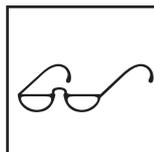




Coding *Matters*

Newsletter of the
National Centre for Classification in Health

Volume 4 Number 2
October 1997



FROM THE DESK OF THE DIRECTOR

Well - another milestone along the road to ICD-10-AM has been reached - the content is complete and tenders have been called for the printing of The Books! Our preparation program is on time, and the publication is scheduled to be available in January 1998. A mighty team effort by NCCH staff, clinician and clinical coding advisers and members of the Coding Standards Advisory Committee (CSAC)!

Dual Coding Study

The Dual Coding Study between ICD-9-CM and ICD-10-AM also qualifies as a mighty effort - this time a combination of Lisa Quick (Project Manager on secondment from NSW Health), NCCH staff, support from the Classification and Payments Branch, Department of Health and Family Services (DHFS), input from staff of the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics, state and territory health authorities, hospital staff responsible for abstracting records for the sample, and of course the clinical coders from the NCCH Coding Educators Network (CEN) who underwent a marathon coding lock-up (not quite) for two weeks to code in both classifications. The study was done under fairly rigorous conditions and our thanks are due to all who took part. It had some significant by products in educating trainers in ICD-10-AM, providing feedback to NCCH on book design and cementing national coding friendships. Results are being passed to Coopers and Lybrand, managers of the Impact Assessment Study, for analysis and reporting to Australian Health Ministers' Advisory Council (AHMAC).

New Staff

Jenni Bibaoui, Publications Assistant, has replaced Simone Lewis who left us for an adventure in Singapore. Simone will be greatly missed and has left a legacy in the Specialty Booklets and Implementation Kit, not to mention her excellent work on typesetting past issues of this newsletter. Chantelle Garrett also joins the Publication Division as Publications Officer, a new position to consolidate the electronic formats which are

the foundation of the NCCH files of ICD-10-AM. This is an extremely important position in providing a basis for NCCH to move to electronic systems of publication to supplement the traditional paper based methods.

Tiffany Chan, Classification Officer, has joined the Coding Services Division where she will assist with coding queries and support work on the second edition of ICD-10-AM due for introduction in July 1999. Tiffany has retained some hands-on coding work at St George Hospital, Sydney, so will be a valuable link for NCCH to hospital coding issues.

Conferences

NCCH has been represented at a number of conferences and seminars either through presentations, publicity material in conference satchels or marketing through NCCH exhibition booths. Dr Karen Luxford (NCCH Publications Manager) attended the RACGP 9th Computers in Medicine Conference in August. At the joint conference of the Asia Pacific Association of Medical Informatics (APAMI) and Health Informatics Society of Australia (HISA) (11-13 August), NCCH exhibited and was involved in presentations and panel



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discussions during the course of the conference (Dr Erich Schulz, Dr Karen Luxford and myself). Following this meeting in Sydney, I attended the 6th International Conference on Health and Medical Informatics Education in Newcastle, where I presented a paper prepared with Jennifer Mitchell, Health Information Management Association of Australia (HIMAA) on *HMI Education for HIMs* (Health and Medical Informatics Education for Health Information Managers). One of the outcomes of this conference is the recommendation that Australian Health Information Management courses be included on the international database providing internet access to information about courses in Health and Medical Informatics.

NCCH also had a prominent presence at the 9th Casemix Conference in Australia where we had an NCCH booth, ran three workshops on ICD-10-AM (Kerry Innes, Sue Walker, Maryann Wood and Debbie Abbott), presented papers on *Quality of care indicators and clinical coding* (Lauren Jones and Rosemary Roberts) and *Data quality: Benchmark coding audits and standardised coding edits*

(Rosemary Roberts and Joanne Chicco). Kerry Innes participated in a pre-conference allied health workshop and presented a paper in the allied health concurrent session on day 1 of the conference. Karen Peasley prepared and presented a poster on her work on *The Quality of HIV Coded Data in NSW*. I am pleased to say that I have been asked to join the Program Committee of the Tenth Casemix Conference to be held in Melbourne in September 1998.

Further afield is the Patient Classification Systems Europe meeting (Florence, 1-3 October) at which I will present a paper on the *Australian Modification of ICD-10 and a new Australian procedure classification*. Following this, Sue Walker and I will be attending a meeting of the WHO Collaborating Centres for Classification of Diseases in Copenhagen October 14-20. Dr Richard Madden, Director, AIHW and Head of the Australian Collaborating Centre, will lead the Australian team at the meeting. At this meeting, the Australian recommendations for third and fourth character update of WHO ICD-10 will be considered, along with other papers on Australian activities in health classification.

NCCH will also be represented at the 18th Conference of Health Information Management Association of Australia (HIMAA) in Canberra (22-24 October).

Publications Division

Work of the Publications Division, headed by Dr Karen Luxford, spans all other functions of NCCH - whatever we do with codes, standards, education programs and special projects - is published either in hard copy or electronically, marketed and distributed. All these functions are the responsibility of this Division and require a detailed understanding of NCCH processes and needs of our customers - especially clinical coders. Publications also administers the NCCH Homepage and maintains electronic lists and discussion groups, such as Code-L.

Staff of the Publications Division have been devoting their energies to preparation of ICD-10-AM for the typesetter, designing specifications for the printing tender, marketing through conferences mentioned above and negotiating sale of NCCH electronic products. The Australian Casemix Clinical Committee (ACCC) has again provided much appreciated support for the Publications Assistant position, with specialty booklets designed for both clinician and clinical coder audiences. The Cardiovascular Medicine and Surgery specialty book is the latest in the series, now selling well, and is the first of such publications to contain coding tips relating to ICD-10-AM.

Damian Hanrahan (Information Systems Officer) continues to provide critical support in maintaining our computer network, creating and maintaining databases

Coding Matters



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for all NCCH functions, training staff in new applications and administering the sale of all NCCH products.

Quality concerns

You will be aware from previous issues of *Coding Matters* of the NCCH interest in using codes for capturing information on adverse events in hospitals. As mentioned earlier, Lauren Jones reported on her work in this area at the Casemix Conference in Brisbane.

This issue of *Coding Matters* carries an article on "Uses of Coded Data in Victoria" by Irene Kearsey. This is particularly timely as the DHFS prepares its 1995–96 edition of *Australian Casemix Report on Hospital Activity* and with the distribution of the AIHW publication *Australian Hospital Statistics 1995–96* which contains information on code use within the report and on its accompanying disc.

The *Medical Journal of Australia* carried an article in its 5 May issue this year on "Reporting of adverse events in hospitals in Victoria, 1994–1995" by Denise O'Hara and Norman Carson from the Public Health Branch, Department of Human Services, Melbourne (MJA 1997;166:460–463). The article describes the occurrence of adverse events reported in the Victorian Inpatient Minimum Database and uses E codes in ranges E870–E876, E878–E879 and E930–E949. Reported rates are compared with those found in the Quality in Australian Healthcare study (reported in 1995). The authors express concern at possible inaccuracies in the data arising "...from the ICD-9 coding system itself, from coding reliability, or from poor recording in the patient file". However, it is through use of data in this way, as well as for casemix reporting, that deficiencies can be identified, causes determined and remedial action taken.

