National Clinical Coding Standards
ICD-10

Accurate data for quality information

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| Reference number                    | 4852  
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| Date of issue                       | April 2015                                                                       |
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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.

The WHO gives specific instruction on the use of the ICD-10 classification for morbidity coding in some areas, whilst it provides options and guidance of a general nature in others. This can lead to differences in interpretation and application of the classification and this, in turn, can reduce the consistency and comparability of the data at local and national levels. Specific instructions are provided in the following pages in the form of national clinical coding standards for those areas of potential ambiguity (as far as practically possible) to safeguard data consistency.

The coding of diagnostic statements or elements of them is ‘mandatory’ only where the information is available in the medical record. The principles of the statistical classification, particularly those relating to basic coding guidelines and the structure of the classification, (as detailed in WHO ICD-10 Volume 2), are adopted as the standard and reinforced within this book where appropriate. Where a standard within the WHO ICD-10 Volume 2 differs to a national clinical coding standard, the national clinical coding standard must take precedence.

Background

The WHO states that ICD is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses and other health problems from words into alphanumeric codes, which permits easy storage, retrieval and analysis of data.1

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

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 caseloads to: determine specialty needs, inform staffing levels, patient admissions and clinic schedules in hospitals.

---

1 World Health Organisation International Classification of Diseases and Related Health Problems’ ICD-10 Volume 2, 2.1 Purpose and applicability.
• Clinical audit uses coded data to compare patient care and measure outcomes within specialties. Doctors may use extracts of 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 international use in the collection of morbidity and mortality information.

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

This reference book provides the national clinical coding standards for use with the ICD-10 for coding of the main condition (morbidity) and related health conditions as recorded in the hospital medical record.

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

Clinical coding

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

Clinical coder

A clinical coder is the health informatics professional that undertakes the translation of the medical terminology in a patient’s medical record into classification codes. A clinical coder will be accredited (or working towards accreditation) in this specialist field to meet a minimum standard. Clinical coders use their skills, knowledge and experience to assign codes accurately and consistently in accordance with the classification and national clinical coding standards. They provide classification expertise to inform coder/clinician dialogue.

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

2 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 electronic or on paper.

The health record (commonly referred to as the medical record and used hereafter) is the source documentation for the purposes of clinical coding. The 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 consistent, high quality information and comparable data to manage health and care.

When the medical record does not contain sufficient information to assign a code, the clinical coder must consult the responsible consultant (or their designated representative3).

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

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

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

Information governance and clinical governance

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

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

3 Hereafter referred to as the responsible consultant. The designated representative could be the clerking doctor, midwife or specialist nurse. As there will be local variations in designated representatives and processes the coding manager should confirm with the medical director the role of designated representative(s) in each specialty and document in the organisation’s clinical coding policy and procedures document.
When agreement has been reached through local governance on how to address a documentation or recording issue the outcome must be documented in the departmental policy and procedure document. This must be agreed and signed-off by the clinical director and/or governance authority dependent on local arrangements. Local coding policies should be reviewed regularly as part of the organisation’s review process.

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

The recording of the patient’s conditions, co-morbidities and medical history for the current admission is the responsibility of the responsible consultant. It is **not** the responsibility of a clinical coder to analyse information from previous hospital provider spells in order to identify and code conditions.

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

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

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

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

**Clinical coding audit**

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

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

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

- are up-to-date
- evidence local agreements and implementation
- have been applied consistently
- do not contravene national clinical coding standards.

**Terminology to ICD-10 cross-maps**

Health care providers that have implemented electronic health records and a clinical terminology such as SNOMED CT use 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 with default and, where appropriate, alternative ICD-10 target codes are provided. The default ICD-10 target codes are acceptable for the terminology concept/term to which they are linked. However where there is more relevant detail within the record, the selection of alternative ICD-10 target codes may need to be undertaken to ensure national clinical coding standards are consistently applied.

The national cross-maps are compliant with clinical coding national standards. They are provided in the UK Terminology Centre (UKTC) biannual releases. They are designed to support those organisations with electronic health systems to fulfil the mandatory requirement for collection and reporting of diagnostic data using the NHS Information Standard, ICD-10.

The classification cross-maps are compiled by the Clinical Classifications Service to reflect the rules and conventions of ICD-10 as well as the national 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:
https://isd.hscic.gov.uk/trud3/user/guest/group/0/home

**Coding 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 the 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.
- Code every condition or reason for encounter which affects the care, or influences health status during the consultant episode, which is available in the classification and supported by the medical record.
- 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 must 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 DGCS.3: Co-morbidities.*
• **Sequencing of codes**
  Codes must be sequenced in accordance with clinical coding standards to provide consistent data for statistical analysis. A significant aspect of sequencing is the selection of the main condition treated. *See also DGCS.1: Primary Diagnosis.*

**The four step coding process**

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

The four step coding process is the key to ensuring correct use of ICD-10 and accurate coding of the diagnostic statement(s) in the medical record. An overview of the four steps is provided below as a reminder. The full detail of each step is fully explored during training using national core curriculum training materials.
The national clinical coding standards provide a reference source primarily aimed at clinical coders. The level of detail reflects the assumption that users will be trained in the use of the ICD-10 classification as well as the abstraction of relevant information from the medical record.

Authorised amendments to the reference book are compiled and issued only by the Health and Social Care Information Centre – Clinical Classifications Service.

This reference book of national clinical coding standards is an evolving product and builds on the previously issued National Clinical Coding Standards ICD-10 4th Edition reference book. As the main emphasis of clinical coding is data quality and accuracy, this reference book will focus on the clinical coding standards that must be applied when assigning ICD-10 codes.

The previous ICD-10 reference book contained a mixture of clinical coding standards, guidance and diagnostic and anatomical information. It is important coders possess knowledge of anatomy and physiology and are aware of the diagnoses that can affect the human body; however detailed information regarding a particular disease or disorder is not always necessary in order to assign the correct code(s) to reflect a given diagnosis. There are many reference sources available to coders if they wish to find out more information about a diagnosis, such as text books, patient information leaflets and the internet. A wealth of knowledge is also held by clinical staff within each organisation.

Structure of the ICD-10 reference book

This reference book is split into distinct sections so that it is clear whether a directive must be applied throughout the classification, if it should be applied throughout a chapter or if it is specific to a code(s) or diagnosis.

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

It is important that users understand how each section of the reference book should be applied when coding.

Rules of ICD-10

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

Rules of ICD-10 are presented within a grey box. Additional information about the rule is contained within an adjoining white box.

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

Conventions of ICD-10

Conventions of ICD-10 are fundamental to accurate coding and apply throughout the classification (including the Alphabetical Index).

The clinical coder must thoroughly understand these conventions and always apply them to ensure correct code assignment and sequencing.

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

A coding standard must be applied by the clinical coder in the manner described. Compliance with a coding standard enables consistent, accurate and uniform coding which in turn supports the collection and comparison of local and national data across time. Standards are clear, concise and unambiguous.

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

**DCS.II.10: Histological types and benign neoplasms**

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

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

Examples of the correct application of a standard are provided, where necessary. The codes reflect the diagnostic statement given within the example. Where required a rationale is provided.

There are three types of standard:

- **General coding standards**
  General coding standards are located at the beginning of the reference book and are applicable throughout the classification.

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

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

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

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

  The unique identifiers for coding standards begin with ‘DCS’ followed by the chapter numeral, the number of the standard and the title (e.g. DCS.I.2: Neutropenic sepsis (A41 and D70.X)).

Coding guidance

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

Coding guidance is contained within a white box. They do not have unique identifiers or titles. Examples may be included after guidance to illustrate the points made – e.g.

Special symbols # and ✧ are used within the neoplasm table in the Alphabetical Index. The use of these symbols is described in the ‘includes’ note before the table.
References

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

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

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

Septic shock (R57.2)
See DCS.XVIII.7: Septic shock (R57.2).

Flow charts

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

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

The unique identifier of the standard(s) and applicable flow chart are referenced to aid the user.
# RULES OF ICD-10

<table>
<thead>
<tr>
<th><strong>DRule.1: Axis of the classification and rules of chapter prioritisation</strong></th>
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<tbody>
<tr>
<td>Where there is any doubt as to where a condition should be coded, the ‘special group’ chapters must take priority.</td>
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<tr>
<td>The ICD is a variable-axis classification. Its 22 chapters are divided into the following three types:</td>
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<tr>
<td><strong>Special group chapters</strong></td>
</tr>
<tr>
<td>Chapters I-V, XV-XVII and XIX classify conditions that do not focus on any one body system. In general, conditions are primarily classified to one of the ‘special group’ chapters.</td>
</tr>
<tr>
<td><strong>Body system chapters</strong></td>
</tr>
<tr>
<td>Chapters VI-XIV classify conditions according to the body system they affect.</td>
</tr>
<tr>
<td><strong>Other chapters</strong></td>
</tr>
<tr>
<td>Chapters XVIII and XX-XXII classify other disorders and factors which do not sit comfortably in either a special group or body system chapter.</td>
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<tr>
<th><strong>DRule.2: Category and code structure</strong></th>
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<tr>
<td>Code assignment must always be made to four character level or five character level (where available and in line with fifth character coding standards), in order for the code to be valid.</td>
</tr>
<tr>
<td>Where a three character category code is not subdivided into four character subdivisions the ‘X’ filler must be assigned in the fourth character field so the codes are of a standard length for data processing and validation. The code is still considered a three character code from a classification perspective.</td>
</tr>
<tr>
<td>Where a three character code requires assignment of both the ‘X’ filler and a fifth character subdivision, the ‘X’ filler must continue to be recorded in the fourth field before the fifth character, for example <strong>M45.X3 Ankylosing spondylitis, cervicothoracic region.</strong></td>
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*See also DConvention.7: Fifth characters.*

The three character category code structure is a three-digit code with an alphabetic character in the first position followed by two numbers. Most three character categories are subdivided to give four character or five character codes (subcategories).
## CONVENTIONS OF ICD-10

### DConvention.1: Cross references
Cross references are provided in the Alphabetical Index to ensure that all possible terms or its synonyms are referenced by the coder. Cross references explicitly direct the coder to other entries in the index:

**See**
This is an explicit direction to look elsewhere as no codes can be found alongside this cross reference. It is used to direct the coder to another 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.

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

### DConvention.2: Instructional notes
Instructional ‘Notes’ are used within the Tabular list at chapter level, block level, three-character and four-character levels. They describe the general content of the succeeding categories, give instruction regarding the use of categories and provide fifth character sub-classifications.

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

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

**Exclusion notes (exclusion terms, ‘Excl.:’)**
Exclusion notes are used to prevent a category or code from being used incorrectly. Exclusion notes tell the coder that, although the category or code description may suggest the term could be classified there, it is in fact classified elsewhere.

**Use notes**
The ‘use’ note is a specific instruction to use an additional code in order to describe a condition more completely and, just like other types of notes, can be found at chapter, block, three character category and fourth character subcategory levels. The ‘use’ note is never optional and must always be adhered to where the information is available in the medical record.

**If desired notes**
Where a note states to ‘Use an additional code, if desired’ to add further information about the disorder, where that information is present in the medical record the additional code must be assigned.
### DConvention.2 continued

**Are for use with**

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

*See also DChS.V.1: Glossary descriptions.*

### DConvention.3: Punctuation

**Brace |**

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

**Square brackets [ ]**

Square brackets are used to:

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

**Colon :**

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

**Point dash –**

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

**Parentheses ( )**

Parentheses are used to enclose nonessential modifiers (*see DConvention.6: Modifiers*). They are also used to enclose chapters, categories and codes listed in instructional notes, code ranges in block titles and dagger or asterisk codes in the Tabular List and to enclose cross-reference terms and morphology codes in the Alphabetical Index.
## DConvention.4: Abbreviations

### NOS (Not Otherwise Specified)

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

### NEC (Not Elsewhere Classified)

Assignment of a tentative code which uses NEC should be avoided if at all possible. The category for the term including NEC is to be used only when the coder lacks the information necessary to code the term to a more specific category. The phrase ‘not elsewhere classified’ is used in the Tabular List for residual categories to indicate that other specified variants of the condition may appear in other parts of the classification.

## DConvention.5: Relational terms

### And

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

### With or with mention of

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

### Without

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

### In, due to and resulting in

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

These terms are usually used where a condition only occurs because of the presence of another condition. ‘In’ and ‘due to’ are used interchangeably as they have the same meaning, and in many cases appear as ‘in (due to)’. In the vast majority of cases, the subentries have both dagger and asterisk codes. ‘In’ and ‘due to’ are also used in other situations such as ‘in pregnancy’ or ‘due to drugs’.
Modifiers are also referred to as qualifiers and are descriptive words used to further describe or modify a diagnosis. They are found in the Alphabetical Index.

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

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

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

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

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

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

- DCS.IX.14: Atherosclerosis (I70)
- DChS.XIII.1: Fifth characters in chapter XIII
- DChS.XIX.2: Fifth characters in chapter XIX
- DChS.XX.2: Activity codes

See also DRule.2: Category and code structure.

Special symbols in chapter II Neoplasms
See guidance in chapter II on the use of the special symbols # and ✧.
DGCS.1: Primary diagnosis

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

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

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

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

Specificity

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

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

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

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

Examples:

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

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

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

L97.X Ulcer of lower limb, not elsewhere classified
L03.1 Cellulitis of other parts of limb
DGCS.2: Absence of definitive diagnosis statement

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

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

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

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

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

Examples:

Probable Myocardial infarction

I21.9 Acute myocardial infarction, unspecified

Abdominal pain – likely appendicitis

R10.4 Other and unspecified abdominal pain

DGCS.3 Co-morbidities

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

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

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

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

Co-morbidities always coded

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

See Coding Clinic Ref 88: Coding of co-morbidities for the list of co-morbidities that must always be coded when documented in the patient’s medical record and other standards specifically related to coding co-morbidities.

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

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

For the purpose of coding co-morbidities the following clinical information may be useful; the GP referral letter for the current admission, Accident & Emergency documentation for the current admission, the associated pre-operative assessment prior to the admission, or transfer documentation provided by the responsible consultant at another hospital. This list is not exhaustive.

DGCS.4: Using diagnostic test results

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

- **Test results must not be interpreted by the coder to arrive at a diagnosis, this is the role of the responsible consultant**

- If a definitive diagnosis is documented on a test result report by the responsible consultant (or designated representative – e.g. a microbiologist or haematologist), it would be correct to assign codes for this diagnosis, as it is the responsible consultant that has interpreted the results to arrive at a definitive diagnosis

- Any uncertainty must always be referred back to the responsible consultant.
Examples of test results which may be used by the coder, but must never be interpreted by the coder, are:

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

Examples:

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

I60.1 Subarachnoid haemorrhage from middle cerebral artery

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

N92.0 Excessive and frequent menstruation with regular cycle

DGCS.5: The dagger and asterisk system

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

- They must always be used in combination and sequenced directly after each other
- The code that reflects the main condition treated or investigated during the consultant episode must be sequenced in the primary position (see DGCS.1: Primary diagnosis)
- In instances where the responsible consultant has not specified, or is unable to confirm, which condition is the main condition treated, the dagger code must be assigned before the associated asterisk code
- Where a dagger and asterisk combination is assigned, and neither condition is the main condition treated, the dagger code must be sequenced before the asterisk code
- Multiple asterisk codes with one dagger code must not be assigned, each asterisk code must have its own dagger code, even where this means repeating dagger codes
- A link must be made by the responsible consultant in the medical record to indicate that the manifestation (asterisk code) is caused by the underlying condition (dagger code); if they are not linked each diagnosis must be coded separately without the dagger and asterisk linkage
DGCS.5: continued

- Codes designated as a dagger code, either at category or code level, must always be used as a dagger code and must never be used alone, in the absence of an asterisk code. Codes not designated as a dagger or asterisk code may be paired with an asterisk code to form a dagger asterisk combination. Dagger codes appear in the following forms in the Tabular List:
  - When the associated asterisk code(s) is listed at the end of the code description of a dagger marked code the dagger code must be used with the listed asterisk code(s)
  - When the associated asterisk code is not listed in the code description of a dagger marked code but is listed as an inclusion underneath the dagger code the dagger code can be used with these inclusion terms or another asterisk marked code to form a dagger asterisk combination
  - When a code is not marked as a dagger code but any of its inclusion terms are marked with a dagger then the code becomes a dagger code when used in combination with the asterisk code listed in brackets in the inclusion.

- Codes designated as an asterisk code, either at category or code level, must always be used as an asterisk code in a dagger asterisk combination. They must never be used alone, in the absence of a dagger code. Asterisk codes appear in the following forms in the Tabular List:
  - When the associated dagger code(s) is listed at the end of the asterisk code description the asterisk code must be used with the listed dagger code(s)
  - When the associated dagger code is not listed in the asterisk code description but is listed as an inclusion underneath the asterisk code the asterisk code can be used with these inclusion terms or a non-asterisk code to form a dagger asterisk combination
  - When the associated dagger code is not listed in the asterisk code description or as an inclusion underneath the asterisk code the asterisk code can be used with a non-asterisk code to form a dagger asterisk combination.

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

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

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

Examples:

-Dementia due to Parkinson’s disease
  - G20.X† Parkinson disease
  - F02.3* Dementia in Parkinson disease (G20†)
Patient admitted for treatment of a diabetic cataract, the patient has type 1 diabetes mellitus.

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

Patient with insulin-dependent, diabetic cataracts and diabetic retinopathy, admitted for cataract surgery

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

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

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

- I84.2 Internal haemorrhoids without complications
- E05.9† Thyrotoxicosis, unspecified
- I43.8* Cardiomyopathy in other diseases classified elsewhere

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

- H26.9 Cataract, unspecified
- E10.9 Insulin-dependent diabetes mellitus, without complications

Retrobulbar neuritis in multiple sclerosis

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

**DGCS.6: Infections and sepsis**

Infections must be coded as follows:

- If only the infectious agent/organism is documented and no site is specified, the infection is coded to the specified organism only using a code from chapter I Certain infectious and parasitic diseases
- If only the site of the infection is documented and no infectious agent/organism is stated, code the site of the infection.
- If both the site of the infection and the agent/organism causing it is documented, a code(s) must be assigned which identifies both the site and organism as follows:
  - Where the Alphabetical Index directs to a dagger and asterisk combination which combines both the organism and the site assign these codes, *see DGCS.5: The dagger and asterisk system.*
  - Where the Alphabetical Index directs to a single code which combines both the organism and the site, assign this code.
Where the Alphabetical Index does not direct to a single code or a dagger and asterisk combination which combine both the organism and the site the following codes and sequencing must be applied:

- Assign a body system chapter code to identify the site of the infection
- Assign a code from categories **B95-B98 Bacterial, viral and other infectious agents** to identify the infective organism. This applies even when a ‘use additional codes from B95-B98’ note is not listed, see also DCS.I.4: **Bacterial, viral and other infectious agents (B95-B98).**

Where the infectious agent/organism is bacterial and it is clearly documented in the medical record that it is resistant to antibiotics a code(s) from categories **U80-U89 Bacterial agents resistant to antibiotics** must be assigned directly after the code for the bacterial infection, see DCS.XXII.2: **Bacterial agents resistant to antibiotics (U80-U89).**

**See also:**
- DCS.XV.5: **Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)**
- DCS.XV.30: **Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)**
- DChS.XIX.3: **Infected open wounds**
- DCS.XIX.7: **Postprocedural complications and disorders – postprocedural infections.**

**Sepsis**

Sepsis, unspecified, is a generalised infection. 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 specified organ or system, unless instructed otherwise by the Alphabetical Index, or where the responsible consultant has clarified a more generalised systemic sepsis.

If there is any doubt as to whether the diagnosis is referring to a generalised systemic infection or an infection of specified organ or system, clarification must be sought from the responsible consultant.

**See also:**
- DCS.I.2: **Neutropenic sepsis (A41 and D70.X)**
- DCS.XVI.5: **Group B streptococcus (GBS) bacterial infections in babies**
- DCS.XVIII.7: **Septic shock (R57.2)**
- DCS.XVIII.9: **Severe sepsis (R65.1, A41.9).**

**Examples:**

**Staphylococcal infection**

- **A49.0** Staphylococcal infection, unspecified site

**Urinary tract infection**

- **N39.0** Urinary tract infection, site not specified
Tuberculosis of the kidney

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

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

Chlamydial infection of anus

A56.3  Chlamydial infection of anus and rectum

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

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

Cellulitis of face due to Staphylococcus aureus

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

MRSA lower respiratory tract infection

J22.X  Unspecified acute lower respiratory infection
B95.6  Staphylococcus aureus as the cause of disease classified to other chapters
U80.1  Methicillin resistant agent

DGCS.7: Syndromes

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

• Search the Alphabetical Index under the general term of ‘syndrome’ or under the syndrome name, or both

• If the syndrome cannot be found in the alphabetical index, the coder must clarify with the responsible consultant whether the syndrome is congenital or acquired in order to determine the most appropriate code(s). Determining if it is of chromosomal origin or not will assist in code assignment, as not all congenital anomalies are of chromosomal origin.

  ○ Congenital
    ■ If it is of chromosomal origin assign a code from categories Q90-Q99 Chromosomal abnormalities, not elsewhere classified in chapter XVII
    ■ If it is not of chromosomal origin assign a code from categories Q00-Q89 from chapter XVII, depending on the body system it affects

  ○ Acquired
    ■ Assign a code from a body system chapter, depending on the body system it affects

• If, after the syndrome has been clinically diagnosed the 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
DGCS.7: continued

- If there is no indication of any presenting or treated manifestations, then only a code for the syndrome itself can be assigned. In most cases there will be presenting manifestations, but unless these are detailed in the patient’s medical record, the coder is unable to assign ICD-10 codes for them.

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

See also:
- DCS.VI.4: POEMS syndrome (C90.0† and G63.1*)
- DCS.IX.3: Cardiac syndrome X (I20.8)
- DCS.IX.9: Brugada syndrome (I49.8)
- DCS.XVII.1: Triple M syndrome (Q87.1).

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

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

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

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

DGCS.8: Sequelae or late effects

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

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

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

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

M24.56 Contracture of joint, lower leg
B91.X Sequelae of poliomyelitis

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

See also DChS.XIII.1: Fifth characters in chapter XIII.
Deviated nasal septum as a result of a fracture of nose sustained during a motor vehicle accident two years ago

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

**DGCS.9: Acute on chronic conditions**

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

**Example:**

*Acute on chronic alcoholic pancreatitis*

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

**DGCS.10: Multiple condition codes**

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

- **DCS.I.3: Human immunodeficiency virus [HIV] disease (B20-B24)** – when there is more than one condition resulting from HIV classified to the same category in B20-B24.
- When assigning codes identifying bi-laterality of the same limb
- **DCS.XIX.3: Bilateral injuries involving the same body site (T00-T07).**

**Example:**

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

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

**Anaemia in other chronic diseases, classified elsewhere**

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

**Pregnant state, incidental**

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

**Signs, symptoms and abnormal laboratory findings**

See **DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings**
### Septic shock

*See DCS.XVIII.7: Septic shock (R57.2)*

### Postprocedural complications and disorders

*See DCS.XIX.7: Postprocedural complications and disorders*

### External causes

*See DChS.XX.1: External causes*

### Hospital acquired conditions

*See DCS.XX.10: Hospital acquired conditions (Y95.X)*
## CHAPTER I

Certain Infectious and Parasitic Diseases  
(A00–B99)

### Chapter standards and guidance

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### Coding standards and guidance

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

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

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

**DCS.I.2: Neutropenic sepsis (A41 and D70.X)**

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

- **A41.-** Other sepsis
- **D70.X** Agranulocytosis

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

*See also:*
- DGCS.6: Infections and sepsis
- DCS.XVIII.7: Septic shock (R57.2)
- DCS.XVIII.9: Severe sepsis (R65.1, A41.9).

During the treatment of neutropenic sepsis, it is the sepsis that is the priority rather than the neutropenia.
**DCS.I.3: Human immunodeficiency virus [HIV] disease (B20 B24)**

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

- Only one code from categories B20-B24 *Human immunodeficiency virus [HIV] disease* is required when this code fully classifies both HIV and the condition resulting from HIV (with the exception of HIV disease resulting in malignant neoplasm – see below).

- When the HIV disease code from categories B20-B24 does not fully classify both the HIV and the condition resulting from HIV, the code that classifies the condition must also be assigned after the HIV disease code.

- If there is more than one condition resulting from HIV classified to the same category in B20-B22 the subdivision .7 from the appropriate category must be used followed by the codes classifying the specific conditions.

- When coding HIV disease resulting in malignant neoplasm the code that classifies the malignant neoplasm must be assigned after the code that classifies HIV resulting in malignant neoplasm from category B21.- *Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms*.
  - When a patient has HIV disease resulting in more than one malignant neoplasm code B21.7 *HIV disease resulting in multiple malignant* neoplasms must be assigned followed by the codes for the specific malignancies.

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

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

### Examples:

**HIV disease resulting in Pneumocystis jirovecii pneumonia**

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

**HIV resulting in candidiasis of the mouth**

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

**HIV disease resulting in respiratory tuberculosis and cytomegaloviral disease**

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

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

- B21.0 *HIV disease resulting in Kaposi sarcoma*
- C46.8 *Kaposi sarcoma of multiple organs*
HIV disease resulting in Kaposi sarcoma of the palate and Burkitt lymphoma

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

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

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

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

See also:
- **DGCS.6: Infections and sepsis**
- **DCS.XIX.7: Postprocedural complications and disorders**
- **DCS.XXII.1: Severe acute respiratory syndrome [SARS] (U04.9 and B97.2).**

**Severe sepsis (R65.1, A41.9)**

See **DCS.XVIII.9: Severe sepsis (R65.1, A41.9).**

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

See **DCS.X.2: Wheeze due to viral infection (B34.9 and R06.2).**
CHAPTER II
Neoplasms
(C00–D48)

Chapter standards and guidance

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

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

DChS.II.2: Anaemia in neoplastic disease (C00-D48† and D63.0*)
Anaemia due to neoplasm is coded to **D63.0* Anaemia in neoplastic disease** with the correct code for the neoplasm as the dagger code (C00–D48†).

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

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

*See DGCS.5: The dagger and asterisk system.*

Examples:

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

- **D63.0*** Anaemia in neoplastic disease (C00-D48†)
- **C17.0†** Malignant neoplasm: Duodenum
- **M8000/3** Neoplasm, malignant

Anaemia due to liver cancer

- **C22.9†** Malignant neoplasm: Liver, unspecified
- **D63.0*** Anaemia in neoplastic disease (C00-D48†)
- **M8000/3** Neoplasm, malignant

DChS.II.3: Endocrine disorder resulting from the presence of neoplasm (E00-E35)
For neoplasms with functional activity, i.e. an endocrine disorder as a result of the neoplasm, a code for the endocrine disorder from Chapter IV categories E00-E35 must be assigned directly after the neoplasm code.

Examples:

Carcinoma of ileum. Carcinoid syndrome.

- **C17.2** Malignant neoplasm: Ileum
- **M8010/3** Carcinoma NOS
- **E34.0** Carcinoid syndrome
Note: May be used as an additional code, if desired, to identify functional activity associated with a carcinoid tumour.

Adenocarcinoma of thyroid gland causing thyrotoxicosis

C73.X Malignant neoplasm of thyroid gland
M8140/3 Adenocarcinoma NOS

E05.8 Other thyrotoxicosis

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 siting the National Clinical Coding Qualification (UK).

If assigning morphology codes to classify behaviour of a neoplasm, the morphology code should be sequenced following the code from chapter II classifying the neoplasm. The exception is when using a dagger and asterisk combination where it is not possible to assign the morphology code after the neoplasm code because dagger and asterisk codes cannot be separated. In these cases the morphology code must be sequenced after the dagger or asterisk code (depending on sequencing) that is being used in combination with the neoplasm code.

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, e.g. malignant, benign, in situ, etc.

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. (A list of morphology and associated one-digit behaviour codes can be found in the Morphology of neoplasms section of the Tabular List).

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 that this is metastatic. It is important that the first five characters of the morphology code, ie M9180, remain the same to denote the correct histological type.

The morphology codes for lymphoid, haematopoietic and related tissues neoplasms (categories C81-C96 and D45-D47) are not contained within the ICD-10 Alphabetical Index. However, the corresponding morphology codes are located in the Morphology of neoplasms tables in the Tabular List.

NOTE: Tabular List entries for morphology codes have only been included in the examples within this chapter to give a full representation of how the diagnostic statement would be coded if morphology codes were assigned. Morphology codes are not shown in other chapters of the reference book as the assignment of morphology codes is not mandatory.

Special symbols # and ✧ are used within the neoplasm table in the Alphabetical Index. The use of these symbols is described in the ‘includes’ note before the table.

Examples:

Epidermoid carcinoma of lower limb.

C44.7 Malignant neoplasm: Skin of lower limb, including hip
M8070/3 Squamous cell carcinoma NOS
The # symbol is present at the lower limb site in the neoplasm table in the Alphabetical Index. The histological type is identified as epidermoid carcinoma, therefore this type of neoplasm must be indexed and classified to skin of lower limb at **C44.7**. Code **C76.5 Malignant neoplasm of other and ill-defined sites: Lower limb** listed under primary malignant neoplasm of lower limb in the Index must not be used in this instance.

**Adenocarcinoma of calvarium**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C80.9</td>
<td>Malignant neoplasm, primary site unspecified</td>
</tr>
<tr>
<td>M8140/3</td>
<td>Adenocarcinoma NOS</td>
</tr>
<tr>
<td>C79.5</td>
<td>Secondary malignant neoplasm of bone and bone marrow</td>
</tr>
<tr>
<td>M8140/6</td>
<td>Adenocarcinoma, metastatic NOS</td>
</tr>
</tbody>
</table>

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

**Osteosarcoma of femur**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C40.2</td>
<td>Malignant neoplasm: Long bones of lower limb</td>
</tr>
<tr>
<td>M9180/3</td>
<td>Osteosarcoma NOS (C40.-, C41.-)</td>
</tr>
</tbody>
</table>

The Alphabetical Index indicates that the morphology code for ‘osteosarcoma’ should be indexed in the neoplasm table under bone, malignant. In the neoplasm table under bone malignant the symbol ✧ is present, but because osteosarcoma is an osseous type, the code listed under primary malignant neoplasm in the neoplasm table must be used, i.e. code **C40.2**.

### Pathological fractures in neoplastic disease

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

### Coding standards and guidance

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

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

- they are specified as secondary (or metastatic)
  - or
  - the site stated is marked with a ✧ and is a carcinoma or adenocarcinoma of any type other than intraosseous or odontogenic.

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

When the primary site of malignancy has not been identified, i.e. the site is unspecified, code **C80.9 Malignant neoplasm, primary site unspecified** must be assigned.

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

Wherever a secondary malignancy is documented, a primary malignancy must also be coded, even if the primary site is unspecified (C80.9) or stated to be unknown (C80.0). The exception to this is when primary malignancy is documented to be no longer present, in which case a code from category **Z85.- Personal history of malignant neoplasm** would be assigned.
**DCS.II.1: continued**

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

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

**Predominantly secondary sites**

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

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

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

**Sequencing of malignant neoplasms**

When a primary malignant neoplasm and a secondary malignant neoplasm are both present, the code for the primary malignant neoplasm must be assigned before the code for the secondary malignant neoplasm, unless the secondary malignant neoplasm is the main condition treated or investigated, *see DGC.S1: Primary diagnosis.*

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

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

**Examples:**

*Adenocarcinoma left lung*

- **C34.9** Malignant neoplasm: Bronchus or lung, unspecified
- **M8140/3** Adenocarcinoma NOS

*Carcinoma of pectoral lymph nodes*

- **C80.9** Malignant neoplasm, primary site unspecified
- **M8010/3** Carcinoma NOS
- **C77.3** Secondary and unspecified malignant neoplasm: Axillary and upper limb lymph nodes
- **M8010/6** Carcinoma, metastatic NOS
Patient with known squamous cell carcinoma of lung (middle lobe) undergoes pleural biopsy and is diagnosed with metastasis to pleura.

**C78.2** Secondary malignant neoplasm of pleura  
M8070/6 Squamous cell carcinoma, metastatic NOS  
**C34.2** Malignant neoplasm: Middle lobe, bronchus or lung  
M8070/3 Squamous cell carcinoma NOS

**Hepatoma**

**C22.0** Malignant neoplasm: Liver cell carcinoma  
M8170/3 Hepatocellular carcinoma NOS (C22.0)

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

**C34.1** Malignant neoplasm: Upper lobe, bronchus or lung  
M8000/3 Neoplasm, malignant  
**C77.1** Secondary and unspecified malignant neoplasm: Intrathoracic lymph nodes  
M8000/6 Neoplasm, metastatic

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

**M90.72** Fracture of bone in neoplastic disease (C00-D48†), upper arm  
**C79.5†** Secondary malignant neoplasm of bone and bone marrow  
M8140/6 Adenocarcinoma, metastatic NOS  
**C50.9** Malignant neoplasm: Breast, unspecified  
M8140/3 Adenocarcinoma NOS

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

**C79.3** Secondary malignant neoplasm of brain and cerebral meninges  
M8000/6 Neoplasm, metastatic  
**Z85.1** Personal history of malignant neoplasm of trachea, bronchus and lung

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

The following must be applied when coding metastatic cancer:

**Metastatic from**

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

**Metastatic to**

Cancer described as ‘metastatic to’ (e.g. metastatic neoplasm to lung, breast metastasis to pleura) a site must be interpreted as a secondary neoplasm of the stated site; ‘to’ indicates the site a neoplasm has travelled to from its point of origin i.e. a secondary site. A code must also be assigned for the specified primary site (if the primary site is known and still present), or for primary malignant neoplasm of unspecified site or unknown (see also **DCS.II.1: Primary and secondary malignant neoplasms (C00-C97)**).
**DCS.II.2: continued**

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

**Metastases of one stated site only**

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

When the diagnostic statement is ‘metastatic’ (e.g. metastatic osteosarcoma of brain) malignant neoplasm of only one site and gives a morphological type which is indexed to a different body site/system stated, this must be coded as a primary neoplasm of an unspecified site (C80.9) for the morphological type, with metastases (secondary) of the site mentioned in the diagnostic statement.

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

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

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

If the statement mentions metastatic neoplasms of two or more sites, and the morphological type stated is indexed to a different body site/system to that of the stated sites (e.g. metastatic melanoma of lung and brain), both sites must be coded as secondary neoplasms. The morphological type must be coded as the primary malignant neoplasm.
Metastases with no stated site

If no site is stated in the diagnostic statement, but the morphological type is stated to be ‘metastatic’, this must be coded as a primary neoplasm of unspecified site (C80.9) for the morphological type involved. Code C79.9 must also be assigned to indicate a secondary neoplasm of unspecified site.

See also:
- DCS.II.1: Primary and secondary malignant neoplasms (C00-C97)
- DCS.II.7: Secondary neoplasms or metastases from haematological malignancies.

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

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

Examples:

Metastatic carcinoma from breast

C50.9  Malignant neoplasm: Breast, unspecified
M8010/3  Carcinoma NOS
C79.9  Secondary malignant neoplasm, unspecified site
M8010/6  Carcinoma, metastatic NOS

Metastatic carcinoma to lung

C80.9  Malignant neoplasm, primary site unspecified
M8010/3  Carcinoma NOS
C78.0  Secondary malignant neoplasm of lung
M8010/6  Carcinoma metastatic NOS

Metastatic osteosarcoma of femur

C40.2  Malignant neoplasm: Long bones of lower limb
M9180/3  Osteosarcoma NOS
C79.9  Secondary malignant neoplasm, unspecified site
M9180/6  Osteosarcoma NOS

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

Metastatic osteosarcoma of brain

C41.9  Malignant neoplasm: Bone and articular cartilage, unspecified
M9180/3  Osteosarcoma NOS
C79.3  Secondary malignant neoplasm of brain and cerebral meninges
M9180/6  Osteosarcoma NOS

Osteosarcoma (morphological type) indexes to neoplasm of bone (body site/system) malignant. As the brain is from a different body site/system (the central nervous system) to bone the brain must be coded as a secondary site.
Metastatic adenocarcinoma of lung

**C34.9**  **Malignant neoplasm: Bronchus or lung, unspecified**
M8140/3  Adenocarcinoma NOS
**C79.9**  **Secondary malignant neoplasm, unspecified site**
M8140/6  Adenocarcinoma NOS

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

Metastatic lung cancer

**C34.9**  **Malignant neoplasm: Bronchus or lung, unspecified**
M8000/3  Neoplasm, malignant
**C79.9**  **Secondary malignant neoplasm, unspecified site**
M8000/6  Neoplasm, metastatic

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

Metastatic bone cancer

**C80.9**  **Malignant neoplasm, primary site unspecified**
M8000/3  Neoplasm, malignant
**C79.5**  **Secondary malignant neoplasm of bone and bone marrow**
M8000/6  Neoplasm, metastatic

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

Metastatic carcinoma of pleura and vertebra

**C80.9**  **Malignant neoplasm, primary site unspecified**
M8010/3  Carcinoma NOS
**C78.2**  **Secondary malignant neoplasm of pleura**
M8010/6  Carcinoma, metastatic NOS
**C79.5**  **Secondary malignant neoplasm of bone and bone marrow**
M8010/6  Carcinoma, metastatic NOS

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

Metastatic melanoma of lung and brain

**C43.9**  **Malignant neoplasm: Malignant melanoma of skin, unspecified**
M8720/3  Malignant melanoma NOS
**C78.0**  **Secondary malignant neoplasm of lung**
M8720/6  Malignant melanoma NOS
**C79.3**  **Secondary malignant neoplasm of brain and cerebral meninges**
M8720/6  Malignant melanoma NOS

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C75.1</td>
<td>Malignant neoplasm: Pituitary gland</td>
</tr>
<tr>
<td>M8270/3</td>
<td>Chromophobe carcinoma (C75.1)</td>
</tr>
<tr>
<td>C79.9</td>
<td>Secondary malignant neoplasm, unspecified site</td>
</tr>
<tr>
<td>M8270/6</td>
<td>Chromophobe carcinoma (C75.1)</td>
</tr>
</tbody>
</table>

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

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

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

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

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

**Examples:**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C02.8</td>
<td>Malignant neoplasm: Overlapping lesion of tongue</td>
</tr>
<tr>
<td></td>
<td>[See note 5 at the beginning of this chapter]</td>
</tr>
<tr>
<td>M8010/3</td>
<td>Carcinoma NOS</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C02.1</td>
<td>Malignant neoplasm: Border of tongue</td>
</tr>
<tr>
<td>M8010/3</td>
<td>Carcinoma NOS</td>
</tr>
</tbody>
</table>

*Malignant neoplasm of the cardio-oesophageal junction*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C16.0</td>
<td>Malignant neoplasm: Cardia</td>
</tr>
<tr>
<td></td>
<td>Cardio-oesophageal junction</td>
</tr>
<tr>
<td>M8000/3</td>
<td>Neoplasm, malignant</td>
</tr>
</tbody>
</table>
Carcinoma of stomach and small intestine, point of origin not confirmed

C26.8  Malignant neoplasm: Overlapping lesion of digestive system
[See note 5 at the beginning of this chapter]
Malignant neoplasm of digestive organs whose point of origin cannot be classified to any one of the categories C15–C26.1
M8010/3  Carcinoma NOS

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

C76.8  Malignant neoplasm of other and ill-defined sites: Overlapping lesion of digestive system
[See note 5 at the beginning of this chapter]
M8010/3  Carcinoma NOS

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

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

Where multiple primary neoplasms exist and it is clear which neoplasm predominates, code C97.X must not be assigned.

Where two or more independent primary malignant neoplasms exists, none of which predominates, and these are classified to the same four character code, code C97.X must still be assigned, followed by a single code which classifies all of the neoplasms.

Examples:

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

C97.X  Malignant neoplasms of independent (primary) multiple sites
C18.7  Malignant neoplasm: Sigmoid colon
M8000/3  Neoplasm, malignant
C34.3  Malignant neoplasm: Lower lobe, bronchus or lung
M8000/3  Neoplasm, malignant

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

C61.X  Malignant neoplasm of prostate
M8140/3  Adenocarcinoma NOS
C44.5  Malignant neoplasm: Skin of trunk
M8070/3  Squamous cell carcinoma NOS

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

C97.X  Malignant neoplasms of independent (primary) multiple sites
C50.3  Malignant neoplasm: Lower-inner quadrant of breast
M8500/3  Infiltrating duct carcinoma
DCS.II.5: Recurrent primary malignant neoplasms

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

Example:

Recurrent malignant neoplasm of posterior wall of bladder

C67.4 Malignant neoplasm: Posterior wall of bladder
M8000/3 Neoplasm, malignant

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

When a patient undergoes further/wider excision for a previously removed 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.

During the excision of a malignant neoplasm some of the tissue that surrounds the malignancy is also removed. The area between the outer edges of the tissue sample and the malignancy 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 malignancy 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.

Example:

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

C43.6 Malignant neoplasm: Malignant melanoma of upper limb, including shoulder
M8720/3 Malignant melanoma NOS

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

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

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

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

Due to the disease progression of lymphomas and leukaemias it is perfectly valid for a patient to be coded to one type of lymphoma/leukaemia on one consultant episode and then coded to a totally different type of lymphoma/leukaemia on a subsequent consultant episode.
**DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7)**

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

**Human Immunodeficiency Virus [HIV] resulting in malignancy**

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

**Screening for malignant neoplasm due to family history of malignancy**

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

**Follow-up examination after treatment for malignant neoplasm**

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

**Prophylactic treatment of malignant neoplasm**

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

**Personal and family history of malignant neoplasm**

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

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

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

**Example:**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C53.9</td>
<td>Malignant neoplasm: Cervix uteri, unspecified</td>
</tr>
<tr>
<td>M8010/3</td>
<td>Carcinoma NOS</td>
</tr>
</tbody>
</table>

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

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

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

*See DCS.XIV.10: Intraepithelial neoplasia of female genital tract (CIN, VAIN, VIN)*
### DCS.II.10: Histological types and benign neoplasms

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

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

**Examples:**

*Polyp of an accessory sinus*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J33.8</td>
<td>Other polyp of sinus</td>
</tr>
</tbody>
</table>

*Adenomatous polyp of an accessory sinus*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D14.0</td>
<td>Benign neoplasm: Middle ear, nasal cavity and accessory sinuses</td>
</tr>
<tr>
<td>M8210/0</td>
<td>Adenomatous polyp NOS</td>
</tr>
</tbody>
</table>

*Polyp of the urinary bladder*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D41.4</td>
<td>Neoplasm of uncertain or unknown behaviour: Bladder</td>
</tr>
<tr>
<td>M8120/1</td>
<td>Transitional cell papilloma NOS</td>
</tr>
</tbody>
</table>

### DCS.II.11: Mongolian blue spot (D22)

Mongolian blue spot must be coded using a code from category D22.- Melanocytic naevi.

Mongolian blue spots are flat melanocytic skin markings commonly appearing near the buttocks at birth (birthmark) or shortly thereafter. The index trail for ‘birthmark’ directs the coder to the ICD-10 code Q82.5 Congenital non-neoplastic naevus. However, the ICD-10 Tabular List indicates that melanocytic naevus are excluded from code Q82.5 and directs to category D22.-.

### DCS.II.12: Neoplasms of uncertain or unknown behaviour (D37-D48)

Codes in categories D37-D48 Neoplasms of uncertain or unknown behaviour must only be assigned when directed to via the Alphabetical index or when it is documented in the medical record that the neoplasm is of uncertain or unknown behaviour.

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

*See also DGCS.2: Absence of definitive diagnosis statement.*

These codes indicate doubt as to whether a neoplasm is malignant or benign and that the future behaviour of the neoplasm cannot be predicted from its present appearance. These types of neoplasms may also be referred to as ‘tumours’.

### Chronic intractable pain in neoplasm

*See DCS.XVIII.5: Chronic intractable pain (R52.1)*
CHAPTER III
Diseases of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism
(D50–D89)

Coding standards and guidance

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

<table>
<thead>
<tr>
<th>D57.3 Sickle-cell trait</th>
<th>must not be coded when it coexists with a condition classified to one of the following categories or codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• D56.- Thalassaemia</td>
<td></td>
</tr>
<tr>
<td>• D57.0 Sickle-cell anaemia with crisis</td>
<td></td>
</tr>
<tr>
<td>• D57.1 Sickle-cell anaemia without crisis.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

As instructed by the includes note at **D63.8* when CKD stages 3 and above and anaemia are both present the dagger and asterisk combination must be used. Stage 1 or stage 2 CKD with anaemia must not be coded using the dagger and asterisk combination unless it is documented that the anaemia is due to CKD stages 1 or 2.

See also:

- DGCS.5: The dagger and asterisk system
- DChS.II.2: Anaemia in neoplastic disease (C00-D48† and D63.0*).

Example:

*Patient with anaemia due to chronic duodenal ulcer*

   
   K26.7† Duodenal ulcer, chronic without haemorrhage or perforation
   D63.8* Anaemia in other chronic diseases classified elsewhere
Patient admitted with stage 2 chronic kidney disease and anaemia

N18.2  Chronic kidney disease, stage 2  
D64.9  Anaemia, unspecified

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

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

*See also DCS.XVIII.12: Raised International Normalised Ratio [INR] (R79.8).*
CHAPTER IV
Endocrine, Nutritional and Metabolic Diseases
(E00–E90)

Coding standards and guidance

Endocrine disorder resulting from the presence of neoplasm (E00-E35)
See DChS.II.3: Endocrine disorder resulting from the presence of neoplasm (E00-E35)

DCS.IV.1: Diabetes mellitus (E10–E14)
The fourth character subdivisions at categories E10-E14 Diabetes mellitus classify manifestations and complications of diabetes. In order to assign fourth characters .0 -.8 it must be clearly documented in the medical record that the manifestation(s) or complication(s) is due to diabetes. Any doubt as to whether a condition is linked to the diabetes must be referred back to the responsible consultant for clarification.

Multiple complications of diabetes

• Where the patient has multiple complications that are classified to a dagger asterisk combination, a dagger asterisk combination must be assigned for each complication. This applies whether the fourth character diabetes code is the same or not for the complications. See also DGCS.5: The dagger and asterisk system.

• Where a patient has multiple complications classified to E10-E14 with the fourth characters of .0, .1, .5 or .6, each complication must be coded following a code from category E10-E14, unless the fourth character code from E10-E14 is the same for all complications in which case only one code for the diabetes is assigned and the codes for the complications are listed afterwards. The exceptions are myocardial infarction, cardiac failure or angina due to diabetes, as explained below.

• The fourth character .7 With multiple complications must only be assigned when it is only stated that the patient has multiple complications of diabetes and the specific conditions are not identified in the medical record. See also DGCS.10: Multiple condition codes.

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

Myocardial infarction, cardiac failure or angina due to diabetes
If a patient is admitted with an acute myocardial infarction, cardiac failure or angina that is a complication of diabetes, the diabetes must be recorded in a secondary position with a fourth character of .6 With other specified complications.
**DCS.IV.1 continued**

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

**Insulin treated non-insulin-dependent (type 2) diabetes**

The use of insulin therapy in non-insulin dependent diabetes patients is not evidence of insulin dependency and patients with type 2 diabetes who are being treated with insulin must still be coded to category **E11.- Non-insulin-dependent diabetes mellitus.**

**Hypoglycaemia and hypoglycaemic coma in diabetes**

- When it is documented in the medical record that a diabetic patient has hypoglycaemia a code from category **E16.- Other disorders of pancreatic internal secretion** must be assigned followed by the code that classifies the type of diabetes from categories **E10-E14**, with the fourth character subdivision .9 Without complications (as hypoglycaemia is not classified as a complication in ICD-10).

- A code from category **E16.-** must also be assigned following a code from **E10-E14**, with the fourth character subdivision .0 With coma when the patient has diabetes with hypoglycaemic coma.

- Coma and/or hypoglycaemia due to a patient taking insulin correctly as prescribed, must be coded as an adverse effect of the insulin, *see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).*

- Coma and/or hypoglycaemia due to a patient taking too much insulin must be coded as a poisoning, *see DCS.XIX.8: Poisoning (T36-T65).*

**Hyperglycaemia and uncontrolled diabetes**

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

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

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

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

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

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

**Patient with insulin-dependent diabetes, diabetic nephropathy and diabetic retinopathy**

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

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

- **E11.2† Non-insulin-dependent diabetes mellitus, with renal complications**
  Diabetic nephropathy (N08.3*)
- **N08.3* Glomerular disorders in diabetes mellitus (E10-E14 with common fourth character .2†)**
- **E11.5 Non-insulin-dependent diabetes mellitus, with peripheral circulatory complications**
  Diabetic:
  - gangrene
- **R02.X Gangrene, not elsewhere classified**
- **E11.3† Non-insulin-dependent diabetes mellitus, with ophthalmic complications**
  Diabetic:
  - cataract (H28.0*)
- **H28.0* Diabetic cataract (E10-E14† with common fourth character .3†)**

**Type 2 diabetic with diabetic coma and diabetic gangrene left leg**

- **E11.0 Non-insulin-dependent diabetes mellitus, with coma**
- **E11.5 Non-insulin-dependent diabetes mellitus, with peripheral circulatory complications**
  Diabetic:
  - gangrene
- **R02.X Gangrene, not elsewhere classified**

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

- **E16.2 Hypoglycaemia, unspecified**
- **E11.9 Non-insulin-dependent diabetes mellitus, without complication**

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

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

**Hypoglycaemic coma, in patient with Type 1 diabetes mellitus**

- **E10.0 Insulin-dependent diabetes mellitus, with coma**
- **E16.2 Hypoglycaemia, unspecified**
Accidental overdose of insulin, resulting in hypoglycaemic coma. Type I insulin-dependent diabetes mellitus.

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

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

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

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

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

**DCS.IV.3: Obesity (E66)**

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

*See also DGCS.4: Using diagnostic test results.*

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

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

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

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

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

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

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

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

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

*See also DGCS.10: Multiple condition codes.*
Examples:

Cystic fibrosis related pseudomonas aeruginosa lower respiratory tract infection.

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

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

- **E84.1†**  Cystic fibrosis with intestinal manifestations
  Meconium ileus in cystic fibrosis† (P75*)
- **P75.X***  Meconium ileus in cystic fibrosis (E84.1†)
- **E84.8**  Cystic fibrosis with other manifestations
- **K74.6**  Other and unspecified cirrhosis of liver
- **K86.1**  Other chronic pancreatitis
- **M85.8**  Other specified disorders of bone density and structure

### DCS.IV.7: Dehydration and hypovolaemia

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

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

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

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

### DChS.V.1: Glossary descriptions

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

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

In addition to the World Health Organisation (WHO) International Statistical Classification of Diseases and Related Health Problems ICD-10 (Tenth Revision), the WHO also provides the specialty-based adaptation called ICD-10 Classification of Mental Health and Behavioural Disorders. It encompasses clinical descriptions and diagnostics. It is recommended that this adaptation should only be used in conjunction with the complete ICD-10 classification in order that all ICD-10 rules and conventions are fully adhered to.

### Coding standards and guidance

#### DCS.V.1: Sequencing of codes in F00-F09 and the underlying disease

For conditions classifiable to categories **F00-F09**, the code describing the underlying disease, injury or other insult to the brain must be added directly after the code from categories **F00-F09**. The exception to this is when assigning dagger and asterisk combination codes where the dagger asterisk sequencing may be reversed, see DGCS.5: The dagger and asterisk system.

The dagger and asterisk code combination of **G30† Alzheimer disease** and **F00* Dementia in Alzheimer disease (G30.0†)** classify one condition; Alzheimer dementia. The dagger and asterisk sequence would rarely be reversed when using these combination codes because they indicate one specific form of dementia, see DGCS.5: The dagger and asterisk system.

**Example:**

*Dementia in early onset Alzheimer’s disease*

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

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

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

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

*See also DGCS.5: The dagger and asterisk system.*
DCS.V.3: Delirium and acute confusional state

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

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

Delirium is synonymous with the term acute confusional state.

Example:

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

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

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

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

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

Example:

Alcoholic admitted with acute drunken episode

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

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

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

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

- the patient has been advised by the responsible consultant to stop drinking because it will have an adverse effect on their medical condition
- or
- the responsible consultant states that the patient is dependent on alcohol.

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

See also DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19).
**DCS.V.6: Mephedrone**

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

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

**DCS.V.7: Current smoker (F17)**

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

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

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

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

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

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

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

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

See also:

- **DCS.V.4: Mental and behavioural disorders due to psychoactive substance use (F10–F19)**
- **DCS.V.7: Current smoker (F17)**.
Examples:
Alcoholic, heroin, cannabis, valium dependent

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

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

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

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

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

DCS.V.10: Anxious

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

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

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

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

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

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

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

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

Examples:

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

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

Significant behavioural impairment with IQ of 25

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

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

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

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

Holiday relief care/respite care (Z75.5)

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

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

See DGCS.1: Primary diagnosis.

Examples:

Patient admitted to acute trust due to deliberate overdose of paracetamol, patient has depression.

Patient transferred to psychiatric unit the next day for treatment of acute depression.

Acute trust

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

Psychiatric unit

F32.9 Depressive episode, unspecified
Z91.5 Personal history of self-harm
Inpatient at psychiatric unit for 6 weeks with acute depression, laceration to wrist after slashing with scissors, (suicide attempt). Patient transferred to acute trust for treatment of laceration to wrist.

Psychiatric unit

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

Acute trust

- **S61.9** Open wound of wrist and hand part, part unspecified
- **F32.9** Depressive episode, unspecified
CHAPTER VI
Diseases of the Nervous System
(G00–G99)

Coding standards and guidance

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

Mixed dementia or mixed vascular and Alzheimer’s dementia

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

DCS.VI.1: Epilepsy and injury

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

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

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

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

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

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

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

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

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

Example:
Flaccid hemiplegia as a result of cerebral infarction five years ago

G81.0  Flaccid hemiplegia
I69.3  Sequelae of cerebral infarction
**DCS.VI.4: POEMS syndrome (C90.0† and G63.1*)**

POEMS syndrome must be coded using the following codes:

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

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

*See also:*

- *DGCS.5: The dagger and asterisk system*
- *DGCS.7: Syndromes.*

The features of POEMS syndrome are:

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

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

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

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

See *DCS.XIX.7: Postprocedural complications and disorders.*
CHAPTER VII
Diseases of the Eye and Adnexa
(H00–H59)

Coding standards and guidance

DCS.VII.1: Senile, age-related, mature, advanced and white cataracts (H25 and H26.9)
Codes in category H25.- Senile cataract must only be assigned when documented as senile cataract or age-related cataract; they must not be assigned for a mature cataract. Mature, advanced or white cataract must be coded using H26.9 Cataract, unspecified.

DCS.VII.2: Posterior capsule opacification (H26.4)
Posterior capsule opacification must be coded using H26.4 After-cataract.

DCS.VII.3: Visual impairment including blindness (H54)
The severity of visual impairment table at category H54.- Visual impairment including blindness (binocular or monocular) must not be used for coding purposes to diagnose levels of visual impairment.

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

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

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

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

H54.0 Blindness, binocular (if unspecified or stated of both eyes)
or
H54.4 Blindness, monocular (if stated to be of one eye only).

DCS.VII.4: Post enucleation socket syndrome, PESS (H59.8 and Y83.6)
Post enucleation socket syndrome must be coded using the following codes and sequencing:

H59.8 Other postprocedural disorders of eye and adnexa
Y83.6 Removal of other organ (partial) (total)

See also DCS.XIX.7: Postprocedural complications and disorders.
DCS.VII.5: Sunken socket syndrome (H59.8 and Y83 or Y84)

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

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

See also **DCS.XIX.7: Postprocedural complications and disorders.**
CHAPTER VIII
Diseases of the Ear and Mastoid Process
(H60–H95)

Coding standards and guidance

<table>
<thead>
<tr>
<th>DCS.VIII.1: Severe or profound hearing loss (H90 and H91)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing loss documented as severe or profound must always be coded using a code from categories <strong>H90.- Conductive and sensorineural hearing loss</strong> or <strong>H91.- Other hearing loss</strong> depending on the type of hearing loss documented.</td>
</tr>
<tr>
<td>When the cause of severe or profound hearing loss is known both conditions must be coded, sequencing will depend on the main condition treated or investigated during the consultant episode, see DGC5.1: Primary diagnosis.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
## CHAPTER IX

### Diseases of the Circulatory System (I00–I99)

### Coding standards and guidance

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

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

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

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

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

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

When a patient has hypertensive renal disease, or hypertensive heart and renal disease, and the renal disease is a condition within category **N18.- Chronic kidney disease**, the code from category **N18.-** is assigned to identify the stage of the chronic kidney disease followed by a code from category **I12.-** or **I13.-**, see **DCS.XIV.2: Chronic kidney disease, CKD (N18)**.

