Discharge Abstract Database Open-Year Data Quality Test Specifications

2017–2018

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Table of contents

Introduction

As part of the Canadian Institute for Health Information's (CIHI's) commitment to quality data, the Discharge Abstract Database (DAD) is routinely analyzed for data quality issues during the submission year and after database closure. Suspect findings are communicated back to the submitting facilities for investigation and correction while the database is still open for submission.

Purpose

This document was created to

- Accompany the Open-Year Data Quality (OYDQ) reports that are disseminated to facilities during the fiscal year to communicate suspect data quality issues for investigation and/or correction as applicable; and
- Help DAD clients create their own data quality audits to identify abstracts with suspected data quality issues.

This document lists the OYDQ tests performed on the DAD, along with their rule, selection criteria, the data elements used in the analysis and, for some tests, one correct example to demonstrate a correct case and the references. It is important to note that the correct example does not cover all possible correct examples. Each test is indexed by a reference number and this number is used for all communication with clients.

The DAD OYDQ Reports are made available to facilities and/or Provincial/Territorial Ministries of Health via the DAD and NACRS Applications web page by clicking the Open-Year DQ Reports link. Facilities are asked to review errors and to resubmit the corrected abstracts, where applicable. Each OYDQ report sent to facilities references the OYDQ test number and title along with the DAD abstract identification data elements, such as Chart Number, Fiscal Year, Fiscal Period, Batch Number, Abstract Number and Discharge Date. The abstract identification information helps facilities link the abstracts with suspect data quality issues to the matching abstracts in their systems.

Note: The same abstract may be identified as having more than one data quality issue. For example, an abstract may be identified in the OYDQ test *Incorrect infant status of singleton within multiparous delivery episode (D1002-32)* and again in OYDQ test *Potential Extra Abstracts (D0103-18).*

Updates

The *DAD Open-Year Data Quality Test Specifications* document is updated every fiscal year with new, modified or deleted OYDQ tests. An OYDQ test may be deleted if new edits are created or if the data quality issue is no longer relevant. An OYDQ test may also be modified to reflect enhancements to the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA),* the *Canadian Classification of Health Interventions (CCI)* and/or to align with the most recent version of the *Canadian Coding Standards for ICD-10-CA and CCI*.

For more information, please contact CIHI at cad@cihi.ca.

Open-Year Data Quality Tests: Summary and Rationale

The following table provides a brief summary of the DAD OYDQ tests for 2017-2018. In the rationale column, the table also highlights a number of key impacts of correcting these DQ issues. Each test is described in greater details in the following section.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D0103-18	Potential Extra Abstracts	One abstract recorded multiple times with the same values in several key fields used to match abstracts.	Recording one discharge multiple times impacts both the Resource Intensity Weight assignment and the rate of over-coverage.
D0112-23	Incomplete Linkage of Mothers and Babies by Chart Number and Maternal/ Newborn Chart Number	Incorrect Chart Number or Maternal/ Newborn Chart Number recorded in mothers' or babies' abstracts.	Linking maternal and newborn abstracts are critical in the measurement of maternal/ newborn health outcomes. The Maternal/Newborn Chart Number is the only data element used to link mothers and their babies.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D0301-117	Mother's Health Care Number Recorded as Health Care Number on Out-of-Province Newborn's Abstracts	When available, the provincial/ territorial health care number (HCN) assigned to the newborn should be recorded.	High percentages of newborn abstracts with the mother's HCN recorded as HCN diminish the ability to link records of the newborn discharge and any subsequent discharges.
D0301-118	Mother's Health Care Number Recorded as Health Care Number on In-Province Newborn's Abstracts	When available, the provincial/ territorial health care number (HCN) assigned to the newborn should be recorded.	High percentages of newborn abstracts with the mother's HCN recorded as HCN diminish the ability to link records of the newborn discharge and any subsequent discharges.
D0402-64	Unknown Admission Time	Admission Time is unknown.	This field is important for episode building.
D0413-147	Date/Time Patient Left ED after SCU Admit Date/Time	Date/Time Patient Left ED must be a date/time earlier or same as SCU Admit Date/Time.	Date/Time Patient Left ED is important for calculating accurate measures of wait times in the ED for the reporting facility.
D0502-65	Unknown Discharge Time	Discharge Time is unknown.	This field is important for episode building.
D0701-149 NEW	Potential Alternative Level of Care (ALC) Under-Reporting	Acute inpatients that are likely ALC but ALC patient service is not recorded.	ALC data is well used at every level of the health service system and across acute and continuing care sectors.
D0703-50	Unknown Weight 0001 Recorded for Newborns and Neonates Less Than 29 Days	Weight is recorded as unknown for newborns & neonates less than 29 days.	Weight impacts the CMG assignment. A high percentage of abstracts with 0001 (Unknown) weight may indicate facility documentation issues.
D1001-150 NEW	Missing Diagnosis Prefix J to Identify the Underlying Conditions for which Medical Assistance in Dying (MAID) is Performed	When MAID-related intervention codes are assigned, the diagnosis prefix J should be assigned to the diagnosis codes that identify the underlying conditions for which MAID is performed.	Accurate capture of MAID data enables monitoring and reporting of MAID, as well as inclusion of patients who receive this health care service in or exclusion of them from indicators and analyses as appropriate.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1001-151 NEW	Diagnosis Prefix J Without Medical Assistance in Dying (MAID) Related Intervention Codes	When Diagnosis Prefix J is assigned, the expected MAID-related interventions should be recorded. Diagnosis prefix J can only be used for diagnosis codes that identify the underlying conditions for which MAID is performed.	Accurate capture of MAID data enables monitoring and reporting of MAID, as well as inclusion of patients who receive this health care service in or exclusion of them from indicators and analyses as appropriate.
D1002-27	Z51.5 Palliative Care Assigned Diagnosis Type 2 (Post-Admit Comorbidity) or 3 (Secondary Diagnosis)	Incorrect Diagnosis Typing for Palliative Care coding.	Impacts comorbidity factor in some MCCs if Palliative Care incorrectly captured as Diagnosis Type 2. Palliative care research is increasing, and this information is accordingly being increasingly used.
D1002-32	Incorrect Infant Status of Singleton Within a Multiparous Delivery Episode	The Diagnosis Code of Z38.– on a newborn's abstract indicates the plurality of birth (singleton, twin, triplet, etc), the same number of newborn abstracts should be linked to the mother's abstract.	Research on multiple birth outcomes is adversely affected by incorrect data.
D1002-52	Post-Procedure Disorder Codes Recorded Without an External Cause Code	All post-procedural disorder codes require an external cause code (Y60–Y84 or V01–X59).	Post-procedural codes are used in reports which are provided to external clients.
D1002-69	Poisoning T Code (T36-T50) Without a Poisoning External Cause Code	When a poisoning T Diagnosis Code of (T36-T50) is assigned, the expected external cause code should represent a 'poisoning'.	Accurate data are required for analysis of poisoning data.
D1002-76	Missing Repeat Cesarean Section Diagnosis Codes When 5.MD.60.^^ Recorded with Status Attribute (RA, RB or RC) Identifying Repeat Cesarean Section	When a Cesarean section Intervention Code from rubric 5.MD.60.^^ is recorded with Status Attribute (RA, RB, RC) that identifies a repeat c-section, it is mandatory to assign a Diagnosis Code to denote this is a repeat c-section (O34.201 or O66.401) and apply Diagnosis Type M or 1 *(Pre-Admit Comorbidity)*.	Impacts CMG assignment. Accurate delivery codes are required for maternal/newborn outcome measures.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1002-96	Missing Asterisk Code With Diabetes Mellitus Code	The dagger/asterisk code convention is mandatory to follow.	May affect CMG assignment if Asterisk Code is significant type 6 and not captured. Diabetes is an area of national research.
D1002-127	Acute Myocardial Infarction Assigned Diagnosis Type (3)	Incorrect Diagnosis Typing for Acute Myocardial Infarction coding.	Impacts important Organisation for Economic Co-operation and Development (OECD) indicator.
D1002-128	Missing Additional Code to Identify the Specific Condition Complicating Pregnancy Childbirth and the Puerperium O99	When a code from any one of the subcategories within O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* ,is assigned, it is mandatory to assign an additional code to identify the specific condition per the use additional code instruction in the tabular at this category.	Research on obstetrical complications is adversely affected by incomplete data.
D1002-129	Missing Additional Diagnosis Code to Specify the Type of Sepsis in SIRS of Infectious Origin and/or Septic Shock	When R65.0 *Systemic inflammatory response syndrome of infectious origin without organ failure* or R65.1 *Systemic inflammatory response syndrome of infectious origin with acute organ failure* or R57.2 *Septic shock,* is assigned, it is mandatory to assign an additional code to identify the type of sepsis.	Impacts important patient safety indicator. Accurate data are required for analysis.
D1002-130	Missing External Cause Code Y60.- with Diagnosis Code T81.2 in the Same Diagnosis Cluster	When T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* is assigned, it is mandatory to assign an external cause code from category Y60.- *Unintentional cut, perforation or haemorrhage during surgical and medical care.*	Impacts important patient safety indicator. Accurate data are required for analysis.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1002-131	Missing Diagnosis Code T81.2 or T81.0 with External Cause Code Y60.- in the Same Diagnosis Cluster	When an external cause of injury code from category *Y60.- Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care* is assigned on an abstract, either T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* or T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* must be recorded on the abstract and in the same Diagnosis Cluster as Y60.-.	Impacts important patient safety indicator. Accurate data are required for analysis.
D1002-132	Incorrect Creation of Diagnosis Cluster with Adverse Effect in Therapeutic Use External Cause Code from Y40-Y59	When an external cause code representing an adverse effect in therapeutic use (Y40-Y59) is assigned with a diagnosis cluster value, there cannot be another external cause code from Y60-Y84 in the same diagnosis cluster.	Impacts important patient safety indicator. Accurate data are required for analysis.
D1002-133	Incorrect Creation of Diagnosis Cluster with External Cause Code from Y60-Y84	When an external cause code from Y60-Y84 is assigned, there cannot be another external cause code from Y60-Y84 in the same diagnosis cluster.	Impacts important patient safety indicator. Accurate data are required for analysis.
D1002-134	MRSA and VRE Infections – Missing Additional Code for Site of Infection	When a current infection is documented as due to one of the “super bugs” referred to as MRSA (methicillin resistant staphylococcus aureus) or VRE (vancomycin resistant enterococcus), it is mandatory to assign the codes that identify the site of the infection, the causative organism and the drug resistance.	Impacts important patient safety indicator. Accurate data are required for analysis.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1002-136	Incorrect Coding of Post-Intervention Sepsis	When a case of sepsis meets the definition of a post-intervention condition, the primary code must be a T-code (from the list provided) and the code identifying the type of sepsis is assigned mandatory as a diagnosis type (3) along with the applicable external cause code from Y83-Y84. The application of the diagnosis cluster links all the codes together.	Impacts important patient safety indicator. Accurate data are required for analysis.
D1002-148	More Than One Outcome of Delivery (Z37) Code	When a delivery occurs during an episode of care, only one outcome of delivery (Z37) code is recorded on abstract.	Impacts the CMG assignment and birthing outcomes are frequently used in analysis.
D1101-97	Same Intervention Episode Start Date and Intervention Episode Start Time Recorded for Each Intervention Code	For intervention episodes performed in Intervention Location 01 *(Main operating room)* or 08 *(Cardiac catheterization room)* the Intervention Episode Start Date and Intervention Episode Start Time are mandatory and must be completed on the occurrence number which corresponds with the first Intervention code in the intervention episode.	Impacts intervention event factor, which influences RIW.
D1102-71	Incorrect Extent Attribute 0 *(Not Applicable)* with Invasive Ventilation CCI code	When an invasive ventilation CCI code is assigned the Extent Attributes should be either: CN (*Continuous but less than 96 hours of invasive ventilation*) or EX (*Extended continuous of 96 hours (or more) of invasive ventilation*).	Impacts Flagged Intervention factor used to adjust RIW/ELOS.
D1102-111	Repair High Vaginal Laceration without a Corresponding Diagnosis Code for High Vaginal Laceration	Surgical repair of high vaginal laceration without a corresponding diagnosis code.	Impacts important patient safety indicator.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1102-116	Mismatch Between Status Attribute Assigned for 5.MD.60.^^ (Cesarean Section) and Diagnosis Codes O34.201 (Uterine Scar due to Previous Caesarean Section) and O66.401 (Failed trial of Labour following Caesarean Section)	Intervention status attribute PA, PB or PC for 5.MD.60.^^ represents a primary caesarean section delivery is mismatched with a diagnoses indicating previous caesarean section.	Impacts CMG assignment, and birthing outcomes are frequently used in analysis.
D1102-119	Repair Laceration of the Cervix, without a Corresponding Diagnosis Code for Cervical Laceration	When an intervention code representing a surgical repair of cervical laceration is assigned, a Diagnosis Code for cervical laceration is expected to be assigned on the abstract.	Impacts important patient safety indicator.
D1103-83	Status Attribute not Equal to DX *(Diagnostic)* With Coronary Angiogram	The Intervention Code 3.IP.10.VX *Xray, heart with coronary arteries of left heart structures using percutaneous transluminal arterial (retrograde) approach* should have a Status Attribute DX *(Diagnostic)* when the only intervention performed during the intervention episode is coronary angiogram 3.IP.10.VX and there is only one intervention recorded in the intervention episode.	It is important to distinguish diagnostic coronary angiogram from other coronary angiograms.
D1103-85	Status Attribute UN *(Unknown)* With Hip Replacement	The Status Attribute UN *(Unknown)* should be rarely used for the implantation of hip or pelvis prosthesis as documentation should support whether the replacement is a primary replacement or revision.	Impacts CMG assignment. This information is used by CIHI to report on hip replacements.
D1103-88	Status Attribute UN *(Unknown)* With Knee Replacement	The Status Attribute UN *(Unknown)* should be used rarely for the implantation of knee as documentation should support whether it is a primary knee replacement or a revision.	Impacts CMG assignment. Status Attribute is used by CIHI to report on knee replacements.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1105-86	Extent Attribute UN *(Unknown)* With Hip Replacement	The Extent Attribute UN *(Unknown)* should be used rarely for the implantation of hip prosthesis as the documentation should identify the components implanted.	Attributes are used by CIHI to report on hip replacements
D1113-35	Three or More OOH Intervention Episodes in One Day	Recording the Intervention Episode Start Date multiple times for OOH interventions may result in erroneously increasing the number of OOH intervention episodes performed.	Impacts intervention event factor. Intervention count is used in Resource Intensity Weight assignment.
D1618-99	Stroke or TIA Diagnosis Code Without Completion of Project 340 Field	When a stroke Diagnosis Code is recorded, the Project Number 340 must be completed.	Stroke is a high priority health initiative.
D1618-103	Not applicable, Unknown or Invalid Value for Field 12 *(Prescription for Antithrombotic Medication at Discharge)* When Project 340 Recorded for Ischaemic Stroke Diagnosis	When Project 340 is recorded, it is mandatory to complete Field 12 *(Prescription for antithrombotic medication at discharge)*. This field captures whether patients with a diagnosis of ischaemic stroke received a prescription for antithrombotic medication at discharge.	Stroke is a high priority health initiative.
D1618-121	Missing, Invalid or Unknown Value for Fields 04 to 11 (*Date and Time of Acute Thrombolysis Administration*) When Project 340 Recorded and Field 03 (*Administration of Acute Thrombolysis*) is Y (Yes) or P (Yes, Prior)	When Project 340 is recorded, it is mandatory to complete Fields 04 to 11 (*Date and Time of Acute Thrombolysis Administration*). This field captures the specific date and time that a patient with acute ischaemic stroke received acute thrombolysis, for those who were administered this medication.	Stroke is a high priority health initiative.
D1618-123	Invalid or Unknown Value for Fields 13 to 24 (*Stroke Symptom Onset Date and Time*) When Project 340 Recorded	When Project 340 is recorded, it is mandatory to complete Fields 13 to 24 (*Stroke Symptom Onset Date and Time*). This field captures the date and time that the patient first started to experience stroke symptoms, regardless of the location of the patient at the time of symptom onset.	Stroke is a high priority health initiative.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1618-124	Stroke Symptom Onset Date and Time after Admission Date and Time When Project 340 Recorded	When Project 340 is recorded, Fields 13 to 20 (*Stroke Symptom Onset Date and Time*) must be a date/time earlier than the emergency department arrival or facility admission date and time.	Stroke is a high priority health initiative.
D1619-137	New Ischaemic or Haemorrhagic Stroke Diagnosis Code Without Completion of Project 740 Field	In Ontario, special project 740 is mandatory to report for all DAD acute inpatient admissions of patients 18 years and older with a new ischaemic and/or haemorrhagic stroke.	Stroke is a high priority health initiative.
D1619-138	Invalid Value for Field 01 *(Documentation of AlphaFIM® Scores*) When Project 740 Recorded	When Project 740 is recorded, Field 01(*Documentation of AlphaFIM® Scores*) must be uppercase Y or N.	Stroke is a high priority health initiative.
D1619-139	Invalid value for Fields 02-09 (*AlphaFIM® Completion Date*) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes)	When special project 740 is recorded and Field 01 (*Documentation of AlphaFIM®*) is recorded with "Y" (Yes, there is documentation) the Fields 02-09 (*AlphaFIM® Completion Date*) must be a valid date or 99999999.	Stroke is a high priority health initiative.
D1619-141	Fields 02-09 (*AlphaFIM® Completion Date*) Not Between Admission Date and Discharge Date When Project 740 is Recorded and Field 01 is Recorded With Y (Yes)	When special project 740 is recorded and Field 01 (*Documentation of AlphaFIM®)* is recorded with "Y" (Yes, there is documentation), Fields 02-09 (*AlphaFIM® Completion Date*) must be greater than or equal to the *Admission Date* and less than or equal to the *Discharge Date.*	Stroke is a high priority health initiative.
D1619-142	Invalid Value for Fields 10-11 (*Projected FIM®-13 Raw Motor Rating*) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes)	When special project 740 is recorded and Field 01 (*Documentation of AlphaFIM®*) is recorded with "Y" (Yes, there is documentation), the Fields 10-11 (*Projected FIM®-13 Raw Motor Rating*) must be greater than or equal to 13 and less than or equal to 91 or equal to 99 (unknown).	Stroke is a high priority health initiative.

