

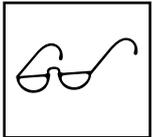


Coding Matters

Newsletter of the National Coding Centre

Volume 2 No. 3 January 1996

FROM THE DESK OF THE DIRECTOR



The National Coding Centre (NCC) is entering the terrible twos - lets hope for *us* that this stage is one of energetic growth without too many growing pains! The signs are certainly auspicious - most noteworthy at the time of writing is the approval by the Australian Institute of Health & Welfare (AIHW) Board for a merger between the NCC and the National Reference Centre for Classification in Health (NRCCH). The recommendation for such a merger was made to the Department of Human Services and Health in the NCC Options Research Paper on the *Future Long Term Suitability of Using the ICD-9-CM in Australian Hospitals* (June 1994). Its realisation will play a major role in consolidating Australian plans to introduce ICD-10 for morbidity and mortality coding in 1998. Details of the merger, to take effect from July 1996, are currently being planned. The NCC welcomes colleagues from NRCCH. Our melded family may in fact have a new name, so our joint identities can be properly reflected in the new organisation.

Talking of reflections, it is salutary to look back on the year past and use its lessons for our immediate and long term future. Much of our activity in 1995 has been directed to further refinement of the *Australian Version of ICD-9-CM* and the *Australian Coding Standards*.

New Australian ICD-9-CM Books for 1996

- see page 7

This has been a major exercise to last us through to 1998 and the introduction of ICD-10 and also to meet deadlines for recommendations for Version 4 of the Australian National Diagnosis Related Groups (AN-DRGs). Collaboration between NCC and clinicians and coders on the Clinical Coding and Classification Groups (CCCGs) has been particularly productive and we acknowledge the help of many individuals throughout Australia who have helped to create new codes and standards that are scientific, realistic and acceptable. So be prepared for a bumper issue of the 1996 Addendum to be incorporated into the 2nd edition of the *Australian Version of ICD-9-CM* for 1996. These efforts will bear fruit in ICD-10 and will help guide the need for further specificity in the Australian version of that classification.

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Karen Luxford, NCC Publications Manager, in her column this issue (*see* page 7) gives details of the new look for the 2nd edition of the *Australian Version of ICD-9-CM* which has come about from feedback from coders on useability of the first edition, coupled with NCC initiatives.

One result of the build up to the NCC/NRCCH merger has been a closer relationship between NCC and AIHW. This has led to the NCC being recognised with NRCCH as a location to carry out the role of AIHW as WHO Collaborating Centre for the Classification of Diseases. I was invited with Sue Walker, Director of NRCCH, to attend a meeting of heads of WHO Collaborating Centres held in Canberra in October 1995. It was extremely helpful in our work towards ICD-10 to have the benefit of meeting representatives from countries which have already experienced the implementation process (UK and Denmark) and those in the throes of planning its introduction. Contact with WHO staff was also useful in linking Australia into the process of developing a national version and participating in the process of updating ICD-10. The week following the meeting, the NCC was host to three international visitors, Marjorie Greenberg and Donna Pickett from the USA and Elizabeth Taylor from Canada (*see* photo below). We have learnt much from both these countries and appreciated the opportunity to exchange at first hand information on classification issues, introduction of new systems of clinical coding and casemix grouping and implications for medical record documentation.

NCC and NRCCH have also been collaborating on production of a video, posters and educational material on completion of front sheets and death certificates directed at hospital interns and residents. This video was made possible with support from the Australian Casemix Clinical Committee (*see* more detail in Janelle Craig's column and order details on page 9).

Since the last issue, the ICD-10 Implementation Committee and ICD-10 Education Committee have met and plans are under way to prepare education and implementation packages for a range of users of ICD-10. We have had excellent response to our call for help in the last issue of *Coding Matters*. The NCC is being assisted with mapping of ICD-9-CM to ICD-10 by staff at NRCCH, Department of Health and Community Services, Victoria, and WA Health. First stages of the mapping were completed at the end of 1995, and more detailed mapping using index terms is to take place early in 1996. Help is also being provided with the creation of the new procedure classification to accompany ICD-10. Christine Erratt and her team (including Gay Lysenko, Anne Elsworthy, Judy Redmond, Gill Bichard and Serena Cheng) have completed the monumental task of analysing the Commonwealth Medicare Benefits Schedule (CMBS) and assigning "extensions" to represent breakdowns such as site, procedure type, approach and use of prosthetic device. These extended codes and descriptions are now being ordered into what we know as a classification, and index entries increased to conform with familiar procedure coding conventions from ICD-9-CM.



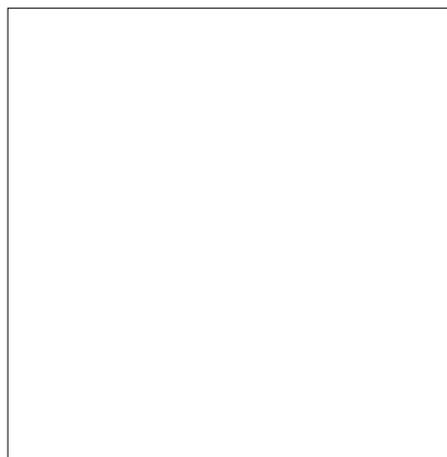
From the left, Rosemary Roberts (NCC Director) discusses the Australian Coding Standards with Marjorie Greenberg (Evaluation Officer, National Center for Health Statistics, USA), Elizabeth Taylor (Manager, Nosology Program, Canadian Institute for Health Information) and Donna Pickett (Medical Classification Administrator, National Center for Health Statistics, USA).

Disease and procedure codes for the Australian version of ICD-10, as well as mappings to ICD-9-CM, will be presented to clinicians between February and June this year before final decisions are made. At the same time, we are working on translation of the *Australian Coding Standards* for ICD-10. All this activity for 1996 and 1998 means that there will be minimal (or no) changes to announce for the *Australian Version of ICD-9-CM* in 1997.

New staff include Leisa Shorrocks, Administrative Assistant, Simone Lewis, Publications Assistant, Jocelyn Lee, Senior Classification Officer and Natalia Alechna, Classification Officer. Leisa was formerly in Medical Administration at Liverpool Hospital and is a most welcome addition to the NCC. Simone will be working with Karen Luxford and will be primarily responsible for coordinating production of specialty booklets for clinical and coding staff. Creation of this position was made possible by a grant from the Australian Casemix Clinical Committee (ACCC). Natalia will also be doing her honours year in Health Information Management in 1996. Jocelyn takes up the position vacated by Michelle Bramley who is now Acting Classification Project Officer. Jocelyn and Natalia will join the Coding Services team, responsible to Kerry Innes, Coding Services Manager, and assist with ICD-10 and procedure code developments. Megan Roach (Stargazer) has also been elevated skyward - to Information Systems Officer - and is now responsible for creating and maintaining databases at the NCC and supporting other packages and network functions. Congratulations to Megan for success in her studies towards a Bachelor of Arts degree! Dr Barry Dale has been appointed as clinician consultant to the NCC. Barry's advice has always been highly valued, and will be even closer to hand when he moves to Sydney early in 1996.

A number of NCC staff attended the very successful Health Information Management Association of Australia (HIMAA) 16th conference in October 1995 in Perth. Following the meeting, Barbara Steinbeck from 3M HIS in Connecticut visited the NCC to discuss the 3M Procedure Classification and compare notes with progress on the Australian procedure

classification. The Perth meeting was surrounded by satellite meetings, including a marathon Coding Standards Advisory Committee (CSAC) which ratified the last of the changes to the *Australian Version of ICD-9-CM* and the *Australian Coding Standards* for 1996. I was also able to attend the WA Coding Executive Committee meeting which coordinates coding and education activities between WA Health, Curtin University and WA Health Information Management Association.



Leisa Shorrocks, new NCC staff member, has already proven to be an Administrative Superwoman.

Staff of the NCC had the opportunity to meet with Carol Lewis, health information management consultant from the USA and visiting fellow in the School of Health Information Management, University of Sydney, during her stay in Sydney in October and November 1995. These discussions and Carol's support of our efforts were much appreciated by the NCC. Close relationships with the School of Health Information Management have been maintained during 1995. Our thanks to Professor Phyllis Watson for her continuing promotion of the Centre. The NCC's work will benefit also from the recent arrival of Professor Beth Reid to the School and we look forward to working with Beth on projects of mutual interest.

And lastly thank you to the readers of *Coding Matters* for your goodwill and support during 1995. We have grown quickly, our staff members are brilliant and enthusiastic, and our aspirations are sometimes higher than reality allows. We look forward to a year where we continue to work with coders and users of coded material to improve data quality and measure accurately the activities of Australian health services.

❖ ***Rosemary Roberts***

Congratulations Associate Professor Roberts!

In December 1995, Judith Kinnear, Dean of the Faculty of Health Sciences, University of Sydney, announced that Rosemary Roberts (NCC Director) had been conferred with the title Associate Professor. Congratulations to Rosemary from NCC staff and her many colleagues for a title well deserved! The following is a brief summary of Rosemary's achievements.

Rosemary holds a pioneering qualification in the area of HIM, that of the Certificate in Medical Record Librarianship, and has expanded her tertiary experience to include a Bachelor of Arts (University of Sydney), Master of Public Health (University of Sydney) and Master of Business Administration (Monash University).

Rosemary's first position in medical records was at Royal Prince Alfred Hospital, Sydney, in 1962, where she concurrently held the position of Deputy Director of Training for the then NSW School of Medical Record Librarians. Soon off to see the world though, her next position was Assistant Medical Record Librarian at Massachusetts General Hospital, Boston, Mass., USA in 1965.

Over the next three decades, Rosemary worked in various positions, in hospital medical record departments, state and federal health departments, and universities. If she was not

administering, she was teaching, checking quality and evaluating, conducting research, performing consultancies, and developing and managing projects. Highlights include: Project Officer, ACT Health & Commonwealth Department of Health; Head of School of Medical Record Administration, Cumberland College of Health Sciences; Quality Assurance Coordinator, Royal Victoria Hospital, Montreal, Canada; Special Projects Officer, Westmead Hospital, Sydney; Administrative Officer, Medical Administration, Royal Melbourne Hospital; and, of course, currently fearless leader of the National Coding Centre.

We could not begin to touch here on Rosemary's numerous research projects and publications, nor on her input to professional organisations and numerous committees over the years - suffice to say, it has been extensive!

The granting of this title is an accolade attesting to Rosemary's many contributions to the field of health information management (HIM) throughout her distinguished career. Her efforts have also afforded her the respect of the wider health sector.



Congratulations once more Associate Professor Roberts - you've earned it!

From the left, Professor Judith Kinnear (Dean, Faculty of Health Sciences, University of Sydney) congratulates Rosemary Roberts (NCC Director) on the conferring of her new title. On hand to join in the celebrations was Professor Phyllis Watson (right), Head of the Faculty's School of Health Information Management.



Letters To The Editor



Dear Editor,

13 September 1995

At the recent National Coding Centre Seminar, I had occasion to consider Coder Accreditation. As accreditation **seems** to be developing - pass marks will require full and detailed knowledge of all clinical specialties. While final decisions regarding "depth" of knowledge required are some way off, all indications are that these will be very difficult exams.

I do not argue that the baseline, general coding must be of high quality. It is the foundation for health information. However, it seems that brand new graduates would have little ability to meet the proposed standards. Also experienced coders who have been working within a decentralised model or at a specialist teaching hospital will fail to meet to maintain the required broad high level coding skills.

Decentralisation and specialisation of coding should be catered for, in the future, by specialist accreditation.

It is, however, a concern to me that we are effectively saying that our graduates from the various coding education programs will be below the "agreed standard" i.e. accreditation for quality coding. This carries a strong message to our health care peers, where their graduates cannot practice until they reach the standard for accreditation/registration. It may be wise to consider a pre-accreditation year/s, similar to the Pharmacists, to address both the issues of experience and accreditation.

I do not advocate a lowering of the standards for accreditation - I do however, suggest that this problem be considered by those responsible for the education of clinical coders.

Yours sincerely

Andrea Griffin
Special Projects Officer
Mater Children's Hospital

In Reply: Sorry your letter missed the deadline for the October 1995 issue of *Coding Matters*, Andrea! Your letter was, however, passed on to the NCWIP Steering Committee for consideration. Their edited reply follows below (for a more detailed reply on similar issues, see *Health Information Management*, Vol. 25, No. 3 (1995), p81):

Dear Andrea,

15 December 1995

Thank you for your letter regarding the Coder Accreditation exam. We hope the following will help explain the rationale behind the way the exam is being developed.

The Coder Accreditation examination is being based on the Clinical Coder National Competency Standards, developed by the HIMAA and submitted for approval to the National Community Services and Health Industry Training Advisory Board. This means that the examination is competency-based, or criterion-referenced. The Standards define the knowledge and skills which competent clinical coders must have. The coder accreditation exam is one method which can be used to measure a coder's knowledge and skills and allow us to judge whether that coder does or does not meet or exceed the standards.

There are two types of evaluation: norm-referenced and criterion-referenced. When you compare the performance of one person or thing with that of other persons or things and then rank-order them, you are carrying out norm-referenced evaluation. When you compare the performance of the person or thing against some objective standard, you are making a criterion-referenced evaluation. In academic results grades such as Pass, Credit and Distinction reflect norm-referenced evaluation; courses in which students are evaluated on a Pass/Fail basis are criterion-referenced. The two evaluation methods are used for different purposes.

All this explanation is merely to try to dispel the notion that the coder accreditation examination will be "very difficult". The examination items are being designed to test whether coders can or cannot code competently. There is no intention to ask tricky questions, only to test fundamental coding skills and knowledge. This will not be difficult for competent coders.

Continued on page 6.....

You suggest that “brand new graduates would have little ability to meet the proposed standards”. This will be true for many new graduates, and as the HIMAA brochure on clinical coder accreditation says, “Although the examination is open to all clinical coders, it is not recommended for newly trained coders”. Following instruction in coding, practical experience is necessary to reinforce that instruction. We know of no-one who disagrees with this concept. This is why sitting for the exam is a voluntary process; coders should only sit for the exam when they feel confident about the level of their skills.

The tentative timetable for the ICD-9-CM exams has them running in October 1996, April 1997 and October 1997. Most health information management students complete their courses in December and would have the opportunity to expand and refine their coding skills before enrolling to take any of these exams.

Your concern for those coders who work in decentralised or specialist hospitals is accepted. However, we feel that someone who is a specialty coder or who works in a rural area should still have fundamental coding skills. We suggest that the development of specialist examinations should come after the general coding exam, not before. We are concerned by the implication that specialist coders only code from their specialty chapter and that coders in small hospitals only code simple, uncomplicated cases. Small hospitals and specialist facilities may well have a higher proportion of straightforward coding but there will always be the occasional more complicated cases because of the nature of disease or injury, or complications and comorbidities. A coder with the requisite general coding skills should be able to cope with the more complicated record.

We feel that to develop specialty specific exams would, in the first instance, created considerable educational and administrative problems. Having to sit multiple exams may also be seen as being discriminatory against the generalist coder and it must be acknowledged that there are more generalist than specialist coders in this country.

In the development of the Competency Standards, we were careful to state that we recognise the value of experience on the proficiency of clinical coders. It was because we did not want the healthcare industry to expect a newly trained coder to be an “expert” that this was specified and to negate the feeling that graduates from the various coding programs are “below the agreed standard” because they may not feel automatically ready to sit the accreditation exam.

Your letter suggests that “pre-accreditation year/s” be advocated. In fact, this is what the HIMAA is

suggesting should happen in an informal way. By advising newly trained coders that they may not have sufficient experience to meet the standards, the HIMAA is encouraging them to ensure that they gain experience before attempting the accreditation exam. Again, because of the type of factors mentioned above, we do not believe that we can state with any confidence how long it takes a coder to hone their skills sufficiently to meet the competency standards.

