Scottish Clinical Coding Standards Consolidation

July 2014
(Formerly Coding Guidelines)
INTRODUCTION

This document has been compiled to enable coders to quickly identify coding standards for ICD-10. All discharges from 1st April 2014 should adhere to the guidance given in this document and subsequent publications of the Scottish Clinical Coding Standards.

At the beginning of the document are articles which are either completely new or have been altered from the original guidance. Alterations may be minor, e.g. a change to an index page number; the code or guidance may not have changed in any way.

New guidance has been published to give updated advice and in some instances this will replace obsolete articles. New and amended articles have all been highlighted in YELLOW.

At the end of the document, articles in PINK are obsolete. This guidance must not be used for discharge episodes after 1st April 2014.

The middle of the document contains guidance which still applies to ICD V4 2010 Edition. The text is in BLACK.

Each section is listed alphabetically and individual articles are coloured as appropriate in the alphabetical index preceding the articles.

Clinical coding staff should ensure that their ICD-10 V4 2010 Edition books are updated to reflect ALL valid, new and amended standards.

If you require this document in an accessible format, please contact the Terminology Services Helpdesk on 0131 275 7283 or e-mail NSS.terminologyhelp@nhs.net
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### “Impression of”

- 23 Sept 2008

### Impulsive overdose

- 11 April 2002

### Infection with leg ulcer

- 17 Jan 2006

### Infections

- SCCS 2 July 2013

### Infections (carrier or infection?)

- 17 Jan 2006

### Infections, hospital acquired (HAI)

- 17 Jan 2006

### Infections, hospital acquired (HAI)

- SCCS 2 July 2013

### Infectious agent, conditions caused by, coding of

- CQ1 Nov 1996

### Infective exacerbation of COAD

- 4 Sept 1999

### Inflammatory bowel disease/inflammation bowel

- SCCS 2 July 2013

### Influenza A (H1N1) [Swine Flu]

- 24 Oct 2009

### Injury with tendon involvement

- CQ1 Nov 1996

### INR, raised

- 16 Aug 2005

### Intramucosal carcinoma (of the gastrointestinal tract)

- 7 Nov 2000

### Intrapartum vs post-partum haemorrhage

- SMR02 Review 2010

### Ischaemic heart disease, chronic and triple vessel disease

- 16 Aug 2005

### Ischaemic heart disease with angina

- 13 Jan 2003

### (IVF) Human fertilisation codes

- 10 Dec 2001

### IVF

- 18 May 2006 OPCS4 Section

## J

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<td>Mobility Scooters</td>
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<td>Conditions/Procedures</td>
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<td>Neutropenic sepsis</td>
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<td>NIDDM patients on insulin</td>
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**O**

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<td>CQ3 May 1997</td>
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<td>Obstructive jaundice</td>
<td>CQ6 Apr 1998</td>
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<tr>
<td>Oedema</td>
<td>SMR02 review 2000</td>
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<tr>
<td>Oesophageal web</td>
<td>SCCS 2 July 2013</td>
</tr>
<tr>
<td>Oesophageal web</td>
<td>29 Oct 2011</td>
</tr>
<tr>
<td>Off legs/off feet/geriatric falls</td>
<td>5 Jan 2000</td>
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<tr>
<td>Old myocardial infarction</td>
<td>SCCS 2 July 2013</td>
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<td>Old myocardial infarction</td>
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<tr>
<td>Old Stroke</td>
<td>17 Jan 2006</td>
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<td>Open wound to artery or vein</td>
<td>10 Dec 2001</td>
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<td>Open wound with infection</td>
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<td>Open wound with infection</td>
<td>11 Apr 2002</td>
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<tr>
<td>Orthopaedic devices associated with adverse incidents</td>
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<td>Orthopaedic fixators, external</td>
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<td>Other Conditions” (Co-morbidities) coding on SMR01</td>
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<td>“Other Conditions” (Co-morbidities) coding on SMR01</td>
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<td>Overdose, patient transferred to psychiatric hospital</td>
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**P**

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<td>Pancreatic intraepithelial neoplasia (PanIN)</td>
<td>26 Oct 2010</td>
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<td>8 Feb 2001</td>
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<td>Parastomal hernia</td>
<td>26 Oct 2010</td>
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<tr>
<td>Passive smoking</td>
<td>14 Jan 2004</td>
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<tr>
<td>Past history in a recurrence of the same condition</td>
<td>13 Jan 2003</td>
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<tr>
<td>Patient who takes overdose transferred to psychiatric hospital</td>
<td>CQ3 May 1997</td>
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<tr>
<td>Perinatal conditions, update to guidance</td>
<td>26 Oct 2010</td>
</tr>
<tr>
<td>Perinatal conditions</td>
<td>23 Sept 2008</td>
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<td>Perinatal Period – definition of</td>
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<td>Perinatal Period – definition of</td>
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<td>Condition</td>
<td>Date of Review</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Periprosthetic fracture and dislocated joint prosthesis</td>
<td>28 March 2011</td>
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<tr>
<td>Pfeiffer’s disease/ syndrome</td>
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<td>PIN III Prostatic intraepithelial neoplasia, Grade III/High grade</td>
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<tr>
<td>glandular intraepithelial neoplasia of the prostate (HGIN)</td>
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<td>Pineal cyst</td>
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<td>Pneumonia + COAD</td>
<td>8 Feb 2001</td>
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<td>Poisoning - intentional self-harm or accidental?</td>
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<tr>
<td>Poisoning with drugs and alcohol</td>
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<tr>
<td>Poisonings and adverse effects, compound drugs, coding of</td>
<td>4 Sept 1999</td>
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<td>Poisonings – external cause codes</td>
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<tr>
<td>Poisonings with the drug ecstasy, coding</td>
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<tr>
<td>Possible, probable diagnoses, unconfirmed conditions</td>
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<td>Post-dates and post-term</td>
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<td>Posterior capsular opacification (also called after-cataract)</td>
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<td>Postnatal administration of Anti D</td>
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<td>Post procedural disorders</td>
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<td>Pre-eclampsia</td>
<td>SMR02 review 2000</td>
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<td>Pregnancy, conditions in</td>
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<td>Pregnancy, vaginal thrush in</td>
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<td>Premature Rupture of Membrane (PROM) O42.-</td>
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<td>Preterm delivery O60.X</td>
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<td>Presumptive diagnoses</td>
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<td>Prosthetic device at the end of its natural life</td>
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<td>Small vessel disease and lacunar infarcts</td>
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<td>Smoker ex</td>
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<td>Smokers/drinkers heavy</td>
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<td>Soft Tissue Injury</td>
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<td>Spiked drink</td>
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<td>Spontaneous Rupture of Membranes</td>
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<td>(see “Presumptive diagnoses”)</td>
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<td>Swine Flu [Influenza A (H1N1)]</td>
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<td>Termination of pregnancy resulting in liveborn</td>
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<td>Termination of pregnancy using Mifepristone (RU486)</td>
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<td>Test Results and their use in SMR01 coding</td>
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<td>Transitional cell carcinoma kidney</td>
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<td>Transitional cell carcinoma of bladder</td>
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<td>Transitional cell carcinoma ureter and renal pelvis nos</td>
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<td>V</td>
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<td>Venous ulcer lower limb</td>
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<td>Viagra - adverse effect</td>
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<td>Viral-associated wheeze</td>
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<td>Wheeze, viral-associated</td>
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<td>WHO amendments</td>
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<td>Wound open, to artery or vein</td>
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<td>Wound open, with infection</td>
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<tr>
<td></td>
<td>Wound open, with infection</td>
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<td>Z</td>
<td>Z41.1 Other plastic surgery for unacceptable cosmetic appearance</td>
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NEW and/or CHANGED FROM ORIGINAL CODING GUIDELINE

Accidental cuts/perforations during procedures
SCCS No. 5 March 2014
It is quite common during some procedures e.g. a laparoscopic cholecystectomy, for accidental cuts/perforations to occur e.g. small liver perforation due to an instrument. If these kinds of problems are recorded on the discharge summary then they should be coded. If they are mentioned only in operation notes and/or clinical notes but not mentioned on the discharge summary then they should not be coded.

Factor V Leiden
SCCS No. 3 September 2013
Factor V Leiden is the name of a specific gene mutation that results in thrombophilia which is an increased tendency to form abnormal blood clots that can block blood vessels.
This is often incorrectly referred to as ‘Factor V Leiden deficiency’.
ICD-10 V4 (2010 Edition) includes a new code which covers this disorder:

D68.5 – Primary thrombophilia
An inclusion term in the Tabular is:
Activated protein C resistance [factor V Leiden mutation].
The only way this can be accessed through the index is via the term ‘mutation’ (P429);

Mutation
- prothrombin gene (factor V Leiden mutation) D68.5
Coders should insert an entry for this disorder under ‘Leiden’ to help assign the correct code.

Heart failure coding – fifth digits and clinical outcomes
SCCS No. 3 September 2013
The Scottish Patient Safety Programme and Health Improvement Scotland have been working with NHS boards to implement a Heart Failure Care Bundle (a set of recommended clinical practices aimed at improving acute care outcomes for heart failure patients). Coded SMR01 data can play a valuable part in measuring some of these outcomes. However to do this the data must capture information about heart failure which cannot be captured using ICD10 codes alone. This guideline describes the extra information required, and shows how to code it.
1 What extra information is required?
Patients with a diagnosis of heart failure can be broadly divided into two groups:
- those who have a reduced left ventricular ejection fraction
- those who have a preserved ejection fraction i.e. the left ventricular (LV) ejection fraction is within normal limits.

It is this information about the LV ejection fraction which must be captured. This will be done by adding a Scottish fifth digit to certain relevant ICD10 codes. The fifth digits are:

Table 1

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Description of LV function</th>
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<tr>
<td>0</td>
<td>Reduced Ejection Fraction</td>
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<tr>
<td>1</td>
<td>Preserved Ejection Fraction</td>
</tr>
<tr>
<td>9</td>
<td>No information on ejection fraction</td>
</tr>
</tbody>
</table>

Note that it is important to record cases where there is no information about LV function available to coders. These should be recorded with fifth digit 9.

2 Which diagnoses require the fifth digit?
The fifth digit must be recorded in cases with a stated diagnosis of heart failure or certain types of cardiomyopathy. The diagnosis codes requiring the 5th digit are:

Table 2

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with (congestive) heart failure</td>
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<tr>
<td>I13.0</td>
<td>Hypertensive heart and renal disease with (congestive) heart failure</td>
</tr>
<tr>
<td>I13.2</td>
<td>Hypertensive heart and renal disease with both (congestive) heart failure and renal failure</td>
</tr>
<tr>
<td>I25.5</td>
<td>Ischaemic cardiomyopathy</td>
</tr>
<tr>
<td>I42.0</td>
<td>Dilated cardiomyopathy</td>
</tr>
<tr>
<td>I42.9</td>
<td>Cardiomyopathy, unspecified</td>
</tr>
<tr>
<td>I50.0</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>I50.1</td>
<td>Left ventricular failure</td>
</tr>
<tr>
<td>I50.9</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>

Doctors recording such diagnoses will often (not always) include information describing LV ejection fraction. This information (or the lack of it) should ALWAYS be recorded by using the appropriate fifth digit from Table 1 with any of the ICD10 codes in Table 2.

To use the fifth digits:
- firstly, code stated diagnoses of heart failure or cardiomyopathy according to normal ICD10 rules and coding standards
• then, if the resulting ICD10 code appears in Table 2, add the appropriate fifth digit from Table 1
• note that Table 2 does not include all possible ICD10 codes for heart failure or cardiomyopathy. The fifth digits should only be used with the codes in the table.

3 Clinical language describing LV function
Unfortunately the clinical language used to describe LV function is not standardised to ‘reduced ejection fraction’ or ‘preserved ejection fraction’. This makes the coder’s job more difficult. Doctors may use other terms instead of, or as well as, these phrases. These other terms are listed below:

• Reduced Ejection Fraction – other terms
For coding purposes any of the following descriptions should be regarded as being synonymous with ‘reduced ejection fraction’:

<table>
<thead>
<tr>
<th>Left ventricular dysfunction</th>
<th>Impaired or reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>- systolic dysfunction (LVSD)</td>
<td>- LV systolic function</td>
</tr>
<tr>
<td>- systolic impairment</td>
<td>- systolic function</td>
</tr>
</tbody>
</table>

• Preserved Ejection Fraction – other terms
For coding purposes any of the following descriptions should be regarded as being synonymous with ‘preserved ejection fraction’:

<table>
<thead>
<tr>
<th>Preserved LV function</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>- LV function</td>
<td>- ejection fraction</td>
</tr>
<tr>
<td>- systolic function</td>
<td>- LV function</td>
</tr>
<tr>
<td></td>
<td>- systolic function</td>
</tr>
</tbody>
</table>

Note that ‘Diastolic heart failure’ is heart failure with preserved ejection fraction.

4 Clinical statements describing LV function WITHOUT a stated diagnosis of heart failure or cardiomyopathy
• If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described by the clinician as having a ‘reduced ejection fraction’ (or a synonymous phrase listed above), the reduced ejection fraction (or synonym) should be recorded by adding fifth digit 0 to the following R code:

R93.1 Abnormal findings on diagnostic imaging of heart and coronary circulation

e.g. clinical statements of ‘left ventricular systolic dysfunction (LVSD)’ or ‘reduced ejection fraction’ (where there is no stated diagnosis of failure or
cardiomyopathy) would be coded as R93.10.

- If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described as having a ‘preserved ejection fraction’ (or a synonymous phrase listed above), NOTHING need be recorded.

5 Abbreviations which may be encountered

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFREF</td>
<td>Heart Failure with reduced ejection fraction</td>
<td>I50.90</td>
</tr>
<tr>
<td>HFPEF</td>
<td>Heart Failure with preserved ejection fraction</td>
<td>I50.91</td>
</tr>
<tr>
<td>HFPSF</td>
<td>Heart Failure with preserved systolic function</td>
<td>I50.91</td>
</tr>
<tr>
<td>LVREF</td>
<td>Left ventricular reduced ejection fraction (if no failure/cardiomyopathy stated)</td>
<td>R93.10</td>
</tr>
<tr>
<td>LVSD</td>
<td>Left ventricular systolic dysfunction (if no failure/cardiomyopathy stated)</td>
<td>R93.10</td>
</tr>
</tbody>
</table>

6 Obsolete coding guidance

Coding Guidelines No.2, January 1999 ‘Left Ventricular Dysfunction’ stated “left ventricular dysfunction should be coded to I50.1 Left ventricular failure”. This 1999 guidance is now completely superseded by the present standard.

This means that

- the phrase ‘left ventricular dysfunction’ used in isolation without a stated diagnosis of heart failure or cardiomyopathy should NOT be coded to I50.1. Instead it should be coded to R93.10 (see 4).
- the phrase ‘left ventricular dysfunction’ used with a stated diagnosis of heart failure or cardiomyopathy should be coded by adding the fifth digit 0 to the appropriate ICD10 code for the stated diagnosis.

- Health Improvement Scotland Heart Disease Service Review 2011
- The contraction (systole) of a filled ventricle does not expel all of the blood it contains. The ejection fraction is a measure of the proportion of the blood which is actually expelled from the ventricle.

Holiday Relief Care

Patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.
**Example:** Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.

Code: Z75.5 - Holiday relief care  
G35.X - Multiple sclerosis

If on the other hand, a patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay, the code Z75.5 should be assigned a secondary position.

**Example:** Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 2 days.

Code: J22.X - Chest Infection  
G35.X - Multiple sclerosis  
Z75.5 - Holiday relief care

Sometimes a patient is pre-booked for holiday relief care, but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and should be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.

**Example:** Patient booked for 2 weeks holiday admission - consultant decides that the patient will have a course of physiotherapy for his multiple sclerosis.

Code: G35.X - Multiple sclerosis  
Z50.1 - Other physical therapy  
Z75.5 - Holiday relief care

It is important that the casenotes are referenced thoroughly in order to reflect each patient’s care on each admission

These guidelines apply to SMR01 coding.

**‘OTHER CONDITIONS’ CODING on SMR01**

**Coding Departments should have received a letter (dated 20th September 2007) concerning the following guideline.**

This guideline falls into two parts. The first deals with the coding of comorbidities, the second deals with the use of some common and important Z codes.

**Comorbidities in SMR01 ‘Other Conditions’ coding**
Reasons for revised guidance.
There is considerable demand for SMR01-derived information on comorbidities from clinicians, researchers and from health service planners at hospital, NHS board and national level. Since the previous guideline (Coding Guidelines 3, June 1999) ISD have carried out two national quality assurance exercises on SMR01 data. Despite areas of good practice these surveys show an under-recording of comorbidities nationally. Some of this under-recording is due to inadequate information reaching coders. It is impossible to offer exhaustive rules to cover every case. This guidance is intended to assist coders’ decision-making when coding comorbidities, to help ensure more consistent recording across Scotland and to inform those responsible for supplying information to coders.

What is a comorbidity?
A comorbidity is a disease or condition which exists alongside another disease. Comorbidities are recorded as SMR01 ‘Other Conditions’ (diagnoses 2 – 6). Not all codes recorded in ‘Other Conditions’ represent comorbidities – e.g. Z codes and external cause codes – although in coding the terms ‘Other Conditions’ and ‘comorbidities’ are often used interchangeably. In the SMR01 context, a comorbidity is:

- a disease or condition (other than the main diagnosis) which is clinically identified as a currently active problem, requiring significant investigation or management, during the admission being coded
- a disease or condition (often long-standing) which is present but is not clinically identified as a major factor in the admission i.e. it does not require anything more than routine management, such as the continuance of the patient’s normal drug regime. We can call this a background comorbidity.

This is an artificial division. For any one patient, a particular disease could be an active problem - or even the main diagnosis - in one admission and a background comorbidity in another. However it can be useful to think about comorbidities in this way when coding. If a condition is present and is described as ‘acute’ it is unlikely that it could be regarded as a background comorbidity.

Active problems
Coders will be familiar with coding the active problems relevant to an SMR01 episode. To do this they rely on the clinical information which they receive to identify health problems which were significant during the admission. Some examples of cases with active problems which should be coded as comorbidities are:

- a patient admitted with an acute MI develops left ventricular failure during the admission. Code the left ventricular failure as a comorbidity
- a patient admitted with abdominal pain and vomiting is diagnosed as having alcoholic pancreatitis. He is also found to have a chest infection which is treated by an antibiotic. The antibiotic causes a rash. Code the chest infection and the rash as comorbidities.

A current symptom which is not attributable to a confirmed diagnosis may also be codable as an active problem if it is managed or investigated during an admission. ISD recognise that the selection and coding of such symptoms (while avoiding the over-coding of symptoms attributable to known diagnoses) can depend on the coder’s experience if the available clinical information is not completely clear. One useful
guide is that if during the admission the responsible clinician decides to refer the patient for investigation of the symptom, then it should be coded. In some cases what might seem to be an active problem does not require coding:

- a patient is admitted to Dermatology for treatment of psoriasis. The clinical notes record that during admission the patient suffered some diarrhoea. However this apparently required no treatment or investigation and is not mentioned on the discharge summary – do not code the diarrhoea.

**Applicability** - all of the patient’s active problems should be recorded in both inpatient and daycase SMR01 episodes

**Background comorbidities**

When any comorbidities which are active problems have been coded, the background comorbidities which are present should be recorded if space permits. These will often be long-standing conditions which do not usually resolve spontaneously, such as diabetes or ischaemic heart disease. A new list of diseases and conditions has been developed to assist coders in coding these comorbidities.

**Applicability** - background comorbidities from the list should be recorded in inpatient SMR01 episodes whenever applicable and where space permits. It is not necessary to record background comorbidities in day case SMR01 episodes, although this may be done if space permits and the information is required for local use.

**Comorbidities list (see the summary list below)**

This has been developed with clinical advice. The list comprises 1127 codes from 232 ICD10 categories arranged in 25 groups. It has been derived from published comorbidity indices, the listed conditions having substantial prognostic significance (see references). This list is designed to assist the coder in several ways:

- it is clear statement of a **minimum requirement** for the coding of background comorbidities
- the groups have been prioritised, to aid decision making
- diseases and conditions are often mentioned on discharge summaries or in clinical notes under the heading ‘Past Medical History’ (PMH). Some of the listed groups have been highlighted to indicate that the diseases and conditions in the group are usually long-standing. If a disease or condition from a highlighted group is referred to as ‘Past Medical History’ it should be regarded as being present and coded as such, except in individual cases where the available clinical information offers clear reason to do otherwise.

**References:**

‘Coding Algorithms for Defining Comorbidities in ICD-9-CM and ICD-10 Administrative Data’,

H. Quan et al. Medical Care 43 (2005) 1130–1139

‘Measuring potentially avoidable hospital readmissions’


**Using the list**

A disease or condition in the list should always be recorded in inpatient episodes when it is present as a comorbidity and when space permits. The priorities can be used in cases where the coder must choose what to code and what to miss out because the
free ‘Other Conditions’ space is limited. ‘Priority 8’ is the highest priority, ‘priority 1’ the lowest. When space is limited:

- a listed comorbidity should be recorded in preference to an unlisted one
- a comorbidity from a higher priority group should be recorded in preference to one with a lower priority.

Some common diseases and conditions e.g. osteoarthritis, are not listed because they have a smaller impact on prognosis than the listed conditions. They may be coded as background comorbidities if space permits after any active problems and any listed comorbidities have been recorded.

**Information on the discharge summary**

Coding decisions made under the guidance above must sometimes be modified by clinical information recorded on the discharge summary. For example this can happen when the discharge summary mentions a disease or condition which is relevant to the *specialty* of admission but is not itself the subject of significant treatment or investigation (i.e. it would not be coded as an active problem) and is either listed with low priority or is not listed at all, as in the two cases following:

- the discharge summary of a patient admitted to Renal Medicine with a main diagnosis of renal failure also mentions chronic glomerulonephritis (N03, priority 2)
- the discharge summary of an Ophthalmology patient with a main diagnosis of cataract states that she suffers from age-related macular degeneration, which is not listed.

In these examples the chronic glomerulonephritis and the macular degeneration should be recorded. Then other applicable comorbidities can be recorded according to the above guidance.

**Comorbidities - summary list**
<table>
<thead>
<tr>
<th>priority</th>
<th>comorbidity group</th>
<th>ICD10 code range</th>
<th>long-standing</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 HIGH</td>
<td>Solid Metastases</td>
<td>C77 - C79</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chronic Pulmonary Disorders</td>
<td>J40X - J67, J684, J701, J703</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Heart Failure / Cardiomyopathy</td>
<td>I110, I130, I132, I42 - I43*, I50 I517</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Malignancies</td>
<td>C00 - C76, C80X - C97X</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Circulation Disorders</td>
<td>I27 - I28</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Peripheral Vascular Disease</td>
<td>I70 - I71, I73, I790*, I792*, K551 - K559</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>AIDS / HIV</td>
<td>B20 - B24X</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>Cerebrovascular Disease</td>
<td>I65 - I69</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>Ischaemic Heart Disease</td>
<td>I20, I25</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes</td>
<td>E10 - E14</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>Liver Disease</td>
<td>B18, I85, I864, I982*, K70 - K76</td>
<td>yes</td>
</tr>
<tr>
<td>4</td>
<td>Hypertension, Complicated</td>
<td>I119, I12, I131, I139, I15</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Cardiac Arrhythmias</td>
<td>I44 - I45, I47 - I49</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Dementia</td>
<td>F00* - F03X, G30</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Obesity</td>
<td>E66</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Valvular Heart Disease</td>
<td>I05 - I08, I34 - I39*, Q23</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Coagulopathy</td>
<td>D66 - D69</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Drug/Alcohol Abuse</td>
<td>F10 - F19</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hemiplegia / Paraplegia</td>
<td>G80 - G83</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Other Neurological Disorders</td>
<td>G10 - G13*, G31 - G40</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Renal Disease</td>
<td>N03, N05, N11 - N12X, N18 - N19X, N25</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>Nutritional Anaemia</td>
<td>D50 - D53</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Hypertension, Uncomplicated</td>
<td>I10X</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>Psychoses</td>
<td>F20 - F29X, F31</td>
<td></td>
</tr>
<tr>
<td>1 LOW</td>
<td>Malnutrition / Weight Loss</td>
<td>E40X - E46X, R634, R64X</td>
<td></td>
</tr>
</tbody>
</table>

Note:

1) The listed diseases and conditions must be recorded in inpatient SMR01 episodes when they are present as comorbidities and where coding space permits.
2) The listed diseases and conditions need not be recorded as comorbidities in day case SMR01 episodes unless they represent active problems. They may be recorded as background comorbidities in day case episodes if space permits and the information is required for local purposes.
3) When applicable, diseases and conditions from the groups highlighted as ‘long-standing’ should be recorded as being present even if mentioned as ‘past medical history’. In individual cases specific clinical information that a highlighted disease or condition is no longer present may override this requirement.
4) ‘Priority 8’ is the highest priority group, ‘priority 1’ is the lowest.
5) Sequencing of sequelae or dagger/asterisk pairs must override questions of priority e.g. when coding hemiplegia due to stroke, G81 (priority 2) must be
6) This list may be augmented in future.

**Use of ‘Z’ codes**

This document is for guidance of when to use codes from the ICD10 chapter – ‘Factors influencing health status and contact with health services’. It is not meant to be exhaustive, but concentrates on the codes that have been identified as being poorly recorded in the past.

As a general rule, where any of the factors are mentioned on the Discharge Summary, then they should be coded against the episode.

Whilst primarily concentrating on the use of these codes on SMR01s, where space allows and information is available, coders should also consider the use of these codes on other SMRs.

**Persons encountering health services for examination and investigation. Z00 – Z13**

Z03.- Medical observation and evaluation for suspected diseases and conditions

Z04.- Examination and observation for other reasons

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, Z03.- and Z04.- should be used when there is a reason (e.g. symptoms, history) for suspecting that the patient may have a condition but after a period of observation there is found to be no condition present.

Examples:

<table>
<thead>
<tr>
<th>a)</th>
<th>child found with empty medicine bottle</th>
<th>Z03.6</th>
<th>Observation for suspected toxic effect from ingested substance.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>b)</th>
<th>a patient was kept in hospital overnight with a minor condition (e.g. superficial head injury) which would not normally warrant an overnight stay</th>
<th>S00.9</th>
<th>Superficial injury of head, part unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X59.9</td>
<td>Accident NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z04.3</td>
<td>Examination and observation following other accident</td>
</tr>
</tbody>
</table>

Z08.- Follow-up examination after treatment for malignant neoplasm

Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms

The above codes have specific rules regarding sequencing, dependant upon other findings during the episode.

Z11.- Special screening examination for infectious and parasitic diseases

Z13.- Special screening examination for other diseases and disorders
Screening examination codes - should be used for elective admissions in main position where the patient currently has no symptoms of a disease but there is reason to suspect they may develop it e.g. strong family history of the disease. This code should be **omitted** if evidence of the disease is found.

**Persons with potential health hazards related to communicable diseases Z20 – Z29**

**Z21.X Asymptomatic human immunodeficiency [HIV] infection status.**
**Z22.- Carrier of infectious disease**
Where the patient has been identified as a carrier or ‘positive’ in this episode.
**Z29.0 Isolation.** This code should always be recorded if it has been necessary to isolate the patient

**Persons encountering health services in circumstances related to reproduction Z30 – Z39**

**Z30.3 Menstrual extraction**
Use in conjunction with O04.- to highlight drug used in interception of pregnancy.
**Z36.- Antenatal screening.**
For use on SMR02s to highlight reason for admission.

**Persons encountering health services for specific procedures and health care Z40 – Z54**

This block contains many ‘Z’ codes that may be used in the primary position, reflecting the main reason for admission, e.g. Patient admitted for change of colostomy; **Z43.3 – Attention to colostomy.**

**Convalescence – Z54.-** These code are normally in a secondary or subsequent position to indicate continuing care for a condition, but may be valid as Main Condition. Please refer to Coding Quarterly (No.2) February 1997 for further information.

**Persons with potential health hazards related to socioeconomic and psychosocial circumstances Z55 – Z65**

Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode in the patient’s record.

**Z60.2 Living alone**
Record where this factor has affected the patient’s length of stay.

**Persons encountering health services in other circumstances Z70 – Z76**

Codes from this block are considered ‘additional information’ and should rarely appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode of the patient’s record.
Z74.- Problems related to care-provider dependency
Z75.- Problems related to medical facilities and other health care
Record where the factor has affected the patient’s length of stay. Particularly important is Z75.1 – Person awaiting admission to adequate facility elsewhere.
Z75.5 – Holiday relief care. This code has its own rules. Please refer to SCCS No.7 July 2014 for further information.

Persons with potential health hazards related to family and personal history and certain conditions influencing health status Z80 – Z99
Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’, with the exception of Z85.6 - Personal history of leukaemia and Z85.7 - Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues where the condition is in remission.

Z80 – Z84 Family history of diseases.
These should be coded if patients are being investigated/treated for suspected cancers, IHD, mental illness etc. Follow the notes against each category to select the appropriate code.

Z85.- Personal history of malignant neoplasm
Only code if relevant to the patient’s current condition;
- If the patient is suspected of having or has been diagnosed with cancer in another part of the body.
- If the patient is admitted with a problem in the part of the body previously affected by cancer.

Z86 - Z87 Personal history of other diseases and conditions.
Only assign if relevant to the patient’s current condition e.g. patient has right-sided weakness and had a previous TIA. PH codes should not be added when the patient is treated for a recurrence of the same disease.

Z90.1 Acquired absence of breast
Record if the patient is admitted with a problem in the remaining breast.

Z92.2 Personal History of long-term (current) use of other medicaments
It is NOT necessary to use this code where a corresponding condition has been recorded e.g. where asthma has been recorded, no need to add long term use of Ventolin.

Z95.- Presence of cardiac and vascular implants and grafts
Record where the patient is in for any investigation or treatment of heart or vascular problems and has had previous cardiac surgery.

Z96.6 Presence of orthopaedic joint implants
It is NOT necessary to record this where patient is in for revision surgery on the same joint or for treatment of a complication of the implant but should be used for continuing care after joint implant surgery or if having an implant on any other joint.
Many of the ‘Z’ codes have their own particular rules for recording e.g. Personal History codes with codes for Follow-up Examinations, Procedures Not Carried Out, Continuing Care, etc. Rules should be followed for all.

When adding ‘Z’ codes to reflect additional information, true co-morbidities should take priority with the exception of ‘Z’ codes which indicate the length of stay has been affected e.g. Z75.1 – Person awaiting admission to adequate facility elsewhere. This guidance applies to all discharges on and after 1st October 2007.

**Rectus Sheath Haematoma**

SCCS No. 3 September 2013

There is no specific ICD10 index trail for Rectus Sheath Haematoma (RSH). The index trail

**Hematoma (traumatic) (skin surface intact) (see also Injury, superficial) T14.0**
- muscle - code as Contusion, by site

**Contusion (skin surface intact) (see also Injury, superficial) T14.0**
- abdomen, abdominal (muscle) wall S30.1

leads to the injury code S30.1 Contusion of abdominal wall. This has caused confusion because many cases of RSH are described as ‘spontaneous’ or ‘non-traumatic’. Very few are reported to originate with trauma.

In the past several different coding solutions have been offered. In order to rationalize the coding of RSH, CCRG have decided that:

a) The terms ‘spontaneous RSH’, ‘non-traumatic RSH’ and ‘RSH’ (i.e. RSH unspecified) should each be recorded by using the following two codes together:

**M62.88 Other specified disorders of muscle** (5th digit 8 trunk)

**R58.X Haemorrhage, not elsewhere classified**

b) RSH stated to be due to trauma should be coded following the index trail above to

**S30.1 Contusion of abdominal wall**

with the appropriate external cause code.
Septic shock - errors in Includes and Excludes notes in ICD10 V4
SCCS No. 5 March 2014

ICD10 V4 Volume 1 contains confusing Inclusion and Exclusion notes relating to septic shock. These notes are incorrect and should be deleted. Please amend your Tabular List as follows:

a) The inclusion term of ‘septic shock’ at A41.9 Sepsis, unspecified (Volume 1 page 117) should be deleted.

b) The exclusion term of ‘shock, septic (A41.9)’ at R57 Shock, not elsewhere classified (Volume 1 page 774) should be deleted.

Termination (abortion)/miscarriage coding
SCCS No.4 February 2014

The term ‘abortion’ refers to the expulsion or removal of an embryo or fetus. Coding staff should be aware that there has been a recent move away from using the term “abortion” for cases of termination/miscarriage because it may be confusing and is often upsetting to patients who usually consider the term to mean termination of pregnancy. It is probably safer to refer to spontaneous and missed abortions as “miscarriages” and to refer to medical or surgically induced abortions as “terminations of pregnancy” or just “terminations”.

Clinical practice of treating terminations/miscarriages has changed in the last few years since we previously issued guidance on this subject. It is also true that practice is different in different areas of the country. This has led to coders being confused about how to code termination/miscarriage episodes, particularly when there may be several episodes for the same termination or miscarriage.

The following scenarios may be quite typical:

Termination of pregnancy (for the purposes of removing a live embryo or fetus)

1. On discharge of first episode should be coded to O04.5 to .9

If patient returns with retained products of conception code to O04.0 to .4

ICD10 Index states - Retention, retained
- products of conception
- - following
- - - abortion - see Abortion, by type
Abortion
- medical O04.-
2. Patient is admitted or attends as an outpatient for start of termination. Given mifepristone orally then sent home. Nothing happens.
This should be recorded on an SMR01 (Inpatient/Daycase) as follows:
O04.5 to .9 PLUS Z51.2 for oral mifepristone.
If recording on an SMR00, the code X39.1 **Oral administration of therapeutic substance** must be entered in the OPCS field.

Patient returns 3 days later and is given misoprostol vaginally. Still nothing happens.
This should be recorded on an SMR01 (Inpatient/Daycase) as follows:
O04.0 to .4 PLUS Z51.2 for vaginal misoprostol
An OPCS code must also be recorded:
Q14.5 - **Insertion of prostaglandin pessary**

If recording on an SMR00, the code Q14.5 - **Insertion of prostaglandin pessary** must be entered in the OPCS field.

The following day, the patient is admitted and is given a second dose of misoprostol orally, and then expels the products of conception.
This episode should also be coded to
O04.0 to .4 PLUS Z51.2 for oral misoprostol.

**Spontaneous miscarriages/spontaneous abortions:**

On the first inpatient or daycase episode of care for a spontaneous miscarriage, a code for complete miscarriage should be used i.e. O03.5 to O03.9. This will apply even if the patient is still bleeding when sent home. The only exception to this rule would be the rare occasion where it is known that the miscarriage is not complete prior to discharge - perhaps if the woman has discharged herself against advice, or the patient is being transferred because of complications.

On discharge of first episode should be coded to O03.5 to .9
If patient returns with retained products of conception code to O03.0 to .4
ICD10 Index states - Retention, retained
- products of conception
  - - following
  - - - abortion - see Abortion, by type
  Abortion
- spontaneous O03.-

Any subsequent in-patient episode of care should be coded to an incomplete miscarriage i.e. O03.0 to O03.4.
All of the above terms should be recorded to O02.1 – Missed abortion.
Where oral mifepristone OR oral prostaglandin (including misoprostol) is given to encourage the expulsion of the fetus/products of conception, the code Z51.2 – Other chemotherapy must be added.
The patient may be discharged prior to expulsion of the fetus/products of conception.

On discharge of first episode should be coded to
If patient returns with retained products of conception code to
ICD10 Index states - Retention, retained
- products of conception
- - early pregnancy (dead fetus)

Coding of abortifacients

<table>
<thead>
<tr>
<th>ICD10 code (in addition to O02.-, O03.- or O04.-)</th>
<th>OP CS4 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral mifepristone OR Oral prostaglandin (including misoprostol)</td>
<td>Z51.2 – Other chemotherapy</td>
</tr>
<tr>
<td>Vaginal/ pessary prostaglandin (including misoprostol)</td>
<td>Z51.2 – Other chemotherapy</td>
</tr>
<tr>
<td>Oral mifepristone – SMR00 ONLY</td>
<td>X39.1 Oral administration of therapeutic substance</td>
</tr>
</tbody>
</table>

Please note that mifepristone is only given orally.

The intention of these coding rules is that only one complete miscarriage/termination episode should ever be recorded for any miscarriage/termination. Analysts counting the number of episodes of care for miscarriages/terminations should be aware of the above rules, but should note that some termination patients are never admitted as inpatients and so a more accurate result of total number of terminations will be obtained by counting the ‘yellow forms’ held on a separate database from SMR information. It is also advisable for analysts to use the linked dataset when analysing for episodes of miscarriage to ensure that they avoid counting multiple admissions for the same episode.

N.B. If the termination/miscarriage information is being recorded on an SMR02 record, the correct condition on discharge code for the above scenarios is 8 - Other (includes missed abortion) unless the clinician states that the patient has aborted in which case the correct code is 2 - Aborted.
Termination of pregnancy resulting in liveborn
SCCS No.4 February 2014

In cases where a patient undergoes termination of pregnancy, resulting in a live fetus where the baby has lived for any amount of time, regardless of gestational age, this must be coded as an abortion using a code from categories O04-O06. An appropriate code from category Z37 Outcome of delivery must also be assigned in the first secondary diagnosis field to indicate that the termination of pregnancy resulted in a live birth.
UNCHANGED GUIDANCE – STILL VALID

Abortion codes on SMR02
Coding Quarterly No. 2, February 1997

On SMR02 abortions must be coded under Main Condition (in ICD10) from 1 April 1997 in addition to coding under the data item Type of Abortion.

Acquired Absence of Breast
Coding Guidelines No. 17, January 2006

Where a patient has previously had a breast removed, the code Z90.1 - Acquired Absence of Breast(s) should be added in appropriate episodes. For example, where a mastectomy was carried out for removal of neoplasm and the patient is now admitted for investigation of breast mass.

Acute Asthma Coding Guidelines No. 13, January 2003

Please note that Acute Asthma without further specification is coded to J45.9. The code J46.X is Status asthmaticus or Acute severe asthma. The word ‘severe’ is an essential modifier.

Acute coronary syndrome SCCS No. 2 July 2013

In the Errata dated January 2013, instruction was given to amend the index trail for Acute coronary syndrome as follows:

Syndrome
- coronary
- - acute NEC I24.9 delete and replace with I20.0

The Clinical Coding Review Group has decided that Scotland will continue to code Acute coronary syndrome to I24.8. Please amend index to reflect this code.

Syndrome
- coronary
- - acute NEC I24.9 delete and replace with I24.8
N.B. This is a Scotland/England difference.
Acute Kidney Injury
Coding Guidelines No. 31, September 2012

Acute Kidney Injury (AKI) is the preferred term used by clinicians to describe Acute Renal Failure (ARF). Clinically AKI is characterised by a rapid reduction in kidney function resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis.

When the term ‘Acute Kidney Injury’ is index trailed in ICD-10 the coder is directed to a traumatic injury code.

Index Trail:
Injury
- kidney S37.0

Tabular List:
S37.0 Injury of kidney

However, in the majority of instances, the clinician documenting the condition of AKI is referring to the non-traumatic condition of acute renal failure.

N17.- Acute renal failure

It is therefore important that when a diagnosis of AKI is documented in a patient’s medical record, and if it is not clear whether the clinical diagnosis of AKI is referring to a traumatic injury or the more familiar term of acute renal failure, the coder must confirm the diagnosis with the responsible clinician before code assignment.

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Acute on chronic conditions
Coding Guidelines No. 2, January 1999

It has been agreed that if no specific single code is available in ICD10 then both the acute and chronic conditions should be coded separately if the information is available, e.g.

Acute on Chronic Bronchitis: Code to J20.9 (Acute bronchitis) and J42.X (Unspecified Chronic bronchitis).

Adverse effect of Viagra
Coding Guidelines No. 4, September 1999

Although this drug was intended initially for the treatment of angina and would, for this have been coded to Y52.3 - Coronary vasodilators, not elsewhere classified - for
adverse effect in therapeutic use, its use in ameliorating erectile dysfunction should be coded to Y52.7 - Peripheral vasodilators - since its effect is mediated through changes in the vascular system.

**Alcohol Excess Coding Guidelines No. 28, March 2011**

The phrase “alcohol excess” is often used in medical notes, frequently with no further information regarding the patient’s condition. “Alcohol excess” implies that someone has had too much to drink, but not necessarily that they are an alcoholic and to this end coders must use F10.0 Mental and behavioural disorders due to the use of alcohol, acute intoxication. Clinicians would need to state clearly in the notes that a patient was demonstrating harmful use or dependence before any other code is used.

The trail that coders must follow when coding “alcohol excess” with no other information is as follows:

- Excess, excessive, excessively
  - alcohol level in blood R78.0
  - drinking (alcohol) NEC F10.0
  - - habitual (continual) F10.2

The code for “excess alcohol not otherwise specified” would therefore be F10.0 Acute intoxication due to use of alcohol. If mentioned in relation to repeated events that are described as continual, habitual, addicted or chronic then the coder should be using F10.2 Dependence syndrome due to use of alcohol.

Where the alcohol excess has a further descriptor – for example “abuse” then the coder should take that into account when selecting the correct code. For example, if the patient is brought in with alcohol excess and the doctor notes that the patient is abusing alcohol then the coder should record both F10.0 and F10.1.

**Alcohol involvement when noted with an overdose of drugs Coding Guidelines No. 16, August 2005**

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.pm. 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)

**Alcohol-related conditions Coding Guidelines No.1 May 1996**

A patient is admitted to hospital in a state of drunkenness. This may be following an accident, he/she may have been found unconscious and brought in by the police or another person, or the patient may be a child or adolescent found drunk and admitted for observation. These situations should be coded as follows:

1) **A child/adolescent has been found drunk, brought in to A&E, then admitted for observation overnight.**
   - F10.0 Mental and behavioural disorders due to alcohol, acute intoxication
   - Z03.6 Observation for suspected toxic effect from ingested substance

2) **Patient admitted with a head injury - drunk**
   - S09.9 Unspecified injury of head
   - X59.9 Unspecified accident
   - F10.0 Mental and behavioural disorders due to alcohol, acute intoxication

3) **Patient admitted with a head injury - smelling of alcohol**
   - S09.9 Unspecified injury of head
   - X59.9 Unspecified accident
   - Y91.9 Alcohol involvement, not otherwise specified

**Allergies Coding Guidelines No. 13, January 2003**

Questions have been raised about whether it is necessary to code allergies (eg penicillin allergy). It has been decided that if the allergy is mentioned in the text of the discharge summary or listed as a diagnosis, it should be coded.

**Anaemia SMR02 review 2000**

Anaemia is considered to exist when haemoglobin (Hb) levels are below 10g/dl blood.
Anaemia (SMR02 Review Update)
Coding Guidelines No.28 March 2011

Coding Guideline No. 27 – October 2010 gave instruction on how and when to code “anaemia” in SMR02 episodes. In addition to the previous guidance, it should be noted that, for SMR02 recording purposes, anaemia is considered to exist when haemoglobin (Hb) levels are below 10g/dl blood. Where a Haematology report confirms such a reading, an anaemia code should be attributed to the patient.

Anaemia complicating pregnancy, childbirth and the puerperium
O99.0
SMR02 Review 2010

O99.0 Anaemia complicating pregnancy, childbirth and the puerperium can only be used in the first position. When using code O99.0, this must be used alone when the anaemia is unspecified. O99.0 should be followed by a code from D50–D64.8 when the cause of the anaemia is known. Haemoglobin levels are slightly lower than usual in pregnancy; therefore care must be taken only to code ‘anaemia in pregnancy’ when clearly defined in the patient’s medical record by the obstetrician or midwife. Statements of “low hb” or “sent home on iron tablets” should not be coded as anaemia.

If there is another obstetric condition to be recorded in Main Condition and the coder needs to record the clinical text “anaemia”, a code from Chapter III (blocks D50-D64) should be recorded in Other Conditions. Where the type of anaemia is not known record D64.9 Anaemia, unspecified.

Anaemia due to neoplasm Coding Guidelines No. 9, July 2001

When a patient is admitted for treatment of anaemia due to a neoplasm and the neoplasm is an ongoing condition, it is recorded with a dagger code to identify the neoplasm followed by D63.0A to identify the anaemia.

However, if the anaemia is a normal manifestation of a neoplastic disease, eg leukaemia, myeloma or myelodysplasia, only one code to identify the neoplasm should be recorded.

Coders have asked if this also applies to lymphomas eg Non-hodgkins. The decision is that for lymphomas the anaemia should be added following the dagger/asterisk principle outlined above.
Anal Intraepithelial Neoplasia (AIN III)  
Coding Guidelines No. 20, June 2007

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.

Angina with Ischaemic Heart Disease  
Coding Guidelines No. 13, January 2003

If a patient has Angina and Ischaemic heart disease, both should be coded.

Ante Partum Haemorrhage  
Coding Quarterly No. 5, January 1998

When is a haemorrhage in pregnancy classified as bleeding in early pregnancy and when as ante partum haemorrhage?

The cut-off period is 24 completed weeks gestation. Before this period code to O20.- Haemorrhage in early pregnancy.

After this period i.e. 24 completed weeks and above, code to O46.- Ante partum haemorrhage, not elsewhere classified.

Anti D  
SMR02 Review 2010

Anti-D can be given to a Rhesus negative mother in the antenatal period as well as in the postnatal period. Anti-D is always given by intramuscular injection.

Record in both ICD10 and OPCS4.  
ICD10 – Z29.1 Prophylactic immunotherapy  
OPCS4 – X30.1 Injection of rh immune globulin

If it is known that Anti-D is given in the delivery episode, code both ICD10 and OPCS4. However, if it is unclear when the Anti-D was administered during the pregnancy, only the ICD10 code is required and must be coded in the delivery episode.
**Anti D administration**

Anti-D can be given to a Rhesus negative mother in the antenatal period as well as in the postnatal period. Anti-D is always given by intra-muscular injection. Record in both ICD10 and OPCS4.

ICD10  Z29.1 (Prophylactic immunotherapy)
OPCS4  X30.1 (Injection of rh immune globulin)

**Arterial disease**

Diagnosis of “rest pain”, “ischaemic leg” and “ischaemic leg ulcer” all indicate that the patient has peripheral vascular disease (PVD).
Code to I73.9 (PVD) with an additional code for the leg ulcer where applicable.

**Arthrosis**

There is a note at the start of block M15-M19 explaining that the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis. The note also explains that the term ‘primary’ used within this block refers to arthrosis of no underlying or determining cause.

Coders are advised to always default to unspecified forms of these conditions (.9) in cases where the clinician has not identified an underlying cause.

Within the ICD-10 Alphabetical Index, the term ‘primary’ is an essential modifier which must be present in the clinical statement to enable coders to assign a code for a specific primary arthrosis.

Where the modifier ‘primary’ is not included in the diagnostic statement, the coder must default to the .9 unspecified code from the relevant ICD-10 category.

**Example:**
Bilateral osteoarthritis of the knees (gonarthrosis).

**Index Trail:**
Gonarthrosis M17.9

**Tabular List:**
M17.9 Gonarthrosis, unspecified

**Rationale:** The fact that the gonarthrosis is bilateral does not change the code assignment in this case. It is not stated that the gonarthrosis is ‘primary’, which as indicated above must be present in the diagnostic statement for the code M17.0

**Primary gonarthrosis, bilateral** to be assigned.
The same rule applies for all other types of osteoarthritis/arthrosis.

Clinical Coding Departments need to work closely with their clinicians to ensure that the precise diagnosis is captured to enable the assignment of the appropriate ICD-10 codes. It is not the responsibility of the clinical coding professional to make a clinical judgement on the type of arthrosis a patient has. The type of arthrosis is a clinical decision, and therefore the relevant information, or confirmation as to whether the condition can be described as ‘primary’, must be accurately documented in the patient medical record.

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Attention to/Flushing of Hickman Line; Sequencing of codes
Scottish Clinical Coding Standards No.1 March 2013

Question

On an SMR01 Inpatient or Day Case episode, should Z45.2 (Adjustment and management of vascular access device) be recorded as the main condition followed by the patient’s clinical diagnosis when the sole purpose of admission is attention to/flushing of Hickman Line?

Answer

In the case of an SMR01 Inpatient or Day Case episode, where the patient has e.g. Lung cancer, and the patient has been admitted solely for the purpose of attention to/flushing of Hickman line, and where no further treatment or investigation was undertaken for the lung cancer during that episode of care then the attention to/flushing of the Hickman line must be considered to be the primary reason for admission and treatment. Therefore this must be reflected by assigning code Z45.2 Adjustment and management of vascular access device in main condition to indicate the attention to/flushing of the Hickman line. If information is available as to why the Hickman Line is in place then this should also be recorded.

The example above would therefore be coded as follows:

Z45.2 Adjustment and management of vascular access device
C34.9 Malignant neoplasm of bronchus or lung, unspecified

Please note that this does not apply to admission for radiotherapy (Z51.0) or chemotherapy (Z51.1) where the cancer code must come first. This is because in these situations the cancer is the primary reason for admission and treatment.
Barrett’s oesophagus  SCCS No.2 July 2013

Barrett’s oesophagus now has the following index entry and code

**Barrett’s**
- disease K22.7
- esophagus K22.7
- ulcer K22.1

**Barrett’s ulcer** will require two codes; K22.1 Ulcer of oesophagus and K22.7 Barrett oesophagus. This will differentiate between ulcers other than Barrett’s included at K22.1.

This is a Scotland/England difference.

Bilateral Injuries  Coding Guidelines No. 15, November 2004

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.

Bile reflux into the stomach and biliary gastritis  Coding Guidelines No. 19, September 2006

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.
Body Piercing  Coding Guidelines No. 15, November 2004

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 of skin and subcutaneous tissue
K13.0 - Disease of lips
W45.9 - Foreign body or object entering through the skin (unknown place of occurrence)

Bowel screening  SCCS No. 2 July 2013

In the Bowel Screening Programme, patients who have a positive Faecal Occult Blood screening result are being called for further examination (colonoscopy). This should be coded to R19.5 (Other faecal abnormalities) in the colonoscopy episode if no further diagnosis is made.

Index trail:
Blood
  - in
    - - feces (see also Melena) K92.1
    - - - occult R19.5

K92.1 – Melaena should only be recorded where this is the statement given.

Burns classified according to percentage of body area
Coding Guidelines No. 4, September 1999

When coding burns, and when the information is available, please remember to code the percentage of body surface affected. If a burn is classified according to the extent of the body surface involved then code accordingly to T31.-

Note T31 - is to be used as the primary code only when the site of the burn is unspecified. It must be used, if available, as a supplementary code with categories T20-T29 when the site is specified.
Cancelled procedure - condition resolved
Coding Quarterly No. 1, November 1996

A procedure may be cancelled because the condition requiring the procedure has resolved itself. The correct way to code this is to use Z53.8, Procedure not carried out for other reasons, followed by a code for personal history of the condition that had required the procedure.

Note: A personal history code cannot be used when the condition was actually a symptom or sign codable to Chapter XVIII, eg. abdominal pain. In this case only code Z53.8 should be recorded.

Cancer Patients Admitted for Chemotherapy
SCCS No.2 July 2013

When patients with cancer are admitted to hospital for chemotherapy how should this be coded?

When the patient is being admitted specifically for chemotherapy, the ICD10 code Z51.1 Chemotherapy session for neoplasm should always be used after the code(s) for neoplasm(s). The appropriate OPCS4 code to identify the route of administration of the chemotherapy (X72- and/or X73.-) should also be recorded, if relevant.

In cases where the patient is receiving chemotherapy as part of routine inpatient care, but was not admitted specifically for this treatment, the coding is slightly different. It is not necessary to code chemotherapy in the diagnostic section. It is only necessary to record the OPCS4 code, if appropriate.

Cardiac Arrest Coding Guidelines No. 12, September 2002

If clinicians wish to record cardiac arrest, I46.0 should be used where an arrest took place and the patient was resuscitated. I46.1 should only be used where there was ‘Sudden cardiac death’ recorded, and I46.9 may be used in those instances where the term ‘cardiac arrest’ was used but no further information is given.

Carrier of Viral Hepatitis Coding Guidelines No. 12, September 2002

Z22.5 - Carrier of viral hepatitis is the correct code for patients described as:

A ‘carrier’ of any viral hepatitis including both the Hepatitis B and Hepatitis C viruses ‘positive’ for one or more of these viruses e.g. ‘Hepatitis C positive’.

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Coders should ensure that the patient is NOT being actively treated for acute or chronic viral Hepatitis, where the correct codes would be in the block B15 - B19.

**Cause of Death**  
**SCCS No. 2 July 2013**

Coders should note that the cause of death of a patient would not always be considered as the main condition.

The main condition is defined as the condition, diagnosed at the end of the episode of health care, primarily responsible for the patient’s need for treatment or investigation. (See [http://www.datadictionaryadmin.scot.nhs.uk/SMR-Datasets/General-Clinical-Information/Diagnostic-Section/Main-Condition.asp](http://www.datadictionaryadmin.scot.nhs.uk/SMR-Datasets/General-Clinical-Information/Diagnostic-Section/Main-Condition.asp))

Therefore the primary condition treated during the patient’s stay should ALWAYS be in the main position. The cause of death may be added in a subsequent position, if it is not the primary condition.

**Cellulitis following a wound injury  
SCCS No. 2 July 2013**

Cellulitis is a bacterial infection of the skin and subcutaneous tissue, which usually enters the skin via a wound or some break in the protective skin. When coding wound infections that progress to cellulitis, it is important that we capture the most significant code to reflect the condition being treated as in the following examples:

**Patient admitted with cellulitis of face (unknown cause)**

Code  L03.2 – Cellulitis of face

**Patient fell in garden, laceration of lower leg treated at A&E, admitted 4 weeks later with cellulitis of lower leg**

Code  L03.1 – Cellulitis of other parts of limb  
      T93.0 – Sequelae of open wound of lower limb  
      Y86.X – Sequelae of other accidents

**Known heroin addict is admitted with cellulitis of arm due to the use of infected needles**

Code  L03.1 – Cellulitis of other parts of limb  
      W46.9 – Contact with hypodermic needle  
      F11.2 – Addiction to heroin

**Patient admitted with cellulitis due to insect bite of finger**
Code  L03.0 – Cellulitis of finger and toe
       W57.9 – Bitten or stung by nonvenomous insect and other nonvenomous arthropods.

**Chronic Ischaemic Heart Disease and Triple Vessel Disease Coding Guidelines No. 16, August 2005**

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

**Chronic schizophrenia Coding Guidelines No. 12, September 2002**

It should be noted that when trying to code ‘Chronic Schizophrenia’ the coder is led to:

Schizophrenia
   - Chronic undifferentiated F20.5

It has been agreed that the preferred code for ‘Chronic Schizophrenia’ is F20.5 and an index change has been requested.

**Clicking hip Coding Quarterly No. 1, November 1996**

In ICD9 the code for clicking hip was in Chapter XIV (Congenital anomalies). In ICD10 the correct code is found in Chapter XVIII (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified). The correct ICD10 code for clicking hip is R29.4, Clicking hip.
This code applies when the disorder is not described as a congenital deformity. If it is described as such, an appropriate code from Q65.-. Congenital deformities of hip, should be selected.

**COAD + pneumonia**

The Coding Review Panel (CRP) have agreed the tabular ‘excludes’ entry at - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection is misleading and should include an exclusion of pneumonia as that is the same block as influenza (J10 - J18 Influenza and Pneumonia). The recommendation is that both pneumonia with COAD and influenza with COAD are dual coded with the pneumonia or influenza sequenced in the primary position.

**Coding of COPD/COAD and associated conditions**

In Coding Guidelines No.22, March 2008, we published a table to help coders assign the appropriate ICD10 codes for COPD/COAD with associated conditions and to ensure consistency in the recording of these conditions. The following new entries have been added to this table;

- Infective exacerbation of asthma, patient known COAD/COPD.
  
  This should be coded to J45.9 + J22.X + J44.9
  or J46.X + J22.X + J44.9

- COPD/COAD with basal pneumonia
  This should be coded to J18.1 + J44.0

- Infective exacerbation of COPD/COAD
  This should be coded to J44.0

The table is reprinted below with the new entry.

### COPD/COAD

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/COAD</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>COPD/COAD with acute bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis (15 years and above)</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis NOS</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with chronic bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>Condition</td>
<td>Code(s)</td>
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<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------</td>
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<tr>
<td>COPD/COAD with asthma</td>
<td>J44.9</td>
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<tr>
<td>COPD/COAD with acute asthma</td>
<td>J45.9 and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with status asthmaticus</td>
<td>J46.X and J44.9</td>
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<tr>
<td>COPD/COAD with emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td>COPD/COAD with pneumonia, unspecified</td>
<td>J18.9 and J44.0</td>
</tr>
<tr>
<td>COPD/COAD with basal pneumonia</td>
<td>J18.1 and J44.0</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>Chest infection</td>
<td>J22.X</td>
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<tr>
<td>Chest infection with acute bronchitis</td>
<td>J20.-</td>
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<tr>
<td>Chest infection with bronchitis NOS</td>
<td>J40.X and J22.X</td>
</tr>
<tr>
<td>Chest infection with chronic bronchitis</td>
<td>(J41.- or J42.-) and J22.X</td>
</tr>
<tr>
<td>Chest infection with cystic fibrosis</td>
<td>E84.0</td>
</tr>
<tr>
<td>Chest infection with emphysema</td>
<td>J43.9 and J22.X</td>
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<tr>
<td>Chest infection, COPD and emphysema</td>
<td>J44.0 and J43.9</td>
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<tr>
<td>Chest infection with lower lobe consolidation on X-ray</td>
<td>J18.1</td>
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<tr>
<td>Chest infection, LVF</td>
<td>J22.X and I50.1</td>
</tr>
<tr>
<td>Sequencing is dependent on the main condition treated</td>
<td></td>
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<tr>
<td>Chronic obstructive bronchitis with acute exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>URTI (Upper respiratory tract infection) with COPD</td>
<td>J44.1 and J06.9</td>
</tr>
<tr>
<td>(Acute) exacerbation of asthma</td>
<td>J45.9</td>
</tr>
<tr>
<td>Infective exacerbation of asthma</td>
<td>(J45.9 or J46.X) and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma with status asthmaticus</td>
<td>J46.X and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma, patient known COAD/COPD</td>
<td>J45.9 + J22.X + J44.9 or J46.X + J22.X + J44.9</td>
</tr>
<tr>
<td>Infective exacerbation of COPD/COAD</td>
<td>J44.0</td>
</tr>
</tbody>
</table>


Please note that previous guidance (Coding Guideline No.8 February 2001) still applies.

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**Coding HIV disease**  
**Coding Quarterly No. 2, February 1997**

A list of HIV codes which do NOT require dual coding was published in Coding Quarterly No.1 (page 3), November 1996.
One code should be added:

**B23.1 HIV disease resulting in (persistent) generalised lymphadenopathy.**

The full list is:

B20.6 HIV disease resulting in Pneumocystis carinii pneumonia

B22.1 HIV disease resulting in lymphoid interstitial pneumonitis

B22.2 HIV disease resulting in wasting syndrome

B23.0 Acute HIV infection syndrome

B23.1 HIV disease resulting in (persistent) generalised lymphadenopathy

B24.X Unspecified HIV disease

---

**Coding HIV disease in ICD10**
**Coding Quarterly No. 1, November 1996**

When coding HIV related conditions, dual-coding is the convention, ie. is to use a code from the range B20 - B24 followed by a second code to identify the specific condition caused by HIV. However, the clinical data section on SMR01 is limited and a maximum of six diagnoses may be entered. In order to make the best use of the available space, the principle is to use only one HIV code - whichever is most appropriate for the patient’s conditions - followed by a list of codes for the specified conditions.

1. Dual coding with codes B20 - B24 is necessary -
   a) when HIV disease results in a single condition and extra value and detail are given by using the second code

   Example: Oral thrush resulting from HIV disease
   B20.4 HIV disease resulting in candidiasis
   B37.0 Candidal stomatitis

   Note: If the condition or symptom is not covered by a specific HIV code, use B23.8 followed by a code for the condition or symptom

   Example: HIV disease causing nausea and vomiting
   B23.8 HIV disease resulting in other specified conditions
   R11.X Nausea and vomiting

   b) when HIV disease results in a malignant neoplasm.
The neoplasm code must always be recorded (even if it doesn’t provide more detail) since this information is required for the analysis of cancer data.

Example: HIV disease resulting in Kaposi’s sarcoma
B21.0 HIV disease resulting in Kaposi’s sarcoma
C46.9 Kaposi’s sarcoma, unspecified

c) when coding multiple HIV related diseases

i - for multiple infections, use B20.7 (HIV disease resulting in multiple infections) followed by a list of codes for the infections

Example: HIV disease resulting in respiratory tuberculosis and herpes simplex infection
B20.7 HIV disease resulting in multiple infections
A16.9 Respiratory tuberculosis
B00.9 Herpes simplex infection

ii - for multiple malignant neoplasms, use B21.7 (HIV disease resulting in multiple malignant neoplasms) followed by a list of codes for the neoplasms

Example: HIV disease resulting in Burkitt’s lymphoma and malignant neoplasm of oesophagus
B21.7 HIV disease resulting in multiple malignant neoplasms
B83.7 Burkitt’s tumour
C15.9 Malignant neoplasm of oesophagus

iii - for multiple diseases which may include both infections and neoplasms, use B22.7 (HIV resulting in multiple diseases classified elsewhere) followed by a list of codes for the specified diseases

Example: HIV disease with Kaposi’s sarcoma, anaemia, oral thrush, depression and nausea
B22.7 HIV disease resulting in multiple diseases classified elsewhere
C46.9 Kaposi’s sarcoma, unspecified
D64.9 Anaemia, unspecified
B37.0 Oral thrush
F32.9 Depression, NOS
R11.X Nausea and vomiting

2. Some codes do not require dual coding as there is no benefit in recording the additional code. Codes which do not require dual coding are:

B20.6 HIV disease resulting in Pneumocystis carinii pneumonia
B22.1 HIV disease resulting in lymphoid interstitial pneumonitis
B22.2 HIV disease resulting in wasting syndrome
B23.0 Acute HIV infection syndrome
B24.X Unspecified HIV disease
Coding poisonings with the drug 'Ecstasy'
Coding Quarterly No. 1, November 1996

Ecstasy is not listed in the Table of Drugs and Chemicals and coding poisonings withEcstasy is proving difficult.
The pharmaceutical name for Ecstasy is Methyleneoxyamphetamine. This drug is classed as a psychostimulant.
The appropriate codes for poisonings with Ecstasy are found in the Table of Drugs and Chemicals under Psychostimulant NEC.

Coding Respiratory Failure
Coding Guidelines No. 23, September 2008

Respiratory failure often occurs with or as a symptom of other respiratory disorders, such as asthma, emphysema, COPD (chronic obstructive pulmonary disease), fibrosing alveolitis and so on. If the clinician has stated that respiratory failure is present then it must be recorded by the coder.

Always code the presenting respiratory condition in main position and respiratory failure J96.- in second position, e.g. COPD and respiratory failure. Code COPD first and respiratory failure second.

COPD J44.9
Respiratory failure J96.-

Compound drugs, adverse effects and poisonings
SCCS No. 2 July 2013

Compound Drugs
When the drug has more than one component, each component should be coded separately and sequenced according to the order in the British National Formulary (BNF) which is a publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain. It is recommended that clinical coders have access to, or obtain a copy of, the British National Formulary which is updated every March and September. Copies are sent to every Pharmacy department, ward and doctor in every NHS organisation. The on-line version can be found at the website below:
http://www.medicinescomplete.com/mc/bnf/current/

There is no rule as to the order in which codes should be listed. The External Cause code for the first listed substance is the only one which needs to be recorded. See Coding Guideline No 14, January 2004 for examples.
Conditions caused by an infectious agent
Coding Quarterly No. 1, November 1996

An infectious condition may be identified by a code for the condition followed by a code from the block B95 - B97 to identify the agent or organism causing the condition.

Example:
Cellulitis caused by streptococcus
L03.9  Cellulitis, unspecified
B95.5  Unspecified streptococcus as the cause of diseases classified to other chapters

Note: It is not appropriate to use a code from another block in Chapter I (eg. A49.1 Streptococcal infection, unspecified) in this context.

Example:
Staphylococcus aureus infection of stump
T87.4  Infection of amputation stump
Y83.5  Amputation of limb as the cause of later complication
B95.6  Staphylococcus aureus as the cause of diseases classified to other chapters

Conditions in pregnancy
Clinical Coding Guidelines 1, 1996

A pregnant woman is admitted for treatment of a condition which may or may not be directly related to her pregnancy. If the patient is treated in a non-obstetrics specialty (eg. General Medicine) and a SMR01 is completed how is the condition coded?

Code the condition in the usual way and follow it with an additional code from Chapter XV to identify that the woman is pregnant and this is a factor affecting her care. For example:

1) Unstable insulin-dependent diabetes mellitus in pregnant patient
   E10.9  Insulin-dependent diabetes mellitus
   O24.0  Pre-existing diabetes mellitus, insulin-dependent

2) Acute viral hepatitis, patient pregnant
   B19.9  Viral hepatitis NOS
   O98.4  Viral hepatitis complicating pregnancy, childbirth and the puerperium

The code Z33 Pregnant state, incidental should only be used when the pregnancy is truly incidental and of no relevance to the woman’s care or condition. For example:
Ingrowing toenail, patient pregnant
L60.0 Ingrowing nail
Z33.X Pregnant state, incidental

‘Consistent with’ Coding Guidelines No. 15, November 2004

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.

Convalescence on SMR01
Coding Quarterly No. 2, February 1997

The rules for coding convalescence have been discussed at the CCRG and the decision made was to abide by the current rules. A patient who has had a condition treated in an acute hospital and is then transferred to another unit for convalescence is still being treated for that condition. Code the problem being treated first with the code for convalescence as a supplementary code. A patient treated at an acute hospital for a fracture of neck of femur caused by a fall at home, and then transferred to another unit for convalesce would be coded as follows for the second episode.

S72.00 - Fracture of neck of femur (closed)
W19.0 - Unspecified fall at home
Z54.4 - Convalescence following treatment of fracture

There are circumstances where patients are brought in directly from the waiting list specifically for convalescence or rehabilitation and no other information is available. Under these circumstances convalescence or rehabilitation may be entered as the main condition, but will be queried on validation.

Current smoker/current heavy smoker/current heavy smoker advised to give up
Coding Guidelines No. 23, September 2008

The Clinical Coding Review Group (CCRG) has issued the following guidance:

If a patient is described as a current smoker code to F17.1
If a patient is described as a current heavy smoker code to F17.1.

If a patient is described as a current heavy smoker and has been advised by a clinician to give up smoking, code to F17.1.

If a patient is described as a current heavy smoker and has been advised by a clinician to give up smoking because it will have an adverse effect on their medical condition, code to F17.1.

N.B. This guidance supersedes that given in Coding Guidelines No. 6 June 2000 with reference to smokers. The guidance on heavy drinkers still applies.

**Dagger and asterisk coding SCCS No. 2 July 2013**

In ICD10 there are asterisk codes for which no dagger codes are specified in either the Tabular List or the Index. They can be used only when the clinician has stated a cause and effect relationship between one of these conditions and an underlying cause.

If any of these codes are used to create a dagger and asterisk pair, approval for use of the code pair must be sought from Terminology Services, ISD. This allows ISD to monitor the use of these codes, and also to ensure the SMR data validation will be amended in order to allow the use of the pair.

If you wish to make a dagger and asterisk code pair using one of the unpaired asterisk codes, please contact Terminology Services. The code pair will be discussed with a Consultant in Public Health medicine (CPHM) at ISD and you will be notified when it has been approved for use. There will be a time delay between your request for approval and the validation accepting the pair. You will be notified of the date when the software will be updated to include the pair, and the codes to use in the interim.

**Deep Vein Thrombosis (DVT) caused by travel Coding Guidelines No. 9, July 2001**

National advice has been issued for ‘DVT caused by travel’.

This should be coded to:

I80.2 Deep vein thrombosis NOS
X51.- Travel and motion
Diagnoses “Impression of”
Coding Guidelines No. 23, September 2008

The term “impression of” is frequently being used by doctors when writing in case notes. In the first instance, the clinician who provided the information should be contacted in an attempt to confirm the diagnosis. If this is not possible then code the recorded symptom(s).

Example: Breathlessness, impression of asthma. Code breathlessness.

Diagnoses, possible, probable, unconfirmed conditions
Clinical Coding Guidelines 1, 1996

Unconfirmed conditions

Unconfirmed conditions may be recorded in the source document (discharge summary or case notes) using various terms, such as “possible”, “suspected”, “probable” or “?”.

This practice makes coding the condition very difficult. Guidelines for dealing with this situation have been drawn up and agreed by the Clinical Coding Review Group, as follows -

In the first instance, the clinician who provided the information should be contacted in an attempt to confirm the diagnosis. If this is impossible, then follow one of the two routes below:

Where the term “probable” is used, code the condition
Example -
probable asthma  code  asthma

Where the terms “possible”, “suspected”, “query” or “?” are used, code the recorded symptom(s) of the suspected condition
Example -
breathlessness, possible asthma  code  breathlessness

Diseases/diagnoses ‘with’ other conditions  SCCS No.2 July 2013

When allocating codes for diseases occurring with another, care should be taken that the instructions in the index and the tabular are followed correctly.

One of the principles of coding is to use the least number of codes to accurately describe the condition. Often the index will link two conditions together where they co-exist whether or not the link has been made by the clinician.

This is shown by the index trail ‘with’.
Patient has laryngitis and flu.

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Trail;
Laryngitis (acute) (edematous) (subglottic) (suppurative) (ulcerative) J04.0
- with
- - influenza, flu, or grippe (see also Influenza, with, respiratory manifestations) J11.1

Also;
Influenza (specific virus not identified) J11.1
- with
- - laryngitis J11.1

This leads the coder to use only J11.1, not J04.0 plus J11.1
The Tabular supports this with appropriate exclusions notes at both codes.

Please note this is not the same as when clinicians make the link between two conditions e.g. diabetes and retinopathy. These are recorded as separate conditions unless the clinician states that one condition causes or is due to the other, in which case the index will lead the coder to a Dagger/Asterisk pair through the term ‘In (due to)’. These two terms are used interchangeably in ICD but for the purposes of ease of understanding, it is preferable to think of it as one condition due to the other and only where this is clearly indicated would the Dagger/Asterisk pair be selected.

Drugs and Alcohol Poisoning    SCCS No. 2 July 2013

If an overdose of drugs has been taken along with alcohol, code this to a poisoning by the drug and by the alcohol (see the Scottish Clinical Coding Reference Manual ICD-10 4th Edition page XIX-40).

If in addition the clinician mentions that the patient is drunk or alcohol dependent, a code from F10.- (Mental and behavioural disorders due to use of alcohol) should also be used.

E Coli 0157  Coding Quarterly No. 2, February 1997

Where E Coli is identified as 0157, the correct ICD10 code is A04.1 because this particular strain is enterotoxigenic.

Eosinophilic Colitis    SCCS No. 2 July 2013

It is difficult to access Eosinophilic Colitis via the ICD10 index. See below:
• Colitis (acute) (catarrhal) (hemorrhagic)
(see also Enteritis) A09.9

• At Enteritis there is no reference to ‘eosinophilic’.
• Eosinophilic gastritis is listed under Gastroenteritis - eosinophilic at K52.8

In order to reach Eosinophilic Colitis the coder should look up

**Gastroenteritis**
- eosinophilic K52.8

K52.8 in the Tabular states **Other specified noninfective gastroenteritis and colitis** and there is an inclusion for ‘Eosinophilic gastritis or gastroenteritis’.

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### Ex-smoker  Coding Guidelines No. 23, September 2008

It has been decided by the Clinical Coding Review Group that there is no suitable code in ICD10 for the term ex-smoker and there is therefore no need for this to be recorded on national returns.

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### External Cause Codes  Coding Quarterly No. 3, May 1997

There is a common misconception that external cause codes can only be used after codes from Chapter XIX, “Injury, poisoning and certain other consequences of external causes”. The note at the beginning of Chapter XX states: “Other conditions that may be stated to be due to external causes are classified in Chapters I to XVIII” and so where relevant, Chapter XX codes should be added to these.

Example: Haematuria caused by jogging

R31.X Haematuria
X50.9 Overexertion and strenuous or repetitive movements

---

### External Cause codes in poisonings  Coding Guidelines No. 14, January 2004

It has been decided that it is more useful to record extra poisoning codes rather than having an external cause code following each poisoning code. Where poisoning is the main reason for a patient being admitted, the following rules should be applied:

Main condition is the main substance taken.
Then code any other substances taken.
External cause code for the main substance taken.
Other medical conditions.

Example: patient is admitted having made a suicide attempt by taking paracetamol, aspirin and whisky, due to depression (at home).

Code:
T39.1 – Chapter XIX code for paracetamol  
T39.0 - Chapter XIX code for aspirin  
T51.0 - Chapter XIX code for alcohol beverage  
X60.0 – Intentional self harm code for paracetamol  
F32.9 – Depression

This advice will take effect from 1st April, 2004, and is the method of coding poisonings in England and Wales

External Orthopaedic Fixators  
Coding Guidelines No. 6, June 2000

ICD10 interprets the word ‘internal’ in relation to orthopaedic fixators as a fixator that has gone through the skin. An external orthopaedic device, such as an Illizarov external fixator, penetrates down into the bone being held by the device and, as such, although the device is known as an external fixator the component parts are considered to be internal. Therefore, when coding complications of these external fixators, the correct ICD10 code would be assigned from the rubric:

T84 - Complications of internal orthopaedic prosthetic device, implants and grafts

Face to pubes presentation  
Coding Guidelines No. 17, January 2006

Coding Guidelines 5, January 2000 indicated that indexes should be changed for this entry. Please note that this amendment is missing from the new index, so it will be necessary for those coders with new indexes to re-enter the change previously advised Please amend your index for:

Presentation,fetal  
- face (mother)  
- - to pubes O32.3 O32.8

Fetal distress:  
SMR02 Review 2010

Coders must not record the terms ‘suspicious CTG’ (Cardiotochography), ‘Non-reassuring CTG’ or ‘Suboptimal CTG’.  
However, if the patient went on to have an operative delivery due to these signs, then the code O68.8 – Labour and delivery complicated by other evidence of fetal stress should be recorded in the Indication for Operative Delivery field.  
The code O68.8 – Labour and delivery complicated by other evidence of fetal stress must be used to code the terms ‘Pathological CTG’ and ‘Abnormal CTG’, where present.
Frailty Coding Guidelines No. 14, January 2004

In the Clinical Coding Update List No.20 April 2000 the ICD10 code R54.X was issued for “Frailty”. The title of this category is “Senility”. The code R54.X should be used for frailty in elderly people. For frailty in younger patients, the code R53.X should be recorded. Please remember that these are default codes where no further information is given in the casenote/discharge summary. For validation purposes, it should be noted that the cut-off age is 60.

Frailty, immobility and geriatric falls SCCS No. 2 July 2013

Following changes to ICD10 v4, the table below documents codes to be used for frail/elderly patients being admitted with no injury.

<table>
<thead>
<tr>
<th>Text</th>
<th>Code</th>
<th>ICDv4 text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immobility</td>
<td>R26.3</td>
<td>Immobility - Only the terms ‘immobility’, ‘chairfast’ and ‘bedfast’ to be coded here.</td>
</tr>
<tr>
<td>Geriatric falls</td>
<td>R29.6</td>
<td>Tendency to fall, NEC</td>
</tr>
<tr>
<td>Off legs/feet</td>
<td>R26.8</td>
<td>Other and unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>Reduced/poor mobility</td>
<td>R26.8</td>
<td>Other and unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>Frailty (60 and over)</td>
<td>R54.X</td>
<td>Senility</td>
</tr>
<tr>
<td>Frailty (under 60)</td>
<td>R53.X</td>
<td>Malaise and fatigue</td>
</tr>
</tbody>
</table>

If any of the above are emergency admissions, Admission Type would be 36 - Patient non-injury.

If there is an injury, the injury and external cause must be coded first.

Example - bruised hip due to (geriatric) falls at home:

Codes S70.0 - Contusion of hip  
W19.0 - Unspecified fall at home

If the patient is prone to falls, the code R29.6 – Tendancy to fall, NEC may be added.

In this case the Admission Type for an emergency admission would be 33 - Patient Injury - Home Accident.
Gangrene Coding Guidelines No. 14, January 2004

When coding gangrene of particular sites, the index trail may lead to a specific code which does not include the term ‘gangrene’; e.g.

Gangrene - intestine K55.0 Acute vascular disorders of intestine.

Clinicians feel that gangrene itself is sufficiently important that it requires an additional code to highlight the infection, therefore please add R02.X where the main code does not include the term ‘gangrene’, as in the above example. This is contrary to the exclusions at R02.X and coders may wish to amend their ICD10 Volume 1 (tabular list) to that affect.

Habitual Abortion/Recurrent Miscarriage Coding Guidelines No. 22, March 2008

If a woman has three consecutive first trimester losses of pregnancy she can be classified as a habitual aborter. It should however be noted that the term habitual aborter is somewhat misleading and out-of-date. Clinicians now use the term recurrent miscarriage.

ICD10 Code O26.2, Pregnancy care of habitual aborter, should only be used if the clinician uses the terms ‘habitual aborter’ or ‘recurrent miscarriage’ and the woman is currently pregnant.

Please note the exclusions at O26.2.

Excludes: habitual aborter:
  • with current abortion (O03 – O06)
  • without current pregnancy (N96)

This guidance applies to all discharges on and after 1st April 2008.

Haemorrhage SMR02 review 2000

Haemorrhages occurring at different stages of gestation are defined as follows:

  • Haemorrhage in early pregnancy - the period up to 24 weeks gestation
  • Antepartum haemorrhage - from 24 weeks onwards. May be connected with placenta praevia or premature separation of the placenta (abruptio placentae)
  • Intrapartum haemorrhage - between the beginning and end of labour
• Postpartum haemorrhage - after the baby is delivered. Includes haemorrhage occurring during a Caesarean section. During labour and delivery a haemorrhage is regarded as such when blood loss is 500mls or more.

**Haemorrhoids with Bleeding**  
**SCCS No. 2 July 2013**

When haemorrhoids (piles) and per rectal bleeding is documented, coders must not assume that the bleeding is from the haemorrhoids unless explicitly stated as such by the clinician.

Where haemorrhoids are diagnosed and bleeding is documented without a link being made to the haemorrhoids, coders must follow the guidance published in the Scottish Clinical Coding Reference Manual on page XVIII-1 of the Symptoms chapter. Under the Chapter rules and conventions this states that: Where a sign or symptom may be due to more than one condition, assign a code for the symptom.

This will be in addition to any clear diagnosis that is made. For example

1. **Diagnosis of Bleeding Haemorrhoids**
   - Trail
   - Hemorrhoids
   - bleeding, prolapsed, strangulated or ulcerated NEC I84.8
   - Code I84.8 Unspecified haemorrhoids with other complications

2. **Diagnosis of Haemorrhoids.** Per rectal bleeding mentioned on Discharge Letter, and further investigations are planned to identify the source of the bleeding.
   - Trail
   - Hemorrhoids I84.9
   - Bleeding (see also Hemorrhage)
   - Hemorrhage
   - gastrointestinal (tract) K92.2
   - Code I84.9 Unspecified haemorrhoids without complication and K92.2
   - Gastrointestinal haemorrhage, unspecified

3. **Diagnosis of Haemorrhoids.** Per rectal bleeding mentioned on Discharge Letter, and no evidence of further investigations planned to identify the source of the bleeding.
   - The coder must clarify with the clinician what has caused the bleeding, but if this is not possible or the clinician is unable to identify the cause of the bleeding then code as follows:
   - Trail
   - Hemorrhoids I84.9
   - Bleeding (see also Hemorrhage)
   - Hemorrhage
   - gastrointestinal (tract) K92.2
Code I84.9 Unspecified haemorrhoids without complication and K92.2 Gastrointestinal haemorrhage, unspecified.

**Hard Coded Diagnostic and Procedure Fields on SMR02**
**SMR02 Review 2010**

There are 7 hard coded items which have ICD/OPCS4 equivalents:

- Type of Abortion
- Management of Abortion
- Induction of Labour
- Sterilisation after Delivery
- Episiotomy
- Tears
- Mode of delivery

These hard coded items (i.e. assigned special non-ICD10 OPCS4 codes) are required by ISD. However, these codes have ICD10 or OPCS4 equivalents which may be more specific than the hard codes. Where the data is hard coded there is no need to duplicate the information by coding again in the diagnostic section unless the ICD10/OPCS4 code gives more specific information (e.g. lower uterine segment caesarean (LUSC) at R17.2 and R18.2).

The exception to this rule is when codes O80.- to O84.- are used as there are no other obstetric conditions to record.

**Head Injuries**

**Coding Guidelines No. 3, June 1999**

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.-).
**Heavy drinkers/smokers**  
**Coding Guidelines No. 6, June 2000**

The new version of the training manual contains further guidance on the difference between codes:
- F10.- Mental and behavioural disorders due to use of alcohol
- F17.- Mental and behavioural disorders due to use of tobacco
- Z72.- Problems related to lifestyle

‘In order to assign a code from F10 or F17, a clinical decision is required when patients are described as heavy drinkers/smokers.

If the patient has been advised by the clinician to stop drinking/smoking because it will have an adverse effect on their medical condition or the clinician states the patient is dependent upon alcohol/tobacco then a code from this category should be selected.

However, if it is noted in the medical record that the patient is a heavy drinker/smoker with no other reference to medical condition, then a code should be selected from:
- Z72 - Problems relating to lifestyle

If it is unclear in the medical record, clinical input is required.’

**Note:** Please see guidelines for *Ex-smoker September 2008*, this guidance supersedes that given in Coding Guidelines No. 6 June 2000 (above) with reference to smokers. The guidance on heavy drinkers still applies.

**Helicobacter infection**  
**SCCS No. 2 July 2013**

Helicobacter infection will remain as A04.8 – Other specified bacterial intestinal infections. There is however, a new code of B98.0 – Helicobacter pylori [H.pylori] as the cause of diseases classified to other chapters, which is to be used as a secondary code where Helicobacter pylori is associated with another disorder.

**Helicobacter positive**  
**Coding Quarterly No. 3, May 1997**

A patient who has a helicobacter test which is positive is regarded as having a helicobacter infection. This should be coded to:

A04.8 Other specified bacterial intestinal infections
High cholesterol  Coding Guidelines No. 19, September 2006

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.

History of TCC bladder  SCCS No. 2 July 2013

History of TCC bladder must be coded to Z86.0 - Personal History of other neoplasms or Z85.5 - Personal History of malignant neoplasm of urinary tract, depending on histological information with Z86.0 being the default code if histology is not available.
Holiday Relief Care (Respite care) Coding on SMR04
SCCS No. 2 July 2013

Coders are reminded that patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. It is essential that the recording rules for respite care be followed to ensure that the information can be correctly analysed.

The field Admission Reason should have the code 5B — Respite/holiday care entered. Whilst this is an Optional field, it is strongly recommended that sites complete this in the case of a respite admission. Clinical codes should be entered as per examples below:

**Situation A.** If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.

**Example:** Patient with dementia in Parkinson’s disease admitted for a week to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.

**Admission diagnoses codes (if completing):**
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

**Discharge diagnoses codes:**
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

**Situation B.** A patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay. The code Z75.5 should be assigned a secondary position.

**Example:** Patient with dementia in Parkinson’s disease admitted for a week to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 5 days.

**Admission diagnoses codes (if completing):**
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

**Discharge diagnoses codes:**
F02.3A — Dementia in Parkinson’s disease
G20.XD — Parkinson’s disease
J22.X — Unspecified acute lower respiratory infection (chest infection)
Z75.5 — Holiday relief care
**Situation C.** Sometimes a patient is pre-booked for holiday relief care, but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and should be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.

**Example:** Patient with dementia in Parkinson’s disease is booked for a week’s holiday admission — consultant decides that the patient will have a course of physiotherapy to help with problems related to their condition.

**Admission diagnoses codes (if completing):**
- Z75.5 — Holiday relief care
- G20.XD — Parkinson’s disease
- F02.3A — Dementia in Parkinson’s disease

**Discharge diagnoses codes:**
- F02.3A — Dementia in Parkinson’s disease
- G20.XD — Parkinson’s disease
- Z50.1 — Other physical therapy
- Z75.5 — Holiday relief care

It is important that the case notes are referenced thoroughly in order to reflect the patient’s care on each admission.

**Hospital acquired infections (HAI)  SCCS No. 2 July 2013**

There is much publicity and concern about hospital acquired infection, and tackling infections is a priority within the NHS.

The dictionary definition for nosocomial is ‘pertaining to or originating in the hospital’

If the record states a diagnosis of a hospital-acquired infection, there is a specific external cause code for nosocomial conditions within the ICD10 classification.

If confirmed, the nosocomial code:

Y95 – Nosocomial condition would be assigned as an additional code following the type of infection.

For example: MRSA infection, clinician confirms hospital acquired. Code:

- A49.0 – Staphylococcal infection, unspecified
- U80.1 – Methicillin resistant agent
- Y95.X – Nosocomial condition
Human Fertilisation Codes
Coding Guidelines No. 10, December 2001

Recording of treatments provided under the Licence of the Human Fertilisation and Embryology Authority (HFEA)

This article is designed to raise awareness for Medical Records and Information Managers who have a responsibility for managing the completion and submission of SMR data at trusts.

The Human Fertilisation and Embryology Act of 1990 indicates that patients receiving Artificial insemination/In Vitro Fertilisation treatment from licensed centres should not be included on SMR returns to ISD as this would be in breach of the Act.

The codes and treatments concerned are as follows:

ICD10
Z31.1   Artificial insemination
Z31.2   In vitro fertilisation

OPCS4
Q13   Introduction of gamete into uterine cavity
Q38.3 Endoscopic intrafallopian transfer of gamete

It is important to stress that under the provisions of the Act the Trust should send information about such patients to the HFEA only, and to no other bodies. If there are concerns then these should be raised with the Trust's Caldicott Guardian.

Human Papillomavirus (HPV)     SCCS No. 2 July 2013

Human papillomaviruses (HPV) can affect the skin and moist membranes which line parts of the body such as the anus, cervix and the lining of the mouth and throat. There are over 100 different strains of HPV which can be transmitted through direct skin contact. The virus can cause warts, verrucas and can develop into cancer of the cervix.

When coding HPV, there is only one trail available:
Papillomavirus, as cause of disease classified elsewhere B97.7

This code can be used where there is another disease classified to an ICD10 Chapter other than Chapter I — e.g. seborrhoeic verruca due to HPV:

L82.X — Seborrhoeic keratosis
B97.7 — Papillomavirus as the cause of diseases classified to other chapters

Where the manifestation of HPV is stated to be ‘anogenital warts’ or ‘viral warts’, only the appropriate Chapter I code should be recorded:
A63.0 — Anogenital (venereal) warts

or

B07.X — Viral warts.

However, where the statement is ‘HPV infection’, with no manifestation, coders should record this as:

B34.4 — Papovavirus infection, unspecified site.

As there is no evident index trail to reach this code, coders are advised to write an entry in the index to direct them to B34.4 Papovavirus infection, unspecified site when there is only a statement of ‘HPV infection’.

Cervical Intraepithelial Neoplasia (CIN) III clinically stated to be ‘HPV+ve’ should be coded

D06.9 — Carcinoma in situ of cervix, unspecified
B97.7 — Papillomavirus as cause of diseases classified to other chapters

This follows clinical advice, which regards “CIN III HPV +ve” as a special case. This guidance is in contrast to the usual, current practice when coding other “infectious organism +ve” statements without an explicit statement of causation (see ‘Test results and their use in SMR01 coding’ Coding Guidelines No. 20, June 2007 etc.).