*See also DCS.IX.10: Heart failure (I50).*

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

### Examples:

**Hypertensive congestive cardiac failure**

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

**Congestive cardiac failure and hypertension**

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

**Kidney failure and hypertension**

- **N19.X Unspecified kidney failure**
- **I10.X Essential (primary) hypertension**
Hypertensive renal failure

I12.0 Hypertensive renal disease with renal failure
Hypertensive renal failure
Incl.: any condition in N00-N07, N18.-, N19 or N26 due to hypertension

Hypertensive kidney failure with hypertensive congestive cardiac failure

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

DCS.IX.3: Cardiac syndrome X (I20.8)
Cardiac syndrome X must be coded using I20.8 Other forms of angina pectoris.
See also DGCS.7: Syndromes.

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

DCS.IX.4: Myocardial infarction (I21, I22, I25.8)
The time reference of four weeks (28 days) stated in categories I21-I25 signifies the interval elapsing between the onset of the ischaemic episode and admission to hospital; this time reference must be observed by coders to ensure consistency in recording myocardial infarctions.

Acute myocardial infarction
A code from category I21.- Acute myocardial infarction must be assigned every time a patient has an acute myocardial infarction (MI), except when a subsequent MI occurs within 4 weeks of the onset of a previous infarction, in which case a code from category I22.- Subsequent myocardial infarction must be used as described below.
Where a new acute MI is diagnosed more than four weeks (28 days) after a previous MI, a code from category I21.- Acute myocardial infarction must be assigned.

STEMI and NSTEMI
Non-ST segment elevation myocardial infarction (NSTEMI) must be coded to I21.4 Acute subendocardial myocardial infarction.
ST segment elevation myocardial infarction (STEMI) must be classified using a code in the range I21.0 - I21.3 depending on the site/extent of damage to the heart documented in the medical record. Where the site/extent of damage is not known, code I21.3 Acute transmural myocardial infarction of unspecified site must be assigned.

Subsequent MI
Category I22.- Subsequent myocardial infarction must only be used to code an MI occurring within four weeks (28 days) from onset of a previous infarction, regardless of site and includes the following:
- Subsequent/further acute myocardial infarction
- extension to an existing MI
- recurrent MI
- reinfarction
If a patient has multiple subsequent MIs in the same consultant episode, or any consultant episode within the same or a different hospital provider spell, occurring within four weeks (28 days) from onset of the original infarction, a code from category **I22.- Subsequent myocardial infarction** must be assigned for each subsequent MI.

Chronic MI and ongoing treatment of MI after 4 weeks

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

Treatment of another condition within 4 weeks of an MI

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

**See also:**

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

The fourth characters at category **I21.-** identify the site of infarction/extent of the damage caused to the heart by the infarction. If the infarction occurs through a wall, the modifier of ‘transmural’ (trans = across, mural = wall) should be referenced in the Alphabetical Index. The term ‘subendocardial’ implies that the dead cells involve only up to two-thirds of the left ventricular wall.

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

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).

**Examples:**

*Patient admitted with chest pains is diagnosed with STEMI.*

**I21.3 Acute transmural myocardial infarction of unspecified site**

*Patient admitted to acute admissions ward and diagnosed with acute transmural anterior myocardial infarction. They have no previous cardiac history (Consultant episode 1). The patient is transferred to CCU for continuing treatment and are discharged home five days later (Consultant episode 2).*  

**Consultant episode 1**

**I21.0 Acute transmural myocardial infarction of anterior wall**

**Consultant episode 2**

**I21.0 Acute transmural myocardial infarction of anterior wall**
Patient diagnosed with an acute transmural myocardial infarction of anterior wall (Hospital provider spell 1). Two weeks after the previous transmural myocardial infarction of the anterior wall the patient is readmitted with an acute transmural myocardial infarction of the inferior wall (Hospital provider spell 2). Six months later the patient is readmitted with another acute transmural myocardial infarction of the inferior wall (Hospital provider spell 3).

Hospital provider spell 1

I21.0  Acute transmural myocardial infarction of anterior wall

Hospital provider spell 2

I22.1  Subsequent myocardial infarction of inferior wall

Hospital provider spell 3

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

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

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

Hospital provider spell 1 (Trust A)

I21.9  Acute myocardial infarction, unspecified

Hospital provider spell 2 (Trust B)

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

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

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

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

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

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

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

See also DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease.
Example:
Patient is admitted to Trust A with an acute MI. The patient also has coronary artery disease (CAD) (Hospital provider spell 1). They are transferred to Trust B where coronary angioplasty and stent of only the most severely atherosclerotic coronary arteries is performed (Hospital provider spell 2). The patient is discharged from Trust B the day after the coronary angioplasty and stent procedure and readmitted directly to Trust A’s rehabilitation unit for cardiac rehabilitation for the acute MI (Hospital provider spell 3).

Hospital provider spell 1 (Trust A)
- I21.9 Acute myocardial infarction, unspecified
- I25.1 Atherosclerotic heart disease

Hospital provider spell 2 (Trust B)
- I25.1 Atherosclerotic heart disease
- I21.9 Acute myocardial infarction, unspecified

Hospital provider spell 3 (Trust A)
- I21.9 Acute myocardial infarction, unspecified
- I25.1 Atherosclerotic heart disease
- Z95.5 Presence of coronary angioplasty implant and graft

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

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

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

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

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

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

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

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

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

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

Acute transmural anterior wall myocardial infarction concurrent with atrial septal defect

- I21.0 Acute transmural myocardial infarction of anterior wall
DCS.IX.7: Chronic ischaemic heart disease (I25)

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

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

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

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

**See also:**

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

**Examples:**

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

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

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

- I21.9 Acute myocardial infarction, unspecified
- I25.1 Atherosclerotic heart disease
- I20.9 Angina pectoris, unspecified
- I25.9 Chronic ischaemic heart disease, unspecified
- I25.2 Old myocardial infarction
DFigure.IX.1: Myocardial infarction and myocardial infarction with other forms of ischaemic heart disease

Acute MI
- I21.-

Subsequent/extension of/further/recurrent/reinfarction of any myocardial site within four weeks (28 days) of previous MI
- I22.-

Chronic or readmitted after 4 weeks (28 days) of MI for ongoing treatment of the MI
- I25.8

Re admitted within 4 weeks (28 days) of MI
- I21.-

For ongoing treatment of the MI

MI with other forms of IHD

Condition being treated plus I24.9 in a secondary position

Coronary artery disease (CAD)

Admitted for an intervention to treat CAD
- I25.1 as primary code and MI code in addition

Treated during same hospital provider spell as MI

As a comorbidity/not treated

Ischaemic heart disease (not acute) and

- I25.9 (or I25.8 if specifically directed by the Index) in a secondary position
- I25.9 (or I25.8 if specifically directed by the Index) and I25.2 all in a secondary position
- I25.2 in a secondary position

Old, past, personal history of MI - MI not being treated, and - occurred more than 4 weeks (28 days) ago or time not stated

See:
- DCS.IX.4: Myocardial infarction (I21, I22, I25.8)
- DCS.IX.5: Coronary artery disease interventions and acute myocardial infarction
- DCS.IX.7: Chronic ischaemic heart disease (I25).
DCS.IX.8: Cardiac arrest (I46)

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

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

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

Cardiac arrest without successful resuscitation (and thus fatal) and not described as ‘sudden cardiac death’ must be coded to I46.9 Cardiac arrest, unspecified.

DCS.IX.9: Brugada syndrome (I49.8)

Brugada syndrome must be coded using I49.8 Other specified cardiac arrhythmias

See also DGCS.7: Syndromes.

DCS.IX.10: Heart failure (I50)

If both congestive cardiac failure (CCF) (I50.0) and left ventricular failure (LVF) (I50.1) are documented in the medical record only assign code I50.0 Congestive heart failure as this code includes both right and left ventricular failure.

If a diagnosis of LVF is made together with mention of pulmonary oedema, only assign code I50.1 as this code includes pulmonary oedema.

If pulmonary oedema is mentioned in the medical record with a condition classified to a code from one of the following categories, assign code I50.1 (instead of J81.X Pulmonary oedema) and the code from the category that classifies the specific heart condition:

- acute rheumatic fever (I00-I01),
- chronic rheumatic heart disease (I05-I09)
- hypertensive disease (I10-I15, with the exception of I11.0 and I13.-)
- ischaemic heart disease (I20-I25)
- endocarditis (I33)
- mitral valve disease (I34)
- aortic valve disease (I35)
- endocarditis (I38-I39)
- myocarditis (I40-I41)
- cardiomyopathy (I42-I43)
- arrhythmias (I44-I49)
- other heart conditions (I51-I52).
DCS.IX.10 continued

If pulmonary oedema is mentioned in the medical record with hypertensive heart disease with (congestive) heart failure (I11.0) or a condition classified to a code from category I13.- Hypertensive heart and renal disease only assign I11.0 or I13.-, see also DCS.IX.2: Renal disease and heart disease due to hypertension (I11, I12, I13).

If pulmonary oedema is mentioned in the medical record with a condition classified to a code from one of the following categories, assign code J81.X Pulmonary oedema and the code from the category that classifies the specific heart condition:

- rheumatic chorea (I02)
- pulmonary heart disease (I26-I28)
- pericarditis (I30-I32)
- tricuspid valve disorders (I36)
- pulmonary valve disorders (I37).

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

Examples:
Patient has left ventricular failure with pulmonary oedema

I50.1  Left ventricular failure

Patient has atrial fibrillation (an arrhythmia) with pulmonary oedema.

I48.9  Atrial fibrillation and atrial flutter, unspecified
I50.1  Left ventricular failure

Hypertensive heart and renal disease with pulmonary oedema

I13.9  Hypertensive heart and renal disease, unspecified

Patient with acute pericarditis and pulmonary oedema

I30.9  Acute pericarditis, unspecified
J81.X  Pulmonary oedema

DCS.IX.11: Stroke, not specified as haemorrhage or infarction (I64.X)

The cause of a stroke must always be coded when known.

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 infarct or a haemorrhage. In such instances 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 data from a report to make a diagnosis themselves, the CT report may document a definitive diagnosis to enable the assignment of a more accurate code.

See also:
- DGCS.4: Using diagnostic test results
- DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia.
Example:

Acute cerebrovascular accident. CT scan of brain documents a confirmed diagnosis of an acute cerebral thrombosis

I63.3 Cerebral infarction due to thrombosis of cerebral arteries

DCS.IX.12: Stroke with hemiplegia, dysphagia and dysphasia

On emergency admissions for strokes, the code for stroke must be assigned in the primary position. Hemiplegia (G81), when due to stroke that is currently being treated, must be coded in a secondary position to the stroke.

Dysphagia and dysphasia are symptoms of stroke and must only be coded in addition when they become a chronic condition, which is being treated in its own right (usually in long stay patients), see DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

See also DCS.IX.11: Stroke, not specified as haemorrhage or infarction (I64.X).

On further admissions following treatment of the stroke if the hemiplegia is still present it will be appropriate to record the hemiplegia as a sequela (late effect) of a stroke, see DGCS.8: Sequelae or late effect.

Other conditions occurring as a result of a stroke, such as dysphagia and dysphasia, must be treated in the same way.

Example:

Left hemiplegia on admission. CT scan reveals a cerebral infarction (verified by the responsible consultant)

I63.9 Cerebral infarction, unspecified
G81.9 Hemiplegia, unspecified

DCS.IX.13: Cerebral atherosclerosis (I67.2)

Code I67.2 Cerebral atherosclerosis must also be assigned when this condition co-exists with any condition in categories I63.- Cerebral infarction or I66.- Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction.

DCS.IX.14: Atherosclerosis (I70)

Fifth character subdivisions are for use with this category to indicate the absence (0) or presence (1) of gangrene associated with the sites mentioned at fourth character level. Where there is no information available within the medical record the coder must use the default ‘0’ to indicate without gangrene.

See also DConvention.7: Fifth characters.

Example:

Atherosclerosis with gangrene of extremities caused by diabetes (Type 2).

E11.5 Type 2 diabetes mellitus, with peripheral circulatory complications
I70.21 Atherosclerosis of arteries of extremities, with gangrene

See also DCS.IV.1: Diabetes mellitus (E10–E14).
DCS.IX.15: Peripheral vascular diseases (I73.9)

If a patient is admitted for an arteriogram, the diagnosis confirmed on the arteriogram report and verified by the responsible consultant must be coded in preference to category I73.9 Peripheral vascular diseases, unspecified, i.e. code to the cause of the PVD if known. I73.9 must only be assigned if the cause is unknown.

Peripheral vascular disease (PVD) can also be referred to as intermittent claudication or ischaemia of lower limbs. These are symptoms of atheroma (cholesterol) or arteriosclerosis (hardening of the arteries).

Example:
Patient admitted for arteriogram to investigate PVD. Arteriogram reveals occlusion of the femoral artery due to embolism which was confirmed by the responsible consultant.

I74.3 Embolism and thrombosis of arteries of lower extremities

DCS.IX.16: Haemorrhoids (I84)

If haemorrhoids (I84-) are stated to be both internal and external, two codes must be assigned.

Deep vein thrombosis due to travel or hospital acquired

See:
- DCS.XX.3: Conditions linked to travel (X51.9)
- DCS.XX.10: Hospital acquired conditions (Y95.X).
CHAPTER X
Diseases of the Respiratory System
(J00–J99)

Coding standards and guidance

DCS.X.1: Recurrent tonsillitis (J03)
Recurrent tonsillitis must be coded using J03.9 Acute tonsillitis, unspecified, in the absence of information on the specific form of tonsillitis.

Acute tonsillitis is inflammation of the tonsillar tissue, which may be viral or bacterial induced. Recurrent tonsillitis refers to multiple distinct episodes of acute tonsillitis.

DCS.X.2: Wheeze due to viral infection (B34.9 and R06.2)
A wheeze that is either induced, caused by, or due to a viral infection must be coded using the following codes and sequencing:

B34.9 Viral infection, unspecified
R06.2 Wheezing

Examples of clinical terms that indicate a wheeze due to viral infection are viral wheeze, viral-induced wheeze, viral-associated wheeze or viral illness with wheeze.

DCS.X.3: Post procedural pneumonia
Post procedural pneumonia must be coded using the body system chapter code that classifies the type of pneumonia followed by a code from category Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

The index trail 'Pneumonia – resulting from a procedure (J95.8)' must not be used.

See also DCS.XIX.7: Postprocedural complications and disorders.

DCS.X.4: Influenza A (H1N1) [swine flu] (J10)
Swine flu, with no documented manifestations, must be coded to J10.1 Influenza with other respiratory manifestations, other influenza virus identified.

If specific manifestations of the influenza are identified a different code from category J10.- Influenza due to other identified influenza virus must be assigned.

The term ‘Chest infection’ is a non-specific diagnosis; this can be written as a proxy for a more definitive respiratory diagnosis such as pneumonia or bronchiectasis. If a more definitive diagnosis is made (e.g. pneumonia), this should be coded instead of the chest infection. Any uncertainty must be referred back to the responsible consultant.
### DCS.X.5: COAD/COPD, chest infection and asthma with associated conditions

The following codes must be assigned for the following diagnoses when recorded in the patient’s medical record.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COAD/COPD with asthma</td>
<td>J44.-</td>
</tr>
<tr>
<td>COAD/COPD with chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COAD/COPD with bronchitis and chest infection</td>
<td>J44.0</td>
</tr>
<tr>
<td>COAD/COPD with acute asthma</td>
<td>J45.9 or J46.X and J44.9</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></td>
<td>If the specific type of pneumonia is known then the appropriate code from categories J12.- to J18.- must be selected in preference to J18.9.</td>
</tr>
<tr>
<td>COPD with haemophilus influenzae present in sputum</td>
<td>J44.0 and B96.3</td>
</tr>
<tr>
<td>Chest infection with bronchitis</td>
<td>J40.X or J20.9</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>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</td>
</tr>
<tr>
<td></td>
<td>or J46.X, J22.X and J44.9</td>
</tr>
</tbody>
</table>

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

### DCS.X.6: Status asthmaticus (J46.X)

**J46.X Status asthmaticus** must only be assigned when the responsible consultant has documented a diagnosis of:

- Acute severe asthma
  - or
- Status asthmaticus

If the term ‘acute asthma’, is documented without mention of ‘severe’ clarification must be sought from the responsible consultant to ensure that the correct diagnosis is coded.

### Pulmonary oedema with heart failure (I50)

*See DCS.IX.10: Heart failure (I50).*
Respiratory failure must always be coded when the diagnosis is recorded in the medical record. When documented with another respiratory condition, the sequencing will be dependent on the main condition being treated.


## Coding standards and guidance

### DChS.XI.1: Constipation in ileus or intestinal obstruction

Constipation is an integral part of a diagnosis of ileus and bowel obstruction and must not be coded in addition.

**Example:**

*Patient with constipation due to umbilical hernia with obstruction.*

- **K42.0** Umbilical hernia with obstruction, without gangrene

### DCS.XI.1: Oesophageal web (K22.2, Q39.4)

The ICD-10 Alphabetical Index assumes that an oesophageal web is a congenital condition and classifies this to **Q39.4 Oesophageal web**. However, an oesophageal web can be either congenital or acquired, with acquired being more common.

The following must be applied when coding oesophageal web:

- A documented diagnosis of congenital oesophageal web must be classified to **Q39.4 Oesophageal web**.
- A documented diagnosis of acquired oesophageal web must be classified to **K22.2 Oesophageal obstruction**.
- An unspecified oesophageal web (i.e. not documented as congenital or acquired) must be classified to **K22.2 Oesophageal obstruction**.

### DCS.XI.2: Barrett oesophagus with low or high grade dysplasia (K22.7)

Barrett’s oesophagus has the potential to lead to cancer. Terms such as ‘low grade dysplasia’ and ‘high grade dysplasia’ are used to describe pre-cancerous forms. The correct code for Barrett’s oesophagus either with or without low or high grade dysplasia is **K22.7 Barrett oesophagus**.

### DCS.XI.3: Peptic ulcer, site unspecified (K27)

Peptic ulcers must only be classified to category **K27.- Peptic ulcer**, when information about the site of the peptic ulcer is not available. When the site of the peptic ulcer is documented, this must be coded to an ulcer of the stated site.

**Example:**

*Bleeding peptic ulcer. Medical record confirms the site of ulcer as stomach.*

- **K25.4** Gastric ulcer, chronic or unspecified with haemorrhage

- **Check endoscopies**

  *See DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)*
DCS.XI.4: Gastritis and duodenitis (K29)

Code K29.9 Gastroduodenitis, unspecified must only be assigned if the patient has both K29.7 Gastritis, unspecified and K29.8 Duodenitis. If a specific type of gastritis is documented, then the code for the specific type must be assigned together with K29.8 Duodenitis.

The following codes must be assigned for Helicobacter pylori associated gastritis:

- K29.6 Other gastritis (if a specific type is stated use a different code from K29.-)
- B98.0 Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters.

See also:
- DGCS.6: Infections and sepsis
- DCS.I.4: Bacterial, viral and other infectious agents (B95-B98).

Gastritis is a normal manifestation of Helicobacter pylori infection.

Example:
Chronic atrophic gastritis due to Helicobacter pylori infection

- K29.4 Chronic atrophic gastritis
- B98.0 Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters

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

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

A ‘presumed’ diagnosis of appendicitis or acute appendicitis is quite often recorded in the medical record, but sometimes when an appendix is removed the histology result will state ‘normal appendix’. In these cases, because a definitive diagnosis has not been made, the coder should clarify the diagnosis with the responsible consultant. If the appendix is confirmed to be normal the presenting symptoms would be coded. Usually this will be acute abdominal pain.

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

When coding diseases of the appendix the method of admission should not be taken into account when deciding on the correct ICD-10 code. For instance, a patient can be admitted as an emergency and then be kept on the ward to see if the suspected appendicitis settles down. The patient may then have an interval appendicectomy or a planned delayed appendicectomy.

DCS.XI.5: Parastomal hernia (K43 and Z93)

Parastomal hernia’s must be coded using a code from category K43.- Ventral hernia. A code from category Z93.- Artificial opening status must be assigned in addition to identify the type of stoma.
DCS.XI.6: Indeterminate colitis (K52.3)

Code K52.3 Indeterminate colitis must only be assigned when so stated by the responsible consultant.

The most common disease that mimics the symptoms of ulcerative colitis is Crohn’s disease, as both are inflammatory bowel diseases that can affect the colon with similar symptoms.

It is important to differentiate between these diseases, since the course of the diseases and treatments may be different in some cases. However, it may not be possible for the responsible consultant to tell the difference, in which case the disease is described by the responsible consultant as indeterminate colitis (K52.3).

Where the non-specific diagnosis of inflammatory bowel disease (IBD) is used, the coder should clarify a more specific diagnosis with the responsible consultant.

DCS.XI.7: Rectal haemorrhage and per rectal haemorrhage (K62.5 and K92.2)

In classification terms there is a difference between a ‘rectal haemorrhage’ and a ‘per rectal haemorrhage’.

Code K62.5 Haemorrhage of anus and rectum must only be assigned for an actual haemorrhage of the anus and/or rectum. It must not be assigned for haemorrhage that has occurred from elsewhere in the gastrointestinal tract that is merely exiting via the rectum, ie per rectal haemorrhage.

Code K92.2 Gastrointestinal haemorrhage, unspecified must be assigned for a haemorrhage that occurred via the rectum but is not specified as being from the actual rectum or anus. This code must not be assigned when it is a symptom of a specific disease which has been diagnosed, see DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2).

DCS.XI.8: Alcoholic liver disease and alcoholic pancreatitis (K70, K85.2 and K86.0)

It must be stated that hepatitis or pancreatitis is due to alcohol use in order to assign codes in category K70.- Alcoholic liver disease and codes K85.2 Alcohol-induced acute pancreatitis or K86.0 Alcohol-induced chronic pancreatitis. If a patient has liver disease or pancreatitis not specified to be due to an infectious organism and the patient is also alcoholic it must not be assumed that the liver disease or pancreatitis is due to the alcoholism.

Alcoholic liver disease or alcoholic pancreatitis due to current misuse of, or dependence on, alcohol must be coded using the following codes and sequencing:

- K70.- Alcoholic liver disease, K85.2 Alcohol-induced acute pancreatitis or K86.0 Alcohol-induced chronic pancreatitis
- F10.- Mental and behavioural disorders due to use of alcohol (fourth character assignment is dependent upon whether or not the responsible consultant has stated that the alcoholic liver disease is due to harmful use of alcohol (F10.1) or dependence (F10.2)).

Alcoholic liver disease or alcoholic pancreatitis due to previous alcohol abuse must be coded using the following codes and sequencing:

- K70.- Alcoholic liver disease, K85.2 Alcohol-induced acute pancreatitis or K86.0 Alcohol-induced chronic pancreatitis
- Z86.4 Personal history of psychoactive substance abuse
Where the responsible consultant has given no information regarding current or past alcohol use/abuse and only states a type of alcoholic liver disease or alcohol induced pancreatitis, only assign a code from category K70.-, or codes K85.2 or K86.0.

See also DGCS.9: Acute on chronic conditions.

Codes in category K70.- and codes K85.2 and K86.0 do not imply that the patient is a current alcoholic but that the liver disease or pancreatitis is due to the use of alcohol.

If a patient has liver disease or pancreatitis and they are also alcoholic and it is not clear if the liver disease or pancreatitis is due to the alcoholism clarification should be obtained from the responsible consultant.

Examples:

Acute hepatitis due to chronic alcoholism

- **K70.1** Alcoholic hepatitis
- **F10.2** Mental and behavioural disorders due to use of alcohol, Dependence syndrome

Alcoholic admitted with acute on chronic pancreatitis

- **K85.9** Acute pancreatitis, unspecified
- **K86.1** Other chronic pancreatitis
- **F10.2** Mental and behavioural disorders due to use of alcohol, Dependence syndrome

DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2)

When **K92.0** Haematemesis, **K92.1** Melaena or **K92.2** Gastrointestinal haemorrhage, unspecified are symptoms of a specific disease which has been diagnosed, such as a malignant neoplasm or bleeding peptic ulcer, these codes must not be assigned in addition, unless they have been treated in their own right.

See also:

- **DCS.XI.7**: Rectal haemorrhage and per rectal haemorrhage (K62.5 and K92.2)
- **DChS.XVIII.1**: Signs, symptoms and abnormal laboratory findings.
CHAPTER XII
Diseases of the Skin and Subcutaneous Tissue
(L00–L99)

Coding standards and guidance

<table>
<thead>
<tr>
<th>Infections and sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>See DGCS.6: Infections and sepsis</td>
</tr>
</tbody>
</table>

Coding standards and guidance

### DCS.XII.1: Decubitus ulcer and pressure area (L89)

If the responsible consultant has not documented the stage/grade of the ulcer or the ulcer is documented as ‘unstageable’, code **L89.9 Decubitus ulcer and pressure area, unspecified** must be assigned.

**R02.X Gangrene, not elsewhere classified** must be assigned in addition to a code from category L89.- Decubitus ulcer and pressure area when gangrene is present with decubitus ulcers and pressure areas.

### DCS.XII.2: Leg ulcers with gangrene, infection and cellulitis (L97.X)

Leg ulcers with associated infection (infected leg ulcer) must be coded using the following codes and sequencing:

- **L97.X** Ulcer of lower limb, not elsewhere classified
- **L08.9** Local infection of skin and subcutaneous tissue, unspecified
- **B95-B98 Bacterial, viral and other infectious agents** if the infective agent is identified

See also DGCS.6: Infections and sepsis.

When associated gangrene is present with leg ulcers, code **R02.X Gangrene, not elsewhere classified** must be assigned in addition.

When cellulitis of the leg is documented with a leg ulcer, both conditions must be coded. Sequencing will depend on the main condition treated in line with DGCS.1: Primary diagnosis.
CHAPTER XIII
Diseases of the Musculoskeletal System and Connective Tissue
(M00–M99)

Coding standards and guidance

DChS.XIII.1: Fifth characters in chapter XIII

The fifth characters in chapter XIII indicate the site of musculoskeletal involvement. The notes at chapter, category or code level indicate which codes can be further specified by the addition of a fifth character and the location of the fifth character code lists in the classification.

The following must be applied when assigning fifth characters in chapter XIII:

- Fifth characters must be used where the data is present in the medical record and where doing so adds more specific information about the site.
- In cases where the four character code is already site specific and the addition of a fifth character will not add further specific information about the site, the fifth character is not required.
- The fifth character of '0' indicates involvement of multiple sites. It should be assigned when the condition classified at the fourth character code affects more than one site. The .0 must not be assigned for conditions only affecting bilateral sites; in these instances, the fifth character reflecting that site must be recorded.
- The 'X' filler code must be assigned in the fourth character position for three character codes which require assignment of a fifth character, for example M45.X6.

See also:

- DRule.2: Category and code structure
- DConvention.7: Fifth characters.

The main subclassification of fifth characters is listed before the block on Arthropathies (M00-M25) in ICD-10 Volume 1. Other subclassifications appear at:

- M23.- Internal derangement of knee
- M40-M54 Dorsopathies
- M99.- Biomechanical lesions, not elsewhere classified.

The following are examples of codes which would never require the addition of a fifth character because they are site specific. The addition of a fifth character would not add further specific information about the site (this is not an exhaustive list):

- M76.0 Gluteal tendinitis
- M76.3 Iliotibial band syndrome
- M76.6 Achilles tendinitis.
Examples:

Idiopathic gout in left knee

M10.06 Idiopathic gout, lower leg

Pseudosarcomatous fibromatosis. No further information is given.

M72.4 Pseudosarcomatous fibromatosis

Paget’s disease of skull

M88.0 Paget’s disease of skull

Paget’s disease of femur

M88.85 Paget’s disease of other bones, pelvic region and thigh

Thoracogenic scoliosis

M41.3 Thoracogenic scoliosis

Cervicalgia of cervicothoracic spine

M54.23 Cervicalgia, cervicothoracic region

Rheumatoid arthritis of knees, hands and feet. Admission for total knee replacement.

