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Introduction

As part of the Canadian Institute for Health Information's (CIHI's) commitment to quality data, the National Ambulatory Care Reporting System (NACRS) is routinely analyzed for G D W D   T X D O L W \

Updates

7 K H   1 $ & 5 6   2 S H Q   < H D U   ' D W D   4 X D O L W \   7 H V W   6 S H F L ¿ F D W L R Q V   G R I
¿ V F D O   T X D U W H U

OYDQ test number	OYDQ test title	Short description	Rationale
N0045-162			

OYDQ test number	OYDQ test title	Short description	Rationale

Open-year data quality tests

1   Length of Stay Greater Than 120 Hours (N0027-146)

Rule

Ambulatory care records are primarily expected to have a Length of Stay (LOS) shorter than 120 hours (5 Days). However, a LOS longer than 120 hours may be acceptable in some situations.

7 K L V   G D W D   T X D O L W \   W H V W   L G H Q W L ¿ H V   U H F R U G V   Z L W K   S R W H Q W (listed below) used to calculate the derived LOS Hours.

Note: This test will be completed for all records where the derived LOS Hours is available.

Criteria	Description
Patient care type	All patient care types
Submission levels	Levels 1–3
Selection criteria	Abstracts where the derived LOS Hours is greater than 120 hours
Data elements	Triage Date; Triage Time; Date of Registration/Visit; Registration/Visit Time; Visit Disposition; Disposition Date; Disposition Time; Date Patient Left Emergency Department (ED); Time Patient Left Emergency Department (RD)
Reference	NACRS Abstracting Manual

2   Visit Disposition Inconsistent With Institution To (N0035-176)

Rule

The Visit Disposition and the CIHI Institution Type assigned to the Institution To number must match.

Note:

3 U07.4 Post COVID-19 condition Assigned as Main Problem (N0044-185)

Rule

When U07.4 Post COVID-19 condition is assigned on an abstract, it must be assigned as Other Problem.

Note: U07.4 Post COVID-19 condition is to be used in multiple coding to identify a case in which the physician/primary care provider documented that a condition or symptom has a relationship or association with past COVID-19.

Criteria	Description
Selection criteria	Abstracts where U07.4 is assigned as Main Problem
Data elements	Main Problem
Correct case example	U07.4 is recorded as Other Problem
Reference	Bulletin November 12, 2020: ICD-10-CA coding direction for post COVID-19 condition and personal history of COVID-19

4   Missing Additional Diagnosis Code to Identify the Specific Condition Complicating Pregnancy Childbirth and the Puerperium O99 (N0045-128)

Rule

When a code from any one of the subcategories within O99 Other maternal diseases classifiable but elsewhere but complicating is assigned, an accompanying code is to be mandatory to assign an additional code to identify the additional code instruction in the tabular at this category.

Criteria	Description
Patient care type	All patient care types
Submission levels	Levels 1–3
Selection criteria	Abstracts where a Diagnosis Code of:
	● O99.0– is recorded <u>without</u> a code from D50–D64
	● O99.1– is recorded <u>without</u> a code from D65–D89
	● O99.2– is recorded <u>without</u> a code from E00–E07, E15–E34, E50–E89
	● O99.3– is recorded <u>without</u> a code from F00–F52, F54–F99, G00–G99
	● O99.4– is recorded <u>without</u> a code from I00–I09 or I20–I99
	● O99.5– is recorded <u>without</u> a code from J00–J99
	● O99.6– is recorded <u>without</u> a code from K00–K63, K65–K66, K80–K93
	● O99.7– is recorded <u>without</u> a code from L00–L99
	● O99.8– is assigned <u>without</u> a code from B90–B94, C00–D48, H00–H95, M00–M82, M83.2–M99, N14–N15.0, N15.8–N15.9, N20–N39, N60–N64, N80–N90, Q00–Q99, R00–R94.8
Data elements	Main Problem; Other Problem
Correct case examples	O99.001 (MP) Anaemia complicating pregnancy, childbirth and the puerperium delivered with or without mention of antepartum condition
	D64.9 (OP) Anaemia unspecified
References	Use Additional Code instruction within ICD-10-CA direction at category O99
	Canadian Coding Standards: Use additional Code/Code Separately Instructions
	Complicated Pregnancy Versus Uncomplicated Pregnancy

