Healthcare Pricing Office

Coding Notes

No. 93
July 2021

Summer Update

Just half way through 2021 and so much has happened for everyone. Getting through the COVID-19 wave in the first quarter and the seemingly interminable lock down and restrictions has been challenging for everyone. The vaccine roll out has provided much needed hope and a real sense of an end to the pandemic. Hopefully people have now had at least one jab or are close to registering for the vaccine.

The HSE Cyberattack on the 14th May was a shock to everyone and, as you know, saw all systems shut down across the services. The HSE IT are working hard to get everything back up and running. Some HPO systems are still affected and please note that due to the HSE Cyberattack coding queries are taking longer to address. Apologies for any inconvenience caused.

Deadlines

HIPE coding deadlines have been impacted by the attack and there will be an impact on coverage over the coming months. Hospitals were affected in different ways and access to charts and systems is still unstable for some. The main issues encountered as reported to the HPO are:

- Limited access to patient records especially results
- HIPE Data Entry and ieBook classification unavailable
- Cases recorded on paper will need to be coded and entered
- Coders redeployed
- PICQ checks
- Issues with PAS/IPMs data.

Hopefully as the months progress and some sort of normality returns we can get back on track. As always HIPE departments across the country were innovative and despite the loss of access to the ieBook and the HIPE Portal, many hospitals continued to extract on to paper where charts were available and used paper copies of the classification. In some hospitals coders were redeployed to support other areas of the hospital. By whatever means HIPE coders once again rose to the challenge.

2020 National file

The good news is that prior to the shut-down of the systems the 2020 national file was completed with 1,499,946 HIPE discharges, representing national coverage of 98.9% , submitted from HIPE departments in the most difficult of years. Sincerest thanks to everyone who worked to achieve this. There was a 15% drop in activity across the system compared to 2019 (1,779,394 representing 99.5%). See page 2 for more on this and on COVID-19 discharges returned in 2020.

Other features in this edition are a summary of the HIPE Coder Survey with thanks to everyone who contributed to this once again. There is also information on the latest Perinatal Statistics reports produced from our sister data set The National Perinatal Reporting System (NPRS) which is also managed by the HPO.

This edition of *Coding Notes* contains a great selection of Coding Queries (pages 8-9) and COVID-19 Coding Queries (pages 10-11) and a training update on page 12. Unfortunately training is paused currently while waiting for systems to return.

Plenty of reading for the beach there!

We hope you all get to have a break from the pressures of recent times. Thanks to you all as always for your ongoing work in these challenging times.

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Inside This Issue

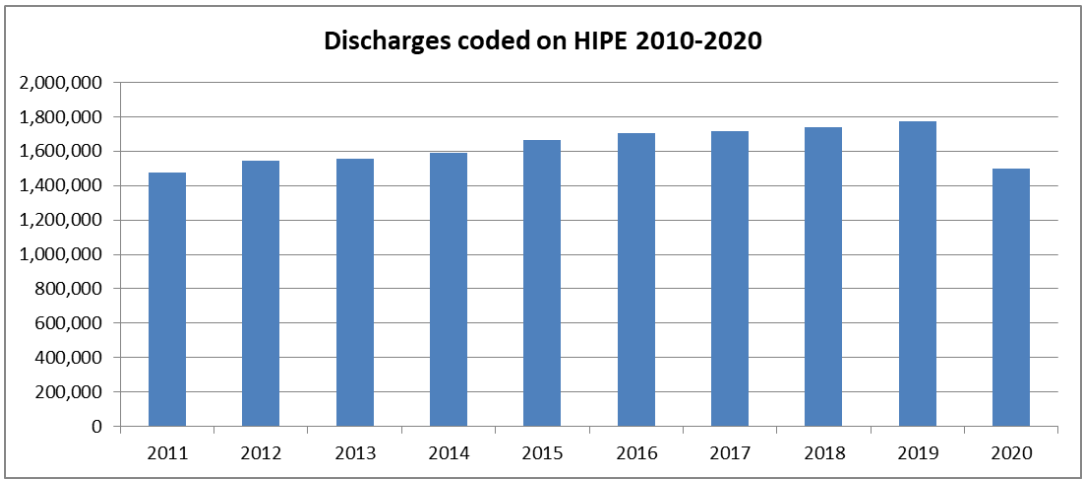
HIPE 2020 & COVID–19

The 2020 HIPE national file was closed in early May after the end of April exports were received. It was fortuitous that it was closed before the Cyberattack struck. The HPO very much appreciate the incredible efforts all HIPE teams put in to getting this 2020 data submitted under the most difficult of circumstances. The HIPE information collected for 2020 will be of national and international benefit and interest for many years to come.

