Acute Kidney Injury

Acute Kidney Injury (AKI) is the preferred term used by clinicians to describe Acute Renal Failure (ARF). Clinically AKI is characterised by a rapid reduction in kidney function resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis.

When the term ‘Acute Kidney Injury’ is index trailed in ICD-10 the coder is directed to a traumatic injury code.

Index Trail:
Injury
- kidney S37.0

Tabular List:
S37.0 Injury of kidney

However, in the majority of instances, the clinician documenting the condition of AKI is referring to the non-traumatic condition of acute renal failure.

N17.- Acute renal failure

It is therefore important that when a diagnosis of AKI is documented in a patient’s medical record, and if it is not clear whether the clinical diagnosis of AKI is referring to a traumatic injury or the more familiar term of acute renal failure, the coder must confirm the diagnosis with the responsible clinician before code assignment.

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Arthrosis

The following is provided to further clarify the guidance regarding the coding of Arthrosis (M15-M19) on pages XIII-7 to XIII-9 of the ICD-10 Clinical Coding Instruction Manual (Version 2.0).

There is a note at the start of block M15-M19 explaining that the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis. The note also explains that the term ‘primary’ used within this block refers to arthrosis of no underlying or determining cause.
Coders are advised to always default to unspecified forms of these conditions (.9) in cases where the clinician has not identified an underlying cause.

Within the ICD-10 Alphabetical Index, the term ‘primary’ is an essential modifier which must be present in the clinical statement to enable coders to assign a code for a specific primary arthrosis.

Where the modifier ‘primary’ is not included in the diagnostic statement, the coder must default to the .9 unspecified code from the relevant ICD-10 category.

**Example:**
Bilateral osteoarthritis of the knees (gonarthrosis).

Index Trail:
**Gonarthrosis M17.9**

Tabular List:
M17.9 Gonarthrosis, unspecified

**Rationale:** The fact that the gonarthrosis is bilateral does not change the code assignment in this case. It is not stated that the gonarthrosis is ‘primary’, which as indicated above must be present in the diagnostic statement for the code **M17.0 Primary gonarthrosis, bilateral** to be assigned.

**The same rule applies for all other types of osteoarthritis/arthrosis.**

Clinical Coding Departments need to work closely with their clinicians to ensure that the precise diagnosis is captured to enable the assignment of the appropriate ICD-10 codes. It is not the responsibility of the clinical coding professional to make a clinical judgement on the type of arthrosis a patient has. The type of arthrosis is a clinical decision, and therefore the relevant information, or confirmation as to whether the condition can be described as ‘primary’, must be accurately documented in the patient medical record.

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**Coding of COPD/COAD and associated conditions**

In Coding Guidelines No.22, March 2008, we published a table to help coders assign the appropriate ICD10 codes for COPD/COAD with associated conditions and to ensure consistency in the recording of these conditions. A new entry has been added to this table; Infective exacerbation of asthma, patient known COAD/COPD.

This should be coded to **J45.9 + J22.X + J44.9**

or **J46.X + J22.X + J44.9**
The table is reprinted below with the new entry.

**COPD/COAD**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/COAD</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>COPD/COAD with acute bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis (15 years and above)</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis NOS</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with chronic bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with asthma</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with acute asthma</td>
<td>J45.9 and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with status asthmaticus</td>
<td>J46.X and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td>COPD/COAD with pneumonia, unspecified</td>
<td>J18.9 and J44.0</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>Chest infection</td>
<td>J22.X</td>
</tr>
<tr>
<td>Chest infection with acute bronchitis</td>
<td>J20.-</td>
</tr>
<tr>
<td>Chest infection with bronchitis NOS</td>
<td>J40.X and J22.X</td>
</tr>
<tr>
<td>Chest infection with chronic bronchitis</td>
<td>(J41.- or J42.-) and J22.X</td>
</tr>
<tr>
<td>Chest infection with cystic fibrosis</td>
<td>E84.0</td>
</tr>
<tr>
<td>Chest infection with emphysema</td>
<td>J43.9 and J22.X</td>
</tr>
<tr>
<td>Chest infection, COPD and emphysema</td>
<td>J44.0 and J43.9</td>
</tr>
<tr>
<td>Chest infection with lower lobe consolidation on X-ray</td>
<td>J18.1</td>
</tr>
<tr>
<td>Chest infection, LVF</td>
<td>J22.X and I50.1 Sequencing is dependent on the main condition treated</td>
</tr>
<tr>
<td>Chronic obstructive bronchitis with acute exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>URTI (Upper respiratory tract infection) with COPD</td>
<td>J44.1 and J06.9</td>
</tr>
<tr>
<td>(Acute) exacerbation of asthma</td>
<td>J45.9</td>
</tr>
<tr>
<td>Infective exacerbation of asthma</td>
<td>(J45.9 or J46.X) and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma with status asthmaticus</td>
<td>J46.X and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma, patient known COAD/COAD</td>
<td>J45.9 + J22.X + J44.9 or J46.X + J22.X + J44.9</td>
</tr>
</tbody>
</table>


Please note that previous guidance (Coding Guidelines No.4 September 1999 and No.8 February 2001) still applies.

