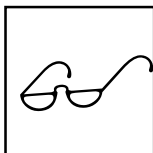


Coding Matters

Newsletter of the National Coding Centre

Volume 3 Number 1
July 1996



DIARY OF THE DIRECTOR

The director's desk was unoccupied for several weeks during April 1996 while I attended the 12th International Health Records Congress in Munich, Germany. Coding was very much in the forefront of the discussions, both in the formal program and in the pre-conference workshops. Janelle Craig (NCC Education Manager) ran a highly successful workshop on coding quality for the International Federation of Health Records Organisations (IFHRO), in conjunction with Professor Phyllis Watson (University of Sydney) and Ms Sue Walker (National Reference Centre for Classification in Health, NRCCH). Before and after the Congress, I took the opportunity to visit several European centres whose work is relevant to the National Coding Centre (NCC).

11 April, 1996

NHS Centre for Coding and Classification (CCC), Loughborough, Leicestershire, England

This visit was in conjunction with a colleague from Victoria, Ms Lynda Dandie, now living and working in England. We met with key staff from the Centre, including Dr James Read, Director, and Ms Yvonne Sutton, Deputy Director and Director of Classifications. The Centre combines work on the Read Codes, ICD-10 and the Office of Population Censuses & Surveys' Classification of Surgical Operations, fourth revision (OPCS 4), having recently negotiated the transfer of Crown copyright for OPCS 4 to the CCC. There are plans to update OPCS 4 but this work has not yet commenced. The Clinical Terms Project – relating to terms used in the Read Codes – is almost completed, having consulted with 43 specialty working groups.

Work continues on development of new Read codes through medical and allied health "authors" employed at the Centre and on implementation of Read Codes Version 3. CAMS, a local company, licences and distributes the Read Code software. Version 3 is updated every quarter.

ICD-10 was implemented in England from April 1995 (Wales, Scotland and Northern Ireland will change to

ICD-10 in October 1996). A major education campaign was carried out through regional coordinators and around 80 coding trainers. Each Trust was appointed an ICD-10 liaison officer. The Centre staff were most generous in providing us with copies of educational material used in this exercise in the UK, including the Instruction Manual (updated quarterly) containing the national coding standards. The coordinators have established networks with Coding Managers. A help desk at the Centre is staffed full time by two people responding to phone queries from all over England. These calls are often routed through the regional coordinators, who also conduct data quality reviews. Queries are answered within three days. A Coding Review Panel meets every month, membership including two Coding Coordinators, representatives from Wales, Scotland and Northern Ireland, the Director of Classifications and two staff from her Training and Data Quality section.

Mapping is being carried out from Read Codes to ICD-10 and ICD-9. No attempt has yet been made to use these mappings to create an ICD-10 index based on Read terms. Read Codes are not seen as a statistical tool but as a terming project. Major implementation of the Read Codes is seen to depend on the wide scale use of electronic records in general practice and hospitals. ▶

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There is little integration between the work of the CCC and the medical record officer profession in the UK. In most hospitals, the medical record and clinical coding functions are separate. The clinical coders I met at the Centre were extremely interested in coder accreditation and the Clinical Coders' Society of Australia, as there is no such recognition for coders or coder education in the UK.

There is a great deal of interest in European collaboration, especially on Read Codes. A recent meeting in Amsterdam proposed the formation of a European Association or Federation of Classification Centres.

12 April, 1996

University of Manchester

Professor Alan Rector

Professor Rector is Reader in Information Sciences & Medical Informatics Group, Department of Computer Science, The University of Manchester and leader of the GALEN Project (Generalised Architecture for Languages, Encyclopaedias and Nomenclatures in Medicine). The main aim of the visit was to discuss possible future collaboration on a hierarchically structured electronic procedure classification.

The GALEN project involves the development of an electronic structured language for diseases and procedures – described in the GALEN brochure as “a semantically valid model of clinical terminology represented in a formal language and associated with sophisticated support for different natural languages and conversion between different coding schemes”. Results of the project are being implemented through GALEN-IN-USE, with support from the European Union. This second project has applied the structured language to protocols and pathways in treatment of diabetes and in orthopaedics, particularly relating to arthroscopy procedures.

It was of interest that there appeared to be little communication between this project and that dealing with the development of the Read Codes. Australian work on developing the procedure classification as an electronic system would benefit from further discussion with Professor Rector.

15th–18th April, 1996

12th International Health Records Congress, Munich

This conference was of particular interest in providing contacts with representatives from the health information profession from over 30 countries. Ms Janelle Craig ran an extremely successful pre-conference workshop on coding and data quality. As a result, IFHRO has expressed interest in further exploring with the World Health Organization (WHO) the international application of data quality indicators developed by workshop participants. My paper on the NCC was well received, with particular interest in the scope of our functions and structures to allow implementation of national coding standards. There was an emphasis on European cooperation, although countries within Europe are implementing ICD-10 at different stages, and using a variety of procedure classifications.

22 April, 1996

Department of Social Medicine, University Hospital, Uppsala, Sweden

WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries

Professor Björn Smedby, Dr Kerstin Carsjö

In operation since 1987, this Centre supports disease classification in the five Nordic countries, with meetings of country representatives three times each year. ICD-10 was implemented in Denmark in 1994, with planned introduction in Finland in 1996, Sweden and Iceland in 1997 and Norway in 1998.

Coding Matters



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**National Coding Centre
PO Box 170
Lidcombe NSW Australia 2141**

phone: (02) 646 6461

fax: (02) 646 6603

email: k.luxford@cchs.su.ed.au

homepage:

<http://www.cchs.su.edu.au/NCC/ncc.html>

Editor: Karen Luxford

Typesetting: Simone Lewis

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From left: Yvonne Sutton (Deputy Director, NHS Centre for Coding and Classification), Dr James Read (Director, NHS Centre for Coding and Classification), and Lynda Dandie (Project Manager, Royal College of Obstetricians and Gynaecologists).

The recently published Nordic classification of procedures is being used as the accompanying procedure classification, with the Centre to be responsible for its updating. An ambulatory classification based on ICD-8 has been used since the early 1970s in some community health settings to develop a longitudinal database for epidemiological use. An ICD-9 classification for primary care was developed by the Association of Ambulatory Practitioners and a primary care adaptation of ICD-10 is also being proposed by the Swedish National Board of Health for introduction in 1997. It will comprise about one thousand 3 or 4 character codes. Some general practitioners in the Nordic countries support the International Classification of Primary Care (ICPC). Although there is a mapping from ICPC to ICD-10, Professor Smedby believes a uniform system would be desirable.

Professor Smedby is keen to support an international mechanism for updating ICD-10. He has already contacted WHO, Geneva, with Nordic changes for discussion at WHO Collaborating Centres meeting in Tokyo in October 1996.

Nordic Diagnosis Related Groups (DRGs) based on HCFA 12 are being developed. In Sweden, casemix introduction is coordinated by SPRI and the National Board of Health. This board is also responsible for data quality and has developed a protocol for data quality which has been in use since 1986. The WHO Centre is to be responsible for coordination of DRG adaptation in the Nordic countries.

23 April, 1996

National Board of Health, Copenhagen, Denmark

Dr Henning Bay Nielsen

Dr Nielsen was responsible for the production of the Nordic Procedure Classification, seven years in development and published in Copenhagen in 1996. It took about seven years to develop. It is available electronically and Dr Nielsen presented me with an English language version. Its maintenance will be the responsibility of the Nordic WHO Collaborating Centre. Dr Nielsen's group is also preparing a new multi-axial classification for external cause of injury, proposed by NOMESCO to replace the external cause of injury codes in ICD-10. A paper outlining the new classification was

presented at a recent international injury meeting in Melbourne and proposals have been made for collaborative work on the classification with WHO.

Comité Européen de Normalisation (CEN) Technical Committee 251 – Medical Informatics

Working Group 2 – Healthcare terminology, semantics and knowledge bases (CEN/TC 21/ WG 2)

Dr Henrik Olesen, Chairman, Rigshospitalet, Copenhagen

In existence for about 12 years, CEN falls under the umbrella of the European Community and the European Free Trade Agreement. Working Group (WG) 2 represents around 20 countries. Six years ago, CEN was given responsibility and support for developing standards for EC countries. About 2000 standards have been prepared, with another 2000 in the pipeline. There are three technical bureaux – transport, communication and health care. Technical committees are formed by these bureaux – TC 251 (health care informatics) having seven working groups, each with a coordinator. The working groups are composed of interested experts, not necessarily representative of colleges or societies. TC 251 has three representatives from each country. WG 2 (terminology) has project teams, for example for medical devices, surgical procedures, clinical laboratory units and imaging. Three day meetings are held twice a year with much work being done by mail and fax.

CEN has developed a pre-standard for coding schemes used in health care information interchange in conformity with International Standards Organisation/ International Electrotechnical Commission (ISO/IEC) directives. It is foreseen that this standard will receive worldwide approval. WHO Division of Information System Management has agreed to act as a Registration Authority in support of the standard. ►

Dr Olesen's main interest is in having an immutable code for a concept or term – even if the term changes, the code remains the same. For example, an enzyme doesn't change its character but it may change its name (Dr Olesen's specialty is clinical chemistry). He believes that CEN is the way of the future. The working groups take their tasks seriously and produce meaningful standards which are useful and applicable. These standards are updated when necessary – no fixed time. Dr Olesen believes that the system used by CEN of putting out draft standards, circulating the pre-standards for comment, compiling the results, then having the standards published by ISO, is a good one.