M06.90 Rheumatoid arthritis, unspecified, multiple sites

Bilateral rheumatoid arthritis of joints of fingers

M06.94 Rheumatoid arthritis, unspecified, fingers

Rheumatoid arthritis of hands, knees and lumbar region of the spine

M06.90 Rheumatoid arthritis, unspecified, multiple sites

M45.X6 Ankylosing spondylitis, lumbar region

<table>
<thead>
<tr>
<th>DChS.XIII.2: Chronic versus current injuries of the musculoskeletal system and connective tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old or recurrent injuries of the musculoskeletal system and connective tissue must be assigned a code from chapter XIII Diseases of the musculoskeletal system and connective tissue.</td>
</tr>
<tr>
<td>Current injuries of the musculoskeletal system and connective tissue must be coded to chapter XIX Injury, poisoning and certain other consequences of external causes unless directed elsewhere by the Alphabetical Index or Tabular List (e.g., DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*))</td>
</tr>
<tr>
<td>If there is any doubt as to whether an injury is current or chronic/old/recurrent then confirmation must be sought from the responsible consultant.</td>
</tr>
<tr>
<td>• A joint injury where the inflammation has resolved, but then inflammation recurs is an chronic/old/recurrent injury</td>
</tr>
<tr>
<td>• Dislocations described as chronic, non-traumatic or recurrent must be coded to Chapter XIII Diseases of the musculoskeletal system and connective tissue.</td>
</tr>
<tr>
<td>• A joint injury that continues to be inflamed is still a current injury.</td>
</tr>
<tr>
<td>• A residual effect of a joint injury, such as fibrosis, indicates inappropriate healing and is considered to be a sequelae and not part of a current injury, see also DGCS.8: Sequelae or late effects.</td>
</tr>
</tbody>
</table>
Examples:

Recurrent dislocation of the elbow joint

M24.42 Recurrent dislocation and subluxation of joint, upper arm

Stress fracture of lumbar vertebra

M48.46 Fatigue fracture of vertebra, lumbar region

Coding standards and guidance

DCS.XIII.1: Juvenile arthritis (M08)

Codes in category M08.- must only be assigned where juvenile arthritis is documented in the medical record. The information in the inclusion note at category M08.- Juvenile arthritis must not be used by the coder to make this diagnosis.

Gouty nephropathy (M10.0, N16.8)

See DCS.XIV.1: Gouty nephropathy (M10.0†, N16.8*).

DCS.XIII.2: Arthrosis (M15-M19)

Terms such as ‘primary’, ‘secondary’ and ‘post-traumatic’ are used within the descriptions of four character codes in categories M15-M19 Arthrosis to describe specific forms of arthrosis of these sites. Within the ICD-10 classification these terms are essential modifiers which must be present in the clinical statement in order for the code for the specific type of arthrosis to be assigned. Where these modifiers are not included in the diagnostic statement, the default fourth character code .9 unspecified from the relevant category must be assigned.

Category M15.- Polyarthrosis must be used for arthrosis/osteoarthritis with mention of more than one site. As indicated at the excludes note at categories M15-M19, osteoarthritis of the spine is excluded from this code range (M47.- Spondylosis)

Category M15.- must not be used to code bilateral involvement of a single joint; this must be coded to categories M16–M19.

Category M19.- Other arthrosis must be used to code osteoarthritis in any site other than hip (M16.- Coxarthrosis [arthrosis of hip]), knee (M17.- Gonarthrosis [arthrosis of knee]), first carpometacarpal joint (M18.- Arthrosis of first carpometacarpal joint), or spine (M47.- Spondylosis).

It is not the responsibility of the clinical coding professional to make a clinical judgement on the type of arthrosis a patient has. The type of arthrosis is a clinical decision, and therefore the relevant information, or confirmation as to whether the condition can be described as, for example ‘primary’ or ‘post-traumatic’, must be documented in the patient’s medical record by the responsible consultant.

Examples:

Osteoarthritis (OA) left hip

M16.9 Coxarthrosis, unspecified

Secondary osteoarthritis (OA) right knee due to osteochondritis dissecans

M17.5 Other secondary gonarthrosis
M93.2 Osteochondritis dissecans
Post-traumatic OA left hip due to fracture neck of femur three years ago

- **M16.5** Other post-traumatic coxarthrosis
- **T93.1** Sequelea of fracture of femur

*See also DGCS.8: Sequela or late effects.*

Osteoarthritis of both the hip and knee

- **M15.9** Polyarthrosis, unspecified

Osteoarthritis of both knees

- **M17.9** Gonarthrosis, unspecified

**Myelopathy** is a term used within ICD-10 to indicate that the stated diagnosis is affecting the spinal cord. Myelopathy is not routinely used within the medical record, therefore where a disorder is stated to be affecting the spinal cord the coder should index the disorder and use the essential modifier ‘with myelopathy’ in order to assign an accurate code.

Displacement of an intervertebral disc is a disorder which often produces myelopathy.

**Example:**

*Intervertebral disc displacement L3-4, with spinal cord compression*

- **M51.0†** Lumbar and other intervertebral disc disorders with myelopathy (G99.2*)
- **G99.2*** Myelopathy in diseases classified elsewhere
  - Myelopathy in:
    - intervertebral disc disorders (M50.0†, M51.0†)

**M54.5 Low back pain** includes loin pain. This code must be used with caution if stated in specialties such as Renal Medicine or Urology, where it could indicate conditions such as renal colic. Coders should clarify with the responsible consultant before assigning this code to a patient admitted to a non-musculoskeletal specialty.

**DCS.XIII.3: Rhabdomyolysis (M62.8, T79.5)**

Rhabdomyolysis may result in kidney damage such as acute renal failure (acute kidney injury). Any kidney damage due to non-traumatic rhabdomyolysis must be coded in addition to **M62.8 Other specified disorders of muscle**. Renal failure due to traumatic rhabdomyolysis must be coded to **T79.5 Traumatic anuria** alone.

*See also:*
- Chapter XIV for Acute kidney injury (AKI) guidance
- DCS.XIV.2: Chronic kidney disease, CKD (N18).

**M70.- Soft tissue disorders related to use, overuse and pressure** covers soft tissue disorders related to use, overuse and pressure, which are more commonly referred to as repetitive strain injuries (RSI).

Code **Z56.6 Other physical and mental strain related to work** would be added if these conditions are confirmed to be work-related.
### DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*)

In order for a code for pathological fracture in osteoporosis (M80.- Osteoporosis with pathological fracture) or pathological fracture resulting from neoplastic disease (C00-D48† Neoplasms and M90.7* Fracture of bone in neoplastic disease) to be assigned it must be documented in the medical record that the fracture was due to osteoporosis or the neoplasm.

If a patient with osteoporosis or neoplastic disease has a fall resulting in a fracture and the fracture is not stated to be due to osteoporosis or neoplastic disease the fracture must be classified as a traumatic fracture with osteoporosis or neoplastic disease coded in addition.

**See also:**
- **DGCS.5:** The dagger and asterisk system
- **DCS.II.1:** Primary and secondary malignant neoplasms (C00-C97) - Sequencing of malignant neoplasms.

A pathological fracture is a fracture that occurs without significant external violence at a bone site weakened by pre-existing diseases such as tumours, osteomalacia, or osteoporosis.

**Examples:**

**Patient admitted with a pathological fracture of the forearm due to osteoporosis**

- M80.93 Unspecified osteoporosis with pathological fracture, forearm

**Patient admitted with fracture neck of femur after falling at home. Known osteoporosis**

- S72.00 Fracture of neck of femur, closed
- W19.0 Unspecified fall, home
- M81.9 Osteoporosis, unspecified

**See also** **DChS.XX.1:** External causes.

**Patient treated on the orthopaedic ward for a pathological fracture of the neck of femur due to osteosarcoma femur**

- M90.75* Fracture of bone in neoplastic disease (C00-D48†), pelvic region and thigh
- C40.2† Malignant neoplasm: Long bones of lower limb
Coding standards and guidance

### Renal disease due to hypertension (N00-N07, N18, N19 or N26)

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

### Rhabdomyolysis (M62.8, T79.5)

See DCS.XIII.3: Rhabdomyolysis (M62.8, T79.5)

### DCS.XIV.1: Gouty nephropathy (M10.0†, N16.8*)

Gout that is causing nephropathy must be coded as follows:

- **M10.0†** Idiopathic gout
- **N16.8** Renal tubulo-interstitial disorders in other diseases classified elsewhere

See also DGCS.5: The dagger and asterisk system.

Acute kidney injury (AKI) is the preferred term used to describe acute renal failure (ARF). When the term ‘Acute Kidney Injury’ is index trailed in ICD-10 the coder is directed to a traumatic injury code. However, in the majority of instances, the responsible consultant documenting the condition of AKI is referring to the non-traumatic condition of acute renal failure. When AKI is documented in a patient’s medical record, and it is not clear whether this is referring to a traumatic injury or acute renal failure, the coder should confirm the diagnosis with the responsible consultant before code assignment is made.

### DCS.XIV.2: Chronic kidney disease, CKD (N18)

The following must be applied when assigning codes from category **N18.- Chronic kidney disease**:

- Where chronic kidney disease (CKD) and the underlying cause are documented both conditions must be coded.

- The code assigned for the stage of CKD must reflect the stage documented in the medical record. The glomerular filtration rate (GFR) (e.g. 45mL/min) or the description of GFR change, (e.g. ‘mild decreased GFR’) must not be used by the coder to decide which stage of CKD the patient has.

- If a patient’s kidney function improves or deteriorates during the consultant episode and the stage of chronic kidney disease changes (e.g. from stage 1 to 2 or stage 2 to 1), the code reflecting the highest stage recorded in the medical record during the consultant episode must be coded (i.e. stage 2).

- **N18.9** must be assigned for a diagnosis of chronic renal failure (CRF).
When coding any condition classifiable to category N18.- Chronic kidney disease that is due to hypertension, a code from category I12.- Hypertensive renal disease (or category I13.- Hypertensive heart and renal disease if the patient also has hypertensive heart disease) must be assigned afterwards.

When coding any condition classifiable to category N18.- Chronic kidney disease in a patient with hypertension that is not due to the hypertension, a code from category I12.- must not be assigned and the hypertension must be coded separately.

Patients with CKD stages 1-3 (codes N18.1 to N18.3) are not always considered to have renal failure. When it is documented in the medical record that the patient also has renal failure this must be coded in addition.

Patients with CKD stages 4 and 5 and CKD with end stage renal failure (codes N18.4 and N18.5) are always considered to have renal failure. Whether renal failure is documented in the medical record or not it must not be coded in addition; the exception is acute renal failure which must always be coded.

The following codes must be applied for the following diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD stages 1-3 with unspecified renal failure.</td>
<td>N18.1 or N18.2 or N18.3 N19.X</td>
</tr>
<tr>
<td>CKD stages 1-3 with acute renal failure.</td>
<td>N17.- N18.1 or N18.2 or N18.3 I12.0</td>
</tr>
<tr>
<td>CKD stages 1-3 due to hypertension, with unspecified renal failure.</td>
<td>N18.1 or N18.2 or N18.3 I12.0</td>
</tr>
<tr>
<td>Acute renal failure and CKD stages 1-3 due to hypertension.</td>
<td>N17.- N18.1 or N18.2 or N18.3 I12.0</td>
</tr>
<tr>
<td>CKD stages 1-3 with unspecified renal failure. Patient has hypertension.</td>
<td>N18.1 or N18.2 or N18.3 N19.X Appropriate hypertension code</td>
</tr>
<tr>
<td>Acute renal failure and CKD stages 1-3. Patient has hypertension.</td>
<td>N17.- N18.1 or N18.2 or N18.3 Appropriate hypertension code</td>
</tr>
<tr>
<td>CKD stages 4 or 5 (including end stage renal failure/disease), with or without unspecified renal failure.</td>
<td>N18.4 or N18.5</td>
</tr>
<tr>
<td>Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease).</td>
<td>N17.- N18.4 or N18.5</td>
</tr>
<tr>
<td>CKD stages 4 or 5 (including end stage renal failure/disease) due to hypertension with or without unspecified renal failure.</td>
<td>N18.4 or N18.5 I12.0</td>
</tr>
</tbody>
</table>
## DCS.XIV.2 continued

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease) due to hypertension.</td>
<td>N17.- N18.4 or N18.5 I12.0</td>
</tr>
<tr>
<td>CKD stages 4 or 5 (including end stage renal failure/disease) with or without unspecified renal failure. Patient has hypertension.</td>
<td>N18.4 or N18.5 Appropriate hypertension code</td>
</tr>
<tr>
<td>Acute renal failure and CKD stages 4 or 5 (including end stage renal failure/disease). Patient has hypertension.</td>
<td>N17.- N18.4 or N18.5 Appropriate hypertension code</td>
</tr>
</tbody>
</table>

### See also:
- **DGCS.9**: Acute on chronic conditions
- **DCS.III.2**: Anaemia in other chronic diseases, classified elsewhere (D63.8*)
- **DCS.IX.2**: Renal disease and heart disease due to hypertension (I11, I12, I13).

Category **N18** classifies the stages of chronic kidney disease which range from stages 1 to 5. These five stages are defined by evidence of kidney damage and level of renal function as measured by glomerular filtration rate (GFR).

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

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### Renal dialysis (Z49 and Z99.2)

See **DCS.XXI.8**: Renal dialysis (Z49 and Z99.2).

### DCS.XIV.3: Calculus at the ureteropelvic junction (N20.0)

Calculus at the ureteropelvic junction must be coded using **N20.0 Calculus of kidney**.

### DCS.XIV.4: Urinary sphincter weakness incontinence (N39.3)

Urinary sphincter weakness incontinence must be coded using **N39.3 Stress incontinence**.

### DCS.XIV.5: Benign prostatic hypertrophy and urethral obstruction (N40.X)

When urethral obstruction is caused by benign prostatic hypertrophy/hyperplasia (BPH), it must not be coded in addition as it is regarded as a symptom of BPH and is therefore implicit in code **N40.X Hyperplasia of prostate**.

**Example:**

*Patient with urethral obstruction due to benign prostatic hypertrophy admitted for catheterisation to treat urinary retention*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N40.X</td>
<td>Hyperplasia of prostate</td>
</tr>
<tr>
<td>R33.X</td>
<td>Retention of urine</td>
</tr>
</tbody>
</table>
Diseases of the Genitourinary System

DCS.XIV.6: Raised Prostate Specific Antigen [PSA] (R79.8)

In the absence of a definitive diagnosis (such as benign prostatic hypertrophy or malignant neoplasm of prostate) the appropriate code for raised/elevated PSA is **R79.8 Other specified abnormal findings of blood chemistry.**

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

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

Code **D07.5 Carcinoma in situ of prostate** must be assigned for a diagnosis of high grade intraepithelial neoplasia of the prostate (HGIN) or high grade dysplasia of the prostate.

Code **N42.3 Dysplasia of prostate** must be assigned for a diagnosis of Grade I or Grade II prostatic intraepithelial neoplasia or low grade dysplasia of prostate.

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

When a patient has infertility and the cause is known, both conditions must be coded. Sequencing will depend on the main condition treated or investigated.

*See also DGCS.1: Primary diagnosis.*

**Examples:**

Azoospermia due to bilateral undescended testes, patient admitted for orchidopexy

- **Q53.2 Undescended testicle, bilateral**
- **N46.X Male infertility**

Infertility due to primary ovarian failure, patient admitted for fertility treatment

- **N97.0 Female infertility associated with anovulation**
- **E28.3 Primary ovarian failure**

DCS.XIV.9: Endometriosis (N80)

Multiple codes from category **N80.- Endometriosis** must be assigned when multiple sites of endometriosis are documented in the medical record.

- **N80.3 Endometriosis of pelvic peritoneum** must be assigned for a diagnosis of endometriosis of the broad ligament.

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

If a patient is diagnosed with more than one grade of cervical intraepithelial neoplasia (CIN), vaginal intraepithelial neoplasia (VAIN) or vulval intraepithelial neoplasia (VIN), e.g. VIN grade I-II, only the code for the highest grade must be assigned.
DCS.XIV.11: Female genital mutilation (N90.8 and Z91.6)

When it is documented in the medical record that a patient has previously undergone female genital mutilation (FGM), either as a current injury or as a historical event the following code combination must be assigned:

N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.6 Personal history of other physical trauma

If the patient is treated or investigated for another condition that has occurred as a result of FGM, a code(s) must also be assigned for the resulting condition(s). Sequencing will be dependent on the main condition treated/investigated. See also DGCS.1: Primary Diagnosis.

Female genital mutilation may also be referred to as female circumcision, infibulation or female genital cutting.

Examples:

Patient attending for reversal of genital mutilation:

N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.6 Personal history of other physical trauma

Urinary tract infection. Female genital mutilation

N39.0 Urinary tract infection, site not specified
N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.6 Personal history of other physical trauma

Vaginal stenosis complicating birth. Baby boy delivered. Previous female genital mutilation

O34.6 Maternal care for abnormality of vagina
Z37.0 Single live birth
N90.8 Other specified noninflammatory disorders of vulva and perineum
Z91.6 Personal history of other physical trauma

See also DChS.XV.1: Outcome of delivery (Z37).

DCS.XIV.12: Prolapse of vaginal vault after hysterectomy (N99.3)

It must be clear in the medical record that the vaginal prolapse is due to the previous hysterectomy in order to assign code N99.3 Prolapse of vaginal vault after hysterectomy. It is not necessary to assign an additional code from categories Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure because the nature of the procedure is implicit in the code description of N99.3.

See also DCS.XIX.7: Postprocedural complications and disorders.

Terms such as ‘posthysterectomy’ and ‘due to hysterectomy’ may be used by the responsible consultant to indicate the prolapse is due to the hysterectomy.

Trial without catheter (Z46.6)

See DCS.XXI.7: Trial without catheter (Z46.6)
CHAPTER XV
Pregnancy, Childbirth and the Puerperium
(O00–O99)

Chapter standards and guidance

DChS.XV.1: Outcome of delivery (Z37)
A code from category Z37.- Outcome of delivery must be assigned in the first secondary diagnostic position on the mother’s delivery episode only, to identify whether the delivery resulted in a liveborn or stillborn infant(s).

See also:
- DCS.XV.2: Termination of pregnancy (O04-O07) - Medical termination of pregnancy resulting in a liveborn infant
- DCS.XV.16: Maternal care for intrauterine death (O36.4).

Codes in category Z37.- Outcome of delivery must not be used on patients who have undergone termination of pregnancy or suffered a miscarriage that has resulted in the delivery of a dead fetus whilst in hospital.

See:
- DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)
- DCS.XV.2: Termination of pregnancy (O04-O07).

Example:
Spontaneous vertex delivery at term of live female infant

O80.0  Spontaneous vertex delivery
Z37.0  Single live birth

Within the ICD-10 classification the term ‘abortion’ is used to describe both ‘miscarriage’ and ‘termination of pregnancy’ and this must be considered when indexing these conditions and assigning codes from within this chapter.

Live birth is the complete expulsion or extraction from its mother of a fetus or baby, which, after such separation, breathes or shows any other evidence of life. This is irrespective of the duration of pregnancy.

Gestational age is the estimated age of the fetus, usually calculated by means of ultrasound scan. Gestational age is expressed in completed weeks. The first day is referred to as day zero and not day one: days zero to six correspond to a completed week zero, while days seven to 13 correspond to a completed week one.

Retained products of conception (RPOC) are the retention of any part of the placental tissue, membranes, gestation sac or fetal pole following miscarriage, termination or delivery of a pregnancy.

Puerperium is the 42 days following the end of the second stage of labour.
Coding Standards and guidance

**DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)**

Codes in categories O00-O03 classify ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of pregnancy.

*See DCS.XV.16: Maternal care for intrauterine death (O36.4)* for coding loss of a pregnancy after the 24th completed week of pregnancy.

**Missed miscarriage**

O02.1 Missed abortion (missed miscarriage) must only be assigned when there has been no bleeding and no products of conception have been passed. The patient may not have symptoms of miscarriage but will eventually start to bleed and physically miscarry the fetus. When bleeding is noted or products of conception are passed, this must be coded to O03.- Spontaneous abortion.

**Medical management of missed miscarriage**

When a patient with missed miscarriage is admitted to receive medication (such as 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, code O02.1 must be assigned.

This applies whether the fetus is passed during the same hospital provider spell as the administration of the medication, or if the patient is given the medication and is discharged home prior to expulsion of the fetus. If bleeding is present after administration of the medication a code from category O03.- must not be used because this is not a spontaneous miscarriage as the passing of the fetus is induced by the medication.

**Spontaneous miscarriage**

If spontaneous delivery of a non-viable fetus occurs before 24 completed weeks of gestation, the episode must be classified using a code from category O03.-.

When assigning the fourth character code with category O03 spontaneous abortion (Spontaneous miscarriage) the following must be observed:

- **Incomplete** miscarriage – the miscarriage has started, bleeding is present but not all of the fetal tissue has been passed, i.e. retained products of conception are present. The fourth character assignment is from .0-.4 depending on whether there were any maternal complications.

- **Complete** miscarriage – the pregnancy has been lost, the uterus is empty and there are no retained products of conception. The fourth character assignment is from .5-.9 depending on whether there were any maternal complications.

If a patient is readmitted with retained products of conception after a previous spontaneous miscarriage this must be coded as an incomplete spontaneous miscarriage using a code from category O03.-, with the relevant fourth character from .0 to .4. This also applies if a procedure for the retained products of conception (e.g. ERPC) was carried out on the previous spontaneous miscarriage episode, as the retained products episode is considered to be ongoing treatment of a spontaneous miscarriage.
Pregnancy, Childbirth and the Puerperium

DCS.XV.1 continued

See also:
- DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06)
- DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)
- DCS.XV.6: Haemorrhage in early pregnancy (O20)
- DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.

Miscarriage is defined as the spontaneous loss of pregnancy, by the expulsion or extraction of all or any part of a non-continuing pregnancy, including placental tissue, membranes, gestation sac and fetus, before the 24th completed week of pregnancy (i.e. up to and including 23 weeks and 6 days of gestation). Miscarriage includes all pregnancy losses from the time of conception until 24 weeks of gestation.

The term ‘miscarriage’ is used here in preference to ‘spontaneous’ or missed ‘abortion’ as this is the recommended term for use in clinical practice for the spontaneous loss of pregnancy before 24 weeks. Therefore, code O02.1 also classifies missed miscarriage and category O03.- also classifies spontaneous miscarriage.

O02.1 Missed abortion refers to what is more commonly called missed miscarriage and may also be referred to as early fetal demise, early uterine death, silent miscarriage or delayed miscarriage. It is the retention of a dead fetus before 24 completed weeks of gestation. This diagnosis is made before any bleeding has taken place, e.g. at a routine scan at the antenatal clinic or a reassurance scan.

Spontaneous abortion (O03) refers to what is more commonly called spontaneous miscarriage and is the expulsion of the baby or fetus before the 24th completed week without deliberate interference, and is a natural end to the pregnancy.

Hydatidiform mole (O01) may also be referred to as gestational trophoblastic disease.

Examples:
Patient admitted for surgical management of miscarriage following scan yesterday which confirmed the diagnosis of missed miscarriage (missed abortion)

O02.1 Missed abortion

Patient admitted for surgical management of miscarriage following scan yesterday, which confirmed a diagnosis of missed miscarriage (missed abortion). On admission patient was found to be bleeding

O03.9 Spontaneous abortion, complete or unspecified, without complication

Patient admitted for administration of 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

O02.1 Missed abortion

See also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).
DCS.XV.2: Termination of pregnancy (O04-O07)

Termination of pregnancy must be coded using a code in categories O04-O07 irrespective of gestational age (i.e. including termination of pregnancy after 24 completed weeks) and regardless of whether the baby was liveborn or stillborn.

The presence of retained products of conception (RPOC) following termination of pregnancy is considered an incomplete abortion and is coded to categories O04-O06 with the relevant fourth character of .0-.4.

Medical termination of pregnancy (O04)

Patients admitted for the administration of abortifacient drugs (for example, Mifepristone) or pessaries for termination of pregnancy must be coded using a code from category O04.- Medical abortion with the appropriate fourth character from the range .5 to .9. This includes patients who:

- are kept in hospital and abort the pregnancy whilst in hospital
- are discharged to abort the pregnancy at home
- begin to bleed before discharge home to abort the pregnancy

If after being discharged the patient is readmitted with an incomplete termination of pregnancy (retained products of conception), the primary diagnosis must be coded to O04.-, with the appropriate fourth character from the range .0 to .4.

See also:

- DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08)
- DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.

Medical termination of pregnancy resulting in a liveborn infant

In cases where a patient undergoes termination of pregnancy resulting in a live fetus where the baby has lived for any amount of time, regardless of gestational age, this must be coded as an abortion using a code from categories O04-O06. A code from category Z37.- Outcome of delivery must also be assigned in the first secondary diagnosis field to indicate that the termination of pregnancy resulted in a live birth.

Unspecified abortion

O06.- Unspecified abortion must not be used for inpatient termination of pregnancy coding as it would be expected that the patient’s medical record would contain complete documentation regarding the patient’s condition. If the type of termination of pregnancy is not documented, the coder must obtain this information from the responsible consultant.

The only circumstance in which this category is valid for use is in cases where a direct inadvertent loss of the pregnancy takes place, see DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06).

See also DCS.XV.3: Cancellation of medical termination of pregnancy.

‘Termination of pregnancy’ is the preferred term used by clinical staff when referring to ‘abortion’ within codes in categories O04-O07 and refers to ending the pregnancy by medical or surgical means resulting in the expulsion or extraction of all or any part of the pregnancy, including placental tissue, membranes, gestation sac and fetus.
Most terminations of pregnancy will take place before the 24th completed week of pregnancy. However, in certain circumstances termination may take place beyond 24 completed weeks.

**Medical abortion (O04)** is the interruption of pregnancy for legally acceptable, medically approved indications. This category includes both elective (planned) termination of pregnancy at the patient’s request, and therapeutic termination of pregnancy performed for suspected fetal abnormalities.

**Other abortion (O05)** includes illegally induced termination of pregnancy: the illegal interruption of pregnancy by any means. A coder would not be expected to use this category.

**Failed attempted abortion (O07)** includes failure of attempted induction of termination of pregnancy, either legal or illegal, and will only be used when the fetus (that is not liveborn) is still present. Fourth character subdivisions are provided with this category to identify maternal complications.

Examples:

Patient admitted to gynaecology ward to receive Mifepristone for termination of pregnancy. Discharged home prior to aborting the pregnancy. The patient has vaginal bleeding prior to discharge

- O04.9 Medical abortion, complete or unspecified, without complication

See also DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).

Patient readmitted to gynaecology ward with an incomplete abortion the day after receiving Mifepristone for termination of pregnancy

- O04.4 Medical abortion, incomplete, without complication

Medical abortion due to spina bifida in fetus. Baby was born with a heartbeat and lived for 15 minutes.

- O04.9 Medical abortion, complete or unspecified, without complication
- Z37.0 Single live birth
- O35.0 Maternal care for (suspected) central nervous system malformation in fetus

**DCS.XV.3: Cancellation of medical termination of pregnancy**

Patients admitted for a medical termination of pregnancy who change their mind resulting in cancellation of the planned procedure must be coded as follows:

Where the patient has no other conditions present which are classifiable to Chapter XV Pregnancy, childbirth and the puerperium or category **Z35.- Supervision of high-risk pregnancy** the following codes and sequencing must be used:

- Z34.- Supervision of normal pregnancy
- Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons.

When the reason for the termination of pregnancy is because of a current pregnancy-related condition classifiable to Chapter XV Pregnancy, childbirth and the puerperium the following codes and sequencing must be used:

- Code from categories O10-O45 or categories O98-O99 that classifies the pregnancy related condition
- Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons.
### DCS.XV.3 continued

When the reason for the termination of pregnancy is because of a **history** of a pregnancy-related condition that is classifiable to categories **O10-O92** the following codes and sequencing must be used:

- **Z35.2** Supervision of pregnancy with other poor reproductive or obstetric history
- **Z53.2** Procedure not carried out because of patient’s decision for other and unspecified reasons.

When the reason for the termination of pregnancy is because the pregnancy is considered to be high risk (e.g. the patient is an elderly primigravida, or because of a social problem, etc) the following codes and sequencing must be used:

- **Z35.-** Supervision of high-risk pregnancy
- **Z53.2** Procedure not carried out because of patient’s decision for other and unspecified reasons.

**See also:**
- **DCS.XV.34**: Supervision of normal pregnancy (Z34)
- **DCS.XXI.11**: Cancelled procedures and abandoned procedures (Z53).