To be valuable, the “pre-accreditation year/s” would have to be an organised program of supervised and monitored coding activities. If such a program was introduced, it would have to be administered. We shudder to think about the clerical work involved, especially keeping track of those coders who change jobs or work part-time.

Those responsible for the education of clinical coders have considered the issues raised in this letter, and believe that the coder accreditation process being introduced by the HIMAA meets the needs of coders, employers and healthcare payers in a fair, effective and efficient way. Clinical coders who believe that they are competent in their work will be able to choose to sit for an exam which will compare their performance against a standard, and so be able to demonstrate to others that they are competent.

Yours sincerely

Sue Walker and Jennifer Mitchell
NCWIP Steering Committee



***NCC Homepage & Resource Centre
is now available on the Internet***

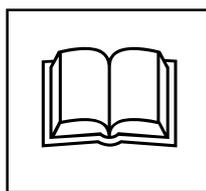
Visit us now on...

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

Find out about our latest projects and new staff. Visit the Resource Centre where you will find direct links to other relevant net sites.

We aim to have a dynamic & active site, so hopefully you will always find something new!

PUBLICATION ISSUES



The big news in publications is that the NCC is producing new Australian ICD-9-CM books for 1996. The second edition of our coding books, effective from July 1996, will have improved features, such as enlarged print and soft bound covers. Your feedback has been valuable to us and independent NCC trials have proved that producing a new, second edition is feasible. Another factor warranting the production of completely new books has been the size of the July 1996 Official Addendum! There are numerous coding improvements and many new codes (*see Coding Tips, page 13*) causing frequent printing changes, which would have been an updating nightmare! The volume of these changes along with the need to change the physical appearance of the book were our main reasons for opting for a brand new publication rather than the publishing of looseleaf updates.

The 1996 *Australian Version of ICD-9-CM* will be an A4 sized publication with enlarged print. All volumes will be bound with soft covers and the publication will be printed as four volumes, with the fourth volume being the *Australian Coding Standards*. As of 1 July 1996, the second edition of the *Australian Version of ICD-9-CM* will supersede the 1995 NCC publication in both Australia and New Zealand. As with the 1995 coding books, new Australian codes will be annotated.

Presently, the intention is that there will be minimal (or no) changes to announce for the *Australian Version of ICD-9-CM* in 1997 and hence that these books will be effective until the introduction of ICD-10 in July 1998.

What does this all mean for our existing customers? As purchasers of the 1995 NCC *Australian Version of ICD-9-CM*, you will receive a complete 4 volume set of new improved 1996 coding books for the update price of only **\$50!** This very reasonable price of \$50 applies only to existing customers and then only as replacement of the same number of complete 4 volume sets purchased of the 1995 NCC

Australian Version of ICD-9-CM. New customers will be able to purchase the 1996 coding books for \$200 per complete 4 volume set (new students \$150). Existing customers of the 1995 *Australian Version of ICD-9-CM* can purchase additional 4 volume sets, over and above their original purchase quantity at the price of \$200. The table below outlines the July 1996 publication prices.

1996 Australian Version of ICD-9-CM		
	Existing Customer	New Customer
1996 <i>Australian Version of ICD-9-CM</i> **	\$50*	\$200
<i>Additional copies of 1996 Australian Coding Standards (Volume 4 only)</i>	\$20*	\$60
* These prices only apply to the quantity of books previously purchased. Purchases over and above this quantity must be made at new customer prices.		
**4 volumes, including <i>Australian Coding Standards</i> .		

Remember that the 1995 *Australian Version of ICD-9-CM* is current until the 1996 second edition becomes effective on the 1st of July 1996.

Order forms for 1996 edition coding books will be posted out in early April 1996.

We hope that the new improved 1996 ICD-9-CM will make the life of Australian and New Zealand coders just that bit easier.

Another special announcement is the appointment of Simone Lewis, Publications Assistant, who comes to the NCC with experience in medical publishing and medical transcription. Simone will be primarily responsible for coordinating the production of specialty specific booklets on the topics of casemix, DRGs and clinical coding. The NCC will shortly be calling on the expertise of CCCG clinicians and clinical coders, amongst others, to help produce a series of booklets tailored to each specialty area. The intended audience for these booklets is clinicians, clinical coders and health information managers. The first three specialties to receive Simone's attention will be Respiratory, Oncology & Haematology and Geriatrics and Rehabilitation. Welcome Simone!

❖ *Karen Luxford*

Maggot Therapy Revisited



Several interesting and enlightening responses to the coding query on “Maggot Therapy” - intended as a hypothetical!

Kerry Innes, NCC Coding Services Manager, suggests code 96.59 *Other irrigation of wound* (including, Wound cleaning NOS!). Here are your responses, some funny and some gruesome.....

Rosemary Cartmill (Longueville Private Hospital, NSW) “Re: Maggot Therapy. There is nothing new under the sun. I have inadvertently used it as Orthopaedic Ward Sister at a major hospital many hot summers ago (open windows, no air-con.). I was then assured by the surgeon that the practice was very common in WWI field hospitals. I would code it 86.28 *Nonexcisional debridement of wound, infection, or burn* or (maybe) 96.59 *Wound cleaning NOS*.”

Lainee Kininmony (Fullarton Private Hospital, SA) “Maggot Therapy? Easy - code 102.3 Worm-eaten ‘souls’!!!!”

Dot Muir (Rockingham/Kwinana Health Service, Qld) “Re: Maggot Therapy - not a new treatment by any means - it was practised, I believe during the war - and in my years of nursing in isolated areas, (I) have seen it used by Aboriginal people - the wound remained clean - no sepsis and granulated internal to external - No ‘debridement’ necessary, therefore how about Debridement, skin and subcutaneous tissue 86.28.”

Paul Strawson (Lithgow District Hospital, NSW) “The diagnosis would relate to a complicated wound. The procedure probably would be ‘debridement of wound using biological agent’, subcategory - insect larvae. Such a code doesn’t exist at present, but it wouldn’t be difficult to assign codes in future ICDs for different agents, including the use of engineered bacteria (which may be more acceptable to patients and clinicians). The

present equivalent is the oil-eating bacteria used in cleaning oil spills. Sounds a bit sci-fi, but didn’t it all once?”

Maryann Wood (NRCCH, QUT, Qld) “Re: Codes for Maggot Therapy. 86.28 Nonexcisional debridement of wound... 86.22 Excisional debridement of wound.... I think the code depends on whether they eat the skin and if eating is considered excisional! P.S. I don’t think I would ever consent to the treatment!”

Thanks to all those readers who joined in the fun, and gave us their tips for coding maggot therapy.

❖ *Karen Luxford*



**Your horoscope
by
Megan Stargazer**

♎ *Capricorn December 23 - January 20*

Take this time to relax Capricorn. Try to avoid situations that may lead to 300.10 and instead go for some 93.81. There is someone who doesn’t appreciate your selective 389.9 and you may find that you have some apologising to do.

♈ *Aquarius January 21 - February 19*

Some of you may be having a bit of New Year 309.29 which leads to some V40.9. Don’t worry this time will pass. Try not to develop a 300.23 as this will make partying difficult. On the health side, avoid falling victim to the occasional E918.

♈ *Pieces February 20 - March 20*

In late December you may have experienced E848. Your E904.1 for adventure may lead you into some strife so take care to avoid E829.2. People you encounter may be up and down over this time but over all you should get through your relationships with only a few E906.8’s.

DOCUMENTATION: A Matter of Life or Death

An overview of morbidity and mortality data collection for Australian health services

BACKGROUND

Quality documentation in healthcare is more important now than ever before. Epidemiological and medical research, and the monitoring, funding and planning of health services are all dependent on the accurate recording of clinical information.

The National Coding Centre (NCC) and the National Reference Centre for Classification in Health (NRCCH), with funding from the Australian Casemix Clinical Committee (ACCC), have developed an educational video and poster package suitable for use during orientation and continuing education sessions for clinicians.

AIMS OF THE EDUCATION PACKAGE

- ♦ To improve the quality of source documentation used for the collection of morbidity and mortality data.
- ♦ To enhance communication between clinicians and health information managers.

TARGET AUDIENCE

- ♦ New resident medical officers and registrars.
- ♦ Other clinicians, including private practitioners, specialists, general practitioners, and medical officers working in private hospitals and same day facilities.
- ♦ Medical, nursing and allied health students, and other practising health professionals.

PRODUCT INFORMATION

The package contains information on:

- ♦ selection of principal diagnosis and underlying cause of death
- ♦ completion of front sheets and death certificates
- ♦ uses of coded data
- ♦ the relationship between documentation, coding and casemix funding.

❖ *Janelle Craig*

Coding Matters Vol.2 No.3

DOCUMENTATION: A Matter of Life or Death

This Video and Poster package is already selling fast, so don't miss out..

Order Now!

Prices: (all prices include postage and handling within Australia).

- ♦ **Package** **\$50.00**
- ♦ **Video only** **\$30.00**
- ♦ **Posters only** **\$20.00**

You may choose to order the complete package (video and posters) or select either the video or the posters.

To place an order, call Leisa Shorrocks at the NCC on **(02) 646 6461**. 

FURTHER INFORMATION

Janelle Craig	Sue Walker
Coding Education Manager	Director
NCC	NRCCH
Ph: (02) 646 6345	Ph:(07) 3864 5873
Fax: (02) 646 6603	Fax:(07)3864 5515

Seen below here filming the "Documentation" video at Concord Repatriation General Hospital are actors Gosia Dobrowolska (Doctor) and Ken Radley (Mort), out on the slab (for all the mothers who also watch "Bananas in Pyjamas", Ken is B1!).

CLINICAL CODERS'

 SOCIETY OF AUSTRALIA

Since the last edition of *Coding Matters*, the Establishment Committee of the Coding Society/Forum has met on a number of occasions to continue work on the formation of the Society.

Significant achievements include:

- ❖ naming the Society/Forum as the **Clinical Coders' Society of Australia (CCSA)**
- ❖ creation of a logo and marketing brochure
- ❖ work on the constitution by which the Society will operate
- ❖ determination of the mission of the Society, which is ***"to provide a forum and support for clinical coders and those interested in the coding of health care data"***
- ❖ development of specific objectives to fulfil the mission of the CCSA (*see* Society objectives in box on this page)

Early in 1996, a marketing brochure will be circulated to all people listed on the National Coder Workforce Issues Project (NCWIP) database. This expression of interest brochure will outline the role and function of the CCSA, advantages of membership and detail how those interested in the society can be placed on the CCSA mailing list.

