The Terminology 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 on line is: http://www.isdscotland.org/terminology
Coding Guidelines - ICD10

MRSA Codes
From April 2006 it has been mandatory to add 5th digits to the following codes to indicate whether MRSA was identified in the episode:

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)

The fifth digits to be added were:
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

Since then 3 more codes have been identified that should also have the same 5th digits added

J15.2 Pneumonia due to staphylococcus
L00.X Staphylococcal scalded skin syndrome
P23.2 Congenital pneumonia due to staphylococcus

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.

Transitional Cell Carcinoma Kidney
Transitional cell carcinomas (M8120/3 to M8130/3) of the kidney are most likely to have arisen in the renal pelvis and should be recorded with an ICD10 site code of C65.X. If there is specific evidence to show that the transitional cell carcinoma arose in any other part of the kidney then code accordingly. This will bring clinical coding in NHS Scotland into line with our colleagues in the Scottish Cancer Registry.

Mobility Scooters
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’.
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.
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.
Please note the exclusions here;
“collision of pedestrian (conveyance) with other pedestrians (conveyance) (W51.-)
• with subsequent fall (W03.-)”
Coding the Acute Coronary Syndromes using ICD10

Introduction
In recent years a number of sensitive and specific diagnostic tests have helped clinicians refine the way acute coronary ischaemia is diagnosed and treated. The tests measure the amounts of troponin T (or troponin I) and creatine kinase – MB (CK-MB) in the blood. These substances are released into the blood when part of the myocardium is damaged e.g. by infarction. The amount and timing of the release is an indicator of the extent of myocardial damage.

Clinicians can use these test results, along with the ECG results and the clinical presentation of the patient, to diagnose a patient who has signs of acute coronary ischaemia as suffering from one of the acute coronary syndromes (ACS).

The terminology associated with ACS now forms part of a national information standard – the SCI – CHD ACS clinical dataset* - and a new national clinical guideline†. It is important that SMR01 clinical coding is nationally consistent with information collected via the SCI – CHD ACS dataset, and so this guideline is designed to clarify how ACS terminology should be coded using ICD10.

ACS terminology

Although some of the terminology includes mention of test results, coders are not expected to, and should not, interpret any test results themselves. Troponin levels regarded as positive vary from laboratory to laboratory so could not easily be interpreted without a knowledge of local reference ranges.

The major innovation in this guideline is the introduction of 5th digits (Table 1) which signify ‘troponin status’. These 5th digits are ONLY for use with the ICD10 code I20.0 Unstable angina:

Table 1

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>clinical statement - ‘troponin positive’</td>
</tr>
<tr>
<td>1</td>
<td>clinical statement - ‘troponin negative’</td>
</tr>
<tr>
<td>2</td>
<td>coder knows troponin measured but has no clinical statement of ‘troponin positive’ or ‘troponin negative’</td>
</tr>
<tr>
<td>9</td>
<td>coder does not know if troponin measured</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>coder knows troponin not measured</td>
</tr>
</tbody>
</table>

Most coders will already have seen at least some ACS terminology. Table 2 lists the terminology most likely to be encountered as the clinical and information standards are rolled out, and shows how it should be coded. Some possible alternative terms are included for some of the diagnoses.

This guidance supersedes the previous guideline on Acute Coronary Syndrome (Coding Guidelines No.10, December 2001) and came into effect from 01 April 2007.

*Scottish Care Information – Coronary Heart Disease Acute Coronary Syndrome dataset
†SIGN Guideline 93 Acute Coronary Syndromes February 2007
<table>
<thead>
<tr>
<th>ACS term</th>
<th>alternative terms</th>
<th>coder’s information regarding troponin status</th>
<th>code</th>
<th>comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome (troponin unspecified)</td>
<td>• Unstable angina - (troponin unspecified)</td>
<td>troponin not measured OR not known if troponin measured</td>
<td>I20.09</td>
<td>Unstable angina</td>
</tr>
<tr>
<td></td>
<td></td>
<td>troponin known to be measured but not stated by clinician as ‘troponin -ve’ or ‘troponin +ve’</td>
<td></td>
<td>Clinical statement could simply be ‘acute coronary syndrome’ or ‘unstable angina’.</td>
</tr>
<tr>
<td>Acute coronary syndrome (troponin negative)</td>
<td>• Unstable angina - (troponin negative)</td>
<td>clinician states ‘troponin –ve’</td>
<td>I20.01</td>
<td>Unstable angina</td>
</tr>
<tr>
<td></td>
<td>• ACS with Unstable angina – (troponin negative)</td>
<td>A clinical statement of ‘positive’ or ‘negative’ is essential.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute coronary syndrome (troponin positive)</td>
<td>• Unstable angina - (troponin positive)</td>
<td>clinician states ‘troponin +ve’</td>
<td>I20.00</td>
<td>Unstable angina</td>
</tr>
<tr>
<td></td>
<td>• ACS with myocyte necrosis – (troponin positive)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction aborted</td>
<td>-</td>
<td>not applicable</td>
<td>I24.0</td>
<td>Coronary thrombosis not resulting in myocardial infarction</td>
</tr>
<tr>
<td>Myocardial infarction Non ST elevation (NSTEMI)</td>
<td>• non-Q wave MI</td>
<td>not applicable</td>
<td>I21.4</td>
<td>Acute subendocardial MI</td>
</tr>
<tr>
<td></td>
<td>• subendocardial MI</td>
<td></td>
<td></td>
<td>If NSTEMI is patient’s first MI. The site (anterior, inferior etc.) of the NSTEMI can be ignored.</td>
</tr>
<tr>
<td></td>
<td>• partial thickness MI</td>
<td></td>
<td>I22.8</td>
<td>Subsequent MI of other sites</td>
</tr>
<tr>
<td></td>
<td>• ACS with clinical MI – NSTEMI</td>
<td></td>
<td></td>
<td>If NSTEMI is patient’s subsequent MI. The site (anterior, inferior etc.) of the NSTEMI can be ignored.</td>
</tr>
<tr>
<td>Myocardial infarction ST elevation (STEMI)</td>
<td>• ACS with clinical MI – STEMI</td>
<td>not applicable</td>
<td>I21.0- or I22.0-</td>
<td>Acute MI or Subsequent MI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Normal rules of MI coding apply. Note I21.4 cannot be used.</td>
</tr>
<tr>
<td>Myocardial infarction (unconfirmed)</td>
<td>-</td>
<td>not applicable</td>
<td>I21.0- or I22.0-</td>
<td>Acute MI or Subsequent MI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Term reserved for patients clinically diagnosed with MI but who die in hospital before troponin tests. Normal rules of MI coding apply. Clinical statement could simply be ‘MI’. Note I21.4 cannot be used.</td>
</tr>
</tbody>
</table>
Malignant pleural effusion

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:
C38.4D – Malignant neoplasm of pleura
J91.XA – 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) C78.2D – Secondary malignant neoplasm of pleura
(c) J91.XA – 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.XA – 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.

N.B. This advice supercedes any previously given in Coding Guidelines.
Test results and their use in SMR01 coding

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 ICD10 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-Hodgkins 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. septicaemia, 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. Septicaemia is a clinical and not just a laboratory diagnosis and only those organisms stated by the clinician to be causative (e.g. “E. coli septicaemia”) should be incorporated into the coding.
Coding Guidelines - OPCS4

Procedures on intestinal pouches
In OPCS4.2 there were no specific codes for procedures and examination of ileo-anal pouches and coders were advised to use G73.8 + Y51.8 (Coding Guidelines No.6 June 2000) and G74.8 (Coding Clinic December 1996). Please note that OPCS4.3 and OPCS4.4 have a special group of codes (H66 - H70) for operations on intestinal pouches.

Abandoned and unintentional procedures
There are occasions where a procedure has to be abandoned in theatre, due to unforeseen circumstances. In these instances, the procedure should be coded to the point of abandonment. The intention of the procedure should not be coded.

*Example:* Patient admitted for fibreoptic gastroscopy. Procedure abandoned due to obstruction in oesophagus. Scope could not progress beyond the obstruction.

The correct OPCS-4 code is:
- G16.9 Unspecified diagnostic fibreoptic endoscopic examination of oesophagus.

There are also circumstances where unintentional incidents take place in theatre (for example, an accidental perforation of an organ). These inadvertent actions should not be coded in the procedural field. There are codes in ICD-10 that adequately reflect these actions (T80 – T88 Complications of surgical and medical care, not elsewhere classified). An additional code must be added, from the External causes of morbidity and mortality (Chapter XX) – Misadventures to patients during surgical and medical care (Y60 – Y69)

*Example:* Patient with fibroids admitted for a total abdominal hysterectomy. Whilst in theatre, the bladder was accidentally punctured and repaired. The correct codes are:
- ICD-10
  - D25.9 Leiomyoma of uterus, unspecified
  - T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified
  - Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical operation

- OPCS-4
  - Q07.4 Total abdominal hysterectomy NEC
  - M37.9 Unspecified repair of bladder.
Arthroscopic Procedures
OPCS4.3 and OPCS4.4 offer the code of Y76.7 – Arthroscopic approach to joint, which is intended for use with a more specific ‘open’ procedure. However, in Scotland, due to the restriction of only being able to add one supplementary code, this causes problems in as much as the name of the joint operated upon may be lost.
For this reason, and for the sake of consistency, it has been decided that Y76.7 should not be used in Scotland. Coders should select the less specific ‘endoscopic’ code, followed by the site code or laterality.
Example:
Debridement of (l) elbow joint, carried out endoscopically.
Possible (but unable to use all these codes in Scotland)
W80.2 Open debridement of joint NEC
Y76.7 – Arthroscopic approach to joint
Z81.5 – Elbow joint
Z94.3 – Left sided operation

Scotland
W86.8 – Other specified therapeutic endoscopic operation on cavity of other joint
Z81.5 – Elbow joint

This option (correct for Scotland) loses the specifics of what was done, but retains the fact that it was a minimally invasive procedure and the joint.

Angioplasty and stenting of coronary artery: Further Guidance.
In Coding Guidelines September 2006 No. 19, guidance was given regarding the insertion of a combination of drug-eluting and non-drug-eluting stents.
If a patient undergoes a balloon angioplasty with insertion of a combination of drug-eluting and metal stents into the coronary artery, use K75.1 or K75.2 and add an appropriate code from category Y14.
Example: Balloon angioplasty and insertion of two drug–eluting and one expanding metal stent into coronary artery
K75.1 Percutaneous transluminal balloon angioplasty and insertion of 1-2 drug-eluting stents into coronary artery
Y14.2 Insertion of expanding metal stent into organ NOC.
Other codes from category Y14 Placement of stent in organ noc can be used as appropriate depending on the type of stent used.

Please note that this is an enhancement to paragraph 2 of the previous guideline “Angioplasty and stenting of coronary artery” in Coding Guidelines No.19 September 2006.

Implanon
Please note the codes at S52.5 – Insertion of hormone into subcutaneous tissue and S52.6 – Replacement of hormone in subcutaneous tissue. This includes IMPLANON and other contraceptive substances.

Hybrid hip replacement codes
A reminder that there are now codes (W93 – W95) which allow the component part replaced or revised to be incorporated in the main code. The supplementary code should now be that for laterality.
OPCS-4.4 Alphabetical Index
Improvements include:
- New Section V is an Alphabetical Index of High Cost Drugs
- Section III Alphabetical Index of Surgical Abbreviations has been expanded
- Clearer layout and styling to improve ease of use.

OPCS-4.4 Tabular List
- Certain codes have amended descriptions to reduce ambiguity, e.g.
  L73 Mechanical embolic protection in OPCS-4.3 becomes
  L73 Mechanical embolic protection of blood vessel in OPCS-4.4
- A number of Notes reading ‘Use subsidiary code for minimal access approach’ that appeared at code or category level in OPCS-4.3 have been removed. These Notes only exist at chapter level in OPCS-4.4 and are now also re-phrased to read ‘Use a subsidiary code for minimal access approach (Y74-Y76)
- Some sequencing Notes have been re-worded to make the sequencing more implicit by the addition of the word ‘a’: for example at category F34 Excision of tonsil Note: Use a supplementary code for concurrent excision of adenoid (E20.1).

Principal and Extended Categories
These have been defined to replace the concept of ‘sister’ categories from OPCS-4.3. Key learning points are:
- Used in instances where an existing category (principal) needs extension (extended)
- Identified in the Tabular List as a note at category heading to ease navigation
- It is important to understand that a coder must only assign the .8 and .9 codes in the principal category and never use the .8 and .9 codes from the extended category. This convention prevents potential conflict between the two sets of .8 and .9 codes, as .8 and .9 codes have been included at extended categories to maintain the structure of the classification.

Overflow categories
Overflow categories continue from their introduction of OPCS-4.3. This type of category appears at the end of chapters which are completely full but where it is required that additional operations/interventions be classified to that chapter. Overflow categories begin with the alpha O, and appear at the end of Chapter L Arteries and Veins (O01-O05, O15), Chapter W Other Bones and Joints (O06-O10), and Chapter Z Subsidiary Classification of Sites of Operation (O11-O14).

N.B. In Scotland do not use O11-O14.

(Above extract courtesy of Connecting for Health Coding Clinic Volume 4 Issue 1 March 2007)
General Information

New name, new website address.
The Coding Advisory Service has been renamed The Terminology Advisory Service to reflect the bringing together of the Coding, Read and Snomed helpdesks. The service is available Tuesday to Thursday 09.00 –17.00. Outwith these hours an answering service operates.
Telephone number 0131-275-7283
Our website address is http://www.isdscotland.org/terminology.
Details of forthcoming training courses are published on this site.

New pair codes in OPCS4.3
You will recall that Coding Guidelines No.18 May 2006 advised coders to use codes L76.- and L89.- as separate operation codes rather than as pair codes as the classification suggests.
We have now had time to set up appropriate OPCS4.3 pair codes, and L76.- and L89., and some others (about 2000 additions altogether), appeared on the March 2007 reference files, and so may be used as pair codes when sites import these reference files.

A full list of currently valid pair codes is sent out with this edition of Coding Guidelines for those sites which require it.

Ordering ICD10 Books
Please be aware that anyone ordering new ICD10 books is likely to be sent Version 2 (rather than Version 1, currently in use in Scotland).
Version 2 contains many new codes and the corresponding index trails which have not yet been approved for use in the U.K.
Should anyone urgently require a new copy of V1, please contact your Clinical Coding Tutor in the first instance.

DQA News
The DQA team has now completed the data collection for the SMR01 and Associated Data QA and is busy compiling hospital reports. Once these are finished some of the team will work on the Scotland report. There has been quite a lot of movement in the team in the last few months and this has had an impact on the project. Chantal Spence recently retired after 17 years working in ISD, four of which were with the DQA team. Graham Robertson moved over to the PTI team (Practice Team Information) and Iain Schreuder moved in to the Benchmarking and Tariff programme. Interviews were held recently for replacements and two new staff were appointed, both of whom have now started with the team.

Anyone requiring further information on the SMR01 and Associated Data QA should contact Margaret.Mason@isd.csa.scot.nhs.uk in the first instance.