National Clinical Coding Qualification (UK)
September 2018 Examination Feedback
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Examination Feedback

The purpose of this feedback is to highlight some of the most common mistakes made by candidates in this examination and to provide useful comments that may help candidates with their revision for forthcoming NCCQ (UK) examinations.

Many candidates performance demonstrated good preparation in both papers for the September 2018 exam. However, areas of poor performance continue to cause concern, particularly with regard to paper 2 Theory with both Section C and Section D being poorly attempted. Candidates are strongly advised to review the NCCQ (UK) Syllabus and Bibliography to identify any gaps in their knowledge and where necessary agree an action development plan with their line manager. These documents along with other aids for examination revision are available for download from the NHS Digital NCCQ (UK) webpage:

https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=298707

Preparing for the Examination:

Candidates preparing for this examination will need to have completed core training¹ and be familiar with current national clinical coding standards. Completion of the following courses is highly recommended as a minimum level of attainment prior to sitting the NCCQ (UK) exam:

- Clinical Coding Standards Course
- Clinical Coding Standards Refresher Course
- National Clinical Coding Qualification Revision Workshop

Candidates need to plan their study in plenty of time before the examination.

The NHS Digital Terminology & Classification Delivery Service provides information about the National Clinical Coding Qualification (UK) Syllabus, Bibliography and Study Guidelines. In addition, a suite of e-learning modules that cover the ICD-10 Four Step Coding Process, Basic Anatomy and Physiology and Introduction to Clinical Coding are available and these are useful materials for revision and exam preparation. In addition, a range of e-learning modules are also available for SNOMED-CT. All of these e-learning modules are all accessible via the Education and Training Library found on Delen.

https://hscic.kahootz.com/connect.ti/t_c_home/viewdatastore?dsid=379620

Sitting the Examination:

Candidates should thoroughly read all instructions provided on the examination paper. Failure to follow specific instructions, such as writing a candidate number on each page of the examination paper, will result in a loss of marks as any unlabelled answers cannot be attributed to the candidate.

¹ The term ‘core training’ refers to the essential specialist training that NHS organisations are required to provide clinical coding staff in order to meet Data Standard 3 in the Data Security & Protection Toolkit.
Common mistakes:
The following highlight some of the common mistakes made by candidates sitting the September 2018 Examination.

**Paper 1 – Practical Coding**

**Section A1**

**Question:** Post-operative wound infection of the skin overlying a femoral artery bypass graft. The infection is resistant to two antibiotics.

**Answer:**
- T81.4 Infection following a procedure, not elsewhere classified
- U83.7 Resistance to multiple antibiotics
- Y83.2 Surgical operation with anastomosis, bypass or graft

A number of incorrect code assignments resulted in many candidates missing out on the marks for this question. Common errors concerned the allocation of the primary diagnosis. The question specifically states that the infection relates to the skin overlying a femoral artery bypass graft. In other words, the infection is genuinely of the wound site and is not due to the graft itself. Therefore, ICD-10 code **T82.7 Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts** is not the correct code in these circumstances since the infection has not been caused by the graft but relates to the surgical wound. Another common error was sequencing of the external cause code and resistance code. As per coding standard **DCS.XXII.2: Resistance to antimicrobial and antineoplastic drugs (U82-U85)** codes within categories **U82-U85 Resistance to antimicrobial and antineoplastic drugs** must be sequenced directly following the code they enhance, i.e. the code classifying the infection/infectious organism.

**Question:** Chronic peptic ulcer of the stomach due to *Helicobacter pylori*.

**Answer:**
- K25.7 Gastric ulcer - Chronic without haemorrhage or perforation
- B98.0 Helicobacter pylori [H.pylori] as the cause of diseases classified to other chapters

Candidates failed to correctly apply coding standard **DCS.XI.3: Peptic ulcer, site unspecified (K27)**, as information about the site of the ulcer was available then it is required to code it as an ulcer of the stated site. Furthermore, candidates did not assign the correct fourth-character code by referring to the subdivisions found at the beginning of the block as indicated by the instructional note printed at categories **K25–K28**.
**Question:** Ruptured spleen and two fractured ribs from a fall off a jet ski off the coast of Devon.

**Answer:**
- S36.00 Injury of spleen - without open wound into cavity
- S22.40 Multiple fractures of ribs – closed
- V92.3 Water-transport-related drowning and submersion without accident to watercraft - Other powered watercraft

Many candidates struggled to identify the correct external cause code needed to classify this accident. The terms ‘drowning and submersion’ appear in the Alphabetical Index enclosed within parentheses indicating that these are non-essential modifiers and as such do not need to be included in the diagnostic statement to enable assignment of that code. A surprisingly large number of candidates also omitted the mandatory fifth characters from the Chapter XIX codes. These supplementary characters must always be assigned when there is an applicable note instructing their use. An injury not indicated as ‘open’ or ‘closed’ must be recorded using fifth character .0.

**Question:** Residual fourth cranial nerve palsy due to previous tuberculous meningitis. Known to have hypertension.

**Answer:**
- H49.1 Fourth [trochlear] nerve palsy
- B90.0 Sequelae of central nervous system tuberculosis
- I10.X Essential (primary) hypertension

The most common error made by candidates answering this question was allocation of ICD-10 code G09.X Sequelae of inflammatory diseases of central nervous system rather than B90.0. When assigning sequelae codes attention must be paid to any instructional notes or *Includes* notes as these will indicate the correct use of these codes. The instructional note printed beneath category G09 indicates that this category is for use only for those conditions whose primary classification is within category range G00–G08 i.e. excluded those marked with an asterisk (*). The primary classification code for tuberculous meningitis is A17.0 Tuberculous meningitis (G01*) this fits within the category range mentioned in the *Note* at block Sequelae of infectious and parasitic diseases (B90-B94). Whenever coding sequelae it is recommended that coders first locate the code for the condition as through it were a current problem, this will in turn allow the coder to verify the correct sequelae code.

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Question: Farmworker admitted with severe Brucella (Gram-negative) sepsis.

Answer: A23.9 Brucellosis, unspecified

A41.5 Sepsis due to other Gram-negative organisms

R65.1 Systemic Inflammatory Response Syndrome of infectious origin with organ failure

Candidates did not correctly apply coding standard DChS.I.1: Sepsis, septic shock, severe sepsis and neutropenic sepsis. Although the Alphabetical Index suggests that ICD-10 code A23.9 classifies Brucella sepsis, verifying the code assignment in the Tabular List reveals that the code title does not include specific mention of sepsis. Therefore, as per DChS.I.1 where the code assigned does not specifically classify sepsis then a code that classifies sepsis must be assigned in any secondary position, in order to describe the condition fully. In this circumstance, Brucella is a gram-negative bacterium and so the addition of ICD-10 code A41.5 was required to fully classify the condition.

Question: Stage 2 and 3 pressure sores (heel and buttock respectively) both found to be infected with coagulase-negative staphylococcus.

Answer: L89.2 Stage III decubitus ulcer

L08.9 Local infection of skin and subcutaneous tissue, unspecified

B95.7 Other staphylococcus as the cause of diseases classified to other chapters

Candidates assigned the incorrect fourth-character code of the pressure ulcer, incorrectly assuming that the fourth-digit corresponds to the stage of the ulcer, i.e. stage 3 would be coded to the .3 subdivision. However, this is not the case with category L89 Decubitus ulcer and pressure area. Care must be taken to ensure code assignments are verified in the Tabular List before being made final. Furthermore, candidates omitted L08.9. As per coding standard DCS.XII.3 Pressure ulcer and leg ulcer with associated infection, cellulitis and gangrene when coding pressure ulcers with associated infection then ICD-10 code L08.9 must be assigned directly following the code classifying the ulcer in order to fully describe the condition.
Section A2

Question:  Second episode for delivery of hypofractionated stereotactic external beam radiotherapy to a pituitary gland adenoma using a megavoltage machine.

Answer:  X65.4 Delivery of a fraction of external beam radiotherapy NEC  
Y91.5 Megavoltage treatment for hypofractionated stereotactic radiotherapy  
Z14.1 Pituitary gland

The main error encountered here was allocation of OPCS codes B02.2 Implantation of radioactive substance into pituitary gland or A10.7 Stereotactic radiosurgery on tissue of brain as the primary procedure. Although the pituitary gland is situated at the base of the brain it is an endocrine gland and so is not classified as 'tissue of the brain' within OPCS-4. Chapter A deals with procedures on the nervous system so procedures performed on the pituitary gland structure are classified in Chapter B which deals with the endocrine system. Furthermore, B20.2 is not necessary since there was no mention of any radioactive substance being implanted during this attendance. Body system chapter codes must only be assigned when they describe the delivery or radiotherapy. As there is no such code available for the pituitary gland then a code from category X65 Radiotherapy delivery is assigned as the primary procedure with a Z-site code to identify the body part being treated by radiotherapy.4

Question:  Emergency admission added to a pre-scheduled theatre list for a replacement of an aneurysmal segment of the aortic arch with anastomosis of the aorta to aorta, under cardiopulmonary bypass.

Answer:  L18.2 Emergency replacement of aneurysmal segment of thoracic aorta by anastomosis of aorta to aorta NEC  
Y73.1 Cardiopulmonary bypass  
Z34.2 Aortic arch

Incorrect coding of the primary procedure was found to be the most common error when answering this question. Candidates were not aware of coding standard PCSL8: Replacement/repair of aorta for aortic aneurysm and aortic dissection (L18-L21, L27-L28) wherein it states that the replacement of the aortic arch must be classified to a code for the replacement of thoracic segment of the aorta, followed by Z34.2 Aortic arch to further specify the particular section of the thoracic aorta. Furthermore, candidates selected the incorrect category. The question states that the patient was added to a pre-scheduled theatre list for their operation, i.e. the use of theatre time for this procedure was unscheduled and so must be regarded as an emergency procedure according to general coding standard PGCS15: Emergency procedures.

Question: Replacement of previous prosthetic right femoral head with a hybrid total hip replacement with a cemented acetabular component.

Answer: W93.2 Conversion to hybrid prosthetic replacement of hip joint using cemented acetabular component

W48.0 Conversion from previous prosthetic replacement of head of femur NEC

Z94.2 Right sided operation

This question was poorly attempted by a large number of candidates. Many candidates incorrectly identified the original procedure as a total hip replacement rather than as a replacement of femoral head only (hemiarthroplasty) resulting in a number of incorrect secondary procedure codes at the three-character level. Other errors included assigning codes for revision rather than using the conversion to/from codes and confusing the cemented components for the hybrid hip replacement.

Question: Dopamine transporter single photon emission computed tomography (SPECT) of the brain tissue.

Answer: U21.4 Single photon emission computed tomography NEC

Y94.1 Dopamine transporter scan

Z01.9 Tissue of brain NEC

It was disappointing to note that candidates were unable to identify the correct primary procedure code for the SPECT scan despite the acronym being provided to direct candidates to look in Section III: Alphabetical Index of Surgical Abbreviations of the OPCS-4 Alphabetical Index where it can be found listed. The most common error was to assign U36.3Single photon emission computed tomography with computed tomography NEC. However, this code classifies the use of SPECT with CT, a different imaging procedure which uses both components separately and then fuses the images together. Another common error was to use an additional code from category Y98 Radiology procedure. However, the Note at code U21.4 (and U36.3 for that matter) does not indicate a requirement to assign a code from Y98. SPECT is a type of nuclear medicine imaging procedure and so the instructional notes correctly advise the coder to assign the appropriate code for the type of radiopharmaceutical imaging instead, in this instance the dopamine transporter. A code from Y98 must not be assigned5.

Question:  Percutaneous transluminal thrombolysis of portal vein under radiological control.

Answer:  J10.6 Percutaneous transluminal thrombolysis of blood vessel of liver
        Y53.1 Approach to organ under radiological control
        Z39.3 Portal vein

The most common error was omission of the Z-site code. Although the Alphabetical Index trail ‘Thrombolysis Vein Portal Transluminal Percutaneous’ directing to J10.6 does specify the portal vein the actual code title found in the Tabular List only states ‘blood vessel of liver’. Therefore, the addition of Z-site code Z39.3 is required since this adds further specificity about the site of the operation that is not covered by the body system chapter code alone. Other common errors included sequencing the Chapter Z code before the Chapter Y code which goes against the sequencing rule established in general coding standard PGCS14: Sequencing of codes in Chapter Y with codes in Chapter Z. Also some candidates lost marks due to incorrectly coding the primary procedure code at the fourth-character level by assigning J10.2 Percutaneous transluminal embolisation of portal vein or J10.5 Percutaneous transluminal thrombectomy of blood vessel of liver.

Question:  Biopsy of the right sentinel inguinal lymph node.

Answer:  T87.7 Excision or biopsy of inguinal lymph node
        O14.2 Sentinel lymph node
        Z94.2 Right sided operation

Candidates failed to apply coding standard PCST3: Sampling, excision, biopsy or drainage of sentinel lymph node (T86-T88, T91.1 and O14.2) and incorrectly assigned T91.1 Biopsy of sentinel lymph node NEC despite the exact site of the sentinel lymph node being known. Some candidates tried to reflect the site of the sentinel lymph node by assigning Z61.6 Inguinal lymph node; however, this is not in accordance with national clinical coding standards.
**Case Studies**

**Index Trails**

Recurrent errors in Case Study 1 concerned the omission of the full Alphabetical Index trails, including essential and non-essential modifiers. Index Trails must include:

- The lead term along with any non-essential modifiers enclosed in parentheses by this term, also any tentative code printed next to this term.
- The essential modifiers which have been used to refine the search for a tentative code, again any non-essential modifiers and tentative codes must also be reproduced. This would need to be repeated for as many essential modifiers are used.
- Index Trails for OPCS-4 should first mention the tentative code followed by the terms for Action, Site, Sub-site and Action Qualifier as relevant since this follows the format of the OPCS-4 Alphabetical Index.

The question asks for Alphabetical Index trails only. There is no need to include text from the Tabular List even in circumstance when the Alphabetical Index directs only to a three-character category. Index trails are required for the Case Study 1 only. Index trails provided for any other case studies will not be considered during marking.

**Case study number 1**

On the whole this question was answered quite well by candidates with the majority getting the correct primary diagnosis, procedure and associated co-morbidities. When marks were lost this was generally in relation to procedure coding.

The most common errors related to use of OPCS code **D13.6 Fitting of external hearing prosthesis to bone anchored fixtures** as either a primary or secondary procedure in addition to **D13.2 Second stage insertion of fixtures for bone anchored hearing prosthesis** despite the actual hearing prosthesis not being fitted during this admission. Some candidates also assigned a subsidiary code from category **Y71 Late operations NOC** to identify the stage of the procedure but as this is already implicit in the body system chapter code then there is no need to do this.

A small number of candidates incorrectly sequenced code **Q17.2 Microtia** in the primary diagnostic field. The main condition treated during this episode of care was the conductive hearing loss, as per coding standard **DCS.VIII.1: Severe or profound hearing loss (H90 and H91)** when the cause for the hearing loss is known both conditions must be coded but sequencing depends on the main condition treated or investigated.
Case study number 2

This question was answered reasonably well by candidates. The most common errors related to the assignment of OPCS codes with either too few or too many codes being assigned that were needed to accurately describe the clinical scenario.

Common errors included:

- Omission of approach codes **Y47.2 Frontal burrhole approach to contents of cranium** and/or **Y53.3 Approach to organ under computed tomography scan control** and to sequence these codes correctly in accordance to coding standard **PCSY6: Approach to organ (Y46–Y52 and Y74–Y76)** which states that codes within category ranges **Y46–Y52 and Y74–Y76** must be sequenced directly following the procedure code that they enhance.

- Omission of a subsidiary Z-site code for the temporal lobe (**Z01.2**) despite this providing further information about the exact site of surgery.

Further to the above many candidates assigned unnecessary codes in an attempt to describe the creation of the subcutaneous pocket that was used to house the pulse generator. However, this is not required since it is an integral part of the neurostimulator insertion procedure and so is all included in the Chapter A code assignment as per coding standard **PCSA3: Neurostimulators (A09, A33, A48 and A70)** which provide the required codes and sequencing for permanent insertion of a neurostimulator beneath the skin.

With regards to the assignment of ICD-10 code the majority of candidates assigned these correctly, However, a handful of candidates were noted to have omitted the required ‘X’ filler character when assigning code **G20.X Parkinson disease**.

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Case study number 3

This question was answered reasonably well by candidates although the diagnostic coding fared much better than the procedure coding.

Most errors in ICD-10 code assignment related to omitted relevant co-morbidities, such as not including all codes for the different clinical states related to use of alcohol. Although most candidates assigned the code for alcohol dependence (F10.2) they omitted the code for acute intoxication (F10.0).

Some candidates assigned the incorrect external cause code fourth-character subdivision to denote the place of occurrence as they had failed to note that a pub is classified as a trade and service area as stated in coding standard DChS.XX.1: External causes.

The main errors in procedure coding concerned use of W24.8 Other specified closed reduction of fracture of bone and internal fixation demonstrating candidates were not aware of coding standard PChSW1: K-wire fixation. K-wire fixation must be coded as rigid fixation (where the option exists). Additional errors in OPCS code assignment were:

- Unnecessary use of Y53.5 Approach to organ under image intensifier when this had only been used to check the position of the fixators.
- Assigning Z83.4 Proximal interphalangeal joint of finger to describe the site of the operation despite the procedure being clearly described as fixation of the phalanx (bone) rather than the adjacent joint. It was clear that these candidates had ignored the Note at category Z81 which instructs that procedures carried out on a single bone of a joint must be coded to the bone site (Z68–Z80) in preference.

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Case study number 4

This question was answered reasonably well by candidates and marks were generally lost due to incorrect assignment of ICD-10 codes.

Some candidates assigned the face to pubes presentation as the primary diagnosis despite the significant tear becoming the main focus of care during this episode.

A large number of candidates mistakenly assigned ICD-10 code O34.2 Maternal care due to uterine scar from previous surgery as they were unable to identify the correct code needed to identify the previous caesarean delivery (O75.7)⁹. A small number of candidates arose some cause for concern as they had incorrectly assigned Z38.0 Singleton, born in hospital despite this being the mother’s delivery episode.

Although the obstetric tear had become the primary diagnosis the primary procedure must remain the delivery itself in accordance with coding standard PChSR1: Coding deliveries (R17-R25), despite this some candidates wrongly sequenced R32.2 Repair of obstetric laceration of perineum and sphincter of anus in the primary procedural field.

Candidates also incorrectly assigned OPCS code R24.9 All normal delivery in preference to a code from category R23 Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument despite this covering the delivery of a face to pubes presentation.

Some candidates omitted to include a code from category R15 Other induction of labour to record the intravenous augmentation while others demonstrated unawareness of coding standard PCSR1: Artificial rupture of membranes (R14.1) as various fourth-character codes were assigned to attempt to cover this.

Case study number 5

This question was answered well by the majority of candidates. The most common error was omission of the procedure code classifying the transthoracic echocardiogram (U20.1). As per coding standard PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37) transthoracic echocardiography must always be coded when it is performed during inpatient episodes.

Other common errors included omission of relevant co-morbidities including congestive cardiac failure (I50.0) and ischaemic heart disease (I25.9). Some candidates assigned J18.9 Pneumonia, unspecified despite the episode summary confirming the presence of lobar consolidation enabling a more specific code to be assigned. As per the general rules for accurate code selection each problem must be coded to the furthest level of specificity, i.e. third, fourth or fifth character, which is available in the classification and supported by the medical record.

Case study number 6

This question was answered to a satisfactory standard.

Although most candidates correctly assigned the primary diagnosis code they omitted to append the dagger († / D) symbol to it to demonstrate the causal relationship with the anaemia. This may have been due to the candidates reading of the question which stated that the anaemia was ‘probably’ due to the cancer. As per coding standard **DGCS.2: Absence of definitive diagnosis statement** terms including ‘probable’ should be accepted and coded as the recorded diagnosis in the absence of any further clarification from the responsible consultant. In some instances when coders had correctly assigned the dagger & asterisk combination there was an unnecessary duplication of C18.2 both with and without the dagger symbol.

A further example of unnecessary additional codes was inclusion of external cause code **Y83.6 Removal of other organ (partial) (total)** following code **K91.4 Colostomy and enterostomy malfunction**. This was not warranted as the prolapse of the ileostomy bud was not related to the hemicolecotomy procedure but to the formation of the external stoma. However, no external cause code is required in this instance since the complication code already describes both the nature of the complication and the procedure that has caused it as much detail as the classification is capable of\(^{10}\).

Common errors in the assignment of OPCS codes were to assign **H07.4 Right hemicolecotomy and ileostomy HFQ** instead of using code **H06.4 Extended right hemicolecotomy and ileostomy HFQ**. It is important to remember that where the abbreviation HFQ (However Further Qualified) is used that it only pertains to the part of the code description which it appears following\(^{11}\). In the case of **H07.4** this is the ileostomy component of the procedure and not the hemicolecotomy which when further qualified as ‘extended’ can be coded elsewhere.

A number of candidates also failed to code **G75.2 Repair of prolapse of ileostomy** which the patient was returned to theatre for as well as the computed tomography (CT) scan of the abdomen and pelvis which can have a significant effect on candidates scores due to number of omitted procedure codes.

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Case study number 7

This question was answered quite well by candidates. Main errors encountered were the omission of relevant secondary codes such as **R33.X Retention of urine** and **Z51.5 Palliative care**. Some candidates incorrectly coded the bladder cancer as a primary malignancy despite it clearly being identified as a secondary cancer of this site. Most candidates were able to correctly code the primary procedure but there were errors in secondary procedure code assignment:

- Incorrect assignment of **Y20.3 Biopsy of lesion of organ** when the procedure did not specify that a lesion was biopsied and as such these candidates have made an incorrect assumption regarding the biopsy procedure. The .9 Unspecified residual codes exist to enable to assignment of codes in the absence of certain information. **Y20.9 Unspecified biopsy of organ NOC** is entirely appropriate in this circumstance.

- Omission of the site code for the biopsy of the bladder outlet was a common mistake.

Another common error in procedure code assignment was the addition of **M47.9 Unspecified urethral catheterisation of bladder**. Although this procedure was performed for urinary retention it was also performed prior to the decision to admit (DTA) had been made in the Emergency Department. Therefore, as per **Ref 60: Clinical coding requirements of admitted patients’ care record following an accident and emergency attendance** only activity carried out after the decision to admit has been made should be coded as part of the Admitted Patient Care (APC) data set, procedures carried out prior to the decision to admit should not be included in the APC dataset.


Paper 2 – Theory

When answering questions in Paper 2 candidates are advised that, to gain marks, it is not necessary to recite in full from the national clinical coding standards reference products the relevant rule, convention or standard that is the subject of the question. Candidates are free to answer using their own words. The examiner awards marks on the basis that candidates have demonstrated the required knowledge in relation to the question.

It may beneficial for candidates to use bulleted lists to structure their answers, so long as there is sufficient detail to answer the question fully. The number of marks available for each question is a good indication of the expected depth of the answer.

Section C

General Theory Short Questions

Question: Describe the Coding Clinic and its function.

Answer: The Coding Clinic is the technical supplement providing new and updated guidance or clinical coding standards for ICD-10 and OPCS-4.

The majority of candidates failed to include all the necessary information to attain full marks for this question. A word-for-word transcription of the above answer is not necessary; answers can be written in the candidates own words as long as the answer describes the relevant points. In this instance the Coding Clinic is described as a technical supplement/supplementary publication, and its function is to provide new and updates clinical coding standards or guidance for the classifications (ICD-10 & OPCS-4). Many candidates chose to answer based on the contents the Coding Clinic describing the comorbidity list in Ref 88. Others described the Coding Review Panel; again this was not relevant for the marks since this is a superannuated body which no longer fulfils the function which candidates were describing.

Question: What is considered a ‘failed or abandoned ERCP’ as stated in the OPCS-4 clinical coding standard?

Answer: Incomplete insertion of the endoscope. Complete insertion of the endoscope but the ampulla cannot be cannulated.

Candidates answered using the more general statements found in coding standard PChSG1: Failed intubation at upper gastrointestinal tract endoscopy as opposed to answering with the more specific detail regarding ERCP stated in coding standard PCSJ2: Failed or abandoned endoscopic retrograde cholangiopancreatography (J43.9).
**Question:** Glossary descriptions exist in multiple chapters in ICD-10, e.g. Chapter V Mental and behavioural disorders. How must they be used in the assignment of codes?

**Answer:** 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.

Most candidates were able to attain a mark for correctly stating that code assignment must be based on the documentation provided by the clinician. However, many failed to note that this must apply even when the clinical diagnosis and glossary description appear to conflict.

**Question:** Where would you find the ICD-10 5th Edition Errata and what should the coder do with it?

**Answer:** It is found in the Coding Clinic and contains all changes that must be made in the printed ICD-10 books.

This question was very poorly attempted by candidates. Examples of incorrect answers include ‘found on Delen’ and ‘found at the back of the reference books’. The errata list compiles all known discrepancies found in the ICD-10 5th Edition books and advises on the necessary changes that must be made to book to ensure correct usage of the ICD-10 5th edition codes. It is concerning that many candidates were unaware of where to find this essential documentation and its purpose.
Paper 2 – Section D1
General Theory ICD-10 questions

Part A

Question (i)
Most candidates were able to attain at least half of the available marks for this question by being able to describe essential modifiers and how they appear in the Alphabatical Index. Many candidates failed to mention the important exceptions to how modifiers appear beneath the lead term. Other common mistakes included confusing essential modifier for lead terms and cross references.

Question (ii)
The question was poorly answered overall. While the majority of delegates included that the use of R52.1 Chronic intractable pain relates to chronic pain affecting multiple organs or body regions they did not go into enough detail about what the standard says about the underlying condition or how to code chronic pain affecting a single body region to attain full marks. Furthermore, many candidates incorrectly stated that R52.1 should be assigned before the underlying condition which is not consistent with the sequencing rules established in coding standard DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings.

Part B

Question (i)
This question was overall well-answered. The most common error was failing to mention that a code from category F17.- Mental and behavioural disorders due to use of tobacco must be assigned in addition to F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances when the patient is also a current smoker. This is regardless of whether the 4th character subdivision denoting the clinical state is the same.

Question (ii)
This question was not very well answered. It was apparent many candidates had not carefully read the question and did not fully understand what was being asked of them. Many candidates drew on knowledge of related standards in their attempts to answer the question (such as DCS.II.1: Primary and secondary malignant neoplasms (C00-C97) & DCS.II.4: Multiple independent primary malignant neoplasms (C97.X)). Many candidates made reference to the list of predominantly secondary sites; however, this was not pertinent information since the question was specifically about those sites not included on this list.

Question (iii)
This was generally well answered. Although the question is specifically about old myocardial infarction a small number of candidates took the opportunity to write about strokes.
**Paper 2 – Section D2**  
**General Theory OPCS-4 questions**

**Part A**

*Question (i)*

This question was very well answered with most candidates demonstrating that they understood the basic principle of coding elective and emergency caesarean sections.

*Question (iii)*

Most delegates who attempted this question performed well. The most commonly omitted answer was that **Chapter X Miscellaneous operations** method of administration codes must not be assigned when coding high cost drugs. A number of candidates did veer away from the actual question being asked and provided detailed answers about coding of high cost drugs in more general terms. Candidates must ensure that they have read the question carefully and answer accordingly. Marks are not awarded for answers which do not directly deal with the subject of the question, regardless of whether the information given is accurate.

**Part B**

This was another reasonably well-answered question with almost all candidates being able to correctly give the full titles for the four abbreviations. There was a noticeable difference in the quality of the answers provided as some candidates were unable to describe the meanings of all the abbreviations or where they were found. NEC was often confused with NFQ.
**Paper 2 – Section D3**

**Clinical Terms**

Answers to this Section were to a better standard than seen in the March 2018 examination although the majority of candidates still fail to achieve close to full marks for either part of this Section. Some candidates failed to grasp the key knowledge pertaining to SNOMED-CT and it is recommended as part of preparation for this examination that candidates review the syllabus for this area to cover any gaps in knowledge. Candidates continue to be unable to distinguish the key benefits of SNOMED from the broader benefits of the Electronic Patient Record (EPR).

**Paper 2 – Section D4**

**Miscellaneous Questions**

This section was generally answered very poorly. There were unanswered questions in each section. Candidates were able to provide some correct statements but very few were able to express all the information required to gain full marks.

**Part A**

I. The majority of candidates who answered this question correctly stated that HES records includes details of operations and diagnoses but few were able to fully answer the question and provide further information on the other kinds of data comprising these records. A summary about HES can be found on the NHS Digital website that covers the basic knowledge candidates must acquire for this exam [https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics)

II. This question was poorly attempted. Most candidates attempting to answer the question simply made reference to Payment by Results or PbR but did not provide a description of what the National Tariff Payment System (NTPS) is. Candidates must refer to the Syllabus and Bibliography which directs to the following online resources hosted on the NHS England website where the required knowledge regarding the NTPS can be found. [https://www.england.nhs.uk/pay-syst/national-tariff/](https://www.england.nhs.uk/pay-syst/national-tariff/)

**Part B**

I. Most candidates made a good attempt at answering this question although few were able to achieve full marks. Most candidates failed to mention that totality of codes is important as it is possible for a list of codes to describe a consultant episode incorrectly in terms of clinical coding rules and standard seven though the individual codes selected are correct.
**Paper 2 – Section E1**

**Anatomy & Physiology**

This section was in general well attempted by the majority of candidates. Correct spelling is required when answering questions in the anatomy and physiology section. This is considered important as incorrect spelling may indicate a different body part to the one the question is asking for *e.g.* ilium (pelvic bone) and ileum (part of the small intestine).

**Question:** Three systems are referred to when considering blood circulation; describe the action and nature of the pulmonary circulation.

**Answer:** The circulation of blood from the right ventricle of the heart to the lungs (where oxygen is absorbed and carbon dioxide is excreted) and back to the left atrium.

Common incorrect answers included confusing the left and right sides of the heart and stating atrium rather than ventricle.

**Question:** Describe the location and function of the thymus gland.

**Answer:** Situated in the upper thorax and neck is the thymus gland. It helps to fight infection by assisting in the maturation of lymphocytes.

Incorrect answers included stating that the thymus gland was located in the brain.
**Paper 2 – Section E2**

**Medical Terminology**

This section was generally well attempted with all questions being generally well answered.

**Question:** What root word is used to describe the ‘vertebra’ or ‘spinal column’?

**Answer:** Spondyl-

For those that attempted the question incorrect answers included spondy, myle, spine and spondylo which is incorrect as the candidate has included the combining vowel ‘o’ which is not a part of the root word.

**Question:** What two prefixes mean ‘above, beyond, superior’?

**Answer:** Super- and supra-

This was very poorly answered. Examples of incorrect answers given were hyper, epi and peri.

**Paper 2 – Section E3**

**Diagrams**

The diagrams were accurately labelled by the majority of candidates demonstrating that this is a section of the exam for which many candidates were well-prepared.

The Upper digestive system diagram (E3 [a]) was well-answered by all candidates.

Unfortunately a number of candidates lost marks when labelling the Interior view of the ear diagram (E3 [b]) due to only giving part answers to the diagrams and for incorrect spelling. Commonly misspelled words included malleus, Eustachian and cochlea for the diagram of the ear and lumbar which was frequently misspelled as lumber.

**Further information:**

The Institute of Health Records and Information Management (IHRIM) is primarily an educational body and provides qualifications at different levels as well as career and professional assistance for members.

The Institute encourages professionalism and a structured examination system exists for those who wish to obtain a professional qualification.

IHRIM is awarding organisation for the National Clinical Coding Qualification.

Further information about membership and registration can be found at [http://www.ihrim.co.uk/](http://www.ihrim.co.uk/)