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

- **Head Injuries**
  For statistical purposes it is important to code head injuries consistently. To this end the Clinical Coding Review Group considered the best advice to issue when a head injury occurs but the main reason for the admission is observation of the patient to ensure nothing more sinister manifests itself overnight is as follows:

  It was agreed that it is impossible to be too prescriptive on scenarios and coders are advised to code the text as given in the source document (discharge letter, medical records, etc). Therefore if the document uses the phrase “superficial head injury” and the patient is admitted for that reason use code S00.9 Superficial Injury of Head, Part Unspecified. However if just “head injury” is stated then the coder should use S09.9 Unspecified Injury of Head.

  The coder would then need to add an appropriate external cause code (V01.- to Y98.X) and observation code (Z04.-).

- **Pfeiffer’s Disease v Pfeiffer’s Syndrome**
  The ICD10 Index has only Pfeiffer’s Disease listed with code B27.0 (type of infectious mononucleosis). The term Pfeiffer’s disease is no longer mentioned in textbooks. However, attention is drawn to the referencing of syndromes v diseases in the ICD10 index. These may, or may not, be synonymous terms and the coder should be careful when using these terms interchangeably. The tabular list should be carefully referenced to ensure the correct code is assigned. The coding of the term Pfeiffer’s syndrome (that is a form of acrocephalosyndactyly type V) to Q87.0-Congenital malformation syndromes predominantly affecting facial appearance is correct.
  Add term Pfeiffer’s Syndrome to index Q87.0.
Co-morbidities on SMR01 Coding

The following notes are for guidance only and are not exhaustive. As with other coding problems, if you are in doubt discuss it with the clinician/HCP responsible for the patient’s care.

A co-morbidity is a condition that exists with another disease and on SMR01 relates to diagnosis 2 to 6 (ie not Main Condition).

A co-morbidity should only be coded if it is specifically mentioned in the final discharge summary/immediate discharge letter and affects the management of the patient or is associated with the current condition.

1. In general, chronic conditions must be recorded on a SMR01 (both inpatient and all types of daycase) as co-morbid conditions.

Examples of common chronic conditions include:

- diabetes
- ischaemic heart disease
- asthma
- chronic obstructive pulmonary disease

Please note that this is not a definitive list.

2. Acute conditions should only be recorded on SMR01 if they have been managed or affect the management of the patient during the episode.

   Example A - code the acute co-morbid condition
   Acute anterior wall myocardial infarction. Has acute heart failure.
   I21.0 Acute transmural myocardial infarction of anterior wall
   I50.9 Heart failure, unspecified

   Example B - do not code the acute co-morbid condition
   Patient admitted with psoriasis vulgaris to dermatology. Also noted to have hypertrophy of prostate. Discharge documents do not mention any treatment/investigation of prostate.
   L40.0 Psoriasis Vulgaris
3. A past history of an acute condition should only be recorded when it is relevant to the current episode and if it is specifically referred to in the final discharge summary/immediate discharge letter.

Example A - code past history

*Patient admitted for a check up to see if bladder cancer has recurred.*
*Previously treated by surgical resection of bladder. No recurrence found.*
Z08.0 Follow up examination after surgery for malignant neoplasm
Z85.5 Personal History of malignant neoplasm of urinary tract

Example B - code past history

*Patient admitted with acute back pain. Has a history of mastectomy for breast cancer. Investigations carried out to check for bone secondaries which may be cause of back pain. Secondaries not confirmed.*
M54.99 Dorsalgia unspecified
Z85.3 Personal History of malignant neoplasm of breast

Example C - do not code past history

*Patient admitted for repair of left femoral hernia. Has a history of mastectomy for breast cancer.*
K41.9 Unilateral or unspecified femoral hernia, without obstruction or gangrene

4. Other factors influencing health status should also be recorded when the circumstance influences the patient’s current condition or has an obvious impact on length of stay.

Example A - Code the factor

*Stroke. Lives alone.*
I64.X Stroke, not specified as haemorrhage or infarction
Z60.2 Living alone

Example B - Code the factor

*Severe diarrhoea. Has a colostomy.*
K52.9 Noninfective gastroenteritis and colitis, unspecified
Z93.3 Colostomy status

Example C - Do not code the factor

K01.1 Impacted teeth
Orthopaedic Devices associated with adverse incidents
There has been confusion on the use of the ICD-10 range of codes
Y70 -Y82 - Medical devices associated with adverse incidents
in diagnostic and therapeutic use.
It should be noted that this group is a continuation of range
Y60 - Y69 - Misadventure to patients during surgical
and medical care. [during surgical/ medical procedures]
e.g. patient’s shaft of femur fractured during removal of a bone prosthesis
Code S72.30 Fracture of shaft of femur [closed]
Y79.2 Orthopaedic devices associated with adverse incident

The codes to use where the incident happened following surgery are:
Y83 - Y84 - Surgical operation and other medical procedures
as the cause of abnormal reaction of the patient, or of
later complication, without mention of misadventure
at the time of the procedure. [following surgical/medical procedures]

Prophylactic Mastectomy
Increasingly, women found to be at high risk of breast cancer for genetic reasons may opt
for prophylactic mastectomy. Although there is some evidence that this procedure
substantially reduces the subsequent risk of developing breast cancer, it will still be
necessary to monitor the long term outcome of such women in Scotland. In order that
these women can be identified in future, it is essential that the clinical coding of this
situation is accurate and consistent across the country. The relevant codes are as follows:

Diagnostic coding
Z40.0 - Prophylactic surgery for risk factors relating to malignant neoplasms.
Z80.3 - Family history of malignant neoplasm of breast.

OPCS4 coding
B27.- Total excision of breast (+ laterality code Z94.-).

Coding Guidelines - OPCS4

Diagnostic Endoscopy where no biopsies taken.
Some sites have requested confirmation of the Note ‘Use subsidiary site code as
necessary’ in for example G45.9. Does this mean that they should specify the ‘lowest’
or most internal) site investigated?
The answer is NO - only use the ‘subsidiary site code’ with Diagnostic Scopes to identify
site of biopsies.
Please refer to Coding Guidelines No 2, January 1999 for further advice on Endoscopies
with multiple biopsies.
• **Cervical Studies**
  It has been agreed that code Q55.8 should be used for cervical studies regardless of diagnosis. SMR02 sites should review their procedures. If these patients are not pregnant they should be recorded on a SMR01.

• **Unlikely Pair Codes.**
  Care should be taken when using an ‘enhance S Chapter’ code. It is left to trained coders using the guidance notes in their OPCS4 to allocate correctly the use of an ‘S’ code to enhance the main OPCS4.
  It was acknowledged that there are a few exceptions within the chapters where no note instructing the use of an S enhance code is made, but a good coder would recognise that they would be correct in enhancing main chapter OPCS4 codes by the use of a Skin Chapter code eg at C14’s - C14.1 [flap] plus S23.1 [more information on the flap]. If in doubt please contact the Coding Helpdesk for guidance.

• **Peripheral Stem Cell Procedures**
  The following list of procedures have been agreed as correct by a meeting of the CCRG:

<table>
<thead>
<tr>
<th>HAEMATOLOGY PROCEDURES:-</th>
<th>OPCS4 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stem cell donation</td>
<td>X46.8</td>
</tr>
<tr>
<td>Stem cell infusion, back up bone marrow</td>
<td>See Bone marrow transplant below</td>
</tr>
<tr>
<td>Bone marrow transplant</td>
<td>If specified as autograft W34.1</td>
</tr>
<tr>
<td></td>
<td>If specified as allograft W34.2</td>
</tr>
<tr>
<td></td>
<td>Otherwise W34.9</td>
</tr>
<tr>
<td>Bone marrow donor</td>
<td>X46.1</td>
</tr>
<tr>
<td>Bone marrow harvest</td>
<td>X46.1/Y66.7</td>
</tr>
<tr>
<td>Peripheral blood stem cell (PBSC) harvest</td>
<td>X36.8/Y69.8</td>
</tr>
<tr>
<td>PBSC transplant (autologous)</td>
<td>If donation and infusion in same admission X33.8/Y69.8</td>
</tr>
<tr>
<td></td>
<td>Otherwise X33.8</td>
</tr>
<tr>
<td>Femoral vein catheter for PBSC</td>
<td>If it is PBSC transfusion X33.8</td>
</tr>
<tr>
<td>Granulocyte colony stimulating factor (GCSF)</td>
<td>Not a procedure</td>
</tr>
<tr>
<td>PBSC collection</td>
<td>X36.8/Y69.8</td>
</tr>
<tr>
<td>Peripheral leucophoresis</td>
<td>Same as PBSC transplant</td>
</tr>
<tr>
<td>Back-up stem cells</td>
<td>Same as stem cell donation</td>
</tr>
<tr>
<td>Back-up bone marrow</td>
<td>Same as bone marrow donation</td>
</tr>
</tbody>
</table>
• **Therapeutic v Diagnostic Procedures**

Although some clinicians have complained that some diagnostic procedures are more resource intensive than some therapeutic procedures, it has been decided to uphold the rule that therapeutic procedures take precedence over diagnostic ones when recording clinical data in SMRs. Analysts should be encouraged to look at all procedures not just main operation code.

**General Information**

• **ICD10 and OPCS4 Courses**

Courses have been arranged for ICD10 and OPCS4 at Trinity Park House, Edinburgh for the autumn. Details are as follows:

OPCS4  Tuesday 19\textsuperscript{th} October to Thursday 21\textsuperscript{st} October, 1999  
ICD10  Monday 8\textsuperscript{th} November to Friday 12\textsuperscript{th} November, 1999

Cost will be £225 per person for the OPCS4 course and £375 per person for the ICD10 course.
Places are limited and will be allocated on a first come, first served basis.
Applications with details of Trust contact for payment of the invoice for the course should be sent to

Mrs Maria Dunlop  
Room B044  
Scottish Clinical Coding Centre  
Trinity Park House  
South Trinity Road  
Edinburgh  
EH5 3SQ

Closing date for applications is 30\textsuperscript{th} September, 1999.

• **National Clinical Coding Qualification**

The first national examination took place on May 10\textsuperscript{th}, 1999. Although there were no candidates from Scotland, it is expected there will be some staff sitting the next examination, which is to be held on November 1\textsuperscript{st}. Details of this new qualification have been included in a flyer enclosed with these Coding Guidelines. Anyone requiring further information about the qualification should contact the Coding Advisory Service.