How to use this document

This document has been compiled to enable coders to quickly identify coding standards for ICD-10. All discharges from 1st April 2017 should adhere to the guidance given in this document and subsequent publications of the Scottish Clinical Coding Standards.

Standards are indexed in order of the ICD-10 chapter to which they mostly apply. Some may be repeated in more than one chapter. They appear alphabetically within the chapters. General Standards – those which are not chapter specific – are at the start of the document.

This document is not intended to be printed out, but to be easily accessed by pinning to a PC menu or desktop.

Clinical coding staff should ensure that their ICD-10 Fifth Edition 2016 books are updated to reflect ALL valid standards.

If you require this document in an accessible format, please contact the Terminology Services Helpdesk on 0131-275-7283 or NSS.terminologyhelp@nhs.net

You can navigate using the following keyboard shortcuts:

- Alt + ← This will allow you to jump back to the exact page you came from.
- ← → This will allow you to move between the next page and the previous page.
- Ctrl + This will allow you to zoom out of the page.
- Ctrl + + This will allow you to zoom into the page.
Consolidation

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General Coding Standards - not specific to an ICD10 chapter

Accidental cuts/perforations during procedures  
SCCS Mar 14

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.

Acute on chronic conditions  
CG2 Jan 99

It has been agreed that if 
no specific single code is available in ICD10 then both the acute and chronic conditions should be coded separately 
if the information is available, e.g.

Acute on Chronic Bronchitis code to:

J20.9 Acute bronchitis, unspecified and J42.X Unspecified chronic bronchitis.

Allergies  
CG13 Jan 03

Questions have been raised about whether it is necessary to code allergies (e.g. penicillin allergy).

If the allergy is mentioned in the text of the discharge summary or listed as a diagnosis, it should be coded.

Cause of Death  
SCCS2 July 13

Coders should note that the cause of death of a patient would 
not always 
be considered as the main condition.

The main condition is defined as the condition, diagnosed at the end of the episode of health care, 
primarily responsible 
for the patient's need for treatment or investigation. 
See data dictionary main condition definition.

Therefore the primary condition treated during the patient's stay should ALWAYS be in the main position. The cause of death may be added in a subsequent position, if it is not the primary condition.

Comorbidities coding ("Other conditions" coding on SMR01)  
CG21 Nov 07

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 (CG 3 June 99) 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:


‘Measuring potentially avoidable hospital readmissions’, P. Halfon et al. Journal Clinical Epidemiology 55 (02) 573–587
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.
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**Note:**

- The listed diseases and conditions must be recorded in inpatient SMR01 episodes when they are present as comorbidities and where coding space permits.
- 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.
- 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.
- ‘Priority 8’ is the highest priority group, ‘priority 1’ is the lowest.
- 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).
- This list may be augmented in future.
**Dagger and asterisk coding**

In ICD10 there are asterisk codes for which no dagger codes are specified in either the Tabular List or the Index. They can be used only when the clinician has stated a cause and effect relationship between one of these conditions and an underlying cause.

If any of these codes are used to create a dagger and asterisk pair, approval for use of the code pair must be sought from Terminology Services, ISD. This allows ISD to monitor the use of these codes, and also to ensure the SMR data validation will be amended in order to allow the use of the pair.

If you wish to make a dagger and asterisk code pair using one of the unpaired asterisk codes, please contact Terminology Services. The code pair will be discussed with a Consultant in Public Health medicine (CPHM) at ISD and you will be notified when it has been approved for use. There will be a time delay between your request for approval and the validation accepting the pair. You will be notified of the date when the software will be updated to include the pair, and the codes to use in the interim.

**Diseases/diagnoses ‘with’ other conditions**

When allocating codes for diseases occurring with another, care should be taken that the instructions in the index and the tabular are followed correctly.

One of the principles of coding is to use the least number of codes to accurately describe the condition. Often the index will link two conditions together where they co-exist **whether or not the link has been made by the clinician**.

This is shown by the index trail ‘with’.

Patient has laryngitis and flu.

Trail;

- **Laryngitis (acute) (edematous) (subglottic) (suppurative) (ulcerative)** J04.0
  - with
    - - influenza, flu, or grippe (see also Influenza, with, respiratory manifestations) J11.1

Also;

- **Influenza (specific virus not identified)** J11.1
  - with
    - - laryngitis J11.1

This leads the coder to use only J11.1, **not** J04.0 plus J11.1

The Tabular supports this with appropriate exclusions notes at both codes.

Please note this is not the same as when clinicians make the link between two conditions e.g. diabetes and retinopathy. These are recorded as separate conditions unless the clinician states that one condition causes or is due to the other, in which case the index will lead the coder to a Dagger/Asterisk pair through the term **‘in (due to)’**. These two terms are used interchangeably in ICD but for the purposes of ease of understanding, it is preferable to think of it as one condition **due to** the other and only where this is clearly indicated would the Dagger/Asterisk pair be selected.

**Last coding position ICD-10 (update to CG4 Sep 99)**

When submitting clinical codes to ISD, the SMR Datasets only allow for 6 ICD-10 codes. Whilst locally it may be possible to record more than 6, coders must be aware that validation rules are applied to the Main Condition, plus 5 ‘Other Conditions’. This means that certain codes should NEVER be entered in the sixth position:

Any ‘Dagger’ code. These require to be followed directly by an Asterisk code when in ‘Other Conditions’.

Chapter XIX codes, which **must** be followed by a code from Chapter XX.
Past history in a recurrence of the same condition  

CG13 Jan 03

We have been asked whether past history should be coded if a condition, which was thought to be eradicated, recurs (e.g. breast cancer). It was felt that coding past history did not add anything and should be dropped. Analysis is now done on linked files, which means that past history is picked up.

Presumptive diagnoses: Treated as, treated for, treated accordingly  

CG25 Apr 10

Advice has been sought regarding the use of the terms “treated as” “treated for” and “treated accordingly”. The CCRG has decided that in these cases the disease/condition should be coded e.g.

Treated as asthma. Code to asthma.
Treated for swine flu. Code to swine flu.
Influenza A (H1N1), lab results awaited, treated accordingly. Code to Influenza A (H1N1).

Below is the updated table of “Presumptive diagnoses”

<table>
<thead>
<tr>
<th>Term</th>
<th>How to code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible, suspected, query, ?</td>
<td>Code the symptom(s)</td>
</tr>
<tr>
<td>Impression of</td>
<td>Code the symptom(s)</td>
</tr>
<tr>
<td>Suggestive of</td>
<td>Code the symptom(s)</td>
</tr>
<tr>
<td>Probable</td>
<td>Code the condition</td>
</tr>
<tr>
<td>Presumptive</td>
<td>Code the condition</td>
</tr>
<tr>
<td>Consistent with, compatible with, in keeping with</td>
<td>Code the condition</td>
</tr>
<tr>
<td>Likely</td>
<td>Code the condition</td>
</tr>
<tr>
<td>Treated as, for, accordingly</td>
<td>Code the condition</td>
</tr>
</tbody>
</table>

(The original table was published in obsolete standard CG24 Oct 09)

Sequelae Codes  

SCCS2 July 13

Sometimes a condition or disease has been caused by another disease which is no longer present. One is said to be the sequelae (late effect) of the other. For example, deafness may be a sequelae of meningitis; therefore a diagnosis of deafness as a late effect of meningitis would be coded to:

H91.9  Deafness NOS

G09.X  Sequelae of inflammatory diseases of central nervous system

Sequelae codes should never be used in main condition but always as a supplementary code to the current problem.

Any sequelae diagnosis with no further information e.g. ‘Old CVA’, needs to be referred back to the clinician for further information on the current problem.
During SMR01 assessment projects, ISD's Data Quality Assurance team quite frequently encounter examples of test results being coded. A typical case is the coding of a urinary tract infection from a microbiology report indicating that a urine culture was “positive” for a particular organism, despite the absence in the medical record of any clinical statement that the patient was suffering from a UTI. Haematology and biochemistry results and blood pressure measurements are also often coded as established diagnoses.

**As a general rule, coders should not interpret test results or measurements to obtain codable diagnoses.**

Healthcare professionals are responsible for recording the information which documents a patient's health status and treatment during an episode of care. Coders should only work with the information they have provided.

This means that if the clinicians have not recorded firm diagnoses derived from any test results, coders:

- should not interpret “positive cultures” as infections just as “MRSA +ve” is not coded with an infection code, as most coders are already aware. Interpreting results is a clinical decision in which the entire clinical picture must be considered. Despite the ICD-10 index entries for ‘bacteria in blood’ and ‘bacteria in urine’ which lead to infection codes, clinical statements must be paramount and these index entries should not be used by coders to code infections in the absence of a clinical statement that the patient is infected.
- should not code infection simply because a patient is receiving antibiotics.
- should not interpret a particular haemoglobin level as “low” and use that as a lead term to code anaemia.
- should not code anaemia simply because a patient has received a blood transfusion.
- should not interpret a blood pressure measurement as “high” and use that as a lead term to code hypertension.

It is probably sensible coding practice to avoid referring to test results unless prompted to do so by a clinical statement.

**ICD10 contains a number of categories (e.g. R03, R70 – R94) which can be used to record test results and measurements which have been stated by the clinicians to be abnormal.**

Test results may be used to add detail to a stated diagnosis. For example, pathology reports may be used to add detail to the diagnosis ‘Non-Hodgkin lymphoma’ and so obtain a lymphoma code more specific than C85.9. The use of blood or urine culture results may allow more specific coding in patients where infection e.g. sepsis, UTI, is a stated diagnosis. However, it should be understood that not every organism reported to be grown in culture is necessarily harmful to the patient and some may be contaminants. Sepsis is a clinical and not just a laboratory diagnosis and only those organisms stated by the clinician to be causative e.g. E. coli sepsis, should be incorporated into the coding.

**CHI Certain infectious and parasitic diseases**

**Code Z22.5 Carrier of viral hepatitis**, has been removed from ICD-10 V5. Although the following terminology is now clinically inappropriate or ambiguous, the following coding applies when the clinical statements below are supplied. Coders should first seek clarification from the responsible clinician and must only use these codes when no further information is available.

- “Carrier of viral hepatitis” B19.9
- “Carrier of acute viral hepatitis B” B16.9
- “Carrier of chronic viral hepatitis C” B18.2
- “Hepatitis B positive/+ve” B18.1
- “Hepatitis C positive/+ve” B18.2

**ICD-10 Consolidation, June 2017 page 16**
## Conditions caused by an infectious agent

An infectious condition may be identified by a code for the condition followed by a code from the block B95 - B98 to identify the agent or organism causing the condition.

**Example:** Cellulitis caused by streptococcus

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L03.9</td>
<td>Cellulitis, unspecified</td>
</tr>
<tr>
<td>B95.5</td>
<td>Unspecified Streptococcus as the cause of diseases classified to other chapters</td>
</tr>
</tbody>
</table>

**Note:** It is not appropriate to use a code from another block in Chapter I (e.g. A49.1 Streptococcal and enterococcal infection, unspecified site) in this context.

**Example:** Staphylococcus aureus infection of stump

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T87.4</td>
<td>Infection of amputation stump</td>
</tr>
<tr>
<td>B95.6</td>
<td>Staphylococcus aureus as the cause of diseases classified to other chapters</td>
</tr>
<tr>
<td>Y83.5</td>
<td>Amputation of limb(s) as the cause of later complication</td>
</tr>
</tbody>
</table>

**E Coli 0157**

Where E Coli is identified as 0157, this particular strain is enterotoxigenic. Therefore the correct ICD10 code is:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A04.1</td>
<td>Enterotoxigenic Escherichia coli infection</td>
</tr>
</tbody>
</table>

**Helicobacter positive**

A patient who has a helicobacter test which is positive is regarded as having a helicobacter infection. This should be coded to:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A04.8</td>
<td>Other specified bacterial intestinal infections</td>
</tr>
</tbody>
</table>

**Helicobacter infection**

Helicobacter infection will remain as:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A04.8</td>
<td>Other specified bacterial intestinal infections</td>
</tr>
</tbody>
</table>

There is however, a new code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B98.0</td>
<td>Helicobacter pylori [H.pylori] as the cause of diseases classified to other chapters</td>
</tr>
</tbody>
</table>

This is to be used as a secondary code where Helicobacter pylori is associated with another disorder.
ICD-10 Consolidation

HIV disease coding in ICD10

When coding HIV related conditions, dual-coding is the convention, i.e. use a code from the range B20 - B24 followed by a second code to identify the specific condition caused by HIV. However, the clinical data section on SMR01 is limited and a maximum of six diagnoses may be entered. In order to make the best use of the available space, the principle is to use only one HIV code - whichever is most appropriate for the patient's conditions - followed by a list of codes for the specified conditions.

1. Dual coding with codes B20 - B24 is necessary
   a) when HIV disease results in a single condition and extra value and detail are given by using the second code

Example: Oral thrush resulting from HIV disease

B20.4  HIV disease resulting in candidiasis
B37.0  Candidal stomatitis

Note: If the condition or symptom is not covered by a specific HIV code, use B23.8 followed by a code for the condition or symptom.

Example: HIV disease causing nausea and vomiting

B23.8  HIV disease resulting in other specified conditions
R11.X  Nausea and vomiting

b) when HIV disease results in a malignant neoplasm

The neoplasm code must always be recorded (even if it doesn't provide more detail) since this information is required for the analysis of cancer data.

Example: HIV disease resulting in Kaposi sarcoma

B21.0  HIV disease resulting in Kaposi sarcoma
C46.9  Kaposi sarcoma, unspecified

c) when coding multiple HIV related diseases
   i) for multiple infections, use B20.7 (HIV disease resulting in multiple infections) followed by a list of codes for the infections

Example: HIV disease resulting in respiratory tuberculosis and herpes simplex infection

B20.7  HIV disease resulting in multiple infections
A16.9  Respiratory tuberculosis
B00.9  Herpes simplex infection

   ii) for multiple malignant neoplasms, use B21.7 (HIV disease resulting in multiple malignant neoplasms) followed by a list of codes for the neoplasms

Example: HIV disease resulting in Burkitt's lymphoma and malignant neoplasm of oesophagus

B21.7  HIV disease resulting in multiple malignant neoplasms
C83.7  Burkitt lymphoma
C15.9  Malignant neoplasm of oesophagus
iii) for multiple diseases which may include both infections and neoplasms, use B22.7 (HIV resulting in multiple diseases classified elsewhere) followed by a list of codes for the specified diseases

Example: HIV disease with Kaposi sarcoma, anaemia, oral thrush, depression and nausea

B22.7 HIV disease resulting in multiple diseases classified elsewhere
C46.9 Kaposi sarcoma, unspecified
D64.9 Anaemia, unspecified
B37.0 Oral thrush
F32.9 Depression, NOS
R11.X Nausea and vomiting

2. Some codes do not require dual coding as there is no benefit in recording the additional code.

Codes which do not require dual coding are:

B20.6 HIV disease resulting in Pneumocystis carinii pneumonia
B22.1 HIV disease resulting in lymphoid interstitial pneumonitis
B22.2 HIV disease resulting in wasting syndrome
B23.0 Acute HIV infection syndrome
B23.1 HIV disease resulting in (persistent) generalized lymphadenopathy
B24.X Unspecified HIV disease

(Please note B23.1 was added in CQ2 Feb 97)

Human Papillomavirus (HPV) | SCCS2 July 13
---|---
Human papillomaviruses (HPV) can affect the skin and moist membranes which line parts of the body such as the anus, cervix and the lining of the mouth and throat. There are over 100 different strains of HPV which can be transmitted through direct skin contact. The virus can cause warts, verrucas and can develop into cancer of the cervix.

When coding HPV, there is only one trail available:

Papillomavirus, as cause of disease classified elsewhere B97.7

This code can be used where there is another disease classified to an ICD-10 Chapter other than Chapter I - e.g. seborrhoeic verruca due to HPV:

L82.X Seborrhoeic keratosis
B97.7 Papillomavirus as the cause of diseases classified to other chapters

Where the manifestation of HPV is stated to be ‘anogenital warts’ or ‘viral warts’, only the appropriate Chapter I code should be recorded:

A63.0 Anogenital (venereal) warts
or
B07.X Viral warts
However, where the statement is ‘HPV infection’, with no manifestation, coders should record this as:

**B34.4 Papovavirus infection, unspecified site**

As there is no evident index trail to reach this code, coders are advised to write an entry in the index to direct them to **B34.4 Papovavirus infection, unspecified site** when there is only a statement of ‘HPV infection’.

**Cervical Intraepithelial Neoplasia (CIN) III** clinically stated to be ‘HPV+ve’ should be coded

**D06.9 Carcinoma in situ of cervix, unspecified**

**B97.7 Papillomavirus as cause of diseases classified to other chapters**

This follows clinical advice, which regards “CIN III HPV +ve” as a special case. This guidance is in contrast to the usual, current practice when coding other “infectious organism +ve” statements without an explicit statement of causation (see Test results in SMR01 coding CG20 June 07).

### Infections (or carrier status)  
\[ \text{SCCS13 Sep 16} \]

Coders have difficulty when coding certain bacterial/viral infections as to whether they should code to the infection or carrier status. The same expression can lead to different coding for different bacteria e.g. Helicobacter positive indicates a Helicobacter infection whereas MRSA positive would be coded to the carrier status.

Below is a table with some of the more common infections and the expressions coders may be given. Where there are blanks, the expression is not applicable to that infection.

<table>
<thead>
<tr>
<th></th>
<th>+ve</th>
<th>Colonised with</th>
<th>Present in nasal swab</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Carrier Z22.3 (+ U82.1)</td>
<td>Carrier Z22.3 (+ U82.1)</td>
<td>Carrier Z22.3 (+ U82.1)</td>
</tr>
<tr>
<td>Helicobacter</td>
<td>Infection A04.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strep B</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
</tr>
<tr>
<td>Hep B</td>
<td>B18.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep C</td>
<td>B18.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRE</td>
<td>Carrier Z22.3 (+ U83.0)</td>
<td>Carrier Z22.3 (+ U83.0)</td>
<td></td>
</tr>
</tbody>
</table>

Coders should not make any assumptions of the current status of a patient who has had a bacterial infection at some time in the past. Current laboratory reports should always be consulted.

**N.B.Use of codes in categories U82-U85 is optional in Scotland.**

### Measles with Febrile Convulsion  
\[ \text{CG17 Jan 06} \]

In a diagnosis of measles with febrile convolution, is the convulsion considered a complication of the measles and assigned to the subdivision B05.8 or to B05.9 without complication, when the febrile convolution R56.0 would also be recorded?

