Coding Notes

Healthcare Pricing Office

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1.7 million HIPE records in '17!

As 2017 draws to a close it is a good time to reflect on the fantastic work done by all working in HIPE across the country. Meeting the deadlines for over 1.7 million discharges is terrific. The emphasis this year has been on **getting it right first time**—making HIPE data both timely *and* accurate. 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. HIPE is an important high quality national dataset produced by the continuing hard work and dedication of the clinical coders, in conjunction with the HPO.

Hospitals and their Groups are now fully engaged with data quality initiatives and the attendance at Data Quality sessions run by the HPO has been impressive with 90 participants attending these courses over the year.

Training is central to good data quality and efficient coding. With a revamp of the coding courses there is plenty of opportunity for new and experienced coders to attend training.

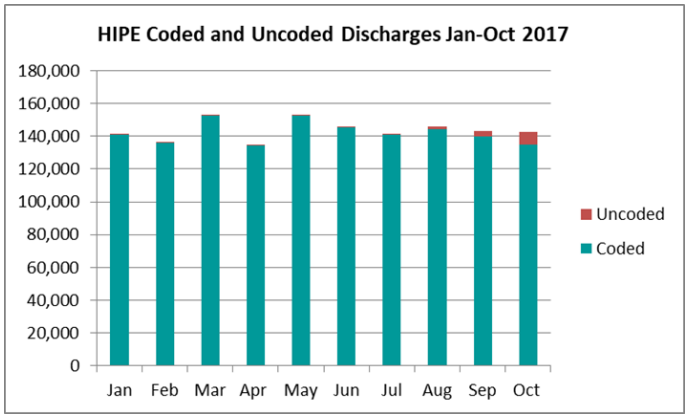
We are now taking applications for the next DIT course which will be held from January 2018 – September 2018. Contact hipetraining@hpo.ie for further information. Closing date for completed applications is Friday, **5th January 2018**. Please note even if you have applied before you must re-apply to be eligible for consideration for this course.

HIPE Coverage

Nationally, in 2017, there has been an average of approximately **142,000 discharges coded monthly** resulting in an impressive **99 per cent of discharges** coded from January to October. This is a major accomplishment for HIPE clinical coders. Phenomenal efforts have been made to meet the deadlines and to reduce the enormous backlogs. HIPE teams across the country have worked hard to meet the deadlines and in some cases have also had to work at reducing big backlogs to meet deadlines and their efforts, along with everyone else's are greatly appreciated.

Exporting timely and accurate HIPE data continues to be critical to Activity Based Funding along with many other purposes such as clinical audit, policy and research. Therefore, it is important that the HPO receives monthly exports from all hospitals. The monthly export date is the third working day of the following month and this timeline ensures that the HPO receives a complete set of data (coded and uncoded) from hospitals. It is also important that hospitals let the HPO know of any issues that may effect coverage in hospitals. Coverage is closely monitored each month and hospitals are contacted regarding their coverage when necessary.

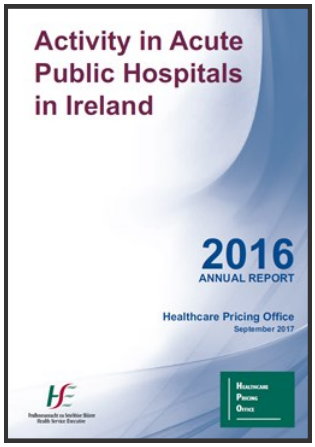
High quality, timely data is a testament to the accomplishments of HIPE coders in each of the hospitals around the country.



Thank you once again to everyone for your enthusiasm, commitment and dedication. Here's to a wonderful 2018 for everyone both professionally and personally.

Inside This Issue

Activity in Acute Public Hospitals In Ireland 2016



This year's HIPE report presents information on coded discharges from 53 Irish acute public hospitals participating in HIPE in 2016. This report is made possible through all of the hard work done by HIPE staff throughout the hospitals. At the national level, HIPE data informs 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 provides details of the admission type for total discharges as reported to HIPE for 2012-2016. The full report is now available for download on www.hpo.ie.

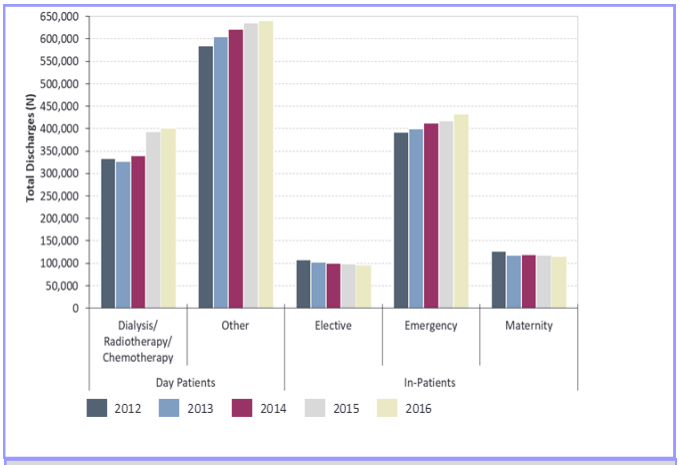


Figure 1: Admission type for total discharges as reported to HIPE for 2012-2016 by Day and Inpatients

