Scottish Clinical Coding Standards - ICD10

Accidental cuts/perforations during procedures
It is quite common during some procedures e.g. a laparoscopic cholecystectomy, for accidental cuts/perforations to occur e.g. small liver perforation due to an instrument. If these kinds of problems are recorded on the discharge summary then they should be coded. If they are mentioned only in operation notes and/or clinical notes but not mentioned on the discharge summary then they should not be coded.

Septic shock - errors in Includes and Excludes notes in ICD10 V4
ICD10 V4 Volume 1 contains confusing Inclusion and Exclusion notes relating to septic shock. These notes are incorrect and should be deleted. Please amend your Tabular List as follows:

a) The inclusion term of ‘septic shock’ at A41.9 Sepsis, unspecified (Volume 1 page 117) should be deleted.

b) The exclusion term of ‘shock, septic (A41.9)’ at R57 Shock, not elsewhere classified (Volume 1 page 774) should be deleted.

Scottish Clinical Coding Standards – OPCS4
One Scope, two or more procedures – clarification of previous standard
1) The ‘One Scope, two or more procedures’ standard was published in Coding Guidelines No.21, November 2007. It deals with the coding of cases where “in one theatre visit a patient undergoes more than one procedure using the same scope”, recommending that only the most important procedure i.e. the code highest up the hierarchy of the potentially applicable codes, is recorded. However, there has been some uncertainty concerning how widely to apply this standard – for example, does it extend to laparoscopic procedures?

2) The Clinical Coding Review Group has now agreed the following points:

2.1) The 2007 standard restricting the number of codes that can be recorded continues to apply to endoscopic examinations and procedures performed solely via existing anatomical passages, such as: UGI endoscopy, colonoscopy and sigmoidoscopy, ERCP, cystoscopy, ureteroscopy, nephroscopy performed via the ureters, bronchoscopy and other ‘natural orifice’ endoscopies. (The recording of a legitimate ERCP pair code does not contravene this guidance).
2.2) The 2007 standard does not apply to procedures performed via approaches such as:

Arthroscopy, laparoscopy, percutaneous nephroscopy via a subcutaneous track, thoracoscopy and similar ‘minimal access’ approaches. Such procedures should be coded (using the appropriate ‘minimal access’ codes) as fully as the equivalent ‘open’ procedures would be coded, as in the following examples:

2.2.1) Laparoscopy and diathermy to endometriosis in Pouch of Douglas, left ovarian fossa, left uterosacral ligament and right ovary and bilateral clipping of fallopian tubes.

These procedures were performed during a single laparoscopy.

Code both procedures:

T42.2 Endoscopic destruction of lesion of peritoneum
Q35.2 Endoscopic bilateral clipping of fallopian tubes

2.2.2) Arthroscopy and sub-acromial decompression with primary repair of rotator cuff.

These procedures were performed during a single arthroscopy.

Code both procedures:

O29.1 Subacromial decompression / Y76.7 Arthroscopic approach to joint
T79.1 Plastic repair of rotator cuff of shoulder NEC / Y76.7 Arthroscopic approach to joint

3) One particular area of coding difficulty is Functional Endoscopic Sinus Surgery (FESS)/Functional Endoscopic Nasal Surgery (FENS). “FESS” and “FENS” are non-specific umbrella terms which comprise a range of endoscopic procedures on the sinuses and nasal passages. Commonly, more than one such procedure is performed in a single FESS/FENS theatre visit.

3.1) Unlike, say, the colonoscopy codes, there is no clear hierarchy of named endoscopic chapter E codes which classify FESS/FENS procedures. To code FESS/FENS procedures, non-endoscopic E codes must be supplemented by Y76.1 Functional endoscopic sinus surgery or Y76.2 Functional endoscopic nasal surgery.

3.2) Consequently, CCRG have agreed that FESS/FENS procedures should not be subject to the ‘one scope one code’ rule and should be coded as described in 2.2 above.

4) This standard cannot offer guidance covering every possible circumstance in endoscopic and ‘minimal access’ surgery. When necessary, advice should be sought from Terminology Services helpdesk, either by telephone (0131 275 7283 - the number is manned Tuesday to Thursday from 09.00 to 17.00 hrs) or by e-mail: NSS.terminologyhelp@nhs.net

Pituitary excision and skull based reconstruction

The pituitary gland is a bean sized structure located at the base of the brain behind the nose, where it is protected by the sphenoid bone. The pituitary gland can be affected by a wide range of tumours and other pathological processes; the most frequent being pituitary adenomas. It was common practice to remove the whole of the pituitary gland, which would have been coded to B01.2 Trans-sphenoidal hypophysectomy. Due to advances in the treatment of these diseases, it is now more common practice for the surgeon to remove only the tumour which would be coded to B04.1 Excision of lesion of pituitary gland.

The most common approach for pituitary surgery is trans-sphenoidal (through the sphenoid sinus) with the use of an endoscope inserted via the nostril. This approach may create a defect in the anterior skull base which can cause the leakage of cerebrospinal fluid. When a leakage occurs, the surgeon may decide to close the defect created in the anterior skull base with the use of a mucosal flap. This is known as an “anterior skull based reconstruction”. OPCS-4 codes E15.8 Other
specified operations on sphenoid sinus and Y26.1 Reconstruction of organ NOC show the reconstructive element of the procedure.