OYDQ Test Number	OYDQ Test Title	Short Description	Rationale
D1619-144	Invalid Value for Fields 12-13 (*Projected FIM® - 5 Raw Cognitive Rating*) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes)	When special project 740 is recorded and Field 01 (Documentation of AlphaFIM®) is recorded with "Y" (Yes, there is documentation) the Fields 12-13 (Projected FIM® - 5 Raw Cognitive Rating) must be greater than or equal to 5 and less than or equal to 35 or equal to 99 (unknown).	Stroke is a high priority health initiative.
D1801-120	Mismatch Between Diagnosis Code or Caesarean Section Status Attribute Indicating a Previous Delivery and Number of Previous Deliveries Indicating No Previous delivery	Mismatch between no previous deliveries and Diagnosis Code or Intervention Status Attribute Indicating Previous Cesarean Section.	Impacts important obstetrical indicators.
D1801-135	Obstetrics Delivered Diagnosis or Intervention Code without Number of Previous Term Deliveries and/or Number of Previous Pre-Term Deliveries Recorded	When obstetrics delivered code is recorded, it is mandatory to report Number of Previous Term Deliveries and Number of Previous Pre-Term Deliveries.	Impacts important obstetrical indicators.

Open-Year Data Quality Tests

1 Potential Extra Abstracts (D0103-18)

Criteria	Description
Selection Criteria	Abstracts where the values recorded in the below group of data elements are the same in more than one abstract.
Data Elements	Province/Territory, Institution Number, Health Care Number, Birth Date, Gender, Postal Code, Admission Date, Admission Time, Discharge Date, Discharge Time, Most Responsible Diagnosis Code, Principal Intervention Code, Weight.

2 Incomplete Linkage of Mothers and Babies by Chart Number and Maternal/Newborn Chart Number (D0112-23)

Rule

The Maternal/Newborn Chart Number on the mother's record must be the same as the Chart Number recorded on her newborn's record. The Maternal/Newborn Chart Number on the newborn's record must be the same as the Chart Number recorded on his or her mother's record.

Criteria	Description
Selection Criteria	Diagnosis Code on mother's record is Z37.0–, Z37.2–, Z37.3–, Z37.5–, Z37.6– or Z37.9– (delivery) and Most Responsible Diagnosis Code is not O02.– to O05.– *(Pregnancy with abortive outcome)* and One of the Intervention Codes is 5.MD.50.^^ to 5.MD.60.^^ (delivery) Entry Code on newborn's record is N (born within the reporting facility) and Most Responsible Diagnosis Code is not P96.*4 Termination of pregnancy, affecting fetus and newborn*. Mothers' abstracts where the Maternal/Newborn Chart Number is not the same as the Chart Number in the newborns' abstracts. Newborns' abstracts where the Maternal/Newborn Chart Number is not the same as the Chart Number in the mother's abstracts.
Data Elements	Maternal/Newborn Chart Number, Chart Number, Entry Code, Diagnosis Code, Diagnosis Type Code, Intervention Code
Correct Case Example	The Chart Number and Maternal/Newborn Chart Number for the Mother should be M00001 and N00001 respectively. The Chart Number and Maternal/Newborn Chart Number for the Newborn should be N00001 and M00001 respectively. The Maternal/Newborn Chart Number on the mother's record is correctly recorded with newborn's Chart Number, and the Maternal/Newborn Chart Number on the newborn's record is correctly recorded with mother's Chart Number.
Reference	DAD Abstracting Manual: Group 01—Submission Control Data Elements, Field 12—Maternal/ Newborn Chart Number.

3 Mother's Health Care Number Recorded as Health Care Number on Out-of-Province Newborn's Abstracts (D0301-117)

Rule

When available, record the provincial/territorial health care number (HCN) assigned to the newborn.

Alberta, Northwest Territories and Yukon:

- When the newborn's HCN is not available, record the mother's HCN.
- When the mother's HCN is not available, record 1 (not applicable) for out-of-province newborns.

New Brunswick:

- When the mother's HCN is not available for out-of-province newborns, record 1 (not applicable).

Newfoundland and Labrador, PEI, Ontario, British Columbia, and Nunavut:

- The mother's health care number cannot be recorded as the health care number on the newborn's abstracts.
- When the newborn's HCN is not available, record 1 (not applicable) for out-of-province newborns.

Nova Scotia and Saskatchewan:

- When the HCN for an out-of-province newborn is not available, record 1 (not applicable).

Manitoba:

- When the newborn's Out of Province HCN is not available, record the mother's HCN on the newborn's abstract.

This test will be completed for all out-of-province newborns' abstracts with a valid HCN. A high percent of out-of-province newborn abstracts with the mother's HCN recorded as HCN may indicate a need to investigate practices around the capturing of out-of-province HCNs for newborns.

Criteria	Description
Selection Criteria	Inclusions: The abstracts of newborns where: • Entry Code is equal N (born alive within the reporting facility), and • Province/Territory Issuing HCN is not the same as the province/territory of the reporting facility, and • HCN has a valid format, and • Province/Territory Issuing HCN and HCN are equal to the Province/Territory Issuing HCN and HCN on a mother's abstract from the same reporting facility. The abstracts of mothers are used to identify newborns' abstracts with the mother's HCN recorded as HCN. The selection criteria for mothers' abstracts are: • One of the Diagnosis Codes is Z37.0–, Z37.2–, Z37.3–, Z37.5–, Z37.6– or Z37.9– (delivery), and • Most Responsible Diagnosis Code is not O02.– to O05.– *(abortive outcome),* and • One of the Intervention Codes is 5.MD.50.^^ to 5.MD.60.^^ (delivery). Exclusions: 1. Province/Territory Issuing Health Care Number is 99 (not applicable) or CA (Canada). 2. Entry Code is S (Stillborn). 3. Admission Category is R (Cadaveric Donor). 4. 0 or 1 is recorded as HCN or HCN has invalid format.
Data Elements	Province/Territory, HCN, Province/Territory Issuing HCN, Entry Code, Admission Category, Diagnosis Code, Intervention Code
Correct Case Example	When available, the provincial/territorial HCN assigned to the newborn is recorded. When the newborn's HCN is not available, record 1 (not applicable) for out-of-province newborn if the province/territory of the reporting facility is Newfoundland and Labrador, PEI, Nova Scotia, Ontario, Saskatchewan, British Columbia, and Nunavut.
Reference	DAD Abstracting Manual: Group 03—Patient/Client Demographics, Field 01—Health Care Number.

4 Mother's Health Care Number Recorded as Health Care Number on In-Province Newborn's Abstracts (D0301-118)

Rule

When available, record the provincial/territorial health care number (HCN) assigned to the newborn.

Alberta, Northwest Territories and Yukon:

- When the newborn's HCN is not available, record the mother's HCN.
- When the mother's HCN is not available, record 0 (HCN not available) for provincial/territorial residents.

Newfoundland and Labrador, PEI, Ontario, British Columbia, and Nunavut:

- The mother's health care number cannot be recorded as the health care number on the newborn's abstracts.
- When the newborn's HCN is not available, record 0 (HCN not available) for provincial/territorial residents.

Nova Scotia, Manitoba and Saskatchewan:

- The newborn's HCN must always be recorded for provincial/territorial residents.

This test will be completed for all in-province newborns' abstracts with a valid HCN. A high percent of in-province newborn abstracts with the mother's HCN recorded as HCN may indicate a need to investigate practices around the capturing of HCNs for newborns.

Criteria	Description
Selection Criteria	Inclusions: The abstracts of newborns where: • Entry Code is equal N (born alive within the reporting facility), and • Province/Territory Issuing HCN is the same as the province/territory of the reporting facility, and • HCN has a valid format, and • Province/Territory Issuing HCN and HCN are equal to the Province/Territory Issuing HCN and HCN on a mother's abstracts from the same reporting facility. The abstracts of mothers are used to identify newborns' abstracts with the mother's HCN recorded as HCN. The selection criteria for mothers' abstracts are: • One of the Diagnosis Codes is Z37.0–, Z37.2–, Z37.3–, Z37.5–, Z37.6– or Z37.9– (delivery), and • Most Responsible Diagnosis Code is not O02.– to O05.– *(abortive outcome),* and • One of the Intervention Codes is 5.MD.50.^^ to 5.MD.60.^^ (delivery). Exclusions: 1. Province/Territory Issuing Health Care Number is 99 (not applicable) or CA (Canada) 2. Entry Code is S (Stillborn). 3. Admission Category is R (Cadaveric Donor). 4. 0 or 1 is recorded as HCN or HCN has invalid format.
Data Elements	Province/Territory, HCN, Province/Territory Issuing HCN, Entry Code, Admission Category, Diagnosis Code, Intervention Code
Correct Case Example	When available, the provincial/territorial HCN assigned to the newborn is recorded. When the newborn's HCN is not available, record 0 (HCN not available) for in-province newborn if the province/territory of the reporting facility is Newfoundland and Labrador, PEI, Ontario, British Columbia, and Nunavut.
Reference	DAD Abstracting Manual: Group 03—Patient/Client Demographics, Field 01—Health Care Number.

5 Unknown Admission Time (D0402-64)

Rule

Admission Date/Time is the date and time that the patient was officially registered as an inpatient or a patient for day surgery. A patient is considered an inpatient when the physician's order to admit is given.

An inpatient abstract should be created when an ED patient is admitted to an acute care unit.

- Record the Admission Date/Time as the date and time the physician gave the order to admit. The date and time the patient was transferred to an inpatient unit will be captured in Date/Time Patient Left the ED.
- When a patient is admitted and is not immediately transferred to the designated unit (for example placed in an ED holding area), the Admission Date/Time must reflect when the order to admit was provided by the physician. The date and time the patient was transferred to the inpatient unit will be captured in Date/Time Patient Left the ED.
- When a patient is admitted but remains in the ED for the entire visit (discharged from ED) because a bed is unavailable in the designated unit, a DAD abstract must still be completed even though the patient was never transferred to an acute care bed.
- The Admission Date/Time for newborns delivered at the reporting facility must be the same as the date and time of birth.

A high percent of abstracts with unknown times may indicate a need to investigate practices around the capture of this crucial data for quality indicators.

Criteria	Description
Selection Criteria	Abstracts where Admission Time = 9999.
Data Element	Admission Time

6 Date/Time Patient Left ED after SCU Admit Date/Time (D0413-147)

Rule

Date/Time Patient Left ED is the date and time the patient physically leaves the emergency department and does not return during that encounter. It may represent the following:

- Exact date/time the patient leaves the emergency department or ED holding area and is transferred directly to the unit; or
- Date/time the patient arrives in a designated bed on the nursing unit; or
- Date/time the patient arrives in the operating room or diagnostic area and does not return to the emergency department or ED holding area.

Date/Time Patient Left ED must be a date/time earlier or same as SCU Admit Date/Time.

Criteria	Description
Selection Criteria	Date Patient Left ED is recorded and is a valid date And SCU Admit Date is recorded and is a valid date And One of the following conditions is met: • If Time Patient Left ED and SCU Admit Time are a valid four digit character of 0000-2359, values recorded in Date and Time Patient Left ED are after the SCU Admit Date and Time • If Time Patient Left ED or SCU Admit Time is not a valid four digit character of 0000-2359, value recorded in Date Patient Left ED is after the SCU Admit Date
Data Elements	Date Patient Left ED, Time Patient Left ED, SCU Admit Date, SCU Admit Time
References	DAD Abstracting Manual: Group 04—Admission and Group 13—Special Care Unit (SCU).

7 Unknown Discharge Time (D0502-65)

Rule

Discharge Date/Time is the date and time when the patient was formally discharged.

- Record the date/time the patient was formally discharged and physically left the bed in the nursing unit.
- Additional information on how to record the date/time for patients absent without leave (AWOL), for patients who do not return from a pass and for what constitutes brain death can be found in the DAD Abstracting Manual.

Criteria	Description
Selection Criteria	Abstracts where Discharge Time = 9999.
Data Element	Discharge Time

8 Potential Alternative Level of Care (ALC) Under-Reporting (D0701-149)

Rule

When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting (acute, chronic or complex continuing care, mental health or rehabilitation), the patient must be designated ALC at that time by the most appropriate care team member, which may be a physician, long term care assessor, patient care manager, discharge planner or other care team member.

The decision to assign ALC status is a clinical responsibility. In order to enter the ALC Patient Service (99) on the DAD abstract, there must be clear, consistent documentation by the clinical staff, preferably on an approved ALC Designation form.

Accurate ALC reporting is key to monitoring and improving access to services, patient flow, as well as outcomes in acute care. This test estimates the percent of acute inpatients that are likely ALC but have no ALC days recorded.

Criteria	Description
Selection Criteria	Acute inpatients that are likely ALC but have no ALC days recorded: • Calculated Length of Stay (LOS) is greater than 25 days, and • Discharge Disposition is 02 (Transferred to continuing care), 03 (Transferred to other) or 04 (Discharged to home or a home setting with support services), and • Main Patient Service is not 99 (ALC), and • Service Transfer Service is not 99 (ALC). Exclusions: 1. Obstetric cases (Major Clinical Category 13 and 14) 2. Pediatric cases (younger than 17) Methodology for calculation of institution, provincial and national percentages: A / B x 100%, where: A = Number of potential ALC cases identified by the above selection criteria. B = A + Number of acute inpatient hospitalizations with Main Patient Service or Service Transfer Service 99 (ALC)
Data Elements	Admission Date, Discharge Date, Discharge Disposition, Main Patient Service, Service Transfer Service
Correct Case Example	Service Transfer Service 99 (ALC) was recorded when the patient was designated as ALC for a portion of his/her stay in the facility and was ALC for more than 24 hours.
Reference	DAD Abstracting Manual: Group 07 — Patient Service, Group 08 — Service Transfers, Additional Abstracting Information – Alternative Level of Care (ALC) Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care Job Aid – Alternate Level of Care Diagnosis List: Clarification of Use Job Aid –Changes to Z-Codes Allowable With ALC Service 99

9 Unknown Weight 0001 Recorded for Newborns and Neonates Less Than 29 Days (D0703-50)

Rule

The weight of a newborn or neonate less than 29 days on admission to the facility must be recorded.

Every effort should be made to record the admission weight since Weight is required for Case Mix Group (CMG+) assignment.

Criteria	Description
Selection Criteria	The abstracts of newborns and neonates where: Age Code = D (Days) or B (Newborn or Stillbirth) and Age Unit = 0-28 and Weight = 0001 and Entry Code is not equal S (Stillbirth)
Data Elements	Entry Code, Age Code, Age Unit, Weight

10 Missing Diagnosis Prefix J to Identify the Underlying Conditions for which Medical Assistance in Dying (MAID) is Performed (D1001-150)

Rule

When the following 3 CCI codes are assigned in the same intervention episode (3 CCI codes representing performance of MAID)

- 1.ZZ.35.HA-P7 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using hypnotic and sedative agent

  and

- 1.ZZ.35.HA-P1 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using anesthetic agent

  and

- 1.ZZ.35.HA-N3 Pharmacotherapy, total body, percutaneous approach, musculoskeletal system agents, using muscle relaxant

and the discharge disposition is (07) death, it is mandatory to assign prefix J to the ICD-10-CA code(s) that identify the underlying condition(s) for which MAID is performed.

Criteria	Description
Selection Criteria	Abstracts where the discharge disposition is 07(death) AND the following 3 CCI intervention codes are recorded in the same intervention episode WITHOUT an ICD-10-CA diagnosis code assigned prefix J. • 1.ZZ.35.HA-P7 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using hypnotic and sedative agent AND • 1.ZZ.35.HA-P1 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using anesthetic agent AND • 1.ZZ.35.HA-N3 Pharmacotherapy, total body, percutaneous approach, musculoskeletal system agents, using muscle relaxant
Data Elements	Intervention Code, Diagnosis Prefix, Diagnosis Code

Criteria	Description
Correct Case Example	Discharge disposition = 07 (death); Intervention codes 1.ZZ.35.HA-P7, 1.ZZ.35.HA-P1 and 1.ZZ.35.HA-N3 are recorded and diagnosis prefix J is assigned to at least one ICD-10-CA code.
Reference	Bulletin April 26, 2017: MAID Coding and Abstracting Direction

11 Diagnosis Prefix J Without Medical Assistance in Dying (MAID) Related Intervention Codes (D1001-151)

Rule

When diagnosis prefix J is assigned to an ICD-10-CA code, there must be CCI codes representing either, MAID intervention or MAID consultation recorded on the abstract.

Note: Prefix J is not to be used for any other purpose except in MAID cases to identify the underlying condition(s) when a MAID consultation is completed or MAID is performed; therefore, the error is either the incorrect use of prefix J or CCI codes are missing to identify performance of MAID intervention or a MAID consultation.

