Irish Coding Standards (ICS)
Version 1 2021
10th Edition ICD-10-AM/ACHI/ACS

For use from 1st January 2021

&

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

HIPE PORTAL

For use with the HIPE Portal

Healthcare Pricing Office (HPO)

Published by the **National Centre for Classification in Health (Sydney),** Faculty of Health Sciences, The University of Sydney, NSW 1825 Australia.

Contents

Note on ICS that are no longer applicable:

- Note that the following Irish Coding Standards are no longer applicable in **10th Edition** ICD-10-AM/ACHI/ACS

- Note that the following Irish Coding Standards are no longer applicable in **8th Edition** ICD-10-AM/ACHI/ACS

- Note the following Irish Coding Standards that are no longer applicable in **6th Edition** ICD-10-AM/ACHI/ACS

Irish Coding Standards (ICS)
Preface to Version 1 2021

The Irish Coding Standards (ICS) Version 1 2021 provides guidelines for the collection of HIPE data for all discharges from January 1st 2021 or as specified using the HIPE Portal software and is to be used in conjunction with 10th Edition ICD-10-AM/ACHI/ACS and the relevant HIPE Instruction Manual. HIPE data was collected using 8th Edition ICD-10-AM/ACHI/ACS from January 2015 until 31st December 2019. All discharges coded in HIPE on or after the 1st January 2020 are coded using ICD-10-AM/ACHI/ACS 10th Edition[1].

Please see Appendix A for a listing of the changes in each version of the ICS from Version 2.0 to date. Within the standards where there is a change related to 10th Edition these standards have been marked with a symbol: 
This is in line with previous updates to the ICS classification whereby for changes to Irish Coding Standards related to 8th Edition ICD-10-AM/ACHI/ACS the symbol  is used. Where there was a change related to 6th edition ICD-10-AM/ACHI/ACS the symbol  has been used.

ICS 2021 Version 1 includes the published ICS 22X2 *Novel Coronavirus/ COVID 19* and Supplementary Guidance for Coding of COVID 19 in the full ICS document. Guidance on the new codes for use with discharges from 2021 on post COVID conditions and multisystem inflammatory syndrome are also included. Guidance on the collection of the administrative data flag for Laboratory confirmed COVID 19 past or present is also provided (see Section 2, XII Laboratory Confirmed COVID 19 Past or Present – Flag).

The Irish Coding Standards for 2021 include the following changes to date:

- **Section 1:** Valid HIPE activity & HIPE Deadlines
  Deadlines for HIPE data and export dates for 2021

- **Section 2**: HIPE Guidelines for Administrative Data
  Section 2 of the Irish Coding Standards contains HIPE Guidelines for Administrative Data.
  - Item V. Patients discharged and readmitted on the same day has been updated to advise on the admission type for admitted daycases.

- **Section 3**: Coding Standards
  Section 3 of the Irish Coding Standards contains standards relating to the coding and classification of data for collection in the HIPE system.
  - 2 new Irish Coding Standards have been created
  - 3 Irish Coding Standards have been updated and expanded

A full listing of all changes made in ICS 2021 Version 1 is provided in Appendix A of this document. Minor amendments have been made to a small number of additional standards.

In December 2016 the Australian Consortium for Classification Development (ACCD) published a revised "Standards for Ethical Conduct in Clinical Coding" document. This has been incorporated into the Irish Coding Standards and is provided in Appendix B of this document. The ACCD have published an additional document *"Clarification on Use of Standards for Ethical Conduct in Clinical Coding"* which has also been incorporated into Appendix B.

[1] For a full listing of all classifications used in HIPE to date please see page 8 of this document

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.

ICD-10-AM/ACHI/ACS 10th Edition is the classification in use in Ireland for all discharges from 1st January 2020.

- **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 ebook 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 ebook 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 ebook format. **The Irish Coding Standards (ICS)** complement these standards.

For information on variables collected by HIPE please also see the HIPE Instruction Manual 2021 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.

[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 10th 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 10th 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.

The responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder.

***A joint effort between the clinician and clinical coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures*.**

Source: Australian Coding Standards. NCCH ICD-10-AM, July 2004 & July 2008, Vol 5, P.1.

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 info@hpo.ie .

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

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 daycases 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 daycase 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.

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.

ICS Updated:	January 2017 ICS V9.0
Reason for Update:	Elective MAU activity not collective by HIPE.
Further Update:	January 2018 ICS V9B2018
Reason for update:	Guideline expanded and moved to separate section.
Further Update:	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.
Further 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 daycase ward.

HIPE Coding Deadlines

- HIPE Clinical Coding Deadlines

The deadline for HIPE data to be coded is within 30 days of discharge.
For example discharges from January 2021 are to be coded by the end of February export

- Prioritised coding of COVID 19 discharges:

For the period of the COVID 19 pandemic the deadline for the coding of OCIVD 19 discharges is 48 hours after discharge or as near as is practicably possible.

- HIPE Export Dates for 2021

HIPE EXPORT MONTH	DOWNLOAD ALL CASES	FINAL RECEIPT DAY
End of January 2021	Sunday 31 January 2021	Wednesday 3 February 2021
End of February 2021	Sunday 28 February 2021	Wednesday 3 March 2021
End of March 2021	Wednesday 31 March 2021	Wednesday 7 April 2021
End of April 2021	Friday 30 April 2021	Thursday 6 May 2021
End of May 2021	Monday 31 May 2021	Thursday 3 June 2021
End of June 2021	Wednesday 30 June 2021	Monday 5 July 2021
End of July 2021	Saturday 31 July 2021	Thursday 5 August 2021
End of August 2021	Tuesday 31 August 2021	Friday 3 September 2021
End of September 2021	Thursday 30 September 2021	Tuesday 5 October 2021
End of October 2021	Sunday 31 October 2021	Wednesday 3 November 2021
End of November 2021	Tuesday 30 November 2021	Friday 3 December 2021

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 dayward 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

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.

ICS Updated: January 2018 V9B2018
Reason for Update: Updated to advise that discharge lounges cannot be discharge wards on HIPE.

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

Prior to coding Acute Medical Assessment Unit (AMAU) activity, hospitals must register 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.*

ICS Updated:	January 2017 ICS V9.0
Reason for Update:	Elective MAU activity not collective by HIPE.

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.

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]**

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

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

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 dayward 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 daycases remains that of the daycase.

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
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 whole grams 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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~~Hospital Activity Not Collected By HIPE~~

~~Activity not currently collected by HIPE includes out-patient activity, virtual wards, A&E/ED cases and/or "well babies". Elective admissions to Acute Medical Assessment Units are not collected by HIPE and are to be reported as outpatient activity~~

ICS Updated: January 2017 ICS V9.0
Reason for Update: Elective MAU activity not collective by HIPE.
ICS Updated & Moved: A new section has been created in ICS V9B2018 to further specify and clarify valid HIPE activity and non-valid HIPE activity.

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

From 1st January 2019 HIPE will collect 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 2020 HIPE Instruction Manual).

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

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

- 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.

- 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

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

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

Note:

- Subsequent periods of CVS in the same episode of care should be added together.
- 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.

Published:	Irish Coding Standards 2019 V1
Effective From:	January 2019
Reason for Standard:	This guideline on duration of continuous ventilatory support has been introduced in preparation for an update to the AR DRG V10. This variable is required in AR DRG V10 and is being introduced in advance of such an update.

XI. CLINICAL CODING SCHEMES USED IN HIPE IN IRELAND:

- From 1st January 2020 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

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XII. LABORATORY CONFIRMED COVID 19 PAST OR PRESENT- FLAG

COVID-19 Flag – Urgent response for collection during the current pandemic

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 COVID-19 during the current episode of care (Laboratory confirmed cases **U07.1 Emergency use of U07.1 [COVID-19, virus identified**]

OR

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

OR

There is documentation in the chart that the patient was previously diagnosed with 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.
- 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,

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

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 (item 31)

Published:	Irish Coding Standards 2020 V1.4
Effective From:	October 2020 (can be applied to all discharges coded from this date, can also be applied to discharges before October 1st 2020 but this is not a requirement)
Reason for Standard:	This flag is an urgent response during the pandemic to identify patients who had laboratory confirmed COVID 19 at any time. This variable was requested by the Department of Health.

