Coding Notes

Healthcare Pricing Office

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2016 HIPE Data in Action

2016 has been another busy year for everyone working in HIPE across all the hospitals and in the HPO. HIPE data are being used increasingly throughout the healthcare system. In this edition of *Coding Notes* there are articles on a number of recently published reports produced thanks to HIPE data. *The HIPE Activity in Acute Public Hospitals in Ireland 2015* report has just been published. This is the annual publication of HIPE activity and it a very useful publication providing lots of information on HIPE data (see page 2). It is available for download at www.hpo.ie. This is the first HIPE report published using 8th edition of ICD-10-AM/ACHI/ACS/ICS. Along with the introduction of 8th edition for clinical coding there is also now an 8th edition ARDRG Grouper. Pages 5 to 6 of this edition of *Coding Notes* give a very good introduction to this updated grouper.

The National Office for Clinical Audit (NOCA) recently published their first report on The National Audit of Hospital Mortality (NAHM) which uses HIPE data as it main source of information (see page 4). This audit monitors hospitals closely using HIPE data returns.

The first *National Sepsis Report* was launched at the National Patient Safety conference in November 2016 (see page 9). The collaboration between HIPE coders and the Sepsis Programme has been very important in ensuring that the data available to manage and monitor this life threatening condition are robust. Over 240 clinical coders have now attended the Sepsis workshop organised by the HPO. With a Sepsis ADON in each hospital group and a sepsis committee in many hospitals, it is good that these contacts are maintained to ensure the data continues to reflect patient activity through HIPE. A document containing many of the sepsis coding queries arising from the training courses has now been prepared and has been distributed to all clinical coders shortly. It is a challenging area to code and the commitment to the education has been excellent from HIPE staff.

There is an update on the *National Audit of Admitted Patient information in Irish Hospitals, September 2016* on page 10. The HPO are working on the recommendations in this report to provide support and to develop HIPE.

With a new year also comes new documentation and the team at the HPO have now prepared the 2017 *Instruction Manual*, *Irish Coding Standards* V9.0 for 2017 and also the 2017 *HIPE Training Calendar* (see pages 3 & 4).

For 2017 in HIPE there is now a facility to capture the medical discharge date. While this will usually be the same as the discharge date, sometimes it will be before the patient is discharged from the hospital . Other changes are detailed on page 4 and the new Instruction Manual will be available for download at www.hpo.ie.

Also available for download will be the 2017 *Irish Coding Standards V9.0* . This has two new standards and one standards has been deleted. Some clarification has been added to some of the existing standards. Please see page 3 for further information. An important addition to the ICS V9.0 is the inclusion of a revised Code of Ethics for Clinical Coders. The Australian Consortium for Classification Development (ACCD) who develop and support ICD-10-AM/ACHI/ACS have published a significant and important revision of the Code of Ethics for Clinical Coders. HIPE coders often reference this Code of Ethics in discussions at courses at the HPO and at hospital level. It is important with increasing pressures on everyone to remember what we do and why we do it.

The 2017 Training Calendar is now available for download at www.hpo.ie. Page 12 has details of upcoming courses. There are some one day workshops coming up in 2017 on Diabetes, Stroke & Circulatory. An article on page 11 details data quality work including training carried out in 2016.

Thanks to everyone for the continued dedication and hard work to ensure that timely and accurate HIPE data are available for so many uses across the system. It is an important national data set produced by the continuing hard work of HIPE clinical coders working with the HPO to ensure the best data are available for all.

Many thanks and a very Happy Christmas and a peaceful new year to all.

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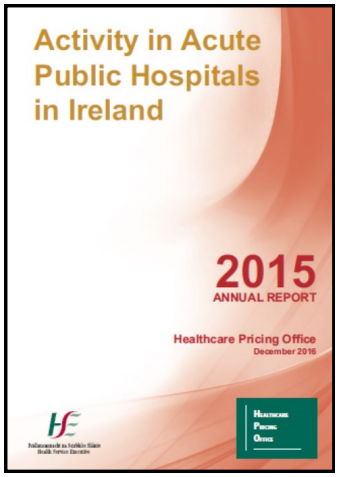
Activity in Acute Public Hospitals In Ireland 2015



This report presents information on coded discharges from 54 Irish acute public hospitals participating in HIPE in 2015. This report is made possible through all of the hard work done by 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. Figure 1 below provides details of the admission type for total discharges as reported to HIPE for 2011-2015. The full report is now available for download on www.hpo.ie.

Main findings of the 2015 Report

Total Discharges

- Over 1.66 million discharges were reported by participating hospitals compared to 1.59 million discharges in 2014 which is an increase of 4.5%. The increase in discharges reported to HIPE between 2011 and 2015 was 13.0%.
- Day patients accounted for 61.9% of total discharges in 2015, an increase of 7.2% since 2014. This is due in part to the addition of activity from St. Luke's Radiation Oncology Network centres located in Beaumont and St. James's hospitals.
- Discharges aged 65 years and over accounted for 35.8% of total discharges, representing an increase of 7.9% since 2014 and an increase of 23.9% since 2011.

