This article provides readers with an understanding of the role and scope of Australia’s national Coding Standards Advisory Committee (CSAC) and provides an insight into the different perspectives and priorities that the various CSAC members (stakeholders) bring to this committee.

Overview of CSAC
The National Centre for Classification in Health (NCCH), then the National Coding Centre, established CSAC in 1994. The main function of CSAC is to introduce new and amended International statistical classification of diseases and related health problems, tenth revision, Australian modification (ICD-10-AM) codes and Australian coding standards. In addition, CSAC:

- provides advice regarding activities and products relating to coding and coding quality measures
- provides and receives reports from the organisations and jurisdictions represented on the committee
- ensures that standards of definition and convention are maintained when ratifying changes to ICD-10-AM and the Australian coding standards
- reviews and considers public submissions for modifications to ICD-10-AM
- receives feedback from users of coded data regarding the impact of standards and codes on current data collections
- ratifies coding advice from the NCCH before publication in Coding Matters
- recommends to the Commonwealth Department of Health and Ageing changes to the Australian Refined Diagnosis Related Groups (AR-DRG) classification system, as they relate to clinical coding
- recommends to the National Health Information Management Group the national adoption of ICD-10-AM modifications on a biennial basis
- provides input to relevant authorities regarding issues related to morbidity and mortality coding, such as data edits, coding quality measurement, and data collection systems
- provides specialist advice to the National Health Data Committee on issues relevant to the National Health Data Dictionary
- provides advice to the NCCH and the Australian Bureau of Statistics on the relationship between the Australian coding standards for morbidity coding and rules for cause of death coding
- provides advice on other relevant health classification systems

In 2002, two subcommittees of CSAC were formed: the Data Quality Subcommittee, and the Education Subcommittee. Their establishment reflects two key priorities requiring consideration in the implementation of new and amended Australian coding standards and ICD-10-AM codes.

Membership
Members of CSAC include staff members from the three NCCH Divisions, plus representatives of:

- the public and private health sectors (one representative each from each state and territory health authority, the Department of Health and Ageing, the Australian Institute of Health and Welfare, and the Australian Private Hospitals Association)
- the Health Information Management Association of Australia, Ltd
- the Clinical Coders’ Society of Australia
- the New Zealand Health Authority.

Impacts of CSAC
The decisions made by CSAC have wide and varied implications for the different members. The introduction of new and revised ICD-10-AM codes and Australian coding standards requires much work at NCCH, including:

- the production of the specifications for new or amended Australian coding standards or ICD-10-AM codes
- the production of mapping tables between the new version and the previous version
- the development of educational materials to inform coders of the changes
- the updating of existing educational and data quality materials, such as the Casemix, DRGs and Clinical Coding speciality book series, and the Performance Indicators for Coding Quality (PICQ) software.

Education requirements
Changes to codes and coding standards are communicated to coders through education packages developed and provided by the NCCH. Additionally, those organisations offering education services (mainly Universities and the Health Information Management Association of Australia [HIMAA] Education Services) must alter their course material to reflect changes, and advise their students of all changes.

Coders
The specificity of codes and coding standards also affects many individuals and organisations. New codes and standards may require a level of documentation that is not readily available in some patients’ medical records. Hospital coders must assess the changes and verify the availability (or otherwise), within their hospital, of the required level of detail. If this is not available, the coder must consult with the relevant hospital staff and determine appropriate methods by which
these data may be collected. Education of relevant hospital staff may be required, by way of discussing the requirements and the necessary level of detail.

Data users

New codes can provide specificity not currently available, enabling researchers and others to receive data on a particular condition, procedure or external cause. The creation of specific codes for new diseases or procedures is undertaken to reflect current clinical practice, and one of the outcomes of this is that changes in practice can be monitored more closely.

Data users also need to be aware of the differences between editions of the ICD-10-AM. As changes are made every two years, data requests can yield interesting results if all of the appropriate versions of ICD-10-AM are not consulted prior to data extraction. Additionally, data users need to ensure that changes in results over time are due to prevalence trends in diseases or treatments, and not to changes in ICD-10-AM.

Other impacts

New codes and Australian coding standards (ACS) also impact on AR-DRGs: new codes need to be incorporated in the grouper logic, and changes in ACS may cause grouping of episodes to shift from one DRG to another, or result in a change in grouper logic to reflect the ACS logic. One of the less tangible impacts of CSAC is the networking of the different members, from different jurisdictions, and the fostering of relationships with NCCH.

Priority of CSAC members

The various members of CSAC represent different organisations and viewpoints, and therefore have different priorities when viewing the CSAC proposals. Generally members’ priorities come from two different angles:

• The application of the Australian coding standards and codes.
  Australian coding standards and ICD-10-AM codes need to be clear, precise and easy to apply from the documentation available. This is a key concern of those primarily representing those who complete the coding.

• The use of ICD-10-AM codes to generate data.
  The level of detail of the information required by data users and the ease with which it can be obtained by using ICD-10-AM codes impact on the decisions that may be made by CSAC.

Many organisations and individuals are interested in using the datasets that incorporate ICD-10-AM codes.

Reports from a selection of CSAC stakeholders

In order to provide a picture of the different members’ perspectives of the CSAC process and priorities, following are six accounts from members and stakeholders, giving their experience and motivation for participating in CSAC.

The Clinical Coders’ Society of Australia

I am the Clinical Coders’ Society of Australia representative on CSAC. As a CSAC member, I receive each proposal document and my role is to consider the proposed changes. (We are currently working with documents for proposed changes for the Fourth Edition of ICD-10-AM for implementation on 1 July 2004). Each proposal contains the background to the change, then details all the changes to the tabular, index, Australian coding standards, notes for education, forward and backward mappings, edits, and ASCII list changes. Questions that need to be addressed when considering these changes include:

• Are there other areas that overlap with these changes?
• Are the index entries clear?
• Do the code titles explain what the code covers?
• Is the Australian coding standard clear?
• Have the ‘best’ maps been chosen?

Many hours of reading later, I e-mail my comments to all members. I am concerned primarily with making the changes as easy and clear as possible, as well as not too onerous for coders. All other members also e-mail their comments to each other; the different stakeholders often have views that are different from mine, which makes for interesting reading, and often raises extra issues requiring resolution.

Some time after submitting our comments, a revised document is circulated by the NCCH. Again I check the changes, especially against the comments I have made previously. The face-to-face meeting is the last chance to make any changes; all documents from the previous quarter are listed, but only those that have not had overwhelming agreement are discussed. With up to 40 papers to consider between meetings, this can be a lengthy, but worthwhile, discussion!

CSAC decisions come into force when the new books are released, and further, unresolved issues sometimes become evident. Coders, as the creators of the data used by the other stakeholders, need to ensure that the classification moves forward and is improved with each new edition.

During the years in which I have been a member of CSAC, the approval process has been constantly improved and streamlined. For instance, the proposals are more structured, and therefore always include the information required to make a decision. The proposals now include an ‘Education’ section which is designed to ensure that all changes can be integrated easily into the education program for the forthcoming edition of ICD-10-AM, and recently there was discussion about including whether or not the change could be written as a PICQ indicator. These improvements lead to a better outcome for those who use the classification, particularly the coder.

As a coder, auditor, Coding Educators’ Network member, and coding educator, I aim to make a difference: I am always considering how the changes will affect coders and try to make sure they will be clear and easy to follow.

Andrea Groom
Coding and Casemix Educator
Health Information Services
Southern Health, Melbourne;
The Commonwealth government

The Commonwealth government has a representative on the CSAC. This enables the Commonwealth to determine whether the suggested changes to codes and coding standards will have an impact on the Australian casemix classification. Coding issues that may affect the casemix classification are raised by the states and territories at the CSAC meeting, thus enabling the Commonwealth to be proactive, rather than reactive.

Katrina Chisholm
Executive Officer, CCCA
Commonwealth Department of Health and Ageing
PO Box 852, Woden, ACT 2606

HIMAA Education Services

The Health Information Management Association of Australia’s (HIMAA) Education Services benefits significantly from its participation in CSAC. The role of HIMAA differs from that of other representatives on the committee, as HIMAA provides distance education courses for inexperienced and experienced coders throughout Australia and New Zealand. HIMAA Education Services has between 180-200 students undertaking their courses at any given time; this gives HIMAA a broad perspective on how students utilise and interpret ICD-10-AM. The courses offered by HIMAA include Introductory, Intermediate and Advanced Coding Courses. HIMAA also publishes the textbook Introduction to Coding with ICD-10-AM, which is widely used by TAFE and Health Information Management programs in universities around Australia.

There are benefits for HIMAA Education Services and the NCCH through involvement in CSAC:

- Coding educators are informed of forthcoming publications in Coding Matters and new edition changes. This enables the coding educators to make enhancements to course material promptly, and guarantees that HIMAA course material is current and credible. It also gives coding educators a background to coding standards and coding convention changes and an appreciation of where and why these changes are made.
- HIMAA endeavours to evaluate discussion papers and proposals circulated to CSAC members from an educative perspective, on behalf of experienced and inexperienced coders. This ensures that new and amended Australian coding standards, coding conventions and ICD-10-AM codes are created, documented and used for education in a way that can be interpreted by all coders. Because HIMAA Education Services is a national and international provider of coder education, there is no direct link with state coding authorities. HIMAA’s involvement in CSAC provides an opportunity for coder educators to liaise with the NCCH and be informed of current coding issues.
- HIMAA gains early access to draft versions of new editions of ICD-10-AM. This enables HIMAA Education Services to update course material before the new edition is implemented. This ensures that students receive the most recent version of ICD-10-AM promptly. HIMAA gives valuable feedback to the NCCH before implementation of new editions.

It is important for HIMAA Education Services to maintain a prominent role in the development of ICD-10-AM through CSAC membership to enable HIMAA coding courses to maintain a high standard in coding education.

Toni Patterson
ICD-10-AM Lecturer
Distance Education (Clinical Coding), HIMAA
For further information about HIMAA courses or enrolment in a course, e-mail: denisej@himaa.org.au

Australian Private Hospitals’ Association

The Australian Private Hospitals’ Association (APHA) representation on CSAC has affected Health Information Managers and clinical coders working in the private hospital sector; however, the primary impact has been on the national morbidity data. The APHA uses the national morbidity data principally:

i. to examine the workload of the private and public sectors;
ii. to track changes over time in the case mix treated in the private sector; and
iii. to compare the private sector case mix with that of the public sector.

The data on treatment of patients by age group are also used for both the current situation and to examine changes over time. In addition, the aggregated data on separations are analysed to track changes over time in the total caseload of each sector, both nationally and in each state. These data are then used in various internal documents and external publications, presented in different forums, and included in articles where relevant.

Kay Bonello
Health Information Manager
NorthPark Private Hospital

The Northern Territory health sector

I became the CSAC representative for the Northern Territory (NT) in November 1999. I have a long association with the NT Department of Health and Community Services, working as a medical record manager at...
both the Royal Darwin Hospital and the Alice Springs Hospital, and latterly as a clinical coder and health information manager at Alice Springs Hospital. Working in health information management in the NT is challenging; there are presently only 3 health information managers and 11 clinical coders working in the NT. I welcomed the opportunity to participate in CSAC and represent the NT in shaping and contributing to the development of future ACS.

The Northern Territory has a little over 200,000 residents and is the smallest jurisdiction represented on CSAC in terms of population. Remote locations and small, scattered groups of people over a wide area comprise the region-of-service provision for the Territory’s 1 private and 5 public hospitals. Indigenous peoples comprise 27% of this population, and there is an over-representation of indigenous patients in the admissions to NT hospitals; in at least one hospital, indigenous clients comprise 77% of admitted patients.

One of the benefits of a small jurisdiction is that there is a small group of people with whom to consult, discuss, liaise and communicate regarding coding dilemmas and decisions. The NT Coders’ Forum is an inclusive committee (all health information managers and clinical coders are members) which was established to foster good coding practice and to provide a peer support network throughout the Territory. The committee meets monthly to discuss all issues pertaining to coding. The meeting is held by teleconference, as health information managers and clinical coders are spread over wide distances ranging from Alice Springs in the south to Gove District Hospital in Arnhem Land in the north. As the CSAC representative, I communicate both to and from the NT Coders’ Forum and also to the NT Hospital Information Management Group.

Although our hospitals serve the population of the NT, some specialist services, for example radiotherapy, are not provided, and hence some of the proposals that come before CSAC regarding new surgical procedures or specialised procedures are not relevant to the NT. Conversely, some diseases, for example a number of infectious diseases, are more prevalent in the NT than in other states.

CSAC is very much a working committee, and between each quarterly meeting there is a flow of communication between NCCH and committee members working towards proposals for the next meeting. Attention to detail and willingness to devote the hours required (plenty of bedtime reading) are definitely prerequisites for membership of the committee. In order to have any impact on decisions one must have a seat at the table and I have found it very valuable to be part of CSAC. The two-yearly ICD-10-AM update cycle encompasses the public submission process, the NCCH query process, and feedback through Clinical Classification and Coding Groups, which channel information into the Quality and Education division and generate articles in Coding Matters (10 Commandments). This forms a complex but interconnected web of information. The interrelationship of these processes through CSAC has given me a greater understanding of how the inputs of all CSAC representatives contribute to a living classification that is continually evolving. One of the benefits of being the NT representative has been in meeting and gaining an understanding of the differing perspectives of each CSAC representative in relation to the ACS and the ICD-10-AM classification in general.

On a practical note, my representation on CSAC has given me a much greater understanding of when and why changes in Australian coding standards and coding practice have occurred. This has been helpful when communicating with users of data who look at information broadly from the NT Department of Health and Community Services’ perspective, as well as those clinicians and researchers in the hospitals who are auditing or reviewing their own data.

The decisions made at CSAC affect all of us in the gathering, abstracting and dissemination of health information. When you are next asked to comment on a proposal or to offer some advice, remember that you are contributing to the development of your national classification.

Jillian Burgoyne
Health Information Manager
Alice Springs Hospital, NT
E-mail: jill.burgoyne@nt.gov.au

The Victorian health sector

Victoria, via the state Department of Human Services, has always welcomed the opportunity to be represented on CSAC. The Victorian representative consults with the Victorian ICD Coding Committee (VICC) members and, where necessary, with other coders from specialist hospitals for advice on Victoria’s response to CSAC issues. The CSAC minutes, proposals and other discussion papers are circulated to the VICC members.

The link between CSAC and the VICC does not stop here. The VICC is a very active committee which meets monthly, primarily to answer coding questions originating from Victorian hospitals. Issues arising at meetings of the VICC often highlight areas within ICD-10-AM which require amendment or enhancement. Numerous public submissions and queries are forwarded to the NCCH by the VICC for action. Many of these ultimately result in changes to the classification.

Victoria’s DRG cost weights for its casemix funding model are based on data received from hospitals in the previous financial year. When changes to the ACS alter the grouping of specific cases, these need to be identified prior to the actual implementation of the revised coding standards so that the Victorian
Department of Human Services (DHS) can determine the financial impact of that grouping shift. Occasionally, Victoria will introduce a VicDRG to overcome grouping changes where the DRG shift may have a potentially significant impact on the funding received by hospitals (Kearsey, 2001).

Due to the high level of usage of ICD-10-AM data in Victoria, the Victorian Department of Human Services has a keen interest in improving the quality and content of the ICD-10-AM data in our dataset. Therefore, we take a strong interest in providing feedback on education and data quality issues raised at CSAC.

Catherine Perry and Sara Harrison
Senior Health Information Management Advisors
Health Data Standards and Systems Section
Metropolitan Health and Aged Care Services Division
Victorian Department of Human Services
Tel: +61 3 9616 6928
E-mail: Catherine.Perry@dhs.vic.gov.au

Reference

Note: All authors are qualified health information managers.