

# **Scottish Clinical Coding Standards**

**OPCS-4  
Consolidation  
2014**

## **INTRODUCTION**

**This document has been compiled to enable coders to quickly identify guidance for OPCS still relevant to version 4.7. All discharges from 1<sup>st</sup> 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 1<sup>st</sup> April 2014.**

**The middle of the document contains guidance which still applies to OPCS-4.7. 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 OPCS-4.7 books or ebooks are updated to reflect ALL valid, new and amended guidance.**

OPCS4 Coding Guidelines

**OPCS4 Scottish Clinical Coding Standards/Coding Guidelines Cumulative Index 2014**

New and amended articles have all been highlighted in **YELLOW**.

Articles in **PINK** are obsolete.

Current standards are in **BLACK**.

**OPCS4 Coding Standards/Guidelines**

Article	OPCS version	SCCS/Coding Guideline/ Coding Quarterly No. and Date
<b>A</b>		
Abandoned and unintentional procedures	4.4	21 Nov 2007 20 June 2007
Abdominoplasty versus Apronectomy	4.4	22 March 2008
Abortifacient drugs at Outpatient departments, Administration of	4.4	22 March 2008
Abortions	4.2	SMR02 Review 2000
Administration of Abortifacient drugs at Outpatient departments	4.4	22 March 2008
Angiographies and angioplasties	4.2	16 Aug 2005 14 Jan 2004
Angioplasty and stenting of coronary artery	4.4/4.3	20 June 2007 19 Sept 2006
Angioplasty coronary with stent	4.2	11 April 2002
Anti D	4.2	CQ4 Sept 1997
Anti D	4.5	SMR02 review 2010
Anti D Administration	4.2	SMR02 Review 2000
Appendicocaecostomy	4.2	10 Dec 2001
Application of patches (Fentanyl, Qutenza)	4.6	SCCS3 Sept 2013
Approach to organ Y52	4.2	8 Feb 2001
Apronectomy versus Abdominoplasty	4.4	22 March 2008
Arterial stents, placement of (L76.-, L89.-)	4.3	18 May 2006
Arthroplasty following removal of internal fixation	4.4	21 Nov 2007
Arthroplasties/joint codes, Two stage revision	4.2	16 Aug 2005 15 Nov 2004

Arthroscopic approach to joint, the use of Y76.7	4.6	30 March 2012
Arthroscopic procedures	4.4	20 June 2007
Aspiration of prosthetic joint	4.5	24 Oct 2009
Aspiration of prosthetic joint; amendment to article in Coding Guidelines No.24 Oct. 2009	4.5	29 Oct 2011
Aspiration of prosthetic joint	4.7	NEW
<b>B</b>		
Banding of haemorrhoids with sigmoidoscopy and biopsy	4.5	24 Oct 2009
Bilateral Mastectomies	4.2	16 Aug 2005 15 Nov 2004
Bilateral procedures, recording of	4.6	30 March 2012
Blood transfusions and scopes	4.2	14 Jan 2004
(Blood transfusions): Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02	4.4	22 March 2008
Blood transfusions, scans, IV fluids, injections	4.2	13 Jan 2003
Bone Grafts	4.5	24 Oct 2009
Bone Marrow Transplants. Peripheral Stem Cell Procedures.	4.7	NEW
	4.6	31 Sept 2012
Botox Injections	4.5	24 Oct 2009
Botox injection into bladder, cystoscopic	4.5	25 April 2010
Bronchoscopies	4.5	25 April 2010
Bronchoscopy with biopsy and brushings (Bronchoscopies)	4.5	25 April 2010
Bronchoscopy with biopsy and washings ( Bronchoscopies)	4.5	25 April 2010
Bronchoscopy with biopsy, washings and brushings	4.2	9 July 2001
Bronchoscopy with washings and brushings	4.3 4.3 4.2	19 Sept 2006 18 May 2006 8 Feb 2001
Brushings for Cytology	4.2	CQ4 Sept 1997
Brushing of organ, OPCS4.4 Index error	4.4	21 Nov 2007
<b>C</b>		
Cadaver coding	4.2	CQ4 Sept 1997
Cardiopulmonary bypass	4.5	25 April 2010
Carpal tunnel release	4.2	14 Jan 2004
Catheterisation	4.2	SMR02 Review

		2000
Cervical studies	4.2	3 June 1999
Chemotherapy codes for neoplasm	4.3	18 May 2006
CLO test	4.2	9 July 2001
CLO test for helicobacter	4.2	CQ1 Nov 1996
Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02	4.4	22 March 2008
Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02. (Amendment to table in Article in CG 22 March 2008). Article entitled "Use of Radiotherapy codes X65, X67 and X68 in OPCS)	4.5	25 April 2010
Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02. <b>Addition of Obstetric Scanning, Assessment and Monitoring codes R36-R43 to table</b>	4.6	31 Sept 2012
Coding of Radiotherapy delivery	4.5	25 April 2010
Cold coagulation to cervix	4.2	CQ6 April 1998
Coleman fat transfer	4.5	26 Oct 2010
(Coleman Fat Transfer) Lipofilling injections	4.6	29 Oct 2011
Colonoscopy with biopsies	4.2	10 Dec 2001
Colonoscopies/sigmoidoscopies	4.2	15 Nov 2004
Colposcopy of cervix	4.2	2 Jan 1999
Colposcopy with Punch biopsy of the cervix (uteri)	4.6	31 Sept 2012
Combined VV ops	4.3	18 May 2006
Coronary angioplasty with stent	4.2	11 April 2002
Coronary artery, stenting of and angioplasty	4.4/4.3	20 June 2007 19 Sept 2006
CTPA and Pulmonary angiography	4.6	29 Oct 2011
Cystoscopic Botox injection into bladder	4.5	25 April 2010
<b>D</b>		
Dacron mesh keratoprotheses	4.2	4 Sept 1999
Dental cystectomy	4.2	16 Aug 2005
Dental procedures	4.3	18 May 2006
Diagnostic and Therapeutic procedures in same episode	4.2	7 Nov 2000
Diagnostic v Therapeutic procedures	4.2	3 June 1999

Diagnostic endoscopy where no biopsies taken	4.2	3 June 1999
Doppler/Duplex studies and intravascular ultrasound	4.2	10 Dec 2001
Doppler/Duplex studies and intravascular ultrasound (IVUS)	4.7	NEW
Dupuytren's release	4.2	5 Jan 2000
<b>E</b>		
ECG	4.2	9 July 2001
Endometrial procedures	4.2	8 Feb 2001
Endoscopic "balloon" ablation of endometrium	4.2	8 Feb 2001 2 Jan 1999
Endometrial procedures	4.7	NEW
Endoscopies with multiple biopsies	4.2	2 Jan 1999
Endoscopy diagnostic with no biopsies	4.2	3 June 1999
Epidural	4.2	SMR02 Review 2000
Eponym Jones (KG), index error	4.2	5 Jan 2000
Errata (OPCS4.3 books)	4.3	18 May 2006
Error index, eponym Jones (KG)	4.2	5 Jan 2000
Error OPCS4.4 index, brushing of organ	4.4	21 Nov 2007
Excision of lesion of skin	4.2	CQ6 April 1998
<b>F</b>		
F09 V F10 Surgical removal versus simple extraction of teeth	4.4	23 Sept 2008
Failed minimal access procedures, guidelines for coding	4.2	CQ7 Sept 1998
Failed trial without catheter (TWOC)	4.5	25 April 2010
Failed trial without catheter (TWOC)	4.7	NEW
Fentanyl/Qutenza patches, Application of	4.6	SCCS3 Sept 2013
Fentanyl patches (Short list of procedures SMR Data Manual)	4.2	7 Nov 2000
<b>G</b>		
Genital swab Q55.6	4.3	18 May 2006
Gestational age codes	4.3	18 May 2006
Golfer's/Tennis elbow surgery	4.4	21 Nov 2007
Grafts bone	4.5	24 Oct 2009
Guidelines for coding failed minimal access procedures in OPCS4	4.2	CQ7 Sept 1998
<b>H</b>		
HALO Haemorrhoidal artery ligation operation	4.6	29 Oct 2011

Haemorrhoidal artery ligation operation (HALO)	4.6	29 Oct 2011
Hard coded diagnostic and procedure fields on SMR02		27 Oct 2010
Hartmann's, Reversal of	4.2	5 Jan 2000
Hartmann's, Reversal of, amendment to previous guideline	4.4	22 March 2008
Hartmann's, Reversal of	4.7	NEW
HEAL – Hysteroscopic endometrial ablation – laser	4.7	NEW
	4.2	8 Feb. 2001 CQ6 April 1998
Hearing aid procedures, staged, D05.- D13.-	4.3	18 May 2006
Hearing aid procedures, staged, D05.- and D13.-	4.7	NEW
Hickman line insertion	4.2	CQ6 April 1998
High cost drug codes/drugs for chemotherapy	4.3	18 May 2006
Human fertilisation codes	4.2	10 Dec 2001 ICD10 Section
(Human fertilisation codes) IVF	4.3	18 May 2006
Hybrid hip replacement codes	4.4/4.3/4.2	20 June 2007 6 June 2000
Hynes	4.2	7 Nov 2000
Hysterectomies laparoscopic and associated procedures	4.7	NEW
Hysterectomy Laparoscopic	4.2	2 Jan 1999
Hysterectomy Laparoscopic/ Oophorectomy Laparoscopic	4.2	2 Jan 1999
Hysteroscopy and D&C	4.2	13 Jan 2003
<b>I</b>		
Ileo-anal pouch	4.2	6 June 2000
(Imaging, injections, infusions, X-rays etc.) Non-operative interventions/procedures on SMR01 and SMR02, coding of	4.4	22 March 2008
Implanon	4.4/4.3	20 June 2007
Implementation OPCS4.6	4.6	28 March 2011
Index error eponym Jones (KG)	4.2	5 Jan 2000
Injection into tendon sheath	4.5	24 Oct 2009
Injection sacroiliac joint	4.5	24 Oct 2009
Injection sacroiliac joint	4.7	NEW
Injections and infusions	4.2	CQ6 April 1998
Injections and Infusions	4.7	NEW
(Injections, infusions): Coding of	4.4	22 March 2008

“Non-operative” interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02		
Injections, scans, blood transfusions, IV fluids	4.2	13 Jan 2003
Insertion Reveal Loop Recorder	4.2	8 Feb 2001
Instrumented spinal fusions with decompression and bone graft	4.6	SCCS1 March 2013
Intermittent infusion of therapeutic substance (X28.-)	4.2	18 May 2006
Intravascular ultrasound/Doppler/Duplex studies	4.2	10 Dec 2001
Intravascular ultrasound (IVUS)/Doppler/Duplex studies	4.7	NEW
Irrigation of peritoneal cavity	4.2	CQ1 Nov 1996
IV antibiotics (Injections and infusions)	4.3/4.2	18 May 2006 16 Aug 2005 CQ6 April 1998
IV fluids	4.3/4.2	18 May 2006 13 Jan 2003
IV immunoglobulin	4.3	18 May 2006
(IVF) Human fertilisation codes	4.2	10 Dec 2001 ICD10 section
IVF codes	4.3	18 May 2006
<b>K</b>		
K-wire fixation	4.6	31 Sept 2012
<b>L</b>		
Laparoscopic hydrotubation (Amendment to Coding Update)	4.2	CQ2 Feb 1997
Laparoscopic hysterectomy	4.2	2 Jan 1999
Laparoscopic hysterectomy/ Laparoscopic oophorectomy	4.2	2 Jan 1999
Laparoscopic hysterectomies and associated procedures	4.7	NEW
Laparoscopically-assisted vaginal hysterectomy and Bilateral salpingoophorectomy	4.6	SCCS1 March 2013
Laparoscopy and dye test	4.2	17 Jan 2006
Laparotomy	4.2	CQ4 Sept 1997
Laterality codes	4.6	31 Sept 2012
Laryngopharyngectomy	4.5	26 Oct 2010
Level of spine, V55 codes	4.3	18 May 2006
Linton’s procedures	4.2	8 Feb 2001
Lipofilling injections (Coleman Fat Transfer)	4.6	29 Oct 2011
LLETZ/Loop diathermy of cervix	4.2	CQ1 Nov 1996



(Amendment to Coding Update)		
Loop Recorder Reveal, Insertion of	4.2	8 Feb 2001
Loop Recorder Reveal, Removal of	4.2	9 July 2001
<b>M</b>		
Metal-on-metal (MoM) hip resurfacing arthroplasty	4.2	13 Jan 2003
Microwave prostatectomy	4.2	6 April 1998
MMR vaccine	4.2	5 Jan 2000
MoM Metal-on-metal hip resurfacing arthroplasty	4.2	13 Jan 2003
Mosaicplasty	4.2	7 Nov 2000
Multiple endoscopic biopsies	4.2	2 Jan 1999
<b>N</b>		
Nebuliser	4.3	19 Sept 2006
Nerve blocks	4.2	4 Sept 1999
New pair codes	4.3	18 May 2006
“Non-operative” interventions/procedures (imaging, injections, infusions, X-rays, etc.), on SMR01 and SMR02, coding of	4.4	22 March 2008
Non-operative interventions	4.7	NEW
<b>O</b>		
One scope, two or more procedures	4.4	21 Nov 2007
One scope, two or more procedures; reminder	4.4	22 March 2008
One scope, two or more procedures – clarification of previous standard	4.7	SCCS5 March 2014
OPCS4.2 Index error eponym Jones (KG)	4.2	5 Jan 2000
OPCS4.4 Index error, brushing of organ	4.4	21 Nov 2007
OPCS4.6	4.6	25 April 2010
OPCS4.6 Implementation	4.6	28 March 2011
Oophorectomy laparoscopic/hysterectomy laparoscopic	4.2	2 Jan 1999
Outpatient attendances for termination of pregnancy	4.6	SCCS4 Feb 2014
O/Z codes	4.5	26 Oct 2010
O/Z codes; amendment to article in CG No. 26 Oct 2010	4.5	28 March 2011
<b>P</b>		
Pacemaker, testing of	4.3	18 May 2006
Pain relief code list	4.2	5 Jan 2000
Pair codes new	4.3	18 May 2006
Panendoscopies	4.2	10 Dec 2001

Patients request termination of pregnancy at outpatient clinic and return to ward to receive oral abortifacient drug (Mifepristone)	4.4	23 Sept 2008
PEG	4.3	18 May 2006
Pelvic region site	4.5	24 Oct 2009
Peripheral stem cell procedures	4.2	3 June 1999
Peripheral stem cell procedures: amendment to previous guidance	4.4	23 Sept 2008
Peripheral stem cell procedures: amendment to CG No.23 Sept 2008	4.5	24 Oct 2009
Peripheral stem cell procedures,(Bone Marrow Transplants).	4.6	NEW
	4.6	31 Sept 2012
Pharyngolaryngectomy (Amendment to Coding Update)	4.2	CQ1 Nov 1996
Pituitary excision and skull based reconstruction	4.7	SCCS5 March 2014
Placement of arterial stents (L76.-, L89.-)	4.3	18 May 2006
Plasmapheresis	4.7	NEW
Plasmapheresis	4.2	5 Jan 2000
Pre-assessment code for a kidney transplant (M17.-)	4.3	18 May 2006
Pre-auricular and post-auricular area	4.2	6 June 2000
Procedures mentioned on the discharge summary	4.3	18 May 2006
Procedures on intestinal pouches	4.4	20 June 2007
Proctoscopy	4.6/4.2	29 Oct 2011 CQ5 Jan 1998
Pulmonary angiography and CTPA	4.6	29 Oct 2011
<b>R</b>		
Radiotherapy	4.3	18 May 2006 25 April 2010
Radiotherapy Codes, Use of X65, X67 and X68 in OPCS	4.5	25 April 2010
Radiotherapy delivery, coding of	4.5	25 April 2010
Radiotherapy delivery	4.7	NEW
Rastelli	4.2	16 Aug 2005
Re-amputations	4.2	5 Jan 2000
Recording bilateral procedures	4.6	30 March 2012
Recording non-operations	4.2	CQ4 Sept 1997
Rehabilitation codes U50.- to U54.-	4.3	18 May 2006
Removal of Reveal Loop Recorder	4.2	9 July 2001
Respiratory support, etc. E85.- to E97.-	4.3	18 May 2006

Reveal Loop Recorder, Insertion of	4.2	8 Feb 2001
Reveal Loop Recorder, Removal of	4.2	9 July 2001
Reversal of Hartmann's	4.2	5 Jan 2000
Reversal of Hartmann's; amendment to previous guideline	4.4/4.2	22 March 2008
Reversal of Hartmann's	4.7	NEW
<b>S</b>		
Scans	4.3	19 Sept 2006 18 May 2006
Scans, blood transfusions, IV fluids, injections	4.2	13 Jan 2003
(Scans): Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02	4.4	22 March 2008
Scopes and blood transfusions	4.2	14 Jan 2004
Secondary reductions	4.7	NEW
	4.2	12 Sept 2002
Shoulder Surgery	4.7	NEW
	4.2	10 Dec 2001 5 Jan 2000
Site of spine	4.5	25 April 2010
Skin cleansing, sterilising, taping codes	4.3	18 May 2006
Skin grafts	4.2	8 Feb 2001
Skin "S" enhance codes (unlikely pair codes)	4.2	3 June 1999
Skin, sutures and debridement	4.2	16 Aug 2005
Skin test codes	4.3	18 May 2006
SMR00 operation codes	4.3	18 May 06
Snare resection of polyps from both sigmoid and rectum	4.2	12 Sept 2002 9 July 2001
Spine, site of	4.5	25 April 2010
Staged hearing aid procedures D05.- D13.-	4.3	18 May 2006
Staged hearing aid procedures D05.- and D13.-	4.7	NEW
Sterilisation	4.2	SMR02 Review 2000
Subcutaneous injections	4.2	5 Jan 2000
Summary of significant changes from OPCS4.3 to OPCS4.4	4.4	20 June 2007
Sutures and debridement	4.2	16 Aug 2005
<b>T</b>		
TAVI Transcatheter aortic valve	4.6	29 Oct 2011

implantation		
Tears	4.2	SMR02 Review 2000
Temporal bone excision	4.5	26 Oct 2010
Tennis/Golfer's elbow surgery	4.4	21 Nov 2007
Tension band wiring of a fracture of the patella	4.2	CQ5 Jan 1998
Tension-free Vaginal Tape procedure	4.2	5 Jan 2000
Termination (abortion)/miscarriage coding	4.6	SCCS4 Feb 2014
Termination of pregnancy, patients request at outpatient clinic, return to ward to receive oral abortifacient drug (Mifepristone)	4.4	23 Sept 2008
Termination of pregnancy using Mifepristone (RU486) pessary	4.2	CQ6 April 1998
Teeth, surgical removal versus simple extraction of, F09 V F10	4.4	23 Sept 2008
Testing of pacemaker	4.3	18 May 2006
The use of Y76.7 Arthroscopic approach to joint	4.6	30 March 2012
The use of Y76.7 Arthroscopic approach to joint (Revised 2012)	4.6	31 Sept 2012
Therapeutic and Diagnostic procedures in same episode	4.2	7 Nov 2000
Therapeutic v Diagnostic procedures	4.2	3 June 1999
Total Hip Replacement with Acetabular bone graft	4.6	31 Sept 2012
Total Hip Replacement with Acetabular bone graft: Updated coding standard	4.7	SCCS5 March 2014
Transcatheter aortic valve implantation (TAVI)	4.6	29 Oct 2011
Transthoracic Echocardiogram (TTE)	4.5	25 April 2010
Transvaginal drainage of ovarian cyst	4.2	10 Dec 2001
Trial without catheter, failed (TWOC)	4.5	25 April 2010
Trial without catheter, failed (TWOC)	4.7	NEW
TTE, Transthoracic Echocardiogram	4.5	25 April 2010
Two stage revision arthroplasties/joint codes	4.2	16 Aug 2005 15 Nov 2004
TWOC, failed trial without catheter	4.5	25 April 2010
TWOC, failed trial without catheter	4.7	NEW
<b>U</b>		
Unicondylar/Unicompartmental knee joint replacement	4.2	CQ6 April 1998
Unlikely pair codes ("S" enhance	4.2	3 June 1999

codes)		
Urethral catheterisation	4.6	31 Sept 2012
Use of codes X60-X62 and X66	4.3	18 May 2006
Use of C90 for local anaesthetic for ophthalmology procedures	4.3	18 May 2006
Use of Obstetric Scanning, Assessment and Monitoring Codes R36-R43. Addition to table in the article entitled "Coding of non-operative interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02" in CG No. 22 March 2008 and updated in CG No. 25 April 2010.	4.6	31 Sept 2012
Use of Radiotherapy Codes, X65, X67 and X68 in OPCS	4.5	25 April 2010
<b>V</b>		
V55 codes to record the level of spine	4.3	18 May 2006
<b>W</b>		
<b>X</b>		
(X-rays): Coding of "Non-operative" interventions/procedures (imaging, injections, infusions, X-rays, etc) on SMR01 and SMR02	4.4	22 March 2008
X65, X67 and X68, Use of Radiotherapy codes in OPCS	4.5	25 April 2010
<b>Y</b>		
Y52 approach to organ	4.2	8 Feb 2001
Y76.7, Arthroscopic approach to joint, the use of	4.6	30 March 2012
Y76.7, Arthroscopic approach to joint, the use of (Revised 2012)	4.6	31 Sept 2012
<b>General Information Section</b>		
Accident and Emergency, recording activity in, on inpatient episodes		24 Oct 2009
Accidental cuts/perforations during procedures		SCCS 5 March 2014
Alcohol in pregnancy		SCCS5 March 2014
Clinical Coding – Staff survey		30 March 2012
Codes for central returns		17 Jan 2006
Definition of a delivery		9 July 2001
ICD10 Books		28 March 2011

National Clinical Coding Qualification (NCCQ)		28 March 2011
National Clinical Coding Qualification (NCCQ)		30 March 2012
New title for “Coding Guidelines”		31 Sept 2012
Recording activity in Accident and Emergency on inpatient episodes		24 Oct 2009
Scottish Morbidity Record (SMR) and Hospital Standardised Mortality Ratios (HSMR)		SCCS3 Sept 2013
SMR04 Discharge Diagnoses		SCCS3 Sept 2013
<b>SMR02 Review – Coding Guidelines</b>		<b>27 Oct 2010</b>
<b>SMR02 Review Update</b>		<b>28 March 2011</b>
<b>SMR02 Data Items</b>		<b>27 Oct 2010</b>
Analgesia during labour and/or delivery		27 Oct 2010
Apgar score – Babies 1-3		27 Oct 2010
Booking date		27 Oct 2010
Drugs and Alcohol use		28 March 2011
Drugs misuse during this pregnancy		27 Oct 2010
Duration of labour		27 Oct 2010
Hard coded diagnostic and procedure fields on SMR02		27 Oct 2010
Height		27 Oct 2010
Mode of delivery – Babies 1 to 3		27 Oct 2010
Mode of delivery - Forceps		28 March 2011
Tears		<b>27 Oct 2010</b> 28 March 2011
Typical weekly alcohol consumption		27 Oct 2010
Weight of mother at booking		27 Oct 2010

**NB:** From Nov 96 to Sep 98 issues were entitled Coding Quarterly

**NB:** When page numbers are mentioned in the following guidelines they refer to the original guideline page numbers.

# OPCS4

## NEW AND/OR CHANGED FROM ORIGINAL CODING GUIDELINE/STANDARD

### **Aspiration of prosthetic joint**

A joint aspiration may be performed for either therapeutic or diagnostic purposes. A sterile needle with an attached syringe is inserted within the joint cavity and fluid is drawn back (aspirated) into the syringe. The correct OPCS-4 code assignment for the aspiration of a joint when the patient has a prosthetic joint replacement in situ is

W90.1 Aspiration of joint.

