NHS England

National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding (2024)

Accurate data for quality information

Terminology and Classifications Delivery Service

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Accurate data for quality information

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Authorised amendments to this publication are compiled and issued by the Terminology and Classifications Delivery Service.

Date of issue: April 2024
Version: 10.1

ICD-10 CONTENTS

INTRODUCTION

The World Health Organization (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision 5th Edition (ICD-10) was developed for use in the collection of morbidity and mortality information.

The purpose of ICD-10 is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses and other health problems from words into alphanumeric codes, which permits easy storage, retrieval and analysis of data[1]. The ICD-10 classification comprises three volumes:

- Volume 1: Tabular List: includes classification codes and titles at three and four character levels, the classification of morphology of neoplasms and definitions
- Volume 2: Instruction Manual: includes information about the structure, principles and conventions, how to use ICD, rules and guidelines for recording and coding and historical background
- Volume 3: Alphabetical Index: includes index terms for diseases, nature of injury and external causes of injury, introduction and instructions on its use.

Whilst WHO gives specific instruction on the use of the ICD-10 classification for morbidity coding in some areas, it provides options and guidance of a general nature in others. This can lead to differences in interpretation and application of the classification and this, in turn, can reduce the consistency and comparability of the data at local and national levels.

The *National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding* are to be used with the three volumes of ICD-10. They reinforce the classification rules and coding conventions inherent in the ICD-10 Volumes 1-3, give specific instructions for morbidity coding including for those areas of potential ambiguity (as far as practically possible) or where data analysis or user feedback requires additional information to safeguard data consistency and comparability. They also include instruction that cannot be embedded into the classification such as the NHS-mandated definition for primary diagnosis. Where a standard or guidance within the WHO ICD-10 Volume 1 or 2 differs to a national clinical coding standard, the national clinical coding standard must take precedence.

Compliance with ICD-10 and these coding standards enables consistent, accurate and uniform coding which in turn supports data collection and comparison of local and national data across time.

The content type and level of detail within this publication is primarily aimed at a clinical coding professional and therefore presumes the user:

[1] World Health Organization International Classification of Diseases and Related Health Problems' ICD-10 Volume 2, 2.1 Purpose and applicability

- Understands the use of the ICD-10 classification
- Is trained in the abstraction of relevant information from the medical record
- Possesses knowledge of anatomy and physiology
- And for coding purposes, understands how a condition can affect the human body.

The National Clinical Coding Standards ICD-10 5th Edition for morbidity coding are the definitive source of clinical coding standards for use in the NHS in England.

These clinical coding standards are also used in Northern Ireland and Wales, with some local variance. For information on specific use of the ICD-10 classification, clinical coding standards, data definitions and collections in Northern Ireland, Wales and Scotland contact the respective national centre:

- Northern Ireland – Digital Health & Care Northern Ireland – About DHCNI Data
- Wales – Digital Health and Care Wales Information Design and Standards Development
- Scotland – Terminology Services - Public Health Scotland

The NHS Classifications Browser provides a way to browse and search the ICD-10 classification online. It is regularly updated to reflect changes to the ICD-10 National Clinical Coding Standards to support consistent application of the classification codes by clinical coders. It is freely available online to anyone with an internet connection.

Background

The ICD-10 is a statistical classification that underpins key information initiatives that support the monitoring of morbidity and health trends. NHS managers and health care professionals use ICD-10 coded data locally and nationally to support operational/strategic planning and performance management. For example:

- Statistical uses include: study of aetiology (cause or origin) and incidence of diseases, health care planning and casemix.
- Epidemiologists use statistical data to study frequency and occurrence of disease. The aggregation of coded data enables health professionals to identify at risk populations based on demographic, diagnostic or environmental factors.
- Planners and managers use statistical data to review caseloads to determine specialty needs, inform staffing levels, patient admissions and clinic schedules in hospitals.
- Clinical audit uses coded data to compare patient care and measure outcomes within specialities. Doctors may use extracts of local information for research purposes.

The UK has a mandatory obligation to collect and submit ICD-10 data to the World Health Organization (WHO) for the production of international statistical and epidemiological data.

ICD-10 is a vital component of national data sets, such as Hospital Episodes Statistics (HES) in England, Hospital In-patient Statistics (HIS) in Northern Ireland, Patient Episode Data for Wales (PEDW), Scottish Morbidity Records (SMR), Cancer Registries, National Service Frameworks, Care Pathways and Performance Indicators.

In England the classification of diagnoses using ICD-10 is a mandatory national requirement for the NHS Admitted Patient Care (APC) Commissioning Data Set (which includes day cases) and other data sets. The requirements for data sets and related definitions are specified in the NHS Data Model and Data Dictionary.

In England ICD-10 is an approved Information Standard published under Section 250 of the Health and Social Care Act 2012, see SCCI0021: International Statistical Classification of Diseases and Health Related Problems (ICD-10) 5th Edition

WHO also refer to the ICD-10 5th Edition as the 2016 Edition. It was implemented by the NHS on 1 April 2016 and includes WHO updates that came into effect between 2011 and 2016.

The NHS uses the ICD-10 5th Edition as released by the WHO. To note that the WHO printed a corrigenda in the back of the ICD-10 5th Edition Volume 1 listing alterations and corrections to code descriptions and notes. These are also available in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document.

Where there is a variance to the assignment of ICD-10 codes in Volumes 1 and 3 e.g. use of subcategory codes or emergency codes, these are highlighted at:

- ***DCS.XX.2: Fourth character subcategory codes at W26, X34 and X59***
- ***DChS.XX.2: Activity codes***
- ***DCS.I.5: Zika virus***
- ***DCS.XXII.4: Vaping related disorder (U07.0)***
- ***Chapter XXII: COVID-19 Standards***

Morbidity versus mortality coding

The classification permits the assignment of codes to diseases (morbidity) and to causes of death (mortality) according to established criteria, providing consistent information for use in the collection of morbidity and mortality information for statistical purposes.

The National Clinical Coding Standards for ICD-10 5th Edition for morbidity coding are for use with the ICD-10 for coding of the main condition (morbidity) and related health conditions as recorded in the hospital medical record. The coding of diagnostic statements or elements of them is ‘mandatory’ only where the information is recorded in the medical record.

The ICD-10 rules for the selection and coding of the underlying cause of death (mortality) are outside the scope of this publication.

Clinical coding

Clinical coding is the translation of medical terminology that describes a patient's complaint, problem, diagnosis, treatment or other reason for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner.

Clinical coder

A clinical coder is the health informatics professional that undertakes the translation of the medical terminology in a patient's medical record into classification codes. A clinical coder will be accredited (or working towards accreditation) in this specialist field to meet a minimum standard. Clinical coders use their skills, knowledge and experience to assign codes accurately and consistently in accordance with the classification and national clinical coding standards. They provide classification expertise to inform coder/clinician dialogue. Clinical coders must abide by local and national confidentiality policies and codes of practice as a breach may lead to disciplinary action, a fine or, in the case of a breach of the Gender Recognition Act 2004, possible prosecution.

Care professional admitted care episode and hospital provider spell

In England a clinical coder must assign ICD-10 codes to the diagnoses recorded in the medical record for each care professional admitted care episode (hereafter referred to as 'episode') within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (CDS) (which includes day cases).

A hospital provider spell may contain several episodes and the definitions for these terms are found in the NHS Data Model and Dictionary at: http://www.datadictionary.nhs.uk/

The NHS Data Model and Dictionary is the source for assured information standards to support health care activities within the NHS in England. It is aimed at everyone who is actively involved in the collection of data and the management of information in the NHS.

An episode can be a consultant episode (hospital provider), a midwife episode or a nursing episode. This term replaces the previous term 'finished consultant episode' commonly abbreviated to "FCE" which was widely used in the NHS and has been used in previous clinical coding guidance.

See the NHS Data Model and Dictionary frequently asked questions for more information at: http://www.datadictionary.nhs.uk/

Emergency Care Department attendance – Decision to Admit

The Emergency Care Commissioning Data Set (ECDS) is one of the mandated data flows for Health Care Providers across the NHS, England. In CDS V6-2-3 Type 011 – Emergency Care CDS emergency care attendances were mandated to flow nationally from 01-08-17. See DCB0092-2062 for more information.

All activity occurring under the responsibility of the Emergency Care Department is part of the Emergency Care Department Attendance and coded as such, including when the patient temporarily leaves the Emergency Care Department, e.g. for an X-ray.

When the patient's care contact originates as an Emergency Care Department Attendance, but later a clinical decision is made to admit the patient to a Health Care Provider, this is described as a 'decision to admit'. The 'Decided to admit date' and 'Decided to admit time' is recorded at the time when the clinical decision to admit is made.

The 'Decided to admit date' and 'Decided to admit time' or 'Admission Date' trigger the start time for an Episode within the Admitted Patient Care CDS.

Following the decision to admit any recorded activity from that point on becomes part of the Admitted Patient Care CDS requiring the application of ICD-10 and OPCS-4 codes, including:

- When the decision to admit is made immediately on the patient presenting to the Emergency Care Department, including when the patient is subsequently taken to an Operating Theatre before ward admission
- When a decision to admit is made but the patient is temporarily accommodated in the Emergency Care Department or elsewhere but remains waiting in the nursing care of the Emergency Care Department for longer than is appropriate for his/her condition before moving to a ward (i.e. a lodged patient).

It is important that this activity data is complete and accurate to avoid inaccuracies or data duplication in CDS flows.

When the patient's care contact originated as an Emergency Care Department Attendance but there is no evidence when the clinical decision to admit was made, the Health Care Provider will need to find a local solution to ensure this information is recorded. This also triggers the start time for the coding department to apply the codes for Admitted Patient Care CDS data flows.

DATA QUALITY

Medical record

A health record (hereafter referred to as ‘medical record’) is defined in the Data Protection Act 2018 as a record which consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates.

It is a medico-legal document and the responsible consultant, or healthcare practitioner, is accountable for the clinical information they record in the medical record. It needs to be complete, accurate, relevant, accessible and timely to the patient's encounter with the health care provider at a given time.

The medical record can be handwritten or digital and may be held in paper or more commonly electronic format as NHS trusts update and improve their systems to adopt Electronic Patient Record (EPR) systems in hospitals.

The structure and contents of the medical record may vary from hospital to hospital. Typically, there are handwritten notes, computerised records, correspondence between health professionals, discharge letters, clinical worksheets and discharge forms, nursing care pathways, histology reports and diagnostic test reports. In the case of post-mortem reports these should always be processed through the responsible consultant in preparation of a summary. Use of the post-mortem report should, therefore, be the responsibility of the responsible consultant, who should decide what goes into the clinical summary for the coder.

Any of these sources may be accessed for coding purposes. The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant episode within the hospital provider spell.

The accuracy, completeness, legibility and timeliness of the information recorded in the medical record is therefore critical to the coding process. As the medical record is the source of truth for the purposes of clinical coding it is recommended that the clinical coder has access to the full medical record in order to extract all relevant information to support the correct assignment of ICD-10 code(s) to produce consistent, high-quality and comparable data.

The National Clinical Coding Standards cannot provide direction to compensate for deficiencies in the documentation, recording or coding process.

When the medical record does not contain sufficient information to assign a code, the clinical coder must consult the responsible consultant (or their designated representative[2]).

The clinical coding manager should use the local information governance and clinical governance arrangements to address documentation and recording issues to support data quality improvements that will generate aggregate data that are valid and comparable.

Information on standards for professional record keeping, developed by the Royal College of Physicians Health Informatics Unit and approved by the Academy of Medical Royal Colleges, can be found on the Royal College of Physicians website at https://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records

See also: https://www.england.nhs.uk/long-read/high-quality-patient-records/

Information governance and clinical governance

The lack of information or presence of discrepancies, in the medical record should be addressed through local information governance and clinical governance mechanisms. Such instances present an opportunity to leverage change which will bring benefits to the organisation: such as improved recording of clinical information, robust local processes and correctly coded clinical data.

It is acceptable to agree local coding policy, provided this does not contravene any national coding standard.

When agreement has been reached through local governance on how to address a documentation or recording issue the outcome must be documented in the departmental policy and procedure document. This must be agreed and signed-off by the clinical director and/or governance authority dependent on local arrangements. Local coding policies should be reviewed regularly as part of the organisation's review process.

Common problems such as lack of recorded diagnosis but presence of investigation results or findings, such as high levels of postpartum blood loss without a documented diagnosis of postpartum haemorrhage, or lack of comorbidities can be used to encourage constructive dialogue between clinical coders and clinicians to support accurate and consistent coded data.

The recording of the patient's conditions, co-morbidities (also described as long-term conditions) and medical history for the current admission is the responsibility of the

[2] Hereafter referred to as the responsible consultant. The designated representative could be the clerking doctor, midwife or specialist nurse. As there will be local variations in designated representatives and processes the coding manager should confirm with the medical director the role of designated

responsible consultant. It is **not** the responsibility of a clinical coder to analyse information from previous hospital provider spells in order to identify and code conditions.

Nor is it the responsibility of a clinical coder to make a judgement on whether previously reported conditions have any bearing on the current episode for coding purposes. Whilst it may seem that extracting diagnostic information from a previous hospital provider spell provides additional clinical information for coding co-morbidities and medical history, there is a risk that this may not be accurate or pertinent to the current episode.

For the standards on using diagnostic test results ***see DGCS.4: Using diagnostic test results***.

For the standards on the coding of previously reported conditions ***see DGCS.3: Co-morbidities***.

Further information on information governance can be found at:
https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance

Clinical coding audit

Coded clinical data is audited against national clinical coding standards. Clinical coding audit must be objective and provide value to the local organisation by highlighting and promoting the benefits of taking remedial actions to improve data quality, processes and training as well as acknowledging evidence of best practice.

When there are documentation discrepancies or recurring reporting issues which are outside the remit or control of the clinical coding department, the audit report should highlight these to be addressed through the local information governance and clinical governance arrangements.

Local coding policy and procedure documents should be inspected as part of a clinical coding audit to ensure these:

- Are up-to-date
- Evidence local agreements and implementation
- Have been applied consistently
- Do not contravene national clinical coding standards.

SNOMED CT to ICD-10 maps

Health care providers that have implemented an EPR system and the clinical terminology SNOMED CT can use the national maps between the SNOMED CT UK Edition and ICD-10

5th Edition. The maps are designed to support those organisations with EPR systems to fulfil the mandatory requirement for collection and reporting of diagnostic data using ICD-10. These maps support the derivation of classification codes directly from SNOMED CT concepts recorded by the clinician in the EPR. They are incorporated in software to present the ICD-10 code(s) attached to a SNOMED CT concept, for validation by the clinical coding expert. Four different types of map are provided to accommodate the different circumstances that may influence ICD-10 code assignment, see the SNOMED CT to Classifications Maps Page on Delen for more information.

The classification maps are compiled by the Terminology and Classifications Delivery Service to reflect the rules and conventions of ICD-10 as well as these national clinical coding standards.

The major releases of SNOMED CT UK Edition include the ICD-10 map files which are available for download via the Technology Reference Data Update Distribution Service (TRUD) following registration at the following website:
https://isd.digital.nhs.uk/trud/user/guest/group/0/home

Coding uniformity

Uniformity means that whenever a given condition or reason for an episode is coded, the same code is always used to represent that condition or reason for the encounter. Uniformity is essential if the information is to be useful and comparable.

General principles for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient's condition during the episode.
- Code every condition or reason for encounter which affects the care, or influences health status during the episode, which is available in the classification and supported by the medical record.
- Code each problem to the furthest level of specificity, i.e. third, fourth or fifth character, which is available in the classification and supported by the medical record.
- Do not code background information or chronic problems which are no longer active, and which do not influence the health care being provided in the relevant episode. It is not always intended that symptoms or history be coded. Just because a condition can be coded does not mean it should be coded each time the patient is admitted. Any uncertainty around issues of relevance or inactive problems should be discussed with the responsible consultant.

Three dimensions of coding accuracy

- **Individual codes**

  Each clinical statement of diagnosis must have the correct code assignment. An individual patient may have many diagnoses (or procedures). Consequently, a coded record for an episode will have at least one or potentially many individual codes.

- **Totality of codes**

  The concept of totality of codes is complex. It means that all codes necessary to give an accurate clinical picture of the patient's diagnosis, problems or other reasons for an episode encounter, must be assigned in accordance with the rules, conventions and standards of the classification. This is important as it is possible for a list of codes to describe an episode incorrectly in terms of clinical coding rules and standards even though the individual codes selected are correct. ***See also DGCS.3: Co-morbidities.***

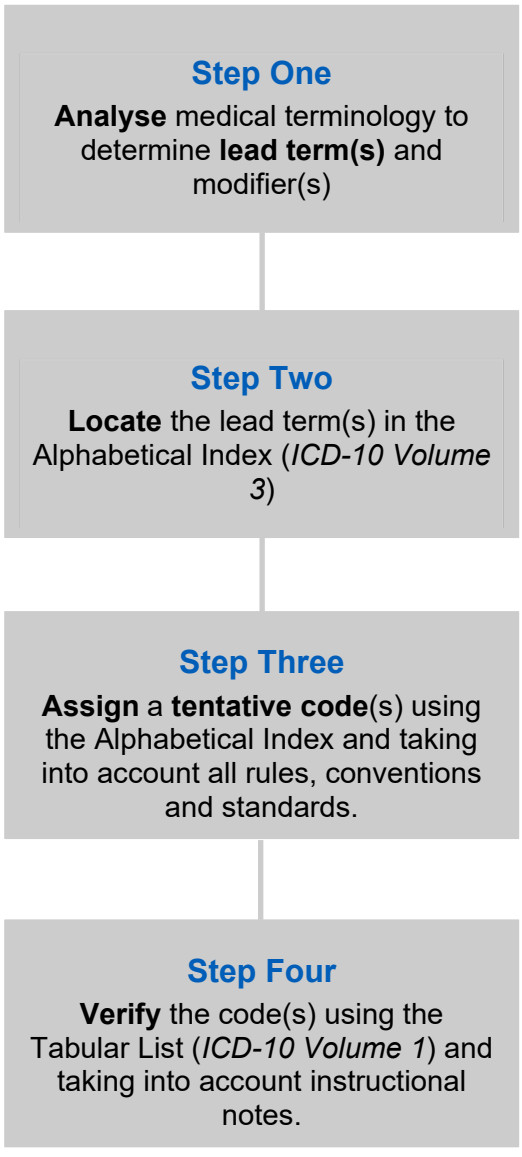
- **Sequencing of codes**

  Codes must be sequenced in accordance with clinical coding standards to provide consistent data for statistical analysis. A significant aspect of sequencing is the selection of the main condition treated. ***See also DGCS.1: Primary Diagnosis***.

The four step coding process

The four staged process that makes up the act of clinical coding is designed to ensure appropriate and consistent code assignments. The coder is required to use ICD-10 Volume 3, Alphabetical Index and Volume 1, Tabular List and to be trained in the use of ICD-10 and the context in which it is used.

The four-step coding process is the key to ensuring correct use of ICD-10 and accurate coding of the diagnostic statement(s) in the medical record. An overview of the four steps is provided below as a reminder. The full detail of each step is fully explored during training using national core curriculum training materials.



HOW TO USE THIS PUBLICATION

The content is split into distinct sections so that it is clear whether the rule, convention or standard must be applied throughout the classification, if it should be applied throughout a chapter or if it is specific to a code(s) or diagnosis.

All rules, conventions, standards and flow charts have a unique identifier (reference number) and title so that they can be easily identified, applied and referenced, and they can be logically and consistently updated, removed or replaced. The unique identifiers are specific to each section, as explained below, but all are preceded by the letter '**D**' for 'diagnostic' to indicate that the rule, convention, standard or flow chart is applicable to ICD-10.

It is important that users understand how each section should be applied when coding.

Rules of ICD-10

Rules of ICD-10 apply throughout the classification and the clinical coder must be aware of these rules to code with consistency and accuracy.

A rule that a coder must comply with is presented in a grey box. Explanatory information about the rule is presented in a white box.

The unique identifiers for rules begin with '**DRule**' and are followed by the number of the rule and the title (e.g. **DRule.2: Category and code structure**).

Conventions of ICD-10

Conventions of ICD-10 are fundamental to accurate coding and apply throughout the classification (including the Alphabetical Index). The clinical coder must thoroughly understand these conventions and always apply them to ensure correct code assignment and sequencing.

Conventions of ICD-10 are presented within a grey box.

The unique identifiers for conventions begin with '**DConvention**' followed by the number of the convention and the title (e.g. **DConvention.1: Cross references**).

Coding Standards

A coding standard must be applied by the clinical coder in the manner described. Standards are clear, concise and unambiguous.

Each standard is contained within a grey box. They may also have associated guidance, and this will be contained within an adjoining white box. **Only the text within the grey area is the coding standard** e.g.

DCS.II.10: Histological types and benign neoplasms
The classification of some terms such as ‘polyp’ or ‘cyst’, depend upon their histological type or site, and must not be coded without reference to the histology report and final confirmation by the responsible consultant.
Careful checking of essential modifiers is also necessary as they may direct the coder elsewhere within the classification.

There are three types of standard:

- **General coding standards**

  General coding standards are applicable throughout the classification.

  The unique identifiers for general coding standards begin with ‘**DGCS**’ followed by the number of the standard and the title (e.g. **DGCS.1: Primary diagnosis**).

- **Chapter standards**

  Chapter standards are located at the beginning of an ICD-10 chapter and are applicable throughout that chapter. Note that not all chapters will have chapter standards.

  The unique identifiers for chapter standards begin with ‘**DChS**’ followed by the chapter numeral, the number of the standard and the title (e.g. **DChS.XIX.1: Multiple injuries**).

- **Coding standards**

  Coding standards are located throughout each ICD-10 chapter and are applicable to a specific diagnosis, disorder, disease or condition, or describe the correct usage of a code, category or range of codes. Coding standards are listed in code, category or range order.

  The unique identifiers for coding standards begin with ‘**DCS**’ followed by the chapter numeral, the number of the standard and the title (e.g. **DCS.IV.1: Diabetes mellitus (E10–E14)**).

Coding guidance

Coding guidance is advice or information provided to aid the clinical coder or user of the classification. It does not describe a precise requirement or coding standard.

Coding guidance is contained within a white box. They do not have unique identifiers or titles. e.g.

Special symbols # and ✧ are used within the neoplasm table in the Alphabetical Index. The use of these symbols is described in 'Notes 2 and 3' before the table.

Examples

Examples are included where necessary to illustrate the correct application of a rule, convention or standard and are provided after guidance to illustrate the points made. They are only included when an example of the practical application of codes may aid the coder in understanding the rule, convention or standard. The codes reflect the diagnostic statement given within the example. Where required a rationale is provided.

Examples are not national standards and should only be used as an aid to coding. Clinical coding must always be based on the information contained within the rule, convention or standard.

Further examples of how standards can be applied can be found in the current ICD-10 and OPCS-4 Exercise and Answer Booklets. These are available to anyone on request via information.standards@nhs.net.

References

References direct the user to a pertinent standard or guidance in a different section . A reference has a title but does not have a unique identifier.

The reference details the unique identifier and title of the relevant standard to aid user navigation. If directing to a standard the reference is shown in a grey box. If the box is not grey, then the reference directs to guidance.

The coder must navigate to and review the full standard that has been referenced in order to ensure correct understanding and application - e.g.

Geriatric and elderly falls (R29.6)
See DCS.XVIII.4: Geriatric and elderly falls (R29.6).

Flow charts

Flow charts are a visual aid to summarise one or a number of standards to help a coder learn how to apply the standard. Coders must always ensure they read and understand the full standard(s) before using the flow charts as they do not contain all the information contained within the standard. Flow charts are contained within a white box.

The unique identifiers for flow charts begin with '**DFigure'** followed by the chapter numeral, the figure number and the title (e.g. **DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease**).

The unique identifier of the standard(s) and applicable flow chart are referenced to aid the user.

Appendices

The appendices contain additional guidance and information that is not appropriate for inclusion within the main content, for example because it is a long list of guidance or is applicable to multiple chapters.

Index of standards

The Index of standards lists all rules, conventions, general coding standards and chapter standards in the order they appear. It can be used to locate a specific standard.

Summary of changes

The summary of changes lists each change that has been made between the previous and current release of the *National Clinical Coding Standards for ICD-10 for Morbidity Coding* in the order that the change appears. Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Updating the National Clinical Coding Standards for ICD-10 for Morbidity Coding

Updated releases of the National Clinical Coding Standards for ICD-10 for Morbidity Coding may contain new or updated rules, conventions, standards and guidance or they may be deleted. In each case the updates are made in a consistent manner and are identified in the summary of changes. Users can also refer back to previous versions to see how a standard and codes were applied historically.

New rule, convention or standard

A new rule, convention, general coding standard or chapter standard is added at the end of the relevant section with a new unique identifier and title.

A new coding standard within a chapter is added in code, category or range order to reflect the location of the code(s) that the standard applies to in the ICD-10 Tabular List. The new entry is given a new unique identifier and title. This means that the unique identifiers for coding standards within a chapter may not always be listed sequentially.

The unique identifiers and titles of all new entries can be referenced in the Index of standards.

Updated rules, conventions and standards

When a rule, convention or standard is updated, the necessary changes are made to the existing text and the unique identifier remains the same.

Deleted rules, conventions and standards

A rule, convention or standard is deleted when it is no longer applicable or has been superseded. Deleted entries are removed.

New, updated and deleted guidance and references

New guidance and references are added in the most relevant location. They are deleted if no longer required. Guidance and references are updated by making the appropriate changes to the existing text of the guidance or reference.

RULES OF ICD-10

DRule.1: Axis of the classification and rules of chapter prioritisation

Where there is any doubt as to where a condition should be coded, the 'special group' chapters must take priority.

The ICD is a variable-axis classification. Its 22 chapters are divided into the following three types:

Special group chapters

Chapters I-V, XV-XVII and XIX classify conditions that do not focus on any one body system. In general, conditions are primarily classified to one of the 'special group' chapters.

Body system chapters

Chapters VI-XIV classify conditions according to the body system they affect.

Other chapters

Chapters XVIII and XX-XXII classify other disorders and factors which do not sit comfortably in either a special group or body system chapter.

DRule.2: Category and code structure

Code assignment must always be made to four character level or five character level (where available and in line with fifth character coding standards), for the code to be valid.

Where a three character category code is not subdivided into four character subdivisions the 'X' filler must be assigned in the fourth character field so the codes are of a standard length for data processing and validation. The code is still considered a three character code from a classification perspective.

Where a three character code requires assignment of both the 'X' filler and a fifth character subdivision, the 'X' filler must continue to be recorded in the fourth field before the fifth character, for example **M45.X3 Ankylosing spondylitis, cervicothoracic region.**

See also DConvention.7: Fifth characters.

Three character codes:

The three character category code structure is a three-digit code with an alphabetic character in the first position followed by two numbers. Most three character categories are subdivided to give four character or five character codes (subcategories).

Four character codes:

In most instances the fourth character .8 is used for other conditions belonging to the three character category but is not included in any of the 0-7 four character codes.

The fourth character .9 usually denotes that the condition(s) is not described sufficiently to permit assignment of a more specific code.

Five character codes:

Supplementary fifth characters are used in Chapters IX, X, XIII and XIX to add greater specificity to the codes. Fifth characters activity codes are also available in Chapter XX, but these codes are not to be used for national collection.

CONVENTIONS OF ICD-10

DConvention.1: Cross references

Cross references are provided in the Alphabetical Index to ensure that all possible terms or its synonyms are referenced by the coder. Cross references explicitly direct the coder to other entries in the index:

See

This is an explicit direction to look elsewhere as no codes can be found alongside this cross reference. It is used to direct the coder to another lead term in the Alphabetical Index where complete information can be found. It is also used after anatomical sites to remind the coder that the Alphabetical Index is organised by condition.

See also

This is a reminder to look under another lead term if the term the coder is looking for cannot be found modified in any way under the first lead term.

Examples:

Hematothorax - *see* Hemothorax

The cross reference directs the coder to the lead term '**Hemothorax**'.

Femur, femoral - *see condition*

The cross reference reminds the coder to look for the condition affecting the femur - e.g. 'femoral fracture' would be found under the lead term '**Fracture**'.

Abrasion (*see also* Injury, superficial) T14.0

This cross reference means that if '**Abrasion**' is the only term in the medical record, then the code **T14.0 Superficial injury of unspecified body region** is assigned. If any additional modifier is documented that is not indented under the lead term '**Abrasion**' (e.g. conjunctiva) the lead term '**Injury**' (with modifier 'superficial') should be used.

Enlargement, enlarged – *see also* Hypertrophy

If the site of the enlargement is not listed in the modifiers under the lead term '**Enlargement**', then the coder should look up '**Hypertrophy**'.

Abdomen, abdominal – *see also condition*
- acute R10.0
- convulsive equivalent G40.8
- muscle deficiency syndrome Q79.4

Modifiers are listed under the anatomical site; if the condition reported in the medical record is not listed, then the coder must look up the condition instead.

DConvention.2: Instructional notes

Instructional 'Notes' are used within the Tabular list at chapter level, block level, three-character and four-character levels. They describe the general content of the succeeding categories, give instruction regarding the use of categories and provide fifth character sub-classifications.

***Inclusion* notes (inclusion terms, '*Incl.:*')**

Inclusion notes clarify the content and intended use of the chapter, block, category or subcategory to which the notes apply. They give examples of the conditions and diagnoses classified at the chapter, block, category or code. The listed inclusion terms are not exhaustive and alternative diagnoses are listed in the Alphabetical Index.

Inclusion notes appearing under chapter and block titles usually give a general definition of the content of the section to which they apply. These inclusion notes apply to **all** categories within the chapter or block.

Inclusion notes at four character code level are not preceded by the abbreviation ***Incl.:***

***Exclusion* notes (exclusion terms, '*Excl.:*')**

Exclusion notes are used to prevent a category or code from being used incorrectly:

- They inform the coder that, although the category or code description may suggest the term could be classified here, it is in fact classified elsewhere, however
- They do not always prevent the use of the code from the category the exclusion note appears in; they can indicate that a code from a different category should be assigned in addition to fully reflect the patient's diagnoses.

***Use* notes**

The '***use***' note is a specific instruction to use an additional code in order to describe a condition more completely and, just like other types of notes, can be found at chapter, block, three character category and fourth character subcategory levels. The '***use***' note is

never optional and must always be adhered to where the information is available in the medical record.

***If desired* notes**

Where a note states to 'Use an additional code, ***if desired***' to add further information about the disorder, where that information is present in the medical record the additional code **must** be assigned.

Are for use with

Where a note contains the phrase '***are for use with***', this instruction is mandatory, and the four-character subdivisions referred to must be used

See also DChS.V.1: Glossary descriptions.

Examples:

A06.0 Acute amoebic dysentery
Acute amoebiasis
Intestinal amoebiasis NOS

Code **A06.0** includes 'acute amoebiasis' and 'intestinal amoebiasis NOS'. Not all conditions classified to **A06.0** are listed within the inclusions and the Alphabetical Index may direct to this code when looking up other conditions. For example, the Alphabetical Index directs the coder to **A06.0** for 'amoebic colitis'.

Tuberculosis
(A15-A19)

Incl.: infections due to *Mycobacterium tuberculosis* and *Mycobacterium bovis*

The inclusion note indicates that all codes in categories **A15-A19** classify infections due to '*Mycobacterium tuberculosis'* and '*Mycobacterium bovis'.*

M85.5 Aneurysmal bone cyst
Excl.: aneurysmal cyst of jaw (K09.2)

The exclusion note at code **M85.5** warns that if the aneurysmal bone cyst is of the jaw then code **M85.5** must not be used; code **K09.2 Other cysts of jaw** must be assigned instead.

M24.6 Ankylosis of joint
Excl.: spine (M43.2)
stiffness of joint without ankylosis (M25.6)

The exclusion note at code **M24.6** warns that ankylosis of the spine is not coded here, but to code **M43.2 Other fusion of spine**. However, this note does not preclude the use of both codes if both conditions exist. If, for example, ankylosis of elbow and ankylosis of spine were both present then codes **M24.62** and **M43.2** would be assigned (***See also DChS.XIII.1: Fifth characters in Chapter XIII***).

I27.2 Other secondary pulmonary hypertension
Use additional code, if desired, to identify the underlying disease.

If the underlying disease is documented in the medical record then this must be coded in addition to code **I27.2.**

Occupant of heavy transport vehicle injured in transport accident (V60–V69)

The following fourth-character subdivisions are for use with categories V60- V68:

.0 Driver injured in nontraffic accident
.1 Passenger injured in nontraffic accident
.2 Person on outside of vehicle injured in nontraffic accident
.3 Unspecified occupant of heavy transport vehicle injured in nontraffic accident
.4 Person injured while boarding or alighting
.5 Driver injured in traffic accident
.6 Passenger injured in traffic accident
.7 Person on outside of vehicle injured in traffic accident
.9 Unspecified occupant of heavy transport vehicle injured in traffic accident

These fourth-character codes must be used with categories **V60-V68**, but not with category **V69** as category **V69** uses different fourth-character codes.

DConvention.3: Punctuation

Brace |

Braces (indicated by a vertical line in the Tabular List) are used in inclusion and exclusion notes to indicate that both the listed condition and one of its modifiers must be present in order to complete the instruction. Braces enclose a series of terms, modified by the statement appearing at the right of the brace.

Square brackets [ ]

Square brackets are used to:

- enclose synonyms, alternative words, or explanatory phrases
- enclose an instruction to 'see' previously listed subdivisions common to a number of categories
- refer to a previous 'see' note.

Colon :

A colon is used above a list of bulleted modifiers (•) in the Tabular List. The word preceding the colon **must** be followed by one of the bulleted modifiers in order for that code to be assigned.

Point dash .–

A point-dash is used in both the Tabular List and the Alphabetical Index to indicate there are fourth character subdivisions.

Parentheses ( )

Parentheses are used to enclose nonessential modifiers (***see DConvention.6: Modifiers***). They are also used to enclose chapters, categories and codes listed in instructional notes, code ranges in block titles and dagger or asterisk codes in the Tabular List and to enclose cross-reference terms in the Alphabetical Index.

Examples:

I34.0 Mitral (valve) insufficiency
Mitral (valve):
• incompetence NOS or of specified cause, except rheumatic
• regurgitation

Code **I34.0** includes mitral valve incompetence and mitral valve regurgitation of unspecified cause (NOS) or of specified cause as long as the cause is not rheumatic.

A30 Leprosy [Hansen disease]

Hansen disease is a synonym of leprosy.

C00.8 Overlapping lesion of lip
[See note 5 at the beginning of this chapter]

Note 5 at the beginning of the chapter must be reviewed before assigning code **C00.8**.

A22.0 Cutaneous anthrax
Malignant:
• carbuncle
• pustule

The medical record must state that the pustule or carbuncle is malignant in order to assign code **A22.0** for these conditions. Without the qualifier of 'malignant', carbuncle would be coded to **L02.9 Cutaneous abscess, furuncle and carbuncle, unspecified** and pustule would be coded to **L08.9 Local infection of skin and subcutaneous tissue, unspecified**, as directed by the Alphabetical Index.

Miscarriage O03.-

Miscarriage should be coded using a code within category **O03.- Spontaneous abortion**.

L85.0 Acquired ichthyosis
Excl.: congenital ichthyosis (Q80.-)

A code from category **Q80.- Congenital ichthyosis** should be used for congenital ichthyosis.

DConvention.4: Abbreviations

NOS (Not Otherwise Specified)

Equivalent to 'unspecified', i.e. **.9**. A term without any essential modifier is usually the unspecified form of the condition. The code assignment is that which directly follows the lead term in the Alphabetical Index. When the clinician states a diagnosis, problem or reason for an encounter as a single term which has no modifiers, in classification terms it is said to be 'unspecified' or unqualified or NOS. The coder must ensure there is no further information in the medical record that would allow for the assignment of a more specific code.

NEC (Not Elsewhere Classified)

Assignment of a tentative code which uses NEC should be avoided if at all possible. The category for the term including NEC is to be used only when the coder lacks the information necessary to code the term to a more specific category. The phrase '***not elsewhere classified***' is used in the Tabular List for residual categories to indicate that

other specified variants of the condition may appear in other parts of the classification. Often, but not always, an exclusion note appears in an 'NEC' category, directing the coder to the code range, category or four character code where the condition is classified.

Examples:

J85.2 Abscess of lung without pneumonia
Abscess of lung NOS

An abscess of the lung with no further information about the condition would be coded using **J85.2**.

K31.3 Pylorospasm, not elsewhere classified
Excl.: pylorospasm:
- congenital or infantile (Q40.0)
- neurotic (F45.3)
- psychogenic (F45.3)

More specific forms of pylorospasm are classified elsewhere, but without any further information the code **K31.3** would be assigned. The exclusion note indicates where in the classification the more specific forms of pylorospasm can be found.

DConvention.5: Relational terms

And

The use of '***and***' within code descriptions means and/or. It indicates that the code can be assigned if either one or both elements within the code description are present.

With or with mention of

'***With***' is used either when two or more conditions combine to form another condition or to provide additional four character specificity. These terms indicate that both elements in the code description must be present in the diagnostic statement in order to assign the code. These terms do not necessarily indicate a cause-effect relationship. '***With***' always appears first in the list of modifiers in the Alphabetical Index. (***See also DConvention.6: Modifiers***)

Without

Indicates that the named element must not be present in the diagnostic statement in order to assign the code.

In, due to and resulting in

Indicate a causal relationship between the elements in the title and requires the responsible consultant to confirm a cause-effect relationship within the medical record before the code(s) can be assigned. This may be clear from the diagnostic statement or in the combinations of conditions. In other instances, ICD-10 presumes a relationship unless otherwise qualified.

These terms are usually used where a condition only occurs because of the presence of another condition. '***In***' and '***due to***' are used interchangeably as they have the same meaning, and in many cases appear as '***in (due to)***'. In the vast majority of cases, the subentries have both dagger and asterisk codes. '***In***' and '***due to***' are also used in other situations such as 'in pregnancy' or 'due to drugs'.

Examples:

T20.2 Burn of second degree of head and neck

Code **T20.2** can be assigned for a second degree burn of the head or a second degree burn of the neck *or* a second degree burn of the head and the neck.

Actinomycosis, actinomycotic A42.9
– with pneumonia A42.0† J17.0*

If both actinomycosis and pneumonia are documented in the medical record, the dagger and asterisk combination of **A42.0† Pulmonary actinomycosis J17.0* Pneumonia in bacterial diseases classified elsewhere** is used. **NB:** Sequencing will be dependent on the main condition treated. ***(See also DGCS.1: Primary diagnosis*** and ***DGCS.5: Dagger and asterisk system)***

K80.0 Calculus of gallbladder with acute cholecystitis

If both calculus of the gallbladder and acute cholecystitis are documented in the medical record, code **K80.0** is assigned.

I26.0 Pulmonary embolism with mention of acute cor pulmonale

If pulmonary embolism and acute cor pulmonale are both documented in the medical record, code **I26.0** is assigned.

K80.2 Calculus of gallbladder without cholecystitis

Code **K80.2** would only be assigned if the patient has a calculus of gallbladder, but cholecystitis is not present. If cholecystitis is present, either code **K80.0 Calculus of**

gallbladder with acute cholecystitis *or* code **K80.1 Calculus of gallbladder with other cholecystitis** would be assigned.

Arthritis, arthritic (acute) (chronic) (subacute) M13.9
– in (due to)
– – acromegaly E22.0† M14.5*

The responsible consultant must indicate that arthritis is due to acromegaly in order for this index trail to be used.

A03.0 Shigellosis due to *Shigella dysenteriae*

It must be clear in the medical record that the shigellosis is due to Shigella dysenteriae to enable the use of code **A03.0**.

I95.2 Hypotension due to drugs
Use additional external cause code (Chapter XX), if desired, to identify drug.

Code **I95.2** is assigned if it is documented in the medical record that the hypotension is due to drugs. A code from Chapter XX would be assigned in addition if the drug is known.

DConvention.6: Modifiers

Modifiers are also referred to as qualifiers and are descriptive words used to further describe or modify a diagnosis. They are found in the Alphabetical Index and the Tabular List.

Nonessential modifiers

Nonessential modifiers are supplementary words and descriptors which **do not** affect the code selection for a given diagnosis. These modifiers may be present or absent in the diagnostic statement but result in the assignment of the same code.

They appear in parentheses (***See also DConvention.3: Punctuation***) following the terms they modify.

Essential modifiers

Essential modifiers are descriptive terms which **do** affect the code selection for a given diagnosis. These modifiers describe essential differences (for the purpose of coding) in site, aetiology, or type of disorder. These terms **must** appear in the diagnostic statement for the code to be assigned.

Essential modifiers appear as subterms indented below lead terms. Each indented list is in alphabetical order, with the following exceptions:

- Whenever the relational term '***with***' (***see also DConvention.5: Relational terms***) is used it is always the first entry of the indented list
- Numbers spelled out into words appear in alphabetical order
- Numbers listed as Arabic numbers appear at the end of the list after all the modifying words in numeric order
- Numbers listed as Roman numerals appear in numeric order.

Examples:

Poliomyelitis (acute) (anterior) (epidemic) A80.9

Poliomyelitis is coded to **A80.9 Acute poliomyelitis, unspecified**. If the poliomyelitis is described as acute, anterior or epidemic the code assignment would not change.

Poliomyelitis (acute) (anterior) (epidemic) A80.9
– paralytic A80.3
– – vaccine-associated A80.0

Code **A80.3 Acute paralytic poliomyelitis, other and unspecified** would only be assigned if the poliomyelitis (which may be acute, anterior or epidemic) is described as paralytic. If it is further qualified as being vaccine-associated, code **A80.0 Acute paralytic poliomyelitis, vaccine-associated** would be assigned instead.

J63.1 Bauxite fibrosis (of lung)

Whether bauxite fibrosis is described as being of the lung or not, code **J63.1** would be assigned.

DConvention.7: Fifth characters

Supplementary fifth characters are used in Chapters IX, X, XIII and XIX to add greater specificity to the codes. Fifth characters activity codes are also available in Chapter XX but these codes are not to be used for national collection. For the standards on the application of these fifth characters see:

- ***DCS.IX.14: Atherosclerosis (I70)***
- ***DCS.X.7: Respiratory failure, not elsewhere classified (J96)***
- ***DChS.XIII.1: Fifth characters in Chapter XIII***
- ***DChS.XIX.2: Fifth characters in Chapter XIX***

- ***DChS.XX.2: Activity codes***

See also DRule.2: Category and code structure.

Special symbols in Chapter II Neoplasms

See guidance in Chapter II on the use of the special symbols # and ✧.

GENERAL CODING STANDARDS AND GUIDANCE

DGCS.1: Primary diagnosis

The primary diagnosis definition must always be applied when assigning ICD-10 codes on the coded clinical record:

i) **The first diagnosis field(s) of the coded clinical record (the primary diagnosis) will contain the main condition treated or investigated during the relevant episode of healthcare.**

ii) **Where a definitive diagnosis has not been made by the responsible clinician the main symptom, abnormal findings, or problem should be recorded in the first diagnosis field of the coded clinical record.**

All other relevant diagnoses must be coded in addition to the primary diagnosis.

Specificity

Where the diagnosis recorded as the main condition describes a condition in general terms, and a term that provides more precise information about the site or nature of the condition is recorded elsewhere, reselect the latter as the main condition.

See also:

- ***DGCS.2: Absence of definitive diagnosis statement***
- ***DGCS.3: Co-morbidities.***

The NHS Executive Health Service Guideline HSG (96)23 published 20 September 1996 mandated the implementation of this standardised primary diagnosis definition for clinical coding.

The application of the NHS-mandated definition for primary diagnosis is crucial to ensure the information now regularly exchanged between NHS organisations is consistent, comparable and meaningful to the many users within the NHS as well as to the WHO.

Examples:

Patient is admitted with cellulitis of the leg and a superficial leg ulcer. The cellulitis is responding poorly to oral antibiotics. A decision is made to treat the cellulitis with intravenous antibiotics.

L03.1 Cellulitis of other parts of limb
L97.X Ulcer of lower limb, not elsewhere classified

Patient is admitted with cellulitis of the leg and a severe leg ulcer. The patient undergoes debridement of the leg ulcer.

L97.X Ulcer of lower limb, not elsewhere classified
L03.1 Cellulitis of other parts of limb

DGCS.2: Absence of definitive diagnosis statement

It is not always possible for the responsible consultant to provide a definitive (confirmed) diagnosis in the medical record for an episode but they may be treating or investigating the patient's condition based on a 'presumed' or 'probable' diagnosis.

If in any doubt and when the diagnosis information is ambiguous seek the advice of the responsible consultant for clarification. If it is not possible to get advice from the responsible consultant code as follows:

- Code the diagnosis recorded as being treated or investigated. (Terms that might be recorded in the medical record are 'working diagnosis' 'treat as', 'presumed' or 'probable').
- If the responsible consultant records a differential diagnosis whilst working to determine which one of several diseases may be producing the symptoms and in the absence of any further information the main symptoms must be coded in line with ***DGCS.1: Primary diagnosis*** (Terms that might be recorded in the medical record are 'likely' or 'likelihood').

Should the absence of a diagnosis relate to documentation or recurring recording issues the coding manager should refer through local information and clinical governance routes. Where applicable the outcome should be documented as local practice in the local policies and procedure manual for reference and audit purposes.

The list of terms above is not exhaustive and the terms used will differ from consultant to consultant and from trust to trust.

Examples:

Probable Myocardial infarction

I21.9 Acute myocardial infarction, unspecified

Abdominal pain – likely appendicitis

R10.4 Other and unspecified abdominal pain

DGCS.3: Co-morbidities

For the purposes of coding, co-morbidity is defined as:

- **Any condition which co-exists in conjunction with another disease that is currently being treated at the time of admission or develops subsequently, and**
- **affects the management of the patient's current episode.**

It is the responsibility of the responsible consultant to identify and report in the medical record any relevant co-morbidity that co-exists at the time of admission for the hospital provider spell (which may include one or more episodes) or that subsequently develops during the current hospital provider spell.

When coding co-morbidities the full medical record for the current hospital provider spell can be used by the clinical coder to ensure all relevant co-morbidities, as reported by the responsible consultant, are coded. The clinical coder must liaise with the consultant if any clarification is required.

In some instances local patient administration systems (PAS) and encoder software may provide a facility that electronically transfers co-morbidities from episode to episode. Where this is the case and these co-morbidities are not recorded in the current documentation, it is the responsibility of the clinical coder to establish with the responsible consultant whether all the transferred co-morbidities are still relevant to the current episode.

Co-morbidities and multiple care professional admitted care episodes

Where there are multiple episodes within one hospital provider spell, it is possible that the patient's co-morbidities will only be documented on the first episode in the medical record and not repeated for each subsequent episode within the hospital provider spell. Where this is the case the coder may code the comorbidities recorded on the first episode on each subsequent episode within that hospital provider spell and any other co-morbidities that develop during the current hospital provider spell. However, as it is possible that some co-morbidities may resolve during a hospital provider spell, care must be taken, and any uncertainty about the presence of a comorbidity should be clarified with the responsible consultant.

Co-morbidities always coded

There are a number of medical conditions and other factors influencing health that must always be coded for each episode when they co-exist in conjunction with another disease that is currently being treated at the time of admission (or develop subsequently). This is regardless of specialty. These have been agreed by the Clinical Co-morbidities Working

Group as co-morbidities that are clinically relevant - as they always affect the management of the patient's current episode.

The conditions included in ***Appendix 1: Co-morbidities list*** must **always** be coded for any Admitted Patient Care episode (including Day cases) when documented in the patient's medical record for the **current** hospital provider spell, regardless of specialty.

The coding standard contained within this National Clinical Coding Standards ICD-10 5th Edition reference book must be applied to the listed conditions. References to related standards have been included where required.

The list does not replace the fundamental clinical coding principles. The four step coding process must still be applied to ensure correct code assignment when translating medical information into ICD-10 codes.

When other conditions, not contained within the co-morbidity list, have been identified in the medical record by the responsible consultant as being relevant to the episode, then these conditions must also be coded.

Any uncertainty as to whether a documented condition is a current condition or a past medical history (PMH) must be clarified with the responsible consultant.

Chemotherapy for cancer

Typically a cancer centre uses a continuous medical record for a patient admitted for a course of chemotherapy to treat malignant neoplasm. The co-morbidities will be recorded in the medical record on the first admission but will not always be repeated in the documentation for the admissions for subsequent chemotherapy cycles. In the situation where a patient is undergoing repeated admission for one or multiple chemotherapy cycles within a course of treatment for cancer, the clinical coder may refer to the co-morbidities documented by the responsible consultant within the continuous medical record for the first admission, for each subsequent admission until the cycles within the course of treatment are completed. However, local protocol should be established to update the conditions that co-exist if there is any change, for instance where the patient has developed a new co-morbidity that requires coding, or a previously documented co-morbidity is no longer present.

Any uncertainty as to whether the co-morbidities documented in the admission for the first treatment are still applicable, must be referred back to the responsible consultant.

Routine surveillance and chronic disease management

In instances where a patient is admitted for routine surveillance or chronic disease management, undertaken within the Admitted Patient Care setting (typically as a day case),

only the information provided for the current admission should be coded. The regularity of surveillance routines and treatment for chronic conditions varies and for example can occur weekly, monthly, annually or every 5 years. Any condition or co-morbidity that affects the management of the patient's current episode of care would need to be recorded by the responsible consultant to ensure the information is coded.

Acute conditions

Acute conditions will **always** affect the patient's episode of care and will **always** be coded when documented in the medical record. This is a fundamental coding principle; consequently acute conditions do not appear in ***Appendix 1: Co-morbidities list*** with the exception of certain conditions that can exist in both an acute or chronic form.

Symptoms

Appendix 1: Co-morbidities list includes a number of symptoms that are always clinically relevant. However, ***DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings*** must still be applied.

Cancelled procedures

The coding of co-morbidities is still clinically relevant where a procedure has been cancelled. For example; there are instances when a patient may have been admitted for a procedure that might otherwise have been performed in outpatients, except for the presence of a co-morbidity. It is not the responsibility of the coding professional to decide whether a co-morbidity has affected the management of the patient, this is a clinical decision.

Therefore, where a patient has been admitted for a procedure that has subsequently been cancelled and any of the listed co-morbidities are documented by the responsible consultant in the medical record for the current hospital spell, they must always be coded, regardless of the reason for cancellation. See also ***DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53)***)

For coding co-morbidities the following clinical information may be useful; the GP referral letter for the current admission, Accident & Emergency documentation for the current admission, the associated pre-operative assessment prior to the admission, or transfer documentation provided by the responsible consultant at another hospital.

DGCS.4: Using diagnostic test results

As diagnostic procedures and associated technology advance clinical coders have access to a wide range of information, including diagnostic test results and reports. Such documents form part of the patient medical record and can be used by the coder to enable assignment of the correct codes for a patient, but the following **must** be applied:

- **Test results must not be interpreted by the coder to arrive at a diagnosis, this is the role of the responsible consultant**
- If a definitive diagnosis is documented on a test result report by the responsible consultant (or designated representative - e.g. a microbiologist or haematologist), it would be correct to assign codes for this diagnosis, as it is the **responsible consultant** that has interpreted the results to arrive at a definitive diagnosis

Any uncertainty must always be referred to the responsible consultant.

Examples of test results which may be used by the coder, but must never be interpreted by the coder, are:

- Results that give ratios and measurements, such as blood pressure readings, BMI (***See also DCS.IV.3: Obesity (E66)***), troponin levels, INR levels etc
- Histopathology reports will describe the microscopic features of a tissue sample and will usually give a full description of the reported condition
- Microbiology reports provide details of organisms present and drug resistance. The organisms identified in the report may not necessarily be viewed by the consultant/doctor as harmful to the patient. Clinical coders should take care not to 'over-report' pathology and microbiology results by attempting to record every organism
- Haematology reports involve the measurement of the various components of blood physiology and the clotting process
- Radiology results may identify a more specific diagnosis; for example, osteoarthritis rather than pain in hip.