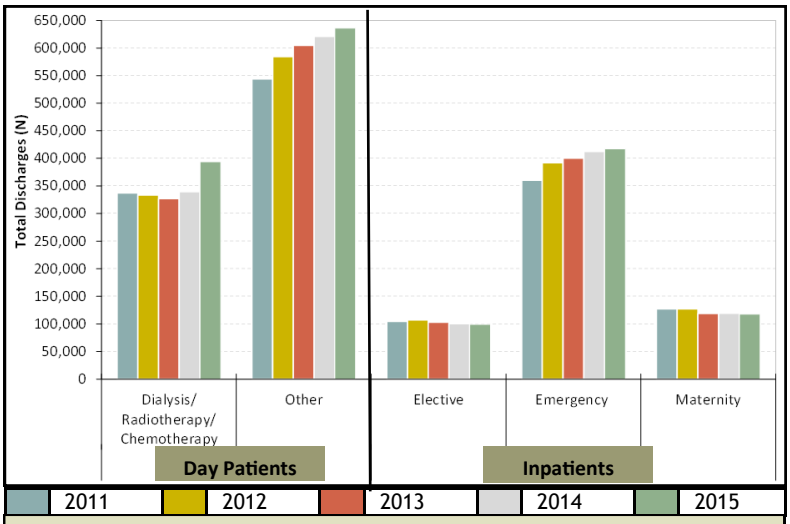


Figure 1: Admission type for total discharges as reported to HIPE for 2011-2015 by Day and Inpatients

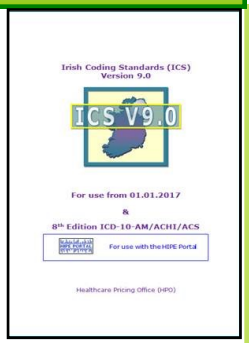
Length of stay

- Nationally, in-patient average length of stay was 5.7 days in 2015 compared to 5.9 days in 2011, a decrease of 3.4%.

Mean Number of Diagnoses and Procedures Reported

- The mean number of diagnoses recorded for total discharges was 2.7.
- The mean number of diagnoses recorded for in-patient discharges was 3.7 compared to 2.0 for day patients.
- A principal procedure was recorded for 79.3% of total discharges.
- For those discharges who underwent at least one procedure, in-patient discharges had a mean number of 2.8 procedures recorded, compared to a mean of 1.5 procedures for day patients.

The Irish Coding Standards (ICS) Version 9.0



Irish Coding Standard (ICS) V9.0 has two new standards and has had one standard deleted. It contains major updates to **ICS 01X0** *Zika Virus*, **ICS 0029** *Coding of contracted procedures*. The HIPE Guidelines for administrative data have been updated to state that elective AMAU activity is not collected by HIPE. There is also now an Appendix B with the revised Code of Ethics for Coders (see below).

Details of Changes to ICS

New standard **ICS *0028*** *Retroperitoneal Lymph Node Dissection* provides additional guidance on the coding of retroperitoneal lymph node dissection and when this procedure is performed following chemotherapy for testicular cancer.

New Standard **ICS 02X1** *Radiotherapy Planning* provides clarification on the coding of admission for radiotherapy planning only

Deleted Standard **ICS 02X0** *Classification of Attendances at Oncology Day Wards* has been deleted as the information collected by the flag is available through data analysis.

ICS 0029 *Coding of Contracted Procedures* has been updated to advise hospitals on valid HIPE activity performed off site.

HIPE Guidelines for Administrative Data – elective admissions to Acute Medical Assessment Units has been added to the list of activity not collected by HIPE (Item VIII). Also the instructions in item III Acute Medical Assessment Units in this section have been updated to reflect this change.

ICS 01X0 *ZIKA Virus WHO Alert* has been extensively updated to incorporate coding advice from ACCD.

Standards for Ethical Conduct in Clinical Coding

The Australian Consortium for Classification Development (ACCD) who develop and support ICD-10-AM/ACHI/ACS have published a significant and important revision of the Code of Ethics for Clinical Coders. This revised code of ethics is now included in the 2017 Irish Coding Standards as an appendix. Please be sure and read this to understand this important aspect of our work in HIPE clinical coding.

The Code of Ethics for Clinical Coders has been in the Appendices of the Australian Coding Standards since its inception (July 1998). The ICD Technical Group (ITG) in Australia suggested that ACCD undertake a revision of the code of ethics in line with changes within the industry. This update was not because it was thought that clinical coders were doing the wrong thing, but because feedback was indicating that clinical coders need a more detailed document to protect them if they are asked to do something that could seem unethical during the coding process.

ACCD undertook a revision of the existing code of ethics, with consideration of issues such as:

- What information is required in a code of ethics in today's coding setting?
- What is impacting on clinical coding in the current environment?
- Why do we have a code of ethics?
- What ethical issues are impacting upon the clinical coding workforce?
- Are clinical coders being pressured to write unethical clinician queries?

The new Standards for ethical conduct in clinical coding has three components:

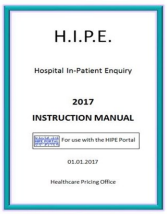
1. Ethics in Clinical Coding Practice
2. Ethics in Clinical Coding Quality and Education
3. Ethics in Clinical Coding and Legal Requirements

1. Ethics in Clinical Coding Practice details the ethics that should be upheld in day to day coding, including clinician queries.

2. Ethics in Clinical Coding Quality and Education details clinical coder participation in activities to improve coding practice within the work environment, and developing the profession.

3. Ethics in Clinical Coding and Legal Requirements details legal ethics, however it does not replace any legal requirement placed on clinical coders.

2017 Instruction Manual



Each year a new Instruction Manual is published to reflect any changes in variables collected by HIPE. It is important that all HIPE coders are familiar with the changes that occur each year.

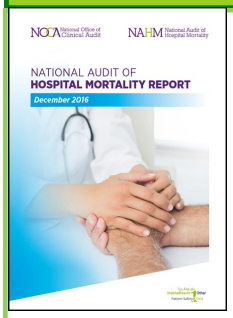
Main Changes in 2017 HIPE Instruction Manual:

- HIPE Summary sheet updated for 2017
- New variable – **Medical Discharge Date**: to be collected when medical discharge date/ medically fit for discharge is documented. This information may also be available for IPMs download if populated.
- New Mode of Emergency Admission added *6: Local Injury Unit: Admission Directly from a HSE listed Local Injury Unit.*
- Instructions added to clarify that Elective AMAU activity is not to be reported to HIPE
- Source of Admission 3 clarified to state transfer of "Admitted patient"
- Reference to HIPE hospital code list removed from Source of Admission *4 Transfer from Non-acute hospital* and *5 Transfer from Hospice*
- Private insurer Aviva changed to Irish Life Health
- List of 2017 dates for download and export added.

The HIPE Portal has been updated to recognise all these changes for patients discharged in 2017.
If you have any questions on the above changes please contact HIPEcoding@hpo.ie.

The 2017 Instruction Manual will be available on www.hpo.ie and a hard copies will be despatched to all hospitals.

NOCA National Audit of Hospital Mortality



NOCA Launches its First Report on In-Hospital Mortality

Available at: www.noca.ie/publications

On 15th December 2016 The National Office of Clinical Audit (NOCA) announces the launch of their first report from National Audit of Hospital Mortality. The data used in this report is HIPE data. Mr Brian O'Mahony, Public Representative on the NAHM Governance Committee launched the report at a meeting in the Royal College of Surgeons in Ireland . This report presents information across five common conditions: acute myocardial infarction (AMI), heart failure, ischaemic stroke, haemorrhagic stroke and chronic obstructive pulmonary disease (COPD) & bronchiectasis in a clear and transparent manner which will be of interest to patients. Mr O'Mahony said "everyone will be a hospital patient at some stage during their lives and will expect to receive care of the highest quality. The ongoing work of NAHM should lead to better patient care and outcomes for patients."

Dr Philip Crowley, National Director, Quality Improvement Division, HSE, stated "this report is a significant step to further understanding, and most importantly promoting, the continuous improvement of the quality and safety of care provided in our acute hospitals." The purpose of the report is to assure patients, families, the public and the wider health system that hospital mortality is continuously monitored. Structures exist within hospitals to investigate areas of concern and implement improvements as required.

Key Findings:

This report presents a crude in-hospital mortality rate[1] between 2005 and 2015.

- In AMI there was a significant reduction in deaths per 100 admissions from 11.1 deaths in 2005 to 5.9 in 2015.
- For heart failure, there was a small but significant reduction from 9.6 deaths in 2005 to 7.9 in 2015.
- For ischaemic stroke, there was a small but significant reduction from 14.2 deaths in 2005 to 10.5 in 2015.
- There was almost no change for haemorrhagic stroke and COPD & bronchiectasis.

Source: *NOCA NAHM Press Release, 16.12.2016 (abridged)*

[1] Crude in-hospital mortality rate: this is a measure of the number of deaths per 100 admissions.

Grouper Change from AR-DRG Version 6.0 to Version 8.0

The Irish system updated to the 8th edition of ICD-10-AM/ACHI/ACS for all discharges on or after 1st January 2015. The follow on from this is the move of the Grouper from AR-DRG V6.0 to V8.0. The last change in the AR-DRG classification in Ireland was from V5.1 to V6.0 in 2009. It is important that all users of the AR-DRG system are aware of and understand the differences between V6.0 and V8.0. The major changes in AR-DRG V8.0 are outlined here.

Revision of ADRG Splitting:

Version 8.0 sees a major change in the methodology used to measure case complexity. The new model represents a significant shift away from the Patient Clinical Complexity Level (PCCL) model using Complications and Comorbidities (C&Cs), and allows for greater scope and precision in splitting Adjacent DRGs (ADRGs) into DRGs.

