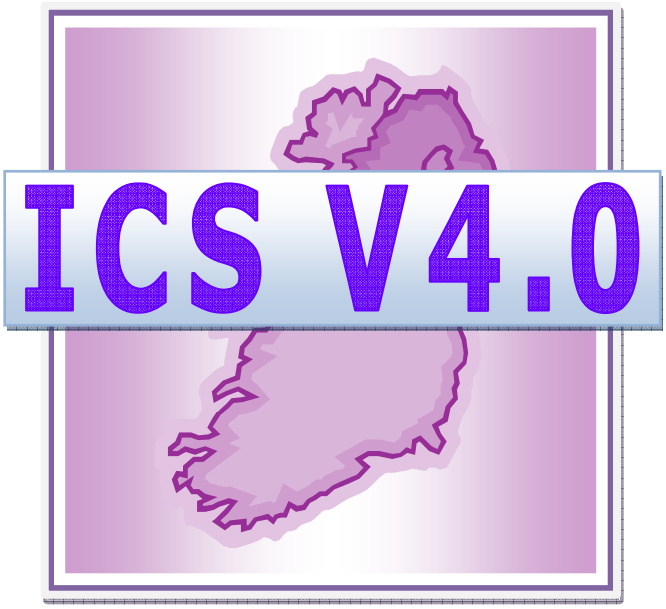
Irish Coding Standards (ICS)
Version 4.0



For use from 01.01.2012

&

6th Edition ICD-10-AM/ACHI/ACS

HIPE PORTAL

For use with the HIPE Portal

ESRI

Health Research & Information Division
Economic & Social Research Institute

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

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Irish Coding Standards

Preface to Version 4.0

Irish Coding Standards version 4.0 provides guidelines for the collection of HIPE data for all discharges from January 1st 2012 using the HIPE Portal software and is to be used in conjunction with 6th Edition ICD-10-AM/ACHI/ACS and the relevant HIPE Instruction Manual.

There are no new standards in version 4.0 however ICS 0229 *Radiotherapy* issued in July 2011 which provides guidelines on the coding of IMRT and IGRT has now been incorporated into this document.

All discharges coded in HIPE on or after the 1st January 2009 are coded using ICD-10-AM/ACHI/ACS 6th Edition[1].

Please see Appendix A for a summary 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 6th Edition these standards have been marked with a symbol:

ICD-10-AM/ACHI/ACS 6th Edition is the classification in use in Ireland for all discharges from 1st January 2009.

- **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. It consists of a tabular list of diseases and accompanying 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 National Centre for Classification in Health (NCCH). 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 NCCH for use with ICD-10-AM and ACHI. These are available in paper or ebook format. The Irish Coding Standards compliment these standards.

For information on variables collected by HIPE please also see the HIPE Instruction Manual 2012 and the HIPE Data Dictionary.

[1] For a full listing of all classifications used in HIPE to date please see page 7 of this document

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. It is anticipated that revisions will be made on an ongoing basis and that further editions will follow. 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 6th Edition, Coding Notes and all instruction materials distributed by the HIPE Unit at the ESRI. 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 6th 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 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.

For further information on any aspect of HIPE please contact;

HIPE & NPRS Unit,
Health Research & Information Division,
Economic & Social Research Institute,
Whitaker Square,
Sir John Rogerson's Quay,
Dublin 2,
Ireland.

Tel: 01-8632000 or visit the Health Information section at www.esri.ie.

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 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 HIPE Unit and the Health Information section at www.esri.ie or see www.HIPE.ie

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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 W-HIPE.

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 is collected for all cases.

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

III. MEDICAL ASSESSMENT UNITS (MAU)

Prior to coding Medical Assessment Unit (MAU) activity, hospitals must register MAUs with the Casemix Programme, HSE.

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

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

- *Mode of emergency admission "5": MAU Day Only*
This code is assigned if the patient is admitted to the MAU and discharged from there on the same day.

While it is expected that the majority of cases in a Medical Assessment Unit (MAU) will be admitted as emergency, it has been noted that it is possible that both Elective and Emergency cases may attend a MAU.