Example 1:
Hypophysectomy (total excision of pituitary gland), followed by anterior skull based reconstruction with mucosal flap (all during the same visit to theatre). All procedures performed using endonasal endoscopic trans-sphenoidal approach.

B01.2 Trans-sphenoidal hypophysectomy
Y76.6 Endonasal endoscopic approach to other body cavity
E15.8 Other specified operations on sphenoid sinus
Y26.1 Reconstruction of organ NOC
S28.8 Other specified flap of mucosa
Y76.6 Endonasal endoscopic approach to other body cavity

Example 2:
Excision of pituitary gland adenoma (only the tumour was removed), defect was reconstructed with the use of a mucosal flap (all during the same visit to theatre). All procedures performed using endonasal endoscopic trans-sphenoidal approach.

B04.1 Excision of lesion of pituitary gland
Y76.6 Endonasal endoscopic approach to other body cavity
E15.8 Other specified operations on sphenoid sinus
Y26.1 Reconstruction of organ NOC
S28.8 Other specified flap of mucosa
Y76.6 Endonasal endoscopic approach to other body cavity

Total hip replacement with acetabular bone graft

Updated coding standard
Clinical input has confirmed that during some primary total hip replacement procedures, bone chippings produced during the operation reamed from the patient’s acetabulum (or occasionally femur) are used to fill defects and secure a prosthetic joint replacement. 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 defects around the implant were packed using bone chippings from the reamed bone of the patient’s acetabulum:

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 support the hip replacement, it is not appropriate to assign a code for the bone chippings in addition.
During some revisional total hip replacements, where there is evidence of extensive bone loss, an acetabular or femoral bone graft, using either morcellised bone or a block of bone, may be performed in addition to the joint replacement. Revision total hip replacements can have extensive bone loss and where this is the case, autograft (from the patient) or allograft (from another patient via a bone bank) bone will be necessary for the reconstruction. In these types of instances, the acetabular or femoral bone graft is considered to be a separate procedure to the joint replacement procedure and requires coding in addition.

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

W38.3 Revision of 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 a code to identify the harvest in addition to the code for the revision total hip replacement.

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

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GENERAL INFORMATION

Alcohol in pregnancy
Midwives undertaking the antenatal booking appointment, are asked to record in the Scottish Woman-held Maternity Record, the number of units of alcohol that the woman states she has drunk “in an average week”. Concern has been raised that simply considering the week prior to the booking appointment will not capture whether a woman was drinking very early in pregnancy, possibly before confirmation of pregnancy.

This was considered in Feb/Mar 2013 by a subject matter expert group including specialist midwives, an obstetrician, a neonatologist, a consultant in public health and Scottish Government professional advisors.

The revised current advice for midwives in Scotland from April 2013, is to ask women about their average weekly consumption of alcohol over the three months prior to booking. Midwives are asked to record the woman’s answer in the SWHMR/ maternity information system so it can be reported on SMR02 (http://www.datadictionaryadmin.scot.nhs.uk/SMR-Datasets/SMR02-Maternity-Inpatient-and-Day-Case/Drug-and-Alcohol-Misuse/Typical-Weekly-Alcohol-Consumption.asp). If the woman says she has not drunk any alcohol at all over the last three months, number of units should be recorded as ‘0’. If the woman states that she has consumed an average of 0 to 1 unit per week over the three months code as ‘1’. Otherwise code as nearest number averaged over the three months.
This advice has been included in e-learning materials being developed for identification and treatment of Fetal Alcohol Spectrum Disorder (FASD) and in the ISD data dictionary. The amendment will allow tracking of alcohol consumption in the three months prior to maternity booking as an all-Scotland Maternity Quality Measure.

As this data should be collected at booking by midwives, this article is only background information for coders.

1 http://www.healthcareimprovementscotland.org/idoc.ashx?docid=61c1f6e3-e202-413f-8bd0-10ee02076d8b&version=-1

**National Clinical Coding Qualification – Results**

Congratulations to Mark Long (Lothian Health Board), Cath Malone (Greater Glasgow Health Board) and Hugh Young (Lothian Health Board). All three passed the National Clinical Coding Examination (NCCQ) which they sat in September last year.

100% pass rate for Scotland – well done all!

In 2011 ISD announced that all candidates from Scotland wishing to sit the qualification, must learn the English method of coding so in addition to the vast amount of work Mark, Cathy and Hugh put in, they were usually doing something different in their day to day jobs. It is good to see all their hard work has paid off.

If anyone is inspired by their success and wishes to undertake the exam, please feel free to contact me for an informal chat.

Further information about the qualification can also be found on the web site of the Institute of Health Records and Information Management (IHRIM). This is the organisation which administers the examination.

[http://www.ihrim.co.uk/](http://www.ihrim.co.uk/)

Liz Williamson Clinical Coding Tutor

**PLEASE NOTE THAT CLINICAL CODING STANDARDS IN THIS EDITION APPLY TO ALL DISCHARGES ON AND AFTER 1ST APRIL 2014.**

**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 standards/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)

Scottish Clinical Coding Standards is the new title for Coding Guidelines. This is to reflect the fact that the standards published herein are coding rules which apply in Scotland.

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