The update to 10th edition of ICD-10-AM/ACHI/ACS/ICS for discharges from 1.1.2020 was overtaken by the arrival of COVID-19 and the blizzard of related new codes and coding guidelines. In addition the ask was to return these discharges within 48 hours, something that had never been required before. Again hospitals have continued to provide the COVID-19 HIPE data in as timely a manner as possible taking into account local issues and policies. As always HIPE coders and HIPE teams across the country showed their tenacity and resilience and met all these changes and challenges head on, continuing to provide timely, accurate and valuable hospital activity data.

The final figure for 2020 at the final export received in the end of April export was 1,499,946 HIPE discharges coded, representing a national coverage of 98.9% of downloaded discharges coded. This compares to 1,771,023 coded discharges representing 99.5% coverage in the previous year, 2019.

There was a drop in acute public activity of 271,077 coded discharges reported to HIPE, representing a 15.3% drop. The drop in cases during the year is COVID-19 related with routine procedures postponed, people staying away from hospitals and activity moving to the private hospitals.



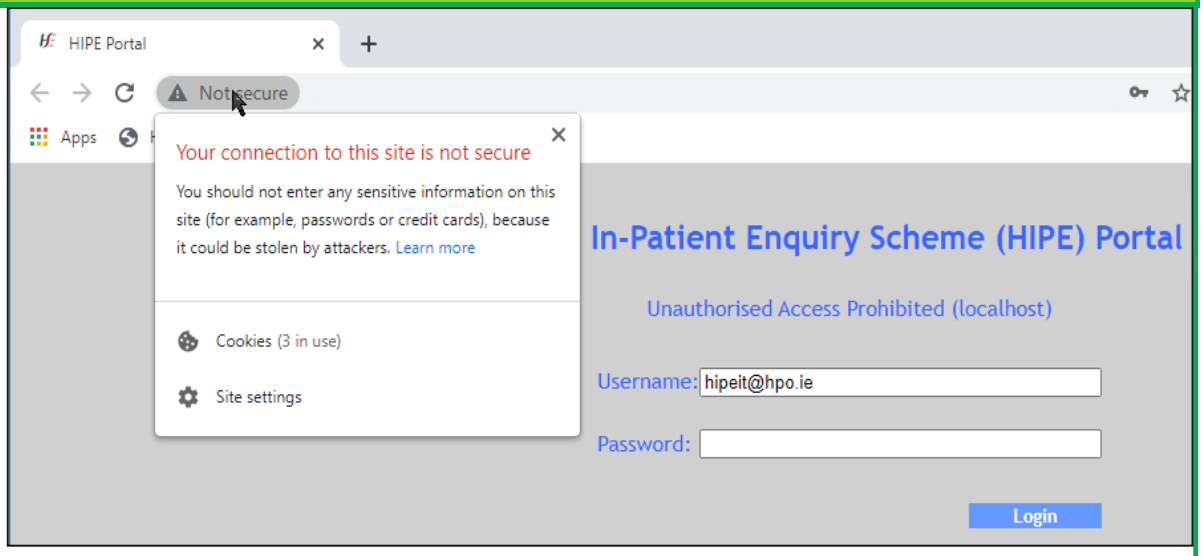
It is a testament to all in HIPE that the coverage figures have remained so high considering the challenges faced with dealing with COVID-19 along with the update to 10th Edition of ICD-10-AM/ACHI/ACS/ICS. The COVID-19 coding guidelines in themselves were a challenge with new codes and guidelines being released by WHO and IHPA throughout 2020 and on in to 2021.

The two codes U07.1 *Emergency Use of U07.1 - [COVID -19 laboratory confirmed]* and U07.2 *Emergency Use of U07.2 - [COVID -19 clinically diagnosed or probable cases]* are the codes used to identify COVID-19 for reporting purposes in the overnight files. In 2020 a total of 7,987 cases were reported with these codes, 7,621 for U07.1 *Emergency Use of U07.1 - [COVID -19 laboratory confirmed]* and 366 for U07.2 *Emergency Use of U07.2 - [COVID -19 Clinically diagnosed or probable cases].*

2020 COVID-19 Discharges		
U071	*Emergency Use of U07.1 - [COVID -19 laboratory confirmed]*	7,621
U072	*Emergency Use of U07.2 - [COVID -19 Clinically diagnosed or probable cases]*	366

HIPE Portal Security

In light of the recent cyberattack, a number of hospitals have contacted the HPO regarding the security of the HIPE Portal and the "Not Secure" message which appears in Google Chrome (and other browsers).



All HIPE Portals are either based locally within the hospital, or on the National Hospitals Network (NHN). In either case, the HIPE Portal is NOT available on the World Wide Web / Internet. The "Not Secure" message indicates that the HIPE Portals are not digitally signed secure websites but as they are based in the safe environment of the NHN or local hospital network, this level of security is not required.

There is no reason to be concerned about this message when you see it in the HIPE Portal.

