HIPE

ICD-10-AM/ACHI/ACS/ICS/Coding Rules
10th Edition

Coronavirus
COVID-19

Coding Notes

In this issue

Editor's Note

Welcome to the Summer Edition of coding notes and we hope you are enjoying the longer and sunnier days that we have been fortunate to get.

We have another packed edition this month with many great articles for you to read. We would like to express a special thanks to the Tobacco Free Ireland Programme who use HIPE data in their work and have included a great article on smoking related harm and the importance of accurate HIPE data.

The training team have included an article for the 12th edition update around some changes to ACS 0002 Additional Diagnoses. They have also included a schedule of dates for upcoming 12th edition education training in the winter months.

We would like to thank everyone who completed the HIPE Coder survey. We are currently analyzing the data and will include information on this in the next edition of Coding Notes.

The next ABF conference will be held on Wednesday 28th June in Galway and we hope to see you there. Full details on the HPO website. www.hpo.ie
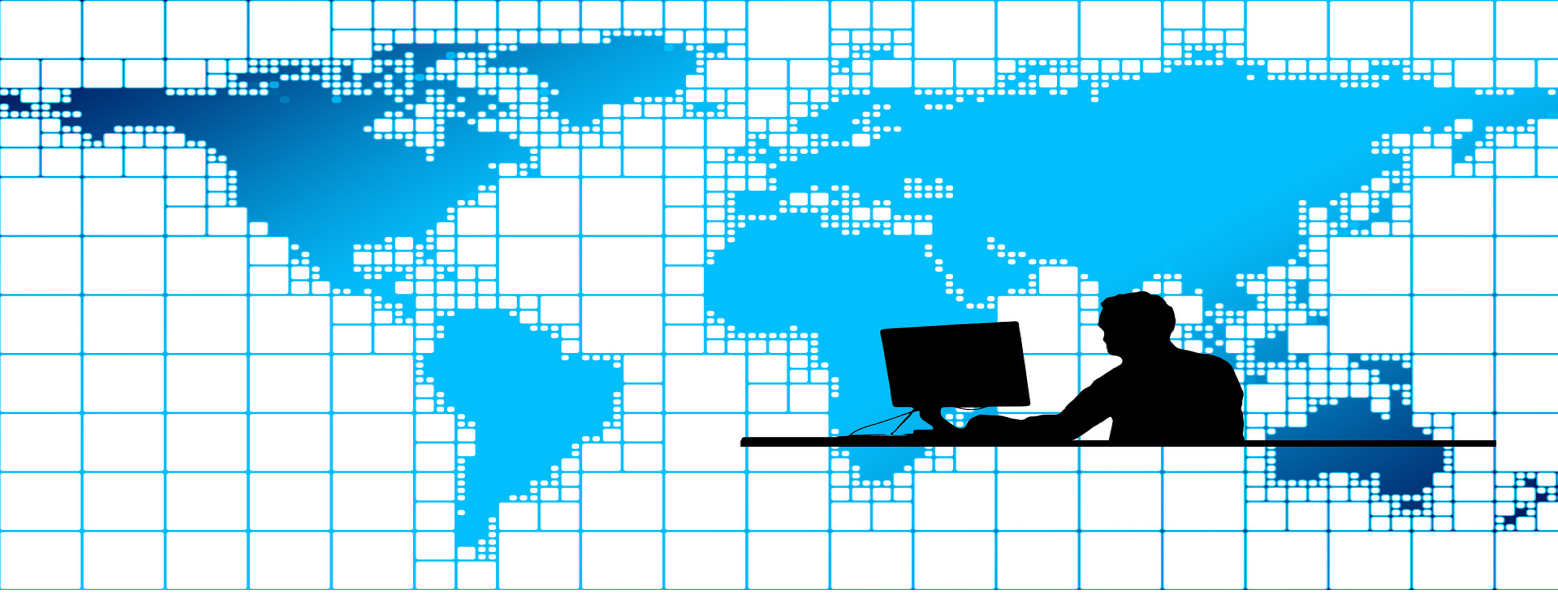
HIPE News Desk

2022 File Closure

The 2022 national file was completed with 1,739,727 HIPE discharges, representing national coverage of 99.4% submitted from HIPE departments.

We acknowledge the significant effort by all HIPE departments to ensure that 2022 HIPE coverage was complete and accurate in yet another challenging year. Sincerest thanks to everyone who worked to achieve this. There was a 6.4% increase in activity across the system compared to 2021 (1,627,915 representing 99.5% coverage for 2021) which shows the return to pre-pandemic levels of activity in acute public hospitals.

As always HIPE departments across the country were innovative despite the many challenges faced this year. Special thanks to all staff at Wexford hospital this year who experienced a catastrophic fire on the 1st March 2023. The resilience and collaboration of the HIPE department and colleagues in surrounding hospitals and beyond during this time is a testament to the hard work, determination, and expertise of HIPE staff.

Reminder - Error ARDRG infant admission weight

For patients aged less than 1 year of age, admission weight is collected in whole grams in the following circumstances:

- All neonates (0-27 days old)
- All infants up to 1 year of age **with** admission weight less than 2,500 grams

The value collected will be the weight in whole grams on admission. If the patient is admitted on the day of birth, the admission weight will be the birth weight.

It is weight in whole grammes – e.g. 2.5 kilos = 2,500 grammes

ARDRG queries arise where there is a very low admission weight without a corresponding diagnosis code. The grouper will also query where cases have a diagnosis code indicating a low admission weight without a corresponding admission weight. The HPO are reviewing checks and data on very low admission weights and will query these cases.

Smoking-related harm – a continuing challenge for health in Ireland

The following article has been submitted to Coding Notes by the HSE Tobacco Free Ireland Programme. This programme routinely uses HIPE data in it's work and is keen to ensure that data on tobacco use is accurately recorded and that HIPE coders are aware of the contribution they make in this area.

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The State of Tobacco Control in Ireland
HSE Tobacco Free Ireland Programme
2022
Second Report

TFI Programme

Smoking-related harm - a continuing challenge for health in Ireland

In Ireland, in 2022, 18% of the adult population currently smoke;[1] this compares to 29% in 2007, and 33% in 1998.[2] In addition, over 50% of our adult population are ex-smokers, that is they previously smoked at some stage during their life, but do not now. Current government policy is to achieve a tobacco-free Ireland by 2025; that is a smoking prevalence of <5%.

The recent Healthy Ireland survey also tells us that both current smokers and ex-smokers are less likely than those who have never smoked to describe their health as good or very good. Approximately three-quarters of current smokers and ex-smokers (76% and 77% respectively) describe their health in this way, compared with 86% of those who have never smoked; and even among those aged under 35 smokers this difference remains persistent. Almost a third (32%) of smokers, and 39% of ex-smokers report having a long-standing illness or health problem; this compares with 27% of those who have never smoked. A quarter (26%) of smokers, and 29% of ex-smokers report being limited in everyday activities because of health problems; in contrast, 19% of those who have never smoked report the same.

Using HIPE data to track the impact of smoking on health services

All of the above suggests that smoking places a significant burden on our health services, and that a significant proportion of our population are living with ill-health and disability as a result of their current or previous smoking. Using HIPE data for years 2010 to 2019, and international evidence regarding the relative risks for current smokers and ex-smokers developing various health conditions, compared to non-smokers, we estimate that there are approximately 44,000 hospital admissions annually for smoking-related conditions, and this represents approximately 3-4% of all hospital activity. The burden of smoking-related hospitalisation is greater for males (4%) than females (3%). And in general, 1-in-5 of respiratory admissions per year are smoking-related, 1-in-10 of cancer admissions per year are smoking-related, and 1-in-8 of circulatory disease admissions per year are smoking-related. This information is particularly valuable, as it allows us to monitor and track the impacts of smoking-related conditions on the health services in Ireland.

Importance of recording of smoking status on patient records

There is however some room for improvement in the recording of smoking status of patients during hospital admission. Previous research has indicated an under-reporting of smoking status,[5] and provisional analysis of 2021 and 2022 data would suggest this remains the case. Hospital admission can be a very stressful time for patients, and if their nicotine dependence is not managed correctly or managed at all, this can lead to poorer outcomes for both the patient and their episode of care. By recording smoking status at each and every interaction, nicotine dependence be addressed, using the effective supports as per clinical guidelines.

What we also know is that most people who smoke, want to quit. Recently launched national stop smoking clinical guidelines recommend that all healthcare professionals **Ask** patients about their smoking status, **Advise** on quitting and the recommended ways of quitting, and **Act** by arranging/prescribing NRT/stop smoking medicines, and arranging referral to HSE stop smoking services for behavioural support to stop smoking for their patients. [6] Stopping smoking is the single-best thing that a person can do for their health, and all of us healthcare professionals have a role in supporting our patients to quit. These **3 steps** when delivered routinely in care can increase the chance that someone will quit and remain smoke-free by 2 to 3 fold. The benefits of quitting begin immediately, and can be life-long for patients, their families, and communities.

Use of HIPE information in tobacco cessation research in Ireland

Professor Patricia Fitzpatrick and a research team from UCD, the HSE Tobacco Free Ireland Programme, specialist cancer hospitals and patient representatives, conducted a research programme funded by the Irish Cancer Society entitled "Smoking cessation for cancer patients in Ireland: a scoping and feasibility initiative". As part of this research programme Hospital Inpatient Enquiry (HIPE) data on the smoking status of discharges with a cancer diagnosis (overall, breast, lung, cervical and head and neck cancer) were sought (2014–2018). During 2014–2017, current smoking increased for overall (10.5–11.7%) and lung cancer (24.7–27.2%), then decreased to 11.4% and 24.1%, respectively, in 2018. Current smoking increased for cervical cancer during 2014–2018 (11–19.8%) and initially (2014–2016) for head and neck cancer (3–12.7%), decreasing to 7.6% in 2018; breast cancer was stable at 6±0.6%. These rates are lower than the Irish (23–20%) and European (29% (average)) general population. During 2014–2017, past smoking increased among overall (15.2–21%) and specific cancers, which was lower than the Irish general population (23–28%). Current smoking was highest among 50–59-year-olds (14–16%), which contrasts with the Irish general population (24–35 years at 32–28%).
HIPE data are subject to potential duplicate episodes of care and under-documentation of smoking. However, trend analysis is useful, as these limitations should be stable. We concluded that rates remain high; therefore, robust documentation and smoking cessation referrals for cancer patients are important.

