

A new way to have your say



NCCH will launch a new on-line public submission process for ICD-10-AM/ACHI/ACS in July 2008.

The National Centre for Classification in Health (NCCH) is excited to announce that the new on-line public submission process for suggesting modifications to ICD-10-AM/ACHI/ACS will commence in July 2008. The NCCH will be accepting public submissions all year round. This will enable interested members of the public and representatives of relevant agencies or organisations to work on submission documents as classification issues are identified and then submit them on-line, via the NCCH website.

In the past, the public submission time frame was limited to a three month period during a two year cycle. The NCCH works to update ICD-10-AM/ACHI/ACS within a two year time frame. It is often difficult to incorporate all public submissions into the next edition of ICD-10-AM/ACHI/ACS when taking into account the time spent on research,

consultation, WHO approval (when required) and production. The NCCH does prioritise public submissions where necessary. This means that not all the public submissions received within the two year cycle will necessarily be implemented in the next edition of ICD-10-AM/ACHI/ACS.

ICD-10-AM is a classification of diseases based upon the World Health Organization's statistical classification ICD-10. ACHI is the Australian Classification of Health Interventions. The Australian Coding Standards (ACS) are guidelines designed to be used in conjunction with ICD-10-AM and ACHI.

The main objectives of the public submission process are to ensure that ICD-10-AM/ACHI/ACS meet users' needs and continue to be comprehensive and clinically meaningful.



Public Submission Request for Modification of ICD-10-AM / ACHI

When completing this form you must refer to the Submission Guidelines.
The submission form must be completed in full.

All documentation supportive of and relevant to the submission should be attached (preferably electronically attached to this online form, otherwise faxed or mailed to NCCH).

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Existing ICD-10-AM/ACHI code lacks specificity

(Please identify in the space below the existing code and include the reason(s) why the code needs expansion)

Existing ICD-10-AM/ACHI code assignment is outdated due to advances in medical knowledge

(Please identify in the space below the existing code and include the reason(s) why the code needs to be reclassified)

Disease or related health problem is currently not classified in ICD-10-AM

(Please describe in the space below why a new code is needed in ICD-10-AM and provide all relevant documentation to support your request)

Procedure or intervention is currently not classified in ACHI

(Please describe in the space below why a new code is needed in ACHI and provide all relevant documentation to support your request)

Typographical Error

(Please describe the error in the space below)

Indexing issue

(Please describe the issue in the space below and provide all relevant documentation to support your request)

Australian Coding Standards issue

(Please describe the issue in the space below and provide all relevant documentation to support your request)

Other issue

(Please describe the issue in the space below and provide all relevant documentation to support your request)

Subject (maximum 50 characters):

Reason(s) why the code needs expansion or reclassification or why a new code is needed in ICD-10-AM or ACHI (maximum 1,000 characters. If this is insufficient, or if you prefer, please attach a document in the section below.):

Do NOT submit file greater than 4 Mb in size.

Guidelines for making a submission

The following guidelines will help you make an on-line public submission

When preparing a submission:

There are a number of reasons to consider modification of the disease and procedure classifications:

1. Existing ICD-10-AM/ACHI code is too general or lacks specificity
2. Existing ICD-10-AM/ACHI code assignment is outdated due to advances in medical knowledge
3. Disease, related health problem or procedure/intervention is currently not classified in ICD-10-AM/ACHI. For example, identification of a new disease, diseases of uncertain aetiology or a new procedure must represent a unique concept to expert clinicians in that specialty. For procedures, they must be sufficiently important and different in terms of frequency, site, procedure, technique, approach, use of technology or device, stage or invasiveness to warrant separate classification.
4. Typographical error has been found within ICD-10-AM/ACHI/ACS
5. ICD-10-AM/ACHI/ACS indexing issues

6. ACS issues

There is also provision for 'other issues' which might lie outside of the reasons listed above.

When developing a submission:

Consideration should be given to the following points:

- Is the problem experienced with the classification a result of data collection methods?
- Is the problem due to a lack of knowledge of the classification?
- Is the recommended modification due to a need for information specific to a unique situation?
- Does the recommendation for modification or new code compromise the purpose and structure of ICD-10-AM or ACHI? That is, does the recommendation follow existing rules and conventions and relate to a disease, an injury, a related health problem, an external cause, or a procedure (intervention)?
- Does the recommended modification or new code overlap with any existing codes in the classification?
- Does the recommended modification or new code require definition to ensure correct usage?





CASEMIX EVOLUTION

extending the boundaries

Casemix-based funding is the dominant form of funding of public hospitals in most states and territories in Australia. Casemix aims to fund on individual outcomes, rather than on a historical level of funding.

On 16-19 November 2008, the Department of Health and Ageing will host 'The Casemix Evolution: extending the boundaries', which aims to view casemix in a holistic manner, across acute, sub-acute and non-acute sectors, including:

- > Its place in broader health reforms;
- > International approaches;
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- > Sustainability of our current approach to casemix.

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16 – 19 NOVEMBER 2008

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IMPORTANT DATES

Abstract submission deadline	30 June, 2008
Close of Earlybird Registration	30 September, 2008
Close of Standard Registration	31 October, 2008
Conference	16 – 19 November, 2008

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How to proceed with your public submission

After consideration of the abovementioned criteria, submissions must be prepared following the format provided on the NCCH website www.fhs.usyd.edu.au/ncch. To lodge a public submission you will need to go to 'Quick Links', 'ICD-10-AM/ACHI/ACS Public Submission'. Here, you will need to sign into the NCCH Information System (NIS). If you already have NIS identification (ID), then you can login and proceed to the public submission page. You must register if you do not have a NIS ID. You will be able to prepare your submission at your convenience and save your work until you have completed it (using 'Save Draft' button). To access your saved draft (prior to submission) go to 'Quick Links', 'ICD-10-AM/ACHI', 'My ICD-10-AM Public Submission'. Once your submission is complete, you can submit (Submit button). All documentation (Word® documents, relevant websites) supportive of, and relevant to, the submission should be attached.

What will happen with your public submission?

Receipt of public submissions will be acknowledged via e-mail. NCCH staff will evaluate the recommendations against the criteria, considering the identified need and the need also to maintain an acceptable level of stability in the classification.

Clinical Classification and Coding Group (CCCG) advice will be sought where necessary during the evaluation process and the Coding Standards Advisory Committee (CSAC) will recommend to the NCCH, those submissions

that should be considered and further developed for inclusion in ICD-10-AM and ACHI. Those making a submission will be able to view their submission's progress via the website by going to 'Quick Links', 'ICD-10-AM/ACHI', 'My ICD-10-AM Public Submission'. At the end of the ICD-10-AM/ACHI/ACS update cycle, you will be advised of the outcome of the ratification process.

More information

For more information on the background to the development of ICD-10-AM/ACHI/ACS, the uses of ICD-10-AM/ACHI data and the modification process of ICD-10-AM/ACHI/ACS, visit the new NCCH website at www.fhs.usyd.edu.au/ncch from 1 July, 2008.



Injury surveillance in Australia

Coding Matters readers will be interested in an article for debate published in the April edition of the Medical Journal of Australia (MJA) by Rebecca Mitchell, Rod McClure, Ann Williamson and NCCH Brisbane's Kirsten McKenzie. The article, titled 'Implementing the national priorities for injury surveillance', stresses the need for high quality data for injury surveillance and the role of clinical coders and the NCCH in its collection.

The abstract of the article states that:

- Injury is a leading cause of disability and death in Australia and is recognised as a national health priority area.
- The foundation of successful injury prevention is injury surveillance, and national policies and strategies developed over the past 20 years to reduce the burden of injury in Australia have included 22 recommendations on surveillance — only three of which have been completely implemented.

- Priorities for improving injury surveillance include:
 - improving current injury mortality and morbidity data collection systems;
 - filling the gaps in injury surveillance;
 - maintaining vigilance over data quality;
 - increasing the integration and accessibility of injury data;
 - developing technical expertise in surveillance.
- Barriers to implementation of the current National Injury Prevention and Safety Promotion Plan include the lack of an implementation plan, performance management structure, appropriate national governance structure and resources — all of which could be overcome with government commitment.

The article can be viewed in MJA 2008; 188: 405–408 and at the eMJA website <http://www.mja.com.au/>

The **IO-AM** Commandments

Calculi of the vesicoureteric junction (VUJ) and pelvoureteric junction (PUJ)

What are the correct codes to assign for calculi of the VUJ and PUJ?

There are no index entries for calculi of the VUJ or PUJ. Therefore, codes should be assigned based on the higher anatomical site. The correct code to assign for a calculus of the vesicoureteric junction is N20.1 *Calculus of ureter* and the correct code to assign for a calculus of the pelvoureteric junction is N20.0 *Calculus of kidney*.

The NCCH will consider indexing the above sites for a future edition of ICD-10-AM.

Capsular/intracapsular tension ring

Should a separate code be assigned for the insertion of a capsular/intracapsular tension ring during cataract surgery?

It is estimated by the World Health Organization (WHO) that 12 to 15 million people go blind from cataracts and 8 million cataract operations are carried out world-wide each year. Such operations involve surgical removal of the opacified lens and substitution with an artificial intraocular lens.

Capsular/intracapsular tension rings are sometimes used to provide stabilisation of the capsular bag and the intraocular lens both during and after surgery and to prevent capsular bag shrinkage. They may also be used for patients with loose or broken zonules (ligaments that suspend the lens), which may have been weakened or broken due to trauma or disease.

Capsular/intracapsular tension rings are in use in Australian health care but they are not used in every cataract repair. There is still debate as to whether these rings prevent the occurrence of capsular bag shrinkage and whether they are appropriate for use in children.

As capsular/intracapsular tension rings are a component procedure of some cataract operations it is unnecessary to assign a separate code for their insertion as per the guidelines in ACS 0016 *General Procedure Guidelines - Procedure components*.

Central venous and arterial lines

Do you need to assign procedure codes for insertion of central venous and arterial lines when inserted under general anaesthetic during coronary artery bypass grafting?