Hypertension SMR02 review 2000

Hypertension is defined as a reading of diastolic BP greater than 110mmHg on any occasion, or a diastolic reading of 90-110mmHg sustained for 4 hours or more.

Coding hypertension:

- Gestational (i.e. pregnancy-induced) hypertension: O13.X
- Pre-existing (i.e. present before pregnancy and still present during pregnancy) Hypertension: O10._
- Unspecified (i.e. not known if present before pregnancy or pregnancy-induced) Hypertension: O16.X
Hypertension and raised BP in pregnancy  SMR02 Review 2010

Clarification of when to code hypertension and raised BP in pregnancy.

- Hypertension should only be coded when a clinician explicitly states that the mother has hypertension. Then a code from O10.-, O13.X, or O16.X can be selected as appropriate.

- Coders should not search for and analyse blood pressure readings, and should not look for the “^BP” symbol (elevated blood pressure) written in the available clinical material, with a view to recording any code whatsoever.

- the code R03.0 can be recorded if there is an explicit clinical statement that the mother was admitted because of raised blood pressure or that raised blood pressure was a significant concern during the admission. R03.0 should only be used if there is no definitive diagnosis given as the cause of raised blood pressure.

ICD10 coding - last position
Coding Guidelines No. 4, September 1999

When coding the last allowable position on a SMR return (position 6 for SMR01, position 4 for SMR04 etc), care should be taken that neither a dagger code nor an injury code (chapter XIX) should be used. A dagger code is followed by an asterisk code. An injury code is followed by an external cause code. If necessary, the order of codes should be re-arranged so that the rules are obeyed. This applies even if local systems are able to record more codes than are allowed on the SMR return.

Impulsive Overdose Coding Guidelines No. 11, April 2002

Following an enquiry regarding the term ‘Impulsive Overdose’, coders should note this is to be allocated a poisoning code from the ‘Deliberate Self Harm’ column of the Table of Drugs and Chemicals.
Coders have difficulty when coding certain bacterial infections as to whether they should code to the infection or carrier status. The same expression can lead to different coding for different bacteria eg Helicobacter positive indicates a Helicobacter infection whereas MRSA positive would be coded to the carrier status.

Below is a table with some of the more common infections and the expressions coders may be given. Where there are blanks, the expression is not applicable to that infection.

<table>
<thead>
<tr>
<th>Infection</th>
<th>+ve</th>
<th>Colonised with</th>
<th>Present in nasal swab</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3 + U80.1</td>
<td>Carrier Z22.3 + U80.1</td>
</tr>
<tr>
<td>Helicobacter</td>
<td>Infection A04.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strep B</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
</tr>
<tr>
<td>Hep B</td>
<td>Carrier Z22.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep C</td>
<td>Carrier Z22.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRE</td>
<td>Carrier Z22.3 + U81.0</td>
<td>Carrier Z22.3 + U81.0</td>
<td></td>
</tr>
</tbody>
</table>

Coders should not make any assumptions of the current status of a patient who has had a bacterial infection at some time in the past. Current laboratory reports should always be consulted.

Inflammatory bowel disease

The clinical statement ‘inflammatory bowel disease’ (IBD) is an umbrella term that includes both Crohn’s disease and ulcerative colitis. Note that clinicians do not use ‘IBD’ to signify conditions which may be of infective origin, and so IBD is not synonymous with ‘(gastro)enteritis unspecified’ or ‘diarrhoea unspecified’. Without further information, ‘inflammatory bowel disease’ should be coded to K52.9 - Noninfective gastroenteritis and colitis, unspecified.

Index trail: Inflammation - intestine (any part) - see Enteritis Enteritis (diarrheal) (hemorrhagic) A09.9 - non-infectious K52.9

The use of the word ‘inflammatory’ indicates that the disease is non-infective. It would clearly be preferable for “inflammatory bowel disease” to be coded more specifically in K50, K51 or a more specific code from K52. Coders are therefore advised to consult with the clinician responsible for the patient’s care to obtain more
specific information wherever possible rather than using the default code K52.9 given above.

**Influenza A (H1N1) [Swine Flu] Coding Guidelines No. 24, October 2009**

The appropriate code assignment for this disease, where no manifestations have been identified, is J10.1 Influenza with other respiratory manifestations, influenza virus identified. This code is arrived at by use of the alphabetical index and the full four step coding process:

Swine flu

Index trail for Influenza:

Influenza (specific virus not identified) J11.1
- virus identified J10.1

Tabular List entry:

J10.1 Influenza with other respiratory manifestations,
Influenza virus identified
The correct code to assign is J10.1

If other specific manifestations of the influenza are identified, another 4th digit subcategory from J10.- may be more appropriate.

**Initiation and Maintenance of Drug Therapy Coding Guidelines No. 14, January 2004**

When a patient is brought in purely for trying out a different medicine/different dosage or some form of drug stabilisation, they are effectively having drug maintenance.

The correct code for this is Z51.2 – Other chemotherapy, and this should be sequenced AFTER the patient’s condition.

On the very rare occasions when a brand new drug is being trialled, i.e. for research purposes, the code would be Z04.8 – Examination and observation for other specified reasons. Any conditions the patient may have would follow this code.
Injury with tendon involvement  
**Coding Quarterly No. 1, November 1996**

In ICD9 one code was used to code both conditions. In ICD10 this is not possible. Therefore, both the injury and tendon involvement must be coded separately.

**Example:**
Laceration of finger with flexor tendon involvement  
S56.1 Injury of flexor muscle and tendon of other finger at forearm level  
S61.0 Open wound of finger without damage to nail  
The sequence of the codes depends on the treatment given. In the example given here, treatment was primary repair of tendon.

Intramucosal Carcinoma (of the Gastrointestinal Tract)  
**Coding Guidelines No. 7, November 2000**

Intramucosal carcinoma is a form of carcinoma in situ as the cancer cells are confined within the lamina propria (intramucosal) with no extension through muscularis mucosae into submucosa.

As there is no clear index trail for this, coders should, in the absence of any other information, code according to site in the neoplasm table, under in situ.

Intrapartum vs. Postpartum haemorrhage  
**SMR02 Review 2010**

Blood loss is likely to be from postpartum cause, rather than intrapartum.  
Intrapartum haemorrhage - between the beginning and end of labour. O67.-  
Intrapartum haemorrhage, must only be recorded where the term ‘intrapartum haemorrhage’ is specifically used.  
Postpartum haemorrhage - after the baby is delivered. The code O72.- Postpartum haemorrhage must be recorded in all cases where either a) the clinician states ‘postpartum haemorrhage’ or b) the clinician makes no statement of intra- or postpartum haemorrhage, but blood loss is recorded as 500mls or more. (Includes haemorrhage occurring during a Caesarean section.)

Jittery baby  
**Coding Guidelines No. 17, January 2006**

It has been agreed that the correct code for Jittery baby is:

R25.8 – Other and unspecified abnormal involuntary movements
**Juvenile/Senile Cataracts**

**Coding Guidelines No. 12, September 2002**

Clarification has been requested regarding the coding of cataracts, specifically ‘Juvenile’ and ‘Senile’ cataracts.

ICD10 Index indicates as follows:-

<table>
<thead>
<tr>
<th>Cataract</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvenile</td>
<td>H26.0</td>
</tr>
<tr>
<td>Senile</td>
<td>H25.9</td>
</tr>
<tr>
<td>(unspecified)</td>
<td>H26.9</td>
</tr>
</tbody>
</table>

ICD10 Tabular describes:

- H26.0 Infantile, juvenile and presenile cataract
- H25.9 Senile cataract, unspecified
- H26.9 Cataract, unspecified

Therefore ‘Juvenile’ and ‘Senile’ are essential modifiers. Cataracts should be coded according to the clinical statement. Please do not apply codes depending on the ‘age’ of the patient.

**Learning Disability**

**Coding Guidelines No. 6, June 2000**

The use of codes F80 to F89 - Disorders of Psychological development, needs to be carefully applied in cases where a patient is over the age of 15, as this will generate a validation query. For example, the coder needs to be certain if given the phrase ‘learning disability’ that the patient has no underlying cause for this eg mental retardation, low IQ. This must be done by checking the patient’s casenotes thoroughly and discussing with the clinician for further guidance if necessary.

**Leg Ulcer with infection**

**SCCS No. 2 July 2013**

If a diagnosis of leg ulcer with infection is given, code the leg ulcer, L97.X, followed by the code L08.9 Local infection of skin and subcutaneous tissue, unspecified and, if the infection is known, an appropriate code from B95.- to B98.-.

Examples:

- Leg ulcer with MRSA infection. Code:
  - L97.X - Ulcer of lower limb, not elsewhere classified
  - L08.9 - Local infection of skin and subcutaneous tissue, unspecified
  - B95.6 - *Staphylococcus aureus* as the cause of diseases classified to other chapters
  - U80.1 – Methicillin resistant agent

- Leg ulcer with infection. Code:
  - L97.X - Ulcer of lower limb, not elsewhere classified
  - L08.9 - Local infection of skin and subcutaneous tissue, unspecified
**Lymphoedema Following a Lumpectomy or Quadrantectomy**  
*Coding Guidelines No. 11, April 2002*

When lymphoedema occurs following excision of any amount of the breast (mastectomy, quadrantectomy, lumpectomy etc) and the link has been established between the surgery and the lymphoedema, the coder must follow the trail:

Lymphedema  
-postmastectomy I97.2

and use I97.2 Postmastectomy lymphoedema syndrome as this code most accurately reflects the clinical situation.

**Malignant pleural effusion**  
*Coding Guidelines No. 20, June 2007*

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.

**Mandatory 5th Characters in Chapter XIII  SCCS No. 2 July 2013**

Please remember that it is mandatory to add a 5th character to codes in Chapter XIII Diseases of the musculoskeletal system and connective tissue (M00 - M99) wherever the category instructs:

[See site code at the beginning of this chapter]

So a diagnosis of Arthritis where no site was specified should be coded to M13.99.

The only exception to this rule is where the site is already incorporated in the code description e.g. Trigger finger which may be coded to M65.3 without adding a fifth character.

**MCAD deficiency  Coding Guidelines No. 17, January 2006**

MCAD deficiency refers to Medium Chain Acyl CoA Dehydrogenase Deficiency. It is a disorder of fatty acid oxidation.

Index entry
Disorder
- fatty acid metabolism E71.3
The correct code assignment is E71.3 – Disorders of fatty-acid metabolism

**Measles with febrile convulsion  Coding Guidelines No. 17, January 2006**

In a diagnosis of measles with febrile convulsion, is the convulsion considered a complication of the measles and assigned to the subdivision B05.8, or to B05.9 without complication, when the febrile convulsion R56.0 would also be recorded?

Answer: convulsion is a symptom not complication of any febrile condition not just measles. Therefore the correct codes and sequence are:
B05.9 Measles without complication  
R56.0 Febrile convulsions

**Meconium Staining**  
*Coding Quarterly No. 4, September 1997*

There is doubt as to whether meconium staining in an otherwise normal delivery should be recorded. If there is mention of meconium staining or meconium in the amniotic fluid in a delivery episode on SMR02, this should be coded as appropriate using

O68.1 - Labour and delivery complicated by meconium in amniotic fluid OR
O68.2 - Labour and delivery complicated by fetal heart rate anomaly with meconium in amniotic fluid

Index trail  
Delivery  
- complicated (by)  
  - meconium in liquor O68.1  
  - - with fetal heart rate anomaly O68.2

Example  
Notes state “Meconium in liquid”. Nothing is done, the baby is fine and no treatment is given.  
Code to O68.1 or O68.2 as appropriate.

**Meconium**  
*SMR02 review 2000*

The presence of Meconium should always be coded if it is mentioned in the notes, even if no complications have resulted from it. When there are no other complications, code to O68.1.
Mephedrone Coding Guidelines No. 28, March 2011

The drug Mephedrone is known by a variety of names such as MCAT, Meow-meow and 4-MMC.

Mephedrone can be considered as a psychostimulant and the correct codes to assign for an accidental poisoning for this drug are:

T43.6 Psychostimulants with abuse potential

X41.- Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified.

The external cause code to add to T43.6 if a patient has intentionally self-harmed using Mephedrone is

X61.- Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified.

F15, Mental and behavioural disorders due to use of other stimulants, including caffeine, is the correct category to select to record any mental and behavioural disorders due to use of Mephedrone.

Example; Mephedrone abuse would be coded to F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine, harmful use.

Please note that there is no specific code in ICD10 to identify Mephedrone individually.

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Methadone Programme Coding Guidelines No. 19, September 2006

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.
Mixed Arterial and Venous Ulcer of Lower Leg  
Coding Guidelines No. 8, February 2001

Please note that the following two codes should be used to reflect this condition:

I73.9 Peripheral vascular disease, unspecified with
I83.0 Varicose veins of lower extremities with ulcer.

Venous ulcer of lower limb is synonymous with varicose ulcer.

Mobility Scooters  
Coding Guidelines No. 20, June 2007

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.-)”

MRSA (Methicillin resistant staphylococcus aureus)  
SCCS No. 2 July 2013

MRSA infection takes various forms. It is usually found in wound infections, but may be present as septicaemia, other generalised infection or a patient may be a carrier of MRSA. These situations are all coded differently, and examples are given below:

1) MRSA infection of surgical wound on abdomen
   T81.4 Infection following a procedure, not elsewhere classified
   Y83.9 Surgical procedure, unspecified
   B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
   U80.1 Methicillin resistant agent

2) MRSA infection of traumatic wound
   T79.3 Post-traumatic wound infection, not elsewhere classified
   X59.9 Unspecified accident
   B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
   U80.1 Methicillin resistant agent
3) MRSA septicaemia
   A41.0 Septicaemia due to Staphylococcus aureus
   U80.1 Methicillin resistant agent

4) MRSA infection
   A49.0 Staphylococcal infection, unspecified
   U80.1 Methicillin resistant agent

5) MRSA positive/carrier
   Z22.3 Carrier of other specified bacterial diseases
   U80.1 Methicillin resistant agent

**Multi-organ failure**

This diagnosis causes great difficulty to coders. When such a diagnosis is recorded, the clinician in charge should be asked to clarify the patient’s condition and state which organs have suffered failure, eg, heart failure and liver failure. Each organ failure should be coded separately. However, this information is not always available. Where it is not possible to find out the organs involved, the code for recording ‘Multi-organ failure’ is

- R68.8 Other specified general symptoms and signs

This should be used regardless of whether the patient lives or dies.

**Multiple gestation O30**

A code from category O30 Multiple gestation should be coded as the primary diagnosis for Ante-natal episodes, (where appropriate) but on an SMR02 Delivery episode, it is not required, as this information is collected in the delivery data items. Where no other relevant obstetric condition exists, the main condition should be recorded as O84.0 – multiple delivery, all spontaneous.

**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.

**Multiple primary neoplasms**  
**SCCS No. 2 July 2013**

The use of C97.X Malignant neoplasms of independent (primary) multiple sites is only to be used to record the phrase ‘multiple primaries’. Where sites of the primaries are known, these must be coded individually. Please delete the note at C97 on P203 of the Tabular. This is a Scotland/England difference.

**Multiple Rehabilitation Procedures**  
**Coding Quarterly No. 2, February 1997**

A patient who has treatment involving several rehabilitation procedures which have not been identified separately should be coded to Z50.8 - Care involving use of other rehabilitation procedures.

**Musculoskeletal Chest Pain**  
**Coding Guidelines No. 13, January 2003**

The term musculoskeletal chest pain is coded to R07.3 – Other chest pain

**Myocardial infarction and unstable angina**  
**Coding Guidelines No. 26, October 2010**

In June 2007 ISD published a guideline on ‘Coding The Acute Coronary Syndromes Using ICD10’ (CG20) to help coders deal with clinical statements associated with the term ‘acute coronary syndrome’. The main feature of the 2007 guideline was the introduction of a fifth digit for use with I20.0 Unstable angina. This fifth digit was used to record clinical statements describing the levels of troponin (a biochemical marker of myocardial damage) found in the patient’s blood.

The Scottish Cardiac Society has now adopted a new, international definition of myocardial infarction (MI). This new definition should have the effect of simplifying the terminology encountered by coders when coding MI patients in Scotland. This guideline outlines the statements most likely to be encountered and clarifies how they should be coded:
1. Unstable angina - this should be coded I20.0 Unstable angina, exactly according to ICD10 rules and conventions. (NOTE that coders no longer need look for, or take account of, clinical statements describing blood troponin levels. The 5th digits signifying “troponin status” which were applied to I20.0 in the 2007 guideline are no longer applicable. This is because unstable angina is always “troponin-negative” by the new definition).

2. ST elevation myocardial infarction (STEMI) and Non-ST elevation myocardial infarction (NSTEMI) – clinicians will usually classify an MI as either a STEMI or NSTEMI. It is clinically important to distinguish between these two types of MI, and consequently it is also important to record them in coded SMR data.

“ST elevation” and “non-elevation” refer to the appearance of a part of the patient’s electrocardiogram (ECG) trace. The ICD10 index and the categories I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction make no explicit mention of ST elevation or non-elevation. Coders will be aware that the sub-categories of I21.- and I22.- classify MIs according to another feature of the patient’s ECG trace, namely the identification of the area of the myocardium affected – anterior wall, inferior wall etc. (NOTE that it is clinicians who are responsible for the interpretation of ECG traces. Coders are responsible only for the coding of clinical statements made after such interpretation).

The need to record STEMI and NSTEMI must fit in with the existing structure of the ICD10 codes for MI. This will be done by adding a 5th digit for use ONLY with codes I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction.

Coders should add a fifth digit from Table 1 whenever they use codes I21.- and I22.-.

Table 1

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Meaning of fifth digit for I21.- and I22.- ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Non-ST Elevation Myocardial Infarction (NSTEMI)</td>
</tr>
<tr>
<td>1</td>
<td>ST Elevation Myocardial Infarction (STEMI)</td>
</tr>
<tr>
<td>9</td>
<td>MI with no statement of ST elevation or non-elevation</td>
</tr>
</tbody>
</table>

To use these 5th digits with I21.- and I22.-, the MI should first be coded as usual, taking into account available information about any previous MIs and about the area of the myocardium affected – anterior, inferior etc. (NOTE that the essential modifier ‘transmural’ which is found in the index trail leading to I21.- Acute myocardial infarction can be ignored. This is because it is unlikely to appear in clinical statements). The 5th digit signifying NSTEMI, STEMI or ‘no statement’ should then be added.

Examples (assuming that this is the patient’s first MI) are shown in Table 2.
### Table 2

<table>
<thead>
<tr>
<th>Example of clinical statement to be coded</th>
<th>ICD10 code</th>
<th>Fifth digit</th>
<th>Final code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior NSTEMI</td>
<td>Anterior MI = I21.0</td>
<td>NSTEMI = 0</td>
<td>I21.00</td>
</tr>
<tr>
<td>Anterior STEMI</td>
<td>Anterior MI = I21.0</td>
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<td>I21.09</td>
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<td>I21.90</td>
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<tr>
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<td>I21.91</td>
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<tr>
<td>MI</td>
<td>MI unspecified = I21.9</td>
<td>no statement = 9</td>
<td>I21.99</td>
</tr>
</tbody>
</table>

3. Aborted MI - this should be coded as I24.0 Coronary thrombosis not resulting in myocardial infarction.

4. The phrase “acute coronary syndrome” should no longer appear as the sole, definitive, diagnostic statement. It may appear as a generic, descriptive term in the clinical information used by the coder. However it should be accompanied by more specific information i.e. “unstable angina”, “NSTEMI” or “STEMI”. The coder should code the more specific information according to this guideline. If “acute coronary syndrome” is the only clinical statement about the acute cardiac event which is available to the coder then:

- firstly the coder should seek clarification from the clinician about how the case should be classified according to the rules in this guideline.

- ONLY if clarification cannot be obtained, then the phrase “acute coronary syndrome” should be coded to I24.8 Other forms of acute ischaemic heart disease.

THE ABOVE GUIDANCE SHOULD BE IMPLEMENTED FOR ALL DISCHARGES
FROM 1st OCTOBER 2010

**Neutropenic sepsis**

**Coding Guidelines No. 31, September 2012**

Neutropenic sepsis develops due to a low white blood cell level, especially the type called neutrophils which fight bacterial infections.
Clinical input has confirmed that during treatment of neutropenic sepsis it is the sepsis that is the main condition treated rather than the neutropenia.

Based on this information, the correct ICD-10 codes and sequence for a stated diagnosis of neutropenic sepsis are:

**A41.- Other septicaemia**

(Fourth character code assignment will depend on whether or not the specific organism has been identified)

**D70.X Agranulocytosis**

If the responsible consultant has confirmed that neutropenic sepsis was due to a drug then an external cause code from Chapter XX must be assigned in addition.

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**NIDDM patients on insulin**

**Coding Guidelines No. 9, July 2001**

It has come to our attention that there are differences in the way sites are coding Non-Insulin Dependent Diabetic Patients treated with Insulin.

If a Non-Insulin Dependent Diabetes Mellitus (Type II / Maturity Onset Diabetic) patient is being treated by means of Insulin Injections this means they become Insulin treated Non-Insulin Dependent Diabetics. They should continue to be coded to E11.- (NIDDM).

They do NOT become Insulin Dependent Diabetics (IDDM) at E10.-.

Please code Type I Diabetes Mellitus to E10.- and Type II Diabetes Mellitus to E11.-

All sites please ensure they code in the above manner, if not already doing so, by 1st October 2001.

**Observation codes (Z03.- and Z04.-) - when to use them**

**Coding Quarterly No. 3, May 1997**

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, these codes should be used when there is a reason (e.g. symptoms, history) for suspecting that the patient may have a condition but after a period of observation there is found to be no condition present.

Examples:
a) Child found with empty medicine bottle.

Z03.6 Observation for suspected toxic effect from ingested substance.

b) A patient was kept in hospital overnight with a minor condition (e.g. superficial head injury) which would not normally warrant an overnight stay.

S00.9 Superficial injury of head, part unspecified
X59.9 Accident NOS
Z04.3 Examination and observation following other accident

**Oedema**

SMR02 review 2000

Oedema need not be recorded. It is an extremely common condition during pregnancy and has no predictive value.

**Oesophageal Web**

SCCS No. 2 July 2013

The ICD-10 Alphabetic Index assumes that an oesophageal web is a congenital condition and classifies this at code Q39.4 Oesophageal web. However, an oesophageal web can be either congenital or acquired, with the latter being more common. It has been agreed that the correct ICD-10 classification codes for oesophageal web are as follows:

- Oesophageal web stated in the patient clinical record as congenital must be classified at Q39.4 Oesophageal web.

- Oesophageal web stated in the patient clinical record as acquired must be classified at K22.2 Oesophageal obstruction.

- Oesophageal web which is not specified in the patient clinical record as either congenital or acquired must be classified at K22.2 Oesophageal obstruction.

Coders should amend the entry for oesophageal web on Page 653 of their ICD10 Index as follows;
Web, webbed
-- esophagus K22.2
-- congenital Q39.4
Old Myocardial Infarction - should it be coded in addition to any ischaemic heart disease?

It has been decided that if old MI is listed in the clinical statement then it should be coded in addition to any ischaemic heart disease, as this gives a fuller picture.

Chronic Coronary Insufficiency; Old Myocardial Infarction
The correct codes are I25.8 and I25.2

Old stroke Coding Guidelines No. 17, January 2006

The index entry for old stroke may be misleading. The trail

Accident
cerebrovascular
- old I69.4

leads the coder to a sequelae code. While this is the correct code if late effects of a stroke have been mentioned eg hemiplegia, sequelae codes have an implied connection to the preceding code(s) and so should not be used in isolation. It may be more appropriate to use a history code

Examples:
1. Hemiplegia due to stroke 2 years ago. Code to:
G81.9 – hemiplegia, unspecified
I69.4 – sequelae of stroke, not specified as haemorrhage or infarction

2. Myocardial infarction
Stroke 2 years ago
Code to:
I21.9 – acute myocardial infarction, unspecified
Z86.7 – Personal history of diseases of the circulatory system

There also appears to be a common misconception that a previous disease must have happened over a year ago for a current condition to be a sequelae of it. This is not the case. Volume 2 of ICD10 p 129 states:
‘Note it is sufficient that the causal condition is described as ‘old’, ‘no longer present’. etc or the resulting condition is described as ‘late effect of’ or ‘sequelae of…’ for this to apply. There is no minimum time interval.
Open Wound to Artery or Vein  
Coding Guidelines No. 10, December 2001

As with injury to tendon or muscle (see Coding Quarterly November 1996), it is not possible to describe fully an open injury to a vein or artery with one code. Therefore, where this occurs, the appropriate code to describe the open wound must follow the artery/vein injury code. It is important that this is added to indicate the increased likelihood of complications such as infection. The external cause code must also be added following the injury codes.

Example
Patient had cut to axillary artery caused by a knife.

Wound, open
- blood vessel - see Injury, blood vessel

Injury
- blood vessel
- - axillary
- - - artery S45.0

This implies that the wound is open - there is no separate 5th digit to indicate this. However, to differentiate between an open wound and (for example) a rupture, add;

Wound, open
- arm
- - upper S41.1

The external cause code for contact with knife (W26.-) would follow.

Open Wound with Infection  
SCCS No. 2 July 2013

A diagnosis of ‘open wound with infection’ has more clinical consequences and resource implications compared to one which has no infection. Valuable information is being lost when an open wound with infection is coded according to the index trail. If the particular infection is identified, there is no problem, as an additional code from B95 to B97 should also be added.

However if no infection has been stated and it is not possible to add such a code, coders should add code T79.3 to the open wound code.

Examples

1. Staphylococcus aureus infection of open wound of finger, caused by contact with sharp glass:
   code to
S61.0 – Open wound of finger(s) without damage to nail  
W25.9 – Contact with sharp glass, place unspecified  
B95.6 – Staphylococcus aureus as the cause of diseases classified to other chapters

2. Infection of open wound of finger caused by contact with sharp glass:  
code to  
S61.0 – Open wound of finger(s) without damage to nail  
T79.3 – Post-traumatic wound infection, not elsewhere classified  
W25.9 – Contact with sharp glass, place unspecified

This advice applies whether the infection is in the same episode or a subsequent episode of care and will take effect from 1st April 2002.

**Orthopaedic Devices associated with adverse incidents**  
**Coding Guidelines No. 3, June 1999**

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]

**Z41.1 Other Plastic Surgery for Unacceptable Cosmetic Appearance**  
**Coding Guidelines No. 12, September 2002**

Clarification has been requested on the correct position of Z41.1. The guidance is that if the underlying condition is known and is a medical problem then this should be in main condition followed by Z41.1 – see the examples below:-

Striae Atrophicae admitted for abdominoplasty.  
Code: L90.6 Striae Atrophicae  
Z41.1 Other Plastic Surgery for Unacceptable Cosmetic Appearance
Patient admitted for breast reduction and is stated to have hypertrophic mammary glands.

Code: N62.X Hypertrophy of Breast
Z41.1 Other Plastic Surgery for Unacceptable Cosmetic Appearance

Where the clinical statement simply identifies the fact that the patient has an unacceptable cosmetic appearance, and attempts to clarify this with the clinician have failed then the coder can use the Z41.1 as Main Condition.

Patient admitted for breast augmentation and no mention is made of an underlying condition.

Code: Z41.1 Other Plastic Surgery for Unacceptable Cosmetic Appearance.
No other code is required

Pancreatic Intraepithelial Neoplasia (PanIN)
Coding Guidelines No. 26, October 2010

Tumours described as PanIN III or high grade Pancreatic intraepithelial neoplasia should be coded to D01.7 Carcinoma in situ of other specified digestive organs.

Paraneoplastic Syndrome
Coding Guidelines No. 8, February 2001

Paraneoplastic syndrome refers to a large group of signs or symptoms that may occur in a patient with cancer. These conditions are not due to the direct impact of the neoplasm, yet rather due to the production of chemical substances from the cancer cells. Not all cancers cause paraneoplastic syndrome.

Among the most commonly seen paraneoplastic syndromes are:

• Blood clot formation in cancer of the pancreas
• Low sodium level in small cell lung cancer
• High calcium levels in various cancers
• Fever
• Eaton Lambert syndrome
• Myasthenia gravis due to thymoma
• Nerve dysfunctions due to various cancers
• Anaemia

From the above it is obvious that there can be no single code given out for paraneoplastic syndrome. When coding it is important to find out the nature of the complication, and code that. This may give rise to a dagger/asterisk combination or to two separate codes.

Example 1 - Myasthenia gravis in thymoma would be coded to:
D15.0 D - Benign neoplasm of thymus  
G73.2 A - Other myasthenic syndromes in neoplastic disease

Example 2 - Low sodium level in small cell lung cancer would be coded to:

C34.9 - Malignant neoplasm of bronchus or lung, unspecified  
E87.1 - Sodium deficiency

**Parastomal Hernia**  
**Coding Guidelines No. 26, October 2010**

A parastomal hernia is by definition a hernia that occurs at and around an operative stoma. The index trail in ICD-10 Volume 1 is:

Hernia, hernial (acquired) (recurrent) K46.9  
- postoperative - see Hernia, ventral  
Hernia  
- ventral K43.9  
- - with  
- - - gangrene (and obstruction) K43.1  
- - - obstruction K43.0

Therefore the correct ICD-10 code for a parastomal hernia is K43.- Ventral hernia (4th character assignment will depend on whether it is a parastomal hernia with or without obstruction/gangrene). It is also appropriate to assign the relevant ICD-10 code from category Z93, Artificial opening status, in a secondary position, in order to identify the presence of a stoma.

**Past History in a recurrence of the same condition**  
**Coding Guidelines No. 13, January 2003**

We have been asked whether past history should be coded if a condition, which was thought to be eradicated, recurs (eg breast cancer). It was felt that coding past history did not add anything and should be dropped. Analysis is now done on linked files, which means that past history is picked up.

**Patient who takes overdose transferred to psychiatric hospital**  
**Coding Quarterly No. 3, May 1997**

A patient with depression attempts suicide by taking an overdose of paracetamol and is admitted to an acute hospital for treatment. After this they are transferred to a psychiatric hospital for treatment of the depression. How should this episode be coded in the psychiatric hospital?
SMR04

On admission -

Code depression

F32.9 Depression NOS

followed by suicide attempt

T39.1 Poisoning by 4-aminophenol derivatives
X60.9 Intentional self poisoning by ....nonopioid analgesics..

On discharge -

Code depression

F32.9 Depression NOS

followed by personal history of self-harm

Z91.5 Personal history of self-harm

Perinatal Conditions Coding Guidelines No. 23, September 2008

The following scenario is for occasions when a code is not available to clearly classify that the condition in question forms a perinatal condition. Conditions arising in the perinatal period should, as far as possible, be coded to chapter XVI, even when morbidity or death occurs later. This takes precedence over chapters containing codes for diseases by their anatomical site.

Exclusions are:

Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Endocrine, nutritional and metabolic diseases (E00-E99)
Injury, poisoning, and certain other consequences of external causes (S00-T98)
Neoplasms (C00-D48)
Tetanus neonatorum (A33)

If the code for the disease by the anatomical site provides additional information which is not contained in the code from Chapter XVI, then it is acceptable to use a second code to express this information. This provides additional information for the coder and for potential analysis.

For example:

Newborn born in hospital with thrombotic occlusion of left superficial femoral artery.
The appropriate ICD-10 codes would be:

P29.8 Other cardiovascular disorders originating in the perinatal period
I74.3 Embolism and thrombosis of arteries of lower extremities

Perinatal Conditions update to guidance
Coding Guidelines No. 26, October 2010

The article entitled “Perinatal conditions” published in Coding Guidelines No.23 September 2008, contained a list of excluded codes as follows:

Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Endocrine, nutritional and metabolic diseases (E00-E99)
Injury, poisoning and certain other consequences of external causes (S00-T98)
Neoplasms (C00-D48)
Tetanus neonatorum (A33)

Please add Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) to the above list.

Perinatal Period- Definition of SCCS No. 2 July 2013

For morbidity coding the Perinatal Period applies to disorders manifesting or originating in the first 7 days of life (i.e. ends at 7 completed days after birth)

Neonatal Period commences at birth and ends 28 completed days after birth

Periprosthetic fracture and dislocated joint prosthesis
Coding Guidelines No. 28, March 2011

In ICD10 there are no clear index trails or specific named codes for coding fractures described by the clinician as ‘periprosthetic’ or cases where a prosthetic joint replacement has become dislocated. As a result, each of these occurrences has been coded in a number of different ways in the past.

ISD’s Clinical Coding Review Group has considered a number of known scenarios resulting in periprosthetic fracture or dislocated joint prosthesis, and has agreed on the codes to be used for each scenario. These are as follows:

1. Periprosthetic fracture without stated cause — code as M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate

2. Periprosthetic fracture due to known cause e.g. a fall — code as
M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate
PLUS
appropriate external cause code for the known cause e.g. W19.- Unspecified fall

3. Intra-operative periprosthetic fracture — occurring during primary or revisional joint replacement procedure. Code using the
S fracture code appropriate to the fractured bone
PLUS
Y79.2 Orthopaedic devices associated with adverse incidents — prosthetic and other implants, materials and accessory devices

4. Dislocated joint prosthesis without stated cause — code as
T84.0 Mechanical complication of internal joint prosthesis
PLUS
Y83.1 Surgical operation with implant of artificial internal device.

5. Dislocated joint prosthesis due to known cause e.g. a fall — code as
T84.0 Mechanical complication of internal joint prosthesis
PLUS
appropriate external cause code for the known cause e.g. W19.- Unspecified fall

Pfeiffer’s Disease v Pfeiffer’s Syndrome
Coding Guidelines No. 3, June 1999

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.

Pineal Cyst Coding Guidelines No. 14, January 2004

It has been decided that the best code for Pineal Cyst is –

G93.0 – Cerebral cysts (also indexed as cyst, brain (acquired) or cyst, intracranial)
Poisoning - intentional self-harm or accidental?
Clinical Coding Guidelines 1, May 1996

Various terms may be used in the source document to record a poisoning. Very often it has not been stated whether or not the poisoning was accidental or intentional self-harm, and this information is required in order to allocate the correct external cause code.

The general guideline is, as always, to try and obtain the missing information from the clinician who completed the source document. Where this is not possible, follow these guidelines:

“Overdose” or “self-poisoning” has been recorded -

- it is not stated as self-inflicted, deliberate or accidental - code as accidental
- it is qualified as self-inflicted, manipulative, parasuicide, attempted suicide, failed suicide attempt or cry for help - code as intentional self-harm

Note: These guidelines apply regardless of the age of the patient

Post-dates and post-term SMR02 review 2000

There is much confusion and disagreement over the definition of these terms. The information is available in the data item Estimated Gestation. It is therefore recommended that the code O48.X (Prolonged pregnancy) is not used in delivery episodes.

Posterior capsular opacification (also called after-cataract)
Coding Guidelines No. 31, September 2012

Posterior capsular opacification (also called after-cataract) may develop in some patients following cataract surgery. Over time the part of the lens capsule holding the prosthetic lens in place can thicken, resulting in symptoms similar to those found in cataracts, such as hazy vision and poor night vision.

The appropriate ICD-10 code for posterior capsular opacification is:
H26.4 After-cataract

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Postnatal administration of Anti D
Coding Quarterly No. 3, May 1997

When a patient is given Anti D injection in the postnatal period, this should be coded to Z29.1 Prophylactic immunotherapy.

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Postprocedural disorders
Clinical Coding Guidelines 1, May 1996

Postprocedural disorders are conditions resulting from surgical or medical procedures. The principle is to use codes which provide the most accurate clinical picture. This usually involves selecting a code for the condition being treated followed by the appropriate external cause code (Y83.- or Y84.-). This provides greater accuracy than using the codes for post-procedural disorders given at the end of each body system chapter. However, in some cases, a specific post-procedural condition may be listed in the Index and have its own individual code.

Examples:

1) Post-op pneumonia
   J18.9 Pneumonia, unspecified
   Y83.9 Surgical procedure, unspecified, as the cause of abnormal reaction........

2) Ovarian failure following radiotherapy
   E89.4 Post-procedural ovarian failure
   Y84.2 Radiological procedure and radiotherapy as the cause of abnormal........

3) Acute cystitis as a result of urinary catheterisation
   N30.0 Acute cystitis
   Y84.6 Urinary catheterisation as the cause of abnormal reaction....

4) Postcholecystectomy syndrome
   K91.5 Postcholecystectomy syndrome

Precipitate labour O62.3 SMR02 Review 2010

As there are varying definitions of this (undue speed of labour to delivery), it is not advisable to use the code unless the particular term has been stated.

Pre-eclampsia SMR02 review 2000

Pre-eclampsia is considered to be present when proteinuria is greater than 300mg/1 and diastolic blood pressure is greater than 110mmHg on any occasion, or a diastolic reading of 90 - 110mmHg is sustained for 4 hours or more. Oedema may or may not be present.

It is very difficult to identify moderate/severe pre-eclampsia as specified in ICD10. Therefore, it is recommended that pre-eclampsia is coded as unspecified: O14.9.
Premature Rupture of Membrane (PROM) O42.-  
SMR02 Review 2010

This means rupture of membranes before onset of labour (contraction stage) regardless of the length of gestation. The fourth-character identifies the length of time before the onset of labour. This code is classified within the section on maternal care related to the fetus and amniotic cavity and possible delivery problems. For Scotland, it is important to record this on the delivery episode, even if it happened earlier. This is to ensure all PROMs are recorded, as it may have occurred outwith the hospital. This may mean an element of double counting, as the PROM event must also be coded in any ante-natal stay where the patient has been treated for that condition.

Presence of CABG (Coronary Artery Bypass Graft)  
Coding Guidelines No. 14, January 2004

When coding the Presence of CABG, please note the correct code is  
Z95.1 - Presence of aortocoronary bypass graft, not  
Z95.5 - Presence of coronary angioplasty implant and graft.

Presumptive diagnoses: Treated as, treated for, treated accordingly  
Coding Guidelines No. 25, April 2010

Advice has been sought regarding the use of the terms “treated as” “treated for” and “treated accordingly”. The CCRG has decided that in these cases the disease/condition should be coded e.g.  
Treated as asthma. Code to asthma.  
Treated for swine flu. Code to swine flu.  
Influenza A (H1N1), lab results awaited, treated accordingly. Code to Influenza A (H1N1).  
Below is the updated table of “Presumptive diagnoses”. The original table was published in Coding Guidelines No.24 October 2009.

<table>
<thead>
<tr>
<th>Term</th>
<th>How to code</th>
<th>Coding Guideline Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible, suspected, query, ?</td>
<td>Code symptom(s)</td>
<td>CG 1 May 1996</td>
</tr>
<tr>
<td>Probable</td>
<td>Code the condition</td>
<td>CG 1 May 1996</td>
</tr>
<tr>
<td>Presumptive</td>
<td>Code the condition</td>
<td>CQ 5 January 1998</td>
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<td>Consistent with, compatible with, in keeping with</td>
<td>Code the condition</td>
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</tr>
<tr>
<td>Impression of</td>
<td>Code the symptom(s)</td>
<td>CG 23 September 2008</td>
</tr>
<tr>
<td>Likely</td>
<td>Code the condition</td>
<td>CG 24 October 2009</td>
</tr>
<tr>
<td>Suggestive of</td>
<td>Code the symptom(s)</td>
<td>CG 24 October 2009</td>
</tr>
<tr>
<td>Treated as, for, accordingly</td>
<td>Code the condition</td>
<td>CG 25 April 2010</td>
</tr>
</tbody>
</table>

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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.-).

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**Prostatic intraepithelial neoplasia, grade III (PIN III)/High grade glandular intraepithelial neoplasia of the prostate (HGIN)**

SCCS No. 2 July 2013

Carcinoma-in-situ of the prostate has generally been replaced by the expression ‘high grade intraepithelia neoplasia of the prostate’. The correct ICD10 code to assign for this diagnosis is D07.5 – Carcinoma in situ prostate.

In cases where there is a system of grading intraepithelial neoplasia (eg cervix, vulva and vagina), all high grade or grade III descriptions are classified as in-situ neoplasms.

Grade I and grade II prostatic intraepithelial neoplasia should be coded to:

- N42.3 – Dysplasia of prostate (includes Low grade dysplasia).
  This is is trailed through the lead term ‘dysplasia’.

Coders should also annotate their Index on P436

Neoplasia
- prostate (PIN) N42.3 (Grade I and II)
Prosthetic device at the end of its natural life
Coding Quarterly No. 3, May 1997

Many prostheses have a limited lifespan and eventually need to be replaced. For example, a prosthetic heart valve may need to be replaced 8 to 10 years after the original operation. This condition is regarded as a complication of the prosthetic device and is coded to T82.- to T85.- (Complications of ..... devices, implants and grafts) depending on which type of prosthetic implant, device or graft is involved.

Raised INR Coding Guidelines No. 16, August 2005

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.
Raised PSA  Coding Guidelines No. 17, January 2006

In Coding Guidelines 8 (February 2001), guidance was published to code raised PSA to R76.8 – Other specified abnormal immunological findings in serum. Recent training material from England gives the advice to code raised PSA to R79.8 – Other specified abnormal findings of blood chemistry. In the interests of consistency with England, our clinicians have decided to agree to this code.

This guidance takes effect from 1st April 2006

Rectal haemorrhage versus per rectal haemorrhage
Coding Guidelines No.30, March 2012

The ICD10 code K62.5 Haemorrhage of anus and rectum refers specifically to haemorrhage of the anus and/or rectum. It does not refer to a haemorrhage that has occurred from elsewhere in the gastrointestinal tract, that is merely exiting via the rectum i.e. a ‘per rectal haemorrhage’.

If the clinician identifies the source of the haemorrhage as the anus or rectum then the correct ICD-10 code is:
K62.5 Haemorrhage of anus and rectum

However, if the bleed is not specified as being from the rectum or anus and has simply occurred via the rectum, then it should be coded as a gastrointestinal haemorrhage of unspecified location and the correct ICD-10 code is:
K92.2 Gastrointestinal haemorrhage, unspecified

Please note that K92.2 excludes neonatal gastrointestinal haemorrhage as per the note at category K92.- Other diseases of digestive system

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Rec current Tonsillitis
Coding Quarterly No. 2, February 1997

Following discussion at CCRG the decision was taken that the index is correct and recurrent tonsillitis should be coded to

J03.9 - Acute tonsillitis, unspecified.

Index trail -
Recurrent - see condition
Tonsillitis (acute).......J03.9
Removal of Grommets  Coding Quarterly No. 3, May 1997

Patient who had grommets inserted for glue ear returns to have the grommets removed (glue ear having cleared). What codes should be used?

Z45.8 Adjustment and management of other implanted devices  
Z86.6 Personal history of diseases of the nervous system and sense organs

If the glue ear had not cleared up the codes would be -  
H65.3 Chronic mucoid otitis media  
Z45.8 Adjustment and management of other implanted devices

Renal Dialysis  Coding Guidelines No. 14, January 2004

If a patient is admitted as a day case or an inpatient specifically to have renal dialysis, then a code from the category Z49. – Care involving dialysis should be used as a secondary code, the primary diagnosis being the renal condition. However, if the patient is admitted for other treatment, for instance for a transplant, but receives dialysis whilst in hospital, it is not appropriate to use a code from category Z49.-

Repetitive strain injury  Coding Guidelines No. 17, January 2006

Where there is no further information about the nature of the injury, the correct ICD10 code for repetitive strain injury is:
M70.8 – Other soft tissue disorders related to use, overuse and pressure

If repetitive strain injury is said to be work related, the code Z56.6 – Other physical and mental strain related to work should also be added.

Retained placenta  SMR02 Review 2010

O72.0 Third-stage haemorrhage  
- In ICD10 O72.0 includes Retained placenta NOS.

However, in Scotland, it has been agreed that in cases of retained placenta where haemorrhage is not mentioned OR where the blood loss is recorded as < 500mls, the retained placenta should be coded to:

O73.0 – Retained placenta without haemorrhage.

Please annotate ICD index as follows;

Retention  
- placenta (total) (with haemorrhage) O72.0
-- portions or fragments (with haemorrhage) O72.2
--- without haemorrhage O73.1 (retained portions of placenta NOS)
-- without haemorrhage O73.0 (Retained placenta NOS)

Even though ‘without haemorrhage’ is an essential modifier, code Retention of placenta NOS to O73.0 where there is no specific mention of haemorrhage OR where the blood loss is < 500mls.
The same rule applies to Retained portions of placenta and membranes, without haemorrhage at O73.1.

There is also another index trail, which should be annotated in the same way;
Placenta
- retention (with postpartum haemorrhage) O72.0
-- fragments, complicating puerperium (delayed haemorrhage) O72.2
--- without haemorrhage O73.1 (retained portions of placenta NOS)
-- without haemorrhage O73.0 (Retained placenta NOS)

Rhabdomyolysis  

Rhabdomyolysis is a breakdown of skeletal muscle tissue and may be caused by physical, chemical or biological factors. The code assignment for rhabdomyolysis will depend on the cause of the muscle cell damage.
The World Health Organisation (WHO) has ratified the addition of ‘Rhabdomyolysis (idiopathic) NEC’ to the alphabetical index (ICD-10 Volume 3) and it now reads:

Rhabdomyolysis (idiopathic) NEC M62.8
- traumatic T79.6

Thus rhabdomyolysis, unspecified further or without a known cause, must be coded to M62.8 Other specified disorders of muscle. Traumatic rhabdomyolysis must be coded to T79.6 Traumatic ischaemia of muscle.
Rhabdomyolysis results in the protein myoglobin being released from the damaged muscle cells into tissue fluid and blood. This may result in damage to the kidneys, ranging from myoglobinuria to acute renal failure or nephritis. Renal problems due to non-traumatic rhabdomyolysis should be coded in addition to the rhabdomyolysis. Renal failure due to traumatic rhabdomyolysis follows the index trail:

Failure, failed
- renal – see Failure, kidney
- following
- - - - - - crushing T79.5
Leading to the Tabular List entry:
T79.5 Traumatic anuria
Crush syndrome
Renal failure following crushing
Seasonal Affective Disorder (SAD)
Coding Guidelines No. 6, June 2000

Confirmation has been sought on a number of occasions on the correct coding of the above disorder. Following discussion at the Clinical Coding Review Group it was agreed that this disorder should be coded to:

F33.- Recurrent depressive disorder
with allocation of the appropriate 4th digit (default F33.9 when no further clinical information is available).

Sequelea Codes

Sequelae Codes
SCCS No. 2 July 2013

Sometimes a condition or disease has been caused by another disease which is no longer present. One is said to be the sequelae (late effect) of the other. For example, deafness may be a sequelae of meningitis; therefore a diagnosis of deafness as a late effect of meningitis would be coded to -

H91.9 Deafness NOS
G09.X Sequelae of inflammatory diseases of central nervous system

Sequelae codes should never be used in main condition, but always as a supplementary code to the current problem. These guidelines are given in the Scottish Clinical Coding Reference Manual: rules of ICD-10, page 17. Any sequelae diagnosis with no further information e.g. ‘Old CVA’, needs to be referred back to the clinician for further information on the current problem.

Site of musculoskeletal involvement
SCCS No. 2 July 2013

In the Musculoskeletal chapter p 558 - 559, 5th character subdivisions are given for site of involvement. Coders have difficulty when the site is specified as “arm” or “leg” without specifying “upper” or “lower”. In the majority of these cases it should be possible to find out which is more appropriate, but where this is not possible it has been decided to use:

3 for arm, nec
6 for leg, nec

Small vessel disease and lacunar infarcts
Coding Guidelines No. 19, September 2006

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.

**Soft Tissue Injury**

**Coding Guidelines No. 9, July 2001**

When coding the term ‘soft tissue injury’ this generally means that no bones have been broken. The question has arisen as to whether to code Soft Tissue Injury to superficial injury or injury to muscle. It has been decided that the default code should be unspecified injury. Therefore, in the absence of further information code Soft Tissue Injury to Back as:

S39.9 – Unspecified injury of abdomen, lower back and pelvis + External cause code.

**Spiked drink**

**Coding Guidelines No. 17, January 2006**

Coders should note in their books the correct external cause code to assign to a patient admitted with a poisoning due to ‘spiked’ drink, i.e.

X85.- Assault by drugs, medicaments and biological substances

**Spontaneous rupture of membranes**

**Coding Quarterly No. 1, November 1996**

Two codes are available in ICD10 relating to spontaneous rupture of membranes:

O42.- Premature rupture of membranes
O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes

O42.- refers to rupture of membranes before labour has started, regardless of the length of gestation. The fourth character identifies the length of time until labour begins. (O42.- does not, therefore, refer to rupture of membranes before 37 weeks’ gestation). O75.6 refers to rupture of membranes after labour has started. There is then a subsequent delay in delivery. The exact time period which defines a delayed delivery following rupture of membranes is for local definition.
Test results and their use in SMR01 coding
Coding Guidelines No. 20, June 2007

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.
Toxic Confusional State  Coding Guidelines No. 2, January 1999

Following a decision by the Coding Review Panel (UK) it has been agreed that the ICD10 code for Toxic Confusional State (WHEN NO FURTHER INFORMATION IS AVAILABLE) is

F05.9  Delirium Unspecified.

Transitional Cell Carcinoma Kidney  Coding Guidelines No. 20, June 2007

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.

Transitional Cell Carcinoma of Bladder  SCCS No.2 July 2013

Where no further information or histology is available for the term ‘Transitional Cell Carcinoma (TCC)’ of the bladder, coders are instructed to code ‘TCC’ to D41.4 Neoplasm of uncertain or unknown behaviour of bladder and not to continue following the index trail which leads to C67.9 Malignant neoplasm of bladder. Coders should consult with medical staff to establish what they mean by Carcinoma Bladder and Cancer Bladder in the absence of further information.

Transitional Cell Carcinoma (TCC) Ureter and Renal Pelvis (not otherwise specified)  Coding Guidelines No. 15, November 2004
SCCS No. 2 July 2013

Advice has been issued 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

**Triple Vessel Disease**

**Coding Guidelines No. 13, January 2003**

In the past, advice may have been given to individual sites to code Triple Vessel Disease to I25.0 - Atherosclerotic cardiovascular disease, so described. This has been checked at national level and all sites should be aware that the correct code for this disease is

I25.1 - Atherosclerotic heart disease

**Uncontrolled Diabetes**

**Coding Guidelines No. 2, January 1999**

Hyperglycemia is a recognized sign/symptom of diabetes and if present the diabetes is considered to be out of control. Patients are occasionally admitted for stabilization. This is not a complication of diabetes as understood within the axis of the
classification for this disease and should therefore be coded with the fourth -character subdivision .9.

**Undetermined Intent; Reminder re previous guidance**

**Coding Guidelines No.30, March 2012**

Coding Guidelines No. 12, September 2002, included the article below. Please note that this guidance still applies.

External Cause codes indicate whether an injury or poisoning was accidental or deliberate self-harm. There is an additional category for those incidents that lead to the death of the patient, but where the intent was not known. These codes should only be used where the Procurator Fiscal has stated at an inquiry into a death, that the death was of ‘undetermined intent’. In the absence of a clinician’s decision, where there is doubt as to whether an incident was accidental or caused by deliberate self harm, then the external cause code should indicate ‘accidental’.

**Undetermined Intent  Coding Guidelines No. 12, September 2002**

External Cause codes indicate whether an injury or poisoning was accidental or deliberate self-harm. There is an additional category for those incidents that lead to the death of the patient, but where the intent was not known. These codes should only be used where the Procurator Fiscal has stated at an inquiry into a death, that the death was of ‘undetermined intent’. In the absence of a clinician’s decision, where there is doubt as to whether an incident was accidental or caused by deliberate self harm, then the external cause code should indicate ‘accidental’.

**Use of codes Y90-Y98**

**Coding Quarterly No. 1, November 1996**

These are supplementary codes which may be used in addition to other external cause codes but must not replace them.

**Use of code Z53.- Procedure not carried out**

**Coding Guidelines No. 9, July 2001**

When training, tutors always emphasise that if the use of code: 
Z53.- ‘Persons encountering health services for specific procedures, not carried’ is appropriate, it should always be used in first position, followed by the diagnosis for which the patient requires treatment. It has come to our attention that some sites are using this code in other positions.
From 1st October 2001, an error will be generated if these codes are used in any condition apart from main condition.

**Vaginal Thrush in Pregnancy**  
**Coding Guidelines No. 23, September 2008**

The correct codes for vaginal thrush in pregnancy are:

- O23.5 Infections of the genital tract in pregnancy
- B37.3D Candidiasis of vulva and vagina (N77.1A)
- N77.1A Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere

**Viral-associated wheeze**  
**Coding Guidelines No. 25, April 2010**

A wheeze linked to a virus that has required treatment in its own right, for example with nebulisers or inhalers, can be described in many different ways within the care record. Some examples of clinical terms found in the care record are viral wheeze, viral-induced wheeze, viral-associated wheeze and viral illness with wheeze. We can advise that where a wheeze is either induced by, caused by or due to a viral infection, the coder must follow the principle for coding symptoms that are important medical problems and sequence the virus in primary position followed by the wheeze:

- B34.9 Viral infection, unspecified
- R06.2 Wheezing
Clinical practice of treating abortions/miscarriages has changed in the last few years since we previously issued guidance on this subject. It is also true that practice is different in different areas of the country. This has led to coders being confused about how to code abortion episodes, particularly when there may be several episodes for the same abortion.

The following scenario may be quite typical:

Patient is admitted or attends as an outpatient for start of termination. Given mifepristone orally then sent home. Nothing happens. Comes back 3 days later and given misoprostol vaginally. Still nothing happens. Following day, comes in and is given a second dose of misoprostol orally, and then aborts.

It has been decided that the following coding should be used:
On the first inpatient or daycase episode of care for a medical abortion, a code for complete abortion should be used i.e. O04.5 to O04.9
On subsequent episodes, code to incomplete abortion i.e. O04.0 to O04.4

Note that the codes given out in Coding Guidelines No.8, February 2001, still apply i.e.

<table>
<thead>
<tr>
<th></th>
<th>ICD10 code (in addition to O04.-)</th>
<th>OPCS4 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral mifepristone</td>
<td>Z30.3</td>
<td></td>
</tr>
<tr>
<td>Oral prostaglandin (including misoprostol)</td>
<td>Z51.2</td>
<td></td>
</tr>
<tr>
<td>Vaginal/ pessary prostaglandin (including misoprostol)</td>
<td>Q14.5</td>
<td></td>
</tr>
</tbody>
</table>

Please note that mifepristone is only given orally.

Miscarriages/spontaneous abortions will be coded as follows:

On the first inpatient or daycase episode of care for a spontaneous abortion, a code for complete abortion should be used i.e. O03.5 to O03.9. This will apply even if the patient is still bleeding when sent home.
Any subsequent episode of care should be coded to an incomplete abortion i.e. O03.0 to O03.4.
By using this coding only one complete abortion episode is ever recorded for any abortion. Analysts counting the number of episodes of care for abortions should be aware of the above rules, but should note that some abortion or miscarriage patients are never admitted as inpatients and so a more accurate result of total number of
Abortions will be obtained by counting the ‘yellow forms’ held on a separate database from SMR information.

N.B. If the abortion information is being recorded on an SMR02 record, the correct condition on discharge code for the above scenarios is 8 - Other (includes missed abortion) unless the clinician states that the patient has aborted in which case the correct code is 2 - Aborted.

This guidance applies to all discharges on and after 1st April 2008.

**Abortion Coding Coding Guidelines No. 2, January 1999**

Clarification was sought via the Clinical Coding Review Group (CCRG) regarding abortion coding as many difficulties are arising because of interpretation of the word ‘abortion’. The term ‘abortion’ refers to the expulsion or removal of an embryo or fetus. Confusion is arising with ‘missed’ and ‘spontaneous’ abortions coming back in for second and third episodes of care due to the original reason for admission. In particular, O04.- (Medical Termination / Legal Abortion) is being used when a Missed abortion (O02) and Spontaneous abortion (O03) are returning because of retained products of conception.

Medical Staff at the CCRG gave clear examples of how the following should be coded:-

**Medical Abortion** (for the purposes of removing a live embryo or fetus)
On discharge of first episode should be coded to O04.5 to .9
If patient returns with retained products of conception code to O04.0 to .4
ICD10 Index states - Retention, retained
 - products of conception
  - - following
    - - - abortion - see Abortion, by type
    Abortion
  - medical

**Spontaneous Abortion**
On discharge of first episode should be coded to O03.5 to .9
If patient returns with retained products of conception code to O03.0 to .4
ICD10 Index states - Retention, retained
 - products of conception
  - - following
    - - - abortion - see Abortion, by type
    Abortion
  - spontaneous

**Missed Abortion**
On discharge of first episode should be coded to O02.1
If patient returns with retained products of conception code to O02.1 +
O08.-
ICD10 Index states - Retention, retained
- products of conception
- - early pregnancy (dead fetus) O02

**Acute Coronary Syndrome**
**Coding Guidelines No. 10, December 2001**

The term "Acute Coronary Syndrome" sometimes appears in clinical information accessed by coders. This term is used to refer to any of a spectrum of acute ischaemic coronary disorders ranging from unstable angina to myocardial infarction (MI).

Because the specific condition referred to by physicians when they use this term can vary from patient to patient and from time to time with the same patient, coders should attempt to identify and code the specific condition referred to each time they are presented with the term "Acute Coronary Syndrome". This specific condition is likely to be codable to:
I20.- Angina pectoris
I21.- Acute myocardial infarction or I22.-. Subsequent myocardial infarction.

If the coder is unable to identify the specific condition referred to (by examining the clinical information or asking the clinician responsible) the default code for "Acute Coronary Syndrome" is:
I24.8 Other forms of acute ischaemic heart disease.

Coders who are able to identify and code the specific condition referred to should not also use the default code I24.8 in the same episode.

**Administration of Abortifacient Drug**
**Coding Quarterly No.6 April 1998**

From 1 April 1998, administration of abortifacient drugs, for example, Mifepristone (RU486) or prostaglandin, is to be coded in ICD10 as:

Z30.3 - Menstrual extraction (includes Interception of pregnancy)

and not Z51.2 as previously advised in the Coding Quarterly of May 1997. This is to bring Scotland into line with practice in England and Wales. Please note that this procedure will normally be carried out as an Outpatient attendance.
Adverse effects and poisonings, compound drugs, coding of Coding Guidelines No. 4, September 1999

**Compound Drugs**

When the drug has more than one component, each component should be coded separately and sequenced according to the order in the British National Formulary (BNF) which is a publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain. It is recommended that clinical coders have access to, or obtain a copy of, the British National Formulary which is updated every March and September. Copies are sent to every Pharmacy department, ward and doctor in every NHS organisation.

A list follows of the most common compound drugs [with external cause codes] which might result in admission to hospital:

<table>
<thead>
<tr>
<th>Product name</th>
<th>Ingredients</th>
<th>XIX</th>
<th>Acc.</th>
<th>Int.self Harm</th>
<th>Undet. Intent</th>
<th>Adverse effect in therapeutic use</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Anadin Extra (please note Anadin only contains paracetamol)</td>
<td>Aspirin, caffeine paracetamol</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.6 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y10.-</td>
</tr>
<tr>
<td>Co-proxamol</td>
<td>Dextropropoxyphene hydrochloride, paracetamol</td>
<td>T40.4 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.4 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.4 X42.- X62.- Y12.-</td>
</tr>
<tr>
<td>Distalgesic</td>
<td>Dextropropoxyphene hydrochloride, paracetamol</td>
<td>T40.4 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.4 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.4 X42.- X62.- Y12.-</td>
</tr>
<tr>
<td>Kapake</td>
<td>Codeine phosphate, paracetamol</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
</tr>
<tr>
<td>Medised (Suspension)</td>
<td>Paracetamol, promethazine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Migraleve (pink)</td>
<td>Paracetamol, codeine, buclizine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Migraleve (yellow)</td>
<td>Paracetamol, codeine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Night Nurse Capsules</td>
<td>Paracetamol, dextromethorphan, promethazine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Night Nurse Liquid</td>
<td>Paracetamol, dextromethorphan, promethazine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Solpadeine</td>
<td>Paracetamol, caffeine, codeine</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.6 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T43.6 X41.- X61.- Y11.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
</tr>
<tr>
<td>Solpadol</td>
<td>Codeine phosphate, paracetamol</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
</tr>
<tr>
<td>*Tixylix Cough and Cold</td>
<td>Chlorpheniramine, pholcodine, pseudophedrine</td>
<td>T45.0 X44.- X64.- Y14.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T44.9 X43.- X63.- Y13.-</td>
<td>T45.0 X44.- X64.- Y14.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
</tr>
<tr>
<td>Tixylix Night Time</td>
<td>Pholcodine, promethazine</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
<td>T43.3 X41.- X61.- Y11.-</td>
<td>T48.3 X44.- X64.- Y14.-</td>
</tr>
<tr>
<td>Tylex</td>
<td>Codeine phosphate, paracetamol</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
<td>T39.1 X40.- X60.- Y10.-</td>
<td>T40.2 X42.- X62.- Y12.-</td>
</tr>
</tbody>
</table>
Poisonings by these drugs should be coded in the order given in the table, with the exception of compound drugs where the same external cause occurs more than once (indicated by * before the product name). Here it is allowable to change the order of the codes so that no duplication occurs, e.g. Accidental poisoning with Anadin Extra may be recorded on SMR01 as follows:

- T39.0 Poisoning by salicylates
- T39.1 Poisoning by 4-Aminophenol derivatives
- X40.- Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
- T43.6 Poisoning by psychostimulants with abuse potential
- X41.- Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs nec

**Angelman’s Syndrome (Happy Puppet Syndrome)**  
**Coding Guidelines No. 22, March 2008**

There has been some confusion with the coding of Angelman’s Syndrome, formerly sometimes known as Happy Puppet Syndrome. In the past both Q87.8 and Q89.8 have been given out as codes for this Syndrome.

Since it is a congenital malformation syndrome mainly affecting the nervous system, it has been decided by the Clinical Coding Review Group (CCRG) that it is more appropriate to code it to:

- Q07.8 – Other specified congenital malformations of the nervous system

As with all syndromes, if any aspect of the syndrome is being treated in the current episode, this should be entered as the first code, before the code for the syndrome, itself.

**This guidance applies to all discharges on and after 1st April 2008.**

**Antiphospholipid Syndrome  Coding Guidelines No. 6, June 2000**

Antiphospholipid syndrome is a coagulation defect which may be due to hereditary or other predisposing factors.

Following a review of the latest World Health Organisation updates the codes have now been changed from D68.8D/M36.8A to correct code now given: D68.8 Other specified coagulation defects

Any specific manifestations of the syndrome could be linked using the dagger/asterisk mechanism if appropriate or coded according to syndrome guidelines.
**Arthrosis Coding Guidelines No. 31, September 2012**

The following is provided to further clarify the guidance regarding the coding of Arthrosis (M15-M19) on pages XIII-7 to XIII-10 of the ICD-10 Clinical Coding Instruction Manual (Version-2.0).

There is a note at the start of block M15-M19 explaining that the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis. The note also explains that the term ‘primary’ used within this block refers to arthrosis of no underlying or determining cause.

Coders are advised to always default to unspecified forms of these conditions (.9) in cases where the clinician has not identified an underlying cause.

Within the ICD-10 Alphabetical Index, the term ‘primary’ is an essential modifier which **must** be present in the clinical statement to enable coders to assign a code for a specific primary arthrosis.

Where the modifier ‘primary’ is not included in the diagnostic statement, the coder must default to the .9 unspecified code from the relevant ICD-10 category.

**Example:**
Bilateral osteoarthritis of the knees (gonarthrosis).

**Index Trail:**
Gonarthrosis M17.9

**Tabular List:**
M17.9 Gonarthrosis, unspecified

**Rationale:** The fact that the gonarthrosis is bilateral does not change the code assignment in this case. It is not stated that the gonarthrosis is ‘primary’, which as indicated above **must** be present in the diagnostic statement for the code M17.0 **Primary gonarthrosis, bilateral** to be assigned.

**The same rule applies for all other types of osteoarthritis/arthritis.**

Clinical Coding Departments need to work closely with their clinicians to ensure that the precise diagnosis is captured to enable the assignment of the appropriate ICD-10 codes. It is not the responsibility of the clinical coding professional to make a clinical judgement on the type of arthrosis a patient has. The type of arthrosis is a clinical decision, and therefore the relevant information, or confirmation as to whether the condition can be described as ‘primary’, must be accurately documented in the patient medical record.

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Bowel Screening – ICD10 coding
Coding Guidelines No. 24, October 2009

In the Bowel Screening Programme, patients who have a positive Faecal Occult Blood screening result are being called for further examination (colonoscopy). This should be coded to K92.1 (Melaena) in the colonoscopy episode if no further diagnosis is made.

Index trail:
Blood
- in
-- feces (see also Melena) K92.1

Cancer Patients Admitted for Chemotherapy
Coding Quarterly No. 3, May 1997

When patients with cancer are admitted to hospital for chemotherapy how should this be coded?

When the patient is being admitted specifically for chemotherapy, the ICD10 code Z51.1 Chemotherapy session for neoplasm should always be used after the code(s) for neoplasm(s). The appropriate OPCS4 code to identify the route of administration of the chemotherapy (eg X35.2 Intravenous chemotherapy) should also be recorded, if relevant.

In cases where the patient is receiving chemotherapy as part of routine inpatient care, but was not admitted specifically for this treatment, the coding is slightly different. It is not necessary to code chemotherapy in the diagnostic section. It is only necessary to record the OPCS4 code, if appropriate.

Cause of Death

Coders should note that the cause of death of a patient would not always be considered as the main condition.

The main condition is defined as the condition, diagnosed at the end of the episode of health care, primarily responsible for the patient’s need for treatment or investigation. (See 4-10 of the SMR Data manuals for full definition.)

Therefore the primary condition treated during the patient’s stay should ALWAYS be in the main position. The cause of death may be added in a subsequent position, if it is not the primary condition.
Cellulitis is a bacterial infection of the skin and subcutaneous tissue, which usually enters the skin via a wound or some break in the protective skin. When coding wound infections that progress to cellulitis, it is important that we capture the most significant code to reflect the condition being treated as in the following examples:

**Patient admitted with cellulitis of face (unknown cause)**

Code  L03.2 – Cellulitis of face

**Patient fell in garden, laceration of lower leg treated at A&E, admitted 4 weeks later with cellulitis of lower leg**

Code  L03.1 – Cellulitis of other parts of limb  
      T93.0 – Sequelae of open wound of lower limb  
      Y86.X – Sequelae of other accidents

**Known heroin addict is admitted with cellulitis of arm due to the use of infected needles**

Code  L03.1 – Cellulitis of other parts of limb  
      W27.9 – Contact with non-powered hand tool  
      F11.2 – Addiction to heroin

**Patient admitted with cellulitis due to insect bite of finger**

Code  L03.0 – Cellulitis of finger and toe  
      W57.9 – Bitten or stung by nonvenomous insect and other nonvenomous arthropods
Chronic Kidney Disease (CKD)
Coding Guidelines No. 28, March 2011

Many coders have seen increased use of the term ‘chronic kidney disease’ (CKD), probably following the publication of SIGN Guideline 103, 2008 ‘Diagnosis and management of chronic kidney disease’ (www.sign.ac.uk/pdf/sign103.pdf). This states that “All patients with evidence of persisting kidney damage, i.e. for >90 days, are defined as having CKD. Kidney damage refers to any renal pathology that has the potential to cause a reduction in renal functional capacity. This is most usually associated with a reduction in glomerular filtration rate (GFR) but other important functions may be lost without this occurring”.

The diagnosis of CKD can be stratified into five stages (1–5). A patient may be described as having “CKD” without further specification, or the stage may be given — “CKD 1” etc. The term CKD and its stages are not specifically indexed or classified in ICD10. ‘Chronic kidney disease’ can be coded via the index trail

Disease kidney (see also Disease, renal)

Disease
- renal
  - - chronic — see Nephritis, chronic
    Nephritis
  - chronic N03.-

To N03.9 Unspecified chronic nephritic syndrome which includes chronic renal disease NOS. This is technically correct coding but does not necessarily reflect clinical reality.

Clinicians may use terms such as ‘impairment’ or ‘failure’ alongside statements of CKD, for the same patient. Coders have been advised to code “CKD” (any stage, or without mention of a stage) to N03.9, and also to code any concurrent mention of renal failure or impairment (chronic or unspecified) to N18.- or N19 as appropriate.

New guidance
Following clinical advice, this guidance can now be changed, to enable coders to reflect the clinical picture more accurately. Coders can use Table 1 (below) to assign the most appropriate single code for statements of CKD, renal impairment and renal failure, used alone or in combination.
Table 1
Coding of CKD and of clinical statements of renal failure or impairment

<table>
<thead>
<tr>
<th>Clinical statement</th>
<th>CKD statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no statement of ‘CKD’</td>
</tr>
<tr>
<td>end stage renal¹ failure</td>
<td>N18.0 End stage renal disease</td>
</tr>
<tr>
<td>or end stage² renal disease</td>
<td>N18.0</td>
</tr>
<tr>
<td>chronic renal failure</td>
<td>N18.9 chronic renal failure unspecified</td>
</tr>
<tr>
<td>or chronic renal impairment</td>
<td>N18.9</td>
</tr>
<tr>
<td>renal failure</td>
<td>N19.X renal failure unspecified</td>
</tr>
<tr>
<td>or renal impairment</td>
<td>N18.9</td>
</tr>
<tr>
<td>no statement of ‘failure’</td>
<td>-</td>
</tr>
<tr>
<td>or ‘impairment’</td>
<td></td>
</tr>
</tbody>
</table>

¹In the clinical statement row headings, ‘kidney’ can replace ‘renal’ with no change in meaning or coding solution.
²End stage disease may also be described as ‘established renal disease’ or ‘established renal failure’

Coders should be aware that very few CKD patients will have had a renal biopsy. However, if a biopsy has been performed and a histological diagnosis is available, this can also be coded according to normal coding rules.

Coders who allocate a code from N18.- or N19 using Table 1 should remember to observe the exclusion notes in both categories regarding patients with hypertension i.e. a patient stated to have CKD 5 and also hypertension should be coded to I12.0 rather than to N18.0 and I10.X.
Scottish Clinical Coding Standards  July 2014

**COAD + pneumonia**  
**Coding Guidelines No. 8, February 2001**

The Coding Review Panel (CRP) have agreed the tabular ‘excludes’ entry at - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection is misleading and should include an exclusion of pneumonia as that is the same block as influenza (J10 - J18 Influenza and Pneumonia). The recommendation is that both pneumonia with COAD and influenza with COAD are dual coded with the pneumonia or influenza sequenced in the primary position.

The Clinical Coding Instruction Manual page X-8 will require amending to read –

*Coad patients are often hospitalised with acute exacerbations of their chronic obstructive airways disease. There is no necessity to use an additional code to identify the condition specified as the acute exacerbation except for influenza and pneumonia J10 - J18.*

**THIS CHANGE SHOULD BE IMPLEMENTED FROM 1ST APRIL 2001.**

**Coding the Acute Coronary Syndromes using ICD10**  
**Coding Guidelines No. 20, June 2007**

**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>
<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 OR 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

For guidance from October 2010 refer to Angina unstable and myocardial infarction, Coding Guidelines No. 26, October 2010.
### Table 2: Coding the Acute Coronary Syndrome

<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>I20.02</td>
<td></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></td>
<td></td>
<td>A clinical statement of ‘positive’ or ‘negative’ is essential.</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</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non ST elevation (NSTEMI)</td>
<td>• non-Q wave MI</td>
<td></td>
<td>I21.4</td>
<td>Acute subendocardial MI</td>
</tr>
<tr>
<td></td>
<td>• subendocardial MI</td>
<td>not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• partial thickness MI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ACS with clinical MI – NSTEMI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td></td>
<td></td>
<td>I22.8</td>
<td>Subsequent MI of other sites</td>
</tr>
<tr>
<td>ST elevation (STEMI)</td>
<td>• ACS with clinical MI – STEMI</td>
<td>not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(unconfirmed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- ACS term: Acute coronary syndrome
- alternative terms: additional terms for coding
- coder’s information regarding troponin status: information based on troponin status
- code: ICD codes
- comments: additional notes and guidelines on coding

Clinical statement could simply be ‘acute coronary syndrome’ or ‘unstable angina’.

If NSTEMI is patient’s first MI. The site (anterior, inferior etc.) of the NSTEMI can be ignored.

If NSTEMI is patient’s subsequent MI. The site (anterior, inferior etc.) of the NSTEMI can be ignored.

Normal rules of MI coding apply. Note I21.4 cannot be used.
**Coding of COPD/COAD and associated conditions**

**Coding Guidelines No. 31, September 2012**

In Coding Guidelines No.22, March 2008, we published a table to help coders assign the appropriate ICD10 codes for COPD/COAD with associated conditions and to ensure consistency in the recording of these conditions. A new entry has been added to this table; Infective exacerbation of asthma, patient known COAD/COPD.

This should be coded to J45.9 + J22.X + J44.9  
or J46.X + J22.X + J44.9

The table is reprinted below with the new entry.

**COPD/COAD**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/COAD</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>COPD/COAD with acute bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis (15 years and above)</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis NOS</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with chronic bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with asthma</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with acute asthma</td>
<td>J45.9 and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with status asthmaticus</td>
<td>J46.X and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td>COPD/COAD with pneumonia, unspecified</td>
<td>J18.9 and J44.0</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>Chest infection</td>
<td>J22.X</td>
</tr>
<tr>
<td>Chest infection with acute bronchitis</td>
<td>J20.-</td>
</tr>
<tr>
<td>Chest infection with bronchitis NOS</td>
<td>J40.X and J22.X</td>
</tr>
<tr>
<td>Chest infection with chronic bronchitis</td>
<td>(J41.- or J42.-) and J22.X</td>
</tr>
<tr>
<td>Chest infection with cystic fibrosis</td>
<td>E84.0</td>
</tr>
<tr>
<td>Chest infection with emphysema</td>
<td>J43.9 and J22.X</td>
</tr>
<tr>
<td>Chest infection, COPD and emphysema</td>
<td>J44.0 and J43.9</td>
</tr>
<tr>
<td>Chest infection with lower lobe consolidation on X-ray</td>
<td>J18.1</td>
</tr>
<tr>
<td>Chest infection, LVF</td>
<td>J22.X and I50.1 Sequencing is dependent on the main condition treated</td>
</tr>
<tr>
<td>Chronic obstructive bronchitis with acute exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>URTI (Upper respiratory tract infection)</td>
<td>J44.1 and J06.9</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/COAD</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>COPD/COAD with acute bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis (15 years and above)</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COPD/COAD with bronchitis NOS</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with chronic bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COPD/COAD with asthma</td>
<td>J44.9</td>
</tr>
<tr>
<td>COPD/COAD with acute asthma</td>
<td>J45.9 and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with status asthmaticus</td>
<td>J46.X and J44.9</td>
</tr>
<tr>
<td>COPD/COAD with emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td>COPD/COAD with pneumonia, unspecified</td>
<td>J18.9 and J44.0</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>Chest infection</td>
<td>J22.X</td>
</tr>
<tr>
<td>Chest infection with acute bronchitis</td>
<td>J20.-</td>
</tr>
<tr>
<td>Chest infection with bronchitis NOS</td>
<td>J40.X and J22.X</td>
</tr>
<tr>
<td>Chest infection with chronic bronchitis</td>
<td>(J41.- or J42.-) and J22.X</td>
</tr>
</tbody>
</table>


Please note that previous guidance (Coding Guidelines No.4 September 1999 and No.8 February 2001) still applies.

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<table>
<thead>
<tr>
<th>Condition</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest infection with cystic fibrosis</td>
<td>E84.0</td>
</tr>
<tr>
<td>Chest infection with emphysema</td>
<td>J43.9 and J22.X</td>
</tr>
<tr>
<td>Chest infection, COPD and emphysema</td>
<td>J44.0 and J43.9</td>
</tr>
<tr>
<td>Chest infection with lower lobe consolidation on X-ray</td>
<td>J18.1</td>
</tr>
<tr>
<td>Chest infection, LVF</td>
<td>J22.X and I50.1</td>
</tr>
<tr>
<td>Chronic obstructive bronchitis with acute exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>URTI (Upper respiratory tract infection) with COPD</td>
<td>J44.1 and J06.9</td>
</tr>
<tr>
<td>(Acute) exacerbation of asthma</td>
<td>J45.9</td>
</tr>
<tr>
<td>Infective exacerbation of asthma</td>
<td>(J45.9 or J46.X) and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma with status asthmaticus</td>
<td>J46.X and J22.X</td>
</tr>
</tbody>
</table>


Please note that previous guidance (Coding Guidelines No.4 September 1999 and No.8 February 2001) still applies.

This guidance applies to all discharges on and after 1st April 2008.

**COAD (with basal pneumonia, with infective exacerbation)**

**Coding Guidelines No. 4, September 1999**

Confirmation has been sought from the Clinical Coding Centre on the following two respiratory conditions:-

1. **Chronic Obstructive Airways Disease (COAD) with Basal Pneumonia**

   Code to:

   J44.0 - Chronic obstructive pulmonary disease with acute lower respiratory infection, with J18.1 - Lobar Pneumonia, unspecified

2. **Infective Exacerbation of Chronic Obstructive Airways Disease**

   Code to:

   J44.0 - Chronic obstructive pulmonary disease with acute lower respiratory infection. If the infection is stated it must be coded
Please Note: It is the Infective nature of the condition which guides you to ‘.0’ at J44.-

Coding Quarterly No. 6, April 1998 - page 5 (OPCS4 section)
Termination of Pregnancy using Mifepristone (RU486)

Please change to read:
From 1 April 1998, administration of abortifacient drug Mifepristone (RU486) should be coded in ICD10 as:
Z30.3 - Menstrual extraction (includes Interception of pregnancy)
This is to bring Scotland into line with practice in England and Wales. Please note that this procedure will normally be carried out as an Outpatient attendance.

Note: Remember to amend any notes you may have made to ICD10 volumes

IN SUMMARY, FROM 1ST APRIL 2001 ADMINISTRATION OF MIFEPRISTONE WILL CONTINUE TO BE CODED TO Z30.3, BUT ADMINISTRATION OF PROSTAGLANDIN ORALLY WILL BE CODED TO Z51.2

Co-morbidities on SMR01 Coding Coding Guidelines No. 3, June 1999

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

Cord Compression complicating delivery
Coding Guidelines No. 19, September 2006

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
Cord entanglement /cord round baby's neck
SMR02 review 2000

It is not possible to code 'cord round neck' if there are no complications. Only code if complications are specified.

Cystocele/Rectocele Coding Guidelines No. 15, November 2004

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

Dagger and asterisk coding
Clinical Coding Guidelines 1, 1996

In ICD10 there are asterisk codes for which no dagger codes are specified in either the Tabular List or the Index. They can be used only when the clinician has stated a cause and effect relationship between the one of these conditions and an underlying cause. If any of these codes are used to create a dagger and asterisk pair, approval for use of the code pair must be sought from the Scottish Clinical Coding Centre (SCCC). This allows the SCCC to monitor the use of these codes, and also to ensure the SMR data validation will be amended in order to allow the use of the pair. Currently, only dagger and asterisk pairs given in the ICD10 Tabular List or the Index can be accepted without raising any query/error message.

If you wish to make a dagger and asterisk code pair using one of these codes, please contact the SCCC. The code pair will be discussed with the Medical Adviser at the SCCC and you will be notified when it has been approved for use. There will be a time delay between your request for approval and the validation accepting the pair. You will be notified of the date when the software will be updated to include the pair, and the codes to use in the interim.

Dagger/Asterisk Codes
Coding Guidelines No. 7, November 2000

The following new dagger asterisk pair codes have been set up in the validation files since the introduction of ICD10. Requests for additional codes to be added are dealt with by the Coding Advisory Service.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D48.9D</td>
<td>Para neoplastic brain stem syndrome</td>
</tr>
<tr>
<td>J18.0D</td>
<td>Bronchopneumonia with pleural effusion</td>
</tr>
<tr>
<td>J18.1D</td>
<td>Lobar pneumonia with pleural effusion</td>
</tr>
<tr>
<td>J18.2D</td>
<td>Hypostatic pneumonia with pleural effusion</td>
</tr>
<tr>
<td>J18.8D</td>
<td>Other pneumonia with pleural effusion</td>
</tr>
<tr>
<td>E84.8D</td>
<td>Cystic fibrosis liver disease</td>
</tr>
<tr>
<td>E10.3D</td>
<td>Vitreous haemorrhage in insulin dependent diabetes</td>
</tr>
<tr>
<td>E11.3D</td>
<td>Vitreous haemorrhage in non-insulin dependent diabetes</td>
</tr>
<tr>
<td>E14.3D</td>
<td>Vitreous haemorrhage in unspecified diabetes</td>
</tr>
<tr>
<td>E10.3H</td>
<td>Other disorders of optic nerve and visual pathways in insulin dep diabetes</td>
</tr>
<tr>
<td>E11.3H</td>
<td>Other disorders of optic nerve and visual pathways in non-insulin dep diabetes</td>
</tr>
<tr>
<td>E14.3H</td>
<td>Other disorders of optic nerve and visual pathways in unspecified diabetes</td>
</tr>
<tr>
<td>N18.9D</td>
<td>Anaemia in chronic renal failure</td>
</tr>
<tr>
<td>B65.1D</td>
<td>Other disorder of kidney/ureter in schistosomias due to S mansoni</td>
</tr>
<tr>
<td>B65.2D</td>
<td>Other disorder of kidney/ureter in schistosomias due to S japonicum</td>
</tr>
<tr>
<td>B65.3D</td>
<td>Other disorder of kidney/ureter in schistosomias due to cercarial dermatitis</td>
</tr>
<tr>
<td>B65.8D</td>
<td>Other disorder of kidney/ureter in schistosomias due to other schist</td>
</tr>
<tr>
<td>B65.9D</td>
<td>Other disorder of kidney/ureter in schistosomias due to schist unspec</td>
</tr>
<tr>
<td>M06.0D</td>
<td>Anemia in seronegative Rheumatoid Arthritis</td>
</tr>
<tr>
<td>M06.9D</td>
<td>Anemia in Rheumatoid Arthritis Unspecified</td>
</tr>
<tr>
<td>C34.9D</td>
<td>Eaton-Lambert syndrome in malignant neoplasm of bronchus or lung unspec</td>
</tr>
<tr>
<td>M32.1D</td>
<td>Lupus myocarditis</td>
</tr>
<tr>
<td>M24.26D</td>
<td>Polynoeyopathy in disorder of ligament (lower leg)</td>
</tr>
<tr>
<td>I50.1D</td>
<td>Pleural effusion in left ventricular failure</td>
</tr>
<tr>
<td>A41.9D</td>
<td>Pyelonephritis in septicemia</td>
</tr>
<tr>
<td>C34.0D</td>
<td>Malignant neoplasm of main bronchus with pleural effusion</td>
</tr>
<tr>
<td>C34.1D</td>
<td>Malignant neoplasm of upper lobe, bronchus or lung with pleural effusion</td>
</tr>
<tr>
<td>C34.2D</td>
<td>Malignant neoplasm of middle lobe, bronchus or lung with pleural effusion</td>
</tr>
<tr>
<td>C34.3D</td>
<td>Malignant neoplasm of lower lobe, bronchus or lung with pleural effusion</td>
</tr>
<tr>
<td>C34.8D</td>
<td>Overlapping lesion of bronchus and lung with pleural effusion</td>
</tr>
<tr>
<td>C78.0D</td>
<td>Secondary malignant neoplasm of lung with pleural effusion</td>
</tr>
<tr>
<td>C85.1D</td>
<td>B-cell lymphoma, unspecified with pleural effusion</td>
</tr>
<tr>
<td>C85.7D</td>
<td>Other specified types of non-Hodgkin's lymphoma with pleural effusion</td>
</tr>
<tr>
<td>A41.8D</td>
<td>Acute pyelonephritis secondary to septicemia due to E coli</td>
</tr>
<tr>
<td>C50.9D</td>
<td>Malignant neoplasm of breast, unspecified with pleural effusion</td>
</tr>
<tr>
<td>Code</td>
<td>ICD-10</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>C50.8D J91.XA</td>
<td>Malignant neoplasm of overlapping lesion of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.6D J91.XA</td>
<td>Malignant neoplasm of axillary tail of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.5D J91.XA</td>
<td>Malignant neoplasm of lower-outer quadrant of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.4D J91.XA</td>
<td>Malignant neoplasm of upper-outer quadrant of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.3D J91.XA</td>
<td>Malignant neoplasm of lower-inner quadrant of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.2D J91.XA</td>
<td>Malignant neoplasm of upper-inner quadrant of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.1D J91.XA</td>
<td>Malignant neoplasm of central portion of breast with pleural effusion</td>
</tr>
<tr>
<td>C50.0D J91.XA</td>
<td>Malignant neoplasm of nipple and areola with pleural effusion</td>
</tr>
<tr>
<td>A41.5D N16.0A</td>
<td>Renal tubulo interstitial disorders in septicaemia due to other gram-negative organisms</td>
</tr>
<tr>
<td>D59.3D G05.8A</td>
<td>Encephalitis resulting from haemolytic-uraemic syndrome</td>
</tr>
<tr>
<td>C45.0D J91.XA</td>
<td>Pleural effusion in mesothelioma of pleura</td>
</tr>
<tr>
<td>M32.1D J99.1A</td>
<td>Systemic Lupus Erythematosus with lung involvement</td>
</tr>
<tr>
<td>C90.0D M49.5A</td>
<td>Vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.50A</td>
<td>Multiple vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.51A</td>
<td>Occipito-atlanta-axial vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.52A</td>
<td>Cervical vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.53A</td>
<td>Cervicothoracic vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.54A</td>
<td>Thoracic vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.55A</td>
<td>Thoracolumbar vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.56A</td>
<td>Lumbar vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.57A</td>
<td>Lumbosacral vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.58A</td>
<td>Sacral and sacroccygeal vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>C90.0D M49.59A</td>
<td>Site unspecified vertebral collapse in multiple myeloma</td>
</tr>
<tr>
<td>D69.0D N08.2A</td>
<td>Glomerular disorder in Henoch (-Schonlein) purpura</td>
</tr>
<tr>
<td>C78.2D J91.XA</td>
<td>Pleural effusion in secondary malignant neoplasm of pleura</td>
</tr>
<tr>
<td>J18.9D J91.XA</td>
<td>Pneumonia with pleural effusion</td>
</tr>
<tr>
<td>C85.9D J91.XA</td>
<td>Non-Hodgkin's Lymphoma with pleural effusion</td>
</tr>
<tr>
<td>C34.9D J91.XA</td>
<td>Malignant neoplasm of the bronchus with pleural effusion</td>
</tr>
<tr>
<td>I50.0D J91.XA</td>
<td>Congestive heart failure with pleural effusion</td>
</tr>
</tbody>
</table>

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Dagger and asterisk coding
Clinical Coding Guidelines 1, 1996

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Diseases/diagnoses ‘with’ other conditions
Coding Guidelines No. 23, September 2008

When allocating codes for diseases occurring with another, care should be taken that the instructions in the index and the tabular are followed correctly. One of the principles of coding is to use the least number of codes to accurately describe the condition. Often the index will link two conditions together where they co-exist whether or not the link has been made by the clinician. This is shown by the index trail ‘with’.

Example 1;
Patient has laryngitis and flu.

Trail;
Laryngitis (acute) (edematous) (subglottic) (suppurative) (ulcerative) J04.0
- with
- - influenza, flu, or grippe (see also Influenza, with, respiratory manifestations) J11.1

Also;
Influenza (specific virus not identified) J11.1
- with
- - laryngitis J11.1

This leads the coder to use only J11.1, not J04.0 plus J11.1
The Tabular supports this with appropriate exclusions notes at both codes.

Example 2;
Patient admitted for treatment of renal sclerosis and has hypertension.

**Trail;**

**Sclerosis, sclerotic**
- renal N26
  - - with
  - - - hypertension (*see also* Hypertension, kidney) I12.9

**Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (primary) (systemic)** I10
  - with
  - - renal sclerosis (conditions in N26.-) (*see also* Hypertension, kidney) I12.9

Again, no need for two codes following the trail and the instructions in the Tabular.

Please note this is not the same as when clinicians make the link between two conditions e.g. diabetes and retinopathy. These are recorded as separate conditions unless the clinician states that one condition causes or is due to the other, in which case the index will lead the coder to a Dagger/Asterisk pair through the term ‘In (due to)’. These two terms are used interchangeably in ICD but for the purposes of ease of understanding, it is preferable to think of it as one condition due to the other and only where this is clearly indicated would the Dagger/Asterisk pair be selected.

**Drugs and Alcohol Poisoning**

*Coding Quarterly No. 3, May 1997*

If an overdose of drugs has been taken along with alcohol, code this to a poisoning by the drug and by the alcohol (see the ICD10 Clinical Coding Instruction Manual, page XIX-23).

If in addition the clinician mentions that the patient is drunk or alcohol dependent, a code from F10.- (Mental and behavioural disorders due to use of alcohol) should also be used.

**Eosinophilic Colitis**

*Coding Guidelines No. 25, April 2010*

It is difficult to access Eosinophilic Colitis via the ICD10 index. See below:

- **Colitis (acute) (catarrhal) (hemorrhagic) (presumed infectious)**
  (see also Enteritis, and note at category A09) A09

- At Enteritis there is no reference to ‘eosinophilic’.

- Eosinophilic gastritis is listed under *Gastroenteritis* - eosinophilic at K52.8
In order to reach Eosinophilic Colitis the coder should look up Gastroenteritis - eosinophilic K52.8

K52.8 in the tabular states Other specified noninfective gastroenteritis and colitis where there is an inclusion for ‘Eosinophilic gastritis or gastroenteritis’.

**Episiotomy and Tears SMR02 review 2000**

An Episiotomy and/or 1st/2nd tear is regarded as part of a normal delivery and does not need to be coded separately in the general clinical section. The Episiotomy/tear is entered as a hard code and O80.0 is entered in the general clinical section. If there is a tear of 3rd degree or more, in an otherwise normal delivery, this is coded in ICD10 in the general clinical section. In both cases, the normal delivery is entered as a hard code in the Mode of Delivery data item.

**Faecal Occult Blood Coding Guidelines No. 14, January 2004**

The question has arisen of whether faecal occult blood should be coded to:
R19.5 - Other faecal abnormalities or
K92.1 - Melaena

It has been decided that because the blood is ‘occult’ and ICD10 can’t measure the quantity of blood, a diagnosis of faecal occult blood should be coded to:
K92.1 - Melaena

**Geriatric Falls/ Off legs/ Off feet Coding Guidelines No. 5, January 2000**

If there is no further information available, the above terms should be coded in the following way:

Geriatric Falls - code R54.X Senility/Old age [no external chapter code required]
Off legs/off feet -code R26.8 Other and unspecified abnormalities of gait and mobility
Unsteadiness on feet NOS

If it is an emergency admission, Admission Type would be 36 - Patient non-injury.

However, if there is an injury, the injury and external cause should be coded first.

Example - bruised hip due to (geriatric) falls at home:

Codes S70.0 - Contusion of hip
W19.0 - Unspecified fall at home
If the patient is prone to falls, the code R54.X - Senility/Old age may be added.

In this case the Admission Type for an emergency admission would be 33 - Patient Injury - Home Accident.

**Haemorrhoids with Bleeding Coding Guidelines No.30, March 2012**

When haemorrhoids (piles) and per rectal bleeding is documented, coders must not assume that the bleeding is from the haemorrhoids unless explicitly stated as such by the clinician.

Where haemorrhoids are diagnosed and bleeding is documented without a link being made to the haemorrhoids, coders must follow the guidance published in the ICD10 Clinical Coding Instruction Manual Version 2.0 on page pXVIII-1 of the Symptoms chapter. Under the Chapter Structure and Principles this states that:

*Where a sign or symptom may be due to more than one condition, assign a code for the symptom.*

This will be in addition to any clear diagnosis that is made. For example

1. **Diagnosis of Bleeding Haemorrhoids**
   
   Trail
   Hemorrhoids
   - bleeding, prolapsed, strangulated or ulcerated NEC I84.8
   Code I84.8 Unspecified haemorrhoids with other complications

2. **Diagnosis of Haemorrhoids. Per rectal bleeding mentioned on Discharge Letter, and further investigations are planned to identify the source of the bleeding.**
   
   Trail
   Hemorrhoids I84.9
   Bleeding (see also Hemorrhage)
   Hemorrhage
   - gastrointestinal (tract) K92.2
   Code I84.9 Unspecified haemorrhoids without complication and K92.2
   Gastrointestinal haemorrhage, unspecified

3. **Diagnosis of Haemorrhoids. Per rectal bleeding mentioned on Discharge Letter, and no evidence of further investigations planned to identify the source of the bleeding.**
   
   The coder must clarify with the clinician what has caused the bleeding, but if this is not possible or the clinician is unable to identify the cause of the bleeding then code as follows:
   
   Trail
   Hemorrhoids I84.9
   Bleeding (see also Hemorrhage)
   Hemorrhage
Scottish Clinical Coding Standards   July 2014

- gastrointestinal (tract) K92.2
Code I84.9 Unspecified haemorrhoids without complication and K92.2
Gastrointestinal haemorrhage, unspecified.

Helicobacter Infection
Coding Quarterly No. 1, November 1996

In the Coding Guidelines issued in May 1996, the code recommended for helicobacter infection was A48.8. Following continuing discussion at the NHS Centre for Coding and Classification (NHSCCC), the decision was taken that the most appropriate code for an acute helicobacter infection is A04.8, Other specified bacterial intestinal infections.

Note: The use of B96.8, where helicobacter is associated with a disorder, remains the same as described in the May publication.

Helicobacter pylori infection
Clinical Coding Guidelines 1, 1996

Helicobacter pylori is a bacterium which can be found in the mucus lining the oesophagus, stomach and duodenum. It is believed to be hazardous to health and may contribute to a chronic condition, such as gastritis or peptic ulcer disease. The way some of these conditions are coded are given below:

1) **Helicobacter infection**
   A48.8 Other specified bacterial diseases

2) **Helicobacter associated chronic superficial gastritis**
   K29.3 Chronic superficial gastritis
   B96.8 Other specified bacterial agents as the cause of diseases classified to other chapters

3) **Helicobacter associated peptic ulceration**
   K27.9 Peptic ulcer, site unspecified
   B96.8 Other specified bacterial agents as the cause of diseases classified to other chapters
Helicobacter Infection  
Coding Quarterly No. 1, November 1996

In the Coding Guidelines issued in May 1996, the code recommended for helicobacter infection was A48.8. Following continuing discussion at the NHS Centre for Coding and Classification (NHSCCC), the decision was taken that the most appropriate code for an acute helicobacter infection is A04.8, Other specified bacterial intestinal infections.

Note: The use of B96.8, where helicobacter is associated with a disorder, remains the same as described in the May publication.

History of TCC bladder  
Coding Guidelines No. 12, September 2002

Further to our advice in Coding Guidelines 8 (February 2001) to code Transitional Cell Carcinoma (TCC) of the bladder to D41.4 - Neoplasm of uncertain or unknown behaviour of bladder, coders should note that history of TCC may now be coded to Z86.0 - Personal History of other neoplasm’s or Z85.5 - Personal History of malignant neoplasm of urinary tract, depending on histological information with Z86.0 being the default code if histology is not available.

Holiday Relief Care  
Coding Guidelines No. 6, June 2000

Patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.

Example: Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.

Code: Z75.5 - Holiday relief care  
G35.X - Multiple sclerosis

If on the other hand, a patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay, the code Z75.5 should be assigned a secondary position.

Example: Patient with multiple sclerosis admitted for 2 weeks to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 2 days.

Code: J22.X - Chest Infection  
G35.X - Multiple sclerosis
Z75.5 - Holiday relief care

Sometimes a patient is pre-booked for holiday relief care, but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and should be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.

**Example:** Patient booked for 2 weeks holiday admission - consultant decides that the patient will have a course of physiotherapy for his multiple sclerosis.

Code:  G35.X - Multiple sclerosis  
Z50.1- Other physical therapy  
Z75.5 - Holiday relief care

It is important that the casenotes are referenced thoroughly in order to reflect each patient’s care on each admission

These guidelines apply to SMR01 coding and to SMR04 and SMR50 coding on discharge. It is not necessary to code Z75.5 on admission for SMR04 or SMR50 as this can be hard coded under Admission Reason/ Status on Admission.

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**Holiday Relief Care (Respite care) Coding on SMR04**  
**Coding Guidelines No. 29, October 2011**

SMR04 will no longer have an indicator for ‘Informal — holiday/respite’ in the Status on Admission field from 01/04/2011 (optional) and 01/10/2011 (mandatory).

Coders are reminded that patients are frequently admitted for holiday relief care (respite care) to enable the carers to have a break. It is essential that the recording rules for respite care be followed to ensure that the information can be correctly analysed.

The field Admission Reason should have the code 5B — Respite/holiday care entered. Whilst this is an Optional field, it is strongly recommended that sites complete this in the case of a respite admission.

Clinical codes should be entered as per examples below:

**Situation A.** If the patient is having only the care and attention that would normally be given at home by the carer then the code Z75.5 should be assigned in primary position, followed by the chronic condition of the patient.

**Example:** Patient with dementia in Parkinson’s disease admitted for a week to allow the carer to take a holiday. No additional treatment other than that normally given at home was required.
Admission diagnoses codes (if completing):
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

Discharge diagnoses codes:
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

Situation B. A patient is given care for another condition acquired while in hospital and this condition alters the expected length of stay. The code Z75.5 should be assigned a secondary position.

Example: Patient with dementia in Parkinson’s disease admitted for a week to allow the carer to take a holiday. While in hospital, the patient developed a chest infection which was treated. This extended the expected length of stay by 5 days.

Admission diagnoses codes (if completing):
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

Discharge diagnoses codes:
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease
J22.X — Unspecified acute lower respiratory infection (chest infection)
Z75.5 — Holiday relief care

Situation C. Sometimes a patient is pre-booked for holiday relief care, but the clinician decides that on this occasion the patient should have additional treatment or reassessment for their condition, for example, adjustment to drug routine or physiotherapy. On these occasions the patient is not being admitted primarily for holiday relief care but for treatment of their condition and should be coded accordingly. It should be emphasised that these additional treatments must be over and above those that they normally receive at home.

Example: Patient with dementia in Parkinson’s disease is booked for a week’s holiday admission — consultant decides that the patient will have a course of physiotherapy to help with problems related to their condition.

Admission diagnoses codes (if completing):
Z75.5 — Holiday relief care
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease

Discharge diagnoses codes:
G20.XD — Parkinson’s disease
F02.3A — Dementia in Parkinson’s disease
Z50.1 — Other physical therapy
Z75.5 — Holiday relief care

It is important that the case notes are referenced thoroughly in order to reflect the patient’s care on each admission.

Coding Guidelines No. 6, June 2000 also gave instruction on holiday relief/respite care coding. For SMR04, this guideline supersedes Coding Guidelines No. 6. The removal of the ‘Informal – holiday/respite’ as an option in Status on Admission makes it essential that coders completing SMR04s follow this new guidance.

Hospital acquired infections (HAI)
Coding Guidelines No. 17, January 2006

There is much publicity and concern about hospital acquired infection, and tackling infections is a priority within the NHS. The dictionary definition for nosocomial is ‘pertaining to or originating in the hospital’

If the record states a diagnosis of a hospital-acquired infection, there is a specific external cause code for nosocomial conditions within the ICD10 classification.

If confirmed, the nosocomial code:

Y95 – Nosocomial condition would be assigned as an additional code following the type of infection.

For example: MRSA infection, clinician confirms hospital acquired. Code:

A49.0 – Staphylococcal infection, unspecified
Y95.X – Nosocomial condition
Human Papillomavirus (HPV) Coding Guidelines No.28 March 2011

Human papillomaviruses (HPV) can affect the skin and moist membranes which line parts of the body such as the anus, cervix and the lining of the mouth and throat. There are over 100 different strains of HPV which can be transmitted through direct skin contact.
The virus can cause warts, verrucas and can develop into cancer of the cervix.

When coding HPV, there is only one trail available; Papillomavirus, as cause of disease classified elsewhere B97.7

This code can be used where there is another disease classified to an ICD10 Chapter other than Chapter I – e.g. seborrhoeic verruca due to HPV;
L82.X – Seborrhoeic keratosis
B97.7 - Papillomavirus as the cause of diseases classified to other chapters

Where the manifestation of HPV is stated to be ‘anogenital warts’ or ‘viral warts’, only the appropriate Chapter I code should be recorded;
A63.0 – Anogenital (venereal) warts
or
B07.X – Viral warts.

However, where the statement is ‘HPV infection’, with no manifestation, coders should record this as:
A63.8 – Other specified predominantly sexually transmitted diseases.
As there is no evident index trail to reach this code, coders are advised to write an entry in the index to direct them to A63.8 when there is only a statement of ‘HPV infection’.

Cervical Intraepithelial Neoplasia (CIN) III clinically stated to be ‘HPV+ve’ should be coded
D06.9 Carcinoma in situ of cervix, unspecified
B97.7 - Papillomavirus as cause of diseases classified to other chapters

This follows clinical advice, which regards “CIN III HPV +ve” as a special case. This guidance is in contrast to the usual, current practice when coding other “infectious organism +ve” statements without an explicit statement of causation (see ‘Test results and their use in SMR01 coding’ Coding Guidelines No. 20, June 2007 etc.).
Human papillomavirus (HPV). Amendment to previous Coding Guideline.
Scottish Clinical Coding Standards No.1 March 2013

Human papillomavirus infection, with no manifestation, should be coded to B34.4, Papovavirus infection, unspecified and not A63.8 Other specified predominantly sexually transmitted diseases, as previously advised in Coding Guidelines No.28 March 2011. Coders are advised to amend their ICD10 Index accordingly.

ICD10 Additions and amendments
Coding Guidelines No. 15, November 2004

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.

ICD10 Additions and amendments
Coding Guidelines No. 14, January 2004

The World Health Organisation has issued corrigenda to the index and introduced ten new ICD10 codes.
ISD have instructed that these new codes and amendments should be implemented from April 1st 2004.
The reference files will be updated with the new codes just prior to April 1st 2004.
Trusts should ensure that all staff referencing ICD10 are either supplied with new books (Vols I and III) or are provided with the information to amend their current volumes.
The files are available from the WHO web site; www.who.int/whosis/icd10/corr-eng.htm
ICD10 code for Burkitt’s Cell Leukaemia
Coding Guidelines No. 14, January 2004

The index (Volume 3) of ICD10, page 79, gives the code C91.0 for Burkitt’s Cell Leukaemia whereas the Morphology code listing in the tabular list (Volume 1), Page 1203, gives the code C91.7. This error has been reported to the NHSIA in England and they will raise it with the WHO in 2004. Until a decision is forthcoming, code Burkitt’s Cell Leukaemia to C91.7.

ICD10 Index Coding Quarterly No. 2, February 1997

The following amendments to the ICD10 Index have been approved by the WHO

p 224   Fever
    - persistent (of unknown origin) R50.1 (amend code from R50.8)

p249   Grand mal
    - epilepsy (idiopathic) G40.6 (amend code from G40.3)

p270   Hydatid
    - Morgagni’s
       - male Q55.4 (amend code from Q55.8)

p361   Mucocele
    - lacrimal sac H04.4 (amend code from H04.6)

p469   Pyrexia (of unknown origin)
    - persistent R50.1 (amend code from R50.8)

p526   Syphilis, syphilitic
    - neuritis
       - acoustic A52.1 † H94.0* (amend code from G94.0*)

You should also add the following to your index:

Effusion
    - pleural
    - - malignant C78.2

Paresthesia R20.2
ICD10 index amendments  Coding Guidelines No. 5, January 2000

The following ICD10 index errors have been noted:-

a) p 457

Presentation, fetal
- face (mother) O32.3
- - causing obstructed labor O64.2
- - to pubes O32.8 (amended from O32.3)

– see Face to pubes presentation Coding Guidelines Jan 2006

b) Table of drugs and chemicals p 695

Meningococcal vaccine adverse effect amend to Y58.9 (from Y59.8)

Please amend your ICD10 Index.

Infections  Coding Guidelines No. 17, January 2006

Coders have difficulty when coding certain bacterial infections as to whether they should code to the infection or carrier status. The same expression can lead to different coding for different bacteria eg Helicobacter positive indicates a Helicobacter infection whereas MRSA positive would be coded to the carrier status.

Below is a table with some of the more common infections and the expressions coders may be given. Where there are blanks, the expression is not applicable to that infection.

<table>
<thead>
<tr>
<th></th>
<th>+ve</th>
<th>Colonised with</th>
<th>Present in nasal swab</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td></td>
<td>Carrier Z22.3</td>
<td></td>
</tr>
<tr>
<td>Helicobacter</td>
<td></td>
<td>Infection A04.8</td>
<td></td>
</tr>
<tr>
<td>Strep B</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
</tr>
<tr>
<td>HepB</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td></td>
</tr>
<tr>
<td>Hep C</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td></td>
</tr>
<tr>
<td>VRE</td>
<td>Carrier Z22.3</td>
<td>Carrier Z22.3</td>
<td></td>
</tr>
</tbody>
</table>

Coders should not make any assumptions of the current status of a patient who has had a bacterial infection at some time in the past. Current laboratory reports should always be consulted.
Inflammatory bowel disease/inflammation bowel
Coding Guidelines No. 25, April 2010

Inflammatory bowel disease is an umbrella term that includes both Crohn’s disease and ulcerative colitis. Without further information, the term “inflammatory bowel disease” is non-specific and can only be coded to K52.9

Noninfective gastroenteritis and colitis, unspecified.

Index trail: Inflammation - intestine (any part) - see Enteritis

Enteritis – noninfective K52.9

It would clearly be preferable for “inflammatory bowel disease” to be coded more specifically in K50 or K51. Coders are therefore advised to consult with the clinician responsible for the patient’s care to obtain more specific information wherever possible rather than using the default code K52.9, given above.

Laceration Coding Guidelines No. 16, August 2005

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.

Left Ventricular Dysfunction Coding Guidelines No. 2, January 1999

This condition should be coded to I50.1 Left Ventricular Failure.

Leg Ulcer with infection; change to guidance
Coding Guidelines No. 26, October 2010

In Coding Guidelines No.17 January 2006, guidance was published regarding the coding of leg ulcer with infection. The guidance should now read:

If a diagnosis of leg ulcer with infection is given, code the leg ulcer, L97.X, followed by the code L08.9 Local infection of skin and subcutaneous tissue, unspecified and, if the infection is known, an appropriate code from B95.- to B97.-.

Examples:

Leg ulcer with MRSA infection. Code:
Scottish Clinical Coding Standards  July 2014

L97.X - Ulcer of lower limb, not elsewhere classified
L08.9 - Local infection of skin and subcutaneous tissue, unspecified
B95.6 - Staphylococcus aureus as the cause of diseases classified to other chapters
U80.1 – Methicillin resistant agent

Leg ulcer with infection. Code:
L97.X - Ulcer of lower limb, not elsewhere classified
L08.9 - Local infection of skin and subcutaneous tissue, unspecified

This will bring us into line with coding in England.

Leg Ulcer with Infection
Coding Guidelines No. 17, January 2006

If a diagnosis of leg ulcer with infection is given and the infection is known, an appropriate code from B95.- to B97.- should be added to the code for the ulcer. However if infection has been mentioned without stating the organism causing it, coders should add the following code to the code for leg ulcer:
L08.9 - Other specified local infection of skin and subcutaneous tissue

Examples:

1. Leg ulcer with MRSA infection. Code:
L97.X - Ulcer of lower limb, not elsewhere classified
B95.6 - Staphylococcus aureus as the cause of diseases classified to other chapters

2. Leg ulcer with infection. Code:
L97.X - Ulcer of lower limb, not elsewhere classified
L08.9 - Other specified local infection of skin and subcutaneous tissue

Lewy Body Dementia / Syndrome / Disease
Coding Guidelines No. 2, January 1999

Previously it had been agreed that as Lewy Body Dementia/Syndrome/Disease could only be detected pathologically in the brain after death then the conditions prior to death, e.g. Parkinson’s disease, Alzheimer’s disease or Dementia should be coded. More recently it has been found that Lewy Body Dementia/Syndrome/Disease can be diagnosed in a live person.

The Clinical Coding Review Panel (UK) have agreed the following codes for Lewy Body Dementia/Syndrome/Disease:
Long QT Syndrome
Coding Guidelines No. 29, October 2011

Long QT Syndrome is a disorder of the electrical system of the heart that triggers the heartbeat, and regulates the muscle contractions that pump the body’s blood. Long QT syndrome results from a delay in conduction of electrical impulses through the heart.

The appropriate ICD-10 code to assign for Long QT Syndrome is:

I45.8 Other specified conduction disorders

Malignant pleural effusion CG No.8 Feb. 2001

CODING QUARTERLY No. 1 November 1996 - page 4

Malignant pleural effusion

Please erase this previous article - and code to the following guidelines:

Usually, a malignant pleural effusion will indicate secondaries in the pleura, but not necessarily. It would also be possible to have a malignant pleural effusion accompanying a primary mesothelioma of the pleura, in which case it would not be appropriate to use:
C78.2 - Secondary malignant neoplasm of pleura.
(C78.2 should only be used when there are secondaries in the pleura)

When coding malignant pleural effusion -
code the primary site …. and add D (Dagger)
(if primary site unknown C80.X D)
plus J91.X A (Asterisk) (Pleural effusion in conditions classified elsewhere)

Please note that if the resulting dagger/asterisk pair has not been set up on the reference files it will be necessary to contact the Coding Advisory Service.

Note:- remember to amend any notes you may have made to ICD10 volumes

THIS CHANGE SHOULD BE IMPLEMENTED FROM 1ST APRIL 2001.
Malignant pleural effusion CQ No.1 Nov. 1996

The code for malignant pleural effusion is C78.2, Secondary malignant neoplasm of pleura. A code for the primary malignancy must also be recorded. Where the site of the primary is not known, use code C80.X, Malignant neoplasm without specification of site.

Mandatory 5th Characters in Chapter XIII
Coding Guidelines No. 7, November 2000

Please remember that it is mandatory to add a 5th character to codes in Chapter XIII Diseases of the musculoskeletal system and connective tissue (M00 - M99) wherever the category instructs:

[See site code pages ...............]

So a diagnosis of Arthritis where no site was specified should be coded to M13.99.

The only exception to this rule is where the site is already incorporated in the code description e.g. Trigger finger which may be coded to M65.3 without adding a fifth character.

MGUS (Monoclonal Gammopathy of Undetermined Significance)
Coding Guidelines No. 15, November 2004

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.

‘Mifepristone - Prostaglandin’
Coding Guidelines No. 8, February 2001

In order to identify those patients who have been given the abortifacent drug Mifepristone (RU486) from the group who are admitted for termination with treatment given as oral Prostaglandin (possibly following previous administration of Mifepristone), it is necessary to change/update previous instructions as follows:-

Coding Quarterly No. 3, May 1997 - page 5 (ICD10 section)
Termination of Pregnancy using Mifepristone (RU486)
Scenario B
Operation Section:
Prostaglandin administered orally - no procedure code is required
Add the following diagnostic code to the above termination code:
(Remains as) - Z51.2 - Other chemotherapy

Mild Cognitive Impairment
Coding Guidelines No. 10, December 2001

When coding the statement "mild cognitive impairment" the coder must clarify with the clinician the underlying cause of the impairment. If the clinician is unable to confirm the cause of the impairment, as a last resort the coder can use F06.7 Mild Cognitive Disorder to record this diagnosis. Coders should note the following trail:

Disorder
- cognitive
-- mild F06.7

Missed abortions Coding Guidelines No. 26, October 2010

1. A woman with a missed abortion is given oral Mifepristone and discharged home prior to 1. aborting the fetus.

Code to O02.1 + Z30.3

2. A woman with a missed abortion is given oral Mifepristone, aborts the fetus and is then 2. discharged.

Code to O02.1 + Z30.3

N.B. If the woman is given oral prostaglandin the code Z51.2 should be used in place of Z30.3.

The above guidance is being issued to add to that already published on Abortion coding in Coding Guidelines No.22, March 2008.

MRSA (Methicillin resistant staphylococcus aureus)
Coding Guidelines No. 24, October 2009

MRSA 5th Digits

The MRSA Steering Group and the CCRG have decided that there is no further requirement to code 5th digits for MRSA. Information about MRSA is collected at source and is collated and reported nationally (Scotland) by Health Protection Scotland (HPS).
The codes to which this applies are as follows:

- A41.0 - Septicaemia due to staphylococcus aureus
- A49.0 - Staphylococcal infection, unspecified
- B95.6 - Staphylococcus aureus as the cause of diseases classified to other chapters
- G00.3 - Staphylococcal meningitis
- J15.2 - Pneumonia due to staphylococcus
- L00.X - Staphylococcal scalded skin syndrome
- P23.2 - Congenital pneumonia due to staphylococcus
- P36.2 - Sepsis of newborn due to staphylococcus aureus
- Z22.3 - Carrier of other specified bacterial diseases (includes MRSA carrier)

This applies to all discharges on and after 1st October 2009.

**MRSA Codes CG No. 20 June 2007**

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

**MRSA CG No. 19 Sept. 2006**

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.

**MRSA (Methicillin resistant staphylococcus aureus)**

MRSA infection takes various forms. It is usually found in wound infections, but may be present as septicaemia, other generalised infection or a patient may be a carrier of MRSA. These situations are all coded differently, and examples are given below:

1) **MRSA infection of surgical wound on abdomen**
   - T81.4 Infection following a procedure, not elsewhere classified
   - Y83.9 Surgical procedure, unspecified
   - B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters

2) **MRSA infection of traumatic wound**
   - T79.3 Post-traumatic wound infection, not elsewhere classified
   - X59.9 Unspecified accident
   - B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters
3) MRSA septicaemia  
   A41.0 Septicaemia due to Staphylococcus aureus

4) MRSA infection  
   A49.0 Staphylococcal infection, unspecified

5) MRSA positive/carrier  
   Z22.3 Carrier of other specified bacterial diseases

**Multi-organ failure Coding Quarterly No. 1, November 1996**

This diagnosis causes great difficulty to coders. When such a diagnosis is recorded, the clinician in charge should be asked to clarify the patients condition and state which organs have suffered failure, eg, heart failure and liver failure. Each organ failure should be coded separately. However, this information is not always available. Where it is not possible to find out the organs involved, the following rules should be applied:

- If the patient is alive at the end of the episode - use R69.X (Unknown and unspecified causes of morbidity)
- If the patient dies - use R99.X (Other ill-defined and unspecified causes of mortality)

**Necrotising fasciitis Coding Guidelines No. 17, January 2006**

The correct codes for necrotising fasciitis are:

- M72.5 – Fasciitis, not elsewhere classified (with 5th digit for site)
- R02.X – Gangrene, not elsewhere classified

If the infection causing the fasciitis is known, an appropriate supplementary code from B95.- to B97.- should be added.

**Obstructive Jaundice Coding Quarterly No. 6, April 1998**

The code for Obstructive Jaundice is currently under review by the WHO (World Health Organisation). Until further advised, use code:

- R17.X Jaundice, unspecified.
Old Myocardial Infarction - should it be coded in addition to any ischaemic heart disease?

It has been decided that if old MI is listed in the clinical statement then it should be coded in addition to any ischaemic heart disease, as this gives a fuller picture.

Coders must therefore amend their Clinical Coding Instruction Manual p IX-19 exercise no 9.

Chronic Coronary Insufficiency; Old Myocardial Infarction
The correct codes are I25.8 and I25.2

Open Wound With Infection  Coding Guidelines No. 11, April 2002

The Training Manual specifically says that ‘open wound with infection’ is given the same code as ‘open wound’ (p XIX-3). However it is now felt that valuable information is being lost as an open wound with infection has more clinical consequences and resource implications compared to one, which has no infection. If the particular infection is identified, there is no problem, as an additional code from B95 to B97 should also be added.

However if no infection has been stated and it is not possible to add such a code, coders should add code T79.3 to the open wound code.

Examples

1. Staphylococcus aureus infection of open wound of finger, caused by contact with sharp glass:
   code to
   S61.0 – Open wound of finger(s) without damage to nail
   W25.9 – Contact with sharp glass, place unspecified
   B95.6 – Staphylococcus aureus as the cause of diseases classified to other chapters

2. Infection of open wound of finger caused by contact with sharp glass:
   code to
   S61.0 – Open wound of finger(s) without damage to nail
   T79.3 – Post-traumatic wound infection, not elsewhere classified
   W25.9 – Contact with sharp glass, place unspecified

Coders should amend their Training manuals.
This advice applies whether the infection is in the same episode or a subsequent episode of care and will take effect from 1st April 2002.
The ICD-10 Alphabetical Index assumes that an oesophageal web is a congenital condition and classifies this at code Q39.4 Oesophageal web. However, an oesophageal web can be either congenital or acquired, with the latter being more common. It has been agreed that the correct ICD-10 classification codes for oesophageal web are as follows:

• Oesophageal web stated in the patient clinical record as congenital must be classified at Q39.4 Oesophageal web.

• Oesophageal web stated in the patient clinical record as acquired must be classified at K22.2 Oesophageal obstruction.

• Oesophageal web which is not specified in the patient clinical record as either congenital or acquired must be classified at K22.2 Oesophageal obstruction.

 Coders should amend the entry for oesophageal web on Page 565 of their ICD10 Index as follows;
 Web, webbed
  -- esophagus K22.2
  -- congenital Q39.4

‘OTHER CONDITIONS’ CODING on SMR01
Coding Guidelines No. 21, November 2007

Coding Departments should have received a letter (dated 20th September 2007) concerning the following guideline.

This guideline falls into two parts. The first deals with the coding of comorbidities, the second deals with the use of some common and important Z codes.

Comorbidities in SMR01 ‘Other Conditions’ coding

Reasons for revised guidance.
There is considerable demand for SMR01-derived information on comorbidities from clinicians, researchers and from health service planners at hospital, NHS board and national level. Since the previous guideline (Coding Guidelines 3, June 1999) ISD have carried out two national quality assurance exercises on SMR01 data. Despite areas of good practice these surveys show an under-recording of comorbidities nationally. Some of this under-recording is due to inadequate information reaching coders. It is impossible to offer exhaustive rules to cover every case. This guidance is intended to assist coders’ decision-making when coding comorbidities, to help ensure
more consistent recording across Scotland and to inform those responsible for supplying information to coders.

**What is a comorbidity?**
A comorbidity is a disease or condition which exists alongside another disease. Comorbidities are recorded as SMR01 ‘Other Conditions’ (diagnoses 2 – 6). Not all codes recorded in ‘Other Conditions’ represent comorbidities – e.g. Z codes and external cause codes – although in coding the terms ‘Other Conditions’ and ‘comorbidities’ are often used interchangeably. In the SMR01 context, a comorbidity is:

- a disease or condition (other than the main diagnosis) which is clinically identified as a currently active problem, requiring significant investigation or management, during the admission being coded
- a disease or condition (often long-standing) which is present but is not clinically identified as a major factor in the admission i.e. it does not require anything more than routine management, such as the continuance of the patient’s normal drug regime. We can call this a background comorbidity.

This is an artificial division. For any one patient, a particular disease could be an active problem - or even the main diagnosis - in one admission and a background comorbidity in another. However it can be useful to think about comorbidities in this way when coding. If a condition is present and is described as ‘acute’ it is unlikely that it could be regarded as a background comorbidity.

**Active problems**
Coders will be familiar with coding the active problems relevant to an SMR01 episode. To do this they rely on the clinical information which they receive to identify health problems which were significant during the admission. Some examples of cases with active problems which should be coded as comorbidities are:

- a patient admitted with an acute MI develops left ventricular failure during the admission. Code the left ventricular failure as a comorbidity
- a patient admitted with abdominal pain and vomiting is diagnosed as having alcoholic pancreatitis. He is also found to have a chest infection which is treated by an antibiotic. The antibiotic causes a rash. Code the chest infection and the rash as comorbidities.

A current symptom which is not attributable to a confirmed diagnosis may also be codable as an active problem if it is managed or investigated during an admission. ISD recognise that the selection and coding of such symptoms (while avoiding the over-coding of symptoms attributable to known diagnoses) can depend on the coder’s experience if the available clinical information is not completely clear. One useful guide is that if during the admission the responsible clinician decides to refer the patient for investigation of the symptom, then it should be coded.

In some cases what might seem to be an active problem does not require coding:

- a patient is admitted to Dermatology for treatment of psoriasis. The clinical notes record that during admission the patient suffered some diarrhoea. However this apparently required no treatment or investigation and is not mentioned on the discharge summary – do not code the diarrhoea.

**Applicability - all of the patient’s active problems should be recorded in both inpatient and daycase SMR01 episodes**
Background comorbidities
When any comorbidities which are active problems have been coded, the background comorbidities which are present should be recorded if space permits. These will often be long-standing conditions which do not usually resolve spontaneously, such as diabetes or ischaemic heart disease. A new list of diseases and conditions has been developed to assist coders in coding these comorbidities.

Applicability - background comorbidities from the list should be recorded in inpatient SMR01 episodes whenever applicable and where space permits. It is not necessary to record background comorbidities in day case SMR01 episodes, although this may be done if space permits and the information is required for local use.

Comorbidities list (see the summary list below)
This has been developed with clinical advice. The list comprises 1127 codes from 232 ICD10 categories arranged in 25 groups. It has been derived from published comorbidity indices, the listed conditions having substantial prognostic significance (see references). This list is designed to assist the coder in several ways:

- it is a clear statement of a minimum requirement for the coding of background comorbidities
- the groups have been prioritised, to aid decision making
- diseases and conditions are often mentioned on discharge summaries or in clinical notes under the heading ‘Past Medical History’ (PMH). Some of the listed groups have been highlighted to indicate that the diseases and conditions in the group are usually long-standing. If a disease or condition from a highlighted group is referred to as ‘Past Medical History’ it should be regarded as being present and coded as such, except in individual cases where the available clinical information offers clear reason to do otherwise.

References:

‘Measuring potentially avoidable hospital readmissions’

Using the list
A disease or condition in the list should always be recorded in inpatient episodes when it is present as a comorbidity and when space permits. The priorities can be used in cases where the coder must choose what to code and what to miss out because the free ‘Other Conditions’ space is limited. ‘Priority 8’ is the highest priority, ‘priority 1’ the lowest. When space is limited:

- a listed comorbidity should be recorded in preference to an unlisted one
- a comorbidity from a higher priority group should be recorded in preference to one with a lower priority.

Some common diseases and conditions e.g. osteoarthritis, are not listed because they have a smaller impact on prognosis than the listed conditions. They may be coded as background comorbidities if space permits after any active problems and any listed comorbidities have been recorded.
Information on the discharge summary
Coding decisions made under the guidance above must sometimes be modified by clinical information recorded on the discharge summary. For example this can happen when the discharge summary mentions a disease or condition which is relevant to the specialty of admission but is not itself the subject of significant treatment or investigation (i.e. it would not be coded as an active problem) and is either listed with low priority or is not listed at all, as in the two cases following:

- the discharge summary of a patient admitted to Renal Medicine with a main diagnosis of renal failure also mentions chronic glomerulonephritis (N03, priority 2)
- the discharge summary of an Ophthalmology patient with a main diagnosis of cataract states that she suffers from age-related macular degeneration, which is not listed.

In these examples the chronic glomerulonephritis and the macular degeneration should be recorded. Then other applicable comorbidities can be recorded according to the above guidance.

Comorbidities - summary list
<table>
<thead>
<tr>
<th>priority</th>
<th>comorbidity group</th>
<th>ICD10 code range</th>
<th>Long-standing</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 HIGH</td>
<td>Solid Metastases</td>
<td>C77 - C79</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chronic Pulmonary Disorders</td>
<td>J40X - J67, J684, J701, J703</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>Heart Failure / Cardiomyopathy</td>
<td>I110, I130, I132, I42 - I43*, I50, I517</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Malignancies</td>
<td>C00 - C76, C80X - C97X</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Circulation Disorders</td>
<td>I27 - I28</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Peripheral Vascular Disease</td>
<td>I70 - I71, I73, I790*, I792*, K551 - K559</td>
<td>yes</td>
</tr>
<tr>
<td>6</td>
<td>AIDS / HIV</td>
<td>B20 - B24X</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Cerebrovascular Disease</td>
<td>I65 - I69</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Ischaemic Heart Disease</td>
<td>I20, I25</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Diabetes</td>
<td>E10 - E14</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Liver Disease</td>
<td>B18, I85, I864, I982*, K70 - K76</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hypertension, Complicated</td>
<td>I119, I12, I131, I139, I15</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Cardiac Arrhythmias</td>
<td>I44 - I45, I47 - I49</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Dementia</td>
<td>F00* - F03X, G30</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Obesity</td>
<td>E66</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Valvular Heart Disease</td>
<td>I05 - I08, I34 - I39*, Q23</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Coagulopathy</td>
<td>D66 - D69</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Drug/Alcohol Abuse</td>
<td>F10 - F19</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hemiplegia / Paraplegia</td>
<td>G80 - G83</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Other Neurological Disorders</td>
<td>G10 - G13*, G31 - G40</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Renal Disease</td>
<td>N03, N05, N11 - N12X, N18 - N19X, N25</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Nutritional Anaemia</td>
<td>D50 - D53</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Hypertension, Uncomplicated</td>
<td>I10X</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Psychoses</td>
<td>F20 - F29X, F31</td>
<td></td>
</tr>
<tr>
<td>1 LOW</td>
<td>Malnutrition / Weight Loss</td>
<td>E40X - E46X, R634, R64X</td>
<td></td>
</tr>
</tbody>
</table>

Note:

7) The listed diseases and conditions must be recorded in inpatient SMR01 episodes when they are present as comorbidities and where coding space permits.

8) The listed diseases and conditions need not be recorded as comorbidities in day case SMR01 episodes unless they represent active problems. They may be recorded as background comorbidities in day case episodes if space permits and the information is required for local purposes.

9) When applicable, diseases and conditions from the groups highlighted as ‘long-standing’ should be recorded as being present even if mentioned as ‘past medical history’. In individual cases specific clinical information that a highlighted disease or condition is no longer present may override this requirement.

10) ‘Priority 8’ is the highest priority group, ‘priority 1’ is the lowest.
11) Sequencing of sequelae or dagger/asterisk pairs must override questions of priority e.g. when coding hemiplegia due to stroke, G81 (priority 2) must be
sequenced before I69 (priority 6), or when coding diabetic angiopathy, E10 – E14D (priority 5) must be sequenced before I792A (priority 7).

12) This list may be augmented in future.

Use of ‘Z’ codes
This document is for guidance of when to use codes from the ICD10 chapter – ‘Factors influencing health status and contact with health services’. It is not meant to be exhaustive, but concentrates on the codes that have been identified as being poorly recorded in the past.

As a general rule, where any of the factors are mentioned on the Discharge Summary, then they should be coded against the episode.

Whilst primarily concentrating on the use of these codes on SMR01s, where space allows and information is available, coders should also consider the use of these codes on other SMRs.

Persons encountering health services for examination and investigation. Z00 – Z13
Z03.- Medical observation and evaluation for suspected diseases and conditions
Z04.- Examination and observation for other reasons

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, Z03.- and Z04.- should be used when there is a reason (e.g. symptoms, history) for suspecting that the patient may have a condition but after a period of observation there is found to be no condition present.

Examples:

<table>
<thead>
<tr>
<th>a)</th>
<th>child found with empty medicine bottle</th>
<th>Z03.6</th>
<th>Observation for suspected toxic effect from ingested substance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>b)</td>
<td>a patient was kept in hospital overnight with a minor condition (eg. superficial head injury) which would not normally warrant an overnight stay</td>
<td>S00.9</td>
<td>Superficial injury of head, part unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X59.9</td>
<td>Accident NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z04.3</td>
<td>Examination and observation following other accident</td>
</tr>
</tbody>
</table>

Z08.- Follow-up examination after treatment for malignant neoplasm
Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms
The above codes have specific rules regarding sequencing, dependant upon other findings during the episode.

Z11.- Special screening examination for infectious and parasitic diseases
Z13.- Special screening examination for other diseases and disorders
Screening examination codes - should be used for elective admissions in main position where the patient currently has no symptoms of a disease but there is reason to suspect they may develop it e.g. strong family history of the disease. This code should be omitted if evidence of the disease is found.

Persons with potential health hazards related to communicable diseases Z20 – Z29

Z22.- Carrier of infectious disease
Where the patient has been identified as a carrier or ‘positive’ in this episode. There are 5th digits to identify time of diagnosis for Carrier of MRSA (included in Z22.3). See Coding Guideline (No.19) September 2006 for further information.

Z29.0 Isolation. This code should always be recorded if it has been necessary to isolate the patient

Persons encountering health services in circumstances related to reproduction Z30 – Z39

Z30.3 Menstrual extraction
Use in conjunction with O04.- to highlight drug used in interception of pregnancy.
Z36.- Antenatal screening.
For use on SMR02s to highlight reason for admission.

Persons encountering health services for specific procedures and health care Z40 – Z54
This block contains many ‘Z’ codes that may be used in the primary position, reflecting the main reason for admission, e.g. Patient admitted for change of colostomy ; Z43.3 – Attention to colostomy.

Convalescence – Z54.- These code are normally in a secondary or subsequent position to indicate continuing care for a condition, but may be valid as Main Condition. Please refer to Coding Quarterly (No.2) February 1997 for further information.

Persons with potential health hazards related to socioeconomic and psychosocial circumstances Z55 – Z65
Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode in the patient’s record.

Z60.2 Living alone
Record where this factor has affected the patient’s length of stay.

Persons encountering health services in other circumstances Z70 – Z76
Codes from this block are considered ‘additional information’ and should rarely appear as ‘Main Condition’. Only use where the clinician has clearly stated the circumstances within this episode of the patient’s record.

Z74.- Problems related to care-provider dependency
Z75.- Problems related to medical facilities and other health care
Record where the factor has affected the patient’s length of stay.
Particularly important is Z75.1 – Person awaiting admission to adequate facility elsewhere.
Z75.5 – Holiday relief care. This code has its own rules.
Please refer to Coding Guideline (No. 6) June 2000 for further information.

Persons with potential health hazards related to family and personal history and certain conditions influencing health status Z80 – Z99
Codes from this block are considered ‘additional information’ and should never appear as ‘Main Condition’, with the exception of Z85.6 - Personal history of leukaemia, where the leukaemia is in remission.

Z80 – Z84 Family history of diseases.
These should be coded if patients are being investigated/treated for suspected cancers, IHD, mental illness etc. Follow the notes against each category to select the appropriate code.

Z85.- Personal history of malignant neoplasm
Only code if relevant to the patient’s current condition;
- If the patient is suspected of having or has been diagnosed with cancer in another part of the body.
- If the patient is admitted with a problem in the part of the body previously affected by cancer.

Z86 - Z87 Personal history of other diseases and conditions.
Only assign if relevant to the patient’s current condition e.g. patient has right-sided weakness and had a previous TIA. PH codes should not be added when the patient is treated for a recurrence of the same disease.

Z90.1 Acquired absence of breast
Record if the patient is admitted with a problem in the remaining breast.

Z92.2 Personal History of long-term (current) use of other medicaments
It is NOT necessary to use this code where a corresponding condition has been recorded e.g. where asthma has been recorded, no need to add long term use of Ventolin.

Z95.- Presence of cardiac and vascular implants and grafts
Record where the patient is in for any investigation or treatment of heart or vascular problems and has had previous cardiac surgery.

Z96.6 Presence of orthopaedic joint implants
It is NOT necessary to record this where patient is in for revision surgery on the same joint or for treatment of a complication of the implant but should be used for continuing care after joint implant surgery or if having an implant on any other joint.

Many of the ‘Z’ codes have their own particular rules for recording e.g. Personal History codes with codes for Follow-up Examinations, Procedures Not Carried Out, Continuing Care, etc. Rules should be followed for all.

When adding ‘Z’ codes to reflect additional information, true co-morbidities should take priority with the exception of ‘Z’ codes which indicate the length of stay has been affected e.g. Z75.1 – Person awaiting admission to adequate facility elsewhere.

This guidance applies to all discharges on and after 1st October 2007.

**Passive Smoking** Coding Guidelines No. 14, January 2004

There is no appropriate code within ICD10 that specifically identifies a patient who has a condition aggravated by passive smoking. The UK Coding Review Panel (CRP) has agreed that at present the code Z58.8 – Other problems related to physical environment can be used as an additional code.

**Definition of Perinatal Period** Coding Guidelines No. 5, January 2000

From 1st April 2000 the following definitions will apply:-

For morbidity coding the Perinatal Period applies to disorders manifesting or originating in the first 7 days of life (i.e. ends at 7 completed days after birth)

Neonatal Period commences at birth and ends 28 completed days after birth.

Please notice that this will be an amendment to the ICD10 Training Manual, Chapter XVI page 1.
Unconfirmed conditions are recorded in the source document (case notes or discharge summary) using various terms. This makes coding the conditions very difficult. The table below covers terms dealt with in previous editions of Coding Guidelines plus two new additions, “likely” and “suggestive of”.

<table>
<thead>
<tr>
<th>Term</th>
<th>How to code</th>
<th>Coding Guideline Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible, suspected, query, ?</td>
<td>Code symptom(s)</td>
<td>CG 1 May 1996</td>
</tr>
<tr>
<td>Probable</td>
<td>Code the condition</td>
<td>CG 1 May 1996</td>
</tr>
<tr>
<td>Presumptive</td>
<td>Code the condition</td>
<td>CQ 5 January 1998</td>
</tr>
<tr>
<td>Consistent with, compatible with, in keeping with</td>
<td>Code the condition</td>
<td>CG 15 November 2004</td>
</tr>
<tr>
<td>Impression of</td>
<td>Code the symptom(s)</td>
<td>CG 23 September 2008</td>
</tr>
<tr>
<td>Likely</td>
<td>Code the condition</td>
<td>CG 24 October 2009</td>
</tr>
<tr>
<td>Suggestive of</td>
<td>Code the symptom(s)</td>
<td>CG 24 October 2009</td>
</tr>
</tbody>
</table>

**Presumptive Diagnoses Coding Quarterly No. 5, January 1998**

In the "Clinical Coding Guidelines" of May, 1996, guidelines were given about the coding of terms "probable", "possible", "suspected" or "query".

We have been asked about the term "presumptive" and have decided that it should be treated in the same way as "probable" i.e. if the clinician who provided the information cannot be contacted in an attempt to confirm the diagnosis, code the condition.

Example -
Presumptive asthma - code asthma

**Preterm delivery O60.X SMR02 Review 2010**

This is a delivery before 37 completed weeks of gestation. It is not necessary to use this code in Scotland, as the information regarding gestation is collected elsewhere. Where no other relevant obstetric condition exists, in a delivery episode, the main condition must be recorded as O80.0 – Spontaneous vertex delivery.
Primary pulmonary hypertension
Coding Guidelines No. 17, January 2006

Primary pulmonary hypertension is a rare and lethal condition that typically affects young women but can affect others. The clinician should record "Primary pulmonary hypertension" as the diagnosis. Unless the word "Primary" is included in the description the condition is unlikely to be Primary pulmonary hypertension.

Secondary pulmonary hypertension is not uncommon. It complicates a range of diseases, most commonly chronic lung disease such as emphysema, chronic bronchitis or chronic obstructive airways disease (COAD). Less often it occurs as a complication of congenital heart disease. Because it is not uncommon, clinicians may record secondary pulmonary hypertension simply as "pulmonary hypertension". "Pulmonary hypertension" should not be recorded as "Primary pulmonary hypertension" without clarification from the clinician preparing the discharge summary.

Prostatic intraepithelial neoplasia, grade III (PIN III)/High grade glandular intraepithelial neoplasia of the prostate (HGIN)
Coding Guidelines No. 17, January 2006

Carcinoma-in-situ of the prostate has generally been replaced by the expression 'high grade intraepithelia neoplasia of the prostate’. The correct ICD10 code to assign for this diagnosis is D07.5 – Carcinoma in situ prostate.

In cases where there is a system of grading intraepithelial neoplasia (eg cervix, vulva and vagina), all high grade or grade III descriptions are classified as in-situ neoplasms.

Grade I and grade II prostatic intraepithelial neoplasia should be coded to:

N42.8 – Other specified disorders of prostate

Raised PSA Coding Guidelines No. 8, February 2001

Some coders are having difficulty with coding raised PSA (Prostate Specific Antigen) where no specific diagnosis has been made after tests. Raised PSA is an abnormal immunological finding in serum, and so should be coded to:

R76.8 - Other specified abnormal immunological findings in serum
Rhabdomyolysis - Index amendment
Coding Guidelines No. 24, October 2009

Rhabdomyolysis is a breakdown of skeletal muscle tissue and may be caused by physical, chemical or biological factors. The code assignment for rhabdomyolysis will depend on the cause of the muscle cell damage.
The World Health Organisation (WHO) has ratified the addition of ‘Rhabdomyolysis (idiopathic) NEC’ to the alphabetical index (ICD-10 Volume 3).
Please annotate the index as follows:
Rhabdomyolysis (idiopathic) NEC M62.8
- traumatic T79.6
Thus rhabdomyolysis, unspecified further or without a known cause, must be coded to M62.8 Other specified disorders of muscle. Traumatic rhabdomyolysis must be coded to T79.6 Traumatic ischaemia of muscle.
Rhabdomyolysis results in the protein myoglobin being released from the damaged muscle cells into tissue fluid and blood. This may result in damage to the kidneys, ranging from myoglobinuria to acute renal failure or nephritis. Renal problems due to non-traumatic rhabdomyolysis should be coded in addition to the rhabdomyolysis.
Renal failure due to traumatic rhabdomyolysis follows the index trail:
Failure, failed
- renal
- - following
- - - crushing T79.5
Leading to the Tabular List entry:
T79.5 Traumatic anuria
Crush syndrome
Renal failure following crushing.

Rhabdomyolysis Coding Quarterly No. 4, September 1997

Although this was indexed in ICD9, there is no entry for rhabdomyolysis in ICD10.
The correct code is:
M62.89 - Other specified disorders of muscle

Secondary pulmonary hypertension Coding Guidelines No. 19, September 2006

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

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This code applies no matter what condition the pulmonary hypertension is secondary to.

**Sequelae Codes**  **Coding Quarterly No. 2, February 1997**

Sometimes a condition or disease has been caused by another disease which is no longer present. One is said to be the sequelae (late effect) of the other. For example, deafness may be a sequelae of meningitis; therefore a diagnosis of deafness as a late effect of meningitis would be coded to -

- H91.9 Deafness NOS
- G09.X Sequelae of inflammatory diseases of central nervous system

Sequelae codes should never be used in main condition, but always as a supplementary code to the current problem. These guidelines are given in the Clinical Coding Instruction Manual. Any sequelae diagnosis with no further information e.g. ‘Old CVA’, needs to be referred back to the clinician for further information on the current problem.

**Sinus Bradycardia and Tachycardia**  **Coding Guidelines No. 16, August 2005**

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). Please see further update on Coding Guidelines No. 23, September 2008.

**Tabular List (Volume 1) p 492 - 493**

<table>
<thead>
<tr>
<th>Modify excludes note and add exclusion terms</th>
<th>I47 Paroxysmal tachycardia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Excludes:</strong> tachycardia: NOS (R00.0)</td>
</tr>
<tr>
<td></td>
<td>• NOS (R00.0)</td>
</tr>
<tr>
<td></td>
<td>• sinoauricular NOS (R00.0)</td>
</tr>
<tr>
<td></td>
<td>• sinus [sinusal] NOS (R00.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modify excludes note and add exclusion terms</th>
<th>I49 Other cardiac arrhythmias</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Excludes:</strong> bradycardia: NOS (R00.1)</td>
</tr>
<tr>
<td>Index (Volume 3) p76</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Delete non-essential modifier</td>
<td>Bradycardia (any type) (sinoatrial) (sinus) (vagal) R00.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Index (Volume 3) p499</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revise code</td>
</tr>
<tr>
<td>Revise code</td>
</tr>
<tr>
<td>Add subterm and code</td>
</tr>
</tbody>
</table>

The implementation date for this in Scotland will be 1st October, 2005

**Sinus tachycardia Coding Guidelines No. 23, September 2008**

Following the article on Sinus bradycardia and Tachycardia in Coding Guidelines No.16, August 2005, it has come to our attention that the World Health Organisation has made further changes to the ICD10 Index relating to sinus tachycardia. Please make the following amendments to your ICD10 Volume 3 Alphabetical Index as confirmed by the Coding Review Panel (UK) and the Clinical Coding Review Group (Scotland).

| Revise code | Tachycardia R00.0 - sinoauricular I47.1 R00.0 |
| Add subterm and code | Tachycardia R00.0 - sinoauricular R00.0 -- paroxysmal I47.1 |
| Revise code | Tachycardia R00.0 - sinusal I47.1 R00.0 |
| Add subterm and code | Tachycardia R00.0 - sinusal R00.0 -- paroxysmal I47.1 |
Site of musculoskeletal involvement  
Coding Quarterly No. 6, April 1998

In the Musculoskeletal chapter p 628-629, 5th character subdivisions are given for site of involvement. Coders have difficulty when the site is specified as “arm” or “leg” without specifying “upper” or “lower”. In the majority of these cases it should be possible to find out which is more appropriate, but where this is not possible it has been decided to use:

- 3 for arm, nec
- 6 for leg, nec

SMR02 v SMR02D  
Coding Guidelines No. 14, January 2004

Following some queries on the correct circumstances for ‘BBAs’ (Born Before Arrivals), please note the following extract from the SMR Data Manual;

“Home Births, whether planned or unexpected should be recorded on an SMR02D form.
An SMR02D form should be completed for;
- a planned home delivery with no hospital admission
- an unplanned home delivery with no hospital admission
- a planned home delivery when, following the birth of the baby, the mother is admitted to hospital. (whilst an SMR02D return should be submitted to record the home birth, the hospital should record the mother’s admission as a postnatal episode on an SMR02)

Please note that when the mother unexpectedly delivers her baby at home, and is then admitted to hospital, an SMR02 return should be completed by the hospital detailing that the patient delivered before arrival. No SMR02D return is required. “

Termination of pregnancy using Mifepristone (RU486)  
Coding Quarterly No.3 May 1997

This drug, which is given orally, has a management plan spanning 48 hours. For SMR01 (or SMR02) completion, the following rules apply:

Initial Treatment: The drug Mifepristone (RU486) is usually given as an outpatient and therefore no SMR01 is required.

All patients are then provisionally booked in as day cases 48 hours later and the following conditions apply for completion of the SMR01 (or SMR02) for the subsequent episode.
A) Those who have aborted completely during the 48 hour period will not be admitted as a day case (they will be regarded as an outpatient) and no SMR01 (or SMR02) will be required.

B) The remainder who have not aborted completely will be admitted and will require an SMR01 (or SMR02). Some will have had bleeding and will require oral or vaginal prostaglandins during the day case admission.

Code as follows:

**Diagnostic Section:**

Main Condition

O04.1 Medical abortion, incomplete, complicated by delayed or excessive haemorrhage

**Operation Section:**

Prostaglandins administered orally — *no procedure code is required.*

Add the following diagnostic code to the above termination code:

Z51.2 Other chemotherapy

Prostaglandins given vaginally:

Q14.5 Insertion of prostaglandin pessary

Occasionally, patients will require evacuation of the uterus rather than prostaglandin treatment. The diagnoses should be coded as above (ie O04.1) but the main operation code should be selected from category Q11.- using the appropriate 4th-digit to indicate the method.

Q11.- Evacuation of uterus

(4th-digit as appropriate).

C) A few patients may require an additional admission for delayed bleeding some days later. Code as follows:

**Diagnostic Section:**

Main Condition

O08.1 Delayed or excessive haemorrhage following abortion ....

**Operation Section:**

The OPCS code to indicate the procedure used to manage the problem should be entered.
D) Finally, a small number of women do not abort after administration of the drug and have no symptoms such as bleeding. These patients are admitted for termination with the codes as follows:

**Diagnostic Section:**
Main Condition

O07.-Failed attempted abortion

**Operation Section:**
Appropriate OPCS code to indicate the procedure.

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**Transitional Cell Carcinoma Bladder**

*Coding Guidelines No. 8, February 2001*

Where no further information or histology is available for the term ‘Transitional Cell Carcinoma (TCC)’ of the bladder, coders are instructed to code ‘TCC’ to D41.4 Neoplasm of uncertain or unknown behaviour of bladder and not to continue following the index trail which leads to C67.9 Malignant neoplasm of bladder.

THIS CHANGE WILL BE IMPLEMENTED FROM 1ST APRIL 2001. PLEASE REMEMBER TO ALSO UPDATE INDEX (VOL. 3).

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**TCC (Transitional Cell Carcinoma of Bladder)**

*Coding Guidelines No. 14, January 2004*

Further to the article in Coding Guidelines No 8 (February 2001), it has been decided that coders should consult with medical staff to establish what they mean by Carcinoma Bladder and Cancer Bladder in the absence of further information.

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**Transitional Cell Carcinoma (TCC) Ureter and Renal Pelvis (not otherwise specified)**

*Coding Guidelines No. 15, November 2004*

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.

**WHO Amendments**  
**Coding Guidelines No. 10, December 2001**

It has been brought to our attention that in recent editions of the ICD10 publication, the corrigenda contains newly issued codes. If you have recently purchased a copy of ICD10 and these codes are included (this can be determined by comparing with an
original version), please do not use them until approved by CCRG when they will be issued for all to use through Coding Guidelines.

Contact

Please note that the Terminology Advisory Service Telephone Number is:

0131 275 7283

The number is manned Tuesday to Thursday from 09.00 to 17.00 hrs.

e-mail:

NSS.terminologyhelp@nhs.net

Website:

http://www.isdscotland.org/Products-and-Services/Terminology-Services/

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