Irish Coding Standards (ICS) 2024 (V1.2) 12th Edition ICD-10-AM/ACHI/ACS

ICS 2024 V1.2

For use from 1st April 2024

&

12th Edition ICD-10-AM/ACHI/ACS

HIPE PORTAL   For use with the HIPE Portal

Healthcare Pricing Office (HPO).

Contents

Note on ICS that are no longer applicable:

- Note that the following Irish Coding Standards are no longer applicable in **12th Edition** ICD-10-AM/ACHI/ACS

- Note that the following Irish Coding Standards are no longer applicable in **10th Edition** ICD-10-AM/ACHI/ACS

- Note that the following Irish Coding Standards are no longer applicable in **8th Edition** ICD-10-AM/ACHI/ACS

- Note the following Irish Coding Standards that are no longer applicable in **6th Edition** ICD-10-AM/ACHI/ACS

Glossary

The information below informs the glossary in the 12th edition Australian Coding Standards (ACS) for use in Ireland. Not all terminology in the Australian glossary will have an exact match in the Irish health system or may not apply in the HIPE system. Please also refer to the glossary as provided in the ACS for guidance.

The Glossary describes terms or phrases used in the Australian Coding Standards (ACS) to assist in the application of the ACS.

Note: Where a term listed below is also described in a specialty standard, the description in the specialty standard is to be used.

Term	Description
Admitted patient stay	**In Ireland a HIPE discharge record is created when a patient is discharged from (or dies in) hospital. This record contains administrative, demographic and clinical information for a discrete episode of care. An episode of care begins at admission to a ward (inpatient or day case) in hospital and ends at discharge from (or death in) that hospital. (source HIPE Instruction Manual)** **Within an episode of admitted care in Ireland there is no collection of care type change.** The ACS Glossary states: An admitted patient stay is the period of admitted care provided by a health care facility between formal admission and a formal separation. The admitted care provided may include that provided by another health service provider under a contracted hospital care arrangement or hospital-in-the-home care. An admitted patient stay may contain one, or more than one, episode of admitted patient care. Where an admitted patient stay contains more than one episode of admitted care it typically involves a care type change (AIHW 2021b). For example, a patient admitted for an episode of acute care has their care type changed and continues their stay with an episode of rehabilitation care provided by the same health care facility.
Care plan	**This applies to HIPE data collection in Ireland** The ACS Glossary states: A care plan is the intended health care activities related to a patient's care during the episode of care as documented by a clinician responsible for providing care to the patient. A care plan may appear in many parts of the health care record but would typically appear in the progress notes or on a clinical pathway. Care plans should be documented, identify a condition and the planned actions of medical, nursing or allied health clinicians for a patient during the episode of care. For example, a care plan may include tests, treatments and other activities planned to be carried out during the patient's episode of care.

Clinical consultation	**This applies to HIPE data collection in Ireland** The ACS Glossary states: A clinical consultation is a clinician's review in relation to the care of a patient that may involve interactions with the patient, other clinicians or review of the patient's health care record. Clinical consultation is evidenced by documentation in the patient's health care record and may also be described as clinical assessment.
Clinician	**This applies to HIPE data collection in Ireland** The ACS Glossary states: A clinician is a health care provider trained as a health professional. Includes registered and non-registered practitioners, and teams of health professionals who spend most of their time providing direct clinical care (Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare 2021). The term 'clinician' refers to the treating medical or surgical clinician, anaesthetists and other consulting health professionals who document in the health care record. A clinician may also refer to allied health professionals, midwives and nurses.
Episode of care	**In Ireland, an episode of care begins at admission to a ward (inpatient or day case) in hospital and ends at discharge from (or death in) that hospital. (Source: HIPE Instruction Manual). HIPE does not include ED activity or non-admitted care. Hospital in the home activity is not currently collected by HIPE.** The ACS Glossary states: An episode of care is the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type (AIHW 2005a). The treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Health care record	**This applies to HIPE data collection in Ireland** The ACS Glossary states: A health care record is a system that is in place for recording, communicating, using and securely storing patient clinical information (The Commission 2019a). This is to provide safe, high-quality care to individual patients, and to enable relevant information to be extracted for quality assurance, teaching and research purposes. Documentation can be in the form of paper, electronic or a mix of both (hybrid). Documentation in the health care record can include care plans, handover notes, checklists, pathology results, operation reports and discharge summaries (The Commission 2019b). The content of a health care record will vary and reflect the documentation appropriate to each health service.

Routine care	**This applies to HIPE data collection in Ireland** The ACS Glossary states: Routine care is the services provided to a patient to support logistical, welfare, personal and health care requirements that do not require a care plan. Routine care may vary according to the services provided by the health facility, and should be considered in the context of the health service providing the care. For example, routine care may include: - administering ordered medication - meal services - personal hygiene - assisting patients to complete other daily self-care activities - preventative health care e.g. turning patients in bed - taking of vital signs and observations - provision of equipment to enable the above care - recording of pre-existing conditions and statuses.
Scope of practice	**This applies to HIPE data collection in Ireland** The ACS Glossary states: Scope of practice is defined by the health service organisation, and is dependent on the practitioner operating within the bounds of their qualifications, education, training, current experience and competence, and within the capability of the facility or service in which they are working (The Commission 2015).

Irish Coding Standards (ICS)
Preface to Version 1.2 2024

The Irish Coding Standards (ICS) Version 1.2 2024 (April 2024) provides guidelines for the collection of HIPE data for all discharges from January 2024, or as specified using the HIPE Portal software, and is to be used in conjunction with 12th Edition ICD-10-AM/ACHI/ACS, and the relevant HIPE Instruction Manual. HIPE data was collected using 10th Edition ICD-10-AM/ACHI/ACS from January 2020 until 31st December 2023. All discharges coded in HIPE on or after the 1st January 2024 are coded using ICD-10-AM/ACHI/ACS 12th Edition[1].

Please see Appendix A for a listing of the changes in each version of the ICS from Version 2.0 2009 to date. Within the standards where there is a change related to 12th Edition these standards have been marked with a symbol: 12

This is in line with previous updates to the ICS classification whereby for changes to Irish Coding Standards related to 10th edition ICD-10-AM/ACHI/ACS the symbol 10 has been used. Where the change related to 8th Edition ICD-10-AM/ACHI/ACS the symbol 8 has been used. Where there was a change related to 6th edition ICD-10-AM/ACHI/ACS the symbol 6 has been used.

ICS 2024 Version 1.2

All sections have been updated as required to reflect the update to 12th edition of ICD-10-AM /ACHI/ACS. The export dates have been added for 2024. It is recommended that HIPE staff review the Irish Coding Standards to ensure they are familiar with the guidance in each section.

The Irish Coding Standards 2024 V1.2 includes the following changes:

Section 2:
- There is one change to the HIPE Guidelines for Administrative data

Section 3:
- There are 3 changes to coding standards in Section 3.
  - ICS 0044 *Pharmacotherapy*
  - ICS 0206 *Pharmacotherapy for Neoplasms*
  - ICS 1012 *Summary of Classification of Influenza*

A full listing of all changes made in ICS 2024 Version 1.2 is provided in Appendix A of this document.

In September 2019 the Clinical Coding Practice Framework was developed from the Standards for Ethical Conduct in Clinical Coding, an appendix within the Australian Coding Standards, by the Health Information Management Association of Australia's Practice Quality and Safety Standards Committee with input from the President of the Clinical Coders' Society of Australia. This has been incorporated into the Irish Coding Standards and is provided in Appendix B of this document. The Clinical Coding Practise Framework has now replaced the Standards for Ethical Conduct in Clinical Coding

From 1st January 2014 the National Casemix Programme and the Health Research & Information Division at the ESRI became part of the Healthcare Pricing Office (HPO) in the Health Service Executive (HSE). For further information see www.hpo.ie.

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[1] For a full listing of all classifications used in HIPE to date please see page 22 of this document

ICD-10-AM/ACHI/ACS 12th Edition is the classification in use in Ireland for all discharges from 1st January 2024.

- **ICD-10-AM** is used for coding diagnoses and conditions and it is the International Classification of Disease, 10th Revision produced by the WHO with the Australian Modification developed by the Australian Consortium for Classification Development. It consists of a tabular list of diseases and accompanying alphabetic index available in paper or iEBook format.

- **ACHI** is used for coding procedures and interventions and is the Australian Classification of Health Interventions developed by the Australian Consortium for Classification Development. It consists of a tabular list of interventions and accompanying alphabetic index available in paper or iEBook format.

- **ACS** are the Australian Coding Standards developed by the Australian Consortium for Classification Development for use with ICD-10-AM and ACHI. These are available in paper or iEBook format. **The Irish Coding Standards (ICS)** complement these standards.

For information on variables collected by HIPE, please also see the appropriate HIPE Instruction Manual and the HIPE Data Dictionary. These documents are available on the HPO website at www.HPO.ie.

Numbering format for Irish Coding Standards[2]:
As with Australian Coding Standards each Irish Coding Standard is allocated a four digit number. The number is unique for each standard. When a standard is deleted, the standard and its unique number are retained to allow for a chronicle of coding standards to be generated.

- Where there is a corresponding Australian Coding Standard the ICS will have the same number.
- Where there is no corresponding ACS the first 2 characters of the ICS will be for the appropriate chapter in the ACS followed by an "x" and a sequential number. Only Irish Coding Standards without a corresponding ACS will have an "x" in the standard number allowing for identification of same.
- Guidelines for administrative and demographic data are numbered sequentially within the relevant section.

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[2] See also Introduction to Australian Coding Standards

Irish Coding Standards (ICS)

INTRODUCTION

The *Irish Coding Standards* for the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM), *Australian Classification of Health Interventions* (ACHI) and *Australian Coding Standards* (ACS) apply to all activity coded in HIPE in Ireland. Revisions are made on an ongoing basis. Irish Coding Standards (ICS) are effective from the date first published unless otherwise stated.

This document provides guidance and instruction on all aspects of HIPE data collection. The intention is to provide clarity and standardization as necessary. This document will be used in conjunction with the source document (chart), the ICD-10-AM/ACHI/ACS 12th Edition, *Coding Notes*[3] and all instruction materials distributed by the Healthcare Pricing Office. It is the responsibility of coding staff to keep up to date with ICS and coding advice published in *Coding Notes*. ICS include advice published in Coding Notes.

CLINICAL CODING

The clinical coding standards have been written with the basic objective of satisfying sound coding convention according to ICD-10-AM/ACHI/ACS 12th Edition and to augment, clarify or replace the Australian Coding Standards as appropriate. Many of the issues addressed are as a direct result of input and feedback from the Irish clinical coding, healthcare and clinical community.

The patient's healthcare record/chart will be the primary source for the coding of inpatient and day case morbidity data. Accurate coding is possible only after access to consistent and complete clinical information. If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.

Documentation within the current episode of admitted care is the primary source of information for the classification of admitted care morbidity data. Accurate classification is possible only after access to consistent and complete clinical information. Without complete clinical documentation, the classification guidelines are difficult, if not impossible, to apply. Where possible, health services should ensure clear and accurate documentation practices and maintain policies to govern these practices.

Those undertaking the clinical coding process must engage with clinicians within a health service to best understand the clinical documentation and medical science behind the care provided to patients. Those responsible for the clinical coding process should enable adequate access and have appropriate policies to ensure that there is access to the relevant health information systems to undertake the clinical coding process.

Source: Introduction, Australian Coding Standards. IHPA, July 2022 (Pg.XI)

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[3] Coding Notes is the quarterly newsletter of the HPO provided to all working in HIPE.

The HPO reserves the right to maintain and ensure compliance with national and international coding guidelines for HIPE data. **The HPO must be informed of all local coding decisions.** If any such local decisions affect the integrity of hospital or national data the HPO will have to give a ruling on the practice continuing.

For further information on any aspect of HIPE see www.hpo.ie or e-mail hporeception@hse.ie

Section 1: Valid HIPE Activity

Valid HIPE activity

HIPE collects information on in-patient and day patient activity from participating hospitals. A HIPE discharge record is created when a patient is discharged from (or dies in) hospital. This record contains administrative, demographic and clinical information for a discrete episode of care. An episode of care begins at admission to hospital and ends at discharge from (or death in) that hospital.

Valid HIPE activity includes inpatients and day cases recorded as admissions on the hospital system. The registration of a ward with the HPO in itself is not sufficient to report activity as HIPE activity. The activity itself must be valid inpatient or day case activity and the HPO reserves the right to review ward registration where activity is not in line with national guidelines and standards both for coding and costing where applicable or where activity is not reported consistently across hospitals.

The pilot to collect HIPE data on patients in ED virtual wards has now ended and this data is no longer collected by HIPE. ED activity is not to be reported to HIPE.

Hospital Activity Not Collected By HIPE

Activity **not** currently collected by HIPE includes:
- Out-patient activity
- Clinics
- Virtual wards (Note: the pilot to collect virtual ward activity has ended)
- A&E/ED activity
    - Please note that patients on trollies in inpatient wards are to be collected by HIPE, there must be a corresponding inpatient admission on the PAS
- "well babies"
- Elective admissions to Acute Medical Assessment Units and/or Elective admissions to Acute Surgical Assessment Units are not valid HIPE activity and are to be reported as outpatient activity
- Clinics such as education clinics, pre-assessment clinics, dressings clinics or other such clinics are not valid HIPE activity and are not to be reported to HIPE regardless of where performed
- Colposcopies performed as part of the National Cervical Screening Programme are not to be reported to HIPE
- Discharge lounges such as transit wards or transit lounges.

See also Section 2: II Ward Identification

ICS Updated:	January 2017 ICS V9.0
Reason for Update:	Elective MAU activity not collective by HIPE.
Standard Updated:	January 2018 ICS V9B2018
Reason for update:	Guideline expanded and moved to separate section.
Standard Updated:	January 2019 ICS V1
Reason for update:	From 1st January 2019 HIPE will collect the number of nights in a virtual ward where the decision to admit has been made. HIPE will also collect the activity for patients in virtual wards as appropriate.
Standard Update:	September 2019 ICS V1.2
Reason for Update:	Pilot to collect virtual ward and ED activity has ceased. HIPE no longer collects activity from ED and/or virtual wards. An admission commences when the patient is admitted to an inpatient or registered day case ward.
Standard Updated:	January 2024 ICS V1.0
Reason for Update:	Information on ward registration and information moved to section 2 II Ward Identification

HIPE Coding Deadlines

The deadline for HIPE data to be coded is within <u>30 days of discharge</u>.
For example, discharges from January 2024 are to be coded by the end of February export.

HIPE Export Dates for 2024 are listed below

HIPE export month	Download all cases	Final receipt
End of January 2024	Wednesday 31 January 2024	Tuesday 6 February 2024
End of February 2024	Thursday 29 February 2024	Tuesday 5 March 2024
End of March 2024	Sunday 31 March 2024	Thursday 4 April 2024
End of April 2024	Tuesday 30 April 2024	Friday 3 May 2024
End of May 2024	Friday 31 May 2024	Thursday 6 June 2024
End of June 2024	Sunday 30 June 2024	Wednesday 3 July 2024
End of July 2024	Wednesday 31 July 2024	Tuesday 6 August 2024
End of August 2024	Saturday 31 August 2024	Wednesday 4 September 2024
End of September 2024	Monday 30 September 2024	Thursday 3 October 2024
End of October 2024	Thursday 31 October 2024	Tuesday 5 November 2024
End of November 2024	Saturday 30 November 2024	Wednesday 4 December 2024
End of December 2024	Tuesday 31 December 2024	Monday 6 January 2025

Section 2: HIPE Guidelines for Administrative Data

HIPE collects information on in-patient and day patient activity from participating hospitals. A HIPE discharge record is created when a patient is discharged from (or dies in) hospital. This record contains administrative, demographic and clinical information for this episode of care. An episode of care begins at admission to an inpatient or registered day ward in a hospital and ends at discharge from (or death in) that hospital.

The HIPE Instruction Manual contains full instructions and details of demographic and administrative data elements collected in HIPE. Further information on any of the fields discussed below will be found in the Instruction Manual. HIPE Instruction Manuals are available from the Healthcare Pricing Office website, see www.hpo.ie .

I.TEMPORARY LEAVE DAYS

For discharges occurring on or after 1st January 2007, HIPE collects the number of days a patient is allowed to go home temporarily during an inpatient stay. Typically, the pattern for these discharges would be weekly (i.e. weekend leave).

Coders determine the number of days where the patient was absent from the hospital. There will be a single HIPE record to include the total length of stay in days from the patient's original admission to the final discharge, with the number of temporary leave days entered as appropriate. Where a PAS/HIS downloads a series of cases and it is clear the patient was only temporarily discharged, these cases will be merged into one episode with the number of temporary leave days counted and collected in the HIPE Portal.

II.WARD IDENTIFICATION 12

For all discharges occurring on or after 1st January 2007 the collection of ward identification codes is mandatory. The admitting and discharge ward codes are collected for all cases.

Please note that the discharge ward cannot be a discharge lounge.

For patients discharged on or after 01/01/2011, the HIPE record also collects information on internal ward transfers of the patient during the episode of care. This information is typically stored in a "ward transfer file" or "ward transfer database" as part of the PAS/HIS system. This information is downloaded to the HIPE portal and can be viewed by the coder but cannot be amended. The information is exported as part of the normal export process. The collection of this information does not affect the coding process and coders will not be asked to enter this information when is it not available.

Where a hospital changes the use of a ward or where numbers are different to that specified in the ward registration document the HPO must be informed prior to the reporting of the activity in HIPE.

III. ACUTE MEDICAL ASSESSMENT UNITS[4] (AMAUs) 12

Prior to coding Acute Medical Assessment Unit (AMAU) activity, AMAU's must be approved by the Acute Medicine Programme before registering AMAUs with the Healthcare Pricing Office.

Emergency AMAU activity:
HIPE collects registered AMAU activity using the "Mode of Emergency Admission" field. The options for collecting AMAU activity are:

▪ *Mode of emergency admission "2": AMAU Admitted as Inpatient*
This code is assigned if the patient is admitted to the hospital through the AMAU.

▪ *Mode of emergency admission "5": AMAU Only*
This code is assigned if the patient is admitted to the AMAU and discharged from there.

Elective AMAU activity:
Elective admissions to the AMAU are not collected by HIPE. Where a patient attends an AMAU electively and goes home on the same day this is to be reported as outpatient activity. **Please note that elective AMAU activity is not to be reported as HIPE activity and will be queried.[5]**

Note: *Once an Acute Medical Assessment Unit has been registered with the HPO, the IT Department at the HPO will activate AMAU options. The HPO require sight of NAMP approval before they can accept any requests for amendments/additions to assessment bed status or capacity from sites. This affords them the assurance that sites are complying with Model of Care requirements.*

ICS Updated:	January 2017 ICS V9.0
Reason for Update:	Elective MAU activity not collective by HIPE.
Standard Updated:	January 2024 ICS V1.0
Reason for Update:	Note on the notification of changes to MAU/AMAU/AMU assessment bed use/capacity.

IV. ACUTE SURGICAL ASSESSMENT UNITS
Prior to coding Acute Surgical Assessment Unit (ASAU) activity, hospitals must register ASAUs with the National Clinical Programme in Surgery before the options for collection are activated by the Healthcare Pricing Office.

Emergency ASAU activity:
HIPE collects registered ASAU activity using the "Mode of Emergency Admission" field. The options for collecting ASAU activity are:

▪ *Mode of emergency admission "7": ASAU Admitted as Inpatient*
This code is assigned if the patient is admitted as an emergency to the hospital through the ASAU.

▪ *Mode of emergency admission "8": ASAU Only*
This code is assigned if the patient is admitted to the ASAU and discharged from there.

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[4] The term "AMAU" also includes Acute Medical Units (AMUs) and Medical Assessment Units (MAUs)
[5] Please contact the Acute Medicine Programme, HSE for information on elective AMAU attendances

It is expected that the majority of cases in an ASAU will be admitted as emergency.

Elective ASAU activity:
Elective admissions to the ASAU are not collected by HIPE. Where a patient attends an ASAU electively and goes home on the same day this is to be reported as outpatient activity. **Please note that elective ASAU activity is not to be reported as HIPE activity and will be queried.[6]**

Note: *Once an Acute Surgical Assessment Unit has been registered with the HPO, the IT Department at the HPO will activate ASAU options.*

ICS Introduced: January 2018 ICS V9B2018
Reason for Standard: From 1st January 2018 HIPE data can be reported by ASAUs registered with the National Clinical Programme in Surgery.

V. PATIENTS DISCHARGED AND RE-ADMITTED ON THE SAME DAY and DAYCASE PATIENTS REQUIRING ADMISSION FROM DAYWARD

Patients re-admitted to the same hospital having been discharged the same day must record an admission type of emergency or elective re-admission if the episode is related to the previous spell of treatment.

If a day case patient is admitted to the hospital from the day ward or 'kept in' then the *two cases are merged*, as the patient was not discharged from the hospital following the day case. The admission type for any such admitted day cases remains that of the day case. In such cases the principal diagnosis remains that of the daycase admission.

VI. PATIENTS SENT FOR A DAY PROCEDURE ELSEWHERE AND RETURNING ON THE SAME DAY

For the purposes of HIPE, patients in Hospital A that are sent to another hospital (Hospital B) for a procedure e.g. coronary angioplasty, and return on the same day for the remainder of their care, are to be recorded as a single HIPE discharge in Hospital A.

There will be a corresponding HIPE record (day case) in Hospital B where the procedure was performed.

In particular, there should not be two separate records appearing on the HIPE system relating to Hospital A, i.e. the hospital the patient is sent from and returns to.

Where there is a patient administration system shared over a number of sites these cases may need to be manually corrected to reflect this guideline.

The HPO monitor for this type of activity and queries may be issued where appropriate to ensure activity is correctly reported.

VII. DAY WARD REGISTRATION
All day ward areas must be registered with the Healthcare Pricing Office, in order to record the day ward indicator.

Day Ward Indicator

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[6] Please contact the National Clinical Programme in Surgery, HSE for information on elective ASAU attendances

If the patient is identified as a day case it is necessary to denote whether the patient was admitted to a dedicated named day ward. The options presented will be:

0 - No   **1** – Yes   **2** - Unknown

Hospitals must register their dedicated day wards with the Healthcare Pricing Office prior to using this option.

VIII. INFANT ADMISSION WEIGHT

For patients aged less than 1 year of age, admission weight is collected in whole grams in the following circumstances:

- All neonates (0-27 days old)
- All infants up to 1 year of age **with** admission weight *less than 2,500 grams.*

The value collected will be the weight in <u>whole grams</u> on admission. If the patient is admitted on the day of birth, the admission weight will be the birth weight.

IX. PARITY

From 1st January 2011 HIPE collects parity for all patients with admission type '6' *Maternity.* This field is optional for all other female patients. For the purposes of HIPE, parity is the number of previous live births and the number of previous stillbirths (over 500g).

Parity=   Number of previous live births
            Plus
            Number of previous stillbirths (over 500g)

1. Parity is collected as two separate integer (whole) numbers separately.
2. The Parity number does not include the current pregnancy/obstetric care/delivery or puerperium.
3. The number of previous miscarriages is not for collection in parity.
4. Please use '0' to record where there are no previous live births and/or stillbirths.
5. If the number of previous live births or the number of previous stillbirths is not documented this will be recorded as NA (not available).
6. Each previous birth is counted;
   For example
   - Patient previously had twins; both live births, no stillbirths
             Parity= Live births 2 + Stillbirths 0 = 2

   - Patient previously had triplets; two live births and one stillbirth
             Parity= Live births 2 + Stillbirths 1 = 3

ICS Updated: January 2018 V9B2018
Reason for update: ICS updated to advise that miscarriages are not collected in parity

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X. DURATION OF CONTINUOUS VENTILATORY SUPPORT (CVS) (CUMULATIVE)

From 1st January 2019 HIPE collects a total number for the cumulative hours of continuous ventilatory support (CVS)/mechanical ventilation (invasive ventilation). This variable will be collected in the administrative data fields and is collected in addition to the relevant diagnosis and procedure codes. This variable is subject to audit.

Duration of continuous ventilatory support will be collected for all cases where a code from block [569] *Ventilatory support* is coded i.e. mechanical ventilation.

This variable will be collected as a 4 character number from 1 hour up to 9999 hours (See also HIPE Instruction Manual).

o This variable is required to be collected where a procedure code from block [569] *ventilatory support* is recorded.

o This variable is not required to be collected for non-invasive ventilation.

o Hours of continuous ventilatory support are to be reported for completed hours only. For example a patient with 35 hours 40 minutes continuous ventilatory support will report 35 hours for duration of CVS.

o Duration of CVS does not include ventilatory support provided during surgery except in the following circumstances:

  ▪ If the patient required CVS prior to surgery and then CVS continued during and post-surgery.
  ▪ CVS provided during surgery continues for more than 24 hours post-surgery.

Calculating the Duration of Continuous Ventilatory Support

  o Begin with:
    o Initiation of CVS at time of intubation or when CVS is commenced via tracheostomy.
    o For patients already ventilated on admission, commence from time of admission.

  o End with:
    o Extubation.
    o Cessation of CVS after weaning.
    o Discharge, transfer or death of patient.

Note:
  o Subsequent periods of CVS in the same episode of care should be added together.
  o If there is a period or one hour or less between cessation and restarting the CVS continue to count the duration. If there is removal and immediate replacement of airway devices, continue to count the duration.

XI. CLINICAL CODING SCHEMES USED IN HIPE IN IRELAND: 6 8 10 12

- From 1st January 2024 ICD-10-AM/ACHI/ACS 12th edition (July 22) for both Diagnoses and Procedures.
- 2020 – 2023 ICD-10-AM/ACHI/ACS 10th edition (July 17) for both Diagnoses and Procedures.
- 2015 - 2019 ICD-10-AM/ACHI/ACS 8th edition (July 13) for both Diagnoses and Procedures.
- 2009 - 2014 ICD-10-AM/ACHI/ACS, 6th edition (July 08) for both Diagnoses and Procedures
- 2005 – 2008 ICD-10-AM 4th Edition (July 04) for both Diagnoses and Procedures
- 1999 – 2004 ICD-9-CM (Oct 98 version) for both Diagnoses and Procedures
- 1995 – 1998 ICD-9-CM (Oct 94 version) for both Diagnoses and Procedures
- 1990 – 1994 ICD-9-CM (Oct 88 version) for both Diagnoses and Procedures
- 1981 – 1989 ICD-9 for Diagnoses and OPCS[7] Procedures classification
- 1969 – 1980 ICD-8 for Diagnoses and OPCS Procedures classification

XII. LABORATORY CONFIRMED COVID 19 PAST OR PRESENT- FLAG

COVID-19 Flag 12

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

Question: Lab-confirmed COVID-19 Past or Present

> Coders will choose "YES" for Laboratory confirmed COVID 19 past or present if:
>
> There is a diagnosis of Lab-confirmed Coronavirus 19 (COVID-19), virus identified during the current episode of care (Laboratory confirmed cases **U07.1X**)
> <div align="center">OR</div>
>
> There is documentation in the chart that the patient had a Lab-confirmed COVID-19 or Tested Positive with COVID-19 during a previous episode of care.
>
> <div align="center">OR</div>
>
> There is documentation in the chart that the patient was previously diagnosed with Lab-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 so 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 box is auto populated.

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[7] Office of Population Censuses and Surveys (OPCS) 1975, *Classification of Surgical Operations*, Second Edition, London

- 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 to this variable originally, coders may review and revise other episodes if necessary.
- **This is effective for discharges from 1st October 2020 regardless of discharge dates.**

Example 1:
Patient admitted with fever and cough. Final diagnosis COVID-19 (Lab 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 5 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 flag will be subject to HPO review and audit, and any information recorded must be available in the patient's healthcare record.

See also HIPE Instruction Manual.

XIII. Discharge Mode

For cases discharged from 01/01/2022, the HIPE Portal allows for the collection of the Discharge Mode. This information will provide further information on a patient's discharge than currently covered in the Discharge Code.
- The existing Discharge Code identifies **WHERE** the patient was discharged to.
- The new Discharge Mode will indicate **WHY** the patient was transferred to a healthcare facility.

The Discharge Mode indicates the type of post-acute care to be received by the patient following their discharge from their acute episode of care (i.e. the end of their inpatient or day case stay) if applicable to a case. The Discharge Mode will only be collected for patients when the patient is being transferred to another healthcare facility (hospital etc.) for additional care and, as a result, is not collected for every Discharge Code.

The values of the Discharge Mode are as follows. When one of the applicable discharge codes is chosen, the new Discharge Mode field will appear and a value must be chosen. The valid Discharge Codes for each of the values that can be collected are also listed.

Discharge Mode	Discharge Mode Description	Valid Discharge Destination codes
1	Acute Care	3, 4, 5, 10, 11
2	Rehabilitation Care	2, 3, 4, 5, 8, 9, 10, 11, 14
3	Palliative Care	2, 3, 4, 5, 8, 9, 10, 11, 14
4	Convalescence/Step Down Care	2, 3, 4, 5, 8, 9, 10, 11, 14
5	Long Term/Nursing Care	2, 3, 4, 5, 8, 9, 10, 11, 14
6	General Psychiatric Care	3, 4, 5, 8, 9
7	Other Care	2, 3, 4, 5, 8, 9, 10, 11, 14
9	Unspecified/Unknown Care	2, 3, 4, 5, 8, 9, 10, 11, 14

The following table gives details on the definitions of the different Discharge Modes

Discharge Mode	Definitions[8]
1) Acute Care	Follow-on care where there is an acute length of stay following an acute length of stay. For example, a patient is transferred from your hospital to another hospital for continuing acute care.
2) Rehabilitation Care	Care in which the primary clinical purpose is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. For example, a patient is transferred to a specific facility for rehabilitation following a surgical intervention.
3) Palliative Care	Care in which the primary clinical purpose or treatment goal is the optimisation of the quality of life of a patient with an active and advanced life-limiting illness. For example, a patient is transferred to a facility for the provision of Palliative Care following a terminal diagnosis.
4)Convalescence/ Step Down Care	Care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition where there is an expectation that the patient will be subsequently discharged home.
5) Long Term/ Nursing Care	Care in which the primary clinical purpose is to support the functioning of a patient who can no longer live independently.
6) General Psychiatric Care	Care in which the primary clinical purpose is improvement in the functional status, behaviour and/or quality of life of a patient with significant psychiatric or behavioural disturbance.
7) Other Care	Further care that is not covered by the other options.
9) Unspecified/ Unknown Care	Care where the intention of the care is not known or not recorded.

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[8] Adapted from the definitions in IHPA - https://www.ihpa.gov.au/what-we-do/subacute-and-non-acute-care

Additional notes on assignment of Discharge Mode:

- The Discharge Mode must record the reason the patient is transferred to another medical facility where a patient is transferred directly to another facility for a stated purpose (such as rehabilitation or palliative care) and where this is recorded in the chart.

- A patient may receive non-acute care in an acute facility so it cannot be assumed that the Discharge Mode is "1 Acute" for patients transferred to acute facilities.

- The definitions above are for reference only and the chart must be clear as to what type of ongoing care is being delivered before applying the Discharge Mode.

- If it is not clear in the patient's chart what type of care the patient will receive in the subsequent facility, then the "9 Unspecified/Unknown Care" should be chosen.

- Convalescence/Step Down care typically covers the transfer of patients to non-acute facilities where it is anticipated that they will reside for a period of time and there is an expectation that they will be discharged home.

- There is no change to the coding of any case in an acute setting as a result of the introduction of this field. For example, if a patient is receiving palliative care in the current acute episode, the relevant codes will be recorded as per the normal coding standards.

- The Discharge Mode is to be collected when the patient is discharged from the hospital as normal. The discharge date of the patient does not change. In particular, the Discharge Mode is not to be collected based on the medical discharge date but rather the actual discharge date.

- Where the user chooses "7) Other Care", they will be asked to identify the type of care in a free text box.

- If it is documented that a patient is transferred for more than one type of care, the main type of care should be chosen.

- The HPO will monitor the Discharge Modes used and review the options if required.

   Additional checks will be added to the HIPE Portal to ensure that valid discharge modes used for each discharge code.

XIV. Specialist palliative Care Team Involvement (Administrative variable)

(For full details, see also ICS 2116 *Palliative Care*)

For cases discharged from 01/01/2022, an administrative field capturing if the specialist palliative care team attended a patient during the episode will be collected. The purpose of collecting this information is to identify where palliative care is being administered by the specialist palliative care team rather than other medical practitioners.

The values for identifying Specialist Palliative Care Team involvement are listed below

PallativeCareInd	Description
0	No (No Specialist Palliative Care Team Involvement in this episode)
1	Yes (Yes Specialist Palliative Care Team Involved in this episode)

Please Note (as stated in ICS 2116):

- The default value for this field is "0 No" (i.e. that the specialist palliative care team did not attend the patient)
- This field is not downloaded and must be manually collected by the HIPE clinical coder
- The admin variable for specialist palliative care team involvement does not impact on the assignment of code Z51.5 *Palliative care* and the guidance in ACS 2116 and ICS 2116 *Palliative Care* applies
- This variable can be collected when there is documented involvement of any member of the specialist palliative care team including palliative care nurse, NCHD or consultant in palliative care
- The admin variable for specialist palliative care can be assigned when there is *assessment only* by the specialist palliative care team (please note that code Z51.5 *Palliative Care* does not apply where there is assessment only as per coding guidance in ACS & ICS 2116)
- Where a specialist palliative care team is involved in a case and palliative care is given to the patient please apply the admin variable for specialist palliative care team involvement and also assign the Z51.5 code and the consultant code for the palliative care consultant
- Where palliative care is delivered by another speciality, do not assign the indicator. Code Z51.5 *Palliative care* may be applied in such cases
- Data entry edits will support coders in assigning the variable for specialist palliative care team involvement
- See also ICS, Section 2, HIPE Guidelines for Administrative Variables, item XIV: Specialist Palliative care team involvement

Section 3: Coding Standards

General Standards for Diseases (00--)

ICS 0003 SUPPLEMENTARY CODES FOR CHRONIC CONDITIONS

Supplementary codes for chronic diseases **U78.- to U88**.- (see also **ACS 0003**) will not be collected in Ireland. Australian Coding Standard is not to be applied to Irish HIPE data collection.

Published:	Irish Coding Standards V1 January 2020
Effective From:	January 2020
Reason for Standard:	Supplementary information not required for HIPE data collection. These codes are under review by IHPA.

ICS 0010   CLINICAL DOCUMENTATION AND GENERAL ABSTRACTION GUIDELINES
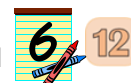
Number of Diagnoses

From 1st January 2011 up to 30 diagnoses can be collected by HIPE.

Clarification of the terminology "Multiple Episodes within an admitted patient stay" for Ireland (see section on **Abstraction from Other Sources of Information**)

In the section on "Abstraction from other sources of information" in ACS 0010, the term "multiple episodes within an admitted patient stay" is referred to (in the third bullet point), because in Australia each admission can be divided into different care types. This terminology does not apply in Ireland, as in Ireland the patient has one episode of care for each discharge.

Abnormal findings/Test results

As per **ACS 0010** *Clinical Documentation and General Abstraction Guidelines* "Do not use test result values, descriptions, health risk screening (assessment) tools, medication charts, symbols and abbreviations from clinical documentation in isolation to assign diagnosis codes" (see *Test Results and Medication Charts* section of **ACS 0010**).

Also, refer to the section on *Test Results With an Unclear or No Associated Condition Documented* which states the following*:* "Do not use test results to determine code assignment where there is no clinical documentation within the health care record to indicate the significance of the test result, or there is an unclear relationship between a test result and a condition." The standard provides a number of scenarios in example 7 including:
> In the following circumstances, do not assign:
> • **N39.0** *Urinary tract infection, site not specified where only microbiology result shows organism(s) have been cultured*.

Ensure that any diagnosis is clearly described in the medical record before assignment of a code. Clarification from the clinician should be sought where necessary, and where appropriate be recorded in the health care record by the clinician.

Example 1:

Patient admitted for banding of haemorrhoids, procedure performed under sedation. During the admission the patient's urine microbiology result showed e-coli organism, also noted in the medical record was the administration of IV antibiotic. There was no written documentation of a urinary tract infection by the treating clinician.

Codes:　　　　**K64.9** *Haemorrhoids, unspecified*
　　　　　　　32135-00 [941] *Rubber band ligation of haemorrhoids*
　　　　　　　92515-99 [1910] *Sedation, ASA 99*

Rationale: The urinary tract infection is not coded as the condition is not documented.

Example 2:

Patient was diagnosed with chronic kidney disease. The eGFR pathology result showed 72mL/min.

Codes:　　　　**N18.2** *Chronic kidney disease, stage 2*

Rationale: The eGFR test result adds support to a documented condition, chronic kidney disease, therefore it is appropriate to assign a code for the stage of kidney disease. (See **ACS 1438** *Chronic Kidney Disease*).

Use of Symbols and shorthand:

Please refer to the section "Shorthand in relation to a condition or finding" in **ACS 0010** *Clinical Documentation and General Abstraction Guidelines* for detailed guidance on the use of symbols, shorthand, abbreviations and values and the criteria that apply for coding purposes.

Clinical Documentation for HIPE coding and Electronic Healthcare Records

ICS 0010 *Clinical Documentation and General Abstraction Guidelines* includes guidance on use of Clinical Documentation for HIPE coding and the Electronic Healthcare Record please also refer to the section in **ACS 0010** on "Clinical Documentation" and the Glossary included in the Australian Coding Standards (12th edition).

The information provided below has been updated to reflect some changes in 12th Edition and provides guidance on the use of clinical documentation including nursing notes.

Guidance on Clinical Documentation and Nursing Notes:

ACS 0010 *Clinical Documentation and General Abstraction Guidelines* states "Generally, documentation by medical or surgical clinicians is the primary source for classification purposes. However, documentation by other clinicians may also be used to inform code assignment or add specificity where the documentation is appropriate to the clinician's scope of practice" *(see Clinical Documentation* section which also provides a number of examples).

Types of clinical documentation:
High quality clinical documentation promotes effective communication between caregivers and facilitates continuity of patient care and patient safety. It also facilitates accurate clinical coding – a diagnosis or procedure can only be coded if documented in the medical record and meets coding standards for coded assignment.

Medical officer documentation:

Diagnosis and treatment of medical conditions is the responsibility of the treating medical officer(s), therefore clinical coders predominantly use medical officer documentation.

Nursing, midwifery and allied health documentation:
Documentation from clinicians other than medical officers (i.e. nurses, midwives, allied health professionals) is also used by coders. It can help to provide clarification and specificity about (or confirm existence of) a diagnosis or procedure documented by a medical officer [doctor]. More importantly, if a nursing, midwifery or allied health documented diagnosis or procedure is **appropriate to that clinician's scope of practice** it can be coded regardless of whether the medical officer [doctor] has documented it. For example, malnutrition (E40.- - E46-.) can be coded if documented by a Dietician.

Diagnosis information is commonly found in the allied health professional's assessment notes. Issues to consider when using allied health documentation include:

- Results/scores from testing tools (e.g. post-traumatic amnesia assessment score, cognitive test sheets) should not be interpreted by coders. The condition must be documented by a clinician as well as the allied professional for it to be used by the coder.
- Documentation such as "Dysphagia review" should have a clear final assessment documenting whether patient has the condition.

Use of nursing documentation:
As per Australian Coding Standards, coding directly from nursing documentation is restricted to conditions appropriate to the nursing discipline.

- General nursing
The main areas of general nursing where patients' documentation may support the coding of conditions are skin integrity e.g. pressure ulcers, wounds, and minor injuries.

- Specialist nursing
Tracheostomy and Stoma care

Diabetic Educator/Diabetic Specialist Nurse
> E.g. Type of diabetes? Documentation such as "poorly controlled", "uncontrolled", "for stabilisation", "unstable" may be used to enable coding of poor control **E1-.65** *Diabetes mellitus with poor control*.

Reference: Coding Education Team, Purchasing & System Performance, Department of Health, Government of Western Australia (November 2015).

Examples

- A diagnosis of pneumonia can only be coded if documented by a medical officer (doctor).
- A diagnosis of pressure injury documented by a nurse (which the medical officer [doctor] fails to document) can be coded because skin integrity management is appropriate to the general nursing discipline.
- A diagnosis of post-partum haemorrhage documented by a midwife (which the medical officer [doctor] fails to document) can be coded because it is appropriate to the midwifery discipline.
- A diagnosis of dysphagia documented by a speech pathologist (which the medical officer fails to document) can be coded because it is appropriate to the speech pathology discipline.

Please note that conditions must meet criteria in ACS 0001 & ACS 0002 (with reference also to specialty standards as required).

Electronic Healthcare Records:

The patient record has extended beyond the paper chart to various electronic systems for example: pathology reports, x-ray reports, discharge summaries and these systems may need to be accessed by HIPE staff in the course of their duties. National coding guidelines apply to paper charts and any electronic information used by coders in the course of their duties in coding a patient's record. Coders cannot assign diagnoses based on laboratory values alone and conditions must be documented by a clinician (see **ACS & ICS 0010** *Clinical Documentation and General Abstraction Guidelines*).

For auditing purposes, access to the same information (or printouts of the information) used by the coder is required during an audit visit in order to verify that the conditions and procedures (and any other variables) coded have been documented in paper or electronic format and coded in accordance with national coding guidelines.

General Standards for Diseases (00--)

ICS 0025   DOUBLE CODING

Australian Coding Standard (ACS) **0025 DOUBLE CODING** instructs coders not to repeat diagnoses codes. This Irish Coding Standard instructs that a diagnosis code (and/or an external cause code) <u>can be repeated</u> when the same code applies to an episode of care where in one instance a HADx flag applies and in the other the HADx flag does not apply. This is the only derogation from **ACS 0025** *Double Coding*. Please note that the AR-DRG assignment will not be affected by duplication of the diagnosis codes.

Example 1

Patient fell from a chair at home and had a laceration of the forehead. Patient also fell from a chair when in hospital and lacerated other side of forehead which required suturing.

Code		HADX
S01.88	*Open wound of other parts of head*	
W07.9	*Fall involving unspecified chair*	
Y92.09	*Other and unspecified place in home*	
U73.9	*Unspecified activity*	
S01.88	*Open wound of other parts of head*	Yes
W07.9	*Fall involving unspecified chair*	Yes
Y92.24	*Health service area, this facility*	Yes
U73.9	*Unspecified activity*	Yes

In this example <u>duplicated codes have been underlined</u>.

Example 2

Patient admitted to hospital with a pressure injury of the left heel – stage II. During the admission the patient develops a pressure injury on the right heel – also stage II

Code:		HADX
L89.17	Pressure injury stage II – heel	No
L89.17	Pressure injury stage II – heel	Yes

ICS 0027   MULTIPLE CODING 🔟2️⃣

Consultant Numbers (see also HIPE Instruction Manual)

If a patient is admitted to hospital and seen by more than one consultant for the same condition while in hospital, the additional consultant(s) can be recorded against the diagnosis code. The diagnosis code need not be repeated in this instance.

Additionally, if more than one consultant takes part in a procedure either as a surgeon or an anaesthetist, the additional consultant(s) can be recorded against the procedure.

Reason for Standard:	ICS 0027 is a continuation of existing practice.
ICS Updated:	September 2008 ICS V1.5 for Recording of consultant encounters by HIPE
ICS Further Updated:	January 2011
Reason Further Updated:	HIPE Portal allows for collection of more than one consultant code per diagnosis or Procedure
Standard Updated:	January 2024 V1.0
Reason for Update:	Please note, there is no equivalent ACS 0027, this is an ICS only

ICS 0048   CONDITION ONSET FLAG

~~Effective From:~~	~~January 2009~~
~~Reason for Standard:~~	~~New variable in Australia, not introduced in Ireland~~
ICS Updated	January 2011 with change in name of variable to Hospital Acquired Diagnosis Indicator
Reason for Update:	Hospital Acquired Diagnosis Indicator introduced from January 2011

ICS 0048   HOSPITAL ACQUIRED DIAGNOSIS (HADX) INDICATOR

This ICS translates, in Part A, the information provided in **ACS 0048** *Condition Onset Flag* into a format that can be applied in Ireland for assignment of the Hospital Acquired Diagnosis flag. The advice previously provided in **ICS 0048** is now provided in **ICS 0048** Part B.

Part A: Translation of ACS 0048 CONDITION ONSET FLAG for use in Ireland

The Hospital Acquired Diagnosis flag is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care.
Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and those conditions that arise during the episode of admitted patient care.
A better understanding of those conditions arising during the episode of admitted patient care may inform prevention strategies particularly in relation to complications of medical care.

> **Hospital Acquired Diagnosis Flag IS assigned:**

Hospital Acquired Diagnosis flag (this equates to COF 1. Condition with onset during the episode of admitted patient care) is assigned in the following circumstances:

Definition
A condition which arises during the episode of admitted patient care and would not have been present or suspected on admission.
Examples of inclusions:

- A condition resulting from an unintentional event during surgical or medical care in the current episode of admitted patient care (e.g. accidental laceration during procedure, foreign body left in cavity, medication infusion error)
- An abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care (e.g. post procedural shock, disruption of wound, catheter associated UTI (urinary tract infection))
- A condition newly arising during the episode of admitted patient care (e.g. pneumonia, rash, confusion, UTI, hypotension, electrolyte imbalance)
- A condition impacting on obstetric care arising after admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management (e.g. labour and delivery complicated by fetal heart rate anomalies, postpartum haemorrhage)
- For neonates, this also includes the condition(s) in the birth episode arising during the birth event (i.e. the labour and delivery process) (e.g. respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures) (see Guide for use, point 3)
- Disease status or administrative codes arising during the episode of admitted patient care (e.g. cancelled procedure, MRSA (Methicillin Resistant or Multi-Resistant Staphylococcus aureus)).

> **Hospital Acquired Diagnosis is NOT assigned:**

A Hospital Acquired Diagnosis flag (this equates to COF 2. Condition not noted as arising during the episode of admitted patient care) <u>is not assigned in the following circumstances</u>:

Definition
A condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease.
Examples of inclusions:
- A condition that has not been documented at the time of admission, but clearly did not develop after admission (e.g. newly diagnosed diabetes mellitus, malignancy and morphology)
- A previously existing condition that is exacerbated during the current episode of admitted patient care (e.g. atrial fibrillation, unstable angina)
- A condition that is suspected at the time of admission and subsequently confirmed during the current episode of admitted patient care (e.g. pneumonia, AMI (acute myocardial infarction), stroke, unstable angina)
- A condition impacting on obstetric care arising prior to admission (e.g. venous complications, maternal disproportion)
- For neonates, this also includes the condition(s) in the birth episode arising before the labour and delivery process (e.g. prematurity, birth weight, talipes, clicking hip)
- Disease status or administrative codes not arising during the episode of admitted patient care (e.g. history of tobacco use, duration of pregnancy, colostomy status)
- Outcome of delivery (Z37) and place of birth (Z38) codes (see Guide for use, point 10).

GUIDE FOR USE (*Please note: numbering of the points below is different to the ACS)

1. Sequencing of ICD-10-AM codes must comply with the Australian Coding Standards and therefore codes should not be re-sequenced in an attempt to list the codes with or without a HADx flag together.
2. The principal diagnosis code is not assigned a HADx flag. The exception to this is neonates in their admitted birth episode in that hospital, where codes sequenced as the principal diagnosis may be assigned HADx if appropriate (see Example 6).
3. For neonates, where a condition in the admitted birth episode is determined to have arisen during the birth event (i.e. labour and delivery process), these conditions should be considered as arising during the episode of admitted patient care and assigned as HADx (see Example 5 and 6).
4. For combination codes (see **ACS 0015** *Combination codes*) where a diagnosis within the code meets the criteria of a HADx, and is not represented by another code with a HADx value, then assign a HADx to the combination code (see Example 2).
5. When it is difficult to decide if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode, do not assign a HADx (see Example 12).
6. Where multiple conditions/sites are classifiable to a single ICD-10-AM code that meets the criteria for different condition onset flag values, assign as HADx (see Example 12). The exception to this is when the condition is sequenced as the principal diagnosis and must not be assigned as HADx (see Example 15).
7. The HADx flag assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.
Injuries which occur during the admitted episode of care but not on the hospital grounds (e.g. hospital in the home (HITH)) should be assigned as HADx as 'arising during the episode of admitted patient care'.
8. Z codes related to the outcome of delivery on the mother's record (Z37), or the place of birth on the baby's record (Z38) should never be assigned as HADx.
9. The HADx flag assignment on aetiology and manifestation (dagger and asterisk) codes should be appropriate to each condition and therefore the dagger and asterisk codes may be assigned with or without a HADx flag as appropriate.
10. An episode of admitted patient care includes all periods when the patient remains admitted and under the responsibility of the health care provider, including periods of authorised leave and HITH.
Where diagnoses arising during this period meet the criteria for **ACS 0002** *Additional diagnoses*, coders should assign the HADx flag if appropriate (see Example 13). Unauthorised leave does not fall under the responsibility of the health care provider and conditions arising during this time should not be assigned as HADx.
11. Where an admission has multiple admitted patient episode 'care type' changes (e.g. acute to rehabilitation), the assignment of the HADx flag to conditions should be relevant to each episode. A condition arising in an episode should be assigned as HADx. If care for that condition continues in subsequent episodes those conditions should not be assigned HADx.

Note: The following examples identify where a Hospital Acquired Diagnosis Flag (HADx) is assigned to a condition. ACHI codes are not included in the following examples.

EXAMPLE 1:
Patient is admitted with acute appendicitis and has an appendicectomy. A wound infection develops in the post-operative period and a swab taken grows MRSA.

Acute appendicitis
HADx- Wound infection
HADx- Staphylococcus aureus (infectious agent)
HADx - MRSA
HADx - Removal of organ (external cause code related to wound infection)
HADx - Place of occurrence (of external cause)

EXAMPLE 2:
A patient admitted with acute cholecystitis for laparoscopic cholecystectomy. Patient also has Type 2 diabetes mellitus and develops lactic acidosis post operatively.

Acute cholecystitis
HADx - Type 2 diabetes mellitus with lactic acidosis, without coma

EXAMPLE 3:
A woman is admitted for induction of labour due to post dates. Fetal distress arises during labour requiring forceps delivery. The baby is born alive with the cord wrapped tightly around its neck.
During delivery she also suffers a second degree perineal tear (that is sutured) and a postpartum haemorrhage. On day three following delivery, the patient experiences chest pain and palpitations and is diagnosed with puerperal cardiomyopathy.

Delivery affected by forceps
Prolonged pregnancy
HADx - Second degree perineal laceration during delivery
HADx - Labour and delivery complicated by fetal distress
HADx - Labour and delivery complicated by other cord entanglement
HADx - Other immediate postpartum haemorrhage
HADx - Cardiomyopathy in the puerperium
Single live birth

EXAMPLE 4:
Patient admitted for preterm confinement at 36 weeks. She was known to be Group B Strep positive and was given antibiotics. She progressed to SVD (spontaneous vertex delivery) of single male infant.
A second degree tear was sutured. Nipple care was discussed as the patient had bleeding nipples with difficulty attaching the baby. During the episode, the patient developed a generalised rash caused by the ibuprofen which was changed to paracetamol.
 Delivery
 Preterm delivery
 Duration of pregnancy
 Group B Strep positive
 Prophylactic antibiotics
HADx – Second degree tear
HADx - Bleeding nipples (attachment difficulty)
HADx - Diseases of skin complicating pregnancy, childbirth and puerperium
HADx - Skin eruption due to drugs
HADx - Adverse effect in therapeutic use HADx - Place of occurrence - health service area
Single live birth

EXAMPLE 5:
Baby born in hospital at 36 weeks (3200g). After delivery, clinical review confirmed 'meconium aspiration syndrome' and newborn given intravenous (IV) 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 which was treated with 15 hours of phototherapy. Physiotherapy review for talipes. Paediatric review on day 3 "left hip subluxatable" for follow up.

Preterm infant
HADx - Neonatal aspiration of meconium
HADx - Other feeding problems of newborn
Tongue tie
Talipes
HADx - Jaundice
Subluxatable hip

EXAMPLE 6:
Singleton born at 38 weeks (2840g) by caesarean section. During caesarean section, scalp laceration occurred requiring suturing by paediatrician. Initial check - cleft palate, Mongolian spot. Newborn seen by specialist team to review cleft palate.

HADx -Other birth trauma to scalp
HADx - Fetus and newborn affected by caesarean delivery
Cleft palate
Singleton born in hospital

In this example, a code for Mongolian spot is not assigned as it has not met the criteria for code assignment in **ACS 0002** *Additional diagnoses*.

EXAMPLE 7:
A patient was admitted with chest pain. He has a history of hypertension. A diagnosis of unstable angina was made. During the admission, test results revealed previously undiagnosed moderate haemolytic anaemia and a consultation regarding management of this was provided by a Haematologist prior to discharge.

Unstable angina
Haemolytic anaemia

EXAMPLE 8:
Patient admitted with pneumonia. On admission chest x-ray showed several nodules in the left lung thought to be metastases. These were biopsied and histology showed SCC (squamous cell carcinoma).

Pneumonia
Metastases to lung
Unknown primary neoplasm site

EXAMPLE 9:
A patient is readmitted with a post cholecystectomy wound infection and the swabs grow MRSA.
The patient had a background of hypertension controlled with regular medication. During the episode, the patient had several hypertensive episodes, managed by adjusting the patient's regular medication.

Wound infection
Staphylococcus aureus (infectious agent)
MRSA
Removal of organ (external cause)
Place of occurrence (of external cause)
Hypertension

EXAMPLE 10:
Patient admitted with bone secondaries (spine and ribs). Left mastectomy 10 years ago - infiltrating duct carcinoma. Patient in pain on admission, has not mobilised for several days. Small red pressure area to sacrum on admission. Day 4 pressure injury stage 2, continue pressure care.
Day 8 some shortness of breath. Investigations reveal Hb (haemoglobin) 80 which was a significant drop from Hb115 on admission (patient's normal).Anaemic - transfused packed cells.

Bone metastases
Breast primary
Pressure injury
HADx - Anaemia, unspecified

EXAMPLE 11:
Patient admitted with uncontrolled Type 2 diabetes. The patient is known to have nephropathy (CKD (chronic kidney disease) stage 3) but no other complications of the diabetes. During admission the patient develops acute kidney failure.

Type 2 diabetes mellitus uncontrolled
HADx - Acute kidney failure
Type 2 diabetes mellitus with acute kidney failure
Type 2 diabetes mellitus with chronic kidney disease
Chronic kidney disease, stage 3

EXAMPLE 12:
Patient admitted with pneumonia. On admission, a stage II pressure injury on the foot is noted requiring management. During admission, the patient was also diagnosed with UTI. It could not be determined whether the UTI arose during or prior to the admitted episode of care. On the fourth day, a newly arising stage II pressure injury on the ankle is identified also requiring management.

Pneumonia
UTI
HADx - Pressure injury, stage II, other site of lower extremity (excluding heel and toe)

EXAMPLE 13:
Elderly patient admitted with chronic respiratory failure. Given permission for home leave for the weekend to attend family event at daughter's house. During the weekend, the patient slips while in the bathroom and fractures her neck of femur. She immediately returns to hospital from approved leave where fracture is treated.

Chronic respiratory failure
HADx - Fractured neck of femur
HADx - External cause code - slip
HADx - Place of occurrence - bathroom
HADx - Activity - other vital activity

EXAMPLE 14:
A patient is admitted with schizophrenia. On the fourth day, patient absconds and returns 16 hours later. On return, patient is found with multiple self-inflicted lacerations to their left forearm.
The patient is taken to the emergency department for treatment before returning to the mental health unit.

Schizophrenia
Open wound of forearm
External cause code - self-inflicted cut
Place of occurrence - unspecified
Activity - other specified

EXAMPLE 15:
Patient admitted with stage II pressure injury of foot. During admission, the patient also develops an additional stage II pressure injury of ankle.
Pressure injury, stage II, other site of lower extremity (excluding heel and toe)

Part B ICS 0048: Hospital Acquired Diagnosis – Additional Guidance for Ireland.

This indicator will allow the diagnoses acquired during the patient's episode of care that were not present prior to admission, to be identified. In Ireland the variable will be called the Hospital Acquired Diagnosis (HADx) Indicator. This variable has been collected from January 2011. The purpose of this variable is to collect information that can be used as an indicator of quality of care. It does not aim to collect information on the profile of chronic disease progression.

The 'Hospital Acquired Diagnosis' indicator will be 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* may serve as a useful guide.

An indicator can be ticked for any secondary diagnosis acquired during this episode of care that was not previously present. The indicator can only be assigned to a true hospital acquired condition and not to an exacerbation of a pre-existing condition.

The principal diagnosis cannot be assigned this indicator as by definition it will have been present when the patient was admitted[9]. 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).

Coders may find it helpful to refer to the information in **ACS 0048** which has been provided for use in Ireland in Part A above, this standard states:

"*The principal diagnosis code is always assigned COF 2* (in Ireland this translates as not a Hospital Acquired Diagnosis). *The exception to this is neonates in their admitted birth episode in that hospital, where codes sequenced as the principal diagnosis may be assigned COF 1* (in Ireland this translates as a Hospital Acquired Diagnosis) *if appropriate*.

HADX for neonates at risk of sepsis
Neonates admitted within the birth episode and observed for risk of sepsis will not have
a HADx flag applied to the codes for this condition. In such cases, as the sepsis is not an established diagnosis it cannot be flagged as a hospital acquired diagnosis.

If in doubt please do not assume a condition is Hospital Acquired. This must be clearly documented before the flag is used.

Example 1: Patient admitted with back pain. Investigations found that patient had prostatic carcinoma and bony mets to the pelvis.		
Dx	**Code**	**HADx**
Primary neoplasm of prostate	**C61**	-
Secondary Neoplasm of bone	**C79.5**	-

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[9] *"The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code."* (Health Data Standards Committee (2006), *National Health Data Dictionary*, Version 13, AIHW).

Example 2:
Patient admitted with shortness of breath and difficulty breathing found to have acute exacerbation of COPD. Patient found to be MRSA+ on nasal swab on day 5 of admission – previous nasal swabs during the admission were negative

Dx	Code	HADx
COPD with acute Exacerbation	**J44.1**	-
Carrier of other specified bacterial disease	**Z22.3**	✓ Yes
Resistance to beta-lactamase resistant [second generation] penicillins	**Z14.02**	✓ Yes

Example 3:
Obstetrics patient admitted with prolonged pregnancy. The following day the patient was induced with oxytocin and delivered a healthy infant via forceps delivery with 2nd degree perineal laceration.

Dx	Code	HADx
Single delivery by forceps & vacuum extractor	**O81**	
Prolonged pregnancy	**O48**	-
2nd Degree Perineal laceration	**O70.1**	✓ Yes
Outcome of delivery: single live birth	**Z37.0**	-

Example 4:
Type II diabetic patient admitted with diabetic foot, during the admission the patient developed acute renal failure.

Dx	Code	HADx
Diabetic Foot	**E11.73**	-
Acute kidney failure	**N17.9**	✓ Yes
Diabetes with other specified kidney complication	**E11.29**	-

Example 5
Patient admitted with abdominal pain. Investigations suggested appendicitis. Patient underwent appendicectomy and during the procedure adhesions were noted and divided. Histology report documents acute appendicitis. Postoperative course was normal but patient developed rash on left arm with no cause found. The patient was reviewed by the dermatologist and given an appointment for dermatology Out-Patients Clinic.

Dx	Code	HADx
Acute Appendicitis Other & unspecified	**K35.8**	-
Peritoneal Adhesions	**K66.0**	-
Rash	**R21**	✓ Yes

Effective From:	From 1st January 2011 HADx indicator will be collected.
Reason for Standard:	To identify those conditions that are acquired during the episode of care
Standard Updated:	Name and content of ICS 0048 updated to state that the Hospital Acquired Diagnoses Indicator is collected from January 2011
Standard Updates:	Standard updated for 8th edition ICD-10-AM/ACHI/ACS as the HADx flag can be assigned for neonates on the birth episode. Examples also updated to reflect code changes in 8th edition.
Standard Updated:	January 2018
Reason for Update:	ICS V9B2018 standard updated to advise that where a neonate has a risk of sepsis a HADX flag is not assigned.
Standard Updated:	January 2021
Reason for Update:	ICS 0048 expanded to include the full advice in ACS 0048 as applies in Ireland. Standard put into Part A and Part B.

ICS 0049   DISEASE CODES THAT MUST NEVER BE ASSIGNED

ACS 0049 *Disease codes that must never be assigned* lists disease codes that are not for use in 12th edition ICD-10-AM/ACHI/ACS. **ICS 0049** removes code **R65.0** *Systemic Inflammatory response syndrome (SIRS) of infectious aetiology without acute organ failure* from the list of disease codes that must never be assigned.

Code **R65.0** *Systemic Inflammatory response syndrome (SIRS) of infectious aetiology without acute organ failure* **can be assigned in Ireland** in line with **ICS 0110** *Sepsis and Septic Shock.*

Please refer to **ICS 0110** when assigning code **R65.0** *Systemic Inflammatory response syndrome (SIRS) of infectious aetiology without acute organ failure*.

Effective From:	January 1st 2020
Reason For standard:	Change to ACS 0049 required for use in Ireland due to Irish approach to coding of SIRS of infectious origin. R65.0 can be assigned for coding of SIRS of infectious origin in Ireland.
First Published:	ICS 2020 V1
Standard Updated:	January 2024 V1.0
Reason for Update:	ICS Tile update for 0110 to Sepsis and Septic Shock

General Standards for Interventions (00--)

~~ICS 0028   PARA AORTIC LYMPH NODE BIOPSY AND RETROPERITONEAL LYMPH NODE DISSECTION PROCEDURES (RPLND)~~

ICS effective from: September 2016 as per coding advice first published in Coding Notes, September
                                   2016. ICS introduced in January 2017 V9.0.
Reason For standard: Clinical input by the National Cancer Control
Standard deleted: January 2024 V1.0. Deleted due to new lymph node procedure codes in 12th Edition.

ICS 0029   CODING OF CONTRACTED PROCEDURES

Contract procedures are not coded. Only code a procedure in the hospital where it is performed.

If a hospital arranges for valid HIPE activity to be performed off site/ on another hospital campus the HPO must be informed prior to the activity being coded.

Reason for Standard: ICS 0029 is a continuation of existing practice.
Standard Updated: ICS V9.0 January 2017
Reason for update: Standard updated to advise hospitals on HIPE activity performed off site/on
                                  another hospital campus.

ICS 0030   ORGAN PROCUREMENT AND TRANSPLANTATION

Donation or harvesting of organs following brain death in hospital is not coded by HIPE. Organ transplantation in the recipient patient is collected by HIPE.

Reason for Standard: ICS 0030 is a continuation of existing practice.
ICS Updated: January 2011
Reason for Update: Clarification of guideline. Information on organ procurement is
                                 maintained by registries.

ICS 002x DATE FOR EACH PROCEDURE CODED

8

From 1st January 2011 HIPE records the date each coded procedure was performed on. Only those procedures performed in the hospital during the admission are to be coded.

- The principal procedure will always be sequenced first regardless of the date it was performed on.
- The principal procedure must have a date recorded
- If the date of a secondary procedure is unknown the date field is to be left blank. Blank date fields are subject to audit and further data quality review
- Refer to ACS 0020 *Bilateral/Multiple Procedures* for information and guidance on coding procedures performed multiple times or bilaterally.

- In line with **ACS 0020** *Bilateral/Multiple procedures,* for multiple procedures recorded once for each admission the date the procedure was **first** performed will be recorded.

Example 1

Patient admitted with abdominal pain on 5th January 2024 and had abdominal CT scan and a colonoscopy (without anaesthesia) performed that day. Patient had laparoscopic appendicectomy performed under GA (ASA 19) on 6th January.

Procedures:		Code	Date
Principal Procedure:	*Laparoscopic appendicectomy*	**30572-00 [926]**	6/1/202x
Add'l Procedures:	*General anaesthetic*	**92514-19 [1910]**	6/1/202x
	Fibre-optic colonoscopy to caecum	**32090-00 [905]**	5/1/202x

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Example 2

Patient admitted as an emergency on 10th January 2024 with multiple lacerations following a car crash, patient was transfused with 2 units of packed cells and later that day had abdominal lacerations (soft tissue level) sutured under sedation in theatre. Patient had multiple contusions on the scalp and underwent a CT brain on the 11th January. On the 12th January patient received 1 unit of packed cells. Patient was discharged on 13th January.

Procedures:		Code	Date
Principal Procedure:	*Suture lacerations-soft tissue*	**30029-00 [1635]**	10/1/202x
Add'l Procedures:	*Sedation*	**92515-99 [1910]**	10/1/202x
	Transfusion packed cells	**13706-02 [1893]**	10/1/202x

ICS effective from:	January 2011
Reason For standard:	Identification of dates for all procedures requested by DoH&C and HSE.
Standard Updated:	References to ACS 0020 revised and Examples updated for 8th edition ICD-10-AM/ACHI/ACS

ICS 0042   PROCEDURES NOT NORMALLY CODED – CODING OF ULTRASOUND GUIDED PROCEDURES 🔢12

ICS 0042 provides additional guidance on the coding of ultrasounds. The general guidance in **ACS 0042** *Procedures Not Normally Coded* applies to ultrasounds. Also for clarification please note the following points in relation to the coding of ultrasounds:

- If cerebral anaesthesia (general anaesthetic or sedation) is required to perform *the ultrasound* itself then the ultrasound can be coded
- If the ultrasound is being performed as guidance for another procedure the ultrasound is not to be coded unless required to do so by a specialty standard.
- If a patient is admitted as a day case specifically for an ultrasound – the ultrasound can be coded. However if the patient is admitted as a day case for an ultrasound guided procedure – code the procedure performed and not the ultrasound.

The following four procedures are listed as exceptions under point 11 of **ACS 0042** *Procedure not Normally Coded* and therefore **will be coded when performed**:

- *Endoscopic ultrasound (EUS)* **(30688-00 [1949])**
- (*Intravascular ultrasound (IVUS)* **(96272-00 [1949])**
- *Transoesophageal echocardiogram (TOE)* **(55118-00 [1942])**
- *Optical coherence tomography (OCT)* **(11219-00 [2016])**

ICS 0044   PHARMACOTHERAPY 🔢10

ICS 0044 provides classification guidance on the coding of pharmacotherapy in Ireland. In Ireland daycases for treatment of neoplasm related conditions are coded in the same way as treatment of neoplasms as this enables reporting of data relating to cancer services.

Note: When coding pharmacotherapy for neoplasms and/or neoplasm related conditions coders are also advised to review **ICS 0206** which complements this standard. Guidelines relating to pharmacotherapy for specific conditions may be found in specialty standards (see for example **ACS 0102** *HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome*) and **ACS 1615** *Specific diseases and interventions related to the sick neonate*).

CLASSIFICATION
Same-day episodes of care for pharmacotherapy for neoplasm or neoplasm related condition.

For episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the
patient is discharged on the same-day as the admission, assign:
- **Z51.1** *Pharmacotherapy session for neoplasm as principal diagnosis*
- a code for the neoplasm being treated as the first additional diagnosis
- additional diagnosis code(s) for any neoplasm related condition(s) being treated
- the appropriate procedure code from [**1920**] *Administration of Pharmacotherapy with an extension of -00 antineoplastic agent*

Same-day episodes of care for pharmacotherapy for conditions other than neoplasms
For episodes of care for pharmacotherapy for conditions other than neoplasms, where the patient is
discharged on the same-day as the admission, assign:
- a code for the condition as per **ACS 0001** *Principal Diagnoses* and **ACS 0002** *Additional Diagnoses*
- the appropriate procedure code/s from [**1920**] *Administration of pharmacotherapy for conditions other than neoplasms* in line with **ACS 0042** *Procedures not normally coded.*

Administration of pharmacotherapy during multi-day episodes of care
Where pharmacotherapy is administered during multi-day episodes of care, assign a code for the condition requiring treatment and the appropriate procedure code(s) (see example 5)

Pharmacotherapy procedure coding
When a patient receives pharmacotherapy a number of times during an episode of care and the same procedure code applies, assign the procedure code only once.
Oral chemotherapy is coded when administered

EXAMPLE 1:
Patient admitted for same-day chemotherapy for prostate cancer. Intravenous (IV) cyclophosphamide given, patient discharged same-day.
Codes:
Z51.1 *Pharmacotherapy session for neoplasm*
C61 *Malignant neoplasm of prostate*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

EXAMPLE 2:
Patient previously diagnosed with metastatic bone cancer from the breast and admitted for same-day
IV infusion of Aredia for hypercalcaemia.
Codes:
Z51.1 *Pharmacotherapy session for neoplasm*
C79.5 *Secondary malignant neoplasm of bone and bone marrow*
C50.- *Malignant neoplasm of breast*
E83.5 *Disorders of calcium metabolism*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

EXAMPLE 3:

Patient admitted for same-day IV infusion of methylprednisone for multiple sclerosis.
Codes:
G35 Multiple *sclerosis*
96199-03 [**1920**] *Intravenous administration of pharmacological agent, steroid*

EXAMPLE 4:

Patient admitted for course of chemotherapy for breast cancer over twelve days. Intravenous chemotherapy (5FU) was administered.
Codes:
C50.- *Malignant neoplasm of breast*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

EXAMPLE 5:

Patient admitted with a five day history of increasing abdominal distension and pain especially on deep inspiration. Last opened bowels today. Diagnosed 12 months ago with serous papillary adenocarcinoma of right ovary with metastases to the peritoneum. Chemotherapy administered over the past six months. A peritoneal tap was performed under local anaesthetic (LA) to treat the malignant ascites. Three days later IV chemotherapy administered without any problems. Final diagnosis: malignant ascites. At discharge, patient well and mobilising freely.
Codes:
C78.6 *Secondary malignant neoplasm of retroperitoneum and peritoneum*
C56 *Malignant neoplasm of ovary*
30406-00 [**983**] *Abdominal paracentesis*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

EXAMPLE 6:

Patient with small cell lung carcinoma admitted for dehydration and anaemia due to recent chemotherapy.
Intravenous (IV) hydration was administered on day 1.
Patient received an IV iron infusion and was discharged on the following day.
Codes:
E86 *Volume depletion*
D64.9 *Anaemia, unspecified*
Y43.3 *Other antineoplastic drugs causing adverse effects in therapeutic use*

In this example, **E86** and **D64.9** are assigned in accordance with **ACS 0001**, as dehydration and anaemia both equally meet the definition for principal diagnosis. **Z51.1** *Pharmacotherapy session for neoplasm* is not assigned as this is an inpatient case and also the admission is for a treatment related condition and not a neoplasm or neoplasm related condition.
Neoplasm codes are not assigned as the lung carcinoma does not meet the criteria in **ACS 0002** (see also **ACS 0236**).
See also **ACS 1902** *Adverse effects*.
ACHI codes for the IV infusions (hydration and iron infusion) are not assigned as they do not meet the guidelines in **ACS 0042**.

EXAMPLE 7

A patient with acquired immunodeficiency syndrome (AIDS) status presents for same-day administration of multidrug intravenous (IV) infusion for pulmonary mycobacterium avium complex (MAIC).
Codes:
A31.0 *Pulmonary mycobacterial infection*
B20 *Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases*
96199-19 [**1920**] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent.*

In this example, **A31.0** is assigned as it meets the definition of principal diagnosis. **B20** is assigned as HIV is a condition requiring mandatory code assignment, in accordance with **ACS 0002**. See also ACS *0102 HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome)*. **96199-19** [**1920**] is assigned as it is the principal reason for admission in a same-day episode of care.

IV Hydration for treatment of neoplasms or neoplasm related conditions

IV hydration for treatment of neoplasms or neoplasm related conditions can be coded. The procedure code assigned is **96199-00** [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent.* Please note:

- Code **96199-00** [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent* will only be assigned once even if different drugs or substances are delivered intravenously during the episode of care to treat the neoplasm or neoplasm related condition e.g. IV chemotherapy drug and IV hydration administered during one admission.
- The advice in **ACS 0042** *Procedures not normally coded* applies to IV hydration and chemotherapy is listed as an exception. IV hydration will not be routinely coded for other conditions.

Effective From:	January 2005 (as code available in ICD-10-AM/ACHI/ACS). Advice first published on coding this procedure provided in ICD-10-AM 4th Edition pre-implementation workshops
Reason for Standard:	Collection of hospital activity
Standard Updated:	September 2021
Reason for Update:	Standard updated following advice in CR Q3073 on IV hydration in chemotherapy.
Standard Deleted:	January 2024 V1.0. ICS 0044 deleted due to changes in 12th Edition. See ICS 0206 for administration of oral chemotherapy for neoplasms. For information on IV hydration, see ACS 0044 and example 3.
Standard Updated & Implemented:	April 2024 V1.2. ICS 0044 implemented as 'Pharmacotherapy'
Effective From:	1st April 2024, coders can apply this guidance to 2024 discharges from before 1st April
Reason for Update:	The 12th edition changes to the coding of neoplasm related conditions will not apply in Ireland as the removal of the Z code, the neoplasm and the procedure code for administration of anti-neoplastic from the data set for these cases would be a challenge in reporting cancer services activity. Also coders may not be able to identify if the admission is for treatment of neoplasm or a neoplasm related condition. For these reasons, Ireland has decided to continue coding neoplasms and neoplasm related conditions in the same way and as per 10th Edition guidance.

ICS 004x SEQUENCING OF RADIOTHERAPY AND CHEMOTHERAPY WHEN ADMINISTERED ON THE SAME DAY CASE ADMISSION.

When radiotherapy and chemotherapy are administered on the same day case admission, sequence the diagnosis and procedure code for the chemotherapy first. This ensures that the sequence of codes is consistent for all such cases. This type of treatment may also be called concurrent chemoradiation.

Due to the low number, and specialist nature, of cases recording this combination of treatments the Batch Coder cannot be used for these discharges.

Example 1
Patient admitted as a day case for IV chemotherapy (Cisplatin) and a radiotherapy treatment (single modality linear accelerator) on the same admission.

Assign: Pdx: **Z51.1** *Pharmacotherapy session for neoplasm*
            Add'l Dx: **Z51.0** *Radiotherapy session*
                        Neoplasm codes
                        Any other conditions meeting **ACS 0002**

            P. Proc: **96199-00** [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*
            Add'l Proc: **15224-00** [**1788**] *Radiation treatment, megavoltage,1 field, single modality linear accelerator*

ICS Effective from: January 2011
Reason for standard: Standardise sequencing of chemo-radiotherapy in day cases.

ICS 0042   PROCEDURES NORMALLY NOT CODED

ICS Effective From:	July 2006
Advice First Published:	Coding Notes April 2005
ICS Updated:	January 2007 to include guidelines for coding haemochromatosis and venesection.
	January 2009 in accordance with revised ACS 0042 in 6th Edition ACS
Reason for Standard:	Collection of blood is a standard treatment that is unnecessary to code.
Standard Deleted:	Standard deleted January 2009 V2 ICS. See ICS 040X Haemochromatosis and venesection. Also see ICS 030X Blood tests
ICS reintroduced:	A new version of ICS 0042 introduced from January 2021 to provide guidance on the coding of ultrasound guided procedures.

ICS 0053 Robotic Assisted Intervention

ICS Effective From:	January 2019
Advice First Published:	Coding Notes July 2018
Reason for Standard:	Introduction of a new procedure code in advance of ICD-10-AM/ACHI/ACS 10th Edition for robotic assisted procedures. ICS 0053 reflects the advice in 10th edition for ACS 0053 robotic assisted procedures. Note that this is a 10th Edition ICD-10-AM/ACHI/ACS code.
Standard Deleted	Standard deleted as advice included in ACS 0053 Robotic assisted procedures and code is available in 10th edition classification.

Chapter 1 Certain Infectious and Parasitic Diseases (01--)

ICS 0104 ~~Viral Hepatitis~~ **8**

First Published:	Coding Notes, March 2008
Effective From:	March 2008
Reason for Standard:	Query to WHO-URC from Ireland on the use of code Z22.52 *carrier of Hepatitis C*. Patients are either in an acute or chronic phase of hepatitis C. Advised by the WHO-URC committee that code Z22.52 *Carrier of Viral Hepatitis C* is under review.
Standard Deleted:	Standard deleted as advice incorporated into 8th edition ICD-10-AM/ACHI/ACS and ACS 0104.

ICS 0110   SEPSIS AND SEPTIC SHOCK   **10** **12**

The guidelines in **ACS 0110** *Sepsis and Septic Shock* apply in Ireland. **ICS 0110** provides guidance on collection of HIPE data in 12th edition of ICD-10-AM for <u>SIRS of infectious origin</u>. **SIRS is not to be coded as Sepsis in Ireland**.

CLASSIFICATION

Systemic Inflammatory Response Syndrome [SIRS]

The causes of SIRS are broadly classified as infectious and <u>non-infectious</u> in origin.

Where there is documentation of SIRS due to non-infectious aetiology, assign:

- First a code for the aetiology (pancreatitis, trauma etc.)
- Followed by either **R65.2** *Systemic inflammatory response syndrome [SIRS] of non-infectious origin without acute organ failure* OR **R65.3** *Systemic inflammatory response syndrome [SIRS] of non-infectious origin with acute organ failure*, as appropriate.

Where there is documentation of SIRS due to <u>infectious aetiology</u>:
- If SIRS due to infectious aetiology and Sepsis are documented code to sepsis only
- If SIRS due to infectious aetiology without mention of sepsis
    - First code the infectious aetiology
    - Followed by code **R65.0** *Systemic inflammatory response syndrome [SIRS] of infectious origin without acute organ failure*
    - SIRS of infectious origin with organ failure – to be queried with clinician as to presence of sepsis.
    - SIRS is not to be coded as Sepsis in Ireland

For instances where SIRS was initially triggered by a non-infectious condition, and during the admission a non-infectious condition developed an infection resulting in sepsis (e.g. burns, infected burns and then sepsis), follow the above guidelines for SIRS due to

non-infectious aetiology and refer to the classification guidelines for Sepsis, Severe sepsis and Septic shock (see below) to code the infection/sepsis.

Figure 1 – flowchart for assigning ICD-10-AM codes for documented SIRS

Documented SIRS

Due to infectious aetiology such as pneumonia, UTI
- Assign first a code for the infectious aetiology
- Followed by R65.0 Systemic inflammatory response syndrome (SIRS) of infectious origin without acute organ failure
- If SIRS is documented with sepsis – code as for sepsis and do not assign R65.0

Due to noninfectious aetiology such as pancreatitis, burns

Noninfectious condition not complicated by sepsis
- Assign first a code for the aetiology
- Followed by either R65.2 or R65.3

Noninfectious condition complicated by sepsis
- Assign first a code for the aetiology
- Followed by either R65.2 or R65.3
- Followed by an appropriate code for sepsis

Example:
Patient admitted with breathing difficulties and persistent cough. Bronchopneumonia was documented and confirmed by X-ray. Patient treated with antibiotics and physiotherapy. The patient was closely monitored due to documented SIRS. No diagnosis of sepsis was made by the clinicians however both pneumonia and SIRS are listed on the discharge summary.
Codes:
J18.0 *Bronchopneumonia unspecified*
R65.0 *Systemic inflammatory response syndrome (SIRS) of infectious origin without acute organ failure*

First Published: Coding Notes July 2005
Published Also: Coding Notes December 2005
                              ICS V2.0 January 2009
ICS Updated: Updated for ICS V2.0 as methicillin resistance is excluded from Z06.8
Reason for Standard: This Standard provides coding advice on colonisation with a drug resistant
                              bacterial agent when no infection is present. Coding advice follows
                              guidelines used in previous classifications.
Standard Updated: Standard updated for 8th edition ICD-10-AM/ACHI/ACS to reflect advice in ACS 0112 on the
                              coding of drug resistance and change of codes in Z06 category
Standard Updated: Standard updated for 10th edition ICD-10-AM/ACHI/ACS to reflect change in the classification of
                              multiple drug resistance when one of the drugs is methicillin – in 10th edition each drug
                              resistance is coded separately.
Standard Deleted: January 2024 V1.0. Standard deleted as advice on colonisation is included in ACS 0112.

ICS 0113   CORONAVIRUS (COVID-19) 12

- Guidance on the coding of COVID-19 is provided in **ACS 0113** *Coronavirus Disease 2019 (COVID-19).*

- Please note that the COVID -19 flag is a separate administrative variable and to flag when a patient has laboratory confirmed COVID-19 at any time in the past or present – See Section 2: *HIPE Guidelines for Administrative Data* – Item XI: *LABORATORY CONFIRMED COVID-19 PAST OR PRESENT FLAG* for full details on the collection of this variable.

- Where a patient has an adverse reaction to a COVID-19 Vaccination the information below provides guidance on the relevant codes for vaccines in use in Ireland

Vaccine	*Vector*	*Coded* *Adverse Effect*
Comirnaty (BioNTech) (Pfizer)	mRNA	Nucleic Acid ✺U07.74
Spikevax (Moderna) (Oxford)	mRNA	Nucleic Acid ✺U07.74
Vaxzevria (AstraZeneca)	Adenoviral vector	Viral Vector ✺U07.71
Jcovden (Janssen) (Johnson & Johnson)	Adenoviral vector	Viral Vector ✺U07.71
Nuvaxovid	Protein	Subunit ✺U07.73
COVID-19 Vaccine Valneva (VLA2001) (Valneva)	Inactivated	Whole Virus ✺U07.72
VidPrevtyn Beta (Sanofi Pasteur)	Protein	Subunit ✺U07.73
Bimervax (HIPRA Human Health S.L.U.)	Protein	Subunit ✺U07.73

(Status: Current)
ICS effective from: January 2024 V1.0
Reason for Standard: ACS 0113 Coronavirus Disease 2019 (COVID-19) introduced in 12th edition which provides detailed
                              coding instructions. ICS 0013 provides guidance specific to Ireland on COVID-19.

ICS 010x   VEROTOXIGENIC E-COLI (VTEC) & Haemolytic Uraemic Syndrome (HUS)

"Verotoxigenic E. coli (VTEC) infections produce a potentially serious, highly infectious diarrhoeal and systemic illness. In about 10% of cases VTEC causes Haemolytic Uraemic Syndrome (HUS), the most common cause of renal failure in children.

HUS is a clinical syndrome characterised by a haemolytic anaemia, acute renal failure and thrombocytopenia. First described in 1955, it is today most frequently associated with diarrhoeal infection with VTEC. HUS is the commonest cause of acute renal failure in children."[10]

Reported VTEC incidence rates in Ireland have been rising steadily over the last five years, such that in 2008 and 2009, Ireland reported the highest VTEC incidence rate of any member state in the European Union.[11]

Classification:
While there is no index entry for Verotoxigenic E. coli infection in ICD-10-AM/ACHI/ACS, a review of other ICD-10 based classifications indicates that this condition is coded to **A04.3** *Enterohaemorrhagic Escherichia coli infection* in Canada[12] and New Zealand[13]. In SNOMED, 240354007 Verotoxigenic E. Coli gastrointestinal tract disorder maps to ICD-10 code **A04.3** *Enterohaemorrhagic Escherichia coli infection*[14].

Coding Guidelines:
1. When a diagnosis of VTEC* is documented please assign
    A04.3 *Enterohaemorrhagic Escherichia Coli infection*.
2. If patients also have Haemolytic-Uraemic Syndrome (HUS) also assign code
    D59.3 *Haemolytic-Uraemic Syndrome*
3. Also, code any associated acute or chronic kidney failure.

Further information on this condition can be found on the Health Protection Surveillance Centre website www.hpsc.ie

* A case of VTEC is someone in whom an infection with a verotoxin-producing E. coli has been detected. E.g. either by isolation of a verotoxin (VT)-producing E. coli from a stool specimen, or by detection of the genes (vt genes) for verotoxin production from a stool specimen using Polymerase Chain Reaction (PCR). VTEC may sometimes also be referred to as Enterohaemorrhagic E. coli (EHEC) or Shiga toxin producing E. coli (STEC) - the genes for the toxin produced by the latter being referred to as shiga toxin (stx) genes. Common strains include serogroup E. coli O157, E. coli O26, E. coli O111 and E. coli O145, although this list is by no means exhaustive.

Example:

[10] http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/GastroenteritisorIID/Guidance/Diseasespecificchapters/File,13525,en.pdf
[11] http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/VTEC/Publications/AnnualReportsonEpidemiologyofVerotoxigenicEcoli/File,13128,en.pdf
[12] http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/vtec_cd.pdf
[13] http://foodsafety.govt.nz/elibrary/industry/foodborne-disease-nz-doc.pdf
[14] http://bioportal.bioontology.org/ontologies/46896?p=terms&conceptid=240354007

A child is admitted through the ED with diarrhoea and haemorrhagic colitis. He also has a headache and anorexia and has gone into acute renal failure. Tests show that the child has Verotoxigenic E. Coli with Haemolytic-Uraemic Syndrome.

Principal Diagnosis: **A04.3** *Enterohaemorrhagic Escherichia coli infection*.
Additional Diagnoses: **D59.3** *Haemolytic-uraemic syndrome*
                         N17.9 *Acute Renal Failure*

First Published:	ICS V6.0
Effective From:	January 2014
Reason for Standard:	This guideline has been developed in conjunction with Specialists in Public Health Medicine and the HPSC to provide a national standard for the coding of VTEC.

~~ICS 01X0   ZIKA VIRUS – WHO alert~~ 12

First Published:	ICS V8.0
Effective From:	January 2016
Reason for Standard:	As per WHO instructions received on 16th December 2015, Zika virus is to be reported using code U06.9 *Emergency use of U06.9* instead of the ICD-10-index entry of A92.8 *Other specified mosquito-borne viral fevers.*
Standard Updated:	ICS V9.0 January 2017
Reason for Update:	As per advice from ACCD on coding of Zika Virus.
Standard Deleted:	January 2024 V1.0. Standard deleted as it is incorporated into the classification and coded to A92.5 ZIKA Virus with additional codes available for maternity and neonates

Chapter 2   Neoplasms (02--)

ICS 0206 PHARMACOTHERAPY FOR NEOPLASMS

In Ireland, day cases for treatment of neoplasm related conditions are coded in the same way as treatment of neoplasms as this enables reporting of data relating to cancer services. **ICS 0206** *Pharmacotherapy for neoplasms* provides classification guidance and examples for Ireland and follows the format of **ACS 0206**. **ICS 0206** provides classification guidance on the coding of pharmacotherapy in Ireland and some of the advice in this ICS is replicated in **ICS 0044** *Pharmacotherapy* for completeness.
Note:
In Ireland, for guidelines regarding pharmacotherapy for treatment of 'neoplasm related' or 'neoplasm treatment related' conditions, see also **ICS 0044** *Pharmacotherapy*.
ICS 0044 *Pharmacotherapy* also provides guidance on pharmacotherapy for conditions other than neoplasms.

DEFINITION/DESCRIPTION
Pharmacotherapy for neoplasms is the administration of a substance (usually a drug) for a neoplasm, for the purposes of treatment or prophylaxis. For classification purposes, an antineoplastic agent is any pharmacotherapy substance used in the treatment of neoplasms. In Ireland, the procedure code for administration of antineoplastic agents is used for neoplasms **and** neoplasm related conditions.
Prophylactic pharmacotherapy for neoplasms is the administration of antineoplastic agents to prevent the development of neoplasia (eg prophylaxis to prevent hydatidiform mole becoming cancerous) or the spread of a neoplasm (eg central nervous system (CNS) prophylaxis to prevent the spread of a neoplasm to the CNS).

CLASSIFICATION
Same-day episodes of care
Where pharmacotherapy is administered for a neoplasm and/or a neoplasm related condition, and the admission and discharge are on the same date, use the following guidelines.
Pharmacotherapy for neoplasm
Where pharmacotherapy is administered for a neoplasm (see Examples 1 and 2), assign:
   - **Z51.1** *Pharmacotherapy session for neoplasm* as principal diagnosis

- additional diagnosis code(s) for the neoplasm(s) (see also **ACS 0236** *Neoplasm coding and sequencing*)
- ACHI code(s) from block [**1920**] with extension -00 Antineoplastic agent.

Simultaneous pharmacotherapy for neoplasms and neoplasm related conditions
Where pharmacotherapy is administered for a neoplasm and a neoplasm related condition
- **Z51.1** *Pharmacotherapy session for neoplasm* as principal diagnosis
- a code for the neoplasm being treated as the first additional diagnosis
- additional diagnosis code(s) for any neoplasm related condition(s) being treated
- the appropriate procedure code from [**1920**] *Administration of pharmacotherapy* with an extension of -00 *antineoplastic agent*. Extension -00 *antineoplastic agent* is applied for treatment of neoplasms and neoplasm related conditions.

Simultaneous pharmacotherapy for neoplasms/neoplasm related conditions and conditions other than neoplasms
Where pharmacotherapy is administered for a neoplasm and/or a neoplasm related condition and a nonneoplastic condition (ie a condition other than a neoplasm) (see Example 3), assign codes in the following sequence:
- **Z51.1** *Pharmacotherapy session for neoplasm* as principal diagnosis
- additional diagnosis code(s) for the neoplasm(s) (see also **ACS 0236** *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition(s) being treated
- additional diagnosis code(s) for other non-neoplastic condition(s) in accordance with **ACS 0002** *Additional diagnoses*
- ACHI code(s) from block [**1920**] with extension -00 *Antineoplastic agent*
- appropriate ACHI code(s) to indicate the treatment for the non-neoplastic condition

Prophylactic pharmacotherapy for neoplasms
Where pharmacotherapy is administered for neoplasm prophylaxis (see Example 4), assign:
- **Z29.21** Prophylactic pharmacotherapy for neoplasm as principal diagnosis
- additional diagnosis code(s) for the neoplasm(s) if applicable (see also **ACS 0236** *Neoplasm coding and sequencing*)
- ACHI code(s) from block [**1920**] with extension -00 *Antineoplastic agent*.

Do not assume the intent of administration of a pharmacotherapy agent is for prophylactic purposes; prophylactic pharmacotherapy must be clearly documented.

Multi-Day Episodes Of Care
Where pharmacotherapy is administered to treat a neoplasm and/or a neoplasm related condition during a multi-day episode of care (see Examples 5, 6 and 7), assign:
- code(s) for the neoplasm(s) in accordance with **ACS 0001** *Principal diagnosis* or **ACS 0002** *Additional diagnoses*, (see also **ACS 0236** *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition(s) being treated
- ACHI code(s) from block [**1920**] with extension -00 *Antineoplastic agent*.

Do not assign **Z51.1** *Pharmacotherapy session for neoplasm* or **Z29.21** *Prophylactic pharmacotherapy for neoplasm* in a multi-day episode of care.

OTHER CLASSIFICATION GUIDELINES
Oral administration of pharmacotherapy for neoplasm **is assigned** when it is administered during the episode of care.

Do not assign the same ACHI code for pharmacotherapy more than once in an episode of care.

EXAMPLE 1:
Patient was admitted for chemotherapy for prostate cancer. Oral docetaxel (Oradoxel) was administered, and the patient was discharged on the same-day.
Codes: **Z51.1** *Pharmacotherapy session for neoplasm*
C61 *Malignant neoplasm of prostate*
96203-00 [**1920**] *Oral administration of pharmacological agent, antineoplastic agent*

In this example, **Z51.1** is assigned as a principal diagnosis to identify a same-day episode of care for pharmacotherapy for a neoplasm. **C61** is assigned to identify the neoplasm being treated. **96203-00** [**1920**] is assigned as oral pharmacotherapy is the only route of administration of treatment for the neoplasm.

EXAMPLE 2:
A patient with Kaposi sarcoma of the skin due to human immunodeficiency virus (HIV) was admitted for sameday intravenous (IV) chemotherapy to treat the Kaposi sarcoma.
Codes: **Z51.1** *Pharmacotherapy session for neoplasm*
C46.0 *Kaposi sarcoma of skin*
B21 *Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

In this example, **Z51.1** is assigned as a principal diagnosis to identify a same-day episode of care for pharmacotherapy for a neoplasm. **C46.0** is assigned to identify the neoplasm in accordance with classification guideline Same-day episode of care/Pharmacotherapy for neoplasm. **B21** is assigned in accordance with ACS *0102 HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome)*. **96199-00** [**1920**] is assigned to identify IV administration of pharmacotherapy for neoplasm.

EXAMPLE 3:
Patient with breast cancer and anaemia was admitted for same-day chemotherapy and iron infusion. Intravenous (IV) Doxorubicin was administered.

The patient was also administered an IV iron infusion for their pre-existing anaemia (not neoplasm or treatment related).
Codes: **Z51.1** *Pharmacotherapy session for neoplasm*
C50.9 *Malignant neoplasm of breast, unspecified part*
D64.9 *Anaemia, unspecified*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*
96199-19 [**1920**] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent*

In this example, simultaneous pharmacotherapy is administered and includes treatment for a neoplasm (chemotherapy for breast cancer) and treatment for a non-neoplastic condition (iron infusion for anaemia).

Z51.1 is assigned as a principal diagnosis and **C50.9** and **D64.9** are assigned as additional diagnoses. **96199- 00** [**1920**] is assigned to identify intravenous administration of pharmacotherapy agents for neoplasm. **96199- 19** [**1920**] Intravenous administration of pharmacological agent, other and unspecified pharmacological agent is assigned for the iron infusion as this is a day case and a reason for admission.

EXAMPLE 4:
Patient with B-cell acute lymphoblastic leukaemia was admitted for same-day chemotherapy for central nervous system (CNS) prophylaxis to prevent potential spread.
Intrathecal chemotherapy (methotrexate) was administered and the patient was discharged the same day.
Codes: **Z29.21** *Prophylactic pharmacotherapy for neoplasm*
C91.00 *Acute lymphoblastic leukaemia [ALL], without mention of remission*
96198-00 [**1920**] *Intrathecal administration of pharmacological agent, antineoplastic agent*

In this example, **Z29.21** is assigned as principal diagnosis to identify a same-day episode of care for prophylactic chemotherapy for a neoplasm, as documented. **C91.00** is assigned as an additional diagnosis to identify the applicable neoplasm. **96198-00** [**1920**] is assigned to identify intrathecal administration of antineoplastic agent.

EXAMPLE 5:
Patient admitted with a five day history of increasing abdominal distension and pain. They were diagnosed 12 months prior with serous papillary adenocarcinoma of the right ovary with metastases to the peritoneum.
A peritoneal tap was performed under local anaesthetic (LA) to treat the malignant ascites.
Three days later IV chemotherapy was administered. Final diagnosis: malignant ascites.
Codes: **C78.6** *Secondary malignant neoplasm of retroperitoneum and peritoneum*
C56 *Malignant neoplasm of ovary*
30406-00 [**983**] *Abdominal paracentesis*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*

In this example, **C78.6** is assigned as it meets the definition of principal diagnosis. **C56** is assigned as it meets the criteria in **ACS 0236** *Neoplasm coding and sequencing*.
96199-00 [**1920**] is assigned to identify intravenous administration of pharmacotherapy for neoplasm. See also ACS *0016 General procedure guidelines*.

EXAMPLE 6:
Patient admitted for a twelve day course of chemotherapy for breast cancer.
Intravenous (IV) Doxorubicin and subcutaneous Trastuzumab were administered.
Codes: **C50.9** *Malignant neoplasm of breast, unspecified part*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*
96200-00 [**1920**] *Subcutaneous administration of pharmacological agent, antineoplastic Agent*

In this example, **C50.9** is assigned as it meets the definition of principal diagnosis. **96199-00** [**1920**] and **96200- 00** [**1920**] are assigned to identify intravenous and subcutaneous administration of pharmacotherapy agents for neoplasm.

EXAMPLE 7:
Patient was diagnosed with small cell lung carcinoma with metastatic spread to bone and is admitted for an
intravenous (IV) Carboplatin and oral etoposide regimen by their oncology specialist. Patient was admitted for cycle 1 of the chemotherapy regimen. On day 1, carboplatin and etoposide were administered intravenously.
Etoposide was administered orally once a day on days 2 and 3. Patient was discharged on day 3.
Codes: **C34.9** *Malignant neoplasm of bronchus and lung, unspecified*
C79.5 *Secondary malignant neoplasm of bone and bone marrow*
96199-00 [**1920**] *Intravenous administration of pharmacological agent, antineoplastic agent*
96203-00 [**1920**] *Oral administration of pharmacological agent, antineoplastic agent*

In this example, **C34.9** is assigned as it meets the definition of principal diagnosis. **C79.5** is assigned as an additional diagnosis as it identifies a secondary (metastatic) site documented in the current episode of care. **96199-00** [**1920**] is assigned to identify intravenous administration of pharmacotherapy for neoplasm. **96203-00** [**1920**] is assigned as oral pharmacotherapy for neoplasm was administered during the episode of care.

ICS 0229 RADIOTHERAPY

Coding of IMRT and IGRT

The following guidelines apply to the coding of intensity modulated radiotherapy (IMRT) and image guided radiotherapy (IGRT). This standard applies to cases where radiotherapy treatment is administered.

- **Intensity Modulated Radiotherapy (IMRT)**: This procedure is coded using 2 codes –
  1. The appropriate radiotherapy treatment code; e.g.
  [**1788**]**15269-00**   *Radiation treatment, megavoltage, ≥2 fields, dual modality linear accelerator*
  2. IMRT Dosimetry code;
  [**1799**] **15524-01**   *Dosimetry by CT interfacing computer for intensity modulated radiation therapy [IMRT]*

- **Image Guided Radiotherapy (IGRT)**: This procedure is coded using 2 codes:
  1. The appropriate radiotherapy treatment code; e.g.
  [**1788**]**15269-00**   *Radiation treatment, megavoltage, ≥2 fields, dual modality linear accelerator*

  2. The following code for image guidance;
  [**1798**] **15550-00**   *Radiation field setting for three dimensional conformal radiation therapy [3DCRT]*

- **Where a patient has both IMRT and IGRT** 3 procedure codes are required;
  1. The appropriate radiotherapy treatment code; e.g.

  [**1788**]**15269-00**   *Radiation treatment, megavoltage, ≥2 fields, dual modality*
  linear accelerator

  2. The IMRT Dosimetry code;

  [**1799**] **15524-01**   *Dosimetry by CT interfacing computer for intensity*
  modulated radiation therapy [IMRT]

  3. IGRT Image guidance code;

  [**1798**] **15550-00**   *Radiation field setting for three dimensional conformal*
  radiation therapy [3DCRT]

ICS 0233   MORPHOLOGY

Morphology codes are not assigned in Ireland.

02X1   RADIOTHERAPY PLANNING

Where a patient is admitted for radiotherapy planning and radiotherapy treatment is not administered during the admission, code **Z51.0** *Radiotherapy Session* is not assigned.

Admission for radiotherapy planning only will have a principal diagnosis of the neoplasm.

For additional information see also Coding Rules *Ref No: Q2687 | Published On: 15-Dec-2012 | Status: Current*

Chapter 3 Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism (03--)

ICS 030x   BLOOD TESTS/COLLECTION OF BLOOD FOR DIAGNOSTIC PURPOSES

Procedure codes for collection of blood for diagnostic purposes or for routine blood tests are not to be coded.

ICS Effective From:	This standard was created in January 2009 and incorporates advice from ICS 0042, July 2007
Advice First Published:	Coding Notes April 2005 and ICS 0042 published July 2007
ICS Updated:	This standard was created in January 2009 in accordance with existing guidelines and contains information previously contained in ICS 0042
Reason for Standard:	Collection of blood is a standard treatment that is unnecessary to code.

ICS 040X   HAEMOCHROMATOSIS AND VENESECTION

HIPE Collection of Haemochromatosis and Venesection

- Day case admissions of patients with a diagnosis of haemochromatosis admitted for venesection may be coded if the activity occurs in an area where activity is normally collected by HIPE e.g. designated dayward.

- *Venesection for haemochromatosis performed in out-patient or clinic type settings are not coded on HIPE.*

- Where venesection is performed in a MAU (Medical assessment unit) this is not to be reported to HIPE as elective AMAU activity is reported as Outpatients activity.

- Inpatients with a principal or secondary diagnosis of haemochromatosis are coded according to existing coding guidelines for inpatients.

ICD-10-AM codes for Haemochromatosis and venesection:

Diagnosis: **E83.1** *Disorders of iron metabolism*
                            Haemochromatosis

Procedure: **13757-00** [**725**] *Therapeutic venesection*

ICS Effective From:	July 2007 (advice previously published in ICS 0042 July 2007)
Advice First Published:	As part of ICS 0042 published July 2007
Reason for Standard:	Provide information on the coding of haemochromatosis and venesection.
ICS Updated:	This standard was created in January 2009 in accordance with existing guidelines and contains information previously published in ICS 0042
Further Update:	Updated in V9B2018 January 2018 as elective AMAU activity is not to be reported to HIPE.

ICS 0604 CEREBROVASCULAR ACCIDENT (CVA) 🔟2️⃣

ICS 0604 has been created to provide an additional example for Irish coders in relation to the transfer of stroke patients following surgery for a stroke.

Example:

Hospital A: Patient brought to A&E where a stroke was diagnosed. They were stabilised in A&E and transferred to Hospital B on 1st February, where they were admitted and a thrombectomy was performed for cerebral infarction of the pre-cerebral arteries due to thrombosis. They were transferred back to Hospital A on 2nd February for continuing treatment and were discharged home on 16th February.

Hospital B (1st - 2nd February)
Pdx: **I63.0** *Cerebral infarction due to thrombosis of precerebral arteries*

Hospital A (2nd – 16th February)
Pdx: **I63.0** *Cerebral infarction due to thrombosis of precerebral arteries*

As per **ACS 0604** *CVA*: "While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign a code from category **I60-I64** (cerebrovascular diseases) with any applicable deficit codes." Therefore, in the example above the stroke will be coded as the principal diagnosis in both episodes of care as the patient is having continuing treatment for the stroke.

First Published:	January 2021
Effective from:	Continuation of existing advice
Reason for standard:	Clarification on the coding of transfers following surgery for stroke and to publish previously issued coding advice.
Standard Updated:	January 2024 V1.0.
Reason for Update:	Change to the title of the standard in 12th Edition update.
Standard Updated:	January 2024 V1.1.
Reason for Update:	Change to the title of the Example from 'Example 3' to 'Example'.

**ICS 090X   MYOCARDIAL INFARCTION (MI) WITH CORONARY ARTERY
DISEASE (CAD)**

Please see guidance below from the Australian Consortium for Classification
Development (ACCD) in response to a query from the HPO on the sequencing of MI and
CAD in patients where both condition are present.

Australian Consortium for Classification Development

HPO QUERY DETAILS:
"We have queries in from hospitals and also The National Audit of Hospital Mortality
(NAHM) querying the sequencing of MIs Vs. CAD when the patient is stented. Coding Rules
Ref No: Q2878 mentions there may be a review of the ACS. We would welcome advice
from the ACCD on the sequencing of the conditions when atherosclerosis is identified and
stented. Does the MI always take precedence or does the CAD take precedence when an
intervention is performed during that short period of time?

This sequencing issue relates to evolving events where the patient is treated across two
hospitals, where the MI is reason for care (or admission i.e. PDX) in the first hospital, does
this diagnosis carry through to the second hospital where the patient is stented for CAD?
This query is arising where patients are brought to hospitals for angiography immediately
following an MI, if stenting is performed for CAD. Which condition is sequenced first, MI or
CAD, where both are present on the initial presentation and the patient is stented?"

ACCD Response:
"A percutaneous coronary intervention (PCI) is performed to open coronary arteries that
are narrowed or blocked by atherosclerotic plaque. PCI may be used to relieve
symptoms of coronary artery disease (CAD) or to reduce heart damage during or after
an acute myocardial infarction (AMI) (National Heart, Lung and Blood Institute, n.d.).

Code assignment for the cited scenarios is dependent upon documentation in the clinical
record (i.e. determined on a case by case basis). Assign principal and additional
diagnoses by applying the guidelines in **ACS 0001** *Principal Diagnosis* and **ACS 0002**
Additional Diagnoses.

However, note also the following:
- Where a patient is admitted with an AMI, a PCI may be performed to provide rapid
  access to reperfusion therapy as well as treat the CAD. Reperfusion therapy is
  treatment that prevents or minimises further tissue damage to the heart by restoring
  blood flow through blocked coronary arteries. It includes thrombolytic drugs,
  coronary artery angioplasty or coronary artery bypass grafting. Early reperfusion
  therapy is critical for eligible patients with AMI as the restored blood flow
  reintroduces oxygen within cells of the heart, resulting in improved cellular activity
  and heart function, ultimately reducing the probability of heart failure, arrhythmias
  and death.

(Continued overleaf)

Contd. / **ACCD Response:**

Where a patient is admitted specifically for a coronary angiogram, angioplasty or bypass graft following a recent AMI, and CAD is a documented finding/indication for the intervention, assign a code for the CAD as principal diagnosis. Assign as an additional diagnosis, a code from category I21 *Acute myocardial infarction,* if the admission is within 4 weeks (28 days) from onset of the AMI.

Documentation within the episode of care should clarify the indication for the PCI. Where documentation is ambiguous, seek clinical clarification. Amendments may be considered for a future edition of ICD-10-AM/ACHI/ACS."

Reference:
National Heart, Lung and Blood Institute, *Percutaneous Coronary Intervention*, NHLBI Bethesda MD USA, viewed 17 September 2018, https://www.nhlbi.nih.gov/health-topics/percutaneous-coronary-intervention

ICS Effective From: January 2019
Advice First Published: January 2019 ICS 2019 V1
Reason for Standard: Clarification provided by ACCD on sequencing of MI and CAD

Chapter 10 Diseases of the Respiratory System (10--)

ICS 10X1   AVIAN INFLUENZA

Effective From   **Discharges on or after 1st January 2007**
Standard Deleted: Standard deleted from 1st January 2009 as code J09 *influenza due to identified avian influenza virus* is contained in 6TH Edition ICD-10-AM

ICS 10X0   A (H1N1) INFLUENZA (SWINE FLU)

ICS effective from: July 2009
Advice first published: Coding Notes July 2009
Reason for Standard: Advisory from WHO on the coding of A (H1N1) influenza
Updated: January 2010 for suspected cases & to include examples
Standard deleted: Standard deleted from 1st January 2020 as 10th edition included a new standard ACS 1012 Influenza *due to identified influenza virus*. Please refer to ACS 1012 *Influenza due to identified influenza virus* for guidance on assignment of code J09 *influenza due to identified zoonotic or pandemic influenza virus*.

ICS 1006   VENTILATORY SUPPORT

ICS 1006 provides guidance on the coding of ventilatory support. Part A provides general guidance on continuous ventilatory support and Part B provides guidance on the coding of "Airvo".

A: Continuous ventilatory support (CVS)

Any CVS conducted prior to admission to an inpatient ward or registered dayward is not to be included in the calculation of duration of ventilatory support.

Activity for patients admitted to virtual wards is **not** captured by HIPE including ventilatory support.

For continuous ventilatory support (CVS)/mechanical ventilation HIPE collects from 01.01.2019 the duration of CVS as an administrative variable. See also Irish Coding Standards, HIPE guidelines for administrative variables *X. Duration of continuous ventilatory support*.

B: Coding Of "AIRVO"

In line with guidance published by the ACCD and IHPA a code for non-invasive ventilatory (NIV) support cannot be assigned based on documentation of "AIRVO" alone. Where possible check with clinical staff as to whether **NIV** was provided and seek documentation of response to queries.

ACS 1006 *Ventilatory support* states "coders should ensure that NIV is being provided via the device, and not assign a code for NIV based on the device alone". In view of the advice from IHPA and in response to coding queries and data quality reviews the following clarification on the coding of AIRVO is provided for use in Ireland.

Where "AIRVO" is documented:

- Check documentation for specification of NIV, if NIV is documented with Airvo then a code for non-invasive ventilation is assigned

- If High Flow Therapy (HFT) is documented with Airvo <u>and</u> delivered via High Flow Nasal Cannula (HFNC) then a code for non-invasive ventilation can be assigned. High flow oxygen is not to be coded as non-invasive ventilation (see further information below)

- If High Flow Nasal Cannula (HFNC) is documented with "Airvo" then a code for non-invasive ventilation can be assigned.

- If only "Airvo" is documented – do not assign a code for non-invasive ventilation.

- Please note: High flow oxygen is not to be coded as non-invasive ventilation as per advice published by the ACCD as high flow oxygen is not the same as high flow therapy – see Coding Rule Q2953

References:
Coding Rules Ref No: Q2953 | Published On: 15-Jun-2016, Updated on 01-09-2023| Status: Current |Supersedes: TN565   SUBJECT: High flow therapy

In addition to Coding Rules Q2953, IHPA have more recently published further advice on the coding of Airvo which again provides instruction that: "Clinical documentation must be clear that high flow therapy is being provided (i.e. high flow oxygen administered via nasal cannula/prongs or tracheostomy)." (See below Coding Rule Ref No: Q3570 | Published On: 21-Sep-2020. Further update to Coding Rule Q953 was updated in September 2023).

Australian Classification Exchange   IHPA

Ref No: Q3570 | Published On: 21-Sep-2020 | Status: Current
Airvo™ device for high flow therapy

Q: What code is assigned when there is documentation of Airvo™ use for high flow therapy?

A: The Airvo™ system is a device that features a humidifier capable of delivering high flows of air/oxygen mixtures to spontaneously breathing patients via a variety of interfaces (Fisher Paykel Healthcare n.d.). The device can deliver flows of up to 60 L/minute.
Where documentation states that a high flow therapy device, such as Airvo™, is used for respiratory support and delivered via high flow nasal cannula, assign an appropriate code from block [**570**] *Noninvasive ventilatory support*.

A code for high flow therapy cannot be assigned based on delivery flow rates alone, due to variability in practice and patient requirements. Documentation must indicate 'high flow therapy' or 'high flow nasal cannula' to access an appropriate lead term, in order to be classified to block [**570**] *Noninvasive ventilatory support*.
See also coding rule Q2953 High flow therapy.

References: Fisher Paykel Healthcare n.d., *Optiflow™ high flow therapy delivery for the entire patient journey: AIRVO™ 2 humidified high flow system*, viewed 18 December 2019, https://www.fphcare.com/au/hospital/adult-respiratory/optiflow/airvo-2-system/.

Effective from:	Continuation of existing practise
First Published:	ICS V1.3 January 2008
ICS Updated:	ICS V2.0 January 2009 changes in coding of ventilatory support
Reason for standard:	Continuation of existing practice for HIPE to collect data on admitted in-patients and day cases only. This standard provides clarification of ACS 1006 for use in Ireland.
Further Update:	ICS 2019 V1
Reason for further update:	- Inclusion of virtual ward activity as valid HIPE data from 01.01.2019 - Also new HIPE administrative data variable from 01.01.2019 for collection of duration of continuous ventilatory support.
Further Update:	ICS 2019 V1.2 (September)
Reason for update:	Cessation of pilot in 2019 to collect virtual ward/ED activity. This standard has been updated to exclude any activity in ED or virtual wards.
Further Update:	Clarification on the coding of "Airvo" and to publish additional coding advice on "Airvo" from ACCD issued in September 2020.
Standard Updated:	January 2024 V1.0
Reason for update: September 2023	ICS to reflect further update to Coding Rules Ref No: Q2953 that was further updated in

ICS 1012   SUMMARY OF CLASSIFICATION OF INFLUENZA

The summary below is for guidance only and does not replace looking up codes in the alphabetic index with verification in the tabular list of diseases.

- **Influenza** – no further information

    o   Look up: **Influenza**
    > -Virus
    > --not identified

- **Influenza** - Other specified types of Influenza e.g. Influenza A, Influenza A (H3N2), Influenza A (H1N1), influenza B:

    o   Look up: **Influenza**
    > -virus
    > --identified

- **Code J09** *influenza due to identified zoonotic or pandemic influenza virus* **is restricted to influenza A/H5N1 (Avian influenza) ONLY**
    - o   This is a rare and significant condition and will be queried.
    - o   Do not assign **J09** for any other types of influenza.
    - o   J09 *influenza due to identified zoonotic or pandemic influenza* is not to be reported without clinical documentation

ICS 1204   PLASTIC SURGERY

8

Effective from:	Continuation of existing practise not to assign history codes as PDx.
First Published:	ICS V6.0 January 2014
Reason for standard:	Clarification of ACS as history codes are not assigned as PDx.
Standard Deleted:	Coding Advice in ICS 1204 incorporated into ACS 2114 in 8th edition ICD-10-AM/ACHI/ACS
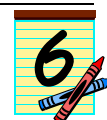
ICS 1404   ADMISSION FOR KIDNEY DIALYSIS

Dialysis day discharges

Patients admitted for dialysis in dedicated dialysis units have been collected by the HIPE system since 1st January 2006. These episodes were previously excluded from HIPE. In order to provide national data regarding the volume of patients receiving dialysis the Department of Health have requested that this activity be collected by HIPE.

- **Coding of dialysis day discharges:**

ACS 1404 *Admission for kidney dialysis* must be applied when coding kidney dialysis episodes. This will ensure that all patients admitted for dialysis, where the <u>intent</u> is a same day admission, can be identified by the principal diagnosis code of **Z49.1** *Extracorporeal dialysis* for extracorporeal dialysis or **Z49.2** *Other dialysis* for peritoneal dialysis. The term "extracorporeal dialysis" used in **ACS 1404** refers to haemodialysis as this type of dialysis takes place "outside" the body while peritoneal dialysis takes place within the body.

Mandatory codes for dialysis day discharges are as follows:

Haemodialysis
    Principal Diagnosis: **Z49.1** *Extracorporeal dialysis*
    Principal Procedure: From block [**1060**] *Haemodialysis*

Peritoneal Dialysis
    Principal Diagnosis: **Z49.2** *Other dialysis (peritoneal)*
    Principal Procedure: From block [**1061**]   *Peritoneal dialysis*

Additional codes may be assigned to collect the underlying kidney disease. Any additional conditions or complications are collected at the hospital's discretion as HIPE is identifying the number of dialysis episodes and the type of dialysis given. Due to the volume of dialysis episodes per patient a batch coding program has been developed to facilitate the collection of these cases, please contact the HIPE Unit for further information on this software.

- **Counting of Dialysis by HIPE:**

Please note that in the HIPE record when dialysis is given multiple times during an episode of care and the same procedure code applies, the procedure code is assigned once only. Therefore, the count of dialysis procedures in HIPE data for inpatients is not a complete count of the number of dialysis treatments provided.

Effective From:	January 2006
First Published:	Coding Notes December 2005
Reason For Standard:	HIPE coding of day episodes for dialysis commenced in January 2006, this ICS provides coding advice for this type of admission.
ICS Updated:	Updated in ICS V2.0 January 2009 to reflect change in terminology from *renal* to *kidney* in 6th Edition ICD-10-AM
ICS Further Updated:	January 2022 ICS Updated to state that dialysis procedures are counted once per Episode in consultation with the National Renal Office.

Effective from:	Valid for relevant activity from January 1st 2010
Advice first Published:	ICS V2.3 (following NCAC meeting March 2010)
Reason for Standard:	Standardised collection of National Cancer Control Programme (NCCP) activity across hospitals
Standard Deleted:	ACS 140x deleted in ICS V9B2018 January 2018 as cervical screening activity is not to be reported to HIPE from this date. Activity performed as part of the national cervical screening programme is not to be reported to HIPE regardless of where performed in the hospital as this information is reported directly to the National Cervical Screening Service by Hospitals.

> **Where a colposcopy or any procedure referred to in ICS 140x is performed as part of a routine day case or inpatient admission please code in accordance with national coding guidelines**.

Chapter 15   Pregnancy, Childbirth and the Puerperium (15--)

~~ICS 15X0   PRINCIPAL DIAGNOSIS SELECTION FOR OBSTETRIC CASES~~
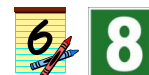
Effective From:	January 2005
First Published:	Coding Matters Volume 13 Number 2, September 2006, page 6, (NCCH)
ICS Updated:	ICS V2.0 January 2009 Changes in ICD-10-AM guidelines for PDx in Obstetrics cases
Reason For Standard:	Clarification of existing guidelines
Standard Deleted:	Standard deleted due to change in PDX assignment for obstetric cases in 8th Edition ICD-10-AM/ACHI/ACS –see ACS 0001 Principal Diagnosis

~~ICS 1510   PREGNANCY WITH ABORTIVE OUTCOME~~

Reason for Standard:	ICS 1510 is a continuation of existing practice.
Revised:	ICS 1510 revised to include the term <u>completed,</u> March 2008 (ICS V1.4)
Standard Updated:	January 2019 ICS 2019 V1
Reason for Update:	Inclusion of full text of standard for use in Ireland where fetal viability is at 22 weeks completed gestation.
Standard deleted	Standard deleted due to deletion of ACS 1510 in 10th edition. Definitions of fetal viability for Ireland are provided in ICS 15X3

~~ICS 1511   TERMINATION OF PREGNANCY~~

Reason for Standard:	ICS 1511 is a continuation of existing practice.
Revised:	ICS 1511 revised to include the term <u>incomplete,</u> March 2008 (ICS V1.4)
Standard Deleted:	Standard deleted ICS V6.0 January 2014 due to change in legislation

ICS 15X1   STERILISATION WITH DELIVERY

When a sterilisation is carried out with a delivery, assign the following as an additional diagnosis:

Z30.22   *Female Sterilisation Intervention*

First Published:	Coding Notes July 2005
Reason for Standard:	ICS 15X1 is a continuation of existing practice.
Standard Updated:	January 2024 V1.0.
Reason for Update:	Update to code & code title Z30.22 Female Sterilisation Intervention

ICS 15X2 ANTI-D IMMUNOGLOBULIN PROPHYLAXIS AND RHESUS INCOMPATIBILITY / ISOIMMUNISATION 6

Blood Types

The two most important classifications to describe blood types in humans are 'ABO' and the 'Rhesus factor'. For example, if a patient has ABO group A and a negative Rhesus factor, then their blood type will be described as A- (A negative).

Anti-D immunoglobulin prophylaxis

To prevent rhesus isoimmunisation, mothers with a rhesus negative (Rh-) blood type are routinely given an injection of anti-D immunoglobulin at 28 and 34 weeks of their pregnancy. If the mother gives birth to a rhesus positive (Rh+) baby, then a postnatal injection of anti-D immunoglobulin prophylaxis will also be administered.

Classification

If a rhesus negative obstetric patient receives injection of Anti-D during her admission and no condition is documented, the following codes are assigned:

Z29.1   *Prophylactic immunotherapy*
92173-00 [**1884**]   *Passive immunisation with Rh(D) immunoglobulin*

Rhesus incompatibility/isoimmunisation

Rhesus (Rh) incompatibility is the condition of a mother with a rhesus negative blood type and a baby with a rhesus positive blood type.

Rhesus (Rh) isoimmunisation occurs when blood cells from a rhesus positive baby enter the bloodstream of a rhesus negative mother causing the mother's immune system to produce antibodies. This is also known as Rh sensitisation. If the mother has a future pregnancy with another rhesus positive baby, then these antibodies can cross the placenta and attack the blood cells of the unborn baby, thus resulting in a condition called haemolytic disease of the newborn. The administration of Anti-D immunoglobulin prophylaxis prevents the development of antibodies in the mother, therefore, **rhesus isoimmunisation is a rare condition.**

Classification

If a rhesus negative obstetric patient has a <u>documented diagnosis</u> of *rhesus isoimmunisation* or *rhesus incompatibility* the following code is assigned:

O36.0   *Maternal care for rhesus isoimmunisation*

EXAMPLE

Diagnosis: A mother with an A- blood type (rhesus negative) delivers a jaundiced live male infant (single spontaneous delivery). Cord blood tests reveal the baby's blood type to be A+ (rhesus positive). Rhesus incompatibility is diagnosed and Anti-D injection is administered to the mother.

Codes:	**O80**	*Single spontaneous delivery*
	O36.0	*Maternal care for rhesus isoimmunisation*
	Z37.0	*Outcome of delivery, single live birth*
	92173-00 [**1884**]	*Passive immunisation with Rh (D) immunoglobulin*

Effective From: January 2005
First Published: Obstetrics Workshops from 16/5/05
Reason for standard: Clarification of ICS and clinical terminology

ICS 15X3   DEFINITION OF TERMS "EARLY" AND "LATE" USED IN CHAPTER

15 OF THE CLASSIFICATION

Fetal viability in Ireland is defined as 22 completed week's gestation. In Ireland the definition of the terms early and late used in the ICD-10-AM/ACHI/ACS classification are;

> Early or before 20 weeks = up to 21 weeks completed gestation in Ireland
> Late or after 20 weeks = 22 completed weeks gestation or more in Ireland

This definition applies:
- Where the term **early** or **late** is used in an ICD-10-AM code
- Where the term **20 weeks** is mentioned in an ICD-10-AM code, **this term is to be interpreted as 22 weeks in Ireland.**

Example:
Code **O21.2** *Vomiting in late pregnancy*. (*Excessive vomiting starting after 20 completed weeks* is to be applied for vomiting after 22 weeks in Ireland).

ICS 1605   CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

Definition

The perinatal period is defined in Ireland as:

*The perinatal period commences at **22 completed weeks** (*154 days*) of gestation and ends at 28 completed days after birth, commencing on the date of birth (day 0) and ending on the completion of day 27.*

For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October" (METeOR: 327284) (Australian Institute of Health and Welfare 2012).

Effective From:	ICS 1605 is a continuation of existing practice.
First Published:	ICS V1.5
Reason for Standard:	Definition of perinatal period in Ireland.
Standard Updated:	January 2018 ICS V9B2018
Reason for Update:	Standard updated to clarify age of neonate where day of birth is counted as day 0 and neonatal period ends on completion of day 27.

ICS 1607   NEWBORN/NEONATE

Coding of unwell newborns/neonates during the birth episode
Codes from **Z38** *Liveborn infants according to place of birth* will be applied only as additional diagnoses to newborns/neonates that are unwell during the birth episode.

On the baby's chart any morbid condition arising during the birth episode will have a code from **Z38** *Liveborn infants according to place of birth*, added as an <u>additional diagnosis</u>.

Example 1
Newborn, born in hospital, with hypoglycaemia, vaginal delivery.

Codes: **P70.4** *Other neonatal hypoglycaemia*
             Z38.0 *Singleton, born in hospital*

Z38 *Liveborn infants according to place of birth* **will not be assigned as principal diagnosis as <u>well babies are not coded in Ireland</u>.** Information on well babies is downloaded to the HIPE system but is not coded.

Z38 *Liveborn infants according to place of birth* cannot be used when treatment is being provided in second or subsequent admissions.

Example 2
Newborn, readmitted at 7 days of age for ritual circumcision.

Codes: **Z41.2**   *Routine and ritual circumcision*
             30653-00 [**1196**]   *Male circumcision*

Effective From:	ICS 1607 is a continuation of existing practice.
First Published:	Coding Notes, July 2006.
Reason for Standard:	Well babies are not collected by HIPE.

Standard Updated:	ICS V9.0 January 2017 as change in download to include all newborns, however well babies are not coded.

~~ICS 1611   NEWBORNS ADMITTED FOR OBERVATION WITH NO CONDITION FOUND~~

Effective From:	Continuation of existing practice
Reason For standard:	In keeping with existing national guidelines regarding coding of neonates and with ICS 1607 newborn/neonate.
First Published:	ICS V1.3
Standard deleted:	Deleted from 1st January 2009 as ACS 1611 was revised and references to code Z38 *Liveborn infants according to place of birth* were removed from ACS 1611.

Chapter 19 Injuries, Poisoning & Certain Other Consequences of External Causes (19--)

ICS 1901   POISONING

Coding of assault by poisoning

There is no column in the Table of Drugs and Chemicals for external cause of poisoning by assault.

In order to code assault by poisoning, assign the following codes;

1.   An appropriate code from the poisoning column from the Table of Drugs and Chemicals

   And

2.   An appropriate assault code located in the Alphabetic Index of External Causes.

Additional codes for place of occurrence and activity are also assigned according to existing guidelines.

Example 1
Patient collapsed in bar from suspected drink spiking. Toxicology results confirmed rohypnol.

Poisoning by rohypnol:	**T42.4** *Poisoning by Benzodiazepines*
Collapse:	**R55** *Syncope and collapse*
Assault:	**X85.09** *Assault by drugs, medicaments and biological substances, unspecified person*
Place of occurrence:	**Y92.53** *Café, hotel and restaurant*
Activity:	**U73.9** *Unspecified activity*

Reason for standard: This standard provides clarification.
First Published: ICS V1.3, January 2008.

ICS 1902   ADVERSE EFFECTS OF DRUGS

A code for place of occurrence (**Y92.**-) is not required with code range **Y40-Y59** *Drugs, medicaments, and biological substances causing adverse effects in therapeutic use*.

For guidance on the coding of adverse effect of COVID-19 Vaccine please see **ICS 0113** *Coronavirus Disease 2019 (COVID-19)*

First Published: Coding Notes March 2006
             Information also provided at ICD-10-AM 4th Edition Pre-Implementation workshops
Standard Updated: September 2021
Reason for Update: Reference added to ICD 22X2 Novel Coronavirus for guidance on coding of adverse effect of
             COVID-19 vaccine.
Standard Updated: January 2024
Reason for Update: Updated Reference to reflect new ICS 0113 Coronavirus Disease 2019 (COVID-19)

ICS 2116   PALLIATIVE CARE

A: Guidance on assignment of Z51.5 Palliative Care

The advice contained in **ACS 2116** *Palliative Care* provides the following instruction;

"Do not assign **Z51.5** *Palliative care* when a palliative care assessment has been performed but no actual care has been given…"

As per advice in **ACS 2116** *Palliative care* in 10th Edition ICD-10-AM/ACHI/ACS, code **Z51.5** *Palliative care* should only be assigned as an additional diagnosis where there is documented evidence that the patient has been provided with palliative care. This Irish Coding Standard provides additional guidance on the use of **Z51.5** *Palliative care* in Ireland.

➢ Do not assign **Z51.5** *Palliative care* when a palliative care assessment has been performed but no actual care has been given.

➢ In Ireland, documentation that the patient has been seen by the palliative care team is not sufficient to assign code **Z51.5** *Palliative care* there must be evidence that palliative care has been given.

➢ The palliative care does not have to be delivered or informed by a specialist palliative care team. However, there must be evidence and documentation to support that palliative care was given to the patient.

➢ Refer also to the guidance in Coding Rules Ref No: Q2914 | Published On: 15-Jun-2015 for information on synonymous terms for palliative care

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Ref No: Q2914 | Published On: 15-Jun-2015 | Status: Current

SUBJECT: Synonymous terms for palliative care
Q:
What are acceptable synonymous terms for palliative care? Some terms are clearly synonymous with palliative care such as 'end of life care' and 'terminal care'; however is documentation of 'comfort measures only' considered synonymous with palliative care?

A:
The ACS for palliative care has been revised and relocated in Ninth Edition and has clarified that terminology such as 'end of life care' and 'terminal care' are synonymous terms used to describe episodes of palliative care. However, the phrase 'comfort measures' may be more widely applied and therefore on its own does not qualify for assignment of **Z51.5** *Palliative care*.
Clinical coders should refer to **ACS 2116** *Palliative care* to determine code assignment. If the documentation is unclear, **Z51.5** should not be assigned.

B: Guidance on collection of administrative variable for Specialist Palliative Care Team Involvement

An administrative variable is now provided in HIPE to separately identify specialist palliative care team involvement in a case. This variable is ticked manually by the HIPE clinical coder to identify any involvement in a case by any member of the specialist palliative care team, including assessment only. There is no change to the guidance on the assignment of code **Z51.5** *Palliative Care*.

This variable will assist in identifying at a national level where specialist palliative care teams are involved in a case as code **Z51.5** *Palliative care* can be applied for many specialties and requires documented palliative care beyond assessment only.

The values for identifying Specialist Palliative Care Team involvement are listed below

PallativeCareInd	Description
0	No (No Specialist Palliative Care Team Involvement in this episode)
1	Yes (Yes Specialist Palliative Care Team Involved in this episode)

Instructions for HIPE Coders on on collection of administrative variable for Specialist Palliative Care Team Involvement:

- The default value for this field is "0 No" (i.e. that the specialist palliative care team did not attend the patient)
- This field is not downloaded and must be manually collected by the HIPE clinical coder
- The admin variable for specialist palliative care team involvement does not impact on the assignment of code **Z51.5** *Palliative care* and the guidance in **ACS 2116** and **ICS 2116** *Palliative Care* applies
- This variable can be collected when there is documented involvement of any member of the specialist palliative care team including palliative care nurse, NCHD or consultant in palliative care
- The admin variable for specialist palliative care can be assigned when there is *assessment only* by the specialist palliative care team (please note that code **Z51.5** *Palliative Care* does not apply where there is assessment only as per coding guidance in **ACS & ICS 2116**)
- Where a specialist palliative care team is involved in a case and palliative care is given to the patient please apply the admin variable for specialist palliative care team involvement and also assign the **Z51.5** *Palliative care* code and the consultant code for the palliative care consultant
- Where palliative care is delivered by another specialty, do not assign the indicator. Code **Z51.5** *Palliative care* may be applied in such cases
- Data entry edits will support coders in assigning the variable for specialist palliative care team involvement
- See also **ICS, Section 2**, *HIPE Guidelines for Administrative Variables*, item *XIV: Specialist Palliative care team involvement*

Effective From:	January 2020
Reason For standard:	ICS developed as a result of changes in 10th edition to the coding of palliative care. New standard developed to provide clarification for Irish coders.
First Published:	ICS 2020 V1
ICS Updated:	ICS 2022 V1
Reason for Update:	ICS updated in 2022 as new administrative variable introduced to capture specialist palliative care team involvement in a case. Standard updated to include Part A: Guidance on assignment of Z51.5 Palliative Care and Part B: Guidance on collection of administrative variable for Specialist Palliative Care Team Involvement
Standard Updated:	January 2024 V1,0
Reason for Update:	ICS 2116 further updated to include full advice contained in Coding Rule Q2914 (Published 15 June 2015, for implementation 01 July 2015)

Chapter 22   Codes for special purposes (22--)

~~ICS 22x0   Severe Acute respiratory Syndrome~~

Effective From:	Discharges on or after 1st January 2007
Standard Deleted:	Deleted from 1st January 2009 in ICS V2 as code U04.9 *Severe acute respiratory syndrome [SARS], unspecified* is included in 6th edition ICD-10-AM/ACHI/ACS

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ICS 22X1   VAPING RELATED DISORDERS

Please see Coding Rules below regarding the coding of vaping related disorders:

Vaping-related disorders are disorders that result from inhaling a vaporised solution (aerosol) via an electronic delivery system. These products frequently contain flavourants, usually dissolved into propylene glycol and/or glycerine. They may also contain doses of nicotine, and other substances and additives. These disorders may also be documented as electronic cigarette related damage or disorders, or e-cigarette or vaping product use-associated lung injury (EVALI).
The exact causation of and mechanism leading to the disorders is currently unclear. The substance or substance combination leading to vaping-related disorders has not yet been identified. While lung disorders related to vaping are recognised, other organs may be affected as well. Although vaping devices may resemble cigarettes, they do not contain tobacco and it is not appropriate to assign **Z72.0** *Tobacco use, current*.

Concern has arisen due to an increase in the incidence of vaping-related disorders internationally. As a result, the World Health Organization (WHO) has advised that **effective from 25 September 2019**, **U07.0** *Vaping Related Disorders* is assigned for vaping-related disorders, to monitor vaping-related disorders internationally.

CLASSIFICATION

Where documentation states that a condition or symptom is vaping related, assign:

➢ A code for the condition as per the guidelines in **ACS 0001** *Principal diagnosis* and **ACS 0002** *Additional diagnoses*

➢ Use of **U07.0** *Vaping Related Disorders* as an additional diagnosis
Note: DO NOT assign **U07.0** *Vaping Related Disorders* to flag that a patient uses a 'vape device'.

Bibliography:

Australian Government Department of Health 2019, About e-cigarettes, DOH, Canberra, viewed 16 October 2019, https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/about-e-cigarettes

Centres for Disease Control and Prevention 2019a, Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping, US Department of Health and Human Services, viewed 1 October 2019, https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

Centres for Disease Control and Prevention 2019b, THC Products May Play a Role in Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping, US Department of Health and Human Services, viewed 1 October 2019, https://www.cdc.gov/media/releases/2019/p0927-thc-vaping.html

ICD-11 Foundation 2019, Vaping related disorder, viewed 2 October 2019, https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1880731274

Published 16 December 2019, for implementation 01 January 2020." Update: The above advice is based on a retired coding rule TN1511

Effective From:	January 1st 2020
Reason For standard:	Advice published by WHO and IHPA on use of code U07.0 for vaping related illness.
First Published:	ICS 2020 V1
Standard Updated:	January 2024 V 1.0.
Reason for Update:	Code title change to reflect the code title change in 12th Edition for U070.

ICS Effective From: 1st January 2020- advice issued by IHPA on 7th February 2020
Reason for Standard: Guidance for coding of Novel Coronavirus (2019-nCoV)
First Published: Issued via e-mail bulletin 10th February 2020.
Standard Updated: The standard has been updated as follows:
- Standard updated to include term "COVID 19" March 2020
- Coding Advisory on coding of Pneumonia in COVID 19 published on 6th April 2020
- Supplementary guidance updated on 1st May on the coding of ruled out COVID 19 in obstetrics
- ICS V1.4 provides publication of the full Irish Coding standard, Supplementary guidelines and the Coding Advisory.
- ICS 2021 V1 January 2021: Additional codes released by WHO and IHPA for the classification of Post COVID conditions and multisystem inflammatory response.

Standard Further Updated: ICS 2021 V2

Reason for Update: Include outline of content of standard

                           Include new code and guidance on adverse effect of COVID-19 vaccine

                           Include graphic of summary of codes for COVID-19

Standard Deleted: January 2024 V1.0 standard deleted as new ICS 0113 CORONAVIRUS DISEASE 2019 (COVID-19) Created.

Appendix A: Summary of Changes for ICS V2.0 2009 to V1.2 2024

The following is a summary of the changes to Irish Coding Standards (ICS) for versions 2.0 2009 to ICS version 1.2 2024. For the complete guidelines and detailed information on the changes to each standard, please refer to the appropriate version of the standards.

ICS 2024 V1.2

Section 2:
- In the HIPE Guidelines for Administrative data, item .V PATIENTS DISCHARGED AND RE-ADMITTED ON THE SAME DAY has been updated to specifically reference DAYCASE PATIENTS REQUIRING ADMISSION FROM DAYWARD and provide guidance on principal diagnosis selection in such cases

Section 3:
3 Irish Coding Standards have been updated

- Ireland has decided to continue coding neoplasms and neoplasm related conditions as per 10th Edition guidance. The 12th edition changes to the coding of neoplasm related conditions will not apply in Ireland as the removal of the Z code, the neoplasm and the procedure code for administration of anti-neoplastic from the data set for these cases would be a challenge in reporting cancer services activity. Also coders may not be able to identify if the admission is for treatment of neoplasm or a neoplasm related condition. In view of this, 2 Irish Coding standards are required to guide Irish coders in the assignment of codes for daycase admissions for neoplasms and neoplasm related conditions which are in line with the 10th edition approach.

  - ICS 0044 *Pharmacotherapy*

  - ICS 0206 *Pharmacotherapy For Neoplasms* (and neoplasm related conditions)

- ICS 1012 *Summary of Classification of Influenza* has been updated to emphasize the restrictions on the use of code J09 *Influenza due to identified zoonotic or pandemic influenza.*

ICS 2024 V1.1

Section 3:
2 Irish Coding Standards have been updated

- ICS 0110 SEPSIS AND SEPTIC SHOCK: The example in this standard that was labelled 'Example 3' has been relabelled ' Example'

- ICS 0604 CEREBROVASCULAR ACCIDENT (CVA): The example in this standard that was labelled 'Example 3' has been relabelled ' Example'

ICS 2024 V1

General information:
- Front cover and colours updated to reflect update to 12th Edition ICD-10-AM/ACHI/ACS
- Glossary for ICS created to provide further context on how the Glossary in the ACS applies to the Irish health system

- Preface introducing ICS 2024 V1 updated – symbols added to identify 12th edition updates.
- Introduction contents updated accordingly to reflect 12th Edition update

Section 1:
- A section has been added on HIPE coding deadlines and HIPE export dates

Section 2:
- List of clinical coding schemes used in Ireland has been updated to include 12th Edition ICD-10-AM/ACHI/ACS
- Information on Ward Registration is now included in section 2
- LABORATORY CONFIRMED COVID 19 PAST OR PRESENT- FLAG code and code descriptions have been updated to reflect the 12th Edition update and new ACS and ICS 0013 CORONAVIRUS DISEASE 2019 (COVID-19)

Section 3:
2 new Irish Coding Standards have been created
- Chapter 1 Certain Infectious and Parasitic Diseases (01--): ICS0113 CORONAVIRUS DISEASE 2019 (COVID-19): This new standard will replace ICS 22X2 Novel coronavirus/ COVID-19 emergency use of U07.11
- Chapter 2 Neoplasms (02--): ICS 0206 PHARMACOTHERAPY FOR NEOPLAMS: This new standard includes guidance on oral chemotherapy for neoplasms

11 Irish Coding Standards have been updated

- ICS 0010 CLINICAL DOCUMENTATION AND GENERAL ABSTRACTION GUIDELINES: Standard name change from GENERAL ABSTRACTION GUIDELINES to CLINICAL DOCUMENTATION AND GENERAL ABSTRACTION GUIDELINES. The contents of this standard has been updated to reflect the 12th Edition update.

- ICS 0027 MULTIPLE CODING - Consultant Numbers: A note has been made to note that there is no equivalent ACS0027 anymore as it was deleted in the 8th Edition update.

- ICS 0042 PROCEDURES NOT NORMALLY CODED – CODING OF ULTRASOUND GUIDED PROCEDURES: A new code has been added to the list of codes: Intravascular Ultrasound (IVUS) (96272-00 [1949]). No further changes.

- ICS 0049 DISEASE CODES THAT MUST NEVER BE ASSIGNED: Wording of contents updated to reflect 12th edition changes.

- ICS 0110 SEPSIS AND SEPTIC SHOCK: Standard name change from SIRS, SEPSIS, SEVERE SEPSIS to SEPSIS AND SEPTIC SHOCK. The contents of this standard has been updated to reflect the 12th Edition update.

- ICS 0604 CEREBROVASCULAR ACCIDENT (CVA): Standard name change from STROKE to CEREBROVASCULAR ACCIDENT (CVA). No further changes.

- ICS 1006 VENTILATORY SUPPORT- B: Coding of "AIRVO": Further update to Coding Rules Ref No: Q2953 that was further updated in September 2023.

- ICS 15X1 STERILISATION WITH DELIVERY: Code change from Z30.2 Sterilisation to Z30.22 Female Sterilisation Intervention.

- ICS 15X3 DEFINITION OF TERMS "EARLY" AND "LATE" USED IN CHAPTER 15 OF THE CLASSIFICATION: Code title change for Code O21.2 to Vomiting in late pregnancy. (Excessive vomiting starting after 20 completed weeks is to be applied for vomiting after 22 weeks in Ireland).

- ICS 2116 PALLIATIVE CARE: ICS Further updated to include full advice contained in Coding Rule Q2914 (Published 15 June 2015, for implementation 01 July 2015).

- ICS 22X1 VAPING RELATED DISORDERS: Updated code title change for U07.0 to Vaping Related Disorders

5 Irish Coding Standards have been deleted

- ICS 0028 Para-Aortic Lymph Node Biopsy and Retroperitoneal Lymph Node Dissection (RPLND): Standard deleted due to new lymph node procedure codes in 12th Edition.

- ICS 0112 Infection with Drug Resistant Micro-organisms: Standard deleted due to new guidelines for colonisation in ACS0012.

- ICS0044 Chemotherapy: Standard deleted due to changes in 12th Edition. See new ICS 0206 for administration of oral chemotherapy for neoplasms. For information on IV hydration, see ACS 0044 and example 3.

- ICS 01X0 Zika Virus WHO Alert: Standard deleted as it is incorporated into the classification and coded to A92.5 ZIKA Virus with additional codes available for maternity and neonates

- ICS22X2 Novel coronavirus/ COVID-19 emergency use of U07.1- Standard deleted and replaced with ICS0013

ICS 2023 V1

General information:
- Front cover updated to V1 2023
- Preface introducing V1 2023 updated

Section 1:
- HIPE export dates for 2023 added

Section 2: No changes to HIPE Guidelines for Administrative data
Section 3: No changes to Coding Standards

ICS 2021 V2

General information:
- Front cover updated to V2 2021
- Preface introducing V2 2021 updated

Section 3:
3 Irish Coding Standards have been updated
- ICS 0044 *Chemotherapy* has been updated to include advice on IV hydration as part of chemotherapy.

- ICS 22X2 *Novel Coronavirus COVID-19* updated to include adverse effect of COVID-19 vaccine and include graphic of COVID-19 codes (this graphic is a summary only)
- ICS 1902 *Adverse effects of Drugs* – updated to include reference to ICS 22X2 for adverse effect of COVID-19 vaccine

ICS 2021 V1

General information:
- Front cover and colours updated for 2021
- Preface introducing ICS 2021 V1 updated

Section 1:
- HIPE export dates for 2021 added

Section 2:
- Item V. Patients discharged and readmitted on the same day has been updated to advise on the admission type for admitted day cases.

Section 3:
- **2 new Irish Coding Standards have been created**
  - ICS 0042 *Procedures not Normally coded* has been created to provide clarification on the coding of ultrasounds
  - ICS 0604 *Stroke* has been created to provide an example on the transfer of a stroke patient following embolectomy in another hospital
- **3 Irish Coding Standards have been updated and expanded**
  - ICS 0048 *Hospital Acquired Diagnosis Indicator* has been expanded to full include the full content of ACS 0048 *Condition Onset Flag* as it applies in Ireland
  - ICS 1006 *Ventilatory support* has been expanded to provide additional guidance on the coding of "Airvo"
  - ICS 22x2 Novel Corona Virus (COVID-19) has been expanded to include the most recent guidance on the classification of Post COVID-19 conditions and multisystem inflammatory system associated with COVID-19.

ICS 2020 V1.4

Section 2:
- New guidelines added on flag for Laboratory confirmed COVID 19 past or present to be collected as an administrative variable.

Section 3:
- Irish Coding Standard 0110 Sepsis updated to correct code description for SIRS of non-infectious origin
- Irish Coding Standard ICS 22X2 Novel Coronavirus/COVID 19 updated and sections added on Supplementary Guidance on coding of COVID 19 and Coding Advisory on Pneumonia in COVID 19.

ICS 2020 V1.3

Section 3:
- **New Irish Coding Standard ICS 22X2 Novel Coronavirus/COVID 19**

ICS 2020 V1.2

Section 3:
- **Irish Coding Standards updated**

ICS 0025 *Double Coding* Standard Updated January 2020 in version 1.2 to update the place of occurrence code in example 1 for 10th edition.

ICS 2020 V1

General information:
- Front cover and colours updated to reflect update to 10th Edition ICD-10-AM/ACHI/ACS
- Preface introducing ICS 2020 V1 updated – symbols added to identify 10th edition updates.

Section 1:
- A section has been added on HIPE coding deadlines and HIPE export dates

Section 2:
- List of clinical coding schemes used in Ireland has been updated to include 10th Edition ICD-10-AM/ACHI/ACS

Section 3:
- **5 new Irish Coding Standards have been created**
  - ICS 0003 *Supplementary codes for chronic condition*s – supplementary codes for chronic conditions will not be collected in Ireland.
  - ICS 0049 *Disease codes that must never be assigned* – code R65.0 *SIRS of infectious origin without acute organ failure* can be assigned in Ireland in accordance with ICS 0110 *SIRS, Sepsis, Severe Sepsis and Septic Shock*.
  - ICS 0110 *SIRS, Sepsis, Severe Sepsis and Septic Shock* provides guidance on the coding of SIRS in Ireland in 10th edition.
  - ICS 2116 *Palliative Care* - palliative care has been moved to Chapter 21 in 10th edition and also the content of the standard has changed. Palliative care can only be coded when there is documented evidence that the patient has been provided with palliative care.
  - ICS 22X1 *Vaping Related Disorder* – advice issued by the WHO/IHPA instructs that code U07.0 *Emergency Use of U07.0* be used when there is documentation of vaping related disorders.

- **3 Irish Coding Standards have been updated**
  - ICS 0025 *Double coding* – an example has been added to reflect the changes in the coding of pressure injuries the assignment of more than one code when the HADx flag applies.
  - ICS 0112 *Infection with Drug Resistant Organisms* has been updated to reflect the 10th edition changes in the coding of multiple drug resistance.
  - ICS 1012 *Summary of classification of influenza* has been updated to reflect changes in 10th edition in the coding of influenza. Only influenza A H5N1 can be classified to J09.

- **4 Irish Coding Standards have been deleted**
  - ICS 0053 *Robotic Assisted Intervention* has been deleted as the advice is consistent with ACS 0053 in 10th edition.
  - ICS 0224 *Palliative Care* has been deleted as the guidance and location of the standard of palliative care has changed in 10th edition. A new ICS on palliative care has been developed – see ICS 2116.
  - ICS 10X0 *A (H1N1) Influenza (swine flu)* has been deleted as 10th edition includes a new ACS 1012 *Influenza due to identified influenza virus*.

o   ICS 1510 *Pregnancy with abortive outcome* has been deleted as information is contained in ICS 15X3 and ACS 1510 has been deleted in 10th edition.

ICS 2019 V1.2

- Preface introducing V1.2 updated to reflect **cessation of pilot** to collect data from ED and virtual wards where the decision to admit has been made.
- Section 1 valid HIPE activity updated as virtual ward and ED activity are no longer collected by HIPE. These areas have been added to the list of activity not collected by HIPE.
- ACS 1006 Ventilatory Support updated to reflect the removal of ED and Virtual ward activity from HIPE.

ICS 2019 V1.1 (January)

- Appendix C: Guidance In The Use Of ICD-10-AM/ACHI/ACS/ICS
    o   Example updated in graphic for "5 steps to Quality Coding".

ICS 2019 V1 (January)

General information:
- Preface introducing ICS 2019 V1 updated
    - Information on numbering of ICS added to preface
    - Update of "5 Steps to Quality Coding" in Appendix C.
    - Appendix C expanded to include "Guidance In The Use Of ICD-10-AM/ACHI/ACS/ICS"

ICS
Section 1:

Valid HIPE Activity

- Updated to include Virtual ward activity where there is decision to admit a patient.
    Invalid HIPE activity

- Updated as from 01.01.2019 ED Virtual ward activity is collected by HIPE.
  - List of invalid activity updated to include;
    o   discharge lounges
    o   ED patients without a decision to admit

Section 2: HIPE Guidelines for Administrative Data

- New guideline added on collection of Cumulative Hours of Mechanical Ventilation (invasive ventilation). This variable will record the total number of hours of mechanical ventilation in addition to the relevant procedure codes for ventilation. This variable is not part of the clinical code set and is recorded as an administrative variable.

Section 3: Coding Standards

- New standard ICS 0053 *Robotic Assisted Intervention* provides guidance and information on a new procedure code to be introduced in advance of ICD-10-AM 10th Edition to identify robotic assisted procedures.
- New standard ICS 090X *Myocardial Infarction (MI) with Coronary Artery Disease* (CAD) new Irish Coding Standard on sequencing of MI and CAD based on advice received by the HPO from the ACCD.

- New Standard ICS 10XI *Summary of classification of influenza* provides summary advice on classification of various types of influenza.

- ICS 1006 *Ventilatory support* amended to include virtual ward activity and to reference new Irish Coding Standard on Duration of Continuous ventilation in Section 2 HIPE Guidelines for administrative data.

- ICS 1510 *Pregnancy with Abortive Outcome* expanded to include of full text of standard 1510 *Pregnancy with Abortive Outcome* for use in Ireland where fetal viability is at least 22 weeks completed gestation.

ICS V9.0 2018 January 2018

General information:
- 3 sections created in ICS
    - Section 1: Valid HIPE Activity
    - Section 2: HIPE Guidelines for Administrative Data
    - Section 3: Coding Standards
- Preface introducing ICS V9B2018 updated
- Clarification on use of *Standards for Ethical Conduct in Clinical Coding* added to Appendix B
- "5 steps to quality coding" added to ICS V9B2018 in Appendix C

ICS:

Section 1: Valid HIPE Activity
- Advice on activity collected and not collected by HIPE expanded and placed in Section 1 of the ICS. This advice was previously contained in the HIPE guidelines on administrative data. The advice in this section has been expanded to further list activity not to be collected by HIPE.

Section 2: HIPE Guidelines for Administrative data:
- New guidelines added on collection of HIPE data from registered Acute Surgical assessment units
- Patients transferred for a day case procedure and returning on the same day: New guideline added to document existing advice.
- Guidelines on ward identification updated to state that discharge lounges cannot be reported as discharge lounges.
- Guideline on parity updated to state that miscarriages are not collected in parity.

Section 3: Coding Standards
- ACS 0010 General Abstraction Guidelines updated to include advice on clinical documentation, nursing notes and electronic healthcare records
- ICS 0025 Double Coding: this New Irish Coding Standard allows for diagnosis codes to be repeated where one requires a HADX flag and one does not.
- ICS 040X haemochromatosis and venesection updated with the advice that elective AMAU activity is not to be reported to HIPE.
- ICS 1605 Conditions Originating in the Perinatal Period updated to clarify that for neonates the date of birth is counted as day 0 and the neonatal period continues until the end of the 27th day giving a total of 28 days.
- One standard has been deleted, ICS 140X Standardisation of collection of colposcopy activity
-

ICS V9.0 January 2017

General information:
- Preface introducing ICS V9.0 updated
- Updated **Standards for Ethical Conduct in Clinical Coding** published in **Appendix B**

ICS:
- HIPE Guidelines for Administrative Data – elective admissions to Acute Medical Assessment Units has been added to the list of activity not collected by HIPE (Item VIII). Also, the instructions in item III Acute Medical Assessment Units in this section have been updated to reflect this change.
- New standard ICS *0028 Retroperitoneal Lymph Node Dissection* provides additional guidance on the coding of retroperitoneal lymph node dissection and when this procedure is performed following chemotherapy for testicular cancer.
- New Standard ICS 02X1 *Radiotherapy Planning* provides clarification on the coding of admission for radiotherapy planning only.
- ICS 0029 *Coding of Contracted Procedures* has been updated to advise hospitals on valid HIPE activity performed off site.
- ICS 01X0 *ZIKA Virus WHO Alert* updated to incorporate coding advice from ACCD.
- ICS 02X0 *Classification of Attendances at Oncology Day Wards* deleted as this information is available through data analysis.
- ICS 1607 *Newborn/Neonate* updated as while only sick neonates are to be coded – all neonates will now be included on downloads. Well babies are not collected by HIPE.

ICS V8.0 January 2016

General information:
- Preface introducing ICS V8.0 updated
- Introduction to Irish Coding Standards updated to include advice on local coding decisions.

ICS:
- HIPE Guidelines for Administrative Data
  - III ACUTE MEDICAL ASSESSMENT UNITS (AMAUs) - updated to reflect that elective AMAU activity is not expected to be reported to HIPE and may be queried.
- Reference to collection of HADx on pilot basis removed from ICS 0048 *Hospital Acquired diagnoses indicator*.
- Examples in ICS 002x *Date for each procedure coded* updated to 2016
- New standard ICS 01X0 *Zika virus* provides guidance on the WHO alert on the coding of Zika virus and the use of U06.9 *Emergency use of U06.9* for same.
- ICS 040X *Haemochromatosis and Venesection* updated to reflect that elective AMAU activity is not expected to be reported to HIPE and may be queried.

