

*ICD Coding Newsletter*  
*May 2002*

**Distribution List**

- Health Information Manager/s (HIMS)
- Clinical Coders
- Information Technology (IT)
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The ICD Coding Newsletter promotes good coding practice by providing relevant information to Health Information Managers and Clinical Coders.

The newsletter, prepared by the Victorian ICD Coding Committee in conjunction with the Department of Human Services, seeks to:

- Ensure the standardisation of coding practice across the state
- Provide a forum for resolution of coding queries
- Address topical coding education issues
- Inform on national and state coding issues from the Victorian perspective.

The scope of the newsletter includes coding feature articles, selected coding queries and responses, and various information updates including feedback on the quality and uses of coded data (as reported to the Victorian Admitted Episodes Dataset).

If you have any mailing list changes or queries or comments regarding the *ICD Coding Newsletter*, contact the HDSS Help Desk:

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HDSS's web site is:

<http://hdss.health.vic.gov.au>

An electronic coding query form can be completed at:

<http://hdss.health.vic.gov.au/icdcoding/codecommit/icdquery.htm>

Indexes to Coding Newsletters can be found at:

<http://hdss.health.vic.gov.au/icdcoding/newslet/qindex/index.htm>

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# *List of Selected ICD-10-AM Coding Queries*

The ICD Coding Committee is an advisory body to Victorian clinical coders and the Department of Human Services. The Committee does not have the authority to establish coding standards but offers advice, based on the combined knowledge and experience of the members, in response to individual coding queries. The Committee's advice printed in this section of the newsletter should be adopted immediately unless an alternative introduction date is stated. Unless otherwise stated, there is no expectation that coders should review similar episodes already coded. It is acknowledged that this might result in a year's data containing episodes coded in a non-standard way.

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## #1699 FESS with sinoscopy

When a FESS is performed, do we code:

**41764-01 [370]**      *Sinoscopy*

The amended ACS for ICD-9-CM directed, when FESS is performed, to use:

**22.19**                      *Other diagnostic procedures on nasal sinuses*

This code maps to the sinoscopy code. The surgeons always document FESS but very rarely sinoscopy. However, they always use the sinoscopy Item number.

FESS stands for Functional Endoscopic Sinus Surgery. ACS 0807 *Functional Endoscopic Sinus Surgery (FESS)* states FESS 'is a term describing a range of procedures performed for the surgical treatment of sinus disease. These procedures may include ...' and 'assign only the appropriate codes'. However, FESS will always include sinoscopy. The Committee sent a submission to NCCH to revise ACS 0807 to indicate that sinoscopy is always coded: the remainder of the procedures listed should be coded 'only if performed'. Note that this has been adopted in the ICD-10-AM Third Edition as displayed in the extract of ACS 0807 *Functional Endoscopic Sinus Surgery (FESS)* below.

Where 'FESS' is documented, also assign 41764-01 [370] *Sinoscopy* to indicate the endoscopic nature of the surgery.

## #1720 Transferred neonates

### Scenario 1:

Baby born at 27 weeks gestation, birth weight 980g, at Hospital A. Treated for prematurity, hyaline membrane disease, anaemia and jaundice. Transferred 6 weeks later to our hospital (33 weeks gestation, weight 1510g), to establish breastfeeding. There was no further treatment required for birth problems apart from general nursing care. Baby discharged after 10 days.

### Scenario 2:

Baby born at 27 weeks gestation, birth weight 980g, at Hospital A. Transferred 3 weeks later to our hospital as closer to parent's home, still requiring oxygen therapy for previous respiratory distress syndrome. The baby is successfully weaned off oxygen and discharged after 22 days.

### Scenario 3:

Baby born at 27 weeks gestation, birth weight 980g, at Hospital A. Transferred to our hospital for weight gain only, with no other significant problems. Baby is discharged home after 7 days following education of parents.

**A)** If the codes for prematurity and low birth weight are used, should the gestation and weight **at birth** be used or the gestation and weight **on admission**?

**B)** Which codes should be used at our hospital in each of the cases above?

We are not sure when to code the conditions and when to code the Z51.88 *Other specified medical care*.

It would be helpful to have a standard to cover these situations.

A new standard has been developed for ICD-10-AM Third edition (ACS 1618 *Prematurity and Low Birth Weight*), which provides guidelines for coding neonatal admissions, and confirms that *codes for gestational age/weight at birth* is appropriate (note, however, that the PRS/2 field *Admission Weight* is the baby's weight at *admission*).