Criteria	Description
Selection Criteria	Abstracts where diagnosis prefix J is assigned to an ICD-10-CA code WITHOUT the following CCI codes assigned on the abstract: • 1.ZZ.35.HA-P7 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using hypnotic and sedative agent AND • 1.ZZ.35.HA-P1 Pharmacotherapy, total body, percutaneous approach, nervous system agents, using anesthetic agent AND • 1.ZZ.35.HA-N3 Pharmacotherapy, total body, percutaneous approach, musculoskeletal system agents, using muscle relaxant OR 2.ZZ.02.ZZ Assessment (examination), total body, general NEC (e.g. multiple reasons)
Data Elements	Intervention Code, Diagnosis Prefix, Diagnosis Code
Correct Case Example	Diagnosis prefix J is assigned to at least one ICD-10-CA code and the intervention codes 1.ZZ.35.HA-P7, 1.ZZ.35.HA-P1 and 1.ZZ.35.HA-N3 are recorded.
Reference	Bulletin April 26, 2017: MAID Coding and Abstracting Direction

12 Z51.5 Palliative Care Assigned Diagnosis Type 2 (Post-Admit Comorbidity) or 3 (Secondary Diagnosis) (D1002-27)

Rule

The Palliative Care coding standard states that Z51.5 *Palliative care* must not be assigned a Diagnosis Type 2 (*Post-admit comorbidity*) or 3 (*Secondary diagnosis*). Depending on the circumstances of the case, Z51.5 may be assigned Diagnosis Type (M, 1, W, X or Y). For those facilities that do not capture service transfers (Diagnosis Types W, X and Y), the equivalent of a Service Transfer Diagnosis Type is Diagnosis Type 1.

Criteria	Description
Selection Criteria	Abstracts where Diagnosis Code Z51.5 is assigned Diagnosis Type 2 or 3.
Data Elements	Diagnosis Code, Diagnosis Type
Correct Case Example	Z51.5 (M) *Palliative care;* C18.9 (3) *Malignant neoplasm colon, unspecified*
Reference	Canadian Coding Standards: Palliative Care.

13 Incorrect Infant Status of Singleton Within a Multiparous Delivery Episode (D1002-32)

Rule

According to the Canadian Coding Standards, every newborn record must include a code from Z38.– *Liveborn infants according to place of birth* to indicate the plurality of birth:

- A live-born singleton is assigned a code from Z38.0– to Z38.2–.
- Live-born twins, triplets or other multiple births are assigned a code from Z38.3– to Z38.8–.

A multiple birth newborn record must not have a code from Z38.0– to Z38.2– (singleton) recorded.

Most multiple births are delivered on the same date; however, some multiple births can occur on different dates. The codes Z38.3– to Z38.8– describe the plurality of the pregnancy and apply even when the births occur on different days or at different locations and/or when one or more of the babies are stillborn.

This analysis focuses on multiple births delivered on the same date. Clients may also perform analyses on different delivery dates, different delivery locations and where one or more newborns are stillborn.

Criteria	Description
Data Elements	Entry Code, Chart Number, Maternal/Newborn Chart Number, Admission Date, Diagnosis Code
Correct Case Example	Mother: Chart Number: 8866766 Baby A: Admission Date: 2013/11/01 Entry Code: N Chart Number: 123455 Maternal/Newborn Chart Number: 8866766 Z38.300 *Twin, born in hospital, delivered vaginally, product of both spontaneous (NOS) ovulation and conception*. Baby B: Admission Date: 2013/11/01 Entry Code: N Chart Number: 123456 Maternal/Newborn Chart Number: 8866766 Z38.310 *Twin, born in hospital, delivered by cesarean, product of both spontaneous (NOS) ovulation and conception*
Reference	Canadian Coding Standards: Diagnosis Typing Definitions for DAD.

14 Post-Procedural Disorder Codes Recorded Without an External Cause Code (D1002-52)

Rule

All post-procedural disorder codes (see Appendix A) require an external cause code (Y60–Y84 or V01–X59).

Criteria	Description
Selection Criteria	Abstracts with a post-procedural disorder Diagnosis Code (see Appendix A) without an External Cause Code (Y60–Y84 or V01–X59).
Data Element	Diagnosis Code
Correct Case Example	Example 1: K91.42 (M) *Malfunction of colostomy stoma, not elsewhere classified* **[Diagnosis Cluster A]** Y83.3 (9) *Surgical operation with formation of external stoma as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure* **[Diagnosis Cluster A]**
References	Canadian Coding Standards: Post-Intervention Conditions; Self-Learning Product: Classifying Post-Intervention Conditions: ICD-10-CA Code Assignment.

15 Poisoning T Code (T36-T50) Without a Poisoning External Cause Code (D1002-69)

Rule

When a poisoning T code of T36 - T50 is assigned, the expected external cause code should represent a “poisoning.”

Criteria	Description
Selection Criteria	Abstracts with T36-T50 Diagnosis Code without a corresponding poisoning external cause code of either: X40, X41, X42, X43, X44, X60, X61, X62, X63, X64, X85, Y10, Y11, Y12, Y13, Y14.
Data Element	Diagnosis Code
Correct Case Example	T42.4 *Poisoning by benzodiazepines* X41 *Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified*
References	ICD-10-CA Table of Drugs. Tip for Coders: How to Select the External Cause Code in the table of Drugs and Chemicals.

16 Missing Repeat Cesarean Section Diagnosis Code When 5.MD.60.^^ Recorded With Status Attribute (RA, RB or RC) Identifying Repeat Cesarean Section (D1002-76)

Rule

When Intervention Code 5.MD.60.^^ (*Cesarean section delivery)* is recorded with a Status Attribute RA *(Repeat, Indicated, Planned)* or RB *(Repeat, Indicated, Emergent)* or RC (Repeat, Not indicated, Planned) then, a Diagnosis Code for repeat cesarean section O34.201 (*Uterine scar due to previous caesarean section, delivered, with or without mention of antepartum condition)* or O66.401 (*Failed trial of labour following previous caesarean, delivered, with or without mention of antepartum condition)* is mandatory to assign as a Diagnosis Type of M or 1.

Criteria	Description
Selection Criteria	Abstracts where Intervention Code from rubric 5.MD.60.^^ is recorded with a Status Attribute of RA, RB, or RC and the Diagnosis Code O34.201 or O66.401 with a significant diagnosis type (M) or (1) is not assigned.
Data Elements	Intervention Code, Status Attribute, Diagnosis Code, Diagnosis Type
Correct Case Examples	5.MD.60.AA *Cesarean section delivery, lower segment transverse incision, without instrumentation* Status Attribute: RA *(Repeat, Indicated, Planned)* *AND* O34.201 *Uterine scar due to previous caesarean section, delivered with or without mention of antepartum condition*
References	Canadian Coding Standards: Delivery With History of Previous Cesarean Section. Education: Moving Forward using v2015 of ICD-10-CA and CCI – Cesarean Section Status Attribute

17 Missing Asterisk Code With Diabetes Mellitus Code (D1002-96)

Rule

The dagger/asterisk coding convention is a World Health Organization (WHO) convention and is mandatory to assign both the dagger and asterisk codes, as applicable. When the following associated complications of diabetes mellitus codes are assigned, it is mandatory to assign the corresponding asterisk code:

- Nephropathy—E1-.20† or E1-.23† mandatory to assign asterisk code N08.3–*
- Ophthalmic—E1-.30†, E1-.31†, E1-.32†, E1-.33† mandatory to assign asterisk code H36.0*
- Mononeuropathy—E1-.40† mandatory to assign either asterisk code G73.0* or G59.0*, as applicable
- Polyneuropathy—E1-.41† mandatory to assign asterisk code G63.2*
- Autonomic neuropathy—E1-.42† mandatory to assign asterisk code G99.0*
- Circulatory complications—E1-.50† and E1-.51† mandatory to assign asterisk code I79.2*

Criteria	Description
Selection Criteria	Diabetes mellitus nephropathy: Identify cases that have E1-.20 or E1-.23. The incorrect cases will be missing N08.3– Diabetes mellitus ophthalmic complications: Identify cases that have E1-.30, E1-.31, E1-.32 or E1-.33. The incorrect cases will be missing H36.0 Diabetes mellitus mononeuropathy: Identify cases with E1-.40. Incorrect cases will be missing either G73.0 OR G59.0 Diabetes mellitus polyneuropathy: Identify cases with E1-.41. Incorrect cases will be missing G63.2 Diabetes mellitus autonomic neuropathy: Identify cases with E1-.42. Incorrect cases will be missing G99.0 Diabetes mellitus circulatory complications: Identify cases that have E1-.50 or E1-.51. Incorrect cases will be missing I79.2
Data Element	Diagnosis Code
Correct Case Examples	E11.23 *Type 2 diabetes mellitus with established or advanced kidney disease* N08.35 *Glomerular disorder in diabetes mellitus, chronic kidney disease, stage 5*
Reference	Canadian Coding Standards: Dagger/Asterisk Convention.

18 Acute Myocardial Infarction Assigned Diagnosis Type (3) (D1002-127)

Rule

A myocardial infarction within the acute phase is always assigned a significant diagnosis type (M, 1, 2, W, X, Y) per the coding standard Acute Coronary Syndrome (ACS).

Exceptions:

1. When a patient is readmitted with a diagnosis classifiable to category I22.-

   Subsequent myocardial infarction, a code from category I21.- *Acute myocardial infarction* may be assigned as an optional diagnosis type (3)/other problem to indicate the site of the original MI.

2. When I21.- is recorded with a Diagnosis Prefix Q, Diagnosis Type (3) may be appropriate for the case.

Criteria	Description
Selection Criteria	Abstracts where Diagnosis Code I21 is recorded as Diagnosis Type (3) AND the Diagnosis Prefix is not Q AND Diagnosis Code I22.- is not recorded on the same abstract.
Data Elements	Diagnosis Code, Diagnosis Type , Diagnosis Prefix
Correct Case Example	I21.1 (M) Acute transmural myocardial infarction of inferior wall R94.30 (3) Electrocardiogram suggestive of ST segment elevation myocardial infarction [STEMI]
Reference	Canadian Coding Standards: Acute Coronary Syndrome

19 Missing Additional Code to Identify the Specific Condition Complicating Pregnancy Childbirth and the Puerperium O99 (D1002-128)

Rule

When a code from any one of the subcategories within O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* is assigned, it is mandatory to assign an additional code to identify the specific condition as per the use additional code instruction in the tabular at this category.

Criteria	Description
Selection Criteria	Abstracts where a Diagnosis Code of: • O99.0- is recorded without a code from D50-D64 . • O99.1- is recorded without a code from D65-D89. • O99.2- is recorded without a code from E00-E07, E15-E34, E50-E89. • O99.3- is recorded without a code from F00-F52, F54-F99, G00-. • O99.4- is recorded without a code from I00-I09,r I20-I99. • O99.5- is recorded without a code from J00-J99. • O99.6- is recorded without a code from K00-K66, K80-K93. • O99.7- is recorded without a code from L00-L99. • O99.8- is assigned without 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 Element	Diagnosis Code
Correct Case Example	O70.101 (M) *Second degree perineal laceration during delivery delivered with or without mention of antepartum condition* O99.001 (1) *Anaemia complicating pregnancy, childbirth and the puerperium delivered with or without mention of antepartum condition* D64.9 (3) *Anaemia, unspecified* Z37.000 (3) *Single live birth, pregnancy resulting from both spontaneous ovulation and conception*
References	Use Additional Code instruction within ICD-10-CA direction at category O99 Canadian Coding Standards: Use additional Code/Code Separately Instructions Tip for Coders: O99 “Use Additional Code”

20 Missing Additional Diagnosis Code to Specify the Type of Sepsis in SIRS of Infectious Origin and/or Septic Shock (D1002-129)

Rule

When R65.0 *Systemic inflammatory response syndrome of infectious origin without organ failure* or *R65.1 Systemic inflammatory response syndrome of infectious origin with acute organ failure* or *R57.2 Septic shock*, is assigned, it is mandatory to assign an additional code to identify the type of sepsis.

Note: If the documentation does not specify the type of sepsis, then the additional code to assign is A41.9 *Sepsis, unspecified*.