- The number of DRGs has increased from 698 in V6.0 to 807 in V8.0.
- The number of ADRGs has increased from 399 in V6.0 to 406 in V8.0.
- In V8.0 there were 194 splits *added* and 22 splits *removed.*

Version	V6.0	V8.0
ADRG splitting	**Number of ADRGs**	
No split (Z)	156	85
One split (A,B)	192	246
Two splits (A,B,C)	46	70
Three splits (A,B,C,D)	5	5
Total ADRGs	399	406
Total DRGs	698	807

Table 1 Changes in ADRG splitting

ADRGs added in AR-DRG Version 8.0

There were 14 ADRGs added in V8.0 (see Table 2). One change to note in this table is the addition of ADRG Z66 *Sleep disorders* to V8.0. The majority of the cases in this ADRG were grouped to U65 *Anxiety disorders in* V6.0. This accounts for the majority of the episodes that moved from MDC 19 *Mental diseases and disorders* in V6.0 to MDC 23 *Factors influencing health status and other contacts with health services* in V8.0.

ADRGs Added to Version 8.0		Examples of where cases were grouped in Version 6.0
I40	Infusions for Musculoskeletal Disorders, Same day	I68 Non-surgical spinal disorders I71 Other musculotendinous disorders I66 Inflammatory Musculoskeletal Disorders
I80	Femoral Fractures, Transferred to Acute Facility <2 Days	I78 Fractures of Neck of Femur
I81	Musculoskeletal Injuries, Same day	I74 Injury to Forearm, Wrist, Hand or Foot I75 Injury to Shoulder, Arm, Elbow, Knee, Leg or Ankle
I82	Other Same day Treatment for Musculoskeletal Disorders	I68 Non-surgical Spinal Disorders I71 Other Musculotendinous Disorders
K10	Revisional and Open Bariatric Procedures	K04 Major Procedures for Obesity
K11	Major Laparoscopic Bariatric Procedures	K04 Major Procedures for Obesity
K12	Other Bariatric Procedures	K07 Obesity Procedures
K13	Plastic OR Procedures for Endocrine, Nutritional and Metabolic Disorders	K07 Obesity Procedures
P07	Neonate, AdmWt <750g W Significant OR Procedure	P61 Neonate, AdmWt <750 g
P08	Neonate, AdmWt 750-999g W Significant OR Procedure	P62 Neonate, AdmWt 750-999 g
P68	Neonate, AdmWt >=2500g W/O Sig OR Proc/ Vent>=96hrs, >=37 Completed Wks Gestation	P67 Neonate, AdmWt > 2499 g W/O Significant OR Procedure
V65	Treatment for Alcohol Disorders, Same day	V60 Alcohol Intoxication and Withdrawal V62 Alcohol Use Disorder and Dependence
V66	Treatment for Drug Disorders, Same day	V61 Drug Intoxication and Withdrawal
Z66	Sleep Disorders	U65 Anxiety Disorders

Table 2 Additional ADRGs in AR-DRG Version 8.0

Grouper Change from AR-DRG Version 6.0 to Version 8.0

Continued.

ADRGs removed in AR-DRG Version 8.0

There were seven ADRGs removed in V8.0 (see Table 3). Some of these have grouped to pre-existing DRGs, while some have grouped to new DRGs.

Note that all cases previously in R64 *Radiotherapy* have grouped to R62 *Other neoplastic disorders* in V8.0, with the majority grouping to R62C *Other Neoplastic Disorders, Minor Complexity*.

ADRG Removed from Version 6.0		Examples of where cases grouped to in Version 8.0
G62	Complicated Peptic Ulcer	G70 Other digestive system disorders
G63	Uncomplicated Peptic Ulcer	G70 Other digestive system disorders
K04	Major Procedures for Obesity	K10 Revisional and open bariatric procedures K11 Major laparoscopic bariatric procedures
K07	Obesity Procedures	K13 Plastic OR procedures for endocrine, nutritional and metabolic disorders
O64	False Labour	O66 Antenatal and other obstetric admission
R64	Radiotherapy	R62 Other neoplastic disorders
S60	HIV, Same day	S65 Human immunodeficiency virus

Table 3 ADRGs in 6th Edition removed in 8th Edition

Additional changes

Along with ADRGs being added and removed, there have been changes to a number of ADRGs that are present in both V6.0 and V8.0 of the classification. One of these changes relates to ADRG A06 *Tracheostomy and/or Ventilation >=96hours,* whereby in V8.0 while the majority of cases remained in A06 *Tracheostomy and/or Ventilation >=96hours*, a small number of cases moved to W01 *Ventilation, Tracheostomy and Cranial Procedures for Multiple Significant Trauma*, and W60 *Multiple Significant Trauma, Died or Transferred to Acute Facility <5 Days.*

Changes in complexity split

The highlight of V8.0 is the complete revision of the case complexity methodology within the DRG classification. All AR-DRG splits have been revised using the Episode Clinical Complexity (ECC) Model. As a result, an ADRG may be the same in both versions but may have different DRG splits. For example, while O60 *Vaginal delivery* is present in both V6.0 and V8.0, V6.0 has no split (O60Z) while V8.0 has two splits – O60A, O60B and O60C.