Conclusion

Hospital Inpatient Enquiry (HIPE) is a vital and valuable health information system in Ireland. This article highlights the important role HIPE can play in tackling the harm caused by smoking, the leading preventable cause of ill-health, disability and premature mortality in Ireland.   Maintaining and continuously improving the quality of recording of smoking status and stop smoking care in HIPE underpins its contribution to HSE Tobacco Free Ireland and research partner efforts to help people who smoke to stop.   We thank all HIPE coding staff for their continuing work and look forward to working with everyone to make best use of HIPE to build a Tobacco Free Ireland.

Note: Full content of this article, to include papers and presentations arising from or linked with the HIPE research, will be sent to HIPE staff separately.

ASA (American Society of Anaesthesiologists) Scores

When assigning procedure codes for the administration of cerebral anaesthesia [1910], conduction anaesthesia [1909] or analgesia and anaesthesia during labour and delivery procedure [1333], the first 5 characters of the code reflect the type of anaesthetic. Codes from these blocks require an additional two-character extension for these codes to be valid.

The first character of the two-character extension of the procedure code is the ASA score representing the patient's status at the time of the procedure as documented by the anaesthetist.

The second character of the extension represents whether or not a modifier of 'E' is recorded on the anaesthetic form in addition to the ASA score. 'E' signifies a procedure that is being performed as an emergency and is to be represented by the digit "0".

This two character extension is to be assigned only from documentation, completed by an anaesthetist on the anaesthetic form.

Example (from training material)

Example 1 (above)

"This patient has had a general anaesthetic for an open reduction and internal fixation of fractured femur. The ASA score documented by the anaesthetist is 2E"

The anaesthetic code to be assigned in this scenario is:

92514-20 [1910] General anaesthesia, ASA 2, emergency

Example 2

"A patient is admitted for a laparoscopic appendectomy under general anaesthetic. Anaesthetist documents ASA 2."

The anaesthetic code to be used in this scenario is:

92514-29 [1910] General anaesthesia, ASA 2, nonemergency

As the anaesthetist has not documented an emergency modifier of "E", assign '9' nonemergency or not known for the last character.

Example 3

"A patient is admitted for a hernia repair under general anaesthetic"

As neither an ASA score nor an emergency modifier of "E" have been documented by the anaesthetist, assign to the 6th digit of '9' (No documentation of ASA score) and '9' (nonemergency or not known) for the final character. The anaesthetic code to be used in this scenario is:

92514-99 [1910] General anaesthesia, ASA 9, nonemergency

Important points for coders to note when assigning ASA scores:

- **Only ASA scores and emergency modifiers documented by the anaesthetist are valid for collection,** ASA scores documented by nursing staff should not be used for code assignment.
- **If there is no documentation of an ASA score**- assign '9' (no documentation of ASA score) should be assigned as the 1st character of the extension.
- **The emergency modifier of "E" must also be documented by the anaesthetist before the coder can assign "0" procedure being performed as an emergency as the 2nd character of the extension**- where this is not documented by the anaesthetist, assign '9' non emergency or not known should be assigned as the 2nd character of the extension. Information elsewhere in the chart cannot be used to determine the emergency modifier e.g. if the patient was admitted through ED and requires surgery, and there is no information regarding the Emergency Modifier on the Anaesthetic form, then '9' nonemergency or not known is assigned (Coding Notes July 2017)
- **The ASA score must be documented on the anaesthetic form at the time the procedure took place before assigning these codes**. ASA scores documented for previous trips to theatre, previous episodes of care or from pre-assessment clinics should not be used as patients status may change, even within an episode of care.
- **Where a single ASA value is not clearly documented** (eg 2/3 or 2-3) the score should be clarified with the anaesthetist, however, if this is not possible, assign the code representing the higher score.

For further information please refer to ACS 0031 Anaesthesia, the note at the beginning of block [1333] Analgesia and anaesthesia during labour and delivery procedure, and the section on Anaesthesia in Chapter 19 of the ACHI Tabular of List of Interventions.

Sequencing of Procedures
ACS 0016 General Procedure Guidelines

The issue of sequencing of procedures has arisen in a number of data quality reviews. HIPE coders must ensure that they are familiar with ACS 0016 General Procedure Guidelines. This ACS contains definitions together with guidelines for sequencing interventions codes. Please refer to the standard for full details.
ACS 0016 General Procedure Guidelines states the following regarding the sequencing of codes.

"The order of codes should be determined using the following hierarchy":

• procedure performed for treatment of the principal diagnosis
• procedure performed for treatment of an additional diagnosis
• diagnostic/exploratory procedure related to the principal diagnosis
• diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

Example 1
Source: ACS 0016 General procedure guidelines

Principal diagnosis: Chronic cervicitis
Additional diagnoses: Human papillomavirus (HPV)
                                         Menorrhagia
Procedures: Dilation and curettage, diathermy and biopsy cervix

Following the hierarchy above, the procedures are sequenced as follows:

Principal Procedure: Diathermy of the cervix (35608-00 [1275])

Sequenced 1st because it is the procedure which treated the principal diagnosis - Chronic Cervicitis

Example 2
Source: A coding query submitted to the HPO.

Principal diagnosis: Gastro-oesophageal reflux disease with oesophagitis
Additional diagnoses: Phimosis
                              Acute kidney failure, unspecified

Procedures: Panendoscopy to the Duodenum with biopsy
                              Sedation
                              Cystoscopy
                              Endoscopic ureteric meatotomy
                              General Anaesthesia

Following the hierarchy above, the procedures are sequenced as follows:

Principal Procedure: Endoscopic ureteric meatotomy

Sequenced 1st because it is the procedure which <u>treated an additional diagnosis</u> - the phimosis

Additional Procedures: General Anaesthesia (associated with the endoscopic ureteric meatotomy)
                              Panendoscopy to duodenum with biopsy
Sequenced next as this is a diagnostic procedure related to the principal diagnosis – Gastro-oesophageal reflux disease with oesophagitis.
                              Sedation
                              Cystoscopy
Sequenced next as this is a <u>diagnostic procedure related to an additional diagnosis</u> – Phimosis.

Urology daycase examples

The following examples for urology day case coding highlight the application of both ACS 0051 Same-Day Endoscopy- Diagnostic and ACS 0052 Same day endoscopy surveillance. Please refer to the full standards for detailed guidance. Urology is a high volume specialty for day case episodes and these queries are similar to those that arise during endoscopy training courses and in coding audits. Examples are presented in his article for ACS 0051 Same-Day Endoscopy- Diagnostic firstly and then for ACS 0052 Same day endoscopy surveillance.

ACS 0051 Same Day Endoscopy – Diagnostic
Daycase Coding – Urology

Scenario 1.
Patient is admitted as a Day Case for a cystoscopy due to haematuria.
During a cystoscopy performed under local anaesthetic, the urologist notes that the bladder is hypertrophic.
Diagnoses Codes:
R31   Unspecified haematuria
N328   Other specified disorders of bladder
Procedure Codes:
Cystoscopy 36812-00 [1089]
Rationale:
As no causal link between the haematuria and hypertrophic bladder was established during the cystoscopy, assign haematuria as the principal diagnosis as per ACS 0051 SAME-DAY ENDOSCOPY - DIAGNOSTIC

Scenario 2.
Patient is admitted as a Day Case for a cystoscopy due to haematuria. At cystoscopy the urologist identified a suspicious lesion which was biopsied. Histololgy shows carcinoma of the bladder.
Diagnoses Codes:
R31   Unspecified haematuria
C67.9   Malignant neoplasm of bladder, unspecified
Procedure Codes:
36836-00 [1098] Endoscopic biopsy of bladder
Rationale:
As no causal link was established between the haematuria and the neoplasm during the cystoscopy, assign haematuria as the principal diagnosis as per ACS 0051 SAME-DAY ENDOSCOPY - DIAGNOSTIC

Scenario 3.
A patient is admitted as a Day Case for a cystoscopy due to the patient's nocturia. During the cystoscopy the urologist diagnosed an enlarged prostate gland and states on the operation sheet that is the reason for the nocturia. The consultant recommends that the patient considers a surgical resection of the prostate.
Diagnoses Codes:
N40   Hyperplasia of Prostate.
Procedure Codes:
36812-00 [1089] Cystoscopy
Rationale: As a causal link was established during the cystoscopy the hyperplasia is coded as the principal diagnosis as per ACS 0051 SAME-DAY ENDOSCOPY - DIAGNOSTIC

Scenario 4.
A patient is admitted to the Urology ward for endoscopic removal of ureteric stent.

Diagnosis Codes:
Z46.6 Fitting and Adjustment of urinary device.
Procedure code:
36833-01 [1067] Endoscopic removal of ureteric stent

Scenario 5.
A patient is admitted for removal of a ureteric stent, but the clinician notes at ureteroscopy that the calculus is still present and the stent is left in place.

Diagnoses:
N20.1 Calculus of ureter
Z96.0 Presence of urogenital implants
Procedure:
36803-00 [1065] Ureteroscopy

Rationale:
As the clinician indicated that the calculus is still present, and as the stent was not removed as planned, a code for the calculus was assigned as the principal diagnosis. Z96.0 was assigned as an additional diagnosis because the stent was left in situ.

