Coding Notes

Healthcare Pricing Office

Number 77
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Managing Coding Services Workshop

The HPO are facilitating a one-day workshop on Managing Coding Services on 20th September 2017. The aim of this interactive workshop is for hospitals to share best practice and to exchange ideas, challenges and innovations.

With the increasingly important and central role of HIPE data it is critical to have well trained, conscientious and motivated staff. Working to deadlines, with data quality always a high priority, is a huge challenge for everyone. By planning and organising strategies to address these issues, HIPE departments can optimize both their staff and their work. By coming together to share best practice we look forward to a busy and fruitful day.

Key areas will be around planning the Hospital HIPE Department including staffing, recruitment and retention strategies. There will be sessions on support, training and mentoring of HIPE Coders and also In-hospital training for other hospital staff. During the day the various tools available will be showcased including The Checker, HCAT, Qlikview and the HIPE Portal Reporter. Chart documentation, whether hard copy or electronic, is still one of HIPE's biggest challenges. We also want to hear about your experiences with EHRs and the MN-CMS. With these new technologies, the role of the coder is evolving and we would like to explore what opportunities are arising.

The workshop will be held at the HPO in the Brunel Building in Dublin and we look forward to welcoming those who have an interest in managing coding services. We would hope that this day will be a starting point for further collaborative work between HIPE staff working throughout the country. By coming together to share best practice it will ensure that the work of HIPE is of the highest standard to meet the growing and changing demands for HIPE data across the system.

It will be a great opportunity to network, catch up with old friends, make new ones and to exchange ideas. If you are interested in participating in this interactive workshop please contact HIPETraining@hpo.ie.

This edition of Coding Notes looks at the different documentation available to clinical coders for abstraction. All of us working in HIPE are very familiar with *The 5 Steps to Quality Coding*. Step one relates to the abstraction of information from the patient's healthcare records. There have been discussions about the use of nursing notes and information provided by allied health professionals. The EHR and the MN-CMS are being used increasingly by coders and this will impact on how abstraction, coding and auditing are done. It is important that coders are clear on how to access all the information required and to understand which information, either electronic or paper, is admissible for coding HIPE discharges.

There is information on coding of procedures and interventions and a refresh on some of the guidelines and related standards. There is a note on the use of the Emergency indicators in the ASA score for anaesthetics. Along with a great selection of queries in Cracking the Code there is plenty of Summer reading in this edition of Coding Notes. Enjoy your summer!

General Abstraction Guidelines

General Abstraction Guidelines

Always follow the 5 Steps for diagnoses and procedure coding.

> The first step in the 5 Steps to quality coding states:
> **Step 1 ANALYSE - Medical Terminology**
> Read the discharge summary and all relevant clinical documentation to identify the diagnoses and interventions.

Guidance on the analyses of the discharge summary and 'all relevant clinical documentation' is provided in ACS 0010 General Abstraction Guidelines. This ACS provides classification guidelines and examples in relation to use of documentation for coding purposes.

- In Ireland the source document is the Medical Record/Chart, and increasingly parts of the Medical Record are available electronically.
- Any diagnosis that is recorded in the discharge letter/summary needs to be documented in the body of the Medical Record.
- Clinical Coders need to review all documentation pertaining to an episode of care.

> It is important to seek clinical advice where necessary for:
>
> Verification of diagnoses recorded on the front sheet and/or the discharge summary which are not supported in the clinical record, **and**
>
> Clarification of discrepancies between investigation results and clinical documentation.

There are **6 Coding Rules** references at the beginning of this standard, and these provide further clarification surrounding general abstraction guidelines.

CR CR CR CR CR CR

- Clinical diagnosis versus histology
- Coding of findings on pathology results
- Use of abbreviations and symbols
- Principal/Additional Diagnoses (1 of 3)
- Resistance to antimicrobial and antineoplastic drugs
- Family history of hereditary non-polyposis colon

> **TEST RESULTS**
>
> **Findings that provide more specificity about a diagnosis**
>
> Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly **add specificity to already documented** conditions that meet the criteria for a principal diagnosis (see ACS 0001 *Principal diagnosis*) or an additional diagnosis (see ACS 0002 *Additional diagnoses).*

Please refer to ACS 0010 General Abstraction Guidelines for further details.

ICS 0010 *General Abstraction Guidelines* provides further examples to illustrate the guidelines in the Australian Coding Standard.

> Please follow the guidelines in **ACS 0001 *Principal Diagnosis* & ACS 0002 *Additional Diagnoses*** when determining conditions, diseases and other circumstances to be coded.

Use of nursing documentation for clinical coding

There's a lot of discussion amongst clinical Coders about when it is appropriate to assign codes based on the information recorded in the Medical Record by nursing Staff.

The following Q & A, was published in *Coding Matters* newsletter by the NCCH in 2012

Q: Are nurses considered clinicians when it comes to documentation for clinical coding? What documentation is sufficient to warrant coding of Diabetes Mellitus? Specifically, should a code for Diabetes Mellitus assigned by virtue of a nurse checking a 'tick box' on a form such as a pre-admission check list?

A: The *Introduction* to the *Australian Coding Standards, How to use this document* contains the following guideline:

> "The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."

The NCCC supports this guideline and maintains that documentation by any clinician can be used to determine conditions that should be coded. However, clinical coders should also be guided by the following from the *Introduction* to the *Australian Coding Standards:*

"If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code."

While ACS 0401, *Rule 1* specifies that DM should always be coded, general coding and abstraction guidelines should still be followed.

(Coding Q&A, June 2012)

Types of clinical documentation

High quality clinical documentation promotes effective communication between caregivers and facilitates continuity of patient care and patient safety. It also facilitates accurate clinical coding – a diagnosis or procedure can only be coded if documented in the medical record.

Medical officer documentation

Diagnosis and treatment of medical conditions is the responsibility of the treating medical officer(s), therefore clinical coders predominantly use medical officer documentation.

Upcoming HIPE Portal Reporter Training

Reporter training is 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. 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, 24th August	10:30am - 12:00pm
HIPE Portal Reporter Training [Part II]	Thursday, 24th August	2:00pm - 4:00pm
Using Scripts & Extracts in the HIPE Portal Reporter [Part III]	Friday, 25th August	10:30am - 12:00pm

Nursing, Midwifery & Allied Health Documentation

Nursing, midwifery and allied health documentation

Documentation from clinicians other than medical officers (i.e. nurses, midwives, allied health professionals) is also used by coders. It can help to provide clarification and specificity about (or confirm existence of) a diagnosis or procedure documented by a medical officer [doctor]. More importantly, if a nursing, midwifery or allied health documented diagnosis or procedure is appropriate to that clinician's discipline it can be coded regardless of whether the medical officer [doctor] has documented it.

Diagnosis information is commonly found in the allied health professional's assessment notes. Issues to consider when using allied health documentation:

- Results/scores from testing tools (e.g. post-traumatic amnesia assessment score) should not be interpreted by coders. The condition must be documented by the allied professional to be used by the coder
- Documentation such as "Dysphagia review" should have a clear final assessment documenting whether patient has the condition

Examples

- A diagnosis of pneumonia can only be coded if documented by a medical officer [doctor].
- A diagnosis of pressure injury documented by a nurse (which the medical officer [doctor] fails to document) can be coded because skin integrity management is appropriate to the nursing discipline.
- A diagnosis of post-partum haemorrhage documented by a midwife (which the medical officer [doctor] fails to document) can be coded because it is appropriate to the midwifery discipline.
- A diagnosis of dysphagia documented by a speech pathologist (which the medical officer fails to document) can be coded because it is appropriate to the speech pathology discipline.

Please note that conditions need to meet criteria in ACS 0001 & ACS 0002 (with reference to specialty standards as required).

Use of nursing documentation

As per Australian Coding Standards, coding directly from nursing documentation is restricted to conditions appropriate to the nursing discipline.

General nursing

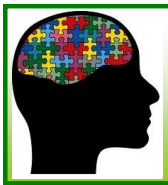
The main areas of general nursing where patients' documentation may support the coding of conditions are skin integrity e.g. pressure ulcers, wounds, minor injuries and incontinence

Specialist nursing

- **Tracheostomy and Stoma care**
  Any obstruction, leakage or other complication? Is it non-transient?

- **Diabetic Educator/Diabetic Specialist Nurse**
  Type of diabetes? Documentation such as "poorly controlled", "uncontrolled", "for stabilisation", "unstable" may be used to enable coding of poor control E1-.65 *Diabetes mellitus with poor control*.

Reference: Coding Education Team, Purchasing & System Performance, Department of Health, Government of Western Australia (November 2015).



Cracking the Code

A selection of ICD-10-AM Queries

Q. Is ventilation via laryngeal mask airway (LMA) considered invasive or non-invasive ventilation?

A. Clinical advice was sought on the classification of ventilation using a laryngeal mask airway (LMA). The National Clinical Programme in Anaesthesia has recommended that ventilation via LMA is to be classified as **non-invasive ventilation**. The clinicians advised that the LMA sits above the glottis and is therefore not an endotracheal device. Patients require anaesthesia for an LMA to be placed.

The codes assigned for ventilation via an LMA will be as per guidelines on non-invasive ventilation in ACS 1006 *Ventilatory Support*. Also code anaesthesia as appropriate.

Q. A patient who was diagnosed with sigmoid cancer and underwent a resection of the affected area in 2016 has now returned with a recurrence of the cancer. It is now being described as rectal ca, and he has liver mets. The clinicians say it is the same cancer and confirmed as a recurrence, but refer to it now as rectal, and do not describe it as mets to rectum. As this is a recurrence is it still the sigmoid ca (C18.7 *Malignant neoplasm of sigmoid colon*) or as the sigmoid has been resected and the cancer is now in the rectum- how do I code this?

A. See ACS 0237 *Recurrence of malignancy*. Please code back to the original site as per classification instructions.

ACS 0237 RECURRENCE OF MALIGNANCY

If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00–C75. Code also any secondary sites mentioned.

EXAMPLE 1:

Patient previously had a sigmoid colectomy in 1996 for carcinoma, now presents with a recurrence in the rectum.

Codes: C18.7 Malignant neoplasm of sigmoid colon

Q. Do you assume when a stroke is described as "thrombolytic" that the patient has an embolism if no MRI scan is available.

A: It is not possible to assume that when "thrombolytic" is stated that the patient has an embolism when there is no MRI detailing specificity.

An embolic stroke occurs when a blood clot forms elsewhere in the body (embolus), breaks loose and travels to the brain via the bloodstream. Eventually the clot lodges in a blood vessel and blocks the flow of blood causing a stroke.

The other type of ischemic stroke is thrombotic stoke which occurs when a blood clot impairs blood flow in an artery that supplies blood to the brain.

Q: If right or left middle cerebral artery (MCA) or lacunar is mentioned, what code do you assign from I63- *Cerebral Infarction*?

A: I63.9 *Cerebral infarction, unspecified* is the correct code to assign for this scenario. The 4th character at I63- *Cerebral infarction* reflects the cause of the infarct and the arteries affected. I63.8 *Other cerebral infarction* would not be assigned. Please also refer to the April 2017 edition of *Coding Notes.*

Q. When coding documented pneumonia with pseudomonas identified on the lab reports some coders were coding pneumonia with Pseudomonas as J15.1 *Pneumonia due to Pseudomonas*. Can we clarify around the coding of organisms in respiratory infections that are identified on the lab report only? This was discussed at a recent respiratory workshop and we would like confirmation of how to code the respiratory infections.

A. The issue discussed at the course was around being aware of false positive results e.g. contaminants rather than a true positive infection being present.

For this query, it is OK to code as the pneumonia is due to pseudomonas – once the pneumonia is documented then the lab results can add specificity – i.e. pseudomonas. See ACS 0010 *General Abstraction Guidelines,* noting Example No.2 and also ICS 0010 *General Abstraction Guidelines* . Please review the patient's notes to ensure that there is no mention of this being a contaminant, this may be documented further on and can happen.

Q. A patient has stricture and achalasia of oesophagus, the procedure is oesophagoscopy with injection of "Dysport". How is this coded in ACHI?

A. Dysport is a pharmacology form of Botox and is used to treat tightness or stricture within the oesophagus. There is no mention of a non-bleeding lesion, the use of the two procedure codes below give a greater specificity as to treatment.

Please assign the following codes:

30473-03 [850] *Oesophagoscopy*

18360-00 [1552] *Administration of botulinum toxin into soft tissue, not elsewhere classified*

Q. If the patient has a common bile duct stone with obstruction *and* gallstones with no mention of obstruction, how is this coded?

A. In this case please assign both of the following codes in order to reflect the sites involved:

K80.51 *Calculus of bile duct without cholangitis or cholecystitis, with obstruction*

K80.20 *Calculus of gallbladder without cholecystitis, without mention of obstruction*

Cracking the Code continued

A selection of ICD-10-AM Queries

Q. How is acute appendicitis with perforation coded?

A. The correct code to assign is
K35.8 *Acute appendicitis, other and unspecified*
(*unless* there is mention of peritonitis),
To locate this code in the alphabetic index look up the main term **Appendicitis,** and perforation is in brackets and is a non-essential modifier. There is no essential modifier for appendicitis with perforation.

There is an entry for appendicitis with peritonitis therefore please check if this term is documented.

Q. We have a Nurse Specialist who sees patients with histories of falls and carries out an intensive report which is included in the clinical notes. Should we be coding this as an intervention under the Allied Health Interventions? This nurse sees a lot of patients as we have a large amount of elderly patients.

A. In HIPE we do not code specialist nurse interventions. The condition will be coded as it meets criteria in ACS 0002 – increased nursing care or monitoring.

Q. If a record states "pulmonary oedema" only – what is it coded to?

A. Please follow the alphabetic index of disease, making sure to follow through to tabular index. Without any further information as to the cause or acuity the term pulmonary oedema is coded to **J81 Pulmonary oedema** when it meets ACS 0002 additional diagnosis.

Q. If a record states "Acute pulmonary oedema" only – what is it coded to?

A. ACS 0920 *Acute Pulmonary Oedema* states: "When acute pulmonary oedema is documented without further qualification about the underlying cause, assign code I50.1 *Left Ventricular Failure*". The ACS refers to Acute pulmonary oedema only.

Q. What code is assigned for endometrial proliferation or proliferative endometrium.

A. Endometrial proliferation or proliferative endometrium is a finding indicating that there is a proliferation of endometrial cells. It is often found on pathology results. It is usually not coded as it is a finding only and there should be a more specific diagnosis if there is a specific condition. Please also refer to ACS 0010 *General abstraction guidelines* 'Finding with an unclear or no associated condition documented'.

Q. We are a general hospital without an obstetrics unit, is there is any definition around using the maternity admission type 6 ? We have received checks back when we use the type of admission as 4 *Emergency* when using an obstetrics code (from O00 to O99) code as PDx.

A. The HIPE Instruction Manual sets out the definitions for the various types of admission. Type of admission 6 – *Maternity* is defined as follows –

"The patient is admitted related to their obstetrical experience. From conception to 6 weeks post delivery."

If the principal diagnosis is obstetric (O00- O99) it would follow that the admission type 6 *maternity* applies as per the definition in the HIPE Instruction Manual. Admission type 6 *maternity* can be collected in all hospitals not just those with a maternity unit, often the most complex obstetric cases are admitted to major acute hospitals. The HIPE Instruction Manual is available at http://www.hpo.ie/hipe/hipe_instruction_manual/HIPE_Instruction_Manual_1.1.2017.pdf

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Q. If a neonate has jaundice and is premature can we assign P59.0 *Neonatal jaundice associated with preterm delivery,* or does the association between the prematurity and the jaundice need to be documented?

A. We have sought additional external advice on this query and advise that you can assign P59.0 *Neonatal jaundice associated with preterm delivery* where a premature neonate has jaundice.

If the baby has jaundice and is premature, the index needs to be followed:

Jaundice (yellow) R17
- fetus or newborn (physiological) P59.9
- - due to or associated with
- - - preterm delivery P59.0

P59.0 Neonatal jaundice associated with preterm delivery

Hyperbilirubinaemia of prematurity

Jaundice due to delayed conjugation associated with preterm delivery

If there is no documentation of any other cause and it was not a preterm delivery then assign the code P59.9 *Neonatal jaundice, unspecified.*

Note: The overriding criteria for all the assignment of any code for the jaundice is that the baby has to have undergone phototherapy for > 12 hours.

Do you have a coding query?

Please email your query to:

hipecodingquery@hpo.ie

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

www.hpo.ie/find-it-fast

Please anonymise any information submitted to the HPO.

Coding Procedures/Interventions in HIPE

Procedures can only be coded if they are performed after admission to hospital.

- Procedures that are performed prior to admission to a ward cannot be coded – e.g. any procedure that is performed in the Emergency Department prior to admission, or in a Virtual Ward cannot be coded.
- Please refer to Guidelines for Administrative Data ICS VIII *Activity not collected in HIPE.*

VIII. HOSPITAL ACTIVITY NOT COLLECTED BY HIPE

Activity not currently collected by HIPE includes out-patient activity, virtual wards, A&E/ED cases and/or "well babies". Elective admissions to Acute Medical Assessment Units are not collected by HIPE and are to be reported as outpatient activity

ICS Updated:	January 2017 ICS V9.0
Reason for Update:	Elective MAU activity not collective by HIPE.

There are General Standards for Interventions in The ACS and The ICS.

- Please note that guidelines in Specialty Coding Standards override the guidelines in General Coding Standards – this applies to both Diagnosis and Intervention Coding.
- Coders always need to follow the conventions in the classification of interventions e.g. 'code also' notes in the tabular list of interventions

ACS 0042 *Procedures normally not coded* contains a list of procedures that are not to be coded.

- Please note that there are exceptions at the beginning of the standard that describe circumstances where these procedures are to be coded.
- There are also some exceptions flagged throughout the list.

Source document – when coding interventions the coder needs have access to the entire medical record, including the operation sheet/report.

Location where the intervention is performed

- Once the patient has been admitted, and the procedure meets criteria for collection, the location of where the procedure is performed can be anywhere in the hospital. This includes procedures that are performed in the operating theatre, on the ward (at the patient's bedside), intensive care, cath lab etc.
- ACS 0020 Bilateral/Multiple Procedures provides the following information: 'For ease of expression 'theatre' is used ... It should be interpreted as an operating theatre or any other place where a procedure is performed during an inpatient episode of care for example, intensive care unit, on the ward.'

Use of Emergency Code in ASA Scores

ASA scores - This information must be documented on the anaesthetic form before assigning these codes.

ACS 0031 *Anaesthesia* contains definitions and guidelines for code assignment and sequencing of anaesthesia codes.
Where there is no documentation of ASA score or the emergency modifier is not indicated, filler digits of '9' should be assigned.

Emergency Modifier – 0 can only be assigned based on the information on the Anaesthetic form. Information elsewhere in the chart cannot be used to determine the use of '0' e.g. if the patient was admitted through ED and requires surgery, and there is no information regarding the Emergency Modifier on the Anaesthetic form, then '9' *nonemergency or not known* is assigned.

Just because a patient is admitted as an emergency does not mean that the ASA would be '0' Emergency.

Example
Patient admitted through ED with acute appendicitis on the 01/01 and Laparoscopic Appendicectomy was performed under GA ASA 1 on 01/01

Procedure codes: 30572-00 [926] *Laparoscopic appendicectomy*
92514-19 [1910] *General anaesthesia, ASA 19*

Note: as there was no information about the Emergency Modifier, so '9' *nonemergency or not known* is assigned.

Upcoming Courses

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

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, 26th July
Time: 10.30am—1.00pm
Location: WebEx only

Coding Skills I

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

Date: Tuesday, 12th to Thursday 14th September
Time: 10.00am – 5.00pm each day
Location: HPO, Brunel Building

Managing Coding Services

For information on this course, please see page 1 of this edition of Coding Notes

Date: Wednesday, 20th September.
Time: 10:00—5:00pm
Location: HPO Brunel Building

Anatomy & Physiology

These courses will be delivered by a specialist speaker.

Anatomy & Physiology— Introduction
Date: Tuesday 5th September
Time: 11.00am – 1.00pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Neuroendocrinology
Date: Tuesday 5th September
Time: 2.00pm—4.00pm
Location: HPO, Brunel Building & WebEx

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

Coding Skills IV— Workshops

Introduction to Obstetrics
This course will bring coders through the basics of coding all aspects of obstetrics including procedures and anaesthesia coding issues related to obstetrics.

Date: Wednesday, 19th July
Time: 10.00 am – 4.30pm
Location: HPO, Brunel Building

Gynaecology Workshop

This workshop will provide coders an overview of common conditions and interventions associated with the female reproductive system (including abbreviations and medical terminology). It is suitable for both beginner and experienced coders.

Dates: Thursday, 20th July
Time : 10.00am – 4.00pm
Location: HPO, Brunel Building

Endoscopies
There are very clear guidelines associated with endoscopy coding and this course will bring coders through these guidelines.
Date: Thursday, 28th September
Time: 10.30am – 1.00pm
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

Thought for Today

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

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