Coding Guidelines—ICD10

Haemorrhoids with Bleeding

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
  - gastrointestinal (tract) K92.2

Code I84.9 Unspecified haemorrhoids without complication and K92.2 Gastrointestinal haemorrhage, unspecified.

Rectal haemorrhage versus per rectal haemorrhage

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

This article is © Crown Copyright, 2012

Contains public sector information licensed under the Open Government Licence v1.0.

Undetermined Intent; Reminder re previous guidance

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’.
Coding Guidelines – OPCS4

Recording Bilateral Procedures

The format of SMR records means that when recording operations/procedures, only one supplementary (Y or Z) code or one ‘pair code’ can be recorded for each operation. Coders sometimes have enough information for more than one such code and are faced with a decision about which to omit. This can sometimes happen when coding bilateral operations.

An operation is coded as ‘bilateral’ when the same procedure (codable to the same code) is performed on the same site on each side of the body in the same theatre session. However the SMR format restrictions mean that it will not always be possible to record the supplementary code Z94.1 Bilateral operation because of the need to record a different supplementary code or a pair code.

Various solutions have been offered to enable coders to identify bilateral procedures when Z94.1 cannot be recorded, such as splitting the pair code or coding the procedure twice. However these solutions create problems in some analyses of SMR data. The Clinical Coding Review Group has now decided that in these circumstances the procedure should only be recorded once.

Examples

Bilateral myringotomy and insertion of grommets
D15.1 Myringotomy with insertion of ventilation tube through tympanic membrane + Z94.1 Bilateral operation
D15.1 includes both the myringotomy and the grommet insertion so Z94.1 can be used.

Patient has bilateral inguinal hernias.
Bilateral laparoscopic mesh repair of inguinal hernias.
T20.2 Primary repair of inguinal hernia using insert of prosthetic material + Y75.2 Laparoscopic approach to abdominal cavity NEC
In Scotland in OPCS, there is a general principle that where there is a conflict over selection of supplementary codes, the general rule is that a “Y” code takes precedence over a “Z” code except in Chapter W.
Please note that there are certain exceptions to this principle. Refer to the OPCS4 Clinical Coding Instruction Manual for further information.

Patient has bilateral distal radial fractures. Procedure performed was manipulation under anaesthetic and insertion of K-wires on both sides.
W24.8 Other specified closed reduction of fracture of bone and internal fixation + Z70.5 Lower end of radius NEC
Z94.1 has not been added to W24.8 because of the principle within Orthopaedic coding that the site of the bone/joint takes precedence over laterality.

Bilateral inguinal herniorrhaphy with release of strangulated colon.
T20.3 Primary repair of inguinal hernia using sutures + H17.5 Open relief of strangulation of colon
T20.3 with H17.5 is a pair code so laterality cannot be recorded.

Bilateral reconstruction of breasts and insertion of breast prostheses.
B29.9 Unspecified reconstruction of breast + B30.1 Insertion of prosthesis for breast
B29.9 with B30.1 is a pair code so laterality cannot be recorded.
Note that this guideline supersedes that on ‘Bilateral mastectomies with block dissection, sampling, excision or biopsy of lymph nodes’, Coding Guidelines No.15, November 2004 i.e. the code pair should no longer be split. Bilateral total mastectomies with bilateral block dissection of axillary lymph nodes will now be coded to B27.4 Total mastectomy NEC + T85.2 Block dissection of axillary lymph nodes.

The use of Y76.7 Arthroscopic approach to joint.

The previous guideline ‘Arthroscopic Procedures’ Coding Guidelines No. 20, June 2007 stated that Y76.7 should not be used in Scotland.

Since then a number of new, specific codes have been introduced (in OPCS4.5, April 2009) which have given rise to a number of requests to use Y76.7.

