CCAP Assessment Day May 2021

Summary of Common Errors

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Contents

Introduction

This Summary of Common Errors document describes the common errors made by the candidates who attended the Clinical Coding Auditor Programme (CCAP) assessment day on 19 May 2021.

The purpose of the document is to support experienced accredited clinical coders who intend to apply for the CCAP in future. It gives an overview of common errors and covers the written practical and theory assessments, as well as providing generic feedback on the Conclusions and Recommendations exercise.

Practical Paper

Section A: ICD-10 Coding Scenarios

This section featured four questions worth an overall total of 39 marks.

Question:

Patient who had had a previous caesarean section admitted at 32 weeks gestation with moderate pre-eclampsia. She went on to deliver twins two days later vaginally following induction of labour. One of the twins was in breech position. During delivery she sustained a 3rd degree tear which required suturing. Clinician confirmed the main condition treated was the breech delivery.

- Some candidates incorrectly assigned a delivery code from **O80-O84** in primary position instead of a code from category **O32 Maternal care for known or suspected malpresentation of fetus**.
    - The main condition treated was confirmed to be the breech presentation. **[DGCS.1: Primary diagnosis in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]**
    - 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. **[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) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]**
- Several candidates assigned code **O34.2 Maternal care due to uterine scar from previous surgery** instead of code **O75.7 Vaginal delivery following previous caesarean section**; other candidates omitted code **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.27: Vaginal delivery following previous caesarean section (O75.7) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Several candidates omitted code **O30.0 Twin pregnancy** so also lost the associated sequencing mark.
    - 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 **O30.-** must be recorded in a secondary position.
      [DCS.XV.14: Multiple gestation (O30) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]
- Some candidates either omitted code **O60.3 Preterm delivery without spontaneous labour** altogether or assigned an incorrect fourth character at category **O60 Preterm labour** and delivery.
    - A code from category **O60 Preterm labour and delivery** is used if the labour is spontaneous or induced and if the delivery is vaginal or surgical. Assign **O60.3 Preterm delivery without spontaneous labour** when the patient or 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.
      [DCS.XV.21: Preterm labour and delivery (O60) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

Question:

Patient admitted with severe *Escherichia coli (*E. coli) sepsis as a result of E. coli meningitis – the sepsis was the main condition treated. The patient was confirmed as having acute renal failure which was successfully treated with dialysis. During the admission they were diagnosed with stage IV kidney disease and hypertensive kidney failure with hypertensive congestive cardiac failure.

- Several candidates omitted code **R65.1** which classifies *severe* sepsis.
    - The patient is confirmed as having severe E. coli sepsis and this must be coded using the following codes and sequencing:

      A41.- Other sepsis (or the specific type of sepsis recorded in the medical record, in this case the coagulase-negative staphylococcal sepsis)
      R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure

      [DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]
- Some candidates chose an incorrect category to classify bacterial meningitis which must be coded to **G00.8 Other bacterial meningitis**, or they failed to add the code to identify the infectious organism (**B96.2**).

  - Codes in **B95-B98** 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 causative organism is not available. These codes must only ever be used in a secondary position to a code classified outside of Chapter I Certain infectious and parasitic diseases.
    [DCS.I.4: Bacterial, viral and other infectious agents (B95-B98) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Some candidates coded end stage renal failure (**N18.5**) instead of chronic kidney disease, stage 4 (**N18.4**).

Question:

Bilateral fractures of distal radii and a hairline skull fracture sustained following a fall from scaffolding whilst working on a local building site. Patient is a current smoker. Investigations revealed a small subdural haematoma which was drained successfully in theatre.

- Several candidates wrongly assigned a single fracture code (**S52.50**) instead of a multiple fracture code for the bilateral distal radii fractures (**T02.40**).

  - Codes in categories **T00-T07 Injuries involving multiple body regions** must only be used for bilateral injuries involving the same body site where the type and site of injury are identical on both sides.
    [DCS.XIX.3: Bilateral injuries involving the same body site (T00-T07) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Some candidates correctly arrived at the multiple fracture category **T02 Fractures involving multiple body regions** but selected the wrong fourth character of **.2 Fractures involving multiple regions of one upper limb** instead of **.4 Fractures involving multiple regions of both upper limbs.**

- A few candidates omitted the fifth character from the radial fracture code.