Elective MAU activity:
Elective day cases who attend the MAU will not be identified in this manner as the mode of emergency admission is not collected. Elective admissions to registered MAUs will record an elective admission type. The admitting ward will record the MAU ward code and the discharge ward will be coded as appropriate.

Note: *Once a Medical Assessment Unit has been registered with the Casemix Programme in the HSE, contact the HIPE Unit, IT Department at ESRI to activate MAU options.*

IV. 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.

V. DAY WARD REGISTRATION

All day ward areas must be registered with the National Casemix Programme, HSE 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 National Casemix Programme of the HSE prior to using this option.

VI. 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.

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 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)

a) Parity will be collected as two separate integer (whole) numbers separately
b) Parity does not include the current pregnancy/obstetric care or delivery
c) Please use '0' to record where there are no previous live births and/or stillbirths.
d) If the number of previous live births or the number of previous stillbirths is not documented this will be recorded as NA (not available).
e) 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

VIII. HOSPITAL ACTIVITY NOT COLLECTED BY HIPE

Activity not currently collected by HIPE includes out-patient activity, virtual wards and A&E/ED cases.

IX. CLINICAL CODING SCHEMES USED IN HIPE IN IRELAND:

- From 1st January 2009, 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[2] Procedures classification
- 1969 – 1980 ICD-8 for Diagnoses and OPCS Procedures classification

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

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: I84.2 Internal haemorrhoids without complication
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.

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

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 Diagnoses Indicator
Reason for Update:	Hospital Acquired Diagnoses Indicator introduced from January 2011

ICS 0048 Hospital Acquired Diagnosis (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. In Ireland the variable will be called the Hospital Acquired Diagnosis (HADx) Indicator. This variable will be collected from January 2011 on a pilot basis. 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[3].

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

---

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

Example 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	Z06.32	✓ 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
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	-
Diabetes with other specified complication	E11.29	-
Acute kidney failure	N17.9	✓ Yes

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	K35.9	-
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

General Standards For Procedures (00--)

ICS 0029 CODING OF CONTRACTED PROCEDURES

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

Reason for Standard: ICS 0029 is a continuation of existing practice.

ICS 0030 ORGAN PROCUREMENT AND TRANSPLANTATION

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

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

ICS 002x DATE FOR EACH PROCEDURE CODED

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
- In line with ACS 0020 *Bilateral/Multiple procedures,* for multiple procedures recorded once for each admission (see list of examples from ACS 0020 below) the date the procedure was **first** performed will be recorded.

As per ACS 0020 *Bilateral/Multiple procedures*, procedures that are coded once for each admission include;

- Procedures where multiples are included in the code descriptor, such as:
  - ECT (see ACS 0533 *Electroconvulsive therapy*)
  - Removal of renal calculi
- Dialysis (haemodialysis, peritoneal)
- Excision/removal of skin lesions (see point 5 in ACS 0020)
- Procedures with specific rules in other coding standards, such as:
  - Burn dressings (see ACS 1911 *Burns*)
  - Chemotherapy (see ACS 0044 *Chemotherapy*)
  - Blood transfusions (see ACS 0302 *Blood transfusions*)
  - Allied health interventions (see ACS 0032 *Allied health interventions*)

Example 1
Patient admitted with abdominal pain on 5th January 2011 and had abdominal CT scan 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]	6/1/2011
Addnl Procedures:	General anaesthetic	92514-19 [1910]	6/1/2011
	Abdominal CT	56401-00 [1962]	5/1/2011

Example 2

Patient admitted as an emergency on 10th January 2011 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]	10/1/2011
Addnl Procedures:	Sedation	92515-99 [1910]	10/1/2011
	Transfusion packed cells	13706-02 [1893]	10/1/2011
	CT Brain	56001-00 [1952]	11/1/2011

ICS effective from: January 2011
Reason For standard: Identification of dates for all procedures requested by DoH&C and HSE.

ICS 0044 CHEMOTHERAPY

Oral chemotherapy is coded when administered.

Effective From: January 2005 (as code available in ICD-10-AM). 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 0104 VIRAL HEPATITIS

As a result of a query to the World Health Organisation on the coding of "Hepatitis C NOS" the following advice has been issued. Where hepatitis C is documented without any further specification please assign code B18.2 *Chronic viral hepatitis C*.