Information on TC 251/WP2 is available on the internet (<http://expasy2.hcuge.ch/papers0995/demoor.html>). General information on electronic data interchange standards can also be found on the NCC Homepage Resource Centre: <http://www.cchs.su.edu.au/NCC/ncc.html>.

25 April, 1996

WHO, Geneva

Dr HR Hapsara, Director, Division of Health Situation and Trend Assessment; Dr Patricia Butler, Publications; Ms Ewa Carlsson Höpferger, Legal Adviser; Mr Andre L'Hours

The main purpose of the visit was to discuss with WHO Australia's intentions in regard to ICD-10. Following communication between NCC and the Australian Institute of Health and Welfare (AIHW), Dr John Donovan had communicated to WHO Australia's desire to enter into a contract with WHO to produce an Australian version of ICD-10. Discussion with Mr L'Hours focussed on international update mechanisms for ICD-10, Collaborating Centre functions and possible topics for discussion at the Tokyo meeting in October 1996. Dr Hapsara is very supportive of IFHRO, and would be receptive to a proposal from that body for an international project to develop data quality indicators.



Other recent NCC landmarks include the Australian Coding Standards (ACS) Workshops, organised brilliantly yet again by Janelle Craig, the publication and distribution of the *1996 NCC Australian Version of ICD-9-CM* (congratulations to Karen Luxford!) and the mammoth task of mapping between ICD-9-CM and ICD-10, not to mention the development of the Australian modification of that publication and the new procedure classification.

The ICD-10 Implementation Committee met on 9 May 1996, where progress on ICD-10 was reported to state and other relevant representatives. Direction of work on ICD-10 is to be endorsed by the National Health

Information Management Group (NHIMG), as recommended by the Australian Health Ministers' Advisory Council (AHMAC). A paper on the MBS-Extended procedure classification methodology has been prepared and widely circulated. An ICD-10 Education Working Party has been formed to carry forward the important educational functions relating to ICD-10 implementation. Mapping between ICD-9-CM and ICD-10 is progressing well and is on schedule, thanks to the dedication of our mapping crew.

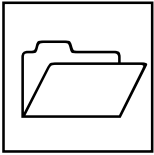
Another activity of note has been our involvement with the Integrated Quality Management Model (IQMM) Project in which the NCC's role is to develop codes and coding standards for adverse outcomes of hospital care. Lauren Jones, consultant to the NCC, is developing guidelines for obstetric and gynaecology complication codes in conjunction with members of the Coordinating Committee of IQMM and the Australian Council on Healthcare Standards (ACHS) Care Evaluation Program. Plans are underway to review general complication codes and complications of anaesthesia. Lauren visited Wimmera Base Hospital on 30 May to examine the medical record review program in place at that hospital. An educational video, "Introducing IQMM", is being developed and will be available shortly. For further information, contact Dr Duncan Stuart, Healthier Outcomes Network International, 101/656 Military Road, Mosman, NSW 2088.

Janelle Craig and members of the Coding Educators Network are in the thick of Australian Coding Standards Workshops, for which there has again been an excellent response from all states and territories. Kerry Innes (NCC Coding Services Manager) has been working with the Casemix Working Party of the Society for Hospital Pharmacists to discuss intervention codes for pharmacy to use with its PharmGroup casemix classification and updates to the drug table for ICD-10. Kerry and Megan Cumerlato have also been doing project work for the Mental Health Classification and Service Cost Project to produce a mapping between ICD-9-CM and ICD-10 for use in community mental health data collection.

The two University of Sydney HIM honours students on NCC staff are involved in projects on burns coding (Natalia Alechna) and pain management (Patricia DahDah). Both are adding a welcome research dimension to the NCC, and are contributing to a recently formed Journal Club for staff of the NCC and School of HIM, University of Sydney.

I hope to report to you in the next issue on the "closer relations" between NCC and NRCCH. Until then, enjoy the new books (thanks for your feedback and the considerable efforts of Dr Karen Luxford).

❖ **Rosemary Roberts**



CODING TIPS

This issue of Coding Tips is a particularly important one. Because a number of coding standards apply from July 1996, which are not included in the *Australian Coding Standards*, second edition (Volume 4, *Australian Version of ICD-9-CM*, second edition), it's essential that you read and understand the following standards and apply them for separations on and from 1 July 1996.

1. Coronary Artery Bypass Grafts (CABGs) (ACS 0909)

There has been some confusion about the number of grafts that should be coded when a left internal mammary artery (LIMA) is involved, which is discussed in the first paragraph of the standard. The important thing to remember when coding CABGs is that it may be documented as "CABGx4" but the coder should always check if a LIMA is involved, as this will reduce the number of "CABGs" coded. If a LIMA is performed in a procedure documented as "CABGx4" then a code for CABGx3 should be assigned with an additional code for the LIMA.

2. Stroke – effective 1 July 1996

a. Late effect

The usual application of a late effect is where a deficit arises as a result of a condition and often occurs later than the initial condition, e.g. scoliosis following rickets. Stroke differs, in that the deficits are an immediate result of the stroke. For this reason, the following standard should be applied.

EXAMPLE 1

A patient suffers a stroke on 1/1/96 and is transferred to a rehabilitation facility on 7/1/96 for continuing rehabilitation.

The first episode (1/1 – 7/1) is assigned code 436 plus codes for any deficits.

Patient transferred for rehabilitation following a previous admission for stroke. The patient suffers from hemiparesis and aphasia.

Second episode: Code V57.xx (rehabilitation), 436 (stroke), 342.9 (hemiparesis) and 784.3 (aphasia).

While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign code 436 with any applicable deficit codes (e.g. hemiplegia).

438 should only be used when the treatment period is complete but residual deficits are still manifest. For

example:

EXAMPLE 2

Patient admitted for excision of multiple BCCs. Examination revealed residual hemiparesis from a previous stroke. No treatment of the residual hemiparesis occurs during the episode of care.

Assign codes for principal diagnosis for BCC, hemiparesis and 438 (indicating that neither the stroke nor the hemiparesis is receiving treatment).

b. Severity

The Neurosciences Clinical Coding and Classification Group (CCCCG) has produced a list of additional diagnosis codes which give some indication as to the severity of a stroke episode. For coders, it is interesting to note that it is not necessarily the deficits, such as hemiplegia, which indicate that a stroke is "severe". This table is provided on the next page (p6) primarily for interest, as the conditions listed here would be coded routinely during the abstraction process. However, note that for a stroke case, dysphagia, urinary incontinence and faecal incontinence, should only be coded when certain criteria are met.

3. Functional endoscopic sinus surgery (FESS)

Sinoscopy (22.19) is routinely performed in this procedure and should be coded when FESS is documented. Note inclusion in the Errata, page 19.

4. Keratoacanthoma

We have been inundated with queries about the correct M code for keratoacanthoma (238.2). The Royal College of Pathologists of Australasia has advised us that M8070/1 is the best available code. If you have been using a different M code then you should change to M8070/1 from July 1996.

5. Dementia NOS – effective 1 July 1996

"Dementia, NOS" was discussed at the Geriatrics & Rehabilitation CCCC meetings in 1995, and clinical advice was that dementia without further qualification should not be coded to either senile or presenile. ►

Accordingly, coders should follow the index from July 1996 and assign code 294.8 *Other specified organic brain syndromes (chronic)*.

In Australian Coding Standard 0504 Dementia, the first paragraph should be deleted (*see* Errata, page 19):

~~“Senile and Pre-Senile Dementia”~~

~~“Dementia NOS” should be coded to senile dementia unless specified as pre-senile dementia. Pre-senile dementia should only be recorded when specifically stated.~~

6. Neonatal diagnoses – effective July 1996

The Neonatal Subcommittee of the Paediatrics CCCG met in late 1995 and discussed a number of issues relating to coding of neonates.

The subcommittee also considered which congenital abnormalities should be coded for neonates. Further work is continuing on developing a list of conditions which should not be coded for neonates. We'll keep you informed.

The coding standards set out below relate to specific interventions for the ill neonate. These standards will provide a valuable body of data over the next two years which will assist in improving AN-DRG classification of neonatal conditions.

Gastric gavage

Gastric gavage feeding (**96.35 Gastric gavage**) should be assigned only when administered multiple (>1) times within an episode of care.

Note: this code should not be used for gastric lavage procedures.

Hypoxic ischaemic encephalopathy (HIE)

This clinical syndrome is the encephalopathic process which follows a significant perinatal hypoxic-ischaemic injury. The encephalopathy is graded clinically as:

- Grade 1 Hyperalertness, hyper-reflexia, dilated pupils, tachycardia but no seizures.
- Grade 2 Lethargy, miosis, bradycardia, depressed reflexes (e.g. Moro), hypotonia and seizures.
- Grade 3 Stupor, flaccidity, seizures, absent Moro and bulbar reflexes.