Main findings of the 2016 Report

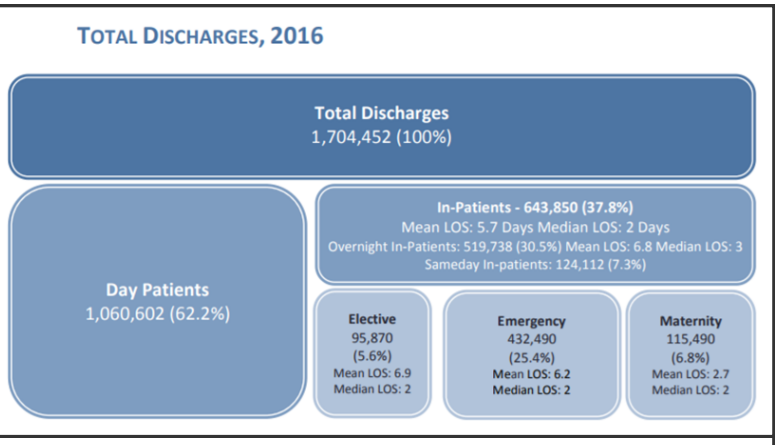


Figure 2—Total Discharges, 2016.

Total Discharges (Figure 2)

Over 1.7 million discharges were reported by participating hospitals compared to 1.66 million discharges in 2015 which is an increase of 2.4%. The increase in discharges reported to HIPE between 2012 and 2016 was 10.3%.

Day patients accounted for 62.2% of total discharges in 2016, an increase of 3.0% since 2015.

Discharges aged 65 years and over accounted for 36.2% of total discharges, representing an increase of 3.5% since 2015 and an increase of 20.2% since 2012.

Length of stay

Nationally, in-patient average length of stay was 5.7 days in 2016, this has remained the same since 2015.

Average 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 3.9 compared to 2.0 for day patients.
- A principal procedure was recorded for 79.5% 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 full report is now available for download on www.hpo.ie.

HIPE Audit Training Course

The HPO are pleased to announce that HIPE audit training will commence in 2018. This course will be scheduled to run twice a year. The course will be reviewed after the first year to ensure that the aims and objectives are being met. For this first course the number participants will be restricted to 8 people and the number of places may be increased for the second run of the course.

Aim

The aim of this course is for experienced HIPE coders to understand the role of the coding auditor and the audit process and to be able to perform all aspects of a HIPE coding chart based audit.

Objectives:

- Understand the role of the auditor and the audit process
- How to identify areas for audit and prepare samples
- How to use the HCAT© (HIPE Coding Audit Toolkit)
- How to undertake /conduct re-abstraction
- How to interpret and report on audit information, make findings and recommendations
- How to communicate audit findings and follow up on recommendations.

Outcomes:

Students will complete and present an audit project to demonstrate learning and understanding of the course objectives. Students will receive a certificate of completion from the HPO.

Course Details:

This course will be held over a total of 3.5 days *and will include an audit project to be completed by participants*. The 3.5 days will comprise of

- 2 days classroom training at the HPO
- A half day WebEx seminar
- A final one day classroom training session
- Audit project – to be agreed with line manager

All materials will be provided however participants must have access to e-books and the HIPE Coding Audit toolkit at hospital level in order to complete projects.

Course Structure:

Day 1:	Role of auditing & audit process
Day 2:	Audit skills & Audit project WebEx: Audit report writing
Day 3:	Reporting & presentation of audit results

One month later: Submission of audit project for assessment

Students are required to complete a hospital based HIPE audit project with access to charts and HIPE data required – this project is to be agreed with the student's line manager.

Course Entry Requirements:

As places are limited priority will be given to those working in the HIPE department with coding audit as part of their role.

Participants must be fully trained experienced HIPE staff with proven expertise and knowledge of both Australian and Irish Coding Standards and the Standards for Ethical Conduct in Clinical Coding.

Participants are required to have experience in using the HIPE Reporter software and Microsoft Office.

Prospective students must complete an application form and demonstrate their knowledge of coding and coding guidelines as part of the application process.

Students will be notified as to whether they have successfully completed the course. While there is no exam, students must produce a high standard audit report document in order to successfully complete this course.

Maintaining Audit Skills:

The HPO recommends that those who successfully undertake this course maintain their coding and auditing skills at the highest level. This will be through attendance at training courses and participating in and conducting chart based audits locally. Each participant will be asked to maintain a log book of their audit work.

Next Steps:

If you are interested in attending this course please let us know and we will issue an application form. Please note that places will be limited on the first course. A second course will be scheduled later in 2018.

2018 HIPE Instruction Manual & Changes to HIPE

Each year a new HIPE 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.

Regular updates to 2018 HIPE Instruction Manual:

- HIPE Summary sheet updated for 2018.
- List of 2018 dates for download and export added.

Main Changes in 2018 HIPE:

- An additional facility to collect the admission status of the transferred patient.
- An additional facility to collect the Eircode of the patient.
- The removal of the collection of the medical card number.
- Update to the Mode of Emergency Admission to facilitate the collection of Acute Surgical Assessment Units (ASAU).
- A change to the collection of colposcopy cases as part of HIPE data (see below)

The HIPE Portal has been updated to recognise all these changes for patients discharged in 2018.
If you have any questions on the above changes please contact HIPEcoding@hpo.ie.

Discontinuation of HIPE coding of colposcopy referral clinic activity in 2018

In 2010, the National Cancer Screening Services (NCSS) Cervical Check Programme requested that colposcopy procedures performed without sedation in an outpatient setting be coded on HIPE. The reason for this request was the fact that the Cervical Check Programme did not have a national information system in place to gather this information at that time. As a result of this request, Irish Coding Standard ICS 140X (Appendix II) was published in order to allow hospitals to code certain procedures in registered Cervical Check referral clinics.
Since 2010, a number of developments led to a review by the HPO where the appropriateness of continuing to capture this activity on the HIPE system was considered. In particular:

- The Cervical Check programme now has a national system to capture this activity with more detail than that available on HIPE.
- A review of this activity in HIPE data has indicated that this activity is not being consistently captured.
- The implementation of Activity Based Funding (ABF) in 2016, which currently only covers inpatient and daycase activity, means that under normal circumstances this activity in an outpatient setting would be out of scope for ABF.

As a result for discharges from 01 January 2018, Irish Coding Standard ICS 140X *Standardisation of collection of colposcopy activity* will be rescinded and the coding of the activity as described in this standard should cease.

As this standard specifically relates to registered colposcopy referral clinics, the cessation of coding only applies to activity taking place in these locations. Where the procedures listed in ICS 140X are carried out in an inpatient or daycase setting then this activity should continue to be coded as usual. To reflect this change, attendances should be counted as outpatient rather than admitted, under the following Irish Outpatient Classifications Code: IOCS Code 10070 IOCS Endoscopy- Gynaecological (Consultant Led).

Amended excerpt from letter issued by HPO 6th December2017 to Group CEOs, CFOs & HCCs.

Irish Coding Standards (ICS) V10.0

Irish Coding Standards (ICS) V10.0 has a number of new and revised standards and has one standard deleted. The "Five Steps to Quality Coding" have been added to the Irish Coding Standards.

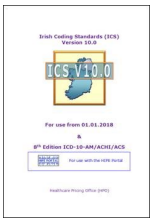
Changes to the ICS V10.0 include the following:

HIPE Guidelines on Administrative Data:

- Revision of guideline on valid and non-valid HIPE activity in order to provide clarity and to highlight this information within the Irish Coding Standards
- Guidance on coding of Acute Surgical Assessment Units (ASAUs) added to HIPE Guidelines on Administrative Data
- All guidelines have been updated as appropriate to state that elective admissions to ASAUs and AMAUs are not to be collected by HIPE – this activity is to be reported as outpatient activity.

New Irish Coding Standard:

ICS 0025 Double Coding allows for the duplication of diagnoses codes where the HADX flag applies in one and not the other. This is the only circumstance where duplicates diagnoses are permitted. The AR DRG assignment is not affected by the duplication of diagnosis codes.



Revised Standard:

ICS 0010 General Abstraction Guidelines has been revised to include information on the use of nursing documentation.

Deleted Standard:

ICS 140x *Standardisation of collection of colposcopy activity* has been deleted as the information is collected by the National Cervical Screening Service.

Appendices:

As always the appendices in ICS V10.0 have been updated as appropriate and the Five Steps to Quality Coding have been added as a new appendices.

Cardiac Arrest

What is Cardiac Arrest?

Cardiac arrest is caused when the heart's electrical system malfunctions. In cardiac arrest death results when the heart suddenly stops working properly. This may be caused by abnormal, or irregular, heart rhythms (called arrhythmias).

A common arrhythmia in cardiac arrest is ventricular fibrillation. This is when the heart's lower chambers suddenly start beating chaotically and doesn't pump blood. Death occurs within minutes after the heart stops. Cardiac arrest may be reversed if CPR (cardiopulmonary resuscitation) is performed and a defibrillator is used to shock the heart and restore a normal heart rhythm within a few minutes. Cardiac Arrest is not the same as a 'heart attack'.

