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.

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Coding Guidelines - ICD10

Sinus Bradycardia and Tachycardia

Following a query regarding the terms Sinus Bradycardia and Sinus Tachycardia, it would appear that there are errors in the index entries. The issue has been passed to the World Health Organisation, but it is likely to be some time before a correction is printed. In the meantime coders should make the following amendments to their ICD10 books, as confirmed by the Coding Review Panel (UK) and the Clinical Coding Review Group (Scotland).

Tabular List (Volume 1) p 492 - 493

<table>
<thead>
<tr>
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<tr>
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<td>I47 Paroxysmal tachycardia</td>
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<td>tachycardia: NOS (R00.0)</td>
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<tr>
<td>• NOS (R00.0)</td>
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<td>• sinoauricular NOS (R00.0)</td>
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<td>• sinus [sinusal] NOS (R00.0)</td>
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<td>I49 Other cardiac arrhythmias</td>
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<td><strong>Excludes:</strong></td>
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<td>bradycardia: NOS (R00.1)</td>
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<td>• NOS (R00.1)</td>
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<td>• sinoatrial (R00.1)</td>
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<td>• sinus (R00.1)</td>
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<td>• vagal (R00.1)</td>
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Index (Volume 3) p76

<table>
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<td>Bradycardia (any type) (sinoatrial) (sinus) (vagal) R00.1</td>
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Index (Volume 3) p499

<table>
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<td>- tachycardia I47.1 R00.0</td>
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<td>- - paroxysmal I47.1</td>
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The implementation date for this in Scotland will be 1st October, 2005
Laceration

There is a code missing from the new ICD10 index. See the entry on p328:

Laceration
  - chordae tendinae
  - following acute myocardial infarction (current complication) I23.4

Please add this code to your index.

Raised INR

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. (In the same way, INR results below the therapeutic range 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 relevant 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.
Alcohol involvement when noted with an overdose of drugs

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)

Chronic Ischaemic Heart Disease and Triple Vessel Disease

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
Multiple Identified Psychoactive Substances

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” code 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.
Coding Guidelines - OPCS4

IV antibiotics

In the past, where no further information was available, we have given out the advice that the default code for IV antibiotics was X35.2 – Intravenous chemotherapy. New training material from England gives the default code as X29.8 – Other specified continuous infusion of therapeutic substance. As usual, our advice is to find out where possible, whether the IV antibiotics were given by injection or infusion but where this information cannot be found and IV antibiotics has been mentioned on the discharge summary, we will default to X29.8 to be consistent with England.

The implementation date for this change to coding practice in Scotland will be 1st October, 2005

Two stage revision arthroplasties

A query has arisen from the guidance given by the Scottish Arthroplasty Project on the coding of patients undergoing a two-stage revision for an infected prosthesis. Under the section of the guidance which relates to ‘Second Stage’, the following is written:
“Diagnosis: if the second stage occurs in a different SMR01 episode to that of the first stage, the Main Diagnosis for the second episode should not be ‘infected prosthesis’
Instead Z47.8 Other specified orthopaedic aftercare should be used”.

To clarify: this should read “Diagnosis: if the second stage occurs in a different admission episode to that of the first stage…”

i.e. where the patient has been discharged from in-patient care following the first stage and re-admitted for the second stage, the diagnosis should be Z47.8 for the second admission.

Patients retained in hospital during the period between the first and second stages should be considered as ‘continuing care patients’, with normal coding rules applied.

Bilateral Mastectomies

In the article in Coding Guidelines No.15 (November, 2004) on Bilateral Mastectomies, reference was made to codes B28.- and B29.- for excision of breast. This should have read B27.- and B28.-. Please correct your copies of Coding Guidelines.

Rastelli

Rastelli procedure involves creation of a valved conduit between the right ventricle of the heart and pulmonary artery and as such is coded to K18.3 (Creation of valved conduit between right ventricle of heart and pulmonary artery). The eponyms section of the OPCS4 index also gives the code K19.3 for Rastelli. This is an error. Please delete this eponym from your index.
Dental Cystectomy

Coders should add a note to their OPCS4 index and tabular list that the correct code for a dental cystectomy is F18.1 – Enucleation of dental cyst of jaw

Sutures and Debridement

Where it is necessary to debride before suturing e.g. remove foreign particles, trim edges of a wound then the debridement should also be coded. This should be mentioned in the notes as such to qualify the use of both codes. Where there is no mention of ‘debridement’, ‘trimming of edges of wound’, ‘removal of glass’, etc. then code only the suturing of the wound.

Examples:
Dx: Open wound of head – fell off motorbike
Op: Suture to laceration of scalp, removed debris and trimmed edges of wound.

OPCS4 Codes:
S41.1 Primary suture of skin of head or neck nec
Z48.1 Skin of scalp
S56.1 Debridement of skin of head or neck nec
Z48.1 Skin of scalp

Dx: Lacerated R arm – fell off step
Op: Sutured R arm

OPCS4 Codes
S42.1 Primary suture of skin nec
Z50.1 Skin of arm

Angiographies and angioplasties

In the Coding Guidelines No.14 (January, 2004), the following advice was given; “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.”

It should be understood that this guideline applies to ALL patients, not just Elective ones, even though the main reason for this instruction was to help monitor Waiting Times. Coders should NOT make a distinction between patients of differing Admission Types.
General Information

Circulatory System and Vascular Workshop
ICD10/OPCS4 Refresher Workshop

The Coding Centre can now offer two new courses
• A 2 day workshop on the Circulatory system and vascular.
• A 3 day ICD10/OPCS4 refresher course for those who have already completed the basic training course

For further details or to arrange a workshop at your site, please contact your Clinical Coding Tutor.

National Clinical Coding Qualification

Despite the fact that the introduction of the National Intervention Classification will no longer go ahead in England, the NHSIA and IHRIM have decided that they will keep to the decision to have no exam in 2006.

There will be a second exam this November:

22\textsuperscript{nd} November 2005 - \textbf{closing date for registrations is 31\textsuperscript{st} August 2005}.
No late registrations will be accepted.

Cost of sitting the exam will be £140 and £70 for resits.

Details about registration, previous exam papers and the syllabus are available from the NHSIA (Connecting for Health) web site:

http://www.nhsia.nhs.uk/dataquality/

Coders considering sitting the exam in November should be aware that recommended length of study is 6 months.

It would be useful if you could let your Clinical Coding Tutor know if you intend to sit this exam in November.
DQA News

The DQA Team has just completed the Waiting Times Data project. All reports have gone out to hospital contacts in the first instance and then on to Board Chief Executives for a Management Response.

An SMR01 and Associated Data QA is in final stages of preparation and the pilot is currently taking place at Monklands Hospital in Lanarkshire. This is a new style QA in that it supports ISD programmes of work. In addition to the standard SMR data items assessed it is also looking to report on the accuracy of revision arthroplasty, mental and behavioural disorders (in the context of SMR01), use of CHI and the identification of ethnic group to name but a few.

Margaret Mason, DQA Manager, will be in contact with hospital staff in the near future to arrange visits etc.

There have been some changes in the DQA Team since the last issue. Graham Robertson and Nicola Starkey have now joined the team. Graham was one of the Clinical Coding and Data Support Officers appointed last year and Nicola worked with the SHRUGS/SCRUGS team before starting in DQA. Kieran Hudson has also been seconded from the Healthcare Information Group and will be with the DQA team until December 2005.

The Clinical Coding and Data Support Officers have settled in well and anyone requiring help with backlog coding should contact Margaret Mason on 0131 275 6528 or email Margaret.Mason@isd.csa.scot.nhs.uk