Effect of the Episode Clinical Complexity (ECC) Model on splits

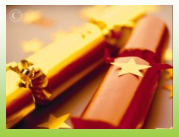
The components of the ECC Model affect DRG assignment. For example, B70 *Stroke and Other Cerebrovascular Disorders* is present in both V6.0 and V8.0, with the same number of splits in each. However, the number of episodes within the splits has changed. For example, analysis of HIPE data showed that just over half of B70A *Stroke and Other Cerebrovascular Disorders W Catastrophic CC* in V6.0 grouped to B70A *Stroke and Other Cerebrovascular Disorders, Major Complexity* in V8.0. The remainder grouped to B70B *Stroke and Other Cerebrovascular Disorders, Intermediate Complexity* and B70C *Stroke and Other Cerebrovascular Disorders, Minor Complexity*.

MDC logic flowcharts

The grouping of cases to ADRGs is controlled by logic flowcharts. There is a separate flowchart for each MDC (including Pre MDC). Branches in the flow charts are ordered from highest to lowest resource usage, and there have been changes in the logic in some of these flowcharts in V8.0.

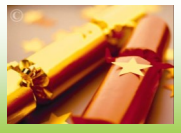
Even when there is no change to a DRG, its contents can be affected by other DRG changes or changes to the grouping logic. For example, not all cases of Pre MDC A05Z *Heart Transplant* in V6.0 group to the same ADRG in V8.0. Some cases may fall into A10Z *Insertion of ventricular assist device* in V8.0. This may occur as the selection for A10Z *Insertion of ventricular assist device* in V8.0 comes before the selection for A05Z *Heart Transplant* in the grouping logic, whereas in V6.0 A05Z *Heart Transplant* was listed before A10Z *Insertion of ventricular assist device*.

Further information on the revision of the case complexity model and the changes from AR-DRG V6.0 to V8.0 is available in the presentation "Change from AR-DRG V6.0 to V8.0" on www.hpo.ie.



Cracking the Code

A selection of Coding Queries



2017 variables:

Q. A patient is seen at the Local injury Unit and then sent to ED. He is admitted from the ED as an inpatient – what Mode of Emergency admission do I use for a 2017 discharge?

A. A new mode of emergency admission for "Admission Directly From a HSE listed Local Injury Unit" (LIU) is available in 2017; *Mode of Emergency Admission 6 : Local Injury Unit.* However as this patient was not admitted directly from the LIU the correct mode of Emergency admission will be *1: Emergency Department*.

Q. A patient is told to come back to the Acute Medical Assessment Unit for blood tests and is booked to come in the following week electively– how is the attendance for the visit when the blood test is done coded?

A. Elective attendances at Acute Medical Assessment Units (AMAUs) are not collected by HIPE. This activity is to be reported as OPD activity. Only emergency activity is collected by HIPE for AMUs.

Q. A patient is admitted with a stroke and recovers well, however the clinician has documented clearly in the chart that the patient is medically discharged. The patient remains in the hospital for another week while community services are put in place. Can I enter the date the patient is medically discharged as well as the actual discharge date?

A. Yes, in 2017 a field is available to record Medical Discharge Date when this is documented. In the scenario above as the medical discharge date is clearly documented and the patient is remaining in hospital for services to be arranged rather than for medical care the medical discharge date can be recorded in addition to the discharge date.

General Coding Queries

Q. A patient has been documented as having a diagnosis of "lung cancer, smoking related" what codes are assigned when the patient returns for chemotherapy related to the lung cancer?

Please see ACS 0503 *Drug, Alcohol and Tobacco use disorders*:

Example 6:

A 65 year old patient has a history of smoking 40 cigarettes per day from the age of 15 until quitting at 51 years. The documented principal diagnosis is emphysema/smoker.

Codes: J43.9 Emphysema, unspecified
F17.1 Mental and behavioural disorders due to use of tobacco, harmful use

Z86.43 should not be assigned as there is a condition documented as being related to tobacco use. A code from *F171 Mental and behavioural disorders due to use of tobacco, harmful use* is used whether the patient is currently smoking or not.

In Standard ACS 0503 *Drug, Alcohol and Tobacco use disorders* please also review the section on Z72.0 *Tobacco use, current*, which states: "This code should be assigned only when sufficient information is not available to assign F17.2 Tobacco dependence syndrome or F17.1 Harmful use of tobacco".

Q. What ACHI code is assigned for a robotic assisted laparoscopic nephrectomy?

A. For a robotic assisted laparoscopic nephrectomy please code this to the laparoscopic nephrectomy. The specific code will depend on whether this is a partial or total nephrectomy or if unilateral or bilateral. There are laparoscopic options for all of these nephrectomies.

There are no procedure codes in 8th edition ACHI to indicate the robotic assistance therefore please code to the nature of the procedure being performed.