Examples:

Patient admitted with slurred speech, right sided weakness and confusion. Elderly care consultant documents CVA in the medical record and sends patient for MRI scan of the brain. Diagnosis documented on the MRI report by the consultant radiologist states 'Middle cerebral artery subarachnoid haemorrhage'

I60.1 Subarachnoid haemorrhage from middle cerebral artery

Endometrial biopsy for investigation of menorrhagia. Proliferative endometrium is recorded in the body of the histology report, but no definitive diagnosis is documented

N92.0 Excessive and frequent menstruation with regular cycle

DGCS.5: Dagger and asterisk system

The following must be applied when assigning dagger (†) and asterisk (*) codes:

- They must always be used in combination and sequenced directly after each other
- The code that reflects the main condition treated or investigated during the episode must be sequenced in the primary position (***see DGCS.1: Primary diagnosis***)
- In instances where the responsible consultant has not specified, or is unable to confirm, which condition is the main condition treated, the dagger code must be assigned before the associated asterisk code
- Where a dagger and asterisk combination is assigned, and neither condition is the main condition treated, the dagger code must be sequenced before the asterisk code
- Multiple asterisk codes with one dagger code must not be assigned, each asterisk code must have its own dagger code, even where this means repeating dagger codes
- A link must be made by the responsible consultant in the medical record to indicate that the manifestation (asterisk code) is caused by the underlying condition (dagger code); if they are not linked each diagnosis must be coded separately without the dagger and asterisk linkage
- Codes designated as a dagger code, either at category or code level, must always be used as a dagger code and must never be used alone, in the absence of an asterisk code. Codes not designated as a dagger or asterisk code may be paired with an asterisk code to form a dagger asterisk combination. Dagger codes appear in the following forms in the Tabular List:
  - When the associated asterisk code(s) is listed at the end of the code description of a dagger marked code the dagger code must be used with the listed asterisk code(s)
  - When the associated asterisk code is not listed in the code description of a dagger marked code but is listed as an inclusion underneath the dagger code the dagger code can be used with these inclusion terms, or another asterisk marked code to form a dagger asterisk combination
  - When a code is not marked as a dagger code but any of its inclusion terms are marked with a dagger then the code becomes a dagger code when used in combination with the asterisk code listed in brackets in the inclusion.
- Codes designated as an asterisk code, either at category or code level, must always be used as an asterisk code in a dagger asterisk combination. They must never be

used alone, in the absence of a dagger code. Asterisk codes appear in the following forms in the Tabular List:

- When the associated dagger code(s) is listed at the end of the asterisk code description the asterisk code must be used with the listed dagger code(s)
- When the associated dagger code is not listed in the asterisk code description but is listed as an inclusion underneath the asterisk code the asterisk code can be used with these inclusion terms or a non-asterisk code to form a dagger asterisk combination
- When the associated dagger code is not listed in the asterisk code description or as an inclusion underneath the asterisk code the asterisk code can be used with a non-asterisk code to form a dagger asterisk combination.

The dagger and asterisk system provides a dual classification of diagnostic statements containing information about both an underlying generalised disease also referred to as aetiology (marked with a dagger †) and a manifestation of that disease in a particular organ or site which is a clinical problem in its own right (marked with an asterisk *). Put more simply, sometimes patients have a condition that has been caused by another condition. This coding convention was provided because it is important for statistical purposes to capture information about such linked conditions, as without the underlying disease, the other condition would not have developed.

The special asterisk categories are listed at the beginning of the relevant chapters in the ICD-10 Tabular List.

Associated dagger and asterisk codes may be listed at the three, or four character level.

Examples:

Dementia due to Parkinson disease

G20.X† Parkinson disease
F02.3* Dementia in Parkinson disease (G20†)

Patient admitted for treatment of a diabetic cataract, the patient has type 1 diabetes mellitus.

H28.0* Diabetic cataract (E10–E14 with common fourth character .3†)
E10.3† Type 1 diabetes mellitus, with ophthalmic complications
Diabetic:
- cataract (H28.0*)

Patient with Type 1 diabetes, diabetic cataracts and diabetic retinopathy, admitted for cataract surgery

H28.0* Diabetic cataract (E10-E14 with common fourth character .3†)
E10.3† Type 1 diabetes mellitus, with ophthalmic complications
Diabetic:
- cataract (H28.0*)

E10.3† Type 1 diabetes mellitus, with ophthalmic complications
Diabetic:
- retinopathy (H36.0*)

H36.0* Diabetic retinopathy (E10-E14 with common fourth character .3†)

Patient admitted for banding of second degree haemorrhoids. They also have thyrotoxic heart disease

K64.1 Second degree haemorrhoids
E05.9† Thyrotoxicosis, unspecified
I43.8* Cardiomyopathy in other diseases classified elsewhere

Patient admitted for treatment of cataract, the patient has insulin-dependent diabetes mellitus

H26.9 Cataract, unspecified
E10.9 Type 1 diabetes mellitus, without complications

Retrobulbar neuritis in multiple sclerosis

G35.X† Multiple sclerosis
H48.1* Retrobulbar neuritis in diseases classified elsewhere
Retrobulbar neuritis in:
- multiple sclerosis (G35†)

DGCS.6: Infections

Infections must be coded as follows:

- If only the infectious agent/organism is documented and no site is specified, the infection is coded to the specified organism only, using a code from Chapter I Certain infectious and parasitic diseases
- If only the site of the infection is documented and no infectious agent/organism is stated, code the site of the infection.
- If both the site of the infection and the agent/organism causing it are documented, a code(s) must be assigned which identifies both the site and organism as follows:

- Where the Alphabetical Index directs to a dagger and asterisk combination which combines both the organism and the site assign these codes: ***see DGCS.5: Dagger and asterisk system***.
- Where the Alphabetical Index directs to a single code which combines both the organism and the site, assign this code.
- Where the Alphabetical Index does not direct to either a single code or a dagger and asterisk combination which combine both the organism and the site, then the following codes and sequencing must be applied:
  - Assign a body system chapter code to identify the site of the infection
  - Assign a code from categories **B95-B98 Bacterial, viral and other infectious agents** to identify the infective organism. This applies even when a 'use additional codes from **B95-B98**' note is not listed, ***see also DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)***.

Where it is clearly documented in the medical record that an infection is resistant to drugs (e.g. resistant to antibiotics, antimicrobials, antivirals etc) a code(s) from **categories U82 Resistance to betalactam antibiotics**, **U83 Resistance to other antibiotics** or **U84 Resistance to other antimicrobial** drugs must be assigned directly after the code for the infection, ***see DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)***.

See also:

- ***DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis***
- ***DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)***
- ***DCS.XV.30: Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)***
- ***DCS.XVI.5: Group B streptococcus (GBS) bacterial infections in babies***
- ***DChS.XIX.3: Infected open wounds***
- ***DCS.XIX.7: Postprocedural complications of medical and surgical care - postprocedural infections***
- ***COVID-19 National Clinical Coding Standards***

Examples:

Staphylococcal infection

A49.0 Staphylococcal infection, unspecified site

Urinary tract infection

N39.0 Urinary tract infection, site not specified

Tuberculosis of the kidney

A18.1† Tuberculosis of genitourinary system
Tuberculosis of:
- kidney† (N29.1*)

N29.1* Other disorders of kidney and ureter in infectious and parasitic diseases classified elsewhere
Disorders of kidney and ureter in:
- tuberculosis (A18.1†)

Chlamydial infection of anus

A56.3 Chlamydial infection of anus and rectum

Urinary tract infection due to Escherichia coli [E. coli]

N39.0 Urinary tract infection, site not specified
B96.2 *Escherichia coli [E. coli]* as the cause of diseases classified to other chapters

Cellulitis of face due to Staphylococcus aureus

L03.2 Cellulitis of face
B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters

MRSA lower respiratory tract infection

J22.X Unspecified acute lower respiratory infection
B95.6 *Staphylococcus aureus* as the cause of disease classified to other chapters
U82.1 Resistance to methicillin

DGCS.7: Syndromes

In many cases a code will not completely describe the abnormal condition and a combination of codes is required. Syndromes must be coded as follows:

- Search the Alphabetical Index under the general term of ‘Syndrome’ or under the syndrome name, or both
- If the syndrome cannot be found in the Alphabetical Index, the coder must clarify with the responsible consultant whether the syndrome is congenital or acquired in order to determine the most appropriate code(s). Determining if it is of chromosomal

origin or not will assist in code assignment, as not all congenital anomalies are of chromosomal origin.
    - Congenital
        - If it is of chromosomal origin assign a code from categories **Q90-Q99 Chromosomal abnormalities, not elsewhere classified** in Chapter XVII
        - If it is not of chromosomal origin assign a code from categories **Q00-Q89** from Chapter XVII, depending on the body system it affects
    - Acquired
        - Assign a code from a body system chapter, depending on the body system it affects
- If, after the syndrome has been clinically diagnosed the patient is treated for one or more manifestations of that syndrome, the manifestation(s) being treated must be coded, with the appropriate code for the syndrome itself entered last
- If there is no indication of any presenting or treated manifestations, then only a code for the syndrome itself can be assigned. In most cases there will be presenting manifestations, but unless these are detailed in the patient's medical record, the coder is unable to assign ICD-10 codes for them.

All of this information will enable the syndrome to be coded, at the very least, to the correct chapter 'catch all' category and, ideally, to a more specific code within that chapter.

See also:

- ***DCS.VI.4: POEMS syndrome (C90.0† and G63.1*)***
- ***DCS.IX.3: Cardiac syndrome X (I20.8)***
- ***DCS.XVII.1: Triple M syndrome (Q87.1)***.

A syndrome is a group of signs and symptoms that collectively characterise or indicate a particular disease or abnormal condition. The names given to syndromes may be based on pathological, biochemical or genetic criteria. They are also given to honour the discoverer.

In ICD-10 many syndromes and their overriding manifestations, such as short stature, are listed in the Alphabetical Index under the general term of 'syndrome' or under the syndrome name, or both.

Example:

Patient treated for a congenital contracture of the left hip joint due to VATER syndrome

Q65.8 Other congenital deformities of hip
Q87.2 Congenital malformation syndromes predominantly involving limbs
Syndrome:
- VATER

DGCS.8: Sequelae or late effects

Sequelae codes are used to indicate that a current condition or disease has been caused by a previously occurring disease or injury which has been treated and is no longer present. Sequelae codes must only ever be used in a secondary position directly after the code for the current condition or disease. They must never be used on their own.

The codes for the original condition or injury that are classified by the sequelae code are listed at block, category, or code level.

Other terms associated with sequelae codes include ‘late effect’, ‘residual of’ and ‘due to old’.

Examples:

Patient has contracture of left knee joint due to his previously treated poliomyelitis

M24.56 Contracture of joint, lower leg
B91.X Sequelae of poliomyelitis
Note at B90-B94: Categories **B90–B94** are to be used to indicate conditions in categories **A00–B89** as the cause of sequelae, which are themselves classified elsewhere. The ‘sequelae’ include conditions specified as such; they also include late effects of diseases classifiable to the above categories if there is evidence that the disease itself is no longer present.

See also DChS.XIII.1: Fifth characters in Chapter XIII.

Deviated nasal septum as a result of a fracture of nose sustained during a motor vehicle accident two years ago

J34.2 Deviated nasal septum
T90.2 Sequelae of fracture of skull and facial bones
Sequelae of injury classifiable to S02.-
Y85.0 Sequelae of motor-vehicle accident

DGCS.9: Acute on chronic conditions

If a condition is described as ‘acute (or sub-acute) on chronic’ and separate codes for each are available, codes for both the acute and chronic condition must be assigned. The acute condition must be sequenced before the chronic condition unless the chronic condition is the main condition treated or investigated in line with ***DGCS.1: Primary diagnosis***.

Example:

Acute on chronic alcoholic pancreatitis

K85.2 Alcohol-induced acute pancreatitis
K86.0 Alcohol-induced chronic pancreatitis

DGCS.10: Multiple condition codes

Some individual categories within ICD-10 contain single codes to classify "multiple" conditions, e.g. **C46.8 Kaposi sarcoma of multiple organs** and **S76.7 Injury of multiple muscles and tendons at hip and thigh level**. Single codes identifying multiple body sites or conditions must not be used where the information is available to enable use of individual codes. The exceptions are:

- ***DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24)*** – when there is more than one condition resulting from HIV classified to the same category in **B20-B24**.
- ***DCS.XIX.3: Bilateral injuries of limbs involving the same body site (T00-T07)*** when there is an identical injury and site classified to the same code(s).

Example:

Patient admitted after being hit by a car whilst walking on a level crossing. Patient sustained an open fracture of the lateral malleolus and closed fracture of the proximal tibia of the left leg.

S82.61 Fracture of lateral malleolus, open
S82.10 Fracture of upper end of tibia, closed
V03.1 Pedestrian injured in collision with car, pick-up truck or van, traffic accident

Anaemia in other chronic diseases classified elsewhere (D63.8)

See DCS.III.2: Anaemia in other chronic diseases classified elsewhere (D63.8*)

Pregnant state, incidental (Z33.X)

See DCS.XV.33: Pregnant state, incidental (Z33.X)

Signs, symptoms and abnormal laboratory findings

See DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings

Postprocedural complications and disorders

See DCS.XIX.7: Postprocedural complications of medical and surgical care

External causes

See DChS.XX.1: External causes

Hospital acquired conditions (Y95.X)

See DCS.XX.10: Hospital acquired conditions (Y95.X)

Female genital mutilation (Z91.7)

See DCS.XIV.11: Female genital mutilation (Z91.7)

CHAPTER I CERTAIN INFECTIOUS AND PARASITIC DISEASES
(A00–B99)

Chapter standards and guidance

Infections

See DGCS.6: Infections.

Resistance to antimicrobial and antineoplastic drugs (U82-U85)

See DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85).

DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis

A code that specifically classifies sepsis must always be assigned when a patient is diagnosed with sepsis in the medical record. Where the code assigned does not specifically classify sepsis (e.g. **A54.8 Other gonococcal infections**, which includes gonococcal sepsis), the code that classifies sepsis must be assigned in any secondary position, to describe the condition fully.

Where clinicians use terms such as urosepsis, biliary sepsis, chest sepsis, intraocular sepsis and urinary sepsis, to mean that the patient has both sepsis and a localised infection of the organ, then both conditions must be coded. Sepsis must not be coded where a patient only has an infection, e.g. a urinary tract infection or a chest infection without sepsis.

Where sepsis is confirmed to be due to a device, implant or graft (e.g. sepsis due to total hip replacement, infusion catheter, tracheostomy stoma, vascular line, haemodialysis catheter, etc.) this means that the patient has both sepsis and a localised infection at the site of the device, implant or graft. In these cases, both the sepsis and the site of the localised infection must be coded.

Sepsis may not always be the main condition treated; therefore, sequencing of sepsis with other infections and conditions (including the situations described in the second and third paragraphs above) must follow ***DGCS.1 Primary diagnosis*** (except where a standard states otherwise).

Organ failure must be coded in addition when documented with sepsis: ***see DCS.IX.10: Heart failure (I50), DCS.X.7: Respiratory failure, not elsewhere classified (J96) and DCS.XVIII.10: Multiple organ failure (R68.8)***.

Septic shock

Whenever septic shock is documented in the medical record by the responsible consultant, code **R57.2 Septic shock** must be assigned in any secondary position following the code that classifies sepsis.

Severe sepsis

The following codes and sequencing must be used for a diagnosis of severe sepsis:

A41.- **Other sepsis** (or the specific type of sepsis recorded in the medical record)
R65.1 **Systemic inflammatory response syndrome of infectious origin with organ failure**
U82.- **Resistance to betalactam antibiotics**, **U83.- Resistance to other antibiotics** or **U84.- Resistance to other antimicrobial drugs** (use only if the severe sepsis is resistant to antibiotics or antimicrobial drugs).

Neutropenic sepsis

The following codes and sequence must be used for a documented diagnosis of neutropenic sepsis:

A41.- **Other sepsis** (or the specific type of sepsis recorded in the medical record)
R65.1 **Systemic inflammatory response syndrome of infectious origin with organ failure** (use only if the sepsis is documented as severe)
U82.- **Resistance to betalactam antibiotics**, **U83.- Resistance to other antibiotics** or **U84.- Resistance to other antimicrobial drugs** (use only if the sepsis is resistant to antibiotics or antimicrobial drugs)
D70.X **Agranulocytosis**

If the responsible consultant has documented that the neutropenic sepsis was due to a drug, then an adverse effects code from Chapter XX must be assigned after **D70.X**, ***see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).***

Enterococcal sepsis

Enterococcal sepsis must be classified using **A40.2 Sepsis due to streptococcus, group D.**

See also:

- ***DGCS.6: Infections***
- ***DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)***
- ***DCS.XVI.5: Group B streptococcus (GBS) bacterial infections in babies***
- ***DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings***
- ***DCS.XIX.7: Postprocedural complications of medical and surgical care***
- ***DCS.XX.10: Hospital acquired conditions (Y95.X)***
- ***DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)***

Sepsis is the reaction to an infection in which the body attacks its own organs and tissues: it is a time-critical life-threatening condition which requires immediate treatment. Sepsis is not an infection in itself.

The clinical guidelines for the identification/diagnosis and management/treatment of sepsis have changed over time and continue to change. There is variation throughout the country in the understanding, awareness and documenting of sepsis.

Sepsis is difficult to diagnose: there is no published evidence of any specific laboratory test that would quickly and reliably confirm or exclude a diagnosis of sepsis in the timeframe within which treatment should be started for sick patients.

There are several different toolkits, scoring systems, early warning screening tools and guidelines used for the identification of patients who are very ill with possible sepsis, and who require immediate treatment.

For example, the UK Sepsis Trust and National Institute for Health and Care Excellence (NICE) introduced the concepts of red flag / high risk sepsis which are a set of criteria to facilitate rapid initiation of care.

Where a patient has a high risk or red flag sepsis criterion, they will be presumed to have sepsis and appropriate treatment for sepsis will commence. However, different Trusts have implemented these flags differently and modified the guidelines on their use. In addition, in a proportion of cases, after further investigations, it may be identified that the patient has an alternative diagnosis such as pancreatitis or poisoning, and it may be unclear whether the patient had sepsis or not.

There are no specific clinical guidelines on the documenting or recording of sepsis in the medical record, and local guidelines will differ between clinicians and hospitals. Clinicians should not use the term “sepsis” to refer to an infection only: however, this is not universally understood. Some clinicians may use terms such as urosepsis, chest sepsis, urinary sepsis, intraocular sepsis and biliary sepsis to indicate the presence of localised infection and sepsis, while others may use these terms to indicate localised infection alone.

These factors combined can make it difficult for the coder to know which patients do actually have sepsis, and it is not possible for a clinical coding standard to compensate for deficiencies in the documentation, recording or coding process.

As well as being a clinical governance issue, inconsistencies and inaccuracies in the recording of sepsis within the medical record will have a negative effect on the reliability of the coded data which in turn will have a statistical and financial impact.

Therefore, in order to ensure patients with sepsis are coded accurately, Trust coding departments should work with their clinical teams and Medical Directors to agree an internal process to clearly identify which patients have sepsis.

An agreed process should also help to reduce the burden of seeking clarification from the responsible consultant for individual patients. (Several Trusts already have a dedicated Sepsis Team that works alongside the coders as part of their internal data assurance process.) Any such process should be documented in the Coding Department Policy and Procedure manual for reference and clinical coding audit purposes. Where recurring recording issues are evident, the coding manager should refer to local information and clinical governance routes.

See '**Coding of Sepsis at SUHNFT**' in the Resource Library on Delen, which describes the processes that have been put in place at Southend University Hospital NHS Foundation Trust to ensure sepsis is recorded and coded correctly. This document illustrates the importance and benefits of engaging with clinical teams when coding sepsis.

The clinical guidelines, terminology and tools used for the identification of patients with sepsis are likely to continue to change as further work is done by the Cross-system Sepsis Programme Board to improve the identification, treatment and outcomes for patients with possible sepsis. Continual clinical engagement is important to ensure that coding departments continue to be able to collect sepsis data correctly.

Examples:

Urinary sepsis (responsible consultant confirms sepsis and urinary tract infection) due to streptococcus group A, with septic shock and kidney and liver failure

A40.0 Sepsis due to *Streptococcus,* group A
N39.0 Urinary tract infection, site not specified
B95.0 *Streptococcus*, group A, as the cause of diseases classified to other chapters
R57.2 Septic shock
N19.X Unspecified kidney failure
K72.9 Hepatic failure, unspecified

Urinary sepsis and biliary sepsis (responsible consultant confirms UTI and cholangitis without sepsis)

N39.0 Urinary tract infection, site not specified
K83.0 Cholangitis

Sepsis following missed miscarriage during the same episode

O02.1 Missed abortion
O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
A41.9 Sepsis, unspecified

Patient with streptococcal urinary tract infection that progresses to severe sepsis due to streptococcus. Acute kidney injury, hepatic failure and septic shock.

A40.9 Streptococcal sepsis, unspecified
R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure
N39.0 Urinary tract infection, site not specified
B95.5 Unspecified *Streptococcus* as the cause of diseases classified to other chapters
N17.9 Acute renal failure, unspecified
K72.9 Hepatic failure, unspecified
R57.2 Septic shock

Post-operative coagulase-negative staphylococcus sepsis due to coagulase-negative staphylococcus haemodialysis catheter infection.

A41.1 Sepsis due to other specified *Staphylococcus*
T82.7 Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts
B95.7 Other staphylococcus as the cause of diseases classified to other chapters
Y83.1 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with implant of artificial internal device

Bowel resection performed to treat malignant neoplasm of descending colon. During the same episode, the patient develops sepsis secondary to a leaking anastomosis.

C18.6 Malignant neoplasm: Descending colon
A41.9 Sepsis, unspecified
K91.8 Other postprocedural disorders of digestive system, not elsewhere classified
Y83.2 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Patient with sepsis due to streptococcus A and E.coli, diagnosed with diverticular disease of the colon with perforated abscess (E.coli confirmed as infective organism). Following initial drainage of the abscess the patient underwent bowel resection. The patient developed a post-operative haemorrhage and a post-operative MRSA wound infection.

K57.2 Diverticular disease of large intestine with perforation and abscess
B96.2 *Escherichia coli* [*E. coli*] as the cause of diseases classified to other chapters
A40.0 Sepsis due to *Streptococcus*, group A
A41.5 Sepsis due to other Gram-negative organisms
T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified
T81.4 Infection following a procedure, not elsewhere classified
B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
U82.1 Resistance to methicillin
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Severe gonococcal sepsis resistant to ceftriaxone

A54.8 Other gonococcal infections
A41.5 Sepsis due to other Gram-negative organisms
R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure
U82.8 Resistance to other betalactam antibiotics

Severe MRSA sepsis with septic shock

A41.0 Sepsis due to *Staphylococcus aureus*
R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure
U82.1 Resistance to methicillin
R57.2 Septic shock

Patient with postoperative methicillin resistant staphylococcus aureus (MRSA) wound infection developed severe MRSA sepsis following gastrectomy 2 weeks ago

A41.0 Sepsis due to *Staphylococcus aureus*
R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure
U82.1 Resistance to methicillin
T81.4 Infection following a procedure, not elsewhere classified
B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
U82.1 Resistance to methicillin
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Sepsis due to urinary tract infection in pregnancy

O98.8 Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium
A41.9 Sepsis, unspecified
O23.4 Unspecified infection of urinary tract in pregnancy

Coding standards and guidance

DCS.I.1: Helicobacter pylori intestinal infection that is not the cause of a disease classifiable to another chapter (A04.8)

Helicobacter (H.) pylori intestinal infection that is **not** the cause of a disease classifiable to another chapter must be coded using **A04.8 Other specified bacterial intestinal infections**.

See also:
- ***DGCS.6: Infections***
- ***DCS.XI.4: Gastritis and duodenitis (K29).***

DCS.I.5: Zika virus

The following codes and sequencing must be applied when coding confirmed cases of Zika virus.

Zika Virus:

A92.8 Other specified mosquito-borne viral fevers
U06.9 Emergency use of U06.9

Zika virus in pregnancy:

O98.5 Other viral diseases complicating pregnancy , childbirth and the puerperium
A92.8 Other specified mosquito-borne viral fevers
U06.9 Emergency use of U06.9

The World Health Organisation (WHO) have advised that code **U06.9 Emergency use of U06.9** should be assigned for confirmed cases of Zika to allow tracking of the virus globally. Synonyms of Zika virus are Zika, Zika virus fever, Zika virus infection.

DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24)

The following must be applied when coding symptomatic (active) HIV disease:

- Only one code from categories **B20-B24 Human immunodeficiency virus [HIV] disease** is required when this code fully classifies both HIV and the condition resulting from HIV (with the exception of HIV disease resulting in malignant neoplasm - see below).
- When the HIV disease code from categories **B20-B24** does not fully classify both the HIV and the condition resulting from HIV, the code that classifies the condition must also be assigned after the HIV disease code.
- If there is more than one condition resulting from HIV classified to the same category in **B20-B22** the subdivision **.7** from the appropriate category must be used followed by the codes classifying the specific conditions.
- When coding HIV disease resulting in malignant neoplasm the code that classifies the malignant neoplasm must be assigned after the code that classifies HIV resulting in malignant neoplasm from category **B21.- Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms**.
    - When a patient has HIV disease resulting in more than one malignant neoplasm code **B21.7 HIV disease resulting in multiple malignant neoplasms** must be assigned followed by the codes for the specific malignancies.

For patients with asymptomatic HIV (non-active, HIV positive) assign the code **Z21.X Asymptomatic human immunodeficiency virus [HIV] infection status**.

See also:

- ***DGCS.6: Infections***
- ***DGCS.10: Multiple condition codes***
- ***DCS.XV.30: Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7).***

Examples:

HIV disease resulting in Pneumocystis jirovecii pneumonia

B20.6 HIV disease resulting in *Pneumocystis jirovecii* pneumonia

HIV resulting in candidiasis of the mouth

B20.4 HIV disease resulting in candidiasis
B37.0 Candidal stomatitis

HIV disease resulting in respiratory tuberculosis and cytomegaloviral disease

B20.7 HIV disease resulting in multiple infections
A16.9 Respiratory tuberculosis unspecified, without mention of bacteriological or histological confirmation
B25.9 Cytomegaloviral disease, unspecified

HIV disease resulting in Kaposi sarcoma of multiple organs

B21.0 HIV disease resulting in Kaposi sarcoma
C46.8 Kaposi sarcoma of multiple organs

HIV disease resulting in Kaposi sarcoma of the palate and Burkitt lymphoma

B21.7 HIV disease resulting in multiple malignant neoplasms
C46.2 Kaposi sarcoma of palate
C83.7 Burkitt lymphoma

DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)

The codes in this block must be used as supplementary codes where a site and a causative organism have been identified and a code that classifies both the site and the causative agent is not available. These codes must only ever be used in a secondary position to a code classified outside of Chapter I Certain infections and parasitic diseases.

See also:

- ***DGCS.6: Infections***
- ***DCS.XIX.7: Postprocedural complications of medical and surgical care***
- ***DCS.XXII.1: Severe acute respiratory syndrome [SARS] (U04.9 and B97.2)***
- ***COVID-19 National Clinical Coding Standards***

Wheeze due to viral infection (B34.9 and R06.2)

See DCS.X.2: Wheeze due to viral infection (B34.9 and R06.2)

COVID-19 (U07.1 – U07.7)

See:

- ***DCS.XXII.6: Confirmed COVID-19 (U07.1)***
- ***DCS.XXII.7: Suspected and clinically or epidemiologically diagnosed COVID-19 (U07.2)***
- ***DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)***
- ***DCS.XXII.9: History of COVID-19 (U07.3)***
- ***DCS.XXII.10: Post COVID-19 condition (U07.4)***
- ***DCS.XXII.11: Multisystem inflammatory syndrome associated with COVID-19 (U07.5)***
- ***DCS.XXII.12: COVID-19 vaccination (U07.6 and U07.7)***
- ***DCS.XXII.13: COVID-19 in Pregnancy, childbirth and the puerperium***

CHAPTER II NEOPLASMS
(C00–D48)

Chapter standards and guidance

DChS.II.1: Complications and symptoms of neoplasms

When it has been determined that a neoplasm is present, the neoplasm and any accompanying complications, or other secondary conditions, caused by the presence of the neoplasm must be coded. ***DGCS.1: Primary diagnosis*** must be applied.

For coding signs and symptoms classifiable to Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings NEC associated with the malignancy ***see DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.***

DChS.II.2: Anaemia in neoplastic disease (C00-D48† and D63.0*)

Anaemia due to neoplasm is coded to **D63.0* Anaemia in neoplastic disease** with the correct code for the neoplasm as the dagger code (**C00–D48†**).

The responsible consultant must specify that the anaemia is due to the neoplasm to enable the use of code **D63.0*.**

Anaemia must **not** be coded in the neoplastic blood disorders leukaemia, myeloma and myelodysplasia as it is a natural symptom in these conditions.

See *DGCS.5: Dagger and asterisk system.*

Examples:

Patient with anaemia due to duodenal cancer is admitted for treatment of the anaemia

D63.0* Anaemia in neoplastic disease (C00-D48†)
C17.0† Malignant neoplasm: Duodenum

Anaemia due to hepatocellular carcinoma

C22.0† Liver cell carcinoma
D63.0* Anaemia in neoplastic disease (C00-D48†)

DChS.II.4: Topography (site) codes and histology (morphology) of neoplasm codes

Site (topography) codes **must** be assigned using the ICD-10 classification (Chapter II Neoplasms (**C00-D48**)).

Morphology codes are not contained in the ICD-10 5th Edition Alphabetical Index or Tabular List.

The WHO International Classification of Diseases for Oncology (ICD-O) is a domain specific extension of the ICD for tumour diseases. This classification is widely used by Cancer Registration for coding the site (topography) and the histology (morphology) of the neoplasm, usually obtained from a histopathology report. The latest version, published by WHO, is the third edition known as ICD-O-3. In England the use of ICD-O-3 morphology codes is defined in the NHS Data Model and Dictionary (www.datadictionary.nhs.uk).

For Admitted Patient Care Commissioning Data Sets in England the ICD-10 5th Edition topography code (from Chapter II Neoplasms (**C00-D48**)) must be coded and not the ICD-O topography codes as there are inconsistencies between the two classifications for the same neoplasm. Where there are local arrangements to collect morphology codes using ICD-O Trusts should be aware of this requirement for commissioning data sets.

Trusts wishing to record morphology of neoplasm codes to identify the histological type of the neoplasm can continue to do so but should use the full ICD-O classification to assign the morphology code only. The morphology code should be sequenced immediately after the ICD-10 code classifying the neoplasm unless using a dagger and asterisk combination. In this instance the morphology code should be sequenced after the dagger and asterisk combination codes to comply with the coding rule that dagger and asterisk codes cannot be separated.

For guidance on the use of the ICD-O coders may wish to seek advice from their regional National Cancer Registration Service (NCRS) in England or their counterparts in the home countries. For more information on the United Kingdom and Ireland Association of Cancer Registries, see www.ukiacr.org.

Special symbols # and ✧ are used within the neoplasm table in the Alphabetical Index. The use of these symbols is described in 'Notes 2 and 3' before the table.

Examples:

Epidermoid carcinoma of lower limb.

C44.7 Malignant neoplasm: Skin of lower limb, including hip
The # symbol is present at the lower limb site in the neoplasm table in the Alphabetical Index. The histological type is identified as 'epidermoid carcinoma'; therefore, following Note 2 at the start of the neoplasm table in the Alphabetical Index, this type of neoplasm must be indexed and classified to 'skin of lower limb' at **C44.7**. Code **C76.5 Malignant neoplasm of other and ill-defined sites: Lower limb** listed under 'primary malignant neoplasm of lower limb' in the Index, must not be used in this instance.

Adenocarcinoma of calvarium

C80.9 Malignant neoplasm, primary site unspecified
C79.5 Secondary malignant neoplasm of bone and bone marrow

The ✧ symbol is present at the calvarium site in the neoplasm table in the Alphabetical Index. The histological type is identified as 'adenocarcinoma'; therefore, following Note 3 at the start of the neoplasm table in the Alphabetical Index, this type of neoplasm must be classified as 'metastatic from an unspecified primary' and coded to **C79.5**.

Pathological fractures in neoplastic disease

See DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*)

Resistance to antineoplastic drugs (U85)

See DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85) – U85 Resistance to antimicrobial drugs

Coding standards and guidance

DCS.II.1: Primary and secondary malignant neoplasms (C00-C97)

All malignancies are coded as primary (*except* those listed as **predominantly secondary**), unless:

- they are specified as secondary (or metastatic)

or

- the site stated is marked with a ✧ and is a carcinoma or adenocarcinoma of any type other than intraosseous or odontogenic.

Any uncertainly as to whether the malignancy is a primary or secondary must be referred to the responsible consultant for clarification.

When the primary site of malignancy has not been identified, i.e. the site is unspecified, code **C80.9 Malignant neoplasm, primary site unspecified** must be assigned, unless the classification defaults to a more specific code for the histological type.

Code **C80.0 Malignant neoplasm, primary site unknown, so stated** must only be assigned when the responsible consultant has explicitly documented within the medical record that the primary site is unknown.

Wherever a secondary malignancy is documented, a primary malignancy must also be coded, even if the primary site is unspecified (**C80.9**) or stated to be unknown (**C80.0**). The exception to this is when primary malignancy is documented to be no longer present, in which case a code from category **Z85.- Personal history of malignant neoplasm** would be assigned.

See also DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99).

When the site(s) of the secondary malignant neoplasm has not been identified or is unknown, code **C79.9 Secondary malignant neoplasm, unspecified site** must be assigned.

Predominantly secondary sites

When a malignancy occurs in one of the following sites it must be coded as a secondary malignancy of that site, unless the responsible consultant confirms that the malignancy is a primary neoplasm, or when the histological type indicates that it is a primary malignancy:

- bone
- brain and spinal cord (including meninges)
- lymph nodes
- pleura
- peritoneum and retroperitoneum
- heart
- mediastinum and diaphragm

- liver.

See also:

- ***DCS.II.2: Metastatic cancer (C77-C79)***
- ***DCS.II.7: Secondary neoplasms or metastases from haematological malignancies.***

Sequencing of malignant neoplasms

When a primary malignant neoplasm and a secondary malignant neoplasm are both present, the code for the primary malignant neoplasm must be assigned before the code for the secondary malignant neoplasm, *unless* the secondary malignant neoplasm is the main condition treated or investigated, **s*ee DGCS.1: Primary diagnosis.***

When the primary malignant neoplasm has been eradicated and the main condition is the secondary neoplasm, a code from category **Z85.- Personal history of malignant neoplasm** must be assigned in a secondary position, as this provides additional information about the site of origin.

See also DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99)

In ICD-10 the histological type refers to the histological characteristics of the neoplasm, e.g. carcinoma, adenocarcinoma, sarcoma, mesothelioma, etc. Where the code for the neoplasm is not found underneath the histological type in the Alphabetical Index, the cross reference (***see DConvention.1: Cross references***) will direct the coder either to the table of neoplasms or elsewhere in the Alphabetical Index (e.g. **Adenocarcinoma** – *see also* Neoplasm, malignant).

Examples:

Adenocarcinoma left lung

C34.9 Malignant neoplasm: Bronchus or lung, unspecified

Female patient with endometrioid carcinoma unspecified site.

C56.X Malignant neoplasm of ovary

For females with endometroid carcinoma, and where the site is unspecified, the classification defaults to code **C56.X**.

Carcinoma of pectoral lymph nodes

C80.9 Malignant neoplasm, primary site unspecified
C77.3 Secondary and unspecified malignant neoplasm: Axillary and upper limb lymph nodes

Patient with known squamous cell carcinoma of lung (middle lobe) undergoes pleural biopsy and is diagnosed with metastasis to pleura.

C78.2 Secondary malignant neoplasm of pleura
C34.2 Malignant neoplasm: Middle lobe, bronchus or lung

Hepatoma

C22.0 Malignant neoplasm: Liver cell carcinoma

Malignant neoplasm of upper lobe bronchus with metastases to intrathoracic lymph nodes

C34.1 Malignant neoplasm: Upper lobe, bronchus or lung
C77.1 Secondary and unspecified malignant neoplasm: Intrathoracic lymph nodes

Patient admitted to the orthopaedic ward with pathological fracture of neck of humerus due to bone metastases from a current primary breast adenocarcinoma. Patient undergoes fixation of the fracture

M90.72* Fracture of bone in neoplastic disease (C00-D48†), upper arm
C79.5† Secondary malignant neoplasm of bone and bone marrow
C50.9 Malignant neoplasm: Breast, unspecified

Admission for radiotherapy for metastasis of brain from a primary tumour of lung (previous pneumonectomy and all treatments for the primary cancer are complete). CT scan last week confirmed brain secondaries

C79.3 Secondary malignant neoplasm of brain and cerebral meninges
Z85.1 Personal history of malignant neoplasm of trachea, bronchus and lung

DCS.II.2: Metastatic cancer (C77-C79)

The following must be applied when coding metastatic cancer:

Metastatic from

Cancer described as metastatic '**from**' a site must be interpreted as a **primary** neoplasm of the stated site (*e.g. metastatic neoplasm from breast, liver metastasis from colon*). The site a neoplasm is '**from**' indicates the origin of the neoplasm, i.e. the starting point. A code must also be assigned for the secondary neoplasm, either of the specified site (if the secondary site is identified) or for secondary neoplasm of unspecified site (if the secondary site is not specified or is unknown).

Metastatic to

Cancer described as metastatic '**to**' a site must be interpreted as a **secondary** neoplasm of the stated site (*e.g. metastatic neoplasm to lung, breast metastasis to pleura*); '**to**' indicates the site a neoplasm has travelled **to** from its point of origin i.e. a secondary site. A code must also be assigned for the specified primary site (if the primary site is known and still present), or for primary malignant neoplasm of unspecified site or unknown (***see also DCS.II.1: Primary and secondary malignant neoplasms (C00-C97)***).

If the primary malignancy is eradicated, a code from **Z85** must be assigned in a secondary position (***See also DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99))***

Metastases of one stated site only

If the diagnostic statement is '**metastatic**' malignant neoplasm of only one site and gives a histological type that can be indexed to the stated body site/system (*e.g. metastatic osteosarcoma of femur*), this must be coded as a primary neoplasm of that specific site with metastases of an unspecified site (**C79.9**).

When the diagnostic statement is **'metastatic'** malignant neoplasm of only one site and gives a histological type which is indexed to a different body site/system to that stated (*e.g. metastatic osteosarcoma of brain*), this must be coded as a primary neoplasm of an unspecified site for the histological type, with metastases (secondary) of the site mentioned in the diagnostic statement.
If the cross reference in the Alphabetical Index directs the coder to '*see also* Neoplasm, malignant' when referencing the histological type, and the neoplasm **is not** on the list of predominantly secondary sites, (*e.g. metastatic adenocarcinoma of lung*) **(*see also DCS.II.1: Primary and secondary malignant neoplasms (C00-C97))***, the stated site must be coded as a primary malignant neoplasm of the stated site. Code **C79.9** must be assigned in addition to indicate a secondary malignant neoplasm of unspecified site.

If the statement mentions metastasis of only one site and does not mention a histological type, and the neoplasm **is not** on the list of predominantly secondary sites (*e.g. metastatic lung cancer*) ***(see also DCS.II.1: Primary and secondary malignant neoplasms (C00-C97))***, the site mentioned must be coded as a primary neoplasm with secondary malignant neoplasm of unspecified site **(C79.9)**.

If the statement mentions metastasis of only one site and does not mention a histological type, and the neoplasm **is** on the list of predominantly secondary sites (*e.g. metastatic bone cancer*) ***(see also DCS.II.1: Primary and secondary malignant neoplasms (C00-C97))***, code **C80.9** must be assigned to denote an unspecified primary neoplasm and the site mentioned must be coded as the secondary neoplasm.

Metastases of two or more stated sites

If two or more sites are stated in a diagnostic statement and some are qualified as 'metastatic' whilst others are not, and the sites are not on the list of predominantly secondary sites (*e.g. metastatic neoplasm of colon and breast*) ***(see also DCS.II.1: Primary and secondary malignant neoplasms (C00-C97))***, clarification must be sought from the responsible consultant as to which site(s) are metastatic. In the absence of clarification, code both stated sites as primary malignant neoplasms with code **C79.9** to denote secondary neoplasm of unspecified site.

If the statement mentions metastatic neoplasm of two or more sites, and both stated sites are on the list of predominantly secondary sites (*e.g. metastatic carcinoma of pleura and vertebra)* ***- see DCS.II.1: Primary and secondary malignant neoplasms (C00-C97),*** code **C80.9** must be assigned to denote an unspecified primary neoplasm and the sites listed from the list of predominantly secondary sites must be coded as secondary neoplasms.

If the diagnostic statement mentions metastatic neoplasms of two or more sites, and the histological type stated is indexed to a *different* body site/system to that of the stated sites (*e.g. metastatic melanoma of lung and brain*), both sites must be coded as secondary neoplasms. The histological type must be coded as the primary malignant neoplasm.

Metastases with no stated site

If no site is stated in the diagnostic statement, but the histological type is stated to be 'metastatic' (*e.g. metastatic chromophobe adenocarcinoma*), this must be coded as a **primary** neoplasm of unspecified site for the histological type involved. Code **C79.9** must also be assigned to indicate a secondary neoplasm of unspecified site.

See also:

- ***DCS.II.1: Primary and secondary malignant neoplasms (C00-C97)***

- ***DCS.II.7: Secondary neoplasms or metastases from haematological malignancies.***

Terms such as ‘metastasis’ or ‘spread’ refer to a secondary malignant neoplasm and are therefore found in the Neoplasm Table under ‘malignant secondary’.

The adjective ‘metastatic’ is used ambiguously. Sometimes this is used to identify a secondary neoplasm from a primary neoplasm elsewhere, and other times it may denote a primary neoplasm which has given rise to metastases.

Examples:

Metastatic carcinoma from breast

C50.9 Malignant neoplasm: Breast, unspecified
C79.9 Secondary malignant neoplasm, unspecified site

Metastatic carcinoma to lung

C80.9 Malignant neoplasm, primary site unspecified
C78.0 Secondary malignant neoplasm of lung

Metastatic osteosarcoma of femur

C40.2 Malignant neoplasm: Long bones of lower limb
C79.9 Secondary malignant neoplasm, unspecified site

Osteosarcoma (histological type) indexes to ‘neoplasm of bone (body site/system), malignant’. As the femur is a bone, this is considered the primary site. **C79.9** is assigned to identify the unspecified secondary site.

Metastatic osteosarcoma of brain

C41.9 Malignant neoplasm: Bone and articular cartilage, unspecified
C79.3 Secondary malignant neoplasm of brain and cerebral meninges

Osteosarcoma (histological type) indexes to ‘neoplasm of bone (body site/system), malignant’. As the brain is from a different body site/system (the central nervous system) to bone, the brain must be coded as a secondary site.

Metastatic adenocarcinoma of lung

C34.9 Malignant neoplasm: Bronchus or lung, unspecified
C79.9 Secondary malignant neoplasm, unspecified site

Adenocarcinoma (histological type) indexes to a note to ‘see also malignant neoplasm’ and is not specific to body site/system; therefore the site of lung must be coded as the primary neoplasm with metastases of an unspecified site.

Metastatic lung cancer

C34.9 Malignant neoplasm: Bronchus or lung, unspecified
C79.9 Secondary malignant neoplasm, unspecified site

Only one site is mentioned, there is no histological type, and lung is not on the predominantly secondary sites list, therefore this must be coded as primary malignancy of lung with an unspecified secondary malignancy.

Metastatic bone cancer

C80.9 Malignant neoplasm, primary site unspecified
C79.5 Secondary malignant neoplasm of bone and bone marrow

Only one site is mentioned and there is no histological type. Bone is on the list of predominantly secondary sites, therefore the bone is coded as a secondary site with an unspecified primary site.

Metastatic carcinoma of pleura and vertebra

C80.9 Malignant neoplasm, primary site unspecified
C78.2 Secondary malignant neoplasm of pleura
C79.5 Secondary malignant neoplasm of bone and bone marrow

Both pleura and bone (vertebra) are on the list of predominantly secondary sites, therefore this is coded as an unspecified primary with metastases to both pleura and vertebra.

Metastatic melanoma of lung and brain

C43.9 Malignant neoplasm: Malignant melanoma of skin, unspecified
C78.0 Secondary malignant neoplasm of lung
C79.3 Secondary malignant neoplasm of brain and cerebral meninges

The histological type (melanoma) refers to a malignant neoplasm of the skin. The skin is a different body site/system to the lung and brain, therefore this is coded to a primary melanoma of skin unspecified, with both the lung and brain coded as secondary neoplasms.

Metastatic chromophobe adenocarcinoma

C75.1 Malignant neoplasm: Pituitary gland
C79.9 Secondary malignant neoplasm, unspecified site

No site is stated but the histological type is stated to be metastatic. The index trail for chromophobe adenocarcinoma defaults to a primary malignant neoplasm of the pituitary gland when the site is unspecified. As there are metastases present, code **C79.9** must also be assigned to denote the secondary neoplasm of unspecified site.

DCS.II.3: Malignant neoplasms overlapping site boundaries (C00-C75 and C76.8)

Primary malignant neoplasms in categories **C00-C75 Malignant neoplasms, stated or presumed to be primary, of specified sites, except lymphoid, haematopoietic and related tissue** are classified to their point of origin, however when a neoplasm overlaps two or more contiguous (next to each other) sites within the same three character category without any indication of which is the site of origin, the fourth character of .**8** (overlapping site boundary) must be assigned. The fourth character .**8** is **not** assigned if:

- the point of origin is known
  or
- the sites are not contiguous
  or
- the Alphabetical Index directs the coder to a specific code for the combined sites

Where a neoplasm overlaps different sites within the same body system and the point of origin of the neoplasm cannot be identified, one of the subcategories listed at *Note 5* at the beginning of Chapter II Neoplasms in the Tabular List is assigned. Where one of the codes listed at *Note 5* is not appropriate, code **C76.8 Overlapping lesion of other and ill-defined sites** must be used.

Examples:

Carcinoma involving the tip and ventral surface of the tongue, the point of origin is not identified

C02.8 Malignant neoplasm: Overlapping lesion of tongue
[See note 5 at the beginning of this chapter]
Malignant neoplasm of tongue whose point of origin cannot be classified to any one of the categories C01–C02.4

Carcinoma of the tip of the tongue extending to involve the ventral surface

C02.1 Malignant neoplasm: Border of tongue

Malignant neoplasm of the cardio-oesophageal junction

C16.0 Malignant neoplasm: Cardia
Cardio-oesophageal junction

Carcinoma of stomach and small intestine, point of origin not confirmed

C26.8 Malignant neoplasm: Overlapping lesion of digestive system
[See note 5 at the beginning of this chapter]
Malignant neoplasm of digestive organs whose point of origin cannot be classified to any one of the categories C15–C26.1

Adenocarcinoma involving the pharynx and cervical oesophagus, the point of origin is not identified.

C76.8 Malignant neoplasm of other and ill-defined sites: Overlapping lesion of other and ill-defined sites
[See note 5 at the beginning of this chapter]

DCS.II.4: Multiple independent primary malignant neoplasms (C97.X)

When the diagnostic statement records two or more independent primary malignant neoplasms none of which clearly predominates, code **C97.X Malignant neoplasms of independent (primary) multiple sites** must be assigned as the main condition. Additional codes must be used to identify the individual malignant neoplasms recorded in the medical record and may be sequenced in any order after **C97.X.**

Where multiple primary neoplasms exist and it is clear which neoplasm predominates, code **C97.X** must not be assigned.
Where two or more independent primary malignant neoplasms exists, none of which predominates, and these are classified to the same **four** character code, code **C97.X** must still be assigned, followed by a single code which classifies all of the neoplasms.

Examples:

Patient on an elderly care ward is diagnosed with primary malignant neoplasms of both sigmoid colon and lower lobe of lung. The responsible consultant is unable to verify which malignancy predominates

C97.X Malignant neoplasms of independent (primary) multiple sites
C18.7 Malignant neoplasm: Sigmoid colon
C34.3 Malignant neoplasm: Lower lobe, bronchus or lung

Patient with both an adenocarcinoma of the prostate and squamous cell carcinoma of the skin of back is admitted to the urology ward for a transurethral resection of prostate (TURP) to treat the prostate adenocarcinoma

C61.X Malignant neoplasm of prostate
C44.5 Malignant neoplasm: Skin of trunk

Patient with independent primary ductal carcinomas of lower inner quadrant of both breasts. The responsible consultant is unable to verify which malignancy predominates

C97.X Malignant neoplasms of independent (primary) multiple sites
C50.3 Malignant neoplasm: Lower-inner quadrant of breast

DCS.II.5: Recurrent primary malignant neoplasms

When a new primary neoplasm is diagnosed in the same site as a previously excised or eradicated primary malignant neoplasm this must be coded as a primary malignant neoplasm of the same site.

Example:

Recurrent malignant neoplasm of posterior wall of bladder

C67.4 Malignant neoplasm: Posterior wall of bladder

DCS.II.6: Further/wider excision of malignant neoplasm

When a patient undergoes further/wider excision for a previously removed primary, secondary or in-situ neoplasm, even if the responsible consultant reports that the histology from this further surgery is negative, the further excision would still be considered part of the primary treatment for the neoplasm, and therefore the neoplasm must continue to be recorded.

During the excision of a malignant or in-situ neoplasm, some of the tissue that surrounds the neoplasm is also removed. The area between the outer edges of the tissue sample and the neoplasm is known as the 'margins'. The pathologist will check the tissue under a microscope to see if the margins are free of neoplastic cells.

The presence of neoplastic cells in the margins may indicate that the neoplasm has not been fully excised, and the patient may need to return to hospital at a later date for a further/wider excision of the neoplasm.

Example:

Patient admitted for a further excision of malignant melanoma of shoulder having already had an excision biopsy on a previous outpatient attendance. Histology on the current admission returns with no evidence of malignancy.

C43.6 Malignant neoplasm: Malignant melanoma of upper limb, including shoulder

DCS.II.7: Secondary neoplasms or metastases from haematological malignancies

Codes in the range **C77-C79** must never be assigned to indicate a secondary neoplasm due to/from a haematological malignancy (codes in categories **C81-C96 malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue**).

Diagnostic statements indicating that metastases are the result of a haematological malignancy (e.g. 'Lymphoma with bone metastases') must be referred to the responsible consultant to clarify that this is spread of the haematological malignancy. If this is confirmed only the code from categories **C81-C96** is assigned.

Haematological malignancies are systemic diseases and the involvement of additional sites is expected as part of the disease. This process of disease spread in haematological malignancies is not the same as that of solid tumours, and as such the recording of 'secondary' or 'metastatic' tumours is not appropriate.

Due to the disease progression of lymphomas and leukaemias it is perfectly valid for a patient to be coded to one type of lymphoma/leukaemia on one episode and then coded to a totally different type of lymphoma/leukaemia on a subsequent episode.

DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7)

When a patient with leukaemia, or other malignant neoplasms of lymphoid, haematopoietic and related tissues in remission (conditions in categories **C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue**), is admitted for maintenance chemotherapy to keep their condition in remission code **Z85.6 Personal history of leukaemia** or **Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues** must be assigned as the primary diagnosis.

Human Immunodeficiency Virus [HIV] resulting in malignancy

See DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24).

Screening for malignant neoplasm due to family history of malignancy

See DCS.XXI.1: Persons encountering health services for examination and investigation (Z00–Z13)

Follow-up examination after treatment for malignant neoplasm

See DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)

Prophylactic treatment of malignant neoplasm

See DCS.XXI.6: Preventative surgery (Z40)

Personal and family history of malignant neoplasm

See DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99)

DCS.II.9: In situ neoplasms with microinvasion (D00-D09)

If carcinoma in situ is reported with evidence of microinvasion, the neoplasm must be coded as a malignant neoplasm.

Example:

Carcinoma in situ cervix. The responsible consultant confirms from the histology report that there is evidence of microinvasion

C53.9 Malignant neoplasm: Cervix uteri, unspecified

Intraepithelial neoplasia and dysplasia of prostate (D07.5, N42.3)

See DCS.XIV.7: Intraepithelial neoplasia and dysplasia of prostate (D07.5, N42.3)

Intraepithelial neoplasia of female genital tract (CIN, VAIN, VIN)

See DCS.XIV.10: Intraepithelial neoplasia of female genital tract (CIN, VAIN, VIN)

DCS.II.10: Histological types and benign neoplasms

The classification of some terms such as ‘polyp’ or ‘cyst’, depend upon their histological type or site, and must not be coded without reference to the histology report and final confirmation by the responsible consultant.

Careful checking of essential modifiers is also necessary as they may direct the coder elsewhere within the classification.

