Coding Notes

Healthcare Pricing Office

No. 92
March 2021

Spring forward

Welcome to the Spring 2021 edition of *Coding Notes.* When we issued the Spring 2020 edition of *Coding Notes* last year little did any of us know what lay ahead of us. But here we are a year on and still facing challenges in our personal and professional lives from this very persistent virus.


Coding Notes
HIPE data more important than ever.

With Spring in the air, the clocks going forward giving us brighter evenings and the vaccine roll out continuing things are starting now to be more hopeful. We are slowly emerging from these dark times into a brighter future with hope of return to life somewhat akin to normal. We have all learned a lot in the past year and it has been a challenge for everyone. The HPO will be eternally grateful to the HIPE community for their ongoing diligence and support of HIPE and submitting the data to tighter guidelines. New coding standards and new COVID-19 codes have been published and the WHO and IHPA are issuing more as things evolve.

As we move to this latest phase of the pandemic the codes being issued reflect this. The most recent code issued is for *Adverse Effects of COVID-19 Vaccine*. The HPO are currently working on implementing this in the HIPE Portal, with edits and guidelines—see page 4 for further information.

The HPO have sought clinical advice where required on some of the COVID-19 coding queries received to date. This clinical support is very much appreciated and helps to ensure correct reporting of this information (page 6). In addition on pages 7 to 9 there are coding queries specifically on COVID-19. There is also a two page summary of the ever expanding ICD 22X2 NOVEL CORONAVIRUS (COVID-19), see pages 10-11.

The regular non COVID-19 work continues for everyone and the regular *Cracking The Code* on pages 14-15 provides responses issued to coding queries received by the HPO recently. There is a PICQ™ Update on page 12 and an update on the Clinical Coder Education Programme is provided on page 13 with the usual back page providing information on upcoming Coder Training.

With 16 pages packed with information this *Coding Notes* provides HIPE with all the updates and information to support our work at this challenging time. The 2020 HIPE file will close at the extended deadline of the End of April Export which is due in at the latest on 6th May 2021. Many thanks to everyone working hard to meet this deadline under difficult conditions.

The HPO wishes the whole HIPE community a Very Happy Easter and hope that brighter safer days lie ahead for everyone.

Many thanks!

"Spring will come and so will happiness. Hold on. Life will get warmer."

Anita Krizzan

Inside This Issue

Bronchoscopies

A bronchoscopy is a technique of visualizing the inside of the airways for diagnostic and therapeutic purposes. An instrument (bronchoscope) is inserted into the airways, usually through the nose or mouth, or occasionally through a tracheostomy. This allows the practitioner to examine the patient's airways for abnormalities such as foreign bodies, bleeding, tumours, or inflammation. Specimens may be taken from inside the lungs. The construction of bronchoscopes ranges from rigid metal tubes with attached lighting devices to flexible optical fibre instruments with real-time video equipment. (Source: http://www.sanchest.com/bronchoscopy.html)

A Bronchoscopy can be performed for the following:

⇒ To see abnormalities of the airway
⇒ To obtain samples of an abnormality or specimens in undiagnosed infections
⇒ To obtain tissue specimens of the lung in a variety of disorders
⇒ To evaluate a person who has bleeding in the lungs, possible lung cancer, a chronic cough, or a collapsed lung
⇒ To remove foreign objects lodged in the airway
⇒ To open the spaces of a blocked airway

There are two types of Bronchoscopy:

Rigid Bronchoscopy: A rigid bronchoscope is a straight, hollow, metal tube. Doctors perform rigid bronchoscopy less often today, but it remains the procedure of choice for removing foreign material and for several other treatments.

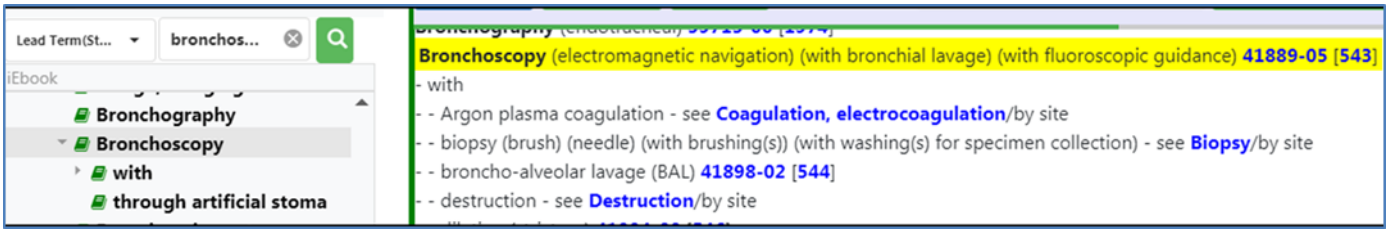
Rigid bronchoscopy also becomes useful when bleeding interferes with seeing the area.

Flexible Bronchoscopy: A flexible bronchoscope is a long thin tube that contains small clear fibres that transmit light images as the tube bends. Its flexibility allows this instrument to reach the farthest points in an airway. The procedure can be performed easily and safely under local anaesthesia or sedation.
(Source: http://www.melbourneheartsurgeon.com.au/bronchoscopy/)

In ACHI 10th edition the terms "rigid" and " flexible" do not impact on the code assignment.

Coding Bronchoscopies

Bronchoscopy or Bronchoscopy with bronchial lavage or washings (without any further information) is classified to: **41889-05 [543]** *Bronchoscopy:*



Bronchoscopy with bronchial washing taken for specimen collection

Bronchial washing taken for specimen collection are classified as a biopsy of bronchus.
Assign **41898-04 [544]** Endoscopic [needle] biopsy of bronchus

41898-04 Endoscopic [needle] biopsy of bronchus
Bronchoscopy with (needle) biopsy of bronchus

Includes: that with:
- fibreoptic bronchoscope
- linear bronchoscope
- rigid bronchoscope

ACHI Index look up

Washing ⇨ for specimen collection (diagnostic) - see **Biopsy**
Biopsy (brush) (with brushing(s)) (with washing(s) for specimen collection⇨ bronchus (closed) (endoscopic) (needle) ⇨ **41898-04 [544]** *Endoscopic [needle] biopsy of bronchus*

Bronchoscopies cont.

Bronchoscopy with broncho-alveolar lavage (BAL)

Bronchoalveolar Lavage or BAL (also known as bronchoalveolar washing) is a minimally invasive procedure that involves instillation of sterile normal saline into a sub segment of the lung, followed by suction and collection of the instillation for analysis. This procedure is typically facilitated by the introduction of a flexible bronchoscope into a sub-segment of the lung.
(Source: Bronchoalveolar Lavage, Pujan H. Patel; Marsha Antoine; Saad Ullah. https://www.ncbi.nlm.nih.gov/books/NBK430762/)

Bronchoscopy with broncho-alveolar lavage is classified in the ACHI tabular as an excisional procedure and is coded to:

41898-02 [544] *Endoscopic broncho-alveolar lavage [BAL]*

Look up:

Bronchoscopy ⇨with ⇨ broncho-alveolar lavage (BAL) ⇨ **41898-02 [544]** *Endoscopic broncho-alveolar lavage [BAL]*

Bronchoscopy (electromagnetic navigation) (with bronchial lavage) (with fluoroscopic guidance) **41889-05** [543]
- with
- - Argon plasma coagulation - see **Coagulation, electrocoagulation**/by site
- - biopsy (brush) (needle) (with brushing(s)) (with washing(s) for specimen collection) - see **Biopsy**/by site
- - broncho-alveolar lavage (BAL) **41898-02** [544]

Bronchoscopy with brushings

Bronchial brushing is a procedure in which cells are taken from the inside of the airway mucosa or bronchial lesions through catheter-based brushing under direct visualization or fluoroscopic guidance. Flexible brushes are passed through the bronchoscope, and the bronchial surface is gently abraded to obtain the specimen.
(Source: https://en.wikipedia.org/wiki/Bronchial_brushing)

Bronchoscopy with brushings is classified to **41898-04 [544]** *Endoscopic [needle] biopsy of bronchus*

ACHI Index look up:

Brush, brushing(s) (for specimen collection) -
see also **Biopsy** ⇨

Biopsy (brush) (with brushing(s)) (with washing(s) for specimen collection) ⇨ bronchus (closed) (endoscopic) (needle) ⇨ **41898-04 [544]** *Endoscopic [needle] biopsy of bronchus*

41898-04 Endoscopic [needle] biopsy of bronchus
Bronchoscopy with (needle) biopsy of bronchus

Includes: that with:
- fibreoptic bronchoscope
- linear bronchoscope
- rigid bronchoscope

Transbronchial needle aspiration (TBNA)

Transbronchial needle aspiration (TBNA) is a procedure to obtain cellular material using a needle that is passed through the bronchial wall. It is used to obtain tissue samples (biopsies) from lung or hilar/mediastinal lesions that are in close proximity to the endobronchial tree.
(Source: Bronchoscopy: Transbronchial needle aspiration, Authors: Omar A Minai, MDAtul C Mehta, MBBS, FCCP https://www.uptodate.com/contents/bronchoscopy-transbronchial-needle-aspiration)

The code selection is determined by the site from where the sampled tissue is obtained from.
Eg: "Transbronchial needle aspiration of lung tissue"

ACHI Index look up:

Bronchoscopy ⇨ with biopsy (brush) (needle) (with brushing(s)) (with washing(s) for specimen collection) - see **Biopsy**/by ⇨
Biopsy ⇨ lung (endoscopic) (needle) ⇨ **38418-06 [550]** *Endoscopic [needle] biopsy of lung*

New Code Released for Adverse Effects of COVID -19 Vaccine

A new ICD-10-AM diagnosis code has been activated for the collection by HIPE of adverse effects of COVID -19 vaccine. This code was released by IHPA on the 16th March following activation of an emergency use code by the WHO. The new code **U07.7** ***Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*** will be assigned in addition to the existing codes to identify an adverse reaction to a COVID-19 vaccine. Please note that place of occurrence codes are not required for adverse effects in Ireland (see ICS 1902 Adverse effects of Drugs).

This code can be applied for discharges from 1st January 2021. The HIPE IT team are currently implementing this new code in the HIPE Portal along with data entry edits. The HPO will let you know when the codes and edits are in place in the HIPE Portal.

HPO Coding Advisory
Unspecified Pneumonia in COVID-19 cases

The HPO issued a coding advisory on the coding of unspecified pneumonia in COVID-19 which allows for the unspecified pneumonia to be coded as viral pneumonia.

COVID-19 Positive with unspecified pneumonia:

Assign *J12.8 Other viral pneumonia*

Do not assign *J12.8 Other viral pneumonia* if a specific type of pneumonia is documented, assign a code for that specific type of pneumonia.

COVID-19 Clinically diagnosed or probable with unspecified pneumonia

Do not assume pneumonia is viral, code as per documentation

Improved access to Anatomy & Physiology Lectures

Improved access to Anatomy & Physiology Lectures

To facilitate flexible learning, recordings of the two 2-hour Anatomy & Physiology Lectures that have been delivered in 2021 are available for viewing. To access the *Introduction to Anatomy & Physiology* lecture and the *ENT* lecture please contact hipe.training@hpo.ie and you will be sent a link to these.

Following release, all lectures will be available for repeat viewing until 31st December 2021.

Upcoming Anatomy & Physiology Lectures

These lectures are available to all HIPE Clinical Coders

Topic: Anatomy & Physiology - Skin
Date: 25th May 2021
Time: TBC

Topic: Anatomy & Physiology - Haematology
Date: 25th May 2021
Time: TBC

NOCA Irish National ICU Audit

INICUA

ICU Data collection in HIPE

HIPE collects data on ICU activity along with the clinical coding of diagnoses and procedures. The ICU data collected includes the number of days in an ICU, and where available the number of days in a critical care bed. ICU wards are also registered on the HIPE portal. The COVID -19 pandemic saw a huge increase in ward registrations for ICUs as hospitals reconfigured their services to meet the surge in demand for these beds.

HIPE data collects diagnoses and procedures for patients in the ICU environment including organ supports such as dialysis and ventilation. HIPE clinical coders require access to clear documentation when coding ICU activity in order to capture diagnoses and interventions fully, and in accordance with national coding guidelines.

Some of the key areas in coding and collection of ICU activity include:

- Registration of ICU wards
- Check for download of ICU days to HIPE
- Continuous Ventilatory Support (CVS) -review ACS and ICS 1006 *Ventilatory Support*
- Collection of cumulative hours of CVS in administrative data – See ICS 2021, page 17
- Non–invasive ventilation - review ACS and ICS 1006 *Ventilatory Support*
- Duration of ventilation
- Sedation
- Organ failure & supports
- Tracheostomy procedures
- Reviewing documentation to identify conditions and procedures that meet criteria for coding

A major national resource on ICU documentation and information available to HIPE staff in many hospitals is the Irish National ICU Audit (INICUA) in NOCA.

INICUA is live in 22 Hospitals that have ICU's and is auditing all COVID-19 admissions even in surge areas. Navan, Portlaoise, Castlebar and Ballinasloe will be implemented this year, completing coverage to all 26 HSE funded Irish hospitals with ICU's. There is also a permanent expansion on beds in some Units and also some new Units within existing ICU Audit hospitals post COVID-19.

The ICU audit team in NOCA would like to remind HIPE staff that the items below and many others can be supported and validated by ICU Audit data in each hospital.

Confirmation on:

- Invasive ventilation hours
- Non-invasive ventilation hours
- Length of stay in ICU

The ICU Audit team in NOCA can facilitate where anyone needs to contact the ICU Audit Coordinator in their hospital (for contact details see https://www.noca.ie/about-noca/meet-the-team).

Mary Baggot, National ICU Audit Manager with NOCA

Clinical Advice on COVID-19 Coding Queries

Clinical coding relies on the information provided by all clinical teams, nursing staff and allied health professionals. Across hospitals clinical colleagues have been generous with their time and support for HIPE staff in collecting HIPE data on COVID-19 Discharges.

For a number of coding queries the HPO may require additional information on the details of the query and even with this additional information occasionally further clinical input may be required. The HPO would like to thank the input and support from clinicians in assisting HIPE teams including the HPO to correctly classify COVID-19 HIPE data. Below are some of the COVID-19 queries that the HPO has sought clinician input on.

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1. A patient is admitted following syncope with dehydration and vomiting.
COVID-19 positive three days previous to admission, it is not documented as Lab confirmed in the chart or on the hospital Lab system but it is documented as 'COVID-19 positive' throughout the chart. Is the COVID-19 flag assigned and how would this be coded?

For this scenario the HPO sought clinical input regarding the assignment of the COVID-19 flag. Clinical advice supported the assignment of the COVID-19 flag in this case. We would highlight the lab result does not have to be on the hospital system as there are test centres in the community and in other hospitals which you would not have access to.

In addition to assigning the COVID-19 flag note that if the COVID-19 infection is linked to the presenting complaint and meets criteria for coding, assign both B97.2 *Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent and U07.1 *Emergency use of U07.1 (COVID-19, virus identified)* as additional diagnoses.

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2. A patient had a positive COVID-19 test three days prior to admission and was admitted with COVID-19 pneumonia superimposed on bacterial pneumonia. I am coding this as J15.9 Bacterial Pneumonia unspecified followed by B97.2 *Coronavirus as the cause of diseases classified to other chapters*. Should U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* be applied in this case even though the test was not done in this facility?

The HPO sought clinical advice on this case regarding the type of pneumonia. Bacterial pneumonia superimposed on viral pneumonia is a common occurrence which is why patients who are admitted with 'COVID-19 pneumonia' are put on antibiotics. It can be community or hospital acquired. Applying codes for both bacterial and COVID-19 (viral) pneumonia would be appropriate in addition to the COVID-19 codes. Therefore the codes we suggest for this case are;

J12.8 *Other viral pneumonia*—(for the COVID-19 pneumonia)
J15.9 *Bacterial pneumonia, unspecified* - Please use a more specific pneumonia code if the specific bacterial agent is known
B97.2 *Coronavirus as the cause of diseases classified to other chapters*
U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*
The COVID-19 flag will also be assigned in this case

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3. A number of patients previously admitted with a positive COVID-19 pneumonia in the first admission are subsequently re-admitted a number of weeks later with a diagnosis of post-COVID-19 pneumonia. The COVID-19 swabs came back as negative in the second admissions. Could you please advise which would be the correct way to code the re-admission with post-COVID-19 pneumonia?

We sought clinical advice on the coding of pneumonia in this type of scenario and whether the post COVID-19 Pneumonia could be assumed to be viral pneumonia. Clinical advice is that post COVID-19 pneumonia cannot be assumed to be viral pneumonia .

Where clinical documentation indicates post-COVID pneumonia, we cannot assume there is a causal relationship between the current condition which the patient presents with e.g. pneumonia and the history of COVID-19. Clinical advice is that there is a temporal association and causality cannot be inferred. Therefore, in the absence of any other information as to the type of pneumonia or availability of clinical clarification, assign *J18.9 Pneumonia, unspecified* with the history code *U07.3 Emergency use of U07.3 [Personal history of COVID-19].* Please refer to the guidance in ACS 22X2 on the classification of post COVID-19 conditions. The COVID -19 flag will be assigned where the patient had lab confirmed COVID-19.

COVID-19 Coding Queries

COVID-Flag and COVID-19 History code

A cancer patient previously admitted with COVID-19 that is no longer current and has no residual effects from COVID-19 is now admitted as a day-case for chemotherapy. The COVID-19 flag is applied, but should the history be applied as an additional code?

In this scenario if the previous COVID-19 infection was lab confirmed then the COVID-19 flag will be applied and where the documentation indicates that the patient had previously confirmed COVID -19 then the U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* code will be assigned.

The COVID-19 flag and the history code, while similar, are assigned independently.

The history code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* will be assigned if there is documentation in the chart that there is a history of COVID-19, it does not need to meet criteria set out in ACS 0002 in order to be assigned and it does not have to be lab confirmed. The flag is assigned for lab confirmed COVID-19 at any time in the past or during the present admission.

COVID-19 Flag & Paediatric Inflammatory Multisystem Syndrome (PIMS)

A patient is admitted with Paediatric Inflammatory Multisystem Syndrome (PIMS) post COVID-19. There is no lab record of them having COVID-19. Would the COVID-19 flag be assigned for this admission?

For this case do not assign the COVID-19 flag unless there is written documentation in the chart of Lab confirmed or tested positive/positive case. Note that you do not need a lab record in your hospital to assign the flag, once it is documented that it was lab confirmed COVID-19 (anywhere or at any time) you can apply the COVID-19 flag.

The diagnosis code U07.*5 Emergency use code U07.5 [multisystem inflammatory response syndrome associated with COVID-19]* will be principal diagnosis in this case.

Personal History of COVID 19

Is U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* to be used for all cases where the clinical /nursing notes say history of COVID 19 where it is no longer active? Or does U07.3 have to meet additional diagnosis criteria?

The Independent Hospital Pricing Authority (IHPA) in Australia have advised that code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* does NOT have to meet criteria set out in ACS 0002 *Additional diagnoses*. This code can be applied when a history of COVID -19 is documented, whether lab confirmed or not.

Personal History of COVID 19

Is code U07.3 *Emergency use of [Personal history of COVID-19]* applied for every episode of care following a positive confirmed test or should it be applied when it is documented in the current episode of care.

IHPA have clarified that code U07.3 *Emergency use of [Personal history of COVID-19]* does NOT have to meet ACS 0002 *Additional diagnoses* but it does have to be documented in the chart before being assigned. As per ICS 22X2 *Novel Coronavirus (COVID-19)* this code is only assigned when previously confirmed COVID-19 is no longer current. Please also refer to examples 2-4 in ICS 22X2 on the application of this history code.

Personal History of COVID 19

Is code U07.3 *Emergency use of [Personal history of COVID-19]* assigned for any patient with a prior history of COVID-19 if they present with a non-related condition e.g. patient admitted with a TIA and a history of COVID-19 two months previously? Is there a time limit on how long ago the patient was positive for COVID-19 and using this code?

As per ICS 22X2 assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current. If a patient has a prior history of COVID-19 documented and is admitted for a non-related condition then U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* will be applied, it does not have to meet ACS 0002 *Additional Diagnoses*. Please refer to example 4 in the standard for reference. There is no time limit on when this code can be used other than that the COVID-19 infection is not current.

COVID-19 Coding Queries
Continued

Post Viral Condition

A patient presented in early January with increasing Shortness of Breath (SOB), Cough and Pyrexia for two days. The patient previously tested positive in the community for COVID-19. Notes state "post viral syndrome". Should this be coded as current COVID-19 positive or coded to post viral syndrome?

The documentation of post viral syndrome would indicate the COVID-19 infection is no longer an acute condition. Code U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* would be assigned as documentation links this condition to the previous COVID-19 infection. We would advise to code all symptoms followed by U07.4 *Emergency use of U07.4 [Post COVID-19 condition].* See example 1 in ICS 22X2 for reference.

For this case the COVID-19 flag is assigned as there is documentation that the patient tested positive.

Post Viral Condition

A patient was admitted to the MAU with Cough and SOB and is Post COVID-19 infection. As per referral letter the patient was previously "COVID-19 +ve (laboratory confirmed)" . The discharge letter and the chart state the patient is suffering from 'post-viral' cough due to the COVID-19 infection. Is this documentation sufficient to assign the U07.4 post covid-19 condition?

Yes the documentation 'Post Viral, Post Covid19 infection' is sufficient to assign U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*. As per ICS 22X2 assign U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis where clinical documentation indicates a current condition is causally related to previous COVID-19.

The COVID-19 flag will also be assigned to this case as the patient has had lab confirmed COVID-19 in the past.

Close Contact of COVID-19

An inpatient was a close contact of a COVID-19 positive patient (same ward together). The patient was counselled re same and was discharged the next day to be swabbed in the community. Would it be appropriate in this case to assign Z20.8 *Contact with and exposure to other communicable diseases*?

Based on the information provided we would agree with assigning Z20.8 *Contact with and exposure to other communicable diseases*, as it appears to meet the criteria in ACS 0002 Additional Diagnoses, the HADX flag will also be applied to the Z20.8 *Contact with and exposure to other communicable diseases* code. Please also place a note in the HIPE Portal explanation box summarising the case for future audit.

Positive COVID -19 test

A patient was ill with COVID-19 in early January 2021 and now presents symptom free however the preadmission COVID-19 test was positive. This test was done two days before an admission in late February for the setting of a fractured ankle. Hospital Infection Control advised that the patient could be admitted for the procedure but in a single room. What COVID-19 codes apply?

Where there is uncertainty around a second positive test we would always advise where possible to liaise with Infection Control to determine if this is a similar scenario to example 3 in ICS 22X2 Novel Coronavirus (COVID-19) as current data informs us that reinfection occurs in rare circumstances. Also as explained in the standard patients may test positive "*where antibodies remain in the system even though an acute infection is no longer present".* Further information is needed before a COVID-19 code can be assigned.

COVID-19 Coding Queries
Continued

Low Positive swabs

There is an increase in patients who were previously treated for COVID-19 and are returning with symptoms. Swabs are returning as a low positive so following the coding guidelines, these cases were coded as laboratory confirmed cases – tested positive. Can you please advise if this is correct?

We would advise that where it is not clear from the clinical documentation the relevance of this second positive COVID - 19 test to liaise with the clinical team or infection control department to determine if this is a re-infection (which is rare), post/long Covid19 or no causal relationship. More information is needed and each case should be coded based on the information for that case as there are many different scenarios that can apply.

Advice around this area issued by IHPA was recently incorporated into ICS 22X2 Novel Coronavirus (COVID-19) and into example 3 in the standard. The advice published by IHPA states

> ***U07.3 Emergency use of [Personal history of COVID-19] and U07.4 Emergency use of U07.4 [Post COVID-19 condition]*** *a**re only assigned when COVID**-19 is documented as no longer current. This includes where clinical documentation indicates that a patient does not have COVID-19, despite a positive laboratory test result for SARS-CoV-2. This scenario may occur where antibodies remain in the system even though an acute infection is no longer present (World Health Organization 2020).*
>
> *Example 3:*
> *Patient admitted with community acquired pneumonia. Laboratory test identifies SARS-CoV2 positive, but a review by the infectious diseases team states 'old viral RNA that is not infectious'. As there is clinical documentation of a previous SARS-CoV-2 infection but no causal relationship with a current condition, assign emergency use code U07.3 Emergency use of U07.3 [Personal history of COVID-19] as an additional diagnosis.*
> *Codes: J18.9 Pneumonia, unspecified*
> *U07.3 Emergency use of U07.3 [Personal history of COVID-19]*
>
> Source: ICS 22X2 Novel Coronavirus: Classification of Post COVID conditions (ICS 2021, page 70)

Vaccination

Patient was admitted 1 day after receiving the COVID-19 vaccine. The patient was diagnosed with inflammatory hip pain due to immune response to the vaccine. What code would apply for the reaction to the vaccine?

IHPA released a specific code for adverse effect of COVID-19 Vaccination on 16th March 2021 which is being implemented by the HPO. The new code is U07.7 *Emergency Use of U07.7 [COVID-19 Vaccines causing adverse effects in therapeutic use).* This code is assigned in addition to existing codes and is for use for discharges from 1st January 2021. For this query if the discharge is in 2021, please assign;

T88.1 *Other complications following immunisation, not elsewhere classified* (Look Up Complications, vaccination)
M25.55 *Pain in joint*, hip
Y59.0 *Viral vaccines,* adverse effect. (Look up Table of Drugs and Chemicals, "Vaccine, viral NEC" in the column for adverse effect in therapeutic use.
U07.7 *Emergency Use of U07.7 [COVID-19 Vaccines causing adverse effects in therapeutic use)*

Is there any direction from WHO, or the HPO regarding the coding of an inpatient been given the Vaccine against COVID 19?
Recently the WHO released an emergency use diagnosis code "need for immunisation against COVID-19 unspecified". The code is not currently available in the ICD-10-AM classification used in Ireland. The HPO will monitor this and will alert the HIPE community as to any changes. In the meantime please follow ACS 0042 *Procedures not normally coded*, drugs are not coded except in certain circumstances e.g. a daycase patient admitted specifically for a vaccination.

Summary of ICS 22X2 NOVEL CORONAVIRUS (COVID-19)

ICS 22X2 Novel Coronavirus (COVID-19) contains classification advice on the coding of COVID-19. This advice has emerged during the pandemic with new codes and guidance introduced since the beginning of 2020. This standard provides the full guidance and the classification advice published by IHPA who manage the ICD-10-AM/ACHI/ACS classification. The following is a summary of ICS 22X2 Novel Coronavirus that may be of assistance however please refer to the full standard for detailed and complete coding guidance.

COVID-19 – Current Condition

Codes for use to identify COVID-19 as a current condition:

Assign *U07.1 Emergency use of U07.1 (COVID-19, virus identified*) when COVID-19 has been documented as confirmed by laboratory testing

Assign *U07.2 Emergency us of U07.2 (COVID-19, virus not identified*) when COVID-19 has been documented as clinically diagnosed COVID-19 including evidence supported by radiological imaging.

Assign *U06.0 Emergency use of U06.0 (COVID-19 ruled out*) when laboratory testing for COVID-19 has been performed, but ruled out (negative test)

Classification guidelines

Laboratory confirmed cases of COVID-19

Lab confirmed COVID-19 with symptoms**,** assign

- A code for the symptom (s) or condition (s)
- Additional code of *B97.2 Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent
- Additional code of *U07.1 Emergency use of U07.1 (COVID-19, virus identified)*

Lab confirmed COVID-19 without symptoms, assign

- B34.2 *Coronavirus infection, unspecified site*
- Additional code of U07.1 *Emergency use of, U07.1 (COVID-19, virus identified)* as an additional diagnosis

Clinically diagnosed or probable COVID-19

Clinically diagnosed or probable COVID-19 with symptoms, assign

- A code for the symptom (s) or condition (s)
- Additional code of *B97.2 Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent
- *U07.2 Emergency use of U07.2 (COVID-19, virus not identified)*

Clinically diagnosed or probable COVID-19 without symptoms, assign

- *B34.2 Coronavirus infection, unspecified site*
- *U07.2 Emergency use of U07.2 (COVID-19, virus not identified)*

Do not use *U07.2 Emergency use of U07.2 (COVID-19 virus not identified*) where test results are pending.

COVID-19 Complicating pregnancy

Lab confirmed or clinically diagnosed COVID-19 complicating pregnancy, assign

- *O98.5 Other viral diseases in pregnancy, childbirth and the puerperium*
- Additional codes as per guidelines for lab confirmed or clinically diagnosed

Summary of ICS 22X2 NOVEL CORONAVIRUS (COVID-19)

continued

Suspected COVID-19 ruled out

Suspected COVID-19 with symptoms, but ruled out assign

- A code for the symptom (s) or condition (s)
- Either *Z03.8 Observation for other suspected diseases and conditions* or *Z03.71 Observation of newborn for suspected infectious condition*
- Additional code of *U06.0 Emergency use of U06.0 (COVID-19, ruled out*) to identify suspected but ruled out COVID-19
- Additional code of *Z20.8 Contact with and exposure to other communicable diseases* if documentation of exposure to confirmed case

For pregnant patients with COVID-19 ruled out follow the advice above

Note: Testing due to hospital protocol (COVID-19 ruled out) should only be coded if admitted specifically for such as a day case.

Post COVID-19 Conditions & Multisystem Inflammatory Syndrome

The following codes have been introduced for discharges from 1st January 2021 to capture Post COVID-19 conditions, personal history of COVID-19 and multisystem inflammatory syndrome.

U07.3 ***Emergency use of U07.3 [Personal history of COVID-19]***

- Assign as an additional diagnosis where previously confirmed COVID-19 is no longer current
- Does not need to meet criteria as per *ACS 0002 additional diagnosis*, can be coded when documented in the current episode of care and does not have to be lab confirmed
- In COVID-19 rehabilitation episodes of care assign *U07.3 Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis NOT *U07.1 Emergency use of U07.1 [COVID-19, virus identified*] as the infection is no longer current

U07.4 ***Emergency use of U07.4 [Post COVID-19 condition]***

- Assign as an additional diagnosis where a current condition is causally related to previous COVID-19
- Do not assign *B94.8 Sequelae of other specified and infectious and parasitic diseases* as this concept is identified by the assignment of U07.*4 Emergency use of U07.4 [Post COVID-19 condition]*

Note:

U07.3 Emergency use of U07.3 [Personal history of COVID-19] and U07.4 Emergency use of U07.4 [Post COVID-19 condition] can be assigned once COVID-19 is no longer current or when a clinician indicates that a patient does not have COVID-19 despite a positive laboratory test result.

U07.5 ***Multisystem inflammatory syndrome associated with COVID-19***

- Assign *U07.5 emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19*] when documented
- Do not assign additional diagnosis codes for the symptoms
- Can be assigned as a principal diagnosis or additional diagnoses as per *ACS 0002 Additional Diagnosis*

COVID 19 Flag

The COVID-19 Flag is assigned as part of the administrative data collected by HIPE. The COVID 19-flag is assigned whenever a patient has or had a laboratory confirmed COVID-19 infection. The flag is assigned independently of the clinical codes. See Irish Coding Standards 2021 page 18.

PICQ™ Update

Finding 'Fixed' indicators that still need to be addressed

When logging into PICQ™, the filters on the Numerator Report will default to only showing 'New' indicators that have been triggered. Indicators can have following status setting:

Status	Explanation	Action Required?
New	This indicator has triggered and has not been addressed	Yes
Fixed	The indicator has been marked 'Fixed' but coding has not yet been updated	Yes
Resolved	A coding change has resolved the indicator	No
Justified (only for W1/W2)	The coder has marked the indicator as Justified.	No

To change the report to view all Status', Uncheck the 'Hide Reviewed' button.

PICQ™ Indicators for use of non-specific codes

The definition of the PICQ R indicator: **The use of 'other' or 'unspecified codes.** There is no requirement for coders to address R indicators. Managers have access to review this data and to decide if action needs to be taken.

PICQ™ Advisory Board Meeting

The PICQ Advisory Board met again on March 8th to discuss PICQ indicators that had been queried. Here are the indicators reviewed:

Indicator	Degree	Description	Rationale	Discussion Topics
102425	F	HIV disease in pregnancy, childbirth and the puerperium without an additional code	This indicator identifies records containing a code for HIV disease in pregnancy, childbirth or the puerperium without an additional code for the specific type of HIV disease. ACS 0102 instructs to assign an additional code for the HIV disease in addition to the Chapter 15 code.	Z21 was coded as the additional code with the 098.7 , with additional pregnancy complicated codes. Indicator logic was updated.
101407	F	Delivery without outcome of delivery code	This indicator identifies records with a diagnosis code or procedure code indicating a delivery but no outcome of delivery code. 'Code also the outcome of delivery' note at Delivery (O80-O84) and 'Code first the delivery' note at Z37 indicates that, for every delivery, the appropriate outcome of delivery code should be added to the mother's record.	The delivery procedure code does not apply before fetal viability
102517	W1	Same day radiotherapy session diagnosis without radiotherapy procedure code	This indicator identifies records where patient is admitted for a radiotherapy session but the radiotherapy procedure and/or the procedure not carried out codes are missing in a same day episode of care. Records with procedure not carried out codes are excluded from this indicator.	Z510 should not be assigned for radiotherapy session planning
102518	W1	Radiotherapy procedure code assigned in same day episode without the Radiotherapy session diagnosis	This indicator identifies records where a radiotherapy procedure code has been assigned without the radiotherapy session diagnosis code in a same day episode of care. ACS 0229 Radiotherapy states that the code for radiotherapy session should be assigned as the principal diagnosis in a same day episode of care.	Changed from F to W1 and edited to comply with Irish standard
New indicators				
102557	F	Emergency use codes for COVID-19, virus identified and COVID-19, virus not identified coded with the history of exposure code.	This indicator identifies episodes where emergency use codes for COVID-19, virus identified and COVID-19, virus not identified have been assigned with the history of exposure code. Coding rule "Assignment of code for exposure to COVID-19" (TN1537) states that the history of exposure to COVID-19is inherent in the assignment of the emergency use codes.	FYI Deanne confirmed that history of exposure is implied when using U071 and U072 and is not required to be coded.
200006	W1	Continuous Ventilatory Support (CVS) coded without CVS hours	ICS states that duration of continuous ventilatory support will be collected for all cases where a code from Ventilatory support is coded i.e. mechanical ventilation. This episode would be correct if the number of hours on continuous ventilatory support is less than 1.	FYI

PICQ™ Support: In order to setup a PICQ account or get an additional hospital added to your profile, send an email to: support@pavilion-health.com which includes your Coder ID (this can vary between hospitals) and the email address.
As always, if you need help or support, please contact Katie Malone at support@pavilion-health.com

Clinical Coding Education Programme

Clinical Coding Education Programme

The HIPE Training Calendar is published in January and additional HIPE training courses are scheduled throughout each year. All Clinical Coder training will be delivered remotely using video conferencing facilities until it is safe to re-introduce in-person classroom courses. HIPE Managers and Clinical Coders will continue to receive regular emails with details of upcoming training.

Course applications

An online application must be completed at www.hpo.ie in advance of course participation.
Completion of this application is required for reasons including: places are limited on some courses, planning, pre-course preparation for trainers and participants, issuing of pre-course and course materials and maintaining training records.

Course preparation & self-directed learning

In advance of each training course an email containing a link to the course together with training materials and instructions is dispatched to the email address provided on the completed course application. If you are participating in the course from an area that is not your usual work location, please ensure that you have access to the email containing this essential information.
Also please remember to check the "spam" or "junk" folder in your email account for course correspondence.
Some components of the HPO clinical coding education programme are undertaken outside of course times: these include pre-course reading, exercises, videos and pre-recorded tutorials and these form an essential part of a clinical coder's training and are required to be completed as prescribed. Therefore it is important that you read all course correspondence and follow instructions carefully.

Remote learning

Utilisation of the chat box and the ability to mute & unmute devices to facilitate interaction, as appropriate during courses is, key to participant engagement.
A camera is desirable (even if only activated for introductions)

Over the past year everyone has embraced new ways of working and learning with an excellent participation rate in HIPE training through video conferencing. We acknowledge that this has been challenging and in particular for many of the new coders that are working in the system for over a year now, and have not attended any in-person classroom training. This is in addition to the challenges faced with on-the-job training and mentoring during COVID-19 and the associated restrictions. We certainly miss meeting up with colleagues at education events in the HPO and throughout the country, and we look forward to seeing you all as soon as possible. We will continue to explore options to improve the delivery of training remotely and to create a positive learning experience for all.

To achieve positive learning outcomes it is of paramount importance that clinical coders have access to the resources that are required to participate in training courses. This includes the following:

Minimum Technical Requirements for HIPE coders

- Please refer to the HIPE Clinical Coding Resources Report, Table 2 page 20 (See http://www.hpo.ie/HIPEClinicalCodingResources/HIPEClinicalCoderResourcesReport.pdf)

⇒ A quiet work station, if possible
⇒ Training materials, the HIPE Instruction Manual, Irish Coding Standards
⇒ ICD-10-AM/ACHI/ACS 10th edition

To facilitate course participation during the COVID-19 pandemic HIPE Clinical Coders can contact hipe.training@hpo.ie to apply for temporary access to the IEbook for use in a location other than their work place, such as home. Terms and conditions of use apply.
If you have any queries about any aspect of training or resources that are available to you please don't hesitate to contact us and we will be happy to discuss your training requirements.

Cracking the Code

A selection of Coding Queries

Q. A patient fell out of his hospital bed during his admission, there was no obvious injury but there was suspicion of injury to the patient's hips, he had an x-ray of his hips and the result was normal. How is this coded?

A. For this case the fall from bed meets criteria as per ACS 0002 *Additional diagnoses* and we would advise assigning the following codes;

Z04.3 *Examination and observation following other accident*

W06.1 *Fall involving special purpose bed.*

Y92.24 *Health service area, this facility*

U73.2 *While resting, sleeping, eating or engaging in other specified activities*

Each of these diagnosis codes will also have the Hospital Acquired Diagnosis flag assigned.

Q. What code do I use for shockwave lithotripsy of the coronary artery? In the IEBook, there is only an entry for 'extracorporeal shockwave lithotripsy 'which is different as this is intravascular.

A. Advice in another jurisdiction is that this new type of procedure is coded as an angioplasty in the absence of a specific code being available in ACHI. Intracorporeal shockwaves are delivered rather than extracorporeal (as in ESWL). Please code as for coronary angioplasty.

Q. A patient was admitted from the renal ward for Angiogram to assess for Renal Replacement for failed Kidney Transplant. The patient is also having dialysis. The patient has been back on Dialysis since 2019 and is now awaiting another transplant. How is the failed transplant coded?

A. Please refer to ACS 1438 Chronic Kidney Disease, and the section on kidney transplant failure which states in bullet point 2; "For chronic (irreversible) kidney failure following a previous kidney transplant which is now requiring maintenance dialysis in the current admission, assign N18.5 *Chronic kidney disease, stage 5* and Z94.0 *Kidney transplant status*."

Q. Could you provide a code for neuroendocrine hyperplasia of stomach? I have currently coded it to K31.88 *Other specified diseases of stomach and duodenum* as any information I have found states it can transform into a Malignant gastrointestinal neuroectodermal tumour (GNET) but is not a tumour itself.

A. We agree with the code K31.88 *Other specified diseases of stomach and duodenum* suggested for this condition as there is currently no specific ICD code available. From our research the most common background in which they arise is atrophic gastritis. If found in the presence of this condition an additional code K29.60 *Other gastritis, without mention of haemorrhage* can be assigned.

Please also place a note in the HIPE Portal explanation box stating Neuroendocrine Hyperplasia of stomach was diagnosed.

Q. A patient fell 1 month prior to this admission with fractures of spine. Two weeks later the patient is admitted with pain and the fractures were all coded again as still current injuries. The patient has just been admitted for a third time with paraesthesia of the legs and back pain which is being described and documented by the clinician as Chronic pain. It's not a sequelae as the fractures are still healing and are current injures. Do I still put in all the fracture codes for a 3rd time as the reason for admission is the chronic pain?

A. We would advise you to refer to the classification section of ACS 1807 Acute and chronic pain which states;

"To classify chronic pain with a documented underlying cause and/or site:

Code first the underlying cause and/or site and assign R52.2 Chronic pain as an additional diagnosis"

Following this guidance we advise assigning the fracture codes followed by R52.2 *Chronic pain* as an additional diagnosis

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Q. If a patient has mild non obstructive cardiac disease, how is this coded please?

A. The 'over 50% obstruction' criterion for the assignment of atherosclerosis has been removed in 10th edition. Clinical coders should assign a code from category I25.1- *Atherosclerotic heart disease* when coronary artery disease is documented and meets the criteria in ACS 0002.

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.

Query submitted to IHPA

ACS 0303 Abnormal coagulation profile due to anticoagulants,

The HPO submitted a query to the Independent Pricing Authority of Australia (IHPA) on ACS 0303 *Abnormal coagulation profile due to anticoagulants* specifically Example No. 4 within the standard. HPO asked:

"What is the reason for coding of atrial fibrillation in this example in 10th edition ICD-10-AM/ACHI/ACS?"

Response from IHPA

In 10th Edition Australian Coding Standard (ACS) 0303 *Abnormal coagulation profile due to anticoagulant* example 4, atrial fibrillation (AF) is assigned as an additional diagnosis as the warfarin dose was reduced (i.e. adjusted) due to overwarfarinisation, and therefore AF meets the criteria for code assignment in ACS 0002 *Additional diagnoses* Tenth Edition as the medication used in the treatment of atrial fibrillation was adjusted.

See also Coding Rule Q2897 ACS 0002 *Additional diagnoses* and alteration to treatment – below.

Ref No:Q2897 Published On: 15-Jun-2015 Status: Current

SUBJECT: ACS 0002 *Additional diagnoses* and alteration to treatment

Question:

Does a condition meet the criteria in ACS 0002 *Additional diagnoses* when the medication to treat the condition has been altered to manage an adverse effect or another condition, as in the following scenarios?

Principal diagnosis of acute on chronic renal failure secondary to Frusemide, with a past history of congestive cardiac failure treated with Frusemide 80mg BD. Dose of Furosemide was decreased to 40mg BD.

Principal diagnosis of aspirin induced ulcers throughout upper gastrointestinal tract, with a past history of atrial fibrillation for which the patient had been commenced on aspirin. Aspirin was with-held for two days, and the patient was commenced on medication to treat the ulcers.

Answer

Based on the limited information in the scenarios described, the conditions listed in the past histo-ry/background (congestive cardiac failure and atrial fibrillation) where medication to treat these conditions has been altered should be coded, as per the criteria in ACS 0002 *Additional diagnoses*; specifically dot point 1, 'commencement, alteration or adjustment of therapeutic treatment'.

Published 15 June 2015,
for implementation 01 July 2015.

Upcoming Courses

Note: All training dates may be subject to change

Please note that due to the COVID-19 restrictions it is necessary to deliver all training courses remotely, online.

Essential materials To participate in courses on-line you will require the following:

- ICD-10-AM/ACHI/ACS 10th edition (IEBook or hard copy)
- Training materials, dispatched in advance of the course
- Irish Coding Standards 2021 (V1)
- 2021 HIPE Instruction Manual (V1.0)

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

CSIV Workshop: Diabetes

This refresher course will include the following:

- Overview of the general classification guidelines for diabetes
- Specific classification principles for DM & IH
- DM & IH with features of insulin resistance
- DM & IH with multiple micro-vascular complications
- Foot ulcers and diabetic foot
- Coding exercises and case studies

Date: Tuesday 13th April 2021

Time: 10.00am – 1.00pm

Location/method of delivery: Online only

CSIV Workshop: COVID-19

This course is suitable for clinical coders at all levels of experience and will include the following:

- An overview of COVID-19
- Coding and classification guidelines for COVID-19 and associated conditions and interventions
- COVID-19 associated administration variables
- HIPE Data Quality presentation
- Coding exercises and case studies

Date: Thursday 15th April 2021
Time: 10.00am – 1.00pm
Location/method of delivery: Online only

HIPE Portal Training

Date: Thursday 18th May 2021
Time: TBC
Location/method of delivery: Online only

Coding Skills II– A

This 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. Materials will be dispatched by email in advance of the course.

Date: Monday 26th – Wednesday 28th April 2021
Time: 10.00am - 5.00pm each day.
Location/method of delivery: Online only

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, 3rd June 2021
Time: 11.00am – 1.00 pm
Location/method of delivery: Online only

Coding Skills II– B: Respiratory

This 1 day course will concentrate on common respiratory conditions, coding and classification guidelines in relation to these conditions, and associated interventions. Participants must complete *Coding Skills II (A)* before attending this course.
Note: Pre-course videos will be dispatched for viewing in advance

Date: Thursday 13th May 2021
Time: 10.00am - 5.00pm
Location/method of delivery: Online only

Coding Skills II (C) Endoscopy Follow up

The half- day course is centred on the clinical coding of same day endoscopies and the associated classification guidelines. Participants must have completed *Coding Skills II (A) & Coding Skills II (B)* before attending this course.

Note: There is a requirement that Endoscopy tutorial videos (2 hours duration) be viewed in advance of the session. These will be dispatched along with other Coding Skills II training materials, as appropriate.

Date: Thursday 10th June 2021
Time: 10.30am-1pm
Location/method of delivery: Online only

Thought for Today

"I never lose.
I either win or learn."
— **Nelson Mandela**