Q. The patient is admitted for drainage of a Pilonidal Cyst under GA. Procedure cancelled as the patient went into Severe Bronchospasm while under GA and was intubated. How is this coded?

A. If this is an adverse reaction to the anaesthetic drug code as follows:

L05.9 Pilonidal Cyst without Abscess
Z53.0 Procedure not carried out because of contraindication
J98.0 Diseases of Bronchus, NEC.
Y48.2 Other and unspecified GA (adverse effect)

92514-99 (1910) General Anaesthesia, ASA 99

The procedural complication code is not used if this is an adverse effect of the anaesthetic.

If this is a complication of the delivery of the anaesthetic or around the procedure of anaesthesia rather than the drug itself code as follows:

L05.9 Pilonidal Cyst without Abscess
Z53.0 Procedure not carried out because of contraindication
T88.5 Complications of anaesthesia
J98.0 Diseases of Bronchus, NEC
Y84.8 Other medical procedures
Y92.22 Health service area
92514-99 (1910) General Anaesthesia, ASA 99

Please also refer to the advice in Coding Rules Ref No: TN200 | Published On: 15-Jun-2009 | Status: Updated | Updated On: 30-Jun-2013 which covers this type of query although a different scenario of headache due to anaesthesia.

Cracking the Code

A selection of Coding Queries

How is Carbapenem Resistant Enterobacteriaceae coded?

Medical information:

Enterobacteriaceae are a family of aerobic and anaerobic gram-negative bacteria that includes both normal and pathogenic entericmicroorganisms. Among the significant genera of the family are Escherichia, Klebsiella, Proteus, and Salmonella. Carbapenemase Producing Enterobacteriaceae (CPE) produce carbapenemase enzymes that can break down many types of antibiotics, making the bacteria very resistant.

There is no specific code in ICD-10-AM for Carbapenemase producing enterobacteriaceae. The infection must meet ACS 0002 *Additional Diagnosis* and that would be in the circumstances of an infection that was resistant to Carbapenem. A code for the site of the infection would be required plus a code from B95-B96 *Bacterial, Viral and Other Infectious Agents,* if appropriate and also assign Z06.53 *Extended spectrum beta-lactamase [ESBL] resistance*.

Q. **What code is assigned for bronchoscopy with Argon Plasma Coagulation (APC)?**

A. Background information:

Argon is a gas that behaves like a liquid, and can be used to treat tumours and control bleeding in the airways. With argon plasma coagulation (APC), the argon gas is passed through the bronchoscope. At the same time, an electrical current is applied, converting the gas into a liquid plasma. The plasma applies itself to tumours, bending to conform to the precise shape. This kills cancerous cells without touching the tumour, which is important for tumours that are bleeding.

Classification:

The procedure classification does have some entries for argon plasma coagulation (look up main term **Coagulation**) but there is no site related to the lung. In the absence of a specific code for APC of any respiratory tract site please use the code below.

90181-00 [558] *Destruction procedures on lung*

Irreversible electroporation [IRE] of lung lesion/tumour
Laser destruction of lung lesion/tumour
Radiofrequency ablation of lung lesion/tumour

Q. We have come across obstetrics patients recently who had CSE (Combined Epidural and Spinal anaesthesia) documented in their charts . Patient one had a greatly elevated BMI and patient two had a history of heart disease. How is this type of anaesthesia coded?

A. When CSE is administered, this is classified as a Neuraxial Block.

A code for Neuraxial block is a assigned when a caudal, epidural and/or spinal block is administered, either via injection or infusion. The code assignment will also depend on whether the anaesthesia is for pain relief during labour, for labour and delivery, or for delivery only.

Code assignment will be as follows:

• Assign 92506-XX [1333] Neuraxial block during labour where a caudal, epidural and/or spinal block is administered, either via injection or infusion, for pain relief during labour.

• Where the labour progresses to delivery via a caesarean section, and the neuraxial block is continued for that procedure or any other delivery procedure assign 92507-XX [1333] Neuraxial block during labour and delivery procedure.

• 92507-XX [1333] Neuraxial block during labour and delivery procedure may also be assigned when following a vaginal delivery, the same neuraxial block is continued for postpartum procedures such as removal of retained placenta and/or repair of obstetrical trauma.

Please note that 92506-XX [1333] Neuraxial block during labour and 92507-XX [1333] Neuraxial block during labour and delivery procedure will not be assigned on the same episode.

- In cases where a neuraxial block is administered only for anaesthesia for caesarean section or delivery procedure, assign 92508-XX [1909] Neuraxial block.

Please note that codes 92506-XX [1333] Neuraxial block during labour and 92507-XX [1333] Neuraxial block during labour and delivery procedure will not be assigned with 92508-XX [1909] Neuraxial block on the same delivery episode. Coders will not assign any combination of these codes for the same labour/ delivery.

See also article in September 2016 Coding Notes (pp. 4-5)

Do you have a HIPE coding query?

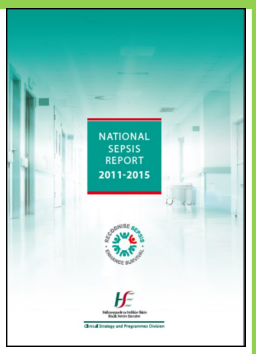
Please email your query to: **hipecodingquery@hpo.ie**

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.

The National Sepsis Report 2011 – 2015



This first national sepsis report highlights the importance of HIPE data for the purposes of monitoring quality improvement projects, in particular sepsis. The report can be found at http://hse.ie/eng/about/Who/clinical/natclinprog/sepsis/SEPSIS-REPORTS.PDF. The Hospital In-Patient Enquiry (HIPE) system was used as the data source.

Key findings:

1. Sepsis-associated

- incidence and associated mortality increases with age
- mortality increases with co-morbidities
- mortality increases in winter
- the most common sites of infection are the respiratory tract, the abdomen and the urinary tract
-

2. In 2015

- there were 10,000 cases documented
- average crude hospital mortality rate was 20.7%
- sepsis was associated with 2% of admissions and 18.8% of mortalities
- 30% of cases were admitted to critical care
- the mortality in cases admitted to critical care was 33.4%
- all critical care sites were equally efficacious

3. Between 2011 and 2015

- the number of cases increased by 37%
- the average length of stay decreased by 13.6%
- the mortality decreased by 15%

Launching the report, Dr Vida Hamilton, HSE National Clinical Lead for Sepsis, stated that "We have an ageing population, by 2041 it is estimated that 25% of the population will be over 65 years, and that sepsis is an age-related condition. The most effective therapy is early recognition and treatment and this occurs in the Emergency Departments and on the Hospital Wards. The Centre for Disease Control (CDC) has reported that 70-80% of all sepsis cases are admitted from the community. Credit must be given to the acute hospitals, all of whom have put together sepsis committees to provide education, training and support to the front line staff who care for these patients in an environment of limited resources and competing priorities." Launch statement 8th December 2016 (Abridged).

A series of sepsis workshops were held throughout 2016 in conjunction with Dr Hamilton. A document with a list of queries on documentation and the classification of sepsis that were reviewed by HPO has been sent by e-mail to all Coders and HCCs (see example below). If you did not receive a copy of this document and would like to receive a copy, please contact hipe.training@hpo.ie

Documentation when coding

If there is incomplete documentation, or where further clarification is required please refer the case back to the treating clinician, infection control nurse or your hospital's Sepsis Committee. If further information is not available at your hospital please contact the ADON (assistant direct of nursing) from National Sepsis Programme for your region. Contact details for the National Sepsis Programme staff are available at http://hse.ie/eng/about/Who/clinical/natclinprog/sepsis/

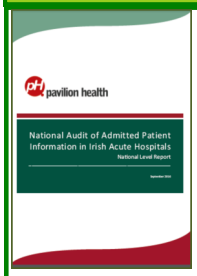
Coding Example

Q . It was mentioned at the Sepsis workshop that if there is documentation of sepsis and SIRS in the medical record that we assign a code for both, however in ACS *Sepsis, severe sepsis and septic shock* under the definitions section, it says that Sepsis is the clinical syndrome defined by the presence of both infection and a systemic inflammatory response. With this in mind is assigning and additional code for SIRS not over coding?

A. You are correct that Sepsis is the clinical syndrome defined by the presence of both infection and a systemic inflammatory response, but the National Clinical Lead on Sepsis advised that 15% of patients who have sepsis do not have SIRS therefore where there is documentation of SIRS in a patient with sepsis an additional code is assigned for the SIRS.

National Audit of Admitted Patient Information in Irish Hospitals

Update



Background of the project

As part of the move to funding through Activity Based Funding (ABF), the HPO identified the need to assess the quality of activity data, to provide assurance that ABF is based on robust information and to identify areas for improvement where necessary. We recognised that we did not have the capacity to complete this work alone so engaged Pavilion Healthcare (through a competitive tender process) to collaborate with us.

The study asked two main questions:

1. is HIPE of sufficient quality to underpin activity based funding?
2. if improvement is needed – where and how?

The study was unique because we took a multidimensional approach and examined coded data from multiple angles, including the assessment of data quality, the implications of variation in quality and actions needed to improve quality overall.

Findings

Good news! The project found that HIPE is of sufficient quality to underpin ABF. However there is variation in coding quality across Ireland and this variation should be reduced.

Elements of the project

Financial implications of variations in capture of complexity
ADRG Benchmarking quantitative analysis.

Objective assessment of compliance with coding rules and measurement of relative data quality
PICQ© tool.

Compare coded activity to charts
Chart audit using HCAT© tool (sample from 10 hospitals).

Assessment of coding service
Qualitative analysis with workshop, interviews and questionnaire.

Results
Pulling together the various methods to come up with a conclusion on data quality and the people and processes underlying it's delivery.

Action plan development
with individual hospitals and at national level.

Thank you!
This project could not have been completed without the support of the Irish coding community – thank you for your help, support and commitment!