Hospital Acquired Diagnosis Data—HADx Review

Review and Analysis of Hospital Acquired Diagnosis Data

The Hospital Acquired Diagnosis (HADx) flag has been collected by HIPE since 2011 to identify conditions that arise after admission to the hospital. This flag is assigned based on documentation available to the coder and guidance on the application of this flag is provided in ICS 0048 *Hospital Acquired Diagnosis Flag.* This ICS was extensively updated in January 2021 to reflect fully the advice contained in ACS 0048 *Condition Onset Flag* (COF) which is the Australian equivalent. There is significant clinical and research interest in this area in Ireland.

As described at the HIPE Managers' session on 30th March 2021, in Australia the Australian Commission on Quality and Safety in Healthcare (www.safetyandquality.gov.au/ourwork/indicators) have identified a set of 16 Hospital Acquired Complications (HACs). Each HAC contains a number of codes and data items (such as the HADx flag) and most of the HACs can be replicated for Irish data as a similar coding system is in place. The HPO have commenced comparisons of the data in Ireland to the data in the HACs in Australia. This is in line with other countries where data on conditions acquired after admission is being utilised to inform analysis and research on areas such as quality of care and patient safety.

The data analytics team in the HPO are reviewing the HADx variable for additional diagnoses in HIPE data. As part of this review the HPO's Data Analytics team are looking at variation and possible causes of variation in the reporting of HADx across hospitals. Part of this review involves developing a report for hospitals on particular conditions where HADx reporting is above or below expected levels. Further information sessions will be held for HIPE staff as this work progresses. In the meantime please review the use of the HADx flag in your hospital and ensure that HIPE staff are familiar with the updated and expanded guidance in ICS 0048 *Hospital Acquired Diagnosis*.

Turbinoplasty

The nasal turbinates are located on the inner walls of the nose on either side of the septum, the structure that divides the nostrils and the nasal passages. They consist of three long, thin surfaces of bone in each side, covered by vascular soft tissue and mucous membrane.

Blood vessels in the turbinates help to warm the air as it is inhaled. The vessels swell and contract, enlarging or shrinking the turbinates, depending on the amount of blood flowing through them. The mucous glands in the lining help to moisturize the air in the nose.

What is Turbinoplasty?

Some people have chronic nasal congestion caused by a septum that is deviated – narrower on one side than the other – often due to a minor injury. When the nasal passages are unequal, the turbinates can compensate with chronic swelling. The goal of turbinoplasty is to reposition or reshape the turbinates, to increase the volume of air that passes through the nose when breathing, while preserving as much tissue as possible for normal turbinate function.

Coding Rule

Ref No: Q3035 | Published On: 15-Jun-2016 | Status: Current | IHPA

SUBJECT: Turbinoplasty

Q:
What is the correct code to assign for a turbinoplasty?

A:
During a turbinoplasty, the turbinates are reshaped either by outfracturing (surgical fracture) or submucosal resection or a combination of the two methods. Both involve removal of turbinate tissue (i.e. a partial turbinectomy) via different mechanisms.
ACHI does not have a specific code for turbinoplasty, therefore assign code(s) according to the documentation within the operation report:

- **41692-00** [**376**] Submucous resection of turbinate, unilateral
- **41692-01** [**376**] Submucous resection of turbinate, bilateral
- **41686-00** [**381**] Surgical fracture of nasal turbinates, unilateral
- **41686-01** [**381**] Surgical fracture of nasal turbinates, bilateral
- **41689-00** [**376**] Partial turbinectomy, unilateral
- **41689-01** [**376**] Partial turbinectomy, bilateral

If outfracturing (surgical fracture) or submucous resection is not specified assign **41689-00** [**376**] Partial turbinectomy, unilateral or **41689-01** [**376**] Partial turbinectomy, bilateral following the Alphabetic Index:
Turbinectomy
- partial (unilateral) **41689-00** [**376**]
- - bilateral **41689-01** [**376**]

However, if a turbinoplasty (by any method) is performed in conjunction with a septoplasty assign **41671-02** [**379**] *Septoplasty* or **41671-03** [**379**] *Septoplasty with submucous resection of nasal septum*; as turbinectomy is included within these codes as per the Includes notes.
Amendments to ACHI will be considered for a future edition.

Published 15 June 2016. For implementation 01 July 2016.

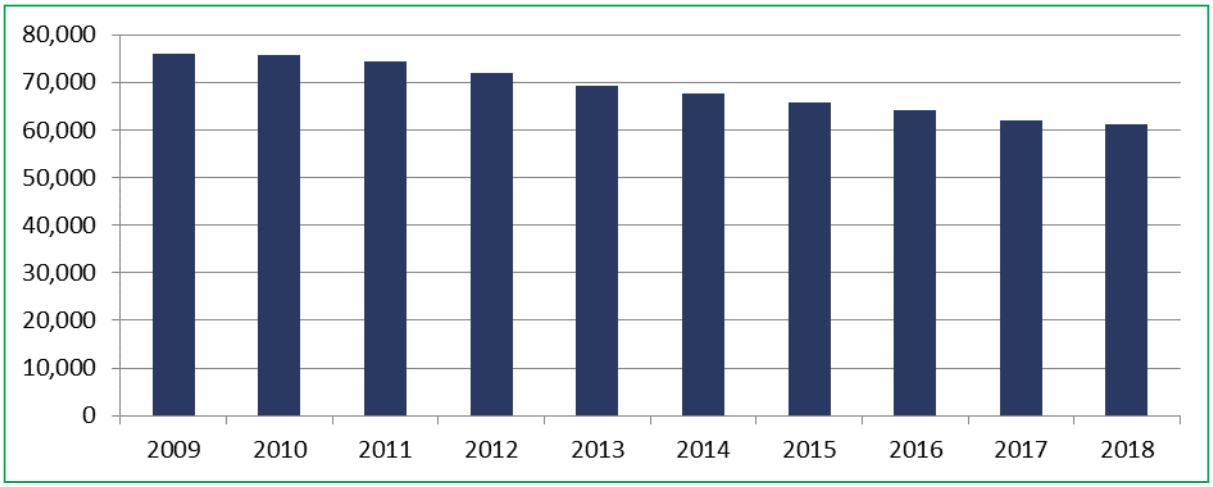
Perinatal Statistics Report, 2018

Along with the HIPE national file, the HPO also manage and maintain the National Perinatal Reporting System (NPRS). A small team in the HPO work with the national maternity services including the independent midwives to collect and report on every birth in Ireland. This is done through the Birth Notification Form (BNF) which is also used by the General Registrar for Births and hospitals as well as by the Director of Public Health and Medicine. NPRS is the only source of information on all births in Ireland. The NPRS data is used nationally and internationally for perinatal epidemiology, planning of maternity services and it has input into population health profiles.

The latest National Perinatal Reporting System (NPRS) Annual Report presents national statistics on perinatal events in Ireland. This report provides information on mothers giving birth and babies born in 2018.

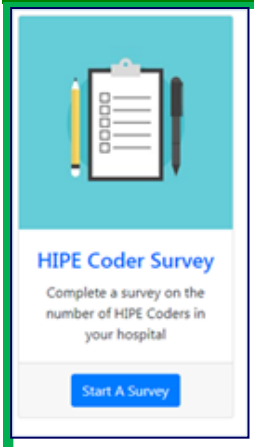
Main Findings of the 2018 Report

- 61,258 births were reported to NPRS in 2018, representing a 1.3% decrease between 2017 and 2018 and a 19.4% decrease between 2009 and 2018
- 7% of total births were preterm (less than 37 weeks gestation)
- 6% of live births were low birthweight (less than 2,500 grams)
- 2% of live births were high birthweight (4,500 grams or more)
- 60% of babies recorded any breastfeeding in 2018, compared to 53% in 2009
- 34% of total live births were delivered by Caesarean section, with 33% of singleton and 70% of multiple live births delivered by this method. In 2009, 27% of total live births were delivered by Caesarean section
- The perinatal mortality rate was 4.9 per 1,000 live births and stillbirths (4.5 per 1,000 singleton births and 15.5 per 1,000 multiple births). This rate has fallen by 42.9% since 2009, when it was 6.9 per 1,000 live births and stillbirths
- The average age of mothers has increased from 30.8 years in 2009 to 32.4 years in 2018
- 39% of mothers were aged 35 years or older, up from 27% in 2009
- 26% of women giving birth for the first time were aged 35 years or older, compared to 15% in 2009.



Number of Total Births, 2009-2018

HIPE Coder Survey 2021



Thanks to everyone for completing the annual HIPE Coder Survey which provides information on HIPE staffing throughout the system. It gives a good snapshot of HIPE. Some of the issues arising around clinician engagement and education in HIPE and also ABF education are areas that the HPO aim to work on at the national level. The improvement of health records, electronic and manual, are areas which many hospitals reported as important for HIPE specifically with regard to timely and accurate HIPE data.

It was lovely to see how many hospitals were grateful for the work of hospital group HIPE staff where appointed.

In total 49 hospitals responded. Some of those who did respond did not answer every question.

"Had assistance from HIPE Clinical Coder Group which proved to be invaluable."

HIPE Reporting Structure in Hospitals

The majority of hospitals report to the Finance departments with only two reporting to Medical Records:

- 32 (65%) of hospitals' HIPE departments report to Finance.
- 8 (16%) of hospitals' HIPE departments report to ICT/eHealth
- 4 (8%) of hospitals' HIPE departments report to Patient Services
- 2 (4%) of hospitals' HIPE departments report to Medical Records

Various other hospitals HIPE departments reported to the 'Clinical Services Manager' and the 'Operations Manager'.

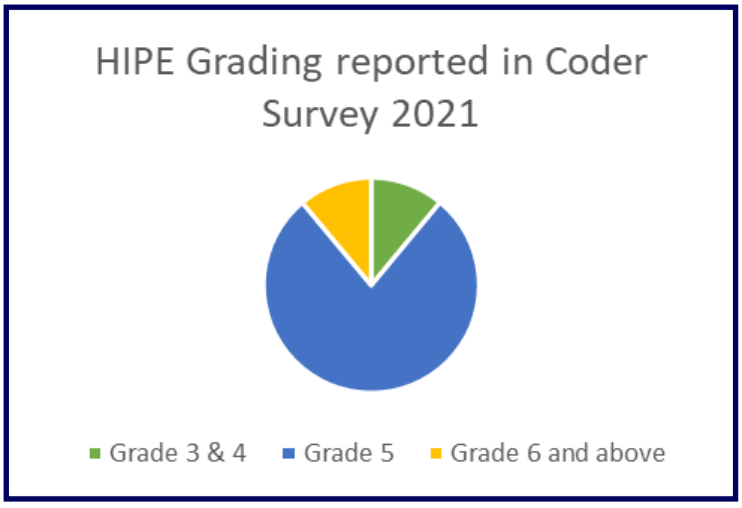
A survey carried out as part of a research project in 2009 reported 28% of HIPE departments being part of Finance and 20% reporting to Medical Records. It is interesting to see the shift of HIPE in many hospitals into the Finance department.

Staff Grading

Out of a total of 283.13 (WTE) HIPE staff reported in the survey:

- 31.2 (11%) are Grades 3 and 4.
- 220.58 are Grade 5 representing 77.9% of all HIPE staff reported in the survey.
- Grades from 6 and above accounted for 31.35 (11%) staff

Note that the totals cannot be used to extrapolate coder productivity as other factors would need to be taken in account e.g. case complexity, size of hospital, coder job specification etc.



Discharge Summaries

All hospitals who participated reported that standard discharge summaries are available with varying completeness from percentage completed reported as varying from 100% down to 50% of discharge summaries.

HIPE Coder Survey 2021

Continued

ABF committee

Fourteen hospitals report that they have an ABF committee in their hospital.

COVID-19 related remote working

Six hospitals reported that COVID-19 related remote working is available with 27.5 WTE coders working remotely. Note that this includes ten coders from one hospital.

"NCHD's and consultants need to be informed by HSE/HPO on how important documentation is in patient notes and that timely discharges summaries are filled out."

Clinician engagement

Forty four hospitals reported that there is clinician engagement varying from 'minimal' and 'on request' to a 'high level of engagement'. One hospital reported a dedicated HIPE Consultant. COVID-19 was reported as affecting some of this engagement. Three hospitals reported no clinician involvement at all.

Data Quality initiatives

Twenty five hospitals cited access to electronic systems as the main data quality initiative they would like to see.

"At a local level, computerized chart to aid collection of uncoded cases to meet deadlines and for reading of chart information."

"Electronic charts would make things more efficient and faster histology results would speed up coding."

Engagement, education and HIPE Profile

Several hospital reported the importance of clinician engagement for data quality assurance in addition to raising the profile of HIPE within the hospital. Additional education on HIPE and ABF, both within the hospital and from the HPO, were also reported as areas that would support data quality initiatives.

The HPO are very grateful for the information provided through this survey. We look forward to working with hospitals to develop education and engagement on HIPE and ABF throughout the system to enhance data quality and use of the data.

"Continued engagement with the Clinicians required to highlight the importance of coded data and correct documentation in charts."

Cracking the Code

A selection of Coding Queries

Please note that due to the HSE Cyberattack coding queries are taking longer to address. Apologies for any inconvenience caused..

Q. In our hospital the charts often provide no diagnosis for an avastin/lucentis injection. This was discussed with the ophthalmology team before and they confirmed these injections are done for a retinal disorder. Can you advise on the coding of the following scenarios?

1.Elective day case of an avastin/lucentis injection with a history of DM type 2 with only retinal disorder documented.
2. A patient with Retinal Detachment and a history of DM Type II (simple day case procedure).
3. The Patient has diabetic macular oedema with DM Type II.

A. Ophthalmology can be a challenging area to code in view of the brevity of documentation and use of abbreviations. The HPO encourage coders to link in with the Ophthalmology team locally, as done here, to try and improve on this area. In the absence of this clinical input we can only code the information provided in the query and we cannot make any assumptions as to diagnosis or procedures. See the responses below.

1. Elective day case of an avastin/lucentis injection with a history of DM type 2 with only retinal disorder documented:

PDx *H35.9 Retinal disorder, unspecified*
ADx *E11.9 Type 2 diabetes mellitus without complication*

Note: Retinal disorder is not a complication of diabetes as indicated by following the index in the IEBook under "Diabetes with" therefore E11.9 Type 2 diabetes mellitus without complication will apply.

2. A patient with Retinal Detachment and a history of DM Type II (simple day case procedure):

PDx *H33.2 Serous retinal detachment*
ADx *E11.35 Type 2 diabetes mellitus with advanced oph thalmic disease*

Note: The descriptive text of the diabetes code does not specify the type of condition therefore the H33.2 *Serous retinal detachment* code is required.