Criteria	Description
Selection Criteria	Abstracts where a Diagnosis Code(s) of R65.0, R65.1 or R57.2 is recorded without one of the following Diagnosis Codes to identify the specific type of sepsis: A02.1, A03.9, A20.7, A21.7, A22.7, A23–, A24.1, A26.7, A28.0, A28.2, A32.7, A39.2, A39.3, A39.4, A40.–, A41.–, A42.7, A54.86, B37.7, P36, P372, or P37.51
Data Element	Diagnosis Code
Correct Case Example	I71.4 (M) Abdominal aortic aneurysm, without mention of rupture T81.4 (2) Infection following a procedure, not elsewhere classified [Dx Cluster A] A41.0 (3) Sepsis due to Staphylococcus aureus [Dx Cluster A] T81.1 (2) Shock during or resulting from a procedure, not elsewhere classified [Dx Cluster A] R57.2 (3) Septic shock [Dx Cluster A] Y83.2 (9) Surgical operation with anastomosis, bypass or graft [Dx Cluster A]
References	Use additional Code Instruction within ICD-10-CA at category R65 and R57.2. Canadian Coding Standards: Use additional Code/Code Separately Instructions; Septicemia/Sepsis; Systemic Inflammatory Response Syndrome (SIRS) Tip for Coders: What is Wrong with the Coding of Septic Shock?; Classification of Sepsis – Key Messages Self-Study Product: Staying on Track with Sepsis and Systemic Inflammatory Response Syndrome (SIRS)

21 Missing External Cause Code Y60.- with Diagnosis CodeT81.2 in the Same Diagnosis Cluster (D1002-130)

Rule

When T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* is assigned, it is mandatory to assign an external cause code from category Y60 *Unintentional cut, perforation or haemorrhage during surgical and medical care*. The rules of Post-Intervention Code Assignment also apply (i.e. mandatory additional code for specificity and diagnosis cluster).

Note: Although the selection criteria in this test does not include identifying cases where an additional code to identify the site of the laceration/puncture/perforation as a diagnosis type (3) is missing from the same diagnosis cluster, we encourage clients to double check the cases received as errors to ensure the 'additional code for site of laceration/puncture/perforation' mandatory requirement has also been met.

Criteria	Description
Selection Criteria	Abstracts where a Diagnosis Code of T81.2 is recorded with a Diagnosis Cluster value AND without an external cause of injury code from category Y60.- with the same Diagnosis Cluster value as T81.2.
Data Elements	Diagnosis Code; Diagnosis Cluster
Correct Case Example	K66.0 (M) *Peritoneal adhesions* T81.2 (2) *Accidental puncture and laceration during a procedure, not elsewhere classified* [Dx Cluster A] S37.0111 (3) Laceration of kidney (without urinary extravasation), with open wound into cavity [Dx Cluster A] Y60.0 (9) *Unintentional cut, puncture or hemorrhage during surgical operation* [Dx Cluster A]
References	Canadian Coding Standards: Misadventures During Surgical and Medical Care – Puncture/Laceration/Perforation During a Procedure Tip for Coders: Accidental cut and puncture during a procedure

22 Missing Diagnosis Code T81.2 or T81.0 with External Cause Code Y60.- in the Same Diagnosis Cluster (D1002-131)

Rule

When an external cause of injury code from category *Y60.- Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care* is assigned on an abstract, it is expected that either T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* or T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* must be recorded on the abstract with Y60.-, depending on the type of injury that occurred. The rules of Post-Intervention Code Assignment also apply (i.e. mandatory additional code for specificity and diagnosis cluster).

Note: A chart review is required in order to determine whether the missing diagnosis code is T81.2 or T81.0.

Note: The combination of T81.0 and Y60.- in a diagnosis cluster equates to a diagnosis of "intraoperative hemorrhage;" whereas, a combination of T81.0 and Y83.- or Y84.- in a diagnosis cluster equates to a diagnosis of "postoperative hemorrhage". This test does not include/cover the postoperative hemorrhage circumstance.

Criteria	Description
Selection Criteria	Abstracts where an External Cause Code from category Y60.- is recorded with a Diagnosis Cluster value AND without a Diagnosis Code of T81.2 or T81.0 recorded with the same Diagnosis Cluster value as Y60.-.
Data Elements	Diagnosis Code; Diagnosis Cluster
Correct Case Example	T81.0 (2) Haemorrhage and haematoma complicating a procedure, not elsewhere classified [Dx cluster A] Y60.0 (9) Unintentional cut, puncture, perforation or haemorrhage during surgical operation [Dx cluster A]
References	Canadian Coding Standards: Misadventures During Surgical and Medical Care – Puncture/Laceration/Perforation During a Procedure; Misadventures During Surgical and Medical Care – Intraoperative Hemorrhage Tip for Coders: Accidental cut and puncture during a procedure

23 Incorrect Creation of Diagnosis Cluster with Adverse Effect in Therapeutic Use External Cause Code from Y40-Y59 (D1002-132)

Rule

When an external cause code representing an adverse effect in therapeutic use (Y40-Y59) is assigned with a diagnosis cluster value, there cannot be another external cause code from Y60-Y84 in the same diagnosis cluster (i.e. cannot have the same diagnosis cluster value).

Note: It is correct in some circumstances to have more than one external cause code from Y40-Y59 in the same diagnosis cluster. This would not be an error.

Criteria	Description
Selection Criteria	Abstracts where External Cause Code from Y40-Y59 is recorded with a Diagnosis Cluster value AND another External Cause Code from Y60-Y84 is in the same Diagnosis Cluster.
Data Elements	Diagnosis Code; Diagnosis Cluster
Correct Case Example	R23.3 (M) Spontaneous ecchymoses [Dx cluster A] Y44.2 (9) Anticoagulants causing adverse effects in therapeutic use [Dx cluster A] Y40.4 (9) Tetracyclines causing adverse effects in therapeutic use [Dx cluster A]
References	Canadian Coding Standards: Diagnosis Cluster; Adverse Reactions in Therapeutic use Versus Poisonings; Post-Intervention Conditions

24 Incorrect Creation of Diagnosis Cluster with External Cause Code from Y60-Y84 (D1002-133)

Rule

When an external cause code from Y60-Y84 is assigned, there cannot be another external cause code from Y60-Y84 in the same diagnosis cluster (i.e. cannot have the same diagnosis cluster value). **There can only be one occurrence of a code from Y60-Y84 in one diagnosis cluster**.

Criteria	Description
Selection Criteria	Abstracts where more than one External Cause Code from Y60-Y84 is recorded with the same Diagnosis Cluster value.
Data Elements	Diagnosis Code; Diagnosis Cluster
Correct Case Example	T81.2 (2) Accidental puncture and laceration during a procedure, not elsewhere classified [Dx cluster A] S36.091 (3) Haematoma NOS, laceration NOS, injury to spleen NOS, with open wound into cavity [Dx cluster A] Y60.0 (9) Unintentional cut, puncture, perforation or hemorrhage, during surgical operation [Dx cluster A] I95.9 (2) Hypotension, unspecified [Dx cluster B] Y83.9 (9) Surgical procedure, unspecified as the cause of abnormal reaction of the patient or of later complication, without mention of misadventure at the time of the procedure [Dx cluster B]
References	Canadian Coding Standards: Diagnosis Cluster; Adverse Reactions in Therapeutic use Versus Poisonings; Post-Intervention Conditions

25 MRSA and VRE Infections – Missing Additional Code for Site of Infection (D1002-134)

Rule

When a current infection is documented as due to one of the “super bugs” referred to as MRSA (methicillin resistant staphylococcus aureus) or VRE (vancomycin resistant enterococcus), it is mandatory to assign the codes that identify the site of the infection, the causative organism and the drug resistance (as described below). The diagnosis cluster is mandatory to link all the codes together.

MRSA infection:

- A code that identifies the site of the infection
- B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*; and
- U82.1 *Resistance to methicillin*

VRE infection:

- A code that identifies the site of the infection;
- B96.81 *Enterococcus as the cause of diseases classified to other chapters*; and
- U83.0 Resistance to vancomycin

Criteria	Description
Selection Criteria	Abstracts where Diagnosis Codes U82.1 *Resistance to methicillin* and B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters* are recorded with the same Diagnosis cluster value AND there is no other code in the same diagnosis cluster OR Abstracts where Diagnosis Codes U83.0 *Resistance to vancomycin* and B96.81 *Enterococcus as the cause of diseases classified to other chapters* are recorded with the same Diagnosis Cluster value AND there is no other code in the same diagnosis cluster.
Data Elements	Diagnosis Code, Diagnosis Cluster

Criteria	Description
Correct Case Examples	M00.01 (M) *Staphylococcal arthritis and polyarthritis, shoulder region* **[Diagnosis Cluster A]** AND B95.6 (3) *Staphylococcus aureus as the cause of diseases classified to other chapters* **[Diagnosis Cluster A]** AND U82.1 (1) *Resistance to methicillin* **[Diagnosis Cluster A]**
References	Canadian Coding Standards: Drug-Resistant Microorganisms; Diagnosis Cluster

26 Incorrect Coding of Post-Intervention Sepsis (D1002-136)

Rule

When a case of sepsis meets the definition of a post-intervention condition, the primary code must be a T-code (from the list below, as applicable) and the code identifying the type of sepsis is assigned mandatory as a diagnosis type (3) along with the applicable external cause code from Y83-Y84. The application of the diagnosis cluster links all the codes together.

T-codes that may apply to a case involving post-intervention sepsis:

- T80.2 Infections following infusion, transfusions and therapeutic injection
- T81.4 Infection following a procedure, not elsewhere classified
- T88.0 Infection following immunization
- T82.6 Infection and inflammatory reaction due to cardiac valve prosthesis
- T82.701 Bloodstream infection and inflammatory reaction due to central venous catheter
- T82.79 Infection and inflammatory reaction due to other and unspecified cardiac and vascular devices, implants and grafts
- T83.5 Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system
- T83.6 Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
- T84.50 Infection and inflammatory reaction due to shoulder prosthesis
- T84.51 Infection and inflammatory reaction due to elbow prosthesis

- T84.52 Infection and inflammatory reaction due to wrist, carpal and interphalangeal prosthesis
- T84.53 Infection and inflammatory reaction due to hip prosthesis
- T84.54 Infection and inflammatory reaction due to knee prosthesis
- T84.55 Infection and inflammatory reaction due to ankle and tarsal prosthesis
- T84.58 Infection and inflammatory reaction due to other joint prosthesis
- T84.59 Infection and inflammatory reaction due to unspecified joint prosthesis
- T84.60 Infection and inflammatory reaction due to internal fixation device of humerus
- T84.61 Infection and inflammatory reaction due to internal fixation device of radius and ulna
- T84.62 Infection and inflammatory reaction due to internal fixation device of bones of hand
- T84.63 Infection and inflammatory reaction due to internal fixation device of femur
- T84.64 Infection and inflammatory reaction due to internal fixation device of tibia and fibula
- T84.65 Infection and inflammatory reaction due to internal fixation device of bones of foot
- T84.68 Infection and inflammatory reaction due to internal fixation device of bones at other site
- T84.69 Infection and inflammatory reaction due to internal fixation device of bones of limb NOS
- T84.7 Infection and inflammatory reaction due to other internal orthopaedic prosthetic devices, implants and grafts
- T85.7 Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts

Criteria	Description
Selection Criteria	Abstracts where any one of the following Diagnosis Codes A02.1, A03.9, A20.7, A21.7, A22.7, A23–, A24.1, A26.7, A28.0, A28.2, A32.7, A39.2, A39.3, A39.4, A40.–, A41.–, A42.7, A54.86, B37.7 is recorded with the same Diagnosis Cluster value as Y83-Y84 AND there is no T-code (from the list included in the Rule above) recorded within the same Diagnosis Cluster.
Data Elements	Diagnosis Code, Diagnosis Cluster

Criteria	Description
Correct Case Examples	T81.4 (2) *Infection following a procedure, not elsewhere classified* **[Dx Cluster A]** A41.9 (3) *Sepsis, unspecified* **[Dx Cluster A]** Y83.8 (9) *Other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure* **[Dx Cluster A]**
References	Canadian Coding Standards: Septicemia/Sepsis, Post-Intervention Conditions, and Assignment of Additional Codes for Specificity Tip for Coders: The Case of the Missing T-Codes and PP-Codes

27 More Than One Outcome of Delivery (Z37) Code (D1002-148)

Rule

When a delivery occurs during an episode of care, it is mandatory to assign one code from category Z37 *Outcome of delivery* on the mother's abstract. The outcome of delivery codes are broken down into subcategories by number of births (singleton versus multiple) and whether the outcome is a livebirth or stillbirth. Only one outcome of delivery code is assigned on the mother's abstract and is dependent on the circumstances of the specific case.

