Coding Notes

Healthcare Pricing Office

Number 73
June 2016

2016 Activity Based Funding Education Event, NUI Galway

The annual ABF education event was held this year on 25th May in NUI, Galway and was attended by over 220 participants with countless more watching the live stream on the day. The welcome address from Dr Jim Browne, President, NUI Galway drew some similarities between ABF funding and the challenges in education funding. The Event was opened by Liam Woods, the National Director of Acute Hospital Services. Maureen Cronin, Assistant CFO, Head of Acute Hospital Finance – ABF/HPO followed with an update on ABF and what lies ahead.

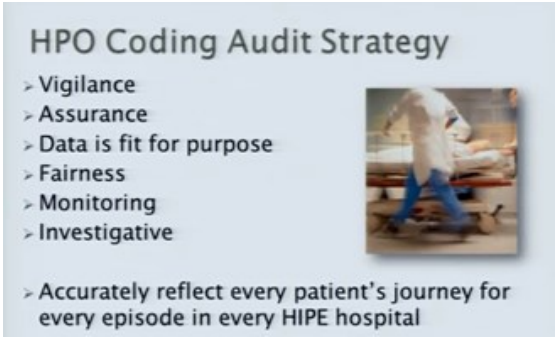
Based around the recent National Audit of Admitted patient Information, Deirdre Murphy, Head of HIPE & NRPS at the HPO, presented on many aspects of HIPE which show how critical robust, timely and accurate HIPE data are to the ABF programme. Deirdre also presented some of the key findings of the National Audit.

A central finding from the audit is the need for clinical engagement in the HIPE and ABF process. Three clinicians presented on their experiences of HIPE and ABF within their hospitals. Dr Tommy Kyaw Tun, Associate Clinical Director for Medicine & Consultant Endocrinologist, Connolly Hospital, Dr Kieran Hannan, Lead Clinician in the Department of Medicine, Cavan Monaghan Hospital and Dr Brendan Murphy, Clinical Lead in the Department of Neonatology, Cork University Maternity Hospital all presented on this topic. It is a great start to have three such engaged clinicians participating and presenting at this annual event.

Brian Donovan, Head of Pricing, HPO provided some insight into how ABF is moving hospitals away from the block funding. Later in the day Mark O'Connor, Management Accountant, HPO gave a very informative and entertaining presentation on costing in an ABF environment, with helpful sporting analogies included.

Cliona O'Donovan, Data Analyst at the HPO brought people through the ABF Monthly Reporting tool that is available through Qlikview. This tool is being developed by Cliona and the HPO team and is proving to be invaluable for hospitals to drill into their hospitals' activity data in a timely way.

Data quality is never far from anyone's mind and Jacqui Curley, the Coding Manager at the HPO presented on the proposed Coding Audit Strategy to support the ABF programme and to ensure that the HIPE data available are of the highest quality possible and reflect accurately the activity taking place in the acute hospital inpatient and day care settings nationally.



Ireland updated to the 8th edition of ICD-10-AM/ACHI/ACS on 1st January 2015. The follow on from this is the move from AR DRG Version 6.0 to Version 8.0. Laura Metcalfe and Karen Kearns, Data Analysts at HPO have done extensive work on the differences between the two versions which are vital for all users of the ARDRG system to be aware of and understand. Their presentation laid out these important differences and changes. Indeed this presentation is the most requested since the conference.

Professor Brendan Kennelly of NUI Galway ended the day with his thought provoking paper on *Measuring the Quality of Outcomes in Healthcare using HIPE data.* With such an interesting mix of presentations we hope the outcome for everyone was a greater understanding of the ABF Programme, where it is and where it's going and how everyone can play a part in its success.

Videos and slides of the presentations are available to view on www.hpo.ie

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DIT Graduation— May 2016

On Saturday, 21st May, the School of Computing in DIT hosted the third graduation for students who have successfully completed the CPD Certificate Course in Clinical Coding. Many of the class were in attendance and after some very congratulatory and supportive words from Dr. Robert Ross, Deputy Head of the School and Dr. John Gilligan the students received their certificates. It was great to meet everyone who could make it there on this day of celebration with family and friends.

