Please note that the Terminology Advisory Service Telephone Number is
0131-275-7283.
The number is manned Tuesday to Thursday from 09.00 to 17.00 hrs.
The link for previous coding guidelines on line is: http://www.isdscotland.org/terminology

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Coding Guidelines - ICD10

‘OTHER CONDITIONS’ CODING on SMR01

Coding Departments should have received a letter (dated 20th September 2007) concerning the following guideline.

This guideline falls into two parts. The first deals with the coding of comorbidities, the second deals with the use of some common and important Z codes.

Comorbidities in SMR01 ‘Other Conditions’ coding

Reasons for revised guidance.
There is considerable demand for SMR01-derived information on comorbidities from clinicians, researchers and from health service planners at hospital, NHS board and national level. Since the previous guideline (Coding Guidelines 3, June 1999) ISD have carried out two national quality assurance exercises on SMR01 data. Despite areas of good practice these surveys show an under-recording of comorbidities nationally. Some of this under-recording is due to inadequate information reaching coders. It is impossible to offer exhaustive rules to cover every case. This guidance is intended to assist coders’ decision-making when coding comorbidities, to help ensure more consistent recording across Scotland and to inform those responsible for supplying information to coders.

What is a comorbidity?
A comorbidity is a disease or condition which exists alongside another disease. Comorbidities are recorded as SMR01 ‘Other Conditions’ (diagnoses 2 – 6). Not all codes recorded in ‘Other Conditions’ represent comorbidities – e.g. Z codes and external cause codes – although in coding the terms ‘Other Conditions’ and ‘comorbidities’ are often used interchangeably. In the SMR01 context, a comorbidity is:

- a disease or condition (other than the main diagnosis) which is clinically identified as a currently active problem, requiring significant investigation or management, during the admission being coded
- a disease or condition (often long-standing) which is present but is not clinically identified as a major factor in the admission i.e. it does not require anything more than routine management, such as the continuance of the patient’s normal drug regime. We can call this a background comorbidity.

This is an artificial division. For any one patient, a particular disease could be an active problem - or even the main diagnosis - in one admission and a background comorbidity in another. However it can be useful to think about comorbidities in this way when coding. If a condition is present and is described as ‘acute’ it is unlikely that it could be regarded as a background comorbidity.

Active problems
Coders will be familiar with coding the active problems relevant to an SMR01 episode. To do this they rely on the clinical information which they receive to identify health problems which were significant during the admission. Some examples of cases with active problems which should be coded as comorbidities are:

- a patient admitted with an acute MI develops left ventricular failure during the admission. Code the left ventricular failure as a comorbidity
- a patient admitted with abdominal pain and vomiting is diagnosed as having alcoholic pancreatitis. He is also found to have a chest infection which is
treated by an antibiotic. The antibiotic causes a rash. Code the chest infection and the rash as comorbidities.

A current symptom which is not attributable to a confirmed diagnosis may also be codable as an active problem if it is managed or investigated during an admission. ISD recognise that the selection and coding of such symptoms (while avoiding the over-coding of symptoms attributable to known diagnoses) can depend on the coder’s experience if the available clinical information is not completely clear. One useful guide is that if during the admission the responsible clinician decides to refer the patient for investigation of the symptom, then it should be coded.

In some cases what might seem to be an active problem does not require coding:

- a patient is admitted to Dermatology for treatment of psoriasis. The clinical notes record that during admission the patient suffered some diarrhoea. However this apparently required no treatment or investigation and is not mentioned on the discharge summary – do not code the diarrhoea.

**Applicability - all of the patient’s active problems should be recorded in both inpatient and daycase SMR01 episodes**

**Background comorbidities**

When any comorbidities which are active problems have been coded, the background comorbidities which are present should be recorded if space permits. These will often be long-standing conditions which do not usually resolve spontaneously, such as diabetes or ischaemic heart disease. A new list of diseases and conditions has been developed to assist coders in coding these comorbidities.

**Applicability - background comorbidities from the list should be recorded in inpatient SMR01 episodes whenever applicable and where space permits.** It is not necessary to record background comorbidities in day case SMR01 episodes, although this may be done if space permits and the information is required for local use.

**Comorbidities list (see the summary list below)**

This has been developed with clinical advice. The list comprises 1127 codes from 232 ICD10 categories arranged in 25 groups. It has been derived from published comorbidity indices, the listed conditions having substantial prognostic significance (see references). This list is designed to assist the coder in several ways:

- it is clear statement of a minimum requirement for the coding of background comorbidities
- the groups have been prioritised, to aid decision making
- diseases and conditions are often mentioned on discharge summaries or in clinical notes under the heading ‘Past Medical History’ (PMH). Some of the listed groups have been highlighted to indicate that the diseases and conditions in the group are usually long-standing. If a disease or condition from a highlighted group is referred to as ‘Past Medical History’ it should be regarded as being present and coded as such, except in individual cases where the available clinical information offers clear reason to do otherwise.

**References:**

Using the list
A disease or condition in the list should always be recorded in inpatient episodes when it is present as a comorbidity and when space permits. The priorities can be used in cases where the coder must choose what to code and what to miss out because the free ‘Other Conditions’ space is limited. ‘Priority 8’ is the highest priority, ‘priority 1’ the lowest. When space is limited:
- a listed comorbidity should be recorded in preference to an unlisted one
- a comorbidity from a higher priority group should be recorded in preference to one with a lower priority.

Some common diseases and conditions e.g. osteoarthritis, are not listed because they have a smaller impact on prognosis than the listed conditions. They may be coded as background comorbidities if space permits after any active problems and any listed comorbidities have been recorded.

Information on the discharge summary
Coding decisions made under the guidance above must sometimes be modified by clinical information recorded on the discharge summary. For example this can happen when the discharge summary mentions a disease or condition which is relevant to the specialty of admission but is not itself the subject of significant treatment or investigation (i.e. it would not be coded as an active problem) and is either listed with low priority or is not listed at all, as in the two cases following:
- the discharge summary of a patient admitted to Renal Medicine with a main diagnosis of renal failure also mentions chronic glomerulonephritis (N03, priority 2)
- the discharge summary of an Ophthalmology patient with a main diagnosis of cataract states that she suffers from age-related macular degeneration, which is not listed.

In these examples the chronic glomerulonephritis and the macular degeneration should be recorded. Then other applicable comorbidities can be recorded according to the above guidance.
## Comorbidities - summary list

<table>
<thead>
<tr>
<th>priority</th>
<th>comorbidity group</th>
<th>ICD10 code range</th>
<th>long-standing</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 HIGH</td>
<td>Solid Metastases</td>
<td>C77 - C79</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chronic Pulmonary Disorders</td>
<td>J40X - J67, J684, J701, J703</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Heart Failure / Cardiomyopathy</td>
<td>I110, I110, I112, I12, I131 - I139</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Malignancies</td>
<td>C00 - C76, C80X - C97X</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Circulation Disorders</td>
<td>I27 - I28</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Peripheral Vascular Disease</td>
<td>I70 - I71, I73, I790*, I792*, K551 - K559</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>AIDS / HIV</td>
<td>B20 - B24X</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>Cerebrovascular Disease</td>
<td>I65 - I69</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>Ischaemic Heart Disease</td>
<td>I20, I25</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes</td>
<td>E10 - E14</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>Liver Disease</td>
<td>B18, B19, B64, I982*, K70 - K74</td>
<td>yes</td>
</tr>
<tr>
<td>4</td>
<td>Hypertension, Complicated</td>
<td>I119, I112, I131, I139, I15</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Cardiac Arrhythmias</td>
<td>I44 - I45, I47 - I49</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Dementia</td>
<td>F00* - F03X, G30</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Obesity</td>
<td>E66</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Valvular Heart Disease</td>
<td>I05 - I08, I34 - I39, Q23</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Coagulopathy</td>
<td>D66 - D69</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Drug/Alcohol Abuse</td>
<td>F10 - F19</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Hemiplegia / Paraplegia</td>
<td>G80 - G83</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Other Neurological Disorders</td>
<td>G10 - G13*, G31 - G40</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Renal Disease</td>
<td>N03, N05, N11 - N12X, N18 - N19X, N25</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>Nutritional Anaemia</td>
<td>D50 - D53</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>Hypertension, Uncomplicated</td>
<td>I10X</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>Psychoses</td>
<td>F20 - F29X, F31</td>
<td>yes</td>
</tr>
</tbody>
</table>

### Note:

1) The listed diseases and conditions must be recorded in inpatient SMR01 episodes when they are present as comorbidities and where coding space permits.

2) The listed diseases and conditions need not be recorded as comorbidities in day case SMR01 episodes unless they represent active problems. They may be recorded as background comorbidities in day case episodes if space permits and the information is required for local purposes.

3) When applicable, diseases and conditions from the groups highlighted as ‘long-standing’ should be recorded as being present even if mentioned as ‘past medical history’. In individual cases specific clinical information that a highlighted disease or condition is no longer present may override this requirement.

4) ‘Priority 8’ is the highest priority group, ‘priority 1’ is the lowest.

5) Sequencing of sequelae or dagger/asterisk pairs must override questions of priority e.g. when coding hemiplegia due to stroke, G81 (priority 2) must be sequenced before I69 (priority 6), or when coding diabetic angiopathy, E10 – E14D (priority 5) must be sequenced before I792A (priority 7).

6) This list may be augmented in future.
Use of ‘Z’ codes
This document is for guidance of when to use codes from the ICD10 chapter – ‘Factors influencing health status and contact with health services’. It is not meant to be exhaustive, but concentrates on the codes that have been identified as being poorly recorded in the past.
As a general rule, where any of the factors are mentioned on the Discharge Summary, then they should be coded against the episode.
Whilst primarily concentrating on the use of these codes on SMR01s, where space allows and information is available, coders should also consider the use of these codes on other SMRs.

Persons encountering health services for examination and investigation. Z00 – Z13
Z03.- Medical observation and evaluation for suspected diseases and conditions
Z04.- Examination and observation for other reasons

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, Z03.- and Z04.- should be used when there is a reason (e.g. symptoms, history) for suspecting that the patient may have a condition but after a period of observation there is found to be no condition present.
Examples:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Z03.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>child found with empty medicine bottle</td>
<td>Observation for suspected toxic effect from ingested substance.</td>
</tr>
<tr>
<td>b)</td>
<td>a patient was kept in hospital overnight with a minor condition (e.g. superficial head injury) which would not normally warrant an overnight stay</td>
<td>S00.9 Superficial injury of head, part unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X59.9 Accident NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z04.3 Examination and observation following other accident</td>
</tr>
</tbody>
</table>

Z08.- Follow-up examination after treatment for malignant neoplasm
Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms
The above codes have specific rules regarding sequencing, dependant upon other findings during the episode.

Z11.- Special screening examination for infectious and parasitic diseases
Z13.- Special screening examination for other diseases and disorders
Screening examination codes - should be used for elective admissions in main position where the patient currently has no symptoms of a disease but there is reason to suspect they may develop it e.g. strong family history of the disease. This code should be omitted if evidence of the disease is found.
Persons with potential health hazards related to communicable diseases Z20 – Z29


Z22.- Carrier of infectious disease
Where the patient has been identified as a carrier or ‘positive’ in this episode. There are 5th digits to identify time of diagnosis for Carrier of MRSA (included in Z22.3). See Coding Guideline (No.19) September 2006 for further information.

Z29.0 Isolation. This code should always be recorded if it has been necessary to isolate the patient

Persons encountering health services in circumstances related to reproduction Z30 – Z39

Z30.3 Menstrual extraction
Use in conjunction with O04.- to highlight drug used in interception of pregnancy.

Z36.- Antenatal screening.
For use on SMR02s to highlight reason for admission.

Persons encountering health services for specific procedures and health care Z40 – Z54
This block contains many ‘Z’ codes that may be used in the primary position, reflecting the main reason for admission, e.g. Patient admitted for change of colostomy;
Z43.3 – Attention to colostomy.

Convalescence – Z54.- These code are normally in a secondary or subsequent position to indicate continuing care for a condition, but may be valid as Main Condition. Please refer to Coding Quarterly (No.2) February 1997 for further information.

Persons with potential health hazards related to socioeconomic and psychosocial circumstances Z55 – Z65
Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode in the patient’s record.

Z60.2 Living alone
Record where this factor has affected the patient’s length of stay.

Persons encountering health services in other circumstances Z70 – Z76
Codes from this block are considered ‘additional information’ and should rarely appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode of the patient’s record.

Z74.- Problems related to care-provider dependency
Z75.- Problems related to medical facilities and other health care
Record where the factor has affected the patient’s length of stay. Particularly important is Z75.1 – Person awaiting admission to adequate facility elsewhere.
Z75.5 – Holiday relief care. This code has its own rules. Please refer to Coding Guideline (No. 6) June 2000 for further information.