Answer: convulsion is a symptom not complication of any febrile condition not just measles. Therefore the correct codes and sequence are:

**B05.9 Measles without complication**

**R56.0 Febrile convulsions**
MRSA (Methicillin resistant staphylococcus aureus)  

MRSA infection takes various forms. It is usually found in wound infections, but may be present as sepsis, other generalised infection or a patient may be a carrier of MRSA. These situations are all coded differently, and examples are given below:

1) MRSA infection of surgical wound on abdomen
   - T81.4 Infection following a procedure, not elsewhere classified
   - B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
   - Y83.9 Surgical procedure, unspecified
   - (U82.1 Resistance to methicillin)

2) MRSA infection of traumatic wound
   - T79.3 Post-traumatic wound infection, not elsewhere classified
   - B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
   - X59.9 Unspecified accident
   - (U82.1 Resistance to methicillin)

3) MRSA sepsis
   - A41.0 Sepsis due to Staphylococcus aureus
   - (U82.1 Resistance to methicillin)

4) MRSA infection
   - A49.0 Staphylococcal infection, unspecified
   - (U82.1 Resistance to methicillin)

5) MRSA positive/carrier
   - Z22.3 Carrier of other specified bacterial diseases
   - (U82.1 Resistance to methicillin)

Codes above in brackets () are from Ch XXII – Codes for special purposes. These are optional in Scotland. They do not require to be submitted on SMRs.

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 sepsis
  - (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.
Viral-associated wheeze

A wheeze linked to a virus that has required treatment in its own right, for example with nebulisers or inhalers, can be described in many different ways within the care record. Some examples of clinical terms found in the care record are viral wheeze, viral-induced wheeze, viral-associated wheeze and viral illness with wheeze.

We can advise that where a wheeze is either induced by, caused by or due to a viral infection, the coder must follow the principle for coding symptoms that are important medical problems and sequence the virus in primary position followed by the wheeze:

B34.9 Viral infection, unspecified

R06.2 Wheezing

Zika Virus Infection – SMR01 and SMR02

The following codes and sequencing must be applied when coding confirmed cases of Zika virus infection.

Zika virus infection – SMR01

A92.8 Other specified mosquito-borne viral fevers
U06.9 Emergency use of U06.9

Zika virus infection in pregnancy - SMR02 or antenatal SMR01

O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
A92.8 Other specified mosquito-borne fevers
U06.9 Emergency use of U06.9

The World Health Organisation (WHO) has advised that code U06.9 Emergency use of U06.9, should be assigned for confirmed cases of Zika virus infection to allow tracking of the virus globally. Synonyms of Zika virus infection are Zika, Zika virus fever, Zika virus.

CHII Neoplasms

Anal Intraepithelial Neoplasia (AIN III)

Carcinoma in situ of the anus is often referred to as AIN III or grade 3 anal intraepithelial neoplasia. The correct ICD10 code to assign for this diagnosis is:

D01.3 Carcinoma in situ of anus and anal canal

Where there is a system of grading intraepithelial neoplasia e.g. prostate, cervix, all high grade or grade III descriptions are classified as in situ neoplasms. Grade I and grade II anal intraepithelial neoplasia should be coded to:

K62.8 Other specified diseases of anus and rectum

History of TCC bladder

History of TCC bladder must be coded to either:

Z86.0 Personal History of other neoplasms

or

Z85.5 Personal History of malignant neoplasm of urinary tract

The coding depends on availability of histological information with Z86.0 being the default code if histology is not available.
Intramucosal Carcinoma (of the Gastrointestinal Tract)  CG7 Nov 00

Intramucosal carcinoma is a form of carcinoma in situ as the cancer cells are confined within the lamina propria (intramucosal) with no extension through muscularis mucosae into submucosa.

As there is no clear index trail for this, coders should, in the absence of any other information, code according to site in the neoplasm table, under in situ.

Malignant pleural effusion  CG20 June 07

In coding terms, there are three types of situation where pleural effusion and cancer may occur together.

Pleural effusion due to a primary malignancy of the pleura. (This could be referred to as a malignant pleural effusion.) In this situation the pleural effusion is a direct result of the pleural malignancy. You should code:

C38.4† Malignant neoplasm of pleura

J91.X* Pleural effusion in conditions classified elsewhere

Pleural effusion due to secondary malignancy of the pleura (This could also be referred to as a malignant pleural effusion.) In this case there is a primary malignancy elsewhere which has spread, resulting in secondary tumour in the pleura. The secondary tumour is the cause of the pleural effusion. In some cases the diagnosis of secondary malignancy of the pleura will be stated in the clinical notes. In other cases the diagnosis will indicate a primary tumour (for example of the breast) and a pleural effusion, without mention of any other condition that causes pleural effusion (see below). In these cases it is reasonable to assume that the pleural effusion is a result of secondary spread of the primary tumour, even if the clinician does not specify this. This is reflected in the fact that “malignant pleural effusion” in the ICD10 index goes to C78.2, secondary malignant neoplasm of pleura.

You should code:

(a) the primary malignancy

(b) C78.2† Secondary malignant neoplasm of pleura

(c) J91.X* Pleural effusion in conditions classified elsewhere

Pleural effusion in cancer without mention of malignancy in the pleura but with mention of another condition as the cause of the pleural effusion (see below). This is a pleural effusion in a condition classified elsewhere rather than a malignant pleural effusion.

(a) Code the malignancy (primary and/or secondary)

(b) Code the underlying condition as Dagger code

(c) Code J91.X* Pleural effusion in conditions classified elsewhere

Examples of conditions causing pleural effusion

Pneumonia, tuberculosis, pulmonary infarction, intra-abdominal abscess, cardiac failure, nephrotic syndrome, connective tissue diseases (such as scleroderma, SLE [systemic lupus erythematosus] etc.), thyroid disease, renal failure, liver failure.

Multiple primary neoplasms  SCCS2 July 13

Code C97.X Malignant neoplasms of independent (primary) multiple sites is only to be used to record the phrase ‘multiple primaries’.

Where sites of the primaries are known, these must be coded individually.

Please delete the note at C97 in the Tabular. This is a Scotland/England difference.
Paraneoplastic Syndrome

Paraneoplastic syndrome refers to a large group of signs or symptoms that may occur in a patient with cancer. These conditions are not due to the direct impact of the neoplasm, yet rather due to the production of chemical substances from the cancer cells. Not all cancers cause paraneoplastic syndrome.

- Among the most commonly seen paraneoplastic syndromes are:
  - Blood clot formation in cancer of the pancreas
  - Low sodium level in small cell lung cancer
  - High calcium levels in various cancers
  - Fever
  - Eaton Lambert syndrome
  - Myasthenia gravis due to thymoma
  - Nerve dysfunctions due to various cancers
  - Anaemia

From the above, it is obvious that there can be no single code given out for paraneoplastic syndrome. When coding it is important to find out the nature of the complication and code that. This may give rise to a dagger/asterisk combination or to two separate codes.

**Example 1:** Myasthenia gravis in thymoma would be coded to:

D15.0 D  Benign neoplasm of thymus
G73.2 A  Other myasthenic syndromes in neoplastic disease

**Example 2:** Low sodium level in small cell lung cancer would be coded to:

C34.9  Malignant neoplasm of bronchus or lung, unspecified
E87.1  Sodium deficiency

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**.

Prostatic Intraepithelial Neoplasia, Grade III (PIN III)/ High Grade Glandular Intraepithelial Neoplasia of the Prostate (HGIN)

Carcinoma in situ of the prostate has generally been replaced by the expression ‘high grade intraepithelial neoplasia of the prostate’. The correct ICD10 code to assign for this diagnosis is **D07.5 Carcinoma in situ prostate**.

In cases where there is a system of grading intraepithelial neoplasia (e.g. cervix, vulva and vagina), all high grade or grade III descriptions are classified as in situ neoplasms. Grade I and grade II prostatic intraepithelial neoplasia should be coded to:

N42.3 Dysplasia of prostate (includes Low- grade dysplasia)

This is trailed through the lead term ‘dysplasia’.

Coders should also annotate their Index:

- Neoplasia
  - prostate (PIN) N42.3 (Grade I and II)
There is a great deal of interest in being able to capture information on disease recurrence as an intermediate outcome indicator of cancer. This comes from Scottish Government, the National Cancer Quality Steering Group (a subgroup of the Scottish Cancer Taskforce) and local clinicians. It is particularly relevant to diseases such as breast cancer, which now have relatively high levels of survival, so that it may be necessary to wait for up to ten years after diagnosis to have a meaningful survival outcome. As surgical techniques are modified, local and/or regional recurrence serves as an earlier warning of potentially unfavourable effects of changes in surgical management.

Clinically, recurrences are described as;

- **Local** – essentially at, or closely associated with, the anatomical site of the primary tumour
- **Regional** – this refers to cancer found in the group(s) of lymph nodes draining the primary site
- **Distant** – this refers to metastasis to non-regional lymph nodes and/or to other organs.

However this clinical terminology might not find its way through to coders. For example, regional and distant recurrence might be described as “positive nodes” following biopsy/sampling/excision of a particular lymph node group or as “metastasis” in a particular organ, respectively.

**Coding regional and distant recurrence**

Codes for regional and distant recurrence already exist in ICD10. These are the codes for ‘secondary malignant neoplasm’ in categories C77 – C79. If the coder has been given clear information about regional and/or distant recurrence, however it is phrased, such information should be recorded using codes C77 – C79 according to normal coding rules and standards.

However, these secondary malignant neoplasm codes will not in themselves allow distinction between known metastasis present at the same time as the original primary (which would not be described as recurrence) and regional and distant recurrence which appears only after the primary has been treated. To distinguish these two cases, linked data will be used.

**Local recurrence and ‘recurrent NOS’**

National coding rules state that malignancies described by the clinician as “recurrent” should be coded with the appropriate primary malignancy code. Unfortunately this approach cannot distinguish between the statements ‘local recurrence’ (which has a specific clinical meaning) and ‘recurrent’ (which is non-specific and could mean any or all of local, regional and distant recurrence).
To allow this distinction to be made, Scottish 5th digits should be added to appropriate primary malignancy codes as follows:

<table>
<thead>
<tr>
<th>5th digit</th>
<th>Meaning of 5th digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>‘Local recurrence’, ‘locally recurrent’</td>
</tr>
<tr>
<td>9</td>
<td>‘Recurrent’ NOS</td>
</tr>
</tbody>
</table>

**NOTE** that these 5th digits should be applied **ONLY** to the ICD10 codes for breast cancer, colorectal cancer and melanoma of skin:

- C18.- Malignant Neoplasm of Colon
- C19.X Malignant Neoplasm of Rectosigmoid Junction
- C20.X Malignant Neoplasm of Rectum
- C43.- Malignant Melanoma of Skin
- C50.- Malignant Neoplasm of Breast

For example:

- the statement ‘recurrent rectal cancer’ would be coded as C20.X9
- the statement ‘locally recurrent breast cancer’ would be coded as C50.91

### Secondary Neoplasms or Metastases from Haematological Malignancies [SCCS10 Sep 15]

Codes in the range C77-C79 must never be assigned to indicate a secondary neoplasm due to/from a haematological malignancy (codes in C81-C96).

Diagnostic statements indicating that metastases are the result of a haematological malignancy (e.g. “Lymphoma with bone metastases”) must be referred back to the responsible consultant to clarify that this is spread of the haematological malignancy. If this is confirmed, only the code from C81–C96 is assigned.

Haematological malignancies are systemic diseases and the involvement of additional sites is expected as part of the disease. This process of disease spread in haematological malignancies is not the same as that of solid tumours, and as such the recording of “secondary” or “metastatic” tumours is not appropriate.

### Transitional Cell Carcinoma (papillary) of urinary tract [SCCS13 Sep 16]

There has been difficulty with coding neoplasms of the urinary tract because of the terminology used in pathology reports and discharge documentation.

After discussion with our colleagues in the Scottish Cancer Registry, please adhere to the following standards.
<table>
<thead>
<tr>
<th>Diagnostic term</th>
<th>Pathological Grade/Stage</th>
<th>Site and ICD-10 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(papillary) TCC, primary invasive</td>
<td>pT1 or worse</td>
<td>Bladder: C67._, Ureter: C66.X, Renal pelvis: C65.X, Urethra: C68.0, Other and unspecified urinary organs: C68.1-C68.9</td>
</tr>
<tr>
<td>(papillary) TCC, in situ</td>
<td>pTis</td>
<td>Bladder: D09.0, Ureter: D09.1, Renal pelvis: D09.1, Urethra: D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, G3 high grade non-invasive</td>
<td>G3pTa</td>
<td>Bladder: D09.0, Ureter: D09.1, Renal pelvis: D09.1, Urethra: D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, G2 (low or high grade) non-invasive</td>
<td>G2pTa</td>
<td>Bladder: D09.0, Ureter: D09.1, Renal pelvis: D09.1, Urethra: D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, G1 low grade non-invasive</td>
<td>G1pTa</td>
<td>Bladder: D09.0, Ureter: D09.1, Renal pelvis: D09.1, Urethra: D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, G1 (low grade not mentioned) non-invasive</td>
<td>G1pTa</td>
<td>Bladder: D41.4, Ureter: D41.2, Renal pelvis: D41.1, Urethra: D41.3, Other and unspecified urinary organs: D41.7 or D41.9 as appropriate</td>
</tr>
<tr>
<td>(papillary) TCC, NOS*</td>
<td>Not known</td>
<td>Bladder: D41.4, Ureter: D41.2, Renal pelvis: D41.1, Urethra: D41.3, Other and unspecified urinary organs: D41.7 or D41.9 as appropriate</td>
</tr>
</tbody>
</table>

*Not otherwise specified and no further information obtainable. **When given statements such as TCC bladder or cancer bladder, coders should first seek clarification from the clinician.**

**Please note** that Transitional cell carcinomas of the kidney are most likely to have arisen in the renal pelvis and should be recorded with the appropriate ICD10 neoplasm code for renal pelvis. See table above. If there is specific evidence to show that the transitional cell carcinoma arose in any other part of the kidney then code accordingly although this is unlikely.
CHIII Diseases of the blood

## Anaemia due to neoplasm or lymphomas

**CG9 July 01**

When a patient is admitted for treatment of anaemia due to a neoplasm and the neoplasm is an ongoing condition, it is recorded with a dagger code to identify the neoplasm followed by D63.0A to identify the anaemia.

**However, if the anaemia is a normal manifestation of a neoplastic disease, e.g. leukaemia, myeloma or myelodysplasia, only one code to identify the neoplasm should be recorded.**

Coders have asked if this also applies to lymphomas e.g. Non-Hodgkin. The decision is that for lymphomas the anaemia should be added following the dagger/asterisk principle outlined above.

---

## Factor V Leiden

**SCCS3 Sep 13**

Factor V Leiden is the name of a specific gene mutation that results in thrombophilia which is an increased tendency to form abnormal blood clots that can block blood vessels. This is often incorrectly referred to as ‘Factor V Leiden deficiency’.

ICD-10 V4 (2010 Edition) introduced a new code which covers this disorder:

### D68.5 Primary thrombophilia

An inclusion term in the Tabular is: Activated protein C resistance [factor V Leiden mutation]

The only way this can be accessed through the index is via the term ‘mutation’:

- **Mutation**
  - prothrombin gene (factor V Leiden mutation) D68.5

Coders should insert an entry for this disorder under ‘Leiden’ to help assign the correct code.

---

## Raised INR

**CG16 Aug 05**

Patients are treated with anti-coagulant therapy (such as Warfarin) because they have a condition (such as atrial fibrillation) which increases the risk of their blood clotting. However, anti-coagulant therapy also increases the risk of adverse effects such as haemorrhaging due to the increased clotting time of their blood. Therefore the clinician in charge of the patient’s care must continually evaluate the patient’s response to the anticoagulants.

The traditional method of evaluating the effectiveness of the anticoagulant therapy is to measure the prothrombin time (PT) using a simple blood test. This measurement is then transformed for comparability purposes into the International Normalised Ratio (the INR). It is important to note that INR is not in itself a diagnosis - it is a mathematical calculation that corrects the variability of the PT results.

Any INR above the ideal (therapeutic) range increases the risk of haemorrhage i.e. the higher the INR, the greater the risk of bleeding. (INR results below the therapeutic range can indicate that the dose is not sufficient.)

**How to code:**

It is important to code the condition for which the patient is taking the Warfarin such as atrial fibrillation (AF).

Raised INR can be coded with the ICD10 code: R79.8 Other specified abnormal findings of blood chemistry but should only be recorded if it is specifically mentioned on the discharge summary.
Code Z92.1 Personal history of long-term (current) use of anticoagulants could be added if appropriate.

The coder should not assign the code D68.3 Haemorrhagic disorder due to circulating anticoagulants (with appropriate external cause code) unless the clinician has made a corresponding clinical statement. If in doubt, always seek clarification from the responsible clinician.

It is the responsibility of each hospital to ensure their clinicians are aware of the need to provide more specific diagnostic statements other than ‘raised INR’. Coding awareness sessions to clinical staff should be given on a regular basis and examples such as ‘raised INR’ could be used.

CHIV Endocrine, nutritional and metabolic diseases

### Cystic Fibrosis with Manifestations  
**SCCS10 Sep 15**

When cystic fibrosis is documented with a manifestation(s), an additional code or codes identifying the manifestation(s) must be assigned immediately after a code from category E84.- Cystic fibrosis, where doing so adds further information about the specific manifestation(s).

Multiple codes from category E84 must be used where multiple manifestations are present.

**Example 1:** Cystic fibrosis related pseudomonas aeruginosa lower respiratory tract infection

- E84.0 Cystic fibrosis with pulmonary manifestations
- B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters

**Example 2:** Cystic fibrosis related meconium ileus, cirrhosis of the liver, chronic pancreatitis and osteopenia

- E84.1† Cystic fibrosis with intestinal manifestations
- E84.8 Cystic fibrosis with other manifestations
- K74.6 Other and unspecified cirrhosis of liver
- K86.1 Other chronic pancreatitis
- M85.8 Other specified disorders of bone density and structure

### Hyperglycaemic hyperosmolar state (HHS)/Hyperosmolar nonketotic state (HONK) in diabetes mellitus  
**SCCS14 Apr 17**

HHS is a rare but potentially fatal complication of diabetes mellitus, also known by the acronym HONK (Hyperosmolar nonketotic state). Patients with diabetes who are diagnosed with (HHS), must be coded using the following ICD-10 codes and sequencing:

In patients with HHS with coma:

A code from categories E10-E14 with a fourth character .0 with coma

- E87.0 Hyperosmolality and hypernatraemia

In patients with HHS without coma:

A code from categories E10-E14 with a fourth character .6 with other specified complications

- E87.0 Hyperosmolality and hypernatraemia

**Example 1:** Patient with Type 2 diabetes is admitted to hospital and found to be unresponsive to stimuli; the patient is diagnosed with a hyperglycaemic hyperosmolar coma.

