Coding Notes

Healthcare Pricing Office

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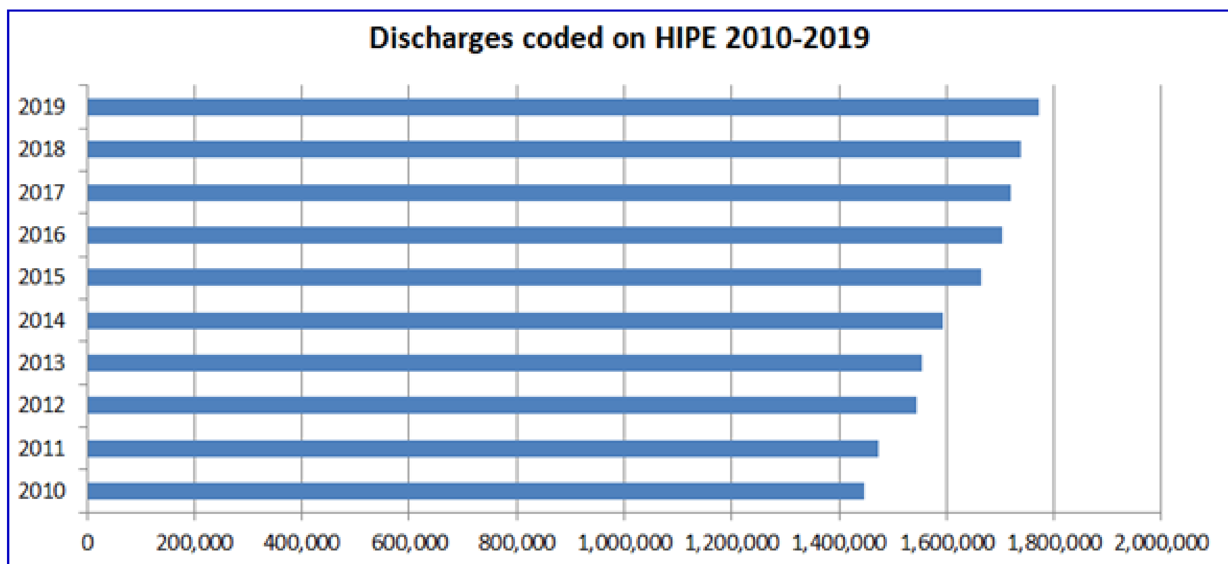
June 2020

Closure of the 2019 HIPE file—Thank You!

As the country starts to slowly return to a new normality the HPO once again wants to thank all the HIPE teams throughout the country for their dedication and work throughout this very challenging time. HIPE teams have been getting used to the 10th Edition of ICD-10-AM/ACHI/ACS and quickly updating on the coding of COVID-19 and associated conditions. With guidelines being issued quickly and the demands to get the COVID-19 cases coded promptly it has been a unprecedented 6 months.

Business carried on as usual with the closure of the 2019 HIPE National File at the end of April 2020. At the time of closing there were **1,771,023** discharges coded on HIPE nationally, resulting in the 2019 file being the largest HIPE National File to date.

The percentage coded overall is **99.5 per cent** and there has been an average **147,585 of discharges per month** that have been coded on HIPE in 2019.



HIPE teams across the country have made fantastic efforts to ensure that discharges were coded in a prompt and efficient way in order to meet the deadlines each month and for the end of the year. Various different challenges across the hospitals have been overcome to get the closed 2019 National File coded.

This file will make a difference in areas such as Activity Based Funding, clinical audit, policy, health research and more. It is therefore important that the HPO receives monthly exports from each hospital with cases downloaded and coded as completely and accurately as possible. The monthly export date is the third working day of each month. Coverage is monitored each month and hospitals can be contacted by the HPO regarding their coverage when necessary. It is very helpful for the HPO to know of issues that can affect coverage of the data in order to have a complete picture of the data on the national file.