Persons with potential heath hazards related to family and personal history and certain conditions influencing health status Z80 – Z99
Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’, with the exception of Z85.6 - Personal history of leukaemia, where the leukaemia is in remission.

Z80 – Z84 Family history of diseases.
These should be coded if patients are being investigated/treated for suspected cancers, IHD, mental illness etc. Follow the notes against each category to select the appropriate code.

Z85.- Personal history of malignant neoplasm
Only code if relevant to the patient’s current condition;
- If the patient is suspected of having or has been diagnosed with cancer in another part of the body.
- If the patient is admitted with a problem in the part of the body previously affected by cancer.

Z86 - Z87 Personal history of other diseases and conditions.
Only assign if relevant to the patient’s current condition e.g. patient has right-sided weakness and had a previous TIA. PH codes should not be added when the patient is treated for a recurrence of the same disease.

Z90.1 Acquired absence of breast
Record if the patient is admitted with a problem in the remaining breast.

Z92.2 Personal History of long-term (current) use of other medicaments
It is NOT necessary to use this code where a corresponding condition has been recorded e.g. where asthma has been recorded, no need to add long term use of Ventolin.

Z95.- Presence of cardiac and vascular implants and grafts
Record where the patient is in for any investigation or treatment of heart or vascular problems and has had previous cardiac surgery.

Z96.6 Presence of orthopaedic joint implants
It is NOT necessary to record this where patient is in for revision surgery on the same joint or for treatment of a complication of the implant but should be used for continuing care after joint implant surgery or if having an implant on any other joint.

Many of the ‘Z’ codes have their own particular rules for recording e.g. Personal History codes with codes for Follow-up Examinations, Procedures Not Carried Out, Continuing Care, etc. Rules should be followed for all.

When adding ‘Z’ codes to reflect additional information, true co-morbidities should take priority with the exception of ‘Z’ codes which indicate the length of stay has been affected e.g. Z75.1 – Person awaiting admission to adequate facility elsewhere. This guidance applies to all discharges on and after 1st October 2007.
Coding Guidelines - OPCS4

One Scope, two or more procedures
If in one theatre visit a patient undergoes more than one procedure using the same scope how should these procedures be coded? The Clinical Coding Review Group has issued the following guidance.
Use the code highest up the hierarchy in the appropriate category i.e. the code with the lowest 4th digit within the appropriate category.
This will avoid double counting of scopes by analysts.

Examples:
1. Patient has three rectal polyps removed using a flexible sigmoidoscope. One is removed by snare resection the other two by hot biopsy.
   Codes:
   H23.1 endoscopic snare resection of lesion of lower bowel using fibreoptic sigmoidoscope
   Z29.1 Rectum

2. Patient has ureter stone shattered with laser lithotripsy and stent inserted into ureter via a nephroscope.
   Codes:
   M26.1 Nephroscopic laser fragmentation of calculus of ureter

3. Cystodiathermy of bladder, excision of lesion of bladder and biopsy of bladder, all done with same scope at same time.
   Codes:
   M42.1 Endoscopic resection of lesion of bladder

4. Food bolus stuck in patient’s oesophagus. Oesophagoscopy performed. Part of bolus removed with scope, other part pushed down with scope. Oesophagus biopsied at same time.
   Code:
   G15.1 Fibreoptic endoscopic removal of foreign body from oesophagus

N.B. There may be exceptions to this guidance, for example:

Patient has ERCP, endoscopic removal of two stones from bile duct, endoscopic sphincterotomy and endoscopic insertion of a plastic stent into bile duct.
   Codes:
   J38.1 + J43.9
   Endoscopic sphincterotomy of sphincter of oddi and removal of calculus HFQ
   + Diagnostic endoscopic retrograde examination of bile duct and pancreatic duct, Unspecified

If an ERCP is performed with any other procedure, it should be coded in addition.
In Scotland it is paired with J38.1.

This guidance applies to all discharges on and after 1st April 2008.
Tennis/golfer’s elbow surgery
Surgery for tennis/golfer’s elbow can take various forms including cutting extensor tendons and suturing them on to fascia. It is generally more complicated than simply freeing a tendon (for example from adhesions). In the absence of more detailed information T70.3 (Adjustment to muscle origin of tendon) should be the default code for surgery for tennis/golfers’ elbow.