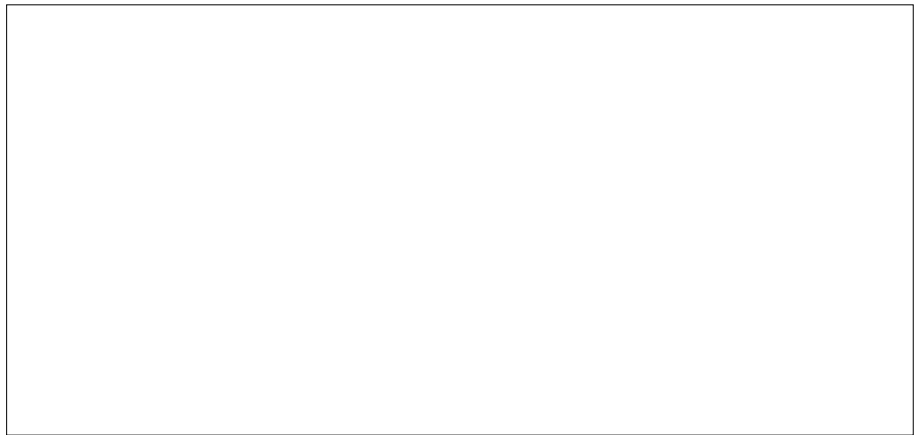
Coding

The ICD-9-CM index does not have an appropriate code assignment for HIE and leads to 767.0 Subdural and cerebral haemorrhage or 767.8 Other specified birth trauma, neither of which being appropriate for this syndrome. HIE should be coded as listed here. ►

Stroke – complicating additional diagnoses

Additional diagnosis	ICD-9-CM code/s
Urinary tract infection, site not specified	599.0
Pneumonitis	507.0
Pneumonia	480.0, 480.1, 480.2, 480.8, 480.9, 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.4, 482.81, 482.82, 482.83, 482.89, 482.9, 483.0, 483.8, 484.1, 484.3, 484.5, 484.6, 484.7, 484.8, 485, 486
Decubitus and lower limb ulcer	707.0, 707.1
Embolism and venous thrombosis	415.11, 415.19, 453.8
Dysphagia – only to be coded when requiring nasogastric tube/enteral feeding	787.2
Urinary incontinence – only to be coded when still present 7 days after admission date	788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.39
Faecal incontinence – only to be coded when still present 7 days after admission date	787.6
Urinary retention	788.20, 788.21, 788.29
Aphasia	784.3
Septicaemia	038.0, 038.1, 038.2, 038.3, 038.40, 038.41, 038.42, 038.43, 038.44, 038.49, 038.8, 038.9
Other bacterial diseases (e.g. gangrene)	040.0, 040.1, 040.2, 040.3, 040.81, 040.89, 041.00, 041.01, 041.02, 041.03, 041.04, 041.05, 041.09, 041.10, 041.11, 41.19, 041.2, 041.3, 041.4, 041.5, 041.6, 041.7, 041.81, 041.82, 041.83, 041.84, 041.85, 041.89, 041.9, 785.4

Jenny Peakall (Coding Manager, East Hertfordshire NHS Trust, UK) gave a sparkle to the NCC office when she visited in March. She is pictured (seated on the left) with NCC staff members Michelle Bramley and Janelle Craig.



The symptoms listed above should not be coded separately, except in the case of convulsions (Grade 3).

Grade 1 Code to 779.1 *Other and unspecified cerebral irritability in newborn*

+

767.8 *Other specified birth trauma*

Grade 2 Code to 779.0 *Convulsions in newborn*

+

767.8 *Other specified birth trauma*

Grade 3 Code to 779.2 *Cerebral depression, coma, and other abnormal cerebral signs*

+

779.0 *Convulsions in newborn*

+

767.8 *Other specified birth trauma*

Any co-existent severe birth asphyxia (768.5) should be coded if documented.

Maternal illness/incapacity to care

In cases where a neonate requires care due to maternal illness or “incapacity to care”, the appropriate code should only be assigned if the neonate is exclusively dependent on nursing care for more than 24 hours (consecutive).

Such cases would include “baby for adoption” (V68.89) or maternal death (761.6).

Oxygen therapy

Code 93.96 *Other oxygen enrichment* should be assigned only if the oxygen therapy (via cot, headbox, mask or cannula) was performed for more than four hours. Examples of diagnoses which may require oxygen therapy are “transient tachypnoea” (770.6) or “other respiratory problems after birth” (770.8).

Parenteral fluid therapy

Codes 99.15 *Parenteral infusion of nutritional substance* and 99.18 *Injection or infusion of*

electrolytes should be assigned when used for management of carbohydrate, hydration or electrolyte disorders. Examples of diagnoses that may require parenteral fluid therapy are “neonatal hypoglycaemia” (775.6) or “other transient neonatal electrolyte disturbances” (775.5).

Note: these codes should not be assigned when these procedures are part of resuscitation at birth.

Parenteral antibiotics/anti-infectives

Codes 99.21 *Injection of antibiotic* and 99.22 *Injection of other anti-infective* should be assigned only when given for >24 hours. Examples of diagnoses which may require such treatment are “perinatal infection” (771.8) or “observation for suspected infectious condition” (V29.0).

Phototherapy

Code 99.83 *Other phototherapy* should only be assigned when sustained phototherapy (>12 hours) is provided for the treatment of neonatal jaundice. Note that ACS 1601 requires that the diagnosis code for jaundice should only be assigned when phototherapy is given. Therefore, the jaundice diagnosis code should only be assigned when >12 hours of phototherapy is provided.

Transfusions

Codes 99.03 *Other transfusion of whole blood*, 99.04 *Transfusion of packed cells*, 99.07 *Transfusion of other serum* (including plasma or albumin), 99.08 *Transfusion of blood expander* (including dextran etc) should be coded when provided for the neonate. Examples of diagnoses which may require transfusion are “foetal blood loss” (772.0), “congenital anaemia” (776.5), “polycythaemia neonatorum” (776.4), “anaemia of prematurity” (776.6), “shock” (785.5x), “hypovolaemia” (276.5).

Note: these codes should not be assigned when these procedures are part of resuscitation at birth. ▶

7. Hyperbaric oxygenation

Thanks to Dr. Mike Bennett, Medical Director, Department of Diving and Hyperbaric Medicine, The Prince of Wales Hospital, Sydney for assisting the NCC in the preparation of coding standards for hyperbaric oxygenation. Following is an extract from the Prince of Wales Hospital's *Handbook of Diving and Hyperbaric Medicine*, February 1996:

"Hyperbaric oxygen (HBO) therapy involves the intermittent inhalation of 100% oxygen under pressures greater than one atmosphere. This treatment is carried out in a high pressure vessel called variously a hyperbaric chamber, recompression chamber or decompression chamber.

Hyperbaric therapy has long been accepted as the definitive treatment for decompression illness (DCI) and much of the terminology and traditional framework surrounding this form of therapy continues to reflect these historical origins. Re-pressurisation with air was first proposed by Paul Bert in 1873 as being the most appropriate treatment for workers suffering mysterious illnesses subsequent to work under hyperbaric conditions.

A variety of conditions respond well to hyperbaric therapy. They are: decompression illness, cerebral arterial gas embolism, carbon monoxide poisoning, Clostridial myonecrosis, osteoradionecrosis and chronic refractory osteomyelitis.

Other conditions for which there is increasing experimental and some clinical evidence of efficacy are: thermal burns, problem wounds (especially diabetic), other myonecroses (e.g. Fourniers gangrene), compromised flaps and grafts, cyanide poisoning, soft tissue radionecrosis, brain injuries and xerostomia."

Coding

There are three ICD-9-CM codes which, according to national morbidity data, have been variously used to describe hyperbaric oxygenation. The use of these codes is clarified as follows:

93.95 Hyperbaric oxygenation

This code should be assigned for all hyperbaric oxygenation. The exclusion note "oxygenation of wound (93.59)" relates only to those small number of cases where a plastic bag is used to enclose a wound and oxygen is pumped into the bag.

93.59 Other immobilisation, pressure, and attention to wound

This code should never be used for hyperbaric oxygenation unless the exclusion note under 93.95 applies.

93.97 Decompression chamber

This code should never be used as "decompression chamber" is synonymous with hyperbaric oxygenation (see explanatory notes above).

❖ **Kerry Innes**

New contact numbers for the National Coding Centre (NCC)

From **29 July 1996**

the NCC will have new phone and fax numbers and voice mail!

Phone: (02) 9351 9461

Fax: (02) 9351 9603

Our contact numbers have changed but we have not moved.

Our postal address remains

National Coding Centre PO Box 170 LIDCOMBE NSW 2141



Coding Guidelines '96

All 1996 changes are included in the NCC's *1996 Australian Version of ICD-9-CM* (2nd ed.) effective for separations on and from 1 July 1996 and can also be accessed as a separate document in the *Official 1996 Addendum* (effective 1 July 1996) which is available from your state/territory health authority.

Below are guidelines for 1996 changes which are not self-explanatory, do not have an associated coding standard in Volume 4 or warrant special attention. (Some of the following guidelines have been reproduced, with authorisation, from "Coding Notes" by Sue Prophet, *J. of AHIMA* Vol. 66, No. 10).

REMEMBER: reading your Addendum prior to implementation date is as vital as using your index, to ensure good coding quality

If you don't have an Addendum – get one now!!! Call your state/territory health authority

Diseases

Alcohol and drug use

Read standard 0503 ALCOHOL AND DRUG DEPENDENCE/USE DISORDER thoroughly as this is one of the most important changes to ICD-9-CM from 1 July 1996.

NB: Make the 1996 Errata change for this standard (page 19 this issue).

ACS 0503 has been expanded to encompass "harmful" use of drugs and alcohol as the members of the Mental Health CCCG identified a need to collect data on alcohol and drug consumption and its relationship with other conditions. The new standard details the definitions of "use disorder", "harmful use" and "dependence" which are consistent with ICD-10. Application of this standard now, will provide continuity with the changeover to ICD-10 where the concept of "harmful use" is also applied.

Tobacco use is treated slightly differently in that "use disorder" and "dependence" have always been classified to the one code 305.1, and this convention has not been altered. However, there is a new code for "current use of tobacco", V15.83 which should be assigned for all patients when it is documented that the patient has smoked any amount within the last month and is not diagnosed as tobacco "use disorder" or "dependence". Similarly, V15.82 History of tobacco use should be assigned when the documentation states that the patient has previously smoked tobacco within the last 5 years, but not within the last month.

It is important that coders apply the criteria strictly in order that meaningful information can be from the data collected over the next two years. Consistently coded data on drug and alcohol use will greatly assist in planning and provision of drug and alcohol services in Australia.

Blood/organ donation – V59.0x/V59.6, V59.7

New codes have been created to distinguish between encounter for donation of whole blood and stem cells. It is important to remember that these codes should not be used if the patient is donating whole blood or stem cells for her/himself. In the latter case, assign a code for the condition necessitating blood donation for multi-day stay patients, and V58.6 Apheresis if the episode is same day. New codes have also been created for liver donation (V59.6) and other organ donations (V59.7), the latter including multiple organ donation.

Note: a new code for procurement of heart for transplantation is now available – 37.51.

Change in bowel habit – 787.8

A new code has been created for this symptom which was previously coded to 787.9.

Complications of the nervous system – 997.0x

New codes have been created to distinguish nervous system complications (997.00) from central nervous system complications (997.01). Iatrogenic/postoperative cerebrovascular infarction or haemorrhage also has a new code, 997.02.

Congenital anomalies

New codes have been created in category 756.0 *Anomalies of skull and face bones* to provide more detail:

- 756.00 *Craniosynostosis*
- 756.01 *Craniofacial dysostosis*
- 756.02 *Hypertelorism*
- 756.03 *Macrocephaly*
- 756.08 *Other specified congenital malformations of skull and face bones*

Similarly, category 759.8 *Other specified anomalies* has been expanded to provide more detail: ►

759.84 *Congenital malformations with metabolic disturbances*

759.85 *Congenital malformations including limbs*

759.86 *Congenital malformation syndromes associated with short stature*

759.87 *Congenital malformation syndromes predominantly affecting facial appearance*

759.89 *Other*

Croup – 464.2x

The code for croup, 464.4 has been deleted. Croup is now classified to 464.2x *Acute laryngotracheitis*.

Cystic fibrosis – 277.0x

New codes have been created for cystic fibrosis with intestinal manifestations (277.01) and cystic fibrosis with pulmonary manifestations (277.02). Any other manifestations of cystic fibrosis should be assigned code 277.09 *Cystic fibrosis with other manifestations*.

Diarrhoea – 787.91

Since diarrhoea is not necessarily due to gastroenteritis, it has been reclassified to Chapter 16 Symptoms, Signs, and Ill-Defined Conditions.

Encounter for planned second/subsequent stage procedure – V58.83

Some procedures are staged and therefore, to reflect the second/subsequent stage of the procedure, V58.83 should be assigned as an additional diagnosis code on the episode of care where the second/subsequent procedure is performed. This code should never appear on the episode of care where the initial stage procedure is performed, nor as the principal diagnosis code. Limb lengthening is an example of such a staged procedure and is described in ACS 1351 LIMB LENGTHENING.

External cause codes

New codes have been created for:

Fall on or from footpath kerb	E880.1
Fall from chair	E884.2
Fall from tree	E884.3
Fall involving bed	E884.4
Fall from trampoline	E884.5
Fall involving wheelchair	E884.6
Fall involving commode	E884.7
Drowning and submersion while in swimming pool	E910.5
Drowning and submersion following fall into swimming pool	E910.6
Drowning and submersion following fall into natural water	E910.7

Maltreatment by spouse or partner E967.2

Maltreatment by acquaintance or friend E967.3

A new category for type of sporting activity E889.x should be used in conjunction with the principal E code for the type of injury. This category will not only provide valuable information about sporting injuries but will also provide continuity in the changeover to ICD-10 where this concept is included.

A new code has been created for accidents caused by hot tap water, E924.2.

Febrile convulsions – 780.31

A new code has been created for febrile convulsions, with 780.32 *Fit* being used for other convulsions or fits.

Fitting and adjustment of catheters – V56.1, V58.81 and V58.82

These codes are for use when identifying encounter for care (such as removal or cleaning) of dialysis or nonvascular catheters that are unrelated to a specific disease. The description of code V58.81 has been revised so this code includes any fitting or adjustment of a vascular catheter (not just removal). The fitting and adjustment codes should not be assigned for catheter complications, dialysis preparation, or dialysis encounters.

Hantavirus – 079.81

This organism has been identified as the causal agent in a type of respiratory distress syndrome.

Helicobacter pylori – 041.86

H. pylori, a gram-negative spiral bacterium, is thought to be the causal agent for most cases of chronic gastritis and peptic ulcer disease.

Iatrogenic hypotension – 458.2

Iatrogenic pulmonary embolism – 415.11

Intracranial injury – 850–854

NB: Make the Errata changes on page 17 before reading this item.

The fifth digit of “9” has been deleted from the list for these codes to bring the classification in line with the coding standard 1905 CLOSED HEAD INJURY/CONCUSSION. As concussion is defined as a head injury with loss of consciousness, codes 850.0 Concussion with no loss of consciousness and 850.5 Concussion with loss of consciousness of unspecified duration have been deleted. Therefore, all head injuries with concussion should be coded to 850–853 as follows:

1. No injury classifiable to 851–853 is present (assign 850) ▶

2. Cerebral laceration or contusion (assign 851)
3. Cerebral haemorrhage (assign a code from 852 or 853)

Category 854 *Intracranial injury of other and unspecified nature* should be used rarely and when used, should only have a fifth digit of “1” as any head injury with loss of consciousness (fifth digits of 2–6) is classified to 850–853.

Morbid obesity – 278.01

The risk of morbidity and certain comorbid conditions (such as congestive heart failure and uncontrolled diabetes mellitus) increases with the degree of obesity. To distinguish between the levels of obesity, a new code has been created for morbid obesity.

Necrotising fasciitis – 728.86

This condition has been referred to as “flesh-eating bacteria” by the media. It is a fulminating, bacterial infection that begins with severe or extensive cellulitis. This cellulitis spreads to the superficial and deep fascia. Thrombosis of the subcutaneous vessels and gangrene of the underlying tissues ultimately occur. The causal agent is commonly Group A *Streptococcus*. An additional code should be assigned to identify the responsible organism or any associated gangrene.

Postoperative hypertension – 997.91

A common query in the past has been in relation to coding of postoperative hypertension which now has a new code, 997.91. A standard on how to interpret the term “postoperative” is still in the development stage. It will be a valuable addition to coding standards as the decision to assign a condition to the “complications” section is a vital one in terms of quality of data and quality of care indicators.

Postpartum care and examination – V24.0x

New codes have been created to distinguish postpartum care following:

- a hospital birth (V24.01)
- a planned birth outside hospital (V24.02)
- an unplanned birth outside hospital (V24.03)

Post traumatic amnesia – 294.0x

New codes have been created to capture the duration of post traumatic amnesia:

<25 hours	294.01
>24 hours – <15 days	294.02
>14 days	294.03
NOS	294.08

Radiation proctitis – 569.43

A new code has been created for radiation proctitis which is much more common than radiation colitis due to the frequency of radiation for pelvic malignancy.

Retrolisthesis and spondylolisthesis – 738.4x

New codes have been created in this category to distinguish acquired retrolisthesis, 738.42 and acquired spondylolisthesis, 738.41.

Schizophrenia – 295

For codes 295.4, 295.5 and 295.6, only a fifth digit of “0” should be applied, as the other fifth digits are clinically meaningless with these conditions.

Secondary hypertension – 405

New codes have been created to distinguish hypertension caused by renal disorders (such as glomerulonephritis, polycystic kidney disease or nephropathy), and hypertension caused by renal artery disorders (usually renal artery stenosis). The new code structure is:

405	Secondary hypertension
405.0	Malignant
	405.01 Renovascular
New	405.02 Due to renal disorders
	405.09 Other
405.1	Benign
	405.11 Renovascular
New	405.12 Due to renal disorders
	405.19 Other
405.9	Unspecified
	405.91 Renovascular
New	405.92 Due to renal disorders
	405.99 Other

The specific condition causing the hypertension should be coded and sequenced after the appropriate 405.xx code.

Secondary Parkinsonism – 332.1x

New codes have been created to describe various types of secondary Parkinsonism:

Drug-induced	332.11
Secondary to other external agents	332.12
Postencephalitic	332.13
Other secondary Parkinsonism	332.18
Secondary Parkinsonism, unspecified	332.19

Pathological fracture of tooth – 525.4

This new code has been created for tooth fractures which are not traumatic.

Ulcerative oesophagitis – 530.11

A new code was considered for this condition which is often a source of queries from coders. However, there are considerable difficulties surrounding the terms used to describe oesophagitis which precluded creation of a new code. For example, doctors use the “generic” term reflux oesophagitis to describe cases where ulceration is present but also when ulceration is not present. As most oesophagitis is caused by reflux of peptic juices and acid, it was decided that 530.11 Reflux oesophagitis was the best solution. As mentioned in ACS 1121, the code for ulceration of oesophagus, 530.2 should not be assigned for ulcerative oesophagitis.

Vertebrobasilar artery syndrome – 435.3

A new code has been created for this syndrome which involves both the vertebral and basilar arteries. Note that when the syndrome involves only one of these arteries (vertebral or basilar) these are coded to 435.1 and 435.0 respectively.

Vibrio vulnificus – 005.81

This bacteria can be isolated from seawater, zooplankton and shellfish from the Gulf of Mexico and along both coasts of the United States of America. It can manifest as a septicaemia after ingestion of raw shellfish, particularly oysters or as a wound infection (progressing to cellulitis, fasciitis, or myositis) after exposure to seawater or after cleaning shellfish.

Procedures**Breast reconstruction – 85.7x**

New codes have been created for breast reconstruction when performed post mastectomy. The category 85.7 Reconstruction of breast includes:

- 85.71 *Pedicle flap to breast, post mastectomy*
- 85.72 *Myocutaneous flap to breast, post mastectomy*
- 85.73 *Unilateral breast implant, post mastectomy*
- 85.74 *Bilateral breast implant, post mastectomy*
- 85.75 *Total reconstruction of breast, post mastectomy*
- 85.79 *Other total reconstruction of breast*

Browplasty – 86.87

This procedure is classified under the new code 86.87 *Forehead rhytidectomy*.

Lasers in gastrointestinal procedures

New codes have been created for some laser procedures in the gastrointestinal system:

- 42.34 *Endoscopic laser therapy of oesophagus*
- 44.45 *Endoscopic laser therapy of stomach and duodenum*
- 45.44 *Endoscopic laser therapy of colon and rectum*

Lasers in ophthalmology

Laser procedures feature in the new codes for ophthalmology. Some are:

- 11.33 *Treatment of pterygium by laser*
- 11.44 *Removal or destruction of corneal lesion by laser*
- 12.10 *Iridotomy by laser*
- 12.36 *Iridoplasty and coreoplasty by laser*
- 12.56 *Trabeculoplasty by laser*
- 12.80 *Treatment of lesion of sclera by laser*
- 12.94 *Intracameral laser lysis*

Lung volume reduction surgery – 32.22

This procedure is performed for selected patients with chronic obstructive pulmonary disease or emphysema. Twenty to thirty percent of the volume of each lung is excised. Reducing the size of the patient’s lungs gives the patient more room to breathe. In emphysema, the air sacs in the lungs become unnaturally enlarged, the lung tissue loses elasticity, and the lungs are unable to expand and contract normally.

Gynaecological procedures

Some common, but hard to code, procedures now have new codes:

- 67.13 *Colposcopy*
- 67.34 *Destruction of lesion of cervix by laser*
- 68.23 *Endoscopic endometrial ablation*
- 70.41 *Vaginectomy*
- 70.42 *Radical vaginectomy*
- 71.31 *Destruction of lesion of vulva by laser*
- 71.39 *Other local excision or destruction of lesion of vulva and perineum*

Management of ectopic pregnancy

Some new procedure codes have been created to describe the different management techniques for ectopic pregnancy:

- 66.90 *Foetotoxic management for removal of ectopic pregnancy of any site*

Note: this procedure code includes management of ectopic pregnancy by chemotherapy.

- 66.98 *Manual/hydrostatic expression of fallopian tube*

Nephrectomy

A new code has been created to distinguish between a nephrectomy (new code 55.50) and a ▶

nephroureterectomy (55.51). Note that this new code makes the old standard ACS 1413 NEPHRECTOMY AND NEPHROURETERECTOMY redundant.

New IVF procedures – 69.8x

- 69.81 *Transvaginal oocyte recovery*
- 69.82 *Transabdominal oocyte recovery*
- 69.83 *Gamete intrafallopian transfer (GIFT)*
- 69.84 *Fresh, frozen/thawed embryo transfer to uterus*
- 69.85 *Fresh, frozen/thawed embryo transfer to fallopian tube*
- 69.89 *Other and unspecified reproductive medicine procedures*

Obstetrical procedures

Existing breech delivery codes have been renamed to facilitate easier coding:

- 72.51 *Assisted breech delivery with forceps to aftercoming head*
- 72.52 *Other assisted breech delivery*
- 72.53 *Breech extraction with forceps to aftercoming head*
- 72.54 *Other breech extraction*

The classical (74.0x) and lower segment (74.1x) caesarean codes have been expanded to indicate “elective” and “emergency”. Refer to ACS 1541 (Volume 4, page 133) for detailed definitions.

Osseointegrated implant procedures

Two new codes have been created to describe:

Intraoral osseointegrated implants	23.61
Extraoral osseointegrated implants	02.97

Details of these procedures can be found in ACS 0809 (Volume 4, page 83) and 1350 (Volume 4, page 115).

Procurement of stem cells

A new code has been created for “procurement of stem cells with cryopreservation” – 99.75.

Prostatectomy

The techniques involved in prostatectomy are varied and consequently a number of new codes have been created to describe these techniques:

- 60.22 *Laser assisted prostatectomy*
- 60.23 *Transurethral needle ablation of prostate (TUNA)*
- 60.24 *Transurethral electrical vaporisation of prostate*

- 60.63 *Cryoablation of prostate*
- 60.64 *Microwave thermotherapy of prostate*
- 60.65 *High intensity focused ultrasound (HIFUS) (transrectal) of prostate*

Other prostate procedures

- 60.96 *Insertion of prostatic stent/coil*
- 97.66 *Removal of prostatic stent/coil*

Second look laparotomy

This new code (54.13) would be used in cases of malignancy where a second laparotomy is required after the initial surgery to stage the malignancy.

Spinal fusion

A new code 81.3 has been created for “segmental implant for spinal fusion”. This code should never be assigned alone. It should be used as an additional code to the spinal fusion code, 81.0x, to indicate the use of a segmental implant. See ACS 1348 (Volume 4, page 114) for details about different types of spinal fusion.

Stereotactic radiosurgery – 92.3.

See ACS 0629 (Volume 4, page 73) for details about this procedure.

Stress incontinence procedures

- 59.72 *Injection of paraurethral bulk*
- 59.73 *Transvaginal needle suspension*

Surgical removal of tooth – 23.1x

From July 1996, coders will need to assign a different code if more than one tooth is removed:

- 23.12 *Surgical extraction of one tooth*
- 23.13 *Surgical extraction of two or more teeth*

Temporal artery biopsy – 38.23

This procedure was previously coded to 38.21 *Biopsy of blood vessel* but now has a new code, 38.23 *Temporal artery biopsy*.

Therapeutic venesection – 38.96

The above list of new codes is not exhaustive and coders should check the new *Australian Coding Standards* and the *1996 Addendum* before beginning to code with the new coding books. Don't forget to look at the index changes in the Addendum, not just the tabular list. A code change in the index may not appear in the tabular and if not applied, can have disastrous effects on coding quality.

**DON'T BE AN
OFFENDER**

**CHECK YOUR
ADDENDA!**

CLINICAL UPDATE

1. Diabetic Foot (ACS 0401)

The following extract from the *Oxford Textbook of Medicine* (3rd ed., Volume 2, New York, 1996, page 1490) will assist coders in further understanding this condition:

“Different types of diabetic tissue damage interact and combine in the feet, giving a wide variety of lesions ranging from relatively harmless dysaesthesiae to fulminating infections and widespread ulceration. Ulcers or ischaemic or dead tissue can develop in the absence of appreciable neuropathy, but never without some circulatory disturbance. However, this may be slight, with neuropathy the main cause of the lesion. Reduction in blood flow may be the consequence of macro- or microangiopathy. There may also be a contribution from autonomic neuropathy which, when combined with microangiopathy, results in a disturbed pattern of blood flow. Collagen change is one cause of the hammer-toe type of deformity that is so common among diabetics, with hyperextension at the metacarpophalangeal joints. This causes excessive pressure on the skin beneath the metacarpal heads and excessive flexion at the first interphalangeal joints, so that shoes put undue pressure on the dorsal aspect. Finally, the leucocytes of hyperglycaemic patients have reduced anti-infective activity.