For further information, please contact your state/territory representative:

ACT	Seija Graham	(06) 201 6281
NSW	Lynn Lehmann	(049) 213 404
VIC	Kathryn Baxter	(03) 9276 3021
QLD	Julie Turtle	(07) 3299 8596
SA	Barbara Levings	(08) 375 5233
WA	Joan Knights	(09) 382 6921
TAS	Mark Ralston	(004) 306 527
NT	Ann Shelby-James	(089) 228 635

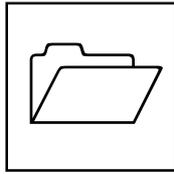
Janelle Craig
 Chair, Establishment Committee

Objectives of the Clinical Coders' Society of Australia (CCSA):

- ◆ advise the Health Information Management Association of Australia (HIMAA) on issues related to the coder workforce and coding policy
- ◆ act as an advisory body to members
- ◆ establish links with organisations which have common areas of interest in clinical coding
- ◆ promote an understanding of the value of quality coded data
- ◆ provide continuing education activities for members
- ◆ support coder training programs
- ◆ encourage research and publications
- ◆ promote ethical behaviour and a high standard of performance amongst members
- ◆ strengthen membership through active recruitment
- ◆ promote clinical coders in the health care community
- ◆ assist in the maintenance of coder accreditation
- ◆ liaise with organisations representing the industrial interests of members



Coding Tips



❑ **Unwanted pregnancy** V61.7 *Other unwanted pregnancy* should be assigned rarely.

Specifically, it should not be used as the principal diagnosis in admissions for termination of pregnancy. Admission for termination of pregnancy should be assigned a principal diagnosis code of 635.xx *Legally induced abortion*.

❑ **Admission for endoscopy with family history of certain condition**

When a patient with a family history of a certain condition or a malignancy is admitted for an endoscopy, use the following rules:

a) Assign the appropriate V16.x - V18.x code as the principal diagnosis if the result of the endoscopy is clear for the condition being investigated:

EXAMPLE: Patient admitted with family history of colon malignancy for endoscopy. The only finding at colonoscopy is a hyperplastic polyp and it is removed with snare forceps.

Code V16.0 *Gastrointestinal tract* as principal diagnosis, then 569.0 *Anal, rectal, and colon polyp* for the polyp and colonoscopy with polypectomy 45.42.

b) Assign the code for the condition being investigated as the principal diagnosis, if this condition is found at endoscopy. Assign the appropriate history code as an additional diagnosis:

EXAMPLE: Patient admitted with family history of colon malignancy for endoscopy. Adenocarcinoma of the descending colon is found at endoscopy and biopsied.

Code 153.2 *Malignant neoplasm, descending colon* for the malignancy, V16.0 *Family history of malignant neoplasm, gastrointestinal tract* as an additional diagnosis and 45.25 for the colonoscopy and biopsy.

Continued top of next column...

c) The V16.x - V18.x series should be given preference over the use of V71.x *Observation and evaluation for suspected conditions not found* for these types of admissions.

d) Any subsequent admissions for followup of family history of malignancy should have the appropriate V16.x code as the principal diagnosis if no malignancy is found, not V71.8 or V67.x.

e) Any subsequent admission for followup of family history of malignancy where malignancy is found should be coded according to the rule in (b) above. Code V67.0 *Follow-up examination, following surgery* should be assigned as an additional diagnosis.

❑ **Suprapubic catheterisation**

Coders should note the difference between codes 57.17 *Percutaneous cystostomy* and 57.18 *Other suprapubic cystostomy*. 57.17 should be assigned for closed (percutaneous) suprapubic catheterisation which is often performed after hysterectomy. 57.18 is an open operation and would involve a urologist and would therefore be used less often.

❑ **Mechanical ventilation of the newborn**

Subsequent to advice published in *Coding Matters, Vol 2, No.1, page 15* (namely, that “mechanical ventilation and intubation for neonates, regardless of duration or means of administration should be coded”), the issue of coding mechanical ventilation for neonates has recently been discussed by the Neonatal Subcommittee of the Paediatric Clinical Coding and Classification Group (CCCG). The neonatologists advised that mechanical ventilation for neonates for a period of <25 hours **should not** be coded, in order that consistency is achieved in the coding of ventilation for both adults and children. My apologies for the confusion that this issue has caused. As a result of the previous advice to code ventilation for neonates, many coders began using 96.70 to reflect this treatment.

However, this subsequent decision means that code 96.70 *Continuous mechanical ventilation of unspecified duration* should never be assigned.

Continued on page 12...



□ Acute HIV infection syndrome

The Infectious & Immunology CCGG has recommended the introduction of a coding method which can identify cases of acute HIV infection syndrome. After consultation with coders and clinicians, the following information is provided:

A significant proportion (40-60%) of patients will develop an acute illness shortly after acquiring HIV infection. This illness most commonly presents as a glandular fever like illness with fever, sore throat, lymphadenopathy, rash and occasionally complications, including meningitis. The diagnosis of acute HIV infection syndrome (or primary HIV infection) is not established until the patient develops antibodies to HIV (i.e. seroconverts). This usually takes 3-6 weeks following the onset of the illness. Although the diagnosis of acute HIV infection syndrome may be strongly suspected at the time of discharge, it will not usually be confirmed at this time. Supportive evidence of acute HIV infection syndrome during the admission would include a positive HIV p24 antigen test. The possibility of acute HIV infection syndrome should have been recorded in the clinical record. A negative HIV antibody test during the admission does not exclude the diagnosis.

Where the diagnosis of "acute HIV infection syndrome" (either confirmed or suspected) is documented, assign code V01.7 *Contact with or exposure to other viral diseases* as an additional diagnosis to the codes for the presenting symptoms (e.g. lymphadenopathy, fever) or complication (e.g. meningitis).

Infrequently, a patient may require re-admission for acute HIV infection syndrome due to complications. The principal diagnosis (e.g. meningitis (047.9)) should be coded first with acute HIV infection syndrome (V01.7 *Contact with or exposure to other viral diseases*) as the additional diagnosis.

After complete resolution of the primary illness, almost all patients will become asymptomatic and remain so for several years. Coding of future admissions would be determined by

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existing guidelines. The acute HIV infection syndrome code (V01.7) should not be used again once the patient has recovered from the primary illness.

When coders are unsure about the correct assignment from the available HIV codes (i.e. 795.71 *Nonspecific serologic evidence of human immunodeficiency virus [HIV]*, V01.7 *Contact with or exposure to other viral diseases*, V08 *Asymptomatic human immunodeficiency virus [HIV] infection status*, or 042 *Human immunodeficiency virus [HIV] disease*) for such cases, the clinician should be consulted.

It will be most helpful to begin coding these cases now, not only for clinicians and others interested in HIV, but also to allow easier transition into ICD-10 from July 1998 where this diagnosis is included as code B23.0.

➤ GENERAL CODING INFORMATION ◀

◆ Mapping of ICD-9-CM codes

An error has been detected in the mappings published in 1995. In the backward mappings for codes in AN-DRG V3.0 back to codes in AN-DRG V2.1 and V2.0 the following corrections should be made:

Procedure codes

Backward mapping 1995-1994 (AN-DRG V3.0-V2.1)	
Map from 1995 code	Map to 1994 code
4104	4101 9979

Backward mapping 1995-1993 (AN-DRG V3.0-V2.0)	
Map from 1995 code	Map to 1993 code
4104	4101 9979

Backward mapping 1995-1992 (AN-DRG V3.0-V1.0)	
Map from 1995 code	Map to 1992 code
4104	4101 9979

Procedure code 41.04 *Autologous haematopoietic stem cell transplant* should map to 41.01 *Autologous bone marrow transplant*, not 99.79 *Other therapeutic apheresis*. State/Territory Health Authorities will be advised separately.

Continued on page 13....

◆ **News about the upcoming**

Huuuuge addendum for July 1996

In December, there was much Xmas cheer in the Coding Services section not only because it was Xmas time but because we had just completed the jumbo addendum for July 1996 which has a total of **280** new codes. Many *Australian Coding Standards* (ACS) have been added to the index of ICD-9-CM which has resulted in a better index and a few standards being deleted from Volume 4. Here are just a few of the changes which will be effective for separations on and from 1 July 1996:

Volume 1- New disease codes, July 1996:

Amyloidosis due to dialysis (277.31)
Change of bowel habit (787.8)
Chronic renal impairment (585.1)
Congenital malformations (759.84, 759.85, 759.86, 759.87, 759.89 756.00, 756.01, 756.02, 756.03, 756.08, 756.09)
Cystic fibrosis with pulmonary (277.02) and intestinal manifestations (277.01)
Diarrhoea (787.91)
Falls, NOS (799.5)
Febrile convulsions (780.31)
Fracture of tooth, pathological (525.4)
Iatrogenic hypotension (458.2)
Loin pain/haematuria syndrome (593.83)
Necrotising fasciitis (729.4)
Postoperative hypertension (997.91)
Postoperative pulmonary embolism (415.11)
Posttraumatic amnesia - new codes for various time period of amnesia
Stomach and duodenum polyps (537.84)
Radiation proctitis (569.43)

Admission for removal of catheters, both vascular (V58.81) and non-vascular (V58.82)
Admission for second/subsequent procedure (V58.83)
Bilateral limb amputation status (V49.68, upper), (V49.78, lower)
Breast feeding difficulties (V24.3)
Harmful use of alcohol (V15.84), drugs (V15.85)
History of tobacco use (V15.82) and current use of tobacco (V15.83)
Reduced foetal movements, undelivered (V28.6)

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Drowning following fall into natural water E910.7
Drowning following fall into swimming pool E910.6

Drowning in swimming pool E910.5

Falls:

bed E884.4
footpath E880.1
toilet E884.7
trampoline E884.5
tree E884.3
wheelchair E884.6

Injuries in sports:

basketball E889.5
cricket, E889.7
football, league E889.0
football, Australian E889.1
hockey (field) E889.3
netball E889.6
roller skating E889.8
soccer E889.2
squash E889.4

Injury by hypodermic needle E920.5

Maltreatment by spouse E967.2

Tabular list of diseases:

All references to "degree" in the burns section have been changed to "thickness".
The concussion section has been revised to provide greater clarity in the assignment of head injuries with/out concussion.

Volume 2 - Index additions, July 1996:

Confusional state (293.9)
Erosion of knee (715); erosion of patella (717.7)
Reduced foetal movements, delivered (656.8)
Ulcerative oesophagitis (530.11)

Volume 3 - New procedure codes, July 1996:

Amniocentesis, diagnostic (75.11) and therapeutic (75.12)
Colposcopy (67.13)
Declotting of arteriovenous shunt/fistula (39.45)
Destruction of cervical lesion by laser (67.34)
Dietetics codes in category 92.9
Dilation/stenting of single coronary vessel (36.06)
Dilation/stenting of multiple coronary vessels (36.07)
Dilation/stenting of other vessels (38.20)
Elective LSCS (74.11)
Emergency LSCS (74.12)

Continued on page 14....



Endoscopic endometrial ablation (68.23)
 Endoscopic laser therapy of stomach and duodenum (44.45)
 Endoscopic release of carpal tunnel (04.45)
 Extraoral osseointegrated implant (02.97) (81.70)
 Foetotoxic management for removal of ectopic pregnancy (66.90)
 Forehead rhytidectomy (86.87)
 General anaesthesia (99.90)
 Insertion of prostatic stent/coil (60.96)
 Insertion of urethral stent (58.94)
 Intraoral osseointegrated implant (23.61)
 IVF procedures - category 69.8x
 Laser assisted prostatectomy (60.21)
 Lung volume reduction surgery (32.22)
 Microscopic reconstruction of the vas deferens (63.86)
 Microwave thermotherapy of prostate (60.64)
 Occupational therapy codes in category 93.8
 Physiotherapy - various new codes
 Second look laparotomy (54.13)
 Segmental implant for spinal fusion (81.3)
 Social work codes in category 94.7
 Stereotactic radiosurgery (92.3)
 Surgical extraction of one tooth (23.12), two or more teeth (23.13)
 Surgical removal peritoneal dialysis catheter (54.90)
 Temporal artery biopsy (38.23)
 Transvaginal needle suspension (59.73)
 Treatment of pterygium by laser (11.33)

Note that the addendum will be incorporated into the 2nd Edition of the Australian Version of ICD-9-CM (see “Publication Issues” column for details, page 7), so that coders will not need to access the addendum for updating purposes, but it will be useful as a guide to the substantial number of changes to be implemented in July 1996. The addendum will be available from State/Territory Health Authorities in early 1996.

◆ **Australian Coding Standards for July 1996**

As mentioned previously, a number of standards have been deleted and transferred to the index of ICD-9-CM. In other cases, the standard will remain in Volume 4 and also appear in the index of ICD-9-CM. Overall, work this year on the ACS has resulted in 76 new standards, a further 30 standards having changes made to the wording and 44 standards being deleted. Some of the new standards are:

Continued top of next column...

- ◆ Degloving injury
- ◆ Functional endoscopic sinus surgery
- ◆ Optic nerve sheath decompression
- ◆ Osseointegration implants
- ◆ Para-aortic lymph node biopsy
- ◆ Postnatal attachment difficulties
- ◆ Stereotactic radiosurgery

◆ **Coding queries**

As a result of the long hours required to generate the jumbo addendum for 1996, responding to state coding queries has been protracted more than we would like. We’ve done our best to keep the flow going to all states and territories to ensure that you don’t end up with a huge pile of unanswered queries. I’d like to take this opportunity to thank the many coders across the country who assist us in answering the queries. Your input is valuable and I’m sure the involvement is generating healthy discussion amongst coders.

◆ **New procedure classification development**

Thanks to all those people who responded to our request for help with the implementation of ICD-10 and the procedure classification in the last *Coding Matters*. As a result, we have been able to employ casual staff to assist Christine Erratt with the development of the CMBS-Extended procedure classification which is progressing according to deadline. Unfortunately, we are not able to employ everyone who responded at this stage, but we have you “on the books” and we will contact you when further opportunities arise.

◆ **Mapping project ICD-10**

The Coding Services section is also beavering away on the mappings from ICD-9-CM to ICD-10. At the time of writing, ten chapters have been completed and work on the further 9 chapters almost finished. The NCC is receiving help with this massive task from Western Australia, Victoria and Queensland.

◆ **Change in terminology for “secondary conditions”**

In order to conform with the National Health Data Dictionary definitions, references to “secondary conditions” have been changed to “additional diagnoses” in the revision to the *Australian Coding Standards* for July 1996.

❖ *Kerry Innes*

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What do coders like most about coding?



For those of you who have not read the results of the NCWIP national questionnaire or have not had the opportunity to attend conference presentations of the results, here are the points that you said you liked most about coding:



Challenging/interesting nature of coding 33%



Learning and acquiring skills 27%

Assigning codes accurately/getting it right 11%



Variety 5%

Following through the patient or disease process 3%



DRGs and casemix 3%

General comments made by coding service managers about 'coders and coding' emphasised four main areas*:

- the need for more communication between coders;
- the need for more continuing education for coders;
- the need for training of medical staff about the requirements for medical records and coding; and
- issues relating to quality

As a national newsletter dealing with coding issues, the staff of the National Coding Centre (NCC) hope that *Coding Matters* helps coders and managers to fulfil these needs. The NCC-NRCCH Video & Poster Package entitled "*Documentation: A Matter of Life or Death*" (see page 9) is aimed at catering for your request for training of medical staff about the requirements for medical records and coding. *Clinical Update Packages* such as those advertised by HIMAA-NCWIP (see page 15) are helping to meet your needs for continuing education.

*Mitchell, J. (1995) Attitudes to coding: A comparison of the perceptions of managers and coders. Proceedings of the 16th Conference of the Health Information Management Association of Australia, Perth.

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Medical Record Managers

Coding Matters contains information that is important to **all** coders. Therefore, could you please ensure that this newsletter is circulated to the coders in your section so that they may also keep up to date with national coding issues. ❖

The National Coding Centre (NCC) is funded by the Casemix Development Program, Commonwealth Department of Human Services and Health. The NCC is an independent national body established by the School of Health Information Management, Faculty of Health Sciences, University of Sydney. ❖