The relevant joint site code must be assigned in addition to W90.1.

The presence of the prosthesis may be connected to the need for aspiration; however the aspiration is performed on the cavity of the joint, and does not involve the physical parts of the prosthesis.

An ICD10 code of Z96.6 to indicate presence of artificial joint should be added.

### **Doppler/ Duplex Studies and Intravascular Ultrasound (IVUS)**

**Q.** What is the difference between a doppler ultrasound study and an intravascular ultrasound study?

**A.** An 'ordinary' doppler ultrasound study is non-invasive. It involves the assessment of arteries or veins (e.g. limb vessels, renal or carotid arteries) using an external probe, providing not only an image of the inside of the vessels and any occlusive plaque or thrombus, but also information on the flow of blood - the haemodynamics - within the vessel. The test is simple, painless and can be performed as an outpatient procedure. It may also be called doppler study, duplex scanning or echodoppler ultrasound.

As this is a non-invasive scan this procedure should be coded according to coding standards associated with scans.

In contrast, intravascular ultrasound is an invasive procedure.

A coronary intravascular ultrasound will always be carried out in conjunction with coronary angiography (and may therefore precede coronary angioplasty). The ultrasound transducer is mounted at the end of a catheter that is introduced into a coronary artery. This investigation can measure the velocity of blood flow within the coronary artery and demonstrate not only the severity of any arterial narrowing, but also show the composition of the underlying atherosclerotic plaque. Such information can be invaluable in determining which of the types of angioplasty would be best to treat the blockage.

The OPCS4 code for this procedure is  
K51.2 – Intravascular ultrasound of coronary artery

If intravascular ultrasound was being performed on other arteries, the coder should follow the index trail below;

L72.6 Ultrasound Artery Intravascular NEC

Plus appropriate artery site code.

For example

Intravascular ultrasound of popliteal artery L72.6/Z38.6

Coders should therefore note that care is needed to determine which type of doppler study has taken place before allocating a code.

## **Endometrial Procedures**

There are various procedures commonly carried out on the endometrium as treatments for menorrhagia. These are coded within the OPCS4 categories:

**Q16** - Other vaginal operations on uterus and

**Q17** - Therapeutic endoscopic operations on uterus.

Some of the most common treatments are identified below:

### Endoscopic microwave ablation of endometrium

An endoscopic microwave ablation of the endometrium is a procedure used to destroy the lining of the uterus (the endometrium) using a microwave probe.

The OPCS4 code to be assigned is:

**Q17.6** - Endoscopic microwave ablation of endometrium

If the procedure is not endoscopic, the correct OPCS4 code is:

**Q16.3** – Microwave ablation of endometrium NEC

### Thermal balloon ablation of endometrium

A thermal balloon ablation of the endometrium is a procedure whereby the endometrium is destroyed by a balloon inserted through the cervix and filled with hot water. This is not an endoscopic procedure.

The OPCS4 code to be assigned is:

**Q16.2** – Balloon ablation of endometrium

## **Failed trial without catheter (TWOC)**

During a trial without catheter (TWOC), the patient's catheter is removed and the patient is then left for a period of time to see if they can void. If the TWOC is successful, it is only necessary to assign OPCS4 code M47.3 Removal of urethral catheter from bladder. If, however, the TWOC fails and the catheter is reinserted, both the removal and the re-insertion of the catheter will need to be shown:

M47.3 Removal of urethral catheter from bladder

M47.9 Unspecified urethral catheterisation of bladder

Please note that, in general, it is not necessary to code urethral catheterisation of bladder unless the patient is specifically admitted for this procedure.



## HEAL - Hysteroscopic endometrium ablation - laser

Hysteroscopic endometrial ablation using a laser (HEAL) involves the destruction of endometrial tissue which is behaving abnormally and **not** the destruction of a lesion. The Clinical Coding Review Group has issued the following codes for HEAL:

Q17.4 Endoscopic destruction of lesion of uterus NEC

*Includes: Endoscopic destruction of uterus NEC.*

Y08.3 Laser destruction of organ noc

Endometrial laser ablation Q17.4 + Y08.3

## Injection sacroiliac joint

The correct codes for the above procedure are;  
W90.3 Injection of therapeutic substance into joint  
Z84.1 Sacroiliac joint

## Injections and Infusions

The Clinical Coding Review Group has issued the following definitions:-

- a) Injections - the person administering the injection needs to be present throughout the administration of the injection.
- b) Infusions - the person administering the infusion can leave the patient while the infusion is taking place. An infusion is continuous administration in the form of a drip.

It is important to note that the purpose of the classification is not to identify the specific drug given, but to indicate the way it is administered.

X29.- Continuous infusion of therapeutic substance

is the only category available to code the continuous infusion of any therapeutic substance with the exception of chemotherapy for neoplasm which is coded to **X72.- Delivery of chemotherapy for neoplasm.**

X35.2 Intravenous chemotherapy

is used to code intravenous chemotherapy i.e. for all conditions other than neoplasms.

Chemotherapy is a generic term for the treatment of disease by a chemical agent and is not restricted to the use of drugs for treatment of neoplasms. Chemotherapy should therefore be coded according to the method of administration as detailed above.

Use X29.2 as the default code if the patient is admitted specifically for the administration of IV fluids.

## **Laparoscopic hysterectomies and associated procedures**

If an operation is stated as being a Laparoscopic Hysterectomy this defaults to Q07.- + Y75.2. Q07 is the category for abdominal hysterectomies. Coders should always check to make sure it is an **abdominal hysterectomy** before selecting the appropriate code from category Q07. If the procedure is a **laparoscopically- assisted** vaginal hysterectomy, it should be coded to Q08.- + Y75.1.

Laparoscopic vaginal hysterectomies so described are, strictly speaking, laparoscopically-assisted vaginal hysterectomies and should be coded as such i.e. Q08.- + Y75.1. If there is any doubt as to how the procedure was carried out, coders should check with the responsible clinician.

Current advice states that when a hysterectomy is carried out simultaneously with an oophorectomy this should be coded as a recognised Scottish OPCS4 pair code. However, when a laparoscopic hysterectomy and laparoscopic oophorectomy are performed simultaneously we lose information concerning minimal access approach. A laparoscopic hysterectomy performed with a laparoscopic oophorectomy, where no further information is available, will be coded as follows:-

Laparoscopic Hysterectomy :

Q07.4 + Y75.2 Total abdominal hysterectomy NEC + Laparoscopic approach to abdominal cavity NEC

Laparoscopic Oophorectomy:

Q24.3 + Y75.2 Oophorectomy NEC + Laparoscopic approach to abdominal cavity NEC

When a vaginal hysterectomy is carried out simultaneously with a bilateral salpingoophorectomy this should also be coded as a recognised Scottish pair code. However, when a laparoscopically-assisted vaginal hysterectomy and bilateral salpingoophorectomy are performed together these should be coded as follows;

Q08.9 Vaginal excision of uterus, unspecified

Y75.1 Laparoscopically assisted approach to abdominal cavity

And

Q22.1 Bilateral salpingoophorectomy

Y75.1 Laparoscopically assisted approach to abdominal cavity

## **Non-operative interventions**

Recording on SMR01 and SMR02 of interventions/procedures such as imaging, injections, infusions, IV fluids e.t.c. tends to be inconsistent. Data on these interventions/procedures is therefore incomplete. Radiology systems are better suited to recording imaging data although not all such interventions/procedures are captured by these systems e.g.obstetric/gynaecology scans.

For obstetric patients on an SMR02 record, who are given several scans of the same type during an episode, it is only necessary to code the first scan given. If an obstetric scan is multi-purpose ( e.g. a nuchal translucency scan in which growth is also checked), code to the main purpose of the scan.

N.B. SMR01/SMR02 - recording administration of Anti D

Continue to code administration of Anti D using OPCS4 code X30.1 - Injection of Rh immune globulin and ICD10 code Z29.1 – Prophylactic immunotherapy .

See Data Dictionary. <http://www.datadictionaryadmin.scot.nhs.uk/> for information on SMR Datasets, SMR Data Manual, SMR02 Diagnostic Section, Guidelines for coding clinical conditions.

Please apply the standards in the table below for recording interventions/procedures.

Intervention/procedure code	Clinical coding standard	Clinical coding standard if Elective admission (inpatient/day case) specifically for this intervention/procedure
U01-U40	Not mandatory to code	Code
R36 – R43	Not mandatory to code	Code
X28-X39	Not mandatory to code	Code
X44, X48-X58	Not mandatory to code	Code
X65	Not mandatory to code	Code
X60-X62, X66, X67.-, X68.-	Not mandatory to code	Not mandatory to code
X70, X71	Not mandatory to code	Not mandatory to code
X81-X97	Not mandatory to code	Not mandatory to code

Boards may record non-mandatory interventions/procedures if they so wish. The decision to do so should be documented as a local coding policy for future reference during data audits.

### One Scope, two or more procedures – clarification of previous standard Scottish Clinical Coding Standards No.5 March 2014

1) The 'One Scope, two or more procedures' standard was published in Coding Guidelines No.21, November 2007. It deals with the coding of cases where "in one theatre visit a patient undergoes more than one procedure using the same scope", recommending that only the most important procedure i.e. the code highest up the hierarchy of the potentially applicable codes is recorded. However, there has been some uncertainty concerning how widely to apply this standard – for example, does it extend to laparoscopic procedures?

2) The Clinical Coding Review Group has now agreed the following points:

2.1) The 2007 standard restricting the number of codes that can be recorded **continues to apply** to endoscopic examinations and procedures performed solely via existing anatomical passages, such as: UGI endoscopy, colonoscopy and sigmoidoscopy, ERCP, cystoscopy, ureteroscopy, nephroscopy performed via the ureters, bronchoscopy and other 'natural orifice' endoscopies. (The recording of a legitimate ERCP pair code does not contravene this guidance).

2.2) The 2007 standard **does not apply** to procedures performed via approaches such as: Arthroscopy, laparoscopy, percutaneous nephroscopy via a subcutaneous track, thoracoscopy and similar 'minimal access' approaches. Such procedures should be coded (using the appropriate 'minimal access' codes) as fully as the equivalent 'open' procedures would be coded, as in the following examples:

2.2.1) Laparoscopy and diathermy to endometriosis in Pouch of Douglas, left ovarian fossa, left uterosacral ligament and right ovary and bilateral clipping of fallopian tubes.

These procedures were performed during a single laparoscopy.

Code both procedures:

T42.2 Endoscopic destruction of lesion of peritoneum

Q35.2 Endoscopic bilateral clipping of fallopian tubes

2.2.2) Arthroscopy and sub-acromial decompression with primary repair of rotator cuff.

These procedures were performed during a single arthroscopy.

Code both procedures:

O29.1 Subacromial decompression / Y76.7 Arthroscopic approach to joint

T79.1 Plastic repair of rotator cuff of shoulder NEC / Y76.7 Arthroscopic approach to joint

3) One particular area of coding difficulty is Functional Endoscopic Sinus Surgery (FESS)/Functional Endoscopic Nasal Surgery (FENS). "FESS" and "FENS" are non-specific umbrella terms which comprise a range of endoscopic procedures on the sinuses and nasal passages. Commonly, more than one such procedure is performed in a single FESS/FENS theatre visit.

3.1) Unlike, say, the colonoscopy codes, there is no clear hierarchy of named endoscopic chapter E codes which classify FESS/FENS procedures. To code FESS/FENS procedures, non-endoscopic E codes must be supplemented by Y76.1 Functional endoscopic sinus surgery or Y76.2 Functional endoscopic nasal surgery.

3.2) Consequently, CCRG have agreed that FESS/FENS procedures should not be subject to the 'one scope one code' rule and should be coded as described in 2.2 above.

4) This standard cannot offer guidance covering every possible circumstance in endoscopic and 'minimal access' surgery. When necessary, advice should be sought from Terminology Services helpdesk, either by telephone (0131 275 7283 - the number is manned Tuesday to Thursday from 09.00 to 17.00 hrs) or by e-mail: [NSS.terminologyhelp@nhs.net](mailto:NSS.terminologyhelp@nhs.net)

### **Outpatient attendances for termination of pregnancy.**

#### **SCCS 4 Feb 2014**

Woman attends Outpatient clinic to request termination of pregnancy. She is asked to return and attend a ward to be given an oral abortifacient drug (Mifepristone).

In these instances, complete an SMR00 return for both the Outpatient attendance and the attendance at the ward. Do not count the attendance for administration of the oral abortifacient drug (Mifepristone) as a ward attendance. Treat it as an Outpatient attendance and record OPCS4 code X39.1 - Oral administration of therapeutic substance in the procedure field.

This is to ensure that all 'non-inpatient' attendances for administration of oral abortifacient drugs (Mifepristone) are recorded in the same manner.

No ICD-10 code is required.

However, the preferred means of recording all terminations is to admit the patient either under SMR01 or SMR02.

### **Peripheral Stem Cell Procedures/Bone Marrow Transplants**

<b>Haematology procedures</b>		<b>OPCS code</b>
Peripheral stem cell donation		X36.1/Y69.8
Stem cell infusion, back up bone marrow	See Bone marrow transplant below	
Bone marrow transplant	Autograft	W34.1
	Allograft NEC	W34.2
	Allograft from sibling donor	W34.3
	Allograft from matched unrelated donor	W34.4
	Allograft from haploidentical donor	W34.5
	Allograft of bone marrow from unmatched unrelated donor	W34.6
	Other specified graft of bone	W34.8

	marrow Unspecified graft of bone marrow	W34.9
Bone marrow harvest (patient as the potential recipient – autologous)		W35.8 and Y66.7
Bone marrow harvest (patient is donating to another person – non-autologous)		X46.1 + 'Z' code for site of harvest.
Peripheral blood stem cell (PBSC) harvest		X36.1/Y69.8
PBSC transplant (autologous)	If donation and infusion in same episode If donation and infusion in different episodes; First episode Second episode	X33.4  X36.1/Y69.8 X33.4/Y71.1
Femoral vein catheter for PBSC If it is PBSC transfusion	Autologous Syngeneic Allogeneic Unknown	X33.4 X33.5 X33.6 X33.8
Granulocyte colony stimulating factor (GCSF)	Subcutaneous injection of haematological growth factor	X38.7
PBSC collection		X36.1/Y69.8
Peripheral leucophoresis	Same as PBSC transplant	
Back-up stem cells	Same as stem cell donation	
Back-up bone marrow	Same as bone marrow donation	
Other blood transfusion	Autologous transfusion of red blood cells	X33.7
Blood withdrawal	Autologous blood salvage	X36.4

#### **Rationale for bone marrow harvest codes.**

X46.1 has to be used for the harvest of bone marrow from a donor (non-autologous). The bone marrow is then transplanted to the recipient patient at a later stage. The trail is Donation Bone Marrow - X46.1.

W35.8 is a therapeutic puncture of bone, and this is used to identify that the patient from whom the bone marrow is harvested is also the potential recipient (autologous).

Bone marrow harvest (patient is donating to another person – non-autologous) – the reason for using the site code ('Z' code) in favour of the Y66.7 is that the second code is repeating the information, Therefore, using the site code adds information.

#### **Pituitary excision and skull based reconstruction**

The pituitary gland is a bean sized structure located at the base of the brain behind the nose, where it is protected by the sphenoid bone. The pituitary gland can be affected by a wide range of tumours and other pathological processes; the most frequent being pituitary adenomas. It was common practice to remove the whole of the pituitary gland, which would have been coded to **B01.2 Trans-sphenoidal hypophysectomy**. Due to advances in the treatment of these diseases, it is now more common practice for the surgeon to remove only the tumour which would be coded to **B04.1 Excision of lesion of pituitary gland**.

The most common approach for pituitary surgery is trans-sphenoidal (through the sphenoid sinus) with the use of an endoscope inserted via the nostril. This approach may create a defect in the anterior skull base which can cause the leakage of cerebrospinal fluid. When a leakage occurs, the surgeon may decide to close the defect created in the anterior skull base with the use of a mucosal flap. This is known as an "anterior skull based reconstruction".

OPCS-4 codes **E15.8 Other specified operations on sphenoid sinus** and **Y26.1 Reconstruction of organ NOC** show the reconstructive element of the procedure.

**Example 1:**

Hypophysectomy (total excision of pituitary gland), followed by anterior skull based reconstruction with mucosal flap (all during the same visit to theatre). All procedures performed using endonasal endoscopic trans-sphenoidal approach.

B01.2 Trans-sphenoidal hypophysectomy

Y76.6 Endonasal endoscopic approach to other body cavity

E15.8 Other specified operations on sphenoid sinus

Y26.1 Reconstruction of organ NOC

S28.8 Other specified flap of mucosa

Y76.6 Endonasal endoscopic approach to other body cavity

**Example 2:**

Excision of pituitary gland adenoma (only the tumour was removed), defect was reconstructed with the use of a mucosal flap (all during the same visit to theatre). All procedures performed using endonasal endoscopic trans-sphenoidal approach.

B04.1 Excision of lesion of pituitary gland

Y76.6 Endonasal endoscopic approach to other body cavity

E15.8 Other specified operations on sphenoid sinus

Y26.1 Reconstruction of organ NOC

S28.8 Other specified flap of mucosa

Y76.6 Endonasal endoscopic approach to other body cavity

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**Plasmapheresis**

Plasmapheresis, also known as an exchange blood transfusion, is classified at category X32, according to the number of exchanges given during the episode of care e.g. codes X32.3 – Exchange of plasma (2 – 9) and X32.5 Exchange of plasma (>19) .

A thorough review of the source document is essential to capture this level of information.

These only require to be coded if the patient is specifically admitted for the procedure.

**Radiotherapy delivery**

When coding radiotherapy, the subsidiary site code (identifying where in the body the radiotherapy was delivered) takes precedence over the subsidiary Y35, Y36 or Y91 codes.

Example; Simple external beam radiotherapy for adenocarcinoma of prostate using linear accelerator (megavoltage machine).

X65.4 Delivery of a fraction of external beam radiotherapy NEC

**Note: use a subsidiary code to identify external beam radiotherapy (Y91)**

Z42.2 Prostate site

**Reversal of Hartmann's**

If a reversal of Hartmann's is carried out, the case notes should be checked for the exact procedure performed.

In Scotland, in the absence of further information, the default codes for Reversal of Hartmann's are:-

H15.4 Closure of colostomy + Y16.2 Anastomosis of organ noc.

## Secondary reductions

The following information further clarifies the guidance found on page W-13 of the OPCS-4.6 Clinical Coding Instruction Manual (Version 4.0):

Secondary reduction of fracture codes must only be assigned when the patient undergoes further reduction on the same fracture site.

When coding 'secondary reduction' procedures, the secondary procedure may be the same or differ from the original procedure. This means that the type of reduction may be:

- The same, for example - primary open reduction followed by further open reduction

or

- different, for example - primary closed reduction followed by subsequent open reduction, or reduction without fixation followed by subsequent reduction with fixation.

### Example 1:

Patient admitted with fracture of the right lateral malleolus. A closed reduction of the fracture was performed in A&E and a POP cast was applied. The patient then went on to have an open reduction and fixation of right lateral malleolus fracture using extramedullary plate a few days later.

Therefore the correct OPCS-4 codes and sequence for the open reduction and fixation of the right lateral malleolus fracture using extramedullary plate are:

**W23.2 Secondary open reduction of fracture of bone and extramedullary fixation HFQ**

**Z78.4 Lateral malleolus**

Rationale: In OPCS-4, the assignment of a secondary reduction code indicates that the patient has required a further reduction operation on the same site to fully reduce the fracture.

### Example 2:

Patient seen in A&E with fracture of the left distal radius. The patient was treated conservatively with an arm splint to immobilise the patients arm. An open reduction and extramedullary fixation using a plate was performed the following morning.

Therefore the correct OPCS-4 codes and sequence for the open reduction and fixation of the left distal radius using extramedullary plate are:

**W20.1 Primary open reduction of fracture of long bone and extramedullary fixation using plate NEC**

**Z70.5 Lower end of radius NEC**

**Rationale:** Although the fracture was previously immobilised, the open reduction and fixation using plate is the **first reduction** and is therefore coded as a primary reduction.

## Shoulder Surgery

Coding Guideline No.10, December 2001 article on Shoulder Surgery is now obsolete. All procedures listed, with the exception of 'open excision of acromioclavicular joint' can now be found by using the OPCS index. The codes for 'excision of acromioclavicular joint (open)' should be W57.2 – Primary excision arthroplasty of joint NEC and Z81.2 Acromioclavicular joint.

## Staged hearing aid procedures D05.- and D13.-

Insertion of auricular or bone anchored hearing aid prosthesis procedures are often carried out in two stages.

If it is not clear from the operation or clinical notes whether the first or second stage of the procedure is being performed, the default code should be that for 'First stage'. – i.e. D05.1 or D13.1.

## **Total hip replacement with acetabular bone graft**

### **Updated coding standard**

Clinical input has confirmed that **during some primary** total hip replacement procedures, bone chippings produced during the operation reamed from the patient's acetabulum (or occasionally femur) are used to **fill defects and secure** a prosthetic joint replacement. This type of method is considered to be an integral part of the procedure and therefore does not require coding in addition to the prosthetic joint replacement.

#### **Example 1:**

Primary uncemented left total hip replacement, the defects around the implant were packed using bone chippings from the reamed bone of the patient's acetabulum:

**W38.1 Primary total prosthetic replacement of hip joint not using cement**

**Z94.3 Left sided operation**

**Rationale:** As the bone chippings are used as a part of the procedure to help support the hip replacement, it is not appropriate to assign a code for the bone chippings in addition.

**During some revisional** total hip replacements, where there is evidence of extensive bone loss, an acetabular or femoral **bone graft**, using either morcellised bone or a block of bone, may be performed in addition to the joint replacement. Revision total hip replacements can have extensive bone loss and where this is the case, autograft (from the patient) or allograft (from another patient via a bone bank) bone will be necessary for the reconstruction. In these types of instances, the acetabular or femoral bone graft is considered to be a separate procedure to the joint replacement procedure and requires coding in addition.

#### **Example 2:**

Revision uncemented left total hip replacement with morcellised autograft of bone to fill large acetabular defect. Bone harvested from iliac crest.

**W38.3 Revision of total prosthetic replacement of hip joint not using cement**

**Z94.3 Left sided operation**

**W31.4 Cancellous chip autograft of bone**

**Z75.6 Acetabulum**

**W08.8 Other specified excision of bone**

**Y66.3 Harvest of bone from iliac crest**

**Rationale:** the bone graft material in this procedure is an autograft which was harvested from the iliac crest of the patient and therefore it is appropriate to assign a code to identify the harvest in addition to the code for the revision total hip replacement.

Any uncertainty as to whether the joint replacement involves a structural bone graft or packing of small defects using bone chippings, must be referred back to the responsible consultant for clarification.

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# **UNCHANGED GUIDANCE – STILL VALID**

## **Abandoned and unintentional procedures: further guidance**

### **OPCS4.4**

### **Coding Guidelines No. 21, November 2007**

In Coding Guidelines No.20 June 2007, guidance was given on the coding of abandoned and unintentional procedures. Please note that this guidance does not affect that given in Coding Guidelines No.15, November 2004, regarding colonoscopies/sigmoidoscopies which fail to progress to the intended area to be examined.

Please also note that an ERCP which has not progressed beyond incomplete insertion of the endoscope, or where insertion is complete but the ampulla cannot be cannulated, will usually be described as a 'failed' or 'abandoned' ERCP and should be coded to:  
J43.9 Diagnostic endoscopic retrograde examination of bile duct and pancreatic duct, unspecified.

## **Abandoned and unintentional procedures**

### **OPCS4.4**

### **Coding Guidelines No. 20, June 2007**

There are occasions where a procedure has to be abandoned in theatre, due to unforeseen circumstances. In these instances, the procedure should be coded to the point of abandonment. The intention of the procedure should not be coded.

Example: Patient admitted for fiberoptic gastroscopy. Procedure abandoned due to obstruction in oesophagus. Scope could not progress beyond the obstruction.

The correct OPCS-4 code is:

G16.9 Unspecified diagnostic fiberoptic endoscopic examination of oesophagus.

There are also circumstances where unintentional incidents take place in theatre (for example, an accidental perforation of an organ). These inadvertent actions should not be coded in the procedural field. There are codes in ICD-10 that adequately reflect these actions

(T80 – T88 Complications of surgical and medical care, not elsewhere classified).

An additional code must be added, from the External causes of morbidity and mortality (Chapter XX) – Misadventures to patients during surgical and medical care (Y60 – Y69)

Example: Patient with fibroids admitted for a total abdominal hysterectomy. Whilst in theatre, the bladder was accidentally punctured and repaired. The correct codes are:

### **ICD-10**

D25.9 Leiomyoma of uterus, unspecified

T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified

Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical operation

### **OPCS-4**

Q07.4 Total abdominal hysterectomy NEC

M37.9 Unspecified repair of bladder.

## **Abortions                      SMR02 review 2000**

There is no requirement to code the abortion procedure in OPCS4. This is identified in the data item Management of Abortion.

## **Angiographies and angioplasties OPCS4.2                      Coding Guidelines No. 16, August 2005**

In the Coding Guidelines No.14 (January, 2004), the following advice was given;

*“Diagnostic angiography should always be recorded on SMR01, even when it takes place in the same episode as CABG or PCTA. Although this is not strictly necessary according to traditional coding convention, it is the only way we have at the moment to ensure that all angiography to CABG/PCTA waiting times are included in national SMR01 statistics.*

*However, if a prior diagnostic angiography has been carried out and the current angiography is performed to allow correct positioning of the balloon, the current angiography should not be recorded on SMR01.”*

It should be understood that this guideline applies to ALL patients, not just Elective ones, even though the main reason for this instruction was to help monitor Waiting Times. Coders should NOT make a distinction between patients of differing Admission Types.

## **Angiographies and angioplasties OPCS4.2                      Coding Guidelines No. 14, January 2004**

Diagnostic angiography should always be recorded on SMR01, even when it takes place in the same episode as CABG or PCTA. Although this is not strictly necessary according to traditional coding convention, it is the only way we have at the moment to ensure that all angiography to CABG/ PCTA waiting times are included in national SMR01 statistics

However if a prior diagnostic angiography has been carried out and the current angiography is performed to allow correct positioning of the balloon, the current angiography should not be recorded on SMR01.

## **Angioplasty and stenting of coronary artery: Further Guidance OPCS4.4/4.3                      Coding Guidelines No. 20, June 2007**

In Coding Guidelines September 2006 No. 19, guidance was given regarding the insertion of a combination of drug-eluting and non-drug-eluting stents.

If a patient undergoes a balloon angioplasty with insertion of a combination of drug-eluting and metal stents into the coronary artery, use K75.1 or K75.2 and add an appropriate code from category Y14.

Example: Balloon angioplasty and insertion of two drug-eluting and one expanding metal stent into coronary artery

K75.1 Percutaneous transluminal balloon angioplasty and insertion of 1-2 drug-eluting stents into coronary artery

Y14.2 Insertion of expanding metal stent into organ NOC.

Other codes from category Y14 Placement of stent in organ noc can be used as appropriate depending on the type of stent used.

Please note that this is an enhancement to paragraph 2 of the previous guideline “Angioplasty and stenting of coronary artery” in Coding Guidelines No.19 September 2006.

### **Angioplasty and stenting of coronary artery OPCS4.4/4.3 Coding Guidelines No. 19, September 2006**

Since the introduction of OPCS4.3, angioplasty and stenting of the coronary artery must be coded using a K75.- code not a K49.- code. There is no code at K75.- for stenting of multiple coronary arteries, therefore it is now not possible to code this information.

It may happen that both drug-eluting and non-drug-eluting stents are used in the procedure. If this is the case, code to the appropriate K75.1 or K75.2 code rather than using 2 different K75.- codes for the same procedure.

### **Anti D Coding Guidelines No. 27 October 2010 SMR02 Review**

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.

### **Scottish Clinical Coding Standards No 3 September 2013**

#### **Application of patches (Fentanyl, Qutenza)**

Application of Fentanyl or Qutenza patches should be coded to:

X39.5 Transdermal administration of therapeutic substance.

Please note that this standard supercedes previous guidance re application of Fentanyl patches in Coding Guidelines No. 7 November 2000.

### **Apronectomy Versus Abdominoplasty OPCS4.4 Coding Guidelines No. 22, March 2008**

An abdominoplasty is a major surgical intervention/procedure (2-4 day inpatient stay) that involves removal of excess skin and fat below the umbilicus plus tightening of abdominal muscles (with sutures), re-positioning of the umbilicus and sometimes, removal of excess fat above the umbilicus.

An apronectomy is less radical surgery (overnight stay) where only surplus skin and fat below the umbilicus are removed.

The Clinical Coding Review Group (CCRG) has decided that Abdominoplasty should be coded to S02.1 and Apronectomy to S02.2.

## **Arthroplasty following removal of internal fixation** **OPCS4.4 Coding Guidelines No. 21, November 2007**

In some patients who have had a fracture which is close to or involved in a joint, a problem with the internal fixation may lead to the fixation device being removed and an arthroplasty performed.

For example, if a patient who had a fractured neck of femur fixed by DHS (Dynamic hip screw) or cannulated screw subsequently developed avascular necrosis of the femoral head or if the fixation itself failed, the fixation might be removed and a hip hemiarthroplasty or a total hip replacement implanted.

Orthopaedic surgeons may use the words 'conversion' or 'revision' to describe the change from a fracture fixation to an arthroplasty. However coders should note that these procedures are not revisions or conversions of existing arthroplasties and so arthroplasty conversion (.2) or revision (.3,.4 or .5) codes should not be recorded in these cases.

Instead, the appropriate primary hemiarthroplasty or total joint replacement code should be recorded in Main Operation, followed by W28.3 Removal of internal fixation from bone NEC with the appropriate site code.

## **Two stage revision arthroplasties** **OPCS4.2 Coding Guidelines No. 16, August 2005**

A query has arisen from the guidance given by the Scottish Arthroplasty Project on the coding of patients undergoing a two-stage revision for an infected prosthesis. Under the section of the guidance which relates to 'Second Stage', the following is written: "Diagnosis: if the second stage occurs in a different SMR01 episode to that of the first stage, the Main Diagnosis for the second episode should not be 'infected prosthesis' Instead Z47.8 Other specified orthopaedic aftercare should be used".

To clarify: this should read "Diagnosis: if the second stage occurs in a different admission episode to that of the first stage..."  
i.e. where the patient has been discharged from in-patient care following the first stage and re-admitted for the second stage, the diagnosis should be Z47.8 for the second admission. Patients retained in hospital during the period between the first and second stages should be considered as 'continuing care patients', with normal coding rules applied.

## **Two Stage Revision Joint Codes** **OPCS4.2 Coding Guidelines No. 15, November 2004**

The following advice was given out at an Arthroplasty Coders' workshop in Dundee: Two stage revisions of hip and knee arthroplasties should be coded as follows, to reflect (as specifically as possible using OPCS4), what actually happens to the patient, whilst giving clear information about the joint and laterality.

### First stage

Diagnosis: the indication for a two-stage revision will almost certainly be an infected prosthesis

Procedure: W57.4 – Conversion to excision arthroplasty of joint with  
Z84.3 – Hip or

## Z84.6 – Knee

### Second stage

Diagnosis: if the second stage occurs in a different episode to that of the first stage, the main diagnosis should not be infected prosthesis. Instead Z47.8 – Other specified orthopaedic follow-up care should be used. However, normal coding rules would apply if, within the same episode, another condition became the main condition being treated during that episode.

### Procedure – hip

W37.2 or W38.2 or W39.2 – Conversion to total prosthetic replacement of hip using cement/not using cement/nec supplemented by Z94.- Laterality

### Procedure - knee

W40.2 or W41.2 or W42.2 - Conversion to total prosthetic replacement of knee using cement/not using cement/nec supplemented by Z94.- Laterality

## **Banding of haemorrhoids with sigmoidoscopy and biopsy OPCS4.5 Coding Guidelines No. 24, October 2009**

When banding of haemorrhoids has been carried out at the same time as a sigmoidoscopy and biopsy, code as follows;

H52.4 Rubber band ligation of haemorrhoid

H25.1 Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel using fiberoptic sigmoidoscope

Z28.6 Sigmoid colon

**N.B.** Where the type of endoscope has not been stated, the classification defaults to a fiberoptic category.

## **Recording Bilateral Procedures OPCS 4.6 Coding Guidelines No.30, March 2012**

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.

## **Bone grafts OPCS4.5**

### **Coding Guidelines No. 24, October 2009**

There are two new codes in OPCS4.5 to describe bone grafts. These are W32.5 and W32.6. W32.5 Cancellous chip allograft of bone has an Includes note of: Morcellised allograft of bone. Cancellous and morcellised allografts are made up of chipped femoral head bones and are obtained from the bone bank of the National Tissue Service. The femoral head bone is cleaned of all cartilage and put through a machine where the bone is washed and crushed into very small pieces.

Cancellous chip or morcellised are synonymous terms, and are often referred to by clinicians as impaction grafts.

At code W31.4 Cancellous chip autograft of bone, there is a new Includes note; Includes: Morcellised autograft of bone. This is where the patient's own bone is used for the graft.

The procedure classified at code W32.6, Bulk allograft of bone, is used in situations of acetabular deficiency where only part of the femoral head is used as a whole piece and is often fixed with internal fixation. This is commonly used in conjunction with a support ring as well as internal fixation (screws).

## **Botox injections OPCS4.5**

### **Coding Guidelines No. 24, October 2009**

#### **Botox injection into gastro-oesophageal sphincter**

Scotland code to G44.8 + Y38.8.

G44.8 Other specified therapeutic fiberoptic endoscopic operations on upper gastrointestinal tract

Y38.8 Other specified injection of therapeutic substance into organ NOC

(England code to G44.8, X85.1, Z27.1)

**N.B. This is a Scottish/English difference**

#### **Botox into eyelid**

Scotland code to C22.4 Injection into eyelid

(England code to C22.4, X85.1)

**N.B. This is a Scottish/English difference**

#### **Botox into sweat glands under arm**

Scotland code to S53.2 + Z49.2

S53.2 Injection of therapeutic substance into skin

Z49.2 Skin of axilla

(England code to S53.2, X85.1 + site code)

**N.B. This is a Scottish/English difference**

#### **Botox into anal sphincter**

Scotland code to H56.8 + Y38.8

H56.8 Other specified operation on anus

Y38.8 Other specified injection of therapeutic substance into organ NOC

(England code to H56.8, X85.1)

**N.B. This is a Scottish/English difference**

### **Botox into muscle**

Scotland code to X37.5 + muscle site code  
X37.5 Intramuscular injection for local action

(England code to X85.1 + muscle site code)

**N.B. This is a Scottish/English difference**

## **Cystoscopic Botox injection into bladder**

**OPCS4.5 Coding Guidelines No. 25, April 2010**

Neurotransmitters are chemical messengers that are released from nerve cells.

Neurotransmitters stimulate and inhibit muscle activity.

When botulinum toxin (Botox) is injected into the detrusor muscle of the bladder wall, it inhibits the release of the neurotransmitters that would normally stimulate contraction of the bladder. Botox is used to treat a variety of bladder and urinary continence disorders such as an overactive bladder.

The appropriate OPCS-4.5 codes for "cystoscopy and injection of botox into the bladder wall/detrusor muscle" are:

M43.4 Endoscopic injection of neurolytic substance into nerve of bladder

(England would add X85.1 Torsion dystonias and other involuntary movements drugs Band 1.)

## **Bronchoscopies**

**OPCS4.5 Coding Guidelines No. 25, April 2010**

### **Bronchoscopy with biopsy and brushings:**

E49.1 Diagnostic fiberoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract

Y21.1 Brush cytology of organ NOC

### **Bronchoscopy with biopsy and washings:**

E49.1 Diagnostic fiberoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract

Y21.8 Other specified cytology of organ NOC

**(England would add the relevant subsidiary site code)**

Other codes for bronchoscopies are as follows:

E49.1 Bronchoscopy with biopsy



E49.2 Bronchoscopy with washings  
E49.3 Bronchoscopy with brushings  
E49.4 Bronchoscopy with washings and brushings  
E49.5 Bronchoscopy with biopsy, washings and brushings

### **Cadaver Coding**

**OPCS4.2                      Coding Quarterly No. 4, September 1997**

Removal of organs from a dead person should not be recorded on SMR01. The code X45.-  
Donation of organ - should only ever be used for removal of an organ from a live donor.

### **Cardiopulmonary bypass**

**OPCS4.5                      Coding Guidelines No. 25, April 2010**

The use of code Y73.1 Cardiopulmonary bypass is optional in Scotland.

(In England, Y73.1, Cardiopulmonary bypass should be used whenever it is stated to have  
been carried out.)

This will be a Scottish/English difference.

### **Carpal Tunnel Release**

**OPCS4.2                      Coding Guidelines No. 14, January 2004**

Since carpal tunnel release (A65.1) is always done on the median nerve, it is not necessary to  
include a supplementary code of Z09.2. A supplementary laterality code should be used in  
preference, where appropriate.

### **Catheterisation**

**SMR02 review 2000**

There is no requirement to code catheterisation in OPCS4 when it is performed prior to a  
forceps delivery or a caesarean section. This is regarded as a part of those procedures.

### **Cervical Studies**

**OPCS4.2                      Coding Guidelines No. 3, June 1999**

It has been agreed that code Q55.8 should be used for cervical studies regardless of  
diagnosis. SMR02 sites should review their procedures. If these patients are not pregnant  
they should be recorded on a SMR01.

### **Chemotherapy codes for neoplasm**

**OPCS4.3                      Coding Guidelines No. 18, May 2006**

If intravenous chemotherapy is given an X72.- code should be used. If oral chemotherapy is  
given an X73.- code should be used. If both oral and intravenous chemotherapy are given  
within the same episode, use both X72 and X73 codes.

Where the method of administration is unknown, coders should check with clinical staff to  
determine a local default code for the hospital/trust. Please remember that all local

policies/codes should be approved in writing by a clinician and retained within the Coding Department's Policy and Procedures for future reference.

## **CLO Test**

### **OPCS4.2**

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

A CLO test normally involves a biopsy of the antrum of the stomach. Therefore, in the absence of further information, this should be coded to:

G45.1 - Fiberoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract *with*  
Z27.2 - Stomach

## **Lipofilling Injections (Coleman Fat Transfer)**

### **OPCS4.6**

### **Coding Guidelines No. 29, October 2011**

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.

S50.2 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

## **Cold Coagulation to Cervix**

### **OPCS4.2**

### **Coding Quarterly No. 6, April 1998**

Cold coagulation is the destruction of tissue by heat and not cold. The correct code assignment is:

Q02.3 Cauterisation of lesion of cervix uteri

## **Colonoscopy with biopsy rectum/ Colonoscopy with biopsy terminal ileum**

### **OPCS4.2 Coding Guidelines No. 10, December 2001**

Although generally a sigmoidoscope would be used to take an endoscopic biopsy from the rectum, occasionally a colonoscopy may have been carried out, with the clinician noticing a lesion of the rectum and deciding to take a biopsy.

It is important that the biopsy is recorded and it is acceptable to use

H22.1 - Diagnostic endoscopic examination of colon with  
Z29.1 – site code for rectum

During some colonoscopies the endoscopic examination proceeds as far as the terminal portion of the ileum, which may be biopsied. In such cases it is important that coders should adhere to the principle outlined above where a rectal biopsy was performed with the colonoscope.

This means that the code G80.- Diagnostic endoscopic examination of ileum should NOT be used when a colonoscopy includes examination of the terminal ileum. Instead, H22.- should be used. There is no need to signify that the terminal ileum has been examined during a colonoscopy unless a biopsy has been performed. In that case a site code (e.g. Z27.6 Ileum) should be added, as the examples below show:-

#### Colonoscopy with examination of terminal ileum, no biopsies

Code to:

H22.9 Diagnostic endoscopic examination of colon

#### Colonoscopy with examination of terminal ileum and biopsy of ascending colon

Code to:

H22.1/Z28.3 Diagnostic endoscopic examination of colon and biopsy of lesion of colon/Ascending colon site

#### Colonoscopy with biopsy of terminal ileum

Code to:

H22.1/Z27.6 Diagnostic endoscopic examination of colon and biopsy of lesion of colon/Ileum site

#### Colonoscopy with biopsies of ascending colon and terminal ileum

Code to:

H22.1/Z29.8 Diagnostic endoscopic examination of colon and biopsy of lesion of colon/Specified part of bowel nec.

In the last example the Z298 Specified part of bowel nec site code is being used for the multiple sites which would be coded individually to Z28.3 and Z27.6 respectively.

The apparent inconsistency of some of the above site codes with the colonoscopy code H22.1 is much less significant than the error of using an incorrect endoscopy code.

G80.- *Diagnostic endoscopic examination of ileum* (or its therapeutic equivalent G81.-) should be used for those occasions when the patient undergoes 'small intestine push enteroscopy', 'sonde enteroscopy' or 'intraoperative enteroscopy' of the ileum.

## **Colonoscopies/Sigmoidoscopies**

### **OPCS4.2 Coding Guidelines No. 15, November 2004**

Because the titles of categories H23.- to H28.- include reference to sigmoidoscopes, when coding colonoscopies or sigmoidoscopies, the coder should use the code applicable to the

instrument rather than the part of the intestine examined. Any colonoscopy/sigmoidoscopy which fails to progress to the intended area, and where nothing but examination was carried out, should have a Z code added to indicate how far it reached.

For example:- patient comes in for a colonoscopy, but because of poor bowel preparation the scope cannot proceed beyond the rectum. Code to

H22.9 Colonoscopy nec with

Z29.1 Rectum

**This change will be implemented from 1st April, 2005.**

## **Colposcopy with Punch Biopsy of the cervix (uteri)**

**OPCS 4.6**

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

A colposcopy is a diagnostic procedure which involves visual examination of the vagina and the cervix of the uterus using a colposcope.

During colposcopy a speculum is inserted into the vagina to hold it open and a colposcope (a magnifying instrument that has a light source attached to it and looks similar to a pair of binoculars) is used to examine the cells of the cervix. If abnormal cells are found a biopsy may be taken from the cervix.

A colposcope is not an endoscope and it does not touch or go inside the vagina, therefore the guidance for the coding of endoscopic procedures does not apply.

When a punch biopsy of the cervix is carried out during a colposcopy examination, this must be coded using the following OPCS-4 codes:

**Q03.4 Punch biopsy of cervix uteri**

**Q55.4 Colposcopy of cervix**

Includes: Colposcopy NEC

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## **Combined VV ops**

**OPCS4.3**

**Coding Guidelines No. 18, May 2006**

Use the combined VV operation codes in preference to the single codes if more than one type of operation (ligation, stripping, stab avulsion) has been performed on varicose veins in the same theatre episode.

## **Dacron Mesh Keratoprostheses**

**OPCS4.2**

**Coding Guidelines No. 4, September 1999**

A new procedure is being carried out to restore the sight of patients who suffer from repeated rejections of corneal transplants implanted in the conventional way. It involves a 'two-stage' operation. Initially two plastic corneas made from Dacron are implanted in pockets of cheek tissue under the patient's eyes, so that they will develop a coating of the patient's own tissue cells. The aim is to trick the eye into accepting a foreign body - the artificial cornea - and reduce the chances of rejection when the prosthesis is inserted in the eye. One implant will stay in the cheek for about two months before being transplanted into the eye. The other implant will be kept as a spare.

The correct OPCS4 codes for this procedure are:

## Stage 1

S50.3 Insertion of inert substance into subcutaneous tissue nec  
Y70.3 First stage of staged operations noc  
Z47.3 Skin of cheek [UK - Scotland will have to drop this site code]

## Stage 2

C46.4 Insertion of prosthesis into cornea  
Y71.1 Subsequent stage of staged operations noc

## **Dental procedures**

### **OPCS4.3 Coding Guidelines No. 18, May 2006**

All patients admitted for any of the new dental procedures should have the appropriate procedure code assigned.

## **Therapeutic and diagnostic procedures in same episode**

### **OPCS4.2 Coding Guidelines No. 7, November 2000**

Following an analysis carried out by the Coronary Heart Disease Task Force it has become apparent that some sites are not adhering to the general principle of recording therapeutic procedures before any diagnostic procedure.

In this particular case sites have recorded procedures such as K63.- Contrast Radiology of Heart in Main Operation field followed by K49.- Transluminal Balloon Angioplasty of Coronary Artery in Other Operation fields. Even though the radiology may occur prior to the angioplasty, the fact that the angioplasty was a therapeutic procedure means from a coding perspective that this procedure is the most clinically significant and therefore should be coded before any diagnostic procedure.

A similar principle was reiterated in Coding Guidelines No 3 June 1999.

## **Therapeutic v Diagnostic Procedures**

### **OPCS4.2 Coding Guidelines No. 3, June 1999**

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

## **Diagnostic Endoscopy where no biopsies taken**

### **OPCS4.2 Coding Guidelines No. 3, June 1999**

Some sites have requested confirmation of the Note 'Use subsidiary site code as necessary' in for example G45.9. Does this mean that they should specify the 'lowest' (or most internal) site investigated?

The answer is NO - only use the 'subsidiary site code' with Diagnostic Scopes to identify site of biopsies.

Please refer to Coding Guidelines No 2, January 1999 for further advice on Endoscopies with multiple biopsies.

### **Dupuytren's Release**

#### **OPCS4.2                      Coding Guidelines No. 5, January 2000**

It has been agreed by the Clinical Coding Review Group that if no further information is available for the term Dupuytren's Release:

Default code - T52.1 - Palmar fasciectomy

### **ECG                      OPCS4.2                      Coding Guidelines No. 9, July 2001**

The SCCC advises coders to check out thoroughly the meaning of abbreviations as the same abbreviation can have a number of different meanings depending on the context in which it is used. For example, a recent audit came across ECG, which is universally used as an abbreviation for Electrocardiogram (check your medical dictionaries!), and would not normally be coded. The phrase ECG was assumed by the coders to be an **Echocardiogram** which is the use of ultrasound waves to investigate and display the action of the heart as it beats.

Where doctors consistently use abbreviations it is useful for the coding staff to agree on the interpretation of the abbreviations and document this for future coders and auditors. Obviously abbreviations will change over time and such a document would need regular updating.

### **Endoscopies with multiple biopsies**

#### **OPCS4.2                      Coding Guidelines No. 2, January 1999**

Questions have arisen about endoscopies where multiple biopsies are taken. The following has been asked. "If several biopsies are performed and one biopsy proves positive, should the coding reflect the positive site?" The answer is NO. Results of biopsies are irrelevant to coding. If multiple sites are biopsied then code as per the following examples:-

1a) Upper GI endoscopy with multiple biopsies (oesophagus, stomach and pylorus)

Code G45.1 + Z27.8 (Specified upper digestive tract nec)

1b) Upper GI endoscopy with multiple biopsies from oesophagus

Code G45.1 + Z27.1 (Oesophagus)

2a) Colonoscopy with multiple biopsies (Transverse Colon and Descending Colon)

Code H22.1 + Z28.7 (Colon nec)

2b) Colonoscopy with two biopsies from the Transverse Colon

Code H22.1 + Z28.4 (Transverse Colon)

## **Epidural SMR02 review 2000**

There is no requirement to code epidural in OPCS4. This is identified in the data items Analgesia During Labour and Analgesia/ Anaesthesia During Delivery.