Insertion of central venous and arterial lines are considered routine for patients undergoing coronary artery bypass grafting. Therefore, it is unnecessary to assign codes for them. However, if they are inserted as a stand alone procedure under an anaesthetic (except local) they should

be coded as per the guidelines in ACS 0042 *Procedures normally not coded*, point b, which states:

“The listed procedures should be coded if anaesthesia (except local) is required for the procedure (see ACS 0031 *Anaesthesia*).”

ACS 0042 *Procedures normally not coded* will be reviewed in conjunction with ACS 0909 *Coronary artery bypass grafts* for a future edition of the ACS.

Note: This advice should also be applied when central venous and arterial lines are performed as a component of any type of surgery.

Diabetes mellitus and blood sugar levels (BSLs)

The ICD-10-AM Third Edition Education Program Frequently Asked Questions (FAQs) – part 2 – contained the following advice:

“Diabetes should be coded when it meets the criteria in ACS 0002 *Additional diagnoses*. The taking of BSLs is one indication that diabetes mellitus meets the criteria of ACS 0002.”

This advice was also published on the NCCH Queries Database.

ACS 0002 *Additional diagnoses* has been revised for the ACS Sixth Edition. During the revision process, the issue of diabetes and BSLs was discussed by the NCCH and the Coding Standards Advisory Committee (CSAC). Both the NCCH and CSAC subsequently supported the advice that diabetes should only be coded when it meets the criteria in ACS 0002. Revision to ACS 0002 advises:

“The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring.”

The above criteria should be applied to each individual case in order to determine the appropriateness of assigning codes for diabetes mellitus. Coders should not automatically assign diabetes codes when BSLs are documented in the clinical record. BSLs are routinely recorded for many diabetic patients and should therefore **not** be assumed to indicate increased clinical care or monitoring.

As this advice may lead to a change in coding practice for some coders it is effective from the implementation of ICD-10-AM Sixth Edition, July 2008.

Diarrhoea due to *Clostridium difficile*

What is the correct code to assign for diarrhoea due to *Clostridium difficile*?

Clostridium difficile is the most common cause of infectious hospital-acquired diarrhoea in developed countries. Although in most cases it causes a relatively mild illness, occasionally, and particularly in elderly patients, it may result in serious illness and even death. The bacterium produces two toxins which are responsible for the diarrhoea and which damage the cells lining the bowel. However, not all strains of *C. difficile* produce toxin; these strains are unlikely to cause disease and patients colonised by them remain healthy.

Almost all patients who develop *C. difficile* diarrhoea are taking, or have recently been given, antibiotic therapy. Diarrhoea is the most common symptom but abdominal pain and fever may also occur. In the majority of patients, the illness is mild and full recovery is usual, although elderly patients may become seriously ill with dehydration as a consequence of the diarrhoea. Occasionally patients may develop a severe form of the disease called *pseudomembranous colitis*, which is characterised by significant damage to the large bowel.

The current index pathway directs coders to assign A04.8 *Other specified bacterial intestinal infections*. However, clinical advice received by the NCCH indicates that

the correct code to assign is A04.7 *Enterocolitis due to Clostridium difficile*.

The indexing of this condition will be reviewed for a future edition of ICD-10-AM.

This advice highlights a change to current coding practice and is effective from the implementation of ICD-10-AM Sixth Edition, July 2008.

Dropped lens/nucleus

What is the correct code to assign for dropped lens/nucleus?

Clinical advice regarding dropped lens/nucleus indicated the following:

"There are two types of lenses that can drop; the human crystalline lens (which can become cataractous) and an intraocular lens.

The most common cause of 'dropped' cataractous lens is when (usually) part of the lens is dropped during cataract surgery, typically the nucleus of the lens. This occurs either because of a hole being torn in the capsule of the lens or because the attachments of the lens to the ciliary body via the zonular fibres are weak and disrupted by the trauma of the surgery.

Intraocular lenses can be dropped at the time of surgery, usually where the capsule is torn. They can also dislodge later in the post-operative course, depending largely on how they have been fixated. Typically, lenses placed in the so called ciliary sulcus are dislodged. Late dislodgement

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can occur when the capsular bag dislodges from the ciliary body. The alignment of the intraocular lens can also change in the longer term because of particular patterns of fibrosis in the capsular bag." (Professor Minas Coroneo, Prince of Wales Hospital, personal communication, 6 March 2008).

When lens fragments/nucleus are dropped into the vitreous cavity after a capsular breach, assign:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

S05.8 *Other injuries of eye and orbit*

Y60.0 *Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, During surgical operation*

Y92.22 *Health service area*

Where there is a later displacement of the lens, without documentation of a capsular breach, assign:

T85.2 *Mechanical complication of intraocular lens*

Y83.1 *Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, Surgical operation with implant of artificial internal device*

Y92.22 *Health service area*

Jejunotomy with removal of calculus

Patient admitted with gallstone ileus. What is the correct code to assign for jejunotomy (open procedure) with removal of calculus and cholecystotomy?

The following codes should be assigned for the abovementioned procedures:

30375-03 [893] *Enterotomy of small intestine*

30375-26 [963] *Cholecystotomy*

The indexing of jejunotomy and the addition of an inclusion term for removal of calculus at 30375-26 [963] *Cholecystotomy* will be considered for a future edition of ACHI.

Malnutrition

The NCCH and CSAC have agreed that malnutrition may be coded when it is documented by a dietitian in the clinical record. This decision is supported in the Introduction to the Australian Coding Standards (ACS) as follows:

"The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."

Dietitians meet the definition of a clinician in the ACS and diagnosis and treatment of malnutrition is appropriate to their profession.

Malnutrition must meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* to be coded.

This advice highlights a change to current coding practice and is effective from the implementation of ICD-10-AM Sixth Edition, July 2008. This advice overrules previous advice published by the NCCH regarding the documentation of malnutrition by dietitians in the clinical record, which advised that a diagnosis of malnutrition documented by a dietitian must be verified by the primary treating clinician for the purposes of morbidity reporting.

Seprafilm®

Is it necessary to assign a code for Seprafilm® inserted during a procedure?

To reduce the occurrence of adhesions following surgery, surgeons can use adhesion barriers to separate tissue and organs while the body heals. Seprafilm® is a type of adhesion barrier composed of chemically modified sugars, some of which occur naturally in the human body. It is a clear film that sticks to the tissues to which it is applied and is slowly absorbed into the body over a period of seven days. It is placed at sites of tissue injury during surgery (commonly abdominal and pelvic surgery) to help prevent the formation of adhesions between tissues and organs.

The insertion of Seprafilm® is a prophylactic measure which is completely absorbed into the body and does not require removal. It is unnecessary to assign a code for this procedure.

Slow coronary flow/slow flow syndrome

What is the correct code to assign for slow coronary flow/slow flow syndrome?

The concept of slow coronary flow was first diagnosed in 1972. The coronary slow flow phenomenon is an angiographic finding characterised by delayed distal vessel opacification in the absence of significant epicardial coronary disease. It typically presents as persistent chest pain or angina pectoris and can significantly impair quality of life.

Clinical advice indicates that this is not a new syndrome but is more frequently identified now due to an increase in the number of angiograms performed. The correct code to assign for slow coronary flow syndrome is I20.8 *Other forms of angina pectoris*.

Bibliography

ASERNIP-S, Australian Safety and Efficacy Register of New Interventional Procedures – Surgical, Rapid Review, Intracapsular Tension Ring, September 2001, The Royal Australasian College of Surgeons. Accessed 12 May 2008. <http://www.surgeons.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=4853>

Association of Medical Microbiologists, Facts about *Clostridium difficile* infection. Accessed 26 October 2007. http://www.amm.co.uk/files/factsabout/fa_cdifff.htm

Beltrame JF, Limaye SB, Horowitz JD, The Coronary Slow Flow Phenomenon – A New Coronary Microvascular Disorder, *Cardiology, International Journal of Cardiovascular Medicine, Surgery, Pathology and Pharmacology*, Vol. 97, No. 4, 2002, pages 197–202. Accessed 12 May 2008. <http://content.karger.com/ProdukteDB/produkte.asp?Aktion=ShowAbstract&ProduktNr=223832&Ausgabe=228422&ArtikelNr=63121>

Chee S-P, Cataract and Refractive Surgery Today, PAL of a Dropped Nucleus. Accessed 15 February 2008. http://www.crstodayeurope.com/Issues/0307/f6_chee.html

Riley TV, Epidemic *Clostridium difficile*, eMJA, The Medical Journal of Australia, Vol. 185, No. 3, 2006, pages 133–134. Accessed 12 November 2007. http://www.mja.com.au/public/issues/185_03_070806/ril10472_fm.html

Fazio VW, Cohen Z, Fleshman JW et al., Reduction in Adhesive Small-Bowel Obstruction by Seprafilm® Adhesion Barrier After Intestinal Resection, (*Dis Colon Rectum* 2005 49 (1): 1–11), Presentation at Prince of Wales Hospital Journal Club by Dr Anita Jacombs BST. Accessed 12 May 2008. <http://www.sesiahs.health.nsw.gov.au/powh/General%20Surgery/Journal%20Club/POWH%20Journal%20Club.ppt>

Genzyme Australasia, Seprafilm®. Accessed 12 May 2008. http://www.genzyme.com.au/prod/sepraf/au_p_hcp_bio-seprafilm.asp

Intermedex, Ultrasonic Phacoemulsification Handpieces. Accessed 15 February, 2008. <http://www.intermedex.com/phaco.html>

Li J-J, Wu Y-J, Qin X-W, Should slow coronary flow be considered as a coronary syndrome? *Medical Hypotheses*, Vol. 66, No. 5, 2006, pages 953-956, ScienceDirect, Health Science Journals. Accessed 12 May 2008. http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6W2-4J2M0NV-3&_user=115085&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000008818&_version=1&_urlVersion=0&_userid=115085&md5=1572a709a309eb16d61c88ec601d6ee8

Visitech, Visitech Eye Hospital, Dropped Lens. Accessed 6 February 2008. <http://www.visitech.org/case-dropped-lens.html>

ACS I618 *Low Birth Weight and Gestational Age* – The use of Z51.88 *Other specified medical care*

The title of this ACS has changed from 'Prematurity and low birth weight' to 'Low birth weight and gestational age' and the prematurity section in this standard has been deleted.

Previous advice in ACS I618 included the following:

However, if the infant is > 28 days old and < 2500g on admission, assign Z51.88 *Other specified medical care* as the principal diagnosis and a code from P07 as an additional diagnosis.

This advice has been amended and incorporated into ACS I605 where the following excerpt is significant.

Codes from ICD-10-AM Chapter I6 *Certain conditions originating in the perinatal period*:

- will still apply for infants > 28 days who are still in the birth episode and

- will still apply for infants > 28 days who are discharged and subsequently readmitted with a condition documented as originating in the perinatal period.

These changes allow coders to assign the codes for prematurity for babies who are transferred for 'fattening up' post premature birth.

Version 6.0 AR-DRGs due for release later this year will allow appropriate grouping of these cases. However, the current and previous versions of AR-DRGs will assign these patients to error DRG 963Z *Neonatal diagnosis not consistent with age/weight*.

Coders should contact their respective health departments to discuss funding implications of this change to the Australian Coding Standard.

International training

Botswana, Africa

In January 2008, Sue Walker travelled to Botswana to conduct an ICD-10 training course. This course was run for the Ministry of Health and funded by the US Centers for Disease Control and Prevention (CDC). Since 1995, Botswana's Ministry of Health and the CDC have collaborated on programs and research to address the AIDS crisis in this African country. The partnership, called BOTUSA, involves more than 170 international, local, and support staff working to provide technical assistance, consultation, funding, program implementation, and research devoted to prevention, care, support, and surveillance of HIV/AIDS, tuberculosis, and related conditions. The HIV/AIDS situation in Botswana ranks it as one of the countries hardest hit by the worldwide HIV pandemic. Recent statistics indicate:

- 35.4% of pregnant women were HIV positive in 2002 (National AIDS Coordinating Agency [NACA]).
- There were 24,000 AIDS deaths in 2001; at the end of 2001, there were 69,000 AIDS orphans and 330,000 people living with HIV/AIDS (UNAIDS).
- Currently, life expectancy is 33.9 years; without AIDS it would be 72.4 years (US Census Bureau).
- Every year approximately 5,500 babies are infected with HIV in Botswana.

(Reference: <http://botswana.usembassy.gov/od-cdc.html> accessed 02 April 2008)

The purpose of the training was, therefore, to improve the capture of hospital admission data across the board, but with the specific intention of improving available information about HIV/AIDS admissions.

The training course was conducted 7–18 January 2008 for 25 participants. Most of them worked in the Ministry of Health, where all coding is performed. However, the Ministry has a goal to decentralise coding to hospitals and, therefore, the two largest hospitals in Botswana – Princess Marina Hospital in Gaborone and Nyangabgwe Hospital in Francistown – also sent Health Information Managers to participate.



Dr Stefan Bodika from BOTUSA and Ms Diemo Motlapele from the Health Statistics Unit in the Ministry of Health



Coders during the final week of the training program

Botswana has been coding hospital admission data using ICD-10 since approximately 1995. However, only one coder had ever received formal training previously (in Brisbane in 2006). Some of the Health Information Managers had received HIM education in the USA in the past.

Participants reported that the greatest problem they have with morbidity coding is the lack of clear and comprehensive clinical documentation on the data reporting sheets submitted by hospitals to the Ministry of Health. Additionally, it was reported that clinical staff have little understanding of coding and, therefore, a lack of appreciation of the need for complete documentation and its effect on complete, specific and accurate coding.

Regardless, the participants who work in the hospitals in Gaborone and Francistown appeared to have a useful and constructive relationship with clinical staff and feel able to ask questions for clarification if required. This communication was encouraged as a means not only for coders to learn more clinical information, but as a strategy to educate doctors about the documentation requirements for coding. Educational sessions about documentation for doctors in all hospitals were strongly recommended prior to the move to hospital-based coding.

The coding of death data in Botswana is performed at the Ministry of Health from information provided by hospitals for patients who die. These are reported in the WHO-recommended international death certificate format on the bottom of the hospital form, which also contains morbidity and obstetric data. The coding of death data to date has been performed using the morbidity coding rules with no attempt to identify the underlying cause of death. Participants were provided with information about this data element during the training and the difference between main condition (principal diagnosis) and underlying cause of death were explained.

The Ministry of Home Affairs also collects mortality data but this is not coded with ICD-10 and is used only for fact of death, not cause of death reporting.

The third and final week of the training program was spent at the Ministry of Health undertaking practical coding from the data reporting sheets sent by hospitals to the Health Statistics Unit. Most of Sue's time was spent assisting the trainees and answering questions but also coding some of the documents herself. This reinforced the impression that the documentation needs improvement.

This was the first training course for coders in Botswana and the beginning of a relationship between the Ministry of Health and the NCCH. It is hoped that several of the participants will be able to travel to Brisbane for the 2008 international ICD-10 course which will include a trainer week this year. This week is aimed at providing skills and knowledge to potential trainers so that they can educate others when they return to their own countries.

Botswana is a fascinating country, despite the health issues that are evident. The people Sue worked with were lovely – warm and friendly and generous with their time.



Course participants in traditional dress

ICD-10-AM/ACHI/ACS Sixth Edition in New Zealand

New Zealand will be using ICD-10-AM/ACHI/ACS Sixth Edition from 1 July 2008. In February 2008, Megan Cumerlato and Vera Dimitropoulos conducted a three-day workshop in Auckland for two members from the New Zealand Health Information Service (NZHIS), Mary-Ellen Wetherspoon and Tracy Thompson, and four representatives of four District Health Boards. The aim of the workshop was to provide 'train-the-trainer' material on ICD-10-AM/ACHI/ACS Sixth Edition that included the changes to the Fourth and Fifth Editions.



l-r Megan Cumerlato, Surya Harijatna, Tracy Thompson, Andrew Wooding, Mary-Ellen Wetherspoon, Kathryn Alexander, Nicky Williams and Vera Dimitropoulos

New Zealand has been using the Third Edition of the classifications since 2002 and is looking forward to the added specificity which the latest version of the classifications will provide.

The workshop provided the participants with the opportunity to discuss the changes across the three editions, complete practical coding exercises, and participate in a coding 'trivia' quiz. The workshop also allowed for questions, discussion and amendments to the training material which will then be used as the basis for the New Zealand training workshops to be conducted throughout the country in May and June.

A meeting was held with the NZHIS to finalise the pre-education and workshop material on the last day of the visit. The response from New Zealand coders to the latest edition of the classification has been very enthusiastic with the opportunity of both countries now being on the same edition cycle.

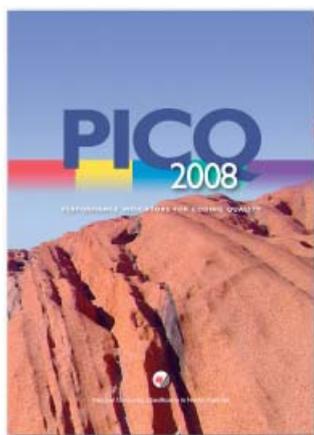
Megan and Vera were made to feel very welcome during their brief visit to Auckland and would like to acknowledge and thank the staff at the NZHIS and wish them all the best with implementing ICD-10-AM/ACHI/ACS Sixth Edition.

PICQ 2008

The NCCH is pleased to announce the forthcoming release of PICQ 2008, incorporating 245 indicators for ICD-10-AM/ACHI/ACS Fifth Edition and 302 indicators for Sixth Edition.

PICQ 2008 and coding quality

PICQ 2008 is a series of indicators that analyse admitted patient morbidity data coded with ICD-10-AM and the Australian Classification of Health Interventions (ACHI) and is based on Australian Coding Standards (ACS) and coding conventions. Users link their coded data to the PICQ database and the records are then compared to the predetermined indicators that test coding quality. The indicators identify records that contain a coding error (or possible coding error) in diagnosis and intervention codes or National Health Data Dictionary (NHDD) fields, such as age or separation mode.



The indicators are categorised by several methods:

- the type of problem the indicator seeks to identify (edit, completeness, redundancy, specificity, sequencing);
- the degree of the problem (fatal, warning or relative);
- the topic (for example, intervention code assigned more than once, mutually exclusive codes assigned together);
- the ICD-10-AM or ACHI chapter that relates to the numerator definition; and
- the Australian Coding Standard number.

PICQ 2008 is able to perform a number of data quality checks. PICQ 2008 can:

- identify actual coding errors and possible coding problems;
- identify specific records for correction, if necessary;
- suggest possible problem causes and possible corrections;
- identify areas where documentation may lead to the use of unspecified codes;
- measure data accuracy against particular indicators;
- measure data quality over time;
- identify areas for coder and clinician education;
- provide feedback to individual coders;

- provide results that can be benchmarked with other health care facilities; and
- complement existing coding audit activities.

New in PICQ 2008

As part of ongoing product improvement there have been some revisions. These include:

- 70 new indicators in Sixth Edition;
- two indicators have been retired from Fifth Edition and 15 retired from Sixth Edition;
- indicator logic and other elements for some indicators have been revised;
 - the indicator degrees have been modified to better reflect the problem identified;
 - two edit reports that identify and report on all import errors, allowing the user to correct the errors prior to re-importing; and
 - the ability to process fields which are blank instead of null, e.g. unused diagnosis and intervention code fields.

Indicators by degree

The new indicator degrees for Sixth Edition indicators are:

- 'A' Fatal has been renamed 'F' Fatal;
- 'B' Warning has been renamed and split into 'W1' Warning – 1% threshold and 'W2' Warning – other. 'W1' indicators should be treated as fatal indicators, as the notification of rare cases has caused their classification as Warning instead of Fatal;
- 'C' Relative has been renamed 'R' Relative.