6 Opioid Poisoning T-Code Without a Corresponding Opioid Poisoning External Cause Code (N0045-162)

Rule

When one of the following T-codes representing an opioid poisoning is recorded

- T40.0 Poisoning by opium
- T40.1 Poisoning by heroin
- T40.2– Poisoning by other opioids
- T40.3 Poisoning by methadone
- T40.4– Poisoning by other synthetic narcotics
- 7   3 R L V R Q L Q J   E \   R W K H U   D Q G   X Q V S H F L ¿ H G   Q D U F R W L F V

One of the following corresponding opioid poisoning external cause codes must also be recorded:

- X42 Accidental poisoning by and exposure to narcotics and psychodysleptics
  > K D O O X F L Q R J H Q V @   Q R W   H O V H Z K H U H   F O D V V L ¿ H G
- X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics
  > K D O O X F L Q R J H Q V @   Q R W   H O V H Z K H U H   F O D V V L ¿ H G
- <   3 R L V R Q L Q J   E \   D Q G   H [S R V X U H   W R   Q D U F R W L F V   D Q G   S V \ F K R G
  Q R W   H O V H Z K H U H   F O D V V L ¿ H G   X Q G H W H U P L Q H G   L Q W H Q W

When the chart review reveals that

Criteria	Description
Patient care type	All patient care types
Submission levels	Ontario: Levels 1 and 3
	Other provinces/territories: Level 3
Selection criteria	Abstracts with a Diagnosis Code T40.0, T40.1, T40.2–, T40.3, T40.4– or T40.6 <u>without</u> external cause code X42, X62 or Y12
	Exclusions: T40.0, T40.1, T40.2–, T40.3, T40.4– or T40.6 <u>with</u> X85 Assault by drugs, medicaments and biological substances
Data elements	Main Problem, Other Problem
Correct case examples	T40.40 (MP) Poisoning by fentanyl and derivatives
	X42 (OP) Accidental poisoning by and exposure to narcotics and psychodysleptics > K D O O X F L Q R J H Q V @ Q R W H O V H Z K H U H F O D V V L ¿ H G
References	ICD-10-CA Table of Drugs
	Coding Standard: Adverse Reactions in Therapeutic Use Versus Poisoning
	Coding Standard Appendix A: Opioid overdose
	& O D V V L ¿ F D W L R Q V E X O O H W L Q 2 S L R L G 2 Y H U G R V H & R G L Q J ' L U H

7 Alcohol Poisoning External Cause Code Without Corresponding Alcohol Poisoning T-Code (N0045-163)

Rule

When one of the following alcohol poisoning external cause codes is recorded

- X45 Accidental poisoning by and exposure to alcohol
- X65 Intentional self-poisoning by and exposure to alcohol
- Y15 Poisoning by and exposure to alcohol, undetermined intent

The corresponding alcohol poisoning T-code from category T51.– 7R[LF HúHFW must DOFRKRO also be recorded.

Criteria	Description
Patient care type	All patient care types
Submission levels	Level 3
Selection criteria	Abstracts with external cause code X45, X65 or Y15 <u>without</u> a Diagnosis Code from category T51.–
Data elements	Main Problem, Other Problem
Correct case examples	7 03 7R[LF H‡HFW RI DOFRKRO XQVSHFL¿HG X45 (OP) Accidental poisoning by and exposure to alcohol
References	ICD-10-CA Table of Drugs Coding Standard: Adverse Reactions in Therapeutic Use Versus Poisoning

8   Alcohol Poisoning T-Code Without Corresponding Alcohol Poisoning External Cause Code (N0045-164)

Rule

When a code from category T51.– 7 R [L F   H ú H F W is recorded, one of the following poisoning external cause codes must also be recorded:

- X45 Accidental poisoning by and exposure to alcohol
- X65 Intentional self-poisoning by and exposure to alcohol
- Y15 Poisoning by and exposure to alcohol, undetermined intent

Criteria	Description

10 Project 340 — Project Not Completed When an "Applicable Condition" Is Recorded (N9340-99)

Rule

Special Project 340 Canadian Stroke Strategy Performance Improvement is mandatory for all Ontario Level 3 emergency department records, with the exception of cases admitted to the acute care facility via its own ED or transferred to another ED facility in the same continuous episode of care.

This project should be completed for all patients who have been diagnosed with an
D F X W H F X U U H Q W V W U R N H   D Q G F H U W D L Q R W K H U F R Q G L W L R Q V
 S H U V S H F W L Y H D U H Q R W F O D V V L ¿ H G D V D K H P R U U K D J L F   L V F K H
conditions included in this project are: transient ischemic attack (TIA), transient retinal artery occlusion, intracranial and intraspinal phlebitis and thrombophlebitis, nonpyogenic thrombosis of intracranial venous system and central retinal artery occlusion.

Note: The term "applicable condition" is used throughout the stroke projects documentation to refer to the ICD-10-CA codes/conditions included.

Inclusion Criteria ICD-10-CA Code List:

- I60.– Subarachnoid haemorrhage
- I61.– Intracerebral haemorrhage
- I63.– Cerebral infarction
- I64 6 W U R N H Q R W V S H F L ¿ H G D V K D H P R U U K D J H R U L Q I D U F W L R Q
- I67.6 Nonpyogenic thrombosis of intracranial venous system
- G08 Intracranial and intraspinal phlebitis and thrombophlebitis
- H34.0 Transient retinal artery occlusion
- H34.1 Central retinal artery occlusion
- G45.– Transient cerebral ischaemic attacks and related syndromes (excluding G45.4 Transient global amnesia)
- O22.5– Cerebral venous thrombosis in pregnancy
- O87.3– Cerebral venous thrombosis in puerperium

Note: 7 K H U H P D \ E H F D V H V À D J J H G Z L W K W K L V W H V W W K D W G R Q

Criteria	Description
Patient care type	ED
Submission level	Level 3
Selection criteria	Abstracts from ON where Project 340 is not completed when a Diagnosis Code for one of the "applicable conditions" is recorded as Main or Other Problem
	Exclusions:
	Cases admitted as inpatient within the same reporting facility (Visit Disposition is 06 or 07)
	& D V H V Z K H U H D Q L Q V W L W X W L R Q Q X P E H U F O D V V L ¿ H G D V $ P E X O
	, Q V W L W X W L R Q 7 R ¿ H O G
	Exclusion: Patients younger than 1
Data elements	Main Problem, Other Problem, Project Number
Reference	NACRS Abstracting Manual, Special Project Information (Data Elements 145 to 169) — Special Projects documentation is now accessible through the DAD/NACRS Abstracting Manual application on CIHI's website.

11 Project 340 — Not Applicable, Unknown or Invalid Value for Prescription for Antithrombotic Medication at Discharge (N9340-103)

Rule

12 Project 340 — Missing, Invalid or Unknown Value for Date and Time of Acute Thrombolysis Administration When Administration of Acute Thrombolysis Is Y or P (N9340-121)

Rule

When Special Project 340 Canadian Stroke Strategy Performance Improvement is completed, it is mandatory to record Fields 149 to 156 Date and Time of Acute Thrombolysis Administration. This field captures the specific date for thrombolysis. The start date/time for administration of the medication should be recorded in these fields as they happen or being recorded.

Note: A high percent of abstracts with missing (blank), invalid or 99 (unknown) date and time may indicate a need to investigate documentation practices.

Criteria	Description
Patient care type	ED
Submission level	Level 3
Selection criteria	An "applicable condition" is recorded
	AND
	Field 148 Administration of Acute Thrombolysis is Y (Yes) or P (Yes, prior)

13 Project 340 — Invalid or Unknown Value for Stroke Symptom Onset Date and Time (N9340-123)

Rule

When Special Project 340 Canadian Stroke Strategy Performance Improvement is completed,
 L W

14 Project 340 — High volume of N for Referral to Stroke Prevention Services at ED

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