CODING GUIDELINES

No. 15
November, 2004

Please note that the Coding Advisory Service Telephone Number is 0131-275-7283. The number is manned Tuesday to Thursday from 09.00 to 17.00 hrs. This is a new number following our move to Gyle Square, Edinburgh, and we apologise for any difficulties customers may have had contacting us during the transition period.

CODING GUIDELINES - ICD10 ...............................................................2
‘CONSISTENT WITH’ ............................................................................................................. 2
BILATERAL INJURIES ........................................................................................................ 2
BODY PIERCING ................................................................................................................. 2
MGUS (MONOCLONAL GAMMOPATHY OF UNDETERMINED SIGNIFICANCE) .......... 2
TRANSITIONAL CELL CARCINOMA (TCC) URETER AND RENAL PELVIS (NOT OTHERWISE SPECIFIED) ................................................................. 3
CYSTOCELE/RECTOCELE ................................................................................................ 3
ICD10 ADDITIONS AND AMENDMENTS ................................................................. 4

CODING GUIDELINES - OPCS4 .........................................................4
TWO STAGE REVISION JOINT CODES ..................................................................... 4
COLONOSCOPIES/SIGMOIDOSCOPIES ..................................................................... 5
BILATERAL MASTECTOMIES ...................................................................................... 5

GENERAL INFORMATION .................................................................................6
HELPDESK QUERIES .............................................................................................. 6
NATIONAL CLINICAL CODING QUALIFICATION .............................................. 6
FAREWELL TO ESTHER ............................................................................................ 6

DQA NEWS ..........................................................................................................7
Coding Guidelines - ICD10

‘Consistent with’

Advice has been asked regarding the use of the terms ‘consistent with’, ‘compatible with’ and ‘in keeping with’. It has been decided that these phrases should be treated the same as ‘probable’, therefore code to the disease; For example “…is consistent with Allergic Asthma.”

Code to Allergic Asthma.

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.

Body Piercing

If there is a problem with body piercing, the appropriate external cause code is: W45.- Foreign body or object entering through the skin. For example: traumatic ulceration and granuloma due to lip piercing should be coded to: L92.3 - Foreign body granuloma or skin and subcutaneous tissue K13.0 - Disease of lips W45.9 - Foreign body or object entering through the skin (unknown place of occurrence)

MGUS (Monoclonal Gammopathy of Undetermined Significance)

In the Cancer Registration update of July, 2002, an article appeared concerning MGUS. It states ‘although the index of ICD10 suggests that MGUS should be coded as D89.2, this is the code for Hypergammaglobulinaemia. The Coding and Classification group of the UKACR has decided that MGUS should more appropriately be coded as D47.2. This decision has gone to WHO for approval, but in the meantime it has been decided to change the coding of MGUS in Scotland to D47.2

This change will take place from 1st April 2005.
Transitional Cell Carcinoma (TCC) Ureter and Renal Pelvis (not otherwise specified)

Advice has been issued previously (Coding Guideline No 8 and 14) regarding how to code TCC of the Bladder (not otherwise specified). Following queries on how to code TCC of the ureter or renal pelvis it has been agreed that the same principle should be followed as for TCC of the bladder.

TCC of the Ureter, not otherwise specified should be coded to D41.2 Neoplasm of uncertain or unknown behaviour of the ureter (not C66.X)

TCC of the Renal Pelvis (not otherwise specified) should be coded to D41.1 Neoplasm of uncertain or unknown behaviour of the renal pelvis (not C65.X)

However, in all cases of TCC, not otherwise specified, clarification should be actively sought by the coder from the urologist. And if the urologists in your hospital advise that, as a matter of policy, they always use the term TCC to refer to invasive disease, then the codes selected should reflect this (C66.X or C65.X), rather than the advice given above.

Suggested coding:

<table>
<thead>
<tr>
<th>Diagnostic term</th>
<th>Pathological Grade/Stage</th>
<th>ICD-10 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(papillary) TCC, primary invasive of renal pelvis</td>
<td>pT1 or worse</td>
<td>C65.X</td>
</tr>
<tr>
<td>(papillary) TCC, primary invasive of ureter</td>
<td>pT1 or worse</td>
<td>C66.X</td>
</tr>
<tr>
<td>(papillary) TCC, in situ of renal pelvis</td>
<td>pTis</td>
<td>D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, in situ of ureter</td>
<td>pTis</td>
<td>D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, high grade non-invasive of renal pelvis</td>
<td>G3pTa</td>
<td>D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, high grade non-invasive of ureter</td>
<td>G3pTa</td>
<td>D09.1</td>
</tr>
<tr>
<td>(papillary) TCC, grade 1 or 2 non-invasive of renal pelvis</td>
<td>G1pTa or G2pTa</td>
<td>D41.1</td>
</tr>
<tr>
<td>(papillary) TCC, grade 1 or 2 non-invasive of ureter</td>
<td>G1pTa or G2pTa</td>
<td>D41.2</td>
</tr>
<tr>
<td>(papillary) TCC, NOS* of renal pelvis</td>
<td>Not known</td>
<td>D41.1</td>
</tr>
<tr>
<td>(papillary) TCC, NOS* of ureter</td>
<td>Not known</td>
<td>D41.2</td>
</tr>
</tbody>
</table>

*Not otherwise specified, and no further information obtainable

This change will be implemented from 1st April, 2005. Please remember to update the ICD10 Index and the Tabular books.

Cystocele/Rectocele
There is a rather confusing entry in the ICD10 index on p130 of
Cystocele (-rectocele), and we have been asked whether a patient with both a
cystocele and rectocele requires one code or two for this. It has been decided that if
both are present, with no uterine prolapse mentioned, each should be coded i.e. code
N81.1 – Cystocele and
N81.6 - Rectocele

ICD10 Additions and amendments

By now you should have either received your new copies of the ICD10 Index or
updated your existing index using the updates given on the NHS web site. Your
tabular lists should also be updated either with the list found on the web site or using
the corrigenda in the new Index. (Please note that the last Coding Guidelines indicated
there were ten new codes, whereas there are actually six).

The updates took effect in Scotland for all discharges from 1st June 2004 onwards.

If any of your systems have cut-down lists of codes these should also be checked to
see that they comply with any changes.

Would Mental Health units also note the changes to Chapter V – Mental and
Behavioral Disorders affects the ‘blue book’ – the MH sub-classification. Any such
books currently in use should also be amended.

Coding Guidelines - OPCS4

Two Stage Revision Joint Codes

The following advice was given out at an Arthroplasty Coders’ workshop in Dundee:
Two stage revisions of hip and knee arthroplasties should be coded as follows, to
reflect (as specifically as possible using OPCS4), what actually happens to the patient,
whilst giving clear information about the joint and laterality.

First stage
Diagnosis: the indication for a two-stage revision will almost certainly be an infected
prosthesis
Procedure: W57.4 – Conversion to excision arthroplasty of joint with
  Z84.3 – Hip or
  Z84.6 – Knee

Second stage
Diagnosis: if the second stage occurs in a different episode to that of the first stage,
the main diagnosis should not be infected prosthesis. Instead Z47.8 – Other specified
orthopaedic follow-up care should be used. However, normal coding rules would
apply if, within the same episode, another condition became the main condition being
treated during that episode.

Procedure – hip
W37.2 or W38.2 or W39.2 – Conversion to total prosthetic replacement of hip using
cement/not using cement/nec supplemented by Z94.- Laterality
Procedure - knee
W40.2 or W41.2 or W42.2 - Conversion to total prosthetic replacement of knee using cement/not using cement/nec supplemented by Z94.- Laterality

Colonoscopies/Sigmoidoscopies

Because the titles of categories H23.- to H28.- include reference to sigmoidoscopes, when coding colonoscopies or sigmoidoscopies, the coder should use the code applicable to the instrument rather than the part of the intestine examined. Any colonoscopy/sigmoidoscopy which fails to progress to the intended area, and where nothing but examination was carried out, should have a Z code added to indicate how far it reached.
For example:- patient comes in for a colonoscopy, but because of poor bowel preparation the scope cannot proceed beyond the rectum. Code to
H22.9 Colonoscopy nec with
Z29.1 Rectum

This change will be implemented from 1st April, 2005.

Bilateral Mastectomies

At the moment if a bilateral excision of breast B28.- or B29.- is done with block dissection, sampling, excision or biopsy of the lymph nodes, the laterality of the operation is lost because the excision is a pair code with the other operation. It is felt that important information is being lost by coding in this way.
From 1st April, 2005, where a bilateral operation of this nature has been performed, the pair code should be split in order to add a laterality code to each operation.

Please note that this advice is for excision of breast only and does not apply to other bilateral operations eg cataracts.

Example 1: Patient has excision of lesion of left breast with sampling of left axillary lymph node. Continue to code to
B28.3 – Excision of lesion of breast with
T86.2 – Sampling of axillary lymph nodes (pair code)

Example 2: Patient has bilateral total mastectomies with bilateral block dissection of axillary lymph nodes. Code to
B27.4 – Total mastectomy nec with
Z94.1 – Bilateral operation
And
T85.2 – Block dissection of axillary lymph nodes with
Z94.1 – Bilateral operation
General Information

Helpdesk Queries

Please note that answers to queries given through the helpdesk service are given only for the specific question asked. It should not be taken for granted that they apply to all similar queries.

National Clinical Coding Qualification

Due to the introduction of the new National Intervention Classification in England in 2006, the NHSIA and IHRIM have decided that there will be no NCCQ exam in that year. Instead, there will be two exams in 2005 as follows;

19th May 2005 - closing date for registrations; 31st January 2005
22nd November 2005 - closing date for registrations; 31st August 2005

Cost of sitting the exam will be £140 and £70 for re-sits. In addition, students must be members of IHRIM which costs £50 (tax can be re-claimed on this).

Details of the exam, including examples of past papers and details of how to register can be found on the NHSIA web-page; http://www.nhsia.nhs.uk/dataquality

It would be useful to know how much interest there is for the exam next year in Scotland. An email or phone call to your tutor would be appreciated.

Farewell to Esther

Esther Morris, Clinical Coding Tutor and Read Advisor is to take a career break of up to 5 years to spend more time with her young family. We wish her well, and look forward to her return.
DQA News

The DQA Team are continuing with the Waiting Times project which covers 28 hospitals and over 5000 records. Most of the data should be collected by the end of December and report writing is ongoing. The two main objectives of this particular project are to look at the reasons for patients who are waiting over 12 months for treatment and the application of Availability Status Codes 3 & 4.

Individual hospital reports will culminate in a Scotland report next year.

The next major piece of work for the DQA Team will be an SMR01 QA.

There have been some changes to the staff in the Team, namely, the retiral of Mary Virtue at the end of November. Mary joined the team in 1996 from the Royal Infirmary in Edinburgh and her knowledge of clinical coding was second to none. We all wish her well for the future. Andrea McMurtrie who joined the Team in November 2003 has moved on to the PTI team and her post along with Mary’s will be filled soon.

In May 2004 six Clinical Coding and Data Support Officers were appointed to help with any backlog coding out at hospitals. If anyone requires their help they should contact Margaret Mason at ISD on 0131 275 6528 or email Margaret.Mason@isd.csa.scot.nhs.uk