When is Cardiac Arrest coded?

A. The following note appears at code I46- *Cardiac Arrest* in the tabular list of diseases

> ***Note:*** Codes from this category should be assigned only if resuscitation intervention is undertaken, regardless of patient outcome.

Further clarification:

In order to assign a code for cardiac arrest, the patient must have had resuscitation, however a procedure code for resuscitation is not coded.

Example 1

If a patient is admitted because they had Cardiac Arrest and they were resuscitated (in the community) and no other condition mentioned, then a code for the Cardiac Arrest is assigned as the PDx.

Example 2

If a patient is admitted because they had an Myocardial Infarction and they go into Cardiac Arrest while in hospital, a code for the MI is assigned as the PDx, and a code for Cardiac Arrest is assigned as an additional diagnosis only if resuscitation is undertaken regardless of the outcome.

Example 3

If a patient is seriously ill with (for example) cancer and they go into Cardiac Arrest and are not resuscitated and die, a code for the Cardiac arrest would not be assigned.

The Checker check on cardiac arrest is to ensure that only cases with cardiac arrest who had resuscitation performed are coded.

Standards for ethical conduct in clinical coding

The Australian Consortium for Classification Development (ACCD) has produced a follow up clarification document on the "Standards for ethical conduct in clinical coding". This article outlines some of the main topics addressed in the document. The full document is available from the ACCD website at https://www.accd.net.au/Ethics.aspx

Clarification on the application of the "Standards for ethical conduct in clinical coding"

Background

"The Standards for ethical conduct in clinical coding (formerly the Code of ethics for clinical coders) is a framework that defines and promotes ethical practices associated with clinical coding. Their primary purpose is to support clinical coders and others involved in the documentation clarification process (e.g. clinicians and clinical documentation improvement specialists) by setting out guidelines around ethical behaviours when undertaking the coding process, ultimately producing national consistency in coding practice."

What are the Standards of Ethical Conduct in Clinical Coding?

"The Standards for ethical conduct in clinical coding are standards of conduct, not coding standards and should not be interpreted as such. They are an adjunct to the ACS and are not to be used as a basis for coding audits. Health services should read the Standards for ethical conduct in clinical coding in conjunction with this clarification document to facilitate improvements in clinical coding practice. They can also be used as general information for other stakeholders involved in the review of coded data.

Why were they changed?

The guidelines were revised by ACCD during the development of the Tenth Edition of ICD-10-AM/ACHI/ACS. This revision was undertaken at the request of the ICD Technical Group (ITG) members who expressed concern that clinical coders were under pressure (particularly in an activity based funding environment) to achieve 'better' Diagnosis Related Group (DRG) outcomes for financial reimbursement . It was purported that clinical coders were asking clinicians 'targeted' or 'leading questions' in order to achieve this outcome. There was also concern that this practice was leading to over coding of certain clinical conditions, including the questionable coding of some conditions as procedural complications to achieve a higher complexity DRG with resultant implications for data quality. Revising the guidelines was a way of addressing this issue.

Another objective for the revision was to make the guidelines more explicit with respect to appropriate use of the interdisciplinary engagement process and the use of clinician queries for the purpose of clarifying diagnostic and/or intervention detail or ambiguity in clinical documentation.

Intent

The intention of the revision of these guidelines has been to:

- strengthen and clarify the wording.
- provide examples of behaviours that the national and international clinical coding profession would normally consider to be ethical versus unethical.
- ensure that all stakeholders involved in the coding process are aware of the importance of ethical practice in clinical coding and its supporting processes.

The Standards for ethical conduct in clinical coding are not meant to replace incentives and processes developed within health services to improve clinical documentation and above all ensure quality clinical care. The guidelines should be used by healthcare facilities to support the clinician query process, and the revision clarified how this process can be achieved ethically.

Standards for ethical conduct in clinical coding Continued

Ethical clinician queries

The document contains detailed information and examples on clinician queries, laboratory and radiology test results

An overarching principle articulated in the introduction to the ACS is that analysis of the entire clinical record is required before code assignment and that clinical coders should seek more information if a clinical record is deemed to be inadequate for complete and accurate code assignment.

Coding queries to clinicians should be written so that they:

- include information about the patient, with direct reference to the documentation prompting the query.
- enhance the clinical truth of the documentation to support quality patient care.
- allow clinicians to elaborate (add context) to their response regarding the significance and cause of the diagnosis/ condition/event.
- do not include leading questions that instruct, or indicate to a clinician what to write as a response.
- do not indicate potential financial impact.

Ethical use of the interdisciplinary engagement process for pathology/radiology test results

Abnormal pathology/radiology test results as a basis for a query to a clinician are ethical when supported by other documentation in the clinical record (electronic or paper based). This may include, but is not limited to, documentation of the need to repeat tests, progress notes indicating intent to monitor a result, or administration of treatment in the medication chart.

Coding from test results or medication charts that are not qualified within the episode of care is not good coding practice. For example:

- Drugs are often used for various conditions, or may be used as a prophylactic measure.
- A test result that is not within the normal range does not necessarily mean that the patient has an abnormal condition. That test result may be normal for that particular patient.

It is not the role of a clinical coder to diagnose. The responsibility for good clinical documentation lies with the clinician. Good clinical documentation is critical to continuity and quality of patient care and for patient safety is the legal record of a patient's episode of care. Importantly, it also supports quality coded data that has multiple uses, including reimbursement and funding.

Therefore, documentation (electronic or paper based) of the administration of a drug from the medication chart; or a microbiology test result which is not qualified within the clinical record is not enough information for clinical coders to perform the coding function. In these instances, the documentation issues must be clarified with the clinician.

The Standards for ethical conduct in clinical coding contain specific guidelines with respect to appropriate use of clinician queries, specifically those sent to clarify existing or missing documentation to support quality documentation and accurate coded data (optimisation) versus those motivated by financial gain (maximisation). Requesting clarification as to the type of pneumonia, for example, rather than coding pneumonia not otherwise specified (NOS) is regarded as optimisation. Optimisation is a process which uses all the documentation within the clinical record to achieve the best outcome and the clinician's response becomes part of the clinical record.

Other points of clarification in the document include:

- A clinician query may be sent to 'clarify' existing documentation for any unspecified or ill-defined diagnosis, however it is appropriate to assign unspecified and not otherwise specified categories when documentation as to the specificity of a condition is unavailable or not known.
- The Independent Hospital Pricing Authority, in consultation with ACCD, the Health Information Management Association of Australia (HIMAA) and the Clinical Coders Society of Australia (CCSA), will determine where the Standards for ethical conduct in clinical coding should reside going forward
- The Standards for ethical conduct in clinical coding may need to be refined in light of advances in clinical information systems, such as the Electronic Health Record.

Changes to the Education Programme for new Clinical Coders - January 2018

With increasing demands on HIPE Data, and with shorter deadlines, it is important that Clinical Coder education is delivered efficiently to support Coders in submitting timely accurate HIPE Data. From January 2018 changes to the Education Programme for new Coders will be implemented to enhance the training for new Clinical Coders. These changes will require a collaborative approach between the Hospital HIPE Department and the HPO, to support the delivery of this training in a timely manner. Below is a brief overview of the steps involved in getting a new coder started on their HIPE training journey.

> On the Job HIPE coding and mentoring by experienced coders is central to ensuring new coders are fully supported to provide timely and accurate HIPE data.

Stage 1: Starter Pack
When a Hospital informs the HPO that a new staff member has joined the Hospital HIPE Department, the HPO will send their supervisor a *Starter Pack*. This *Starter Pack* will include instructions for the supervisor/mentor in addition to instructions for the Trainee. The Trainee Clinical Coder is expected to study the essential reading materials and complete the exercises that are included in the pack. This will be done with the guidance of their coding mentor, in advance of attending the **Introduction to HIPE course (Part 1**). The *Starter Pack* will contain details of the complete Education Programme and schedule of training courses for new HIPE Clinical Coders. Their mentor must sign the form included in the *Starter Pack* confirming that the new coder has studied the pack and completed the exercises in order for the coder to attend.

Stage 2: Introduction to HIPE – Part 1 will be held at the HPO. This **one day** course is for new HIPE Clinical Coders who have received and studied their *Starter Pack* Material, and completed the exercises within the Pack. The course will include an overview of HIPE, patient flow, the variables collected in HIPE, and an introduction to Medical terminology. This course must be completed in advance **of Introduction to HIPE - Part 2.** Follow-up exercises will be provided for completion on their return to the Hospital.

Stage 3: Introduction to HIPE Part 2 will be an interactive training session delivered via WebEx, and will provide feedback on completed pre-course exercises. It will address queries from participants in relation to HIPE and their role, information and materials will be provided in preparation for Coding Skills I. This course must be completed in advance of Coding Skills I

Stage 4: Coding Skills I will be held at the HPO. This **two day** course will provide training on abstraction skills and an introduction to ICD-10-AM/ACHI/ACS and ICS.

> In addition to on-the-job experience in coding patient records, on-going training and mentoring for Trainee Clinical Coders within the Hospital HIPE Department is an important component of their education programme. Where pre-course reading and exercises are provided, Clinical Coders need to be supported to ensure completion of these tasks.

Upcoming HIPE Portal Reporter Training

Reporter training is now delivered via WebEx in three consecutive half day sessions, over a full day and followed by a half day, and covers all aspects of working on the HIPE Portal Reporter. Two courses are upcoming (dates below) and these are 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 courses are scheduled for:

WebEx based Course	Date	Time
HIPE Portal Reporter Training [Part I]	Wednesday, 10th January Tuesday, 6th February	10:30am – 12:00pm
HIPE Portal Reporter Training [Part II]	Wednesday, 10th January Tuesday, 6th February	2:00pm – 4:00pm
Using Scripts & Extracts in the HIPE Portal Reporter [Part III]	Thursday, 11th January Wednesday, 7th February	10:30am – 12:00pm

Cracking the Code

A selection of Coding Queries

Q. How are soft tissue injuries coded. Are they coded to injury of the site?

A. When coding soft tissue injuries refer to *ACS 1331 Soft tissue injuries* for guidance. As the advice states "*where the nature of the soft tissue injury cannot be obtained, code to 'injury, site' and not open wound*". Where on other information is available please code to injury.

See also *Coding Rule Ref No: TN200/ Published On: 15-Jun-2009/ Status: Current*

Q. How is removal of cyst from labia coded?

A. As the labia is part of the vulva, we suggest coding as follows:
90440-00 [1293] *Excision of lesion of vulva.*

Q. An obstetric patient previously had a termination at 25 weeks for a congenital abnormality. She is currently pregnant so what is her parity ?

A. The number of times the patient was pregnant i.e.Gravidity, is not collected. Parity is the number of times that a patient gives birth to a foetus with a gestational age of more than 22 weeks regardless of whether the child was born alive or still born. Therefore the parity in this case is 0.

Q. What is the code for the procedure Flexible Ureterorenoscopy (FURS) ?

A. FURS is when a very thin flexible telescope is passed up from the urethra into the bladder and up the ureter and the kidney. See: http://www.essexurology.co.uk/downloads/pdf/furs_info_sheet_v1.pdf

Based on this we would suggest you code to
36627-00 [1043] *Percutaneous nephroscopy*

Q. When a patient is admitted for an elective caesarean section that she herself has requested, how is this coded?

A. Please code as follows:

O82 *Single delivery by caesarean section*
Plus outcome of delivery Z37.- *Outcome of delivery*

Plus one of the procedure codes below, as per documentation.

16520-00 [1340] *Elective classical caesarean section*
16520-02 [1340] *Elective lower segment caesarean section*

Q. How do you code Syndesmosis of Ankle and reduction of Syndesmosis with internal fixation?

A. Syndesmosis of Ankle is the point just above the ankle where the tibia and fibula bones meet.

If this is a current injury please code the diagnosis to:

S93.43 *Sprain and strain of tibiofibular (ligament)*

Code also appropriate external cause codes

For the procedures, see:

49709-00 [1542] *Stabilisation of ankle*
47921-00 [1554] *Insertion of internal fixation device, not elsewhere classified*

Q. What is the code for Radiofrequency of Varicose Veins by ablation performed under LA?

A. As per Coding Rule *Ref No: Q2762/ Published On: 15-Mar-2014 / Status: Current*, there is no specific code for this procedure, therefore assign an appropriate site code from *Block [727] Interruption of sapheno-femoral or sapheno-popliteal junction varicose veins.*

Q. A patient is admitted with a principal diagnosis of hypocalcaemia secondary to Denosumab, which is being used to treat her osteoporosis. What is the adverse effect code for this drug?

A. Denosumab is an antibody, also known as immunoglobulins.

http://study.com/academy/lesson/what-are-antibodies-definition-function-types.html

The most appropriate code to use for an adverse effect of Denosumab is:

Y59.3 *Drugs, Medicaments and Biological Substances causing Adverse Effects in Therapeutic Use - Immunoglobulin*

Q. How is "infective exacerbation of asthma" coded?

A. There is no index entry for infective exacerbation of asthma. Assign a code for the asthma and the infection (as documented in chart) following the guidelines in ACS 001 Principal Diagnosis and ACS 0002 Additional Diagnosis to determine the PDX and ADX sequencing.

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.

Obstetrics

An *Introduction to Obstetrics* Workshop was held at the HPO on 16th November 2017. This workshop provided participants with an overview of medical terms and abbreviations and of complications associated with pregnancy, childbirth and the puerperium, together with classification guidelines and examples.

Focus on terms and definitions—The following terms and definitions were discussed and their associated impact on code assignments.

Preterm

This is defined as being < 37 completed weeks of gestation

Note: 37 completed weeks refers to 36 weeks plus 7 days. Duration of pregnancy less than 37 completed weeks is deemed premature.

Term

This is the period of time from 37 completed weeks to less than 41 completed weeks.

Post-term

This is defined as being > 42 weeks completed weeks of gestation.

True labour is defined as regular, rhythmic contractions of the uterus that result in the progressive dilation and effacement of the cervix. At times, it is accompanied by a 'show' of blood and mucous, which indicates that the cervical canal is opening.

If there is spontaneous rupture of membranes (SROM) before the cervix is dilated, this is considered premature rupture of membranes.

Premature rupture of membranes

Premature rupture of membranes (PROM), also known as pre-labour rupture of membranes, is 'the spontaneous rupture of the amniotic sac before the onset of labour'.

- PROM can occur at term, that is, at or beyond 37 completed weeks of gestation, or
- Preterm (PPROM), before 37 completed weeks of gestation.

A follow up document of coding queries Q & A document, arising from the workshop will be sent to all coders in the new year.

A query to the National Casemix and Classification Centre Australia:

Q. Could the NCCC please clarify the coding of 'premature rupture of membranes', including whether there is a requirement for the word 'spontaneous' to be specified?

A. Premature rupture of membranes (PROM), also known as pre-labour rupture of membranes, is 'the spontaneous rupture of the amniotic sac before the onset of labour' (Mosby, 2009). PROM can occur at term, that is, at or beyond 37 completed weeks of gestation, or preterm (PPROM), before 37 completed weeks of gestation, which can pose a significant risk for morbidity and mortality in both the mother and the foetus, and is a major cause of preterm delivery (Jazayeri, 2011).

The appropriate code for both term and preterm PROM is assigned following the index pathway:

Rupture, ruptured

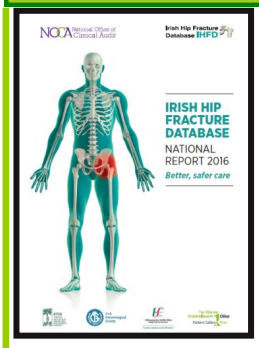
- membranes (spontaneous)

- - premature

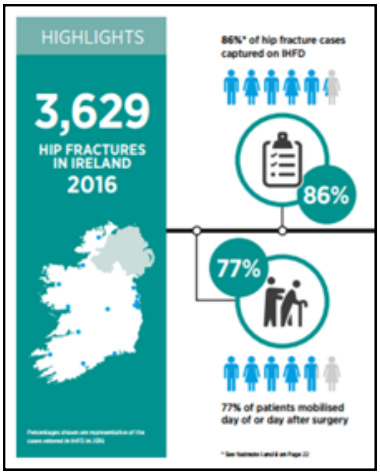
As 'spontaneous' is not an essential modifier it does not need to be specified in order to assign a code for premature rupture of membranes, however it is implicit in the condition.

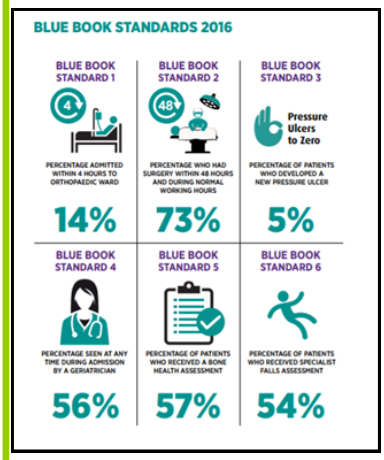
A code from O42 *Premature rupture of membranes* should not be assigned where membranes are ruptured artificially. NCCC notes that a public submission has been submitted requesting index entries for 'pre-labour rupture of membranes'. This will be considered along with other index entries for PROM and PPROM for a future edition of ICD-10 -AM.

Irish Hip Fracture Database (IHFD)



The Irish Hip Fracture Database (IHFD) is a clinically led, web-based audit which measures the care and outcomes of patients with hip fractures. Data is entered through an additional screen on the HIPE Portal developed and supported in conjunction with the IT team at the HPO. In November 2017 the fourth IHFD national report detailing 3,159 hip fracture cases in patients aged 60 years and over was published in the RCSI. There were 3,629 hip fractures in Ireland in patients aged over 60 recorded on HIPE in 2016 and 3,159 of those had additional IHFD data added to their HIPE episode. The National Office of Clinical Audit (NOCA) governs the IHFD and the IHFD governance group and includes representatives from all the clinical specialties involved in the care of hip fractures as well as representatives from the HPO.





The IHFD measures case-mix, care and outcomes for these patients and this year published the first national report showing comparison of individual hospital performance against the 6 "Blue Book Standards".

If you have any queries about the IHFD please contact the National IHFD Audit Coordinator, Louise Brent: louisebrent@noca.ie. The report is available for download from www.noca.ie .

Useful information on hip fractures and associated procedures

The hip: The hip joint is made up of a ball and socket joint. The ball (head of the femur) is located on top of the thigh bone and the socket sits within the pelvis. The hip joint is contained within a fibrous capsule and much of the head of the femur receives its blood supply through blood vessels in the capsule.

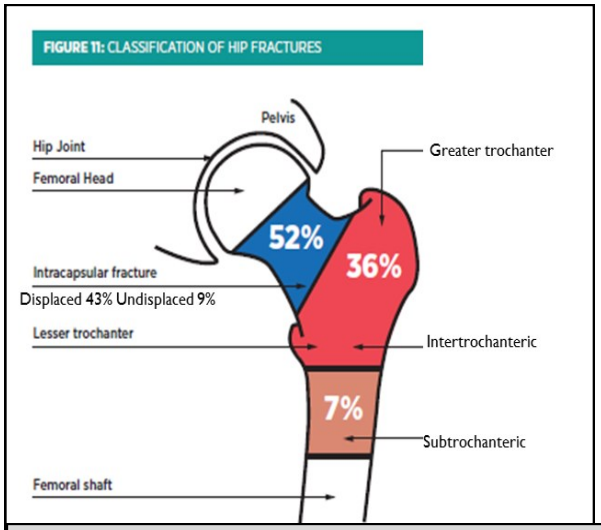


Figure 1 Classification of Hip Fractures (reproduced with permission from the 2016 Hip fracture report p34.)

What is a hip fracture? A hip fracture is any break in the upper portion of the thigh bone (femur) where the bone meets the pelvis. **Figure 1** illustrates the classification of hip fractures and also gives the percentage occurrence according to the 2016 HIP fracture report.

Figure 2 provides information on the types of fixation by fracture type and also the percentage of each type of procedure as reported for the 2016 HIP fracture report.

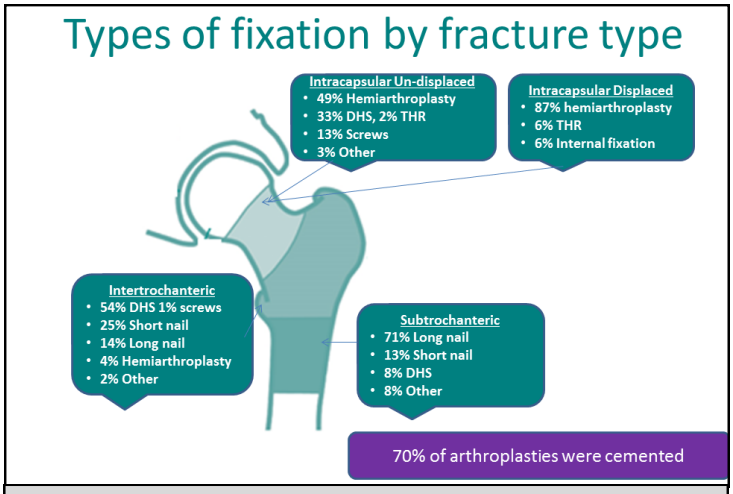


Figure 2 Types of fixation by fracture type (reproduced with permission from Louise Brent's presentation at the 2016 Hip fracture meeting.)

Upcoming Courses

Introduction to HIPE I & II

Introduction to HIPE I

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

Date: Wednesday 31st January 2018
Time: 10.00am – 4.00pm
Location: HPO only

Introduction to HIPE II

Follow up session for coders who attended the day above.

Date: Thursday, 8th February 2018
Time: 10:30– 1:00pm
Location: WebEx Only

Coding Skills I

This **2 day course** is for new coders who have attended *Introduction to HIPE I & II.*

Date: Tuesday, 20th—Wednesday, 21st February
Time: 10.00am – 5.00pm 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, 20th—Thursday 22nd March
Time: 10.00am - 5.00pm each day.
Location: HPO, Brunel Building only

Data Quality Session

This session will cover many aspects of data quality and the tools available to hospitals.

Date: Thursday 29th March
Time: 11.00am - 1.00pm
Location: WebEx only

Anatomy & Physiology

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

These courses will be delivered by a specialist speaker.

Anatomy & Physiology—Introduction

Date: Thursday, 15th February
Time: 11.00am – 1.00pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Musculoskeletal System

Date: Thursday, 15th February
Time: 2.00pm—4.00pm
Location: HPO, Brunel Building & WebEx

Coding Skills IV– Workshops

Sepsis Workshops—Full Day courses

Sepsis affects all ages and specialties is it critical that all coders are aware of the guidelines around coding this serious, life threatening condition. Dr. Vida Hamilton, National Clinical Sepsis Lead, will present at these courses.

Dates: Wednesday, 14th February, 2018
Time : 10.00am—4.00pm
Location: HPO

Dates: Tuesday, 27th February, 2018
Time : 10.00am—4.00pm
Location: HPO

Dates: Monday, 12th March, 2018
Time : 10.00am—4.00pm
Location: Galway

Dates: Wednesday, 11th April, 2018
Time : 10.00am—4.00pm
Location: Cork

Same Day Endoscopies

There are very specific standards and guidelines around the coding of Same Day endoscopies. This course will go through these in detail.

Date: Tuesday, 7th March 2018
Time: 10.30am – 1.00 pm
Location: WebEx Only

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

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Thought for Today

The most important decision you make is to be in a good mood.

Voltaire – 1694-1778, Writer, Historian, and Philosopher