Coding *Matters*

FROM THE DESK OF THE DIRECTOR

National Centre for Classification in Health (NCCH)

I am extremely pleased to be able to announce that the University of Sydney (SU) and the Queensland University of Technology (QUT) have reached agreement on the joint venture that will unite the functions of the National Coding Centre [NCC] (SU) and the National Reference Centre for Classification in Health [NRCCH] (QUT). The joint venture will result in one centre to be called the National Centre for Classification in Health (NCCH) with Sydney and Brisbane sites. Funding for the Sydney site will continue until June 1998 from the Department of Health and Family Services, while that for Brisbane is for the same period jointly from the Department of Health and Family Services (DHFS), Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

As Director of the NCCH, I will be assisted by Associate Directors Kerry Innes (Sydney) and Sue Walker (Brisbane). There is to be a revised management structure involving a small Executive Committee with representation from the two universities, the funding organisations, the National Health Information Management Group (NHIMG), the NCCH Director and the Associate Directors. A Management Advisory Committee will have wider membership, amalgamating the present NCC and NRCCH Management Committees.

Sydney and Brisbane sites of the NCCH will work together on many functions, including introduction of ICD-10-AM (Australian Modification). Specific functions relating to mortality coding, completion of death certificates and advice to the Australian Bureau of Statistics will be located in Brisbane. Both sites will be delegated responsibilities relating to the AIHW role as World Health Organization (WHO) Collaborating Centre for Classification of Diseases. The organisational structure of the new NCCH is included as an insert in this issue.

NCCH
It's official!

Joint agreement has created the National Centre for Classification in Health

This merger has been some years in the making and has involved many individuals. My thanks to the NCC Management Committee, especially Professor John Young, Professor Phyllis Watson and the staff of the NCC and NRCCH for patience and support. Staff of the Business Liaison Office at the University of Sydney and the Office of Commercial Services, QUT have been most cooperative in expertly drafting and redrafting the Agreement. Dr John Donovan, AIHW, was instrumental in gaining agreement from the AIHW Board for the merger, and Mr Warren Talbot (Assistant Secretary, Classification and Payments Branch) was the mainstay in securing DHFS funding for both sites.

Yes, this does mean a change in name – we will now be known as the 'National Centre for Classification in Health'! It is sad that our zippy and succinct title will be no more, but it has served us well and established the reputation of coders and coding. Together, the NCC and NRCCH have provided the foundation on which to now build the future of health classification systems in Australia. The logo of the NCC will remain as the logo for the new NCCH, so that you will still recognise

In this issue

us!

NCC Seminar

The Third Annual NCC Seminar at Coolum in November '97 was a real 'event', expertly managed by Janelle Craig and attended by nearly 200 coders and coders' colleagues from around Australia and neighbouring countries. Each NCC Seminar has had its individual traits, and this one will be remembered for its beautiful setting, stimulating program and as a milestone to mark the partnership between the Sydney and Brisbane sites of the new National Centre for Classification in Health. A full report of the Seminar (*see* page 5) has been compiled by Janelle from Singapore where she is teaching at the Singapore Institute of Management for the School of Health Information Management, University of Sydney.

Coding Standards Advisory Committee

The NCC Seminar provided an opportunity for many pre- and post-meetings. The Coding Standards Advisory Committee (CSAC) met on 20 November. It discussed progress with ICD-10-AM including results of the pilot studies of the procedure classification MBS-Extended. Members have offered to assist with final checking of the ICD-10-AM diseases index against chapters in the tabular list. A sub-group of CSAC convened by Ms Irene Kearsey and with representatives from the states and

commonwealth is working on a national approach to edits for ICD-10-AM.

ICD-10-AM

Momentum for the introduction of ICD-10-AM in July 1998 is increasing, with a number of groups working on various aspects of its implementation. These include the National Committee for Implementation of ICD-10 in Australian Hospitals, the Education Working Party which reports to this committee and to CSAC and a Working Group of NHIMG which was charged by the Australian Health Ministers' Advisory Council with responsibility for overseeing the methodology of the procedure classification.

An Impact Assessment Workshop was held in Sydney on 9 December 1996 to consolidate state and commonwealth implementation plans. Important background for this workshop was provided by a draft Implementation Package prepared at the NCC by Shahn Campbell (on secondment from the Department of Human Services, Victoria) and Janelle Craig. Input to this package from coders around Australia has been much appreciated. Thanks to Shahn for all her hard work! Support for development of the package and for other national education activities associated with ICD-10-AM implementation has been provided by the Commonwealth Department of Health and Family Services.

Now that the classifications themselves and mappings to and from ICD-9-CM are nearing completion by the Coding Services team (headed by Kerry Innes), our next large task for the New Year is the development of Australian Coding Standards for ICD-10-AM. Some work has already been done on translating ICD-9-CM standards to ICD-10-AM, but major refinement will be necessary because of the structural changes in the new disease and procedure classifications.

Meeting of WHO Heads of Collaborating Centres for Classification of Diseases, Tokyo, 14 – 21 October 1996

Australian representatives at this meeting were Dr John Donovan, AIHW, Ms Sue Walker, National Centre for Classification in Health (Brisbane) and myself. Australian changes to ICD-10 were presented to the meeting and will appear in the Australian Modification with annotations to indicate Australian changes. The 20 or so changes at the third and fourth character level are to be submitted to WHO in 1997 for consideration for inclusion in ICD-10 updates. The meeting was extremely interesting and fruitful, bringing together heads of collaborating centres from 12 countries to discuss issues of classification of morbidity and causes of death. Although ICD-10 and various national versions occupied the most time, other classifications such as the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and International Classification of Primary Care (ICPC) were also covered.

The Centres reported on general activities, including introduction of automated multiple cause of death coding, timing of ICD-10 introduction, national and language versions, specialty adaptations, update mechanism, education, copyright and licensing issues and mappings between classifications. This was the second such meeting I had attended (the last was in Canberra in 1995), and I was most grateful for the opportunity to compare notes with our colleagues confronting similar issues in other countries, not the least of which is the introduction of casemix grouping and funding arrangements.

Damian Hanrahan – new Information Systems Officer.

Changes '94 – '96

To mark all the changes made by the NCC to ICD-9-CM, the NCC has produced *Changes '94–'96: A chronicle of new Australian ICD-9-CM codes and changes to Australian Coding Standards*. This publication brings together by specialty Australian code additions and changes to ICD-9-CM as well as Australian Coding Standards, giving the date of introduction of changes that affect use of coded data. It is a historical document to record our changes now that ICD-9-CM will not be further updated in Australia (*see* Order Form in this issue).

Quality Issues

Joanne Chicco (*see* "Quality Concerns" column on page 10) and Lauren Jones are working on aspects of coding quality and coding to reflect quality of care, especially in relation to adverse events. Standards for coding quality studies, standards for the coding service and ethical standards for coders will form part of the Australian Coding Standards volume of ICD-10-AM.

Christine Erratt has been seconded from the NCC for 12 months to work with the Central Cancer Registry, New South Wales Cancer Council, to develop and implement a quality assurance plan. Karen Peasley, in conjunction with health information managers and clinical coders from NSW hospitals with HIV services, is collecting data on quality of HIV coding. A report of this project will be submitted to NSW Health early in 1997.

Information Systems Officer

Lengthy farewells for Megan Roach (on leave to study at Sacramento State University in the US for 12 months) were followed by welcomes to Damian Hanrahan. Damian brings a disciplined mind and valued database and computer skills to the NCC from his previous employment at the main campus of the University of Sydney.

Publications Division

Karen Luxford, as well as preparing for the onslaught of ICD-10-AM publication, has been producing the *Changes '94-'96* document, maintaining the NCC Homepage and the Code-L Listserver, organising future production schedules and marketing the work of NCC, especially the introduction of ICD-10-AM. Typesetting of ICD-10-AM will commence in the New Year and a new NCC position for typesetter has been created in anticipation.

Simone Lewis (Publications Assistant) continues to produce the popular casemix and coding specialty booklets with Geriatric Medicine being the next available in the series.

MBS Mapping

A report on Stage 1 of the Medicare Benefits Schedule-to-Current Procedural Terminology (CPT) mapping project for the Medicare Schedule Review Taskforce was presented to the Medicare Schedule Review Board on 3 December.

Stage 2, an in-depth mapping in Urology and Neurosurgery, will be carried out in the first quarter of 1997.

National Coder Workforce Issues Project (NCWIP)

Congratulations to all clinical coders who were successful in the first accreditation examination! As you know, the coder accreditation function will move to the Sydney office of Health Information Management Association of Australia (HIMAA) in January 1997, and the Steering Committee of NCWIP, chaired by Sue Walker, has held its final meeting.

Congratulations from NCC to NCWIP and HIMAA on the completion of this important project to launch and consolidate the Australian coder workforce.

Best wishes to you all for 1997!

❖ **Rosemary Roberts**

Couldn't make it to the 1996 NCC Seminar?

But want to keep up with current issues in clinical coding?

★ **Abstracts of Proceedings**

Abstracts of Proceedings of the NCC 3rd Annual Seminar, "Partnerships in Coding" held at the Hyatt Regency, Coolum, Queensland, 20-21 November, 1996 are now available.

Highlights:

★ Update on the MBS-Extended project

★ Integrated Quality Management Model

★ Coding Adverse Events

★ Coders, the Internet and Code-L

Only $7 (including postage within Australia)

Also from the NCC Seminar and available on Video ...

★ **"Clinical Coding Update: Respiratory Medicine"**

Presented by Kerry Innes (NCC Coding Services Manager) and Dr Christopher Clarke (Consultant Physician, Respiratory Medicine and Member, Respiratory CCCG).

This 40 minute video, taped as part of the NCC Seminar program, features current clinical information on respiratory disease processes, as well as guidance on coding respiratory conditions. Supplementary notes accompany the video. The video aims to keep clinical coders up to date with advances in this clinical speciality, provides instructions to assist in clinical coding, and makes available information discussed at the Seminar to those unable to attend in 1996.

Only $25 (including postage within Australia)

Both products now available from the NCC – see order form this issue

Kerry Innes (NCC Coding Services Manager) and Dr Chris Clarke (Respiratory CCCG) give a presentation worthy of the Oscars at the NCC Seminar '96.

REPORT ON THE THIRD ANNUAL NCC SEMINAR

The beautiful five star Hyatt Regency at Coolum on Queensland's Sunshine Coast was the venue for the 3rd Annual NCC Seminar held on 20-21 November, 1996.

This year 190 registrants from throughout Australia, New Zealand and Hong Kong joined us for two days of discussion, exchange and interaction, not to mention finding time to partake of the odd game of golf, dip in the pool (yes some of you were spotted in swimmers!) or cocktail party.

The theme of "Partnerships in Coding" seemed appropriate for this year's Seminar, given the joint venture agreement between the NCC and the National Reference Centre for Classification in Health (NRCCH), and to reflect the strong partnerships and alliances which have been forged in the area of coding in recent times, whether they be with the Commonwealth, the State Health Authorities, computer and IT specialists, clinicians, allied health professionals, other organisations, and most importantly, with each other.

During the jam-packed two day program a range of partnerships were explored: Commonwealth and state/territory partnerships, clinical coder/clinician partnerships, international partnerships but to name a few. Professor Phyllis Watson (Head, School of Health Information Management at the University of Sydney) and Professor Oldenburg (Head, School of Public Health at Queensland University of Technology) opened the Seminar by describing the work of the NCC and NRCCH to date and predicting the future role of the new partnership between the organisations, to be known as the National Centre for Classification in Health (NCCH).

Selected highlights from the program, all of which was highly informative and relevant to clinical coders, included:

- Dr Karen Luxford's paper in which she described the use of the Internet and development of CODE-L, the internet discussion group for clinical coders set up by the NCC;

- Professor Bill Runciman (Head, Department of Anaesthesia and ICU, Royal Adelaide Hospital) discussing the importance of coding adverse events, the development of the Generic Occurrence Classification to help identify such events and of the importance of utilising the skills of clinical coders in coding adverse events, as well as 'outing' himself as a closet clinical coder; and

- the all-singing, all-dancing, stars of the program, Kerry Innes and Dr Christopher Clarke (Consultant Physician, Respiratory Medicine and member of the Respiratory CCCG), providing coders with a much needed clinical and coding update in the area of respiratory medicine (*see* page 4 for details on purchasing the video of this session).

Liz Beazley (Coding Manager, Royal Prince Alfred Hospital, Sydney) and Nina Messina (Deputy Coding Manager, Royal Prince Alfred Hospital) enjoy a tea break at the NCC Seminar and talk of ... coding, of course!

This years' Seminar also saw the first formal meeting of the Clinical Coders' Society of Australia (CCSA) take place. Barbara Levings (CCSA President) and her fellow Board Members discussed the activities of the Society so far and outlined plans for future activities. Barbara then handed over to Leanne Holmes (Project Manager, National Coder Workforce Issues Project) who discussed the inaugural examination of the Accredited Clinical Coder Program, conducted by the Health Information Management Association of Australia (HIMAA) in September, 1996. Leanne reported on the conduct of the exam and outcomes, as well as providing a profile on candidates who sat the exam. There was a tremendous level of support and interest for the accreditation program and this was demonstrated by the discussion that followed Leanne's presentation.

Feedback from Seminar registrants who sat the examination was extremely valuable and will prove useful in enhancing future exams. ▶

As the person responsible for organising the NCC Annual Seminar, it is always satisfying when the program is well received and feedback from registrants is positive. This was the case from responses to our Seminar evaluation forms. We thank registrants for their comments and will take on board suggestions for improving future NCC Seminars (in particular, those relating to the Seminar registration process and audiovisual/technical equipment).

In concluding this report, I'd like to say how rewarding it is for NCC staff to see each progressive Seminar grow and evolve, and more importantly, to see clinical coders develop.

For me, this year's Seminar had a certain confidence, a feeling that the NCC and clinical coders have come a long way and that we have bright and exciting times ahead.

Once again, thanks go to all speakers who providing such a stimulating program, to the staff of the NCC who, as always, work extremely hard to make our annual
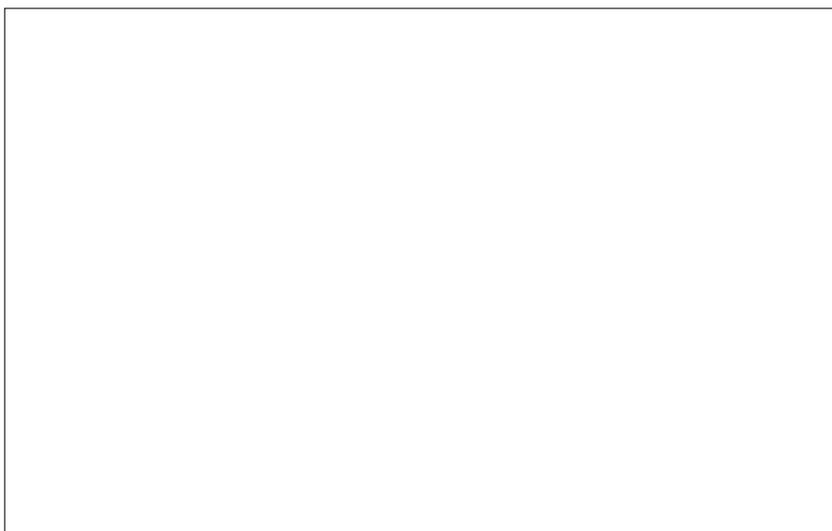
A likely bunch of dudes, or dudettes, from the left, Sharyn Clark (Luminaire Training Enterprises), Julie Gofton (Head, PIMS Dept, King Edward Memorial & Princess Margaret Hospital, Perth) and Kavia Cheng (Assistant Head, PIMS, Princess Margaret Hospital).

Seminars a success, and to you, those members of the coding community, for your enthusiasm and continued support. I look forward to seeing you in Adelaide in 1997 for our next Seminar. Stay in touch with future editions of *Coding Matters* for details.

❖ **Janelle Craig**

Expressions of interest

Coding Educators Network

During the previous two years, the NCC's Coding Educators Network has been used extensively to help with the Australian Coding Standards Workshops throughout Australia, and also to assist in the delivery of course material as part of training courses for clinical coders from same day facilities and staff from private health insurance companies. Currently there are 25 members on this network.

More than ever, we need to strengthen the number of educators on this network if we are to keep up with the demands for education and training that will be generated by the introduction of ICD-10-AM in Australia in July, 1998. This education will principally be directed towards clinical coders, but will also need to focus on education for clinicians, researchers/epidemiologists, computer software/IT vendors and other users of coded data.

Applications would be welcome from clinical coders who have experience and skills in coding and ideally who have had some experience in conducting coder training programs. Your background may be as a Clinical Coder or Health Information Manager.

We need

you!

Although you may currently be employed, this does not exclude you from applying, as the NCC can negotiate involvement with the network with your employer and involvement will be required only when courses are being conducted. Training sessions for members of the network will be provided by the NCC prior to the conduct of any courses. Salary to be negotiated based on qualifications and experience.

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

> Janelle Craig
> Coding Education Manager
> National Coding Centre
> PO Box 170
> LIDCOMBE NSW 2141

Applications close on Friday 7 February 1997.

Enquiries can be directed to Janelle Craig, on phone: (02) 9351 9345 or email: j.craig@cchs.usyd.edu.au

EDUCATION '97 – WHAT'S IN STORE

1997 will be a little different for the National Coding Centre in terms of education compared to those activities conducted in our previous three years of operation.

While April through June generally sees the NCC and members of its Coding Educators Network furiously travelling throughout Australia to conduct the annual Coding Standards Workshops, in 1997, because there will be no new edition of the Australian ICD-9-CM or Australian Coding Standards, such workshops will not take place. So what education activities, I hear you say, can you expect the NCC to undertake in 1997?

Our education schedule commences early in 1997 with our annual 'Train-the-Trainer' sessions aimed at educating members of the Coding Educators Network (*see* page 6 for the Call for Expressions of Interest to join the Network). However, unlike the sessions in 1995 and 1996, in 1997 there will be a two-phased approach to this event.

Phase I of these sessions will take place in the last week of February, and will see a five-day workshop held on site at the University of Sydney (Faculty of Health Sciences, Lidcombe campus) to educate a core of expert trainers to provide education in ICD-10-AM. Participants will consist of NCC staff involved in the development of ICD-10-AM diseases and procedures, lecturers from the University Schools of Health Information Management (HIM), the Open Training and Education Network (OTEN) and the Health Information Management Association of Australia (HIMAA) Education Service, as well as key staff from other states.

Phase II of the program will aim to train members of the Coding Educators Network, State Coding Committees, ICD-10 Education Working Party members and clinical coders from hospitals involved in the ICD-10-AM Impact Assessment. These workshops will be held in April 1997 and will be conducted in NSW (for NSW and ACT participants) Queensland (QLD and NT participants), Victoria (for VIC and TAS participants) and WA (for WA and SA participants).

During February 1997, the NCC will work with HIMAA to repeat the Training Course for Coders from Sameday Facilities, which was conducted for the first time in July–August, 1995. This course was very successful and there has been a strong demand from sameday facilities to again provide access to such educational courses. This program runs over a five–six week period, commencing in early February and concluding in mid March. A combination of workshops and correspondence learning form the basis of the course (Phase I: two-day workshop;

Phase II: four weeks to complete specialty modules via correspondence; Phase III: final two-day workshop).

As outlined by Shahn Campbell at the 3rd Annual NCC Seminar and also included in her article in this edition of *Coding Matters* (*see* page 9), the ICD-10-AM Implementation Kit she has worked so hard to produce will be available for distribution in March 1997. This kit will be of great assistance in providing background and educational information to all those involved in the move to ICD-10-AM and clinical coders are advised to look out for its arrival.

In March, two forums are scheduled, both of which aim to provide advice to the NCC regarding specific topic areas. One forum relates to coding in the rehabilitation sector, the other to coding quality. Participation in both forums will be by invitation to stakeholders and relevant organisations involved in these areas. The NCC will undertake to provide clinical coders with updates on the outcomes of these forums in future editions of *Coding Matters*.

Late in the first quarter of 1997 through to the middle of the year will be the time during which education material will be developed for the extensive and diverse range of education activities needed for the introduction of ICD-10-AM. In addition to course material designed specifically for existing clinical coders converting to ICD-10-AM, education material will be required for those health professionals who:

- provide the codes (i.e. clinicians, allied health professionals and other healthcare providers);

- those who make use of the resulting information (i.e. researchers, epidemiologists, health authorities); and

- those who are affected by the change.

The main thrust of education for existing clinical coders will be approximately six to eight months prior to implementation in July 1998. The first stage of this program will be aimed at providing clinical coders with more detailed information regarding ICD-10-AM. Education material will include extensive information regarding the ICD-10-AM classification, which will build on the information outlined in the ICD-10-AM Implementation Kit. Where possible, exercises for the practical application of theoretical material will be provided. These documents will be available in the latter half of 1997 (estimated at September/October). ▶

The second stage of the education program will be the most intensive period of skill development. A series of information sessions and workshops will be held during March, April and May, 1998. It is essential that all clinical coders attend these practical coding skills in the application of ICD-10-AM. Such workshops will be held in all metropolitan areas and a wide range of rural locations to facilitate attendance by all clinical coders. Additional training may be required post implementation to further enhance skill.

Responsibility for training new clinical coders (i.e. students undertaking entry-level training) in ICD-10-AM will continue to lie with the Schools of HIM, HIMAA Education Service and OTEN. These organisations are members of the ICD-10 Education Working Party and thus liaise closely with the NCC regarding ICD-10-AM education issues.

As always, 1997 will also see an Annual Seminar conducted. Initial planning for this event has already begun, with the location chosen as Adelaide, the date being sometime in the second half of the year, and the theme tentatively being mooted as focusing on the future of coding with ICD-10-AM.

As you may gather, 1997 will indeed be a busy year for the NCC's education service. We will be hard at work developing ICD-10-AM education material and gearing up for a hectic 1998. Please feel free to drop me a line on email: j.craig@cchs.usyd.edu.au or contact me directly on (02) 9351 9345 if you would like to discuss ICD-10-AM education issues further or would like to add feedback/suggestions to the education plans outlined above.

❖ **Janelle Craig**

EDITORIAL

The advent of a new year is always a good time to reflect on progress and ponder what the future holds. With a new identity in 1997, it is also a good opportunity to look at the main achievements of the National Coding Centre (1994–1996). Have we met our objectives? Here's a brief summary...

1. **Promote & develop national coding standards and sound coding practices**
   - publication of *Australian Coding Standards* (1995, 1996)
   - publication of *Australian Version of ICD-9-CM* (1995, 1996). Australian & New Zealand distribution.
   - publication of *Australian Standards for Ethical Coding & Standards for Coding Service*

2. **Provide an avenue of advice on coding & coding queries**
   - regular coding query responses to state coding committees
   - responses to queries regarding coding standards

3. **Produce & disseminate information on national coding issues**
   - quarterly newsletter, *Coding Matters*, national distribution of over 3,800
   - publication of specialty-specific casemix & coding booklets, brochures, reports, books, posters, diskettes & videos
   - conference exhibitions

4. **Present regular national education workshops on coding**
   - establishment of national Coding Educators Network
   - annual NCC Seminar (1994, 1995, 1996)
   - annual Australian Coding Standards Workshops (1995, 1996)
   - educational workshops for sameday facilities
   - co-production video/poster package on medical documentation

5. **Participate in development of national coder accreditation program**
   - member of HIMAA/NCWIP Steering Committee, Coder Accreditation Expert Panel (ACC exam Sept. 1996), & Clinical Coder Competency Standards Committee
   - involvement in accreditation education programs

6. **Development of quality improvement process; organise mechanisms for independent quality review**
   - development of coding quality indicators & standard for coding quality audits
   - involvement in Integrated Quality Management Model project

7. **Increase awareness of need for coding quality & standards amongst relevant health care professionals**
   - numerous conference/seminar presentations on coding quality & medical documentation
   - workshops for private health insurance companies
   - booklets for coder/clinician audience on casemix & coding issues
   - frequent articles in journals for health care professionals
   - involvement in the establishment of the Clinical Coders' Society of Australia (CCSA)

8. **Maintain currency of coding systems to reflect Australian clinical practice**
   - participation in Clinical Coding & Classification Groups (clinician & coder membership)
   - publication of *Official ICD-9-CM Addendum*, new disease & procedure codes (1994, 1995, 1996)
   - development of new disease codes for ICD-10, Australian modification
   - development of new Australian procedure classification, MBS-E (based on Medicare Benefits Schedule), effective 1 July 1998

ICD-10-AM IMPLEMENTATION KIT: MARCH 1997

The finalisation of the content of the ICD-10-AM diagnosis and procedure classification is imminent; as is a peak in the interest of its introduction! To satisfy this desire for information, the ICD-10-AM Implementation Kit has been developed.

ICD-10-AM is the *International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification.* Australian hospitals and day procedure centres will adopt this classification for separations on or after 1 July 1998 superseding the second edition of the *Australian Version of ICD-9-CM.*

ICD-10-AM will be a multi-volume publication consisting of diagnosis and procedure classifications and revised Australian Coding Standards. The diagnosis classification is based on the World Health Organization's publication ICD-10 with modifications to ensure a current and appropriate classification for Australian clinical practice. This will be accompanied by a new Australian procedure classification which is based on the Medicare Benefits Schedule; referred to as MBS-Extended or MBS-E.

ICD-10-AM is being developed by the National Coding Centre (NCC). Its introduction is being overseen by the *National Committee for the Implementation of ICD-10 in Australian Hospitals.* This committee, chaired by Dr John Holmes (Director, Professional Services Review), has a membership that reflects the interests of a wide range of stakeholders. A working party of this committee has also been formed to consider education issues related to the implementation. The *ICD-10 Education Working Party*, chaired by Associate Professor Rosemary Roberts, includes organisations and associations that are actively involved in the education and training of clinical coders.

These two bodies, as well as the NCC's *Coding Standards Advisory Committee* (CSAC), have been consulted during the development of the ICD-10-AM Implementation Kit. The kit has also been reviewed by a number of individuals and organisations to ensure the content meets the needs of the creators and users of coded data.

The Implementation Kit has been designed to assist with the dissemination of information regarding ICD-10-AM and its implementation. The kit will be distributed in March 1997 to:

- public and private hospitals and day procedure centres
- software vendors
- state and territory health authorities
- health insurers
- universities and other coding and classification course providers
- epidemiologists and researchers
- health industry consultants
- a range of relevant organisations and associations.

The Implementation Kit contains information regarding the composition of ICD-10-AM, background to the development of this classification and introduction in Australia, as well as history of the classification of diseases internationally and in Australia.

Benefits of implementing ICD-10-AM are explained and a comparison is made of ICD-9-CM and ICD-10-AM.

The ICD-10-AM Implementation Kit has been designed to enable Australia prepare for the introduction of ICD-10-AM on 1 July 1998

Details on the creation of the ICD-10-AM procedure classification (MBS-Extended) and further information on who is responsible for overseeing implementation are provided.