Please amend the "General Issues" column in the classification box for hepatitis C provided in ACS 0104 accordingly to read as:

- When 'history of hepatitis C' is documented, coders should check with the clinician to determine if the patient still has signs of the disease. If further information is not available assign the code for chronic viral hepatitis C (B18.2).

- When the patient is asymptomatic and ambiguous terms such as 'hepatitis C' or 'hepatitis C positive' are recorded, assign the code for chronic viral hepatitis C (B18.2).

- Code O98.4 *viral hepatitis complicating pregnancy childbirth or the puerperium* is assigned where acute or chronic hepatitis C complicates the pregnancy, childbirth or puerperium (along with either B17.1 or B18.2 to specify the type of hepatitis). If the obstetric patient is a carrier assign chronic viral hepatitis C (B18.2).

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.

ICS 0112 INFECTION WITH DRUG RESISTANT MICROORGANISMS

The abbreviation M.R.S.A. has two different meanings and therefore two different code assignments. Please check locally to see which definition is in use at your hospital.

Methicillin Resistant *Staphylococcus aureus* (Z06.32)
OR
Multi-Resistant *Staphylococcus aureus* (Z06.8)
(Note: code Z06.8 excludes methicillin resistance)

- When **ONLY** Methicillin resistant is documented: assign **Z06.32**
- When Methicillin resistant **AND** Multi-resistant are documented together: assign **Z06.32**
- When **ONLY** Multi-resistant is documented: assign **Z06.8**

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.-	*Bacterial agents resistant to antibiotics*

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*
Z06.32 *Methicillin resistant agent*

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.

ICS 02X0 CLASSIFICATION OF ATTENDANCES AT ONCOLOGY DAY WARDS

Beginning January 2010, the following amendments to data entry for attendances at oncology day wards were introduced.

Oncology/Chemotherapy Day Ward Flags:

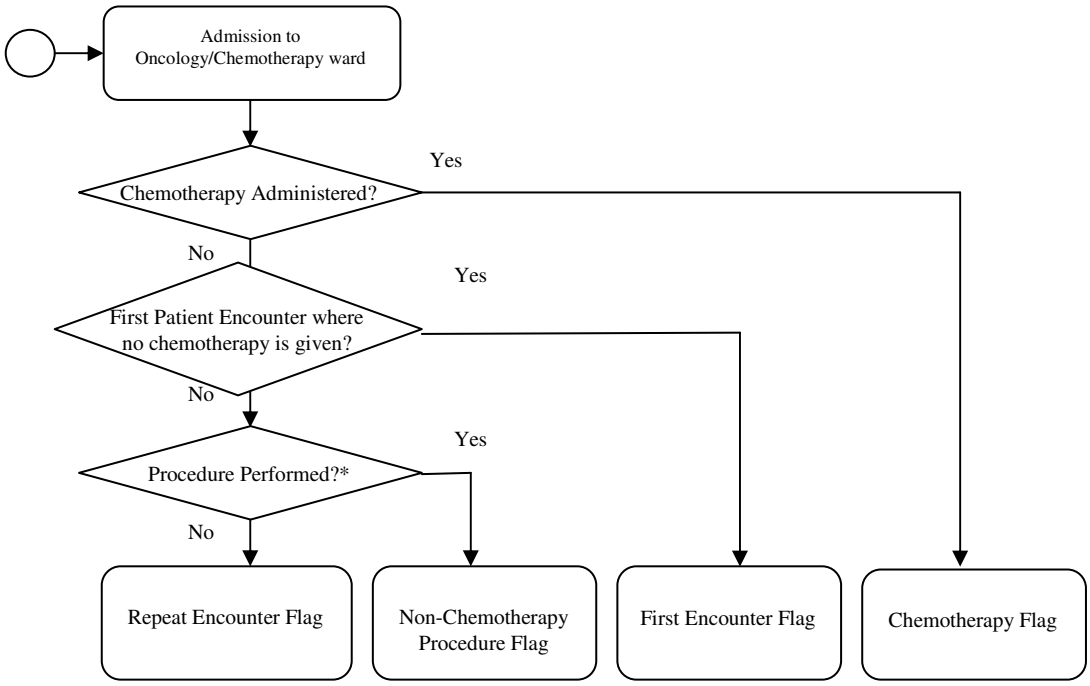
- Day case admissions for chemotherapy are assigned a *chemotherapy flag*
- The first patient encounter as a day case in an oncology/chemotherapy ward where no chemotherapy is administered is assigned a *first encounter flag*.
- Cases where a procedure* is performed, e.g. blood transfusions or biopsies, are assigned *non-chemotherapy procedure flag*
- Where a patient has a repeat attendance(s) at an oncology/chemotherapy day ward and no procedure* is performed a *repeat encounter flag* is assigned.