3. The patient has diabetic macular oedema with DM Type II:

PDx *H35.8 Other specified retinal disorders*
ADx *E11.34 Type 2 diabetes mellitus with other retinopathy.*

Note: For reference see Example 2 in ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycamia* and the general classification rules for DM and IH (Rules 1-6).

Q. Can you advise on the correct code assignment for a patient diagnosed with Diffuse Large B Cell primary bone lymphoma – primary site, ischium?

A. For a similar query IHPA have acknowledged the challenges for coders in the classification of extranodal lymphomas (see Coding Rule Ref No: Q3356 | Published On: 15-Mar-2019 | Status: Current). In Ireland as the morphology codes to classify the lymphoma are not used in HIPE please see Note 7 Use *of the Alphabetic Index in coding neoplasms* at the beginning of Chapter 2 *Neoplasms* which states:

> In addition to site, morphology and behaviour must also be taken into consideration when coding neoplasms, and reference should always be made first to the Alphabetic Index entry for the morphological description.

With this in mind we would recommend assigning C83.3 *Diffuse large B-cell lymphoma* based on the alphabetic index entry for Lymphoma, B-cell, diffuse large.
Please enter the background information on this case and the full clinical description into the HIPE Portal explanation box to capture the entire picture of this rare case.

Q. What ACHI code is assigned for removal of a JJ stent with strings? They are removing the stent on the ward by pulling the strings out.

A. When looking up the alphabetic index of ACHI for **Removal**, *Stent, ureter* it states that endoscopic is a non-essential modifier along with other routes/approaches and therefore this code can be used to classify this type of stent removal.
We recommend code 36833-01 [1067] *Endoscopic removal of ureteric stent*

Q. Can you confirm the code for blocked PEG tube or mechanical complication of PEG tube?

A. Code this to *K91.49 Malfunction of stoma of the digestive system, not elsewhere classified .* The index look up is **Complication,** *gastrostomy, obstruction.*
Also see ACS 1904 *Procedural complications* Example 13 where it states that a gastrostomy tube is a digestive system stoma, not a prosthetic device, implant or graft.

Q. What procedure code would apply for a patient with plantar fasciitis who is given a common peroneal nerve block?

A. Please assign the following code; *90022-00 [63] Administration of anaesthetic agent around other peripheral nerve.*

Cracking the Code

Continued

Q. If a patient has a colonoscopy with polypectomy and a biopsy is performed how is it coded?

A. Please assign a procedure code for both procedures as there is no combined code for a biopsy and a polypectomy.

32093-00 [911] Fibreoptic colonoscopy to caecum, with polypectomy <u>*AND*</u>

32090-01[911] Fibreoptic colonoscopy to caecum, with biopsy

You can also refer to ACS 0020 *Multiple/Bilateral Procedures* for further guidance.

Q. How is 'infusion of rituximab' coded? It is being administered for non-Hodgkins lymphoma and is administered intravenously as a day case patient.

A. Please see the beginning of ACS 0044 *Chemotherapy* which states the following

> For coding purposes, chemotherapy is defined as: The administration of any therapeutic substance (usually a drug), excluding blood and blood products.

In your example a therapeutic substance is being administered for the treatment of the non-Hodgkins lymphoma and therefore the chemotherapy procedure code *96199-00 [1920] Intravenous administration of pharmacological agent, antineoplastic agent* would apply.

Q. What code would you use for a knee aspiration procedure?

A. In the absence of any further information we would advise assigning the following code;

50124-00 [1553] Aspiration of joint or other synovial cavity, not elsewhere classified.

Q. What procedure code is assigned for Cystolitholapaxy?

A. Cystolitholapaxy is Litholapaxy (Bladder stone crushing) of the bladder. Assign *36863-00 [1096] Litholapaxy of bladder*

Q. What code is assigned for tricuspid insufficiency without any further information as to its origin?

A. Assign I07.1 *Tricuspid insufficiency*. Codes from I07 Rheumatic tricuspid valve diseases can be assigned whether specified as rheumatic or of unspecified origin. Please refer to the includes note at I07 *Rheumatic tricuspid valve diseases*.

Q. When a patient has insufficiency of both the mitral and aortic valve, but there is no history of rheumatic fever documented in the chart can code I08.0 *Disorders of both the mitral and aortic valves* be assigned?

The excludes note at I08 is causing confusion.

> ***Excludes:*** endocarditis, valve unspecified (I38) multiple valve diseases of specified origin other than rheumatic heart disease (use appropriate codes in I34-I38, Q22-Q23 and Q24.87) rheumatic diseases of endocardium, valve unspecified (I09.1)

A. I08.0 *Disorders of both the mitral and aortic valves* can be assigned as there is an includes note at I08 *Multiple valve diseases* – "includes: whether specified as rheumatic or of unspecified origin". As there is no documentation of a specified origin I08.0 *Disorders of both the mitral and aortic valves* is assigned.

Q. If a patient had a diabetic cataract (Type 2 Diabetes) and had an operation a year ago to remove the cataract and insert an intraocular lens, do we still collect this information as E11.39 *Type 2 diabetes mellitus with other specified ophthalmic complication* on this admission?

A. Please refer to ACS 0401 *Diabetes Mellitus And Intermediate Hyperglycaemia*, 7. *Eradicated Conditions and DM* (pg. 83 in the hard copy of the ACS book).

> **CLASSIFICATION**
> Eradicated cataract and DM
> When a cataract has been eradicated as a result of surgery, assign either:
> code/s for the current complications of diabetes
> <u>OR</u>
> *E1-.9 *Diabetes mellitus without complication*
> as appropriate
>
> <u>WITH</u>
> a code to indicate the status of the previous surgery.

In this scenario as there is no mention of a current complication of diabetes assign E11.9 *Diabetes mellitus without complication* with a status code of *Z96.1 Presence of intraocular lens.*

COVID-19 Coding Queries

A selection of COVID-19 coding queries

Please note that due to the HSE Cyberattack coding queries are taking longer to address. Apologies for any inconvenience caused..

Q. When is the COVID-19 flag assigned on HIPE?

A. Please see Irish Coding Standards - XII *Laboratory confirmed COVID-19 Past or Present Flag* (page 18 of ICS V1 2021) for full details and examples. This standard states that the coder will choose 'Yes' for laboratory confirmed COVID-19 past or present if:

> There is a diagnosis of Lab-confirmed COVID-19 during the current episode of care (Laboratory confirmed cases U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*
>
> **OR**
>
> There is documentation in the chart that the patient had a Lab-confirmed COVID-19 or tested positive with COVID-19 during a previous episode of care.
>
> **OR**
>
> There is documentation in the chart that the patient was previously diagnosed with Lab-confirmed COVID-19 or tested positive with COVID-19 anytime, anywhere (e.g. community, any hospital/nursing home), including outside of Ireland.

The COVID-19 flag and U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* are assigned independently. The COVID-19 flag pertains only to Lab confirmed COVID-19. The lab result does not have to be on the hospital system as there are test centres in the community and in other hospitals, information which you would not have access to. The flag assignment therefore is dependent on the documentation in the chart which must state 'Laboratory confirmed' or 'Tested Positive COVID -19' or 'COVID-19 positive' for this flag to be assigned. Diagnosed as 'COVID-19' or 'Had COVID-19' or 'Post COVID-19' is not sufficient for the flag to be applied as this can be interpreted as either Lab confirmed or clinically diagnosed.

Q. Can you please advise if U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* has to meet criteria in ACS 0002 *Additional Diagnoses* to be assigned? Example 4 in the ICS seems to indicate that it is coded whenever it is documented.

A. Code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* is indeed an exception and does not need to meet criteria as per ACS 0002. The HPO have confirmed this advice with IHPA.

Q. A patient has a history of COVID-19 and the clinician stated in their chart that they still have 'a post COVID-19 cough'. The following codes were assigned to the case U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* and U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* but PICQ sent this back with a query. Can you please advise?

A. Please see the section on classification of post COVID-19 conditions in ICS 22X2 *Novel Coronavirus COVID-19*.

The codes *U07.3 Emergency use of U07.3 [Personal history of COVID-19] and U07.4 Emergency use of U07.4 [Post COVID-19 condition]* are mutually exclusive therefore cannot be assigned in the same episode of care.

Where clinical documentation indicates previous COVID-19 but it is not clearly linked to a current condition, seek clarification from the treating clinician before assigning U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*. Where a causal relationship is not established, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19].*

Documentation of 'post COVID 19 cough' is not enough to assume the cough is related or due to COVID-19.
In the absence of a causal relationship and based on information provided we would advise assigning U07.3 *Emergency use of U07.3 [Personal history of COVID-19].*

Q. A patient has tested positive with SARS-CoV-2 but it's a very weak positive. In the report it states that the case may reflect resolved /resolving infection as weak positive results may persist for many weeks. The patient had a positive test a month earlier. Do you still code the current case as a positive case?

A. The HPO advises that you to refer to example 3 in ICS 22X2 *Novel Coronavirus (COVID-19)* which is a similar scenario. COVID -19 detection can persist for many weeks post infection. As documentation states in your example "resolved /resolving infection as weak positive results may persist for many weeks" this would support the assignment of *U07.3 Emergency use of U07.3 [Personal history of COVID -19*]. In cases where there is any ambiguity around whether this is still an *Acute infection* Vs *Resolved* we would always advise to seek clarity from infection control or the treating team as determining the timeline is a clinical judgement.
The COVID-19 flag variable would also apply as it is documented that the patient had tested positive.

COVID-19 Coding Queries

Continued

Q. A patient was admitted for irritable bowel disease but on the discharge sheet the consultant mentioned that they have a post COVID-19 cough which was not treated in hospital. Is it correct to assign a history code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* only as this patient had lab confirmed COVID-19 in January 2021?