Criteria	Description
Selection Criteria	Abstracts with more than one Z37.- Diagnosis Code.
Data Element	Diagnosis Code
Correct Case Example	O36.491 *Maternal care for intrauterine death, unspecified trimester, delivered, with or without mention of antepartum condition* O30.001 *Twin pregnancy, delivered, with or without mention of antepartum condition* Z37.300 *Twins, one liveborn and one stillborn, pregnancy resulting from both spontaneous ovulation and conception*
References	ICD-10-CA coding convention and rule

28 Same Intervention Episode Start Date and Intervention Episode Start Time Recorded for Each Intervention Code (D1101-97)

Rule

For intervention episodes performed in Intervention Location 01 *(Main operating room)* or 08 *(Cardiac catheterization room)*, the Intervention Episode Start Date and Time are mandatory. These fields must be completed only on the occurrence number which corresponds with the first Intervention Code in the intervention episode. Note that a new Intervention Episode is derived every time an Intervention Episode Start Date and Time is recorded on the abstract.

Criteria	Description
Selection Criteria	Abstracts where Intervention Location is 01 or 08, the same Intervention Episode Start Date and Intervention Episode Start Time is recorded and there is more than one Intervention Episode derived in the abstract.
Data Elements	Intervention Location, Intervention Episode Start Date, Intervention Episode Start Time
Reference	DAD Abstracting Manual: Group 11—Interventions.

29 Incorrect Extent Attribute 0 (*Not Applicable*) with Invasive Ventilation CCI Code (D1102-71)

Rule

Invasive ventilation is identified by codes:

- 1.GZ.31.CA–^^ *Ventilation, respiratory system NEC, invasive per orifice approach by endotracheal tube*
- 1.GZ.31.CR-ND *Ventilation, respiratory system NEC, invasive per orifice with incision approach for intubation for intubation through tracheostomy, positive pressure (e.g. CPAP, BIPAP)*, or
- 1.GZ.31.GP-ND *Ventilation, respiratory system NEC, invasive percutaneous transluminal approach (e.g. transtracheal jet) through needle, positive pressure (e.g. CPAP, BIPAP)*

The mandatory extent attribute exists to capture the number of hours (duration) of continuous invasive ventilation during a hospitalization.

The Extent Attribute values of CN (*Continuous but less than 96 hours of invasive ventilation*) or EX (*Extended continuous of 96 hours (or more) of invasive ventilation*) are applicable with the "invasive" ventilation codes.The Extent Attribute value of 0 (Not applicable-use only for non-invasive ventilation) is assigned with the non-invasive ventilation codes (1.GZ.31.CB–^^ or 1.GZ.31.JA–^^).

Criteria	Description
Selection Criteria	Abstracts where one of Intervention Codes 1.GZ.31.CA-ND, 1.GZ.31.CA-EP, 1.GZ.31.CA-PK, 1.GZ.31.CR-ND, or 1.GZ.31.GP-ND is recorded and the Extent Attribute is 0.
Data Elements	Intervention Code, Extent Attribute
Correct Case Example	1.GZ.31.CA-ND *Ventilation, respiratory system NEC, invasive per orifice approach by endotracheal intubation, positive pressure (e.g. CPAP, BIPAP)* Extent: CN *Continuous but less than 96 hours of invasive ventilation*
References	Canadian Coding Standards: Invasive Ventilation. Tip for Coders: Extent Attribute at 1.GZ.31.^^ Ventilation, respiratory system NEC.

30 Repair High Vaginal Laceration without a Corresponding Diagnosis Code for High Vaginal Laceration (D1102-111)

Rule

For obstetrics delivered or obstetric postpartum episodes of care, the Intervention Code 5.PC.80.JU *Surgical repair, postpartum, of current obstetric high vaginal laceration* must have a corresponding Diagnosis Code of O71.401 or O71.404 recorded on the same abstract.

Note: A chart review must be completed to identify if the error is due to:

- The intervention code is assigned correctly and the diagnosis code is missing, OR
- The intervention code is assigned incorrectly

Criteria	Description
Selection Criteria	Intervention Code 5.PC.80.JU *Surgical repair, postpartum, of current obstetric high vaginal laceration* is recorded without Diagnosis Code O71.401 or O71.404 *Obstetric high vaginal laceration* Exclude abortion abstracts with a diagnosis code from O08.6–
Data Elements	Intervention Code, Diagnosis Code
Correct Case Example	5.PC.80.JU *Surgical repair, postpartum, of current obstetric high vaginal laceration* AND O71.401 *Obstetric high vaginal laceration, delivered, with or without mention of antepartum condition*

31 Mismatch Between Status Attribute Assigned for 5.MD.60.^^ (Cesarean Section) and Diagnosis Codes O34.201 (Uterine Scar due to Previous Caesarean Section) and O66.401 (Failed Trial of Labour following Caesarean Section) (D1102-116)

Rule

For a primary caesarean section delivery case, the Intervention Code from 5.MD.60.^^ (*Cesarean section delivery)* with a Status Attribute of PA *(Primary, Indicated, Planned)*, PB *(Primary, Indicated, Emergent)* or PC *(Primary, Not Indicated, Planned)* must not be recorded with a Diagnosis Code of O34.201 (*Uterine scar due to previous Caesarean section, delivered, with or without mention of antepartum condition)* or O66.401 (*Failed trial of labour following previous caesarean, delivered, with or without mention of antepartum condition)* because the Diagnosis Code and Status Attribute selected contradict one another. Intervention Status Attribute PA, PB and PC represent a primary caesarean section delivery (i.e., mom has not had a previous caesarean section); therefore, either the Diagnosis Code or the Intervention Status Attribute is incorrect.

Criteria	Description
Selection Criteria	Abstracts where an Intervention Code 5.MD.60.^^ is recorded with a Status Attribute of PA, PB or PC and the Diagnosis Code O34.201 or O66.401 .
Data Elements	Intervention Code, Status Attribute, Diagnosis Code
Correct Case Example	5.MD.60.AA *Cesarean section delivery, lower segment transverse incision, without instrumentation* Status Attribute: PC *(Primary, Not Indicated, Planned)* *AND* O65.401 *Obstructed labour due to fetopelvic disproporation, unspecified, delivered, with or without mention of antepartum condition*.
Reference	Canadian Coding Standards: Delivery With History of Previous Cesarean Section. Self Study Product: Obstetrical Coding – Moving Beyond the Basics, Module 8: Cesarean Section. CCI: Status attribute Note at rubric 5.MD.60.^^.

32 Repair Laceration of the Cervix, without a Corresponding Diagnosis Code for Cervical Laceration (D1102-119)

Rule

The Intervention Code 5.PC.80.*JJ Surgical repair postpartum of current obstetric laceration of cervix occurring at vaginal delivery* or Intervention Code 5.PC.80.JK *Surgical repair postpartum of current obstetric laceration of cervix occurring at Cesarean section or during surgical termination of pregnancy* must have a corresponding Diagnosis Code of either O71.301, O71.304, or O08.6 recorded on the same abstract.

Note: A chart review must be completed to identify if the error is due to:

- The intervention code is assigned correctly and the diagnosis code is missing, OR
- The intervention code is assigned incorrectly

Criteria	Description
Selection Criteria	Abstracts where Intervention Code 5.PC.80.JJ or 5.PC.80.JK is recorded without one of the following Diagnosis Codes O71.301, O71.304 *or O08.6.*
Data Elements	Intervention Code, Diagnosis Code
Correct Case Example	5.PC.80.JJ *Surgical repair, postpartum of current obstetric laceration of cervix occurring at vaginal delivery* AND O71.301 *Obstetric laceration of cervix*

33 Status Attribute Not Equal to DX *(Diagnostic)* With Coronary Angiogram (D1103-83)

Rule

The code 3.IP.10.VX *Xray, heart with coronary arteries of left heart structures using percutaneous transluminal arterial (retrograde) approach* must have a Status Attribute of DX (Diagnostic) when the only intervention performed during the intervention episode is coronary angiogram 3.IP.10.VX and there is only one intervention recorded in the intervention episode.

Criteria	Description
Selection Criteria	Abstracts where there is only one Intervention Code recorded in the intervention episode, the Intervention Code is 3.IP.10.VX and the Status Attribute is not equal to DX.
Data Elements	Intervention Code, Intervention Episode, Status Attribute
Correct Case Examples	3.IP.10.VX *Xray, heart with coronary arteries, of left heart structures using percutaneous transluminal arterial (retrograde) approach* Status Attribute: DX *(Diagnostic)*
References	Education: Staying on Track with Cardiac Interventions

34 Status Attribute UN *(Unknown)* With Hip Replacement (D1103-85)

Rule

The Status Attribute UN (*Unknown*) should be rarely used for the rubric 1.VA.53.^^ *Implantation of internal device, hip joint* or 1.SQ.53.^^ *Implantation of internal device, pelvis* as the documentation should state whether the implantation was a primary implantation (P) or revision (R).

A primary insertion is the first insertion of prosthesis component(s) within the joint, whereas, a revision is replacement of previous prosthesis component(s) within the joint.

Criteria	Description
Selection Criteria	Abstracts where the Intervention Code from rubric 1.VA.53.^^ or 1.SQ.53.^^ is recorded with the Status Attribute of UN.
Data Elements	Intervention Code, Status Attribute
Correct Case Examples	1.VA.53.LA-PN-N *Implantation of internal device, hip joint, dual component prosthetic device [femoral with acetabular] using synthetic material (e.g. bone paste, cement, Dynagraft, Osteoset)* Status Attribute: P (*Primary (first insertion of prosthesis component(s) within the joint))*

35 Status Attribute UN *(Unknown)* With Knee Replacements (D1103-88)

Rule

The Status Attribute UN (*Unknown*) should be used rarely for the rubric 1.VG.53.^^ *Implantation of internal device, knee joint*, as the documentation should state whether the implantation was a primary implantation (P) or revision (R).

A primary insertion is the first insertion of prosthesis component(s) within the joint, whereas, a revision is replacement of previous prosthesis component(s) within the joint.

Criteria	Description
Selection Criteria	Abstracts where the Intervention Code from rubric 1.VG.53.^^ is recorded with the Status Attribute UN.
Data Elements	Intervention Code, Status Attribute
Correct Case Examples	1.VG.53.LA-PN-A *Implantation of internal device, knee joint, dual component prosthetic device, with bone autograft* Status Attribute: P *(Primary (first insertion of prosthesis component(s) within the joint))*
Reference	Education: Knee Joint Replacement e-learning.

36 Extent Attribute UN *(Unknown)* With Hip Replacement (D1105-86)

Rule

The Extent Attribute UN *(Unknown)* should be used rarely as the documentation will identify the component used with a hip replacement procedure 1.VA.53.^^ *Implantation of internal device, hip joint*.

Criteria	Description
Selection Criteria	Abstracts where the Intervention Code from rubric 1.VA.53.^^ is recorded with the Extent Attribute UN.
Data Elements	Intervention Code, Extent Attribute
Correct Case Examples	1.VA.53.LA-PN-N *Implantation of internal device, hip joint, dual component prosthetic device [femoral with acetabular] using synthetic material (e.g. bone paste, cement, Dynagraft, Osteoset)* Extent Attribute: FH *(Modular (two or more interlocking pieces) stem with exchangeable ball, or stem with modular neck and exchangeable ball (Includes: Femoral component NOS))*

37 Three or More OOH Intervention Episodes in One Day (D1113-35)

Rule

According to the guideline provided in the *DAD Abstracting Manual*, an intervention episode represents a patient's visit to a physical location where one or more interventions may take place. When more than one CCI code is required to capture the interventions performed in a single intervention episode, the Intervention Episode Start Date will be recorded once on the first line of the abstract. Every time an Intervention Episode Start Date is recorded on the abstract, a new Intervention Episode is derived.

The Out-of-Hospital (OOH) Indicator field indicates that an intervention episode was performed in the day surgery or other ambulatory care setting of another facility during the current inpatient stay in the reporting facility.

This data quality test identifies abstracts with potential errors of over-recording Intervention Episode Start Date for multiple OOH interventions in a single episode.

Criteria	Description
Selection Criteria	Abstracts where the OOH indicator is Y and the same Intervention Episode Start Date is recorded for three or more OOH intervention episodes.
Data Elements	OOH Indicator, Intervention Episode Start Date, Intervention Episode
Correct Case Example	Only one Intervention Episode Start Date is recorded for OOH interventions performed in a single intervention episode.
Reference	DAD Abstracting Manual: Group 11—Interventions.

38 Stroke or TIA Diagnosis Code Without Completion of Project 340 Field (D1618-99)

Rule

Project Number 340 is mandatory in Newfoundland & Labrador, Nova Scotia, Ontario and Manitoba. This test will only be completed for these jurisdictions.

Project 340 is expected to be completed for all new acute ischemic stroke, hemorrhagic stroke and transient ischemic attack (TIA) cases. This encompasses cases with at least one of the following Diagnosis Codes assigned as a Diagnosis Type M, 1, W, X or Y. This special Project should be completed for all confirmed cases of stroke or TIA and cases with a diagnosis of "query" stroke.

- I60.- *Subarachnoid haemorrhage*;
- I61.- *Intracerebral haemorrhage*;
- I63.- *Cerebral infarction (***excluding** *I63.6 Cerebral infarction due to cerebral venous thrombosis, nonpyogenic)*;
- I64 *Stroke, not specified as haemorrhage or infarction*;
- I67.6 *Nonpyogenic thrombosis of intracranial venous system*;
- 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)*.

Note: There may be cases flagged with this test that do not require completion of project 340. Refer to the DAD manual for project completion guidelines and complete data collection instructions.

Criteria	Description
Selection Criteria	Acute care abstracts from MB, NL, NS or ON where Project Number 340 is not completed when a Diagnosis Code for ischemic stroke, hemorrhagic stroke or transient ischemic attack (see code list above) is recorded as Diagnosis Type (M, 1, W, X, or Y). Excluded from this test: Abstracts where a Diagnosis Code for ischemic stroke, hemorrhagic stroke or transient ischemic attack is assigned Diagnosis Type (M) and the same code is repeated as a Diagnosis Type (2).
Data Elements	Diagnosis Code, Diagnosis Type , Project Number
References	DAD Abstracting Manual: Group 16—Projects. CAD Bulletin: Update Notice June 2016

39 Not Applicable, Unknown or Invalid Value for Field 12 *(Prescription for Antithrombotic Medication at Discharge)* When Project 340 Recorded for Ischaemic Stroke Diagnosis (D1618-103)

Rule

When Project 340 is recorded, it is mandatory to complete Field 12 *(Prescription for Antithrombotic Medication at Discharge)*. This field captures whether patients with a diagnosis of ischaemic stroke (I63.– (excluding I63.6), I64, I67.6, H34.0, H34.1, G45.– (excluding G45.4)) receive a prescription for antithrombotic medication at discharge.

This test will be completed for all abstracts where Project 340 has been completed, regardless of whether it is mandatory in a particular jurisdiction. A high percent of abstracts with not applicable (8), unknown (9) or invalid value for Field 12 may indicate a need to investigate practices around the capturing of prescription for antithrombotic medication at discharge.

Criteria	Description
Selection Criteria	Project Number 340 for ischaemic stroke diagnosis cases (I63.– (excluding I63.6), I64, I67.6, H34.0, H34.1, G45.– (excluding G45.4)) is recorded and Discharge Disposition is not 07 (Died) and Field 12 Prescription for Antithrombotic Medication at Discharge is not applicable (8), unknown (9) or invalid (is missing or has a value recorded other than Y or N).
Data Elements	Project Number, Field 12
Reference	DAD Abstracting Manual: Group 16—Project - 340.

40 Missing, Invalid or Unknown Value for Fields 04 to 11 (*Date and Time of Acute Thrombolysis Administration*) When Project 340 Recorded and Field 03 (*Administration of Acute Thrombolysis*) is Y (Yes) or P (Yes, Prior) (D1618-121)

Rule

When Project 340 is recorded, it is mandatory to complete Fields 04 to 11 *(Date and Time of Acute Thrombolysis Administration)*. This field captures the specific date and time that a patient with acute ischaemic stroke (i.e. ICD-10-CA code is I63.- (excluding I63.6), I64, I67.6, H34.0, H34.1 or G45.- (Excluding G45.4) received acute thrombolysis, for those who were administered this medication. The start time for administration of the medication should be the time recorded in these fields.

This test will be completed for all abstracts where Project 340 has been completed and Field 03 (*Administration of Acute Thrombolysis)* is Y (Yes) or P (Yes, prior), regardless of whether it is mandatory in a particular jurisdiction. A high percent of abstracts with missing (blank), invalid or unknown (99) date and time for Fields 04 to 11 may indicate a need to investigate practices around the capturing of date and time of acute thrombolysis administration.

Criteria	Description
Selection Criteria	Project Number 340 is recorded, And Field 03 Administration of Acute Thrombolysis is Y (yes) or P (yes, prior) And One or more of the following fields are blank, unknown or invalid: • Fields 04-05 (Month): is blank, or has unknown value (99) or is not valid two character code of 01-12 • Fields 06 -07 (Day): is blank, or has an unknown value (99) or is not a valid two character code of 01-31 • Fields 08-09 (Hour): is blank, or has an unknown value (99) or is not a valid two digit character of 00-23 • Fields 10- 11 (Minutes): is blank, or has an unknown value of (99) or is not a valid two digit character of 00-59
Data Elements	Project Number, Fields 03 to 11
Reference	DAD Abstracting Manual: Group 16—Project 340.

41 Invalid or Unknown Value for Fields 13 to 24 (*Stroke Symptom Onset Date and Time*) When Project 340 Recorded (D1618-123)

Rule

When Project 340 is recorded, it is mandatory to complete Fields 13 to 24 *(Stroke Symptom Onset Date and Time)*. This field captures the date and time that the patient first started to experience stroke symptoms, regardless of the location of the patient at the time of symptom onset.

This test will be completed for all abstracts where Project 340 has been completed, regardless of whether it is mandatory in a particular jurisdiction. A high percent of abstracts with invalid or unknown date and time for Fields 13 to 24 may indicate a need to investigate practices around the capturing of stroke symptom onset date and time.

Criteria	Description
Selection Criteria	Project Number 340 is recorded, Fields 13 to 24 are invalid or unknown date and/or time And One or more of the following fields are unknown or invalid: • Fields 13-16 (Year): has unknown value (9999) or is not a valid four character code of less than or equal to current calendar year. • Fields 17-18 (Month): has an unknown value (99) or is not a valid two character code of 01-12 • Fields 19-20 (Day): has an unknown value (99) or is not a valid two character code of 01-31 • Fields 21-22 (Hour): has an unknown value (99) or is not a valid two digit character of 00-23 • Fields 23-24 (Minutes): has an unknown value of (99) or is not a valid two digit character of 00-59
Data Elements	Project Number, Fields 13 to 24
Reference	DAD Abstracting Manual: Group 16—Project 340.

42 Stroke Symptom Onset Date and Time after Admission Date and Time When Project 340 Recorded (D1618-124)

Rule

When Project 340 is recorded, it is mandatory to complete Fields 13 to 24 *(Stroke Symptom Onset Date and Time)*. This field captures the date and time that the patient first started to experience stroke symptoms, regardless of the location of the patient at the time of symptom onset. The Stroke Symptom Onset Date and Time must be a date/time earlier than the emergency department arrival or facility admission date and time.

This test will be completed for all abstracts where Project 340 has been completed, regardless of whether it is mandatory in a particular jurisdiction.

Criteria	Description
Selection Criteria	Project Number 340 is recorded And Admission Date is a valid date And Fields 13 to 20 (Stroke Symptom Onset Date) is a valid date: • Fields 13-16 (Year): is a valid four character code of any year • Fields 17-18 (Month): is a valid two character code of 01-12 • Fields 19-20 (Day): is a valid two character code of 01-31 And One of the following conditions is met: • If Admission Time and Fields 21-24 (Stroke Symptom Onset Time) are a valid four digit character of 0000-2359, values recorded in Fields 13 to 24 are after the Admission Date and Time • If Admission Time or Fields 21-24 (Stroke Symptom Onset Time) is not a valid four digit character of 0000-2359, values recorded in Fields 13 to 20 are after the Admission Date
Data Elements	Admission Date, Admission Time, Project Number, Fields 13 to 24
Reference	DAD Abstracting Manual: Group 16—Project 340.

43 New Ischaemic or Haemorrhagic Stroke Diagnosis Code Without Completion of Project 740 Field (D1619-137)

Rule

In Ontario, special project 740 is mandatory to report for all DAD acute inpatient admissions of patients 18 years and older with a new ischaemic and/or haemorrhagic stroke.

Inclusion criteria: This project encompasses cases with at least one of the following Diagnosis Codes assigned as a Diagnosis Type (M, 1, W, X or Y):

I60.– *Subarachnoid haemorrhage*;

I61.– *Intracerebral haemorrhage;*

I63.– *Cerebral infarction* (**excluding** I63.6 *Cerebral infarction due to cerebral venous thrombosis, nonpyogenic*);

I64.– *Stroke, not specified as haemorrhage or infarction*;

I67.6 *Nonpyogenic thrombosis of intracranial venous system*;

H34.1 *Central retinal artery occlusion*;

Note: Special project 740 is **not** to be reported for transient ischemic attacks (TIA), i.e. the codes listed below.

G45.- – Transient ischaemic attacks (TIAs) and related syndromes;

H34.0 – Transient retinal artery occlusion (another valid type of TIA)

Criteria	Description
Selection Criteria	Acute care abstracts from Ontario where Project 740 is not completed when a Diagnosis Code for a new ischaemic and/or haemorrhagic stroke (see code list above) is recorded as Diagnosis Type (M, 1, W, X, or Y) and the patient is 18 years or older Excluded from this test: Abstracts where a Diagnosis Code for ischemic or hemorrhagic stroke is assigned Diagnosis Type (M, W, X or Y) and the same code is repeated as a Diagnosis Type (2).
Data Elements	Diagnosis Code, Diagnosis Type , Project Number
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

44 Invalid Value for Field 01 (Documentation of AlphaFIM® Scores) When Project 740 Recorded (D1619-138)

Rule

When Project 740 is recorded, it is mandatory to record Field 01 (Documentation of AlphaFIM® Scores).

This field captures whether AlphaFIM® scores (Projected FIM® -13 Raw Motor Rating and/or the Projected FIM® -5 Raw Cognitive Rating) were documented for patients diagnosed with a new ischaemic or haemorrhagic stroke.

Criteria	Description
Selection Criteria	Project Number 740 for new ischaemic or haemorrhagic stroke cases is recorded And Field 01 (Documentation of AlphaFIM® Scores) is not equal to Y or N.
Data Elements	Project Number, Field 01
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

45 Invalid Value for Fields 02-09 (AlphaFIM® Completion Date) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes) (D1619-139)

Rule

When special project 740 is recorded and Field 01 (Documentation of AlphaFIM®) is recorded with “Y” (Yes, there is documentation) the Fields 02-09 (AlphaFIM® Completion Date) must be a valid date or 99999999.

This field captures the first date when the AlphaFIM® scores (Projected FIM® -13 Raw Motor Rating and/or the Projected FIM® -5 Raw Cognitive Rating) were documented.