Applications have now been received for the next course due to start in August 2016, running through until January 2017. The participation in the course has been really wonderful with many coders choosing to complete this certification course. Feedback from those who have completed the course is, that although it is a challenging programme, the benefits both personally and professionally make it a very worthwhile course to undertake.

It is a great opportunity for coders to put their skills to the test and prove their abilities through the assessments and final examination. Although the pass mark is 80%, coders have proved they can consistently attain these marks. This is an important element in the continual improvement of HIPE data and it is a way to demonstrate to data users the high quality of HIPE coded data.

HSE Excellence Award for project based on HIPE data

National Clinical Programme for Acute Coronary Syndrome (ACS)

The Runner Up Award was presented to the National Clinical Programme for Acute Coronary Syndrome (ACS) which was initiated in 2010 to save lives by standardising the care of ACS patients across the country as a joint venture between the Irish Cardiac Society (under the auspices of the Royal College of Physicians of Ireland (RCPI) and the HSE.

The ACS programme has been responsible for PPCI (Primary percutaneous coronary intervention) being rolled-out nationally and results show a major shift towards the treatment of STEMI patients with PPCI in Ireland. In 2014, 92% of eligible patients received PPCI compared with a report of 55% in 2011.

The data for this project is based on HIPE and the additional ACS data collected via the HIPE Portal.

For further information please see:

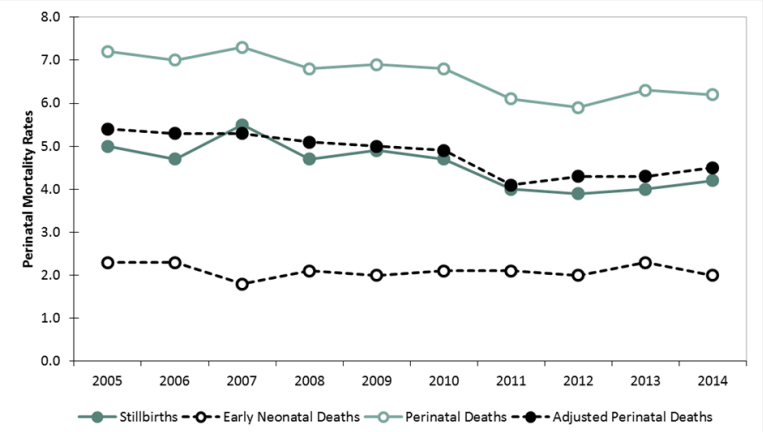
http://www.hse.ie/eng/staff/HealthServiceExcellenceAwards2016/ACS.html

Perinatal Statistics Report 2014

This report, on all babies born in Ireland in 2014, presents information reported to the National Perinatal Reporting System (NPRS) in the HPO, on pregnancy outcomes, together with descriptive social and biological characteristics of all mothers giving birth.

Main findings of the 2014 Report

- 67,610 births were reported to NPRS in 2014, representing a 2.4 per cent decrease between 2013 and 2014
- 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)
- 57% of babies recorded any breastfeeding in 2014, compared to 54% in 2010 and 48% in 2005
- 30% of total live births were delivered by caesarean section. In 2005, 26% of total live births were delivered by caesarean section
- The perinatal mortality rate was 6.2 per 1,000 live births and stillbirths in 2014. This rate has fallen by 14% since 2005, when it was 7.2 per 1,000 live births and stillbirths



Stillbirth, Early Neonatal and Perinatal Mortality Rates, Ireland, 2005–2014

Age Profiles

- The average age of mothers has increased from 30.5 years in 2005 to 31.8 years in 2014
- 33% of mothers were aged 35 years or older, up from 26% in 2005
- 21% of first births were to women aged 35 years or older, compared to 13% in 2005
- 2% of total mothers giving birth were aged under 20 years, compared to 4% in 2005
- In 2014 38% gave birth for the first time, with an average age for first time mothers of 30.0 years
- 22% of births in 2014 were to mothers born outside Ireland compared to 25% in 2010 and 17% in 2005.