A. It is correct to assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* in this scenario. Documentation of "post COVID-19 cough" would not be enough to assume a causal relationship between the current condition and COVID-19 so code U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* will not apply.

The guidance in ICS 22X2 *Novel Coronavirus (COVID-19)* states:

> Where clinical documentation indicates previous COVID-19 but it is not clearly linked to a current condition, seek clarification from the treating clinician before assigning U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*. Where a causal relationship is not established, assign U07.3 Emergency use of U07.3 [Personal history of COVID-19].

The COVID-19 Flag would also apply as it is documented that the patient had lab confirmed COVID-19.

Q. If a patient is COVID-19 positive on a COVID-19 only ward do I assign Z29.0 *Isolation*, whether documented or not?

A. The HPO advises that you can assign a code for isolation if it is documented in the clinical record. This would also apply for the assignment of an isolation code based on the ward – there must be documentation to support this in the chart. We acknowledge this may not be documented for these patients as these are considered isolation wards

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Q. If a patient is admitted with COVID 19 and is automatically isolated should I apply HADX to Z29.0 *Isolation*?

A. As COVID-19 is present when the patient is admitted and the patient is isolated the HADx will not be assigned to Z29.0 *Isolation*. If it is clear from documentation that COVID-19 is acquired *after* admission and the patient is isolated at this point then the Z29.0 I*solation* can be flagged as hospital acquired.

Q. A patient was admitted for an adverse effect due to a recent COVID-19 vaccine. I entered the following;

T88.1 Other complications following immunisation, not elsewhere classified

L50.0 Allergic urticaria,

Y59.0 Viral vaccines

U07.7 Emergency use of U07.7 [COVID- 19 vaccines causing adverse effects in therapeutic use].

This was as per HPO advice. It has come up as an unverified check on the Checker©, why can I not verify this?

A. These are the correct codes to assign for this case as per guidance issued by the HPO via email on 9th April – *COVID-19 vaccines causing adverse effects in therapeutic use*.

The Checker© is currently been updated by the HPO IT team to reflect this guidance. Please bear with us.

Do you have a HIPE coding query?

Please email your query to: **hipe.coding@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.

HIPE Training Update

Due to the recent cyberattack on the HSE IT systems, the HPO and HIPE Clinical Coders are currently unable to access some of the systems that are necessary for the delivery of HIPE Clinical Coder training.

Unfortunately, this means that the following courses are postponed until further notice:

- **Coding Skills II C- Endoscopy Follow- up** (scheduled for 10th June 2021)
- **Coding Skills III** (scheduled for 15th – 17th June 2021)
- **Coding Skills IV Introduction to Obstetrics** (scheduled for 23rd June 2021)
- **Coding Skills III B- Circulatory** (scheduled for Wednesday 7th July 2021)
- **Coding Skills IV - Z Code Workshop** (scheduled for Thursday 8th July 2021)

It will also be necessary to reschedule some of the other courses that were advertised on the training calendar and HPO website. We will resume the delivery of the clinical coding education programme as soon as possible. We will keep you informed of further schedule changes and any other developments once details have been confirmed.

Anatomy & Physiology Lectures

We understand that during the COVID-19 pandemic and due to associated social distancing regulations, and changes to working arrangements, it is not always possible for coders to participate in "Live" lectures. In response to this, and to make the Anatomy & Physiology lectures accessible to as many coders as possible, Professor Clive Lee has kindly pre-recorded the 8 lectures that were due to be delivered throughout 2021, and once the HPO website becomes available again, we will be delighted to be able to make these available to HIPE staff for viewing at a time of their own choosing. The available lectures are as follows:

- Introduction to Anatomy and Physiology
- ENT
- Neuroendocrine System
- Digestive System
- Circulatory System
- Genitourinary System
- Haematology
- Skin

These lectures are available to HIPE staff nationally. To access any of the lectures, please contact hipe.training@hpo.ie and a link will be forwarded to your email address. When you have completed this important component of your training, please notify us at hipe.training@hpo.ie and we will update your training records accordingly. These pre-recorded lectures will be available for repeat viewing until 31st December 2021. Please note that these lectures are to be accessed by HIPE clinical coders & HIPE Managers only and are not to be circulated beyond their intended audience.

New Coders

Please inform the HPO if a new member of staff joins your HIPE department and we will dispatch a starter pack and we will arrange training as appropriate.

If you have any queries in relation to HIPE Training, please don't hesitate to contact us at hipe.training@hpo.ie.

TU Dublin- Certificate in Clinical Coding

Due to the on-going disruption caused by the cyber-attack, we have had to suspend Module 2B Clinical Coding (Ire) until September 2021. All students taking this course have been informed and this announcement has also been issued on the TUDublin Brightspace app. A new Module 2B time table will be issued in due course.

Thought for Today

The best thing about the future is that it comes only one day at a time.

Abraham Lincoln 1809-1865,
16th U.S. President