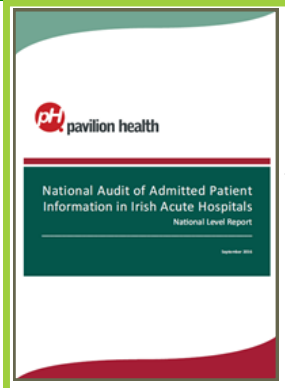
Healthcare Pricing Office

Coding Notes

Number 74
September 2016

National Audit of Admitted Patient Information



In 2015 the Healthcare Pricing Office (HPO) selected Pavilion Health Australia after a competitive tendering process to conduct a project with the objective to assess if the data coded onto the Hospital InPatient Enquiry (HIPE) system was of sufficient quality to support the introduction of Activity Based Funding (ABF). The project involved the assessment of HIPE data from multiple perspectives including a comparison of measurement of complexity, both between Irish hospitals and internationally, an assessment of compliance with coding standards, chart based audits, together with a detailed assessment of the management of coding services. The related report titled *'HSE Ireland National Audit of Admitted Patient Information'* reaches the conclusion that the data and the processes and systems underpinning those data are indeed sufficiently sound to support ABF and contains recommendations that will continue to increase the accuracy and completeness of this data. The national report which summarises the issues contained in the hospital-specific action plans and includes Pavilion Health's recommendations has now been published.

Recommendations in the report include the sharing of the **best practices** that currently exist within the current hospital network in relation to coding. There is emphasis throughout the report on the importance of increasing the **visibility** of coding managers and clinical coders within hospitals. There is a recommendation to develop an independent tool for better estimating the clinical coder workforce needs at a hospital level and also to look at a workforce structure and common job specifications for trainee, competent and senior coder roles. The senior coders would have additional responsibility such as internal auditors, mentors, trainers, data managers and quality control managers. HIPE coding staff need a higher profile within the hospital with their visibility improved through on-going engagement and communication with hospital staff including clinicians and finance staff.

Data Quality features throughout the recommendations with improvements required in clinical documentation, more engagement with clinical staff with suggestions including the establishment of committees with membership from HIPE clinical coders and clinicians with regular scheduled meetings. There is a need to improve the quality of the discharge summary and ensure compliance with the current national medical records standard. A national standards review of the structure of the medical record to meet clinical as well as classification needs is recommended.

The report recommends increasing the use of quality tools; all HIPE Clinical Coders should use quality tools and correct the errors identified in a timely manner. There is also a recommendation to implement a standard HPO audit process calibrated with internal audits at hospitals

There are recommendations for expanding existing **training** to include training for senior coders for 'on the job training' and also for auditing. There is a recommendation for developing education and awareness of DRG assignment and ABF within HIPE. The report recommends developing a clinician focused online education programme on clinical documentation improvement. The existing HPO clinical coder entry courses need to include competencies for clinical coders in topics common across the hospitals, such as privacy and confidentiality policies. The HPO need to review the existing training content for the complex coding identified in the project. The expansion of the training team at the HPO is recommended to meet the greater demands in this area.

In summary the report recognises that Irish HIPE data are sufficiently sound to support ABF. With the implementation of the recommendations above, over time, the system will improve with best practice in the management of coding services introduced nationally to include coder workforce size and structure, enhanced education for coders and hospital staff in HIPE and in ABF and improvements in data quality activities. This will enhance the visibility of coders and the HIPE function and the important role played within the hospital system. Greater collaboration and communication will further improve the data provided. Coders need to be recognised and valued throughout the system. The HPO project team will continue to work on the implementation of the recommendations and agreed action plans with hospitals at regular intervals.

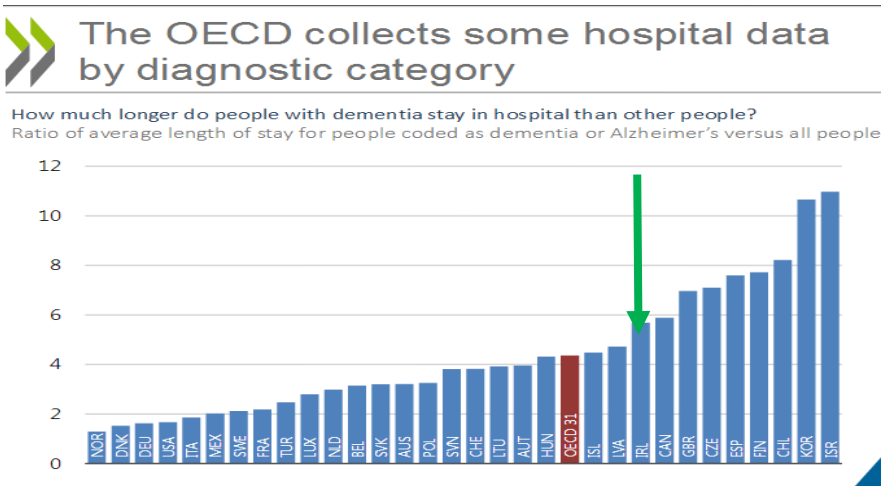
We would like to take this opportunity to thank all of those who were involved in and supported this important project which will inform and guide our work for years to come.