Scenario 6.
A lady is attending the urology day case ward , as her urologist felt a course of prophylactic anti-biotic therapy administered into the bladder would be of benefit in preventing future urinary tract infections.
Diagnosis
Z29.2 Other prophylactic pharmacotherapy
Z87.4   Personal history of diseases of the genitourinary system
Procedure:

96201-02 [1920] Intracavitary administration of pharmacological agent, anti-infective agent
Rationale: As the patient does not have a current condition, and the treatment is given as a prophylactic measure, the Z codes provide sufficient information for this episode.

ACS 0052 SAME-DAY ENDOSCOPY – SURVEILLANCE
Urology Daycases.

Scenario 1.
Patient with a history of prostate cancer treated by radiotherapy two years ago was admitted for a follow-up cystoscopy. No recurrence of the malignance was found
Diagnoses Codes:
Z08.1 Follow-up examination after radiotherapy for malignant neoplasm
Z85.5 Personal history of malignancy neoplasm of urinary tract
Procedure Code:
36812-00 [1089] Cystoscopy

Scenario 2
Patient admitted following treatment of a bladder ulcer with an Intracavitary drug. Endoscopy revealed a healed ulcer with no evidence of active ulceration.
Diagnoses Codes:
Z09.2 Follow-up examination after pharmacotherapy for other conditions
Z87.4 Personal history of the genitourinary system
Procedure Code:
36812-00 [1089] Cystoscopy

Scenario 3
Patient admitted for a cystoscopy due to family history of bladder cancer. No neoplasm was identified.

Diagnoses Codes
Z12.6 Special screening examination for neoplasm of bladder
Z80.5   Family history of malignant neoplasm of urinary tract.
Procedure Code:
36812-00 [1089] Cystoscopy

Scenario 4
Patient admitted for a cystoscopy due to family history of bladder cancer. Histopathology revealed a carcinoma of the bladder.

Diagnoses Codes
C67.9   Malignant neoplasm bladder, unspecified
Z80.5   Family history of malignant neoplasm of urinary tract.
Procedure Code:
36812-00 [1089] Cystoscopy

Endoscopy that incorporates both diagnostic and surveillance components
**Coding Rule Ref No: TN1248/Published On:22-Sept-2017/Status: Current**
Q:
Where an endoscopy incorporates both diagnostic and surveillance components or where a diagnostic endoscopy and a surveillance endoscopy are performed in the same episode, should the diagnostic findings be sequenced before the surveillance diagnoses?

A:
There is no hierarchy for assignment of the principal diagnosis in the above scenario. Follow the guidelines in ACS 0051 Same-day endoscopy – diagnostic and ACS 0052 Same-day endoscopy – surveillance where there are both diagnostic and surveillance endoscopies in the one episode. Then, apply the general principles in ACS 0001 Principal diagnosis to determine the principal diagnosis. This has always been the case in these scenarios and did not change with the introduction of the Tenth Edition.

Cracking The Code
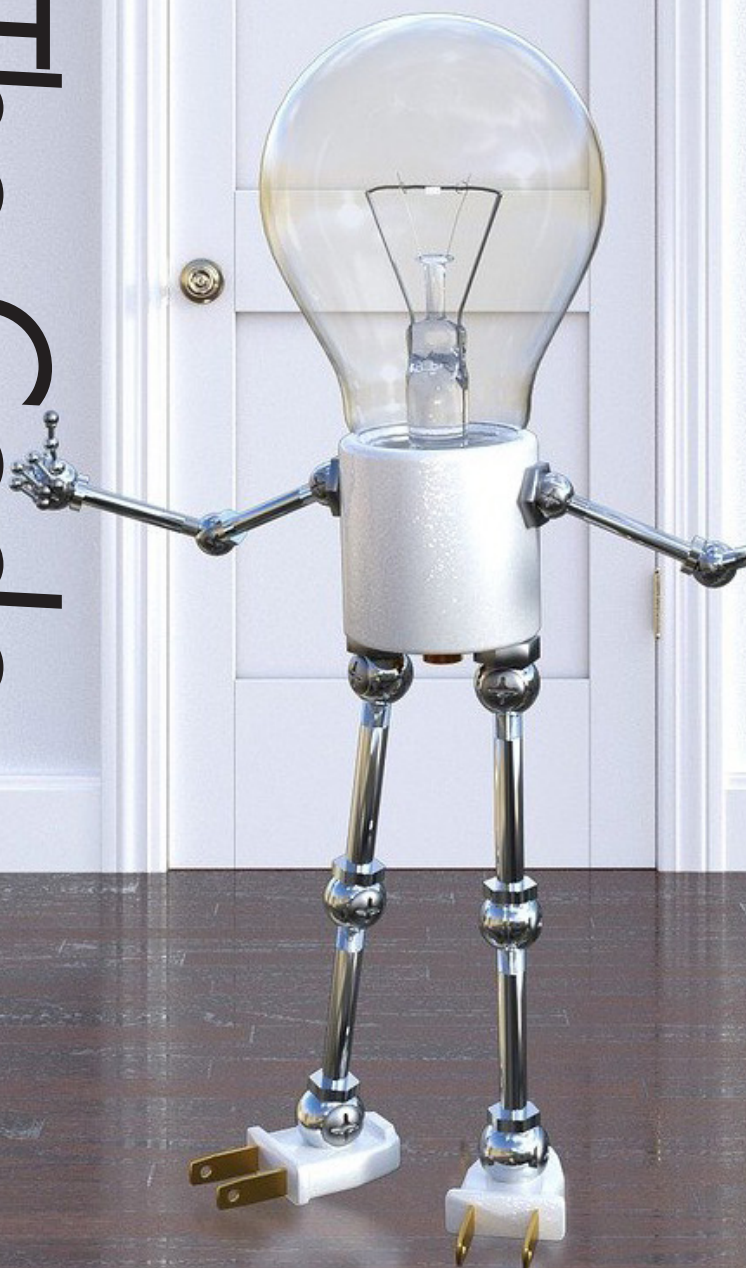
Q What is the correct code(s) to use for Gastroscopy with insertion of PEG tube with jejunal extension (PEG-J).