The full report will be available shortly for download at www.hpo.ie

Chronic Kidney Disease - Staging

A code for CKD cannot be assigned based on eGFR results alone – CKD must be documented in the Medical Record before a code from N18.- *Chronic Kidney Disease* can be assigned.

A number of queries have arisen recently about the use of the eGFR when coding Kidney Disease. This was a change that came in with 6th Edition of ICD-10-AM/ACHI/ACS & with the introduction of ACS 1438 *Chronic Kidney Disease.*

ACS 1438 *Chronic Kidney Disease provides information on the use of the eGFR.*

Chronic kidney disease (N18.-) must be assigned in all episodes of care when a diagnosis of chronic kidney disease (or chronic renal failure) is **documented** and meets the criteria for an additional diagnosis (see ACS 0002 *Additional diagnoses*).

Where CKD is documented, assign the stage based on:

1. documentation of a stage by clinician,
   OR
2. documentation of GFR (or eGFR) by clinician,
   OR
3. GFR (eGFR) from pathology result.

STAGES OF KIDNEY FUNCTION REDUCTION
For use with when Kidney failure is documented.

STAGE	DESCRIPTION	GFR (mL/min/1.73m²)
1	Kidney damage with normal or increased GFR	⩾ 90
2	Kidney damage with mild decreased GFR	60–89
3	Moderate decreased GFR	30–59
4	Severe decreased GFR	15–29
5	Kidney failure	< 15

Source: ACS 1438 *Chronic Kidney Disease*

***Note*:** The eGFR will not be reported for patients under the age of 18 years, or for patients on dialysis treatment.

Example:

A 63 year old woman with known polycystic kidney disease was referred for investigation of persistent haematuria, tiredness and loss of appetite. Blood chemistry with a eGFR result of 42mL/min and electrolyte imbalance confirmed suspected deteriorating kidney function. Her medications were reviewed and adjusted, and she was discharged with a final diagnosis of chronic kidney disease due to polycystic kidney disease.

Codes: N18.3 *Chronic kidney disease, stage 3*
Q61.3 *Polycystic kidney disease, NOS*

Diabetic Nephropathy

Diabetic Nephropathy (Source: ACS 1438 Chronic Kidney disease)

Diabetic nephropathy is also known as diabetic glomerulosclerosis. It is a common underlying condition for CKD. In this condition, the glomeruli of the kidney thicken and slowly become scarred over time. The kidneys begin to leak and protein (albumin) passes into the urine (U.S. National Library of Medicine 2012). This is termed microalbuminuria and is one of the earliest markers of CKD (see also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia)*.

Classification

Assign a code from N18.- *Chronic kidney disease* in conjunction with the diabetic nephropathy code, to indicate the severity of the kidney disease.

EXAMPLE 6 (ACS 1438):

A 74 year old man with chronic kidney disease and diabetic nephropathy (Type 2 diabetes) was admitted for review of his kidney function. Biochemistry results included a decreased eGFR = 41 mL/min, down from 47 mL/min one month previously.

Codes: N18.3 *Chronic kidney disease, stage 3*
E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy*

In the above example CKD is documented. Please refer to the coding rules below also.

See also Coding Rules below (Source: *Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Current)*

Diabetic Nephropathy Contd.