Criteria	Description
Selection Criteria	Project Number 740 for new ischaemic or haemorrhagic stroke cases is recorded And Field 01 (Documentation of AlphaFIM® Scores) has the value Y And Field 02-09 is recorded and one or more of the following conditions are met: • Fields 02-05 (Year): not a valid calendar year or not unknown value (9999). • Fields 06-07 (Month): not a valid calendar month or not unknown value (99) • Fields 08-09 (Day): not a valid calendar day or not unknown value (99)
Data Element	Project Number, Field 01, Fields 02-09
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

46 Fields 02-09 (AlphaFIM® Completion Date) Not Between Admission Date and Discharge Date When Project 740 is Recorded and Field 01 is Recorded With Y (Yes) (D1619-141)

Rule

When special project 740 is recorded and Field 01 (Documentation of AlphaFIM®) is recorded with “Y” (Yes, there is documentation) and Admission Date, Discharge Date and Fields 02-09 (AlphaFIM® Completion Date) are valid dates (not blank or 99999999), Fields 02-09 must be greater than or equal to the Admission Date and less than or equal to the Discharge Date.

This field captures the first date when the AlphaFIM® scores (Projected FIM® -13 Raw Motor Rating and/or the Projected FIM® -5 Raw Cognitive Rating) were documented.

Criteria	Description
Selection Criteria	Project Number 740 for new ischaemic or haemorrhagic stroke cases is recorded And Field 01 (Documentation of AlphaFIM® Scores) has the value Y And Admission Date, Discharge Date and Fields 02-09 are valid dates (not blank or 99999999) And Fields 02-09 is not greater than or equal to the Admission Date and less than or equal to the Discharge Date
Data Elements	Project Number, Field 01, Fields 02-09, Admission Date, Discharge Date
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

47 Invalid Value for Fields 10-11 (Projected FIM®-13 Raw Motor Rating) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes) (D1619-142)

Rule

When special project 740 is recorded and Field 01 (Documentation of AlphaFIM®) is recorded with “Y” (Yes), Fields 10-11 (Projected FIM®-13 Raw Motor Rating) must be greater than or equal to 13 and less than or equal to 91 or equal to 99 (unknown).

This data element captures the total score documented for a patient’s motor functional status from among the relevant tasks of eating, grooming, transfers, locomotion and bowel management.

Criteria	Description
Selection Criteria	Project Number 740 for new ischaemic or haemorrhagic stroke cases is recorded And Field 01 (Documentation of AlphaFIM® Scores) is equal to Y And Fields 10-11(Projected FIM®-13 Raw Motor Rating) is not greater than or equal to 13 and less than or equal to 91 or equal to unknown value 99.
Data Elements	Project Number, Field 01, Fields 10-11
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

48 Invalid Value for Fields 12-13 (Projected FIM® - 5 Raw Cognitive Rating) When Project 740 is Recorded and Field 01 is Recorded With Y (Yes) (D1619-144)

Rule

When special project 740 is recorded and Field 01 (Documentation of AlphaFIM®) is recorded with “Y” (Yes), Fields 12-13 (Projected FIM® - 5 Raw Cognitive Rating) must be greater than or equal to 5 and less than or equal to 35 or equal to 99 (unknown).

This data element captures the total score documented for a patient’s cognitive functional status for expression and memory.

Criteria	Description
Selection Criteria	Project Number 740 for new ischaemic or haemorrhagic stroke cases is recorded And Field 01 (Documentation of AlphaFIM® Scores) is equal to Y And Fields 12-13 (Projected FIM® - 5 Raw Cognitive Rating) is not greater than or equal to 5 and less than or equal to 35 or equal to unknown value 99
Data Elements	Project Number, Field 01, Fields 12-13
References	DAD Application – Unreserved Projects document Special Project 740 – AlphaFIM® available on the MOHLTC website https://hsim.health.gov.on.ca/hdbportal/

49 Mismatch Between Diagnosis Code or Caesarean Section Status Attribute Indicating a Previous Delivery and Number of Previous Deliveries Indicating No Previous delivery (D1801-120)

Rule

When the Diagnosis Code O75.701 (Vaginal Delivery Following Caesarean Section), or O34.201 (Uterine scar due to previous caesarean section), or O66.401 (Failed trial of labour following caesarean section), or Intervention Code 5.MD.60.^^ (Caesarean section delivery) with a Status Attribute RA (Repeat, Indicated, Planned), RB (Repeat, Indicated, Emergent) or RC (Repeat, Not indicated, Planned) is assigned on an abstract, the Number of Previous Term Deliveries and Number of Previous Pre-Term Deliveries must not be 00.

Important: The limitation with this test is that it can only look at Cesarean Section deliveries. A similar logic cannot be applied to vaginal deliveries.

Criteria	Description
Selection Criteria	Abstracts where Diagnosis Code O75.701, or O34.201 or O66.401 or Intervention Code 5.MD.60.^^ with a Status Attribute of RA, RB, or RC is assigned and the Number of Previous Term Deliveries or Number of Preterm Deliveries recorded is 00.
Data Elements	Number of Previous Term Deliveries, Number of Previous Pre-Term Deliveries, Diagnosis Code, Intervention Code, Status Attribute
Correct Case Examples	Diagnosis code that is not O75.701 or O34.201 or O66.401 AND Number of Previous Pre-Term Deliveries 00 AND Number of Previous Term Deliveries 00 AND 5.MD.60.AA *Cesarean section delivery, lower segment transverse incision, without instrumentation* Status Attribute: PB (Primary, Indicated, Emergent)
Reference	DAD Abstracting Manual: Group 18—Reproductive Care

50 Obstetrics Delivered Diagnosis or Intervention Code without Number of Previous Term Deliveries and/or Number of Previous Pre-Term Deliveries Recorded (D1801-135)

Rule

When an obstetrics delivered code is recorded, it is mandatory to report Number of Previous Term Deliveries and Number of Previous Pre-Term Deliveries in Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, Northwest Territories, Yukon, and Nunavut. For PEI obstetrics delivered cases, these fields should be collected only by Prince County Hospital (PCH) and Queen Elizabeth Hospital (QEH). It is mandatory for these two facilities.

When there is no information in the patient's chart indicating whether previous deliveries are full term or pre-term, assume that the previous deliveries were always full term. The use of 99 (not available) will result in losing the information pertaining to previous deliveries and should be avoided.

Multiple births delivered during the same delivery episode count as one delivery. The number of deliveries is not dependent on the number of babies or condition of the babies (that is, live births or stillborn). If one twin was delivered earlier than the other(s), and it involved a separate delivery episode, then the number of deliveries would be two.

Indicate 00 if no previous full term or pre-term delivery occurred.

Criteria	Description
Selection Criteria	Abstracts where Diagnosis Code from category O10 to O99 with a sixth digit of 1 or 2 is recorded; or Diagnosis Code Z37.- (outcome of delivery) is assigned Diagnosis Type M; or Intervention code 5.MD.50.^^ or 5.MD.60.^^. AND Data element “Number of Previous Term Deliveries and/or Number of Previous Preterm Deliveries” is blank.
Data Elements	Number of Previous Term Deliveries, Number of Previous Pre-Term Deliveries, Diagnosis Code, Diagnosis Type, Intervention Code
Correct Case Examples	Z37.000 (M) Single live birth, pregnancy resulting from both spontaneous ovulation and conception AND Data element: Number of Previous Pre-Term Deliveries has value recorded as00 AND Data element: Number of Previous Term Deliveries has value recorded as 01
Reference	DAD Abstracting Manual: Group 18—Reproductive Care.

Appendix A — Post-Procedural Disorder Codes

This list identifies all post-procedural disorder codes. When a code from this list is assigned, it always requires an external cause code. When the applicable external cause is from Y60–Y84, a Diagnosis Cluster must be applied.

E89.0 Postprocedural hypothyroidism

E89.1 Postprocedural hypoinsulinaemia

E89.2 Postprocedural hypoparathyroidism

E89.3 Postprocedural hypopituitarism

E89.4 Postprocedural ovarian failure

E89.5 Postprocedural testicular hypofunction

E89.6 Postprocedural adrenocortical (-medullary) hypofunction

E89.8 Other postprocedural endocrine and metabolic disorders

E89.9 Postprocedural endocrine and metabolic disorder, unspecified

G97.0 Cerebrospinal fluid leak from spinal puncture

G97.1 Other reactions to spinal and lumbar puncture

G97.2 Intracranial hypotension following ventricular shunting

G97.8 Other postprocedural disorders of nervous system

G97.9 Postprocedural disorder of nervous system, unspecified

H59.0 Keratopathy (bullous aphakic) following cataract surgery

H59.80 Cataract (lens) fragments in eye following cataract surgery

H59.81 Cystoid macular oedema following cataract surgery

H59.88 Other postprocedural disorders of eye and adnexa

H59.9 Postprocedural disorder of eye and adnexa, unspecified

H95.0 Recurrent cholesteatoma of postmastoidectomy cavity

H95.1 Other disorders following mastoidectomy

H95.8 Other postprocedural disorders of ear and mastoid process

H95.9 Postprocedural disorder of ear and mastoid process, unspecified

I97.0 Postcardiotomy syndrome

I97.1 Other functional disturbances following cardiac surgery

I97.2 Postmastectomy lymphoedema syndrome

I97.8 Other postprocedural disorders of circulatory system, not elsewhere classified

I97.9 Postprocedural disorder of circulatory system, unspecified

J95.00 Haemorrhage from tracheostomy stoma

J95.01 Infection of tracheostomy stoma

J95.02 Malfunction of tracheostomy stoma

J95.03 Tracheo-esophageal fistula following tracheostomy

J95.08 Other tracheostomy complication

J95.1 Acute pulmonary insufficiency following thoracic surgery

J95.2 Acute pulmonary insufficiency following nonthoracic surgery

J95.3 Chronic pulmonary insufficiency following surgery

J95.4 Mendelson’s syndrome

J95.5 Postprocedural subglottic stenosis

J95.80 Postprocedural pneumothorax

J95.81 Transfusion related acute lung injury (TRALI)

J95.88 Other postprocedural respiratory disorders

J95.9 Postprocedural respiratory disorder, unspecified

K91.0 Vomiting following gastrointestinal surgery

K91.1 Postgastric surgery syndromes

K91.2 Postsurgical malabsorption, not elsewhere classified

K91.3 Postoperative intestinal obstruction

K91.40 Haemorrhage from colostomy stoma

K91.41 Infection of colostomy stoma

K91.42 Malfunction of colostomy stoma, not elsewhere classified

K91.43 Haemorrhage from enterostomy stoma

K91.44 Infection of enterostomy stoma

K91.45 Enterostomy malfunction, not elsewhere classified

K91.5 Postcholecystectomy syndrome

K91.60 Haemorrhage from gastrostomy stoma

K91.61 Infection of gastrostomy stoma

K91.62 Gastrostomy malfunction, not elsewhere classified

K91.8 Other postprocedural disorders of digestive system, not elsewhere classified

K91.9 Postprocedural disorder of digestive system, unspecified

M96.0 Pseudarthrosis after fusion or arthrodesis

M96.1 Postlaminectomy syndrome, not elsewhere classified

M96.2 Postradiation kyphosis

M96.3 Postlaminectomy kyphosis

M96.4 Postsurgical lordosis

M96.5 Postradiation scoliosis

M96.60 Fracture of bone following insertion of joint prosthesis

M96.68 Fracture of bone following insertion of other and unspecified orthopaedic implant

M96.8 Other postprocedural musculoskeletal disorders

M96.9 Postprocedural musculoskeletal disorder, unspecified

N99.0 Postprocedural renal failure

N99.1 Postprocedural urethral stricture

N99.2 Postoperative adhesions of vagina

N99.3 Prolapse of vaginal vault after hysterectomy

N99.4 Postprocedural pelvic peritoneal adhesions

N99.50 Haemorrhage from external stoma of urinary tract

N99.51 Infection of external stoma of urinary tract

N99.52 Other malfunction of external stoma of urinary tract, NEC

N99.8 Other postprocedural disorders of genitourinary system

N99.9 Postprocedural disorder of genitourinary system, unspecified

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