

Coding *Matters*

Newsletter of the National Coding Centre

Volume 2 No. 1 July 1995

FROM THE DESK OF THE DIRECTOR

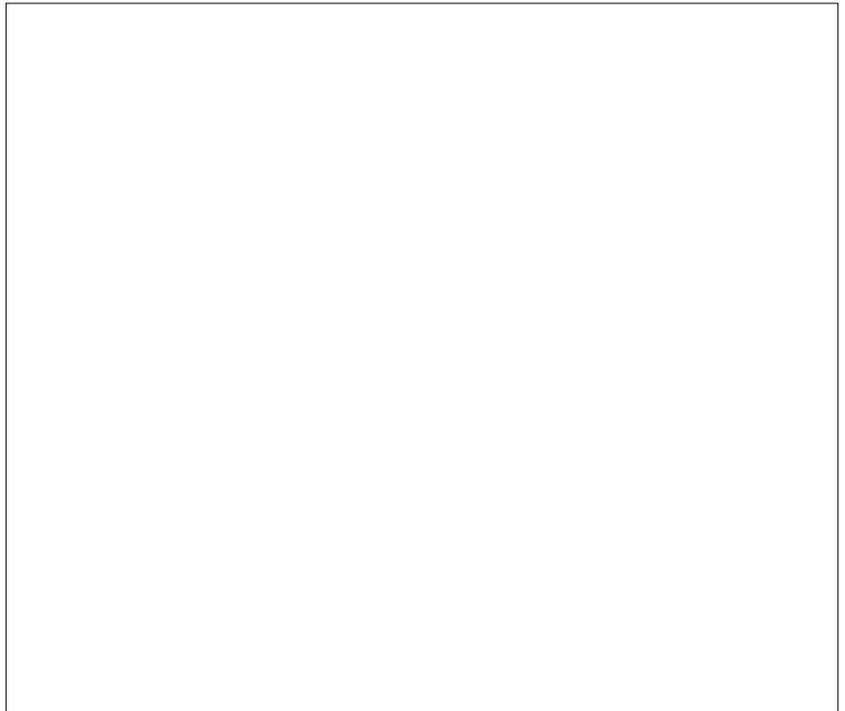


The big news from the NCC is that we have a new lease of life! The original contract with the

Commonwealth Department of Human Services and Health (DHS), which was to end in June 1996, has now been extended until June 1998. Our major task between now and then is to introduce ICD-10, and the funding of the Centre has been increased by the Department to cover the work necessary to achieve this major changeover, scheduled for July 1998. Additional staff will be required for various tasks, including the modification of ICD-10, consultation with Clinical Coding and Classification Groups (CCCGs), preparation of mappings from ICD-9-CM to ICD-10 and publication of the finished product. Our thanks to Warren Talbot and staff of the Casemix Branch for this very tangible support of the NCC.

Another major task is the development of a procedure classification to accompany ICD-10. At the time of writing, the proposal to use an extended Commonwealth Medicare Benefits Schedule (CMBS) has been approved by the DHS. The NCC has indicated its interest in developing the CMBS in conjunction with the Medicare Benefits Branch of the DHS so that preparation of the disease and procedure classifications can proceed together. A draft timetable for the introduction of ICD-10 and MBS-Extended is shown in the box on page 2 of this issue of *Coding Matters*.

Continued on page 2.....



Mrs Gemala Hatta (right) President of PORMIKI (Indonesian Professionals on Medical Records and Health Information Organisation) flies the flag at a lecture given in Jakarta by Dr Karen Luxford (second left), NCC Publications Manager. Ms Lee-Anne Clavarino (left) also attended, previously NCC Coding Quality Manager, now living in Jakarta.

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Timetable For Introduction Of ICD-10 & MBS-Extended

July 1995 - March 1996

NCC to prepare preliminary mappings from ICD-9-CM to ICD-10 (WHO) and MBS-Extended and vice versa.

March 1996 - July 1996

Full scale review of ICD-10 and MBS-Extended by CCCGs (joint Australian Casemix Clinical Committee (ACCC) and NCC nominees). Members of each group will be asked to look at structure of ICD-10 and MBS-Extended, make recommendations for new codes, ensure that changes made to ICD-9-CM are mirrored in ICD-10 and MBS-Extended, and suggest coding standards for use with ICD-10 and MBS-Extended. Members will also review mappings from ICD-9-CM to ICD-10 and MBS-Extended and vice versa.

July 1996

Final deadline for ICD-10 (Australia) and MBS-Extended content from CCCGs.

July 1996 - March 1997

NCC to work on preparation of Australian version of ICD-10 and MBS-Extended.

April 1997

ICD-10 (Australia) and MBS-Extended ready for typesetting.

April 1997

ASCII Electronic list of ICD-10 (Australia) and MBS-Extended available.

May - June 1997

Preparation of definitive mappings from ICD-9-CM to ICD-10 (Australia) and MBS-Extended.

January 1998

Printing of ICD-10 (Australia) and MBS-Extended.

February 1998

ICD-10 (Australia) and MBS-Extended available for distribution.

January - July 1998

Education of coders in ICD-10 (Australian version) and MBS-Extended.

July 1998

Introduction of ICD-10 and MBS-Extended for use in Australia.

TENDON, a computer based training package in ICD-10 for basic training of coders and re-orientation for coders familiar with ICD-9 is available from WHO. If you wish to get a head start and purchase TENDON now, contact Sue Walker or Maryann Wood at the National Reference Centre for Classification in Health (NRCCH) on ph: (07) 864 5873 or fax: (07) 864 5515.

Back to the present, and to the future of ICD-9-CM. We must remember that ICD-9-CM will be with us for another three years, and after that will need to be referenced in relation to the AN-DRG grouper which will not be available in ICD-10 until we have sufficient data in ICD-10 and MBS-Extended to review the composition of the groups and develop cost weights based on the ICD-10 AN-DRG. This may not be until after the year 2000, so there's life in the old girl yet, and do not discard your NCC Australian versions of ICD-9-CM, which the NCC will continue to maintain and update until ICD-10 (Australia) comes along. Also, publication of ICD-9-CM has taught us a lot, and will form a sound basis for changes we make to ICD-10. In fact, all CCCG deliberations and changes to codes and standards from now on will be looking at structure and composition of ICD-10 to make sure that changes made to ICD-9-CM are compatible with ICD-10. Much of the NCC corporate energy in the last few months has been absorbed by these groups, and we continue to find them stimulating and informative with excellent cooperation from clinical and coding colleagues as well as support from the Casemix Branch.

Work continues on refinement of the Australian Coding Standards (ACS). The NCC ACS Workshops have put the spotlight on the standards and demonstrated areas which need elaboration or pruning. Work has been contracted to Sue Stevens of WA Health to review the Standards and make recommendations about those standards which can be incorporated into index entries in ICD-9-CM. She has also been asked to prepare a code number index to the ACS, and to review new Paediatric and Obstetrics & Gynaecology specialty handbooks for compatibility with the ACS. All members of the Coding Standards Advisory Committee and the CCCGs continue to provide major input to the maintenance of ICD-9-CM, for which we are

extremely grateful. Thanks also to the state and territory health authorities who provided financial support for the conduct of the ACS Workshops. This subsidy has been a major factor in allowing over 1,000 coders to attend. We thank the health services and coders too for their involvement in the standards development process, and last but not least the members of the Coding Educators Network who have worked so hard with Janelle Craig to make the workshops come alive.

The Management Committee of the NCC met on 5 May 1995. The position of NCC Coding Quality Manager, vacant since the departure of Lee-Anne Clavarino for Jakarta in November last year, was discussed, and recommendations made for the creation of a full time position as soon as possible. Another important change in NCC staff is the appointment of a new Administrative Assistant, Annette Berryman, who commenced work on the 29th of May. Penny Wilson has provided efficient and cheerful support in this position while the appointment was being made, and we thank Penny for her contribution to the Centre. (Deborah, our previous fount of all wisdom, has given birth to a baby boy. Congratulations!)

NCC has made several presentations relating to ICD-10 and the new procedure classification, the most recent being to the APHA Casemix Conference in Melbourne on 25 May. Karen Luxford has been a bit further afield promoting the work of the NCC, in fact to South East Asia (*see* Karen's column, "*Publication Issues*").

On 10 May, a joint meeting was held between NCC, School of Health Information Management, (University of Sydney), Professor Charles Bridges-Webb and staff from the Department of General Practice and Family Medicine Research Unit (University of Sydney) to discuss issues of mutual interest in relation to general practice coding. This was especially timely because of Professor Bridges-Webb's involvement in the International Classification of Primary Care (ICPC) which is being mapped to ICD-10 (*see* page 4 of this issue). Also in regard to "other" classifications, the NCC attended a meeting on June 13 between Commonwealth and state officers to discuss classification developments in ambulatory, mental health, acute, sub- and non-

acute services and also to review timing for ICD-10 and the Australian procedure classification.

Just a final mention again of the ACS Workshops. Congratulations to Janelle for her excellent organisation and devotion to the cause. Each workshop has allowed us to get to know you and provided a forum for you to have a voice - and above all to reinforce that coders matter as much as coding matters!

❖ **Rosemary Roberts**

CODING SOCIETY/FORUM UPDATE

Thank you to all those who have expressed interest in the concept of a Coding Society/ Forum. I am pleased to announce that we have now formed an Establishment (Steering) Committee. This Committee will consist of a representative from each state (we have mostly used volunteers rather than a more formal process) and representatives from the HIMAA Education Centre, HIMAA Council, NCWIP and NCC.

It is anticipated that the work of the Establishment Committee will last for six months and will be specifically aimed at preparing a draft constitution and terms of reference for use by the first Executive Committee of the Coding Society/ Forum. At this stage it is envisaged that the Establishment Committee will need two face-to-face meetings and some teleconferences. Both face-to-face meetings will be held in Sydney and the first one is planned for Friday 28th July, 1995.

For those who have been anxiously awaiting news of the Coding Society/Forum, I apologise for the delay but the first half of 1995 has been a busy one for the HIMAA. I look forward to bringing you news of the progress of the Establishment Committee in forthcoming issues of *Coding Matters*.

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International Classifications for Primary Care

An article by

Charles Bridges-Webb

**Emeritus Professor of General Practice
University of Sydney and
Chairman, WONCA Classification Committee**

Introduction

The International Classification of Disease (ICD) is the most widely recognised classification of diseases. The latest revision, the tenth (ICD-10)¹ in 1992 will be used for morbidity coding in

Australian hospitals from July 1998. Primary health care physicians may also need to use other classifications such as the International Classification of Health Problems in Primary Care (ICHPPC)² or the International Classification of Primary Care (ICPC)³. Following is an account of the historical development, role, relationships, and relative merits of these international classification systems.

Historical background

Morbidity data are necessary for the study of causation of disease and factors influencing the incidence and natural history of disease, and in the evaluation of the effect of preventive procedures and medical care on the prevalence and severity of disease and the disability resulting from disease.

The International Classification of Diseases began its career in 1893 as an international list of causes of death. Listing for both mortality and morbidity purposes, and change of name, did not occur until the sixth revision in 1948. The emphasis has therefore been on diseases in terms of their aetiology, pathology and morphology.

In primary care many of the conditions treated are vague and ill-defined and they can be classed only under broad general headings. In 1963, the

Royal College of General Practitioners estimated that only fifty-five per cent of diseases in general practice could be diagnosed accurately in terms of aetiology, pathology and morphology. Others can only be diagnosed in terms of symptoms or complaints, and some consultations such as for immunisation or medical examination do not relate to an underlying condition. For these and other reasons ICD is an unsatisfactory classification for use unaltered in primary care.

When large scale surveys of morbidity in general practice began in the 1950s and 1960s new classifications were needed. In the interests of comparability of data between countries and between primary, secondary and tertiary care, these were usually based on, or at least linked with, ICD.

The WONCA Classification Committee first met in 1972 in Melbourne at the time of the inauguration of WONCA (World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians). Many of its members had already been corresponding for some years about morbidity classifications for general practice.

The committee's first publication was the International Classification of Health Problems in Primary Care (ICHPPC), published by the American Hospital Association in 1975. In 1979, a second edition was published by Oxford University Press. In order to promote consistency of coding in morbidity surveys, inclusion criteria for rubrics in the classification were devised and field tested in many countries before publication of ICHPPC-2-Defined in 1983. This also included an international glossary of terms for primary care.

In 1978, the year in which the Alma Ata conference emphasised primary health care as the basis of "health for all by the year 2000", the World Health Organisation (WHO) set up a working party to develop a classification of patient reasons for encounter in primary health care. Most of the members of this working party were also members of the WONCA Classification Committee. This working party developed what was to become the International Classification of Primary Care (ICPC). Unfortunately, because the new classification departed from the basic format

of ICD, WHO decided not to proceed with publication, and WONCA further developed and published the classification alone in 1987. It is a comprehensive classification of patient reasons for encounter, process, and morbidity in general practice/family medicine, and forms the basis for the Committee's ongoing work.

The committee has always accepted a responsibility to relate its classifications to the world standard set by the International Classification of Disease of the World Health Organisation. ICHPPC was cross referenced to both ICD-8 and ICD-9, and ICPC similarly to ICD-9⁴ and ICD-10, covering the three editions of ICD in use over the period of the classification committee's activities.

No one classification meets all requirements. Even if one did, it would not necessarily be ideal for all purposes, since no one classification will meet all needs. It is however important in the interests of comparability of data, particularly but not only on an international basis, to use classifications which have a defined relationship to others, and specially to the most used, ICD. The narrow pathological basis of ICD has been considerably widened in the 9th and 10th revisions, the latter now including in its title "diseases and related health problems". However, it is far from easy to use for primary care purposes, and the classifications specially developed for that purpose are to be preferred.

"In primary care many of the conditions treated are vague and ill-defined and they can be classed only under broad general headings"

The International Classification of Primary Care (ICPC)

This is a comprehensive classification covering not only morbidity, but also reasons for encounter of patients with primary care practitioners, and the processes used in providing care including prevention, investigations, treatments and administrative procedures, although these processes are included in general outline only. Patient reasons for encounter cover a much wider spectrum than morbidity and include symptoms

and complaints, need for information, and attendance for treatment and procedures. They may also include conventional morbidity, as when the patient states their reason for encounter as "for my diabetes".

The basis of the classification is a grid made up of 7 components and 17 chapters.

The components are:

- 1) Symptoms and complaints
- 2) Diagnostic, screening and prevention
- 3) Treatment, procedures, medication
- 4) Test results
- 5) Administrative
- 6) Other
- 7) Diagnoses, disease.

For morbidity recording components 1 and 7 are the most emphasised, and they are the largest and most varied.

The 17 chapters are based on body systems, most of them conventional and similar to those used in ICD, but including psychological, pregnancy and family planning, and social.

ICPC meets more of the requirements for a good classification for primary care than any other. It very fully covers the spectrum of conditions treated, including even such matters as "fear of disease", "relationship problems with a family member", "question of pregnancy" and "pain attributed to the heart". The two axes of the classification are logical and not overlapping, it is hierarchical, and it has consistent rules and guidelines. It is cross-referenced to ICD-9, to ICHPPC-2-Defined, and to the British Royal College of General Practitioners classification. The classification is available on computer disc, which includes many translations (including Spanish) and is cross referenced to ICD-10.

The two major disadvantages of ICPC are its inadequate alphabetical index and the lack of inclusion criteria for rubrics. Both are currently being dealt with by the WONCA Classification Committee in preparation for the second edition. A much more comprehensive alphabetical index, four to five times longer, has been developed on computer disc in Australia and is now available. Inclusion criteria for rubrics are being developed,

based on updated versions of those in ICHPPC-2 -Defined and newly devised ones. It is hoped that the second edition of ICPC will be published in 1997.

ICPC is widely used in Europe and Australasia, where it is officially recognised in some countries, and its use in other countries is spreading. It is particularly valuable as a classification system for ordering data output even when data has been coded for input in more comprehensive systems such as ICD-10 or the Read codes of the British National Health Service. Aspects of either of these latter systems are appropriate to use as nomenclatures for data input in particular primary care applications when more detail is required than is provided in ICPC. For instance, ICPC includes all liver disease (except viral hepatitis) in one rubric, but there are 8 three-digit codes in ICD-10 and many more at the four digit level.

ICPC is a good classification for primary care at present, it is being improved, and is in a good position to lead into the future as ICD-10 is taken up as the major world classification for secondary and tertiary care.

For further information, contact:

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References

1. World Health Organisation, International Statistical Classification of Diseases and Related Health Problems, 10th Revision, ICD-10, Geneva, WHO, 1992
2. Classification Committee of WONCA, ICHPPC-2-Defined; International Classification of Health Problems in Primary Care, Oxford University Press, 1983
3. Lamberts H and Wood M (eds) ICPC: International Classification of Primary Care, Oxford, Oxford University Press, 1987.
4. World Health Organisation, International Classification of Diseases, 9th Revision. Geneva, WHO 1977

**NORTHERN TERRITORY
CODING COMMITTEE**

The Northern Territory is pleased to announce the formation of a Coding Committee that meets monthly. The postal address for this Committee is:

☐ NT CODING COMMITTEE
Chairperson (Andrea Morrison)
Royal Darwin Hospital
PO Box 40596
Casuarina NT 0811

 **Coderscope** 

**Your horoscope
by
Megan Stargazer**

 **Cancer June 22-July 23**

This quarter will be filled with 780.50 and 300.00 as you wonder why the pens on you desk are no longer parallel.....? You may be going on holiday or some kind of travel, so E845.9 could be a possibility. The planets are all in line for your birthday month, so relax Cancer, have a great time and don't indulge in too much 305.00 .

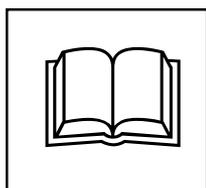
 **Leo July 24-August 23**

You get the feeling that things are not going your way Leo, as 297.1 sets in. Don't despair though, as that special someone you've been waiting for may come along in early August. You spend the rest of August in a dreamlike state so watch out for E885.

 **Virgo August 24-September 23**

Some of your friends are wondering about your 301.4, but don't let them phase you. Your five year plan has brought you to the point of 293.0. and you seem to be having V40.1, but this period will pass by late August and you will be free of all V69.9's. Smooth sailing till the end of the year.

PUBLICATION ISSUES



During June, I had the good fortune to embark on a fact-finding and marketing trip to several South-East Asian countries following the *Information Technology (IT) in Health Summit* in Singapore (more on the Summit on page 9). In each country, I endeavoured to visit the respective Health Ministries and Medical Record Organisations.

Leaving Singapore, I travelled to Jakarta, **Indonesia** and was graciously accommodated by Lee-Anne Batts (or Clavarino, as we know her!), previously the NCC Coding Quality Manager, whom is now living in Jakarta. Assisted by the unerring organisational skills of Gemala Hatta (President of the Indonesian Professionals on Medical Records and Health Information Organisation, "PORMIKI" for short), I met with the staff members, including Mrs Fitriati, of the Information Section of the Directorate General for Medical Care, Ministry of Health. As with many other countries in this region, Indonesia uses ICD-9 for clinical coding, unchanged from the original revision date of 1975, and therefore only diseases, and not procedures, are coded. Coding in Indonesia is performed using the Basic Tabular List at the back of the book, and therefore is only recorded to the three digit level. Data is also collected using a sampling technique, where information is recorded in only one week in every four. The Indonesian Ministry of Health expressed interest in the adoption of ICD-10, however, appeared uncertain as to when exactly this would be. ICD-10 training has already begun in 200 of their 1000 hospitals. A brief visit was also made to Indonusa Esa Unggul (IEU) University where Gemala teaches medical record coding, amongst other things, to a group of enthusiastic students.

Gemala Hatta asked me to speak to PORMIKI members at Persahabatan Hospital, where, after being greeted by the hospital Director, Dr Yudanarso Dawud, I found not the small group I had anticipated, but a room full of about 50 people (who appeared to have registered!),

including some doctors. Many of the students had also attended (a keen group, as this was a Saturday!). I explained the developments and changes in coding in Australia on a national level and the role of the NCC. A discussion ensued, where the same old problems were discussed: incomplete medical records, timeliness, lack of clinician interest, etc. Another problem experienced in Indonesia is the documenting of the medical record in Indonesian and the subsequent coding being performed using the English language ICD-9. Coders fear that some things may be being lost in the translation!

We discussed some of the approaches being undertaking in Australia to increase clinician involvement, such as the weekly meetings already being conducted in many Australian hospitals between coding services and clinicians. Medical records should not be viewed as an end point, but rather as the beginning point for accessing health information within any health service. Doctors and hospital administration need feedback. In Australia in recent years, coding has undeniably received increasing attention as a direct consequence of casemix funding. However, DRGs do not exist in countries such as Indonesia and getting people motivated is still very much a problem. Some interest was expressed by the Indonesian Ministry of Health in the AN-DRG system, however, there are currently no concrete plans to adopt such a funding model.

I was pleasantly surprised to be presented with a PORMIKI pin and pendant of the organisations' flag following a morning of lively conversation. Indonesian coders are very keen to be involved in such exchanges of information. My sincere thanks to Gemala Hatta and PORMIKI members for making my visit a most enjoyable one. Many thanks to Lee-Anne for looking after me during my stay and devoting time to accompany me on my various meetings. Lee-Anne has now also been asked to be guest speaker at the next PORMIKI conference later this year. Good luck Lee-Anne and thanks again!

ICD-9 was introduced for coding in **Malaysia** in 1985 and is still in use today. In Kuala Lumpur,

I met with Mr Chong Yok Ching, Head of the Information and Documentation System Unit, Ministry of Health (and also President of the Malaysian Medical Records Association). Several of the staff of the Unit have been educated at the School of Health Information Management, University of Sydney (and everyone knows and speaks highly of Professor Phyllis Watson - whom seemed to have been *everywhere* just ahead of me!!). Formal coding training is not presently available in Malaysia, although the Ministry runs a 2 week course every one-to-two years before people commence working in hospitals. The remainder of the training is performed informally, on the job.

Unlike Indonesia, Malaysian medical records are documented in English and all coded data is pooled at a provincial level before being sent to the Ministry of Health. Coding is performed to the 4 digit level, using the whole ICD-9 classification. Only the principal diagnosis is recorded and procedures are not coded. The inadequacies that coders find with ICD-9 forces them to select the nearest or most similar code to that required. V and E codes, although available, are not always used in cases where they clearly should be. A quality assurance study undertaken in Malaysia in the recent past suggested that approximately 23% of medical records were incorrectly coded. Unlike Australia, public hospitals account for 90% of all Malaysia hospitals. Once more, there appeared to be little support or enthusiasm emanating from the clinicians, and documentation problems abound, causing concern for the Ministry.

Malaysia also intends to adopt ICD-10, with no definite date for implementation set at this stage. DRGs have received some attention, yet many felt such an exercise would be futile at this point with so many basic coding problems still in existence.

In **Hong Kong**, I meet with Aussie expat. Katrina Chisholm, who works at the Hospital Authority. Katrina informed me that there are 9 major acute care hospitals in Hong Kong, 7 of which use ICD-9-CM for clinical coding and 2 that use ICD-9. Six of the

hospitals submit data on-line to the Hospital Authority. I also had the good fortune to meet with Dr Fung Hong, the Senior Executive Manager of Operations & Service Development at the Hospital Authority. We discussed the casemix system currently under trial in Hong Kong based on Patient Related Groups (PRGs). Unlike the AN-DRG system, the 100 PRGs are costed on the cumulative length of stay over a period of one year and are patient based rather than episode based. The Hospital Authority is aiming to introduce the PRG system of resource allocation in 1995-1996.

During my visit, I was introduced to the innovative young team in the Systems Section and Manager Mr Anthony Cheung. I was shown a new program they were developing for outpatient coding, called OPCOSS, in anticipation of future billing trends. Whilst most medical records are recorded in English in Hong Kong, the Hospital Authority is mindful of the future and developing bilingual systems to also include Chinese. Past research indicates to the Hospital Authority that coding accuracy using ICD-9-CM is very high, however, as elsewhere, they are still concerned about problems with discharge summary completion.

Dr Karen Luxford discusses coding issues with the staff of Medical Record Department, Siriraj Hospital, Bangkok, including the previous Head of Department, Dr Somporn Ekarat (seated first left), current Department Head, Mrs Supa Weerawat (seated second left) and Miss Nantaya Kaewwatanapatama (back row, second from the right).

An association of HIMs has recently formed in Hong Kong (HKHIMA) and I was pleased to meet the current members during a lecture at a hospital and the dinner that followed. The developments occurring in Hong Kong are inspiring and if you wish to hear about them first hand, Katrina Chisholm will be a guest speaker at the *2nd Annual NCC Seminar* to be held in Canberra on September 8 & 9, 1995 (*see the back cover of this issue for further details*).

The coding scene in **Thailand** was different again, since in 1994 this country introduced ICD-10 for clinical coding. During my stay, I was in the capable hands of the staff of the Medical Record Department of Siriraj Hospital, Bangkok, primarily the Head of Department, Mrs Supa Weerawat and Miss Nantaya Kaewwatanapatama (and Dr Somporn Ekarat, the previous Head, even came out of retirement for a day!). Diseases and procedures are coded in Thailand, and as ICD-10 is not accompanied by a procedure classification, procedures are coded using a 1986 edition of ICD-9-CM. Thailand does not have a HIM association and coding education is largely conducted informally through in-service training.

At the time of my visit, the Index for ICD-10 had not yet been received in Thailand, so you can imagine the fun the coders were having! Summary front sheets are recorded in English, whilst the rest of the medical record is documented in Thai. Most Thai hospitals send a copy of the summary sheet to the Public Health Ministry where coding is performed. Siriraj Hospital, however, being a university hospital, performs its own coding, as it does not fall under the jurisdiction of the Ministry.

Discussions with Dr Pradit Wongkanaratanakul, Director of the Health Information Division at the Ministry, revealed that a Thai translation of ICD-10 is already underway. Currently, the Ministry monitors 75 broad inpatient diagnostic items and 21 items for outpatients, based on coded data collected at the 3 character level. Whilst procedure data may be collected at the local hospital level, it is not monitored by the Ministry. Due to the existing problems experienced with data collection, the Ministry does not envisage utilising a DRG-based funding system in Thailand for another 3-5 years. Whilst

Thai coders voiced their approval of the increased detail and accuracy represented by ICD-10, they also alluded to some terminology problems. Thailand's experience in ICD-10 coding will prove invaluable to other countries in the Asia-Pacific region in the forthcoming years.

Thank you once more to all my new-found friends for making me feel so welcome during my visit!

❖ **Karen Luxford**

An Electronic Future...

From May 29-June 1, I attended the *Pan Asian IT in Health '95 Summit* in Singapore where many Health Ministry and hospital representatives from the South-East Asian region gathered to talk about how information technology was being harnessed in the area of health services within the various countries. The Summit was followed by a Workshop on the progress in *Electronic Patient Records*, a topic that should be of interest to all coders. It proved to be an information-packed, full 4 days!

"Be Prepared! Take every opportunity to increase the range of your skills and become involved in health information as a discipline"

The future of Information Technology (IT) in relation to health looks to be exciting, challenging and *different* (the later point being the main area of current interest for coders!). In an increasingly computerised world, IT applications in health are becoming more and more of a realisation. Yet, IT in health appears to have made much slower progress than in other service areas, such as finance and education.

If the predictions made at this Summit come true in the Australasian region, or for that matter the world, the average coder and HIM can expect major changes in their roles and in the nature of their work in the future. For most, the changes may be perceived as a vast improvement, with computers relieving us of many of the more mundane aspects of the

medical record service (e.g. document storage & retrieval; chasing records all over the hospital; leafing through wads of paper, etc). The envisaged future of a truly electronic patient record, as described at the *IT Summit*, is in reality a couple of decades away, since many limiting problems remain to be resolved, such as the legal aspects of electronic medical records, standards for electronic signatures, integratable electronic systems, compatible coding systems, and overcoming the inhibition experienced by many clinicians when faced with computer usage.

So, briefly, what is the message for coders right now? Be Prepared! Take every opportunity to increase the range of your skills and become involved in health information as a discipline. Try to look beyond the fact that you may be experiencing trouble in your own facility just trying to get clinicians to fill in the front sheet correctly. If the projections of the *IT in Health Summit* come true, then by early next century automatic coding with direct clinician input, performed at workstations, will be the norm and many of the problems of medical record documentation will be solved. The role of the coder as we know it could well disappear, to be replaced with more focus on abstracting and confirming codes against coding convention, education of clinicians, software design, etc. The Singapore Defence Forces illustrated such a future during the course of the Summit with a software programme they are currently using in which an episode of care (including ICD-9 code allocation) was completely documented by a doctor in under 4 mins!

Having scared you half to death, I'd like to say that I believe the future is bright! Change of this nature can be a liberating experience for medical record departments everywhere. Your role will increase in breadth to include information access control, design consultation for data storage, systems maintenance, auditing and quality assurance, physician systems training, data retrieval, generation of internal & external reports, intrafacility liaison, establishment of internal standards, input into classification development & improvement, the study of international developments in classifications pertaining to areas such as A&E, radiology, ophthalmology, oncology, etc. Use your

expertise to contribute to new developments and highlight problem areas identified in the past. Because, who knows the demands of a medical record service better than you??

The future is exciting and challenging! So, take some time now and be prepared: seek education and start thinking of a strategy for beyond 2000. With escalating pressure being placed on health facilities to increase the pace of service delivery, not least due to the changes in the funding processes, IT may prove to have some of the answers. Take time to find out what the implications are for you. The future is not really that far off!

❖ *Karen Luxford*

HIMAA Publications Officer Ann Jones

I am pleased to take this opportunity to introduce myself to the members of the coding profession as the Publications Officer of the Health Information Management Association of Australia (HIMAA). I will be working part-time and can be contacted at the HIMAA office at North Ryde (*see next page*).

The emphasis on contact details is because of our interest in you and your activities! We are seeking contributions and even if yours is not anticipated for some time, please contact me so that your work can be pencilled-in as a potential future publication. We are particularly interested in coding issues, so please inform us of any news or upcoming learned papers.

The major component of my role is to collect, record and disseminate papers generated empirically and scientifically. I will also go out on a limb here and suggest that in some cases, there is much value and interest for anecdotal papers.

Broadly, I hope to act as a print-based communication coordinator within the profession. To succeed, your input is needed. Have you recently completed (or are planning or in progress of) a new, interesting or challenging project? Are you part of a less conspicuous arm of the

profession and would like to raise awareness of your work? Please give these and other issues some thought. Your input is crucial. In late July, a strategic planning workshop will be conducted to commence a critical pathway for HIMAA's journal. The expected outcomes from the workshop include:

- review of current journal status
- publication scheduling
- content, format, frequency and style of publication
- planning for reader needs and preferences questionnaire

The proposed questionnaire will be a valuable tool to make HIMAA publications responsive to your needs. In the meantime, your comments, suggestions or other feedback is most welcome - as are your articles, letters and diary dates for publication.

I will be attending the Casemix Conference in Adelaide this year and hope that delegates might meet me at HIMAA's stand there. I look forward to meeting you and hearing your views and opinions about your journal.

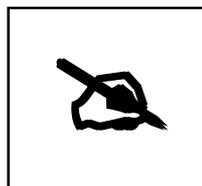
During the short time I have been in the role of Publications Officer, I have been fortunate to meet HIMs, MRAs, coders, data managers and others in health information services. As a newcomer, my observation is that the profession is comprised of people with enormous commitment, energy and vigour.

Commitment is exemplified by the voluntary roles carried out by HIMAA members. Particular gratitude is due to JoAnne Fisher who has been editor of the journal, *Health Information Management*, in recent years. Congratulations and many thanks JoAnne.

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EDUCATIONAL MATTERS

“On the Road Again!!” An Update on the Australian Coding Standards Workshops



As most clinical coders will be aware, during April - June, the NCC conducted workshops throughout Australia to advise on the use and interpretation of the 2nd version of the *Australian Coding Standards*, published as Volume 4 of the *Australian Version of ICD-9-CM*.

This whirlwind tour saw the Centre:

- * cover 29 locations nation wide
- * enrol 1147 participants in our workshops (an estimated 95% of the national clinical coder workforce) representing -

NSW =	341
VIC =	332
QLD =	205
SA =	124
WA =	90
TAS =	26
ACT =	19
NT =	10

The workshops were evaluated by 712 attendees, which represented 62% of total course participants. The workshops were received with overwhelming support by clinical coders as our workshop evaluations reflected:

- * 95% of respondents rated the overall workshop program as a useful educational activity
- * 74% of respondents expressed that their expectations of the workshops were fully or largely met
- * only 9% of respondents considered the workshops would do little to help them to do a better job as a clinical coder/supervisor of a coding service

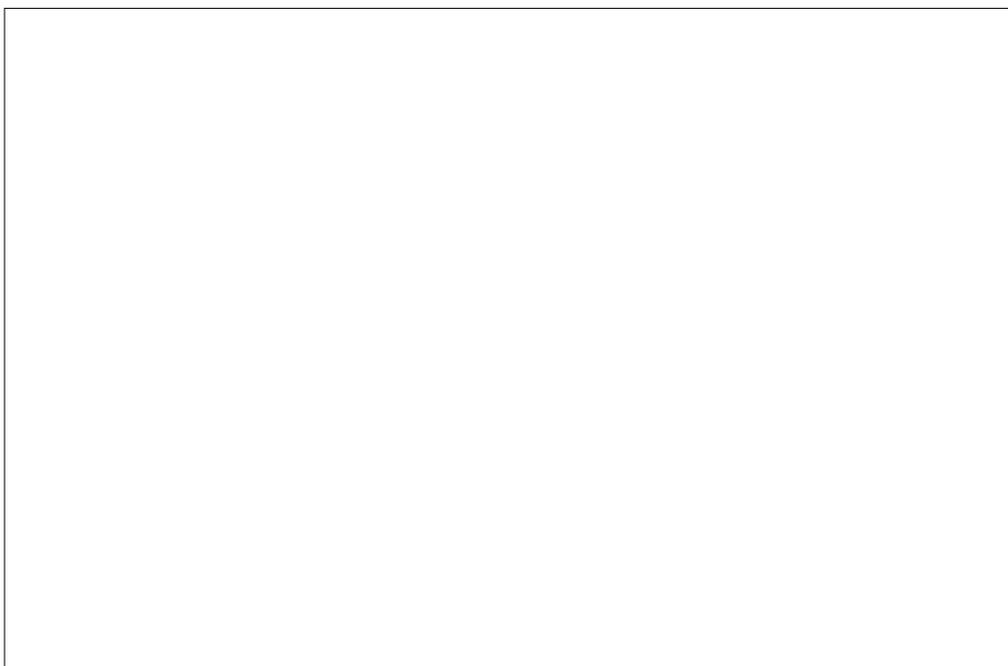
In general, participants considered the scenarios and workshop quiz to be beneficial in reinforcing material covered in the workshops. However, some participants would have liked the answers to the scenarios fully coded, while a number of felt the scenarios were slightly ambiguous and could have been made more difficult.

Participants acknowledged that, where possible, coding queries were clarified at the workshops, and that where this was not possible, issues would be referred back to the relevant clinical groups (CCCGs) for further consideration.

One of the main comments raised via course evaluation was that many participants would have liked the workshop to run for only one day, these sentiments being based on either the inability to be away from normal duties for two days, or the consideration that course content did not warrant the workshops to be conducted over a two day period. While we appreciate these views, the NCC and its consultative bodies, such as the Coding Standards Advisory Committee and the Coding Educators Network did consider this issue during the planning of the workshops. However, we felt that, given the breadth of changes to the ACS for introduction in July, 1995 and for national consistency, the workshops should run as a two day education session. A number of participants had some interesting suggestions on ways to help the workshops run more effectively, and these comments will be considered when developing Standards Workshops in the future.

While the main aim of the workshops was to “spread the word” about the new coding standards, from the Centre’s point of view, the workshops were also very useful in providing a forum through which clinical coders and the NCC could meet, as well as allowing us to become more familiar with idiosyncrasies in coding practice at the individual state/territory level. The workshops helped to clarify issues surrounding many of the new Standards; most of the queries that were not fully resolved at the workshops will be included in our *Australian Coding Standards - Update* on page 14. Feedback regarding the new Australian publication of ICD-9-CM has also been helpful and has been taken back to our Publications Manager, Karen Luxford.

Thanks must be extended to the state and territory health authorities who subsidised the workshops, and in some cases provided officers to discuss changes to inpatient statistical collections or health authority updates. Your support was very much appreciated by workshop participants and helped to highlight a strong commitment to coding and coders. Another big thanks goes to members of the NCC’s Coding Educators Network who assisted with the delivery of the workshops and finally, of course to our Coding Services Manager, Kerry Innes, who not only helped to conduct many of the workshops, but whose efforts have been responsible for producing Standards that are well written, easy to interpret and apply, and which reflect current clinical practice.



Attendees of the Australian Coding Standards Workshop held in Geelong, Victoria on 26 -27 June, 1995.

So what’s in store for coding education for the remainder of 1995 I hear you ask? In the first instance, the NCC will continue to provide assistance to the National Coder Workforce Issues Project in formulating an overall educational strategy and in developing course material for a range of programs to be offered in the lead up to Coder Accreditation in August 1996. Further the NCC, together with the Health Information Management Association of Australia (HIMAA) and the Private Sector Casemix Unit have been awarded the contract for training of ICD-9-CM coders for Australian private same day facilities (we will report on the

conduct of this project in the next edition of *Coding Matters*).

While we have started our educational activities by targeting clinical coders, we also realise that as part of our "team approach" to coding, clinicians need to be kept up to date with advances in classification systems, coding standards and coding practice. Thus, the NCC will be pursuing mechanisms to ensure clinicians receive education in relation to coding standards, clinical documentation and the role they have to play in the coding process. Having also forged a close relationship with our trans-Tasman colleagues, the NCC will be undertaking additional workshops in New Zealand in the latter half of the year in order to maintain and enhance the skills of clinical coders.

Finally, as a reminder from the previous issue of *Coding Matters*, the Second Annual NCC Seminar, entitled "*Managing Coding*" will be held in Canberra on the 8 and 9 September 1995. We hope you can join us in our national capital for what promises to be another information packed, but fun filled program! Until then,

❖ *Janelle Craig*



Youngest attendee of the Australian Coding Standards Workshop, Michael Halange, seen here with mother Paula, sporting NCC baseball cap and Volume 4. At the Melbourne Workshop on 17 & 24 June, Michael proved the book covers were dribble proof.

NZ Coders praise NCC Workshops

☐ The Introduction Course to the Australian ICD-9-CM held in Wellington, New Zealand on 27 February - 3 March 1995 has been given the seal of approval by NZ coders. The course, conducted by Janelle Craig and Joy Smith, has been described as "excellent" in the May issue of the NZ newsletter "*Coder's Update*", published by the New Zealand Health Information Service. Course attendee's comments included such statements as "stimulating", "extremely well presented, fun and informative", "excellent job". We hope that the comments of Karen Brown (Tairāwhiti Healthcare) sum up the thoughts of NZ attendees: "This course has given us all a feeling of self worth and knowledge that we have an important role to play in the health sector". Congratulations Janelle and Joy!

ADDENDUM AND GUIDELINES FOR JULY 1995

A number of enquiries have been received about the Addendum and Guidelines which was discussed on page 7 of *Coding Matters*, Vol.1 No.4. As mentioned in the previous edition of *Coding Matters*, these documents were given to each state/territory health authority with the intention that they would be distributed to coders by the state/territory health authority. If you have not yet received your copy, please contact your state health authority/territory office.

Australian Coding Standards - Update

As those of you who attended the recent *Australian Coding Standards* (ACS) workshops over the last few months will know, there are unfortunately some typographical errors in Volume 4 which were highlighted during the workshops. A full Errata for ICD-9-CM is included on page 20 of *Coding Matters* and should be used to update your *Australian Version of ICD-9-CM*, including the *Australian Coding Standards* (Volume 4), as soon as possible.

During the *Australian Coding Standards* workshops, various queries were raised in relation to certain standards, and questions asked about current coding practices. Unfortunately, not all queries can be solved immediately, as many need further evaluation by the Coding and Classification Clinical Groups (CCCGs) and the Coding Standards Advisory Committee. Listed below are those queries which were raised **consistently** throughout the workshops and for which we can provide advice. Hope this helps!

PROCEDURES

Multiple Procedures

The *Australian Coding Standards* (ACS) state:
“Procedures which may be related to the treatment of the principal diagnosis or secondary condition(s) or are required for research purposes, but are not surgical in nature, should be coded.”
(ACS 0016, page 16)

The definition of what is and is not “surgical” is becoming more blurred with the use of

radiological intervention (e.g. fine needle aspiration), percutaneous procedures, cardiological interventional procedures (e.g. angioplasty), endoscopic therapeutic procedures and other treatments which may or may not be carried out in the operating theatre (e.g. mechanical ventilation).

Many of these traditional “nonsurgical” procedures are very resource intensive and affect AN-DRG assignment. It is extremely important that they be coded, and if multiples of such procedures are performed, that multiple codes be assigned (e.g. multiple cardiac catheterisations, multiple endoscopy for treatment of oesophageal varices).

For the purposes of coding multiple procedures, apply the following general guidelines, noting the exceptions for existing *Australian Coding Standards* (ACS) which override these general guidelines:

❑ Any procedure from **Chapters 1 - 15 of Vol. 3 ICD-9-CM** which is performed more than once during an episode of care should be coded as many times as the procedure is performed.

Exceptions: ♦Renal dialysis.

♦Specific ACS standard which directs coders otherwise. For example: Standard on multiple skin lesion excisions (*ACS 0020 Bilateral/Multiple Procedures*).

❑ Any procedure from **Chapter 16 of Vol. 3 ICD-9-CM** need only be coded once.

Inclusions: ♦Blood transfusions*

♦CT scans

♦ECT

Exceptions: ♦Procedures which may affect AN-DRG assignment**

♦Specific ACS standard which directs coders otherwise.

♦Multiple dressings to ulcers, burns or wounds

*Note: paragraph c) no longer applies in light of the above standard.

**Note : procedures which may affect AN-DRG assignment are indicated by an asterisk in Volume 3 of the *Australian Version of ICD-9-CM*.

Blepharoplasty

In the example on ACS 0020 page 18, **Exclusion criteria** paragraph b), blepharoplasty on both upper and lower eyelids of the same eye is excluded from double coding. In fact, this would involve two different procedure codes, 08.86 and 08.87 (as described in ACS 1205

BLEPHAROPLASTY, page 85) and it would therefore be necessary to assign both these codes. This example is included in the Errata for deletion.

CHAPTER 1 INFECTIOUS AND PARASITIC DISEASES

Streptococcus pneumoniae

ACS 0103 **STREPTOCOCCAL INFECTION** includes *S. pneumoniae* (pneumococcus) under the group “other” (ACS page 28). These terms are synonymous, (as are pneumococcus and pneumococcus) so coders should take care not to use the ICD-9-CM Index entry “Infection, pneumococcus NEC” as this will lead to 041.2, rather than the correct code 041.09 *Other streptococcus*.

CHAPTER 2 NEOPLASMS

Intragam

ACS 0214 **INTRAGAM** advises coders to assign the code 279.00 *Hypogammaglobulinaemia* as the principal diagnosis for patients admitted specifically for injection of Intragam. A number of clinical coders queried why code V07.2 was not assigned as the principal diagnosis in these cases. This decision is based on the fact that V07.2 is appropriate for prophylactic (i.e. preventative) treatment to treat a potential condition/illness, whereas Intragam is being given therapeutically to treat the active/current condition of hypogammaglobulinaemia.

Chemotherapy

While most oral chemotherapy will be given on an outpatient basis, there will be rare occasions where the patient is admitted. An admission for oral chemotherapy should be assigned the principal diagnosis of V58.11 *Chemotherapy, parenteral, NOS*.

CHAPTER 4 ENDOCRINE, METABOLIC AND NUTRITIONAL DISORDERS

Diabetes Mellitus

- * If a noninsulin dependent (NIDDM) patient is admitted and treated with insulin then the coder should assume that the diabetes is uncontrolled.
- * Portacaths are used rarely for insulin infusion or nutritional purposes. It could occur as an incidental procedure for diabetic patients with malignancy.

CHAPTER 5 MENTAL AND BEHAVIOURAL DISORDERS

Confusion in Parkinson’s disease

Confusion is not a normal feature of Parkinson’s disease and should be coded as a secondary condition if documented.

CHAPTER 10 RESPIRATORY SYSTEM

Pneumonia

Several coders asked if a finding of ‘consolidation’ on X-ray should be interpreted as pneumonia. This will be referred on to the Respiratory Coding and Classification Clinical Group for further clinical advice.

Mechanical Ventilation

- * mechanical ventilation and intubation for neonates, regardless of duration or means of administration should be coded.
- * do not code intubation for adults, if mechanical ventilation duration is <25 hours.

CHAPTER 11 DIGESTIVE SYSTEM

Mesenteric Adenitis

ACS 1111 should be ignored until further notice as this Standard was intended to address the problem below but fails to do so as it is currently written:

A patient is admitted with abdominal pain, undergoes an appendectomy, the histo-

pathology of the appendix is normal and mesenteric adenitis is noted on the operation report. Should the mesenteric adenitis be sequenced as the principal diagnosis based on the assumption that the adenitis caused the pain? There has been some clinical disagreement about the answer to this question and we will advise you when this is clarified.

Campylobacter

Campylobacter infection can occur (rarely) outside the gastrointestinal tract, specifically in the meninges, gall bladder, as vascular infection, bacteraemia and abscesses and causing peritonitis in patients with chronic renal failure on renal dialysis. The code for the organism in these cases should be 041.89 *Other specified bacterial infection*, and sequenced as a secondary diagnosis code to the principal diagnosis.

CHAPTER 12 SKIN AND SUBCUTANEOUS TISSUE

Elective Removal of Breast Implants

Subsequent to this Standard (ACS 1206, page 85) being published, the Plastic Surgery CCCG members agreed that V52.4 *Fitting and adjustment of prosthetic device* (which includes removal of device) should be used as principal diagnosis, rather than the reasons for removal, which are often not documented in the clinical record. If the reason for removal of breast implants is known, this should be assigned as a secondary condition code.

CHAPTER 13 MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Meniscus/Ligament Tear, NOS

There was much debate at the ACS workshops about whether we need this Standard given the new definitions for “current” and “old” injury (ACS 1906). The Coding Standards Advisory Committee will be considering this issue at its next meeting. Until a decision is made, coders should use the rule for meniscus/ligament tears as stated in ACS 1319 (code to “old” unless stated as “current”) and apply the definitions of “current” and “old” in ACS 1906 for all other injuries.

CHAPTER 14 GENITOURINARY SYSTEM

Dialysis

The Coding Standards Advisory Committee discussed the coding of overnight dialysis patients at the meetings on 31 March and 30 June 1995. Initially, the committee members recommended that overnight dialysis admissions should be coded with V56.0 as the principal diagnosis rather than the condition which requires the patient to stay overnight, as stated in ACS 1404. However, it was agreed that the existing Standard (ACS 1404) should be used from July 1995 until further data analysis of intended sameday overnight cases is available.

Infection of peritoneal catheter

ACS 1425 **INFECTION COMPLICATING TENCKHOFF CATHETER** instructs the coder to assign 996.62 (*Infection*) *due to other vascular device, shunt, and graft*, however, this code is incorrect as Tenckhoff catheters are peritoneal, not vascular catheters. A new code specifically for infections of peritoneal dialysis catheter will be introduced in 1996. Until then, assign code 996.73 *Other complications due to renal dialysis device, implant, and graft* with peritonitis 567.2 (*generalised peritonitis*) as a secondary diagnosis if applicable. E879.1 *Kidney dialysis as the cause of abnormal reaction of patient, or of later complication* should also be assigned.

Elevated Prostate Specific Antigen (PSA)

Note that in ACS 1414 **ELEVATED PROSTATIC SPECIFIC ANTIGEN (PSA)**, elevated PSA would only be coded when documented as clinically significant.

CHAPTER 19 INJURY AND POISONING

Head injury/concussion

Those coders who have used “*Getting it Right in Paediatric Coding*” will realise that the standard on head injury in that document is different to the *Australian Coding Standard, 1905*. **The classical definition of concussion is head injury with a loss of consciousness.** The neurosciences and paediatric CCCG members have agreed that the current *Australian Coding Standard* should apply

with some minor modifications recommended for July 1996, which includes an exclusion note under the section 854, indicating that any head injury which involves concussion should be coded to either a specific code from 851 - 853 with an appropriate fifth digit for the loss of consciousness or to 850 when no specificity about the type of head injury is documented.

Place of occurrence for complication codes

The fifth digit “7” should be used only when the postoperative complication occurs during the episode of care during which surgery was performed.

The fifth digit “9” should be used only when the postoperative complication occurs after the patient is discharged from hospital after surgery.

* Adverse effects of drugs:

The fifth digit “7” should be used only when the drug was prescribed in hospital and the patient was treated for the adverse effect during the same episode of care.

The fifth digit “9” should be used only when the drug is prescribed in hospital, the patient is discharged and then readmitted due to an adverse effect of the prescribed drug. Similarly, “9” should be used when a drug is prescribed by a GP and the patient is then admitted to hospital for treatment of the adverse effect.

Although there can be much discussion about the best way to do this, it should be borne in mind that although there is a requirement to use place of occurrence codes for all E codes (ACS 2003 **PLACE OF OCCURRENCE**), we recognise that place of occurrence is fairly meaningless and difficult to apply in cases of surgical complication and in certain instances of adverse effects of drugs. This Standard should therefore serve to provide some national consistency in application.

Change of Burns Dressing

Note that in ACS 1911 **BURNS - Admission for change of burn dressing**, the burn should be coded as a secondary condition to the principal diagnosis of V58.3 *Attention to surgical dressing and sutures*.

QUERIES FROM THE WORKSHOPS YET TO BE RESOLVED:

- Use of suicidal tendency/ideation (300.9)
- Should duodenal erosions be treated similarly to gastric erosions
- Maximum age for children in the hydrocele standard
- When to code “obstruction” in obstetrics
- Coding for falling oestriols in obstetrics
- Transfer of patients with suspected diagnosis on transfer:
 - ? use information from the hospital to which patient transferred to confirm the diagnosis;
 - ? code the suspected condition at the transferring hospital or the symptom
- Admissions for follow up for a specific condition but found to have another condition - code the V code or the condition?
- When to use code 411.89 *Other acute and subacute forms of ischaemic heart disease*
- Admission for removal of grommets

THE REFRESHING CORNER

□ NEC

There are two meanings which may be attributed to the abbreviation NEC (not elsewhere classified) and coders need to reference the ICD-9-CM Tabular List to distinguish between the two meanings:

NEC in the Index:

1. Ill defined terms - NEC serves as a warning to coders that more specific terminology can be applied to the diagnostic statement and the condition can be classified elsewhere. Coders should obtain more information concerning the condition from their resources or check with the clinician and then allocate a code based on the more precise information. The codes given for NEC terms should only be used if more precise information cannot be obtained.

Continued over page.....

For example: when coding a pneumococcal infection, the Index directs the coder to 041.2 Pneumococcus:

Infection, infected, infective

- pneumococcal NEC 041.2
- - generalised (purulent) 038.2
- Pneumococcus NEC 041.2

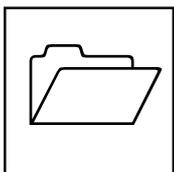
Pneumococcus is an individual organism of the species *Streptococcus pneumoniae*. Coders should therefore apply ACS 0103 **STREPTOCOCCAL INFECTION** and code pneumococcal infection to 041.09 *Other streptococcus*.

NEC in the Tabular List:

2. When a more specific category is not provided in ICD-9-CM: ICD-9-CM does not provide a separate code for every diagnosis; many diagnoses are grouped to an “other” or “not elsewhere classified” rubric. In these instances, the diagnostic statement will be specific and no amount of additional information will alter the selection of a code.

For example, a mucocele of the uterus is included in code 621.8 *Other specified disorders of the uterus, not elsewhere classified*.

Coding Tips



Dehydration with Gastroenteritis

In admissions for treatment of gastroenteritis and dehydration, the gastroenteritis should be sequenced as the principal diagnosis with dehydration as a secondary condition. The criterion for assigning a code for dehydration should **not** be taken as rehydration (I.V. fluid administration) as this

could be to prevent as well as to treat dehydration; dehydration should be clinically documented before assigning the code.

Disseminated/General Malignancy -199.0

This code should only be used when the malignancy is described as “disseminated carcinomatosis” or “generalised malignancy” (or other similar terms as described in the inclusion list for 199.0) and the specific sites are not documented. In cases where specific secondary sites are documented, these should be coded separately.

Open Wound with Arterial and Nerve Damage

The overriding factor in a vascular injury is the potential of limb loss or compromise. In these instances where arterial and nerve damage may occur together, priority should be given to sequencing arterial damage first, followed by nerve damage, followed by laceration. Where there is no potential for loss of limb, yet both nerve and artery damage have occurred, the clinician should be consulted as to the correct sequencing.

Optic Nerve Decompression

The optic nerve is enclosed in three sheaths continuous with the meninges and prolonged to the eyeball. The outer sheath is continuous with the dura mater, the intermediate sheath is continuous with the arachnoid mater, and the inner sheath is continuous with the pia mater.

This procedure is not currently indexed in ICD-9-CM. Although many coders have been assigning 04.49 *Other peripheral nerve or ganglion decompression or lysis of adhesions* or 04.42 *Other cranial nerve decompression*, the correct coding is 01.31 *Incision of cerebral meninges*. The Ophthalmology CCGG has recommended that this code be an acceptable procedure code in Major Diagnostic Category (MDC) 2 in AN-DRG Version 4.0.

❑ Grafts and Flaps

The following information is provided, courtesy of the Royal Melbourne Hospital Coding Committee and Mr. Bruce Johnstone, a member of the Plastic Surgery CCCG.

GRAFT A graft is separated from its blood supply and placed in its new position. A new blood supply then establishes itself. Skin grafting is a good example.

A full thickness graft is a layer of skin plus all of the underlying dermis.

A split skin graft is a piece of skin shaved off with the top of the dermis, leaving a defect very similar to a gravel rash which then heals naturally.

FLAP A flap has its own blood supply.

A free flap is raised from the donor site complete with blood vessels which are then anastomosed to the blood vessels at the recipient site under a microscope.

A pedicle flap is raised from the donor site with the major blood vessels still attached at the donor site via a "pedicle". The flap is then rotated, advanced or transposed to the new site.

A delayed flap is raised from the donor site as a pedicle flap but it is left "resting" in the donor site for a few days or week before it is placed in its new site. This allows the blood supply in the flap to strengthen before it is moved, thus increasing the flap's chances of survival.

CODING When coding flaps it is possible that codes *86.71 Cutting and preparation of pedicle grafts or flaps*, *86.72 Advancement of pedicle graft*, *86.73 Attachment of pedicle or flap graft to*

hand and *86.74 Attachment of pedicle or flap graft to other sites* could all be used for the one operative episode. If it is a delayed flap then *86.71* may be used at the first operative episode and *86.72*, *86.73* and *86.74* may be used at the second operative episode.

It is important to remember to code *39.50 Microvascular tissue transfer* when the vessels are anastomosed under the microscope.

❖ **Kerry Innes**



Cyberspace Hospital

In May 1995, the National University of Singapore (NUS) launched "*Cyberspace Hospital*" aimed at providing a Global Health Information Network. Designed and administered by Associate Professor K.C. Lun (NUS & Association for Informatics in Medicine Singapore), this resource centre links medical and medical-related Web resources via the Internet using a virtual hospital setting. Various educational resources are located on different "levels" of the hospital, accessed by click buttons. For example, "Specialist Departments", including Microbiology, Surgery, Paediatrics, Ophthalmology, and Obstetrics and Gynaecology, are listed and give either instant information/graphics or connections to organisations elsewhere on the net (e.g. CDC - Centers for Disease Control and Prevention, USA). I've yet to find the Medical Record Department (basement level doesn't exist??) and some sections, although labelled, have not been constructed yet. I'm currently trying to contact Prof. Lun to have the NCC and Australian coding contact information accessed through the *Cyberspace Hospital*. Contact address: <http://ch.nus.sg> Happy surfing!!

❖ **Karen Luxford**

Continued top of next column.....

NATIONAL CODING CENTRE

ERRATA 1995

Australian Version of ICD-9-CM

The following corrections will also be rectified in the July 1996 Update Pages for the *Australian Version of ICD-9-CM*.

Volume 1 - Tabular List of Diseases

Page

xxv		Other Conventions
Add		<i>“Italics:</i> Italicised type face is used for all exclusion notes and to identify those rubrics which are not <u>to</u> be.....”
9		045 Acute poliomyelitisfifth digit subclassification...
Amend		3 poliovirus type III
13	Add	<u>§ c/c 070.2</u> Viral hepatitis B with hepatic coma
Add		<u>§ c/c 070.3</u> Viral hepatitis B without mention of hepatic coma
189	Add	646.4 Peripheral neuritis in pregnancy <u>[0-4]</u>
190	Add	648.4 Mental disorders Conditions classifiable to 290-303, 305-316, <u>317-319</u>
Add		648.6 Other cardiovascular diseases Conditions classifiable to 390-398, 410-429, <u>440-459</u>
196	Delete	669.4 Other complications of obstetrical surgery [0-4]
Amend		<u>[0-4]</u> other procedures
206	Add	<u>c/c 707.0</u> Decubitus ulcer
Add		<u>c/c 707.1</u> Ulcer of lower limbs, except decubitus
253		789 Other symptoms involving abdomen and pelvisfifth-digit subclassification...
Delete		9 other specified site multiple site
Add		<u>multiple sites</u>
305		997.3 Respiratory complications <i>Excludes: iatrogenic [postoperative]</i> <i>pneumothorax (512.1)</i>
Amend & Realign		
306		998.2 Accidental puncture or laceration during procedure <i>Excludes: iatrogenic [postoperative]</i> <i>pneumothorax (512.1)</i>
Amend & Realign		
307	Amend	998.89 Other specified complications

ERRATA 1995 Continued

Volume 2 - Alphabetic Index of Diseases

<u>Page</u>		<u>Page</u>	
214	History - disease - - digestive system Amend - - - specified NEC <u>V12.79</u>	384	Removal (of) Add - <u>ileostomy V55.2</u> Add - <u>vascular catheter V58.81</u>
358	Plica Add - <u>synovial 727.89</u>	418	Syndrome Add - <u>Cornelia de Lange.....759.89</u>
361	Pneumothorax - sucking 512.8 - - iatrogenic 512.1 - - postoperative 512.1 Delete == <u>spontaneous 512.0</u> - tension 512.0 Add - <u>iatrogenic 512.1</u> Add - <u>postoperative 512.1</u> Add - <u>spontaneous 512.0</u>	439	Transposition (congenital) - heart 746.87 - - with complete transposition of viscera Amend <u>759.3</u>
		456	Vasculitis Amend - <u>retinal 362.18</u>

Volume 3 - Tabular List and Index of Procedures

<u>Page</u>	
p-43	38.4 Resection of vessel with replacementfourth digit subclassification.... 7 abdominal veins Amend <u>Iliac</u>
p-90	74.1 Lower segment caesarean section Amend <u>Low cervical</u> caesarean section
p-96	78.9 Insertion of bone growth stimulator [0-9] Insertion of: Add totally implanted device (invasive)
pi-14	Cholangiotomy Delete - <u>laparoscopic 51.23</u> Cholecystectomy Add - <u>laparoscopic 51.23</u>
pi-94	Repair Add - <u>enterocele (female) 70.92</u>

Volume 4 - Australian Coding Standards

<u>Page</u>	
ix	Amend IPPB Intermittent Positive Pressure <u>Breathing</u>
x	Add PIN <u>Prostatic Intraepithelial Neoplasia</u>

ERRATA 1995 Continued

Volume 4 Continued

Page

- 4 Delete 0006 **CLINICAL DIAGNOSIS IN CONFLICT WITH HISTOLOGY**
“...patient will-be still be treated for the clinical diagnosis.”
- 12 Amend 0015 **COMBINATION CODES**
2nd paragraph:
“...conditions involved and when the index so directs”
- 17 Delete 0016 **GENERAL**
“e) ~~When multiple or bilateral procedures are being coded.....~~”
Delete this paragraph and the boxed example.
- Amend d) to read c).
- 18 0020 **BILATERAL/MULTIPLE PROCEDURES**
Exclusion Criteria
b) Some procedures always involve bilateral sites, that is, it is
- Delete EXAMPLE
Delete the part of the example about blepharoplasty in the example box.
- 26 0102 **HIV/AIDS**
Manifestations
Last sentence of section:
“The principal HIV manifestation should be sequenced as the principal diagnosis code and the HIV condition sequenced as a secondary condition.”
- Amend
- 27 **Kaposi’s Sarcoma**
Amend the last sentence of this section to read:
“Continue to code the Kaposi’s sarcoma for each subsequent episode of care.”
- Amend
- 27 **AZT Conditions**
Amend Anaemia, drug induced 285.0
Amend Anaemia, drug induced 285.0
- 52 0401 **DIABETES MELLITUS**
Neonatal Conditions Associated with Maternal Diabetes
Amend “Australian clinicians do not recognise the concept of neonatal diabetes mellitus 775.1, nor do they refer.....”
- 53 0502 **CLOZAPINE MONITORING**
Code as:
V58.89 *Other specified aftercare*
Add Code Secondary code for the psychiatric condition
94.25 *Other psychiatric drug therapy*
- 59 Delete “0617 **NERVE INJURY IN AN OPEN WOUND..**”
This Standard duplicates ACS 1908. Delete ACS 0617.
- 61 0618 **PAIN MANAGEMENT PROCEDURES**
(Cryo) rhizotomy 03.1
Disc block 03.91
Realign Dural tap
Phenol 03.8

ERRATA 1995 Continued

Page

Volume 4 Continued

- 64 0702 **CATARACT SPECIFICITY**
Amend second line to read:
Amend "...specified as senile, toxic, intumescent, etc."
- 66 0717 **LACRIMAL PROCEDURES**
Amend "...with a principal diagnosis of V58.49 *Other specified aftercare following surgery.*"
- 71 0921 **SARCOIDOSIS...**
Delete this Standard.
- 80 1103 **GASTROINTESTINAL (GI) HAEMORRHAGE**
Amend last sentence to read:
Amend "In the case of oesophagitis, code oesophagitis (530.1x) and oesophageal haemorrhage (530.82) as a secondary code."
- 82 1108 **RECTAL AND COLONIC POLYPS**
Amend second sentence to read:
Amend "Rectal, anal and colonic polyps should be coded as 569.0 *Anal, rectal and colon polyp* unless the polyp....."
- 84 1210 **CELLULITIS**
Amend first sentence to read:
Amend "Where cellulitis is associated with an open wound or with skin ulcer, sequence the complicated wound code or the skin ulcer as principal diagnosis....."
- 85 1207 **SUBCUTANEOUS PROPHYLACTIC MASTECTOMY**
Amend last sentence to read:
Amend "V50.41 *Prophylactic organ removal, breast* should only be assigned as the principal diagnosis when a more definitive diagnosis cannot be abstracted from the clinical record".
- 90 1309 **DISLOCATION OF HIP PROSTHESIS**
Amend In this Standard, change 996.79 to 996.77 *Other complications of internal joint prosthesis.*
- 90 1319 **MENISCUS/LIGAMENT TEAR, NOS**
Add the following sentence:
Add "Note that this Standard is an exception to ACS 1906 **DEFINITION OF CURRENT AND OLD INJURIES**, page 120".
- 97 1418 **TRANSURETHRAL RESECTION (TUR) OF BLADDER WITH CYSTOSCOPY**
Amend title of this Standard to read:
1418 **TRANSURETHRAL RESECTION (TUR) WITH CYSTOSCOPY**
- 105 1518 **DURATION OF PREGNANCY**
Amend "...premature labour (630 -637, 640.0, 644.0)...."
- 109 1523 **DELAYED DELIVERY AFTER RUPTURE OF MEMBRANES**
Amend first paragraph to read:
Amend "...membrane rupture and onset of regular contractions with cervical dilatation."
- 115 1607 **NEWBORNS**
a) V30 -V39 must be used for all newborns born in hospital or on the way to hospital.
Amend first example in box under a) to the following:
Amend "Newborn, born in hospital, with hypoglycaemia, vaginal delivery.
Amend Principal diagnosis: 775.6 *Neonatal hypoglycaemia*"

The Second Annual National Coding Centre Seminar

To be held at Old Parliament House, Canberra
on **8 and 9 September 1995**.

The 2nd Annual NCC Seminar will focus on "**Managing Coding**", whether this be managing a coding service, managing with coded data, or managing classification systems.

Register your intent to attend with:
Ms Janelle Craig or Mrs Annette Berryman
National Coding Centre
PO Box 170 LIDCOMBE NSW 2141
AUSTRALIA

ph: (02) 646 6345/646 6461
fax: (02) 646 6603
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☺ *You Decide!*

Coder Bumper Sticker Competition

We need your help! Entries came in thick and fast for the *Bumper Sticker Competition* in the last issue of *Coding Matters*. We have narrowed it down to 8 entries, but we just can't decide. To register your vote, pick **one** of the entries below and phone, fax or post your choice to the NCC "Sticker Competition", by 6 September 1995. The winner/s will be announced at the NCC Seminar in Canberra, 8-9 September.

1. **Coders do it with CLASSification**
(Morningson Peninsula Hospital MRAs)
2. **Come any closer and I'll code you!**
(Paul Hussein, Canterbury Hospital)
3. **Coders do it by numbers**
(Too many entrants to list!)
4. **Old coders never die, they just confuse their ICM-9-CDs**
(Geoff Schaedel, Adelaide Day Surgery)
5. **Coders do it in record time...**
(Morningson Peninsula Hospital MRAs)
6. **Coders do it to a national standard**
(Viktoria King, Fremantle Hospital)
7. **Old coders never die, their numbers never up!**
(Dale McCurley, Nepean Hospital)
8. **Coders digitise doctors diagnoses**
(Kerry Innes, NCC - who had to sneak this one in, but as a staff member will not be allowed to win any prizes!!)