

# Codefile

Newsletter of the Queensland Coding Committee

ISSUE NUMBER 13

June 2003

## *Welcome.....*

Edition 13, Quarter 2 2003, of Codefile marks the re-establishment of the publication, last released in June 2002.

To refresh, the Queensland Coding Committee is a statewide forum for the resolution of queries related to Australian Coding Standards, clinical coding, edits and grouping. The QCC is also a forum where other related health information issues are raised and discussed. This year, the committee has extended the monthly meetings by one hour to include a quality coding session. Presentations are organised for these sessions by committee members on a rotational basis to educate and highlight coding quality issues, ultimately to improve the quality of coded data.

## *Highlights included in this issue:*

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## **So where does the QCC sit within Corporate Office?**

The Data Quality & Standards (DQ&S) section, Data Services Unit, Health Information Centre, resources the QCC. The Chairperson, currently Meredith Shallcross, and secretariat, currently Hayley Elder, are responsible for the co-ordination of the committee. It is the responsibility of QCC members to actively participate in order to fulfil the committee's terms of reference, and clinical coders/health information managers statewide to liaise with DQ&S and the committee representatives regarding coding queries and quality issues.

Currently there are representatives from public hospitals, private hospitals, Queensland University of Technology, Clinical Coding & Classification Group, Clinical Coders' Society of Australia and Coding Standards Advisory Committee. A special welcome to our most recent representative for the Regional Hospitals area, Debbie Whitworth. For further information on the QCC representatives please refer to the QCC QHEPS web site located at <http://qheps.health.qld.gov.au/hic/qcc.htm>

Data Quality & Standards is currently in the process of organising for the QCC QHEPS web site to be available on the QH internet site. Further updates on this process will be in the next Codefile edition.

It is anticipated that by the Quarter 3 2003 publication of Codefile, the dissemination method will be through the DSU E-bulletin. This is an electronic document that will include all DSU data collection newsletters.

If you would like to be added to the distribution list for Codefile and the DSU E-bulletin, or know others in your department who would like to be added, can you please notify Data Quality & Standards via e-mail at [DQSTD@health.qld.gov.au](mailto:DQSTD@health.qld.gov.au)

## Queensland Cancer Registry – An Overview

At the March 2003 meeting, the QCC welcomed a presentation from Julie Bourke, Queensland Cancer Registry (QCR).

The QCR is a register of all cases of cancer diagnosed in Queensland and cancer mortality since 1982 and is located at the Queensland Cancer Fund.

### Registry Data

The QCR data is available for use for such things as:

- research
- projects

The following are notification and sources of QCR data:

- hospitals (public and private)
- Pathology laboratories
- Nursing homes
- Mortality files of Registrar General of Births, Deaths and Marriages

### When should a notification be completed?

- At discharge or transfer of a patient being first diagnosed with cancer
- When an additional new primary site is diagnosed
- When a different histological type is identified at the same site
- A patient's first date of attendance in each calendar year for chemotherapy or radiotherapy
- At discharge or transfer from the first admission for each calendar year for all other patients suffering from or with a history cancer.

- At the death of a patient suffering from or with a history of cancer, where the patient died within the hospital

### What are the most common errors on a Cancer Registration Form?

- The reason for Clinical Diagnosis is not completed or is incorrectly completed
- The usual suburb/locality at first diagnosis is not completed or is incorrectly completed
- The indigenous status is not completed
- There is a missing UR number

**Star Tip:** "Level 1" in relation to histology means in situ. Therefore 'Level 1 malignant melanoma' is actually 'melanoma in situ'.

### What is the output?

- National Cancer Statistics and publications such as Cancer Survival in Australia, Cancer in Australia – AIHW
- Annual Reports – Cancer in Qld
- Cancer Incidence in five continents – IARC
- Brochure
- Other registries and research organisations
- Registry round-up Newsletter
- Ad hoc requests

### The Future:

- Electronic Processing
- More timely data for release
- Cancer coding guidelines
- Fewer validation queries for Hospitals

For publications detailing general cancer information: [www.health.qld.gov.au/hic](http://www.health.qld.gov.au/hic)

The Queensland Cancer Registry uses this table as a guide to record the level of melanoma.

### LEVEL

- Known as Clarks Level, this is a measure of how far the Melanoma has invaded into the levels of skin.

LEVEL	DEPTH OF INVASION
Level 1 (In-situ)	Tumour confined to the epidermis
Level 2 (Invasive)	Tumour invades the papillary dermis (superficial dermis)
Level 3 (Invasive)	Tumour extends to the interface between the papillary & reticular dermis
Level 4 (Invasive)	Tumour infiltrates into the reticular dermis
Level 5 (Invasive)	Tumour infiltrates into the subcutaneous tissue

Always assign a code for the highest level of the melanoma. For example the patient may have had a punch biopsy and then a wide excision of the same Melanoma. Assign the highest level utilising the information from both pathology reports.

**NOTICE:**

**The QCC has introduced an hour extension to each monthly meeting for issues relating to coding quality.....if you have any suggestions for topics please contact DQ&S.**

**Email: [DQSTD@health.qld.gov.au](mailto:DQSTD@health.qld.gov.au)**

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## Care Type Supplement

Attached with this edition of Codefile is a feature supplement that details all Care Types. The supplement contains definitions, examples and edits applicable to each Care Type.

The supplement is a revised version of the Care Type feature in the 8<sup>th</sup> edition of Codefile, September 2000.

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## Use of ICD 10-AM Code 'Y96'

Data Quality & Standards would like to highlight the use of the ICD 10-AM code **Y96 Work-related condition**, which is available to be assigned to all work-related conditions.

Data Quality & Standards recommends that Y96 be used with all work-related conditions as these conditions may not necessarily have an external cause code assigned and therefore are not identifiable as being work-related.

Y96 must only be used when there is a link documented that the illness/condition is considered to be work-related.

Following are some examples of scenarios to apply the Y96 code:

### Example 1:

Asbestosis resulting from 50 years working as a builder

PD	J61
OD	Y96

### Example 2:

Patient has a heavy lifting job. Inguinal Hernia as a result of heavy lifting

PD	K40.90
OD	Y96

### Example 3:

Patient was admitted with chest pain and a cough worsening over the past 8-12 months. The patient was a motor body builder and stated that the sprays at work irritated his cough. The treating doctor noted that the sprays were the cause of the cough.

PD	R07.4
OD	R05
OD	Y96
OD	Z57.5

If you have further queries on the application of Y96 *Work-related condition* please don't hesitate to contact Data Quality & Standards at [DQSTD@health.qld.gov.au](mailto:DQSTD@health.qld.gov.au).

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## Additional Diagnosis Flowchart

The additional diagnosis flowchart has been published and distributed to clinical coders statewide. The Queensland Coding Committee would like to acknowledge and thank Derelle Pratt, Clinical Coder, Coding Services, Mater Health Services, for the initial development of the flowchart.

Please contact the Data Services Unit if you require additional copies. We hope that this flowchart will be a useful tool in consistently selecting the most appropriate additional diagnosis codes.

Please remember also that the QCC would appreciate all Health Information Managers/Clinical Coders to share with the QCC any quality tools that may be being utilised in your department to enhance coding quality.

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## Quality Corner

The following are the articles summarising the QCC quality presentations for the relevant quarter (please click on the relevant hyperlink to view the entire presentation):

- April** Sheree Gray and Lisa Richmond, NCCH  
**May** [Samantha Daly, Pricing Strategy Team](#)  
**June** [Maria O'Neill, Princess Alexandra Hospital](#)

### About the NCCH

The National Centre for Classification in Health (NCCH) supports staff members' visits to state and territory coding committees meetings. QCC members welcomed Sheree Gray, Classification Support Officer and Lisa Richmond, Project Officer from the Classification Support and Development Division, NCCH Sydney, at the April meeting. Sheree and Lisa participated in the monthly coding query discussions and coding quality session. Sheree presented information about the Sydney office's activities, including the process for making changes to the ICD-10-AM classification and the expected areas of change for the ICD-10-AM Fourth Edition. A brief synopsis of Sheree's presentation follows:

#### NCCH Sydney

Divisions include:

##### 1. Classification support and development

Responsible for:

- Updating and control of ICD 10-AM content.
- Co-ordination and publication of coding matters.

##### 2. Education

Provides:

- Programs for clinical coders and HIMs Australia wide to coincide with implementation of new editions of ICD-10-AM
- Biennial conferences
- Update workshops
- International education consultancies
- Education for clinicians and other health care professionals

##### 3. Publications

Publishes:

- *Coding Matters*
- The Centre's web site  
[www.fhs.usyd.edu.au/ncch](http://www.fhs.usyd.edu.au/ncch)

- The Centre's other print-based and electronic products including ICD-10-AM

#### 4. Administration

- Supports the activities of the other units and assists NCCH's clients

#### Modifications to the ICD-10-AM Classification

Modifications to the classification are based on input from:

1. expert bodies such as the World Health Organisation (WHO) and Department of Health and Aging
2. public submissions and
3. State and Territory coding committees' coding queries.

Receipt of all submissions is acknowledged and NCCH staff then researches them. Requests for modifications are prioritised according to their category and/or speciality. Submissions and modifications that result in a change to coding standards and/or classification content or actual code assignment are processed as follows:

1. NCCH staff responsible for the specialty concerned prepare the addenda proposal
2. The proposal is distributed to the relevant Clinical Classification and Coding Group (CCCG) for comment and/or endorsement
3. NCCH staff make any necessary amendments as advised by the CCCGs and distribute the proposals to members of the Coding Standards Advisory Committee (CSAC), which has responsibility for deciding on inclusion of changes to each edition of ICD-10-AM
4. Accepted proposals are entered into the database according to agreed ICD-10-AM specifications
5. Data are exported from the database to create the new edition of the ICD-10-AM classification.

Published errata rectify errors identified during the life of each edition. Common errors include incorrect transcription of a code or index entry. Errors are identified and corrected in the database. Errata are published 4-5 times during the two-year lifecycle of each edition of ICD-10-AM.

Sheree emphasised that errors do occasionally occur and that the NCCH invites notification of any identified errors through the State and Territory coding committees.

### **Main areas of change for ICD-10-AM Fourth Edition**

Sheree outlined the proposed changes in ICD-10-AM Fourth Edition. It is anticipated that a final summary of changes will be available after the September 2003 CSAC meeting.

**Please note:** If you would like a summary of proposed changes for fourth edition please contact the Data Quality and Standards section of Data Services Unit on (07) 3234 1318 or via e-mail at [DQSTD@health.qld.gov.au](mailto:DQSTD@health.qld.gov.au)

## *Hospital Benchmarking Prices Model 2002 - 2003*

The Hospital Benchmarking Prices Model (HBPM) is the 2002-2003 modification of previous Hospital Funding Models (HFM). The formulation of the HBPM is a primary responsibility of the Pricing Strategy Team (PST), Queensland Health. The HBPM is not a funding tool, Queensland hospitals are not allocated budgets on casemix. The objectives, scope and components of the model are included in this review.

The purpose of the HBPM is to introduce and apply formal performance benchmarks for Queensland Public Hospitals. The purpose of these benchmarks is to specifically identify areas where performance could be improved and initiate appropriate management action. The performance benchmarks contained in the HBPM effectively replace previous versions of the HFM for Queensland public hospitals.

### **Objectives of the Model:**

The objectives of the model are:

- To act as a management tool that utilises benchmarking to identify specific areas where performance could be improved.
- To allow comparative benchmarking (note, this model is not a funding tool – Queensland hospitals are not allocated budgets based on casemix)

### **Scope:**

The scope for this model is more realistic in terms of providing consideration for those facilities that have a high fixed cost component. The model covers

- Hospitals with recurrent budgets of >\$2m report the Measured Quality Program indicators
- Hospitals with recurrent budgets of >\$6m also submit comparative budgets.

### **Major Changes for 2002-2003:**

- Name change from Hospital Funding Model (HFM) to Hospital Benchmarking Prices Model (HBPM)
- For acute inpatients the base price was previously \$1000; for this model the base price has been modified to \$2500 to better reflect the actual average cost per case.

Following input from the relevant Zones, the following changes to peer groups have been made for the 2002-2003 HBPM:

- Mater Mothers (Group P to A)
- Gold Coast (Group B to A)
- Redland, Gladstone (Group T to B)
- Group T contains 12 hospitals (reflects the extent of costing structures established in smaller facilities)

### **Components:**

The following are specific components that the HBPM covers.

- Acute Inpatients
- Sub and Non-Acute patients (General wards)
- Sub and Non-Acute patients (Designated units)
- Designated psychiatric units
- Ambulatory
- Emergency
- Renal Dialysis
- Other Specified Activity

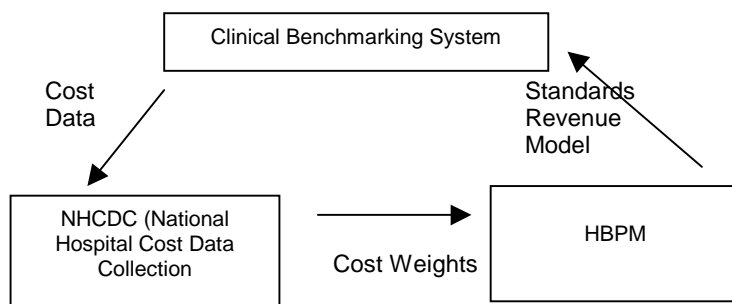
### **Operation of the Model:**

The HBPM is purely a benchmarking tool; it is not for funding purposes. The model is utilised with reference to:

- Comparative and notional casemix budgets
  - benchmarking
- Surgical Access Service
  - elective surgery funding
- Veterans' Health Services Unit
  - contract with Commonwealth to fund Veterans

### **Summary:**

The HBPM incorporates quality measures, not just cost efficiency.



For further information regarding the HBPM, please refer to the [QCC website](#) and view the HBPM powerpoint presentation that is published under the May quality presentation details.

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## *De-Mystifying DRG Assignment*

The *De-Mystifying DRG Assignment* paper is attached for your convenience. The paper was presented to the QCC by Maria O'Neill, Coding Manager, Princess Alexandra Hospital, and provides an overview of grouping methodology in order to understand how ICD-10-AM code assignment and other patient episode factors impact on DRG assignment.

In essence, the paper highlights the DRG classification as a method for categorising admitted hospital inpatients into a manageable number of classes that are clinically meaningful and similarly resource consumptive. DRG's enable measurement of hospital output and therefore can be utilised for resource allocation, comparative analysis and monitoring of trends.

The attached document helps you understand the General Grouping Process and DRG Numbering. Also provided, Grouping Episodes to DRG's with case examples.

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## *NCCH 8<sup>th</sup> Biennial Conference*

I was lucky enough to attend the NCCH conference in March 2003. The conference, '*Coder Connect: Linking concepts in health*' focused on issues such as, the relationship between clinical coding and health care planning, coding and research, health data and communication between health care sectors, terminologies and vocabularies, data quality, health information and classification technology issues (NCCH, 2003).

Approximately 260 delegates including representatives from all Australian States and Territories, New Zealand, Singapore, Sweden, United Kingdom and the United States of America attended the conference. Keynote presenters Associate Professor Stephen Bolsin, Geelong Hospital, and Ms Christine Sweeting, Data Quality & Classifications Advisor, National Health Service Information Authority UK, discussed the use of coded morbidity data during the Bristol Royal

Infirmery Inquiry. Both presenters demonstrated and emphasised the importance of good quality coded data.

Examples of other topics covered at the conference include:

- Clinical updates on infectious diseases and vascular access devices.
- Future roles for Health Information Managers and clinical coders.
- Evaluation of the implementation of Performance Indicators in Coding Quality (PICQ) in Victoria, including perspectives from a coder and the Department of Human Services.
- The Australian clinical coder workforce survey – An update 2002.
- Meeting the needs for coder education in the day surgery arena.
- The use of coded data in change management.
- The correlation between clinical documentation and coding.

Conference papers (PowerPoint presentations) are available on the NCCH website (<http://www2.fhs.usyd.edu.au/ncch/>), follow the links to "Conference 2003".

The conference also included an ICD-10-AM Third edition coding tutorial developed by the NCCH and the Clinical Coders' Society of Australia (CCSA) and was attended by approximately 100 coders. Participants were provided with coding workbooks and case studies (de-identified case notes from actual medical records). Presenters focused on topics from ICD-10-AM 3<sup>rd</sup> edition coding queries received by the NCCH. Topics included diabetes, arterial disease, sepsis, non-invasive ventilation, anaesthesia, same day endoscopy and drug – resistant microorganisms. The tutorial offered participants the chance to discuss specific coding issues related to these topics, whilst the presenters reinforced new or modified coding standards and provided coding tips and pointers. The session proved to be very interactive and educational.

If you would like further information regarding the conference please do not hesitate to contact me on (07) 3234 1318 or via e-mail at [meredith\\_shallcross@health.qld.gov.au](mailto:meredith_shallcross@health.qld.gov.au)

Meredith Shallcross  
Chairperson, QCC

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## *ICD-10-AM THIRD EDITION CODING WORKSHOPS*

As published in the June Coding Matters, the above coding tutorials are now being offered by the NCCH in all states and territories. Proposed Queensland dates and venues include:

<b>Cairns</b>	<b>17 September</b>
<b>Rockhampton</b>	<b>18 September</b>
<b>Brisbane</b>	<b>10 November</b>
<b>Brisbane</b>	<b>11 November</b>
<b>Toowoomba</b>	<b>12 November</b>

If you would like further information regarding the tutorials please contact the NCCH as per June Coding Matters. Please note that neither the QCC nor the Data Services Unit is responsible for organising these workshops and all communication should be directed to the NCCH.

Expressions of interest should be made as soon as possible as feedback from the NCCH indicates sessions will be cancelled if there is a lack of interest.

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## *Clinical Documentation Video*

The Organisational Improvement Unit within Corporate Office commissioned a clinical documentation video some time ago. The Royal Brisbane Hospital was involved in the production of the video.

The video outlined the importance of correct clinical documentation and a number of outcomes of poor clinical documentation in the patient medical record. The video mainly covered medico-legal issues related to documentation therefore did have less emphasis on documentation for coding purposes. However, the QCC members who viewed the video felt that the information would be beneficial, in particular, for a hospital orientation program.

The video was disseminated via hospital clinical development co-ordinators; however, the Corporate Office library service has a number of copies of the video available for loan.

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## *Comments, Queries and Suggestions*

All Codefile comments, queries and suggestions can be forwarded to:

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