## **Excision of lesion of skin OPCS4.2 Coding Quarterly No. 6, April 1998**

This operation is frequently miscoded in OPCS4. The use of the code S06.8 follows the same rules as any other .8 code in OPCS4 i.e. it is an 'Other excision of lesion of skin' (category title) but not one of those previously listed in the category (marsupialisation or shave excision). It should not be used merely when the operation specifies a different site from head or neck. For example, the correct codes for excision of lesion of skin of back are:

S06.9 - Unspecified other excision of lesion of skin; with  
Z49.4 - Skin of back

## **F09 V F10 Surgical removal versus simple extraction of teeth OPCS4.4 Coding Guidelines No. 23, September 2008**

A simple tooth extraction is a procedure where any tooth or part of a tooth e.g. a root is removed. It does not require surgical removal i.e. it does not require the raising of a tissue flap. Raising of a tissue flap means cutting into the gum with a scalpel. A surgical removal is a more complex process than a simple extraction. Surgical removal is usually carried out for impacted teeth, wisdom teeth, or very badly broken down teeth. Clinically, the definition includes the use of a scalpel to cut the gum with or without bone removal prior to tooth / root removal.

## **Genital Swab Q55.6 OPCS4.3 Coding Guidelines No. 18, May 2006**

It is optional whether or not sites choose to use this code.

## **Gestational age codes OPCS4.3 Coding Guidelines No. 18, May 2006**

It is only necessary to use gestational age codes (Y95.-) on SMR01 abortion or miscarriage episodes. The information is already hard-coded on SMR02 episodes and so the codes would be redundant.

## **Tennis/golfer's elbow surgery OPCS4.4 Coding Guidelines No. 21, November 2007**

Surgery for tennis/golfer's elbow can take various forms including cutting extensor tendons and suturing them on to fascia. It is generally more complicated than simply freeing a tendon

(for example from adhesions). In the absence of more detailed information **T70.3** (Adjustment to muscle origin of tendon) should be the default code for surgery for tennis/golfers' elbow.

## **Haemorrhoidal artery ligation operation (HALO)**

### **OPCS4.6**

#### **Coding Guidelines No. 29, October 2011**

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.

## **Hard coded diagnostic and procedure fields on SMR02**

### **Coding Guidelines No. 27, October 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 OPCS 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.

## **Hickman Line Insertion**

### **OPCS4.2**

#### **Coding Quarterly No. 6, April 1998**

The default code for the eponym Hickman Line is L91.1 (Open insertion of central venous catheter). However it is advisable to check if this is carried out as an open procedure. If not, the code L91.2 (Insertion of central venous catheter nec) maybe more appropriate.



## **High cost drug codes/ Drugs for chemotherapy OPCS4.3 Coding Guidelines No. 18, May 2006**

It is not necessary to use the high cost drug codes at the moment. Future guidelines may contain further advice.

## **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.

## **Hybrid hip replacement codes OPCS4.2/3/4 Coding Guidelines No. 20, June 2007**

A reminder that there are now codes (W93 – W95) which allow the component part replaced or revised to be incorporated in the main code. The supplementary code should now be that for laterality.

## **Hysteroscopy and D&C OPCS4.2 Coding Guidelines No. 13, January 2003**

It has been brought to our attention that clinicians are carrying out biopsy of uterus using a hysteroscope and calling the procedure 'hysteroscopy and D&C'. However the full dilation and curettage of the womb is still sometimes done. It is important to distinguish between the two procedures, which are very different in terms of equipment, staff training, and cost. Coders should discuss this article with their clinicians and ask them to ensure that it is always made clear in the operation notes which type of D&C procedure has been performed. Where no further information is available the default code for hysteroscopy and D&C will continue to be:

Q10.3 – Dilation of cervix uteri and curettage of uterus nec

Q18.9 – hysteroscopy nec

**Implanon  
OPCS4.3/4**

**Coding Guidelines No. 20, June 2007**

Please note the codes at S52.5 – Insertion of hormone into subcutaneous tissue and S52.6 – Replacement of hormone in subcutaneous tissue. This includes IMPLANON and other contraceptive substances.

**Injection into Tendon Sheath**

**OPCS4.5**

**Coding Guidelines No. 24, October 2009**

The code T74.4 Injection of therapeutic substance into tendon NEC was added into the OPCS-4.3 revision of the classification. Subsequently, further research and clinical consultation has clarified that the usual practice is to inject the tendon sheath rather than the tendon itself. However, this may be documented in the clinical record as either 'Injection into tendon' or 'Injection into tendon sheath'.

The correct OPCS-4 code to assign when an injection is described as 'into tendon' or 'into tendon sheath' is T74.4 Injection of therapeutic substance into tendon NEC.

**Scottish Clinical Coding Standards March 2013**

**Instrumented spinal fusions with decompression and bone graft**

When a spinal decompression is performed in addition to a spinal fusion and instrumentation procedure, it is only necessary to assign an additional code for the spinal decompression if the code description (for the fusion/instrumentation procedure) does not state both 'fusion' and 'decompression'.

Example: Patient admitted for L5/S1 Transforaminal Lumbar Interbody Fusion (TLIF) with posterior decompression of lumbar spine.

V38.6 Primary transforaminal interbody fusion of joint of lumbar spine V25.5 Primary posterior decompression of lumbar spine NEC

An example of a code which describes both decompression and fusion is V25.3 Primary posterior decompression of lumbar spine and intertransverse fusion of joint of lumbar spine.

A bone graft (synthetic or allograft) is an integral part of the spinal fusion and instrumentation procedure. Therefore it is not necessary to assign an additional OPCS-4 code for the bone graft when it is performed together with spinal fusion and instrumentation. However, in instances where an autograft has been used during the fusion and instrumentation procedure, it is necessary to assign an additional OPCS-4 code from category Y66 Harvest of bone to identify the location where the bone was harvested from.

Example: Patient admitted for L3/L5 primary anterior lumbar interbody fusion (ALIF) and posterior instrumentation with the use of bone autograft from the right iliac crest:

V33.6 Primary anterior excision of lumbar intervertebral disc and posterior instrumentation of lumbar spine Y66.3 Harvest of bone from iliac crest

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## **IV antibiotics**

**OPCS4.2/3**

**Coding Guidelines No. 18, May 2006**

Use X29.2 as the default code where it is not known if the IV antibiotics are given by injection or continuous infusion.

## **IV immunoglobulin**

**OPCS4.3**

**Coding Guidelines No. 18, May 2006**

If it is known that the IV immunoglobulin has been given continuously, it should be coded to X29.2, but otherwise the default is X30.2 - Injection of gamma globulin, which includes 'intravenous immunoglobulin NEC'.

## **K-Wire Fixation**

**Coding Guidelines No.31 September 2012**

Kirschner wires (K-wires) are steel wires frequently used to hold fragments of bone in position in the treatment of bone fractures.

Medical documentation and procedure notes do not usually clarify whether K-wire fixation should be classified as a rigid or flexible form of internal fixation.

In the term "flexible fixation", the word flexible means that the implant can adapt to a path by changing direction without damage to the internal structure. Kirschner wires (K-wires) may be bent, and whilst this changes the internal properties of the K-wire, this is not because it is flexible but because force has been applied. K-wire fixation is always a form of rigid fixation.

The OPCS-4 code assignment may vary depending on the type of reduction performed, for example primary, secondary, closed, open, etc.

Example: Primary closed reduction and K-wire fixation of right sided fracture of lower end of radius, performed under image intensifier:

W24.2 Closed reduction of fracture of long bone and rigid internal fixation NEC Z70.5 Lower end of radius NEC

This guidance is only relevant where coders have a choice of using a rigid or flexible fixation code as in the W24.- rubric. Often the fixation within the OPCS classification is not further defined as flexible or rigid, for example W20.- where the extramedullary fixation is classified by type of fixator rather than whether it is flexible or not.

Note that K-wires may also be used to augment anchorage of cerclage wires and in skeletal traction; in such instances the K-wires do not require coding in addition.

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## **Laparoscopy and dye test**

**OPCS4.2**

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

Laparoscopy and dye test are both diagnostic procedures. If a laparoscopy and dye test is done, code to Q41.3 + either Q39.9 if the laparoscopy is only of fallopian tube or T43.9 if with a full laparoscopy. This advice replaces any previously given.

**This guidance takes effect from 1st April, 2006.**

## Laparotomy

### OPCS4.2

### Coding Quarterly No. 4, September 1997

When an exploratory laparotomy is performed to search for possible pathology and a further procedure is carried out straightaway as a result of the exploration, it is only necessary to record the subsequent procedure and not the laparotomy.

Example:

Admission reason	Acute abdominal pain
Operation	Exploratory laparotomy reveals ruptured ovarian cyst Marsupialisation of ovarian lesion

The only operation code required is Q43.3 - Marsupialisation of lesion of ovary

## Laterality Codes September 2012

### OPCS 4.6

### Coding Guidelines No. 31,

Where space is available on the SMR, laterality (Z94.-) should be recorded where appropriate to reflect the side of the body on which the procedure/intervention was carried out.

Where there is a conflict over selection of supplementary codes, the general rule is that a 'Y' code would take precedence over a 'Z' code, **except** in Chapter W, where the Orthopaedic specialists require the bone/joint and/or laterality in preference to any 'Y' code.

#### Example 1:

Excision of left kidney:  
M02.5 Nephrectomy NEC  
Z94.3 Left sided operation

**Rationale:** There is no supplementary information about the method of procedure being carried out and the title of the code includes the organ, therefore the laterality code can be added.

#### Example 2:

Primary suture of laceration to skin on the left side of the back:  
S42.1 Primary suture of skin NEC  
Z49.4 Skin of back

**Rationale:** There is no supplementary information about the method of procedure being carried out, but the Site code is added to be more specific about the area of skin. There is no space to add laterality.

#### Example 3:

Failed laparoscopic right nephrectomy – converted to open procedure.  
M02.5 Nephrectomy NEC  
Y71.4 Failed minimal access approach converted to open

**Rationale:** There is a requirement to add a supplementary code to show the change in the method of operation. There is no space to add laterality.

#### Example 4:

Endoscopic drainage of cyst of right ovary  
Q49.3 Endoscopic drainage of cyst of ovary  
Z94.2 Right sided operation

**Rationale:** The supplementary information about the method of procedure is included in the main code title, as is the name of the organ. There is therefore space to add the laterality code.

**Example 5:**

Tension band wiring of fracture of right patella.

W21.4 Primary intra-articular fixation of intra-articular fracture of bone nec

Z78.7 Patella

**Rationale:** The main operation code does not record information about the site of the operation, therefore the supplementary code gives the bone involved and there is no space to record laterality.

**V55 codes to record the level of the spine**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

Do not use the V55 codes just now.

**Removal of Reveal Loop Recorder**  
**OPCS4.2 Coding Guidelines No. 9, July 2001**

Following advice given in Coding Guideline No 8 for Insertion of Loop Recorder, additional instructions are now issued for coding 'Removal of Loop Recorder'.

This should be coded to:

S62.3 - Removal of inserted substance from subcutaneous tissue with  
Z49.3 - Skin of anterior trunk

**Metal-on-metal (MoM) hip resurfacing arthroplasty**  
**OPCS4.2 Coding Guidelines No. 13, January 2003**

This procedure is emerging as an alternative to conventional total hip replacement (THR) for certain patients with advanced hip disease. Candidates for MoM hip resurfacing will usually be amongst the younger and more active of such patients, who would be likely to outlive the expected lifespan of a conventional hip prosthesis.

Unlike a THR, the MoM resurfacing procedure conserves the femoral head and neck, the shaped femoral head being fitted with a metal surface and the acetabulum being lined with a metal cup. This technique leaves open the option of subsequent revision to THR.

The OPCS4 coding for a metal-on-metal hip resurfacing arthroplasty is -

W58.1 Primary resurfacing arthroplasty of joint  
Z84.3 Hip Joint

This guidance supersedes any previous guidance given on the coding of MoM hip resurfacing arthroplasty.

**Note:** This procedure should not be confused with metal-on-metal total hip replacement.

**Nebuliser**  
**OPCS4.3 Coding Guidelines No. 19, September 2006**

Although OPCS4.3 gives the default code for Nebuliser NEC as E85.5 – Nebuliser ventilation, patients who are given a nebuliser for asthma or cystic fibrosis are generally not having nebuliser ventilation.

Where "Nebuliser given" is mentioned on the discharge summary of such patients, use the code E89.3 – Nebuliser therapy unless there is evidence to the contrary.

**This advice is effective from 1st October, 2006.**

**One Scope, two or more procedures**  
**OPCS4.4 Coding Guidelines No. 21, November 2007**

If in one theatre visit a patient undergoes more than one procedure using the same scope how should these procedures be coded? The Clinical Coding Review Group has issued the following guidance.

Use the code highest up the hierarchy in the appropriate category i.e. the code with the lowest 4th digit within the appropriate category.

This will avoid double counting of scopes by analysts.

Examples:

1. Patient has three rectal polyps removed using a flexible sigmoidoscope. One is removed by snare resection the other two by hot biopsy.

Codes:

H23.1 endoscopic snare resection of lesion of lower bowel using fiberoptic sigmoidoscope

Z29.1 Rectum

2. Patient has ureter stone shattered with laser lithotripsy and stent inserted into ureter via a nephroscope.

Codes:

M26.1 Nephroscopic laser fragmentation of calculus of ureter

3. Cystodiathermy of bladder, excision of lesion of bladder and biopsy of bladder, all done with same scope at same time.

Codes:

M42.1 Endoscopic resection of lesion of bladder

4. Food bolus stuck in patient's oesophagus. Oesophagoscopy performed. Part of bolus removed with scope, other part pushed down with scope. Oesophagus biopsied at same time.

Code:

G15.1 Fiberoptic endoscopic removal of foreign body from oesophagus

N.B. There may be exceptions to this guidance, for example:

Patient has ERCP, endoscopic removal of two stones from bile duct, endoscopic sphincterotomy and endoscopic insertion of a plastic stent into bile duct.

Codes:

J38.1 + J43.9

Endoscopic sphincterotomy of sphincter of oddi and removal of calculus HFQ

+ Diagnostic endoscopic retrograde examination of bile duct and pancreatic duct, Unspecified

If an ERCP is performed with any other procedure, it should be coded in addition.

In Scotland it is paired with J38.1.

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

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

**OPCS4.5 Coding Guidelines No. 28, March 2011**

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

## 'O/Z' codes

### OPCS4.5

### Coding Guidelines No. 26, October 2010

Following an update to the National Reference Files, the following 'overflow' codes representing body sites have been added to the OPCS4 files:

#### **O11.- Other upper digestive tract (Principal Z27)**

- O11.1 Gastro-oesophageal junction
- O11.8 Specified other upper digestive tract NEC
- O11.9 Other upper digestive tract NEC

#### **O12.- Branch of external carotid artery**

- O12.1 Superficial temporal artery
- O12.2 Maxillary artery
- O12.3 Specified branch of external carotid artery
- O12.9 Branch of external carotid artery NEC

#### **O13.- Other leg region (Principal Z90)**

- O13.1 Multiple digits of foot NEC
- O13.8 Specified other leg region NEC
- O13.9 other leg region NEC

#### **O14.- Other lymph node (Principal Z61)**

- O14.1 Pelvic lymph node
- O14.2 Sentinel lymph node
- O14.8 Specified other lymph node NEC
- O14.9 Other lymph node NEC

These codes have the same validation applied as all 'Z' (site) codes.

## **Panendoscopies**

### OPCS4.2

### Coding Guidelines No. 10, December 2001

Coders may sometimes encounter the term panendoscopy. This term is used by clinicians in several different specialties, and therefore has a number of different meanings. Even within a specialty, there may be slight variations in meaning. Generally, the term seems to cover the endoscopic examination of a number of different sites. These sites may cross OPCS4 'body-system' boundaries.

The term 'panendoscopy' by itself cannot be coded.

In order to assign the correct code(s) it is essential that further information is sought from the clinician who is using the term. The procedure(s) covered by the term should then be coded fully according to the rules of coding.

Example: "Panendoscopy and biopsy of larynx and tongue".

When asked, the clinician gives the information that his/her use of the term 'panendoscopy' signifies laryngoscopy, nasopharyngoscopy and flexible oesophagoscopy.

<b>Index trail</b>	<b>Tabular list</b>	<b>Code</b>
Biopsy larynx endoscopic	Diagnostic endoscopic examination of larynx and biopsy of lesion of larynx	E36.1
Biopsy tongue	Biopsy of lesion of tongue	F24.1



Nasopharyngoscopy	Diagnostic endoscopic examination of nasopharynx nec	E25.3
Oesophagoscopy fiberoptic	Diagnostic fiberoptic endoscopic examination of oesophagus, unspecified	G16.9

The codes E36.1, F24.1, E25.3 and G16.9 should all be assigned.

### **PEG                    OPCS4.3                    Coding Guidelines No. 18, May 2006**

The code for PEG is now G44.5 and you should add Y70.5 if coding a temporary PEG. The default is permanent PEG.

### **Laryngopharyngectomy                    OPCS4.6 Coding Guidelines No. 26, October 2010**

The following OPCS-4.5 codes and sequencing apply when coding laryngopharyngectomy.

Total Laryngopharyngectomy  
E19.1 Total pharyngectomy + E29.1 Total laryngectomy

Partial Laryngopharyngectomy  
E19.2 Partial pharyngectomy + one of the following codes:  
E29.2 Partial horizontal laryngectomy  
E29.3 Partial vertical laryngectomy  
E29.4 Partial laryngectomy NEC

Laryngopharyngectomy  
E19.2 Partial pharyngectomy Includes: Pharyngectomy NEC  
+ E29.6 Laryngectomy NEC

This is an update to the guidance published in Coding Quarterly No.1 November 1996.

### **Pre-assessment code for a kidney transplant (M17.-) OPCS4.3                    Coding Guidelines No. 18, May 2006**

Use a pre-assessment code from M17.- for a kidney transplant only if carried out in a separate episode from the transplant itself.

## **Pre-auricular and post-auricular area OPCS4.2 Coding Guidelines No. 6, June 2000**

Clarification has been sought on a number of occasions for the correct OPCS4 code for excision of cyst of pre-auricular area.

Correct codes are:

Excision cyst of pre-auricular area	D01.3 Excision of pre-auricular abnormality (as there is a specific code in Chapter D)
Excision cyst of post-auricular area	S06.5 Excision of lesion of skin of head or neck Z48.8 Skin of specified part of head nec (as there is no code specific to this site of the ear)

## **Proctoscopy OPCS4.6 Coding Guidelines No. 29, October 2011**

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 Coding Guidelines No. 29, October 2011**

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.

## **Re-amputations**

### **OPCS4.2 Coding Guidelines No. 5, January 2000**

There has been some confusion around the correct use of the OPCS-4 codes for re-amputation.

The following two examples are used to illustrate their correct use.

1. A patient is admitted and has an amputation of the right foot through the ankle, and then a few days later goes back to theatre for a right below knee amputation.

Code - first amputation

X10.1 Amputation of foot through ankle

second amputation

X09.5 Amputation of leg below knee

2. Patient has amputation 8 inches below the knee, taken back to theatre later and re-amputated to 4 inches below the knee. [re-amputation takes place through the same bone]

Code - first amputation

X09.5 Amputation of leg below the knee

second amputation

X12.1 Re-amputation at a higher level

Z78.9 Bone of lower leg nec

Code X12.1 - Reamputation at a higher level should only be used when the re-amputation would take the coder to the same code as the original amputation. When using X12.1, a Z code should also be added to identify the specific site of the amputation.

**Rehabilitation codes U50.- to U54.-**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

If a patient is transferred for rehabilitation, a procedure code from U50.- to U54.- should be used in addition to the ICD10 Z50.- code (Care involving use of rehabilitation procedures). It is not necessary to use either the ICD10 Z50.- codes or the U50.- to U54.- codes in the same episode as the original treatment

**Respiratory support etc E85.- to E97.-**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

Use E85.- to E97.- codes if mentioned on the discharge summary. E85.1 (Invasive ventilation) should be used for a statement of 'intubation and ventilation'.

**Scans**  
**OPCS4.3 Coding Guidelines No. 19, September 2006**

Since OPCS4.3 was introduced there have been several problems with the coding of scans. Some decisions were given out through helpdesk, but it was decided that the whole subject needed to be reviewed. The following general guidelines should be followed:

1. If only one scan is done, only one code should be used, even if more than one part of the body has been scanned
2. If multiple sites are examined use a .8 in the appropriate site code category (as we do with multiple biopsies)
3. Type of scan should take precedence over site, e.g. if a CT scan has been done use a CT scan code
4. Next in priority is site
5. Last in priority is contrast material

**This article replaces any previous verbal guidance, and queries not covered by this general advice should be referred to the helpdesk. Guidance given in CG18 May 2006 still applies.**

Example: Ultrasound scan of kidney, ureter and bladder (one scan). Code to  
U12.3 – Ultrasound of kidneys +  
Z41.8 – Specified upper urinary tract NEC  
(Select U12.3 in preference to U12.4 because higher in hierarchy. Reason for selecting site code Z41.8: Genitourinary sites come under categories Z41 and Z42. Z41 is higher up the hierarchy so select Z41. Select .8 for multiple sites.)

**Scopes and Blood Transfusions**  
**OPCS4.2 Coding Guidelines No. 14, January 2004**

We have been asked whether a scope would take precedence over a blood transfusion in order of recording, if both have been given during an episode of care. In general, therapeutic procedures have priority over diagnostic procedures, but in this case clinicians have decided that since scopes are more resource intensive than blood transfusions, it is correct to give them higher priority.

**Skin cleansing sterilizing taping codes**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

It is only necessary to use the following codes if nothing else is done.

S40.- - Other closure of skin

S56.6 – Cleansing and sterilization of skin of head or neck NEC

S57.6 - Cleansing and sterilization of skin NEC

**Skin Grafts**  
**OPCS4.2 Coding Guidelines No. 8, February 2001**

In Scotland when coding skin grafts - the graft to and its site should take priority over graft from

When information is available regarding the harvesting of a graft, this must be coded. This is a subsidiary Y code which may require to be preceded with a code from Chapter S eg S60.8 (Other operations on skin)

This advice conflicts with the example given in the OPCS4 Training Instructions Manual - Version 1.6, page S-5.

**Example 1:**

Full thickness autograft of skin to back. Skin for graft harvested (random pattern) from thigh.

Code to:

S36.2 - Autograft of skin nec/Z49.4 - Skin of back

S60.8 - Other operations on skin/Y55.5 - Harvest of random pattern flap of skin from thigh

Coders should also be aware that the enhancing code (from Chapter S) relates to the code selected in first position and should not be used to identify a separate procedure.

**Example 2:** (not in training manual)

Excision of lump on nose with harvest of full thickness postauricular skin and split skin graft to the nose.

Code to:

E09.1 - Excision of lesion of external nose

E02.8 - Other specified plastic operation/S35.3 - Split autograft of skin to head or neck nec

S60.8 - Other specified operation on skin/Y58.1 - Harvest of full thickness skin from postauricular region.

However if the code for the primary operation specifies that that the operation includes a graft, it is not required to have a separate code for the harvest.

**Example 3:**

Myringoplasty using temporalis flap.