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 in 2020. 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 GENERAL ABSTRACTION GUIDELINES

Number of Diagnoses

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

Abnormal findings/Test results

As per **ACS 0010** General Abstraction Guidelines 'Do not code laboratory, x-ray, pathological and other diagnostic results which require the interpretation of the treating clinician to decide their clinical significance and/or relationship to a specific condition.'

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

Do not assign a code based on a test result. A test result should only support a documented condition.

Example 2:

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

Codes: N18.2 Chronic kidney disease, stage 2

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)*

Example 3:
A patient has Hb 8.8 documented in the clinical notes and is given a blood transfusion. A code for anaemia would **not** be assigned in this case unless the condition is clearly documented by the treating clinician.

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.

Clinical Documentation for HIPE coding and Electronic Healthcare Records

ICS 0010 General Abstraction Guidelines has been expanded to include guidance on use of Clinical Documentation for HIPE coding and the Electronic Healthcare Record:

The information provided below has previously been published in Coding Notes (July 2017) and provides guidance on the use of clinical documentation including nursing notes.

Guidance on Clinical Documentation and Nursing Notes:

The introduction to the Australian Coding Standards states: *"The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."*

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.

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 discipline it can be coded regardless of whether the medical officer [doctor] has documented it.

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) should not be interpreted by coders. The condition must be documented by a clinician including 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, minor injuries and incontinence

- 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 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.

Published:	Coding Notes July 2006
Effective From:	Guideline has been in place with all classifications used in Ireland
Reason For Standard:	ICS 0010 is a continuation of existing practice
ICS Updated:	January 2009 ICS V2
Reason for Update:	Addition of further examples to the existing standard
Further Updated	Jan 2011 to include increase in number of diagnoses
Further Updated:	January 2018 ICS V9B2018 to include section on clinical documentation, nursing notes and electronic healthcare records.

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) can be repeated 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 duplicated codes have been underlined.

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

Published:	Irish Coding Standards V9B2018 January 2018
Effective From:	January 2018
Reason for Standard:	ICS 0025 allows for duplication of codes when one is HADx and the other is not a HADx. This is the only reason where duplication of diagnoses codes is permitted.
Standard Updated:	January 2020 – example added to show double coding for pressure injuries of same site and stage.
Standard Updated	January 2020 in version 1.2 to update the place of occurrence code in example 1 for 10th edition.

ICS 0027 MULTIPLE CODING

Consultant Numbers (see also HIPE Instruction Manual page 12)

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

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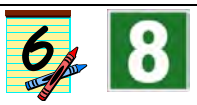
ICS 0048 CONDITION ONSET FLAG

~~The condition onset flag, detailed in ACS 0048, is not currently assigned in Ireland.~~

~~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 <u>IS</u> assigned:**

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

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. postprocedural 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 4)
- 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) is not assigned in the following circumstances:

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

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[8]. 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.

[8] *"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).

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	-

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
Methicillin resistant agent	Z06.52	✓ 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.
Further Update:	January 2018 ICS V9B2018 standard updated to advise that where a neonate has a risk of sepsis a HADX flag is not assigned.
Further Update:	January 2021: 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 10th 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 SIRs, Sepsis, severe 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

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

This is supplementary information to the existing ACS 0028 *Para-aortic lymph node biopsy*

Care should be taken when coding **Retroperitoneal Lymph Node Dissection** (RPLND). If 'para-aortic node biopsy' is documented, check the operation report as this term may describe a more extensive procedure such as:

> A procedure performed by urologists, following treatment for germ cell tumours of the testis. The posterior parietal peritoneum is opened between the bifurcation of the aorta up to the third part of the duodenum and all the fat tissue above and between the great vessels is removed. In addition, the major vessels are retracted so that nodal tissue is also removed from around the lumbar veins. This procedure can take up to one hour to perform.

This procedure should be coded as 37607-00 [811] *Radical excision of retroperitoneal lymph nodes.*

Note: Where Retroperitoneal Lymph Node Dissection (RPLND) is performed **following** chemotherapy/radiotherapy for testicular cancer the procedure code 37610-00 [811] *Radical excision of retroperitoneal lymph nodes, subsequent* is to be assigned in order to identify that the procedure is being performed after chemotherapy/ radiotherapy for the neoplasm.

The RPLND procedure is currently performed in a small number of hospitals. The HPO will monitor the reporting of this code by hospitals.

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 Programme to ensure collection of RPLND procedures

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 ORGANPROCUREMENT 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

From 1st January 2011 HIPE will record 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 2017 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]	6/1/201x
Addnl Procedures:	General anaesthetic	92514-19 [1910]	6/1/201x
	Fibre-optic colonoscopy to caecum	32090-00 [905]	5/1/201x

Example 2

Patient admitted as an emergency on 10th January 2017 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]	10/1/201x
Addnl Procedures:	Sedation	92515-99 [1910]	10/1/201x
	Transfusion packed cells	13706-02 [1893]	10/1/201x

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

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 daycase specifically for an ultrasound − the ultrasound can be coded. However if the patient is admitted as a daycase for an ultrasound guided procedure − code the procedure performed and not the ultrasound.

The following two 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])
- Transoesophageal echocardiogram (TOE) (55118-00 [1942])

Finally please note that the ACCD have updated the coding advice in Coding Rule Q2712 to state that the ultrasound element of the procedure is not coded. This ICS is in line with advice issued by ACCD on the coding of ultrasounds and ultrasound guided procedures.

First Published:	January 2021
Effective from:	Continuation of existing advice
Reason for standard:	Clarification on the coding of ultrasounds and to publish previously issued coding advice.

ICS 0044 CHEMOTHERAPY

Oral chemotherapy is coded when administered.

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

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
	Addnl 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
	Addnl 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.

~~ICS 0104 Viral Hepatitis~~

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 SIRS, SEPSIS, SEVERE SEPSIS AND SEPTIC SHOCK

The guidelines in ACS 0110 SIRS, Sepsis, Severe Sepsis and Septic Shock apply in Ireland except for the coding of Systemic Inflammatory Response Syndrome (SIRS) of infectious origin. ICS 0110 provides guidance on collection of HIPE data in 10th edition of ICD-10-AM for SIRS of infectious origin.

CLASSIFICATION

Systemic Inflammatory Response Syndrome [SIRS]

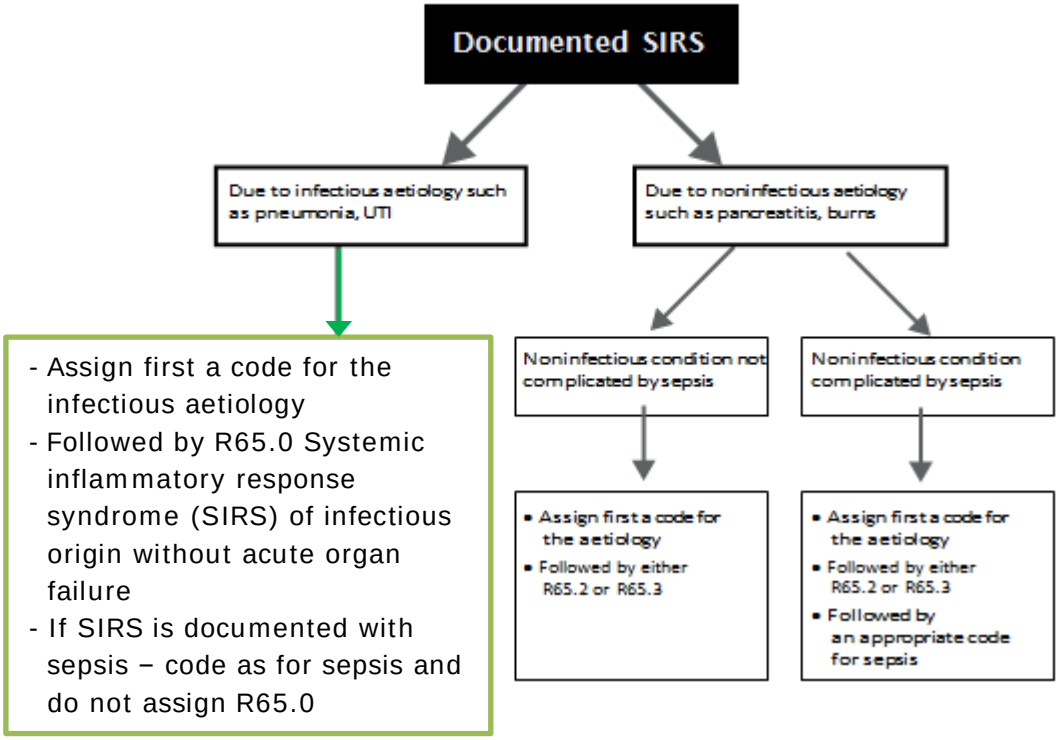
The causes of SIRS are broadly classified as infectious and noninfectious in origin.