A

With this procedure the gastrostomy tube is extended into the jejunum.

Therefore the correct code to assign by following the index is:
Insertion
-tube
--intestine
---small
----jejunum - see Insertion/tube/jejunostomy

30478-05 [892] Percutaneous endoscopic jejunostomy [PEJ].

Q What codes are assigned for a blocked PEG tube or mechanical complication of PEG tube?

A

A gastrostomy tube is a digestive system stoma, not a prosthetic device, implant or graft

Assign to code:
K91.49 Malfunction of stoma of the digestive system, not elsewhere classified by following the index:

Complication
- gastrostomy
--obstruction (mechanical) K91.49
Code also appropriate external cause codes

Also see ACS 1904 Procedural complications, Example 13

Q Is vaping to be coded as a smoker? If the chart states ex-smoker and now vaping, should we code to Z72.0?

A

As per ACS 0503 DRUG, ALCOHOL AND TOBACCO USE DISORDERS "electronic nicotine delivery systems (eg e-cigarettes, vape-pipes, e-shisha) deliver nicotine without tobacco, <u>use of these devices does not require assignment of a code for tobacco use disorder</u>"
As the patient is an ex-smoker assign code:

Z86.43 Personal history of tobacco use disorder

Q **A** A 45 year old admitted for re-excision of margins of basal cell carcinoma (BCC) of lower leg. After re-excision of margins, no evidence of BCC found on histopathology result. How is this coded?

As per **ACS 0236 Neoplasm coding and sequencing,** The primary malignancy should be coded as a current condition if the episode of care is for: treatment aimed at stopping the cancer progression, such as:
- subsequent admissions for wider excision (even if there is no residual malignancy on histopathology).

Based on this assign code to:
C44.7 Other malignant neoplasms of skin of lower limb, including hip

Please refer to ACS 0236 for full details on when a primary malignancy should be coded as a current condition

Q **A** Patient admitted with a bleeding vessel in the duodenum and had adrenaline injection to same followed by clipping the bleeding vessel. What procedure code(s) should be assigned for this case?

Following the guidelines in coding rule *Q3240 Control of bleeding during ERCP*, we suggest to assign the following for the injection of the adrenaline:

30478-07 [870] Endoscopic administration of agent into lesion of stomach or duodenum
Endoscopic injection of sclerosing agent (sclerotherapy) into lesion of stomach or duodenum

In addition as per guidelines in coding rule *Q3338 Endoscopic clipping of bleeding upper gastrointestinal lesions*, an ACHI code for the clipping of the bleeding vessel should also be assigned as follows:

90296-00 [887] Endoscopic control of peptic ulcer or bleeding
This code can be used for duodenal bleeding

Q **A** Please advise on how to code the following. Patient presented with 'bleeding from bellybutton, Umbilical hernia with varicose vein with abrasion that has eroded and is bleeding' was documented as the diagnosis.

We suggest to code the following:

Pdx: *K42.9   Umbilical hernia without obstruction or gangrene*

Adx: *I86.8   Varicose veins of other specified sites*
         S30.81   Other superficial injuries of abdomen, lower back and pelvis, abrasion

In addition code also appropriate external cause codes for the abrasion.