Infections of painless traumatic abrasions of neuropathic feet have the best prognosis. They occur particularly after trauma to the sole, which becomes progressively infected to an extent that would be impossible if there were normal sensation. The poor eyesight of elderly diabetics exacerbates this problem. The spreading infection may cause acute local vascular damage as a result of endarteritis obliterans, which leads to cell death and faster spread of the infection, resulting in wet gangrene. This contrasts with the dry gangrene that occurs with ischaemia of uninfected tissue, although such dead tissue may be secondarily infected to produce a common wet state.”

2. Human Immunodeficiency Virus

The *Medical Journal of Australia* (MJA) is currently running a series on “Managing Human Immunodeficiency Virus (HIV)” which is particularly valuable reading in relation to the coding of acute infection syndrome (featured in *Coding Matters*, Vol. 2, No. 3). The series began in the MJA, Vol 164, No. 2 (January 1996).

❖ **Kerry Innes**



Update

Readers of *Coding Matters* will be aware that in recent months the CCSA Establishment Committee has undertaken a number of significant activities to help action the development of the Society. Most recently, the CCSA's Constitution has been finalised and, together with the application for registration, has been submitted to the Australian Securities Commission to facilitate the process of incorporation.

As the legal formalities of establishing the Society have now been undertaken, we are able to progress to membership recruitment. You will shortly be receiving a membership form for the CCSA. If you are interested in joining the Society, you should complete this form and return it, together with payment, to the HIMAA Office. Remember, membership of the Society is open to all clinical coders, health information managers and those with an interest in coding. Membership fees are tax deductible.

So where do we go from here? Most members of the Establishment Committee have agreed to continue on and form the first (interim) Board of the CCSA. The interim Board will continue the work of the CCSA until the first Annual General Meeting and elections, anticipated to be held in November 1996. During these early months, the Board will undertake to:

- conduct a strategic planning day (aimed at determining the future direction of the CCSA in the upcoming twelve months)
- form special interest groups to address key issues
- establish a national education program
- publish a newsletter.

If you would like more information on the CCSA or about becoming a member, please contact:

- ♦ your state/territory representative on the CCSA,
- ♦ Anne Irwin, HIMAA Executive Officer on ph: (02) 887 5001 or
- ♦ Janelle Craig, Chair CCSA Establishment Committee on ph: (02) 646 6345 or email: j.craig@cchs.su.edu.au

“MANIFESTATIONS” OF THE DATA

A recent look at national coded data for the year 93/94, provided by the Department of Health & Family Services (DHFS), has revealed some errors in code assignment in relation to manifestation codes (those codes that play second fiddle to the aetiology codes). You'll be pleased to know that we can't tell which coder/s is assigning manifestation codes as the principal diagnosis (HORROR !!!!!) but YOU know who you are, so remember:

Any code in italics (i.e. a manifestation code) must *never* be the principal diagnosis as these codes are sequenced second to the aetiology code (non italicised).

The most common manifestation codes incorrectly used as principal diagnosis in 93/94 were:

Wrong principal Dx	Right principal Dx
366.41 <i>Diabetic cataract</i>	250.5x <i>Diabetes with ophthalmic complications</i>
443.81 <i>Peripheral angiopathy in diseases classified elsewhere</i>	250.7x <i>Diabetes with peripheral circulatory disorders</i>
456.2x <i>Oesophageal varices in diseases classified elsewhere</i>	Aetiology codes such as: 571.x <i>Chronic liver disease and cirrhosis</i> 572.3 <i>Portal hypertension</i>
583.81 <i>Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere</i>	Aetiology codes such as: 277.3x <i>Amyloidosis</i> 250.4x <i>Diabetes with renal manifestations</i> 098.19 <i>Gonococcal infection, other</i> 446.21 <i>Goodpasture's syndrome</i> 710.0 <i>Systemic lupus erythematosus</i> 016.0x <i>Renal tuberculosis</i>
590.81 <i>Pyelitis or pyelonephritis in diseases classified elsewhere</i>	Aetiology codes such as: 016.0x <i>Renal tuberculosis</i>

CODING REFRESHER

So you've been coding for years, can assign at least 30 codes from memory and only open the index when you can't find the code you need in Volume 1 –

BAD
BAD
BAD

The index is absolutely critical to correct code assignment.

Being July 1996, it is time you opened your brand new index and LOOKED INSIDE IT. The 1996 Addendum will alert you to changes in the index, particularly for codes you commonly use. Here's just a few of the common codes you probably have committed to memory which are now very wrong:

- ✧ Been using two codes for *Postoperative pulmonary embolism*? – you can now **BREATHE EASY** – it has its own code – **415.11**

- ✧ **Vertebrobasilar artery syndrome** – NOT TWO CODES, BUT ONE **435.3!!**
- ✧ Don't go assigning 464.4 for **CROUP** anymore – its gone to live at **464.2x**
- ✧ Get **ORGAN**ised with the new **V59.x** codes for **donors**
- ✧ There are codes falling from the **CHAIRS, BEDS, TRAMPOLINES AND WHEELCHAIRS** – **E884.x**
- ✧ Extract 23.19 from your memory and start pulling out the **number of teeth** from that record – **ONE for 23.12, >TWO for 23.13**
- ✧ **Dilate your vessels** with these **stentsational** codes: **39.90, 36.06, 36.07 and 38.20**
- ✧ Don't be one of the 'colprits' using 70.21 instead of **67.13** for **Colposcopy**
- ✧ **74.1x, 74.0x** When in Rome do as the Romans do and give that **caesarean section** **FOUR DIGITS**



PUBLICATION ISSUES

The new 1996 Australian Version of ICD-9-CM coding books have now been distributed throughout Australia and New Zealand. The feedback to date on the new improved second edition has been marvellous. As of July 1996, the NCC softcover books should replace your 1995 books for coding purposes. Make sure you also add to your books the "Errata 1996" changes included in this issue of *Coding Matters*. We hope you continue to enjoy using the 1996 edition until the introduction of ICD-10 in July 1998. To order your books, call (02) 646 6461.

Here is your opportunity to have a say on the format of the **1998 Australian modification of ICD-10 (ICD-10-AM)**. Do you have any helpful format suggestions for this new classification due for release in July 1998? Provide us with your input on this issue!

Write to: Publications Manager, National Coding Centre, PO Box 170, LIDCOMBE NSW 2141.

❖ **Karen Luxford**

Looking to advertise for new coding or HIM staff? How can you reach all Australian coders to ensure you get the best staff for the position? Consider advertising in *Coding Matters*! Subject to space availability, advertising deadlines for 96/97 are: Sept. 20 (mid-October '96 issue); Dec. 14 (mid-January '97 issue); March 21 (mid-April '97 issue); June 20 (mid-July '97 issue). Call Karen Luxford on ph: (02) 646 6478 for information on advertising rates.

Sue Walker (Director, NRCCH) and Janelle Craig (NCC Education Manager) pictured here at the IFHRO Congress in Munich.

SPECIALTY BOOKLETS

As we go to press, the first three NCC specialty booklets on **Casemix, DRGs and Clinical Coding** near completion. The NCC anticipates that these booklets will be available in **late July/early August 1996**. The first three booklets cover the specialty areas of:

- ★ **respiratory medicine & thoracic surgery**
- ★ **oncology & haematology**
- ★ **geriatric medicine and rehabilitation.**

Each booklet contains general information on casemix-based funding and AN-DRGs, and specialty-specific information on important AN-DRGs, clinical documentation and coding. These new booklets are an essential publication for those wishing to know more about casemix and clinical coding for a particular clinical specialty. A valuable educational tool – ideal for clinicians, interns, coders and health information managers. Only **\$10** per booklet. Don't miss out – call now on **ph: (02) 646 6461** to obtain an order form.

NATIONAL CODING CENTRE

ERRATA 1996

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

The following corrections need to be made to the *1996 Australian Version of ICD-9-CM*.
[An “Addendum only” note means that this change has already been done in the
1996 Australian Version of ICD-9-CM books].