The Clinical Coding Review Group has agreed that Y76.7 may be used with the following list of codes when the relevant procedures are performed arthroscopically:

- W78.1 Release of Contracture of Shoulder Joint
- W78.2 Release of Contracture of Hip Joint
- W78.3 Release of Contracture of Knee Joint
- W78.5 Release of Contracture of Elbow Joint
- O27.2 Repair Capsule and Anterior and Posterior Labrum for Stabilisation of Glenohumeral Joint
- O27.3 Repair Capsule and Anterior Labrum for Stabilisation of Glenohumeral Joint
- O27.4 Repair Capsule and Posterior Labrum for Stabilisation of Glenohumeral Joint
- O29.1 Subacromial Decompression
- T79.1 Plastic Repair of Rotator Cuff of Shoulder NEC
- T79.3 Revisional Repair of Rotator Cuff NEC
- T79.4 Plastic Repair of Multiple Tears of Rotator Cuff of Shoulder
- T79.5 Revisional Repair of Multiple Tears of Rotator Cuff of Shoulder
- V21.8 Other specified operations on temporomandibular joint (for temporomandibular arthroscopy)

The use of Y76.7 with any of the above codes will of course prevent the recording of laterality. Y76.7 should not be used with any other codes. This list may be augmented in the future.

PLEASE NOTE THAT ALL NEW GUIDANCE IN THIS EDITION APPLIES TO ALL DISCHARGES ON AND AFTER 1ST APRIL 2012.
GENERAL INFORMATION

The National Clinical Coding Qualification

Anyone considering sitting the exam organised by IHRM and CfH from April 2012 onwards, needs to be aware that the ICD10 element of the exam will be based on ICD10 V4 (also known as the 2010 edition) which is not implemented in Scotland yet. Coders should still be able to answer questions following the Step by Step coding process but this does mean that anyone sitting the exam needs to ensure that they have these new books.

Please remember that all questions should be answered following the full English version of the Clinical Coding Instruction Manuals, both OPCS and ICD, and candidates need to ensure they have access to the most up to date version. Any questions regarding this, please contact your Coding Tutor or the Terminology Services Helpdesk.

Clinical Coding – Staff Survey

In June 2011, Terminology Services sent out a staff survey to Clinical Coding Departments in all Health Board areas.

The purpose of the questionnaire was to establish the customer base for clinical coding training and development and to help plan relevant training courses for the next 3 years.

We approached managers or supervisors in charge of staff who carry out clinical coding, either at board or hospital level.

We did not contact hospice coding staff, Read coding staff or clinical staff who code.

These will be contacted in a separate exercise.

Twenty six forms from eleven of the fourteen Health Board areas were returned, but five of the areas which did make returns were not complete.

Mainly, information on non acute hospital services was omitted from the returns.

In terms of training provided by ISD, all Health Board areas had accessed some of the clinical coding courses.

Boards identified future requirements as follows;
Introduction to ICD courses
Introduction to OPCS courses
Full ICD courses
Full OPCS courses
Refresher courses
Neoplasm workshops
Orthopaedic workshops
Maternity (SMR02) courses
Mental Health courses

In addition, we asked if there were any coding courses not provided by Terminology Services that the sites would like us to consider.

Subjects mentioned included;

Anatomy, Physiology and Terminology
Vascular
Neuroscience
We asked about the National Clinical Coding Qualification and from the replies received, we were informed that 16 clinical coding staff are ACC qualified, 7 have attempted the NCCQ and 25 say they are considering sitting it.

This information will help us to focus on providing training requirements for the clinical coding staff in the specific areas they require.

We will shortly be prioritising, planning and preparing new materials based on your feedback.

The Clinical Coding Tutors would like to thank everyone who completed and returned the forms to us. We appreciate the time you spent on helping us with this survey and your ideas and suggestions will be used to inform our service planning for 2012-15.

© National Services Scotland 2012. You can copy or reproduce the information in this document for use within NHSScotland and for non-commercial educational purposes. Use of this document for commercial purposes is permitted only with the written permission of NSS.

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/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines](http://www.isdscotland.org/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines)