Coding Notes

Healthcare Pricing Office

Number 78
September 2017

Forthcoming Changes to HIPE in 2018

Every year, the HPO reviews the HIPE data collected to assess if changes are required. The purpose of the review is twofold, to ensure that HIPE remains relevant in the hospital environment, and to assess the requests for additional fields received by the HPO. For discharges in 2018 onwards, we have completed this exercise and the following are the main changes.

Eircode

It is proposed to collect the Eircode in addition to the HIPE residence code for each patient. The data will be stored locally in the hospitals' HIPE Portal and part of the code (the first three characters) will be submitted to the national file.

Medical Card Number (GMS)

The Medical Card Number (GMS) will no longer be collected as part of HIPE. This change does not affect the collection of the medical card indicator.

Hospital Transfers – Admission status

An additional data field called Hospital Transfer Admitted Status will be collected when a patient is transferred from another hospital. This status will be used to flag if the patient was:

- Admitted (inpatient/daycase) in the previous hospital or
- An ED attendance at the previous hospital.

Hospital Transfers – Hospital list

The list of hospitals for which patients can be transferred will change and non-acute hospitals will be removed from the list. Transfers in to and out of the non-acute hospitals will, from then on, be coded using appropriate Admission source and Discharge codes.

Mode of Emergency Admission for ASAU

From 2018 onwards, the range of cases eligible for HIPE coding will be expanded as Acute Surgical Assessments Unit (ASAU) wards will be included. As a result of this, the mode of emergency admission will be expanded to allow for the flagging of emergency cases in ASAU. These wards must be registered with the HPO in the same way as MAUs, in advance of collecting data.

Additional information will be circulated to hospitals over the next few weeks. We will be asking hospitals to arrange to have their Patient Systems updated to accommodate these changes.

Please email HIPEIT@hpo.ie if there are any questions at this stage.

Managing Coding Services Day

Managing Coding Services Day, HPO, September 2018

Thanks to everyone who attended the Managing Coding Services Day held in the HPO on the 20th September.

We had about 40 attendees who spent a large part of the day sharing best practice and networking. There was a wealth of experience and knowledge in the room and it was a great day full of ideas and innovations to help all working in HIPE to optimise our work. From deadlines to data quality, everything HIPE related was discussed and debated.

The *HIPE Data Quality Strategy* was launched and this document is going to be key to hospitals for their data quality and audit work. Ann Hannon and Trina Dooley gave wonderful insights into their work and experience and how they navigate this world of HIPE data with all its challenges. HPO staff spoke on issues on working in HIPE in hospitals of all sizes, on training, data quality, the Pavilion report and on the ABF programme. A quick survey completed by 25 participants showed that there was almost 500 years coding experience between them—that's some amount of experience and knowledge! We will be following up with participants with a report on the breakout sessions and feedback. Watch out for further similar days in 2018. Thanks to all who participated!

Coding Queries from HIPE Coders

When submitting a coding query to the HPO please provide as much information as possible to help us answer your query as quickly as possible. Remember to anonymise information with regard to patients or clinicians. For guidance please refer to the HIPE Help form available at www.HPO.ie in the 'Find It Fast' section.

At Hospital level:

Steps to follow when you have a coding query

- Check the healthcare record documentation for further information.
- Follow The Five Steps to Quality Coding.
- Check The ACS & The ICS.
- Check for relevant Coding Rules, Coding Notes Articles including Cracking the Code (Index available).
- Discuss with colleagues and supervisor, or treating clinician, as appropriate.
- If clarification is required from the treating clinician in relation to documentation the *Clinical Clarification Form* may assist with communicating the query. This is available on request from the HPO.
- If the query can't be resolved locally, submit query to HPO.
- Please provide as much information as possible including the discharge date when submitting a coding query.
- Remove any patient or clinician identifying information from anything submitted.
- For guidance please refer to the HIPE Coding Help form available at www.HPO.ie in the 'Find It Fast' section.

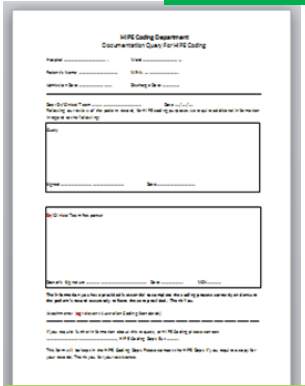
At HPO:

Steps taken in the HPO when a coding query comes in.