Indicators where the logic (code unseen by the user) has changed from PICQ 2006

- I00196 Noninfective gastroenteritis and colitis – from Sixth Edition, the default for unspecified gastroenteritis and diarrhoea in children and adults is to gastroenteritis and colitis of unspecified origin;
- I00854 Abortion, threatened abortion, fetal death in utero, threatened premature labour or pre-term delivery code without duration of pregnancy code – from Sixth Edition, fetal death in utero also requires a duration of pregnancy code;
- I01418 Appendicitis, acute, without appendicectomy – now also checks if a right hemicolectomy or caecectomy procedure was performed and does not report those episodes as being in error;

- I01895 Paraplegia/quadruplegia with sequela of external cause code but no sequela of spinal cord, intracranial injury or complications of surgical or medical care code – revised wording of the Rationale to reinforce that the code for sequela of injury of spinal cord should immediately follow the paraplegia or quadruplegia code to indicate there has been some form of injury to the spinal cord which has resulted in the paraplegia or quadruplegia. Similar logic applies to paraplegia/quadruplegia due to intracranial injury which requires the sequela of intracranial injury code. Clinical advice states traumatic paraplegia and quadruplegia results from a traumatic insult, either to the spinal cord or brainstem (the latter is much rarer), and if the cause is not specified, a code for sequela of injury of spinal cord should be assigned;
- I01945 Diabetes mellitus or impaired glucose regulation (IGR) with retinopathy code assigned more than once – from Sixth Edition, this indicator includes impaired glucose regulation;
- I01946 Diabetes mellitus or impaired glucose regulation (IGR) with multiple microvascular complications code as principal diagnosis with additional codes for Diabetes mellitus or impaired glucose regulation (IGR) with specific complications – from Sixth Edition, this indicator includes impaired glucose regulation; and
- I02001 Banding/ligation of haemorrhoids without internal haemorrhoids – indicator logic has been reversed to enable the indicator to be Fatal instead of Warning degree.
- ACS I438 *Chronic kidney disease* – hypertension, anaemia in chronic kidney disease, transplant status, dialysis procedure, use of unspecified code;
- Dental cleaning, clearance, extraction;
- Electroconvulsive therapy without corresponding number of anaesthetic codes;
- Anaesthetic code with ASA indicating brain death;
- Place of occurrence other than health service area with complication of medical or surgical care external cause code;
- Activity at the time of transport accident;
- Infection or inflammatory reaction of nervous system device, implant or graft;
- Complication of open wound code without open wound code;
- Use of unspecified fall external cause code compared to use of all fall external cause codes;
- Benign neoplasm of prostate;
- Lymphoma code with secondary malignant neoplasm code;
- Neoplasm code as principal diagnosis with administration of antineoplastic agent code in a same-day episode;
- Use of unspecified effects of radiation therapy code compared to use of all radiation therapy codes;
- Use of unspecified talipes equinovarus code compared to use of all talipes equinovarus codes;
- Unilateral undescended testicle assigned more than once;
- Botox injection for specific sites;
- Percutaneous carotid artery stenting;
- Correction of stenosis of arteriovenous fistula or access device with patch graft;
- Cardiac ablation of left atrium with cardiac ablation of right atrium;
- Insertion of automatic defibrillator generator code without leads or patches code;
- Testing of cardiac pacemaker or defibrillator with insertion, adjustment or replacement;
- Endoscopic retrograde cholangiopancreatography (ERCP) with other procedure performed via ERCP;
- Laparoscopic radical prostatectomy;
- Anaemia complicating pregnancy;
- Neuraxial block in labour and delivery procedure;
- Drug delivery and vascular access devices;
- Procedure not carried out code as principal diagnosis; and
- Unavailability and inaccessibility of healthcare facilities code without transferred separation mode.

New indicators for Sixth Edition

PICQ 2008 includes 70 new indicators for ICD-10-AM/ACHI/ACS Sixth Editions. The majority of new indicators have been developed because of changes to the classification, for example, new codes, new fifth characters on codes and alterations to ACS or coding conventions (new hierarchies etc).

The new indicators relate to:

- ACS 0020 *Bilateral/multiple procedures* – dialysis codes assigned more than once; excision or removal of lesion of skin and subcutaneous tissue code assigned more than once;
- ACS 0027 *Multiple coding* – puerperal sepsis without specific infection code;
- ACS 0401 *Diabetes mellitus or impaired glucose regulation (IGR)* – peripheral angiopathy code with unspecified atherosclerosis of extremities code; diabetes mellitus in pregnancy with more than one type of treatment code;
- ACS 0503 *Drug, alcohol and tobacco use disorders* – evidence of alcohol involvement by blood alcohol level;
- ACS 1006 *Ventilatory support* – management of noninvasive ventilatory support code assigned more than once;

PICQ 2008 will be available later this year.

This is the second of a two-part series to provide guidance on the coding of dental procedures. It provides advice on the classification of dental procedures and tables listing the types of interventions that may be performed.

In ACHI, Sixth Edition dental intervention codes are based on *The Australian Schedule of Dental Services and Glossary* (8th Edition) published by the Australian Dental Association Incorporated (see reference details below).

Classification

Dental procedures should be coded following ACS 0016 *General procedure guidelines*, and ACS 0809 *Intraoral osseointegrated implants*. Dental procedures are excluded from ACS 0020 *Bilateral/multiple procedures*.

ACS 0016 General procedure guidelines

This standard instructs that procedures which are individual components of another procedure should not be coded. For example, fissure sealing may be performed alone or it may be performed as part of tooth preparation for a restoration procedure. In this latter instance, the fissure sealing procedure should not be coded.

ACS 0809 Intraoral osseointegrated implants

The intraoral osseointegrated implants procedure is a complicated two stage procedure. This standard provides guidelines to assist with coding in this area.

ACS 0020 Bilateral/multiple procedures

Codes in *Chapter 6 Dental services* do not meet the criteria in ACS 0020 *Bilateral/multiple procedures* for ACHI Sixth Edition. Generally, dental procedures should be coded as many times as they are performed. However, the following guidelines should be applied to the coding of dental procedures:

- When a code includes reference to a number of teeth, it should only be assigned once. For example, 97311-03 [457] *Removal of 3 teeth or part(s) thereof* specifies the removal of 3 teeth therefore this procedure code should only be assigned once.
- Dental codes that specify per tooth, per root or per cusp (etc) should be coded as many times as they are performed. For example, 97171-00[455] *Odontoplasty, per tooth* should be coded as many times as it is performed.

- Codes that don't indicate a specific number of teeth should be coded as many times as performed. For example, if documentation specifies 97414-00 [462] *Pulpotomy* was performed on four teeth, it should be assigned four times.

ACHI Sixth Edition

In ACHI Sixth Edition, a range of codes have been created to reflect the number of teeth extracted; – 1 tooth, 2 teeth, 3 teeth, 4 teeth, 5–9 teeth, 10–14 teeth and ≥ 15 teeth. These values have been added to the codes in blocks [457] *Nonsurgical removal of tooth* and [458] *Surgical removal of tooth* to simplify the code selection when the mucosa has been incised and the mucoperiosteal flap raised. Multiple codes will no longer need to be assigned for the surgical and nonsurgical extraction of teeth.

The distinction between surgical extraction of teeth and nonsurgical extraction of teeth is not always clear. Amendments have been made to ACHI Sixth Edition to clarify the difference. Documentation of 'incision of mucosa' is an indication of a surgical tooth extraction. Therefore, the following inclusion terms have been added to aid code selection:

- 'Incision of mucosa and raising of mucoperiosteal flap to remove tooth, followed by suturing of the wound' in block [458] *Surgical removal of tooth*
- 'Extraction of tooth without incision of mucosa' in block [457] *Non surgical removal of tooth*.

A full dental clearance is the process whereby all remaining teeth in the mouth are removed. That is, no teeth remain in the mouth after the procedure. A definition has been added to 97322-01 [458] *Full dental clearance* to clarify the meaning of the term. Codes have been created for a 'full upper clearance' and a 'full lower clearance'. A 'full upper clearance' is when there are no teeth remaining in the upper jaw after the procedure and a 'full lower clearance' is when there are no teeth left in the lower jaw after the procedure.

ACHI Dental procedures and definitions

NCCH published tables in *Coding Matters* Vol 7, No 3 containing commonly performed dental procedures with definitions. The following tables are an update of the previously published information.

Preventative Dental Services

Procedure/Terms	Definition
Removal of plaque or stain	Removal of dental plaque and or stains from the surfaces of all teeth.
Fissure sealing	Sealing of non-carious pits, fissures or cracks in a tooth with a bonded resin or adhesive cement to prevent development of dental caries at the site.
Odontoplasty	Modification of the contour or the anatomy of the crown of a tooth to provide an improved contour.

Periodontic Interventions

Procedure/Terms	Definition
Root planing with subgingival curettage	The surface of the tooth root is planed to remove rough or contaminated cementum, dentine or deposits of calculus with curettage of the soft tissues of the periodontal pocket and removal of granulation tissue. 97222-00 [456] has been amended and 97222-01 [456] has been created in ACHI Sixth Edition to distinguish between ≤ 8 teeth and > 8 teeth.
Gingivectomy	A surgical procedure to remove the soft tissue wall of the periodontal pocket or swollen gum tissue. 97231-00 [456] has been amended and 97231-01 [456] has been created in ACHI Sixth Edition to distinguish between ≤ 8 teeth and > 8 teeth.
Periodontal flap surgery	Incision and raising of a flap of gingival tissue to enable removal of inflammatory or granulation tissue. 97232-00 [456] has been amended and 97232-01 [456] has been created in ACHI Sixth Edition to distinguish between ≤ 8 teeth and > 8 teeth.
Crown lengthening	A flap procedure to establish an apical gingival margin for greater exposure of the tooth structure.
Osseous graft	A surgical procedure in which a piece of bone or a synthetic substitute is used to replace or repair alveolar bone.
Osseous surgery	Re-shaping and modifying defects and deformities in the bone supporting and surrounding teeth. 97233-00 [456] has been amended and 97233-01 [456] has been created in ACHI Sixth Edition to distinguish between ≤ 8 teeth and > 8 teeth.
Gingival graft	Transference or transplanting gingival or other soft tissue from a donor area in the patient's mouth to an area around a tooth or implant to remedy a gingival deficiency.

Oral Surgery

Procedure/Terms	Definition
Nonsurgical removal of teeth	Removal of teeth not requiring a surgical incision (i.e. without incision of mucosa). Codes for 2, 3, 4, 5-9, 10-14 and ≥ 15 teeth have been created in ACHI Sixth Edition.
Sectional removal of teeth	Removal of teeth in sections. Bone removal may be necessary however a surgical incision is not required. Codes for 2, 3, 4, 5-9, 10-14 and ≥ 15 teeth have been created ACHI Sixth Edition.
Surgical removal of teeth	Removal of teeth where a surgical incision is required. Codes for 2, 3, 4, 5-9, 10-14 and ≥ 15 teeth have been created for ACHI Sixth Edition.
Full upper dental clearance	Removal of all remaining teeth in the upper jaw.
Full lower dental clearance	Removal of all remaining teeth in the lower jaw.
Full dental clearance	Removal of all remaining teeth in the jaw
Surgical removal of teeth requiring bone removal and tooth division	Removal of teeth where both removal of bone and sectioning of the tooth is required following a surgical incision. Codes for 2, 3, 4, 5-9, 10-14 and ≥ 15 teeth have been created in ACHI Sixth Edition.

Endodontics

Procedure/Terms	Definition
Pulpotomy	Removal of part of the vital tooth pulp from the pulp chamber. The remaining pulp is then covered with a protective dressing or cement.
Obturation	The phase of a root canal treatment that creates a fluid tight seal along the length of the root canal system.
Extirpation of pulp	Removal of pulp, or necrotic debris of pulp, from a tooth's root canal system.

Restorative Types

Procedure/Terms	Definition
Restoration	Construction and insertion into a tooth of a restoration which may be metallic, resin-based or porcelain.
Pin retention	Small pins are inserted into the tooth to provide extra support for the restoration material.
Stainless steel crown	A preformed crown is trimmed, contoured and used as coronal tooth restoration.
Post	Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration.

Prosthodontics

Procedure/Terms	Definition	
Cast for crown	A post and core fabricated accurately to the dimension of a prepared root canal to provide a foundation for an artificial crown.	
Temporary crown	Construction of a temporary restoration, usually made from a resin, to protect the underlying tooth prior to construction of a permanent crown.	
Full crown	An artificial crown or full veneer is used to restore a tooth's size, shape and strength.	
Pontic bridge	That part of a bridge which replaces clinical crowns of missing teeth.	
Complete denture	A removable dental prosthesis constructed to replace all missing teeth and tissues.	
Partial denture	A denture provided for a dental arch in which one or more natural teeth remain.	
Partial denture components	Retainer	Metal clasp carefully designed to fit round a tooth. Its main purpose is to hold the denture in place.
	Occlusal rest	A unit of a partial denture that rests upon a tooth surface to provide support for the denture.
	Connecting bar	A bar that joins sections of a partial denture.
Overlay	An extension of a denture covering the occlusal surface of remaining teeth.	
Immediate replacement of tooth	This procedure involves the addition of one or more teeth to a denture.	
Resilient lining	A resilient tissue bearing surface is added to a denture.	
Denture maintenance	Relining	Replacement of the tissue fitting surface of a denture to improve its accuracy and fit.
	Remodelling	Replacement of the resin base of a denture to improve its accuracy and fit. It is different from rebasing in that it also permits rearrangement of teeth.
	Rebasing	This involves the removal and replacement of a denture base.
Splints	An appliance constructed from either acrylic resin or metal designed to hold or maintain mobile teeth in their predetermined position.	
Obturator	A prosthesis constructed to close a congenital or acquired opening in the palate. Usually attached to a partial or complete denture.	
Denture characterisation	This process involves the staining and carving of the outer surfaces of the denture.	
Dental impression	A negative imprint from which a reproduction or cast can be made.	

Orthodontics

Procedure/Terms		Definition
Removable orthodontic appliance	Passive removable appliance	An appliance designed to maintain the position of the teeth.
	Active removable appliance	As opposed to the passive appliance, an active appliance exerts force on teeth or arches to achieve tooth or dental arch movement.
Fixed orthodontic appliance – banding		The application of bands and/or brackets to correct tooth position or arch form.
Extraoral appliance		Extraoral head gear connected to an intra-oral appliance which makes use of the support of the back of the head and neck to transmit extraoral force which is then distributed to the teeth.

General Dental Services

Procedure/Terms		Definition
Occlusal splint		An appliance made of acrylic resin which is designed to relieve abnormal pressures exerted on the temporomandibular joint (TMJ) and other supporting structures.

Bibliography

Australian Dental Association Inc. (2004), *The Australian Schedule of Dental Services and Glossary* (8th ed.), Australian Dental Association, Sydney.

Australian Refined Diagnosis Related Groups (AR-DRG) Version 5.2

AR-DRG is a classification scheme based on ICD-10-AM/ACHI/ACS codes. It provides a way of grouping episodes of care in a hospital according to clinical characteristics and resource use.

AR-DRG Version 5.2 incorporates ICD-10-AM/ACHI/ACS Fifth Edition codes.

AR-DRG definition manuals are published by the Australian Government Department of Health and Ageing and distributed by the NCCH.

For further information and to order:

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VADs, VCs and DDDs

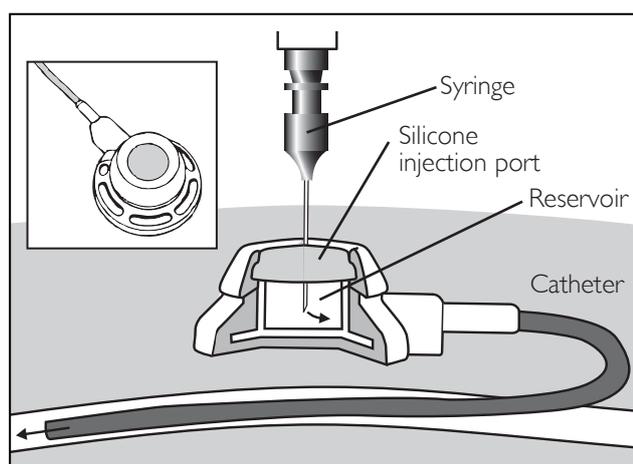
Vascular Access Devices, Venous Catheters And Drug Delivery Devices

Changes have been made to both ICD-10-AM andACHI Sixth Edition regarding vascular access devices, venous catheters and drug delivery devices. A number of problems have been identified during the Sixth Edition education workshops. These will be rectified via errata. The purpose of this article is to clarify the codes that are applicable to each device and highlight some of the areas to which errata will apply.

Vascular access devices

ACHI defines a *vascular access device* (VAD) as an implanted venous catheter with a reservoir attached. The subcutaneous reservoir is designed to accept multiple punctures from special types of needles (e.g. Huber or Gripper needles) and may be accessed to withdraw fluid or to infuse substances. A Port-A-Cath is a type of VAD used in Australian facilities.

Vascular access device



Classification

Where patients are admitted for adjustment, management, fitting or removal of a *vascular access device*, assign:

Z45.2 *Adjustment and management of vascular access device*

ACHI codes for insertion, revision and removal of VADs are in block [766] *Vascular access device*.

Example 1: Same-day admission for removal of Port-A-Cath. Device removed under sedation. Assign:

Z45.2 *Adjustment and management of vascular access device*

34530-05 [766] *Removal of vascular access device*
Sedation

ACHI also contains a code for maintenance of vascular access devices:

13939-02 [1922] *Maintenance (alone) of vascular access device*

Example 2: Same-day admission to check patency of Port-A-Cath, which had been inserted the previous week. Device accessed for pathology and flushed with heparin. Assign:

Z45.2 *Adjustment and management of vascular access device*

13939-02 [1922] *Maintenance (alone) of vascular access device*

Note: Activities such as *withdrawal of fluid for culture* and *flushing of a vascular access device* are routine components of administration of pharmacotherapy. Therefore, when assigning a code from block [1920] *Administration of pharmacotherapy*, it is not necessary to also assign 13939-02 [1920] *Maintenance (alone) of vascular access device*.

ACHI will be rectified via errata to clarify this (for example):

13939-02 Maintenance (alone) of vascular access device

Maintenance (alone) of:

- infusion port
- Port-A-Cath
- reservoir (subcutaneous)

Includes: catheterisation

flushing

withdrawing sample of fluid for culture

Note: A vascular access device is an implanted venous catheter with a reservoir attached.

Excludes: that:

- for vascular catheter without reservoir attached (92058-00 [1890])
- with administration of pharmacotherapy (96199 [1920])

Example 3: Patient admitted for same-day episode of care for chemotherapy for their neoplasm. Port-A-Cath accessed for pathology and chemotherapy administered. Port flushed and heparin locked. Patient discharged home. Assign:

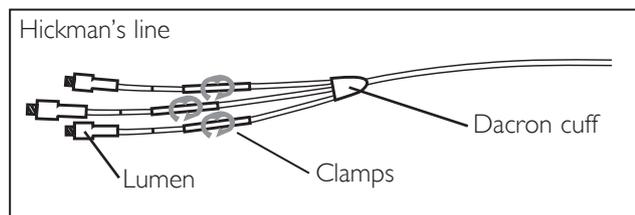
Z51.1 *Pharmacotherapy session for neoplasm*
Neoplasm codes

96199-00 [1920] *Intravenous administration of pharmacotherapy agent, antineoplastic agent*

Vascular/venous catheters

In ACHI, central venous catheters that don't have subcutaneous reservoirs (Hickman's, PICC lines) are classified as *vascular/venous catheters* and not as *vascular access devices*.

Venous catheter



Classification

Where patients are admitted for adjustment, management, fitting or removal of vascular/venous catheters (without reservoirs), assign:

Z45.8 *Adjustment and management of other implanted devices*

ICD-10-AM will be rectified via errata to clarify this (for example):

Z45.2 Adjustment and management of vascular access device

Adjustment and management of:

- infusion port
- Port-A-Cath
- reservoir (subcutaneous)
- ~~vascular catheter~~

Note: A vascular access device is an implanted venous catheter with a reservoir attached.

Excludes: adjustment and management of vascular catheter without reservoir attached (Z45.8)

that for pharmacotherapy for neoplasm (Z51.1)

Admission (for)
 - adjustment (of)
 - - catheter
 - - - vascular Z45.8~~2~~

ACHI codes for insertion and removal of vascular/venous catheters (Hickman's, PICCs and CVCs) are in block [738] *Venous catheterisation*.

Example 4: Same-day admission for insertion of a Hickman's line. Line inserted using sedation. Assign:

Z45.8 *Adjustment and management of other implanted devices*

I3815-01 [738] *Percutaneous central vein catheterisation*
 Sedation

Example 5: Same-day admission for flushing of PICC line and change of dressing surrounding the catheter. Procedures performed and patient returned home. Assign:

Z45.8 *Adjustment and management of other implanted devices*

92058-00 [1890] *Irrigation of vascular catheter*

Drug delivery devices

A *drug delivery device* is a piece of equipment used to administer pharmacological substances.

An **ambulatory, external** infusion pump is a type of *drug delivery device* that is attached to a vascular access device to infuse substances over long periods. The pump is computerised to allow the administration of a prescribed dose and rate of medication over a defined time period. External *drug delivery devices* may also be attached to venous catheters (without reservoirs) – for example, a Hickman's line – or other, nonvascular catheters for administration of pharmacological agents via other routes – for example, for the subcutaneous administration of insulin (via an insulin pump).

External infusion pump



ACHI also contains codes for **implantable** *drug delivery devices*, such as the *implantable spinal infusion device or pump*. These devices administer drug therapy for pain control directly into the intrathecal space. A catheter is inserted into the spinal canal and attached to a pump implanted in the abdomen or chest wall.

ICD-10-AM will be rectified via errata to clarify this (for example):

Z45.1 Adjustment and management of drug delivery device

Adjustment and management of: ~~infusion device or pump (external)~~

- external _____ }
- implantable spinal _____ } *infusion device or pump*

Note: ~~A drug delivery device is an ambulatory, external infusion pump that is attached to a (vascular) access device to infuse substances over long periods of time.~~

A drug delivery device is an (external) infusion pump that is attached to a vascular access device or venous, spinal or other catheter to infuse substances over long periods of time.

Excludes: that for pharmacotherapy for neoplasm (Z51.1)

Admission

- removal (of)
- - device
- - - drug delivery or pump (CADD) (external) (implantable spinal) Z45.1

Classification

Where patients are admitted for adjustment, management, fitting or removal of a *drug delivery device*, (except for *loading of a drug delivery device for same-day admission of chemotherapy to treat a neoplasm* – see examples 7 and 8) assign:

Z45.1 *Adjustment and management of drug delivery device*

ACHI codes for insertion, replacement or removal of an implantable spinal infusion device or pump are:

39127-00 [39] *Insertion of implantable spinal infusion device or pump*

39126-00 [56] *Revision of implantable spinal infusion device or pump*

39133-02 [40] *Removal of implantable spinal infusion device or pump*

Example 6: Same-day admission for removal of spinal infusion device. Device removed under sedation. Assign:

Z45.1 *Adjustment and management of drug delivery device*

39133-02 [40] *Removal of implantable spinal infusion device or pump*
Sedation

ACHI also contains codes for *loading and maintenance* of drug delivery devices:

96209-xx [1920] *Loading of drug delivery device*

13942-02 [1922] *Maintenance (alone) of drug delivery device*

Note: *External* drug delivery devices (infusion pumps) are not inserted into the body – they are attached to VADs or venous or other catheters. Therefore, procedure codes should only be assigned for *loading* or *maintenance* of the device, as appropriate.

Where patients are admitted for a same-day episode of care for chemotherapy for a neoplasm and have their *drug delivery device loaded*, assign:

Z51.1 *Pharmacotherapy session for neoplasm* (see ACS 0044 *Chemotherapy*)

Example 7: Same-day admission for chemotherapy for treatment of a neoplasm via an external drug delivery device (CADD pump). The CADD pump was set for 7 days at a dose of 200mg per 24 hours and attached to the patient's Port-A-Cath (which had been inserted on a previous admission). Assign:

Z51.1 *Pharmacotherapy session for neoplasm*
Neoplasm codes

96209-00 [1920] *Loading of drug delivery device, antineoplastic agent*

Example 8: Same-day admission for chemotherapy for treatment of a neoplasm. Port-A-Cath (which had been inserted on a previous admission) accessed for pathology, then chemotherapy administered. On completion, the patient's CADD pump was filled with antineoplastic agent and attached to the Port-A-Cath for continued infusion at home. Assign:

Z51.1 *Pharmacotherapy session for neoplasm*
Neoplasm codes

96199-00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*

96209-00 [1920] *Loading of drug delivery device, antineoplastic agent*

ICD-10-AM/ACHI/ACS
Sixth Edition

ICD-10-AM/ACHI/ACS Sixth Edition is now available in printed volumes and as eCompress@desktop software.
For further information and to order: NCCH Sydney
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E-mail: fhsNCCHsales@usyd.edu.au

Australian Refined Diagnosis Related Groups

AR-DRG Version 6.0

Background

Casemix may be defined as an information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. (Eagar, K., Hindle, D. 1994, *The Australian Casemix Dictionary*, National Casemix Education Series No. 9, Department of Human Services and Health, Canberra). Casemix provides the health care industry with a consistent method of classifying types of patients, their treatment and associated costs. It includes developing and implementing casemix classifications, tools and services.

The Australian Refined Diagnosis Related Groups (AR-DRGs) are a patient classification scheme which allows the measurement of inpatient hospital activity. The Australian Government introduced casemix in the early 1990's and has been committed to its continual development. Updating the AR-DRG classification has occurred every two years in order to remain abreast of changes in clinical practice.

The development process

The Department of Health and Ageing is in the final stage of production of the Australian Refined Diagnosis Related Groups Version 6.0 (AR-DRG V6.0). AR-DRG V6.0 is built upon the foundation of Version 5.2 and incorporates ICD-10-AM/ACHI/ACS Sixth Edition codes.

Changes to the casemix classification are made as a result of submissions. Clinicians, clinical coders and industry bodies who believe the DRG's should be modified send a public submission to the Department. Submissions may also be a result of research and development work conducted within the Department. All submissions are prioritised, investigated and then recommendations are developed for review and discussion at stakeholder meetings. During the development process for the recommendations, Departmental staff consult with members of the Clinical Classification and Coding Groups (CCCG), by e-mail or phone. The CCCG are panels of expert clinicians and clinical coders separated into 23 groups which represent areas of medical specialty. Members are consulted about recommendations relating directly to their clinical knowledge base and specialty area.

Formal approval from clinical stakeholders is sought through the Clinical Casemix Committee – Australia Refined - Diagnosis Related Groups version 6 (CCC-AR-DRG v6). The CCC-AR-DRG V6 members consider each recommendation from a clinical perspective and using statistical data presented by the Department. Ratification and endorsement of the recommendations are then sought from State and Territory representatives through a meeting at which each of the recommendations

for Version 6.0 is discussed. The State and Territory representatives inform the Department of any implications for funding models and systems. The Commonwealth has a responsibility to collaborate with States and Territories in working towards creation and maintenance of existing information infrastructure, as stated in the Australian Health Care Agreements (2003–2008), clauses 57–59.

For more details about casemix and AR-DRGs visit www.health.gov.au/internet/main/publishing.nsf/Content/Casemix-I.

AR-DRG V6.0

The Department of Health and Ageing has recently developed Version 6.0. It is considered a major release, and incorporates DRG creations and deletions and code movements throughout the classification. Over 80 recommendations were included in this revision. The nature of these recommendations involved either creation, deletion or a merge of DRGs; DRG name change; high cost DRGs; large code/case movements; altering data to avoid error DRGs; and major logic change.

The main changes for this version include:

- A full review of 'ventilation' throughout the classification, including the inclusion of the Noninvasive Ventilation (NIV) and Invasive Ventilation (IV) code concept changes of ACHI Sixth Edition;
- Some AR-DRGs have been deleted, combined or created. Some AR-DRGs have had their meaning changed;
- The hierarchy order of Major Diagnostic Category (MDC) assignments in Pre-MDC, and ADRGs in surgical partitions and 'other' partitions has been revised;
- All DRG splits have been revised. As a result, AR-DRGs that are the same as in Version 5.2 may now have different DRG splits;
- Age is not used for partitioning AR-DRGs, hence no DRG has age as part of its definition;
- A sex value of 3 *Intersex or indeterminate* will bypass the sex edit in MDCs 12 (male reproduction system), 13 (female reproductive system) and 14 (pregnancy, childbirth and puerperium);
- Patients less than 1 year old and coded with a diagnosis in the code range P07.01–P07.32 (low birth weight and immaturity) will group to MDC 15 *Newborns and other neonates*; and

- Error DRGs 901Z (extensive OR procedures), 902Z (non-extensive OR procedures) and 903Z (prostatic OR procedures) have been replaced by DRGs 801A–801C (OR procedures unrelated to principal diagnosis). The new DRGs are classified as unrelated OR DRGs, instead of error DRGs.

The definitions manual which assists users to understand the new version of the classification can be purchased from NCCH Sydney, phone: 02 9351 9461 or Email: fhsncchadmin@usyd.edu.au.

Release of AR-DRG-6.0 at the 2008 Casemix Conference

On 16-19 November 2008, the Department of Health and Ageing will host the launch of the AR-DRGs V6.0 at the biennial Casemix Conference.

The theme for this year's conference is '*The Casemix Evolution: extending the boundaries*'. The conference will view casemix in the holistic manner, across acute, sub-acute and non-acute sectors, including:

- its place in broader health reforms;
- international approaches;
- workforce issues; and
- sustainability of our current approach to casemix.

For further information, visit www.casemixconference2008.com.au.

Important announcement

The NCCH's Coding Standards Advisory Committee (CSAC) has made two important decisions, both effective from 1 July 2008. They are:

NCCH Query Database and Code-L

The NCCH Query Database and Code-L services for clinical coders will be discontinued from 1 July 2008. Some of the issues which influenced this decision are:

- Advice changes from edition to edition.
- Advice may no longer be valid.
- Lack of NCCH resources to remove or update previous advice – moreover, this is an historical document for the NCCH i.e. a working document that provides information on how decisions were made.
- Advice in the database is not ratified by CSAC and sometimes when a '10-AM Commandment' is created, the advice changes and there is risk of contradiction – possibly resulting in inconsistent coding practice.
- Advice related to specific queries may be incorrectly applied to other cases, i.e. there have been instances where a coder(s) has used previous advice to support decisions in the coding of a case which is different to the case for which the original query advice was intended.
- Possible use of the database answers as a punitive tool by auditors.

- Use of the database for purposes other than originally intended, i.e. to influence changes to the classification rather than using the public submission process. '10-AM Commandments' sometimes appears to be used as a similar tool.
- It is another source of reference for coders and there is a view that too many sources (ACS, Query database, answers to queries in Coding Matters, answers on Code-L, answers by state-based coding committees) can potentially create more confusion and therefore errors.

We advise you to cease using any saved versions of the database due to the outdated nature of the advice.

The only national authoritative sources of coding guidance from 1 July will be the Australian Coding Standards and the ICD-10-AM Commandments.

The NCCH's priority now is to ensure that 10-AM Commandment advice is implemented into subsequent ICD-10-AM/ACHI/ACS editions.

Also, clinical coders should follow the official coding query process which remains unchanged. See page 22 for details of the coding query process.

Coders are advised to contact HIMAA in regard to advertising coding positions as NCCH will not be providing this service from 1 July 2008.

ICD-10-AM/ACHI/ACS coding queries

The ICD-10-AM/ACHI/ACS coding queries mechanism is a two-way process that has two major roles. Firstly, it provides an avenue for coders to resolve coding problems they encounter when coding actual medical records, enabling them to assign correct and relevant codes. Secondly, it becomes a feedback process to the NCCH, highlighting any problem areas within the classification. These areas may then be reviewed and updated for subsequent editions of ICD-10-AM, ACHI and the ACS.

Individual queries

The query process requires clinical coders to follow these steps before submitting a query to their State coding advisory committee:

1. Review the current edition of ICD-10-AM, ACHI and ACS including any errata
2. Reference texts, perform a web search (if available)
3. Seek advice from peers/local coding group/clinicians

If a problem remains, the query should then be sent to the State/Territory coding committee. It is important that coding queries directed to the State/Territory coding advisory committees include any supporting documents, references and clinical advice.

State/Territory coding advisory committee queries

The coding advisory committees (CAC) act as reference groups in each State/Territory who request assistance on coding issues. These committees are responsible for responding to coding queries from coders. Any query sent to the NCCH from the state/territory CAC must be of a significantly complex/difficult nature or require a national consensus. The following steps must be performed by the committee before submitting a query to the NCCH:

1. Review the current edition of ICD-10-AM, ACHI and ACS including any errata
2. Reference texts, perform a web search (if available)
3. Seek advice from clinicians (if available)
4. Review and discuss the query using the documentation and any references or clinical advice supplied and decide if a State decision can be made.
5. Determine if the query is significantly complex or of a difficult nature or requires national consensus before forwarding to the NCCH.

These submissions need to include supporting documents, references and clinical advice. Without these the NCCH cannot definitively answer queries.

NCCH query process

The NCCH carefully reviews and considers every query received in order to provide consistent and relevant coding advice. This may be a lengthy process, especially if clinical or other support is required prior to a decision being made. Significant queries will be selected for ratification by the Coding Standards Advisory Committee (CSAC) and publication in the 10-AM Commandments.

The process includes:

1. Reviewing the current edition of ICD-10-AM, ACHI and ACS including any errata
2. Checking the historical query database (now removed from public view) for any similar/related queries
3. Checking other classifications
4. Referencing texts
5. Performing a web search
6. Seeking clinical advice from the appropriate CCCG or other affiliated clinicians
7. Reviewing NCCH documentation pertaining to development of ICD-10-AM, ACHI and ACS
8. Where relevant, seeking international advice (WHO and members of the Update Reference Committee) on issues of ICD-10 convention
9. Circulating and discussing the query at the Classification Support Division (CSD) query meeting
10. Preparing a response based on information gained through the previous steps
11. Submitting selected responses to the Coding Standards Advisory Committee (CSAC) for ratification
12. Publishing the query and answer in 10-AM Commandments featured in Coding Matters
13. Adding to a new edition of 10-AM as relevant

Grouping issues

Queries about AR-DRG grouping should be forwarded directly to the Acute Care Division, Australian Government Department of Health and Ageing (www.health.gov.au).

When a query sent to the NCCH involves both coding and grouping issues, the NCCH will address the coding issue and then liaise with the Acute Care Division, Australian Government Department of Health and Ageing.

Morbidity Reference Group

mid-year meeting

The Morbidity Reference Group (MbRG) was formally established by the WHO Family of International Classifications network in 2006 to improve the international comparability of morbidity data and the use of ICD for morbidity purposes by analysing and integrating user needs. There are 29 members, representing 13 WHO Collaborating Centers and regional offices. Kerry Innes and Julie Rust (NCCH, Sydney) currently hold the positions of co-chair and secretariat, respectively, for this group. The majority of the work is conducted by e-mail throughout the year, with two face to face meetings in October and March.

The most recent meeting of the MbRG was hosted by our Swedish colleagues, Olafr Steinum (who is also co-chair) and Gunnar Henriksson, in February 2008, at the beautiful Bjertorp Slott (castle) in Kvanum, Sweden. Meticulous planning by the hosts enabled 23 international participants to meet for three days of intensive work on both the updating of ICD-10 and the revision process for ICD-11, focusing on the morbidity applications of the classification.

Work progressed on proposals for the following topics for ICD-10, and, consequently, submissions were prepared for the Update and Revision Committee for consideration in 2008:

- major revision of the classification and terminology relating to leukaemia and lymphoma
- septic shock
- new bacteria codes
- improvements for patient safety (clearer classification of decubitus ulcer and post-procedural sepsis)
- post polio syndrome



I-r Martin Braun (Germany), Lori Moskal (Canada) and Julie Rust (NCCH) with Bjertorp castle welcome bear

Two papers developed by the NCCH to inform the revision process (*ICD-11 rules, conventions and structure from a morbidity perspective* and *Revision topics for Topic Advisory Groups*) were tabled for discussion. Valuable feedback was provided by participants; both papers were revised, and have now been forwarded to the Revision Steering Committee (ICD-11) of WHO.

Establishing the definition for main condition for ICD-11 is a major focus of this group, and discussion during the meeting was favourable towards a definition consistent with the current Australian and USA definition for principal diagnosis, i.e. the 'admitting condition'. Two other major conventions of the ICD, sequelae and excludes notes, were highlighted as topics which require further evaluation and review by the MbRG for the revision process.

Bjertorp castle, site of the MbRG meeting in Sweden



New features in Sixth Edition

interactive software

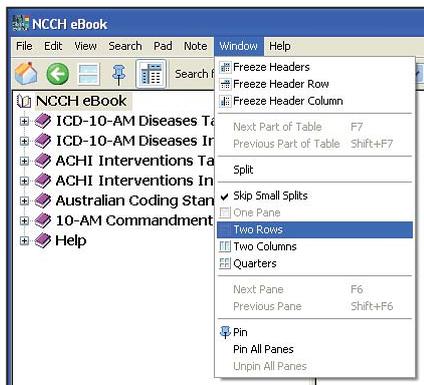
The multi-screen view and smart table heading are the latest features of the eCompress® interactive version of ICD-10-AM/ACHI/ACS Sixth Edition. The multi-screen feature allows you to view more than one volume at a time by splitting the screen into either two or four panes. As an example, you can leave the Australian Coding Standards open continuously while you navigate and browse other volumes. The 4-way split works best with larger screens.

The smart table feature allows you to freeze the table headings such as that in the neoplasm table, and scroll down the table list while the heading remains fixed.

Split screen view

The split screen function is found under the control bar heading 'Window' or on the tool bar. The drop-down menu offers 1-pane, 2-pane or 4-pane views. The 2-pane view can be either horizontal or vertical. The navigation panel remains on the left of your screen and can be adjusted to suit your requirements in width and text size. If the 'Skip Small Splits' option on the 'Window' menu is set, impractical splits for your screen size are omitted.

'Window' drop-down menu with screen split selection. Note that 'Freeze Headers' and 'Pin' can also be selected from this menu.



The navigation panel displays the active screen only, so it's a good idea to turn on 'Caret' in the 'View' menu. This will provide a blinking 'I'-beam that will indicate which volume is active. Alternatively you can activate the new inactive screen dimmer – see next page.

Try the following step-by-step example to understand how it works:

1. Select 'Next split' from the tool bar to see a horizontal 2-pane split screen.
2. Select the Alphabetic Index of Diseases in the top pane of the split view. Use the pin tool to pin the active screen. A pin icon will appear in the left corner of the volume. The pin button keeps the displayed material in the active pane.
3. Select the Australian Coding Standards (ACS) in the lower screen to be the static alternate pane and also pin. (Alternatively, use the 'Pin All Panes' in the 'Window' drop-down menu.) See Figure 1.



Note that the volumes can also be identified by the colour strips on the right hand side of the frame. The colours correspond with their matching print volumes.

4. Search the Index for 'Asthma' using the search tool. See Figure 2.
5. Click on 'J46' at '- acute severe J46' in the index. This will take you to the Disease Tabular in the active pane.
6. Click on the ACS symbol located at 'J46 Status asthmaticus'. The ACS will now display the standard 1002 in the alternate pane. See Figure 3.

To unpin a pane, highlight the pin symbol and click on the pin button to release it or use the 'Unpin All Panes' in the 'Window' menu.

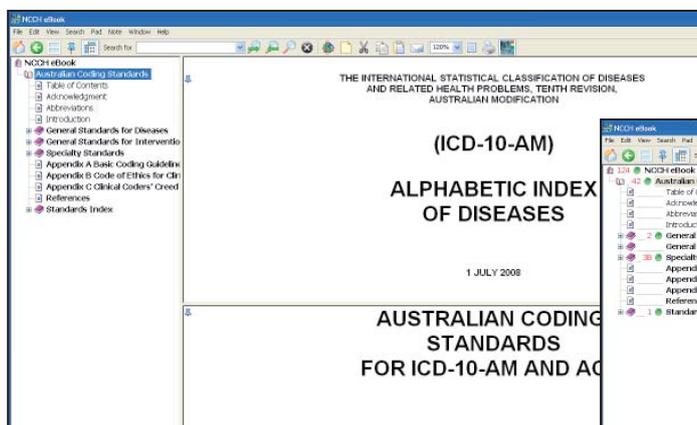


Figure 1: Note the pin icon appears on the left of each pinned volume

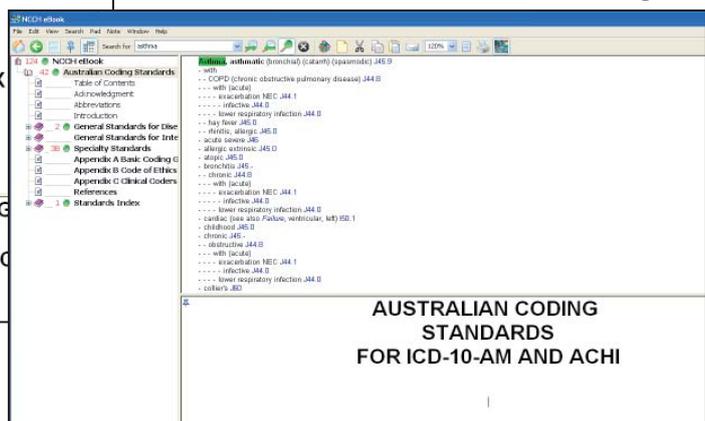


Figure 2:

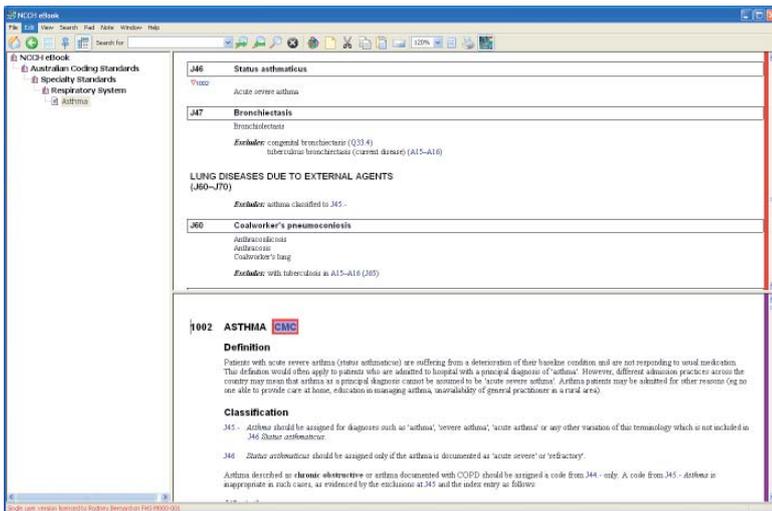


Figure 3:
The Australian Coding Standards volume will be static in the lower frame while it remains pinned.

Smart table headings

The smart table headings function allows the column headings of the tables to remain static as you scroll through the lists in long tables in the Diseases Index such as Neoplasms and the Table of Drugs and Chemicals in Section III. The smart table headings are activated by using either the 'Freeze headers' button or in the 'Window' drop-down menu. It can be turned off just as easily if not required.



Backing up your notes

The personal notes you create are important and should be regularly backed-up. They can then be used for restoration if ever needed, e.g. if a computer is replaced. Unless modified, your personal notes will always be stored on your computer's 'C' drive (C:\Documents and Settings\ User name\My Documents\Notes). The 'Notes' folder can be copied to a flash drive or other media and stored until required. Alternatively, you can e-mail them to yourself or a colleague using the envelope icon on the tool bar. This feature will bundle the notes you choose into a self-contained .ecx file.

Should you ever need to restore your 'Notes' on a new installation, you can use your saved 'Notes' folder to overwrite the newly created 'Notes' folder. If you have backed-up by e-mail you need only to drag the .ecx file onto the eBook and the notes will be automatically placed correctly.

Inactive screen dimmer

A new feature of the Sixth Edition update file is the 'Inactive screen dimmer'. This feature places a light shade of grey over the inactive pane(s) of your eBook and highlights the active screen. The inactive screen dimmer is switched on and off by selecting 'Dim inactive windows' in the 'View' drop-down menu.



The 'View' menu provides a number of options to customise your desktop

30-day trial version

The software version of ICD-10-AM/AHI/ACS Sixth Edition is available in a free trial version with all the new features for 30 days from installation. Visit the NCCH website for more information on how to download it. Registered users will gain the newest features with the first errata update file of the Sixth Edition software.

ICD-10-AM/AHI/ACS

CHRONICLE

OF CHANGES FROM FIRST TO SIXTH EDITION

The Second Edition of the ICD-10AM/AHI/ACS Chronicle summarises the changes made from First to Sixth Editions. The Chronicle is an important electronic reference tool for those who need to interpret ICD-10-AM/AHI coded morbidity data. Available July 2008. Visit the NCCH website for more information.

Coding Matters Index Volume 14

The following index is for coding advice contained within the Coding Commandments of Coding Matters volume 14, issues 1–4. Visit the NCCH website for a complete index of all Coding Matters issues – www.fhs.usyd.edu.au/ncch

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**ICD-10-AM/ACHI/ACS
Sixth Edition**

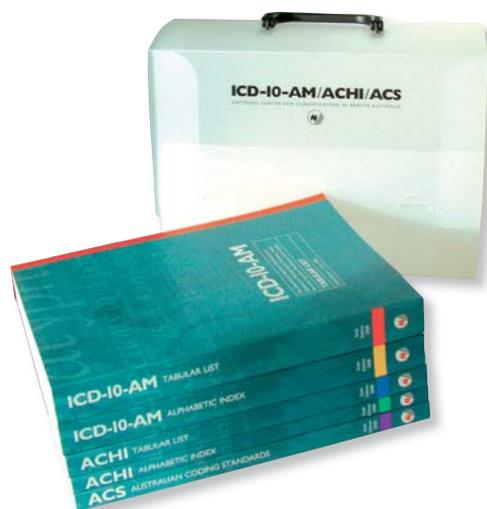
ICD-10-AM/ACHI/ACS Sixth Edition is now available in printed volumes and as eCompress@desktop software.

For further information and to order: NCCH Sydney
Phone: +61 2 9351 9461
E-mail: fhsNCCHsales@usyd.edu.au

CONFERENCES 2008

Jun 23-24	Australia's Health 2008 Conference	Canberra, ACT	www.aihw.gov.au/eventsdiary/ah08/index.cfm
Jul 7-9	Population Health Congress 2008 A Global World Practical Action for Health and Well Being	Brisbane, QLD	www.phaa.net.au/conferences.php
Jul 8	EHR – Let's Set the Record Straight	Auckland, NZ	http://www.hinz.org.nz/content/view/175/59/
Aug 6-8	Australian College of Health Service Executives National Congress Health Services Management – Different Faces, Different Places	Alice Springs, NT	www.achse.org.au
Aug 20-21	2nd Australian Health Congress 2008	Sydney, NSW	www.acevents.com.au/health2008
Aug 31-Sept 2	HIC08 – The Person in the Centre	Melbourne, VIC	www.hisa.org.au/hic08
Sept 16-18	11th National Immunisation Conference	Gold Coast, QLD	www.phaa.net.au/conferences.php
Sept 3	CHIK Health-e-Nation '08	Melbourne, VIC	www.health-e-nation.com.au/
Sept 25-26	HIMAA Symposium 2008	Canberra, ACT	www.himaa.org.au/2008/default.htm
Oct 2-5	WONCA 2008 Asia Pacific Regional Conference combined with the RACGP 51st Annual Scientific Convention 2008	Melbourne, VIC	www.racgp.org.au/asc2008
Oct 8-11	24th PCS International Working Conference	Lisbon, Portugal	www.pcsi2008.org/en/welcome/
Oct 26-Nov 1	WHO-FIC meeting	New Delhi, India	www.who.int/classifications/en/
Nov 4-6	World of Health IT Conference and Exhibition	Copenhagen, Denmark	www.cfp.worldofhealthit.org/
Nov 8-12	AMIA 2008 Annual Symposium	Washington, DC, USA	www.amia.org/meetings/f08/
Nov 16-19	Casemix Conference	Adelaide, SA	www.casemixconference2008.com.au
Nov 24	5th Annual Understanding Mortality Data workshop	Brisbane, QLD	www.fhs.usyd.edu.au/ncch
Mar 11-13 2009	11th NCCH Conference and Workshop	Sydney, NSW	www.fhs.usyd.edu.au/ncch

Conference information is also published at the NCCH website www.fhs.usyd.edu.au/ncch



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**coding
matters**



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Coding Matters is the quarterly newsletter of the
National Centre for Classification in Health (NCCH).



Call for papers

The NCCH is pleased to invite prospective participants to submit abstracts for presentation at the NCCH conference in Sydney, New South Wales, 12–13 March 2009.

Conference program scope

The following list provides suggested areas that contributors may wish to address:

- Professional development and education programs
- Innovation in clinical coding
- Communication strategies
- Quality issues
- Technology issues
- New ways of meeting everyday challenges
- Emerging opportunities and trends in health information management

Criteria for selection

The NCCH conference program committee will select papers for presentation on the basis of relevance to contemporary needs and interest, innovation, professional interest, novelty and timeliness. Presentations are generally 20 minutes.

What to include

Submitted papers should include:

- Working title of the presentation
- A 500 word abstract
- Authors' names, titles and organisational affiliation
- Presenter's name, title and organisational affiliation
- A 50 word biography for each contributing author
- Mailing address, telephone and fax numbers and e-mail address for the corresponding author

How to submit abstracts

Please send abstracts:

- as e-mail attachments (.RTF or .DOC files only) to Tina Stanhope t.stanhope@usyd.edu.au or
- by mail on floppy disk or CD-ROM (.RTF or .DOC files) to the mailing address below

Final date for receipt of abstracts

Abstracts are to be submitted by **31 August 2008**.

Notification of acceptance

Acceptance of abstracts will be made at the discretion of the NCCH conference program committee. Authors will be notified in writing of acceptance or otherwise before 16 October 2008.

Upon acceptance, authors will be advised about the session, date and time for the presentation.

Submission of full papers and conference proceedings

Successful authors are asked to prepare full papers for publication in the conference proceedings. Proceedings will be distributed to all registered conference delegates at the conference. Full papers are to be submitted before 25 February 2009.

Cost

Successful presenters will be offered a reduced registration fee that will include attendance at the conference social events – welcome reception and conference dinner. This subsidy applies to presenting authors only.

Further information

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