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Neutropenic sepsis

Neutropenic sepsis develops due to a low white blood cell level, especially the type called neutrophils which fight bacterial infections.

Clinical input has confirmed that during treatment of neutropenic sepsis it is the sepsis that is the main condition treated rather than the neutropenia.

Based on this information, the correct ICD-10 codes and sequence for a stated diagnosis of neutropenic sepsis are:

A41.- Other septicaemia

(Fourth character code assignment will depend on whether or not the specific organism has been identified)

D70.X Agranulocytosis

If the responsible consultant has confirmed that neutropenic sepsis was due to a drug then an external cause code from Chapter XX must be assigned in addition.

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Posterior capsular opacification (also called after-cataract)

Posterior capsular opacification (also called after-cataract) may develop in some patients following cataract surgery. Over time the part of the lens capsule holding the prosthetic lens in place can thicken, resulting in symptoms similar to those found in cataracts, such as hazy vision and poor night vision.

The appropriate ICD-10 code for posterior capsular opacification is:

H26.4 After-cataract

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Coding Guidelines – OPCS4

Bone Marrow Transplants

Update to article in Coding Guidelines No. 23 September 2008, entitled “Peripheral Stem Cell Procedures: Amendment to Previous Guidance”.

When bone marrow transplants occur the coder needs to be clear whether they are coding a harvest/donation or a graft, AND whether the patient having the bone marrow removed is to be the potential recipient of the bone marrow or not.

The following chart aims to simplify this and supersedes guidance previously issued in Coding Guidelines No. 23, September 2008, published as part of a list of haematological procedures.

<table>
<thead>
<tr>
<th></th>
<th>Harvest/donation</th>
<th>Graft</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient as the Potential</td>
<td>W35.8 + Y66.7</td>
<td>Recipient (Autologous)</td>
</tr>
<tr>
<td>Recipient (Autologous)</td>
<td></td>
<td>W34.1</td>
</tr>
<tr>
<td>Patient is donating bone</td>
<td>X46.1 + site of</td>
<td>Recipient – not the</td>
</tr>
<tr>
<td>marrow to another person</td>
<td>donation</td>
<td>donating patient (Allograft)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>W34.2-.9</td>
</tr>
</tbody>
</table>

Rationale
X46.1 has to be used for the donation for a non-autologous transplant because W35.8 is a therapeutic puncture of bone, and this would not be therapeutic to the donor. The trail is Donation Bone Marrow X46.1. Also where there is an autologous transplant taking place the extraction of the bone marrow would generally be described as a harvest of bone marrow rather than a donation. The trail is Harvest Bone Marrow Y66.7

Colposcopy with Punch Biopsy of the cervix (uteri)

A colposcopy is a diagnostic procedure which involves visual examination of the vagina and the cervix of the uterus using a colposcope.

During colposcopy a speculum is inserted into the vagina to hold it open and a colposcope (a magnifying instrument that has a light source attached to it and looks similar to a pair of binoculars) is used to examine the cells of the cervix. If abnormal cells are found a biopsy may be taken from the cervix.

A colposcope is not an endoscope and it does not touch or go inside the vagina, therefore the guidance for the coding of endoscopic procedures does not apply.

When a punch biopsy of the cervix is carried out during a colposcopy examination, this must be coded using the following OPCS-4 codes:

Q03.4 Punch biopsy of cervix uteri
Q55.4 Colposcopy of cervix

Includes: Colposcopy NEC

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K-Wire Fixation

Kirschner wires (K-wires) are steel wires frequently used to hold fragments of bone in position in the treatment of bone fractures.

Medical documentation and procedure notes do not usually clarify whether K-wire fixation should be classified as a rigid or flexible form of internal fixation.

In the term “flexible fixation”, the word flexible means that the implant can adapt to a path by changing direction without damage to the internal structure. Kirschner wires (K-wires) may be bent, and whilst this changes the internal properties of the K-wire, this is not because it is flexible but because force has been applied. K-wire fixation is always a form of rigid fixation.

The OPCS-4 code assignment may vary depending on the type of reduction performed, for example primary, secondary, closed, open, etc.

Example:
Primary closed reduction and K-wire fixation of right sided fracture of lower end of radius, performed under image intensifier:

W24.2 Closed reduction of fracture of long bone and rigid internal fixation NEC
Z70.5 Lower end of radius NEC

This guidance is only relevant where coders have a choice of using a rigid or flexible fixation code as in the W24.- rubric. Often the fixation within the OPCS classification is not further defined as flexible or rigid, for example W20.- where the extramedullary fixation is classified by type of fixator rather than whether it is flexible or not.

Note that K-wires may also be used to augment anchorage of cerclage wires and in skeletal traction; in such instances the K-wires do not require coding in addition.

Laterality Codes

Where space is available on the SMR, laterality (Z94.-) should be recorded where appropriate to reflect the side of the body on which the procedure/intervention was carried out.

Where there is a conflict over selection of supplementary codes, the general rule is that a ‘Y’ code would take precedence over a ‘Z’ code, except in Chapter W, where the Orthopaedic specialists require the bone/joint and/or laterality in preference to any ‘Y’ code.

Example 1:
Excision of left kidney:
M02.5 Nephrectomy NEC
Z94.3 Left sided operation

Rationale: There is no supplementary information about the method of procedure being carried out and the title of the code includes the organ, therefore the laterality code can be added.

Example 2:
Primary suture of laceration to skin on the left side of the back:
S42.1 Primary suture of skin NEC
Z49.4 Skin of back
**Rationale:** There is no supplementary information about the method of procedure being carried out, but the Site code is added to be more specific about the area of skin. There is no space to add laterality.

**Example 3:**
Failed laparoscopic right nephrectomy – converted to open procedure.
M02.5 Nephrectomy NEC  
Y71.4 Failed minimal access approach converted to open

**Rationale:** There is a requirement to add a supplementary code to show the change in the method of operation. There is no space to add laterality.

**Example 4:**
Endoscopic drainage of cyst of right ovary  
Q49.3 Endoscopic drainage of cyst of ovary  
Z94.2 Right sided operation

**Rationale:** The supplementary information about the method of procedure is included in the main code title, as is the name of the organ. There is therefore space to add the laterality code.

**Example 5:**
Tension band wiring of fracture of right patella.  
W21.4 Primary intra-articular fixation of intra-articular fracture of bone nec  
Z78.7 Patella

**Rationale:** The main operation code does not record information about the site of the operation, therefore the supplementary code gives the bone involved and there is no space to record laterality.

**The use of Y76.7 Arthroscopic approach to joint (Revised 2012)**

**Addition of code W42.6 to list.**

The previous guideline ‘Arthroscopic Procedures’ Coding Guidelines No. 20, June 2007 stated that Y76.7 should not be used in Scotland.

Since then a number of new, specific codes have been introduced (in OPCS4.5, April 2009) which have given rise to a number of requests to use Y76.7.

The Clinical Coding Review Group has agreed that Y76.7 may be used with the following list of codes when the relevant procedures are performed arthroscopically:

**W42.6 Arthrolysis of Total Prosthetic Replacement of Knee Joint**
W78.1 Release of Contracture of Shoulder Joint  
W78.2 Release of Contracture of Hip Joint  
W78.3 Release of Contracture of Knee Joint  
W78.5 Release of Contracture of Elbow Joint  
O27.2 Repair Capsule and Anterior and Posterior Labrum for Stabilisation of Glenohumeral Joint  
O27.3 Repair Capsule and Anterior Labrum for Stabilisation of Glenohumeral Joint  
O27.4 Repair Capsule and Posterior Labrum for Stabilisation of Glenohumeral Joint  
O29.1 Subacromial Decompression  
T79.1 Plastic Repair of Rotator Cuff of Shoulder NEC  
T79.3 Revisional Repair of Rotator Cuff NEC  
T79.4 Plastic Repair of Multiple Tears of Rotator Cuff of Shoulder  
T79.5 Revisional Repair of Multiple Tears of Rotator Cuff of Shoulder
Total Hip Replacement with Acetabular Bone Graft

During most total hip replacement procedures, bone chippings produced from bone reamed from the patient’s femur are used to pack and secure a prosthetic joint replacement, providing additional stability of the joint implant. This type of method is considered to be an integral part of the procedure and therefore does not require coding in addition to the prosthetic joint replacement.

Example 1:
Primary uncemented left total hip replacement, the joint implant was packed and secured using bone chippings from the reamed bone of the patient’s femur:

W38.1 Primary total prosthetic replacement of hip joint not using cement
Z94.3 Left sided operation

Rationale: As the bone chippings are used as a part of the procedure to help secure the hip replacement, it is not appropriate to assign a code for the bone chippings in addition.

However, in other types of total hip replacements, and where there is evidence documented of extensive acetabular bone loss, an acetabular bone graft (using either morcellised bone or bone block), will be performed in addition to the total hip replacement. The acetabular bone graft is considered to be in addition to the joint replacement procedure, and therefore a code for the bone graft must be assigned in addition to the code for the total hip replacement.

The appropriate OPCS-4 code to assign for the acetabular bone graft will depend on whether it is an ‘autograft’ or ‘allograft’ of bone. Whenever an autograft is performed, the bone is taken from one part of the body and is placed in another site on the same individual. This requires a harvest code to be assigned in addition to the code for the total hip replacement.

Example 2:
Primary uncemented left total hip replacement with morcellised autograft of bone to large acetabular defect. Bone harvested from left iliac crest.

W38.1 Primary total prosthetic replacement of hip joint not using cement
Z94.3 Left sided operation
W31.4 Cancellous chip autograft of bone
Z75.6 Acetabulum
W08.8 Other Specified Excision of Bone
Y66.3 Harvest of bone from iliac crest

Rationale: The bone graft material in this procedure is an autograft which was harvested from the iliac crest of the patient, and therefore it is appropriate to assign codes to identify the autograft and harvest in addition to the code for the total hip replacement.

Example 3:
Primary uncemented left total hip replacement with acetabular bone graft using bone block obtained from the bone bank to address the defect in the left acetabulum.
W38.1 Primary total prosthetic replacement of hip joint not using cement
Z94.3 Left sided operation

W32.2 Allograft of bone NEC
Z75.6 Acetabulum

**Rationale:** It is appropriate to assign a code to identify the allograft of bone, as the bone graft was obtained from the bone bank. Where an allograft or xenograft has been donated from a bone bank, or supplied from a different individual, it is not appropriate to assign a harvest code in addition, as the graft was not harvested from the original patient.

Any uncertainty as to whether the joint replacement involves a bone graft, or a packing using bone chippings, must be referred back to the responsible consultant for clarification

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**Urethral Catheterisation**

**Question**

Is it appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder in instances where an inpatient who is being treated for some other condition goes on to develop urinary retention during their hospital stay, and is subsequently treated by urethral catheterisation?

**Answer**

It is appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder where it is clearly documented in the patient’s medical record that during their hospital stay for treatment of another condition the patient also developed urinary retention, which was treated with catheterisation. This is because the catheterisation would not be considered to be part of the patient’s routine care for the other condition.

However, it is not appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder in circumstances where the catheterisation is performed routinely as part of, or following, a procedure.

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**Use of Obstetric Scanning, Assessment and Monitoring OPCS codes R36 – R43**

It has been agreed that obstetric scanning, assessment and monitoring codes should be treated in the same way as other scans.

Therefore the table produced in the article entitled “Coding of “non-operative” interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02”, in Coding Guidelines No.22 March 2008 and updated in Coding Guidelines No.25 April 2010, now contains guidance on the coding of obstetric scans, assessments and monitoring.

This decision requires that an amendment be made to the table referred to above, to incorporate codes R36- R43.

The updated table is printed below.
### General Information

**New title for “Coding Guidelines”**

Please note that as of March 2013, the title of this publication will change to “Scottish Clinical Coding Standards”.

**Terminology Services Team News**

Esther Morris has left the Terminology Services Team to take up a new role in ISD. We wish her well in her new post. Notification of Esther’s replacement will be issued in due course.

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Please note that all new guidance in this edition applies to all discharges on and after 1st October 2012.

<table>
<thead>
<tr>
<th>Intervention/procedure code</th>
<th>General Guidance</th>
<th>Guidance if Elective admission (inpatient/day case) specifically for this intervention/procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>U01-U40</td>
<td>Not mandatory to code</td>
<td>Code</td>
</tr>
<tr>
<td>R36 – R43</td>
<td>Not mandatory to code</td>
<td>Code</td>
</tr>
<tr>
<td>X28-X39</td>
<td>Not mandatory to code</td>
<td>Code</td>
</tr>
<tr>
<td>X44, X48-X58</td>
<td>Not mandatory to code</td>
<td>Code</td>
</tr>
<tr>
<td>X65</td>
<td>Not mandatory to code</td>
<td>Code</td>
</tr>
<tr>
<td>X60-X62, X66, X67.-, X68.-</td>
<td>Not mandatory to code</td>
<td>Not mandatory to code</td>
</tr>
<tr>
<td>X70, X71</td>
<td>Not mandatory to code</td>
<td>Not mandatory to code</td>
</tr>
<tr>
<td>X81-X97</td>
<td>Not mandatory to code</td>
<td>Not mandatory to code</td>
</tr>
</tbody>
</table>

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Contact

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 online is: [www.isdscotland.org/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines](http://www.isdscotland.org/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines)