Healthcare Pricing Office

Coding Notes

Number 72
April 2016

HIPE Coding

There is no quiet time in the HIPE department and the last year has been no exception—The advent of Activity Based Funding (ABF) with an increased requirement for faster, better data has been a great challenge to all in HIPE. With the tremendous efforts by all involved in HIPE to meet the reduced deadlines in addition to the external review carried out by Pavilion, the focus on the quality and timeliness of HIPE is at an all time high. The 2014 HIPE Report is now available at www.hpo.ie (see page 2) and we look forward to publishing the 2015 report in the coming months as the 2015 national file is closing at the end of April 2016.

With increased use of HIPE and faster turnarounds required of HIPE data we all have to work towards getting it right first time around. Reviews on data and data quality need also to be done in a timely manner. One way to ensure reduction in errors occurring, queries returned, cases for audit etc. is to apply and to understand the coding guidelines thoroughly. This includes the guidance in the ICD-10-AM and ACHI classifications as well as a thorough knowledge of the ACS and the ICS. The training provided by the HPO can provide a lot of support, help and guidance for coders but it is only one part of this process. For new coders it is vital that they attend all aspects of their HIPE training. Coding Skills I is now increased to a 3 day course as there is so much to cover in these initial training sessions.

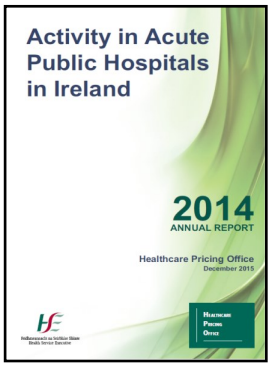
The workshop held in February this year (see page 3) was very useful for hospitals to share their experiences in how best to support and mentor new and experienced coders. There was a wealth of information shared on the day and the feedback is provided on page 3. We can facilitate further days like this if hospitals felt it useful to hold these kind of forums.

One issue that did arise on the day was the turnaround time for coding queries submitted to the HPO, particularly with the new shortened deadlines as mentioned above. We fully acknowledge this and please be assured that we do everything we can, within our own resources, to answer your queries as promptly as possible and we appreciate your understanding in this regard. The small coding team in the HPO work hard to provide as much support to HIPE stakeholders as possible within the resources available. There are many requests for workshops and training courses and we will endeavour to meet these demands where possible. A further DIT Coder Certification course has just commenced with another due to start in the Autumn. It is important that coders read and understand all the materials available through attendance at training courses and workshops and all the information available in each edition of Coding Notes. This edition of Coding Notes contains 12 pages of information on HIPE and it is critical that each coder takes the time to read and understand the coding issues outlined.

Inside This Issue

Activity in Acute Public Hospitals in Ireland

2014 Annual Report



This report presents information on coded discharges from 54 Irish acute public hospitals participating in HIPE in 2014. This report is made possible by the continuing hard work and dedication of HIPE staff throughout the hospitals. At the national level, HIPE data can inform policy decisions and developments in areas such as hospital budgeting, service planning, workload measurement etc. Information on the number of day patient and in-patient discharges, together with their demographic characteristics is presented. The number and type of diagnoses and procedures reported for discharges, together with the case mix treated, are also profiled. The demographic and morbidity analyses for *Maternity* discharges are presented separately to enable a more comprehensive overview of trends in this area.

Main findings of the 2014 Report

Total Discharges

- Over 1.59 million discharges were reported by the participating hospitals compared to 1.55 million discharges in 2013 – an increase of 2.5%. The increase in discharges reported to HIPE between 2010 and 2014 was 10.1%.
- Day patients accounted for 60% of total discharges in 2014, an increase of 3.1% since 2013. This compares with 59.1% of total discharges in 2010; the increase over the period 2010 and 2014 was 12.3%.
- At 34.7%, over one-third of total discharges were aged 65 years and older, an increase of 4.2% between 2013 and 2014.

Length of stay

- Nationally, acute in-patient average length of stay was 4.1 days in 2014, a decrease of 6.8% since 2010.

Mean Number of Diagnoses and Procedures Reported

- The mean number of diagnoses recorded for total discharges (excl. *Maternity*) was 2.6.
- The mean number of diagnoses recorded for in-patient discharges was 3.8 compared to 2.0 for day patients.
- A principal procedure was recorded for 83.8 per cent of total discharges (excl. Maternity).
- For those discharges who underwent at least one procedure, in-patient discharges had a mean number of 2.9 procedures recorded, compared to a mean of 1.4 procedures for day patients.

Figure 1 provides details of the admission type for total discharges as reported to HIPE for 2010-2014

Activity in Acute Public Hospitals in Ireland Annual Report, 2014 is available at www.hpo.ie

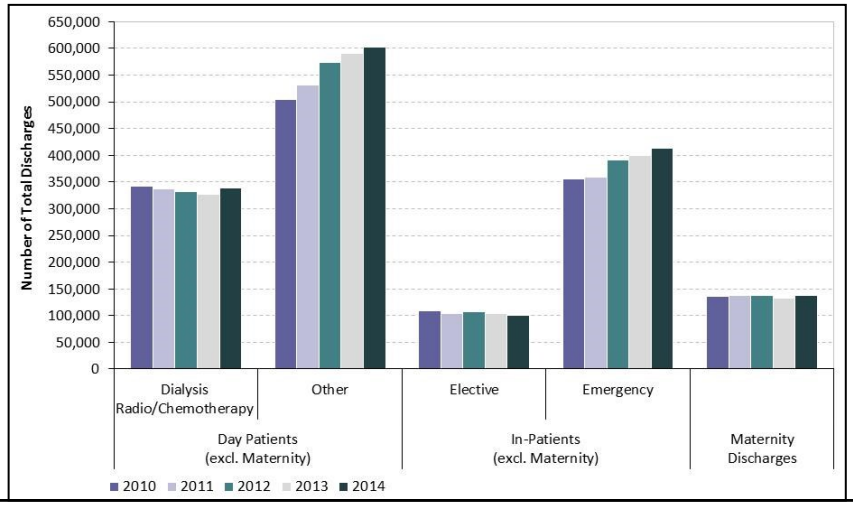


Figure 1: Admission type for total discharges as reported to HIPE for 2010-2014

Coding Services— Workshop Report

A Workshop on supporting HIPE coders and managing coding in hospitals was held recently at the Healthcare Pricing Office . This Workshop was attended by many HIPE staff and focussed on how best to ensure that all HIPE Coders receive support in their work. The importance of integrating the training that is provided by the HPO with on the job learning, and training within Hospitals' HIPE Departments was highlighted.

Topics covered— There were presentations and discussions around a number of key areas for planning coding services including: Planning the Hospital HIPE Department, Recruitment, Monitoring and Managing Training (HPO and In-Hospital Training), Training for new and experienced Coders, Organising the work in HIPE Department and Planning. The workshop also included a presentation on the importance of communication and building links with relevant stakeholders to assist with the collection of timely accurate HIPE Data. The workshop ended with a presentation on *Data Quality Resources for Trainers* – using training as a data quality tool and vice versa.

In addition, Anna Maria Sealy, Clinical Coder, University Hospital Waterford delivered a presentation on *Training New Coders - A Hospital experience*. This provided participants with step by step details of training, mentoring and monitoring provided to new coders who join the HIPE Coding Department at University Hospital Waterford. This presentation was followed by a *Break out session* and participants shared ideas regarding the management of coding services, in particular training, mentoring and monitoring of coders at all levels of experience within hospitals.

FEEDBACK FROM THE DAY

What In-Hospital HIPE training is currently provided at your hospital?

For New Coders:

- Induction - Charts, ICD-10-AM, ACHI/ACS/ICS, HIPE Portal & Hospital information systems (X-ray, ICU, Lab, HIS)
- Contact HPO for Starter Pack
- Provide coding exercises for completion by new Coders – line coding
- Start coding easy charts
- Shadow code with new coders
- Check all coded charts

What In-Hospital HIPE training would you like to introduce that would enhance the training currently provided at your hospital?

- Better communication
- Regular roundtable discussions with coding team
- Include HIPE Coders in Grand Rounds and MDTs, liaising with clinicians
- Clinicians more involved in monthly team meeting
- Talks from consultants & clinical nurse specialists
- Time to read the Australian Coding Standards and training materials
- Education for Clinicians
- Visibility (raise profile, improve documentation)

What In-Hospital HIPE training is currently provided at your hospital?

Experienced Coders:

- Participation in on-going training
- Discussion of difficult charts as team
- Discussion of queries from HPO
- Discussion of responses to queries submitted to the HPO
- Read Coding Notes
- Regular Audits
- Use of the Checker
- Liaise with Clinicians
- Meetings/Round table chart discussions for general and difficult charts
- Mandatory attendance to courses especially where there is major changes since the update to 8th edition (Diabetes, Obstetrics)

What areas would you like assistance from the HPO on in relation to training and mentoring within the hospital?

- Online training / information packages for Non HIPE staff
- ABF training
- DRG Training
- On-site training
- Quicker responses to coding queries that are submitted to the HPO

Useful links:

Casemix

http://www.health.wa.gov.au/activity/docs/cch.pdf

http://www.hpo.ie/seminar/pdf/Jacqui_Curley_and_Mark_O_Connor_Chart_Documentation_and_HIPE_Coding.pdf

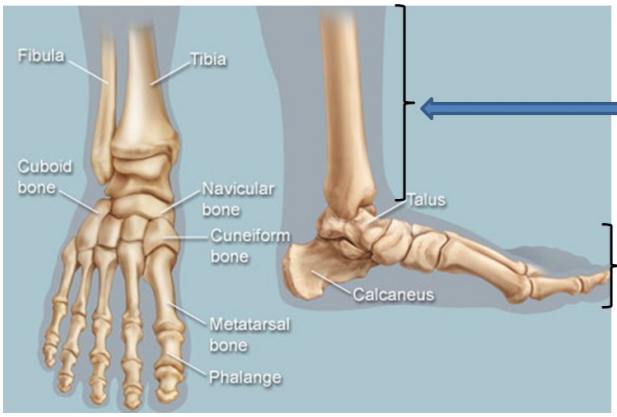
Clinical Coding for Non-Coders

http://systems.hscic.gov.uk/data/clinicalcoding/noncoders/clinicians/index_html

Foot Ulcers in Diabetes & Diabetic Foot

Diabetic Foot

The code E1-.73 **Diabetes mellitus with foot ulcer due multiple causes* should be assigned only when a patient has diabetes mellitus with an ulcer or infection of the **foot** and peripheral and/or neurological complications and/or other distinct clinical factors (as per ACS 0401 *Diabetes mellitus, 6 Diabetic Foot*). Category 1 of the diabetic foot criteria (ACS 0401, 6. Diabetic foot) is limited to ulcer and/or infection of the **foot region** (including heel and toes).



to

Example:

This 74 year old male with a long history of Type 2 diabetes mellitus presented with a non-healing 4 cm ulcer on his left heel. His other medical history includes polyneuropathy, peripheral vascular disease, previous amputation of 2 toes and smoked for 40 years (quit 10 years ago). Swabs of the ulcer grew pseudomonas. He was taken to theatre where an excisional debridement of the heel was performed under GA (ASA 2). He was given IV antibiotics for 3 days and on day 4 changed to oral antibiotics. He was discharged on Day 6 and will be reviewed in the diabetes clinic in 2 weeks time.

Codes:

PDx: E11.73 *Type 2 DM with foot ulcer due to multiple causes*

ADx:

B96.5 *Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters*
E11.42 *Type 2 diabetes mellitus with diabetic polyneuropathy*
E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
Z86.43 *Personal history of tobacco use - Disorder*

Procedure codes:

90665-00 [1628] *Excisional debridement of skin and subcutaneous tissue*
92514-29 [1910] *General anaesthesia, ASA 29*

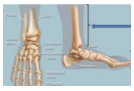
Note: While amputation of the two toes is one of the criteria for assigning E11.73 in the above example, Z89.4 *Acquired absence of foot and ankle* will not be coded in this case as it does not meet criteria for collection under Rule 4a or 4b

Remember in the GENERAL CLASSIFICATION RULES FOR DM AND IH, Rule 4a and 4b - when coding Diabetes cases in 8th Edition the following rules apply to assignment of Additional Diagnoses codes;

4a – complications in DM or IH classified to category **E09-E14** should always be coded
4b – complications in DM or IH classified to conditions **outside of category E09-E14** should only be coded when they meet criteria for collection in ACS 0001 *Principal Diagnosis* or ACS 0002 *Additional Diagnoses*

When assigning codes always verify codes in the tabular list of diseases and follow any instructional notes e.g. "Code also" notes.

Please also refer to ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia* for full coding guidelines when coding DM and IH cases. For code assignment for foot ulcers in Diabetes and Diabetic Foot specifically refer to ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia, 5 Foot Ulcers in DM and 6 Diabetic Foot.*



COPD , Pneumonia, acute lower respiratory infection.

