details:

Phone 02 9351 9091

Email D.Truran@cchs.usyd.edu.au

❖ **Donna Truran**
Research Officer

Clinical Coder's Survey – analysis of responses received

Preliminary analysis of the survey results has been undertaken and some highlights are reported here. Further analysis will be done when final responses have been received (so keep sending your completed surveys).

A comprehensive report will appear in a future issue of *Coding Matters*.

Coping with the changeover

The survey revealed that clinical coders believed they coped better with coding in ICD-10-AM during November and December, than when ICD-10-AM was first introduced in July. However, while clinical coders felt they were coping more effectively with ICD-10-AM six months after the implementation, their confidence levels did not change significantly over that time.

Training

Coders also reported that the less time they spent in an ICD-10-AM training course, the more likely they were to encounter problems. Conversely, the more hours a clinical coder spent engaged in ICD-10-AM training, the fewer problems they encountered and the higher they rated their ability to cope. Those clinical coders who spent longer in training also assessed their quality of coding to be higher. This appears to be a good advertisement for taking advantage of ICD-10-AM training when it is available.

Coding and other duties

Survey results reveal a significant relationship between clinical coders' assessments of coding quality, and the number of other duties a clinical coder performed. The survey showed that clinical coders who performed a variety of tasks (other than just coding) also believed that the quality of their coding work was lower.

Medical records

A direct and statistically significant relationship was found between inadequacies in the medical record, and clinical coders' perceptions of their coding. Poor documentation in the medical record was directly related to assessments of lower coding quality. Inadequacies with the medical record, however, are not a problem unique to ICD-10-AM and existed under ICD-9-CM as well.

Errata

Many clinical coders complained about having 'so many' or 'too many' errata and of having to incorporate them. Other respondents were unconcerned and expressed the view that any new classification would entail considerable review, and they expected to encounter some change in the early stages of implementation.

Generally, the response has been encouraging and informative and will no doubt assist the NCCH in providing future education, services and publications.

❖ **Joanne Fitzgerald**

continued on page 22 ►

National Centre for Classification in Health

(in conjunction with Clinical Coders' Society of Australia)

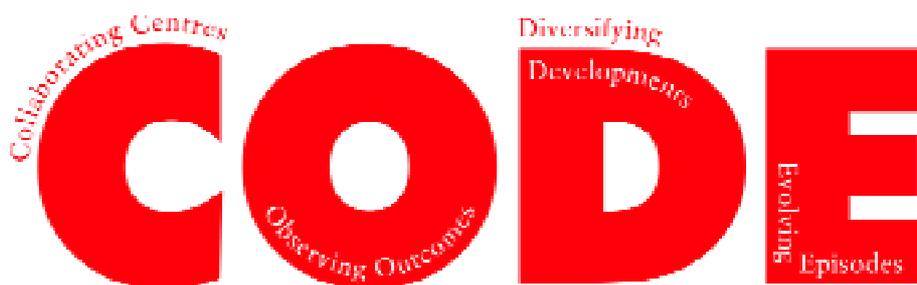


6th Annual Conference

22nd – 24th September 1999

Hotel Grand Chancellor, Hobart, Tasmania

CALL FOR PAPERS



The NCCH and CCSA invites prospective participants to submit abstracts for presentation at their 6th Annual Conference. Abstracts which relate to 'code' focus areas are sought from clinical coders, health information managers, clinicians and other readers of *Coding Matters*.

Authors may wish to focus their paper on the following suggestions:

- C** Collaboration between coders and clinicians/
NCCH/hospital network/other organisations
Collaboration through technology such as list
servers/email/internet
International/interstate collaboration between
coding centres
- O** Outcomes and uses of coded data and
improvements in coded data
Coding outcomes of care
- D** The diversifying role of the clinical coder
Experiences of coders in non-traditional
workplace settings
Developments in codesets, classifications and
groupers
- E** The evolution of clinical coders for the future
Innovations in information technology
Enhancements within the coding environment
Coding episodes of illness in co-ordinated/
linked care

Papers will be selected on their relevance to the conference theme and their written clarity. Guidelines for those wishing to submit an abstract are:

1. Please provide two copies of a typed abstract of the paper (maximum of 500 words)
2. The abstract should include the title of the paper, the author's name/presenter's name, title, position and organisation
3. Provide abstract in a formatted copy (saved in Word 7 format onto an IBM formatted disk and labelled with author's name and organisation) or as an email attachment to address below
4. More than one abstract may be submitted
5. Abstracts should be submitted to:

**Ms Karen Peasley, Education Manager
National Centre for Classification in Health
Faculty of Health Sciences, University of Sydney
PO Box 170, Lidcombe NSW 1825**

or email: k.peasley@cchs.usyd.edu.au

before Friday 7th May 1999

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

Research and coding system: what are the challenges?

