DSC Notice: 12/2007
Date of Issue: May 2007

NHS Information Standards Board

Sponsor Organisation:	Implementation Date: Immediate
NHS Connecting for Health	Subject: **Data Standards: Update to Clinical Coding Introduction**

DATA SET CHANGE NOTICE

This paper informs users of changes to the NHS Data Model or the NHS Data Dictionary that have been approved by the NHS Information Standards Board

Summary:

The classification of interventions and procedures was enhanced and a new version implemented in 2007 (OPCS-4.4) (DSCN 10/2007). As a result, paragraphs 46 to 51 of the Clinical Coding Introduction of the NHS Data Dictionary are out of date.

To support the new version, the NHS Data Dictionary has been updated in the following areas:

- Clinical Coding Introduction (supporting information):
  - paragraphs 46 – 51 have been updated to reflect implementation of OPCS-4.4. This updated information does not change the technical content or code values within the NHS Data Dictionary
  - the website links have been updated to reflect the change of website addresses of NHS Data Standards and Products and the NHS Classifications Service
  - the layout of the page has been updated to correct errors with the spacing and layout.

Datasets / return affected:

Related DSCNs

DSCN 10/2007 - OPCS Classification of Interventions and Procedures Version 4.4

Impact of Change:

Service:	Minor	**System Suppliers:**	Minor

The NHS Information Standards Board (ISB) is responsible for approving information standards. This change has been appraised and approved by ISB

More information about the ISB can be found at www.isb.nhs.uk
Data set change notices can be found at www.connectingforhealth.nhs.uk/dscn

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 869
Version No:	1.0
Subject:	Update to Clinical Coding Introduction
Type of Change:	Changes to NHS Data Standards
Effective Date:	Immediate
Reason for Change:	Paragraphs 46 to 51 of the Clinical Coding Introduction require updating

Background:

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Summary of changes:

Supporting Information

CLINICAL CODING INTRODUCTION Change to Supporting Information

Date: 30 April 2007
Sponsor: Ken Lunn, NHS Connecting for Health

Note: New text is shown with a blue background. Deleted text is crossed out. Within the Diagrams deleted classes and relationships are red, changed items are blue and new items are green.

CLINICAL CODING INTRODUCTION

Change to Supporting Information: Change to Supporting Information

CLINICAL CODING

A. International Classification of Diseases (ICD-10)

1. The International Statistical Classification of Diseases and Related Health Problems (ICD) is a comprehensive classification of causes of morbidity and mortality, and is published by the World Health Organisation. The previous 9th revision (ICD-9) was published in 1975 and came into use in hospital information systems in 1979. It was superseded by the 10th revision (ICD-10) from April 1995.

2. ICD permits the systematic analysis, interpretation, and comparison of morbidity data collected in different areas and at different times. Thus, the specified purpose of the ICD is to provide a means

of classifying medical terminology and is defined as a system of categories to which morbid entries are assigned according to established criteria.

3. Categories have been chosen and logically sequenced to facilitate the statistical study of disease phenomena. A specific disease entity that is of particular public health importance, or that occurs frequently, has its own category. Otherwise, categories are assigned to groups of separate but related conditions.

4. Each category has a title reflecting its composition, and an alphanumeric code as a means of unique identification.

5. ~~ICD-10 is published as a three volume set:~~

   - ~~Volume 1 is the Tabular List, comprising a descriptive classification of diseases and injuries, supplementary classifications, and appendices;~~
   - ~~Volume 2 is the Instruction Manual which contains the World Health Organisation's guidelines for coding;~~
   - ~~Volume 3 is the Alphabetical Index to diseases and nature of injury. It covers external causes of injury and provides a Table of drugs and chemicals.~~

6. ~~In addition, NHS Data Standards & Products also distributes the following files;~~

   - ~~codes and titles file, containing a list of ICD-10 codes together with abbreviated titles;~~
   - ~~metadata file, containing codes, titles and validation criteria for each ICD-10 code;~~
   - ~~tables of equivalence files, identifying the relationship between ICD-9 and ICD-10 codes.~~

7. ~~Further details regarding the use of individual diagnostic fields within the minimum dataset HES record format will be found within each listed HES record, see Messages Menu.~~

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7. Further details regarding the use of individual diagnostic fields within the minimum data set HES record format will be found within each listed HES record, see Commissioning Data Sets Menu.