Diabetes mellitus and Chronic Kidney Disease
(Source: Coding Rules *Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Current)*

"Question:
If E1-.22 **Diabetes mellitus with established diabetic nephropathy* is assigned should a code from category N18.- *Chronic kidney disease* also be assigned (following the *Use additional code* instruction at E1-.22) if the chronic kidney disease itself does not meet ACS 0002 *Additional diagnoses?*

Answer:
Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. When E1-.22 **Diabetes mellitus with established diabetic nephropathy* is assigned, the instruction *Use additional code to identify the presence of chronic kidney disease (N18.-)* should be followed. The chronic kidney disease should be documented but does not have to meet ACS 0002 *Additional diagnoses."*

Question:

If there is a diagnosis of Diabetes and Nephropathy documented in the chart, the disease index sends you to E1-.22 *Diabetes mellitus with established diabetic nephropathy* and there is an instruction in the Tabular List of Diseases at E1-.22 *Diabetes mellitus with established diabetic* to assign a code for the presence of CKD. Can an additional diagnosis code for Chronic Kidney Disease be assigned based on the eGFR results alone (in the absence of documentation for CKD)?

E1-.22 Type 1 diabetes mellitus with established diabetic nephropathy CR
Type 1 diabetes mellitus with:
- advanced kidney disease
- chronic kidney:
  - disease ≥ stage 3
  - failure
  - impairment
- end-stage kidney disease
- glomerulosclerosis:
  - diffuse
  - intracapillary
  - nodular
- Kimmelstiel-Wilson (disease)(lesion)
- macroalbuminuria
- nephropathy (advanced)(NOS)(progressive)
- nephrosis
- nephrotic syndrome
- proteinuria:
  - fixed
  - persistent

Use additional code to identify the presence of chronic kidney disease (N18.-)

Answer:

- A code for CKD can only be assigned if CKD is documented in the chart. If CKD is documented in the chart, then the eGFR results can be used to specify the stage of the CKD. The eGFR results alone can't be used to assign a code for CKD, as there are reasons other than CKD that can influence the eGFR reading.
- As conditions other than CKD are classified to E1-.22 *Diabetes mellitus with established diabetic nephropathy* e.g. Diabetes with nephrosis, a code for chronic kidney disease won't always be assigned in addition to E1-.22 *Diabetes mellitus with established diabetic nephropathy*.
- If there is documentation of diabetes and nephropathy in the chart without any documentation of CKD assign E1-.22 *Diabetes mellitus with established diabetic nephropathy*. A code for CKD is not assigned.
- If there is documentation of diabetes and nephropathy in the chart without any documentation of CKD, but there are eGFR results that indicate chronic kidney disease refer the case to the treating Clinician for clarification. If it's not possible to refer the case to the Clinician assign E1-.22 *Diabetes mellitus with established diabetic nephropathy* (a code for CKD won't be assigned as an additional diagnosis).

Instructional notes in the tabular list of diseases

The *use additional code/code also* instructions indicate that an additional code should be assigned to fully describe the condition or injury (see also ACS 0002 *Additional Diagnoses/Multiple coding*)

Example: At I20 – I25 *Ischaemic heart diseases*.

There is an instruction *use additional code to identify presence of hypertension*. This code applies when there is documentation of hypertension. The additional code for hypertension wouldn't be assigned based on blood pressure readings alone.

THE INTERNATIONAL STATISTICAL CLASSIFICATION
OF DISEASES AND RELATED HEALTH PROBLEMS,
TENTH REVISION, AUSTRALIAN MODIFICATION

ICD-10-AM

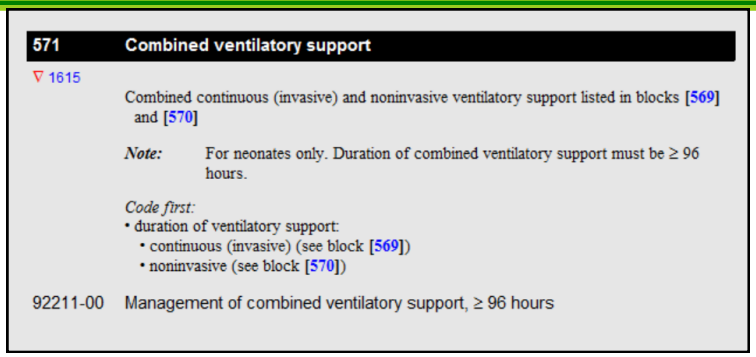
TABULAR LIST
OF DISEASES

Ventilatory Support for Neonates

The 8th edition of ICD-10AM/ACHI/ACS includes a new code 92211-00 [571] *Management of combined ventilatory support,* ≥96 hours for neonates

ACS 1615 *Specific interventions for sick neonates* provides the following guidelines for coding Ventilatory support for neonates:

Combined ventilatory support (invasive and non-invasive)



571 Combined ventilatory support

▽ 1615

Combined continuous (invasive) and noninvasive ventilatory support listed in blocks [569] and [570]

Note: For neonates only. Duration of combined ventilatory support must be ≥ 96 hours.

Code first:
- duration of ventilatory support:
  - continuous (invasive) (see block [569])
  - noninvasive (see block [570])

92211-00 Management of combined ventilatory support, ≥ 96 hours

- Neonates may receive both continuous ventilatory support (**CVS**) *and* non-invasive ventilatory support **(NIV)** in the same episode of care.
- CVS and NIV should be assigned separate codes as per the guidelines in ACS 1006 *Ventilatory support*, *Classification, point 1a*.
- **In addition**, when the hours of invasive and non-invasive ventilatory support are added together and the total is ≥96 hours, assign 92211-00 [571] *Management of combined ventilatory support,* ≥96 hours.

Example
A baby is born with severe respiratory failure arising during delivery. Neonate intubated and ventilated (combined with nitric oxide gas) for 48 hours, switches to non-invasive BIPAP for 37 hours, but deteriorates and returns to intubated ventilation for a further 23 hours. (Total = 108 hours)

Codes:

P28.5 *Respiratory failure of newborn* **HADx** ✓

Z38.0 *Singleton, born in hospital*

13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours*

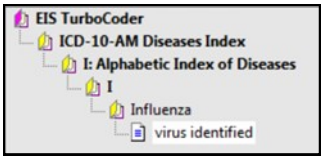
92209-01 [570] *Management of non-invasive ventilatory support, > 24 and < 96 hours*

92211-00 [571] *Management of combined ventilatory support, ≥ 96 hours*

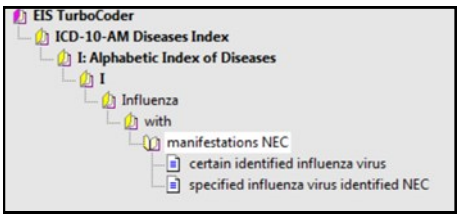
92210-00 [1889] *Nitric oxide therapy*

Clarification on coding of Influenza B

The correct code for Influenza B without any manifestions present is:
J10.1 *Influenza with other respiratory manifestations, other influenza virus identified*
Look Up
Influenza,
-virus identified J10.1



If there are manifestations present in addition to the Influenza B
Look up
Influenza,
With
- Manifestions
Locate the manifestation present and select the code indexed at
- - Specified influenza virus identified



Cracking the Code

A selection of ICD-10-AM Queries

Q. We had a case where sepsis was ticked on the sepsis form but the form wasn't signed by the clinician. Sepsis was documented in the chart so we assigned a code for sepsis and we also sent the form back to the clinician to be signed. Is it okay to assign a code for the sepsis even though the form wasn't signed?

A. Yes, a code can be assigned for sepsis in the following circumstances:

• If sepsis is documented in the medical record only, without the sepsis form being completed or signed.

• If the form is completed indicating sepsis and signed by the clinician, without any other documentation of sepsis in the Medical Record.

• If the form is completed indicating Sepsis and signed by the clinician and sepsis is documented elsewhere in the Medical Record.

It is good practice to contact the clinician where the form is ticked but not signed, you may also want to contact your sepsis ADON in relation to this type of documentation query.

Q. The chart indicates that the patient has confirmed H1N1 influenza A, which code would I assign in this case?

A. We suggest that the appropriate code for Influenza A/ H1N1 to assign is J09 *Influenza due to certain identified influenza virus*. Please see the Coding Rules indexed at code J10.