This report aims to give a taste of some of the research issues impacting on NCCH. There are no profound words of wisdom here, just some insight into the murky depths of the cerebral machinations of at least one of the NCCH research fellows.

There are numerous unanswered questions and unresolved issues surrounding health coding and classification systems. Over my last two years at NCCH nearly all of them have arisen at some time.

These issues have sneaked up on us as a result new information technology. This has had a great effect not only on the potential role but also the structural constraints of coding systems. The imminent arrival of longitudinal electronic health records with integrated computerised clinical decision support is the major force. From just being an epidemiological tool, our coding systems will need to support detailed representation of health related concepts.

Many issues involve the creation and maintenance of new, or evolving, coding systems:

- What is their best structure from a technical perspective?
- What is the most effective method of involving stakeholders?
- What are the roles and responsibilities of each stakeholder?
- How can we best resolve the differing requirements of each stakeholder?
- What is the most effective method of funding coding system maintenance?
- How should custodians distribute their coding system to users?

When there are multiple options for coding systems, a different set of issues emerges:

- How can we objectively evaluate and select the best coding system?
- To what extent is it possible to standardise coding systems across domains?
- Can we effectively implement multiple coding systems?
- To what extent is it possible to convert data from one coding system to another? And, more specifically how much information is lost or corrupted in the process?

Another set of issues involves implementation of coding systems:

- Is it possible to implement coding systems so that we minimise disruption should we need to change to a different coding system?
- How can we reduce the need to convert data from one system to another?
- What steps are necessary to enable collection of comparable data in software produced by different software developers?
- How can we reduce the time taken for data collection while maintaining reliability of the data?
- How can we minimise the overall cost of coding system implementation?

Most of these questions are multi-disciplinary, cutting across professional, technical and business domains.

We are yet to experience the full impact of new information technology and, for the large part, it is often unclear how we should alter our practices to best exploit the new possibilities and needs.

There are, however, startling differences between the recommendations of information scientists for the structure of coding systems and their actual structure. Although the medical informatics literature has clearly defined the characteristics of ideal coding systems, most producers of present health coding systems have not yet implemented these recommendations. The reasons why these recommendations have not been implemented need closer examination.

A lack of evidence will force many to be resolved on the basis of gut-instinct and political reality. The role of research is to enable a shift from gut-based to evidence-based decision making. Otherwise it may only be in hindsight that we can be sure we have made good decisions – the cost of rectifying our mistakes in ten years time may be considerable.

❖ **Erich Schulz**
Research Fellow

The 6th Annual National Centre for Classification in Health Conference



**will be held from the 22nd to 24th September 1999
at the Hotel Grand Chancellor, Hobart, Tasmania.**

The conference will again be jointly managed by the NCCH
and the Clinical Coders' Society of Australia (CCSA).

Features of the conference will include a pre-conference workshop conducted by
members of CCSA, recognised guest speakers and a fun filled social programme.

Suggested topics of interest for papers are available on page 21
so start thinking now about interesting work being undertaken in the coding arena
that you wish to share with the nation.



**Mark your
diaries now!**

Commence planning now for your attendance at one of the
most informative and enjoyable educational experiences for 1999.
Registration brochures will be distributed in July.

Further information is available from
Karen Peasley, Education Manager, NCCH
on (02) 9351 9461 or email k.peasley@cchs.usyd.edu.au

Coding Matters Readers' Survey

I'm particularly interested in the following
areas of *Coding Matters* (please tick as many
as you wish):

- Coding Tips
- Profiles
- Vital Signs
- Publication Issues
- Educational Matters
- Q&A from the Coding Query Database
- NCCH News
- Quality Concerns
- ACBA Audit Trail
- Research Reports

Other

How do you rate the publication?
(please circle the number that best fits your opinion –
Poor-1, Satisfactory-2, Good-3, Very Good-4, Excellent-5)

Quality of information	1 - 2 - 3 - 4 - 5
Usefulness of information	1 - 2 - 3 - 4 - 5
Layout and Design	1 - 2 - 3 - 4 - 5
Delivery	1 - 2 - 3 - 4 - 5

Would you prefer to receive your
Coding Matters via email? Yes No

Do you have Internet access? Yes No

Please fax (02)9351 9603 or post to:
Coding Matters/Readers' Survey
NCCH, PO Box 170 Lidcombe NSW 1825

or complete on website at
<http://www.cchs.usyd.edu.au/ncch/reader.htm>

Survey responses are required by the close of
business 21 May 1999.

If any of your mailing details have changed
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