A timeline for the implementation and an outline of the training and education strategy is given. Details of electronic ASCII code files, code mappings, grouper software, and transition issues are described along with details of IT system changes required. Local implementation issues are covered and contact details for relevant organisations and further reading references are included.

Information will be set out on briefing or information sheets within the kit. Fact sheets will summarise key topics for distribution or display, and visual aids will assist with local education presentations.

The materials that will be provided in the kit may be copied for distribution and presenters may then choose to use only certain sections of the kit. Information may also be added to make presentations, and other educational materials, more relevant to local situations.

The ICD-10-AM Implementation Kit has been designed to enable Australia prepare for the introduction of ICD-10-AM on 1 July 1998. Make sure you see this kit when it becomes available in March 1997!

For further information, contact Janelle Craig on (02) 9351 9345.

❖ **Shahn Campbell**
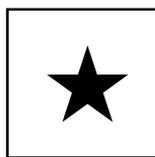
★ QUALITY CONCERNS

New NCC staff member Joanne Chicco (NCC Quality Manager) will
keep you in touch with "Quality Concerns".

I'd like to take this opportunity to introduce myself to all *Coding Matters* readers. I graduated in 1987 from Cumberland College of Health Sciences with a Bachelor of Applied Science in Medical Record Administration, and have spent the past 10 years working in a number of coding, quality improvement, casemix and HIM positions.

Most of my working life has been in the Private Sector. I was employed at St. Vincent's Private Hospital for eight and a half years as DRG and Project Coordinator, a position which taught me the techniques of Continuous Quality Improvement (CQI). I was responsible for applying CQI to many aspects of medical record practice and casemix at St. Vincent's Private, including the implementation of a comprehensive coding quality review system. I am an Accredited Clinical Coder (ACC), and I am currently enrolled in a Master of Business Administration at the University of Technology, Sydney.

Since beginning at the NCC in October 1996, I have been working on the development of a national standard for performance of coding quality audits. After a thorough literature review, the NCC has drafted appropriate procedures for sampling, recoding, categorisation of errors, feedback mechanisms and suggestions on how to change any processes that may lead to coding errors.

The whole coding quality review process has been built into a CQI framework, which will aim to distinguish errors made by the Clinical Coder (for example, assigning a wrong code due to failure to follow a coding rule) from problems caused by the "system" (for example assigning a wrong code due to ambiguity within a record or illegible writing).

By comparing your hospital's coding error result with a national benchmark, you will be able to measure how well your coding service is performing.

The NCC believes that if a national standard for auditing exists and is applied consistently, a national coding error benchmark should be able to be established. By comparing your hospital's coding error result with a national benchmark, you will be able to measure how well your coding service is performing.

The Coding Quality Review standard is currently in a testing phase. If you would like your organisation to be involved with testing the standard, or you have any suggestions that you would like to contribute, please contact me at the NCC [phone: (02) 9351 9461, fax: (02) 9351 9603, email j.chicco@cchs.usyd.edu.au].

If you code within a specialist setting (e.g. a Day Surgery Centre), you will be interested to know we also aim to modify the national standard to apply to as many specialist settings as possible. These modifications will not be made until after we have agreed on the best methods to use in a generalist hospital setting, so please be patient! ▶

◇   ◇   ◇
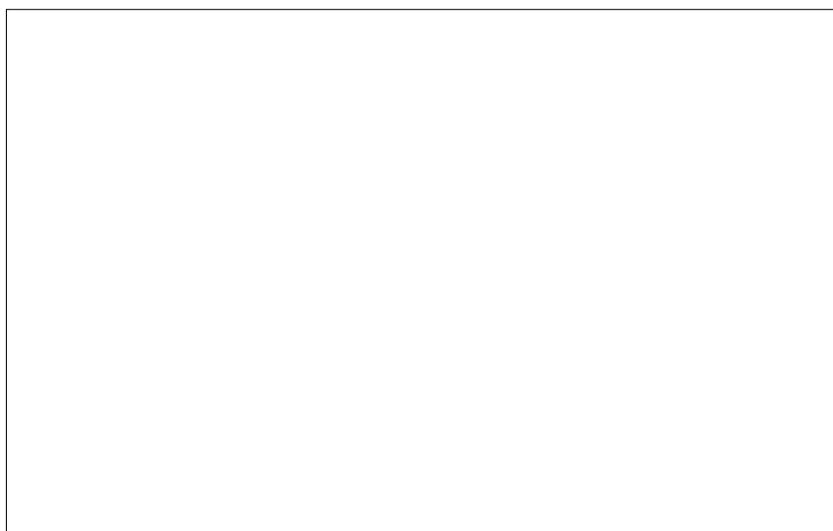
Sue Walker (avid coding graffiti monitor) spotted this artwork referring to the mental health classification DSM-IV in Brisbane and wondered if it was done by a psychiatrist who was good with a spray can or a graffiti-ist with a coding fetish??

Other "targets" in my quality sights are:

- development and application of national Coding Quality Indicators (to be developed for testing by May 1997)

- ensuring national consistency of coding edits (currently each state and the Commonwealth apply different computer edits to their coded data!)

- application of *Australian Standards of Ethical Coding* (in collaboration with the Clinical Coders Society of Australia)

- updating and implementing *Australian Standards for the Coding Service*. These standards currently exist as Appendix C in Volume 4 of the NCC's 1996 *Australian Version of ICD-9-CM*. Again we will be looking at modifications for specialist settings (as stated above).

Another of my major goals is to review the current use of codes and the adherence to Australian Coding Standards (ACS). We are lucky enough to have access to national databases which tell us how existing codes are being used, and whether or not clinical coders are applying their knowledge of the new codes and standards that are introduced each year. So far, I have done a quick quality review on the use of codes in the following specialities and can offer the following suggestions:

Neurosurgery

Brachial neuritis

When a diagnosis of *Brachial neuritis* (723.4) or *Cervicobrachial syndrome* (723.3) is supplied by the clinician, coders should seek to discover whether the condition is due to *Intervertebral disc disorder* (722.x) or due to *Spondylosis* (721.x). Clinical coders are reminded of the exclusion note that exists under the 723 rubric which prevents the use of this code when the condition is due to spondylosis or disc disorder. It is important to follow this exclusion note, as failure to do so may cause patients undergoing laminectomy and/or discectomy to group to an incorrect AN-DRG.

(Neuro)vascular surgery

- Endarterectomy

Clinical coders should remember that there is no need to code any vessel patch graft occurring during *Endarterectomy* (38.1x), as the graft is already included within the endarterectomy code.

Neurology

- Stroke

Code 436, *Acute, but ill-defined, cerebrovascular disease* is a non-specific code, and should only be used when no better diagnosis is available [e.g. *Cerebral*

embolism with infarction (434.11) or *Subdural haemorrhage* (432.1)]. Clinical coders are encouraged to seek more specificity from clinicians if documentation is poor and if radiology and other reports are not present.

- Diabetic peripheral autonomic neuropathy and Diabetic eye changes

Clinical coders are reminded that the diabetes code should always be sequenced before the manifestation code [*see* ACS 0401, page 56, Volume 4, 1996].

Thus 250.6x *Diabetes with neurological complications* should be sequenced before 337.1 P*eripheral autonomic neuropathy,* and 250.5x *Diabetes with ophthalmic complications* should be sequenced before 366.41 *Diabetic cataract.*

- Epilepsy

Attempt to gain greater specificity from the clinician before coding 345.9x *Epilepsy, unspecified*. Coders are also encouraged to ask clinicians whether the epilepsy is intractable [*see* ACS 0622, page 69, Volume 4, 1996].

Ophthalmology

- Glaucoma and cataract sequencing

Please remember the sequencing requirements of ACS 0713, page 79, Volume 4. "If treatment for glaucoma and cataract is received during the same operation, sequence the glaucoma before the cataract for the diagnosis and procedure codes".

- Excision of eyelid lesion

Clinical coders are encouraged to seek more detail on whether lesions of eyelids are considered "minor" (08.21-08.22 *Excision of minor lesion of eyelid*) or "major" (08.23-08.24 *Excision of major lesion of eyelid, partial or full-thickness)*. Databases suggest that malignant skin lesions are often coded as "minor" lesions, when they may be "major" lesions. Clinical coders are advised to check the size of the lesion and the extent of the excision with the surgeon. Failure to clarify these points may result in patients being grouped into an inappropriate DRG.

- Hyphaema

Coders are reminded that all haemorrhages occurring post-ophthalmic surgery should be coded to 364.41 *Hyphaema*, and not to 998.1 *Haemorrhage or haematoma complicating a procedure.*

I trust that these quality issues are enough to digest for the present. I look forward to hearing from you with ideas and suggestions of what you would like to see in "Quality Concerns". Bye for now.

❖ **Joanne Chicco**
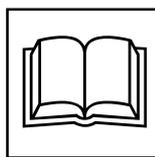
PUBLICATION ISSUES

As you will now all be aware, the NCC and NRCCH are undertaking a joint venture with the combined Centre being known as NCCH or the National Centre for Classification in Health. Just to reassure you, *Coding Matters* will continue to be published, bringing you important information on coding issues. Judging from the recent Reader Questionnaire, we are on the right track!

