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# HIPE Coding Process

Extraction of information from medical record to summary of the discharge in HIPE record

- HIPE Record
- Summary of admitted episode of care
  - Demography information (from PAS)
  - Administrative information (from PAS)
  - Clinical Information (extract by coder from medical record)
    - Principal Diagnosis
    - Up to 29 additional diagnoses
    - Up to 20 procedures

- Classification used for clinical information
  - ICD10-AM 8th edition
    - Australian Modification of ICD10 – extra codes with more specificity
  - ACHI
    - Australian Classification of Health Interventions
  - Supported by Australian Coding Standards
  - Irish Coding Standards
- Internationally comparable classification with strict rules on code selection

- Coding Rules
  - Definition of Principal Diagnosis
    - “the diagnosis established after study to be chiefly responsible for occasioning the episode of care”
  - Rules for collection of additional diagnoses
    - “A condition or complaint either coexisting with Pdx or arising during episode of care, that affects patient management”
  - Rules for collection of procedures (interventions)
    - “intervention that is surgical in nature and/or carries a procedural risk and/or carries an anaesthetic risk and/or requires specialised training”
    - “ procedures that are routine in nature, performed for most patients or where the procedure is inherent in a diagnosis are not normally coded”

# Coding Process – code selection

- Review full medical record
  - Analyse medical terminology to identify diagnoses and procedures
- Locate main terms from classification
  - eBook – use alphabetical index to search conditions, diseases, external causes, symptoms, factors influencing health status, procedures
- Select tentative code
- Check code against Tabular list
  - check instructions on conventions e.g. *code also, includes, excludes* to guarantee correct code assignment
- Apply Coding Standards
  - Check for specific guidelines

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# Coding Process – creation of HIPE record

- Download from PAS to HIPE
  - Administrative and demographic data
  - uncoded HIPE record

- Coder selects uncoded HIPE record and adds clinical information through entry of codes, responsible consultant and procedure dates
- Data Validation checks run as record saved, coder resolves discrepancies
  - For example
    - Inappropriate principal diagnosis assignment
    - Age, sex, diagnoses, procedure consistency
    - Surgical procedure without Anaesthesia

# Coding Process – Check HIPE record

- Coder runs suite  of checks on HIPE data
  - resolves issues
  - queries unclear documentation with clinicians
  - queries code selection with HPO as necessary

- Coder/Coding Manager audits HIPE data
  - Identify one-off and systematic issues
  - Corrective action plan including remediation ad preventative actions
- Coder updates previously entered HIPE record as appropriate

- HPO Coding team provide advice on code selection
- HPO coding team review HIPE data centrally, queries sent back to coder for resolution
- HPO audit HIPE records against medical records
  - Identify once-off and systematic issues
  - Hospital develops Corrective action plan including remediation and preventative actions
  - HPO develops Corrective action plan including remediation and preventative actions including training strategies and further audits

# Submit HIPE record to National File

- Hospital provides monthly transfer of HIPE to HPO
  - De identified secure data transfer
  - Includes newly coded HIPE data
  - Includes updated/changed HIPE data

- Annual finalisation/closure of HIPE file