National Clinical Coding Standards
Accurate data for quality information
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The World Health Organisation ICD-10 classification is used in the United Kingdom to classify the diagnoses of all inpatient consultant episodes and attendances. Therefore, it is an important component of mandatory hospital-generated national data sets; such as the Admitted Patient Care Commissioning Data Set collected for secondary uses.

The ICD-10 classification is also used in hospitals for strategic and operational planning and reimbursement. It is a statistical tool and, as such, is not designed to support direct clinical care.

The ICD-10 classification underpins key information initiatives. These support the monitoring of specific diseases and health trends for national and international purposes. The classification is used for United Kingdom submissions of aggregated information to international database collections for statistical and epidemiological comparison.


It is crucial that coded clinical data is complete, accurate, consistent and timely. Those responsible for abstracting and coding clinical information from the medical record are pivotal in supporting this requirement.

This reference book, produced by the NHS Classifications Service, provides specific instructions in the form of national clinical coding standards to reduce ambiguity and differences in interpretation. The reference book will standardise application of the ICD-10 classification across the NHS and safeguard data accuracy, consistency and comparability at local, national and international levels.

The standards have been updated to reflect changes introduced in the ICD-10 4th Edition (also referred to as the 2010 edition). This reference book is an evolving product. Future publications will continue to provide changes to the national clinical coding standards to support information requirements for healthcare.

Authorised amendments are only compiled and issued by the NHS Classifications Service.

NHS Classifications Service
[http://systems.hscic.gov.uk/data/clinicalcoding](http://systems.hscic.gov.uk/data/clinicalcoding)
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INTRODUCTION


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 as outlined in the section below.

The WHO also refers to ICD-10 4th Edition as the 2010 edition. It includes updates that came into effect between 1998 and 2010, as well as the corrigenda to Volume 1, which appeared as an addendum to Volume 3 of the first edition.

National clinical coding standards

The WHO gives specific instruction in 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.

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.

This reference book of national clinical coding standards is an evolving product and future publications will continue to provide changes to the national clinical coding standards to support information requirements for healthcare.

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Introduction

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 alphanumerical code, which permits easy storage, retrieval and analysis of data’\(^1\).

ICD-10 is a vital component of the following national data sets; such as: Hospital Episodes Statistics (HES) in England, Patient Episode Data for Wales (PEDW), Scottish Morbidity Records (SMR), cancer registries, National Service Frameworks, care pathways, performance indicators and Payment by Results.

The statistical classification underpins key information initiatives that support the monitoring of morbidity and health trends. NHS managers and health care professionals use it locally 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 case loads to: determine specialty needs, inform staffing levels, patient admissions and clinic schedules in hospitals.
- Clinical audit uses coded data to provide comparisons of patient care and measurement of outcomes within specialities. Doctors may use extracted local information for research purposes.

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

Morbidity versus mortality coding

The ICD-10 is designed for the classification of diseases and injury as well as signs, symptoms, abnormal findings, complaints and social circumstances. This reference book provides the national clinical coding standards for use with the ICD-10 for morbidity coding.

The ICD-10 classification is also designed for mortality coding from death certificates. Mortality coding requires different guidelines, rules and standards to support national mortality statistics. These are outside the scope of this reference book.

\(^1\) World Health Organisation International Classification of Diseases and Related Health Problems’ ICD-10 Volume 2, 2.1 Purpose and applicability.
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/doctor dialogue.

Hospital provider spell and consultant episode

A clinical coder must assign ICD-10 codes to the diagnoses recorded in the medical record for each consultant episode (hospital provider) within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (which includes day cases).

A hospital provider spell may contain a number of consultant episodes (hospital provider) 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.

The concept of a finished consultant episode, commonly abbreviated to “FCE” is 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://systems.hscic.gov.uk/data/nhsdmds/faqs/cds/admitpat/consep

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22 Consultant episode (hospital provider) is hereafter referred to as consultant episode.
**DATA QUALITY**

**Medical record**

A health record is defined in the Data Protection Act 1998 as a record consisting of information about the physical or mental health or condition of an individual made by or on behalf of a health professional in connection with the care of that individual. The health record can be held partially or wholly electronically 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 responsible consultant, or healthcare practitioner, is accountable for the clinical information they provide. It must accurately reflect the patient's encounter with the health care provider at a given time.

The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant consultant 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 and discharge forms, nursing care pathways 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 robust health care information.

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). The clinical coder (or manager) should use the local information governance and clinical governance arrangements to address documentation issues and support data quality improvements.

The national clinical coding standards cannot provide direction to compensate for deficiencies in the documentation or coding process.

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: http://www.rcplondon.ac.uk/projects/generic-standards-clinical-records

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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.
Uniformity

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

General rules for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient’s condition during the consultant episode.
- However, code every relevant condition or reason for encounter which affects the care, or influences health status during the consultant episode.
- Code each problem to the furthest level of specificity, ie 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 consultant 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 should have the correct code assignment. An individual patient may have many diagnoses (or procedures). Consequently a coded record for a consultant 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 a consultant 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 a consultant episode incorrectly in terms of clinical coding rules and standards even though the individual codes selected are correct. See also Section Co-morbidities.

- **Sequencing of codes**
  Codes must be organised in a sequence which is statistically consistent. A significant aspect of sequencing is the selection of main condition treated. See section Primary Diagnosis.
The four step coding process

The four staged process that make up the act of 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 and requirements is fully explored in training and national core curriculum training materials.

**Step One**
**Analyse** medical terminology to determine **lead term(s)** and modifier(s)

**Step Two**
**Locate** the lead term(s) in the Alphabetical Index (*ICD-10 Volume 3*)

**Step Three**
**Assign a tentative code(s)** using the Alphabetical Index and taking into account all rules, conventions and standards.

**Step Four**
**Verify** the code(s) using the Tabular List (*ICD-10 Volume 1*) and taking into account instructional notes.
Clinical coding audit

Coded clinical data are 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 as well as acknowledging evidence of best practice. When there are documentation discrepancies or systemic 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.

Information governance and clinical governance

The recording of the patient’s conditions, co-morbidities 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 condition.

Nor is it the responsibility of a clinical coder to make a judgement on whether previously reported conditions have any bearing on the current consultant episode for coding purposes. The coding of previously reported conditions is discussed under co-morbidities.

Whilst it may seem that extracting diagnostic information from a previous hospital provider spell provides additional clinical information for coding purposes, there is a risk that this may not be accurate or pertinent to the current consultant episode.

The lack of information, or discrepancies, in the medical record should be addressed through local information governance and clinical governance mechanisms. Such instances present an opportunity to lever change which will bring benefits to the organisation: such as improved recording of clinical information, robust local processes and correctly coded clinical data. The requirements to code co-morbidities can be used to encourage constructive dialogue between clinical coders and doctors to support accurate and consistent coded data.

Further information on information governance can be found at: http://systems.hscic.gov.uk/infogov

Terminology to ICD-10 cross-maps

Health care providers that have implemented electronic health records and a clinical terminology such as SNOMED CT use standards-based linkages between the terminology and ICD-10 known as ‘cross-maps’ to enable the clinical coding of electronic health records.

These cross-maps are semi-automated and, where appropriate, default and alternative target codes are provided. The default target codes are acceptable for the concept/term to which they are linked. However where there is greater relevant detail within the record, the selection of alternative target codes must be undertaken to ensure the classification standards’ rules and conventions are consistently applied.
The national cross-maps are compliant with clinical coding national standards. They are provided in the UK Terminology Centre (UKTC) biannual releases. These are designed to support those organisations who implement electronic health systems 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 NHS Classifications Service to reflect the rules and conventions of ICD-10 as well as the clinical coding standards contained in this standards’ reference book.

The cross-maps are available for download via the Technology Reference Data Update Distribution Service (TRUD) following registration at the following website: www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/login/form
GENERAL CODING STANDARDS

The following coding standards are generic, and must be applied to the whole of ICD-10. Coding standards pertinent to a chapter will be included in the relevant chapter section.

Primary diagnosis

The Health Service Guideline HSG (96)23⁴ mandated the implementation of a standardised primary diagnosis definition for clinical coding which remains the standard.

Primary diagnosis definition:

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.

The above define the contents of the first diagnosis field of the coded clinical record. Clinical coders must continue to code any other relevant clinical information.

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 user groups within the NHS as well as to the WHO.

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.

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,
- that affects the management of the patient’s current consultant episode.

Co-morbidity is coded according to the ICD-10 diagnoses classification and national clinical coding rules and standards.

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.

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provider spell (which may include one or more consultant 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. For the purpose of coding co-morbidities the following clinical information may be useful; the GP referral letter, Accident & Emergency documentation, pre-operative assessment prior to the admission, or transfer documentation provided by the responsible consultant at another hospital. The list is not exhaustive.

In some instances local patient administration systems (PAS) and encoder software may provide a facility that electronically transfers co-morbidities from consultant episode to consultant 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 consultant episode.

Co-morbidities and multiple consultant episodes
Where there are multiple consultant episodes within one hospital provider spell, the relevant co-morbidities may not have been recorded for each consultant episode. For example:

Patient was admitted under a general surgeon on a general surgery ward with rectal haemorrhage. During the admission process it was reported the patient has Type I diabetes which would be coded as a co-morbidity.

The same day the patient is transferred to an endoscopy unit under a gastroenterologist for a couple of hours whilst a colonoscopy was performed. When this was completed the patient was transferred back to the general surgeon on the general surgery ward.

The co-morbidity recorded by the clerking doctor may not necessarily be reported again by the gastroenterologist but was reported during the first consultant episode and is part of the current hospital provider spell. A clinical coder would code the co-morbidity of Type I diabetes for each consultant episode within that hospital provider spell.

Co-morbidities always coded
There are a number of medical conditions and other factors influencing health that must always be coded for each consultant 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 consultant episode.

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 clinically relevant, then these conditions must also be coded.

Any uncertainty as to whether a documented condition is a current condition must be clarified with the responsible consultant by the clinical coder.

The list and additional guidance is published in the Coding Clinic downloaded from: www.cfh.nhs.uk/clinicalcoding/codingstandards/publications/codingclinic

**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, on which to apply extraction skills and assign codes for classification purposes.

The information in a diagnostic test result can be used by the clinical coder when it clearly adds specificity to the documented conditions and enables the assignment of the most appropriate diagnosis code.

When a condition is suggested by a diagnostic test result the clinical coder must always refer to the responsible consultant to confirm the clinical significance of the test results and/or relationship to a specific condition. It is not the role of the clinical coder to interpret test results for coding purposes.

Where there is a discrepancy between the diagnostic test results and the clinical information, the clinical coder must refer to the responsible consultant for clarification of anomalies and confirmation of the diagnosis. The clinical coder must be advised by the responsible consultant of the definitive diagnosis for the medical record, and never interpret results.

**Examples of diagnostic test results**

- Pathology reports provide details of organisms present. The organisms identified in the report may not necessarily be viewed by the consultant/doctor as harmful to the patient. Clinical coders must take care not to ‘over-report’ pathology and microbiology results by attempting to record every organism. Only causative organisms, if they are being treated and confirmed as such by the responsible consultant, should be coded.

- Haematology reports involve the measurement of the various components of blood physiology and the clotting process and should never be interpreted by clinical coders.

- Histology reports usually give a full description of the reported condition. Clinical coders may find these reports provide details that would enable a more specific code for the condition, but should only use the additional information if agreed by the responsible consultant.

- Troponin results should not be used by clinical coders to define whether or not a patient has either a myocardial infarction or acute coronary syndrome. The responsible consultant must determine the diagnosis; it must not be inferred from test results.
General coding standards

- Radiology results may identify a more specific diagnosis; for example, osteoarthritis rather than pain in hip. The responsible consultant should be consulted for confirmation of the definitive diagnosis.

Syndromes

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.

In many cases a code will not completely describe the abnormal condition and a combination of codes is required as explained below.

- If, after the syndrome has been clinically diagnosed the admission is for treatment of 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 a syndrome cannot be specifically indexed the coder must seek clarification from the responsible consultant.

- Ascertain if the syndrome is ‘congenital’ or ‘acquired’. If congenital, it should be noted that not all congenital anomalies are of chromosomal origin. Therefore, in these cases, efforts must be made to determine whether or not it is. If it is ‘acquired’, efforts must be made to determine which body system it affects.

- 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.

Insertion of the character ‘X’

The insertion of character X into the fourth field of codes where only three characters exist is mandatory so the codes are of a standard length for data processing and validation. This provides a standard ‘filler’ character. The code is still considered a three character code from a classification perspective.

Many hospital patient administration systems (PAS), but not all hospital systems, automatically insert the filler ‘X’ therefore all users of coded clinical data should be aware of this requirement.
Where a three character code requires assignment of both the filler ‘X’ and a fifth character subdivision to specify the site of involvement, the filler ‘X’ must continue to be recorded in the fourth field before the fifth character. The format would be as in the example of M45.X3 Ankylosing spondylitis, Cervicothoracic region.
RULES OF THE ICD-10

ICD-10 contains a number of rules in order to provide information in a consistent manner and these must be applied when coding.

Axis of classification

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

‘Special group’ chapters
These chapters classify conditions that do not focus on any one body system:

- Chapter I  Certain infectious and parasitic diseases
- Chapter II  Neoplasms
- Chapter III  Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
- Chapter IV  Endocrine, nutritional and metabolic diseases
- Chapter V  Mental and behavioural disorders
- Chapter XV  Pregnancy, childbirth and the puerperium
- Chapter XVI  Certain conditions originating in the perinatal period
- Chapter XVII  Congenital malformations, deformations and chromosomal abnormalities
- Chapter XIX  Injury, poisoning and certain other consequences of external causes.

‘Body system’ chapters
These chapters classify conditions according to the body system they affect:

- Chapter VI  Diseases of the nervous system
- Chapter VII  Diseases of the eye and adnexa
- Chapter VIII  Diseases of the ear and mastoid process
- Chapter IX  Diseases of the circulatory system
- Chapter X  Diseases of the respiratory system
- Chapter XI  Diseases of the digestive system
- Chapter XII  Diseases of the skin and subcutaneous tissue
- Chapter XIII  Diseases of the musculoskeletal system and connective tissue
- Chapter XIV  Diseases of the genitourinary system
‘Other’ chapters
These chapters classify other disorders, factors which do not sit comfortably in either a special group or body system chapter.

- Chapter XVIII  Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- Chapter XX  External causes of morbidity and mortality
- Chapter XXI  Factors influencing health status and contact with health services
- Chapter XXII  Codes for special purposes

Rules of chapter prioritisation
In general, conditions are primarily classified to one of the ‘special group’ chapters. Where there is any doubt as to where a condition should be positioned, the ‘special group’ chapters should take priority.

Dagger and asterisk system

In ICD-10 the dagger and asterisk system provides a dual classification of diagnostic statements containing information about both an underlying generalised disease (aetiology) and a manifestation of that disease in a particular organ or site which is a clinical problem in its own right. 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 primary code relates to the underlying disease and is marked with a dagger (†); an additional code for the manifestation is marked with an asterisk (*). However, in the ICD-10 4th Edition the dagger and asterisk sequence may be reversed for morbidity coding depending on the main condition treated or investigated during the consultant episode. This sequencing rule aligns with the primary diagnosis definition.

Multiple asterisk codes with one dagger code are disallowed due to validation rules, therefore each asterisk code must have its own dagger code, even where this means repeating dagger codes. An asterisk code is never used alone when coding.

In instances where the responsible consultant has not specified or is unable to confirm which condition is the main condition being treated, the dagger/asterisk default must be used, ie the dagger code must be assigned in primary position, followed by the associated asterisk code.

The dagger-marked terms appear in different forms as follows:

- When the dagger symbol and the alternative asterisk code both appear in the subcategory heading, all terms classifiable to that subcategory are subject to dual classification and all have the same alternative code.
• When the symbol appears in the subcategory heading, but the alternative asterisk code does not, all terms classifiable to that rubric are subject to dual classification but have different alternative codes for each inclusion term (which are listed in brackets).

• If neither the symbol nor alternative code appears in the title, the subcategory as a whole is not subject to dual classification but individual inclusion terms may be. If so, these terms will be marked with the symbol and their alternative codes.

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

Sequencing rules

General sequencing rules applicable across all ICD-10 chapters. These are explained more fully below.

Dagger and asterisk code combinations
Sequencing will depend on the main condition treated. See Section Dagger and asterisk system.

Dual coding
There are situations, other than in the dagger and asterisk system, which permits two ICD-10 codes to be used to fully describe a patient’s condition. The ICD-10 Volume 2 (Instruction Manual) provides a list of six instances of dual coding, where the ‘additional’ code must directly follow in sequence. These are:

• For local infections classifiable to body system chapters, a code from B95-B98 must be added directly following the infection code.

• For neoplasms where there is functional activity, a code from Chapter IV Endocrine, nutritional and metabolic diseases must be added directly after the neoplasm code; unless there is a requirement to also assign a morphology code, in which case it must be sequenced after the morphology code.

• For neoplasms where there is a requirement to assign a morphology code, this must be added directly after the neoplasm code.

• For conditions classifiable to categories F00-F09 in Chapter V, the code describing the underlying disease, injury or other insult to the brain must be added directly after the Chapter V code.

• Where a condition is caused by a toxic agent, the Chapter XX code identifying the toxic agent must be added directly after the condition it is causing.

• Where two codes are used to describe an injury, poisoning or other adverse effect, the code from Chapter XX External causes of morbidity and mortality, must be added directly after the code describing the injury, poisoning or other adverse effect.
Acute and chronic conditions
If a condition is described as both acute (or sub-acute) as well as chronic, and separate
categories (or subcategories) for each are found in the Alphabetical Index and not for the
combination, the category for the acute condition should normally be coded first. This is then
followed by the code for the chronic condition; however the sequencing may change on
occasions due to the primary diagnosis definition.

Sequela codes or ‘late effects’ codes
These are for use when the current condition or disease has been caused by a previous
occurring disease which has been treated, and is no longer present. Sequelae codes must
only ever be used in a secondary position.

Sequencing related to specific codes within chapters are covered in the relevant chapter
section.

Nature of Injury
Coding of both the external cause and the actual injury is mandatory where the information is
present in medical record.

The code for the injury, and the associated external cause code, should be recorded in
succeeding fields in the data record or PAS system. In the case of more than one injury
caused by the same event, one external cause code will serve all injuries and will be
sequenced after the final injury.

Multiple codes
Some individual categories within ICD-10 suggest the use of multiple codes. Single codes
identifying multiple body sites must not be used where the information is available to enable
use of individual codes; with the exception of those identifying bi-laterality of the same limbs
and apart from those specific instances detailed in each chapter section.

Identification of infecting organism
Where the name of the Infecting organism is not identified in the title of the three character
category description an additional code must be used when the infecting organism has been
identified.

Antibiotic resistant bacteria
Where a bacterial agent is resistant to antibiotics (and this information is clearly documented
in the medical record) an additional code from categories U80.- to U89.- can be used to
identify the antibiotic to which the bacterial agent is resistant. These codes are never used in
the primary position and are sequenced immediately following the code for a bacterial
infection classified elsewhere.
Functional activity of neoplasms
These codes should be used ‘as appropriate’. This refers to the instruction in ICD-10 that codes ‘may be added’ in order to describe the functional activity of neoplasms. How and when these codes are used is in fact part of standard clinical coding training and ensures coders recognise and understand ‘appropriate’ use.

Organic and mental disorders
The use of these categories is mandatory when the data is present in the medical record and when recording it helps identify all the elements of the diagnostic statement.

External cause codes
The use of external cause codes (Chapter XX: External causes of morbidity and mortality) is mandatory when the data is present in the medical record.

Multiple coding of injuries
The single code for ‘multiple injuries’ (ie the fourth character code .7) is only to be used where no further detail is present in the medical record.

Alcohol involvement
The use of these codes is mandatory when the data is present in the medical record. These codes must not be used in isolation. This covers use of categories Y90 and Y91.
CONVENTIONS OF THE ICD-10

ICD-10 follows a number of conventions in order to provide information in a consistent manner. As these are integral to coding a definition of each has follows.

Instructional notes

Throughout the Tabular List, notes are present which:

- describe the general content of the succeeding categories
- give instruction regarding the use of categories
- provide fifth character sub-classifications.

Inclusion note (inclusion term, ‘includes’ note)

Because the category and code titles are not always self-explanatory, inclusion notes appear in the Tabular List for the purpose of clarifying the content and intended use of the chapter, block, category or subcategory to which the notes apply.

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.

Exclusion note (exclusion term, ‘excludes’ note)

Exclusion notes are used to prevent a category from being used incorrectly. There are two kinds of exclusion notes based on intended use:

- **Cautionary** exclusion notes say, in effect, ‘if you are looking for such and such here, you are in the wrong place’. They appear in categories that might be confused because they share common terms or concepts.

- **Prohibitive** exclusion notes, on the other hand, are used to show that though the condition to be classified is, indeed, sometimes assigned to the code where the exclusion note appears, in other cases it is assigned elsewhere.

‘Use’ note

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.

Status of ‘are for use with’ characters

Where the phrase ‘are for use with’ is seen, this instruction is mandatory, and the codes referred to must be used, e.g. Y70-Y82.
Status of ‘if desired’ codes
Where the phrase ‘if desired’ is seen, in relation to coding additional information, where that information is present in the medical record this instruction is mandatory.

The ‘if desired’ means that the coder may have to use the given code on its own if there is no more information in the case notes.

Implied ‘use’ notes
There are implied ‘use’ notes with all dagger (†) and asterisk (*) codes directing the coder to the companion code. They may appear at the three, or four, character level or in an inclusion note.

Additional characters

Fifth characters
ICD-10 identifies optional supplementary characters (henceforth referred to as fifth characters) in four chapters of the classification. These supplementary fifth characters are available in Chapters IX, XIII, XIX and XX and can be used to add greater specificity to the codes. Details on whether the use of fifth characters is recommended as best practice or mandatory are provided in the relevant chapter section. The exception is Chapter XX sub classification of activity codes which are not required for national collection.

Fourth character subcategory codes at X34 and X59
The WHO Update Revision Committee agreed that ‘place of occurrence’ codes should be separated from the three character Chapter XX code. Following this agreement ICD-10 4th Edition introduced new fourth character subcategory codes at X34 Victim of earthquake and X59 Exposure to unspecified factor. Present NHS practice is to add a fourth character to these three character codes in order to identify the ‘place of occurrence’ of an injury. This re-designation and re-use of the fourth character by the WHO is incompatible with data already held under X34 and X59. Going forward, the re-use of the fourth character could impact any of the codes in the range W00-Y34.

Following consultation with the home countries and the NHS Information Centre (NHS IC) it was agreed to defer implementation of these fourth character subcategories. This allows for careful consideration and consultation with all stakeholders, including WHO, in order to ensure that an agreed robust and future-proof solution is available in a future update to ICD-10.
Punctuation marks in ICD-10

Brace }
Braces (indicated by a vertical line in Volume 1) 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 wordings, 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 Volume 1. 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 Alphabetical Index to indicate there is a fourth character subdivision.

Parentheses ( )
In the Tabular List parentheses are used to enclose supplementary words which may be present or absent in the statement of a disease without affecting the code to which it is assigned.

Parentheses can also be used to enclose:

- codes listed in an exclusion note
- the code range in block titles
- the dagger or asterisk codes.

In the Alphabetical Index the parentheses are used to enclose nonessential modifiers. That is, the presence or absence of the modifier does not affect the classification of the term so modified.

Parentheses can also be used to enclose:

- cross-reference terms
- morphology codes.
Abbreviations

NOS (not otherwise specified)
This abbreviation is the equivalent of 'unspecified', ie the .9. A term without any essential modifier is usually the unspecified form of the condition.

When the clinician states a diagnosis, problem or reason for an encounter as a single term which has no modifiers, it is said to be 'unspecified' or unqualified or NOS (not otherwise specified). The code assignment is that which directly follows the lead term.

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 which do not appear in sequence with, ie immediately following, the specific categories to which they pertain. (Residual categories which do immediately follow the specific categories to which they pertain are entitled ‘Other specified . . .’).

Cross references
Cross references are used in the Alphabetical Index to ensure that all the possible modifiers for a term or its synonyms are referenced by the coder. The use of cross references allows the Alphabetical Index to be kept to a manageable size.

There are three types of cross reference:

1. ‘ - 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 term in the Index where complete information can be found. It is also used after anatomical sites to remind the coder that the Index is organised by condition.

2. ‘ - see also...’ This cross reference reminds coders to look under another lead term if the term they are looking for cannot be found modified in any way under the first lead term.

3. ‘ - see category...’ This cross reference directs the coder to a specific three - character category in the Tabular List (Volume 1 of ICD-10) where important information governing the use of that category is located.
Relational terms

There are a number of relational terms used in the Tabular List and Alphabetical Index.

‘And’
The use of ‘and’ means and/or. It can indicate that either or both elements are present.

‘With’ or ‘with mention of’
There are certain categories which have been provided for diseases in combination. ‘With’ always appears first in the alphabetical order and is used either when two or more conditions combine to form another condition (see Hypertension, with) or to provide additional four character specificity (see Hernia, with). These terms indicate that both elements in the title must be present in the diagnostic statement in order to assign the code. These terms do not necessarily indicate a cause-effect relationship.

‘Without’
Indicates a category in which the named element must not be present.

‘In’, ‘due to’ and ‘resulting in’
Indicates 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 condition. In other instances, the ICD 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’.
Modifiers

These are sometimes referred to as qualifiers and are descriptive words used to further describe or modify the condition or reason for encounter. Modifiers might identify the site of the condition, eg leg, arm, intestine, the stage of the condition, eg acute, chronic or the type of consultation, problem, or encounter, eg follow-up examination. Modifiers are not always present in every statement.

Two types of modifiers appear in the Alphabetical Index:

- **Nonessential modifiers**
  Nonessential modifiers are descriptors which do not affect the code selection for a given diagnosis. They appear in parentheses (curvy brackets) following the terms they modify and, like lead terms, they are in bold face.

- **Essential modifiers**
  Essential modifiers are descriptive terms which do affect the selection of code 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, hence the name ‘essential’ modifier. Essential modifiers appear as subterms indented below lead terms in the Alphabetical Index.

Order of modifiers

Essential modifiers are usually words describing disorders or anatomical sites which give further specificity to the lead term. Each indented list is in alphabetical order, with two exceptions. The first exception is that whenever combinations of diseases are involved, the word ‘with’ denotes the combination and is always the first entry of the indented list.
CHAPTER I
CERTAIN INFECTIOUS AND PARASITIC DISEASES
A00–B99

Coding Standards

Coding infections
When coding an infection the information given by the responsible consultant is vital in order to apply the correct ICD-10 codes.

The four principal ways to record infections are:

1. If only the infectious agent is known and no site is specified, the infection is recorded to the specified organism only.

Example:
Patient treated for a staphylococcal infection

Index trail:
Infection, infected (opportunistic) B99
- staphylococcal NEC A49.0

Tabular List entry:
A49.0 Staphylococcal infection, unspecified site

2. If the diagnosis states only the site of the infection, code infection by site.

Example:
Patient diagnosed with a urinary tract infection

Index trail:
Infection, infected (opportunistic) B99
- urinary (tract) NEC N39.0

Tabular List entry:
N39.0 Urinary tract infection, site not specified

3. If the clinical information gives both the site of the infection and the organism causing it, code both. It is vital that all cross references in subterms under the lead term ‘infection’ are examined for relevance.
Certain infectious and parasitic diseases

Where the name of the infectious organism is not identified in the title of the three character rubric (category) an additional code must be used when the infectious organism has been identified. If the causative agent is known, it may be classified in one of the following ways:

a) Using the dagger/asterisk convention.

**Example:**

**Patient admitted with tuberculosis of the kidney**

Index trail:

**Tuberculosis, tubercular, tuberculous (caseous) (degeneration) (gangrene) (necrosis)** A16.9
- kidney A18.1† N29.1*

Tabular List entries:

A18.1† Tuberculosis of genitourinary system

N29.1* Other disorders of kidney and ureter in infectious and parasitic diseases classified elsewhere

The ‘dagger and asterisk’ system applies.

b) Using a combination code which shows both the organism and the site.

**Example:**

**Patient admitted with chlamydial infection of anus**

Index trail:

**Infection, infected (opportunistic)** B99
- chlamydia, chlamydial A74.9
- anus A56.3

Tabular List entry:

A56.3 Chlamydial infection of anus and rectum
c) Using two codes.

**Example:**

Patient admitted with a urinary tract infection due to Escherichia coli [E. coli]

- Index trail for site of infection:
  - **Infection, infected (opportunistic)** B99
    - urinary (tract) NEC N39.0

  Tabular List entry:
  
  N39.0 Urinary tract infection, site not specified

- Index trail for organism:
  - **Infection, infected (opportunistic)** B99
    - *Escherichia coli* (E. coli) NEC A49.8
    - - as cause of disease classified elsewhere B96.2

  Tabular List entry:
  
  B96.2 *Escherichia coli* [E. coli] as the cause of diseases classified to other chapters

4. There are also instances when infections are classified according to the circumstances surrounding the infection.

These include:

- postoperative wound infections (Chapter XIX)
- infections complicating pregnancy or childbirth (Chapter XV)
- infections complicating traumatic wounds (Chapter XIX).

These conditions are referenced in the Alphabetical Index under the lead term **Infection** with the appropriate subterm indicating the circumstances. (These scenarios are covered in the appropriate chapters).
Intestinal infectious diseases  
(A00–A09)

Other bacterial intestinal infections (A04)  
Helicobacter (H.) pylori is a bacterium which lives in the mucosal lining of the oesophagus, stomach and duodenum in some people.

Helicobacter (H.) pylori infection (when it is not the cause of a disease classified to another chapter) cannot be indexed in ICD-10 therefore code A04.8 Other specified bacterial intestinal infections must be assigned when it is not associated with a condition in categories K25–K29.

Assign code B98.0 Helicobacter pylori [H.pylori] as the cause of diseases classified to other chapters when it is associated with a condition in categories K25–K29.

Bacterial foodborne intoxications are classified at category A05. The exception is foodborne intoxication by Clostridium difficile which is an inclusion term classified at code A04.7 Enterocolitis due to Clostridium difficile

Other gastroenteritis and colitis of infectious and unspecified origin (A09)  
All cases of gastroenteritis and colitis that are stated to be of infectious or unspecified origin must be coded to the appropriate fourth character at category A09 Other gastroenteritis and colitis of infectious and unspecified origin. In the United Kingdom it must not be assumed that these terms are always of a non-infectious origin.

Code K52.9 Noninfective gastroenteritis and colitis, unspecified must only be used to classify those cases specifically stated as non-infective gastroenteritis and colitis.

Example:  
Patient admitted with diarrhoea

Index trail:  
Diarrhoea, diarrheal (disease) (infantile) A09.9

Tabular List entry:  
A09.9 Gastroenteritis and colitis of unspecified origin

Rationale: Code A09.9 is assigned as the diarrhoea is of unspecified origin. By following the correct index trail for these conditions the coder is directed to the appropriate code in the Tabular List.
Tuberculosis (A15–A19)

Tuberculosis (TB) is an infectious disease caused by a bacterium called Mycobacterium tuberculosis. It most commonly affects the lungs, but can affect any part of the body.

Respiratory tuberculosis, bacteriologically and histologically confirmed (A15)

In order for the coder to use a code from this category the responsible consultant must have documented in the patient’s medical record that the tuberculosis was confirmed either histologically and/or bacteriologically, whereas category A16 Respiratory tuberculosis, not confirmed bacteriologically or histologically is used when the responsible consultant has made a diagnosis of tuberculosis but has not confirmed if this was made using bacteriology or histology.

Other bacterial diseases (A30-A49)

The term ‘septicaemia’ previously used throughout the Alphabetical Index and Tabular List has been replaced with the term ‘sepsis’. This terminology is now used to describe infection. Sepsis is not limited to the blood but can affect the whole body, including organs, and can be caused by bacterial, fungal and viral agents. Septicaemia, or blood poisoning, refers to bacterial infection of the blood.

Terms such as urosepsis, biliary sepsis, chest sepsis and urinary sepsis may be used to describe an infection of a specified organ or system; or an infection that has developed into a systemic infection. These must be coded as infections of the organ or systems - unless instructed otherwise by the Alphabetical Index - or in instances where the responsible consultant has clarified a more generalised systemic sepsis. Sepsis, unspecified, is a generalised infection.

If there is any doubt as to whether the diagnosis is referring to an infection of a specified organ or system or is a generalised systemic infection, clarification must be sought from the responsible consultant.
Neutropenic sepsis develops due to a low white blood cell level, especially the type called neutrophils which fight bacterial infections. The symptoms of neutropenic sepsis include fever and rigors. During treatment of neutropenic sepsis, it is the sepsis that is the priority rather than the neutropenia. The codes and sequence for a stated diagnosis of neutropenic sepsis are:

A41.- Other sepsis (fourth character assignment will depend on whether or not the specific organism is identified)

D70.X Agranulocytosis.

If the responsible consultant has confirmed that neutropenic sepsis was due to a drug, then an external cause code from Chapter XX must also be assigned in addition.

**Viral hepatitis**
(B15–B19)

This block contains codes which classify various forms of viral hepatitis. Code Z22.5 Carrier of viral hepatitis is assigned if a patient has a clinical statement clearly indicating that they are a carrier or a suspected carrier of hepatitis.

**Human immunodeficiency virus [HIV] disease**
(B20–B24)

**HIV**

HIV is short for Human Immunodeficiency Virus.

**AIDS**

AIDS stands for Acquired Immune Deficiency Syndrome.

When coding HIV disease there are specific rules to follow. In some instances there is a need to dual code. This is only necessary if the additional code is adding specific detail. The exception to this rule is HIV disease associated with neoplasm, where dual coding is essential. This is necessary for cancer registries.
Certain infectious and parasitic diseases

1. Only one code is required from B20-B24 if this code fully describes the condition.

**Example:**

Patient admitted with HIV disease resulting in *Pneumocystis jirovecii* pneumonia

- **Index trail:**
  - Human
    - - immunodeficiency virus (HIV) disease (infection) B24
    - - resulting in
    - - - infection B20.9
    - - - - *Pneumocystis jirovecii* (pneumonia) B20.6

- **Tabular List entry:**
  - B20.6 HIV disease resulting in *Pneumocystis jirovecii* pneumonia

2. Two codes are required when the HIV disease code from B20-B24 does not fully describe the condition; a second code to further describe the condition is assigned.

**Example:**

Patient admitted with HIV resulting in candidiasis of the mouth

- **Index trail for the disease:**
  - Human
    - - immunodeficiency virus [HIV] disease (infection) B24
    - - resulting in
    - - - candidiasis B20.4

- **Index trail for manifestation:**
  - Candidiasis, candidal B37.9
    - - mouth B37.0

- **Tabular List entries:**
  - B20.4 HIV disease resulting in candidiasis
  - B37.0 Candidal stomatitis
    - Oral thrush

**Rationale:** In this example the addition of B37.0 specifies that the candidiasis is of the mouth.
3. If there is more than one manifestation, use the subdivision .7 from the appropriate three character category must be used, eg **B20.7 HIV disease resulting in multiple infections**, followed by the codes classifying the specific manifestations as in the example below:

<table>
<thead>
<tr>
<th>Example:</th>
<th>HIV disease resulting in respiratory tuberculosis and cytomegaloviral disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Index trail for the <strong>disease</strong>:</td>
</tr>
<tr>
<td></td>
<td>Human</td>
</tr>
<tr>
<td></td>
<td>- immunodeficiency virus [HIV] disease (infection) B24</td>
</tr>
<tr>
<td></td>
<td>- - resulting in</td>
</tr>
<tr>
<td></td>
<td>- - - infection B20.9</td>
</tr>
<tr>
<td></td>
<td>- - - - multiple B20.7</td>
</tr>
<tr>
<td></td>
<td>Index trails for the <strong>manifestations</strong>:</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis, tubercular, tuberculous (caseous) (degeneration) (gangrene) (necrosis) A16.9</td>
</tr>
<tr>
<td></td>
<td>- respiratory A16.9</td>
</tr>
<tr>
<td></td>
<td><strong>Disease, diseased - see also Syndrome</strong></td>
</tr>
<tr>
<td></td>
<td>- cytomegaloviral B25.9</td>
</tr>
<tr>
<td></td>
<td><strong>Tabular List entries:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>B20.7</strong> HIV disease resulting in multiple infections</td>
</tr>
<tr>
<td></td>
<td><strong>A16.9</strong> Respiratory tuberculosis unspecified, without mention of bacteriological or histological confirmation Respiratory tuberculosis NOS</td>
</tr>
<tr>
<td></td>
<td><strong>B25.9</strong> Cytomegaloviral disease, unspecified</td>
</tr>
</tbody>
</table>
4. When coding HIV disease with a neoplastic condition dual coding for the given conditions must be used with the HIV disease being sequenced in primary position. The main purpose for this is cancer registration.

**Example:** HIV disease resulting in Kaposi sarcoma of multiple organs

[ ] Index trail for the **disease**:

**Human**
- immunodeficiency virus [HIV] disease (infection) B24
- - resulting in
- - - Kaposi sarcoma B21.0

[ ] Index trail for the **manifestation**:

**Kaposi**
- sarcoma (M9140/3)
- - multiple organs C46.8

**or**

**Sarcoma - see also Neoplasm, connective**
- Kaposi (M9140/3)
- - multiple organs C46.8

Tabular List entries:

- **B21.0** HIV disease resulting in Kaposi sarcoma
- **C46.8** Kaposi sarcoma of multiple organs
5. When coding HIV disease with more than one neoplastic manifestation, use code **B21.7 HIV disease resulting in multiple malignant neoplasms**, then list the specific malignancies.

**Example:**

<table>
<thead>
<tr>
<th>HIV disease resulting in Kaposi sarcoma of the palate and Burkitt lymphoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for the <strong>disease</strong>:</td>
</tr>
<tr>
<td><strong>Human</strong></td>
</tr>
<tr>
<td>- immunodeficiency virus [HIV] disease (infection) B24</td>
</tr>
<tr>
<td>- - resulting in</td>
</tr>
<tr>
<td>- - - multiple</td>
</tr>
<tr>
<td>- - - - malignant neoplasms B21.7</td>
</tr>
<tr>
<td>Index trails for the <strong>manifestations</strong>:</td>
</tr>
<tr>
<td><strong>Kaposi</strong></td>
</tr>
<tr>
<td>- sarcoma (M9140/3)</td>
</tr>
<tr>
<td>- - palate (hard) (soft) C46.2</td>
</tr>
<tr>
<td><strong>or</strong></td>
</tr>
<tr>
<td><strong>Sarcoma</strong>- see also Neoplasm, connective</td>
</tr>
<tr>
<td>- Kaposi (M9140/3)</td>
</tr>
<tr>
<td>- - palate (hard) (soft) C46.2</td>
</tr>
<tr>
<td><strong>Burkitt</strong></td>
</tr>
<tr>
<td>- lymphoma (malignant) C83.7</td>
</tr>
<tr>
<td><strong>or</strong></td>
</tr>
<tr>
<td><strong>Lymphoma</strong> (malignant) C85.9</td>
</tr>
<tr>
<td>- Burkitt (atypical) (-like) (small noncleaved, diffuse) (undifferentiated) C83.7</td>
</tr>
<tr>
<td>Tabular List entries:</td>
</tr>
<tr>
<td><strong>B21.7</strong> HIV disease resulting in multiple malignant neoplasms</td>
</tr>
<tr>
<td><strong>C46.2</strong> Kaposi sarcoma of palate</td>
</tr>
<tr>
<td><strong>C83.7</strong> Burkitt lymphoma</td>
</tr>
</tbody>
</table>

HIV disease in pregnancy is excluded from this chapter and must be coded using **O98.7 Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium.**

For patients who have symptomatic (active) HIV an additional code from categories **B20-B24** must be assigned in a secondary position to identify the specific condition.

For patients who are asymptomatic (non-active or HIV positive) then the code **Z21.X** would be assigned in a secondary position.
The following codes may be assigned when HIV infection is asymptomatic or undiagnosed.

- Laboratory evidence of human immunodeficiency virus [HIV] (R75.X) relates to when laboratory tests have been carried out but no firm diagnosis has been confirmed.
- Contact with and exposure to human immunodeficiency virus [HIV] (Z20.6) identifies patients who have had contact with and/or exposure to HIV.
- Asymptomatic human immunodeficiency virus [HIV] infection status (Z21.X) identifies patients who carry the HIV virus but are asymptomatic, i.e. they are HIV positive.

**Sequelae of infectious and parasitic diseases (B90–B94)**

Sequelae, or late effects, are for use when the current condition (or disease) has been caused by a previously occurring disease which has been treated and is therefore no longer present. They are not to be used for chronic infections. Current infections must be coded to chronic or active infectious disease, as appropriate.

Sequelae codes must only ever be assigned in a secondary position.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Patient has contracture of left knee joint due to his previously treated poliomyelitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>condition</strong>:</td>
<td>Contraction, contracture, contracted</td>
</tr>
<tr>
<td></td>
<td>- joint (abduction) (acquired) (adduction) (flexion) (rotation) M24.5</td>
</tr>
<tr>
<td>Index trail for <strong>sequelae</strong>:</td>
<td>Sequelae (of) – see also condition</td>
</tr>
<tr>
<td></td>
<td>- poliomyelitis (acute) B91</td>
</tr>
<tr>
<td>Tabular List entries:</td>
<td>M24.5 Contracture of joint</td>
</tr>
<tr>
<td></td>
<td>(fifth character of 6 to identify knee joint)</td>
</tr>
<tr>
<td></td>
<td>B91.X Sequelae of poliomyelitis</td>
</tr>
</tbody>
</table>
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. These codes must only ever be used in any secondary position.

Example:

Patient admitted with an infection of the tongue due to a staphylococcal infection

- Index trail for site of infection:
  - Infection, infected (opportunistic) B99
    - tongue NEC K14.0

  Tabular List entry:
  - K14.0 Glossitis

- Index trail for organism:
  - Infection, infected (opportunistic) B99
    - staphylococcal NEC A49.0
    - - as cause of disease classified elsewhere B95.8

  Tabular List entry:
  - B95.8 Unspecified staphylococcus as the cause of diseases classified to other chapters

MRSA (Methicillin Resistant Staphylococcus Aureus)

MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

Categories U80-U89 are provided for use as supplementary codes where the antibiotic to which a bacterial agent is resistant has been clinically identified and documented in the patient’s medical record. Where MRSA is documented in the patient’s medical record it is implied that the bacteria is resistant to Methicillin and therefore code U80.1 Methicillin resistant agent must always be assigned in addition to the code which identifies that the infective agent is staphylococcus aureus, as shown in the two examples below.
**Example:**

Patient re-admitted with a postoperative methicillin antibiotic resistant staphylococcus aureus (MRSA) infection of the abdomen following gastrectomy 2 weeks ago.

- **Index trail for infection:**
  - Infection, infected (opportunistic) B99
    - post operative wound T81.4

  Tabular List entry:
  
  **T81.4** Infection following a procedure, not elsewhere classified

- **Index trail for organism:**
  - Staphylococcus, staphylococcal – see also condition
    - aureus, as cause of disease classified elsewhere B95.6

  Tabular List entry:
  
  **B95.6** Staphylococcus aureus as the cause of diseases classified to other chapters

- **Index trail for organism:**
  - Resistance, resistant (to)
    - antibiotic(s), by bacterial agent
    - - methicillin U80.1

  Tabular List entry:
  
  **U80.1** Methicillin resistant agent

- **Index trail for external cause code to indicate previous surgery:**
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
    - removal of organ (partial) (total) NEC Y83.6

  Tabular List entry:
  
  **Y83.6** Removal of other organ (partial) (total)

In the above example there is no national guidance on the sequencing of post-procedural complication codes (Y83-Y84) and infectious agent codes (B95-B98) when they are both required to be coded. They can appear in any order, provided that both codes are present and recorded immediately following the primary post-procedural infection code.
A code from categories B95-B98 must be recorded if the infectious agent has been identified.

Where it has been clearly documented that the bacteria is resistant to an antibiotic then a code from U80-U89 must also be assigned and must be sequenced directly after the code from Chapter I.

**Example:**

Patient admitted with an unspecified MRSA infection

- Index trail for *infection*:
  - Infection, infected (opportunistic) B99
    - staphylococcal NEC A49.0

  Tabular List entry:
  - A49.0  Staphylococcal infection, unspecified site

- Index trail for *organism*:
  - Resistance, resistant (to)
    - antibiotic(s), by bacterial agent
      - - methicillin U80.1

  Tabular List entry:
  - U80.1  Methicillin resistant agent
A code from **U80-U89** must be assigned in addition to **Z22.3 Carrier of other specified bacterial diseases** to identify the antibiotic to which the bacteria is resistant when this is clearly stated by the responsible consultant in the patient’s medical record. Examples below:

**Examples:**

**Patient confirmed to be MRSA positive carrier**

- Index trail for **carrier**:
  - Carrier (suspected) of
    - staphylococci Z22.3

- Tabular List entry:
  - Z22.3 Carrier of other specified bacterial diseases

- Index trail for **organism**:
  - Resistance, resistant (to)
    - antibiotic(s), by bacterial agent
    - - methicillin U80.1

- Tabular List entry:
  - U80.1 Methicillin resistant agent

**MRSA found on nasal swab only**

- Index trail for **carrier**:
  - Carrier (suspected) of
    - staphylococci Z22.3

- Tabular List entry:
  - Z22.3 Carrier of other specified bacterial diseases

- Index trail for **organism**:
  - Resistance, resistant (to)
    - antibiotic(s), by bacterial agent
    - - methicillin U80.1

- Tabular List entry:
  - U80.1 Methicillin resistant agent
Other and unspecified infectious agents (B99)

This code should only be used in exceptional circumstances. Clinical coders should ask for more definitive information instead of using this ‘catch all’ code.
Chapter rules and conventions

- There are two special symbols used in Chapter II; cross hatch and diamond, to denote the histological type of neoplasm.

- All neoplasms are classified to this chapter, whether they are functionally active or not. An additional code from Chapter IV may be used to identify functional activity associated with any neoplasm.

- When coding neoplasms in patients with HIV, both conditions must be coded.

- When the neoplastic disease is the reason for seeking care or investigation the primary neoplasm is coded as the main condition. When the primary neoplasm has been eradicated and/or the main condition treated is the secondary neoplasm, the secondary neoplasm is coded as the main condition.

- The use of morphology codes is optional; they can be used nationally or locally, when local systems are provided for their transfer to cancer registries. Although it is not currently mandatory for morphology codes to be input onto hospital systems (with the exception of Wales), it is a requirement that coders assign morphology codes when sitting the National Clinical Coding Qualification (UK).
Coding Standards

Types of code involved in coding neoplasms

Behaviour and anatomical site codes
The first axis for coding is the behaviour categories; the second axis is the anatomical site of the neoplasm. Anatomical site codes are found in Chapter II Neoplasms in the Tabular List. For each site there are five possible codes depending on the behaviour of the neoplasm:

- malignant primary
- malignant secondary
- in situ
- benign
- uncertain behaviour or unspecified nature.

The neoplasm codes are sequenced before morphology codes.

Morphology codes (histology)
Morphology of neoplasms refer to their histological characteristics, eg carcinoma, adenocarcinoma, sarcoma, mesothelioma, etc.

They are composed of six characters identifying the histological type and the behaviour of the neoplasm, eg malignant, benign, in situ, etc.

The morphology codes for lymphoid, haematopoietic and related tissues neoplasms (categories C81-C96 and D45-D47) are not contained within the ICD-10 4th Edition Alphabetical Index. However, the corresponding morphology codes are located in the Tabular List (see Morphology of neoplasms tables, pages 1027 to 1050 Morphology codes M959-M998), if required for local use.

The morphology codes consist of the letter M, followed by four characters that identify the histological type, with a slash mark and a fifth character indicating the behaviour code. The selection of the behaviour code is dependent on the clinical information in the medical record.

For example, the morphological lead term of osteosarcoma, which has the morphology code of M9180/3, has no essential modifier of ‘metastatic’ in the Alphabetical Index. To assign a code for metastatic osteosarcoma, the behaviour character within the morphology code M9180/3 must be changed to M9180/6 to reflect this is metastatic. It is important that the first five characters of the morphology code, i.e. M9180, remain the same to denote the correct histological type.

NOTE: Tabular List entries for morphology codes have only been included in the examples within this chapter to demonstrate how they are seen in the Tabular List.
Instructional notes when coding neoplasms
Reference should be made to the notes introducing Chapter II in the Tabular List and those at the beginning of the Neoplasm Table in the Alphabetical Index. These notes give valuable information regarding:

- code assignment
- symbols used within the Neoplasm Table and
- the use of morphological descriptions.

Special symbols
The notes preceding the Neoplasm Table refer to two special symbols: # and ◊. The use of these symbols in ICD-10 is dependent upon the histological type of neoplasm to be coded.

The cross hatch symbol (#)
Any site marked with the sign #, e.g. face NEC #, must be classified as follows:

- To a malignant neoplasm of skin of that site if the histological type is either:
  - squamous cell carcinoma
  - epidermoid carcinoma.
- To a benign neoplasm of skin of these sites if the histological type is a:
  - papilloma of any type.
**Example:**

<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant</td>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>epidermoid (M8070/3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neoplasm, neoplastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limb #</td>
<td>C76.7</td>
<td></td>
</tr>
<tr>
<td>lower #</td>
<td>C76.5</td>
<td></td>
</tr>
<tr>
<td>Neoplasm, neoplastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>skin (nonmelanotic)</td>
<td>C44.9</td>
<td></td>
</tr>
<tr>
<td>limb NEC</td>
<td>C44.9</td>
<td></td>
</tr>
<tr>
<td>lower</td>
<td>C44.7</td>
<td></td>
</tr>
</tbody>
</table>

**Tabular List entry for epidermoid carcinoma:**

<table>
<thead>
<tr>
<th>C44.-</th>
<th>Other malignant neoplasms of skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>C44.7</td>
<td>Skin of lower limb, including hip</td>
</tr>
</tbody>
</table>

**Tabular List entry for Morphology of epidermoid carcinoma:**

| M8070/3 | Squamous cell carcinoma NOS |

**Rationale:** With the # symbol at the limb site and the histological type identified as epidermoid carcinoma, this type of neoplasm would be classified to skin of lower limb at C44.7, as C76.5 indicates an unspecified neoplasm of lower limb.
The diamond (◇) symbol
Any site marked with the ◇ sign, e.g. neoplasm bone (periosteum) ◇, that is a carcinoma or adenocarcinoma of any type other than intraosseous or odontogenic, must be considered to be a metastatic spread from an unspecified primary site.

They must therefore be coded to **C79.5 Secondary malignant neoplasm of bone and bone marrow** and **C80.9 Malignant neoplasm, primary site unspecified**. Sequencing will depend on the main condition treated.

**Example:**

**Adenocarcinoma of calvarium**


<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>C41.0</th>
<th>C79.5</th>
</tr>
</thead>
</table>

Tabular List entry:

**C79.5 Secondary malignant neoplasm of bone and bone marrow**

Tabular List entry for **Morphology of adenocarcinoma**:

**M8140/6 Adenocarcinoma, metastatic NOS**


<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>C80.9</th>
</tr>
</thead>
</table>

Tabular List entry:

**C80.9 Malignant neoplasm, primary site unspecified**


<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>M8140/3 Adenocarcinoma NOS</th>
</tr>
</thead>
</table>

**Rationale:** Wherever there is a secondary malignancy, a primary malignancy must be coded. Code **C80.9** has been selected in the above example as the primary site of malignancy has not been identified, i.e. it is unspecified. Sequencing will depend on the main condition treated during the consultant episode.
Example:

<table>
<thead>
<tr>
<th>Osteosarcoma of femur</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index trail for osteosarcoma:</strong></td>
</tr>
<tr>
<td><strong>Osteosarcoma</strong> (M9180/3) - see also Neoplasm, bone, malignant</td>
</tr>
<tr>
<td>Malignant</td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td><strong>Neoplasm, neoplastic</strong></td>
</tr>
<tr>
<td>- bone</td>
</tr>
<tr>
<td>- - femur (any part) C40.2</td>
</tr>
</tbody>
</table>

| Tabular List entry for osteosarcoma: |
| **C40** Malignant neoplasm of bone and articular cartilage of limbs |
| **C40.2** Long bones of lower limb |

| Tabular List entry for Morphology: |
| **M9180/3 Osteosarcoma NOS (C40.-, C41.-)** |

**Rationale:** Referencing the Alphabetic Index first by the morphological name of the neoplasm leads to primary malignancy of bone. This is confirmed by the morphology codes for osseous and chondromatous neoplasms M918-M924.
Neoplasms coded outside Chapter II

Human immunodeficiency virus [HIV] disease resulting in a malignant neoplasm is recorded at category **B21 Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms** (Chapter I Certain infectious and parasitic diseases).

Both the HIV and neoplasm must be coded, with the HIV disease being sequenced first.

**Example:**

<table>
<thead>
<tr>
<th>HIV disease resulting in Kaposi sarcoma</th>
</tr>
</thead>
</table>

- **Index trail for HIV disease:**
  - **Human**
    - - immunodeficiency virus (HIV) disease (infection) B24
    - - - resulting in
    - - - - Kaposi sarcoma B21.0

- **Tabular List entry for HIV disease:**
  - **B21.0** HIV disease resulting in Kaposi sarcoma

- **Index trail for Kaposi sarcoma:**
  - **Sarcoma - see also Neoplasm, connective tissue, malignant**
    - - Kaposi (M9140/3)
    - - - unspecified site C46.9

- **Tabular List entry for Kaposi sarcoma:**
  - **C46.9** Kaposi sarcoma, unspecified

- **Tabular List entry for Morphology Kaposi sarcoma:**
  - **M9140/3** Kaposi sarcoma (C46.-)
**Functional activity**

All neoplasms are classified to Chapter II Neoplasms, regardless of whether they are functionally active or not. Appropriate codes in Chapter IV are used in addition to neoplasm codes to indicate any functional activity, e.g. E05.8, E07.0, E16-E31, E34.

**Example:**

<table>
<thead>
<tr>
<th>Adenocarcinoma of thyroid gland causing thyrotoxicosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for adenocarcinoma:</td>
</tr>
<tr>
<td>Adenocarcinoma (M8140/3) - see also Neoplasm, malignant</td>
</tr>
<tr>
<td>Malignant</td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>Neoplasm, neoplastic</td>
</tr>
<tr>
<td>- thyroid (gland)</td>
</tr>
<tr>
<td>C73</td>
</tr>
<tr>
<td>Tabular List entry for adenocarcinoma:</td>
</tr>
<tr>
<td>C73.X Malignant neoplasm of thyroid gland</td>
</tr>
<tr>
<td>Tabular List entry for Morphology of adenocarcinoma:</td>
</tr>
<tr>
<td>M8140/3 Adenocarcinoma NOS</td>
</tr>
<tr>
<td>Index trail for functional activity:</td>
</tr>
<tr>
<td>Thyrotoxicosis (recurrent) E05.9</td>
</tr>
<tr>
<td>- due to</td>
</tr>
<tr>
<td>- - specified cause NEC E05.8</td>
</tr>
<tr>
<td>Tabular List entry for thyrotoxicosis:</td>
</tr>
<tr>
<td>E05.8 Other thyrotoxicosis</td>
</tr>
</tbody>
</table>
Malignant neoplasms
(C00–C97)

Primary malignancies
A malignancy is coded as primary, unless it is specified as secondary (or metastatic) or unless there is evidence to the contrary, for all sites except lymph nodes.

Malignancy of the lymph nodes, which is not specified as primary or secondary, is assumed to be secondary.

Examples:

Adenocarcinoma left lung

Index trail for adenocarcinoma:

Adenocarcinoma (M8140/3) – see also Neoplasm, malignant
Malignant
Primary

Neoplasm, neoplastic
- lung C34.9

Tabular List entry for anatomical site:

C34 Malignant neoplasm of bronchus and lung
C34.9 Bronchus or lung, unspecified

Tabular List entry for Morphology:

M8140/3 Adenocarcinoma NOS
Examples (cont):

**Carcinoma of pectoral lymph nodes**

```
Index trail for carcinoma:

Carcinoma (M8010/3) – see also Neoplasm, malignant
- secondary (M8010/6) – see Neoplasm, secondary
  Malignant
  Secondary

Neoplasm, neoplastic
- lymph, lymphatic
- - gland (secondary)
  - - pectoral C77.3

Tabular List entry:

C77    Secondary and unspecified neoplasm of lymph nodes
C77.3  Axillary and upper limb lymph node

Tabular List entry for Morphology of secondary neoplasm:

M8010/6 Carcinoma, metastatic NOS

Index trail for primary malignant neoplasm of unspecified site:

Malignant
Primary

Neoplasm, neoplastic C80.9

Tabular List entry:

C80.9    Malignant neoplasm, primary site unspecified

Index trail for primary Morphology:

Carcinoma (M8010/3) – see also Neoplasm, malignant

Tabular List entry:

M8010/3 Carcinoma NOS
```

**Rationale:** Wherever there is a secondary malignancy, a primary malignancy must be coded. Code C80.9 has been selected in the above example as the primary site of malignancy has not been identified, ie it is unspecified. Sequencing will depend on the main condition treated during the consultant episode.

Code C80.0 Malignant neoplasm, primary site unknown, so stated is not appropriate in the above example as this code must only be assigned when the responsible consultant has explicitly stated within the medical record that the primary site is unknown.
Example:

**Lymphosarcoma**

Index trail for *lymphosarcoma*:

**Lymphosarcoma (diffuse)** C85.9

Tabular List entry for *lymphosarcoma*:

C85.9  Non-Hodgkin lymphoma, unspecified

**Rationale:** Lymphosarcoma comes under the heading of ‘other’ and unspecified non-Hodgkin lymphoma, which is a primary malignancy of the lymphatic system.

**Neoplasms overlapping site boundaries**

Neoplasms 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 one is the site of origin, the fourth character of .8 (overlapping site boundary) is assigned - unless the combination is specifically indexed elsewhere.

If the point of origin is known, or the sites are not contiguous, the fourth character .8 is not assigned.

Example:

**Malignant neoplasm involving the tip and ventral surface of the tongue where the point of origin cannot be identified**

Index trail for *neoplasm of tip and ventral surface of the tongue*:

Malignant
Primary

Neoplasm, neoplastic
- tongue C02.9
- - surface (dorsal) C02.0
- - - ventral C02.2
- - - - tip C02.1

Tabular List entry for:

C02  Malignant neoplasm of other and unspecified parts of tongue
C02.8  Overlapping lesion of tongue

**Rationale:** The point of origin of these contiguous sites cannot be identified, and as they are both classified to the three character category C02, the subdivision C02.8 must be used.

Had the diagnosis been malignant neoplasm of tip of tongue extending to involve the ventral surface of tongue this would have been coded to C02.1 as the point of origin, ie the tip, is known.
However, if the Alphabetical Index directs the coder to a specific code for the combination then this code must be assigned.

**Example:**

Malignant neoplasm of the cardioesophageal junction

<table>
<thead>
<tr>
<th>Index trail for:</th>
<th>Malignant neoplasm of stomach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasm, neoplastic</td>
<td>Primary</td>
</tr>
<tr>
<td>- cardioesophageal junction</td>
<td>C16.0</td>
</tr>
</tbody>
</table>

Tabular List entry for:

| C16   | Malignant neoplasm of stomach |
| C16.0 | Cardia |
|       | Cardio-oesophageal junction |

**Rationale:** A malignant neoplasm of the stomach and oesophagus is coded to **C16.0 Cardia** as this is where the Alphabetical Index directs the coder.

In the rare event of lesions overlapping between different sites within different systems, where the point of origin of the neoplasm cannot be identified, one of the following subcategories can be assigned, eg malignant neoplasm of stomach and small intestine is coded to **C26.8**.

**List of designated overlapping lesions**

- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity and pharynx
- C21.8 Overlapping lesion of rectum, anus and anal canal
- C24.8 Overlapping lesion of biliary tract
- C26.8 Overlapping lesion of digestive system
- C39.8 Overlapping lesion of respiratory and intrathoracic organs
- C41.8 Overlapping lesion of bone and articular cartilage
- C49.8 Overlapping lesion of connective and soft tissue
- C57.8 Overlapping lesion of female genital organs
- C63.8 Overlapping lesion of male genital organs
- C68.8 Overlapping lesion of urinary organs
- C72.8 Overlapping lesion of central nervous system

Where one of these codes is not appropriate, code **C76.8 Overlapping lesion of other and ill-defined sites** is used, eg malignant neoplasm involving the pharynx and cervical oesophagus where the point of origin of the neoplasm cannot be identified) is classified to code **C76.8**.
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)

The morphology codes for lymphoid, haematopoietic and related tissues neoplasms (categories C81-C96 and D45-D47) are not contained within the ICD-10 4th Edition Alphabetical Index. However, the corresponding morphology codes are located in the Tabular List (see Morphology of neoplasms tables, pages 1027 to 1050 Morphology codes M959-M998), if required for local use.

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 consultant episode; and then coded to a totally different type of lymphoma/leukaemia on a subsequent consultant episode.

Multiple primaries (C97)
When the diagnostic statement records two or more independent primary malignant neoplasms none of which clearly predominates, code C97.X is 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
**Example:**

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.

- **Index trail:**
  - Malignant
  - Primary
  - Neoplasm, neoplastic
    - multiple, malignant NEC C80.9
    - independent primary sites C97

Tabular List entry for **multiple malignant primaries**:
- C97.X Malignant neoplasms of independent (primary) multiple sites

- **Index trail for sigmoid colon:**
  - Malignant
  - Primary
  - Neoplasm, neoplastic
    - intestine, intestinal
    - large
    - - colon
    - - - sigmoid (flexure) C18.7

Tabular List entry for **sigmoid colon primary**:
- C18 Malignant neoplasm of colon
- C18.7 Sigmoid colon

- **Index trail for Morphology:**
  - Malignancy (M8000/3) – see Neoplasm, malignant

Tabular List entry for **Morphology**:
- M8000/3 Neoplasm, malignant

- **Index trail for lower lobe of lung:**
  - Malignant
  - Primary
  - Neoplasm, neoplastic
    - lung
    - - lower lobe C34.3

Tabular List entry for **lower lobe of lung primary**:
- C34 Malignant neoplasm of bronchus and lung
- C34.3 Lower lobe, bronchus or lung

- **Index trail for Morphology:**
  - Malignancy (M8000/3) – see Neoplasm, malignant

Tabular List entry for **Morphology**:
- M8000/3 Neoplasm, malignant
In instances where multiple primary neoplasms exist and the responsible consultant is able to identify which of the primaries predominates during that particular consultant episode, code C97.X is not required as demonstrated in the example below.

**Example:**

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

- **Index trail for prostate adenocarcinoma:**
  - **Adenocarcinoma** (M8140/3) - see also Neoplasm, malignant
    - Malignant
    - Primary
  - Neoplasm, neoplastic
    - prostate (gland)  C61

- **Tabular List entry for prostate primary:**
  - C61.X  Malignant neoplasm of prostate

- **Tabular List entry for Morphology:**
  - M8140/3  Adenocarcinoma NOS

- **Index trail for squamous cell carcinoma:**
  - **Carcinoma** (M8010/3) - see also Neoplasm, malignant
    - squamous (cell)  M8070/3

- **Index trail for skin of back:**
  - **Malignant**
  - Primary
  - Neoplasm, neoplastic
    - skin (nonmelanotic)  C44.9
    - - back  C44.5

- **Tabular List entry for skin of back:**
  - C44  Other malignant neoplasms of skin
  - C44.5  Skin, of trunk

- **Tabular List entry for Morphology:**
  - M8070/3  Squamous cell carcinoma NOS

**Rationale:** The prostate adenocarcinoma is the predominant malignant primary in the above example as it is the neoplasm being treated on this consultant episode.
Recurring primaries

‘Recurrent malignancy’ is generally considered to be a new primary lesion in the same site as the previously excised or eradicated malignant neoplasm.

The rules of the classification state that when the primary tumour has been eradicated/excised, it is coded to ‘history of’, but only when there is no recurrence.

Example:

<table>
<thead>
<tr>
<th>Recurrent malignant neoplasm of posterior wall of bladder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for recurrent malignancy:</td>
</tr>
<tr>
<td>Recurrent - see condition</td>
</tr>
<tr>
<td>Neoplasm, neoplastic</td>
</tr>
<tr>
<td>- bladder (urinary)</td>
</tr>
<tr>
<td>- - wall</td>
</tr>
<tr>
<td>- - - posterior</td>
</tr>
<tr>
<td>Malignant</td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>C67.9</td>
</tr>
<tr>
<td>C67.4</td>
</tr>
</tbody>
</table>

Tabular List entry for anatomical site malignancy:

<table>
<thead>
<tr>
<th>C67</th>
<th>Malignant neoplasm of bladder</th>
</tr>
</thead>
<tbody>
<tr>
<td>C67.4</td>
<td>Posterior wall of bladder</td>
</tr>
</tbody>
</table>

Index trail for Morphology:

Malignancy (M8000/3) – see Neoplasm, malignant

Tabular List entry for Morphology:

M8000/3 Neoplasm, malignant
Secondary malignancy (C77-C79)
In the Alphabetical Index these are found in the Neoplasm Table under 'malignant secondary'.

Rules for coding secondary malignant neoplasms:

1. Terms such as ‘metastasis’ or ‘spread’ refer to a secondary malignant neoplasm.

**Example:**

**Squamous-cell carcinoma of lung (middle lobe) with metastasis to pleura**

- **Index trail for primary neoplasm:**
  - **Carcinoma** (M8010/3) - see also Neoplasm, malignant
    - squamous (cell) (M8070/3)

- **Neoplasm, neoplastic**
  - lung C34.9
  - - middle lobe C34.2

- **Tabular List entry for primary anatomical site:**
  - C34  Malignant neoplasm of bronchus and lung
  - C34.2 Middle lobe, bronchus or lung

- **Tabular List entry for Morphology of primary malignancy:**
  - M8070/3 Squamous cell carcinoma NOS

- **Index trail for secondary neoplasm anatomical site:**
  - **Neoplasm, neoplastic**
    - pleura C78.2

- **Tabular List entry for secondary anatomical site:**
  - C78.2 Secondary malignant neoplasm of pleura

- **Index trail for Morphology of squamous cell carcinoma:**
  - **Carcinoma** (M8010/3) - see also Neoplasm, malignant
    - squamous (cell) (M8070/3)
    - - metastatic (M8070/6) - see Neoplasm, secondary

- **Tabular List entry for Morphology of secondary neoplasm:**
  - M8070/6 Squamous cell carcinoma, metastatic NOS
2. When the site and/or tissue type (histological type) of the secondary malignant neoplasm are unknown, it must be coded as **C79.9 Secondary malignant neoplasm, unspecified site**.

3. When the diagnosis is given as any of ‘disseminated cancer/malignancy’, or ‘generalised cancer/malignancy’, or ‘carcinomatosis’, or ‘sarcomatosis’, or ‘multiple secondary cancer’ without further site specification, the code **C79.9** must be used.

4. **Predominantly secondary sites**
   - bone
   - brain and spinal cord (including meninges)
   - lymph nodes
   - pleura
   - peritoneum and retroperitoneum
   - heart
   - mediastinum and diaphragm
   - liver.

The above are **predominantly** secondary sites, but they can also be coded to a primary malignancy when described as such by the responsible consultant, or when indicated by the morphological type. For example a hepatoma is identified in the Alphabetical index as a ‘malignant neoplasm’ and therefore, must be coded to **C22.0 Liver cell carcinoma** to identify a primary malignant neoplasm of the liver.

**Guidelines to coding ‘metastatic cancer’**

The following guidelines on the coding of ‘metastatic cancer’ are adapted from the section on ‘Medical Certification and Rules for Classification’. (*International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Volume 2*).

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.

No rule can satisfactorily solve this problem since language usage varies.

The following rules must be used when there is doubt as to the meaning intended.
1. Cancer described as ‘metastatic from’ a site must be interpreted as a primary neoplasm of the stated site. A code must also be assigned for the secondary neoplasm of the specified site (if the secondary site is identified) or for secondary neoplasm of unspecified site (if the secondary site is not identified). This is because the named site that the neoplasm is going from is the starting point, so this is the original primary site.

**Example:**

**Metastatic carcinoma from breast**

- Index trail for *carcinoma of breast*:
  - Carcinoma (M8010/3) – see also Neoplasm, malignant
    - Malignant
    - Primary
  - Neoplasm, neoplastic
    - breast (connective tissue) C50.9

- Tabular List entry for *breast primary*:
  - C50 Malignant neoplasm of breast
  - C50.9 Breast, unspecified

- Tabular List entry for *primary Morphology*:
  - M8010/3 Carcinoma NOS

- Index trail for *secondary malignant neoplasm of unspecified site*:
  - Malignant
  - Secondary
  - Neoplasm, neoplastic
    - metastatic (multiple) C79.9

- Tabular List entry for *unspecified site secondary*:
  - C79.9 Secondary malignant neoplasm, unspecified site

- Index trail for *secondary Morphology*:
  - Carcinoma
    - metastatic (M8010/6) – see Neoplasm, secondary
  - Tabular List entry for *secondary Morphology*:
    - M8010/6 Carcinoma, metastatic NOS

2. Cancer described as ‘metastatic to’ a site must be interpreted as a secondary neoplasm of the stated site. In these cases the appropriate code is also assigned for the specified primary site (if the primary site is known and still present), or for primary malignant neoplasm of unspecified site (if the primary site is not identified). The named site the neoplasm is going to is the site that it is spreading to from the original primary, so this is the secondary site.
Example:

Metastatic carcinoma to lung

Index trail for carcinoma:
Carcinoma (M8010/3) – see also Neoplasm, malignant

Index trail for primary malignant neoplasm of unspecified site:
Neoplasm, neoplastic C80.9

Tabular List entry for primary of unspecified site:
C80.9 Malignant neoplasm, primary site unspecified

Tabular List entry for primary carcinoma Morphology:
M8010/3 Carcinoma NOS

Index trail for secondary malignant neoplasm of lung:
Neoplasm, neoplastic - lung C78.0

Tabular List entry for lung secondary:
C78.0 Secondary malignant neoplasm of lung

Index trail for secondary Morphology:
Carcinoma (M8010/3) – see also Neoplasm, malignant secondary (M8010/6)

Tabular List entry for secondary carcinoma Morphology:
M8010/6 Carcinoma metastatic NOS

Rationale: Wherever there is a secondary malignancy, a primary malignancy must be coded. Code C80.9 has been selected in the above example as the primary site of malignancy is unspecified. Sequencing will depend on the main condition treated during the consultant episode.

Code C80.0 Malignant neoplasm, primary site unknown, so stated is not appropriate in the above example as this code must only be assigned when the responsible consultant has specifically stated within the medical record that the primary site is unknown.
3. Metastases stated of one site only

   a) If the diagnostic statement mentions only one site that is qualified as ‘metastatic’ and gives a morphological type that is indexed to that body site/system, this must be coded as a primary neoplasm of that specific site with metastases of an unspecified site.

Example:

**Metastatic osteosarcoma of femur**

- Index trail for osteosarcoma:  
  **Osteosarcoma** (M9180/3) – *see also* Neoplasm, bone, malignant

- Index trail for primary malignant neoplasm of bone of femur:  
  Neoplasm, neoplastic  
  - bone (periosteum)  
  - - femur (any part)  
  C41.9  
  C40.2

- Tabular List entry for primary of bone of femur:  
  C40  Malignant neoplasm of bone and articular cartilage of limbs  
  C40.2  Long bones of lower limb

- Tabular List entry for primary osteosarcoma Morphology:  
  M9180/3 Osteosarcoma NOS

- Index trail for secondary malignant neoplasm of unknown site:  
  Neoplasm, neoplastic  
  Malignant  
  Secondary  
  C79.9

- Tabular List entry for secondary of unknown site:  
  C79.9  Secondary malignant neoplasm, unspecified site

- Tabular List entry for metastatic osteosarcoma Morphology:  
  M9180/3 Osteosarcoma NOS  
  Change the behaviour digit to /6

**Rationale:** In the example above, osteosarcoma denotes a primary malignancy of a bone. As the femur is a bone, this must be considered the primary site and code C79.9 would be recorded, in addition to identify the unspecified secondary site. As there is no essential modifier of ‘metastatic’ under the lead term ‘osteosarcoma’ in the Alphabitical Index, the behaviour digit in the morphology code must be changed to /6 following code C79.9 to reflect the metastatic osteosarcoma.
b) When a diagnostic statement mentions only one site and this is qualified as 'metastatic' plus this gives a morphological type which is indexed to a different body site/system to that of the site mentioned in the statement, it must be coded as a primary neoplasm of an unspecified site for the morphological type with metastases (secondary) of the site mentioned in the diagnostic statement.

**Example:**

**Metastatic osteosarcoma of brain**

- Index trail for **osteosarcoma**:  
  Osteosarcoma (M9180/3) – see also Neoplasm, bone, malignant

- Index trail for **primary malignant neoplasm of bone**:
  Malignant  
  Neoplasm, neoplastic  
  Primary  
  - bone (periosteum)  
  C41.9

Tabular List entry for primary of **bone**:

C41 Malignant neoplasm of bone and articular cartilage, of other and unspecified sites  
C41.9 Bone and articular cartilage, unspecified

Tabular List entry for **primary osteosarcoma Morphology**:

M9180/3 Osteosarcoma NOS

- Index trail for **secondary malignant neoplasm of brain**:
  Malignant  
  Secondary  
  Neoplasm, neoplastic  
  - brain NEC  
  C79.3

Tabular List entry for **secondary of brain**:

C79.3 Secondary malignant neoplasm of brain and cerebral meninges

Tabular List entry for **metastatic osteosarcoma Morphology**:

M9180/3 Osteosarcoma NOS  
Change the behaviour digit to /6

**Rationale:** If the morphological type pertains to a different body system to that of the site mentioned in the statement, the site must be coded as a secondary. In the above example, osteosarcoma denotes a primary malignancy of the bone. As the brain is from a different body system (the central nervous system) the brain must be coded as a secondary site.
As there is no essential modifier of ‘metastatic’ under the lead term osteosarcoma in the Alphabetical Index, the behaviour character in the morphology code must be changed to /6 following code C79.3 to reflect the metastatic osteosarcoma.

c) If the cross reference in the Alphabetical Index directs the coder to ‘see also Neoplasm, malignant’ when referencing the morphological type the stated site must be coded as a primary malignant neoplasm and in addition code C79.9 must be assigned to indicate a secondary malignant neoplasm of unspecified site.

Example:

Metastatic adenocarcinoma of lung

Index trail for adenocarcinoma:
Adenocarcinoma (M8140/3) – see also Neoplasm, malignant

Index trail for primary malignant neoplasm of lung:

Neoplasm, neoplastic
- lung        C34.9

Tabular List entry for primary of lung:
C34    Malignant neoplasm of bronchus and lung
C34.9  Bronchus or lung, unspecified

Tabular List entry for primary adenocarcinoma Morphology:
M8140/3  Adenocarcinoma NOS

Index trail for secondary malignant neoplasm of unknown site:

Neoplasm, neoplastic
- C79.9

Tabular List entry for secondary of unknown site:
C79.9    Secondary malignant neoplasm, unspecified site

Tabular List entry for primary adenocarcinoma Morphology:
M8140/3  Adenocarcinoma NOS
Change the behaviour digit to /6

Rationale: The ‘see also’ note alongside ‘adenocarcinoma’ is not specific to any particular site; therefore the site mentioned in the statement must be coded as the primary neoplasm with metastases of an unspecified site. In the above example the lung becomes the primary site and code C79.9 is recorded to classify the secondary neoplasm of unspecified site.

As there is no essential modifier of ‘metastatic’ under the lead term ‘adenocarcinoma’ in the Alphabetical Index, the behaviour character for the
morphology code must be changed to /6 following code C79.9 to reflect the metastatic adenocarcinoma.

d) If the statement mentions only one site and does not mention a morphological type, eg metastatic lung, breast or colon cancer and the neoplasm is not on the list of predominantly secondary sites, the site mentioned must be coded as a primary neoplasm with metastases to an unspecified site.

Example:

<table>
<thead>
<tr>
<th>Metastatic lung cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Index trail for primary Morphology:" /></td>
</tr>
<tr>
<td>Primary (M8000/3) – Neoplasm, malignant</td>
</tr>
<tr>
<td><img src="image" alt="Index trail for primary malignant neoplasm of lung:" /></td>
</tr>
<tr>
<td>Malignant Neoplasm, neoplastic - lung C34.9</td>
</tr>
<tr>
<td><img src="image" alt="Tabular List entry for primary of lung:" /></td>
</tr>
<tr>
<td>C34 Malignant neoplasm of bronchus or lung</td>
</tr>
<tr>
<td>C34.9 Bronchus or lung, unspecified</td>
</tr>
<tr>
<td><img src="image" alt="Tabular List entry for primary Morphology:" /></td>
</tr>
<tr>
<td>M8000/3 Neoplasm, malignant</td>
</tr>
<tr>
<td><img src="image" alt="Index trail for secondary malignant neoplasm of unknown site:" /></td>
</tr>
<tr>
<td>Malignant Neoplasm, neoplastic C79.9</td>
</tr>
<tr>
<td><img src="image" alt="Tabular List entry for secondary of unknown site:" /></td>
</tr>
<tr>
<td>C79.9 Secondary malignant neoplasm, unspecified site</td>
</tr>
<tr>
<td><img src="image" alt="Index trail for secondary Morphology:" /></td>
</tr>
<tr>
<td>Secondary(M8000/6)</td>
</tr>
<tr>
<td><img src="image" alt="Tabular List entry for secondary Morphology:" /></td>
</tr>
<tr>
<td>M8000/6 Neoplasm, metastatic</td>
</tr>
</tbody>
</table>

If, however, the site mentioned is on the list of predominantly secondary sites, code C80.9 must be assigned to denote an unspecified primary neoplasm and the site mentioned must be coded as the secondary neoplasm.
Example:

Metastatic bone cancer

- Index trail for primary Morphology:
  Primary (M8000/3) – Neoplasm, malignant

- Index trail for primary malignant neoplasm of unspecified site:
  Neoplasm, neoplastic
  Malignant
  Primary

  C80.9

  Tabular List entry for primary of unspecified site:
  C80.9  Malignant neoplasm, primary site unspecified

  Tabular List entry for primary Morphology:
  M8000/3 Neoplasm, malignant

- Index trail for secondary malignant neoplasm of bone:
  Neoplasm, neoplastic
  Malignant
  Secondary

  - bone (periosteum)  C79.5

  Tabular List entry for secondary of unknown bone site:
  C79.5 Secondary malignant neoplasm of bone and bone marrow:

- Index trail for secondary Morphology:
  Secondary (M8000/6)

  Tabular List entry for secondary Morphology:
  M8000/6 Neoplasm, metastatic

Rationale: In the above example of ‘metastatic bone cancer’, bone is on the list of predominantly secondary sites, therefore the bone is coded as a secondary site with an unspecified primary site.

4. Metastases of two or more stated sites

a) 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 (eg metastatic lesions of colon and breast), clarification must be sought from the responsible consultant as to which site(s) are metastatic. In the absence of clarification, code both mentioned sites as primary malignant neoplasms with code C79.9 to denote secondary neoplasm of unspecified site.
b) If the statement mentions metastatic lesions of two or more sites, and both stated sites are on the list of predominantly secondary sites (e.g., metastatic lesions of pleura and brain), both mentioned sites must be coded as secondary neoplasms, and the primary must be coded as an unspecified site (C80.9).

**Example:**

**Metastatic carcinoma of pleura and vertebra**

- **Index trail for carcinoma:**
  
  Carcinoma (M8010/3) – see also Neoplasm, malignant

- **Index trail for primary malignant neoplasm of unspecified site:**
  
  Malignant
  
  Primary
  
  Neoplasm, neoplastic
  
  C80.9

  Tabular List entry for primary of unspecified site:
  
  C80.9 Malignant neoplasm, primary site unspecified

  Tabular List entry for primary adenocarcinoma Morphology:
  
  M8010/3 Carcinoma NOS

- **Index trail for secondary malignant neoplasm of pleura:**
  
  Malignant
  
  Secondary
  
  Neoplasm, neoplastic
  
  - pleura, pleural (cavity) C78.2

  Tabular List entry for secondary of pleura:
  
  C78.2 Secondary malignant neoplasm of pleura:

- **Index trail for secondary carcinoma Morphology:**
  
  Carcinoma (M8010/3) – see also Neoplasm, malignant
  
  - metastatic (M8010/6) – see Neoplasm, secondary or
  
  - secondary (M8010/6) – see Neoplasm, secondary

  Tabular List entry for secondary carcinoma Morphology:
  
  M8010/6 Carcinoma, metastatic NOS

- **Index trail for secondary malignant neoplasm of vertebra:**
  
  Malignant
  
  Secondary
  
  Neoplasm, neoplastic
  
  - vertebral (column) C79.5

  Tabular List entry for secondary of vertebra:
  
  C79.5 Secondary malignant neoplasm of bone and bone marrow
Example (cont):

Index trail for **secondary carcinoma Morphology:**
- **Carcinoma** (M8010/3) – see also Neoplasm, malignant
- metastatic (M8010/6) – see Neoplasm, secondary
  or
- secondary (M8010/6) – see Neoplasm, secondary

Tabular List entry for **secondary carcinoma Morphology:**
**M8010/6** Carcinoma, metastatic NOS

**Rationale:** In the above example, the term ‘carcinoma’ is not site-specific. As the two sites mentioned are both found on the list of predominantly secondary sites, this is coded as an unspecified primary with metastases to both the mentioned sites.

c) If the diagnostic statement mentions metastatic lesions of two or more sites (eg metastatic lesions of lung and liver), and the morphological type stated is indexed to a *different* body site/system to that of the mentioned sites, both mentioned sites must be coded as secondary neoplasms. The morphological type must be coded as the primary malignant neoplasm.
Example:

**Metastatic melanoma of lung and brain**

Index trail for **melanoma of unspecified site**:

*Melanoma (malignant) (M8720/3) C43.9*

Tabular List entry for primary of **melanoma**:

*C43.9  Malignant melanoma of skin, unspecified*

Tabular List entry for primary **Morphology**:

*M8720/3 Malignant melanoma NOS*

Index trail for **secondary malignant neoplasm of lung**:

*Secondary malignant neoplasm of lung C78.0*

Tabular List entry for secondary of **lung**:

*C78.0  Secondary malignant neoplasm of lung*

Tabular List entry for metastatic melanoma **Morphology**:

*M8720/3  Malignant melanoma NOS*

Change the behaviour digit to /6

Index trail for **secondary malignant neoplasm of brain**:

*Secondary malignant neoplasm of brain NEC C79.3*

Tabular List entry for secondary of **brain**:

*C79.3  Secondary malignant neoplasm of brain and cerebral meninges:

Tabular List entry for metastatic melanoma **Morphology**:

*M8720/3  Malignant melanoma NOS*

Change the behaviour digit to /6

**Rationale:** In the above example, the morphological type (melanoma) refers to a malignant neoplasm of the skin. Therefore the sites of lung and brain must both be coded as secondary sites.
5. **Metastases with no stated site**

If no site is stated in the diagnostic statement, but the morphological type is stated to be ‘metastatic’, this must be coded as a primary neoplasm of unspecified site for the morphological type involved. A code for secondary neoplasm of unspecified site (C79.9) must also be assigned.

**Example:**

**Metastatic chromophobe adenocarcinoma**

Index trail for chromophobe adenocarcinoma of unspecified site:

- Adenocarcinoma (M8140/3) – see also Neoplasm, malignant
  - chromophobe (M8270/3)
  - - unspecified site C75.1

Tabular List entry for primary of malignant neoplasm:

- C75 Malignant neoplasm of other endocrine glands and related structures
  - C75.1 Pituitary gland

Tabular List entry for primary chromophobe Morphology:

- M8270/3 Chromophobe carcinoma (C75.1)

Index trail for secondary malignant neoplasm of unknown site:

- Neoplasm, neoplastic
  - Malignant
  - Secondary
  - C79.9

Tabular List entry for secondary of unknown site:

- C79.9 Secondary malignant neoplasm, unspecified site

**Rationale:** In the example of ‘metastatic chromophobe adenocarcinoma’, the 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.

As there is no further essential modifier of ‘metastatic’ under ‘chromophobe adenocarcinoma’ in the Alphabetical Index, the behaviour digit for the morphology code must therefore be changed to /6 following code C79.9 to reflect the metastatic chromophobe adenocarcinoma.
**Sequencing rules**

When the primary site and secondary site are both present, the code for the primary site precedes the code for the secondary site, *unless* the stated reason for admission was solely for the management of the secondary malignancy.

**Example:**

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

The correct sequence would be:

**C34.1 Malignant neoplasm of upper lobe, bronchus or lung**  
(The primary neoplasm plus morphology code M8000/3)

**C77.1 Secondary malignant neoplasm of Intrathoracic lymph nodes**  
(The secondary neoplasm plus morphology code M8000/6)

In instances where the secondary neoplasm is the main condition treated during the consultant episode, this must be assigned in the primary diagnostic position to comply with the primary diagnosis definition. The primary neoplasm, if still current/present, must be coded in a secondary position.
**Example:**

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

**Index trail for fracture:**

Fracture (abduction) (adduction)
- pathological (cause unknown) M84.4
- - due to neoplastic disease NEC (M8000/1) (see also Neoplasm) D48.9† M90.7*

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M90.7*</td>
<td>Fracture of bone in neoplastic disease (C00-D48†)</td>
</tr>
<tr>
<td></td>
<td>[fifth character 2 before M00 to identify humerus]</td>
</tr>
</tbody>
</table>

**Index trail for adenocarcinoma:**

Adenocarcinoma (M8140/3) – see also Neoplasm, malignant
Malignant
Secondary

Neoplasm
- bone (periosteum) ✷
- - humerus (any part) C79.5

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C79.5†</td>
<td>Secondary malignant neoplasm of bone and bone marrow</td>
</tr>
</tbody>
</table>

Tabular List entry for secondary Morphology:

M8140/6 Adenocarcinoma, metastatic NOS

**Index trail for adenocarcinoma of breast:**

Adenocarcinoma (M8140/3) – see also Neoplasm, malignant
Malignant
Primary

Neoplasm, neoplastic
- breast (connective tissue) C50.9

Tabular List entry for breast primary:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C50</td>
<td>Malignant neoplasm of breast</td>
</tr>
<tr>
<td>C50.9</td>
<td>Breast, unspecified</td>
</tr>
</tbody>
</table>

Tabular List entry for primary Morphology:

M8140/3 Adenocarcinoma NOS

**Rationale:** The dagger and asterisk sequence may be reversed when the manifestation of a disease is the primary focus of care. This is in line with the primary diagnosis definition.
In situ neoplasms
(D00–D09)

Histological background
A designation of carcinoma in situ denotes that tumour cells seen microscopically are showing malignant changes, but the tumour cells are still confined to their point of origin and have not invaded any of the surrounding tissue.

If there is any doubt as to whether a carcinoma in situ is present, then the responsible consultant must be consulted for confirmation.

If carcinoma in situ is reported with evidence of microinvasion by the responsible consultant, the neoplasm must be regarded as a malignant neoplasm.

Example:

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

Index trail for carcinoma of cervix:
Carcinoma (M8010/3) – see also Neoplasm, malignant
Malignant
Primary

Neoplasm, neoplastic
- cervix (uteri) C53.9

Tabular List entry for primary of cervix:
C53 Malignant neoplasm cervix uteri
C53.9 Cervix uteri, unspecified

Tabular List entry for carcinoma Morphology:
M8010/3 Carcinoma NOS
Benign neoplasms
(D10–D36)

A benign tumour is a localised group of cells that do not spread but, because of enlargement of the neoplasm, may be the cause of localised symptoms on adjacent tissues or structures.

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.

Example:

Polyp of an accessory sinus is classified to J33.8 Other polyp of sinus. But should the polyp be shown to be adenomatous it would be classified to D14.0 Benign neoplasm of nasal cavity.

A polyp of the urinary bladder is classified as a neoplasm of uncertain and unknown behaviour.

A cyst without any further specification would not be classified as a neoplasm.

Mongolian blue spots
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 Congenital non-neoplastic naevus and must be coded to codes in category D22.-.

Therefore the correct ICD-10 code to assign for a Mongolian blue spot must be taken from category D22.- Melanocytic naevi.
Neoplasms of uncertain or unknown behaviour
(D37–D48)

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. This type of neoplasm may also be referred to as tumours.

This type of neoplasm is usually of a specific histological/morphological type, and reference should be made to the histological type before assigning a code (with the exception of D48.9 Neoplasm of uncertain or unknown behaviour, unspecified).

Codes from this block must not be used when there is a diagnosis of suspected or ‘? cancer’. In the absence of a definitive diagnosis, only the symptoms must be recorded.

Special coding and sequencing guidelines

Signs and symptoms
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 as appropriate.

Signs and symptoms associated with the malignancy are not to be coded. Codes from Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings NEC must not be used in place of established conditions, but may be used in addition if they represent important medical problems treated or investigated in their own right, ie the patient is admitted for treatment of the symptom.

For example, when a patient is admitted for the control of chronic intractable pain due to a neoplasm, the principal diagnosis code must be the neoplasm with adherence to the sequencing for the primary and secondary sites. If pain control is the reason for admission, then R52.1 Chronic intractable pain must be assigned as an additional code. Although this term is not normally used in the medical record the ICD-10 code R52.1 fully describes the type of generalised chronic pain suffered by patients with cancer. Any treatment administered for the pain will be identified in the procedure codes.
Example:

Patient with vertebral metastatic deposits is admitted for control of
generalised chronic pain. Mastectomy for breast malignancy two
years ago

Index trail for vertebral metastases:
  Metastasis, metastatic
    - deposits (in) (M8000/6) – see Neoplasm, secondary, by site
      Malignant
      Secondary
  Neoplasm, neoplastic
    - vertebral (column) ◊ C79.5

Tabular List entry for vertebral metastatic deposits:
C79.5 Secondary malignant neoplasm of bone and bone marrow

Tabular List entry for Morphology:
M8000/6 Neoplasm, metastatic

Index trail for pain:
  Pain(s) R52.9
    - chronic NEC
    - - intractable R52.1

Tabular List entry for pain:
R52.1 Chronic intractable pain

Index trail for history of breast malignancy:
  History (personal) (of)
    - malignant neoplasm (of) Z85.9
    - - breast Z85.3

Tabular List entry for history of breast malignancy:
Z85.3 Personal history of malignant neoplasm of breast

Anaemia due to neoplasm

Anaemia due to neoplasm is coded to D63.0* with the correct code for the
neoplasm as the main condition (dagger) code (C00–D48†). However, the
dagger and asterisk sequence may be reversed when the manifestation of a
disease is the primary focus of care. This is in line with the primary diagnosis
definition. In instances where the responsible consultant has indicated a link
between the anaemia and the malignant neoplasm, but has not specified or
is unable to confirm which condition is the main condition being treated, the
coder must use the dagger/asterisk default. This would assign the dagger
code in primary position, followed by the associated asterisk code.
The responsible consultant must specify that the anaemia is due to the neoplasm to enable the use of code D63.0*. This is because anaemia can also be due to other causes, such as the treatment given for the neoplasm.

**Example:**

Patient with anaemia due to duodenal cancer is admitted solely for the purpose of a blood transfusion

- **Index trail for anaemia:**
  - Anemia D64.9
    - in neoplastic disease NEC (M8000/1) *(see also Neoplasm)* D48.9†
  - D63.0*

  **Tabular List entry:**
  - **D63.0** *Anaemia in neoplastic disease*
    - Conditions in Chapter II (C00-D48)

- **Index trail for colon cancer:**
  - Cancer (M8000/3) – *(see also Neoplasm, malignant*
    - Malignant
    - Primary

  **Neoplasm, neoplastic**
  - duodenum
  - C17.0

  **Tabular List entry:**
  - **C17.0†** *Malignant neoplasm of small intestine, duodenum*

  **Tabular List entry for Morphology:**
  - **M8000/3 Neoplasm, malignant**

- **Index trail:**
  - Transfusion
    - blood (session) Z51.3

  **Tabular List entry:**
  - **Z51.3** *Blood transfusion (without reported diagnosis)*

**Rationale:** In this example the dagger and asterisk combination must be used as the anaemia has been linked to the cancer so **C17.0** becomes the dagger code. The patient is admitted for a blood transfusion to treat the anaemia so the asterisk code becomes the primary code, as this is the primary focus of care and the duodenal cancer is sequenced after the anaemia.

Anaemia is a natural symptom of neoplastic blood disorders such as leukaemia, myeloma, lymphoma and myelodysplasia. It is therefore not necessary to also code anaemia with these conditions.
History of primary malignancy (family/personal) (Z80 and Z85)

Category **Z80 Family history of malignant neoplasm** must be assigned as an additional code when it adds relevant information such as in the investigation of symptoms which could be due to a malignancy, and when a patient has been diagnosed with a malignant neoplasm.

Category **Z85** is used to code patients with a personal history of a malignant neoplasm which is no longer present and for which the treatment has been completed.

---

**Example:**

**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**

- Index trail for **metastasis of brain**:
  - Metastasis, metastatic
    - cancer or neoplasm (M8000/6) C80
    - to specified site (M8000/6) - see Neoplasm, secondary, by site
      - Malignant
      - Secondary
  - Neoplasm, neoplastic
    - brain NEC C79.3

- Tabular List entry for **anatomical site**:
  - C79.3 Secondary malignant neoplasm of brain and cerebral meninges

- Tabular List entry for **Morphology**:
  - M8000/6 Neoplasm, metastatic

- Index trail for **history**:
  - History (personal) (of)
    - malignant neoplasm (of) Z85.9
    - lung Z85.1

- Tabular List entry:
  - Z85.1 Personal history of malignant neoplasm of trachea, bronchus and lung

- Index trail for **radiotherapy session**:
  - Radiotherapy session Z51.0

- Tabular List entry:
  - Z51.0 Radiotherapy session
**Rationale:** In the above example, the treatment for the primary cancer was completed. The treatment is now for the new secondary malignancy, so the previous primary malignant neoplasm must be coded to ‘history of’.

**Example:**

<table>
<thead>
<tr>
<th>Admission for chemotherapy following oophorectomy for malignant ovarian teratoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>ovarian teratoma:</strong></td>
</tr>
<tr>
<td>Teratoma (solid) (M9080/1) - see also Neoplasm, uncertain behavior</td>
</tr>
<tr>
<td>- malignant (M9080/3) - see also Neoplasm, malignant</td>
</tr>
<tr>
<td>Malignant</td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>Neoplasm, neoplastic</td>
</tr>
<tr>
<td>- ovary</td>
</tr>
<tr>
<td>C56</td>
</tr>
</tbody>
</table>

Tabular List entry for **anatomical site:**

C56.X Malignant neoplasm of ovary

Tabular List entry for **Morphology:**

M9080/3 Teratoma, malignant NOS

<table>
<thead>
<tr>
<th>Index trail for <strong>chemotherapy:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy (session) (for) Z51.2</td>
</tr>
<tr>
<td>- cancer Z51.1</td>
</tr>
</tbody>
</table>

Tabular List entry:

Z51.1 Chemotherapy session for neoplasm

**Rationale:** In the above example the neoplasm is not coded to ‘history of’ as the treatment of the primary neoplasm has *not been* completed.
Example:

<table>
<thead>
<tr>
<th>Sebaceous cyst of breast and history of carcinoma of breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for sebaceous cyst of breast:</td>
</tr>
<tr>
<td>Cyst (colloid) (mucous) (retention) (simple)</td>
</tr>
<tr>
<td>- sebaceous (duct) (gland) L72.1</td>
</tr>
<tr>
<td>- breast N60.8</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>N60.8 Other benign mammary dysplasias</td>
</tr>
<tr>
<td>Index trail for history:</td>
</tr>
<tr>
<td>History (personal) (of)</td>
</tr>
<tr>
<td>- malignant neoplasm (of) Z85.9</td>
</tr>
<tr>
<td>- breast Z85.3</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>Z85.3 Personal history of malignant neoplasm of breast</td>
</tr>
</tbody>
</table>

Subcategories Z85.6–Z85.7 are used in the primary position when a patient with leukaemia or other malignant neoplasms of lymphoid, haematopoietic and related tissues in remission is admitted for maintenance chemotherapy. These are the only two codes from Z85–Z88 that are permitted to be assigned in the primary position.

Maintenance treatment

One of the uses of subcategory Z51.1 Chemotherapy session for neoplasm is to record patients stated to be in remission whose episode of care represents treatment intended to maintain the remissive state. When coding these scenarios, the code Z51.1 will always be coded in the secondary position.
Prophylactic treatment

Code **Z40.0 Prophylactic surgery for risk factors related to malignant neoplasms** must be assigned to a patient who is admitted for preventative surgery. For example, a mastectomy may be performed on a patient with a family history of breast cancer.

When a patient is admitted solely for the purpose of prophylactic surgery, code **Z40.0** must be recorded as the primary diagnosis.

A patient may be admitted for screening or prophylactic surgery because of a strong family history of malignant neoplasm. The addition of a code from **Z80.-** will provide valuable information in these instances because the patient does not have a morbid condition.

**Example:**

Admission for prophylactic mastectomy. Mother and one sister have breast cancer.

📖 Index trail for **prophylactic mastectomy:**

- **Prophylactic**
  - surgery Z40.9
  - - for risk factors related to malignant neoplasms Z40.0

Tabular List entry:

- **Z40.0** Prophylactic surgery for risk-factors related to malignant neoplasms
  - Admission for prophylactic organ removal

📖 Index trail for family **history of breast cancer:**

- **History (personal) (of)**
  - family, of
  - - malignant neoplasm (of) NEC Z80.9
  - - - breast Z80.3

Tabular List entry:

- **Z80.3** Family history of malignant neoplasm of breast
Further/wider excision

During the excision of a malignant neoplasm some of the tissue that surrounds the malignant tumour is also removed. The area between the outer edges of the tissue sample and the tumour is known as the ‘margins’. The pathologist will check the tissue under a microscope to see if the margins are free of malignant cells. The presence of malignant cells in the margins may indicate that the tumour 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 malignancy.

Even if the responsible consultant reports that the histology from this further surgery is negative, the further excision would still be considered as part of the primary treatment for the malignancy, and therefore the malignancy must continue to be recorded as the primary diagnosis.

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 comes back with no evidence of malignancy.

Index trail for melanoma:

Melanoma (malignant) (M8720/3) C43.9
- site classification
- - shoulder C43.6

Tabular List entry:

C43 Malignant melanoma of skin
C43.6 Malignant melanoma of upper limb, including shoulder

Tabular List entry for Morphology:

M8720/3 Malignant melanoma NOS
Follow-up examination after treatment for malignant neoplasm (Z08)

This category must only be assigned to record patients who are admitted for surveillance or examination following treatment of a malignant neoplasm. The fourth character will identify what the type of treatment was. Category Z08.- will only be used when no evidence of malignant disease is found.

**Example:**

Admitted for follow-up examination of bladder cancer (previously treated by surgical transurethral resection): no recurrence.

- Index trail for examination:
  - Examination (general) (routine) (of) (for) Z00.0
  - follow-up (routine) (following) Z09.9
  - - surgery NEC Z09.0
  - - - malignant neoplasm Z08.0

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z08.0</td>
<td>Follow-up examination after surgery for malignant neoplasm</td>
</tr>
</tbody>
</table>

- Index trail for history of bladder cancer:
  - History (personal) (of)
  - - malignant neoplasm (of) Z85.9
  - - urinary organ or tract Z85.5

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z85.5</td>
<td>Personal history of malignant neoplasm of urinary tract</td>
</tr>
</tbody>
</table>

Should evidence of malignancy be found, the code identifying the active neoplasm must be assigned. The code for follow up examination would not be assigned in these instances.
Example:

Admitted for follow up of bladder cancer (previously treated by transurethral resection); recurrence on bladder wall.

🔍 Index trail for cancer:
   Cancer (M8000/3) – see also Neoplasm, malignant

🔍 Index trail for malignant neoplasm bladder wall:
   Malignant
   Primary
   Neoplasm, neoplastic
   - bladder (urinary)
   - - wall
      C67.9

Tabular List entry for anatomical site:
C67 Malignant neoplasm of bladder
C67.9 Bladder, unspecified

Tabular List entry for Morphology:
M8000/3 Neoplasm, malignant

Occasionally, follow up examinations can reveal other conditions referred to as incidental findings. When incidental findings are reported by the responsible consultant, they must always be coded. Sequencing will depend on whether the incidental finding was treated or not.
**Example:**

Patient admitted for a follow up examination for carcinoma of bladder treated by excision. No recurrence. On examination the patient is found to have a trabeculation of bladder which was not treated.

- Index trail for **examination**:
  - Examination (general) (routine) (of) (for) Z00.0
  - - follow-up (routine) (following)
  - - - malignant neoplasm Z08.9
  - - - surgery Z08.0

  Tabular List entry:
  - Z08.0 Follow-up examination after surgery for malignant neoplasm

- Index trail for **history of bladder cancer**:
  - History (personal) (of)
  - - malignant neoplasm (of)
  - - - urinary organ or tract Z85.5

  Tabular List entry:
  - Z85.5 Personal history of malignant neoplasm of urinary tract

- Index trail:
  - Trabeculation, bladder N32.8

  Tabular List entry:
  - N32.8 Other specified disorders of bladder

**Rationale:** In the example above, trabeculation of bladder is found but not treated; the follow up examination code is therefore sequenced in the primary position. However, if the trabeculation of bladder had been treated in this consultant episode, it would have been assigned in the primary position instead.
Nutritional anaemias (D50–D53)

Nutritional anaemia is a deficiency of any materials necessary for the formation of erythrocytes, and may be caused by the following:

- incorrect diet
- chronic blood loss resulting from a slowly bleeding peptic ulcer or chronic menorrhagia
- interference with absorption. Notable among these substances improperly absorbed are vitamin B12, folic acid and protein.
**Example:**

Patient admitted solely for a blood transfusion to treat haemorrhagic anaemia due to a chronic bleeding duodenal ulcer

- Index trail:
  - Anemia D64.9
    - hemorrhagic (chronic) D50.0

- Tabular List entry:
  - D50.0 Iron deficiency anaemia secondary to blood loss (chronic)

- Index trail:
  - Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
    - duodenum, duodenal (eroded) (peptic) K26.9
    - chronic K26.7
    - with
    - - hemorrhage K26.4

- Tabular List entry:
  - K26 Duodenal ulcer
    [See at the beginning of this block for subdivisions]
    .4 Chronic or unspecified with haemorrhage

- Index trail:
  - Transfusion
    - blood (session) Z51.3

- Tabular List entry:
  - Z51.3 Blood transfusion (without reported diagnosis)

**Rationale:** Codes Z51.3 must be used in a secondary position whenever the patient has been admitted solely for the purpose of a blood transfusion.
Haemolytic anaemias (D55–D59)

Anaemia can also result from excessive destruction of red cells through a process of dissolution or lysis (haemolysis). These disorders are called haemolytic anaemias and can be either hereditary (congenital) or acquired.

Specific points about this block that must be noted:

- haemolytic anaemia in the newborn due to isoimmunisation is excluded from this chapter
- when an individual receives a defective Hb-S gene from only one parent, they will demonstrate the sickle-cell trait D57.3. If they receive the gene from both parents, they will present with both the clinical syndrome of sickle-cell trait D57.3 and haemolytic anaemia D57.0 or D57.1
- sickle-cell trait D57.3 is not coded when it coexists with either thalassaemia D56 or sickle-cell anaemia D57.0 or D57.1.
Aplastic and other anaemias
(D60–D64)

Aplastic anaemias (D60, D61)
Another cause of anaemia is failure of the bone marrow to produce red cells. It may also be described as bone marrow failure, hypoplastic anaemia, medullary hypoplasia, or primary red cell aplasia.

Aplastic anaemia can be:

- congenital in origin
- acquired from exposure to drugs, chemicals or radiation. An additional code must be used to identify the drug or external cause, where the information is present within the medical record
- from underlying disease
- idiopathic (cause unknown).

Example:

Aplastic anaemia due to Chloramphenicol

Index trail:

Anemia D64.9
- aplastic D61.9
- - due to
- - - drugs D61.1

Index trail from Table of Drugs and Chemicals:

Chloramphenicol

Y40.2 Chloramphenicol group
Other anaemias
(D62–D64)

Anaemia in neoplastic disease (C00–D48†) (D63.0*)
Anaemia due to neoplasm is coded to D63.0* with the correct code for the
neoplasm as the main condition (dagger) code. However, the dagger and
asterisk sequence may be reversed when the manifestation of a disease is
the primary focus of care. This is in line with the primary diagnosis definition.

Examples:

Anaemia due to liver cancer

Index trail:
- Cancer (M8000/3) – see also Neoplasm, malignant
  - Malignant
  - Primary
- Neoplasm, neoplastic
  - liver C22.9

Tabular List entry:
D63.0* Anaemia in neoplastic disease (C00-D48†)

[Note: The examples are repeated for clarity.]

Anaemia due to liver cancer. Main condition treated is the anaemia

Index trail:
- Anemia D64.9
  - in neoplastic disease NEC (M8000/1)
    (see also Neoplasm) D48.9† D63.0*

Tabular List entry:
D63.0* Anaemia in neoplastic disease (C00-D48†)
Anaemia is a natural symptom of neoplastic blood disorders such as leukaemia, myeloma, lymphoma and myelodysplasia. It must not be assigned as an additional code in these conditions.

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

Anaemia due to other chronic diseases is coded to D63.8* with the correct code for the chronic condition as the associated dagger code. The sequencing will depend on which disease is the primary focus of care. This is in line with the primary diagnosis definition.

This code must only be used if the responsible consultant clearly states a link between the anaemia and the chronic disease, e.g. chronic kidney disease (CKD) stages 3, 4 or 5 as per the implied Includes note at this code. Coders cannot assume a cause and effect relationship between these conditions, unless stated by the responsible consultant. If there is no link stated, or in the case of CKD the stage is stage 1 or stage 2, the conditions must be coded separately, as demonstrated in the following example.

**Example:**

<table>
<thead>
<tr>
<th>Patient with stage 2 chronic kidney disease is admitted with anaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index trail:</strong></td>
</tr>
<tr>
<td><strong>Anemia</strong> D64.9</td>
</tr>
<tr>
<td><strong>Tabular List entry:</strong></td>
</tr>
<tr>
<td>D64.9 Anaemia, unspecified</td>
</tr>
<tr>
<td><strong>Index trail:</strong></td>
</tr>
<tr>
<td><strong>Disease, diseased</strong> – see also Syndrome</td>
</tr>
<tr>
<td>- kidney (functional) (pelvis) N28.9</td>
</tr>
<tr>
<td>- chronic N18.9</td>
</tr>
<tr>
<td>- - stage 2 N18.2</td>
</tr>
<tr>
<td><strong>Tabular List entry:</strong></td>
</tr>
<tr>
<td>N18.2 Chronic kidney disease, stage 2</td>
</tr>
</tbody>
</table>
Coagulation defects, purpura and other haemorrhagic conditions
(D65–D69)

Haemorrhagic disorder due to circulating anticoagulants (D68.3)
Haemorrhagic disorders/haemorrhage due to circulating anticoagulants (D68.3) may be due to anticoagulant drugs administered to the patient or the patient developing antibodies to one of their own clotting factors.

This code excludes long term use of anticoagulants without haemorrhage (Z92.1) and must not be used to record a stated diagnosis of 'Raised INR' as described in Chapter XVIII of this manual. Code D68.3 must only be assigned if the responsible consultant has confirmed a haemorrhage due to the anticoagulants in the clinical statement. If in doubt the coder must consult the responsible consultant for clarification.

Coagulation disorders occurring in obstetric patients and in the newborn are excluded from this chapter.
Other diseases of blood and blood-forming organs (D70–D77)

An additional code must be used to identify the drug if the disorder is drug induced and the information is present within the medical record.

**Example:**

Neutropenia due to Vincristine therapy for Hodgkin lymphoma

- Index trail for **Neutropenia**:
  
  Neutropenia, neutropenic (congenital) (cyclic) (drug-induced) (periodic) (primary) (splenic) (toxic) D70

- Tabular List entry:
  
  D70 Agranulocytosis
  
  Neutropenia:
  
  • drug-induced
  
  Use additional external cause code (Chapter XX) to identify drug, if drug-induced

- Index trail from **Table of Drugs and Chemicals**:
  Adverse effect in therapeutic use

  Vincristine Y43.3

- Tabular List entry:
  
  Y43.3 Other antineoplastic drugs

- Index trail for **Lymphoma**:
  Lymphoma (malignant) C85.9
  - Hodgkin C81.9

  or

  Hodgkin
  
  - lymphoma, malignant (classical) C81.9

- Tabular List entry:

  C81.9 Hodgkin lymphoma, unspecified
Certain disorders involving the immune mechanism (D80-D89)

HIV (human immunodeficiency virus) is excluded from this chapter and is classified in the infectious and parasitic disease chapter in categories B20–B24, or in the pregnancy, childbirth and puerperium chapter at code O98.7 Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium. Refer to Chapters I and XV in this manual for coding standards pertaining to HIV.
CHAPTER IV
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES
E00–E90

Chapter rules and conventions

Codes from this chapter may be used as additional codes to indicate either functional activity by neoplasms and ectopic endocrine tissue or hyperfunction and hypofunction of endocrine glands associated with neoplasms and other conditions classified elsewhere.
Coding Standards

E00-E35

The first four blocks (E00-E35) classify disorders of the endocrine system, eg pituitary gland, thyroid gland. These are disorders of ductless glands affecting the production and release of hormones (chemical messengers or regulators) into the blood stream to control body functions.

Functional activity

Codes E05.8, E07.0, E16–E31, E34.- may be used to further classify functional activity classified elsewhere. ‘Functional activity’ refers to any disorder resulting from the presence of the neoplasm. This rule is demonstrated in the following example.

Example: Carcinoma of ileum. Carcinoid syndrome

- Index trail for carcinoma:
  Carcinoma (M8010/3) – see also Neoplasm, malignant

- Index trail for malignant neoplasm of ileum:
  Neoplasm
  - ileum – malignant C17.2

  Tabular List entry:
  C17.2 ileum

- Index trail for carcinoid syndrome:
  Syndrome – see also Disease
  - carcinoid E34.0

  Tabular List entry:
  E34.0 Carcinoid syndrome
Disorders of the thyroid gland  
(E00–E07)

Coders should pay particular attention to all the *Includes* and *Excludes* notes at these categories.

Hypothyroidism is classified by cause. It can be congenital (E03.-), postoperative (E89.0), or due to other causes. The note at subcategory E03.2 allows identification of the cause when it is the result of treatment.

Coders need to be aware that goitre can be classified as toxic when associated with hyperthyroidism, and non-toxic when not associated with hyperthyroidism.

**Examples:**

**Toxic diffuse goitre (with hyperthyroidism)**

- Index trail for *goitre*:
  - Goiter (plunging) (substernal) E04.9
    - with
      - - hyperthyroidism (recurrent)(*see also* Goiter, toxic) E05.0
      - - toxic E05.0

- Tabular List entry:
  - E05.0 Thyrotoxicosis with diffuse goitre

**Diffuse goitre (without hyperthyroidism)**

- Index trail:
  - Goiter(plunging) (substernal) E04.9
    - nontoxic E04.9
    - - diffuse (colloid) E04.0

- Tabular List entry:
  - E04.0 Nontoxic diffuse goitre
Diabetes mellitus
(E10–E14)

All forms of diabetes mellitus (E10–E14) have a fourth character subdivision to identify any associated conditions. These are listed at block level in the Tabular List.

Coders must assign an additional external cause code from Chapter XX to identify the drug if the diabetes is drug-induced as per the note at block level in the Tabular List.

Whatever the reason is for the consultant episode, if diabetes is present it must always be coded. Where it is present it will always influence the care process.

The term diabetes comes from a Greek word meaning ‘to pass through’ and is a general term referring to disorders characterised by excessive urine excretion (polyuria), as in diabetes mellitus and diabetes insipidus. When used alone the term ‘diabetes’ refers to diabetes mellitus.

Diabetes mellitus is a metabolic disorder in which the ability to oxidize carbohydrates is more or less completely lost due to faulty pancreatic activity, especially of the Islets of Langerhans, and consequent disturbance of the normal insulin mechanism. This produces hyperglycaemia, which results in glycosuria and polyuria, giving rise to symptoms of thirst, hunger, emaciation, and weakness. Imperfect combustion of fats leads to acidosis, ketosis, ketonuria, and finally coma.

E23.2 Diabetes insipidus is contained in the category E23 Hypofunction and other disorders of pituitary gland. Diabetes insipidus is a type of diabetes marked by an increased flow in urine of low specific gravity accompanied by great thirst.

Diabetes mellitus occurs in two major forms:

- **E10 Insulin dependent diabetes mellitus or Type I (IDDM)**
  This is a severe form of diabetes, usually with an abrupt onset occurring before the age of 40 years. It is difficult to control and can also be described as Type I, brittle, unstable, or juvenile onset diabetes. Oral hypoglycaemics and diet control are rarely effective and daily injections of insulin are nearly always required.

- **E11 Non-insulin dependent diabetes mellitus or Type II (NIDDM)**
  This is a mild, often asymptomatic form of diabetes, usually with onset after the age of 40 years and frequently in overweight persons. Although the pancreatic reserve is diminished, it is nearly always sufficient to prevent ketoacidosis. This type is also known as Type II or maturity-onset diabetes. Oral hypoglycaemics and diet control are usually effective in this type of diabetes.
Insulin treated Type II diabetes

Although most patients with Type II diabetes are treated with diet, exercise and oral drugs, some patients intermittently or persistently require insulin to control hyperglycaemia and prevent coma. Treatment by insulin therapy does not determine the type of diabetes and is not evidence of insulin dependency. In these circumstances, the status of a Type II (NIDDM) still remains, and the diabetes must therefore still be coded to E11.- Non-insulin dependent diabetes mellitus.

Uncontrolled diabetes

Hyperglycaemia is a recognised sign of diabetes, or an indication that the diabetes is considered to be 'out of control'. Patients are occasionally admitted for stabilisation. This is not a complication as understood within the ICD-10 Classification, and should therefore be coded with the fourth character subdivision .9.

Example:

Uncontrolled Type II non-insulin-dependent diabetes mellitus (NIDDM)

📖 Index trail:
   Diabetes, diabetic (mellitus) (controlled) (familial)
   (severe) E14.-
   - type II (nonobese)(obese) E11.-

Tabular List entry:
   E11  Non-insulin-dependent diabetes mellitus
       [See before E10 for subdivisions]
       .9 Without complications

Coders should only very rarely assign category E14 Unspecified diabetes mellitus, as the information about the type of diabetes is usually in the medical record.

The category E14 Unspecified diabetes mellitus must only be assigned where the type of diabetes is not specified. The responsible consultant must ensure that the type of diabetes is documented correctly for each hospital spell in the medical record.
Hyperglycaemia and hypoglycaemia in diabetes

In diabetes blood sugar is usually raised (hyperglycaemia), however hypoglycaemia (low blood sugar) also often occurs. It is not uncommon for a patient to swing between both conditions.

**Hyperglycaemia**

Diabetes may become severely out of control, resulting in a coma. In these instances, the type of diabetes should be recorded from the range **E10–E14** with the fourth character subdivision .0.

Example:  
Hyperglycaemic coma in a patient with Type I insulin dependent diabetes (IDDM)

📖 Index trail:

- Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- coma (hyperglycemic) (hyperosmolar) - code to E10–E14 with fourth character .0

Tabular List entry:

<table>
<thead>
<tr>
<th>E10</th>
<th>Insulin-dependent diabetes mellitus</th>
</tr>
</thead>
<tbody>
<tr>
<td>.0 With coma</td>
<td></td>
</tr>
</tbody>
</table>

**Hypoglycaemia**

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

A coder should report the cause of the hypoglycaemia in the code assignments if the information is available.
Examples:

Hypoglycaemia, direct cause of insulin taken as prescribed Type I insulin dependent diabetes mellitus (IDDM)

- Index trail for hypoglycaemia:
  Hypoglycemia (spontaneous) E16.2
  - due to insulin E16.0

Tabular List entry:

E16.0 Drug-induced hypoglycaemia without coma
  Use additional external cause code (Chapter XX) to identify drug.

- Index trail from Table of Drugs and Chemicals:
  Adverse effect
  in therapeutic use

Insulin NEC

Y42.3 Insulin and oral hypoglycaemic [antidiabetic] drugs

- Index trail:
  Diabetes, Diabetic (mellitus) (controlled) (familial) (severe) E14.-
  - insulin-dependent... E10.-

Tabular List entry:

E10 Insulin-dependent diabetes mellitus
  [See before E10 for subdivisions]
  .9 Without complications

Hypoglycaemia, in Type II non-insulin dependent diabetes mellitus (NIDDM) patient has skipped meals

- Index trail:
  Hypoglycemia (spontaneous) E16.2

Tabular List entry:

E16.2 Hypoglycaemia, unspecified

- Index trail:
  Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
  - non-insulin-dependent (of the young) E11.-

Tabular List entry:

E11 Non-insulin-dependent diabetes mellitus
  [See before E10 for subdivisions]
  .9 Without complications
If hypoglycaemia is not treated quickly, a patient can lapse into a hypoglycaemic coma. The fourth character subdivision .0 is used to describe both the coma and the diabetes.

The fourth character subdivision .0 includes both hyperglycaemic coma and hypoglycaemic coma. Because of the fundamental difference between hyper- and hypo-glycaemic coma, an additional code of E16.2 must be recorded to identify the hypoglycaemia. It is not necessary to record an additional code with a diagnosis of hyperglycaemic coma.

**Example:**

Hypoglycaemic coma, in patient with Type I insulin-dependent diabetes mellitus (IDDM)

Index trail:

- Hypoglycemia (spontaneous) E16.2
- coma
- - diabetic - *code to* E10-E14 with fourth character .0

**Diabetes, diabetic (mellitus) (controlled) (familial) (severe)**

- E14.-
- coma (hyperglycemic) (hyperosmolar) - *code to* E10-E14 with fourth character .0

Tabular List entry:

- E10 Insulin-dependent diabetes mellitus
  [See before E10 for subdivisions]
  .0 With coma

Index trail:

- Hypoglycemia (spontaneous) E16.2

Tabular List entry:

- E16.2 Hypoglycaemia, unspecified
If the coma or the hypoglycaemia is due to the patient taking too much insulin, it is considered a poisoning and should be coded appropriately.

**Example:**

<table>
<thead>
<tr>
<th>Hypoglycaemic coma due to overdose of insulin, patient has Type I insulin-dependent diabetes mellitus (IDDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail from <strong>Table of Drugs and Chemicals:</strong></td>
</tr>
<tr>
<td>Poisoning</td>
</tr>
<tr>
<td>Insulin NEC</td>
</tr>
</tbody>
</table>

- Tabular List entries:
  - **T38.3** Insulin and oral hypoglycaemic [antidiabetic] drugs
  - **X44** Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .9 Unspecified place

- Index trail:
  - Diabetes, diabetic (mellitus) (controlled) (familial) (severe)
  - E14.-
  - - insulin-dependent E10.-

- Tabular List entry:
  - **E10** Insulin-dependent diabetes mellitus
    - [See before E10 for subdivisions]
    - .0 With coma

- Index trail:
  - Hypoglycemia (spontaneous) E16.2

- Tabular List entry:
  - **E16.2** Hypoglycaemia, unspecified
Manifestations and complications of diabetes

All manifestations and complications of diabetes affecting different body systems are recorded using the fourth character subdivisions found at block level in the Tabular List. There are many associated diseases of diabetes and if any are present in the medical record all should be recorded.

The dagger and asterisk system is used to classify the underlying disease and the manifestations of diabetes. The dagger and asterisk sequence may be reversed when the manifestation of a disease is the main condition treated. This is in line with the primary diagnosis definition. In instances where the responsible consultant has not specified or is unable to confirm which condition is the main condition being treated, the dagger/asterisk default must be used, ie the dagger code must be assigned in primary position, followed by the associated asterisk code.

Where there are multiple dagger and asterisk codes for diabetes assigned, and these are not the main condition being treated, the dagger and asterisk default remains, ie the only time the dagger and asterisk is reversed is where the treatment is for the main manifestation of the diabetes.

A cause and effect relationship between diabetes and any chronic disease should not be presumed. If ever there is any doubt, advice should be sought from the responsible consultant.

The fourth character .7 With multiple complications must only be used as the ‘primary diagnosis’ when no specific conditions are identified.

It is permissible to record two or more fourth character codes from categories E10–E14 to identify multiple manifestations and complications of diabetes in the same patient.
**Example:**

Patient admitted for treatment of diabetic cataracts, the patient also has polyneuropathy both confirmed as being caused by Type II non-insulin dependent diabetes mellitus.

- **Index trail:**
  - Cataract (cortical) (immature) (incipient) (incipient) (see also Cataracta) H26.9
  - diabetic (see also E10-E14 with fourth character .3) E14.3†H28.0*

  **Tabular List entry:**
  - H28.0*  Diabetic cataract

- **Index trail:**
  - Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
  - cataract - code to E10-E14 with fourth character .3

  **Tabular List entry:**
  - E11  Non-insulin dependent diabetes mellitus
    - [See before E10 for subdivisions]
      - .3† With ophthalmic complications

- **Index trail:**
  - Diabetes, diabetic (mellitus) (controlled) (familial) (severe)
    - E14.-
    - neuropathy E14.4† G63.2*
    - - polyneuropathy E14.4† G63.2*

  **Tabular List entry:**
  - E11  Non-insulin dependent diabetes mellitus
    - [See before E10 for subdivisions]
      - .4† With neurological complications

- **Index trail:**
  - Polyneuropathy (peripheral) G62.9
    - in (due to)
    - - diabetes (see also E10-E14 with fourth character .4)
      - E14.4† G63.2*

  **Tabular List entry:**
  - G63.2*  Diabetic polyneuropathy (E10-E14† with common fourth character .4)

**Rationale:** The dagger and asterisk sequence has been reversed as the manifestation of the disease is the primary focus of care. Where there are multiple dagger and asterisk codes for diabetes assigned, and these are not the main condition being treated, the dagger and asterisk default remains.
**Example:** Type I Insulin dependent diabetes mellitus (IDDM) complicated by nephropathy, gangrene and cataracts (confirmed as linked by responsible consultant) main condition not specified.

Index trail:

**Diabetes, diabetic (mellitus) (controlled) (familial) (severe)** E14.-
- nephropathy - *code to E10-E14 with fourth character .2*
- type I E10.-

Tabular List entries:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10</td>
<td>Insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td></td>
<td>[See before E10 for subdivisions]</td>
</tr>
<tr>
<td>.2†</td>
<td>With renal complications</td>
</tr>
<tr>
<td></td>
<td>Diabetic nephropathy (N08.3*)</td>
</tr>
<tr>
<td>N08.3*</td>
<td>Glomerular disorders in diabetes mellitus</td>
</tr>
<tr>
<td></td>
<td>(E10-E14† with common fourth character .2)</td>
</tr>
</tbody>
</table>

Index trail:

**Diabetes, diabetic (mellitus) (controlled) (familial) (severe)** E14.-
- gangrene - *code to E10-E14 with fourth character .5*

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10</td>
<td>Insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td></td>
<td>[See before E10 for subdivisions]</td>
</tr>
<tr>
<td>.5</td>
<td>With peripheral circulatory complications</td>
</tr>
</tbody>
</table>

Index trail:

**Gangrene, gangrenous (dry) (moist) (skin) (ulcer)** *(see also Necrosis)* R02
- diabetic (any site) - *code to E10-E14 with fourth character .5*

This leads to E10.5 but we need to record ‘gangrene’ unspecified as to site (R02).

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R02</td>
<td>Gangrene, not elsewhere classified</td>
</tr>
</tbody>
</table>

Index trail:

**Diabetes, diabetic (mellitus) (controlled) (familial) (severe)** E14.-
- cataract - *code to E10-E14 with fourth character .3*

Tabular List entries:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10</td>
<td>Insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td></td>
<td>[See before E10 for subdivisions]</td>
</tr>
<tr>
<td>.3†</td>
<td>With ophthalmic complications</td>
</tr>
<tr>
<td></td>
<td>Diabetic Cataract (H28.0*)</td>
</tr>
<tr>
<td>H28.0*</td>
<td>Diabetic cataract (E10-E14† with common fourth character .3)</td>
</tr>
</tbody>
</table>
Rationale: As the responsible consultant has not identified that the manifestations are the primary focus of care, the dagger and asterisk default must be used.

When coding a condition that is listed as an inclusion at the fourth character subdivision .5, the code for the complication (such as gangrene) must also be assigned.

If a diabetic ulcer of the lower limb is diagnosed the same principle as for gangrene would be applied and an additional code of L97.X would also be assigned to identify the ulcer as this is listed as an inclusion at the fourth character subdivision .5.

If a patient is admitted with an acute myocardial infarction, cardiac failure or angina that the responsible consultant has stated is a complication of the diabetes, the diabetes should be recorded in a secondary position with a fourth character of .6.

Abnormal glucose tolerance tests
Important diagnostic investigations in suspected cases of diabetes include the testing of the urine for sugar and ketone bodies. These tests are commonly termed glucose tolerance tests (GTT).

An abnormal glucose tolerance test may indicate a clinical risk and should be reported with a code assignment from the signs and symptoms chapter. If a diagnosis of diabetes is made the abnormal glucose tolerance test should not be coded.

Diabetes in pregnancy (024)
This is most often detected in the second half of the pregnancy when increased glucose appears in the mother's urine, or the baby may be found to be bigger than expected. The mother does not produce enough insulin to keep the blood glucose levels normal during the pregnancy. True gestational diabetes disappears with the delivery of the baby. Treatment is through dietary control and continued monitoring of blood glucose levels.

If a diabetic pregnant patient develops any manifestations (where an asterisk would be assigned in non-pregnant state), the relevant code from category O24 must be made a dagger code.
Disorders of other endocrine glands (E20–E35)

Ovarian dysfunction is coded to category E28 and testicular dysfunction to E29. If these disorders are associated with infertility there are certain sequencing rules which are dependent on the main condition being treated:

- if the main condition being treated, or investigated, is the dysfunction then this must be sequenced before the infertility
- if the infertility is the main condition treated, or investigated, this must be sequenced before the dysfunction.

Nutritional disorders (E40–E64)

These are disorders due to malnutrition and deficiencies of protein, vitamins, or minerals.

There is a note at block level in the Tabular List that describes how a diagnosis of malnutrition is determined. A coder must only use these definitions to confirm correct code assignment from the responsible consultant’s diagnosis.

The code E64 Sequelae of malnutrition and other nutritional deficiencies must not be used for chronic malnutrition or nutritional deficiency; these must be coded to current malnutrition or nutritional deficiency.

If the nature of the residual condition is recorded a code from category E64 may be used as an optional additional code.
Obesity and other hyperalimentation (E65–E68)

Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obese adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²).

In order to assign a code from category **E66 Obesity** there must be a corresponding clinical statement in the medical record to confirm obesity. A clinical coder must always refer to the responsible consultant to confirm the clinical significant of a test result, eg BMI reading and/or relationship to a specific condition.

If a condition is drug-induced and the drug is identified, the coder must also assign an additional external cause code from Chapter XX.

**Example:**

<table>
<thead>
<tr>
<th>Obesity due to growth hormone (human)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail:</td>
</tr>
<tr>
<td><strong>Obesity (simple)</strong> E66.9</td>
</tr>
<tr>
<td>- drug-induced E66.1</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td><strong>E66.1</strong> Drug induced obesity</td>
</tr>
<tr>
<td>Use additional external cause code (Chapter XX) to identify drug</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Index trail from <strong>Table of Drugs and Chemicals:</strong></td>
</tr>
<tr>
<td>Adverse effect in therapeutic use</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Human</strong></td>
</tr>
<tr>
<td>- growth hormone (HGH) Y42.8</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td><strong>Y42.8</strong> Other and unspecified hormones and their synthetic substitutes</td>
</tr>
</tbody>
</table>

Code **E68.X Sequelae of hyperalimentation** is not to be used for the recording of chronic hyperalimentation this should be coded to the current condition. If the nature of the residual condition is recorded, code **E68.X** may be used as an optional additional code.
**Metabolic disorders (E70–E90)**

**Disorders of fatty-acid metabolism (E71.3)**
MCAD deficiency refers to Medium Chain Acyl CoA Dehydrogenase Deficiency. This is a disorder of fatty acid oxidation.

**Pure hypercholesterolaemia (E78.0)**
A diagnosis of 'high cholesterol' or 'Cholesterol' must only be coded to E78.0 if confirmed to be a definitive diagnosis of hypercholesterolaemia by the responsible consultant and it is not merely an abnormal test result. Abnormal test results must be coded to R79.8 Other specified abnormal findings of blood chemistry instead.

Do not confuse hypercholesterolaemia with E78.5 Hyperlipidaemia unspecified.

**Cystic fibrosis (E84)**
Cystic fibrosis is a disorder of the pancreas and not of the lungs. However, the most common area of manifestation of this disease is in the lung.

For example, if a cystic fibrosis patient develops a chest infection, it should be coded using E84.0 Cystic fibrosis with pulmonary manifestations. An additional code should be assigned if the infectious organism is known.

**Dehydration and hypovolaemia (E86)**
Dehydration occurs when the body’s normal water content is reduced due to either decreased water intake or fluid loss. Dehydration can be described as mild, moderate, or severe, depending on the percentage of body weight lost due to fluid.

For mild dehydration drinking plenty of water is all that is needed. Moderate to severe dehydration requires replacement of lost electrolytes, oral rehydration solutions can be given to patients with moderate dehydration. Severe dehydration is a life-threatening emergency and requires treatment with intravenous solutions. Dehydration must always be coded where it is confirmed to be severe dehydration, or where it has been treated with intravenous fluids using the appropriate ICD-10 code.

Hypovolaemia is an abnormal decrease in blood volume, or an abnormal decrease in the volume of blood plasma. Hypovolaemia can occur as a result of dehydration, severe burns, vomiting or severe blood loss. Hypovolaemia can progress to hypovolaemic shock; in which organs begin to fail as a result of reduced blood and oxygen levels. Hypovolaemic shock requires replacement of lost blood and body fluids using intravenous fluids, blood transfusion may also be required.
Hypovolaemia must always be coded when it is confirmed to have been treated with intravenous fluids or blood transfusion.

**Metabolic acidosis (E87.2)**
Code E87.2 Metabolic acidosis where the blood pH is abnormally low excludes diabetic acidosis, which is assigned to categories E10–E14 with the fourth character subdivision .1.
Chapter rules and conventions

- The definitions of the categories and subcategories in this chapter are provided to assist the responsible consultant in reaching a diagnosis. They must not be used by coders to assign a code.

- The ‘main condition’ code should be assigned on the basis of the diagnosis recorded by the responsible consultant, even if there appears to be a conflict between the condition (as recorded) and the definition. In some categories there is provision for optional additional codes.

- In addition to the World Health Organisation (WHO) International Statistical Classification of Diseases and Related Health Problems ICD-10 4th Edition (Tenth Revision), the WHO also provides the specialty-based adaptation called ICD-10 Classification of Mental Health and Behavioural Disorders. It encompasses clinical description 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.

- When coding mental health hospital provider spells and consultant episodes coders must follow the rules of the classification to record all mental health disorders and any accompanying disorders and comorbidities to give an accurate clinical picture of the patient’s stay in hospital.
Coding Standards

Organic, including symptomatic, mental disorders (F00–F09)

There are many diseases, including diseases of the brain itself, which can affect mental function. Temporary or permanent dysfunction of the brain with a recognisable cause is said to have an organic basis.

The dysfunction of brain tissue is often the result of ageing, drugs, alcohol, infection, brain injury, metabolic disorders or cerebrovascular disease.

The underlying diseases must also be coded, when known, as instructed in the ‘Use additional code’ note featured in the Tabular List and when the responsible consultant has confirmed a link between the conditions. There are two asterisk categories within this block which further define the aetiology:

- F00* Dementia in Alzheimer’s disease (G30.-†)
- F02* Dementia in other diseases classified elsewhere

Example: Dementia due to Parkinson’s disease, patient admitted for treatment of the dementia.

Index trail for dementia:
- Dementia (persisting) F03
  - in (due to)
  - - Parkinson’s disease (parkinsonism) G20† F02.3*

Tabular List entries:
- F02.3* Dementia in Parkinson’s disease (G20†)
- G20.X† Parkinson’s disease

Rationale: In this example, the responsible consultant has confirmed a link between the two conditions by stating that the dementia is due to the Parkinson’s disease. As the dementia has been specified as the main condition treated, the asterisk code is sequenced before the dagger code.
Dementia (F00*–F03)

Codes within category F00* Dementia in Alzheimer disease (G30.-†) are asterisk codes which are always used in combination with codes from category G30 Alzheimer disease. The combination of codes classifies one condition; Alzheimer dementia which is a specific form of dementia. The fourth character subdivisions at these categories denote the stage of onset of the disease.

Within the ICD-10 4th Edition dagger and asterisk combination codes may be reversed so that the asterisk code is sequenced before the dagger code when this is the primary focus of care. However when using codes in category F00* Dementia in Alzheimer disease (G30.-†) the dagger and asterisk would rarely be reversed as the combination of codes indicates one specific form of dementia, therefore the dagger and asterisk default must be used and the dagger code is sequenced before the asterisk code.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G30.0†</td>
<td>Alzheimer’s disease with early onset</td>
</tr>
<tr>
<td>F00.0*</td>
<td>Dementia in Alzheimer’s disease with early onset</td>
</tr>
</tbody>
</table>

A diagnosis of mixed dementia or mixed vascular and Alzheimer’s dementia must be coded using the following codes:

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

The fourth character code at G30.† Other Alzheimer disease may change if the stage of onset of Alzheimer disease is stated.

Vascular dementia coded at F01 can be due to several underlying diseases, including stroke. An additional code to identify the underlying disease must also be assigned if known. Category F03.X Unspecified dementia does not include senility not otherwise specified. This is coded at R54.X Senility, which includes old age without mention of psychosis. Category F03.X must be assigned when the only information provided by the responsible consultant is ‘dementia’.
Delirium and acute confusional state
Delirium is sometimes called acute confusional state. Whenever a stated 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 recorded using the appropriate ICD-10 code. The correct sequencing will depend on the main condition treated or investigated during the consultant episode.
Mental and behavioural disorders due to psychoactive substance use
(F10–F19)

This block contains a variety of disorders which differ in severity and clinical form, but which can all be attributed to the use of one or more psychoactive substances. A psychoactive substance is one which affects the mind, e.g. drugs, alcohol and tobacco.

The third character of the code identifies the substance involved and the fourth character identifies the clinical state.

Drug ‘abuse’ includes any code from categories F10 to F19, and fourth character assignment will depend on the diagnosis documented in the medical record by the responsible consultant.

Other diagnoses should also be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth characters .3 to .9). It is therefore permissible to assign multiple codes from categories F10-F19.

Example:

Alcoholic admitted with acute drunken episode

Index trail for drunkenness:

Drunkenness F10.0
  - acute in alcoholism F10.0
  - chronic F10.2

Tabular List entry:

F10.- Mental and behavioural disorders due to use of alcohol
  [See before F10 for subdivisions]
  .0 Acute intoxication

F10.- Mental and behavioural disorders due to use of alcohol
  [See before F10 for subdivisions]
  .2 Dependence syndrome

Rationale: In the above example, two codes are required from category F10 to record both the acute intoxication and the alcohol dependence.

Alcohol ‘abuse’ includes any code from category F10, and fourth character assignment will depend on the diagnosis documented in the medical record by the responsible consultant.
In order to assign a code from **F10 Mental and behavioural disorders due to use of alcohol**, a clinical decision is required if patients are described as ‘heavy drinkers’.

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, then a code from this category must be selected.

If it is noted in the medical record that the patient is a heavy drinker with no other reference to medical condition, then a code must be selected from category **Z72 Problems related to lifestyle**. The final code assigned will always depend on what has been documented in the medical record by the responsible consultant. If this is unclear, clinical input is required.

Smoking in any amount, regardless of the frequency, will always have an adverse effect on a person’s health. When it is stated 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 a dependence, then the fourth character code may change.

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

Category **F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances** should only be assigned in one of the following instances:

- when it is not possible for the responsible consultant to identify which substance is contributing most to the disorders
- when the exact identity of some (or even all) the psychoactive substances being used is uncertain or unknown
- when it is not evident which substance the patient is most dependent upon.

**Example:**

**Alcoholic, heroin, cannabis, valium dependent**

Index trail for dependence:

Dependence

- due to

- - drug NEC F19.2

- - - combinations NEC F19.2

Tabular List entry:

**F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances**

[See before F10 for subdivisions]

.2 Dependence syndrome
In cases where the responsible consultant has confirmed and documented that the patient is dependent on multiple drugs and other psychoactive substances and where no single drug is stated to be contributing most to the disorder, eg an alcoholic who takes heroin and is also a ‘current smoker’, a code from category F19 (fourth character identifying the clinical state) 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, eg dependence etc a different fourth character from F17 Mental and behavioural disorders due to use of tobacco may be assigned.

This block does not include abuse of non-dependence-producing substances such as laxatives and antacids where the abuse does not produce withdrawal or dependence symptoms. These are classified to category F55.X Abuse of non-dependence-producing substances.
Mood [affective] disorders
(F30–F39)

This block includes manic disorders where a distinction is made between a single manic episode (F30) and recurrent bipolar affective disorders (F31). A single depressive episode (F32) is also distinguished from recurrent depressive disorder (F33). Depression NOS is coded at F32.9.

Example:

<table>
<thead>
<tr>
<th>Episode of mania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for mania:</td>
</tr>
<tr>
<td>Mania (monopolar) F30.9</td>
</tr>
</tbody>
</table>

Tabular List entry:
F30.9 Manic episode, unspecified
Neurotic, stress-related and somatoform disorders (F40–F48)

Whilst a stated diagnosis of ‘depression, anxiety’ 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.

**F41 Other anxiety disorders**
This does not include patients that are described as ‘anxious’. Patients who are described as ‘anxious’ without a definitive diagnosis of anxiety, or anxiety disorder, must not be coded.

**Fatigue syndrome**
Coders must be cautious when given the description of ‘fatigue syndrome’ as a diagnosis; it 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 nervous system disorder ME (myalgic encephalomyelitis) coded to **G93.3 Postviral fatigue syndrome**.

Fatigue NOS is coded to **R53.X Malaise and fatigue**. Coders must therefore always clarify the exact nature of the fatigue with the responsible consultant before assigning a code.

**Example:** Patient diagnosed with fatigue syndrome

- **Index trail for syndrome:**
  - Syndrome – see also Disease
  - fatigue F48.0

- **Tabular List entry:**
  - **F48.0** Neurasthenia
  - Fatigue syndrome
  - Use additional code to identify previous physical illness
  - **Excludes:** asthenia NOS (R53)
    - burn-out (Z73.0)
    - malaise and fatigue (R53)
    - postviral fatigue syndrome (G93.3)
    - psyhasthenia (F48.8)
### Mental and behavioural disorders

**Example:**

<table>
<thead>
<tr>
<th>Patient diagnosed with chronic fatigue syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>syndrome:</strong></td>
</tr>
<tr>
<td>Syndrome – see also Disease</td>
</tr>
<tr>
<td>- fatigue F48.0</td>
</tr>
<tr>
<td>- chronic G93.3</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td><strong>G93.3  Postviral fatigue syndrome</strong></td>
</tr>
<tr>
<td>Benign myalgic encephalomyelitis</td>
</tr>
</tbody>
</table>

**Example:**

<table>
<thead>
<tr>
<th>Patient diagnosed with fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>fatigue:</strong></td>
</tr>
<tr>
<td>Fatigue R53</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td><strong>R53  Malaise and fatigue</strong></td>
</tr>
<tr>
<td>Excludes:</td>
</tr>
<tr>
<td>debility:</td>
</tr>
<tr>
<td>fatigue syndrome (F48.0)</td>
</tr>
<tr>
<td>postviral (G93.3)</td>
</tr>
</tbody>
</table>
Behavioural syndromes with physiological disturbances (F50–F59)

All of these categories contain glossaries to assist in assignment of the correct code – these are NOT to be used by the coder to diagnose the patient.

Behavioural disorders related to eating at F50, include anorexia nervosa at F50.0 and bulimia nervosa at F50.2 Anorexia NOS is excluded from this category and is coded to R63.0 instead.

Postnatal mental and behavioural disorders at F53 includes postnatal depression at F53.0. This code can be assigned whenever the postnatal depression occurs. This might be, for example, at three months/six months/two years after the birth of the baby.

When coding a patient with a psychological/psychogenic disorder (F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere), an additional code must be assigned to identify the associated physical disorder.

**Example:**

**Asthma with psychogenic overlay (psychogenic asthma)**

- **Index trail:**
  - Psychogenic - see also condition
  - factors associated with physical conditions F54

- **Tabular list entry:**
  - F54.X Psychological and behavioural factors associated with disorders or diseases classified elsewhere (Use additional code to identify the associated physical disorder)

- **Index trail for asthma:**
  - Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9

- **Tabular list entry:**
  - J45.9 Asthma, unspecified
Mental retardation (F70–F79)

The more common term for this disorder is ‘learning disability’ and may also be referred to as intellectual disability. However, these conditions are indexed in ICD-10 under the lead term Retardation in the Alphabetical Index.

ICD-10 codes from F70–F79 would only be assigned to record impairment of skills manifested during the development period and are skills which contribute to the overall level of intelligence, such as cognitive language, motor, and social abilities.

Care must be taken when assigning codes from F70–F79. If the term ‘learning disability’ or ‘intellectual disability’ is used within the medical record the coder must liaise with the responsible consultant to ensure the correct code assignment is made. This depends on whether the patient has a true mental retardation (deficiency or subnormality) being described as a ‘learning difficulty’ which would be captured at block F70-F79, or if the ‘learning disability’ is actually a scholastic disorder (F80 and F81).

Therefore, confirmation from the responsible consultant will always be required to ensure that codes from F70-F79 are appropriate for the individual patient.

If the responsible consultant confirms that the learning disability refers to specific problems with scholastic skills, ie problems with reading, spelling or arithmetic etc, there is a specific index trail which refers to specific problems with scholastic skills as shown below:

Disability
- learning F81.9

F81.9 Developmental disorder of scholastic skills, unspecified.

This diagnosis can be further specified by the assignment of one of the other codes from ICD-10 categories F80 or F81 with the fourth character dependant on which skill is affected.

The term scholastic skills must not be confused with impairment of skills manifested during the development period (F70-F79) which, as stated above, can also be referred to as learning disability.
Mental and behavioural disorders

Categories F70–F73 are classified in order of increasing mental impairment/retardation (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. If the level of behavioural impairment has not been stated by the responsible consultant, the coder must default to .9 Without mention of impairment of behaviour.

Example:

Significant behavioural impairment with IQ of 25

📖 Index trail for IQ:

   IQ
   - 20-34 F72.-

Tabular List entry:

<table>
<thead>
<tr>
<th>F72</th>
<th>Severe mental retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The level of impairment of behaviour is identified with a fourth character of .1</td>
</tr>
</tbody>
</table>

If a patient is described as having more than one level of impairment (retardation), eg mild to moderate, code to the most severe degree which in this scenario would be moderate.

The coder must assign an additional code to identify any associated conditions such as autism, other developmental disorders, epilepsy, conduct disorders or severe physical handicap.
Disorders of psychological development
(F80–F89)

If a patient exhibits dysfunctions which meet the criteria for two or more of the disorders coded at categories F80, F81 and F82.X, then a code from category F83 Mixed specific developmental disorders must be used instead.

Example:

Developmental dyslexia and developmental dyspraxia

Index trail for dyslexia:
Dyslexia R48.0
- developmental F81.0

Tabular List entry:
F81.0 Specific reading disorder

Index trail for dyspraxia:
Dyspraxia R27.8
- developmental (syndrome) F82

Tabular List entry:
F82.X Specific developmental disorder of motor function
F83.X Mixed specific developmental disorders

Rationale: As this patient has conditions classified to categories F81. and F82.X then code F83.X must be assigned.

Category F84 Pervasive developmental disorders includes Autism and Rett’s syndrome. An additional code must be assigned to identify any associated medical condition or learning disabilities/mental retardation.
Example:

Rett’s syndrome with IQ of 20

Index trail for Rett's syndrome:

- Rett's disease or syndrome F84.2

Tabular List entry:

- F84.2 Rett's syndrome

Use additional code to identify any associated medical condition and mental retardation

Index trail for IQ:

- IQ
- 20-34 F72.

Tabular List entry:

- F72 Severe mental retardation

(There is no mention of behavioural impairment, therefore the fourth character must be .9)

Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98)

Behavioural disorders occurring in childhood and adolescence are grouped together in this block. It is only when the behaviour or anxiety becomes persistent and extreme that these disorders would be diagnosed. Conditions classified within this block can persist into adulthood.

Exclusion notes at categories F91 and F93 explain that combined conduct and emotional disorders should be coded to F92 Mixed disorders of conduct and emotions. They must not be coded individually.

Mental disorder, not otherwise specified (F99)

Category F99.X must only be used when more specific information is not available.
**Patient transfer in / out of mental health unit**

When a patient is being transferred in or out of a unit, the coder must 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.

**Example:**

**Transfer from acute Trust to mental health Trust -**

Deliberate drug overdose of paracetamol and alcohol treated at acute unit - transferred to psychiatric unit for treatment of acute depression.

- **Index trail:**
  
  **Depression** F32.9
  - acute F32.9

- **Tabular list entry:**
  
  **F32.9 Depressive episode, unspecified**

- **Index trail:**
  
  **History (personal) (of)**
  - self-harm Z91.5

- **Tabular list entry:**
  
  **Z91.5 Personal history of self-harm**

**Rationale:** The patient is not being treated for the overdose, as this was treated at the acute unit, but it is important to record that the patient has a history of self-harm. The condition being treated at the mental health unit is acute depression. In the acute unit the primary diagnosis would be the overdose and the depression would be recorded as a secondary diagnosis.
Example:

Imminent transfer from mental health Trust to acute Trust -
Treated at psychiatric unit for acute depression, slashed wrist with scissors – to be transferred to acute unit for further treatment of injury. (Suicide attempt)

📖 Index trail:

**Depression**
- acute F32.9

Tabular list entry:

**F32.9  Depressive episode, unspecified**

📖 Index trail:

**Cut (external)** – see also wound, open

**Wound, open (animal bite) (cut) (laceration) (puncture wound) (shot wound)**
- wrist S61.9

Tabular list entry:

**S61.9  Open wound of wrist and hand part, part unspecified**

📖 Index trail (from External causes of injury index):

**Suicide, suicidal (attempted) (by)**
- cutting or piercing instrument X78.-

Tabular index:

**X78  Intentional self-harm by sharp object**

[See at the beginning of this chapter for the classification of the place of occurrence]

.2 School, other institution and public administrative area

**Rationale:** The patient is about to be transferred to the acute unit for treatment of a cut wrist, therefore the main condition treated at the psychiatric unit is acute depression. At the acute unit the primary diagnosis is the open wound of the wrist as this is the main condition being treated, here the acute depression is recorded as a secondary code.
**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. The medical record for holiday relief patients must always be accessed to determine whether the episode has been purely for holiday relief, or has involved care for their chronic condition or some other condition. The detailed guidance for coding holiday relief care can be found within Chapter XXI Factors influencing health status and contact with health services.
Inflammatory diseases of the central nervous system (G00–G09)

This block covers conditions where nerve tissue is attacked by various organisms. Meningitis is classified in G00–G03.

Other bacterial meningitis (G00.8)
Code G00.8 requires the assignment of an additional code to identify the infectious organism.

**Example:**

**Escherichia coli (E. coli) meningitis**

- Index trail for meningitis:
  - Meningitis (basal) (cerebral) (spinal) G03.9
    - Escherichia coli (E. coli) G00.8

Tabular List entry:

**G00.8 Other bacterial meningitis**

Meningitis due to:
- *Escherichia coli*
- Friedländer bacillus
- *Klebsiella*

- Index trail for E coli infection:
  - Infection, infected (opportunistic) B99
    - Escherichia (E.) coli NEC A49.8
    - - as cause of disease classified elsewhere B96.2

Tabular List entry:

**B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters**

**Rationale:** Although there is no ‘Use additional code…’ note at category G00, an additional code is required to specifically identify *Escherichia coli* as being the infectious organism, as this is not identified in the code title, but only as one of several inclusions at G00.8.
Sequelae of inflammatory diseases of central nervous system (G09)

The term ‘sequelae’ identifies a condition that is no longer present, but is causing a current problem which the patient is undergoing treatment or investigations for. Other terms associated with sequelae codes include ‘late effect’, ‘residual of’ and ‘due to old’. A sequelae code must never be used on its own. It must always be assigned secondary to the code for the current condition, as in the following examples.

**Example:**
Mild obstructive hydrocephalus – residual of intracranial abscess

Index trail for **hydrocephalus**:

- Hydrocephalus (acquired) (external) (internal) (malignant) (recurrent) G91.9
  - obstructive G91.1

Tabular List entry:

- G91.1 Obstructive hydrocephalus

Index trail for **residual intracranial abscess**:

- Sequelae (of) – see also condition
  - abscess, intracranial or intraspinal (conditions in G06.-) G09

Tabular List entry:

- G09.X Sequelae of inflammatory diseases of central nervous system

If the example above had stated ‘mild obstructive hydrocephalus – residual of tuberculous intracranial abscess’, then the sequelae code would not have been **G09.X Sequelae of inflammatory diseases of central nervous system**, but **B90.0 Sequelae of central nervous system tuberculosis** instead.

This is because when originally present, tuberculous intracranial abscess would have been coded using codes **A17.8† and G07.X**. The note at **G09.X** explains that the sequelae of categories **G01**, **G02**, **G05** and **G07** must not be assigned to **G09.X**, but to the categories outlining the sequelae of the underlying condition (infection) from the range **B90-B94**. The Alphabatical Index gives the appropriate reference.
Example:

Mild obstructive hydrocephalus – residual of tuberculous intracranial abscess

📖 Index trail for hydrocephalus:
Hydrocephalus (acquired) (external) (internal) (malignant) (recurrent) G91.9
- obstructive G91.1

Tabular List entry:
G91.1 Obstructive hydrocephalus

📖 Index trail for residual intracranial abscess:
Sequelae (of) – see also condition
- tuberculosis B90.9
- - central nervous system B90.0

Tabular List entry:
B90.0 Sequelae of central nervous system tuberculosis

Systemic atrophies primarily affecting the central nervous system (G10–G13)

Hereditary ataxia (G11)
There are different subcategories at G11 depending on whether cerebellar ataxia is of early-onset (G11.1), ie onset before the age of 20, or late-onset (G11.2), ie onset after the age of 20.
Extrapyramidal and movement disorders (G20–G26)

Parkinson’s disease is coded at categories G20-G22*.

Secondary parkinsonism (G21)
Category G21 contains several ‘Use additional external cause code…’ notes which must be followed wherever the additional information is available.

Example:

**Parkinsonism due to tricyclic antidepressants**

- Index trail for **drug-induced parkinsonism**:
  - Parkinsonism (idiopathic) (primary) G20
    - due to drugs NEC G21.1
  or
  - Parkinsonism (idiopathic) (primary) G20
    - secondary G21.9
    - - due to
      - - - drugs NEC G21.1

  Tabular List entry:
  - G21.1 **Other drug-induced secondary parkinsonism**
    Use additional external cause code (Chapter XX) to identify drug

- Index trail **Table of drugs and chemicals**:
  - Adverse effect in therapeutic use
  - Antidepressant NEC Y49.2
    - tricyclic or tetracyclic Y49.0

  Tabular List entry:
  - Y49.0 **Tricyclic and tetracyclic antidepressants**
Other degenerative diseases of the nervous system (G30–G32)

Alzheimer's disease (G30)
Alzheimer's disease, a progressive form of neuronal degeneration in the brain, is classified at G30. The age of onset of Alzheimer's disease determines the code selected:

- **Early onset**: usually before 65, also known as Type 2 = G30.0
- **Late onset**: usually after 65, also known as Type 1 = G30.1

When a diagnosis of dementia in Alzheimer’s disease is given, a dagger must be applied to a code from category G30 Alzheimer’s disease to identify this as the underlying disease causing the manifestation of dementia; which is coded at F00* Dementia in Alzheimer's disease.

Although G30 is not marked as a dagger category in the Tabular List, instructions to use it as such are given at category F00* Dementia in Alzheimer's disease in the Tabular List.

---

**Example:**

Dementia in late onset Alzheimer’s disease

Index trail for dementia:
Dementia (persisting) F03
- in (due to)
  - - Alzheimer’s disease G30.9† F00.9*
  - - - with onset
  - - - - late G30.1† F00.1*

Tabular List entries:

- G30.1† Alzheimer’s disease with late onset
- F00.1* Dementia in Alzheimer’s disease with late onset (G30.1†)

**Rationale:** The responsible consultant must confirm a link between the Alzheimer’s disease and the dementia. As the responsible consultant has not specified whether the dementia or the Alzheimer's is the primary focus of care, the dagger/asterisk default must be used.
Episodic and paroxysmal disorders (G40–G47)

Epilepsy is the paroxysmal disturbance of electrical activity in the brain. Coders must always check the medical record carefully when provided with a diagnosis of epilepsy G40, as there are many different types.

Epileptic patients are often on long-term medication to control their condition. Epilepsy is an important co-morbidity, particularly in patients admitted for surgery, and must therefore always be recorded as it will always affect the management of the patient.

Example:

Grand mal epilepsy

Index trail for epilepsy:
Epilepsy, epileptic, epilepsy G40.9
- grand mal (seizures) G40.6

Tabular List entry:
G40.6 Grand mal seizures, unspecified (with or without petit mal)

Status epilepticus (G41)

G41 Status epilepticus is a state which may sometimes develop in epileptic patients, either in an exceptionally prolonged single attack or, more often, as a consequence of repeated attacks, occurring so frequently that the patient does not recover between them. This code must only be assigned if the responsible consultant confirms the patient is in status epilepticus.

Example:

Grand mal status epilepticus

Index trail for status epilepticus:
Status (post)
- epilepticus G41.9
- - grand mal G41.0

Tabular List entry:
G41.0 Grand mal status epilepticus
Tonic-clonic status epilepticus

If a patient sustains any type of injury during an epileptic fit and is admitted to hospital for treatment of the injury, such as a head injury due to a fall sustained during an epileptic fit, then the injury must be sequenced in primary position. The appropriate external cause code would also be assigned, followed by the relevant epilepsy code.
Amaurosis fugax (G45.3)
Amaurosis fugax is a temporary loss of vision in one eye due to insufficient flow of blood to the eye. Only one code is required to code this condition which is (G45.3), therefore there is no need to add an extra code for loss of vision.

Sleep disorders (G47)
Sleep disorders are coded at category G47. Codes from this category can be assigned to patients admitted for sleep studies if they are diagnosed with a sleep disorder, eg G47.3 Sleep apnoea.

If a diagnosis is not confirmed, symptom codes must be assigned instead, for example: R06.5 Mouth breathing includes: snoring.
Diseases of the nervous system

Nerve, nerve root and plexus disorders (G50–G59)

The term **plexus** refers to an interlacing network of nerves.

The **Excludes Note** at the start of this block in the Tabular List states that a current injury to a nerve must be classified under the relevant body region. There are many references to the musculoskeletal system.

The primary axis of classification for these categories is the specific nerve, which can sometimes be seen written as a Roman numeral in the medical record, but is printed in full (either by name or number) in the Alphabetic Index.

**Example:**

**VII nerve palsy**

- Index trail for **palsy**:
  - Palsy (see also Paralysis) G83.9
  - seventh nerve (see also Palsy, facial) G51.0

- Tabular List entry:
  - G51.0 **Bell's palsy**
  - Facial palsy

There are exclusions at category **G52 Disorders of other cranial nerves** in the Tabular List. Certain disorders of the cranial nerves are classified in other chapters because of the result of the disorder.

**Example:**

**Right VI nerve palsy**

- Index trail for **palsy**:
  - Palsy (see also Paralysis) G83.9

  - Paralysis, paralytic (complete) (incomplete) (see also Paresis)
    - G83.9
    - nerve see also Disorder, nerve
    - - sixth or abducent H49.2

- Tabular List entry:
  - H49.2 **Sixth [abducent] nerve palsy**

**Rationale:** As paralysis of the sixth cranial nerve results in strabismus (a squinting of the eye), this condition is classified to Chapter VII Diseases of the eye and adnexa instead of Chapter VI.
POLYNEUROPATHIES AND OTHER DISORDERS OF THE PERIPHERAL NERVOUS SYSTEM (G60–G64)

POEMS SYNDROME (C90.0† and G63.1*)
POEMS syndrome has the features of polyneuropathy, endocrinopathy, monoclonal gamopathy, skin changes and myeloma, and has been classified as a polyneuropathy with a myeloma. The correct codes are:

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

Coders must always verify that the patient has all the features of this syndrome before assigning codes. The dagger and asterisk sequence applies.
Cerebral palsy and other paralytic syndromes (G80–G83)

Hemiplegia (G81)
The most frequent of the acquired paralytic syndromes is hemiplegia at G81. All other paralytic syndromes are coded at G82.

Coders must pay attention to the notes appearing at categories G81-G83, which state that these codes must only be assigned in primary position if their cause is not recorded. These codes may be used as optional additional codes for use in multiple coding to identify these conditions resulting from any cause.

There is sometimes confusion as to whether hemiplegia should be recorded in conjunction with a diagnosis of stroke.

The standard is that signs and symptoms do not require recording in addition to a definitive diagnosis unless they are felt to be an important problem in medical care.

On emergency admissions for strokes, it is of paramount importance to make sure that the stroke itself is recorded as the primary diagnosis. The Alphabetical Index implies this.

Example:

Patient admitted with cerebral thrombosis causing an infarction and hemiplegia

Index trail for cerebral thrombosis:
Thrombosis, thrombotic (multiple) (progressive) (septic) (vein) (vessel) I82.9
- cerebral (artery) (see also Occlusion, artery, cerebral) I66.9

Occlusion, occluded
- artery – see also Embolism, artery
  - cerebral I66.9
  - - with infarction (due to) I63.5
  - - - thrombosis I63.3

or

Index trail for hemiplegia:
Hemiplegia G81.9
- thrombotic (current episode) I63.3

Tabular List entry:
I63.3 Cerebral infarction due to thrombosis of cerebral arteries

Rationale: Coders must use the essential modifier of ‘with infarction’ as strokes are either due to infarction or haemorrhage.
There are some instances where patients are admitted to an acute bed with a stroke and cannot be transferred elsewhere for a variety of reasons. If the hemiplegia then becomes a chronic condition, which is being treated, it is perfectly legitimate to add a code from category **G81 Hemiplegia** as an additional code to the stroke code.

On further admissions it may be appropriate to record the hemiplegia as a sequelae of the stroke. Just as with signs and symptoms, every patient episode has to be looked at individually.

**Example:**

Flaccid hemiplegia as a result of a cerebral infarction five years ago

- Index trail for **flaccid hemiplegia**:
  - Hemiplegia G81.9
  - flaccid G81.0

- Tabular List entry:
  - **G81.0 Flaccid hemiplegia**

- Index trail for **sequelae**:
  - Sequelae (of) – see also condition
    - infarction, cerebral I69.3

- Tabular List entry:
  - **I69.3 Sequelae of cerebral infarction**
Other disorders of the nervous system (G90-G99)

The correct codes for the condition persistent vegetative state (PVS) are:

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

Postviral fatigue syndrome (G93.3)

G93.3 Postviral fatigue syndrome is more commonly known as ME (myalgic encephalitis). A further alternative term is ‘chronic fatigue syndrome’. Coders be cautious when given the description of ‘fatigue syndrome’ as a diagnosis and seek clarification from the responsible consultant as to whether it is ‘chronic fatigue syndrome’ or ‘fatigue syndrome’. Fatigue syndrome takes the coder to code F48.0 from Chapter V Mental and behavioural disorders.

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

Postprocedural disorders of nervous system, not elsewhere classified are coded at category G97. These disorders occur either as a consequence of specific procedures, or as the result of the absence of an organ.

Codes from this category must only be assigned if specifically directed here by the Alphabetic Index. A link to the procedure must be documented by the responsible consultant.
Disorders of sclera, cornea, iris and ciliary body (H15–H22)

Corneal pigmentation and deposits (H18.0)
An additional external cause code (Chapter XX) must be used to identify the drug, if drug-induced, and the drug is known.

**Example:**
Haematocornea due to long term effect of Diazepam

- Index trail for haematocornea:
  - Hematocornea H18.0

  Tabular List entry:
  - H18.0 Corneal pigmentation and deposits
    - Haematocornea
    - Use additional external cause code (Chapter XX) to identify drug, if drug-induced.

- Index trail for table of drugs and chemicals:
  - Adverse effect in therapeutic use
  - Diazepam Y47.1

  Tabular List entry:
  - Y47.1 Benzodiazepines
Disorders of lens
(H25–H28)

A cataract develops when the crystalline lens of the eye, or its capsule, becomes partially or completely opaque.

Cataracts are either congenital (coded to Chapter XVII) or acquired in life. There are several types of cataracts, for example infantile, juvenile, senile and diabetic.

If the responsible consultant does not qualify the type of cataract the patient has, the coder must default to **H26.9 Cataract, unspecified**.

**Senile cataract (H25)**
The term senile cataract, also referred to as age-related cataract, must be specified by the responsible consultant before the code for senile cataract can be assigned. In the absence of this specification in the medical record, code **H26.9 Cataract, unspecified**, must be assigned.

**Example:**
Immature senile cataract (described as such by responsible consultant). Patient is 74 years old.

📖 Index trail for cataract:
Cataract (cortical) (immature) (incipient) (see also Cataracta)
H26.9
- senile H25.9

Tabular List entry:
**H25.9 Senile cataract, unspecified**
Drug-induced cataract (H26.3)
An additional external cause code (Chapter XX) must be used to identify the drug, if drug-induced, and the drug is known.

Example:

Cataract due to long-term effect of Diazepam

Index trail for cataract:

Cataract (cortical) (immature) (incipient) (see also Cataracta)
H26.9
- drug-induced H26.3

Tabular List entry:

H26.3 Drug-induced cataract
Use additional external cause code (Chapter XX) to identify drug.

Index trail from Table of Drugs and Chemicals:

Adverse effect
in therapeutic use
Diazepam Y47.1

Tabular List entry:

Y47.1 Benzodiazepines

Posterior capsule opacification (sometimes called after-cataract) may develop in some patients following cataract surgery. Over time the part of the lens capsule holding the prosthetic lens in place can thicken, resulting in symptoms similar to those found in cataracts. The appropriate code for a diagnosis of posterior capsule opacification is H26.4 After-cataract.

Mature cataract is a term used to describe an advanced cataract or white cataract, both of which must be coded to H26.9 Cataract, unspecified.
Cataract and other disorders of lens in diseases classified elsewhere (H28*)

When diagnoses of cataract and diabetes are made in the same consultant episode, the responsible consultant must state a link before a dagger and asterisk code combination can be used.

**Example:**

Patient admitted for treatment of their diabetic cataract, the patient has type 1 insulin-dependent diabetes mellitus. Patient also has hypertension.

- Index trail for cataract:
  - Cataract (cortical) (immature) (incipient) *(see also Cataracta)*
  - H26.9
  - diabetic *(see also E10–E14 with fourth character .3)* E14.3†
  - H28.0*

Tabular List entries:

- **H28.0** Diabetic cataract *(E10 – E14† with common fourth character .3)*
- **E10** Insulin-dependent diabetes mellitus
  [See before E10 for subdivisions]
  - .3† with ophthalmic complications
    Diabetic:
    - cataract *(H28.0*)

- Index trail for hypertension:
  - Hypertension, hypertensive (accelerated) (benign) (essential)
    (idiopathic) (malignant) (primary) (systemic) I10

Tabular List entry:

- **I10.X** Essential (primary) hypertension

**Rationale:** In the above example the responsible consultant stated a link between the diabetes and the cataract; therefore the dagger and asterisk system can be applied. As the manifestation of the disease is the primary focus of care the asterisk code is sequenced in the primary position.

Had the responsible consultant made a diagnosis of cataract, hypertension, and Type 1 diabetes mellitus (IDDM) a link between the cataract and IDDM could not be assumed, and each diagnosis would be coded separately without the dagger and asterisk linkage so it would be coded to **H26.9, I10.X** and **E10.9**.
Disorders of choroid and retina
(H30–H36)

A retinal detachment is the separation of the retina, or part of it, from the choroids which are the vascular coat of the eyeball. It can occur with or without a retinal break.

Examples:

Horseshoe tear of retina without detachment

Index trail for tear of retina:

- Tear, torn (traumatic) – see also Wound, open
- retina, retinal (horseshoe) (without detachment) H33.3

Tabular List entry:

H33.3 Retinal breaks without detachment
Horseshoe tear of retina, without detachment

Retinal detachment, right eye

Index trail for retinal detachment:

- Detachment
  - retina (without retinal break) H33.2

Tabular List entry:

H33.2 Serous retinal detachment
Retinal detachment:
  - NOS
Glaucoma (H40–H42)

Glaucoma is the accumulation of fluid in the anterior chamber of the eyeball, causing an increase in intraocular pressure.

Glaucoma secondary to drugs (H40.6)

An additional external cause code (Chapter XX) must be used to identify the drug, if drug induced, and the drug is known.

Example:

Glaucoma secondary to corticosteroid eyedrops

<table>
<thead>
<tr>
<th>Index trail for glaucoma:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma H40.9</td>
</tr>
<tr>
<td>- corticosteroid-induced H40.6</td>
</tr>
</tbody>
</table>

Tabular List entry:

H40.6 Glaucoma secondary to drugs

Use additional external cause code (Chapter XX) to identify drug

<table>
<thead>
<tr>
<th>Index trail from table of drugs and chemicals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effect in therapeutic use</td>
</tr>
<tr>
<td>Corticosteroid - ophthalmic Y56.5</td>
</tr>
</tbody>
</table>

Tabular List entry:

Y56.5 Ophthalmological drugs and preparations

Glaucoma can be caused by an underlying disease. If so, a code from category H42* Glaucoma in diseases classified elsewhere must be used and the dagger and asterisk system will apply.
Disorders of vitreous body and globe (H43–H45)

An intraocular foreign body in the globe is coded dependent upon whether it is magnetic, such as metal like iron, nickel, or steel, or less commonly non-magnetic, eg wood, stone, plastic. It is a serious condition that can result in permanent visual damage.

Example:
Retained intraocular steel splinter

- Index trail:
  - Retention, retained
    - foreign body – see also Foreign body, retained
  - Foreign body
    - retained (nonmagnetic) (old) (in)
    - - intraocular H44.7
    - - - magnetic H44.6

- Tabular List entry:
  - H44.6 Retained (old) intraocular foreign body, magnetic
Disorders of optic nerve and visual pathways (H46–H48)

The optic nerve is the second cranial nerve, and disorders are coded depending on whether they are caused by an underlying disease or not.

**Example:**

Retrobulbar neuritis in multiple sclerosis

- Index trail for **neuritis**:
  - **Neuritis** M79.2
  - - retrobulbar H46
  - - in (due to)
  - - - multiple sclerosis G35† H48.1*

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

**Rationale:** Although **G35.X** is not a dagger code, it becomes one in this example as it is the underlying disease causing the retrobulbar neuritis. The dagger and asterisk system will therefore apply.
Disorders of ocular muscles, binocular movement, accommodation and refraction (H49–H52)

Much of this block is for the coding of strabismus. A strabismus (squint) is an abnormality resulting from a lack of coordination of the orbital muscles. This results in the visual axes of the two eyeballs, which are normally parallel, either converging or diverging.

**Example:**

<table>
<thead>
<tr>
<th>Vertical strabismus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail:</td>
</tr>
<tr>
<td>Strabismus (alternating) (congenital) (nonparalytic) H50.9</td>
</tr>
<tr>
<td>- vertical H50.2</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>H50.2  Vertical strabismus</td>
</tr>
</tbody>
</table>

The term binocular at category H51 Other disorders of binocular movement relates to both eyes.
Visual disturbances and blindness  
(H53–H54)

Category H54 Visual impairment including blindness (binocular or monocular) contains a table defining the severity of visual impairment.

This table is NOT for coders to diagnose levels of visual impairment in patients. If no detailed information is provided by the responsible consultant then code H54.9 should be used.

Where a patient is documented as being ‘registered blind’ with no further detail regarding the level of visual impairment this must be coded to either:

- H54.0 Blindness, binocular, if unspecified or stated of both eyes, or
- H54.4 Blindness, monocular if stated to be of one eye only.

However, if the level of visual impairment is known, such as H54.5 Severe visual impairment, monocular, this would be coded in preference to H54.0 or H54.4.

Example: Severe visual impairment in one eye (monocular)

<table>
<thead>
<tr>
<th>Index trail:</th>
<th>Tabular entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired, impairment (function)</td>
<td>H54.5 Severe visual impairment, monocular</td>
</tr>
<tr>
<td>- visual</td>
<td></td>
</tr>
<tr>
<td>- - monocular</td>
<td></td>
</tr>
<tr>
<td>- - - severe H54.5</td>
<td></td>
</tr>
</tbody>
</table>

When the cause of the visual impairment or blindness is known, both conditions must be coded (with the exception of G45.3 Amaurosis fugax where only this code is required).

The cause for the visual impairment or blindness is recorded as the primary diagnosis, with a code from category H54 assigned in addition.
Example:

Patient with active trachoma and moderate visual impairment in both eyes

Index trail:
- Trachoma, trachomatous A71.9
  - active (stage) A71.1

Tabular entry:
- A71.1 Active stage of trachoma

Index trail:
- Impaired, impairment (function)
  - visual
  - - binocular
  - - - moderate H54.2

Tabular entry:
- H54.2 Moderate visual impairment, binocular

Other disorders of eye and adnexa (H55-H59)

Post enucleation socket syndrome (PESS) is a complication of surgery to remove the eyeball and is coded to **H59.8 Other postprocedural disorders of eye and adnexa** plus code **Y83.6 Removal of other organ (partial) (total)**.

Sunken Socket Syndrome is also classified to **H59.8 Other postprocedural disorders of eye and adnexa**. A code from category **Y83** or **Y84** must be assigned in addition when the responsible consultant has documented the original procedure that caused the syndrome.
Coding Standards

Diseases of external ear
(H60–H62)

Otitis externa (H60)
Otitis externa is inflammation/infection of the external ear and is coded to category H60.

Malignant otitis externa does not mean a malignant neoplasm of the external ear, but a rapidly progressive condition, which is much more serious than the usual form of the disease.

Example:

Malignant otitis externa

Index trail for malignant otitis externa:

- Otitis H66.9
  - externa H60.9
  - - malignant H60.2

Tabular List entry:

H60.2 Malignant otitis externa

A dagger code must be selected when using asterisk category H62* Diseases of external ear in diseases classified elsewhere. Sequencing will depend on which disease is the primary focus of care. This is in line with the primary diagnosis definition. In instances where the responsible consultant has not specified or is unable to confirm which condition is the main condition being treated, the coder must use the dagger/asterisk default.
Example: Otitis externa in herpes simplex. The otitis externa is the main condition treated

Index trail for **otitis externa**:

- **Otitis** H66.9
- - externa H60.9
- - in (due to)
- - - herpes (simplex) virus infection B00.1† H62.1*

Tabular List entries:

- **H62.1*** Otitis externa in viral diseases classified elsewhere
- **B00.1†** Herpesviral vesicular dermatitis

Rationale: The dagger and asterisk sequence has been reversed in the above example as it has been confirmed that the manifestation (otitis externa) is the main condition treated. Although **B00.1** is not shown as a dagger code in the Tabular List, the Alphabetical Index directs the coder to use it as a dagger code.
Diseases of middle ear and mastoid
(H65-H75)

Otitis media is inflammation/infection of the middle ear, and is coded to categories H65 and H66. Otitis media is classified at category H65 when it is non-suppurative, and at category H66 when it is suppurative or unspecified.

Clinicians often use abbreviations for different types of otitis media, so the coder must therefore be certain of the meaning of each abbreviation for the correct diagnostic code to be chosen.

Listed below are the two common abbreviations, and the differing codes that can be allocated:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meanings</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSOM</td>
<td>chronic secretory otitis media,</td>
<td>(H65.3)</td>
</tr>
<tr>
<td></td>
<td>chronic seromucinous otitis media</td>
<td>(H65.4)</td>
</tr>
<tr>
<td></td>
<td>chronic serous otitis media</td>
<td>(H65.2)</td>
</tr>
<tr>
<td></td>
<td>chronic suppurative otitis media</td>
<td>(H66.3)</td>
</tr>
<tr>
<td>SOM</td>
<td>secretory otitis media</td>
<td>(H65.9)</td>
</tr>
<tr>
<td></td>
<td>seromucinous otitis media</td>
<td>(H65.9)</td>
</tr>
<tr>
<td></td>
<td>serous otitis media</td>
<td>(H65.9)</td>
</tr>
<tr>
<td></td>
<td>suppurative otitis media</td>
<td>(H66.4)</td>
</tr>
</tbody>
</table>

**Example:**

CSOM. Responsible consultant has confirmed that the diagnosis is chronic suppurative otitis media.

Index trail for chronic suppurative otitis media:

- Otitis H66.9
  - media H66.9
  - chronic H66.9
  - secretory H65.3
  - seromucinous H65.4
  - serous H65.2
  - suppurative H66.3

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H66.3</td>
<td>Other chronic suppurative otitis media</td>
</tr>
</tbody>
</table>
Perforation of the tympanic membrane (H72)

Perforation of the tympanic membrane (ear drum) must be coded to the site of the perforation, if known, and must be shown in addition to the code for otitis media (H65, H66) when both are present.

**Example:**

<table>
<thead>
<tr>
<th>Chronic suppurative tubotympanic otitis media with central perforation</th>
</tr>
</thead>
</table>

- Index trail for **chronic suppurative otitis media**:
  - **Otitis** H66.9
  - - media H66.9
  - - chronic H66.9
  - - - suppurative H66.3
  - - - - tubotympanic H66.1

- Tabular List entry:
  - **H66.1 Chronic tubotympanic suppurative otitis media**

The note at category level instructs the coder to use an additional code to identify presence of perforated tympanic membrane (H72.-).

- Index trail for **site of perforation**:
  - **Perforation, perforated (nontraumatic)**
  - - tympanum (membrane) (persistent post-traumatic) (postinflammatory) H72.9
  - - central H72.0

- Tabular List entry:
  - **H72.0 Central perforation of tympanic membrane**
Diseases of inner ear
(H80–H83)

Ménière's disease is coded to H81.0. Additional codes for vertigo, tinnitus, or progressive deafness are not required as these are all symptoms of the disease.

Otitis interna is inflammation/infection of the inner ear or labyrinth, coded to H83.0. This is also known as labyrinthitis.

Cholesteatoma can be found in the external ear as well as the middle ear and postmastoidectomy cavity. The coder must ensure they assign the code which identifies the correct part of the ear.

**Example:**

Cholesteatoma tympani

📚 Index trail:

Cholesteatoma (ear) (middle) (mastoid) (with reaction) H71
- tympani H71

Tabular List entry:

H71.X  Cholesteatoma of middle ear
       Cholesteatoma tympani
Other disorders of ear
(H90–H95)

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.

When hearing loss is described as severe or profound by the responsible consultant, this must always be coded using a code from categories **H90** or **H91** depending on the type of hearing loss documented eg profound sensorineural hearing loss, bilateral.

When the cause of severe or profound hearing loss is known both conditions must be coded eg severe hearing loss in Ménière's disease.

**Conductive and sensorineural hearing loss (H90)**

Hearing loss is classified at category **H90 Conductive and sensorineural hearing loss** and includes the two main types: conductive hearing loss and sensorineural hearing loss.

Codes in category **H90** are very detailed as they allow the recording of conductive hearing loss alone, sensorineural hearing loss alone, or a combination of both. The fourth character assignment identifies the laterality.

When conductive and sensorineural deafness occur together, just one code is required (**H90.6–H90.8**).

**Example:**

Right conductive and sensorineural deafness – normal hearing left side

Index trail:

- Deafness (acquired) (complete) (hereditary) (partial) H91.9
- - conductive H90.2
- - and sensorineural, mixed H90.8
- - - bilateral H90.6
- - - unilateral (unrestricted hearing other side) H90.7

Tabular List entry:

**H90.7** Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side
Ototoxic hearing loss (H91.0)

Deafness may also be due to drugs which cause damage to the cochlea and/or the vestibular part of the inner ear. This is coded to H91.0 and an additional code from Chapter XX must be shown to identify the drug when this information is known.

Example: Deafness due to Streptomycin

Index trail:
- Deafness (acquired) (complete) (hereditary) (partial)
- due to toxic agents H91.0

Tabular List entry:
H91.0 Ototoxic hearing loss
Use additional external cause code (Chapter XX) to identify toxic agent

Index trail for drug in Table of drugs and chemicals:
- Adverse effect in therapeutic use

Streptomycin (derivative) Y40.5

Tabular List entry:
Y40.5 Aminoglycosides
Streptomycin
Hypertensive diseases
(I10–I15)

Hypertension is a persistently raised blood pressure.

The following hypertensive disorders are not included within these categories:

- complicating pregnancy, childbirth or the puerperium (O10–O11), (O13–O16)
- when involving coronary vessels (I20–I25)
- neonatal hypertension (P29.2)
- pulmonary hypertension (I27.0)
- when involving cerebral vessels (I60–I69).

Hypertension must be recorded in any secondary position when associated with any ischaemic heart condition classifiable to categories I20–I25 or any cerebrovascular disease classifiable to categories I60–I69.

The non-essential modifier of ‘malignant’ hypertension does not refer to cancer, but to a rapidly progressive form of the condition.

Essential (primary) hypertension (I10)

This category is used when the patient is diagnosed as hypertensive and therefore treated for the condition. It is not to 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.

Hypertensive heart disease (I11)

This category must only be used when the responsible consultant clearly states a link between the hypertension and the heart disease by using such modifying terms as ‘hypertensive’ or ‘due to hypertension’. Coders cannot assume a cause and effect relationship between these conditions. If there is no link stated the conditions must be coded separately.

The fourth character identifies whether the hypertensive heart disease is with or without (congestive) heart failure.
Example: Congestive cardiac failure and hypertension

Index trail for failure:
Failure, failed
- heart (acute) (sudden) (senile) I50.9
- - congestive I50.0

Tabular List entry:
I50.0 Congestive heart failure

Index trail for hypertension:
Hypertension, hypertensive (accelerated) I10

Tabular List entry:
I10.X Essential (primary) hypertension
High blood pressure
Hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
Excludes: involving vessels of:
- brain (I60-I69)
- eye (H35.0)

Rationale: As the clinical statement does not state a link between these two conditions, they must be coded separately.

Example: Hypertensive congestive cardiac failure

Index trail for hypertension:
Hypertension, hypertensive (accelerated) I10
- heart (disease) (conditions in I51.4-I51.9 due to hypertension) I11.9
- - with
- - - heart failure (congestive) I11.0

Tabular List entry:
I11.0 Hypertensive heart disease with (congestive) heart failure
Hypertensive heart failure

Rationale: Category I11 Hypertensive heart disease is assigned, as the clinical statement indicates a link to hypertension.
Hypertensive renal disease (I12)

There is an important includes note which states that this category must be used when coding any renal condition classifiable to categories N00-N07, N18, N19 or N26 that is due to hypertension. The responsible consultant must clearly state a link between the hypertension and the renal disease by using such modifying terms as 'hypertensive' or 'due to hypertension'. Coders cannot assume a cause and effect relationship between these conditions. If there is no link stated, the conditions must be coded separately. This category specifically excludes secondary hypertension (I15).

When a condition in category N18 Chronic kidney disease is due to hypertension, a code from N18 must be used followed by a code from category I12 in order to identify both the stage of the chronic kidney disease and that it is due to hypertension.

The fourth characters used at category I12 identify whether the hypertensive renal disease is with or without renal failure.

Example:

Hypertensive kidney failure

Index trail for failure:

Failure, failed
- kidney N19
- - hypertensive (see also Hypertension, kidney) I12.0

Tabular List entry:

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

Rationale: The diagnosis of ‘hypertensive' kidney failure signifies that the kidney failure is due to hypertension, so code I12.0 must be assigned. Had the diagnosis been kidney failure and hypertension both conditions would have been coded separately, ie N19.X Unspecified kidney failure and I10.X Essential (primary) hypertension.
Diseases of the circulatory system

Example: Stage 1 chronic kidney disease due to malignant hypertension

- Index trail for disease:
  Disease, diseased – see also Syndrome
  - kidney (functional) (pelvis) N28.9
  - chronic N18.9
  - - - stage 1 N18.1

- Tabular List entry:
  N18.1 Chronic kidney disease, stage 1

- Index trail for hypertension:
  Hypertension, hypertensive (accelerated) I10
  - with
  - - kidney involvement (see also Hypertension, kidney) I12.9

- Tabular List entry:
  I12.9 Hypertensive renal disease without renal failure
  Hypertensive renal disease NOS

Rationale: As the clinical statement identifies that the kidney disease is due to hypertension, I12.9 must be assigned following N18.1. When a code from N18 is due to hypertension, a code from N18 must be assigned followed by a code from I12. If the chronic kidney disease is not stated as being due to hypertension, I10.X would be assigned instead of a code from category I12.

Hypertensive heart and renal disease (I13)
This category must be assigned to describe hypertensive disorders affecting both heart and kidneys, ie any condition in I11 Hypertensive heart disease together with any condition in I12 Hypertensive renal disease.

The fourth character identifies whether (congestive) heart failure and/or renal failure is present.
**Example:**

<table>
<thead>
<tr>
<th>Hypertensive kidney failure with hypertensive congestive cardiac failure</th>
</tr>
</thead>
</table>

**Index trail for failure:**
- **Failure, failed**
  - renal – see Failure, kidney

**Failure, failed**
- kidney N19
- - with
- - - hypertensive
- - - - heart disease (conditions in I11) I13.1
- - - - - with heart failure (congestive) I13.2

**Tabular List entry:**

| I13.2 | Hypertensive heart and renal disease with both (congestive) heart failure and renal failure |

**Rationale:** As hypertensive congestive cardiac failure would normally be coded to I11.0, and renal failure due to hypertension would be coded to I12.0, a code from category I13 Hypertensive heart and renal disease must be used.
When a patient has hypertensive heart and renal disease, and the renal disease is a condition within category **N18 Chronic kidney disease**, the code from category **N18** must be assigned to identify the stage of the chronic kidney disease. This is followed by a code from category **I13** to identify that it is due to hypertension and that the patient also has hypertensive heart disease.

**Example:**

Hypertensive chronic kidney disease stage 2 with hypertensive congestive cardiac failure

Index trail for disease:

- Disease, diseased – see also Syndrome
  - kidney (functional) (pelvis) N28.9
  - chronic N18.9
  - - stage 2 N18.2

Tabular List entry:

**N18.2 Chronic kidney disease, stage 2**

Index trail for failure:

- Failure, failed
  - cardiac (see also Failure, heart) I50.9

- Failure, failed
  - heart (acute) (sudden) I50.9
  - - congestive
  - - - hypertensive (see also Hypertension, heart) I11.0
  - - - - with renal disease I13.0

Tabular List entry:

**I13.0 Hypertensive heart and renal disease with (congestive) heart failure**
Ischaemic heart diseases (I20–I25)

Ischaemic heart disease is most commonly documented in the medical record as IHD.

Angina pectoris (I20)  
The diagnosis ‘Acute coronary syndrome’ is frequently used by clinicians. Without further qualification the code I20.0 Unstable angina must be assigned for this diagnosis. Coders must ensure that their consultants are aware that this is how ‘Acute coronary syndrome’ will be classified in England.

Code I20.8 Other forms of angina pectoris is the correct code to record ‘Cardiac syndrome X’.

Acute myocardial infarction (I21)  
The coding of myocardial infarction is explained in detail here and summarised diagrammatically following this section.

Category I21 Acute myocardial infarction has a time reference of four weeks (28 days) attached to it, which refers to the interval elapsing between the onset of the ischaemic episode and admission to hospital. It is important that this time reference be observed by coders to ensure consistency in recording acute myocardial infarctions.

The fourth characters identify the site of the infarction. If the infarction occurs through a wall, the modifier of ‘transmural’ (trans = across, mural = wall) should be referenced. The term ‘subendocardial’ implies that the dead cells involve only up to two-thirds of the left ventricular wall.

A code from category I21 Acute myocardial infarction must be assigned every time a patient has an acute myocardial infarction (MI). The exceptions are when the responsible consultant documents that the MI is an extension to an existing MI, or a reinfarction of any myocardial site occurring within four weeks (28 days) from onset of a previous infarction in which case a code from category I22 Subsequent myocardial infarction must be used.

It is permissible to assign a code from category I21 to multiple consultant episodes within a hospital provider spell, also to those patients receiving ongoing treatment for an MI at multiple hospital providers and to patients readmitted within four weeks (28 days) of an MI for ongoing treatment of the original MI. A patient may therefore have the code I21 assigned multiple times during their lifetime.
Example:

Consultant episode 1 – Patient admitted to acute admissions ward and diagnosed with acute transmural anterior myocardial infarction. They have no previous cardiac history.

Consultant episode 2 – They are transferred to CCU for continuing treatment and are discharged home five days later.

Consultant episode 1:

Index trail for infarction:
Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - transmural I21.3
- - - anterior (wall) (anteroapical) (anterolateral) (anteroseptal) I21.0

Tabular List entry:
I21.0 Acute transmural myocardial infarction of anterior wall

Consultant episode 2:

Index trail for infarction:
Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - transmural I21.3
- - - anterior (wall) (anteroapical) (anterolateral) (anteroseptal) I21.0

Tabular List entry:
I21.0 Acute transmural myocardial infarction of anterior wall

Rationale: In the above example code I21.0 Acute transmural myocardial infarction of anterior wall must be assigned on both consultant episodes.

STEMI and NSTEMI (I21.9)
Myocardial infarction is classified by the extent of the damage caused to the heart muscle, i.e. either transmural, non-transmural or unspecified.

The terms STEMI (ST-segment-elevation myocardial infarction) and NSTEMI (Non-ST-segment-elevation myocardial infarction) are regularly documented within the medical record to describe myocardial infarctions.

However, as these terms do not indicate the extent of damage to the heart muscle, further clarification must be obtained from the responsible consultant whenever these terms are used.

If the extent of the damage remains unknown and the only diagnosis is ‘STEMI’ or ‘NSTEMI’, code I21.9 Acute myocardial infarction, unspecified must be assigned.
Example: Patient admitted with chest pains is diagnosed with NSTEMI. Further clarification from the responsible consultant confirms that the patient suffered a subendocardial myocardial infarction.

Index trail for infarction: 
Infarct, infarction (of) 
- subendocardial (acute) (nontransmural) I21.4

Tabular List entry: I21.4 Acute subendocardial myocardial infarction

Rationale: In this instance the responsible consultant has confirmed the extent of damage to the heart muscle. If the only information provided was ‘NSTEMI’ without further qualification the code I21.9 Acute myocardial infarction, unspecified would have been assigned.

Subsequent myocardial infarction (I22)
Category I22 Subsequent myocardial infarction must only be used to classify any subsequent/further acute myocardial infarction, regardless of site, occurring within four weeks (28 days) from onset of a previous infarction. It also includes an extension to an existing MI, recurrent MI and reinfarction. 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 (refer to earlier descriptions of these terms).

If the 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 used. If an acute MI is diagnosed after four weeks (28 days) following a previous MI, a code from category I21 Acute myocardial infarction must be used again.

The fourth characters used with codes within category I22 Subsequent myocardial infarction identify the site of the infarction.
**Example:**
Patient diagnosed with an acute transmural myocardial infarction of anterior wall.

Index trail for **infarction**:
- **Infarct, infarction (of)**
  - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
  - transmural I21.3
  - anterior (wall) (anteroapical) (anterolateral) (anteroseptal) I21.0

Tabular List entry:
- **I21.0** Acute transmural myocardial infarction of anterior wall

**Example:**
The patient is readmitted with an acute transmural myocardial infarction of the inferior wall two weeks after the previous acute transmural myocardial infarction of the anterior wall.

Index trail for **infarction**:
- **Infarct, infarction (of)**
  - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
  - subsequent (extension) (recurrent) (reinfarction) I22.9
  - inferior (wall) I22.1

Tabular List entry:
- **I22.1** Subsequent myocardial infarction of inferior wall

**Rationale:** The patient has been readmitted with another MI to a *different* myocardial site within four weeks (28 days) of the previous MI.

**Example:**
The patient is diagnosed with another acute transmural myocardial infarction of the inferior wall six months after the previous acute transmural myocardial infarction of the inferior wall.

Index trail for **infarction**:
- **Infarct, infarction (of)**
  - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
  - transmural I21.3
  - inferior (wall) (diaphragmatic) (inferolateral) (inferoposterior) I21.1

Tabular List entry:
- **I21.1** Acute transmural myocardial infarction of inferior wall
Example (cont):

Index trail for **myocardial infarction**:

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - healed or old I25.2

or

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - past (diagnosed on ECG or other special investigation, but currently presenting no symptoms) I25.2

Tabular List entry:

**I25.2 Old myocardial infarction**

**Rationale:** This further acute MI of the inferior wall occurred over four weeks (28 days) after the initial acute MI of the inferior wall. Code **I25.2 Old myocardial infarction** must be assigned in addition to identify the previous MI which occurred six months ago.

**Myocardial infarction transfers between hospital providers (I21, I22)**

It is a common occurrence for a patient who has suffered a myocardial infarction to be either transferred to another hospital within the same Trust, or to be discharged to another Trust for rehabilitation (or further treatment) of their acute myocardial infarction.

If the patient is discharged from the first Trust, this will end the first hospital provider spell and the admission to the second Trust will generate a new hospital provider spell. It is permissible to assign a code from category **I21** when the patient is receiving ongoing treatment for an MI at multiple hospital providers (Trusts).

**Example:**

Consultant episode 1 - A patient with severe chest pain is admitted to hospital under the care of Dr Brown who makes a diagnosis of acute MI.

Consultant episode 2 - The patient is transferred to the care of Dr Black (a consultant cardiologist), thereby generating a second consultant episode within one hospital provider spell.

Consultant episode 1:

Index trail for **infarction**:

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
### Example (cont):

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
<th>I21.9 Acute myocardial infarction, unspecified</th>
</tr>
</thead>
</table>

**Consultant episode 2:**

- Index trail for **infarction**:
  - Infarct, infarction (of)
    - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
<th>I21.9 Acute myocardial infarction, unspecified</th>
</tr>
</thead>
</table>

**Rationale:** As the two episodes have both occurred within the same hospital provider spell and involved ongoing treatment of the same MI, both consultant episodes would be coded to **I21.9 Acute myocardial infarction, unspecified**.

### Example:

**Hospital provider spell 1** - A patient is admitted to Trust A with an acute MI. The patient has coronary artery disease (CAD).

**Hospital provider spell 2** - They are transferred to Trust B where angioplasty and stent of only the most severely atherosclerotic coronary arteries is performed.

**Hospital provider spell 3** - The patient is discharged from Trust B the day after the procedure and readmitted directly to Trust A for cardiac rehabilitation primarily for the acute MI.

**Hospital provider spell 1:**

- Index trail for **infarction**:
  - Infarct, infarction (of)
    - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
<th>I21.9 Acute myocardial infarction, unspecified</th>
</tr>
</thead>
</table>

- Index trail for **disease**:
  - Disease, diseased – see also Syndrome – artery I77.9
  - - coronary I25.1

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
<th>I25.1 Atherosclerotic heart disease</th>
</tr>
</thead>
</table>
Example (cont):

Hospital provider spell 2:

Index trail for disease:
Disease, diseased – see also Syndrome
- artery I77.9
- coronary I25.1

Tabular List entry:
I25.1 Atherosclerotic heart disease

Index trail for infarction:
Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

Tabular List entry:
I21.9 Acute myocardial infarction, unspecified

Hospital provider spell 3:

Index trail for infarction:
Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

Tabular List entry:
I21.9 Acute myocardial infarction, unspecified

Index trail for disease:
Disease, diseased – see also Syndrome
- artery I77.9
- coronary I25.1

Tabular List entry:
I25.1 Atherosclerotic heart disease

Index trail for rehabilitation:
Rehabilitation Z50.9
- cardiac Z50.0

Tabular List entry:
Z50.0 Cardiac rehabilitation

Index trail for presence of angioplasty and graft:
Presence (of)
- coronary artery graft or prosthesis Z95.5

Tabular List entry:
Z95.5 Presence of coronary angioplasty implant and graft
Rationale: The correct codes for the first hospital provider spell (Trust A) are **I21.9 Acute myocardial infarction, unspecified** and **I25.1 Atherosclerotic heart disease**. The correct codes for the second hospital provider spell (Trust B) are **I25.1 Atherosclerotic heart disease** and **I21.9 Acute myocardial infarction, unspecified** as the patient was admitted solely for reparative surgery for the coronary artery disease.

The correct codes for the third hospital provider spell (Trust A) are **I21.9 Acute myocardial infarction, unspecified**, **I25.1 Atherosclerotic heart disease**, **Z50.0 Cardiac rehabilitation** and **Z95.5 Presence of coronary angioplasty implant and graft** as the patient received cardiac rehabilitation for the acute MI but the coronary artery disease remains an ongoing condition.

If the patient had undergone all treatment at the same Trust, the acute MI must be recorded as the primary diagnosis followed by the coronary artery disease as the MI is considered more clinically significant.

**Example:**

Hospital provider spell 1 - A patient is admitted to Trust A with an MI whilst on holiday.

Hospital provider spell 2 - Four days after admission the patient is discharged from Trust A and is admitted directly to Trust B closer to home for cardiac rehabilitation. Two days after admission they suffer another acute MI.

**Hospital provider spell 1:**

- Index trail for **infarction**:
  - Infarct, infarction (of)
    - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

  Tabular List entry:
  
  **I21.9 Acute myocardial infarction, unspecified**

**Hospital provider spell 2:**

- Index trail for **infarction**:
  - Infarct, infarction (of)
    - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
    - - subsequent (extension) (recurrent) (reinfarction) I22.9

  Tabular List entry:
  
  **I22.9 Subsequent myocardial infarction of unspecified site**
Example (cont):

Index trail for infarction:
- Infarct, infarction (of)
  - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

Tabular List entry:
I21.9  Acute myocardial infarction, unspecified

Index trail for rehabilitation:
- Rehabilitation Z50.9
  - cardiac Z50.0

Tabular List entry:
Z50.0  Cardiac rehabilitation

Rationale: The correct code for the first hospital provider spell (Trust A) is I21.9 as this patient has suffered an acute MI. The correct codes for the second hospital provider spell (Trust B) are I22.9 Subsequent myocardial infarction of unspecified site, I21.9 Acute myocardial infarction, unspecified and Z50.0 Cardiac rehabilitation. As the MI that occurred in the second hospital provider spell is a separate MI to the one suffered during the first spell, it is appropriate to assign code I22.9 Subsequent myocardial infarction of unspecified site to indicate a reinfarction occurring within four weeks (28 days) from onset of a previous infarction. The subsequent MI is recorded as the main condition in this second hospital provider spell.

To summarise: If a patient has another subsequent MI in the same consultant episode, or any consultant episode within the same or a different hospital provider spell, and this occurs within four weeks (28 days) from onset of the previous infarction, the code I22 Subsequent myocardial infarction will be assigned for each subsequent MI.
Certain current complications following acute myocardial infarction (I23)

This category identifies certain current complications that must be coded when they occur following an acute myocardial infarction, whereas current complications which occur concurrently with (i.e. at the same time as) the myocardial infarction must be coded to I21–I22 as directed by the Excludes note at category I23.

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.

Concurrent 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 as the complication would still be current.

Example:

Acute transmural anterior wall myocardial infarction concurrent with atrial septal defect

Index trail for defect:
- Defect, defective
  - septal (heart) NEC Q21.9
  - atrial
    - concurrent with acute myocardial infarction – see Infarct, myocardium

Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- transmural I21.3
- anterior (wall) (anteroapical) (anterolateral) (anterosseptal) I21.0

Tabular List entry:
I21.0 Acute transmural myocardial infarction of anterior wall

Rationale: The category exclusion note at I23 Certain current complications following acute myocardial infarction instructs the coder to only assign the code for the MI as this encompasses both the MI and complication when they occur at the same time.
Example: New admission for atrial septal defect following anterior wall myocardial infarction 10 days previously

Index trail for defect:
- Defect, defective
  - septal (heart) NEC Q21.9
  - atrial
  - following acute myocardial infarction (current complication) I23.1

Tabular List entry:
I23.1 Atrial septal defect as current complication following acute myocardial infarction

Rationale: Only a code from I23 Certain current complications following acute myocardial infarction is required, as the complication has occurred following an MI. Had the atrial septal defect occurred following the MI but in the same consultant episode, the codes would be I21.0 Acute transmural myocardial infarction of anterior wall or I22.0 Subsequent myocardial infarction of anterior wall followed by I23.1 Atrial septal defect as current complication following acute myocardial infarction.

Other acute ischaemic heart diseases (I24)
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 is assigned in a secondary position. This code is indexed in the ICD-10 Alphabetical index under the lead term ‘Disease’ and the essential modifiers of ‘heart’, ‘ischaemic’ and ‘acute or with a stated duration of four weeks (28 days) or less’.

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

Index trail for pain:
- Pain(s)
  - chest R07.4

Tabular List entry:
R07.4 Chest pain, unspecified

Index trail for acute ischaemic heart disease:
- Disease, diseased – see also Syndrome
  - heart (organic) I51.9
  - ischemic (chronic…) I25.9
  - acute or with a stated duration of 4 weeks or less I24.9

Tabular List entry:
I24.9 Acute ischaemic heart disease, unspecified
Rationale: As the chest pain is the main condition investigated, code **R07.4 Chest pain, unspecified** is assigned as the primary diagnosis. As the patient had an acute MI 3 weeks ago, code **I24.9 Acute ischaemic heart disease, unspecified** is assigned in a secondary position because the admission has occurred within the four week (28 day) period after the acute MI.

**Chronic ischaemic heart disease (I25)**

The most common cause of ischaemic heart disease (IHD) is coronary atherosclerosis.

Code **I25.1 Atherosclerotic heart disease** classifies coronary atherosclerosis/arteriosclerotic heart disease which is the underlying cause of a variety of manifestations, including angina pectoris, and are commonly the reason why patients are admitted to hospital.

In these cases the atherosclerosis would be coded in a secondary position, as is appropriate where a patient is being treated primarily for the manifestation of an underlying disorder. However, if the patient is admitted solely for reparative surgery or investigation for the atherosclerosis this would then be recorded in the primary position.

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 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’
  
  and

- the patient is not being treated for the old myocardial infarction.

In cases where the responsible consultant has stated that the patient has ischaemic heart disease that is not acute, this must be coded using either code **I25.9 Chronic ischaemic heart disease, unspecified** or **I25.8 Other forms of chronic ischaemic heart disease** if specifically directed to this code by the ICD-10 Alphabetical Index.
Example:

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

Index trail for ulcer:

Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- esophagus (peptic) K22.1

Tabular List entry:

K22.1 Ulcer of oesophagus

Index trail for ischaemic heart disease:

Disease, diseased – see also Syndrome
- heart (organic) I51.9
- - ischemic (chronic or with a stated duration of over 4 weeks) I25.9

Tabular List entry:

I25.9 Chronic ischaemic heart disease, unspecified

Index trail for myocardial infarction:

Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - healed or old I25.2
or

Infarct, infarction (of)
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - past (diagnosed on ECG or other special investigation, but currently presenting no symptoms) I25.2

Tabular List entry:

I25.2 Old myocardial infarction

Rationale: As this patient has an unspecified IHD, code I25.9 Chronic ischaemic heart disease, unspecified is assigned. As they have also previously had an MI, code I25.2 Old myocardial infarction is assigned in addition.

Summary:

- Patients with an old MI (i.e. over four weeks (28 days) ago or the time the MI occurred has not been stated by the responsible consultant and they are not receiving treatment for the MI) are assigned code I25.2

- Patients with ischaemic heart disease (not acute) are assigned code I25.9 (or code I25.8 if specifically directed by the Alphabetical Index)
Patients with ischaemic heart disease (not acute) and an old MI (over four weeks (28 days) ago or the time the MI occurred has not been stated and they are not receiving treatment for the MI) are assigned codes I25.2 and I25.9 (or code I25.8 if specifically directed by the Alphabetical Index). When neither condition is identified as the primary diagnosis there are no sequencing rules to apply, the codes can appear in any order, provided that both codes are present and recorded in a secondary position.

It is frequently documented in the medical record that patients have both angina (I20) and 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.

**Example:**

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.

- **Index trail for infarction:**
  - **Infarct, infarction (of)**
    - myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9

  Tabular List entry:
  - I21.9 Acute myocardial infarction, unspecified

- **Index trail for arteriosclerosis:**
  - **Arteriosclerosis, arteriosclerotic (diffuse) (disease) (general) (obliterans) (senile) (with calcification)** I70.9
  - coronary (artery) I25.1

  Tabular List entry:
  - I25.1 Atherosclerotic heart disease

- **Index trail for angina:**
  - **Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor)** I20.9

  Tabular List entry:
  - I20.9 Angina pectoris, unspecified

- **Index trail for ischaemic heart disease:**
  - **Disease, diseased– see also Syndrome**
    - heart (organic) I51.9
    - - ischemic (chronic or with a stated duration of over 4 weeks) I25.9
**Example (cont):**

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
<th>I25.9</th>
<th>Chronic ischaemic heart disease, unspecified</th>
</tr>
</thead>
</table>

📖 Index trail for *myocardial infarction*:

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - healed or old I25.2

or

**Infarct, infarction (of)**
- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - past (diagnosed on ECG or other special investigation, but currently presenting no symptoms) I25.2

Tabular List entry:

| I25.2  | Old myocardial infarction |
Diseases of the circulatory system

Acute MI

Subsequent/extension of/further/recurrent/reinfarction of any myocardial site within four weeks (28 days) of previous MI

Chronic or readmitted after 4 weeks (28 days) of MI for ongoing treatment of the MI

Re admitted within 4 weeks (28 days) of MI

Condition being treated plus I24.9 in a secondary position

MI with other forms of IHD

Atherosclerosis

Admitted solely for reparative surgery or investigation

I25.1 as primary code and MI code in addition

Treated during same hospital provider spell as MI

Code for MI plus I25.1 in a secondary position

As a comorbidity/not treated

Code for MI plus I25.1 in a secondary position

Ischaemic heart disease (not acute)

I25.9 (or I25.8 if specifically directed by the Index) in a secondary position

Old, past, previous, personal history of MI

- MI not being treated, and
- occurred more than 4 weeks (28 days) ago or time not stated

I25.2 in a secondary position

MI with other forms of IHD

Admitted solely for reparative surgery or investigation

I25.1 as primary code and MI code in addition

Treated during same hospital provider spell as MI

Code for MI plus I25.1 in a secondary position

As a comorbidity/not treated

Code for MI plus I25.1 in a secondary position

Ischaemic heart disease (not acute)

I25.9 (or I25.8 if specifically directed by the Index) in a secondary position

Old, past, previous, personal history of MI

- MI not being treated, and
- occurred more than 4 weeks (28 days) ago or time not stated

I25.2 in a secondary position

MI with other forms of IHD

Admitted solely for reparative surgery or investigation

I25.1 as primary code and MI code in addition

Treated during same hospital provider spell as MI

Code for MI plus I25.1 in a secondary position

As a comorbidity/not treated

Code for MI plus I25.1 in a secondary position

Ischaemic heart disease (not acute)

I25.9 (or I25.8 if specifically directed by the Index) in a secondary position

Old, past, previous, personal history of MI

- MI not being treated, and
- occurred more than 4 weeks (28 days) ago or time not stated

I25.2 in a secondary position
Other forms of heart disease (I30-I52)

Cardiomyopathy (I42–I43)
Cardiomyopathy is where the myocardium (heart muscle) undergoes atrophy (wasting away), and is often due to alcoholism or drugs. If so, an external cause code is added.

Conduction disorders (I44–I45)
Conduction disorders consist of interference with the heart’s contraction, causing disturbances in transmission of impulses. Common types featured in the medical record include first degree atrioventricular block (I44.0), left bundle branch block (LBBB) (I44.7), right bundle branch block (RBBB) (I45.1) and long QT syndrome (I45.8).

The common underlying reasons why conduction disorders occur include the presence of IHD, degeneration in the heart, and myocardial fibrosis following repeated infarctions. It is important that these conditions are also coded when present.

Cardiac arrest (I46)
Code I46.0 Cardiac arrest with successful resuscitation must be assigned to all patients who have a cardiac arrest and are resuscitated, regardless of the underlying cause of the arrest.

Any patient who survives a cardiac arrest must have received resuscitation, so all patients who live through an arrest are coded with 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 with the exception of any sudden cardiac death due to conditions specifically documented as exclusions at this code, ie 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.

Cardiac arrhythmias (I47–I49)
Cardiac arrhythmia is the contracting of the heart muscle in a disorderly sequence. Common forms of cardiac arrhythmia seen in the medical record include ventricular tachycardia (VT) (I47.2), atrial fibrillation (AF) (I48.X), ventricular fibrillation and flutter (VF) (I49.0) and Brugada syndrome (I49.8).

The common underlying reasons why cardiac arrhythmias occur include the presence of IHD, degeneration in the heart and myocardial fibrosis following repeated infarctions. It is important that these conditions are also coded when present and known.
Heart failure (I50)
Cardiac failure occurs when the heart can no longer contract with sufficient force to maintain a normal stroke volume. It is clinically identified according to the ventricle primarily affected, ie left ventricular failure at **I50.1** or right ventricular failure at **I50.0** (CCF).

If both congestive cardiac failure (**I50.0**) and left ventricular failure (**I50.1**) are documented in the medical record, then it is only necessary to code CCF, as **I50.0** includes both right and left ventricular failure.

If a diagnosis of LVF is made together with mention of pulmonary oedema, only the code for LVF (**I50.1**) is assigned as this code includes pulmonary oedema.

### Example:

**Left ventricular failure with pulmonary oedema**

- **Index trail for** failure:
  - Failure, failed
    - ventricular (*see also* Failure, heart) I50.9
    - - left I50.1

- **Tabular List entry:**
  - **I50.1** Left ventricular failure
    - Oedema of lung
    - Pulmonary oedema
    - Cardiac asthma
    - Left heart failure

- **Edema, edematous**
  - pulmonary – *see* Edema, lung

- **Edema, edematous**
  - lung (acute) J81
  - - with heart condition or failure (*see also* Failure, ventricular, left)
    - I50.1

- **Tabular List entry:**
  - **I50.1** Left ventricular failure
    - Cardiac asthma
    - Left heart failure
    - Oedema of lung
    - Pulmonary oedema

**Rationale:** Where pulmonary oedema occurs together with other types of heart failure or heart disease, the code **I50.1 Left ventricular failure** must be used.
Heart failure resulting in pulmonary oedema occurs in acute rheumatic fever (I00-I01), chronic rheumatic heart disease (I05-I09), hypertensive disease (I10-I15), 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) and other heart conditions (I51-I52).

In these instances, if pulmonary oedema is mentioned among the diagnoses by the responsible consultant, then it is appropriate to use code I50.1 Left ventricular failure instead of code J81.X Pulmonary oedema. The code classifying the specific heart condition must also be assigned.

**Example:**

Patient has atrial fibrillation (an arrhythmia) with pulmonary oedema.

- Index trail for fibrillation:
  - Fibrillation
  - atrial or auricular (established) I48

  Tabular List entry:
  - I48.X Atrial fibrillation and flutter

- Index trail for oedema:
  - Edema, edematous R60.9
  - pulmonary – see Edema, lung

  Tabular List entry:
  - J81.X Pulmonary oedema

  *Excludes:* pulmonary oedema:
  - With mention of heart disease NOS or heart failure (I50.1)

  Tabular List entry:
  - I50.1 Left ventricular failure

  Cardiac asthma
  Left heart failure
  Oedema of lung
  Pulmonary oedema

Conditions not usually associated with heart failure and pulmonary oedema are rheumatic chorea (I02), pulmonary heart disease (I26-I28), pericarditis (I30-I32), tricuspid valve disorders (I36) and pulmonary valve disorders (I37).
In these instances, if pulmonary oedema is mentioned, it must be coded to **J81.X Pulmonary oedema**. The code classifying the specific heart condition must also be coded.

**Example:**

<table>
<thead>
<tr>
<th>Patient with acute pericarditis and pulmonary oedema</th>
</tr>
</thead>
<tbody>
<tr>
<td>📑 Index trail for <strong>pericarditis:</strong></td>
</tr>
<tr>
<td>Pericarditis (with decompensation) (with effusion) I31.9</td>
</tr>
<tr>
<td>- acute (nonrheumatic) I30.9</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>I30.9</td>
</tr>
<tr>
<td>📑 Index trail for <strong>oedema:</strong></td>
</tr>
<tr>
<td>Edema, edematous R60.9</td>
</tr>
<tr>
<td>- pulmonary – see Edema, lung</td>
</tr>
<tr>
<td>Edema, edematous R60.9</td>
</tr>
<tr>
<td>- lung J81</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>J81.X</td>
</tr>
</tbody>
</table>

However the code **I11.0 Hypertensive heart disease with (congestive) heart failure** and category **I13 Hypertensive heart and renal disease** are exceptions. When recording code **I11.0**, or a code from **I13**, together with pulmonary oedema, only the **I11.0** or **I13** code will be assigned. For example, hypertensive heart and renal disease with pulmonary oedema would simply be coded to **I13.9 Hypertensive heart and renal disease, unspecified**.
Cerebrovascular diseases
(I60–I69)

The term ‘cerebrovascular disease’ refers to a number of disorders affecting the vascular system of the brain. These types of disorders may be due to haemorrhage, thrombosis or occlusion of the cerebral and/or precerebral arteries.

The code I64.X *Stroke, not specified as haemorrhage or infarction* includes the term ‘cerebrovascular accident’ (CVA). This is a very vague term, as a CVA can only ever be either an infarction or a haemorrhage. The coder must always endeavour to obtain the results of a CT scan report of the brain (or similar report) which should confirm the cause of the stroke - though coders **must not** attempt to interpret such data in the absence of a diagnosis from the responsible consultant. This will enable the assignment of a more accurate and relevant code, ie *always code the cause of a stroke, when known*.

**Examples:**

**Acute cerebrovascular accident**

- Index trail for accident:
  - Accident
  - - cerebrovascular I64

- Tabular List entry:
  - I64.X *Stroke, not specified as haemorrhage or infarction (CVA)*
  - Cerebrovascular accident NOS

**Acute cerebrovascular accident (responsible consultant verifies that the CT scan of brain has identified an acute cerebral thrombosis)**

- Index trail for thrombosis:
  - Thrombosis, thrombotic (multiple) (progressive)… I82.9
  - - cerebral (artery) (see also Occlusion, artery, cerebral) I66.9

  - Occlusion, occluded
    - - artery – see also Embolism, artery
      - - - cerebral I66.9
      - - - - with infarction (due to) I63.5
      - - - - - thrombosis I63.3

  - Tabular List entry:
    - I63.3 *Cerebral infarction due to thrombosis of cerebral arteries*
Hemiplegia and strokes

On emergency admissions for strokes, it is of paramount importance that the coder assigns the code for stroke in the primary position. Hemiplegia must not be coded while the stroke is in the acute phase.

Example:

Left hemiplegia on admission. CT scan reveals a cerebral infarction (verified by the responsible consultant)


Hemiplegia must not be coded while the stroke is in the acute phase.

Example:

Left hemiplegia on admission. CT scan reveals a cerebral infarction (verified by the responsible consultant)

- Index trail for infarction:
  - Infarct, infarction (of)
  - cerebral (hemorrhagic) I63.9

- Tabular List entry:
  - I63.9 Cerebral infarction, unspecified

However, if the hemiplegia then becomes a chronic condition, which is being treated in its own right (usually in long stay patients), it is perfectly legitimate to add a code from category G81 Hemiplegia as an additional code to the stroke code.

On further admissions it may be appropriate to record the hemiplegia as a sequela (late effect) of a stroke. This will be covered later in this chapter.

Other conditions occurring as a result of a stroke, such as dysphagia and dysphasia, must be treated in the same way.

Intracranial haemorrhage (I60–I62)

This is most commonly the result of trauma, hypertension, or the rupture of an aneurysm. Only non-traumatic intracranial haemorrhages are coded here. Traumatic brain haemorrhages are coded to Chapter XIX Injury, Poisoning and Certain Other Consequences of External Causes, at codes S06.3–S06.8.

Code assignment is based upon the site of the haemorrhage whether subarachnoid, intracerebral, or other and unspecified haemorrhage site.

Various non-traumatic intracranial haemorrhages are classified to other chapters, eg intracranial haemorrhage of a newborn due to birth trauma is classified in code P10. Other fetal and neonatal intracranial haemorrhages are classified in category P52.

Also excluded from categories I60–I62 are intracranial haemorrhages complicating pregnancy, childbirth and the puerperium (O99.4). However, codes I60–I62 can be used as additional codes to identify the specific condition.
Cerebral infarction (I63)
The classification of cerebral infarction in ICD-10 is based on aetiology (ie underlying cause) rather than site, therefore if the cause is not documented it must not be assumed. When following the ICD-10 index trail, the coder must note that the terms ‘occlusion’ and ‘stenosis’ are both essential modifiers and must therefore be present in the clinical statement to enable the assignment of a more accurate code from category I63. In the absence of these essential modifiers, ICD-10 code I63.9 Cerebral infarction, unspecified must be assigned.

Oclusion and stenosis of the precerebral arteries not resulting in cerebral infarction (I65)
Occlusions can also be described as a narrowing, complete or partial obstruction, thrombosis or embolism.

Other cerebrovascular diseases (I67)
Code I67.2 Cerebral atherosclerosis must also be assigned when this condition co-exists with any condition in categories I63 or I66.

Code I67.8 Other specified cerebrovascular diseases includes cerebral ischaemia (chronic). As this is a very non-specific code, the coder must always code to the cause of the cerebral ischaemia if known.

Transient cerebral ischaemia (TIA) is classified in Chapter VI Nervous System at category G45.

Sequelae of cerebrovascular disease (I69)
The term 'sequelae' refers to a current condition that is the late effect of a condition which is no longer present. This category represents late effects of cerebrovascular diseases such as haemorrhages (I69.0–I69.2), infarction (I69.3) and unspecified strokes (I69.4). This category is not to be used for chronic cerebrovascular disease which must be coded to I60-I67 instead.

Sequelae codes must only be assigned in a secondary position.

Example:
Hemiplegia due to cerebral infarction one year ago

Index trail for current condition first:
Hemiplegia G81.9
Tabular List entry:
G81.9   Hemiplegia, unspecified

Index trail for sequelae code:
Sequelae (of) – see also condition
- infarction, cerebral I69.3
Tabular List entry:
I69.3   Sequelae of cerebral infarction
Diseases of arteries, arterioles and capillaries (I70–I79)

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.

Example:
Atherosclerosis with gangrene of extremities caused by diabetes (Type II). Patient admitted for bilateral femoral angioplasty.

Index trail:
Atherosclerosis – see Arteriosclerosis

Arteriosclerosis, arteriosclerotic (diffuse) (disease) (general) (obliterans) (senile) (with calcification) I70.9
- extremities I70.2

Tabular List entry:
I70.2 Atherosclerosis of arteries of extremities
(Fifth character 1 with gangrene)

Index trail:
Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- type II (nonobese) (obese) E11.-

Tabular List entry:
E11 Non-insulin-dependent diabetes mellitus
[See before E10 for subdivisions]
.5 With peripheral circulatory complications

Rationale: It is not necessary to assign code R02.X Gangrene, not elsewhere classified after code E11.5 in the above example because the gangrene has already been captured with the assignment of the fifth character ‘1’ at code I70.2. The sequencing of codes is dependent on the main condition treated or investigated during the consultant episode.

Aneurysms (I71–I72)
Aortic aneurysms at category I71 Aortic aneurysm and dissection are classified as to whether they are with or without rupture, for example:

I71.1 Thoracic aortic aneurysm, ruptured
I71.2 Thoracic aortic aneurysm, without mention of rupture
When coding an aneurysm of other sites at category **I72 Other aneurysm and dissection**, the term ‘*and*’ means ‘*and/or*’ in ICD-10.

For example, code **I72.0 Aneurysm and dissection of carotid artery** is used to classify any of the following:

- an aneurysm of the carotid artery
- or dissection of the carotid artery
- or both aneurysm and dissection of the carotid artery.

**Other peripheral vascular diseases (I73)**

Peripheral vascular disease (PVD) is also referred to as intermittent claudication or ischaemia of lower limbs. These are often symptoms of atheroma (cholesterol) or arteriosclerosis (hardening of the arteries).

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 Other peripheral vascular diseases**, ie code to the cause of the PVD if known. A code from category **I73** must only be assigned if the cause is unknown.

---

**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.

📖 Index trail for the cause of the PVD:

Occlusion, occluded
- artery – see also Embolism, artery

**Embolism (septic) I74.9**
- artery I74.9
  - - limb I74.4
  - - - lower I74.3

Tabular List entry:

**I74.3 Embolism and thrombosis of arteries of lower extremities**

**Rationale:** The arteriogram would be captured using a procedure code.
Diseases of the circulatory system

Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified (I80–I89)

Phlebitis and thrombophlebitis (I80)
One of the most common conditions coded within this category is a deep vein thrombosis (DVT) at I80.2.

Where the responsible consultant clearly states that the DVT is travel-related, it is important to add the external cause code of X51.- Travel and motion.

**Example:**

<table>
<thead>
<tr>
<th>Deep vein thrombosis (DVT) due to patient travelling home from Australia by plane three days ago</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

- **Index trail:**
  - Thrombosis, thrombotic (multiple) (progressive) (septic) (vein) (vessel) I82.9
  - deep I80.2

- **Tabular List entry:**
  - I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities
    - Deep vein thrombosis NOS

- **External Cause Index Trail:**
  - Travel (effects) (sickness) X51.-

- **Tabular List entry:**
  - X51 Travel and motion
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .9 Unspecified place

**Rationale:** The fourth character .9 Unspecified place is assigned if the exact place of occurrence cannot be identified.

When the responsible consultant documents within the medical record that the DVT was acquired in hospital, code Y95 Nosocomial condition must be assigned in addition.
Varicose veins of lower extremities (I83)

These are classified according to whether the condition is with or without the mention of ulcer and/or inflammation, for example:

- **I83.0** Varicose veins of lower extremities with ulcer
- **I83.2** Varicose veins of lower extremities with both ulcer and inflammation

Haemorrhoids (I84)

Haemorrhoids are varicose dilations of the veins of the lower part of the intestine and/or anal canal. They are more commonly referred to as ‘piles’ and are coded according to whether they are internal, external, residual or unspecified. On the whole, clinicians do not tend to provide the type, so most haemorrhoids are coded to ‘unspecified’.

If haemorrhoids are stated to be both internal and external, two codes must be assigned.

Oesophageal varices (I98.2* and I98.3*)

These are classified according to whether the condition is with or without bleeding, eg

- **I98.2*** Oesophageal varices without bleeding in diseases classified elsewhere
- **I98.3*** Oesophageal varices with bleeding in diseases classified elsewhere

The coder must also assign the appropriate dagger code. The dagger and asterisk system applies; so sequencing will depend on which disease is the primary focus of care. In instances where the responsible consultant has not specified, or is unable to confirm which condition is the main condition being treated, the coder must use the dagger/asterisk default.
Chapter rules and conventions

When a respiratory condition is described as occurring in more than one site and is not specifically indexed it must be classified to the lower anatomical site, eg tracheobronchitis to bronchitis at J40.X. See Note at Chapter level.
Diseases of the respiratory system

Coding standards

Acute upper respiratory infections (J00–J06)

Acute maxillary sinusitis (J01.0)
The axis is the site of the infection.

Example:

Acute maxillary sinusitis

Index trail for acute maxillary sinusitis:
Sinusitis (accessory) (chronic) (hyperplastic) (nasal)
(nonpurulent) (purulent) J32.9
- acute J01.9
- maxillary J01.0

Tabular List entry:

J01.0  Acute maxillary sinusitis
       Acute antritis

Acute tonsillitis, unspecified (J03)
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. Each presentation should be diagnosed and documented using the same criteria as for acute tonsillitis. Specific management of each episode will be determined by the suspected aetiology (viral or bacterial).

Example:

Patient with recurrent tonsillitis admitted for a tonsillectomy

Index trail for recurrent tonsillitis:
Tonsillitis (acute) (follicular) (gangrenous) (infective) (lingual)
(septic) (subacute) (ulcerative) J03.9

Tabular List entry:

J03.9  Acute tonsillitis, unspecified
       Tonsillitis (acute):
       • NOS
       • follicular
       • gangrenous
       • infective
       • ulcerative

Rationale: As there is no essential modifier for ‘recurrent’, the index trail for tonsillitis leads to J03.9 Acute tonsillitis, unspecified which includes tonsillitis (acute). The term ‘acute’ is shown as a non-essential modifier.
Whilst acute tonsillitis is sometimes a reason for emergency admission to hospital, chronic tonsillitis almost never is. Admissions to hospital for elective tonsillectomy are most commonly for recurrent acute tonsillitis.

**Example:**

Patient diagnosed with chronic tonsillitis

- Index trail for recurrent **tonsillitis**:
  - Tonsillitis (acute) (follicular) (gangrenous) (infective) (lingual) (septic) (subacute) (ulcerative) J03.9
  - chronic J35.0

- Tabular List entry:
  - **J35.0** Chronic tonsillitis

**Rationale:** The term chronic is an essential modifier and therefore must be present in the diagnostic statement to be able to assign code **J35.0**.
Codes from categories B95–B98 must be added to provide specific information about the causative organism, if known.

**Example:**

Streptococcal laryngitis

[INDEX TRAIL FOR LARYNGITIS:]

Laryngitis (acute) (edematous) (subglottic) (suppurative) (ulcerative) J04.0
- streptococcal J04.0

Tabular List entry:

J04.0 **Acute laryngitis**
Laryngitis (acute):
- NOS
- oedematous
- subglottic
- suppurative
- ulcerative

**Excludes:** chronic laryngitis (J37.0)
influenzal laryngitis, influenza virus:
- identified (J09,J10.1)
- not identified (J11.1)

**NOTE** **At category heading:** ‘Use additional code (B95–B98) to identify infectious agent’.

[INDEX TRAIL FOR INFECTIOUS AGENT:]

Infection, infected (opportunistic) B99
- streptococcal NEC A49.1
- - as cause of disease classified elsewhere B95.5

Tabular List entry:

B95.5 **Unspecified streptococcus as the cause of diseases classified to other chapters**

**Rationale:** The Alphabetic Index directs the coder to J04.0. However as the code title does not include 'streptococcal' the note at category heading instructs the coder to 'Use an additional code (B95-B98) to identify the infectious agent' therefore the code B95.5 must be assigned as well.

Supplementary or additional codes from U80-U89 are also provided for use where the antibiotic to which a bacterial agent is resistant has been clinically identified and documented in the medical record. These are purely related to bacterial agents, **NOT** viral, fungal or parasitic. These categories must never be used in primary coding and must be sequenced following the code for a bacterial infection classified elsewhere.
Influenza and pneumonia
(J09–J18)

The axes of classification for these categories are the manifestations of the influenza and the organisms causing the pneumonia.

Code J09.X classifies influenza due to identified avian influenza virus.

A code from category J10 Influenza due to other identified influenza virus can only be selected if a diagnosis of influenza is made and the influenza virus has been identified.

Influenza A (H1N1) [swine flu]
The appropriate code assignment for this disease, where no manifestations have been identified, is J10.1 Influenza with other respiratory manifestations, other influenza virus identified. If other specific manifestations of the influenza are identified, the whole of category J10 Influenza due to other identified influenza should be considered where appropriate.

A code from category J11 Influenza, virus not identified must be assigned if the diagnosis of influenza has been given but the influenza virus has not been identified.

Example:

**Pneumococcal pneumonia**

Index trail for pneumococcal pneumonia:

- Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9
- pneumococcal (broncho) (lobar) J13

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J13.X</td>
<td>Pneumonia due to Streptococcus pneumoniae</td>
</tr>
<tr>
<td></td>
<td>Bronchopneumonia due to <em>S. pneumoniae</em></td>
</tr>
<tr>
<td></td>
<td>Excludes: congenital pneumonia due to <em>S. pneumoniae</em> (P23.6)</td>
</tr>
<tr>
<td></td>
<td>pneumonia due to other streptococci (J15.3-J15.4)</td>
</tr>
</tbody>
</table>

Rationale: As the organism is mentioned in the title at code J13.X, it is not necessary to assign an additional code from the range B95-B98.
Example: Pneumonia in *Bordetella pertussis* whooping cough

- Index trail for pneumonia in whooping cough:
  Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9
  - in (due to)
  - whooping cough A37.-† J17.0*

Tabular List entries:
- **A37.0†** Whooping cough due to *Bordetella pertussis*
- **J17.0** Pneumonia in bacterial diseases classified elsewhere
  Pneumonia (due to)(in):
  - actinomycosis (A42.0†)
  - anthrax (A22.1†)
  - gonorrhoea (A54.8†)
  - nocardiosis (A43.0†)
  - salmonella infection (A02.2†)
  - tularaemia (A21.2†)
  - typhoid fever (A01.0†)
  - whooping cough (A37.-†)

**Rationale:** Although the dagger codes are shown at J17*, they do not always appear as dagger codes in the relevant chapter. This is because it is possible to have these other diseases without pneumonia as a manifestation. J17* itself is a category for asterisk codes. The dagger and asterisk system applies.

If a known chronic obstructive airways disease (COAD) or chronic obstructive pulmonary disease (COPD) patient is admitted with any type of pneumonia, certain sequencing rules must be observed. The type of pneumonia must be sequenced first, followed by the code **J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection**, as pneumonia is an acute lower respiratory infection.
Example: Pneumococcal pneumonia in a known chronic obstructive pulmonary disease (COPD) patient

Index trail for the type of pneumonia:
- Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9
- pneumococcal (broncho) (lobar) J13

Tabular List entry:
J13.X Pneumonia due to Streptococcus pneumoniae
Bronchopneumonia due to S. pneumoniae
Excludes: congenital pneumonia due to S. pneumoniae (P23.6)
- pneumonia due to other streptococci (J15.3-J15.4)

Index trail for the COPD:
- Disease, diseased - see also Syndrome
- - lung J98.4
- - - obstructive (chronic) J44.9
- - - - with
- - - - - lower respiratory infection (except influenza) J44.0

Tabular List entry:
J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
Excludes: with influenza (J09-J11)

Postoperative/postprocedural pneumonia must be coded as follows:

J18.9 Pneumonia, unspecified

Y83.- 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.

The World Health Organisation has instructed coders to delete the current Index entry for:

Pneumonia
- resulting from a procedure J95.8

The code Y95.X Nosocomial condition must be assigned as a supplementary code where a patient has a documented diagnosis of 'hospital acquired' pneumonia (HAP).
Diseases of the respiratory system

Other acute lower respiratory infections (J20–J22)

Bronchitis is coded to category J20 Acute bronchitis in patients under 15 years of age, and to category J40 Bronchitis, not specified as acute or chronic in those patients 15 years of age and above, as per the Includes and Excludes notes in the Tabular List.

Acute bronchitis can be coded according to the causative organism, if known. This is identified at fourth character level.

Example:

<table>
<thead>
<tr>
<th>Acute bronchitis due to rhinovirus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for acute bronchitis due to rhinovirus:</td>
</tr>
<tr>
<td>Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous) (with tracheitis) (15 years of age and above)</td>
</tr>
<tr>
<td>- acute or subacute (with bronchospasm or obstruction)</td>
</tr>
<tr>
<td>- - due to</td>
</tr>
<tr>
<td>- - - rhinovirus</td>
</tr>
</tbody>
</table>

Tabular List entry:

J20.6 Acute bronchitis due to rhinovirus

Viral-associated wheeze

A wheeze linked to a virus that has required treatment in its own right, for example with nebulisers or inhalers, can be described in many different ways within the medical record. Some examples of clinical terms found in the medical record are viral wheeze, viral-induced wheeze, viral-associated wheeze or viral illness with wheeze.

Where a wheeze is either induced, caused by (or due to) a viral infection, the coder must follow the principle for coding symptoms that are important medical problems and sequence the virus in primary position, followed by the wheeze:

B34.9 Viral infection, unspecified
R06.2 Wheezing

Chest infection

A diagnosis of ‘chest infection’ must be treated with caution by the coder for the following reasons:

- This is a non-specific diagnosis, and the coder’s remit is to translate clinical terminology.
- The diagnosis could be written as a proxy for conditions such as pneumonia, bronchiectasis, or cystic fibrosis, which then go unrecorded.
• When used in conjunction with co-morbidities such as emphysema, bronchitis and COPD, this diagnosis also creates issues with sequencing of codes. Current research indicates that no standard sequencing can be applied when these conditions occur simultaneously.

Ideally the responsible consultant should not be making a diagnosis of chest infection on its own, but must attempt to provide a more definitive diagnosis. However, it is recognised that this is not always possible, particularly within the paediatric specialty.

Current advice to coders faced with this problem is:

• If chest infection is the only condition recorded in an adult the medical record must be referred back to the responsible consultant for a more specific diagnosis.

• If chest infection is recorded with other co-morbidities (such as COPD and asthma) the chest infection must be assigned in a secondary position, if at all, as the co-morbidities are likely to be the main conditions treated. Again, the responsible consultant must be consulted.

• Where it is not specified as being an upper or lower chest infection the infection will be presumed to be lower and classified to the category for unspecified acute lower respiratory infection at J22.X.

**Example:**

Chronic obstructive pulmonary disease (COPD) with chest infection

- Index trail for COPD:
  - Disease, diseased – see also Syndrome
  - - pulmonary – see also Disease, lung

- Disease
  - - lung J98.4
  - - - obstructive (chronic) J44.9
  - - - - with
  - - - - - lower respiratory infection (except influenza) J44.0

- Tabular List entry:
  - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
    - Excludes: with influenza (J09-J11)

**Rationale:** The chest infection does not require coding in addition, as it is mentioned at fourth character level and it is an acute lower respiratory infection.
Example: Patient admitted with infective exacerbation of asthma

- Index trail for asthma:
  Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9

  Tabular List entry:
  J45.9  Asthma, unspecified
         Asthmatic bronchitis NOS

- Index trail for chest infection (ie infective):
  Infection, infected (opportunistic) B99
  - respiratory (tract) NEC J98.8
  - - lower (acute) J22

  Tabular List entry:
  J22.X  Unspecified acute lower respiratory infection
         Acute (lower) respiratory (tract) infection NOS
         Excludes: upper respiratory infection (acute) (J06.9)

Rationale: This condition usually starts with a virus that increases airway activity. It is the asthma that would be the main condition treated, and therefore this must be sequenced first.

When a patient is admitted to hospital with a diagnosis of ‘infective exacerbation of asthma’, and they are also known to have COPD, it is clinically important to identify both the acute management of the ‘infective exacerbation of asthma’ and the chronic management of the ‘COPD’.

Multiple ICD-10 codes must therefore be assigned to fully reflect that the primary condition treated/investigated was the ‘infective exacerbation of asthma’, as this is the main condition treated. It is necessary to code the COPD in a secondary field as this is a chronic respiratory condition that will require continued management.
Example:

Patient admitted with infective exacerbation of asthma, patient known COPD

- Index trail for **asthma**:
  - Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9

  Tabular List entry:
  - **J45.9** Asthma, unspecified
    - Asthmatic bronchitis NOS

- Index trail for **chest infection (ie infective)**:
  - Infection, infected (opportunistic) B99
    - respiratory (tract) NEC J98.8
    - - lower (acute) J22

  Tabular List entry:
  - **J22.X** Unspecified acute lower respiratory infection
    - Acute (lower) respiratory (tract) infection NOS
    - **Excludes:** upper respiratory infection (acute) (J06.9)

- Index trail for **disease**:
  - Disease diseased - see also Syndrome
    - pulmonary – see also Disease, lung

  - Disease diseased - see also Syndrome
    - lung J98.4
    - - obstructive (chronic) J44.9

  Tabular List entry:
  - **J44.9** Chronic obstructive pulmonary disease, unspecified
Diseases of the respiratory system

Chronic lower respiratory diseases (J40–J47)

Bronchitis not specified as acute or chronic in those under 15 years of age can be assumed to be of acute nature and must be classified to J20.-. Reference must be made to the Note at category J40.X in the Tabular List.

Example:

**Bronchitis in a 10 year old child**

- Index trail for bronchitis in a 10 year old:
  - Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous)(with tracheitis) (15 years of age and above) J40
  - acute or subacute (with bronchospasm or obstruction) J20.9

Tabular List entry:

| J20.9 | Acute bronchitis, unspecified |

COAD/COPD

A common lower respiratory disease seen written in the medical record is chronic obstructive airways disease (COAD), sometimes also seen as chronic obstructive pulmonary disease (COPD).

Most of the COAD/COPD related conditions can be indexed under the lead term disease, as shown in the following example:

Example:

**Patient admitted with acute exacerbation of COPD**

- Index trail for disease:
  - Disease diseased - see also Syndrome
    - pulmonary – see also Disease, lung

  Disease diseased - see also Syndrome
  - lung J98.4
  - - obstructive (chronic) J44.9
  - - - with
  - - - - exacerbation J44.1

Tabular List entry:

| J44.1 | Chronic obstructive pulmonary disease with acute exacerbation, unspecified |
There are many COAD/COPD related codes. National standards for coding chronic obstructive airways disease/chronic obstructive pulmonary disease with associated conditions are summarised below:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>COAD/COPD</td>
<td>J44.9</td>
</tr>
<tr>
<td>COAD/COPD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COAD/COPD with exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>COAD/COPD with bronchitis (15 years and above)</td>
<td>J44.8</td>
</tr>
<tr>
<td>COAD/COPD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COAD/COPD with chronic bronchitis</td>
<td>J44.8</td>
</tr>
<tr>
<td>COAD/COPD with acute asthma</td>
<td>J44.9 or J46.X and J45.9</td>
</tr>
<tr>
<td>COAD/COPD with emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td>COAD/COPD with pneumonia, unspecified</td>
<td>J18.9 and J44.0</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>COAD/COPD with asthma</td>
<td>J44.-</td>
</tr>
<tr>
<td>Chest infection</td>
<td>J22.X</td>
</tr>
<tr>
<td>Chest infection with bronchitis</td>
<td>J40.X or J20.9</td>
</tr>
<tr>
<td>Chest infection with cystic fibrosis</td>
<td>E84.0</td>
</tr>
<tr>
<td>Chest infection with emphysema</td>
<td>J43.9 and J22.X</td>
</tr>
<tr>
<td>Chest infection, COPD and emphysema</td>
<td>J44.0 and J43.9</td>
</tr>
<tr>
<td>Chest infection with lower lobar consolidation</td>
<td>J18.1</td>
</tr>
<tr>
<td>Chest infection, LVF</td>
<td>J22.X and I50.1</td>
</tr>
<tr>
<td>Chronic obstructive bronchitis with acute exacerbation</td>
<td>J44.1</td>
</tr>
<tr>
<td>URTI with COPD</td>
<td>J44.1 and J06.9</td>
</tr>
<tr>
<td>Infective exacerbation of asthma</td>
<td>J45.9 or J46.X and J22.X</td>
</tr>
<tr>
<td>Infective exacerbation of asthma, patient known COPD</td>
<td>J45.9,J22.X and J44.9 or J46.X,J22.X and J44.9</td>
</tr>
</tbody>
</table>
Diseases of the respiratory system

Asthma (J45)/Status asthmaticus (J46)
Coders must be careful when coding asthma and status asthmaticus.

Childhood asthma (J45.0)
Childhood asthma is a very specific form of asthma and the ICD-10 code J45.0 Predominantly allergic asthma is assigned when the responsible consultant has confirmed a diagnosis of childhood asthma within the medical record.

Status asthmaticus (J46)
J46.X Status asthmaticus must only be used when the responsible consultant has confirmed a diagnosis of acute severe asthma or status asthmaticus within the medical record.

Coders are advised to consult the responsible consultant when given the term ‘acute asthma’, without mention of ‘severe’, to ensure that all acute severe asthma cases are identified.

Examples:

Patient admitted with acute exacerbation of his asthma

Index trail for asthma:
Asthma, asthmatic, (bronchial) (catarrh) (spasmodic) J45.9

Tabular List entry:
J45.9 Asthma, unspecified
Excludes: acute severe asthma (J46)

Patient admitted with acute severe asthma

Index trail for asthma:
Asthma, asthmatic, (bronchial) (catarrh) (spasmodic) J45.9
- acute, severe J46

Tabular List entry:
J46.X Status asthmaticus
Acute severe asthma

Rationale: The comma at the index trail for acute, severe indicates that both the words ‘acute’ and ‘severe’ are essential modifiers and both must be present in order to assign the code J46.X.
Lung diseases due to external agents
(J60–J70)

Respiratory conditions due to inhalation of chemicals, gases, fumes and vapours (J68)
An additional external cause code (Chapter XX) must be used to identify the cause if specified in the medical record.

Example:

Pulmonary oedema due to carbon monoxide

Index trail for pulmonary oedema:
Oedema, oedematous – see Edema

Edema, edematous R60.9
- lung (acute) J81
- - due to
- - - chemicals, fumes, or vapors (inhalation) J68.1

Tabular List entry:
J68.1 Pulmonary oedema due to chemicals, gases, fumes and vapours
Chemical pulmonary oedema (acute)
Use additional external cause code (Chapter XX) to identify cause

Index trail for carbon monoxide from Table of Drugs and Chemicals:

Carbon
- monoxide (from incomplete combustion) X47.-

Tabular List entry:
X47 Accidental poisoning by and exposure to other gases and vapours
Includes: carbon monoxide
lacrimogenic gas [tear gas]
motor (vehicle) exhaust gas
nitrogen oxides
sulphur dioxide
utility gas

Excludes: metal fumes and vapours (X49.-)
[See at the beginning of this chapter for the classification of the place of occurrence]
.9 Unspecified place
Other diseases of the respiratory system (J95-J99)

J96 Respiratory failure, not elsewhere classified
Respiratory failure often occurs with, or as a symptom of, other respiratory disorders, such as asthma, emphysema, COPD, fibrosing alveolitis, and so on. If the responsible consultant has stated that respiratory failure is present, then it must be recorded by the coder.

The main condition treated must be sequenced in the primary position. If the patient is being treated in that consultant episode for their respiratory failure, then that would be sequenced first, with any contributory respiratory disorders being sequenced in subsequent positions. If the main condition being treated is a respiratory disorder and respiratory failure is noted as being present but is not the main condition being treated, then the respiratory disorder is coded in the primary position with the respiratory failure in a subsequent position.
Coding Standards

Diseases of oral cavity, salivary glands and jaws (K00–K14)

A common condition is embedded or impacted teeth. The correct code assignment will depend on the position of the teeth. If the teeth are in the correct position a code from category K01 Embedded and impacted teeth would be used. If they, or any adjacent teeth, are in an abnormal position then the correct code to use would be K07.3 Anomalies of tooth position.

Another common condition is dental caries (the medical term for tooth decay), which is coded to K02.9 Dental caries, unspecified. Young children, any patients with specific chronic or disabling diseases, and high risk patients are often admitted for extraction of teeth due to dental caries as an inpatient. Any other condition(s) present, such as Down’s syndrome, epilepsy, heart disease, etc, must also always be coded.
Diseases of the oesophagus, stomach and duodenum (K20–K31)

Although hiatus hernia is a condition involving protrusion of the stomach through the diaphragm, it is excluded from this block and included in the block dealing with hernias.

Oesophagitis (K20)
Oesophagitis NOS is coded here; if it is caused by drugs, a code from Chapter XX must be used to identify the drug when this information is known.

Gastro-oesophageal reflux disease (K21)
Gastro-oesophageal reflux disease is coded at category K21, and the fourth character identifies the presence or absence of oesophagitis.

Other diseases of oesophagus (K22)
The ICD-10 Alphabetical Index assumes that an oesophageal web is a congenital condition and classifies this at code Q39.4 Oesophageal web. However, an oesophageal web can be either congenital or acquired, with acquired being more common. Following consultation with the WHO, the correct ICD-10 codes for oesophageal web are as follows:

- Oesophageal web stated in the patient’s medical record as congenital must be classified at code Q39.4 Oesophageal web.
- Oesophageal web stated in the patient’s medical record as acquired must be classified at code K22.2 Oesophageal obstruction.
- Oesophageal web which is not specified in the patient’s medical record as either congenital or acquired must be classified at K22.2 Oesophageal obstruction.

Barrett’s oesophagus is a complication of reflux oesophagitis (gastro-oesophageal reflux disease at K21) and in some cases 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 this is K22.7 Barrett’s oesophagus, and this code also applies to Barrett’s oesophagus with low or high grade dysplasia.
Peptic ulcer disease (K25-K28)

The term ‘peptic ulcer’ is non-site-specific. Peptic ulcers are found mainly in the stomach and duodenum, but can also be found in the lower oesophagus.

Peptic ulcers are classified by site, so additional information must be sought to identify the specific site of the ulcer. The fourth character subdivisions for use with categories K25-K28 identify chronicity and presence of haemorrhage and/or perforation.

Example:

Bleeding peptic ulcer – case notes confirm the site as stomach

- Index trail for ulcer:
  - Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
  - peptic (site unspecified) K27.9

(as the site is specified trail to:)

- Ulcer, ulcerated, ulcerating, ulceration ulcerative L98.4
  - stomach (eroded) (peptic) (round) K25.9
  - - with
  - - - hemorrhage K25.4

Tabular List entry:

K25 Gastric ulcer
[See at the beginning of this block for subdivisions]
.4 Chronic or unspecified with haemorrhage

Peptic ulcers may also occur in the jejunum, usually as a consequence of certain types of operation which establish a direct communication (anastomosis) between the stomach and jejunum, ie certain forms of partial gastrectomy and gastrojejunostomy. Anastomotic peptic ulcers are classified to category K28 Gastrojejunal ulcer.
Drugs (particularly aspirin) are a common cause of peptic ulcers. If an ulcer is drug-induced then a code from Chapter XX must be used to identify the drug, where this information is known.

**Example:**

Chronic gastric ulcer caused by long term use of aspirin

- Index trail for *ulcer*:
  - Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
    - gastric see Ulcer, stomach
  - Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
    - stomach (eroded) (peptic) (round) K25.9
    - - chronic K25.7

Tabular List entry:

<table>
<thead>
<tr>
<th>K25</th>
<th>Gastric ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[See at the beginning of this block for subdivisions]</td>
</tr>
<tr>
<td>.7</td>
<td>Chronic without haemorrhage or perforation</td>
</tr>
</tbody>
</table>

- Index trail in Table of Drugs and Chemicals:
  - Adverse effect in therapeutic use
  - Aspirin (aluminum) (soluble) Y45.1

Tabular List entry:

| Y45.1 | Salicylates |

*Helicobacter (H.) pylori* is a bacterium found in the stomach which is known to contribute to the cause of ulceration, and it is present in almost all patients with gastric ulcers. When coders have the information that *H. pylori* is associated with any condition in categories K25-K29, the code B98.0 *Helicobacter pylori* [H. pylori] as the cause of diseases classified to other chapters must be assigned as a secondary code.

Patients are frequently admitted for check endoscopies following treatment of upper digestive tract disorders, such as ulcers, to ensure that treatment has been successful.

When no abnormalities are found on a check endoscopy, performed following treatment for upper digestive tract disorders (excluding neoplasms, see Chapter II Neoplasms), a code from category Z09 Follow-up examination after treatment for conditions other than malignant neoplasms is assigned.

Fourth character code assignment is dependent on the type of treatment the patient received for the condition. A code from Chapter XXI is also assigned to identify a personal history of the upper digestive tract disorder.
Example:

Routine check gastroscopy, previous surgery for gastric ulcer. No abnormality found on examination.

Index trail for follow-up examination:
Examination (general) (routine) (of) (for) Z00.0
- follow-up (routine) (following) Z09.9
- - surgery NEC Z09.0

Tabular List entry:
Z09.0 Follow-up examination after surgery for other conditions

Index trail for history of gastric ulcer:
History (personal) (of)
- disease or disorder (of) Z87.8
- - digestive system Z87.1

Tabular List entry:
Z87.1 Personal history of diseases of the digestive system
Conditions classifiable to K00-K93

Should evidence of recurrent ulcer be found, the code identifying the ulcer must be assigned. The code for the follow-up examination would not be assigned in these instances.

Example:

Routine check gastroscopy, previous surgery for gastric ulcer. A recurrent gastric ulcer is found on examination.

Index trail for gastric ulcer:
Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- gastric – see Ulcer, stomach
- stomach (eroded) (peptic) (round) K25.9

Tabular List entry:
K25 Gastric ulcer
[See at the beginning of this block for subdivisions]
.9 Unspecified as acute or chronic, without haemorrhage or perforation
If, during the check endoscopy, incidental findings such as gastritis and duodenitis are noted on examination and these are not given treatment in hospital, these conditions must be coded in addition to the follow-up examination and history of codes.

**Example:**

Routine check gastroscopy for previous gastric ulcer, following treatment by drugs. No presenting symptoms. Gastritis found but not treated. Patient discharged home the same day.

- Index trail for **follow-up examination**:
  - Examination (general) (routine) (of) (for) Z00.0
  - follow-up (routine) (following) Z09.9
  - chemotherapy NEC Z09.2

  Tabular List entry:
  Z09.2 Follow-up examination after chemotherapy for other conditions

- Index trail for **history of gastric ulcer**:
  - History (personal) (of)
  - disease or disorder (of) Z87.8
  - - digestive system Z87.1

  Tabular List entry:
  Z87.1 Personal history of diseases of the digestive system
  Conditions classifiable to K00-K93

- Index trail for **gastritis**:
  - Gastritis (simple) K29.7

  Tabular List entry:
  K29.7 Gastritis unspecified

**Rationale:** ‘Chemotherapy’ is the generic term for treatment by drugs and is not exclusive to drugs used to treat cancers. Coders must therefore select the essential modifier ‘chemotherapy’ as shown in the above example.

However, if treatment is given for the incidental finding(s) while the patient is in hospital and this affects the length of stay of that patient, the incidental finding must be recorded as the primary diagnosis.
Example: Routine check gastroscopy for previous gastric ulcer, following treatment by drugs. No presenting symptoms. Acute gastritis found and treated in hospital, and the patient remains in hospital overnight.

📖 Index trail for **acute gastritis**:
Gastritis (simple) K29.7
- acute (erosive) K29.1

Tabular List entry:
K29.1 Other acute gastritis

📖 Index trail for **follow-up examination**:
Examination (general) (routine) (of) (for) Z00.0
- follow-up (routine) (following) Z09.9
- - chemotherapy NEC Z09.2

Tabular List entry:
Z09.2 Follow-up examination after chemotherapy for other conditions

📖 Index trail for **history of gastric ulcer**:
History (personal) (of)
- disease or disorder (of) Z87.8
- - digestive system Z87.1

Tabular List entry:
Z87.1 Personal history of diseases of the digestive system
Conditions classifiable to K00-K93
Gastritis and duodenitis (K29)
Gastritis (inflammation of the stomach) and duodenitis (inflammation of the duodenum) are both coded to this category. The fourth characters identify site and chronicity. Code K29.9 Gastroduodenitis, unspecified must only be used if a patient has both an unspecified gastritis, which would be coded to K29.7, and duodenitis coded to K29.8. If a patient has a specific type of gastritis, then the code for the specific type must be used with that for duodenitis, K29.8.

Gastritis is a normal manifestation of Helicobacter pylori infection. The correct code assignment for H. pylori associated gastritis is K29.6 Other gastritis followed by B98.0 Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters.

Example:

<table>
<thead>
<tr>
<th>Chronic atrophic gastritis due to Helicobacter pylori infection</th>
</tr>
</thead>
</table>
| ![Index trail for gastritis:](index-trail)
| Gastritis (simple) K29.7
| - chronic (antral) (fundal) K29.5
| - - atrophic K29.4
| Tabular List entry:
| K29.4 Chronic atrophic gastritis
| Gastric atrophy
| ![Index trail for Helicobacter pylori:](index-trail)
| Infection, infected (opportunist) B99
| - Helicobacter pylori, as cause of disease classified elsewhere B98.0
| Tabular List entry:
| B98.0 Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters

Rationale: A code from categories B95–B98 must never be used in the primary position. These codes must only be used as additional codes to identify an infectious agent causing diseases classified elsewhere.
Diseases of appendix
(K35–K38)

For diseases of the appendix the method of admission must not be taken into account when deciding either the diagnosis or operation 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.

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’. When this occurs, clarification from the responsible consultant must be sought. If the appendix is confirmed to be normal by the responsible consultant, the presenting symptom must be coded. In most instances it will be acute abdominal pain.

Clinical clarification and confirmation is paramount in these cases, and coders must never interpret histology.

Codes in category K35 Acute appendicitis classify acute appendicitis with either generalised peritonitis (K35.2), localised peritonitis (K35.3), or without mention of localised or generalised peritonitis (K35.8). The coder must therefore take care when indexing.

**Example:**

<table>
<thead>
<tr>
<th>Appendicitis with peritonitis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>peritonitis</strong>:</td>
</tr>
<tr>
<td>Peritonitis (adhesive) (fibrinous) (with effusion) K65.9</td>
</tr>
<tr>
<td>- with or following</td>
</tr>
<tr>
<td>- - appendicitis K35.3</td>
</tr>
</tbody>
</table>

Tabular List entry:  
K35.3 Acute appendicitis with localized peritonitis

**Rationale:** There is no entry for an unspecified form of peritonitis under the lead term ‘Appendicitis’ in the Alphabetic Index. Appendicitis with an unspecified form of peritonitis defaults to code K35.3 Acute appendicitis with localized peritonitis.
Hernias
(K40–K46)

Codes in this block include acquired, congenital and recurrent hernias.

Hernias are classified by site at the three character level, and presence or absence of complications at the fourth character level, eg obstruction and/or gangrene.

Hernia with both gangrene and obstruction must be classified to hernia with gangrene.

Inguinal K40 and femoral K41 hernias can be classified as bilateral or unilateral.

**Example:**

**Unilateral inguinal hernia with obstruction and gangrene**

📖 Index trail for inguinal hernia:

- Hernia, hernial (acquired) (recurrent) K46.9
- inguinal (direct) (external) (funicular) (indirect) (internal) (oblique) (scrotal) (sliding) K40.9
- - unilateral K40.9
- - - with
- - - - gangrene (and obstruction) K40.4

Tabular List entry:

**K40.4** Unilateral or unspecified inguinal hernia, with gangrene

Ventral hernias are coded at category K43 and include incisional hernias; which are hernias arising at the site of a previous surgical incision. This is also the correct category to classify a parastomal hernia; which is by definition a hernia that occurs at and around an operative stoma such as colostomy, caecostomy, ileostomy, etc.

When coding a parastomal hernia, it is also appropriate to assign the relevant code from category Z93 Artificial opening status in a secondary position to identify the presence of a stoma.
Example:

Parastomal hernia with obstruction in a colostomy patient

Index trail for hernia:
- Hernia, hernial (acquired) (recurrent) K46.9
  - postoperative – see Hernia, ventral
  - ventral K43.9
  - - with
  - - - obstruction K43.0

Tabular List entry:
- K43.0 Ventral hernia with obstruction, without gangrene

Index trail for colostomy status:
- Colostomy
  - status Z93.3

or

- Status (post)
  - colostomy Z93.3

Tabular List entry:
- Z93.3 Colostomy status
Noninfective enteritis and colitis (K50–K52)

**Crohn’s disease [regional enteritis] (K50)**
Crohn’s disease is a chronic inflammatory disease which can affect any part of the gastrointestinal tract. The fourth character identifies the site of the disease.

**Ulcerative colitis (K51)**
Ulcerative colitis is chronic inflammation and ulceration of the lining of the colon and rectum. The fourth character identifies the site of the colitis.

**Other noninfective gastroenteritis and colitis (K52)**
Clinicians do not always differentiate between infectious and non-infectious forms of these conditions. All the terms included in the brace at code K52.9 **Noninfective gastroenteritis and colitis, unspecified** are classified to this code only when specified as noninfectious within the medical record. The *Excludes* notes at code K52.9 indicate that infectious or unspecified forms of gastroenteritis and colitis must be coded to category A09 instead.

**Examples:**

**Noninfectious diarrhoea**

Index trail for diarrhoea:
Diarrhea, diarrheal (disease) (infantile) A09.9
- noninfectious K52.9

Tabular List entry:
**K52.9** Noninfective gastroenteritis and colitis, unspecified

**Diarrhoea due to campylobacter**

Index trail for campylobacter diarrhoea:
Diarrhea, diarrheal (disease) (infantile) A09.9
- due to
  - - Campylobacter A04.5

Tabular List entry:
**A04.5** Campylobacter enteritis
Indeterminate colitis (K52.3)
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 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). Code K52.3 Indeterminate colitis must only be assigned when so stated by the responsible consultant.

Where the non-specific diagnosis of inflammatory bowel disease (IBD) is used instead, the coder must clarify a more specific diagnosis with the responsible consultant, as without an indication of 'non-infectious', this will default to the unspecified enteritis code (A09.9).
Other diseases of intestines (K55–K63)

The principal category for classifying obstruction of the bowel is K56 *Paralytic ileus and intestinal obstruction without hernia*. Any obstruction of the bowel with a hernia is classified to the block K40–K46 *Hernia*, where the fourth character will identify the obstruction. There are several other exclusions listed at category K56. This is because a bowel obstruction should generally be coded to the cause of the obstruction, if this is known.

**Example:**

**Congenital intussusception**

- Index trail for *congenital intussusception*:
  - Intussusception (bowel) (colon) (intestine) (rectum) K56.1
  - congenital Q43.8

  Tabular List entry:
  - Q43.8 Other specified congenital malformations of intestine

Coders must be aware that there is no exclusion note at K56.1 *Intussusception* to alert them that congenital intussusception (obstruction caused by part of the intestine telescoping on itself) is excluded from this category. Care must be taken to read all the subterms in the Alphabetical Index as well as notes in the Tabular List.

As shown in the above example, congenital is an essential modifier, which will identify the correct code to be used. Constipation is an integral part of a diagnosis of bowel obstruction and must not be coded in addition.

In classification terms there is a difference between a ‘rectal haemorrhage’ and a ‘per rectal haemorrhage’. Code K62.5 *Haemorrhage of anus and rectum* refers specifically to haemorrhage of the anus and/or rectum. It does not refer to a haemorrhage that has occurred from elsewhere in the gastrointestinal tract that is merely exiting via the rectum, ie *per* rectal haemorrhage. The responsible consultant must specifically identify the source of the haemorrhage as being the anus and/or rectum in order to assign code K62.5.

If the bleed is not specified as being from the rectum or anus and has simply occurred via the rectum, then it must be coded as a gastrointestinal haemorrhage of unspecified location, ie code K92.2 *Gastrointestinal haemorrhage, unspecified*. 
Diseases of the digestive system

Diseases of peritoneum
(K65–K67)

Peritonitis NOS would be assigned to code K65.9 Peritonitis, unspecified, but peritonitis of specific named sites or associated with other known conditions would be coded elsewhere. Coders must always read the list of exclusions at the beginning of category K65 Peritonitis before assigning a code for this condition.

Example:

Patient admitted with peritonitis. Patient also has diverticular disease.

Index trail for peritonitis:
- Peritonitis (adhesive) (fibrinous) (with effusion) K65.9
  - with or following
  - - diverticular disease (intestine) K57.8

Tabular List entry:
- K57.8 Diverticular disease of intestine, part unspecified, with perforation and abscess
- Diverticular disease of intestine NOS with peritonitis
Diseases of liver
(K70–K77)

Liver disease is classified primarily to categories K70–K77. Certain liver disorders of congenital or perinatal origin, and those due to infectious organisms, are classified in other chapters by aetiology.

**Examples:**

**Congenital cystic liver disease**

- Index trail for congenital cystic liver disease:
  - Disease, diseased - see also Syndrome
    - liver (chronic) (organic) K76.9
    - - cystic, congenital Q44.6

  Tabular List entry:
  Q44.6 Cystic disease of liver

**Herpesviral hepatitis**

- Index trail for herpesviral hepatitis:
  - Hepatitis K75.9
    - herpesviral B00.8† K77.0*

  Tabular List entry:
  B00.8† Other forms of herpesviral infection
  - Herpesviral:
    - hepatitis† (K77.0*)

  K77.0* Liver disorders in infectious and parasitic diseases classified elsewhere
  - Hepatitis:
    - cytomegaloviral (B25.1†)
    - herpesviral [Herpes simplex] (B00.8†)
    - toxoplasma (B58.1†)

**Rationale:** In instances where the responsible consultant has not specified, or is unable to confirm, which condition is the main condition being treated, the coder must use the dagger/asterisk default.

Where a disease of the liver is not specified as due to an infectious organism and the patient is a chronic alcoholic, clarification must be obtained from the responsible consultant as to whether the liver disease is due to the alcoholism.
Alcoholic liver disease (K70)
Alcoholic liver disease refers to a range of conditions that develop when the liver becomes damaged due to alcohol misuse. This may be due to consuming harmful amounts of alcohol, or due to alcohol dependence.

Alcoholic liver diseases can be present even after the patient has stopped drinking. Codes in K70 do not imply that the patient is a current alcoholic but that the liver disease is due to alcohol.

For patients in which the alcoholic liver disease is due to current misuse of, or dependence on, alcohol a code from category F10 Mental and behavioural disorders due to use of alcohol is assigned with the fourth character subdivision. This 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).

Where the patient has alcoholic liver disease due to previous alcohol abuse, code Z86.4 Personal history of psychoactive substance abuse is assigned in addition to the code for the alcoholic liver disease.

Where the responsible consultant has given no information regarding current or past alcohol use/abuse and only states a type of alcoholic liver disease, only a code from K70 is assigned.

Example:

Acute hepatitis due to chronic alcoholism

Index trail for acute hepatitis:
Hepatitis K75.9
- acute NEC B17.9
- - alcoholic K70.1

Tabular List entry:
K70.1 Alcoholic hepatitis

Index trail for chronic alcoholism:
Alcoholism (chronic) 10.2

Tabular List entry:
F10.- Mental and behavioural disorders due to use of alcohol
[See before F10 for subdivisions]
.2 Dependence syndrome
Diseases of the digestive system

Diseases of gallbladder, biliary tract and pancreas (K80–K87)

Cholelithiasis (K80)

Cholelithiasis and choledocholithiasis are classified to category K80. The coder must always code to the location of the calculus and presence of inflammation if known. These are identified by the fourth character subdivisions.

Cholelithiasis, unspecified is assumed to be of the gallbladder and is reported in code **K80.2 Calculus of gallbladder without cholecystitis**.

**Example:**

<table>
<thead>
<tr>
<th>Cholelithiasis with acute cholecystitis</th>
</tr>
</thead>
</table>

📖 Index trail for cholelithiasis:

Cholelithiasis (cystic duct) (gallbladder) (impacted) (multiple)  
K80.2  
- with cholecystitis (chronic) K80.1  
- - acute K80.0

or

Cholecystitis K81.9  
- acute K81.0  
- - with  
- - - calculus, stones in  
- - - - gallbladder K80.0

or

- - - cholelithiasis K80.0

Tabular List entry:

**K80.0 Calculus of gallbladder with acute cholecystitis**  
Any condition listed in K80.2 with acute cholecystitis
Acute pancreatitis (K85)
Acute pancreatitis is classified according to the cause, for example;

- gallstone pancreatitis included at code K85.1 which is the most common cause of acute pancreatitis
- alcohol-induced acute pancreatitis (K85.2) and
- drug-induced acute pancreatitis (K85.3) which also requires a code from Chapter XX to be assigned to identify the drug (if known).

It is important to note the difference between an alcohol-induced acute pancreatitis at code K85.2 and an alcohol-induced chronic pancreatitis at code K86.0.

Alcohol-induced acute pancreatitis can occur within hours, or as long as two days after consuming alcohol. The chronic form is caused by many years of heavy alcohol use and can be triggered by one acute attack that damages the pancreatic duct (‘acute on chronic’ alcoholic pancreatitis).

As with other ‘acute on chronic’ conditions, both conditions must be recorded with the acute state normally being coded first. ‘Acute on chronic’ pancreatitis (alcoholic or otherwise) would therefore have the relevant codes from both categories K85 and K86 assigned, with the K85 code normally having sequencing priority. The Primary Diagnosis Definition must be followed.

Example:

Acute on chronic alcoholic pancreatitis

Index trail for pancreatitis:
Pancreatitis K85.9  
- acute (edematous) (hemorrhagic) (recurrent)
  - alcohol-induced K85.2

Tabular List entry:
K85.2 Alcohol-induced acute pancreatitis

Index trail for pancreatitis:
Pancreatitis K85.9  
- chronic (infectious) K86.1
  - alcohol-induced K86.0

Tabular List entry:
K86.0 Alcohol-induced chronic pancreatitis
For patients in which the alcoholic pancreatitis is due to current misuse of, or
dependence on, alcohol a code from category **F10 Mental and behavioural
disorders due to use of alcohol** is assigned. The fourth character
subdivision is dependent upon whether or not the responsible consultant has
stated that the alcohol-induced pancreatitis is due to harmful use of alcohol
**F10.1** or dependence **F10.2**.

Where the patient has alcoholic pancreatitis due to previous alcohol abuse,
code **Z86.4 Personal history of psychoactive substance abuse** is
assigned in addition to the code for the alcoholic pancreatitis. Where the
responsible consultant has given no information regarding current or past
alcohol use/abuse, and only states alcoholic pancreatitis, only code **K86.0** is
assigned.
Other diseases of the digestive system (K90–K93)

Postprocedural disorders of digestive system, not elsewhere classified (K91)
Refer also to the ‘Coding postprocedural disorders in body system chapters’ section in Chapter XIX.

When postprocedural conditions and complications are recorded as the main condition, reference to modifiers or qualifiers in the Alphabetical Index is essential for assigning the correct code.

A code from K91 Postprocedural disorders of digestive system, not elsewhere classified must only be assigned if directed by the Alphabetical Index. This is because codes within postprocedural categories at the end of body system chapters are not always specific about the nature of the original procedure performed.

Example:

Postgastrectomy dumping syndrome

Index trail for postgastrectomy dumping syndrome:
Syndrome – see also Disease
- dumping (postgastrectomy) K91.1

Tabular List entry:
K91.1 Postgastric surgery syndromes
Syndrome:
• dumping
• postgastrectomy
• postvagotomy

External Cause Index trail for complication:
Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
- removal of organ (partial) (total) NEC Y83.6

Tabular List entry:
Y83.6 Removal of other organ (partial) (total)

Rationale: In the above example, code Y83.6 Removal of other organ (partial) (total) is also assigned as it provides more detail about the nature of the procedure.
Other diseases of digestive system (K92)

This category includes codes for haemorrhage from the gastrointestinal tract, and is usually only used when the cause is unknown. The patient may be under investigation for the symptoms, or admitted as an emergency because of the bleeding.

When the bleeding is a symptom of another disease which has been diagnosed, such as a malignant neoplasm or bleeding peptic ulcers, it is not necessary to add a code from this category (K92 Other diseases of digestive system).

In the case of bleeding peptic ulcers, the bleeding will be identified by the fourth character of the relevant code.

Example:

Patient admitted with GI (gastrointestinal) bleeding. Following investigations, a diagnosis of a bleeding duodenal ulcer was made.

Index trail for bleeding duodenal ulcer:
- Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- duodenum, duodenal (eroded) (peptic) K26.9
- - with
- - - hemorrhage K26.4

Tabular List entry:

K26  Duodenal ulcer
[See at the beginning of this block for subdivisions]
.4 Chronic or unspecified with haemorrhage

Code K92.1 Melaena excludes occult blood in faeces (FOB) which must be recorded to code R19.5 Other faecal abnormalities instead. Code R19.5 would only be assigned where no further abnormality has been found.
CHAPTER XII
DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE
L00–L99

Chapter rules and conventions

Some skin infections are classified to Chapter I Certain infectious and parasitic diseases, instead of to Chapter XII. It must be noted that even for those infections classified to this chapter, certain body sites are excluded, notably eye, ear, nose, mouth, breast and genital organs.
Coding Standards

Infections of the skin and subcutaneous tissue (L00–L08)

L00 Staphylococcal scalded skin syndrome is an infection of the skin rather than an injury due to heat. This condition, when originating in the perinatal period, is also coded here.

L03.1 Cellulitis of other parts of limb includes the leg.

Some skin infections are classified to Chapter I Certain infectious and parasitic diseases, instead of to Chapter XII. It must also be noted that even for those infections assigned to this chapter, certain body sites are excluded, notably eye, ear, nose, mouth, breast and genital organs.

Examples:

Cellulitis of face

Index trail:
Cellulitis (diffuse) (with lymphangitis) L03.9
- face (any part, except ear, eye and nose) L03.2

Tabular List entry:
L03.2 Cellulitis of face

Cellulitis of ear

Index trail:
Cellulitis (diffuse) (with lymphangitis) L03.9
- ear (external) H60.1

Tabular List entry:
H60.1 Cellulitis of external ear

When coding skin infections, if the name of the infecting organism is not identified in the title of the three character rubric (category) an additional code from categories B95-B98 must be used when the infecting organism has been identified.

Where a bacterial agent is resistant to an antibiotic, and the information has been clearly documented by the responsible consultant, an additional code from the range U80–U89 can be used to identify the antibiotic to which a bacterial agent is resistant.
These are only to be used in a secondary position and must be sequenced following the code for a bacterial infection classified elsewhere. They must never be used as primary codes.

**Example:**

**Cellulitis of face due to Staphylococcus aureus**

- **Index trail:**
  - *Cellulitis (diffuse) (with lymphangitis)* [L03.9]
  - face (any part, except ear, eye and nose) [L03.2]

- **Tabular List entry:**
  - L03.2 Cellulitis of face

- **Index trail for the infectious organism:**
  - *Infection, infected (opportunistic)* [B99]
  - staphylococcal NEC [A49.0]
  - - as cause of disease classified elsewhere [B95.8]

- **Tabular List entry:**
  - B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters
    - (Reference to the Tabular List provides a more accurate fourth-character description)

Wound infections can often progress to cellulitis. Code assignment is dependent on the main condition treated.
Examples:

Patient fell in garden and sustained a laceration to lower leg which was treated in A&E two weeks ago. Patient has now been admitted with a diagnosis of cellulitis of lower leg.

Index trail for **cellulitis of lower leg**:
- **Cellulitis (diffuse) (with lymphangitis)** L03.9
- leg except toe(s) L03.1

Tabular List entry:
- **L03.1** Cellulitis of other parts of limb

Index trail for **sequelae of wound**:
- **Sequelae (of)** - *see also condition*
- wound, open T94.1
- - limb
- - - lower T93.0

Tabular List entry:
- **T93.0** Sequelae of open wound of lower limb
  Sequelae of injury classifiable to S71.-, S81.-, S91.-and T13.1

Patient admitted with cellulitis due to insect bite on finger

Index trail for **cellulitis of finger**:
- **Cellulitis (diffuse) (with lymphangitis)** L03.9
- finger (intrathecal) (periosteal) (subcutaneous) (subcuticular) L03.0

Tabular List entry:
- **L03.0** Cellulitis of finger and toe

External Cause Index trail for **insect bite**:
- **Bite, bitten by**
- insect (nonvenomous) W57.

Tabular List entry:
- **W57** Bitten or stung by nonvenomous insect and other nonvenomous arthropods
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .9 to identify unspecified place of occurrence
Bullous disorders
(L10–L14)

Bullous (characterised by bullae - large fluid-filled blisters) disorders are classified to L10–L14.

- **L10 Pemphigus** (a group of diseases marked by successive crops of bullae which absorb and leave pigmented spots on the skin); and
- **L12 Pemphigoid** (resembling, but distinguishable from pemphigus) are distinct disorders, and care must be taken when referencing the Alphabetical Index and assigning a code, eg 'us' vs 'oid'.
Dermatitis and eczema (L20–L30)

These disorders refer to inflammation of the skin, with many different causes ranging from infection to allergy. The terms dermatitis and eczema are used interchangeably in this block. Therefore, whenever the term dermatitis is used, it is understood to also mean eczema, and vice versa.

Three categories are provided to classify contact dermatitis:

- **L23 Allergic contact dermatitis** (hypersensitivity to substances)
- **L24 Irritant contact dermatitis** (irritant in contact with skin)
- **L25 Unspecified contact dermatitis**.

The symptoms and treatment of both types of contact dermatitis are similar. These terms must only be assigned when specified by the responsible consultant.

The axis of classification at fourth character level is causative agent. When a drug is identified as the external cause, this must also be coded in secondary position.

**Examples:**

**Allergic dermatitis due to application of hydrocortisone cream**

Index trail for dermatitis:

- **Dermatitis** L30.9
  - due to
  - - drugs and medicaments (correct substance properly administered) (generalized) (internal use) L27.0
  - - - in contact with skin L25.1
  - - - - allergic L23.3

Tabular List entry:

**L23.3 Allergic contact dermatitis due to drugs in contact with skin**

Use additional external cause code (Chapter XX) to identify drug

Index trail in Table of Drugs and Chemicals:

- **Hydrocortisone (derivatives)** Y56.0

Tabular List entry:

**Y56.0 Local antifungal, anti-infective and anti-inflammatory drugs, not elsewhere classified**
**Examples (cont):**

Irritant contact dermatitis due to detergent

- Index trail for dermatitis:
  - Dermatitis L30.9
    - due to
    - - detergents (contact) (irritant) L24.0

  Tabular List entry:
  
  L24.0  Irritant contact dermatitis due to detergents

Category L27 identifies dermatitis due to substances taken internally by ingestion or injection.

**Example:**

Rash from eating strawberries

- Index trail:
  - Rash R21
    - food (see also Dermatitis, due to, food) L27.2

  Dermatitis L30.9
    - due to
    - - food (ingested) L27.2

  Tabular List entry:
  
  L27.2  Dermatitis due to ingested food

However, if the rash was due to strawberries in contact with the skin and not specified as allergic or irritant, then the index trail would be as follows:

**Examples:**

Rash due to strawberries in contact with the skin

- Index trail:
  - Rash R21
    - food (see also Dermatitis, due to, food) L27.2

  Dermatitis L30.9
    - due to
    - - food (ingested) L27.2
    - - - in contact with skin L25.4

  Tabular List entry:
  
  L25.4  Unspecified contact dermatitis due to food in contact with skin
Examples (cont):

Rash from penicillin (intramuscular (IM) injection)

- Index trail:
  Rash R21
    - drug (internal use) L27.0

- Tabular List entry:
  L27.0  Generalised skin eruption due to drugs and medicaments
    Use additional external cause code (Chapter XX) to identify drug

- Index trail in Table of Drugs and Chemicals:
  Adverse effect in therapeutic use
    Penicillin (any) Y40.0

- Tabular List entry:
  Y40.0  Penicillin
Papulo-squamous disorders  
(L40–L45)

Psoriasis (L40)
Some patients can develop a distinctive form of inflammatory arthritis associated with psoriasis. The cause and effect relationship cannot be assumed. The responsible consultant must clearly state the link before L40.5† Arthropathic psoriasis can be used.

Example:

Juvenile arthritis (multiple sites) in psoriasis, link confirmed by responsible consultant.

Index trail for juvenile arthritis:
Psoriasis L40.9
- arthropathic L40.5† M07.3*

Arthritis, arthritic (acute) (chronic) (subacute) M13.9
- juvenile M08.9
- - in (due to)
- - - psoriasis L40.5† M09.0*

Tabular List entries:
L40.5† Arthropathic psoriasis (M07.0-M07.3*, M09.0*)
M09.0* Juvenile arthritis in psoriasis (L40.5†)  
[fifth-character of 0 from before M00 to identify Multiple sites]

Rationale: In the above example the responsible consultant has not confirmed which condition was the main condition treated, therefore the dagger and asterisk default sequencing must be applied.
Radiation related disorders
(L55–L59)

L56.0 Drug phototoxic response occurs when a high concentration of an active substance in the skin is exposed to light. The response occurs only on light-exposed areas and subsides rapidly on withdrawal of the drug. The drug is identified by the use of an external cause code and must be coded in secondary position.

Example:

Phototoxic response to nalidixic acid

Index trail:
Response, drug
- phototoxic L56.0

Tabular List entry:
L56.0 Drug phototoxic response
Use additional external cause code (Chapter XX) to identify drug.

Index trail in Table of Drugs and Chemicals:
Adverse effect in therapeutic use
Nalidixic acid Y41.8

Tabular List entry:
Y41.8 Other specified systemic anti-infectives and antiparasitics
Hydroxquinoline derivatives

L56.1 Drug photoallergic response occurs after a latent interval following drug administration and may be produced by small quantities of the drug. Skin response often extends beyond light-exposed areas and may persist for weeks after stopping the drug.
Example:

**Photoallergic reaction to tetracycline**

- Index trail:
  - Reaction – see also Disorder
    - drug NEC T88.7
    - photoallergic L56.1

- Tabular List entry:
  - **L56.1** Drug photoallergic response
    - Use additional external cause code (Chapter XX) to identify drug.

- Index trail in Table of Drugs and Chemicals:
  - Adverse effect in therapeutic use
    - Tetracycline Y40.4

- Tabular List entry:
  - **Y40.4** Tetracyclines

**Skin appendages**

*(L60–L75)*

The sweat glands, hairs, nails and sebaceous glands are known collectively as the skin appendages.

For conditions that are drug-induced disorders an additional external cause code must be used to identify the drug, when this is known.
Other disorders of skin
(L80–L99)

Three categories are provided in Chapter XII for skin ulcers. These are classified differently depending on type:

- **L89** Decubitus ulcer and pressure area
- **L97** Ulcer of lower limb, not elsewhere classified
- **L98.4** Chronic ulcer of skin, not elsewhere classified.

Exclusions relating to different forms of ulcers are listed at each category, directing the coder to a more specific code.

If the cause of the ulcer has not been clearly given, advice must be sought from the responsible consultant.

Codes within category **L89** classify the ‘stage’ or ‘grade’ of a decubitus ulcer and pressure area. A decubitus ulcer and pressure area, or pressure sore, is a localised injury to the skin and/or underlying tissue usually over a bony prominence and as a result of pressure. There are four levels of injury which are shown as stages or grades from I-IV.

In instances where the stage/grade of the ulcer is not documented by the responsible consultant the coder will default to the code:

- **L89.9** Decubitus ulcer and pressure area, unspecified
  Decubitus [pressure] ulcer without mention of stage

As per the *note* at category level, where a patient has ulcers of multiple skin sites on the body which are of differing stages/grades, it is only necessary to assign one code indicating the ulcer with the highest stage/grade.

**Example:**

Patient treated for grade II pressure area of the left heel and grade IV pressure area of the buttocks.

- Index trail for pressure sore:
  - Pressure
    - area, skin ulcer L89.-
    - - stage
    - - - IV L89.3

- Tabular List entry:
  - **L89.3** Stage IV decubitus ulcer

Pressure ulcers that are gangrenous must also have code **R02.X Gangrene, not elsewhere classified** assigned in a secondary position.
Example:

<table>
<thead>
<tr>
<th>Patient treated for gangrenous grade IV pressure ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for pressure ulcer:</td>
</tr>
<tr>
<td>Pressure</td>
</tr>
<tr>
<td>- ulcer (chronic) L89.-</td>
</tr>
<tr>
<td>- - stage</td>
</tr>
<tr>
<td>- - - IV L89.3</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>L89.3 Stage IV decubitus ulcer</td>
</tr>
</tbody>
</table>

Index trail for gangrene:

Gangrene, gangrenous (dry) (moist) (skin) (ulcer) R02

Tabular List entry:

R02.X Gangrene, not elsewhere classified

Leg ulcers (other than varicose leg ulcers at I83) are classified at code L97.X Ulcer of lower limb, not elsewhere classified. Associated gangrene and/or infection of the affected leg must be coded in addition to the leg ulcer.

If the infective agent has been identified, an additional code from B95-B98 must also be assigned.

Examples:

<table>
<thead>
<tr>
<th>Patient diagnosed with a leg ulcer and gangrene of the leg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for ulcer:</td>
</tr>
<tr>
<td>Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4</td>
</tr>
<tr>
<td>- leg – see Ulcer, lower limb</td>
</tr>
</tbody>
</table>

Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- lower limb (atrophic) (chronic)(neurogenic) (perforating) (pyogenic) (trophic) (tropical) L97

Tabular List entry:

L97.X Ulcer of lower limb, not elsewhere classified

Index trail for gangrene:

Gangrene, gangrenous (dry) (moist) (skin) (ulcer) R02

Tabular List entry:

R02.X Gangrene, not elsewhere classified
Examples (cont):

Patient diagnosed with a leg ulcer and gangrene of the leg due to Type II diabetes mellitus.

Index trail:

Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- type II (nonobese)(obese) E11.-

Tabular List entry:

E11 Non-insulin-dependent diabetes mellitus
[See before E10 for subdivisions]
.5 With peripheral circulatory complications

Index trail for ulcer:

Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- leg – see Ulcer, lower limb

Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
- lower limb (atrophic) (chronic), (neurogenic) (perforating)
- (pyogenic) (trophic) (tropical) L97

Tabular List entry:

L97.X Ulcer of lower limb, not elsewhere classified

Index trail for gangrene:

Gangrene, gangrenous (dry) (moist) (skin) (ulcer) R02

Tabular List entry:

R02.X Gangrene, not elsewhere classified
Example (cont):

Patient diagnosed with an infected leg ulcer. Streptococcus group A is identified and confirmed by the responsible consultant as the infectious agent.

Index trail for ulcer:

- **Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - leg – see Ulcer, lower limb

- **Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - lower limb (atrophic) (chronic), (neurogenic) (perforating)
  - (pyogenic) (trophic) (tropical) L97

Tabular List entry:

- **L97.X** Ulcer of lower limb, not elsewhere classified

Index trail for infection:

- **Infection, infected (opportunist)** B99
  - skin (local) (staphylococcal) (streptococcal) L08.9

Tabular List entry:

- **L08.9** Local infection of skin and subcutaneous tissue, unspecified

Index trail for the infectious organism:

- **Infection, infected (opportunist)** B99
  - streptococcal NEC A49.1
  - - as cause of disease classified elsewhere B95.5

Tabular List entry:

- **B95.0** Streptococcus, group A, as the cause of diseases classified to other chapters
  
  *(Reference to the Tabular List provides a more accurate fourth-character description)*

When cellulitis of the leg is mentioned with a leg ulcer, both conditions must be coded. If it is not clear whether the cellulitis or the leg ulcer is the main condition being treated during the consultant episode, advice must be sought from the responsible consultant.
Example: 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.

- Index trail for cellulitis of lower leg:
  
  **Cellulitis (diffuse) (with lymphangitis)** L03.9
  - leg except toe(s) L03.1

  Tabular List entry:
  
  **L03.1** Cellulitis of other parts of limb

- Index trail for ulcer:
  
  **Ulc er, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - leg – see Ulcer, lower limb

  **Ulc er, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - lower limb (atrophic) (chronic). (neurogenic) (perforating)
  - (pyogenic) (trophic) (tropical) L97

  Tabular List entry:
  
  **L97.X** Ulcer of lower limb, not elsewhere classified

Rationale: As the cellulitis was treated with IV antibiotics, the cellulitis is recorded as the main condition.

Example: A patient is admitted with cellulitis of the leg and a severe leg ulcer. The cellulitis is responding well to treatment with oral antibiotics, but the leg ulcer is showing no signs of healing. The patient is sent to theatre for debridement of the leg ulcer under general anaesthetic.

- Index trail for ulcer:
  
  **Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - leg – see Ulcer, lower limb

  **Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4
  - lower limb (atrophic) (chronic). (neurogenic) (perforating)
  - (pyogenic) (trophic) (tropical) L97

  Tabular List entry:
  
  **L97.X** Ulcer of lower limb, not elsewhere classified

- Index trail for cellulitis of lower leg:
  
  **Cellulitis (diffuse) (with lymphangitis)** L03.9
  - leg except toe(s) L03.1

  Tabular List entry:
  
  **L03.1** Cellulitis of other parts of limb
**Rationale:** As the patient was taken to theatre for debridement of the leg ulcer, this is the main condition treated.

**Treatment of healed scars**

Code **Z42 Follow-up care involving plastic surgery** is used in a secondary position when the original course of treatment for an injury is completed, and the patient requests treatment to improve the appearance of the scar.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Patient with keloid scar of face following a burn injury is discharged following reconstructive surgery to improve facial appearance (the original course of treatment is complete).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>scar:</strong></td>
<td><strong>Scar, scarring</strong> <em>(see also Cicatrix)</em> L90.5 - keloid L91.0</td>
</tr>
</tbody>
</table>
| Tabular List entry: | L91.0 **Hypertrophic scar**  
  Keloid scar |
| Index trail for **sequelae:** | **Sequelae (of)** *(see also condition)*  
  - burn and corrosion T95.9  
  - - face, head and neck T95.0 |
| Tabular List entry: | T95.0 **Sequelae of burn, corrosion and frostbite of head and neck** |
| Index trail for **surgery:** | **Surgery**  
  - reconstructive (following healed injury or operation) Z42.9  
  - - head and neck Z42.0 |
| Tabular List entry: | Z42.0 **Follow-up care involving plastic surgery of head and neck** |
CHAPTER XIII
DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE
M00–M99

Chapter rules and conventions

- Chapter XIII covers diseases and conditions relating to the spine, joints, muscles and connective tissue of the body. It also covers deformities acquired after birth. There are some diseases of the musculoskeletal system and connective tissue that are specifically excluded from Chapter XIII.

- The chapter covers chronic and not current injuries.

- The fifth character is for use within the entire Musculoskeletal Chapter, and its use is mandatory where the data is present in the medical record, and where doing so adds more specific information about the site. In cases where the fourth character code is already site specific and the addition of a fifth character will not add further information about the site, the fifth character is not required.
Coding Standards

Supplementary characters

The majority of categories within Chapter XIII require the assignment of fifth characters to specify additional detail about the site of musculoskeletal involvement. This main subclassification is listed before the block on Arthropathies (M00-M25) in ICD-10 Volume 1. Other subclassifications appear at:

- category M23 Internal derangement of knee
- block M40-M54 Dorsopathies and
- category M99 Biomechanical lesions, not elsewhere classified.

The chapter will indicate when these fifth characters are required. The use of fifth characters is mandatory where the data is present in the medical record and where doing so adds more specific information about the site.

Example:

**Idiopathic gout in left knee**

Index trail for gout:
- Gout, gouty M10.9
  - idiopathic M10.0

Tabular List entry:
- M10.0 Idiopathic gout
  [fifth character of six from before M00 to identify lower leg]

Rationale: The site of involvement has been specified so the fifth character must be assigned.

Example:

Patient with pseudosarcomatous fibromatosis. No further information is given.

Index trail for fibromatosis:
- Fibromatosis M72.9
  - pseudosarcomatous (proliferative) (subcutaneous) M72.4

Tabular List entry:
- M72.4 Pseudosarcomatous fibromatosis

Rationale: The site of involvement has not been stated by the responsible consultant therefore a fifth character is not assigned.

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.
Example: Paget's disease of skull

Index trail for Paget's disease:
  Paget's disease
  - bone M88.9
  - - skull M88.0

Tabular List entry:
  M88.0   Paget's disease of skull

Rationale: M88.0 Paget's disease of skull does not require a fifth character as the site of skull is specifically stated at the fourth character level and adding the fifth character '8' to specify skull does not add further information.

However, code M88.8 Paget's disease of other bones does require a fifth character to indicate the site of the bone.

Examples of other site specific codes which do not require fifth character assignment as it does not add further specific information about the site includes:

  M76.0 Gluteal tendinitis
  M76.3 Iliotibial band syndrome and
  M76.6 Achilles tendinitis.

The fifth character subdivisions used for codes within block M40-M54 (except for M50 and M51) all define the site of involvement in the spine.

These fifth characters include single regions such as thoracic region and lumbar region but also adjoining regions, such as cervicothoracic region and lumbosacral region.

Some four character codes within this block are already site specific, such as M41.3 Thoracogenic scoliosis. The additional fifth characters must only be added when the data is present in the medical record and when they add further specific information about the site at the fourth character code.

Example: Thoracogenic scoliosis

Index trail for scoliosis:
  Scoliosis (acquired) (postural) M41.9
  - thoracogenic M41.3

Tabular List entry:
  M41.3   Thoracogenic scoliosis

Rationale: In the above example there is no further information about any adjoining regions affected, therefore the fifth character 4 Thoracic region is
not required in addition, as it does not add further specific information about the site.

**Example:**

Cervicalgia of cervicothoracic spine

Index trail for **cervicalgia**:

Cervicalgia M54.2

Tabular List entry:

M54.2 Cervicalgia

[fifth character of 3 from before M40 to identify cervicothoracic region]

**Rationale:** In the above example the responsible consultant has stated that the condition affects the cervicothoracic region, therefore it is appropriate to assign the fifth character ‘3’ as this adds further specific information about the site.

The fifth character of ‘0’ indicates involvement of multiple sites. It should be assigned to patients who are known to have a disorder, such as arthritis, that is affecting more than one site.

**Example:**

Rheumatoid arthritis of knees, hands and feet. Admission for total knee replacement.

Index trail for **rheumatoid arthritis**:

Arthritis, arthritic (acute) (chronic) (subacute) M13.9
- rheumatoid M06.9

Tabular List entry:

M06.9 Rheumatoid arthritis, unspecified

[fifth character of 0 from before M00 to identify multiple sites]

**Rationale:** Although the admission is for treatment of the knee, the fifth character in the diagnosis represents the fact that multiple joints are affected. The type of treatment and site of knee are identified by the procedure codes.

If coding conditions affecting bilateral sites, the fifth character reflecting that site must be recorded as follows:
Example: Bilateral rheumatoid arthritis of joints of fingers

Index trail for rheumatoid arthritis:
- Arthritis, arthritic (acute) (chronic) (subacute) M13.9
- rheumatoid M06.9

Tabular List entry:
- M06.9 Rheumatoid arthritis, unspecified
  [fifth character of 4 from before M00 to identify fingers]

Rationale: This example illustrates the fact that multiple sites of the same body region, eg fingers, are identified by the site affected.
Arthropathies
(M00–M25)

Arthropathies cover disorders affecting predominantly peripheral (limb) joints. They *exclude* the spine. Rheumatoid arthritis of the spine is included in the block *Spondylopathies M45–M49* and is identified separately.

**Example:**

<table>
<thead>
<tr>
<th>Rheumatoid arthritis of hands, knees and lumbar region of the spine</th>
</tr>
</thead>
</table>

```
Index trail for *rheumatoid arthritis*:
- *Arthritis, arthritic (acute) (chronic) (subacute)* M13.9
- rheumatoid M06.9
- - spine M45

Tabular List entry:
- M06.9 *Rheumatoid arthritis, unspecified* [fifth character of 0 from before M00 to identify multiple sites except spine]
- M45.X *Ankylosing spondylitis*
  Rheumatoid arthritis of spine
  [fifth character of 6 from before M40 to indicate lumbar region]
```

**Rationale:** The ‘X’ filler code must be assigned in the fourth character position for three character codes. In instances where a three character category requires assignment of a fifth character, the code must be seen as follows: *M45.X6*.

**Infectious arthropathies (M00-M03)**

The note at *M00-M03* clearly defines infectious arthropathies as being of *direct* infection, ie as a result of a direct infection to a joint, or *indirect* infection, ie a generalised infection that manifests itself within a joint and can be reactive or postinfective.

Where the infectious organism is not specified in the code title, a code from the range *B95-B98* must be added.
Inflammatory polyarthropathies (M05–M14)

Juvenile arthritis (M08)
The inclusion note at category M08 Juvenile arthritis clearly defines this diagnosis as applying to arthritis diagnosed in children with onset before their 16th birthday and lasting longer than three months. It can recur throughout the patient's life. This code must only be assigned when this diagnosis has been confirmed by the responsible consultant.

Arthropathies may be associated with other conditions, as in the following example:

Example: Juvenile arthritis left hip due to psoriasis

Index trail for juvenile arthritis:
- Arthritis, arthritic (acute) (chronic) (subacute) M13.9
  - juvenile M08.9
  - - in (due to)
  - - - psoriasis L40.5† M09.0*

Tabular List entries:
- L40.5† Arthropathic psoriasis (M07.0-M07.3*, M09.0*)
- M09.0* Juvenile arthritis in psoriasis (L40.5†)
  [fifth character of 5 from before M00 to identify hip]

Rationale: In the above example the responsible consultant has not specified which condition is the main condition being treated, therefore the coder must use the dagger/asterisk default.

Arthrosis (M15–M19)
There is a note at the start of this block explaining that the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis.

Each of the codes within categories M15-M19 use terms such as ‘primary, ‘secondary’ and ‘post-traumatic’ 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 to enable coders to assign a code for a specific type of arthrosis.

Where these modifiers are not included in the diagnostic statement, the coder must default to the .9 unspecified code from the relevant ICD-10 category. 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 accurately documented in the patient’s medical record by the responsible consultant.

**Examples:**

### Osteoarthritis (OA) left hip

- Index trail for osteoarthritis:
  - Osteoarthritis *(see also Arthrosis)* M19.9
  - Arthrosis *(deformans) (degenerative)* M19.9
    - hip – see Coxarthrosis
  - Coxarthrosis M16.9

Tabular List entry:

M16.9 Coxarthrosis, unspecified

### Secondary osteoarthritis (OA) right knee due to osteochondritis dissecans

- Index trail for osteoarthritis:
  - Osteoarthritis *(see also Arthrosis)* M19.9
  - Arthrosis *(deformans) (degenerative)* M19.9
    - knee – see Gonarthrosis
  - Gonarthrosis M17.9
    - secondary NEC (unilateral) M17.5

Tabular List entry:

M17.5 Other secondary gonarthrosis

- Index trail for osteochondritis:
  - Osteochondritis *(see also Osteochondrosis)* M93.9
    - dissecans M93.2

Tabular List entry:

M93.2 Osteochondritis dissecans
Examples (cont):

<table>
<thead>
<tr>
<th>Post-traumatic OA left hip due to fracture neck of femur three years ago</th>
</tr>
</thead>
</table>

Index trail for osteoarthritis:

Osteoarthritis *(see also Arthrosis)* M19.9

Arthrosis (deformans) (degenerative) M19.9
- hip – see Coxarthrosis

Coxarthrosis M16.9
- post-traumatic (unilateral) M16.5

Tabular List entry:

**M16.5 Other post-traumatic coxarthrosis**

- Post-traumatic coxarthrosis:
  - NOS
  - unilateral

Index trail for sequelae:

Sequelae *(of)* *(see also condition)*
- fracture T94.1
- - limb
- - - lower NEC T93.2
- - - - femur T93.1

Tabular List entry:

**T93.1 Sequelae of fracture of femur**

Sequelae of injury classifiable to S72.-

Categories M16 and M17 are specific to the hip and knee respectively.

Category M15 Polyarthrosis includes arthrosis/osteoarthritis with mention of more than one site. A patient who has osteoarthritis of both the hip and knee would be coded to M15. This category excludes bilateral involvement of a single joint (M16–M19).

Category M19 Other arthrosis must be used to code osteoarthritis in any site other than hip (M16), knee (M17) or first carpometacarpal joint (M18).
Example: Primary osteoarthritis of both elbow joints

Index trail for osteoarthritis:
Osteoarthritis (see also Arthrosis)

Arthrosis (deformans) (degenerative) M19.9
- joint NEC
- - primary M19.0

Tabular List entry:
M19.0 Primary arthrosis of other joints
[fifth character of 2 from before M00 to identify upper arm, includes elbow joint]
Other joint disorders
(M20–M25)

Internal derangement of knee (M23)
The supplementary subclassification provided here is to be used only with codes from category M23 and indicates the sub-site involvement of the knee, which includes ligaments and/or meniscus. The use of these fifth characters is mandatory where the data is present in the medical record and where doing so adds specific information about the site.

Example: Old tear anterior horn of medial meniscus

Index trail for tear:
Tear, torn...
- meniscus (knee) (current injury) S83.2
- - old (anterior horn) (lateral) (medial) (posterior horn) M23.2

Tabular List entry:
M23.2 Derangement of meniscus due to old tear or injury
Old bucket-handle tear
[fifth character of 1 from category M23 for sub site]

Rationale: Codes in Chapter XIII describe chronic (old) conditions only. Had the tear been a current injury, a code from Chapter XIX Injury, poisoning and certain other consequences of external causes would have been assigned instead.

Other specific joint derangements at category M24 use the supplementary site subclassification listed before M00 in the Tabular List.

Example: Recurrent dislocation of knee

Index trail for dislocation:
Dislocation (articular) T14.3
- knee S83.1
- - recurrent M24.4

Tabular List entry:
M24.4 Recurrent dislocation and subluxation of joint
[fifth character 6 from before M00 Lower leg, includes knee joint]

The axis of classification for categories M23 and M24 is specific type of joint derangement. A joint derangement due to a current injury would not be coded here.
Diseases of the musculoskeletal system

To assist in assigning the correct code, the following guidelines are provided:

- A joint injury that continues to be inflamed is still a current injury.
- A joint injury where the inflammation has resolved, but then the inflammation recurs, is an old/recurrent injury.
- A residual effect of a joint injury, such as fibrosis, indicates inappropriate healing and is considered to be a sequela (late effect) and not part of a current injury.
Dorsopathies
(M40–M54)

The fifth character subdivisions, found at block level in the Tabular List, are used for codes within this block (except for M50 and M51) and define the site of involvement in the spine. These fifth characters include single regions such as thoracic region and lumbar region but also adjoining regions, such as cervicothoracic region and lumbosacral region. Some of the four character codes within this block are site specific already, such as M41.3
Thoracogenic scoliosis. The additional fifth characters must only be added when the data is present in the medical record and when they add further specific information about the site at the fourth character code.

The same multiple-site principle as before applies when coding multiple sites affected within the spine, ie assign the fifth character 0.

Spondylopathies (M45–M49)

These include inflammatory and degenerative conditions such as rheumatoid arthritis of the spine and spondylosis.

Spondylitis is inflammation of the vertebrae, spondylopathy is any disorder of the vertebrae and spondylosis is a general term for osteoarthritis of the spine.

The diagnosis ankylosing spondylitis indicates the stiffening of a joint. This can be due to injury, disease, or surgical intervention. Ankylosing spondylitis covered at category M45.X refers to the condition that is the result of a disease or old injury.

Other dorsopathies (M50–M54)

Other dorsopathies include disc disorders and other back disorders not covered elsewhere.

The general term myelopathy is used within this block. It is a term used within ICD-10 to indicate that the stated diagnosis is affecting the spinal cord. Coders must be aware that the responsible consultants do not routinely use the term myelopathy. However, coders need to 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 cord compression

- Index trail for **displacement**:
  - **Displacement, displaced**
    - intervertebral disk NEC M51.2
    - - with myelopathy M51.0† G99.2*

Tabular List entries:

- **M51.0†** Lumbar and other intervertebral disc disorders with myelopathy (G99.2*)
  (site specified in subcategory so fifth character is not required)

- **G99.2*** Myelopathy in diseases classified elsewhere
  Myelopathy in:
  - intervertebral disc disorders (M50.0†, M51.0†)

**Rationale:** In the example the responsible consultant has not specified which condition is the main condition being treated therefore the coder must use the dagger/asterisk default.

The diagnosis of loin pain is included at code **M54.5 Low back 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 must always clarify with the responsible consultant before assigning this code to a patient admitted to a non-musculoskeletal specialty.
Soft tissue disorders
(M60–M79)

This block covers disorders of muscles, tendons and synovium, and is divided into three further sub-blocks. If the disorder is caused by an injury, it must be classified to Chapter XIX.

Disorders of muscles (M60–M63)
Disorders of muscles include inflammation, wasting and calcification of the muscle. However, if the muscle disorder is caused by an injury, a code from Chapter XIX must be assigned instead.

Rhabdomyolysis is a breakdown of skeletal muscle tissue and may be caused by physical, chemical or biological factors. Code assignment will depend on the cause of the muscle cell damage, for example rhabdomyolysis, unspecified or without a known cause is classified at code M62.8 Other specified disorders of muscle, whilst traumatic rhabdomyolysis is coded in Chapter XIX to T79.6 Traumatic ischaemia of muscle.

Rhabdomyolysis may result in kidney damage such as acute renal failure. Any kidney damage due to non-traumatic rhabdomyolysis must be coded in addition to M62.8. Renal failure due to traumatic rhabdomyolysis is coded to T79.5 Traumatic anuria.

Disorders of synovium and tendon (M65–M68)
Disorders of synovium and tendons include inflammation and spontaneous ruptures. Additional codes must be used to identify a bacterial agent or underlying cause of disease, when the information is available in the medical record.

Code M65.8 Other synovitis and tenosynovitis includes the description ‘irritable hip’. Where possible, coders must look for a more definitive diagnosis.

Other soft tissue disorders (M70–M79)
M70.- covers soft tissue disorders related to use, overuse and pressure, which are more commonly referred to as repetitive strain injuries (RSI).

Other soft tissue disorders include rotator cuff syndrome (M75.1) and tennis elbow (M77.1).

Code Z56.6 Other physical and mental strain related to work can be added to indicate that these conditions are work-related.
Although these conditions are called injuries, they are conditions that come about through long-term use and are therefore chronic conditions, and subsequently recorded to this chapter rather than to Chapter XIX.

Necrotising fasciitis is a rapidly advancing infection of the soft tissue caused by a number of bacteria and can be fatal if not treated. This is coded at **M72.6 Necrotising fasciitis** and an additional code(s) from Chapter I must be used to identify the infecting organism, if known.
Osteopathies and chondropathies (M80–M94)

This block covers osteopathies and chondropathies, which are diseases of the bone (osteo) and cartilage (chondro), and is divided into three further sub-blocks.

Disorders of bone density and structure (M80–M85)

This sub-block covers bone disorders which affect density and structure of bone, and therefore its strength to support the body. One of these conditions is osteoporosis (M80–M82), which can often cause pathological fractures in patients.

Example:

<table>
<thead>
<tr>
<th>Pathological fracture of femur in postoophorectomy osteoporosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for fracture:</td>
</tr>
<tr>
<td>Fracture (abduction) (adduction) ......</td>
</tr>
<tr>
<td>- pathological (cause unknown) M84.4</td>
</tr>
<tr>
<td>- - with osteoporosis M80.9</td>
</tr>
<tr>
<td>- - - postoophorectomy M80.1</td>
</tr>
</tbody>
</table>

Tabular List entry:

M80.1 Postoophorectomy osteoporosis with pathological fracture

[fifth character 5 from before M00 to identify femur]

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.

In instances where a patient has had a traumatic fall which results in a fracture, and the patient also has osteoporosis, the fracture would be classified as a traumatic fracture with osteoporosis coded as a co-morbidity.

The responsible consultant would need to indicate that the patient had suffered a fracture due to osteoporosis, for the code to be assigned for osteoporosis with a pathological fracture.
Examples:

Patient admitted with a pathological fracture of the forearm due to osteoporosis

📖 Index trail for osteoporosis:
Osteoporosis M81.9
- with pathological fracture M80.9

Tabular List entry:
M80.9 Unspecified osteoporosis with pathological fracture
[fifth character 3 from before M00 to identify forearm]

Patient admitted with fracture neck of femur after falling at home. Known osteoporosis

📖 Index trail for fracture:
Fracture (abduction) (adduction) ......
- femur, femoral S72.9
- neck S72.0

Tabular List entry:
S72.0 Fracture of neck of femur
[fifth character 0 for closed]

📖 External Cause Index trail for fall:
Fall, falling (accidental) W19.-

Tabular List entry:
W19 Unspecified fall
Includes: accidental fall NOS
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home

📖 Index trail for osteoporosis:
Osteoporosis M81.9

Tabular List entry:
M81.9 Osteoporosis, unspecified
(site is not specified so fifth character is not required)
Disorders of continuity of bone (M84)
There are several fracture codes in category M84 Disorders of continuity of bone. These are all chronic rather than current fractures, which are coded to Chapter XIX.

Other osteopathies (M86–M90)
Other osteopathies cover other bone diseases not elsewhere classified.

Fracture of bone in neoplastic disease (M90.7-*)
If a patient has a pathological fracture resulting from cancer (ICD-10 code M90.7-* Fracture of bone in neoplastic disease), the linked dagger must be the neoplasm code (C00-D48) associated with the fracture.

Example:

Patient treated on the orthopaedic ward for a pathological fracture of the neck of femur due to osteosarcoma femur

Index trail for fracture:
Fracture (abduction) (adduction)...
- pathological (cause unknown) M84.4
- - due to neoplastic disease NEC (M8000/1) (see also Neoplasm) D48.0† M90.7*

Tabular List entry:
M90.7* Fracture of bone in neoplastic disease (C00-D48†)
[fifth character 5 before M00 to identify femur]

Index trail for osteosarcoma:
Osteosarcoma (M9180/3) – see also Neoplasm, bone, malignant Malignant
Primary

Neoplasm
- bone (periosteum) ♦
- - femur (any part) C40.2

Tabular List entry:
C40.2† Malignant neoplasm of long bones of lower limb

The dagger and asterisk sequence may be reversed when the manifestation of a disease is the primary focus of care. This is in line with the primary diagnosis definition.
Other disorders of the musculoskeletal system and connective tissue (M95–M99)

This block covers postprocedural musculoskeletal disorders not elsewhere classified, as well as acquired deformities.

Biomechanical lesions, not elsewhere classified (M99)
Category **M99 Biomechanical lesions, not elsewhere classified** must not be used if the condition can be classified elsewhere. A supplementary subclassification indicating site of lesion is provided in the Tabular List for use with the appropriate subcategories in **M99.-**. The use of these fifth characters is mandatory where the data is present in the medical record and where doing so adds specific information about the site.
CHAPTER XIV
DISEASES OF THE GENITOURINARY SYSTEM
N00–N99

Coding Standards

Glomerular diseases
(N00–N08)

An additional code must be used to identify any of the following: associated chronic kidney disease (N18.-); the external cause of the glomerular disease; or the presence of renal failure (either acute at N17.-, or unspecified at N19.-).

Any condition within categories N00–N07 must be assigned a fourth character from the list provided at block level in the Tabular List.

The fourth character subdivisions classify morphological changes and histology reports confirmed by the responsible consultant must be referenced to accurately assign the fourth character subdivision. The .9 must be used if the morphological changes have not been specifically identified.

Example:

Nephrotic syndrome. Renal biopsy identifies a diagnosis of diffuse mesangial proliferative glomerulonephritis confirmed by the responsible consultant.

Index trail for nephrotic syndrome:
Syndrome – see also Disease
- nephrotic (congenital) (see also Nephrosis) N04.-

Tabular List entry:
N04 Nephrotic syndrome
[See before N00 for subdivisions]
.3 Diffuse mesangial proliferative glomerulonephritis

A syndrome is a set of symptoms occurring together.

Nephrotic syndrome and Nephritic syndrome differ in the combination and types of symptoms they produce in response to damage of the glomeruli. Care must be taken when coding these syndromes to accurately record the responsible consultant’s diagnosis as, when handwritten, these syndromes appear very similar.
Category **N02 Recurrent and persistent haematuria** must only be assigned if the responsible consultant describes the haematuria as being either persistent or recurrent. Usually the responsible consultant simply writes the term ‘haematuria’, which is excluded from this category and coded to **R31.X Unspecified haematuria** from Chapter XVIII instead.

When coding any condition classifiable to categories **N00-N07** 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 be assigned instead.

The responsible consultant must clearly state a link between the hypertension and the renal disease by using such modifying terms as ‘hypertensive’ or ‘due to hypertension’. Coders **cannot** assume a cause and effect relationship between these conditions. If there is no link stated, the conditions must be coded separately.
Renal tubulo-interstitial diseases
(N10–N16)

An additional code must be used to identify either any associated chronic kidney disease (N18.-) or infectious or toxic agents.

**Example:**

Analgesic nephropathy due to use of paracetamol for recurrent headaches

📖 Index trail for analgesic nephropathy:
  
  Nephropathy *(see also Nephritis)* N28.9
  - analgesic N14.0

Tabular List entry:

| N14.0 | Analgesic nephropathy |

The note at category level instructs the coder to use an additional external cause code from Chapter XX to identify the toxic agent.

📖 Index trail from Table of drugs and chemicals:

<table>
<thead>
<tr>
<th>Adverse effect in therapeutic use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
</tr>
<tr>
<td>Y45.5</td>
</tr>
</tbody>
</table>

Tabular List entry:

| Y45.5 | 4-Aminophenol derivatives |

**Gouty nephropathy**

Gout that is causing nephropathy is coded as follows:

<table>
<thead>
<tr>
<th>M10.0†</th>
<th>Idiopathic gout</th>
</tr>
</thead>
<tbody>
<tr>
<td>N16.8*</td>
<td>Renal tubulo-interstitial disorders in other diseases classified elsewhere</td>
</tr>
</tbody>
</table>

The sequencing will be dependent on the main condition treated. In instances where the responsible consultant has not specified, or is unable to confirm, which condition is the main condition being treated the coder must use the dagger/asterisk default.
Renal failure
(N17–N19)

An additional code must be used to identify any external cause of the renal failure.

Acute renal failure/acute kidney injury

Acute kidney injury (AKI) is the preferred term used by responsible consultants 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. It is therefore important that when a diagnosis of AKI is documented in a patient’s medical record, and it is not clear whether the clinical diagnosis of AKI is referring to a traumatic injury or the more familiar term of acute renal failure, the coder must confirm the diagnosis with the responsible consultant before code assignment is made.

Chronic kidney disease (N18)

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). Coders must not use the GFR or the description of GFR change, eg ‘mild decreased GFR’, as an indicator of kidney disease. This is a clinical decision and coders must only code to the stage of chronic kidney disease documented by the responsible consultant in the medical record. If the stage of chronic kidney disease is not documented, code N18.9 Chronic kidney disease, unspecified must be assigned. N18 is the correct category to record a diagnosis of chronic renal failure (CRF).

Where the underlying disease is known this must be coded in addition, and sequencing will depend on the main condition treated.
Example: Patient with chronic nephritis, dense deposit disease and chronic kidney disease (GFR of 45mL/min noted).

Index trail for nephritis:
Nephritis, nephritic N05.-
- chronic N03.-

Tabular List entry:
N03 Chronic nephritic syndrome
[See before N00 for subdivisions]
.6 Dense deposit disease

Index trail for disease:
Disease, diseased – see also Syndrome
- kidney (functional) (pelvis) N28.9
- - chronic N18.9

Tabular List entry:
N18.9 Chronic kidney disease, unspecified

Rationale: As the patient has both nephritis and chronic kidney disease, both conditions must be coded, and sequencing will depend on the main condition treated. As the GFR has only been noted and the stage of chronic kidney disease has not been confirmed by the responsible consultant, N18.9 is the correct code to assign as the coder must not interpret the GFR. Similarly, if the responsible consultant states CKD with ‘moderately decreased GFR’, code N18.9 would still be correct.

During an episode of inpatient care the patient’s kidney function may improve as a result of treatment; similarly their kidney function may also deteriorate as their condition worsens and therefore the stage of chronic kidney disease may change during an episode of care, eg from stage 2 to 3 or from stage 2 to 1. In these circumstances, the coder must code to the highest stage only and not assign multiple codes from category N18.-. For example, a patient whose stage of chronic kidney disease changes from stage 1 to 2 during the same consultant episode must be coded to N18.2 Chronic kidney disease, stage 2.

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 be assigned in addition.

The responsible consultant must clearly state a link between the hypertension and the chronic kidney disease by using such modifying terms as ‘hypertensive’ or ‘due to hypertension’, as coders cannot assume a cause and effect relationship between these conditions. If there is no link stated, the hypertension must be coded separately.
Example:

Stage 1 chronic kidney disease due to malignant hypertension

Index trail for disease:
Disease, diseased – see also Syndrome
- kidney (functional) (pelvis) N28.9
- - chronic N18.9
- - - stage 1 N18.1

Tabular List entry:
N18.1 Chronic kidney disease, stage 1

Index trail for hypertension:
Hypertension, hypertensive (accelerated)… I10
- with
- - kidney involvement (see also Hypertension, kidney) I12.9

Tabular List entry:
I12.9 Hypertensive renal disease without renal failure
Hypertensive renal disease NOS

Rationale: As the responsible consultant has stated that the kidney disease is due to hypertension, code I12.9 must be assigned following code N18.1.

Acute on chronic renal failure

When acute renal/kidney failure and chronic renal failure/kidney disease are both present two codes are required. The acute renal/kidney failure (N17.-) should normally be coded first, followed by the code for the chronic renal failure/kidney disease (N18.-); however the sequencing may change due to the Primary Diagnosis Definition.

Example:

Acute on chronic renal failure

Index trail for renal failure:
Failure, failed
- renal – see Failure, kidney
- kidney N19
- - acute N17.9
- - chronic N18.9

Tabular List entries:
N17.9 Acute renal failure, unspecified
N18.9 Chronic kidney disease, unspecified
End stage renal disease/failure

A diagnostic statement of either end-stage renal failure (ESRF) or end-stage renal disease (ESRD) implies the patient has irreversible chronic renal failure. These diagnoses are classified at code N18.5 Chronic kidney disease, stage 5. A patient with this disease is often receiving haemodialysis.

Code N18.5 is also used in a number of dagger and asterisk combinations as indicated by the inclusions within the Tabular List, for example, uraemic apoplexia is classified at codes N18.5† and I68.8*.

If a patient is admitted as a day case, or an inpatient solely for the purpose of renal dialysis, then a code from category Z49 Care involving dialysis must be used as a secondary code; the primary diagnosis being the renal condition.

However, if the patient is admitted for other treatment, for instance a transplant, but receives dialysis while in hospital, it is not appropriate to record a code from category Z49.

Patients who are on a regular programme of dialysis treatments and who are admitted for other reasons must have code Z99.2 Dependence on renal dialysis assigned as a secondary code in order to capture the important information that they are a dialysis patient. This code can be found under the lead term Status in the Alphabetical Index.
**Examples:**

Patient with end-stage renal disease admitted to have his Tenckhoff cannula removed due to aseptic peritonitis. While in hospital, he has ten haemodialysis sessions.

**NOTE** The cannula had been inserted for haemodialysis

- **Index trail for** aseptic peritonitis:
  - Peritonitis (adhesive) (fibrinous) (with effusion) K65.9
    - aseptic T81.6

  **Tabular List entry:**
  - **T81.6** Acute reaction to foreign substance accidentally left during a procedure
    - Peritonitis:
      - aseptic
      - chemical

- **External cause Index trail for** complication of dialysis:
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
    - dialysis (kidney) Y84.1

  **Tabular List entry:**
  - **Y84.1** Kidney dialysis

- **Index trail for** renal disease:
  - Disease, diseased – see also Syndrome
    - end-stage kidney N18.5

  **Tabular List entry:**
  - **N18.5** Chronic kidney disease, stage 5

- **Index trail for** dialysis status:
  - Status (post)
    - renal dialysis Z99.2

  **Tabular List entry:**
  - **Z99.2** Dependence on renal dialysis
    - Presence of arteriovenous shunt for dialysis
    - Renal dialysis status
<table>
<thead>
<tr>
<th>Examples (cont):</th>
<th>Patient admitted with end-stage renal failure for help and supervision with his first five haemodialysis sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for end-stage renal failure:</td>
<td>Index trail for dialysis:</td>
</tr>
<tr>
<td>Failure, failed</td>
<td>Dialysis (intermittent) (treatment)</td>
</tr>
<tr>
<td>- renal – see Failure, kidney</td>
<td>- renal Z49.1</td>
</tr>
<tr>
<td>- kidney N19</td>
<td></td>
</tr>
<tr>
<td>- - end-stage (chronic) N18.5</td>
<td>Tabular List entry:</td>
</tr>
<tr>
<td></td>
<td>N18.5 Chronic kidney disease, stage 5</td>
</tr>
<tr>
<td></td>
<td>Tabular List entry:</td>
</tr>
<tr>
<td></td>
<td>Z49.1 Extracorporeal dialysis</td>
</tr>
<tr>
<td></td>
<td>Dialysis (renal) NOS</td>
</tr>
</tbody>
</table>
Urolithiasis
(N20–N23)

A calculus at the ureteropelvic junction, ie the point where the ureter joins the kidney pelvis, must be coded as if it were a kidney stone (N20.0).

Acquired obstruction of the ureter is coded depending on the cause. Obstruction due to ureteric calculus is included in the code for calculus (N20.1). Obstruction due to ureteric kink or stricture may be associated with other conditions such as hydronephrosis and pyelonephritis, and be implied in these codes.

Example:

Ureteral stricture with hydronephrosis

Index trail for stricture

Stricture (see also Stenosis) R68.8
- ureter (postoperative) N13.5
  - with
  - - - hydronephrosis N13.1

Tabular List entry:

N13.1 Hydronephrosis with ureteral stricture, not elsewhere classified

Gout that is causing nephrolithiasis (kidney stones) is coded as follows:

M10.0† Idiopathic gout
N22.8* Calculus of urinary tract in other diseases classified elsewhere

The dagger and asterisk sequence may be reversed when the manifestation of a disease is the primary focus of care. This is in line with the primary diagnosis definition. In instances where the responsible consultant has not specified or is unable to confirm which condition is the main condition being treated, or this information is unknown, the coder must use the dagger/asterisk default, ie assign the dagger code in primary position, followed by the associated asterisk code.
Other disorders of kidney and ureter
(N25-N29)

Unspecified contracted kidney (N26)
When N26.X Unspecified contracted kidney 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 be assigned instead.

The responsible consultant must clearly state a link between the hypertension and the contracted kidney by using such modifying terms as 'hypertensive' or 'due to hypertension', as coders cannot assume a cause and effect relationship between these conditions. If there is no link stated, the conditions must be coded separately, i.e. N26.X and I10.X.
Other diseases of the urinary system
(N30–N39)

There are a number of important exclusions at block level in the Tabular List.

Cystitis (N30)

Cystitis is classified differently depending on cause. Cystitis can be classified to category N30 and requires an additional code from the range B95-B98 when due to an infectious agent, or to Chapter XX when due to an external agent, as instructed in the note at category level in the Tabular List.

Cystitis due to a sexually transmitted disease is classified in Chapter I Certain infectious and parasitic diseases.

Example:

Gonococcal cystitis

Index trail for cystitis:
Cystitis (exudative) (hemorrhagic) (septic) (suppurative) N30.9
- gonococcal A54.0

Tabular List entry:
A54.0 Gonococcal infection of lower genitourinary tract
without periurethral or accessory gland abscess
Gonococcal:
• cervicitis NOS
• cystitis NOS

Cystitis due to an underlying disease is given a dagger/asterisk code.

Example:

Tuberculous cystitis. Patient admitted for treatment of the cystitis.

Index trail for cystitis:
Cystitis (exudative) (hemorrhagic) (septic) (suppurative) N30.9
- tuberculous A18.1† N33.0*

Tabular List entries:
N33.0* Tuberculous cystitis (A18.1†)
A18.1† Tuberculosis of genitourinary system
Tuberculosis of:
• bladder † (N33.0*)

Rationale: The dagger and asterisk sequence has been reversed in the above example as the manifestation is the primary focus of care.
Urethritis and urethral syndrome (N34)

Urethritis is also classified depending on cause. When due to an infectious agent, an additional code from B95-B98 is required as per the note at category level in the Tabular List.

When due to a sexually transmitted disease, a code from the range A50–A64 must be assigned.

Example:

**Chlamydial urethritis**

- Index trail for **urethritis**:
  - **Urethritis (anterior) (posterior) N34.2**
    - chlamydial A56.0
  
  Tabular List entry:
  - **A56.0 Chlamydial infection of lower genitourinary tract**
  
  Chlamydiaal:
  - cervicitis
  - cystitis
  - urethritis

A diagnostic term sometimes causing confusion is ‘nonspecific urethritis’ (NSU). Nonspecific urethritis does **not** mean unspecified urethritis. It refers to a non-sexually transmitted urethritis, and is coded at **N34.1**.

Urethritis due to an underlying disease is given a dagger/asterisk code.

Example:

**Candidal urethritis. Patient admitted for treatment of the urethritis.**

- Index trail for **urethritis**:
  - **Urethritis (anterior) (posterior) N34.2**
    - candidal B37.4† N37.0*
  
  Tabular List entries:
  - **N37.0* Urethritis in diseases classified elsewhere**
    - Candidal urethritis (B37.4†)
  - **B37.4† Candidiasis of other urogenital sites**
    - Candidal:
      - balanitis † (N51.2*)
      - urethritis † (N37.0*)

**Rationale:** The dagger and asterisk sequence may be reversed if the manifestation of a disease is the primary focus of care. This is in line with the primary diagnosis definition.
Diseases of the genitourinary system

One of the most important causes of acquired urethral obstruction is urethral stricture. In order to code urethral stricture, it is necessary to know the cause of the stricture. For example, urethral stricture due to sexually transmitted disease is coded using codes from Chapter I Certain infectious and parasitic diseases. However, a postprocedural urethral stricture is coded at N99.1 Postprocedural urethral stricture and a code from either categories Y83- Y84 must be assigned in addition if this adds further information about the nature of the procedure causing the stricture.

Urinary incontinence (N39)
Both male and female stress incontinence is coded at N39.3 Stress incontinence. This is also the correct code to record a diagnosis of urinary sphincter weakness incontinence. Cough-urge incontinence of urine is not the same as stress incontinence, as it is an urge incontinence precipitated by a cough. This type of incontinence is coded at N39.4 Other specified urinary incontinence.

The coder must assign an additional code of N32.8 Other specified disorders of bladder to identify any overactive bladder or detrusor muscle hyperactivity associated with urinary incontinence classifiable to codes N39.3 Stress incontinence and N39.4 Other specified urinary incontinence.
Diseases of male genital organs
(N40–N51)

There are many ‘Use additional code’ notes throughout this block of which the coder must be aware.

**Benign prostatic hypertrophy**
Acquired urethral obstruction is coded depending on cause. When caused by prostatic hyperplasia, it is regarded as a symptom of the hyperplasia and, as such, is included in the code for hyperplasia. A statement of urethral obstruction due to benign prostatic hypertrophy (BPH) is coded to **N40.X**.

If, however, the obstruction due to the BPH leads to retention of urine and the patient is admitted solely for the purpose of treatment of that retention, the code **R33.X Retention of urine** must be recorded as an additional code.

**Example:**
Patient with benign prostatic hypertrophy admitted for catheterisation to treat urinary retention

📖 Index trail for **prostatic hypertrophy**:
  - Hypertrophy, hypertrophic
    - prostate (adenofibromatous) (asymptomatic) (benign) (early) (recurrent) N40

Tabular List entry:
- **N40.X Hyperplasia of prostate**
  - Adenofibromatous hypertrophy
  - Enlargement (benign)
  - Hypertrophy (benign)

📖 Index trail for **urinary retention**:
  - Retention, retained
    - urine R33

Tabular List entry:
- **R33.X Retention of urine**

**Intraepithelial neoplasia/dysplasia of prostate**
Carcinoma in situ of the prostate has generally been replaced by the term ‘high grade intraepithelial neoplasia of the prostate’ (HGIN) or high grade dysplasia. The correct ICD-10 code to assign for this diagnosis is **D07.5 Carcinoma in situ of prostate**.
In cases where there is a system of grading intraepithelial neoplasia (such as cervix, vulva and vagina), all high grade or grade III descriptions are classified as in situ neoplasms (the note at the beginning of the block D00-D09 In situ neoplasms in the Tabular List gives further guidance). Grade I and Grade II prostatic intraepithelial neoplasia or low grade dysplasia of prostate must be coded to N42.3 Dysplasia of prostate.

Male infertility (N46)
When coding male infertility and the current cause is known, the cause must be sequenced first, with N46.X Male infertility assigned as an additional code.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Azoospermia due to bilateral undescended testes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for undescended testicle:</td>
<td></td>
</tr>
<tr>
<td>Undescended – see also Malposition, congenital</td>
<td></td>
</tr>
<tr>
<td>- testicle Q53.9</td>
<td></td>
</tr>
<tr>
<td>- - bilateral Q53.2</td>
<td></td>
</tr>
<tr>
<td>Tabular List entry:</td>
<td></td>
</tr>
<tr>
<td>Q53.2 Undescended testicle, bilateral</td>
<td></td>
</tr>
<tr>
<td>Index trail for Azoospermia:</td>
<td></td>
</tr>
<tr>
<td>Azoospermia N46</td>
<td></td>
</tr>
<tr>
<td>Tabular List entry:</td>
<td></td>
</tr>
<tr>
<td>N46.X Male infertility</td>
<td></td>
</tr>
<tr>
<td>Azoospermia NOS</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale:** In the above example, the cause of the infertility is the bilateral undescended testes.
Disorders of the breast
(N60–N64)

These codes are non gender specific.

Where a statement of ‘breast lump’ is made by the responsible consultant, a more specific diagnosis must be established if possible by confirmation of the histology by the responsible consultant. If only the code N63.X Unspecified lump in breast is assigned, some breast cancers may go unrecorded.
Inflammatory diseases of female pelvic organs  
(N70–N77)

It is important to read the exclusion notes throughout this block, many of which direct the coder to Chapter XV Pregnancy, childbirth and the puerperium.

As the conditions within this block are inflammatory disorders, there are many ‘Use additional code’ notes to instruct the coder to use an additional code from the range B95–B98 to identify the infectious agent.

**Pelvic cellulitis**

Pelvic cellulitis is coded differently in males and females. In males it is coded to Chapter XI Diseases of the digestive system.

An unusual convention is used in the inclusion notes in Tabular List category N73 **Other female pelvic inflammatory diseases**. The diseases listed as inclusions under (or indexed to) code N73.0 **Acute parametritis and pelvic cellulitis** also apply to code N73.1 **Chronic parametritis and pelvic cellulitis** when they are specified as chronic; and to N73.2 **Unspecified parametritis and pelvic cellulitis** when they are not specified as either acute or chronic.

Example:

**Chronic pelvic cellulitis in a 39 year old female patient**

Index trail for cellulitis:

- **Cellulitis (diffuse) (with lymphangitis)** L03.9
  - pelvis, pelvic (chronic)
  - - female (see also Disease, pelvis, inflammatory) N73.2

**Disease, diseased – see also Syndrome**

- pelvis, pelvic
- - inflammatory (female) N73.9
- - - chronic N73.1

Tabular List entry:

- **N73.1 Chronic parametritis and pelvic cellulitis**
  Any condition in N73.0 specified as chronic

**Rationale:** The above example reinforces the importance of always verifying codes in the Tabular List. In this case the inclusion note at N73.2 identifies this code would be an incorrect assignment for chronic pelvic cellulitis.
Example:

Chronic pelvic cellulitis in a 39 year old male patient

Index trail for **cellulitis**:

- **Cellulitis (diffuse) (with lymphangitis)** L03.9
  - pelvis, pelvic (chronic)
  - - male K65.0

Tabular List entry:

**K65.0 Acute peritonitis**
Noninflammatory disorders of female genital tract (N80–N98)

Many of the exclusion notes throughout this block direct the coder to Chapter XV Pregnancy, childbirth and the puerperium.

Endometriosis (N80)
Endometriosis is the presence of endometrial deposits at sites other than the uterine lining (the endometrium). It is classified to category N80 where the axis of classification is site of implant. Endometriosis is often found in more than one site. Coders must assign a code from category N80 for each different site affected.

Example:

<table>
<thead>
<tr>
<th>Ovarian and rectal endometriosis</th>
</tr>
</thead>
</table>

Index trail for endometriosis:

Endometriosis N80.9
- intestine N80.5
- ovary N80.1

Tabular List entry:

<table>
<thead>
<tr>
<th>N80.1</th>
<th>Endometriosis of ovary</th>
</tr>
</thead>
<tbody>
<tr>
<td>N80.5</td>
<td>Endometriosis of intestine</td>
</tr>
</tbody>
</table>

Rationale: Sequencing will depend on the site receiving the most treatment, or that which is listed first by the responsible consultant. The correct code for endometriosis of the broad ligament is N80.3 Endometriosis of pelvic peritoneum.

Prolapses (N81)
A prolapse is the downward displacement of part or all of an organ or tissue from its normal position. The following five conditions are all classified at category N81 Female genital prolapse:

- a prolapsed uterus (N81.2 - N81.4) is a uterus that has descended into the vagina
- a cystocele (N81.1) is a herniation of a portion of the bladder into the vagina
- a rectocele (N81.6) is a herniation of the rectum through the vaginal wall
- a vaginal enterocele (N81.5) is a herniation of the intestine through the back of the vaginal wall
- an urethrocele (N81.0) is a prolapse of the female urethra. When associated with a cystocele, it is called a cystourethrocele.
These conditions must be considered in relation to each other when coding. It is important to understand that cystoceles, rectoceles, enteroceles and urethroceles are all **vaginal wall prolapses**.

When a vaginal wall prolapse (cystocele, etc) and a uterine prolapse are both present, a diagnosis of uterovaginal prolapse is recorded and classified according to the extent (degree) of the uterine prolapsed:

- Uterine prolapse of **first** and **second degree** N81.2 = an incomplete prolapse.
- Uterine prolapse of **third degree** or **procidentia** N81.3 = a complete prolapse.

The *Excludes* notes at codes N81.0, N81.1, N81.5 and N81.6 in the Tabular List which indicate that it is only necessary to assign a code from the range N81.2-N81.4 (uterovaginal prolapse) when coding cystocele, urethrocele, enterocele or rectocele together with a prolapsed uterus. Two codes are **not** required unless two different vaginal wall prolapses have been recorded by the responsible consultant, such as cystocele and rectocele.

**Examples:**

<table>
<thead>
<tr>
<th>Second degree uterine prolapse with cystocele</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for prolapse:</td>
</tr>
<tr>
<td>Prolapse, prolapsed</td>
</tr>
<tr>
<td>- uterovaginal N81.4</td>
</tr>
<tr>
<td>- incomplete N81.2</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>Prolapse, prolapsed</td>
</tr>
<tr>
<td>- uterus (with prolapse of vagina) N81.4</td>
</tr>
<tr>
<td>- second degree N81.2</td>
</tr>
</tbody>
</table>

Tabular List entry:

```
N81.2  Incomplete uterovaginal prolapse
      Prolapse of cervix NOS
      Uterine prolapse:
      • first degree
      • second degree
```
Examples (cont):

Patient has both cystocele and rectocele

- Index trail for cystocele:
  - Cystocele (-urethrocele)
    - female N81.1
  - Cystocele with urethrocele
    - female N81.1
  - Prolapse of (anterior) vaginal wall NOS
    - Excludes: cystocele with prolapse of uterus (N81.2-N81.4)

- Index trail for rectocele:
  - Rectocele
    - female N81.6
  - Prolapse of posterior vaginal wall
    - Excludes: rectal prolapse (K62.3)
    - rectocele with prolapse of uterus (N81.2-N81.4)

CIN, VAIN, VIN

Cervical intraepithelial neoplasia (CIN) is new and abnormal changes in the tissues covering the cervix uteri. Dysplastic changes begin in the deepest layer of the cervical epithelium.

CIN I and CIN II are assigned to category N87 Dysplasia of cervix uteri, as is severe cervical dysplasia NOS. CIN III, however, is classified to carcinoma in situ (D06).

Vaginal intraepithelial neoplasia (VAIN) and vulval intraepithelial neoplasia (VIN) are classified in the same way. VAIN I and VAIN II are assigned to N89.+, and VAIN III to D07.2. VIN I and VIN II are assigned to N90 Other inflammatory disorders of vulva and perineum, and VIN III to D07.1.

Occasionally, patients are diagnosed with CIN Grade I-II or CIN Grade II-III. Coders must code to the highest grade of CIN in these instances.
Abnormal bleeding
Abnormal bleeding from the female genital tract may be due to a number of different disorders.

In most cases that are not related to the menstrual cycle, the bleeding is merely a symptom of the disorder and, as such, is included in the code for the cause. Disorders of the menstrual cycle are classified to categories N91 Absent, scanty and rare menstruation and N92 Excessive, frequent and regular menstruation.

Menorrhagia (excessive or prolonged menstruation) is classified according to whether it occurs at puberty (N92.2), during the child-bearing years, with regular cycle (N92.0) or irregular cycle (N92.1), or at the onset of menopause (N92.4). It is very rare that the responsible consultant will provide this level of detail in the case notes; menorrhagia is therefore most commonly coded to its default code of N92.0.

When menorrhagia is associated with uterine fibroids (leiomyoma), the coder must assign the code for the fibroid first, unless the responsible consultant specifically states that the heavy bleeding is not due to the fibroid.

Example:

Menorrhagia due to intramural uterine leiomyoma

Index trail for leiomyoma:
Leiomyoma (M8890/0) – see also Neoplasm, connective tissue, benign
- uterus (cervix) (corpus) D25.9
- - intramural D25.1

Tabular List entry:
D25.1 Intramural leiomyoma of uterus

Index trail for menorrhagia:
Menorrhagia (primary) N92.0

Tabular List entry:
N92.0 Excessive and frequent menstruation with regular cycle
    Heavy periods NOS
    Menorrhagia NOS
    Polymenorrhoea

Menopausal and perimenopausal disorders are classified in category N95. Postmenopausal bleeding, postmenopausal atrophic vaginitis and other menopausal symptoms, eg hot flushes, are coded to one code if they are associated with natural menopause and to another if associated with artificial menopause.
Example:

Menopausal vertigo – bilateral oophorectomy two years ago resulting in an artificial menopause

Index trail for vertigo:
Vertigo R42
- menopausal N95.1

Tabular List entry:
N95.1 Menopausal and female climacteric states
Excludes: those associated with artificial menopause (N95.3)
N95.3 States associated with artificial menopause

Rationale: The above example illustrates the importance of always checking the Tabular List, as the Alphabetical Index used alone directs the coder to an inappropriate code.

Occasionally a term will be recorded as a diagnostic statement when it is really a pathology report indicating a normal condition. For example, a statement of ‘proliferative endometrium’ or ‘secretory endometrium’ may be given in the patient record. Both of these are normal findings at different stages of the menstrual cycle. These are not classifiable and must therefore be ignored by the coder.
Female infertility (N97)
Infertility is, of course, a symptom of an underlying disorder. When coding a patient with infertility due to a known cause and the cause is being treated, the coder must always record the cause first and the infertility second. Where the treatment is for infertility, the infertility is coded first with the cause second.

Example:
Infertility due to primary ovarian failure. Treatment is for the ovarian failure.

Index trail for ovarian failure:
Failure, failed
- ovarian (primary) E28.3

Tabular List entry:
E28.3 Primary ovarian failure

Index trail for infertility:
Infertility
- female N97.9
- - associated with
- - - anovulation N97.0

Tabular List entry:
N97.0 Female infertility associated with anovulation
Other disorders of the genitourinary system (N99)

Refer also to the ‘Coding Postprocedural categories in body system chapters’ section in Chapter XIX.

Category **N99 Postprocedural disorders of genitourinary system, not elsewhere classified** is available for conditions that occur either as a consequence of specific procedures and techniques, or as a result of the removal of an organ.

When postprocedural conditions and complications are recorded as the main condition, reference to modifiers or qualifiers in the Alphabetical Index is essential for choosing the correct code.

Codes from this category must only be assigned if the coder is specifically directed here by the Alphabetical Index. The linkage between the condition and the procedure must be documented by the responsible consultant.

**Example**

**Posthysterectomy vaginal prolapse**

- Index trail for **prolapse**:
  - **Prolapse, prolapsed**
    - vagina (anterior) (wall) N81.1
    - - posthysterectomy N99.3

- Tabular List entry:
  - **N99.3 Prolapse of vaginal vault after hysterectomy**

**Rationale:** In the above example, the Alphabetical Index directly refers the coder to a code from the postprocedural disorder category at the end of Chapter XIV.

The responsible consultant must document that the vaginal prolapse is due to the previous hysterectomy, using terms such as ‘posthysterectomy’ and ‘due to 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** when assigning code **N99.3** because the nature of the procedure is implicit in the code description of **N99.3**.
Example: Postoperative urinary tract infection (Escherichia coli) following total abdominal hysterectomy two days ago

Index trail for postoperative urinary tract infection:
Infection, infected (opportunistic) B99
- urinary (tract) NEC N39.0

Tabular List entry:
N39.0 Urinary tract infection, site not specified
Use additional code (B95-B98) to identify infectious agent

Index trail for infectious agent:
Infection, infected (opportunistic) B99
- Escherichia (E.) coli NEC A49.8
- - as cause of disease classified elsewhere B96.2

Tabular List entry:
B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters

External Cause Index trail for postoperative, ie a complication:
Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
- removal of an organ (partial) (total) NEC Y83.6

Tabular List entry:
Y83.6 Removal of other organ (partial) (total)

Rationale: In this example an external cause code has to be assigned to identify that the urinary tract infection is a postoperative UTI. This is because there is no ‘postoperative’ or similar modifier at the index entry for urinary tract infection. Nor can the coder default this to a code from category N99, because the Alphabetical Index does not specifically direct them to such a code.

The various ways of recording postprocedural complications are described in more detail in Chapter XIX, and linkage must always be made by the responsible consultant.
CHAPTER XV
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
O00–O99

Chapter rules and conventions

UK specific rules are applicable to this chapter
Coding Standards

Pregnancy with abortive outcome (O00–O08)

Within this block the following are classified:

- Ectopic pregnancy, molar pregnancy and miscarriage before the 24th completed week of gestation (Categories O00-O03)
- Termination of pregnancy (abortion), irrespective of gestational age (Categories O04-O07).
- Complications of miscarriage and termination of pregnancy (Category O08)

Clinical coders must note that 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 block.

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.

Retained products of conception (RPOC) are the retention of any part of the placental tissue, membranes, gestation sac or fetal pole following miscarriage or termination of pregnancy.
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.

Miscarriage is defined as the spontaneous loss of pregnancy before 24 completed weeks of gestation, and is 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 Missed abortion also classifies missed miscarriage and category O03 Spontaneous abortion also classifies spontaneous miscarriage.

After the 24th completed week the loss of a pregnancy is defined as a stillbirth or late intrauterine fetal death, and must be coded to O36.4 Maternal care for intrauterine death.

A code from category O08 Complications following abortion and ectopic and molar pregnancy may be assigned in addition to:

i) Identify any maternal complication associated with categories O00-O02 as these categories do not identify the complication within the code

ii) Category O03 to give further information about the complication.

The rules for using category O08 are covered in more detail later in this chapter in the section 'Complications following miscarriage and abortion'.

Ectopic pregnancy (O00)
Ectopic pregnancies are those that develop in a site other than the uterus; the most common site being the fallopian tube. The fourth character subdivision identifies the site of the ectopic pregnancy.

Hydatidiform mole (O01)
This category is used to classify a hydatidiform mole, which may also be referred to as gestational trophoblastic disease. Hydatidiform moles can be diagnosed on ultrasound but can only be definitively confirmed by histological examination of the products of conception. Hydatidiform moles are notifiable to the cancer registry as, if left, they have the potential to become malignant.
Other abnormal products of conception (O02)
The code **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. **O02.1 Missed abortion** must only be used 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**.

**Examples:**

Patient admitted for surgical management of miscarriage following scan yesterday which confirmed the diagnosis of missed miscarriage (missed abortion).

- Index trail for **missed abortion**:
  - Missed
    - abortion O02.1
  or
  - Abortion (complete) (incomplete) O06.-
    - missed O02.1

Tabular List entry:

**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.

- Index trail for **spontaneous abortion**:
  - Abortion (complete) (incomplete) O06.-
    - spontaneous O03.-
  or
  - Miscarriage O03.-

Tabular List entry:

**O03 Spontaneous abortion**

[See before O00 for subdivisions]

**.9 Complete or unspecified, without complication**
Spontaneous abortion (O03)
This 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.

Category O03 requires the addition of a fourth character (found in the Tabular List before category O00) to identify whether the miscarriage was complete, or incomplete, and if there were any maternal complications.

Spontaneous miscarriage can be subdivided into:

- **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 assignment of fourth characters .0-.4 indicate that the miscarriage was incomplete and also if 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 assignment of fourth characters .5-.9 indicate that the miscarriage was complete and also if there were any maternal complications.

If spontaneous delivery of a non-viable fetus occurs prior to 24 completed weeks of gestation, the episode must be classified as a spontaneous abortion.

Threatened miscarriage
Threatened miscarriage is bleeding in pregnancy prior to 24 completed weeks and is classified at code O20.0 Threatened abortion within the haemorrhage in early pregnancy category.

Medical management of missed miscarriage
Code O02.1 Missed abortion must be assigned to patients with a missed miscarriage admitted to receive medication (such as prostaglandins) 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.

This applies whether the fetus is passed during the same hospital provider spell as the administration of the medication, or whether the patient is given the medication and is discharged home prior to expulsion of the fetus. Code O03.- Spontaneous abortion must not be used when bleeding is present after administration of the medication because this is not a spontaneous miscarriage as the passing of the fetus is induced by the medication.

Code Z51.2 Other chemotherapy is also assigned in a secondary position if the patient is admitted solely for the purpose of receiving the medication to induce delivery of the retained dead fetus.
Examples:

Patient solely admitted for administration of prostaglandins following scan yesterday which confirmed the diagnosis of missed miscarriage (missed abortion). Following administration of the prostaglandin the patient starts bleeding and continues to complete delivery of the fetus prior to discharge home.

📖 Index trail for missed abortion:
Missed
- abortion O02.1

or

Abortion (complete) (incomplete) O06.-
- missed O02.1

Tabular List entry:
O02.1 Missed abortion

📖 Index trail for Chemotherapy:
Chemotherapy (session) (for) Z51.2

Tabular List entry:
Z51.2 Other chemotherapy
Termination of pregnancy (O04-O07)

Categories O04-O07 classify termination of pregnancy.

**Abortion** is the termination of a continuing pregnancy by medical or surgical means, and is the expulsion or extraction of all or any part of the pregnancy, including placental tissue, membranes, gestation sac and fetus.

The term ‘termination of pregnancy’ is the preferred term used by clinical staff when referring to ‘abortion’ within codes in categories O04-O07.

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. 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) or if the baby was liveborn or stillborn.

Categories O04–O06 all require the addition of a fourth character (found in the Tabular List before category O00) to identify whether the termination of pregnancy was complete, or incomplete, and if there were any maternal complications.

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-.4.

Codes in category O08 Complications following abortion and ectopic and molar pregnancy may be used in addition to add further information about complications following termination of pregnancy. The rules for using category O08 are covered in more detail later in this chapter in the section ‘Complications following miscarriage and abortion’.

**Medical abortion (O04)**

This 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.

Terminations may be performed using surgical methods such as vacuum aspiration or by medical means using abortifacient drugs.

Sometimes a patient may attend for a medical termination of pregnancy but subsequently change their mind; the detailed national clinical coding standards for recording these cases are explained in the section ‘Cancellation of medical termination of pregnancy’.
Other abortion (O05)
This code includes illegally induced termination of pregnancy: the illegal interruption of pregnancy by any means. A coder would not be expected to use this category.

Unspecified abortion (O06)
This category indicates that the type of termination of pregnancy is not known. Category O06 must not be used for inpatient termination of pregnancy coding as it would be expected that the patient medical records 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, the detailed national clinical coding standards for recording of these cases are explained in the section ‘Inadvertent loss of pregnancy’.

Failed attempted abortion (O07)
This includes failure of attempted induction of termination of pregnancy, either legal or illegal, and will only be used when the fetus is still present. Fourth character subdivisions are provided with this category to identify maternal complications.
Termination of pregnancy resulting in liveborn

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 in the first secondary diagnosis field to indicate that the termination of pregnancy resulted in a live birth.

**Example:** Medical abortion due to spina bifida in fetus. Baby was born with a heartbeat and lived for 15 minutes.

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.–
    - medical O04.–

  Tabular List entry:
  - O04 Medical abortion
    [See before O00 for subdivisions]
    - 9 Complete or unspecified, without complication

- Index trail for live birth:
  - Outcome of delivery Z37.9
    - single Z37.9
    - liveborn Z37.0

  Tabular List entry:
  - Z37.0 Single live birth

- Index trail for pregnancy affected by fetal spina bifida:
  - Pregnancy (single) (uterine)
    - management affected by
      - - fetal (suspected)
      - - - spina bifida O35.0

  Tabular List entry:
  - O35.0 Maternal care for (suspected) central nervous system
  - malformation in fetus
    Maternal care for (suspected) fetal:
    - anencephaly
    - spina bifida
Inadvertent loss of pregnancy
Inadvertent or unintentional loss of pregnancy may result from two possible different causes.

1. Inadvertent loss of pregnancy due to direct cause
A direct cause of inadvertent loss of pregnancy is when the 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.

Category **O06 Unspecified abortion** is used to classify an inadvertent loss of pregnancy due to direct cause because the pregnancy has been terminated due to the uterine surgery.

The main condition treated during the relevant consultant episode is recorded as the primary diagnosis, followed by category **O06** with the appropriate fourth character.

**Example:**
Fibroid uterus – Inadvertent termination of pregnancy (hysterectomy performed; patient found to be pregnant)

- Index trail for the fibroid:
  Fibroid (tumour) (M8890/0) – see also Neoplasm, connective tissue, benign
  - uterus D25.9

  Tabular List entry:
  
  D25.9  Leiomyoma of uterus, unspecified

- Index trail for abortion:
  Abortion (complete) (incomplete) O06.-

  Tabular List entry:
  
  O06  Unspecified abortion
  [See before O00 for subdivisions]
  .9 Complete or unspecified, without complication
2. Inadvertent loss of pregnancy due to indirect cause

An indirect cause of inadvertent loss of pregnancy is when the 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.

Category **O03 Spontaneous abortion** is used to classify the inadvertent loss of pregnancy due to indirect cause.

The main condition treated during the consultant episode is recorded as the primary diagnosis, followed by the appropriate code from category **O03** to indicate spontaneous miscarriage.

**Example:**

Acute appendicitis – Inadvertent termination of pregnancy. (Appendicectomy performed, complete spontaneous miscarriage occurred one day later).

Index trail for the **appendicitis**:

Appendicitis K37
- acute (catarrhal) (fulminating) (gangrenous) (obstructive) (retrocecal) (suppurative) K35.8

Tabular List entry:

K35.8 Acute appendicitis, other and unspecified

Index trail for the **abortion**:

Abortion (complete) (incomplete) O06.–
- spontaneous O03.–

Tabular List entry:

O03 **Spontaneous abortion**
[See before O00 for subdivisions]
.9 Complete or unspecified, without complication
Medical termination of pregnancy
Patients admitted for the administration of abortifacient drugs (for example, Mifepristone) or pessaries for termination of pregnancy are usually kept in hospital until they have aborted the pregnancy, however sometimes they may be discharged to abort the pregnancy at home.

If the patient is kept in hospital and they abort the pregnancy whilst in hospital then this must be coded as a complete medical abortion, by assigning **O04 Medical abortion** with the appropriate fourth character from the range .5 to .9.

If the patient is discharged to abort the pregnancy at home, they must also be coded to **O04 Medical abortion** with the appropriate fourth character from the range .5 to .9, to indicate an unspecified medical termination of pregnancy (i.e. not specified as incomplete or complete). This is because the termination process has started by the administration of the abortifacient. This guidance would also apply in instances where the patient begins to bleed before discharge home to abort the pregnancy, as this is a sign that the process of aborting the pregnancy has begun.

If the patient is admitted solely for the purpose of receiving abortifacient drugs for termination of pregnancy code **Z51.2 Other chemotherapy** is assigned as an additional code whether the patient aborts the pregnancy whilst in hospital or subsequently at home.

**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.

- Index trail for the abortion:
  Abortion (complete) (incomplete) O06.–
  - medical O04.–

  Tabular List entry:
  **O04 Medical abortion**
  [See before O00 for subdivisions]
  .9 Complete or unspecified, without complication

- Index trail for Chemotherapy:
  Chemotherapy (session) (for) Z51.2

  Tabular List entry:
  **Z51.2 Other chemotherapy**

**Rationale:** Code **Z51.2 Other chemotherapy** is also assigned in a secondary position because the patient was admitted solely for the purpose of receiving Mifepristone for termination of pregnancy.
If the patient is readmitted with an incomplete termination of pregnancy following the above treatment, the primary diagnosis would be **O04 Medical abortion** with the appropriate fourth character from the range .0 to .4.

**Examples:**

Patient readmitted to gynaecology ward with an incomplete abortion the day after receiving Mifepristone for termination of pregnancy

Index trail for **incomplete abortion**:

Abortion (complete) (incomplete) O06.-
- medical O04.-

Tabular List entry:

O04 Medical abortion
[See before O00 for subdivisions]
.4 Incomplete, without complication

**Cancellation of medical termination of pregnancy**

In some cases a patient is admitted for a medical termination of pregnancy but changes their mind which results in cancellation of the planned procedure. In these circumstances a code from category **Z34 Supervision of normal pregnancy** followed by **Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons** is assigned, providing there are no other conditions present classifiable to Chapter XV Pregnancy, childbirth and the puerperium or category **Z35 Supervision of high-risk pregnancy**.

When a patient has been admitted for a termination of pregnancy due to a **current condition** classifiable to Chapter XV Pregnancy, childbirth and the puerperium but changes their mind, the appropriate code from categories **O10-O45** or categories **O95-O99** must be assigned to identify the pregnancy related condition, followed by code **Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons**.

**Example:**

Patient admitted at 15 weeks gestation for surgical termination of pregnancy due to suspected damage to the fetus by drug use. Following admission, the patient changes her mind and the planned procedure is cancelled.

Index trail for **maternal care**:

Maternal care (for) (known) (suspected)
- damage to fetus from
  - drugs O35.5

Tabular List entry:

O35.5 Maternal care for (suspected) damage to fetus by drugs
Example (cont):

Index trail for **procedure cancelled**:
- **Procedure (surgical)**
- - not done Z53.9
- - because of
- - - patient’s decision NEC Z53.2

Tabular List entry:

```
Z53.2  Procedure not carried out because of patient’s decision for other and unspecified reasons
```

If a patient has been admitted for a termination of pregnancy because it is considered to be high risk (e.g. the patient is an elderly primigravida, or the pregnancy is high-risk due to social problems, etc) and changes their mind, a code from category **Z35 Supervision of high-risk pregnancy** and code **Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons** must both be assigned.

Example:

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.

Index trail for **pregnancy**:
- **Pregnancy (single) (uterine)**
- - management affected by
- - - poor obstetric history (conditions in O10-O92) Z35.2

Tabular List entry:

```
Z35.2  Supervision of pregnancy with other poor reproductive or obstetric history
```

Index trail for **procedure cancelled**:
- **Procedure (surgical)**
- - not done Z53.9
- - because of
- - - patient’s decision NEC Z53.2

Tabular List entry:

```
Z53.2  Procedure not carried out because of patient’s decision for other and unspecified reasons
```

If a patient has been admitted for a termination of pregnancy due to a history of a pregnancy-related condition that is classifiable to categories **O10-O92**, and changes their mind, then codes **Z35.2 Supervision of pregnancy with other poor reproductive or obstetric history** and **Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons** must both be assigned.
Complications following abortion and ectopic and molar pregnancy (O08)
Codes in this category are not to be used in a primary position except where there is a new consultant episode or hospital provider spell which is solely for treatment of the complication, e.g. a current complication of a previous abortion or miscarriage.

Codes in category O08 must be used as additional codes with categories O00–O02 to identify associated complications, and may be used with categories O03–O07 to give further information about the complication.
Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy

There are three types of complications associated with ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy, these are explained in detail below and summarised diagrammatically following this section.

1. Maternal complications of ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (abortion)

The first type of complication refers to maternal complications; conditions affecting the mother which cause, result from, or are otherwise associated with the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy.

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.

The third column identifies the fourth character to be used with category O08.

Code assignment for maternal complications is dependent upon when the complication occurred. Maternal complications of miscarriage and termination of pregnancy themselves can be classified in three different ways.

a. Firstly, maternal complications occurring during the same consultant episode as the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy itself are classified using codes in categories O00—O07. Categories O03–O06 all require the assignment of a fourth character to identify the type of complication, e.g. haemorrhage.
A code from category **O08 Complications following abortion and ectopic and molar pregnancy** must be used in addition to the codes from the range **O00–O02** to identify any associated complications, and may be used with categories **O03–O07** to give further information about the complication if it is not stated at four character level.

**Example:**

Pelvic peritonitis following a tubal pregnancy. Same consultant episode as tubal pregnancy.

- Index trail for the **tubal pregnancy**:
  - Pregnancy (single) (uterine)
    - tubal (with abortion) (with rupture) O00.1

  Tabular List entry:
  - O00.1 Tubal pregnancy

- Index trail for the **peritonitis**:
  - Peritonitis (adhesive) (fibrinous) (with effusion) K65.9
    - following
    - - ectopic or molar pregnancy O08.0

  Tabular List entry:
  - O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy

**Rationale:** Code **O08.0** must also be assigned to identify the associated complication of pelvic peritonitis.

**Example:**

Incomplete spontaneous miscarriage with pelvic peritonitis during same consultant episode

- Index trail for **abortion**:
  - Abortion (complete) (incomplete) O06.-
    - spontaneous O03.-
  or
  - Miscarriage O03.-

  Tabular List entry:
  - O03 Spontaneous abortion
    [See before O00 for subdivisions]
    .0 Incomplete, complicated by genital tract and pelvic infection

**Rationale:** It is not necessary to assign code **O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy** in addition as it adds no further information about the complication. The complication of pelvic peritonitis is indicated at fourth character level within
code O03.0 Spontaneous abortion incomplete, complicated by genital tract and pelvic infection.

**Example:**

Complete spontaneous miscarriage with renal failure in the same consultant episode as the miscarriage

- Index trail for abortion:
  Abortion (complete) (incomplete) O06.-
  - spontaneous O03.-

or

Miscarriage O03.-

Tabular List entry:

O03 Spontaneous abortion
[See before O00 for subdivisions]
.8 Complete or unspecified, with other and unspecified complications

- Index trail for renal failure:
  Failure, failed
  - renal – see Failure, kidney
  - kidney N19
  - - following
  - - - abortion (subsequent episode) O08.4
  - - - - current episode – see Abortion

Tabular List entry:

O08.4 Renal failure following abortion and ectopic and molar pregnancy

**Rationale:** Code O08.4 is used in addition to code O03.8 as it adds further specificity about the complication.
Pregnancy-related complications occurring during the same consultant 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, are coded separately.

**Example:**
Incomplete spontaneous miscarriage with excessive haemorrhage, the patient is also treated for severe pre-eclampsia during the same consultant episode.

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.-
  - spontaneous O03.-
  or
  - Miscarriage O03.-

Tabular List entry:

```
O03  Spontaneous abortion
    [See before O00 for subdivisions]
    .1 Incomplete, complicated by delayed or excessive haemorrhage
```

- Index trail for severe pre-eclampsia:
  - Pre-eclampsia O14.9
  - severe O14.1

Tabular List entry:

```
O14.1 Severe pre-eclampsia
```

The sequencing of codes may on occasion change to accurately reflect the main condition treated. This follows the primary diagnosis definition.

**Example:**
Patient admitted with severe pre-eclampsia, and during this consultant episode an incomplete miscarriage also occurred.

- Index trail for severe pre-eclampsia:
  - Pre-eclampsia O14.9
  - severe O14.1

Tabular List entry:

```
O14.1 Severe pre-eclampsia
```

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.-
  - spontaneous O03.-
  or
  - Miscarriage O03.-
Example (cont):

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O03</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>.4</td>
<td>Incomplete, without complication</td>
</tr>
</tbody>
</table>

[See before O00 for subdivisions]

b. The second type of maternal complication refers to maternal complications occurring on a subsequent consultant episode where the patient has retained products of conception following a previous medical termination of pregnancy or spontaneous miscarriage. These are recorded as follows:

**Retained products of conception after previous medical termination of pregnancy**

*Medical termination of pregnancy episode*

This must be coded as a complete medical termination of pregnancy on completion of the procedure. The code assigned would be from category **O04 Medical abortion**, with the relevant fourth character from .5 to .9 to indicate a complete termination of pregnancy.

*Retained products of conception episode (following previous medical termination of pregnancy)*

This must be coded as an incomplete medical termination of pregnancy by assigning a code from category **O04**, with the relevant fourth character from .0 to .4 to indicate an incomplete termination of pregnancy.

**Retained products of conception after previous spontaneous miscarriage.**

*Spontaneous miscarriage episode*

This must be coded as a spontaneous miscarriage using **O03 Spontaneous abortion** with the appropriate fourth character from .0 to .9, as a spontaneous miscarriage can be either complete or incomplete.

*Retained products of conception episode (following previous spontaneous miscarriage)*

This must be coded as an incomplete spontaneous miscarriage, assigning a code from category **O03**, with the relevant fourth character from .0 to .4 to indicate an incomplete miscarriage. Even if a procedure for the retained products of conception (e.g. ERPC) was carried out on the previous spontaneous miscarriage episode, the retained products episode would still be coded to an incomplete spontaneous miscarriage, as it is considered to be ongoing treatment of a spontaneous miscarriage.
c. The third type of maternal complications are those occurring in a subsequent consultant episode to that in which the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy occurred, and where there are no retained products of conception. These are classified using codes in category O08 Complications following abortion and ectopic and molar pregnancy.

A code from O08 must not be used as a primary diagnosis code except where the new consultant episode is solely for treatment of a complication of a previous miscarriage or termination of pregnancy.

**Example:**

Patient re-admitted with pelvic peritonitis following a medical termination of pregnancy performed five days previously. No retained products of conception present.

📖 Index trail for the *peritonitis*:
- Peritonitis (adhesive) (fibrinous) (with effusion) K65.9
  - following
  - - ectopic or molar pregnancy O08.0

Tabular List entry:
- O08.0  Genital tract and pelvic infection following abortion and ectopic and molar pregnancy

**Rationale:** In this example a code from category O08 is the only code required as there is no current termination of pregnancy, only a previous termination of pregnancy. If retained products of conception were present, this would be coded to O04.0 Medical abortion, incomplete, complicated by genital tract and pelvic infection.
2. Fetal complications as the reason for termination of pregnancy (abortion)

The second type of complication refers to fetal complications as the reason for early termination of pregnancy. These are assigned as follows:

- Assign a code for the termination of pregnancy itself (O04–O07) as the primary diagnosis.
- Assign a code for the fetal complication.

**Example:**

Complete termination of pregnancy because the fetus was affected by spina bifida.

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.-
  - therapeutic O04.-

Tabular List entry:

- **O04** Medical abortion
  - [See before O00 for subdivisions]
  - .9 Complete or unspecified, without complication

- Index trail for pregnancy affected by fetal spina bifida:
  - Pregnancy (single) (uterine)
  - - management affected by
  - - - fetal (suspected)
  - - - spina bifida O35.0

Tabular List entry:

- **O35.0** Maternal care for (suspected) central nervous system malformation in fetus
  - Maternal care for (suspected) fetal:
    - anencephaly
    - spina bifida
The fetal complication(s) may also be the result of a condition which has been experienced by the mother that is no longer present.

**Example:**

Complete termination of pregnancy at 16 weeks due to maternal rubella at five weeks gestation.

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.–
    - therapeutic O04.–

- Tabular List entry:
  - O04 Medical abortion
    - [See before O00 for subdivisions]
      - .9 Complete or unspecified, without complication

- Index trail for the pregnancy complicated by rubella:
  - Pregnancy (single) (uterine)
    - management affected by
      - - - fetal (suspected)
      - - - - damage from
        - - - - maternal
          - - - - - rubella O35.3

- Tabular List entry:
  - O35.3 Maternal care for (suspected) damage to fetus from viral disease in mother
    - Maternal care for (suspected) damage to fetus from maternal:
      - cytomegalovirus infection
      - rubella
3. **Fetal complications and maternal complications occurring in the same consultant episode**

The third type of complication refers to fetal complications as the reason for termination of pregnancy and maternal complications of the termination occurring during the same consultant episode.

When a fetal complication is the reason for termination of pregnancy and maternal complications also occur, 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 for the fetal complication.
- 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).

**Example:**

Complete termination of pregnancy complicated by renal failure. Termination of pregnancy performed because the fetus was affected by Down’s Syndrome.

- Index trail for the abortion:
  - Abortion (complete) (incomplete) O06.–
    - therapeutic O04.–

  Tabular List entry:
  - O04 Medical abortion
    [See before O00 for subdivisions]
    .8 Complete or unspecified, with other and unspecified complications

- Index trail for pregnancy affected by fetal Down’s Syndrome:
  - Pregnancy (single) (uterine)
    - management affected by
    - - fetal (suspected)
    - - - chromosomal abnormality (conditions in Q90-Q99) O35.1

  Tabular List entry:
  - O35.1 Maternal care for (suspected) chromosomal abnormality in fetus

- Index trail for renal failure:
  - Failure, failed
    - renal – see Failure, kidney
    - kidney N19
    - - following
    - - - abortion (subsequent episode) O08.4
    - - - - current episode – see Abortion
Example (cont):

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O08.4 Renal failure following abortion and ectopic and molar pregnancy</td>
</tr>
</tbody>
</table>

**Rationale:** As the fourth character at category O04 does not further specify the renal failure, a code from category O08 must also be assigned.
Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (TOP)

Maternal complications of ectopic pregnancy, molar pregnancy, miscarriage and TOP

Maternal complications occurring during the same consultant episode as:
- Ectopic pregnancy, molar pregnancy or miscarriage - code separately
- Termination of pregnancy O04-O07
  - + O08 as an additional code with O00-O02 to identify associated complications or
    + O08 as an additional code if gives further information
- Retained products of conception (RPOC) after previous spontaneous miscarriage
  - + O08 as an additional code if gives further information
- Retained products of conception (RPOC), after previous medical TOP
- Spontaneous miscarriage episode O03 with 4th character from .0 to .9
- Medical TOP episode O04 with 4th character from .5 to .9
- RPOC episode O03 with 4th character from .0 to .4
- RPOC episode O04 with 4th character from .0 to .4

Fetal complications as the reason for TOP and maternal complications of the TOP occurring in the same consultant episode

O04-O07 + code for the fetal complication + O08 as an additional code if the complication is not stated in the fourth character at O04-O07

Fetal complications as the reason for TOP

Maternal complications occurring on a subsequent consultant episode

O04-O07 + code for the fetal complication

Pregnancy-related complications not associated with the ectopic pregnancy, molar pregnancy or miscarriage - code separately

Retained products of conception (RPOC) after previous spontaneous miscarriage

Spontaneous miscarriage episode O03 with 4th character from .0 to .9

Medical TOP episode O04 with 4th character from .5 to .9

RPOC episode O03 with 4th character from .0 to .4

RPOC episode O04 with 4th character from .0 to .4

No retained products of conception (RPOC) following previous miscarriage or TOP

Subsequent episode with maternal complications O08

Pregnancy, childbirth and the puerperium


XV-26
Oedema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium (O10–O16)

Eclampsia (convulsions and coma in pregnancy or puerperium associated with hypertension, oedema and proteinuria), pre-eclampsia (hypertension, oedema, and proteinuria in pregnancy), oedema, proteinuria and hypertensive disorders are coded to this block for all stages of pregnancy, childbirth and the puerperium.

Hypertension may be a pre-existing condition which is complicated by pregnancy, childbirth and the puerperium, or it may be gestational (pregnancy-induced). There are two categories provided for pre-existing hypertension (O10 and O11). The fourth character subdivisions at category O10 Pre-existing hypertension complicating pregnancy, childbirth and the puerperium correspond to hypertensive diseases coded to categories I10–I15 in Chapter IX.

Example:
Patient twenty weeks pregnant with pre-existing hypertensive heart disease

Index trail for pregnancy:

- Pregnancy (single) (uterine)
  - complicated by (see also Pregnancy, management, affected by)
  - - hypertensive
  - - - heart disease, pre-existing O10.1

Tabular List entry:

O10.1 Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium
Examples: Patient twenty weeks pregnant with pregnancy induced hypertension (PIH)

Index trail for pregnancy:

Pregnancy (single) (uterine)
- complicated by hypertension (see also Hypertension, complicating pregnancy) O16

Hypertension, hypertensive (accelerated) (benign) (essential)
(idiopathic) (malignant) (primary) (systemic)
- complicating pregnancy, childbirth or puerperium
- - pregnancy-induced (see also Hypertension, gestational) O13

Tabular List entry:

O13.X Gestational [pregnancy-induced] hypertension with significant proteinuria

Gestational hypertension with oedema

Index trail for hypertension:

Hypertension, hypertensive (accelerated) (benign) (essential)
(idiopathic) (malignant) (primary) (systemic) I10
- complicating pregnancy, childbirth or puerperium O16
- - with
- - - edema (see also Pre-eclampsia) O14.9

Tabular List entry:

O14.9 Pre-eclampsia, unspecified
Other maternal disorders predominantly related to pregnancy
(O20–O29)

Most disorders coded within this block relate only to pregnancy. The exceptions to this are categories O24 Diabetes mellitus in pregnancy and O25.X Malnutrition in pregnancy, which must also be used to classify these disorders during childbirth and the puerperium.

Haemorrhage in early pregnancy (O20)
This category includes bleeding before 24 weeks completed gestation in the UK, but excludes pregnancy with abortive outcome which is coded to O00-O08. Code O20.0 classifies a diagnosis of ‘threatened miscarriage’; bleeding in pregnancy prior to 24 completed weeks, the cervix is found to be tightly closed and the pregnancy is most likely to continue. If a threatened miscarriage proceeds to miscarriage then this must be coded to O03 Spontaneous abortion.

Excessive vomiting in pregnancy (O21)
Hyperemesis gravidarum, or excessive vomiting, in pregnancy is only coded when clinically significant. For this code to be assigned the patient must have been admitted because of, or treated solely for, the vomiting. The fourth character subdivisions identify the number of weeks gestation.

Venous complications in pregnancy (O22)
Any venous complications in pregnancy are classified here, but those occurring in labour, delivery and the puerperium are classified to category O87 Venous complications in the puerperium.

**Example:**
Deep vein thrombosis (DVT) complicating pregnancy. Patient is 26 weeks pregnant.

Index trail for pregnancy:
Pregnancy (single) (uterine)
- complicated by (see also Pregnancy, management, affected by)
  - thrombosis O22.9
  - - venous O22.9
  - - - deep O22.3

Tabular List entry:
O22.3 Deep phlebothrombosis in pregnancy
Example: Deep phlebothrombosis. Patient readmitted 10 days following delivery.

Index trail for phlebothrombosis:
Phlebothrombosis (see also Thrombosis) I82.9
- puerperal, deep O87.1

Tabular List entry:
O87.1 Deep phlebothrombosis in the puerperium

Infections of genitourinary tract in pregnancy (O23)
The fourth character subdivisions at this category identify the site of infection. Urinary infections of named anatomical sites other than kidney, bladder and urethra must be coded to O23.3 Infections of other parts of urinary tract in pregnancy. Infections of the genital tract (reproductive organs) such as salpingo-oophoritis must be coded to O23.5 Infections of the genital tract in pregnancy. A code from categories B95-B98 must be assigned in addition to identify the organism causing the infection, when this is known.

Genitourinary infections following delivery are classified to O86 Other puerperal infections, and infection (unqualified) during labour to O75.3 Other infection during labour.

Example: Patient 24 weeks pregnant admitted with bladder infection

Index trail for pregnancy:
Pregnancy (single) (uterine)
- complicated by (see also Pregnancy, management, affected by)
- - infection(s)
- - - bladder O23.1

Tabular List entry:
O23.1 Infections of bladder in pregnancy

Vaginal thrush in pregnancy is coded to O23.5 Infections of the genital tract in pregnancy, B37.3† Candidiasis of vulva and vagina and N77.1* Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere.
Diabetes mellitus in pregnancy (O24)

Diabetes mellitus in pregnancy, childbirth and the puerperium is always classified here, regardless of the outcome or circumstances.

Fourth character subdivisions are available to identify either pre-existing diabetes by type, or gestational diabetes.

If the diabetes is causing certain manifestations which would normally be classified using the dagger and asterisk system, a code from O24 will become the dagger code as shown in the following example.

Example:

Patient 30 weeks pregnant admitted with diabetic polyneuropathy. Pre-existing insulin-dependent diabetes.

Index trail for diabetes:

Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- complicating pregnancy, childbirth or puerperium (maternal) O24.-
- - pre-existing O24.3
- - - insulin-dependent O24.0

Tabular List entry:

O24.0† Pre-existing diabetes mellitus, insulin-dependent

Index trail for polyneuropathy:

Polyneuropathy (peripheral) G62.9
- diabetic (see also E10–E14 with fourth character .4) E14.4†
  G63.2

Tabular List entry:

G63.2 Diabetic polyneuropathy (E10–E14† with common fourth character .4)

Rationale: In this example the responsible consultant has not confirmed which condition is the main condition being treated and the dagger/asterisk default must be used, ie the dagger code must be assigned in primary position, followed by the associated asterisk code.

Maternal care for other conditions predominantly related to pregnancy (O26)

This category must be used for conditions that are solely pregnancy induced. Pre-existing conditions that affect the pregnancy should be coded to O99 Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium.

Pregnancy care of habitual aborter (O26.2) is recorded here, and consequently excluded from category Z35 Supervision of high-risk pregnancy.
O26.6 Liver disorders in pregnancy, childbirth and the puerperium includes obstetric cholestasis which may also be referred to as cholestasis of pregnancy or intrahepatic cholestasis of pregnancy, it is not necessary to assign a code from Chapter XI in addition.

O26.8 Other specified pregnancy-related conditions is used to record any condition which has occurred purely because the patient is pregnant, and which does not have a separate subterm for ‘complicating pregnancy’ in the Alphabatical Index.

Several conditions coded to Chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, may be coded this way if specifically caused by the pregnancy, eg abdominal pain, high blood pressure (not diagnosed as hypertension), or frequency of micturition. An additional code to identify the condition must be used.

Examples:

Lumbar backache due to pregnancy. Patient 30 weeks pregnant. No previous history of backache.

Index trail for pregnancy related conditions:
Complications (from) (of)
- pregnancy NEC (see also Pregnancy, complicated by) O26.9

Tabular List entry (after checking category):
O26.8 Other specified pregnancy-related conditions

Index trail for backache:
Backache (postural) M54.9

Tabular List entry:
M54.9 Dorsalgia, unspecified
Backache NOS
[See site code before M40]
.6 Lumbar region
Abnormal findings on antenatal screening of mother (O28)
This would only be used when an abnormal finding did not result in a definitive diagnosis.

Pregnancy of unknown location (O28.1)
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).

For a diagnosis of “pregnancy of unknown location” (PUL) the coder must assign code O28.1 Abnormal biochemical finding on antenatal screening of mother unless a more specific diagnosis is made such as ectopic pregnancy.

Complications of anaesthesia during pregnancy (O29)
Complications of anaesthesia are coded according to the time the anaesthesia was administered, and not to the time when the complications arise. This category is only to be used when complications arise from anaesthesia which was given during pregnancy.

Complications arising from anaesthesia given during labour and delivery are coded to category O74 Complications of anaesthesia during labour and delivery.
Complications arising from anaesthesia given during the puerperium are coded to category **O89 Complications of anaesthesia during the puerperium**.

**Example:**

Patient admitted for elective caesarean section under epidural anaesthesia for disproportion. Epidural anaesthesia induced severe headache.

- Index trail for **delivery for disproportion**:
  - Delivery (single) O80.9
  - - cesarean (for) O82.9
  - - - disproportion NEC O33.9

- Tabular List entry:
  - O33.9  Maternal care for disproportion, unspecified

- Index trail for **epidural-induced severe headache**:
  - Headache R51
    - - spinal and epidural anaesthesia-induced (in) T88.5
    - - - pregnancy O29.4

- Tabular List entry:
  - O29.4  Spinal and epidural anaesthesia-induced headache during pregnancy

**Rationale:** The anaesthesia was given before delivery, but the headache occurred following delivery. As complications of anaesthesia are coded according to the time the anaesthesia is administered, the correct code is the one which reflects that the anaesthesia was given before delivery. A code from category **Z37 Outcome of delivery** must be assigned in the first secondary position as described later in this chapter.
Maternal care related to the fetus and amniotic cavity and possible delivery problems (O30–O48)

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, followed by the appropriate outcome of delivery code.

When the patient has conditions requiring the use of another code from Chapter XV on the delivery episode and is also a multiple gestation, then an appropriate code from category O30 is recorded in a secondary position.

Example:

Patient admitted for delivery of triplets. During delivery she sustains a second degree perineal laceration.

Index trail for laceration:

Laceration (see also Wound, open T14.1
- perineum, perineal S31.0
- - complicating delivery O70.9
- - - second degree O70.1

Tabular List entry:

O70.1  Second degree perineal laceration during delivery

Index trail for triplet:

Pregnancy (single) (uterine)
- triplet O30.1

Tabular List entry:

O30.1  Triplet pregnancy

Rationale: A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.

Maternal care for known or suspected malpresentation of fetus, disproportion and abnormality of pelvic organs (O32–O34)

Codes in categories O32-O34 are assigned before onset of labour when the listed condition is a reason for observation, hospitalisation other obstetric care of the mother or for caesarean section.

If the patient goes into labour these codes will 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.
**Example:**

Breech extraction with version for transverse lie

- Index trail for **transverse lie**:
  - **Presentation, fetal**
    - transverse (mother) O32.2

  Tabular List entry:
  - **O32.2 Maternal care for transverse and oblique lie**
    - **Presentation**:
      - oblique
      - transverse

**Rationale:** A code from category **Z37 Outcome of delivery** must be assigned in the first secondary position as described later in this chapter.

**Example:**

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.

- Index trail for **breech presentation**:
  - **Presentation, fetal**
    - breech (mother) O32.1

  Tabular List entry:
  - **O32.1 Maternal care for breech presentation**

**Rationale:** A code from category **Z37 Outcome of delivery** must be assigned in the first secondary position as described later in this chapter.

Face to pubes presentation must not be coded unless it is causing obstructed labour. Face to pubes presentation causing obstructed labour is classified at code **O64.0 Obstructed labour due to incomplete rotation of fetal head**.

**Maternal care for intrauterine death (O36.4)**

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.

The code **O36.4 Maternal care for intrauterine death** must be assigned for stillbirths and late intrauterine fetal deaths. If the cause of death is known **O36.4** is assigned after the codes which describe 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 as described later in this
chapter.

**Example:**

Antenatal scan at 28 weeks due to vaginal haemorrhage reveals placenta praevia and fetal death, patient proceeds to deliver stillborn infant.

Index trail for **praevia**:

- Placenta praevia (with haemorrhage) *(see also Placenta, previa)* O44.1

Tabular List entry:

O44.1 Placenta praevia with haemorrhage

Index trail for **live birth**:

- Outcome of delivery Z37.9
  - single Z37.9
  - stillborn Z37.1

Tabular List entry:

Z37.1 Single stillbirth

Index trail for **intrauterine death**:

- Pregnancy (single) (uterine)
  - management affected by
  - - intrauterine death (late) O36.4

Tabular List entry:

O36.4 Maternal care for intrauterine death

**Rationale:** Code Z37.1 Single stillbirth is assigned in the first secondary position to indicate that the outcome of delivery was a stillbirth.

If it is not known prior to delivery that there is a stillbirth or that intrauterine fetal death has occurred, the code O36.4 should not be recorded.

**Example:**

Delivery at 39 weeks because of fetal hypoxia, baby born dead.

Index trail for **hypoxia**:

- Hypoxia – *(see also Anoxia)*
  - fetal – *(see Distress, fetal)*
  - - affecting management of pregnancy *(unrelated to labor or delivery)* O36.3

Tabular List entry:

O36.3 Maternal care for signs of fetal hypoxia
Example (cont):

Index trail for live birth:

- **Outcome of delivery** Z37.9
  - single Z37.9
  - stillborn Z37.1

Tabular List entry:

| Z37.1 | Single stillbirth |

**Rationale:** Code **Z37.1 Single stillbirth** is assigned in the first secondary position to indicate that the outcome of delivery was a stillbirth.

The correct code for a patient admitted with reduced fetal movements (often seen as ↕FM in the medical record) is **O36.8 Maternal care for other specified fetal problems**.

**Premature rupture of membranes (O42)**

This category is only used to classify rupture of membranes before the onset of labour, regardless of the length of gestation. Fourth character subdivisions are provided to identify onset of labour within or after 24 hours.
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.

Antepartum haemorrhage, not elsewhere classified (O46)
Haemorrhage **after** 24 completed weeks gestation but **before** labour is classified here.

Haemorrhage during the two later stages of pregnancy is coded to the following categories:

- **O67 Labour and delivery complicated by intrapartum haemorrhage, not elsewhere classified**
- **O72 Postpartum haemorrhage**

False labour (O47)
This is a common condition which may also be known as ‘Braxton-Hicks’ contractions. Fourth character subdivisions are provided for the number of completed weeks gestation.

Prolonged pregnancy (O48)
Prolonged pregnancy relates to pregnancy that exceeds 42 weeks. Gestational age is the age calculated from the date of the first day of the last normal menstrual period to the date of delivery.

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 (**ICD-10 Volume 2**)

It is very important for consistent interpretation of the term ‘prolonged pregnancy’ that this equation be applied accurately. However, clinical judgement is paramount. If the responsible consultant documents in the medical record that the patient is ‘post-term’, or ‘post-dates’, then this code must be assigned.
Complications of labour and delivery (O60–O75)

Preterm labour and delivery (O60)
This category is used to classify onset (spontaneous) of labour before 37 completed weeks of gestation. Labour may be spontaneous or induced and delivery may be vaginal or surgical.

It may be necessary to assign more than one code from this category when the delivery admission contains multiple consultant episodes.

O60.0 Preterm labour without delivery
This code is used to classify patients who are admitted in preterm labour which stops and they are sent home to await further events.

O60.1 Preterm spontaneous labour with preterm delivery
This code is used to classify 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
This code classifies patients who deliver to term but who at some point, during the current pregnancy, have been admitted in spontaneous preterm labour which then stopped by itself or was delayed with the help of medication such as tocolytics. These patients may have remained in hospital following admission in preterm labour and delivered to term during the same hospital provider spell or they may have gone home following a previous admission with preterm labour and been readmitted and delivered to term.

In patients who have gone home in between the preterm labour stopping and the term delivery, this code can only be assigned on the delivery episode if it is documented in the medical record that they were previously admitted in preterm labour.

Example:
Mother readmitted in active labour at 37+1 week’s gestation goes on to deliver term baby boy in hospital. She was admitted 4 days previously in spontaneous preterm labour and given Atosiban acetate to delay delivery.

📖 Index trail for labour:
Labor (see also Delivery)
- early onset (before 37 completed weeks of gestation)
- - with
- - - term delivery O60.2

Tabular List entry:
O60.2 Preterm spontaneous labour with term delivery
Example (cont):

Index trail for live birth:

Outcome of delivery Z37.9
- single Z37.9
- - liveborn Z37.0

Tabular List entry:
Z37.0 Single live birth

O60.3 Preterm delivery without spontaneous labour

This code must be used to classify those patients where there is a condition in the mother/or baby 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.

Example:

Mother with severe pre-eclampsia admitted at 35 weeks for caesarean section. Baby born in hospital preterm.

Index trail for severe pre-eclampsia:

Pre-eclampsia O14.9
- severe O14.1

Tabular List entry:
O14.1 Severe pre-eclampsia

Index trail for live birth:

Outcome of delivery Z37.9
- single Z37.9
- - liveborn Z37.0

Tabular List entry:
Z37.0 Single live birth

Index trail for delivery:

Delivery (single) O80.9
- cesarean (for) O82.9
- - preterm NEC O60.1
- - - without spontaneous labor O60.3

Tabular List entry:
O60.3 Preterm delivery without spontaneous labour

Long labour (O63)

Clinical judgement is required here, as there are no guidelines for the length of time constituting a long labour. It must be stated in the medical record that the labour or stage of labour is prolonged for this category to be used. If the reason why the labour was prolonged is stated, then this must be coded instead.
Obstructed labour (O64-O66)
Obstructed labour due to malposition and malpresentation of fetus, disproportion and abnormality of maternal pelvic organs is classified to categories O64–O66.

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.

Codes in categories O64-O66 must only be assigned in the following instances:

- It is clearly documented by the responsible consultant in the patient’s medical record that the labour was obstructed.
- The index trail directly takes the coder to the codes from categories O64-O66.

If obstructed labour has not been documented, and the index trail does not direct the coder to codes in categories O64-O66, codes from categories O32–O34 must be assigned instead.

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.

Example:
Obstructed labour due to a fetopelvic disproportion caused by mother’s deformed pelvis, emergency caesarean section performed.

Index trail for obstructed labour:
Labor (see also Delivery)
- obstructed O66.9
  - by or due to
    - - - deformity (acquired) (congenital)
    - - - - pelvis (bony) NEC O65.0

Tabular List entry:
O65.0 Obstructed labour due to deformed pelvis

Rationale: The labour has been documented as ‘obstructed’, therefore code O65.0 Obstructed labour due to deformed pelvis, must be assigned. A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.
Example: Dystocia due to oversized fetus - emergency caesarean section delivery

Index trail for dystocia:

Dystocia O66.9
- fetal, fetus O66.9
- - oversized O66.2

Tabular List entry:

O66.2 Obstructed labour due to unusually large fetus

Rationale: The term ‘obstructed labour’ has not been used, however the index trail for ‘dystocia’ takes the coder directly to the category O66 Other obstructed labour. A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.

Obstructed labour due to incomplete rotation of fetal head (O64.0)

Face to pubes presentation confirmed as causing obstructed labour is classified at code O64.0 Obstructed labour due to incomplete rotation of fetal head. Although a code is available within ICD-10 to classify maternal care for face to pubes presentation (O32.8), if the face to pubes presentation does not cause an obstructed labour, then it must not be recorded, as clinically it does not cause a problem with delivery.

Failed trial of labour, unspecified (O66.4)

This code must not be used if the condition giving rise to the intervention is known.

Failed application of vacuum extractor and forceps, unspecified (O66.5)

This code should 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 due to cephalopelvic disproportion

Index trail for disproportion:

Disproportion (fetopelvic) O33.9
- cephalopelvic O33.9
- - causing obstructed labour O65.4

Tabular List entry:

O65.4 Obstructed labour due to fetopelvic disproportion, unspecified
Rationale: A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.

Postpartum haemorrhage (O72)
Haemorrhage following delivery is classified here according to the time it occurs, which is identified by the fourth character subdivisions:

- **Third-stage haemorrhage O72.0** includes haemorrhage associated with retained placenta.
- **Other immediate postpartum haemorrhage O72.1** is one occurring up to 24 hours following delivery.
- **Delayed and secondary postpartum haemorrhage O72.2** is one occurring more than 24 hours following delivery.

Postpartum haemorrhage must only be coded when documented as such in the patient’s medical record by the responsible consultant. The coder must not interpret the levels of blood loss 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.

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.

**Complications of anaesthesia during labour and delivery (O74)**
Codes from this category relate to the time the anaesthesia was given and not to the time the complication arises.

**Other complications of labour and delivery, not elsewhere classified (O75)**
Clinical judgement is required when coding **O75.5 Delayed delivery after artificial rupture of membranes** and **O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes**. There are no guidelines for the length of time constituting a delayed delivery.

Code **O75.6** is used when rupture of membranes occurs after the onset of labour. There is then a subsequent delay in delivery. The exact time period which defines a delayed delivery following rupture of membranes is for local definition.

Premature rupture of membranes, ie before onset of labour, is coded to **O42**.

**Vaginal delivery following previous caesarean section (O75.7)**
A caesarean section previous to a current vaginal delivery must always be considered a complication.

In episodes in which the mother delivers vaginally following a previous caesarean section, both mother and baby require close monitoring.
throughout the labour to ensure that any problems are identified and treated before delivery commences.

Therefore, 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. This is dependent on whether or not this is the main condition treated during the consultant episode.
Delivery (O80–O84)

In the UK use of codes from categories **O80–O84 Delivery** is limited to cases where the only information recorded is a statement of delivery or the method of delivery. They must only be used if no other condition classifiable to Chapter XV is recorded, eg code **O80.0** cannot be used in conjunction with any other code from this chapter.

**Example:**

Spontaneous vertex delivery, first degree tear left unsutured

- Index trail for tear:
  - **Laceration** (see also Wound, open) T14.1
    - - perineum, perineal S31.0
    - - - complicating delivery O70.9
    - - - first degree O70.0

- Tabular List entry:
  - **O70.0** First degree perineal laceration during delivery

**Rationale:** A code from category **Z37 Outcome of delivery** must be assigned in the first secondary position as described later in this chapter.

**Example:**

Spontaneous vertex delivery at 39 weeks, with episiotomy

- Index trail for delivery:
  - **Delivery** (single) O80.9
    - - spontaneous O80.9
    - - - vertex O80.0

- Tabular List entry:
  - **O80.0** Spontaneous vertex delivery

**Rationale:** Certain routine obstetric procedures, such as episiotomy or artificial rupture of membranes, do not contraindicate the use of **O80.0**. A code from category **Z37 Outcome of delivery** must be assigned in the first secondary position, as described later in this chapter.

The **only** codes which should be used from this block are **O80.0 Spontaneous vertex delivery**, or **O82.0 Delivery by elective caesarean section**. 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. Delivery information will be identified in the UK by OPCS-4 procedure codes.

For example, if a patient requests a caesarean section and there is no medical/clinical reason for a caesarean section to be performed, the correct ICD-10 code is **O82.0 Delivery by elective caesarean section**.
This standard covers caesarean sections being performed at the mother’s or responsible consultant’s request where there are no maternal or fetal complications to be recorded.

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.
Complications predominantly related to the puerperium (O85–O92)

The puerperium is the 42 days following the end of the second stage of labour.

It is important to note that postnatal depression is recorded in Chapter V Mental and behavioural disorders at category F53, and not at a category within this block.

When coding infections in the puerperium, a code from categories B95-B98 must be shown in addition to identify the organism causing the infection, when this is known.

Example:

**Escherichia coli [E.coli] urinary infection following delivery**

- Index trail for infection:
  - Infection, infected (opportunistic) B99
    - urinary (tract) NEC N39.0
    - - puerperal (postpartum) O86.2

- Tabular List entry:
  - O86.2 Urinary tract infection following delivery

- Index trail for organism causing infection:
  - Infection, infected (opportunistic) B99
    - Escherichia coli [E.coli] NEC A49.8
    - - as cause of disease classified elsewhere B96.2

- Tabular List entry:
  - B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters

**Rationale:** A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.
Other obstetric conditions, not elsewhere classified (O94–O99)

Sequelae of complication of pregnancy, childbirth and the puerperium (O94)
Sequelae or late effects are for use when the current condition or disease has been caused by a previously occurring disease which has been treated, and is therefore no longer present. They are not to be used for chronic complications of pregnancy. Any current complications must be coded as appropriate.

Sequelae codes must only ever be assigned in a secondary position.

Example:
Patient has uterovaginal fistula due to previous obstetric tear

Index trail for fistula:
Fistula L98.8
- uterovaginal N82.8

Tabular List entry:
N82.8 Other female genital tract fistulae

Index trail for sequelae:
Sequelae (of) – see also condition
- obstetric cause O94

Tabular List entry:
O94.X Sequelae of complication of pregnancy, childbirth and the puerperium

Categories for obstetric deaths (O95–O97) are intended for mortality coding only.

Categories O98–O99 must be used as main condition codes in preference to categories outside Chapter XV when the conditions being classified have been indicated by the health care practitioner to have complicated the pregnant state, to have been aggravated by the pregnancy, or to have been the reason for obstetric care.

The pertinent codes from other chapters may be used as additional codes to allow specification of the condition.
Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O98)

Most infectious diseases occurring during pregnancy are coded to O98. An additional code from Chapter I must be used to identify the specific condition where the information is available.

Example: Pregnant, gonococcal infection of lower genitourinary tract

- Index trail for pregnancy:
  - Pregnancy (single) (uterine)
    - complicated by
      - - gonococcal infection O98.2

  Tabular List entry:
  - O98.2 Gonorrhoea complicating pregnancy, childbirth and the puerperium
    - Conditions in A54.-

- Index trail for gonococcal infection of lower genitourinary tract:
  - Infection, infected (opportunistic) B99
    - gonococcal NEC (see also Gonococcus) A54.9

  Gonococcus, gonococcal (disease) (infection)...
  - genitourinary (organ) (system) (tract) (acute)
    - - lower A54.0

  Tabular List entry:
  - A54.0 Gonococcal infection of lower genitourinary tract without periurethral or accessory gland abscess

Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)

Code O98.7 classifies HIV complicating pregnancy and must be assigned whenever a patient with HIV is admitted during pregnancy, childbirth and the puerperium as HIV always complicates pregnancy.

For patients who have symptomatic (active) HIV an additional code from categories B20-B24 must be assigned in a secondary position to identify the specific condition. For patients who are asymptomatic (non-active or HIV positive) then the code Z21.X would be assigned in a secondary position.
Example: Baby delivered by elective caesarean section because the mother has symptomatic (active) HIV

Index trail for HIV:
   Human
      - immunodeficiency virus (HIV) disease (infection) B24
      - - complicating pregnancy, childbirth or the puerperium O98.7

Tabular List entry:
   O98.7  Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium

Index trail for HIV:
   Human
      - immunodeficiency virus (HIV) disease (infection) B24

Tabular List entry:
   B24.X  Unspecified human immunodeficiency virus [HIV] disease

Rationale: A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.

Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99)
This category includes conditions for which the Alphabetical Index does not indicate a specific code in Chapter XV and which complicate the pregnant state, are aggravated by the pregnancy, or are a main reason for obstetric care.

An additional code must be used to identify the specific condition where it adds information. The use of a code from this category, with that for a chronic condition, will differentiate between a pre-existing condition that is complicating the pregnancy, childbirth or the puerperium, and one that is not.

Anaemia complicating pregnancy, childbirth and the puerperium (O99.0)
The statement of anaemia in pregnancy must only be coded when clearly defined in the medical record by the responsible consultant. Coding 'low Hb' or 'sent home on iron tablets' when written in the patient's medical records could lead to inaccurate coding.

An additional code from the range D50–D64.8 must be used if the type of anaemia is known. If the type is unknown, only code O99.0 must be used.
Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium (O99.5)

This code must only be used when a respiratory condition such as asthma complicates the pregnancy, is aggravated by the pregnancy, or is the main reason for obstetric care. The relevant code for the respiratory condition must be assigned in addition.

When a patient has a respiratory condition which does not complicate the pregnancy, code O99.5 must not be assigned.

Example:

Spontaneous vertex delivery at 38 weeks. Asthma attack immediately following delivery. Diagnosed with asthma two years ago. On Ventolin.

- Index trail for pregnancy complicated by asthma:
  - Pregnancy (single) (uterine)
    - complicated by (see also Pregnancy, management, affected by)
      - conditions in
        - - J00-J99, O99.5

  Tabular List entry:
  O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium
  Conditions in J00-J99

- Index trail for asthma:
  - Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9

  Tabular List entry:
  J45.9 Asthma, unspecified

Rationale: In this example, the asthma complicates the pregnancy; therefore code O99.5 precedes code J45.9. A code from category Z37 Outcome of delivery must be assigned in the first secondary position as described later in this chapter.
**Example:** Spontaneous vertex delivery at 38 weeks. Patient is asthmatic, takes Ventolin as required.

- Index trail for **delivery**:
  - Delivery (single) O80.9
    - spontaneous O80.9
    - - vertex O80.0

  Tabular List entry:
  - O80.0 Spontaneous vertex delivery

- Index trail for **asthma**:
  - Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9

  Tabular List entry:
  - J45.9 Asthma, unspecified

**Rationale:** In this example code O99.5 is not used as the asthma does not complicate the pregnancy. The delivery code of O80.0 is shown because no other code from Chapter XV is present. Code J45.9 is used in addition because asthma is a condition that must always be coded for any consultant episode when documented in the patient record, regardless of specialty. A code from category Z37 **Outcome of delivery** must be assigned in the first secondary position as described later in this chapter.
Other obstetric factors  
(Z32–Z39)

These categories are used to identify an admission for circumstances other than disease, injury or external cause and which are related to pregnancy.

**Pregnant state, incidental (Z33)**

This category must be used as an additional code 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.

- **Index trail for the sprain:**
  - Sprain, strain (joint) (ligament) T14.3
  - ankle S93.4

  Tabular List entry:
  - S93.4 Sprain and strain of ankle

- **External cause index trail for circumstance:**
  - Tripping
  - over
  - - animal W64.-
  - - - with fall W01.-

  Tabular List entry:
  - W01 Fall on same level from slipping, tripping and stumbling
    [See at the beginning of this chapter for the classification of the place of occurrence]
    - .0 Home

- **Index trail for pregnant state:**
  - Pregnancy (single) (uterine)
  - incidental finding Z33

  Tabular List entry:
  - Z33.X Pregnant state, incidental
Examples (cont):


Index trail for Pain:
- Pain(s) R52.9
  - abdominal R10.4
  - lower abdomen R10.3

Tabular List entry:
- R10.3 Pain localized to other parts of lower abdomen

Index trail for pregnant state:
- Pregnancy (single) (uterine)
  - incidental finding Z33

Tabular List entry:
- Z33.X Pregnant state, incidental

Supervision of normal pregnancy (Z34)
This category is intended to be used if a patient is admitted for a suspected problem related to the pregnancy, but on further examination no abnormality relating to the pregnancy is found. It is commonly used for women who think their waters have broken. The fourth character subdivisions reflect the first or other pregnancy.

This category must only be used when the patient has not received treatment or investigation for any other condition that is classifiable to Chapter XV.

This category is also 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. It must be stated in the patients medical record that the patient is in the early stages of term labour in order to assign a code from Z34 in these circumstances.

Code O60.0 Preterm labour without delivery must be used instead if the responsible consultant confirms that the patient is in preterm labour and they are sent home to await further events.

Z34 Supervision of normal pregnancy must not be assigned when the responsible consultant has made a diagnosis of Braxton-Hicks contractions or false labour. Both of these conditions are classified to category O47 False labour.
Supervision of high-risk pregnancy (Z35)
This category is intended to be used only when the history of a previous condition, which is not present in the current pregnancy, is a reason for supervision, eg previous infertility.

This category includes:

Z35.4  Supervision of pregnancy with grand multiparity; a woman who has given birth to five or more infants, alive or dead and

Z35.5  Supervision of elderly primigravida; a woman pregnant for the first time who is more than 35 years of age.

There is no nationally recognised age for a very young primigravida classified at code Z35.6 Supervision of very young primigravida. The coder must seek advice from the responsible consultant before assigning this code.

Outcome of delivery (Z37)
This category must be used as an additional code to identify the outcome of delivery, on the mother’s delivery episode only. It is mandatory, and should be sequenced in the first secondary position.

Example:

Spontaneous vertex delivery at term of live female infant

Index trail for delivery:
Delivery (single) O80.9  
- spontaneous O80.9  
- - vertex O80.0

Tabular List entry:
O80.0  Spontaneous vertex delivery

Index trail for live birth:
Outcome of delivery Z37.9  
- single Z37.9  
- - liveborn Z37.0

Tabular List entry:
Z37.0  Single live birth
Postpartum care and examination (Z39)

This category is limited to uncomplicated cases, and is usually assigned on the mother’s record where birth occurs at home or on the way to hospital. No complications are found when the mother is admitted for postpartum check. If any complications are found on examination, they are reported with the appropriate code from Chapter XV, and a code from Z39.- is not used.

Example: Admission following delivery en route to hospital. Mother’s record.

Index trail for postpartum care:
Care (of) (for) (following)
- postpartum
- - immediately after delivery Z39.0

Tabular List entry:
Z39.0 Care and examination immediately after delivery
CHAPTER XVI
CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD
P00–P96

Chapter rules and conventions

- Within the ICD-10 classification in the UK, when used for morbidity coding, the perinatal period is defined as the period from before birth through the 27th day, 23rd hour and 59th minute of life, ie the period before the start of the 28th day. As long as a condition originates in this period, a code from P05–P96 can be used.

- A code from Z38 must be recorded on the baby’s birth episode. It is assigned in the primary position if the baby is completely well. If a morbid condition is present which has been treated or investigated then the morbid condition must be sequenced first, followed by Z38 in the first secondary position. If other morbid conditions are present, they must be coded after Z38.

- Most conditions classified in this chapter are transitory (passing) disorders that do not have lasting effects. However, certain conditions that originate in the perinatal period and persist beyond this time are also classified to Chapter XVI.
Coding Standards

Persons encountering health services in circumstances related to reproduction (Z30–Z39)

Liveborn infants according to place of birth (Z38)

Z38 is to be recorded on the baby’s birth episode only and sequencing will depend on whether the coder is coding a completely well baby or not.

A code from Z38 must be recorded in the primary position if the baby does not have a morbid condition, ie they are a completely well baby. Examples of morbid conditions include such disorders as prematurity, asphyxia, etc.

Example:

Single term male infant born in hospital

Index trail:
- Newborn (infant) (liveborn) (singleton) Z38.2
- - born in hospital Z38.0

Tabular List entry:
- Z38.0 Singleton, born in hospital
If a morbid condition is present, ie the baby is not a completely well baby, and this has been treated or investigated, then the morbid condition must be sequenced first followed by Z38 in the first secondary position. Any other morbid conditions present must be coded after Z38.

**Example:**

Baby born in hospital with untreated jaundice developed a skin infection which was treated with antibiotics

- Index trail:
  - Infection, infected (opportunistic) B99
  - skin (local) (staphylococcal) (streptococcal) L08.9
  - - newborn P39.4

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P39.4</td>
<td>Neonatal skin infection</td>
</tr>
</tbody>
</table>

- Index trail:
  - Newborn (infant) (liveborn) (singleton) Z38.2
  - born in hospital Z38.0

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z38.0</td>
<td>Singleton, born in hospital</td>
</tr>
</tbody>
</table>

- Index trail:
  - Jaundice (yellow) R17
  - fetus or newborn (physiological) P59.9

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P59.9</td>
<td>Neonatal jaundice, unspecified</td>
</tr>
</tbody>
</table>

**Rationale:** The skin infection is sequenced in the primary position because the skin infection is a morbid condition that was treated with antibiotics.
Example: Newborn born in hospital, noted to be jittery. Following investigation the jitteriness subsided and baby and mother were discharged home.

Index trail:
- Involuntary movement, abnormal R25.8

Tabular List entry:
- R25.8 Other and unspecified abnormal involuntary movements

Index trail:
- Newborn (infant) (liveborn) (singleton) Z38.2
  - born in hospital Z38.0

Tabular List entry:
- Z38.0 Singleton, born in hospital

Rationale: As the newborn was investigated for the jittery state (the correct code for jittery baby is R25.8 as described in Chapter XVIII Symptom signs and abnormal clinical and laboratory findings, not elsewhere classified) it is appropriate to assign the code R25.8 as the primary diagnosis followed by Z38 in the first secondary position.

Whilst the general rule is for conditions arising in the perinatal period to be coded to Chapter XVI Certain conditions originating in the perinatal period, Chapter XVIII Symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified is one of the chapters contained on the list of exclusions (see section on Perinatal conditions classified outside Chapter XVI).
Example: Newborn born in hospital, noted to have a birthmark on their right buttock, but no treatment given or further investigations carried out.

Index trail:
- **Newborn (infant) (liveborn) (singleton)** Z38.2
- born in hospital Z38.0

Tabular List entry:
- **Z38.0** Singleton, born in hospital

Index trail:
- **Birthmark** Q82.5

Tabular List entry:
- **Q82.5** Congenital non-neoplastic naevus

Rationale: The newborn did not receive any treatment or further investigations for the birthmark. Therefore, the primary diagnosis is code **Z38.0 Singleton, born in hospital**. The birthmark is an incidental finding and must be recorded in a secondary position.

Perinatal conditions classified outside Chapter XVI

Conditions arising in the perinatal period must, as far as possible, be coded to Chapter XVI even when morbidity or death occurs later. This takes precedence over chapters containing codes for diseases by their anatomical site.

This excludes:

- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Endocrine, nutritional and metabolic diseases (E00-E99)
- 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).

However, if the code for the disease by the anatomical site provides additional information which is not contained in the code from Chapter XVI, then it is acceptable to use an additional code to express this information and provide further detail.
**Example:**

Newborn born in hospital with thrombosis of left superficial femoral artery

- **Index trail:**
  - Conditions arising in the perinatal period
    - disease, diseased – see also Conditions originating in the perinatal period, syndrome
    - cardiovascular, fetus or newborn P29.9
    - specified NEC P29.8

- **Tabular List entry:**
  - P29.8 Other cardiovascular disorders originating in the perinatal period

- **Index trail:**
  - Newborn (infant) (liveborn) (singleton) Z38.2
  - born in hospital Z38.0

- **Tabular List entry:**
  - Z38.0 Singleton, born in hospital

- **Index trail:**
  - Thrombosis, thrombotic (multiple) (progressive) (septic) (vein) (vessel) I82.9
  - femoral (superficial) I80.1
  - artery I74.3

- **Tabular List entry:**
  - I74.3 Embolism and thrombosis of arteries of lower extremities

**Rationale:** In order to show that the thrombosis is a perinatal condition, a code from Chapter XVI must be assigned in the primary position. Code I74.3 Embolism and thrombosis of arteries of lower extremities is assigned to specifically identify that the cardiovascular disorder is thrombosis.
Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00–P04)

- Identifies the underlying maternal cause or the external cause for the baby’s condition.
- Can only be used if there is a morbid condition in the baby.
- Must always be used secondary to the morbid condition itself.
- Must never appear as the primary diagnosis except when the baby is stillborn. In these instances, these codes will appear as a solo diagnosis on the baby’s record.

**Example:**

<table>
<thead>
<tr>
<th>Baby born in hospital with severe birth asphyxia due to cord tightly around neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>severe birth asphyxia:</strong></td>
</tr>
<tr>
<td>Asphyxia, asphyxiation R09.0</td>
</tr>
<tr>
<td>- newborn P21.9</td>
</tr>
<tr>
<td>- - severe P21.0</td>
</tr>
<tr>
<td>Tabular List entry:</td>
</tr>
<tr>
<td>P21.0 Severe birth asphyxia</td>
</tr>
</tbody>
</table>

**Index trail:**

Newborn (infant) (liveborn) (singleton) Z38.2
- born in hospital Z38.0

Tabular List entry:

Z38.0 Singleton, born in hospital

**Index trail for** cord around neck:

Cord - see also condition
- around neck (tightly) (with compression)
- - affecting fetus or newborn P02.5

Tabular List entry:

P02.5 Fetus and newborn affected by other compression of umbilical cord
Cord (tightly) around neck

**Rationale:** In the above example code **P02.5** is assigned in addition to indicate that the asphyxia was due to compression of the umbilical cord.
Disorders related to length of gestation and fetal growth (P05–P08)

Conditions classified here relate specifically to length of gestation and fetal growth.

Category **P05 Slow fetal growth and fetal malnutrition** relates to conditions developing in the fetus which can present problems at birth, e.g. a baby born ‘small-for-dates’ due to malnourishment in the womb. These conditions are usually picked up on scans prior to the birth, and will often be the reason for early induction of labour. IUGR (Intrauterine growth retardation) is a common term used, and is coded to **P05.9**. The codes at **P05** can apply to infants of premature, normal or long gestation.

Category **P07 Disorders related to short gestation and low birth weight not elsewhere classified**, specifically relates to premature births, i.e. short gestation. If both the birth weight and gestational age are available when assigning codes from categories **P07** and **P08**, priority of assignment must be given to birth weight. Only one code for the birth weight is required, as the premature gestation is already implied in the three character category.

**Example:**

Premature infant born at 34 weeks in hospital weighing 2100gms

- Index trail for premature infant:
  - Premature - see also condition
  - Low
    - birthweight (2499 grams or less) P07.1

- Tabular List entry:
  - P07.1 Other low birth weight
    - Birth weight 1000 – 2499 g

- Index trail:
  - Newborn (infant) (liveborn) (singleton) Z38.2
  - born in hospital Z38.0

- Tabular List entry:
  - Z38.0 Singleton, born in hospital

**Rationale:** NOTE under **P07**: When both birth weight and gestational age are available, priority of assignment must be given to birth weight.

As the birth weight in this example is known, i.e. 2100g, the correct code to use is **P07.1**.
Respiratory and cardiovascular disorders specific to the perinatal period (P20–P29)

Birth asphyxia (P21)
Within the classification there is NO code to record a stated diagnosis of only low Apgar score. There must be mention of asphyxia in order to assign a code from P21 with the fourth character identifying the level of severity of the asphyxia.

**Example:**

Asphyxiated newborn born in hospital with an Apgar score of 2

- Index trail for asphyxiated newborn, Apgar score 2:
  - Asphyxia, asphyxiation R09.0
  - newborn P21.9
  - - with 1 minute Apgar score
  - - - 0–3 P21.0

  Tabular List entry:
  - **P21.0 Severe birth asphyxia**
  - Asphyxia with 1 minute Apgar score 0-3

- Index trail:
  - Newborn (infant) (liveborn) (singleton) Z38.2
  - born in hospital Z38.0

  Tabular List entry:
  - **Z38.0 Singleton, born in hospital**

The code **P22.0 Respiratory distress of newborn** is the correct code to record surface deficient lung disease (SDLD) in the newborn. SDLD means that the lungs cannot fully expand due to phospholipid deficiency.
Infections specific to the perinatal period
(P35–P39)

Group B streptococcus (GBS) bacterial infections
A newborn baby diagnosed with GBS infection by blood test or diagnosed with GBS sepsis is coded as:

- P36.0 Sepsis of newborn due to streptococcus, group B
- Z38.0 Singleton, born in hospital

A newborn baby diagnosed with meningitis due to GBS is coded as:

- 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 chapter

A newborn baby receiving prophylactic antibiotics and whose mother has previously had a streptococcus infection or because the mother is a carrier of GBS is coded as:

- Z38.0 Singleton, born in hospital
- Z29.2 Other prophylactic chemotherapy
- Z83.1 Family history of other infectious and parasitic diseases

A newborn baby who is found to be positive for streptococcus group B (i.e. by umbilical swab, or other surface swabs such as ear and skin) with no signs of infection is coded as:

- Z38.0 Singleton, born in hospital
- Z22.3 Carrier of other specified bacterial diseases
Haemorrhagic and haematological disorders of fetus and newborn
(P50–P61)

**Neonatal jaundice due to drugs or toxins transmitted from mother or given to newborn (P58.4)**

When neonatal jaundice is drug-induced and the drug has been identified, an external cause code (from Chapter XX) must be assigned in addition to identify the drug.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Baby born in hospital with neonatal jaundice due to methadone taken by mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>![Index trail for neonatal jaundice:](Jaundice_(yellow)_R17 - neonatal - see Jaundice, fetus or newborn)</td>
</tr>
<tr>
<td></td>
<td>![Jaundice (yellow) R17 - fetus or newborn (physiological) P59.9 - - due to or associated with - - - drugs or toxins - - - transmitted from mother P58.4](Jaundice_(yellow)_R17 - fetus or newborn (physiological) P59.9 - - due to or associated with - - - drugs or toxins - - - transmitted from mother P58.4)</td>
</tr>
<tr>
<td></td>
<td>Tabular List entry: <strong>P58.4 Neonatal jaundice due to drugs or toxins transmitted from mother or given to newborn</strong></td>
</tr>
<tr>
<td></td>
<td>![Index trail:](Newborn_(infant)<em>(<em>liveborn</em>)</em>(singleton) Z38.2 - born in hospital Z38.0)</td>
</tr>
<tr>
<td></td>
<td>Tabular List entry: <strong>Z38.0 Singleton, born in hospital</strong></td>
</tr>
<tr>
<td></td>
<td>![Index trail from Table of drugs and chemicals:](Poisoning Accidental Methadone X42.-)</td>
</tr>
<tr>
<td></td>
<td>Tabular List entry: <strong>X42 Accidental poisoning and exposure to narcotics and psychodysleptics [hallucinogens] not elsewhere classified</strong></td>
</tr>
<tr>
<td></td>
<td>![.9 Unspecified place](.9 Unspecified place)</td>
</tr>
</tbody>
</table>
Rationale: The external cause denotes that the baby developed jaundice due to the mother taking methadone.

Dehydration of newborn (P74.1)
Dehydration in newborns is always considered a serious medical issue, therefore when a newborn has a stated diagnosis of dehydration this must always be captured in the coded record.
Other disorders originating in the perinatal period (P90–P96)

Fetal death of unspecified cause (P95)
Stillbirths are coded to the cause of death, if known. If the cause of death is not known, P95.X must be used.

A code from category Z38 Liveborn infants according to place of birth is not assigned on a stillborn baby’s episode.

Examples:

<table>
<thead>
<tr>
<th>Still birth due to compression of umbilical cord</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail:</td>
</tr>
<tr>
<td>Compression</td>
</tr>
<tr>
<td>- umbilical cord</td>
</tr>
<tr>
<td>- - affecting fetus or newborn P02.5</td>
</tr>
</tbody>
</table>

Tabular List entry:
P02.5 Fetus and newborn affected by other compression of umbilical cord

<table>
<thead>
<tr>
<th>Stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail:</td>
</tr>
<tr>
<td>Death</td>
</tr>
<tr>
<td>- fetus, fetal (cause not stated) (intrauterine) P95</td>
</tr>
</tbody>
</table>

Tabular List entry:
P95.X Fetal death of unspecified cause
Dearborn fetus NOS
Stillbirth NOS

History of perinatal condition
Code Z87.6 Personal history of certain conditions arising in the perinatal period can be assigned when a patient over 28 days old had a condition that arose in the perinatal period, which is no longer present, but is relevant to their current condition. This code must never be used as a primary diagnosis code.
Example: Moderate mental retardation due to cerebral haemorrhage at birth. The patient is three years old.

- Index trail:
  - Retardation
    - mental F79.-
    - moderate (IQ 35-49) F71.-

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F71</td>
<td>Moderate mental retardation</td>
</tr>
<tr>
<td></td>
<td>(See before F70 for subdivisions)</td>
</tr>
<tr>
<td>.9</td>
<td>without mention of impairment of behaviour</td>
</tr>
</tbody>
</table>

- Index trail:
  - History (personal) (of)
    - perinatal problems Z87.6

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z87.6</td>
<td>Personal history of certain conditions arising in the perinatal period</td>
</tr>
</tbody>
</table>

**Rationale:** A sequelae code is not appropriate in this instance because an intracerebral haemorrhage due to a birth injury is coded to P10.1 and not to a code in the range I60-I67 as perinatal conditions are excluded from ICD-10 Chapter IX.
Chapter rules and conventions

Congenital malformations and abnormalities are present and exist from the time of birth; they are NEVER acquired. Therefore the codes in this chapter are intended to be used for patients of ANY age.
Coding Standards

Definitions of congenital malformations, deformations and chromosomal abnormalities

Congenital malformations and abnormalities are present and exist from the time of birth; they are NEVER acquired. Unless these anomalies are corrected by medical intervention, they will almost always persist through life. Therefore the codes in this chapter are intended to be used for patients of ANY age.

Some congenital conditions are classified to other chapters, but these are mainly disorders of function.

Example:

**Congenital diabetes mellitus**

Index trail for diabetes:

Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- congenital E10.-

Tabular List entry:

E10.- Insulin-dependent diabetes mellitus
[See before E10 for subdivisions]
.9 Without complications

Coders must correctly index the lead terms and modifiers within this chapter. In the following examples one condition is assumed to be acquired, whilst the other is assumed to be congenital within the structure of the classification. These codes would be selected where there is no further information in the medical record to state whether these conditions are either congenital or acquired.
**Examples:**

<table>
<thead>
<tr>
<th>Patient aged 55 is admitted for correction of left clawhand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>clawhand</strong></td>
</tr>
<tr>
<td><strong>Clawhand (acquired)</strong> M21.5</td>
</tr>
<tr>
<td>- congenital Q68.1</td>
</tr>
</tbody>
</table>

Tabular List entry:

**M21.5** Acquired clawhand, clubhand, clawfoot and clubfoot
[fifth-character of 4 from before M00 to identify hand]

<table>
<thead>
<tr>
<th>Patient aged 55 is admitted for correction of left clawfoot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for <strong>clawfoot</strong></td>
</tr>
<tr>
<td><strong>Clawfoot (congenital)</strong> Q66.8</td>
</tr>
<tr>
<td>- acquired M21.5</td>
</tr>
</tbody>
</table>

Tabular List entry:

**Q66.8** Other congenital deformities of feet
Congenital malformations of the circulatory system (Q20–Q28)

Congenital heart disease
Congenital heart disease is a general term that may be used to document a specific abnormality such as VSD (ventricular septal defect) or to summarise, multiple cardiac anomalies without listing the individual conditions.

When a diagnosis of congenital heart disease is made without any further information, clarification must be sought from the responsible consultant to allow a more specific diagnosis to be coded.

Laevocardia (Q24.1)
The code Q24.1 must only be assigned if ‘Laevocardia’ is specifically documented within the patient’s medical record.

Congenital malformation of the heart, unspecified (Q24.9)
The code Q24.9 is very unspecific. Coders must ascertain more information, so that the particular condition may be recorded using the applicable code(s) from Q20–Q24.
Congenital malformations of the respiratory system, the digestive tract and associated organs, and the urinary system (Q30–Q64)

Male hydatid morgagni can appear on the testes, spermatic cord or the epididymis. Hydatid morgagni of the testis is classified at code Q55.2 Other congenital malformations of testis and scrotum and hydatid morgagni of the epididymis or spermatic cord are classified at code Q55.4 Other congenital malformations of vas deferens, epididymis, seminal vesicles and prostate.

Cystic kidney disease (Q61)
A diagnosis of polycystic kidney disease, coded to Q61.1-Q61.3, differs to that of a diagnosis of multicystic dysplastic kidney or multicystic kidney (disease) which is coded to Q61.4.
Other congenital malformations (Q80–Q89)

Mongolian blue spots
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 Congenital non-neoplastic naevus and must be coded to codes in category D22.-.

Therefore the correct ICD-10 code to assign for a Mongolian blue spot must be taken from category D22.- Melanocytic naevi.

Categories Q86 and Q87 classify congenital malformation syndromes due to known exogenous causes (due to conditions of external origin or those caused by environmental factors) and congenital malformation syndromes affecting multiple systems.

As with all syndromes if, after the syndrome has been clinically diagnosed, the admission is for treatment of one or more manifestations of that syndrome the manifestation(s) in question must be coded. The appropriate code for the syndrome itself is entered last.

**Example:**

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

Index trail for contracture:
- Contraction, contracture, contracted
  - joint (abduction) (acquired) (adduction) (flexion) (rotation) M24.5
  - - congenital NEC Q68.8
  - - - hip Q65.8

Tabular List entry:
- Q65.8 Other congenital deformities of hip

Index trail for syndrome:
- Syndrome – see also Disease
  - VATER Q87.2

Tabular List entries:
- Q87.2 Congenital malformation syndromes predominantly involving limbs
  - Syndrome
    - VATER
Triple M syndrome (Q87.1)
This syndrome is associated with skeletal dysplasia and short stature. Children with this syndrome will have a degree of microcephaly, frontal bossing with a broad forehead, rather small mid-face and prominent jaw. As the major congenital abnormality of triple M Syndrome is short stature, Q87.1 Congenital malformation syndromes predominantly associated with short stature is the most appropriate code. As with all syndromes, all treated manifestations must be coded before the code for the syndrome.

‘History of’ codes
When an anomaly/condition has been corrected, a ‘history of’ code can be assigned but only if relevant to the current consultant episode. In these circumstances the appropriate code would be:

Z87.7 Personal history of congenital malformations, deformations and chromosomal abnormalities.

When a patient who had a cleft palate repaired is now admitted for oral surgery in order to treat another condition, the history of cleft palate would then be an important factor during this consultant episode and must therefore also be assigned.

Example:
Patient 12 years of age admitted with temporomandibular joint disorder. Personal history of cleft lip and palate.

Index trail for disorder:
Disorder (of) see also Disease
- temporomandibular joint K07.6

Tabular List entry:
K07.6 Temporomandibular joint disorders

Index trail for personal history of:
History (personal) (of)
- congenital malformation Z87.7

Tabular List entry:
Z87.7 Personal history of congenital malformations, deformations and chromosomal abnormalities
CHAPTER XVIII
SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED
R00–R99

Chapter rules and conventions

- A code from Chapter XVIII must only be used for primary diagnosis when no specific diagnosis is made by the end of the patient’s consultant episode, or there is no codeable current illness or injury present.
- If a diagnosis is identified from the sign or symptom, a code for the specific diagnosis must be assigned instead.
- Where a sign or symptom may be due to more than one condition, a code for the symptom is assigned.
Symptoms, signs, abnormal clinical etc

Coding Standards

Recording signs and symptoms

There are six circumstances in which signs and symptoms may be recorded:

1. A more specific diagnosis cannot be made even after full investigation.
   
   **Example:**
   Patient admitted with haematuria. Cystoscopy performed but no abnormality shown.
   
   Code to:  **R31.X**  Unspecified haematuria

2. They are transient (temporary or passing) and the cause could not be determined.
   
   **Example:**
   Patient is brought into hospital with ‘confusion’. No cause is identified on examination.
   
   Code to:  **R41.0**  Disorientation, unspecified

3. They record a provisional diagnosis in a patient who failed to have further investigation.
   
   **Example:**
   Patient admitted for excision biopsy of lump in neck but refused surgery on arrival in theatre.
   
   Code to:  **R22.1**  Localised swelling, mass and lump, neck
   
   **Z53.2**  Procedure not carried out because of patient's decision for other and unspecified reasons

4. The case is referred elsewhere for investigation or treatment before a diagnosis was made.
   
   **Example:**
   Patient admitted with central chest pain. A myocardial infarction is suspected, so patient is transferred to a hospital with a coronary care unit.
   
   Code to:  **R07.2**  Precordial pain
5. A more precise diagnosis was not available for any other reason.

**Example:**
Patient admitted with signs and symptoms which could belong to a schizotypal disorder. The responsible consultant is unwilling to make a diagnosis at the time, and only records symptoms of visual hallucinations, agitation and stupor in the medical record.

Code to:  
R44.1 Visual hallucinations  
R45.1 Restlessness and agitation  
R40.1 Stupor

**Example:**
The medical record states possible epilepsy, but the responsible consultant cannot be certain, as the symptoms are suggestive of more than one diagnosis. Symptoms of fit and blackout are recorded by the responsible consultant.

Code to:  
R56.8 Other and unspecified convulsions  
R55.X Syncope and collapse

6. The cause of the symptoms and signs is known, but they are important problems in medical care requiring treatment. The symptoms and signs must be recorded in a secondary position, in addition to the known cause.

**Example:**
Patient admitted for treatment of hypertension. While on the ward patient suffers a heavy nosebleed for which their nose had to be packed.

Code to:  
I10.X Essential (primary) hypertension  
R04.0 Epistaxis
Symptoms and signs involving the circulatory and respiratory systems
(R00–R09)

Abnormalities of heart beat (R00)
Coders must ensure that they follow the correct index trails for conditions such as tachycardia R00.0 and bradycardia R00.1 as other specific forms of arrhythmias are coded to Chapter IX Diseases of the circulatory system at categories I47-I49. If the bradycardia or tachycardia is drug-induced, then an additional code must be assigned.

Gangrene, not elsewhere classified (R02)
This code can be used as an additional code when it is a complication of another disease, such as diabetes.

Example:

| Gangrene complicating Type II (non-insulin-dependent diabetes mellitus. |

Index trail for type II diabetes:
Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-
- type II (nonobese) (obese) E11.-

Tabular List entry:

<table>
<thead>
<tr>
<th>E11</th>
<th>Non-insulin-dependent diabetes mellitus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[See before E10 for subdivisions]</td>
</tr>
<tr>
<td>.5</td>
<td>With peripheral circulatory complications</td>
</tr>
</tbody>
</table>

Index trail for gangrene:
Gangrene, gangrenous (dry) (moist) (skin) (ulcer) (see also Necrosis) R02
- diabetic (any site) – code to E10-E14 with fourth character .5

Tabular List entry:

| R02.X | Gangrene, not elsewhere classified |

Abnormal blood pressure reading, without diagnosis (R03)
Codes from this category must only be used to identify an abnormal blood pressure reading confirmed by the responsible consultant, and not for a definite diagnosis of hypertension or hypotension. Coders must not interpret blood pressure readings recorded in the medical record.
Precordial pain (R07.2)

R07.2 Precordial pain is the correct code to assign when central chest pain is documented in the medical record.

Other chest pain (R07.3)

R07.3 Other chest pain is the correct code to assign when musculoskeletal chest pain is documented in the medical record.

Symptoms and signs involving the digestive system and abdomen (R10–R19)

Abdominal and pelvic pain (R10)

Use of this category is intended for unspecified types of abdominal pain only, when the cause is not known. Other types, such as that caused by renal colic, are classified elsewhere.

Pain localised to other parts of the lower abdomen (R10.3)

This is the code used to identify right iliac fossa (RIF) pain and left iliac fossa (LIF) pain.

Ascites (R18)

This category does not include malignant ascites, which must be coded as a secondary malignancy of the peritoneum C78.6, when confirmed by the responsible consultant.

Occult blood in stools (R19.5)

Occult blood in stools may also be described as Faecal occult blood (FOB) which must be recorded to R19.5 Other faecal abnormalities. Occult blood in stools is not the same as melaena which must be recorded to K92.1 Melaena.
Symptoms and signs involving the skin and subcutaneous tissue
(R20–R23)

Localised swelling, mass and lump of skin and subcutaneous tissue (R22)
This category must only be used when the nature of the swelling or lump is not known. If a procedure has been performed, the swelling or lump will be sent for histology. The histology report must be checked for a firm diagnosis, and confirmed with the responsible consultant.

Examples:

Mass removed from neck. Responsible consultant confirms that the histology report is inconclusive and no firm diagnosis is made.

Index trail for mass:
Mass
- neck R22.1

Tabular List entry:
R22.1 Localised swelling, mass and lump, neck

Mass removed from neck. Responsible consultant confirms lipoma.

Index trail for lipoma:
Lipoma (M8850/0) D17.9
- site classification
- -neck (skin) (subcutaneous) D17.0

Tabular List entry:
D17.0 Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
Symptoms and signs involving the nervous and musculoskeletal systems (R25–R29)

Abnormal involuntary movements (R25)
Specific movement disorders are classified to Chapter VI, Diseases of the nervous system (G20–G26). Only unspecified types of movement disorders are classified here.

The correct code for jittery baby is **R25.8 Other and unspecified abnormal involuntary movements**.

Abnormalities of gait and mobility (R26)
Only the terms ‘immobility’, ‘chairfast’, ‘bedfast’, ‘bedbound’ and ‘bedridden’ are recorded to code **R26.3 Immobility** when documented in the medical record. Terms such as ‘reduced mobility’ and ‘poor mobility’ are recorded at code **R26.8 Other and unspecified abnormalities of gait and mobility**.

Geriatric and elderly falls (R29.6)
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.

**R29.6 Tendency to fall, not elsewhere classified** includes tendency to fall because of old age or other unclear health problems. Geriatric and elderly falls must be coded to **R29.6** alone when the patient suffers no injury due to the fall. An external cause code from categories **W00-W19** must not be assigned.

If the patient sustains any injury due to the fall, then that injury must be coded with the addition of an external cause code from categories **W00-W19**. Code **R29.6** is assigned following the injury and external cause code(s) to indicate that the fall was a geriatric/elderly fall.
Example:

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.

📖 Index trail for laceration:

- **Laceration** (see also Wound, open) T14.1
  - eyelid S01.1

Tabular List entry:

- **S01.1** Open wound of eyelid and periocular area

📖 External causes index trail for fall:

- **Fall, falling (accidental)** W19.-

Tabular List entry:

- **W19** Unspecified fall
  - [See at the beginning of this chapter for the classification of the place of occurrence]
  - **0** Home

📖 Index trail for falls:

- **Falls**
  - Repeated R29.6

Tabular List entry:

- **R29.6** Tendency to fall, not elsewhere classified
  - Tendency to fall because of old age or other unclear health problems

However, if the patient remains in hospital for investigation of the falls and this becomes the primary focus of care, then code **R29.6** is sequenced before the codes for the injury.
### Example:

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

- **Index trail for contusion:**
  - Contusion (skin surface intact) (see also Injury, superficial) T14.0
  - - leg
  - - lower S80.1

  Tabular List entry:
  - S80.1 Contusion of other and unspecified parts of lower leg

- **External cause index trail for fall:**
  - Fall, falling (accidental) W19.-

  Tabular List entry:
  - W19 Unspecified fall
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .0 Home

- **Index trail for falls:**
  - Falls
    - - repeated R29.6

  Tabular List entry:
  - R29.6 Tendency to fall, not elsewhere classified
    - Tendency to fall because of old age or other unclear health problems

#### Second episode.

- **Index trail for falls:**
  - Falls
    - - repeated R29.6

  Tabular List entry:
  - R29.6 Tendency to fall, not elsewhere classified
    - Tendency to fall because of old age or other unclear health problems

- **Index trail for contusion:**
  - Contusion (skin surface intact) (see also Injury, superficial) T14.0
  - - leg
  - - lower S80.1

  Tabular List entry:
  - S80.1 Contusion of other and unspecified parts of lower leg
Symptoms and signs involving urinary system (R30–R39)

Retention of urine (R33.X)
Must be used as an additional code when the cause of retention is known, but the patient has been admitted for catheterisation to treat the retention.

**Example:**
Benign prostatic hypertrophy. Patient admitted for catheterisation to relieve discomfort due to retention of urine.

- Index trail for **prostate hypertrophy**:
  - Hypertrophy, hypertropic
    - prostate (adenofibromatous) (asymptomatic) (benign) (early) (recurrent) N40

  Tabular List entry:
  - N40.X Hyperplasia of prostate

- Index trail for **urine retention**:
  - Retention, retained
    - urine R33

  Tabular List entry:
  - R33.X Retention of urine
Symptoms and signs involving cognition, perception, emotional state and behaviour (R40–R46)

Persistent vegetative state (PVS) is a state of grossly impaired consciousness following severe head injury or brain disease, in which the subject is incapable of speech and involuntary or purposive acts, but will respond reflexively to painful stimuli. A diagnosis of persistent vegetative state (PVS) must be assigned codes:

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

It is necessary to use the code **R40.2** to identify the unconscious state common to PVS. Patients suffering from anoxic brain damage are not necessarily unconscious. Therefore the combination of two codes is important to distinguish PVS.

In many cases, the symptoms and signs classified in this block are merely symptoms of a mental or other disorder. If the other disorder is known, it must be coded in preference to these conditions.

Suicidal ideation (tendencies) and suicidal risk are classified at code **R45.8** Other symptoms and signs involving emotional state, however if the responsible consultant identifies that the suicidal ideation, tendencies or risk constitute part of a mental disorder then the mental disorder is coded in preference. A personal history of attempted suicide or self-harm is coded to **Z91.5 Personal history of self-harm**.

**R46.8 Other symptoms and signs involving appearance and behaviour** is the correct code to assign for a diagnosis of self neglect. Where this self-neglect causes insufficient intake of food and water, it must be coded to **R63.6 Insufficient intake of food and water due to self neglect** instead.

Symptoms and signs involving speech and voice (R47–R49)

Underlying symptoms of mental disorders and cerebrovascular disorders are included here. If the mental or cerebrovascular condition is known, (such as stroke), the specific condition must be recorded in preference. Symptoms of cerebrovascular disorders (such as hemiplegia, dysphasia and dysphagia) must be coded in addition if they become an important problem requiring treatment.
General symptoms and signs  
(R50–R69)

Chronic intractable pain (R52.1)
This code must be used to identify patients who are admitted for treatment of generalised chronic pain affecting more than one organ or body region caused by a more specific condition - which would be sequenced first. Chronic intractable pain must not be coded if the pain is located in one organ or body region, e.g. pain in hip.

Example:
Patient admitted for control of chronic joint pains in hands, feet, elbows and shoulders caused by rheumatoid arthritis.

Index trail for rheumatoid arthritis:
- Arthritis, arthritic (acute) (chronic) (subacute) M13.9
- rheumatoid M06.9

Tabular List entry:
- M06.9  Rheumatoid arthritis, unspecified
  (fifth character of 0 from before M00 to identify multiple sites)

Index trail for pain:
- Pain(s) R52.9
  - chronic NEC R52.2
  - - intractable R52.1

Tabular List entry:
- R52.1  Chronic intractable pain

Rationale: This patient was admitted for control of chronic pain in multiple body regions caused by rheumatoid arthritis, therefore code M06.9 must be assigned as the primary diagnosis as this is the specific condition causing the chronic pain. Code R52.1 is assigned in addition.
Example: Patient with osteosarcoma of the femur is admitted for control of generalised chronic pain.

Index trail for osteosarcoma femur:

- **Osteosarcoma** (M9180/3) – see also Neoplasm, bone, malignant
  - Malignant
  - Primary
- Neoplasm, neoplastic
  - bone (periosteum) ◊
  - femur (any part) C40.2

Tabular List entry for osteosarcoma:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C40</td>
<td>Malignant neoplasm of bone and articular cartilage of limbs</td>
</tr>
<tr>
<td>C40.2</td>
<td>Long bones of lower limb</td>
</tr>
</tbody>
</table>

Tabular List entry for morphology:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M9180/3</td>
<td>Osteosarcoma NOS (C40.-, C41.-)</td>
</tr>
</tbody>
</table>

Index trail for pain:

- **Pain(s)** R52.9
  - chronic NEC R52.2
  - intractable R52.1

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R52.1</td>
<td>Chronic intractable pain</td>
</tr>
</tbody>
</table>

**Rationale:** This patient has osteosarcoma, a type of malignant neoplasm, which is causing generalised chronic pain throughout their body. Therefore **C40.2** is the primary diagnosis and **R52.1** is assigned in addition. 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 patients with cancer. For example, had the patient been admitted for treatment of chronic pain only in their femur due to osteosarcoma, then only **C40.2** would be assigned.

In circumstances where a patient is admitted for treatment of chronic pain in one organ or body region caused by a specific condition, only the code for the specific condition is required.
Example: Patient with chronic back pain due to lumbar disc displacement is admitted solely for epidural steroid injection:

Index trail for displacement:
- Displacement, displaced
- - Intervertebral disk NEC M51.2
- - - lumbar, lumbosacral (with) M51.2

Tabular List entry:
- M51.2 Other specified intervertebral disc displacement

Index trail for Chemotherapy:
- Chemotherapy (session) (for) Z51.2

Tabular List entry:
- Z51.2 Other chemotherapy

Rationale: Code R52.1 is not assigned in this example because the patient was admitted for treatment of chronic pain in one body region (back pain). The patient has been admitted solely for the purpose of the epidural steroid injection which is a form of chemotherapy (which can be any drug), therefore, Z51.2 is assigned as an additional code. The code Z51.2 was not assigned in the previous two examples to this because the form of treatment for the pain was not stated.

Senility (R54.X)
Elderly patients are often admitted with a diagnosis of ‘gone off legs’. The correct code to assign for this diagnosis is R54.X Senility, which includes senile debility.

Septic shock (R57.2)
Whenever septic shock is recorded in the medical record by the responsible consultant, this must be coded using R57.2 Septic shock. R57.2 may be assigned in a primary or secondary diagnosis position.

Systemic Inflammatory Response Syndrome (SIRS) (R65)
Codes within category R65 must only be used in a secondary position following the condition or underlying disease causing SIRS.
Four character code assignment is dependent on the SIRS being:

- of infectious origin in conditions such as meningitis, pyelonephritis and cholecystitis or
- of non-infectious origin, in conditions such as pulmonary embolism, myocardial infarction and cirrhosis and
- whether the patient has organ failure or not.

The appropriate codes for the organ failure, if present, are coded in addition when assigning codes within this category.

**Example:**

Patient with influenza due to avian influenza virus causing SIRS with kidney failure.

Index trail for influenza:

- Influenza (specific virus not identified) J11.1
  - avian J09

Tabular List entry:

- J09.X Influenza due to identified avian influenza virus

Index trail for SIRS:

- Syndrome – see also Disease
  - systemic inflammatory response
  - - infectious origin
  - - - with organ failure R65.1

Tabular List entry:

- R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure

Index trail for failure:

- Failure, failed
  - kidney N19

Tabular List entry:

- N19.X Unspecified kidney failure
Severe sepsis (R65.1)
Code **R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure** includes severe sepsis. Severe sepsis must only be coded to **R65.1**, in a secondary position to the underlying disease or condition causing the severe sepsis and when the responsible consultant has documented severe sepsis in the medical record.

**Example:**

Patient with severe sepsis due to falciparum malaria

<table>
<thead>
<tr>
<th>Index trail for <strong>malaria</strong>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria, malarial (fever) B54</td>
</tr>
<tr>
<td>- Falciparum B50.9</td>
</tr>
<tr>
<td>- - with complications NEC B50.8</td>
</tr>
</tbody>
</table>

Tabular List entry:

| B50.8 | Other severe and complicated *Plasmodium falciparum* malaria |

<table>
<thead>
<tr>
<th>Index trail for <strong>sepsis</strong>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis (generalised) (see also Infection) A41.9</td>
</tr>
<tr>
<td>- severe, as a result of disease classified elsewhere R65.1</td>
</tr>
</tbody>
</table>

Tabular List entry:

<table>
<thead>
<tr>
<th>R65.1</th>
<th>Systemic Inflammatory Response Syndrome of infectious origin with organ failure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Severe sepsis</td>
</tr>
</tbody>
</table>

A diagnosis of severe sepsis alone in the absence of an underlying disease or condition must be coded to **A41.9 Sepsis, unspecified** and **R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure**.

**Multiple organ failure (R68.8)**

When this diagnosis is recorded coders must seek clarification of 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** should be assigned.

**Unknown and unspecified causes of morbidity (R69.X)**

This category must not be used when further information is available from any source, eg test results, admission books, casualty records, X-ray records, etc and which has been verified by the responsible consultant.
Abnormal findings on examination of blood, without diagnosis
(R70–R79)

Codes within this block must only be used if a specific diagnosis is not made.

Abnormal glucose tolerance test (R73.0)
This code includes prediabetes and impaired glucose tolerance test, but must only be used when a diagnosis of diabetes is not made.

Other specified abnormal findings of blood chemistry (R79.8)
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.

Care must be taken when coding raised INR. Raised INR is recorded by coding the condition being treated by the anticoagulant, e.g. atrial fibrillation, with the additional code R79.8 Other specified abnormal findings of blood chemistry. Code Z92.1 Personal history of long-term (current) use of anticoagulants must also be coded, if the patient is currently taking anticoagulants or if they have a personal history of anticoagulation therapy. However, the sequencing of these codes will be dependent on whether the patient undergoes investigations/treatment of the raised INR.
Example: Patient taking Warfarin for the treatment of atrial fibrillation, routine blood test indicates a dangerously high INR. The patient is admitted for treatment to reduce the high INR.

Index trail for Raised INR:
- Abnormal, abnormality, abnormalities – see also Anomaly
  - chemistry, blood R79.9
  - specified NEC R79.8

Tabular List entry:
R79.8 Other specified abnormal findings of blood chemistry

Index trail for atrial fibrillation:
- Fibrillation
  - atrial or auricular (established) I48

Tabular List entry:
I48.X Atrial fibrillation and flutter

Index trail for use of anticoagulants:
- History (personal) (of)
  - use of medicaments (current) (long-term) NEC Z92.2
  - anticoagulants Z92.1

Tabular List entry:
Z92.1 Personal history of long term (current) use of anticoagulants

The coder must not assign the code D68.3 Haemorrhagic disorder due to circulating anticoagulants (with appropriate external cause code), unless the responsible consultant has made a corresponding clinical statement.

Raised PSA
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.
Abnormal findings on examination of urine, without diagnosis (R80–R82)

Codes within this block must only be used if a specific diagnosis is not made.

Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis (R83–R89)

Codes within this block must only be used if a specific diagnosis is not made.

Abnormal findings on diagnostic imaging and in function studies, without diagnosis (R90–R94)

Abnormal results of laboratory studies are recorded only when a more specific diagnosis has not been made. If a diagnosis is stated in addition to an abnormal finding, code only the stated diagnosis.

Example: Abnormal ECG with paroxysmal atrial tachycardia

Index trail for tachycardia:
- Tachycardia R00.0
- paroxysmal I47.9
- - atrial I47.1

Tabular List entry:
- I47.1 Supraventricular tachycardia
  - Paroxysmal tachycardia
    - atrial
Ill-defined and unknown causes of mortality (R95–R99)

These categories, with the exception of R95.X Sudden infant death syndrome, must not be used when further information is available from any source which has been verified by the responsible consultant, eg test results, admission books, casualty records, X-ray records etc.

Sudden infant death syndrome (SIDS) (R95)
This code is used to record a sudden infant death only when no cause can be determined and the responsible consultant records it as a sudden infant death or SIDS (sudden infant death syndrome). This is also known as 'cot death'.
CHAPTER XIX
INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES
S00–T98

Chapter rules and conventions

- Coding of both the external cause and the actual injury is mandatory where the information is present in medical record. In the case of more than one injury caused by the same event, one external cause code will serve all injuries and will be sequenced after the final injury.

- Traumatic injuries are those that occur as the result of an external force. Codes from Chapter XX External causes of morbidity and mortality must be used to identify the circumstance of the injury, complication, poisoning or adverse effect. External cause codes within categories V01-Y34 must be assigned on the first episode only, in a secondary position.

- Some individual categories within ICD-10 suggest the use of multiple codes. Single codes identifying multiple body sites must not be used where the information is available to enable use of individual codes (with the exception of those identifying bi-laterality of the same limbs).

- The single code for 'multiple injuries' is only to be used where no further detail is present in medical record.

- The fifth character to identify open and closed fractures and open and closed wounds must be used with all codes in the 'Injury' section within the 'Injury, poisoning and certain other consequences of external causes' chapter where there is an instruction to do so. An injury not indicated as 'open' or 'closed' must be recorded as closed.

- The only exclusions to this chapter are birth and obstetric injuries, pathological fractures, and non-traumatic sprains and strains.
Coding standards

The first axis for coding injuries is the site; the second axis is the type of injury.

Detailed guidance regarding the assignment of external cause codes for use with codes in this chapter are provided in Chapter XX External causes of morbidity and mortality of this manual. Some examples in this section show the index trails and tabular list entries for the appropriate external cause codes, others do not. Where there is no mention of an external cause code or its index trail notes appear under the example to confirm the need for an external cause code to be assigned, similarly when an external cause code is not required, this has been explained.

Injuries related to single body regions
(S00–S99)

At the beginning of this chapter in the Tabular List there is a list of classification definitions relating to specific injuries. These definitions provide coders with an understanding of terms such as superficial injuries, open wounds, fractures, etc.

Most injuries are classified according to a single body site (or region), e.g., left arm, right leg, and for each site (or region), the injuries are arranged in a standard sequence describing the type of injury. The sequence begins with superficial injuries, and proceeds to identify more serious injuries, such as injury to internal organs.

Superficial injuries
These can be indexed using the term that describes the type of injury such as ‘abrasion’, ‘contusion’, etc, or by referencing the lead term Injury.

Example:

Splinter in hand

Index trail for splinter:
Splinter – code as Injury, superficial, by site

Injury (see also specified injury type) T14.9
- superficial (for contusions, see first Contusion) T14.0
- - hand S60.9
- - - specified NEC S60.8

Tabular List entry:
S60.8 Other superficial injuries of wrist and hand
Rationale: The .8 other specified code has been selected in this example as a ‘splinter’ is another specified type of superficial injury to the hand. An external cause code from Chapter XX must also be assigned.

Open wounds
Open wounds are generally indexed under the lead term Wound with an essential modifier (subterm) to describe the site of the wound.

Example:
Laceration of finger. Cut with knife in kitchen at home.

Index trail for laceration:
Laceration (see also Wound, open) T14.1

Wound, open (animal bite) (cut) (laceration) (puncture wound) (shot wound) (with penetrating foreign body) T14.1
- finger(s) S61.0

Tabular List entry:
S61.0 Open wound of finger(s) without damage to nail
Open wound of finger(s) NOS
Excludes: open wound involving nail (matrix) (S61.1)

Index trail for cut with knife:
Cut, cutting (any part of body) (accidental) (by) (see also Contact, with, by object or machine) W49.-
Contact (accidental)
- with
-- knife W26.-

Tabular List entry:
W26 Contact with knife, sword or dagger
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home

When coding open wounds if the wound is infected, it is coded in the same way as a non-infect ed open wound, ie 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 added.
Examples:

Open wound of finger with infection

- Index trail for wound with infection:
  - Infection, infected (opportunistic) B99
  - wound (local) (post-traumatic) NEC T79.3
  - - open – see Wound, open

- Wound, open (animal bite) (cut) (laceration) (puncture wound) (shot wound) (with penetrating foreign body) T14.1
  - finger(s) S61.0

  Tabular List entry:
  S61.0  Open wound of finger(s) without damage to nail

Open wound of finger infected with staphylococcus

- Index trail for wound with infection:
  - Infection, infected (opportunistic) B99
  - wound (local) (post-traumatic) NEC T79.3
  - - open – see Wound, open

- Wound, open (animal bite) (cut) (laceration) (puncture wound) (shot wound) (with penetrating foreign body) T14.1
  - finger(s) S61.0

  Tabular List entry:
  S61.0  Open wound of finger(s) without damage to nail

- Index trail for staphylococcal infection:
  - Infection, infected (opportunistic) B99
  - staphylococcal NEC A49.0
  - - as cause of disease classified elsewhere B95.8

  Tabular List entry:
  B95.8  Unspecified staphylococcus as the cause of diseases classified to other chapters
Fractures
Fractures are classified according to the bone suffering the break. Terms such as ‘condyle’, ‘coronoid process’, ‘ramus’ and ‘symphysis’ indicate an area of a bone, not the bone involved.

Fifth character subdivisions are used with all fracture categories to describe the fracture as ‘open’ or ‘closed’. An open fracture is one where there is an external wound which leads to the fracture site, ie the skin has been broken. A closed fracture is without an external wound leading to the fracture site.

A fracture not indicated as ‘open’ or ‘closed’ must be recorded as closed in all fracture categories in the Tabular List. This is because the majority of fractures tend to be without an external wound.

**Examples:**

Fracture neck of femur. Fall down stairs at home.

- Index trail for fracture:
  - Fracture (abduction) (adduction) (avulsion) (comminuted) (compression) (dislocation) (oblique) (separation) T14.2
  - - femur, femoral S72.9
  - - - neck S72.0

  Tabular List entry:
  - S72.0 Fracture of neck of femur
    - [See tabular list for fifth character subdivisions]
    - 0 closed

- External cause index trail for fall down stairs:
  - Fall, falling (accidental) W19.-
    - - down
    - - - stairs, steps (involving ice or snow) W10.-

  Tabular List entry:
  - W10 Fall on and from stairs and steps
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .0 Home
Examples (cont):

Open fracture shaft of tibia

Index trail for fracture:
Fracture (abduction) (adduction) (avulsion) (comminuted)
(compression) (dislocation) (oblique) (separation) T14.2
- tibia (shaft) (with fibula) S82.2

Tabular List entry:
S82.2 Fracture of shaft of tibia
  With or without mention of fracture of fibula
  [See tabular list for fifth character subdivisions]
  1 open

Rationale: An external cause code from Chapter XX must also be assigned.
Head injuries
(S00–S09)

There is a specific sequencing rule when coding skull fractures (S02.-) associated with intracranial injuries (S06.-); the intracranial injury must be sequenced first. Fifth characters are available at these two categories to identify open and closed fractures of the skull and intracranial injuries with and without open intracranial wounds. These must be used where there is an instruction to do so. An injury not indicated as ‘open’ or ‘closed’ must be recorded as closed.

Example:
Open fracture of frontal bone of skull with open intracranial injury

Index trail for injury:
Injury (see also specified injury type) T14.9
- intracranial S06.9

Tabular List entry:
S06.9 Intracranial injury, unspecified
[see tabular list for fifth character subdivision]
1 open

Index trail for fracture:
Fracture (abduction) (adduction) (avulsion) (comminuted) (compression) (dislocation) (oblique) (separation) T14.2
- frontal (bone) (skull) S02.0

Tabular List entry:
S02.0 Fracture of vault of skull
Frontal bone
[see tabular list for fifth character subdivisions]
1 open

Rationale: An external cause code from Chapter XX must also be assigned.

The code S09.9 Unspecified injury of head must only be used when a patient is admitted with an unspecified head injury. If the responsible consultant has specified the type of injury to the head, then this must be coded instead of S09.9, as in the following example:
Example: Five year old boy admitted with head injury – laceration to scalp

Index trail for laceration:
Laceration (see also Wound, open) T14.1

Wound, open (animal bite) (cut) (laceration) (puncture wound) (shout wound) (with penetrating foreign body) T14.1
- scalp S01.0

Tabular List entry:
S01.0 Open wound of scalp

Rationale: An external cause code from Chapter XX must also be assigned.

Dislocations
Included in the dislocation categories are current injuries to ligaments such as strains, sprains and ruptures.

Example: Sprained finger

Index trail for sprain:
Sprain, strain (joint) (ligament) T14.3
- finger(s) S63.6

Tabular List entry:
S63.6 Sprain and strain of finger(s)

Rationale: An external cause code from Chapter XX must also be assigned.

Dislocations described as chronic, non-traumatic or recurrent must be coded to Chapter XIII Diseases of the musculoskeletal system and connective tissue.

Example: Recurrent dislocation of the elbow joint

Index trail for dislocation:
Dislocation (articular) T14.3
- elbow S53.1
- - recurrent M24.4

Tabular List entry:
M24.4 Recurrent dislocation and subluxation of joint
[fifth character of 2 from M00 to identify elbow joint]
Internal injuries
Internal injuries include blast injuries, blunt trauma, bruises, non cerebral concussion injuries, crushing, haematomas, lacerations, punctures, tears and traumatic ruptures of internal organs.

The fifth character subdivision is used to identify the absence or presence of an open wound into the body cavity.

When assigning the fifth character subdivision and the presence or absence of an open wound into body cavity is not indicated then the fifth character subdivision 0 without open wound into cavity is selected, this applies at all categories where this fifth character subdivision is available in the Tabular List.

Example:

<table>
<thead>
<tr>
<th>Traumatic haematoma of kidney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail for hematoma:</td>
</tr>
<tr>
<td>Hematoma (traumatic) (skin surface intact) (see also Injury, superficial) T14.0</td>
</tr>
<tr>
<td>- internal organs – see Injury, by site</td>
</tr>
</tbody>
</table>

Injury (see also specified injury type) T14.9
- kidney S37.0

Tabular List entry:
S37.0 Injury of kidney
[See tabular list for fifth character subdivisions]
0 without open wound into cavity

Rationale: An external cause code from Chapter XX must also be assigned to these scenarios.

Chronic versus current injuries
There is sometimes difficulty in deciding whether a joint injury is current or old/recurrent. In the case of current joint injuries, these must be assigned a code from ICD-10 Chapter XIX. Old or recurrent injuries must be assigned a code from Chapter XIII Diseases of the musculoskeletal system and connective tissue.

A good indication of an old injury is if the patient is admitted electively, i.e. off a waiting list. If there is any doubt whether an injury is current or old/recurrent then confirmation must be sought from the responsible consultant.
The following guidelines must be followed:

- A joint injury that continues to be inflamed is still a current injury.
- A joint injury where the inflammation has resolved, but then inflammation recurs is an old/recurrent 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.

**Multiple injuries**

Where a consultant episode concerns multiple injuries, each injury must be coded separately where the specific sites and types of injuries are mentioned. The injury that is clearly the most severe and demanding of resources must be recorded as the ‘main condition’, and the others as secondary conditions. Where no one condition obviously predominates, the responsible consultant’s advice must be sought.

**Example:**

Laceration left hand. Concussion. Open fracture left tibia and fibula requiring open reduction and internal fixation.

- **Index trail for open fracture:**
  
  Fracture (abduction) (adduction) (avulsion) (comminuted)
  (compression) (dislocation) (oblique) (separation) T14.2
  - tibia (shaft) (with fibula) S82.2

  **Tabular List entry:**
  
  S82.2  Fracture of shaft of tibia
  
  With or without mention of fracture of fibula
  
  [See tabular list for fifth character subdivisions]
  
  1 open

- **Index trail for laceration hand:**

  Laceration (see also Wound, open) T14.1

  Wound, open (animal bite) (cut) (laceration) (puncture wound)
  (shot wound) (with penetrating foreign body) T14.1
  - hand S61.9

  **Tabular List entry:**
  
  S61.9  Open wound of wrist and hand part, part unspecified

- **Index trail for concussion:**

  Concussion (current) S06.0

  **Tabular List entry:**
  
  S06.0  Concussion
  
  [See tabular list for fifth character subdivisions]
  
  0 closed
**Rationale:** In this example, the open fracture to the tibia/fibula was the main condition treated as this required surgery. This would therefore be coded in primary position. As there is no national guidance for the sequencing of the other injuries it will usually be the first documented in the patient’s medical record. The open reduction/internal fixation would be recorded with procedure codes.

An external cause code from Chapter XX must also be assigned.
Injuries involving multiple body regions (T00–T07)

The *Includes* note at block level instructs the coder that the multiple injury codes featured in categories T00-T07 can also be used to identify specified bilateral injuries when those bilateral injuries involve the *same* body site, eg a patient who fractures both left and right forearm. The type of and site of injury must be identical on both sides in order to assign a code from T00-T07 for bilateral injuries.

**Example:**

Multiple contusions to legs

- Index trail for *contusion*:
  - *Contusion (skin surface intact) (see also Injury, superficial)* T14.0
  - *Injury (see also specified injury type)* T14.9
    - superficial (*for contusions, see first Contusion*) T14.0
    - - multiple T00.9
      - - leg
        - - - meaning lower limb – *see Injury, superficial, multiple, limb, lower
        - - - limb
        - - - lower (with) T00.3

- Tabular List entry:
  - T00.3 *Superficial injuries involving multiple regions of lower limb(s)*

Rationale: If the coder indexes leg under the lead term *Contusion* in the Alphabetical Index, they are taken to category S80.-. There is an exclusion note at block S80-S89 in the Tabular List that tells the coder it excludes bilateral involvement of knee and lower leg (T00–T07). An external cause code from Chapter XX must also be assigned.

As a general rule, injuries must be recorded separately where the specific sites are mentioned.
Where multiple sites of injury are specified in the code titles, the word ‘with’ indicates involvement of both sites and the word ‘and’ indicates involvement of either or both sites. For example:

**T06.5 Injuries of intrathoracic organs with intra-abdominal and pelvic organs**

This code should therefore only be assigned if the injuries to the intrathoracic organs are with any of the following:

- with both intra-abdominal and pelvic organs
- with only intra-abdominal organs
- with only pelvic organs.
Effects of foreign body entering through natural orifice (T15–T19)

Foreign body injuries must be classified according to the site where the foreign body is currently located.

Example:

Coin in stomach (swallowed)

Index trail for foreign body:

Foreign body
- entering through orifice
- - stomach T18.2

Tabular List entry:

T18.2 Foreign body in stomach

An external cause code from Chapter XX must also be assigned.

The .9 subdivisions at categories T15–T19 must be used when the site of the lodged foreign body within various body systems has not been identified.
Burns and corrosions
(T20–T32)

Burns are caused by heat (flames) or friction, and corrosions are caused by chemicals that erode and destroy tissue.

Degree of burns
A fourth character subdivision is used to identify the degree of the burn or corrosion.

Burns of the same site that exhibit multiple degrees are to be coded to the most severe degree of that site.

Example:
Second and third degree burns of forearm

Index trail for burn:
   Burn (electricity) (flame) (hot gas, liquid or object) (radiation)
   (steam) (thermal) T30.0
   - arm (lower) (upper) – see Burn, limb, upper
   - limb(s)
   - - upper (except wrist and hand alone) T22.-

Tabular List entry:
T22.3 Burn of third degree of shoulder and upper limb, except wrist and hand

Rationale: An external cause code from Chapter XX must also be assigned.

Treatment for current burn injuries
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.

Extent of body surface (T31, T32)
The size of the body surface affected by burns injury is both a major factor in terms of survival and resource, and of crucial importance when understanding the incidence of burns. The size of the body surface affected by a burn is worked out by accident and emergency staff using a system called the 'Rule of nines'.
When the responsible consultant has documented the total percentage of body surface involved in a burn or corrosion, a code from categories T31 or T32 must be assigned. These categories are used as supplementary codes with categories T20–T25, T29. However, categories T31 and T32 can be used in the primary position only when the site of the burn is unspecified, as per the notes at these categories in the Tabular List.

**Examples:**

**Third degree burn of hand (2% of body surface)**

- Index trail for burn:
  - Burn (electricity) (flame) (hot gas, liquid or object) (radiation) (steam) (thermal) T30.0
  - hand(s) (phalanges) (and wrist) T23.-

  Tabular List entry:
  - T23.3 Burn of third degree of wrist and hand

- Index trail for extent of body coverage:
  - Burn (electricity) (flame) (hot gas, liquid or object) (radiation) (steam) (thermal) T30.0
  - unspecified site with extent of body surface involved specified
  - - less than 10 per cent T31.0

  Tabular List entry:
  - T31.0 Burns involving less than 10% of body surface

**Burn, 50% of body surface**

- Index trail for burn:
  - Burn (electricity) (flame) (hot gas, liquid or object) (radiation) (steam) (thermal) T30.0
  - unspecified site with extent of body surface involved specified
  - - 50-59 per cent T31.5

  Tabular List entry:
  - T31.5 Burns involving 50-59% of body surface

**Rationale:** An external cause code from Chapter XX must also be assigned to these scenarios.
Other and unspecified effects of external causes (T66–T78)

Maltreatment syndromes (T74)
Category T74 is used to record non-accidental injuries (NAI). The responsible consultant must clearly state that an injury is a non-accidental injury before a code from this category can be assigned.

There is a ‘Use additional code’ note at category level in the Tabular List to instruct the coder to record the nature of the injury in addition. A further code from category Y07 Other maltreatment can be assigned if information is provided by the responsible consultant about who inflicted the non-accidental injury.

Example:

**Baby physically abused by parent admitted with fractured rib**

- Index trail for physical abuse:
  - Abuse
    - physical (adult) (child) T74.1

  Tabular List entry:
  **T74.1 Physical abuse**
  Battered:
  - baby or child syndrome NOS
  - spouse syndrome NOS

- Index trail for fracture:
  - Fracture (abduction) (adduction) (avulsion) (comminuted)
    (compression) (dislocation) (oblique) (separation) T14.2
  - rib S22.3

  Tabular List entry:
  **S22.3 Fracture of rib**
  [See tabular list for fifth character subdivisions]
  0 closed

- External Cause Index trail for maltreatment by parent:
  - Maltreatment (syndrome) NEC Y07.9
  - by
    - - parent Y07.1

  Tabular List entry:
  **Y07.1 Other maltreatment by parent**
Certain early complications of trauma, not elsewhere classified (T79)

Certain complications which frequently occur in trauma patients may be reported in category T79. These include Post-traumatic wound infection at T79.3, which can have a code added from the range B95–B98 Bacterial, viral and other infectious diseases to identify the infectious organism.

T79.5 Traumatic anuria includes crushing syndrome and renal failure following crushing and is the correct code to assign for renal failure due to traumatic rhabdomyolysis.

T79.6 Traumatic ischaemia of muscle is the correct code for a diagnosis of Traumatic rhabdomyolysis (without renal failure). T79.6 also includes the conditions ‘Compartment syndrome’. This is the effects of tissue swelling within a compartment of the body, usually the forearm or the lower leg. There is compression of the blood vessels, resulting in muscular atrophy. An operation to open up the tissue planes and relieve the pressure is often needed.

An external cause code from Chapter XX must be assigned with codes from category T79.
Sequelae of injuries
(T90–T98)

A sequelae or ‘late effect’ is a current condition in a patient that is caused by a previous condition which is no longer present.

The code describing the current condition must be sequenced before a code from categories T90–T98.

Example:

Hemiplegia as a result of an old spinal cord injury

- Index trail for hemiplegia:
  Hemiplegia G81.9

  Tabular List entry:
  G81.9  Hemiplegia, unspecified

- Index trail for the sequelae:
  Sequelae (of) – see also condition
  - injury NEC T94.1
  - spine, spinal T91.8
  - - cord T91.3

  Tabular List entry:
  T91.3  Sequelae of injury of spinal cord
  Sequelae of injury classifiable to S14.0-S14.1, S24.0-S24.1, S34.0-S34.1 and T09.3

Rationale: If the cause of the original injury is also known, an external sequelae code can also be assigned. This is explained in Chapter XX External causes of morbidity and mortality.
Postprocedural complications and disorders

The coding of postprocedural complications and disorders is explained in detail here and summarised diagrammatically following this section.

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 complications, postoperative disorders, following surgery or following a procedure.

The principle is to use codes which fully describe the condition and the procedure that caused it. Postprocedural complications and disorders can be coded in three different ways:

1. Use a code from the range T80–T88 followed by the external cause code from Y83–Y84 if doing so adds further information about the nature of the procedure

2. Assign a code for the condition itself, followed by the external cause code from Y83–Y84 to identify the procedure

3. Assign a code from the postprocedural disorders category at the end of the relevant body system chapter followed by the external cause code from Y83–Y84 if doing so adds further information about the nature of the procedure.

A coder must never assume a condition is a postprocedural complication or disorder unless it is clearly documented as such by the responsible consultant.
1. Coding complications of surgical and medical care, not elsewhere classified (T80–T88)

The range of conditions in categories T80–T88 are often complications relating to certain procedures or internal devices such as complications of injections T80, internal orthopaedic devices T84, or other cardiac and vascular prosthetic devices T82, and all have specific index entries.

Example:

Displacement of heart valve prosthesis

Index trail for displacement:
Displacement, displaced
- device, implant or graft (see also Complications, by site and type, mechanical) T85.6
- - heart NEC T82.5
- - - valve (prosthesis) T82.0

Tabular List entry:

T82.0 Mechanical breakdown of heart valve prosthesis

<table>
<thead>
<tr>
<th>Breakdown (mechanical)</th>
<th>due to heart valve prosthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displacement</td>
<td></td>
</tr>
<tr>
<td>Leakage</td>
<td></td>
</tr>
<tr>
<td>Malposition</td>
<td></td>
</tr>
<tr>
<td>Obstruction, mechanical</td>
<td></td>
</tr>
<tr>
<td>Perforation</td>
<td></td>
</tr>
<tr>
<td>Protrusion</td>
<td></td>
</tr>
</tbody>
</table>

Displacement, obstruction, etc. are all classed as mechanical complications of prosthetic devices as they prevent the prosthesis from functioning correctly. Refer to the list of inclusions under the mechanical complication codes in the Tabular List, Volume 1.

Complications classifiable to categories T80–T88 can also be referenced under the lead term that describes the specific condition, with the appropriate modifier to indicate that it is the result of a procedure or treatment, e.g. ‘postoperative’, ‘following surgery’, ‘following infusion’.

Example:

Phlebitis due to IV infusion

Index trail for phlebitis:
Phlebitis (infective) (pyemic) (septic) (suppurative) I80.9
- following infusion, therapeutic injection or transfusion T80.1

Tabular List entry:

T80.1 Vascular complications following infusion, transfusion and therapeutic injection
When there is no entry for either the specific condition or the appropriate modifier, the lead term **Complications** must be referenced.

**Example:**

<table>
<thead>
<tr>
<th>Displacement of hip prosthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Index trail for complications:" /></td>
</tr>
<tr>
<td>Complications (from) (of)</td>
</tr>
<tr>
<td>- prosthetic device, graft or implant T85.9</td>
</tr>
<tr>
<td>- joint T84.9</td>
</tr>
<tr>
<td>- - - mechanical T84.0</td>
</tr>
</tbody>
</table>

Tabular List entry:

**T84.0 Mechanical complication of internal joint prosthesis**

**Rationale:** The above condition can also be indexed under the lead term **Displacement** in the Alphabetical Index.

It is not necessary to add an external cause code from categories **Y83–Y84** to a code from the range **T80-T88** when the postprocedural condition is classified to a code that fully describes both the nature of the condition and the procedure that has caused it.

This rule applies both if the complication occurs during the same Consultant Episode on which the procedure took place, or on a subsequent Consultant Episode / subsequent readmission for treatment of the postoperative complication.

**Example:**

<table>
<thead>
<tr>
<th>Air embolism due to transfusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Index trail for embolism:" /></td>
</tr>
<tr>
<td>Embolism (septic) I74.9</td>
</tr>
<tr>
<td>- following</td>
</tr>
<tr>
<td>- - infusion, therapeutic injection or transfusion</td>
</tr>
<tr>
<td>- - - air T80.0</td>
</tr>
</tbody>
</table>

Tabular List entry:

**T80.0 Air embolism following infusion, transfusion and therapeutic injection**

**Rationale:** In the above example, the postprocedural condition is classified to a code that fully describes the nature of the condition and the procedure that caused it therefore it is not necessary to assign an external cause code.
Example: Postoperative haemorrhage five hours after a tonsillectomy

- Index trail for postoperative haemorrhage:
  Hemorrhage, hemorrhagic R58
  - postoperative T81.0

  Tabular List entry:
  T81.0  Haemorrhage and haematoma complicating a procedure, not elsewhere classified

- External Cause Index trail for complication:
  Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - removal of organ (partial) (total) NEC Y83.6

  Tabular List entry:
  Y83.6  Removal of other organ (partial) (total)

Rationale: In the above example, the external cause code is required to add more specific information about the procedure causing the postprocedural complication as it is not implicit in the code title for T81.0.

Example: Patient readmitted with swab in-situ following cholecystectomy

- Index trail for foreign body (i.e. swab):
  Foreign body
  - accidentally left during a procedure T81.5

  Tabular List entry:
  T81.5  Foreign body accidentally left in body cavity or operation wound following a procedure

- External Cause Index trail for complication:
  Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - removal of organ (partial) (total) NEC Y83.6

  Tabular List entry:
  Y83.6  Removal of other organ (partial) (total)

Rationale: In the above example, the postprocedural condition is classified to a code that does not fully describe the nature of the procedure therefore it is necessary to assign an external cause code.

When assigning a code from categories Y83-Y84 with codes from categories T80-T88 a .8 or .9 code from categories Y83-Y84 must not be assigned because these codes do not add further detail about the nature of the procedure.
Postprocedural infections following insertion of prostheses, implants or grafts

It is important to seek clarification from the responsible consultant when coding postprocedural wound infections in patients with prosthetic devices, implants or grafts 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.

Example:

Readmission with a postoperative wound infection at incision site following a femoral/popliteal bypass graft

Index trail for postoperative wound infection:
Infection, infected (opportunistic) B99
- postoperative wound T81.4
or
Infection, infected (opportunistic) B99
- wound (local) (post-traumatic) NEC T79.3
- - surgical T81.4

Tabular List entry:

T81.4 Infection following a procedure, not elsewhere classified
Abscess:
• intra-abdominal
  stitch
subphrenic
wound
Sepsis

Use additional code, if desired, to identify other manifestations of infection, such as sepsis or abscess.

External Cause Index trail for complication:
Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
- bypass Y83.2
or
- graft Y83.2

Tabular List entry:

Y83.2 Surgical operation with anastomosis, bypass or graft

Rationale: The responsible consultant has confirmed that the postprocedural wound infection is due to the wound and not the bypass graft. The external cause code is required as this adds further information about the nature of the procedure which is not implicit in the code description for T81.4.
Example:

Patient readmitted 12 weeks post total hip replacement. Documented diagnosis of postoperative wound infection due to hip joint prosthesis

Index trail for the complication (i.e. infected joint prosthesis):

Complications (from) (of)
- prosthetic device, graft or implant T85.9
- joint T84.9
- - - infection or inflammation T84.5

or

Infection, infected (opportunistic) B99
- due to or resulting from
  - - device, implant or graft (see also Complications, by site and type)
    T85.7
  - - - joint prosthesis T84.5

Tabular List entry:

T84.5 Infection and inflammatory reaction due to internal joint prosthesis

Rationale: The responsible consultant has confirmed that the postprocedural wound infection has been caused by the hip joint prosthesis; therefore, the appropriate code from category T84 Complications of internal orthopaedic prosthetic devices, implants and grafts is assigned. In the above example, the postprocedural condition is classified to a code that also fully describes the nature of the procedure therefore it is not necessary to assign an external cause code.

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 must be coded as the main condition. Clinical advice must be sought as to the reason for the occlusion if it is not clear in the medical record.
## Sequencing of postprocedural complications and disorders

The sequencing of codes may on occasions change. A postprocedural complication or disorder may present problems that affect the patient’s management and/or length of stay.

In instances where a patient is admitted for treatment of a condition, and a postprocedural complication occurs that then becomes the main condition treated, the primary diagnosis definition must be adhered to.

**Example:**

Patient admitted for reconstruction of torn anterior cruciate ligament sustained playing football 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.

- **Index trail for postoperative wound infection:**
  - Infection, infected (opportunistic) B99
  - postoperative wound T81.4
  
  or

  - Infection, infected (opportunistic) B99
  - wound (local) (post-traumatic) NEC T79.3
  - - surgical T81.4

- **Tabular List entry:**
  - T81.4 Infection following a procedure, not elsewhere classified

- **External Cause Index trail for complication:**
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - - surgical operation NEC (see also Complication, by type of operation) Y83.9
  - - - reconstructive NEC Y83.4

- **Tabular List entry:**
  - Y83.4 Other reconstructive surgery
Example (cont):

Index trail for **Sepsis**:

**Sepsis (generalized)** *(see also Infection)* A41.9

Tabular List entry:

A41.9 Sepsis, unspecified

Index trail for **torn anterior cruciate ligament**:

**Tear, torn (traumatic)** – *(see also)* Wound, open
- **ligament** – *(see)* Sprain

**Sprain, strain (joint) (ligament)** T14.3
- **cruciate, knee** S83.5

Tabular List entry:

S83.5 Sprain and strain involving (anterior)(posterior) cruciate ligament of knee

**Rationale:** The external cause code **Y83.4 Other reconstructive surgery** is required because it identifies that the postprocedural wound infection was due to reconstructive surgery. A further external cause code from Chapter XX External Causes of morbidity and mortality would also be assigned to identify how the torn anterior cruciate ligament (ACL) occurred. The ACL reconstruction and the amputation would be recorded as procedure codes.

**Complications of orthopaedic fixators**

Complications of **internal** fixators are classified within category **T84 Complications of internal orthopaedic prosthetic devices, implants and grafts**. It is not necessary to assign code **Y83.1 Surgical operation with implant of artificial internal device** in addition to a code from category **T84** as doing so does not add further detail about the nature of the procedure.

For complications of **external** fixators, such as Ilizarov external fixators, the correct code is **T88.8 Other specified complications of surgical and medical care, not elsewhere classified**. It is not necessary to assign an additional code from categories **Y83-Y84** as there is no dedicated external cause code for an external fixator so adding a code from this range would not add any further information about the nature of the procedure.
2. Coding the condition plus external cause code

In the Alphabetical Index or Tabular List many postprocedural disorders do not have any modifiers such as ‘postoperative’, ‘postprocedural’, etc. that direct the clinical coder to categories T80-T88 Complications of surgical and medical care, not elsewhere classified.

When this is the case a code for the condition being treated is assigned, followed by the appropriate external cause code from the following categories:

- **Y83** 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.
- **Y84** 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.

When assigning a code from categories Y83-Y84 with a condition code from a body system chapter it is appropriate to use a fourth character code of .8 or .9 from categories Y83-Y84 (if fourth characters .0 to .7 are not appropriate). This is because the code provides more detail that the condition was due to a procedure.

Codes from categories Y83-Y84 are indexed in the External causes of injury Index under the lead term Complication in Section II of the Alphabetical Index.

**Example:**

Postoperative urinary tract infection after cholecystectomy
(condition linked to the procedure by the responsible consultant)

- Index trail for **postoperative urinary tract infection**:
  - Infection, infected (opportunistic) B99
    - urinary (tract) NEC N39.0

  Tabular List entry:
  - N39.0 Urinary tract infection, site not specified

- External Cause Index trail for **complication**:
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
    - removal of organ (partial) (total) NEC Y83.6

  Tabular List entry:
  - Y83.6 Removal of other organ (partial) (total)
Reference to modifiers is essential for choosing the correct code when postoperative procedures are recorded. This will ensure that the code(s) assigned reflect the maximum clinical detail.

**Example:** Pulmonary embolism as a result of percutaneous embolisation of liver.

- Index trail for pulmonary embolism:
  - Embolism (septic) I74.9
  - pulmonary (artery) (vein) I26.9

  Tabular List entry:
  - I26.9 Pulmonary embolism without mention of acute cor pulmonale

- External Cause Index trail for complication:
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - surgical operation NEC (see also Complication, by type of operation) Y83.9
  - - specified NEC Y83.8

  Tabular List entry:
  - Y83.8 Other surgical procedures
3. Coding postprocedural disorders in body system chapters

Most body system chapters provide a postprocedural disorder category. In theory, as there will be a .8 subcategory in these body system postprocedural categories, nearly every type of postprocedural condition could be coded using these codes. However, as specificity would be lost these codes must only be used when the condition is specifically index-trailed to a postprocedural disorder category code in a body system chapter or where specific guidance exists indicating that these codes must be used (such as in the case of Post Enucleation Socket Syndrome).

A code from categories Y83-Y84 must be assigned in addition if it adds additional information about the nature of the procedure. A .8 or .9 code from categories Y83-Y84 must not be assigned in these circumstances because these codes will not add further detail about the nature of the procedure.

In the following examples, there are specific index entries for the postprocedural disorders which lead to a code within a body system chapter.

### Examples:

**Tracheostomy malfunction due to airway obstruction**

- Index trail for **malfunction**:
  - Malfunction – see also Dysfunction
    - tracheostomy J95.0

- Tabular List entry:
  - J95.0 Tracheostomy malfunction
    - Haemorrhage from tracheostomy stoma
    - Obstruction of tracheostomy airway
    - Sepsis of tracheostomy stoma
    - Tracheo-oesophageal fistula following tracheostomy

**Rationale:** In the above example, an additional code from the categories Y83–Y84 would not be necessary as a full description of the procedure is stated in code J95.0.

**Postgastrectomy dumping syndrome**

- Index trail for **Syndrome**:
  - Syndrome – see also Disease
    - postgastrectomy (dumping) K91.1

- Tabular List entry:
  - K91.1 Postgastric surgery syndromes
**Example (cont):**

- External Cause Index trail for **complication**:
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - removal of organ (partial) (total) NEC Y83.6

Tabular List entry:

Y83.6 Removal of other organ (partial) (total)

**Rationale:** In the above example, code **Y83.6 Removal of other organ (partial) (total)** is assigned in addition as it adds information about the nature of the gastric surgery.

If the ICD-10 Alphabetical Index leads to a postprocedural category code in a body system chapter ending in .8 or .9 (for example, pneumonia), the specific condition plus a code from categories Y83 or Y84 must be used instead as described in the Coding the condition plus external cause code section above, unless a specific condition code does not exist.

---

**Breakdown internal anastomosis of intestine**

- Index trail for the **complication** (i.e. breakdown):
  - Complications (from) (of)
    - anastomosis (and bypass) NEC T85.9
    - - intestinal (internal) NEC K91.8

Tabular List entry:

K91.8 Other postprocedural disorders of digestive system, not elsewhere classified

- External Cause Index trail for **complication**:
  - Complication (delayed) (of or following) (medical or surgical procedure) Y84.9
  - anastomosis (arteriovenous) (blood vessel) (gastrojejunal) (skin) (tendon) (natural, artificial material, tissue) Y83.2

Tabular List entry:

Y83.2 Surgical operation with anastomosis, bypass or graft

**Rationale:** A specific condition code does not exist for the breakdown of an internal anastomosis of intestine therefore it is correct to assign code K91.8. Code **Y83.2** is assigned in addition as this provides further information about the nature of the procedure.
Injury, poisoning etc.

Postprocedural complications and disorders

Use codes which fully describe the condition and the procedure that caused it

The postprocedural complication/disorder does not have modifiers such as 'postoperative', 'postprocedural', 'following surgery' etc. in the alphabetical index or tabular list

The postprocedural complication/disorder cannot be indexed under lead term 'complications'

Assign a code from T80-T88

+ Y83-Y84 if doing so adds further information about the nature of the procedure (do not use .8 or .9 codes)

The condition can be specifically index-trailed to a postprocedural disorder category in a body system chapter

Index leads to a body system chapter with a postprocedural disorder code that ends in .8 or .9

Index leads to a body system chapter with a postprocedural disorder code that does not end in .8 or .9

Specific condition code for the complication exists

Specific condition code for the complication does not exist

Assign a code from the postprocedural disorder category in a body system chapter

+ Y83-Y84 if doing so adds further information about the nature of the procedure (do not use .8 or .9 codes)
Poisoning and adverse effects
(T36–T78)

Reactions to drugs/medicines can occur from either their proper or improper use.

In ICD-10 these reactions are classified in one of two ways:

- **poisoning** (improper use)
- **adverse effects** (proper use).

Where a reaction to a drug/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.

Poisoning (T36-T50)

Poisoning is a reaction that results from the improper use of a substance. This type of reaction can also be described as:

- intoxication
- overdose
- ‘therapeutic misadventure’
- toxic effect/toxicity
- wrong dosage given or taken
- wrong substance given or taken.

‘Intoxication’ does not include cumulative effect – a build up over time – as this constitutes an adverse effect instead. Wrong dosage given or taken includes taking a drug originally prescribed for another person, or for a previous illness.

When reporting a poisoning or reaction to the improper use of a substance, eg wrong dose, wrong substance or wrong route of administration, the following must be coded:

1. The substance.
2. The circumstance of the poisoning.
3. The manifestation or reaction, if known.
1. The substance

These codes are found in the Table of Drugs and Chemicals in Section III of the Alphabetical Index. The Table contains an extensive but not exhaustive list of drugs, medicinal and non-medicinal chemicals, and solvents. Proprietary names, ie 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, eg 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.

The Table is used to assign a diagnosis code to identify a poisoning by a substance and the circumstance involved. The coder must locate the substance causing the poisoning in the ‘Substance’ column, and then read across to the column entitled ‘Poisoning’ to find the correct diagnosis code. These codes describe the type of drug or other medicine that was the cause of the poisoning.

**Example:**

<table>
<thead>
<tr>
<th>Patient admitted following codeine overdose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index trail in Table of Drugs and Chemicals:</td>
</tr>
<tr>
<td>Poisoning</td>
</tr>
<tr>
<td>Chapter XIX</td>
</tr>
<tr>
<td>Codeine  T40.2</td>
</tr>
</tbody>
</table>

Tabular List entry:

**T40.2 Other opioids**

<table>
<thead>
<tr>
<th>Codeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
</tr>
</tbody>
</table>

**Rationale:** An external cause code from Chapter XX must also be assigned.
Frequently patients overdose on more than one drug. If each drug is identified by the responsible consultant, separate codes must be assigned. The responsible consultant must determine which drug is the most clinically dangerous.

**Example:**

**Overdose on 30 paracetamol tablets and 14 sedatives**

- Index trail in *Table of Drugs and Chemicals*:
  - Poisoning
  - Chapter XIX
  - Paracetamol
    - T39.1

Tabular List entry:

T39.1 4-Aminophenol derivatives

- Index trail in *Table of Drugs and Chemicals*:
  - Poisoning
  - Chapter XIX
  - Sedative NEC
    - T42.7

Tabular List entry:

T42.7 Antiepileptic and sedative-hypnotic drugs, unspecified

**Rationale:** External cause codes from Chapter XX must also be assigned.

When a drug has more than one component, eg cocodaprin made up of codeine phosphate and aspirin, each component should be coded separately and sequenced according to the sequence in the British National Formulary (BNF); a copy of which should be available in all clinical coding departments. Alternatively the online version is available at: [http://bnf.org/bnf/index.htm](http://bnf.org/bnf/index.htm)
**Example:**

<table>
<thead>
<tr>
<th>Patient admitted with overdose of cocodaprin</th>
</tr>
</thead>
<tbody>
<tr>
<td>(BNF confirms the correct sequence as codeine, then aspirin)</td>
</tr>
</tbody>
</table>

- Index trail in **Table of Drugs and Chemicals:**
  - Poisoning
  - Chapter XIX
  - Codeine T40.2

  **Tabular List entry:**
  - T40.2 Other opioids
    - Codeine
    - Morphine

- Index trail in **Table of Drugs and Chemicals:**
  - Poisoning
  - Chapter XIX
  - Aspirin (aluminium) (soluble) T39.0

  **Tabular List entry:**
  - T39.0 Salicylates

**Rationale:** External cause codes from Chapter XX must also be assigned.

2. **The circumstance of the poisoning**

The circumstances involved in a poisoning by drugs and other agents are reported with external cause codes found in the Table of Drugs and Chemicals (Section III of the Alphabetical Index). External cause codes must always be sequenced in a secondary position. Further guidance about assigning external cause codes to poisonings is given in Chapter XX External causes of morbidity and mortality of this Instruction Manual.

Again, the coder must locate the substance in the column titled ‘Substance’ and read across to select an external cause code from the appropriate column. The columns used to identify these circumstances are titled ‘Accidental’, ‘Intentional self-harm’ and ‘Undetermined intent’.

The column entitled ‘Undetermined intent’ must only be used if there is insufficient evidence to enable a medical or legal authority to make a distinction between accidental or self-harm, eg open verdict by a coroner at an inquest. It is **not** to be used by the coder where no information has been given about the circumstances of a poisoning.

*If the coder does not know whether the overdose is an accidental or intentional self-harm attempt, the ‘Accidental’ column must be selected.*
If it is clear from the medical record that the patient has intended to harm themselves as a ‘cry for help’ then the ‘Intentional self-harm’ column must be selected. It is important to understand that the ‘Intentional self-harm’ column not only applies to a patient who has intended to commit suicide, but also to a patient who has intended to harm themselves in any way.

There are no age limits attached to the circumstance columns. Each case has to be looked at individually before code assignment is made.

**Example:**

Patient admitted having deliberately taken a bottle of paracetamol following an argument with her boyfriend

📖 Index trail in **Table of Drugs and Chemicals:**

**Poisoning**

**Intentional**

**Chapter XIX self-harm**

<table>
<thead>
<tr>
<th>Paracetamol</th>
<th>T39.1</th>
<th>X60.-</th>
</tr>
</thead>
</table>

**Tabular List entries:**

T39.1 4-Aminophenol derivatives

X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics

[See at the beginning of this chapter for the classification of the place of occurrence]

.9 Unspecified place

**Rationale:** The external cause codes require fourth character subdivisions to indicate place of occurrence.
Example: Codeine overdose in a six year old child who helped herself to mother’s pills from a cupboard at home

Index trail in Table of Drugs and Chemicals:
Poisoning
Chapter XIX Accidental
Codeine

Tabular List entries:
T40.2 Other opioids
  Codeine
  Morphine

X42 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .0 Home

Rationale: The ‘Accidental’ column has been selected in the above example because the coder has not been given any information about the circumstance of the overdose, rather than the fact that the patient is only six years old.

Mephedrone
Mephedrone is described as a chemical stimulant closely related to the ‘cathinone’ group of drugs which include, Methcathinone, Methylendioxyamphetamine 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’.

If the patient is described by the responsible consultant as having ‘acute intoxication’ from taking Mephedrone then the correct code to assign is F15.0 Mental and behavioural disorders due to use of other stimulants, including caffeine, acute intoxication.

Poisoning by assault
There are also external cause codes to identify assault as the circumstance involved in a poisoning. These codes are indexed in the External causes of injury Index under the lead term ‘Assault’ (Section II of the Alphabetical Index). Coders will often see this type of poisoning described in medical records as ‘spiked’ drink.
Example:

Patient admitted from a nightclub after having a non-alcoholic drink spiked with LSD

Index trail in Table of Drugs and Chemicals:
- Poisoning
  - Chapter XIX
  - T40.8

Tabular List entry:
T40.8 Lysergide [LSD]

External Cause Index trail for assault (spiked drink):
- Assault (homicidal) (by) (in) Y09.-
  - drugs or biological substances X85.-

Tabular List entry:
X85. Assault by drugs, medicaments and biological substances
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .5 Trade and service area

Rationale: If it is an alcoholic drink spiked with a drug, poisoning by alcohol would be coded in addition. The correct fourth character subdivision for a place of occurrence of pub or nightclub is .5 Trade and service area.

3. Manifestation or reaction, if known

The manifestations or reactions of the poisoning must be coded in addition if the reaction is stated in the diagnosis, sequencing is as follows:

- Manifestations and reactions classified within chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99), such as coma and vomiting 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) that have been treated, such as renal failure or kidney failure 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.
Examples:

Coma due to accidental codeine overdose at home

Index trail in Table of Drugs and Chemicals:
- Poisoning
  - Chapter XIX  Accidental

Codeine
- T40.2
- X42

Tabular List entries:

T40.2 Other opioids
- Codeine
- Morphine

X42 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
[See at the beginning of this chapter for the classification of the place of occurrence]
- .0 Home

Index trail in main Alphabetical Index for coma:
- Coma R40.2

Tabular List entry:
- R40.2 Coma, unspecified

Rationale: The coma must be assigned in a secondary position as the code for a coma is classified within chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99).
Patient admitted for treatment of kidney failure following deliberate overdose of paracetamol at home

Index trail for kidney failure:
Failure, failed
- kidney N19

Tabular List entry:
N19.X Unspecified kidney failure

Index trail in Table of Drugs and Chemicals:
Poisoning
Intentional
Chapter XIX self-harm
Paracetamol T39.1 X60.-

Tabular List entries:
T39.1 4-Aminophenol derivatives
X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home

Rationale: The patient has been admitted for treatment of kidney failure following an overdose, therefore this is the main condition treated and is sequenced before the codes for the overdose.
Adverse effects

Adverse effects result from the proper use of a substance. This type of reaction can be described as:

- adverse effect of drug
- allergic reaction
- cumulative toxicity
- hypersensitivity
- idiosyncratic reaction
- interaction of drugs
- ‘side effects’.

The interaction of drugs applies when each one is a correct substance properly administered, or for two or more prescription drugs used correctly.

When reporting an adverse effect, the following must be coded:

1. The nature of the adverse effect or the patient’s reaction.
2. The substance causing the adverse reaction.

1. **The nature of the adverse effect or the patient’s reaction**

   Adverse effects of correct substances properly administered are **coded according to the nature of the adverse effect**, eg rash, swelling, vomiting. The nature of the reaction is referenced in the main Alphabetical Index (Section I) under the appropriate lead term.

2. **The substance causing the adverse reaction**

   The cause of the adverse reaction is identified by an external cause code found in the Table of Drugs and Chemicals in the column entitled ‘Adverse effect in therapeutic use’. These external cause codes from Chapter XX are mentioned in the ‘Use additional external cause code’ notes throughout the Tabular List.

   Codes from this column only identify substances when administered **properly** and, therefore, should **never** be used with a code from the ‘poisoning’ column since poisoning implies the improper use of a substance.

   Never use a poisoning code from Chapter XIX with an adverse effect code from Chapter XX.

   Data regarding the substance involved in reactions to substances administered properly can be obtained through the use of these external cause codes. **It is therefore strongly recommended that they always be recorded.**

   The external cause code is recorded **secondary** to the code for the nature of the adverse effect(s).
### Examples:

**Patient admitted with a generalised rash due to penicillin**

- **Index trail for rash:**
  - Rash R21
  - drug (internal use) L27.0

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>L27.0 Generalized skin eruption due to drugs and medicaments</td>
</tr>
<tr>
<td>Use additional external cause code (Chapter XX), to identify drug</td>
</tr>
</tbody>
</table>

- **Index trail in Table of Drugs and Chemicals:**
  - Penicillin (any) Y40.0

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y40.0 Penicillins</td>
</tr>
</tbody>
</table>

**Patient admitted with a bleeding stomach ulcer due to aspirin**

- **Index trail for stomach ulcer:**
  - Ulcer, ulcerated, ulcerating, ulceration, ulcerative L98.4
  - stomach (eroded) (peptic) (round) K25.9
  - - with hemorrhage K25.4

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>K25 Gastric ulcer</td>
</tr>
<tr>
<td>[See at the beginning of this block for subdivisions]</td>
</tr>
<tr>
<td>.4 Chronic or unspecified, with haemorrhage</td>
</tr>
<tr>
<td>Use additional external cause code (Chapter XX), to identify drug, if drug-induced</td>
</tr>
</tbody>
</table>

- **Index trail in Table of Drugs and Chemicals:**
  - Aspirin (aluminium) (soluble) Y45.1

<table>
<thead>
<tr>
<th>Tabular List entry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y45.1 Salicylates</td>
</tr>
</tbody>
</table>
Drugs taken in combination
In certain situations, when two (or more) drugs or chemicals are taken in combination, the rules that would be followed if the drug had been taken alone may not apply.

Medication combined with alcohol
An adverse reaction to a drug, either properly or improperly administered, taken in combination with alcohol of any kind is to be coded as a poisoning by both agents.

Example:
Patient admitted with anoxic brain damage due to Seconal (barbiturate) taken in combination with alcoholic beverages (accidental) at home

Index trail in Table of Drugs and Chemicals:

<table>
<thead>
<tr>
<th>Poisoning</th>
<th>Chapter XIX</th>
<th>Accidental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbiturate NEC</td>
<td>T42.3</td>
<td>X41</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- beverage</td>
<td>T51.0</td>
<td>X45</td>
</tr>
</tbody>
</table>

Index trail for brain damage:

<table>
<thead>
<tr>
<th>Damage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- brain (nontraumatic)</td>
<td>G93.9</td>
</tr>
<tr>
<td>- anoxic, hypoxic</td>
<td>G93.1</td>
</tr>
</tbody>
</table>

Tabular List entries:

T42.3 Barbiturates

X41 Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home

T51.0 Ethanol

X45 Accidental poisoning by and exposure to alcohol
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home

Index trail for brain damage:

G93.1 Anoxic brain damage, not elsewhere classified
Seconal is a proprietary drug name that cannot be indexed in the Table of Drugs and Chemicals. The coder must therefore index under the generic term for the type of drug that Seconal is, ie a barbiturate, in order to assign a code. General Practitioners, and instructions on the back of medicine packets, always advise never to mix drugs with alcohol; which explains the rationale why this must be coded as a poisoning.

*Prescribed drug taken in combination with a non-prescribed drug*
An adverse reaction occurring because of the combination of a prescribed drug and a non-prescribed drug is also coded as a poisoning by both agents.

**Example:**
Patient admitted with a coma due to accidentally taking a combination of antiallergics (prescribed) and barbiturates (not prescribed)

- **Index trail in Table of Drugs and Chemicals:**
  - Poisoning
  - Chapter XIX Accidental
  - Antiallergic NEC T45.0 X44.-
  - Barbiturate NEC T42.3 X41.-

- **Tabular List entries:**
  - **T45.0** Antiallergic and antiemetic drugs
  - **X44** Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .9 Unspecified
  - **T42.3** Barbiturates
    - **X41** Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
      - *Includes:* antidepressants
      - barbiturates
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .9 Unspecified

- **Index trail for coma:**
  - **Coma** R40.2

- **Tabular List entry:**
  - **R40.2** Coma, unspecified
Rationale: The sequence in which the poisoning codes are recorded is unimportant. In the example above, code T42.3 could have equally been recorded as the primary diagnosis.

Patients are always advised never to mix drugs without first consulting their GP, hence the rationale as to why this scenario must be coded as a poisoning.

Two or more prescribed drugs taken in combination
In an adverse reaction occurring because of the combination of two (or more) prescribed drugs, both agents are coded as adverse effects of correct substances properly administered, as long as each drug is taken correctly.

Example:

Coma due to antiallergics and barbiturates taken in combination (each prescribed by different responsible consultants)

Index trail for coma:
Coma R40.2

Tabular List entry:
R40.2 Coma, unspecified

Index trail in Table of Drugs and Chemicals:
Adverse effect in therapeutic use
Antiallergic NEC Y43.0
Barbiturate NEC Y47.0

Tabular List entries:
Y43.0 Antiallergic and antiemetic drugs
Y47.0 Barbiturates, not elsewhere classified

If it is not known whether or not a prescription drug has been prescribed, code as though it had been, ie code as an adverse effect.

Patient transfer in / out of mental health units
Often patients who are admitted to hospital due to self harm are transferred to a mental health unit for treatment of their mental health condition. Similarly patients admitted to a mental health unit may be transferred to an acute hospital for treatment of a non mental health condition, see Chapter V Mental and behavioural disorders for guidance relating to the transfer in and out of mental health units.
CHAPTER XX
EXTERNAL CAUSES OF MORBIDITY AND MORTALITY
V01–Y98

Chapter rules and conventions

- Coding of both the external cause code and the actual injury is mandatory when the information is present in the medical record.
- Codes from Chapter XX are not to be used as main condition codes. They are to be used as additional codes to identify the external cause of conditions classified in other chapters of the Tabular List.
- UK specific rules are applicable to this chapter.
External causes of morbidity and mortality

Coding Standards

External causes

Chapter XX allows outside factors to be shown as the cause of injury, poisoning and other adverse effects. In these cases it is important to fully describe both the nature of the condition and how it occurred (the circumstance).

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, eg fall
- circumstance, eg suicide
- event, eg legal intervention
- specified agent, eg poisoning, carbon monoxide.

Where a code from this chapter applies, it must be used in addition to a code from another chapter of the classification which will indicate the nature of the condition. Conditions due to external causes are most often classified to Chapter XIX Injury, poisoning and certain other consequences of external causes (S00–T98). Codes from Chapters I to XVIII may be used with a code from Chapter XX when stated to be due to external causes.

Example:

Fracture of neck of femur due to falling down stairs at home

[Index trail for injury:]
Fracture (abduction) (adduction) (avulsion) ……
- femur, femoral S72.9
- - neck S72.0

Tabular List entry:
S72.0 Fracture of neck of femur
(fracture not classified as open or closed S72.00)

[External cause index trail for circumstance:]
Fall, falling (accidental) W19.-
- down
- - stairs, steps (involving ice or snow) W10.-

Tabular List entry:
W10 Fall on and from stairs and steps
[See at the beginning of this chapter for the classification of the place of occurrence]
.0 Home
The notes at block and category level indicate when a fourth character subdivision must be added.

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 in the United Kingdom.

Codes from this chapter are always to be used as a supplementary code sequenced immediately following the injury, poisoning or adverse effect code(s).

External cause codes within categories V01-Y34 are only to be recorded on the first consultant episode in which the condition is recorded in the United Kingdom. Patients who have initially been treated in an Accident and Emergency (A&E) department who are subsequently admitted, would also require the assignment of an external cause code on the first episode, as A&E departments do not assign ICD-10 external cause codes. Any subsequent episode where the same condition is being treated does not require an external cause code. This ruling also applies when a patient is transferred from one unit to another and to injuries occurring whilst the patient is in hospital.
Example:

First consultant episode – Patient being treated for angina. Patient fell from toilet on medical ward and fractured shaft of humerus. Second consultant episode Patient transferred from medical ward to orthopaedic ward for treatment of fracture.

First consultant episode:

- Index trail for **angina**:
  Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor) I20.9

  Tabular List entry:
  I20.9 Angina pectoris, unspecified

- Index trail for **injury**:
  Fracture (abduction) (adduction) (avulsion) …
  - humerus S42.3
  - shaft S42.3

  Tabular List entry:
  S42.3 Fracture of shaft of humerus
  (fracture not classified as open or closed S42.30)

- **External cause** index trail for **circumstance**:
  Fall, falling (accidental) W19.-
  - from, off
  - toilet W18.-

  Tabular List entry:
  W18 Other fall on same level
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .2 School, other institution and public administrative area

Second consultant episode:

- Index trail for **injury**:
  Fracture (abduction) (adduction) (avulsion) …
  - humerus S42.3
  - shaft S42.3

  Tabular List entry:
  S42.3 Fracture of shaft of humerus
  (fracture not classified as open or closed S42.30)

- Index trail for **angina**:
  Angina (attack) (cardiac) (chest) I20.9

  Tabular List entry:
  I20.9 Angina pectoris, unspecified
When multiple injuries occur during the same accident then it is only necessary to record one external cause code following the injuries.

**Example:**

Patient admitted with closed fracture of neck of femur and contusion of the upper arm sustained in a tackle during a football match at a local football ground

- Index trail for **fracture**
  - Fracture (abduction) (adduction) (avulsion) ……
    - femur, femoral S72.9
    - neck S72.0

  Tabular List entry:
  - **S72.0** Fracture of neck of femur
    - [See tabular list for fifth-character subdivisions]
    - 0 closed

- Index trail for **contusion**:  
  - Contusion (skin surface intact) (see also Injury, superficial) T14.0
    - arm
    - - upper (and shoulder) S40.0

  Tabular List entry:
  - **S40.0** Contusion of shoulder and upper arm

- **External cause** index trail for **circumstance**:  
  - Tackle in sport W03.-

  Tabular List entry:
  - **W03** Other fall on same level due to collision with, or pushing by, another person
    - [See at the beginning of this chapter for the classification of the place of occurrence]
    - .3 Sports and athletics area
When coding external cause codes associated with drugs, there is no need to repeat the external cause code if the same code is used for several drugs.

**Example:**

Patient admitted with overdose (intentional self-harm) of aspirin and paracetamol at home

<table>
<thead>
<tr>
<th>Index trail in <strong>Table of Drugs and Chemicals:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
</tr>
<tr>
<td>Intentional</td>
</tr>
<tr>
<td>Chapter XIX self-harm</td>
</tr>
<tr>
<td>Aspirin (aluminium) (soluble) T39.0 X60.-</td>
</tr>
<tr>
<td>Paracetamol T39.1 X60.-</td>
</tr>
</tbody>
</table>

Tabular List entries:

<table>
<thead>
<tr>
<th>T39.0</th>
<th>Salicylates</th>
</tr>
</thead>
<tbody>
<tr>
<td>T39.1</td>
<td>4-Aminophenol derivatives</td>
</tr>
<tr>
<td>X60</td>
<td>Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics [See at the beginning of this chapter for the classification of the place of occurrence] .0 Home</td>
</tr>
</tbody>
</table>
When the external cause codes for the drugs taken differ, each one must be assigned, as in the following example.

**Example:**

Patient admitted with overdose (intentional self-harm) of codeine and paracetamol at home

Index trail in **Table of Drugs and Chemicals**:

<table>
<thead>
<tr>
<th>Poisoning</th>
<th>Intentional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter XIX</td>
<td>self-harm</td>
</tr>
</tbody>
</table>

| Codeine | T40.2 | X62.- |
| Paracetamol | T39.1 | X60.- |

Tabular List entries:

**T40.2 Other opioids**

- Codeine

**X62.- Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified**

[See at the beginning of this chapter for the classification of the place of occurrence]

- 0 Home

**T39.1 4-Aminophenol derivatives**

**X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics**

[See at the beginning of this chapter for the classification of the place of occurrence]

- 0 Home
Transport accidents
(V01–V99)

A transport accident is any accident involving a device designed primarily for, or being used at the time for, conveying persons or goods from one place to another.

All types of transport accidents are classified within block V01-V99, and are further subdivided to show the type of transport accident.

Land transport accidents
(V01–V79)

In this section, the first-character (V) is used to identify the code as representing an external cause of a land traffic accident. The second character identifies the injured person, eg a character of 0 identifies a pedestrian, 1 a pedal cyclist, etc, and the third character identifies what the injured person was in collision with.

Additional fourth character subdivisions are found at the beginning of each block, and must be used to give further information regarding the injured person or other details.

Example:

Pedestrian collided with cyclist in street sustaining an injury to their chin

Index trail for injury:

Injury (see also specified injury type) T14.9
- chin S09.9

Tabular List entry:
S09.9 Unspecified injury of head

External cause index trail:

Collision (accidental) NEC (see also Accident, transport) V89.9

Accident (to) X59.-
- transport (involving injury to) .... V99
- - pedestrian (in) V09.9
- - - collision (with)
- - - - pedal cycle V01.-

Tabular List entry:
V01 Pedestrian injured in collision with pedal cycle
[See before V01 for subdivisions]
.1 Traffic accident
If a transport accident is unspecified as to whether it is a traffic or non-traffic accident, it is assumed to be:

- A traffic accident when the external cause is classifiable to categories V10–V82 and V87. For these categories the victim is usually an occupant of a vehicle designed primarily for use on the public highway.
- A non-traffic accident when the external cause is classifiable to categories V83–V86. For these categories the victim is either a pedestrian, or an occupant of a vehicle designed primarily for off-road use.

The ‘Classification and coding instructions for transport accidents’ at the beginning of Chapter XX gives detailed instructions regarding the coding of transport accidents including the order of preference when more than one kind of transport is involved.

**Accidents involving electric wheelchairs and mobility scooters**

Electric wheelchairs (powered wheelchairs) and mobility scooters (power-operated vehicles/scooters or electric scooters) are powered mobility aids used by disabled users, with limited or reduced mobility, as a means of transport. They are forms of pedestrian conveyance.

The following must be applied when coding accidents involving electric wheelchairs and mobility scooters:

<table>
<thead>
<tr>
<th>Occupant of electric wheelchair or mobility scooter</th>
<th>Without fall</th>
<th>With fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved in a collision (excluding collision with a pedestrian or another electric wheelchair or mobility scooter or stationary object)</td>
<td>V01.- to V09.-</td>
<td>V01.- to V09.-</td>
</tr>
<tr>
<td>Involved in non-collision</td>
<td>V09.-</td>
<td>V09.-</td>
</tr>
<tr>
<td>Involved in collision with a pedestrian or another electric wheelchair or mobility scooter</td>
<td>W51.-</td>
<td>W03.-</td>
</tr>
<tr>
<td>Involved in collision with a stationary object</td>
<td>W22.-</td>
<td>W18.-</td>
</tr>
</tbody>
</table>

Fourth character code assignment at codes V01-V09 is dependent on whether the accident is considered a non-traffic, traffic or unspecified traffic accident. For codes in W03, W18, W22 and W51 fourth character code assignment is made according to the place where the accident occurred.
Examples: Patient sustained a closed fracture of the right humerus when a car drove into his mobility scooter on a level crossing

- Index trail for injury:
  - Fracture (abduction) (adduction) (avulsion) ……
    - humerus S42.3

- Tabular List entry:
  - S42.3 Fracture of shaft of humerus
    - humerus S42.3
    - [See tabular list for fifth-character subdivisions]
    - 0 closed

- External cause index trail:
  - Collision (accidental) NEC (see also Accident, transport)

- Accident (to) X59.-
  - transport (involving injury to)…. V99
  - - pedestrian (in) V09.9
  - - - collision (with)
  - - - - car V03.-

- Tabular List entry:
  - V03 Pedestrian injured in collision with car, pick-up truck or van
    - [See before V01 for subdivisions]
    - .1 Traffic accident
Examples (cont):

Patient sustained an open fracture of the left neck of femur after falling from his mobility scooter at home

- Index trail for injury:
  Fracture (abduction) (adduction) (avulsion) ……
  - femur, femoral S72.9
  - - neck S72.0

Tabular List entry:
S72.0 Fracture of neck of femur
[See tabular list for fifth-character subdivisions]
1 open

- External cause index trail:
  Accident (to) X59.-
  - transport (involving injury to)…. V99
  - - pedestrian (in) V09.9
  - - - nontraffic V09.1

Tabular List entry:
V09.1 Pedestrian injured in unspecified nontraffic accident

Patient sustained contusion of the temple after his electric wheelchair collided with a man standing in the bus station

- Index trail for injury:
  Contusion (skin surface intact) (see also Injury, superficial) T14.0
  - temple (region) S00.8

Tabular List entry:
S00.8 Superficial injury of other parts of head

- External cause index trail:
  Collision (accidental) NEC (see also Accident, transport) V89.9
  - pedestrian (conveyance) W51.-

Tabular List entry:
W51 Striking against or bumped into by another person
[See at the beginning of this chapter for the classification of the place of occurrence]
.5 Trade and service area
Examples (cont):

Patient fractures fifth and sixth ribs due to falling from a mobility scooter after being driven into by another person on a mobility scooter in a nursing home

Index trail for injury:
Fracture (abduction) (adduction) (avulsion) ……
  - rib S22.3
  - - multiple S22.4

Tabular List entry:
S22.4 Multiple fractures of ribs
  (fracture not classified as open or closed S22.40)

External cause index trail:
Collision (accidental) NEC (see also Accident, transport) V89.9
  - pedestrian (conveyance) W51.-
  - - with fall W03.-

Tabular List entry:
W03 Other fall on same level due to collision with, or pushing by, another person
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .1 Residential institution

Patient sustained concussion after driving his electric wheelchair into a door frame at his care home

Index trail for injury:
Concussion (current) S06.0

Tabular List entry:
S06.0 Concussion
  [See tabular list for fifth-character subdivisions]
  0 without open intracranial wound

External cause index trail:
Collision (accidental) NEC (see also Accident, transport) V89.9
  - pedestrian (conveyance) W51.-
  - - and
  - - - object (stationary) W22.-

Tabular List entry:
W22 Striking against or struck by other objects
  [See at the beginning of this chapter for the classification of the place of occurrence]
  .1 Residential institution
**Examples (cont):**

Patient sustained a contusion to her right shoulder after driving her mobility scooter into a wall and falling off of the scooter at her care home.

- **Index trail for injury:**
  - Contusion (skin surface intact) *(see also Injury, superficial)*
  - T14.0
  - shoulder (and arm) S40.0

  **Tabular List entry:**
  - S40.0 Contusion of shoulder and upper arm

- **External cause index trail:**
  - Collision (accidental) NEC *(see also Accident, transport)* V89.9
  - pedestrian (conveyance) W51.-
  -  - and
  -  - - object (stationary) W22.-
  -  - - - with fall W18.-

  **Tabular List entry:**
  - W18 Other fall on same level
    [See at the beginning of this chapter for the classification of the place of occurrence]
    - 1 Residential institution
Other land transport accidents
(V80–V89)

This block covers all other types of land transport accidents, including those involving animal riders, trains, special construction vehicles, etc. Each category has its own fourth character subdivisions.

**Example:**

Passenger fell getting off train sustaining open wound to forehead

- **Index trail for injury:**
  - Wound, open (animal bite) (cut) (laceration) ……T14.1
  - forehead S01.8

- Tabular List entry:
  - S01.8 Open wound of other parts of head

- **External cause index trail:**
  - Fall, falling (accidental) W19.-
  - from, off
  - - train NEC V81.6
  - - - while boarding or alighting V81.4

- Tabular List entry:
  - V81.4 Person injured while boarding or alighting from railway train or railway vehicle
**Water transport accidents**  
(V90–V94)

A fourth character subdivision identifying type of craft is required for watercraft accidents and is found at the beginning of the block.

**Air and space transport accidents**  
(V95–V97)

This block covers accidents involving all types of craft using air space. Each category has its own fourth character subdivisions.

**Other external causes of accidental injury**  
(W00–X59)

Fourth character subdivisions are to be used with all categories within these blocks to identify the place of occurrence of the external cause, where relevant. These are found at the beginning of this chapter.

**Travel and motion (X51)**

Conditions linked to travel, such as deep vein thrombosis (DVT), must have an external cause code of X51.9 Travel and motion shown as an additional code. As it is impossible to define at which point on a journey a DVT occurred, the location fourth digit .9 is used.

**Exposure to unspecified factor (X59)**

When details of outside factors causing an injury are not known, ie the external cause is not given, then the code X59 Exposure to unspecified factor must be used. This can be indexed using the lead term Accident.
Intentional self-harm  
(X60–X84)

Codes from this block are used to identify attempted suicides or purposely self-inflicted poisoning or injury. The external cause codes for poisonings are found in the Table of Drugs and Chemicals in Section III of the Alphabetical Index. If it is not known if the poisoning was accidental or intentional, then the column for accidental must be selected.

If it is clear from the medical record that the patient has intended to harm themselves as a ‘cry for help’ then the ‘intentional self-harm’ column must be selected. It is important to understand that the ‘intentional self-harm’ column not only applies to a patient who has intended to commit suicide, but also to a patient who has intended to harm themselves in any way.

There are no age limits attached to the circumstance columns. Each case has to be looked at individually before code assignment is made.

Fourth character subdivisions at the beginning of this chapter in the Tabular List are to be used with all categories in this block.

**Example:**

Patient admitted with overdose of aspirin and paracetamol at home

- Index trail in Table of Drugs and Chemicals:
  - Poisoning
    - Chapter XIX  Accidental
    - Aspirin (aluminium) (soluble)  T39.0  X40.-
    - Paracetamol  T39.1  X40.-

- Tabular List entries:
  - T39.0  Salicylates
  - T39.1  4-Aminophenol derivatives
  - X40  Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
    [See at the beginning of this chapter for the classification of the place of occurrence]
    - .0 Home

**Rationale:** This example does not specify that the overdose was intentional, and there was no indication that this was a ‘cry for help’, therefore a code from the Accidental column in the Table of Drugs and Chemicals must be selected. It is only necessary to assign X40.0 once following both codes from Chapter XIX, in the above example, because there is no need to repeat the external cause code if the same code is used for several drugs.
External causes of morbidity and mortality

Assault
(X85–Y09)

Codes from this block identify any type of assault and must have a fourth character subdivision from the beginning of this chapter of the Tabular List, with the exception of Y06 Neglect and abandonment and Y07 Other maltreatment.

Assault by drugs, medicaments and biological substances (X85)
This is the external cause code to be used when a patient is admitted with poisoning due to a 'spiked' drink. It will be found in External causes of injury, in Section II of the Alphabetical Index, under the lead term Assault.

Example:

Patient admitted from a nightclub after having drink spiked with LSD

Index trail in Table of Drugs and Chemicals:
Poisoning
Chapter XIX
LSD
T40.8

Tabular List entry:
T40.8 Lysergide [LSD]

External Cause Index trail for assault (spiked drink):
Assault (homicidal) (by) (in) Y09.-
- drugs or biological substances X85.-

Tabular List entry:
X85 Assault by drugs, medicaments and biological substances
[See at the beginning of this chapter for the classification of the place of occurrence]
.5 Trade and service area

The correct fourth character subdivision for a place of occurrence of pub or nightclub is .5 Trade and service area. If the patient had been admitted after having had an alcoholic drink spiked with a drug then poisoning by alcohol would be also coded in addition.
Event of undetermined intent
(Y10–Y34)

Codes from this block must not be used unless undetermined intent is stated by a medical or legal authority, such as a coroner at an inquest. If the intent is not known, a code from the 'accidental' column must be selected.

Where these codes are to be used, a fourth character subdivision from the beginning of this chapter of the Tabular List must also be added.

Legal intervention and operations of war
(Y35–Y36)

These categories are available to record injuries sustained during any type of legal intervention, such as arrest or operations of war, and have their own fourth-character subdivisions.

Complications of medical and surgical care
(Y40–Y84)

Care must be taken to differentiate between abnormal reaction of the patient at the time of the procedure (Y60-Y69), and abnormal reaction of the patient that occurs postprocedurally (Y83-Y84). The external cause code identifies whether the complication arose during or after the procedure.

Postprocedural disorders are conditions resulting from surgical or medical procedures. The principle is to use codes which fully describe the condition and the procedure that caused it. To use a code from categories Y83 or Y84, the responsible consultant must document the link between the condition and surgery by using terms such as ‘postoperative’, ‘postprocedural’ or ‘post-op’. Refer to Chapter XIX for detailed guidance on the use of codes in categories Y83 and Y84.
**Example:**

Postoperative urinary tract infection following appendicectomy

Index trail:
- **Infection, infected (opportunistic)** B99
- urinary (tract) NEC N39.0

**External cause** index trail:
- **Complication (delayed) (of or following) (medical or surgical procedure)** Y84.9
- removal of organ (partial) (total) NEC Y83.6

Tabular List entries:
- **N39.0** Urinary tract infection, site not specified
- **Y83.6** Removal of other organ (partial) (total)

**Rationale:** No essential modifier for ‘complicating medical or surgical care’ appears in the Alphabetical Index for a urinary tract infection. The only way to show that it is a postprocedural complication is to add an external cause code from **Y83** or **Y84**.

When codes from post-procedural complication categories (**Y83-Y84**) and infectious agent categories (**B95-B98**) are required to be coded together they can be sequenced in any order. This is provided that both codes are present and recorded immediately following the primary post-procedural infection code. The first code assigned would usually be the first condition mentioned within the patient’s care record.

For example:

- J18.9  Pneumonia, unspecified
- **B96.5** *Pseudomonas (aeruginosa)(mallei)(pseudomallei)* as the cause of diseases classified to other chapters
- **Y83.1** Surgical operation with implant of artificial internal device

or

- J18.9  Pneumonia, unspecified
- **Y83.1** Surgical operation with implant of artificial internal device
- **B96.5** *Pseudomonas (aeruginosa) (mallei) (pseudomallei)* as the cause of diseases classified to other chapters
External causes of morbidity and mortality

Where it has been clearly documented that the bacteria are resistant to an antibiotic a code from **U80-U89** is assigned after the code for a bacterial infection classified elsewhere.

**Medical devices associated with adverse incidents in diagnostic and therapeutic use (Y70–Y82)**

These codes are used to indicate adverse incidents at the time of the procedure which are out of the surgeon’s control. They are not in themselves classified as surgical misadventures as in the categories **Y60–Y69 Misadventures to patients during surgical and medical care.** A code from the block **Y70-Y82** is used instead to show the difference.

**Example:**

Patient’s femur shaft fractured during removal of a bone prosthesis

- Index trail:
  - Fracture (abduction) (adduction) (avulsion)....
  - - femur, femoral S72.9
  - - - shaft (lower third) (middle third) (upper third) S72.3

- **External cause** index trail:
  - Incident, adverse
  - - device
  - - orthopedic Y79.-

Tabular List entries:

- **S72.3 Fracture of shaft of femur**
  - (fracture not classified as open or closed S72.30 closed)

- **Y79 Orthopaedic devices associated with adverse incidents**
  - [See before Y70 for subdivisions]
  - .2 Prosthetic and other implants, materials and accessory devices
Sequelae of external causes of morbidity and mortality (Y85–Y89)

The residual condition (which is the sequelae or late effect) must be coded in the primary position and the disease or injury itself must no longer be present.

Example:

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

📖 Index trail for **deviated nasal septum**:

- Deviation
  - septum (nasal) (acquired) J34.2

📖 Index trail for **sequelae**:

- Sequealae (of) – see also condition
  - fracture T94.1
  - - facial bones T90.2

📖 **External cause** index:

- Sequealae (of) Y89.9
  - motor vehicle accident Y85.0

Tabular List entries:

- J34.2 Deviated nasal septum
- T90.2 Sequelae of fracture of skull and facial bones
- Y85.0 Sequelae of motor-vehicle accident
Supplementary factors related to causes of morbidity and mortality classified elsewhere (Y90–Y98)

These categories are used to provide supplementary information concerning causes of morbidity. Like all other codes in this chapter, they are never to be used in the primary position.

The use of codes in categories Y90 and Y91 is mandatory when the data is present in the medical record.

**Example:**

Patient admitted drunk with a blood-alcohol level of 60-79 mg/100ml

- Index trail for:
  - Drunkenness F10.0

- External cause index trail:
  - Factors, supplemental
    - alcohol
    - blood level
    - 60-79 mg/100ml Y90.3

Tabular List entries:

- F10 Mental and behavioural disorders due to use of alcohol
  [See before F10 for subdivisions]
  - .0 Acute intoxication

- Y90.3 Blood alcohol level of 60-79 mg/100ml

**Nosocomial condition (Y95)**

Within the ICD-10 classification a nosocomial condition is any condition that has been acquired whilst in hospital. Examples include hospital acquired pneumonia (HAP), infections such as clostridium difficile and MRSA and deep vein thrombosis.

In order to assign this code, directly after the code for the condition, the responsible consultant must link the condition to the hospital stay ie they **must state** that the condition was acquired in hospital. It must not be assumed that a condition has been acquired in hospital.

In cases where a patient is transferred from another hospital with a hospital-acquired condition; **Y95.X** must still be assigned as the **Y95.X** is linked to the actual condition and not the hospital that it was acquired in.
**Example:**

Elderly patient admitted with intracerebral haemorrhage is also diagnosed with a deep vein thrombosis (DVT) of the left leg whilst in hospital. Responsible consultant confirms the DVT is hospital acquired.

- Index trail for **haemorrhage:**
  - Hemorrhage, hemorrhagic R58
    - Intracerebral (nontraumatic) I61.9

  Tabular List entry:
  - I61.9 Intracerebral haemorrhage, unspecified

- Index trail for **Thrombosis:**
  - Thrombosis, thrombotic (multiple) (progressive) (septic) (vein) (vessel) I82.9
    - deep I80.2

  Tabular List entry:
  - I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities

- **External causes** Index trail:
  - Factors, supplemental
    - nosocomial condition Y95

  Tabular List entry:
  - Y95.X Nosocomial condition
CHAPTER XXI
FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES
Z00–Z99

Coding Standards

Types of codes

Service codes
Service codes cover instances where patients encounter health services not because of illness, but for some other specific purpose. All service codes can be used in a primary diagnostic position, unless there is a diagnosis, symptom, complication or injury code that could be used to explain the encounter instead.

The blocks of service codes are:

- **Z00–Z13** Persons encountering health services for examination and investigation.
- **Z30–Z39** Persons encountering health services in circumstances related to reproduction, excluding Z37 and Z38.
- **Z40–Z54** Persons encountering health services for specific procedures and health care.
- **Z70–Z76** Persons encountering health services in other circumstances.

Problem codes
Codes relating to problems are seldom used in a primary diagnostic position, there are exceptions which must never be used in the primary position, these are indicated at block level during this chapter. These codes are almost always recorded in addition to the code(s) for the current illness or injury, classifiable to categories A00–T98 to provide relevant additional information. Examples include past history of certain diseases.

These Z codes must only be used when the circumstance influences the patient’s current condition. The exception is those problem codes contained on the list of co-morbidities which must always be coded when recorded in the medical record – see introduction.
The blocks of problem codes are:

- **Z20–Z29** Persons with potential health hazards related to communicable diseases.
- **Z55–Z65** Persons with potential health hazards related to socioeconomic and psychosocial circumstances.
- **Z80–Z99** Persons with potential health hazards related to family and personal history and certain conditions influencing health status.

**Fact codes**

There are only two categories in Chapter XXI where the codes can be described as ‘fact’ codes, and which are mandatory where appropriate, as they provide additional information that is not representative of a ‘service’ or ‘problem’.

The categories of fact codes are:

- **Z37** Outcome of delivery
- **Z38** Liveborn infants according to place of birth

**Outcome of delivery (Z37)**

This category is intended to provide additional information on the mother’s delivery episode. It must be assigned in the first secondary field for data extraction purposes. See Chapter XV Pregnancy, childbirth and the puerperium for further guidance.

**Liveborn infants according to place of birth (Z38)**

A code from **Z38** must be recorded on the baby’s birth episode in the primary position if the baby is completely well. If a morbid condition is present which has been treated or investigated then the morbid condition must be sequenced first, followed by **Z38** in the first secondary position. If other morbid conditions are present, they must be coded after **Z38**. See Chapter XVI Certain conditions originating in the perinatal period for further guidance.
Persons encountering health services for examination and investigation (Z00–Z13)

The note at the beginning of this block in the Tabular List states that:

“Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.”

If one of these abnormal findings is detected during examination, a code from R70-R94 must be used instead of a code from Z00–Z13.

Codes in this block can be described as service codes, these codes can be used in a primary diagnostic position, unless there is a diagnosis, symptom, complication or injury code that could be used to explain the encounter instead.

The codes in these categories are exceptions to this block and can NEVER be used in a primary position:

- Z02 Examination and encounter for administrative purposes
- Z10 Routine general health check-up of defined subpopulation

**Examples:**

Toddler admitted for suspected overdose, having been found with an empty bottle of Aspirin. After examination, no evidence of poisoning was confirmed.

Index trail for **observation**:

Observation (for) Z04.9  
- suspected (undiagnosed) (unproven)  
- - toxic effects from ingested substance (drug) (poison) Z03.6

Tabular List entry:

Z03.6 Observation for suspected toxic effect from ingested substance
Factors influencing health status etc.

**Examples (cont):**

Follow-up examination after surgery for carcinoma of bladder. No recurrence detected.

- Index trail for *examination*:
  - Examination (general) (routine) (of) (for) Z00.0
  - follow-up (routine) (following) Z09.9
  - -surgery NEC Z09.0
  - - - malignant neoplasm Z08.0

- Tabular List entry:
  - Z08.0 Follow-up examination after surgery for malignant neoplasm

- Index trail for *history of*:
  - History (personal) (of)
  - - malignant neoplasm (of) Z85.9
  - - - urinary organ or tract Z85.5

- Tabular List entry:
  - Z85.5 Personal history of malignant neoplasm of urinary tract

Follow-up DMSA scan (tc-99m dimercaptosuccinic acid) after a previous urinary tract infection treated with antibiotics. No abnormalities detected.

- Index trail for *examination*:
  - Examination (general) (routine) (of) (for) Z00.0
  - follow-up (routine) (following) Z09.9
  - - chemotherapy NEC Z09.2

- Tabular List entry:
  - Z09.2 Follow-up examination after chemotherapy for other conditions

- Index trail for *history of*:
  - History (personal) (of)
  - - disease or disorder (of) Z87.8
  - - - urinary system Z87.4

- Tabular List entry:
  - Z87.4 Personal history of diseases of the genitourinary system
Factors influencing health status etc.

**Rationale:** This guidance also applies to other diagnostic procedures such as cystoscopy, ureteroscopy, and endoscopic retrograde pyelography when these procedures have been specifically performed following a previous urinary tract infection (UTI) which has now resolved following treatment with antibiotics.

**Example:**

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.

- Index trail for **screening:**
  - **Screening (for) Z13.9**
  - neoplasm (of) Z12.9
  - - intestinal tract NEC Z12.1

Tabular List entry:

- **Z12.1 Special screening examination for neoplasm of intestinal tract**

- Index trail for **history of:**
  - **History (personal) (of)****
  - family, of
  - - malignant neoplasm (of) NEC Z80.9
  - - - gastrointestinal tract Z80.0

Tabular List entry:

- **Z80.0 Family history of malignant neoplasm of digestive organs**

**Rationale:** The screening code must only be assigned if no abnormality is found. If the patient had been found to have colonic cancer in the above example, the primary diagnosis would have been malignant neoplasm of colon followed by the family history of code.
Factors influencing health status etc.

Persons with potential health hazards related to communicable diseases (Z20–Z29)

These Z codes must only be used when the circumstance influences the patient’s current condition 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 introduction.

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).

-index trail for false labour:

<table>
<thead>
<tr>
<th>Labor (see also Delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- false O47.9</td>
</tr>
<tr>
<td>- - before 37 completed weeks of gestation O47.0</td>
</tr>
</tbody>
</table>

Tabular List entry:

| O47.0 | False labour before 37 completed weeks of gestation |

-index trail for carrier:

<table>
<thead>
<tr>
<th>Carrier (suspected) of</th>
</tr>
</thead>
<tbody>
<tr>
<td>- bacterial disease NEC Z22.3</td>
</tr>
</tbody>
</table>

Tabular List entry:

| Z22.3 | Carrier of other specified bacterial diseases |

Rationale: Code Z22.3 is assigned in addition to identify that the mother is a carrier of GBS. This is an important factor in the patient’s care as she will be treated as a potential GBS risk patient.

A code from U80-U89 must be assigned in addition to Z22.3 Carrier of other specified bacterial diseases to identify the antibiotic to which the bacteria is resistant, when this is clearly stated by the responsible consultant in the patient’s medical record.
Persons encountering health services in circumstances related to reproduction (Z30–Z39)

Codes in this block are service codes (with the exception of Z37 and Z38, which are ‘fact’ codes), these codes can be used in a primary diagnostic position, unless there is a diagnosis, symptom, complication or injury code that could be used to explain the encounter instead.

The mandatory codes of Z37 Outcome of delivery and Z38 Liveborn infants according to place of birth (when not recorded as a well baby) must be coded in the first secondary diagnostic field for data extraction purposes. Refer to Chapters XV and XVI for further guidance.

The following codes are exceptions to this block and must NEVER be used in a primary position:

- Z30.0 General counselling and advice on contraception
- Z30.4 Surveillance of contraceptive drugs
- Z33.X Pregnant state, incidental
- Z37 Outcome of delivery.

Liveborn infants according to place of birth (Z38)

For the standards regarding the use of the codes in this category refer to Chapter XVI Conditions originating in the perinatal period.

Postpartum care and examination (Z39)

For the standards regarding the use of the codes in this category refer to Chapter XV Pregnancy, childbirth and the puerperium.
Persons encountering health services for specific procedures and health care (Z40–Z54)

Codes in this block can be described as service codes. These codes can be used in a primary diagnostic position; unless there is a diagnosis, symptom, complication or injury code that could be used to explain the encounter instead.

There is an important note at the beginning of this block in the Tabular List which states:

“Categories Z40–Z54 are intended for use to indicate a reason for care. They may be used for patients who have already been treated for a disease or injury, but who are receiving follow-up or prophylactic care, convalescent care, or care to consolidate the treatment, to deal with residual states, to ensure that the condition has not recurred, or to prevent recurrence”.

The following codes are exceptions to this block and must NEVER be used in a primary position.

- Z49 Care involving dialysis
- Z50 Care involving use of rehabilitation procedures
- Z51 Other medical care
- Z53 Persons encountering health services for specific procedures, not carried out
- Z54 Convalescence
  Only to be used in a dedicated convalescent unit.

Adjustment and management of cardiac pacemaker (Z45.0)
This code is to be used for routine change of cardiac pacemaker where there are no complications. It is only necessary to assign the additional code for the disease/condition for which the pacemaker was required if this is still present.

Adjustment and management of vascular access device (Z45.2)
This code is used in a primary position to classify the removal of a central line following dialysis treatment if it is confirmed by the responsible consultant that the admission was solely for the purpose of removal of the central line, and no other treatment or investigation was undertaken during the episode of care.
Example:

Patient with end stage renal disease admitted solely for the removal of a central line. No other treatment was given during the patient’s episode of care.

- Index trail for removal:
  - Removal (from) (of)
    - vascular access device or catheter Z45.2

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z45.2</td>
<td>Adjustment and management of vascular access device</td>
</tr>
</tbody>
</table>

- Index trail for renal disease:
  - Disease, diseased – see also Syndrome
    - end-stage kidney N18.5

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N18.5</td>
<td>Chronic kidney disease, stage 5</td>
</tr>
</tbody>
</table>

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.

Example:

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.

- Index trail for removal:
  - Removal (from) (of)
    - catheter (indwelling) (urinary) Z46.6

Tabular List entry:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z46.6</td>
<td>Fitting and adjustment of urinary device</td>
</tr>
</tbody>
</table>

However, if a TWOC fails, the code describing the condition for which the patient was catheterised is assigned and not code **Z46.6**.
**Example:**

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 unsuccessful.

- Index trail for retention:
  - Retention, retained
    - urine R33

  Tabular List entry:
  - R33.X Retention of urine

Code **Z47.0** is also commonly used in primary position.

**Example:**

Follow-up care for removal of internal fixation after treatment of fracture

- Index trail for removal:
  - Removal (from) (of)
    - device
    - - fixation (internal) Z47.0

  Tabular List entry:
  - Z47.0 Follow-up care involving removal of fracture plate and other internal fixation device

**Rationale:** It is not necessary to add the fracture code or a ‘history of’ fracture code, as this is implicit in the code **Z47.0**.
Care involving dialysis (Z49)

The codes in this category must NEVER be used in a primary position.

If a patient is admitted solely for the purpose of renal dialysis, a code from category Z49 Care involving dialysis must be used secondary to the code describing the renal condition. However, if the patient is admitted for other treatment, such as a kidney transplant, but receives dialysis whilst in hospital it is not appropriate to assign a code from Z49.

Example:

Patient with chronic end stage renal failure admitted for renal dialysis

Index trail for failure:
   Failure, failed
      - renal – see Failure kidney

   Failure, failed
      - kidney N19
      - - chronic N18.9
      - - - end stage N18.5

Tabular List entry:
N18.5 Chronic kidney disease, stage 5

Index trail for dialysis:
   Dialysis (interruption) (treatment)
      - renal Z49.1

Tabular List entry:
Z49.1 Extracorporeal dialysis
   Dialysis (renal) NOS

Patients who are on a regular programme of dialysis treatments and who are admitted for other reasons must have code Z99.2 Dependence on renal dialysis assigned as a secondary code in order to capture the important information that they are a dialysis patient. This code can be found under the lead term Status in the Alphabetical Index.
Care involving use of rehabilitation procedures (Z50)

The codes in this category must NEVER be used in a primary position.

Codes in Z50 must only be assigned in if the patient is being transferred for the purpose of receiving rehabilitation after the original condition has been treated. The exception is when rehabilitation has been given during respite care, as explained in the Holiday relief care (Z75.5) section later in this chapter. The original condition must continue to be coded as the main diagnosis. The type of rehabilitation (Z50), such as cardiac rehabilitation or physical therapy, must be recorded as a secondary diagnosis. This is because the patient will be receiving continuing in-patient care in these circumstances.

Example: Patient admitted with fracture of neck of femur at an acute hospital trust. The patient is then transferred to another unit for rehabilitation (physical therapy).

NOTE This is the rehabilitation episode.

Index trail for fracture:
Fracture (abduction) (adduction) (avulsion) (comminuted) (compression) (dislocation) (oblique) (separation) T14.2
- femur, femoral S72.9
- - neck S72.0

Tabular List entry:
S72.0 Fracture of neck of femur
(fracture not classified as open or closed S72.00)

Index trail for rehabilitation:
Therapy Z51.9
- physical NEC Z50.1
or
Physical therapy NEC Z50.1

Tabular List entry:
Z50.1 Other physical therapy
Therapeutic and remedial exercises

Rationale: As the physical therapy was part of the patient’s initial ongoing treatment the fracture is coded as the primary diagnosis.
**Example:**

Patient with complete heart block transferred back to original unit (Hospital A) for cardiac rehabilitation after operation to fit cardiac pacemaker at specialist unit (Hospital B).

**NOTE** This is the episode where the patient is transferred back to Hospital A for cardiac rehabilitation with cardiac pacemaker in situ.

- **Index trail for heart block:**
  - Block
    - heart I45.9
    - complete (atrioventricular) I44.2

  Tabular List entry:

  | I44.2 | Atrioventricular block, complete
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete heart block NOS</td>
</tr>
</tbody>
</table>

- **Index trail for rehabilitation:**
  - Rehabilitation Z50.9
    - cardiac Z50.0

  Tabular List entry:

  | Z50.0 | Cardiac rehabilitation          |

- **Index trail for pacemaker:**
  - Presence (of)
    - cardiac
    - pacemaker Z95.0

  Tabular List entry:

  | Z95.0 | Presence of cardiac pacemaker  |

**Rationale:** As the cardiac rehabilitation was part of the patient’s initial ongoing treatment, the complete heart block is coded as the primary diagnosis.
**Example:**

Patient admitted to acute hospital trust for total hip replacement for primary osteoarthritis (O.A.) of hip. Patient transferred after surgery for physiotherapy rehabilitation to other unit.

**NOTE** This is the episode of transfer to other unit for rehabilitation now that the joint prosthesis is in place.

- **Index trail for osteoarthritis:**
  - Osteoarthritis *(see also Arthrosis)* M19.9
    - Arthrosis *(deformans)* *(degenerative)* M19.9
      - hip – *see* Coxarthrosis
    - Coxarthrosis M16.9
      - primary *(unilateral)* M16.1

  **Tabular List entry:**
  - **M16.1** Other primary coxarthrosis

- **Index trail for physiotherapy:**
  - Therapy Z51.9
    - physical NEC Z50.1
  - Physical therapy NEC Z50.1

  **Tabular List entry:**
  - **Z50.1** Other physical therapy

- **Index trail for presence of joint prosthesis:**
  - Presence *(of)*
    - orthopaedic joint implant *(prosthetic)* *(any)* Z96.6
  - Replacement by artificial or mechanical device or prosthesis of
    - joint Z96.6

  **Tabular List entry:**
  - **Z96.6** Presence of orthopaedic joint implants
    - Finger-joint replacement
    - Hip-joint replacement *(partial)* *(total)*

**Rationale:** As the physical therapy was part of the patient’s initial ongoing treatment the osteoarthritis is coded as the primary diagnosis.
A code from Z50 must not be assigned when the patient is readmitted at a later date with a late effect (sequelae) of the original condition and does not undergo rehabilitation. In these instances the patient’s current problem must be recorded as the primary diagnosis followed by the relevant sequelae code.

**Example:**

Patient was previously admitted for treatment of a fracture left neck of femur. Discharged after treatment. Readmitted six months later with post-traumatic osteoarthritis (O.A.) of the left hip due to the fracture.

- **Index trail for osteoarthritis:**
  Osteoarthritis (see also Arthrosis) M19.9

- Arthrosis (deformans) (degenerative) M19.9
  - hip – see Coxarthrosis

- Coxarthrosis M16.9
  - post-traumatic (unilateral) M16.5

Tabular List entry:

- **M16.5 Other post-traumatic coxarthrosis**
  Post-traumatic coxarthrosis:
  - NOS
  - unilateral

- **Index trail for sequelae:**
  Sequeleae (of) – see also condition
  - fracture T94.1
  - - femur T93.1

Tabular List entry:

- **T93.1 Sequeleae of fracture of femur**
  Sequeleae of injury classifiable to S72.-
Factors influencing health status etc.

Other medical care (Z51)

The codes in this category must NEVER be used in a primary position.

The following codes must be used in a secondary position whenever the patient has been **admitted solely for the purpose of** the treatment stated in the code description:

- **Z51.0** Radiotherapy session
- **Z51.1** Chemotherapy session for neoplasm
- **Z51.2** Other chemotherapy (i.e., admission solely for the purpose of administration of *any* type of drug other than that used to treat a neoplasm)
- **Z51.3** Blood transfusion (without reported diagnosis).

Chemotherapy is the treatment of disease with chemical compounds or drugs. It is often wrongly assumed that the word ‘chemotherapy’ is solely linked with the specialty of Oncology and the use of cytotoxic drugs used in the treatment of neoplasms. This is **NOT** the case within ICD-10, where the word ‘chemotherapy’ is used in its literal sense and means *any* drug treatment.

ICD-10 distinguishes between chemotherapy for neoplasms, and chemotherapy for other conditions.

**Examples:**

**Patient with adenocarcinoma of breast is admitted solely for chemotherapy**

- **Index trail for breast adenocarcinoma:**
  - *Adenocarcinoma* (M8140/3) – *see also* Neoplasm, malignant

- **Index trail for:**
  - **Malignant**
  - **Primary**

  **Neoplasm, neoplastic**
  - breast (connective tissue)… C50.9

- **Tabular List entry for:**
  - **C50.9** Malignant neoplasm of breast, unspecified

- **Index trail for chemotherapy:**
  - *Chemotherapy (session) (for)* Z51.2
  - cancer Z51.1

- **Tabular List entry:**
  - **Z51.1** Chemotherapy session for neoplasm
Examples (cont):

Cystic fibrosis patient is admitted solely for the purpose of intravenous antibiotics to treat a chest infection

Index trail for cystic fibrosis with chest infection:
  Fibrosis, fibrotic
  - cystic (of pancreas) E84.9
  - - with
  - - - pulmonary manifestations E84.0

Tabular List entry:
E84.0  Cystic fibrosis with pulmonary manifestations

Index trail for chemotherapy:
  Chemotherapy (session) (for) Z51.2

Tabular List entry:
Z51.2  Other chemotherapy

Patient with strabismus is admitted solely for the purpose of receiving a Botulinum toxin (Botox) injection

Index trail for strabismus:
  Strabismus (alternating) (congenital) (nonparalytic) H50.9

Tabular List entry:
H50.9  Strabismus, unspecified

Index trail for chemotherapy:
  Chemotherapy (session) (for) Z51.2

Tabular List entry:
Z51.2  Other chemotherapy

The coder must also assign the relevant radiotherapy, chemotherapy and blood transfusion codes in OPCS-4.

Palliative Care (Z51.5, Z51.8)

Codes Z51.5 Palliative care and Z51.8 Other specified medical care are used differently to capture:

- palliative care according to whether this is specialised palliative care
- specialised palliative care support or
- palliative care not specified as either specialised palliative care or specialised palliative care support and
- includes patients on an end of life care pathway.
The table below summarises the correct use of these two codes, regardless of where the palliative care is being provided.

<table>
<thead>
<tr>
<th>Specialised Palliative Care/ Specialised Palliative Care Support</th>
<th>Palliative Care not specified as Specialised Palliative Care or Specialised Palliative Care Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign code <strong>Z51.5 Palliative care in a secondary position</strong></td>
<td>Assign code <strong>Z51.8 Other specified medical care in a secondary position</strong></td>
</tr>
<tr>
<td>This includes ‘End of Life Care’ pathway patients receiving specialised palliative care/ specialised palliative care support</td>
<td>This includes ‘End of Life Care’ pathway patients receiving palliative care not specified as Specialised Palliative Care or Specialised Palliative Care Support</td>
</tr>
</tbody>
</table>

**Donors of organs and tissues (Z52)**

This category is used to identify live donors of organs and tissues only. The term ‘live’ is interpreted as meaning ‘having brain cell activity’.

**Persons encountering health services for specific procedures, not carried out (Z53)**

The codes in this category must NEVER be used in a primary position.

A code from this category must only be used when the procedure was not started for any reason. It is only appropriate to assign the relevant code from category Z53 on elective admissions and when there has been no other procedure carried out, ie the coded record contains no OPCS-4 procedure codes within that particular episode.

If a procedure is cancelled the appropriate code from category Z53 must be assigned as a secondary diagnosis, and the condition prompting the admission must be reported as the primary diagnosis. A code from Z53 must NOT be assigned in addition if the procedure was started and then abandoned.

If a planned procedure is not carried out 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 be reported in addition.
**Example:**

Patient with chronic tonsillitis admitted electively for tonsillectomy. The procedure is cancelled as the patient is noted to have chickenpox.

- **Index trail for tonsillitis:**
  - Tonsillitis (acute) (follicular) (gangrenous) (infective) (lingual) (septic) (subacute) (ulcerative) J03.9
  - chronic J35.0

  **Tabular List entry:**
  
  **J35.0 Chronic tonsillitis**

- **Index trail for cancelled procedure:**
  - Procedure (surgical)
    - not done Z53.9
    - - because of
      - - - contraindication Z53.0

  **Tabular List entry:**
  
  **Z53.0 Procedure not carried out because of contraindication**

- **Index trail for chickenpox:**
  - Chickenpox (see also Varicella) B01.9

  **Tabular List entry:**
  
  **B01.9 Varicella without complication**

Contraindications include instances where the patient has eaten prior to surgery, or they have failed to stop taking medication as instructed, eg Warfarin.
Examples:

Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has failed to stop taking their Warfarin.

Index trail for inguinal hernia:

Hernia, hernia (acquired) (recurrant) K46.9
- inguinal (direct) (external) (funicular) (indirect) (internal) (oblique) (scrotal) (sliding) K40.9

Tabular List entry:

K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene

Index trail for cancelled procedure:

Procedure (surgical)
- not done Z53.9
- - because of
- - - contraindication Z53.0

Tabular List entry:

Z53.0 Procedure not carried out because of contraindication

Index trail for use of Warfarin:

History (personal) (of)
- anticoagulant use (current) (long-term) Z92.1

Tabular List entry:

Z92.1 Personal history of long-term (current) use of anticoagulants
Factors influencing health status etc.

**Examples (cont):**

Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has eaten prior to surgery.

- Index trail for **inguinal hernia**:
  - Hernia, hernia (acquired) (recurrent) K46.9
  - - inguinal (direct) (external) (funicular) (indirect) (internal) (oblique) (scrotal) (sliding) K40.9

  Tabular List entry:
  - **K40.9** Unilateral or unspecified inguinal hernia, without obstruction or gangrene

- Index trail for **cancelled procedure**:
  - Procedure (surgical)
  - - not done Z53.9
  - - because of
  - - - contraindication Z53.0

  Tabular List entry:
  - **Z53.0** Procedure not carried out because of contraindication

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**.

Occasionally patients are admitted for treatment/investigations of conditions originally found in the out-patient setting, and by the time they are admitted the condition has cleared/disappeared. Common examples include breast lumps and skin lesions. The procedure is no longer required and is therefore cancelled when the patient is re-examined on the admission episode. These scenarios must be coded as in the following examples:
Example: Patient admitted as a day case for excision of left breast lump. On examination, the breast lump has disappeared and the procedure is cancelled.

- Index trail for **observation of suspected disease**:  
  Observation (for) Z04.9  
  - suspected (undiagnosed) (unproven)  
  - - condition NEC Z03.8  

  Tabular List entry:  
  Z03.8 Observation for other suspected diseases and conditions

- Index trail for **cancelled procedure**:  
  Procedure (surgical)  
  - not done Z53.9  
  - - because of  
  - - - specified reason NEC Z53.8  

  Tabular List entry:  
  Z53.8 Procedure not carried out for other reasons

- Index trail for **history of breast lump**:  
  Lump - see also Mass  
  - breast N63  

  History (personal) (of)  
  - disease or disorder (of) Z87.8  
  - - genital system Z87.4  

  Tabular List entry:  
  Z87.4 Personal history of diseases of genitourinary system

**Rationale:** The only way the coder can confirm that the condition has cleared/disappeared is to use the code for observation for suspected disease (Z03.8).
When a patient undergoes an endoscopy (for example a gastroscopy) which is abandoned because the patient was unable to tolerate the scope, this is often written as ‘failed intubation - patient unable to tolerate scope’ in the medical record.

A code from Z53 must not be assigned in these circumstances because the procedure has commenced. It is also not a complication of surgical or medical care (T80-T88). In this circumstance the procedure has been abandoned and it is only necessary to record the appropriate code for the condition(s) which prompted the endoscopy to be performed (eg gastric ulcer, epigastric pain, gastrointestinal bleed).

An OPCS-4 code(s) is assigned, using the guidance for coding incomplete, unfinished, abandoned or failed operations or procedures in the OPCS-4 Tabular List.
Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55–Z65)

The codes in this block are all problem codes and must not be used in the primary diagnostic position, except for Z63.8 Other specified problems related to primary support group. They must only be used when the circumstance influences the patient’s current condition and adds relevant 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. Please see the introduction for further guidance.

Example: Acute severe asthma aggravated by husband’s heavy smoking

Index trail for asthma:
Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.9
- acute, severe J46
Tabular List entry:
J46.X Status asthmaticus
Acute severe asthma

Index trail for exposure to tobacco smoke:
Exposure (to) (see also Contact, with) T75.8
- air
- - contaminants NEC Z58.1
- - - tobacco smoke Z58.7

Tabular List entry:
Z58.7 Exposure to tobacco smoke
Passive smoking

Rationale: If an indication of 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.
Living alone (Z60.2)

Code Z60.2 is 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.

**Example:**

Mild stroke. Patient kept in hospital for several days beyond the normal length of stay due to the fact that she lives alone.

- Index trail for stroke:
  - Stroke (apoplectic) (brain) (paralytic) I64

  Tabular List entry:
  - I64.X Stroke not specified as haemorrhage or infarction

- Index trail for problem:
  - Problem (related to) (with)
  - living alone Z60.2

  Tabular List entry:
  - Z60.2 Living alone

If a patient lives alone and it is not affecting their length of stay in any way, there is **NO requirement** to assign code Z60.2 in addition.

There is also no need to assign code Z60.2 on an episode where a patient dies.

**Example:**

79 year old lady who lives alone admitted as a day case for excision lipoma left arm.

- Index trail for lipoma:
  - Lipoma (M8850/0) D17.9
  - site classification
  - limbs (skin) (subcutaneous) D17.2

  Tabular List entry:
  - D17.2 Benign lipomatous neoplasm of skin and subcutaneous tissue of limbs
The only code within this block acceptable for use in a primary position is 
**Z63.8 Other specified problems related to primary support group.**

**Example:**

Child on ‘at risk’ register is admitted (with no problems) at the same 
time as their sibling is admitted for care

📖 Index trail for problem:
**Problem (related to) (with)**
- primary support group (family) Z63.9
- - specified NEC Z63.8

Tabular List entry:
**Z63.8** Other specified problems related to primary support group
Factors influencing health status etc.

Persons encountering health services in other circumstances (Z70–Z76)

Codes in this block are service codes, these codes can be used in a primary diagnostic position, unless there is a diagnosis, symptom, complication or injury 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
- Z75 Problems related to medical facilities and other health care (except Z75.5 Holiday relief care)
- Z76.0 Issue of repeat prescription
- Z76.3 Healthy person accompanying sick person
- Z76.4 Other boarder in health care facility

Acopia (Z73.9)
Code Z73.9 Problem related to life-management difficulty, unspecified is used to classify patients admitted to hospital because of an inability to cope. It predominantly applies to the elderly. This is different from codes in category Z74 Problems related to care-provider dependency which classifies problems associated with the care-provider relationship.

Need for assistance due to reduced mobility (Z74.0)
The only instance when it is appropriate to use this code is where a patient, who has assistance at home because they have reduced mobility, is solely admitted for care because the assistance they receive at home with their reduced mobility is not available. The condition prompting why the person needs assistance with their mobility must be recorded in the primary position.

Note that terms such as ‘reduced mobility’ and ‘poor mobility’ are recorded at code R26.8 Other and unspecified abnormalities of gait and mobility.
Persons awaiting admission to adequate facility elsewhere (Z75.1)

This code can be assigned in a secondary position to patients whose medical record clearly state that they are ‘bed-blocking’ or 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

- Index trail for infarction:
  Infarct, infarction (of)
  - cerebral I63.9

Tabular List entry:
I63.9 Cerebral infarction, unspecified

- Index trail for awaiting admission elsewhere:
  Unavailability (of)
  - bed at medical facility Z75.1

Tabular List entry:
Z75.1 Person awaiting admission to adequate facility elsewhere
Holiday relief care (Z75.5)
Patients are frequently admitted for holiday relief care (respite care) to enable their carers to take a break. The medical record for holiday relief patients must always be accessed to determine whether the episode has been purely for holiday relief, or has involved care for some other condition, as the following guidance demonstrates.

1. If the patient receives only the same level of care and attention that would normally be given at home by their carer, the code Z75.5 Holiday relief care must be assigned in the primary position, followed by the code describing the patient’s chronic condition.

Example: 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.

- Index trail for care:
  Care (of) (for) (following)
  - holiday relief Z75.5

or

  - respite Z75.5

Tabular List entry:
Z75.5 Holiday relief care

- Index trail for multiple sclerosis:
  Sclerosis, sclerotic
  - multiple (brain stem) (cerebral) (generalised) (spinal cord) G35

Tabular List entry:
G35.X Multiple sclerosis
Factors influencing health status etc.

2. If a patient is given care for another condition, confirmed to have been acquired whilst in hospital (ie a nosocomial condition), the code **Z75.5 Holiday relief care** must be assigned in a secondary position. This is in line with the Primary Diagnosis Definition.

**Example:**

Patient with multiple sclerosis admitted for two weeks respite care to allow their carer to take a holiday. The patient developed a hospital-acquired bronchopneumonia which was treated.

- Index trail for **bronchopneumonia**:  
  **Bronchopneumonia** *(see also Pneumonia, broncho)* J18.0  

  Tabular List entry:  
  J18.0  **Bronchopneumonia, unspecified**

- External Cause Index trail for **hospital acquired**:  
  **Factors, supplemental**  
  - nosocomial condition Y95  

  Tabular List entry:  
  Y95.X  **Nosocomial condition**

- Index trail for **multiple sclerosis**:  
  **Sclerosis, sclerotic**  
  - multiple (brain stem) (cerebral) (generalised) (spinal cord) G35  

  Tabular List entry:  
  G35.X  **Multiple sclerosis**

- Index trail for **holiday relief**:  
  **Care (of) (for) (following)**  
  - holiday relief Z75.5  

  or  
  - respite Z75.5  

  Tabular List entry:  
  Z75.5  **Holiday relief care**
3. Sometimes a patient is pre-booked for holiday relief care but the responsible consultant decides that, on this occasion, the patient must have additional treatment or reassessment for their condition such as adjustment to drug routine or physiotherapy. In these instances, the patient is no longer being admitted primarily for holiday relief care but for treatment of their condition, and must be coded accordingly. It must be emphasised that these additional treatments must be over and above those that they normally receive at home.

**Example:**

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.

- Index trail for multiple sclerosis:
  - Sclerosis, sclerotic
    - multiple (brain stem) (cerebral) (generalised) (spinal cord) G35

Tabular List entry:

| G35.X | Multiple sclerosis |

- Index trail for physiotherapy:
  - Physical therapy NEC Z50.1

Tabular List entry:

| Z50.1 | Other physical therapy |

- Index trail for holiday relief:
  - Care (of) (for) (following)
    - holiday relief Z75.5
  - respite Z75.5

Tabular List entry:

| Z75.5 | Holiday relief care |

**Rationale:** Codes in category Z50 must only be assigned when the patient has been transferred for the purpose of receiving rehabilitation after the original condition has been treated, however the exception is when rehabilitation is given during respite care. Therefore Z50.1 Other physical therapy is assigned in this example even though the patient wasn’t transferred for the purpose of receiving rehabilitation.

**Person encountering health services in unspecified circumstances (Z76.9)**

It is not expected that this code would ever be used, as the reason for admission must always be known.
Persons with potential health hazards related to family and personal history and certain conditions influencing health status
(Z80–Z99)

The codes in this block are all problem codes and 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. They would only be used 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 introduction.

Example:

Patient admitted with chest pain. Myocardial infarction (MI) not proven. Patient’s father died of an MI at 43 and his brother was diagnosed with ischaemic heart disease (IHD) at the age of 26.

Index trail for chest pain:

Pain(s) R52.9
- chest R07.4

Tabular List entry:

R07.4 Chest pain, unspecified

Index trail for family history:

History (personal) (of)
- family, of
- - disease or disorder (of)
- - - ischaemic heart Z82.4

Tabular List entry:

Z82.4 Family history of ischaemic heart disease and other diseases of the circulatory system

Codes Z85.6 Personal history of leukaemia and Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues must only be used in a primary position when a patient with leukaemia, or other malignant neoplasms of lymphoid, haematopoietic and related tissues in remission, is admitted for maintenance chemotherapy to keep their condition in remission.
### Example:
**Patient with leukaemia in remission is admitted solely for maintenance chemotherapy**

Index trail for **personal history**:

- **History (personal) (of)**
  - leukaemia Z85.6

Tabular List entry:

- **Z85.6** Personal history of leukaemia

Index trail for **chemotherapy**:

- **Chemotherapy (session) (for)** Z51.2
  - maintenance NEC Z51.2
  - - neoplasm Z51.1

Tabular List entry:

- **Z51.1** Chemotherapy session for neoplasm

Codes from this block are used to add relevant information.

### Example:
**Follow-up examination after excision of carcinoma in situ of cervix six months ago**

Index trail for **examination**:

- **Examination (general) (routine) (of) (for)** Z00.0
  - follow-up (routine) (following) Z09.9
  - - surgery NEC Z09.0

Tabular List entry:

- **Z09.0** Follow-up examination after surgery for other conditions

Index trail for **personal history**:

- **History (personal) (of)**
  - in situ neoplasm Z86.0

Tabular List entry:

- **Z86.0** Personal history of other neoplasms

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**Factors influencing health status etc.**
Factors influencing health status etc.

**Examples (cont):**

<table>
<thead>
<tr>
<th>Patient admitted with unstable angina. Has previously had a coronary artery bypass graft (CABG)</th>
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<td>Index trail for <strong>angina:</strong></td>
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<tr>
<td>Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor) I20.9</td>
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<td>I20.0 Unstable angina</td>
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<td>Tabular List entry:</td>
</tr>
<tr>
<td>Z95.1 Presence of aortocoronary bypass graft</td>
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</table>

Code **Z87.6 Personal history of certain conditions arising in the perinatal period** can be assigned in a secondary position when a patient over 28 days old had a condition that arose in the perinatal period, which is no longer present, but is relevant to their current condition.

Codes **Z92.3 Personal history of irradiation** and **Z92.6 Personal history of chemotherapy for neoplastic disease** may be assigned in a secondary position when relevant to the patient's episode of care. These codes may be used in addition to the personal history of malignant neoplasm codes in category **Z85**.

**Postsurgical states**

Postsurgical states are coded to **Z98 Other postsurgical states**. These are different from postoperative complications, and include such states as **Z98.0 Intestinal bypass and anastomosis status** and **Z98.1 Arthrodesis status**.

When coding postoperative complications it is imperative that the Alphabetical Index is consulted to ensure accurate code assignment, as described in Chapter XIX Injury, poisoning and certain other consequences of external causes.
Severe acute respiratory syndrome [SARS] (U04)

Severe Acute Respiratory Syndrome (SARS) is a viral disease caused by coronavirus. It has been described for the first time in 2003 in patients in Asia, later also in North America, and Europe. The illness generally begins with a fever and the patient may have other symptoms including headache, malaise, and myalgias. Lower respiratory symptoms develop and in some cases the respiratory illness is severe enough to require intubation and mechanical ventilation.

Code U04.9 Severe acute respiratory syndrome [SARS], unspecified must only be assigned, in either a primary or secondary position, 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 following code U04.9.
Bacterial agents resistant to antibiotics
(U80-U89)

The codes within this block must NEVER be used as primary diagnosis
codes.

They must only be used in a secondary position and must be sequenced
directly following a code for a bacterial infection classified elsewhere.

They are used to identify the antibiotic to which a bacterial agent is resistant
when this information is clearly documented within the patient’s medical
record. These codes only apply to bacterial agents, not viral, fungal or
parasitic agents. Coders must not interpret laboratory results in order to
identify the antibiotics to which a bacterial agent is resistant.

Example:

Patient with pneumonia due to Streptococcus pneumoniae
documented as being resistant to penicillin.

Index trail for pneumonia:
- Pneumonia (acute) (double) (migratory) (purulent) (septic)
  (unresolved) J18.9
- Streptococcus pneumoniae J13

Tabular List entry:
- J13.X  Pneumonia due to Streptococcus pneumoniae

Index trail for resistant:
- Resistance, resistant (to)
  - antibiotic(s), by bacterial agent
    - penicillin U80.0

Tabular List entries:
- U80.0 Penicillin resistant agent

When it is documented that a patient has MRSA infection it is implied that the
bacteria is resistant to methicillin. Consequently code U80.1 Methicillin
resistant agent must be assigned in addition to the code which identifies that
the infective agent is staphylococcus aureus.

The codes in categories U80 Agent resistant to penicillin and related
antibiotics, U81 Agent resistant to vancomycin and related antibiotics
and U89 Agent resistant to other and unspecified antibiotics are used
when an agent is resistant to a single antibiotic. When a bacterial agent is
resistant to two or more antibiotics which are specified within these
categories, a code for each antibiotic the agent is resistant to must be
assigned.
Example:

Patient with MRSA pneumonia documented as also being resistant to vancomycin.

- Index trail for pneumonia:
  Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9
  - staphylococcal (broncho) (lobar) J15.2

  Tabular List entry:
  J15.2 Pneumonia due to staphylococcus

- Index trail for infection:
  Infection, infected (opportunistic) B99
  - staphylococcal NEC A49.0
  - - as cause of disease classified elsewhere B95.8

  Tabular List entry:
  B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters

- Index trail for resistant:
  Resistance, resistant (to)
  - antibiotic(s), by bacterial agent
    - - methicillin U80.1
    - - vancomycin U81.0

  Tabular List entries:
  U80.1 Methicillin resistant agent
  U81.0 Vancomycin resistant agent

Code U88 Agent resistant to multiple antibiotics must only be used when a bacterial agent is resistant to two or more antibiotics and it is not specified which antibiotics they are.
Example: Patient with E.coli meningitis, responsible consultant documents that the infection is resistant to all three antibiotics tried.

Index trail for meningitis:
Meningitis (basal) (cerebral) (spinal) G03.9
- *Escherichia coli (E.coli)* G00.8

Tabular List entry:
**G00.8 Other bacterial meningitis**

Index trail for infection:
Infection, infected (opportunistic) B99
- *Escherichia (E.) coli* NEC A49.8
- - as cause of disease classified elsewhere B96.2

Tabular List entry:
**B96.2 *Escherichia coli [E. coli]* as the cause of diseases classified to other chapters**

Index trail for resistant:
Resistance, resistant (to)
- antibiotic(s), by bacterial agent
- - multiple U88

Tabular List entry:
**U88.X Agent resistant to multiple antibiotics**

A code from **U80-U89** must be assigned in addition to code **Z22.3 Carrier of other specified bacterial diseases** to identify the antibiotic to which the bacteria is resistant, when this is clearly stated in the medical record.
National Clinical Coding Standards
Accurate data for quality information

Summary of changes

For more information please contact
NHS Classifications Service
Health and Social Care Information Centre
Princes Exchange
Princes Square
Leeds LS1 4HY
datastandards@hscic.gov.uk

Website:
http://systems.hscic.gov.uk/data/clinicalcoding

Date of this version: August 2013

The table below lists the pages in the updated National Clinical Coding Standards ICD-10 4th Edition reference book (2013) which have been subject to change and a short description of the amendment made.

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