Coding Matters Reader Questionnaire Results – October 1996

Thank you to our readers for all your wonderful words of congratulations and the new ideas!! Here is a brief report on the main results:

Total respondents = **140**
(About 14% of the Australian coder workforce)

Q1   Title to best describe your occupation?

Clinical Coder	36.0%
HIM/MRM*	45.0%
Casemix Coordinator*	3.5%
Info. Systems Manager	3.0%
Senior Manager/CEO	2.0%
Clinician	–
Academic	0.5%
Other	10.0%

(quality managers; consultants; clerks; claims analysts)

(* many respondents stated that they were all three: Coder/HIM/Casemix Coordinator)

Q2   Time spent reading *Coding Matters*?

Greater than 1hr	29%
30mins – 1hr	49%
Less than 30 mins	22%
Do not read	0%

Q3   How useful is information to your work?

Very useful	62%
Useful	32%
Somewhat useful	6%
Not useful	0%

Q4   How satisfied are you with *Coding Matters* content?

Very satisfied	40.0%
Satisfied	55.5%
Neither satisfied nor dissatisfied	4.0%
Dissatisfied (one respondent)	0.5%
Very dissatisfied	0.0%

Q5   Which *Coding Matters* topics do you:

	like most*?	like more of#?
Directors Report	7%	1%
New Classifications	11%	12%
CodingTips	21%	24%
Clinical Updates	15%	22%
New ACS	13%	18%
Publications	9%	5%
Educational W/shops	13%	9%
CCSA/HIMAA	10%	8%
Other	1%	2%

* Many respondents liked all areas.

This response is very evenly spread, with 'Coding Tips' leading at 21%.

 # What do readers want more of that is already covered?

Response again spread over topics, with clustering around Coding Tips, Clinical Updates, and New Standards.

Q6   Most frequently suggested new topics?

- quality audit methods
- responses to state coding queries
- hospital news & profiles
- casemix & coding
- positions vacant/ classifieds
- NCC staff profiles/backgrounds
- book reviews
- end uses of coded data
- coder accreditation
- ICD-10
- research results

Q7 Do you keep *Coding Matters* for reference?

Yes	99.5%
No (one respondent)	0.5%

Q8 Most frequent general comments?

- keep up the good work
- excellent publication
- well done!
- vital reading
- very informative
- well presented
- easy to read
- improving all the time

Q9 Do you have internet access (email, WWW)?

Yes	28%
No	72% *

(*Many respondents stated that they would be getting internet access soon)

Q10 If so, have you accessed NCC Homepage?

Yes	14%
No	86% *

(*Many respondents that replied 'yes' to internet access then stated they only had email and not WWW and hence could not access NCC Homepage)

Q11 If so, how useful was NCC Homepage?

Very useful	46%
Somewhat	24%
Useful	15%
Not useful	15%

Thank you once more for your kind words of encouragement!

So what can we do now to further improve *Coding Matters*? Having assessed your responses, we immediately set about acting on your suggestions.

In this issue of *Coding Matters*, you will find:

- the first "Quality Concerns" column by Joanne Chicco (including a profile on her background);

- in Kerry Innes' "Coding Tips" section you will find an example of a state coding query (information from such queries have actually featured in *Coding Matters* previously, however, maybe they were not clearly identified for our readers). Twenty workshop coding queries are also included in this issue;

- two job classifieds appear on the backpage of this issue;

- Jennifer Mitchell provides feedback on the Coder Accreditation Exam; and

- Shahn Campbell keeps us all posted on the ICD-10-AM Implementation Kit.

So, hopefully all this will keep you busy until next time!

Code-L

The number of Code-L subscribers has now reached 100 and is growing daily. Issues discussed by subscribers to date have included:

- anaphylactic shock following milk ingestion
- accidental puncture during laminectomy
- perineal grazes
- future uses of coded data
- Barrett's oesophagitis
- cardiotocography and decreased foetal movements.

If you wish to subscribe to Code-L, a free internet listserver devoted to coding issues, just address an email to:

Majordomo@listserv.cchs.usyd.edu.au

– and in the body of the message type:

Subscribe Code-L

Bye for now until the April issue of *Coding Matters*, which will be brought to you by the NCCH!

❖ **Karen Luxford**

And the winner of the Competition for the Casemix, DRGs and Clinical Coding booklet series is ...

**Luellen Thele,
Donvale Rehabilitation Hospital,
Donvale VIC!**

Congratulations Luellen!
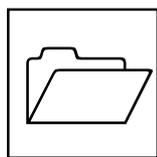
CODING TIPS

1. Cardiac biopsy via catheterisation

This query from the Victorian ICD Coding Committee is included here for your information:

Query

"Patients are admitted for cardiac biopsy following a heart or heart lung transplant. This procedure is performed to monitor the levels of rejection post transplant and is performed via a right catheter. Most biopsies show some level of rejection and these cases are currently assigned the following codes: 996.83, V42.1, 37.25 and 37.21. Adding 37.21 would more appropriately reflect the complexity and diagnostic nature of this procedure."

The Victorian ICD Coding Committee agreed that code 37.21 *Diagnostic procedures on heart and pericardium, right heart cardiac catheterisation* should be added to the codes already assigned, to reflect the approach used in obtaining the biopsy (in keeping with the intent of the Australian Coding Standard (ACS) 0023 Laparoscopic/arthroscopic/ endoscopic surgery). Code V42.1 is not needed with code 996.83.

The recommended codes are:

996.83 *Complication of transplanted organ, heart*

E878.09 *Surgical operation and other surgical procedures as the cause of abnormal reaction of patient, or of later complication, without mention of misadventure at the time of operation, surgical operation with transplant of whole organ*

37.25 *Biopsy of heart*

37.21 *Right heart cardiac catheterisation.*

NCC comment

The NCC agrees with the Victorian ICD Coding Committee that this approach is consistent with ACS 0023.

2. Chronic obstructive pulmonary disease (COPD)

Dr Christopher Clarke (Respiratory CCCG) and Kerry Innes presented a joint paper on Respiratory Medicine and Clinical Coding at the recent 1996 NCC Seminar in Coolum Queensland. Some important points from their presentation about COPD are included here.

Note that the Video of this presentation is available from the NCC for $25 (*see* page 4 for more details).

✧ Chronic obstructive pulmonary disease (COPD) is the current preferred terminology, with chronic obstructive airways disease (COAD) and chronic airway limitation (CAL) being synonymous terms.

✧ Documentation of "COPD" may relate to any of the following codes in ICD-9-CM depending on the underlying condition. Coders should therefore check the record thoroughly to abstract the appropriate information about the following conditions:

Chronic asthmatic bronchitis – 491.2x

Chronic emphysematous bronchitis – 491.2x

Chronic bronchitis with airway obstruction – 491.2x

Obstructive asthma – 493.2x

Chronic obstructive pulmonary disease – 496

Emphysema (obstructive) – 492.8

These are all regarded clinically as COPD as they are all "obstructive" in nature.

The schema of COPD reproduced on page 15 has been adapted from:

American Thoracic Society. "Standards for the diagnosis and care of patients with chronic obstructive pulmonary disease." *Am J Respir Crit Care Med* 1995 (Suppl): S77-S120.

This is a particularly good article and is highly recommended further reading.

An important feature of the COPD classification in ICD-9-CM is that 496 is regarded as a "last resort". The specific conditions resulting in the obstruction are assigned in preference to 496, if known (see the exclusion note at 496).

In contrast, this is not a feature of ICD-10-AM:

J44 includes all the various conditions, such as asthma, chronic bronchitis and emphysema when described as "obstructive".

Another good feature of ICD-10-AM is the inclusion of codes for "COPD with acute lower respiratory infection" and "COPD with acute exacerbation, unspecified" (*see next page*).

Key to schema:
1. Chronic bronchitis
2. Emphysema
3. Chronic bronchitis with obstruction = COPD
4. Emphysema with obstruction = COPD
5. Chronic bronchitis and emphysema with obstruction = COPD
6. Chronic bronchitis and asthma with obstruction = COPD
7. Emphysema and asthma with obstruction = COPD
8. Chronic bronchitis, emphysema and asthma with obstruction = COPD
9. Asthma
10. Airflow obstruction
11. Chronic bronchitis and emphysema

Figure adapted from: *Am J Respir Crit Care Med 1995* (Suppl): S77-S120.