Q **A** *Could you advise me please on how to code "MOG Antibody Disease"*

MOG Antibody Disease – Myelin Oligodendrocyte glycoprotein antibody Disease, is an idiopathic, inflammatory demyelinating disease of the central nervous system.
https://my.clevelandclinic.org/departments/neurological/depts/multiple-sclerosis/ms-approaches/
mog-antibody-disease
Following the index in the IE Book, we suggest to code the following:

Disease
- demyelinating, demyelinisating (nervous system)
--specified NEC G37.8

G37.8 Other specified demyelinating diseases of central nervous system

Update to ICD-10-AM/ACHI/ACS 12th Edition education

The March 2023 edition of Coding Notes contained information about the update to ICD-10-AM/ACHI/ACS 12th Edition and we hope you found this information helpful.

In this edition we will highlight some of the amendments to ACS 0002 Additional Diagnoses. Further details together with examples will be provided at the ICD-10-AM/ACHI/ACS 12th edition Implementation Courses later this year.

Please refer to page 16 for details on the update to ICD-10-AM/ACHI/ACS 12th edition training courses.

ACS 0002 Additional Diagnoses in 12th edition

Amendments were made to ACS 0002 **Additional Diagnoses** and the objective of reviewing the standard was not to change the intent of ACS 0002 but to **clarify the three criteria** for classification purposes, and to **prevent the coding of insignificant conditions.**

The following table contains a summary of key changes to ACS 0002 Additional Diagnoses between 10th & 12th edition of ICD-10-AM

Key changes to ACS 0002 *Additional Diagnoses*

10th edition	12th edition
Number of pages = 2.75 pages **Number of examples** = 7	**Number of pages** = 8.75 pages **Number of examples** = 23 *(New heading & Revised content)*
For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following: • commencement, alteration or adjustment of therapeutic treatment • diagnostic procedures • Increased clinical care and/or monitoring	**Additional diagnosis criteria** Additional diagnoses are conditions that significantly affect patient management in an episode of care in terms of requiring any of the following: • Commencement, alteration or adjustment of therapeutic treatment • Diagnostic interventions • Increased clinical care ~~and/or monitoring~~ *(Amended)* Also contains new headings for: ✓ **Commencement, alteration or adjustment of therapeutic treatment** ✓ **Diagnostic interventions** ✓ **Increased clinical care**
	Classification guidelines & a list of Do's & Don'ts with references to relevant examples within ACS 0002 are contained under each of the above headings

Please note that there are no significant changes to the first section of ACS 0002 Additional Diagnoses that contains the definition of an additional diagnosis

Commencement, alteration or adjustment of therapeutic treatment

In addition to classification guidelines and a list of Dos & Don'ts, the section on this criteria for additional diagnosis assignment contains **7 examples** with explanations. The following are 2 of these examples.

Example 1 (12th edition)

Patient was admitted for low back pain. During the episode of care the patient reported worsening epigastric discomfort and reflux after eating meals. Patient was on regular pantoprazole 20mg prior to admission for ongoing gastro-oesophageal reflux disease (GORD). After clinical consultation the dosage of pantoprazole was increased to 40mg daily. Patient's symptoms had improved by discharge.

Principal Diagnosis: Low back pain
Additional Diagnoses: Gastro-oesophageal reflux disease

In this example, the GORD meets the additional diagnosis criteria under **adjustment of therapeutic treatment** as the patient's regular reflux medication (ie. Pantroprazole) was adjusted.


Example 7 (12th edition)

An 86 year old man was admitted with community acquired pneumonia. Patient had a long history of urinary incontinence. During the admission, zinc oxide cream was applied daily to his skin and his incontinence pads were changed regularly, by the nurse.

Principal Diagnosis: Pneumonia

In this example, the urinary incontinence and skin care **do not** meet the additional diagnosis criteria under **commencement of therapeutic treatment**, as they were managed with general nursing care (ie. zinc oxide cream and incontinence pads) without the need for clinical consultation.

In 12th Edition ACS 0002 *Additional Diagnoses* the information on the criteria for assigning additional diagnoses has been expanded the section titled ***Diagnostic interventions*** contains 8 examples and the section titled ***Increased clinical care*** contains 5 examples. All examples contain explanations.

For further information on the changes to ACS 0002 Additional Diagnoses please refer to https://www.ihacpa. gov.au/sites/default/files/2022-09/ihacpa_education_fact_sheet_-_icd-10-am_achi_acs_twelfth_edition_-_ acs_0002_additional_diagnoses.pdf

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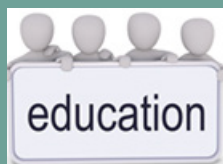
All discharges from 1st January 2024 will be coded using ICD-10-AM/ ACHI/ACS 12th Edition.

To ensure all coders are ready for coding discharges in the updated classification the HPO are holding a series of 2-day workshops at a number of locations across the country. These will be held in November and December 2023.

Registration will open later in the year and notification will be sent out when it opens. In the meantime please note the dates that suit you best in your diaries and save those dates for this training as all HIPE staff must attend <u>one</u> of these courses.

Location	Date	Time
Dublin—1 Ashling Hotel Parkgate St, Dublin 8	Tue 7th & Wed 8th Nov	10am – 4.00pm each day
Galway Merlin Park Hospital.	Tue 14th & Wed 15th Nov	10am – 4.00pm each day
Dublin—2 Healthcare Pricing Office (HPO).	Tue 21st & Wed 22nd Nov	10am – 4.00pm each day
Sligo Sligo University Hospital	Mon 27th & Tue 28th Nov	10am - 4.00pm each day
Limerick Houston Hall, Ballycummin Avenue, Raheen, Business Park.	Thurs 30th Nov & Fri 1st Dec	10am – 4.00pm each day
Cork Bru-Columbanus, Wilton.	Thurs 7th & Fri 8th Dec	10am – 4.00pm each day

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When applying to participate in training courses please take note of the details regarding the venue or method of delivery.

Closing date for completion of online application forms for all courses

To allow time for the HPO Education Team to dispatch training materials and for completion of precourse learning activities by participants in advance of courses, it is paramount that applications are submitted on time. Please submit completed applications no later than 7 working days in advance of the course start date.

Essential materials to participate in courses online you will require the following:

- ICD-10-AM/ACHI/ACS 10th edition (IEBook or hard copy)
- Training materials, dispatched in advance of the course
- Irish Coding Standards 2023(V1)
- 2023 HIPE Instruction Manual (V1.0)

HIPE Variables Training

There was no new changes to the HIPE variables for 2023. A link to a training video for variables introduced in 2022 was despatched to all HIPE coders in April of last year. Please contact **hipetraining@ HPO.ie** if you require a copy of this link.

Please inform the HPO if a new member of staff joins your HIPE department and we will dispatch a starter pack and arrange training as appropriate

Coding Skills III (B)

This 1 day course will concentrate on common circulatory conditions, coding and classification guidelines in relation to these conditions and associated interventions. Participants must complete Coding Skills II and Coding Skills III (A) before attending this course. Pre-course videos will be dispatched for viewing in advance as part of this course.

Date: Thursday 6th July2023
Time: 10.00am -5.00pm
Location: HPO

Coding Skills IV Workshops

Half-day or one-day clinical coding workshops for HIPE clinical coders provide clinical and coding information on specialty areas such as Sepsis, Obstetrics, Diabetes and Z-codes. Workshops will primarily address coding issues in depth and also where appropriate will incorporate a guest speaker who is an expert in the area to address the clinical aspects of the topic. HIPE clinical coders are invited to submit specific requests for topics and questions to be covered at specialty workshops. Sessions are also held on Data Quality, Data Quality tools such as HIPE Coding Audit Toolkit (HCAT) and the Checker software.

Z Codes
Date: Tuesday 11th July 2023
Time: 10.00am -5.00pm
Location: HPO

Introduction to Obstetrics
Date: Wednesday 19th July 2023
Time: 10.00am – 5.00 pm
Location: HPO

Introduction to HIPE 1

This 1 day course is held at the HPO. It is for new HIPE clinical coders who have received and studied their Starter Pack, and completed the exercises within the pack. The course includes a comprehensive overview of HIPE, the patient journey and information flow. It provides training on the variables collected in HIPE, an overview of Activity Based Funding (ABF) and an introduction to medical terminology and medical abbreviations. This course provides new HIPE clinical coders with an opportunity to meet the HIPE education team and other HPO staff that they will be liaising with in relation to their role in HIPE. Participants are also provided with guidance on joining HIPE training courses via WebEx (and/or other virtual meeting facilities). Follow-up exercises are provided for completion on their return to the Hospital. New HIPE clinical coders must attend this course in advance of attending *Introduction to HIPE II*

Date: Wednesday 23rd August 2023
Time: 10.00am -5.00pm
Location: HPO

Data Quality

This is an update on data quality activities and tools including The Portal, HCAT and Checker. This session will be repeated subject to demand.

Date: Thursday 7th September 2023
Time: 11.00am - 1.00pm
Location: Online

Introduction to HIPE II

This 2 and half hours training course is delivered remotely, via virtual conference facilities, for HIPE clinical coders who have attended Introduction to HIPE I. This interactive session provides feedback on completed pre-course exercises. During this session the HPO training team monitor the participant's progress, and provide support, as appropriate. Queries from participants in relation to HIPE and their role are addressed. Information and materials are provided in preparation for Coding Skills I. This course must be completed in advance of Coding Skills I

Date: Wednesday 13th September 2023
Time: 10.30am - 1.00pm
Location: Online

Coding Skills I

This two day training course is held at the HPO within two weeks following the Introduction to HIPE II, and provides HIPE clinical coders with an introduction to the ICD-10-AM/ACHI/ACS classification. It provides training on analysing documentation in the medial record, and abstracting relevant information to be coded. Coding Skills I includes training in the use of the HIPE Portal software. Participants must complete the Introduction to HIPE I & II before attending this course.

Date: Tue 10th - Wed 11th October 2023
Time: 10.00am – 5.00pm each day
Location: HPO

Smell the sea and feel the sky.
Let your soul and spirit fly.

Van Morrison