  - Supplementary fifth characters are used 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’.
    [DChS.XIX.2: Fifth characters in Chapter XIX in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

Question:

Pneumonia as a result of pneumococcus. Patient also suffers from chronic obstructive pulmonary disease (COPD). Whilst in hospital they suffered a lacunar infarction which resulted in left sided paralysis. The patient was in hospital 10 days longer than necessary due to the delay in a nursing home bed becoming available. The clinician confirmed the main condition treated as being the pneumonia.

This question was well answered by all candidates with no common error themes identified.

Section B: OPCS-4 Coding Scenarios

This section featured four questions worth an overall total of 40 marks.

Question:

Patient added to a pre-scheduled list for replacement of an aneurysmal segment of juxtarenal abdominal aorta by anastomosis of aorta to aorta. During the same visit to theatre a percutaneous transluminal insertion of a metal stent into the left renal artery using fluoroscopic and image intensifier guidance was performed via the femoral artery. During the same admission a computed tomography (CT) angiogram using contrast of the abdominal aorta was carried out.

- Several candidates incorrectly assigned code **L19.4** from category **L19 Other replacement of aneurysmal segment of aorta** instead of code **L18.4 Emergency replacement of aneurysmal segment of infrarenal abdominal aorta by anastomosis of aorta to aorta** when the patient had been added to a pre-scheduled list.
    - When deciding which category to assign, the *nature* of the procedure and not the nature of the admission must be taken into account. The term emergency pertains to the use of operating theatre time that has not been pre-scheduled (including operations added to a pre-scheduled list).
      [PGCS15: Emergency procedures in the National Clinical Coding Standards OPCS-4 reference book (2021)]
- Several candidates omitted site code **O45.2 Juxtarenal abdominal aorta** to specifically classify the juxtarenal element.
    - Site codes from Chapter Z must always be assigned when this adds further information about the site the procedure was performed on.
      [PCSZ1: Site codes in the National Clinical Coding Standards OPCS-4 reference book (2021)]
- A few candidates incorrectly assigned code **Y78.1 Arteriotomy approach to organ using image guidance with fluoroscopy** instead of **Y53.4 Approach to organ under fluoroscopic control**. There was no mention of terms such as ‘incision into artery’, ‘surgical cut-down’ or ‘cutting of artery’ to suggest an arteriotomy approach.
- A few candidates assigned the incorrect fourth character of **.1** instead of **Y97.3 Radiology with post contrast**.
    - Codes within category **Y97 Radiology with contrast** must only be assigned if it is stated in the patient’s medical record that the imaging procedure has been performed using contrast media.
    - When only ‘radiology with contrast’ is stated in the medical record **Y97.3 Radiology with post contrast** must be used as the default.
      [PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2021)]
- Several candidates omitted code **Y98.1 Radiology of one body area (or < 20 minutes)** following the CT angiography so also lost the associated sequencing mark.
    - The ‘***Notes***’ at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast**, if used, are required.

[PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Question:

Patient attended for delivery of a terminated 25-week fetus. The fetus with cephalic presentation was delivered vaginally following an episiotomy being performed to facilitate the delivery. Post-delivery an anti-D injection was given.

- A few candidates omitted the code for the Anti-D injection (**X30.1**).
    - When Anti-D is injected prophylactically, whether it is during pregnancy or following delivery, abortion or miscarriage, it must be recorded each time it is given using code **X30.1 Injection of Rh immune globulin**.

      [PCSR8: Anti-D injection during pregnancy and following delivery (X30.1) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- A few candidates omitted the code **Y95.1 Over 20 weeks gestational age**.
    - Codes in category **Y95 Gestational age** must be assigned in a subsidiary position, where this information is available, with various codes in Chapters Q and R as indicated by the Notes at category and code level.
      [PCSY11: Gestational age (Y95) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Question:

Patient admitted for a reduction and internal fixation of a right ankle joint compound fracture following a successful initial reduction in the Emergency Department earlier the same day. An open reduction and internal fixation (ORIF) of the right fracture dislocation was performed in theatre. The skin of the lower leg was also debrided. They had a computed tomography (CT) scan of the right ankle joint to check the alignment of the fracture the day after theatre.

- A few candidates assigned the incorrect fourth character for skin of lower leg at **Z50 Skin of other site**. It should have been **Z50.4 Skin of leg NEC**.
- A few candidates assigned **U21.2 Computed tomography NEC** rather than **U13.6 Computed tomography of bone** to identify the CT of the ankle joint.
    - When one body site alone is scanned and this can be indexed to a code range from **U01–U18**, **U35** or **U37** assign the following codes:

      • Specific body system code from **U01–U18**, **U35** or **U37**

      • **Y97 Radiology with contrast** (if used)

      • **Y98.1 Radiology of one body area** (or < 20 minutes)

      • **Z site code** (if doing so adds further information).