### Examples:

**Patient admitted at 15 weeks gestation for surgical termination of pregnancy due to suspected damage to the fetus by maternal heroin addiction. Following admission, the patient changes her mind and the planned procedure is cancelled.**

- **O35.5** Maternal care for (suspected) damage to fetus by drugs
- **Z53.2** Procedure not carried out because of patient’s decision for other and unspecified reasons
- **O99.3** Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium
- **F11.2** Mental and behavioural disorders due to use of opioids, dependence syndrome

**Patient admitted for a termination of pregnancy due to a history of severe pre-eclampsia. Following discussions with the responsible consultants, the patient decides to continue with the pregnancy and the planned procedure is cancelled.**

- **Z35.2** Supervision of pregnancy with other poor reproductive or obstetric history
- **Z53.2** Procedure not carried out because of patient’s decision for other and unspecified reasons

### DCS.XV.4: Inadvertent loss of pregnancy (O03 and O06)

Inadvertent or unintentional loss of pregnancy must be coded as follows:

#### Inadvertent loss of pregnancy due to direct cause

When a patient undergoes uterine surgery, e.g. hysterectomy, for a known or suspected condition, and the pregnancy is unavoidably terminated due to the nature of the procedure a code from category **O06.- Unspecified abortion** must be assigned in addition to the code for the disorder that is the reason for the uterine surgery.
Inadvertent loss of pregnancy due to indirect cause

When a patient is known to be pregnant but requires surgery, not on the uterus, for a life-threatening (or other) condition, the treatment of which cannot be postponed and the patient experiences a spontaneous miscarriage as a result of this treatment a code from category O03.- *Spontaneous abortion* must be assigned in addition to the code for the disorder that is the reason for the surgery.

Examples:

*Patient with fibroid uterus undergoes hysterectomy. The patient is found to be pregnant during the procedure and the pregnancy is inadvertently lost.*

- D25.9 Leiomyoma of uterus, unspecified
- O06.9 Unspecified abortion, complete or unspecified, without complication

*Patient 15 weeks pregnant with acute appendicitis undergoes appendicectomy. Complete spontaneous miscarriage occurs the next day.*

- K35.8 Acute appendicitis, other and unspecified
- O03.9 Spontaneous abortion, complete or unspecified, without complication

Codes in category O08.- *Complications following abortion and ectopic and molar pregnancy* must not be used in a primary position except where there is a new consultant episode or hospital provider spell in which the patient primarily receives treatment of the complication, e.g. a current complication of a previous termination of pregnancy or miscarriage.

Codes in category O08.- are used as additional codes with categories O00–O02 to identify associated complications, and with categories O03–O07 to give further information about the complication.

There are three types of complications associated with ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy. These must be coded as follows. *See also DFigure.XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy.*

### Maternal complications of ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (abortion)

These are conditions affecting the mother which cause, result from, or are otherwise associated with the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy. Code assignment is dependent upon when the complication occurred.

### Maternal complications associated with and occurring during the same consultant episode as the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy

- Assign a code from O00–O02 or O03–O07 and a code from category O08.- to identify any associated complications. If the complication is stated at four character level at O03-O07 a code from category O08.- is not required.
Pregnancy-related complications occurring during the same 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, must not be coded using a code from category O08. A different code describing the complication from chapter XV must be assigned.

Maternal complications occurring in a subsequent consultant episode to that in which the ectopic pregnancy, molar pregnancy, miscarriage or termination of pregnancy occurred where there are no retained products of conception.

- Assign a code from category O08.- Complications following abortion and ectopic and molar pregnancy.

**See:**

- **DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)** for coding of retained products of conception after previous spontaneous miscarriage

- **DCS.XV.2: Termination of pregnancy (O04-O07) – Medical termination of pregnancy (O04)** for coding retained products of conception after previous medical termination of pregnancy.

### Known or suspected fetal complication as the reason for termination of pregnancy (abortion)

- Assign a code for the termination of pregnancy itself (O04–O07) as the primary diagnosis.

- Assign a code from categories O30-O48 Maternal care related to the fetus and amniotic cavity and possible delivery problems describing the disorder affecting the fetus.

### Known or suspected fetal complications as the reason for termination of pregnancy and maternal complications of the termination occurring during the same consultant episode.

Codes for both types of complication must be assigned as follows:

- Assign a code for the termination of pregnancy itself (O04–O07) as the primary diagnosis.

- Assign a code from categories O30-O48 Maternal care related to the fetus and amniotic cavity and possible delivery problems describing the disorder affecting the fetus.

Assign a code from category O08.- to give further information about the maternal complication if it is not stated at the fourth character level in the termination code (O04-O07)

A table of complications is shown in the Alphabetical Index under the term Abortion, complicated (by). This table identifies the fourth character subdivisions to be used for miscarriages and terminations of pregnancy as follows:

### Miscarriage

- First column identifies the fourth character to be used with category O03, when complete or unspecified.

- Second column identifies the fourth character to be used with category O03, when incomplete.
Termination of pregnancy

- First column identifies the fourth character to be used with categories O04–O06, when complete or unspecified.
- Second column identifies the fourth character to be used with categories O04–O06, when incomplete.
- Third column identifies the fourth character to be used with category O08.

Examples:

**Pelvic peritonitis due to streptococcus B following a tubal pregnancy. Same consultant episode as tubal pregnancy**

- O00.1 Tubal pregnancy
- O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
- B95.1 Streptococcus, group B, as the cause of disease classified to other chapters

*See also DGCS.6: Infections and sepsis.*

**Incomplete spontaneous miscarriage with pelvic peritonitis during same consultant episode**

- O03.0 Spontaneous abortion, incomplete, complicated by genital tract and pelvic infection

**Complete spontaneous miscarriage with renal failure in the same consultant episode as the miscarriage**

- O03.8 Spontaneous abortion, complete or unspecified, with other and unspecified complications
- O08.4 Renal failure following abortion and ectopic and molar pregnancy

**Incomplete spontaneous miscarriage with excessive haemorrhage, the patient is also treated for mild pre-eclampsia during the same consultant episode.**

- O03.1 Spontaneous abortion, incomplete, complicated by delayed or excessive haemorrhage
- O13.X Gestational [pregnancy-induced] hypertension without significant proteinuria

**Patient admitted with severe pre-eclampsia, and during this consultant episode an incomplete miscarriage also occurred.**

- O14.1 Severe pre-eclampsia
- O03.4 Spontaneous abortion, incomplete, without complication

**Patient re-admitted with pelvic peritonitis following a medical termination of pregnancy performed five days previously. No retained products of conception present.**

- O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy

**Complete termination of pregnancy because the fetus was affected by spina bifida.**

- O04.9 Medical abortion, complete or unspecified, without complication
- O35.0 Maternal care for (suspected) central nervous system malformation in fetus
Complete termination of pregnancy at 16 weeks due to suspected damage to fetus due to maternal rubella at five weeks gestation.

- O04.9 Medical abortion, complete or unspecified, without complication
- O35.3 Maternal care for (suspected) damage to fetus from viral disease in mother

Complete termination of pregnancy complicated by renal failure. Termination of pregnancy performed because the fetus was affected by Down’s Syndrome.

- O04.8 Medical abortion, complete or unspecified, with other and unspecified complications
- O35.1 Maternal care for (suspected) chromosomal abnormality in fetus
- O08.4 Renal failure following abortion and ectopic and molar pregnancy
Figure XV.1: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy

Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (TOP)

- Maternal complications of ectopic pregnancy, molar pregnancy, miscarriage and TOP
- Fetal complications as the reason for TOP
- Fetal complications as the reason for TOP and maternal complications of the TOP occurring in the same consultant episode

Maternal complications occurring during the same consultant episode as:
- Ectopic pregnancy, molar pregnancy or miscarriage O00-O03
- Termination of pregnancy O04-O07
- Retained products of conception (RPOC), after previous medical TOP
- Medical TOP episode O04 with 4th character from .5 to .9
- Spontaneous miscarriage episode O03 with 4th character from .0 to .4

Maternal complications occurring on a subsequent consultant episode
- + code for the fetal complication
- No retained products of conception (RPOC) following previous miscarriage or TOP
- + code for the fetal complication

Fetal complications as the reason for TOP and maternal complications of the TOP occurring in the same consultant episode
- + code for the fetal complication
- No retained products of conception (RPOC) following previous miscarriage or TOP

See:
- DCS.XV.1: Ectopic pregnancy, molar pregnancy and miscarriage before 24 completed weeks of gestation (O00-O03)
- DCS.XV.2: Termination of pregnancy (O04-O07)
- DCS.XV.5: Complications following ectopic pregnancy, molar pregnancy, miscarriage and termination of pregnancy (O08).
DCS.XV.6: Haemorrhage in early pregnancy (O20)

Codes in category **O20.- Haemorrhage in early pregnancy** must be used for any vaginal bleeding before 24 completed weeks of gestation, except when the pregnancy proceeds to abortive outcome when a code from categories **O00-O08 Pregnancy with abortive outcome** must be used instead.

If a threatened miscarriage (O20.0 Threatened abortion) proceeds to miscarriage then this must be coded to **O03.- Spontaneous abortion**.

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DCS.XV.7: Excessive vomiting in pregnancy (O21)

Codes in category **O21.- Excessive vomiting in pregnancy** must only be coded when the patient has been admitted because of, or is being treated for, the vomiting.

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DCS.XV.8: Vaginal thrush in pregnancy (O23.5, B37.3† and N77.1*)

Vaginal thrush in pregnancy is coded using the following codes and sequencing:

- **O23.5** Infections of the genital tract in pregnancy
- **B37.3†** Candidiasis of vulva and vagina
- **N77.1*** Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere.

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

Diabetes mellitus in pregnancy, childbirth and the puerperium must always be coded using a code from category **O24.- Diabetes mellitus in pregnancy**.

If the diabetes is causing manifestations these must be coded in addition. Where appropriate a dagger and asterisk combination will be used.

**See also:**
- **DGCS.5: The dagger and asterisk system**
- **DCS.IV.1: Diabetes mellitus (E10-E14).**

**Example:**

Patient 30 weeks pregnant admitted for control of pre-existing Type I diabetes. Patient also has diabetic neuropathy.

- **O24.0†** Pre-existing diabetes mellitus, insulin-dependent
- **G63.8*** Polyneuropathy in other diseases classified elsewhere

Code **G63.8* must be assigned instead of G63.2* Diabetic polyneuropathy (E10–E14† with common fourth character .4) because G63.2* can only be assigned with codes E10–E14† with common fourth character .4 as indicated in the code description.
DCS.XV.10: Maternal care for other conditions predominantly related to pregnancy (O26)

Conditions that are pregnancy induced that are not classified elsewhere within chapter XV must be coded using a code from category O26.- Maternal care for other conditions predominantly related to pregnancy. A further code to identify the pregnancy induced condition must be assigned in addition. This includes signs or symptoms from chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, that are specifically caused by the pregnancy, that are not symptoms of a specific condition.

The exception to this is when coding obstetric cholestasis (cholestasis of pregnancy, intrahepatic cholestasis of pregnancy) using code O26.6 Liver disorders in pregnancy, childbirth and the puerperium. As cholestasis is an explicit inclusion at code O26.6, it is not necessary to assign a code from Chapter XI in addition.

Conditions that complicate the pregnant state, are aggravated by the pregnancy, or are a main reason for obstetric care (this includes pre-existing conditions) not classified elsewhere within chapter XV must be coded using a code from category O99 Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium, see DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99).

Examples:

Lumbar backache due to pregnancy. Patient 30 weeks pregnant. No previous history of backache.

- O26.8 Other specified pregnancy-related conditions
- M54.96 Dorsalgia, unspecified, lumbar region

High blood pressure reading (not diagnosed as hypertension) in pregnant patient. 15 weeks gestation.

- O26.8 Other specified pregnancy-related conditions
- R03.0 Elevated blood pressure reading, without diagnosis of hypertension

DCS.XV.11: Abnormal findings on antenatal screening of mother (O28)

Codes in this category must only be used when an abnormal finding does not result in a definitive diagnosis.

DCS.XV.12: Pregnancy of unknown location (O28.1)

A diagnosis of pregnancy of unknown location (PUL) must be coded to O28.1 Abnormal biochemical finding on antenatal screening of mother unless a more specific diagnosis, such as ectopic pregnancy, is made.

In pregnancy of unknown location (PUL) there is a positive pregnancy test but on scanning there is no sign of a pregnancy inside or outside of the uterus. The serum human chorionic gonadotropin (hCG; a hormone produced during pregnancy) levels are rising or persisting, but no evidence of the pregnancy can be found. In most cases PUL will result in disappearance of the pregnancy. However, PUL may also result in progression to confirmation of normal intrauterine or ectopic pregnancy, or ‘persisting PUL’ (which is defined as PUL where the hCG levels don’t decrease, there are no signs of trophoblastic disease, and the location of the pregnancy cannot be identified).
### DCS.XV.13: Complications of anaesthesia during pregnancy, labour, delivery and the puerperium (O29, O74, O89)

When coding complications of anaesthesia in categories **O29.- Complications of anaesthesia during pregnancy**, **O74.- Complications of anaesthesia during labour and delivery** and **O89.- Complications of anaesthesia during the puerperium** code assignment must reflect the time the anaesthesia was administered, and not the time when the complication(s) arose.

**Example:**

Patient admitted for elective caesarean section under epidural anaesthesia for disproportion. Epidural anaesthesia induced severe headache. Baby boy born

- O33.9 Maternal care for disproportion, unspecified
- Z37.0 Single live birth
- O29.4 Spinal and epidural anaesthesia-induced headache during pregnancy

### DCS.XV.14: Multiple gestation (O30)

When recording an episode with a normal multiple delivery, a code from category **O30.- Multiple gestation** must be recorded as the primary diagnosis, unless the patient has a condition classified to another code from Chapter XV on the delivery episode, in which case the appropriate code from category **O30.-** must be recorded in a secondary position.

**See also** DCS.XV.28: Delivery (O80–O84).

**Example:**

Patient admitted for delivery of triplets. During delivery she sustains a second degree perineal laceration. (All babies liveborn).

- O70.1 Second degree perineal laceration during delivery
- Z37.5 Other multiple births all liveborn
- O30.1 Triplet pregnancy

### DCS.XV.15: Maternal care for known or suspected malpresentation of fetus, disproportion and abnormality of pelvic organs (O32–O34) and Obstructed labour (O64–O66)

Codes in categories **O32-O34** are assigned when the listed condition is a reason for observation, hospitalisation or other obstetric care of the mother or for caesarean section, at any point during pregnancy, labour or delivery.

If a condition in categories **O32-O34** is diagnosed during labour the code from these categories must still be assigned, unless the responsible consultant confirms that the labour is obstructed or if the ICD-10 index trail directs the coder to an obstructed labour code, in which case a code from categories **O64–O66** must be used instead.

**See also:**

- DCS.XV.23: Face to pubes presentation (O64.0)
- DCS.XV.24: Failed trial of labour, unspecified (O66.4) and Failed application of vacuum extractor and forceps, unspecified (O66.5)
Obstructed labour means that, in spite of strong contractions of the uterus, the fetus cannot descend through the pelvis because there is an insurmountable barrier preventing its descent. The term ‘obstructed labour’ does not apply to a presumption of the likelihood of obstruction. It can only be clinically applied retrospectively after an attempt at vaginal delivery has occurred and has been unsuccessful.

In developed countries such as the UK, where standards of healthcare are high, it is unlikely that a pregnant woman with an earlier diagnosed mechanical problem will be allowed by an obstetrician to attempt a vaginal delivery. Therefore one would expect that the ICD-10 codes from categories O64-O66 would be used much less frequently in the UK than the codes from categories O32-O34.

Examples:

**Breech extraction of baby girl with version for transverse lie**

- O32.2 Maternal care for transverse and oblique lie
- Z37.0 Single live birth

Patient was booked for an elective lower segment caesarean section (ELSCS) for breech presentation. Two days prior to the booked admission the patient was admitted in first stage of labour and a lower caesarean section was performed and a baby girl was born.

- O32.1 Maternal care for breech presentation
- Z37.0 Single live birth

Obstructed labour due to a fetopelvic disproportion caused by mother’s deformed pelvis, emergency caesarean section performed. Baby boy born.

- O65.0 Obstructed labour due to deformed pelvis
- Z37.0 Single live birth

Dystocia due to oversized fetus – emergency caesarean section delivery of baby girl.

- O66.2 Obstructed labour due to unusually large fetus
- Z37.0 Single live birth

### DCS.XV.16: Maternal care for intrauterine death (O36.4)

The code **O36.4 Maternal care for intrauterine death** must be assigned for stillbirths and late intrauterine fetal deaths, where it is known before delivery that the fetus has no signs of life. If the cause of death is known, code **O36.4** must be assigned in a secondary position to the code(s) which describes the cause of death of the fetus.

A code from category **Z37.- Outcome of delivery** indicating that the outcome of delivery was a stillbirth must be assigned in the first secondary position on all stillbirth and late intrauterine fetal death episodes.

If it is not known prior to delivery that there is a stillbirth or that intrauterine fetal death has occurred, the code **O36.4** must not be recorded and a different code from chapter XV must be used. A code from **Z37.-** would still be assigned to indicate that the outcome of delivery was a stillbirth.

**See also DChS.XV.1: Outcome of delivery (Z37).**

Stillbirth is defined as ‘a baby delivered with no signs of life, known to have died after 24 completed weeks of pregnancy’. Late Intrauterine fetal death refers to babies with no signs of life in utero after 24 completed weeks of pregnancy.
Examples:
Antenatal scan at 28 weeks due to vaginal haemorrhage reveals placenta praevia and fetal death, patient proceeds to deliver stillborn infant.

- O44.1 Placenta praevia with haemorrhage
- Z37.1 Single stillbirth
- O36.4 Maternal care for intrauterine death

Delivery at 39 weeks because of fetal hypoxia, baby born dead.

- O36.3 Maternal care for signs of fetal hypoxia
- Z37.1 Single stillbirth

**DCS.XV.17: Reduced fetal movements (O36.8)**

The correct code for a patient admitted with reduced fetal movements is **O36.8 Maternal care for other specified fetal problems**.

Reduced fetal movements is often documented as \(\nabla\)FM or DFM in the medical record.

**DCS.XV.18: Premature rupture of membranes (O42)**

A code from category **O42.- Premature rupture of membranes** must only be assigned for premature rupture of membranes before the onset of labour, regardless of the length of gestation.

**DCS.XV.19: Morbidly adherent placenta (O43.2)**

Code **O43.2 Morbidly adherent placenta** must be assigned following **O72.0 Third-stage haemorrhage** or **O73.0 Retained placenta without haemorrhage** when both conditions are documented in the medical record.

**O46 Antepartum haemorrhage, not elsewhere classified** classifies a haemorrhage after 24 completed weeks of gestation but before labour.

*See also DCS.XV.25: Postpartum haemorrhage (O72).*

False labour (O47) is a common condition which may also be known as ‘Braxton-Hicks’ contractions.

**DCS.XV.20: Prolonged pregnancy (O48.X)**

Codes in category **O48.X Prolonged pregnancy** must be used when the pregnancy exceeds 42 weeks or if the responsible consultant documents in the medical record that the patient is ‘post-term’, or ‘post-dates’.

**DCS.XV.21: Preterm labour and delivery (O60)**

A code from this category is used if the labour is spontaneous or induced and if delivery is vaginal or surgical all before 37 completed weeks of gestation.

Codes in this category must be used as follows:

- **O60.0 Preterm labour without delivery**

Assign for patients who are admitted in preterm labour which stops and are sent home to await further events.
For patients with a normal pregnancy admitted in the early stages of term labour (with contractions) who are subsequently discharged and told to return when the contractions become more established, see DCS.XV.34: Supervision of normal pregnancy (Z34).

**O60.1 Preterm spontaneous labour with preterm delivery**
Assign for patients who are admitted in preterm labour and go on to deliver a preterm baby by any means.

**O60.2 Preterm spontaneous labour with term delivery**
Assign for patients who deliver to term but who at some point, during the current pregnancy, have been admitted in spontaneous preterm labour 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.

When the patient has gone home in between the preterm labour stopping and the term delivery, this code must only be assigned on the delivery episode if it is documented in the medical record that they were previously admitted in preterm labour.

**O60.3 Preterm delivery without spontaneous labour**
Assign when the patient or the fetus has a condition which requires either an induced preterm delivery or caesarean section preterm delivery. This code must be used in addition to the code describing the condition prompting the preterm delivery.

It may be necessary to assign more than one code from this category when the delivery admission contains multiple consultant episodes.

**Examples:**
*Mother readmitted in active labour at 37+1 weeks gestation goes on to deliver term baby boy in hospital. Was admitted 4 days previously in spontaneous preterm labour and given Atosiban acetate to delay delivery.*

**O60.2 Preterm spontaneous labour with term delivery**

**Z37.0 Single live birth**

*Mother with severe pre-eclampsia admitted at 35 weeks for delivery of a baby boy by caesarean section.*

**O14.1 Severe pre-eclampsia**

**Z37.0 Single live birth**

**O60.3 Preterm delivery without spontaneous labour**

**DCS.XV.22: Long labour (O63)**

It must be documented in the medical record that the labour or stage of labour is prolonged/long for this category to be used. If the reason for the prolonged/long labour is stated, then this must be coded instead.

There are no guidelines for the length of time constituting a long/prolonged labour.
DCS.XV.23: Face to pubes presentation (O64.0)

Face to pubes presentation must only be coded using O64.0 Obstructed labour due to incomplete rotation of fetal head when it is confirmed to have caused obstructed labour. See also DCS.XV.15: Maternal care for known or suspected malpresentation of fetus, disproportion and abnormality of pelvic organs (O32–O34) and Obstructed labour (O64-O66).

DCS.XV.24: Failed trial of labour, unspecified (O66.4) and Failed application of vacuum extractor and forceps, unspecified (O66.5)

Codes O66.4 Failed trial of labour, unspecified and O66.5 Failed application of vacuum extractor and forceps, unspecified must not be used if the condition giving rise to the intervention is known.

Example:

Caesarean section performed after failed application of forceps following prolonged second stage of labour due to cephalopelvic disproportion. Baby boy born.

O65.4 Obstructed labour due to fetopelvic disproportion, unspecified
Z37.0 Single live birth

DCS.XV.25: Postpartum haemorrhage (O72)

Codes in category O72.- Postpartum haemorrhage must only be coded when documented as such in the patient’s medical record by the responsible consultant.

The levels of blood loss must not be interpreted by the coder in order to decide if the levels constitute a diagnosis of postpartum haemorrhage. The responsible consultant must always be consulted to confirm the clinical significance of a high level of blood loss if a diagnosis of postpartum haemorrhage has not been specifically documented in the medical record.

See also:
- DGCS.4: Using diagnostic test results
- DCS.XV.19: Morbidly adherent placenta (O43.2).

O72.1 Other immediate postpartum haemorrhage is one occurring up to 24 hours following delivery.

O72.2 Delayed and secondary postpartum haemorrhage is one occurring more than 24 hours following delivery.

DCS.XV.26: Delayed delivery (O75.5, O75.6)

It must be stated in the medical record that the delivery was delayed for either code O75.5 Delayed delivery after artificial rupture of membranes or O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes to be assigned.

There are no guidelines for the length of time constituting a delayed delivery.

DCS.XV.27: Vaginal delivery following previous caesarean section (O75.7)

If it is documented in the patient’s medical record that the mother has delivered vaginally following a previous caesarean section (regardless of how far in the past that caesarean section was), code O75.7 Vaginal delivery following previous caesarean section must be assigned, in either a primary or secondary position.
DCS.XV.28: Delivery (O80–O84)

Codes in categories O80–O84 Delivery must only be used when the only information recorded is a statement of ‘delivery’ or when only the method of delivery has been recorded and the patient has no other conditions classifiable to Chapter XV.

In the case of multiple births, a code from O84.- Multiple delivery must not be used. A code from category O30.- Multiple gestation must be assigned instead.

See also DCS.XV.14: Multiple gestation (O30).

It is not expected that any codes other than O80.0 Spontaneous vertex delivery and O82.0 Delivery by elective caesarean section would be assigned from the codes in this block (O80-O84). Any other code from this block would only be used in the rare event when no mention of reason for the method of delivery is given.

Examples:

Spontaneous vertex delivery of baby girl, first degree tear left unsutured

- O70.0 First degree perineal laceration during delivery
- Z37.0 Single live birth

Spontaneous vertex delivery of baby girl at 39 weeks, with episiotomy

- O80.0 Spontaneous vertex delivery
- Z37.0 Single live birth

Caesarean section performed at patient’s request. Patient has no medical/clinical reason for the caesarean section to be performed. Baby boy born

- O82.0 Delivery by elective caesarean section
- Z37.0 Single live birth

DCS.XV.29: Obstetric death (O95-O97)

Codes in categories O95–O97 must not be used for morbidity coding.

DCS.XV.30: Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium (O98.7)

Code O98.7 Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium must be assigned whenever a patient with HIV is admitted during pregnancy, childbirth and the puerperium as HIV always complicates pregnancy.

For patients with symptomatic (active) HIV – assign an additional code from categories B20-B24 Human immunodeficiency virus [HIV] disease in a secondary position.

For patients with asymptomatic (non-active or HIV positive) HIV – assign the code Z21.X Asymptomatic human immunodeficiency virus [HIV] infection status in a secondary position.

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

Example:

Baby delivered by elective caesarean section because the mother has symptomatic (active) HIV

- O98.7 Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium
- Z37.0 Single live birth
- B24.X Unspecified human immunodeficiency virus [HIV] disease
DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99)

Conditions that complicate the pregnant state, are aggravated by the pregnancy, or are a main reason for obstetric care (this includes pre-existing conditions) which are not classified elsewhere within chapter XV must be coded using a code from category O99.- Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium. An additional code must be used to identify the specific condition where it adds information.

Where a pregnant patient has a condition which is present but is not complicating the pregnant state, aggravating the pregnancy, or the main reason for obstetric care a code from O99.- must not be used, only a code for the condition is assigned.

Conditions that are pregnancy induced and are not classified elsewhere within chapter XV must be coded using a code from category O26.- Maternal care for other conditions predominantly related to pregnancy, see DCS.XV.10: Maternal care for other conditions predominantly related to pregnancy (O26).

See also DCS.XV.32: Anaemia complicating pregnancy, childbirth and the puerperium (O99.0).

Examples:
Spontaneous vertex delivery of baby boy at 38 weeks. Asthma attack immediately following delivery. Diagnosed with asthma two years ago. On Ventolin.

- O99.5 Diseases of the respiratory system complicating pregnancy, childbirth and the puerperum
- Z37.0 Single live birth
- J45.9 Asthma, unspecified

Spontaneous vertex delivery of baby boy at 38 weeks. Patient is asthmatic, takes Ventolin as required.

- O80.0 Spontaneous vertex delivery
- Z37.0 Single live birth
- J45.9 Asthma, unspecified

DCS.XV.32: Anaemia complicating pregnancy, childbirth and the puerperium (O99.0)

O99.0 Anaemia complicating pregnancy, childbirth and the puerperum must only be assigned when it is documented in the medical record that the patient has anaemia complicating pregnancy, childbirth or the puerperium. Statements such as ‘low Hb’ or ‘sent home on iron tablets’ must not be used as an indication that this code should be used.

An additional code from the range D50–D64.8 must be used if the type of anaemia is known.

See also DCS.XV.31: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium (O99).

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

Code Z33.X Pregnant state, incidental must never be used in a primary position. Z33.X is only assigned in a secondary position when a pregnant patient is treated for an unrelated condition that does not affect or complicate the management of the pregnancy.
Examples:
Sprained ankle. Tripped and fell over cat at home. Patient 26 weeks pregnant.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S93.4</td>
<td>Sprain and strain of ankle</td>
</tr>
<tr>
<td>W01.0</td>
<td>Fall on same level from slipping, tripping and stumbling, home</td>
</tr>
<tr>
<td>Z33.X</td>
<td>Pregnant state, incidental</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R10.3</td>
<td>Pain localized to other parts of lower abdomen</td>
</tr>
<tr>
<td>Z33.X</td>
<td>Pregnant state, incidental</td>
</tr>
</tbody>
</table>

**DCS.XV.34: Supervision of normal pregnancy (Z34)**

A code from category **Z34.- Supervision of normal pregnancy** must be assigned for patients who are:

- admitted for a suspected problem related to the pregnancy where on further examination no abnormality relating to the pregnancy is found
- and
- they have not received treatment or investigation for any other condition that is classifiable to Chapter XV.

Codes in this category must also be used for patients with a normal pregnancy admitted in the early stages of term labour (with contractions) who are subsequently discharged and told to return when the contractions become more established. If the responsible consultant confirms that the patient is in preterm labour and they are sent home to await further events code **O60.0 Preterm labour without delivery** must be used instead, see **DCS.XV.21: Preterm labour and delivery (O60)**.

Codes in category **Z34.- Supervision of normal pregnancy** must not be assigned when the responsible consultant has made a diagnosis of Braxton-Hicks contractions or false labour, which are classified to category **O47.- False labour**.

*See also DCS.XV.3: Cancellation of medical termination of pregnancy.*

**Grand multiparity (Z35.4 Supervision of pregnancy with grand multiparity)** is a woman who has given birth to five or more infants, alive or dead.

