Coding Guidelines - ICD10

Myocardial infarction and unstable angina

In June 2007 ISD published a guideline on ‘Coding The Acute Coronary Syndromes Using ICD10’ (CG20) to help coders deal with clinical statements associated with the term ‘acute coronary syndrome’. The main feature of the 2007 guideline was the introduction of a fifth digit for use with I20.0 Unstable angina. This fifth digit was used to record clinical statements describing the levels of troponin (a biochemical marker of myocardial damage) found in the patient’s blood.

The Scottish Cardiac Society has now adopted a new, international definition of myocardial infarction (MI). This new definition should have the effect of simplifying the terminology encountered by coders when coding MI patients in Scotland. This guideline outlines the statements most likely to be encountered and clarifies how they should be coded:

1. **Unstable angina** - this should be coded I20.0 Unstable angina, exactly according to ICD10 rules and conventions.

   (NOTE that coders no longer need look for, or take account of, clinical statements describing blood troponin levels. The 5th digits signifying “troponin status” which were applied to I20.0 in the 2007 guideline are no longer applicable. This is because unstable angina is always “troponin-negative” by the new definition).

2. **ST elevation myocardial infarction (STEMI)** and **Non-ST elevation myocardial infarction (NSTEMI)** – clinicians will usually classify an MI as either a STEMI or NSTEMI. It is clinically important to distinguish between these two types of MI, and consequently it is also important to record them in coded SMR data.

   “ST elevation” and “non-elevation” refer to the appearance of a part of the patient’s electrocardiogram (ECG) trace. The ICD10 index and the categories I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction make no explicit mention of ST elevation or non-elevation. Coders will be aware that the sub-categories of I21.- and I22.- classify MIs according to another feature of the patient’s ECG trace, namely the identification of the area of the myocardium affected – anterior wall, inferior wall etc. (NOTE that it is clinicians who are responsible for the interpretation of ECG traces. Coders are responsible only for the coding of clinical statements made after such interpretation).

   The need to record STEMI and NSTEMI must fit in with the existing structure of the ICD10 codes for MI. This will be done by adding a 5th digit for use ONLY with codes I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction.

   Coders should add a fifth digit from Table 1 whenever they use codes I21.- and I22.-.
Table 1

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Meaning of fifth digit for I21.- and I22.- ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Non-ST Elevation Myocardial Infarction (NSTEMI)</td>
</tr>
<tr>
<td>1</td>
<td>ST Elevation Myocardial Infarction (STEMI)</td>
</tr>
<tr>
<td>9</td>
<td>MI with no statement of ST elevation or non-elevation</td>
</tr>
</tbody>
</table>

To use these 5th digits with I21.- and I22.-, the MI should first be coded as usual, taking into account available information about any previous MIs and about the area of the myocardium affected – anterior, inferior etc. (NOTE that the essential modifier ‘transmural’ which is found in the index trail (vol 3 p 290) leading to I21.- Acute myocardial infarction can be ignored. This is because it is unlikely to appear in clinical statements). The 5th digit signifying NSTEMI, STEMI or ‘no statement’ should then be added.

Examples (assuming that this is the patient’s first MI) are shown in Table 2.

<table>
<thead>
<tr>
<th>Example of clinical statement to be coded</th>
<th>ICD10 code</th>
<th>Fifth digit</th>
<th>Final code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior NSTEMI</td>
<td>Anterior MI = I21.0</td>
<td>NSTEMI = 0</td>
<td>I21.00</td>
</tr>
<tr>
<td>Anterior STEMI</td>
<td>Anterior MI = I21.0</td>
<td>STEMI = 1</td>
<td>I21.01</td>
</tr>
<tr>
<td>Anterior MI</td>
<td>Anterior MI = I21.0</td>
<td>no statement = 9</td>
<td>I21.09</td>
</tr>
<tr>
<td>NSTEMI</td>
<td>MI unspecified = I21.9</td>
<td>NSTEMI = 0</td>
<td>I21.90</td>
</tr>
<tr>
<td>STEMI</td>
<td>MI unspecified = I21.9</td>
<td>STEMI = 1</td>
<td>I21.91</td>
</tr>
<tr>
<td>MI</td>
<td>MI unspecified = I21.9</td>
<td>no statement = 9</td>
<td>I21.99</td>
</tr>
</tbody>
</table>

3. Aborted MI - this should be coded as I24.0 Coronary thrombosis not resulting in myocardial infarction.

4. The phrase “acute coronary syndrome” should no longer appear as the sole, definitive, diagnostic statement. It may appear as a generic, descriptive term in the clinical information used by the coder. However it should be accompanied by more specific information i.e. “unstable angina”, “NSTEMI” or “STEMI”. The coder should code the more specific information according to this guideline.

If “acute coronary syndrome” is the only clinical statement about the acute cardiac event which is available to the coder then:

- firstly the coder should seek clarification from the clinician about how the case should be classified according to the rules in this guideline.
- **ONLY** if clarification cannot be obtained, then the phrase “acute coronary syndrome” should be coded to I24.8 Other forms of acute ischaemic heart disease.

THE ABOVE GUIDANCE SHOULD BE IMPLEMENTED FOR ALL DISCHARGES FROM 1st OCTOBER 2010
Perinatal Conditions update to guidance

The article entitled “Perinatal conditions” published in Coding Guidelines No.23 September 2008, contained a list of excluded codes as follows:

- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Endocrine, nutritional and metabolic diseases (E00-E99)
- Injury, poisoning and certain other consequences of external causes (S00-T98)
- Neoplasms (C00-D48)
- Tetanus neonatorum (A33)

Please add Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) to the above list.

Parastomal Hernia

A parastomal hernia is by definition a hernia that occurs at and around an operative stoma. The index trail in ICD-10 Volume 1 is:

**Hernia, hernial (acquired) (recurrent)** K46.9
- postoperative - see Hernia, ventral

**Hernia**
- ventral K43.9
- - with
  - - - gangrene (and obstruction) K43.1
  - - - obstruction K43.0

Therefore the correct ICD-10 code for a parastomal hernia is **K43.- Ventral hernia** (4th character assignment will depend on whether it is a parastomal hernia with or without obstruction/gangrene). It is also appropriate to assign the relevant ICD-10 code from category **Z93, Artificial opening status**, in a secondary position, in order to identify the presence of a stoma.

Leg Ulcer with infection; change to guidance

In Coding Guidelines No.17 January 2006, guidance was published regarding the coding of leg ulcer with infection. The guidance should now read:

If a diagnosis of leg ulcer with infection is given, code the leg ulcer, L97.X, followed by the code L08.9 Local infection of skin and subcutaneous tissue, unspecified and, if the infection is known, an appropriate code from B95.- to B97.-

**Examples:**

Leg ulcer with MRSA infection. Code:

- L97.X - Ulcer of lower limb, not elsewhere classified
- L08.9 - Local infection of skin and subcutaneous tissue, unspecified
- B95.6 - *Staphylococcus aureus* as the cause of diseases classified to other chapters

Leg ulcer with infection. Code:

- L97.X - Ulcer of lower limb, not elsewhere classified
- L08.9 - Local infection of skin and subcutaneous tissue, unspecified

This will bring us into line with coding in England.
Missed abortions

1. A woman with a missed abortion is given oral Mifepristone and discharged home prior to aborting the fetus.
   Code to O02.1 + Z30.3

2. A woman with a missed abortion is given oral Mifepristone, aborts the fetus and is then discharged.
   Code to O02.1 + Z30.3

N.B. If the woman is given oral prostaglandin the code Z51.2 should be used in place of Z30.3.

The above guidance is being issued to add to that already published on Abortion coding in Coding Guidelines No.22, March 2008.

Pancreatic Intraepithelial Neoplasia (PanIN)

Tumours described as PanIN III or high grade Pancreatic intraepithelial neoplasia should be coded to D01.7 Carcinoma in situ of other specified digestive organs.

Coding Guidelines OPCS4

Coleman Fat Transfer

A Coleman Fat Transfer is an eponymous procedure used commonly for cosmetic or reconstructive purposes. It involves the extraction of fat cells from one site, which are then centrifuged to cleanse the cells before being injected, usually by a tunnelling process, to the site requiring restoration. This technique is normally performed by needle, but how the fat transfer is actually carried out should be clarified with the clinician if there is any uncertainty. Within the NHS this is commonly carried out for face and breast reconstructions, but may be used on other areas of the body.

As there are many combinations of this type of procedure, in order to record this accurately and consistently coders are advised to follow the principle for skin harvests and grafts published in Coding Guideline No 8, February 2001. This states that “the graft to and its site should take priority over the graft from”.

Examples:

1. Patient is having a breast reconstruction by a transfer of fat taken from abdomen.
   - B29.8 Other specified reconstruction of breast + Y39.8 Other specified injection of other substance into organ NOC
   - S62.2 Liposuction of subcutaneous tissue NEC + Z49.3 Skin of anterior trunk

2. Fat transfer from abdomen to cheek, using liposuction on the abdomen and injecting the fat into the cheek.
   - S50.2 Injection of organic inert substance into subcutaneous tissue + Z47.3 Skin of cheek
   - S62.2 Liposuction of subcutaneous tissue NEC + Z49.3 Skin of anterior trunk

Laryngopharyngectomy

The following OPCS-4.5 codes and sequencing apply when coding laryngopharyngectomy.

Total Laryngopharyngectomy

- E19.1 Total pharyngectomy + E29.1 Total laryngectomy

Partial Laryngopharyngectomy

- E19.2 Partial pharyngectomy + one of the following codes:
E29.2 Partial horizontal laryngectomy
E29.3 Partial vertical laryngectomy
E29.4 Partial laryngectomy NEC

**Laryngopharyngectomy**
- E19.2 Partial pharyngectomy *Includes: Pharyngectomy NEC*
  + E29.6 Laryngectomy NEC

This is an update to the guidance published in Coding Quarterly No.1 November 1996.

**Temporal Bone Excision**

The temporal bones form part of the sides and base of the cranium. Procedures on the cranium are classified to OPCS4.5 Chapter V Bones and Joints of Skull and Spine.

The OPCS4.5 codes for a temporal bone excision are:
- V05.8 Other specified other operations on cranium
- Z63.3 Temporal bone

England would code V05.8 Y05.- Z63.3 Z94.-.

**‘O/Z’ codes**

Following an update to the National Reference Files, the following ‘overflow’ codes representing body sites have been added to the OPCS4 files:

**O11.- Other upper digestive tract (Principal Z27)**
- O11.1 Gastro-oesophageal junction
- O11.8 Specified other upper digestive tract NEC
- O11.9 Other upper digestive tract NEC

**O12.- Branch of external carotid artery**
- O12.1 Superficial temporal artery
- O12.2 Maxillary artery
- O12.8 Specified branch of external carotid artery
- O12.9 Branch of external carotid artery NEC

**O13.- Other leg region (Principal Z90)**
- O13.1 Multiple digits of foot NEC
- O13.8 Specified other leg region NEC
- O13.9 Other leg region NEC

**O14.- Other lymph node (Principal Z61)**
- O14.1 Pelvic lymph node
- O14.2 Sentinel lymph node
- O14.8 Specified other lymph node NEC
- O14.9 Other lymph node NEC

These codes have the same validation applied as all ‘Z’ (site) codes.

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**PLEASE NOTE THAT THE GUIDANCE GIVEN IN THIS EDITION APPLIES TO ALL DISCHARGES ON AND AFTER 1ST OCTOBER 2010**
SMR02 Review

As a result of the DQA audit of SMR02 data last year, a separate Coding Guideline will be sent out soon. It will explain changes to the recording of maternity data in line with the proposals of the Maternity Data Development Alignment Working Group which were recently approved by the Clinical Coding Review Group.

DQA News

The Data Quality Assurance team has completed a third of the hospitals they are going to assess for the current SMR01 QA. Due to use of relative weighting for calculating accuracy rates, the number of hospitals included in the QA has decreased from 38 to 24 but there will be a larger sample of records assessed at those 24 sites. As it is important that the sample is representative of all hospitals, ISD analysts were involved in selecting similarly sized hospitals with similar results before a final decision was taken on what hospitals to include.

The style of the hospital report is also going to change in that it will appear less technical than previously with the focus on the quality of the hospital discharge summary as this is a key document for the coders.

The SMR01 QA will be put on hold over the early winter months as the team has been asked to concentrate on an audit of cancer waiting times. The SMR01 project will resume early in the New Year.

One of the team analysts, Hazel Mackay, has moved to another area within ISD to work with the Scottish Intensive Care Society Audit Group. Hazel’s valuable input will be missed and the team wishes her well in her new role.

Please feel free to contact Margaret Mason, Data Quality Assurance Manager on margaretmason@nhs.net or telephone 0131 275 6528 if you would like further information.