Coding Notes

Healthcare Pricing Office

No. 71
December 2015

The Year in Review

Thank you to everyone for the hard work and dedication in 2015. We started the year with the update to 8th Edition and the changes have been welcomed and implemented across the HIPE system. It's hard to believe that this time last year we were all so busy preparing for the 8th edition update. It continued to be a busy year for everyone with the emphasis on HIPE coding and the importance of the work of coders increasing. Hospitals are auditing, running the Checker©, reviewing their own data as well as meeting the shorter deadlines. We held more data quality sessions than ever before this year and everyone is really working together to meet the HIPE goals of quality and timely HIPE data. With the external audit on-going it really has been one busy year for everyone!

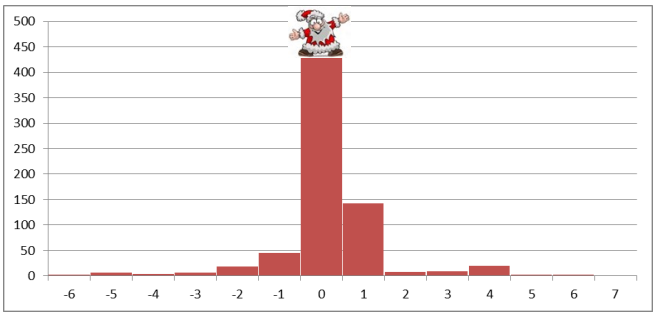
This Christmas edition of Coding Notes is packed with lots of coding information and answers to queries. An article on page 2, although about coding in the NHS is very relevant to us here in Ireland. Also on page 2 there is information on the Irish Hip Fracture Database which is one example of where HIPE data are really at the forefront. There is information on new variables for 2016 plus a reminder of those introduced in 2015. The updated Instruction Manual, Irish Coding Standards and the 2016 Training Calendar are also now available on www.hpo.ie. New and additional courses are available as the HPO continues to provide training at all levels. The next DIT course is scheduled to begin in February and applications are open now. Please contact HIPEtraining@HPO.ie if you are working in a HIPE department and would like to apply for this course. There is a specific date schedule, connected to the DIT examinations timetable, for assessments and the final exam which you must be able to commit to before applying. Further information from the HPO is available at the above email address. We have now had 46 students who either completed or are in the process of completing the course and the feedback has been that although it is challenging, it is extremely worthwhile. So maybe your New Year's resolution for 2016 will be to get certified as a HIPE coder!

HIPE Exports

2015 has been another exceptional year for HIPE data and the HIPE portal. Exporting timely HIPE data continues to be critical to Activity Based Funding and now, coupled with this, we have the news that the HIPE data has been used for Service Plan purposes for 2015. This is on top of the fact that the data continues to be used for hospital management, for hospital measurement, for patient level costing and for research purposes.

The continuing high regard the data are held in and the on-going use is a major success for us all but, more especially, it is a major accomplishment for HIPE coders in each of the hospitals.

Export dates are chosen as the third working day each month to ensure that the HPO receive a complete set of data (coded and uncoded) from the hospitals. It is great to see that most hospitals are sending the export on the correct date (or near it). The graph below shows the distribution of export creation dates with "0" meaning that the export was created on expected export date. Some of the variation relates to weekends and bank holiday weekends. If the export is created too early, we may miss out on uncoded cases which need to be downloaded. Where the export is created too late, it may not be included in the national file until the following month.



The HPO try to ensure that all exports are included from each hospital but we need to create the file for all the HIPE data users each month and we cannot delay this.

Thank you once again to everyone for your hard work and commitment and here's to a wonderful 2016 for everyone both professionally and personally.

Inside This Issue

Unsung stars—The Coders!

An article on Coders in the NHS

The following article, written by Roy Lilley, NHS commentator, writer and broadcaster, was published on the NHSManagers.net website in October 2015. Although it is written about the British system it is interesting to read that the same issues are there for coders also. With the author's permission an abridged version is presented below. Please see also www.nhsmanagers.net for more.

"**Team work**; just as it is in the NHS. Centre stage the heroic medicine, lifesaving; so complicated it defies understanding. Nursing, imaging, diagnostics, physio, occupational therapies, porters, security, car parking, maintenance, discharge, pharmacy and the whole shebang. Modern healthcare, inside and outside of hospital, is a complex web of interdependence.

And, when all have done their bit what remains is for someone to count what happened. This week I met some of the unsung stars, heroes and (it seems to me) mostly heroines, that do that job. The coders! Yes, the coders. The people who unfathom the notes, read the handwriting, correct the mistakes, ask the questions, cost the procedures and keep Trusts solvent. The indispensable, crucial, essential coders.

How do you think we know how much the NHS spends? How, do you imagine the NHS knows what it has done and when it did it? Is it some jaw dropping clever algorithm? No, for the most part it depends on an army of sharp-eyed, shrewd, focussed and unbelievably knowledgeable back-room staff who are the power house of the NHS, the centrifuge and the after burners. They are detectives and problem solvers. Exciting work. Coders average 'coding' around one episode of care every 13 minutes. A complicated patient could take all day. There are not enough coders. Departments are stretched and as it is a mainly female profession, when maternity calls, departments are decimated. The vacancy rate is high. We have to think about coding, the role it plays and the future.

The interface between the coders and financial stability seems to be junior doctors making legible notes and cajoling consultants to write intelligible records. It is a fragile crossing point.

There are those that say close the coding department and have them attached to the specialty; closer to the action. Others disagree. There are those that say give us more coders and others that say, we can't keep doing what we've always done.

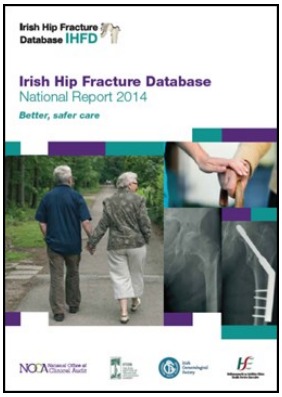
What is obvious to me is this: if we are seriously interested in who gets sick; from what; how were they fixed up; did it work; what did it cost and do we want to do it again... we urgently need to better manage the use of information by the use of technology.

We need to get the NHS' super troopers into the spotlight."

www.Roylilley.co.uk

Irish Hip Fracture Database (IHFD)

Annual Report 2014

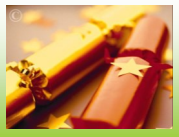


There were approximately 3,200 discharges aged 60 years and over reported to HIPE in 2014 with a diagnosis of hip fracture due to injury. The ICD-10-AM codes used to identify these are:

S72.0x	Fracture of neck of femur
S72.10	Fracture of trochanteric section of femur, unspecified
S72.11	Fracture of intertrochanteric section of femur
S72.2	Subtrochanteric fracture

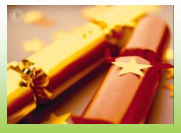
In 2014, 14 hospitals of the 16 who treat hip fractures nationally used the additional 'Hip Fracture' screen on the HIPE portal to add additional data related to 2,664 (84%) of the HIPE discharges described above. This additional hip fracture data was entered by the orthopaedic / geriatric / physio team in each participating hospital. All 16 of the hospitals nationally who treat hip fractures are now submitting hip fracture data to the national dataset and this will be included in the 2015 report.
The main focus of the annual Irish Hip Fracture Database (IHFD) report is "The Six Blue Book Standards" which are based on the standards described by the British Orthopaedic Association. The standards include a target time to admission to an orthopaedic ward of 4 hours, and a target time to surgery of 48 hours.

The full 2014 report is available on the NOCA website (www.noca.ie) or on the HPO website (www.hpo.ie/ihfd/rep2014.pdf).



Cracking the Code

A selection of Coding Queries



Q. Can you advise please if Hypertension should be coded in a diabetic patient who has both Chronic Kidney Disease (CKD) and Hypertension – when neither the CKD nor Hypertension are treated during the admission?

A. In this scenario please code as follows:

- Diabetes with Chronic Kidney Disease: E1x.2x . The diabetes code will depend on the type of diabetes and the stage of the CKD.
- Also assign the code for the CKD – from category N18 *Chronic kidney disease*, the code will depend on the stage of the CKD. This is assigned because of the "*Use additional code to identify the presence of chronic kidney disease (N18.-)"* at E1x.2x—even if the CKD is not treated.
- At N18 *Chronic kidney disease* in the tabular index there is an instruction to "code also Hypertension" – therefore I10 *Hypertension* will also be assigned even if it does not meet ACS 0002.

Q. Patient admitted with Hypocalcaemia who has a primary neoplasm of the breast with Secondaries in the liver. Do I code as E83.5 *Disorders of calcium metabolism* followed by the Neoplasms?

A. The codes assigned in this case will depend on whether the patient was a day case or an inpatient. Also please review ACS 0236 *Neoplasm Coding and Sequencing.*

If this is a **day case admission** for administration of agent such as arredia (to replace bone minerals) code to:

- Z51.1 *Pharmacotherapy session for neoplasm*
- plus E83.5 *Disorders of calcium metabolism* – for hypocalcaemia
- code also the breast primary, liver mets and check if there are any other mets e.g. bone.
- A procedure code from procedure block [1920] *Administration of pharmacotherapy* with an extension of -00 *antineoplastic agent* if there is administration of any agent to treat a neoplasm or neoplasm related disease.

If this is an **inpatient admission** code to:

- The principal diagnosis will be assigned according to ACS 0001 *Principal Diagnosis*.
- code associated conditions e.g. hypocalcaemia, breast primary or liver mets and check if there are any other mets e.g. bone.
- A procedure code from block [1920] *Administration of pharmacotherapy* with an extension of -00 *antineoplastic agent* if there is administration of any agent to treat a neoplasm or neoplasm related disease.

Q. When coding Nausea and Vomiting after a Hernia Repair and the patient was given anti sickness treatment, do we code the Hernia, then the Nausea and Vomiting followed by External Cause Codes? Also does Postoperative Renal Failure require External Cause Codes?

A. When coding post-procedural complications and **there is a link between the condition and the procedure** – external cause codes are assigned to indicate the procedure that the condition has been caused by, and the place where this procedure was performed. Please review ACS 1904 *Procedural complications* where this is explained in detail. This is the case for both the Nausea and Vomiting and the Postoperative Renal Failure if they are linked to a procedure.

There must be a link between the condition and the procedure – not just that it happened after the procedure. Please review ACS 1904 *Procedural complications* for full guidance on coding Procedural Complications. If there is no link made between the condition and the procedure and the condition meets ACS 0002 then it can be coded but not as a procedural complication. Also remember to assign the HADx flag as appropriate to conditions arising after admission.

Q. Could you confirm what code would be assigned for a diagnosis of "Smouldering Multiple Myeloma". This is a male patient, having a bone marrow aspirate on this episode but already being given Zometa monthly and NeoRecormon weekly. Is this coded as Multiple Myeloma without mention of remission?

A. We would advise coding this to multiple myeloma (and only code to "in remission" if this is specifically mentioned). This advice is based on the instructional notes at the beginning of Chapter 2 Neoplasms – see Note 2. that states…."2. Functional activity. All neoplasms are classified in this chapter, whether they are functionally active or not."

Useful information about this type of myeloma can be found at http://www.myeloma.org.uk/wp-content/uploads/2013/09/Smouldering-myeloma-Infosheet-Dec-2014.pdf

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Q. How do we code a patient with Diabetes Mellitus Type 2 with Stage 3 Chronic Kidney Disease (CKD) and they also have a cataract?

A. Please code as follows:

• N18.3 *Chronic kidney disease, stage 3* will be the PDx if it is the reason for admission.

• E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy*

• If the cataract is present but does not meet ACS 0002 Additional Diagnoses use code E11.39 *Type 2 diabetes mellitus with other specified ophthalmic complication* only. If cataract does

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meet criteria for coding please also code the specific cataract along with E11.39.

AND also assign

• E11.71 *Type 2 diabetes mellitus with multiple microvascular and other specified nonvascular complications* as the patient has two conditions that meet the criteria for multiple microvascular complications. See ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia* - Example 9 and the classification box before it.

Q. We have patients with Type 1 diabetes mellitus brought in for investigation of blood sugar levels. Is this coded to E10.65 *Type 1 diabetes mellitus with poor control*?

A. The codes will depend on the reason for admission. E10.65 *Type 1 diabetes mellitus with poor control* can only be used if the patient's diabetes is documented as with "poor control", "for stabilisation", "unstable" or other such terms indicating poor control. If this is the case then code E10.65 *Type 1 diabetes mellitus with poor control* is correct. Please check for the results as there may be some other conditions to be coded.

Q. A patient with Type II diabetes mellitus is admitted with a principal diagnosis of LRTI. The patient also has acute and chronic kidney failure, nephropathy and retinopathy. The patient is blind and has increased nursing care as a result of this. If all these conditions meet ACS 0002 *Additional Diagnoses* then how is the case coded and how are the codes sequenced.

A: We would advise assigning the following codes based on the information provided, please check for specificity around the lower respiratory tract infection (LRTI).

PDx: J22 *Unspecified acute lower respiratory infection*

ADx: E11.71 *Type 2 diabetes mellitus with multiple micro vascular and other specified nonvascular complications*
E11.29 *Type 2 diabetes mellitus with other specified kidney complication*
N17.9 *Acute kidney failure, unspecified*
E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy*
N18.9 *Chronic kidney disease, unspecified* – check for specific stage of CKD in order to assign a more specific code.
E11.31 *Type 2 diabetes mellitus with background retinopathy*
H54.0 *Blindness, binocular*

The code E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy* includes nephropathy and therefore as per *Rule 6* in ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia* an additional code for the nephropathy is not required as it is included in the code title at E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy*. Similarly an additional code is not assigned for retinopathy as the code E11.31 *Type 2 diabetes mellitus with background retinopathy* identifies all the elements – *Rule 6*.

Q. If a patient is admitted under the care of a Palliative Care Consultant is it still necessary to enter Z51.5 *Palliative care* as a diagnosis?

A. Please review ICS 0224 *Palliative Care*. When palliative care is documented or the patient is documented as having been seen by or attended by the palliative care team then code Z51.5 *Palliative care* is assigned. Do not omit the Z51.5 *Palliative care* if the patient is attended to by the palliative care consultant – both pieces of information are collected in this case. Where there is a consultant code for the palliative care clinician this can also be entered in addition to the diagnosis code for palliative care.

Q. Is it correct to assign the code K29.70 *Gastritis, unspecified, without mention of haemorrhage* for Antral/Fundal Gastritis as there is no further index entry under Gastritis for Antral or Fundal or should the code for Chronic Gastritis (K29.50 *Chronic gastritis, unspecified, without mention of haemorrhage*) be used as "Antral" and "Fundal" appear as non-essential modifiers at the index entry for chronic gastritis?

A. The correct code for antral gastritis without any further information is K29.70 *Gastritis, unspecified, without mention of haemorrhage*.

Codes from K29.5x *Chronic gastritis, unspecified* –can only be used when the gastritis is documented as chronic. In the alphabetic index under the main term "Gastritis", the term "chronic" is an essential modifier and must be documented in order for the coder to use codes provided at that entry. Only code to the essential modifiers you have documented.

Do you have a HIPE 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.

Acute Kidney Failure and Acute Kidney Injury

Please see Coding Rules below which refers to acute kidney injury.
Coding Rules Ref No: Q2773 | Published On: 15-Mar-2014 | Status: Current
Hypertension due to acute kidney failure
Q: Coding Q&A December *2011* Hypertension due to acute kidney disease advised that:
"Hypertension can arise due to acute kidney disease, therefore *I15.0 Renovascular hypertension* and *I15.1 Hypertension secondary to other kidney disorders* can be assigned as per the guidelines in ACS *0925 Hypertension and related conditions"*
Could you clarify whether the reference to 'acute kidney disease' in the Q&A above also includes acute kidney failure?

A: Unlike chronic kidney disease (CKD) which has a well-established definition, acute kidney disease is a general term with no exact definition being described in the literature, although it has occasionally been used in reference to acute kidney failure, the term which is now widely called acute kidney injury.
The term acute kidney disease in the Q&A cited is used broadly to mean all acute kidney diseases and disorders which have been specified as the cause of hypertension including acute kidney failure and other acute kidney diseases such as acute glomerulonephritis and acute interstitial nephritis.
Assign codes from category N17 *Acute kidney failure* and *I15 Secondary hypertension* when hypertension is documented as being 'due to' or 'secondary to' acute kidney failure' following the guidelines in ACS *0925 Hypertension and related conditions/ Secondary hypertension. (Coding Rules, March 2014)*

Using previous admissions to inform code assignment for diabetes mellitus

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Documentation of diabetes mellitus ACS 0401 Diabetes mellitus and intermediate hyperglycaemia – Education Workshop FAQs. Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q: Can you refer to previous admissions to inform code assignment for diabetes mellitus? How far back in the clinical record can you go for information? Do you use past admissions to gather information about complications of DM to assign codes from E1-.7 - **Diabetes mellitus with multiple complications?*

A: The following statement is included in the *Introduction* to the *Australian Coding Standards* (ACS):
"It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment."
Therefore, previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:

- to assign diabetes mellitus if it has not been documented in the current admission.
- to inform the assignment of diabetes mellitus codes which have contributing conditions which may no longer be relevant or where criteria has changed over previous editions of the classification, e.g. hypertension being used to assign a code for features of insulin resistance.

Upcoming HIPE Portal Reporter Training

Reporter training is now delivered via WebEx in three consecutive half day sessions, over a half day and followed by a full day, and covers all aspects of working on the HIPE Portal Reporter. This course is open to all working within the system who are using HIPE data through the HIPE Portal or through the HOP. Please complete the online training application at: **www.hpo.ie/training.** The next course is scheduled for:

WebEx based Course	Date	Time
HIPE Portal Reporter Training [Part I]	**Tue 16th** February 2016	2:00pm – 4:00pm
HIPE Portal Reporter Training [Part II]	**Wed 17th** February 2016	10:30am – 12:00pm
Using Scripts & Extracts in the HIPE Portal Reporter [Part III]	**Wed 17th** February 2016	2:00pm – 3:30pm

Multiple excisions of skin lesions

8th Edition brought changes to the guidelines on coding multiple excisions of skin lesions. We have had a few queries in on this so please see **Section 5 ACS 0020 Bilateral/multiple procedures** highlighted below. This is a specific section on excision/s of skin lesion/s – please note the instructions and examples. Please note the difference in example 5 for excisions of specific types of warts, anal skin tags and multiple excisions or biopsies of the same lesion.

This section of the standard states that:

5. Skin or subcutaneous lesion removal, excision or biopsy

For multiple excisions or biopsies or removals performed on:

- separate skin lesions: assign relevant code(s) as many times as it is performed
- same lesion: assign relevant code once.

For excision or biopsy or removal of skin lesions repeated during the episode of care at different visits to theatre – see point 1.

EXAMPLE 3:

Excision of two lesions from forearm.

Codes:	31205-00 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of other sites*
	31205-00 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of other sites*

EXAMPLE 4:

Excision of four lesions from eyelid (1) and nose (1) and neck (2).

Codes:	31230-00 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of eyelid*
	31230-01 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of nose*
	31235-01 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of neck*
	31235-01 [1620]	*Excision of lesion(s) of skin and subcutaneous tissue of neck*

EXAMPLE 5:

Assign one code only in the following examples:
- diathermy of anal warts
- diathermy of vulval warts
- removal of plantar warts
- excision of anal skin tags
- multiple excisions or biopsies of the same lesion

EXAMPLE 6:

3 x biopsy of SCC (1) on face.

Code:	30071-00 [1618]	*Biopsy of skin and subcutaneous tissue*

EXAMPLE 7:

Biopsy of BCC on forearm and compound naevus on neck.

Codes:	30071-00 [1618]	*Biopsy of skin and subcutaneous tissue*
	30071-00 [1618]	*Biopsy of skin and subcutaneous tissue*

Additional Diagnoses

Back to Basics.

Recent reviews on HIPE Data and conversations with HIPE coders at coding courses has highlighted the need to remind all coders of the factors to bear in mind when recording additional diagnoses in HIPE

Reviewing the Medical Record

Coders need to review the entire medical record to ensure that all information relevant to the episode is captured – this can include parts of the medical record that are stored electronically. Coders need to be familiar with all sections of the medical record that need to be reviewed to include:

- Discharge letter/summary (if present)
- Progress notes
- Operative reports
- Pathology, Laboratory & Radiology reports (bearing in mind ACS 0010 *General Abstraction Guidelines* – TEST RESULTS)
- Allied Health
- Nursing Notes

Australian Coding Standard 0002 *Additional Diagnoses*

ACS 0002 *Additional Diagnoses* needs to be followed when coding all episodes of care in HIPE.

Coders need to be familiar with all sections of the standard including the following main sections:

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

PROBLEMS AND UNDERLYING CONDITIONS

If a problem with a known underlying cause is being treated, then both conditions should be coded (see also ACS 0001 *Principal diagnosis/Problems and underlying conditions*).

MULTIPLE CODING

There are situations which require the assignment of additional codes to reflect the various components of a disease, which may themselves not meet the above criteria of an additional diagnosis (see also ICD-10-AM Tabular List: *Conventions used in the Tabular List of Diseases/Instructional notes/terms*).

Example I20 – I25 Ischaemic heart diseases – *use additional code to identify the presence of hypertension*

ADDITIONAL DIAGNOSIS REPORTING REFERRED TO IN OTHER STANDARDS

Examples include

- Tobacco use, ACS 0503 *Drug, alcohol and tobacco use disorders*
- ACS 1521 *Conditions complicating pregnancy*
- ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*

RISK FACTORS

Risk factors should only be coded if they meet the additional diagnosis criteria above or another standard indicates they should be coded.

PLEASE REVIEW THE ENTIRE STANDARD TO ENSURE THAT YOUR ARE FAMILIAR WITH THE GUIDELINES FOR CODING ADDITIONAL DIAGNOSES

Additional Diagnoses

Frequently Asked Questions

Frequently asked questions in relation to additional diagnoses include the following:

Q. Is a code for history of cancer always coded?

A. No, it would have to meet criteria in ACS 0002 Additional Diagnoses

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Q. If a patient has cancer is it always coded as an additional diagnoses?

A. No. The condition has to meet criteria in ACS 0002 Additional Diagnoses

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Q. Is hypertension always coded?

A. No. Hypertension has to meet criteria in ACS 0002 – remember ACS 0002 instructs coders to follow the conventions in the tabular list including *code also* instructions and additional diagnoses reporting referred to in other standards

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Q. Why is tobacco use always recorded as an additional diagnosis even if it has no bearing on the episode of care?

A. ACS 0503 *Drug, alcohol and tobacco use disorders* provides guidelines that instructs the coder to assign a code for current tobacco use, or a history of tobacco use, depending on the information provided in the Medical Record. The tobacco does not have to affect the episode of care to be recorded.

2016 HIPE Documentation

As always at this time of year some of the key HIPE documentation is updated. Please see the website www.hpo.ie for 2016 versions of:

- The HIPE Instruction Manual
- The Irish Coding Standards

Please ensure you are using the correct version of these documents. Always keep the previous year's Instruction Manuals and Coding Standards on file as you may need to refer to these when running reports on previous years' data.

Training Calendar 2016

The 2016 training calendar is now available on www.hpo.ie. This is the listing of confirmed courses. As always the HPO will be holding many more courses not listed at this stage as we meet the increasing demands for courses at all levels. For 2016 we have introduced a new 'Train The Trainer' one day workshop**.** This course, on the 9th February, is for HCCs, Coding Managers and Senior Coders who support and mentor coders and will focus on how best to ensure all HIPE coders receive support in their work in these challenging times. It will help the HPO and hospitals plan and prepare training schedules and for all to understand the role we all play in supporting coders in their work. There is another data quality workshop scheduled as well as more specialist workshops and the very popular Anatomy and Physiology sessions continue again this year. The one day Sepsis workshop on 2nd March is one that all should try and attend as along with lots of coding advice there will be a session presented by Dr. Vida Hamilton, The National Clinical Sepsis Lead. All hospitals will benefit from this day.

2015 HIPE Variables
A gentle reminder!

HIPE downloads for discharges since 01/01/2015 onwards were changed to allow the download of specific bed day totals for different types and classes of bed occupancy. This information is needed to ensure that the private chargeable income is appropriately calculated for each patient and is specifically required for the HSE's on-going income projection project. At the same time, information on the critical care bed days was also requested.

A number of hospitals have yet to implement this change which has led to difficulties in determining the hospital income.
A summary of the requested fields is below and in the HIPE Instruction Manual:

Existing HIPE Field (Public & Private Patients)	2015 Field for Single Occupancy (Private Patients)	2015 Field for Multi occupancy (Private Patients)
Number of days in a Public bed	Number of days in a Public bed in a Single Occupancy Room/ Ward	Number of days in a Public bed in a Multiple Occupancy Room/ Ward
Number of days in a Private bed	Number of days in a Private bed in a Single Occupancy Room/ Ward	Number of days in a Private bed in a Multiple Occupancy Room/ Ward
Number of days in a Semi-Private bed	Number of days in a Semi-Private bed in a Single Occupancy Room/Ward	Number of days in a Semi-Private bed in a Multiple Occupancy Room/Ward
Number of days in a ITU bed	Number of days in a ITU bed in a Single Occupancy Room/Ward	Number of days in a ITU bed in a Multiple Occupancy Room/ Ward
and		
Critical Care Bed Days (Public and Private Patients)		

Please check that this information is downloading in your hospital. The easiest way to do this is by checking a recent private case. If the information is not downloading and not appearing on the **Hospital tab** in the data entry, please contact your local IT to work out when this will download.

Hospitals who use the IPMS system who do not have the new fields should immediately contact local IT and arrange for the download to be updated. The changes have been made nationally to the IPMS system in order for these HIPE variables to be downloaded.

2016 HIPE Variables

The download file format for all cases discharged on or after 01/01/2016 has been updated to include two new pieces of information. The first is the inclusion of Work In Progress information, while the second is the inclusion of an extended episode number field patients. These fields are needed for a number of projects including the Patient Level Costing Project. The good news for coders is that these changes will be implemented on hospital systems so require no change in the HIPE Portal, in data entry for coders or in data extracted by coders from patient records. In summary:

1. A Work in Progress case is an inpatient case on the PAS/HIS/IPMS system who is admitted but not discharged. For HIPE download purposes, they need to be included in the download with the existing discharged cases. The patient level costing (PLC) project will use these data to more accurately allocate costs for the hospital. The ABF project will use these data as an indication of the level of short stay and long stay patients in the hospital.

2. Extended episode number field. The episode number field is used to link HIPE data with PAS/HIS/IPMS data for hospital and national projects. If the length of the episode number exceeds eight characters, then you need to download the longer episode number in the extended episode number field.

Upcoming Courses

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

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 January 2016
Time: 10am – 5pm each day
Location: HPO, Brunel Building

Introduction to HIPE

This is a general introduction to the variables collected by HIPE for new coders and others working in the HIPE system.

Date: Tuesday, 15th March 2016
Time: 10.30am – 1pm
Location: WebEx

Coding Skills I

This course is for new coders who have attended the Introduction to HIPE course.

Date: Tuesday, 19th - Thursday, 21st April 2016
Time: 10am – 5pm each day
Location: HPO, Brunel Building

Data Quality Session

Date: Thursday, 28th April 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.

Coding Skills IV— Workshop Sepsis

Full Day course

This course will include a session from the National Clinical Sepsis Lead—Dr. Vida Hamilton.

Date: Wednesday, 2nd March 2016
Time: 10.00 am – 4 pm
Location: HPO, Brunel Building.

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/

Train the Trainer

This course is for HCCs, Coding Managers and Senior Coders who support and mentor coders. The course will focus on how best to ensure all HIPE coders receive support in their work in these challenging times.

Date: Tuesday 9th February 2016
Time: 10am – 4pm
Location: HPO, Brunel Building

Anatomy & Physiology

These courses will be delivered by a specialist speaker.

Anatomy & Physiology—Introduction

****This course is open to all HIPE coders****

Date: Wednesday, 6th April 2016
Time: 11am – 1pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Topic—To be confirmed

Date: Wednesday, 6th April 2016
Time: 2pm—4pm
Location: HPO, Brunel Building & WebEx

Reporter Training

In addition to the regular WebEx Reporter Training sessions (see page 5) this course is being offered as a face to face—'hands on' course. We have had many requests for this course to be held again and this session will suit those who use the reporter on a regular basis.

Date: Tuesday, 12th April 2016
Time: 10.30am-12.30pm
Location: HPO, Brunel Building

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

Thought for Today

"What the New Year brings to you will depend a great deal on what you bring to the New Year."

— Vern McLellan