- E11.0 Type 2 diabetes mellitus, with coma
- E87.0 Hyperosmolality and hypernatraemia
Example 2: Patient admitted due to drowsiness; the patient has Type 2 diabetes. The patient is diagnosed with hyperglycaemic hyperosmolar state.

- **E11.6  Type 2 diabetes mellitus, with other specified complications**
- **E87.0  Hyperosmolality and hypernatraemia**

### MCAD deficiency

MCAD deficiency refers to Medium Chain Acyl CoA Dehydrogenase Deficiency. It is a disorder of fatty acid oxidation. Index entry:

- **Disorder**
  - fatty acid metabolism E71.3

The correct code assignment is **E71.3 Disorders of fatty-acid metabolism**.

### Patient with Type 2 diabetes treated with Insulin (update to CG9 July 01)

It has come to our attention that there are differences in the way sites are coding patients with Type 2 diabetes who are treated with insulin. If a patient with Type 2 diabetes is started on treatment with insulin injections this does not mean that they have Type 1 diabetes (the condition that used to be called insulin dependent diabetes mellitus). They are a patient with Type 2 diabetes on insulin treatment and should continue to be coded to E11.-.

### Uncontrolled Diabetes

Hyperglycaemia is a recognized sign/symptom of diabetes and if present the diabetes is considered to be out of control. Patients are occasionally admitted for stabilization. This is not a complication of diabetes as understood within the axis of the classification for this disease and should therefore be coded with the fourth character subdivision .9.

### CHV Mental and behavioural disorders

#### Alcohol Excess

The phrase “alcohol excess” is often used in medical notes, frequently with no further information regarding the patient’s condition. “Alcohol excess” implies that someone has had too much to drink, but not necessarily that they are an alcoholic and to this end coders must use:

- **F10.0  Mental and behavioural disorders due to use of alcohol, acute intoxication**

Clinicians would need to state clearly in the notes that a patient was demonstrating harmful use or dependence before any other code is used.

The trail that coders must follow when coding “alcohol excess” with no other information is as follows:

- **Excess, excessive, excessively**
  - alcohol level in blood R78.0
  - drinking (alcohol) NEC F10.0
  - habitual (continual) F10.2

The code for “excess alcohol not otherwise specified” would therefore be F10.0 Acute intoxication due to use of alcohol. If mentioned in relation to repeated events that are described as continual, habitual, addicted or chronic then the coder should be using **F10.2 Dependence syndrome due to use of alcohol**.

Where the alcohol excess has a further descriptor – for example “abuse” then the coder should take that into account when selecting the correct code. For example, if the patient is brought in with alcohol excess and the doctor notes that the patient is abusing alcohol then the coder should record both F10.0 and F10.1.
Alcohol-related conditions

A patient is admitted to hospital in a state of drunkenness. This may be following an accident, he/she may have been found unconscious and brought in by the police or another person, or the patient may be a child or adolescent found drunk and admitted for observation. These situations should be coded as follows:

1) A child/adolescent has been found drunk, brought in to A&E then admitted for observation overnight

   F10.0   Mental and behavioural disorders due to use of alcohol, acute intoxication
   Z03.6   Observation for suspected toxic effect from ingested substance

2) Patient admitted with a head injury - drunk

   S09.9   Unspecified injury of head
   X59.9   Unspecified accident
   F10.0   Mental and behavioural disorders due to use of alcohol, acute intoxication

3) Patient admitted with a head injury - smelling of alcohol

   S09.9   Unspecified injury of head
   X59.9   Unspecified accident
   Y91.9   Alcohol involvement, not otherwise specified

Chronic schizophrenia

It should be noted that when trying to code ‘Chronic Schizophrenia’ the coder is led to:

   Schizophrenia
   - chronic undifferentiated F20.5

It has been agreed that the preferred code for ‘Chronic Schizophrenia’ is F20.5 and an index change has been requested.

Current Smoker/Current Heavy Smoker Advised to Give Up

If a patient is described as a current smoker code to F17.1

If a patient is described as a current heavy smoker code to F17.1

If a patient is described as a current heavy smoker and has been advised by a clinician to give up smoking, code to F17.1.

If a patient is described as a current heavy smoker and has been advised by a clinician to give up smoking because it will have an adverse effect on their medical condition, code to F17.1.

For further information on this see standard Heavy Drinkers CG6 June 00.

E-cigarettes

It is not clear what the clinical risks associated with the use of electronic cigarettes are or which substances contained within an e-cigarette may cause damage to its user. There is also no specific code within ICD-10 which classifies the use of e-cigarettes. As a consequence, their use should not be coded using the ICD-10 classification.
**Ex-smoker**

<table>
<thead>
<tr>
<th>CG23 Sep 08</th>
</tr>
</thead>
</table>

It has been decided by the Clinical Coding Review Group that **there is no suitable code in ICD10 for the term ex-smoker** and there is therefore no need for this to be recorded on national returns.

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**F19.- Multiple Identified Psychoactive Substances**

<table>
<thead>
<tr>
<th>CG16 Aug 05</th>
</tr>
</thead>
</table>

Mental and behavioural disorders due to psychoactive substances are coded in the block F10 to F19.

In cases where two or more identified psychoactive substances are the cause of such disorders, coders must whenever possible use specific codes from F10 to F18 for each substance in preference to the “multiple” category F19.

It is recognised that coders may not always be able to do this. In some cases, the application of coding rules and guidelines may result in other diagnostic codes occupying the available code positions in preference to the selected F10.- to F18.- codes. If only one code position is available, it may be necessary to use F19.-. However, the overall intention of coders should be to code these disorders as specifically as possible.

---

**Heavy Drinkers**

| CG6 June 00 |

The training manual contains guidance on the difference between categories

F10  Mental and behavioural disorders due to use of alcohol

and

Z72  Problems related to lifestyle

F10  Mental and behavioural disorders due to use of alcohol

In order to assign a code from category F10, a clinical decision is required when patients are described as heavy drinkers.

If the patient has been advised by the clinician to stop drinking because it will have an adverse effect on their medical condition or the clinician states the patient is dependent upon alcohol then a code from this category should be selected.

Z72  Problems related to lifestyle

If it is noted in the medical record that the patient is a heavy drinker with no other reference to medical condition then a code should be selected from Z72.

If it is unclear in the medical record, clinical input is required.

For further information on smoking see coding standard *Heavy/Current smokers CG23 Sep 08*.

---

**Learning Disability**

| CG6 June 00 |

The use of codes in categories F80 to F89 - Disorders of Psychological development, needs to be carefully applied in cases where a patient is over the age of 15, as this will generate a validation query. For example, the coder needs to be certain if given the phrase ‘learning disability’ that the patient has no underlying cause for this e.g. mental retardation, low IQ. This must be done by checking the patient's case notes thoroughly and discussing with the clinician for further guidance if necessary.

---

**Low Mood**

| SCCS14 Apr 17 |

The clinical statement “low mood” with no other information should be coded as:

F39.X  Unspecified mood [affective] disorder

If the low mood is described as being recurrent then it should be coded as:

F38.1  Other recurrent mood [affective] disorders
If the low mood is described as being persistent then it should be coded as:

**F34.9 Persistent mood [affective] disorder, unspecified**

---

**Methadone Programme**

CG19 Sep 06

Coders should note that if a patient is said to be on a methadone programme, this means they are dependent on opiates and a code of **F11.2 Mental and behavioural disorders due to use of opioids (dependence syndrome)** should be used.

---

**Mixed dementia or mixed vascular and Alzheimer dementia**

SCCS14 Apr 17

The following codes must be used for diagnoses of ‘mixed dementia’ or ‘mixed vascular and Alzheimer dementia’:

- **G30.8† Other Alzheimer disease**
- **F00.2* Dementia in Alzheimer disease, atypical or mixed type (G30.8†)**

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**Patient who takes overdose transferred to psychiatric hospital**

CQ3 May 97

A patient with depression attempts suicide by taking an overdose of paracetamol and is admitted to an acute hospital for treatment. After this they are transferred to a psychiatric hospital for treatment of the depression. How should this episode be coded in the psychiatric hospital?

SMR04

On admission - Code depression

- **F32.9 Depression NOS**
  - followed by suicide attempt
- **T39.1 Poisoning by 4-aminophenol derivatives**
- **X60.9 Intentional self poisoning by....nonopioid analgesics..**

On discharge - Code depression

- **F32.9 Depression NOS**
  - followed by personal history of self-harm
- **Z91.5 Personal history of self-harm**

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**Seasonal Affective Disorder (SAD)**

CG6 June 00

Confirmation has been sought on a number of occasions on the correct coding of the above disorder. Following discussion at the Clinical Coding Review Group it was agreed that this disorder should be coded to:

- **F33.- Recurrent depressive disorder**
  - with allocation of the appropriate 4th digit (default F33.9 when no further clinical information is available).

---

**Suicidal Ideation (SMR04)**

SCCS14 Apr 17

When a patient is admitted to a mental health facility (SMR04) with suicidal intention/ideation this information should be recorded in **BOTH** the admission **AND** the discharge diagnosis sections using the code **R45.8 Other symptoms and signs involving emotional state (includes suicidal ideation/tendencies)**.

Previously this code has been recorded in the admission diagnoses when appropriate, but then has been omitted from the discharge diagnoses. Clinical advice is now that this should also be recorded in the discharge diagnosis of SMR04 following any confirmed psychiatric diagnoses.
Toxic Confusional State

Following a decision by the Coding Review Panel (UK) it has been agreed that the ICD10 code for Toxic Confusional State (WHEN NO FURTHER INFORMATION IS AVAILABLE) is:

F05.9  Delirium, unspecified

CHVI Diseases of the nervous system

Pineal Cyst

It has been decided that the best code for Pineal Cyst is:

G93.0  Cerebral cysts
(Also indexed as Cyst, brain (acquired) or Cyst, intracranial)

CHVII Diseases of the eye and adnexa

Juvenile/Senile Cataracts

Clarification has been requested regarding the coding of cataracts, specifically ‘Juvenile’ and ‘Senile’ cataracts.

ICD10 Index indicates as follows:

- Cataract
  - Juvenile H26.0
  - Senile H25.9

- Cataract (unspecified) H26.9

ICD10 Tabular describes:

- H26.0  Infantile, juvenile and presenile cataract
- H25.9  Senile cataract, unspecified
- H26.9  Cataract, unspecified

Therefore ‘Juvenile’ and ‘Senile’ are essential modifiers. Cataracts should be coded according to the clinical statement. Please do not apply codes depending on the ‘age’ of the patient.

Posterior capsular opacification (after-ataract)

Posterior capsular opacification (also called after-ataract) 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-ataract

CHIX Diseases of the circulatory system

Angina with Ischaemic Heart Disease

If a patient has Angina and Ischaemic heart disease, both should be coded.
Arterial disease  
**CQ2 Feb 97**

Diagnosis of “rest pain”, “ischaemic leg” and “ischaemic leg ulcer” all indicate that the patient has peripheral vascular disease (PVD).

Code to I73.9 (PVD) with an additional code for the leg ulcer where applicable.

Cardiac Arrest  
**CG12 Sep 02**

If clinicians wish to record cardiac arrest, I46.0 should be used where an arrest took place and the patient was resuscitated. I46.1 should only be used where there was ‘sudden cardiac death’ recorded, and I46.9 may be used in those instances where the term ‘cardiac arrest’ was used but no further information is given.

Chronic ischaemic heart disease and triple vessel disease  
**CG16 Aug 05**

We have been asked if it is necessary to code both triple vessel disease and chronic ischaemic heart disease if both are mentioned in the diagnoses.

Since Triple vessel disease (I25.1) is a form of Chronic Ischaemic heart disease (I25.-) clinicians at ISD have decided that there is no need to record both and only the more specific code (triple vessel disease) should be recorded.

**Example:** Patient in for coronary artery bypass graft.

Listed as having triple vessel disease, angina, ischaemic heart disease and previous MI.

Code to:  
- I25.1 Triple vessel disease
- I20.9 Angina pectoris, unspecified
- I25.2 Old myocardial infarction

Deep Vein Thrombosis (DVT) caused by travel  
**CG9 July 01**

National advice has been issued for ‘DVT caused by travel’.

This should be coded to:

- I80.2 Deep vein thrombosis NOS
- X51.- Travel and motion

Heart failure coding – fifth digits and clinical outcomes  
**SCCS3 Sep 13**

The **Scottish Patient Safety Programme** and **Health Improvement Scotland** have been working with **NHS boards** to implement a Heart Failure Care Bundle (a set of recommended clinical practices aimed at improving acute care outcomes for heart failure patients). Coded SMR01 data can play a valuable part in measuring some of these outcomes. However to do this the data must capture information about heart failure which cannot be captured using ICD10 codes alone. This guideline describes the extra information required, and shows how to code it.

1. **What extra information is required?**

Patients with a diagnosis of heart failure can be broadly divided into two groups:

- those who have a **reduced left ventricular ejection fraction**
- those who have a **preserved ejection fraction** i.e. the left ventricular (LV) ejection fraction is within normal limits.
It is this information about the LV ejection fraction which must be captured. This will be done by adding a Scottish fifth digit to certain relevant ICD10 codes. The fifth digits are:

**Table 1**

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Description of LV function</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Reduced Ejection Fraction</td>
</tr>
<tr>
<td>1</td>
<td>Preserved Ejection Fraction</td>
</tr>
<tr>
<td>9</td>
<td>No information on ejection fraction</td>
</tr>
</tbody>
</table>

Note that it is important to record cases where there is no information about LV function available to coders. These should be recorded with fifth digit 9.

**2 Which diagnoses require the fifth digit?**

The fifth digit must be recorded in cases with a **stated diagnosis** of heart failure or certain types of cardiomyopathy. The diagnosis codes requiring the 5th digit are:

**Table 2**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with (congestive) heart failure</td>
</tr>
<tr>
<td>I13.0</td>
<td>Hypertensive heart and renal disease with (congestive) heart failure</td>
</tr>
<tr>
<td>I13.2</td>
<td>Hypertensive heart and renal disease with both (congestive) heart failure and renal failure</td>
</tr>
<tr>
<td>I25.5</td>
<td>Ischaemic cardiomyopathy</td>
</tr>
<tr>
<td>I42.0</td>
<td>Dilated cardiomyopathy</td>
</tr>
<tr>
<td>I42.9</td>
<td>Cardiomyopathy, unspecified</td>
</tr>
<tr>
<td>I50.0</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>I50.1</td>
<td>Left ventricular failure</td>
</tr>
<tr>
<td>I50.9</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>

Doctors recording such diagnoses will often (not always) include information describing LV ejection fraction. This information (or the lack of it) should ALWAYS be recorded by using the appropriate fifth digit from Table 1 with any of the ICD10 codes in Table 2.

To use the fifth digits:

- firstly, code stated diagnoses of heart failure or cardiomyopathy according to normal ICD10 rules and coding standards
- then, if the resulting ICD10 code appears in Table 2, add the appropriate fifth digit from Table 1
- note that Table 2 does not include all possible ICD10 codes for heart failure or cardiomyopathy. The fifth digits should only be used with the codes in the table.
3 Clinical language describing LV function

Unfortunately the clinical language used to describe LV function is not standardised to ‘reduced ejection fraction’ or ‘preserved ejection fraction’. This makes the coder’s job more difficult. Doctors may use other terms instead of, or as well as, these phrases. These other terms are listed below:

Reduced Ejection Fraction – other terms

For coding purposes any of the following descriptions should be regarded as being synonymous with ‘reduced ejection fraction’:

**Left ventricular**
- dysfunction
- systolic dysfunction (LVSD)
- systolic impairment

**Impaired or reduced**
- LV function
- LV systolic function
- systolic function

Preserved Ejection Fraction – other terms

For coding purposes any of the following descriptions should be regarded as being synonymous with ‘preserved ejection fraction’:

**Preserved**
- LV function
- systolic function

**Normal**
- ejection fraction
- LV function
- systolic function

Note that ‘Diastolic heart failure’ is heart failure with preserved ejection fraction.

4 Clinical statements describing LV function WITHOUT a stated diagnosis of heart failure or cardiomyopathy

If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described by the clinician as having a ‘reduced ejection fraction’ (or a synonymous phrase listed above), the reduced ejection fraction (or synonym) should be recorded by adding **fifth digit 0** to the following R code:

R93.1 Abnormal findings on diagnostic imaging of heart and coronary circulation

e.g. clinical statements of ‘left ventricular systolic dysfunction (LVSD)’ or ‘reduced ejection fraction’ (where there is no stated diagnosis of failure or cardiomyopathy) would be coded as R93.10.

If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described as having a ‘preserved ejection fraction’ (or a synonymous phrase listed above), NOTHING need be recorded.

5 Abbreviations which may be encountered

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFREF</td>
<td>Heart Failure with reduced ejection fraction</td>
<td>I50.90</td>
</tr>
<tr>
<td>HFPEF</td>
<td>Heart Failure with preserved ejection fraction</td>
<td>I50.91</td>
</tr>
<tr>
<td>HFPSF</td>
<td>Heart Failure with preserved systolic function</td>
<td>I50.91</td>
</tr>
<tr>
<td>LVREF</td>
<td>Left ventricular reduced ejection fraction</td>
<td>R93.10</td>
</tr>
<tr>
<td></td>
<td>(if no failure/cardiomyopathy stated)</td>
<td></td>
</tr>
<tr>
<td>LVSD</td>
<td>Left ventricular systolic dysfunction</td>
<td>R93.10</td>
</tr>
<tr>
<td></td>
<td>(if no failure/cardiomyopathy stated)</td>
<td></td>
</tr>
</tbody>
</table>
6 Obsolete coding guidance

CG2 Jan 99 ‘Left Ventricular Dysfunction’ stated “left ventricular dysfunction should be coded to I50.1 Left ventricular failure”. This 1999 guidance is now completely superseded by the present standard.

This means that the phrase ‘left ventricular dysfunction’ used in isolation without a stated diagnosis of heart failure or cardiomyopathy should NOT be coded to I50.1. Instead it should be coded to R93.10 (see 4).

The phrase ‘left ventricular dysfunction’ used with a stated diagnosis of heart failure or cardiomyopathy should be coded by adding the fifth digit 0 to the appropriate ICD10 code for the stated diagnosis.

a Health Improvement Scotland Heart Disease Service Review 2011

b The contraction (systole) of a filled ventricle does not expel all of the blood it contains. The ejection fraction is a measure of the proportion of the blood which is actually expelled from the ventricle.