Coding Services Division

Abbreviated descriptors are nearing completion for a new ICD-10-AM ASCII Code List file for diseases (NCCH Brisbane) and for MBS-E (NCCH Sydney).

Judith Hooper (Coding Services Coordinator) and Karen Luxford (Publications Manager) have been working with the DHFS and the Business Liaison Office, University of Sydney, on licence agreements for purchasing electronic files of the disease and procedure tabular lists and indexes including the Australian Coding Standards and mappings between ICD-9-CM and ICD-10-AM. These agreements are in place to enable software developers to produce new and updated products by July 1998. Judith has also been meeting with hospitals concerning the use of MBS-E in hospital

operating theatre systems. As well as making the classification content available to software producers, approval in principle has been given to NCCH by the ICD-10 Implementation Committee to develop a browser in ICD-10-AM.

At the end of August, Judith Hooper and Tiffany Chan represented NCCH at a National Diabetes Indicator Workshop. The NCCH welcomes the opportunity to be involved in these discussions. Diabetes mellitus, as one of the National Health Priority Areas, is a vital focus of attention for clinical coders and for NCCH in developing codes and standards to capture complications of diabetes such as neuropathy, retinopathy, ulcers and foot problems.

At the last meeting of the National Committee for Implementation of ICD-10 in Australian Hospitals, one of the key issues identified was the need for electronic logical mappings between ICD-10-AM and ICD-9-CM so that clinical coders entering ICD-10-AM codes from 1 July 1998 can expect those codes to be mapped to ICD-9-CM and grouped in whichever AN-DRG

Version is currently being used in that hospital or state. The DHFS is to contact those companies developing post Version 3 groupers

and companies responsible for hospital administration systems to explore the possibility of developing an integrated system for these mappings.

Kerry Innes (Associate Director, NCCH Sydney) has had several sojourns in Canberra for final work on the logical mappings between ICD-9-CM and ICD-10-AM with staff from the Classification and Payments Branch, DHFS. Some of the "problem maps" are being considered by the Acute Subcommittee of the ACCC where Kerry represents the NCCH. Most of these problems occur where ICD-9-CM is more specific than ICD-10-AM and where the ICD-9-CM codes concerned are in different AN-DRGs. This one (ICD-10-AM) to many (ICD-9-CM) relationship is also a problem where only one of the 9 codes influences DRG assignment. Patricia DahDah (Classification Officer) has also been involved in the mapping exercise, as well as assisting the Medicare Benefits Schedule (MBS) Professional Relativity Study team (Project Manager, Lauren Jones) on the allocation of MBS items to specialty group.

Kerry Innes is again working with HIMAA on the Expert Panel for the Third Coder Accreditation Exam. In August, Kerry also attended a meeting of the NSW Perinatal Services Network to discuss neonatal classification issues.

Michelle Bramley (Senior Classification Officer) continues her work at NSW Health on the community health codeset for issue and activity for the Community

*... it is through use of data in this way ...
that deficiencies can be identified, causes
determined and remedial action taken*

Health Information Management Enterprise (CHIME). Kerry Innes and Dr Erich Schulz represent the NCCH on the CHIME Steering Committee.

Internet access to coding queries for state coding committees is imminent. The NCCH has also established a list server which will enable NCCH to discuss particular coding issues with CSAC members. A plan for handling ICD-10-AM coding queries will be developed in the next few months.

Education Division

Julie Rust (Acting Education Manager) and Karen Peasley (Project Officer, Education Services), organised a one day forum on functional coding and classification issues held on 17 July 1997 at the Faculty of Health Sciences, University of Sydney. The forum was a result of a collaborative project between the NCCH, the AIHW and Alpha Healthcare. With the introduction of ICD-10-AM in July 1998, as well as a new version of the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and results of the Australian National Sub-Acute and Non-Acute Patient Classification Study (AN-SNAP), opportunities have been created for improvement in coding standards and classification issues, especially in the area of rehabilitation. Twenty-one representatives from various rehabilitation colleges and related interest groups attended and made recommendations to NCCH on definition of principal diagnosis in rehabilitation and use of Impairment Codes rather than ICD-10-AM disease codes as principal diagnosis for rehabilitation episodes. These recommendations will be considered by CSAC and will be forwarded to the National Health Data Committee and to the ACCC.

A meeting of ICD-10-AM Education Group was held on 27 August. The draft ICD-10-AM education plan is under revision and is expected to be finalised in the near future. HIMAA has received funding from DHFS to prepare ICD-10-AM educational material for new students just beginning to learn coding.

Julie Rust and Karen Peasley, current mainstays of the Education Division, are now planning the NCCH Conference in Adelaide in November 1997 and preparing a series of written educational material on key changes in ICD-10-AM (General Introduction, Procedure Coding, Obstetrics, Mental Health, Injuries and Trauma, and Common Medical Conditions). This education series is designed to give you "A Taste of Ten!" (?????)

NCCH was invited by the Hospital Authority, Hong Kong, to run a two day seminar on Introduction to ICD-10 on 28-29 July 1997. Julie Rust represented NCCH in presenting this seminar during this exciting time in Hong Kong's history.

Visitors

NCCH has recently hosted visitors from South Africa (Dr Neil Soderlund, Centre for Health Policy, University of Witwatersrand) and South Korea (A/Professor Cho Eun Hee, Won Kwang College). Thanks to Mr Joe Christiansen, AIHW, who demonstrated the National Health Information Knowledgebase at the Faculty of Health Sciences on 6 August, 1997.

Safety and Efficacy Register

The Royal Australasian College of Surgeons has asked NCCH to participate in a three year pilot project to determine the feasibility of establishing an Australian safety and efficacy register of new surgical procedures. The project, funded by DHFS, will require a part time Classification Officer from NCCH as well as representation on its steering committee. This will be a very pertinent follow-up to work on development of MBS-E and will allow integration of new techniques into the procedure classification.

The Future

Although we have spent so much energy on ICD-10-AM, it is exciting to be involved in development of classification systems in community health and in rehabilitation and to oversee their integration with ICD-10-AM systems in hospitals. Also, developments with electronic classification systems will now be essential to carry us (and you) through to the next century so that the coding function remains relevant with the use of information technologies in health. The APAMI/HIC 97 Conference and Health and Medical Informatics Education Conference both reinforced to me the need for our future to be electronic. I hope you will join us at the Adelaide NCCH Conference, *The Future of Coding*, November 19-21, 1997 so that we can discuss our future in more detail!

Warren Talbot

You may know that Mr Warren Talbot, former Assistant Secretary, Classification and Payments Branch, has moved to another section of the DHFS. I should like to acknowledge the support Warren has given to NCCH over the last four years. Warren was present at the birth of NCCH (Sydney) (then the National Coding Centre) and has been an enormous source of wisdom in guiding the development of the Centre, including the joint venture between University of Sydney and Queensland University of Technology that led to the creation of NCCH. Thank you, Warren. I hope you will always remain a "friend of NCCH".