- The query is logged in a central record and a check is run to see has this or a similar query been submitted before.
- The query is reviewed by the coding team.
- Additional information may be sought from the coder on the query or on the documentation.
- The HPO may access external coding advice as required.
- Final response is agreed at a meeting of the coding team at the HPO.
- The response is logged and returned to the hospital.
- A selection of coding queries are published in Cracking the Code section of *Coding Notes* quarterly newsletter.

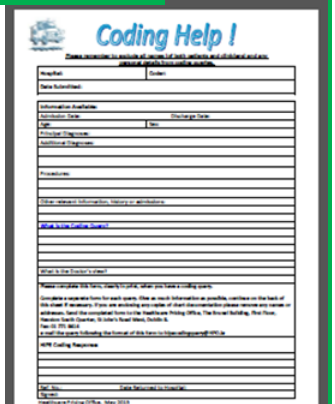
At Hospital Level: Steps to follow when you receive a response to a coding query

- Circulate the response to coding colleagues
- Code the relevant episode(s) of care appropriately based on response
- Keep a central record of all responses to queries for future reference



Clinical Clarification Form

The HPO have dedicated resources to work on the coding queries received from hospitals. As outlined above each query received is reviewed and researched. The office is in the process of clearing the backlog of coding queries and also addressing the new queries received. The HPO appreciate your patience on submitting queries and the HPO work as quickly as possible to respond to queries as there is pressure on coders with coding deadlines. So far this year the HPO have answered 371 queries.



Coding Help Form

Assigning HADx in Neonates

As stated in ICS 0048, Hospital Acquired Diagnosis (HADx) this indicator allows for any diagnoses acquired during the patient's episode of care that were not present prior to admission, to be identified. The purpose of this variable is to collect information that can be used as an indicator of quality of care. The 'Hospital Acquired Diagnosis' indicator is collected by HIPE for diagnoses that were not present on admission but are acquired by the patient during the current episode of care. The guidelines contained in ACS 0048 *Condition Onset Flag* serve as a useful guide.

In general, the principal diagnosis cannot be flagged as a HADx indicator as by definition it will have been present when the patient was admitted. **The only exception to this rule is for neonates during the birth episode where the principal diagnosis can be flagged as a Hospital Acquired Diagnosis (HADx).** For neonates this includes the condition(s) in the birth episode arising during the birth event i.e. the labour and delivery process. This could include for example respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures.

Example 1

Single born male, born at 38 weeks (2840g) by caesarean section, during section scalpel laceration (superficial) occurred requiring admission for treatment – suturing under L.A. On examination a cleft palate was noted and baby was seen by the cleft co-ordinator who arranged future follow-up. Baby was discharged with mother on day 3.

	HADx
Principal Diagnosis	
Other specified birth trauma	**Yes**
Additional Diagnoses	
Fetus and newborn affected by	
Caesarean delivery	**Yes**
Cleft palate, unspecified	No
Singleton, born in hospital	No

Example 2

Baby born in hospital at 36 weeks(3200g). After delivery, clinical review confirmed 'meconium aspiration syndrome' and the newborn is given I.V. antibiotics and oxygen. Initial check – talipes. Nursing staff felt that there was a slight hip click. Baby was unsettled and fussed at breast. Required assistance with feeding due to tongue tie. Developed jaundice on the second day. Paediatric review on day 3 'L hip subluxatable' for follow up.

	HADx
Principal Diagnosis	
Preterm Infant	No
Additional Diagnoses	
Neonatal aspiration of meconium	**Yes**
Tongue tie	No
Talipes	No
Jaundice	**Yes**
Subluxatable hip	No
Singleton born in hospital	No
Feeding problems of newborn	**Yes**

Upcoming HIPE Portal Reporter Training

Reporter training is delivered via WebEx in three consecutive half day sessions, over a full day and followed by a half-day, and covers all aspects of working on the HIPE Portal Reporter. This course is open to all working within the system who are using HIPE data through the HIPE Portal or through the HOP. Please complete the online training application at: **www.hpo.ie/training.** The next courses are scheduled for:

WebEx based Course	Date(s)	Time
HIPE Portal Reporter Training [Part I]	18th October / 13th December	10:30am - 12:00pm
HIPE Portal Reporter Training [Part II]	18th October / 13th December	2:00pm - 4:00pm
Using Scripts & Extracts in the HIPE Portal Reporter [Part III]	19th October / 14th December	10:30am - 12:00pm

Audit and Data Quality Update

HPO Coding Audits

The HPO's chart based coding audit schedule continues nationwide with ten chart based audits completed to date in 2017. Feedback from hospitals about the audits has been very positive. The HPO continue with their audit schedule and will be contacting hospitals to arrange the next audits. The audit team will also follow up with hospitals and HIPE departments on the recommendations made in the HIPE coding audit reports. Hospital HIPE staff have been very engaged in the audit process and where possible the HPO audit staff deal with coding questions and queries that arise during the audit visit. HIPE coding audits have identified that basic coding guidelines not being applied are most often the reason for differences between original coding and audit coding.

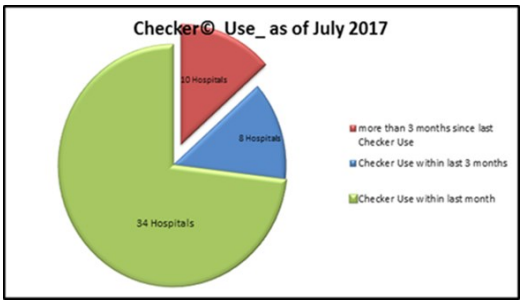
A new version of the HIPE Coding Audit Toolkit (HCAT) is in preparation and we will be in contact with all hospitals when it is released. This new version uses ABF information and V8.0 of the AR DRG grouper making audit reporting more relevant for ABF hospitals. The HCAT update also includes reports on the Hospital Acquired Diagnoses field – e.g. number of HADx flags assigned by the original coding and the number assigned by the auditor.

The HPO are developing a HIPE auditing course and aim to hold the first auditing course in 2018. This course will be aimed at those who conduct coding audits as part of their current role and significant experience in HIPE coding is required. There will be a limited number of places available and again we will keep all HIPE departments posted with developments and dates for this course.

The Checker©

The HPO have run the Checker© on the 2017 HIPE national file (end of July) and these queries have been issued to hospitals, cases already verified by your hospitals on the Checker© locally are excluded from the HPO checks, however, this will depend on the date the cases were reviewed locally.

The HPO monitor Checker© use by hospitals on a regular basis. In August we followed up with hospitals individually on their Checker© use. Some of the 10 hospitals that have not used The Checker© in the last 3 months are hospitals with no on-site coder and we are following up with those sites as appropriate. The HPO recommends that hospitals use The Checker© each month prior to export. It is important for each hospital, regardless of size or complexity of activity, to utilize this tool as part of their data quality work. Running your data through The Checker© helps you to further ensure data quality for your HIPE data prior to export to the HPO and therefore can potentially reduce queries arising either locally or from ourselves at a later time. If you need assistance with The Checker© please contact HIPEIT@HPO.ie. Advice is also available from HIPE IT if you need to run the software over a number of sites.



Data Quality Review of HIPE 2017 National File

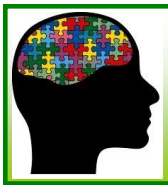
As at the end of July 2017 national HIPE coverage was at 96.7% for all HIPE hospitals for discharges from January to June 2017. Given the high level of HIPE coverage, tight deadlines and the emphasis on quality data, the HPO have commenced the review of high and low frequency use of codes and AR DRGs for January to June 2017. Previously this review was performed on an annual basis. The HPO review 10 spread sheets for each hospital's activity and summarise the queries for issue. Please let us know if you would like to receive the full output for your hospital in addition to the query summary.

Checking Lists

The HPO review 200 discharges for each hospital by producing a detailed patient report. Both inpatients and daycases are included. By reviewing case level data the HPO can identify where errors in coding guidelines may be occurring. For example unusual sequencing of codes, *code also* instructions, over use of additional diagnosis codes – such as codes for personal or family history. We aim to produce a checking list for each hospital by the end of 2017 and please note that only the cases marked for review are being queried. We are reviewing our process in this area and please let us know if you have any suggestions.