Code to:

D14.1 - Tympanoplasty using graft (includes myringoplasty using graft)/ Y59.1 - Harvest of temporalis flap of skin and fascia

## **Skin test codes**

### **OPCS4.3**

### **Coding Guidelines No. 18, May 2006**

All patients admitted for skin testing should have the appropriate skin test code from U27.- or U28.- assigned.

## **Sterilisation**

### **SMR02 review 2000**

The procedure performed for sterilisation should be coded in OPCS4. This provides greater detail than that given in the data item Sterilisation After Delivery.

## **Sutures and Debridement**

### **OPCS4.2**

### **Coding Guidelines No. 16, August 2005**

Where it is necessary to debride before suturing e.g. remove foreign particles, trim edges of a wound then the debridement should also be coded. This should be mentioned in the notes as such to qualify the use of both codes. Where there is no mention of 'debridement', 'trimming of edges of wound', 'removal of glass', etc. then code only the suturing of the wound.

#### **Examples:**

Dx: Open wound of head – fell off motorbike  
Op: Suture to laceration of scalp, removed debris and trimmed edges of wound.

#### **OPCS4 Codes:**

S41.1 Primary suture of skin of head or neck nec  
Z48.1 Skin of scalp  
S56.1 Debridement of skin of head or neck nec  
Z48.1 Skin of scalp

Dx: Lacerated R arm – fell off step  
Op: Sutured R arm

#### **OPCS4 Codes**

S42.1 Primary suture of skin nec  
Z50.1 Skin of arm

## **Testing of pacemaker**

### **OPCS4.3**

### **Coding Guidelines No. 18, May 2006**

It is not necessary to code the testing of the pacemaker (U31.-) if it is done in the same episode as the insertion.

## **The use of Y76.7 Arthroscopic approach to joint (Revised 2012)** **OPCS 4.6 Coding Guidelines No. 31, September 2012**

### **Addition of code W42.6 to list.**

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:

W42.6 Arthrolysis of Total Prosthetic Replacement of Knee Joint  
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.

## **Transcatheter Aortic Valve Implantation (TAVI)** **OPCS4.6 Coding Guidelines No. 29, October 2011**

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

**Transapical (transventricular) approach:**

K26.2 Xenograft replacement of aortic valve

Y49.4 Transapical approach to heart

**Tears SMR02 review 2000**

There is no requirement to code repair of tears in OPCS4. The degree of tear is identified in the data item Tear and it is assumed that all tears will be sutured if necessary.

**Temporal Bone Excision Coding Guidelines No. 26, October 2010**

The temporal bones form part of the sides and base of the cranium. Procedures on the cranium are classified to OPCS4.5 Chapter V Bones and Joints of Skull and Spine.

The OPCS4.5 codes for a temporal bone excision are:

V05.8 Other specified other operations on cranium

Z63.3 Temporal bone

England would code V05.8 Y05.- Z63.3 Z94.-.

**Tension Band Wiring of a fracture of the patella  
OPCS4.2 Coding Quarterly No. 5, January 1998**

Tension band wiring is a type of internal fixation used to stabilise a fracture of the patella. The patella is the small circular sesamoid bone forming the kneecap and as such has no medulla, so this cannot be classified as an intramedullary fixation. The correct codes to be assigned for tension band wiring of a fracture of the patella are:

W21.4 - Primary intraarticular fixation of intraarticular fracture of bone nec; with

Z78.7 - Patella

**Transthoracic Echocardiogram (TTE)  
OPCS4.5 Coding Guidelines No. 25, April 2010**

Can the terms "echo" and "echocardiogram" be used as a default for TTE (Transthoracic echocardiogram) and coded to U20.1 Transthoracic echocardiography?

A transthoracic echocardiogram (TTE) is an 'echo'.

A TTE is the most common type of echocardiogram. During a TTE a probe (known as a transducer) is placed on the thorax, and high frequency sound waves are transmitted into the



body. The sound waves are bounced off the heart, and the transducer picks up the echoes. The echoes are converted into moving images that are then viewed on a TV monitor. Therefore, when the clinical statement is echocardiogram or echo with no further specification (for example 'transoesophageal', which would be coded to U20.2), then the correct OPCS-4.5 code is:

U20.1 Transthoracic echocardiography

**Please note that it is not mandatory to code a TTE unless the patient is specifically admitted for this procedure.**

### **Transvaginal Drainage of Ovarian Cyst OPCS4.2 Coding Guidelines No. 10, December 2001**

There is no designated category in OPCS4 for ovarian procedures that are neither open nor endoscopic. The Coding Review Panel agreed that in order to preserve the integrity of the categories, the correct OPCS4 codes for a transvaginal drainage of ovarian cyst (not using an endoscope) are:

Q56.8 Other specified other operations on female genital tract  
Y22.2 Aspiration of other lesion of organ noc.

### **Unicondylar / Unicompartmental knee joint replacement OPCS4.2 Coding Quarterly No. 6, April 1998**

Are Unicondylar/Unicompartmental knee joint replacements considered to be total or hemi replacements? The Clinical Coding Review Group have issued the following guidelines. Unicondylar/Unicompartmental knee joint replacements are total and therefore should be coded within categories W40.-, W41.- or W42.-. Hemiarthroplasty, knee should be coded within categories W52.-, W53.- or W54.-. with site code Z84.6.

### **Unlikely Pair Codes. OPCS4.2 Coding Guidelines No. 3, June 1999**

Care should be taken when using an 'enhance S Chapter' code. It is left to trained coders using the guidance notes in their OPCS4 to allocate correctly the use of an 'S' code to enhance the main OPCS4.

It was acknowledged that there are a few exceptions within the chapters where no note instructing the use of an S enhance code is made, but a good coder would recognise that they would be correct in enhancing main chapter OPCS4 codes by the use of a Skin Chapter code eg at C14's - C14.1 [flap] plus S23.1 [more information on the flap]. If in doubt please contact the Coding Helpdesk for guidance.

## **Urethral Catheterisation**

**OPCS 4.6**

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

### **Question**

Is it appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder in instances where an inpatient who is being treated for some other condition goes on to develop urinary retention during their hospital stay, and is subsequently treated by urethral catheterisation?

### **Answer**

It is appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder where it is clearly documented in the patient's medical record that during their hospital stay for treatment of another condition the patient also developed urinary retention, which was treated with catheterisation. This is because the catheterisation would not be considered to be part of the patient's routine care for the other condition.

However, it is not appropriate to assign the OPCS-4 code M47.9 Unspecified urethral catheterisation of bladder in circumstances where the catheterisation is performed routinely as part of, or following, a procedure.

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## **Use of C90 for local anaesthetic for ophthalmology procedures**

**OPCS4.3**

**Coding Guidelines No. 18, May 2006**

Code local anaesthetic for ophthalmology procedures using C90.- if the information is available, but code as a separate operation, rather than as a pair code for the moment.

# **OBSOLETE GUIDANCE**

## **Administration of abortifacient drugs at Outpatient Departments OPCS4.4 Coding Guidelines No. 22, March 2008**

The process of treating patients for termination of pregnancy differs from hospital to hospital and often from patient to patient.

Many patients are not treated as inpatients or day cases and therefore the treatment they receive is not well recorded in terms of national submissions.

To enable NHS Scotland to better study the types of treatment and instances of 'non-admission' for terminations, it has been decided that outpatient attendances for patients receiving abortifacient drugs should be recorded as follows;

An SMR00 must be raised at each outpatient attendance for patients requesting a termination. No diagnostic information need be recorded.

At an outpatient attendance where the patient is given an abortifacient drug, the code **X39.1 - Oral administration of therapeutic substance** should be entered in the Procedure Code (OPCS) field.

In Gynaecology Outpatient settings, code X39.1 will only be used for this purpose and not for recording any other procedure/intervention.

Where the patient goes on to have an inpatient or day case episode, record linkage will show the previous treatment.

Those patients who are not admitted will have completed the termination at home.

**This guidance applies to all SMR00 attendances on and after 1st April 2008.**

**N.B.** A letter will be sent to Medical and Nursing directors, Medical Records and Information staff, regarding this guidance and its implementation.

See also - **Coding Guidelines No. 23, September 2008:**

**Patients request termination of pregnancy at Outpatient clinic and return to ward to receive oral abortifacient drug (Mifepristone)**

## **Anti D administration SMR02 review 2000**

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)

## **Anti-D**

## **OPCS4.2 Coding Quarterly No. 4, September 1997**

If an injection of Anti-D is given, it needs to be recorded both in ICD10 and OPCS4. The appropriate OPCS4 code to use is

X30.1 - Injection of rh immune globulin

## **Appendicocaecostomy**

**OPCS4.2 Coding Guidelines No. 10, December 2001**

The correct code for appendicocaecostomy is  
H14. 8 - Other specified exteriorisation of caecum.

Please note that this procedure is for exteriorisation of colon and appendix. It does NOT include excision of appendix, for which a code from H01.- to H03.- should be recorded.

## **Y52 Approach to organ**

**OPCS4.2 Coding Guidelines No. 8, February 2001**

Please note that there are differences between the different published editions of OPCS4 Tabular.

If you have an earlier edition - please remove the term 'artificial' from the heading at Y52. It should read:

Y52 - Approach to organ through other opening.

## **Placement of arterial stents (L76.-, L89.-)**

**OPCS4.3 Coding Guidelines No. 18, May 2006**

Where placement of arterial stents (L76.-, L89.-) is recorded, code as a separate operation, rather than as a pair code for the moment. The stent codes should be secondary to the main procedure.

## **Arthroscopic Procedures**

**OPCS4.4 Coding Guidelines No. 20, June 2007**

OPCS4.3 and OPCS4.4 offer the code of Y76.7 – Arthroscopic approach to joint, which is intended for use with a more specific 'open' procedure. However, in Scotland, due to the restriction of only being able to add one supplementary code, this causes problems in as much as the name of the joint operated upon may be lost.

For this reason, and for the sake of consistency, it has been decided that Y76.7 should not be used in Scotland. Coders should select the less specific 'endoscopic' code, followed by the site code or laterality.

Example:

Debridement of (l) elbow joint, carried out endoscopically.

Possible (but unable to use all these codes in Scotland)

W80.2 Open debridement of joint NEC

Y76.7 – Arthroscopic approach to joint

Z81.5 – Elbow joint

Z94.3 – Left sided operation

Scotland

W86.8 – Other specified therapeutic endoscopic operation on cavity of other joint

Z81.5 – Elbow joint

This option (correct for Scotland) loses the specifics of what was done, but retains the fact that it was a minimally invasive procedure and the joint.

**Amendment to “Aspiration of prosthetic joint” article in Coding Guidelines No.24 October 2009.  
Coding Guidelines No. 29, October 2011**

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

**Aspiration of prosthetic joint  
OPCS4.5 Coding Guidelines No. 24, October 2009**

A joint aspiration may be performed for either therapeutic or diagnostic purposes. A sterile needle with an attached syringe is inserted within the joint cavity and fluid is drawn back (aspirated) into the syringe. The correct OPCS-4 code assignment for the aspiration of a joint when the patient has a prosthetic joint replacement in situ is

W90.1 Aspiration of joint.

The relevant joint site code must be assigned in addition to W90.1.

*(In England the joint site and laterality codes would be added and a code from Y53 Approach to organ under image control would also be assigned if image control was used.)*

The presence of the prosthesis may be connected to the need for aspiration; however the aspiration is performed on the cavity of the joint, and does not involve the physical parts of the prosthesis.

An ICD10 code of Z96.9 to indicate presence of artificial joint should be added.

**N.B. This is a Scottish/English difference**

**Bilateral Mastectomies  
OPCS4.2 Coding Guidelines No. 16, August 2005**

In the article in Coding Guidelines No.15 (November, 2004) on Bilateral Mastectomies, reference was made to codes B28.- and B29.- for excision of breast. This should have read B27.- and B28.-. Please correct your copies of Coding Guidelines.

**Bilateral Mastectomies  
OPCS4.2 Coding Guidelines No. 15, November 2004**

At the moment if a bilateral excision of breast B28.- or B29.- is done with block dissection, sampling, excision or biopsy of the lymph nodes, the laterality of the operation is lost because the excision is a pair code with the other operation. It is felt that important information is being lost by coding in this way.

**From 1st April, 2005**, where a bilateral operation of this nature has been performed, the pair code should be split in order to add a laterality code to each operation.

**Please note that this advice is for excision of breast only and does not apply to other bilateral operations eg cataracts.**

Example 1: Patient has excision of lesion of left breast with sampling of left axillary lymph node. Continue to code to  
B28.3 – Excision of lesion of breast with  
T86.2 – Sampling of axillary lymph nodes (pair code)

Example 2: Patient has bilateral total mastectomies with bilateral block dissection of axillary lymph nodes. Code to  
B27.4 – Total mastectomy nec with  
Z94.1 – Bilateral operation  
And  
T85.2 – Block dissection of axillary lymph nodes with  
Z94.1 – Bilateral operation

**For coding of 'Bilateral mastectomies with block dissection, sampling, excision or biopsy of lymph nodes' from April 2012 see *Recording Bilateral Procedures, Coding Guidelines No.30, March 2012.***

### **Bronchoscopy with biopsy, washings and brushings OPCS4.2 Coding Guidelines No. 9, July 2001**

How would I code to show that all three procedures had been carried out?  
As the Scottish validation would not allow us to add both the Y21.1 (brushings) and Y21.8 (washings) to the E49.1 (bronchoscopy with biopsy) advice is to code as follows:

E49.1 Diagnostic fiberoptic endoscopic examination of lower respiratory tract and biopsy of lesion *with*  
Y21.9 [multiple] Unspecified cytology of organ

### **Bronchoscopy with washings and brushings**

#### **Correction to code published in Coding Guidelines 18 OPCS4.3 Coding Guidelines No. 19, September 2006**

In Coding Guidelines 18 (May 2006), there was a misprint in the article on Bronchoscopy with washings and brushings

The last line read;

Biopsy, bronchoscopy with washings and brushings E49.1 and E29.2 + Y21.1

It should have read

Biopsy, bronchoscopy with washings and brushings E49.1 and **E49.2** + Y21.1

Please amend your Coding Guidelines accordingly.

#### **Bronchoscopy with washings and brushings OPCS4.3 Coding Guidelines No. 18, May 2006**

Use E49.2 for coding bronchoscopy with washings, E49.8 and Y21.1 for coding bronchoscopy with brushings, E49.2 and Y21.1 for coding bronchoscopy with washings and brushings. If biopsy is taken along with washings and/ or brushings 2 E49.- codes should be used.

Bronchoscopy with washings - E49.2

Bronchoscopy with brushings - E49.8 + Y21.1

Bronchoscopy with washing and brushings - E49.2 + Y21.1

Biopsy, bronchoscopy with washings and brushings E49.1 and E29.2 + Y21.1

Analysts should note this and adjust any calculations made on total number of scopes.

**Bronchoscopy with brushings/washings**  
**OPCS4.2 Coding Guidelines No. 8, February 2001**

**CODING QUARTERLY No. 4 SEPTEMBER 1997 - page 5**

**Brushings for Cytology**

When a bronchoscopy is performed, diagnostic bronchial brushings or washings are often taken at the same time. Washings are acquired by placing saline into the endobronchial tree and retrieving the aspirate by direct suction. Brushings (or brush biopsies) are obtained by rubbing a brush over the lesion.

The OPCS4 code Y21.1 Brush cytology of organ noc should be used to indicate that brushings are taken for cytology and Y21.8 Other specified cytology of organ noc to indicate washings taken for cytology.

Examples of the correct codes to use for these procedures when done in conjunction with a bronchoscopy are:

Flexible bronchoscopy with brushings for cytology

E49.8 - Other specified fiberoptic endoscopic examination of lower respiratory tract

Y21.1 - Brush cytology of organ noc

Flexible bronchoscopy with washings (for cytology)

E49.8 - Other specified fiberoptic endoscopic examination of lower respiratory tract

Y21.8 - Other specified cytology of organ noc

Note: Unless there is evidence that the washings were intended to be therapeutic, coders should always code 'diagnostic bronchoscopy with washings', supplemented by Y21.8

Flexible bronchoscopy with biopsy

E49.1 - Diagnostic fiberoptic endoscopic examination of lower respiratory tract and biopsy of lesion (add appropriate site code)

Note: Y21.- should be used for cytology only and should not be used for histology or microbiology

ALL THE ABOVE CHANGES SHOULD BE IMPLEMENTED FROM 1ST APRIL 2001.

**Brushings for Cytology**  
**OPCS4.2 Coding Quarterly No. 4, September 1997**

***NB: see Coding Guidelines No. 8, February 2001, Bronchoscopy with brushings/washings***

The code Y21.1 (Brush cytology of organ noc) should be used to indicate that brushings were taken for cytology

Examples:

Flexible bronchoscopy with washings/brushings for cytology E49.8/ Y21.1

Flexible bronchoscopy with washings/ brushings and biopsy E49.1/ Y21.1

Flexible bronchoscopy with biopsy E49.1

NB: Y21.1 is for cytology only and should not be used for histology or microbiology

**OPCS4.4 Index Error, Brushing of Organ**  
**OPCS4.4 Coding Guidelines No. 21, November 2007**

On page 25 of the OPCS 4.4 Alphabetical Index is an entry;  
"Brush Cytology NEC – Y22.1"

It should read **Y21.1**

This will be submitted for correction in the next version of the OPCS4 index.

**CLO test for helicobacter**  
**OPCS4.2 Coding Quarterly No. 1, November 1996**

The code for a CLO test for helicobacter is G45.1 (Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract), followed by a code from Chapter Z to identify the site of the procedure, if known.

Note: There is no OPCS4 code for a helicobacter breath test.

**Coding of Radiotherapy delivery**  
**OPCS4.5 Coding Guidelines No. 25, April 2010**

When coding radiotherapy, the subsidiary site code (identifying where in the body the radiotherapy was delivered) takes precedence over the subsidiary Y35, Y36 or Y91 codes.

Example; Simple external beam radiotherapy for adenocarcinoma of prostate using linear accelerator (megavoltage machine).

X65.4 Delivery of a fraction of external beam radiotherapy NEC

**Note: use a subsidiary code to identify external beam radiotherapy (Y91)**

Z42.2 Prostate site

England would add Y91.2 - Megavoltage treatment for simple radiotherapy after X65.4 .  
**This is a Scottish/English difference.**

**Radiotherapy**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

If using X65.- Radiotherapy Delivery codes, it is only necessary to code fractions of radiation using Y91.- code if the information is readily available in the case record. When coding radiotherapy a Y35.- code (introduction of removable radioactive material into organ NOC) will normally take precedence over a Y91.- code or a site code.

**Use of Radiotherapy Codes X65, X67 and X68 in OPCS**  
**OPCS4.5 Coding Guidelines No. 25, April 2010**

Category X65 Radiotherapy delivery was omitted from the table in the article entitled

"Coding of "non-operative" interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02.", published in Coding Guidelines No.22 March 2008. OPCS4.5 has seen the addition of two new categories for radiotherapy preparation; X67 Preparation for



external beam radiotherapy and X68 Preparation for brachytherapy. Use of these two categories in Scotland will not be mandatory.

This will be a Scottish/English difference.

This decision requires that an amendment be made to the table referred to above.

The updated table is printed below.

<b>Intervention/procedure code</b>	<b>General Guidance</b>	<b>Guidance if Elective admission (inpatient/day case) specifically for this intervention/procedure</b>
U01-U40	Not mandatory to code	Code
X28-X39	Not mandatory to code	Code
X44, X48-X58	Not mandatory to code	Code
X65	Not mandatory to code	Code
X60-X62, X66, X67.-, X68.-	Not mandatory to code	Not mandatory to code
X70, X71	Not mandatory to code	Not mandatory to code
X81-X97	Not mandatory to code	Not mandatory to code

Update to 2012 table.

### **Coding of “non-operative” interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02. OPCS4.4 Coding Guidelines No. 22, March 2008**

The recording on SMR01 and SMR02 of interventions/procedures such as imaging, injections, infusions, IV fluids, etc. tends to be inconsistent. Data on these interventions/procedures is therefore incomplete. Radiology systems are better suited to recording imaging data although not all such interventions/procedures are captured by these systems e.g. obstetric/gynaecology scans.

Previous guidance published on recording these interventions/procedures indicated that they should be recorded if mentioned on the discharge summary (Coding Guidelines No.13 January 2003, No.18, May 2006).

It will no longer be mandatory to record these interventions/procedures unless the patient is specifically admitted for this purpose.

Boards may record these interventions/procedures locally if they so wish.

**This will apply to all discharges on and after the 1st April 2008.**

The table below indicates the codes to which this guidance applies and codes for which previous guidance on recording was issued.

N.B. SMR01/SMR02 Recording administration of Anti D  
Continue to code administration of Anti D using OPCS4 code X30.1 and ICD10 code Z29.1.  
(See Data Dictionary ([www.datadictionaryadmin.scot.nhs.uk](http://www.datadictionaryadmin.scot.nhs.uk)), SMR Datasets, SMR Data Manual, SMR02, Diagnostic section, Guidelines for coding clinical conditions).

Please note that this list is not exhaustive.

Contact the Terminology Advisory Service with any queries.

<b>Intervention/procedure code</b>	<b>General Guidance</b>	<b>Guidance if Elective admission (inpatient/daycase) specifically for this intervention/procedure</b>
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U01-U40	Not mandatory to code	Code
X28-X39	Not mandatory to code	Code
X44, X48-X58	Not mandatory to code	Code
X60-X62, X66	Not mandatory to code	Not mandatory to code
X70, X71	Not mandatory to code	Not mandatory to code
X81-X97	Not mandatory to code	Not mandatory to code

Update to 2012 table

### **Scans, blood transfusions, IV fluids, injections** **OPCS4.2 Coding Guidelines No. 13, January 2003**

These procedures should always be coded if they are mentioned on the discharge summary. Please remind clinicians that there are codes in OPCS4 for these procedures and that they should be included on the discharge summary if they want them to be recorded.

### **Coleman Fat Transfer** **OPCS4.5 Coding Guidelines No. 26, October 2010**

A Coleman Fat Transfer is an eponymous procedure used commonly for cosmetic or reconstructive purposes. It involves the extraction of fat cells from one site, which are then centrifuged to cleanse the cells before being injected, usually by a tunnelling process, to the site requiring restoration. This technique is normally performed by needle, but how the fat transfer is actually carried out should be clarified with the clinician if there is any uncertainty. Within the NHS this is commonly carried out for face and breast reconstructions, but may be used on other areas of the body.

As there are many combinations of this type of procedure, in order to record this accurately and consistently coders are advised to follow the principle for skin harvests and grafts published in Coding Guideline No 8, February 2001. This states that "the graft to and its site should take priority over the graft from".

Examples:

1. Patient is having a breast reconstruction by a transfer of fat taken from abdomen.  
B29.8 Other specified reconstruction of breast + Y39.8 Other specified injection of other substance into organ NOC  
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.  
S50.2 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

### **Colposcopy of Cervix** **OPCS4.2 Coding Guidelines No. 2, January 1999**

Following a decision by the Coding Review Panel (UK)  
Colposcopy of Cervix should be coded to:

Q55.8 + Z45.1 Other specified examination of female genital tract + site Cervix uteri

### **Coronary Angioplasty with Stent** **OPCS4.2 Coding Guidelines No. 11, April 2002**

A query has arisen regarding the coding of PCTAs with introduction of a stent. From 1st April 2002 coders should code angioplasties as follows:

#### **'PCTA'**

Code to

**K49.-** - Transluminal balloon angioplasty of coronary artery

There is no need to add the Y53.- to indicate radiological control, as this is the normal procedure.

#### **'PCTA with insertion of stent'**

Code to:

**K49.-** - Transluminal balloon angioplasty of coronary artery +

**Y02.2** - Insertion of prosthesis into organ noc

### **Dental Cystectomy**

**OPCS4.2**

**Coding Guidelines No. 16, August 2005**

Coders should add a note to their OPCS4 index and tabular list that the correct code for a dental cystectomy is –

F18.1 – Enucleation of dental cyst of jaw

### **Doppler/ Duplex Studies and Intravascular Ultrasound (IVUS)**

**OPCS4.2**

**Coding Guidelines No. 10, December 2001**

**Q.** What is the difference between a doppler ultrasound study and an intravascular ultrasound study?

**A.** An 'ordinary' doppler ultrasound study is non-invasive. It involves the assessment of arteries or veins (e.g. limb vessels, renal or carotid arteries) using an external probe, providing not only an image of the inside of the vessels and any occlusive plaque or thrombus, but also information on the flow of blood - the haemodynamics - within the vessel. The test is simple, painless and can be performed as an outpatient procedure. It may also be called doppler study, duplex scanning or echodoppler ultrasound.

As this is a non-invasive scan this procedure should be coded X55.8/Y90.3

In contrast, intravascular ultrasound is an invasive procedure.

A coronary intravascular ultrasound will always be carried out in conjunction with coronary angiography (and may therefore precede coronary angioplasty). The ultrasound transducer is mounted at the end of a catheter that is introduced into a coronary artery. This investigation can measure the velocity of blood flow within the coronary artery and demonstrate not only the severity of any arterial narrowing, but also show the composition of the underlying atherosclerotic plaque. Such information can be invaluable in determining which of the types of angioplasty would be best to treat the blockage.

The OPCS4 code for this procedure is

K51.8 - Other specified diagnostic transluminal operations on coronary artery with

Y90.3 - Scanning nec

If intravascular ultrasound was being performed on other arteries, the coder should start by following the instructions for coding procedures on named vessels and their branches, which may be found at the beginning of Chapter L in OPCS4. The coder should then select as appropriate the 'other specified diagnostic transluminal operations on ...' or the 'other specified transluminal operations on....' 4 digit code for the artery concerned. The supplementary code Y90.3 — Scanning nec may then be added to this L code.

For example

Intravascular ultrasound of popliteal artery L63.8/ Y90.3

Intravascular ultrasound of peroneal artery L72.8/ Y90.3

Intravascular ultrasound of carotid artery L31.8/ Y90.3

Coders should therefore note that care is needed to determine which type of doppler study has taken place before allocating a code.

## Endometrial Procedures

### OPCS4.2 Coding Guidelines No. 8, February 2001

There are various procedures commonly carried out on the endometrium as treatments for menorrhagia. These are coded within the OPCS4 categories:

**Q16** - Other vaginal operations on uterus and

**Q17** - Therapeutic endoscopic operations on uterus.

To be able to clearly identify the different types of treatment and to make the subcategories compatible with the title of Q17, the words 'lesion of' at codes Q17.1 to Q17.4 (inclusive) should be put in brackets e.g. Q17.1 Endoscopic resection of (lesion of) uterus, thus making 'lesion' a non-essential modifier.

Some of the most common treatments are identified below:

#### Endoscopic microwave ablation of endometrium

An endoscopic microwave ablation of the endometrium is a procedure used to destroy the lining of the uterus (the endometrium) using a YAG laser. This does not constitute a resection, cauterisation or cryotherapy and therefore should be assigned a code with 'destruction nec' in the rubric.

The OPCS4 codes to be assigned are:

**Q17.4** - Endoscopic destruction of (lesion of) endometrium nec

**Y11.4** - Radiofrequency controlled thermal destruction of organ noc

If the procedure is not endoscopic, the correct OPCS4 code is:

**Q16.8** - Other specified vaginal operations on uterus

**Y11.4** - Radiofrequency controlled thermal destruction of organ noc

#### Thermal balloon ablation of endometrium

A thermal balloon ablation of the endometrium is a procedure whereby the endometrium is destroyed by a balloon inserted through the cervix and filled with hot water. This is not an endoscopic procedure.

The OPCS4 codes to be assigned are:

**Q16.8** - Other specified vaginal operations on uterus

**Y11.8** - Other specified destruction of organ noc

## Endoscopic "Balloon" Ablation of Endometrium

### OPCS4.2 Coding Guidelines No. 8, February 2001

Endoscopic "Balloon" Ablation of Endometrium  
Endoscopic balloon ablation of lesion of the endometrium should be coded as stated in Coding Guidelines No. 2 January 1999 to:

Q17.4 - Endoscopic destruction of (lesion of) uterus nec  
Y13.8 - Other destruction of lesion of organ noc - other specified

but Endoscopic balloon ablation of endometrium is now coded to:

**Q17.4** - Endoscopic destruction of (lesion of) uterus nec  
**Y11.8** - Other destruction of organ noc - other specified

### **Endoscopic "Balloon" Ablation of Endometrium** **OPCS4.2 Coding Guidelines No. 2, January 1999**

Ablation of lesion of endometrium is being coded to Q17.1 as the index automatically takes you to this code via the trail.

(Ablation endometrium lesion endoscopic Q17.1)

It has been agreed that the correct OPCS4 codes for this procedure should be as follows:-

Endoscopic balloon ablation of lesion of the endometrium:

Q17.4 (Endoscopic destruction of lesion of uterus nec) +  
Y13.8 (Other destruction of lesion of organ noc - Other specified)

Endoscopic balloon ablation of endometrium:

Q17.8 (Therapeutic endoscopic operations on uterus - other specified) +  
Y11.8 (Other destruction of organ noc - other specified)

The rationale for this decision is that the balloon ablation is a form of destruction rather than ablation (or resection as the trail currently takes you.). In addition the coder needs to choose the correct code depending on whether the destruction is for a lesion or the whole endometrium as the examples above highlight.

### **Eponym Jones (KG), index error** **OPCS4.2 Coding Guidelines No. 5, January 2000**

#### **Index error**

The following index error has been noted in the Eponym section of OPCS4 -

W74.2 Jones (KG) Reconstruction Ant. Cruciate Ligament (Z84.6)  
(amended from W74.3)

Please amend your OPCS4 index

### **Errata**

## **OPCS4.3 Coding Guidelines No. 18, May 2006**

We have been advised of the following errata by Connecting for Health. Please amend your new Coding Books.

### **OPCS-4.3 Alphabetical Index**

#### **Additions:**

Page 118 add: K57.3 Removal from Heart Foreign Body Transluminal Percutaneous

Page 23 add E49.- Bronchoscopy NEC

#### **Amendments:**

Page 52 amend: G16.1 Examination Oesophagus Ultrasound Endoscopic Fibreoptic as follows:

G16.2 Examination Oesophagus Ultrasound Endoscopic Fibreoptic

Page 81 amend: X29.3 Infusion Fluids Continuous Intravenous as follows:

X29.3 Infusion Fluids Continuous Subcutaneous

### **OPCS-4.3 Tabular List**

#### **Amendments:**

#### **G16.3 Insertion of bravo pH capsule**

Add exclusion note:

Excludes: When associated with general fibreoptic endoscopic examination of upper gastrointestinal tract (G45.3)

#### **G19.2 Insertion of bravo pH capsule**

Add exclusion note:

Excludes: When associated with general fibreoptic endoscopic examination of upper gastrointestinal tract (G45.3)

#### **G45.3 Insertion of bravo pH capsule**

Add exclusion note:

Excludes: When associated with examination limited to oesophagus (G16.3, G19.2)

#### **K34.4 Excision of vegetations of valve of heart**

Add exclusion note:

Excludes: Open excision of vegetations of heart NEC (K55.4)

#### **K55.4 Open removal of cardiac vegetations**

Add 'NEC' to code descriptor

Add exclusion note:

Excludes: Excision of vegetations of valve of heart (K34.4)

#### **L71 Therapeutic transluminal operations on other artery (SEE ALSO L66 & L89).**

Delete code L89 from the 'SEE ALSO' reference

#### **M29.5 Endoscopic renewal of tubal prosthesis into ureter.**

Add exclusion note:

Excludes: Ureteroscopic renewal of ureteric stent (M27.8 + Y15.2)

**M49.2 Change of suprapubic tube into bladder**

Includes: Insertion of suprapubic catheter NEC

Delete inclusion term as this intervention is classifiable at M38.2

**S40.2 Tissue adhesive closure of ski**

Add 'n NEC' to code descriptor

**X70 – X73 Procurement and delivery of chemotherapy for neoplasms**

Under the three character title add an exclusion note as follows:

Excludes: Chemotherapy for other conditions

**Y02 Placement of prosthesis in organ NOC**

Add exclusion note:

Excludes: Placement of stent in organ NOC (Y14)

**Y03 Attention to prosthesis in organ NOC**

Add exclusion note:

Excludes: Attention to stent in organ NOC (Y15)

**Z39.5 Saphenous vein NEC**

Amend exclusion note as follows:

Excludes: Specified saphenous vein (Z98)

**Errata****OPCS4.3****Coding Guidelines No. 19, September 2006**

We have been advised of more errata by Connecting for Health. Please amend your new Coding Books.

**CHEMOTHERAPY GUIDANCE ERRATA**

Ref no.	
16	Alemtuzumab is a High Cost Drug listed at X89.1 Monoclonal antibodies Band 1 in the table at the back of OPCS-4.3. It should be coded as X89.1 if it is not used for the treatment of a neoplasm. If it is used for the treatment of a neoplasm then it should be coded at X71.5 for procurement and X72.1 for delivery. It may appear as part of a chemotherapy regimen as Mabcampath or Campath or Alemtuzumab.
17	Rituximab is a High Cost Drug listed at X89.2 Monoclonal antibodies Band 2 in the table at the back of OPCS-4.3. It should be coded as X89.2 if it is not used for the treatment of a neoplasm. If it is used for the treatment of a neoplasm then it should be coded with its regimen. e.g. as part of ICE+ Rituximab (=RICE) X71.5 for procurement and X72.1 for delivery.
18	Filgrastim, Lenograstim and Pegfilgrastim are High Cost Drugs listed at X90.3 Neutropenia Drugs Band 1 in the table at the back of OPCS-4.3. These drugs can be used to treat neutropenia which is a side effect of antineoplastic chemotherapy and should be coded as High Cost Drugs.

**TABULAR ERRATA**

Page no.	Code	Correction
Front cover	N/A	Typographical error: Carotid
10	Ileum (G69 – G82)	Typographical error: Ileum (G68 – G82)
73	Chapter E title (CODES E01 – E97)	Typographical error: (CODES E01 – E63, E85 – E97)
85	E94.1	Typographical error: Bronchodilator response to inhaled therapy using simple measures of airflow
103	G45	Typographical error at three character inclusion note: Oesophagus
121	J02.3	Typographical error: Resection of segment of liver
133	J73.1	Typographical error : Laparoscopic ultrasound examination of pancreas and biopsy of lesion of pancreas
141	K34.2	Typographical error: Note: use as supplementary code for concurrent tricuspid valve repair (K27.6)
143	K47.2	Typographical error: Repair of arteriovenous fistula of coronary artery
164	L69	Add note: Note: Use supplementary code for placement of stent (L76, L89)
166	L79	Add note: Note: Use supplementary code for placement of stent (L76, L89)
169	L94.4	Delete the inclusion term as it is a duplicate of the four character descriptor



205	Chapter R title	Typographical error: Note: Use subsidiary code to identify gestational age (Y95) for R01 – R12 and R36 – R43
230	T41.5	Typographical errors: Freeing of extensive adhesions of peritoneum Includes: Division of extensive adhesions of bowel
231	T43.4	Typographical error: Diagnostic endoscopic ultrasound examination of peritoneum and biopsy of intraabdominal organ Add note: Use subsidiary site code as necessary
253	V42.5	Typographical error: Anterior epiphysiodesis of spine for correction of deformity NEC
253	V42.6	Posterior epiphysiodesis of spine for correction of deformity NEC
256	V63.1	Typographical error (word break) : Revisional percutaneous intradiscal radiofrequency thermocoagulation to cervical intervertebral disc
257	Chapter W Title	Typographical error (delete additional '0' within code range): Amend to: (CODES W01 – 99 O06 – O10)
278	Chapter X title	Change code range as follows: (CODES X01 – X97)
300	Y67.1	Typographical error: Harvest of composite of skin and cartilage from ear
302	Y76	Add an inclusion note at three character title level: Includes: Minimal access to other body area
181	M55.8	Strike through this code – do not use. Use M54.8 instead
181	M55.9	Strike through this code - do not use. Use M54.9 instead

**INDEX ERRATA**

Page no.	Code	Correction
Front cover index	Cartoid	Typographical error: Carotid
49	M10.5	Delete index entry: Endobrst Kidney Percutaneous
49	M27.6	Delete index entry: Endobrst Surgery Ureteroscopic
65	G17.-	Typographical error: Replace G17.- Extirpation Oesophagus Lesion Endoscopic NEC With G14.- Extirpation Oesophagus Lesion Endoscopic NEC
112	B36.-	Add index entry: B36 Reconstruction Areola
113	B36.-	Add index entry: B36 Reconstruction Nipple
130	M10.5	Add index entry: M10.5 Rupture Kidney Pelviureteric Junction Stenosis Endoscopic Endoluminal Balloon
130	M27.6	Add index entry: M27.6 Rupture Ureter Stenosis Ureteroscopic Endoluminal Balloon
138	A84.7	Typographical error: Study Sleep
163	W06.8 Darrach	Change eponym list entry as follows: W08.5 Darrach Distal excision ulna (Z71.6)
177	K33.2 Ross	Change eponym list entry as follows: K33.1 Ross Pulmonary autograft aortic root replacement
177	K33.6 Ross- Konno	Change eponym list entry as follows: K33.2 Ross-Konno Aortoventriculoplasty pulmonary autograft aortic root replacement

**Failed minimal access procedures, guidelines for coding  
OPCS4.2 Coding Quarterly No. 7, September 1998**

GUIDELINES FOR CODING FAILED MINIMUM ACCESS APPROACH PROCEDURES IN  
OPCS4

EFFECTIVE FROM 1ST OCTOBER 1998

Following the increase in the number of minimum access procedures performed within the NHSIS, there have been many requests from the service to identify a minimum access procedure that fails and is converted to an open procedure during the same visit to theatre.

The Clinical Coding Review Group has agreed that an OPCS4 code should be allocated to enable the service to identify that there was a failed approach. This is in line with the decision taken by the Coding Review Panel on behalf of the NHS in England, Wales and Northern Ireland. Research on UK-wide hospital data shows that the code Y71.8 Other specified late operations is not used. It has therefore been decided that **Y71.8 should be used to identify a failed minimum access approach and used as a supplementary code. Where appropriate, episodes ending on or after 1st October 1998 should be coded in this manner.**

Y71.8 should always be sequenced in secondary position after the code for the open procedure performed. Examples of the use of Y71.8 are given below:

#### Example 1

##### **Laparoscopic cholecystectomy failed, converted to an open cholecystectomy J18.- Y71.8**

J18.- Excision of gall bladder  
Y71.8 Failed minimum access approach

#### Example 2

##### **Laparoscopic abdominal hysterectomy failed, converted to open abdominal hysterectomy Q07.4 Y71.8**

Q07.4 Total abdominal hysterectomy nec  
Y71.8 Failed minimum access approach

#### Example 3

##### **Percutaneous transluminal embolisation of renal artery failed, converted to open embolisation of renal artery L42.2 Y71.8**

L42.2 Open embolisation of renal artery  
Y71.8 Failed minimum access approach

### **Failed trial without catheter (TWOC) OPCS4.5 Coding Guidelines No. 25, April 2010**

During a trial without catheter (TWOC), the patient's catheter is removed and the patient is then left for a period of time to see if they can void. If the TWOC is successful, it is only necessary to assign OPCS4.5 code M47.3 Removal of urethral catheter from bladder. If, however, the TWOC fails and the catheter is reinserted, both the removal and the re-insertion of the catheter will need to be shown:

M47.3 Removal of urethral catheter from bladder  
M47.9 Unspecified urethral catheterisation of bladder

Please note that, in general, it is not necessary to code urethral catheterisation of bladder unless the patient is specifically admitted for this procedure.

Guidance regarding the diagnosis relating to a TWOC can also be found on Page XXI-12 of the ICD-10 Clinical Coding Instruction Manual (version 2.0) .

**Short List of Procedures SMR Data Manual**  
**OPCS4.2 Coding Guidelines No. 7, November 2000**

Please add the following to Short List of Procedures performed on Outpatients.

PAIN CONTROL

**Fentanyl Patches [opiate/analgesic].....S53.8**

This is a new procedure mainly used for terminal care.

It has also been noticed that there are typing errors on the Short List of Procedures. Please amend SMR Data Manuals.

P6-27 (Surgery Procedures)

Golfers elbow - injection .....T74.8 Y38.9

p 6-30 (Skin Procedures)

Laser destruction skin of face nec.....S09.1 Z47.9

Shave excision of leg/hip/ankle .....S06.4 Z50.4

**Reversal of Hartmann's; amendment to previous guideline**  
**OPCS4.4 Coding Guidelines No. 22, March 2008**

If a reversal of Hartmann's is carried out, the case notes should be checked for the exact procedure performed.

In Scotland, in the absence of further information, the default codes for Reversal of Hartmann's are:-

H15.4 Closure of colostomy + Y16.2 Anastomosis of organ noc.

This supersedes advice given in Coding Guidelines No 5, January 2000

**Reversal of Hartmanns**  
**OPCS4.2 Coding Guidelines No. 5, January 2000**

Hartmann's procedure is coded to:-

H33.5 - Rectosigmoidectomy and closure of rectal stump and exteriorisation of bowel with an appropriate secondary code of G74.-, H14.- or H15.-.

If a Reversal of Hartmann's is carried out, the notes should be checked for the exact procedure performed. However, in the absence of further information, the default code for Reversal of Hartmann's is:-

H15.4 - Closure of colostomy

Y16.2 - Anastomosis of organ noc (England only)

Z29.1 - Rectum

In Scotland, since only 2 codes may be recorded the default will be H15.4 and Z29.1. For National Clinical Coding Qualification examination questions, use H15.4, Y16.2 and Z29.1.

**HEAL - Hysteroscopic endometrium ablation - laser  
OPCS4.2 Coding Quarterly No. 6, April 1998**

Hysteroscopic endometrial ablation using a laser (HEAL) involves the destruction of endometrial tissue which is behaving abnormally and not the destruction of a lesion. The Clinical Coding Review Group have issued the following codes for HEAL:

Q17.8 Other specified therapeutic endoscopic operation on uterus; with  
Y08.8 Other specified laser therapy to organ noc  
Endometrial laser ablation Q17.4 + Y08.2

**HEAL - Hysteroscopic Endometrial Ablation with Laser  
OPCS4.2 Coding Guidelines No. 8, February 2001**

**CODING QUARTERLY No. 6 April 1998 - page 6**

**HEAL - Hysteroscopic Endometrial Ablation - Laser**

The OPCS4 codes to be assigned are:

**Q17.4** - Endoscopic destruction of (lesion of) uterus nec

**Y08.8** - Other specified laser therapy to organ noc

*Note: The index entries for ablation endometrium should be amended as follows:*

**Q17.- Ablation Endometrium Endoscopic Nec** (*Not Q17.8*)

**Q17.- Ablation Endometrium Lesion Endoscopic** (*not Q17.1*)

*Please ensure that your OPCS4 index is amended*

**Staged hearing aid procedures D05.- D13.-  
OPCS4.3 Coding Guidelines No. 18, May 2006**

If the stage is unspecified, use the .9 code in the appropriate category.

**'Hybrid' Total Hip Replacements  
OPCS4.2/3/4 Coding Guidelines No. 6, June 2000**

There is no separate category in OPCS4 to identify a 'hybrid' total hip replacement, sometimes referred to as a partially cemented total hip replacement (ie a total hip replacement where cement is used for only one component). The identification of this type of replacement is important, in terms of statistical use, clinical use, central returns and data quality improvements.

Therefore, to enable a 'hybrid' replacement to be distinguished from a total cemented hip replacement, the following codes should be assigned for the 'hybrid' type.

W37.1 Primary total prosthetic replacement of hip joint using cement, with an appropriate site code from the 'Z' chapter (either Z75.6 Acetabulum or Z76.1 Head of femur) to indicate the appropriate site of the cemented component).

If the site of the component using cement is unknown, the default site code Z84.3 Hip joint should be assigned.

**EPONYM HYNES (E21.1)**  
**OPCS4.2 Coding Guidelines No. 7, November 2000**

Because there are differences in the way HYNES procedure can be performed, the Coding Review Panel (CRP) have agreed that the index entry should be amended to read:

E21.- Hynes Pharyngoplasty.

**Injection sacroiliac joint**  
**OPCS4.5 Coding Guidelines No. 24, October 2009**

The correct codes for the above procedure are;  
W90.3 Injection of therapeutic substance into joint  
Z84.1 Sacroiliac joint

(England currently code this procedure to V54.4, V55.1, Z84.1). **N.B.** This is a Scottish/English difference. Please amend your OPCS4 Clinical Coding Instruction Manuals, Version 2.0, Page V-10, Example; L3/4, L4/5 and L5/S1 Discography and Lt SIJ (Sacroiliac joint) injection.

**Insertion of Reveal Loop Recorder**  
**OPCS4.2 Coding Guidelines No. 8, February 2001**

The Insertable Loop Recorder (ILR) is a device implanted into the subcutaneous tissue of the chest wall to monitor arrhythmias. This procedure is carried out as a Day Case or even in Outpatients, using local anaesthetic and thus there is usually no overnight stay. The recorder can stay in for up to two years.

The Reveal ILR system has three primary components:

Insertable Loop Recorder [ILR] - An implantable, single use, programmable device containing two electrodes on the body of the device for continuous (ie looping) recording of the patient's ECG

Activator - A hand-held, battery-operated telemetry device used by the patient during or after a symptomatic event to store an event into the ILR memory.

Programmer - The ILR's operations are enabled, and stored data are viewed and/or printed.

The correct OPCS4 Codes for this procedure are:

K66.8 - Other operations on heart - Other specified

Y70.5 - Temporary operations

S62.8 - Other operations on subcutaneous tissue

**Intermittent infusion of therapeutic substance (X28.-)**  
**OPCS4.2 Coding Guidelines No. 18, May 2006**

This code may only be used if the term intermittent infusion has been used on the discharge summary.

**Irrigation of peritoneal cavity**  
**OPCS4.2 Coding Quarterly No. 1, November 1996**

The code given in the OPCS4 Index is T46.4. This is a typographical error - the correct code is T46.3, as given in the Tabular List.

**Guideline from Coding Guidelines No. 16, August 2005**

**IV antibiotics OPCS4.2/3 Coding Guidelines No. 16, August 2005**

In the past, where no further information was available, we have given out the advice that the default code for IV antibiotics was X35.2 – Intravenous chemotherapy.

New training material from England gives the default code as X29.8 – Other specified continuous infusion of therapeutic substance.

As usual, our advice is to find out where possible, whether the IV antibiotics were given by injection or infusion but where this information cannot be found and IV antibiotics has been mentioned on the discharge summary, we will default to X29.8 to be consistent with England.

The implementation date for this change to coding practice in Scotland will be 1st October, 2005

**Guideline from Coding Quarterly No. 6, April 1998**

**Injections and Infusions**  
**OPCS4.2 Coding Quarterly No. 6, April 1998**

The Clinical Coding Review Group have issued the following definitions:-

a) Injections - the person administering the injection needs to be present throughout the administration of the injection.

b) Infusions - the person administering the infusion can leave the patient while the infusion is taking place. An infusion is continuous administration in the form of a drip.

It is important to note that the purpose of the classification is not to identify the specific drug given, but to indicate the way it is administered.

X29.- Continuous infusion of therapeutic substance

is the only category available to code the continuous infusion of any therapeutic substance.

X35.2 Intravenous chemotherapy

is used to code intravenous chemotherapy.

Chemotherapy is a generic term for the treatment of disease by a chemical agent and is not restricted to the use of cytotoxic drugs for treatment of malignant neoplasm. Chemotherapy should therefore be coded according to the method of administration as detailed above.

**IV fluids**  
**OPCS4.2/3 Coding Guidelines No. 18, May 2006**

Contrary to advice in the OPCS4.3 conversion training material, use X29.2 as the default code if IV fluids are given.

### **Guideline from Coding Guidelines No. 13, January 2003**

#### **IV Fluids**

**OPCS4.2/3                      Coding Guidelines No. 13, January 2003**

The statement 'IV fluids given', where no further information as to what the fluids were, should be coded to X29.9 - Continuous infusion of therapeutic substance, unspecified.  
IV fluids usually, but not always, consist of dextrose and/or saline, therefore it is safer to default to 'unspecified'.

#### **IVF codes**

**OPCS4.3                      Coding Guidelines No. 18, May 2006**

Do not use IVF codes (Q13.-).

**-See Coding Guidelines No. 10, December 2001 (Human Fertilisation Codes)**

#### **Amendment to Coding Update**

**OPCS4.2                      Coding Quarterly No. 2, February 1997**

The Coding Update of April 1996 gave OPCS4 codes Q39.9 and Q41.3 for Laparoscopic hydrotubation. These are incorrect. The correct codes are:

Q41.2 - Hydrotubation of fallopian tube; with  
Y50.8 - Access minimal

### **Scottish Clinical Coding Standards    March 2013**

#### **Laparoscopically-assisted vaginal hysterectomy and Bilateral salpingoophorectomy**

When a vaginal hysterectomy is carried out simultaneously with a bilateral salpingoophorectomy this should be coded as a recognised Scottish pair code. However, when a laparoscopically-assisted vaginal hysterectomy and bilateral salpingoophorectomy are performed together these should be coded as follows;

Q08.9 Vaginal excision of uterus, unspecified

Y75.1 Laparoscopically assisted approach to abdominal cavity

And

Q22.1 Bilateral salpingoophorectomy

Y75.1 Laparoscopically assisted approach to abdominal cavity

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**Laparoscopic Hysterectomy**  
**OPCS4.2 Coding Guidelines No. 2, January 1999**

If an operation is stated as being a Laparoscopic Hysterectomy this defaults to Q07.- + Y50.8 in the OPCS4 Index. This is the category for abdominal hysterectomies. Coders should always check to make sure it is an abdominal hysterectomy before selecting the appropriate code from category Q07. If the procedure is a laparoscopic assisted vaginal hysterectomy, it should be coded to Q08.- + Y50.8.

**Laparoscopic Hysterectomy / Laparoscopic Oophorectomy**  
**OPCS4.2 Coding Guidelines No. 2, January 1999**

Current advice states that when a hysterectomy is carried out simultaneously with an oophorectomy this should be coded as a recognised Scottish OPCS4 pair code. However, when a laparoscopic hysterectomy and laparoscopic oophorectomy are performed simultaneously we lose information concerning minimal access approach. From 1/4/99 a laparoscopic hysterectomy performed with a laparoscopic oophorectomy, where no further information is available, will be coded as follows:-

Laparoscopic Hysterectomy : Q07.4 + Y50.8 Total abdominal hysterectomy nec + Other specified approach through abdominal cavity

Laparoscopic Oophorectomy: Q24.3 + Y50.8 Oophorectomy nec + Other specified approach through abdominal cavity

**Linton's procedure - Correction of Eponym**  
**OPCS4.2 Coding Guidelines No. 8, February 2001**

OPCS4, Section II, Alphabetical Index of Surgical Eponyms - L Linton  
The text should be altered and the following inserted:

L83.2 – Linton - subfascial ligation perforating vein leg  
L87.8 – Linton - interruption perforating varicose vein.

We would once again reiterate, the importance of checking when eponyms are used whether the text listed in the eponym corresponds with the actual procedure performed.

**This change should be implemented from 1st April 2001.**

**LLETZ / Loop diathermy of cervix**  
**OPCS4.2 Coding Quarterly No. 1, November 1996**

From Coding Quarterly No. 1, November 1996 – “These (are shown below and) apply to the procedure(s) as specified. Any variation on the procedure(s) stated (eg. total pharyngolaryngectomy) will require different codes.”

LLETZ / Loop diathermy of cervix Q01.3 + Y13.1

## **Microwave Prostatectomy** **OPCS4.2 Coding Quarterly No. 6, April 1998**

Microwave prostatectomy is a procedure commonly used to treat benign prostatic hyperplasia (BPH). Part of the confusion between assigning codes from categories M65 or M67 is that the "ectomy" element of the medical term "prostatectomy" actually means excision i.e. surgical removal of the prostate gland. However, prostatectomy is now performed in different ways. A useful working principle to follow is that category M65, Endoscopic resection of outlet of male bladder, is applicable for excision or resection procedures when tissue samples are also obtained for histology. The category M67 is however, applicable for destruction procedures, e.g. laser, cauterisation, cryotherapy, coagulation, diathermy, thermotherapy, etc.

On this basis, Microwave prostatectomy which is thermotherapy or a coagulation type destructive procedure should be assigned a code from category M67.

For microwave prostatectomy, the correct OPCS4 codes are:

M67.2 Endoscopic destruction of lesion of prostate nec; with

Y13.4 Radiofrequency controlled thermal destruction of lesion of organ noc.

If the microwave prostatectomy is performed "blind" via the urethra or transrectally, this should be identified by using codes:

M70.8 Other specified operation on outlet of male bladder; with

Y13.4 Radiofrequency controlled thermal destruction of lesion of organ noc.

Transurethral vaporisation of the prostate (sometimes referred to as Vaportrode TURP) is a new electrosurgical treatment for BPH, which is performed as an alternative to transurethral resection of the prostate (TURP). It uses a destruction technique called electrovaporisation (EVAP) and combines the use of high electrical power with specially developed EVAP-elements to vaporise the prostate. The correct OPCS4 codes for this procedure are:

M67.2 Endoscopic destruction of lesion of prostate nec; with

Y13.1 Cauterisation of lesion of organ noc.

## **MMR Vaccine** **OPCS4.2 Coding Guidelines No. 5, January 2000**

The default code for MMR Injection is -  
X37.4 - Intramuscular immunotherapy

However if it is stated that MMR was given subcutaneously then code to -  
X38.5 - Subcutaneous immunotherapy

## **Mosaicplasty** **OPCS4.2 Coding Guidelines No. 7, November 2000**

There are many different types of Mosaicplasty and each should be coded according to the individual set of casenotes.

However, it was agreed by the National Clinical Coding Review Panel -

For a mosaicplasty on a joint with no further qualification:-

Open Procedure

W71.8 Other specified open operations on intraarticular structure

Y27.1 Autograft to organ

Endoscopic Procedure

W83.8 Other specified therapeutic endoscopic operations on other articular cartilage

Y27.1 Autograft to organ noc

[Rest of UK will add Y67.8 Other specified harvest of other multiple tissue, if appropriate]

## Nerve blocks

**OPCS4.2**

**Coding Guidelines No. 4, September 1999**

Some of you may have noticed in the SMR Update No 4, January 1998, page 8, that a list of additional procedures for SMR00 short list was published. This included codes for Nerve blocks, some of which had a supplementary Y code, while others had a supplementary Z code. Each code given was carefully considered by clinicians at ISD as to whether a supplementary Y or Z code gave the best possible information, but no general rule can be given. When coding nerve blocks, this list should be consulted to find the most appropriate codes. This advice applies whether SMR00 or SMR01 records are being coded.

## New Pair Codes

**OPCS4.3**

**Coding Guidelines No. 18, May 2006**

The following pair codes have been set up and should be available to coders after the import of the June, 2006 OPCS4 file

B276T851	F347E201	Q076Q235	W372W940
B276T852		Q076Q236	W382W940
B276T861	M451M303	Q076Q238	W392W940
B276T862	M452M303	Q076Q239	W462W940
B276T863	M453M303	Q076Q241	W472W940
B276T864	M454M303	Q076Q242	W482W940
B276T871	M455M303	Q076Q243	W372W950
B276T872	M458M303	Q076Q248	W382W950
B276T873	M459M303	Q076Q249	W392W950
B284T851	M451M304		W462W950
B284T852	M452M304	W932W370	W472W950
B284T861	M453M304	W932W380	W482W950
B284T862	M454M304	W932W390	
B284T863	M455M304	W932W460	W962W980
B284T864	M458M304	W932W470	W962O060
B284T871	M459M304	W932W480	W962O070
B284T872	M453M301	W932W940	W962O080
B284T873	M453M302	W932W950	W972W960
	M453M308	W942W370	W972W980
C754C711	M453M309	W942W380	W972O060
C754C712	M454M301	W942W390	W972O070
C754C713	M454M302	W942W460	W972O080
C754C718	M454M308	W942W470	W982W960
C754C719	M454M309	W942W930	W982W970
C754C721	M455M301	W942W950	W982O060
C754C722	M455M302	W952W370	W982O070

C754C723	M455M308	W952W380	W982O080
C754C728	M455M309	W952W390	
C754C729		W952W460	O062W960
C754C731	P235Q081	W952W470	O062W970
C754C732	P235Q082	W952W480	O062W980
C754C733	P235Q083	W952W930	O062O070
C754C734	P235Q088	W952W940	O062O080
C754C738	P235Q089		O072W960
C754C739		W372W930	O072W970
C754C741	Q076Q221	W382W930	O072W980
C754C742	Q076Q222	W392W930	O072O060
C754C743	Q076Q223	W462W930	O072O080
C754C748	Q076Q228	W472W930	O082W960
C754C749	Q076Q229	W482W930	O082W970
C791C795	Q076Q231		O082W980
C792C795	Q076Q232		O082O060
C791C796	Q076Q233		O082O070
C792C796	Q076Q234		

**One scope, two or more procedures; Reminder  
OPCS4.4 Coding Guidelines No. 22, March 2008**

The guidance entitled "One scope, two or more procedures" published in Coding Guidelines No.21 Nov. 2007, applies to all discharges on and after 1st April 2008.

**OPCS4.6 Coding Guidelines No. 25, April 2010**

There will be no update to OPCS in 2010. Connecting for Health plans to implement OPCS4.6 from 1st April 2011.

**Implementation of Latest Revision to the OPCS Classification of Interventions and Procedures OPCS Version 4.6  
OPCS4.6 Coding Guidelines No. 28, March 2011**

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.

**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](mailto:Lizwilliamson@nhs.net)

### **Pain Relief Code List**

#### **OPCS4.2 Coding Guidelines No. 5, January 2000**

In SMR Update No 4, January 1998, a list of additional procedures for SMR00 Short List was published which included a list of procedures for Pain Control. The following list of amendments to that list has been agreed by the Clinical Coding Review Group:

Intravenous regional sympathetic block - A81.8 + Y38.8 (amend from A73.5 + Z12.7)

LA stellate ganglion block - A81.8 + Y82.1 (amend from A73.5 + Z12.7)

LA/diagnostic lumbar sympathetic block - A81.8 + Y82.1 (amend from A73.5 + Z12.7)

Acupuncture - A70.8 + Y33.1 (amend from S53.3 + Y33.1)

The new codes should be used from 01/04/00. Note also that the codes given in this list have been carefully considered to give the best information possible and should be used wherever these procedures have been performed whether on a SMR00 or SMR01.

It is suggested that you keep a copy of the list with your Coding Guidelines. If you do not have the original list, please contact your Clinical Coding Co-ordinator.

### **Patients request termination of pregnancy at Outpatient clinic and return to ward to receive oral abortifacient drug (Mifepristone)**

#### **OPCS4.4 Coding Guidelines No. 23, September 2008**

Following the publication of the 'Abortion coding' article in **Coding Guidelines No.22, March 2008**, we have been informed that some hospitals have the following scenario:

Woman attends Outpatient clinic to request termination of pregnancy. She is asked to return and attend a ward to be given an oral abortifacient drug (Mifepristone).

In these instances, complete an SMR00 return for both the Outpatient attendance and the attendance at the ward. Do not count the attendance for administration of the oral abortifacient drug (Mifepristone) as a ward attendance. Treat it as an Outpatient attendance and record OPCS4 code X39.1 in the procedure field.

This is to ensure that all 'non-inpatient' attendances for administration of oral abortifacient drugs (Mifepristone) are recorded in the same manner.

### **Pelvic Region Site**

#### **OPCS4.5 Coding Guidelines No. 24, October 2009**

The correct site code to assign for the pelvic region where the site is not specified as 'Bone of pelvis' is: Z92.7 Trunk NEC

### **Guideline from Coding Guidelines No. 3, June 1999**

### **Peripheral Stem Cell Procedures**

**OPCS4.2 Coding Guidelines No. 3, June 1999**

The following list of procedures have been agreed as correct by a meeting of the CCRG:

<b>Haematology procedures</b>		<b>OPCS code</b>
Stem cell donation		X46.8
Stem cell infusion, back up bone marrow	See Bone marrow transplant below	
Bone marrow transplant	If specified as autograft If specified as allograft Otherwise	W34.1 W34.2 W34.9
Bone marrow donor		X46.1
Bone marrow harvest		X46.1/Y66.7
Peripheral blood stem cell (PBSC) harvest		X36.8/Y69.8
PBSC transplant (autologous)	If donation and infusion in same admission Otherwise	X33.8/Y69.8 X33.8
Femoral vein catheter for PBSC	If it is PBSC transfusion	X33.8
Granulocyte colony stimulating factor (GCSF)	Not a procedure	
PBSC collection		X36.8/Y69.8
Peripheral leucopheresis	Same as PBSC transplant	
Back-up stem cells	Same as stem cell donation	
Back-up bone marrow	Same as bone marrow donation	

**Bone Marrow Transplants  
OPCS 4.6 Coding Guidelines No. 31, September 2012**

**Update to article in Coding Guidelines No.23 September 2008, entitled “Peripheral Stem Cell Procedures: Amendment to Previous Guidance”.**

When bone marrow transplants occur the coder needs to be clear whether they are coding a harvest/donation or a graft, AND whether the patient having the bone marrow removed is to be the potential recipient of the bone marrow or not.

The following chart aims to simplify this and supersedes guidance previously issued in Coding Guidelines No. 23, September 2008, published as part of a list of haematological procedures.

	<b>Harvest/donation</b>		<b>Graft</b>
Patient as the Potential Recipient (Autologous)	W35.8 + Y66.7	Recipient (Autologous)	W34.1
Patient is donating bone marrow to another person	X46.1 + site of donation	Recipient – not the donating patient (Allograft)	W34.2-.9

**Rationale**

X46.1 has to be used for the donation for a non-autologous transplant because W35.8 is a therapeutic puncture of bone, and this would not be therapeutic to the donor. The trail is Donation Bone Marrow X46.1. Also where there is an autologous transplant taking place the extraction of the bone marrow would generally be described as a harvest of bone marrow rather than a donation. The trail is Harvest Bone Marrow Y66.7

**Peripheral Stem Cell Procedures: Amendment to Previous Guidance  
OPCS4.4 Coding Guidelines No. 23, September 2008**

Guidance on coding Peripheral Stem cell Procedures was published in Coding Guidelines No. 3 June 1999. With the introduction of OPCS4.3 in 2006, OPCS4.4 in 2007 and Version 2 of the OPCS4 Clinical Coding Instruction Manual in 2008, the guidance has been amended as follows:

<b>Haematology procedures</b>		<b>OPCS code</b>
Peripheral stem cell donation		X36.1/Y69.8
Stem cell infusion, back up bone marrow	See Bone marrow transplant below	
Bone marrow transplant	Autograft Allograft NEC Allograft from sibling donor Allograft from matched unrelated donor Allograft from haploidentical donor Unspecified	W34.1 W34.2 W34.3 W34.4  W34.5 W34.9
Bone marrow donor		X46.1
Bone marrow harvest		X46.1/Y66.7
Peripheral blood stem cell (PBSC) harvest		X36.1/Y69.8
PBSC transplant (autologous)	If donation and infusion in same episode If donation and infusion in different episodes; First episode Second episode	X33.4  X36.1/Y69.8 X33.4/Y71.1
Femoral vein catheter for PBSC If it is PBSC transfusion	Autologous Syngeneic Allogeneic Unknown	X33.4 X33.5 X33.6 X33.8
Granulocyte colony stimulating factor (GCSF)	Not a procedure	
PBSC collection		X36.1/Y69.8
Peripheral leucopheresis	Same as PBSC transplant	
Back-up stem cells	Same as stem cell donation	
Back-up bone marrow	Same as bone marrow donation	

**Please note that all guidance in this edition applies to all discharges on and after 1<sup>st</sup> October 2008**

**Peripheral Stem cell Procedures; amendment to CG No.23 Sept 2008  
OPCS4.5 Coding Guidelines No. 24, October 2009**

Please note the following amendment:  
Granulocyte colony stimulating factor injection (GCSF)  
Code to **X38.7** Subcutaneous injection of haematological growth factor

**Plasmapheresis  
OPCS4.2 Coding Guidelines No. 5, January 2000**

Plasmapheresis is the taking out or withdrawal of contaminated plasma and should be coded:

X36.8 Other specified blood withdrawal

If plasma is re-inserted then this should be coded:

X34.2 Transfusion of plasma

Where both procedures occur in the same episode, use both codes.

### **Pharyngolaryngectomy**

**OPCS4.2 Coding Quarterly No. 1, November 1996**

From Coding Quarterly No. 1, November 1996 – “These (are shown below and) apply to the procedure(s) as specified. Any variation on the procedure(s) stated (eg. total pharyngolaryngectomy) will require different codes.”

Pharyngolaryngectomy E19.2  
E29.6

### **Procedures mentioned on the discharge summary**

**OPCS4.3 Coding Guidelines No. 18, May 2006**

The following codes need only be used if the procedure has been mentioned on the discharge summary.

U22.- to U32.- for neuropsychology tests etc.  
X39.- Other route of administration of therapeutic substance  
X49.- Other external support of limb  
X50.3 – Advanced cardiac pulmonary resuscitation  
X56.- Intubation of trachea  
X58.- Artificial support for body system

### **Procedures on intestinal pouches**

**OPCS4.4 Coding Guidelines No. 20, June 2007**

In OPCS4.2 there were no specific codes for procedures and examination of ileo-anal pouches and coders were advised to use G73.8 + Y51.8 (Coding Guidelines No.6 June 2000) and G74.8 (Coding Clinic December 1996). Please note that OPCS4.3 and OPCS4.4 have a special group of codes (H66 - H70) for operations on intestinal pouches.

### **Ileo-Anal Pouch**

**OPCS4.2 Coding Guidelines No. 6, June 2000**

Some patients have had all of the large bowel including rectum and terminal ileum removed and now have an ileo-anal pouch constructed. Coders have been uncertain as to the correct codes when examination under anaesthetic with flexible sigmoidoscopy of ileo-anal pouch has been carried out.

Code: G73.8 Other specified attention to connection of ileum

Y51.8 Other specified approach to organ through artificial opening into gastrointestinal tract.



## **Proctoscopy**

**OPCS4.2**

**Coding Quarterly No. 5, January 1998**

A proctoscope is a speculum not an endoscope.

Therefore the codes used for proctoscopy are as follows:

H41.9 - Unspecified operation on rectum through anus (for therapeutic)

H62.8 - Other specified operation on bowel (for diagnostic or NEC) .

## **Rastelli**

**OPCS4.2**

**Coding Guidelines No. 16, August 2005**

Rastelli procedure involves creation of a valved conduit between the right ventricle of the heart and pulmonary artery and as such is coded to K18.3 (Creation of valved conduit between right ventricle of heart and pulmonary artery). The eponyms section of the OPCS4 index also gives the code K19.3 for Rastelli. This is an error. Please delete this eponym from your index.

## **Recording non-operations**

**OPCS4.2**

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

Various non-operations can be recorded in OPCS4 using a code from Y90. These include:-

Y90.2 - Radiotherapy NEC

Y90.3 - Scanning nec including CATs, MRIs and ultrasound.

Y90.4 - Barium Meal/Barium swallow

Y90.5 - Barium Enema

All these should be preceded by X55.8 - Other specified operations on unspecified organ.

### **For coding of non-operations see also -**

Use of Radiotherapy Codes X65, X67 and X68 in OPCS, Coding Guidelines No. 25, April 2010

Coding of "non-operative" interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02, Coding Guidelines No. 22, March 2008

Scans, blood transfusions, IV fluids, injections, Coding Guidelines No. 13, January 2003

## **Guideline from Coding Guidelines No. 18, May 2006**

**Scans**

**OPCS4.3**

**Coding Guidelines No. 18, May 2006**

The advice that scans should be coded if mentioned on the discharge summary is still applicable. Where several types of scan are mentioned, each should be coded if space allows. For obstetric patients, on a SMR02 record, who are given several scans of the same type during an episode, it is only necessary to code the first scan given. If an obstetric scan is multi-purpose (eg a nuchal translucency scan in which growth is also checked), code to the main purpose of the scan.

## Secondary Reductions

OPCS4.2

Coding Guidelines No. 12, September 2002

In the OPCS4 classification, the term 'secondary' is used to denote later or repeated treatment when the primary treatment proved ineffective. The second procedure may be the same or differ from the original procedure.

### Example 1

An open reduction of a fractured ulna with extramedullary fixation was performed. The fracture did not heal and the procedure was repeated.

Code the final operation to:

W23.2 Secondary open reduction of fracture of bone and extramedullary fixation hfq

Z71.2 Shaft of ulna nec

### Example 2

A closed reduction of a fractured ulna with extramedullary fixation was performed. The procedure was not effective and an open reduction was performed.

Code the final operation again to:

W23.2 Secondary open reduction of fracture of bone and extramedullary fixation hfq

Z71.2 Shaft of ulna nec

### Example 3

Manipulation of fractured radius performed. Patient re-admitted because of loss of alignment. Had an open reduction and internal fixation of fracture radius using plate.

Code as:

W23.2 Secondary open reduction of fracture of bone and extramedullary fixation hfq Z70.-

Radius

Please note that the application of a plaster cast is considered to be a form of primary reduction, so any further treatment would be coded as secondary.

## Shoulder Surgery

OPCS4.2

Coding Guidelines No. 10, December 2001

A list of shoulder surgery codes were published in Coding Guidelines No 5, January 2000, page 4 as approved by the Arthroplasty Project. The aim of the project is to feedback information to individual orthopaedic surgeons on their arthroplasty workload.

Part of the list previously published refers to total shoulder replacements, using the code range W52.- to W54.-. In fact, these codes are for use only when the shoulder arthroplasty involves a bone other than the humerus and is more like a hemiarthroplasty. Where the medical notes state that a total shoulder replacement has occurred, a code from the range W43.- to W45.- must be used.

Please replace the previously published list with the following complete list:-

### Operation/Procedure

### OPCS4 Codes

#### Shoulder Hemiarthroplasty Humerus only

primary cemented

W49.1 + laterality

primary uncemented

W50.1 + laterality

primary nec

W51.1 + laterality

revision (includes conversions) cemented

W49.3 + laterality

revision (includes conversions) uncemented

W50.3 + laterality

revision (includes conversions) nec

W51.3 + laterality

### Other bone

primary cemented	W52.1 + bone
primary uncemented	W53.1 + bone
primary nec	W54.1 + bone
revision (includes conversions) cemented	W52.3 + bone
revision (includes conversions) uncemented	W53.3 + bone
revision (includes conversions) nec	W54.3 + bone

### Total Shoulder Replacements

primary cemented	W43.1 + Z81.4
primary uncemented	W44.1 + Z81.4
primary nec	W45.1 + Z81.4
revision (includes conversions) cemented	W43.3 + Z81.4
revision (includes conversions) uncemented	W44.3 + Z81.4
revision (includes conversions) nec	W45.3 + Z81.4

### Acromioplasty

sub acromial decompression - open	W81.8 + Z68.2
- endoscopic	W84.8 + Z68.2

### Other Shoulder Procedures

Rotator cuff repair	- open	T79.1 + laterality
	- endoscopic	T79.1 + Y52.8
Open joint stabilisation	- gleno humeral	W77.- + Z81.3
	- acromial clavicular	W77.- + Z81.2
Excision of acromial clavicular joint (open only)		W08.5 + Z81.2

## **Guidance from Coding Guidelines No. 5, January 2000**

### **Shoulder Surgery**

#### **OPCS4.2 Coding Guidelines No. 5, January 2000**

The following code list has been agreed by the Scottish Register of Shoulder Arthroplasty Group.

#### **OPERATION/PROCEDURE**

#### **OPCS4 CODES**

#### **Shoulder Hemiarthroplasty**

primary cemented	W49.1 + laterality
primary uncemented	W50.1 + laterality
primary nec	W51.1 + laterality
revision (includes conversions) cemented	W49.3 + laterality
revision (includes conversions) uncemented	W50.3 + laterality
revision (includes conversions) nec	W51.3 + laterality

#### **Total Shoulder Replacements**

primary cemented	W52.1 Z81.3
primary uncemented	W53.1 Z81.3
primary nec	W54.1 Z81.3
revision (includes conversions) cemented	W52.3 Z81.3
revision (includes conversions) uncemented	W53.3 Z81.3
revision (includes conversions) nec	W54.3 Z81.3

### Acromioplasty

Sub acromial decompression - (open)	W81.8 Z68.2
- (endoscopic)	W84.8 Z68.2

### Other Shoulder Procedures

Rotator cuff repair - (open)	T79.1 + laterality
- (endoscopic)	T79.1 Y52.8
Joint stabilisation (open only)	
Gleno humeral	W77.- Z81.3
Acromial clavicular	W77.- Z81.2
Excision of acromial clavicular joint (open only)	W08.5 Z81.2

## Site of Spine

### OPCS4.5 Coding Guidelines No. 25, April 2010

While there are OPCS-4 site codes that identify the vertebrae, or the spinal cord, there are no OPCS-4 codes that identify the "spine" (cervical, thoracic, lumbar or sacral).

The most appropriate site codes for spine not elsewhere classified are:

Cervical spine Z66.3 Cervical vertebra  
 Thoracic spine Z66.4 Thoracic vertebra  
 Lumbar spine Z66.5 Lumbar vertebra  
 Sacral spine Z66.8 Specified vertebra NEC

Example:

CT of cervical spine, no contrast:

U05.4 Computed tomography of spine  
 Z66.3 Cervical vertebra

(England would add Y98.1 Radiology of one body area (or < twenty minutes) after U05.4)

## SMR00 Operation codes

### OPCS4.3 Coding Guidelines No. 18, May 2006

Continue coding SMR00 as before. Further guidance will follow in September.

## Correction to article Snare resection of polyps

### OPCS4.2 Coding Guidelines No. 12, September 2002

In Coding Guidelines 9, July 2001 there was an article on snare resection of polyps from both sigmoid and rectum. While the point of this article was correct i.e. site codes of .8 could signify multiple sites, the article should have referred to a flexible sigmoidoscopy rather than a colonoscopy.

### **Guideline from Coding Guidelines No. 9, July 2001**

#### **Snare Resection of polyps from both sigmoid and rectum OPCS4.2 Coding Guidelines No. 9, July 2001**

As this is a therapeutic procedure should I code the colonoscopy twice with the appropriate Z code for each of the sites?

No, code the procedure only once:

H23.1 Endoscopic snare resection of lesion of lower bowel using fiberoptic sigmoidoscope

Z29.8 Specified part of bowel NEC

### **Subcutaneous injections**

#### **OPCS4.2 Coding Guidelines No. 5, January 2000**

Since the introduction of OPCS4 coders have had great difficulty in allocating a code for subcutaneous injections. This has resulted in inconsistencies in recording with some coders coding to:

S52 - Introduction of therapeutic substance into subcutaneous tissue and others to

X38 - Subcutaneous injection.

It has been agreed by the UK Coding Review Panel that as from 1/4/2000 - we should **delete the codes S52.2 and S52.4** from our OPCS4 Tabular List.

Add at beginning of category S52 - Excludes: subcutaneous injections (X38)

Add brackets to the term 'local action'[non-essential modifiers] at X38.1 .2 .3 and .6.

These codes will then be suitable for either local or systemic action.

#### **ALPHABETICAL INDEX**

Delete

S52- Injection subcutaneous tissue therapeutic

Add

X38.- Injection subcutaneous tissue therapeutic

### **Summary of significant changes from OPCS-4.3 to OPCS-4.4**

#### **OPCS4.4 Coding Guidelines No. 20, June 2007**

#### **OPCS-4.4 Alphabetical Index**

Improvements include:

- New Section V is an Alphabetical Index of High Cost Drugs
- Section III Alphabetical Index of Surgical Abbreviations has been expanded
- Clearer layout and styling to improve ease of use.

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#### **OPCS-4.4 Tabular List**

- Certain codes have amended descriptions to reduce ambiguity, e.g.

**L73 Mechanical embolic protection** in OPCS-4.3 becomes

**L73 Mechanical embolic protection of blood vessel** in OPCS-4.4

- A number of **Notes** reading '**Use subsidiary code for minimal access approach**' that

appeared at code or category level in OPCS-4.3 have been removed. These **Notes** only exist at chapter level in OPCS-4.4 and are now also re-phrased to read

**'Use a subsidiary code for minimal access approach (Y74-Y76)**

- Some sequencing **Notes** have been re-worded to make the sequencing more implicit by the addition of the word 'a': for example at category **F34 Excision of tonsil Note: Use a supplementary code for concurrent excision of adenoid (E20.1)**.

### Principal and Extended Categories

These have been defined to replace the concept of 'sister' categories from OPCS-4.3. Key learning points are:

- Used in instances where an existing category (principal) needs extension (extended)
- Identified in the Tabular List as a note at category heading to ease navigation
- It is important to understand that a coder must only assign the **.8** and **.9** codes in the principal category and **never** use the **.8** and **.9** codes from the extended category. This convention prevents potential conflict between the two sets of **.8** and **.9** codes, as **.8** and **.9** codes have been included at extended categories to maintain the structure of the classification.

### Overflow categories

Overflow categories continue from their introduction of OPCS-4.3. This type of category appears at the end of chapters which are completely full but where it is required that additional operations/interventions be classified to that chapter.

Overflow categories begin with the alpha O, and appear at the end of Chapter L Arteries and Veins (**O01-O05, O15**), Chapter W Other Bones and Joints (**O06-O10**), and Chapter Z Subsidiary Classification of Sites of Operation (**O11-O14**).

**N.B. In Scotland do not use O11-O14.**

(Above extract courtesy of Connecting for Health Coding Clinic Volume 4 Issue 1 March 2007)

## Tears SMR02 review 2010 (data items) Coding Guidelines No. 27, October 2010

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.

Codes and Values: Tear (Code order)

0	No (includes intact perineum and/or vaginal and cervical lacerations)
1	Tear 1 (1st Degree)
2	Tear 2 (2nd Degree)
3	Tear 3 (3rd Degree)
4	Tear 4 (4th Degree)
5	Vaginal lacerations – removed from options
6	Cervical lacerations – removed from options
8	Unspecified tear
9	Not known if tear

## Tension-free Vaginal Tape Procedure

## **OPCS4.2 Coding Guidelines No. 5, January 2000**

A new procedure for the treatment of stress incontinence in women is now being carried out, using a tension-free vaginal tape. The tape is put into position as a support for the urethra (bladder outlet).

In order to perform this procedure, the clinician makes an incision in the vagina to insert the tape, which is like a thread or ribbon, with a needle at each end. The tape is introduced with the curved rounded needles through the vaginal incision and around the bladder neck, on each side. Two small incisions are made in the abdomen suprapubically, purely as a mechanism for getting the needles out and to allow the tape to travel through, and eventually anchor into, the pelvic tissues. The tape is adjusted to effectively support the urethra and the excess tape material is trimmed off. The bit of tape left in-situ grips into the pelvic tissues without the need to suture it. Both the abdominal and the vaginal cuts are then closed with absorbable sutures.

From 01/04/00, the correct OPCS4 code to reflect this procedure is:

M53.8 Other specified vaginal operations to support outlet of female bladder.

This code replaces any interim codes previously given out.

## **Termination of Pregnancy using Mifepristone (RU486) pessary OPCS4.2 Coding Quarterly No. 6, April 1998**

When coding termination of pregnancy using an abortifacient pessary there is a choice of two codes depending on the type of abortifacient drug used. Prostaglandins administered in pessary form are coded to Q14.5 Insertion of prostaglandin pessary. Mifepristone (which belongs to a different class of drugs) administered in pessary form is coded to Q14.6 Insertion of abortifacient pessary nec.

## **The use of Y76.7 Arthroscopic approach to joint. OPCS 4.6 Coding Guidelines No.30, March 2012**

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.

## **Total Hip Replacement with Acetabular Bone Graft** **OPCS 4.6 Coding Guidelines No. 31, September 2012**

During most total hip replacement procedures, bone chippings produced from bone reamed from the patient's femur are used to **pack and secure** a prosthetic joint replacement, providing additional stability of the joint implant. This type of method is considered to be an integral part of the procedure and therefore does not require coding in addition to the prosthetic joint replacement.

### **Example 1:**

Primary uncemented left total hip replacement, the joint implant was packed and secured using bone chippings from the reamed bone of the patient's femur:

**W38.1 Primary total prosthetic replacement of hip joint not using cement**

**Z94.3 Left sided operation**

**Rationale:** As the bone chippings are used as a part of the procedure to help secure the hip replacement, it is not appropriate to assign a code for the bone chippings in addition.

However, in other types of total hip replacements, and where there is evidence documented of extensive acetabular bone loss, an acetabular **bone graft** (using either morcellised bone or bone block), will be performed in addition to the total hip replacement. The acetabular bone graft is considered to be in addition to the joint replacement procedure, and therefore a code for the bone graft must be assigned in addition to the code for the total hip replacement.

The appropriate OPCS-4 code to assign for the acetabular bone graft will depend on whether it is an 'autograft' or 'allograft' of bone. Whenever an autograft is performed, the bone is taken from one part of the body and is placed in another site on the same individual. This requires a harvest code to be assigned in addition to the code for the total hip replacement.

### **Example 2:**

Primary uncemented left total hip replacement with morcellised autograft of bone to large acetabular defect. Bone harvested from left iliac crest.

**W38.1 Primary total prosthetic replacement of hip joint not using cement**

**Z94.3 Left sided operation**

**W31.4 Cancellous chip autograft of bone**

**Z75.6 Acetabulum**

**W08.8 Other Specified Excision of Bone**

**Y66.3 Harvest of bone from iliac crest**

**Rationale:** The bone graft material in this procedure is an autograft which was harvested from the iliac crest of the patient, and therefore it is appropriate to assign codes to identify the autograft and harvest in addition to the code for the total hip replacement.

### **Example 3:**

Primary uncemented left total hip replacement with acetabular bone graft using bone block obtained from the bone bank to address the defect in the left acetabulum.



**W38.1 Primary total prosthetic replacement of hip joint not using cement**  
**Z94.3 Left sided operation**

**W32.2 Allograft of bone NEC**  
**Z75.6 Acetabulum**

**Rationale:** It is appropriate to assign a code to identify the allograft of bone, as the bone graft was obtained from the bone bank. Where an allograft or xenograft has been donated from a bone bank, or supplied from a different individual, it is not appropriate to assign a harvest code in addition, as the graft was not harvested from the original patient.

Any uncertainty as to whether the joint replacement involves a bone graft, or a packing using bone chippings, must be referred back to the responsible consultant for clarification

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**Use of codes X60 – X62, and X66**  
**OPCS4.3 Coding Guidelines No. 18, May 2006**

It is not necessary to use codes X60 – X62 or X66.- on in-patient returns, at present

**Use of Obstetric Scanning, Assessment and Monitoring OPCS codes**  
**R36 – R43**  
**OPCS 4.6 Coding Guidelines No. 31, September 2012**

It has been agreed that obstetric scanning, assessment and monitoring codes should be treated in the same way as other scans.

Therefore the table produced in the article entitled “Coding of “non-operative” interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02”, in Coding Guidelines No.22 March 2008 and updated in Coding Guidelines No.25 April 2010, now contains guidance on the coding of obstetric scans, assessments and monitoring.

This decision requires that an amendment be made to the table referred to above, to incorporate codes R36- R43.

The updated table is printed below.

<b>Intervention/procedure code</b>	<b>General Guidance</b>	<b>Guidance if Elective admission (inpatient/day case) specifically for this intervention/procedure</b>
U01-U40	Not mandatory to code	Code
R36 – R43	Not mandatory to code	Code
X28-X39	Not mandatory to code	Code
X44, X48-X58	Not mandatory to code	Code
X65	Not mandatory to code	Code
X60-X62, X66, X67.-, X68.-	Not mandatory to code	Not mandatory to code
X70, X71	Not mandatory to code	Not mandatory to code
X81-X97	Not mandatory to code	Not mandatory to code

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

**Use of Radiotherapy Codes X65, X67 and X68 in OPCS**

## **OPCS4.5 Coding Guidelines No. 25, April 2010**

Category X65 Radiotherapy delivery was omitted from the table in the article entitled

“Coding of “non-operative” interventions/procedures (imaging, injections, infusions, x-rays, etc.) on SMR01 and SMR02.”, published in Coding Guidelines No.22 March 2008. OPCS4.5 has seen the addition of two new categories for radiotherapy preparation; X67 Preparation for external beam radiotherapy and X68 Preparation for brachytherapy. Use of these two categories in Scotland will not be mandatory.

***This will be a Scottish/English difference.***

This decision requires that an amendment be made to the table referred to above.

The updated table is printed below.

<b>Intervention/procedure code</b>	<b>General Guidance</b>	<b>Guidance if Elective admission (inpatient/day case) specifically for this intervention/procedure</b>
U01-U40	Not mandatory to code	Code
X28-X39	Not mandatory to code	Code
X44, X48-X58	Not mandatory to code	Code
X65	Not mandatory to code	Code
X60-X62, X66, X67.-, X68.-	Not mandatory to code	Not mandatory to code
X70, X71	Not mandatory to code	Not mandatory to code
X81-X97	Not mandatory to code	Not mandatory to code

## **General Information**

### **Accidental cuts/perforations during procedures Scottish Clinical Coding Standards 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.

### **Alcohol in pregnancy Scottish Clinical Coding Standards No. 5, March 2014**

Midwives undertaking the antenatal booking appointment, are asked to record in the Scottish Woman-held Maternity Record<sup>1</sup>, the number of units of alcohol that the woman states she has drunk “in an average week”. Concern has been raised that simply considering the week prior to the booking appointment will not capture whether a woman was drinking very early in pregnancy, possibly before confirmation of pregnancy.

This was considered in Feb/Mar 2013 by a subject matter expert group including specialist midwives, an obstetrician, a neonatologist, a consultant in public health and Scottish Government professional advisors.

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The revised current advice for midwives in Scotland from April 2013, is to ask women about their average weekly consumption of alcohol over the three months prior to booking. Midwives are asked to record the woman's answer in the SWHMR/ maternity information system so it can be reported on SMR02 (<http://www.datadictionaryadmin.scot.nhs.uk/SMR-Datasets/SMR02-Maternity-Inpatient-and-Day-Case/Drug-and-Alcohol-Misuse/Typical-Weekly-Alcohol-Consumption.asp>). If the woman says she has not drunk any alcohol at all over the last three months, number of units should be recorded as '0'. If the woman states that she has consumed an average of 0 to 1 unit per week over the three months code as '1'. Otherwise code as nearest number averaged over the three months'.

This advice has been included in e-learning materials being developed for identification and treatment of Fetal Alcohol Spectrum Disorder (FASD) and in the ISD data dictionary. The amendment will allow tracking of alcohol consumption in the three months prior to maternity booking as an all-Scotland Maternity Quality Measure.

**As this data should be collected at booking by midwives, this article is only background information for coders.**

<sup>1</sup> <http://www.healthcareimprovementscotland.org/idoc.ashx?docid=61c1f6e3-e202-413f-8bd0-10ee02076d8b&version=-1>

## **Recording activity in Accident and Emergency on inpatient episodes Coding Guidelines No. 24, October 2009**

Please do not record any activity carried out in Accident and Emergency on subsequent inpatient episodes.

## **ICD10 Books Coding Guidelines No. 28, March 2011**

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.

## **Definition of a Delivery Coding Guidelines No. 9, July 2001**

For the purposes of determining whether an SMR02 or an SMR02D is completed, "delivery" has been defined as "the expulsion or extraction of the baby from the mother". This means that if the mother delivers the baby at home as planned, but is admitted to hospital for the removal of the placenta, then an SMR02D should be submitted for the home delivery, followed by an SMR02 postnatal episode for the hospital admission. Please note that where the mother unexpectedly delivers the baby at home (ie this is not as planned) and she is admitted to hospital for the removal of the placenta, then an SMR02 only should be submitted by the hospital detailing that the patient delivered before arrival. No SMR02D is required.

## **Codes for central returns Coding Guidelines No. 17, January 2006**

Coders may be able to enter into their local systems many more codes than are actually returned to ISD. Please ensure that the most important information is always returned to ISD and that within those codes validation rules are adhered to (injury codes must be followed by an external cause code, dagger codes must be followed by asterisk codes). The number of discharge codes on each type of return is as follows:

<b>SMR type</b>	<b>Number ICD10 codes</b>	<b>Number OPCS4 pair codes</b>
SMR00	2	2
SMR01	6	4
SMR02	6	2
SMR04	4	0
SMR50	4	0

## MATERNITY DATA ITEMS

### **Analgesia during labour and/or delivery SMR02 review 2010 (data items) Coding Guidelines No. 27, October 2010**

Options have been expanded to include some of the newer complementary therapies. More than one method of analgesia may be used in labour. The highest method in the following hierarchy should be used for coding this item:

General anaesthetic

Spinal (includes 'combined spinal epidural')

Epidural

Pethidine/Morphine or other opiates/opioids

Gas/Air

None

Codes and values

0 None

1 Pethidine/morphine or other opiates/opioids

2 Epidural

3 Gas and air only

4 General anaesthetic

5 Spinal (includes 'combined spinal/epidural')

8 Other

9 Not known

Code 8 should be used for other types of analgesia such as TENS, water births and other complementary medicines.

Coders should note that it is not necessary to record spinals and epidurals in the OPCS4 Clinical Section of the SMR02.

### **Apgar score – Babies 1 - 3                      SMR02 review 2010 (data items) Coding Guidelines No. 27, October 2010**

Apgar score is almost always documented and is a mandatory field. The code 'RR' should be used if the baby is being actively resuscitated at the 5 minute check, to indicate that the Apgar score cannot be accurately taken.

### **SMR02 review 2010 (data items)**

### **Booking Date                      SMR02 review 2010 (data items) Coding Guidelines No. 27, October 2010**

Due to the various ways mums can now access maternity services, the definition of Booking Date is no longer appropriate. The new definition reflects the flexibility of the service, whilst allowing for consistency of recording.

Change to definition;

From: The booking date is the date on which the woman attends the antenatal booking clinic.  
To: The booking date is the date of the first appointment where history is taken.

### **Drugs and Alcohol Use                      SMR02 Review Update** **Coding Guidelines No. 28, March 2011**

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.

### **Drugs Misuse During This Pregnancy** **SMR02 review 2010 (data items)** **Coding Guidelines No. 27, October 2010**

This data item will become mandatory on 1st April 2011.  
Please note, although it may be April 2011 before data items are made mandatory on systems, coders should complete these fields forthwith.

### **Duration of labour                      SMR02 review 2010 (data items)** **Coding Guidelines No. 27, October 2010**

Duration of labour is the length of time the state of labour lasts from its onset to the delivery of the placenta, expressed as the number of completed hours.

Please note that the total time of the three stages of labour should be rounded down to the complete hour to give a total duration of labour.

Example:

Stage 1 3 hrs 59

Stage 2 1 hr 36

Stage 3 15mins

Total 5hrs 50 = 5hrs total

Time must also be recorded for an Emergency Caesarean Section where patient has undergone stages 1 and 2 of labour before the operation.

### **Height    SMR02 review 2010 (data items)** **Coding Guidelines No. 27, October 2010**

This data item will become mandatory on 1st April 2011.

### **Mode of delivery – Babies 1 - 3                      SMR02 review 2010 (data items)** **Coding Guidelines No. 27, October 2010**

The use of forceps has changed over the years. This has resulted in a re-classification of 'Haig-Ferguson' forceps. Previously, these would have been recorded as 'low forceps' (Code 2), but these are now considered to be 'mid cavity forceps' and must be recorded as 'A'. See Codes and Values below:

Codes and Values: Delivery

- |   |   |
|---|---|
| 0 | Normal, spontaneous vertex delivery, occipito-anterior.   |
| 1 | Cephalic vertex delivery, with abnormal presentation of the head at delivery, without instruments, with or without manipulation |
| 2 | Low forceps, no rotation, forceps NOS. (incl Wrigley's)   |
| 5 | Breech delivery, spontaneous, assisted or unspecified partial breech extraction.  |
| 6 | Breech extraction, NOS. Version with breech extraction.   |
| 7 | Elective (planned) caesarean section.   |
| 8 | Emergency and unspecified caesarean section.  |
| 9 | Other and unspecified method of delivery.   |

- A Mid cavity forceps, no rotation (incl Haig Fergusson, Neville-Barnes e.g.)
- B Rotational forceps (incl Kiellands)
- C Ventouse, no rotation or unspecified
- D Ventouse with rotation

When coding forceps, where the term, 'low', 'mid' or 'high' cavity is mentioned, this should take priority over the type of forceps.

Code 2 - should be used when forceps are specified, but no further information is provided (i.e. forceps NOS); also for Wrigley's Forceps, where no note of the position of the forceps is available. (Haig-Ferguson forceps will now be considered as usually denoting mid cavity). If more than one type of forceps is used, only the most resource intensive should be recorded. Code B – Rotational is most important, followed by A – Mid cavity and lastly, 2 – Low forceps, no rotation.

Coders should be aware that a woman for whom a caesarean section is planned may go into labour and require an emergency caesarean section. This would be coded to '8'.

### **Mode of Delivery - Forceps SMR02 Review Update Coding Guidelines No. 28, March 2011**

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.

### **Tears SMR02 Review Update Coding Guidelines No. 28, March 2011**

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)**

0	No (includes intact perineum and/or vaginal and cervical lacerations)
1	Tear 1 (1st Degree)
2	Tear 2 (2nd Degree)
3	Tear 3 (3rd Degree)
4	Tear 4 (4th Degree)

8	Unspecified tear
9	Not known if tear

**Typical Weekly Alcohol Consumption**  
**SMR02 review 2010 (data items)**  
**Coding Guidelines No. 27, October 2010**

This data item will become mandatory on 1st April 2011.

**Weight of Mother at Booking**                      **SMR02 review 2010 (data items)**  
**Coding Guidelines No. 27, October 2010**

This data item will become mandatory on 1st April 2011.