❖ Rosemary Roberts
Director



VITAL SIGNS

Having a hard time in Bangkok . . .

Hi everyone! This column is written as Maryann Wood and I are in Bangkok conducting the second of three ICD-10 training courses for the World Health Organization South East Asia Regional Office (SEARO). The course runs from 25 August until 5 September 1997 and is being held in the ICD-10 International Training Centre in the Ministry of Public Health, Royal Thai Government. We have fourteen official participants this time - three from Myanmar, three from Sri Lanka, four from Indonesia, two from the Maldives and two Thais (see picture below). There are also several other Thai folk who are sitting in on various sections of the course. It has been a wonderful experience for me returning to the Ministry after running the first course here in April/May.

I can see the progress that has been made in the ICD-10 Training Centre since that time, in the capable hands of Mrs Ratana Konsilp (the "Chief" of the Centre). During the first course, I trained twelve Thai doctors as well as five other SEARO students. This time, ten of the doctors are assisting Maryann and I in conducting the course, as well as beginning the translation of the ICD-10 Tabular List into Thai. Volume II (WHO Instructional Manual) has already been partially translated and will be completed, but the Index will remain in English at the moment. This is because many Thai doctors use English when providing diagnoses and having a multi-language classification is thought to assist the clinical coders.

On Sunday night, Maryann and I had a wonderful dinner with Saranuj, whom many of you may remember as a postgraduate student and subsequent research assistant

at the School of Health Information Management, University of Sydney. Saranuj has now returned home to Bangkok and is working on a new hospital accreditation project. We have been able to put her into contact with the staff in the ICD Training Centre and it is hoped that Saranuj will be able to assist with the development of the HIM and clinical coding professions in Thailand. Saranuj sends her best regards to her many friends in Australia.

One of the objectives of the Training Centre is to begin the formation of an association or group for HIM people in hospitals, particularly those that are responsible for coding. To this end, the Centre has raised funding for a newsletter from a local health informatics company and has begun organising meetings of interested folks to discuss coding and HIM issues in Thailand. We certainly wish them every success in this endeavour! There are also plans for a university degree course - a Bachelor of Science (clinical coding) in addition to the medical record degree that is already offered. Now that's something to think about, Australia!

It is a real experience teaching outside one's own country and therefore, outside one's own comfort zone. As well as remembering to speak slowly, there is also the need to adapt one's training materials and ways of thinking. Clinical coders in Australia are well catered for in terms of having coding books that reflect diagnostic and therapeutic experiences in our country and which are in our own language, there is provision for obtaining coding advice and standards, the Clinical Coders' Society of Australia (CCSA) provides a support network for coders and so on. Many of the clinical coders we are working with struggle to code in the most timely and accurate fashion that they can without access to any of these things.

Yet they have enormous pride in the jobs that they do despite the difficulties that they face. It's a real inspiration to us!

Bangkok is a wonderful city - crowded and hot - but with immense charm and character. Yesterday, Maryann and I were delighted to see three elephants wandering down the road in the middle of a traffic jam! Our training room is always full of fresh flowers, beautifully arranged, and we are having a great time eating the local spicy foods and fresh tropical fruits. Until we report in the next *Coding Matters*, its 'sawadee kha' from Bangkok.



❖ Sue Walker
Associate Director, Brisbane

ICD-10-AM Dual Coding Study

The Dual Coding Study (DCS), funded by the Commonwealth Department of Health and Family Services (DHFS), was managed by the National Centre for Classification in Health (NCCH), under the guidance of the Dual Coding Study Subcommittee (a subcommittee of the National Committee for Implementation of ICD-10 in Australian Hospitals). The subcommittee consisted of:

- Dr John Holmes* Chair, National Committee for Implementation of ICD-10-AM in Australian Hospitals
- Mr Peter Watson* Classification and Payments Branch, DHFS
- Mr Peter Gray* Classification and Payments Branch, DHFS
- A/Prof. Rosemary Roberts* NCCH
- Ms Kerry Innes* NCCH
- Ms Lisa Quick* Health Information Management Association of Australia ((HIMAA) then as Project Manager of DCS)
- Ms Lynelle Moon* Australian Institute of Health and Welfare
- Mr John Preston* Australian Bureau of Statistics, Queensland
- Mr Ric Marshall* Department of Human Services, Victoria
- Mr Greg Curry* NSW Health

The final results from the Dual Coding Study will be analysed by the Impact Assessment Project Managers, Coopers & Lybrand Consultants. It will then be provided to the Commonwealth, State and Territory Health Authorities and to the Australian Health Ministers' Advisory Council (AHMAC) for discussion and comment. Thus, the results of the Impact Assessment Project will be used to confirm the date of implementation of ICD-10-AM as 1 July 1998.

The implementation of ICD-10-AM from 1 July 1998 will require a number of activities to occur as part of the preparation. The National Committee for Implementation of ICD-10-AM in Australian Hospitals is overseeing these activities and the membership of the committee ensures that all key stakeholders and participants in the implementation process are involved.

Specifically, the aims of the Dual Coding Study were to:

- 1 Assess the impact on resource levels by measuring the time taken to code in ICD-9-CM and ICD-10-AM and identify factors which contribute to any difference in time.
- 2 Provide an indicative analysis of the concordance between ICD-9-CM and ICD-10-AM.
- 3 Provide information to assist in the assessment of the wider impact of the classification change (e.g. mapping, grouping, funding, population data).

The Dual Coding Study commenced with the formulation of a study design. Once this was determined, the task of requesting and then collecting 12,000 abstraction forms began. All states and territories sent

Lisa Quick, Health Information Manager, was seconded from NSW Health to manage the project under the direction of the NCCH. Lisa currently works in the Information and Data Services Branch of NSW Health as Manager, ICD-10-AM Implementation (NSW).



Dual Coding Study team (from left) Fiona McManus, Karen Peasley, Lisa Quick (DCS Manager) and Judith Hooper.

Dual Coding Study clinical coders were kept busy coding in two classifications.



out requests, sample selection lists and abstraction instructions to public and private hospitals throughout Australia. They then assisted in the collection of the forms as they were returned.

At the same time that abstraction information was being requested from hospitals throughout Australia, the project team were busy recruiting clinical coders to assist in the major part of the study - the coding of abstraction forms.

The recruitment of clinical coders for the DCS commenced firstly with the NCCCH Coding Educators Network. However, when it became clear that recruitment from this group would not supply enough clinical coders to code the potential 24,000 abstraction forms, recruitment was expanded to include clinical coders who had participated in "Train-the-Trainer Two" sessions held in May 1997, with additional coders being

Almost 10,000 of the 12,000 forms requested were returned. This was a fine effort from the clinical coders and health information managers of Australia. Such a return meant that 20,000 episodes would be coded, with 10,000 in ICD-9-CM and 10,000 in ICD-10-AM. The time taken to code in ICD-9-CM and ICD-10-AM was timed using stopwatches.

Almost 10,000 of the 12,000 forms requested were returned . . . a fine effort from the clinical coders and health information managers of Australia.

To ensure that the clinical coders participating in the study had exactly the same experience level with ICD-10-AM, any clinical coders who worked on development of ICD-10-AM were excluded from participating.

trained specifically for the DCS. These clinical coders were representatives from the various State/Territory health authorities, State Coding Committees and 3M Healthcare. This increased the total number of clinical coders within NSW who were participating, however, it was not felt that this would bias the final results of the study.

At the completion of the study, a total of forty-three (43) clinical coders had participated in the coding of abstraction forms. A state/territory breakdown is shown in Table 1, including two participants from New Zealand.

Part of the study design determined that the clinical coders would code the abstraction forms at the same place and at the same time. To do this, a venue and state had to be organised. The venue was the



Table 1. State breakdown of clinical coders participating in the DCS

State or Territory	Number of Clinical Coders
NSW and ACT	15
Victoria	10
Queensland and Northern Territory	5
South Australia	6
Western Australia	4
Tasmania	1
New Zealand	2



Thanks to all who participated in the Dual Coding Study - your involvement is appreciated!



Camperdown Travelodge in Sydney, NSW due to the room availability for the time required, accommodation for interstate clinical coders and convenient location in Sydney.

Over a two week period, the DCS clinical coders coded abstraction forms in ICD-9-CM and then again in ICD-10-AM. The time taken to code each abstraction form was recorded by each coder (stopwatch) and will be one of the main data items studied in the final analysis of the DCS data. The exact method by which this was

merged into the DCS database and sent to the Australian Institute of Health and Welfare (AIHW) for processing before being handed over to Coopers & Lybrand for analysis.

Results from the Dual Coding Study will be reported by Coopers & Lybrand in its final report to the Commonwealth on the Impact Assessment of the introduction of ICD-10.

Any questions regarding the study should be directed to the NCCH or to Lisa Quick at NSW Health.

As Project Manager, I would like to take this opportunity to thank all clinical coders and health information managers who contributed by providing abstraction forms to the study. Without your effort, the study could not have taken place.

The time taken to code each abstraction form . . . will be one of the main data items studied in the final analysis of the DCS data.

done will be explained further in the project report and again in depth at the NCCH Conference being held in November this year in Adelaide.

At the completion of coding, each clinical coder answered a DCS Coder Questionnaire. This questionnaire took at least two hours to complete. Coders provided their views on the study in general, ICD-9-CM, ICD-10-AM, and specifically their thoughts on coding in ICD-10-AM from 1 July 1998. This questionnaire is being analysed by the DCS Project Manager and the NCCH and the results will be provided to consultants Coopers & Lybrand for incorporation in their report on the impact assessment project.

Once all the DCS coders returned home, the project team commenced work on organising the data entry of the 20,000 forms coded during the study. A data entry company was used for this process. The data will be

Thanks again also to the following people:

- **The DCS Coders**
- **NCCH staff** - Karen Peasley, Judith Hooper, Simone Lewis, Patricia DahDah, Damian Hanrahan and Linda Maleszka.
- **Violet and Julie-Ann** at the Travelodge, Camperdown.
- **DCS Project Team** - Iris Wetterings and Fiona McManus.

❖ Lisa Quick
Project Manager, Dual Coding Study



EDUCATIONAL MATTERS

With only weeks to go until the NCCH conference in Glenelg, Adelaide, life has certainly been hectic for Education Services. *"The Future of Coding"* is the theme of the conference and I'm sure most of you will agree that the programme offers some exciting and informative sessions on the changes ahead for coding and classification systems. If you have not yet received a registration form, please contact Julie Rust or Karen Peasley on (02) 9351 9461.

Functional Coding Forum

As reported in the July issue of *Coding Matters*, a one day forum on functional coding and classification issues was held on 17 July, 1997. A core group, representing the professions involved in rehabilitation were invited to attend. The aim of the forum was to advise the NCCH on:

- coding of functional measures in acute, sub-acute and non-acute episodes
- principal diagnosis in the rehabilitation episode of care
- the Australian Coding Standard for rehabilitation
- diagnostic and intervention codes applicable to rehabilitation coding
- content of the speciality coding booklet on rehabilitation

Presentations included advice on ICIDH, an update on the AN-SNAP, rehabilitation in the private sector, the need for specialised rehabilitation classification systems and functional coding for allied health. The afternoon session was an open discussion on the issues presented in the morning, with reference to the aims of the day.

A number of recommendations have arisen from this discussion, including a definition of a Rehabilitation Impairment Category, the utilisation of the Uniform Data Set (UDS) Impairment Group codes and the development of revised rehabilitation coding standards.



Julie Rust (centre front) receives a warm welcome from the Hong Kong Hospital Authority staff.



These recommendations will be forwarded to relevant organisations for comment before any final decisions are made in the area of functional coding for rehabilitation. We will keep you posted!

Hong Kong Seminar

The NCCH was approached by Dr. Hong Fung earlier this year to hold an introductory seminar on ICD-10 for staff of the Hong Kong Hospital Authority.

The seminar was held in the Pamela Youde Nethersole Eastern Hospital on 29th July 1997 and topics covered included an introduction to ICD-10, major differences between ICD-9-CM and ICD-10, the Australian modification ICD-10-AM, mapping procedures and an overview of education and implementation in Australia. There were approximately 70 participants in this day, including Health Information and Record Managers (HIRMs), clinicians, managers, IT specialists and clinical coders. As this was my first overseas assignment with the NCCH, it was very reassuring to see some familiar faces in the audience who had been students at the School of Health Information Management, University of Sydney.

A half day meeting with the HIRMs from the public hospitals in Hong Kong was held following the seminar. This was an informal session which included a review of the *ICD-10-AM Implementation Kit*, an introduction to Tendon and a question and answer session.

Visiting Hong Kong so soon after the hand over celebrations was certainly an exciting experience. During my stay, I was well looked after by Katrina Chisholm (an Aussie ex-pat) and Vicki Fung, with some wonderful meals and memorable shopping expeditions!

An evaluation of the seminar revealed that all of the participants found it to be a good introduction to ICD-10. The NCCCH looks forward to maintaining close links with the Hong Kong Hospital Authority in the future.

Distance Education for Queensland

A proposal has been submitted by NCCCH Brisbane and Queensland University of Technology (QUT) for a Rural Health Education and Training grant to develop a training package for conversion to ICD-10-AM for HIMs and clinical coders who are currently working in rural and remote areas of Australia. A positive outcome on this proposal would help to consolidate our education plan for the successful implementation of ICD-10-AM.

Educational Booklets

You will find in this issue of *Coding Matters* an order form including a new series of educational booklets titled "A Taste of Ten". These booklets are designed to give clinical coders an introduction to ICD-10-AM in certain areas where there have been major changes between ICD-9-CM and ICD-10-AM. Topics covered include:

- ★ *General introduction to ICD-10-AM*
- ★ *Procedure coding*
- ★ *Injuries and trauma*
- ★ *Common medical conditions*
- ★ *Mental health*
- ★ *Obstetrics*

The content of each book includes clinical background (if relevant), major changes between the two classifications, relevant Australian Coding Standards,

excerpts from the Tabular Lists and Indices and exercises to complete.

Feedback from preliminary education sessions has consistently alerted us to the need for exercises and hands on experience in ICD-10-AM. The challenge, of course, is to provide this experience when clinical coders do not yet have the "tools of the trade". We hope that by providing clinical coders with both theoretical material and practical examples, we can address this problem and offer people a "taste" of what ICD-10-AM is all about!

Update of Education Timetable

An update of the ICD-10-AM Education Timetable is included on page 19 in this issue of *Coding Matters*. Many thanks to all the people who have so far provided valuable feedback and comments regarding the education plan for ICD-10-AM. It is very important for us to "get it right" when it comes to the enormous task of planning and organising education services for clinical coders throughout Australia, so we appreciate your input.

CEN

Another group whose help is essential in educational matters is the Coding Educators Network (CEN). You will find three more profiles of current CEN members on page 12. In providing this information, we hope that by next year, when the face-to-face training is in full swing, some of the "faces" will be that bit more familiar to our readers.

In the meantime, we look forward to catching up with all our friends and colleagues in Adelaide during the NCCCH Conference (*see* page 20).

❖ Julie Rust
Acting Education Manager

ICD-10-AM Implementation - State Coordinators

State	Name	Phone	Facsimile	Email
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ACT	Elaine Harris	(02) 62050884	(02) 62050842	
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Australian Standards for the Coding Service

In the April 1997 issue of *Coding Matters*, clinical coders were given the opportunity to have input into the revision of the current industry benchmark for coding output. It was intended to use the results of the questionnaire to assist the Coding Standards Advisory Committee (CSAC) in updating the current benchmark.

... CSAC will pursue the revision of an industry benchmark through the Coding Output Benchmark Working Party.

Unfortunately, the number of responses received was very low and consequently the results will not be utilised. However, CSAC will pursue the revision of an industry benchmark through the Coding Output Benchmark Working Party.

The working party was recently formed and is yet to have its first meeting. Its main objective will be to develop a benchmark(s) based on a statistically valid methodology. It was agreed at the September 1997 meeting of CSAC that any benchmark(s) should be based on ICD-10-AM and should be developed at least 12 – 24 months post national implementation.

Below are some issues that the Working Party will be considering in the revision of the current benchmark.

Should:

- there be one benchmark for all clinical coders or should there be several benchmarks, that is, a benchmark for each type of health service? For example, a rural facility may have a benchmark that requires a higher number of records to be coded per day than a tertiary hospital;
- the benchmark(s) be a single figure or a range (or several ranges depending on the type of health service)?;
- should the benchmark(s) be based purely on coding? As the work duties and responsibilities for clinical coders range significantly throughout health services in Australia, is it practicable to determine a benchmark containing a standard set of duties? Would it be more efficient to have a benchmark(s) that hospital managers, who require this information for workforce planning, incentive programs etc, can utilise as a starting point, factoring in other duties as required to determine a suitable output range for clinical coders in their health service?; and
- the benchmark(s) be based on an hourly/weekly/monthly or yearly output rate?

If you have any suggestions or comments, please forward them to Sandy Juriansz, Convenor - Coding Output Benchmark Working Party, Data Services Unit, Queensland Health, PO Box 48, Brisbane 4001 or email: jurianss@health.qld.gov.au

❖ Karen Peasley
Project Officer

Profiles of Coding Educators Network (CEN) members

Barbara Campbell (WA)

I have been associated with clinical coding since re-entering the full time workforce in 1981. My background includes nursing and a degree in Health Education. I have practical coding experience in hospitals and was the Morbidity Coding Trainer at the Health Department of WA (HDWA) for 8 years. Currently, I teach Nosology in the Health Information Management course at Curtin University of Technology and have been a member of the Coding Educators Network since 1995.

My current position at the HDWA is within the section responsible for Casemix and my coding knowledge is now used during data analysis. Although I became a



clinical coder by default, I have been fascinated by disease classification from the time I was first exposed to ICD-9. The changes to the classification used in Australia and the increased emphasis on accurate coding in recent years have

been a challenge. The most challenging time is probably ahead with a successful change to ICD-10-AM (including MBS-E) scheduled for the not too distant future.

I look forward to continuing involvement with clinical coders both in WA and the through the Coding Educators Network and the Clinical Coders' Society of Australia (CCSA).

Kylie Holcombe (VIC)

In 1989, I completed the Medical Record Administrator (MRA) course at La Trobe University and entered the workforce prior to the introduction of casemix and the establishment of the Australian Coding Standards. After a year of full time coding, I commenced work in various MRA roles which did not require me to code.

Late 1995, I chose to return to coding, which is now dominated by casemix and regulated by standards. This was challenging, but I found the guidance of the Australian Coding Standards invaluable as they had eliminated a lot of 'grey' areas that had previously existed with coding. I currently have three coding jobs which amount to full time work, at the Alfred Hospital, Donvale Rehabilitation Hospital and Waverley Private

Hospital.

Having passed the Accredited Clinical Coder Examination in 1996, I joined the Coding Educators Network earlier this year in order to play a part in the introduction of ICD-10-AM. This has enabled me to participate



in a Train-the-Trainer workshop and more recently the Dual Coding Study. Now that I have been able to preview ICD-10-AM, including MBS-E, I am looking forward to the next twelve months and the positive changes that I am sure this new classification will bring.

Lisa Timmins (Qld)

Hello everyone from the beautiful Sunshine Coast in Queensland! I have recently moved to become part of a progressive team in a private hospital in Nambour. I graduated from the Queensland University of Technology in Brisbane in 1990 after a period of full-time/part-time and external study. Since that time I have hopped around the nation from Brisbane to Maryborough, Brisbane to Cowra and then to Lismore. This has given me insights into both small and large hospitals and a feel for the challenges faced by clinical coders and managers.

In 1996, I became an Accredited Clinical Coder and joined the NCCH Coding Educators Network in 1997. I enjoy providing guidance and holding informative discussions with other clinical coders. I believe the introduction of ICD-10-AM may be similar to motherhood, (to those who can relate), with both joys and trials. I look forward to providing hope to both clinicians and fellow clinical coders as the scope of information available and the opportunities for better communication are realised.



Sue Edmonds (SA)



I always wanted to be a MRA (as it was then), ever since my mother showed me an article when I was about 13. I fancied working in health but knew I hadn't the stomach for medicine or nursing. The idea of playing detective with medical

records to assign codes really intrigued me and even now coding is something that I really enjoy. Being very reserved (not that my friends believe that!) I failed the interview at my first attempt to join the course at Lincoln Institute in Melbourne. Thirteen years later, I was made redundant from my job and tried again - the two year course was now three, Lincoln was part of La Trobe

University and there were NO INTERVIEWS. Although, I think I've left my quiet days behind now. . .

I graduated after a pretty gruelling honours year and came straight to Adelaide in 1993, where I started in the Medical Record Department of the Royal Adelaide Hospital. Later, I worked in both Medical Records and the Coding Unit, which prepared me for my current role as Coding Manager for the NWAHS (North Western Adelaide Health Service), comprising The Queen Elizabeth Hospital & the Lyell McEwin Health Service. I have been at NWAHS for just over one year and joined the Coder Education Network in May 1997.

In early August 1997, I participated in the ICD-10-AM Dual Coding Study in Sydney which was a very interesting and educational time. I made new friends from around Australia, caught up with some old friends, and learnt a lot about ICD-10-AM. It's introduction will be a very busy, challenging and exciting time and I look forward to being able to assist others in learning about it. I also look forward to having REAL ICD-10-AM books and not the draft books we juggled in Sydney!!



Uses of Coded Data in Victoria

When we asked you, as Coding Matters readers, what would you like to see more of in your newsletter, you said you wanted more detail on the uses of all the coded data that you generate! So, in this issue, we look at Victoria for a state level perspective by Irene Kearsey.

Victoria's collection of admitted patient data, the Victorian Inpatient Minimum Database (VIMD), is managed by the Department of Human Services' Health Data Standards and Systems unit. Patient identification in the VIMD is limited to Medicare Number and the hospital's Unit Record (UR) Number. Since commencing in 1979, the VIMD has always been completely computerised. The VIMD is consolidated on the 21st of each month and finally for the year on 21 September [a deadline that would have seemed totally unrealisable to Health Information Managers (HIMs) in 1979].

Originally, the collection provided morbidity data to the Australian Bureau of Statistics (ABS) for publication of summary tables but this ceased some years ago. However, as we achieved complete coverage of public hospitals, the Department became able to reduce the demand on hospitals for paper returns: we could extract information from the electronic collection. The first

return to be dropped was a summary of admissions by area of residence.

The VIMD is provided to the Commonwealth for inclusion in the national collection. For private hospitals, we use the VIMD to produce parts of their annual reports to the ABS.

Epidemiologists stress their need for clinical data to the greatest degree of detail available.

The annual VIMD is a massive file and was difficult to analyse until personal computers became more powerful. However, the Department has always attempted to meet the needs of researchers. One method now is to produce disks of a year's separations as

continued page 14 ►

Uses of Coded Data in Victoria continued . . .

standard data sets; these aggregate data or include only a few fields. This protects patient confidentiality and enables us to fit a whole year's data on one disk!

We provide full copies of the VIMD each month to the Regional Offices. Other Department divisions receive copies of the VIMD limited to the category of patients relevant to that division (e.g. aged patients or rehabilitation patients).

Public Health Division's Epidemiology unit uses a full copy of the VIMD. Both staff and epidemiology students on placement use the data, and researchers' requests are also met. Epidemiologists stress their need for

. . . the annual refining of Victoria's payment formula has extended the type of VIMD fields that have financial implications.

clinical data to the greatest degree of detail available. With numerous journal papers being accepted or submitted for peer review literature to date, the Department's epidemiologists have demonstrated the quality of the VIMD data and the quality of the information derived from it.

For the Koori Health unit, the Public Health Division produces an easily accessed package of all episodes for patients recorded as Aboriginal or Torres Strait Islander.

Health Data Standards and Systems' HIMs use the VIMD to identify coding quality issues and distribute information to hospitals (a whole topic in itself). Other data collectors (such as the Perinatal Unit and the Cancer Registry) have made useful comparisons between the VIMD and their collections, to identify problems of data quality and completeness in either collection.

After the final consolidation of the VIMD each year, we produce for hospitals a suite of reports based on DRGs and ICD codes. These include comparisons of the hospital's performance against State means.

In 1993, Victoria introduced casemix funding. Although DRG allocation is based on the clinical coding, the annual refining of Victoria's payment formula has extended the type of VIMD fields that have financial implications. Some are information that would be abstracted and verified by clinical coders (e.g. birth weight of newborns and the count of hours on continuous mechanical ventilation).

Other funders now also rely on the VIMD. The Department of Veterans' Affairs (DVA) receives a tape of records of DVA patients for calculating its payments

in the State. The Victorian Accident Commission (VAC) and the Transport Accident Commission (TAC), covering workers' compensation and road accident compensation respectively, now pay public hospitals by casemix. For VAC and TAC patients (identified by their account class), the VIMD provides the hospital with a DRG Statement. This sets out diagnosis and procedure codes and rubrics, DRG number and rubric, the DRG's weight and therefore the amount to be paid, and the patient's Unit Record (UR) Number. The hospital attaches this to an invoice that includes the patient's name.

We have instituted an annual program of recoding audits, managed by consultants, however, the Department sets the criteria that must be met by the clinical coders they employ. The audits aim to assess and improve the quality of the clinical coding.

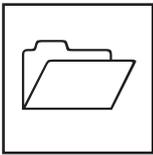
The introduction of casemix funding in Victoria in 1993 at a few month's notice could only have happened so quickly because the Department and the hospitals accepted the VIMD and the clinical coding provided by hospitals and their clinical coders as robust and reliable.

❖ Irene Kearsey
Department of Human Services, Victoria

Songs to Code By . . . 

In the course of preparing ICD-10-AM, NCCH staff have resorted to some light relief . . . Here are some "songs to code by . . ." we thought we'd share with you. If you're very lucky and our staff get some spare time some day, we may record an album!!!

- You're My Lucky Number *Lyna Lovitch*
- One is the Loneliest
Number *John Farnham*
- Help *The Beatles*
- You're My Number
One *Christie Allen*
- One in Ten *UB40*
- I Just Can't Get
Enough *Depeche Mode*
- The Race Is On *George Jones*
- Medical Love Song *Monty Python*
- I'd rather have a bottle
in front of me, then a
frontal lobotomy *Tom Waits*



CODING SERVICES

This edition of Coding Tips covers the topics of abdominal aortic aneurysm repair with stent, airway care, Grover's disease, hindwater leak and limbal stem cell transplantation, with codes from both ICD-9-CM and a taste of ICD-10-AM.

Coding tips

Abdominal aortic aneurysm repair with stent

The NCCH has received a couple of queries about whether 39.90 *Dilation/stenting of major great vessels* can be used for this procedure. 39.90 was introduced in July 1994 and the guidelines published by the NCCH in 1994 indicate that 39.90 is intended for major great vessels which are thoracic aorta, pulmonary arteries, pulmonary veins and the superior or inferior vena cavae and intracardiac baffles. This procedure code **does not include the abdominal aorta** and should be assigned only where stenting is performed on the above vessels. Stenting of any other vessels should be assigned code 38.20 *Dilation/stenting of other vessels*.

Code abdominal aortic aneurysm repair with stent to:

39.52 Other repair of aneurysm
38.20 Dilation/stenting of other vessel

[ICD-10-AM: 90228-00 Endoluminal repair of aneurysm]

Airway care

The code 96.55 *Tracheostomy toilette* was chosen to represent "airway care" by a physiotherapist consultant as there is no better existing code in ICD-9-CM to represent this procedural concept.

Grover's disease

Grover's disease is an acquired, monomorphous, papulovesicular eruption of unknown cause first characterized by Ralph W. Grover in 1970¹. Grover's disease is also known as transient acantholytic dermatosis.

(see top of next column)

¹ Jerome Michael Parsons. Transient acantholytic dermatosis (Grover's disease): A global perspective. *J Am Acad Dermatol* 1996;35: 653-666.

Coding:

ICD-9-CM: 702.8 Other specified dermatoses
[ICD-10-AM: L11.1 Transient acantholytic dermatosis [Grover]]

Don't you just love ICD-10-AM!!

Hindwater leak

Q Should "hindwater leak" be coded as a premature rupture of membranes?

A Yes - assign the appropriate code from 658.1x, 658.2x, 658.5x *Premature rupture of membranes* . . . If an Artificial rupture of membrane (ARM) is subsequently performed on the forewaters this should be coded (73.0x *Artificial rupture of membranes*).

Limbal stem cell transplantation

The junctional zone between the corneal and conjunctival epithelia is known as the limbus. It is believed that the basal epithelial cells of the limbus include the stem cells for corneal epithelial proliferation and differentiation. In cases of corneal scarring, chemical or thermal burns and other long-term ocular surface failures, conjunctival transplantation including limbal epithelium results, in many cases, in restoration of the corneal epithelial phenotype.

The procedure involves the transfer of grafts of limbal tissue from the uninjured eye to the injured eye. The limbal tissue can also be obtained from a donor eye.

Coding:

ICD-9-CM: 11.69 Other corneal transplant
[ICD-10-AM: 90065-00 Limbal stem cell transplant]

❖ Kerry Innes
Associate Director, Sydney

National Codeset Project: Community Based Health Services, Community Health Information Development Project, NSW Health

NSW Health commenced the Community Health Information Development (CHID) Project in August 1994. The primary goal of this project is to provide an information solution to the community health sector that:

- provides an overview of the business functions of the sector
- facilitates the analysis of continuity of care
- allows for casemix or servicemix funding decisions and
- prepares for the development of best practice guidelines and benchmarking.

During 1995, there was extensive consultation with Community Health workers and management to identify their information needs, focusing in particular on the requirements for a “clinically useful” system. These requirements were documented in a detailed data and function model that was released in March 1996. The Community Health Information Model (CHIM) is an extremely comprehensive, client focused data model that includes 210 entities, 485 attributes and 357 relationships between the entities and attributes. A data dictionary accompanies CHIM that defines, and provides examples for, each entity and attribute.

The focus of the CHIME partnership is to develop both an information system and the necessary codesets to meet the needs of a wide range of service units within Community Health.

Also during 1996, NSW Health entered into negotiation for joint development with a number of other Australian states and territories. In August 1996, the Community Health Information Management Enterprise (CHIME) was formed between NSW, Queensland, South Australia and the ACT. The focus of the CHIME partnership is to develop both an information system and the necessary codesets to meet the needs of a wide range of service units within Community Health. During late 1996, workshops were conducted to review and expand the data model to meet the needs of the CHIME partners, resulting in a new version of the data model, known as CHIM-V2.1, released in January 1997.

The CHIM-V2.1 identifies the need for a significant number of classification schemes to support both administrative and clinical business functions. To populate the entities and attributes of CHIM, the National Codeset Project: Community Based Health Services was established.

Michelle Bramley (NCCH Senior Classification Officer) is currently on secondment to NSW Health (four days per week), with Kerry Innes (NCCH Associate Director, Sydney) providing a supporting role. The NCCH is assisting NSW Health to develop codesets for two major entities of CHIM, “Issue” and “Activity”.

The “Issue” entity represents the area of concern for a client or population group. It incorporates the medical diagnosis as well as less formalised behavioural and lifestyle issues. Therefore, the scope is broader than purely health related issues and includes general life matters, such as accommodation and financial problems. This scope reflects the holistic philosophy of community health services to a client’s situation.

The “Activity” entity represents the way that service providers spend their time and the method by which outcomes for clients are achieved.

The National Codeset Project is still in its infancy. The major task of the project to date has been the collection of information regarding existing national, state and local data collections, minimum data sets or codesets. These are being mapped to the relevant entities and attributes of CHIM and a series of classification hierarchies and codesets being built. This preliminary work will inform the national workshops that are due to begin mid October 1997. The aim of the workshops will be to gain national acceptance on the codesets used for the CHIM.

For further information, please contact Julie Bargaquast, Project Manager, CHID Project, NSW Health, ph: (02) 9391 9093.

❖ Michelle Bramley
Senior Classification Officer



PUBLICATION ISSUES

As the count down commences to ICD-10-AM introduction, the NCCH Publications Division has been in a flurry of anticipation, preparing book proofs and print tenders. Due to the amount of content contained in the new classification, it now looks as though the book set will consist of 5 volumes, with Procedures (MBS-E) consisting of separate volumes for Tabular List and Index.

In August, we advertised a tender for the printing and distribution of the new classification and received widespread interest. Upon assessing the applicants, we shall know which company will be responsible for delivering your ICD-10-AM books to you in January 1998!

Feedback from clinical coders taking part in the recent Dual Coding Study (DCS), ably managed by Lisa Quick, has proved invaluable. It has also been comforting to know that in our final typesetting design for ICD-10-AM we had already anticipated many of your comments on the draft books you used in the study. Yes - we have included a Tabular annotation to tell you if a code is referred to in the *Australian Coding Standards* and - yes - the Standards volume has a code index!! Thanks also for your positive feedback on the sample sections of ICD-10-AM already typeset!

The NCCH successfully applied to the Australian Clinical Casemix Committee (ACCC) for the refunding of our Publications Assistant position for a further year. We are grateful to the ACCC for their ongoing financial and technical support of this position.

September has seen the arrival of two new staff members in Publications: Jenni Bibaoui, replacing Simone Lewis as Publications Assistant, and Chantelle Garrett, appointed to the newly created position of Publications Officer. Jenni will continue the production of the popular *Casemix, DRGs and Clinical Coding* booklet series. Next booklet scheduled in the series is Orthopaedics.

Chantelle has a wide experience in publications and will be guardian of the ICD-10-AM electronic files. She will be primarily responsible for updating classification content, be it for books or

New publications staff Jenni Bibaoui (left) and Chantelle Garrett (right), with Publications Manager Karen Luxford.

ASCII lists, and for collating and subediting the content for numerous upcoming NCCH publications. You might also want to check out the new updated information Chantelle has put on our NCCH Homepage. In their short time with NCCH, both new staff members have already proved invaluable!

Many of you will be pleased to know that shortly the NCCH will be releasing a document that collates all Errata issued to date for the *1996 Australian Version of ICD-9-CM* books (i.e. July 1996 – October 1997). This booklet will be sent free of charge to all existing customers and provided to all new customers at the time of invoicing.

The much awaited Australian Coding Benchmark Audit (ACBA), prepared by former NCCH Quality Manager Joanne Chicco, will be available for purchase in coming months. Excerpts of this valuable guide to performing coding audits will also be included in the ICD-10-AM *Australian Coding Standards* volume.

Whilst largely preoccupied with preparing ICD-10-AM for implementation in 1998, the NCCH is also looking further into the future and considering ways of streamlining the maintenance and annual updating of the voluminous classification content. We believe that it is important to anticipate the needs of clinical coders in the years to come and are investigating potential electronic formats that will support the creation of a range of products including books, ASCII lists, browsers, or electronic medical record applications.

❖ Karen Luxford
Publications Manager



National Centre for Classification in Health

Errata Part III October 1997

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

Volume 2 – Diseases Index

Page		Amputation
		- traumatic (complete) (partial) - - arm 887.94
25	Delete	one dash level from every entry from “at or above elbow...” to and including
26		“upper limb(s)...”
		Amputee (bilateral)(old)...
26		Amputation
		- traumatic (complete) (partial)
	Delete	- - arm - continued
		- - lower limb(s) except . . .

Volume 3 - Procedures Index

Page		Debridement
21	Add	- burn (<u>excisional</u>) (skin) 86.22
	Delete	- - excisional 86.22
		- - nonexcisional 86.28
	Add	- infection (<u>excisional</u>) (skin) 86.22
	Delete	- - excisional 86.22
		- - nail bed or nail fold 86.27
		- - nonexcisional 86.28
	Add	- skin or subcutaneous tissue (burn) (<u>excisional</u>) (infection) (wound) 86.22
	Delete	- - excisional 86.22

Learning more about ICD-10-AM - Procedures (MBS-E)

OOPS !!!

A wee typo mistake on the MBS-E code examples from *Coding Matters* Volume 4 Number 1 (page 10) (just in case you thought one MBS-E code covered 4 procedure types!). The correct MBS-E codes appear here. Apologies! ▶



Conference Proceedings (including papers on coding and GP) for the RACGP 9th Computers in Medicine Conference can be found on their homepage:
<http://www.racgp.aone.net.au>

Example 2

CHAPTER XIV

OBSTETRIC PROCEDURES

DELIVERY PROCEDURES

[1st level]

CAESAREAN DELIVERY [2nd level - procedural type axis]

1340

Caesarean section

[3rd level - block axis]

16520-00 Elective classical caesarean section

16520-01 Emergency classical caesarean section

16520-02 Elective lower segment caesarean section

16520-03 Emergency lower segment caesarean section



Timetable: ICD-10-AM education activities 1997/98

1997

october 1997

Distribution of ICD-10-AM educational material to:

- Clinical Coders (Phase I) Educational booklets

Development of ICD-10-AM education material for other stakeholders:

- Clinicians (including medical, nursing and allied health professionals)
- Researchers/Epidemiologists/Public Health professionals

HIMAA Conference, 22–24/10/97, Canberra

- NCCH paper on “ICD-10-AM goes electronic?”

WHO Heads of Collaborating Centres for the Classification of Diseases Meeting

- Copenhagen
- NCCH paper on Australian activities regarding ICD-10-AM and ICD-10

november 1997

Development of ICD-10-AM education material for:

- Clinical Coders (Phase II)
- Practical exercise booklets for use with ICD-10-AM coding books, to provide exposure to the classification prior to face-to-face workshops.

Development of ICD-10-AM education material for other stakeholders *continued*

NCCH Conference, 19–21/11/97, Adelaide

- Theme: “The Future of Coding”
- Includes a short ‘hands on’ ICD-10-AM workshop and a meeting of the Coding Educators Network (CEN)

december 1997

Development of ICD-10-AM education material *continued*:

- Clinical Coders (Phase II) Exercise booklets

Intended IT Workshop (if required)

- Repeat workshop for IT professionals, IT vendors, software suppliers, state/territory health authorities.

1998

(NB: ICD-10 education for mortality coders will be required during 1998, dependent upon the introduction date for ICD-10 for mortality coding).

january 1998

Phase III of ICD-10-AM education for Clinical Coders

- Organisation/planning of workshops

Distribution of ICD-10-AM education material for:

- Clinicians (including medical, nursing and allied health professionals)
- Researchers/Epidemiologists/Public Health professionals

Stay tuned for a timetable update in the January issue of Coding Matters . . .



1997 NCCH Annual Conference

Date:

Wednesday 19 – Friday 21 November, 1997

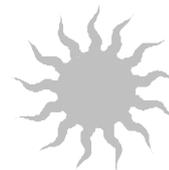
Venue:

Stamford Grand Hotel, Glenelg, Adelaide

Theme:

'The Future of Coding', to focus on:

- the changes in classification systems
- innovations in information technology for classification systems
- implications of changes for coders and other health professionals



Cost:

Full registration (<i>three days – inclusive of workshop, two day conference, catering & cocktail party</i>)	\$300
Attendance at conference only (<i>inclusive of catering & cocktail party</i>)	\$280
Attendance at one day of conference only	\$165
Attendance at workshop only	\$50

Contact:

Karen Peasley, Project Officer – Education Services

telephone: (02) 9351 9461
 fax: (02) 9351 9603
 email: k.peasley@cchs.usyd.edu.au

**CENTRAL SYDNEY AREA HEALTH SERVICE
 ROYAL PRINCE ALFRED HOSPITAL**
 An ACHS Accredited Service

Clinical Coder

PATIENT INFORMATION SERVICES DEPARTMENT
 MEDICAL RECORD DEPARTMENT

Clerk Grade 4 or MRA – Full-Time/Part-Time

A challenging position exists in the Coding section of this department for anyone interested in furthering their coding skills across a range of clinical specialties. RPAH is at the forefront of medical and surgical innovation and as such provides an opportunity for coders to enhance their skill in a casemix conscious environment. Flexibility of working hours will be considered. There are several positions available.

Duties: Coding of records utilising the Encoder and ICD-9-CM. Attendance at educational and clinical sessions. Associated clerical tasks.

Qualifications - Essential: Successful completion of approved courses in medical terminology and coding. Knowledge of Australian Coding Standards. Good organisational and communication skills.

Desirable: Teaching hospital coding experience. Experience with Encoding software. Ability to work in a team environment. Acquired or working towards Coder Accreditation.

Salary: \$532.60 – \$562.50 per week or MRA Incremental (according to experience).

Contact: Nina Maree Messina, phone (02) 9515 6100

Applications to: Nina Maree Messina, Medical Record Department, Royal Prince Alfred Hospital, Missenden Road, Camperdown NSW 2050.

Appointments are subject to a satisfactory relevant criminal record check. Applications and enquiries via E-Mail: pcompton@fin.rpa.cs.nsw.gov.au

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TASMANIAN DEPARTMENT OF COMMUNITY
 & HEALTH SERVICES

ROYAL HOBART HOSPITAL

MANAGER, CLINICAL CODING

Duties

Assist with the overall strategic planning and development of the Patient Information Management Service. Manage the provision of a high level, effective and efficient clinical coding service.

Conditions

Administrative & Clerical Stream, Level 8

Desirable Requirements

- Tertiary qualifications in Health Information Management
- Sound knowledge of the health system with particular emphasis on morbidity coding and casemix within a large healthcare service
- High level communication and interpersonal skills together with an ability to liaise effectively with a wide range of staff at different levels in clinical and non-clinical areas

Enquiries to:

Richard Hayes on telephone (03) 6222 8687, or email richard.hayes@rhh-con.dchs.tas.gov.au