### Prematurity

Birth episode: principal diagnosis is P07.2 *Extreme immaturity* or P07.3 *Other preterm infants*.

Subsequent episodes for treatment of a specific condition should have the specific condition coded as principal diagnosis. In addition P07.x is assigned if ACS 0002 *Additional Diagnosis* criteria is met.

Subsequent episodes where prematurity is the only reason for admission (for example, hospitalisation for monitoring, weight gain or establishing feeding) should have a principal diagnosis of P07.x. However, if the infant is no longer a neonate, that is, greater than 28 days old and admission weight is greater than or equal to 2500g, assign Z51.88 *Other specified medical care* as principal diagnosis and P07.x as additional code.

### **Answer to A**

The correct codes to use are those that reflected the baby's **birth** weight and **birth** gestation.

### **Answers to B**

*Scenario 1:* Principal diagnosis of Z51.88 *Other specified medical care* if general nursing care only, or to establish breastfeeding, with additional codes for prematurity (birth weight and gestation) and any other relevant problems, if they meet the requirements of ACS 0002. If a feeding problem is documented, P92.x *Feeding problems of newborn* should be coded as principal diagnosis instead.

*Scenario 2:* Principal diagnosis of respiratory condition requiring oxygen therapy, with additional codes for prematurity (birth weight and gestation) and any other relevant problems, if they meet the requirements of ACS 0002. A procedure code for the oxygen therapy would also be added.

*Scenario 3:* Principal diagnosis of Z51.88 *Other specified medical care* if general nursing care only, or to establish breastfeeding, with additional codes for prematurity (birth weight and gestation) and any other relevant problems, if they meet the requirements of ACS 0002. If a feeding problem is documented, P92.x *Feeding problems of newborn* should be coded as principal diagnosis instead.

## #1731 Attention to defibrillator (AICD)

What is the best procedure code to use for 'interrogation & adjustment of defibrillator (AICD)'? This was performed on the ward for abnormal discharging of a defibrillator.

The first suggested code is:

**11718-00 [1856]**      *Testing of other implanted cardiac pacemaker*

This code is not completely correct as it relates to a pacemaker and not an AICD.

In the case we are coding, this would go to DRG F42A: *Circulatory Disorder No AMI+Invasive Card Inv Pr+Cx Dx/Pr*, with a WIES of 1.2008.

The second suggested code is:

**38524-02 [656]**      *Adjustment of automatic defibrillator generator*

In the case we are coding, this would go to DRG F01Z: *Implant or Replace of AICD, Total System*, with a WIES of 14.9982.

This code does not appear to be correct as it involves repair and repositioning of the defibrillator generator, which was not performed: this is also reflected in the DRG and WIES generated. Our preference is to use the first listed code in the absence of a code for reprogramming of an AICD.

Our Cardiology Registrar says the procedure performed involves reprogramming and telemetry and is similar to cardiac pacemaker reprogramming; however, it is slightly more involved for an AICD.

As this case is not a surgical case, code 38524-02 [656] *Adjustment of automatic defibrillator generator* is inappropriate.

After review of documentation from the inquirer, the Committee agreed the following was the most appropriate code:

**11718-00 [1856]**      *Testing of other implanted cardiac pacemaker*

The Committee felt that a resulting DRG assignment (DRG F42A: *Circulatory Disorder No AMI+Invasive Card Inv Pr+Cx Dx/Pr*) was not due to a mapping problem. DRG assignment for this particular case would be driven by the coronary angiography performed.

The inquirer is correct in stating that code 38524-02 [656] and DRG F01Z would not be appropriate, as the code for adjustment of an automatic defibrillator generator is much more involved than the procedure performed for the patient in the query.

The NCCH has agreed to amend the inclusion notes for [1856] codes, to further define all devices similar to AICDs and to amend the title of code 11718-00 [1856] from 'pacemaker'

to 'devices'. These amendments will be included in revisions for ICD-10-AM Fourth Edition.

## #1760      **Antibiotic challenge**

There are a number of patients being admitted to our Respiratory Medicine Unit for 'Antibiotic Challenge'. This involves patients with a previous suspected antibiotic reaction being administered oral penicillin and then observed. So far there have been no anaphylactic reactions.

We are unsure which of the following codes (or other) would be appropriate:

**Z03.6**                      *Observation for suspected toxic effect from ingested substance*

Or

**Z01.5**                      *Diagnostic skin and sensitisation tests*

(although our clinical staff are not happy with this description)

With both, we would add the following:

**Z88.0**                      *Personal history of allergy to penicillin*

The two codes suggested as principal diagnosis by the inquirer are reached by the following index entries:

1.      Observation (for)
  - suspected (undiagnosed) (unproven)
  - - adverse effect from drug Z03.6
2.      Test(s)
  - allergens Z01.5

Both result in the following DRG assignment (v4.1):

**Z64B (or Z64A)**      *Other factors Influencing Health Status Age <80 or (Age >79)*

The Committee consulted the NCCH, and the following code assignment was confirmed as correct:

**Z03.6**                      *Observation for suspected toxic effect from ingested substance*

and

**Z88.0**                      *Personal history of allergy to penicillin*

Although the code Z03.6 *Observation for suspected toxic effect from ingested substance* also includes cases of observation following self-poisoning and ingestion of other substances, the addition of Z88.0 *Personal history of allergy to penicillin* will assist in distinguishing these cases as drug challenges.

## #1774      **Incision/drainage of hydrocele**

We are unable to decide which code to assign for incision/drainage of hydrocele.

Patient presented with a recurrent (2°) hydrocele. 150mls fluid drained at operation.

We note the code for *excision* of hydrocele:

**30631-00 [1182]**      *Excision of hydrocele*

and *excision* of hydrocele *with exploration* of spermatic cord:

**30644-01 [1178]**      *Exploration of spermatic cord*

However, no excision procedure was performed on our patient.

The title of block seems to indicate that we should select a code from this block:

**[1178]**                      *Incision procedures on testis, vas deferens, epididymis or spermatic cord*

Could you please advise which index entry and code to use?

Drainage of hydrocele code depends on the location of the hydrocele and the manner in which the drainage is performed.

Aspiration or tapping of hydrocele of the tunica vaginalis should be coded to:

**30628-00 [1171]**      *Percutaneous aspiration of hydrocele*

Incision and drainage of hydrocele of the tunica vaginalis should be coded to either:

**37604-00 [1172]**      *Exploration of scrotal contents, unilateral*

or

**37604-01 [1172]**      *Exploration of scrotal contents, bilateral*

Incision and drainage of hydrocele within the spermatic cord (where the spermatic cord is actually incised) should be coded to:

**30644-01 [1178]**      *Exploration of spermatic cord*

Incision and drainage of hydrocele on the surface of the spermatic cord (where the spermatic cord is not incised) should be coded to:

**30644-12 [1189]**      *Other procedures on spermatic cord, epididymis or vas deferens*

The inquirer would need to obtain more detail about the operation to determine the correct codes.

## **#1775      Babies born outside of hospital**

What is the correct application of the following three codes from the Z38 block:

**Z38.1**                      *Singleton, born outside hospital*

**Z38.4**                      *Twin, born outside hospital*

**Z38.7**                      *Other multiple, born outside hospital*

ACS 1607 *Newborn/Neonate* indicates that these codes are for babies born 'outside the hospital and admitted immediately post delivery.' Should a more specific definition (such as 24 or 48 hours) be given to coders, to ensure consistent assignment of these codes?

If a baby was admitted for the first time, at two days of age, with a minor medical condition, is it appropriate to assign one of the above codes?

We note that an example of such a case still groups to the neonatal DRG of 'born here', even when the code Z38.1 specifically states that the baby was not born in hospital. Is this a grouper anomaly?

The first admission of a baby does not *routinely* warrant the use of code Z38.x. If the birth does not occur in a hospital the Z38.x should be used only when the baby is admitted immediately post-delivery, related to the birth episode/event, either for routine post-delivery care, or for treatment of a condition apparent on delivery requiring treatment. They are not intended for use where the baby has been admitted in its first days of life for a medical condition that has arisen in the *post-delivery* period.

The Commonwealth has advised that these babies group to 'born in hospital' DRGs because there are no other appropriate DRGs for these cases. The Committee has recommended that the Commonwealth remove 'born in hospital' from the DRG title.

## #1776      Tonsillectomy for resolving acute tonsillitis

What is the correct code for a diagnosis of 'resolving acute tonsillitis'? Is it acute or chronic? The patient had a tonsillectomy in the same episode.

