CODING GUIDELINES—ICD10

Holiday Relief Care (Respite care) Coding on SMR04

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.

Long QT Syndrome
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

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Oesophageal Web
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

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**Coding Guidelines—OPCS4**

Amendment to “Aspiration of prosthetic joint” article in Coding Guidelines No.24 October 2009.

Please note that the ICD10 code for presence of artificial joint is Z96.6 not Z96.9.

**Transcatheter Aortic Valve Implantation (TAVI)**

Transcatheter aortic valve implantation (TAVI) is performed in patients with severe aortic stenosis. During TAVI the aortic valve may be accessed using several possible approaches.

These approaches include:

1. **Femoral approach**
2. **Direct aortic access**
3. **Subclavian (axillary)**
4. **Transapical (transventricular) approach**

With all of these approaches, a balloon catheter is advanced into the left ventricle and positioned within the opening of the aortic valve. The existing aortic valve is dilated in order to make room for the prosthetic valve. The new valve is moved into position and is either self-expanding or deployed using balloon inflation.

The following OPCS-4.6 codes have been agreed as the most appropriate available at present for the different approaches for TAVI:

**Femoral/direct aortic access/ subclavian (axillary) approach:**
K26.2 Xenograft replacement of aortic valve
Y79.- Approach to organ through artery
Haemorrhoidal artery ligation operation (HALO)

During a haemorrhoidal artery ligation operation (HALO), a doppler ultrasound is used to locate the arteries supplying blood to the haemorrhoids. Sutures are placed around the arteries, in order to cut off the blood source. As a result of the interrupted blood supply, the haemorrhoids begin to shrink and the symptoms resolve.

The codes to be recorded for this procedure are as follows:

- L70.3 Ligation of artery NEC
- Y53.2 Approach to organ under ultrasonic control

For analysis purposes, these codes do not specifically identify a HALO procedure for haemorrhoids but looked at in conjunction with an appropriate ICD10 code for haemorrhoids, the HALO procedure can be identified using the above OPCS4 codes.

Lipofilling Injections (Coleman Fat Transfer)

OPCS4.6 has introduced two new codes which have an impact on previously published advice in Coding Guidelines No. 26, October 2010 for Coleman Fat Transfer.

The two new codes are:

- B37.5 Lipofilling of breast and
- Y39.4 Lipofilling injection into organ NOC

The principles outlined in the article in 2010 regarding the coding of fat transfers still remain in force in that “the graft to and its site should take priority over the graft from”.

The two examples must now be coded as follows:

1. Patient is having a breast reconstruction by a transfer of fat taken from abdomen.
   - B37.5 Lipofilling of Breast + Z code for laterality
   - S62.2 Liposuction of subcutaneous tissue NEC + Z49.3 Skin of anterior trunk

2. Fat transfer from abdomen to cheek, using liposuction on the abdomen and injecting the fat into the cheek.
   - SS0.2 Injection of organic inert substance into subcutaneous tissue + Z47.3 Skin of cheek
   - S62.2 Liposuction of subcutaneous tissue NEC + Z49.3 Skin of anterior trunk

Proctoscopy

Further to the previously published guideline (Coding Quarterly No 5 January 1998) on how to code proctoscopy, OPCS4.6 has introduced a new code of H62.6 Proctoscopy, and the following guidance must now be followed by coders.

The CCRG has agreed that coders should continue to consider a proctoscope as a speculum rather than an endoscope and therefore the following coding guidance must be applied:

Where a proctoscopy has been carried out for diagnostic reasons and no other activity has occurred, the following code should be used:

- H62.6 Proctoscopy (other operations on bowel)
Where a proctoscopy has been carried out and a biopsy has been taken from the rectum, the trail is:

**Biopsy rectum peranal**
and the code to use is:
H41.2 Peranal excision of lesion of rectum.

Where therapeutic work is carried out using a proctoscope, code according to the detail provided. For example, where the clinical statement is:

**Polypectomy of rectum using proctoscope**
the index trail is:
**Excision rectum lesion peranal**
and the appropriate code is:
H41.2 Peranal excision of lesion of rectum

Where the clinical statement is:

**Sclerotherapy injection into haemorrhoids via proctoscope**
the index trail is:
**Sclerotherapy haemorrhoid**
and the appropriate code is:
H52.3 Injection of sclerosing substance into haemorrhoid.

### Pulmonary angiography and CTPA

OPCS4.6 has introduced a new code U35.4 Computed tomography of pulmonary arteries. This Guideline explains the two ways of performing a pulmonary angiogram, and how the coder must code the different methods.

1. Where there is no further qualification to the phrase “pulmonary angiography” coders can assume that this means advancing a catheter through a peripheral vein into the heart and out into the pulmonary arteries, directly injecting contrast material into the pulmonary arteries. This produces a high enough concentration of contrast in these arteries that it can be seen on a conventional X-ray, so CT is not needed to see the contrast. OPCS4 categorises this as a ‘percutaneous transluminal’ procedure, and so in these cases coders must use L13.3 Arteriography of pulmonary artery.

2. When the clinician has documented that a “CTPA” has been performed, coders can assume that CTPA means Computed Tomography Pulmonary Angiogram. This second method of visualising the pulmonary arteries involves injecting contrast into a peripheral vein. This contrast will in due course appear in the pulmonary arteries, but CT is required to visualise it because the contrast is only present in low concentrations as it is not injected directly into the pulmonary arteries. This is not a ‘percutaneous transluminal’ procedure but a CT scan, and must be coded to U35.4 Computed tomography of pulmonary arteries.

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

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**General Information**

**New website address.**
Please note our website address is:
[www.isdscotland.org/Products-and-Services/Terminology-Services](http://www.isdscotland.org/Products-and-Services/Terminology-Services)
The DQA team has now completed half of the hospitals included in the 2010–2011 SMR01 QA. It is hoped that the Scotland report will be produced in the Spring of 2012. The DQA analyst, Sophie Houston, retired on 25th August and will be greatly missed by all in the team though we wish her a long and happy retirement.

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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/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines