Chronic Kidney Disease (CKD)

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 to assign the most appropriate single code for statements of CKD, renal impairment and renal failure, used alone or in combination.
<table>
<thead>
<tr>
<th>Clinical statement</th>
<th>CKD statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD statement</td>
<td>no statement of ‘CKD’</td>
</tr>
<tr>
<td>end stage renal failure or end stage renal disease</td>
<td>N18.0</td>
</tr>
<tr>
<td>chronic renal failure or chronic renal impairment</td>
<td>N18.9</td>
</tr>
<tr>
<td>renal failure or renal impairment</td>
<td>N19.X</td>
</tr>
<tr>
<td>no statement of ‘failure’ or ‘impairment’</td>
<td>-</td>
</tr>
</tbody>
</table>

1 In the clinical statement row headings, ‘kidney’ can replace ‘renal’ with no change in meaning or coding solution.
2 End 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.

**Periprosthetic fracture and dislocated joint prosthesis**

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*

**Mephedrone**

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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**Alcohol Excess**

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.

**Human Papillomavirus (HPV)**

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.).

**CODING GUIDELINES—OPCS4**

**Amendment to “O/Z” codes article in Coding Guidelines No. 26 October 2010.**

Please note that the code for Specified branch of external carotid artery is O12.8 not O12.3.

**Implementation of Latest Revision to the OPCS Classification of Interventions and Procedures OPCS Version 4.6**

As previously indicated, our colleagues in NHS England Connecting for Health, who are responsible for maintaining the operations and interventions classification, (OPCS4) have committed to an annual revision cycle, until such times as SNOMED CT becomes the preferred method of capturing this type of data.

The current version, OPCS v 4.5 has been implemented across acute sites in NHS Scotland and, in keeping with the NHS in England, ISD has made the decision to release the OPCS v 4.6 files in the March download of National Reference Files.

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**THE NEW CODES MUST BE USED WITH EFFECT FROM APRIL 1st 2011, FOR ALL DISCHARGES ON OR AFTER THAT DATE.**

Suppliers of the Medicode and Simplecode products have indicated that they will be providing the updated version of the software to support OPCS v 4.6, but sites using these products should contact their suppliers to ensure availability of the software within an acceptable time frame.

Version 4.6 has no structural changes and only around 140 new codes, plus some corrections and minor changes to text. We do not anticipate any requirement for additional training.

Clinical coding staff will need access to the revised OPCS v 4.6 books. These are available directly from The Stationery Office (TSO) at a cost of £39 per set plus postage and packaging, for NHS customers. There is no VAT payable. Details on how to order can be found on the Terminology Services website.

Should you have any questions regarding the implementation of OPCS v 4.6, please contact Liz Williamson on Lizwilliamson@nhs.net.

**SMR02 Review Update**

Following the publication of Coding Guideline No.27, October 2010 which recommended changes to the capture of some SMR02 data, a number of queries have arisen which require further clarification.

1. **Tears.** Coding Guideline No. 27—October 2010 stated that vaginal and cervical lacerations, where present, should be coded in the diagnostic section of SMR02 to O71.4 and O71.3 respectively.

   **CG 27 Item No. 6 Tears stated the following:**

   During the SMR02 Review, it was noted that there was an element of double coding and under-coding against this data item. It is hard-coded, but some sites were adding an ICD10 code where lacerations and tears were both recorded.

   Although the data item is ‘tears’ and the ICD10 index trail is also ‘tear’, in fact the description for O70.- is “Perineal laceration during delivery”. ‘Minor’ (i.e. cervical and vaginal) lacerations
are recorded under “Other obstetrical trauma” at O71.-. For this reason, perineal tears only are now recorded in the table.

Where vaginal and cervical lacerations are present, these should be coded in the diagnostic section using O71.4 and O71.3 respectively.

If there is only a vaginal or cervical laceration and no tear of perineum, record ‘0’ in the data item. See table below.

Please replace the above with the re-edited statement below:

During the SMR02 Review, it was noted that there was an element of double coding and under-coding against this data item. It is hard-coded, but some sites were adding an ICD10 code where lacerations and tears were both recorded.

Although the data item is ‘tears’ and the ICD10 index trail is also ‘tear’, in fact the description for O70.- is “Perineal laceration during delivery”. ‘Minor’ (i.e. cervical and vaginal) lacerations are recorded under “Other obstetrical trauma” at O71.- and these should be recorded in the clinical section, as noted below. For this reason, perineal tears only are now recorded in the table below.

O71.4—Obstetric high vaginal laceration alone should ONLY be coded in the clinical section where there is no tear of the perineum i.e. only code O71.4 where the code value of ‘0 – No’ has been recorded in the data item. Alternatively, if there is a high vaginal laceration and a tear of the perineum then coders should use codes 1,2,3,4 or 8 from the table below and NOT add an ICD10 code.

O71.3—Obstetric laceration of cervix CAN be recorded in the diagnostic section in addition to the code value of ‘0 – No’ being recorded in the data item and also, with code values 1,2,3,4 and 8. This is because tears 1 to 4 do not include laceration to the cervix in O70.- Perineal laceration during delivery. See table below.

**Codes and Values: Tear (Code order)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No (includes intact perineum and/or vaginal and cervical lacerations)</td>
</tr>
<tr>
<td>1</td>
<td>Tear 1 (1st Degree)</td>
</tr>
<tr>
<td>2</td>
<td>Tear 2 (2nd Degree)</td>
</tr>
<tr>
<td>3</td>
<td>Tear 3 (3rd Degree)</td>
</tr>
<tr>
<td>4</td>
<td>Tear 4 (4th Degree)</td>
</tr>
<tr>
<td>8</td>
<td>Unspecified tear</td>
</tr>
<tr>
<td>9</td>
<td>Not known if tear</td>
</tr>
</tbody>
</table>

2. **Anaemia.** 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.

3. **Mode of Delivery—Forceps.** Although ‘high cavity forceps’ should not be used in deliveries today, it is possible that they may be and there is currently no category to which these can be assigned. A Change Control has been requested and there will shortly be a value added to **Mode of Delivery** code E—Other forceps delivery (includes ‘high-cavity’, high forceps). Any instances of this should be recorded there. **N.B.** Please ensure that not only are reference files updated, but that any local tables mapped to the national reference files are also altered. This may need to be done in consultation with the PAS suppliers.
4. **Drugs and Alcohol use.** Although there are a few questions asked of the patients at booking, this does not always reflect their intake of drugs and alcohol during the whole pregnancy. If it is noted that the patient has been abusing or is an addict, this should continue to be recorded in the diagnostic conditions using the appropriate F10–F19 categories.

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**Please note that all the guidance given in this edition applies to discharges on and after 1st April 2011.**

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**General Information**

**ICD10 Books**

There are different versions of the Index and Tabular in use and it is difficult to verify the editions.

Please note that the latest version contains a large number of codes which have not yet been agreed by Connecting for Health or ISD. If you find that a code is being errored on local validation, please, in the first instance, check your previous tabular and if the code in question is not listed therein then it has not yet been approved.

**National Clinical Coding Qualification (NCCQ)**

Anyone wishing to sit the National Clinical Coding Qualification (NCCQ) in September 2011 should note that the closing date for registrations will be June 30th 2011. More information regarding the exam can be found on the website below:


It would be helpful if you could contact your Clinical Coding Tutor to let us know if you are intending to sit the exam, as we are not notified of candidates’ details by any other means.

**DQA News**

SMR01 QA is on hold until completion of the New Cancer Waiting Times QA.

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**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.

The link for previous coding guidelines online is: [www.isdscotland.org/terminology](http://www.isdscotland.org/terminology)