ACS 0804 *Tonsillitis* rules 'where tonsillitis is not otherwise specified in the record and the patient has a tonsillectomy, the tonsillitis is coded as chronic'. ACS 0804 also clarifies that 'recurrent acute' means 'chronic'.

We coded 'resolving acute tonsillitis' as acute but the episode was scored as a Fatal error in a PICQ analysis.

The histology (microscopic) report states, 'in some areas there is also inflammatory exudates present'.

After discussion, the Committee decided that, when a tonsillectomy is performed, acute tonsillitis should be coded only when there is no documentation to indicate either chronic tonsillitis or recurrent acute tonsillitis. Acute tonsillitis (only) can be the reason for tonsillectomy; however, this is quite rare.

## #1780      **Diabetic foot**

We put in an earlier query for coding diabetic foot with vascular procedures performed. For example: This patient with peripheral angiopathy, rest pain and ulcer is admitted for elective bypass grafting. This is coded to:

**E11.73**                      *Type 2 diabetes mellitus with foot ulcer due to multiple causes*

as principal diagnosis, followed by:

**I70.22**                      *Atherosclerosis of arteries of extremities with rest pain*

with

**32754-02 [713]**            *Femoral to tibial or peroneal artery bypass using composite graft*

**92502-02 [1910]**        *Intravenous general anaesthesia*

His length of stay is 15 days. This groups to DRG K09Z *Other Endocrine, Nutritional and Metabolic O.R. Procedures* with a weight of 1.2704 in this case (2000/2001)[1.4185 for 2001/2002].

However, if the patient is not diabetic and you code I70.2x, or the code E11.51, *Diabetes with peripheral angiopathy, without gangrene* as PDx (which is the incorrect code as discussed below), the DRG is F08x *Major Reconstruct Vascular Procedures W/O Pump* with a weight of 3.5041 [3.6688 for 2001/2002].

We received the following response from Jennie Shephard which was very helpful in clarifying that our coding was correct:

'Following the index for diabetes with ulcer, with peripheral angiopathy, you must assign E11.73. You can't assign E11.51 for this case. The reason you would get a different DRG for E11.51 is because you change to a different MDC when you use E11.51 as principal diagnosis (circulatory system). E11.73 goes to MDC 10 (endocrine system). The difference in cost weight reflects the different cases being grouped to the respective DRGs - the variance in the high trim for the two DRGs also reflects the difference in the severity of the cases in each DRG.'

However, our vascular surgeons felt that someone with 'diabetic foot' should also get this higher DRG/cost weight as the clinical scenario is more complex than someone with just diabetic peripheral angiopathy and no other complications or in fact, a non-diabetic with PVD. So would it be logical for E1x.73 (diabetic foot) as principal diagnosis, to be included in the grouping for DRGs F08A and F08B? We would like the committee to further discuss and address with the Commonwealth.

The Committee agreed with the opinion of the inquirer and recommended that this situation be referred to VACCDI for Victorian funding consideration.

Steve Gillett (DHS VACCDI member) acknowledged there appeared to be an anomaly in the grouping process. However, he was reluctant to recommend a Victorian fix so radical

that it changes the Grouper logic (that is, moves a case between MDCs). The advice received was to refer the issue to the Commonwealth for full investigation.

A public submission was forwarded to the Commonwealth, requesting a review of DRG K09Z *Other Endocrine, Nutritional and Metabolic O.R. Procedures*. One possible solution would be to split K09Z on major and minor procedures, as is the case with some other DRGs.

The Commonwealth undertook analysis of actual data, which found that this problem affected a small number of cases, and does not support moving the additional vascular procedure codes to DRG K01Z *Diabetic Foot*.

The Endocrinology CCG discussed this proposal and it was its considered opinion that this recommendation should be held over until more data are available, particularly more costing data.

After reviewing the response from the Commonwealth, the Committee accepts that E11.7x *Type 2 Diabetes Mellitus with Multiple Complications* must be assigned in these cases. A public submission will be developed and presented to NCCH, regarding the coding of patients with Type 2 Diabetes Mellitus with multiple complications, who undergo vascular reconstruction.

## #1784      NIDDM with IHD/Angina

We code a patient with admission diagnosis of NIDDM and ischaemic heart disease (IHD), to:

**E11.59**                      *Type 2 diabetes mellitus with other specified circulatory complication*

**I25.11**                      *Atherosclerotic heart disease of native coronary artery*

After much discussion with many HIMs we have been advised that, in the case of a patient with NIDDM and angina (also classified as an IHD), we should not code the E11.59. Is this correct?

We understand that the term needs to be specified in the index entry but neither IHD or peripheral vascular disease (PVD) are indexed specifically. Rather, the general disease term is indexed, not the specific.

Angina is usually associated with ischaemic heart disease, but not always. Refer to *Coding Matters*, Vol 8, no 1, p17: IHD does not always represent atherosclerosis.

More information is required in order to determine whether there is coronary artery disease present (refer ACS 0940 *Ischaemic Heart Disease - Chronic Ischaemic Heart Disease, unspecified (I25.9)*). If only 'IHD' is documented, and there is no confirmation in the history of coronary artery disease (CAD)(eg, previous angiogram report), the code E11.59 *Type 2 diabetes mellitus with other specified circulatory complication* **cannot** be used.

In relation to the comment regarding indexing of PVD, please refer to ACS 0401 *Diabetes Mellitus*, which provides guidelines for coding these conditions.

This answer relates to ICD-10-AM Second Edition. Please note that with ICD-10-AM Third Edition (for use for separations from the 1<sup>st</sup> July), diabetes with CAD **cannot** be linked without specific documentation.

## #1792 Induction of labour/premature ROM

Obstetrics patient at 40 weeks gestation, admitted with prelabour rupture of membranes, not contracting. Next day (<24 hours), patient induced with syntocinon, at which time she was 3-4 cms dilated with bulging forewaters, which were ruptured. Are the following codes correct?

**O42.0**                      *Premature rupture of membranes, onset of labour within 24 hours*

**90465-05 [1334]**        *Medical and surgical induction of labour*

The Committee agreed with the suggested codes. Rupture of membranes includes that of forewaters or hindwater.

## #1793 Cellulitis following open wound

How do you code cellulitis post an open wound? The open wound has been previously treated, and the current admission is for treatment of the cellulitis. Do you follow ACS1210 *Cellulitis*? If so, can you assign a code from T89 *Other complications of trauma*, without coding the site of the open wound (as it is no longer open)?

Where the reason for admission is for treatment of cellulitis, code according to ACS 1210 *Cellulitis*, and ACS 1917 *Open wounds*:

**L03.x**                      *Cellulitis*

**Sxx.x**                      *Open wound*

**T89.03**                    *Other complications of open wound*

Add the relevant external cause codes.

## #1794 Delivery prior to admission

Obstetric patient in labour, began to travel to her delivering hospital, some distance away. When it became apparent that the baby was going to be born, she stopped at a friend's home where the ambulance was called and the baby was born. Mother and baby were transported to our hospital (not the planned delivering hospital). The placenta was delivered at our hospital. She also had a postpartum haemorrhage. My questions are:

- Is the mother's episode a delivery episode (the baby was not technically born at home, and wasn't a planned home birth), or is it a postpartum episode?
- Can the baby be reported to PRS/2, classification 'Newborn Unqualified', as the baby has not been admitted to any other hospital?

**ACS 1519 *Delivery prior to admission*** and **ACS 1548 *Postpartum condition or complication*** don't give me much direction. My interpretation, and that of the hospital midwives, is that the delivery episode is not completed until the placenta has been delivered. Therefore, this is not technically a delivery prior to admission. Following this interpretation, the postpartum haemorrhage is not technically a 'postpartum' episode.

### The Mother

The episode of care would be a postpartum episode, as the admission was post delivery of baby.

The Committee referred to a previous Victorian ICD Coding Newsletter query (#1316 Delivery, assignment of 5th digits when delivery occurs on the way to hospital). [Note this answer is in ICD-9-CM]

'Where a patient delivers in the hospital car park or surrounds and the delivery is attended by hospital clinical staff, then the delivery should be regarded as an 'in hospital' delivery and obstetric codes should have the appropriate fifth digit of '1' or '2'. .... [In ICD-9-CM, whether the delivery occurred in the episode, and whether conditions occurred antenatally or postpartum, was denoted in by a fifth digit for the majority of codes related to pregnancy. Fifth digits of 1 and 2 denoted delivery in the episode]. The admission time should be recorded as the time clinical staff attended the patient. Code V27.x is assigned.

If the delivery occurs in the hospital car park or surrounds and is *not* attended by the hospital's clinical staff, then the delivery should be considered to have occurred before admission. Similarly, deliveries at home or in a taxi or ambulance would be considered to have occurred before admission. In such instances, ACS 1519 *Delivery prior to admission* should be applied. Complications of the delivery should be recorded as the principal diagnosis with a fifth digit of '4' assigned. [A fifth digit of 4 indicated postpartum condition or complication]. Where no complications or additional diagnoses apply, then the appropriate V24.0x *Postpartum care and examination, immediately after delivery* code should be used. Intent to deliver at home has no bearing on selection of fifth digits for obstetric codes, and is only relevant when it is appropriate to assign a V24.0x code. Code V27.x is not assigned.'

In light of this previous advice, and following ACS 1519 *Delivery prior to admission*, the appropriate code assignment would be:

**O72.1**                    *Other immediate postpartum haemorrhage*

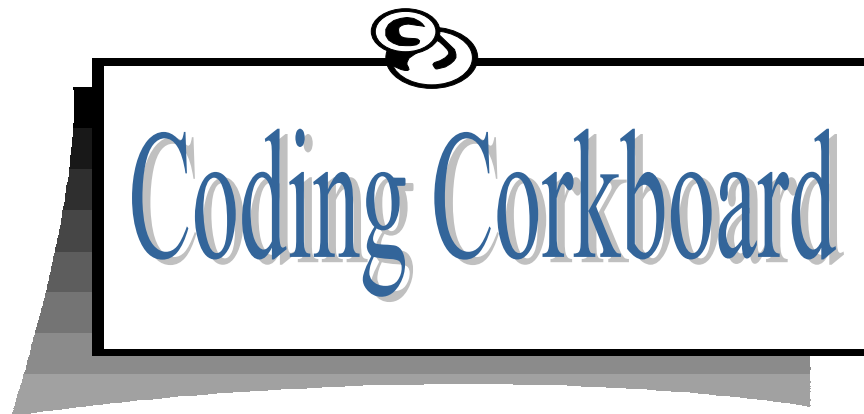
**Z39.03**                    *Postpartum care after unplanned, out of hospital delivery*

### **The Baby**

The baby has not had any prior hospital admission and has arrived at this hospital very soon after being born so, according to the current DHS rules, can be reported as an Unqualified newborn.

**Z38.1**                    *Singleton, born outside hospital*

Refer to query #1775 *Babies born outside of hospital* in this newsletter, for further information about this decision.



## NCCH ICD-10-AM query database

The most recent posting of queries to the NCCH database was 24 April 2002. Coders have three options for viewing queries:

- Downloading the searchable database in Microsoft Access 97 format
- Viewing the whole database online
- Searching the database online

The database, as well as current and previous editions of *Coding Matters* can be viewed and/or downloaded from the NCCH's website:

<http://www.fhs.usyd.edu.au/ncch>

## Coding *Transfusions*

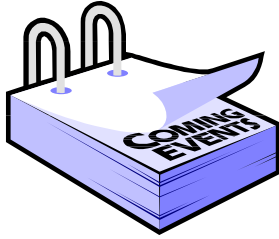
Following the item in the last Victorian *ICD Coding Newsletter* (February 2002), see the Departmental circular on the requirement for Hospital/Health Service Transfusion Committees and actions to promote transfusion best practice:

[www.dhs.vic.gov.au/ahs/circular/circ0702.htm](http://www.dhs.vic.gov.au/ahs/circular/circ0702.htm)

## Websites

If you've found some useful sites, send details to: [PRS2.Help-Desk@dhs.vic.gov.au](mailto:PRS2.Help-Desk@dhs.vic.gov.au)

<p>ASERNIP-S</p> <p>Looking for information on a new procedure?</p>	<p>The ASERNIP-S mission is to provide quality and timely assessments of new and emerging surgical technologies and techniques. Services provided include systematic reviews of the peer-reviewed literature, the establishment and facilitation of clinical audits or trials, the identification of emerging technologies by horizon scanning and the production of clinical practice guidelines. Our ultimate aim is to improve the quality of health care through the wide dissemination of our evidence-based research to surgeons, health care providers and consumers, both nationally and internationally.</p> <p><a href="http://www.surgeons.org/open/asernip-s.htm">http://www.surgeons.org/open/asernip-s.htm</a></p>
<p>Australian Bureau of Statistics</p> <p>Looking for recently released 2001 Census figures?</p>	<p>The Australian Bureau of Statistics is Australia's official statistical organisation. We assist and encourage informed decision-making, research and discussion within governments and the community, by providing a high quality, objective and responsive national statistical service.</p> <p><a href="http://www.abs.gov.au/">http://www.abs.gov.au/</a></p>



## Coding Calendar of Events

Date	Event	Details
4-8 August 2002	<b>Combined HISA/HIMAA Conference</b>	<a href="http://www.himaa.org.au">http://www.himaa.org.au</a> Melbourne
25-29 August 2002	<b>European Conference on Health Records Dublin 2002</b>	Email: <a href="mailto:info@conferencepartners.com">info@conferencepartners.com</a> Dublin
1-4 September 2002	<b>Casemix Conference</b>	<a href="http://www.health.gov.au/casemix/conf.htm">http://www.health.gov.au/casemix/conf.htm</a> <a href="mailto:casemix_conf@health.gov.au">casemix_conf@health.gov.au</a> Melbourne
21-26 September 2002	<b>National Convention, American Health Information Management Association</b>	<a href="http://www.ahima.org/convention/">http://www.ahima.org/convention/</a> San Francisco
March 2003	<b>NCCH 8<sup>th</sup> Biennial Conference</b>	Details later, from: <a href="http://www.fhs.usyd.edu.au/ncch/">http://www.fhs.usyd.edu.au/ncch/</a> Victoria
October 2003	<b>National Convention, American Health Information Management Association</b>	<a href="http://www.ahima.org/products/events/calendar.html">http://www.ahima.org/products/events/calendar.html</a> Minneapolis

For a comprehensive list of health information events, see:

<http://www.himaa.org.au/Calendar.html>

# *Victorian ICD Coding Committee*

## **Members as at 1 May 2002**

Irene Kearsey	Convener (Department of Human Services)
Jenny Wischer	Secretary (Department of Human Services)
Lisa Basile	Peninsula Health
Moira Cameron	Austin and Repatriation Medical Centre
Rhonda Carroll	The Alfred Hospital
Andrea Groom	Southern Health
Sonia Grundy	St John of God Health Care, Geelong
Susan Peel	Healesville and District Hospital
Evelyn Robinson	Peninsula Health
Fiona Rounds	Ballarat Health Services
Jennie Shephard	La Trobe University representative
Kathy Wilton	Royal Children's Hospital
Kylie Holcombe ( <i>on leave</i> )	St Vincent's Hospital
Ruth Rundell ( <i>on leave</i> )	Barwon Health - The Geelong Hospital

Committee's representative on VACCDI: Pauline Cripps, Box Hill Hospital

## **Future Meetings**

Tuesday 16 July	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor
Tuesday 20 August	DHS, 10:00 am, 555 Collins Street, Melbourne, 13th floor
Tuesday 17 September	DHS, 10:00 am, 555 Collins Street, Melbourne, 16th floor

## *On a Lighter Note*

From the Washington Post: The Washington Post recently had a contest for readers in which they were asked to supply alternate meanings for various words. The following were some of the winning entries:

Abdicate (v.), to give up all hope of ever having a flat stomach.

Carcinoma (n.), a valley in California, notable for its heavy smog.

Willy-nilly (adj.), impotent

Flabbergasted (adj.), appalled over how much weight you have gained.

Lymph (v.), to walk with a lisp.

Coffee (n.), a person who is coughed upon.

Flatulence (n.), the emergency vehicle that picks you up after you are run over by a steamroller.

Balderdash (n.), a rapidly receding hairline.

Testicle (n.), a humorous question on an exam.

Rectitude (n.), the formal, dignified demeanor assumed by a proctologist immediately before he examines you.

Circumvent (n.), the opening in the front of boxer shorts.

# *Abbreviations*

ACBA	Australian Coding Benchmark Audit
ACS	Australian Coding Standard
ADx	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CCCG	Clinical Classification and Coding Groups
DHS	Department of Human Services
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
HMA	Healthcare Management Advisors Pty Ltd
ICD-9-CM	International Classification of Diseases - 9th Revision – Clinical Modification
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IFHRO	International Federation of Health Records Organizations
LOS	Length Of Stay
MDC	Major Diagnostic Categories
NCCH	National Centre for Classification in Health
PDx	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee