Coding Notes

Healthcare Pricing Office

Number 90
October 2020

COVID-19 Flag in HIPE

From October 2020 HIPE has the facility to collect a COVID-19 Flag to indicate where a patient has laboratory confirmed COVID-19 or tested positive at any time past or present, anywhere.

From October 2020 HIPE has the facility to collect a COVID-19 Flag to indicate where a patient has laboratory confirmed COVID-19 or tested positive at any time past or present, anywhere.

COVID-19 is still, unfortunately, very much part of all our lives, both personally and professionally. We do appreciate the ongoing work by HIPE teams around the country in providing timely and accurate HIPE data which for 2020 will be so important, as always, when reviewed now and in future years.

The HPO have been requested to provide the facility to collect a COVID-19 Flag identifying Laboratory confirmed COVID-19, past or present, on the current case, being coded, or anytime, anywhere previously. This is an urgent response in HIPE to the current pandemic. The HIPE Portal will now facilitate the collection of this new variable. This variable will be collected for all inpatient and day cases. This is collected separately to ICD-10-AM codes for COVID-19. It must be clearly stated in the chart that the patient had a positive laboratory test for COVID-19 at some point before the Flag can be activated. The HPO are very grateful that the HPO Software Development team were able to address this urgent response to the pandemic so quickly.

The National Clinical Adviser and Group Lead (NCAGL) for acute hospitals has provided guidance to the HPO on the collection of this new variable. In addition NCAGL have developed a number of forms which will be used in patient charts to identify and assess patient's COVID-19 status and/or history. We will continue to update the HIPE system if further classification advice becomes available. Please see pages 2 & 3 for information on the new COVID-19 Flag. In addition pages 4 –6 contain more responses to queries on coding COVID-19 recently received to the HPO.

We thank hospitals for returning COVID-19 positive cases within 48 hours as requested by the HSE. The HPO understands that some local issues may delay this. Please let us know if there is undue delay in your hospital and why so we can inform Acute Operations. See page 7 for further information.

Having the HPO IEBook developed in-house, for the classifications, means the HPO are able to adapt and update the information through the work of the Software Development team in the HPO working with the Coding team. There were a number of *Coding Rules* that needed to be added and these are now in the process of being included in the IEBook. Please see page 3 for further information.

In other news, the HPO are very pleased to announce the publication of two HPO annual reports; NPRS 2017 and HIPE 2019. These are both available on www.hpo.ie and further information is available on pages 8 & 9.

The 2019 HIPE report shows that over 1.7 million discharges were reported in HIPE by participating hospitals in 2019, of which day patients accounted for 63.3%. In addition the Inpatient mean length of stay was 5.7 days in 2019, this has remained the same since 2015. Further detail is available on page 8.

The NPRS reports that in 2017, 62,070 births were reported representing a 3.2 per cent decrease between 2016 and 2017. NPRS is the only source of information on all births in Ireland. Both reports are available on www.hpo.ie. See page 9.

HIPE teams nationally continue to work hard collecting timely and accurate data on all inpatients and days cases, not every case is COVID-19. The regular *Cracking the Code* on pages 10 & 11 is full of coding advice based on queries submitted to the HPO coding team.

Training continues with a range of courses advertised on page 12. The team are working hard on providing training and support to all levels of coders. The 2021 Calendar is also being developed as we look optimistically to next year.

We live in interesting times as the Chinese proverb says and 2020 is no exception but it has also showed how dedicated, resourceful and resilient people can be when pushed to their limits, not least the HIPE community. We thank you all for your continued work and support. Stay safe.

Inside This Issue

Coronavirus COVID-19

COVID-19 Flag

Urgent response for collection during the current pandemic

The COVID-19 Flag is available for every HIPE discharge to identify
Laboratory Confirmed or COVID-19 Tested Positive Past or Present, anywhere.

The HPO is now providing the facility to collect a COVID-19 Flag on HIPE identifying Laboratory confirmed (Tested Positive) COVID-19, past or present, on the current case or anytime, anywhere previously. This is an urgent response in HIPE to the current pandemic. The HIPE Portal has been adapted for the collection of this administration variable and there are also some edits to quality check its use. Please contact HIPEIT@hpo.ie if you have comments or suggestions on this.

This variable is collected for all inpatient and day cases. This is collected completely separately to ICD-10-AM codes for COVID-19.

Question on the HIPE Portal: Lab confirmed COVID-19 Past or Present?

When to choose Yes

Coders will choose "YES" for Laboratory confirmed COVID-19 Past or Present if:

- There is a diagnosis of Laboratory confirmed or Tested Positive COVID-19 during the current episode of care (Laboratory confirmed cases **U07.1 Emergency use of U07.1 [COVID-19, virus identified**]

  OR

- There is documentation in the chart that the patient had a Laboratory confirmed COVID-19 or Tested Positive with COVID-19 during a previous episode of care.

  OR

- There is documentation in the chart that the patient was previously diagnosed with Laboratory confirmed COVID-19 or Tested positive with COVID-19 anytime, anywhere (e.g. community, any hospital/nursing home), including outside of Ireland.

Notes:

Documentation for this variable includes clinical notes, nursing notes, laboratory report, scans etc.

Coders are only expected to review the current episode of care for this variable. However coders can review previous episodes if they wish to.

It is assumed that once a patient has a value of "YES" for the COVID-19 Flag, every subsequent admission will have a value of "YES". This Flag will be auto populated for subsequent episodes once ticked. No further action is required by coders if the Flag is auto populated.

If required coders may take COVID-19 information from the patient's healthcare record back to the start of the pandemic to determine if the patient was previously diagnosed with Lab-confirmed COVID-19 or Tested Positive for COVID-19. For operational reasons, the start of the pandemic will be from 01/01/20. The entire record may be utilised including previous episodes.

If in rare cases there is uncertainty as to whether the 'Yes' was correctly assigned originally, coders may review and revise other episodes if necessary.

This will be operational from 1st October 2020 regardless of discharge dates.

This Flag will be subject to HPO review and audit, and any information recorded must be available in the patient's healthcare record.

Coronavirus
COVID-19

COVID-19 Flag

Urgent response for collection during the current pandemic

Example 1:

Patient admitted with fever and cough. Final diagnosis COVID-19 (Laboratory confirmed)

Lab-confirmed COVID-19 Past or Present **YES**

Example 2:

Patient admitted for repair of inguinal hernia. Documented in chart that patient was diagnosed with Lab-confirmed or tested positive with COVID-19 10 weeks ago in this hospital.

Lab-confirmed COVID-19 Past or Present **YES**

Example 3:

Patient admitted from A/E with fractured radius. Documented in chart that patient tested positive for COVID-19 in the community 2 months ago.

Lab-confirmed COVID-19 Past or Present **YES**

Example 4:

Patient transferred from nursing home with myocardial infarction. Documented that patient had COVID-19 five weeks previously in the nursing home.

Lab confirmed COVID-19 Past or Present

In this case the variable box will be left blank as there is no documentation of **Lab-confirmed** or **Tested positive** for COVID-19

This information is taken from the ICS V.1.4 and the latest 2020 Instruction Manual available on www.hpo.ie

The HIPE Portal has been amended to collect this information and a number of edits will support the use of this important new variable.

Update to Coding Rules in IEBook

Following the initial release of the HPO developed IEBook last year in preparation for the update to 10th Edition ICD-10-AM/ACHI/ACS, the HPO are now working on further enhancements to the IEBook. A number of key areas were prioritised for the "go live" date on January 1st 2020. The HPO IT team are continuing to develop and update the IEBook in a staged process since the 'go live' date.

During the course of the pandemic the HPO were able to add and update the guidelines for the coding of COVID 19 in the IEBook as required which was a significant and timely benefit of having this product in house.

One area which is currently under development for implementation in the IEBook is the second update of the *Coding Rules'* Coding advice in the form of national coding rules are generally published every quarter by the Independent Hospital Pricing Authority (IHPA) in Australia. To date there are over 400 *Coding Rules* in place within the IEBook. A further 200 Coding Rules are now in the final stages of being added to the IEBook, once complete and tested the HPO will issue an update to the coding community. This is a significant piece of work as each *Coding Rule* must be validated for use in 10th edition in Ireland and located in the correct place in the classification. The HPO Coding team are liaising closely with the IT team to ensure that these additional *Coding Rules* are readily available for HIPE Coders within the software.

Coronavirus COVID-19

FAQ—COVID-19 Codes

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

Please note that where a patient has laboratory confirmed COVID -19 or tested positive at any time past or present please assign the COVID-19 Flag. Please refer to the article on the COVID-19 Flag in this issue of Coding Notes.

Significance of subsequent positive COVID testing

The HPO have received a number of queries around patients who had a previous COVID-19 infection, recovered and subsequently test positive again at a later date, and what is the significance of this second result and how should it be captured?
The HPO have submitted a query to IHPA as to the coding of a COVID-19 positive result described as not being of clinical significance and we are awaiting their response. We have also discussed this with the National Clinical Advisor & Group Lead, HSE.
The Health Protection Surveillance Centre (HPSC) recently published guidance around this area and have issued the following advice;
"If this person received a positive test for COVID-19 within 12 weeks of the start of their symptoms of COVID-19, but are currently clinically well, this can be considered persistent detection of non-viable virus material rather than re-infection and are treated the same as well people." (source https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/algorithms/masstesting/Mass%20testing%20scenarios.pdf).

Each case should be reviewed on its own merit, please always link in with the relevant clinical team to determine whether the COVID-19 is of clinical significance. See examples 1a & 1b below:

Example 1a

Q. A patient is readmitted 4 weeks after being treated for COVID-19. On this admission they are treated for LRTI, exacerbation of CCF. The patient tested positive for COVID-19 on readmission, but the clinician states that this is not clinically significant. Will this case be coded as COVID-19 positive?

A. Please apply the guidelines set out in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

If in this case the documentation & clinical advice does not support a re-infection of COVID-19 but rather persistent detection of non-viable virus material, we would advise assigning a history code Z86.18 *Personal history of other infectious and parasitic diseases* as this meets criteria for coding as the patient was tested.

Note: In addition, all laboratory confirmed or tested positive cases post 1st October 2020 will also have the Lab positive COVID-19 past/present Flag –Yes.

Example 1b

Q. A patient was admitted with shortness of breath and diagnosed with LRTI with COVID-19 positive on swab. They were previously diagnosed with COVID-19 in April but the test has come back positive this time also.

Clinical documentation states the patient could be positive due to residual shedding. What codes are applied?

A. As per ACS 0001 *Principal diagnosis* please assign J22 *Unspecified acute lower respiratory infection* as the principal diagnosis.

In the absence of further clinical guidance, after reviewing this query the documentation would support that this is not a re-infection of COVID-19 but rather persistent detection of non-viable virus material therefore we would advise assigning a history code *Z86.18 Personal history of other infectious and parasitic diseases* as this meets criteria for coding as the patient was tested. Please also code any condition that meets criteria as per ACS 0002 *Additional diagnoses*.

Note: In addition, all laboratory confirmed or tested positive cases post 1st October 2020 will also have the Lab positive COVID-19 past/present Flag –Yes.

Coronavirus COVID-19

FAQ—COVID-19 Codes

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

Please note that where a patient has laboratory confirmed COVID -19 or tested positive at any time past or present please assign the COVID-19 Flag. Please refer to the article on the COVID-19 Flag in this issue of Coding Notes.

Sequelae & Post COVID-19 conditions

Currently there is no specific guidance on the coding of sequelae or history of COVID-19. There is some discussion in the WHO around COVID-19 and sequelae but there is no published classification guidance from the WHO on this as their research is still underway.

In the absence of expert international guidance for now HPO advises that if the history of COVID-19 meets criteria in ACS 0002 *Additional diagnoses* the code Z86.18 *Personal history of other infectious and parasitic diseases* may be assigned. **Please consider each case before routinely assigning this code and seek additional advice where needed.**

This advice apples to Examples 2, 3 & 4 below.

Example 2

Q. A patient had lab confirmed COVID-19 elsewhere in April and is now admitted to this hospital, with a recurrent exacerbation of asthma, and what consultants described as a post COVID-19 wheeze and depression, also related to the asthma. How would this case be coded?

A. Please apply the guidelines set out in ACS 0001 Principal Diagnosis and ACS 0002 Additional Diagnoses and assign a codes as follows:

PDx: *J45.9 Asthma, unspecified*
Add Dx: *R06.2 Wheezing*
F32.90 Depressive episode, unspecified, not specified as arising in the postnatal period
Z86.18 Personal history of other infectious and parasitic diseases.

Note: In addition, all laboratory confirmed COVID-19 or tested positive cases post 1st October 2020 will also have the Lab positive COVID-19 past/present Flag –Yes.

Example 3

Q. A patient was diagnosed COVID-19 positive in April and was readmitted feeling unwell. On the chart it clearly states "Post COVID-19 pneumonia". A further swab was done for COVID-19 on this admission which was negative. Would it be appropriate to code B94.8 *Sequelae of other specified infectious and parasitic diseases* as an additional diagnosis?

A. Please apply the guidelines set out in ACS 0001 *Principal Diagnosis* assign a code for the pneumonia:
PDx: *J18.9 Pneumonia, unspecified*

Following the guidelines in ACS 0002 *Additional Diagnoses* as it meets criteria apply *Z86.18 Personal history of other infectious and parasitic diseases*. WHO have not issued guidelines as yet on the coding of sequelae of COVID-19.

Note: In addition, all laboratory confirmed COVID-19 or tested positive cases post 1st October 2020 will also have the Lab positive COVID-19 past/present Flag –Yes.

FAQ—COVID-19 Codes

Please note that where a patient has laboratory confirmed COVID -19 or tested positive at any time past or present please assign the COVID-19 Flag. Please refer to the article on the COVID-19 Flag in this issue of Coding Notes.

Sequelae & Post Covid19 conditions continued

Example 4

Q. A patient was admitted in July with "Post COVID-19 Pulmonary Syndrome" having had lab confirmed COVID-19 in March. The patient did not have a COVID-19 test during this episode. What is the code for pulmonary syndrome and also does the virus meet criteria for coding?

A. Without further information as to the nature of the pulmonary syndrome please follow the alphabetic index as for **Syndrome** – see also Disease . Look up **Disease**, pulmonary, leads to code *J98.4 Other disorders of lung*.

Also refer to ACS 0005 *Syndromes* regarding any other manifestations of the syndrome. The documentation in the chart for this case will dictate how you apply this.

To capture the previous COVID-19 infection, follow the guidelines in ACS 0002 *Additional Diagnoses* and if it meets criteria apply *Z86.18 Personal history of other infectious and parasitic diseases.* There is no ICD-10-AM code assigned for a COVID-19 infection on this episode of care.

Note: In addition, all laboratory confirmed COVID-19 or tested positive cases post 1st October 2020 will also have the Lab positive COVID-19 past/present Flag –Yes.

Example 5

Q. Many patients are routinely tested for COVID-19 and a negative result is recorded, do we capture this information?

A. HPO advice at present is to only code a negative result if there is documentation of clinical suspicion of COVID-19 or in limited circumstances if the patient is admitted solely for testing (as per ICS 22X2 *Novel Coronavirus COVID-19*).

Testing as per hospital protocol without clinical suspicion that a patient has COVID-19 does not meet criteria for coding U06.0 *Emergency use of U06.0 COVID-19, ruled out*.

ICS 22X2 (1st April 2020) states the following in relation to U060 Emergency use of U06.0 [COVID-19, ruled out]:

"Suspected COVID-19, ruled out: An individual suspected of having COVID-19 but COVID-19 has subsequently been excluded on laboratory testing and in whom a clinical diagnosis of COVID-19 has not been made. In this circumstance assign U06.0 Emergency use of U06.0 *COVID-19, ruled out*."

Please also refer to the HPO's email '*COVID-19 Implications for HIPE Coding (Update No. 3)*' circulated on 13.05.20.

Example 6

Q. Please can you advise on how to code a cancer patient that is brought in specifically to test for COVID-19 only?

A. Where the only reason for admission is for the test then the following codes would apply depending on the outcome of test:

Positive result and no other symptoms

Pdx: B34.2 *Coronavirus infection, unspecified site*
Add Dx: U07.1 *Emergency use of U07.1 (COVID –19 Virus identified)*
Plus the COVID-19 Flag is marked 'YES'

Negative result

Pdx: Z11.5 *Special screening examination for other viral diseases*
Add Dx: U06.0 *Emergency use of U06.0 (COVID-19 ruled out).*

Note: Regardless of results the codes for the neoplasm would also be assigned if it meets ACS 0002 *Additional diagnoses.*

COVID-19 Coding Deadline

Locating COVID 19 Discharges in Hospitals for HIPE Coding

The availability, reliability and coverage of the HIPE data set is of national and international importance in the reporting of COVID 19. The Department of Health, the HSE and other health agencies have access to this data to track, monitor and support the health system. In response to the Department of Health timelines, coders are asked to code these cases within 48hrs from discharge. COVID-19 cases are automatically exported each night for immediate use.

Some hospitals are experiencing difficulties locating these cases and turnaround times are exceeding the 48hr deadline. Please refer to HPO's Pathway for Prioritised Coding of COVID- 19 (Issued 19.03.20 with Update No.2).

The flow chart below may assist coders in locating COVID-19 cases based on feedback from a number of hospitals.

COVID-19 Coding Pathway

Has the hospital designated COVID-19 wards?

NO

- Link in with infection control team.
- Check with Lab office - do they keep a record?
- Does your hospital have a COVID-19 tracker that HIPE teams can access?
- Is there a COVID-19 committee you can link in with?
- Refer to HPO's Pathway for Prioritised Coding of COVID-19 (Issued 19.03.20 with Update No.2).

YES

- Print off the uncoded discharge list from HIPE Portal for each COVID-19 ward daily
- Check for COVID-19 discharges from other wards

The prioritised coding of COVID 19 is fully supported by the Department of Health and the HSE. If there are any issues with the collection of this information in your hospital please contact the HPO.

Activity in Acute Public Hospitals in Ireland, 2019 Annual Report

The latest HIPE Annual Report presents information on coded discharges from 53 Irish acute public hospitals participating in HIPE in 2019. The data presented in this report is only possible through the on-going work of HIPE teams nationally and their contribution to this is greatly acknowledged. The report is available on www.hpo.ie.

Main findings of the 2019 Report

Total Discharges

- Over 1.7 million discharges were reported by participating hospitals in 2019.
- Day patients accounted for 63.3 per cent of total discharges, an increase of 3.2 per cent since 2018 and an increase of 8.8 per cent from 2015–2019.
- In-patients accounted for 36.7 per cent of total discharges, an decrease of 0.1 per cent since 2018 and an increase of 2.5 per cent from 2015–2019.
- Over the period 2015–2019, the number of elective in-patient discharges decreased by 4.9 per cent, maternity in -patients decreased by 8.5 per cent, while emergency in-patients increased by 7.4 per cent.

Length of Stay

- In-patient mean length of stay was 5.7 days in 2019, this has remained the same since 2015.

Over the period 2015–2019, the mean length of stay has remained relatively constant for elective, emergency and maternity in-patients at 6.9 days, 6.3 days and 2.6 days in 2019 respectively.

Figure 1 below provides details of the admission type for total discharges as reported to HIPE for 2015-2019

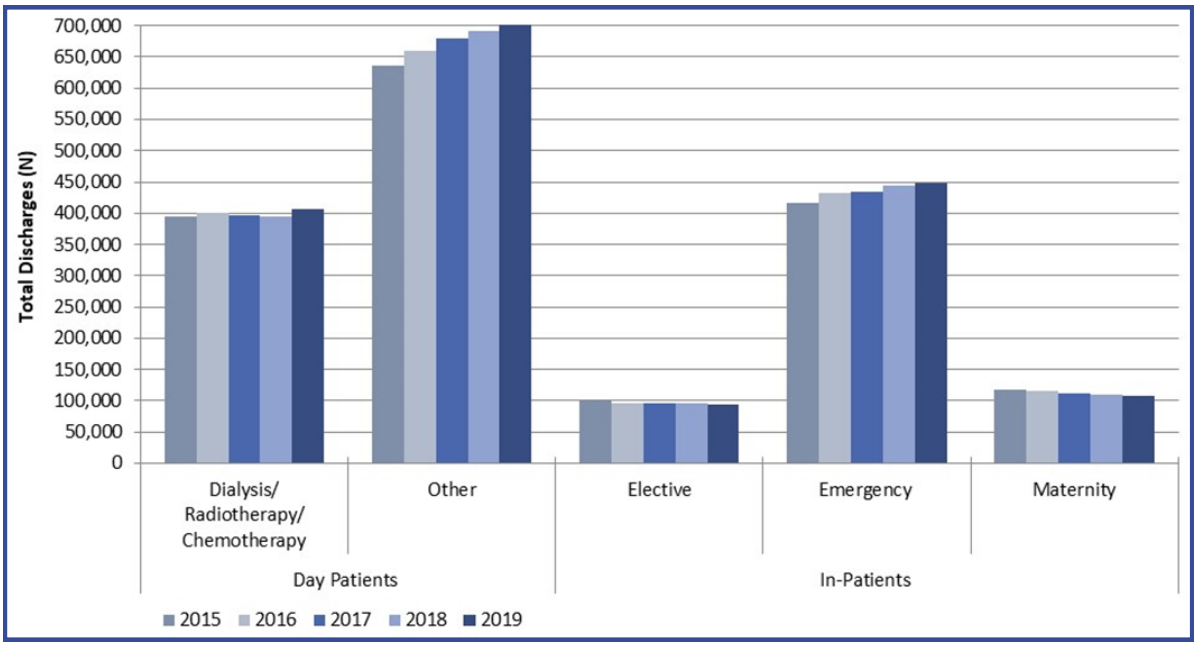

Figure 1: Admission Type for Total Discharges reported to HIPE, 2015-2019

Annex 2019 - Hospital Acquired Diagnosis (HADx) Indicator

The report annex is designed to highlight particular topics of interest that merit further analysis. This year's topic of interest is a discussion and analysis of the Hospital Acquired Diagnosis (HADx) Indicator over the period 2017-2019. The HPO is actively monitoring these variables in conjunction with the *PICQ*© tool to assess the data quality of these variables and to better understand variations across hospitals. The overall national rate also shows a steady increase each year, increasing from 4.7 per cent in 2017 to 6.8 per cent in 2019. The HPO are focused on increasing reporting and analysis of the HADx variables in HIPE, and will continue to work with hospitals to ensure that any future use as indicators for patient safety and quality of care are based on the most robust reporting of these variables.

Perinatal Statistics Report, 2017

Along with the HIPE national file, the HPO also manage and maintain the National Perinatal Reporting System (NPRS). A small team in the HPO work with the maternity services including the independent midwives to collect and report on every birth in Ireland. This is done through the Birth Notification Form (BNF) which is also used by the General Registrar and hospitals as well as by Director of Public Health and Medicine . NPRS is the only source of information on all births in Ireland. This is used nationally and internationally for perinatal epidemiology, planning of maternity services and it has input to population health profiles.

The latest National Perinatal Reporting System (NPRS) Annual Report presents national statistics on perinatal events in Ireland. This report provides information on mothers giving birth and babies born in 2017.

Main findings of the 2017 Report

- 62,070 births were reported to NPRS in 2017, representing a 3.2 per cent decrease between 2016 and 2017.
- 7% of total births were preterm (less than 37 weeks gestation)
- 6% of live births were low birth weight (less than 2,500 grams)
- 2% of live births were high birth weight (4,500 grams or more)
- 60% of babies recorded any breastfeeding in 2017, compared to 56% in 2013 and 51% in 2008
- 33% of total live births were delivered by Caesarean section. In 2008, 27% of total live births were delivered by Caesarean section
- The perinatal mortality rate was 5.2 per 1,000 live births and stillbirths in 2017. This rate has fallen by 23.2% since 2008, when it was 6.8 per 1,000 live births and stillbirths
- The average age of mothers has increased from 30.6 years in 2008 to 32.3 years in 2017
- 37% of mothers were aged 35 years or older, up from 27% in 2008
- 25% of women giving birth for the first time were aged 35 years or older, compared to 14% in 2008

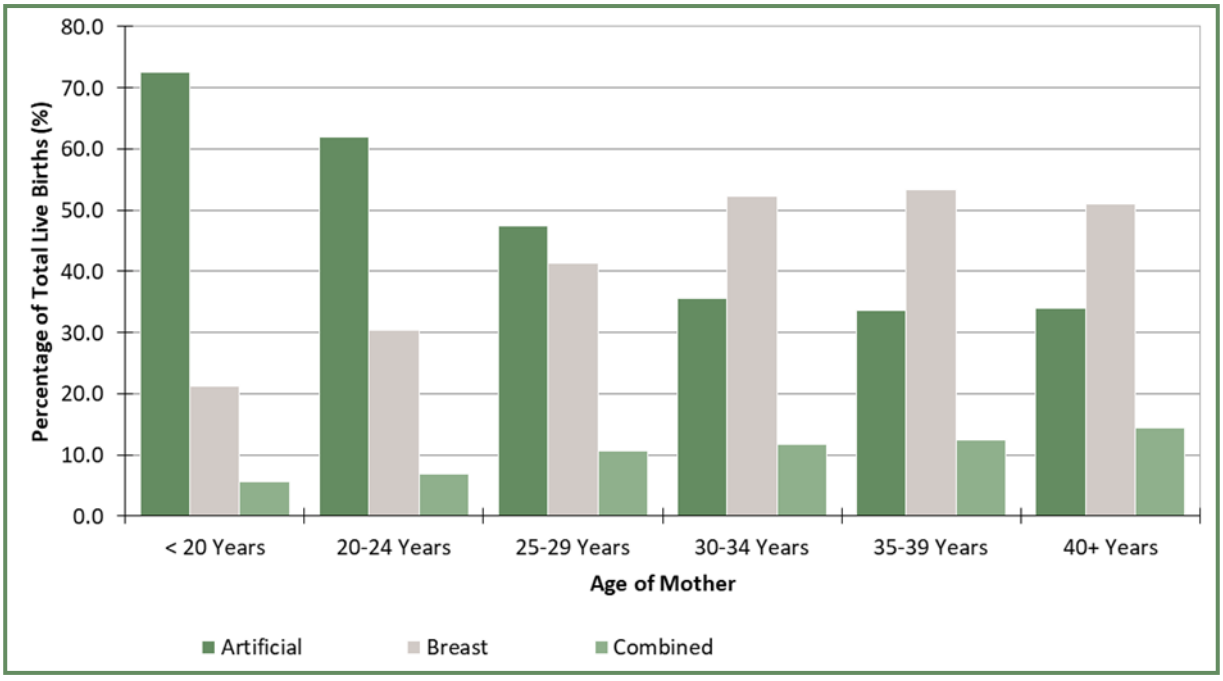

Figure 2: Percentage Distribution of Infant's Type of Feeding by Age of Mother, Total Live Births, 2017

Cracking the Code

A selection of Coding Queries

Q.1 What code is applied for Curosurf Surfactant administered to preterm infants?

A.1 As per ICS 1614 *Respiratory Distress Syndrome/Hyaline Membrane Disease/Surfactant Deficiency* this drug administration is not coded.

"Surfactant is administered routinely for the treatment of Respiratory Distress Syndrome of the newborn and should not be coded."

Q.2 A patient had a lesion removed from their temple. The histology report result states: '*Sections show an invasive moderately differentiated squamous cell carcinoma. Vascular and/or perineural invasion is not identified. Squamous cell carcinoma in situ reaches a short axis margin but invasive tumour is completely excised.'* What codes are assigned?

A.2 Coders will code cases like this to the most severe behaviour as the sample was taken from the same lesion. The histological description of invasive means the in situ cannot be assigned for this case as invasive behaviour takes precedence over the in situ. The following code should be applied;

C44.3 *Skin of other and unspecified parts of face (other malignant neoplasm of skin)*

Q.3 What is the correct code assignment for the following two procedures for termination of pregnancy and for treatment of miscarriage?

Electric vacuum aspiration (EVA)
Manual vacuum aspiration (MVA)

A.3 The EVA and MVA procedures use a suction method to remove contents from the uterus. Based on this information we would advise using the following code;

35640-03 [1265] *Suction curettage of uterus*.

Q.4 A patient was admitted to Hospital A and was diagnosed with Ischaemic Heart Disease. They were transferred to Hospital B. They were transferred back to Hospital A, a few days later having had angioplasty and stenting performed. What is the correct code assignment

A.4 Please refer to ACS 2103 *Admission for Post Acute Care* and refer to the classification section. Please review the documentation for this admission to determine if the patient is;

a) Patient is transferred for post-surgical aftercare, assign as principal diagnosis Z48.8 *Other specified surgical follow-up care*. Assign an additional code for the condition that required surgery and a status code can also be assigned for presence of the stent Z95.5 *Presence of coronary angioplasty implant and graft*

Or

b) The patient is transferred for continued active treatment of a condition, do not assign an aftercare code and instead follow ACS 0001 *Principal diagnosis*. A status code can also be assigned for presence of the stent *Z95.5 Presence of coronary angioplasty implant and graft.*

Q.5 What is the correct code assignment for mucosal melanoma of cheek and mucosal melanoma of stomach?

A.5 There is a note in the Index at Melanoma which states;

"**Melanoma** (malignant) (M8720/3) C43.9
Note: *Except where otherwise indicated, the morphological varieties of melanoma in the list below should be coded by site as for 'Melanoma (malignant)', i.e. according to the list under 'site classification' below. Internal sites should be coded to malignant neoplasm of those sites*."

As these mucosal melanoma are internal sites following the guidance provided assign the following codes;

C06.0 *Cheek Mucosa (look up is* **Neoplasm** *– Mucosa – Cheek)*

C16*– Malignant neoplasm of stomach (look up is* **Melanoma** *– Site Classification – Specified Site NEC – see Neoplasm Malignant.*

Unusually there will be two primary neoplasms recorded for this case.

Q.6 A patient came in as a day case to have a hysteroscopy done to investigate abnormal vaginal bleeding. A mirena coil (IUD) was fitted during the hysteroscopy, to help with the bleeding.

Is it correct to code the *Insertion of the mirena coil* in this case, as well as the intervention code for the insertion of the mirena coil (IUD)?

A.6 It cannot be assumed the IUD was inserted for contraceptive management unless this is clearly documented in the chart as there are other uses for this device https://www.healthline.com/health/menopause/mirena-coil-menopause. HPO advises coders to seek further clinical advice on this, in the absence of this advice we do not advise coders to assign the code Z30.1 *Insertion of contraceptive device*.

The insertion of the IUD will be captured as a procedure.

See also Coding rule Ref No: Q2815 | Published On: 15-Dec-2013 | for information on assigning Z30.1 *Insertion of contraceptive device* for contraceptive purposes.

Cracking the Code

A selection of Coding Queries

Q.7 Please advise on the coding of a patient who has a diagnosis of *Goodpasture's syndrome*. Clinical documentation states the clinician will treat the Acute Kidney Injury (AKI) and metabolic acidosis. Are these conditions coded separately, or are they classed as symptoms of the condition?

A.7 If there is documentation in the clinical notes which states the AKI and metabolic acidosis meet criteria for coding as per criteria in ACS 0002 *Additional diagnoses*:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring

If these conditions meet criteria in their own right they can be coded in addition to the code for *Goodpasture's syndrome*.

Q.8 What does HIPE set as readmission criteria? Is it 48 hours, 7 days, or some other timeframe?

A.8 There is currently no time specification for a readmission in HIPE. Please see the HIPE *Instruction Manual* where the following information is provided:

Admission Type 2: *Elective Readmission*: Patient admitted electively to continue on-going treatment of care

For example, patients being readmitted for a course of chemotherapy – the patient knows they are going back as does the hospital.

Admission Type 5: *Emergency Readmission*: This is an unscheduled readmission following a previous spell of treatment in the same hospital and relating to the treatment or care previously given.

For example, patient readmitted with bleeding following a tonsillectomy. The readmission must relate to the previous care or treatment rather than the condition. For example a patient could be readmitted as an emergency with COPD a number of times but these are not considered emergency readmissions.

Q.9 What is the correct code to assign for Rectus sheath hematoma?

A.9 The code assignment will depend on the cause of the haematoma – non traumatic or traumatic.

• If this is a non-traumatic rectus sheath haematoma please assign *M79.88 Other specified soft tissue* disorders, other, following the look up below

Haematoma (skin surface intact) (traumatic) (see also Contusion)
- muscle — see also Contusion/by site
- - nontraumatic M79.8-

> If it is non traumatic but due to over warfarinisation – see the advice at Coding Rule Q3188 (this is indexed at M79.88)

• If this is a traumatic rectus sheath haematoma assign *S30.1 Contusion of abdominal wall*. Look up the index under Contusion

Contusion (skin surface intact) (see also Injury/superficial)
- abdomen, abdominal (muscle) (wall) S30.1.

Q.10 A patient was admitted for stapling of pharyngeal pouch. What is the correct diagnosis code to assign?

A.10 The code indexed for pharyngeal pouch is as follows:

Pouch
- pharynx Q38.7
- - acquired K22.5

- *If it is acquired* assign K22.5 *Diverticulum of oesophagus, acquired*

- If it is not acquired then the default code is:
  Q38.7 Other congenital malformations of tongue, mouth and pharynx, Pharyngeal pouch

---

Q.11 What is the code(s) for Subcutaneous Implantable Cardiac Defibrillator (SICD)? The leads are subcutaneous and do not go into the heart chamber.

A.11 Please assign the following:
38393-00 [653] *Insertion of cardiac defibrillator generator*
Code also when performed
Permanent electrode (38390-01, 38390-02 [648], 38470-01, 38473-01, 38654-03 [649]

See *Coding Rule*
Ref No: Q3014 | Published On: 15-Sep-2016 | Status: Current
SUBJECT: *Subcutaneous implantable cardiac defibrillator (S-ICD) electrodes* for guidance on re coding of subcutaneous electrodes.

See also the following Coding Rule for guidance
Ref No: Q2874 | Published On: 15-Mar-2015 | Status: Current
SUBJECT: Interpretation of ACS 0936 Cardiac and implanted defibrillators.

Upcoming Training

Please inform The HPO if a new member of staff joins the HIPE team and we will arrange training as appropriate.

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

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

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

Z-Code Workshop

Date: Thursday, 22nd October
Time: 10am - 5pm
Location: WebEx

Coding Skills III

Refresher—Respiratory Coding

Date: Tuesday, 10th November
Time: 10am - 4pm
Location: WebEx

Refresher - Circulatory coding

Date: Wednesday,11th November
Time: 10am - 4pm
Location: WebEx

Data Quality Session

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

Date: Thursday, 10th December
Time: 11am - 1.00 pm
Location: WebEx

HIPE Portal Reporter Training

Date: Thursday, 17th November
Time: TBC
Location: WebEx

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.

Anatomy & Physiology

****These courses are open to all HIPE coders****

These courses will be delivered by a specialist speaker.

Anatomy & Physiology—Morning Session

Topic: Musculoskeletal system
Date: Thursday, 8th October
Time: 11.00am - 1.00pm
Location: WebEx

Anatomy & Physiology—Afternoon Session

Topic: Genitourinary system
Date: Thursday, 8th October
Time: 2.00pm- 4.00pm
Location: WebEx

HIPE Data Users Update

This is a **2 hour** WebEx for HIPE Data Users who have previously attended HIPE Data User training with the HPO. This session will focus on the 10th edition of ICD-10-AM/ACHI/ACS and also on COVID-10 coding guidelines.

Date: Tuesday, 13th October
Time: 10.30am - 1pm
Location: Zoom

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

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

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

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

Thought for Today

Kindness is the language that the deaf can hear and the blind can see.
Mark Twain , Author.