Examples:

Polyp of an accessory sinus

J33.8 Other polyp of sinus

Adenomatous polyp of an accessory sinus

D14.0 Benign neoplasm: Middle ear, nasal cavity and accessory sinuses

Polyp of the urinary bladder

D41.4 Neoplasm of uncertain or unknown behaviour: Bladder

DCS.II.11: Mongolian blue spot (D22)
Mongolian blue spot must be coded using a code from category **D22.- Melanocytic naevi**.
Mongolian blue spots are flat melanocytic skin markings commonly appearing near the buttocks at birth (birthmark) or shortly thereafter. The index trail for 'birthmark' directs the coder to the ICD-10 code **Q82.5 Congenital non-neoplastic naevus**. However, the ICD-10 Tabular List indicates that melanocytic naevus are excluded from code **Q82.5** and directs to category **D22.-**.

DCS.II.12: Neoplasms of uncertain or unknown behaviour (D37-D48)
Codes in categories **D37-D48 Neoplasms of uncertain or unknown behaviour** must only be assigned when directed to via the Alphabetical index or when it is documented in the medical record that the neoplasm is of uncertain or unknown behaviour Codes from this block **must not** be used when there is a diagnosis of suspected or '? cancer' documented in the medical record. In the absence of a definitive diagnosis, only the symptoms must be recorded. ***See also DGCS.2: Absence of definitive diagnosis statement.***
These codes indicate doubt as to whether a neoplasm is malignant or benign and that the future behaviour of the neoplasm cannot be predicted from its present appearance. These types of neoplasms may also be referred to as 'tumours'.

Chronic intractable pain in neoplasm

See DCS.XVIII.5: Chronic intractable pain (R52.1)

CHAPTER III DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM (D50–D89)

Coding standards and guidance

DCS.III.1: Sickle-cell trait with thalassaemia or Sickle-cell anaemia (D57.3 and D56, D57.0 or D57.1)

D57.3 Sickle-cell trait must not be coded when it coexists with a condition classified to one of the following categories or codes:

- **D56.- Thalassaemia**
- **D57.0 Sickle-cell anaemia with crisis**
- **D57.1 Sickle-cell anaemia without crisis**.

An individual with a defective Hb-S gene from only one parent will demonstrate sickle-cell trait. If the gene is received from both parents they will present with both sickle cell trait and Sickle-cell anaemia**.**

Anaemia in neoplastic disease (C00-D48† and D63.0*)

See DChS.II.2 Anaemia in neoplastic disease (C00-D48† and D63.0*)

DCS.III.2: Anaemia in other chronic diseases, classified elsewhere (D63.8*)

When the responsible consultant has clearly stated a link between anaemia and a chronic condition; code **D63.8* Anaemia in other chronic diseases, classified elsewhere** must be assigned together with the code for the chronic condition as the associated dagger code. Sequencing must reflect ***DGCS.5: Dagger and asterisk system***.

When a link is not stated by the responsible consultant the conditions must be coded separately.

See also:

- ***DConvention.5: Relational terms - In, due to and resulting in***
- ***DChS.II.2: Anaemia in neoplastic disease (C00-D48† and D63.0*).***

Examples:

Patient with anaemia due to chronic duodenal ulcer

K26.7† Duodenal ulcer, chronic without haemorrhage or perforation
D63.8* **Anaemia in other chronic diseases classified elsewhere**

Patient admitted with stage 4 chronic kidney disease and anaemia

N18.4 Chronic kidney disease, stage 4
D64.9 Anaemia, unspecified

DCS.III.3: Haemorrhagic disorder due to circulating anticoagulants (D68.3)

Code **D68.3 Haemorrhagic disorder due to circulating anticoagulants** must only be assigned when the responsible consultant has confirmed and documented a haemorrhage due to anticoagulants.

See also DCS.XVIII.12: Raised International Normalised Ratio [INR] (R79.8).

Neutropenic sepsis (A41.-, D70.X)

See DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis

CHAPTER IV ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES
(E00–E90)

Coding standards and guidance

DCS.IV.1: Diabetes mellitus (E10–E14)

The fourth character subdivisions at categories **E10-E14 Diabetes mellitus** classify manifestations and complications of diabetes. In order to assign fourth characters **.0 - .8** it must be clearly documented in the medical record that the manifestation(s) or complication(s) is due to diabetes. Any doubt as to whether a condition is linked to the diabetes must be referred back to the responsible consultant for clarification.

Multiple complications of diabetes

- Where the patient has multiple complications that are classified to a dagger asterisk combination, a dagger asterisk combination must be assigned for each complication. This applies whether the fourth character diabetes code is the same or not for the complications. ***See also DGCS.5: Dagger and asterisk system.***
- Where a patient has multiple complications classified to **E10-E14** with the fourth characters of **.0, .1, .5 or .6**, each complication must be coded following a code from category **E10-E14,** unless the fourth character code from **E10-E14** is the same for all complications in which case only one code for the diabetes is assigned and the codes for the complications are listed afterwards. The exceptions are myocardial infarction, cardiac failure or angina due to diabetes, as explained below**.**
- The fourth character **.7 With multiple complications** must only be assigned when it is only stated that the patient has multiple complications of diabetes and the specific conditions are not identified in the medical record. ***See also DGCS.10: Multiple condition codes***.

Diabetic gangrene and diabetic ulcer

Diabetic gangrene or diabetic leg ulcer must be coded to the fourth character subdivision .**5 With peripheral circulatory complications** and the code(s) to identify the gangrene and/or leg ulcer must be coded in a secondary position.

Myocardial infarction, cardiac failure or angina due to diabetes

If a patient is admitted with an acute myocardial infarction, cardiac failure or angina that is a complication of diabetes, the diabetes must be recorded in a secondary position with a fourth character of **.6 With other specified complications**.

See also:

- ***DCS.IX.4: Myocardial infarction (I21, I22, I25.8)***
- ***DCS.IX.10: Heart failure (I50)***.

Insulin treated Type 2 diabetes

The use of insulin therapy in type 2 (non-insulin dependent) diabetes patients is not evidence of insulin dependency and these patients must still be coded to category **E11.- Type 2 diabetes mellitus**.

Hypoglycaemia and hypoglycaemic coma in diabetes

- When it is documented in the medical record that a diabetic patient has hypoglycaemia a code from category **E16.- Other disorders of pancreatic internal secretion** must be assigned followed by the code that classifies the type of diabetes from categories **E10**-**E14**, with the fourth character subdivision **.9 Without complications** (as hypoglycaemia is not classified as a complication in ICD-10).
- A code from category **E16.-** must also be assigned following a code from **E10**-**E14**, with the fourth character subdivision **.0 With coma** when the patient has diabetes with hypoglycaemic coma.
- Coma and/or hypoglycaemia due to a patient taking insulin correctly as prescribed, must be coded as an adverse effect of the insulin, ***see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).***
- Coma and/or hypoglycaemia due to a patient taking too much insulin must be coded as a poisoning, ***see DCS.XIX.8: Poisoning (T36-T65).***

Hyperglycaemia and uncontrolled diabetes

Hyperglycaemia in diabetic patients, uncontrolled diabetes and out of control diabetes are not considered to be complications of diabetes within the ICD-10 Classification (with the exception of hyperglycaemic hyperosmolar state), and must be coded with the appropriate code from the range **E10**-**E14**, with the fourth character subdivision **.9**. An additional code to classify the hyperglycaemia is **not** required (this includes patients with hyperglycaemic coma, **E10**-**E14** with fourth character **.0)**.

See also DCS.XV.9: Diabetes mellitus in pregnancy (O24).

Hyperglycaemic hyperosmolar state in diabetes mellitus

Diabetic patients diagnosed with hyperglycaemic hyperosmolar state (HHS) must be coded using the following ICD-10 codes and sequencing:

In patients with HHS with coma:

A code from the range of categories **E10-E14** with a fourth character **.0 With coma**
E87.0 Hyperosmolality and hypernatraemia

In patients with HHS without a coma:

A code from the range of categories **E10-E14** with a fourth character **.6 With other specified complications**

E87.0 Hyperosmolality and hypernatraemia

Type 1 diabetes mellitus may also be documented as IDDM or Insulin dependent diabetes mellitus.

Most patients with type 2 (non-insulin-dependent) diabetes mellitus are treated with diet, exercise and oral drugs, but some patients require insulin intermittently or persistently to control hyperglycaemia and prevent coma.

Hypoglycaemia in diabetes typically occurs as a result of treatment, most commonly insulin, but can also occur as a result of the patient not eating an appropriate diabetic diet. Patients require a careful balancing of treatment, diet and energy requirements.

Hyperglycaemia is a recognised sign of diabetes, or an indication that the diabetes is considered to be 'out of control' and patients are occasionally admitted for stabilisation.

Hyperglycaemic hyperosmolar state (HHS) is a rare but potentially fatal complication of diabetes mellitus, also known by the acronym HONK (Hyperosmolar nonketotic state).

Examples:

Patient with Type 1 diabetes, diabetic nephropathy and diabetic retinopathy

E10.2† Type 1 diabetes mellitus, with renal complications
Diabetic nephropathy (N08.3*)
N08.3* Glomerular disorders in diabetes mellitus (E10-E14 with common fourth character .2†)
E10.3† Type 1 diabetes mellitus, with ophthalmic complications
Diabetic:
- retinopathy (H36.0*)

H36.0* Diabetic retinopathy (E10-E14 with common fourth character .3†)

Non-Insulin-dependent diabetes mellitus complicated by nephropathy, gangrene and cataracts (confirmed as linked by responsible consultant).

E11.2† Type 2 diabetes mellitus, with renal complications
Diabetic nephropathy (N08.3*)
N08.3* Glomerular disorders in diabetes mellitus (E10-E14 with common fourth character .2†)
E11.5 Type 2 diabetes mellitus, with peripheral circulatory complications
Diabetic:
- gangrene

R02.X Gangrene, not elsewhere classified
E11.3† Type 2 diabetes mellitus, with ophthalmic complications
Diabetic:
- cataract (H28.0*)

H28.0* Diabetic cataract (E10-E14† with common fourth character .3†)

Type 2 diabetic with diabetic coma and diabetic gangrene left leg

E11.0 Type 2 diabetes mellitus, with coma
E11.5 Type 2 diabetes mellitus, with peripheral circulatory complications
Diabetic:
- gangrene

R02.X Gangrene, not elsewhere classified

Hypoglycaemia in non-insulin-dependent diabetes mellitus due to patient skipping meals.

E16.2 Hypoglycaemia, unspecified
E11.9 Type 2 diabetes mellitus, without complication

Hypoglycaemia, direct cause of insulin taken as prescribed. Insulin-dependent diabetes mellitus

E16.0 Drug-induced hypoglycaemia without coma
Use additional external cause code (Chapter XX), if desired, to identify drug.
Y42.3 Insulin and oral hypoglycaemic [antidiabetic] drugs
E10.9 Type 1 diabetes mellitus, without complication

Hypoglycaemic coma, in patient with Type 1 diabetes mellitus

E10.0 Type 1 diabetes mellitus, with coma
E16.2 Hypoglycaemia, unspecified

Accidental overdose of insulin, resulting in hypoglycaemic coma. Type I diabetes mellitus.

T38.3 Insulin and oral hypoglycaemic [antidiabetic] drugs
X44.9 Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, unspecified place
E10.0 Type 1 diabetes mellitus, with coma
E16.2 Hypoglycaemia, unspecified

Type 2 diabetic patient found to be unresponsive to stimuli; the patient is diagnosed with a hyperglycaemic hyperosmolar coma.

E11.0 Type 2 diabetes mellitus, with coma
E87.0 Hyperosmolality and hypernatraemia

Drowsiness in Type 2 diabetic patient; the patient is diagnosed with hyperglycaemic hyperosmolar state.

E11.6 Type 2 diabetes mellitus, with other specified complications
E87.0 Hyperosmolality and hypernatraemia

Infertility due to ovarian or testicular dysfunction (E28 and E29)

See DCS.XIV.8: Infertility with known cause (N46 and N97).

DCS.IV.2: Malnutrition (E40-E46)

The notes in the Tabular List at block and category level **E40-E46 Malnutrition** must not be used by coders to diagnose malnutrition in a patient. Code assignment must be based on the diagnosis documented in the medical record, and any uncertainty must be referred back to the responsible consultant.

DCS.IV.3: Obesity (E66)

Codes in category **E66 Obesity** must only be coded when a diagnosis of obesity is recorded in the medical record. Where body mass index (BMI) has been recorded in the medical record, this must not be used to assign a code from category **E66.- Obesity**. A clinical coder must always refer to the responsible consultant to confirm the clinical significance of a test result, e.g. BMI reading and/or relationship to a specific condition.

See also DGCS.4: Using diagnostic test results.

DCS.IV.4: Medium Chain Acyl CoA Dehydrogenase Deficiency [MCAD deficiency] (E71.3)

Medium Chain Acyl CoA Dehydrogenase Deficiency (MCAD deficiency) is a disorder of fatty acid oxidation and must be coded to **E71.3 Disorders of fatty metabolism**.

DCS.IV.5: Pure hypercholesterolaemia (E78.0)

A diagnosis of 'high cholesterol' or '↑Cholesterol' must only be coded to **E78.0 Pure hypercholesterolaemia** if confirmed to be a definitive diagnosis of hypercholesterolaemia by the responsible consultant and it is not merely an abnormal test result.

Abnormal cholesterol detected from a blood test without a definitive diagnosis of hypercholesterolaemia must be coded to **R79.8 Other specified abnormal findings of blood chemistry** instead.

See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

DCS.IV.6: Cystic fibrosis with manifestations (E84)

When cystic fibrosis is documented with a manifestation(s), an additional code or codes identifying the manifestation(s) must be assigned immediately after a code from category **E84.- Cystic fibrosis,** where doing so adds further information about the specific manifestation(s).

Multiple codes from category **E84.-** must be used where multiple manifestations are present.

See also DGCS.10: Multiple condition codes.

Examples:

Cystic fibrosis related pseudomonas aeruginosa lower respiratory tract infection.

E84.0 Cystic fibrosis with pulmonary manifestations
J22.X Unspecified acute lower respiratory tract infection
B96.5 *Pseudomonas (aeruginosa)* as the cause of diseases classified to other chapters

Cystic fibrosis related meconium ileus, cirrhosis of the liver, chronic pancreatitis and osteoporosis

E84.1† Cystic fibrosis with intestinal manifestations
Meconium ileus in cystic fibrosis† (P75*)
P75.X* Meconium ileus in cystic fibrosis (E84.1†)
E84.8 Cystic fibrosis with other manifestations
K74.6 Other and unspecified cirrhosis of liver
K86.1 Other chronic pancreatitis
M81.9 Osteoporosis, unspecified

DCS.IV.7: Dehydration and hypovolaemia

Dehydration must always be coded where the dehydration is documented as severe, or where it has been treated with intravenous fluids (except for dehydration in newborn which must always be coded, ***see DCS.XVI.6: Dehydration of newborn (P74.1)***.

Hypovolaemia must always be coded when it is confirmed to have been treated with intravenous fluids or blood transfusion.

Dehydration can be described as mild, moderate, or severe, depending on the percentage of body weight lost due to fluid. Severe dehydration is a life-threatening emergency and requires treatment with intravenous solutions.

Hypovolaemia can progress to hypovolaemic shock, which can result in organ failure. Hypovolaemic shock requires treatment with intravenous fluids or blood transfusion.

CHAPTER V MENTAL AND BEHAVIOURAL DISORDERS
(F00–F99)

DChS.V.1: Glossary descriptions

In addition to inclusion and exclusion terms, Chapter V Mental and behavioural disorders, uses glossary descriptions to indicate the content of categories and codes. This is used because the terminology of mental disorders varies greatly, particularly between different countries, and the same name may be used to describe quite different conditions.

The glossary descriptions must not be used by coders to assign codes; code selection must be made on the basis of the diagnoses documented by the responsible consultant, even if there appears to be a conflict between the condition (as documented) and the definition.

Chapter standards and guidance

The WHO also provides the specialty-based adaptation called ICD-10 Classification of Mental Health and Behavioural Disorders which is intended for use by mental health professionals. It encompasses clinical descriptions and diagnostics. It is recommended that this adaptation should only be used in conjunction with the complete ICD-10 classification in order that all ICD-10 rules and conventions are fully adhered to.

Coding standards and guidance

The dagger and asterisk code combination of **G30† Alzheimer disease** and **F00* Dementia in Alzheimer disease (G30.-†)** classifies Alzheimer's dementia.

The terms Alzheimer's disease and Alzheimer's dementia are often used interchangeably; however, it is possible for patients to be diagnosed with Alzheimer's disease before displaying the clinical symptoms of dementia. Therefore, when Alzheimer's disease is documented in the medical record with no mention of dementia, the responsible consultant should be consulted to confirm the presence of dementia before assignment of the dagger and asterisk combination **G30† Alzheimer disease** and **F00* Dementia in Alzheimer disease (G30.-†).**

Example:

Dementia in early onset Alzheimer disease

G30.0† Alzheimer disease with early onset
F00.0* Dementia in Alzheimer disease with early onset (G30.0†)

DCS.V.2: Mixed dementia or mixed vascular and Alzheimer dementia (G30.8† and F00.2*)

The following codes must be used for diagnoses of 'mixed dementia' or 'mixed vascular and Alzheimer dementia':

G30.8† Other Alzheimer disease
F00.2* Dementia in Alzheimer disease, atypical or mixed type (G30.8†)

See also DGCS.5: Dagger and asterisk system.

DCS.V.3: Delirium and acute confusional state

Whenever a documented diagnosis of 'delirium', or 'acute confusional state', is made in the patient's medical record this must be coded using the appropriate ICD-10 code.

Where the cause of the delirium or acute confusional state is known, this must also be coded using the appropriate ICD-10 code. The correct sequencing will depend on the main condition treated or investigated during the episode, in line with ***DGCS.1: Primary diagnosis***.

A documented diagnosis of 'delirium' together with a documented co-morbidity/diagnosis of 'dementia' must be coded using the following code:

F05.1 Delirium superimposed on dementia

Delirium is synonymous with the term acute confusional state.

Example:

Elderly patient with urinary tract infection and acute confusional state. Urinary tract infection treated with antibiotics.

N39.0 Urinary tract infection, site not specified
F05.9 Delirium, unspecified

DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19)

When assigning codes in categories **F10-F19 Mental and behavioural disorders due to psychoactive substance use** and the patient has a number of conditions/ states classified at four character level due to the same substance, each condition/ state must be coded, i.e. multiple four character codes must be assigned to the same category from **F10-F19**.

See also:

- ***DCS.V.5: Alcohol abuse and heavy drinker (F10)***
- ***DCS.V.7: Current smoker (F17)***
- ***DCS.V.8: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances (F19).***

Example:

Alcoholic admitted with acute drunken episode

F10.0 **Mental and behavioural disorders due to use of alcohol, acute intoxication**
F10.2 **Mental and behavioural disorders due to use of alcohol, dependence syndrome**

DCS.V.5: Alcohol abuse and heavy drinker (F10)

Alcohol 'abuse' includes any code from category **F10.- Mental and behavioural disorders due to use of alcohol,** and fourth character assignment will depend on the diagnosis documented in the medical record by the responsible consultant.

A statement of 'heavy drinker' when written in the medical record must only be coded using a code from **F10.-**, if:

- the patient has been advised by the responsible consultant to stop drinking because it will have an adverse effect on their medical condition

  or

- the responsible consultant states that the patient is dependent on alcohol.

If it is documented in the medical record that the patient is a heavy drinker with **no** other reference to medical condition, code **Z72.1 Alcohol use** must be assigned instead.

See also DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19).

DCS.V.6: Mephedrone

If the patient is described by the responsible consultant as having 'acute intoxication' from taking Mephedrone, code **F15.0 Mental and behavioural disorders due to use of other stimulants, including caffeine, acute intoxication** must be assigned.

Mephedrone is described as a chemical stimulant closely related to the 'cathinone' group of drugs which include, Methcathinone, Methylenedioxyamphetamine and amphetamine compounds such as MDMA and ecstasy. Mephedrone is also known by a variety of names such as MCAT, MEOW-MEOW and 4-MMC. Mephedrone has been declared as an illegal substance. The drug Mephedrone can be considered as a 'psychostimulant'.

DCS.V.7: Current smoker (F17)

When it is documented in the medical record that a patient smokes, code **F17.1 Mental and behavioural disorders due to use of tobacco, harmful use** must be assigned. If further information is given such as dependence, then the fourth character code may change.

Code **Z72.0 Tobacco use** must **not** be assigned for a current smoker.

See also DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19).

Smoking any number of cigarettes, regardless of the frequency, will always have an adverse effect on a person's health.

As there is no specific code within ICD-10 to classify the use of a vaping device or e-cigarettes, their use should not be recorded using the ICD-10 classification.
See also DCS.XXII.4: Vaping related disorder.

DCS.V.8: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances (F19)

Codes in category **F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances** must only be assigned when two or more psychoactive substances are known to be involved and :

- the exact identity of some (or even all) of the psychoactive substances being used is uncertain or unknown

or

- it is not evident which substance the patient is most dependent upon

or

- it is not possible for the responsible consultant to identify which substance is contributing most to the disorder.

If the patient is dependent on **multiple** drugs / other psychoactive substances and no single drug is stated to be contributing most to the disorder and they are also a 'current smoker', a code from category **F19.-** must be used in combination with **F17.1 Mental and behavioural disorders due to use of tobacco, harmful use.** If further information is given regarding the smoking (e.g. dependence) a different fourth character from **F17.- Mental and behavioural disorders due to use of tobacco** must be assigned.

See also:

- ***DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19)***
- ***DCS.V.7: Current smoker (F17).***

Examples:

Alcoholic, heroin, cannabis, valium dependent

F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substance, dependence syndrome

Alcoholic patient, dependent on heroin and is also a 'current smoker'

F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances, dependence syndrome
F17.1 Mental and behavioural disorders due to use of tobacco, harmful use

DCS.V.9: Anxiety depression (F41.2)

Whilst a stated diagnosis of 'depression anxiety' or 'anxiety depression' can be indexed to the ICD-10 code **F41.2 Mixed anxiety and depressive disorder**; if diagnoses of anxiety and depression are documented individually by the responsible consultant both diagnoses must be recorded separately and the code **F41.2** must not be used.

DCS.V.10: Anxious

Anxiety must not be coded in patients who are described as 'anxious' without a definitive diagnosis of anxiety, or anxiety disorder.

Caution is required when 'fatigue syndrome' is used as a diagnosis within the medical record. The Alphabetical Index takes the coder to **F48.0 Neurasthenia** which includes fatigue syndrome. However many patients actually have chronic fatigue syndrome, which is an alternative name for the postviral fatigue syndrome or myalgic encephalomyelitis (ME). Chronic fatigue syndrome is coded to **G93.3 Postviral fatigue syndrome**.

Coders should therefore clarify the nature of the fatigue with the responsible consultant before assigning a code.

Codes in category **F53.- Mental and behavioural disorders associated with the puerperium, not elsewhere classified**, which includes **postnatal depression** at **F53.0 Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified**, can be assigned for a diagnosis of postnatal depression regardless of how long after the birth of the baby this occurs. This might be, for example, at three months/six months/two years after the birth.

DCS.V.11: Learning disability (F70-F79)

The more common terms for the disorders classified at categories **F70-F79 Mental retardation** are '**learning disability**' or '**intellectual disability**'.

If these terms are used within the medical record the coder must liaise with the responsible consultant to ensure the correct code assignment is made:

- If it is confirmed the patient has a true learning disability (i.e. impairment of skills manifested during the development period; skills which contribute to the overall level of intelligence, such as cognitive language, motor, and social abilities) a code from categories **F70-F79** must be assigned
- If it is confirmed the patient actually has a scholastic disorder (i.e. problems with reading, spelling or arithmetic) a code from categories **F80.- Specific developmental disorders of speech and language** or **F81.- Specific developmental disorders of scholastic skills** must be assigned, ***see also DCS.V.12: Mixed developmental disorders (F80–F83)***.

If a patient is described as having more than one level of impairment classified at fourth character level in codes in categories **F70-F79** (e.g. mild to moderate) code to the most severe level of impairment.

Categories **F70–F73** are classified in order of increasing mental impairment (mild, moderate, severe and profound). Increasing mental impairment is associated with decreasing IQ (as described in the glossaries contained at each of these categories). A list of fourth character subdivisions specifying the degree of behavioural impairment is found at the beginning of the block in the Tabular List.

Examples:

Patient confirmed to have moderate learning disability with minimal impairment of behaviour

F71.0 Moderate mental retardation, with the statement of no, or minimal, impairment of behaviour

Significant behavioural impairment with IQ of 25

F72.1 Severe mental retardation, significant impairment of behaviour requiring attention or treatment

DCS.V.12: Mixed developmental disorders (F80–F83)

If a patient is diagnosed with dysfunctions classified to two or more of the codes within categories **F80.- Specific developmental disorders of speech and language**, **F81.- Specific developmental disorders of scholastic skills** or **F82.X Specific developmental disorders of motor function**, a code from category **F83.- Mixed specific developmental disorders** must be used instead.

See also DCS.V.11: Learning disability (F70-F79).

Holiday relief care/respite care (Z75.5)

Patients may be admitted to a mental health unit for holiday relief care (respite care) to enable their carers to take a break. ***See DCS.XXI.20: Holiday relief care (Z75.5)*** for standards.

When a patient is being transferred in or out of a mental health unit, the coder should consider the Primary Diagnosis Definition when deciding on sequencing of the patient's conditions in the coded record. When a patient is transferred, it is often for treatment of a different condition than the one treated at the first unit.

See DGCS.1: Primary diagnosis.

Examples:

Patient admitted to acute trust due to deliberate overdose of paracetamol, patient has depression. Patient transferred to psychiatric unit the next day for treatment of acute depression.

Acute trust

T39.1 4-Aminophenol derivatives
X60.9 Intentional self-poisoning by and exposure to nonopioid analgesic, antipyretics and antirheumatics, unspecified place
F32.9 Depressive episode, unspecified

Psychiatric unit

F32.9 Depressive episode, unspecified
Z91.5 Personal history of self-harm

Inpatient at psychiatric unit for 6 weeks with acute depression, laceration to wrist after slashing with scissors, (suicide attempt). Patient transferred to acute trust for treatment of laceration to wrist.

Psychiatric unit

F32.9 Depressive episode, unspecified
S61.9 Open wound of wrist and hand, part unspecified
X78.2 Intentional self-harm by sharp object, school, other institution and public administrative area

Acute trust

S61.9 Open wound of wrist and hand, part unspecified
F32.9 Depressive episode, unspecified
Z91.5 Personal history of self-harm

CHAPTER VI DISEASES OF THE NERVOUS SYSTEM (G00–G99)

Coding standards and guidance

See Chapter V for guidance on the coding of Dementia in Alzheimer disease.

Mixed dementia or mixed vascular and Alzheimer dementia (G30.8† and F00.2*)

See DCS.V.2: Mixed dementia or mixed vascular and Alzheimer dementia (G30.8† and F00.2*).

DCS.VI.1: Epilepsy and injury

If an epileptic patient is admitted for treatment of an injury sustained during an epileptic fit, the injury must be coded as the primary diagnosis followed by the appropriate external cause code and the relevant epilepsy code.

See *also:*

- ***Standards in Chapter XIX for coding of injuries, poisoning, other trauma and external causes***
- ***DChS.XX.1: External causes.***

DCS.VI.2: Amaurosis fugax (G45.3)

An additional code must not be assigned to classify loss of vision in patients with Amaurosis fugax as this is inherent in the code **G45.3 Amaurosis fugax**.

See also DCS.VII.3: Visual impairment including blindness (H54).

DCS.VI.3: Hemiplegia, paraplegia and tetraplegia and other paralytic syndromes (G81-G83)

Codes within categories **G81-G83** must only be assigned in the primary position if their cause is not recorded. If the cause is known they are assigned in a secondary position.

The exception is when the cause is no longer present and the hemiplegia, paraplegia, tetraplegia or other paralytic syndrome is a sequela of the cause.

See also:

- ***DGCS.8: Sequelae or late effects***
- ***DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia.***

Example:

Flaccid hemiplegia as a result of cerebral infarction five years ago

G81.0 Flaccid hemiplegia
I69.3 Sequelae of cerebral infarction

DCS.VI.4: POEMS syndrome (C90.0† and G63.1*)

POEMS syndrome must be coded using the following codes:

C90.0† Multiple myeloma
G63.1* Polyneuropathy in neoplastic disease (C00-D48†)

These codes must only be assigned when all the features of this disease are present and have been confirmed by the responsible consultant.

See also:

- ***DGCS.5: Dagger and asterisk system***
- ***DGCS.7: Syndromes***.

The features of POEMS syndrome are:

- Polyneuropathy
- endocrinopathy
- monoclonal gammopathy
- skin changes
- myeloma.

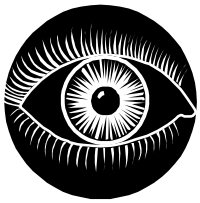
DCS.VI.5: Persistent vegetative state (G93.1 and R40.2)

Persistent vegetative state (PVS) must be coded using the following codes:

G93.1 Anoxic brain damage, not elsewhere classified
R40.2 Coma, unspecified

Postprocedureal disorders of nervous system, not elsewhere classified (G97)

See DCS.XIX.7: Postprocedural complications of medical and surgical care.



CHAPTER VII DISEASES OF THE EYE AND ADNEXA (H00–H59)

Coding standards and guidance

DCS.VII.1:Age-related, mature, advanced and white cataracts (H25 and H26.9)

Age-related cataract must be coded to category **H25.- Senile cataract**.

Mature, advanced or white cataract must be coded using **H26.9 Cataract, unspecified**.

DCS.VII.2: Posterior capsule opacification (H26.4)

Posterior capsule opacification must be coded using **H26.4 After-cataract.**

DCS.VII.3: Visual impairment including blindness (H54)

The severity of visual impairment table at category **H54.- Visual impairment including blindness (binocular or monocular)** must not be used for coding purposes to diagnose levels of visual impairment.

For patients who are visually impaired or blind and the cause is documented in the medical record the following codes and sequencing must be applied:

Code for the cause of visual impairment or blindness
H54.- Visual impairment including blindness (binocular or monocular)

The exception is **G45.3 Amaurosis fugax** where only this code is required, ***see DCS.VI.2: Amaurosis fugax (G45.3).***

Patients who are registered blind must be coded to the level of visual impairment (eg. severe, moderate, mild) documented in the medical record. If no detail is given about the level of visual impairment one of the following codes must be assigned:

H54.0 **Blindness, binocular** (if unspecified or stated of both eyes)

or

H54.4 **Blindness, monocular** (if stated to be of one eye only).

DCS.VII.4: Post enucleation socket syndrome, PESS (H59.8 and Y83.6)

Post enucleation socket syndrome must be coded using the following codes and sequencing:

H59.8 **Other postprocedural disorders of eye and adnexa**
Y83.6 **Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)**

See also DCS.XIX.7: Postprocedural complications of medical and surgical care.

DCS.VII.5: Sunken socket syndrome (H59.8 and Y83 or Y84)

Sunken socket syndrome must be coded using the following codes and sequencing:

H59.8 **Other postprocedural disorders of eye and adnexa**
Y83-Y84 **Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure** (where the responsible consultant has documented the original procedure)

See also DCS.XIX.7: Postprocedural complications of medical and surgical care.

CHAPTER VIII DISEASES OF THE EAR AND MASTOID PROCESS
(H60–H95)

Coding standards and guidance

DCS.VIII.1: Severe or profound hearing loss (H90 and H91)
Hearing loss documented as severe or profound must always be coded using a code from categories **H90.- Conductive and sensorineural hearing loss** or **H91.- Other hearing loss** depending on the type of hearing loss documented. When the cause of severe or profound hearing loss is known both conditions must be coded, sequencing will depend on the main condition treated or investigated during the episode, ***see DGCS.1: Primary diagnosis***.
The existence of severe or profound hearing loss can be indicative of a serious underlying illness and, as these patients require extra resources, it is always clinically relevant.

CHAPTER IX DISEASES OF THE CIRCULATORY SYSTEM
(I00–I99)

Coding standards and guidance

DCS.IX.1: Essential (primary) hypertension (I10.X)

Hypertension must only be coded when a patient has been diagnosed as hypertensive. **I10.X Essential (primary) hypertension** must not be used to record a diagnosis of raised or elevated BP *without* mention of hypertension. This would be coded to **R03.0 Elevated blood-pressure reading, without diagnosis of hypertension**.

When assigning hypertension as a secondary code with an ischaemic heart condition classifiable to categories **I20–I25 Ischaemic heart diseases** or cerebrovascular disease classifiable to categories **I60–I69 Cerebrovascular disease** as instructed in the category 'Use' note, the hypertension can be sequenced in **any** secondary position.

DCS.IX.2: Renal disease and heart disease due to hypertension (I11, I12, I13)

Categories **I11.- Hypertensive heart disease**, **I12.- Hypertensive renal disease** and **I13.- Hypertensive heart and renal disease** must be used when the responsible consultant clearly states a link between hypertension and heart disease (**I50.-** or **I51.4-I51.9**) or renal disease (**N00-N07**, **N18.-**, **N19.-** or **N26.-**). If there is no link stated the conditions must be coded separately.

Where the patient has a condition in category **I11.-** together with a condition in category **I12.-,** a code from category **I13.-** must be used instead.

When a patient has hypertensive renal disease, or hypertensive heart and renal disease, and the renal disease is a condition within category **N18.- Chronic kidney disease**, the code from category **N18.-** is assigned to identify the stage of the chronic kidney disease together with a code from category **I12.-** or **I13.-**. Sequencing is dependent on the main condition treated or investigated.

See also:
- ***DGCS.1: Primary diagnosis***
- ***DCS.XIV.2: Chronic kidney disease, CKD (N18)***
- ***DCS.IX.10: Heart failure (I50).***

The responsible consultant will use modifying terms such as 'hypertensive' or 'due to hypertension' to indicate that a heart or renal disease is due to hypertension.

Examples:

Hypertensive congestive cardiac failure

I11.0 Hypertensive heart disease with (congestive) heart failure
Incl.: any condition in I50.-, I51.4-I51.9 due to hypertension

Congestive cardiac failure and hypertension

I50.0 Congestive heart failure
I10.X Essential (primary) hypertension

Kidney failure and hypertension

N19.X Unspecified kidney failure
I10.X Essential (primary) hypertension

Hypertensive renal failure

I12.0 Hypertensive renal disease with renal failure
Hypertensive renal failure

Incl.: any condition in N00-N07, N18.-, N19 or N26 due to hypertension

Hypertensive kidney failure with hypertensive congestive cardiac failure

I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
Incl.: any condition in I11.- with any condition in I12.-

DCS.IX.3: Cardiac syndrome X (I20.8)

Cardiac syndrome X must be coded using **I20.8 Other forms of angina pectoris**.

See also DGCS.7: Syndromes.

Myocardial infarction, cardiac failure or angina due to diabetes

See DCS.IV.1: Diabetes mellitus (E10–E14) - Myocardial infarction, cardiac failure or angina due to diabetes.

DCS.IX.4: Myocardial infarction (I21, I22, I25.8)

The time reference of four weeks (28 days) stated in categories **I21-I25** signifies the interval elapsing between the onset of the ischaemic episode and admission to hospital; this time reference must be observed by coders to ensure consistency in recording myocardial infarctions.

Acute myocardial infarction

A code from category **I21.- Acute myocardial infarction** must be assigned every time a patient has an acute myocardial infarction (MI), except when a subsequent MI occurs within 4 weeks of the onset of a previous infarction, in which case a code from category **I22.- Subsequent myocardial infarction** must be used as described below.

Where a new acute MI is diagnosed more than four weeks (28 days) after a previous MI, a code from category **I21.- Acute myocardial infarction** must be assigned.

Acute NSTEMI and STEMI

Non-ST segment elevation myocardial infarction (NSTEMI) must be coded to **I21.4 Acute subendocardial myocardial infarction.**

ST segment elevation myocardial infarction (STEMI) must be classified using a code in the range **I21.0 - I21.3** depending on the site of the damage to the heart documented in the medical record. Where the site of the damage is not known, code **I21.3 Acute transmural myocardial infarction of unspecified site** must be assigned.

Subsequent MI, NSTEMI and STEMI

Category **I22.- Subsequent myocardial infarction** must only be used to code an MI occurring within four weeks (28 days) from onset of a previous infarction, regardless of site and includes the following:

- Subsequent/further acute myocardial infarction
- extension to an existing MI
- recurrent MI
- reinfarction

Subsequent NSTEMI must be classified using **I22.9 Subsequent myocardial infarction of unspecified site**.

Subsequent STEMI must be classified using a code in the range **I22.0 - I22.8** depending on the site of the damage to the heart documented in the medical record. Where the site of the damage is not known, code **I22.8 Subsequent myocardial infarction of other sites** must be assigned.

If a patient has multiple subsequent MIs in the same episode, or any episode within the same or a different hospital provider spell, occurring within four weeks (28 days) from onset of the original infarction, a code from category **I22.- Subsequent myocardial infarction** must be assigned for each subsequent MI.

Chronic MI and ongoing treatment of MI after 4 weeks

If an MI is stated as chronic, or the patient is admitted for treatment of the original MI after four weeks (28 days) from onset of the MI, code **I25.8 Other forms of chronic ischaemic heart disease** must be assigned.

Treatment of another condition within 4 weeks of an MI

When a patient is admitted to hospital within four weeks (28 days) of an acute MI for treatment or investigation of another condition, code **I24.9 Acute ischaemic heart disease, unspecified** must be assigned in a secondary position.

See also:

- ***DCS.IV.1: Diabetes mellitus (E10–E14) - Myocardial infarction, cardiac failure or angina due to diabetes***
- ***DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease***

The fourth characters at category **I21.-** identify the site of infarction/extent of the damage caused to the heart by the infarction. Codes **I21.0-I21.3** classify transmural MI and STEMI, code **I21.4** classifies non-transmural MI and NSTEMI. Transmural (*trans = across, mural = wall*) means the infarction has occurred across the full thickness of the heart muscle, from endocardium to epicardium. When documenting acute myocardial infarction through a wall the clinical statement may not contain the term ‘transmural’; the diagnostic statement given may only state the site of the infarction (e.g. Anterior MI, Inferior MI etc). When indexing myocardial infarction for such descriptions, the coder should continue past the essential modifier of ‘transmural’ in order to assign ICD-10 codes **I21.0-I21.2** for the site involved.

The term ‘subendocardial’ implies that the infarction involves only up to two-thirds of the heart muscle, from the endocardium to the myocardium.

It is permissible to assign a code from category **I21.-** on multiple episodes within a hospital provider spell where a patient is transferred to another consultant but is still undergoing treatment of the MI. This also applies where patients receive ongoing treatment (such as rehabilitation) for an MI at multiple hospital providers (Trusts) and to patients readmitted within four weeks (28 days) of an MI for ongoing treatment of the original MI. A patient may have a code from category **I21.-** assigned multiple times during their lifetime.

Acute NSTEMI is coded to **I21.4** which classifies non-transmural myocardial infarction, therefore subsequent NSTEMI is coded to **I22.9** because the other codes in **I22.-,** including **I22.8**, classify subsequent transmural myocardial infarctions (i.e. subsequent STEMI).
An extended MI is a progressive increase in the amount of myocardial necrosis within the infarct zone of the original MI. This may manifest as an infarction that extends and involves the adjacent myocardium, or as a subendocardial infarction that becomes transmural.

Examples:

Patient admitted with chest pains is diagnosed with STEMI.

I21.3 Acute transmural myocardial infarction of unspecified site

Patient admitted to acute admissions ward and diagnosed with acute anterior myocardial infarction. They have no previous cardiac history (Episode1). The patient is transferred to CCU for continuing treatment and is discharged home five days later (Episode 2).

Episode 1

I21.0 Acute transmural myocardial infarction of anterior wall

Episode 2

I21.0 Acute transmural myocardial infarction of anterior wall

Patient diagnosed with an acute myocardial infarction of anterior wall (Hospital provider spell 1). Two weeks after the previous myocardial infarction of the anterior wall the patient is readmitted with an acute myocardial infarction of the inferior wall (Hospital provider spell 2). Six months later the patient is readmitted with another acute myocardial infarction of the inferior wall (Hospital provider spell 3).

Hospital provider spell 1

I21.0 Acute transmural myocardial infarction of anterior wall

Hospital provider spell 2

I22.1 Subsequent myocardial infarction of inferior wall

Hospital provider spell 3

I21.1 Acute transmural myocardial infarction of inferior wall
I25.2 Old myocardial infarction

See also DCS.IX.7: Chronic ischaemic heart disease (I25).

A patient is admitted to Trust A with an MI whilst on holiday (Hospital provider spell 1). Four days after admission the patient is discharged from Trust A and is admitted directly to the coronary care unit at Trust B closer to home for cardiac rehabilitation. Two days after admission they suffer another acute MI (subsequent MI) (Hospital provider spell 2).

Hospital provider spell 1 (Trust A)

I21.9 Acute myocardial infarction, unspecified

Hospital provider spell 2 (Trust B)

I22.9 Subsequent myocardial infarction of unspecified site
I21.9 Acute myocardial infarction, unspecified
Z50.0 Cardiac rehabilitation

Z50.0 ***can*** be assigned in addition because in this instance an OPCS-4 code would not be assigned for the rehabilitation**, *see also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).***

Patient admitted for investigation of chest pain 3 weeks after an acute MI. A further MI is ruled out.

R07.4 Chest pain, unspecified
I24.9 Acute ischaemic heart disease, unspecified

DCS.IX.5: Coronary artery disease interventions and acute myocardial infarction

If a patient who has coronary artery disease is admitted with and treated for an acute MI, and is transferred from one hospital provider to another for an intervention to treat the coronary artery disease (for example coronary angioplasty etc), the coronary artery disease must be assigned as the primary diagnosis.

If the patient undergoes all treatments at the same Trust, the acute MI must be recorded as the primary diagnosis, followed by the code for the coronary artery disease, as the MI is considered more clinically significant.

See also DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease.

Example:

Patient is admitted to Trust A with an acute MI. The patient also has coronary artery disease (CAD) (Hospital provider spell 1). They are transferred to Trust B where coronary angioplasty and stent of only the most severely atherosclerotic coronary arteries is performed (Hospital provider spell 2). The patient is discharged from Trust B the day after the coronary angioplasty and stent procedure and readmitted directly to Trust A's rehabilitation unit for cardiac rehabilitation for the acute MI (Hospital provider spell 3).

Hospital provider spell 1 (Trust A)

I21.9 Acute myocardial infarction, unspecified
I25.1 Atherosclerotic heart disease

Hospital provider spell 2 (Trust B)

I25.1 Atherosclerotic heart disease
I21.9 Acute myocardial infarction, unspecified

Hospital provider spell 3 (Trust A)

I21.9 Acute myocardial infarction, unspecified
I25.1 Atherosclerotic heart disease
Z95.5 Presence of coronary angioplasty implant and graft

See also:

- ***DCS.IX.7: Chronic ischaemic heart disease (I25)***
- ***DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).***

DCS.IX.6: Certain current complications following acute myocardial infarction (I23)

Codes in category **I23.- Certain current complications following acute myocardial infarction** must be assigned when the complications occurred ***following*** an acute myocardial infarction.

Where a complication occurs concurrently ***with*** (i.e. at the same time as) the myocardial infarction a code from categories **I21–I22** is assigned instead.

A code from category **I23.-** can be used in the same episode as a code from either **I21.-** or **I22.-** as long as the complication is *not* concurrent with the MI.

Current complications are *not* subject to the 'four week (28 days)' rule, e.g. a patient admitted with a ventricular septal defect resulting from an acute myocardial infarction which occurred eight weeks previously, would be coded to **I23.2 Ventricular septal defect as current complication following acute myocardial infarction** as the complication would still be current.

Examples:

Atrial septal defect occurring following subsequent MI of anterior wall in the same episode.

I22.0 Subsequent myocardial infarction of anterior wall
I23.1 Atrial septal defect as current complication following acute myocardial infarction

New admission for atrial septal defect following anterior wall myocardial infarction 10 days previously

I23.1 Atrial septal defect as current complication following acute myocardial infarction
I24.9 Acute ischaemic heart diseases, unspecified

Acute transmural anterior wall myocardial infarction concurrent with atrial septal defect

I21.0 Acute transmural myocardial infarction of anterior wall

DCS.IX.7: Chronic ischaemic heart disease (I25)

Code **I25.2 Old myocardial infarction** is used to classify an old MI, a previous MI, a past MI and a personal history of myocardial infarction and must be used when the patient is not being treated for the previous myocardial infarction and either:

- the old myocardial infarction occurred more than four weeks (28 days) ago
  or
- the length of time since the patient had the MI has not been stated and the responsible consultant uses terms such as ‘previous’, ‘old’, ‘past MI’

When both an old, previous or past MI and IHD are documented in the medical record, both conditions must be coded.

It is frequently documented in the medical record that patients have both angina (**I20.-**) and Ischaemic heart disease (IHD) (**I25.-**). When both conditions have been recorded by the responsible consultant, both must be coded. If a patient with a previous MI has any other cardiac problems, these conditions must also be recorded.

See also:

- ***DCS.IX.4: Myocardial infarction (I21, I22, I25.8)***
- ***DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease.***

Examples:

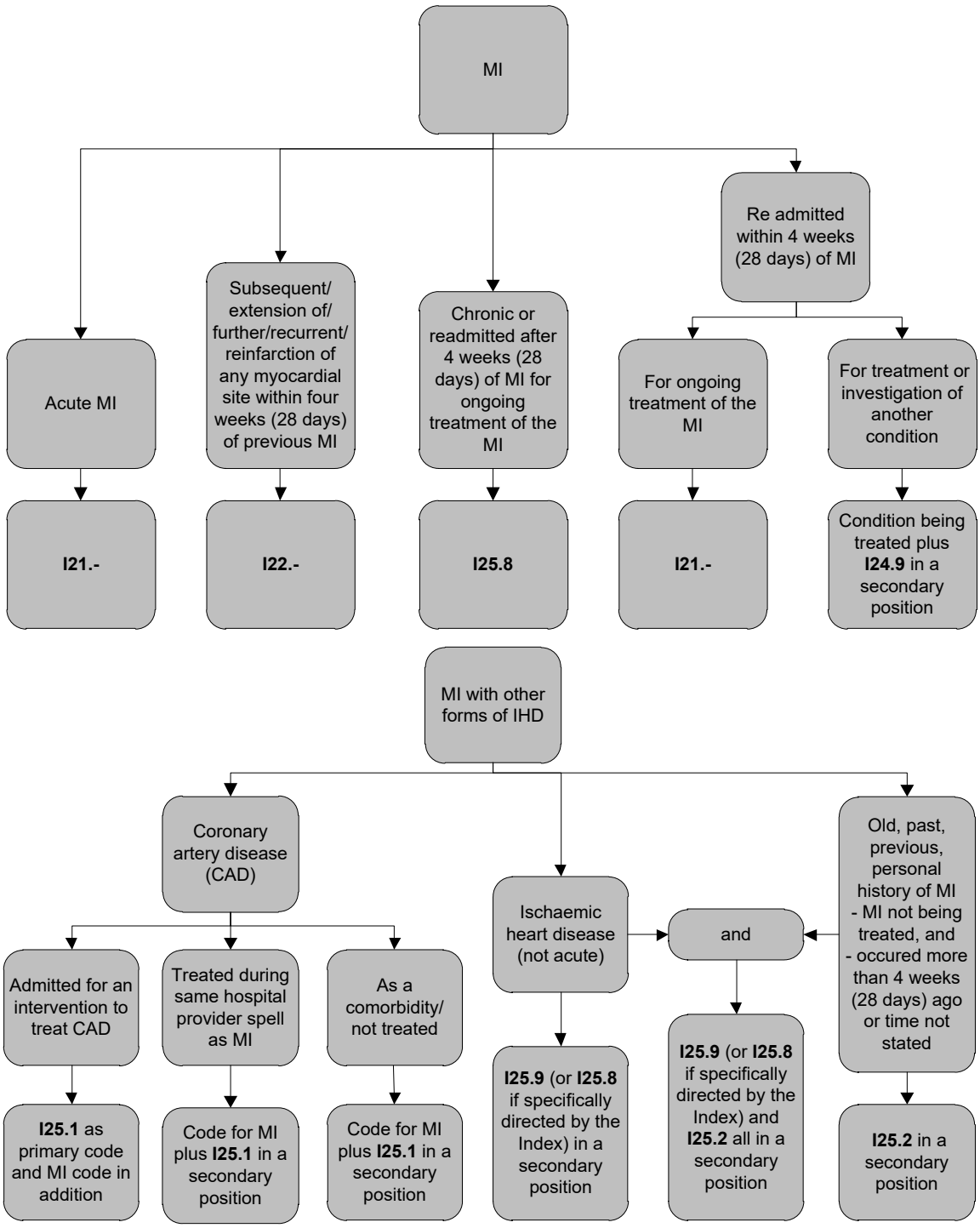
Patient admitted for endoscopy due to an oesophageal ulcer. Patient has ischaemic heart disease and had an MI 3 years ago.

K22.1 Ulcer of oesophagus
I25.9 Chronic ischaemic heart disease, unspecified
I25.2 Old myocardial infarction

Patient admitted with an acute myocardial infarction. This is their second MI. Their first MI occurred 6 months ago. They also have coronary arteriosclerosis, angina and ischaemic heart disease.

I21.9 Acute myocardial infarction, unspecified
I25.1 Atherosclerotic heart disease
I20.9 Angina pectoris, unspecified
I25.9 Chronic ischaemic heart disease, unspecified
I25.2 Old myocardial infarction

DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease



See:

- ***DCS.IX.4: Myocardial infarction (I21, I22, I25.8)***
- ***DCS.IX.5: Coronary artery disease interventions and acute myocardial infarction***
- ***DCS.IX.7: Chronic ischaemic heart disease (I25).***

DCS.IX.8: Cardiac arrest (I46)

Code **I46.0 Cardiac arrest with successful resuscitation** must always be assigned when a cardiac arrest with successful resuscitation has occurred; this includes patients who are admitted to hospital following a cardiac arrest outside of the hospital. As any patient who survives a cardiac arrest will have received resuscitation, all patients who live through a cardiac arrest must be coded to **I46.0**.

If the underlying cause of the arrest is documented in the patient's medical record then this must be sequenced before code **I46.0**.

A sudden cardiac death, *specifically described as such* by the responsible consultant, must be coded to **I46.1 Sudden cardiac death, so described**. This is with the exception of sudden cardiac death due to conditions specifically listed as exclusions at this code, i.e. myocardial infarction and conduction disorders. In these cases, the code **I46.1** is not necessary.

Cardiac arrest without successful resuscitation (and thus fatal) and not described as 'sudden cardiac death' must be coded to **I46.9 Cardiac arrest, unspecified**.

DCS.IX.10: Heart failure (I50)

If both congestive cardiac failure (CCF) (**I50.0**) and left ventricular failure (LVF) (**I50.1**) are documented in the medical record only assign code **I50.0 Congestive heart failure** as this code includes both right and left ventricular failure.

If a diagnosis of LVF is made together with mention of pulmonary oedema, only assign code **I50.1** as this code includes pulmonary oedema.

If pulmonary oedema is mentioned in the medical record with a condition classified to a code from one of the following categories, assign code **I50.1** (instead of **J81.X Pulmonary oedema**) and the code from the category that classifies the specific heart condition:

- acute rheumatic fever (**I00-I01**),
- chronic rheumatic heart disease (**I05-I09**)
- hypertensive disease (**I10-I15, with the exception of I11.0 and I13.-**)
- ischaemic heart disease (**I20-I25**)
- endocarditis (**I33**)
- mitral valve disease (**I34**)
- aortic valve disease (**I35**)
- endocarditis (**I38-I39**)

- myocarditis (**I40-I41**)
- cardiomyopathy (**I42-I43**)
- arrhythmias (**I44-I49**)
- other heart conditions (**I51-I52**).

If pulmonary oedema is mentioned in the medical record with hypertensive heart disease with (congestive) heart failure (**I11.0**) or a condition classified to a code from category **I13.- Hypertensive heart and renal disease** only assign **I11.0** or **I13.-**, ***see also DCS.IX.2: Renal disease and heart disease due to hypertension (I11, I12, I13).***

If pulmonary oedema is mentioned in the medical record with a condition classified to a code from one of the following categories, assign code **J81.X Pulmonary oedema** and the code from the category that classifies the specific heart condition:

- rheumatic chorea (**I02**)
- pulmonary heart disease (**I26-I28**)
- pericarditis (**I30-I32**)
- tricuspid valve disorders (**I36**)
- pulmonary valve disorders (**I37**).

See also DCS.IV.1: Diabetes mellitus (E10–E14) - Myocardial infarction, cardiac failure or angina due to diabetes.

Examples:

Patient has left ventricular failure with pulmonary oedema

I50.1 Left ventricular failure

Patient has atrial fibrillation (an arrhythmia) with pulmonary oedema.

I48.9 Atrial fibrillation and atrial flutter, unspecified
I50.1 Left ventricular failure

Hypertensive heart failure and renal disease with pulmonary oedema

I13.0 Hypertensive heart and renal disease with (congestive) heart failure

Patient with acute pericarditis and pulmonary oedema

I30.9 Acute pericarditis, unspecified
J81.X Pulmonary oedema

DCS.IX.11: Stroke, not specified as haemorrhage or infarction (I64.X) and lacunar infarction (I63.5)

Strokes must be classified by type, i.e. haemorrhagic or infarction (ischaemic), when known.

The code **I64.X Stroke, not specified as haemorrhage or infarction** does not indicate the type of stroke. The coder must always endeavour to obtain the results of a CT scan report of the brain (or similar report) which should confirm the type of stroke. Whilst coders **must not** attempt to interpret data from a report to make a diagnosis themselves, the CT report may document a definitive diagnosis to enable the assignment of a more accurate code.

Where there is a documented diagnosis of cerebrovascular accident (CVA) or stroke and this is confirmed by the responsible consultant to be due to a thrombosis or embolism, this must be coded to category **I63 Cerebral infarction**.

A documented diagnosis of lacunar infarction must be coded to **I63.5 Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries**.

See also:

- ***DGCS.4: Using diagnostic test results***
- ***DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia.***

Cerebral infarction or ischaemia is caused by inadequate blood supply to an area of the brain due to a blockage of blood vessels leading to that area.

Lacunar infarctions are small infarctions resulting from non thrombotic obstruction of small, deep cerebral arteries, and are a well known cause of ischaemic stroke.

Example:

Acute cerebrovascular accident. CT scan of brain documents a confirmed diagnosis of an acute cerebral thrombosis

I63.3 Cerebral infarction due to thrombosis of cerebral arteries

DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia

On emergency admissions for strokes, the code for stroke must be assigned in the primary position.

As indicated by the note at category **G81**; Hemiplegia, when due to a stroke that is currently being treated, must be coded in a secondary position to the stroke.

Symptoms of stroke such as dysphagia and dysphasia that are classified in Chapter XVIII must only be coded when they have been treated as a problem in their own right. They must be sequenced in a secondary position in line with ***DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings***.

See also DCS.IX.11: Stroke, not specified as haemorrhage or infarction (I64.X) and lacunar infarction (I63.5).

On further admissions following treatment of the stroke if the hemiplegia is still present it will be appropriate to record the hemiplegia as a sequela (late effect) of a stroke, ***see DGCS.8: Sequelae or late effect.***

Other conditions occurring as a result of a stroke, such as dysphagia and dysphasia, must be treated in the same way.

Example:

Left hemiplegia on admission. CT scan reveals a cerebral infarction (verified by the responsible consultant)

I63.9 Cerebral infarction, unspecified
G81.9 Hemiplegia, unspecified

Percutaneous endoscopic gastrostomy insertion for dysphagia in patient with cerebral lobe haemorrhage.

I61.1 Intracerebral haemorrhage in hemisphere, cortical
R13.X Dysphagia

DCS.IX.13: Cerebral atherosclerosis (I67.2)

Code **I67.2 Cerebral atherosclerosis** must also be assigned when this condition co-exists with any condition in categories **I63.- Cerebral infarction** or **I66.- Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction.**

DCS.IX.14: Atherosclerosis (I70)

Fifth character subdivisions are for use with this category to indicate the absence (**0**) or presence (**1**) of gangrene associated with the sites mentioned at fourth character level. Where there is no information available within the medical record the coder must use the default '**0**' to indicate without gangrene.

Code **I70.8 Atherosclerosis of other arteries** must be assigned to classify atherosclerosis of iliac artery.

See also DConvention.7: Fifth characters.

The iliac arteries are situated within the pelvic region and are therefore not considered arteries of the extremities.

Example:

Atherosclerosis with gangrene of extremities caused by diabetes (Type 2).

E11.5 Type 2 diabetes mellitus, with peripheral circulatory complications
I70.21 Atherosclerosis of arteries of extremities, with gangrene

See also DCS.IV.1: Diabetes mellitus (E10–E14).

DCS.IX.15: Peripheral vascular diseases (I73.9)

If a patient is admitted for an arteriogram, the diagnosis confirmed on the arteriogram report and verified by the responsible consultant must be coded in preference to category **I73.9 Peripheral vascular diseases, unspecified**, i.e. code to the cause of the PVD if known. **I73.9** must only be assigned if the cause is unknown.

Peripheral vascular disease (PVD) can also be referred to as intermittent claudication or ischaemia of lower limbs. These are symptoms of atheroma (cholesterol) or arteriosclerosis (hardening of the arteries).

Example:

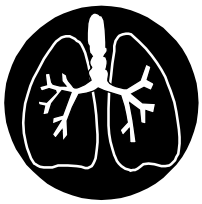
Patient admitted for arteriogram to investigate PVD. Arteriogram reveals occlusion of the femoral artery due to embolism which was confirmed by the responsible consultant.

I74.3 Embolism and thrombosis of arteries of lower extremities

Deep vein thrombosis due to travel or hospital acquired

See:

- ***DCS.XX.3: Conditions linked to travel (X51.9)***
- ***DCS.XX.10: Hospital acquired conditions (Y95.X).***



CHAPTER X DISEASES OF THE RESPIRATORY SYSTEM
(J00–J99)

Coding standards and guidance

DCS.X.1: Recurrent tonsillitis (J03)

Recurrent tonsillitis must be coded using **J03.9 Acute tonsillitis, unspecified**, in the absence of information on the specific form of tonsillitis.

Acute tonsillitis is inflammation of the tonsillar tissue, which may be viral or bacterial induced. Recurrent tonsillitis refers to multiple distinct episodes of acute tonsillitis.

DCS.X.2: Wheeze due to viral infection (B34.9 and R06.2)

A wheeze that is either induced, caused by, or due to a viral infection must be coded using the following codes and sequencing:

B34.9 Viral infection, unspecified
R06.2 Wheezing

Examples of clinical terms that indicate a wheeze due to viral infection are viral wheeze, viral-induced wheeze, viral-associated wheeze or viral illness with wheeze.

DCS.X.3: Postprocedural pneumonia

Postprocedural pneumonia must be coded using the body system chapter code that classifies the type of pneumonia followed by a code from category **Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure**

The index trail **'Pneumonia -** resulting from a procedure (J95.8)' must not be used.

See also DCS.XIX.7: Postprocedural complications of medical and surgical care.

DCS.X.4: Influenza A/H1N1 [swine flu] (J10)

Influenza A/H1N1 (also known as swine flu) must be coded to category **J10.- Influenza due to identified seasonal influenza virus.** Fourth character assignment is dependent on whether there are any documented manifestations.

Swine flu, with no documented manifestations, must be coded to **J10.1 Influenza with other respiratory manifestations, seasonal influenza virus identified.**

Influenza A/H1N1 was named 'swine flu' because it closely resembled the influenza virus that affects pigs. H1N1 was responsible for the flu pandemic in 2009-10, but now circulates worldwide as a seasonal flu virus.

The term 'Chest infection' is a non-specific diagnosis; this can be written as a proxy for a more definitive respiratory diagnosis such as pneumonia or bronchiectasis. If a more definitive diagnosis is made (e.g. pneumonia), this should be coded instead of the chest infection. Any uncertainty must be referred back to the responsible consultant.

DCS.X.5: COAD/COPD, chest infection and asthma with associated conditions

The following codes must be assigned for the following diagnoses when recorded in the patient's medical record.

Diagnosis	Code(s)
COAD/COPD with asthma	**J44.-**
COAD/COPD with chest infection	**J44.0**
COAD/COPD with bronchitis and chest infection	**J44.0**
COAD/COPD with acute asthma	**J45.9** or **J46.X** and **J44.9**
COAD/COPD with emphysema	**J43.9**
COAD/COPD with pneumonia, unspecified	**J18.9** and **J44.0** If the specific type of pneumonia is known then the appropriate code from categories

	J12.- to **J18.-** must be selected in preference to **J18.9.**
COPD with haemophilus influenzae present in sputum	**J44.0** and **B96.3**
Chest infection with bronchitis	**J40.X** or **J20.9**
Chest infection, COPD and emphysema	**J44.0** and **J43.9**
Chest infection with lower lobar consolidation	**J18.1**
Chronic obstructive bronchitis with acute exacerbation	**J44.1**
URTI with COPD	**J44.1** and **J06.9**
Infective exacerbation of asthma	**J45.9** or **J46.X** and **J22.X**
Infective exacerbation of asthma, patient known COPD	**J45.9**, **J22.X** and **J44.9** or **J46.X**, **J22.X** and **J44.9**

See also DCS.IV.6: Cystic fibrosis with manifestations (E84).

DCS.X.6: Status asthmaticus (J46.X)

J46.X Status asthmaticus must only be assigned when the responsible consultant has documented a diagnosis of:

- Acute severe asthma

  or
- Status asthmaticus

If the term ‘acute asthma’, is documented without mention of ‘severe’ clarification must be sought from the responsible consultant to ensure that the correct diagnosis is coded.

Pulmonary oedema with heart failure (I50)

See DCS.IX.10: Heart failure (I50).

DCS.X.7: Respiratory failure, not elsewhere classified (J96)

Respiratory failure must always be coded when the diagnosis is recorded in the medical record. When documented with another respiratory condition, the sequencing will be dependent on the main condition being treated.

The fifth character subdivisions used with this category indicate the type of failure and must always be assigned whether the type has been specified (**0, 1**) or not (**9**).

See also DConvention 7: Fifth characters.

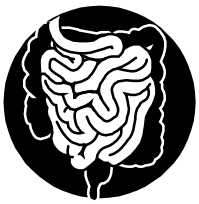
Vaping related disorder (U07.0)

See DCS.XXII.4: Vaping related disorder (U07.0).

COVID-19 (U07.1 – U07.7)

See:

- ***DCS.XXII.6: Confirmed COVID-19 (U07.1)***
- ***DCS.XXII.7: Suspected and clinically or epidemiologically diagnosed COVID-19 (U07.2)***
- ***DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)***
- ***DCS.XXII.9: History of COVID-19 (U07.3)***
- ***DCS.XXII.10: Post COVID-19 condition (U07.4)***
- ***DCS.XXII.11: Multisystem inflammatory syndrome associated with COVID-19 (U07.5)***
- ***DCS.XXII.12: COVID-19 vaccination (U07.6 and U07.7)***
- ***DCS.XXII.13: COVID-19 in Pregnancy, childbirth and the puerperium***



CHAPTER XI DISEASES OF THE DIGESTIVE SYSTEM (K00–K93)

Chapter standards and guidance

DChS.XI.1: Constipation in Ileus or intestinal obstruction

Constipation is an integral part of a diagnosis of ileus and bowel obstruction and must not be coded in addition.

Example:

Patient with constipation due to umbilical hernia with obstruction.

K42.0 Umbilical hernia with obstruction, without gangrene

Coding standards and guidance

DCS.XI.1: Oesophageal web (K22.2, Q39.4)

The ICD-10 Alphabetical Index assumes that an oesophageal web is a congenital condition and classifies this to **Q39.4 Oesophageal web**. However, an oesophageal web can be either congenital or acquired, with acquired being more common.

The following must be applied when coding oesophageal web:

- A documented diagnosis of congenital oesophageal web must be classified to **Q39.4 Oesophageal web**.
- A documented diagnosis of acquired oesophageal web must be classified to **K22.2 Oesophageal obstruction**.
- An unspecified oesophageal web (i.e. not documented as congenital or acquired) must be classified to **K22.2 Oesophageal obstruction**.

DCS.XI.2: Barrett oesophagus with low or high grade dysplasia (K22.7)

Barrett oesophagus has the potential to lead to cancer. Terms such as ‘low grade dysplasia’ and ‘high grade dysplasia’ are used to describe pre-cancerous forms. The

correct code for Barrett oesophagus either with or without low or high grade dysplasia is **K22.7 Barrett oesophagus**.

DCS.XI.3: Peptic ulcer, site unspecified (K27)

Peptic ulcers must only be classified to category **K27.- Peptic ulcer**, when information about the site of the peptic ulcer is not available. When the site of the peptic ulcer is documented, this must be coded to an ulcer of the stated site.

Example:

Bleeding peptic ulcer. Medical record confirms the site of ulcer as stomach.

K25.4 Gastric ulcer, chronic or unspecified with haemorrhage

Check endoscopies

See DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)

DCS.XI.4: Gastritis and duodenitis (K29)

Code **K29.9 Gastroduodenitis, unspecified** must only be assigned if the patient has both **K29.7 Gastritis, unspecified** and **K29.8 Duodenitis**. If a specific type of gastritis is documented, then the code for the specific type must be assigned together with **K29.8 Duodenitis**.

The following codes must be assigned for *Helicobacter pylori* associated gastritis:

K29.6 Other gastritis (if a specific type is stated use a different code from **K29.-**)
B98.0 *Helicobacter pylori [H. pylori]* as the cause of diseases classified to other chapters.

See also:

- ***DGCS.6: Infections***
- ***DCS.I.4: Bacterial, viral and other infectious agents (B95-B98).***

Gastritis is a normal manifestation of *Helicobacter pylori* infection.

Example:

Chronic atrophic gastritis due to Helicobacter pylori infection

K29.4 Chronic atrophic gastritis
B98.0 *Helicobacter pylori [H. pylori]* as the cause of diseases classified to other chapters

Helicobacter pylori intestinal infection that is not the cause of a disease classifiable to another chapter (A04.8)

See DCS.I.1: Helicobacter pylori intestinal infection that is not the cause of a disease classifiable to another chapter (A04.8)

A 'presumed' diagnosis of appendicitis or acute appendicitis is quite often recorded in the medical record, but sometimes when an appendix is removed the histology result will state 'normal appendix'. In these cases, because a definitive diagnosis has not been made, the coder should clarify the diagnosis with the responsible consultant. If the appendix is confirmed to be normal the presenting symptoms would be coded. Usually this will be acute abdominal pain.

See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

When coding diseases of the appendix the method of admission should not be taken into account when deciding on the correct ICD-10 code. For instance, a patient can be admitted as an emergency and then be kept on the ward to see if the suspected appendicitis settles down. The patient may then have an interval appendicectomy or a planned delayed appendicectomy.

DCS.XI.5: Parastomal hernia (K43.3-K43.5 and Z93)

A code from category **Z93.- Artificial opening status** must be assigned in addition to a code from **K43.3-K43.5** to identify the type of stoma.

DCS.XI.6: Indeterminate colitis (K52.3)

Code **K52.3 Indeterminate colitis** must only be assigned when so stated by the responsible consultant.

The most common disease that mimics the symptoms of ulcerative colitis is Crohn's disease, as both are inflammatory bowel diseases that can affect the colon with similar symptoms.

It is important to differentiate between these diseases, since the course of the diseases and treatments may be different in some cases. However, it may not be possible for the responsible consultant to tell the difference, in which case the disease is described by the responsible consultant as indeterminate colitis (**K52.3**).

Where the non-specific diagnosis of inflammatory bowel disease (IBD) is used, the coder should clarify a more specific diagnosis with the responsible consultant.

DCS.XI.7: Rectal haemorrhage and per rectal haemorrhage (K62.5 and K92.2)

In classification terms there is a difference between a ‘rectal haemorrhage’ and a ‘per rectal haemorrhage’.

Code **K62.5 Haemorrhage of anus and rectum** must only be assigned for an actual haemorrhage of the anus and/or rectum. It must not be assigned for haemorrhage that has occurred from elsewhere in the gastrointestinal tract that is merely exiting via the rectum, ie **per** rectal haemorrhage.

Code **K92.2 Gastrointestinal haemorrhage, unspecified** must be assigned for a haemorrhage that occurred via the rectum but is not specified as being from the actual rectum or anus. This code must not be assigned when it is a symptom of a specific disease which has been diagnosed, ***see DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2).***

DCS.XI.10: Haemorrhoids and perianal venous thrombosis (K64)

When more than one degree, stage or grade of haemorrhoid is documented in the medical record, only the code for the highest degree, stage or grade must be assigned.

Where patients have a condition classified to codes **K64.0-K64.3** and also a condition classified to codes **K64.4 Residual haemorrhoidal skin tags** or **K64.5 Perianal venous thrombosis** a code for both conditions must be assigned.

Example:

Patient with second and third degree haemorrhoids and perianal haematoma

K64.2 Third degree haemorrhoids
K64.5 Perianal venous thrombosis

DCS.XI.8: Alcoholic liver disease and alcoholic pancreatitis (K70, K85.2 and K86.0)

It must be stated that hepatitis or pancreatitis is due to alcohol use in order to assign codes in category **K70.- Alcoholic liver disease** and codes **K85.2 Alcohol-induced acute pancreatitis** or **K86.0 Alcohol-induced chronic pancreatitis.** If a patient has liver disease or pancreatitis not specified to be due to an infectious organism and the patient is also alcoholic it must not be assumed that the liver disease or pancreatitis is due to the alcoholism.

Alcoholic liver disease or alcoholic pancreatitis due to current misuse of, or dependence on, alcohol must be coded using the following codes and sequencing:

K70.- **Alcoholic liver disease, K85.2 Alcohol-induced acute pancreatitis** or **K86.0 Alcohol-induced chronic pancreatitis**
F10.- **Mental and behavioural disorders due to use of alcohol** (fourth character assignment is dependent upon whether or not the responsible consultant has stated that the alcoholic liver disease is due to harmful use of alcohol (**F10.1**) or dependence (**F10.2**)).

Alcoholic liver disease or alcoholic pancreatitis due to previous alcohol abuse must be coded using the following codes and sequencing:

K70.- **Alcoholic liver disease, K85.2 Alcohol-induced acute pancreatitis** or **K86.0 Alcohol-induced chronic pancreatitis**
Z86.4 **Personal history of psychoactive substance abuse**

Where the responsible consultant has given no information regarding current or past alcohol use/abuse and only states a type of alcoholic liver disease or alcohol induced pancreatitis, only assign a code from category **K70.-**, or codes **K85.2** or **K86.0.**

See also DGCS.9: Acute on chronic conditions.

Codes in category **K70.-** and codes **K85.2** and **K86.0** do not imply that the patient is a current alcoholic but that the liver disease or pancreatitis is due to the use of alcohol.

If a patient has liver disease or pancreatitis and they are also alcoholic and it is not clear if the liver disease or pancreatitis is due to the alcoholism clarification should be obtained from the responsible consultant.

Examples:

Acute hepatitis due to chronic alcoholism

K70.1 Alcoholic hepatitis
F10.2 Mental and behavioural disorders due to use of alcohol, Dependence syndrome

Alcoholic admitted with acute on chronic pancreatitis

K85.9 Acute pancreatitis, unspecified
K86.1 Other chronic pancreatitis
F10.2 Mental and behavioural disorders due to use of alcohol, Dependence syndrome

DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2)

When **K92.0 Haematemesis**, **K92.1 Melaena** or **K92.2 Gastrointestinal haemorrhage, unspecified** are symptoms of a specific disease which has been diagnosed, such as a malignant neoplasm or bleeding peptic ulcer, these codes must not be assigned in addition, unless they have been treated in their own right.

See also:

- ***DCS.XI.7: Rectal haemorrhage and per rectal haemorrhage (K62.5 and K92.2)***
- ***DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.***

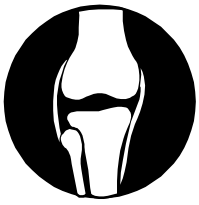
CHAPTER XII DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE
(L00–L99)

Chapter standards and guidance

Infections
See DGCS.6: Infections

Coding standards and guidance

DCS.XII.3 Pressure ulcer and leg ulcer with associated infection, cellulitis and gangrene
If the responsible consultant has not documented the stage/grade of the pressure ulcer or the pressure ulcer is documented as 'unstageable', code **L89.9 Decubitus ulcer and pressure area, unspecified** must be assigned. Pressure ulcer or leg ulcer with associated infection (infected leg ulcer/infected pressure ulcer) must be coded using the following codes and sequencing: **L89.- Decubitus ulcer and pressure area** (fourth character will depend on the stage/grade documented) OR **L97.X Ulcer of lower limb, not elsewhere classified** **L08.9 Local infection of skin and subcutaneous tissue, unspecified** **B95-B98 Bacterial, viral and other infectious agents** if the infective agent is identified. If the infection spreads to another organ or body system (e.g. osteomyelitis or generalised sepsis) the subsequent infection must be coded in addition. In such instances, the sequencing of the codes will depend on the main condition treated. ***See also DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis*** When cellulitis is documented with pressure ulcer or leg ulcer, both conditions must be coded. Sequencing will depend on the main condition treated. ***See also DGCS.1: Primary diagnosis.*** When associated gangrene is present with pressure ulcer or leg ulcer, code **R02.X Gangrene, not elsewhere classified** must be assigned in a secondary position in addition to the ulcer code. ***See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings***



CHAPTER XIII DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE
(M00–M99)

Chapter standards and guidance

DChS.XIII.1: Fifth characters in Chapter XIII

The fifth characters in Chapter XIII indicate the site of musculoskeletal involvement. The notes at chapter, category or code level indicate which codes can be further specified by the addition of a fifth character and the location of the fifth character code lists in the classification.

The following must be applied when assigning fifth characters in Chapter XIII:

- Fifth characters must be used where the data is present in the medical record and where doing so adds more specific information about the site.
- In cases where the four character code is already site specific and the addition of a fifth character will not add further specific information about the site, the fifth character is not required.
- The fifth character of '**0**' indicates involvement of multiple sites. It should be assigned when the condition classified at the fourth character code affects more than one site. The **.0** must not be assigned for conditions only affecting bilateral sites; in these instances, the fifth character reflecting that site must be recorded.
- The **'X'** filler code must be assigned in the fourth character position for three character codes which require assignment of a fifth character, for example **M45.X6**.

See also:

- ***DRule.2: Category and code structure***
- ***DConvention.7: Fifth characters.***

The main subclassification of fifth characters is listed before the block on Arthropathies (**M00-M25**) in ICD-10 Volume 1. Other subclassifications appear at:

- **M23.- Internal derangement of knee**
- **M40-M54 Dorsopathies**
- **M99.- Biomechanical lesions, not elsewhere classified**.

The following are examples of codes which would never require the addition of a fifth character because they are site specific. The addition of a fifth character would not add further specific information about the site (this is not an exhaustive list):

- **M76.0 Gluteal tendinitis**
- **M76.3 Iliotibial band syndrome**
- **M76.6 Achilles tendinitis**.

Examples:

Idiopathic gout in left knee

M10.06 Idiopathic gout, lower leg

Pseudosarcomatous fibromatosis. No further information is given.

M72.4 Pseudosarcomatous fibromatosis

Paget disease of skull

M88.0 Paget disease of skull

Paget disease of femur

M88.85 Paget disease of other bones, pelvic region and thigh

Thoracogenic scoliosis

M41.3 Thoracogenic scoliosis

Cervicalgia of cervicothoracic spine

M54.23 Cervicalgia, cervicothoracic region

Rheumatoid arthritis of knees, hands and feet. Admission for total knee replacement.

M06.90 Rheumatoid arthritis, unspecified, multiple sites

Bilateral rheumatoid arthritis of joints of fingers

M06.94 Rheumatoid arthritis, unspecified, fingers

Rheumatoid arthritis of hands, knees and lumbar region of the spine

M06.90 Rheumatoid arthritis, unspecified, multiple sites
M45.X6 Ankylosing spondylitis, lumbar region

DChS.XIII.2: Chronic versus current injuries of the musculoskeletal system and connective tissue

Old or recurrent injuries of the musculoskeletal system and connective tissue must be assigned a code from Chapter XIII Diseases of the musculoskeletal system and connective tissue.

Current injuries of the musculoskeletal system and connective tissue must be coded to Chapter XIX Injury, poisoning and certain other consequences of external causes unless directed elsewhere by the Alphabetical Index or Tabular List (e.g. ***DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*)***)

If there is any doubt as to whether an injury is current or chronic/old/recurrent then confirmation must be sought from the responsible consultant.

- A joint injury where the inflammation has resolved, but then inflammation recurs is an chronic/old/recurrent injury
- Dislocations described as chronic, non-traumatic or recurrent must be coded to Chapter XIII Diseases of the musculoskeletal system and connective tissue.
- A joint injury that continues to be inflamed is still a current injury.
- A residual effect of a joint injury, such as fibrosis, indicates inappropriate healing and is considered to be a sequelae and not part of a current injury, ***see also DGCS.8: Sequelae or late effects***.

Examples:

Recurrent dislocation of the elbow joint

M24.42 Recurrent dislocation and subluxation of joint, upper arm

Stress fracture of lumbar vertebra

M48.46 Fatigue fracture of vertebra, lumbar region

Coding standards and guidance

DCS.XIII.1: Juvenile arthritis (M08)

Codes in category **M08.-** must only be assigned where juvenile arthritis is documented in the medical record. The information in the inclusion note at category **M08.- Juvenile arthritis** must not be used by the coder to make this diagnosis.

Gouty nephropathy (M10.0†, N16.8*)

See DCS.XIV.1: Gouty nephropathy (M10.0†, N16.8*).

DCS.XIII.2: Arthrosis (M15-M19)

Terms such as 'primary, 'secondary' and 'post-traumatic' are used within the descriptions of four character codes in categories **M15-M19 Arthrosis** to describe specific forms of arthrosis of these sites. Within the ICD-10 classification these terms are essential modifiers which **must** be present in the clinical statement in order for the code for the specific type of arthrosis to be assigned. Where these modifiers are not included in the diagnostic statement, the default fourth character code **.9 unspecified** from the relevant category must be assigned.

Category **M15.- Polyarthrosis** must be used for arthrosis/osteoarthritis with mention of more than one site. As indicated at the excludes note at categories **M15-M19**, osteoarthritis of the spine is excluded from this code range (**M47.- Spondylosis**)

Category **M15.-** must not be used to code bilateral involvement of a single joint; this must be coded to categories **M16–M19**.

Category **M19.- Other arthrosis** must be used to code osteoarthritis in any site other than hip (**M16.- Coxarthrosis [arthrosis of hip]**), knee (**M17.- Gonarthrosis [arthrosis of knee]**), first carpometacarpal joint (**M18.- Arthrosis of first carpometacarpal joint**), or spine (**M47.- Spondylosis**).

It is not the responsibility of the clinical coding professional to make a clinical judgement on the type of arthrosis a patient has. The type of arthrosis is a clinical decision, and therefore the relevant information, or confirmation as to whether the condition can be described as, for example 'primary' or 'post-traumatic', must be documented in the patient's medical record by the responsible consultant.

Examples:

Osteoarthritis (OA) left hip

M16.9 Coxarthrosis, unspecified

Secondary osteoarthritis (OA) right knee due to osteochondritis dissecans

M17.5 Other secondary gonarthrosis
M93.2 Osteochondritis dissecans

Post-traumatic OA left hip due to fracture neck of femur three years ago

M16.5 Other post-traumatic coxarthrosis
T93.1 Sequelae of fracture of femur

See also DGCS.8: Sequelae or late effects.

Osteoarthritis of both the hip and knee

M15.9 Polyarthrosis, unspecified

Osteoarthritis of both knees

M17.9 Gonarthrosis, unspecified

Myelopathy is a term used within ICD-10 to indicate that the stated diagnosis is affecting the spinal cord. Myelopathy is not routinely used within the medical record, therefore where a disorder is stated to be affecting the spinal cord the coder should index the disorder and use the essential modifier 'with myelopathy' in order to assign an accurate code.

Displacement of an intervertebral disc is a disorder which often produces myelopathy.

Example:

Intervertebral disc displacement L3-4, with spinal cord compression

M51.0† Lumbar and other intervertebral disc disorders with myelopathy (G99.2*)
G99.2* Myelopathy in diseases classified elsewhere
Myelopathy in:
- intervertebral disc disorders (M50.0†, M51.0†)

M54.5 Low back pain includes loin pain. This code must be used with caution if stated in specialties such as Renal Medicine or Urology, where it could indicate conditions such as renal colic. Coders should clarify with the responsible consultant before assigning this code to a patient admitted to a non-musculoskeletal specialty.

DCS.XIII.3: Rhabdomyolysis (M62.8, T79.5)

Rhabdomyolysis may result in kidney damage such as acute renal failure (acute kidney injury). Any kidney damage due to non-traumatic rhabdomyolysis must be coded in addition to **M62.8 Other specified disorders of muscle**. Renal failure due to traumatic rhabdomyolysis must be coded to **T79.5 Traumatic anuria** alone.

See also:

- ***Chapter XIV for Acute kidney injury (AKI) guidance***
- ***DCS.XIV.2: Chronic kidney disease, CKD (N18).***

M70.- Soft tissue disorders related to use, overuse and pressure covers soft tissue disorders related to use, overuse and pressure, which are more commonly referred to as repetitive strain injuries (RSI).

Code **Z56.6 Other physical and mental strain related to work** would be added if these conditions are confirmed to be work-related.

DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*)

In order to assign a code for pathological fracture in osteoporosis (**M80.- Osteoporosis with pathological fracture**) or pathological fracture resulting from neoplastic disease (**C00-D48† Neoplasms** and **M90.7* Fracture of bone in neoplastic disease** or **M49.5* Collapsed vertebra in diseases classified elsewhere**) it must be documented in the medical record that the fracture was **due to** the osteoporosis or neoplasm.

If a patient with osteoporosis or neoplastic disease has a fall resulting in a fracture and the fracture is not stated to be due to osteoporosis or neoplastic disease the fracture must be classified as a traumatic fracture with osteoporosis or neoplastic disease coded in addition.

See also:

- ***DGCS.5: Dagger and asterisk system***
- ***DCS.II.1: Primary and secondary malignant neoplasms (C00-C97) - Sequencing of malignant neoplasms.***

A pathological fracture is a fracture that occurs without significant external violence at a bone site weakened by pre-existing diseases such as tumours, osteomalacia, or osteoporosis.

Examples:

Patient admitted with a pathological fracture of the forearm due to osteoporosis

M80.93 Unspecified osteoporosis with pathological fracture, forearm

Patient admitted with fracture neck of femur after falling at home. Known osteoporosis

S72.00 Fracture of neck of femur, closed
W19.0 Unspecified fall, home
M81.9 Osteoporosis, unspecified

See also DChS.XX.1: External causes.

Patient treated on the orthopaedic ward for a pathological fracture of the neck of femur due to osteosarcoma femur

M90.75* Fracture of bone in neoplastic disease (C00-D48†), pelvic region and thigh
C40.2† Malignant neoplasm: Long bones of lower limb

DCS.XIII.5: Periprosthetic and peri-implant fractures (M96.6)

A documented diagnosis of *'periprosthetic/peri-implant fracture'* without an identified cause must be coded as follows:

M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate

A documented diagnosis of *'traumatic periprosthetic/peri-implant fracture'* must be coded as follows:

M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate
Chapter XX External causes of morbidity and mortality code

Intraoperative fractures (including intraoperative periprosthetic/peri-implant fractures) occurring during the insertion, removal or revision of a prosthesis must be coded as follows:

Chapter XIX Injury, poisoning and certain other consequences of external causes (S00-T98) code that classifies the fractured bone
Chapter XX External causes of morbidity and mortality code

See also:

- ***DChS.XX.1: External causes***
- ***DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)***

Examples:

Patient had left total hip replacement six years ago and is now complaining of pain and swelling around left hip area. Patient denied sustaining any trauma. Peri-prosthetic fracture diagnosed following investigations

M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate

Peri-prosthetic fracture left femur. Fracture sustained when patient fell from their bed in a nursing home

M96.6 Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate
W06.1 Fall involving bed, residential institution

Fracture of shaft of right femur during total uncemented hip replacement, responsible consultant confirms this is due to incorrect sized prosthesis

S72.30 Fracture of shaft of femur, closed
Y65.8 Other specified misadventures during surgical and medical care

CHAPTER XIV DISEASES OF THE GENITOURINARY SYSTEM
(N00–N99)

Coding standards and guidance

Renal disease due to hypertension (N00-N07, N18, N19 or N26)

See DCS.IX.2: Renal disease and heart disease due to hypertension (I11, I12, I13).

Rhabdomyolysis (M62.8, T79.5)

See DCS.XIII.3: Rhabdomyolysis (M62.8, T79.5)

DCS.XIV.1: Gouty nephropathy (M10.0†, N16.8*)

Gout that is causing nephropathy must be coded as follows:

M10.0† Idiopathic gout (5th character to specify site)
N16.8* Renal tubulo-interstitial disorders in other diseases classified elsewhere

See also:

- ***DGCS.5: Dagger and asterisk system***
- ***DChS.XIII.1: Fifth characters in Chapter XIII.***

Example(s):

Gouty nephropathy with idiopathic gout in left foot

M10.07† Idiopathic gout, Ankle and foot
N16.8* Renal tubulo-interstitial disorders in other diseases classified elsewhere

Acute Kidney Injury (AKI) is the preferred term used to describe Acute Renal Failure (ARF). When the term ‘Acute Kidney Injury’ is index trailed in ICD-10 the coder is directed to a traumatic injury code. However, in the majority of instances, the responsible consultant documenting the condition of AKI is referring to the non-traumatic condition of acute renal

failure. When AKI is documented in a patient's medical record, and it is not clear whether this is referring to a traumatic injury or acute renal failure, the coder should confirm the diagnosis with the responsible consultant before code assignment is made.

DCS.XIV.2: Chronic kidney disease, CKD (N18)

The following must be applied when assigning codes from category **N18.- Chronic kidney disease**:

- Where chronic kidney disease (CKD) and the underlying cause are documented both conditions must be coded.
- The code assigned for the stage of CKD must reflect the stage documented in the medical record. The glomerular filtration rate (GFR) (e.g. 45mL/min) or the description of GFR change, (e.g. 'mild decreased GFR') must **not** be used by the coder to decide which stage of CKD the patient has.
- If a patient's kidney function improves or deteriorates during the episode and the stage of chronic kidney disease changes (e.g. from stage 1 to 2 or stage 2 to 1), the code reflecting the highest stage recorded in the medical record during the episode must be coded (i.e. stage 2).
- **N18.9** must be assigned for a diagnosis of chronic renal failure (CRF).
- When coding any condition classifiable to category **N18.- Chronic kidney disease** that is **due to** hypertension, a code from category **I12.- Hypertensive renal disease** (or category **I13.- Hypertensive heart and renal disease** if the patient also has hypertensive heart disease) must also be assigned. Sequencing is dependent on the main condition treated or investigated.
- When coding any condition classifiable to category **N18.- Chronic kidney disease** in a patient with hypertension that is **not due to** the hypertension, a code from category **I12.-** must not be assigned and the hypertension must be coded separately.
- Patients with CKD stages 1-3 (codes **N18.1** to **N18.3**) are not always considered to have renal failure. When it is documented in the medical record that the patient also has renal failure this must be coded in addition.
- Patients with CKD stages 4 and 5 and CKD with end stage renal failure (codes **N18.4** and **N18.5**) are always considered to have renal failure. Whether renal failure is documented in the medical record or not it must **not** be coded in addition; the exception is acute renal failure which must always be coded.

The following codes must be applied for the following diagnoses:

Diagnosis	ICD-10 codes

CKD stages 1-3 with unspecified renal failure.	**N18.1** or **N18.2** or **N18.3** **N19.X**
CKD stages 1-3 with acute renal failure.	**N17.-** **N18.1** or **N18.2** or **N18.3**
CKD stages 1-3 **due to** hypertension, with unspecified renal failure.	**N18.1** or **N18.2** or **N18.3** **I12.0**
Acute renal failure and CKD stages 1-3 **due to** hypertension.	**N17.-** **N18.1** or **N18.2** or **N18.3** **I12.0**
CKD stages 1-3 with unspecified renal failure. Patient has hypertension.	**N18.1** or **N18.2** or **N18.3** **N19.X** Appropriate hypertension code
Acute renal failure and CKD stages 1-3. Patient has hypertension.	**N17.-** **N18.1** or **N18.2** or **N18.3** Appropriate hypertension code
CKD stages 4 or 5 (including end stage renal failure/disease), with or without unspecified renal failure.	**N18.4** or **N18.5**
Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease).	**N17.-** **N18.4** or **N18.5**
CKD stages 4 or 5 (including end stage renal failure/disease) **due to** hypertension with or without unspecified renal failure.	**N18.4** or **N18.5** **I12.0**
Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease) due to hypertension.	**N17.-** **N18.4** or **N18.5** **I12.0**
CKD stages 4 or 5 (including end stage renal failure/disease) with or without unspecified renal failure. Patient has hypertension.	**N18.4** or **N18.5** Appropriate hypertension code

Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease). Patient has hypertension.	**N17.-** **N18.4** or **N18.5** Appropriate hypertension code

See also:

- ***DGCS.1: Primary diagnosis***
- ***DGCS.9: Acute on chronic conditions***
- ***DCS.IX.2: Renal disease and heart disease due to hypertension (I11, I12, I13)***.

Category **N18** classifies the stages of chronic kidney disease which range from stages 1 to 5. These five stages are defined by evidence of kidney damage and level of renal function as measured by glomerular filtration rate (GFR).

The responsible consultant will use modifying terms such as ‘hypertensive’ or ‘due to hypertension’ to indicate that a heart or renal disease is due to hypertension.

Renal dialysis (Z49 and Z99.2)

See DCS.XXI.8: Renal dialysis (Z49 and Z99.2).

DCS.XIV.3: Calculus at the ureteropelvic junction (N20.0)

Calculus at the ureteropelvic junction must be coded using **N20.0 Calculus of kidney.**

DCS.XIV.4: Urinary sphincter weakness incontinence (N39.3)

Urinary sphincter weakness incontinence must be coded using **N39.3 Stress incontinence**.

DCS.XIV.5: Benign prostatic hypertrophy and urethral obstruction (N40.X)

When urethral obstruction is caused by benign prostatic hypertrophy/hyperplasia (BPH), it must not be coded in addition as it is regarded as a symptom of BPH and is therefore implicit in code **N40.X Hyperplasia of prostate**.

Example:

Patient with urethral obstruction due to benign prostatic hypertrophy admitted for catheterisation to treat urinary retention

N40.X Hyperplasia of prostate
R33.X Retention of urine

DCS.XIV.6: Raised Prostate Specific Antigen [PSA] (R79.8)

In the absence of a definitive diagnosis (such as benign prostatic hypertrophy or malignant neoplasm of prostate) the appropriate code for raised/elevated PSA is **R79.8 Other specified abnormal findings of blood chemistry**.

See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

DCS.XIV.7: Intraepithelial neoplasia and dysplasia of prostate (D07.5, N42.3)

Code **D07.5 Carcinoma in situ of prostate** must be assigned for a diagnosis of high grade intraepithelial neoplasia of the prostate (HGIN) or high grade dysplasia of the prostate.

Code **N42.3 Dysplasia of prostate** must be assigned for a diagnosis of Grade I or Grade II prostatic intraepithelial neoplasia or low grade dysplasia of prostate.

DCS.XIV.8: Infertility with known cause (N46 and N97)

When a patient has infertility and the cause is known, both conditions must be coded. Sequencing will depend on the main condition treated or investigated.

See also DGCS.1: Primary diagnosis.

Examples:

Azoospermia due to bilateral undescended testes, patient admitted for orchidopexy

Q53.2 Undescended testicle, bilateral
N46.X Male infertility

Infertility due to primary ovarian failure, patient admitted for fertility treatment

N97.0 Female infertility associated with anovulation
E28.3 Primary ovarian failure

DCS.XIV.9: Endometriosis (N80)

Multiple codes from category **N80.- Endometriosis** must be assigned when multiple sites of endometriosis are documented in the medical record.

N80.3 Endometriosis of pelvic peritoneum must be assigned for a diagnosis of endometriosis of the broad ligament.

DCS.XIV.10: Intraepithelial neoplasia of female genital tract (CIN, VAIN, VIN)

If a patient is diagnosed with more than one grade of cervical intraepithelial neoplasia (CIN), vaginal intraepithelial neoplasia (VAIN) or vulval intraepithelial neoplasia (VIN), e.g. VIN grade I-II, only the code for the highest grade must be assigned.

DCS.XIV.11: Female genital mutilation (Z91.7)

When it is documented in the medical record for the current admission that a patient has undergone female genital mutilation (FGM), either as a current injury or as a historical event, code **Z91.7 Personal history of female genital mutilation** must be assigned in a secondary position, regardless of whether the current admission is for treatment of the FGM or not.

When the patient is being treated or investigated for FGM, and **no** further information is given about the resultant genital disorder/damage or any other condition resulting from the FGM, the following codes must be assigned:

N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.7 Personal history of female genital mutilation

When the patient is being treated or investigated for FGM and the specific genital disorder/damage is documented, or the patient is being treated or investigated for another condition that has occurred as a result of FGM, then the following codes must be assigned:

Code for the specific genital disorder/damage, or code for the condition that has occurred as a result of FGM.

Z91.7 Personal history of female genital mutilation
Female genital mutilation may also be referred to as female circumcision, infibulation or female genital cutting.

Examples:

Patient attending for reversal of genital mutilation:

N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.7 Personal history of female genital mutilation

Urinary tract infection. Previous female genital mutilation

N39.0 Urinary tract infection, site not specified
Z91.7 Personal history of female genital mutilation

Vaginal stenosis complicating birth, previous female genital mutilation. Baby boy delivered.

O34.6 Maternal care for abnormality of vagina
Z37.0 Single live birth
Z91.7 Personal history of female genital mutilation

See also DChS.XV.1: Outcome of delivery (Z37).

DCS.XIV.12: Prolapse of vaginal vault after hysterectomy (N99.3)
It must be clear in the medical record that the vaginal prolapse is due to the previous hysterectomy in order to assign code **N99.3 Prolapse of vaginal vault after hysterectomy**. ***See also DCS.XIX.7: Postprocedural complications of medical and surgical care.***
Terms such as ‘posthysterectomy’ and ‘due to hysterectomy’ may be used by the responsible consultant to indicate the prolapse is due to the hysterectomy.

Example:

Patient attends for a repair of a prolapse of the vaginal vault confirmed as being due to a previous hysterectomy

N99.3 Prolapse of vaginal vault after hysterectomy
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Trial without catheter (Z46.6)

See DCS.XXI.7: Trial without catheter (Z46.6)

CHAPTER XV PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
(O00–O99)

Chapter standards and guidance

DChS.XV.1: Outcome of delivery (Z37)

A code from category **Z37.- Outcome of delivery** must only be assigned on the mother's delivery episode, to identify whether the delivery resulted in a liveborn or stillborn infant(s).

Z37.- can be sequenced in any secondary diagnosis field but must never be sequenced in the primary diagnosis field.

See also:

- ***DCS.XV.2: Termination of pregnancy (O04-O07) - Medical termination of pregnancy resulting in a liveborn infant***
- ***DCS.XV.16: Maternal care for intrauterine death (O36.4).***

Codes in category **Z37.- Outcome of delivery** must not be used on patients who have undergone termination of pregnancy or suffered a miscarriage that has resulted in the delivery of a dead fetus whilst in hospital.

See:

- ***DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)***
- ***DCS.XV.2: Termination of pregnancy (O04-O07).***

Example:

Spontaneous vertex delivery at term of live female infant

O80.0 Spontaneous vertex delivery
Z37.0 Single live birth

Within the ICD-10 classification the term 'abortion' is used to describe both 'miscarriage' and 'termination of pregnancy' and this must be considered when indexing these conditions and assigning codes from within this chapter.

Live birth is the complete expulsion or extraction from its mother of a fetus or baby, which, after such separation, breathes or shows any other evidence of life. This is irrespective of the duration of pregnancy.

Gestational age is the estimated age of the fetus, usually calculated by means of ultrasound scan. Gestational age is expressed in completed weeks. The first day is referred to as day zero and not day one: days zero to six correspond to a completed week zero, while days seven to 13 correspond to a completed week one.

Retained products of conception (RPOC) are the retention of any part of the placental tissue, membranes, gestation sac or fetal pole following miscarriage, termination or delivery of a pregnancy.

Puerperium is the 42 days following the end of the second stage of labour.

Coding standards and guidance

DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)

Codes in categories **O00-O03** classify ectopic pregnancy, molar pregnancy and miscarriage **before 24 completed weeks of pregnancy**.

Codes in category **O08.- Complications following abortion and ectopic and molar pregnancy** are used in addition to codes in categories **O00-O02** to identify associated complications, and with category **O03.-** to give further information about the complication, ***see DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)***.

See also DCS.XV.16: Maternal care for intrauterine death (O36.4) for coding loss of a pregnancy **after the 24th completed week of pregnancy**.

Missed miscarriage

O02.1 Missed abortion (missed miscarriage) must only be assigned when there has been no bleeding and no products of conception have been passed. The patient may not have symptoms of miscarriage but will eventually start to bleed and physically miscarry the fetus. When bleeding is noted or products of conception are passed, this must be coded to **O03.- Spontaneous abortion**.

Medical management of missed miscarriage

When a patient with missed miscarriage is admitted to receive medication (such as prostaglandin) to induce delivery of the retained dead fetus, before 24 completed weeks of

gestation, **with no signs of spontaneous miscarriage (such as bleeding), prior to the administration of the medication to induce delivery,** code **O02.1** must be assigned.

This applies whether the fetus is passed during the same hospital provider spell as the administration of the medication, or if the patient is given the medication and is discharged home prior to expulsion of the fetus. If bleeding is present **after administration of the medication** a code from category **O03.-** must not be used because this is not a spontaneous miscarriage as the passing of the fetus is induced by the medication.

Spontaneous miscarriage

If spontaneous delivery of a non-viable fetus occurs before 24 completed weeks of gestation, the episode must be classified using a code from category **O03.-.**

When assigning the fourth character code with category **O03 spontaneous abortion** (Spontaneous miscarriage) the following must be observed:

- **Incomplete** miscarriage – the miscarriage has started, bleeding is present but not all of the fetal tissue has been passed, i.e. retained products of conception are present. The fourth character assignment is from **.0-.4** depending on whether there were any maternal complications.
- **Complete** miscarriage – the pregnancy has been lost, the uterus is empty and there are no retained products of conception. The fourth character assignment is from **.5-.9** depending on whether there were any maternal complications.

If a patient is readmitted with **retained products of conception after a previous *spontaneous* miscarriage this must be** coded as an incomplete **spontaneous** miscarriage using a code from category **O03.-**, with the relevant fourth character from **.0** to **.4**. This also applies if a procedure for the retained products of conception (e.g. ERPC) was carried out on the previous spontaneous miscarriage episode, as the retained products episode is considered to be ongoing treatment of a spontaneous miscarriage.

See also:

- ***DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06)***
- ***DCS.XV.6: Haemorrhage in early pregnancy (O20)***
- ***DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.***

Miscarriage is defined as the spontaneous loss of pregnancy, by the expulsion or extraction of all or any part of a non-continuing pregnancy, including placental tissue, membranes, gestation sac and fetus, **before the 24th completed week** of pregnancy (i.e. up to and including 23 weeks and 6 days of gestation). Miscarriage includes all pregnancy losses from the time of conception until 24 weeks of gestation.

The term 'miscarriage' is used here in preference to 'spontaneous' or missed 'abortion' as this is the recommended term for use in clinical practice for the spontaneous loss of pregnancy before 24 weeks. Therefore, code **O02.1** also classifies missed miscarriage and category **O03.-** also classifies spontaneous miscarriage.
O02.1 Missed abortion refers to what is more commonly called **missed miscarriage** and may also be referred to as early fetal demise, early uterine death, silent miscarriage or delayed miscarriage. It is the retention of a dead fetus before 24 completed weeks of gestation. This diagnosis is made before any bleeding has taken place, e.g. at a routine scan at the antenatal clinic or a reassurance scan.

Spontaneous abortion (O03) refers to what is more commonly called **spontaneous miscarriage** and is the expulsion of the baby or fetus before the 24th completed week without deliberate interference, and is a natural end to the pregnancy.

Hydatidiform mole (O01) may also be referred to as **gestational trophoblastic disease**.

Examples:

Patient admitted for surgical management of miscarriage following scan yesterday which confirmed the diagnosis of missed miscarriage (missed abortion)

O02.1 Missed abortion

Patient admitted for surgical management of miscarriage following scan yesterday, which confirmed a diagnosis of missed miscarriage (missed abortion). On admission patient was found to be bleeding

O03.9 Spontaneous abortion, complete or unspecified, without complication

Patient admitted for administration of prostaglandin following scan yesterday, which confirmed the diagnosis of missed miscarriage (missed abortion). Following administration of the prostaglandin pessary the patient starts bleeding and continues to complete delivery of the fetus prior to discharge home

O02.1 Missed abortion

See DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).

DCS.XV.2: Termination of pregnancy (O04-O07)

Termination of pregnancy must be coded using a code in categories **O04-O07** irrespective of gestational age (i.e. including termination of pregnancy after 24 completed weeks) and regardless of whether the baby was liveborn or stillborn.

The presence of retained products of conception (RPOC) following termination of pregnancy is considered an incomplete abortion and is coded to categories **O04-O06** with the relevant fourth character of **.0** to **.4**.

Medical termination of pregnancy (O04)

Patients admitted for the administration of abortifacient drugs (for example, Mifepristone) or pessaries for termination of pregnancy must be coded using a code from category **O04.- Medical abortion** with the appropriate fourth character from the range **.5** to **.9**. This includes patients who:

- are kept in hospital and abort the pregnancy whilst in hospital
- are discharged to abort the pregnancy at home
- begin to bleed before discharge home to abort the pregnancy

If after being discharged the patient is readmitted with an incomplete termination of pregnancy (retained products of conception), the primary diagnosis must be coded to **O04.-** , with the appropriate fourth character from the range **.0** to **.4.**

Assign a code from category **O08.- Complications following abortion and ectopic and molar pregnancy in addition to codes in category O04.-** to give further information about any complications of medical termination of pregnancy, ***see DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)***.

See also DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.

Medical termination of pregnancy resulting in a liveborn infant

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

Unspecified abortion

O06.- Unspecified abortion must not be used for inpatient termination of pregnancy coding as it would be expected that the patient's medical record would contain complete

documentation regarding the patient's condition. If the type of termination of pregnancy is not documented, the coder must obtain this information from the responsible consultant.

The only circumstance in which this category is valid for use is in cases where a direct inadvertent loss of the pregnancy takes place, ***see DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06).***

See also DCS.XV.3: Cancellation of medical termination of pregnancy.

'**Termination of pregnancy**' is the preferred term used by clinical staff when referring to '**abortion**' within codes in categories **O04-O07** and refers to ending the pregnancy by medical or surgical means resulting in the expulsion or extraction of all or any part of the pregnancy, including placental tissue, membranes, gestation sac and fetus.

Most terminations of pregnancy will take place before the 24th completed week of pregnancy. However, in certain circumstances termination may take place beyond 24 completed weeks.

Medical abortion (O04) is the interruption of pregnancy for legally acceptable, medically approved indications. This category includes both elective (planned) termination of pregnancy at the patient's request, and therapeutic termination of pregnancy performed for suspected fetal abnormalities.

Other abortion (O05) includes illegally induced termination of pregnancy: the illegal interruption of pregnancy by any means. A coder would not be expected to use this category.

Failed attempted abortion (O07) classifies when an intervention intended to terminate the pregnancy (either legal or illegal) does not result in termination of the pregnancy, i.e. the fetus is still alive and the pregnancy is ongoing.

Examples:

Patient admitted to gynaecology ward to receive Mifepristone for termination of pregnancy. Discharged home prior to aborting the pregnancy. The patient has vaginal bleeding prior to discharge

O04.9 Medical abortion, complete or unspecified, without complication

See also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).

Patient readmitted to gynaecology ward with an incomplete abortion the day after receiving Mifepristone for termination of pregnancy

O04.4 Medical abortion, incomplete, without complication

Medical abortion due to spina bifida in fetus. Baby was born with a heartbeat and lived for 15 minutes.