Schema of chronic obstructive pulmonary disease
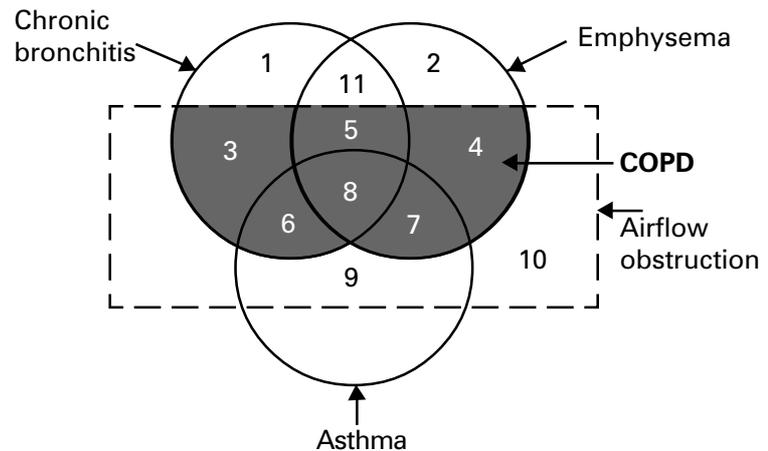
Exercise

Read through the inclusion and exclusion notes below from J44 in ICD-10-AM and note the way in which these conditions are classified differently from ICD-9-CM:

J44   Other chronic obstructive pulmonary disease

Includes: chronic:
    . bronchitis:
      . asthmatic (obstructive)
      . emphysematous
      . with:
         . airways obstruction
         . emphysema
    . obstructive:
      . asthma
      . bronchitis
      . tracheobronchitis

Excludes: asthma (J45.-)
    asthmatic bronchitis NOS (J45.9)
    bronchiectasis (J47)
    chronic:
    . bronchitis:
      . NOS (J42)
      . simple and mucopurulent (J41.-)
    . tracheitis (J42)
    . tracheobronchitis (J42)
    emphysema (J43.-)
    lung diseases due to external agents (J60-J70)

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified

3. Stemetil poisoning

The NCC has had some queries about why Stemetil, a drug often used for antiemetic purposes, is listed in the Drug Table with diagnosis code 969.1 *Phenothiazine-based tranquillisers* rather than code 963.0 *Antiallergic and antiemetic drugs*.

The reason for this classification is that both ICD-9-CM and ICD-10 usually classify drugs according to the type of drug (phenothiazine) rather than the way it effects the body (antiemetic). This is a consistent way of classifying drugs, as many drugs have more than one "action" on the body.

It should be noted that under 963.0 there is an exclusion note alerting coders to the fact that "Phenothiazine-based tranquillisers" are coded to 969.1. Stemetil is the brand name for prochlorperazine maleate, a phenothiazine.

4. Injection of 5FU at trabeculectomy and/or cataract extraction

5FU and Mitomycin C are used as antifibrotics either intra or postoperatively in trabeculectomy or cataract extraction. The antimitotic properties help to reduce postoperative fibrosis (reducing fibroblast proliferation). Mitomycin C is applied intraoperatively (usually for one minute).

5FU is typically given over a number of courses during the immediate postoperative period (up to three weeks or so). The typical dose of 5FU is 5mg, injected subconjunctivally with topical anaesthetic plus antibiotic cover. Usually the needle is placed through the conjunctiva from a temporal approach. Code subconjunctival injection of 5FU to 10.91 *Subconjunctival injection.*

❖ **Kerry Innes**

AUSTRALIAN CODING STANDARDS WORKSHOPS – coding query feedback

The following 20 queries were selected from the questions raised at the national NCC workshops held in May 1996 and are published here for your information.

Question 1

If a person presents with HPV of multiple sites, do we code the sites with 1 HPV code at the end or the HPV code after each site? The codes 624.8, 622.8, 079.4 fail to indicate that HPV is also of the vulva.

Because diagnosis codes cannot be duplicated, it is necessary, in the cases you cite, to list the site codes first, followed by the 079.4. It is acknowledged that the HPV code cannot be interpreted as being associated with both codes. This is not an uncommon issue in interpreting a string of codes - associations are not necessarily obvious.

Question 2

Why is gastroenteritis the principal diagnosis when the patient may be specifically brought in for dehydration?

The sequencing of gastroenteritis and dehydration has been debated for some time. Although arguments for and against sequencing gastroenteritis first are often sound, it was agreed that consistency in application of a national rule is essential if any value is to be gained from the coded data.

Question 3

What 5th digit should be used for a legally-induced abortion without complication and with dilatation and curettage? In Victoria – coders over the last few years have been taught to use "2", however, I note in your example you use "0" as fifth digit (P.S. I agree with "0").

The clinicians from the Obstetrics & Gynaecology CCCG advise that the fifth digits are unimportant in the 634-638 range. In ICD-10 this distinction is de-emphasised. There is much debate about whether an induced abortion should be regarded as complete or not. As the fifth digit is of little significance, the NCC advises the use of "0".

Question 4

With FESS, should endoscopy (no biopsy) also be coded? Local clinical advice says "yes". Agree? Inferred by inclusion of "closed biopsy".

▶

Coding Matters, Vol.3 No.1, Coding Tips section (page 5) advised that "sinoscopy 22.19 is routinely performed in this procedure and should be coded when FESS is documented. Note inclusion in the Errata, page 19."

Question 5

Previous practice was to code 97.82 + 54.95, but now that we have the new code of 54.90, operative removal of Tenckhoff, do we also need to code 97.82 non-operative removal of Tenckhoff?

The new code 54.90 "Surgical (operative) removal of peritoneal dialysis catheter", replaces the use of the codes cited in the ACS 1412. Due to the lack of one "surgical" code to describe removal of Tenckhoff catheter, these two codes were previously chosen to best describe the nature of the procedure. The new code 54.90 now reflects the surgical nature of the procedure. Note that ACS 1412 was deleted in 1996 as the creation of the new code 54.90 made the standard obsolete.

Question 6

Patient admitted for removal of a lesion/condition. Lesion/condition is not present when the Medical Officer examines the patient before operation. Which code to use, V71 or V64.3?

The NCC consider the better code to use is V71. The inclusion note under the V71 category is important and highlights the rationale for using a code from this range (i.e. "abnormal condition... which requires study, but after examination and observation is found not to exist"). The code V64.3 has no way of indicating that the condition is no longer/or never was present.

Question 7

Ventilation <24 hrs should be coded – uses a lot of resources (particularly in small hospitals that transfer patients out).

Ventilation for 24 hours or less should <u>not</u> be coded. This includes patients who may be in ICU for a period of time and ventilated. The Standard 1006 is based on the premise that ventilation for periods <25 hours occurs, in the main, during the postoperative recovery period and is therefore reflected in the resource intensity of the relevant operative procedure. This was agreed following consultation with relevant clinicians. ▶

Question 8

Staged procedures (V58.83): more examples are needed. When should V58.83 not be used (e.g. colostomy, chemotherapy)?

V58.83 should be used as an additional code for planned staged surgical procedures. This code should not be used for second or subsequent episodes for dialysis, chemotherapy or radiotherapy. However, it may be used for epispadias, limb lengthening, osseointegration, reconstruction of eyelid or lip and plastic repairs and any procedure which requires more than one procedure to "complete" the treatment.

Question 9

Is the use of V26.8 correct to indicate that a patient is on IVF when admitted for micro-epididymal sperm aspiration. Codes presently used are V26.8 and 63.99.

V26.2 "Investigation and testing" should be used as the principal diagnosis for episodes for micro-epididymal sperm aspiration (63.99). Advice on the use of this code appears in the Errata in this issue (*see* page 23).

Question 10

ACS 0501: A patient admitted for the first episode of schizophrenia diagnosed as acute schizophrenia. What would the fifth digit be as the condition is not really chronic as such, e.g. 295.8x? Fifth digits only allow for chronic or subchronic patients with acute exacerbations, etc.

Coders should consult the clinician about the type of schizophrenia. If no further information can be obtained and this is the first episode of "acute schizophrenia", code 295.80 "Other specified types of schizophrenia, unspecified".

Question 11

ACS 1309: At the workshop, it was suggested to use V43.64 in addition to 996.4. It was felt this may be unnecessary double coding as 996.4 indicates presence of device. Also, the standard mentioned including V43.64 with dislocation of hip code but not with 996.4 code.

Code 996.4 "Mechanical complication of internal orthopaedic device, implant and graft" does not indicate what type of internal orthopaedic device, implant or graft caused the mechanical complication. The addition of V43.64 "Hip replacement" helps to provide greater detail in this situation as it indicates that the internal orthopaedic device is a prosthetic hip joint. The standard should indicate that V43.64 should also be used as an additional code with 996.4 as was shown in the quiz at the workshop and hence appears in the Errata on page 23 of this newsletter.

Question 12

Re: ACS 0032 Allied Health

Dietetics
5. Provision of enteral nutrition
6. Provision of parenteral nutrition

Do you need to also code 96.6 and 99.15 for these two? (giving of total parenteral nutrition (TPN), etc usually set up by pharmacist)

Yes, you need to code both 96.6 "Enteral infusion of nutritional substances" and 99.15 "Parenteral infusion of nutritional substances".

Question 13

Re: ACS 0032 Allied Health

1. Private physiotherapists are billed separately. If a private physiotherapist performs a procedure/ intervention using hospital equipment should the procedure/intervention be coded? Code all? Code once as flag?

2. Should each type of intervention be coded or every "visit" associated with a particular type of intervention?

1. If physiotherapy is performed, whether it is performed by a private physiotherapist or a staff/hospital physiotherapist, the intervention should be coded.

2. *Coding Matters* Vol.3 No.2, page 9 advised:

"As per advice in the coding of multiple/bilateral procedures (ACS 0020, p19) "any procedure from Chapter 16 of Volume 3, ICD-9-CM need only be coded once". However, if different procedures within the same allied health discipline are performed (e.g. an occupational therapist performs occupational therapy assessment and sensory motor occupational therapy), or if allied health professionals from more than one allied health discipline are involved in the care of the patient (e.g. a physiotherapist and a social worker), then codes for each appropriate discipline specific intervention can be applied."

Question 14

Re: ACS 1521 Conditions Complicating Pregnancy

A 646-648 code is sequenced first followed by condition to provide more detail. Does this apply to all codes in 646 as some appear to have sufficient detail?

The ICD convention is to code conditions in 646–648 as the principal diagnosis, then use the complication as the additional diagnosis. It is good practice to always code the condition/complication as an additional diagnosis in order to produce as much specificity as possible. ▶

Question 15

Re: ACS 1215 Grafts and Flaps

Do the "flap" codes 86.7x include muscle flaps? It is not stated either way in codes or standards.

Category 86 "Operations on skin and subcutaneous tissue" lists only skin components under the inclusions and excludes certain sites of skin. If the flap involves muscle, code 83.82 "Graft of muscle or fascia" should also be assigned.

Question 16

Re: ACS 1909 Child Abuse

What do you use for a "history of sexual abuse" for an adult patient? The closest I could get is V62.89, V15.4

History of sexual abuse of an adult patient should be coded to V62.89 "Other psychological or physical stress NEC".

Question 17

Re: ACS 1009 Pulmonary Embolus

Can the same 12 week rule be applied for post delivery patients who develop embolus?

Yes, the same rule can be applied.

Question 18

Use of tobacco. These codes should be assigned as additional diagnoses for all cases where tobacco use is documented. Does this mean only if the definition of secondary conditions is met, or on all cases irrespective of treatment or relevance? ▶

Use of tobacco codes should be assigned as additional diagnoses for all cases where documentation is provided regarding tobacco consumption. It is important that all such cases are picked up routinely. Researchers and epidemiologists are keen to monitor the use of tobacco and to investigate its relationship with the diseases/conditions with which it appears.

Question 19

If baby is "difficult" and doesn't feed (no physical problems), can the code entered be 779.3 without the need to enter another code?

Yes, 779.3 "Feeding problems in newborn" can be used alone if there is no documentation as to the neonatal problem causing the feeding disorder or attachment difficulty. However, if there is a specific neonatal disorder documented as responsible for the attachment difficulty, the appropriate code for the disorder should be assigned, followed by the 779.3 code.

Question 20

A patient is treated for a suspected condition and further tests are ordered (e.g. MRI scans), but the patient is discharged and has the test as an outpatient. Can the result be used to confirm the suspected condition and subsequently coded accordingly on the inpatient record?

Documentation of a patient's episode of care reflects their condition, treatment and care at a particular point in time. Information which becomes available at a later point in time, whether from another hospital or from results of outpatient tests, should not be used to inform the coding decision or alter the way in which the suspected condition was coded. ■
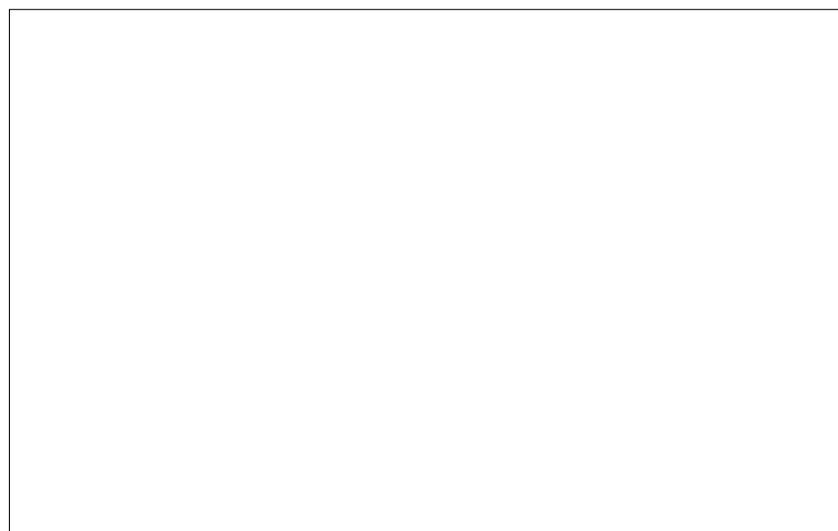
✧   1 9 9 6   C O D E R   A C C R E D I T A T I O N   E X A M   ✧

COMMON CODING ERRORS

Report by Jennifer Mitchell

> On Saturday 21 September 1996, 142 candidates sat for the first Australian
> Clinical Coder Accreditation examination at 19 sites across Australia and New Zealand.
> This event was an important milestone for clinical coders in Australia.

Results

Around one third of the candidates who sat for the exam gained accreditation. The results show that the candidates who were most likely to be successful in gaining accreditation:

- worked in public hospitals (of any size) or private hospitals with more than 150 beds

- spent 25 hours or more each week on coding activities

- had been coding for three or more years. The greatest percentage of successful candidates had been coding for 10 or more years.

(A detailed statistical report on the results and characteristics of exam candidates will be published by the HIMAA in early 1997. Look for information about this report in future issues of *Coding Matters*.)

Evaluation and feedback

A number of candidates wrote in their evaluation sheets that although they knew that the exam was a pass/fail accreditation assessment, they were also hoping it would help them improve the quality of their coding.

Although this was not the purpose of the exam, to assist those people, and to provide some guidance for other coders, the HIMAA has asked me to highlight the more common errors which candidates made in the practical coding component of the exam (Part 2).

Part 2 of the Accredited Clinical Coder (ACC) exam required candidates to code ten medical records. These medical records had been carefully chosen and edited to ensure that they represented the type of records seen in Australian health care facilities, with a variety of specialties and levels of complexity.

We were pleased to receive feedback from many candidates about the appropriateness of the level of coding required in the exam and in particular from a candidate who said that there was nothing in the exam that she had not seen in her regional hospital.

• • • • •

Common errors

✧ **RECORD 1 ERRORS:**

Bunion and hammer toe

- *Coding "1st metatarsal bunionectomy; old incision" (77.59) to "Bunionectomy with soft tissue correction and osteotomy of first metatarsal" (77.51)*

- *Coding "2nd toe proximal interphalangeal joint fillet for hammer toe; e/o distal half prox. phalanges" to 77.89 "Other partial ostectomy" instead of 77.56 "Repair hammer toe"*

- *Coding 787.02 "Nausea, alone"*

  This was the most common unnecessary code. The record stated that the patient had nausea for two hours on the day after surgery, and was given Maxolon. Nausea is a common symptom in the postoperative period, and does not require coding.

✧ **RECORD 2 ERRORS:**

Rotavirus gastroenteritis

- *Sequencing "dehydration" as the principal diagnosis.*

  Australian Coding Standard (ACS) 1120 says that the dehydration should not be the principal diagnosis in cases such as this.

- *Omitting the code for "dehydration"*

- *Coding the "rotavirus gastroenteritis" (008.61) as an ill defined intestinal infection (009.0 or 009.1)*

- *Coding rotavirus gastroenteritis as 009.0 with 079.89 "Other specified viral infections" or 079.50 "Retrovirus, unspecified"*

- *Coding the rotavirus gastroenteritis to 558.9 "Other and unspecified noninfectious gastroenteritis and colitis"*

▶

⬦ **RECORD 3 ERRORS:**

Fractured neck of femur

- *"Closed intertrochanteric fracture of femur" coded as 820.20 "Trochanteric section, unspecified; 820.31 "Intertrochanteric, open"; or 820.8 "Unspecified part of neck of femur".*

- *"COAD with asthma" coded as 493.90 "Asthma, unspecified" or 496 "Chronic airway obstruction"*

- *"Open reduction and internal fixation" coded as 79.15 "Closed reduction with internal fixation", 79.25 "Open reduction without internal fixation" or 78.55 "Internal fixation of bone without fracture reduction"*

The external cause was stated as "tripped and fell at nursing home" and should have been coded as E885.0 (fifth digits of "0" or "7" were accepted). Many coders used E888.0 "Other and unspecified fall" and a number of candidates opted for E928.9 "Unspecified accident".

⬦ **RECORD 4 ERRORS:**

Incomplete uterovaginal prolapse

- *Coding 618.4 "Uterovaginal prolapse, unspecified"*

- *Coding both 618.2 "Uterovaginal prolapse, incomplete" and 618.0 "Prolapse of vaginal walls without mention of uterine prolapse"*

- *Coding tobacco and alcohol use and dysuria when the history and examination notes showed "°cigs °ETOH ...°dysuria"*

  Suggests a lack of understanding of the symbols used in medical records (e.g. above symbol usually indicates "nil").

- *Omitting code for epidural for postoperative analgesia*

- *Coding both 70.50 "Repair of cystocele and rectocele" and 70.52 "Repair of rectocele"*

⬦ **RECORD 5 ERRORS:**

Neutropenia following chemotherapy for carcinoma of the lung

- *Carcinoma of the lung sequenced as the principal diagnosis instead of the neutropenia*

- *Neutropenia coded as 038.9 "Unspecified septicaemia" instead of 288.0 "Agranulocytosis"*

- *Codes missing for fever (febrile neutropenia), anaemia, E code for adverse effect of chemotherapy, angina, nutritional assessment/counselling*

- *Adverse effect of chemotherapy E code coded as E947.8 "Other drugs and medicinal substances" or E947.9 "Unspecified drug or medicinal substance"*

- *Fifth digit place of occurrence on E code incorrect*

- *Carcinoma of left upper lobe of lung code to 162.9 "Lung, unspecified"*

⬦ **RECORD 6 ERRORS:**

Inguinal hernia

- *Inguinal hernia coded as 550.10 "Inguinal hernia with obstruction, without mention of gangrene"*

  There was no mention of obstruction in the record.

- *Fifth digit omitted on hernia code*

- *Emphysema coded as 496 "Chronic airway obstruction"*

- *Coding 788.20 "Urinary retention" and 599.6 "Obstructive uropathy" in addition to 600 "Hyperplasia of the prostate"*

  Minor urinary symptoms were listed in the history taken by a medical student (hesitancy, poor stream). There was no mention of retention, and although the medical student's notes state "Evidence of some obstructive uropathy", this is in the context of the patient's prostatism.

- *"Repair of direct right inguinal hernia with prolene mesh" (53.03) coded as 53.00, 53.01, 53.05, 53.11, or 53.14*

  The variety of procedure codes provided suggests that many candidates did not understand how a herniorrhaphy is carried out or what prolene mesh is or how it is used. The use of bilateral codes for a procedure which was clearly carried out on the right side was a fairly common mistake.

⬦ **RECORD 7 ERRORS:**

First episode of hypomania

- *Fifth digit missing from hypomania code*

- *Coding 737.20 "Lumbar lordosis" instead of or in addition to 724.2 "Low back pain"*

  Although the X-ray report stated "flattening of lumbar lordosis. No other abnormality", a significant number of coders included the code for lordosis.

✧ **RECORD 8 ERRORS:**

Caesarean delivery

- *Incorrect or missing fifth digits on obstetric codes*

- *Use of V30 instead of V27*

- *Symptoms of pre-eclampsia (e.g. headache, blurred vision) coded*

- *Staphylococcus aureus coded to 041.10 "Staphylococcus, unspecified"*

- *Disruption of caesarean wound coded to 998.5 instead of 674.12*

  There is an exclusion note at 998 for obstetric wounds.

- *Coding 669.42 "Complications of obstetrical surgery and procedures"*

  There is an exclusion note at 669.4 excluding complications of obstetrical surgical wounds.

- *Common missing codes included disruption of the caesarean wound, the caesarean wound infection, staphylococcus aureus, outcome of delivery (V27), and current tobacco use*

✧ **RECORD 9 ERRORS:**

Diabetic foot

- *Principal diagnosis for diabetic foot (250.81) listed as diabetes with renal complications, neurological complications or peripheral circulatory complications*

  ACS 0401 explains the coding for diabetic foot.

- *Wrong fifth digits for the IDDM*

- *Missing codes included many of the diabetic conditions, manifestations of the diabetic conditions, and the haemodialysis procedure code*

Although this was a complex case, all the information needed to code the patient's many problems was detailed in the record. Many candidates appeared to be confused about the coding of the haemodialysis. The record stated that the patient had end-stage renal failure and was having haemodialysis three times a week. As the patient was in hospital for five days he would need to have dialysis during this time. Any doubt about whether he had dialysis or not was cleared up by the entry in the discharge summary which said "… was given vancomycin via haemodialysis".

✧ **RECORD 10 ERRORS:**

Bladder stones

- *Hyperplasia of prostate listed as the principal diagnosis instead of the bladder stones*

  Although the patient in this case had a prostatectomy during his admission, his reason for admission was for treatment of his bladder stones.

- *Fourth digit missing from the TURP code.*

• • • • •

Conclusion

Of course there were many more individual errors made by candidates in the exam, but the common mistakes listed above highlight general problems which coders may wish to address when examining their coding performance:

- using unspecified codes when the detail is available in the record

- not reading exclusion notes in the Tabular List

- poor use of the Alphabetic Index to locate appropriate codes

- coding symptoms of established diagnoses

- correct use of fifth digits

- not following Australian Coding Standards.

All of these problems relate to fundamental principles and practises in coding. Those coders who believe that they would be unlikely to make the kind of errors listed above, and who are contemplating sitting for the next ACC exam in April 1997, should feel confident about passing and gaining accreditation.

❖ **Jennifer Mitchell**
  Chair, NCWIP Expert Panel

NATIONAL CODING CENTRE

ERRATA 1996 – Part 3

1996 Australian Version of ICD-9-CM, second edition

Subsequent to the Errata published July & October 1996, the following corrections need to be made to the *1996 Australian Version of ICD-9-CM*.

Volume 1 – Tabular List of Diseases

<u>Page</u>

| 214 | Amend | **724.3 Sciat<u>ic</u>a** |

Volume 2 – Alphabetic Index of Diseases

20		**Admission...**
		- for
		- - removal of
	Amend	- - - Kirschner wire <u>V54.0</u>

| 51 | | **Bacteria** |
| | Amend | - in urine (see also Bacteriuria) <u>791.9</u> |

54		**Bleeding**
	Add	- intermenstrual <u>626.8</u>
		- - irregular 626.6
		- - regular 626.5

| 66 | | **Cap** |
| | Amend | - cradle <u>690.11</u> |

113		**Delivery**
		- complicated (by) NEC
		- - placenta, placental
	Amend	- - - battledore <u>656.7</u>

| 123 | Delete | **Diarrhoea**, ... ~~(chronic)~~ ... 787.91 |

158		**Embolism** ...
		- postoperative NEC 997.2
	Amend	- - pulmonary <u>415.11</u>

172		**Failure, failed**
		- testis, primary (seminal) 257.2
	Add	<u>- to progress in labour NEC (*see also* Deliver, complicated, inertia, uterus)</u>

230		**Impaired, impairment**
		- renal (*see also* Disease, renal) 593.9
	Add	<u>- - chronic 585.1</u>

| 423 | | **Syndrome** |
| | Amend | - oral-facial-digital <u>759.87</u> |

Page		**Volume 3 – Tabular List of Procedures**
p-79		**59.79 Other**

                           Anterior urethropexy

   Delete   ~~Polytef augmentation urethroplasty~~

Volume 3 – Alphabetic Index of Procedures

pi-24   Move   **Discectomy, intervertebral ...** should appear above "Discission" on same page

Volume 4 – Australian Coding Standards

65   0511   PANIC ATTACKS WITH PHOBIA

Amend as follows:

Both the panic attacks (300.01) and the phobia should be coded, with the phobia (300.21, 300.23 or 300.29) sequenced first.

103   1210   CELLULITIS

It should be noted that although the standard advises to assign 682.0 *Other cellulitis and abscess of face* for periorbital cellulitis, 682.0 does have an exclusion note for "cellulitis of the eyelid" which is coded to 373.13 *Abscess of eyelid*.

110   1309   DISLOCATION OF HIP PROSTHESIS

"*When the documentation states "osteoarthritis" as the principal diagnosis and the patient is undergoing a second or third hip replacement."

Add   V43.64 *Organ or tissue replaced by other means, joint, hip* should be assigned as an additional diagnosis code to 996.4 to indicate the exact type of internal orthopaedic device involved.

121   1402   IN VITRO FERTILISATION (IVF) currently requires V26.8 *Other specified procreative management* to be assigned as the principal diagnosis when the episode relates to admission for an IVF procedure. **From July 1997**, the principal diagnosis will change to 628.x *Infertility, female* with an additional diagnosis code of V26.8 *Other specified procreative management*. This change is necessary because code V26.8 was omitted from the list of acceptable principal diagnoses for surgical AN-DRGs 655-657 "Uterine Adnexa Procedure for Non-Malignancy" in Version 3.0 & 3.1.

122   1419   MICRO-EPIDIDYMAL SPERM ASPIRATION

The principal diagnosis for admissions for micro-epididymal sperm aspiration is V26.2 *Procreative management, investigation and testing*.

118   1430   CHRONIC RENAL IMPAIRMENT

Amend the following values:

Clinical criteria for assignment to chronic renal impairment (585.1) is:
        Adults ...
        Children ($\leq$15 yrs)

Clinical criteria for assignment to chronic renal failure (585.9) is:
        Adults ...
        Children ($\leq$15 yrs)

126   1505   SINGLE SPONTANEOUS VAGINAL DELIVERY

Note that all allied health procedures can be included with a diagnosis code of 650 *Single spontaneous vaginal delivery*.

Guessing competition

Guess the number of codes in ICD-10-AM!

1. **How many disease codes in the Australian modification of ICD-10*?**

2. **How many procedure codes in MBS-E?**

excludes Morphology codes.

Remember: "E" and "V" codes are no longer supplementary, but rather are in the main!

Answers should include all valid codes.

Hint:

1996 Australian Version of ICD-9-CM has 12,495 disease codes (including V & E codes) and 3624 procedure codes.

A winner will be drawn for each category – i.e. closest to either the correct number of:

i) diseases codes   *or*   ii) procedure codes

and two lucky people will each win a set of ICD-10-AM coding books in 1998!

Entries to: Guessing Competition, National Coding Centre, PO Box 170, Lidcombe NSW 2141.

Competition is not open to current or previous NCC staff!