Lymphoedema Following a Lumpectomy or Quadrantectomy  CG11 Apr 02

When lymphoedema occurs following excision of any amount of the breast (mastectomy, quadrantectomy, lumpectomy etc.) and the link has been established between the surgery and the lymphoedema, the coder must follow the trail:

Lymphedema
- postmastectomy I97.2

and use I97.2 Postmastectomy lymphoedema syndrome as this code most accurately reflects the clinical situation.

Mixed Arterial and Venous Ulcer of Lower Leg  CG8 Feb 01

Please note that the following two codes should be used to reflect this condition:

I73.9 Peripheral vascular disease, unspecified with
I83.0 Varicose veins of lower extremities with ulcer

Venous ulcer of lower limb is synonymous with varicose ulcer.

Myocardial Infarction and Unstable Angina – STEMI & NSTEMI 5th Digits  SCCS14 Apr 17

In June 2007 ISD published a guideline on ‘Coding the Acute Coronary Syndromes Using ICD10’ (CG20 June 07) 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. NSTEMI is index-trailed and included in I21.4 Acute subendocardial myocardial
infarction, but in Scotland this index trail and inclusion should be ignored (see SCCS 11 March 2016 ‘Recording of NSTEMI’) and NSTEMI should be recording as instructed here.

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 categories I21 Acute myocardial infarction and I22 Subsequent myocardial infarction.

Coders should add a fifth digit from Table 1 whenever they use codes from categories 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.

(NO NOTE that the essential modifier ‘transmural’ which is found in the index trail 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 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. Acute Coronary Syndrome

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 I24.9 Acute ischaemic heart disease, unspecified.
### Recording of NSTEMI

ICD10 V5 contains the following index trails and inclusion note:

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- non-ST elevation (NSTEMI) I21.4
- non-ST elevation (NSTEMI) I21.4

**I21.4 Acute subendocardial myocardial infarction**
Myocardial infarction with non-ST elevation

**These index trails and inclusion should be ignored by Scottish coders.**

Please continue to record both NSTEMI and STEMI using I21–I22 with added 5th digits according to the standard **Myocardial infarction and unstable angina.**

It may be helpful to cross out the above index trails and inclusion in your V5 books.

### Old Myocardial Infarction

It has been decided that if old MI is listed in the clinical statement then it should be coded in addition to any ischaemic heart disease, as this gives a fuller picture.

**Chronic Coronary Insufficiency; Old Myocardial Infarction**

The correct codes are **I25.8** and **I25.2**.

### Old stroke

The index entry for old stroke may be misleading. The trail:

**Accident**
- cerebrovascular
- old I69.4

This leads the coder to a sequelae code. While this is the correct code if late effects of a stroke have been mentioned e.g. hemiplegia, sequelae codes have an implied connection to the preceding code(s) and so should not be used in isolation. It may be more appropriate to use a history code.

**Examples:**

1. Hemiplegia due to stroke 2 years ago. Code to:

   **G81.9 Hemiplegia, unspecified**

2. Myocardial infarction. Stroke 2 years ago. Code to:

   **I21.99 Acute myocardial infarction, unspecified**

   **Z86.7 Personal history of diseases of the circulatory system**

There also appears to be a common misconception that a previous disease must have happened over a year ago for a current condition to be a sequela of it. This is not the case. Volume 2 states:

“Note it is sufficient that the causal condition is described as ‘old’, ‘no longer present’ etc. or the resulting condition is described as ‘late effect of…’ or ‘sequela of…’ for this to apply. **There is no minimum time interval.**"
Small Vessel Disease and Lacunar Infarcts

These terms, describing a manifestation of cerebrovascular disease, may be encountered together or separately in radiology reports or discharge summaries for patients who have had a CT/MRI of the brain.

Without any further clinical information the terms represent ‘abnormal findings’ only, and if necessary may be coded to:

R90.8 Other abnormal findings on diagnostic imaging of central nervous system

If the small vessel disease / lacunar infarcts are stated to be the cause of subsequent conditions (sequelae), the normal rules for sequelae coding should be followed. The code(s) for the subsequent condition(s) e.g. hemiparesis, should be followed by

I69.3 Sequelae of cerebral infarction

A code from I63 Cerebral infarction should only be used for lacunar infarction if it is clear from the available clinical information that the infarction is current.

Stroke with Hemiplegia, Dysphagia and Dysphasia

On emergency admission for strokes, the code for stroke must be assigned in the primary position.

As indicated by the note at category G81; Hemiplegia (G81) when due to stroke that is currently being treated, must be coded in a secondary position to the stroke.

Symptoms of stroke such as dysphagia and dysphasia that are classified in chapter XVIII, must only be coded when they have been treated as a problem in their own right, in a secondary position.

On further admissions following treatment of the stroke if the hemiplegia is still present it will be appropriate to record the hemiplegia as a sequela (late effect) of a stroke. Other conditions occurring as a result of a stroke, such as dysphagia and dysphasia, must be treated in the same way.

Triple Vessel Disease

In the past, advice may have been given to individual sites to code Triple Vessel Disease to I25.0 Atherosclerotic cardiovascular disease, so described. This has been checked at national level and all sites should be aware that the correct code for this disease is:

I25.1 Atherosclerotic heart disease

Type 2 Myocardial Infarction

Coders are likely to come across the term “Type 2 myocardial infarction”. This must be coded to I24.8 Other forms of acute ischaemic heart disease. Conditions linked to ‘Type 2 myocardial infarction’ should be coded in addition to I24.8, as documented in Comorbidities Coding (“Other conditions” coding on SMR01) CG21 Nov 07.

CHX Diseases of the respiratory system

Acute Asthma

Please note that Acute Asthma without further specification is coded to J45.9. The code J46.X is Status asthmaticus or Acute severe asthma. The word ‘severe’ is an essential modifier.
The Coding Review Panel (CRP) have agreed the tabular ‘excludes’ entry at -

**J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection** is misleading and should include an exclusion of pneumonia as that is the same block as influenza (J10 - J18 Influenza and Pneumonia).

The recommendation is that both pneumonia with COAD and influenza with COAD are **dual coded** with the pneumonia or influenza sequenced in the primary position.
Coding of COPD/COAD and associated conditions

In CG22 Mar 08, 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. The following new entries have been added to this table:

Infective exacerbation of asthma, patient known COAD/COAD is coded to J45.9 + J22.X + J44.9 or J46.X + J22.X + J44.9

COPD/COAD with basal pneumonia is coded to J18.1 + J44.0

Infective exacerbation of COPD/COAD is coded to J44.0

The table is reprinted below with the new entry.

<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/COAD with basal pneumonia</td>
<td>J18.1 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</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/</td>
<td>J45.9 + J22.X + J44.9 or J46.X + J22.X + J44.9</td>
</tr>
<tr>
<td>COPD</td>
<td></td>
</tr>
<tr>
<td>Infective exacerbation of COPD/COAD</td>
<td>J44.0</td>
</tr>
</tbody>
</table>
**Influenza A (H1N1) [Swine Flu]**  
SCCS11 Mar 16

The appropriate code assignment for this disease, where no manifestations have been identified, is:

**J10.1 Influenza with other respiratory manifestations, seasonal influenza virus identified**

This code is arrived at by use of the alphabetical index and the full four step coding process:

Swine flu  
Index trail for Influenza:  
*Influenza (specific virus not identified) J11.1*  
- seasonal virus identified J10.1

Tabular List entry:

**J10.1 Influenza with other respiratory manifestations, seasonal influenza virus identified**

The correct code to assign is J10.1.

If other specific manifestations of the influenza are identified, another 4th digit subcategory from J10.- may be more appropriate.

**Recurrent Tonsillitis**  
CQ2 Feb 97

Following discussion at CCRG the decision was taken that the index is correct and recurrent tonsillitis should be coded to:

**J03.9 Acute tonsillitis, unspecified**

Index trail:  
*Recurrent see condition*  
*Tonsillitis (acute)........J03.9*

**Respiratory failure**  
SCCS11 Mar 16

Respiratory failure (J96.-) often occurs with or as a symptom of other respiratory disorders, such as asthma, emphysema, COPD (chronic obstructive pulmonary disease), fibrosing alveolitis and so on.

If the clinician has stated that respiratory failure is present then it must be recorded by the coder. When documented with another respiratory condition, the sequencing will depend on the main condition being treated.

Please note that the 5th character subdivisions used with this category must always be assigned:

0 Type I [hypoxic]  
1 Type II [hypercapnic]  
9 Type unspecified

**CH1XI Diseases of the digestive system**

**Barrett's Oesophagus**  
SCCS2 July 13

Barrett's oesophagus now has the following index entry and code

Barrett's  
- disease K22.7  
- esophagus K22.7  
- ulcer K22.1

**Barrett's ulcer** will require two codes; **K22.1 Ulcer of oesophagus** and **K22.7 Barrett oesophagus**. This will differentiate between ulcers other than Barrett’s included at K22.1.

This is a Scotland/England difference.
Bile reflux into the Stomach and Biliary Gastritis (update to CG19 Sep 06)  
SCCS14 Apr 17

The terms bile reflux or biliary gastritis may sometimes be used to describe endoscopic findings in the stomach. They refer to the reflux of bile into the stomach, either from the duodenum or from an anastomosis such as a gastrojejunostomy, and its effects. Bile reflux and biliary gastritis both have index trails which lead to **K29.6**.

In a patient where there is no clinical statement that gastro-oesophageal reflux (GORD) is also occurring e.g. the endoscopy report clearly states that the oesophagus is normal, both bile reflux and biliary gastritis may be coded to:

**K29.6  Other gastritis**

However if bile reflux or biliary gastritis is noted in a patient stated to have GORD there is no need to use the code **K29.6**. Instead **K21.- gastro-oesophageal reflux disease** will cover these circumstances.

Eosinophilic Colitis  
SCCS2 July 13

It is difficult to access Eosinophilic Colitis via the ICD10 index. See below:

- Colitis (acute) (catarrhal) (hemorrhagic) *(see also Enteritis)* A09.9
- At Enteritis there is no reference to ‘eosinophilic’
- Eosinophilic gastritis is listed under **Gastroenteritis** - eosinophilic at K52.8

In order to reach Eosinophilic Colitis the coder should look up:

**Gastroenteritis**  
- eosinophilic K52.8

**K52.8** in the Tabular states **Other specified noninfective gastroenteritis and colitis** and there is an inclusion for ‘Eosinophilic gastritis or gastroenteritis’.

Haemorrhoids and perianal venous thrombosis (K64)  
SCCS11 Mar 16

When more than one degree of haemorrhoid is documented in the medical record, only the code for the highest degree must be assigned.

Where patients have a condition classified to codes **K64.0-K64.3** and also a condition classified to codes **K64.4 Residual haemorrhoidal skin tags** or **K64.5 Perianal venous thrombosis** a code for both conditions must be assigned.

**Example:**

Patient with second and third degree haemorrhoids and perianal haematoma

**K64.2  Third-degree haemorrhoids**

**K64.5  Perianal venous thrombosis**
Haemorrhoids with bleeding

When haemorrhoids (piles) and per rectum bleeding is documented, coders must not assume that the bleeding is from the haemorrhoids unless explicitly stated as such by the clinician.

Where haemorrhoids are diagnosed and bleeding is documented without a link being made to the haemorrhoids, coders must follow the guidance published in the Symptoms chapter of the ICD10 Scottish Clinical Coding Reference Manual. This states “where a sign or symptom may be due to more than one condition, assign a code for the symptom”. This will be in addition to any clear diagnosis that is made.

Example:

1) Diagnosis of Bleeding Haemorrhoids

Trail: Hemorrhoids (bleeding) (without mention of degree) K64.9
Code: K64.9 Haemorrhoids, unspecified

2) Diagnosis of Haemorrhoids. Per rectum bleeding mentioned on Discharge Letter and further investigations are planned to identify the source of the bleeding.

Trail: Hemorrhoids (bleeding) (without mention of degree) K64.9
   Bleeding (see also Hemorrhage) R58
   Hemorrhage, hemorrhagic
      - gastrointestinal (tract) K92.2

Code: K64.9 Haemorrhoids, unspecified
      and
      K92.2 Gastrointestinal haemorrhage, unspecified

3) Diagnosis of Haemorrhoids. Per rectum bleeding mentioned on Discharge Letter and no evidence of further investigations planned to identify the source of the bleeding.

The coder must clarify with the clinician what has caused the bleeding but if this is not possible or the clinician is unable to identify the cause of the bleeding then code as follows:-

Trail: Hemorrhoids (bleeding) (without mention of degree) K64.9
   Bleeding (see also Hemorrhage)
   Hemorrhage, hemorrhagic
      - gastrointestinal (tract) K92.2

Code: K64.9 Haemorrhoids, unspecified
      and
      K92.2 Gastrointestinal haemorrhage, unspecified

Please Note: if the diagnosis is bleeding haemorrhoids and the degree of the haemorrhoid is stated then select the appropriate code in category K64 and follow the above instructions. For example:
4) Diagnosis of first degree haemorrhoids. Per rectum bleeding mentioned on Discharge Letter and further investigations are planned to identify the source of the bleeding.

Trail: **Hemorrhoids (bleeding) (without mention of degree)** K64.9  
- 1st degree (grade/stage I) (without prolapse) K64.0  
  - **Bleeding** (see also Hemorrhage) R58  
  - **Hemorrhage, hemorrhagic**  
    - gastrointestinal (tract) K92.2

Code: **K64.0 First-degree haemorrhoids**  
and  
**K92.2 Gastrointestinal haemorrhage, unspecified**

### Inflammatory Bowel Disease (IBD)  
SCCS2 July 13

The clinical statement ‘inflammatory bowel disease’ (IBD) is an umbrella term that includes both Crohn’s disease and ulcerative colitis. Note that clinicians do not use ‘IBD’ to signify conditions which may be of infective origin, and so IBD is not synonymous with ‘(gastro)enteritis unspecified’ or ‘diarrhoea unspecified’.

Without further information, ‘inflammatory bowel disease’ should be coded to **K52.9 Noninfective gastroenteritis and colitis, unspecified**.

Index trail:

**Inflammation, inflamed**  
- intestine (any part) - see Enteritis

**Enteritis (diarrheal) (hemorrhagic)** A09.9  
- non-infectious K52.9

The use of the word ‘inflammatory’ indicates that the disease is **non-infective**.

It would clearly be preferable for “inflammatory bowel disease” to be coded more specifically in K50, K51 or a more specific code from K52. Coders are therefore advised to consult with the clinician responsible for the patient’s care to obtain more specific information wherever possible rather than using the default code K52.9 given above.

### Oesophageal Web  
SCCS2 July 13

The ICD-10 Alphabetical Index assumes that an oesophageal web is a congenital condition and classifies this at code **Q39.4 Oesophageal web**. However, an oesophageal web can be either congenital or acquired, with the latter being more common. It has been agreed that the correct ICD-10 classification codes for oesophageal web are as follows:

- Oesophageal web stated in the patient clinical record as congenital must be classified at  
  **Q39.4 Oesophageal web**

- Oesophageal web stated in the patient clinical record as acquired must be classified at  
  **K22.2 Oesophageal obstruction**

- Oesophageal web which is not specified in the patient clinical record as either congenital or acquired must be classified at: K22.2 Oesophageal obstruction.

Coders should amend the entry for oesophageal web on in their ICD10 Index as follows;

**Web, webbed**  
- esophagus K22.2  
- - congenital Q39.4
Rectal Haemorrhage vs Per Rectal Haemorrhage

The ICD10 code **K62.5 Haemorrhage of anus and rectum** refers specifically to haemorrhage of the anus and/or rectum. It does not refer to a haemorrhage that has occurred from elsewhere in the gastrointestinal tract, that is merely exiting via the rectum i.e. a ‘per rectal haemorrhage’.

If the clinician identifies the source of the haemorrhage as the anus or rectum then the correct ICD-10 code is:

**K62.5  Haemorrhage of anus and rectum**

However, if the bleed is not specified as being from the rectum or anus and has simply occurred via the rectum, then it should be coded as a gastrointestinal haemorrhage of unspecified location and the correct ICD-10 code is:

**K92.2  Gastrointestinal haemorrhage, unspecified**

Please note that K92.2 excludes neonatal gastrointestinal haemorrhage as per the note at category K92 Other diseases of digestive system.

CHXII Diseases of the skin and subcutaneous tissue

Cellulitis following a wound injury

Cellulitis is a bacterial infection of the skin and subcutaneous tissue which usually enters the skin via a wound or some break in the protective skin. When coding wound infections that progress to cellulitis, it is important that we capture the most significant code to reflect the condition being treated as in the following examples:

**Patient admitted with cellulitis of face (unknown cause)**

- **L03.2  Cellulitis of face**

**Patient fell in garden, laceration of lower leg treated at A&E, admitted 4 weeks later with cellulitis of lower leg**

- **L03.1  Cellulitis of other parts of limb**
- **T93.0  Sequelae of open wound of lower limb**
- **Y86.X  Sequelae of other accidents**

**Known heroin addict is admitted with cellulitis of arm due to the use of infected needles**

- **L03.1  Cellulitis of other parts of limb**
- **W46.9  Contact with hypodermic needle**
- **F11.2  Addiction to heroin**

**Patient admitted with cellulitis due to insect bite of finger**

- **L03.0  Cellulitis of finger and toe**
- **W57.9  Bitten or stung by nonvenomous insect and other nonvenomous arthropod**
Leg ulcer with infection

If a diagnosis of leg ulcer with infection is given, code the leg ulcer, L97.X, followed by the infectious agent, if known, using an appropriate code from B95.- to B98.-.

Examples:

Leg ulcer with MRSA infection

- L97.X Ulcer of lower limb, not elsewhere classified
- B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
  (U82.1 Resistance to methicillin)

Note: Use of U82-U85 is optional in Scotland.

Where the infectious agent is unknown, the default code of L08.9 should be used to record the infection. This code follows the code for leg ulcer.

Leg ulcer with infection

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

CHXIII Diseases of the musculoskeletal system and connective tissue

Arthrosis

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.

**Juvenile Arthritis**

Codes in category **M08 Juvenile arthritis**, must only be assigned where juvenile arthritis is documented in the medical record. The information in the inclusion note at category M08 Juvenile arthritis must not be used by the coder to make this diagnosis.

**Mandatory 5th Characters in Chapter XIII**

Please remember that it is mandatory to add a 5th character to codes in Chapter XIII Diseases of the musculoskeletal system and connective tissue (M00 - M99) wherever the category instructs:

[See site code at the beginning of this chapter]

So a diagnosis of Arthritis where no site was specified should be coded to M13.99.

The only exception to this rule is where the site is already incorporated in the code description e.g. Trigger finger which may be coded to M65.3 without adding a fifth character.

**Musculoskeletal Chest Pain**

The term musculoskeletal chest pain is coded to **R07.3 – Other chest pain**.

**Rectus Sheath Haematoma (RSH)**

There is no specific ICD10 index trail for Rectus Sheath Haematoma (RSH).

The index trail:

- **Hematoma (traumatic) (skin surface intact)** (see also Injury, superficial) T14.0
- **Contusion (skin surface intact)** (see also Injury, superficial) T14.0
- abdomen, abdominal (muscle) wall S30.1

leads to the injury code **S30.1 Contusion of abdominal wall**. This has caused confusion because many cases of RSH are described as ‘spontaneous’ or ‘non-traumatic’. Very few are reported to originate with trauma.

In the past several different coding solutions have been offered. In order to rationalize the coding of RSH, CCRG have decided that:

a) The terms ‘spontaneous RSH’, ‘non-traumatic RSH’ and ‘RSH’ (i.e. RSH unspecified) should each be recorded by using the following two codes together:

- **M62.88 Other specified disorders of muscle** (5th digit 8 trunk)
- **R58.X Haemorrhage, not elsewhere classified**

b) RSH stated to be due to trauma should be coded following the index trail above to

**S30.1 Contusion of abdominal wall**

with the appropriate external cause code.
Rettitive strain injury

Where there is no further information about the nature of the injury, the correct ICD10 code for repetitive strain injury is: M70.8 Other soft tissue disorders related to use, overuse and pressure

If repetitive strain injury is said to be work related, the code Z56.6 Other physical and mental strain related to work should also be added.

Site of musculoskeletal involvement

At the beginning of Chapter XIII, Diseases of the Musculoskeletal system and connective tissue, 5th character subdivisions are given for site of involvement. Coders have difficulty when the site is specified as “arm” or “leg” without specifying “upper” or “lower”. In the majority of these cases it should be possible to find out which is more appropriate, but where this is not possible it has been decided to use:

3 for arm, nec
6 for leg, nec

CHXIV Diseases of the genitourinary system

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.

Cellulitis of breast

The coding of “cellulitis of breast” is difficult because there is no specific trail for that phrase.

There are no exclusions of breast at L03.3 Cellulitis of trunk, although the exclusion note at L02.2 Cutaneous abscess, furuncle and carbuncle of trunk suggests that some breast infections should be coded under category N61 Inflammatory disorders of breast.

Cellulitis of the breast and mastitis (Inflammation of the ducts and mammary glands) often coexist. It is clinically preferable to have infective breast conditions coded consistently, therefore where there is no further specific information, a statement of “Cellulitis of breast” must be coded to N61.X Inflammatory disorders of breast.
CHXV Pregnancy, childbirth and the puerperium

Abortion codes on SMR02

On SMR02 abortions must be coded under Main Condition (in ICD10) from 1 April 1997 in addition to coding under the data item Type of Abortion.

For latest guidance on coding Abortion, Termination, Miscarriage please refer to Termination (abortion)/miscarriage coding SCCS 4 Feb 14.

Termination (abortion)/miscarriage coding

The term ‘abortion’ refers to the expulsion or removal of an embryo or fetus.

Coding staff should be aware that there has been a recent move away from using the term “abortion” for cases of termination/miscarriage because it may be confusing and is often upsetting to patients who usually consider the term to mean termination of pregnancy. It is probably safer to refer to spontaneous and missed abortions as “miscarriages” and to refer to medical or surgically induced abortions as “terminations of pregnancy” or just “terminations”.

Clinical practice of treating terminations/miscarriages has changed in the last few years since we previously issued guidance on this subject. It is also true that practice is different in different areas of the country. This has led to coders being confused about how to code termination/miscarriage episodes, particularly when there may be several episodes for the same termination or miscarriage.

The following scenarios may be quite typical:

**Termination of pregnancy** (for the purposes of removing a live embryo or fetus)

1. On discharge of first episode should be coded to: O04.5 to .9
   If patient returns with retained products of conception code to: O04.0 to .4

   ICD10 Index states:
   - Retention, retained
   - - products of conception
   - - following
   - - - abortion - see Abortion, by type
   - Abortion
   - - medical O04.-

2. Patient is admitted or attends as an outpatient for start of termination. Given mifepristone orally then sent home. Nothing happens.
   This should be recorded on an SMR01 (Inpatient/Daycase) as follows: O04.5 to .9 PLUS Z51.2 for oral mifepristone
   If recording on an SMR00, the code X39.1 Oral administration of therapeutic substance must be entered in the OPCS field.

3. Patient returns 3 days later and is given misoprostol vaginally. Still nothing happens.
   This should be recorded on an SMR01 (Inpatient/Daycase) as follows: O04.0 to .4 PLUS Z51.2 for vaginal misoprostol
   An OPCS code must also be recorded:
   - Q14.5 Insertion of prostaglandin pessary
   If recording on an SMR00, the code Q14.5 Insertion of prostaglandin pessary must be entered in the OPCS field.

4. The following day, the patient is admitted and is given a second dose of misoprostol orally and then expels the products of conception.
   This episode should also be coded to: O04.0 to .4 PLUS Z51.2 for oral misoprostol
**Spontaneous miscarriages/spontaneous abortions**

On the first inpatient or daycase episode of care for a spontaneous miscarriage, a code for complete miscarriage should be used i.e. O03.5 to O03.9. This will apply even if the patient is still bleeding when sent home. The only exception to this rule would be the rare occasion where it is known that the miscarriage is not complete prior to discharge - perhaps if the woman has discharged herself against advice, or the patient is being transferred because of complications.

On discharge of first episode should be coded to **O03.5 to .9**

If patient returns with retained products of conception code to **O03.0 to .4**

ICD10 Index states:
- **Retention, retained**
  - products of conception
  - - following
  - - abortion - see Abortion, by type

**Abortion**
- spontaneous O03.-

Any subsequent in-patient episode of care should be coded to an incomplete miscarriage i.e. O03.0 to O03.4.

**Missed abortion/missed miscarriage/fetal demise/early uterine death/silent miscarriage/ delayed miscarriage**

All of the above terms should be recorded to O02.1 – Missed abortion.

Where oral mifepristone OR oral prostaglandin (including misoprostol) is given to encourage the expulsion of the fetus/products of conception, the code Z51.2 – Other chemotherapy must be added.

The patient may be discharged prior to expulsion of the fetus/products of conception.

On discharge of first episode should be coded to: **O02.1**

If patient returns with retained products of conception code to: **O02.1 + O08.-**

ICD10 Index states:
- **Retention, retained**
  - products of conception
  - - early pregnancy (dead fetus) O02.1

**Coding of abortifacients**

<table>
<thead>
<tr>
<th>ICD10 code (in addition to O02.-, O03.- or O04.-)</th>
<th>OPCS4 code</th>
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</thead>
<tbody>
<tr>
<td>Oral mifepristone* OR Oral prostaglandin (including misoprostol)</td>
<td>Z51.2 – Other chemotherapy</td>
</tr>
<tr>
<td>Vaginal/ pessary prostaglandin (including misoprostol)</td>
<td>Z51.2 – Other chemotherapy</td>
</tr>
<tr>
<td>Oral mifepristone * – SMR00 ONLY</td>
<td>X39.1 Oral administration of therapeutic substance</td>
</tr>
</tbody>
</table>

* Please note that mifepristone is only given orally.

The intention of these coding rules is that **only one complete miscarriage/termination episode should ever be recorded** for any miscarriage/termination. Analysts counting the number of episodes of care for miscarriages/ terminations should be aware of the above rules, but should note that some termination patients are never admitted as inpatients and so a more accurate result of total number of terminations will be obtained by counting the ‘yellow forms’ held on a separate database from SMR information. It is also advisable for analysts to use the linked dataset when analysing for episodes of miscarriage to ensure that they avoid counting multiple admissions for the same episode.

**Note:** If the termination/miscarriage information is being recorded on an SMR02 record, the correct condition on discharge code for the above scenarios is 8 - Other (includes missed abortion) unless the clinician states that the patient has aborted in which case the correct code is 2 – Aborted.
Anaemia

When completing SMR02 returns:

Anaemia is considered to exist when haemoglobin (Hb) levels are below 10g/dl blood.

Where a Haematology report confirms such a reading, an anaemia code should be attributed to the patient.

<table>
<thead>
<tr>
<th>Anaemia complicating pregnancy, childbirth and the puerperium O99.0</th>
<th>SMR02 Review 10</th>
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</thead>
</table>

O99.0 Anaemia complicating pregnancy, childbirth and the puerperium can only be used in the first position.

When using code O99.0, this must be used alone when the anaemia is unspecified. O99.0 should be followed by a code from D50–D64.8 when the cause of the anaemia is known.

Haemoglobin levels are slightly lower than usual in pregnancy; therefore care must be taken only to code ‘anaemia in pregnancy’ when clearly defined in the patient’s medical record by the obstetrician or midwife.

Statements of “low hb” or “sent home on iron tablets” should not be coded as anaemia.

If there is another obstetric condition to be recorded in Main Condition and the coder needs to record the clinical text “anaemia”, a code from Chapter III (blocks D50-D64) should be recorded in Other Conditions. Where the type of anaemia is not known record D64.9 Anaemia, unspecified.

Ante Partum Haemorrhage

When is a haemorrhage in pregnancy classified as bleeding in early pregnancy and when as ante partum haemorrhage?

The cut-off period is 24 completed weeks gestation. Before this period code to O20.- Haemorrhage in early pregnancy.

After this period i.e. 24 completed weeks and above, code to O46.- Ante partum haemorrhage, not elsewhere classified.

Conditions in pregnancy

A pregnant woman is admitted for treatment of a condition which may or may not be directly related to her pregnancy. If the patient is treated in a non-obstetrics specialty e.g. General Medicine and a SMR01 is completed, how is the condition coded?

Code the condition in the usual way and follow it with an additional code from Chapter XV to identify that the woman is pregnant and this is a factor affecting her care. For example:

1) Unstable insulin-dependent diabetes mellitus in pregnant patient
   - E10.9 Insulin-dependent diabetes mellitus
   - O24.0 Pre-existing diabetes mellitus, insulin-dependent

2) Acute viral hepatitis, patient pregnant
   - B19.9 Viral hepatitis NOS
   - O98.4 Viral hepatitis complicating pregnancy, childbirth and the puerperium
The code Z33 Pregnant state, incidental should only be used when the pregnancy is truly incidental and of no relevance to the woman’s care or condition. For example:

**Ingrowing toenail, patient pregnant**

- L60.0 Ingrowing nail
- Z33.X Pregnant state, incidental

**Fetal distress**

Coders must **not** record the terms ‘suspicious CTG’ (Cardiotocography), ‘Non-reassuring CTG’ or ‘Suboptimal CTG’.

However, if the patient went on to have an operative delivery due to these signs, then code **O68.8 Labour and delivery complicated by other evidence of fetal stress**, should be recorded in the Indication for Operative Delivery field.

The code **O68.8 Labour and delivery complicated by other evidence of fetal stress** must be used to code the terms ‘Pathological CTG’ and ‘Abnormal CTG’, where present.

**Habitual Abortion/Recurrent Miscarriage**

If a woman has three consecutive first trimester losses of pregnancy she can be classified as a habitual aborter. It should however be noted that the term habitual aborter is somewhat misleading and out-of-date. Clinicians now use the term **recurrent miscarriage**.

ICD10 Code **O26.2, Pregnancy care of habitual aborter**, should only be used if the clinician uses the terms ‘habitual aborter’ or ‘recurrent miscarriage’ and the woman is currently pregnant.

Please note the exclusions at O26.2.

**Excl.**: habitual aborter:

- with current abortion (O03 – O06)
- without current pregnancy (N96)

**Haemorrhage & Stage of Gestation**

Haemorrhages occurring at different stages of gestation are defined as follows:

- Haemorrhage in early pregnancy - the period up to 24 weeks gestation
- Antepartum haemorrhage - from 24 weeks onwards. May be connected with placenta praevia or premature separation of the placenta (abruptio placentae)
- Intrapartum haemorrhage - between the beginning and end of labour

Postpartum haemorrhage - after the baby is delivered. Includes haemorrhage occurring during a Caesarean section.

During labour and delivery a haemorrhage is regarded as such when blood loss is 500mls or more.
Intrapartum vs. Postpartum haemorrhage

Blood loss is likely to be from postpartum cause, rather than intrapartum.

Intrapartum haemorrhage - between the beginning and end of labour

O67.- Intrapartum haemorrhage, must only be recorded where the term ‘intrapartum haemorrhage’ is specifically used.

Postpartum haemorrhage - after the baby is delivered

The code O72.- Postpartum haemorrhage must be recorded in all cases where either:

a) the clinician states ‘postpartum haemorrhage’ or

b) the clinician makes no statement of intra- or postpartum haemorrhage, but blood loss is recorded as 500mls or more (Includes haemorrhage occurring during a Caesarean section.)

Hard Coded Diagnostic and Procedure Fields on SMR02

There are 7 hard coded items which have ICD/OPCS4 equivalents:

- Type of Abortion
- Management of Abortion
- Induction of Labour
- Sterilisation after Delivery
- Episiotomy
- Tears
- Mode of delivery

These hard coded items (i.e. assigned special non-ICD10 OPCS4 codes) are required by ISD. However, these codes have ICD10 or OPCS4 equivalents which may be more specific than the hard codes. Where the data is hard coded there is no need to duplicate the information by coding again in the diagnostic section unless the ICD10/OPCS4 code gives more specific information e.g. lower uterine segment caesarean (LUSC) at R17.2 and R18.2.

The exception to this rule is when codes O80.- to O84.- are used as there are no other obstetric conditions to record.

Hypertension in Pregnancy

Hypertension is defined as a reading of diastolic BP greater than 110mmHg on any occasion or a diastolic reading of 90-110mmHg sustained for 4 hours or more.

Coding hypertension:

- Gestational i.e. pregnancy-induced, hypertension: O13.X
- Pre-existing i.e. present before pregnancy and still present during pregnancy, hypertension: O10.-
- Unspecified i.e. not known if present before pregnancy or pregnancy-induced, hypertension: O16.X
Hypertension and raised BP in pregnancy

Clarification of when to code hypertension and raised BP in pregnancy.

Hypertension should only be coded when a clinician explicitly states that the mother has hypertension. Then a code from O10.-, O13.X, or O16.X can be selected as appropriate.

Coders should not search for and analyse blood pressure readings, and should not look for the "^BP" symbol (elevated blood pressure) written in the available clinical material, with a view to recording any code whatsoever.

The code R03.0 can be recorded if there is an explicit clinical statement that the mother was admitted because of raised blood pressure or that raised blood pressure was a significant concern during the admission. R03.0 should only be used if there is no definitive diagnosis given as the cause of raised blood pressure.

Meconium

The presence of Meconium should always be coded if it is mentioned in the notes, even if no complications have resulted from it. When there are no other complications, code to O68.1.

Meconium Staining

There is doubt as to whether meconium staining in an otherwise normal delivery should be recorded. If there is mention of meconium staining or meconium in the amniotic fluid in a delivery episode on SMR02, this should be coded as appropriate using:

O68.1  Labour and delivery complicated by meconium in amniotic fluid OR

O68.2  Labour and delivery complicated by fetal heart rate anomaly with meconium in amniotic fluid

Index trail:

Delivery
- complicated (by)O75.9
- - meconium in liquor O68.1
- - - with fetal heart rate anomaly O68.2

Example:

Notes state “Meconium in liquid”. Nothing is done, the baby is fine and no treatment is given. Code to O68.1 or O68.2 as appropriate.

Multiple gestation O30

A code from category O30 Multiple gestation should be coded as the primary diagnosis for Ante-natal episodes, where appropriate but on an SMR02 Delivery episode, it is not required, as this information is collected in the delivery data items. Where no other relevant obstetric condition exists, the main condition should be recorded as O84.0 Multiple delivery, all spontaneous.

Oedema

Oedema need not be recorded. It is an extremely common condition during pregnancy and has no predictive value.
Post-dates and post-term

There is much confusion and disagreement over the definition of these terms. The information is available in the data item Estimated Gestation.

It is therefore recommended that the code O48.X (Prolonged pregnancy) is not used in delivery episodes.

Precipitate labour O62.3

As there are varying definitions of this (undue speed of labour to delivery), it is not advisable to use the code unless the particular term has been stated.

Pre-eclampsia

Pre-eclampsia is considered to be present when proteinuria is greater than 300mg/1 and diastolic blood pressure is greater than 110mmHg on any occasion, or a diastolic reading of 90 - 110mmHg is sustained for 4 hours or more. Oedema may or may not be present.

It is very difficult to identify moderate/severe pre-eclampsia as specified in ICD10. Therefore, it is recommended that pre-eclampsia is coded as unspecified: O14.9.

Premature Rupture of Membrane (PROM) O42

This means rupture of membranes before onset of labour (contraction stage) regardless of the length of gestation. The fourth-character identifies the length of time before the onset of labour. This code is classified within the section on maternal care related to the fetus and amniotic cavity and possible delivery problems.

For Scotland, it is important to record this on the delivery episode even if it happened earlier. This is to ensure all PROMs are recorded, as it may have occurred outwith the hospital. This may mean an element of double counting, as the PROM event must also be coded in any ante-natal stay where the patient has been treated for that condition.

Reason for Operative Delivery Recording – SMR02

For ALL instances of operative delivery, where there are NO other complications, the 'Indication for Operative Delivery' code must be repeated in the Main Condition field. Previously, the Main Condition field would have recorded the 'type of delivery' in these circumstances.

Example:

Obstructed labour due to a fetopelvic disproportion caused by mother’s deformed pelvis. Emergency caesarean section performed. No other conditions. Mother and baby both well.

Index trail for obstructed labour:

Labor (see also Delivery)
- obstructed O66.9
- - by or due to
- - - deformity (acquired) (congenital)
- - - - pelvis (bony) NEC O65.0

Tabular List entry:

O65.0 Obstructed labour due to deformed pelvis
For SMR02 coding, O65.0 Obstructed labour due to deformed pelvis, will be the Indication for Operative Delivery code AND the Main Condition.

To summarise, the Indication for Operative Delivery code should **be repeated** in the Main Condition field in the event of no other condition/complication being present.

This is a change in practice, which should be followed with immediate effect.

### Retained placenta

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**O72.0 Third-stage haemorrhage** - In ICD10 O72.0 includes Retained placenta NOS.

However, in Scotland, it has been agreed that in cases of retained placenta where haemorrhage is not mentioned OR where the blood loss is recorded as < 500mls, the retained placenta should be coded to:

**O73.0 Retained placenta without haemorrhage**

Please annotate ICD index as follows;

- **Retention, retained**
  - placenta (total) (with haemorrhage) O72.0
  - - portions or fragments (with haemorrhage) O72.2
  - - - without haemorrhage O73.1 (retained portions of placenta NOS)
  - - without haemorrhage O73.0 (Retained placenta NOS)

Even though ‘without haemorrhage’ is an essential modifier, code Retention of placenta NOS to O73.0 where there is no specific mention of haemorrhage OR where the blood loss is < 500mls.

The same rule applies to Retained portions of placenta and membranes, without haemorrhage at O73.1.

There is also another index trail, which should be annotated in the same way;

- **Placenta, placental**
  - retention (with postpartum haemorrhage) O72.0
  - - fragments, complicating puerperium (delayed haemorrhage) O72.2
  - - - without haemorrhage O73.1 (retained portions of placenta NOS)
  - - without haemorrhage O73.0 (Retained placenta NOS)

### Spontaneous rupture of membranes

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Two codes are available in ICD10 relating to spontaneous rupture of membranes:

**O42.- Premature rupture of membranes**

**O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes**

O42.- refers to rupture of membranes before labour has started, regardless of the length of gestation. The fourth character identifies the length of time until labour begins. (O42.- does not, therefore, refer to rupture of membranes before 37 weeks’ gestation).

O75.6 refers to rupture of membranes after labour has started. There is then a subsequent delay in delivery. The exact time period which defines a delayed delivery following rupture of membranes is for local definition.

### Termination of pregnancy resulting in liveborn

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In cases where a patient undergoes termination of pregnancy, resulting in a live fetus where the baby has lived for any amount of time, regardless of gestational age, this must be coded as an abortion using a code from categories O04-O06. An appropriate code from category Z37 Outcome of delivery must also be assigned in the first secondary diagnosis field to indicate that the termination of pregnancy resulted in a live birth.
Vaginal Thrush in Pregnancy

The correct codes for vaginal thrush in pregnancy are:

- **O23.5 Infections of the genital tract in pregnancy**
- **B37.3† Candidiasis of vulva and vagina (N77.1*)**
- **N77.1* Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere**

CHXVI Certain conditions originating in the perinatal period

Disorders related to length of gestation and fetal growth (P05-P08)

If both low birth weight and short gestational age are documented in the medical record, two codes from category **P07 Disorders related to short gestation and low birth weight, not elsewhere classified** must be assigned. The low birth weight code must be sequenced before the code for the short gestational age.

When a condition(s) classified to categories P07 or P08 and a condition(s) classified to **P05 Slow fetal growth and fetal malnutrition** are present, codes from both categories must be assigned. The exclusion note at category P07 does not preclude this.

The codes at P05 can apply to infants of premature, normal or long gestation who have slow fetal growth or fetal malnourishment with or without being small or light for gestational age.

Category P07 classifies premature births and/or low birth weight.

Category P08 classifies post term births and/or high birth weight.

Example:

Premature infant born at 34 weeks in hospital weighing 2100gms and is small for dates:

- **P07.1 Other low birth weight**
- **P07.3 Other preterm infants**
- **P05.1 Small for gestational age**

Perinatal Conditions

The following scenario is for occasions when a code is not available to clearly classify that the condition in question forms a perinatal condition.

Conditions arising in the perinatal period should, as far as possible, be coded to chapter XVI even when morbidity or death occurs later. This takes precedence over chapters containing codes for diseases by their anatomical site.

Exclusions are:

- 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 another exclusion: **Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)**
If the code for the disease by the anatomical site provides additional information which is not contained in the code from Chapter XVI, then it is acceptable to use a second code to express this information. This provides additional information for the coder and for potential analysis.

Example:

Newborn born in hospital with thrombotic occlusion of left superficial femoral artery.

P29.8  Other cardiovascular disorders originating in the perinatal period
I74.3  Embolism and thrombosis of arteries of lower extremities

Perinatal Period - Definition of  SCCS2 July 13

For morbidity coding the Perinatal Period applies to disorders manifesting or originating in the first 7 days of life i.e. ends at 7 completed days after birth.

Neonatal Period commences at birth and ends 28 completed days after birth.

CHXVII Congenital malformations, deformations and chromosomal abnormalities

Developmental Dysplasia of the Hip (DDH)  SCCS8 Sep 14

The clinical term ‘Congenital Dislocation of the Hip’ is no longer routinely used in Scotland. The term ‘Developmental Dysplasia of the Hip (DDH)’ is now used instead. ICD10 coding rules do not yet reflect this change in terminology, in particular the use of ‘developmental’ rather than ‘congenital’.

This coding guidance is to confirm that ICD10 code Q65 should be used for patients noted as having Developmental Dysplasia of the Hip (DDH) as well as any that are still noted as having Congenital Dislocation of the Hip.

• Q65.0, Q65.1, or Q65.2 should be used if a patient is noted as having DDH with a dislocated hip.
• Q65.3, Q65.4, or Q65.5 should be used if a patient is noted as having DDH with a subluxated hip.
• Q65.6 should be used if a patient is noted as having DDH with an unstable, dislocatable, or subluxatable hip.
• Q65.8 should be used if a patient is noted as having DDH with no further details provided.
• Q65.9 should be used if a patient is noted as having a congenital deformity of the hip with no further details provided.

Note that children noted as having ‘clicky’ or ‘clicking’ hips, with no mention of DDH, should continue to be coded to R29.4.

Pfeiffer’s Disease v Pfeiffer’s Syndrome  CG3 June 99

The ICD10 Index has only Pfeiffer’s Disease listed with code B27.0 (type of infectious mononucleosis). The term Pfeiffer’s disease is no longer mentioned in textbooks. However, attention is drawn to the referencing of syndromes v diseases in the ICD10 index. These may, or may not, be synonymous terms and the coder should be careful when using these terms interchangeably. The tabular list should be carefully referenced to ensure the correct code is assigned. The coding of the term Pfeiffer’s syndrome (that is a form of acrocephalosyndactyly type V) to Q87.0-Congenital malformation syndromes predominantly affecting facial appearance is correct.

Add term Pfeiffer’s Syndrome to index Q87.0.
CHXVIII Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified

**Bowel screening**

In the Bowel Screening Programme, patients who have a positive Faecal Occult Blood screening result are being called for further examination (colonoscopy).

This should be coded to R19.5 (Other faecal abnormalities) in the colonoscopy episode if no further diagnosis is made.

Index trail:

- **Blood**
  - in
  - - feces (see also Melena) K92.1
  - - - occult R19.5

**K92.1 Melaena**, should only be recorded where this is the statement given.

**Clicking hip**

In ICD9 the code for clicking hip was in Chapter XIV (Congenital anomalies). In ICD10 the correct code is found in Chapter XVIII (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified).

The correct ICD10 code for clicking hip is R29.4, Clicking hip.

This code applies when the disorder is not described as a congenital deformity. If it is described as such, an appropriate code from Q65.-, Congenital deformities of hip, should be selected.

**Frailty**

In the Clinical Coding Update List No.20, April 2000, the ICD10 code R54.X was issued for “Frailty”. The title of this category is “Senility”.

The code **R54.X** should be used for frailty in elderly people.

For frailty in younger patients, the code **R53.X** should be recorded.

Please remember that these are default codes where no further information is given in the casenote/discharge summary. For validation purposes, it should be noted that the cut-off age is 60.
Frailty, immobility and geriatric falls

The table below documents codes to be used for frail/elderly patients being admitted with no injury.

<table>
<thead>
<tr>
<th>Text</th>
<th>Code</th>
<th>ICD-10 text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immobility</td>
<td>R26.3</td>
<td>Immobility - Only the terms ‘immobility, ‘chairfast’ and ‘bedfast’to be coded here.</td>
</tr>
<tr>
<td>Geriatric falls</td>
<td>R29.6</td>
<td>Tendency to fall, NEC</td>
</tr>
<tr>
<td>Off legs/feet</td>
<td>R26.8</td>
<td>Other and unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>Reduced/poor mobility</td>
<td>R26.8</td>
<td>Other and unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>Frailty (60 and over)</td>
<td>R54.X</td>
<td>Senility</td>
</tr>
<tr>
<td>Frailty (under 60)</td>
<td>R53.X</td>
<td>Malaise and fatigue</td>
</tr>
</tbody>
</table>

If any of the above are emergency admissions, Admission Type would be 36 - Patient non-injury.

If there is an injury, the injury and external cause must be coded first.

Example:

Bruised hip due to (geriatric) falls at home:

Codes: S70.0 Contusion of hip  W19.0 Unspecified fall at home

If the patient is prone to falls, the code R29.6 Tendency to fall, NEC may be added.

In this case the Admission Type for an emergency admission would be 33 - Patient Injury - Home Accident.

Gangrene

When coding gangrene of particular sites, the index trail may lead to a specific code which does not include the term ‘gangrene’.

Example:

**Gangrene**
- intestine, intestinal (hemorrhagic) (massive) K55.0 Acute vascular disorders of intestine.

Clinicians feel that gangrene itself is sufficiently important that it requires an additional code to highlight the infection, therefore please add R02.X where the main code does not include the term ‘gangrene’, as in the above example.

This is contrary to the exclusions at R02.X and coders may wish to amend their ICD10 Volume 1 (Tabular list) to that affect.
### High cholesterol

<table>
<thead>
<tr>
<th>CG19 Sep 06</th>
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</table>

There has been some confusion over coding the statement ‘high cholesterol’ with some coders taking it to

**E78.0 Pure hypercholesterolaemia**

and others to

**R79.8 Other specified abnormal findings of blood chemistry**

The CCRG have discussed this and decided that the term ‘pure hypercholesterolaemia’ refers to a group of specific conditions, often genetic, in which cholesterol alone is raised and other lipids have been confirmed to be normal. Some of these other conditions are listed under E78.0.

A statement of ‘high cholesterol’ should therefore be coded to:

**R79.8 Other specified abnormal findings of blood chemistry**

This applies even if the coder notices that the clinician has started treatment for the high cholesterol e.g. statins.

### Jittery baby

<table>
<thead>
<tr>
<th>CG17 Jan 06</th>
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It has been agreed that the correct code for Jittery baby is:

**R25.8 Other and unspecified abnormal involuntary movements**

### Multi-organ failure

<table>
<thead>
<tr>
<th>SCCS2 July 13</th>
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</table>

This diagnosis causes great difficulty to coders. When such a diagnosis is recorded, the clinician in charge should be asked to clarify the patient’s condition and state which organs have suffered failure, e.g. heart failure and liver failure. Each organ failure should be coded separately. However, this information is not always available. Where it is not possible to find out the organs involved, the code for recording ‘Multi-organ failure’ is:

**R68.8 Other specified general symptoms and signs**

This should be used regardless of whether the patient lives or dies.

### Raised PSA

<table>
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<th>CG17 Jan 06</th>
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</table>

Raised PSA must be coded to:

**R79.8 Other specified abnormal findings of blood chemistry**

### CHXIX Injury, poisoning and certain other consequences of external causes

#### Alcohol involvement when noted with an overdose of drugs

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<tr>
<th>CG16 Aug 05</th>
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</table>

A query was raised regarding ‘alcohol involvement’ when noted with an overdose of drugs. Alcohol and drugs taken together is considered a poisoning and should be coded as such.

The query concerned when alcohol had been consumed, but not at the same time as the drugs.

There is a very wide range of drugs that react with alcohol. Of course, reactions differ according to how much alcohol was consumed; how many pills; time at which they were taken.

Clinically and for research purposes, it is very important that ‘alcohol involvement’ be recorded. ISD advise that, where there is evidence that alcohol was consumed within 24 hours of the drugs overdose, then it should be regarded as a poisoning, by the drugs and alcohol.
Example:

“Patient got drunk at lunchtime. Drank 10 + pints of beer. Went home to sleep it off. Woke up around 8.p.m. feeling depressed. Decided to ‘end it all’ and swallowed a bottle of aspirin.”

Code to:

T39.0 Poisoning by salicylates
T51.0 Toxic effect of ethanol
X60.0 Intentional self-poisoning by nonopioid analgesics, antipyretics and antirheumatics (in the home)

Bilateral Injuries

The codes T00.- to T07.- Injuries involving multiple body regions include bilateral involvement of limbs of the same body region.

This means that (for example) bilateral fractures of both upper arms should be recorded at T02.4 Fractures involving multiple regions of both upper limbs. However, this loses specificity about the site of the fractures.

It has been agreed that where space allows, the individual injury codes should be recorded in preference to the T00.- to T07.- multiple codes, otherwise the use of multiple will be satisfactory.

Burns Classified According to Percentage of Body Area

When coding burns, and when the information is available, please remember to code the percentage of body surface affected. If a burn is classified according to the extent of the body surface involved then code accordingly to T31.-.

Note T31 is to be used as the primary code only when the site of the burn is unspecified. It must be used, if available, as a supplementary code with categories T20-T29 when the site is specified.

Compound drugs, multiple drug and alcohol involvement

When the drug has more than one component, each component should be coded separately and sequenced according to the order in the British National Formulary (BNF) which is a publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain. It is recommended that clinical coders have access to, or obtain a copy of, the British National Formulary which is updated every March and September. Copies are sent to every Pharmacy department, ward and doctor in every NHS organisation.

The on-line version can be found at the Medicines Complete website.

Where there is multiple drug involvement in a poisoning case, each drug identified by the clinician must be coded separately. The poisoning codes should be sequenced in the order in which the drugs are listed by the clinician on the source document.

When there is also alcohol involvement, the alcohol code must be recorded, even if this means dropping another substance code.

The External Cause code for the first listed substance is the only one which needs to be recorded.

For examples see standard External Cause codes in poisonings CG14 Jan 04.
Periprosthetic Fracture and Dislocated Joint Prosthesis

In ICD10 there are no clear index trails or specific named codes for coding fractures described by the clinician as ‘periprosthetic’ or cases where a prosthetic joint replacement has become dislocated. As a result, each of these occurrences has been coded in a number of different ways in the past.

ISD’s Clinical Coding Review Group has considered a number of known scenarios resulting in periprosthetic fracture or dislocated joint prosthesis, and has agreed on the codes to be used for each scenario. These are as follows:

Periprosthetic fracture without stated cause - code as:

**M96.6  Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate**

Periprosthetic fracture due to known cause e.g. a fall - code as:

**M96.6  Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate**

PLUS

appropriate external cause code for the known cause e.g. **W19.- Unspecified fall**

Intra-operative periprosthetic fracture - occurring during primary or revisional joint replacement procedure. Code using the:

S fracture code appropriate to the fractured bone

PLUS

Y79.2  Orthopaedic devices associated with adverse incidents - prosthetic and other implants, materials and accessory devices

Dislocated joint prosthesis without stated cause - code as:

**T84.0  Mechanical complication of internal joint prosthesis**

PLUS

Y83.1  Surgical operation with implant of artificial internal device

Dislocated joint prosthesis due to known cause e.g. a fall - code as:

**T84.0  Mechanical complication of internal joint prosthesis**

PLUS

appropriate external cause code for the known cause e.g. **W19.- Unspecified fall**

External Cause Codes

There is a common misconception that external cause codes can only be used after codes from Chapter XIX, “Injury, poisoning and certain other consequences of external causes”. The note at the beginning of Chapter XX states: “Other conditions that may be stated to be due to external causes are classified in Chapters I to XVIII” and so where relevant, Chapter XX codes should be added to these.

*Example:* Haematuria caused by jogging

**R31.X  Haematuria**

**X50.9  Overexertion and strenuous or repetitive movements**
External Cause codes in poisonings

It has been decided that it is more useful to record extra poisoning codes rather than having an external cause code following each poisoning code. Where poisoning is the main reason for a patient being admitted, the following rules should be applied:

- Main condition is the main substance taken.
- Then code any other substances taken.
- External cause code for the main substance taken.
- Other medical conditions.

Example: patient is admitted having made a suicide attempt by taking paracetamol, aspirin and whisky, due to depression (at home).

Code:

T39.1 Chapter XIX code for paracetamol
T39.0 Chapter XIX code for aspirin
T51.0 Chapter XIX code for alcohol beverage
X60.0 Intentional self harm code for paracetamol
F32.9 Depression

External Orthopaedic Fixators

ICD10 interprets the word ‘internal’ in relation to orthopaedic fixators as a fixator that has gone through the skin. An external orthopaedic device, such as an Ilizarov external fixator, penetrates down into the bone being held by the device and, as such, although the device is known as an external fixator the component parts are considered to be internal. Therefore, when coding complications of these external fixators, the correct ICD10 code would be assigned from the rubric:

T84 Complications of internal orthopaedic prosthetic device, implants and grafts

Head Injuries

For statistical purposes it is important to code head injuries consistently. To this end the Clinical Coding Review Group considered the best advice to issue when a head injury occurs but the main reason for the admission is observation of the patient to ensure nothing more sinister manifests itself overnight, is as follows:

It was agreed that it is impossible to be too prescriptive on scenarios and coders are advised to code the text as given in the source document (discharge letter, medical records, etc). Therefore if the document uses the phrase “superficial head injury” and the patient is admitted for that reason use code S00.9 Superficial injury of head, part unspecified. However if just “head injury” is stated then the coder should use S09.9 Unspecified injury of head.

The coder would then need to add an appropriate external cause code (V01.- to Y98.X) and observation code (Z04.-).

Impulsive Overdose

Following an enquiry regarding the term ‘Impulsive Overdose’, coders should note this is to be allocated a poisoning code from the ‘Intentional self-harm’ column of the Table of Drugs and Chemicals.
Injury with Tendon Involvement

Both injury and tendon involvement must be coded separately.

Example:
Laceration of finger with flexor tendon involvement

S56.1 Injury of flexor muscle and tendon of other finger(s) at forearm level
S61.0 Open wound of finger(s) without damage to nail

The sequence of the codes depends on the treatment given. In the example given here, treatment was primary repair of tendon.

Mephedrone

The drug Mephedrone is known by a variety of names such as MCAT, Meow-meow and 4-MMC.

Mephedrone can be considered as a psychostimulant and the correct codes to assign for an accidental poisoning for this drug are:

T43.6 Psychostimulants with abuse potential
X41.- Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified

The external cause code to add to T43.6 if a patient has intentionally self-harmed using Mephedrone is:

X61.- Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified

F15, Mental and behavioural disorders due to use of other stimulants, including caffeine, is the correct category to select to record any mental and behavioural disorders due to use of Mephedrone.

Example: Mephedrone abuse would be coded to F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine, harmful use.

Please note that there is no specific code in ICD10 to identify Mephedrone individually.

Open Wound to Artery or Vein

As with injury to tendon or muscle (above), it is not possible to describe fully an open injury to a vein or artery with one code.

Therefore, where this occurs, the appropriate code to describe the open wound must follow the artery/vein injury code.

It is important that this is added to indicate the increased likelihood of complications such as infection. The external cause code must also be added following the injury codes. For example:

Patient had cut to axillary artery caused by a knife.

Wound, open
- blood vessel - see Injury, blood vessel

Injury
- blood vessel
- - axillary
- - - artery S45.0
This implies that the wound is open - there is no separate 5th digit to indicate this. However, to differentiate between an open wound and (for example) a rupture, add:

**Wound, open**
- arm
- - upper S41.1

The external cause code for contact with knife (W26.-) would follow.

---

**Open Wound with Infection**

A diagnosis of ‘open wound with infection’ has more clinical consequences and resource implications compared to one which has no infection. Valuable information is being lost when an open wound with infection is coded according to the index trail. If the particular infection is identified, there is no problem, as an additional code from B95 to B97 should also be added.

However if no infection has been stated and it is not possible to add such a code, coders should add code T79.3 to the open wound code.

*Examples:*

1. Staphylococcus aureus infection of open wound of finger, caused by contact with sharp glass code to:
   - **S61.0 Open wound of finger(s) without damage to nail**
   - **W25.9 Contact with sharp glass, place unspecified**
   - **B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters**

2. Infection of open wound of finger caused by contact with sharp glass code to:
   - **S61.0 Open wound of finger(s) without damage to nail**
   - **T79.3 Post-traumatic wound infection, not elsewhere classified**
   - **W25.9 Contact with sharp glass, place unspecified**

This advice applies whether the infection is in the same episode or a subsequent episode of care and will take effect from 1st April 2002.

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**Poisoning - Intentional Self-harm or Accidental?**

Various terms may be used in the source document to record a poisoning. Very often it has not been stated whether or not the poisoning was accidental or intentional self-harm, and this information is required in order to allocate the correct external cause code.

The general guideline is, as always, to try and obtain the missing information from the clinician who completed the source document. Where this is not possible, follow these guidelines:

“Overdose” or “self-poisoning” has been recorded -

- it is not stated as self-inflicted, deliberate or accidental - code as accidental
- it is qualified as self-inflicted, manipulative, parasuicide, attempted suicide, failed suicide attempt or cry for help - code as intentional self-harm

Note: These guidelines apply regardless of the age of the patient.
Drugs and Alcohol Poisoning

If an overdose of drugs has been taken along with alcohol, code this to a poisoning by the drug and by the alcohol.

If in addition the clinician mentions that the patient is drunk or alcohol dependent, a code from F10.- (Mental and behavioural disorders due to use of alcohol) should also be used.

Poisonings with the Drug 'Ecstasy'

Ecstasy is not listed in the Table of Drugs and Chemicals and coding poisonings with Ecstasy is proving difficult.

The pharmaceutical name for Ecstasy is Methyleneoxyamphetamine. This drug is classed as a psychostimulant.

The appropriate codes for poisonings with Ecstasy are found in the Table of Drugs and Chemicals under Psychostimulant NEC.

Postprocedural disorders

Postprocedural disorders are conditions resulting from surgical or medical procedures. The principle is to use codes which provide the most accurate clinical picture. This usually involves selecting a code for the condition being treated followed by the appropriate external cause code (Y83.- or Y84.-). This provides greater accuracy than using the codes for postprocedural disorders given at the end of each body system chapter. However, in some cases, a specific postprocedural condition may be listed in the Index and have its own individual code.

Examples:

1) Post-op pneumonia

   J18.9 Pneumonia, unspecified
   Y83.9 Surgical procedure, unspecified, as the cause of abnormal reaction...

2) Ovarian failure following radiotherapy

   E89.4 Postprocedural ovarian failure
   Y84.2 Radiological procedure and radiotherapy as the cause of abnormal reaction...

3) Acute cystitis as a result of urinary catheterisation

   N30.0 Acute cystitis
   Y84.6 Urinary catheterization as the cause of abnormal reaction...

4) Postcholecystectomy syndrome

   K91.5 Postcholecystectomy syndrome

Prosthetic device at the end of its natural life

Many prostheses have a limited lifespan and eventually need to be replaced. For example, a prosthetic heart valve may need to be replaced 8 to 10 years after the original operation. This condition is regarded as a complication of the prosthetic device and is coded to T82.- to T85.- (Complications of ..... devices, implants and grafts) depending on which type of prosthetic implant, device or graft is involved.
**Rhabdomyolysis**

Rhabdomyolysis is a breakdown of skeletal muscle tissue and may be caused by physical, chemical or biological factors. The code assignment for rhabdomyolysis will depend on the cause of the muscle cell damage.

The World Health Organisation (WHO) has ratified the addition of ‘Rhabdomyolysis (idiopathic) NEC’ to the alphabetical index (ICD-10 Volume 3) and it reads:

**Rhabdomyolysis (idiopathic) NEC M62.8**
- traumatic T79.6

Thus rhabdomyolysis, unspecified further or without a known cause, must be coded to M62.8 Other specified disorders of muscle.

Traumatic rhabdomyolysis must be coded to T79.6 Traumatic ischaemia of muscle.

Rhabdomyolysis results in the protein myoglobin being released from the damaged muscle cells into tissue fluid and blood. This may result in damage to the kidneys, ranging from myoglobinuria to acute renal failure or nephritis. Renal problems due to non-traumatic rhabdomyolysis should be coded in addition to the rhabdomyolysis.

Renal failure due to traumatic rhabdomyolysis follows the index trail:

**Failure, failed**
- renal – see Failure, kidney
- - following
- - - crushing T79.5

Leading to the Tabular List entry:

T79.5 Traumatic anuria
Crush syndrome
Renal failure following crushing

**Soft Tissue Injury**

When coding the term ‘soft tissue injury’ this generally means that no bones have been broken. The question has arisen as to whether to code Soft Tissue Injury to superficial injury or injury to muscle. It has been decided that the default code should be unspecified injury. Therefore, in the absence of further information code Soft Tissue Injury to Back as:

S39.9 Unspecified injury of abdomen, lower back and pelvis + External cause code.

**Undetermined Intent; Reminder re previous guidance**

CG12 Sep 02, included the article below. Please note that this guidance still applies.

External Cause codes indicate whether an injury or poisoning was accidental or deliberate self-harm. There is an additional category for those incidents that lead to the death of the patient, but where the intent was not known. These codes should only be used where the Procurator Fiscal has stated at an inquiry into a death, that the death was of ‘undetermined intent’.

In the absence of a clinician’s decision, where there is doubt as to whether an incident was accidental or caused by deliberate self harm, then the external cause code should indicate ‘accidental’.
CHXX External causes of morbidity and mortality

<table>
<thead>
<tr>
<th>Body Piercing</th>
<th>CG15 Nov 04</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>W45</strong> Foreign body or object entering through skin</td>
<td></td>
</tr>
<tr>
<td>For example: Traumatic ulceration and granuloma due to lip piercing should be coded to:</td>
<td></td>
</tr>
<tr>
<td><strong>L92.3</strong> Foreign body granuloma of skin and subcutaneous tissue</td>
<td></td>
</tr>
<tr>
<td><strong>K13.0</strong> Diseases of lips</td>
<td></td>
</tr>
<tr>
<td><strong>W45.9</strong> Foreign body or object entering through the skin (unknown place of occurrence)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital acquired infections (HAI)</th>
<th>SCCS2 July 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is much publicity and concern about hospital acquired infection, and tackling infections is a priority within the NHS.</td>
<td></td>
</tr>
<tr>
<td>The dictionary definition for nosocomial is ‘pertaining to or originating in the hospital’</td>
<td></td>
</tr>
<tr>
<td>If the record states a diagnosis of a hospital-acquired infection, there is a specific external cause code for nosocomial conditions within the ICD10 classification.</td>
<td></td>
</tr>
<tr>
<td>If confirmed, the nosocomial code: <strong>Y95</strong> Nosocomial condition, would be assigned as an additional code following the type of infection</td>
<td></td>
</tr>
<tr>
<td>For example: MRSA infection, clinician confirms hospital acquired. Code:</td>
<td></td>
</tr>
<tr>
<td><strong>A49.0</strong> Staphylococcal infection, unspecified site</td>
<td></td>
</tr>
<tr>
<td>(U82.1 Resistance to methicillin)</td>
<td></td>
</tr>
<tr>
<td><strong>Y95.X</strong> Nosocomial condition</td>
<td></td>
</tr>
<tr>
<td>Note: Use of categories U82-U85 is optional in Scotland, see the standard from SCCS11 Mar 16 for more information.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility Scooters</th>
<th>CG20 June 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>A query has arisen as to how mobility scooters should be classified when a person is injured as a result of an accident whilst ‘driving’ one of these ‘vehicles’.</td>
<td></td>
</tr>
<tr>
<td>They do not fit accurately the definitions within ICD10; some are 3-wheeled, some have 4 wheels; some are allowed on the public roads; most are not.</td>
<td></td>
</tr>
<tr>
<td>It is extremely unlikely that coders would know which type was involved. Looking at the definitions and inclusions, it has been decided that mobility scooters are replacing powered wheelchairs and therefore, the patient would be classified as a Pedestrian V01 – V09.</td>
<td></td>
</tr>
<tr>
<td>Please note the exclusions here;</td>
<td></td>
</tr>
<tr>
<td>“collision of pedestrian (conveyance) with other pedestrians (conveyance) (W51)</td>
<td></td>
</tr>
<tr>
<td>collision of pedestrian (conveyance) with other pedestrians (conveyance)</td>
<td></td>
</tr>
<tr>
<td>• with subsequent fall (W03)”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthopaedic Devices Associated with Adverse Incidents</th>
<th>CG3 June 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>There has been confusion regarding the use of the ICD-10 range of codes <strong>Y70-Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use.</strong></td>
<td></td>
</tr>
</tbody>
</table>
It should be noted that this group is a continuation of range **Y60-Y69 Misadventure to patients during surgical and medical care** [during surgical/medical procedures].

**Example:** Patient's shaft of femur fractured **during** removal of a bone prosthesis

- **S72.30 Fracture of shaft of femur [closed]**
- **Y79.2 Orthopaedic devices associated with adverse incidents**

The codes to use where the incident happened following surgery are:

**Y83-Y84 Surgical operation and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure** [following surgical/medical procedures].

**Spiked drink**

Coders should note in their books the correct external cause code to assign to a patient admitted with a poisoning due to ‘spiked’ drink, i.e.

**X85.- Assault by drugs, medicaments and biological substances**

**Use of codes Y90-Y98**

These are supplementary codes which may be used in addition to other external cause codes but must not replace them.

**Viagra - adverse effect**

Although this drug was intended initially for the treatment of angina and would for this, have been coded to **Y52.3 Coronary vasodilators, not elsewhere classified** - for adverse effect in therapeutic use. Its use in ameliorating erectile dysfunction must be coded to **Y52.7 Peripheral vasodilators** - since its effect is mediated through changes in the vascular system.

**CHXXI Factors influencing health status and contact with health services**

**Acquired Absence of Breast**

Where a patient has previously had a breast removed, the code **Z90.1 Acquired absence of breast(s)**, should be added in appropriate episodes.

For example, where a mastectomy was carried out for removal of neoplasm and the patient is now admitted for investigation of breast mass.

**Anti-D**

Anti-D can be given to a Rhesus negative mother in the antenatal period as well as in the postnatal period. Anti-D is always given by intramuscular injection.

Record in both ICD10 and OPCS4.

**ICD10**

- Z29.1 Prophylactic immunotherapy

**OPCS4**

- X30.1 Injection of Rh immune globulin

If it is known that anti-D is given in the delivery episode, code both ICD10 and OPCS4. However, if it is unclear when the anti-D was administered during the pregnancy, only the ICD10 code is required and must be coded in the delivery episode.
**Attention to/Flushing of Hickman Line; Sequencing of codes**

**SCCS1 Mar 13**

**Question:**

On an SMR01 Inpatient or Day Case episode, should Z45.2 (Adjustment and management of vascular access device) be recorded as the main condition followed by the patient’s clinical diagnosis when the sole purpose of admission is attention to/flushing of Hickman Line?

**Answer:**

In the case of an SMR01 Inpatient or Day Case episode, where the patient has e.g. Lung cancer, and the patient has been admitted solely for the purpose of attention to/flushing of Hickman line, and where no further treatment or investigation was undertaken for the lung cancer during that episode of care then the attention to/flushing of the Hickman line must be considered to be the primary reason for admission and treatment. Therefore this must be reflected by assigning code Z45.2 Adjustment and management of vascular access device in main condition to indicate the attention to/flushing of the Hickman line. If information is available as to why the Hickman Line is in place then this should also be recorded.

The example above would therefore be coded as follows:

**Z45.2 Adjustment and management of vascular access device**

**C34.9 Malignant neoplasm of bronchus or lung, unspecified**

Please note that this does not apply to admission for radiotherapy (Z51.0) or chemotherapy (Z51.1) where the cancer code must come first. This is because in these situations the cancer is the primary reason for admission and treatment.

**Cancelled procedure - condition resolved**

**CQ1 Nov 96**

A procedure may be cancelled because the condition requiring the procedure has resolved itself. The correct way to code this is to use **Z53.8 Procedure not carried out for other reasons**, followed by a code for personal history of the condition that had required the procedure.

Note: A personal history code cannot be used when the condition was actually a symptom or sign codable to Chapter XVIII e.g. abdominal pain. In this case only code Z53.8 should be recorded.

**Cancer patients admitted for chemotherapy**

**SCCS2 July 13**

When patients with cancer are admitted to hospital for chemotherapy how should this be coded?

When the patient is being admitted specifically for chemotherapy, the ICD10 code **Z51.1 Chemotherapy session for neoplasm** should always be used after the code(s) for neoplasm(s). The appropriate OPCS4 code to identify the route of administration of the chemotherapy (X72- and/or X73.-) should also be recorded, if relevant.

In cases where the patient is receiving chemotherapy as part of routine inpatient care, but was not admitted specifically for this treatment, the coding is slightly different. It is not necessary to code chemotherapy in the diagnostic section. It is only necessary to record the OPCS4 code, if appropriate.

**Convalescence/Rehabilitation on SMR01**

**CQ2 Feb 97**

The rules for coding convalescence have been discussed at the CCRG and the decision made was to abide by the current rules.

A patient who has had a condition treated in an acute hospital and is then transferred to another unit for convalescence is still being treated for that condition. **Code the problem being treated first with the code for convalescence as a supplementary code.**

*Example:* Patient treated at an acute hospital for a fracture of neck of femur caused by a fall at home, and then transferred to another unit for convalescence would be coded as follows for the second episode.
There are circumstances where patients are brought in directly from the waiting list specifically for convalescence or rehabilitation and no other information is available. Under these circumstances convalescence or rehabilitation may be entered as the main condition, but will be queried on validation.

**Drug therapy - initiation and maintenance of**

When a patient is brought in purely for trying out a different medicine/different dosage or some form of drug stabilisation, they are effectively having drug maintenance. The correct code for this is **Z51.2 Other chemotherapy**, and this should be sequenced AFTER the patient’s condition.

On the very rare occasions when a brand new drug is being trialled i.e. for research purposes, the code would be **Z04.8 Examination and observation for other specified reasons**. Any conditions the patient may have would follow this code.

**Female Genital Mutilation coding on SMR01, SMR02 and SMR04**

There is a great deal of interest in Female Genital Mutilation (FGM) and the Scottish Government has written to medical and nursing staff to instruct them to document (on discharge summaries and in case notes) all cases of FGM coming into contact with the services, so that figures can be monitored. The term FGM encompasses all procedures involving the partial or total removal, or other injury, of the external female genital organs for cultural, non-therapeutic reasons. The different degrees of injury are often described as FGM types 1–4 (I–IV).

ICD10 V5 includes a new code which allows FGM to be recorded specifically. This is:

**Z91.7 Personal history of female genital mutilation**

In Scotland a Scottish 5th digit must always be added to Z91.7 to record the type of FGM, as follows:

<table>
<thead>
<tr>
<th>5th digit</th>
<th>FGM Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type 1 (or I)</td>
</tr>
<tr>
<td>2</td>
<td>Type 2 (or II)</td>
</tr>
<tr>
<td>3</td>
<td>Type 3 (or III)</td>
</tr>
<tr>
<td>4</td>
<td>Type 4 (or IV)</td>
</tr>
<tr>
<td>9</td>
<td>FGM type unspecified</td>
</tr>
</tbody>
</table>

FGM must always be recorded on SMR01, SMR02 and SMR04, using Z91.7 plus the appropriate 5th digit, when the clinical information accessed by the coder states that the patient has undergone FGM at any time.

FGM should be recorded regardless of whether the FGM is being investigated/treated or is incidental to the admission.

If incidental, FGM should be recorded with just Z91.7 + 5th digit.

If the FGM is more than just an incidental finding in the admission, an appropriate N code from Chapter XIV (SMR01) or O code from Chapter XV (SMR02) should be recorded, followed by Z91.7 with the appropriate 5th digit.

**Example 1:** When the patient is being investigated/treated for FGM, and no further information is given about the genital disorder/damage or any other condition resulting from the FGM, the following codes must be assigned:

- **N90.8 Other specified noninflammatory disorders of vulva and perineum**
- **Z91.7 Personal history of female genital mutilation** + 5th digit
**Example 2:** When the patient is being investigated/treated for FGM and the specific genital disorder/damage is documented or the patient is being investigated/treated for another condition that has occurred as a result of FGM then the following codes must be assigned:

- The code for the specific genital disorder/damage or code for the condition that has occurred as a result of FGM.
- Z91.7 Personal history of female genital mutilation + 5th digit

**Example 3:** (on SMR02) Vaginal stenosis complicating birth, previous female genital mutilation. Baby boy delivered. The following codes must be assigned:

- O34.6 Maternal care for abnormality of vagina
- Z91.7 Personal history of female genital mutilation + 5th digit

There are two codes in OPCS4.7 which are used to record the initial corrective procedure for certain cases of FGM:

- P07.2 Deinfibulation of vulva
- R27.2 Deinfibulation of vulva to facilitate delivery

P07.2 is for use on SMR01, whilst R27.2 would be expected on an SMR02.

---

**Holiday Relief Care (Respite Care) Coding on SMR01**

Patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.

**Example:** Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.

Code:  

- Z75.5 Holiday relief care
- G35.X Multiple sclerosis

If on the other hand, a patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay, the code Z75.5 should be assigned a secondary position.

**Example:** Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 2 days.

Code:  

- J22.X Chest Infection
- G35.X Multiple sclerosis
- Z75.5 Holiday relief care

Sometimes a patient is pre-booked for holiday relief care but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and must be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.

**Example:** Patient booked for 2 weeks holiday admission - consultant decides that the patient will have a course of physiotherapy for his multiple sclerosis.

Code:  

- G35.X Multiple sclerosis
- Z50.1 Other physical therapy
- Z75.5 Holiday relief care

It is important that the case notes are referenced thoroughly in order to reflect each patient’s care on each admission.
Coders are reminded that patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. It is essential that the recording rules for respite care be followed to ensure that the information can be correctly analysed.

The field Admission Reason should have the code 5B - Respite/holiday care entered. Whilst this is an Optional field, it is strongly recommended that sites complete this in the case of a respite admission.

Clinical codes should be entered as per examples below:

**Situation A. If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.**

*Example: Patient with dementia in Parkinson's disease admitted for a week to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.*

Admission diagnoses codes:

- Z75.5 Holiday relief care
- G20.X† Parkinson disease
- F02.3* Dementia in Parkinson disease

Discharge diagnoses codes:

- Z75.5 Holiday relief care
- G20.X† Parkinson disease
- F02.3* Dementia in Parkinson disease

**Situation B. A patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay. The code Z75.5 should be assigned a secondary position.**

*Example: Patient with dementia in Parkinson's disease admitted for a week to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 5 days.*

Admission diagnoses codes:

- Z75.5 Holiday relief care
- G20.X† Parkinson disease
- F02.3* Dementia in Parkinson disease

Discharge diagnoses codes:

- F02.3* Dementia in Parkinson disease
- G20.X† Parkinson disease
- J22.X Unspecified acute lower respiratory infection (chest infection)
- Z75.5 Holiday relief care

**Situation C. Sometimes a patient is pre-booked for holiday relief care but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and should be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.**
Example: Patient with dementia in Parkinson’s disease is booked for a week’s holiday admission — consultant decides that the patient will have a course of physiotherapy to help with problems related to their condition.

Admission diagnoses codes:

- Z75.5  Holiday relief care
- G20.X† Parkinson disease
- F02.3* Dementia in Parkinson disease

Discharge diagnoses codes:

- F02.3* Dementia in Parkinson disease
- G20.X† Parkinson disease
- Z50.1  Other physical therapy
- Z75.5  Holiday relief care

It is important that the case notes are referenced thoroughly in order to reflect the patient’s care on each admission.

### Human Fertilisation Codes

Recording of treatments provided under the Licence of the Human Fertilisation and Embryology Authority (HFEA)

This article is designed to raise awareness for Medical Records and Information Managers who have a responsibility for managing the completion and submission of SMR data at trusts.

The Human Fertilisation and Embryology Act of 1990 indicates that patients receiving Artificial insemination/In Vitro Fertilisation treatment from licensed centres should not be included on SMR returns to ISD as this would be in breach of the Act.

The codes and treatments concerned are as follows:

- ICD10
  - Z31.1  Artificial insemination
  - Z31.2  In vitro fertilisation

- OPCS4
  - Q13  Introduction of gametes into uterine cavity
  - Q38.3  Endoscopic intrafallopian transfer of gametes

It is important to stress that under the provisions of the Act, the Trust should send information about such patients to the HFEA only and to no other bodies. If there are concerns then these should be raised with the Trust’s Caldicott Guardian.

### Multiple Rehabilitation Procedures

A patient who has treatment involving several rehabilitation procedures which have not been identified separately should be coded to:

- Z50.8  Care involving use of other rehabilitation procedures

### Observation codes (Z03.- and Z04.-) - when to use them

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, these codes must 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:

a) Child found with empty medicine bottle.

**Z03.6  Observation for suspected toxic effect from ingested substance**

b) A patient was kept in hospital overnight with a minor condition e.g. superficial head injury which would not normally warrant an overnight stay.

**S00.9  Superficial injury of head, part unspecified**

**X59.9  Accident NOS**

**Z04.3  Examination and observation following other accident**

### Prophylactic Mastectomy  [CG3 June 99]

Women found to be at high risk of breast cancer for genetic reasons may opt for prophylactic mastectomy. Although there is some evidence that this procedure substantially reduces the subsequent risk of developing breast cancer, it will still be necessary to monitor the long term outcome of such women in Scotland. In order that these women can be identified in future, it is essential that the clinical coding of this situation is accurate and consistent across the country. The relevant codes are as follows:

**ICD10**

**Z40.0  Prophylactic surgery for risk factors relating to malignant neoplasms**

**Z80.3  Family history of malignant neoplasm of breast**

**OPCS4**

**B27.-  Total excision of breast (+ laterality code Z94.-)**

### Presence of CABG (Coronary Artery Bypass Graft)  [CG14 Jan 04]

When coding the Presence of CABG, please note the correct code is:

**Z95.1  Presence of aortocoronary bypass graft**

*not*

**Z95.5  Presence of coronary angioplasty implant and graft**

### Removal of Grommets  [CQ3 May 97]

Patient who had grommets inserted for glue ear returns to have the grommets removed (glue ear having cleared). What codes should be used?

**Z45.8  Adjustment and management of other implanted devices**

**Z86.6  Personal history of diseases of the nervous system and sense organs**

If the glue ear had not cleared up the codes would be:

**H65.3  Chronic mucoid otitis media**

**Z45.8  Adjustment and management of other implanted devices**
Renal Dialysis

CG14 Jan 04

If a patient is admitted as a day case or an inpatient specifically to have renal dialysis, then a code from the category Z49 Care involving dialysis must be used as a secondary code, the primary diagnosis being the renal condition.

However, if the patient is admitted for other treatment, for instance for a transplant, but receives dialysis whilst in hospital, it is not appropriate to use a code from category Z49.

Use of Z53 Procedure not carried out

CG9 July 01

Codes in category Z53 Persons encountering health services for specific procedures, not carried must always be used in first position, followed by the diagnosis for which the patient requires treatment.

Use of ‘Z’ codes

CG21 Nov 07

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:

a) Child found with empty medicine bottle.

Z03.6 Observation for suspected toxic effect from ingested substance

b) A patient was kept in hospital overnight with a minor condition (e.g. superficial head injury) which would not normally warrant an overnight stay.

S00.9 Superficial injury of head, part unspecified
X59.9 Accident NOS
Z04.3 Examination and observation following other accident

Persons encountering health services for examination and investigation Z00 – Z13 (cont.)

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

Z21.X  Asymptomatic human immunodeficiency [HIV] infection status
Z22.-  Carrier of infectious disease
Where the patient has been identified as a carrier or ‘positive’ in this episode.

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
Z54.-  Convalescence
These codes 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 CQ2 Feb 97 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. For further information please refer to standards Holiday relief care coding SMR01 and Holiday Relief Care (Respite care) Coding SMR04 SCCS2 July 13.

Persons with potential health 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 and Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues where the condition 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 comorbidities 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.

**Z41.1 Other Plastic Surgery for Unacceptable Cosmetic Appearance**

Clarification has been requested on the correct position of Z41.1. If the underlying condition is known and is a medical problem then this must be in main condition followed by Z41.1. See the examples below:

Striae Atrophicae admitted for abdominoplasty

L90.6 Striae atrophicae

**Z41.1 Other plastic surgery for unacceptable cosmetic appearance**

Patient admitted for breast reduction and is stated to have hypertrophic mammary glands

**N62.X Hypertrophy of breast**

**Z41.1 Other plastic surgery for unacceptable cosmetic appearance**

Where the clinical statement simply identifies the fact that the patient has an unacceptable cosmetic appearance, and attempts to clarify this with the clinician have failed then the **coder can use the Z41.1 as Main Condition**.

Patient admitted for breast augmentation and no mention is made of an underlying condition

**Z41.1 Other plastic surgery for unacceptable cosmetic appearance**

No other code is required.
CHXXII Codes for special purposes

### U06 and U07

Codes in categories **U06 Emergency use of U06** and **U07 Emergency use of U07**, must only be used when specifically instructed to do so by Terminology Services.

### U82-U85 Resistance to antimicrobial and antineoplastic Drugs

The Clinical Coding Review Group (CCRG) has agreed that it is not necessary to use ICD10 codes U82 –U85 in Scotland.

U82-U85 may be used locally if required, but relevant comorbidities¹ should take precedence over any codes from U82–U85 in nationally submitted SMR01 data. If any space is left after recording comorbidities and other necessary codes, the appropriate code(s) from U82-U85 may be recorded if desired.

Please note that if using the codes within categories U82-U85, the following applies:

They must:

- Never be used as primary diagnosis codes
- Only be used in a secondary position, sequenced directly following the code they enhance
- Only be assigned when drug resistance is clearly documented in the medical record by the responsible consultant.

¹ see [Comorbidities Coding (Other Conditions coding on SMR01) CG21 Nov 07](#)
HSCIC in England has identified errata in ICD10 V5. These are listed in the tables below. Please amend your ICD10-V5 books accordingly.

**W26 Contact with other sharp objects, X34 Victim of earthquake and X59 Exposure to unspecified factor**

The ICD-10 5th Edition, fourth character codes at categories **W26 Contact with other sharp objects(s), X34 Victim of earthquake and X59 Exposure to unspecified factor** must not be used.

Therefore the following changes must be made in Volume 1 – Tabular List and Volume 3 – Alphabetical Index of the ICD-10 5th Edition.

**ICD-10 5th Edition Volume 3 - Alphabetical index, External causes of injury**

<table>
<thead>
<tr>
<th>Page</th>
<th>Instruction</th>
<th>Action (Underline – insert text, Strikethrough – delete text)</th>
</tr>
</thead>
<tbody>
<tr>
<td>665</td>
<td>Delete fourth character</td>
<td>Accident (to) X59:9&lt;br&gt;- caused by, due to&lt;br&gt;- cutting or piercing instrument (<em>see also</em> Contact, with, by type of instrument) W26:9</td>
</tr>
<tr>
<td>674</td>
<td>Delete fourth character</td>
<td>Bayonet wound W26:9</td>
</tr>
<tr>
<td>674</td>
<td>Delete fourth character</td>
<td>Blow X59:9</td>
</tr>
<tr>
<td>677</td>
<td>Delete fourth character</td>
<td>Casualty (not due to war) NEC X59:9</td>
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<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 155  | Add modifier and code | Contusion (skin surface intact) *(see also Injury, superficial)* T14.0...  
- epigastric region S30.1  
- epiglottis S10.0  
- esophagus (thoracic) S27.8 |
| 166  | Amend fourth characters | Cyst *(continued)*  
...  
- nasoalveolar K09.81  
- nasolabial K09.81 |
| 190  | Amend modifier | Delivery *(continued)*  
- complicated *(continued)*  
- laceration *(continued)*  
...  
- - vagina, vaginal wall (low) (minor) O70.0  
- - - and muscles *(perianal, perineal)* *(vaginal)* O70.1 |
| 191  | Delete modifier and code | Delivery *(continued)*  
...  
- - postoperative F05.8 |
| 202  | Add fourth character | Diarrhea, diarrheal (disease) *(infantile)* A09.-.9 |
| 226  | Amend fourth character | Disorder *(continued)*  
...  
- personality *(see also Personality)* F60.9  
...  
- - organic F07.90 |
| 241  | Delete modifiers | Dyspepsia *(allergic)* *(congenital)* *(functional)* *(gastrointestinal)* *(occupational)* *(reflex)* R10.1 |
| 258  | Delete/ Amend modifiers and code | Enteritis *(continued)*  
...  
- influenzal *(specific virus not identified)* J11.8  
- - certain identified influenza virus J09  
- - - other seasonal influenza virus identified J10.8  
- - zoonotic or pandemic influenza virus identified J09 |
| 323  | Delete extra hyphen | History *(continued)*  
- - female  
- - circumcision Z91.7 |
| 351  | Add modifiers and codes | Infection, infected *(continued)*  
...  
- Enterobius vermicularis B80  
- - enterococcal *(faecalis)* NEC A49.1  
- - as cause of disease classified elsewhere B95.2  
- enterovirus NEC B34.1 |
| 405  | Amend cross reference | Lymphangitis I89.1  
- with  
- - abscess – see Abscess, by site  
- - cellulitis – see Abscess, by site *Cellulitis* |
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<th>Page</th>
<th>Instruction</th>
<th>Action (Blue Underline – insert text, Red Strikethrough – delete text)</th>
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</table>
| 406 – 407 | Amend fourth characters and delete modifiers | Lymphoma - continued  
...  
- centroblastic-centrocytic (diffuse) C83.9  
- - follicular C82.69  
...  
- follicular (centroblastic-centrocytic) (nodular) (with or without diffuse areas) C82.9  
...  
- - noncleaved (large cell) C82.32  
...  
- nodular (with or without diffuse areas) C82.9  
...  
- small cell (diffuse) C83.0  
...  
- - cleaved (diffuse) C83.1  
...  
- - - follicular C82.90                                                                                                                                                                                                 |
| 436   | Delete extra hyphen                       | Neglect (newborn) T74.0  
...  
- - self R46.8                                                                                                                                                                                                                                                          |
| 473   | Move modifier and code                   | Nephropathy (see also Nephritis) N28.9  
...  
- hereditary NEC N07.-  
- - end-stage (failure) I12.0  
Nephropathy - continued  
- hypertensive (see also Hypertension, kidney) I12.9  
- - end-stage (failure) I12.0  
- IgA N02.8                                                                                                                                                                                                 |
| 479   | Delete modifier                           | Nevus - continued  
...  
- - Spitz—see Nevus, spindle cell                                                                                                                                                                                                                                         |
| 492   | Delete extra hyphen                       | Osteophyte M25.7  
- - facet joint - see Spondylosis                                                                                                                                                                                                                                     |
| 522   | Add code                                 | Polyarteritis  
- - microscopic M31.7  
- - nodosa M30.0                                                                                                                                                                                                                                                         |
| 615   | Delete modifier and code                 | Tear, torn (traumatic) - see also Wound, open  
...  
- cartilage – see also Sprain  
- - articular, old M24.1  
- - - traumatic S37.6                                                                                                                                                                                                                                                  |
| 643   | Add modifier                             | Ulcer, ulcerated - continued  
- retina H30.0  
- - rodent – see also Neoplasm, skin, malignant                                                                                                                                                                                                                          |
| 686   | Delete extra hyphen                       | Earthquake (any injury) X34  
- - cataclysmic earth movements X34                                                                                                                                                                                                                                        |
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<thead>
<tr>
<th>Page</th>
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<tbody>
<tr>
<td>95</td>
<td>Amend category range</td>
<td>Codes for special purposes (U00-U99)</td>
<td></td>
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<tr>
<td>101</td>
<td>Amend category description</td>
<td>A04 Other bacterial intestinal infections</td>
<td></td>
</tr>
<tr>
<td>158</td>
<td>Amend excludes notes</td>
<td>B81 Other intestinal helminthiases, not elsewhere classified <em>Excl.</em>: angiostrongyliasis due to:  - <em>Angiostrongylus costaricensis cantonensis</em> (B83.2)  - <em>Parastrongylus eestaricensis cantonensis</em> (B83.2)</td>
<td></td>
</tr>
<tr>
<td>223</td>
<td>Amend code description</td>
<td>D46.0 Refractory anaemia without ringed sideroblasts, so stated D46.1 Refractory anaemia with ringed sideroblasts</td>
<td></td>
</tr>
<tr>
<td>426</td>
<td>Amend note</td>
<td>I22 Subsequent myocardial infarction Note: For morbidity coding, this category should be assigned for infarction of any myocardial site, occurring within 4 weeks (28 days) from onset of a previous infarction</td>
<td></td>
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<tr>
<td>461</td>
<td>Amend excludes note</td>
<td>J09 Influenza due to identified zoonotic or pandemic influenza virus  ... <em>Excl.</em>: <em>Haemophilus influenzae</em> [<em>H. influenzae</em>]:  - Infection NOS (A49.2)  - Meningitis (G00.0)  - Pneumonia (J14) Influenza due to identified seasonal influenza virus (J09 J10)</td>
<td></td>
</tr>
<tr>
<td>464</td>
<td>Amend code description</td>
<td>J10 Influenza due to seasonal influenza virus</td>
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<tr>
<td>464</td>
<td>Amend code description</td>
<td>J15.3 Pneumonia due to <em>Staphylococcus, group B</em></td>
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<tr>
<td>464</td>
<td>Amend code description</td>
<td>J15.6 Pneumonia due to other <em>aerobic</em> Gram-negative bacteria</td>
<td></td>
</tr>
<tr>
<td>495</td>
<td>Delete/Add inclusion terms</td>
<td>K09.0 Developmental odontogenic cysts Cyst (ed):  - <em>nasolabial</em> [nasoalveolar]  - <em>nasopalatine duct</em> [incisive canal]  - dentigerous  - eruption  - follicular  - gingival  - lateral periodontal  - primordial</td>
<td></td>
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<tr>
<td>499</td>
<td>Amend note</td>
<td>K14 Diseases of tongue <em>Incl</em> <em>Excl.</em>: erythroplakia</td>
<td></td>
</tr>
<tr>
<td>616</td>
<td>Delete excludes note</td>
<td>N18 Chronic kidney disease ... <em>Excl.</em>: chronic renal failure with hypertension (I12.0)</td>
<td></td>
</tr>
<tr>
<td>619</td>
<td>Amend excludes note</td>
<td>N28.1 Cyst of kidney Cyst (acquired) (multiple) (solitary) of kidney <em>Excl.</em>: cystic kidney disease, (congenital) (Q61.-)</td>
<td></td>
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<td>Text</td>
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</tbody>
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| 703  | Amend excludes note | P78.3  | Noninfective neonatal diarrhoea  
  *Excl.*: neonatal diarrhoea:  
  • NOS (A09.9)  
  • infectious (A09.9) |
| 735  | Amend inclusion | Q61.1  | Polycystic kidney, autosomal recessive  
  *Congenital cyst of kidney (single)*  
  *Polycystic kidney, infantile type* |
| 939  | Amend code description | W26  | Contact with other sharp object(s) |
| 942  | Amend includes and excludes notes | W45  | Foreign body or object entering through skin  
  *Incl.*: foreign body or object embedded in skin:  
  • nail  
  • splinter  
  *Excl.*: contact with:  
  • hand tools (nonpowered)(powered) (W27-W29)  
  • hypodermic needle (W46)  
  • *knife, sword or dagger* other sharp object(s) (W26)  
  • sharp glass (W25)  
  • struck by objects (W20-W22) |
| 957  | Amend excludes note | X54  | Lack of water  
  ...  
  *Excl.*: insufficient intake of water due to self neglect (R63.86) |
| 1033 | Amend category range | Codes for special purposes (U00-U9985) |