The level of coding completed for 2019 shows the dedication and enthusiasm of HIPE coders in what have been challenging times. As the file is now closed the HPO want to thank all coders for the level of work, perseverance and dedication put into getting each of the 1,771,023 cases coded on the 2019 HIPE National File.

Stay safe and thank you all!

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Coronavirus
COVID-19

FAQ—COVID-19 Codes

A selection of queries received to hipe.coding@hpo.ie

Q1: What is the correct code for "lung infiltration consistent with COVID-19"? In the alphabetical index "lung infiltration" has a nonessential modifier "(eosinophilic)". When I check the tabular code 'Eosinophilia' is in the title – Pulmonary eosinophilia, not elsewhere classified – J82.

I spoke with the Consultant to check if there was any more specific diagnosis but there wasn't.

A1. In the absence of a more specific acute respiratory disease and based on the clinical documentation for this case we would advise the following codes;

J82 *Pulmonary eosinophilia, not elsewhere classified*.

Followed by appropriate codes for COVID-19, please refer to ICS 22X2 for guidance on assigning the correct codes for COVID-19 .

Q2. Patient admitted with a principal diagnosis of "Syncope" and additional diagnosis of "? COVID". Patient had a cough. Test was carried out. Patient discharged without test result and advised to self-isolate. How would this be coded?

A2. We would advise never coding a case without the laboratory result. For pending result please refer to ICS 22X2 Novel Coronavirus for further guidance on the correct code assignment. This case cannot be coded until the COVID-19 results are available

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Q3. Please advise on the coding of a maternity patient who was admitted with an LRTI at 27 weeks gestation. On admission she was treated as a suspected COVID-19 case, isolated and tested for same. Her test came back negative. How do I code this case?

A3. The advice in the Supplementary Guidelines document (Table) on coding of COVID-19 includes advice on coding COVID-19 ruled out in pregnant patients whereby coders are directed to follow the guidelines for the circumstances of the case e.g. symptoms, exposure.

For this query it is unclear if the patient had exposure to COVID-19 and that will affect code assignment. Based on the information provided the codes suggested are based on the patient having symptoms but no exposure. We advise assigning:

O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium*
J22 *Unspecified Acute Lower Respiratory Infection*
Z03.8 *Observation for Other Suspected Disease & Condition*
U06.0 *Emergency Use Of U06.0 [COVID 19 ruled out]*
Z29.0 *Isolation*

Note: Do not assign O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium* for a pregnant patient with COVID-19 ruled out as this advice has been changed by IHPA- see Supplementary Guidelines for classifying COVID-19 scenarios in admitted patient care V1.2 (please refer to footnote 6).

Q4. Please advise on the coding of COVID-19 where the patient tested positive and was in confirmed contact with another positively proven case of COVID-19 due to travel.

Do we need an additional "Z" code to identify positive patients with confirmed contact (to identify clusters etc.)?

A4. The exposure to COVID-19 is inherent in the assignment of the codes from category U07 for COVID-19. There is no need to add an additional code to identify exposure to the virus. ICS 22X2 Novel Coronavirus is in line with international guidelines on the coding of COVID-19.

The use of Z20.8 *Contact with and exposure to other communicable diseases* is only to be assigned for cases which have been tested as negative. This code is not designed to identify clusters.

Q5. Patient admitted with non COVID illness, no swab taken for same – no reference made to COVID. Patient died , RIP, and a post mortem (PM) was performed. Hospital management notified that patient was positive for COVID which was detected on the PM report. Do I need to capture this when coding the chart or as it was not documented if it is not relevant?

A5. As per Coding Rule CR 2640 - A clinical diagnosis on a death certificate/PM must be supported in the body of the chart and meet ACS 0002 *Additional diagnoses* before assigning a code. For reference we would advise reading ACS 0010 *General abstraction guidelines* which advises similar guidance on information documented on discharge summaries also CR Q2640 can be found at ACS 0002. In this case as the patient was not treated for COVID-19 during the episode of care a code cannot be assigned for COVID-19. The condition will be captured by other data collection systems outside of HIPE.

Coronavirus
COVID-19

FAQ—COVID-19 Codes

A selection of queries received to hipe.coding@hpo.ie

Q6. An inpatient, developed fever, was tested for COVID-19 but result came back negative. Few weeks later, during the same episode), the patient became febrile again, was tested for COVID-19 but this time patient tested positive. Is there a way to document that the patient tested both positive and negative on the same episode of care as you will get an edit if both the U06.0 and U07.1 are entered.

A6. The use of the *U* codes for COVID-19 are mutually exclusive i.e. as per ICS 22X2 Novel Coronavirus you cannot assign more than one COVID-19 *U* code on a case, it is either diagnosed or ruled out.

Therefore in this scenario, after study, a diagnosis of COVID-19 positive was made through laboratory testing and the code U07.1 *Emergency use of U07.1 [COVID-19 Virus identified]* is assigned.

We would also advise you to refer to 'ICS 0048 Hospital Acquired Diagnosis (HADx) Indicator' and apply the guidance in this standard to this case if appropriate.

Q7. A paediatric patient was admitted for a swab to rule out COVID-19 as a day case and was readmitted the following day as the swab was clear for the procedure.

How would this be coded?

A7. If the patient had no symptoms and was not in contact with or exposed to COVID-19 and the swab test was the reason for admission, then the appropriate codes to assign are as follows;

Z11.5 *Special screening examination for other viral diseases*
U06.0 *Emergency use of U06.0 [COVID 19, ruled out]*.

Q8. A patient was exposed to another patient with COVID-19 and they were swabbed as a result. They were asymptomatic and their swab was negative. Would you agree with the following code assignment

Z20.8 *Contact with and exposure to other communicable diseases*
and
U06.0 *Emergency use of U06.0 [COVID 19, ruled out]*

I did not assign *Z03.8 Observation for other suspected diseases and conditions* as the patient was asymptomatic and was only swabbed due to exposure.

A8. Yes we agree with your code assignment of;

Z20.8 *Contact with and exposure to other communicable diseases*
and
U06.0 *Emergency use of U06.0 [COVID-19 ruled out]*

Also assign HADx flags to these codes as appropriate – i.e. if the exposure occurred on this episode of care.

We also agree that Z03.8 *Observation for other suspected diseases and conditions* is not assigned as the patient had no symptoms.

In this case the patient had clinically confirmed exposure to COVID-19 while an inpatient. This is not routine testing to rule out COVID-19 and therefore U06.0 *Emergency use of U06.0 [COVID-19 ruled out]* meets criteria and can be coded.

Q9. A patient presented with shortness of breath (SOB), over the last 10 days getting worse and feels increased swelling in both legs, no cough and no chest pain. History of CCF.

Covid swab taken in E/D, results back in E/D (negative) before the patient was admitted to the ward. Do I code the Z03.8 *Observation for other suspected diseases and conditions* and U06.0 *Emergency use of U06.0 [COVID 19, ruled out]* , or leave them out, as all happened in E/D before patient admitted?

A9. As per Section 1 of the Irish Coding Standard on "Valid HIPE Activity", ED activity is not collected by HIPE. As per ACS 0002 *Additional diagnoses*, If no further intervention, monitoring etc. was performed for COVID-19 during the patients admitted episode of care it will not meet criteria for coding and therefore no COVID-19 codes are assigned for this case.

"Life isn't about waiting for the storm to pass.

It's about learning how to dance in the rain."

Vivian Green

Coding of angiogram with angioplasty

In 10th edition ICD-10-AM/ACHI/ACS the "code also when performed" instruction for coronary angiography has been deleted from a number of percutaneous cardiac procedures to avoid confusion with catheter access for percutaneous procedures which should not be assigned a separate code. This has led to confusion as to when an angiogram can be coded with an angioplasty performed in the same visit.

Coding guidance

The code assignment depends on the initial intent of the angiogram.

- If the angiogram is being performed as a procedure within its own right, then it **IS** coded, no matter what else might be done after.
- Diagnostic cardiac catheter/angiograms will be coded when such procedures are evident by a separate report detailing the procedure and results.
- The approach is inherent in the procedure and does not require the assignment of an additional code of angiogram. If the angiogram is being performed as the entry to allow for a procedure to be performed and/or performed to check that the procedure has been done correctly (e.g. positioning of the stent) then it is **NOT** coded.

The HPO will consider creating an Irish Coding Standard to include the advice above.

Example 1:

Patient admitted for angiogram with left heart catheterisation which is done and clinician decides to proceed with angioplasty (1 artery) due to severe CAD.

Code both the angiogram/catheterisation and angioplasty as the original reason for performing the angiogram was to investigate (diagnostic). The decision to do the angioplasty was made after the "investigation".

Diagnosis

I25.11 *Atherosclerotic heart disease of native coronary artery*

Procedures

38300-00 *Percutaneous transluminal balloon angioplasty of 1 coronary artery*

38218-00 *Coronary angiography with left heart catheterisation*

Example 2

Patient admitted for angioplasty (1 artery) due to severe CAD and angiogram with left heart catheterisation performed as well.

Code the angioplasty only. The intention was to perform an angioplasty. In this scenario the angiogram is inherent as it is done to access the artery to perform the angioplasty.

Diagnosis

I25.11 *Atherosclerotic heart disease of native coronary artery*

Procedure

38300-00 *Percutaneous transluminal balloon angioplasty of 1 coronary artery*

PICQ Update

PICQ 8.6 Upgrade

PICQ is due to be upgraded to PICQ 8.6 over a weekend in the future. On the weekend in question, PICQ will be available up to 6pm on Friday and then again from 6am on Monday morning. From 6pm Friday to 6am on Monday, there will be no access to PICQ.

All episodes coded during this period will be analysed on Sunday night and emails will be sent early on Monday morning. We will advise the exact weekend via email. The improvements in 8.6 are in the table below.

	PICQ 8.6 Improvements
General	- When an episode is modified by a different coder, the episode now appears on the most recent coders numerator report. This fixes the 'You are not authorised to perform this task' error - Degree filter is remembered between reports
Dashboard Report	- Filter 'By Hospital Group' added (requires State Health Department level access)
Numerator Report	- 'Fixed' indicators will show when 'Hide Reviewed' is unchecked - DOB, DOA and DOS columns can be sorted by date - Filter 'By Hospital Group' added (requires State Health Department level access)
Summary Report	- Filter 'By Hospital Group' added (requires State Health Department level access)
Justification Report	- Filter 'By Hospital Group' added (requires State Health Department level access)
Specificity Report	- Filter 'By Hospital Group' added (requires State Health Department level access)
Benchmark Report	- Filter 'By Extract' added

PICQ® Advisory Board Volunteers

We are still looking for volunteers to sit on the PICQ Advisory Board. Meetings are held by phone at least every 6 months at dates and times agreed by the attendees and last approx. 1 hour. The quorum for meetings is the chair and at least one member from each of Pavilion Health, HPO and the Irish Coding community. Agendas, including any specific items/indicators for discussion are distributed in advance of all meetings. The expectation is that Board meeting attendees are prepared for the meetings and will have reviewed all items for discussion prior to the meeting. If unable to attend ,Board members can submit comments in writing by email at least one week before the meeting to ensure circulation to all members. All meetings are minuted; minutes and agreed actions will be circulated within 2 weeks of each meeting. All Board members follow up on agreed actions even if the member was unable to attend the meeting. If you would like to volunteer to sit on the Board, please email support@pavilion-health.com.

Finding old indicators

When logging into PICQ, the filters on the reports will default to last 7 days by Date of Separation (Discharge Date). This will not display older indicators. To see indicators since Jan 01, 2020. This is how the filters should be set:

↑ 7 days by Date of separation are the default filters. Click on 7 Days to change the date range. This brings up this → menu. To select open indicators since Jan 2020, select 'Date Range' and used the calendar to select the dates.

To see F indicators that were marked 'Fixed', click the 'Download' button and open the excel file.

Indicator Review

We are constantly reviewing the indicators to ensure they reflect the Irish and Australian coding standards and classifications. From our recent review we have identified a handful of indicators that we are revising. These will be applied to data from 1st January (we will advise you before we run these). We do appreciate that this will cause some inconvenience in that coders may see an indicator triggered on cases coded some time ago, and we apologise for that. We will be in touch by email when we apply this.

As always, if you need help or support, please contact support@pavilion-health.com

Training & Mentoring Course

HIPE Clinical Coder Education is paramount in the collection of timely accurate HIPE Data. The COVID-19 pandemic and associated restrictions in relation to travel and meetings in person have highlighted the value for hospital HIPE departments having a structured approach to training and mentoring for Clinical Coders at all levels of experience.

It is important that all HIPE Clinical Coders participate in on-going training, delivered by the HPO and that they receive on the job training and mentoring in their own hospitals.

Hospital HIPE Departments need to have a structured approach to training and mentoring for Clinical Coders at all levels of experience. To support this, the HPO delivered the first Clinical Coder Training and Mentoring course during 2019.

Course Content:

- Performing training needs analysis
- Designing training plans
- Development, implementation & delivery of clinical coder education
- Designing assessments
- Evaluation and feedback
- A one day, *presentation skills* course delivered by an external expert.

13 experienced Clinical Coders participated in this course that was delivered over **5 separate days** from February to September 2019. The course was a great opportunity for this enthusiastic group to share their ideas and knowledge with each other and to learn new skills. Each participant completed a Training and Mentoring Project at their hospital, and submitted a report on their project to the HPO. On completion of their project reports, participants were invited to the HPO where they delivered presentations on their projects.

Next Training and Mentoring Course

The HPO are preparing to run another Training and Mentoring course later this year, and will adapt the delivery, according to any restrictions that may be in place. As all training courses are offered subject to numbers requiring training, please contact us as soon as possible at hipe.training@hpo.ie if you are interested in signing up for this course.

Feedback from participants

- ◊ The course was structured very well and group participation was excellent
- ◊ The course was very informative with a great bunch of people from other hospitals present
- ◊ The presentation skills course was excellent

Most valuable aspect of the course

- ◊ Having a structured approach to training for HIPE Clinical Coders
- ◊ Group discussion/brainstorming was very beneficial
- ◊ Learning styles
- ◊ The content was very relevant to my role
- ◊ Excellent overview, tips and guidelines for training clinical coders
- ◊ Learning how to perform a Training Needs Analysis

We would like to take this opportunity to congratulate all participants on completing the course.

We would also like to thank you for your patience as we arrange to have your certificates posted out.

Participants attending one of the Training & Mentoring Workshops

Cracking the Code

A selection of Coding Queries

Q1 I'm having difficulty locating the Australian Coding Standard 1436 *Trial of Void* in the new IEbook. Can you direct me please?

A1. This standard has been removed from 10th edition but IHPA have provided the following guidelines:

> Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Current. Subject: Tenth Edition FAQs Part 1: ACS deleted for Tenth Edition
>
> A coding standard is evaluated for clinical and classification currency or redundancy before the decision is made to delete it from the ACS. When a coding standard is deleted from the ACS, the content is relocated to either another standard or incorporated into the Tabular List and/or Alphabetic Index, as applicable.
>
> In some instances, a specialty standard is considered redundant if the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (or other general/specialty standards) are applicable to the topic.
>
> For example, ACS 1436 *Admission for trial of void* was deleted for Tenth Edition as the following principles apply:
>
> - Follow the Alphabetic Index: *Trial of void/ admission for*
> - Assign a code for urinary retention when it meets the criteria in ACS 0002
> - Assign codes for intervention(s) as per the guidelines in ACS 0042 *Procedures normally not coded/Classification/Dot point 2*)
>
> Note: Information regarding ACS deletion is documented in the *Chronicle* available on the ACCD website (https://www.accd.net.au/Downloads.aspx).
>
> **Published 15 September 2017, for implementation 01 October 2017.**

The HPO are reviewing the Coding Rules to ensure that relevant Coding Rules are provided in the IE Book.

Q2. What is the code for ulnar nerve decompression/cubital tunnel release ?

A2. We would recommend the following code;
39330-00 [77] *Open neurolysis of peripheral nerve, not elsewhere classified.* This code can be applied for both ulnar nerve decompression/cubital tunnel release.

In the alphabetic index of procedures look up:

Decompression, Nerve- peripheral

Q3. Can you please recommend a procedure code for a patient admitted for repair of divarication of recti?

A3. Please refer to the following coding rule for guidance;

> Ref No: Q3117 | Published On: 15-Dec-2016 | Status: Current
> SUBJECT: Repair of diastasis recti
> Q: What ACHI code is assigned for repair of diastasis recti (recti divarication)?
>
> A: The rectus abdominis muscle is part of the musculoaponeurotic layer of the anterior abdominal wall. Diastasis recti (also known as rectus abdominis diastasis or recti divarication) are separation of the two rectus muscles. In severe cases, surgical closure of the separated muscles may be required.
> Assign 45570-00 [1000] *Closure of abdomen with repair of musculoaponeurotic layer* for repair of diastasis recti (recti divarication) by following the Alphabetic Index:
> Repair
> - abdominal wall
> - - musculoaponeurotic layer 45570-00 [1000]
>
> Note: Assignment of the above ACHI code with principal diagnosis M62.08 *Diastasis of muscle*, other will result in assignment of DRG 801C *OR Procedures Unrelated to Principal Diagnosis, Minor Complexity* in version 9 of the grouper. ACCD will consider this issue in a future version of the AR-DRG classification.

Q4. A patient has septic arthritis of the knee and group G strep showed up on the aspiration of the joint/swab. How is this coded?

A4. Septic arthritis, also known as joint infection or infectious arthritis, may represent a direct invasion of joint space by various microorganisms, most commonly caused by bacteria. However, viruses, mycobacteria, and fungi have been implicated. Reactive arthritis is a sterile inflammatory process that may result from an extra-articular infectious process. The term septic is being used to identify that there is a localised bacterial infection in the joint, not that the patient has sepsis.

We would recommend using the following codes;

M00.26 *Other streptococcal arthritis and polyarthritis, lower leg*
B95.42 *Streptococcus, group G, as the cause of diseases classified to other chapters.*

Cracking the Code

A selection of Coding Queries

The index look up is

Arthritis,

streptococcal (any site) NEC M00.2-

Code B95.1 *Streptococcus, group B* is assigned as an additional diagnosis to further specify the type of streptococcal infection.

Q5. Please advise on how to code a procedure where the op note states "Bone nibbling and FTSG of left ring finger with excision of germinal matrix".

A5. Bone nibbling is referring to a device (forceps) that are used to "nibble away bone" in preparation for the full thickness skin graft (FTSG). We recommend the following codes:

30023-01 [1566] *Excisional debridement of soft tissue involving bone or cartilage*
46534-00 [1631] *Radical excision of fingernail bed*
45451-07 [1649] *Full thickness skin graft of finger*

Q6. Please advise as to how PICO vacuum dressings are coded, also does ACS 0042 *Procedures not normally coded* – dressing apply to this code?

A6. A "PICO" dressing is a negative pressure vacuum dressing and can be coded as per the exception listed in ACS 0042 *Procedures not normally coded* at the entry for "Dressings".
In ACS 0042 *Procedures not normally coded*, Dressings are listed at No.7 in the list of procedures not normally coded and in 10th edition there is an exception added for Vacuum Dressing. Vacuum dressings should be coded when performed. However this activity needs to be in a valid day case ward (See ICS 2020 V1.3 Pg. 11)

VAC dressings are classified to non-excisional debridement – please assign:

90686-01 [1628] *Nonexcisional debridement of skin and subcutaneous tissue.*

Q7. How is Yao Syndrome coded?
It manifests as fever, diarrhoea, joint pains and swelling and skin erythema for the patient and after genetic testing YAO syndrome was confirmed.

A7. Yao syndrome (formerly called NOD2-associated autoinflammatory disease) is a disorder involving episodes of fever and abnormal inflammation affecting many parts of the body, particularly the skin, joints, and gastrointestinal system. (https://ghr.nlm.nih.gov/condition/yao-syndrome). In the absence of a specific code for this syndrome we would advise you to please follow the guidelines set out in ACS 0005 *Syndromes*.

Q8. We have come across a number of cases where it states incisional biopsy of skin. What is the correct way to code this please?

A8. The code 90661-00 *Other incision of skin and subcutaneous tissue* is generally used when a clinician performs an incisional procedure into the skin for exploration purposes i.e. looking for a retained foreign body. This code would not be applicable for skin biopsy procedures.
An incisional biopsy removes a larger and generally deeper ellipse of skin, using a scalpel blade. This differs to an excisional biopsy in that excision biopsy refers to complete removal of a skin lesion. Therefore 'excision of lesion codes' would not be appropriate here.

For an incisional biopsy we advise following the index at:
Biopsy
- skin

which brings you to 30071-00 [1618] *Biopsy of skin and subcutaneous tissue.*

Please review the index if an excision of a lesion is performed under the main term "Excision".

Q9. When is it appropriate to assign code Z43.6 *Attention to other artificial openings of urinary tract*? If a patient is in for a significant amount of time and has a long term catheter, which is flushed and checked daily by nursing staff, is it okay to assign this code as an additional diagnosis? Toilet or cleansing is in the included section.

A9. The use of Z43.6 *Attention to other artificial openings of urinary tract* is for those patients who have undergone a surgical procedure which involves the creation of an artificial opening within the urinary system, for example an Urethrostomy. In your example it appears the patient has a standard urinary catheter in place. As per ACS 0042 *Procedures not normally coded,* in particular points 2 & 5, maintenance of a urinary catheters i.e. washout should not be coded.

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 Clinical Coder Education Programme

The April edition of *Coding Notes* provided an overview of how the HIPE Clinical Coder Education Programme is adapting in response to the restrictions associated with COVID-19. Since then, in response to requests from hospital HIPE departments several training sessions were scheduled and delivered. Training materials have also been dispatched on request.

We would like to thank those who contacted us requesting training and support. We want to assure you that we will continue to do our best to support you in any way we can so please don't hesitate to contact with any training requests.

Blended and online Learning

The HIPE Clinical Coder Education Programme currently consists of a blend of classroom training, training delivered remotely through WebEx and self-directed learning through pre-course reading and exercises, recorded tutorials and videos, and through on-the job training and mentoring.

We continue to explore options to advance the delivery of Clinical Coder education through the use of technology. The use of platforms such as a Learning Management System would facilitate a flexible and efficient education programme for Clinical Coders at all levels of experience. It would allow Clinical Coders to participate in some components of Clinical Coder education through online and self-directed learning and to access training that is tailored to their needs in a timely manner. A blended learning approach through increased accessibility would also help to reduce the time spent travelling to training courses. It would also play an important part in reducing the time that it takes to train a new Clinical Coder.

The arrival of COVID-19 has brought changes to working arrangements with a need for some HIPE Departments to introduce staggered working hours to adhere to social distancing guidelines and this has further highlighted the need for advancements in this area. The delivery of Clinical Coder education through an increase in online learning is dependent on having the IT infrastructure to support this throughout the system. We will continue to engage with you and keep you updated on any further developments.

Accessing training resources

Having access to the training resources that are made available to clinical coders electronically is and will continue to be an important part of clinical coder education programme.

Your role

If you experience technical difficulties accessing links to training materials or pre-recorded tutorials/videos, or have issues joining courses that are delivered through WebEx, and your local IT Department are unable to resolve these please contact us.

Educational resources

In addition to training workbooks we have a number of pre-recorded presentations and tutorials that are available on request including the following:

Endoscopy training tutorial/video. This is accompanied with a workbook & exercises and contains an overview on endoscopies, classification guidelines and examples. Samples of endoscopies are also included for coding practice.

Audio feature - WebEx

Please note that the audio feature has been activated on WebEx so there is no requirement to join by phone if you have a PC with a sound card. Alternatively you can access the presentation slides by WebEx and use PowWowNow to access audio (approximately 8 cent per minute charge).

Classroom training

As the restrictions are lifted and when it is safe to do so, we will resume classroom training, which will continue to be a key component of the Clinical Coder Education Programme. We look forward to seeing you all again and hope it will be soon.

If you have any queries or concerns in relation to Clinical Coder education, at any level, please don't hesitate to contact us on hipe.training@hpo.ie.

As always details of upcoming training will continue be available at www.hpo.ie where you can sign up to participate in courses and we will continue to dispatch emails to hospitals' HIPE departments with details of upcoming training.

Stay safe and enjoy the summer.

Kind regards from the HIPE Training Team.

Upcoming Training

Please note that due to the COVID-19 associated restrictions it was necessary to reschedule some training courses and change the mode of delivery.

Essential materials
To participate in courses through WebEx you will require the following:

- ICD-10-AM/ACHI/ACS 10th edition (IEBook or hard copy)
- Training materials, dispatched in advance of the course

Coding Skills II

The **3 day course** is centred on clinical coding and clinical coding guidelines and includes HIPE Portal training. Participants must complete Introduction to HIPE I & II and Coding Skills I before attending this course.

Date: 21st – 23rd July

Time: 10am – 4pm each day

Mode of delivery: WebEx

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: 15th – 17th September

Time: 10am – 5pm each day

Mode of delivery: TBC

Obstetrics Workshop

This **1.5 day** workshop is suitable for Clinical Coders with no previous experience in coding Obstetrics and for Clinical Coders with experience in the area who would like a refresher. There were significant changes in the classification of Obstetrics between 8th and 10th edition of ICD-10-AM/ACHI/ACS and these will be highlighted as appropriate throughout the workshop.

Date: 15th July **Time:** 10am – 4pm &

Date: 16th July **Time:** 10am –1pm

Mode of delivery: WebEx

Data Quality Session

This is an update on data quality activities and tools including The Portal, HCAT and Checker. This session will be repeated subject to demand.

Date: Thursday, 24th September

Time: 11.00am – 1.00 pm

Location: WebEx Only

Update to ICD-10-AM/ACHI/ACS 10th edition training

The following resources were provided as part of the update to ICD-10-AM/ACHI/ACS 10th edition training that was delivered during November and December 2019:

Update to 10th edition training workbook containing an overview of the changes between 8th and 10th edition of the classification – a link to the pdf copy is now available.

Obstetrics training tutorial/video. This tutorial contains an overview on the changes to the classification of obstetrics between 8th and 10th editions of the classification.

If you were unable to participate in this training and/or would like to access these materials please contact hipe.training@hpo.ie

To apply for any of the advertised courses, please complete the online training applications form at: www.hpo.ie/training or use the link below.

http://www.hpo.ie/training/frmTraining.aspx

Please ensure you enter the correct email addresses when applying for courses. All information provided will be kept confidential and only used for the purpose it is supplied.

Please inform us of any training requirements by emailing hipe.training@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.

www.hpo.ie/find_it_fast/

Thought for Today

In the rush to return to normal, use this time to consider which parts of normal are worth rushing back to.
Davie Hollis - Author