- Where there is documentation of SIRS due to noninfectious aetiology, assign:
  - first a code for the aetiology (pancreatitis, trauma etc)
  - followed by either **R65.2** *Systemic inflammatory response syndrome [SIRS] of noninfectious origin without acute organ failure* OR **R65.3** *Systemic inflammatory response syndrome [SIRS] of noninfectious origin with acute organ failure*, as appropriate.

- Where there is documentation of SIRS due to infectious aetiology:
- 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.

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



EXAMPLE 1:
A 55 year old male admitted to hospital with a diagnosis of severe acute pancreatitis (alcohol-induced) with documentation of systemic inflammatory response syndrome and acute multi-organ failure (renal and respiratory).
Codes:
K85.2 Alcohol-induced acute pancreatitis
R65.3 Systemic inflammatory response syndrome [SIRS] of noninfectious origin with acute organ failure
F10.1 Mental and behavioural disorders due to use of alcohol, harmful use
N17.9 Acute kidney failure, unspecified
J96.09 Acute respiratory failure, type unspecified

EXAMPLE 2:
A 55 year old male admitted to hospital with a diagnosis of severe acute pancreatitis (alcohol-induced) with documentation of systemic inflammatory response syndrome and acute multi-organ failure (renal and respiratory).
The patient's condition worsened and a fine needle aspiration biopsy of the pancreas revealed pancreatic necrosis.
The patient was diagnosed with sepsis and blood cultures were positive for Clostridium perfringens.
Codes:
K85.2 Alcohol-induced acute pancreatitis
R65.3 Systemic inflammatory response syndrome [SIRS] of noninfectious origin with acute organ failure
F10.1 Mental and behavioural disorders due to use of alcohol, harmful use
N17.9 Acute kidney failure, unspecified
J96.09 Acute respiratory failure, type unspecified
A41.4 Sepsis due to anaerobe
30094-05 [**977**] Percutaneous needle biopsy of pancreas

Example 3

Patient admitted with breathing difficulties and persistant 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*

ICS Effective From:	January 2020
Reason for Standard:	The introduction of 10th edition required an Irish Coding Standard to be introduced on the coding of SIRS of infectious origin. There is no change to the other sections of ACS 0110 in relation to sepsis, severe sepsis and septic shock. In Australia SIRS is coded as sepsis in 10th edition and this guidance is not to be applied in Ireland. In Ireland Code R65.0 is retained for use for the coding of SIRS. This Irish coding standard also required ICS 0049 to be developed due to a change to the list of codes contained in ACS 0049 *Disease codes that must never be assigned*.
Standard Updated:	Updated in ICS V1.4 with correct code description added for R65.0 *Systemic inflammatory response syndrome (SIRS) of infectious origin without acute organ failure* in one instance in ICS 0110.

ICS 0112 INFECTION WITH DRUG RESISTANT MICROORGANISMS

Drug Resistance:

- When **ONLY** Methicillin resistant is documented: assign Z06.52 *Resistance to methicillin.*
- When Methicillin resistant **AND** Multi-resistant are documented together: assign a code for each type of resistance. Z06.52 *Resistance to methicillin* only includes methicillin resistance, an additional code must be assigned for resistance to any other antibiotics.
- When **ONLY** Multi-resistant is documented and the drugs are specified – code each resistant drug type separately.
- Z06.67 *Resistance to multiple antibiotics* and Z06.77 *Resistance to multiple antimicrobial drugs* are only assigned when an agent is **resistant to two or more** antibiotics or antimicrobials drugs **but the type of drug is not specified.**
- Where **multiple resistant** antibiotics or antimicrobials **are specified – code each type separately.**

Coding of colonisation with a drug resistant bacterial agent
If a patient has a positive swab for a drug resistant bacterial agent but no infection is present as per ACS 0112 *Infection with drug resistant microorganisms*, then the following additional diagnoses codes may be assigned:

Z22.3	*Carrier of other specified bacterial disease*
Z06.--	*Resistance to antimicrobial drugs*

These codes will only be assigned if they meet the criteria in ACS 0002 *Additional diagnoses*.

Example 1
A patient is admitted with inferior myocardial infarction. Routine nasal swab is positive for methicillin resistant staphylococcus aureus, which leads to increased barrier nursing care.

Codes: I21.1 *Acute transmural infarction of inferior wall*
Z22.3 *Carrier of other specified bacterial diseases*
Z06.52 *Resistance to methicillin*

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.

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."[9]

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.[10]

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[11] and New Zealand[12]. In SNOMED, 240354007 Verotoxigenic E. Coli gastrointestinal tract disorder maps to ICD-10 code A04.3 *Enterohaemorrhagic Escherichia coli infection*[13].

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:
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

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

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

ACCD Ref No: TN1037 | Published On: 03-Feb-2016 | Status: Current

Zika virus (synonymously known as Zika fever and Zika virus infection) is a mosquito-borne viral disease caused by Zika virus (ZIKV). Symptoms include mild fever, rash, headaches, arthralgia, myalgia, asthenia, and non-purulent conjunctivitis. Symptoms appear between three to twelve days after the mosquito vector bite. One in four people may not develop symptoms, but in those who are affected the disease is usually mild with symptoms that last between two and seven days, and usually clears from the blood within a week.

A recent concern has arisen due to an increase in the incidence of Zika virus internationally, with possible links between the infection in pregnant women and subsequent birth defects (including microcephaly). As a result, the WHO has advised that effective from 21 December 2015 U06.9 *Emergency use of U06.9* is to be assigned to monitor Zika virus internationally.

Zika virus is currently classified to A92.8 *Other specified mosquito-borne viral fevers.* This is a residual code that classifies a number of disease concepts and so WHO have requested that U06.9 is assigned for all cases of Zika virus from 21 December 2015 to facilitate unique identification of Zika virus for global monitoring.

Therefore, in the event that cases of Zika virus are confirmed, assign **both**:

A92.8 *Other specified mosquito-borne viral fevers* **and**

U06.9 *Emergency use of U06.9.*

For confirmed Zika virus in pregnant patients, assign:

O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium*

with A92.8 and U06.9 as additional diagnoses.

Assign P00.2 *Fetus and newborn affected by maternal infectious and parasitic diseases* if maternal infection with Zika virus is documented as affecting a fetus or newborn (meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses)*. However, do not assign A92.8 or U06.9 to the infant's episode of care unless the infant has documentation of confirmed (congenital) Zika virus.

Continued on next page

ICS 01X0 ZIKA VIRUS – WHO alert *Contd.*

Where patients are transferred to another facility for *suspected Zika virus*, follow the guidelines in ACS 0012 *Suspected conditions* and assign:

A92.8 *Other specified mosquito-borne viral fevers*

Z75.3 *Unavailability and inaccessibility of health-care facilities*

Do not assign U06.9 for patients transferred with unconfirmed cases of Zika virus.

A unique code for Zika virus in Chapter 1 *Certain infectious and parasitic diseases* will be considered for ICD-10-AM Tenth Edition.

References

Centers for Disease Control and Prevention 2016, *'Questions and answers for pediatric healthcare providers: infants and Zika virus infection,* viewed 2 February 2016 http://www.cdc.gov/zika/hc-providers/qa-pediatrician.html

Medew, J, Miletic, D & Flitton, D 2016, 'Six cases of Zika virus in Australia last year as pregnant women warned not to travel', *The Sydney Morning Herald,* 26 January, viewed 1 February 2016, http://www.smh.com.au/national/urgent-travel-warning-for-pregnant-australian-women-at-risk-of-zika-virus-20160125-gmdv5u.html

Pan American Health Organisation n.d. '*Zika virus infection',* viewed 17 December 2015 http://www.paho.org/hq/index.php?option=com_topics&view=article&id=427&Itemid=41484&lang=en

Published 03 February 2016,
for implementation 21 December 2015

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.*
ICS Updated:	ICS V9.0 January 2017 as per advice from ACCD on coding of Zika Virus.

~~ICS 02X0 CLASSIFICATION OF ATTENDANCES AT ONCOLOGY DAY WARDS~~

ICS effective from: January 2010
Advice first published: October 2009
Updated: January 2013
1. Decision tree updated at "First Patient Encounter" to state "First Patient Encounter without chemotherapy" as per text of standard
2. Numbers added to options in decision tree to reflect text and data entry options

Reason for Standard: To identify repeat non-chemotherapy admissions to oncology day wards for previously diagnosed neoplasms.
Standard Updated: Example updated for 8th edition ICD-10-AM/ACHI/ACS
Standard Deleted: Standard deleted in ICS V9.0 as information available through data analysis.

~~ICS 0224 Palliative Care~~

First Published: ICS V5.0 January 2013
ICS Effective From: January 2013
Reason for standard: This guideline is to provide clarification for coders on the coding of Z51.5 *Palliative Care.*
Standard Deleted: In 10th edition the standard on palliative care was updated and relocated to Chapter 21. An Irish Coding Standard ICS 2116 *Palliative care* has now been created.

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]*

First Published: ICS V3.1 July 2011
ICS Effective From: July 2011
Reason for standard: This guideline has been developed in conjunction with the National Cancer Control Programme (NCCP) to provide a national standard for the coding of radiotherapy treatment delivered by IMRT and IGRT.

ICS 0233 MORPHOLOGY

Morphology codes are not assigned in Ireland.

Reason For Standard: ICS 0233 is a continuation of existing practice.

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*

First Published: ICS V9.0 January 2017
ICS Effective From: January 2017
Reason for standard: Clarification of coding instructions for radiotherapy planning

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.
- V*enesection 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 STROKE

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 3.

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 Stroke: "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 example 3 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.

Chapter 9 Circulatory System (09--)

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.

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

~~**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 and 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 | 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: "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 below Coding Rule Ref No: Q3570 | Published On: 21-Sep-2020).

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 vald 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.

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

- **Influenza – other types**
    - **Code J09** *influenza due to identified zoonotic or pandemic influenza virus* **is restricted to influenza <u>A/H5N1</u> ONLY.** Do not assign J09 for any other types of influenza.

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

Effective from:	Continuation of existing practise
First Published:	advice issued to all HIPE staff by HPO in February 2018
Reason for standard:	Continuation of existing practice. This standard provides general information on the coding of Influenza.
Standard updated:	Standard renumbered and revised due to the introduction of ACS 1012 in 10th edition and changes to the alphabetic index for looking up influenza.

~~ICS 1204 PLASTIC SURGERY~~

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 intent 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.

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 140X STANDARDISATION OF COLLECTION OF COLPOSCOPY ACTIVITY

All procedures falling within the category specified below are to be reported to HIPE. In so doing, all areas where these procedures are performed are to be registered in advance with the Healthcare Pricing Office.

The specific procedures are:

1275 Destruction procedures on cervix

Code also when performed:
• colposcopy (35614-00 **[1279]**)

35608-00 Cautery of cervix
Diathermy of cervix

35646-00 Radical diathermy of cervix

Includes: biopsy

35647-00 Large loop excision of transformation zone [LLETZ]
LLETZ excisional cone biopsy
Loop electrosurgery excision procedure [LEEP]

35539-02 Laser destruction of lesion of cervix

35608-01 Other destruction of lesion of cervix
Cryotherapy of lesion of cervix

1279 Examination procedures on vagina

35614-00 Colposcopy

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 daycase or inpatient admission please code in accordance with national coding guidelines.

~~ICS 15X0 PRINCIPAL DIAGNOSIS SELECTION FOR OBSTETRIC CASES~~

Effective From:	January 2005
First Published:	Coding Matters Volume 13 Number 2, September 2006, page 6
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 completed, 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 incomplete, 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:

Z30.2 *Sterilisation*

First Published:	Coding Notes July 2005
Reason For Standard:	ICS 15X1 is a continuation of existing practice.

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

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 documented diagnosis 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 Updated:	ICS V2 Jan 2009
Reason for Update:	Example updated
Standard updated:	Example updated for 8th Edition to reflect new delivery diagnosis codes.

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

Fetal viability in Ireland is defined as 22 completed weeks 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 *Excessive vomiting after 20 weeks* is to be applied for vomiting after 22 weeks in Ireland.

Effective From:	January 2008
Reason for Standard:	Differences between Ireland and Australia in the definition of fetal viability. This standard maintains appropriate use of codes for Irish system.
First Published:	ICS V1.3

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 additional diagnosis.

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 well babies are not coded in Ireland. Information on well babies is downloaded to the HIPE system but is not coded.

Z38 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.

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*.

First Published: Coding Notes March 2006
Information also provided at ICD-10-AM 4th Edition Pre-Implementation workshops

ICS 2116 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 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.
- Also refer to the guidance in Coding Rules Ref No: Q2914 | Published On: 15-Jun-2015 for information on synonymous terms for palliative care

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 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

ICS 22X1 VAPING RELATED DISORDERS

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

"Ref No: TN1511 | Published On: 16-Dec-2019 | Status: Current
SUBJECT: Vaping-related disorders; use of WHO code for emergency use
Effective from 25 September 2019

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 *Emergency use of U07.0* 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*
- U07.0 *Emergency use of U07.0* as an additional diagnosis

Note: DO NOT assign U07.0 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

Centers 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

Centers 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."**

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

ICS 22X2: NOVEL CORONAVIRUS (COVID-19)

Please see Coding Rules below published by the Independent Hospital Pricing Authority (IHPA) which incorporates guidance from the WHO regarding the HIPE coding of Novel Coronavirus (COVID-19).

A further supplementary guidance document (V1.2) is provided in addition to the classification advice below to provide further detail and scenarios for clinical coders.

The Coding Advisory CA1- 060420 Coding of pneumonia is also provided.

Australian Classification Exchange

IHPA

Coding Rule

Ref No: TN1530 | Published On: 07-Feb-2020 | Status: Current

SUBJECT: Coronavirus disease 2019 (COVID-19)

Effective from 1 January 2020 (Updated 27/03/20)

Novel coronavirus (COVID-19) is a new (or 'novel') strain of coronavirus not previously identified in humans before the outbreak in Wuhan, Hubei Province, China.

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV).

Common signs of COVID-19 infection include respiratory symptoms such as cough, shortness of breath, breathing difficulties and fever. In severe cases, the infection can cause pneumonia, severe acute respiratory syndrome, kidney failure and death.

The World Health Organization (WHO) have advised the following;

- *U07.1 Emergency use of U07.1* (COVID-19, virus identified) is to be assigned when COVID-19 has been documented as confirmed by laboratory testing

- *U07.2 Emergency use of U07.2* (COVID-19, virus not identified) is to be assigned when COVID-19 has been documented as clinically diagnosed COVID-19, including evidence supported by radiological imaging (i.e. where a clinical determination of COVID-19 is made but laboratory testing is inconclusive, not available or unspecified)

IHPA also advise that Emergency use of *U06.0 Emergency use of U06.*0 (COVID-19, ruled out) is to be assigned when laboratory testing for COVID-19 has been performed, but ruled out (i.e. negative test result)

References:

- Australian Government Department of Health 2020, *Novel coronavirus (2019-nCoV)*, DOH, Canberra, viewed 4 February 2020, https://www.health.gov.au/health-topics/novel-coronavirus-2019-ncov .
- Centers for Disease Control and Prevention 2020, *2019 Novel coronavirus*, US Department of Health and Human Services, viewed 4 February 2020, https://www.cdc.gov/coronavirus/index.html .
- World Health Organization 2020a, *Coronavirus*, viewed 4 February 2020, https://www.who.int/health-topics/coronavirus .
- World Health Organization 2020b, *Q&A on coronavirus*, viewed 4 February 2020, https://www.who.int/news-room/q-a-detail/q-a-coronaviruses .

Initially published by IHPA on 07 February 2020, for implementation 01 January 2020. Updated by IHPA 27 March 2020.

CLASSIFICATION GUIDELINES FOR COVID 19

Laboratory Confirmed cases of COVID 19

Laboratory confirmed COVID-19: An individual with a laboratory confirmation of infection with COVID-19, irrespective of clinical signs and symptoms. Use U07.1 Emergency use of U07.1 [COVID-19, virus identified] when COVID-19 has been confirmed by laboratory testing irrespective of severity of clinical signs or symptoms.

Where documentation indicates confirmed COVID-19 **with symptoms**, assign:

Principal Diagnosis: A code for the symptom (s) or condition (s) as per the guidelines in ACS 0001 *Principal diagnosis*

Additional Diagnoses: *B97.2 Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent

and

U07.1 Emergency use of U07.1 (COVID-19, virus identified)

Where laboratory confirmed COVID-19 is documented **without symptoms**, assign:

Principal Diagnosis: *B34.2 Coronavirus infection, unspecified site*

Additional Diagnosis: *U07.1 Emergency use of, as an additional diagnosis U07.1* (COVID-19, virus identified)

Note:

- DO NOT assign U07.1 *Emergency use of, as an additional diagnosis U07.1* (COVID-19, virus identified) to episodes where novel coronavirus is only suspected/clinically diagnosed.
- Where COVID 19 is acquired during an episode of care the codes above can be assigned as additional diagnosis with the HADX flag(s) assigned as appropriate.

Clinically diagnosed or probable COVID-19

Clinically diagnosed or probable COVID-19: An individual who is suspected of having COVID-19 but laboratory testing for COVID-19 is inconclusive or not available but in whom a clinical determination of COVID-19 has been made. Use U07.2 Emergency use of U07.2 [COVID-19, virus not identified] when COVID-19 is diagnosed clinically but laboratory testing is inconclusive, not available, or unspecified.

Please Note:

- Do not use U07.2 *Emergency use of U07.2,* (COVID-19, virus not identified) where test results are pending.

Where clinically diagnosed or probable COVID-19 is documented **with symptoms**, assign:

Principal Diagnosis: A code for the symptom (s) or condition (s) as per the guidelines in ACS 0001 Principal diagnosis

Additional Diagnoses: *B97.2 Coronavirus as the cause of diseases classified to other chapters to identify the infectious agent*

and

U07.2 Emergency use of U07.2 (COVID-19, virus not identified) to identify cases documented as clinically diagnosed COVID-19 but laboratory testing is inconclusive, not available or unspecified.

Where clinically diagnosed or probable COVID-19 is documented **without symptoms**, assign:

Principal Diagnosis: *B34.2 Coronavirus infection, unspecified site*

Additional Diagnosis: *U07.2 Emergency use of U07.2,* (COVID-19, virus not identified) to identify cases documented as clinically diagnosed COVID-19 but laboratory testing is inconclusive, not available or unspecified.

COVID-19 complicating pregnancy

Where laboratory confirmed or clinically diagnosed COVID-19 is documented as complicating pregnancy, the correct obstetric chapter code is *O98.5 Other viral diseases in pregnancy, childbirth and the puerperium* which is followed by the guidelines in this standard ICS 22X2.

Code the remainder of the episode in accordance with ACS 1521 *Conditions and injuries in pregnancy* and ACS 1500 *Diagnosis sequencing on obstetric episodes of care*.

Suspected COVID-19, ruled out

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

Where suspected COVID-19 is documented **with symptoms**, **but is ruled out**, assign:

Principal Diagnosis:	A code for the symptom(s) or condition(s) as per guidelines in ACS 0001 Principal diagnosis
Additional Diagnosis:	Either *Z03.8 Observation for other suspected diseases and conditions* **Or** *Z03.71 Observation of newborn for suspected infectious condition* **And also assign** *U06.0 Emergency use of U06.0* (COVID-19, ruled out) to identify suspected but ruled out COVID-19

Please Note:

- For cases where COVID 19 has been ruled out a further additional code *Z20.8 Contact with and exposure to other communicable diseases* can be coded as appropriate and only as determined and documented by a clinician.
- Please refer to the supplementary guidance document for further case scenarios for suspected COVID 19, ruled out.

Isolation:

Where isolation is documented, assign Z29.0 *Isolation* as an additional diagnosis.

Post COVID-19 Conditions & Multisystem Inflammatory Syndrome

The following advice on the coding of post COVID-19 Conditionswas published by IHPA in December 2020 effective for discharges from 1st January 2021.

This advice provides guidance on the following codes:

- U07.3 Emergency use of U07.3 [Personal history of COVID-19]
- U07.4 Emergency use of U07.4 [Post COVID-19 condition]

- U07.5 Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]

Ref No: TN1545 | Published On: 18-Dec-2020 | Status: Current

Classification of post COVID-19 conditions

The long term health outcomes of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease 2019 (COVID-19) are uncertain and unfolding.

The World Health Organization has activated two additional emergency use codes to identify episodes of care where documentation indicates a post COVID-19 condition, resulting from either a previous COVID-19 diagnosis or SARS-CoV-2 infection.

These emergency use codes are not for the classification of current infections of SARS-CoV-2 and are never assigned as a principal diagnosis.

In Australia, the post COVID-19 emergency use codes will be implemented as follows:

- assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current.
- assign U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis where clinical documentation indicates a current condition is causally related to previous COVID-19.

Do not assign B94.8 *Sequelae of other specified and infectious and parasitic diseases* as this concept is identified by the assignment of U07.4.

Where clinical documentation indicates previous COVID-19 but it is not clearly linked to a current condition, seek clarification from the treating clinician before assigning U07.4. Where a causal relationship is not established, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19].*

U07.3 and U07.4 are only assigned when COVID-19 is documented as no longer current. This includes where clinical documentation indicates that a patient does not have COVID-19, despite a positive laboratory test result for SARS-CoV-2. This scenario may occur where antibodies remain in the system even though an acute infection is no longer present (World Health Organization 2020). See also Coding Rule *Coronavirus disease 2019 (COVID-19)* when COVID-19 is documented as current.

Example 1:

A patient is diagnosed with interstitial lung disease associated with previous COVID-19. As the clinical documentation states a causal relationship between the interstitial lung disease and previous history of COVID-19, assign emergency use code U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis.

Codes: J84.9 *Interstitial pulmonary disease, unspecified*
U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*

Example 2:

Following a full recovery from viral pneumonia with a SARS-CoV-2 (COVID-19) infection a patient is statistically discharged from an acute admitted episode of care and transferred to rehabilitation. The SARS-CoV-2 infection is no longer active in the rehabilitation episode of care.

In the rehabilitation episode of care, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis NOT U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as the SARS-CoV-2 infection is no longer current.

Codes: J12.8 *Other viral pneumonia*
Z50.9 *Rehabilitation*
U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 3:

Patient admitted with community acquired pneumonia. Laboratory test identifies SARS-CoV-2 positive, but a review by the infectious diseases team states 'old viral RNA that is not infectious'. As there is clinical documentation of a previous SARS-CoV-2 infection but no causal relationship with a current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: J18.9 *Pneumonia, unspecified*
U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 4:

Patient presents with gastro-oesophageal reflux disease. Clinical documentation in the current episode of care notes a recent history of COVID-19. As there is no causal relationship documented between COVID-19 and the current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: K21.9 *Gastro-oesophageal reflux disease without oesophagitis*
U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Reference:

World Health Organization 2020, Serology and early investigation protocols, viewed 2 September 2020,https://www.who.int/emergencies/diseases/novel-coronavirus-2019/serology-in-the-context-of-covid-19.

Published 18 December 2020,
for implementation 01 January 2021.

See next page for TN1545 Multisystem inflammatory syndrome associated with COVID 19

Ref No: TN1545 | Published On: 18-Dec-2020 | Status: Current

Multisystem inflammatory syndrome associated with COVID-19

The COVID-19 pandemic has resulted in reports describing patients with COVID-19-associated multisystem inflammatory conditions that appear to develop after the infection rather than during the acute stage of COVID-19. This condition may be synonymously referred to as:

- paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2 (PIMS-TS)
- multisystem inflammatory syndrome in children (MIS-C) associated with COVID-19
- multisystem inflammatory syndrome in adults (MIS-A).

While the clinical presentation may vary, signs and symptoms generally include persistent fever, abdominal pain, vomiting, diarrhoea, skin rash, mucocutaneous lesions and, in severe cases, hypotension and shock. Some patients may develop myocarditis, cardiac dysfunction or acute kidney injury (Centres for Disease Control and Prevention 2020a; World Health Organization 2020).

To identify this condition, the World Health Organization has activated an emergency use code that will be implemented in Australia as U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19].*

U07.5 *Multisystem inflammatory syndrome associated with COVID-19* is assigned in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Example 1: A patient is diagnosed with multisystem inflammatory syndrome after recovering from COVID-19. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* in accordance with the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

Example 2: A paediatric patient is diagnosed with Kawasaki-like syndrome. Symptoms include fever, odynophagia, two days of diarrhoea and vomiting, and abdominal pain. Laboratory tests reveal residual antibodies from a previous SARS-CoV-2 infection. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* as principal diagnosis. Do not assign additional diagnosis codes for the symptoms or M30.3 *Mucocutaneous lymph node syndrome [Kawasaki]* in addition to U07.5.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

References:

- Centres for Disease Control and Prevention 2020a, Information for healthcare providers about Multisystem Inflammatory Syndrome in Children (MIS-C), United States Department of Health Human Services, viewed 2 September 2020, https://www.cdc.gov/mis-c/hcp.
- Centres for Disease Control and Prevention 2020b, Multisystem Inflammatory Syndrome in Adults (MIS-A), United States Department of Health Human Services, viewed 2 December 2020, https://www.cdc.gov/mis-c/mis-a.html.
- Jiang, L., Tang, K., Levin, M., Irfan, O., Morris, S.K., Wilson, K., Klein, J.D., Bhutta, Z.A. 2020, 'COVID-19 and multisystem inflammatory syndrome in children and adolescents', Lancet Infectious Diseases: Online first, viewed 2 September 2020, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30651-4/fulltext#:~:text=This%20COVID%2D19%2Dassociated%20multisystem,19%2C%20and%20herein%20is%20referred.
- World Health Organization 2020, Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19: Scientific brief, viewed 2 September 2020, https://www.who.int/news-room/commentaries/detail/multisystem-inflammatory-syndrome-in-children-and-adolescents-with-covid-19.

Published 18 December 2020,
for implementation 01 January 2021.

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.

Standard Further Updated: ICS 2021 V1 January 2021

Reason for update: Additional codes released by WHO and IHPA for the classification of Post COVID conditions and multisystem inflammatory response.

See Also: Supplementary Guidance for Classifying COVID 19 (V1.2) and Coding Advisory

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Supplementary guidelines for classifying COVID-19 scenarios in admitted patient care* (V1.2) May 2020

Presentation scenarios	Laboratory confirmed cases [1] Tested positive	Clinically diagnosed or probable cases [2] Testing is inconclusive, unavailable or not specified	Ruled out cases [3] Tested negative
Patient exhibiting symptoms (Symptoms) = Yes Exposure to confirmed case (Exposure [4]) = Yes	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** B97.2 *Coronavirus as the cause of diseases classified to other chapters* U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* [1]	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** B97.2 *Coronavirus as the cause of diseases classified to other chapters* U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* [2]	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** Z20.8 *Contact with and exposure to other communicable diseases* Z03.8 *Observation for other suspected diseases and conditions* [5] - **Or** Z03.71 *Observation of newborn for suspected infectious condition* for neonates U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* [3]
Symptoms = Yes Exposure [4] = No	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** B97.2 *Coronavirus as the cause of diseases classified to other chapters* U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* [1]	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** B97.2 *Coronavirus as the cause of diseases classified to other chapters* U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* [2]	**Principal diagnosis:** Symptom(s) or condition(s) **Additional diagnoses:** Z03.8 *Observation for other suspected diseases and conditions* [5] U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* [3]
Symptoms = No Exposure [4] = Yes	**Principal diagnosis:** B34.2 *Coronavirus infection, unspecified site* **Additional diagnoses:** U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* [1]	**Principal diagnosis:** B34.2 *Coronavirus infection, unspecified site* **Additional diagnoses:** U07.2 *Emergency use of U07.2 [COVID-19, virus not identified* [2]	**Principal diagnosis:** Z20.8 *Contact with and exposure to other communicable diseases* **Additional diagnoses:** U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* [3]
Pregnancy complicated by COVID-19 /other condition (as per ACS 1521 *Conditions and injuries in pregnancy)*	**Code first:** O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium* **Additional diagnoses:** As per advice above	**Code first:** O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium* **Additional diagnoses:** As per advice above	For pregnant patients with COVID 19 ruled out please follow the advice above depending on the circumstances[6].

1 **Laboratory confirmed COVID-19** An individual with a laboratory confirmation of infection with COVID-19, irrespective of clinical signs and symptoms. Use U07.*1 Emergency use of U07.1 [COVID-19, virus identified]* when COVID-19 has been confirmed by laboratory testing irrespective of severity of clinical signs or symptoms.

2 **Clinically diagnosed or probable COVID-19** An individual who is suspected of having COVID-19 but laboratory testing for COVID-19 is inconclusive or not available but in whom a clinical determination of COVID-19 has been made. Use U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* when COVID-19 is diagnosed clinically but laboratory testing is inconclusive, not available, or unspecified.

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

4 This refers to exposure as determined and documented by a clinician, as opposed to patient-reported exposure to COVID-19 alone.

5 From 1 January 2020, an exception has been made to ACS 0012 *Suspected conditions* for coding of symptomatic presentations with suspected COVID-19, ruled out. For newborn cases (infants less than 28 days old) assign Z03.71 *Observation of newborn for suspected infectious condition*.

6 Updated advice from IHPA 9th April 2020 regarding ruled out COVID 19 in pregnancy

Note 1: Where isolation (as opposed to quarantined) is documented, assign Z29.0 *Isolation* as an additional diagnosis.
* Source: Independent Hospital Pricing Authority, March 2020, updated by IHPA 9th April 2020 – adapted for implementation in Ireland
https://www.ihpa.gov.au/what-we-do/how-classify-covid-19

HPO Coding Advisory: Unspecified Pneumonia in COVID 19 cases

Effective from 6th April 2020

Ref (CA1- 060420)

In response to queries the HPO have sought clinical and classification clarification on the appropriate coding of unspecified pneumonia in COVID 19 positive cases. In addition to the advice below please refer also to ICS 22X2 Novel Coronavirus (COVID-19)

This advice does not apply where a specific type of pneumonia is documented; in such cases please assign a code for that specific type of pneumonia.

COVID 19 Positive with unspecified pneumonia:

Where only the term "pneumonia" is documented without any further specificity in COVID 19 positive patients please code as:

J12.8 *Other viral pneumonia*

And

B97.2 *Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent (as this adds specificity to the type of viral pneumonia and would be normal coding practice)

And

U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* (this is a flag code to identify the COVID-19 pandemic)

Clinical and classification advice supports the coding of unspecified pneumonia as viral without documentation where the patient is COVID 19 positive.

COVID 19 Clinically diagnosed or probable with unspecified pneumonia:

For patients suspected of COVID 19 but where there is no laboratory confirmation with documentation of pneumonia without any further specificity do not make the assumption that the pneumonia is viral. In these cases assign the following codes:

J18.9 *Pneumonia, unspecified*

B97.2 Coronavirus as the cause of diseases classified to other chapters to identify the infectious agent

And

U07.2 Emergency use of U07.2 (COVID-19, virus not identified) to identify cases documented as clinically diagnosed COVID-19 but laboratory testing is inconclusive, not available or unspecified.

The HPO acknowledges the valuable contribution from clinical colleagues in the HSE and classification colleagues in IHPA in the development of this guidance. HPO Coding Advisory issued 6th April 2020

Date Published: Coding Advisory Published 6th April 2020 on the coding of pneumonia in COVID 19

Appendix A: Summary of Changes for ICS V2.0 to 2021 V1

The following is a summary of the changes to Irish Coding Standards (ICS) for versions 2.0 to ICS 2021 V1. For the complete guidelines and detailed information on the changes to each standard please refer to the appropriate version of the standards.

ICS 2021 V1

General information:

- Front cover and colours updated for 2021
- Preface introducing ICS 2020 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 daycases.

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 conditions* – 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*.
  - 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
  - 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;
  - discharge lounges
  - 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 V9B2018 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 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 daycase 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 15X2Anti-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* (page 7).
- ICS 02X0 *Classification of Attendences 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 New standard

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) New standard

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 6th edition 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 ACSz

ICS 22X0 Severe Acute Respiratory Syndrome
- Standard deleted
- Code U04.9 Severe acute respiratory syndrome (SARS) is contained within 6th edition 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: Standards For Ethical Conduct In Clinical Coding

See also: *"Clarification on Use of Standards for ethical conduct in clinical coding"*

Standards For Ethical Conduct In Clinical Coding

Australian Consortium for Classification Development, December 2016

To ensure national consistency in coding practice, the Standards for Ethical Conduct in Clinical Coding have been developed to provide guidance in defining and promoting ethical practices associated with clinical coding undertaken by Clinical Coders and/or Health Information Managers.

These standards should also assist other related health care administrators/stakeholders to understand the ethics surrounding the process of clinical coding.

Ethical practices are core to the clinical coding role to ensure the integrity of coded clinical data at a national level. Those performing the clinical coding function should endeavour to uphold the Standards for Ethical Conduct in Clinical Coding in all situations related to the collection and use of health information within the health care facility or organisation.

The Standards for Ethical Conduct in Clinical Coding applies regardless of the type of facility or organisation, level of authority within the facility or local coding protocols.

Ethics in Clinical Coding Practice

A clinical coder should:

1. Ensure that they have access to all the relevant clinical information (electronic or paper-based) to undertake the abstraction and coding processes

2. Ensure that the documentation within the clinical record justifies selection of diagnoses and intervention codes, consulting clinicians as appropriate

3. Apply the *Australian Coding Standards* (ACS) and other official reporting requirements[1] for the purpose of:
   - abstracting diagnoses and procedures using the entire clinical record
   - selecting and sequencing diagnosis and procedure codes

4. Participate (as required) in interdisciplinary engagement for the purpose of **clarification** of diagnostic or interventional detail or ambiguity in clinical documentation, and improve clinician understanding of the role of a clinical coder in the health setting. This may be via one-to-one interactions, team meetings, education sessions, publications or presentations.

A clinical coder should not:

5. Code diagnoses/interventions without supporting documentation for the purpose of 'maximising' hospital reimbursement. 'Maximising' for reimbursement is **not** an ethical practice.
   - 'maximising' is defined as undertaking a practice not based on fact (ie addition or alteration of codes for conditions not documented within the clinical record), for the sole purpose of increasing reimbursement
   - this is not to be confused with 'optimisation' which is defined as using all documentation within the clinical record to achieve the best outcome.
6. Omit diagnoses/interventions for the purpose(s) of minimising financial loss, or legal liability.
7. Use the interdisciplinary engagement process inappropriately. This includes:
   - prompt or use leading questions for purposes of 'maximising' reimbursement
   - use details for potential financial gain as part of a clinician query process
   - seek additional documentation for conditions not already apparent in the existing clinical documentation. This includes use of pathology or radiology results as a basis for a clinician query.
8. Submit to pressure from others to manipulate coded data for any purpose.

Ethics in Clinical Coding Quality and Education

A clinical coder should:

- Participate in quality improvement activities to ensure that the quality of coding supports the use of data (such as for research, health care management and planning, evaluation and reimbursement).
  - Assist in the application of ethical 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 coding and clinical experts[2].
- Participate in developing and strengthening of the clinical coding profession through supporting peers and networking with others interested in health information management, including non-traditional clinical coding/HIM activities (eg private health funds or casemix units).

Ethics in Clinical Coding and Legal Requirements

A clinical coder should:

- Observe policies and legal requirements regarding privacy, confidentiality, disclosure and security of patient related information.
- Refuse to participate in, or conceal, illegal or unethical processes or procedures.

Notes:

- Reporting requirements may be set by:
  - states and territories (eg state data definitions)

- national bodies through publications such as *METeOR: Metadata Online Registry, Australian Coding Standards* and other Australian Consortium for Classification Development (ACCD) publications.

- Involvement may be achieved through dialogue with ACCD and other organisations associated with health classification (such as, but not limited to, state coding advisory committees).

Source:

Australian Consortium for Classification Development, December 2016, accessed at https://www.accd.net.au/Ethics.aspx

In 2017 the ACCD published the following clarification on the application of the *Standards for Ethics in Clinical Coding*. Please note that Australia moved to 10th Edition of ICD-10-AM/ACHI/ACS in July 2017 and specific references to the 10th edition of the classification are not applicable to Ireland at the current time [January 2019].

Clarification on the application of the
"Standards for ethical conduct in clinical coding"[14]

Background

The *Standards for ethical conduct in clinical coding* (formerly the Code of ethics for clinical coders) is a framework that defines and promotes ethical practices associated with clinical coding. Their primary purpose is to support clinical coders and others involved in the documentation clarification process (e.g. clinicians and clinical documentation improvement specialists) by setting out guidelines around ethical behaviours when undertaking the coding process, ultimately producing national consistency in coding practice.

These guidelines have been an appendix to the Australian Coding Standards (ACS) since First Edition (1998). While they were updated at the time Second Edition was released (2000), they remained largely unchanged until they were revised and published on the Australian Consortium for Classification Development (ACCD) website ahead of the implementation of the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (ICD-10-AM)/Australian Classification of Health Interventions (ACHI)/ACS Tenth Edition (on 1 July 2017),

The *Standards for ethical conduct in clinical coding* are standards of conduct, not coding standards and should not be interpreted as such. They are an adjunct to the ACS and are not to be used as a basis for coding audits. Health services should read the *Standards for ethical conduct in clinical coding* in conjunction with this clarification document to facilitate improvements in clinical coding practice. They can also be used as general information to other stakeholders involved in the review of coded data.

Revision

The guidelines were revised by ACCD during the development of the Tenth Edition of ICD-10-AM/ACHI/ACS. This revision was undertaken at the request of the ICD Technical Group (ITG) members who expressed concern that clinical coders were under pressure (particularly in an activity based funding environment) to achieve 'better' Diagnosis Related Group (DRG) outcomes for financial reimbursement. It was purported that clinical coders were asking clinicians 'targeted' or 'leading questions' in order to achieve this outcome. There was also concern that this practice was leading to over coding of certain clinical conditions, including the questionable coding of some conditions as procedural complications to achieve a higher complexity DRG with resultant implications for data quality. Revising the guidelines was a way of addressing this issue.

Another objective for the revision was to make the guidelines more explicit with respect to appropriate use of the interdisciplinary engagement process and the use of clinician queries for the purpose of clarifying diagnostic and/or intervention detail or ambiguity in clinical documentation.

Intent

The intention of the revision of these guidelines has been to:

- strengthen and clarify the wording

[14] Published by ACCD and available online at: https://www.accd.net.au/Ethics.aspx

- provide examples of behaviours that the national and international clinical coding profession would normally consider to be ethical versus unethical.
- ensure that all stakeholders involved in the coding process are aware of the importance of ethical practice in clinical coding and its supporting processes.

The *Standards for ethical conduct in clinical coding* are not meant to replace incentives and processes developed within health services to improve clinical documentation and above all ensure quality clinical care. The guidelines should be used by healthcare facilities to support the clinician query process, and the revision clarified how this process can be achieved ethically.

Ethical clinician queries

An overarching principle articulated in the Introduction to the ACS is that analysis of the entire clinical record is required before code assignment and that clinical coders should seek more information if a clinical record is deemed to be inadequate for complete and accurate code assignment.

Coding queries to clinicians should be written so that they:

- include information about the patient, with direct reference to the documentation that has prompted the query
- enhance the clinical truth of the documentation to support quality patient care
- allow clinicians to elaborate (add context) to their response regarding the significance and cause of the diagnosis/condition/event
- do not include leading questions that instruct, or indicate to a clinician what to write as a response
- do not indicate potential financial impact.

Example 1 shows a scenario where a clinician query was initiated because treatment was commenced for which a diagnosis was not documented. Reference to decreased air entry in the background to the query allows the clinician to have all pertinent information at hand when responding. The query also allows the clinician to elaborate as to the cause of the condition/event (if any).

Example 1
Patient underwent total knee replacement on 11/8/2016. Patient noted to have decreased air entry (AE) to both bases by doctor (progress note 12/08/2016 at 2145hrs). There is documentation of ↓ AE by physiotherapist on 13/08/2016 at 0850hrs with cough/breathing exercises and TriFlo (spirometry) commenced.
Ethical query
What condition, if any, caused the decreased air entry and was being treated by the cough/breathing exercises and TriFlo?

Example 2 demonstrates that in some instances, it makes sense for the coder to ask a 'Yes/No' or use a multiple choice format, but this must include the provision for the clinician to elaborate or add context around the response. This will preclude the coding of conditions incorrectly or inappropriately. For example, coding a condition as a post procedural complication when it clearly is a condition that commonly occurs during or following an intervention.

<table>
<tr><th colspan="2">Example 2</th></tr>
<tr><td colspan="2">Patient underwent an appendicectomy under general anaesthetic (GA) on 20/9/2016. During the intervention, the anaesthetist adjusted the anaesthetic in response to the patient's blood pressure dropping. Apart from the anaesthetic report documentation, there was no other mention of the drop in blood pressure within the episode of care.</td></tr>
<tr><th>Ethical query</th><th>Ethical query</th></tr>
<tr><td>Was the patient's drop in blood pressure an unexpected occurrence?
If yes, is this:
• a diagnosis of hypotension?
• simply a low blood pressure reading?
• a complication of the anaesthetic?
Please tick as many that apply.</td><td>Did the patient have hypotension?
If so, is this:
• a complication of the anaesthetic?
• a routine part of the management of the anaesthetic?</td></tr>
</table>

Ethical use of the interdisciplinary engagement process for pathology/radiology test results

Abnormal pathology/radiology test results as a basis for a query to a clinician are ethical when supported by other documentation in the clinical record (electronic or paper based). This may include, but is not limited to, documentation of the need to repeat tests, progress notes indicating intent to monitor a result, or administration of treatment in the medication chart.

Coding from test results or medication charts that are not qualified within the episode of care is not good coding practice. For example:

- Drugs are often used for various conditions, or may be used as a prophylactic measure.
- A test result that is not within the normal range does not necessarily mean that the patient has an abnormal condition. That test result may be normal for that particular patient.

It is not the role of a clinical coder to diagnose. The responsibility for good clinical documentation lies with the clinician. Good clinical documentation is critical to continuity and quality of patient care, patient safety and is the legal record of a patient's episode of care. Importantly it also supports quality coded data that has multiple use cases, including reimbursement and funding.

Therefore, documentation (electronic or paper based) of the administration of a drug from the medication chart; or a microbiology test result which is not qualified within the clinical record is not enough information for clinical coders to perform the coding function. In these instances, the documentation issues may be clarified with the clinician.

In **Example 3**, a query was initiated because of commencement of a new medication for which no indication was documented. Reference to the pathology results in the background to the query allows the clinician to have all pertinent information at hand when responding.

Example 3
Patient was admitted for laparoscopic appendectomy for acute appendicitis. The patient commenced new medication of Slow K on 3/4, as documented on the medication chart by the clinician. Pathology results from the 1/4, 2/4, 3/4 and 4/4 show K+3.1, K+3.1, K+3.4 and K+3.5 respectively.
Ethical query
Why was the patient commenced on Slow K?

In **Example 4** a query was initiated because a blood transfusion was given for which no indication was documented. Reference to the pathology result in the background to the query assists the clinician to provide an informed response

Example 4
Pathology result indicates Hb of 98 prior to a transfusion being given but neither the progress notes or blood transfusion form indicates a reason for the transfusion.
Ethical query
Why was the patient given a blood transfusion?

Other points of clarification

The following points of clarification should be noted:

- The date of the release of the Standards for ethical conduct in clinical coding has been removed from the ACCD website. As an adjunct to the ACS, this document is always relevant and therefore does not have an implementation date.
- Perceived inconsistencies between the Standards for ethical conduct in clinical coding slides presented at the 2016 HIMAA and National Centre for Classification in Health (NCCH) National Conference and those available as part of the ICD-10-AM/ACHI/ACS Tenth Edition Education Modules will be revised to clarify that a clinician query may be sent on the basis of inadequate documentation in any part of the clinical record, including:
- progress notes
- consultation requests/reports
- operation reports
- anaesthetic reports
- wound management charts
- orders for tests and treatment (including medication charts).
- The Standards for ethical conduct in clinical coding contain specific guidelines with respect to appropriate use of clinician queries, specifically those sent to clarify existing or missing documentation to support quality documentation and accurate coded data (optimisation) versus those motivated by financial gain (maximisation). Requesting clarification as to the type of pneumonia, for example, rather than coding pneumonia not otherwise specified (NOS) is regarded as optimisation. Optimisation is a process which uses all the documentation within the clinical record to achieve the best outcome and the clinician's response becomes part of the clinical record.

- A clinician query may be sent to 'clarify' existing documentation for any unspecified or ill-defined diagnosis However it is appropriate to assign unspecified and not otherwise specified categories within ICD-10-AM when documentation as to the specificity of a condition is unavailable or not known.
- The example in the ICD-10-AM/ACHI/ACS Tenth Edition Education Modules which incorrectly implies the drug Resonium may be used to treat hypokalaemia will be amended.

- The ICD-10-AM/ACHI/ACS Tenth Edition Education provided on the ACCD website will be updated to reflect these points of clarification and further education will be provided by ACCD at the HIMAA and NCCH National Conference, 1 − 3 November 2017 in Cairns.
- The Independent Hospital Pricing Authority, in consultation with ACCD, the Health Information Management Association of Australia (HIMAA) and the Clinical Coders Society of Australia (CCSA), will determine where the Standards for ethical conduct in clinical coding should reside going forward
- The Standards for ethical conduct in clinical coding may need to be refined in light of advances in clinical information systems, such as the Electronic Health Record.

Source: https://www.accd.net.au/Ethics.aspx

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

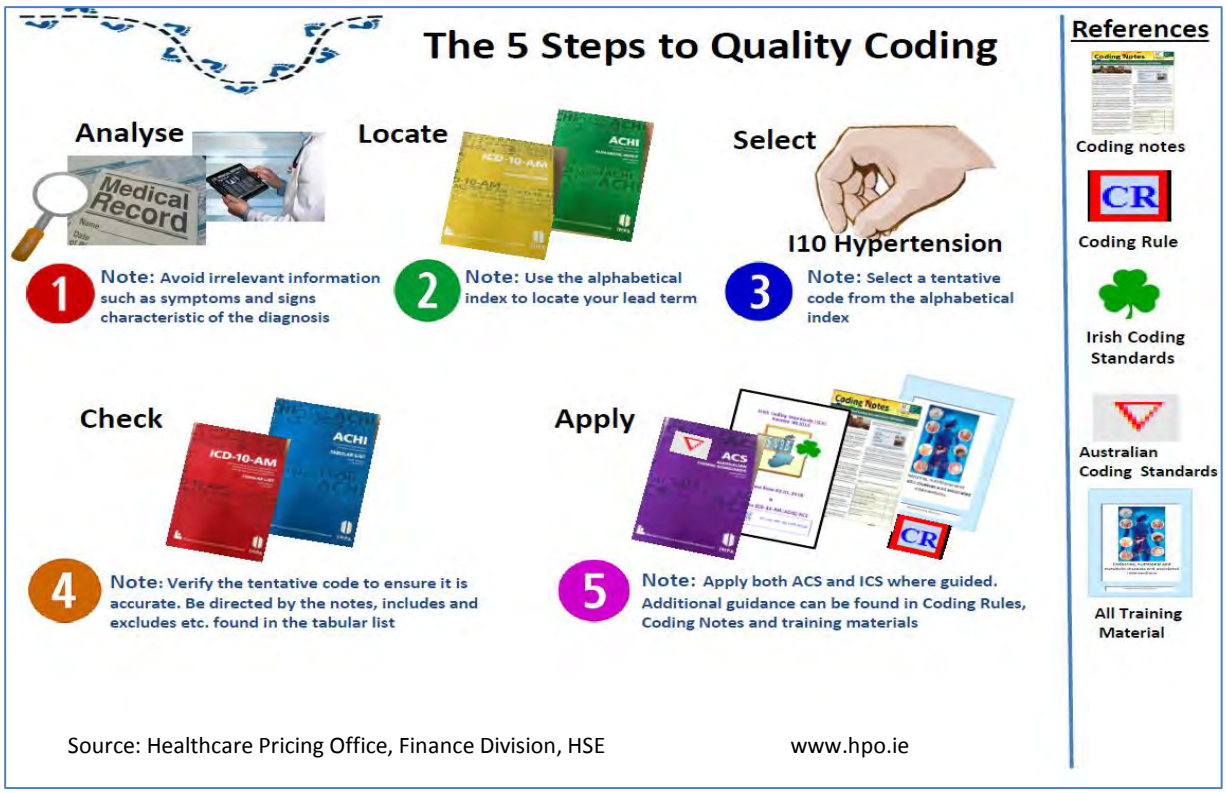
The main aim of coding is: ***To classify clinical concepts into code***

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 (ie a disease, complication or injury, an intervention or procedure) into code is a complex activity. Because coded data are 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.

*Please refer to Irish Coding Standards, 2020 V1.1, pages 84 & 85 for further details



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 – eg 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.
   - ○ 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 (eg 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.