Coding Standards

8. ~~The following standards have been developed to provide specific instruction in areas where ICD-10 allows a variety of approaches to be taken. Readers may wish to refer to Volume 2 of ICD-10 to obtain further information. Further detailed standards are included in the A&E Diagnosis Tables Instruction Manual; the *Coding Clinic* insert of the Data Quality Review Newsletter publishes changes to national standards and these are included in the next following amendment set to the Instruction manual. The Data Quality Review Newsletter is available from NHS Classifications Service.~~

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Adoption of basic coding guidelines (cf: Vol 2, 3.3 p28)

9. The basic principles of the classification, particularly those relating to basic coding guidelines and the structure of the classification, as detailed at 2.3 and 2.4, pages 11-13 of Volume 2, are to be adopted as the standard for the implementation of ICD-10.

Priority of Allocation to Special Groups (cf: Vol 2, 2.4, p13)

10. Where a diagnosis could be coded to either a Special Group Chapter or any of the other chapters, then it should always be coded to the appropriate Special Group Chapters.

11. Special Group Chapters include those chapters relating to epidemic diseases, constitutional and general diseases, developmental diseases and injuries. Therefore, these should be used in preference to chapters relating to local disease arranged by site.

Use of U and other unused codes (cf: Vol 2, 2.4.7, p17)

12. ~~Codes U00 – U49 are reserved by the World Health Organisation for the future provisional assignment of diseases of uncertain etiology. Codes U50-U99 are potentially available for local use, for instance in research. However, no U codes may be used unless specifically designated for use by the NHS Classifications Service.~~

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Filler "X" character for three character codes

13. Insertion of the character "X" into the fourth field of codes where only three characters exist is mandatory. This provides a standard "filler" character. The fourth character ,"X", is only applicable to UNDIVIDED three-digit codes for which no valid fourth character exists; it is not an option for completing diagnoses which have not been coded to 4 - characters.

Use of fifth character

14. The fifth character will continue to be available for use within the entire Musculo-skeletal Chapter. Its use is recommended when the data is present in the source document, and where doing so adds information.

15. The fifth character for open fractures/internal injuries will continue to be available for use within the entire "Injury" section within the "Injury, poisoning and certain consequences of external causes " Chapter. Use of fifth character is recommended.

Use of Specialty-based adaptations

16. WHO have provided an undertaking to ensure that any such classification endorsed by them will be fully compatible with the main classification at the fourth character level, but will not necessarily be compatible either at the fifth character level or with each other. For instance the meaning of a five character code in one Specialty adaptation can be quite different in another.

17. Use of such classifications, including the Royal College of Paediatrics & Child Health (formerly British Paediatric Association (BPA)) Classification of Diseases, and the application of the ICD to

Dentistry and Stomatology is optional.

UK extensions to ICD-10

18. It is not intended to issue or support extensions to ICD-10. The other extensions previously issued for use with ICD-9 have either been incorporated into ICD-10, are no longer relevant, or are covered by separate arrangements.

Guidelines on coding "main" and "other" conditions, etc

19. Guidelines for coding "main condition" and "other" conditions, rules for reselection when the main code is incorrectly recorded, and chapter-specific notes are provided in Vol 2, 4.4.2-4.

20. **Primary Diagnosis** has been defined and was mandated for use in England from 1 April 1996. It is:

    - ~~the main condition treated or investigated during the relevant episode of healthcare,~~ ~~**and**~~
      ~~where there is no definitive diagnosis, the main symptom, abnormal findings or problem.~~
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      where there is no definitive diagnosis, the main symptom, abnormal findings or problem.

~~Using Secondary Diagnosis fields~~
Using Secondary Diagnosis fields

21. The secondary diagnoses fields follow the primary diagnosis.

Status of "are for use with" characters (cf: Vol 1 pp276, 320, 680, 724, 1013, 1026, 1027, 1029, 1032, 1034, 1037, 1039, 1042, 1052)

22. Where the phrase "are for use with" is seen, this instruction is mandatory, and the codes referred to must be used. **Note:** these characters represent the fourth character subdivision of the related categories.

Status of "if desired" codes (cf: Vol 1 p496)

23. Where the phrase "if desired" is seen, in relation to coding additional information, where that information is present in source documentation this instruction is not optional.

Multiple body sites

24. Single codes identifying multiple body sites must not be used where the information is available to enable use of individual codes, with the exception of those identifying bi-laterality of the same limbs and apart from those specific instances detailed in other paragraphs in this section.

Dagger and asterisk system (Vol 2, 3.1.3, p20)

25. Provision has been made for dual classification by aetiology (denoted by a "† " or dagger symbol), and manifestation (denoted by a "*" or asterisk symbol).

26. Where conditions to be coded correspond to dagger/asterisk pairs, both should be recorded, in succeeding fields, with the dagger code first. Multiple asterisk codes with one dagger code are not allowed, due to validational difficulties. Each asterisk code must, therefore, be preceded by its own dagger code, even where this means repeating dagger codes.

27. Alpha characters are to be used instead of daggers and asterisks because of possible confusion with other characters (not all keyboards carry a uniform dagger symbol, but all carry uniform

alpha characters). Upper case "A" (asterisk) and upper case "D" (dagger) should be used.

28. For those codes which include a dagger or an asterisk, the appropriate symbol should always be entered at the sixth position in the code.

Identification of Infecting Organism (cf: Vol 2, 3.1.3, p22 and Vol 1, p178)

29. Where the name of the Infecting Organism is not identified in the title of the three character rubric, an additional code must be used when the infecting organism has been identified.

Functional Activity of Neoplasms (cf: Vol 2, 3.1.3, p22, and Vol 1, pp182, 271)

30. These codes should be used as appropriate i.e. as defined in national standard training.

Organic, including Symptomatic, Mental Disorders (F00-F09) (cf: Vol 2, 3.1.3, p22 and Vol 1, p312)

31. The use of these categories is mandatory when the data is present in source documents and when recording it helps to identify all the elements of the diagnostic statement as presented in the case note.

Toxic Agents (cf: Vol 2, 3.1.3, p22)

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

Multiple coding of multiple injuries (cf: Vol 1, p892)

33. The single code for "multiple injuries" is only to be used where no further detail is present in source documents.

Nature of Injury (cf: Vol 2, 3.1.3, p22 and Vol 1, p1011)

34. Coding of both the external cause and the actual injury is mandatory where the information is present in source documents.

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

Alcohol Involvement (cf: Vol 1, p1122)

36. The use of these codes is recommended when the data is present in the source documents. These codes must not be used in isolation.

Use of Morphology codes

37. The use of morphology codes is optional. They can be used for local purposes, or where systems are provided for their transfer to Cancer Registers, but must be kept distinct from ICD-10 diagnosis codes.

Use of ICD-0

38. Where data is collected using ICD-0 (Oncology) classification, recording of both topographical and morphological codes is mandatory, as is translation of the data to ICD-10 using the appropriate conversion tables. Conversion tables are obtainable from the National Cancer Institute, EPN343J, Bethesda, Maryland, 2089, USA.

Unknown/unspecified causes of morbidity/mortality (cf: Vol 1 pp879, 890)

39. ICD-9 code 799.9 was used in cases of undiagnosed disease where the site or system involved had not been specified, and for unknown causes of morbidity and mortality. These categories must not be used where further information is available from any source e.g. test results, admission books, casualty records, X-ray records.

40. ICD-10 has two codes for these purposes:

- R69X Unknown and unspecified causes of morbidity;

~~R99X Other ill-defined and unspecified causes of mortality.~~
R99X Other ill-defined and unspecified causes of mortality.

~~**Diarrhoea and Gastroenteritis (cf: Vol 1, p112)**~~

Diarrhoea and Gastroenteritis (cf: Vol 1, p112)

41. Currently in the UK Diarrhoea and Gastroenteritis are presumed non-infectious in origin and must be coded to K52.9 in the absence of a clinical description of the disease as infectious.

HIV Coding

42. Use of the fourth character sub-divisions of B20-B23 to identify specific conditions is recommended where the information exists. Conditions classifiable to two or more subcategories of the same category should be coded to the .7 subcategory of the relevant category; the resulting conditions should then be coded as 'other conditions'. Double coding should only occur where value and specific detail is added. The exceptions to the rule are malignant neoplasms, where there is a need to identify malignant neoplasms for Cancer Registers. It is therefore necessary to double code these conditions with the appropriate B21 code plus the neoplasm code from Chapter II.

B. Read Coded Clinical Terms

43. The Read Coded Clinical Terms are a comprehensive computerised coded thesaurus for use by clinicians. They are available in three main formats, known as Version 3, Version 2 and the 4-Byte sets, and are designed for use in the electronic health care record. Version 3 of the Read Codes is a "Superset" of the earlier versions as it contains all codes and terms from Version 2 and the 4-Byte set.

44. Read Coded Clinical Terms may be used for coding within local systems but are not acceptable directly for coding Hospital Episode Statistics which are extracted from Admitted Patient Care CMDSs. Version 3 and Version 2 of the Read Codes both, however, contain mapping tables which can be used to generate ICD-10 and OPCS-4 codes.

45. For further information; see Contact Details.

~~C. Classification of Surgical Operations and Procedures (OPCS-4) Fourth Revision Consolidated version~~
C. OPCS Classification of Interventions and Procedures

46. ~~The classification of Surgical Operations and Procedures was originally issued by the Office of Population Censuses and Surveys (OPCS). The 4th revision was first implemented in hospital information systems in 1987. This was subject to a significant number of amendments and a consolidated version was reproduced in 1990.~~

46. The classification of Surgical Operations and Procedures was originally issued by the Office of Population Censuses and Surveys (OPCS). The 4th revision was first implemented in hospital information systems in 1987. This was subject to a significant number of amendments and a consolidated version was reproduced in 1990 with future updates to reflect on-going maintenance.

47. The classification of interventions and procedures (OPCS-4.2) was substantially enhanced and a new version implemented in 2006 (OPCS-4.3) with a commitment to undertake annual review and potential update. This will be continued until further notice.

47. ~~The 4th revision was presented in a totally new format, being brought more into line with the ICD-10, and comprises a list of alphanumeric codes.~~

48. From OPCS version 4.3 onwards, the classification comprises a list of alphanumeric codes with mainly anatomically based chapters, most of which relate to the whole or part of a system of the body. Each is designated alphabetically e.g. Chapter A covers the nervous system and Chapter K the heart. The alphabetic character for each chapter forms the leading digit of the 3 and 4 digit codes within it. Chapters are based on body systems with specific operations being listed for individual organs.

48. ~~Chapters are based on body systems with specific operations being listed within individual organs, with each chapter. In general, the operations are listed in descending order of complexity.~~

49. There are instances where an existing category needs extension. In such cases, and dependent on the chapter capacity, an extended category is added within the Tabular List chapter. These categories are referred to as principal category or extended category and identified by an accompanying note to ease navigation.

49. ~~There is an additional chapter (Chapter X) for operations on multiple systems, using miscellaneous procedures.~~

50. Chapters that have reached capacity are then extended using alphanumeric categories which are assigned using the free alpha O. This has occurred within three chapters (Chapters L, W and Z). Codes created in this way still form part of an existing chapter even though they have a different alpha prefix to the rest of that chapter. Such new codes will, therefore, logically sit at the end of the body system chapter and are readily identified within the alphabetical index. There is an additional (Chapter X) for operations on multiple systems using miscellaneous procedures.

50. ~~There are two supplementary chapters (Chapters Y and Z) for method and site of operation. These codes should never be used in primary position – they are to be used in addition to codes from the other chapters where the specific detail is not present within the main categories.~~

51. The list of High Cost Drugs can be found in the Alphabetical Index. A separate detailed listing of common chemotherapy regimens used in the treatment of neoplasms is provided on the website at Chemotherapy Regimens for OPCS-4.4.

51. ~~The classification is published in two volumes. The Tabular List is available from HMSO. The Alphabetical Index is available in hard copy and electronic format from~~ ~~NHS Classifications Service~~.

52. The classification is published in two volumes. The Tabular List and Alphabetical Index are available from The Stationary office.

D.~~A&E Diagnosis Tables Structure~~
A&E Diagnosis Tables Structure

53. A review of the A&E minimum data set identified the need for a national set of codes to be used in A&E departments to reflect activity relating to diagnosis. These codes were developed and are used in the A&E MDS.

54. In developing the coding and classification structure, the following criteria were used:

    - the coding should involve minimal change from structures currently used in computerised A&E Departments;

the information produced should be relevant for MDS purposes and therefore specify the minimum level of detail that users of A&E information would require;

the coding structure should facilitate coding for more detailed analysis at the discretion of individual A&E departments;

~~the structure should, where possible, avoid potential ambiguities where more than one code would accurately reflect an A&E attender's condition.~~

55. ~~The recommended classifications and coding structure are presented in the following tables:~~

~~A&E Diagnosis Tables~~

~~A&E Investigation Table~~

~~A&E Treatment Tables~~

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A&E Diagnosis Tables

A&E Investigation Table

A&E Treatment Tables

For enquiries about this Data Set Change Notice, please email datastandards@nhs.net