Admission Type 2- elective readmission

Please ensure that, where appropriate, admission type 2- *elective readmission* (patient admitted electively to continue ongoing treatment or care –HIPE Instruction Manual 2009) is recorded.

All valid day case and inpatient activity is to be collected by HIPE and all HIPE data are subject to audit, including chart based reviews.

Decision Tree for Coding Guideline



* In accordance with HIPE procedure coding guidelines

Example 1: Repeat Encounter Flag

Patient has been attending the oncology day ward for 2 months with a diagnosis of malignant neoplasms of the colon. On this episode, the patient is admitted as a day case to the oncology day ward for review before the next chemotherapy dose is administered in two days time. Patient reviewed by clinician and oncology nurse and blood tests were performed, no other conditions are documented.

Assign: PDx: Colon cancer C18.9
No procedure code is assigned in this case

Flag: Repeat encounter flag

Example 2: Non- Chemotherapy Procedure Flag

Patient has been attending the oncology day ward regularly for chemotherapy treatments for a malignant breast cancer. On this episode, the patient is admitted as a day case to the oncology day ward for a blood transfusion for documented anaemia in neoplastic disease.

Assign:	PDx:	C50.9 Malignant Neoplasm, breast unspecified site
	Addnl Dx:	D63.0 Anaemia in neoplastic disease
	Procedure:	[1893]13706-01 Administration of whole blood
	Flag:	Non-chemotherapy procedure flag

ICS effective from:	January 2010
Advice first published:	October 2009
Updated:	January 2012 – Decision tree updated at "First Patient Encounter" to state "First Patient Encounter where no chemotherapy is given?" as per text of standard
Reason for Standard:	To identify repeat non-chemotherapy admissions to oncology day wards for previously diagnosed neoplasms.

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.

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.

Chapter 4 Endocrine, Nutritional and Metabolic Diseases (04--)

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) the MAU must be registered with the Casemix Programme, HSE in order to collect this 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
ICS Updated:	This standard was created in January 2009 in accordance with existing guidelines and contains information previously published in ICS 0042
Reason for Standard:	Provide information on the coding of haemochromatosis and venesection.

~~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)

From the 1st July 2009 the following guidelines apply to the coding of A(H1N1) influenza.

World Health Organisations recommendations for coding A(H1N1) [Swine Flu]:

1. **Influenza A(H1N1) [swine flu] is categorized to J09**
2. In future editions of the classification the new title of J09 will be "Influenza due to certain identified influenza virus"
3. Future inclusions will mention the particular influenza virus strains that are included in this category.
4. Countries have to identify the cases with identified Influenza A(H1N1) coding the relevant cases to J09.

Suspected Swine Flu

- Only **confirmed** cases of swine flu are coded to J09 *Influenza due to identified avian influenza virus,* with an additional code of Z29.0 *Isolation*, if appropriate.

- For cases described as 'suspected' or 'probable' and the patient is treated for swine flu, but **not confirmed** by laboratory testing, assign: **J11. -** *Influenza, virus not identified* & Z29.0 *Isolation,* if appropriate.

- This advice is specific to suspected cases of swine flu: please refer to ACS 0012 *Suspected Conditions* for other conditions

Example 1
Patient admitted with flu-like symptoms including sore throat, coughing, fever, headache, and muscle pain. Documentation in chart states 'probable swine flu', the patient was treated for swine flu and was isolated. Laboratory tests did not confirm swine flu.
Assign Codes:

J11. 1	*Influenza with other respiratory manifestations, virus not identified*
Z29.0	*Isolation*

Example 2
Patient admitted with flu-like symptoms including sore throat, coughing, fever, headache, and muscle pain. Documentation in chart states 'probable swine flu', the patient was treated for swine flu and was isolated. Laboratory tests were positive for swine flu.
Assign Codes:

J09	*Influenza due to identified avian influenza virus*
Z29.0	*Isolation*

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

ICS 1006 VENTILATORY SUPPORT

Continuous ventilatory support (CVS)

Any CVS conducted prior to admission to a ward is not to be included in the calculation of duration of ventilatory support.

See also *Guidelines on Hospital Activity Not Collected by HIPE*, Irish Coding Standards page 6.

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.

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 & Children 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 National Casemix Programme, HSE.

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[4]

1279	**Examination procedures on vagina**
35614-00	Colposcopy[5]

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

[4] Extracted from NCCH eBook, July 2008, Gynaecological Procedures.
[5] Extracted from NCCH eBook, July 2008, Gynaecological Procedures.

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

ICS 15X0 PRINCIPAL DIAGNOSIS SELECTION FOR OBSTETRIC CASES

Chapter 15 of the ACS provides one specialty standard (ACS 1530 *Premature delivery*) relating to the assignment of principal diagnosis in obstetrics cases. If *ACS 1530 Premature delivery* does not apply then ACS 0001 *Principal diagnosis* will be followed in selecting the principal diagnosis.

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

ICS 1510 PREGNANCY WITH ABORTIVE OUTCOME

Fetal viability

A live birth in Ireland is defined as at least 22 weeks completed gestation.

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)

ICS 1511 TERMINATION OF PREGNANCY

Codes from category O04 *Medical abortion* are only assigned for patients admitted to hospital with a complication following an incomplete legal abortion in another state (please see ACS 1544 *Complications following abortion and ectopic and molar 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)

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. 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:	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

ICS15X3 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

Chapter 16 Certain Conditions Originating in the Perinatal Period (16--)

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.*

Effective From:	ICS 1605 is a continuation of existing practice.
First Published:	ICS V1.5
Reason for Standard:	Definition of perinatal period in Ireland.

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.

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.

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

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

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

ICS 1901 POISONING

Coding of assault by poisoning

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

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

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

   And

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

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

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

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

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

ICS 1902 ADVERSE EFFECTS OF DRUGS

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

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

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~~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

Appendix A: Summary of Changes for ICS V2.0 to V4.0

The following is a summary of the changes to Irish Coding Standards (ICS) for versions 2.0, 2.1, 2.3, 3.0 and 4.0. For the complete guidelines and detailed information on the changes to each standard please refer to the appropriate version of the standards.

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 hospital 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 party 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 for the collection of procedures listed in ACS 0042 where the procedure is the principal reason for admission in same day cases (see Note C, ACS 0042 Procedures Not Normally Coded).

ICS 0112 Infection with Drug Resistant Microorganisms

- Revised to incorporate 6th Edition changes for the coding of methicillin resistance.

ICS 030X Blood tests/ collection of bloods for diagnostic purposes

- New standard required following deletion of ICS 0042
- No change to guidelines on the coding of blood tests
- Collection of blood is a standard treatment that is unnecessary to code

ICS 040X Haemochromatosis & Venesection

- New standard for coding advice previously contained in ICS 0042 on the coding of haemochromatosis and venesection
- No change to coding guidelines for haemochromatosis and venesection

ICS 10X1 Avian Influenza

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

ICS 1006 Ventilatory Support

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

ICS1404 Admission for Kidney Dialysis

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

ICS 15X0 Principal Diagnosis Selection for Obstetric Cases

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

ICS 15X2 Anti-D immunoglobulin prophylaxis and rhesus incompatibility/isoimmunisation

- Revision of example provided in this standard

ICS1611 Newborns admitted for Observation with no condition found

- Standard deleted
- ICS not required due to the removal of references to code *Z38 liveborn infants according to place of birth* from ACS 1611 in 6th Edition ACS

ICS 22X0 Severe Acute Respiratory Syndrome

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

For further information on HIPE variables please see HIPE Instruction Manual and also the Health Information section of our website at www.esri.ie