Summary Update

Coder resources – Clinical coder posts have been approved and more coders are being recruited across the system.
Improved understanding of coded data - Many hospitals are implementing meetings between coding, finance and clinical leads to explore their own activity further and to understand how it influences funding
Data Quality – as additional resources come on board more coders are making time to use the existing data quality tools to check their own work (e.g. Checker , HCAT)
Increased clinical engagement – some coders have implemented processes to make it easier to follow up with clinicians to clarify documentation, more coders are getting involved in training NCHDs on the challenges for coding from charts.
Training – coders are attending training courses in increasing numbers, at the same time the HPO are expanding the training offering to other stakeholders including hospital management and finance

And plenty more to do….

Update on Audit training and use of Data Quality tools

HCAT & Checker Training in 2016

91 HIPE staff attended HCAT and/or Checker training and 38 hospitals were represented.

Hands on HCAT training was held during 2016 and a number of these courses involved hands on practical sessions. The feedback from these sessions has been very positive and we will run additional HCAT training in 2017 and expand on the audit training provided.

The majority of hospitals are now using the Checker data quality tool on a monthly basis and an extensive programme of Checker training was provided in 2016. Hands on training was provided and the HPO also facilitated site specific webex sessions. To request further training on the Checker please contact us.

Data quality sessions:

In 2016, 4 Data Quality WebEx sessions were held and almost 100 people participated. The sessions aim to provide hospitals with an update on data quality issues and highlight areas that are flagged for further review. We regularly cover areas where queries have arisen, explain results of reviews and highlight areas identified by chart based audits. In 2016 we also addressed topics in relation the *National Audit of Admitted Information in Irish Acute Hospitals* report. A schedule of sessions is 2017 provided on the HIPE Training calendar – it is an important way to keep in contact regarding data quality issues. If there is a topic you would like covered please let us know.

Chart based Audits:

The HPO are rolling out a national audit schedule and will contact hospitals in this regard. Following on from the 10 chart based audits conducted as part of the *National Audit of Admitted Information in Irish Acute Hospitals,* the HPO performed 5 chart based audits in 2016. The schedule of audits will be expanded in 2017.

Data Quality reviews:

HIPE data is subject to on-going monitoring and review. These checks can arise from various sources and hospitals are contacted in order to ensure that data is reported correctly. The national file for 2016 is under review and in particular reviews of high and low frequency reporting of codes and AR DRGs. The HPO will be reviewing a number of areas in 2017 including topics such as the Hospital Acquired Diagnosis indicator.

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]	Thursday, 9th February	10:30am – 12:00pm
HIPE Portal Reporter Training [Part II]	Thursday, 9th February	2:00pm – 4:00pm
Using Scripts & Extracts in the HIPE Portal Reporter [Part III]	Friday, 10th February	10:30am – 12:00pm

2017 HIPE Training Calendar is now available on www.hpo.ie

Upcoming Courses

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

DON'T BE A DNA!

If you register for a WebEx or HPO course and cannot participate please let the HPO know immediately.

Recently we have had a number of people not taking up places on courses they have booked on to. We understand that circum stances can change and cancellations are unavoidable but please let us know if you will not be attending. Along with all the prepa-ration that goes into each course delivered these courses are often booked out with waiting lists. Non or late cancellation is both unfair to other coders and also to those organising these courses. Please do not sign up for course that you will not be attending and if you realise you cannot attend a course please let us know as soon as possible.

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, 10th January 2017
Time: 10.30am – 1pm
Location: WebEx Only

Coding Skills I

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

Date: Tuesday, 17th - Thursday, 19th January 2017
Time: 10am – 5pm each day
Location: HPO, Brunel Building

Coding Skills II

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

Date: Tuesday 14th – Thursday 16th February
Time: 10am - 5pm each day.
Location: HPO, Brunel Building only

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: Wednesday, 8th March 2017
Time: 10.30am – 1pm
Location: WebEx Only

Data Quality Session

Date: Thursday, 30th March 2017
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.

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/

Anatomy & Physiology

****This courses are open to all HIPE coders****

These courses will be delivered by a specialist speaker.

Anatomy & Physiology—Introduction
Date: Tuesday, 21st March 2016
Time: 11am – 1pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Respiratory System
Date: Tuesday, 21st March 2016
Time: 2pm—4pm
Location: HPO, Brunel Building & WebEx

Coding Skills IV— Workshops

Endoscopies Workshop

This workshop is open to HIPE coders of all levels and experi-ence. It covers all the important guidelines associated with endoscopy coding.

Dates: Wednesday, 1st February 2017
Time : 10.30 am -1pm
Location: WebEx Only

Full Day Diabetes Workshop

Dates: Wednesday, 8th February 2017
Time : 10.00 am –5pm
Location: HPO, Brunel Building Only

Full Day Stroke and Circulatory Workshop

Dates: Wednesday, 22nd February 2017
Time : 10.00 am –5pm
Location: HPO, Brunel Building Only

Guest Speaker

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

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

Ralph Waldo Emerson - 1803-1882, Essayist, Lecturer, and Poet