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. The link for previous coding guidelines and the cumulative summary on line is:
http://www.isdscotland.org/clinical_coding

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**Coding Guidelines - ICD10**

**High cholesterol**
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 eg statins

**Bile reflux into the stomach and biliary gastritis**
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. There are no specific ICD10 index entries for *bile reflux* or *biliary gastritis*.

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.

**Secondary pulmonary hypertension**
As stated in Coding Guidelines No 17, January 2006, a diagnosis of ‘pulmonary hypertension’ should always be checked with the clinician, even though the index trail defaults to primary pulmonary hypertension. If the clinician confirms that the diagnosis is secondary pulmonary hypertension, the correct code to use is I27.8 – Other specified pulmonary heart diseases. This code applies no matter what condition the pulmonary hypertension is secondary to.
MRSA
Coding departments should have had a letter giving the following advice about MRSA coding.
There has been a great deal of interest in the incidence of MRSA in hospitals, but codes at present do not distinguish MRSA from other types of staphylococcal infection. It has been decided in Scotland that we will use a 5th digit to identify whether staphylococcal infections are MRSA or not, and when MRSA was identified. Codes affected will be:

A49.0 – Staphylococcal infection, unspecified
B95.6 – Staphylococcus aureus as the cause of diseases classified to other chapters
A41.0 - Septicaemia due to staphylococcus aureus
G00.3 - Staphylococcal meningitis
P36.2 - Sepsis of newborn due to staphylococcus aureus
Z22.3 – Carrier of other specified bacterial diseases (includes MRSA carrier and MRSA positive)

Each of these codes will be allocated 5th digits as follows:

0 not MRSA
1 MRSA identified before admission to this episode
2 MRSA identified after admission to this episode
3 MRSA not known when identified
9 Not known whether MRSA

Note that the time identified refers to the episode, so the 5th digit could change between episodes in the same hospital stay.

Also if MRSA infection has been identified and coded, it is not necessary to add a code for MRSA carrier or MRSA positive (Z22.3).

From 1st April, 2006, whenever coders select one of the codes given above, they must add one of the appropriate 5th digits.

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

**Cord Compression complicating delivery**

There is conflicting advice in the index about how cord compression complicating delivery should be coded.

**P 112**

Compression
- umbilical cord
- - complicating delivery O69.2

**p 146**

Delivery
- complicated (by)
- - cord (umbilical)
- - compression NEC O69.8

It has been decided by the CCRG that the correct code for delivery complicated by cord compression is O69.8. Coders should therefore alter their index on p 112.

**P 112**

Compression
- umbilical cord
- - complicating delivery O69.2. O69.8
Coding Guidelines - OPCS4

Scans
Since OPCS4.3 was introduced there have been several problems with the coding of scans. Some decisions were given out through helpdesk, but it was decided that the whole subject needed to be reviewed. The following general guidelines should be followed:

1. If only one scan is done, only one code should be used, even if more than one part of the body has been scanned
2. If multiple sites are examined use a .8 in the appropriate site code category (as we do with multiple biopsies)
3. Type of scan should take precedence over site, e.g. if a CT scan has been done use a CT scan code
4. Next in priority is site
5. Last in priority is contrast material

This article replaces any previous verbal guidance, and queries not covered by this general advice should be referred to the helpdesk. Guidance given in CG18 May 2006 still applies.

Example: Ultrasound scan of kidney, ureter and bladder (one scan). Code to U12.3 – Ultrasound of kidneys + Z41.8 – Specified upper urinary tract NEC
(Select U12.3 in preference to U12.4 because higher in hierarchy. Reason for selecting site code Z41.8: Genitourinary sites come under categories Z41 and Z42. Z41 is higher up the hierarchy so select Z41. Select .8 for multiple sites.)

Angioplasty and stenting of coronary artery
Since the introduction of OPCS4.3, angioplasty and stenting of the coronary artery must be coded using a K75.- code not a K49.- code. There is no code at K75.- for stenting of multiple coronary arteries, therefore it is now not possible to code this information.
It may happen that both drug-eluting and non-drug-eluting stents are used in the procedure. If this is the case, code to the appropriate K75.1 or K75.2 code rather than using 2 different K75.- codes for the same procedure.

Correction to code published in Coding Guidelines 18
In Coding Guidelines 18 (May 2006), there was a misprint in the article on Bronchoscopy with washings and brushings
The last line read;
Biopsy, bronchoscopy with washings and brushings E49.1 and E29.2 + Y21.1
It should have read
Biopsy, bronchoscopy with washings and brushings E49.1 and **E49.2** + Y21.1

Please amend your Coding Guidelines accordingly.
**Nebuliser**

Although OPCS4.3 gives the default code for Nebuliser NEC as E85.5 – Nebuliser ventilation, patients who are given a nebuliser for asthma or cystic fibrosis are generally not having nebuliser ventilation.

Where “Nebuliser given” is mentioned on the discharge summary of such patients, use the code **E89.3 – Nebuliser therapy** unless there is evidence to the contrary.

This advice is effective from 1st October, 2006

**Errata**

We have been advised of more errata by Connecting for Health. Please amend your new Coding Books.

**CHEMOTHERAPY GUIDANCE ERRATA**

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<thead>
<tr>
<th>Ref no.</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>16</td>
<td>Alemtuzumab is a High Cost Drug listed at X89.1 Monoclonal antibodies Band 1 in the table at the back of OPCS-4.3. It should be coded as X89.1 if it is not used for the treatment of a neoplasm. If it is used for the treatment of a neoplasm then it should be coded at X71.5 for procurement and X72.1 for delivery. It may appear as part of a chemotherapy regimen as Mabcampath or Campath or Alemtuzumab.</td>
</tr>
<tr>
<td>17</td>
<td>Rituximab is a High Cost Drug listed at X89.2 Monoclonal antibodies Band 2 in the table at the back of OPCS-4.3. It should be coded as X89.2 if it is not used for the treatment of a neoplasm. If it is used for the treatment of a neoplasm then it should be coded with its regimen. e.g. as part of ICE+ Rituximab (=RICE) X71.5 for procurement and X72.1 for delivery.</td>
</tr>
<tr>
<td>18</td>
<td>Filgrastim, Lenograstim and Pegfilgrastim are High Cost Drugs listed at X90.3 Neutropenia Drugs Band 1 in the table at the back of OPCS-4.3. These drugs can be used to treat neutropenia which is a side effect of antineoplastic chemotherapy and should be coded as High Cost Drugs.</td>
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## INDEX ERRATA

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<tr>
<th>Page no.</th>
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<tr>
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<td>B36.-</td>
<td>Add index entry: B36 Reconstruction Areola</td>
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<td>B36.-</td>
<td>Add index entry: B36 Reconstruction Nipple</td>
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<tr>
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<td>Add index entry: M10.5 Rupture Kidney Pelviureteric Junction Stenosis Endoscopic Endoluminal Balloon</td>
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<td>K33.2</td>
<td>Change eponym list entry as follows: K33.1 Ross Pulmonary autograft aortic root replacement</td>
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<tr>
<td>177</td>
<td>K33.6</td>
<td>Change eponym list entry as follows: K33.2 Ross-Konno Aortoventriculoplasty pulmonary autograft aortic root replacement</td>
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</table>
General Information

Coding Examinations
Several Scottish candidates have been successful over the past year in passing the National Clinical Coding Qualification. Congratulations to them all.

Additional Training Support for new SMR submission targets
In order to help support the Service to meet new SMR submission targets, ISD Terminology Service is pleased to be able to provide the following additional two day introductory coding courses:

Location: Cirrus House, Glasgow Airport Industrial Estate, Paisley
Thursday 23rd November 2006
ICD10 (tutor: Carol Roulston)
Friday 24th November
OPCS4 (tutor: Carol Roulston)

Location: ISD Headquarters, South Gyle Square, Edinburgh
Monday December 4th
ICD10 (tutor: Julia Ewen)
Tuesday December 5th
OPCS4 (tutor: Julia Ewen)

It is possible to attend any of the above as a one day session if deemed more suitable. Please note that further sessions across Scotland can be arranged, subject to demand and availability.

For booking and availability please either contact the tutors directly (carol.roulston@isd.csa.scot.nhs.uk or Julia.ewen@isd.csa.scot.nhs.uk) or phone the Coding Advisory Helpdesk on 0131-275-7283.

Please note there are also standard courses already currently available throughout Scotland during the fourth quarter of 2006, for example:
3-6th October - Dumfries (mainly ICD10)
30th October - 3rd November – Ayrshire – ICD10
7th-9th November - Ayrshire – OPCS4
12th-14th November – Aberdeen - ICD10 (psychiatry specific).

For a complete list of courses, contact the Coding Advisory Helpdesk on 0131-275-7283.
DQA News

The Data Quality Assurance team is now three quarters of the way through the SMR01 and Associated Data QA. Already, lots of ideas have been discussed on how all the information will be presented in the Scotland Report due out next year. The first Powerpoint presentation of the findings from the three Lanarkshire hospitals was presented to the Lanarkshire clinical coding, secretarial and admin staff and that went really well. It is the plan to offer all health board areas a similar presentation based on local findings.

The Dental QA is now complete and the final Scotland summary is with the Chief Dental Officer and data collection is continuing for the Angiography/Revascularisation QA.

Will Vanderbyl, who joined us in 2002, has moved on from DQA to the National Clinical Data Development Programme at ISD. We wish him well in his new post!