ACS 1008 *Chronic Obstructive Pulmonary Disease (COPD)*

The recent review of HIPE Data by Pavilion Health using PICQ highlighted issues with the code assignment for COPD with Pneumonia and COPD with acute lower respiratory infection.

Summary of guidelines:

- When there is documentation of Pneumonia or acute lower respiratory infection with COPD assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection***.**
- Other codes from J44.- *Other Obstructive Pulmonary Disease* should not be assigned when the patient has pneumonia or acute lower respiratory infection with COPD.
- Infective exacerbation of COPD does not require an additional code to reflect the infective description unless the infective condition is a condition in its own right, such as pneumonia (see *COPD with pneumonia* below).
- If there is no documented infective disorder, a diagnosis of 'infective exacerbation of COPD' or 'chest infection exacerbating COPD' should be assigned the code J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*.

When looking up codes always refer to the Alphabetic Index of diseases

Disease, diseased

- lung J98.4

- - obstructive (chronic) J44.9

- - - with (acute)

- - - - asthma J44.8

Verify codes in the tabular list of diseases. Watch out for *Excludes* notes.

J20–J22 OTHER ACUTE LOWER RESPIRATORY INFECTIONS

Excludes: chronic obstructive pulmonary disease with acute:

- exacerbation NOS (J44.1)
- lower respiratory infection **(J44.0)**

COPD WITH ACUTE LOWER RESPIRATORY INFECTION

Example 1:
Discharge summary documented PDx as Infective COPD.
J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

Example 2:
Discharge summary documented PDx as Infective COPD. Staphylococcal documented as the infective agent.
J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*
B95.8 *Unspecified staphylococcus as the cause*

COPD WITH PNEUMONIA

Clinically, pneumonia may not always exacerbate COPD. It is often the case that clinical documentation is unclear whether pneumonia exacerbates COPD. From a classification point of view, the presence of COPD **with** pneumonia is sufficient to assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*.

When there is unclear documentation of the principal diagnosis, such as 'COPD/Pneumonia' or 'Pneumonia + COPD' coders should find documentation in the clinical record or seek clinical advice on which condition meets the criteria in ACS 0001 *Principal diagnosis*. If not available, the section on *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* of ACS 0001 *Principal diagnosis*, should be applied (see below).

TWO OR MORE INTERRELATED CONDITIONS, EACH POTENTIALLY MEETING THE DEFINITION FOR PRINCIPAL DIAGNOSIS

When there are two or more interrelated conditions (such as diseases in the same ICD-10-AM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition. If no further information is available, code as the principal diagnosis the first mentioned diagnosis (World Health Organization 2011, pp. 133–134). Source: ACS 0001 Principal Diagnosis.

Continued overleaf

COPD , Pneumonia, acute lower respiratory infection.

Continued

Example 3:
Discharge summary documented PDx as COPD/Pneumonia
J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*
J18.- *Pneumonia, organism unspecified*

Example 4:
Discharge summary documented PDx as Pneumonia + COPD exacerbation.
J18.- *Pneumonia, organism unspecified*
J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

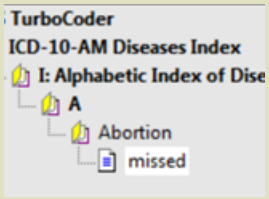
EXAMPLE 5:
Discharge summary documented PDx as Staphylococcal Pneumonia + COPD exacerbation
J15.2 *Pneumonia due to staphylococcus*
J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

Spontaneous /Missed Miscarriage or Spontaneous Abortion

A miscarriage may also be called a "**spontaneous abortion**"

When looking up the codes for a missed miscarriage or missed abortion please refer to the following look ups.

Alphabetical Index of Diseases



Tabular list of Diseases

O02.1 Missed abortion
Early fetal death with retention of dead fetus

A selection of queries submitted to the HPO in relation to the classification of missed abortion/miscarriage:

Q. What is the difference between a spontaneous abortion/miscarriage and a missed abortion/miscarriage?

A. The difference between a spontaneous abortion/miscarriage and a missed abortion/miscarriage is that with the spontaneous abortion the patient has symptoms and signs at the time of the miscarriage/abortion, but with the missed abortion/miscarriage the symptoms and signs are not apparent until after the event.

Q . When is it appropriate to assign a code for a missed spontaneous abortion/miscarriage?

A. A code for a missed abortion will only be assigned if the condition is documented in the Medical Record.

Q. If the term 'miscarriage/abortion' is used and then the term 'missed miscarriage/missed abortion' is used on the same episode how will this be coded?

A. If the both terms are used on the same episode of care the case will need to be referred back to the Clinician for clarification.

Cracking the Code

A selection of ICD-10-AM Queries

Q. ACS 0042 states clearly that insertion of a CVC, Hickman or PICC is not normally coded, except when required in certain standards elsewhere in the Australian Coding Standards, if cerebral anaesthesia is required in order for the procedure to be performed or if they are the principal reason for admission in same-day episodes of care. Do we code **removal** of a CVC, Hickman or PICC when the above criteria are not met?

A. The removal of the catheter is not coded. ACS 0042 *Procedures Normally Not Coded* is indexed at the block [738] venous catheterisation where removal is classified to. The standard ACS0042 applies to all codes in block [738]. As mentioned removals are coded if they meet criteria i.e. performed under anaesthetic or a principal reason for admission in a day case.

Q. Can you please advise on the correct code for Influenza B?

A. The appropriate code to assign is J10.8 *Influenza with other manifestations, other influenza virus identified*.

Q. What is the ACHI code for a Synacthen test? I have a case here where a patient comes in for this test and it states in the chart "Baseline blood test, 250mcg Synacthen given IM (Dorsogluteal)". The patient was admitted electively for the test.

A. The appropriate ACHI code to assign is

30097-00 [1858] *Adrenocorticotropic hormone stimulation test*
Synacthen stimulation test (long) (short)

Index look up **Synacthen**, stimulation test.

The diagnosis will depend on the results of the test.

Q. A patient had a drain inserted for post cholecystectomy collection and was admitted because the drain had migrated into the duodenum. What codes are assigned?

A. This will be coded as a mechanical complication of the device:

T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts*

Y83.3 *Surgical operation with formation of external stoma*

Y92.22 *Health service area*

Q. A patient has a primary malignant melanoma of the shoulder and now has brain, bone, axillary and liver mets. Is C79.88 *Secondary malignant neoplasm of other specified sites* sufficient for metastatic melanoma or should the other sites be coded out separately?

A. Code out the secondaries to each specific site rather than the code C79.88 *Secondary malignant neoplasm of other specified sites*. Please see ACS 0236 Neoplasm coding and sequencing where the last line in this standard states this advice.

Q. A patient was admitted with post traumatic glaucoma with a background of type 2 diabetes (NIDDM). How is this coded?

A. Rule 5 of ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia* applies to this scenario:

"**Rule 5.** Where the classification (Alphabetic Index) has linked a condition with DM, yet a specific cause other than DM is documented as the cause of the condition, then a code for the causal condition should be sequenced before the DM code(s) (see examples 5 and 6)."

We suggest that appropriate codes to assign are:

H40.3 *Glaucoma secondary to eye trauma*

External cause codes

Place of occurrence

E11.35 *Type 2 diabetes mellitus with advanced ophthalmic disease.* (Index look up: Diabetes with glaucoma - E1.35)

Q. If a patient comes in for subcutaneous chemotherapy and also receives IV chemotherapy should we assign both codes or would one override the other?

A. We suggest that both routes of administration are coded when a patient has both IV and subcutaneous chemotherapy:

96199-00 [1920] *Intravenous administration of pharma cological agent, antineoplastic agent*
and
96200-00 [1920] *Subcutaneous administration of Pharmacological agent, antineoplastic agent*

Q. What is the code for Transperineal biopsy of prostate?

A. We recommend 37218-00 [1163] *Percutaneous [needle] biopsy of prostate* as this is a needle biopsy rather than an open biopsy through the perineum.

There is no specific procedure code in 8th edition for transperineal biopsy of prostate.

Cracking the Code

A selection of ICD-10-AM Queries

Q. Can you please confirm what is the correct code to assign when a patient has delirium and it is documented as being due to a UTI?

A. We suggest coding as follows:

Look up:

Delirium,

-due to

- - general medical condition

And code to:

F05.0 *Delirium not superimposed on dementia, so described*

N39.0 *Urinary tract infection, site not specified*

The sequence of the codes will depend on reason for admission as per ACS 0001. See also Coding Rules Q2649 15 March 2014 at code F050 (in the TurboCoder only).

Check the code assignment if the patient also has dementia.

Q. How do we code End Stage Renal Failure (ESRF) due to Anti-GBM disease.

A. We suggest the following code look up:

Disease,

-antiglomerular basement membrane (anti-GBM) anti body M31.0† N08.5*

Code to:

M31.0 *Hypersensitivity angiitis*

N08.5* *Glomerular disorders in systemic connective tissue disorders*

And also code the End Stage Renal Failure (ESRF)

The code sequencing will depend on the reason for admission as per ACS 0001. Please bear in mind changes to dagger and asterisk sequencing in 8th edition.

Q. Could you advise which code from I25.1x ***Atherosclerotic heart disease*** will be assigned in cases where the documentation does not specify whether the disease is native or not?

This is in response to the new check that suggests that I25.10 *Atherosclerotic heart disease of unspecified vessel* is rarely assigned. It's our experience that the opposite is true as clinicians do not document which type it is.

A. Please see ACS 0940 *Ischaemic heart disease*, section 6 on arteriosclerotic heart disease (I25.1-) which states;

"**Classification**

The fifth character subdivision indicates the nature of the coronary artery involved. If it is clear from the documentation that there has been no previous coronary artery bypass surgery, assign code I25.11 *Atherosclerotic heart disease of native coronary artery*."

Therefore if there is no previous CABG, the guideline is to assign I25.11 *Atherosclerotic heart disease of native coronary artery*.

Q. A patient comes in every six months to the hospital as a day case for IV infusion of Bisphosphonates (Zometa infusion) for Non Hodgkin's lymphoma. What codes are assigned?

A. Code this case to:

PDX Z51.1 *Pharmacotherapy session for neoplasm*

ADx C85.9 *Non-Hodgkin lymphoma, unspecified*

Procedure 96199-**00** [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*

As the infusion of Zometa is to treat a neoplasm or a neoplasm related condition the procedure code is 96199-**00** [1920] *Intravenous administration of pharmacological agent, antineoplastic agent.* Codes from Block [1920] with an extension of -00 are assigned for treatment of a neoplasm or neoplasm related condition.

Q. Is there a Dx code for gastroenteritis due to astrovirus?

A. For gastroenteritis due to astrovirus we suggest assigning A08.3 *Other viral enteritis*. For more information on this virus in viral gastroenteritis http://www.hpsc.ie/A-Z/Gastroenteric/ViralGastroenteritis/Factsheet/

Look up

Enteritis,

- viral

--virus specified NEC A08.3

Or

Gastroenteritis,

-viral,

--Specified type NEC A08.3

Do you have a coding query?

Please email your query to:

hipecodingquery@hpo.ie

To answer your query we need as much information as possible, please use the Coding Help Sheet as a guide to the amount of detail required, available at:

www.hpo.ie/find-it-fast

Please anonymise any information submitted to the HPO.

Combined ventilatory support for neonates [571]

Q 1. Do the continuous (invasive) block [569] and the non-invasive block [570] have to be at the same time in order to use the combined ventilatory support for greater than 96 hours 92211-00 block [571]?

Q 2. Is the code 92211-00 block [571] used if the baby comes off an intervention coded from block [569] *Ventilatory support* and then continues with an intervention coded code from block [570] *Non-invasive ventilatory support*?

Please see ACS 1615 *Specific interventions for the sick neonate*, which states "When the hours of invasive and non-invasive ventilation are added together and the total is ≥ 96 hours assign also 92211-00 [571] *Management of combined ventilatory support, 96 hours*".

Also note:

- The hours on the ventilation do not have to be *at the same time*.
- The neonate must have codes from both blocks [569] + [570] in order to assign the code from block [571] for combined ventilatory support.
- The total hours must be more than or equal to 96 hours in any combination of types of ventilation
- The code 92211-00 [571] *Management of combined ventilatory support, 96 hours* is **for use in neonates only**

Patients presenting for Colonoscopy with No Symptoms

A number of queries have been received in the HPO regarding patients presenting for colonoscopy with no symptoms and how these cases are to be coded.

Please see the advice in **Coding Rules (Ref No TN211/ Published on 15 September 2006)** below:

Ref No: TN211 | Published On: 15-Sep-2006 | Status: Current

Admissions for colonoscopy with no underlying symptoms or family history

The NCCH received a query on principal diagnosis assignment when no abnormalities are detected in a patient admitted for colonoscopy with no underlying symptoms or family history. The query specifically related to cases where colonoscopy is performed due to age or anxiety, such as anxiety about death of a friend from colon cancer.

Classification

ACS *2111 Screening for specific disorders* should be followed in these cases. Assign an appropriate screening code (Z11, *Z12, Z13)* as the principal diagnosis. Assign Z71.1 *Person with feared complaint in whom no diagnosis is made* as an additional diagnosis.

Example 1: Patient admitted for colonoscopy due to anxiety from death of a close friend with colon cancer. No abnormalities were detected on colonoscopy.

Codes:

Z12.1 *Special screening examination for neoplasm of intestinal tract*

Z71.1 *Person with feared complaint in whom no diagnosis is made*

32090-00 **[905]** *Fibreoptic colonoscopy to caecum*

(Coding Matters September 2006 Volume 13, Number 2)

Clarification—ACS 0044 Chemotherapy

ACS 0044 Chemotherapy states under the classification advice for day cases:

> **CLASSIFICATION**
>
> **Same-day episodes of care for chemotherapy for neoplasm**
>
> For episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the patient is discharged on the same-day as the admission, assign:
>
> • Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis
>
> • a code for the neoplasm being treated as the first additional diagnosis (see also ACS 0236 *Neoplasm coding and sequencing*)
>
> • additional diagnosis code(s) for any neoplasm related condition(s) being treated
>
> • the appropriate procedure code.

Please note the following points in relation to the coding of chemotherapy:

⇒ Extension code -00 in block [1920] is used for **any** drug/medication/steroids/vitamin etc. given to treat a neoplasm **OR A NEOPLASM RELATED CONDITION**.

⇒ Intervention codes are always assigned for chemotherapy (day case and multiday).

⇒ Oral chemotherapy is coded when administered during the episode of case (day or multiday) as per ICS 0044 *Chemotherapy*.

A query was submitted to the HPO regarding **ACS 0044 *Chemotherapy,* Example 2**. The query stated that the diagnosis and procedure are incorrect on this example as the patient came in for infusion for hypercalcemia and not for chemotherapy .

EXAMPLE 2:
Patient previously diagnosed with metastatic bone cancer from the breast and admitted for same-day infusion of Aredia for hypercalcaemia.

Codes:	Z51.1	*Pharmacotherapy session for neoplasm*
	C79.5	*Secondary malignant neoplasm of bone and bone marrow*
	M8000/6	*Neoplasm, metastatic*
	C50.-	*Malignant neoplasm of breast*
	M8000/3	*Neoplasm, malignant*
	E83.5	*Disorders of calcium metabolism*
	96199-00 [1920]	*Intravenous administration of pharmacological agent, antineoplastic agent*

HPO response:

The above example in ACS 0044 Chemotherapy is correct. Chemotherapy for neoplasm (extension -00 in ACHI Block 1920) includes treatment of neoplasm **or <u>neoplasm related condition</u>**. Please refer to the tabular index and the code description for extension code -00 in [1920].

- 00	Antineoplastic agent Agents used in the treatment of neoplasms and/or neoplasm related conditions

As the example referred to is on the treatment of a metastatic bone cancer and the Aredia <u>is being given to treat a neoplasm related condition</u> – the PDx of Z51.1 *Pharmacotherapy session for neoplasm* is assigned.

The procedure code is correct as 96199 -00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent.*

This guideline is at the core of coding neoplasms . If you have not been applying this guideline please contact your manager and ensure cases are corrected. If you need any further clarification on this please contact us immediately.

Sepsis Workshops

The HPO in conjunction with Dr. Vida Hamilton National Clinical Lead Sepsis are holding a number of Sepsis Workshops around the country. The first of these was held at the HPO on 2nd March and was a great success. Many questions and issues were discussed during the day and as the HPO prepares to hold 4 more workshops we will endeavour to produce an information bulletin on coding Sepsis in HIPE in the coming months. The Sepsis form being used in hospitals now will prove a useful tool for coders along with the new 8th edition codes. With such a serious condition affecting so many patients across all specialities it is important that all coders understand how to extract and code the correct information.

Dr. Vida Hamilton, National Clinical Lead Sepsis presenting at the recent Sepsis Workshop in the HPO, Dublin.

Six Hospital Group Assistant Directors of Nursing for Sepsis have been appointed and they will attend the courses also. It is a good opportunity for the National Sepsis Team and hospitals to get together to ensure the optimum information is collected on this critical condition. Coders will have an opportunity to meet with members of the Sepsis team and establish links for further collaboration where clinical clarification is needed in relation to Sepsis.

Hospital-acquired pneumonia (HAP) or **Nosocomial pneumonia**

Hospital-acquired pneumonia (HAP) or nosocomial pneumonia refers to any pneumonia contracted by a patient in a hospital after being admitted. Please be cautious assigning nosocomial codes for hospital acquired pneumonia, this would need to be clearly documented. The pneumonia may have been acquired during a previous healthcare spell e.g. in a hospital or maybe in a nursing home – "nosocomial" means hospital or healthcare facilities.

The HADx flag can be used to identify conditions arising after admission. If the pneumonia was acquired during this episode of care the HADx flag can be assigned to indicate it was not present on admission. The HADx flag by its nature and definition indicates a hospital acquired diagnosis (HADx). HADx cannot be assigned to the principal diagnosis except in the case of neonates.

Hospital Acquired Pneumonia:

If it is appropriate to assign this pneumonia as a nosocomial condition the appropriate codes to assign are;

J18.9 Pneumonia, unspecified – check for specificity,

Y95 Nosocomial condition

Assign HADx flag only if the pneumonia is acquired during this admission – the HADx flag would be assigned to *both codes* if the pneumonia arose *after* admission.

Community Acquired Pneumonia - "Community acquired" means not acquired in a health care setting, in this case just code to pneumonia and do not assign a HADx flag.

Upcoming Courses

NOTE: All HIPE coding courses are now in 8th Edition ICD-10-AM/ACHI/ACS/ICS.

Coding Skills I

This 3 day course is for new coders who have participated in the Introduction to HIPE course.

Date: Tuesday 19th - Thursday 21st April
Time: 10am – 5pm each day
Location: HPO, Brunel Building only

Coding Skills II

This 3 day course is for new coders who have attended Coding Skills I

Date: Tuesday 17th May - Thursday 19th May
Time: 10am - 5pm each day.
Location: HPO, Brunel Building only

Coding Skills III

This course is for coders who have previously attended Coding Skills II. Experienced coders are welcome to attend this course for refresher training.

Date: Tuesday 12th – Thursday 14th July
Time: 10am – 5pm each day
Location: HPO, Brunel Building only

Coding Skills IV– Workshops Sepsis–4 options

Full Day courses

With guest speaker Dr. Vida Hamilton,
National Clinical Sepsis Lead

1. Date: Wednesday, 13th April 2016
Time: 10.00 am – 4 pm
Location: Centre for Nurse Education, Mercy Hospital, Cork

2. Date: Friday, 15th April 2016
Time: 10.30 am – 4 pm
Location: Lecture Theatre (228), Clinical Sciences Building, University Hospital Galway

3. Date: Wednesday, 27th April 2016
Time: 10.00 am – 4 pm
Location: HPO, Dublin

Limited availability

4. Date: Wednesday, 8th June 2016
Time: 10.00 am – 4 pm
Location: HPO, Dublin

To apply for any of the advertised courses, please complete the online training applications form at:
www.hpo.ie/training
Please inform us of any training requirements by emailing hipetraining@hpo.ie.

Coding Skills IV– Workshops

Same Day Endoscopies

Date: Tuesday, 10th May 2016
Time: 10.30 am – 1 pm
Location: HPO, Brunel Building & WebEx

Z Codes Workshop—Part 1 & Part 2

Dates: 28th & 29th June (both mornings)
Time : 10.30 am -1pm (each day)
Location: HPO, Brunel Building & WebEx

HCAT© & Checker© Training

Date: Thursday, 28th April 2016
Time: 10.00am – 4.30pm
Location: HPO, Brunel Building

Limited availability

Data Quality Session

Date: Thursday, 23rd June 2016
Time: 11.00am – 1.30pm
Location: WebEx only
Note: This is an update on data quality activities and tools including the portal HCAT and Checker. This session will be repeated subject to demand.

Anatomy & Physiology

These courses will be delivered by a specialist speaker.

Anatomy & Physiology— Musculoskeletal System

Date: Thursday, 26th May
Time: 11am – 1pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Digestive System

Date: Thursday, 26th May
Time: 2pm—4pm
Location: HPO, Brunel Building & WebEx

What would you like to see in Coding Notes?

If you have any ideas for future topics, please let us know.
Thanks and keep in touch: info@hpo.ie

See the 'Find it Fast' section of the HPO website for easy access.
www.hpo.ie/find_it_fast/

Thought for Today

Don't be pushed by your problems.
Be led by your dreams.

Ralph Waldo Emerson - 1803-1882, Poet.