Code J09 can only be used for two very specific variants of Influenza A. Without either of these two very specific variants being documented influenza A would not be coded to J09. We had a note on this in Coding Notes of April 2015 (page 6).

Q. A colposcopy was performed with a procedure called 'Cold Co-Ag', this is the process of burning off abnormalities. It is similar to a LLETZ but not the same. What code is assigned for Cold Co-Ag?

A. While the procedure is called Cold Co-Ag (Cold Coagulation), it uses heat to destroy the tissue and is a cauterization. Please use 35608-00 [1275] *Cautery of cervix* for this procedure.

Q. A child was diagnosed with TB and all of the other children from their class were admitted as day cases for screening for TB. What code(s) are assigned for the other children?

A. The code assignment will depend on the results of the tests. If the tests are negative the classmates admitted for screening will be assigned the following codes:

Z11.1 *Special screening examination for respiratory tuberculosis*

Z20.1 *Contact with and exposure to tuberculosis*

Q. A patient was transferred to this hospital from a maternity hospital following a Caesarean Section (4 days previously). The chart documents a post C- Section bilateral pulmonary embolism. How do we code this?

A. We suggest that appropriate codes to assign are

O88.2 *Obstetric blood clot embolism*

Z39.01 *Postpartum care after hospital delivery*

See ACS 1548 Postpartum Condition or Complication (Example 1)

Q. How is GOLD stage of COPD coded?

A. This is a staging of COPD to mild, moderate, severe or very severe. In the ICD-10-AM classification and the WHO ICD-10 classification, COPD is not currently classified in this way. COPD is classified in ICD-10 as to whether there is exacerbation, obstruction or other conditions present with COPD. Please see ACS 1008 for further information on the classification on COPD.

Q. If a patient is admitted to hospital for a procedure and when they are admitted, after review the condition is no longer present, what diagnosis code is assigned?

A. In the absence of any further information, assign a code for the condition that was the reason for admission.

Example: A patient is admitted for removal of a skin lesion and on admission the skin lesion was no longer present, code as follows:

Assign a code for the skin lesion as the PDx followed by Z53.8 *Procedure not carried out for other reasons*

Also enter an explanation note on the HIPE Portal.

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.

Upcoming Courses

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

Coding Skills I

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

Date: Tuesday 27th – Thursday 29th September
Time: 10am – 5pm each day
Location: HPO, Brunel Building only

Coding Skills II

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

Date: Tuesday 25th – Thursday 27th October
Time: 10am - 5pm each day.
Location: HPO, Brunel Building only

Coding Skills III

This 3 day course is for coders who have previously attended *Coding Skills II*. Experienced coders are welcome to attend this course for refresher training.

Date: Tuesday 12th – Thursday 14th July
Time: 10am – 5pm each day
Location: HPO, Brunel Building only

Introduction to HIPE

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

Date: Friday, 12th August 2016
Time: 10.30am – 1pm
Location: WebEx only

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.

What would you like to see in Coding Notes?

If you have any ideas for future topics, please let us know. Thanks and keep in touch: info@hpo.ie

See the 'Find it Fast' section of the HPO website for easy access.

Coding Skills IV— Workshops

Endoscopies Workshop

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

Dates: Friday, 14th October
Time : 10.30 am -1pm
Location: HPO, Brunel Building & WebEx

Data Quality Session

Date: Thursday, 15th September 2016
Time: 11.30am – 1.30pm
Location: WebEx only

Note: This is an update on data quality activities and tools including the HCAT© audit tool available on the HIPE Portal and Checker©. This session will be repeated subject to demand.

Anatomy & Physiology

These courses will be delivered by a specialist speaker and are open to all HIPE coders.

Anatomy & Physiology— Introduction

Date: Tuesday, 6th September
Time: 11am – 1pm
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology— Cardiovascular System

Date: Tuesday, 6th September
Time: 2pm—4pm
Location: HPO, Brunel Building & WebEx

Thought for Today

'If my mind can conceive it, and my heart can believe it – then I can achieve it.'

Mohammad Ali (1942—2016)