Irish Coding Standards (ICS)
Version 9B2018

For use from 01.01.2018

&

8th Edition ICD-10-AM/ACHI/ACS

For use with the HIPE Portal

Healthcare Pricing Office (HPO)

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Contents

Specialty Standards:

Note that the following Irish Coding Standards that are no longer applicable in **8th Edition** ICD-10-AM/ACHI/ACS

Note the following Irish Coding Standards that are no longer applicable in **6th Edition** ICD-10-AM/ACHI/ACS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 9B2018

Irish Coding Standards (ICS) version 9B2018 provides guidelines for the collection of HIPE data for all discharges from January 1st 2018 using the HIPE Portal software and is to be used in conjunction with 8th Edition ICD-10-AM/ACHI/ACS and the relevant HIPE Instruction Manual.

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). For further information see www.hpo.ie.

ICS Version 9B2018 contains the following changes:

- General information: The Irish Coding Standards (ICS) are now divided into three sections as described below.

- **Section 1:** Valid HIPE activity
  A new section has been added to strengthen and clarify activity collected by HIPE and the activity not collected by HIPE.
  - Elective admissions to Acute Surgical Assessment Units have been added to the list of activity not collected by HIPE.

- **Section 2**: HIPE Guidelines for Administrative Data
  Section 2 of the Irish Coding Standards contains HIPE Guidelines for Administrative Data. These guidelines have been expanded to include guidance on:
  - Acute Surgical Assessment Units
  - Patients transferred to another hospital for a day case procedure and returning on the same day

- **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.
  - ICS 0010 General Abstraction Guidelines has been extensively revised to include guidance on clinical documentation, nursing notes and electronic healthcare records.
  - One new coding standard has been introduced in ICS V9B2018; ICS 0025 *Double Coding*: this standard allows for diagnosis codes to be repeated where one requires a HADX flag and one does not.
  - One standard has been deleted, ICS 140X *Standardisation of collection of colposcopy activity*
  - ICS 0048 *Hospital Acquired Diagnosis (HADx) Indicator* has been updated to advise that where a neonate has a risk of sepsis a HADX flag is not assigned.

Minor amendments have been made to a small number of additional standards. A full listing of all changes made in ICS V9B2018 is provided in Appendix A of this document.

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 of ICS V9B2018.

The "Five steps to quality coding" are now incorporated into the Irish Coding Standards – see Appendix C.

Since 1st January 2015 all discharges coded in HIPE are coded using ICD-10-AM/ACHI/ACS 8th 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 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.

ICD-10-AM/ACHI/ACS 8th Edition is the classification in use in Ireland for all discharges from 1st January 2015.

- **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 (ICS)** compliment these standards.

  For information on variables collected by HIPE please also see the HIPE Instruction Manual 2017 and the HIPE Data Dictionary. These documents are available on the HPO website at www.HPO.ie.

[1] For a full listing of all classifications used in HIPE to date please see page 17 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. 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 8th Edition, *Coding Notes*[2] 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 8th 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 .

[2] 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.

HOSPITAL ACTIVITY NOT COLLECTED BY HIPE

Activity **not** currently collected by HIPE includes:

- Out-patient activity
- Clinics
- Virtual wards
- Patients in ED or in virtual wards where a "decision to admit" has been made are not reported to HIPE until admitted into an inpatient ward.
- A&E/ED cases
    - 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

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.

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 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 stay. 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[3] (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.[4]**

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

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

activity. **Please note that elective ASAU activity is not to be reported as HIPE activity and will be queried.**[5]

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.

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.

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

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)

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

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

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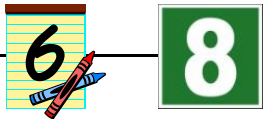
~~X. HOSPITAL ACTIVITY NOT COLLECTED BY HIPE~~

~~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.

XI. CLINICAL CODING SCHEMES USED IN HIPE IN IRELAND:



- From 1st January 2015 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[6] Procedures classification
- 1969 – 1980 ICD-8 for Diagnoses and OPCS Procedures classification

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

Section 3: Coding Standards

General Standards For Diseases (00--)

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

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
Y92.22	*Health service area*	Yes
U73.9	*Unspecified activity*	Yes

In this example duplicated codes have been underlined.

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.

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

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 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[7]. 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 states

[7] *"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).

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

HADX for neonates at risk of sepsis

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

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

Example 1:
Patient admitted with back pain. Investigations found that patient had prostatic carcinoma and bony mets to the pelvis.

Dx	Code	HADx
Primary neoplasm of prostate	C61	-
Secondary Neoplasm of bone	C79.5	-

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.

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 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
- 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
	Fibreoptic 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 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 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 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 Z06.52 *Resistance to methicillin* **(**Z06.52 includes multiple antibiotics including methicillin)
- When **ONLY** Multi-resistant is documented: assign Z06.52 *Resistance to methicillin* when one of the agents is methicillin
- Z06.67 *Resistance to multiple antibiotics* and Z06.77 *Resistance to multiple antimicrobial drugs* are 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

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."[8]

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.[9]

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

Coding Guidelines:

- When a diagnosis of VTEC* is documented please assign A04.3 *Enterohaemorrhagic Escherichia Coli infection*.
- If patients also have Haemolytic-Uraemic Syndrome (HUS) also assign code D59.3 *Haemolytic-uraemic syndrome*
- 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.

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

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

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 • Decision tree updated at "First Patient Encounter" to state "First Patient Encounter without chemotherapy" as per text of standard • 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

ACS 0224 Palliative care provides guidance on the use of code Z51.5 Palliative care and states:

> *Z51.5 Palliative care should be assigned (as an additional diagnosis code) when the intent of care at admission is 'for palliation', or if at any time during the admission the intent of care becomes 'for palliation', and the care provided to the patient meets the definition above.*

In order to provide clarity for Irish Coders the code Z51.5 *Palliative care* is to be coded when there is documentation that the patient has been seen by (or attended to) by the palliative care team as the phrase "for palliation" may not be used.

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.*

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.

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) 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 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 Influenza 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.

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.

Chapter 12 Diseases of the Skin and Subcutaneous Tissue (12--)

~~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.

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

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

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

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~~

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.

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, commencing on the date of birth (day 0) and ending on the completion of day 27.*

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

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

ICS 1607 NEWBORN/NEONATE

Coding of unwell newborns/neonates during the birth episode

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

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

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

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

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

Z38 cannot be used when treatment is being provided in second or subsequent admissions.

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

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

Effective From:	ICS 1607 is a continuation of existing practice.
First Published:	Coding Notes, July 2006.
Reason for Standard:	Well babies are not collected by HIPE.
Standard Updated:	ICS V9.0 January 2017 as change in download to include all newborns, however well babies are not coded.

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

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

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

ICS 1901 POISONING

Coding of assault by poisoning

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

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

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

   And

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

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

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

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

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

ICS 1902 ADVERSE EFFECTS OF DRUGS

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

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

~~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 V9B2018

The following is a summary of the changes to Irish Coding Standards (ICS) for versions 2.0 to 9B2018. For the complete guidelines and detailed information on the changes to each standard please refer to the appropriate version of the standards.

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 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

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 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" (page 60)*

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:

- Ensure that they have access to all the relevant clinical information (electronic or paper-based) to undertake the abstraction and coding processes
- Ensure that the documentation within the clinical record justifies selection of diagnoses and intervention codes, consulting clinicians as appropriate
- 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
- 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:

- 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.
- Omit diagnoses/interventions for the purpose(s) of minimising financial loss, or legal liability.
- 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.
- 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:

1. 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.
2. 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 2018].

Clarification on the application of the "Standards for ethical conduct in clinical coding"[13]

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.

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

Intent

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

- strengthen and clarify the wording
- 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 : The Five Steps to Quality Coding

The 5 Steps to Quality Coding

1. ANALYSE - Medical Terminology

Read the discharge summary and all relevant clinical documentation to identify diagnoses and procedures.

2. LOCATE - Main Terms

Use the alphabetical index to search for conditions, diseases, external causes, symptoms and other factors influencing health status. An alphabetical index also applies to procedures.

3. SELECT - a *tentative* code

Select the most appropriate code from the alphabetical index.

CHECK - the code against the Tabular List

Verify the *tentative* code within the tabular list to ensure that it is the most accurate code. Check for instructions on conventions e.g., *includes* and *excludes* notes and *code also* to guarantee correct code assignment.

5. APPLY - Australian Coding Standards (ACS) and Irish Coding Standards (ICS)

Check both ACS and ICS for specific guidelines to assist accurate code assignment. Additional guidelines are published in training material provided by the HPO, Coding Notes, Coding Rules (and Coding Matters/10 Commandments).

Quality Coding