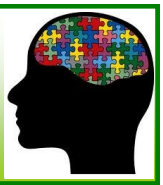
Data Entry Edits

The data entry edits on the HIPE Portal are continuously reviewed. The next version of the portal will include some new and amended edits; for example, in cerebral anaesthetics (procedure block [1910] Cerebral anaesthesia) there will be an edit on the use of fifth character ASA 9 – *no documentation of ASA score*. Please let us know if you need any clarification on any data entry edit or if you have a suggestion for an edit. Also please ensure that you respond appropriately to edits to prevent these issues reoccuring in all reviews of the data and also in Checker© checks.



Cracking the Code

A selection of ICD-10-AM Queries



Q. On coding Obstetric charts, when an e-coli comes back on a placental surface swab fetal side, nothing on maternal side, should this e-coli be coded? The baby was not admitted to NICU. There is no maternal sign of infection, the baby has a pyrexia. Chorioamnionitis is not documented on the mother's chart.

A. Without a documented associated condition the finding of e-coli on a swab cannot be coded. Please check to see if there is a condition present. ACS 0010 General Abstraction Guidelines provides advice on this type of scenario.

Q. How is "Serotonin Syndrome" coded?

A. If this is an adverse effect code first the manifestations plus

Y49.2 *Other and unspecified antidepressants*

If this is a poisoning code assign first a code for poisoning by the specified drug

T43.2 *Other and unspecified antidepressants*

Plus manifestations

Plus the appropriate external cause code of either X41, X61 or Y11.

See also table of commonly occurring drugs

Q. How do we code the following scenario; a Type II Diabetic, with Central Retinal Vein Occlusion and Macular Oedema?

A. Assignment and sequencing of codes depends on what the reason for admission is.

If the patient is admitted for treatment of central retinal vein occlusion and macular oedema code, as follows

H34.8 *Other retinal vascular occlusions*

H35.8 *Other specified retinal disorders*

E11.34 *Type 2 diabetes mellitus with other retinopathy*

E11.39 *Type 2 diabetes mellitus with other specified ophthalmic complication*

If neither the central retinal vein occlusion or macular oedema are treated on this admission code the condition responsible for admission followed by:

E11.34 *Type 2 diabetes mellitus with other retinopathy*

E11.39 *Type 2 diabetes mellitus with other specified ophthal mic complication*

Please refer to ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia*, and Classification Rules 1 to 6.

Q. How is a "Ligasure" haemorrhoidectomy coded?

A. Ligasure is defined as a suture-less, closed haemorrhoidectomy using electro-surgical device to achieve tissue and vessel sealing. The ACHI code we would suggest for this procedure is:

32135-01 [941] *Destruction of haemorrhoids.*

Q. A patient has a colonoscopy and no neoplasm is found. The "Same day endoscopy flow chart" document* indicates that if the disease is not detected I should code the PDX as Z12.1 and I am then directed to code the reason for screening. I have a case where no disease is detected and I am unsure what to code as the additional diagnosis as there is no family or personal history.

A. If there is no family history or other specified reason documented it is correct to code a principal diagnosis without an additional code. In this scenario the only code assigned is Z12.1 *Special screening examination for neoplasm of intestinal tract*

*If you would like a copy of the "Same day endoscopy flow chart" document please contact the HPO.

Q. A case has post procedural haemorrhage in the colon (post snaring of sigmoid polyp) and adrenaline is injected to stop the bleeding. What procedure code do I assign?

A. Assign procedure code:

90308-00 [908] *Endoscopic destruction of lesion of large intestine*

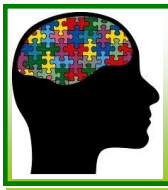
Endoscopic:

- ablation of tumour of colon
- Argon plasma coagulation
- control of colonic bleeding
- destruction of tissue of colon

This advice is consistent with Coding Rules Ref No: TN697 | Published On: 15-Jun-2014.

Q. Where is the coding standard stating that "place of occurrence is not required when coding adverse effects of drugs given in therapeutic doses" located?

A. ICS 1902 *Adverse Effects of Drugs* states "A place of occurrence (Y92.-) is not required with code range Y40 – Y59 Drugs, medicaments and biological substances causing adverse effects in therapeutic use".



Cracking the Code continued

A selection of ICD-10-AM Queries

Q: Can I46.0 be assigned when the patient has a cardiac arrest and resuscitation has been performed prior to admission?

A: Cardiac arrest occurs when the heart stops pumping blood around the body. This is usually the result of an underlying heart condition such as ventricular fibrillation but may also be the result of non-cardiac causes such as respiratory arrest, choking, trauma, electric shock or drowning.

Where a patient has a cardiac arrest prior to admission, and is admitted following successful resuscitation (eg performed by paramedics):

- if there is documentation of an underlying cause (see examples above), assign a code for the underlying cause only
- if there is no documentation of an underlying cause, assign I46.0 *Cardiac arrest with successful resuscitation*

Source: ACCD. Ref No: Q3079 | Published On: 15-Jun-2017

Q. A lesion is excised from the skin of the patient's arm. Histology result states that it is a fibroepithelial polyp. The histology confirms that there is no malignancy. How is this coded?

A. The correct look up term is the polyp. At the index entry for "Polyp" there is a note as follows,

> Polyp, polypus
>
> Note: Polyps of organs or sites that do not appear in the list below should be coded to the residual category for diseases of the organ or site concerned.

As there is no entry for skin under polyp please assign:

L98.8 *Other specified disorders of skin and subcutaneous tissue*

Q. What codes are used for CRE Infection (Carbapenem-resistant enterobacteriaceae) in a wound?

A. Please code this as a drug resistant infection. CRE (Carbapenem-resistant enterobacteriaceae) are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics.

B96.88 *Other and unspecified bacterial agents as the cause of diseases classified to other chapters* (this code represents the enterobacteriaceae infection).

Z06.58 *Resistance to other beta-lactam antibiotics* (this code represents the carbapenam resistence).

Q. A patient is admitted to a general hospital with meningitis and is 26 weeks pregnant. The patient had a lumbar puncture performed and was admitted under general medicine. Is Z33 *incidental pregnancy* correct to use?

A. It seems likely that the pregnancy is monitored during this type of episode. If extra/obstetric care and or monitoring is given to patient as she is pregnant we suggest you code as follows:

Look Up:

> **Pregnancy** (single) (uterine)
>
> -complicated by — see also Pregnancy/management affected by
>
> - - conditions in G00–G99 NEC O99.3

Assign:

O99.3 *Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium*

Also code appropriate code for meningitis G00 – G99

Q. If a patient is admitted as a day case for follow up investigation for colitis and IBD, and the colitis and IBD are still present, how is this coded? The patient had colonoscopies and infliximab in the past.

A. As per Standard 2113 *Follow up examinations for specific disorders*, if the condition has recurred or residual condition present then code as follows,

PDx = condition

ADx = Select the appropriate code from Z09 Follow-up examination after treatment for conditions other than malignant neoplasms.

Please note that Z09.0 *Follow-up examination after surgery for other conditions* is not appropriate if the patient had previous biopsies to investigate the condition as biopsies are considered diagnostic and not surgery, as per Coding Rule Ref No: Q2671 | Published On: 15-Jun-2012 .

Any other findings will only be coded if they meet ACS 0002.

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.

HIPE Coding Milestones

There are a number of HIPE Coding Milestones that need to be met. Once the regular coding deadline of within 30 days of discharge is met these milestones will each be achieved. This is being widely achieved now and thank you all for your on-going efforts in what can be challenging circumstances.

For each of these deadlines (monthly and annual) it is important for everyone to be aware that the HIPE data are being used immediately for a wide variety of purposes and need to be as accurate and correct as possible.

A lot of estimates must be made around uncoded data, so high volumes of uncoded cases can significantly impact the hospital's performance. Similarly, incorrectly coded data can cause misleading hospital results. Importantly, in addition to funding, live monthly HIPE data is used to inform measures of quality of care and patient safety.

Monthly

HIPE data are being used each month as part of the ABF monthly reporting cycle, where both coded and uncoded data are included and reported on.

Annual – Target setting for coming year

Activity Based Funding (ABF) works by linking funding to activity. Hospital ABF budgets are based on the value of a "target" level of activity. Since 2016 the ABF target and the National Service Plan target have been linked.

The starting point for setting the target level of activity will be based on the activity reported to HIPE in a previous period. The exact timing may change each year but it is likely that the file at the end of August or the end of September each year will be used for setting hospital targets and therefore budgets for the coming year.

Annual – finalise the National file for the previous year

The annual HIPE finalisation cycle will continue, with the previous year being locked and finalised at the end of March of the following year.

Please continue your great work in meeting coding deadlines and please continue to use the various data quality tools to check your data as you code it. Existing tools include all the checks built into the HIPE portal, the Checker© suite and HCAT©. A procurement process is underway to get another tool to allow coders to measure their compliance with the coding rules – we will update you as this procurement process progresses.

Clíona O'Donovan, Statistician, Healthcare Pricing Office.

Mitral Valve repair with Mitraclip©

Q: What is the correct code to assign for percutaneous mitral valve repair with the MitraClip® device?

A: Percutaneous mitral valve repair with MitraClip® device is a new procedure to treat mitral regurgitation without cardiopulmonary bypass. The MitraClip® is inserted by a catheter through the femoral vein and guided to the left atrium. A transeptal puncture is performed and the device is positioned by grasping both leaflets of the mitral valve. Once the device is properly attached to the leaflets of the mitral valve the catheter is removed.

This is different from percutaneous balloon mitral valvuloplasty which is performed to treat mitral stenosis. In this procedure the balloon tipped catheter is positioned in the opening of the stenosed heart valve and the balloon is inflated repeatedly to widen the valve opening. Once the valve is widened, the balloon tipped catheter is removed.

Currently there is no specific code in ACHI for mitral valve repair with Mitraclip®. However a new code is being considered for a future edition. In the interim, assign 38270-02 [626] *Percutaneous balloon mitral valvuloplasty* following the index pathway:

Valvuloplasty
- heart (without valve replacement)
- - mitral valve
- - - percutaneous (balloon) 38270-02 [626]

Although different in technique, both are percutaneous procedures performed to repair the mitral valve.

Source Coding Rules Ref No: Q2899 | Published On: 15-Sep-2014 Percutaneous repair of mitral valve using MitraClip®

Upcoming Courses

Coding Skills II

This course will focus on clinical coding and clinical coding guidelines. The course also includes HIPE Portal software training. Participants must have completed Introduction to HIPE and Coding Skills I before attending this course.

Date: Tuesday, 3rd to Thursday 5th October
Time: 10.00am – 5.00pm each day
Location: HPO, Brunel Building.

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, 28th to Thursday 30th November
Time: 10.00am - 5.00pm each day
Location: HPO, Brunel building.

Anatomy & Physiology

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

Anatomy & Physiology - Haematology
Date: Tuesday, 14th November
Time: 11.00am - 1.00pm
Location: HPO, Brunel Building & WebEx.

Anatomy & Physiology - ENT
Date: Tuesday, 14th November
Time: 2.00pm - 4.00pm
Location: HPO, Brunel Building & WebEx.

Data Quality Session

This is an update on data quality activities

Date: Thursday, 7th December

Time: TBC

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.

Coding Skills IV— Workshops

Z-Codes Workshop—2 half days

Dates: Tuesday, 31st October & Wednesday, 1st November
Time : 10.30am - 1.00pm - each day
Location: HPO, Brunel Building & WebEx .

Introduction to Obstetrics

This full day workshop will provide coders with an introduction to the coding of obstetrics. Open to all HIPE coders.

Dates: Thursday, 16th November
Time : 10.00am - 4:30pm
Location: HPO, Brunel Building.

Education News for 2018

The HPO are currently preparing the training calendar for 2018 which will give the skeleton courses that will be run throughout the year. Many more courses will be organised at the HPO, regionally and via WebEx. We are hoping to organise a HIPE auditing course for experienced coders working in the area. We also intend to hold a 'Train-the Trainer' day for coders and managers who work in this area with both new and experienced coders. A further DIT course will also be advertised in the coming months.

We will follow up on the Managing Coding Services Day with those who attended and we will host similar events throughout the year. We want to be sure that we support and educate all involved in HIPE and value your attendance and input into the education run by the HPO. Please contact us if you have specific training requirements.

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

Thought for Today

Do more than belong: participate.
Do more than care: help.
Do more than believe: practice.
Do more than be fair: be kind.
Do more than forgive: forget.
Do more than dream: work.

William Arthur Ward – 1921-1994, Writer