ICS V7.0 January 2015

General information:
- Preface introducing ICS V7.0 updated
- List of Coding schemes used in HIPE in Ireland updated

ICS:

- ICS 0048 Hospital Acquired Diagnosis Indicator updated for 8th edition ICD-10-AM/ACHI/ACS as the HADx flag can be assigned for neonates on the birth episode. Examples in ICS 0048 also updated to reflect code changes in 8th edition.

- ICS 1204 Plastic Surgery - deleted as advice incorporated into ACS 2114 in 8th Edition ICD-10-AM/ACHI/ACS

- ICS 0104 Viral Hepatitis – deleted as advice incorporated into ACS 0104 in 8th Edition ICD-10-AM/ACHI/ACS

- ICS 0112 Infection With Drug Resistant Microorganisms - Standard updated for 8th edition ICD-10-AM/ACHI/ACS to reflect advice in ACS 0112 on the coding of drug resistance and change of codes in Z06 category

- ICS 15X0 Principal Diagnosis Selection for Obstetric Cases Deleted - Standard deleted due to change in PDX assignment for obstetric cases in 8th edition ICD-10-AM/ACHI/ACS – see ACS 0001 Principal Diagnosis

- ICS 15X2 Anti-D Immunoglobulin Prophylaxis And Rhesus Incompatibility/ Isoimmunisation – example updated for 8th edition

- ICS 002x Date For Each Procedure Coded - References to ACS 0020 revised and Examples updated for 8th edition ICD-10-AM/ACHI/ACS

- ICS 02x0 Classification of Attendances At Oncology Day wards - examples updated for 8th edition ICD-10-AM/ACHI/ACS

ICS V6.0 January 2014

- Preface introducing ICS V6.0 updated

- New standard ICS 010x Verotoxigenic E-Coli (VTEC) & Haemolytic Uraemic

  Syndrome (HUS) provides advice on the coding of VTEC.

- New Standard ICS 1204 Plastic Surgery updates the advice on sequencing of diagnosis codes for prophylactic mastectomy surgery in ACS 1204 as history codes cannot be sequenced as PDx.
    - ICS 1511 termination of pregnancy deleted.

ICS V5.0 January 2013

- Preface introducing ICS V5.0 updated

- New standard ICS 0224 *Palliative Care* to clarify when Z51.5 is to be coded

- The term Acute Medical Assessment Unit (AMAU) has been added to HIPE Guidelines for Administrative Data item *III Acute Medical Assessment Unit*

- Note b in HIPE Guidelines for Administrative Data item *VII Parity* has been updated to include the puerperium.

- The term 'Well Babies' has been added to list of activity not currently collected by HIPE at HIPE Guidelines for Administrative Data item VII *Activity Not Collected by HIPE*.

- ICS 02X0 *Classification of Attendances at Oncology Daywards* has been updated to reflect the numbering used in the data entry of such cases onto the HIPE Portal.

ICS V4.0 January 2012

- Preface introducing ICS V4.0 updated

- ICS 0229 *Radiotherapy* issued in July 2011 which provides guidelines on the coding of IMRT and IGRT has now been incorporated into this document.

- Decision tree in ICS 02x0 *Classification of Attendances At Oncology Day wards* updated at "First Patient Encounter" to state "First Patient Encounter where no chemotherapy is given?" as per text of standard

ICS V3.0 January 2011

In conjunction with the introduction of the HIPE Portal in use for all discharges from 1.1.2011

HIPE Guidelines for Administrative Data
Introduction to this section has been added and also numbering added to each item in this section.Two items added to HIPE Guidelines for Administrative Data:

II. Ward Identification:
Guideline updated as ward transfer file will be downloaded from hospitals' PAS/IMS system to HIPE for export. The collection of this information will not affect the coding process.

VII. Parity:
From 1st January 2011 HIPE will collect parity for all patients with admission type '6' *maternity* this field will be optional for all other patients. For the purposes of HIPE parity is the number of previous live births and the number of previous stillbirths (over 500g).

ICS:

ICS 0010   General Abstraction Guidelines
- Updated to state that from 1st January 2011 HIPE can collect up to   30 diagnoses.

ICS 0048   Hospital Acquired Diagnoses (HADx) Indicator
- This indicator will allow the diagnoses acquired during the patient's episode of care that were not present prior to admission, to be identified.

ICS 0030   Organ Procurement and Transplantation
- Donation of organs following brain death in hospital is not coded.

ICS 002x   Date for Each Procedure Coded
- From 1st January 2011 HIPE will record the date each coded procedure was performed on.

ICS 0027   Multiple Coding
- Updated as HIPE Portal allows for more than one consultant or anaesthetist to be recorded for each diagnosis or procedure.

ICS 004x   Sequencing of Radiotherapy and Chemotherapy when administered on the same day case admission.
- When radiotherapy and chemotherapy are administered on the same day case admission, sequence the diagnosis and procedure code for the chemotherapy first.

ICS V2.3 April 2010

ICS 140x   Standardisation of collection of colposcopy activity

ICS V2.2 January 2010

ICS 20x0   Classification of attendances at oncology day wards <u>new standard</u>
             Reason for Standard: To identify repeat non-chemotherapy admissions to
                                   oncology day wards for previously diagnosed neoplasms.
             ICS effective from: January 2010
             Advice first published: October 2009

ICS 10x0   A (H1N1) influenza (Swine Flu) standard updated January 2010 for advice
on

             suspected cases of A (H1N1) & to include examples

ICS V2.1 July 2009

ICS 10x0   A (H1N1) influenza (Swine Flu) <u>New standard</u>
             New standard introduced for coding of A (H1N1) influenza based on WHO
             advice. As this information is not contained in the classification at code J09
             an ICS is required.
             ▪   Influenza A(H1N1) [swine flu] is categorized to J09
             ICS effective from: July 2009
             Advice first published: Coding Notes July 2009
             Reason for Standard: Advisory from WHO on the coding of A (H1N1) influenza

ICS V2.0 January 2009

General information:
             ▪   Preface introducing ICS V2.0 updated
             ▪   List of Coding schemes used in HIPE in Ireland

ICS:
ICS 0010   General Abstraction guidelines
➢   Revised to include additional examples

ICS 0048   Condition onset flag
             ➢   New standard created as this variable not collected in Ireland at this
                 time

ICS 0042   Procedures not normally coded
             ➢   ICS 0042 deleted
             ➢   New standards created for blood tests & haemochromatosis

             NOTE:
             6th Edition ACS includes a change in guidelines to allow for the collection
             of procedures listed in ACS 0042 where the procedure is the principal
             reason for admission in same day cases (see Note C, ACS 0042
             Procedures Not Normally Coded).

ICS 0112   Infection with Drug Resistant Microorganisms
➤ Revised to incorporate 6th Edition changes for the coding of methicillin resistance.

ICS 030X   Blood tests/ collection of bloods for diagnostic purposes
➤ New standard required following deletion of ICS 0042
➤ No change to guidelines on the coding of blood tests
➤ Collection of blood is a standard treatment that is unnecessary to code

ICS 040X   Haemochromatosis & Venesection
➤   New standard for coding advice previously contained in ICS 0042 on the coding of haemochromatosis and venesection
➤   No change to coding guidelines for haemochromatosis and venesection

ICS 10X1   Avian Influenza
- ICS 10X1 deleted
- Code J09 influenza due to identified avian influenza is contained within the 6thedition of ICD-10-AM/ACHI/ACS

ICS 1006   Ventilatory Support
- Standard revised
- Revision of standard to incorporate changes in ACS 1006

ICS1404   Admission for Kidney Dialysis
- Standard revised
- Standard updated to reflect change in terminology in 6th edition ICD-10-AM/ACHI/ACS from renal to kidney

ICS 15X0   Principal Diagnosis Selection for Obstetric Cases
- Standard revised
- Coding advice to apply ACS 0001 Principal diagnoses unless ACS 1530 Premature delivery applies
- Coding advice for 6th edition is in line with previous ICS

ICS 15X2   Anti-D immunoglobulin prophylaxis and rhesus incompatibility/isoimmunisation
- Revision of example provided in this standard

ICS 1611   Newborns Admitted for Observation with no condition found
- Standard deleted
- ICS not required due to the removal of references to code *Z38 liveborn infants according to place of birth* from ACS 1611 in 6th Edition ACS

ICS 22X0   Severe Acute Respiratory Syndrome
- Standard deleted
- Code U04.9 Severe acute respiratory syndrome (SARS) is contained within 6thedition of ICD-10-AM/ACHI/ACS

For further information on HIPE variables please see the HIPE Instruction Manual and also the Healthcare Pricing Office website at www.hpo.ie

Appendix B: Clinical Coding Practice Framework

The Clinical Coding Practice Framework has been included here with the kind permission of HIMAA

Background
This Framework was developed from the Standards for Ethical Conduct in Clinical Coding, an appendix within the Australian Coding Standards [1], by the Health Information Management Association of Australia's Practice Quality and Safety Standards Committee with input from the President of the Clinical Coders' Society of Australia. Stakeholder feedback from a consultation period between August 2018 and August 2019 was also considered, including a symposium on 5 March 2019 in Sydney.

This was in response to the transfer of stewardship of the Standards for Ethical Conduct in Clinical Coding (now known as the Clinical Coding Practice Framework) to the Health Information Management Association of Australia (HIMAA) by the Independent Hospital Pricing Authority (IHPA) at the beginning of 2018.

Introduction
To support national consistency in clinical coding practice, the Clinical Coding Practice Framework has been developed to provide guidance in defining and promoting good practices for those involved in the clinical coding process (e.g. clinical coders, clinical documentation improvement specialists, clinical coding auditors, health information managers, and managers (at all levels) of the clinical coding process).

Specifically, this Practice Framework is to be used by those involved in the production of coded clinical data to ensure the integrity of the data for use in patient safety and quality, research, epidemiology, health care management and planning, evaluation and reimbursement.

The Framework also assists other related health care administrators/stakeholders to understand good practice surrounding the process of clinical coding (e.g. those working in clinical roles, hospital performance units, finance units and hospital executive/management).

The Framework should be adopted and/or applied in any type of health care facility or organisation undertaking the clinical coding function. It is not intended for the purposes of coding audit.

Clinical Coding and Legal Requirements
Those involved in the clinical coding process must:

• Protect the confidentiality of all information obtained in the course of service provision.

• Respect confidential information shared by colleagues in the course of professional relationships and transactions.

• Disclose only information that is directly relevant or necessary to achieve the specific purpose of an instance of disclosure.

• Be aware of, uphold and comply with local, State, Territory and Commonwealth policies and legal requirements regarding privacy, confidentiality, disclosure and security of patient related information.

• Ensure work-related information privacy and confidentiality policies are enacted.

Clinical Coding Practice

Good practices are core to the clinical coding process to ensure the integrity of coded clinical data at a national level. Those involved in the clinical coding process should endeavour to uphold this Clinical Coding Practice Framework in all aspects of their role. The Framework consists of the practices detailed below

Those involved in the clinical coding process should:

• Endeavour to have access to all the relevant clinical information (electronic or paper-based) to undertake the abstraction and clinical coding process.

• Ensure that the assignment of diagnoses and intervention codes is justified by documentation relevant to the episode of care.

• Apply the classification conventions, the Australian Coding Standards (ACS) and other official reporting requirements[2] for the purpose of abstracting, classifying and sequencing diagnoses and intervention codes to accurately reflect the clinical truth of the patient's episode of care.

• Participate in interdisciplinary engagement for the purpose of clarification of diagnosis or intervention detail or of ambiguity in clinical documentation.

• Improve clinician understanding of the roles of those involved in the clinical coding process. This may be via one-to-one interactions, team meetings, education sessions, publications or presentations.

Those involved in the clinical coding process must not:

• Assign diagnoses or intervention codes without supporting documentation relevant to the episode of care as defined in the current edition of the ACS.

• For the purpose(s) of minimising financial loss or legal liability:
    o Omit or assign diagnosis or intervention codes;
    o Amend or influence other data items such as the assignment of the Condition Onset Flag.

• Use the interdisciplinary engagement process inappropriately. This includes:
    o prompting or using leading clinician documentation queries that instruct, or indicate a desired response from a clinician;
    o use details for potential financial gain or avoidance of financial loss as part of a clinician documentation query process.

• Participate in processes that prevent a patient's episode of care from being reported accurately.

• Submit to pressure from others, or apply such pressure, to manipulate coded clinical data or other related data for any purpose that misrepresents the patient's episode of care or prevents adherence to classification conventions, Australian Coding Standards and other official reporting requirements.

Appropriate Clinician Documentation Queries

If the documentation within the health care record is inadequate for complete and accurate classification, those involved in the clinical coding process should seek more information from the clinician. This should be undertaken using an appropriately formulated clinician documentation query.

Clinical Coding Quality and Education
Those involved in the clinical coding process should:

• Participate in quality improvement activities to ensure the quality of clinical coded data.

• Assist in the development and application of appropriate clinical coding protocols, including demonstration of courtesy towards, and mutual respect for, colleagues, and accountability for the individuals' work.

 • Participate in ongoing education to ensure that clinical coding skills and clinical knowledge meet the appropriate level of competence for the health care/organisational setting.

• Contribute (where appropriate) to ongoing development of classification systems in conjunction with appropriate classification and clinical experts[3].

• Participate in developing and strengthening of the clinical coding workforce through supporting peers and networking with others interested in the management of health information and clinical coding.

Effective from 5 September, 2019

1. Australian Consortium for Classification Development, 2017, Australian Coding Standards for the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, Tenth Edition and the Australian Classification of Health Interventions, Independent Hospital Pricing Authority, Australia.
2. Reporting requirements may be set by states and territories (e.g. state data definitions) and/or national bodies through publications such as METeOR: Metadata Online Registry, Australian Coding Standards and other classification maintenance and development publications (e.g. Coding Rules).
3. Involvement may be achieved through dialogue with organisations, groups, committees associated with developing and maintaining health classifications (such as, but not limited to, state coding advisory committees)

Source: Health Information Management Association of Australia (HIMMA), September 2019 (accessed at: https://www.himaa.org.au/our-work/clinical-coding-practice-framework/)

Appendix C: GUIDANCE IN THE USE OF ICD-10-AM/ACHI/ACS/ICS

The main aim of coding is: *To classify clinical concepts into code*

Originally designed to provide access to information contained in clinical records for research, education, and administration, medical codes are now also utilised to facilitate payment of health services, to determine utilisation patterns and to evaluate the appropriateness of health care costs. Coding also provides the basis for epidemiological studies and research into the quality of health care.

The classification of clinical concepts and/or entities (i.e. a disease, complication or injury, an intervention or procedure) into code is a complex activity. Because coded data is used in so many areas, it is essential that classification is performed **correctly and consistently** in order to produce meaningful statistics to aid in the planning of the health care needs.

In order to classify accurately, it is essential to have a working knowledge of medical science and to understand the characteristics, terminology and conventions of ICD-10-AM. The Alphabetic Index contains many terms not included in the Tabular List, and clinical coding requires that the Alphabetic Index, the Tabular List, the *Australian Coding Standards* and the *Irish Coding Standards* are consulted before a code is assigned.
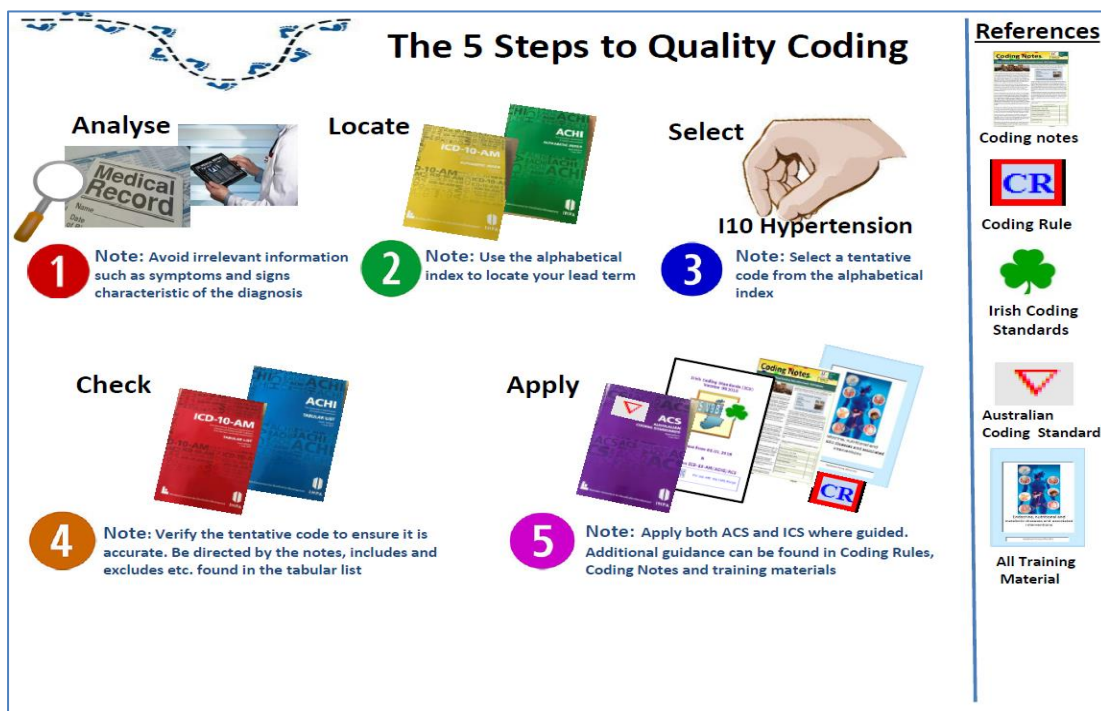
Source: Healthcare Pricing Office, Finance Division, HSE   www.hpo.ie

Detailed guidance on the five steps to quality coding is provided on the following pages for the classification of diseases and procedures.

CLASSIFICATION OF DISEASES

There are several steps in classifying diseases and the following is a summary to assist with the classification of complete and accurate HIPE Data.

1. **ANALYSE:** Identify the clinical concept to be classified and refer to the appropriate section of the Alphabetic Index.
   Note: Avoid indiscriminate multiple coding of irrelevant information, such as symptoms or signs characteristic of the diagnosis.

2. **LOCATE** the **lead/main term** & any essential modifiers.
   - Use the alphabetical index to search for conditions, diseases, external causes, symptoms and other factors influencing health status. For diseases and injuries, this is usually a noun for the pathological condition. However some conditions expressed as adjectives or eponyms are included in the Alphabetic Index as lead/main terms.
   - Identify any terms indented (with a dash) under the lead/main term, these *essential modifiers* may affect the code – e.g. site or stage of a disease
     Read any terms enclosed in parentheses after the lead term or essential modifiers (these *non-essential modifiers* do not affect the code) until all the words in the clinical concept have been accounted for.
   - Read and be guided by any instructional note(s) that appears under the lead term.

   - Follow carefully any cross references ('*see*' and '*see also*') found in the Alphabetic Index.

3. **SELECT** – a tentative code
   - Select the most appropriate code from the alphabetical index.

4. **CHECK –** the code against the Tabular list.
   - Refer to the Tabular List to verify the suitability of the code selected.
   - For disease classification note that a three character code in the Alphabetic Index with a dash in the fourth or fifth position means that there is a fourth or fifth character to be found in the Tabular List. Further subdivisions to be used in a supplementary character position may not be indexed and therefore must be located in the Tabular List.
   - Be guided by any inclusion terms, instructional notes and excludes notes under the selected code or under the chapter, block or category heading.

5. **APPLY** – Australian Coding Standards, Irish Coding Standards & assign the code.
   Check both ACS and ICS for specific guidelines to assist accurate code assignment. Refer to the General standards for diseases, and specialty standards, as indicated by an ACS symbol in the Tabular List.

   Please note*:*

   - Classification guidelines in Specialty Standards can override guidelines in General Standards.
   - There is an alphabetic index to assist with the location of Australian Coding Standards
   - Additional guidelines are published in training material provided by the HPO, Coding Notes & Coding Rules.

CLASSIFICATION OF INTERVENTIONS/PROCEDURES

There are several steps in classifying interventions and the following is a summary to assist with the classification of complete and accurate HIPE Data.

1. **ANALYSE:** Identify the clinical concept to be classified and refer to the appropriate section of the Alphabetic Index.

    Note: Avoid indiscriminate multiple coding of irrelevant information, such as operative approach or procedural components.

2. **LOCATE** the **lead/main term** & any essential modifiers.
    *   Use the alphabetical index to interventions. For interventions, this is usually a noun identifying the type of intervention performed. However some interventions expressed as adjectives or eponyms are included in the Alphabetic Index as lead/main terms.

    *   Identify any terms indented (with a dash) under the lead/main term, these *essential modifiers* may affect the code – e.g. site or terms providing more information about the intervention.
        Read any terms enclosed in parentheses after the lead term or essential modifiers (these *non-essential modifiers* do not affect the code) until all the words in the clinical concept have been accounted for.
    o   Read and be guided by any instructional note(s) that appears under the lead term.
    *   Follow carefully any cross references ('*see*' and '*see also*') found in the Alphabetic Index.

3. **SELECT** – a tentative code
    *   Select the most appropriate code from the alphabetical index.

4. **CHECK –** the code against the Tabular list.
    *   Refer to the Tabular List to verify the suitability of the code selected.
    *   In the ACHI Alphabetic Index, a code with five digits and a block number in parentheses (e.g. 92514 [1910]), requires the addition of a further two digits located in the Tabular List at the appropriate block.
    *   Be guided by any inclusion terms, instructional notes & exclusion notes under the selected code or under the chapter, block or category heading.

5. **APPLY** – Australian Coding Standards, Irish Coding Standards & assign the code.
    Check both ACS and ICS for specific guidelines to assist accurate code assignment. Refer to the General standards for diseases, and specialty standards, as indicated by an ACS symbol in the Tabular List.

    **Please note*:*
    *   Classification guidelines in Specialty Standards can override guidelines in General Standards.
    *   There is an alphabetic index to assist with the location of Australian Coding Standards
    *   Additional guidelines are published in training material provided by the HPO, Coding Notes & Coding Rules.