Inside This Issue

Dementia & Alzheimer's

Dementia is an umbrella term for a number of diseases that show a loss of capacity resulting in deterioration in memory, thinking, behaviour and the capability of performing everyday activities. Whilst often dementia is a disease of old age, it can also strike those in their middle years too. It is devastating for those it affects, as well as their family and friends. It also has high costs for health systems. The WHO says that worldwide, 47.5 million people have dementia, with 7.7 million new cases every year.

Policies require data if they are to show how they improve care for people. The OECD is currently exploring what types of data are available at national level across countries that could assist with informing policy development and then monitoring policy implementation and this is where your role as a coder comes in. It is so important to ensure that where the condition meets ACS 0001 *Principal Diagnosis* or ACS 0002 *Additional diagnoses* that this information is included on the patient's HIPE record. The slide below shows some work that has been done by the OECD on the data for people in hospitals who have dementia.



Graph: Ratio average length of stay for people with dementia/Alzheimer's versus all others

As you can see from the graph, Ireland is in the top third for average longer length of stay in hospitals and there could be any number of reasons for this, such as they are sicker when they go into hospital or there is a delay in getting a care package in place for when they go home. Note also that the data in the graph is based on principal diagnoses of dementia/ Alzheimer's only.

Coding of Dementia/Alzheimer's in HIPE.

ACS 0528 *Alzheimer's Dise*ase advises that

"When only 'Alzheimer's disease' is documented, rather than 'Alzheimer's dementia', the dementia component can be assumed and thus two codes should always be assigned, G30.- *Alzheimer's disease* and F00.-* *Dementia in Alzheimer's disease."*

Example 1

Q. A patient admitted with progressive dementia- described as Mixed Alzheimer's with Vascular Dementia. How is this coded?

A. For Mixed Alzheimer's with Vascular Dementia assign the following codes:

G30.8 *Other Alzheimer's disease*

Note: For Mixed Alzheimer's look up Alzheimer's dementia- atypical or mixed

F00.2* *Dementia in Alzheimer's disease, atypical or mixed type*

Note: Dementia element can be assumed as per ACS 0528 *Alzheimer's disease* and this dementia code is specific to atypical or mixed type of Alzheimer's)

F01.9 *Vascular dementia, unspecified*

Note: Also assign a code for the vascular dementia as there is no excludes notes at category F01 if there is a code from F00 present.

The dementia can have more than one cause – as per the note at the beginning of section F00- F09 in the tabular index.

Testicular Cancer Surgery

The National Cancer Control Programme is working closely with specialist clinicians in the area of testicular cancer and the surgery involved. Clinicians are actively using and reviewing HIPE data in this area and we recently met with a lead clinician on the team to discuss the specialist surgeries and procedure codes associated with this area. The HPO would like to acknowledge the input and assistance of the consultant urologists involved and the National Cancer Control Programme.

Orchidectomy/orchidectomy with prosthesis

The ACHI classification provides the following codes for orchidectomy procedures in procedure block [1184] *Orchidectomy* and coders are advised to always code the insertion of prosthesis when performed. This surgery may be performed for conditions other than testicular neoplasms.

1184 Orchidectomy

Includes: excision of hydrocele
repair of varicocele

30641-00 Orchidectomy, unilateral
Excision of testis
Removal of remaining (solitary) testis

30641-01 Orchidectomy, bilateral
Excision of testes

30641-02 Orchidectomy with insertion of testicular prosthesis, unilateral

30641-03 Orchidectomy with insertion of testicular prosthesis, bilateral

Retroperitoneal Lymph Node Dissection (RPLND)

A specialised surgery called Retroperitoneal Lymph Node Dissection (RPLND) may be performed following treatment for germ cell tumours of the testis and coders are directed to review the advice in **ACS 0028 *Para- aortic lymph node biopsy*** which provides information on the circumstances in which this surgery may be performed. Currently RPLND following testicular cancer is performed in a small number of hospitals and coders in these hospitals are advised to ensure the correct code is being used as per below.

Clinical advice in Ireland is that where the procedure Retroperitoneal Lymph Node Dissection (RPLND) is performed following chemotherapy/radiotherapy treatment for testicular cancer the code 37610-00 [811] *Radical excision of retroperitoneal lymph nodes, **subsequent*** is to be used**.** This will allow the fact that there has been previous treatment to be recorded as an element of the procedure code.

37610-00 [811] Radical excision of retroperitoneal lymph nodes, subsequent
Radical dissection of retroperitoneal lymph nodes following previous retroperitoneal:
- chemotherapy
- dissection
- irradiation

Code also when performed:
- sentinel lymph node biopsy or excision (30300-01 **[805]**)

Example:
A patient was previously admitted for an orchiectomy for testicular cancer and has been treated with chemotherapy. The patient is now being admitted to have surgery to remove retroperitoneal lymph nodes, the operative sheet states that the patient had a "RPLND" performed. Histology confirms metastases in the retroperitoneal lymph nodes.

In this case for diagnosis code assignment please follow the advice in ACS 0236 *Neoplasm coding and sequencing*. The primary site will be coded as a current neoplasm (even though an orchiectomy has been performed) and the metastases to the lymph nodes will also be coded. When coding the procedure in this case it is necessary to have information on the previous treatments the patient has had. See also ACS 0028 *Para- aortic lymph node biopsy* .

Diagnoses: C77.2 *Intra-abdominal lymph nodes* (secondary malignant neoplasm)
C62.1 Malignant neoplasm, *Descended testis*
Procedures: 37610-00 [811] Radical *excision of retroperitoneal lymph nodes, subsequent*

Note: Please check the includes and excludes notes at this code to ensure the full complexity of the procedure is captured. Code Anaesthesia as documented

A new Irish Coding Standard (ICS) **ICS 0028 Retroperitoneal Lymph Node Dissection (RPLND)** which compliments the existing ACS 0028 Para-Aortic Lymph Node Biopsy will be published in the next edition of the ICS.

Neuraxial Blocks during Labour and Delivery episode

The HPO received several queries in relation to administration of Neuraxial blocks during labour and delivery.

This article aims to address the differences between the codes for Neuraxial blocks and their application.

ACS 0031 *Anaesthesia* contains definitions and classification guidelines for anaesthesia (partial or complete loss of sensation), anaesthetics (drugs used to induce anaesthesia), and certain types of postprocedural analgesia. Careful inspection of the medical record, including the nursing notes is required to ensure that the correct code is assigned. Coders need to check the perioperative record as it will contain details where an epidural is topped up/ continued to perform a delivery procedure.

The codes available are:

925**06**-XX [**1333**] *Neuraxial block during labour*
925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure*
925**08**-XX [**1909**] *Neuraxial block*

NOTES:

- Epidural plus top up for a patient in labour who delivers with no delivery procedure = 925**06**-XX [**1333**] *Neuraxial block during labour* is assigned.
- Epidural plus top up in order to provide continued labour pain relief <u>but also has a delivery procedure</u> = 925**06**-XX [**1333**] *Neuraxial block during labour*
- Epidural, administered during labour, plus <u>top up/continued</u> to provide anaesthetic relief <u>to perform a delivery procedure</u> = 925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure*
- It must be evident from the documentation that the top-up/continuation of the epidural is specifically to provide anaesthesia to perform a delivery procedure before 925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure* can be assigned.
- When an epidural, spinal or caudal is administered <u>for anaesthesia only to perform a delivery procedure</u> assign 92508-XX [**1909**] *Neuraxial block*.

Careful inspection of the Medical Record including the nursing notes is required to ensure that the correct code is assigned. Coders need to check the perioperative record as it will contain details where an epidural is topped up to perform a delivery procedure.

Queries on epidurals submitted to the HPO

1. Q. If the patient is administered an epidural (Neuraxial block) for pain relief in labour (and has it topped up or not) and <u>no delivery procedure</u> is performed, what code is assigned?

A. 92506-XX [1333] *Neuraxial block during labour* is assigned.

2. Q. If an epidural (Neuraxial block) is topped up/continued to perform a delivery procedure e.g. C-section, for ceps, vacuum delivery etc. what code is assigned?

A. 925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure* is assigned.

3. Q. If a neuraxial block, administered for labour, is topped up and there is no delivery procedure performed what code is assigned?

A. If a top up is documented and there is no delivery procedure performed 925**06**-XX [**1333**] *Neuraxial block during labour* is assigned.

Neuraxial Blocks during Labour and Delivery episode
Continued

4. **Q.** If a patient is given an epidural for pain relief in labour and has a forceps delivery, and no top up/continuation of the epidural is documented what code is assigned?

A. 925**06**-XX [**1333**] *Neuraxial block during labour* is assigned as the epidural is not topped up/continued to per form the delivery procedure (even though there was a delivery procedure performed).

5. **Q.** When is it appropriate to assign 925**08**-XX [**1909**] *Neuraxial block*?

A. If a Neuraxial block is administered only for anaesthesia for caesarean section or delivery procedure, assign 925**08**-XX [**1909**] *Neuraxial block* (the neuraxial block wasn't administered during labour for pain relief). 925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure* is assigned if an epidural is topped up/ continued to perform a delivery procedure.

6. **Q**. If a patient has CSE (**Combined spinal and epidural anaesthesia)** during labour and delivery what code is assigned?
A. A code for a neuraxial block will be assigned. Please follow the guidelines in ACS 0031 *Anaesthesia* as discussed above. Code assignment will depend on the circumstances surrounding the delivery.

If CSE is for pain relief during labour and delivery – assign 925**06**-XX [**1333**] *Neuraxial block during labour.*

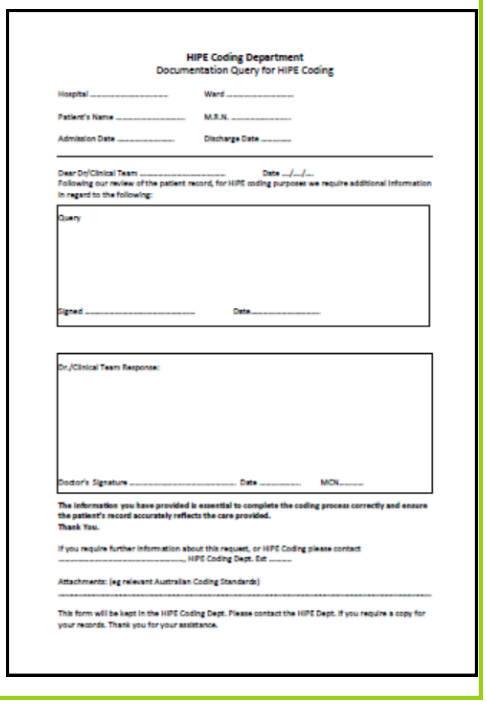
If Neuraxial is topped up/continued to perform a delivery procedure- assign 925**07**-XX [**1333**] *Neuraxial block during labour and delivery procedure*

If CSE is administered for delivery procedure only - assign 925**08**-XX [**1909**] *Neuraxial block*

Clarification of Documentation

Communication with Clinical staff in relation to documentation in the medical record

Clear communication between HIPE staff and clinicians is important when clarification is required in relation to medical record documentation. Issues relating to documentation in the medical record are often cited as one of the biggest challenges faced by clinical coders. HIPE Data have many applications including ABF so it is important that the codes applied to each discharge reflect the hospital activity accurately. Raising a query with clinical staff can be a challenge. A good way to approach this is to complete a Documentation Query form. Be as clear and succinct as possible with the query, bearing in mind that clinical staff will not be familiar with the ICD-10-AM/ACHI or ACS codes and conventions. The response will provide clarification of the documentation to allow coders perform their job of assigning the correct codes to best reflect the patient's activity in the hospital.



HIPE Coding Department
Documentation Query for HIPE Coding

Hospital ..... Ward .....

Patient's Name ..... M.R.N. .....

Admission Date ..... Discharge Date .....

Dear Dr/Clinical Team ..... Date .../.../...
Following our review of the patient record, for HIPE coding purposes we require additional information in regard to the following:

Query

Signed ..... Date.....

Dr./Clinical Team Response:

Doctor's Signature ..... Date ..... MCN.....

The information you have provided is essential to complete the coding process correctly and ensure the patient's record accurately reflects the care provided.
Thank You.

If you require further information about this request, or HIPE Coding please contact ..... HIPE Coding Dept. Ext .....

Attachments: (eg relevant Australian Coding Standards)

This form will be kept in the HIPE Coding Dept. Please contact the HIPE Dept. if you require a copy for your records. Thank you for your assistance.

The HIPE Coding Department Documentation Query for HIPE Coding form may be helpful to use when you have a query in relation to documentation. It can also be used as a template to help you design your own query form. This type of form is used internationally by clinical coders to seek clarification on documentation. You will need to check with the Medical Records Officer in your hospital in relation to storage of information contained in completed forms and if your hospital will accept this form, when completed by the clinician, as being a valid document for the patient's record. These forms are available from the HPO.

Cracking the Code

Q. Please advise on a code for frontotemporal dementia.

A. Please look up the main term **Dementia**, there is a modifier for -frontotemporal.

The codes to assign are a dagger and asterisk combination

G31.0† Circumscribed brain atrophy *and*
F02.0* Dementia in Pick's disease

Q. Patient admitted with "Hypothermia/sepsis; frail, cachexic, sepsis syndrome, likely respiratory sepsis" and this phrase to a lesser or greater degree is repeated throughout the admission. Patient died and no post-mortem is performed and there is nothing isolated in the limited bloods which were drawn. How is this coded?

A. Assign a code for respiratory tract infection and also a code from A40 *Streptococcal Sepsis* – A41 *Other Sepsis* to reflect the sepsis and a code for R65.x *Systemic inflammatory response syndrome (SIRS)*, if documented.

Q. At the Sepsis workshop we were told that if a patient has sepsis and SIRS documented in the chart to code both, however the definition of sepsis is SIRS with an infection. Would it not make sense that all patients with sepsis have SIRS as well, so assigning an additional code for the SIRS would be over coding, we would be coding a symptom of the sepsis?

A. You are correct in saying that when sepsis and SIRS are documented that a code is assigned for both the sepsis and SIRS. The majority of patients who have Sepsis (infection) also have SIRS (the body's reaction to the infection), but our advice from the Sepsis National Lead is that not all patients who have a clinical diagnoses of sepsis will present with SIRS. Approximately 15% of patients with a clinical diagnoses of sepsis **will not** have SIRS. Assigning the additional code for the SIRS provides additional information about the diagnosis.

Q. If an inpatient's record has a signed entry from the pharmacist during the episode of care should it be coded to 95550 -09 Allied *health intervention, pharmacy?*

A. This code can be used to record the pharmacist's entry in the chart using the code you have suggested. There is no requirement to do this but some hospitals collect this information routinely. This information can be collected where the pharmacist has made an entry in the patient's chart.

Q. How do I code PDT (Photodynamic therapy) of a scalp skin lesion?

A. PDT is where a special drug is used under a special light to treat a skin lesion. The ACHI code assignment will depend on whether the lesion is a neoplasm or not.

If this is PDT of a **non-neoplastic lesion** we advise assigning 90677-00 [1611] *Other phototherapy, skin*, this block is classified under Destruction procedures of the skin.

If this is PDT of a **neoplastic lesion** and it is a daycase where the patient is admitted for PDT to treat a neoplasm please assign:

Diagnosis: Z51.1 *Pharmacotherapy session for neoplasm*

Plus a code for the neoplasm

Procedures: 96200-00 [1920] *Subcutaneous administration of pharmacological agent, antineoplastic agent*

And

90677-00 [1611] *Other phototherapy, skin,*

See: www.cancerresearchuk.org/about-cancer/type/skin-cancer/treatment/photodynamic-therapy-for-skin-cancer.

Q. A patient was admitted with Febrile Convulsion secondary to Upper Respiratory Tract Infection (URTI). How do I sequence these?

A. Please see the advice in ACS 1809 *Febrile convulsions*, which states that;

"R56.0 *Febrile convulsions* should be assigned as the principal diagnosis in cases of febrile convulsions (simple or non simple) where no underlying cause is documented.

Where an underlying cause is documented, the principal diagnosis convention should be followed (see ACS 0001 *Principal diagnosis*)."

The URTI in this case seems to be the underlying cause of the febrile convulsions – therefore following the advice in ACS 1809 *Febrile convulsions* we would advise coding the URTI as the principal diagnosis, followed by R56.0 *Febrile convulsions*.

Cracking the Code

A selection of ICD-10-AM Queries

Q. We have a query in relation to the coding of resuscitation following a cardiac arrest. When you look up the code 92052-00 [1889] *Cardiopulmonary resuscitation* in the intervention tabular the following coding rule below is adjacent to it:

> Ref No: Q2678 | Published On: 15-Jun-2012 | Status: Current
>
> Coding a resuscitation intervention with cardiac arrest
>
> Q:If patient has a cardiac arrest and resuscitation is performed should procedure codes for non-mechanical or cardiopulmonary resuscitation be assigned?
>
> A:The NCCC advises that procedure codes for non-mechanical or cardiopulmonary resuscitation performed after cardiac arrest should not be assigned as per the principle in ACS 0016 *General procedure guidelines* which states: "Many procedures may meet the above AIHW definition of a clinical intervention but if they are routine in the treatment of the diagnosis being coded, it may not be necessary to code them. For example, many nursing procedures may require 'specialised training' but these procedures are not coded." The NCCC will consider adding 92042-00 [1889] Non-mechanical methods of resuscitation and 92052-00 [1890] *Cardiopulmonary resuscitation* to ACS 0042 *Procedures normally not coded* for a future edition of the ACS.
>
> (Coding Q&A, June 2012)

According to this coding rule it is not necessary to assign a code for non-mechanical or cardiopulmonary resuscitation done following a cardiac arrest. Could you please advise as to whether or not this coding rule is still applicable in ICD-10-AM/ACHI/ACS 8th edition?

A. The procedure codes for resuscitation for cardiac arrest are not required as per the advice in the Coding Rules referenced above which is valid for 8th edition.

However please note that a diagnosis code for cardiac arrest is only assigned when resuscitation is undertaken regardless of outcome – see instruction at diagnosis code category I46 *Cardiac arrest*:

> ***Note:*** Codes from this category should be assigned only if resuscitation intervention is undertaken, regardless of patient outcome.

Q. Please can you confirm if we should be coding Airvo via nasal prongs in our hospital. One of our Anaesthetists in the hospital believes it should be coded as non-invasive ventilation and I would just like clarification of same.

A. Thank you for your query. The coding query published in Coding Rules provides classification guidelines in relation to high flow therapy.

> **High flow nasal cannula (HFNC)**
>
> Eighth Edition Education Workshop FAQs - Part 2
>
> **Q:** Where high flow therapy is delivered through a mask, is it the same as high flow nasal cannula therapy?
>
> **A:** Clinical advice indicates that high flow therapy delivered through a mask is not the same as high flow nasal therapy. High flow nasal cannula therapy depends on the nasal airways partly sealing the cannula to generate a pressure gradient to improve oxygenation and this cannot be generated with a face mask even if high flow oxygen is administered. Therefore, despite the modalities listed for NIV in ACS 1006 Ventilatory support including mask, high flow therapy must be delivered through a nasal cannula to be coded as non-invasive ventilation.
>
> (Coding Rules, December 2013)
>
> Ref No: TN565 | Published On: 12-Dec-2013 | Status: Current

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 II

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

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

Coding Skills III

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

Date: Tuesday 29th November – Thursday 1st December
Time: 10am – 5pm each day
Location: HPO, Brunel Building only

Data Quality Sessions

Hands on HCAT and Checker training in the HPO.
Audit methodology will also be covered.

Limited availability

Date: Wednesday, 2nd November
Time: 10.00am – 4.30pm
Location: HPO

Note: This is an update on data quality including the portal HCAT and Checker. This session will be repeated subject to demand.

Date: Thursday, 17th November
Time: 11.30am – 1.30pm
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.
www.hpo.ie/find_it_fast/

Coding Skills IV– Workshop

Endoscopies Workshop

Date: Thursday, 13th October
Time : 10.30 am -1.00pm
Location: WebEx

Coding Skills IV– Workshops

Introduction to Obstetrics—Full Day Workshop

Date: Friday, 11th November
Time : 10.00am –4.30pm
Location: HPO, Brunel Building

Coding Skills IV– Workshops

Z-Codes Workshop—2 half days

Dates: Tuesday, 22nd November &
Wednesday, 23rd November
Time : 10.30am –1.00pm—each day
Location: HPO, Brunel Building & WebEx

Anatomy & Physiology

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

Anatomy & Physiology— Genitourinary System

Date: Tuesday, 15th November

Time: 11.00am – 1.00pm

Location: HPO, Brunel Building & WebEx

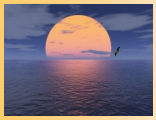
Anatomy & Physiology— Infectious Diseases

Date: Tuesday, 15th November

Time: 2.00pm – 4.00pm

Location: HPO, Brunel Building & WebEx

Thought for Today



**We all live under the same sky,
but we don't all have the same horizon.**

Konrad Adenauer – 1876-1967,
Former Chancellor of Germany