Elderly primigravida (Z35.5 Supervision of elderly primigravida) is a woman pregnant for the first time who is more than 35 years of age.

There is no nationally recognised age for a very young primigravida (Z35.6 Supervision of very young primigravida). The coder should seek advice from the responsible consultant before assigning this code.

*See also DCS.XV.3: Cancellation of medical termination of pregnancy.*

**DCS.XV.35: Care and examination immediately after delivery (Z39.0)**

**Z39.0 Care and examination immediately after delivery** must be assigned for patients who have given birth outside of hospital and are admitted for a postpartum check and no complications are found. If any complications are found on examination a different code from chapter XV must be assigned instead.
Example:
Admission following delivery en route to hospital. Mother’s record.

Z39.0 Care and examination immediately after delivery

<table>
<thead>
<tr>
<th>Female genital mutilation (N90.8 and Z91.6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>See DCS.XIV.11: Female genital mutilation (N90.8 and Z91.6).</td>
</tr>
</tbody>
</table>
Chapter standards and guidance

DChS.XVI.1: Liveborn infants according to place of birth (Z38)

A code from category Z38.- Liveborn infants according to place of birth must always be coded on the birth episode for every liveborn infant and be sequenced as follows:

- If the baby is a completely well baby and has no morbid conditions that have been treated or investigated a code from Z38.- must be assigned as the primary diagnosis
- If the baby is not completely well and a morbid condition(s) is present which has been treated or investigated a code from Z38.- must be assigned in the first secondary position.

Examples:

Baby born in hospital with untreated jaundice developed a skin infection which was treated with antibiotics

P39.4 Neonatal skin infection
Z38.0 Singleton, born in hospital
P59.9 Neonatal jaundice, unspecified

Newborn born in hospital, noted to have a birthmark on their right buttock, but no treatment given or further investigations carried out

Z38.0 Singleton, born in hospital
Q82.5 Congenital non-neoplastic naevus

DChS.XVI.2: Coding perinatal conditions

The perinatal period must be regarded as the period before birth through to the 27th day, 23rd hour and 59th minute of life, i.e. the period before the start of the 28th day.

A code from chapter XVI Certain conditions originating in the perinatal period must only be assigned for conditions that originate in the perinatal period.

Where a condition arises in the perinatal period it must be coded to chapter XVI even when the condition persists beyond the perinatal period. A code from outside chapter XVI must also be assigned where this provides additional information about the condition which is not contained in the code from chapter XVI.
This excludes conditions classified to the following codes. When a condition classified to these codes arises in the perinatal period only a code from these chapters or categories is required:

- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Endocrine, nutritional and metabolic diseases (E00-E90)
- Injury, poisoning, and certain other consequences of external causes (S00-T98)
- Neoplasms (C00-D48)
- Tetanus neonatorum (A33)
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

**Examples:**

**Newborn born in hospital with neonatal hypertension**

- P29.2 Neonatal hypertension
- Z38.0 Singleton, born in hospital

**Newborn born in hospital, noted to be jittery. Following investigation the jitteriness subsided and baby and mother were discharged home**

- R25.8 Other and unspecified abnormal involuntary movements
- Z38.0 Singleton, born in hospital

*See also DCS.XVI.8: Jittery baby (R25.8).*

**Newborn born in hospital with thrombosis of left superficial femoral artery**

- P29.8 Other cardiovascular disorders originating in the perinatal period
- Z38.0 Singleton, born in hospital
- I74.3 Embolism and thrombosis of arteries of lower extremities

**Coding standards and guidance**

**DCS.XVI.1: Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04)**

Codes in categories **P00-P04 Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery** must be assigned when the underlying maternal cause or the external cause for a baby’s morbid condition is known. They must be sequenced in a secondary position to the code that classifies the morbid condition.

Codes in **P00-P04** must never be used in the primary diagnosis position except when the baby is stillborn and the cause is known.

*See also DCS.XVI.7: Stillbirths (P95.X).*

**Example:**

**Baby born in hospital with severe birth asphyxia due to cord tightly around neck**

- P21.0 Severe birth asphyxia
- Z38.0 Singleton, born in hospital
- P02.5 Fetus and newborn affected by other compression of umbilical cord
### DCS.XVI.2: Disorders related to length of gestation and fetal growth (P05-P08)

If both the birth weight and gestational age are known when assigning codes from categories **P07.- Disorders related to short gestation and low birth weight, not elsewhere classified** and **P08.- Disorders related to long gestation and high birth weight**, two codes from the same category must be assigned to classify both the weight and the gestational age, and the birth weight code must be sequenced before the code for the gestational age.

When a condition(s) classified to categories **P07.-** or **P08.-** and a condition(s) classified to category **P05.- Slow fetal growth and fetal malnutrition** are present, codes from both categories must be assigned. The exclusion note at category **P07.-** does not preclude this.

The codes at **P05.-** can apply to infants of premature, normal or long gestation who have slow fetal growth or fetal malnourishment with or without being small or light for gestational age.

Category **P07.-** classifies premature births and/or low birth weight.

Category **P08.-** classifies post term births and/or high birth weight.

**Example:**

Premature infant born at 34 weeks in hospital weighing 2100gms and is small for dates

- P07.1 Other low birth weight
- Z38.0 Singleton, born in hospital
- P07.3 Other preterm infants
- P05.1 Small for gestational age

### DCS.XVI.3: Low Apgar score and birth asphyxia (P21)

A diagnosis of ‘Low Apgar score’ alone is not classified in ICD-10 and codes must not be assigned when this diagnosis alone is made. If the responsible consultant records the Apgar score in a newborn with asphyxia the Apgar score is used to assign the fourth character subdivision from category **P21.- Birth asphyxia**.

**Example:**

Asphyxiated newborn born in hospital with an Apgar score of 2

- P21.0 Severe birth asphyxia
- Z38.0 Singleton, born in hospital

### DCS.XVI.4: Surface deficient lung disease (P22)

Code **P22.0 Respiratory distress of newborn** must be assigned for the diagnosis of Surface deficient lung disease (SDLD) in the newborn.

### DCS.XVI.5: Group B streptococcus (GBS) bacterial infections in babies

The following codes and sequencing must be applied when coding Group B streptococcus (GBS) infections in newborn babies:

GBS infection diagnosed by blood test or GBS sepsis:

- P36.0 Sepsis of newborn due to streptococcus, group B
- Z38.0 Singleton, born in hospital
**DCS.XVI.5: continued**

**Meningitis due to GBS:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>P39.8</td>
<td>Other specified infections specific to the perinatal period</td>
</tr>
<tr>
<td>Z38.0</td>
<td>Singleton, born in hospital</td>
</tr>
<tr>
<td>G00.2</td>
<td>Streptococcal meningitis</td>
</tr>
<tr>
<td>B95.1</td>
<td>Streptococcus, group B, as the cause of diseases classified to other chapter</td>
</tr>
</tbody>
</table>

Newborn receiving prophylactic antibiotics because the mother has previously had a streptococcus infection or because the mother is a carrier of GBS:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z38.0</td>
<td>Singleton, born in hospital</td>
</tr>
<tr>
<td>Z29.2</td>
<td>Other prophylactic chemotherapy</td>
</tr>
<tr>
<td>Z83.1</td>
<td>Family history of other infectious and parasitic diseases</td>
</tr>
</tbody>
</table>

Streptococcus group B positive/carrier (i.e. found by umbilical swab, or other surface swabs such as ear and skin) with no signs of infection:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z38.0</td>
<td>Singleton, born in hospital</td>
</tr>
<tr>
<td>Z22.3</td>
<td>Carrier of other specified bacterial diseases</td>
</tr>
</tbody>
</table>

*See also DGS.6: Infections and sepsis.*

**DCS.XVI.6: Dehydration of newborn (P74.1)**

Dehydration must always be coded when documented in a newborn’s medical record.

*See also DCS.IV.7: Dehydration and hypovolaemia.*

Dehydration is a serious medical condition in newborns.

**DCS.XVI.7: Stillbirths (P95.X)**

Stillbirths must be coded as follows:

- If the cause of the stillbirth is known, the cause must be coded as the primary diagnosis. Code **P95.X Fetal death of unspecified cause** is not required in any diagnostic position.
- If the cause of the stillbirth is not known, code **P95.X** must be assigned as the primary diagnosis.
- A code from category **Z38.- Liveborn infants according to place of birth** must not be assigned on a stillborn baby’s episode.

*See also DCS.XVI.1: Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04).*

**P95.X** is only recorded when there is no other diagnostic information available. The information regarding the stillbirth can be identified for data extraction purposes by the method of discharge. The stillbirth will also be recorded on the mother’s episode using a code from **Z37 Outcome of delivery, see DChS.XV.1: Outcome of delivery (Z37).**

**Examples:**

*Stillbirth due to compression of umbilical cord*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P02.5</td>
<td>Fetus and newborn affected by other compression of umbilical cord</td>
</tr>
</tbody>
</table>

*Stillbirth*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P95.X</td>
<td>Fetal death of unspecified cause</td>
</tr>
</tbody>
</table>
## Certain Conditions Originating in the Perinatal Period

### DCS.XVI.8: Jittery baby (R25.8)
Jittery baby must be coded using code **R25.8 Other and unspecified abnormal involuntary movements**.
*See also DChS.XVIII.1: Signs symptoms and abnormal laboratory findings.*

### DCS.XVI.9: Sudden infant death syndrome (R95.X)
Codes in category **R95.X Sudden infant death syndrome** (SIDS, cot death) must only be assigned when no cause has been recorded in the medical record and the responsible consultant records the diagnosis as ‘a sudden infant death’, ‘sudden infant death syndrome’, ‘cot death’ or ‘SIDS’.

### History of perinatal conditions
*See DCS.XXI.21: Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z80–Z99).*
Chapter standards and guidance

**Syndromes**

See DGCS.7: Syndromes.

Congenital malformations and abnormalities are present and exist from the time of birth; they are never acquired. They will almost always persist throughout life unless they have been corrected by medical intervention. Therefore the codes in this chapter are intended for use in patients of any age. Not all congenital conditions are classified to this chapter.

Some conditions in the Alphabetical Index are assumed to be acquired, whilst others are assumed to be congenital. The codes the Alphabetical index directs to are selected where there is no further information in the medical record to indicate whether they are either congenital or acquired.

**Examples:**

55 year old with left clawhand

M21.54 Acquired clawhand, clubhand, clawfoot and clubfoot, hand

55 year old with left clawfoot

Q66.8 Other congenital deformities of feet

**Coding Standards and guidance**

Congenital heart disease is a general term that may be used to document a specific abnormality, e.g. ventricular septal defect (VSD) or to summarise multiple cardiac anomalies without listing the individual conditions.

When a diagnosis of congenital heart disease is documented without any further information, a more specific diagnosis should be sought from the responsible consultant.
**DCS.XVII.1: Triple M syndrome (Q87.1)**

Triple M syndrome must be coded using:

- **Q87.1** Congenital malformation syndromes predominantly associated with short stature

*See also DGC5.7: Syndromes.*

The major congenital abnormality of triple M Syndrome is short stature.

**Personal history of congenital malformations, deformations and chromosomal abnormalities (Z87.7)**

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

Symptoms, Signs and Abnormal Laboratory Findings, Not Elsewhere Classified
(R00–R99)

Chapter standards and guidance

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

If a diagnosis is identified from a sign, symptom or abnormal laboratory finding classifiable to Chapter XVIII (R00-R99), a code for the specific diagnosis must be assigned instead.

Codes that classify signs, symptoms and abnormal laboratory findings in Chapter XVIII must only be assigned when a more specific diagnosis has not been made or if there is no classifiable current illness or injury present.

Signs, symptoms and abnormal laboratory findings from the range R00-R99 can be assigned in addition to a specific diagnosis only when:

- there is a specific standard which states that a sign or symptom must always be coded (e.g. DCS.XVIII.7: Septic shock (R57.2)).
- the cause of the sign, symptom or abnormal laboratory finding is known, but the sign, symptom or abnormal laboratory finding is treated as a problem in its own right. In this instance the code from R00-R99 must be recorded in a secondary position to the known cause.

**See also:**
- DGCS.2: Absence of definitive diagnosis statement
- DGCS.4: Using diagnostic test results
- DChS.II.1: Complications and symptoms of neoplasms
- DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53).

There are codes outside of chapter XVIII that may appear to be symptoms of another condition, however codes outside of this chapter are, in the main, considered definitive diagnoses or problems in their own right and when documented in the medical record by the responsible consultant, would be coded except where a specific standard exists which states that a condition is considered to be a symptom of another condition and does not require coding (e.g. DCS.XI.9: Haemorrhage of digestive system (K92.0, K92.1 and K92.2)) or where the ICD-10 Alphabetical Index or Tabular List indicates otherwise.

**Examples:**

*Patient admitted with central chest pain and shortness of breath. Diagnosed with acute myocardial infarction*

**I21.9** Acute myocardial infarction, unspecified

*Patient admitted with haematuria. Cystoscopy performed but no abnormality shown*

**R31.X** Unspecified haematuria
Patient admitted with ‘confusion’. No cause is identified on examination

R41.0 Disorientation, unspecified

Patient admitted with central chest pain. A myocardial infarction is suspected but not confirmed. Patient is transferred to a hospital with a coronary care unit

R07.2 Precordial pain

Patient admitted with visual hallucinations, agitation and stupor. Schizotypal disorder is suspected but the responsible consultant is unwilling to make a diagnosis at the time

R44.1 Visual hallucinations
R45.1 Restlessness and agitation
R40.1 Stupor

Abnormal glucose tolerance test in patient with family history of diabetes. Diagnosis of diabetes is not made

R73.0 Abnormal glucose tolerance test
Z83.3 Family history of diabetes mellitus

Abnormal ECG with paroxysmal atrial tachycardia

I47.1 Supraventricular tachycardia

Mass removed from neck. Histology report is inconclusive and no firm diagnosis is made

R22.1 Localised swelling, mass and lump, neck

Mass removed from neck. Responsible consultant confirms lipoma

D17.0 Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck

Patient admitted for treatment of hypertension. While on the ward patient suffers a heavy nosebleed for which their nose had to be packed

I10.X Essential (primary) hypertension
R04.0 Epistaxis

Gangrene complicating Type 2 diabetes mellitus

E11.5 Non-insulin-dependent diabetes mellitus, with peripheral circulatory complications
R02.X Gangrene, not elsewhere classified

Patient admitted with cerebral infarction 4 weeks ago. Patient received speech therapy for dysphasia

I63.9 Cerebral infarction, unspecified
R47.0 Dysphasia and aphasia

Patient with urethral stricture is admitted for catheterisation due to retention of urine

N35.9 Urethral stricture, unspecified
R33.X Retention of urine

Coding standards and guidance

Elevated blood-pressure reading, without diagnosis of hypertension (R03.0)

See DCS.IX.1: Essential (primary) hypertension (I10.X).
DCS.XVIII.1: Central and musculoskeletal chest pain (R07.2 and R07.3)

Central chest pain must be classified to code R07.2 Precordial pain.
Musculoskeletal chest pain must be classified to code R07.3 Other chest pain.

DCS.XVIII.2: Right iliac fossa pain and left iliac fossa pain (R10.3)

Right iliac fossa (RIF) pain and left iliac fossa (LIF) pain must be classified to code R10.3 Pain localised to other parts of the lower abdomen.

Occult blood in faeces classified at R19.5 Other faecal abnormalities may also be described as occult blood in stools and faecal occult blood (FOB).

Jittery baby (R25.8)

See DCS.XVI.8: Jittery baby (R25.8).

DCS.XVIII.3: Immobility and reduced mobility (R26.3, R26.8)

The terms ‘immobility’, ‘chairfast’, ‘bedfast’, ‘bedbound’ and ‘bedridden’ must be classified to code R26.3 Immobility when documented in the medical record.
Terms such as ‘reduced mobility’ and ‘poor mobility’ must be classified to R26.8 Other and unspecified abnormalities of gait and mobility.
See also DCS.XXI.18: Problems related to care-provider dependency (Z74).

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

Geriatric and elderly falls must be coded as follows:

Geriatric and elderly fall without injury:

R29.6 Tendency to fall, not elsewhere classified

Geriatric and elderly fall with injury:

Code classifying the injury sustained from chapter XIX
External cause code from categories W00-W19
R29.6 Tendency to fall, not elsewhere classified

If the patient remains in hospital for investigation of the falls and this becomes the primary focus of care, then code R29.6 must be sequenced before the codes for the injury.

See also DChS.XX.1: External causes.

The elderly are at a higher risk of falling and often fall without sustaining an injury, these falls may be described as geriatric or elderly falls.

Examples:

Elderly patient admitted to hospital following geriatric fall at home sustaining laceration of eyelid which is sutured. The patient is discharged home the next day.

S01.1 Open wound of eyelid and periorcular area
W19.0 Unspecified fall, home
R29.6 Tendency to fall, not elsewhere classified
Elderly patient has geriatric fall at home, sustains contusion to lower leg. The patient is transferred on the second day to an elderly ward for investigations of their repeated falls.

**First consultant episode**

- **S80.1** Contusion of other and unspecified parts of lower leg
- **W19.0** Unspecified fall, home
- **R29.6** Tendency to fall, not elsewhere classified

**Second consultant episode**

- **R29.6** Tendency to fall, not elsewhere classified
- **S80.1** Contusion of other and unspecified parts of lower leg

### Persistent vegetative state (G93.1 and R40.2)

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

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

When patients are admitted for treatment of generalised chronic pain affecting more than one organ or body region caused by a more specific condition, code **R52.1 Chronic intractable pain** must be assigned in addition to the code classifying the specific condition causing the pain.

Chronic intractable pain must not be coded if the chronic pain caused by a specific condition is located in only one organ or body region (e.g., pain in hip); in these cases, only the code for the specific condition must be assigned.

Although ‘chronic intractable pain’ is not a term that is normally used in the medical record, ICD-10 code **R52.1** fully describes the type of generalised chronic pain suffered by some patients, particularly those with cancer.

### Examples:

Patient admitted for control of chronic joint pains in hands, feet, elbows and shoulders caused by rheumatoid arthritis.

- **M06.90** Rheumatoid arthritis, unspecified, multiple sites
- **R52.1** Chronic intractable pain

Patient with osteosarcoma of the femur is admitted for control of generalised chronic pain.

- **C40.2** Malignant neoplasm: Long bones of lower limb
- **R52.1** Chronic intractable pain

Patient admitted for pain relief for chronic back pain due to lumbar disc displacement

- **M51.2** Other specified intervertebral disc displacement

### DCS.XVIII.6: Off legs (R54.X)

The diagnosis of ‘off legs’ in an elderly patient must be classified to code **R54.X Senility**.

### DCS.XVIII.7: Septic shock (R57.2)

Whenever septic shock is documented in the medical record by the responsible consultant, this must be coded using **R57.2 Septic shock**.
## DCS.XVIII.8: Systemic Inflammatory Response Syndrome [SIRS] (R65)

Codes within category **R65.- Systemic Inflammatory Response Syndrome [SIRS]** must only be used in a secondary position following the condition or underlying disease causing SIRS. The appropriate codes for the organ failure, if present, must also be coded in addition.

*See also DCS.XVIII.9: Severe sepsis (R65.1, A41.9).*

### Example:

*Patient with influenza due to avian influenza virus causing SIRS with kidney failure.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J09.X</td>
<td>Influenza due to certain identified influenza virus</td>
</tr>
<tr>
<td>R65.1</td>
<td>Systemic Inflammatory Response Syndrome of infectious origin with organ failure</td>
</tr>
<tr>
<td>N19.X</td>
<td>Unspecified kidney failure</td>
</tr>
</tbody>
</table>

## DCS.XVIII.9: Severe sepsis (R65.1, A41.9)

Code **R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure** includes severe sepsis and must be assigned in a secondary position to the cause of the severe sepsis when the responsible consultant has documented severe sepsis in the medical record.

A diagnosis of severe sepsis alone in the absence of an underlying disease or condition must be coded using the following codes and sequencing:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A41.9</td>
<td>Sepsis, unspecified</td>
</tr>
<tr>
<td>R65.1</td>
<td>Systemic Inflammatory Response Syndrome of infectious origin with organ failure</td>
</tr>
</tbody>
</table>

Codes for the organ failure, if documented.

### Example:

*Patient with severe sepsis due to falciparum malaria*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B50.8</td>
<td>Other severe and complicated Plasmodium falciparum malaria</td>
</tr>
<tr>
<td>R65.1</td>
<td>Systemic Inflammatory Response Syndrome of infectious origin with organ failure</td>
</tr>
</tbody>
</table>

## DCS.XVIII.10: Multiple organ failure (R68.8)

When multiple organ failure is recorded in the medical record, the coder must seek clarification about which individual organs have failed and code each organ failure separately. If no further clarification is provided and the only information available is that the patient has multiple organ failure, the code **R68.8 Other specified general symptoms and signs** must be assigned.

*See also DGCS.10: Multiple condition codes.*
DCS.XVIII.11: Unknown and unspecified causes of morbidity (R69.X) and ill-defined and unknown causes of mortality (R96–R99)

The codes in categories R69.X Unknown and unspecified causes of morbidity, R96.- Other sudden death, cause unknown, R98.X Unattended death and R99.X Other ill-defined and unspecified causes of mortality must only be used when no further information about the patient’s condition is available.

To avoid use of these codes, the coder should investigate sources such as admission books, casualty records, X-ray records etc. for more information. Only information which has been verified by the responsible consultant should be used.

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

Raised INR must be coded as follows:

- Code classifying the condition being treated by the anticoagulant
  - R79.8 Other specified abnormal findings of blood chemistry
  - Z92.1 Personal history of long-term (current) use of anticoagulants (if the patient is currently taking anticoagulants or if they have a personal history of anticoagulation therapy)

If the patient undergoes investigations/treatment of the raised INR during the consultant episode, therefore becoming the main condition treated, R79.8 must be sequenced before the code classifying the condition being treated by the anticoagulants, in line with DGCS.1: Primary diagnosis.

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

Patients who are taking anticoagulants (such as Warfarin) undergo regular monitoring to ensure that their blood is clotting correctly and that they are on the correct anticoagulant dosage. This is determined using the International Normalised Ratio (INR). Often a patient’s INR may be raised.

Example:

Patient taking Warfarin for the treatment of atrial fibrillation, routine blood test indicates a dangerously high INR. The patient is admitted for treatment to reduce the high INR.

- R79.8 Other specified abnormal findings of blood chemistry
- I48.X Atrial fibrillation
- Z92.1 Personal history of long term (current) use of anticoagulants

Raised Prostate Specific Antigen [PSA]

See DCS.XIV.6: Raised Prostate Specific Antigen [PSA] (R79.8)

Sudden infant death syndrome (R95.X)

See DCS.XVI.9: Sudden infant death syndrome (R95.X).
Chapter standards and guidance

**Injuries, poisoning, other trauma and external cause**

When coding an injury, poisoning or other trauma from chapter XIX, an external cause code from Chapter XX must be assigned in a secondary position to identify the circumstance of the injury, complication, poisoning or adverse effect, as described in DChS.XX.1: External causes.

Example:

Laceration of finger. Cut with knife in kitchen at home.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S61.0</td>
<td>Open wound of finger(s) without damage to nail</td>
</tr>
<tr>
<td>W26.0</td>
<td>Contact with knife, sword or dagger, home</td>
</tr>
</tbody>
</table>

**DChS.XIX.1: Multiple injuries**

Multiple injuries must be coded separately where the specific sites and types of injuries are documented. The injury that is clearly the most severe and demanding of resources must be sequenced in the primary position as per the primary diagnosis definition (See DGCS.1: Primary diagnosis). Where no one condition obviously predominates, the responsible consultant’s advice must be sought.

Codes in chapter XIX that classify ‘multiple injuries’ must only be used where no detail is documented in the medical record about the individual sites or types of the injury (e.g. S01.7 Multiple open wounds of head, S09.7 Multiple injuries of head).

The exceptions are bilateral injuries involving the same body site, see DCS.XIX.3 Bilateral injuries involving the same body site (T00-T07).

When multiple injuries are caused by the same event, only one external cause code is assigned directly after the final injury code, see DChS.XX.1: External causes.

See also DGCS.10: Multiple condition codes.

**Examples:**

Laceration left hand, concussion and open fracture of left tibia and fibula requiring open reduction and internal fixation. All sustained during fall from tree in the local park.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S82.21</td>
<td>Fracture of shaft of tibia, open</td>
</tr>
<tr>
<td>S61.9</td>
<td>Open wound of wrist and hand, part unspecified</td>
</tr>
<tr>
<td>S06.00</td>
<td>Concussion, without open intracranial wound</td>
</tr>
<tr>
<td>W14.8</td>
<td>Fall from tree, other specified places</td>
</tr>
</tbody>
</table>

Multiple open wounds of left upper arm due to contact with a combine harvester in farm

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S41.7</td>
<td>Multiple open wounds of shoulder and upper arm</td>
</tr>
<tr>
<td>W30.7</td>
<td>Contact with agricultural machinery, farm</td>
</tr>
</tbody>
</table>
Injury, Poisoning and Certain Other Consequences of External Causes

DChS.XIX.2: Fifth characters in chapter XIX

Supplementary fifth characters are used in this chapter to identify open and closed fractures, intracranial injuries with or without open intracranial wound and internal injuries with or without open wound into cavity. They must be assigned when instructed by the note at code, category or block level.

An injury not indicated as ‘open’ or ‘closed’ must be recorded using fifth character .0.

See also DConvention.7: Fifth characters.

Examples:
Fracture neck of femur. Fall down stairs at home

S72.00 Fracture of neck of femur, closed
W10.0 Fall on and from stairs and steps, home

Traumatic haematoma of kidney. Hit by pedal cyclist whilst crossing the road walking to shops

S37.00 Injury of kidney, without open wound into cavity
V01.1 Pedestrian injured in collision with pedal cycle, traffic accident

DChS.XIX.3: Infected open wounds

Infected open wounds must be coded in the same way as a non-infected open wound, i.e. code assignment is the same but if the organism causing the infection is known, a code from categories B95–B98 Bacterial, viral and other infectious agents must be coded in addition.

See also:
- DGCS.6: Infections and sepsis
- DCS.I.4: Bacterial, viral and other infectious agents (B95-B98).

Examples:
Readmission with infected open wound of finger

S61.0 Open wound of finger(s) without damage to nail

Readmission with open wound of finger infected with staphylococcus

S61.0 Open wound of finger(s) without damage to nail
B95.8 Unspecified staphylococcus as the cause of diseases classified to other chapters

Chronic versus current injuries of the musculoskeletal system and connective tissue

See DChs.XIII.2: Chronic versus current injuries of the musculoskeletal system and connective tissue.

Coding Standards and guidance

DCS.XIX.1: Skull fracture with intracranial injuries (S02 and S06)

When coding skull fractures (S02.-) associated with intracranial injuries (S06.-), the intracranial injury (S06.-) must be sequenced first.

Example:
Open fracture of frontal bone of skull with open intracranial injury. Hit by hockey stick when playing hockey on the hockey field
### National Clinical Coding Standards ICD-10 4th Edition

#### S06.91 Intracranial injury, unspecified, with open intracranial wound
#### S02.01 Fracture of vault of skull, open
#### W21.3 Striking against or struck by sports equipment, sports and athletics area

<table>
<thead>
<tr>
<th>DCS.XIX.2: Unspecified head injury (S09.9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code <strong>S09.9 Unspecified injury of head</strong> must not be assigned when the responsible consultant has specified the type of injury to the head.</td>
</tr>
</tbody>
</table>

**Example:**
Five year old boy admitted with head injury – laceration to scalp. Fall at home.

- **S01.0** Open wound of scalp
- **W19.0** Unspecified fall, home

<table>
<thead>
<tr>
<th>DCS.XIX.3: Bilateral injuries involving the same body site (T00-T07)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes in categories <strong>T00-T07 Injuries involving multiple body regions</strong> must only be used for bilateral injuries involving the same body site where the type and site of injury are identical on both sides.</td>
</tr>
</tbody>
</table>

**See also:**
- DCGS.10: Multiple condition codes
- DChS.XIX.1: Multiple injuries.

**Examples:**
Multiple contusions to lower legs. Struck by dog.

- **T00.3** Superficial injuries involving multiple regions of lower limb(s)
- **W54.9** Bitten or struck by dog, unspecified place

Fractures of both left and right forearm. Fall from balcony in hotel.

- **T02.40** Fractures involving multiple regions of both upper limbs, closed
- **W13.5** Fall from, out of or through building or structure, trade and service area

**Epilepsy and injury**

**See DCS.VI.1: Epilepsy and injury.**

**Geriatric and elderly falls (R29.6)**

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

<table>
<thead>
<tr>
<th>DCS.XIX.4: Foreign bodies (T15-T19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign body injuries must be classified according to the site where the foreign body is currently located.</td>
</tr>
</tbody>
</table>

**Example:**
Coin in stomach (swallowed in residential home)

- **T18.2** Foreign body in stomach
- **W44.1** Foreign body entering into or through eye or natural orifice, residential institution
Injury, Poisoning and Certain Other Consequences of External Causes

**DCS.XIX.5: Burns and corrosions (T20-T32)**

Burns and corrosions of the same site that exhibit multiple degrees must be coded to the most severe degree of that site using codes in categories **T20-T30 Burns and corrosions**.

A code from categories **T31.- Burns classified according to extent of body surface involved** or **T32.- Corrosions classified according to extent of body surface involved** must be assigned in addition to a code from categories **T20-T25 Burns and corrosions of external body surface, specified by site** or **T29.- Burns and corrosions of multiple body regions** when the total percentage of body surface involved in a burn or corrosion is documented.

When the site of the burn is unspecified and only the total percentage of body surface is documented only a code from categories **T31.-** or **T32.-** is required.

Many patients with burns will have to undergo several admissions for grafting after the original admission, and this usually forms part of the care plan. It is similar to a cancer patient having a series of chemotherapy treatments as part of their primary treatment. On the subsequent admissions the original burn injury would still be coded, but without the external cause code.

*See also DChS.XX.1: External causes.*

**Examples:**

*Third degree burn of hand (2% of body surface) from campfire at scouts forest camp*

- T23.3 Burn of third degree of wrist and hand
- T31.0 Burns involving less than 10% of body surface
- X03.8 Exposure to controlled fire, not in building or structure, other specified places

*Readmission for grafting of second and third degree burns of forearm*

- T22.3 Burn of third degree of shoulder and upper limb, except wrist and hand

**DCS.XIX.6: Maltreatment syndromes (T74)**

Codes in category **T74.- Maltreatment syndromes** classify non-accidental injuries (NAI) and must be assigned using the following codes and sequencing:

- T74.- Maltreatment syndromes
  - Code for the injury caused
  - Y07.- Other maltreatment

The responsible consultant must clearly state that an injury is a non-accidental injury before a code from category **T74.-** can be assigned.

**Example:**

*Baby, physically abused by parent, admitted with fractured rib*

- T74.1 Physical abuse
- S22.30 Fracture of rib, closed
- Y07.1 Other maltreatment by parent
**DCS.XIX.7: Postprocedural complications and disorders**

When coding postprocedural complications and disorders the codes which fully describe the condition and the procedure that caused it must be assigned. It must *never* be assumed that a condition is a postprocedural complication or disorder unless it is clearly documented as such by the responsible consultant.

Postprocedural complications and disorders can be coded in three different ways:

**Coding T80–T88 complications of surgical and medical care, not elsewhere classified**

When the Alphabetical index directs to a code from categories **T80-T88 Complications of surgical and medical care, not elsewhere classified**, (using lead terms for the actual complication, such as displacement and leakage, or via the specific condition with modifiers to indicate that it was a result of a procedure or under ‘Complication’), apply the following codes and sequencing:

<table>
<thead>
<tr>
<th>T80-T88</th>
<th>Complications of surgical and medical care, not elsewhere classified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y83-Y84</td>
<td>Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure</td>
</tr>
</tbody>
</table>

- Do not assign a code from categories **Y83-Y84** when the postprocedural condition code (in categories **T80-T88**) fully describes both the nature of the condition and the procedure that has caused it.
- Do not assign codes **Y83.8, Y83.9, Y84.8** and **Y84.9** with codes from categories **T80-T88** because these codes do not add further detail about the nature of the procedure.

This applies regardless of whether 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.

**Coding postprocedural disorders in body system chapters**

When the Alphabetical index directs to a code in a postprocedural disorder category in a body system chapter not ending in **.8** or **.9** (e.g. **N99.1 Postprocedural urethral stricture**), or where a specific standard indicates that these codes must be used (e.g. **DCS.VII.4: Post enucleation socket syndrome, PESS (H59.8 and Y83.6)**), apply the following codes and sequencing:

| Y83-Y84 | Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure |

- Do not assign a code from categories **Y83-Y84** when the postprocedural disorder code from the body system chapter fully describes both the nature of the condition and the procedure that has caused it.
- Do not assign codes **Y83.8, Y83.9, Y84.8** and **Y84.9** with codes from the postprocedural disorder category in a body system chapter because these codes do not add further detail about the nature of the procedure.

When the Alphabetical index directs to a code in a postprocedural disorder category in a body system chapter ending in **.8** or **.9** (e.g. **N99.8 Other postprocedural disorders of genitourinary system**), do not assign this code, apply the codes described in **Coding the condition plus external cause code** section (described below). The exception is if a code for the specific condition does not exist, then the **.8** or **.9** code from the postprocedural disorder category in a body system chapter must be assigned.
Coding the condition plus external cause code

When the Alphabetical index does not direct to a code in categories T80-T88 Complications of surgical and medical care, not elsewhere classified, or a code in a postprocedural disorders category in a body system chapter (as described above) apply the following codes and sequencing:

Code from a body system chapter classifying the specific condition
Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
- A code from categories Y83-Y84 must always be assigned (including fourth characters Y83.8, Y83.9, Y84.8 and Y84.9) as this indicates that the condition was due to a procedure.

Postprocedural infections

Postprocedural infections must be coded following the standards listed above. Where it is necessary to indicate the infectious organism causing the infection the following codes and sequencing must be applied:

Code from categories T80-T88 or the code from a postprocedural disorder category in a body system chapter or the code from a body system chapter classifying the specific condition
B95-B98 Bacterial, viral and other infectious agents
U80-U89 Bacterial agents resistant to antibiotics (If the infective organism is bacterial and resistant to an antibiotic(s))
Y83-Y84 (if required).

See also:
- DDCS.6: Infections and sepsis
- DCS.X.3: Post procedural pneumonia
- DFigure. XIX.1: Postprocedural complications and disorders
- DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)
- DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)
- DCS.XXII.2: Bacterial agents resistant to antibiotics (U80-U89).

Postprocedural complications and disorders are conditions arising as a result of surgical or medical procedures. In the medical record they may be referred to as postoperative/postprocedural/post-op complications or disorders following surgery or following a procedure.

Codes from categories Y83-Y84 are indexed under the lead term ‘Complication’ in Section II of the Alphabetical Index.

Postprocedural infection and complication following insertion of prosthesis, implant or graft

When coding postprocedural wound infections in patients with prosthetic devices, implants or grafts it is important to determine if the infection is actually due to the prosthetic device itself, or genuinely of the wound site, as this will affect code assignment from categories T80-T88.
Other types of complications in patients with prosthetic devices, implants or grafts must be treated with the same caution. For example, a femoral/popliteal bypass graft often becomes occluded after a period of time. This occlusion can occur because of a mechanical complication of the graft (T82.3 Mechanical complication of other vascular grafts) or due to a recurrence of the original disease, such as occluded femoral artery. Where the occlusion is due to recurrence of the original disease, the original disease would be coded as the main condition. Clinical advice should be sought as to the reason for the occlusion if it is not clear in the medical record.

Sequencing

The sequencing of postprocedural complication codes may on occasions change as the complication may present problems that affect the patient’s management and become the main condition treated instead of the condition that the procedure was performed for.

Examples:

Phlebitis due to IV infusion

- T80.1 Vascular complications following infusion, transfusion and therapeutic injection

Postoperative haemorrhage five hours after a tonsillectomy

- T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified
- Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Patient readmitted with swab in-situ following cholecystectomy

- T81.5 Foreign body accidentally left in body cavity or operation wound following a procedure
- Y83.6 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

Readmission with a postoperative wound infection (due to streptococcus, group A) at incision site following a femoral/popliteal bypass graft

- T81.4 Infection following a procedure, not elsewhere classified
- B95.0 Streptococcus, group A, as the cause of diseases classified to other chapters
- Y83.2 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Patient readmitted 12 weeks post total hip replacement. Documented diagnosis of postoperative wound infection due to hip joint prosthesis

- T84.5 Infection and inflammatory reaction due to internal joint prosthesis

Tracheostomy malfunction due to airway obstruction

- J95.0 Tracheostomy malfunction
Postgastrectomy dumping syndrome

**K91.1** Postgastric surgery syndromes

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

Postprocedural urethral stricture following gastric bypass

**N99.1** Postprocedural urethral stricture

**Y83.2** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Breakdown internal anastomosis of intestine

**K91.8** Other postprocedural disorders of digestive system, not elsewhere classified

**Y83.2** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, surgical operation with anastomosis, bypass or graft

Postoperative urinary tract infection after cholecystectomy

**N39.0** Urinary tract infection, site not specified

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

Pulmonary embolism as a result of percutaneous embolisation of liver

**I26.9** Pulmonary embolism without mention of acute cor pulmonale

**Y83.8** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other surgical procedures

Postoperative urinary tract infection (Escherichia coli, resistant to vancomycin) following total abdominal hysterectomy two days ago

**N39.0** Urinary tract infection, site not specified

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

**U81.0** Vancomycin resistant agent

**Y83.6** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)
Patient admitted for reconstruction of torn anterior cruciate ligament after being tackled by another player when playing football at his local football field earlier that day. The day after surgery, the patient develops a postoperative wound infection which fails to respond to antibiotics and results in a return to theatre one week later for an above knee amputation due to sepsis (all during the same consultant episode).

- **T81.4** Infection following a procedure, not elsewhere classified
- **Y83.4** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other reconstructive surgery
- **A41.9** Sepsis, unspecified
- **S83.5** Sprain and strain involving (anterior) (posterior) cruciate ligament of knee
- **W50.3** Hit, struck, kicked, twisted, bitten or scratched by another person, sports and athletics area
Injury, Poisoning and Certain Other Consequences of External Causes

See DCS.XIX.7: Postprocedural complications and disorders.
Post Enucleation Socket Syndrome, PESS (H59.8 and Y83.6)

See DCS.VII.4 Post Enucleation Socket Syndrome, PESS (H59.8 and Y83.6).

Sunken Socket Syndrome (H59.8 and Y83 or Y84)

See DCS.VII.5 Sunken Socket Syndrome (H59.8 and Y83 or Y84).

DCS.XIX.8: Poisoning (T36-T65)

Reactions to drugs and medicines can occur from either their improper use (poisoning) or proper use (adverse effects), see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).

Where a reaction to a drug or medicine is not stated as being the result of proper or improper use, it is assumed to be the result of proper use and must therefore be coded as an adverse effect.

Poisonings must be coded as follows:

- Assign a code from chapter XIX for the substance causing the poisoning as indicated in the Table of Drugs and Chemicals in Section III of the Alphabetical Index
- Assign an external cause code from chapter XX for the circumstance of the poisoning (accidental, intentional, undetermined intent, see DCS.XX.4: Accidents (V01-X59) and intentional self harm (X60-X84), DCS.XX.5: Event of undetermined intent (Y10-Y34) and DCS.XX.6: Assault by drugs, medicaments and biological factors (X85)) as indicated in the Table of Drugs and Chemicals in Section III of the Alphabetical Index
- Assign a code(s) for any manifestations or reactions, if stated in the medical record
  - Manifestations or reactions classified within chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) must be coded in a secondary diagnosis position following the external cause code for the poisoning.
  - Manifestations and reactions classified outside of chapter XVIII Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) must be coded in a secondary diagnosis position following the external cause code for the poisoning unless it is clear that the reaction or manifestation is the main condition treated.

When a drug has more than one component, (e.g. Cocodaprin made up of codeine phosphate and aspirin), each component must be coded separately and sequenced according to the sequence in the British National Formulary (http://bnf.org/bnf/index.htm).

Where the poisoning is due to more than one drug and each drug has been identified in the medical record, separate codes must be assigned for each drug. The responsible consultant must determine which drug is the most clinically dangerous.

Do not assign the same external cause code multiple times when coding multiple drugs or components. Assign each external cause code once after all of the drugs/components it is associated with.

An adverse reaction due to a drug (either properly or improperly administered) taken in combination with alcohol of any kind must be coded as a poisoning by both agents.

An adverse reaction occurring due to the combination of taking a prescribed drug and a non-prescribed drug must be coded as a poisoning by both agents.
Injury, Poisoning and Certain Other Consequences of External Causes

DCS.XIX.8 continued

See also:
- **DCS.XX.4**: Accidents (V01-X59) and intentional self harm (X60-X84)
- **DCS.XX.5**: Event of undetermined intent (Y10-Y34)
- **DCS.XX.6**: Assault by drugs, medicaments and biological factors (X85)
- **DCS.XX.7**: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)
- **DCS.XXI.1**: Persons encountering health services for examination and investigation (Z00–Z13) for coding of suspected overdose.

Poisoning can also be described as:
- intoxication
- overdose
- therapeutic misadventure
- toxic effect/toxicity
- wrong dosage given or taken
- wrong substance given or taken.

Examples:

**Patient admitted following codeine overdose**

- **T40.2** Poisoning: Other opioids
  - **X42.9** Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, unspecified place

  Overdose on 30 paracetamol tablets and 14 sedatives at home. Consultant confirms paracetamol is the most dangerous drug.

- **T39.1** Poisoning: 4-Aminophenol derivatives
  - **X40.0** Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home

- **T42.7** Poisoning: Antiepileptic and sedative-hypnotic drugs, unspecified
  - **X41.0** Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, home

**Patient admitted with intentional overdose of Cocodaprin (BNF confirms the correct sequence as codeine, then aspirin)**

- **T40.2** Poisoning: Other opioids
  - **X62.9** Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, unspecified place

- **T39.0** Poisoning: Salicylates
  - **X60.9** Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, unspecified place

**Codeine overdose in a six year old child who helped herself to mother’s pills from a cupboard at home**

- **T40.2** Poisoning: Other opioids
  - **X42.0** Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home
Patient admitted from a nightclub after having a non-alcoholic drink spiked with LSD

- **T40.8** Poisoning: Lysergide [LSD]
- **X85.5** Assault by drugs, medicaments and biological substances, trade and service area

Coma due to accidental codeine overdose at home

- **T40.2** Poisoning: Other opioids
- **X42.0** Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, home
- **R40.2** Coma, unspecified

Patient admitted for treatment of acute renal failure following deliberate overdose of paracetamol at home

- **N17.9** Acute renal failure, unspecified
- **T39.1** Poisoning: 4-Aminophenol derivatives
- **X60.0** Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home

Patient admitted with anoxic brain damage due to Seconal (barbiturate) taken in combination with alcoholic beverages at home

- **T42.3** Poisoning: Barbiturates
- **X41.0** Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, home
- **T51.0** Toxic effect: Ethanol
- **X45.0** Accidental poisoning by and exposure to alcohol, home
- **G93.1** Anoxic brain damage, not elsewhere classified

Patient admitted with a coma due to accidentally taking a combination of antiallergics (prescribed) and barbiturates (not prescribed)

- **T45.0** Poisoning: Antiallergic and antiemetic drugs
- **X44.9** Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, unspecified place
- **T42.3** Poisoning: Barbiturates
- **X41.9** Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, unspecified
- **R40.2** Coma, unspecified

Intentional overdose of aspirin and paracetamol at home.

- **T39.0** Poisoning: Salicylates
- **T39.1** Poisoning: 4-Aminophenol derivatives
- **X60.0** Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, home

The Table of Drugs and Chemicals in Section III of the Alphabetical Index contains an extensive but not exhaustive list of drugs, medicinal and non-medicinal chemicals, and solvents. Proprietary names, i.e. trade names of drugs and medicaments, are not always listed. If a drug or medicament is not listed, the coder must obtain information about the type of drug, e.g. antidepressant, antihypertensive, and use these generic lead terms to look up a code in the Table of Drugs and Chemicals instead. For example, Antidepressant NEC and Antihypertensive drug NEC can both be found in the Alphabetical Index.
Mephedrone

See DCS.V.6: Mephedrone.

Rhabdomyolysis (M62.8, T79.6)

See DCS.XIII.3: Rhabdomyolysis (M62.8, T79.6).

See chapter V for guidance for patient transfers in / out of mental health units.
## External Causes of Morbidity and Mortality

(V01–Y98)

### Chapter standards and guidance

<table>
<thead>
<tr>
<th>DChS.XX.1: External causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes in chapter XX classify outside factors as the cause of injury, poisoning and other adverse effects. The following must be applied when using external cause codes:</td>
</tr>
<tr>
<td>• They must be assigned in addition to a code from chapter XIX Injury, poisoning and certain other consequences of external causes or a code from chapters I to XVIII when stated to be due to an external cause.</td>
</tr>
<tr>
<td>• They must be sequenced immediately following a code which describes the injury, poisoning or adverse effect from chapter XIX Injury, poisoning and certain other consequences of external causes or a condition.</td>
</tr>
<tr>
<td>• When multiple injuries from chapter XIX or conditions from chapters I to XVIII are due to the same external cause it is only necessary to record one external cause code from chapter XX following all codes that classify the injuries or conditions.</td>
</tr>
<tr>
<td>◦ For standards on recording the external cause code for poisonings by multiple drugs see DCS.XIX.8: Poisonings (T36-T65) and for standards on recording the external cause code for adverse effects of multiple drugs and multiple adverse effects of drugs see DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)</td>
</tr>
<tr>
<td>• When the external cause of an injury is not specified code X59.- Exposure to unspecified factor must be assigned.</td>
</tr>
<tr>
<td>• Codes in categories V01-Y36 must only be assigned on the first consultant episode in which the condition is recorded in the United Kingdom. Any subsequent episode where the same condition is being treated does not require the external cause code from V01-Y36. This includes when a patient is transferred from one unit to another and to injuries occurring whilst the patient is in hospital.</td>
</tr>
<tr>
<td>• Codes in categories Y40-Y98 must be assigned on every episode in which the condition is recorded (except for codes in categories Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure which are not always assigned when coding postprocedural complications and disorders, see DCS.XIX.7: Postprocedural complications and disorders).</td>
</tr>
<tr>
<td>• The ‘definitions of transport accidents’ and the ‘Classification and coding instructions for transport accidents’ at the beginning of chapter XX give detailed definitions and instructions regarding the coding of transport accidents (V01-V99), including the order of preference when more than one kind of transport is involved. These must be referred to when assigning fourth character codes with these categories.</td>
</tr>
</tbody>
</table>
A fourth character must be assigned with codes from categories W00-Y34 to identify where
the injury, poisoning or adverse effect took place. The fourth characters can be found in the
‘Place of occurrence code’ section at the beginning of the chapter. The exceptions are codes
in categories Y06.- Neglect and abandonment and Y07.- Other maltreatment,
see DCS.XIX.6: Maltreatment syndromes (T74).

See also:
- DCS.VI.1: Epilepsy and injury
- DCS.XVIII.4: Geriatric and elderly falls (R29.6)
- Chapter XIX for standards on coding injuries, poisoning, other trauma and external
cause and for further examples of the application of external cause codes
- DChS.XIX.1: Multiple injuries
- DChS.XX.2: Activity codes
- DCS.XX.2: Fourth character subcategory codes at X34 and X59
- DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in
therapeutic use (Y40-Y59).

External causes of injury are found in Section II of the Alphabetical Index. The index is organised by
lead terms that describe the cause of the injury or other adverse effect:

- the accident, e.g. fall
- circumstance, e.g. suicide
- event, e.g. legal intervention
- specified agent, e.g. poisoning, carbon monoxide.

The coding external cause code standard also applies to patients initially treated in an Accident and
Emergency (A&E) department for a condition due to an external cause who are subsequently
admitted, as A&E departments do not assign ICD-10 external cause codes.

The correct fourth character subdivision for a place of occurrence of pub or nightclub is X59.- Trade
and service area.

X59.- Exposure to unspecified factor can be indexed using the lead term ‘Accident’.

Examples:
Patient admitted under general medical consultant for treatment of angina. Patient fell from toilet on
medical ward sustaining fracture of shaft of right humerus and open wound of the right temple.
Transferred to orthopaedic consultant for treatment of fracture.

First consultant episode (general medical consultant):

<table>
<thead>
<tr>
<th>I20.9</th>
<th>Angina pectoris, unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>S42.30</td>
<td>Fracture of shaft of humerus, closed</td>
</tr>
<tr>
<td>S01.8</td>
<td>Open wound of other parts of head</td>
</tr>
</tbody>
</table>
W18.2 Other fall on same level, school, other institution and public administrative area

Second consultant episode (orthopaedic consultant):

S42.30 Fracture of shaft of humerus, closed
S01.8 Open wound of other parts of head
I20.9 Angina pectoris, unspecified

Patient admitted with cellulitis due to insect bite on finger

L03.0 Cellulitis of finger and toe
W57.9 Bitten or stung by nonvenomous insect and other nonvenomous arthropods, unspecified place

Low back pain due to fall at home. No injury documented in the patient’s medical record.

M54.5 Low back pain
W19.0 Unspecified fall, home

Rib and arm pain following fall from chair at home. No evidence of injury on examination.

R07.3 Other chest pain
M79.6 Pain in limb
W07.0 Fall involving chair, home

DChS.XX.2: Activity codes

ICD-10 provides an activity subclassification as an extra character for use with categories V01–Y34 to indicate the activity of the injured person at the time the event occurred. However, due to the general unavailability of this information, these activity subclassification codes shown at the beginning of this chapter must not be used.

See also DConvention.7: Fifth characters.

Coding Standards and guidance

DCS.XX.1: Accidents involving electric wheelchairs and mobility scooters

The following external cause codes 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>

Geriatric and elderly falls (R29.6)

See DCS.XVIII.4: Geriatric and elderly falls (R29.6).
**DCS.XX.2: Fourth character subcategory codes at X34 and X59**

The fourth character codes printed at categories X34.- Victim of earthquake and X59.- Exposure to unspecified factor in the ICD-10 Tabular List must not be used and must be crossed through as indicated in Coding Clinic Ref 92: X34 Victim of earthquake and X59 Exposure to unspecified factor.

The ‘Place of occurrence codes’ must be used for fourth character code assignment with categories X34.- and X59.-.

See also DChS.XX.1: External causes.

The WHO Update Revision Committee previously agreed that ‘Place of occurrence codes’ should be separated from the three character Chapter XX code. Following this agreement WHO introduced new fourth character subcategory codes at X34.- and X59.-. This re-designation and re-use of the fourth character by the WHO is incompatible with current UK practice when using categories X34.- and X59.-, therefore the implementation of these fourth character subcategories has been deferred.

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**DCS.XX.3: Conditions linked to travel (X51.9)**

When conditions such as deep vein thrombosis (DVT) are linked to travel, the external cause code X51.9 Travel and motion must be assigned in addition. As it is impossible to define at which point on a journey a DVT occurred, the place of occurrence fourth character .9 must be used.

**Example:**
Deep vein thrombosis (DVT) due to patient travelling home from Australia by plane three days ago

I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities

X51.9 Travel and motion, unspecified place

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**DCS.XX.4: Accidents (V01-X59) and intentional self-harm (X60-X84)**

Intentional self-harm codes (X60-X84) are used to identify attempted suicides or purposely self-inflicted poisoning or injury and must be assigned for any patient who has intended to harm themselves in any way. This includes any ‘cry for help’.

Where it is not clear whether an injury or overdose is an accidental or intentional self-harm attempt or an assault, the code that classifies the accidental external cause or accidental poisoning must be assigned (V01-X59).

See also DCS.XIX.8: Poisoning (T36-T65).

**Examples:**
Open wound of right wrist due to deliberately slashing with razor blade in bath at home.

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

W26.9 Contact with knife, sword or dagger, unspecified place

Open wound of right wrist caused by razor blade

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

W26.9 Contact with knife, sword or dagger, unspecified place
### DCS.XX.5: Event of undetermined intent (Y10-Y34)

Event of undetermined intent codes (Y10-Y34) must only be used when undetermined intent is stated by a medical or legal authority, such as a coroner at an inquest. It must not be used when no information has been given about the circumstances of an event. If the intent is not known, a code that classifies an accidental external cause must be assigned.

*See also DCS.XIX.8: Poisoning (T36-T65).*

### DCS.XX.6: Assault by drugs, medicaments and biological factors (X85)

A code from category X85.- Assault by drugs, medicaments and biological substances must be assigned when a patient is admitted with poisoning due to a ‘spiked’ drink.

*See also DCS.XIX.8: Poisoning (T36-T65).*

### Other maltreatment (Y07)

*See DCS.XIX.6: Maltreatment syndromes (T74).*

### DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)

Adverse effects result from the proper use of a substance. Where a reaction to a drug or medicine is not stated as a result of proper or improper use, it is assumed to be the result of proper use and must therefore be coded as an adverse effect.

Adverse effects must be coded as follows:

- Assign a code for the nature of the adverse effect or the patient’s reaction (e.g. a rash).
- Assign an external cause code from categories Y40-Y59 as indicated in the column ‘Adverse effect in therapeutic use’ in the Table of Drugs and Chemicals in Section III of the Alphabetical Index.

Where multiple adverse effects (e.g. a rash and swelling) result from a drug, a code from categories Y40-Y59 must be assigned after each of the adverse effects.

Where an adverse effect(s) is due to multiple drugs and each drug has been identified in the medical record, separate codes from categories Y40-Y59 must be assigned for each drug.

An adverse reaction due to the combination of two (or more) prescribed drugs must be coded as an adverse effect of both agents, as long as each drug has been taken correctly.

If an adverse reaction is due to a prescription drug and it is not known whether the drug was prescribed or not, code as an adverse effect.

An adverse reaction due to a drug (either properly or improperly administered) taken in combination with alcohol of any kind must to be coded as a poisoning by both agents.

An adverse reaction occurring due to the combination of taking a prescribed drug and a non-prescribed drug must be coded as a poisoning by both agents.

A poisoning code from Chapter XIX must never be used with an adverse effect code in categories Y40-Y59.

*See also DCS.XIX.8: Poisoning (T36-T65).*
Adverse effects can be described as:

- adverse effect of drug
- allergic reaction
- cumulative toxicity
- hypersensitivity
- idiosyncratic reaction
- side effects
- interaction of drugs

*See also Chapter XIX for guidance on the Table of Drugs and Chemicals in Section III of the Alphabetical Index.*

**Examples:**

Patient admitted for treatment of neutropenia due to Vincristine therapy for Hodgkin lymphoma

- **D70.X** Agranulocytosis
  - Use additional external cause code (Chapter XX), to identify drug, if drug-induced.
- **Y43.3** Other antineoplastic drugs
- **C81.9** Hodgkin lymphoma, unspecified

Patient admitted with a generalised rash due to penicillin

- **L27.0** Generalized skin eruption due to drugs and medicaments
  - Use additional external cause code (Chapter XX), if desired, to identify drug.
- **Y40.0** Penicillins

Coma due to antiallergics and barbiturates taken in combination (each prescribed by different responsible consultants)

- **R40.2** Coma, unspecified
- **Y43.0** Antiallergic and antiemetic drugs
- **Y47.0** Barbiturates, not elsewhere classified

Bleeding gastric ulcer and duodenal ulcers both due to aspirin and celecoxib

- **K25.4** Gastric ulcer, chronic or unspecified with haemorrhage
- **Y45.1** Salicylates
- **Y45.3** Other nonsteroidal anti-inflammatory drugs [NSAID]
- **K26.9** Duodenal ulcer, unspecified as acute or chronic, without haemorrhage or perforation
- **Y45.1** Salicylates
- **Y45.3** Other nonsteroidal anti-inflammatory drugs [NSAID]
DCS.XX.8: Misadventure and adverse incidents during medical and surgical care (Y60-Y82)

Where misadventure to a patient occurs during a procedure, a code from categories Y60-Y69 Misadventure to patients during medical and surgical care must be assigned in a secondary position to the code describing the misadventure caused.

If an adverse incident that is out of the surgeon’s control occurs during a procedure, a code from categories Y70-Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use must be assigned in a secondary position to the code describing the adverse incident caused.

Where an abnormal reaction of the patient occurs after the procedure a code from categories Y83-Y84 must be assigned, see DCS.XIX.7: Postprocedural complications and disorders.

See also DCS.XX.7: Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59).

It is not the purpose of the ICD-10 classification to implicate a surgeon or Trust as responsible for a complication that may be due to any current or past procedure or that may have occurred prior to the current complication. ICD-10 does not necessarily indicate any mistake on the part of the consultant; it only shows that the current situation is in some way as a result of an operation.

Examples:
Bladder perforation during total abdominal hysterectomy

T81.2 Accident puncture and laceration during a procedure, not elsewhere classified
Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, during surgical operation

Patient’s femur shaft fractured during removal of a bone prosthesis

S72.30 Fracture of shaft of femur, closed
Y79.2 Orthopaedic devices associated with adverse incidents, prosthetic and other implants, materials and accessory devices

DCS.XX.9: Evidence of alcohol involvement (Y90 and Y91)

Codes in categories Y90.- Evidence of alcohol involvement determined by blood alcohol level and Y91.- Evidence of alcohol involvement determined by level of intoxication must be assigned in a secondary position when evidence of alcohol involvement, determined by blood alcohol level or by level of intoxication, is documented in the medical record.

Example:
Patient admitted drunk with a blood-alcohol level of 60-79 mg/100ml

F10.0 Mental and behavioural disorders due to use of alcohol, acute intoxication
Y90.3 Blood alcohol level of 60-79 mg/100ml
**DCS.XX.10: Hospital acquired conditions (Y95.X)**

When the responsible consultant has documented in the medical record that a condition is ‘hospital acquired’ code **Y95.X Nosocomial condition** must be assigned directly after the code for the condition that has been documented as being ‘hospital acquired’.

It must never be assumed that a condition is hospital acquired based on the fact that it was diagnosed whilst the patient was in hospital.

In cases where a patient is transferred from another hospital with a hospital acquired condition, code **Y95.X** must still be assigned as the **Y95.X** is linked to the actual condition and not to the hospital that it was acquired in.

A hospital acquired condition (also known as a nosocomial condition) is a condition that has developed as a result of an individual being in a hospital environment. Examples include hospital acquired pneumonia (HAP), hospital acquired clostridium difficile, hospital acquired MRSA and hospital acquired deep vein thrombosis.

Code **Y95.X** can be index trailed in Section II, External causes of Injury of the Alphabetical Index under the lead term ‘Factors, supplemental’

**Example:**

*Elderly patient with documented diagnosis of intracerebral haemorrhage and a hospital acquired deep vein thrombosis (DVT) of the left leg*

- I61.9  Intracerebral haemorrhage, unspecified
- I80.2  Phlebitis and thrombophlebitis of other deep vessels of lower extremities
- Y95.X  Nosocomial condition
CHAPTER XXI
Factors Influencing Health Status and Contact with Health Services
(Z00–Z99)

Coding standards and guidance

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

Codes in categories Z00–Z13 Persons encountering health services for examination and investigation must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead. If an abnormal finding is detected or a specific diagnosis is made as a result of the investigation a code from Z00-Z13 must not be assigned.

The exceptions to this are:

- The following categories which must NEVER be used in a primary position:
  - Z02.- Examination and encounter for administrative purposes
  - Z10.- Routine general health check-up of defined subpopulation

- Codes in categories Z08.- Follow-up examination after treatment for malignant neoplasm and Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms, see DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)

See also DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53).

**Examples:**

Toddler admitted with suspected overdose, having been found with an empty bottle of Aspirin. After examination, no evidence of poisoning was confirmed.

  - Z03.6 Observation for suspected toxic effect from ingested substance

Patient admitted for colonoscopy for screening due to a strong family history of cancer of the colon, the patient has no symptoms. Examination showed no evidence of any abnormality.

  - Z12.1 Special screening examination for neoplasm of intestinal tract
  - Z80.0 Family history of malignant neoplasm of digestive organs
### DCS.XXI.2: Follow-up examinations after treatment for a condition (Z08 and Z09)

Follow-up examinations for conditions that have been treated and are no longer present must be coded using the following codes and sequencing:

No recurrence of the condition is found during the follow-up examination:

- **Z08.-** Follow-up examination after treatment for malignant neoplasm or
- **Z09.-** Follow-up examination after treatment for conditions other than malignant neoplasms

Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for

An incidental finding(s) is noted on examination but not treated in hospital:

- **Z08.-** or **Z09.-**

  Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for

  Code(s) for incidental finding(s)

An incidental finding(s) is noted on examination and treatment is given in hospital for the finding(s):

- Code(s) for incidental finding(s)

- **Z08.-** or **Z09.-**

  Code from Chapter XXI to identify a personal history of the condition the follow-up examination has been performed for

Recurrence of the condition is found during the follow-up examination:

- Code for the recurrent condition

- Code(s) for any incidental finding(s)

Fourth character code assignment at categories **Z08.-** and **Z09.-** is dependent on the type of treatment the patient received for the original condition.

#### Examples:

*Follow-up DMPSA scan (tc-99m dimercaptosuccinic acid) after a previous urinary tract infection treated with antibiotics. No abnormalities detected.*

- **Z09.2** Follow-up examination after chemotherapy for other conditions

- **Z87.4** Personal history of diseases of the genitourinary system

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

- **Z08.0** Follow-up examination after surgery for malignant neoplasm

- **Z85.5** Personal history of malignant neoplasm of urinary tract

- **N32.8** Other specified disorders of bladder

*Routine check gastroscopy following drug treatment for previous gastric ulcer. Acute gastritis found and treated in hospital.*

- **K29.1** Other acute gastritis

- **Z09.2** Follow-up examination after chemotherapy for other conditions

- **Z87.1** Personal history of diseases of the digestive system

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

- **C67.9** Malignant neoplasm: Bladder, unspecified
DCS.XXI.3: Persons with potential health hazards related to communicable diseases (Z20–Z29)

Codes in categories Z20–Z29 Persons with potential health hazards related to communicable diseases must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead.

Codes in categories Z20–Z29 may be used in a secondary position to a code from another chapter if they add further information.

Example:
Patient 34 weeks pregnant is admitted with contractions. Responsible consultant confirms Braxton Hicks contractions (false labour) and she is discharged. The patient is known to be a carrier of group B streptococcus (GBS).

O47.0 False labour before 37 completed weeks of gestation
Z22.3 Carrier of other specified bacterial diseases

Asymptomatic human immunodeficiency virus [HIV] infection status (Z21.X)


DCS.XXI.4: Carrier of drug resistant bacterial diseases (Z22.3 and U80-U89)

A code from U80-U89 Bacterial agents resistant to antibiotics must be assigned in a secondary position to Z22.3 Carrier of other specified bacterial diseases to identify the drug to which the bacteria is resistant, when this is documented by the responsible consultant in the patient’s medical record.

See also DCS.XXI.9: Bacterial agents resistant to antibiotics (U80-U89).

Examples:
MRSA positive carrier.

Z22.3 Carrier of other specified bacterial diseases
U80.1 Methicillin resistant agent

MRSA found on nasal swab only.

Z22.3 Carrier of other specified bacterial diseases
U80.1 Methicillin resistant agent

DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54)

Codes in categories Z30-Z54 must be used as follows:

Assign codes in categories Z30-Z54 in a primary diagnostic position when there is no diagnosis, complication, injury or symptom code from another chapter in ICD-10 to explain the encounter instead.

The following codes are exceptions which must never be used in a primary position:

- Z30.0 General counselling and advice on contraception
- Z30.4 Surveillance of contraceptive drugs
- Z50.- Care involving use of rehabilitation procedures
- Z51.- Other medical care – see also DCS.XXI.9: Palliative Care (Z51.5, Z51.8)
Factors Influencing Health Status and Contact with Health Services

**DCS.XXI.5 continued**

Assign codes in categories Z30-Z54 in a secondary position to the diagnosis, symptom, complication or injury code from another chapter where doing so adds further information. They must not be assigned in a secondary position to identify an intervention or procedure, when the procedure/intervention has been identified by the assignment of an OPCS-4 code following correct application of the OPCS-4 national standards.

The exceptions to this standard are:

- **Z33.X** Pregnant state, incidental – see DCS.XV.33: pregnant state, incidental (Z33.X)
- **Z34.-** Supervision of normal pregnancy – see DCS.XV.34: Supervision of normal pregnancy (Z34)
- **Z37.-** Outcome of delivery – see DChS.XV.1: Outcome of delivery (Z37)
- **Z38.-** Liveborn infants according to place of birth – see DChS.XVI.1: Liveborn infants according to place of birth (Z38)
- **Z49.-** Care involving dialysis – see DCS.XXI.8: Renal dialysis (Z49 and Z99.2)
- **Z53.-** Persons encountering health services for specific procedures, not carried out – see DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53)
- **Z54.-** Convalescence – see DCS.XXI.12: Convalescence (Z54).

**Examples:**

*Follow-up care for removal of internal fixation after treatment of fracture*

- **Z47.0** Follow-up care involving removal of fracture plate and other internal fixation device

*Patient with end stage renal disease admitted for removal of a central venous catheter*

- **N18.5** Chronic kidney disease, stage 5

  Code **Z45.2** Adjustment and management of vascular access device is not assigned because the removal of the central venous catheter is classified using OPCS-4 codes.

*Patient admitted to gynaecology ward to receive Mifepristone pessary for termination of pregnancy. Discharged home prior to aborting the pregnancy. The patient has vaginal bleeding prior to discharge.*

- **O04.9** Medical abortion, complete or unspecified, without complication

  Code **Z51.2** Other chemotherapy is not assigned because the introduction of the mifepristone pessary is classified using OPCS-4 codes.

*Patient with dysphasia due to a previous cerebral infarction undergoes speech therapy*

- **R47.0** Dysphasia and aphasia
- **I69.3** Sequelae of cerebral infarction
- **Z50.5** Speech therapy

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

**Supervision of high-risk pregnancy (Z35)**

*See DCS.XV.3: Cancellation of medical termination of pregnancy.*

*See chapter XV for guidance on definitions used in codes within category Z35 Supervision of high-risk pregnancy.*
### Care and examination immediately after delivery (Z39.0)

*See DCS.XV.35: Care and examination immediately after delivery (Z39.0).*

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

When a patient is admitted for preventative surgery due to a personal or family history of a condition, a code from category **Z40.- Prophylactic surgery** must be recorded as the primary diagnosis. A code from categories **Z80-Z87** must be assigned in a secondary position to identify the personal or family history of a condition.

Where the preventative surgery is being performed due to the presence of a current condition a code classifying the condition must be assigned in a primary position and a code from **Z40.-** would be assigned in a secondary position.

**Example:**

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

- **Z40.0** Prophylactic surgery for risk-factors related to malignant neoplasms
- **Z80.3** Family history of malignant neoplasm of breast

### DCS.XXI.7: Trial without catheter (Z46.6)

When a patient is admitted for trial without catheter (TWOC) and the trial is successful code **Z46.6 Fitting and adjustment of urinary device** is assigned as the primary diagnosis.

However, if a TWOC fails, the code describing the condition for which the patient was catheterised is assigned and not code **Z46.6**.

**Examples:**

*Patient who had a prostatectomy three weeks ago and had to have a urethral catheter inserted because of urinary retention is now admitted for a trial without catheter (TWOC). The trial is successful.*

- **Z46.6** Fitting and adjustment of urinary device

*Patient who had a prostatectomy three weeks ago had a urethral catheter inserted because of urinary retention is now admitted for a trial without catheter (TWOC). The trial is unsuccessful.*

- **R33.X** Retention of urine

### DCS.XXI.8: Renal dialysis (Z49 and Z99.2)

Codes in category **Z49.- Care involving dialysis** must never be assigned in the primary position. They are assigned as follows:

- If a patient is admitted for the purpose of renal dialysis, a code from category **Z49.-** must be assigned in secondary position to the code describing the renal condition the patient is undergoing dialysis for.

- If a patient is admitted for other treatment, and receives dialysis whilst in hospital a code from category **Z49.-** must not be assigned.

Patients who are on a regular programme of dialysis treatments and who are admitted for reasons other than receiving dialysis must have code **Z99.2 Dependence on renal dialysis** assigned as a secondary code.
Examples:

Patient with chronic end stage renal failure admitted for renal dialysis

- **N18.5** Chronic kidney disease, stage 5
- **Z49.1** Extracorporeal dialysis

Patient with end-stage renal disease admitted for total knee replacement for primary osteoarthritis of the right knee. While in hospital, he has ten haemodialysis sessions.

- **M17.1** Other primary gonarthrosis
- **N18.5** Chronic kidney disease, stage 5
- **Z99.2** Dependence on renal dialysis

**DCS.XXI.9: Palliative Care (Z51.5, Z51.8)**

Codes **Z51.5** Palliative care and **Z51.8** Other specified medical care must only be assigned in a secondary position, as described in the table below, when a patient receives palliative care.

<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</strong> Palliative care in a secondary position.</td>
<td>Assign code <strong>Z51.8</strong> Other specified medical care in a secondary position.</td>
</tr>
<tr>
<td>This includes ‘End of Life Care’ plan patients receiving specialised palliative care/ specialised palliative care support</td>
<td>This includes ‘End of Life Care’ plan patients receiving palliative care not specified as Specialised Palliative Care or Specialised Palliative Care Support</td>
</tr>
</tbody>
</table>

**DCS.XXI.10: Donors of organs and tissues (Z52)**

Codes in category **Z52.-** Donors of organs and tissues must only be assigned for live donors of organs and tissues.

**DCS.XXI.11: Cancelled procedures and abandoned procedures (Z53)**

Codes in category **Z53.-** Persons encountering health services for specific procedures, not carried out must never be assigned in a primary position. **Z53.-** must only be used for patients admitted electively for a procedure which is subsequently cancelled/not carried out/not started for any reason and no other procedure has been carried out, ie the coded record contains no OPCS-4 procedure codes within that particular consultant episode. The following codes and sequencing must be applied:

- Code that classifies the condition prompting the admission
- **Z53.-** Persons encountering health services for specific procedures, not carried out
  - If the planned procedure is cancelled because of a medical problem, condition or factor that makes it inadvisable to perform the procedure (such as a contraindication), the problem, condition or factor must also be coded.

Circumstances where a patient’s surgery is cancelled due to the lack of a bed or theatre time is not a contraindication and such situations must be coded using **Z53.8 Procedure not carried out for other reasons.**
If a patient is admitted for a procedure for a condition and the procedure is cancelled because on examination the condition has resolved, the following codes and sequencing must be applied:

- **Z03.** Medical observation and evaluation for suspected diseases and conditions or
- **Z04.** Examination and observation for other reasons
- **Z53.8** Procedure not carried out for other reasons

Chapter XXI code classifying personal history of diseases

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

A code from **Z53.** must not be assigned if a procedure was started and then abandoned; it is only necessary to record the appropriate code for the condition(s) which prompted the procedure to be performed and/or complication codes if the procedure was abandoned due to a complication.

**See also:**
- **DCS.XV.3: Cancellation of medical termination of pregnancy**
- **Coding Clinic Ref 88: Coding of co-morbidities – cancelled procedures.**

A contraindication is any condition or factor that makes it inadvisable to perform a particular procedure or treatment. Contraindications include instances where the patient has eaten prior to surgery, or they have failed to stop taking medication as instructed, eg Warfarin.

When an endoscopy is abandoned due to ‘failed intubation’ because the patient is unable to tolerate the scope this is not considered a complication and would not be coded using codes in categories **T80-T88 Complications of surgical and medical care, not elsewhere classified.** A code for the condition which prompted the endoscopy to be performed would be assigned.

**Examples:**

**Patient with chronic tonsillitis admitted electively for tonsillectomy. The procedure is cancelled as the patient is noted to have chickenpox**

- J35.0 Chronic tonsillitis
- Z53.0 Procedure not carried out because of contraindication
- B01.9 Varicella without complication

**Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has failed to stop taking their Warfarin.**

- K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
- Z53.0 Procedure not carried out because of contraindication
- Z92.1 Personal history of long-term (current) use of anticoagulants

**Patient admitted electively for an inguinal hernia repair. The procedure is cancelled because the patient has eaten prior to surgery.**

- K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
- Z53.0 Procedure not carried out because of contraindication

**Patient admitted as a day case for excision of left breast lump. On examination, the breast lump has disappeared and the procedure is cancelled.**

- Z03.8 Observation for other suspected diseases and conditions
- Z53.8 Procedure not carried out for other reasons
- Z87.4 Personal history of diseases of genitourinary system
Patient with chronic gastric ulcer admitted for gastroscopy. Intubation failed as the patient could not tolerate the scope and the procedure is abandoned.

**K25.7 Gastric ulcer, chronic without haemorrhage or perforation**

Patient admitted for excision biopsy of lump in neck but refused surgery on arrival in theatre.

**R22.1 Localised swelling, mass and lump, neck**

**Z53.2 Procedure not carried out because of patient’s decision for other and unspecified reasons**

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

### DCS.XXI.12: Convalescence (Z54)

Codes in category **Z54.- Convalescence** must never be assigned in a primary position. They must only be assigned in a secondary position when a patient has received convalescence in a **dedicated convalescent unit**.

### DCS.XXI.13: Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55–Z65)

The codes in categories **Z55–Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances** must not be used in the primary diagnostic position, (with the exception of **Z63.8 Other specified problems related to primary support group** which may be assigned in a primary position).

They must only be used in a secondary position to a code from another chapter when the circumstance influences the patient’s current condition and adds relevant information or there is an explicit national standard that instructs otherwise, e.g. **DCS.XXI.14: Passive smoking (Z58.7)** and **DCS.XXI.15: Living alone (Z60.2)**.

*See also chapter XIII for guidance on the use of Z56.6 Other physical and mental strain related to work when coding repetitive strain injuries (M70.-).*

#### Example:

*Child on ‘at risk’ register is admitted (with no problems) at the same time as their sibling is admitted for care*

**Z63.8 Other specified problems related to primary support group**

### DCS.XXI.14: Passive smoking (Z58.7)

If passive smoking is documented within the medical record by the responsible consultant, code **Z58.7 Exposure to tobacco smoke** must be assigned in a secondary position.

#### Example:

*Acute severe asthma aggravated by husband’s heavy smoking*

**J46.X Status asthmaticus**

**Z58.7 Exposure to tobacco smoke**

### DCS.XXI.15: Living alone (Z60.2)

Code **Z60.2 Living alone** must only be assigned as an additional code when it is evident in the medical record that the fact that a patient lives alone has extended their length of stay.

**Z60.2** must not be assigned on an episode where the patient dies.
Examples:
Patient with senile incipient cataract admitted for cataract surgery. Kept in overnight due to the fact she lives alone.

H25.0 Senile incipient cataract
Z60.2 Living alone

79 year old lady who lives alone admitted as a day case for excision lipoma left arm.

D17.2 Benign lipomatous neoplasm of skin and subcutaneous tissue of limbs

<table>
<thead>
<tr>
<th>DCS.XXI.16: Persons encountering health services in other circumstances (Z70–Z76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes in categories Z70–Z76 Persons encountering health services in other circumstances must only be assigned in a primary position when there is no diagnosis, complication, injury, symptom or abnormal finding code that could be used to explain the encounter instead.</td>
</tr>
<tr>
<td>The following categories/codes are exceptions to this block and must NEVER be used in a primary position:</td>
</tr>
<tr>
<td>Z71.0 Person consulting on behalf of another person</td>
</tr>
<tr>
<td>Z72 Problems relating to lifestyle</td>
</tr>
<tr>
<td>Z73.2 Lack of relaxation and leisure</td>
</tr>
<tr>
<td>Z73.4 Inadequate social skills, not elsewhere classified</td>
</tr>
<tr>
<td>Z73.5 Social role conflict, not elsewhere classified</td>
</tr>
<tr>
<td>Z73.6 Limitation of activities due to disability</td>
</tr>
<tr>
<td>Z74 Problems related to care-provider dependency, see DCS.XXI.18: Problems related to care-provider dependency (Z74)</td>
</tr>
<tr>
<td>Z75 Problems related to medical facilities and other health care (except Z75.5 Holiday relief care, see DCS.XXI.20: Holiday relief care (Z75.5))</td>
</tr>
<tr>
<td>Z76.0 Issue of repeat prescription</td>
</tr>
<tr>
<td>Z76.3 Healthy person accompanying sick person</td>
</tr>
<tr>
<td>Z76.4 Other boarder in health care facility</td>
</tr>
</tbody>
</table>

Codes in categories Z70-Z76 may be used in a secondary position to a code from another chapter if they add further information.

Alcohol use (Z72.1) and Tobacco use (Z72.0)

See:
- DCS.V.5: Alcohol abuse and heavy drinker (F10)
- DCS.V.7: Current smoker (F17).

DCS.XXI.17: Acopia (Z73.9)

Code Z73.9 Problem related to life-management difficulty, unspecified must be assigned for patients admitted to hospital because of an inability to cope.
Factors Influencing Health Status and Contact with Health Services

**DCS.XXI.18: Problems related to care-provider dependency (Z74)**

Codes in category **Z74.- Problems related to care-provider dependency** must only be assigned in a secondary position when a patient, who is care provider dependent, is admitted for care because their care provider is not available. The condition prompting why the person needs care provision must be recorded in the primary position.

*See also DCS.XVIII.3: Immobility and reduced mobility (R26.3, R26.8).*

**DCS.XXI.19: Persons awaiting admission to adequate facility elsewhere (Z75.1)**

**Z75.1 Persons awaiting admission to adequate facility elsewhere** must only be assigned in a secondary position in patients whose medical record clearly state that they are ‘bed-blocking’ or medically fit for discharge (MFD) but awaiting suitable accommodation elsewhere, such as a nursing or residential home.

**Example:**

Patient who has suffered a cerebral infarction is awaiting admission to local nursing home

- I63.9 Cerebral infarction, unspecified
- Z75.1 Person awaiting admission to adequate facility elsewhere

**DCS.XXI.20: Holiday relief care (Z75.5)**

Patients who are admitted for holiday relief care or respite care to enable their carers to take a break must be coded as follows:

- If the patient receives only the same level of care and attention that would normally be given at home by their carer, code **Z75.5 Holiday relief care** must be assigned in the primary position, followed by the code describing the patient’s chronic condition.

- If treatment is given for a different condition to the condition they have a carer for (this may be a pre-existing condition or a condition that is diagnosed whilst the patient is in hospital) and this becomes the main condition treated during the consultant episode, this condition must be assigned as the primary diagnosis and code **Z75.5 Holiday relief care** is assigned in a secondary position. The patient’s chronic condition that they have a carer for must also be coded.

- If a patient is pre-booked for holiday relief care but the responsible consultant decides that the patient must have additional treatment or reassessment for their chronic condition which is over and above those that they normally receive at home, (such as adjustment to drug routine or physiotherapy), the chronic condition must be recorded as the primary diagnosis. Code **Z75.5 Holiday relief care** is assigned in a secondary position.

*See also:*

- **DCS.XX.10: Hospital acquired conditions (Y95.X)**
- **DCS.XXI.5: Persons encountering health services in circumstances related to reproduction and for specific procedures and health care (Z30–Z54).**
Examples:
Patient with multiple sclerosis admitted for two weeks respite care to allow their carer to take a holiday. No additional treatment other than that normally given at home was required.

Z75.5  Holiday relief care
G35.X  Multiple sclerosis

Patient with multiple sclerosis admitted for two weeks respite care to allow their carer to take a holiday. The patient developed bronchopneumonia which required intensive treatment.

J18.0  Bronchopneumonia, unspecified
G35.X  Multiple sclerosis
Z75.5  Holiday relief care

Patient booked for two weeks respite care to allow their carer to take a holiday. The responsible consultant decides that the patient will have a course of physiotherapy for his multiple sclerosis.

G35.X  Multiple sclerosis
Z50.1  Other physical therapy
Z75.5  Holiday relief care

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

The codes in categories Z80–Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status must not be used in a primary diagnosis position, with the exception of Z85.6 Personal history of leukaemia and Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues, see DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7).

They must only be used in a secondary position to a code from another chapter when the circumstance influences the patient’s current condition and to provide relevant additional information; with the exception of those problem codes contained on the list of co-morbidities which must always be coded when recorded in the medical record, see Coding Clinic Ref 88 coding comorbidities.

Examples:
Patient admitted with chest pain. Myocardial infarction (MI) not diagnosed. Patient’s father died of an MI at 43 and his brother was diagnosed with ischaemic heart disease (IHD) at the age of 26.

R07.4  Chest pain, unspecified
Z82.4  Family history of ischaemic heart disease and other diseases of the circulatory system

Patient admitted with acute depression. Has previously deliberately overdosed and self harmed.

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

Sebaceous cyst of breast and history of carcinoma of breast

N60.8  Other benign mammary dysplasias
Z85.3  Personal history of malignant neoplasm of breast
Patient 12 years of age admitted with temporomandibular joint disorder. Personal history of cleft lip and palate.

K07.6  Temporomandibular joint disorders
Z87.7  Personal history of congenital malformations, deformations and chromosomal abnormalities

Moderate learning disability (mental retardation) due to cerebral haemorrhage at birth. The patient is three years old.

F71.9  Moderate mental retardation without mention of impairment of behaviour
Z87.6  Personal history of certain conditions arising in the perinatal period

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

### Personal history of malignant neoplasm (Z85)

See:
- DCS.II.1: Primary and secondary malignant neoplasms (C00-C97) - Sequencing of malignant neoplasms
- DCS.II.8: Maintenance treatment for malignant neoplasm of lymphoid, haematopoietic and related tissues in remission (Z85.6 and Z85.7).

### Female genital mutilation (N90.8 and Z91.6)

See DCS.XIV.11: Female genital mutilation (N90.8 and Z91.6).

### Dependence on renal dialysis (Z99.2)

See DCS.XXI.8: Renal dialysis (Z49 and Z99.2).
CHAPTER XXII
Codes for Special Purposes
(U00–U99)

Coding standards and guidance

**DCS.XXII.1: Severe acute respiratory syndrome [SARS] (U04.9 and B97.2)**

Code **U04.9 Severe acute respiratory syndrome [SARS], unspecified** must only be assigned when the responsible consultant has made a clear clinical diagnosis of SARS in the patient’s medical record. All treated manifestations of the condition must also be coded.

When the responsible consultant clearly documents in the patient’s medical record that coronavirus has been identified as the cause of SARS, code **B97.2 Coronavirus as the cause of diseases classified to other chapters** must be assigned immediately following code **U04.9**.

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

**DCS.XXII.2: Bacterial agents resistant to antibiotics (U80-U89)**

The codes within categories **U80-U89 Bacterial agents resistant to antibiotics** must:

- Never be used as primary diagnosis codes
- Only be used in a secondary position, sequenced directly following a code for a bacterial infection classified elsewhere
- Only be assigned when the antibiotic to which a bacterial agent is resistant is clearly documented in the medical record by the responsible consultant. The coder must not interpret laboratory results in order to identify the antibiotic to which an agent is resistant, *see also DGCS.4: Using diagnostic test results.*
- Never be used for viral, fungal or parasitic agents that are resistant to drugs.

When a bacterial agent is resistant to two or more antibiotics which are specified within categories **U80. Agent resistant to penicillin and related antibiotics** or **U81. Agent resistant to vancomycin and related antibiotics**, a code for each antibiotic the agent is resistant to must be assigned.

Code **U88.X Agent resistant to multiple antibiotics** must only be used when an agent is resistant to two or more antibiotic drugs and the antibiotics drugs are not specified.

**Methicillin resistant staphylococcus aureus (MRSA)**

When it is documented that a patient has methicillin resistant staphylococcus aureus (MRSA) infection it is implied that the bacteria is resistant to methicillin. Consequently code **U80.1 Methicillin resistant agent** must be assigned immediately after the code which identifies that the infective agent is staphylococcus aureus.

*See also:*
- **DGCS.6: Infections and sepsis**
- **DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)**
- **DCS.XXI.4: Carrier of drug resistant bacterial diseases (Z22.3 and U80-U89)**.
Examples:

*Pneumonia due to Streptococcus pneumoniae resistant to amoxicillin*

- **J13.X** Pneumonia due to *Streptococcus pneumoniae*
- **U80.0** Penicillin resistant agent

*MRSA pneumonia also resistant to vancomycin*

- **J15.2** Pneumonia due to *Staphylococcus*
- **B95.6** *Staphylococcus aureus* as the cause of diseases classified to other chapters
- **U80.1** Methicillin resistant agent
- **U81.0** Vancomycin resistant agent

*E.coli meningitis, resistant to multiple antibiotics*

- **G00.8** Other bacterial meningitis
- **B96.2** *Escherichia coli* [*E. coli*] as the cause of diseases classified to other chapters
- **U88.X** Agent resistance to multiple antibiotics

*Postoperative methicillin antibiotic resistant staphylococcus aureus (MRSA) wound infection following gastrectomy 2 weeks ago*

- **T81.4** Infection following a procedure, not elsewhere classified
- **B95.6** *Staphylococcus aureus* as the cause of diseases classified to other chapters
- **U80.1** Methicillin resistant agent
- **Y83.6** Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, removal of other organ (partial) (total)

*See also DCS.XIX.7: Postprocedural complications and disorders.*
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