Healthcare Pricing Office
National Finance Division
HSE
Brunel Building
Heuston South Quarter
Dublin 8
D08 X01F
t: 01 7718401 *e:* hporeception@hpo.ie

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Submission to IHPA on Development of ICD-10-AM/ACHI/ACS 13th Edition

Ireland has used the Australian Modification of ICD-10 along with ACHI and the ACS since 2005. In January 2024 Ireland will move from 10th edition to 12th edition. We have developed Irish Coding Standards to address areas of difference or to provide additional guidance for coders. The comments below are in advance of the introduction of 12th edition in Ireland and also in advance of feedback from the Irish coding community and data users.

1. Do you agree with the proposed changes to capture new, missing or important public health considerations in ICD-10-AM Thirteenth Edition?

We agree with the proposed changes in the 13th edition. In particular, the use of vaping device.

We have had a number of requests regarding the collection of "Do Not Resuscitate" orders however we see the capture of this information as beyond the role of the coder as these orders may change or be updated during an episode of care. Further information would be welcome on the end of life care and how this is captured beyond the current palliative care code available. We have had a number of issues raised around the code Z51.5 *palliative care* and what this code is collecting. For audits of hospital mortality this code is of huge significance and there is a question as to how care to manage end of life by those who are not palliative care specialists or who do not document palliative care is captured through coding.

In 12th edition the alphabetic index under Syndrome, inflammatory response, infectious origin directs coders to "see Sepsis" and assign a code for Sepsis. In Ireland SIRS is not to be captured as sepsis and we will continue to use code R65.0 for SIRS of infectious origin in agreement with the National Sepsis Clinical Programme. In Ireland SIRS will be coded very separately to sepsis. Can consideration be given to removing the instruction in the alphabetic index to code SIRS as sepsis and reinstating the use of R65.0 *Systemic inflammatory response syndrome of infectious origin without organ failure*?

2. Are there additional considerations for the capture of social factors that should be considered for ICD-10-AM Thirteenth Edition (or a future edition)?

The issue arising is identifying when conditions meet criteria for coding rather than the codes themselves. Clarity is needed as to when these codes are assigned – for example code assignment for self-reporting of social factors such as psychological abuse or coercive control where no intervention or action is requested by the patient.

3. Are there other new interventions that should be uniquely classifiable in ACHI for Thirteenth Edition (or a future edition)?

We are preparing to implement 12th edition and we are concerned around how to capture admissions for pharmacotherapy where it is unclear if the neoplasm or neoplasm related condition is treated. Could there be consideration of an extension code in [1920] *Pharmacotherapy* for neoplasm related conditions or where not stated if neoplasm or neoplasm related. Documentation for daycases is usually the name of the drug rather than clearly specifying the condition it is given for and we this may cause issues with national data collection. Coders will have to assume the diagnosis code to be a neoplasm or not in the absence of guidance.

4.Are there any additional considerations for organ, tissue and cell and procurement and transplantation that should be prioritised for ICD-10-AM and ACHI Thirteenth Edition?

We welcome the suggested advancements in the classification of transplants.

5. Are there any additional considerations for the implementation of cluster coding that should be prioritised for ICD-10-AM Thirteenth Edition?

Ireland will await further details on the clustering of codes in advance of any introduction. The changes to data entry and reporting systems required will need to be considered. Ireland does not currently capture U codes for chronic conditions. The approach suggested is clear and logical. Where a code can be assigned to a number of clusters e.g. Z51.5 palliative care guidance will be needed. Clustering of codes may be a challenge for new coders or where a patient has multiple co-morbidities as to the full extent of the interrelated conditions. The onus will be on the coder to be fully aware of all of the interaction of conditions and diagnosis and be responsible for linking of conditions into clusters.

6. Are there any additional considerations for the implementation of ACS 1904 *Complications of surgical and medical care* that should be prioritised for Thirteenth Edition?

In Ireland the auditing and training of coders has identified issues with the application of the codes and guidelines on complications of surgical and medical care introduced in 10th edition. The alphabetic index is difficult to follow and the codes are very spread out. Also, the retrieval of data and reporting of complications is now a challenge as the codes are spread across the whole classification and coders are unsure of code assignment. This area has been a huge challenge for data quality and training since we moved to 10th edition in January 2020. The ACS is expansive and the guidelines are very technical and difficult to follow. We welcome approaches to simplifying the guidance and would also ask for the consideration of codes in the T80 –T88 range to be applicable for complications of surgical and medical care with the conditions themselves coming from other chapters.

7. Are there any additional considerations for difficult intubation that should be prioritised for Thirteenth Edition?

We welcome the suggested changes to the coding of difficult intubation.

8. Are there any additional considerations in relation to the standardisation of the ACS that should be prioritised for Thirteenth Edition?

We welcome the proposed approach to the standardisation of the ACS. The inclusion of explanations of code assignment in examples is most helpful. It is useful if the sections in the guidance are numbered so they can be referenced easily. It is clearer when coding advice is not just provided in an example but contained in the text of the standard. Challenges remain in the documentation available to coders and it is welcome when there is advice on no further information being available as per previously mentioned in relation to pharmacotherapy when it is not known which condition is being treated.

9 Do you have any additional feedback on the proposed changes for ICD-10-AM/ACHI/ACS Thirteenth Edition?

Many thanks to all at IHACPA for their ongoing support of the use of the classification in Ireland, we look forward to introducing 12th edition ICD-10-AM/ACHI/ACS for the collection of acute hospital activity from 1st January 2024 and we look forward to the developments in the 13th edition of ICD-10-AM/ACHI/ACS.

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