      • **Z94.- Laterality of operation** (if applicable)

[PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- Several candidates omitted code **Y98.1 Radiology of one body area (or < 20 minutes)** following the CT scan of the ankle so also lost the associated sequencing mark.
    - The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast**, if used, are required.
      [PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Question:

Patient admitted for a laparoscopic prosthetic repair of left inguinal hernia using synthetic mesh.

- Several candidates omitted code **Y28.1 Insertion of synthetic mesh into organ NOC** to specify the type of mesh used.
    - When coding procedures where mesh is inserted, a code from **Y28.1** to **Y28.3** must be assigned in addition when the type of mesh used is known.
      [PCSY13: Insertion and removal of mesh (Y26 and Y28) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- Several candidates assigned all the correct codes but incorrectly sequenced codes **Y28.1** and **Y75.2**.
    - When an endoscopic or minimally invasive procedure is undertaken but no specific code exists to capture this type of approach, dual coding is required. The following codes and sequencing is required:
        - Open procedure code
        - **Y74-Y76** Minimal access code
        - Chapter Y Subsidiary Classification of Methods of Operation code (if required)
        - Chapter Z site code(s)
        - **Z94.- Laterality of operation** (if applicable)

      [PGCS1: Endoscopic and minimal access operations that do not have a specific code in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- A few candidates omitted the laterality code.
    - When laterality is documented in the medical record, and is not already implicit in the code description, it must be coded.
      [PCSZ2: Laterality of operation (Z94) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Section C: Case Studies

This section featured two case studies worth an overall total of 49 marks.

Case Study 1 – General Surgery

Overall, this case study was answered well.

ICD-10:

- Several candidates assigned an incorrect code for the anaemia due to the large acute PR bleed suffered. Based on the information provided, the correct code was **D62.X Acute haemorrhagic anaemia.**

- Some candidates omitted the skin infection code **L08.9 Local infection of skin and subcutaneous tissue, unspecified** following the code for the stage III decubitus ulcer (**L89.2**). The associated sequencing mark was therefore also lost.

    - Pressure ulcers with associated infection (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)
        - **L08.9 Local infection of skin and subcutaneous tissue, unspecified**
        - **B95-B98 Bacterial, viral and other infectious agents** if the infective agent is identified.

      [DCS.XII.3 Pressure ulcer and leg ulcer with associated infection, cellulitis and gangrene in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

OPCS-4:

- A few candidates assigned incorrect fourth characters for the anterior resection performed on the rectum up to mid sigmoid, the end colostomy formed with the end of the remaining sigmoid colon and the partial excision of dome of bladder. The correct fourth character codes were **H33.6 Anterior resection of rectum and exteriorisation of bowel**, **H15.2 End colostomy** and **M35.9 Partial excision of bladder, unspecified.** As the axis of classification at category **M35** is the type/nature of partial excision that has been performed, the **.9** must be assigned as the operative statement simply lists ‘partial bladder excision’ or ‘partial excision of dome of bladder’. Assigning the **.8** would not indicate that the partial excision of the bladder was of the dome.

- Several candidates incorrectly assigned the colonoscopy with biopsy code (**H22.1**) instead of code **H25.1 Fibreoptic endoscopic examination of lower bowel using a sigmoidoscope** together with **Z28.6 Sigmoid colon** when the case study confirmed that the colonoscopy was unable to advance beyond a large tumour in the sigmoid colon.

    - The *Excludes* note at category **H22** confirms that where a diagnostic fibreoptic endoscopic examination is limited to the sigmoid colon, as in this case, a code from category **H25** must be assigned instead.

      PConvention 2: Instructional notes and paired codes in the National Clinical Coding Standards OPCS-4 reference book (2021)

Case Study 2 – General Medicine

Overall, this case study was also answered well.

ICD-10:

- Several candidates assigned the incorrect fourth character at **I63 Cerebral infarction**. A CT confirmed the presence of a thrombus in the middle cerebral artery, which the responsible consultant confirmed as having caused the cerebral infarction. The correct fourth character was **I63.3 Cerebral infarction due to thrombosis of cerebral arteries.**

- The primary diagnosis was the patient's stroke. Several candidates omitted code **R13.X Dysphagia** which was treated with a NG tube.

    - 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.
      [DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Several candidates sequenced the acute IHD code (**I24.9**) before code **I23.1 Atrial septal defect as concurrent complication following acute myocardial infarction** which was investigated and confirmed by a TTE during the episode. The associated sequencing mark was therefore also lost.

    - Codes in category **I23.- Certain current complications following acute myocardial infarction** must be assigned when the complications occurred ***following*** an acute myocardial infarction. When a complication occurs concurrently with the MI, a code from categories **I21-I22** is assigned instead.
      [DCS.IX.6: Certain current complications following acute myocardial infarction (I23) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]
    - When a patient is admitted to hospital with four weeks (28 days) of an acute MI for investigation or treatment of another condition, code **I24.9 Acute ischaemic heart disease, unspecified** must be assigned in a secondary position.
      [DCS.IX.4: Myocardial infarction (I21, I22, I25.8) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Several candidates assigned the incorrect fourth character of **.8** instead of **.1** for eyebrow wound at category **S01 Open wound of head**. This is indexed by following the lead term **Wound,** and the essential modifier of 'brow'.

- A few candidates assigned the incorrect external cause code for slipping on a wet floor in hospital – they assigned **W19.2 Unspecified fall – School, other institution and public administrative area** instead of **W01.2 Fall on same level from slipping, tripping and stumbling – School, other institution and public administrative area.**

OPCS-4:

- A few candidates omitted the approach code **Y76.3 Endoscopic approach to other body cavity** directly after code **G47.5 Insertion of nasogastric tube.**
    - Endoscopic insertion of a nasogastric (NG) or nasojejunal (NJ) feeding tube must be coded using **G47.5 Insertion of nasogastric tube** or **G67.5 Insertion of nasojejunal tube** and **Y76.3 Endoscopic approach to other body cavity**. **[PCSG6: Endoscopic insertion of nasogastric or nasojejunal feeding tube (G47.5 and G67.5) in the National Clinical Coding Standards OPCS-4 reference book (2021)]**
- Some candidates incorrectly assigned code **S41.1 Primary suture of skin of head or neck NEC** in preference to the body system code **C10.4 Suture of eyebrow** for suture of the eyebrow.
    - Operations on skin of eyebrow are excluded from Chapter S in OPCS-4 and are classified to Chapter C instead as per the Note at the start of Chapter S. **[PConvention 2: Instructional notes and paired codes in the National Clinical Coding Standards OPCS-4 reference book (2021)]**
- Some candidates either omitted code **Y97.3 Radiology with post contrast** altogether or assigned the incorrect fourth character of **.1**.
    - Codes within category **Y97 Radiology with contrast** must only be assigned if it is stated in the patient's medical record that the imaging procedure has been performed using contrast media.
    - When only 'radiology with contrast' is stated in the medical record **Y97.3 Radiology with post contrast** must be used as the default. **[PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2021)]**
- Several candidates omitted code **Y98.1 Radiology of one body area (or < 20 minutes)** following the TTE so also lost the associated sequencing mark.
    - The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast**, if used, are required. **[PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2021)]**

Theory Paper

Section D: National Clinical Coding Standards – Multiple Choice

ICD-10

This sub-section was worth 4 marks and overall was answered extremely well. Whilst Question 2 about hypertensive heart and renal disease was answered correctly by all candidates, a few candidates chose the wrong option for Questions 1, 3 and 4 which tested national standards relating to heavy drinker, missed abortion/miscarriage and adverse effects/reactions respectively.

OPCS-4

This sub-section was also worth 4 marks and overall was answered extremely well. Whilst Question 2 about obstetric scan coding was answered correctly by all candidates, a few candidates chose the wrong option for Questions 1, 3 and 4 which tested national standards relating to ESWL of ureteric calculus, oral and parenteral chemotherapy administration, and insertion of mesh respectively. Question 4 was the one most frequently answered incorrectly, possibly because candidates had not familiarised themselves with new coding standard PCSY13: Insertion and removal of mesh (Y26 and Y28) in the National Clinical Coding Standards OPCS-4 reference book (2021) – this is reinforced by the omission and sequencing errors made to the mesh question in Section B of the practical paper.

Section E: National Clinical Coding Standards – Data Extraction and Communication Skills

This section contained five questions, two ICD-10 and three OPCS-4, worth a total of 67 marks. Most of these questions were well answered and, similar to previous years, the main errors involved:

- Some candidates omitted the codes which differed between the Trust and Auditor coding. The corresponding explanations of contraventions and national standard reference and title were also absent. For example, omission of site and/or laterality codes from the answers provided.
- Candidates correctly selected the code that was contravening a national standard but failed to correctly or fully explain the standard that was being contravened, i.e. they chose an irrelevant national standard for the particular scenario as an explanation or did not fully elaborate on their explanations.
- Failing to identify all examples of contraventions of national standards within a scenario.
- Repeating explanations for the same contravention.
- Omission of standard reference number and/or title or providing an inappropriate standard reference to match their explanation.

We have provided the questions and the key common errors and rationales in more detail below.

ICD-10

Question 1:

Trust codes and sequence		Auditor codes and sequence	
1.	J22.X Unspecified acute lower respiratory infection	1.	J18.9 Pneumonia, unspecified
2.	J44.9 Chronic obstructive pulmonary disease, unspecified	2.	Y95.X Nosocomial condition
3.	S52.50 Fracture of lower end of radius – closed	3.	J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
4.	S52.50 Fracture of lower end of radius – closed	4.	T02.40 Fractures involving multiple regions of one upper limb – closed
5.	W14.9 Fall from tree, unspecified place	5.	

The most common errors made at this question were:

- Omission of an explanation for why the primary diagnosis had been contravened along with the associated reference of DGCS.1, i.e. that chest infection is a non-specific diagnosis and the more specific diagnosis of pneumonia should be coded as the primary diagnosis.

  Explanation of contravention:

  - 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.
  - 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.

    [DGCS.1: Primary diagnosis and Guidance on page 109 of the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

- Failing to provide an explanation at all, or fully describe why the external cause code standard had been contravened.

  Explanation of contravention:

  - Codes in categories **V01**-**Y36** must only be assigned on the first consultant 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.

[DChS.XX.1: External causes in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

Question 2:

Trust code and sequence		Auditor codes and sequence	
1.	C50.9 Malignant neoplasm of breast, unspecified	1.	C79.5 Secondary malignant neoplasm of bone and bone marrow
2.	C79.5 Secondary malignant neoplasm of bone and bone marrow	2.	R52.1 Chronic intractable pain
3.	Z72.0 Tobacco use	3.	I10.X Essential (primary) hypertension
4.		4.	Z85.3 Personal history of malignant neoplasm of breast
5.		5.	F17.1 Mental and behavioural disorders due to tobacco, harmful use

The most common errors made at this question were:

Explanation of contravention:

- Omission of an explanation for why the primary diagnosis had been contravened along with the associated reference of DGCS.1, i.e. that the metastases were the main condition treated.
    - 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.

      [DGCS.1: Primary diagnosis in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

Explanation of contravention:

- Incomplete explanation about incorrect assignment of code **Z72.0** instead of **F17.1**.
    - 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.

      [DCS.V.7: Current smoker (F17) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2021)]

OPCS-4

Question 1:

Trust code and sequence		Auditor codes and sequence	
1.	S06.3 Shave excision of lesion of skin of head or neck	1.	E09.1 Excision of lesion of external nose
2.	Y20.3 Biopsy of lesion of organ NOC	2.	S06.3 Shave excision of lesion of skin of head or neck
3.	Z22.1 External nose	3.	
4.		4.	
5.		5.	

The most common errors made at this question were:

- An incomplete explanation as to why operations on the external nose are classified in OPCS-4 Chapter E instead of Chapter S.

  Explanation of contravention:

  - Chapter E External nose is excluded from Chapter S in OPCS-4, however codes from Chapter S Skin can be assigned in addition to enhance the code assigned from the body system chapter where necessary.
  - When using a code from Chapter S to enhance a code from another body system chapter the code from Chapter S must be assigned:
    - When it provides further information about the procedure that is not specified in the primary body system code
    - In a secondary position, directly after the body system code it is enhancing.

  [PChSS1: Enhancing body system codes using codes from Chapter S in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- An incorrect explanation and/or incorrect standard reference number for excision/biopsy as a biopsy code in not required. Several candidates quoted PChSY1: Use of codes in Chapter Y when it wasn't appropriate for a Chapter Y code to be assigned anyway.

  Explanation of contravention:

  - When an excision and biopsy is performed on the same site during the same theatre visit (often referred to as an excision biopsy), only assign a code(s) for the excision as a biopsy is an integral part of the excision.

  [PGCS9: Excision and biopsy procedures in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- Omission of the code, contravention explanation and standard to describe why code **Z22.1 External nose** is not required.

  Explanation of contravention:

  - A site code is not required when it does not provide any additional information.

    [PCSZ1: Site codes in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Question 2:

Trust code and sequence		Auditor codes and sequence	
1.	L63.1 Percutaneous transluminal angioplasty of femoral artery	1.	L63.1 Percutaneous transluminal angioplasty of femoral artery
2.	Z94.3 Left sided operation	2.	Y53.4 Approach to organ under fluoroscopic control
3.	Y53.5 Approach to organ under image intensifier	3.	Z38.3 Common femoral artery
4.	Y53.4 Approach to organ under fluoroscopic control	4.	Z94.3 Left sided operation
5.		5.	
6.		6.	

The most common errors made at this question were:

- Incorrectly identifying code **Y53.4 Approach to organ under fluoroscopic control** as the wrong code instead of code **Y53.5 Approach to organ under image intensifier** but providing the correct contravention explanation.

  Explanation of contravention:

  - When fluoroscopy is used with an image intensifier, the only approach code required is **Y53.4 Approach to organ under fluoroscopic control**.

    [PCSY7: Approach to organ under image control (Y53, Y68 and Y78) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- Failing to identify, explain or reference the site code contravention as the Trust had missed code **Z38.3 Common femoral artery**.

  Explanation of contravention:

  - Site codes from Chapter Z must always be assigned when this adds further information about the site the procedure was performed on.

    [PCSZ1: Site codes in the National Clinical Coding Standards OPCS-4 reference book (2021)]

- Omitting the Chapter Y and Chapter Z code sequencing contravention.

Explanation of contravention:

- The code from category **Y53** must be sequenced after the intervention and before the site and laterality codes.

  OR

- When assigning codes from both Chapter Y Subsidiary Classification of Methods of Operation and Chapter Z Subsidiary Classification of Sites of Operation, the Chapter Y code must precede the Chapter Z code.

  [PCSY7: Approach to organ under image control (Y53, Y68 and Y78) OR PGCS14: Sequencing of codes in Chapter Y with codes in Chapter Z in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Question 3:

Trust code and sequence		Auditor codes and sequence	
1.	W31.4 Cancellous chip autograft of bone	1.	W37.3 Revision of total prosthetic replacement of hip joint using cement
2.	W37.1 Primary total prosthetic replacement of hip joint using cement	2.	W31.4 Cancellous chip autograft of bone
3.		3.	Z75.6 Acetabulum
4.		4.	Y66.3 Harvest of bone from iliac crest
5.		5.	Z94.2 Right sided operation
6.		6.	

This question was perfectly answered by most candidates.

- The small amount of errors were due to failing to reference the need to code harvest, site and laterality codes to reflect the full sequencing instructions in PCSW4: Total hip replacement with acetabular bone graft (W37-W39).

  Explanation of contravention:

  - If during a primary or revisional total hip replacement, an acetabular or femoral bone graft, using either morcellised bone or block of bone, is performed in addition to the joint replacement the following codes must be assigned:
    - Primary or revisional total prosthetic replacement of hip joint code
    - **W31.- Other autograft of bone** or **W32.- Other graft of bone**

- **Z75.6 Acetabulum** or **Z76.- Femur**
- **Y66.- Harvest of bone** (only if an autograft was used)
- Z site code of the harvest (if not identified in the code from **Y66.-**)
- **Z94.- Laterality of operation**

[PCSW4: Total hip replacement with acetabular bone graft (W37-W39) in the National Clinical Coding Standards OPCS-4 reference book (2021)]

Conclusions and Recommendations Exercise

In this section candidates are asked to write three conclusions and three associated SMART recommendations using the given information.

Whilst most candidates did well in this exercise, the issues that continue to be problematic are:

- Writing conclusions that were actually findings or 'facts' that didn't offer on opinion as to why they may have led to errors in the clinical coding, for example:

  "Coders cannot access the radiology system and radiology reports were not always filed in the medical record."

  This offers no opinion (conclusion) as to how the unavailability of radiology reports may have contributed to the number of errors found at audit.

- Failing to provide timeframes for completion in the recommendations (the T in SMART). Examples of formats that could be used include 'within 6 months', 'by the end of 2021/22', 'by 31-Dec-2021'.