OPCS4.4 Index Error, Brushing of Organ
On page 25 of the OPCS 4.4 Alphabetical Index is an entry; “Brush Cytology NEC – Y22.1”

It should read Y21.1.

This will be submitted for correction in the next version of the OPCS4 index.

Abandoned and unintentional procedures: further guidance
In Coding Guidelines No.20 June 2007, guidance was given on the coding of abandoned and unintentional procedures. Please note that this guidance does not affect that given in Coding Guidelines No.15, November 2004, regarding colonoscopies/sigmoidoscopies which fail to progress to the intended area to be examined.

Please also note that an ERCP which has not progressed beyond incomplete insertion of the endoscope, or where insertion is complete but the ampulla cannot be cannulated, will usually be described as a ‘failed’ or ‘abandoned’ ERCP and should be coded to: J43.9 Diagnostic endoscopic retrograde examination of bile duct and pancreatic duct, unspecified.

Arthroplasty following removal of internal fixation
In some patients who have had a fracture which is close to or involved in a joint, a problem with the internal fixation may lead to the fixation device being removed and an arthroplasty performed.

For example, if a patient who had a fractured neck of femur fixed by DHS (Dynamic hip screw) or cannulated screw subsequently developed avascular necrosis of the femoral head or if the fixation itself failed, the fixation might be removed and a hip hemiarthroplasty or a total hip replacement implanted.

Orthopaedic surgeons may use the words ‘conversion’ or ‘revision’ to describe the change from a fracture fixation to an arthroplasty. However coders should note that these procedures are not revisions or conversions of existing arthroplasties and so arthroplasty conversion (.2) or revision (.3,.4 or .5) codes should not be recorded in these cases.

Instead, the appropriate primary hemiarthroplasty or total joint replacement code should be recorded in Main Operation, followed by W28.3 Removal of internal fixation from bone NEC with the appropriate site code.
**General Information**

**OPCS4**

Connecting for Health (CfH) has announced that there will be no new release of OPCS4 in 2008, with the next update likely to be in April 2009. They have decided to let things settle for now, but are taking into consideration any requests for new codes/changes received before April 2007. CfH are also considering developing an electronic version of the classification which should solve the problems we had in getting hold of OPCS4.4 books from The Stationery Office earlier this year.

**ICD10 Books**

As mentioned in a previous Coding Guideline, there are different versions of ICD10 in print. Connecting for Health (CfH) have managed to convince the World Health Organisation to re-print the revised 2000 edition. It should be available from The Stationery Office from October 2007. If you need to order ICD10 books, please ensure you request the Revised 2000 edition, otherwise you may find codes which are not used in the U.K.

**Terminology Advisory Service (formerly Coding Advisory Service)**

With a change to the service and staff other than Clinical Coding Tutors manning the help-line, here are a few reminders to those calling or e-mailing the service.

We speak to lots of Anns, Ians and Irenes etc. Unfortunately, we don’t know all of you personally, so don’t be offended if we ask for your surname. We record all queries on our database, so we need that information from you.

Please have the notes/discharge summary or whatever you are coding from next to you at the telephone or have access to your system, as we often need more information to help us find the correct code.

Even if you are asking for a procedure code, please tell us the diagnosis – it can be important to the end result.

Please don’t expect an answer right away. We always check previous queries and other databases, which takes time, so it is often easier to call you back. If a query has to be passed on to another tutor/clinician and it will take more than 24 hours to get back to you, we will let you know when to expect an answer.

Remember, answers to coding queries are for that particular query and answers cannot automatically be transferred to other instances, where the situation e.g. type of scope used, type of injection, virus etc. might be different.

**DQA News**

The DQA team has been busy on the Scotland Report showing the national findings from the SMR01 and Associated Data QA. This was published at the end of September and can be viewed on our website:

http://www.isdscotland.org/data_quality_assurance

The next project the team is working towards is the Timeliness QA which is expected to commence towards the end of October. This is a mini project covering seven hospitals across Scotland to look at the potential impact the timeliness targets implemented last year have had on the quality of data.

There have been some changes in the DQA staffing since the last Coding Guideline was issued and we now have three new team members: Arlene Robinson, Heather Leslie and Julie Hynd, all of whom have previous coding experience. Tim Varley who has been with the team for seven years is going on a secondment to NCDDP so we will be looking to replace Tim for a year. If anyone would like to gain experience in this area, they should contact Margaret Mason, DQA Manager for an informal chat.