O04.9 Medical abortion, complete or unspecified, without complication
O35.0 Maternal care for (suspected) central nervous system malformation in fetus
Z37.0 Single live birth

DCS.XV.3: Cancellation of medical termination of pregnancy

Patients admitted for a medical termination of pregnancy who change their mind resulting in cancellation of the planned procedure must be coded as follows:

Where the patient has no other conditions present which are classifiable to Chapter XV Pregnancy, childbirth and the puerperium or category **Z35.- Supervision of high-risk pregnancy** the following codes and sequencing must be used:

Z34.- Supervision of normal pregnancy
Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons.

When the reason for the termination of pregnancy is because of a **current pregnancy-related** condition classifiable to Chapter XV Pregnancy, childbirth and the puerperium the following codes and sequencing must be used:

Code from categories **O10-O45** or categories **O98-O99** that classifies the pregnancy related condition
Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons.

When the reason for the termination of pregnancy is because of a **history** of a pregnancy-related condition that is classifiable to categories **O10-O92** the following codes and sequencing must be used:

Z35.2 Supervision of pregnancy with other poor reproductive or obstetric history
Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons.

When the reason for the termination of pregnancy is because the pregnancy is considered to be high risk (e.g. the patient is an elderly primigravida, or because of a social problem, etc) the following codes and sequencing must be used:

Z35.- **Supervision of high-risk pregnancy**
Z53.2 **Procedure not carried out because of patient's decision for other and unspecified reasons.**

See also:

- ***DCS.XV.34: Supervision of normal pregnancy (Z34)***
- ***DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53).***

Examples:

Patient admitted at 15 weeks gestation for surgical termination of pregnancy due to suspected damage to the fetus by maternal heroin addiction. Following admission, the patient changes her mind and the planned procedure is cancelled.

O35.5 **Maternal care for (suspected) damage to fetus by drugs**
F11.2 **Mental and behavioural disorders due to use of opioids, dependence syndrome**
Z53.2 **Procedure not carried out because of patient's decision for other and unspecified reasons**

Patient admitted for a termination of pregnancy due to a history of severe pre-eclampsia. Following discussions with the responsible consultants, the patient decides to continue with the pregnancy and the planned procedure is cancelled.

Z35.2 **Supervision of pregnancy with other poor reproductive or obstetric history**
Z53.2 **Procedure not carried out because of patient's decision for other and unspecified reasons**

DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06)

Inadvertent or unintentional loss of pregnancy must be coded as follows:

Inadvertent loss of pregnancy due to direct cause

When a patient undergoes uterine surgery, e.g. hysterectomy, for a known or suspected condition, and the pregnancy is unavoidably terminated due to the nature of the procedure

a code from category **O06.- Unspecified abortion** must be assigned in addition to the code for the disorder that is the reason for the uterine surgery.

Inadvertent loss of pregnancy due to indirect cause

When a patient is known to be pregnant but requires surgery, not on the uterus, for a life-threatening (or other) condition, the treatment of which cannot be postponed and the patient experiences a spontaneous miscarriage as a result of this treatment a code from category **O03.- Spontaneous abortion** must be assigned in addition to the code for the disorder that is the reason for the surgery.

Examples:

Patient with fibroid uterus undergoes hysterectomy. The patient is found to be pregnant during the procedure and the pregnancy is inadvertently lost.

D25.9 Leiomyoma of uterus, unspecified
O06.9 Unspecified abortion, complete or unspecified, without complication

Patient 15 weeks pregnant with acute appendicitis undergoes appendicectomy. Complete spontaneous miscarriage occurs the next day.

K35.8 Acute appendicitis, other and unspecified
O03.9 Spontaneous abortion, complete or unspecified, without complication

DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)

Codes in category **O08.- Complications following abortion and ectopic and molar pregnancy** must not be used in a primary position except where there is a new episode or hospital provider spell in which the patient primarily receives treatment of the complication, e.g. a current complication of a previous termination of pregnancy or miscarriage.

Codes in category **O08.-** are used as additional codes with categories **O00–O02** to identify associated complications, and with categories **O03–O07** to give further information about the complication.
There are three types of complications associated with ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy. These must be coded as follows.
See also DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.

Maternal complications of ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (abortion)

These are conditions affecting the mother which cause, result from, or are otherwise associated with the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy. Code assignment is dependent upon when the complication occurred.

Maternal complications associated with and occurring during the same episode as the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy

- Assign a code from **O00–O02** or **O03–O07** and a code from category **O08.-** to identify any associated complications. If the complication is stated at four character level at **O03-O07** a code from category **O08.-** is **not** required.

Pregnancy-related complications occurring during the same episode as the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy, but ***not*** associated with the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy process, must not be coded using a code from category **O08**. A different code describing the complication from Chapter XV must be assigned.

Maternal complications occurring in a subsequent episode to that in which the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy occurred where there are no retained products of conception.

- Assign a code from category **O08.- Complications following abortion and ectopic and molar pregnancy**.

See:

- ***DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)*** for coding of retained products of conception after previous spontaneous miscarriage
- ***DCS.XV.2: Termination of pregnancy (O04-O07) - Medical termination of pregnancy (O04)*** for coding retained products of conception after previous medical termination of pregnancy.

Known or suspected fetal complication as the reason for termination of pregnancy (abortion)

- Assign a code for the termination of pregnancy itself (**O04–O07**) as the primary diagnosis.
- Assign a code from categories **O30-O48 Maternal care related to the fetus and amniotic cavity and possible delivery problems** describing the disorder affecting the fetus.

Known or suspected fetal complications as the reason for termination of pregnancy and maternal complications of the termination occurring during the same episode.

Codes for ***both*** types of complication must be assigned as follows:

- Assign a code for the termination of pregnancy itself (**O04–O07**) as the primary diagnosis.
- Assign a code from categories **O30-O48 Maternal care related to the fetus and amniotic cavity and possible delivery problems** describing the disorder affecting the fetus.

Assign a code from category **O08.-** to give further information about the maternal complication if it is not stated at the fourth character level in the termination code (**O04-O07**).

A table of complications is shown in the Alphabetical Index under the term **Abortion**, complicated (by). This table identifies the fourth character subdivisions to be used for miscarriages and terminations of pregnancy as follows:

Miscarriage

- First column identifies the fourth character to be used with category **O03**, when complete or unspecified.
- Second column identifies the fourth character to be used with category **O03**, when incomplete.

Termination of pregnancy

- First column identifies the fourth character to be used with categories **O04–O06**, when complete or unspecified.
- Second column identifies the fourth character to be used with categories **O04–O06**, when incomplete.
- Third column identifies the fourth character to be used with category **O08**.

Examples:

Pelvic peritonitis due to streptococcus B following a tubal pregnancy. Same episode as tubal pregnancy

O00.1 Tubal pregnancy
O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
B95.1 Streptococcus, group B, as the cause of disease classified to other chapters

See also DGCS.6: Infections.

Incomplete spontaneous miscarriage with pelvic peritonitis during same episode

O03.0 Spontaneous abortion, incomplete, complicated by genital tract and pelvic infection

Complete spontaneous miscarriage with renal failure in the same episode as the miscarriage

O03.8 Spontaneous abortion, complete or unspecified, with other and unspecified complications
O08.4 Renal failure following abortion and ectopic and molar pregnancy

Incomplete spontaneous miscarriage with excessive haemorrhage, the patient is also treated for mild pre-eclampsia during the same episode.

O03.1 Spontaneous abortion, incomplete, complicated by delayed or excessive haemorrhage
O14.0 Mild to moderate pre-eclampsia

Patient admitted with severe pre-eclampsia, and during this episode an incomplete miscarriage also occurred.

O14.1 Severe pre-eclampsia
O03.4 Spontaneous abortion, incomplete, without complication

Patient re-admitted with pelvic peritonitis following a medical termination of pregnancy performed five days previously. No retained products of conception present.

O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy

Complete termination of pregnancy because the fetus was affected by spina bifida.

O04.9 Medical abortion, complete or unspecified, without complication
O35.0 Maternal care for (suspected) central nervous system malformation in fetus

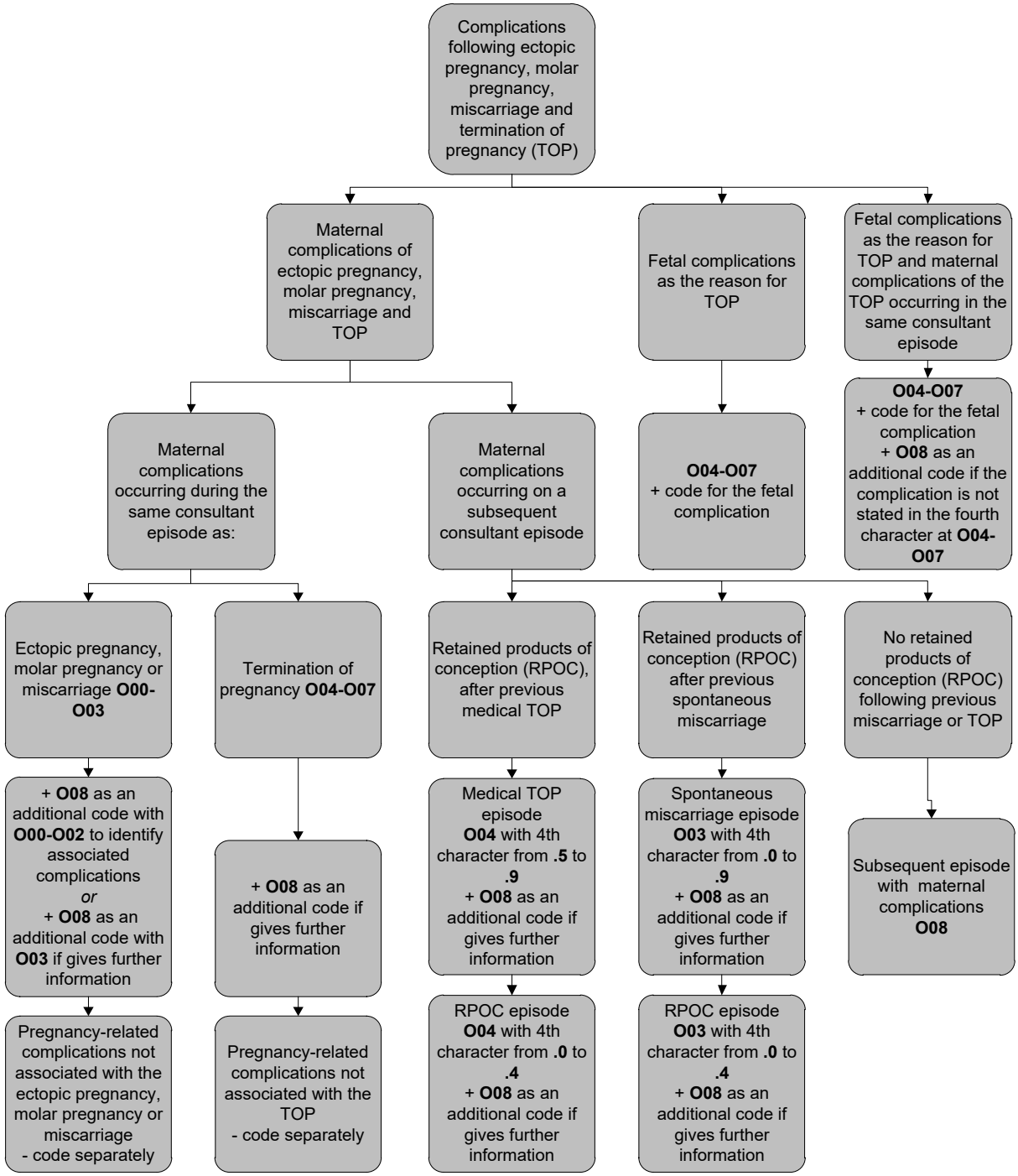
Complete termination of pregnancy at 16 weeks due to suspected damage to fetus due to maternal rubella at five weeks gestation.

O04.9 Medical abortion, complete or unspecified, without complication
O35.3 Maternal care for (suspected) damage to fetus from viral disease in mother

Complete termination of pregnancy complicated by renal failure. Termination of pregnancy performed because the fetus was affected by Down Syndrome.

O04.8 Medical abortion, complete or unspecified, with other and unspecified complications
O35.1 Maternal care for (suspected) chromosomal abnormality in fetus
O08.4 Renal failure following abortion and ectopic and molar pregnancy

DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy



See:

- ***DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)***
- ***DCS.XV.2: Termination of pregnancy (O04-O07)***
- ***DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08).***

DCS.XV.6: Haemorrhage in early pregnancy (O20)

Codes in category **O20.- Haemorrhage in early pregnancy** must be used for any vaginal bleeding **before** 24 completed weeks of gestation, except when the pregnancy proceeds to abortive outcome when a code from categories **O00-O08 Pregnancy with abortive outcome** must be used instead.

If a threatened miscarriage (**O20.0 Threatened abortion**) proceeds to miscarriage then this must be coded to **O03.- Spontaneous abortion**

DCS.XV.7: Excessive vomiting in pregnancy (O21)

Codes in category **O21.- Excessive vomiting in pregnancy** must only be coded when the patient has been admitted because of, or is being treated for, the vomiting.

DCS.XV.8: Vaginal thrush in pregnancy (O23.5, B37.3† and N77.1*)

Vaginal thrush in pregnancy is coded using the following codes and sequencing:

O23.5	**Infections of the genital tract in pregnancy**
B37.3†	**Candidiasis of vulva and vagina**
N77.1*	**Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere.**

DCS.XV.9: Diabetes mellitus in pregnancy (O24)

Diabetes mellitus in pregnancy, childbirth and the puerperium must always be coded using a code from category **O24.- Diabetes mellitus in pregnancy**.

If the diabetes is causing manifestations these must be coded in addition. Where appropriate a dagger and asterisk combination will be used.

See also:

- ***DGCS.5: Dagger and asterisk system***
- ***DCS.IV.1: Diabetes mellitus (E10-E14).***

Example:

Patient 30 weeks pregnant admitted for control of pre-existing Type I diabetes. Patient also has diabetic neuropathy.

O24.0† Pre-existing type 1 diabetes mellitus
G63.8* Polyneuropathy in other diseases classified elsewhere

Code **G63.8*** must be assigned instead of **G63.2* Diabetic polyneuropathy (E10–E14† with common fourth character .4)** because **G63.2*** can only be assigned with codes **E10–E14†** with common fourth character **.4** as indicated in the code description.

DCS.XV.10: Maternal care for other conditions predominantly related to pregnancy (O26)

Conditions that are pregnancy induced that are not classified elsewhere within Chapter XV must be coded using a code from category **O26.- Maternal care for other conditions predominantly related to pregnancy**. A further code to identify the pregnancy induced condition must be assigned in addition. This includes signs or symptoms from Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, that are specifically caused by the pregnancy, that are not symptoms of a specific condition.

The exception to this is when coding obstetric cholestasis (cholestasis of pregnancy, intrahepatic cholestasis of pregnancy) using code **O26.6 Liver disorders in pregnancy, childbirth and the puerperium.** As cholestasis is an explicit inclusion at code **O26.6,** it is not necessary to assign a code from Chapter XI in addition.

Conditions that complicate the pregnant state, are aggravated by the pregnancy, or are a main reason for obstetric care (this includes pre-existing conditions) not classified elsewhere within Chapter XV must be coded using a code from category **O99 Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium**, ***see DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99).***

Examples:

Lumbar backache due to pregnancy. Patient 30 weeks pregnant. No previous history of backache.

O26.8 Other specified pregnancy-related conditions
M54.56 Low back pain, lumbar region

High blood pressure reading (not diagnosed as hypertension) in pregnant patient. 15 weeks gestation.

O26.8 Other specified pregnancy-related conditions
R03.0 Elevated blood pressure reading, without diagnosis of hypertension

DCS.XV.11: Abnormal findings on antenatal screening of mother (O28)

Codes in this category must only be used when an abnormal finding does not result in a definitive diagnosis.

DCS.XV.12: Pregnancy of unknown location (O28.1)

A diagnosis of pregnancy of unknown location (PUL) must be coded to **O28.1 Abnormal biochemical finding on antenatal screening of mother** unless a more specific diagnosis, such as ectopic pregnancy, is made.

In **pregnancy of unknown location (PUL)** there is a positive pregnancy test but on scanning there is no sign of a pregnancy inside or outside of the uterus. The serum human chorionic gonadotropin (hCG; a hormone produced during pregnancy) levels are rising or persisting, but no evidence of the pregnancy can be found. In most cases PUL will result in disappearance of the pregnancy. However, PUL may also result in progression to confirmation of normal intrauterine or ectopic pregnancy, or 'persisting PUL' (which is defined as PUL where the hCG levels don't decrease, there are no signs of trophoblastic disease, and the location of the pregnancy cannot be identified).

DCS.XV.13: Complications of anaesthesia during pregnancy, labour, delivery and the puerperium (O29, O74, O89)

When coding complications of anaesthesia in categories **O29.- Complications of anaesthesia during pregnancy, O74.- Complications of anaesthesia during labour and delivery and O89.- Complications of anaesthesia during the puerperium** code assignment must reflect the stage of pregnancy when the anaesthesia was administered (i.e. pregnancy, labour and/or delivery, or during the puerperium), and not the stage when the complication(s) arose.

See also:

- ***DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA]***
- ***DCS.XIX.7: Postprocedural complications of medical and surgical care***

Chapter XV is structured so that the conditions are classified to three distinct stages - pregnancy, childbirth (including labour and/or delivery) and the puerperium. Anaesthetic administered for a delivery of any type would be considered to be part of the childbirth stage.

Example:

Patient admitted for elective caesarean section under epidural anaesthesia for disproportion. Baby boy born. Severe headache one day post partum, induced by epidural anaesthesia.

O33.9 Maternal care for disproportion, unspecified
O74.5 Spinal and epidural anaesthesia-induced headache during labour and delivery
Y48.3 Local anaesthetics
Z37.0 Single live birth

Code **O74.5** has been assigned because the epidural was administered during the childbirth stage to facilitate the caesarean delivery (***See also DConvention.5: Relational terms***).

DCS.XV.14: Multiple gestation (O30)

When recording an episode with a normal multiple delivery, a code from category **O30.- Multiple gestation** must be recorded as the primary diagnosis, unless the patient has a condition classified to another code from Chapter XV on the delivery episode, in which case the appropriate code from category **O30.-** must be recorded in a secondary position.

See also DCS.XV.28: Delivery (O80–O84).

Example:

Patient admitted for delivery of triplets. During delivery she sustains a second degree perineal laceration. (All babies liveborn).

O70.1 Second degree perineal laceration during delivery
O30.1 Triplet pregnancy
Z37.5 Other multiple births, all liveborn

DCS.XV.15: Maternal care for known or suspected malpresentation of fetus, disproportion and abnormality of pelvic organs (O32–O34) and Obstructed labour (O64-O66)

Codes in categories **O32-O34** are assigned when the listed condition is a reason for observation, hospitalisation or other obstetric care of the mother or for caesarean section, at any point during pregnancy, labour or delivery.

If a condition in categories **O32-O34** is diagnosed during labour the code from these categories must still be assigned, unless the responsible consultant confirms that the labour is obstructed or if the ICD-10 index trail directs the coder to an obstructed labour code, in which case a code from categories **O64–O66** must be used instead.

See also:

- ***DCS.XV.24: Failed trial of labour, unspecified (O66.4) and Failed application of vacuum extractor and forceps, unspecified (O66.5)***

Obstructed labour means that, in spite of strong contractions of the uterus, the fetus cannot descend through the pelvis because there is an insurmountable barrier preventing its descent. The term 'obstructed labour' does not apply to a presumption of the likelihood of obstruction. It can only be clinically applied retrospectively after an attempt at vaginal delivery has occurred and has been unsuccessful.

In developed countries such as the UK, where standards of healthcare are high, it is unlikely that a pregnant woman with an earlier diagnosed mechanical problem will be allowed by an obstetrician to attempt a vaginal delivery. Therefore one would expect that the ICD-10 codes from categories **O64-O66** would be used much less frequently in the UK than the codes from categories **O32-O34**.

Examples:

Breech extraction of baby girl with version for transverse lie

O32.2 Maternal care for transverse and oblique lie
Z37.0 Single live birth

Patient was booked for an elective lower segment caesarean section (ELSCS) for breech presentation. Two days prior to the booked admission the patient was admitted in first stage of labour and a lower caesarean section was performed and a baby girl was born.

O32.1 Maternal care for breech presentation
Z37.0 Single live birth

Obstructed labour due to a fetopelvic disproportion caused by mother's deformed pelvis, emergency caesarean section performed. Baby boy born.

O65.0 Obstructed labour due to deformed pelvis
Z37.0 Single live birth

Dystocia due to oversized fetus - emergency caesarean section delivery of baby girl.

O66.2 Obstructed labour due to unusually large fetus
Z37.0 Single live birth

DCS.XV.16: Maternal care for intrauterine death (O36.4)

The code **O36.4 Maternal care for intrauterine death** must be assigned for stillbirths and late intrauterine fetal deaths, where it is known before delivery that the fetus has no signs of life. If the cause of death is known, code **O36.4** must be assigned in a secondary position to the code(s) which describes the cause of death of the fetus.

A code from category **Z37.- Outcome of delivery** indicating that the outcome of delivery was a stillbirth must be assigned on all stillbirth and late intrauterine fetal death episodes.

If it is not known prior to delivery that there is a stillbirth or that intrauterine fetal death has occurred, the code **O36.4** must not be recorded and a different code from Chapter XV must be used. A code from **Z37.-** would still be assigned to indicate that the outcome of delivery was a stillbirth.

See also:

- ***DChS.XV.1: Outcome of delivery (Z37)***
- ***DCS.XVI.7: Stillbirths (P95.X)***

Stillbirth is defined as 'a baby **delivered** with no signs of life, known to have died **after 24 completed weeks** of pregnancy'. Late Intrauterine fetal death refers to babies with no signs of life in utero **after 24 completed weeks** of pregnancy.

Examples:

Antenatal scan at 28 weeks due to vaginal haemorrhage reveals placenta praevia and fetal death, patient proceeds to deliver stillborn infant.

O44.1 Placenta praevia with haemorrhage
O36.4 Maternal care for intrauterine death
Z37.1 Single stillbirth

Delivery at 39 weeks because of fetal hypoxia, baby born dead.

O36.3 Maternal care for signs of fetal hypoxia
Z37.1 Single stillbirth

DCS.XV.17: Reduced fetal movements (O36.8)

The correct code for a patient admitted with reduced fetal movements is **O36.8 Maternal care for other specified fetal problems**.

Reduced fetal movements is often documented as ↓FM or DFM in the medical record.

DCS.XV.18: Premature rupture of membranes (O42)

A code from category **O42.- Premature rupture of membranes** must only be assigned for premature rupture of membranes before the onset of labour, regardless of the length of gestation.

DCS.XV.19: Morbidly adherent placenta (O43.2)

Code **O43.2 Morbidly adherent placenta** must be assigned following **O72.0 Third-stage haemorrhage** or **O73.0 Retained placenta without haemorrhage** when both conditions are documented in the medical record.

O46 Antepartum haemorrhage, not elsewhere classified classifies a haemorrhage **after** 24 completed weeks of gestation but **before** labour.

See also DCS.XV.25: Postpartum haemorrhage (O72).

False labour (**O47**) is a common condition which may also be known as ‘Braxton-Hicks’ contractions.

DCS.XV.20: Prolonged pregnancy (O48.X)

Codes in category **O48.X Prolonged pregnancy** must be used when the pregnancy exceeds 42 weeks or if the responsible consultant documents in the medical record that the patient is 'post-term', or 'post-dates'.

DCS.XV.21: Preterm labour and delivery (O60)

A code from this category is used if the labour is spontaneous or induced and if delivery is vaginal or surgical.

Codes in this category must be used as follows:

O60.0 Preterm labour without delivery

Assign for patients who are admitted in preterm labour and are sent home to await further events.

For patients with a normal pregnancy admitted in the early stages of term labour (with contractions) who are subsequently discharged and told to return when the contractions become more established, ***see DCS.XV.34: Supervision of normal pregnancy (Z34).***

O60.1 Preterm spontaneous labour with preterm delivery

Assign for patients who are admitted in preterm labour and go on to deliver a preterm baby by any means.

O60.2 Preterm spontaneous labour with term delivery

Assign for patients who deliver to term but who at some point during the current pregnancy have been admitted in spontaneous preterm labour. The labour may have stopped by itself or delayed with the help of medication such as tocolytics. In some instances, the patient may go on to deliver to term naturally, during the same hospital provider spell.

If the patient has gone home in between the preterm labour stopping and the term delivery, this code must only be assigned on the delivery episode if it is documented in the medical record that they were previously admitted in preterm labour.

O60.3 Preterm delivery without spontaneous labour

Assign when the patient or the fetus has a condition which requires either an induced preterm delivery or caesarean section preterm delivery. This code must be used in addition to the code describing the condition prompting the preterm delivery.

Preterm is defined as labour or delivery occurring before 37 completed weeks of gestation.

It may be necessary to assign more than one code from this category when the delivery admission contains multiple episodes.

Examples:

Following successful delay of preterm labour at 25+5 weeks using tocolytics, mother is admitted in spontaneous labour and delivered a term baby boy at 38+1 weeks.

O60.2 Preterm spontaneous labour with term delivery
Z37.0 Single live birth

Mother admitted at 36+6 weeks in spontaneous preterm labour. Progression of labour was slow, so oxytocin was introduced to augment the labour. Labour progressed at a steady pace and mother delivered a term baby girl at 37+1 weeks.

O60.2 Preterm spontaneous labour with term delivery
Z37.0 Single live birth

Mother with severe pre-eclampsia admitted at 35 weeks for delivery of a baby boy by caesarean section.

O14.1 Severe pre-eclampsia
O60.3 Preterm delivery without spontaneous labour
Z37.0 Single live birth

DCS.XV.22: Long labour (O63)

It must be documented in the medical record that the labour or stage of labour is prolonged/long for this category to be used. If the reason for the prolonged/long labour is stated, then this must be coded instead.

There are no guidelines for the length of time constituting a long/prolonged labour.

DCS.XV.24: Failed trial of labour, unspecified (O66.4) and Failed application of vacuum extractor and forceps, unspecified (O66.5)

Codes **O66.4 Failed trial of labour, unspecified** and **O66.5 Failed application of vacuum extractor and forceps, unspecified** must not be used if the condition giving rise to the intervention is known.

Example:

Caesarean section performed after failed application of forceps following prolonged second stage of labour, obstructed due to cephalopelvic disproportion. Baby boy born.

O65.4 Obstructed labour due to fetopelvic disproportion, unspecified
Z37.0 Single live birth

DCS.XV.25: Postpartum haemorrhage (O72)

Codes in category **O72.- Postpartum haemorrhage** must only be coded when documented as such in the patient's medical record by the responsible consultant.

The levels of blood loss must not be interpreted by the coder in order to decide if the levels constitute a diagnosis of postpartum haemorrhage. The responsible consultant must always be consulted to confirm the clinical significance of a high level of blood loss if a diagnosis of postpartum haemorrhage has not been specifically documented in the medical record.

See also:

- ***DGCS.4: Using diagnostic test results***
- ***DCS.XV.19: Morbidly adherent placenta (O43.2).***

O72.1 Other immediate postpartum haemorrhage is one occurring up to 24 hours following delivery.

O72.2 Delayed and secondary postpartum haemorrhage is one occurring more than 24 hours following delivery.

DCS.XV.26: Delayed delivery (O75.5, O75.6)

It must be stated in the medical record that the delivery was delayed for either code **O75.5 Delayed delivery after artificial rupture of membranes** or **O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes** to be assigned.

There are no guidelines for the length of time constituting a delayed delivery.

DCS.XV.27: Vaginal delivery following previous caesarean section (O75.7)

If it is documented in the patient's medical record that the mother has delivered vaginally following a previous caesarean section (regardless of how far in the past that caesarean section was), code **O75.7 Vaginal delivery following previous caesarean section** must be assigned, in either a primary or secondary position.

DCS.XV.28: Delivery (O80–O84)

Codes in categories **O80–O84 Delivery** must only be used when the only information recorded is a statement of 'delivery' or when only the method of delivery has been recorded and the patient has no other conditions classifiable to Chapter XV.

In the case of multiple births, a code from **O84.- Multiple delivery** must not be used. A code from category **O30.- Multiple gestation** must be assigned instead.

See also DCS.XV.14: Multiple gestation (O30).

It is not expected that any codes other than **O80.0 Spontaneous vertex delivery** and **O82.0 Delivery by elective caesarean section** would be assigned from the codes in this block (**O80-O84**). Any other code from this block would only be used in the rare event when no mention of reason for the method of delivery is given.

Examples:

Spontaneous vertex delivery of baby girl, first degree tear left unsutured

O70.0 First degree perineal laceration during delivery
Z37.0 Single live birth

Spontaneous vertex delivery of baby girl at 39 weeks, with episiotomy

O80.0 Spontaneous vertex delivery
Z37.0 Single live birth

Caesarean section performed at patient's request. Patient has no medical/clinical reason for the caesarean section to be performed. Baby boy born

O82.0 Delivery by elective caesarean section
Z37.0 Single live birth

DCS.XV.29: Obstetric death (O95-O97)

Codes in categories **O95–O97** must not be used for morbidity coding.

DCS.XV.30: Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)

Code **O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium** must be assigned whenever a patient with HIV is admitted during pregnancy, childbirth and the puerperium as HIV always complicates pregnancy.

For patients with symptomatic (active) HIV – assign an additional code from categories **B20-B24 Human immunodeficiency virus [HIV] disease** in a secondary position.

For patients with asymptomatic (non-active or HIV positive) HIV – assign the code **Z21.X Asymptomatic human immunodeficiency virus [HIV] infection status** in a secondary position.

See also DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24).

Example:

Baby delivered by elective caesarean section because the mother has symptomatic (active) HIV

O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
B24.X Unspecified human immunodeficiency virus [HIV] disease
Z37.0 Single live birth

Zika virus in pregnancy

See DCS.I.5: Zika virus.

DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99)

Conditions that complicate the pregnant state, are aggravated by the pregnancy, or are a main reason for obstetric care (this includes pre-existing conditions) which are not

classified elsewhere within Chapter XV must be coded using a code from category **O99.- Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium.** An additional code must be used to identify the specific condition where it adds information.

Where a pregnant patient has a condition which is present but is not complicating the pregnant state, aggravating the pregnancy, or the main reason for obstetric care a code from **O99.-** must not be used, only a code for the condition is assigned.

Conditions that are pregnancy induced and are not classified elsewhere within Chapter XV must be coded using a code from category **O26.- Maternal care for other conditions predominantly related to pregnancy, *see DCS.XV.10: Maternal care for other conditions predominantly related to pregnancy (O26).***

See also DCS.XV.32: Anaemia complicating pregnancy, childbirth and the puerperium (O99.0).

Examples:

Spontaneous vertex delivery of baby boy at 38 weeks. Asthma attack immediately following delivery. Diagnosed with asthma two years ago. On Ventolin.

O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium
J45.9 Asthma, unspecified
Z37.0 Single live birth

Spontaneous vertex delivery of baby boy at 38 weeks. Patient is asthmatic, takes Ventolin as required.

O80.0 Spontaneous vertex delivery
Z37.0 Single live birth
J45.9 Asthma, unspecified

DCS.XV.32: Anaemia complicating pregnancy, childbirth and the puerperium (O99.0)

O99.0 Anaemia complicating pregnancy, childbirth and the puerperium must only be assigned when it is documented in the medical record that the patient has anaemia complicating pregnancy, childbirth or the puerperium. Statements such as ‘low Hb’ or ‘sent home on iron tablets’ must not be used as an indication that this code should be used.

An additional code from the range **D50–D64.8** must be used if the type of anaemia is known.

See also DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99).

DCS.XV.33: Pregnant state, incidental (Z33.X)

Code **Z33.X Pregnant state, incidental** must never be used in a primary position. **Z33.X** is only assigned in a secondary position when a pregnant patient is treated for an unrelated condition that does not affect or complicate the management of the pregnancy.

Examples:

Sprained ankle. Tripped and fell over cat at home. Patient 26 weeks pregnant.

S93.4 Sprain and strain of ankle
W01.0 Fall on same level from slipping, tripping and stumbling, home
Z33.X Pregnant state, incidental

Abdominal pain in right iliac fossa (RIF). ?Appendicitis. Patient 29 weeks pregnant. Pain confirmed as not related to pregnancy.

R10.3 Pain localized to other parts of lower abdomen
Z33.X Pregnant state, incidental

DCS.XV.34: Supervision of normal pregnancy (Z34)

A code from category **Z34.- Supervision of normal pregnancy** must be assigned for patients who are:

- admitted for a suspected problem related to the pregnancy where on further examination no abnormality relating to the pregnancy is found

  and

- they have not received treatment or investigation for any other condition that is classifiable to Chapter XV.

Codes in this category must also be used for patients with a normal pregnancy admitted in the early stages of term labour (with contractions) who are subsequently discharged and told to return when the contractions become more established. If the responsible consultant confirms that the patient is in preterm labour and they are sent home to await further events

code **O60.0 Preterm labour without delivery** must be used instead, ***see DCS.XV.21: Preterm labour and delivery (O60).***

Codes in category **Z34.- Supervision of normal pregnancy** must not be assigned when the responsible consultant has made a diagnosis of Braxton-Hicks contractions or false labour, which are classified to category **O47.- False labour**.

See also DCS.XV.3: Cancellation of medical termination of pregnancy.

Grand multiparity (**Z35.4 Supervision of pregnancy with grand multiparity**) is a woman who has given birth to five or more infants, alive or dead.

Elderly primigravida (**Z35.5 Supervision of elderly primigravida**) is a woman pregnant for the first time 35 years of age or older.

There is no nationally recognised age for a very young primigravida (**Z35.6 Supervision of very young primigravida**). The coder should seek advice from the responsible consultant before assigning this code.

See also DCS.XV.3: Cancellation of medical termination of pregnancy.

DCS.XV.35: Care and examination immediately after delivery (Z39.0)

Z39.0 Care and examination immediately after delivery must be assigned for patients who have given birth outside of hospital and are admitted for a postpartum check and no complications are found. If any complications are found on examination a different code from Chapter XV must be assigned instead.

Example:

Admission following delivery en route to hospital. Mother's record.

Z39.0 Care and examination immediately after delivery

Female genital mutilation (Z91.7)

See DCS.XIV.11: Female genital mutilation (Z91.7).

CHAPTER XVI CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD
(P00–P96)

Chapter standards and guidance

DChS.XVI.1: Liveborn infants according to place of birth (Z38)

A code from category **Z38.- Liveborn infants according to place of birth** must always be coded on the birth episode for every liveborn infant and be sequenced as follows:

- If the baby is a completely well baby and has no morbid conditions that have been treated or investigated, a code from **Z38.-** must be assigned as the primary diagnosis.
- If the baby is not completely well, and a morbid condition(s) is present which has been treated or investigated, a code from **Z38.-** must be assigned in the first secondary position.

Examples:

Baby born in hospital with untreated jaundice developed a skin infection which was treated with antibiotics

P39.4 Neonatal skin infection
Z38.0 Singleton, born in hospital
P59.9 Neonatal jaundice, unspecified

Newborn born in hospital, noted to have a birthmark on their right buttock, but no treatment given or investigations carried out

Z38.0 Singleton, born in hospital
Q82.5 Congenital non-neoplastic naevus

Baby born in hospital, and was observed due to maternal premature rupture of membranes (PROM), no morbid condition or symptom found

Z38.0 Singleton, born in hospital
Z03.8 Observation for other suspected diseases and conditions

DChS.XVI.2: Coding perinatal conditions

The perinatal period must be regarded as the period before birth through to the 27th day, 23rd hour and 59th minute of life, i.e. the period before the start of the 28th day.

A code from Chapter XVI Certain conditions originating in the perinatal period must only be assigned for conditions that originate in the perinatal period.
Where a condition arises in the perinatal period it must be coded to Chapter XVI even when the condition persists beyond the perinatal period. A code from outside Chapter XVI must also be assigned where this provides additional information about the condition which is not contained in the code from Chapter XVI.

This excludes conditions classified to the following codes. When a condition classified to these codes arises in the perinatal period only a code from these chapters or categories is required:

- **Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)**
- **Endocrine, nutritional and metabolic diseases (E00-E90)**
- **Injury, poisoning, and certain other consequences of external causes (S00-T98)**
- **Neoplasms (C00-D48)**
- **Tetanus neonatorum (A33)**
- **Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)**

Examples:

Newborn born in hospital with neonatal hypertension

P29.2 Neonatal hypertension
Z38.0 Singleton, born in hospital

Newborn born in hospital, noted to be jittery. Following investigation the jitteriness subsided and baby and mother were discharged home

R25.8 Other and unspecified abnormal involuntary movements
Z38.0 Singleton, born in hospital

See also DCS.XVI.8: Jittery baby (R25.8).

Newborn born in hospital with thrombosis of left superficial femoral artery

P29.8 Other cardiovascular disorders originating in the perinatal period
Z38.0 Singleton, born in hospital
I74.3 Embolism and thrombosis of arteries of lower extremities

Coding standards and guidance

DCS.XVI.1: Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04)

Codes in categories **P00-P04 Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery** must be assigned when the underlying maternal cause or the external cause for a baby's morbid condition is known. They must be sequenced in a secondary position to the code that classifies the morbid condition.

Codes in **P00-P04** must never be used in the primary diagnosis position except when the baby is stillborn and the cause is known.

See also DCS.XVI.7: Stillbirths (P95.X).

Example:

Baby born in hospital with severe birth asphyxia due to cord tightly around neck

P21.0 Severe birth asphyxia
Z38.0 Singleton, born in hospital
P02.5 Fetus and newborn affected by other compression of umbilical cord

DCS.XVI.2: Disorders related to length of gestation and fetal growth (P05-P08)

If both low birth weight and short gestational age are documented in the medical record two codes from category **P07.- Disorders related to short gestation and low birth weight, not elsewhere classified** must be assigned. The low birth weight code must be sequenced before the code for the short gestational age.

When a condition(s) classified to categories **P07.-** or **P08.-** and a condition(s) classified to category **P05.- Slow fetal growth and fetal malnutrition** are present, codes from both categories must be assigned. The exclusion note at category **P07.-** does not preclude this.

The codes at **P05.-** can apply to infants of premature, normal or long gestation who have slow fetal growth or fetal malnourishment with or without being small or light for gestational age.

Category **P07.-** classifies premature births and/or low birth weight.

Category **P08.-** classifies post term births and/or high birth weight.

Example:

Premature infant born at 34 weeks in hospital weighing 2100gms and is small for dates

P07.1 Other low birth weight
Z38.0 Singleton, born in hospital
P07.3 Other preterm infants
P05.1 Small for gestational age

DCS.XVI.10 Meconium in liquor (P20)

When meconium in liquor is documented in the baby's medical record, a code from category **P20.- Intrauterine hypoxia** must be assigned.

If no further treatment or investigation is required following observations, and no other morbid conditions are treated or investigated, a code from **Z38.- Liveborn infants according to place of birth** must be assigned in the primary position followed by the code from **P20.-**.

If further treatment or investigation is required, the code from **P20.-** must be sequenced as per **DGCS.1: Primary diagnosis**.

See also

- ***DGCS.1: Primary diagnosis***
- ***DChS.XVI.1: Liveborn infants according to place of birth (Z38)***

In accordance with NICE guidance, the presence of any meconium in liquor warrants clinical observation of the baby. If any risk factors are observed during this time, the baby will require a neonatology assessment and potential further investigation and/or treatment following this.

DCS.XVI.3: Low Apgar score and birth asphyxia (P21)

A diagnosis of 'Low Apgar score' alone is not classified in ICD-10 and codes must not be assigned when this diagnosis alone is made. If the responsible consultant records the Apgar score in a newborn with asphyxia the Apgar score is used to assign the fourth character subdivision from category **P21.- Birth asphyxia**.

Example:

Asphyxiated newborn born in hospital with an Apgar score of 2

P21.0 Severe birth asphyxia
Z38.0 Singleton, born in hospital

DCS.XVI.4: Surfactant deficient lung disease (P22)

Code **P22.0 Respiratory distress of newborn** must be assigned for the diagnosis of Surfactant deficient lung disease (SDLD) in the newborn.

DCS.XVI.5: Group B streptococcus (GBS) bacterial infections in babies

The following must be applied when coding Group B streptococcus (GBS) infections in newborn babies:

GBS infection diagnosed by blood test or GBS sepsis:

P36.0 Sepsis of newborn due to Streptococcus, group B

Meningitis due to GBS:

P39.8 Other specified infections specific to the perinatal period
G00.2 Streptococcal meningitis
B95.1 Streptococcus, group B, as the cause of diseases classified to other chapters

Newborn receiving prophylactic antibiotics during birth episode because the mother has previously had a streptococcus infection or because the mother is a carrier of GBS:

Z38.- Liveborn infants according to place of birth
Z29.2 Other prophylactic chemotherapy
Z83.1 Family history of other infectious and parasitic diseases

Newborn streptococcus group B positive/carrier (i.e. found by umbilical swab, or other surface swabs such as ear and skin) with no signs of infection on birth episode:

Z38.- **Liveborn infants according to place of birth**
Z22.3 **Carrier of other specified bacterial diseases**

See also:

- ***DGCS.6: Infections***
- ***DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis***
- ***DChS.XVI.1: Liveborn infants according to place of birth***

Example:

Newborn with meningitis due to GBS during birth episode (born in hospital)

P39.8 **Other specified infections specific to the perinatal period**
Z38.0 **Singleton, born in hospital**
G00.2 **Streptococcal meningitis**
B95.1 **Streptococcus, group B, as the cause of diseases classified to other chapters**

DCS.XVI.6: Dehydration of newborn (P74.1)

Dehydration must always be coded when documented in a newborn's medical record.

See also DCS.IV.7: Dehydration and hypovolaemia.

Dehydration is a serious medical condition in newborns.

DCS.XVI.7: Stillbirths (P95.X)

Stillbirths must be coded as follows:

- If the cause of the stillbirth is known, the cause must be coded as the primary diagnosis. Code **P95.X Fetal death of unspecified cause** is not required in **any** diagnostic position
- If the cause of the stillbirth is not known, code **P95.X** must be assigned as the primary diagnosis

- A code from category **Z38.- Liveborn infants according to place of birth** must not be assigned on a stillborn baby's episode.

See also:

- ***DCS.XVI.1: Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04)***
- ***DCS.XV.16: Maternal care for intrauterine death (O36.4).***

P95.X is only recorded when there is no other diagnostic information available about the cause of the stillbirth. The information regarding the stillbirth can be identified for data extraction purposes by the method of discharge. The stillbirth will also be recorded on the mother's episode using a code from **Z37 Outcome of delivery, *see DChS.XV.1: Outcome of delivery (Z37)***.

Examples:

Stillbirth due to compression of umbilical cord

P02.5 Fetus and newborn affected by other compression of umbilical cord

Stillbirth

P95.X Fetal death of unspecified cause

DCS.XVI.8: Jittery baby (R25.8)

Jittery baby must be coded using code **R25.8 Other and unspecified abnormal involuntary movements.**

See also DChS.XVIII.1: Signs symptoms and abnormal laboratory findings.

DCS.XVI.9: Sudden infant death syndrome (R95)

Codes in category **R95.- Sudden infant death syndrome** (SIDS, cot death) must only be assigned when no cause has been recorded in the medical record and the responsible consultant records the diagnosis as 'a sudden infant death', 'sudden infant death syndrome', 'cot death' or 'SIDS'.

History of perinatal conditions

See DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99).

CHAPTER XVII CONGENITAL MALFORMATIONS, DEFORMATIONS AND CHROMOSOMAL ABNORMALITIES
(Q00–Q99)

Chapter standards and guidance

Syndromes
See DGCS.7: Syndromes.

Congenital malformations and abnormalities are present and exist from the time of birth; they are **never** acquired. They will almost always persist throughout life unless they have been corrected by medical intervention. Therefore the codes in this chapter are intended for use in patients of **any** age. Not all congenital conditions are classified to this chapter.

Some conditions in the Alphabetical Index are assumed to be acquired, whilst others are assumed to be congenital. The codes the Alphabetical index directs to are selected where there is no further information in the medical record to indicate whether they are either congenital or acquired.

Examples:

55 year old with left clawhand

M21.54 Acquired clawhand, clubhand, clawfoot and clubfoot, hand

55 year old with left clawfoot

Q66.8 Other congenital deformities of feet

Coding Standards and guidance

Congenital heart disease is a general term that may be used to document a specific abnormality, e.g. ventricular septal defect (VSD) or to summarise multiple cardiac anomalies without listing the individual conditions.

When a diagnosis of congenital heart disease is documented without any further information, a more specific diagnosis should be sought from the responsible consultant.

Mongolian blue spot (D22)

See DCS.II.11: Mongolian blue spot (D22).

Congenital oesophageal web (K22.2, Q39.4)

See DCS.XI.1: Oesophageal web (K22.2, Q39.4).

DCS.XVII.1: Triple M syndrome (Q87.1)

Triple M syndrome must be coded using:

Q87.1 Congenital malformation syndromes predominantly associated with short stature

See also DGCS.7: Syndromes.

The major congenital abnormality of triple M Syndrome is short stature.

Personal history of congenital malformations, deformations and chromosomal abnormalities (Z87.7)

See DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99).

CHAPTER XVIII SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED
(R00–R99)

Chapter standards and guidance

DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings

If a specific diagnosis is identified from a sign, symptom or abnormal laboratory finding classifiable to Chapter XVIII (**R00-R99**), a code for the diagnosis must be assigned instead.

Codes in Chapter XVIII must only be assigned when:

- a specific diagnosis related to the documented signs, symptoms or abnormal findings has not been made
- there is a specific standard which states that a sign or symptom must always be coded (e.g. septic shock (**R57.2**) ***- see DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis*)**.
- the cause of the sign, symptom or abnormal laboratory finding is known, but the sign, symptom or abnormal laboratory finding is treated as a problem in its own right. In this instance the code from **R00-R99** must be recorded in a **secondary** position to the known cause.

See also:

- ***DGCS.2: Absence of definitive diagnosis statement***
- ***DGCS.4: Using diagnostic test results***
- ***DChS.II.1: Complications and symptoms of neoplasms***
- ***DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53).***

There are codes outside of Chapter XVIII that may appear to be symptoms of another condition, however codes outside of this chapter are, in the main, considered definitive diagnoses or problems in their own right and when documented in the medical record by the responsible consultant, would be coded except where a specific standard exists which states that a condition is considered to be a symptom of another condition and does not require coding (e.g. ***DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2)***) or where the ICD-10 Alphabetical Index or Tabular List indicates otherwise.

Examples:

Patient admitted with central chest pain and shortness of breath. Diagnosed with acute myocardial infarction

I21.9 Acute myocardial infarction, unspecified

Patient admitted with haematuria. Cystoscopy performed but no abnormality shown

R31.X Unspecified haematuria

Patient admitted with 'confusion'. No cause is identified on examination

R41.0 Disorientation, unspecified

Patient admitted with central chest pain. A myocardial infarction is suspected but not confirmed. Patient is transferred to a hospital with a coronary care unit

R07.2 Precordial pain

Patient admitted with visual hallucinations, agitation and stupor. Schizotypal disorder is suspected but the responsible consultant is unwilling to make a diagnosis at the time

R44.1 Visual hallucinations
R45.1 Restlessness and agitation
R40.1 Stupor

Abnormal glucose tolerance test in patient with family history of diabetes. Diagnosis of diabetes is not made

R73.0 Abnormal glucose tolerance test
Z83.3 Family history of diabetes mellitus

Abnormal ECG with paroxysmal atrial tachycardia

I47.1 Supraventricular tachycardia

Mass removed from neck. Histology report is inconclusive and no firm diagnosis is made

R22.1 Localised swelling, mass and lump, neck

Mass removed from neck. Responsible consultant confirms lipoma

D17.0 Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck

Patient admitted for treatment of hypertension. While on the ward patient suffers a heavy nosebleed for which their nose had to be packed

I10.X Essential (primary) hypertension
R04.0 Epistaxis

Gangrene complicating Type 2 diabetes mellitus

E11.5 Type 2 diabetes mellitus, with peripheral circulatory complications
R02.X Gangrene, not elsewhere classified

Patient admitted with cerebral infarction 4 weeks ago. Patient received speech therapy for dysphasia

I63.9 Cerebral infarction, unspecified
R47.0 Dysphasia and aphasia

ICD-10 code **Z50.5 Speech therapy *can*** be assigned in addition, as speech therapy is not specifically classified in OPCS-4. ***See also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).***

Patient with urethral stricture is admitted for catheterisation due to retention of urine

N35.9 Urethral stricture, unspecified
R33.X Retention of urine

Coding standards and guidance

Elevated blood-pressure reading, without diagnosis of hypertension (R03.0)
See DCS.IX.1: Essential (primary) hypertension (I10.X).

DCS.XVIII.1: Central chest pain (R07.2)
Central chest pain must be classified to code **R07.2 Precordial pain.**

DCS.XVIII.2: Right iliac fossa pain and left iliac fossa pain (R10.3)

Right iliac fossa (RIF) pain and left iliac fossa (LIF) pain must be classified to code **R10.3 Pain localised to other parts of the lower abdomen**

Occult blood in faeces classified at **R19.5 Other faecal abnormalities** may also be described as occult blood in stools and faecal occult blood (FOB)

Jittery baby (R25.8)

See DCS.XVI.8: Jittery baby (R25.8).

DCS.XVIII.3: Immobility and reduced mobility (R26.3, R26.8)

The terms ‘immobility, ‘chairfast’, ‘bedfast’, ‘bedbound’ and ‘bedridden’ must be classified to code **R26.3 Immobility** when documented in the medical record.

Terms such as ‘reduced mobility’ and ‘poor mobility’ must be classified to **R26.8 Other and unspecified abnormalities of gait and mobility**

See also DCS.XXI.18: Problems related to care-provider dependency (Z74).

DCS.XVIII.4: Geriatric and elderly falls (R29.6)

Geriatric and elderly falls **must be coded as follows:**

Geriatric and elderly fall without injury:

R29.6 Tendency to fall, not elsewhere classified

Geriatric and elderly fall with injury:

Code classifying the injury sustained from Chapter XIX
External cause code from categories **W00-W19**
R29.6 Tendency to fall, not elsewhere classified

If the patient remains in hospital for investigation of the falls and this becomes the primary focus of care, then code **R29.6** must be sequenced before the codes for the injury.

See also DChS.XX.1: External causes.

The elderly are at a higher risk of falling and often fall without sustaining an injury, these falls may be described as geriatric or elderly falls.

Examples:

Elderly patient admitted to hospital following geriatric fall at home sustaining laceration of eyelid which is sutured. The patient is discharged home the next day.

S01.1 Open wound of eyelid and periocular area
W19.0 Unspecified fall, home
R29.6 Tendency to fall, not elsewhere classified

Elderly patient has geriatric fall at home, sustains contusion to lower leg. The patient is transferred on the second day to an elderly ward for investigations of their repeated falls.

First episode

S80.1 Contusion of other and unspecified parts of lower leg
W19.0 Unspecified fall, home
R29.6 Tendency to fall, not elsewhere classified

Second episode

R29.6 Tendency to fall, not elsewhere classified
S80.1 Contusion of other and unspecified parts of lower leg

Persistent vegetative state (G93.1 and R40.2)

See DCS.VI.5: Persistent vegetative state (G93.1 and R40.2).

Accidental awareness during general anaesthesia [AAGA] due to equipment failure

See DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA].

DCS.XVIII.5: Chronic intractable pain (R52.1)

When patients are admitted for treatment of generalised chronic pain affecting more than one organ or body region caused by a more specific condition, code **R52.1 Chronic**

intractable pain must be assigned in addition to the code classifying the specific condition causing the pain.

Chronic intractable pain must not be coded if the chronic pain caused by a specific condition is located in only one organ or body region (eg pain in hip); in these cases only the code for the specific condition must be assigned.

Although 'chronic intractable pain' is not a term that is normally used in the medical record, ICD-10 code **R52.1** fully describes the type of generalised chronic pain suffered by some patients, particularly those with cancer.

Examples:

Patient admitted for control of chronic joint pains in hands, feet, elbows and shoulders caused by rheumatoid arthritis.

M06.90 Rheumatoid arthritis, unspecified, multiple sites
R52.1 Chronic intractable pain

Patient with osteosarcoma of the femur is admitted for control of generalised chronic pain.

C40.2 Malignant neoplasm: Long bones of lower limb
R52.1 Chronic intractable pain

Patient admitted for pain relief for chronic back pain due to lumbar disc displacement

M51.2 Other specified intervertebral disc displacement

DCS.XVIII.6: Off legs (R54.X)

The diagnosis of 'off legs' in an elderly patient must be classified to code **R54.X Senility**.

Severe sepsis and septic shock (R57.2, R65.1)

See DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis

DCS.XVIII.8: Systemic Inflammatory Response Syndrome [SIRS] (R65)

Codes within category **R65.- Systemic Inflammatory Response Syndrome [SIRS]** must only be used in a secondary position following the condition or underlying disease causing SIRS. The appropriate codes for the organ failure, if present, must also be coded in addition.

See also DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis.

Example:

Patient with biliary acute pancreatitis causing SIRS with kidney failure.

K85.1 Biliary acute pancreatitis
R65.3 Systemic Inflammatory Response Syndrome of non-infectious origin with organ failure
N19.X Unspecified kidney failure

DCS.XVIII.10: Multiple organ failure (R68.8)

When multiple organ failure is recorded in the medical record, the coder must seek clarification about which individual organs have failed and code each organ failure separately. If no further clarification is provided and the only information available is that the patient has multiple organ failure, the code **R68.8 Other specified general symptoms and signs** must be assigned.

See also DGCS.10: Multiple condition codes.

DCS.XVIII.11: Unknown and unspecified causes of morbidity (R69.X) and Ill-defined and unknown causes of mortality (R96–R99)

The codes in categories **R69.X Unknown and unspecified causes of morbidity**, **R96.- Other sudden death, cause unknown**, **R98.X Unattended death** and **R99.X Other ill-defined and unspecified causes of mortality** must only be used when no further information about the patient's condition is available.

To avoid use of these codes, the coder should investigate sources such as admission books, casualty records, X-ray records etc. for more information. Only information which has been verified by the responsible consultant should be used.

DCS.XVIII.12: Raised International Normalised Ratio [INR] (R79.8)

Raised INR must be coded as follows:

Code classifying the condition being treated by the anticoagulant
R79.8 Other specified abnormal findings of blood chemistry
Z92.1 Personal history of long-term (current) use of anticoagulants (if the patient is currently taking anticoagulants or if they have a personal history of anticoagulation therapy)

If the patient undergoes investigations/treatment of the raised INR during the episode, therefore becoming the main condition treated, **R79.8** must be sequenced before the code classifying the condition being treated by the anticoagulants, in line with ***DGCS.1: Primary diagnosis***.

See also DCS.III.3: Haemorrhagic disorder due to circulating anticoagulants (D68.3).

Patients who are taking anticoagulants (such as Warfarin) undergo regular monitoring to ensure that their blood is clotting correctly and that they are on the correct anticoagulant dosage. This is determined using the International Normalised Ratio (INR). Often a patient's INR may be raised.

Example:

Patient taking Warfarin for the treatment of paroxysmal atrial fibrillation, routine blood test indicates a dangerously high INR. The patient is admitted for treatment to reduce the high INR.

R79.8 Other specified abnormal findings of blood chemistry
I48.0 Paroxysmal atrial fibrillation
Z92.1 Personal history of long term (current) use of anticoagulants

Raised Prostate Specific Antigen [PSA] (R79.8)

See DCS.XIV.6: Raised Prostate Specific Antigen [PSA] (R79.8)

Sudden infant death syndrome (R95)

See DCS.XVI.9: Sudden infant death syndrome (R95).

CHAPTER XIX INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00–T98)

Chapter standards and guidance

Injuries, poisoning, other trauma and external cause

When coding an injury, poisoning or other trauma from Chapter XIX, an external cause code from Chapter XX must be assigned in a secondary position to identify the circumstance of the injury, complication, poisoning or adverse effect, as described in ***DChS.XX.1: External causes.***

Example:

Laceration of finger. Cut by chisel when doing DIY at home.

S61.0 Open wound of finger(s) without damage to nail
W27.0 Contact with nonpowered hand tool, home

DChS.XIX.1: Multiple injuries

Multiple injuries must be coded separately where the specific sites and types of injuries are documented. The injury that is clearly the most severe and demanding of resources must be sequenced in the primary position as per the primary diagnosis definition (***See DGCS.1: Primary diagnosis***). Where no one condition obviously predominates, the responsible consultant's advice must be sought.

Codes in Chapter XIX that classify 'multiple injuries' must only be used where no detail is documented in the medical record about the individual sites or types of the injury (e.g. **S01.7 Multiple open wounds of head, S09.7 Multiple injuries of head**).

The exceptions are bilateral injuries of limbs involving the same body site, ***see DCS.XIX.3 Bilateral injuries of limbs involving the same body site (T00-T07).***

When multiple injuries are caused by the same event, only one external cause code is assigned directly after the final injury code, ***see DChS.XX.1: External causes***.

See also DGCS.10: Multiple condition codes.

Examples:

Laceration left hand, concussion and open fracture of left tibia and fibula requiring open reduction and internal fixation. All sustained during fall from tree in the local park.

S82.21 Fracture of shaft of tibia, open
S61.9 Open wound of wrist and hand, part unspecified
S06.00 Concussion, without open intracranial wound
W14.8 Fall from tree, other specified places

Multiple open wounds of left upper arm due to contact with a combine harvester in farm

S41.7 Multiple open wounds of shoulder and upper arm
W30.7 Contact with agricultural machinery, farm

DChS.XIX.2: Fifth characters in Chapter XIX

Supplementary fifth characters are used in this chapter to identify open and closed fractures, intracranial injuries with or without open intracranial wound and internal injuries with or without open wound into cavity. They must be assigned when instructed by the note at code, category or block level.

An injury not indicated as 'open' or 'closed' must be recorded using fifth character **.0**.

See also DConvention.7: Fifth characters.

Examples:

Fracture neck of femur. Fall down stairs at home

S72.00 Fracture of neck of femur, closed
W10.0 Fall on and from stairs and steps, home

Traumatic haematoma of kidney. Hit by pedal cyclist whilst crossing the road walking to shops

S37.00 Injury of kidney, without open wound into cavity
V01.1 Pedestrian injured in collision with pedal cycle, traffic accident

DChS.XIX.3: Infected open wounds

Infected open wounds must be coded in the same way as a non-infected open wound, i.e. code assignment is the same but if the organism causing the infection is known, a code from categories **B95–B98 Bacterial, viral and other infectious agents** must be coded in addition.

See also:

- ***DGCS.6: Infections***
- ***DCS.I.4: Bacterial, viral and other infectious agents (B95-B98).***

Examples:

Readmission with infected open wound of finger

S61.0 Open wound of finger(s) without damage to nail

Readmission with open wound of finger infected with staphylococcus

S61.0 Open wound of finger(s) without damage to nail
B95.8 Unspecified staphylococcus as the cause of diseases classified to other chapters

Chronic versus current injuries of the musculoskeletal system and connective tissue

See DChS.XIII.2: Chronic versus current injuries of the musculoskeletal system and connective tissue.

Coding Standards and guidance

DCS.XIX.1: Skull fracture with intracranial injuries (S02 and S06)

When coding skull fractures (**S02.-**) associated with intracranial injuries (**S06.-**); the intracranial injury (**S06**.-) must be sequenced first.

Example:

Open fracture of frontal bone of skull with open intracranial injury. Hit by hockey stick when playing hockey on the hockey field

S06.91 Intracranial injury, unspecified, with open intracranial wound
S02.01 Fracture of vault of skull, open
W21.3 Striking against or struck by sports equipment, sports and athletics area

DCS.XIX.2: Unspecified head injury (S09.9)

Code **S09.9 Unspecified injury of head** must not be assigned when the responsible consultant has specified the type of injury to the head.

Example:

Five year old boy admitted with head injury – laceration to scalp. Fall at home.

S01.0 Open wound of scalp
W19.0 Unspecified fall, home

DCS.XIX.3: Bilateral injuries of limbs involving the same body site (T00-T07)

Codes in categories **T00-T07 Injuries involving multiple body regions** must only be used for bilateral injuries of limbs where the type and site of injury are identical on both sides.

See also:

- ***DGCS.10: Multiple condition codes***
- ***DChS.XIX.1: Multiple injuries.***

Examples:

Multiple contusions to lower legs. Struck by dog.

T00.3 Superficial injuries involving multiple regions of lower limb(s)
W54.9 Bitten or struck by dog, unspecified place

Fractures of both left and right forearm. Fall from balcony in hotel.

T02.40 Fractures involving multiple regions of both upper limbs, closed
W13.5 Fall from, out of or through building or structure, trade and service area

Epilepsy and injury

See DCS.VI.1: Epilepsy and injury.

Periprosthetic and peri-implant fractures (M96.6)

See DCS.XIII.5: Periprosthetic and peri-implant fractures (M96.6).

Geriatric and elderly falls (R29.6)

See DCS.XVIII.4: Geriatric and elderly falls (R29.6).

DCS.XIX.4: Foreign bodies (T15-T19)

Foreign body injuries must be classified according to the site where the foreign body is currently located.

Example:

Coin in stomach (swallowed in residential home)

T18.2 Foreign body in stomach
W44.1 Foreign body entering into or through eye or natural orifice, residential institution

DCS.XIX.5: Burns and corrosions (T20-T32)

Burns and corrosions of the same site that exhibit multiple degrees must be coded to the most severe degree of that site using codes in categories **T20-T30 Burns and corrosions**.

A code from categories **T31.- Burns classified according to extent of body surface involved** or **T32.- Corrosions classified according to extent of body surface involved** must be assigned in addition to a code from categories **T20-T25 Burns and corrosions of external body surface, specified by site** or **T29.- Burns and corrosions of multiple body regions** when the total percentage of body surface involved in a burn or corrosion is documented.
When the site of the burn is unspecified and only the total percentage of body surface is documented only a code from categories **T31.-** or **T32.-** is required.

Many patients with burns will have to undergo several admissions for grafting after the original admission, and this usually forms part of the care plan. It is similar to a cancer patient having a series of chemotherapy treatments as part of their primary treatment. On the subsequent admissions the original burn injury would still be coded, but without the external cause code.

***See also DChS.XX.1: External causes**.*

Examples:

Third degree burn of hand (2% of body surface) from campfire at scouts forest camp

T23.3 **Burn of third degree of wrist and hand**
T31.0 **Burns involving less than 10% of body surface**
X03.8 **Exposure to controlled fire, not in building or structure, other specified places**

Readmission for grafting of second and third degree burns of forearm

T22.3 **Burn of third degree of shoulder and upper limb, except wrist and hand**

DCS.XIX.6: Maltreatment syndromes (T74)

Codes in category **T74.- Maltreatment syndromes** classify non-accidental injuries (NAI) and must be assigned using the following codes and sequencing:

T74.- **Maltreatment syndromes**
Code for the injury caused
Y07.- **Other maltreatment**

The responsible consultant must clearly state that an injury is a non-accidental injury before a code from category **T74.-** can be assigned.

Example:

Baby, physically abused by parent, admitted with fractured rib

T74.1 Physical abuse
S22.30 Fracture of rib, closed
Y07.1 Other maltreatment by parent

DCS.XIX.7: Postprocedural complications of medical and surgical care

When coding postprocedural complications and disorders it must *never be* assumed that a condition is a postprocedural complication or disorder; it must be clearly documented as such by the responsible consultant.

Postprocedural complications and disorders can be coded in three different ways.

Reference to modifiers and qualifiers, such as ‘postoperative’ in the Alphabetical Index, is essential for selecting the correct code.

A code from categories **Y40-Y84** must always be assigned for complications of medical or surgical care to allow for accurate reporting of external causes.

Conditions that result from another external cause that are not directly due to the medical or surgical care, e.g. rupture of an operative wound due to a fall, must have the appropriate external cause code assigned to cover the circumstance. A code from **Y40-Y84** must not be assigned. ***See DChS.XX.1: External causes.***

Coding T80–T88 Complications of surgical and medical care, not elsewhere classified

When the Alphabetical Index directs to a code from categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**, (using lead terms for the actual complication, such as displacement and leakage, or via the specific condition with modifiers to indicate that it was a result of a procedure or under ‘Complication’), apply the following codes and sequencing:

T80-T88 Complications of surgical and medical care, not elsewhere classified
Any additional code(s) as directed by the ‘Use additional code’ notes in the Tabular List (Additional code may be sequenced in Primary diagnostic position

when this is the main condition treated or investigated. See **DGCS.1: Primary diagnosis**)

Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural complications classified to categories **T80-T88** are due to the same external cause, the external cause code must only be assigned once, following all the applicable postprocedural complication codes from categories **T80-T88**.

This applies regardless of whether the complication occurs during the same episode on which the procedure took place, or on a subsequent episode / subsequent readmission for treatment of the postoperative complication.

Coding postprocedural disorders in body system chapters

When the Alphabetical Index directs to a code, in a postprocedural disorder category in a body system chapter, not ending in **.8** or **.9** (e.g. **N99.1 Postprocedural urethral stricture**), or where a specific standard indicates that these codes must be used (e.g. ***DCS.VII.4: Post enucleation socket syndrome, PESS (H59.8 and Y83.6)***), apply the following codes and sequencing:

Code from postprocedural disorder category in a body system chapter

Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural complications are classified to codes in the postprocedural disorder categories within the body system chapters, and are due to the same external cause, the external cause code must only be assigned once, following all the codes from the postprocedural disorder category or categories.

When the Alphabetical index directs to a code in a postprocedural disorder category in a body system chapter ending in **.8** or **.9** (e.g. **N99.8 Other postprocedural disorders of genitourinary system**), do not assign this code, but follow the instruction in **Coding the condition plus external cause code** section (found below) instead. The exception is if a code for the specific condition does not exist; in this case the **.8** or **.9** code from the postprocedural disorder category in the body system chapter must be assigned.

Coding the condition plus external cause code

When the Alphabetical Index does not direct to a code in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**, or a code in a postprocedural disorders category in a body system chapter (as described above) apply the following codes and sequencing:

Code from Chapters I-XVIII classifying the specific condition

Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural conditions due to the same external cause are classified using codes from Chapters I-XVIII (that are not classified to one of the postprocedural disorder categories), the external cause code must be assigned multiple times, i.e. following each code from Chapters I-XVIII.

Postprocedural infections

Postprocedural infections must be coded following the standards listed above. Where it is necessary to indicate the infectious organism causing the infection the following codes and sequencing must be applied:

Code from categories **T80-T88** or the code from a postprocedural disorder category in a body system chapter or the code from a body system chapter classifying the specific condition
Any additional code(s) as directed by the 'Use additional code' notes in the Tabular List *
B95-B98 Bacterial, viral and other infectious agents
U82 Resistance to betalactam antibiotics, **U83 Resistance to other antibiotics** or **U84 Resistance to other antimicrobial drugs** (If the infective organism is resistant to a drug(s))
Y40-Y84 Complications of medical and surgical care

* The sequencing of **T81.4 Infection following a procedure, not elsewhere classified** and the manifestation of infection code(s) is dependent upon the main condition treated.
See: DGCS.1: Primary diagnosis

See also:

- ***DGCS.6: Infections***
- ***DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis***
- ***DCS.X.3: Postprocedural pneumonia***
- ***DFigure.XIX.1: Postprocedural complications of medical and surgical care***
- ***DChS.XX.1: External causes***
- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***
- ***DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)***
- ***DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)*** .

Postprocedural complications and disorders are conditions arising as a result of surgical or medical procedures. In the medical record they may be referred to as

postoperative/postprocedural/post-op complications or disorders following surgery or following a procedure.

The majority of postprocedural complications/disorders will be classified to a code from the range **T80-T88 Complications of surgical and medical care, not elsewhere classified** *or* one of the postprocedural disorder codes within a body system chapter. Codes in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified** specifically classify complications of surgery and medical care that are not classified elsewhere, i.e. postprocedural disorders that are not specifically classified to a postprocedural disorder code within a body system chapter.

The assignment of a code for the specific condition together with an external cause code is required for those conditions that can arise in the postoperative period, but are not unique to this situation. For example, a urinary tract infection can occur as a postoperative complication; however, this will not always be the case. Postoperative conditions such as this are coded in the usual way, but a code from **Y40-Y84** is added to identify the relationship between the condition and the procedure.

Codes from categories **Y83-Y84** are indexed under the lead term ‘Complication’ in Section II of the Alphabetical Index.

Postprocedural infection and complication following insertion of prosthesis, implant or graft
When coding postprocedural wound infections in patients with prosthetic devices, implants or grafts it is important to determine if the infection is actually due to the prosthetic device itself, or genuinely of the wound site, as this will affect code assignment from categories **T80-T88**.

Other types of complications in patients with prosthetic devices, implants or grafts must be treated with the same caution. For example, a femoral/popliteal bypass graft often becomes occluded after a period of time. This occlusion can occur because of a mechanical complication of the graft (**T82.3 Mechanical complication of other vascular grafts**) or due to a recurrence of the original disease, such as occluded femoral artery. Where the occlusion is due to recurrence of the original disease, the original disease would be coded as the main condition. Clinical advice should be sought as to the reason for the occlusion if it is not clear in the medical record.

Sequencing
The sequencing of postprocedural complication codes may on occasions change as the complication may present problems that affect the patient’s management and become the main condition treated instead of the condition that the procedure was performed for.

Examples:

Phlebitis following IV infusion

T80.1 Vascular complications following infusion, transfusion and therapeutic injection
Y84.8 Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other medical procedures

Postoperative haemorrhage five hours after a tonsillectomy

T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Patient readmitted with swab in-situ following cholecystectomy

T81.5 Foreign body accidentally left in body cavity or operation wound following a procedure
Y61.0 Foreign object accidentally left in body during surgical and medical care, During surgical operation

Readmission with a postoperative wound infection (due to streptococcus, group A) at incision site following a femoral/popliteal bypass graft

T81.4 Infection following a procedure, not elsewhere classified
B95.0 *Streptococcus*, group A, as the cause of diseases classified to other chapters
Y83.2 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Rupture of an operative wound following a fall

T81.3 Disruption of operation wound, not elsewhere classified
W19.9 Unspecified fall, unspecified place

Patient readmitted 12 weeks post total hip replacement. Documented diagnosis of postoperative wound infection due to hip joint prosthesis

T84.5 Infection and inflammatory reaction due to internal joint prosthesis
Y83.1 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with implant of artificial internal device

Postgastrectomy dumping syndrome

K91.1 Postgastric surgery syndromes
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Postprocedural urethral stricture following gastric bypass

N99.1 Postprocedural urethral stricture
Y83.2 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Breakdown of internal anastomosis of intestine

K91.8 Other postprocedural disorders of digestive system, not elsewhere classified
Y83.2 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Postoperative urinary tract infection and wound infection after cholecystectomy

N39.0 Urinary tract infection, site not specified
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)
T81.4 Infection following a procedure, not elsewhere classified
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Code **Y83.6** has been assigned twice, as it is necessary to show that the urinary tract infection is postoperative, as well as to provide additional information to **T81.4**.

Postoperative haematoma and wound dehiscence following total hip replacement

T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified
T81.3 Disruption of operation wound, not elsewhere classified
Y83.1 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with implant of artificial internal device

Pulmonary embolism as a result of percutaneous embolisation of liver

I26.9 Pulmonary embolism without mention of acute cor pulmonale
Y83.8 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other surgical procedures

Postoperative urinary tract infection (Escherichia coli, resistant to vancomycin) following total abdominal hysterectomy two days ago

N39.0 Urinary tract infection, site not specified
B96.2 *Escherichia coli [E. coli]* as the cause of diseases classified to other chapters
U83.0 Resistance to vancomycin
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

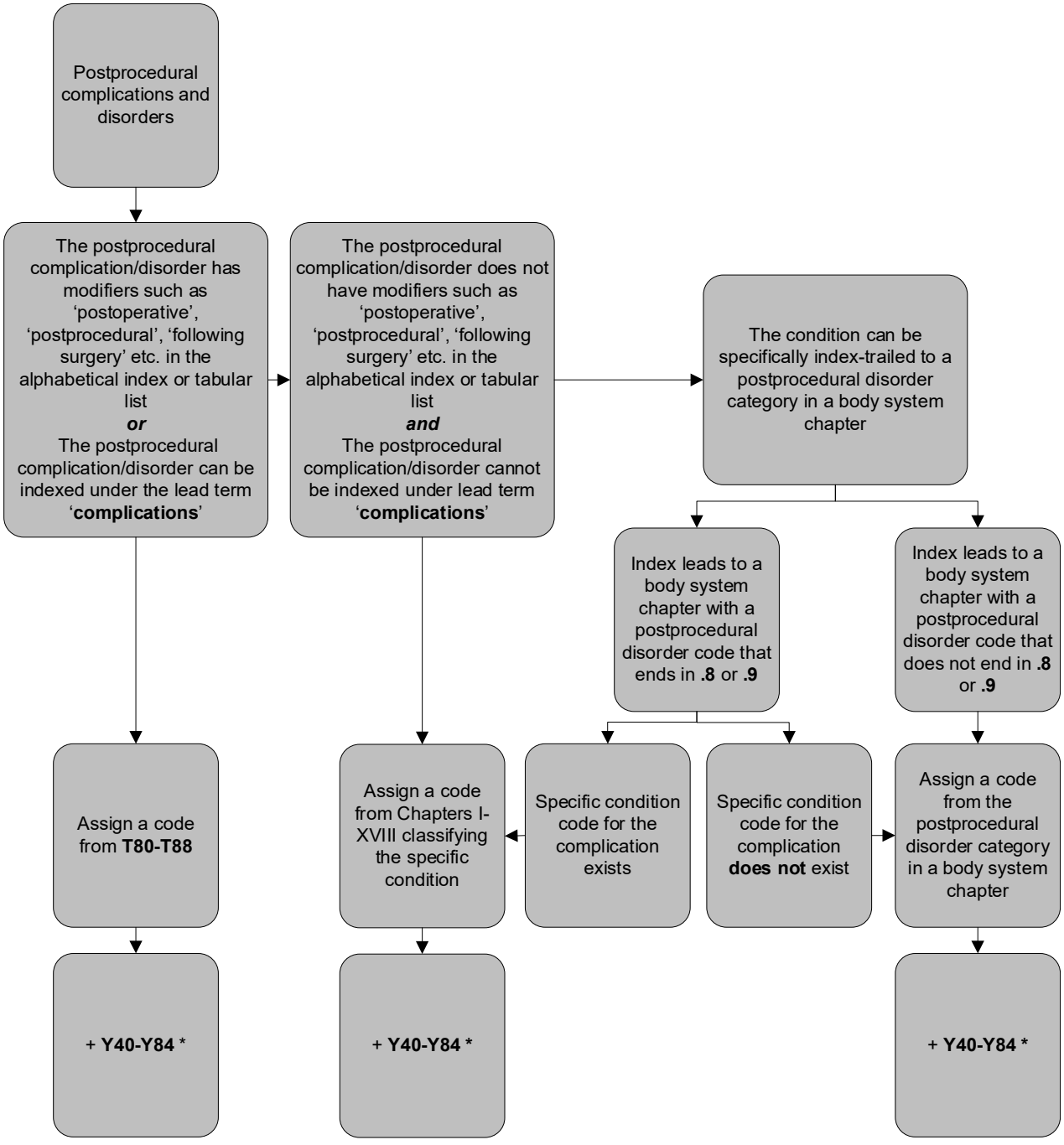
Patient admitted for reconstruction of torn anterior cruciate ligament after being tackled by another player when playing football at his local football field earlier that day. The day after surgery, the patient develops a postoperative wound infection which fails to respond to antibiotics and results in a return to theatre one week later for an above knee amputation due to sepsis (all during the same episode).

A41.9 Sepsis, unspecified
T81.4 Infection following a procedure, not elsewhere classified
Y83.4 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other reconstructive surgery
S83.5 Sprain and strain involving (anterior) (posterior) cruciate ligament of knee
W03.3 Other fall on same level due to collision with, or pushing by, another person, sports and athletics area

Patient admitted for the drainage of a postoperative abdominal wound abscess following a bowel resection.

L02.2 Cutaneous abscess, furuncle and carbuncle of trunk
T81.4 Infection following a procedure, not elsewhere classified
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

DFigure.XIX.1: Postprocedural complications of medical and surgical care



* Conditions that result from another external cause that are not directly due to the medical or surgical care, e.g. rupture of an operative wound due to a fall, must have the appropriate external cause code assigned to cover the circumstance. A code from **Y40-Y84** must not be assigned.

See DCS.XIX.7: Postprocedural complications of medical and surgical care.

Post Enucleation Socket Syndrome, PESS (H59.8 and Y83.6)

See DCS.VII.4 Post Enucleation Socket Syndrome, PESS (H59.8 and Y83.6).

Sunken Socket Syndrome (H59.8 and Y83 or Y84)

See *DCS.VII.5 Sunken Socket Syndrome (H59.8 and Y83 or Y84).*

DCS.XIX.8: Poisoning (T36-T65)

Reactions to drugs and medicines can occur from either their improper use (**poisoning**) or proper use (**adverse effects**), ***see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***).

Where a reaction to a drug or medicine is not stated as being the result of proper or improper use, it is assumed to be the result of proper use and must therefore be coded as an adverse effect.

Poisonings must be coded as follows:

- Assign a code from Chapter XIX for the substance causing the poisoning as indicated in the Table of Drugs and Chemicals in Section III of the Alphabetical Index
- Assign an external cause code from Chapter XX for the circumstance of the poisoning (accidental, intentional, undetermined intent, ***See DCS.XX.4: Accidents (V01-X59) and intentional self harm (X60-X84), DCS.XX.5: Event of undetermined intent (Y10-Y34) and DCS.XX.6: Assault by drugs, medicaments and biological factors (X85)***) as indicated in the Table of Drugs and Chemicals in Section III of the Alphabetical Index
- Assign a code(s) for any manifestations or reactions, if stated in the medical record
    - Manifestations or reactions classified within Chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (**R00-R99**) must be coded in a secondary diagnosis position following the external cause code for the poisoning.
    - Manifestations and reactions classified outside of Chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (**R00-R99**) must be coded in a secondary diagnosis position following the external cause code for the poisoning unless it is clear that the reaction or manifestation is the main condition treated.

When a drug has more than one component (e.g. Co-codaprin, which is a combination of codeine phosphate and aspirin), each component must be coded separately and sequenced according to the order in which the components appear in the drug name (e.g. when coding Co-fluampicil, **flu**cloxacillin must be sequenced before **ampicil**lin).

Where the poisoning is due to more than one drug and each drug has been identified in the medical record, separate codes must be assigned for each drug. The responsible consultant must determine which drug is the most clinically dangerous.

Do not assign the same external cause code multiple times when coding multiple drugs or components. Assign each external cause code once after all of the drugs/components it is associated with.

An adverse reaction due to a drug (either properly or improperly administered) taken in combination with alcohol of any kind must be coded as a **poisoning** by both agents.

An adverse reaction occurring due to the combination of taking a prescribed drug and a non-prescribed drug must be coded as a **poisoning** by both agents.

See also:

- ***DCS.XX.4: Accidents (V01-X59) and intentional self harm (X60-X84)***
- ***DCS.XX.5: Event of undetermined intent (Y10-Y34)***
- ***DCS.XX.6: Assault by drugs, medicaments and biological factors (X85)***
- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***
- ***DCS.XXI.1: Persons encountering health services for examination and investigation (Z00–Z13) for coding of suspected overdose.***

Poisoning can also be described as:

- intoxication
- overdose
- therapeutic misadventure
- toxic effect/toxicity
- wrong dosage given or taken
- wrong substance given or taken.

Any uncertainty regarding drugs with multiple components can be clarified by referring to the British National Formulary (BNF) which can be accessed online. Alternatively, a Trust pharmacy department may be able to supply an up-to-date copy of the BNF.

Examples:

Patient admitted following codeine overdose

T40.2 Poisoning: Other opioids
X42.9 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, unspecified place

Overdose on 30 paracetamol tablets and 14 sedatives at home. Consultant confirms paracetamol is the most dangerous drug.

T39.1 Poisoning: 4-Aminophenol derivatives
X40.0 Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home
T42.7 Poisoning: Antiepileptic and sedative-hypnotic drugs, unspecified
X41.0 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, home

Patient admitted with intentional overdose of Co-codamol (BNF confirms the correct sequence as codeine phosphate, then paracetamol)

T40.2 Poisoning: Other opioids
X62.9 Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, unspecified place
T39.1 Poisoning: 4-Aminophenol derivatives
X60.9 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, unspecified place

Codeine overdose in a six year old child who helped herself to mother's pills from a cupboard at home

T40.2 Poisoning: Other opioids
X42.0 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home

Patient admitted from a nightclub after having a non-alcoholic drink spiked with LSD

T40.8 Poisoning: Lysergide [LSD]
X85.5 Assault by drugs, medicaments and biological substances, trade and service area

Coma due to accidental codeine overdose at home

T40.2 Poisoning: Other opioids
X42.0 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home
R40.2 Coma, unspecified

Patient admitted for treatment of acute renal failure following deliberate overdose of paracetamol at home

N17.9 Acute renal failure, unspecified
T39.1 Poisoning: 4-Aminophenol derivatives
X60.0 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home

Patient admitted with anoxic brain damage due to Seconal (barbiturate) taken in combination with alcoholic beverages at home

T42.3 Poisoning: Barbiturates
X41.0 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, home
T51.0 Toxic effect: Ethanol
X45.0 Accidental poisoning by and exposure to alcohol, home
G93.1 Anoxic brain damage, not elsewhere classified

Patient admitted with a coma due to accidentally taking a combination of antiallergics (prescribed) and barbiturates (not prescribed)

T45.0 Poisoning: Antiallergic and antiemetic drugs
X44.9 Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, unspecified place
T42.3 Poisoning: Barbiturates
X41.9 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, unspecified
R40.2 Coma, unspecified

Intentional overdose of aspirin and paracetamol at home.

T39.0 Poisoning: Salicylates
T39.1 Poisoning: 4-Aminophenol derivatives
X60.0 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home

DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA]

When it is documented in the patient's medical record, on the current admission, that the patient reported awareness during a procedure performed under general anaesthesia, the following codes must be assigned:

T88.5 Other complications of anaesthesia
Y48.- Drugs, medicaments and biological substances causing adverse effects in therapeutic use: Anaesthetics and therapeutic gases

When it is specifically stated in the medical record that the AAGA was due to failure in dosage of anaesthetic, failure of effect of dosage of anaesthetic or an incorrect anaesthetic was given; assign external cause code **Y63.6 Failure of dosage during surgical and medical care: Nonadministration of necessary drug, medicament or biological substance** instead of **Y48.-.**

If the awareness was reported during a procedure performed during pregnancy, labour, delivery or the puerperium using general anaesthesia, code **O29.8 Other complications of anaesthesia during pregnancy**, **O74.8 Other complications of anaesthesia during labour and delivery** or **O89.8 Other complications of anaesthesia during the puerperium** must be assigned instead of code **T88.5**. ***See also DCS.XV.13: Complications of anaesthesia during pregnancy, labour, delivery and the puerperium (O29, O74, O89).***

When it is specifically stated in the medical record that the AAGA was due to equipment failure the following codes must be assigned:

R41.8 Other and unspecified symptoms and signs involving cognitive functions and awareness
Y70.- Anaesthesiology devices associated with adverse incidents

See also:

- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***
- ***DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)***

Accidental awareness during general anaesthesia (AAGA) occurs when the patient becomes conscious during a general anaesthetic procedure and can remember things that happened in the operating theatre**.** Following the procedure the patient may report awareness. AAGA can lead to serious psychological disorder, such as post-traumatic stress disorder, and may lead to avoidance of future healthcare.

The Table of Drugs and Chemicals in Section III of the Alphabetical Index contains an extensive but not exhaustive list of drugs, medicinal and non-medicinal chemicals, and solvents. Proprietary names, i.e. trade names of drugs and medicaments, are not always listed. If a drug or medicament is not listed, the coder must obtain information about the type of drug, e.g. antidepressant, antihypertensive, and use these generic lead terms to look up a code in the Table of Drugs and Chemicals instead. For example, Antidepressant NEC and Antihypertensive drug NEC can both be found in the Alphabetical Index.

Mephedrone

See DCS.V.6: Mephedrone.

Rhabdomyolysis (M62.8, T79.5)

See DCS.XIII.3: Rhabdomyolysis (M62.8, T79.5).

See Chapter V for guidance for patient transfers in / out of mental health units.

CHAPTER XX EXTERNAL CAUSES OF MORBIDITY AND MORTALITY
(V01–Y98)

Chapter standards and guidance

DChS.XX.1: External causes

Codes in Chapter XX classify outside factors as the cause of injury, poisoning and other adverse effects. The following must be applied when using external cause codes:

- They must be assigned in addition to a code from Chapter XIX Injury, poisoning and certain other consequences of external causes or a code from Chapters I to XVIII when stated to be due to an external cause
- They must be sequenced immediately following a code which describes the injury, poisoning or adverse effect from Chapter XIX Injury, poisoning and certain other consequences of external causes or a condition.
- When multiple injuries from Chapter XIX or conditions from Chapters I to XVIII are due to the same external cause it is only necessary to record one external cause code from Chapter XX following all codes that classify the injuries or conditions.
    - For standards on recording the external cause code for poisonings by multiple drugs ***see DCS.XIX.8: Poisonings (T36-T65)*** and for standards on recording the external cause code for adverse effects of multiple drugs and multiple adverse effects of drugs ***see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***
- When the external cause of an injury is not specified code **X59.- Exposure to unspecified factor** must be assigned.
- Codes in categories **V01-Y36** must only be assigned on the first episode in which the condition is recorded in the United Kingdom. Any subsequent episode where the same condition is being treated does not require the external cause code from **V01-Y36**. This includes when a patient is transferred from one unit to another and to injuries occurring whilst the patient is in hospital.
- Codes in categories **Y40-Y98** must be assigned on every episode in which the condition is recorded, ***see DCS.XIX.7: Postprocedural complications of medical and surgical care***.
- The ‘definitions of transport accidents’ and the ‘Classification and coding instructions for transport accidents’ at the beginning of Chapter XX give detailed definitions and instructions regarding the coding of transport accidents (**V01-V99**), including the order of preference when more than one kind of transport is involved. These must be referred to when assigning fourth character codes with these categories.

- A fourth character must be assigned with codes from categories **W00-Y34** to identify where the injury, poisoning or adverse effect took place. The fourth characters can be found in the 'Place of occurrence code' section at the beginning of the chapter. The exceptions are codes in categories **Y06.- Neglect and abandonment** and **Y07.- Other maltreatment**, ***see DCS.XIX.6: Maltreatment syndromes (T74)***.
- The correct fourth character subdivision for a place of occurrence of pub or nightclub is **.5 Trade and service area**.

See also:

- ***DCS.VI.1: Epilepsy and injury***
- ***DCS.XIII.5: Periprosthetic and peri-implant fractures (M96.6)***
- ***DCS.XVIII.4: Geriatric and elderly falls (R29.6)***
- ***Chapter XIX for standards on coding injuries, poisoning, other trauma and external cause and for further examples of the application of external cause codes***
- ***DChS.XIX.1: Multiple injuries***
- ***DChS.XX.2: Activity codes***
- ***DCS.XX.2: Fourth character subcategory codes at W26, X34 and X59***
- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).***

External causes of injury are found in Section II of the Alphabetical Index. The index is organised by lead terms that describe the cause of the injury or other adverse effect:

- the accident, e.g. fall
- circumstance, e.g. suicide
- event, e.g. legal intervention
- specified agent, e.g. poisoning, carbon monoxide.

The coding external cause code standard also applies to patients initially treated in an Accident and Emergency (A&E) department for a condition due to an external cause who are subsequently admitted, as A&E departments do not assign ICD-10 external cause codes.

X59.- Exposure to unspecified factor can be indexed using the lead term '**Accident'**.

Examples:

Patient admitted under general medical consultant for treatment of angina. Patient fell from toilet on medical ward sustaining fracture of shaft of right humerus and open wound of the right temple. Transferred to orthopaedic consultant for treatment of fracture.

First episode (general medical consultant):

I20.9 Angina pectoris, unspecified
S42.30 Fracture of shaft of humerus, closed
S01.8 Open wound of other parts of head
W18.2 Other fall on same level, school, other institution and public administrative area

Second episode (orthopaedic consultant):

S42.30 Fracture of shaft of humerus, closed
S01.8 Open wound of other parts of head
I20.9 Angina pectoris, unspecified

Patient admitted with cellulitis due to insect bite on finger

L03.0 Cellulitis of finger and toe
W57.9 Bitten or stung by nonvenomous insect and other nonvenomous arthropods, unspecified place

Low back pain due to fall at home. No injury documented in the patient's medical record.

M54.5 Low back pain
W19.0 Unspecified fall, home

Rib and arm pain following fall from chair at home. No evidence of injury on examination.

R07.3 Other chest pain
M79.6 Pain in limb
W07.0 Fall involving chair, home

DChS.XX.2: Activity codes

ICD-10 provides an activity subclassification as an extra character for use with categories **V01–Y34** to indicate the activity of the injured person at the time the event occurred. However, due to the general unavailability of this information, these activity subclassification codes shown at the beginning of this chapter must not be used.

See also DConvention.7: Fifth characters.

Coding standards and guidance

DCS.XX.1: Accidents involving electric wheelchairs, mobility scooters and e-scooters

The following external cause codes must be applied when coding accidents involving electric wheelchairs, mobility scooters and e-scooters:

Occupant of electric wheelchair, mobility scooter or e-scooter	Without fall	With fall
Involved in a collision (*excluding* collision with a pedestrian or another electric wheelchair, mobility scooter, e-scooter or stationary object)	**V01.- to V09.-**	**V01.- to V09.-**
Involved in non-collision	**V09.-**	**V09.-**
Involved in collision with a pedestrian or another electric wheelchair, mobility scooter or e-scooter	**W51.-**	**W03.-.**
Involved in collision with a stationary object	**W22.-**	**W18.-**

Geriatric and elderly falls (R29.6)

See DCS.XVIII.4: Geriatric and elderly falls (R29.6).

DCS.XX.2: Fourth character subcategory codes at W26, X34 and X59

The fourth character codes printed at categories **W26.- Contact with other sharp object(s) X34.- Victim of earthquake** and **X59.- Exposure to unspecified factor** in the ICD-10 Tabular List must not be used and must be crossed through in the ICD-10 5th Edition books. The content that must be crossed through can be found in the **ICD-10 and *OPCS-4 Classifications Content Changes*** document on Delen.

The 'Place of occurrence codes' must be used for fourth character code assignment with categories **W26.-**, **X34.-** and **X59.-**.

See also DChS.XX.1: External causes.

The WHO Update Revision Committee previously agreed that 'Place of occurrence codes' should be separated from the three character Chapter XX code. Following this agreement WHO introduced new fourth character subcategory codes at **W26.-**, **X34.-** and **X59.-** . This re-designation and re-use of the fourth character by the WHO is incompatible with current UK practice when using categories **W26.-**, **X34.-** and **X59.-**, therefore the implementation of these fourth character subcategories has been deferred.

DCS.XX.3: Conditions linked to travel (X51.9)

When conditions such as deep vein thrombosis (DVT) are linked to travel, the external cause code **X51.9 Travel and motion** must be assigned in addition. As it is impossible to define at which point on a journey a DVT occurred, the place of occurrence fourth character **.9** must be used.

Example:

Deep vein thrombosis (DVT) due to patient travelling home from Australia by plane three days ago

I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities
X51.9 Travel and motion, unspecified place

DCS.XX.4: Accidents (V01-X59) and intentional self-harm (X60-X84)

Intentional self-harm codes **(X60-X84)** are used to identify attempted suicides or purposely self-inflicted poisoning or injury and must be assigned for any patient who has intended to harm themselves in any way. This includes any 'cry for help'.

Where it is not clear whether an injury or overdose is an accidental or intentional self-harm attempt or an assault, the code that classifies the accidental external cause or accidental poisoning must be assigned **(V01-X59)**.

See also DCS.XIX.8: Poisoning (T36-T65).

Examples:

Open wound of right wrist due to deliberately slashing with razor blade in bath at home.

S61.9 Open wound of wrist and hand, part unspecified
X78.0 Intentional self-harm by sharp object, home

Open wound of right wrist caused by razor blade

S61.9 Open wound of wrist and hand, part unspecified
W26.9 Contact with other sharp object(s), unspecified place

DCS.XX.5: Event of undetermined intent (Y10-Y34)

Event of undetermined intent codes **(Y10-Y34)** must only be used when undetermined intent is stated by a **medical** or **legal** authority, such as a coroner at an inquest. It must not be used when no information has been given about the circumstances of an event. If the intent is not known, a code that classifies an accidental external cause must be assigned.

See also DCS.XIX.8: Poisoning (T36-T65).

DCS.XX.6: Assault by drugs, medicaments and biological factors (X85)

A code from category **X85.- Assault by drugs, medicaments and biological substances** must be assigned when a patient is admitted with poisoning due to a ‘spiked’ drink.

See also DCS.XIX.8: Poisoning (T36-T65).

Other maltreatment (Y07)

***See DCS.XIX.6: Maltreatment syndromes (T74*).**

DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)

Adverse effects result from the proper use of a substance. Where a reaction to a drug or medicine is not stated as a result of proper or improper use, it is assumed to be the result of proper use and must therefore be coded as an adverse effect.

Adverse effects must be coded as follows:

- Assign a code for the nature of the adverse effect or the patient's reaction (e.g. a rash).
- Assign an external cause code from categories **Y40-Y59** as indicated in the column 'Adverse effect in therapeutic use' in the Table of Drugs and Chemicals in Section III of the Alphabetical Index.

Where multiple adverse effects (e.g. a rash and swelling) result from a drug, a code from categories **Y40-Y59** must be assigned after each of the adverse effects.

Where an adverse effect(s) is either due to multiple drugs where each drug has been identified in the medical record, or a drug containing multiple components, separate codes from categories **Y40-Y59** must be assigned for each drug or component.

An adverse reaction due to the combination of two (or more) prescribed drugs must be coded as an adverse effect of both agents, as long as each drug has been taken correctly.

If an adverse reaction is due to a prescription drug and it is not known whether the drug was prescribed or not, code as an adverse effect.

An adverse reaction due to a drug (either properly or improperly administered) taken in combination with alcohol of any kind must to be coded as a **poisoning** by both agents.

An adverse reaction occurring due to the combination of taking a prescribed drug and a non-prescribed drug must be coded as a **poisoning** by both agents.

A poisoning code from Chapter XIX must never be used with an adverse effect code in categories **Y40-Y59**.

See also:

- ***DCS.XIX.8: Poisoning (T36-T65)***
- ***DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA]***

Adverse effects can be described as:

- adverse effect of drug

- allergic reaction
- cumulative toxicity
- hypersensitivity
- idiosyncratic reaction
- side effects
- interaction of drugs

See also Chapter XIX for guidance on the Table of Drugs and Chemicals in Section III of the Alphabetical Index.

Examples:

Patient admitted for treatment of neutropenia due to Vincristine therapy for Hodgkin lymphoma

D70.X Agranulocytosis
Use additional external cause code (Chapter XX), to identify drug, if drug-induced.
Y43.3 Other antineoplastic drugs
C81.9 Hodgkin lymphoma, unspecified

Patient admitted with a generalised rash due to penicillin

L27.0 Generalized skin eruption due to drugs and medicaments
Use additional external cause code (Chapter XX), if desired, to identify drug.
Y40.0 Penicillins

Coma due to antiallergics and barbiturates taken in combination (each prescribed by different responsible consultants)

R40.2 Coma, unspecified
Y43.0 Antiallergic and antiemetic drugs
Y47.0 Barbiturates, not elsewhere classified

Bleeding gastric ulcer and bleeding duodenal ulcers both due to aspirin and celecoxib

K25.4 Gastric ulcer, chronic or unspecified with haemorrhage
Y45.1 Salicylates
Y45.3 Other nonsteroidal anti-inflammatory drugs [NSAID]
K26.4 Duodenal ulcer, chronic or unspecified with haemorrhage
Y45.1 Salicylates
Y45.3 Other nonsteroidal anti-inflammatory drugs [NSAID]

Constipation due to co-codamol (contains codeine and paracetamol)

K59.0 Constipation
Y45.0 Opioids and related analgesics
Y45.5 4-Aminophenol derivatives

DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)

Where misadventure to a patient occurs **during** a procedure, a code from categories **Y60-Y69 Misadventure to patients during medical and surgical care** must be assigned in a secondary position to the code describing the result of the misadventure.

Codes in **Y70-Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use** must be assigned in a secondary position to the code describing an adverse incident only when it is documented that a medical device itself has malfunctioned or broken either during a procedure, following implantation, or in the ongoing use of a device. Codes in **Y70-Y82** must not be assigned where external force causes a previously implanted device to break.

Where a patient has an abnormal reaction to a surgical or medical procedure, either during or following a procedure, and there is no mention of misadventure or device malfunction at the time of the procedure, a code from **Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure** must be assigned in a secondary position to the code describing the abnormal reaction. **See *DCS.XIX.7: Postprocedural complications of medical and surgical care.***

See also:

- ***DCS.XIII.5: Periprosthetic and peri-implant fractures (M96.6)***
- ***DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA]***
- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).***

In ICD-10, misadventure (**Y60-Y69**) is classified as an accident or injury that causes or has the potential to cause harm during surgical and medical care: the classification does not identify whether the misadventure was the result of the current or previous surgical or medical care, nor does it identify whether this occurred at the current or another health care provider. Use of these ICD-10 codes does not necessarily indicate any mistake on the part of the consultant, as a resulting accident/injury may be an unavoidable consequence of treatment; it only shows that the current situation is in some way the result of an accident/incident during a procedure.

Examples:

Bladder perforation during total abdominal hysterectomy

T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified
Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, during surgical operation

Multiple ribs fractured during chest compression for cardiopulmonary resuscitation

S22.40 Multiple fractures of ribs, closed
Y65.8 Other specified misadventures during surgical and medical care

DCS.XX.9: Evidence of alcohol involvement (Y90 and Y91)

Codes in categories **Y90.- Evidence of alcohol involvement determined by blood alcohol level** and **Y91.- Evidence of alcohol involvement determined by level of intoxication** must be assigned in a secondary position when evidence of alcohol involvement, determined by blood alcohol level or by level of intoxication, is documented in the medical record.

Example:

Patient admitted drunk with a blood-alcohol level of 60-79 mg/100ml

F10.0 Mental and behavioural disorders due to use of alcohol, acute intoxication
Y90.3 Blood alcohol level of 60-79 mg/100ml

DCS.XX.10: Hospital acquired conditions (Y95.X)

When the responsible consultant has documented in the medical record that a condition is 'hospital acquired' code **Y95.X Nosocomial condition** must be assigned directly after the code for the condition that has been documented as being 'hospital acquired'.

It must never be assumed that a condition is hospital acquired based on the fact that it was diagnosed whilst the patient was in hospital.

In cases where a patient is transferred from another hospital with a hospital acquired condition, code **Y95.X** must still be assigned as the **Y95.X** is linked to the actual condition and not to the hospital that it was acquired in.
A hospital acquired condition (also known as a nosocomial condition) is a condition that has developed as a result of an individual being in a hospital environment. Examples include hospital acquired pneumonia (HAP), hospital acquired clostridium difficile, hospital acquired MRSA and hospital acquired deep vein thrombosis. Code **Y95.X** can be index trailed in Section II, External causes of Injury of the Alphabetical Index under the lead term **'Factors, supplemental'**

Example:

Elderly patient with documented diagnosis of intracerebral haemorrhage and a hospital acquired deep vein thrombosis (DVT) of the left leg

I61.9 Intracerebral haemorrhage, unspecified
I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities
Y95.X Nosocomial condition

CHAPTER XXI FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES (Z00–Z99)

Coding standards and guidance

DCS.XXI.1: Persons encountering health services for examination and investigation (Z00–Z13)

Codes in categories **Z00–Z13 Persons encountering health services for examination and investigation** must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead. If an abnormal finding is detected or a specific diagnosis is made as a result of the investigation a code from **Z00-Z13** must not be assigned.

The exceptions to this are

- The following categories which must NEVER be used in a primary position:
  - **Z02.- Examination and encounter for administrative purposes**
  - **Z10.- Routine general health check-up of defined subpopulation**
- Codes in categories **Z08.- Follow-up examination after treatment for malignant neoplasm** and **Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms, *see DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)***

See also DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53).

Examples:

Toddler admitted with suspected overdose, having been found with an empty bottle of Aspirin. After examination, no evidence of poisoning was confirmed.

Z03.6 Observation for suspected toxic effect from ingested substance

Patient admitted for colonoscopy for screening due to a strong family history of cancer of the colon, the patient has no symptoms. Examination showed no evidence of any abnormality.

Z12.1 Special screening examination for neoplasm of intestinal tract
Z80.0 Family history of malignant neoplasm of digestive organs

DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)

Follow-up examinations for conditions that have been treated and are no longer present must be coded using the following codes and sequencing:

No recurrence of the condition is found during the follow-up examination:

> **Z08.- Follow-up examination after treatment for malignant neoplasm** or **Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms**
> Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for

An incidental finding(s) is noted on examination but not treated in hospital:

> **Z08.-** or **Z09.-**
> Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for
> Code(s) for incidental finding(s)

An incidental finding(s) is noted on examination and treatment is given in hospital for the finding(s):

> Code(s) for incidental finding(s)
> **Z08.-** or **Z09.-**
> Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for

Recurrence of the condition is found during the follow-up examination:

> Code for the recurrent condition
> Code(s) for any incidental finding(s)

Fourth character code assignment at categories **Z08.-** and **Z09.-** is dependent on the type of treatment the patient received for the original condition.

Examples:

Follow-up DMSA scan (tc-99m dimercaptosuccinic acid) after a previous urinary tract infection treated with antibiotics. No abnormalities detected.

> **Z09.2 Follow-up examination after chemotherapy for other conditions**
> **Z87.4 Personal history of diseases of the genitourinary system**

Patient admitted for a follow up examination for carcinoma of bladder previously treated by excision. No recurrence. On examination the patient is found to have a trabeculation of bladder which was not treated.

Z08.0 Follow-up examination after surgery for malignant neoplasm
Z85.5 Personal history of malignant neoplasm of urinary tract
N32.8 Other specified disorders of bladder

Routine check gastroscopy following drug treatment for previous gastric ulcer. Acute gastritis found and treated in hospital.

K29.1 Other acute gastritis
Z09.2 Follow-up examination after chemotherapy for other conditions
Z87.1 Personal history of diseases of the digestive system

Admitted for follow up of bladder cancer (previously treated by transurethral resection); recurrence on bladder wall.

C67.9 Malignant neoplasm: Bladder, unspecified

DCS.XXI.3: Persons with potential health hazards related to communicable diseases (Z20–Z29)
Codes in categories **Z20–Z29 Persons with potential health hazards related to communicable diseases** must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead.
Codes in categories **Z20–Z29** may be used in a secondary position to a code from another chapter if they add further information.

Example:

Patient 34 weeks pregnant is admitted with contractions. Responsible consultant confirms Braxton Hicks contractions (false labour) and she is discharged. The patient is known to be a carrier of group B streptococcus (GBS).

O47.0 False labour before 37 completed weeks of gestation
Z22.3 Carrier of other specified bacterial diseases

Asymptomatic human immunodeficiency virus [HIV] infection status (Z21.X)

See DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24).

DCS.XXI.4: Carrier of drug resistant bacterial diseases (Z22.3 and U82-U84)

A code from categories **U82 Resistance to betalactam antibiotics**, **U83 Resistance to other antibiotics** or **U84 Resistance to other antimicrobial drugs** must be assigned in a secondary position to code **Z22.3 Carrier of other specified bacterial diseases** to identify the drug to which the bacteria is resistant, when this is documented by the responsible consultant in the patient's medical record.

See also DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85).

Examples:

MRSA positive carrier.

Z22.3 Carrier of other specified bacterial diseases
U82.1 Resistance to methicillin

MRSA found on nasal swab only.

Z22.3 Carrier of other specified bacterial diseases
U82.1 Resistance to methicillin

DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54)

Codes in categories **Z30-Z54** must be used as follows:

Assign codes in categories **Z30-Z54** in a **primary** diagnostic position only when there is no diagnosis, complication, injury or symptom code from another chapter in ICD-10 to explain the encounter.

The following codes are exceptions which must **never** be used in a primary position**:**

- **Z30.0 General counselling and advice on contraception**
- **Z30.4 Surveillance of contraceptive drugs**
- **Z50.- Care involving use of rehabilitation procedures**
- **Z51.- Other medical care - *see also DCS.XXI.9: Palliative Care (Z51.5, Z51.8)***

Codes in categories **Z30-Z54** must not be assigned in a secondary position to identify an intervention or procedure, when the procedure/intervention has been fully classified by the assignment of an OPCS-4 code following correct application of the OPCS-4 national standards.

The exceptions to this standard are:

- **Z33.X Pregnant state, incidental – *see DCS.XV.33: pregnant state, incidental (Z33.X)***
- ***Z34*.- Supervision of normal pregnancy – *see DCS.XV.34: Supervision of normal pregnancy (Z34)***
- **Z37.- Outcome of delivery** - ***see DChS.XV.1: Outcome of delivery (Z37)***
- **Z38.- Liveborn infants according to place of birth - see *DChS.XVI.1: Liveborn infants according to place of birth (Z38)***
- **Z40.- Preventative surgery – *see DCS.XXI.6: Preventative surgery (Z40)***
- **Z49.- Care involving dialysis** - ***see DCS.XXI.8: Renal dialysis (Z49 and Z99.2)***
- **Z53.- Persons encountering health services for specific procedures, not carried out – *see DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53)***
- **Z54.- Convalescence – *see DCS.XXI.12: Convalescence (Z54).***

Codes in categories **Z30-Z54 *<u>can</u>*** be assigned in a **secondary** position to the diagnosis, symptom, complication or injury code from another chapter where doing so adds further information ***or*** where the procedure/intervention has not been fully described by the relevant OPCS-4 code(s)).

Examples:

Follow-up care for removal of internal fixation after treatment of fracture

Z47.0 Follow-up care involving removal of fracture plate and other internal fixation device

Patient with end stage renal disease admitted for removal of a central venous catheter

N18.5 Chronic kidney disease, stage 5

Code **Z45.2 Adjustment and management of vascular access device** would not be assigned in addition because the removal of the central venous catheter is fully classified using OPCS-4 codes.

Patient admitted to gynaecology ward to receive Mifepristone pessary for termination of pregnancy. Discharged home prior to aborting the pregnancy. The patient has vaginal bleeding prior to discharge

O04.9 Medical abortion, complete or unspecified, without complication

Code **Z51.2 Other chemotherapy** would not be assigned in addition because the introduction of the mifepristone pessary is fully classified using OPCS-4 codes.

Patient with dysphasia due to cerebral infarction (transferred to a rehabilitation specialty) undergoes speech therapy

I63.9 Cerebral infarction
R47.0 Dysphasia and aphasia
Z50.5 Speech therapy

The rehabilitation for stroke would be coded using an OPCS-4 code (***See PCSU7: rehabilitation (U50-U54)***); however as speech therapy is not specifically classified in OPCS-4, ICD-10 code **Z50.5 Speech therapy *can*** be assigned in addition. ***See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.***

Supervision of high-risk pregnancy (Z35)
See DCS.XV.3: Cancellation of medical termination of pregnancy.
See Chapter XV for guidance on definitions used in codes within category Z35 Supervision of high-risk pregnancy.

Care and examination immediately after delivery (Z39.0)
See DCS.XV.35: Care and examination immediately after delivery (Z39.0).

DCS.XXI.6: Preventative surgery (Z40)
When a patient is admitted for preventative (prophylactic) surgery due to a personal or family history of a condition, a code from category **Z40.- Prophylactic surgery** must be recorded as the primary diagnosis. A code from categories **Z80-Z87** must be assigned in a secondary position to identify the personal or family history of a condition.

Where the preventative surgery is being performed as a precautionary measure for a current condition, the code classifying the condition must be assigned in a primary position and a code from category **Z40.-** must be assigned in a secondary position.

Examples:

Admission for prophylactic mastectomy. Mother and one sister have breast cancer

Z40.0 Prophylactic surgery for risk-factors related to malignant neoplasms
Z80.3 Family history of malignant neoplasm of breast

Prophylactic nailing of femur to prevent fracture in patient with metastases of femur from primary malignancy of breast

C79.5 Secondary malignant neoplasm of bone and bone marrow
C50.9 Malignant neoplasm of breast: Breast, unspecified
Z40.0 Prophylactic surgery for risk-factors related to malignant neoplasms

DCS.XXI.7: Trial without catheter (Z46.6)

When a patient is admitted for trial without catheter (TWOC) and the trial is successful code **Z46.6 Fitting and adjustment of urinary device** is assigned as the primary diagnosis.

However, if a TWOC fails, the code describing the condition for which the patient was catheterised is assigned and not code **Z46.6**.

Examples:

Patient who had a prostatectomy three weeks ago and had to have a urethral catheter inserted because of urinary retention is now admitted for a trial without catheter (TWOC). The trial is successful.

Z46.6 Fitting and adjustment of urinary device

Patient who had a prostatectomy three weeks ago had a urethral catheter inserted because of urinary retention is now admitted for a trial without catheter (TWOC). The trial is unsuccessful.

R33.X Retention of urine

DCS.XXI.8: Renal dialysis (Z49 and Z99.2)

Codes in category **Z49.- Care involving dialysis** must never be assigned in the primary position. They are assigned (or not) as follows:

- Where a patient is admitted for the purpose of renal dialysis preparation or treatment, a code from category **Z49.-** must be assigned in a *secondary* position to the code describing the renal condition for which the patient is undergoing dialysis
- Where a patient is admitted for other treatment, and receives dialysis preparation or treatment whilst in hospital, a code from category **Z49.-** must not be assigned.

Z99.2 Dependence on renal dialysis must be assigned in a secondary position to classify patients who are on a regular programme of dialysis treatment, irrespective of whether the patient is attending for dialysis.

Examples:

Patient on a regular programme of dialysis for chronic end stage renal failure admitted for renal dialysis

N18.5 Chronic kidney disease, stage 5
Z49.1 Extracorporeal dialysis
Z99.2 Dependence on renal dialysis

Patient with end-stage renal disease admitted for total knee replacement for primary osteoarthritis of the right knee. While in hospital, he has ten haemodialysis sessions.

M17.1 Other primary gonarthrosis
N18.5 Chronic kidney disease, stage 5
Z99.2 Dependence on renal dialysis

DCS.XXI.9: Palliative Care (Z51.5, Z51.8)

Palliative care must be coded using **Z51.5 Palliative care** or **Z51.8 Other specified medical care** in a secondary position, as described in the table below:

Specialised Palliative Care/ **Specialised** Palliative Care Support	Palliative Care **not specified** as Specialised Palliative Care or Specialised Palliative Care Support

Assign code **Z51.5 Palliative care** in a secondary position.	Assign code **Z51.8 Other specified medical care** in a secondary position.
This includes 'End of Life Care' plan patients receiving **specialised** palliative care/ **specialised** palliative care support	This includes 'End of Life Care' plan patients receiving palliative care **not specified** as Specialised Palliative Care or Specialised Palliative Care Support

Code **Z51.8 Other specified medical care** is not restricted to palliative care and may be used to identify other instances of medical care.

DCS.XXI.10: Donors of organs and tissues (Z52)

Codes in category **Z52.- Donors of organs and tissues** must only be assigned for live donors of organs and tissues.

DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53)

Codes in category **Z53.- Persons encountering health services for specific procedures, not carried out** must never be assigned in a primary position. **Z53.-** must only be used for patients admitted electively for a procedure which is subsequently cancelled/not carried out/not started for any reason and **no other procedure** has been carried out, ie the coded record contains no OPCS-4 procedure codes within that particular episode. The following codes and sequencing must be applied:

Code(s) that classify the condition(s) prompting the admission

Z53.- Persons encountering health services for specific procedures, not carried out

If the planned procedure is cancelled because of a medical problem, condition or factor that makes it inadvisable to perform the procedure (such as a contraindication), the problem, condition or factor must also be coded.

Circumstances where a patient's surgery is cancelled due to the lack of a bed or theatre time is **not** a contraindication and such situations must be coded using **Z53.8 Procedure not carried out for other reasons**.

If a patient is admitted for a procedure for a condition and the procedure is cancelled because on examination the condition has resolved, the following codes and sequencing must be applied:

Z03.- Medical observation and evaluation for suspected diseases and conditions, or **Z04.- Examination and observation for other reasons**
Z53.8 Procedure not carried out for other reasons
Chapter XXI code classifying personal history of diseases

See also DCS.XXI.1: Persons encountering health services for examination and investigation (Z00–Z13).

A code from **Z53.-** must not be assigned if a procedure was started and then abandoned; it is only necessary to record the appropriate code(s) for the condition(s) which prompted the procedure to be performed, and/or complication codes if the procedure was abandoned due to a complication.

See also:

- ***DCS.XV.3: Cancellation of medical termination of pregnancy***
- ***DGCS.3: Co-morbidites – cancelled procedures.***

A contraindication is any condition or factor that makes it inadvisable to perform a particular procedure or treatment. Contraindications include instances where the patient has eaten prior to surgery, or they have failed to stop taking medication as instructed, eg Warfarin.

When an endoscopy is abandoned due to 'failed intubation' because the patient is unable to tolerate the scope this is not considered a complication and would not be coded using codes in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**. A code for the condition which prompted the endoscopy to be performed would be assigned.

Examples:

Patient with chronic tonsillitis admitted electively for tonsillectomy. The procedure is cancelled as the patient is noted to have chickenpox

J35.0 Chronic tonsillitis
Z53.0 Procedure not carried out because of contraindication
B01.9 Varicella without complication

Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has failed to stop taking their Warfarin.

K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
Z53.0 Procedure not carried out because of contraindication
Z92.1 Personal history of long-term (current) use of anticoagulants

Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has eaten prior to surgery.

K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
Z53.0 Procedure not carried out because of contraindication

Patient admitted for diagnostic laparoscopy for unexplained abdominal pain and vomiting. The procedure is cancelled because of lack of theatre time.

R10.4 Other and unspecified abdominal pain
R11.X Nausea and vomiting
Z53.8 Procedure not carried out for other reasons

Patient admitted as a day case for excision of left breast lump. On examination, the breast lump has disappeared and the procedure is cancelled.

Z03.8 Observation for other suspected diseases and conditions
Z53.8 Procedure not carried out for other reasons
Z87.4 Personal history of diseases of the genitourinary system

Patient with chronic gastric ulcer admitted for gastroscopy. Intubation failed as the patient could not tolerate the scope and the procedure is abandoned.

K25.7 Gastric ulcer, chronic without haemorrhage or perforation

Patient admitted for excision biopsy of lump in neck but refused surgery on arrival in theatre.

R22.1 Localised swelling, mass and lump, neck
Z53.2 Procedure not carried out because of patient's decision for other and unspecified reasons

See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

DCS.XXI.12: Convalescence (Z54)

Codes in category **Z54.- Convalescence** must never be assigned in a primary position. They must only be assigned in a secondary position when a patient has received convalescence in a **dedicated** convalescent unit.

DCS.XXI.13: Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55–Z65)

The codes in categories **Z55–Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances** must not be used in the primary diagnostic position, (with the exception of **Z63.8 Other specified problems related to primary support group** which may be assigned in a primary position).

They must only be used in a secondary position to a code from another chapter when the circumstance influences the patient's current condition and adds relevant information or there is an explicit national standard that instructs otherwise, e.g. ***DCS.XXI.14: Passive smoking (Z58.7) and DCS.XXI.15: Living alone (Z60.2).***

See also Chapter XIII for guidance on the use of Z56.6 Other physical and mental strain related to work when coding repetitive strain injuries (**M70.-**).

Example:

Child on 'at risk' register is admitted (with no problems) at the same time as their sibling is admitted for care

Z63.8 Other specified problems related to primary support group

DCS.XXI.14: Passive smoking (Z58.7)

If passive smoking is documented within the medical record by the responsible consultant, code **Z58.7 Exposure to tobacco smoke** must be assigned in a secondary position.

Example:

Acute severe asthma aggravated by husband's heavy smoking

J46.X Status asthmaticus
Z58.7 Exposure to tobacco smoke

DCS.XXI.15: Living alone (Z60.2)

Code **Z60.2 Living alone** must only be assigned as an additional code when it is evident in the medical record that the fact that a patient lives alone has extended their length of stay.

Z60.2 must not be assigned on day case episodes.

Z60.2 must not be assigned on an episode where the patient dies.

The NHS Data Model and Dictionary for England provides a definition for day case admissions; this involves the intention of a patient receiving care, not requiring the use of a Hospital Bed overnight and returning home as scheduled. If the patient does stay overnight, then this admission should be counted as an ordinary admission (Inpatient), not a day case.

https://www.datadictionary.nhs.uk/attributes/patient_classification.html

Examples:

Patient with senile incipient cataract admitted for cataract surgery. Kept in overnight due to the fact she lives alone.

H25.0 Senile incipient cataract
Z60.2 Living alone

79 year old lady who lives alone admitted as a day case for excision lipoma left arm.

D17.2 Benign lipomatous neoplasm of skin and subcutaneous tissue of limbs

DCS.XXI.16: Persons encountering health services in other circumstances (Z70–Z76)

Codes in categories **Z70–Z76 Persons encountering health services in other circumstances** must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead.

The following categories/codes are exceptions to this block and must NEVER be used in a primary position:

Z71.0 Person consulting on behalf of another person
Z72 Problems relating to lifestyle
Z73.2 Lack of relaxation and leisure

Z73.4	**Inadequate social skills, not elsewhere classified**
Z73.5	**Social role conflict, not elsewhere classified**
Z73.6	**Limitation of activities due to disability**
Z74	**Problems related to care-provider dependency,** ***see DCS.XXI.18: Problems related to care-provider dependency (Z74)***
Z75	**Problems related to medical facilities and other health care** (except **Z75.5 Holiday relief care, see** ***DCS.XXI.20: Holiday relief care (Z75.5)***)
Z76.0	**Issue of repeat prescription**
Z76.3	**Healthy person accompanying sick person**
Z76.4	**Other boarder in health care facility**

Codes in categories **Z70-Z76** may be used in a secondary position to a code from another chapter if they add further information.

Alcohol use (Z72.1) and Tobacco use (Z72.0)

See:

- ***DCS.V.5: Alcohol abuse and heavy drinker (F10)***
- ***DCS.V.7: Current smoker (F17).***

DCS.XXI.17: Acopia (Z73.9)

Code **Z73.9 Problem related to life-management difficulty, unspecified** must be assigned for patients admitted to hospital because of an inability to cope.

DCS.XXI.18: Problems related to care-provider dependency (Z74)

Codes in category **Z74.- Problems related to care-provider dependency** must only be assigned in a secondary position when a patient, who is care provider dependent, is admitted for care because their care provider is not available. The condition prompting why the person needs care provision must be recorded in the primary position.

See also DCS.XVIII.3: Immobility and reduced mobility (R26.3, R26.8).

DCS.XXI.19: Persons awaiting admission to adequate facility elsewhere (Z75.1)

Z75.1 Persons awaiting admission to adequate facility elsewhere must only be assigned in a secondary position in patients whose medical record clearly state that they are 'bed-blocking' or medically fit for discharge (MFD) but awaiting suitable accommodation elsewhere, such as a nursing or residential home.

Example:

Patient who has suffered a cerebral infarction is awaiting admission to local nursing home

I63.9 Cerebral infarction, unspecified
Z75.1 Person awaiting admission to adequate facility elsewhere

DCS.XXI.20: Holiday relief care (Z75.5)

Patients who are admitted for holiday relief care or respite care to enable their carers to take a break must be coded as follows:

- If the patient receives only the same level of care and attention that would normally be given at home by their carer, code **Z75.5 Holiday relief care** must be assigned in the primary position, followed by the code describing the patient's chronic condition.
- If treatment is given for a different condition to the condition they have a carer for (this may be a pre-existing condition or a condition that is diagnosed whilst the patient is in hospital) and this becomes the main condition treated during the episode, this condition must be assigned as the primary diagnosis and code **Z75.5 Holiday relief care** is assigned in a secondary position. The patient's chronic condition that they have a carer for must also be coded.
- If a patient is pre-booked for holiday relief care but the responsible consultant decides that the patient must have additional treatment or reassessment for their chronic condition which is over and above those that they normally receive at home, (such as adjustment to drug routine or physiotherapy), the chronic condition must be recorded as the primary diagnosis. Code **Z75.5 Holiday relief care** is assigned in a secondary position

See also:

- ***DCS.XX.10: Hospital acquired conditions (Y95.X)***
- ***DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).***

Examples:

Patient with multiple sclerosis admitted for two weeks respite care to allow their carer to take a holiday. No additional treatment other than that normally given at home was required.

Z75.5 Holiday relief care
G35.X Multiple sclerosis

Patient with multiple sclerosis admitted for two weeks respite care to allow their carer to take a holiday. The patient developed bronchopneumonia which required intensive treatment.

J18.0 Bronchopneumonia, unspecified
G35.X Multiple sclerosis
Z75.5 Holiday relief care

Patient booked for two weeks respite care to allow their carer to take a holiday. The responsible consultant decides that the patient will have a course of physiotherapy for his multiple sclerosis.

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

See also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).

DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99)

The codes in categories **Z80-Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status** must not be used in a primary diagnosis position, with the exception of **Z85.6 Personal history of leukaemia** and **Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues, *see DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7)***.

They must only be used in a secondary position to a code from another chapter when the circumstance influences the patient's current condition and to provide relevant additional information; with the exception of those problem codes contained on the list of co-morbidities which must always be coded when recorded in the medical record, ***see DGCS.3: Co-morbidities*** *and* ***Appendix 1: Co-morbidities list***.

Examples:

Patient admitted with chest pain. Myocardial infarction (MI) not diagnosed. Patient's father died of an MI at 43 and his brother was diagnosed with ischaemic heart disease (IHD) at the age of 26.

R07.4 Chest pain, unspecified
Z82.4 Family history of ischaemic heart disease and other diseases of the circulatory system

Patient admitted with acute depression. Has previously deliberately overdosed and self harmed.

F32.9 Depressive episode, unspecified
Z91.5 Personal history of self-harm

Sebaceous cyst of breast and history of carcinoma of breast

N60.8 Other benign mammary dysplasias
Z85.3 Personal history of malignant neoplasm of breast

Patient 12 years of age admitted with temporomandibular joint disorder. Personal history of cleft lip and palate.

K07.6 Temporomandibular joint disorders
Z87.7 Personal history of congenital malformations, deformations and chromosomal abnormalities

Moderate learning disability (mental retardation) due to cerebral haemorrhage at birth. The patient is three years old.

F71.9 Moderate mental retardation without mention of impairment of behaviour
Z87.6 Personal history of certain conditions arising in the perinatal period

See also DCS.V.11: Learning disability (F70-F79).

Personal history of malignant neoplasm (Z85)

See:

- ***DCS.II.1: Primary and secondary malignant neoplasms (C00-C97) - Sequencing of malignant neoplasms***
- ***DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7).***

Female genital mutilation (Z91.7)

See DCS.XIV.11: Female genital mutilation (Z91.7).

Dependence on renal dialysis (Z99.2)

See DCS.XXI.8: Renal dialysis (Z49 and Z99.2).

CHAPTER XXII CODES FOR SPECIAL PURPOSES
(U00–U85)

Coding standards and guidance

DCS.XXII.1: Severe acute respiratory syndrome [SARS] (U04.9 and B97.2)

Code **U04.9 Severe acute respiratory syndrome [SARS], unspecified** must only be assigned when the responsible consultant has made a clear clinical diagnosis of SARS in the patient's medical record. All treated manifestations of the condition must also be coded.

When the responsible consultant clearly documents in the patient's medical record that coronavirus has been identified as the cause of SARS, code **B97.2 Coronavirus as the cause of diseases classified to other chapters** must be assigned immediately following code **U04.9**.

See also DCS.I.4: Bacterial, viral and other infectious agents (B95-B98).

DCS.XXII.3: Emergency use codes (U06 and U07)

Codes in categories **U06.- Emergency use of U06** and **U07.- Emergency use of U07** must only be used when specifically instructed by the Terminology and Classifications Delivery Service under direction from the WHO.

The content that must be crossed through can be found in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document on Delen.

DCS.XXII.4: Vaping related disorder (U07.0)

The following codes and sequence must be assigned when it is clearly documented in the medical record that a respiratory condition has resulted from vaping or the use of e-cigarettes:

U07.0 Emergency use of U07.0
J68.- Respiratory conditions due to inhalation of chemicals, gases, fumes and vapours

Where only 'vaping related disorder' is documented then **U07.0** may be used alone.

Where the condition(s) caused by vaping or the use of e-cigarettes is classified elsewhere then the appropriate code(s) to describe that condition must be used instead of **J68.-**

Code **U07.0** must not be used to classify the use of a vaping device or e-cigarette.

See also guidance following DCS.V.7: Current smoker (F17)

The World Health Organisation (WHO), in consultation with the WHO Framework Convention on Tobacco Control, and the WHO-Family of International Classifications Network (Classifications and Statistics Advisory Committee), have issued guidance on the ICD-10 emergency code in response to the emergence of vaping related disorders in order to monitor this until more detail is known.

The WHO have advised code **U07.0 Emergency use of U07.0** should be assigned for confirmed cases of vaping related disorder to allow tracking of the disorder globally. Synonyms of vaping related disorder are E-Cigarette or Vaping Associated Lung Injury (EVALI), dabbing related lung damage, dabbing related disorder, electronic cigarette related lung damage, and electronic cigarette related disorder.

Various pathologies have been described, including lipoid pneumonia; chemical pneumonitis; giant cell interstitial pneumonitis and hypersensitivity pneumonitis; other organs may also be affected but evidence of this is currently limited. The substance or substance combination leading to the lung damage has not yet been identified.

Depending on outcomes of ongoing research, WHO could assign specific codes in the future and this will be communicated to hospital coding departments.

Advice from Medicines and Healthcare products Regulatory Agency (MHRA)

MHRA run the Yellow Card scheme for collecting and monitoring information on suspected problems or incidents involving medicines, medical devices and e-cigarette products through the Yellow Card Scheme. Members of the public and healthcare professionals can use the Yellow Card Scheme to report any suspected side effects or safety concerns with e-cigarettes and the e-liquids used for vaping.

As part of routine clinical practice, clinicians are advised to document use of e-cigarettes or vaping devices in medical records for all patients as they would with smoking.

Further information is available via MHRA’s Drug Safety Update bulletin: https://www.gov.uk/drug-safety-update/e-cigarette-use-or-vaping-reporting-suspected-adverse-reactions-including-lung-injury

Example:

Patient treated for hypersensitivity pneumonitis confirmed as vaping related

U07.0 Emergency use of U07.0
J68.0 Bronchitis and pneumonitis due to chemicals, gases, fumes and vapours

An external cause code from Chapter XX is not required as the substance or substance combination leading to the lung damage has not yet been identified.

DCS.XXII.6: Confirmed COVID-19 (U07.1)

U07.1 COVID-19, virus identified must only be assigned for cases of COVID-19 which are confirmed by a positive diagnostic test result.

U07.1 fully classifies the COVID-19 disease resulting from SARS-CoV-2 infection, therefore:

- **B34.2 Coronavirus infection, unspecified site** must not be assigned to classify COVID-19.
- **B97.2 Coronavirus as the cause of diseases classified to other chapters** must not be assigned directly after **U07.1**.

Codes for any condition (including non-infectious conditions) classified outside of Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, that are documented as being due to or caused by COVID-19, must be assigned after **U07.1.** Each code must be followed by **B97.2** (excluding codes from Chapter I – *see **DCS.I.4: Bacterial, viral and other infectious agents (B95-B98**)*. This will indicate that these conditions are due to COVID-19 for data analysis.

Symptom codes from Chapter XVIII must be assigned in addition to a confirmed diagnosis of COVID-19 (**U07.1**) unless the symptoms are attributed to another condition classified outside of Chapter XVIII. This is an exception to **DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings** and must only be applied to cases of COVID-19. **B97.2** must not be assigned directly after Chapter XVIII symptom codes.

U07.1 is assigned without additional codes in cases of confirmed COVID-19, through diagnostic testing where patients are asymptomatic.

See also:
- ***DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)***

- ***DCS.XXII.11: Multisystem inflammatory syndrome associated with COVID-19 (U07.5)***

A positive diagnostic test result, for example a positive lateral flow test (LFT) for COVID-19, can be accepted for identification of the virus.

Examples:

Laboratory confirmed COVID-19 pneumonia

U07.1 COVID-19, virus identified
J12.8 Other viral pneumonia
B97.2 Coronavirus as the cause of diseases classified to other chapters

Cough, shortness of breath and fever due to COVID-19 (positive lateral flow test)

U07.1 COVID-19, virus identified
R05.X Cough
R06.0 Dyspnoea
R50.9 Fever, unspecified

(**B97.2** must not be assigned directly after Chapter XVIII symptom codes)

COVID-19 diarrhoea

U07.1 COVID-19, virus identified
A08.3 Other viral enteritis

*(***B97.2** must not be assigned in addition to **A08.3*, see DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)**)*

DCS.XXII.7: Suspected and clinically or epidemiologically diagnosed COVID-19 (U07.2)

U07.2 COVID-19, virus not identified must be assigned when diagnostic testing for COVID-19 is reported as inconclusive, or has not been carried out, but the responsible consultant confirms a diagnosis of COVID-19 based on clinical or epidemiological evidence.

U07.2 must also be assigned when testing is negative, but the responsible consultant continues to suspect COVID-19 (i.e. COVID-19 is clinically diagnosed and is not ruled out by negative testing).

U07.2 includes cases of suspected, probable, and presumed COVID-19, or patients being treated as having COVID-19 in the absence of a positive diagnostic test where COVID-19 has not been ruled out. *See **DGCS.2: Absence of definitive diagnosis statement***

Assign the following codes and sequencing for patients who are clinically diagnosed with COVID-19 in the absence of a confirmed positive diagnostic test:

U07.2 COVID-19, virus not identified
Z20.8 Contact with and exposure to other communicable diseases (assign if confirmed or suspected exposure to COVID-19 is documented)
Codes for any symptoms or conditions documented as being due to, or caused by, COVID-19*
Z29.0 Isolation (assign if the patient has been isolated in hospital)

***** Symptom codes from Chapter XVIII must be assigned in addition to a diagnosis of suspected COVID-19 (**U07.2**) in patients who present with symptoms of COVID-19 unless the symptoms are attributed to another condition classified outside of Chapter XVIII. This is an exception to **DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings**.

B97.2 Coronavirus as the cause of diseases classified to other chapters must not be assigned in addition to any codes for conditions or symptoms related to suspected COVID-19 (**U07.2**) as coronavirus has not been definitively identified.

COVID-19 suspected but subsequently ruled out by a negative diagnostic test

Where the responsible consultant rules out COVID-19 due to a negative test result assign the following codes and sequencing:

Code for the relevant stated conditions or symptoms
Z03.8 Observation for other suspected diseases and conditions

See also:
- ***DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)***
- ***DCS.XXII.11: Multisystem inflammatory syndrome associated with COVID-19 (U07.5)***

COVID-19 clinically diagnosed and not ruled out (false negative result)

One or more negative results do not rule out the possibility of COVID-19 virus infection. Several factors could lead to a negative result in an infected individual, including:

- poor quality of the specimen, containing little patient material.
- the specimen was collected late or very early in the infection.

- the specimen was not handled and shipped appropriately.
- technical reasons inherent in the test, e.g. virus mutation or PCR inhibition.

It is therefore important that negative diagnostic test results must not be interpreted by the coder to arrive at a diagnosis, this is the role of the responsible consultant.

Example:

Clinically diagnosed COVID-19 pneumonia despite negative test result, consultant confirms treat as COVID-19 pneumonia

U07.2 COVID-19, virus not identified
J12.8 Other viral pneumonia
(**B97.2** must not be assigned in addition to any codes for conditions or symptoms attributed to suspected COVID-19 (**U07.2**) as coronavirus has not been definitively identified)

DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)

Where **U07.1 COVID-19, virus identified** or **U07.2 COVID-19, virus not identified** is assigned but the main condition treated or investigated is unrelated to COVID-19, **DGCS.1: Primary diagnosis** must be applied.

Where a condition or symptom documented as being due to, or caused by, COVID-19 is the main condition treated or investigated, **U07.1** or **U07.2** must be assigned in the primary diagnostic position followed by the code(s) for the condition or symptom.

Where **U07.1** or **U07.2** does not appear in the primary diagnosis field, it must be sequenced directly after the code for the primary diagnosis, except where another standard prevents this, such as always using dagger and asterisk codes in combination, in ***DGCS5: Dagger and asterisk system***. This ensures that COVID-19 is recorded in systems and data collections where diagnostic code fields are limited.

Hospital acquired COVID-19

Where COVID-19 is documented as hospital acquired, **Y95.X Nosocomial condition** must be assigned directly after **U07.1** or **U07.2**. **Y95.X** must also be assigned after each code for any other conditions that have been documented as hospital acquired.

See also DCS.XX.10: Hospital acquired conditions (Y95.X).

Examples:

Patient admitted with fractured neck of femur after falling down the stairs at home and underwent open reduction and internal fixation (ORIF). After 5 days the patient developed a cough and fever and tested positive for COVID-19, patient discharged to isolate at home.

S72.00 Fracture of neck of femur, closed
W10.0 Fall on and from stairs and steps, home
U07.1 COVID-19, virus identified
R05.X Cough
R50.9 Fever, unspecified

Hospital acquired COVID-19 pneumonia (positive test)

U07.1 COVID-19, virus identified
Y95.X Nosocomial condition
J12.8 Other viral pneumonia
B97.2 Coronavirus as the cause of diseases classified to other chapters
Y95.X Nosocomial condition

DCS.XXII.9: History of COVID-19 (U07.3)

U07.3 Personal history of COVID-19 is assigned to classify personal history of COVID-19.

See also DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99).

U07.3 must not be assigned on episodes where patients are being treated for an acute COVID-19 infection (**U07.1 COVID-19, virus identified** or **U07.2 COVID-19, virus not identified**) or a post COVID-19 condition (**U07.4 Post COVID-19 condition**).

DCS.XXII.10: Post COVID-19 condition (U07.4)

Where a condition or symptom has been documented by the responsible consultant as a post COVID-19 condition (i.e. the patient is no longer positive for COVID-19 and is not being treated for COVID-19), **U07.4 Post COVID-19 condition** must be assigned directly after the code for the current condition or symptom described as post COVID-19.

Where multiple conditions or symptoms are described as post COVID-19, **U07.4** must be assigned directly after each of the codes that classify the conditions or symptoms.

Where the only information available is 'Post COVID-19 condition' or 'Post COVID-19 syndrome', **U07.4** may be assigned alone.

U07.4 must only be recorded on episodes where **U07.1** or **U07.2** are assigned when it is clear that the patient has recovered from acute COVID-19, is no longer positive for COVID-19 and is not being treated for acute COVID-19.

The National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and the Royal College of General Practitioners (RCGP) have developed a clinical guideline on the management of the long-term effects of COVID-19.

The NICE guideline [NG188] defines post-COVID syndrome (also known as 'long COVID'). Although the guideline has been agreed, NICE are using a 'living' approach for the guideline, which means that targeted areas will be continuously reviewed and updated in response to emerging evidence.

If there is any doubt that a condition is linked to the previous COVID-19 infection or whether the acute infection has resolved, we recommend this is validated by the responsible consultant. This clinical validation will help to ensure **U07.4** is not assigned to conditions that occur after COVID-19 and are unrelated to the previous COVID-19 infection, which will avoid over-counting within the coded data.

Examples:

Deep vein thrombosis secondary to recent COVID-19, responsible consultant confirms post-COVID-19 condition.

I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities
U07.4 Post COVID-19 condition

Patient readmitted with on-going intermittent shortness of breath and fatigue, confirmed as post COVID-19 symptoms. A Computed Tomography Pulmonary Artery (CTPA) was performed, which excluded a pulmonary embolism.

R06.0 Dyspnoea
U07.4 Post COVID-19 condition
R53.X Malaise and fatigue
U07.4 Post COVID-19 condition

Patient admitted with COVID-19 positive pneumonia. After recovering from COVID-19 pneumonia and testing negative on two occasions the patient was diagnosed with post COVID-19 fibrosis within the same episode of care.

U07.1 COVID-19, virus identified
J12.8 Other viral pneumonia
B97.2 Coronavirus as the cause of diseases classified to other chapters
J84.1 Other interstitial pulmonary diseases with fibrosis
U07.4 Post COVID-19 condition

DCS.XXII.11: Multisystem inflammatory syndrome associated with COVID-19 (U07.5)

Where multisystem inflammatory syndrome is diagnosed and linked to COVID-19 by the responsible consultant, **U07.5 Multisystem inflammatory syndrome associated with COVID-19** must be assigned.

Where a patient is also documented as having an acute COVID-19 infection (confirmed or suspected), **U07.5** must be assigned directly after **U07.1** or **U07.2**.

Where multisystem inflammatory syndrome associated with COVID-19 leads to complications (e.g. acute kidney injury (AKI), myocarditis), codes for these complications must be assigned following **U07.5**, this sequencing is an exception to **DGCS.7: Syndromes**. It is not necessary to assign codes from Chapter XVIII unless the symptom is treated as a problem in its own right.

See also DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

Multisystem inflammatory syndrome linked to COVID-19 may also be described as Cytokine storm, Kawasaki-like syndrome, Paediatric Inflammatory Multisystem Syndrome (PIMS) and Multisystem Inflammatory Syndrome in Children (MIS-C)).

The Royal College of Paediatrics and Child Health (RCPCH) guidance includes a case definition of Paediatric multisystem inflammatory syndrome temporally associated with COVID-19 (PIMS) for clinicians. This guidance outlines the clinical and laboratory features which are included in the case definition, therefore there is no requirement to capture the associated symptoms of PIMS within the coded record.

DCS.XXII.12: COVID-19 vaccination (U07.6 and U07.7)

U07.6 Need for immunization against COVID-19 is to be used in the same way as codes from category **Z24 Need for immunization against certain single viral diseases** and

must be assigned in accordance with ***DCS.XXI.3: Persons with potential health hazards related to communicable diseases (Z20–Z29)***

U07.7 COVID-19 vaccines causing adverse effects in therapeutic use is to be used in the same way as codes from category **Y59 Other and unspecified vaccines and biological substances** and must be assigned in accordance with ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***

Example:

Anaphylactic shock due to COVID-19 vaccine.

T88.6 Anaphylactic shock due to adverse effect of correct drug or medicament properly administered
U07.7 COVID-19 vaccines causing adverse effects in therapeutic use

DCS.XXII.13: COVID-19 in Pregnancy, childbirth and the puerperium

Obstetric care for confirmed or suspected case of COVID-19

Assign the following codes when COVID-19 is complicating the pregnant state, aggravating the pregnancy, or is the reason for obstetric care:

U07.1 COVID-19, virus identified or **U07.2 COVID-19, virus not identified**
O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium
Code(s) to identify conditions caused by or due to COVID-19 or symptoms of COVID-19 (where applicable) *

* Conditions due to or caused by laboratory confirmed COVID-19 (**U07.1**) (e.g. pneumonia) must be followed by **B97.2 Coronavirus as the cause of diseases classified to other chapters**.

B97.2 may also be assigned with other codes from Chapter XV Pregnancy, childbirth and the puerperium to identify that a symptom of COVID-19 is complicating labour or delivery, for example **O75.2 Pyrexia during labour, not elsewhere classified.**

In instances where **U07.1 or U07.2** is assigned but the main obstetric condition treated or investigated is unrelated to COVID-19 apply **DGCS.1: Primary diagnosis**.

See also DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)

Examples:

Patient admitted for induction of labour at 38 weeks for Intrauterine Growth Retardation (IUGR). Patient developed pyrexia in labour and subsequently tested positive for COVID-19 but did not require any treatment for the COVID-19. Healthy baby born.

O36.5 Maternal care for poor fetal growth
Z37.0 Single live birth
U07.1 COVID-19, virus identified
O75.2 Pyrexia during labour, not elsewhere classified
B97.2 Coronavirus as the cause of diseases classified to other chapters

Spontaneous vertex delivery of liveborn infant at 38 weeks. Patient is asthmatic, takes Ventolin as required. Tested positive for COVID-19 but asymptomatic.

O80.0 Spontaneous vertex delivery
Z37.0 Single live birth
U07.1 COVID-19, virus identified
J45.9 Asthma, unspecified

DCS.XV.28: Delivery (O80–O84) must be applied for cases of normal deliveries (no other conditions classifiable to Chapter XV) where the patient is COVID-19 positive but asymptomatic and does not require treatment.

DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)

The codes within categories **U82-U85 Resistance to antimicrobial and antineoplastic drugs** must:

- Never be used as primary diagnosis codes
- Only be used in a secondary position, sequenced directly following the code they enhance
- Only be assigned when drug resistance is clearly documented in the medical record by the responsible consultant.

U82 Resistance to betalactam antibiotics, U83 Resistance to other antibiotics and U84 Resistance to other antimicrobial drugs

Codes in categories **U82.-, U83.-** and **U84.-** are used to identify the antibiotic/antimicrobial drugs to which a bacterial, fungal, viral, parasitic agent or other condition is resistant. These codes must be used when this information is clearly documented within the patient's medical record. The coder must never interpret laboratory results in order to identify the

antibiotic/antimicrobial drug to which an agent is resistant, ***see also DGCS.4: Using diagnostic test results***.

When an agent is resistant to two or more antibiotic/antimicrobial drugs classifiable to individual four-character codes within categories **U82.-**, **U83.-** or **U84.-**, a code for each drug the agent is resistant to must be assigned.

The exceptions to this are when:

- An agent is resistant to two or more antibiotic/antimicrobial drugs each classifiable to **U83.8 Resistance to other single specified antibiotic** or **U84.8 Resistance to other specified antimicrobial drug**.
- An agent is resistant to two or more antibiotic/antimicrobial drugs where the antibiotic/antimicrobial drugs are not specified. (Instances where the antibiotic/antimicrobial drugs are not specified should be referred back to the responsible consultant for clarification where possible).

  If either of these exceptions applies, code **U83.7 Resistance to multiple antibiotics** or **U84.7 Resistance to multiple antimicrobial drugs** must be assigned.

Methicillin resistant staphylococcus aureus (MRSA)
When it is documented that a patient has methicillin resistant staphylococcus aureus (MRSA) infection it is implied that the bacteria is resistant to methicillin. Consequently code **U82.1 Resistance to methicillin** must be assigned immediately after the code which identifies that the infective agent is staphylococcus aureus.

U85 Resistance to antineoplastic drugs

Category **U85.X** must only be used to identify resistance, non-responsiveness and refractive properties of a neoplasm or other condition to antineoplastic drugs.

See also:

- ***DGCS.6: Infections***
- ***DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)***
- ***DCS.XXI.4: Carrier of drug resistant bacterial diseases (Z22.3 and U82-U84).***

Examples:

Pneumonia due to Streptococcus pneumoniae resistant to amoxicillin

J13.X Pneumonia due to *Streptococcus pneumoniae*
U82.0 Resistance to penicillin

MRSA pneumonia also resistant to vancomycin

J15.2 Pneumonia due to staphylococcus
B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
U82.1 Resistance to methicillin
U83.0 Resistance to vancomycin

Klebsiella pneumonia urinary tract infection resistant to gentamicin and trimethoprim

N39.0 Urinary tract infection, site not specified
B96.1 *Klebsiella pneumonia [K. pneumonia]* as the cause of diseases classified to other chapters
U83.7 Resistance to multiple antibiotics

Gentamicin and trimethoprim are both individually classifiable to **U83.8 Resistance to other single specified antibiotic:** therefore in this instance code **U83.7 Resistance to multiple antibiotics** must be assigned.

E.coli meningitis, resistant to multiple antibiotics

G00.8 Other bacterial meningitis
B96.2 *Escherichia coli* [*E. coli*] as the cause of diseases classified to other chapters
U83.7 Resistance to multiple antibiotics

Postoperative methicillin antibiotic resistant staphylococcus aureus (MRSA) wound infection following gastrectomy 2 weeks ago

T81.4 Infection following a procedure, not elsewhere classified
B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
U82.1 Resistance to methicillin
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

See also DCS.XIX.7: Postprocedural complications of medical and surgical care.

Primary pulmonary tuberculosis confirmed bacteriologically and histologically, resistant to tuberculostatic drugs isoniazid and rifampicin

A15.7 Primary respiratory tuberculosis, confirmed bacteriologically and histologically
U84.3 Resistance to tuberculostatic drug(s)

Multiple antimicrobial resistant infective endocarditis

I33.0 Acute and subacute infective endocarditis
U84.7 Resistance to multiple antimicrobial drug(s)

Ovarian cancer non-responsive to antineoplastic drug paclitaxel

C56.X Malignant neoplasm of ovary
U85.X Resistance to antineoplastic drugs

Zika virus

See DCS.I.5: Zika virus.

APPENDICES

Appendix 1: Co-morbidities list

The list below contains a number of medical conditions and other factors influencing health that must always be coded for each episode when they co-exist in conjunction with another disease that is currently being treated at the time of admission (or develop subsequently). This is regardless of specialty. These have been agreed by the Clinical Co-morbidities Working Group as co-morbidities that are clinically relevant - as they always affect the management of the patient's current episode.

For the instructions on the use of this list see ***DGCS.3: Co-morbidities***.

Condition	Reference(s)
Abnormal liver function tests (in the absence of an underlying cause)	***DChS.XVIII.1***
Alcohol abuse	***DCS.V.5***
Alzheimer's disease including dementia in Alzheimer's disease	*Chapter V Guidance* ***DCS.V.2***
Anxiety disorders including anxiety	***DCS.V.9***
Asthma	***DCS.X.5*** ***DCS.X.6***
Autism	
Cerebrovascular diseases	***DCS.IX.11*** ***DCS.IX.12*** ***DCS.IX.13***
Chronic bronchitis	***DCS.X.5***
Chronic kidney diseases including chronic tubulo-interstitial nephritis, small kidney(s) and polycystic kidney(s)	***DCS.IX.2*** ***DCS.XIV.1*** ***DCS.XIV.2***
Chronic obstructive pulmonary disease/ Chronic obstructive airways disease	***DCS.X.5***

Congestive cardiac failure	***DCS.IX.2*** ***DCS.IX.10***
Current anti-coagulant therapy	***DCS.XVIII.12***
Current smoker	***DCS.V.4*** ***DCS.V.7***
Dementia including dementia in Alzheimer's disease	*Chapter V* *Guidance* ***DCS.V.2***
Depressive disorders including depression and bipolar disorder	***DCS.V.9*** ***DCS.V.10***
Developmental delay including learning difficulties and learning disability	***DCS.V.11*** ***DCS.V.12***
Diabetes Mellitus	***DCS.IV.1***
Drug abuse	***DCS.V.4*** ***DCS.V.8***
Dysphagia (difficulty in swallowing)	***DCS.IX.12*** ***DChS.XVIII.1***
Dysphasia	***DCS.IX.12*** ***DChS.XVIII.1***
Eating disorders	
Emphysema	***DCS.X.5***
Epilepsy	***DCS.VI.1***
Elderly / Geriatric falls	***DCS.XVIII.4***
Heart failure	***DCS.IX.2*** ***DCS.IX.10***

Hemiplegia	***DCS.VI.3*** ***DCS.IX.12***
Hypertension	***DCS.IX.1*** ***DCS.IX.2*** ***DCS.XIV.2***
Ischaemic heart disease	***DCS.IX.2*** ***DCS.IX.3*** ***DCS.IX.4*** ***DCS.IX.7***
Jaundice	***DChS.XVIII.1***
Left ventricular failure	***DCS.IX.2*** ***DCS.IX.10***
Living alone	***DCS.XXI.15***
Mitral valve disease	
Multiple sclerosis	
Personal history of anti-coagulant therapy	
Personal history of self harm	
Presence of cardiac pacemaker	
Psychosis and psychotic disorders including schizophrenia, schizotypal and delusional disorders	
Registered blind	***DCS.VI.2*** ***DCS.VII.3***
Renal failure	***DCS.IX.2*** ***DCS.XIV.2***
Respiratory failure	***DCS.X.7***

Rheumatoid arthritis	
Severe or profound hearing loss	***DCS.VIII.1***
Urinary retention	***DChS.XVIII.1***

INDEX OF STANDARDS

SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding, for use from 1 April 2024.

Each entry is shown with tracked changes to indicate what has changed. Deletions appear as strikethrough in red font whilst additions appear underlined in blue font. Where part of a standard or guidance has been updated, the whole standard or guidance will be displayed. Where examples are updated, only the example that has been updated will be displayed.

Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Changes between National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding version 10.0 (April 2024) to 10.1 (April 2024).

DCS.XIX.7: Postprocedural complications of medical and surgical care

Examples:

Rupture of an operative wound following a fall

T81.3 Disruption of operation wound, not elsewhere classified
W19.9 Unspecified fall, unspecified place

Patient admitted for the drainage of a postoperative abdominal wound abscess following a bowel resection.

L02.2 Cutaneous abscess, furuncle and carbuncle of trunk
T81.4 Infection following a procedure, not elsewhere classified
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding, for use from 1 April 2024.

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Changes between National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding version 9.0 (April 2023) to 10.0 (April 2024).

INTRODUCTION

~~These national clinical coding standards are for use with the~~The World Health ~~Organisation~~Organization (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision 5th Edition (ICD-10) ~~when translating diagnoses and other health related problems recorded in a patient's medical record~~was developed for ~~morbidity coding~~ use in the ~~NHS in England.~~

~~The classification~~collection of ~~diagnoses using ICD-10 is a mandatory national requirement for the NHS Admitted Patient Care (APC) Commissioning Data Set (which includes day cases) and other data sets as outlined in the section below. ICD-10 is an approved NHS Fundamental Information Standard, see http://www.digital.nhs.uk/isce/publication/scci0021.~~

morbidity and mortality ~~WHO also refer to the ICD-10 5th Edition as the 2016 Edition. It was implemented on 1 April 2016 and includes updates that came into effect between 2011 and 2016.~~

~~The NHS in England uses the ICD-10 content as released by the WHO with the following exceptions which users must be aware of when using ICD-10 5th Edition:~~

- ~~The errors in the printed ICD-10 5th Edition volumes published by the World Health Organisation (WHO), notified in the ***ICD-10 5th Edition Errata****~~
- ~~The use of the four character codes in categories **W26 Contact with other sharp objects(s), X34 Victim of earthquake** and **X59 Exposure to unspecified factor**. See ***DCS.XX.2: Fourth character subcategory codes at W26, X34 and X59****~~
- ~~The use of activity codes with categories **V01–Y34.** *See **DChS.XX.2: Activity codes***~~

- ~~The emergency use codes in categories **U06** and **U07**. See ***DCS.I.5: Zika virus***, ***DCS.XXII.4: Vaping related disorder (U07.0)***and ***COVID-19 Standards*** in Chapter XXII*.~~

~~* A list of alterations and corrections to code descriptions and notes that must be made in the printed ICD-10 5th Edition books is available in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document.~~

~~The WHO gives specific instruction on the use of the ICD-10 classification for morbidity coding in some areas, whilst it provides options and guidance of a general nature in others. This can lead to differences in interpretation and application of the classification and this, in turn, can reduce the consistency and comparability of the data at local and national levels. Specific instructions are provided in the following pages in the form of national clinical coding standards for those areas of potential ambiguity (as far as practically possible) to safeguard data consistency.~~

~~The coding of diagnostic statements or elements of them is 'mandatory' only where the~~information ~~is available in the medical record. The principles of the statistical classification, particularly those relating to basic coding guidelines and the structure of the classification, (as detailed in WHO ICD-10 Volume 2), are adopted as the standard and reinforced within this book where appropriate. Where a standard within the WHO ICD-10 Volume 2 differs to a national clinical coding standard, the national clinical coding standard must take precedence.~~

~~For information on the use of the ICD-10 Classification and Clinical Coding Standards used in Northern Ireland, Scotland and Wales contact the respective national centre:~~

- ~~Northern Ireland - Clinical Coding Sharing platform (only available to NI Clinical Coders)~~

~~Scotland – Public Health Scotland Terminology Services~~.

- ~~The purpose of ICD-10~~
- ~~Wales – Digital Health and Care Wales Information Design and Standards Development~~

~~Background~~

~~The WHO states that ICD~~ is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses and other health problems from words into alphanumeric codes, which permits easy storage, retrieval and analysis of data~~'~~[1].
~~The ICD-10 classification comprises three volumes:~~

[1] World Health ~~Organisation~~Organization International Classification of Diseases and Related Health Problems' ICD-10 Volume 2, 2.1 Purpose and applicability

Volume 1: Tabular List: includes classification codes and titles at three and four character levels, the classification of morphology of neoplasms and definitions

Volume 2: Instruction Manual: includes information about the structure, principles and conventions, how to use ICD, rules and guidelines for recording and coding and historical background

Volume 3: Alphabetical Index: includes index terms for diseases, nature of injury and external causes of injury, introduction and instructions on its use.

Whilst WHO gives specific instruction on the use of the ICD-10 classification for morbidity coding in some areas, it provides options and guidance of a general nature in others. This can lead to differences in interpretation and application of the classification and this, in turn, can reduce the consistency and comparability of the data at local and national levels.

The *National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding* are to be used with the three volumes of ICD-10. They reinforce the classification rules and coding conventions inherent in the ICD-10 Volumes 1-3, give specific instructions for morbidity coding including for those areas of potential ambiguity (as far as practically possible) or where data analysis or user feedback requires additional information to safeguard data consistency and comparability. They also include instruction that cannot be embedded into the classification such as the NHS-mandated definition for primary diagnosis. Where a standard or guidance within the WHO ICD-10 Volume 1 or 2 differs to a national clinical coding standard, the national clinical coding standard must take precedence.

Compliance with ICD-10 and these coding standards enables consistent, accurate and uniform coding which in turn supports data collection and comparison of local and national data across time.

The content type and level of detail within this publication is primarily aimed at a clinical coding professional and therefore presumes the user:

- Understands the use of the ICD-10 classification
- Is trained in the abstraction of relevant information from the medical record
- Possesses knowledge of anatomy and physiology
- And for coding purposes, understands how a condition can affect the human body.

The National Clinical Coding Standards ICD-10 5th Edition for morbidity coding are the definitive source of clinical coding standards for use in the NHS in England~~, Hospital In-patient Statistics (HIS)~~.

These clinical coding standards are also used in Northern Ireland~~, Patient Episode Data for~~ and Wales ~~(PEDW), Scottish Morbidity Records (SMR), Cancer Registries, National Service Frameworks, Care Pathways, Performance Indicators, Commissioning Data Sets (CDS) and other Central Returns.~~ , with some local variance. For information on specific use of the ICD-

10 classification, clinical coding standards, data definitions and collections in Northern Ireland, Wales and Scotland contact the respective national centre:

- Northern Ireland – Digital Health & Care Northern Ireland – About DHCNI Data
- Wales – Digital Health and Care Wales Information Design and Standards Development
- Scotland – Terminology Services and clinical coding - Services - Public Health Scotland

The NHS Classifications Browser provides a way to browse and search the ICD-10 classification online. It is regularly updated to reflect changes to the ICD-10 National Clinical Coding Standards to support consistent application of the classification codes by clinical coders. It is freely available online to anyone with an internet connection.

Background

The ICD-10 is a statistical classification that underpins key information initiatives that support the monitoring of morbidity and health trends. NHS managers and health care professionals use ~~it~~ ICD-10 coded data locally and nationally to support operational/strategic planning and performance management. For example:

- Statistical uses include: study of aetiology (cause or origin) and incidence of diseases, health care planning and casemix.
- Epidemiologists use statistical data to study frequency and occurrence of disease. The aggregation of coded data enables health professionals to identify at risk populations based on demographic, diagnostic or environmental factors.
- Planners and managers use statistical data to review caseloads to~~:~~ determine specialty needs, inform staffing levels, patient admissions and clinic schedules in hospitals.
- Clinical audit uses coded data to compare patient care and measure outcomes within specialities. Doctors may use extracts of local information for research purposes.

The ~~United Kingdom~~UK has a mandatory obligation to collect and submit ICD-10 data to the World Health ~~Organisation~~Organization (WHO) for the production of international statistical and epidemiological data.

