Please note that the Coding Advisory Service Telephone Number is 0131-552-7325. The number is manned Tuesday to Thursday from 09.00 to 17.00 hrs.

CODING GUIDELINES - ICD10 ...........................................................2
CODING GUIDELINES - OPCS4 .........................................................6
GENERAL INFORMATION ..................................................................7
DQA NEWS .......................................................................................8
**Coding Guidelines - ICD10**

**TCC (Transitional Cell Carcinoma of Bladder)**

Further to the article in Coding Guidelines No 8 (February 2001), it has been decided that coders should consult with medical staff to establish what they mean by Carcinoma Bladder and Cancer Bladder in the absence of further information.

**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)  
  Code 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  
  Code 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  
  Code L03.1 – Cellulitis of other parts of limb  
  W27.9 – Contact with non-powered hand tool  
  F11.2 – Addiction to heroin

- Patient admitted with cellulitis due to insect bite of finger  
  Code L03.0 – Cellulitis of finger and toe  
  W57.9 – Bitten or stung by nonvenomous insect and other nonvenomous arthropods

**Faecal Occult Blood**

The question has arisen of whether faecal occult blood should be coded to:

- R19.5 – Other faecal abnormalities  
  or  
- K92.1 - Melaena

It has been decided that because the blood is ‘occult’ and ICD10 can’t measure the quantity of blood, a diagnosis of faecal occult blood should be coded to:

- K92.1 - Melaena
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

This advice will take effect from 1st April, 2004, and is the method of coding poisonings in England and Wales

Initiation and Maintenance of Drug Therapy

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.

Gangrene

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

e.g.
Gangrene
- intestine  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.
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.

Renal Dialysis

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 should 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.-

SMR02 v SMR02D

Following some queries on the correct circumstances for ‘BBAs’ (Born Before Arrivals), please note the following extract from the SMR Data Manual;

“Home Births, whether planned or unexpected should be recorded on an SMR02D form.
An SMR02D form should be completed for;

? a planned home delivery with no hospital admission
? an unplanned home delivery with no hospital admission
- a planned home delivery when, following the birth of the baby, the mother is admitted to hospital. (whilst an SMR02D return should be submitted to record the home birth, the hospital should record the mother’s admission as a postnatal episode on an SMR02)

Please note that when the mother unexpectedly delivers her baby at home, and is then admitted to hospital, an SMR02 return should be completed by the hospital detailing that the patient delivered before arrival. No SMR02D return is required. “

Presence of CABG (Coronary Artery Bypass Graft)

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.
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)

Passive Smoking

There is no appropriate code within ICD10 that specifically identifies a patient who
has a condition aggravated by passive smoking. The UK Coding Review Panel
(CRP) has agreed that at present the code Z58.8 – Other problems related to physical
environment can be used as an additional code.

ICD10 code for Burkitt’s Cell Leukaemia

The index (Volume 3) of ICD10, page 79, gives the code C91.0 for Burkitt’s Cell
Leukaemia whereas the Morphology code listing in the tabular list (Volume 1), Page
1203, gives the code C91.7. This error has been reported to the NHSIA in England
and they will raise it with the WHO in 2004. Until a decision is forthcoming, code
Burkitt’s Cell Leukaemia to C91.7.

ICD10 Additions and amendments

The World Health Organisation has issued corrigenda to the index and introduced ten
new ICD10 codes.
ISD have instructed that these new codes and amendments should be implemented
from April 1st 2004.
The reference files will be updated with the new codes just prior to April 1st 2004.
Trusts should ensure that all staff referencing ICD10 are either supplied with new
books (Vols I and III) or are provided with the information to amend their current
volumes.
The files are available from the WHO web site;
www.who.int/whosis/icd10/corr-eng.htm
Coding Guidelines - OPCS4

Scopes and Blood Transfusions

We have been asked whether a scope would take precedence over a blood transfusion in order of recording, if both have been given during an episode of care. In general, therapeutic procedures have priority over diagnostic procedures, but in this case clinicians have decided that since scopes are more resource intensive than blood transfusions, it is correct to give them higher priority.

Angiographies and angioplasties

*Diagnostic* angiography should always be recorded on SMR01, even when it takes place in the same episode as CABG or PCTA. Although this is not strictly necessary according to traditional coding convention, it is the only way we have at the moment to ensure that all angiography to CABG/ PCTA waiting times are included in national SMR01 statistics

However if a prior diagnostic angiography has been carried out and the current angiography is performed to allow correct positioning of the balloon, the current angiography should not be recorded on SMR01.

Carpal Tunnel Release

Since carpal tunnel release (A65.1) is always done on the median nerve, it is not necessary to include a supplementary code of Z09.2. A supplementary laterality code should be used in preference, where appropriate.
General Information

Coding Clinics

Some coders may receive Coding Clinics from the NHSIA in England. These contain decisions made by the Coding Review Panel about coding queries. Please note that these should not be implemented by Scottish coders until they are approved by the Clinical Coding Review Group, when they will be published in Coding Guidelines.

National Clinical Coding Qualification

For anyone planning to sit the National Clinical Coding Qualification in May 2004, a reminder that the final registration date is 31st January. Applications to the Institute of Health Record Information & Management office, 141 Leander Drive, Castleton, Rochdale, OL11 2XE
DQA News

DQA Staff Changes

The DQA Team have been through many changes this year. Margaret Mason joined the team as Manager in June. Margaret came from Fife Primary Care NHS Trust where she had been the Medical Records Manager for 9 years. Prior to this she had worked in Ninewells, King’s Cross and Dundee Royal Infirmary as well as General Practice for many years.

Mary Virtue, DQA Advisor is off on long term sick and I’m sure you will join us in wishing her a speedy recovery!

Kjersti Fergusson left the DQA team at the end of November on a 2 year secondment to work with Social Care Standards.

Andrea McMurtrie recently joined the team having moved over from the Data Deficit and Development programme in ISD. Many of you may well know Andrea from the backlog coding work she did for some of the Trusts.

Will Van Der Byl joined the DQA team in February 2003 and he has been helping the Data Monitoring Team as well as DQA.

Coding Backlogs

The DQA Team have been heavily involved in the backlog coding out at Trust level and this has given them a useful insight into how coders operate out at the sites. Hopefully it will have also created good working relationships between the coders and the DQA staff!

SMR01 Audit

The SMR01 audit has now been completed and it is hoped that the Report will be on the Scottish Health Statistics website by the end of the year. A preview has already gone out to Chief Executives, Medical Directors and Medical Records Managers.

Clinical Priorities and Outcomes

4 out of 5 assessments have now been completed and 3 reports have gone out to Trusts for comment.