Volume 1 – Tabular List of Diseases

Page			
9	Amend	041.01 Group A Streptococcus pyogenes	
89		330.4 Mitochondrial cytopathy Code also the manifestation: Amend generalised <u>convulsive</u> epilepsy (345.1)	
96	Amend	354.4 Causalgia of upper limb	
126	Amend	411 Other acute and subacute forms...	
207		710.18 Other forms of systemic sclerosis Includes: similar clinical..... Delete Use additional code to identify systemic sclerosis with: lung involvement (517.8) myopathy (359.6)	
215	Amend	727.3 Other bursitis <u>Bursitis</u> NOS	
234	Amend	755.26 Longitudinal deficiency, radial, complete or partial... Agenesis of <u>radius</u>	
	Amend ☆☆☆	759.84 Congenital malformations with metabolism disturbances (Addendum only)	
272		INTRACRANIAL INJURY, EXCLUDING THOSE WITH SKULL FRACTURE (850-854) Amend The following fifth-digit subclassification is for use with categories 851- <u>854</u> :	
273	Add c/c §	854.0 Without mention of open intracranial wound	
	Add c/c §	854.1 With open intracranial wound	
315		V23.6 Duration of pregnancy Add Note: This category is intended for the coding of the duration of pregnancy on the mother's record in cases of abortion (threatened) and threatened premature labour (630-637, 640.0, 644.0, <u>658.1, 658.2, 658.5</u>)	
317		V28.6 Screening for decreased foetal movements Excludes: that with delivery, no underlying cause (656.81, 656.83) Amend	

<u>Page</u>		Volume 1 Continued
325		V67.51 Following completed treatment with.....
	Delete	<i>Excludes: long-term (current) drug-use (V58.61-V58.69)</i>
		E889.3 Hockey
		Field hockey
	Add (Addendum only)	<i>Excludes: ice hockey (E889.9)</i>
349		E884.9 Other fall from one level to another
		Fall from: Fall from:
		embankment stationary vehicle
	Delete	haystack tree
401	Amend	Cerebrovascular heart disease (430-438)
Volume 2 – Alphabetic Index of Diseases		
13	Amend	Acrosclerosis (<i>see also</i> Scleroderma) 710.1 <u>8</u>
56		Blood
		- donor...
	Amend	- - other products, NEC <u>V59.09</u>
		- transfusion
		- - donor...
		- - - other products, NEC <u>V59.09</u>
121		Dermatosis 709.9
	Amend	- neurophilic, acute febrile 695. <u>2</u>
398		Seborrhoea, seborrhoeic 706.3
	Amend	- eczema 690.1 <u>8</u>
415	Amend	Sweet's syndrome (...) 695. <u>2</u>
436		Thrombosis,...
		- mesenteric....557.0
	Amend	- vein (inferior) (superior) <u>557.0</u>
Volume 3 – Index of Procedures		
pi-13		Capsulotomy
	Amend	- lens 13.6 <u>3</u>
pi-44		Graft, grafting
		- skin....
		- - pedicle....
		- - - breast 85.84
	Amend	- - - - transverse rectus abdominis <u>myocutaneous</u> (TRAM) 85.7 <u>2</u>
pi-51		Infusion (...)
		- thrombolytic agent....
		- - with percutaneous transluminal angioplasty
	Amend	- - - non coronary vessel(s) 39.5 <u>9</u>
pi-95		Removal
		- uterine septum 68.22
	Delete	--- hysteroscopic 69.11
pi-105		Section
		- tooth...
	Amend	- - multiple teeth 23.1 <u>3</u>
pi-114	Amend	TRAM (transverse rectus abdominis <u>myocutaneous</u>) flap of breast 85.7 <u>2</u>

Page	Volume 4 – Australian Coding Standards	
25	0032	ALLIED HEALTH
		Allied health interventions for dietitians, social workers, occupational therapists and physiotherapists should only be coded when documented by allied health staff.
	Add	<u>Note:</u> not all interventions for the professions listed are included as new codes. As the interventions had to be “grafted” into the existing ICD-9-CM structure, it was not possible to include all interventions. For example, cardiorespiratory intervention in physiotherapy does not have a separate code as some components of this intervention are coded elsewhere in ICD-9-CM (postural drainage, 93.99, cardiac retraining, 93.36). Similarly, psychosocial skills and environmental adaption interventions in occupational therapy are also not included due to unavailability of codes in ICD-9-CM.
		Definitions for allied health intervention codes are as follows:
30		9. Education (93.30) Assign code 93.30 <i>Physical therapy education</i> .
	Add	10. <u>Cardiorespiratory intervention - physiotherapy</u> The following components of cardiorespiratory intervention should be coded as follows:
		<u>Airway care</u> 96.55
		<u>Breathing exercise</u> 93.18
		<u>Postural drainage/positioning</u> 93.99
		<u>Positive pressure:</u>
		CPAP 93.90
		IPPB 93.91
		PEP 93.99
		<u>Sputum mobilisation</u> not codable
		<u>Sputum clearance</u> not codable
		<u>Suction</u> not codable
		<u>Cardiorespiratory rehabilitation</u> 93.99
		[Please note: the note on the top of page 30 applies to point 2 on the previous page <u>only</u> .]
	0401	DIABETES MELLITUS
56		Diabetic foot
		When “diabetic foot” is documented in the clinical record, assign the following codes:
		250.8x <i>Diabetes with other specified complications</i>
		+
		250.7x <i>Diabetes with peripheral circulatory disorders</i>
		and/or
		250.6x <i>Diabetes with neurological complications</i>
	Add	
62	0503	ALCOHOL AND DRUG DEPENDENCE/USE DISORDER
63		Guidelines for coding “Use of alcohol”
	Revise	V15.84 <i>Harmful use of alcohol</i> is intended for use when there is documentation of “harmful use” of alcohol as distinct from “use disorder” (305) and “dependence” (303). V15.84 should be assigned with diagnoses from within the Mental Disorders chapter of ICD-9-CM (excluding <u>codes 303 and 305</u>), and also with
	Delete	Similarly, a patient admitted in a state of acute alcoholic intoxication with an additional diagnosis of “harmful use of alcohol” should have 305.x <i>Alcohol use disorder</i> assigned as the principal diagnosis and an additional code of V15.84 <i>Harmful use of alcohol</i> .
64	0504	DEMENTIA
	Delete	“Senile and Pre-Senile Dementia” “Dementia NOS” should be coded to senile dementia unless specified as pre-senile dementia. Pre-senile dementia should only be recorded when specifically stated.
		Arteriosclerotic Dementia The term vascular dementia is equivalent to arteriosclerotic dementia. If in doubt about the diagnosis, consult with clinicians.

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84	0807	FUNCTIONAL ENDOSCOPIC SINUS SURGERY (FESS)
		22.2 <i>Intranasal antrotomy</i> (includes the formation of an antral meatal window)
		22.63 <i>Ethmoidectomy</i>
		22.42 <i>Frontal sinusectomy</i>
		22.64 <i>Sphenoidectomy</i>
		22.11 <i>Closed [endoscopic] [needle] biopsy of nasal sinus</i>
Add		22.19 <i>Other diagnostic procedures on nasal sinuses</i>
88	0935	CARDIOMYOPLASTY
Revise		Cardiomyoplasty is a relatively.....heart muscle. A <u>cardiomyoplasty</u> , usually implanted into the anterior abdominal wall, is attached to the heart and the latissimus dorsi muscle, which causes the muscle wrap to contract in time with the heart.
		Code as:
		37.99 <i>Other operations on heart and pericardium</i>
		83.77 <i>Muscle transfer or transplantation</i>
Add		39.50 <i>Microvascular tissue transfer</i>
Delete		Code also the insertion of pacemaker (37.8x) and pacemaker leads (37.7x)
Add		<u>An additional code of 37.94 <i>Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]</i> should be assigned when a cardiomyostimulator is performed in addition to those above.</u>
121	Revise whole standard as below:	
	1408	HUMAN PAPILLOMA VIRUS (HPV)
		There are over 50 identified types of HPV. Human papilloma viruses selectively infect the epithelium of skin or mucous membranes. These infections may:
		* be asymptomatic
		* produce warts
		* be associated with a variety of both benign and malignant neoplasms.
		Clinical manifestations of HPV infections depend upon both the location of the lesions and the virus type. Skin lesions may be common warts (<i>verrucae vulgaris</i>), flat warts (<i>verrucae plana</i>), anogenital warts (<i>condylomata acuminata</i>), or Bowenoid papulosis (flat, macular lesions). Mucosal lesions may have the appearance of common warts in the oral cavity, or may be non-warty lesions such as focal epithelial hyperplasia (small, slightly elevated pink or white papules).
		The occurrence of certain types of HPV are associated with cervical dysplasia and carcinoma of the cervix, as well as other genital tract malignancies (penile, vulvar and anal carcinomas).
		The following coding standard applies from July 1996:
		1. HPV associated with conditions other than warts
		If HPV is documented as being associated with a condition, other than warts , assign a code for the condition as the principal diagnosis with 079.4 <i>Human papilloma virus</i> as an additional diagnosis.
		EXAMPLE:
		Cervical biopsy and diathermy performed with pathology result of “dysplasia with HPV effect”.
		PDx: 622.1 <i>Dysplasia of cervix (uteri)</i>
		SDx: 079.4 <i>Human papilloma virus</i>
		PP: 67.32 <i>Destruction of lesion of cervix by cautery or diathermy</i>
		2. HPV associated with warts
		Assign 078.1x <i>Viral warts</i> alone when coding warts other than anogenital . Anogenital sites are coded with a principal diagnosis from the list below with an additional diagnosis code of 078.19 <i>Other specified viral warts</i> :
		Perianal 569.49 <i>Other specified disorders of rectum & anus</i>
		Cervical 622.8 <i>Other specified noninflammatory disorders of cervix</i>
		Vaginal 623.8 <i>Other specified noninflammatory disorders of vagina</i>
		Vulval 624.8 <i>Other specified noninflammatory disorders of vulva and perineum</i>
		Penile 607.89 <i>Other specified disorders of penis</i>

<u>Page</u>	Volume 4 Continued	
119	Delete	standard
	1412	REMOVAL OF TENCKHOFF CATHETER
126	1505	SINGLE SPONTANEOUS VAGINAL DELIVERY
		The only procedures which can be reported in combination with a principal diagnosis code of 650 are:
	Revise	03.91 <i>Injection of anaesthetic into spinal canal for analgesia</i>
	Revise	<u>66.2</u> <i>Other bilateral endoscopic destruction or occlusion of fallopian tubes</i>
	Revise	<u>66.3</u> <i>Other bilateral destruction or occlusion of fallopian tubes</i>
130	1531	PREMATURE RUPTURE OF MEMBRANES
	Revise	Note: A additional code from the V23.6 category should be used as an additional diagnosis with codes 658.1, 658.2 and 658.5 to indicate gestational age <u>less than 37 weeks</u> .
136	1607	NEWBORNS
		EXAMPLE
		Newborn, transferred from hospital A ...
		Hospital A codes: 769 <i>Respiratory distress syndrome</i>
		770.2 <i>Interstitial emphysema and related conditions</i>
		V30.01 <i>Single liveborn, born in hospital, delivered by caesarean section</i>
		74.11 <i>Elective low segment caesarean section</i>
	Delete	



AUSTRALIAN CODING STANDARDS - WHAT'S NEW AND WHAT'S CHANGED FOR JULY 1996

Those of you who attended the Australian Coding Standards (ACS) Workshops during May and June this year will know that there are a number of new standards effective from 1 July 1996, not all of which could be discussed in the one day dedicated to the workshops.

Some standards have been modified, and special attention should be given to these when you purchase your second edition of the ACS (i.e. Volume 4, Australian Version of ICD-9-CM).

Listed here for your information are the existing standards which have been modified as well as the completely new standards:

Significantly modified standards

* = revised ACS discussed during the workshops.

- 0001 *Principal diagnosis**
- 0012 *Suspected conditions**
- 0016 *General*
- 0020 *Multiple/bilateral procedures*
- 0207 *Complications associated with neoplasms*
- 0214 *Intragam*
- 0218 *Lymphangitis carcinomatosis*
- 0225 *Prostatic intraepithelial neoplasia (PIN)*
- 0401 *Diabetes mellitus**
- 0501 *Schizophrenia**
- 0502 *Clozapine monitoring*
- 0503 *Alcohol and drug dependence/use disorder*
- 0708 *Yag laser (now Laser Procedures)*
- 0803 *Admission for removal of grommets*
- 1111 *Mesenteric adenitis with appendicectomy*

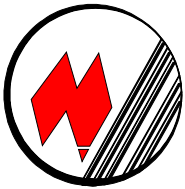
1120 Gastroenteritis
 1204 Elective plastic surgery*
 1210 Cellulitis*
 1321 Osteoarthritis of the spine with disc degeneration
 1309 Dislocation of hip prosthesis*
 1402 In vitro fertilisation (IVF)*
 1407 Diabetic nephropathy
 1408 Human papilloma virus (HPV)*
 1424 (Revision of) arteriovenous (AV) fistula (AV grafts)
 1427 Hydrocele
 1511 Termination of pregnancy
 1513 Induction
 1518 Duration of pregnancy*
 1531 Premature rupture of membranes
 1908 Laceration with nerve damage
 1909 Child abuse*
 2003 Place of occurrence
 2103 Admission for convalescence/aftercare

New standards, effective 1 July 1996:

0026 Admission for clinical/drug trial
 0027 Multiple coding
 0028 Para-aortic lymph node biopsy
 0029 Coding of contracted procedures
 0030 Organ procurement and transplantation
 0031 General anaesthesia
 0032 Allied health
 0241 Malignancy of lip
 0242 Disseminated carcinomatosis
 0243 Admission for stem cell or bone marrow procurement
 0301 Autologous haematopoietic stem cell transplant
 0403 Hyperglycaemia
 0526 Munchausen's by proxy
 0527 Attention deficit disorder
 0528 Alzheimer's disease
 0622 Epilepsy
 0623 Lennox-Gastaut syndrome
 0624 Autonomic dysreflexia
 0625 Quadriplegia and paraplegia
 0626 Chiari malformation
 0627 Mitochondrial cytopathy
 0628 Neuroleptic malignant syndrome (NMS) and neurologic neglect
 0629 Stereotactic radiosurgery
 0630 Quadriplegic hand surgery
 0631 Benign shuddering attacks
 0731 Corneal graft rejection or failure
 0732 Postoperative hyphaema
 0733 Haemodilution
 0734 Jensen's procedure
 0735 Carlson-Jampolsky procedure

0736 Simmond's shell
 0737 Optic nerve sheath decompression
 0738 Membrane peeling
 0739 Scleral buckling
 0740 Trabeculectomy
 0807 Functional endoscopic sinus surgery (FESS)
 0808 Concha bullosa
 0809 Intraoral osseointegrated implants
 0934 Cardiac revision procedure
 0935 Cardiomyoplasty
 0936 Pacemakers
 0937 Stenting of vessels
 0938 Extracorporeal membrane oxygenation (ECMO)
 1008 Chronic airway limitation (CAL)
 1009 Pulmonary embolus
 1124 Healed gastric ulcer
 1215 Grafts and flaps
 1343 Erosion of knee
 1344 Postlaminectomy syndrome
 1345 Rotator cuff syndrome
 1346 Patello-femoral compression syndrome
 1347 Laminectomy
 1348 Spinal fusion
 1349 Repair of subluxation and dislocation of patella
 1350 Extraoral osseointegrated implants
 1351 Limb lengthening
 1429 Loin pain/haematuria syndrome
 1430 Chronic renal impairment
 1431 Examination under anaesthesia, gynaecology
 1432 Vaginoscopy and colposcopy
 1433 Bladder retraining
 1536 Foetal reduction
 1537 Decreased foetal movements
 1538 Post natal attachment difficulties
 1539 Suppressed lactation
 1540 Obstructed labour
 1541 Elective and emergency caesarean
 1542 Breech delivery and extraction
 1543 Manual removal of placenta
 1611 Category V29, Observation and evaluation of newborn and infants for suspected condition not found
 1612 Chronic bronchitis
 1613 Massive aspiration syndrome
 1614 Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency
 1806 Falls
 1914 Degloving injury
 2110 Amputation status





1996 NCC Annual Seminar

Invitation to attend

We invite you to attend our third annual seminar to be held at the Hyatt Regency, Coolumb, Queensland on the **21 – 22 November 1996**.

Call for papers

Abstracts from clinical coders, health information managers and readers of *Coding Matters*, which address the theme “*Partnerships in Coding*” are most welcome. Authors may wish to focus their paper on:

- ⚙ clinical partnerships (whether these be between coders and clinicians or coders and other health professionals)
- ⚙ partnerships with other organisations (relating to coding or the use of coded data)
- ⚙ partnerships with the Commonwealth (for example, the development of classification systems, grouper technology, encoding software or other initiatives relating to coding)
- ⚙ international partnerships in coding.

Papers will be selected on their relevance to the seminar topic and their written clarity. Guidelines for those wishing to submit an abstract are as follows:

- ❶ Please provide two copies of a typed abstract of the paper (maximum of 500 words).
- ❷ The abstract should include the title of the paper, the author’s name/presenter’s name, title, position and organisation with address and telephone/facsimile numbers.
- ❸ More than one abstract may be submitted.
- ❹ Abstracts should be submitted to:

Coding Education Manager, National Coding Centre,

PO Box 170, LIDCOMBE NSW 2141

by 27 September 1996

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 Centre.

For further information please contact the address above or:

ph: (02) 646 6345

fax: (02) 646 6603

e mail: j.craig@cchs.su.edu.au

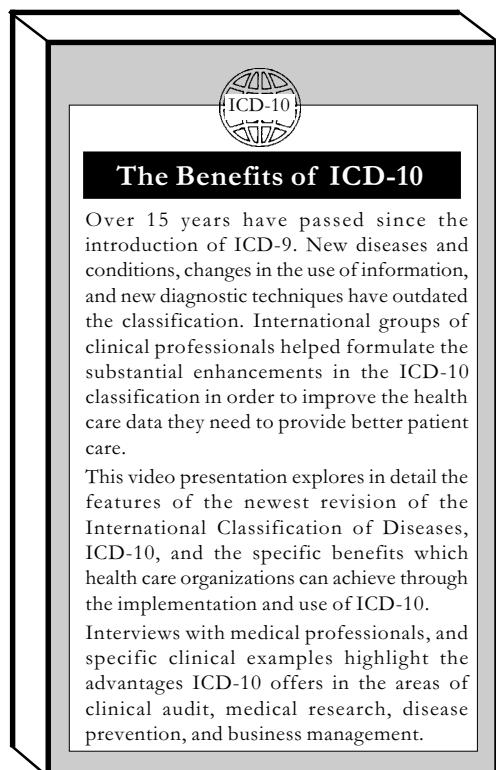
(NB: Remember new contact numbers apply for the NCC from 29 July 1996,

with (02) 646 6345 becoming (02) 9351 9345)



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For further information and a copy of the registration form contact Leanne Holmes on (07) 3250 1533, or send your registration form and payment to:

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PO Box 762
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HEALTH INFORMATION MANAGEMENT
ASSOCIATION OF AUSTRALIA



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