ICD-10 is a vital component of national data sets, such as Hospital Episodes Statistics (HES) in England, Hospital In-patient Statistics (HIS) in Northern Ireland, Patient Episode Data for Wales (PEDW), Scottish Morbidity Records (SMR), Cancer Registries, National Service Frameworks, Care Pathways and Performance Indicators.

In England the classification of diagnoses using ICD-10 is a mandatory national requirement for the NHS Admitted Patient Care (APC) Commissioning Data Set (which includes day cases) and other data sets. The requirements for data sets and related definitions are specified in the NHS Data Model and Data Dictionary.

In England ICD-10 is an approved Information Standard published under Section 250 of the Health and Social Care Act 2012, see SCCI0021: International Statistical Classification of Diseases and Health Related Problems (ICD-10) 5th Edition

WHO also refer to the ICD-10 5th Edition as the 2016 Edition. It was implemented by the NHS on 1 April 2016 and includes WHO updates that came into effect between 2011 and 2016.

The NHS uses the ICD-10 5th Edition as released by the WHO. To note that the WHO printed a corrigenda in the back of the ICD-10 5th Edition Volume 1 listing alterations and corrections to code descriptions and notes. These are also available in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document.

Where there is a variance to the assignment of ICD-10 codes in Volumes 1 and 3 e.g. use of subcategory codes or emergency codes, these are highlighted at:

- ***DCS.XX.2: Fourth character subcategory codes at W26, X34 and X59***
- ***DChS.XX.2: Activity codes***
- ***DCS.I.5: Zika virus***
- ***DCS.XXII.4: Vaping related disorder (U07.0)***
- ***Chapter XXII: COVID-19 Standards***

Morbidity versus mortality coding

~~The ICD-10 is designed for international use in the collection of morbidity and mortality information.~~

The classification permits the assignment of codes to diseases (morbidity) and to causes of death (mortality) according to established criteria, providing consistent information for use in the collection of morbidity and mortality information for statistical purposes.

~~This reference book provides the national clinical coding standards~~The National Clinical Coding Standards for ICD-10 5th Edition for morbidity coding are for use with the ICD-10 for coding of the main condition (morbidity) and related health conditions as recorded in the hospital medical record. The coding of diagnostic statements or elements of them is 'mandatory' only where the information is recorded in the medical record.

The ICD-10 rules for the selection and coding of the underlying cause of death (mortality) are outside the scope of this ~~reference book.~~publication.

Clinical coding

Clinical coding is the translation of medical terminology that describes a patient's complaint, problem, diagnosis, treatment or other reason for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner.

Clinical coder

A clinical coder is the health informatics professional that undertakes the translation of the medical terminology in a patient's medical record into classification codes. A clinical coder will be accredited (or working towards accreditation) in this specialist field to meet a minimum standard. Clinical coders use their skills, knowledge and experience to assign codes accurately and consistently in accordance with the classification and national clinical coding standards. They provide classification expertise to inform coder/clinician dialogue. Clinical coders must abide by local and national confidentiality policies and codes of practice as a breach may lead to disciplinary action, a fine or, in the case of a breach of the Gender Recognition Act 2004, possible prosecution.

~~Hospital provider spell and care~~Care professional admitted care episode and hospital provider spell

~~A~~In England a clinical coder must assign ICD-10 codes to the diagnoses recorded in the medical record for each care professional admitted care episode (hereafter referred to as 'episode'~~in the National Clinical Coding Standards reference books~~) within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (CDS) (which includes day cases).

A hospital provider spell may contain several episodes and the definitions for these terms are found in the NHS Data Model and Dictionary at: http://www.datadictionary.nhs.uk/

The NHS Data Model and Dictionary is the source for assured information standards to support health care activities within the NHS in England. It is aimed at everyone who is actively involved in the collection of data and the management of information in the NHS.

~~A care professional admitted care~~An episode[2] can be a~~:~~ consultant episode (hospital provider), a midwife episode or a nursing episode. ~~The~~ This term replaces the previous term 'finished consultant ~~episode~~episode' commonly abbreviated to "FCE" which was widely used in the NHS and has been used in previous clinical coding guidance.

See the NHS Data Model and Dictionary frequently asked questions for more information at: http://www.datadictionary.nhs.uk/

Emergency Care Department attendance – Decision to Admit

The Emergency Care Commissioning Data Set (ECDS) is one of the mandated data flows for Health Care Providers across the NHS, England. In CDS V6-2-3 Type 011 – Emergency Care CDS emergency care attendances were mandated to flow nationally from 01-08-17. See DCB0092-2062 for more information.

~~[2] Care Professional Admitted Care Episode (datadictionary.nhs.uk)~~

All activity occurring under the responsibility of the Emergency Care Department is part of the Emergency Care Department Attendance and coded as such, including when the patient temporarily leaves the Emergency Care Department, e.g. for an X-ray.

When the patient's care contact originates as an Emergency Care Department Attendance, but later a clinical decision is made to admit the patient to a Health Care Provider, this is described as a 'decision to admit'. The 'Decided to admit date' and 'Decided to admit time' is recorded at the time when the clinical decision to admit is made.

The 'Decided to admit date' and 'Decided to admit time' or 'Admission Date' trigger the start time for an Episode within the Admitted Patient Care CDS.

Following the decision to admit any recorded activity from that point on becomes part of the Admitted Patient Care CDS requiring the application of ICD-10 and OPCS-4 codes, including:

- When the decision to admit is made immediately on the patient presenting to the Emergency Care Department, including when the patient is subsequently taken to an Operating Theatre before ward admission
- When a decision to admit is made but the patient is temporarily accommodated in the Emergency Care Department or elsewhere but remains waiting in the nursing care of the Emergency Care Department for longer than is appropriate for his/her condition before moving to a ward (i.e. a lodged patient).

It is important that this activity data is complete and accurate to avoid inaccuracies or data duplication in CDS flows.

When the patient's care contact originated as an Emergency Care Department Attendance but there is no evidence when the clinical decision to admit was made, the Health Care Provider will need to find a local solution to ensure this information is recorded. This also triggers the start time for the coding department to apply the codes for Admitted Patient Care CDS data flows.

DATA QUALITY

Medical record

A health record (hereafter referred to as 'medical record') ~~)~~is defined in the Data Protection Act 2018 as a record which consists of data concerning health~~,~~ and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates. ~~The health record can be held partially or wholly electronic or on paper.~~

~~The health record (commonly referred to as the medical record and used hereafter) is the source documentation for the purposes of clinical coding. The~~It is a medico-legal document and the responsible consultant, or healthcare practitioner, is accountable for the clinical information they ~~provide.~~record in the medical record. It ~~must accurately reflect~~needs to be complete, accurate, relevant, accessible and timely to the patient's encounter with the health care provider at a given time.

The medical record can be handwritten or digital and may be held in paper or more commonly electronic format as NHS trusts update and improve their systems to adopt Electronic Patient Record (EPR) systems in hospitals.

~~The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant episode within the hospital provider spell.~~

The structure and contents of the medical record may vary from hospital to hospital. Typically, there are handwritten notes, computerised records, correspondence between health professionals, discharge letters, clinical ~~work-sheets~~worksheets and discharge forms, nursing care pathways, histology reports and diagnostic test reports. ~~Any of these sources may be accessed for coding purposes. The accuracy, completeness and legibility of the medical record are critical to the assignment of the correct ICD-10 code(s) and the production of consistent, high quality information and comparable data to manage health and care.~~

In the case of post-mortem reports these should always be processed through the responsible consultant in preparation of a summary. ~~-~~Use of the post-mortem report should, therefore, be the responsibility of the responsible consultant, who should decide what goes into the clinical summary for the coder.

Any of these sources may be accessed for coding purposes.

The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant episode within the hospital provider spell.

The accuracy, completeness, legibility and timeliness of the information recorded in the medical record is therefore critical to the coding process. As the medical record is the source of truth for the purposes of clinical coding it is recommended that the clinical coder has access to the full medical record in order to extract all relevant information to support the correct assignment of ICD-10 code(s) to produce consistent, high-quality and comparable data.

The National Clinical Coding Standards cannot provide direction to compensate for deficiencies in the documentation, recording or coding process.

When the medical record does not contain sufficient information to assign a code, the clinical coder must consult the responsible consultant (or their designated representative[3]).

~~The national clinical coding standards cannot provide direction to compensate for deficiencies in the documentation, recording or coding process.~~

The clinical coding manager should use the local information governance and clinical governance arrangements to address documentation and recording issues to support data quality improvements that will generate aggregate data that are valid and comparable.

Information on standards for professional record keeping, developed by the Royal College of Physicians Health Informatics Unit and approved by the Academy of Medical Royal Colleges, can be found on the Royal College of Physicians website at https://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records

See also: https://www.england.nhs.uk/long-read/high-quality-patient-records/

Information governance and clinical governance

The lack of information or presence of discrepancies, in the medical record should be addressed through local information governance and clinical governance mechanisms. Such instances present an opportunity to ~~lever~~leverage change which will bring benefits to the organisation: such as improved recording of clinical information, robust local processes and correctly coded clinical data.

[3] Hereafter referred to as the responsible consultant. The designated representative could be the clerking doctor, midwife or specialist nurse. As there will be local variations in designated representatives and processes the coding manager should confirm with the medical director the role of designated representative(s) in each specialty and document in the organisation's clinical coding policy and procedures document

It is acceptable to agree local coding policy, provided this does not contravene any national coding standard.

When agreement has been reached through local governance on how to address a documentation or recording issue the outcome must be documented in the departmental policy and procedure document. This must be agreed and signed-off by the clinical director and/or governance authority dependent on local arrangements. Local coding policies should be reviewed regularly as part of the organisation's review process.

Common problems such as lack of recorded diagnosis but presence of investigation results or findings, such as high levels of postpartum blood loss without a documented diagnosis of postpartum haemorrhage, or lack of comorbidities can be used to encourage constructive dialogue between clinical coders and clinicians to support accurate and consistent coded data.

The recording of the patient's conditions, co-morbidities (also described as long-term conditions) and medical history for the current admission is the responsibility of the responsible consultant. It is **not** the responsibility of a clinical coder to analyse information from previous hospital provider spells in order to identify and code conditions.

Nor is it the responsibility of a clinical coder to make a judgement on whether previously reported conditions have any bearing on the current episode for coding purposes. Whilst it may seem that extracting diagnostic information from a previous hospital provider spell provides additional clinical information for coding co-morbidities and medical history, there is a risk that this may not be accurate or pertinent to the current episode.

For the standards on using diagnostic test results ***see DGCS.4: Using diagnostic test results***.

For the standards on the coding of previously reported conditions ***see DGCS.3: Co-morbidities***.

Further information on information governance can be found at:
https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance

Clinical coding audit

Coded clinical data is audited against national clinical coding standards. Clinical coding audit must be objective and provide value to the local organisation by highlighting and promoting the benefits of taking remedial actions to improve data quality and, processes and training as well as acknowledging evidence of best practice.

When there are documentation discrepancies or recurring reporting issues which are outside the remit or control of the clinical coding department, the audit report should highlight these to be addressed through the local information governance and clinical governance arrangements.

Local coding policy and procedure documents should be inspected as part of a clinical coding audit to ensure these:

- ~~are~~Are up-to-date
- ~~evidence~~Evidence local agreements and implementation
- ~~have~~Have been applied consistently
- ~~do~~Do not contravene national clinical coding standards.

~~Terminology~~SNOMED CT ~~to~~ to ICD-10 ~~cross-~~maps

Health care providers that have implemented ~~electronic health records~~an EPR system and ~~a~~the clinical terminology ~~such as~~ SNOMED CT can use ~~linkages~~ the national maps between the ~~terminology~~SNOMED CT UK Edition and ICD-10 ~~known as 'cross-maps'~~5th Edition. The maps are designed to ~~enable the clinical coding~~support those organisations with EPR systems to fulfil the mandatory requirement for collection and reporting of ~~electronic health records.~~ diagnostic data using ICD-10.

These maps support the derivation of classification codes directly from SNOMED CT concepts recorded by the clinician in the EPR. They are incorporated in software to present the ICD-10 code(s) attached to a SNOMED CT concept, for validation by the clinical coding expert. Four different types of map are provided to accommodate the different circumstances that may influence ICD-10 code assignment, see the SNOMED CT to Classifications Maps Page on Delen for more information.

~~These cross-maps are semi-automated with default and, where appropriate, alternative ICD-10 target codes are provided. The default ICD-10 target codes are acceptable for the terminology concept/term to which they are linked. However where there is more relevant detail within the record, the selection of alternative ICD-10 target codes may need to be undertaken to ensure national clinical coding standards are consistently applied.~~

~~The national cross-maps are compliant with clinical coding national standards. They are provided in the UK SNOMED CT Clinical Edition biannual releases. They are designed to support those organisations with electronic health systems to fulfil the mandatory requirement for collection and reporting of diagnostic data using the NHS Information Standard, ICD-10.~~

The classification ~~cross-~~maps are compiled by the Terminology and Classifications Delivery Service to reflect the rules and conventions of ICD-10 as well as ~~the~~these national clinical coding standards ~~contained in this standards' reference book~~.

~~The cross-maps~~The major releases of SNOMED CT UK Edition include the ICD-10 map files which are available for download via the Technology Reference Data Update Distribution Service (TRUD) following registration at the following website: ~~https://isd.hscic.gov.uk/trud3/user/guest/group/0/home~~https://isd.digital.nhs.uk/trud/user/guest/group/0/home

Coding uniformity

Uniformity means that whenever a given condition or reason for an episode is coded, the same code is always used to represent that condition or reason for the encounter. Uniformity is essential if the information is to be useful and comparable.

General ~~rules~~principles for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient's condition during the episode.
- Code every condition or reason for encounter which affects the care, or influences health status during the episode, which is available in the classification and supported by the medical record.
- Code each problem to the furthest level of specificity, i.e. third, fourth or fifth character, which is available in the classification and supported by the medical record.
- Do not code background information or chronic problems which are no longer active, and which do not influence the health care being provided in the relevant episode. It is not always intended that symptoms or history be coded. Just because a condition can be coded does not mean it should be coded each time the patient is admitted. Any uncertainty around issues of relevance or inactive problems should be discussed with the responsible consultant.

Three dimensions of coding accuracy

- **Individual codes**

  Each clinical statement of diagnosis must have the correct code assignment. An individual patient may have many diagnoses (or procedures). Consequently, a coded record for an episode will have at least one or potentially many individual codes.

- **Totality of codes**

  The concept of totality of codes is complex. It means that all codes necessary to give an accurate clinical picture of the patient's diagnosis, problems or other reasons for an episode encounter, must be assigned in accordance with the rules, conventions and standards of the classification. This is important as it is possible for a list of codes to describe an episode incorrectly in terms of clinical coding rules and standards even though the individual codes selected are correct. ***See also DGCS.3: Co-morbidities.***

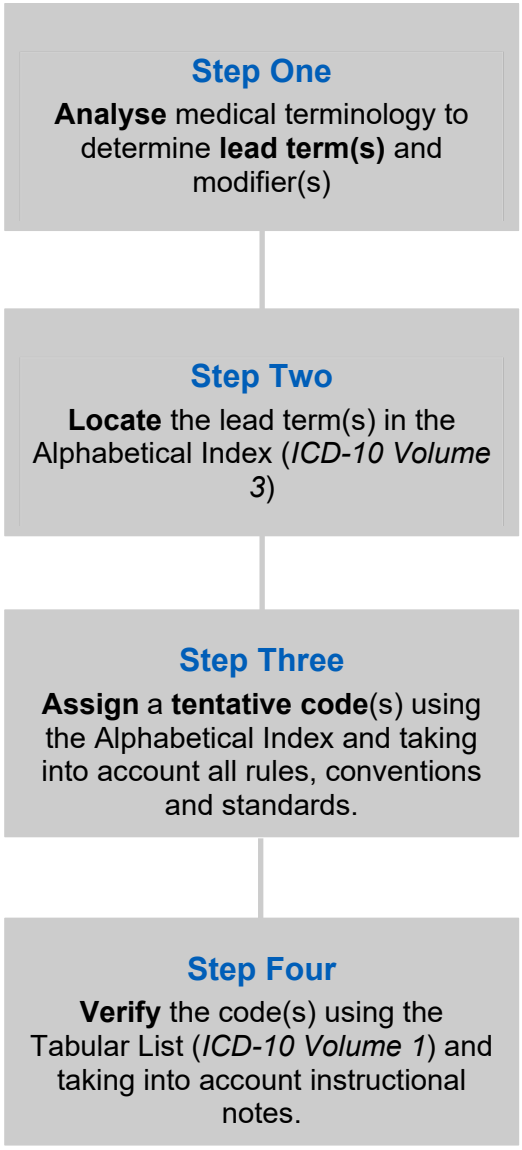
- **Sequencing of codes**

  Codes must be sequenced in accordance with clinical coding standards to provide consistent data for statistical analysis. A significant aspect of sequencing is the selection of the main condition treated. ***See also DGCS.1: Primary Diagnosis***.

The four step coding process

The four staged process that makes up the act of clinical coding is designed to ensure appropriate and consistent code assignments. The coder is required to use ICD-10 Volume 3, Alphabetical Index and Volume 1, Tabular List and to be trained in the use of ICD-10 and the context in which it is used.

The four-step coding process is the key to ensuring correct use of ICD-10 and accurate coding of the diagnostic statement(s) in the medical record. An overview of the four steps is provided below as a reminder. The full detail of each step is fully explored during training using national core curriculum training materials.



~~NATIONAL CLINICAL CODING STANDARDS ICD-10 REFERENCE BOOK~~

~~The national clinical coding standards provide a reference source primarily aimed at clinical coders. The level of detail reflects the assumption that users will be trained in the use of the ICD-10 classification as well as the abstraction of relevant information from the medical record.~~

~~Authorised amendments to the reference book are compiled and issued only by the Terminology and Classifications Delivery Service.~~

~~As the main emphasis of clinical coding is data quality and accuracy, this reference book focusses on the clinical coding standards that must be applied when assigning ICD-10 codes.~~

~~It is important coders possess knowledge of anatomy and physiology and understand how a condition can affect the human body. There are many reference sources available to coders if they wish to find out more information about a diagnosis, such as text books, patient information leaflets and the internet. A wealth of knowledge is also held by clinical staff within each organisation.~~

~~Structure of the ICD-10 reference book~~

~~THIS REFERENCE BOOK~~HOW TO USE THIS PUBLICATION

The content is split into distinct sections so that it is clear whether the rule, convention or standard must be applied throughout the classification, if it should be applied throughout a chapter or if it is specific to a code(s) or diagnosis.

All rules, conventions, standards and flow charts ~~within the reference book~~ have a unique identifier (reference number) and title so that they can be easily identified, applied and referenced, and they can be logically and consistently updated, removed or replaced. The unique identifiers are specific to each section ~~of the reference book~~, as explained below, but all are preceded by the letter '**D**' for 'diagnostic' to indicate that the rule, convention, standard or flow chart is applicable to ICD-10.

It is important that users understand how each section ~~of the reference book~~ should be applied when coding.

Rules of ICD-10

Rules of ICD-10 apply throughout the classification and the clinical coder must be aware of these rules to code with consistency and accuracy.

A rule that a coder must comply with is presented in a grey box. Explanatory information about the rule is presented in a white box.

The unique identifiers for rules begin with '**DRule**' and are followed by the number of the rule and the title (e.g. **DRule.2: Category and code structure**).

Conventions of ICD-10

Conventions of ICD-10 are fundamental to accurate coding and apply throughout the classification (including the Alphabetical Index).

The clinical coder must thoroughly understand these conventions and always apply them to ensure correct code assignment and sequencing.

Conventions of ICD-10 are presented within a grey box.

The unique identifiers for conventions begin with '**DConvention**' followed by the number of the convention and the title (e.g. **DConvention.1: Cross references**).

Coding Standards

A coding standard must be applied by the clinical coder in the manner described. ~~Compliance with a coding standard enables consistent, accurate and uniform coding which in turn supports the collection and comparison of local and national data across time.~~ Standards are clear, concise and unambiguous.

Each standard is contained within a grey box. They may also have associated guidance, and this will be contained within an adjoining white box. **Only the text within the grey area is the coding standard** e.g.

DCS.II.10: Histological types and benign neoplasms
The classification of some terms such as 'polyp' or 'cyst', depend upon their histological type or site, and must not be coded without reference to the histology report and final confirmation by the responsible consultant.
Careful checking of essential modifiers is also necessary as they may direct the coder elsewhere within the classification.

There are three types of standard:

- **General coding standards**

General coding standards are ~~located at the beginning of the reference book and are~~ applicable throughout the classification.

The unique identifiers for general coding standards begin with '**DGCS**' followed by the number of the standard and the title (e.g. **DGCS.1: Primary diagnosis**).

- **Chapter standards**

  Chapter standards are located at the beginning of an ICD-10 chapter ~~of the reference book~~ and are applicable throughout that chapter. Note that not all chapters will have chapter standards.

  The unique identifiers for chapter standards begin with '**DChS**' followed by the chapter numeral, the number of the standard and the title (e.g. **DChS.XIX.1: Multiple injuries**).

- **Coding standards**

  Coding standards are located throughout each ICD-10 chapter ~~of the reference book~~ and are applicable to a specific diagnosis, disorder, disease or condition, or describe the correct usage of a code, category or range of codes. Coding standards are~~, generally,~~ listed in code, category or range order.

  The unique identifiers for coding standards begin with '**DCS**' followed by the chapter numeral, the number of the standard and the title (e.g. **DCS.IV.1: Diabetes mellitus (E10–E14)**).

Coding guidance

Coding guidance is advice or information provided to aid the clinical coder or user of the classification. It does not describe a precise requirement or coding standard.

Coding guidance is contained within a white box. They do not have unique identifiers or titles. e.g.

> Special symbols # and ✧ are used within the neoplasm table in the Alphabetical Index. The use of these symbols is described in 'Notes 2 and 3' before the table.

Examples

Examples are included ~~throughout the reference book~~where necessary to illustrate the correct application of a rule, convention or standard and are provided after guidance to illustrate the points made. They are only included when an example of the practical application of codes may aid the coder in understanding the rule, convention or standard. The codes reflect the diagnostic statement given within the example. Where required a rationale is provided.

Examples are not national standards and should only be used as an aid to coding. Clinical coding must always be based on the information contained within the rule, convention or standard.

Further examples of how standards can be applied can be found in the current ICD-10 and OPCS-4 Exercise and Answer Booklets. These are available to anyone on request via information.standards@nhs.net.

References

References direct the user to a pertinent standard or guidance ~~elsewhere in the reference book.~~in a different section . A reference has a title but does not have a unique identifier.

The reference details the unique identifier and title of the relevant standard to aid user navigation. If directing to a standard the reference is shown in a grey box. If the box is not grey, then the reference directs to guidance.

The coder must navigate to and review the full standard that has been referenced in order to ensure correct understanding and application - e.g.

Geriatric and elderly falls (R29.6)
See DCS.XVIII.4: Geriatric and elderly falls (R29.6).

Flow charts

Flow charts are a visual aid to summarise one or a number of standards to help a coder learn how to apply the standard. Coders must always ensure they read and understand the full standard(s) before using the flow charts as they do not contain all the information contained within the standard. Flow charts are contained within a white box.

The unique identifiers for flow charts begin with '**DFigure'** followed by the chapter numeral, the figure number and the title (e.g. **DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease**).

The unique identifier of the standard(s) and applicable flow chart are referenced to aid the user.

Appendices

The appendices contain additional guidance and information that is not appropriate for inclusion within the main content ~~of the reference book~~, for example because it is a long list of guidance or is applicable to multiple chapters.

Index of standards

The Index of standards lists all rules, conventions, general coding standards and chapter standards in the order they appear ~~in the reference book.~~. It can be used to locate a specific standard ~~in the reference book~~.

Summary of changes

The summary of changes lists each change that has been made between the previous and current release of the ~~reference book~~*National Clinical Coding Standards for ICD-10 for Morbidity Coding* in the order that the change appears ~~in the reference book~~. Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Updating the ~~reference book~~National Clinical Coding Standards for ICD-10 for Morbidity Coding

Updated releases of the ~~reference book~~National Clinical Coding Standards for ICD-10 for Morbidity Coding may contain new or updated rules, conventions, standards and guidance or they may be deleted. In each case the updates are made in a consistent manner and are identified in the summary of changes. Users can also refer back to previous ~~reference books~~versions to see how a standard and codes were applied historically.

New rule, convention or standard

A new rule, convention, general coding standard or chapter standard is added at the end of the relevant section with a new unique identifier and title.

A new coding standard within a chapter is added in code, category or range order to reflect the location of the code(s) that the standard applies to in the ICD-10 Tabular List. The new entry is given a new unique identifier and title. This means that the unique identifiers for coding standards within a chapter may not always be listed sequentially.

The unique identifiers and titles of all new entries can be referenced in the Index of standards.

Updated rules, conventions and standards

When a rule, convention or standard is updated, the necessary changes are made to the existing text and the unique identifier remains the same.

Deleted rules, conventions and standards

A rule, convention or standard is deleted when it is no longer ~~to be applied~~applicable or has been superseded. Deleted entries are removed ~~from the reference book~~.

New, updated and deleted guidance and references

New guidance and references are added in the most relevant location. They are deleted if no longer required. Guidance and references are updated by making the appropriate changes to the existing text of the guidance or reference.

RULES OF ICD-10

DRule.2: Category and code structure

Code assignment must always be made to four character level or five character level (where available and in line with fifth character coding standards), for the code to be valid.

Where a three character category code is not subdivided into four character subdivisions the 'X' filler must be assigned in the fourth character field, so the codes are of a standard length for data processing and validation. The code is still considered a three character code from a classification perspective.

Where a three character code requires assignment of both the 'X' filler and a fifth character subdivision, the 'X' filler must continue to be recorded in the fourth field before the fifth character, for example **M45.X3 Ankylosing spondylitis, cervicothoracic region.**

See also DConvention.7: Fifth characters.

Three character codes:

The three character category code structure is a three-digit code with an alphabetic character in the first position followed by two numbers. Most three character categories are subdivided to give four character or five character codes (subcategories).

Four character codes:

In most instances the fourth character .8 is used for other conditions belonging to the three character category but is not included in any of the 0-7 four character codes.

The fourth character .9 usually denotes that the condition(s) is not described sufficiently to permit assignment of a more specific code.

Five character codes:

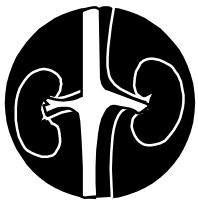
Supplementary fifth characters are used in Chapters IX, X, XIII and XIX to add greater specificity to the codes. Fifth characters activity codes are also available in Chapter XX, but these codes are not to be used for national collection.

GENERAL CODING STANDARDS AND GUIDANCE

DGCS.10: Multiple condition codes

Some individual categories within ICD-10 contain single codes to classify "multiple" conditions, e.g. **C46.8 Kaposi sarcoma of multiple organs** and **S76.7 Injury of multiple muscles and tendons at hip and thigh level**. Single codes identifying multiple body sites or conditions must not be used where the information is available to enable use of individual codes. The exceptions are:

- ***DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24)*** – when there is more than one condition resulting from HIV classified to the same category in **B20-B24**.
- ~~When assigning codes identifying bi-laterality of the same limb~~
- ***DCS.XIX.3: Bilateral injuries of limbs involving the same body site (T00-T07)*** when there is an identical injury and site classified to the same code(s).



CHAPTER XIV DISEASES OF THE GENITOURINARY SYSTEM
(N00–N99)

Coding standards and guidance

DCS.XIV.1: Gouty nephropathy (M10.0†, N16.8*)

Gout that is causing nephropathy must be coded as follows:

M10.0† **Idiopathic gout** (5th character to specify site)
N16.8* **Renal tubulo-interstitial disorders in other diseases classified elsewhere**

See also:

- ***DGCS.5: Dagger and asterisk system***
- ***DChS.XIII.1: Fifth characters in Chapter XIII***.

Example(s):

Gouty nephropathy with idiopathic gout in left foot

M10.07† Idiopathic gout, Ankle and foot
N16.8* Renal tubulo-interstitial disorders in other diseases classified elsewhere

DCS.XIV.12: Prolapse of vaginal vault after hysterectomy (N99.3)
It must be clear in the medical record that the vaginal prolapse is due to the previous hysterectomy in order to assign code **N99.3 Prolapse of vaginal vault after hysterectomy**~~. It is not necessary to assign an additional code from categories **Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure** because the nature of the procedure is implicit in the code description of **N99.3**.~~ ***See also DCS.XIX.7: Postprocedural complications and disorders.***
Terms such as 'posthysterectomy' and 'due to hysterectomy' may be used by the responsible consultant to indicate the prolapse is due to the hysterectomy.

Example:

Patient attends for a repair of a prolapse of the vaginal vault confirmed as being due to a previous hysterectomy

N99.3 Prolapse of vaginal vault after hysterectomy
Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

The **Y83.6** is assigned in accordance with ***DCS.XIX.7.***

CHAPTER XV PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
(O00–O99)

Chapter standards and guidance

DChS.XV.1: Outcome of delivery (Z37)

A code from category **Z37.- Outcome of delivery** must only be assigned ~~in the first secondary diagnostic position~~ on the mother's delivery episode ~~*only*~~, to identify whether the delivery resulted in a liveborn or stillborn infant(s). **Z37.-** can be sequenced in any secondary diagnosis field but must never be sequenced in the primary diagnosis field.

See also:

- ***DCS.XV.2: Termination of pregnancy (O04-O07) - Medical termination of pregnancy resulting in a liveborn infant***
- ***DCS.XV.16: Maternal care for intrauterine death (O36.4).***

Codes in category **Z37.- Outcome of delivery** must not be used on patients who have undergone termination of pregnancy or suffered a miscarriage that has resulted in the delivery of a dead fetus whilst in hospital.

See:

- ***DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)***
- ***DCS.XV.2: Termination of pregnancy (O04-O07).***

The specific sequencing of **Z37.- Outcome of delivery** has been removed as national-level data collections are no longer limited by number of fields and there are no other national-level requirements for the specific sequencing.

Coding standards and guidance

DCS.XV.2: Termination of pregnancy (O04-O07)

Termination of pregnancy must be coded using a code in categories **O04-O07** irrespective of gestational age (i.e. including termination of pregnancy after 24 completed weeks) and regardless of whether the baby was liveborn or stillborn.

The presence of retained products of conception (RPOC) following termination of pregnancy is considered an incomplete abortion and is coded to categories **O04-O06** with the relevant fourth character of **.0** to **.4**.

Medical termination of pregnancy (O04)

Patients admitted for the administration of abortifacient drugs (for example, Mifepristone) or pessaries for termination of pregnancy must be coded using a code from category **O04.- Medical abortion** with the appropriate fourth character from the range **.5** to **.9**. This includes patients who:

- are kept in hospital and abort the pregnancy whilst in hospital
- are discharged to abort the pregnancy at home
- begin to bleed before discharge home to abort the pregnancy

If after being discharged the patient is readmitted with an incomplete termination of pregnancy (retained products of conception), the primary diagnosis must be coded to **O04.-** , with the appropriate fourth character from the range **.0** to **.4.**

Assign a code from category **O08.- Complications following abortion and ectopic and molar pregnancy in addition to codes in category O04.-** to give further information about any complications of medical termination of pregnancy, ***see DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)***.

See also DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.

Medical termination of pregnancy resulting in a liveborn infant

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

Unspecified abortion

O06.- Unspecified abortion must not be used for inpatient termination of pregnancy coding, as it would be expected that the patient's medical record would contain complete documentation regarding the patient's condition. If the type of termination of pregnancy is not documented, the coder must obtain this information from the responsible consultant.

The only circumstance in which this category is valid for use is in cases where a direct inadvertent loss of the pregnancy takes place, ***see DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06).***

See also DCS.XV.3: Cancellation of medical termination of pregnancy.

'**Termination of pregnancy**' is the preferred term used by clinical staff when referring to '**abortion**' within codes in categories **O04-O07** and refers to ending the pregnancy by medical or surgical means resulting in the expulsion or extraction of all or any part of the pregnancy, including placental tissue, membranes, gestation sac and fetus.

Most terminations of pregnancy will take place before the 24th completed week of pregnancy. However, in certain circumstances termination may take place beyond 24 completed weeks.

Medical abortion (O04) is the interruption of pregnancy for legally acceptable, medically approved indications. This category includes both elective (planned) termination of pregnancy at the patient's request, and therapeutic termination of pregnancy performed for suspected fetal abnormalities.

Other abortion (O05) includes illegally induced termination of pregnancy: the illegal interruption of pregnancy by any means. A coder would not be expected to use this category.

Failed attempted abortion (O07) classifies when an intervention intended to terminate the pregnancy (either legal or illegal) does not result in termination of the pregnancy, i.e. the fetus is still alive and the pregnancy is ongoing.

Medical abortion due to spina bifida in fetus. Baby was born with a heartbeat and lived for 15 minutes.

O04.9 Medical abortion, complete or unspecified, without complication
~~**Z37.0 Single live birth**~~
O35.0 Maternal care for (suspected) central nervous system malformation in fetus
Z37.0 Single live birth

DCS.XV.13: Complications of anaesthesia during pregnancy, labour, delivery and the puerperium (O29, O74, O89)

When coding complications of anaesthesia in categories **O29.- Complications of anaesthesia during pregnancy, O74.- Complications of anaesthesia during labour**

and delivery and O89.- Complications of anaesthesia during the puerperium code assignment must reflect the stage of pregnancy when the anaesthesia was administered (i.e. pregnancy, labour and/or delivery, or during the puerperium), and not the stage when the complication(s) arose.

See also:

- ***DCS.XIX.9: Accidental awareness during general anaesthesia [AAGA]***
- ***DCS.XIX.7: Postprocedural complications and disorders***

Chapter XV is structured so that the conditions are classified to three distinct stages - pregnancy, childbirth (including labour and/or delivery) and the puerperium. Anaesthetic administered for a delivery of any type would be considered to be part of the childbirth stage.

Example:

Patient admitted for elective caesarean section under epidural anaesthesia for disproportion. Baby boy born. Severe headache one day post partum, induced by epidural anaesthesia.

O33.9 Maternal care for disproportion, unspecified
~~**Z37.0 Single live birth**~~
O74.5 Spinal and epidural anaesthesia-induced headache during labour and delivery
Y48.3 Local anaesthetics
Z37.0 Single live birth

Code **O74.5** has been assigned because the epidural was administered during the childbirth stage to facilitate the caesarean delivery (***See also DConvention.5: Relational terms***).

An external cause code has been added to **O74.5** in keeping with **DCS.XIX.7**

DCS.XV.14: Multiple gestation (O30)

Patient admitted for delivery of triplets. During delivery she sustains a second degree perineal laceration. (All babies liveborn).

O70.1 Second degree perineal laceration during delivery
~~**Z37.5 Other multiple births all liveborn**~~
O30.1 Triplet pregnancy
Z37.5 Other multiple births, all liveborn

DCS.XV.16: Maternal care for intrauterine death (O36.4)

The code **O36.4 Maternal care for intrauterine death** must be assigned for stillbirths and late intrauterine fetal deaths, where it is known before delivery that the fetus has no signs of life. If the cause of death is known, code **O36.4** must be assigned in a secondary position to the code(s) which describes the cause of death of the fetus.

A code from category **Z37.- Outcome of delivery** indicating that the outcome of delivery was a stillbirth must be assigned ~~in the first secondary position~~ on all stillbirth and late intrauterine fetal death episodes.

If it is not known prior to delivery that there is a stillbirth or that intrauterine fetal death has occurred, the code **O36.4** must not be recorded and a different code from Chapter XV must be used. A code from **Z37.-** would still be assigned to indicate that the outcome of delivery was a stillbirth.

See also:

- ***DChS.XV.1: Outcome of delivery (Z37)***
- ***DCS.XVI.7: Stillbirths (P95.X)***

Stillbirth is defined as 'a baby **delivered** with no signs of life, known to have died **after 24 completed weeks** of pregnancy'. Late Intrauterine fetal death refers to babies with no signs of life in utero **after 24 completed weeks** of pregnancy.

Antenatal scan at 28 weeks due to vaginal haemorrhage reveals placenta praevia and fetal death, patient proceeds to deliver stillborn infant.

O44.1 Placenta praevia with haemorrhage
~~**Z37.1 Single stillbirth**~~
O36.4 Maternal care for intrauterine death
Z37.1 Single stillbirth

DCS.XV.21: Preterm labour and delivery (O60)

Mother with severe pre-eclampsia admitted at 35 weeks for delivery of a baby boy by caesarean section.

O14.1 Severe pre-eclampsia
~~**Z37.0 Single live birth**~~
O60.3 Preterm delivery without spontaneous labour
Z37.0 Single live birth

DCS.XV.30: Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)

Baby delivered by elective caesarean section because the mother has symptomatic (active) HIV

O98.7 Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium
~~**Z37.0 Single live birth**~~
B24.X Unspecified human immunodeficiency virus [HIV] disease
Z37.0 Single live birth

DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99)

Spontaneous vertex delivery of baby boy at 38 weeks. Asthma attack immediately following delivery. Diagnosed with asthma two years ago. On Ventolin.

O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium
~~**Z37.0 Single live birth**~~
J45.9 Asthma, unspecified
Z37.0 Single live birth

CHAPTER XVI CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD
(P00–P96)

Coding standards and guidance

DCS.XVI.10 Meconium in liquor (P20)

When meconium in liquor is documented in the baby's medical record, a code from category **P20.- Intrauterine hypoxia** must be assigned.

If no further treatment or investigation is required following observations, and no other morbid conditions are treated or investigated, a code from **Z38.- Liveborn infants**

according to place of birth must be assigned in the primary position followed by the code from **P20.-**.

If further treatment or investigation is required, the code from **P20.-** must be sequenced as per **DGCS.1: Primary diagnosis**.

See also

- ***DGCS.1: Primary diagnosis***
- ***DChS.XVI.1: Liveborn infants according to place of birth (Z38)***

In accordance with NICE guidance, the presence of any meconium in liquor warrants clinical observation of the baby. If any risk factors are observed during this time, the baby will require a neonatology assessment and potential further investigation and/or treatment following this.

CHAPTER XIX INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00–T98)

Chapter standards and guidance

DChS.XIX.1: Multiple injuries

Multiple injuries must be coded separately where the specific sites and types of injuries are documented. The injury that is clearly the most severe and demanding of resources must be sequenced in the primary position as per the primary diagnosis definition (***See DGCS.1: Primary diagnosis***). Where no one condition obviously predominates, the responsible consultant's advice must be sought.

Codes in Chapter XIX that classify 'multiple injuries' must only be used where no detail is documented in the medical record about the individual sites or types of the injury (e.g. **S01.7 Multiple open wounds of head, S09.7 Multiple injuries of head**).

The exceptions are bilateral injuries of limbs involving the same body site, ***see DCS.XIX.3 Bilateral injuries of limbs involving the same body site (T00-T07).***

When multiple injuries are caused by the same event, only one external cause code is assigned directly after the final injury code, ***see DChS.XX.1: External causes***.

See also DGCS.10: Multiple condition codes.

Coding standards and guidance

DCS.XIX.3: Bilateral injuries of limbs ~~involving the same body site~~ (T00-T07)

Codes in categories **T00-T07 Injuries involving multiple body regions** must only be used for bilateral injuries of limbs ~~involving the same body site~~ where the type and site of injury are identical on both sides.

See also:

- ***DGCS.10: Multiple condition codes***
- ***DChS.XIX.1: Multiple injuries.***

This standard has been updated to instruct that the use of **T00-T07** codes for bilateral injuries is only applicable to injuries of limbs and only when the injuries are identical and on identical sites.

DCS.XIX.7: Postprocedural complications of medical and surgical care ~~and disorders~~

When coding postprocedural complications and disorders it must *never be* assumed that a condition is a postprocedural complication or disorder; it must be clearly documented as such by the responsible consultant.

Postprocedural complications and disorders can be coded in three different ways.

Reference to modifiers and qualifiers, such as ‘postoperative’ in the Alphabetical Index, is essential for selecting the correct code.

A code from categories **Y40-Y84** must always be assigned for complications of medical or surgical care to allow for accurate reporting of external causes.

Conditions that result from another external cause that are not directly due to the medical or surgical care, e.g. rupture of an operative wound due to a fall, must have the appropriate external cause code assigned to cover the circumstance. A code from **Y40-Y84** must not be assigned. ***See DChS.XX.1: External causes.***

Coding T80–T88 Complications of surgical and medical care, not elsewhere classified

When the Alphabetical Index directs to a code from categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**, (using lead terms for the actual complication, such as displacement and leakage, or via the specific condition with modifiers

to indicate that it was a result of a procedure or under 'Complication'), apply the following codes and sequencing:

T80-T88 Complications of surgical and medical care, not elsewhere classified
Any additional code(s) as directed by the 'Use additional code' notes in the Tabular List (Additional code may be sequenced in Primary diagnostic position when this is the main condition treated or investigated. See **DGCS.1: Primary diagnosis**)

Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural complications classified to categories **T80-T88** are due to the same external cause, the external cause code must only be assigned once, following all the applicable postprocedural complication codes from categories **T80-T88**.

This applies regardless of whether the complication occurs during the same episode on which the procedure took place, or on a subsequent episode / subsequent readmission for treatment of the postoperative complication.

Coding postprocedural disorders in body system chapters

When the Alphabetical Index directs to a code, in a postprocedural disorder category in a body system chapter, not ending in **.8** or **.9** (e.g. **N99.1 Postprocedural urethral stricture**), or where a specific standard indicates that these codes must be used (e.g. ***DCS.VII.4: Post enucleation socket syndrome, PESS (H59.8 and Y83.6)***), apply the following codes and sequencing:

Code from postprocedural disorder category in a body system chapter
Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural complications are classified to codes in the postprocedural disorder categories within the body system chapters, and are due to the same external cause, the external cause code must only be assigned once, following all the codes from the postprocedural disorder category or categories.

When the Alphabetical index directs to a code in a postprocedural disorder category in a body system chapter ending in **.8** or **.9** (e.g. **N99.8 Other postprocedural disorders of genitourinary system**), do not assign this code, but follow the instruction in **Coding the condition plus external cause code** section (found below) instead. The exception is if a code for the specific condition does not exist; in this case the **.8** or **.9** code from the postprocedural disorder category in the body system chapter must be assigned.

Coding the condition plus external cause code

When the Alphabetical Index does not direct to a code in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**, or a code in a postprocedural disorders category in a body system chapter (as described above) apply the following codes and sequencing:

Code from Chapters I-XVIII classifying the specific condition
Y40-Y84 Complications of medical and surgical care

- Where multiple postprocedural conditions due to the same external cause are classified using codes from Chapters I-XVIII (that are not classified to one of the postprocedural disorder categories), the external cause code must be assigned multiple times, i.e. following each code from Chapters I-XVIII.

Postprocedural infections

Postprocedural infections must be coded following the standards listed above. Where it is necessary to indicate the infectious organism causing the infection the following codes and sequencing must be applied:

Code from categories **T80-T88** or the code from a postprocedural disorder category in a body system chapter or the code from a body system chapter classifying the specific condition
Any additional code(s) as directed by the 'Use additional code' notes in the Tabular List *
B95-B98 Bacterial, viral and other infectious agents
U82 Resistance to betalactam antibiotics, **U83 Resistance to other antibiotics** or **U84 Resistance to other antimicrobial drugs** (If the infective organism is resistant to a drug(s))
Y40-Y84 Complications of medical and surgical care

* The sequencing of **T81.4 Infection following a procedure, not elsewhere classified** and the manifestation of infection code(s) is dependent upon the main condition treated. ***See: DGCS.1: Primary diagnosis***

See also:

- ***DGCS.6: Infections***
- ***DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis***
- ***DCS.X.3: Postprocedural pneumonia***
- ***DFigure.XIX.1: Postprocedural complications of surgical and medical care***

- ***DChS.XX.1: External causes***
- ***DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)***
- ***DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)***
- ***DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)***

Postprocedural complications and disorders are conditions arising as a result of surgical or medical procedures. In the medical record they may be referred to as postoperative/postprocedural/post-op complications or disorders following surgery or following a procedure.

The majority of postprocedural complications/disorders will be classified to a code from the range **T80-T88 Complications of surgical and medical care, not elsewhere classified** *or* one of the postprocedural disorder codes within a body system chapter. Codes in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified** specifically classify complications of surgery and medical care that are not classified elsewhere, i.e. postprocedural disorders that are not specifically classified to a postprocedural disorder code within a body system chapter.

The assignment of a code for the specific condition together with an external cause code is required for those conditions that can arise in the postoperative period, but are not unique to this situation. For example, a urinary tract infection can occur as a postoperative complication; however, this will not always be the case. Postoperative conditions such as this are coded in the usual way, but a code from **Y40-Y84** is added to identify the relationship between the condition and the procedure.

Codes from categories **Y83-Y84** are indexed under the lead term ‘Complication’ in Section II of the Alphabetical Index.

Postprocedural infection and complication following insertion of prosthesis, implant or graft
When coding postprocedural wound infections in patients with prosthetic devices, implants or grafts it is important to determine if the infection is actually due to the prosthetic device itself, or genuinely of the wound site, as this will affect code assignment from categories **T80-T88**.

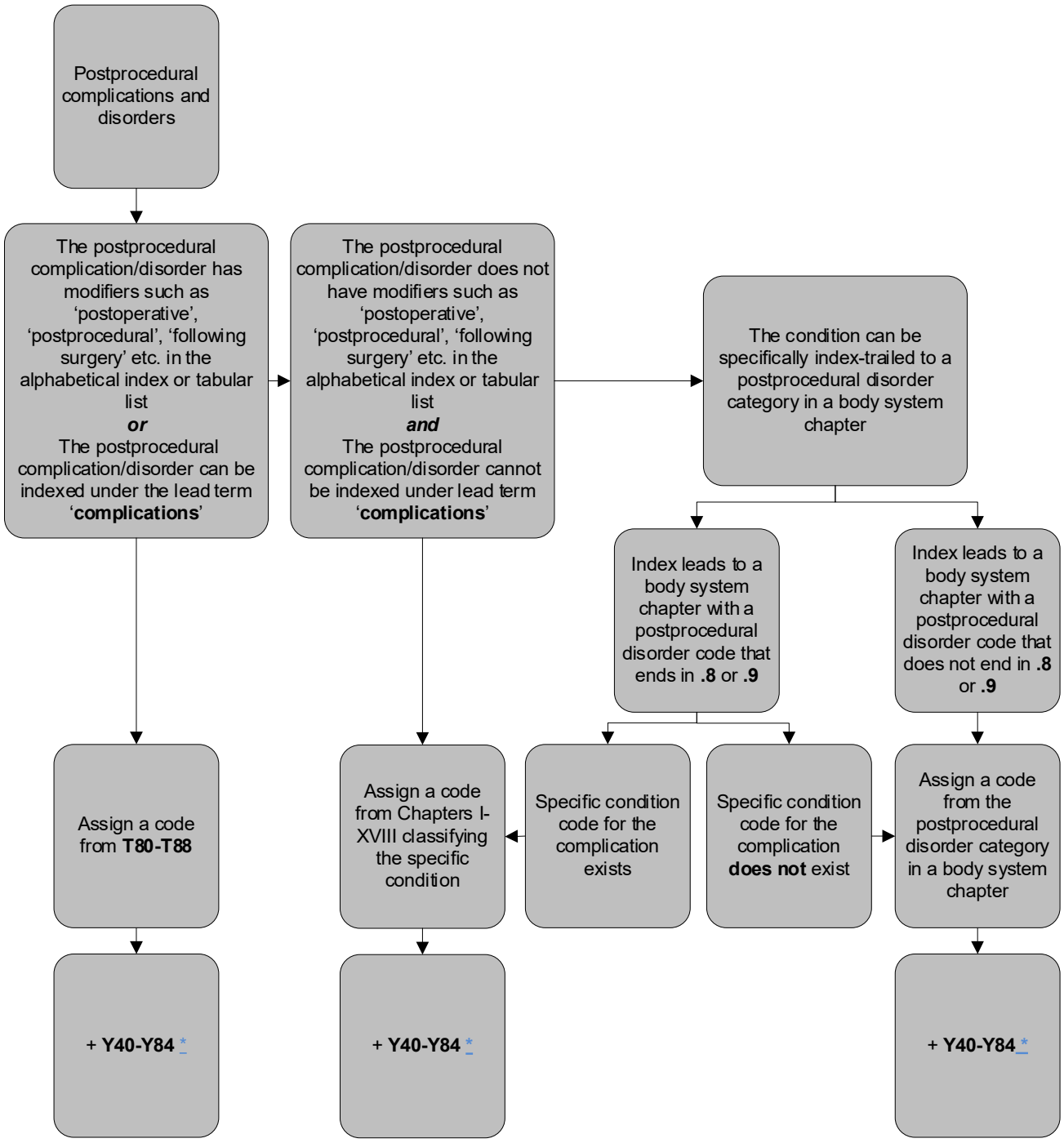
Other types of complications in patients with prosthetic devices, implants or grafts must be treated with the same caution. For example, a femoral/popliteal bypass graft often becomes occluded after a period of time. This occlusion can occur because of a mechanical complication of the graft (**T82.3 Mechanical complication of other vascular grafts**) or due to a recurrence of the original disease, such as occluded femoral artery.

Where the occlusion is due to recurrence of the original disease, the original disease would be coded as the main condition. Clinical advice should be sought as to the reason for the occlusion if it is not clear in the medical record.

Sequencing
The sequencing of postprocedural complication codes may on occasions change as the complication may present problems that affect the patient's management and become the main condition treated instead of the condition that the procedure was performed for.

This standard has been amended to describe situations where the complication is due to another external cause and to include manifestations of the complication for example, abscess, sepsis etc.

DFigure.XIX.1: Postprocedural complications of medical and surgical care~~and disorders~~



* Conditions that result from another external cause that are not directly due to the medical or surgical care, e.g. rupture of an operative wound due to a fall, must have the appropriate external cause code assigned to cover the circumstance. A code from **Y40-Y84** must not be assigned.

See DCS.XIX.7: Postprocedural complications of medical and surgical care.

CHAPTER XXI FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES (Z00–Z99)

Coding standards and guidance

DCS.XXI.15: Living alone (Z60.2)
Code **Z60.2 Living alone** must only be assigned as an additional code when it is evident in the medical record that the fact that a patient lives alone has extended their length of stay. **Z60.2** must not be assigned on day case episodes. **Z60.2** must not be assigned on an episode where the patient dies.
The NHS Data Model and Dictionary for England provides a definition for day case admissions; this involves the intention of a patient receiving care, not requiring the use of a Hospital Bed overnight and returning home as scheduled. If the patient **does** stay overnight, then this admission should be counted as an ordinary admission (Inpatient), not a day case. https://www.datadictionary.nhs.uk/attributes/patient_classification.html

By definition, day case episodes cannot involve an overnight stay in a hospital bed. This standard has been updated to instruct that the assignment of Z60.2 is therefore inappropriate on a day case admission.

CHAPTER XXII CODES FOR SPECIAL PURPOSES (U00–U85)

Coding standards and guidance

DCS.XXII.8: Sequencing of COVID-19 (U07.1 and U07.2)

Where **U07.1 COVID-19, virus identified** or **U07.2 COVID-19, virus not identified** is assigned but the main condition treated or investigated is unrelated to COVID-19, **DGCS.1: Primary diagnosis** must be applied.

Where a condition or symptom documented as being due to, or caused by, COVID-19 is the main condition treated or investigated, **U07.1** or **U07.2** must be assigned in the primary diagnostic position followed by the code(s) for the condition or symptom.

Where **U07.1** or **U07.2** does not appear in the primary diagnosis field, it must be sequenced directly after the code for the primary diagnosis, except where another standard prevents this, such as always using dagger and asterisk codes in combination, in ***DGCS5: Dagger and asterisk system*** ~~the use of codes in category **Z37.-** in **DChS.XV.1: Outcome of delivery (Z37)**~~. This ensures that COVID-19 is recorded in systems and data collections where diagnostic code fields are limited.

Hospital acquired COVID-19

Where COVID-19 is documented as hospital acquired, **Y95.X Nosocomial condition** must be assigned directly after **U07.1** or **U07.2**. **Y95.X** must also be assigned after each code for any other conditions that have been documented as hospital acquired.

See also DCS.XX.10: Hospital acquired conditions (Y95.X).

National Clinical Coding Standards ICD-10 5th Edition for Morbidity Coding